Baseline Survey on the Most Prevalent HTP and Sanitation Practices among the Community of the Hamer, Dassenech, and Nyangatom Woredas of the South Omo Zone in the SNNPRS

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
BCC	Behaviour Change Communication
BoSP	Bureau of Statistics and Population
EDHS	Ethiopian Demographic and Health Survey
EPaRDA	Ethiopian Pastoralist Research and Development Association
EGLDAM	Ye Ethiopia Goji Lemadawi Dirgitoch Aswagaji Mahber
EM	Early Marriage/child marriage
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FP	Family Planning
FUS	Follow Up Survey
HIV	Human Immunodeficiency Virus
HU	Health Unlimited
HTPs	Harmful Traditional Practices
IEC	Information, Education, Communication
IGA	Income Generating Activity
KII	Key Informant In-depth Interview
MBA	Marriage by Abduction
MTE	Milk teeth extraction
MOH	Ministry of Health
NCTPE	National Committee on traditional Practices of Ethiopia
NGO	Non-governmental organization
PA	Pastoralist Association (Sub-district level, smallest administrative unit)
Q1	Questionnaire one – The structured Questionnaire
Q2	Questionnaire 2 – key informant In-depth Interview
SNNPR	Southern Nation Nationalities and Peoples Region
TBAs	Traditional Birth Attendants
TOR	Terms of reference
UC	Uvula cutting
WHO	World Health Organization

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The Consultant Team

EXECUTIVE SUMMARY

In South Omo there are 16 indigenous ethnic groups that have different traditional practices. Among these 7 of them are living in Hamer, Dassenech, and Nyangtom districts. Previous studies have documented severe HTP like Mingi, forced abortion, whipping during cattle jumping and others in these three districts. In line with this, SCN-E has recently launched a new project entitled *Supporting Community Changes through the Abandonment of Harmful Traditional practices (HTPs) and Promotion of Health and Sanitation for the Wellbeing of Children in the Hamer, Dassenach, and Nyangatom woredas of the Southern Nations, Nationalities and Peoples Regional State (SNNPRS) of Ethiopia.* The main objective of this baseline survey is to generate baseline information including basic indicators of KAP on HTP and WASH that will primarily serve as a benchmark in gauging post project intervention status of the problem as well as progress of the project in bringing about the intended changes and to what extent the project has achieved its objective. It has 6 specific objectives focusing on KAP on HTP and WASH including the identification of activities performed, challenges and gaps to come up with feasible recommendation for the success of the project and sustainability of the results expected to be achieved by the project.

The study was conducted in Hamer, Dassenech, and Nyangtom districts. Document review and both quantitative and qualitative data collection method have been used. Review of National Baseline Survey on Harmful traditional practices conducted by NCTPE, the study conducted by SNNPR Statistics and Population Office and the study conducted by Health Unlimited in South Omo were consulted. Under the quantitative approach 1208 individuals above the age of 15 years have been interviewed using a structured questionnaire from the three district's capitals and rural kebeles to incorporate the six ethnic groups residing in Hamer, Dassenech, and Nyangtom districts. Under the qualitative approach 60 key informants in-depth interview and 10 FGDs were performed by the research team. The quantitative data were entered and analyzed using SPSS.

A total of 12 and 25 different types of beneficial and harmful traditional practices have been identified by the key informant in-depth interview (KII) respondents and focus group discussion (FGD) participants respectively. In-depth information have been collected on 12 selected HTPs and produced important indicators such as information coverage on HTPs, Knowledge, attitude and intention. Major findings are highlighted below:

- The key informants and FGD participants have identified 12 Priority HTPs which are grouped in to two. The first group are those priorities from 1- 7 and includes whipping, forced abortion, *Mingi*, inheritance marriage, old aged man marrying young girl (*yalachagabecha*), FGM, and MTE. Group two consists of

the remaining five HTP as second categories (EM, MBA, excessive feast, Skin cutting around the chest (*dretmeteltel*) and Robbery/killing each other.

- Information –74..8%, 67.2%, 60.1%, 58.6%, 58.4% and 56.6% of the respondents got information on MBA, inheritance marriage, Mingi, MTE, EM and excessive feast respectively. It is below 55% among the rest four HTPs. The major sources of information varies based on the type of HTP mainly meeting places for most HTPs while health facilities for UC and MTE.
- Knowledge- Above 65% of the respondents considers *Mingi*, forced abortion and MBA as harmful traditional practices. The rest lies between 60 to 65% while it is below 60% for MTE and whipping.
- Attitude/intention – Over 60% of the respondents support the eradication of and promised not to perform 9 different HTP included in the current studies except MTE and Whipping.
- Prevalence- The prevalence of whipping, forced abortion, widow's inheritance, FGM, milk teeth extraction and UC are 18.5%, 8.9%. 18.2, 23.6, 36.7 and 18.6 respectively.
- Knowledge of the respondents on modes of transmission of communicable disease through water and sanitation is at minimal stage and their support for the construction of latrine is below average.
- The major sources of water are river and *chiroshe* and the majority of the community members do not have latrine and those with latrine are not using it properly and continuously.

The current assessment has shown that sever harmful traditional practice like whipping, forced abortion, *Mingi*, inheritance marriage, Old aged man marrying young girl, burning around the chest (*deretmeteltel*), FGM, MTE and others do occur in the three districts at different magnitude. There is an attempt to disseminate information on the negative effect of these sever HTPs. However, a lot has to be done to reduce these sever HTP from the community. About 9 different gaps and future intervention strategies in the area of BCC, perpetrators, victims, legal application and capacity building have been suggested by the qualitative respondents. This suggestion should get due consideration by the project implementers during the intervention program. Based on the current assessment result the following points are recommended:

- Adopt indigenous communication mechanisms to reach the remotest PAs of the study area through community members at market places, religious institutions and CBO like *Debo* or *Jege*. Community promoters, club members and community based reproductive health (CBRH) workers could be encouraged to pass the information to grassroots level. At the same time use interpersonal

communication in the form of peer education to bring attitudinal change among individuals and CC to have common decision against sever HTP.

- In the process of sustained and consistent education intervention the project can use: Health facilities and workers to play an important role in awareness raising and in other responses to HTPs. It can also support to school based initiatives (clubs, teachers against HTPs, pupils/students against HTPs …) including provision of updated education materials appropriate to school youth. It is important to involve more and more schools in HTP networks and advocate for strengthening curricular material on HTP both for students and teachers' trainings.
- Establishing and continuously updating a registry of practitioners in the community and following them up, informing them on the laws regarding HTPs, Providing HTP practitioners with training for alternative employment and/or income generating activities and encouraging them to serve as change agents can bring behavioral change. Taking legal measures on recalcitrant practitioners; those who do it secretly in particular will be a model for others.
- In relation to the law it is advisable: a) Relating, as much as possible, formal legal provisions with traditional/customary laws/norms to make them easily accessible and acceptable to the communities and more easily implemented b) educating the population in general about the legal provisions and c) to do advocacy to strengthen the implementing capacity of law enforcement authorities.
- It is also advisable to give legal, medical, psychological and economic support as required and feasible to victims of HTPs like women who faced fistula and complications of illegal abortion, widows' inheritance. This also assists to bring practical behavioral change if the project mobilizes victims as change agents and invite them to share their experience for community members.
- Family planning practice can be promoted in the project area extensively to reduce the two practices significantly as the cause for illegal abortion is fear of *Mingi* and one of the reasons for the classifying a child as *Mingi* is when s/he is born outside of marriage, without fulfilling the *Denb* and in a short time interval following another birth.
- Concerning *Mingi* the long-term solution should be to demystify the belief associated with children classified as *Mingi*. Where as in the short term it is advisable to give an option for elders of the community to transfer children to government and non-government organizations who can assist in their upbringing instead of killing, throwing to the hill or abandoning them outside of their areas.

- It is very important to integrate the issues of marriage through widow's inheritance and milk teeth extraction with efforts of preventing HIV transmission. As a long term solution the practice of widows' inheritance must be removed from the community. Interventions should aim at eradication of the practice. But, as suggested by the FGD participants, as a short term solution it is advisable to teach people take HIV test before this marriage.
- It is advisable a) to substitute the expression of love during cattle jumping by local dances instead of whipping; b) develop appropriate educational materials against the negative effects of whipping (including the potentials for HIV transmission) and c) to educate the harmful effects of the bad belief associated with wasteful expenses for rituals in regard of a dead person in family, like *Gelo*.
- In relation to child marriage and abduction, specific measures should be taken to promote: Community collective decision on these practices through community dialogue, girls' education (high enrollment, low drop out…) and Status of women empowerment at different levels
- Concerning FGM it will be good to encourage total eradication instead of harm reduction, Use Community Conversation, encourage the community form non – FGM areas to share their experience and to involve the young boys to declare marriage with uncircumcised girls as FGM is performed around marriage in the study area particularly in Erbore.
- In order to ensure the sustainability of water, sanitation, and hygiene practices it is recommendable to strengthen the public sector working on WASH program like the health extension program who are in charge of training and supervising community health promoters who directly work with the community with help of both interpersonal communication and group dynamics since the study area community are leading more of communal life and are egalitarian. Thus, it would be also advisable to associate any of WASH program intervention with community structures and community/opinion leader to challenge established pattern of behaviors or social norms related with WASH for sustainable program intervention.
- It would be vital to design community based WASH program in which the community would identify its WASH related program, plan interventions and implement and evaluate the program using participatory review and reflection process (PRRP). For example, if the program has intended to avail potable water services, the community need to identify the problem, select construction site, establish committee to run the construction process and take the responsible of water point maintenance and protection.
- It would also be vital to empower women through providing water management

knowledge and skill in this issue since it is women and children who are in charge of this vital resource for the household. One type of community based WASH program is Community Led Total Sanitation (CLTS). It is an approach that facilitates a process of empowering local communities to completely eliminate open defecation and build and use latrine without any external hardware support. Communities conduct their own appraisal and analysis of open defecation and take their own action to become open defecation free. By raising awareness that as long as even a minority continues to defecate in the open everyone is at risk of disease, CLTS triggers the community's desire for change, propels them into action and encourages innovation, mutual support and appropriate local solutions, thus leading to greater ownership and sustainability

- Concerning capacity building, different activities like giving training, experience sharing, coordination, networking and mainstreaming should be encouraged in the project areas by establishing task force at district and kebele level. It is advisable to use these partners for the project implementation, establish link of reporting system between kebele and district and finally encourage them to take over during exist strategy for sustainably.
- The activities planned under the current project are more or less in agreement with the current finding. Especially on BCC and Capacity building thematic areas. We suggest the program will be more fruit full if it includes the issue of assisting victims of HTP and use them as change agents. It is also important to identify perpetrators to convince them and use them as change agents. Introduce legal application for grave HTPs like whipping women during cattle jumping, forced abortion, old man marrying young girls (*yalachagabecha*) and others in due course of time.

1. INTRODUCTION

1.1 Background

Ethiopia has over 80 ethnic groups whose cultures are rich and varied as their compositions. The country has beneficial traditional practices such as breast feeding, settling quarrels, social gathering and others that can be examples for the external world. On the other hand, there are harmful traditional practices that affect the health and social well-being of women and children in the country. Some of these practices include female genital mutilation, early marriage, abduction, milk teeth extraction, uvulectomy, bloodletting and others that seriously affect the health of children and contribute for the transmission of HIV/AIDS (NCTPE 1998 Baseline Survey on Harmful Traditional Practices in Ethiopia).

Women and children who are the vast majority of the population suffer from harmful traditional practices, work stereotypes and gender distribution of labor. Harmful traditional practices are the most humiliating and degrading experiences to girls and women. Female Genital mutilation (FGM), marriage by abduction, milk teeth extraction, uvulectomy, tonsillectomy, soiling the umbilical cord, incision and others are the common HTPs that affect children in SNNP (The Bureau of Statistics and Population (BoSP) of SNNPR, 2005). Traditional practices vary by different ethnic group. In SNNPR over 56 different indigenous ethnic groups are residing and the number and types of HTP varies among these ethnic group. In South Omo Zone alone there are 16 different types of ethnic group residing in different districts. Among these almost half, about 7 of them are residing in Hamer, Dassenech, and Nyangtom districts.

Save the Children Norway-Ethiopia (SCN-E) is an international non-governmental organization with an overall goal of contributing to the national initiatives to fulfill children's rights and address their basic needs, SCN-E's vision is to see a world in which every child attains the right to survival, protection, development and participation, Its mission is to inspire breakthroughs in the way the world treats children, and to achieve immediate and lasting changes in their lives. Accountability, ambition, collaboration, creativity, and integrity are the shared values of the organization SCN-E works in various regions of Ethiopia particularly in the Amhara, Oromia, Afar, and Southern Regional States.

SCN-E has recently launched a new project entitled supporting community changes through the abandonment of Harmful Traditional practices (HTPs) and promotion of health and sanitation for the wellbeing of children in the Hamer, Dassenach, and Nyangatom woredas of the Southern Nations, Nationalities and Peoples Regional State (SNNPRS) of Ethiopia. The three project woredas are found in South Omo Zone, which is one of the 13 Zones in the region, and they are predominantly populated by pastoralist

communities who are mostly characterized by livestock rearing and have a mobile or semi-mobile lifestyle subject to the availability of water and pasture. In all development aspects, the three woredas are categorized as some of the most underserved and disadvantaged areas in Ethiopia. Consequently, children suffer from easily preventable disease caused by lack of clean drinking water and poor sanitation. A number of horrible Harmful Traditional practices (HTPs) including *Mingi* - this is killing of children for various superstitious reasons - are also inflicted on children and women in particular.

The project has the purpose of contributing to the overall survival, development, protection, and wellbeing of children in the woredas with the following specific objectives.

- To reduce the prevalence of harmful traditional practices through Enhancing awareness of more than 130,000 (female: 67,000; male: 63,000) community members in the three intervention woredas.
- To improve the sanitation, hygiene, nutritional, and health status of 6000 Children through promoting school based health and nutrition in early Childhood development centers, Alternative Basic Education (ABE) Centers and primary schools.
- To provide Water, Sanitation, and Hygiene (WASH) services for 3,000 childhood Development (ECD) facilities for 600 preschool children (3-6 year).

1.2 Objectives

The main objectives of this baseline survey will be to:

1. Identify the most grave harmful traditional practices in the three woredas and assess their current status/prevalence rate and underlying causes behind the practices
2. Assess on the level of knowledge, attitude and practice of the communities in the woredas towards these harmful traditional practices
3. Assess on the status, knowledge, attitude, and practice of children and other members of the communities in the woredas vis-à-vis hygiene and sanitation
4. Identify measures taken and or being taken by other actors in the woredas to alleviate problems that related to harmful traditional practices, hygiene, and sanitation
5. Identify what the challenges and gaps would be in addressing the problems of harmful traditional practices, hygiene, and sanitation in the woredas
6. Come up with feasible recommendation for the success of the project and sustainability of the results expected to be achieved by the project.

The geographic scope of the survey is limited to three adjacent wordas of South Omo Zone in SNNPR and these woredas are namely, Hamer, Dessenech, and Nyangatom. The survey has the overall objective of generating basic indicators of KAP on HTP and WASH and understanding on the underlining causes and status of the major harmful traditional practices in the three woredas as well as to understanding the levels and overall situations of hygiene and sanitation practices of the communities in the woredas.

2. METHODOLOGY

2.1 General

The current assessment used participatory and other technically acceptable assessment tools to provide the basic indicators and area specific recommendations. The assessment was participatory involving partners and key informants for in-depth interview and group discussions. Under this assessment, the first step was to make a thorough review of literature and to look into past studies so as to document best practices. According to the TOR, the following methods were applied to conduct this baseline survey on HTP and WASH:

1. Review of available documents including project related documents, studies undertaken and data collected by NGOs and government offices
2. Collection of quantitative information from the general public using standard quantitative methods
3. In-depth Interview (structured/semi-structured, open ended) with NGOs, sector offices, staff members, community leaders, traditional healers, TBAs, teachers, elders and mothers
4. Focus Group Discussions (FGDs)

Both quantitative and qualitative approaches were applied. Under the quantitative approach, a structured questionnaire was prepared, translated and piloted and administered through interview of individuals from households that were included in the sample. Under the qualitative approach, in-depth interview of key informants and FGDs were conducted at kebele and woreda level. In general, in order to achieve the objectives of the assessment different methods of data collection were employed. Each method is highlighted below

Desktop Review: Secondary sources of information were used in order to generate valuable data. Furthermore, to comprehend deeply the situation of HTPs in the three woreda various reports, including survey findings and other written documents were used as secondary sources from various ministerial offices and bureaus and other key stakeholders like CSOs and UN agencies. This helped to design appropriate instrument and to link the assessment with theories and conceptual frameworks.

Focus Group Discussion (FGD): Focus group discussions were conducted with traditional leaders/opinion leaders, women, male and female children under the age of 18 years and mix of both sex. FGD guideline was developed in relation with objectives of the baseline survey and employed in all the study woredas.

In-depth Interview: A semi structure questions was employed to various government offices such as SNNPR's Education Bureau, Women, Children and youth affairs Bureau and Health Bureau. This was done also with woreda women, children and youth's affair, education and health departments. Other sectors such as selected NGOs

and UN agencies working in the assessment areas were interviewed about grave HTPs and situation of total sanitation and hygiene practices in the selected three woreds.

Participatory Action Research (PAR): was conducted with children in the project area. This was performed by explaining the problem for children and allowing them to explain their idea by drawing, drama, in writing poem, essay and others. This was done in Hamer woreda in one elementary school.

Survey Questionnaire: The quantitative data was generated from the sampled households in the three woredas using structured questionnaire. The questionnaire consisted socio-economic and demographic characteristics of the sampled household. In each household 2 persons, one male and one female, preferably the husband and the wife were the respondents on their KAP in relation to HTP and WASH. They were asked on prevalence situation of their children and other house hold members of major HTP. In the absence of the husband the elder son was interviewed where as in the absence of the wife the elder daughter was interviewed. This assessment used qualitative information with appropriate triangulation with survey findings.

2.2 Document Review

The document review included an assessment of available information from the existing planning, reporting and study documents of the organization, memoranda of understanding signed between partners, progress reports and other relevant documents from different governmental and non-governmental organizations related to HTP, wash and hygiene. The document review also included other works conducted globally, in African countries and in Ethiopia to record their experiences, lessons and best practices on issues related to the subject area. A checklist of documents were prepared and reviewed exhaustively by the consultant team.

Some of the major list of the documents reviewed includes:

- Any document that shows HTP KAPB indicators at global, National, zonal and district level.
- Any document that show WASH and Hygiene and other related issues at global, National, zonal and district levels.
- Other relevant documents such as policy and program papers in country and globally related to the subject area of the assessment.

2.3 Sampling Methodology

Under the quantitative approach, information was collected from the general public to generate information on KAPB on HTP, WASH and Hygiene. Assuming the P=50% for any possible events, 5% allowance and 95% confidence, the maximum estimated sample

size for one woreda was 384 individuals around 400 subjects. For the three woredas the calculation showed 1200 subjects.

The Baseline Survey conducted on HTP by EGLDAM in 2007 showed that harmful traditional practices differ by different ethnic groups. For example based on previous literature FGM is performed only among the two ethnic groups (Dassenech and Erborie) among the seven indigenous ethnic groups. On the other hand some grave and serious HTP like *Mengi* is performed among Hamer ethnic group. Hence, under the current assessment all the seven ethnic groups were planned but six of them were included since adequate number of Murile ethnic members were not in the selected kebele for Murile.

The above document review clearly shows that including and considering the different ethnic groups in the current baseline survey is very important. These ethnic groups have different cultural practices that the intended study should look at each of them specifically and separately to clearly show the occurrence of HTP and KAP in the three woredas. The sampling was done using a combined convenience and multistage stratified cluster sampling technique. Accordingly, from each of the three study Woredas, three (3) rural PAs and two urban Kebele were selected by taking the maximum care to accommodate the different ethnic groups residing in the woredas using probability proportional to size (PPS), meaning their respective population sizes.

In cases where the smaller ethnic groups are residing in only one PA, for instance the Karo, Mugije, Murile, and Erborie Ethnic groups, that particular PA was selected. If on the other hand one ethnic group is residing scattered in more than one PAs, one PA was selected among the many by random sampling or using the necessary scientific selection criteria. Hence the three PAs that were selected from Hamer Woreda were stratified by the three ethnic groups.

The selection of the households was done using cluster sampling after selecting the sample PAs using stratified sampling by ethnic group. Each PA was further divided in to clusters with average size of 30-60 households. Out of these, 2 clusters were selected randomly from the available clusters. Then all households were visited from the selected clusters. From the two clusters 50 households are expected to be visited by allowing 10 houses for “closed” and “ruin houses” among the 30 household sizes.

As mentioned above the husband and the wife were interviewed in every sample household. In their absence the elder son and daughter were interviewed. On the average 2 individuals were included in one household. A total of 200 households were planned to be visited in each Woreda and 600 from the three Woredas and about 400 individuals in each Woreda and 1200 from the three Woredas. The following table shows the number of respondents interviewed by Woreda.

Table 2.3.1: Number of respondents by district

District	No of individuals
Hammer	**423**
Dassenech	401
Nyangatom	384
Total	**1208**

On top of the questionnaire interviews, key informants like staff members, sectors TBAs, traditional healers, health workers, teachers, women association representatives, youth association representatives and community leaders were consulted through in-depth interviews to get information addressing the major and specific objectives of the study. In each Woreda about 20 key informants were approached for the in-depth interview and 60 in the three woredas.

Under the qualitative approach, focus group discussions (FGDs) were conducted with sector officials at Woreda level to collect information about the Woreda and at each PA level with community leaders to get a general idea about each ethnic group. In general, (10) FGDs were conducted in the three woredas.

On top of this Participatory Action Research was conducted with children in the project area. This was performed by explaining the problem for children and allowing them to explain their idea by drawing, drama, in writing poem, essay and others. This was done in Hamer woreda in one elementary school.

2.4 Data Collection Instruments

Three data collection instrument were prepared to collect information from the selected households/individuals, key informants and FGDs.

2.4.1 The Questionnaire for Sample Household/Individuals/Survey

The questionnaire that was used to collect the quantitative information from individuals (Q1) was structured as much as possible and was designed to collect information from two members of the household and mainly included:

- Address
- background characteristics
- Knowledge, attitudes and practice (KAP) on HTP
- Knowledge, attitude and practice (KAP) on WASH and Hygiene
- Information coverage and intention on HTP, WASH and Hygiene

- Other indicators

2.4.2 The Key Informant Questionnaire

The key informant questionnaire (Q2) was general questions on address, background characteristics and the rest was open ended (see annexes) questions to answer most of the specific objectives of this assignment. The major respondents were:

- Staff members
- Religious leaders
- Health Workers
- Education workers, school directors
- Other Sector offices
- Key Partners
- Community leaders
- Others

The key informant in-depth interview open ended questionnaire was prepared (see annex) in details. The Key points for interview included:

- Address
- Background Characteristics
- Major HTP occurring in the area
- Community support on these HTP
- Measures taken by other actors in the woredas to alleviate problems that related to harmful traditional practices, hygiene, and sanitation
- Challenges and problems and solutions undertaken in addressing the problems of harmful traditional practices, hygiene, and sanitation in the woredas and the specific ethnic groups
- Major achievements, lessons learnt, best practices and gaps in the three woredas and among the seven ethnic groups in relation to HTP, WASH and Hygiene
- Intervention strategies to fill the gap in the future
- Intervention strategies or recommendation for the success of the project and sustainability of the results expected to be achieved by the project
- Others in relation to the specific objectives of this assessment

2.4.3 FGD Guide/Checklist

For the FGD discussion guide points were prepared and mainly included general points:

- Background information about the site to be studied

- Beneficial and harmful traditional practices that occur at district and ethnic group level
- Top priority HTP and reasons, process and harm full effect of the five priority HTP
- Major communicable diseases in the area
- Activities performed in relation to HTP, WASH and Hygiene
- Problems faced and solutions under taken
- Achievements, lessons and best practices
- Gaps and future intervention strategies and
- Others related to the general and specific objectives

Both the questionnaires and check list were pre-tested and finalized by incorporating points found during the pre-testing.

2.4 Check list for the Participatory Action Research (PAR)

- Introduce yourself with the children
- Explain them about the objective of your visit
- Advise the PAR participants to explain on the reasons, harmful effects, future intervention on HTP and WASH using
  - Diagrams
  - Poem
  - Essays
  - Role plays and others
- Collect their diagram, poems and essays
- Interpret their diagram, poem and essays as information source under the qualitative approach to include them in the finding , discussion and for recommendations

2.5 Interviewer Guide

After finalizing the data collection instrument interview guide was prepared for Q1 Q2 and for the FGD points. The guide was clearly prepared on how to complete the questionnaire, on the selection of the samples and on the process of recording after interview. In a similar manner a guideline was also prepared for Q2 and FGD points to serve a common working manual for the consultant team and the supervisor during in-depth interview and focus group discussion.

2.6 Organizational Arrangement

In general, the consultant team in close consultation with SCN-E coordinated the study activity from the design stage till report writing. The consultant team worked closely with SCN and its partners in the course of identifying the target group to be sampled from each site.

During data collection team members participated in the field to organize the work in the three districts. Interviewers who completed 12^{th} grade and who can speak the local language were recruited and get practical training on the objective of the survey and on the method of data collection through applying the data collection instruments. Supervisors were employed to follow up the interviewers closely to clearly maintain the quality of data and information collected. Certainly, the focus group discussions were conducted by the core consultant team members and the supervisors.

The consultant team is composed of experts from multidisciplinary backgrounds including a public health specialist, biostatistician, sociologist, physiologists and others. The team members were actively participating in the planning of the fieldwork, and preparation of guidelines questions and checklists, facilitate initiation and follow up contact with focal institutions in the study area, actively participate in the administration of interview with key informants, and execution of other selected methodologies under the guidance of the lead consultant and prepare the Baseline survey report.

2.7 Data Entry, Analysis and Report Writing

After appropriate final editing and coding collected data was entered into a computer using the SPSS software. Encoders/data entry clerks were employed on a temporary basis to enter the data to a computer. The consultant team supervised the entry process and ensures the quality of the work. Finally, the analysis was performed using SPSS/PC. Uni-variate and bivariate analyses were performed to generate the information that can answer the general and specific objectives of this assessment. The necessary tables and graphs were produced for report writing. The consultant team performed a comparative analysis of the findings (status of relevant indicators) with regional and national estimates.

Finally a document was produced that accommodated all the general and specific objectives as shown in the TOR. During the analysis all desegregation or stratification were performed by woreda, ethnic groups, sex, age, religion and other relevant variables.

The report format is as follows:

- Executive Summary
- Background

- Objectives
- Methodology
- Findings
- Discussions and analysis
- Conclusions and recommendations
- Annexes

2.8 Data Quality

To ensure the quality of the quantitative data adequate training was given for the interviewer. On top of this supervisors and consultant team members were closely following the data collection process.

To ensure the quality of qualitative data collection, permission was requested from respondents to record the in-depth interview and the FGD sessions. In most cases the respondent agreed to recording and the interviews or discussions were recorded. In cases when respondents did not agree to recording, hand written notes were taken. These were re-written on the same day to ensure that points raised during the in-depth interview or the discussion were not missed.

2.9 Ethical Considerations

Assessment permission letter were obtained from SCN-E. All concerned bodies were communicated through formal letter from SCN-E and permission were obtained from all governmental institutions and concerned individuals. The objectives of the survey were explained to all participants of the assessment in order to get informal verbal and/or written consent. Moreover; the participants of the research were informed that their name will not appear in any part of the assessment document.

3. LITERATURE REVIEW

3.1 Harmful Traditional Practices

The prevalence of FGM and other priority HTP are mainly concentrated in African countries and to some extent in Asia and among immigrants of Africa in the West and European countries. In Africa FGM and other priority like early marriage, abduction, skin cutting do occur at different degree. For this, there are 28 national committees in 28 African countries to follow up the issue of FGM and other HTP under the umbrella of Inter African Committee (IAC).

In Ethiopia, two important national surveys (baseline and follow up) have been conducted by EGLDAM on top of different pocket studies and the 2005 EDHS. EGLDAM survey identified five top priority HTP including FGM, UC, MTE, EM and MBA at national level. According to the FUS of EGLDAM there has been major information dissemination effort in the last 15 years mostly through health services, mass meetings, schools and to a limited degree the mass media. Consequently, awareness of the harm of HTP and supportive attitude to their elimination has reached almost saturation levels. For example on FGM the knowledge has increased from 33.6% to 82.7% with an increase rate of 146% when compared with the original. Knowledge on the new legislations, on the other hand, is very limited even among the law enforcement agencies. There have been important decreases in the prevalence of HTP but this is not commensurate with the effort exerted at least for FGM. The reasons for, the processes and harmful effects remain similar to those in the baseline survey. However, there are clear indications of growing overt resistance to the elimination of uvula cutting in particular and of increased clandestine practices of a number of the major HTP. Mass 'education'/awareness raising remains the dominant intervention with growing community conversations and other community dialogue approaches. Lack of continuity and consistency in messages and growing 'meeting fatigue' are frequently reported problems. There are also a growing, even though not adequate, number of legal-related interventions and interventions geared to practitioners/perpetrators and victims. A large number of government and non-government organizations are involved in these activities with rather limited resources and the need for better leadership and coordination is manifest.

The study conducted in 2005, by Bureau of population and statistics (BoPS) in SNNP identified over 100 types of harmful traditional practices in the region. In South Omo Zone alone, around 30 types of HTPs have been identified. According to their study, the top fifteen priorities HTPs identified by key informants and FGD participants included: abduction, female genital mutilation, milk teeth extraction, uvulectomy, tonsillectomy, polygamy, inheritance marriage, early marriage, massaging the abdomen of pregnant women, dowry, believing in witch craft, wizards (*Kalecha*), excessive waste of property

and time, isolation of women during menstruation and delivery, HTPs related with scarification (pulling out the lower teeth and splitting the lower lip) and nutritional and work taboos. This study also revealed that all identified HTPs in one way or the other retard the socioeconomic development of the region. It was also shown that the crude prevalence rate of FGM at regional level was 33.0%. This varies significantly by zones, districts and ethnic groups. Among the sixty ethnic groups studied FGM is not a problem or zero prevalence is reported among twenty indigenous ethnic groups. The prevalence is high among larger population size such as Sidama, Hadia, Kenbata, Gurage, and Keffa. There is a sign of decrease on the prevalence of FGM in the region. This is confirmed by both the quantitative and qualitative information. The prevalence of other practices such as uvulectomy, milk teeth extraction, early marriage and abduction are 52.4%, 49.4% 10.1 and 20.7% respectively. There is a sign of decrease on the prevalence of abduction and early marriage when compared with the baseline survey conducted by NCTPE in 1998. But no significant change is observed on the prevalence of uvulectomy and milk teeth extraction. The BoPS in SNNP forwarded general and specific recommendations and suggested to a) Design short and long term plans on the eradication of HTPs b) Design area and target specific intervention strategies c) Strengthen Monitoring and follow up activities c) Encourage multi-sectoral integrated intervention approach d) Improve the IEC-BCC system and e) Make decisions on HTPs through community participation using community conversation

In 2008 Health Unlimited conducted a study in Hammer and Bena Tesmay districts among six indigenous ethnic groups. Under this study a total of 15 and 30 different types of beneficial and harmful traditional practices have been identified by the KIIs and FGD participants respectively. In-depth information have been collected on 20 selected HTPs and produced important indicators such as information coverage on HTPs, Knowledge, attitude and intention. Priority HTPs identified included forced abortion, whipping, inheritance marriage, *Mingi* and milk teeth extraction. The second group is early marriage, abduction, not washing under the waist, excessive feast and FGM. This study recommend that to bring appropriate behavioral change awareness raising program should continue in a consistent and sustainable manner and further reach grassroots level, Interpersonal communication in the form of peer education and community dialogue (CC) should be in place in the study areas

3.2 Water, Sanitation, and Hygiene

The situation of access to potable water and sanitation is very low in the continent of Africa compared to other continents in the globe. A water and sanitation assessment conducted in Zambia found that only 54% of clients fetch water from improved sources. This study also showed that 28% of respondents walk at least 40 minutes and an average

walking distance of 400 meters to fetch water as study done by Kangamba M. indicated (http://pdf.usaid.gov/pdfdocs/PNDAJ423.pdf). Similar study in Malawi indicated that only 53% of the clients have access to improved water sources. In this study, client walk on average 25.33 minutes and 55% reported that their water source was located outside their plots as assessment conducted by Lockwood K indicated (accessed, http://pdf.usaid.gov/pdfdocs/PNADJ422.pdf). Another study conducted in Botswana on access to safe water among poor community showed that people use several sources of water and the unreliability leads to use of poor quality water and poor hygiene (Ngwenya B. and Kgathi D, 2006). A community household's survey in Addis Ababa also showed that there is great discrepancy in accessibility of safe water by wealth, sex of house hold head and functional areas. The distance of fetching water falls between 100 and 500 meters.

Ethiopia is known as country with low Coverage levels for water and sanitation in sub Saharan country. According to official figures access to safe water is nationally estimated to be 76% in urban areas and as low as 20% in rural areas. Access to sanitation is nationally estimated at 50% in urban area and 4% in rural areas (CSA, 2006). This puts strain on girls and women who are widely responsible for the collection of this vital resource. Access to safe water is defined as 20 liters per person per day within a distance of 1-2 kilometers. The coverage level of water, sanitation and hygiene is not uniform in among various regions of the country; there are considerable gaps between urban and rural, pastoralist and agro pastoralist areas of the country. In addition to low coverage levels, water quality is another major problem, as evidenced by frequent outbreaks of water related epidemics in both rural and urban areas. In addition to this, there are low levels of hygiene awareness, which compound the health risks associated with low water and sanitation coverage levels. The main problem is increased susceptibility to water-borne diseases such as diarrhea and dysentery, water-washed diseases such as trachoma and scabies, water-based diseases such as Bilharzia, and water-related insect vectors including malaria (UNICEF, 2007)

In Ethiopia, almost three quarters of health problems in children and communicable diseases originate from the environment. Diarrheal disease alone accounts for 46 per cent of total under-five mortality. In addition to diarrheal disease, a large section of the population is afflicted with trachoma and especially guinea-worm disease. Low levels of water and sanitation coverage also have important social implications. Women and children spend several hours every day fetching water. The water carried often equals 70 percent of the carrier's body weight, which has a heavy impact in terms of physical exertion and burning up calories from a meager dietary intake. The time spent fetching water could be used to care for children in the home, rest or employment in income generating.

Access to safe water, sanitation and hygiene is one of the key development challenges in Southern Ethiopia. A baseline study conducted by SNV in 2007 in six *Woredas* (districts) in southern Ethiopia (Alaba, Misrak Badawacho, Kedida Gamela, Damboya, Boloso Sore and Shashego) showed that only 42% of the population had access to safe water and 49% had access to latrines. The situation in public institutions like schools, health centers and market places is extremely poor. Only 10% of these institutions have access to safe water. Markets are the most neglected, with a complete lack of safe latrines and access to a safe water Supply (the outsider factor in community led total sanitation: SNV, 2007). There is almost no baseline data regarding the situation of water, sanitation and hygiene in South Omo Zone and the three woredas where the current baseline survey is conducted.

4. RESULTS/FINDINGS

4.1 Harmful Traditional Practices

Under the current Baseline Survey about 1208 respondents have been interviewed to generate knowledge, attitude and practice (KAP) indicators on major HTP prevalent in the project area (three woredas). The following Table presents Background information of the study subjects.

Table 4.1.1: Frequency distribution of the study subjects by district, residence and ethnic group

Variable	Label	Frequency	%
District	Hamer	423	35.0
	Dassenech	401	33.2
	Nyangtom	384	31.8
Residence	Rural	827	68.5
	Semi Urban	381	31.5
Ethnic Group	Hamer	274	22.7
	Karo	31	2.6
	Erborie	61	5.0
	Dassench	245	20.3
	Nyangtom	326	24.0
	Mugejie	28	2.3
	Amhara	66	5.5
	Others	177	14.7

Table 4.1.2: Frequency distribution of the study subjects by sex, age and educational level

Variable	Label	Frequency	%
Sex	Male	596	49.3
	Female	612	50.7
Age	15-24l	269	22.3
	25-44	698	57.8
	45+	240	20.0
	Ns	1	0.1
Education	Illiterate	861	77.3
	Read & write	229	19.0
	Elementary & above	118	9.8
Marital Status	Single	80	6.6

Variable	Label	Frequency	%
	Married	934	77.3
	Others	184	15.2
	Ns	11	0.9
Religion	Orthodox	143	11.6
	Protestant	310	25.7
	Muslim	21	1.7
	Others	732	54.2
	Ns	2	0.2

4.1.1 Types and Prevalence of HTPs in the Study Area

The key informant in-depth interview and the FGD participants were asked to identify major positive traditional practices in the project area. The positive traditions identified to be useful for the society are highlighted below. Some of them are good to keep the health of children and women and mainly in social relationships that must be promoted and shared to others.

- Assisting each other when members face problems
- Respecting elders
- Birth spacing
- Assisting families at older age
- Conflict resolution practices (settling quarrels) among community members through elders
- The absence of the FGC/FGM practice in five out of the seven indigenous ethnic groups in the study area
- Assistance to poor members in the ethnics group through contribution of cattle and goat
- Working together or in groups, a communal working culture
- Working together and assisting each other during important social events such as in wedding ceremonies and funeral ceremonies through *Debo* or *Jege*
- Eating together and sharing what they have
- Welcoming and good treatment for newcomers to the area
- Care for postpartum women
- Cultural plays, and
- Others

The key informants and FGD participants were also asked to identify major harmful traditional practices in the three project areas. The list includes over 15 and show below.

1. Mingi
2. FGM
3. Forced abortion
4. abduction
5. old aged man marring young girls (*yalachagabecha*)
6. Inheritance marriage
7. Giving marriage without the interest of the girl
8. Milk teeth extraction
9. Early marriage/Child Marriage
10. Skin cutting
11. Excessive feast
12. Whipping a woman during cattle jumping
13. Under estimating women
14. Dowry
15. Firing a gun when somebody die
16. Husband & wife not eating together
17. Polygamy
18. Giving respect for someone who killed a person
19. Killing each other
20. Inheritance marriage
21. Taking property or robbery in group
22. Conflict
23. Work load of women, and
24. Others

Among the above HTP, the following table shows frequency of mention of priority in the three woredas.

Table 4.1.1.1: Frequency of priority HTP by the key informants

	Hamer	**Dassenech**	**Nyangtom**	**Total**
Mingi	18	0	4	**22**
Inheritance Marriage	9	0	14	**23**
Old aged man marring young girls (*yalachagabecha*)	15	6	11	**32**
Forced abortion	20	0	0	**20**
Whipping a woman during cattle jumping	16	6	6	**28**
FGM	9	18	0	**27**
MTE	10	14	0	**24**
Early Marriage	5	6	7	**18**
Cutting around the chest (*Deret Meteltel*)	5	9	3	**17**
Excessive feast	6	8	0	**14**
Abduction	5	0	9	**14**
Robbery and killing each other	0	0	8	**8**

4.1.2 Knowledge, Attitude, and Practice (KAP)

Table 4.1.2.1: Information coverage on selected HTP and major sources of information

HTP	% who got information	Source of major information	% major information
FGM	51.3	Meeting	29.6
Uvulectomy	45.8	Health facility (HF)	28.8
Milk Teeth Extraction	58.6	Health Facility	29.5
Marriage <15 years	58.4	Meeting	34.4
Forced abortion	49.3	Meeting	29.1
Whipping a women	47.2	Meeting	20.9
Inheritance marriage	67.2	Meeting	32.9
Excessive feast	56.6	Meeting	29.5
MBA	74.8	Meeting	35.7
Mingi	41.7	Meeting	16.3

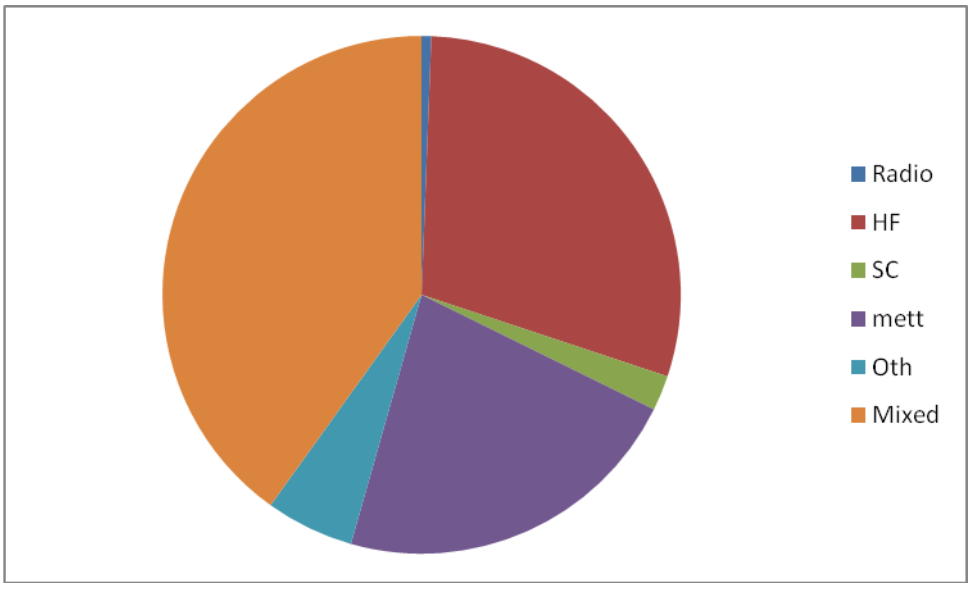


Figure 4.1.2.1: Source of information for milk teeth extraction.

From Table 4.1.1 information coverage on MTE is about 58.6. The above figure shows the source of information for MTE. From the figure like other HTPs the mixed sources of information dominate and were found to be 40.1%. On the other hand when the four sources are compared separately the health facility takes the higher share (29.5%) followed by meeting (22.1%).

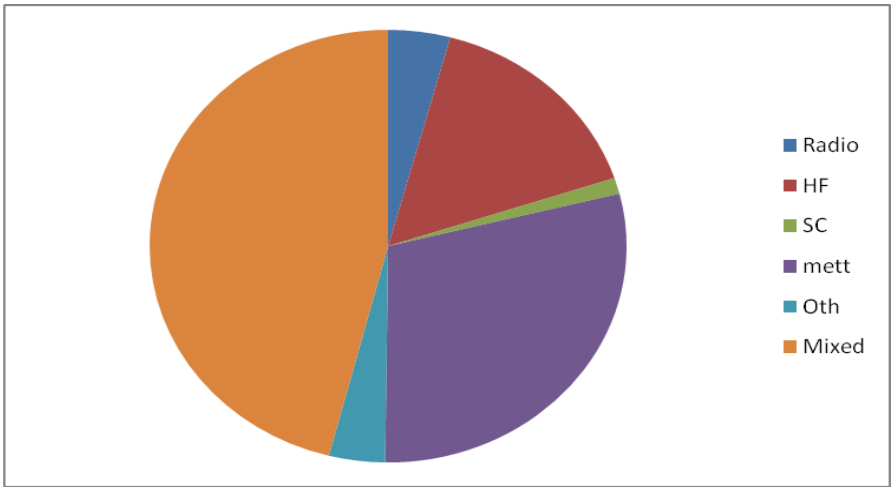


Figure 4.1.2.2: Sources of information on forced abortion.

Under figure 4.1.2.2 the major sources of information is meeting (29.1%) followed by health facilities (15.7%). Like other the mixed source take the highest share (46%).

Table 4.1.2.2 Knowledge, attitude and intention on selected HTP in South Omo in Hamer, Dassench and Nyangatom districts, 2011

HTP	**% who consider as harmful (knowledge)**	**% who support eradication (attitude)**	**% who promised not to do it (intention)**
FGM	63.1	62.3	60.8
Uvulectomy	62.5	62.1	62.0
Milk Teeth Extraction	59.4	58.0	56.0
Marriage <15 years	64.9	63.9	56.0
Forced abortion	66.0	65.0	64.3
Whipping women	57.9	57.1	54.6
Inheritance marriage	65.2	65.1	61.2
Excessive feast	61.9	61.4	60.8
MBA	69.6	68.2	66.8
Mingi	69.3	69.2	65.1

4.1.3 Details on the twelve selected priority HTP

About 12 priorities HTPs have been identified by the key informants and FGD participants. These can be grouped into two.

Group one: The first seven top priority HTPs with frequency of mention above 20 respondents. These includes FGM, whipping a woman during cattle jumping, inheritance marriage, forced abortion, MTE, Mingi, old aged man marring young girls (*yalachagabecha*).

Group two: the rest five priorities HTP with a frequency of mention as priority below 20 respondents. This includes EM, MBA, excessive feast, cutting around the breast (*deretmeteltel*) and robbery/killing each other.

Group one:

This group includes:

1. Whipping during cattle jumping,
2. Forced abortion,
3. Inheritance marriage,
4. FGM,
5. MTE,
6. Mingi, and
7. Old aged man marrying young girl *yalachagabecha*

1. Whipping women during cattle jumping

The overall estimated prevalence is 18.5% where 41.7% is recoded in Hamer while the corresponding figure for Dassenech and Nyangatom are 20.4% and 2.2% respectively. The following Table shows the prevalence of whipping woman during cattle jumping by district, ethnic group and age. As witnessed by the quantitative respondents the highest prevalence is documented in Hamer district (41.7%), among Hamer ethnic group (56.0%) and among the older group (23.2%).

Table 4.1.3.1: Prevalence of whipping women during cattle jumping by district, ethnic group and age

Variable	Label	Prevalence
District	Hamer	41.7
	Dassenech	20.4
	Nyangatom	2.2
Ethnic Group	Hamer	56.0
	Karo	50.0
	Erborie	35.1
	Dassench	25.7
	Nyangatom	3.4
	Mugejie	0.0
	Amhara	0.0
	Others	0.0
Age	15-24	15.6
	25-44	17.5
	45+	23.2
	All	18.5

About 47.2% of the respondents got information on whipping of women during cattle jumping. The major sources of information is meeting places with a share of 20.9%. The information coverage varies by district where the highest is documented in Hamer (70.6%) followed by Dassenech (58.7%) and the least at Nyangatom (39.8%).

About 57.9% of the respondents consider whipping as harmful traditional practice (Knowledge), 57.1% support is eradication (attitude) and 54.6% promised not to do it in the future (Intention). The knowledge and attitude of the respondents towards whipping varies by educational level. The following figure 4.3.1 shows that both knowledge and attitude are significantly higher among the literate group indicating the importance of education in the reduction of HTP.

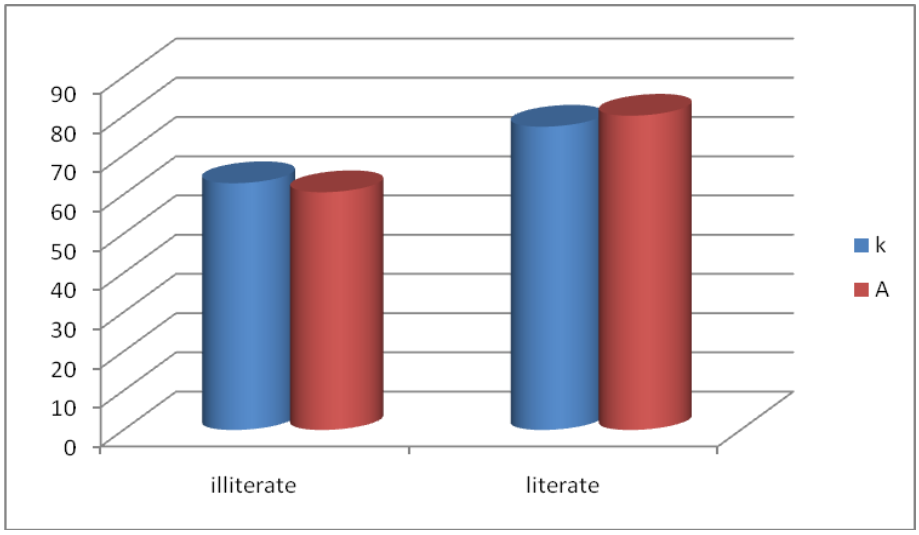


Figure 4.3.1: Knowledge and attitude towards whipping women during cattle jumping by educational level

When all men are ready for marriage, they are expected to jump cattle in a cultural ceremony. In the process, sisters or other female close relatives of the young man are whipped to express their happiness. In fact someone jumping the cattle is considered as a brave man. Hence women are slashed to support his act. The other reasons for whipping include a) showing their love for their brother or close relative b) To get recognition c) If not slashed for the sake of their brother, they are considered as cowards d) The men cannot marry without jumping and in the process if no one is slashed it is considered that he does not have relatives.

Concerning the process of whipping women, when the young man is ready for jumping, a stick *archume* (in some places they use *Alenga*) prepared by other strong persons who will be made ready to whip the women with as a concomitant process with the cattle jumping. Sisters and other female close relatives will be ready and give their back for whipping. In concurrence with the jumping the whipping of the women will proceed till the strong men got exhausted whipping them and the back of the women gets wounded and spits blood.

Wound infection, transmission of HIV from whipping a number of women in turn, excessive bleeding and physiological problems are the major harmful effects identified by the FGD participants.

Though there are efforts to educate the community on the harmful effect of this tradition, there is still resistance to stop it. There were incidences that community members clashed with the police with attempts to stop while the whipping was taking place.

On top of continuous community education, FGD participants have suggested to work more with elders to draft customary or local law that restrict the practice

2. Forced Abortion

Forced abortion is mainly practiced in Hamer district and almost nil in Dassenech and Nyangatom.

The overall estimated prevalence is 8.9% where 24.4% is recoded in Hamer while the corresponding figure for Dassnech and Nyangatom are 3.9% and 1.9% respectively. The following Table shows the prevalence of forced abortion by district, ethnic group and age. Under this study, the highest prevalence of forced abortion is documented in Hamer district (24.4%), among Hamer ethnic group (30.3%) and among the older group (10.8%).

Table 4.1.3.2: Prevalence of forced abortion by district, ethnic group and age

Variable	Label	Prevalence
District	Hamer	24.4
	Dassenech	3.9
	Nyangatom	1.9
Ethnic Group	Hamer	30.3
	Karo	21.0
	Erborie	22.0
	Dassench	2.6
	Nyangtom	1.1
	Mugejie	0.0
	Amhara	0.0
	Others	0.0
Age	15-24	9.2
	25-44	8.1
	45+	10.8
	All	8.9

About 49.3% of the respondents got information on forced abortion. The major sources of information is meeting places with a share of 29.1%. The information coverage varies by

district where the highest is documented in Hamer (66.9%) followed by Dassenech (64.0%) and the least at Nyangatom (30.5%).

About 66.0% of the respondents consider forced abortion as harmful traditional practice (Knowledge), 65.0% support is eradication (attitude) and 64.3% promised not to do it in the future (Intention). The knowledge and attitude of the respondents towards forced abortion varies by educational level. The following figure 4.3.2 shows that both knowledge and attitude are significantly higher among the literate group indicating the importance of education in the reduction of forced abortion.

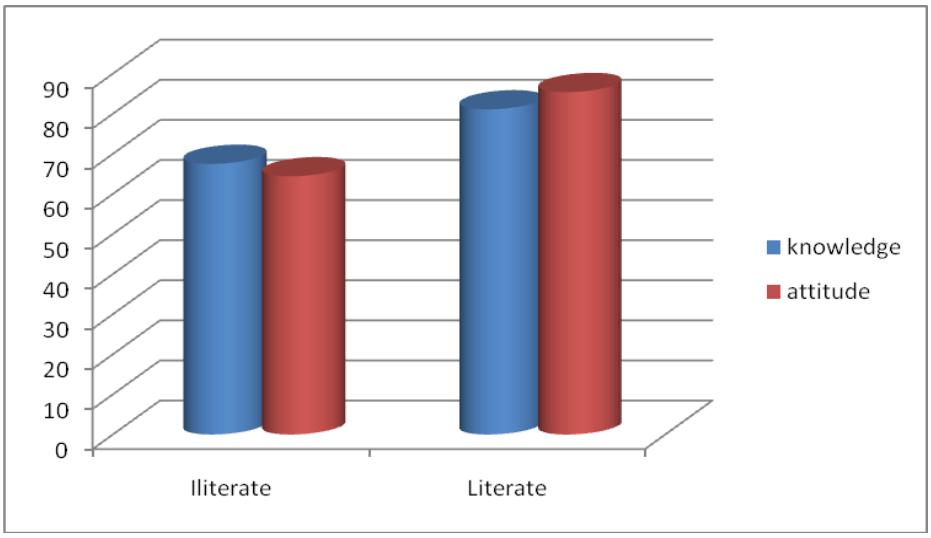


Figure 4.3.2: Knowledge and attitude on forced abortion by educational level

The major reasons associated with forced abortion by massaging the abdomen is related to the bad belief in relation to the *Mingi* concept. Based on the information from the FGDs, about 7 different reasons are forwarded for the performance of forced abortion. These reasons include:

- If a woman delivers before marriage she will not get a husband;
- A girl who has delivered before marriage will be made an outcast
- If the premarital pregnancy is from a person other than her fiancée, the two can kill each other
- Persons who have in any way participated in the process that led to the pregnancy will be beaten by strong persons under the order of the elders
- A child delivered outside of marriage and without going through the *denb* (a ritual) the child is considered a *Mingi* leading to so massaging the abdomen to avoid the birth of a *Ming* child who is perceived to come with all the bad lucks to the family and the community at large and deserves to be avoided by all means.

Forced abortion is performed by massaging the pregnant abdomen heavily by the victims themselves or by persons considered ‘knowledgeable’ in the community till the fetus is affected and expelled. The traditional knowledgeable persons who are massaging the

abdomen of the victims can be either male or female. To facilitate the abortion to take place within a short period of time, the use of traditional herbal extracts and animal products taken by mouth or put as vaginal 'suppositories' is also reported in different localities of the study area.

This is one of the most serious harmful traditional practices in the study area that have a serious effect on the lives and reproductive health status of women and girls. Some of the harmful effects identified by the FGD participants include:

- Infections of the uterus
- Excessive bleeding
- Death

According to the FGD participants, though there is an effort to educate the community through Community conversation sessions and other community health education programs (the MoH and HU/EPaRDA), the level of change observed so far is below acceptable. The major problems identified related to difficulty of intervention include: the community is not transparent on the issue (it is still a taboo); and the place where abortion is done is not known. Since the problem of this harmful traditional practice was silent and not recognized as a major health problem for long, it needs serious and immediate attention to mitigate its fatal impacts. Other future intervention strategies suggested against this problem is to mainstream it with sector offices and to create access to family planning (FP) information and services to avoid unwanted pregnancy at any stage of the woman's life.

3. Inheritance Marriages

Inheritance marriage is dominated in Nyangtom and to some extent in Hamer. It is lower at Dassenech.

The overall estimated prevalence is 18.2% where 18.5% is recoded in Hamer while the corresponding figure for Dassenech and Nyangatom are 11.4% and 21.5% respectively. The highest prevalence is documented in Nyangatom district (21.5%), among Erborie (28.0%) and Nyangatom, ethnic group (23.9%) and among the middle age group (23.98%).

Table 4.1.3.3: Prevalence of inheritance marriage by district, ethnic group and age

Variable	Label	Prevalence
District	Hamer	19.5
	Dassenech	11.4
	Nyangatom	21.5
Ethnic Group	Hamer	18.2
	Karo	18.4

Variable	Label	Prevalence
	Erborie	28.0
	Dassench	16.5
	Nyangtom	23.5
	Muguji	9.3
	Amhara	1.1
	Others	15.1
Age	15-24	16.4
	25-44	23.9
	45+	17.5
	All	18.2

The Main Reasons for widows' inheritance include:

1. To protect the property of the husband within his family circle
2. To take care of children by a family rather than by an ordinary stepfather
3. To keep the name of the person who has passed away. The children to be named after his name rather than by that of the step father
4. Due to high dowry the woman is taken as a commodity or property of the husband, in this case the person who has died. So she is not allowed to marry with other individuals outside the family circle of her husband. This is also a reason for their intention to keep up the high dowry practice in these communities

According to the FGD participants, the younger brother is eligible to inherit women when her husband passes away. Even if he does not have a brother other close relative will marry her. In general, if the older brother dies the younger is eligible to inherit. The vice versa is not possible.

Some of the harmful effects identified by the FGD participants include:

- Psychological problem of the women
- HIV Transmission
- This encourages polygamy
- STIs
- Wives have no right on property and are themselves considered a property of the husbands

Since this issue has not received the necessary attention so far and has been perceived as beneficial by majority of the community members, there is no significant intervention made on widows' inheritance. There are some attempts in connection with HIV information dissemination in the project area. However, there is no behavioral change in connection to widows' inheritance. In fact some community members argue that this is a positive tradition that must be promoted. Some FGD participants suggested that elders,

men, women and youth should sit tighter, discuss on the issue and have to come to a common agreement to stop the practice. At the same encouraging women to own land will minimize the problem.

4. FGM

Among the indigenous ethnic group FGM is prevalent only among the Erborie and Dassenech Ethnic group. Due to this the prevalence is significantly higher in Dassenech Woreda. In Nyangatom district the prevalence is nil among the indigenous ethnic group. The 1.1% prevalence observed in this district can be attributed to the other respondents from other ethnic group.

From Table 4.1.2.2 about 63.1% of the respondents consider FGM as harmful (knowledge) and 62.3% support its eradication (attitude). These indicators vary by educational level as shown in figure 4.1.3.3.

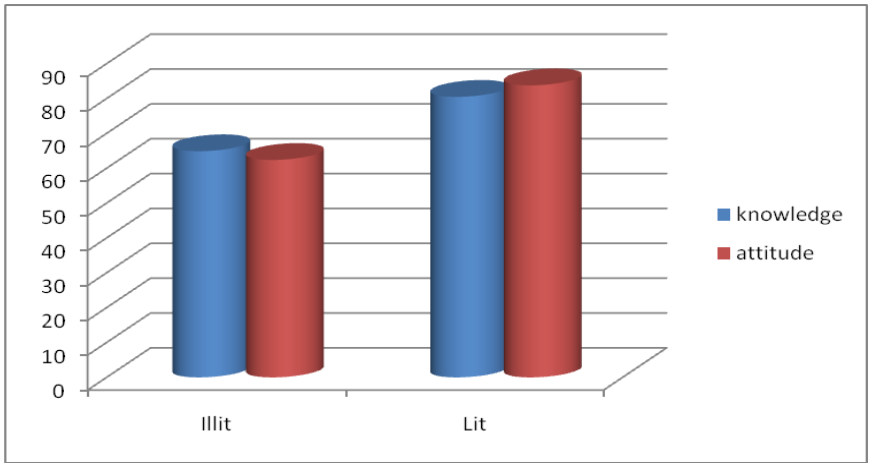


Figure 4.1.3.3: Knowledge and attitude towards FGM by educational level

FGD participants from Erbore discussed in detail that FGM is highly practiced among the Erbores. The Erbore girl is circumcised around marriage. The type of circumcision among the Erbore is between excision and infibulations. It is not infibulations because they do not stitch the wound together nor it is not an excision since the cutting is more severe than excision. They remove the clitoris, the labia majora and labia minora. Currently, some have improved the degree/severity of circumcision procedure and cut only the tip of the clitoris. The prevalence of FGM among Erbore ethnic group currently is 32.1%.

Excessive bleeding, infection, problem during delivery because of the scar, HIV transmission and loosing sexual drive are the common negative effects identified by the community. Education is given on the issue and the situation has greatly improved in the community.

The prevalence of FGM in Dassenech was 100% during EGLDAM Baseline Survey in 1997. At the BoPS, SNNP it was documented to be 80.5% and this reduced to 79.9%

during EGLDAM follow Up Survey in 2007. The current study showed 75.8% prevalence which can be categorized with the strong hold ethnic group classification. In Dassench, a girl is expected to be circumcised before she gets married. During the circumcision ceremony a feast is prepared where families and community members participate at the ceremony. The major reason associated for circumcision among the Dassenech ethnic group is the belief that a woman cannot marry a husband unless she is circumcised. They believe that if a girl gets married without circumcision her property and other materials she touches is evil and will not stay longer with her. They cut the clitoris, labia minora and majora and sever than the excision type of circumcision. They also use the circumcision as ethnic identity. They use knife and apply it for many girls.

5. MTE

This is one of the priorities HTP identified as top five priorities especially in Hamer and Dassenech districts. The overall prevalence of MTE is 26.7% and varies by district and ethnic group.

About 59.4% of the respondents consider MTE as harmful and 58.0% support its eradication and 56% promised not to perform MTE in the future as shown in figure 4.1.3.2 knowledge and attitude on MTE differ significantly by educational level. It is significantly higher among the educated group. This clearly shows that on top of information coverage by creating awareness improving the educational level of the community assists to reduce MTE in the community.

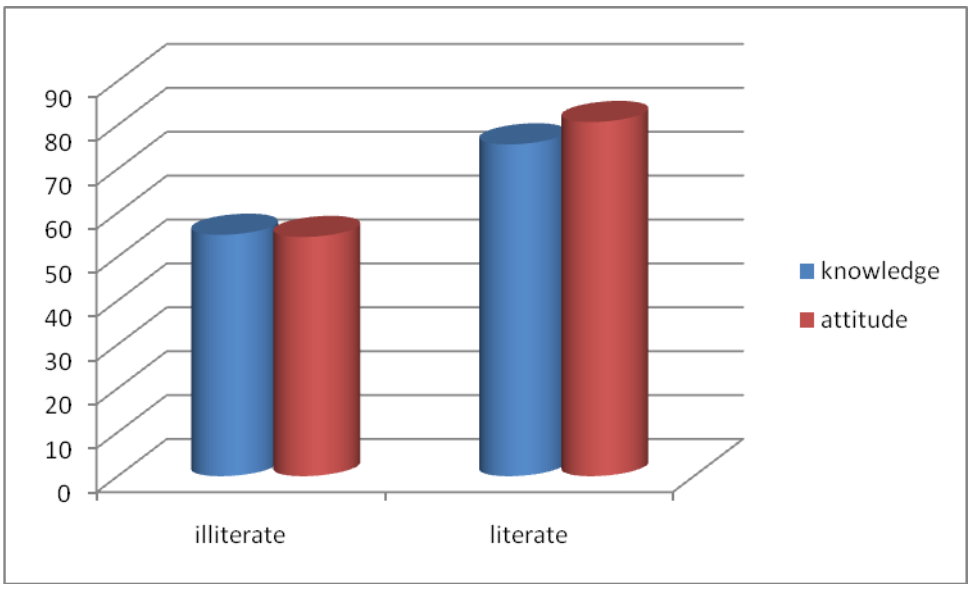


Figure 4.1.3.4: Knowledge and attitude towards MTE by educational level

The Main reasons forwarded for the practice include

- To prevent diarrhea &/or vomiting, fever
- To prevent problems related to growth & development
- Root of Milk-Teeth has/grows worms/hair underneath
- Milk-Teeth extraction prevents/cures diseases in infancy and childhood
- Milk-Teeth extraction prevents teething problems

Milk-teeth extraction is carried out early in infancy. The extraction is typically carried out by creating an incision by blade, knife or sharp iron. The "root" is then extracted using a pointed iron (*wosfe*) or pincers (*worentto*) or even finger nails specially grown for the purpose. The wound is then made to bleed well. Bleeding is considered a sign of good therapy. The wound is finally cauterized using heated mustard or garlic. Milk-teeth extraction is carried out by traditional experts. As identified by the FGD participants the major harmful effect of milk teeth extraction include wound infection, bleeding, HIV transmission, pain, deformation of the teeth, infection of the gum, other complications and death.

Education is given on MTE in the study area by the MOH and NGOs operating in the area. The main problem related to MTE identified by the FGD participants is resistance of the community to stop the practice. They sometimes claim that MTE is a permanent cure for the child against a worm beneath the milk teeth that will affect the growth of the child unless drawn out.

6. *Mingi*

The worst type of HTPs, almost considered as criminal act by all FGD/KII respondents, is practiced mainly in Hammer district and to some extent in Nyangatom woreda.

The major reasons associated with *Mingi* are bad belief and has a lot of impact the fear of which leading to the high occurrence of forced abortion by massaging the abdomen of pregnant mothers. The major criteria for a pregnancy or a child to be categorized as *Mingi* are the following:

- If the upper teeth of the baby comes out first, it is believed that there will be a bad fortune for the family members and for the community
- *Mingi* is a taboo where the baby with perceived bad luck must be removed or else others would die if the *Mingi* is allowed to live;
- There will be a loss in property of the family and the community if the *Mingi* is allowed to thrive;
- On top of the upper teeth, a child is considered or classified as *Mingi* if delivered without marriage
- A child is considered or classified as *Mingi* if delivered without fulfilling *Denbe* – a ritual, as is the case with an extra or premarital pregnancy.

- If the mother gets pregnant for second child before the teeth of the immediate elder child come out, this leads to both children to be classified as *Mingi*.
- It is believed that in the presence of *Mingi* there will be no rain and no good harvest and famine will pursue.

The above points illustrate the major reasons given for *Mingi* in the study area. It is very important to understand the cause for a child to be *Mingi* and why a *Mingi* child is abandoned or killed. The three major reasons to classify a child as *Mingi* are (a) When the upper teeth come out first, (b) when delivered without marriage and *Denb*/ritual (c) when mother get pregnant before the teeth of the preceding child comes out. The three major beliefs as reasons to avoid a child after being categorized as *Mingi* include:

(a) Other members of the family or even the community will die or suffer from a disaster unless the child classified as *Mingi* is avoided by any means;

(b) Unless the child classified as *Mingi* is avoided there will be no rain, no harvest and famine ensues; and

(c) Unless the child classified as a *Mingi* is removed there will be no good crop and cattle will die in mass and famine will ensue.

The role of avoiding a child classified as *Mingi* involves mainly elders of the community, the family members and the parents at different degrees. The elders of the community members are highly concerned in avoiding the child labeled as *Mingi* as it is believed that there will be no rain, bad crop in the presence of a child classified as *Mingi*. Hence, they will approach the family members to leave the child at home and leave the house for some time. Then the selected community members mainly the elders go to the house and take the child to the hills and push him down to die on the process. This could in some cases go to the extent of infanticide where the baby is killed right way with a family member. If parents would refuse this proposal they will be rejected by the community and excluded from any social relationships. On top of these, they themselves also believe that other members of the family will die if he child classified as *Mingi* is allowed to live. Hence, if parents refuse for the community members or elders, the family member will steal the child and throw him on the hill. The most favorable way of removing the child from the family is to take and abandon the child somewhere far from their residence area where the child could get adopted by other people.

Concerning the harmful effect of the *Mingi* phenomenon, FGD participants believe that it is one of the savage and cruelest acts in the world performed upon innocent children in the study area. The negative impact clearly extends beyond the child, i.e. to the parents. One can imagine the feelings of distresses when parents allow their children to be thrown away on the hill or in the river for death. Those mentioned as harmful effect include:

- Killing the child
- An act against humanity and human rights
- Against child rights
- Parents are seriously affected
- It is a crime done
- It is not accepted by God

In the area of *Mingi* the woreda administration, other sectors and NGOs have worked a lot with elders of the community members. They have connected the issue even to the country's legal framework instead of looking it as a mere harmful traditional practice.

The only problem identified by the FGD participants is the education and the follow up actions are not continuous. About three major intervention strategies are suggested:

(a) To close the condition for a child to be *Mingi*, that is by closing all the possible ways to avoiding giving birth before marriage and to have adequate interval between the childbirth and other related issues. To this end, family planning promotion and access to FP information and methods must be in place not only to control population growth but also to reduce the number of children that can be classified as *Mingi* in the community.

(b) To encourage community elders and members to give the child classified as *Mingi* to NGOs and GOs, instead of throwing or killing.

(c) The surest way of avoiding *Mingi* can be to have common decision by the elders and community members not to throw a child anymore and they can do *Denb* for that in relation with their culture.

7. Unequal marriage (Old man marrying young girls) *yalachagabecha*

This is the first top priority HTP in all the three woredas of the project areas. It is widely practiced and the main reasons associated with it are a) Parents of girls can get excessive dowry in the form of cattle and needs to have relation with wealthy family b) The husband prefer younger girls for enjoyment. The process is mainly similar to early marriage where elders are sent to the parents of the girl to ask their consent. Definitely the parents give the consent if the husband can afford the required cattle. Then the parents give her to the old husband without her consent. This practice has different harmful effects including a) there is no love between them b) some girls are taking suicide c) They use forced abortion when they get pregnant.

There are a lot of efforts to stop this practice. However, still there are no big differences from former situation. The FGD participants have witnessed that there is no significant change in this HTP, where serious measures have to be taken to decrees this practice. In the future girls must be encouraged to attend school and a close follow up must be in place to stop the practice.

Group Two Five HTP of priority as second categories:

These include:

1. EM
2. Abduction
3. *Deretmeteltel*
4. Excessive feast
5. Robbery/killing each other

Highlight of the four is presented below.

1. EM

Early marriage is reported to occur in all the three districts of the project areas. All the reasons and process identified in other places holds true for this practice. One particular issue added here is the excessive dowry given to the family. In these communities if a person has enough property he can marry a girl at any age he wishes. Her family sells her as far as the husband pay the required amount.

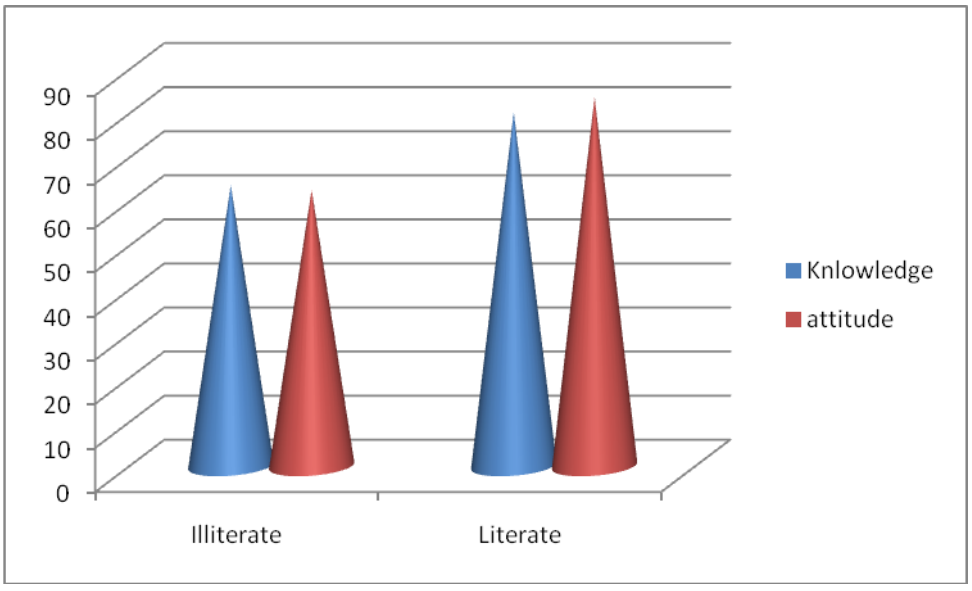


Figure 4.1.3.5: Knowledge and attitude towards early marriage by educational level

In general EM is one of the practices recorded at national level and is also documented as one of the common practices in the study area especially among the non-native ethnic groups such as Amhara and others. Early marriage is practiced among Karo Ethnic group, less than 18 years of age. The type and the reasons in this area differ from those of other places. In this area, both the boy and the girl decide to marry during the dance of *Evangadi* events. Sometimes there will be a quarrel between parents in which case elders are sent to settle the issue. Though this type of marriage involves the participation and voluntariness of both the boy and the girl, due to its occurrence in early ages a problem can arise during

pregnancy and delivery. The overall prevalence of EM in the three districts is estimated to be 24.8% and varies by district and ethnic group.

2. Abduction

Marriage by abduction is one of the priority HTPs at national level, the top priority for SNNP Region, South Omo Zone and also common in the two Woredas of the project area. The main reason for that is refusal of the parents, refusal of the girl when the girl is going to school Some of the harmful effect is obstructed labor, deformation of the body, school dropouts, HIV transmission and others. The overall prevalence of abduction in the three districts is estimated to be 26.4% and varies by district and ethnic group.

3. Skin cutting around the breast (*Deret Meteltel*)

This is practiced in all the three woredas of the project area. When someone killed a person he is considered as a hero of the community. To separate him from the community his breast is cut at different places (*Deret Meteltel*).

4. Excessive Feast

Excessive fest is one of widely practiced HTPs in the project area. It is mostly related with death of individuals.

Excessive feast and taking crops is performed in all Karo ethnic groups. It is considered as part of dowry when the bride prepares a lot of food and drinks and allows elders and , community members to eat. Elders pray for crops of the owner and take it. The economic problem that arises on the owner is too much that education is given for community members in this line.

The form of excessive feast among the Hamer Ethnic group is called *Duki* (*Tezkar*). These excessive amounts of food and drinks are prepared to remember the dead and to pray for him. When any problem arises in the community or in the family of the dead, if they have not done the *Duki* they directly associate it to be the result of not fulfilling the *Duki*. Hence they do it regularly to even after 30 or 40 years of the death of the family members. This is one of the serious forms of excessive feast in the area and education is given to the community by sector offices and NGOs to stop it. This education should continue further.

Based on the participatory action research conducted with children, they have expressed their view using diagram, poem and essays. Like the other targets they identified mingi, whipping women during cattle jumping, forced abortion, MTE and an old man marrying a young girl as priority HTP. In their essays and poem they have suggested as students should participate actively in information dissemination on the negative effect of HTP that affect children and mothers. They stressed the importance of their school clubs to get

information from actors working on HTP. They also suggested as they have to teach their friends and parents on the negative effect of HTP for abandoning it from their society

4.1.4 Activities performed, challenges and future interventions

Major activities performed in relation to harmful traditional practices as mentioned by the qualitative respondents include:

- Identification of HTP
- Training
- Information dissemination at meeting places, mass media and other channels
- Community Conversation
- Application of the law – limited examples
- Establishing HTP task force

Some of the major problems identified by the respondents are related to resistant, low community participation, not giving education regularly, low coordination, no networking and others. The respondents said some of the major HTPs are deep rooted where the community members are not convinced easily to stop the practice. In addition some sever practice like *Mingi* are associated with local belief where it needs repeated education to convince elders for eradication. The other limitation is low application of the law.

To solve the above problems actors on HTP in the area have tried to arrange several training for influential target groups. They also tried to follow up the information dissemination by the community leaders and encouraged community members to participate at the CC program.

The major achievements identified by the qualitative respondents include:

- Information coverage on the issue of HTP has increased
- Knowledge and support for eradication (attitude) have increased for major priority HTP in the project area.
- Due to this there is a sign of behavioral change in the community. Girls have started attending school. Some community members are deciding in group not to perform sever HTP any more in the project area. Respecting the rights of women have started in different keels. Prevalence of different HTPs have decreased at different districts. For example the prevalence of FGM during the Baseline Survey in 1997 was 100%. The BoPS in SNNP study in 2005 the prevalence was documented to be 80%. Currently, the present study findings show a prevalence of 75%. This indicates that the trend is decreasing among Dassenech.
- Some kebeles have started to establish anti HTP committee
- The legal implementation has strewed in limited areas of the project

Actors on HTP in the project area have learnt a lot of things in their past experience. They have learnt that a behavioral change can be obtained if we work hard in a repeated manner

by respecting their positive culture or tradition and teaching the community. They have also learnt that awareness raising both on the harmful effect of HTP and on the existence of the law should come first before trying to punish some community members. Otherwise, some perpetrators and parents can do it in the form of clandestine.

Some of the best practices identified by the qualitative respondents are a) Building the capacity of influential target groups assisted to start the communication with the community b) Doing the sensitization through community and religious leaders is effective c) Using the educated indigenous ethnic member with community leaders assisted a lot to explain for the community members voluntary and easily d) using role models to share their experiences.

Some of the major challenges or gaps identified by the key informants and FGD participants include:

- Not giving the training, mass sensitization and the CC program continuously and repeatedly for community members
- A shift from severe form of circumcision to mild form of circumcision
- Community resistance to some HTP like MTE by associating it with treatment
- Resistant on some HTP since these traditions are deep rooted and associated with local belief
- Identification of perpetrators and giving them intensive training has not been yet started
- Application of the law is at initial stage
- Less follow up and monitoring
- Occurrence of conflict between the local ethnic group at some times
- Assisting victims of HTP has not started yet
- Low coordination, networking and mainstreaming
- Low capacity building and system building

Suggested future intervention strategies are classified in the following areas.

a) BCC

Under behavioral change communication they have suggested the following points.

- At the beginning give training for the community gate keepers or influential
- Continue mass sensitization using indigenous communication till grass root level using local institutions such as religious institutions, ‘’IDIR’’ and others
- Encourage peer education and CC
- Focus in one or limited kebele to serve as a model. Then the rest will follow
- Encourage the schools to form anti HTP clubs and involve both boys and girls
- Work with the HEWs since they are doing frequent home visits
- Produce IEC materials like leaf lets, posters and others in local language
- Encourage role models
- Give prizes

b) Assisting victims

Under this area they have suggested:

- Identify victims
- Assist them by refereeing to health facilities
- Support them with IGA program after returning home
- Provide them training on the negative effect of HTP
- Encourage them to teach the community by sharing their experience on the negative effect of HTP

c) Involving perpetrators

Under this:

- Establish the profile of perpetrator by registering their background status and their address
- Provide them intensive intervention by giving repeated training and awareness creation on the negative effect of the major HTP
- Encourage them to serve as change agents
- Provide them with practical and local IGA program
- Apply the law if they still insist and continue secretly in a clandestine manner
- Give prize for the good and role models

d) Application of the law

Under this they suggested:

- Teach the community leaders first on the content of the law in relation to HTP to convince them for its application
- Awareness raising for the community members on the existence of the law
- Advocacy for legal bodies
- Follow its implementation
- Share the experience through media to teach others

e) Capacity building

Under this they suggested:

- Giving training
- Experience sharing
- Coordination, networking and mainstreaming
- Establish committee or task force at kebele level on HTP, link them with school clubs
- Establish a HTPs task force at district level to follow the kebele task force
- Establish reporting system with the kebele task force

4.2 Water, Sanitation, and Hygiene

Under this section community KAP on water, sanitation and hygiene and activities performed in the area, challenges and future intervention strategies are presented shortly based on findings from household survey, key informant and Focus Group Discussion (FGD) findings.

4.2.1 KAP on Water, Sanitation and Hygiene

Knowledge related to Water, Sanitation and Hygiene

In the current study three variables are used to measure the knowledge level of the community about water, sanitation and hygiene such as mode of disease transmission, knowledge of diseases and infections prevention and advantage of using protected water source and latrine using household survey. The finding of household survey has also triangulated with key informant and focus group discussions findings.

The survey result revealed that majority of the respondents in the study area, 72.1 percent, does not know if contaminated food and unprotected water are main modes of disease transmission. However, there is significant difference on number of respondents who know if contaminated food and unprotected water are mode of disease transmission among woredas, ethnicity and educational status. It was found out that 56% of the respondents from Hamer, 69% from Dassenech and 94% of respondents from Nyangatom do not know that contaminated food and unprotected water sources are the major mode of disease transmission. It was found out that 60 percent of the respondents who completed at least primary school and 72% of illiterate respondents do not know that if contaminated food and unprotected water source are major source of disease transmission.

Thus, it is possible to say that the majority of the communities in the study area do not know if contaminated food and unprotected water sources are major mode of disease transmission with significant difference among woredas, educational status and ethnicity. The common communicable disease transmission methods identified by the key informants in the three woreda of the study area are:

1. Breathing;
2. Environmental and personal hygiene;
3. Mosquito;
4. Drinking milk without boiling;
5. Unprotected sexual intercourse;
6. Dust particles.

The respondents were asked about major diseases that transmitted through unprotected water source and feces and the results are depicted in the table below.

Table 4.2: Respondents knowledge of Disease and Infection prevention

Knowledge of Disease and infection through unprotected water and feces	**Frequency**	**Percent**
1. Unprotected water source		
▪ Intestinal parasite and diarrhea disease	567	46.9
▪ Malaria and acute respiratory infection	639	82.9
▪ I do not know	2	0.2
2. Feces		
▪ Intestinal parasite and diarrhea disease	523	43.3
▪ I do not know	3	0.2

Source: SCN-E Household Survey, 2011

Table 4.2 above shows that considerable number of the respondents, 17%, does not know if unprotected water source would cause communicable disease like malaria and acute respiratory infection and majority of the respondents, 53%, does not know if unprotected water source would cause communicable disease like diarrhea and intestinal parasite.

The table also reveals that majority of the respondents (57%) do not know if disposing feces in the field would cause communicable diseases like diarrhea and intestinal parasite. Thus, it is possible to say that majority of the respondents do not know major communicable diseases prevention ways such as diarrhea, respiratory infection, intestinal parasite and malaria by protecting water source and using of latrine. However, majority of Key informant and focus group discussant argued that the knowledge level of the community in the study area is not uniform across the woredas and ethnicity in which communities from Hamer, and Nyagatom area has better understanding about disease prevention ways in relation with water, sanitation and hygiene as compare to community members from Karo, Dassenech, Murule, and Muguji mainly due to health extension program and other non -governmental intervention in the locality.

The most common mode of disease prevention methods identified by key informant and focus group discussant in the study area includes:

1. Personal hygiene
2. Using toilet
3. Environmental sanitation and burning garbage
4. Boiling water before drinking

5. Using mosquito net but no one has mentioned the importance of protecting water points.

The respondents were asked about major advantages of using protected water source for disease prevention and the majority (61.8%) said the major advantage of using protected water is that it enables water sources to be free from Germs and microbes where 38.2 percent of the respondents mentioned its importance in terms of physical accessibility and test of water. This shows considerable, 38.2%, number of the population in the study area does not know the advantage of using protected water sources for communicable disease prevention. They were also asked if they know the advantage of using latrine for communicable disease prevention and considerable, 61.8%, number of the respondents related the advantage of using latrine with its physical accessibility than its importance for communicable disease prevention.

However, there is considerable knowledge difference among the respondents in terms of woredas, ethnicity, sex and educational status. In terms of woreda 65% of the respondents in Hamer, 62% in Nyangatom, and 58% in Dassenech woreda know the importance of protecting water source for prevention of infection with Germs and microbes whereas in terms of sex 38% female and 41% of male respondents (38%) do not know the advantage of protecting water sources for disease prevention. There is also significant difference in understanding advantage of water source protection for disease and infection prevention between respondents who at least completed primary school and those who are illiterate. It was only 60% of the illiterate respondents who mentioned the importance of protecting water source for disease prevention as compared to 78% for those who have at least completed primary school.

The household survey also showed that there is considerable knowledge difference among woredas, educational status and sex about the advantage of latrine for communicable disease prevention. Thus, 41% of respondents from Hamer, 43% of respondents from Dassenech, and 67% of respondents from Nyangatom do not know the advantage of latrine for disease prevention. The survey depicted 48% of female respondents and 46% of the male respondents do not know the advantage of latrine for disease prevention and 51% of illiterate respondents and 18% of respondents who at least completed primary school do don’t know the advantage of latrine for disease prevention.

Thus, the household survey revealed that majority of the community member in the study area do not know the advantage of protecting water source and using of latrine for communicable diseases prevention with considerable knowledge difference among woredas, educational status and sex. Based on key informant and focus group discussants all the community under this study has low knowledge about communicable disease in general term. However, the level of knowledge various across the community, Key

informant and focus group discussant clearly reveled that Karo, Erbore, Kore, Murele, and Muguji communities have relatively low understanding about communicable disease that relates to water, sanitation and hygiene as compared to Hamer and Nyangatom.

The key informant discussant disclosed that HIV &AIDS and TB are the two major communicable diseases among Hamer community in South Omo area during this study. They have also stated cases like Sexually transmitted disease (STI), respiratory infection, typhoid, common cold, Trachoma, diarrhea, measles outbreak, and typhus. However, among Karo community only two cases are reported; measles outbreak and meningitis while among Erbore community TB is the major communicable disease where diarrhea and HIV is reported only by few key informants.

Malaria and TB is the major communicable disease among Dassenech and HIV & AIDS, typhus, and measles outbreak are the common communicable diseases among Nyangatom community. TB, Trachoma and common cold are also reported by key informants from Nyangtom community.

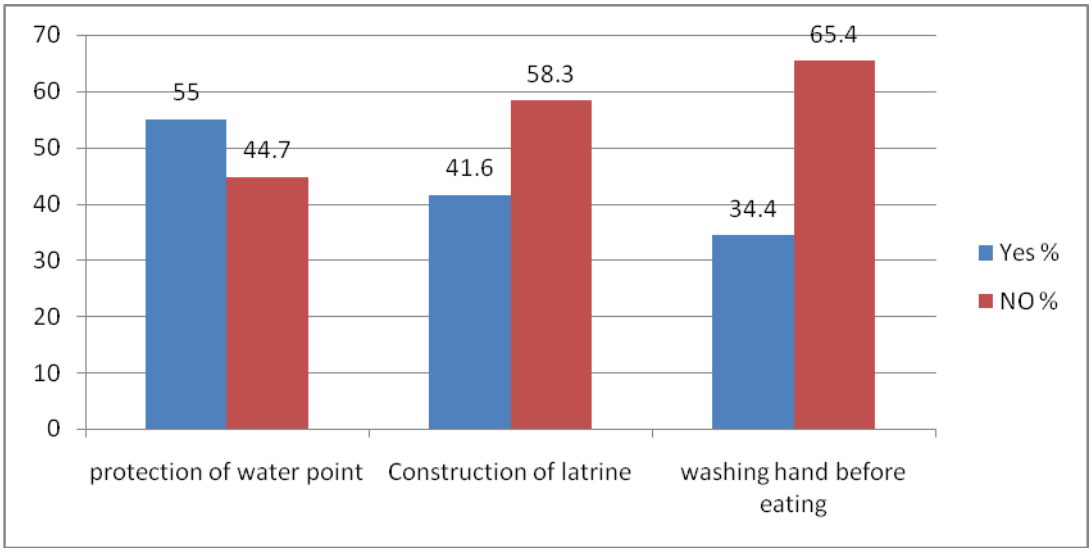
Compared to other communities in the area Hamer and Nyangatom communities are more affected by communicable disease like HIV & AIDS and TB and others.

The focus group discussant were asked for major communicable disease in the area and majority of them agreed that HIV & AIDS, TB, measles, and malaria are the main communicable disease in Hamer, karo, Erbore, Dessenech, and Nyangatom community.

The major communicable diseases in Hamer woreda are TB and HIV & AIDS where as in Dessenech woreda Malaria and TB are the major communicable disease. In Nyangatom woreda HIV & AIDS, typhus, and measles outbreak are the major communicable disease. Based on key informant reports Hamer is more affected by communicable diseases as compared to others followed by Nyangatom whereas Dassenech is least affected by communicable diseases.

Attitude related to Water Sanitation and Hygiene

The attitude of the respondents towards water, sanitation and hygiene were measured using three major variables such as protection of water point, construction of latrine and washing hand before eating. Thus, the respondents were asked if they support the protection of water point, construction of latrine and washing hand before eating for disease and infection prevention and their response is presented in figure 4.2.1



Source: SCN-E baseline Survey, 2011

Figure 4.2.1: Distribution of respondents on attitude toward WASH

Figure 4.2.1 shows that 44.7 percent of the respondents do not support protection of water point as means of communicable disease prevention, 58.8 percent of the respondents do not support the construction of latrine for disease prevention and 65.4 present of the respondents do not support washing hand before eating as means of disease and infection prevention.

Thus, it is possible to say that majority of the community members in the study area do not support protection of water point, construction of latrine and washing hand as means of disease prevention with various degree of attitude for each of the parameters having relatively favorable attitude towards water point protection and less favor arable attitude towards washing hand for disease prevention.

The major source of drinking water is river and *chirosh*, it literally means shallow and temporary bore hole over sandstone. The household survey depicted that 63.7% of the household use river water and 9% of the household in the study area uses *chirosh* as major source drinking and cooking water. In addition, 88% of the population does not use protected water source. This figures various across the woredas, ethnicity, and place of residence. Table 4.2.2 shows the distribution of latrine and protected water usage by woreda, ethnicity and place of residence.

Table 4.2.2: Distribution of protected water and latrine usage

Variable	Category	% who use protected water source	% who have latrine	% who use latrine
Residence	Rural	11.4	25.0	16.6
	Urban	13.4	59.6	52.1
District	Hamer	31.9	47.3	34.5
	Dassenech	1.7	34.5	25.4
	Nyangtom	0.8	24.2	22.7
	Others	18.2	77.3	66.7
Ethnic Group	Hamer	25.2	41.6	28.3
	Karo	38.7	48.4	32.3
	Erborie	27.9	50.8	44.3
	Dassenceh	1.2	14.3	10.6
	Nyangtom	0.9	23.6	23.0
	Muguji	0.0	53.6	35.7
	Others	16.4	54.2	36.9

Source: SCN –E baseline survey, 2011

Table 4.2.2 shows that 13.4% urban dwellers and 11.4% of rural dwellers use protected water which shows very low number of the residents both in rural and urban area use protected water sources. It is also found out that 31.9% of the residents in Hamer woreda, 1.7% of residents in Dassenech and 0.7% of the residents in Nyangatom woreda uses protected water source which shows significant variation among the woredas in using protected water sources where Hamer is relatively in better situation and almost all residents of Dassenech use unprotected water source. In terms of ethnicity 38.7 percent of Karo, 25.2 percent of Hamer and 27.9 percent Erbore community respectively uses protected water points where it is significantly very low among others and almost nail for Muguji community.

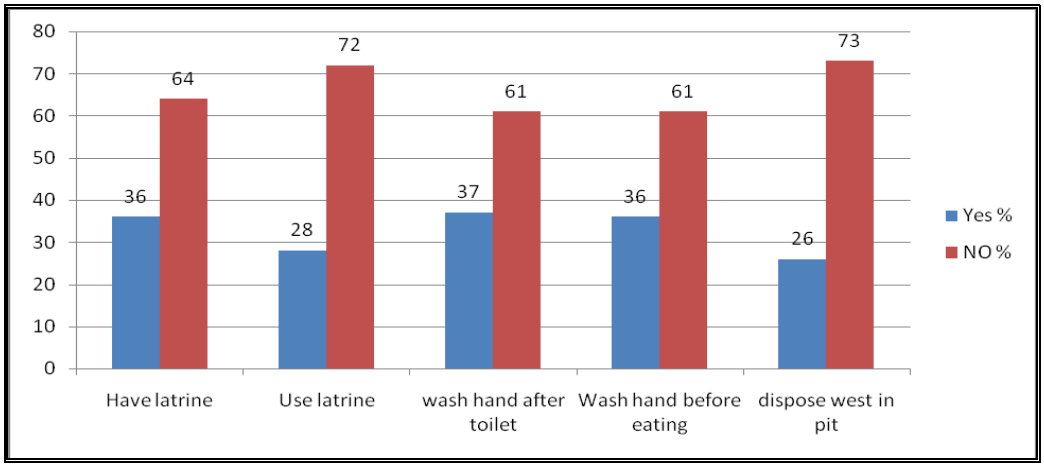
The table also shows magnitude of respondents who have latrine and as well use latrine by woreda, place of residence and ethnicity. Thus, 59 percent of the household in urban have a latrine and 52 percent of them use latrine. The same table also shows 25 percent of rural the residents have latrine and 16.6 percent of theme use it which shows considerable gaps in having latrine and using latrine in terms of place of residence.

In Hamer district 47 percent of the population have latrines but only 34 percent of them use it, in Dassenech woreda 34 percent of the residents have latrine but only 25 percent of them use it and in Nyangatom woreda 24 percent of the population have latrine but only 22 percent of them use it. The table also shows latrine availability and usage by ethnicity in which latrine use is high among Erbore, 44 percent, and very low, 10 percent, among Dassenech.

Thus, it is possible to argue that majority of the population does not have latrine and even those who have reported to have latrine does not use it with significant variation between place residence, ethnicity and woredas.

Water Sanitation and Hygiene Related Practices

Figure 4.2.2 shows the distribution of water, sanitation and hygiene related practices in the three woredas of the study area with help of household survey.



Source: SCN-E, baseline survey, 2011

Figure 4.2.2: Distribution of WASH related practices

Figure 4.2.2 above shows that 64 percent of the population does not have latrine, 72 percent of the population does not use latrine and about 61 percent of the population does not wash hand after toilet and 61 percent does not wash hand before eating with soap or ash. It is found out that majority of the population, 73 percent, threw solid and liquid materials in open field.

The finding of key informant and FGD discussants also revealed similar results. The major source of drinking water among Hamer, Erebore, Dassenech, Murele, and Muguji is river water and *Chiroshe* during rainy season. In areas like Hamer and Erbore few people use potable water constructed by Government.

All key informant and majority of FGD discussant disclosed that all the community in this study area does not use latrine and most community members does not wash hand after latrine and before eating. The major reason the key informant and FGD discussant revealed for not using latrine are:

- Low knowledge about importance of using latrine;
- They perceive if they use latrine it would bring bad stench;
- Luck of experience and knowledge on how to construct latrine;
- Established social norm about latrine. They consider that using latrine in one place is a taboo;
- They perceive that it may cause a disease if human feces is gathered in one area and
- Since they are mobile pastoral community they cannot find latrine everywhere as required.

Under the participatory action research with children, they explained their concern by drawing pictures, writing essays and poems. They underlined the importance of safe adequate water to keep their personal hygiene in their school compounds. They have explained that fulfilling such issues will contribute for the success of their education

4.2.2 Major activities undertaken, Gaps and future intervention strategies in the area related to water, sanitation and hygiene

Some of the major interventions undertaken among woredas and ethnic groups are indicated in the table 4.2.2 below.

Table 4.2.2: List of major WASH related activities undertaken by Ethnicity and woreda

Hamer woreda			**Dassenech woreda**	**Nyagatom woreda**		
Hamer	**Karo**	**Erbore**	**Dassenech**	**Nyagatom**	**Murule**	**Muguji**
▪ Community health promoters Trained ▪ latrine constructed but not used ▪ Award was given to those who -Practices Water, sanitation and Hygiene Activities ▪ Tap water constructed ▪ Health extension workers trained the community	▪ awareness creation	▪ Awareness creation ▪ Tap water constructed	▪ Awareness creation ▪ Community health promoters trained ▪ latrine constructed but not used ▪ Health education on importance of drinking boiled water	▪ Awareness creation ▪ Health education on importance of drinking water after boiling ▪ latrine constructed by NGO but not used ▪ Training given on personal hygiene ▪ Water treating chemical introduced *wuhahagar*	▪ Latrine constructed by government but not used	▪ Soap distributed ▪ water collecting tank constructed

Source: SCN-E baseline survey, 2011

Thus, in summary some of the major interventions undertaken and/or program achievement by various stakeholders including Government and NGOs are:

- Awareness raising and community sensitizations activities were done although it was not in a continuous manner
- Community health promoters who train the community on WASH has been trained and deployed by Health extension workers
- Latrines were constructed as demonstration in some localities although majority of the community members are not using it
- Rewarding households who have started WASH practices
- Soup, water collecting tank and water treating chemicals were distributed in some localities
- In few localities water taps were constructed

As result, of these interventions the following results were achieved:

- Few latrine were built as demonstration latrine in some areas;
- Number of household who constructed latrine increased every year;
- In few areas like Hamer using latrine has started;
- Few household have started taking sick child to health facilities, and
- Washing hand before mail started in some area like Hamer.

The key informants were asked some of the common lesson learnt from these intervention and they have disclosed that they have learned several lessons chief among which are:

- The importance of cascading trainings down to the community level once it is given at woreda and zonal level through appropriate channels of communication;
- Establishing a reward system for households that practices improved water protection, sanitation and hygiene practices would reinforce others to adopt similar behavior;
- Strengthen the health extension program would enable to reach remote rural communities and households with appropriate water, sanitation and hygiene knowledge and practices;
- Strengthening community groups, coordinators, and committees to work in close collaboration would scale up the current intervention to large scale;
- Conducting periodic monitoring and follow up is vital for continuity of the interventions;
- The practices of WASH relates with established pattern of behavior and norms and it requires close cooperation and partnership between the practitioners and community leaders;
- Conducting continuous awareness raising forums would help to challenge the established norms and behavior patterns;
- More works need to be done to participate the pastoralist community in any of the interventions to be conducted, and

- It is clear that a lot of activities need to be done on awareness creation and behavior change on water, sanitation and hygiene activities.

The key informant and FGD discussant were also asked major challenges associated with water, sanitation and hygiene practices among the community and enlisted the following issues as major challenge:

- Low communities awareness on the link between water, sanitation and hygiene with their health
- Absence of solid and liquid waste disposable place
- Serious potable water shortage
- Poor implementation capacity by public sector
- Services related to water, sanitation and hygiene is limited to urban and surrounding areas
- Underutilization of available services like latrine
- Improper utilization of services like water points
- Persistent child illness
- High prevalence of malaria
- In some areas where latrine is built diarrhea and other health problem has occurred due to improper utilization of the latrine

In line with this the key informant were asked what steps has been taken to minimize the challenge associated with WASH practices and they have informed:

- Awareness creation activities were given on importance of using latrine, boiling water before drinking, and related issues;
- Households who constructed a latrine were awarded;
- Health extension workers were trained and deployed, and
- Health extension workers have started training households.

Key informants were asked major gaps observed in WASH program in the study area and they disclosed that the major gaps are:

- Some community members do not accept WASH education given by health extension workers and other coordinators. For instance among Hamer community;
- Failure to use latrine after construction;
- Health extension workers, committees and community coordinators are not working with full capacity;
- Absence of committed leadership in the program;
- Low attention to WASH program by government;
- Knowledge gap by most community members about WASH;
- Absence of potable water in most areas;
- Difference in level of knowledge among communities, community members and households about WASH practices;

- Low literacy rate in the area, it is difficult to get educated community coordinator and committee leader;
- Luck of knowledge about how to construct latrine among most community members;
- Low follow up and supervision by health extension workers;
- Most government build health facilities (health posts) are not functional;
- Luck of sufficient drug supply, and
- Low community awareness about WASH practices.

Finally, the key informants were asked how to improve WASH program in the area and majority of them recommended:

- Providing skill based and action oriented sanitation and hygiene training;
- Conducting continuous awareness raising forums and meetings to the community through community health coordinators;
- Establishing strong monitoring and evaluation system on the program implementers;
- Provide more education on household equipment management and handling;
- Establish and/or strength community level committee that oversee and support the program implementers;
- Train more number of community health promoters to reach more number of household and remote area communities;
- Conduct periodic review and reflection meetings to solve bottlenecks, for common decision makings and to solve challenges together with Health extension worker, community health promoters, government structure and community level committees;
- Conduct participatory planning with community and/or community representative;
- Ensure community ownership on WASH programming;
- Organizing experience sharing visit with neighbor community;
- Develop evidence based implementation strategy and Conduct evidence based interventions;
- Since the community is mobile community expand common latrine in various areas following their mobility routes;
- Establish reward and award system for model community and households to diffusion improved WASH practices;
- Decentralize program based decisions making process and make decisions with the community;
- Strengthen personal and environmental hygiene interventions;
- Develop awareness about washing their cloths frequently;
- Provide detailed education on use of latrine;
- Expand health extension program;
- Construct water tap in central places;
- Build hospital and other health facilities in the area;

- Construct public toilet in every kebeles and areas;
- Ensure provision of potable water in every kebele;
- Distribute water treatment chemical in all kebeles;
- Educate community members on how to maintain water pumps;
- Distribute rain water collecting equipment in every Kebele, and
- Improve the literacy rate of the community.

5. DISCUSSION

5.1 Harmful Traditional Practices

A. General

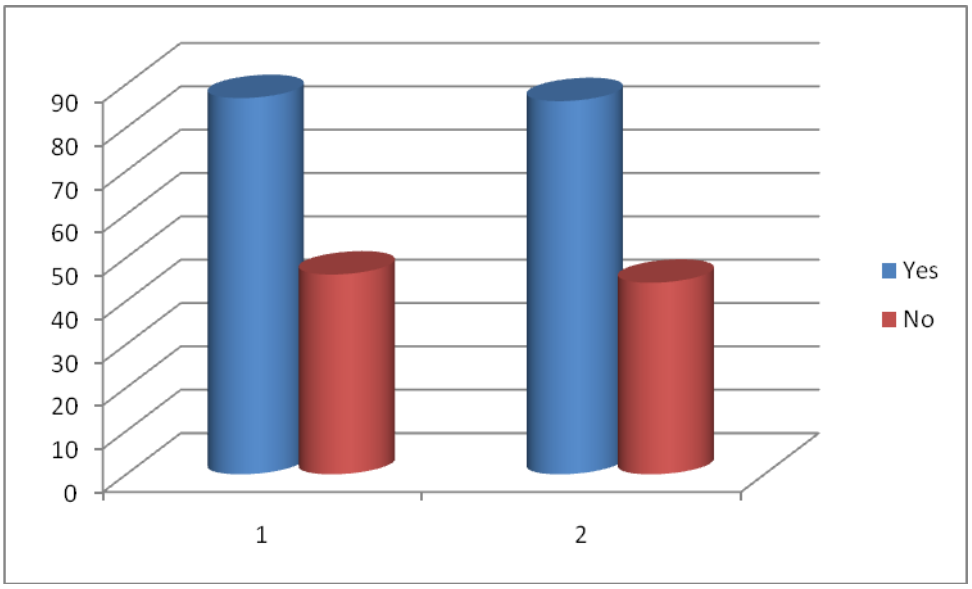
Under the current Baseline Survey about 1208 respondents have been interviewed to generate knowledge, attitude and practice (KAP) indicators on major HTP prevalent in the project area (three woredas). About seven indicators have been generated on 15 selected HTPs prevalence in the project areas. These indicators include:

- Information coverage
- Source of information
- Occurrence/performance on self
- Knowledge
- Attitude
- Intention
- Occurrence/performance at HH level

The information coverage varies for the 11 selected HTPs. The highest is documented for MBA (74.8%), followed by inheritance marriage (67.2%). The rest are below 60 percent around 50 and 40%. For example FGM, MTE, EM and excessive feast range from 50 to 59% while the reaming four (UC, forced abortion, Whipping during cattle jumping and *mingi*) range from 41 to 49%. The information coverage varies by the three woredas considered in this study. For some HTPs like FGM, UC, EM, inheritance marriage and MBA the information coverage is higher in Dassenceh woreda followed by Hammer and the least for Nyangatom. For example the highest information coverage on FGM at Dassenech could be attributed to the focus of the actors; hence this woreda can be classified with the strong hold ethnic group or district concerning FGM. For the remaining HTP like MTE, forced abortion, whipping, *mingi*, and excessive feast the highest information coverage is documented in Hammer followed by Dassenech and the least at Nyangatom. This can be attributed for two important things. The first is exposure to information as Hammer is in a better position for communication with others. The second can be the focus of the actors as the five HTP are highly prevalent in Hammer when compared with the two districts.

The other interesting finding under the current study is the relationship of information coverage with knowledge and attitude. For example, as shown in the figure 5.1.1 the percentage of respondents who consider FGM as harmful (knowledge) is 86.8% among those who got the information while it is only 46.1% among those who did not get the information. The same is true for those who supported the eradication of FGM (attitude) are 86.1% among those who got the information while it is only 44.8% among those who did not get the information. This clearly shows the importance of awareness creation by

providing information to increase the knowledge and attitude of the community towards different HTP.



Key: 1 = Knowledge 2 = Attitude

Figure 5.1.1: Knowledge and attitude towards FGM by information coverage status

The other important factors to increase knowledge and attitude are the educational level of the community members. The following figure illustrates that those respondents who have a better educational status have a better knowledge and attitude when compared with the illiterate. This clearly shows that promoting education in the community can contribute for the reduction of HTP in the project area.

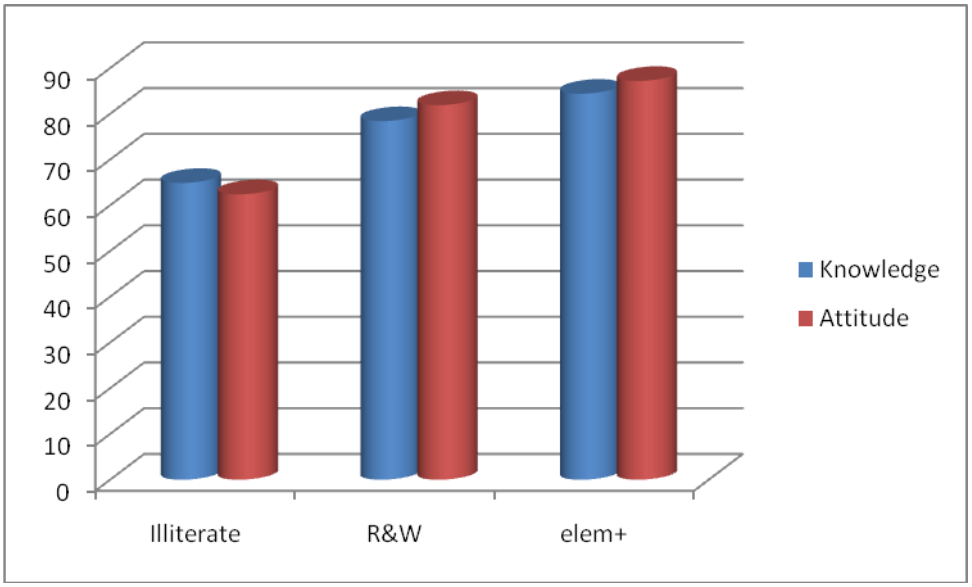


Figure 5.1.2: Knowledge and attitude towards FGM by educational status

B. Priority HTP by districts

Among the 25 HTPs identified in the project area about 11 of them are categorized as priority in Hammer woreda. Among these FGM, EM, MTE and MBA are the national priority HTP and are also common in Hamer districts among the three indigenous ethnic groups. In the urban community Amhara and other non-indigenous ethnic group also face with problem of these national priorities HTP.

Inheritance marriage, excessive feast, unequal marriages (old marring young) are also common in other parts of the country.

Those HTPs that are unique for Hamer Woredas are:

- Forced abortion
- *Mingi*
- Whipping during cattle jumping

The above three HTPs are not only unique when compared with the other parts of the country, but they are also wider in magnitude in Hamer woreda.

In Dassenech, about 7 priority HTPs have been documented where FGM is a serious issue and a concern in the project area especially in Dassenceh woreda. The other unique HTP in Dassench is skin cutting around the breast *Deret Meteltel* which is performed as a sign of a hero person in the community. The rest five like EM, MTE, MBA, Excessive feast and inheritance marriage are common in other parts of the community where the reasons, process and harmful effects motioned at the FUS holds true in Dassenceh respondents.

In Nyangtom the major priority HTP are eight in number and common in other parts of the country except robbery and killing each other.

C. Related HTPs

Forced abortion and *Mingi*

These two practices are serious and top priority HTPs especially in Hamer district. Pregnancy is a detrimental exercise to both the mother and the fetus unless different requirements/rituals that are needed by the society are fulfilled. The Prevalence of forced abortion is higher among currently married and even higher among widowed or divorced women. It also increases with age of women where the highest is documented for age 45+ years. This can be attributed to the longer the women live the higher the probability to experience forced abortion by massaging the abdomen. Forced abortion by massaging the abdomen is not only performed when pregnancy occurs before marriage but also to pregnancies which could be delivered before the teeth of the preceding child came out. Hence, forced abortion by massaging the abdomen is a continuous process, which women cannot easily escape throughout their life even before marriage when they are single. In

here, the link between the *Mingi* concept and forced abortion in these communities can be viewed clearly that forced abortion is done to prevent or resolve the coming of the *Mingi* child. Hence the fight against one should include the same on the other.

Table 5.1.1: Prevalence of Forced abortion by age

Variable	**Label**	**Prevalence of forced abortion**
Age	15-24	9.2
	25-44	8.1
	45+	10.8
	All	8.9

Mingi is in fact a top priority HTP because its consequence is a matter of life and death of innocent children.

One Common issue that has been observed under the current study is the link between forced abortion by massaging the abdomen and *Mingi*. Other main factors to classifying children as *Mingi* are when a woman delivers a child outside of marriage and without fulfilling the *Denb*/rituals. The other reason is when the second child is delivered before the first child's teeth have erupted. Hence the purpose of doing forced abortion is to prevent the delivery of a *Mingi* child. If abortion attempt fails and the pregnancy survives, the child will be delivered bound to being abandoned or killed. It is important to note that in extreme cases, the *Mingi* child's fate is early infanticide, which seems a silent removal of the child with bad lucks. Of course, there are also other reasons for labeling a child as *Mingi*, like when the first teeth unusually erupt on the upper jaw. But, the FGD analysis clearly shows that the major reasons are when a child is delivered outside of marriage (pre-marital or extra-marital) and when delivered between "untimely" after a delivery.

The other commonality between these two practices is the knowledge and attitude of the community. Over 60% of the respondents consider both the two HTPs as harmful and support their eradication and vow not to perform.

Another important common issue to these two traditional practices is the common preventive intervention strategies suggested by the FGD participants. That is, effective use of family planning in the project area. If there will be effective use of both modern and traditional family planning methods, unwanted pregnancies such as those before marriage could be avoided and the interval between two children can be maintained as needed. If the prevalence of unwanted pregnancy can be reduced, the prevalence of forced abortion will decrease significantly. Hence if the prevalence of unwanted pregnancies is reduced

consequently the proportion of children classified as *Mingi* will also be reduced. However, the effort to demystify the *Mingi* concept should be a focus of education as variations among children such as the age of eruption of milk teeth or eruption on the upper or lower jaw do not mean anything but are natural and are not associated to any causation of bad luck at all.

In both HTPs, those who considered the two as harmful, who support eradication and who, vowed not to perform the two in the future are significantly higher among the younger and the educated group. This clearly shows that intervention actors can use both groups during intervention by forming both in and out of school youth clubs.

Widows' Inheritance and Polygamy

Marriage through inheritance of widows is one of the common HTPs in SNNP, in South Omo Zone, especially the two study Woredas, Hamer and Nyangatom have high prevalence. Though classifying polygamy as harmful traditional practices is still debatable, FGD participants and the key informants have classified it as a harmful traditional practice.

On top of women rights, psychological problems, HIV transmission one of the serious harmful effect identified by the FGD participants of widows' inheritance is its effect on the increasing rate of polygamy in the study communities. If someone, in these societies is interested to get married to only one wife, the system of widows' inheritance, as a cultural and traditional practice of salvaging families who have lost breadwinners, will compel him to have more than one wife by increasing the prevalence of polygamy in the society. It is worth to notice that the practice of polygamy is not related to religious beliefs but purely a cultural practice in the study communities.

The other serious difficulty concerning marriage by inheritance of widows is the community's attitude towards it. Some community members consider it as a beneficial traditional practice and only less than 40% of the respondents consider it as harmful, support its eradication and promised not to do it in the future. This clearly calls for an intensive education of the community members by integrating the issue with HIV/AIDS prevention program and women rights. Although this needs further investigation in the study communities, the fact that most deaths of men and women in prime productive and reproductive ages is nowadays attributed to AIDS, heightens the danger associated to inheritance of widows in these communities. Hence getting tested for HIV before proceeding with inheritance marriages with widows of the couple is an intermediary and urgent response to the situation till possible elimination of the practice of marriage through inheritance of widows. The brother of the person who has passed away gets priority to inherit his brother's wife. If there is any someone who is close in the extended family will inherit her.

Whipping Women and Cattle Jumping

Cattle Jumping is considered as beneficial while the concurrent practice of whipping women is regarded as a harmful traditional practice by FGD participants and key informants. Some community members support both whipping women and cattle jumping as beneficial traditional practices that should be fostered to continue in these societies.

Accordingly, the knowledge, attitude and intention towards the practice of whipping women are not as high as that of forced abortion or *Mingi*. The community should clearly understand the potential effect of whipping, i.e. causing HIV transmission; sever wound infection and dreadful pain among women in the study communities. Hence, women to express their love for their brother or relative who is the bridegroom should substitutes other deeds such as dancing for his sake like in other communities. For example the culture from the Amhara ethnic group can be taken to play *Eskista*, a traditional dance, to show their love for their brother or relative during wedding.

D. Other priority HTP

FGM

FGM is practiced among three Ethnic groups, Ari, Erbore, and Dassenech, In South Omo Zone. In the rest, the practice is almost non-existent. In fact among Bena and Hamer ethnic groups the practice of FGM is a taboo where any women circumcised is considered as *Mingi* and classified as unwanted that must be avoided from the community by abandoning away like the child classified as *Mingi*. This might be the main reason precluding even the adoption of this harmful practice from the non-native ethnic groups like Amhara and others.

The unique nature of FGM among the Dassenech ethnic group is the main reason associated with it is that it is considered as a tribal mark.

In the case of Erbore the unique nature of FGM is that a type, which is in between Excision and infibulations where clitoris, labia minora and labia majora are removed. The other unique nature of FGM in Erbore is the reason given for the practice. None of the premises given in other places for doing circumcision of women and girls such as to moderate the libido (sexual desire) of the women, religious requirement or any other are no more given for FGM in Erbore. The main reason is a promise for her husband symbolizing that “she is always for him and to formalize and reaffirm that in practice she is bleeds for him”. Like that of the Borena ethnic group residing just adjacent to the Erbore, FGM is carried out around marriage. The girl is circumcised in the husband house after the weeding. Since wedding ceremonies are conducted at different time there is no group circumcision. The circumcision is performed by traditional perpetrators who are the circumciser. Formerly they were using sharp stone known as *Bualchet*. Currently the

circumcisers use new blade for circumcision. Now days the villagers among the Erbore Ethnic group are receiving blade from new comers as a gift to be used for circumcision.

According to the FGD participants from previous and ongoing efforts, some community members are trying to reduce the harm by shifting from severe form of FGM (excision) to a less damaging type of circumcision. Though this can be considered an improvement among the Erbores, it is better and possible to go for total eradication of FGM to make the study area free from FGM among the native ethnic groups. The population of Erbore is small, manageable and live in a limited geographic area, providing favorable grounds for feasibility of interventions. Hence, an intensive intervention using community conversations and by engaging tribal leaders could facilitate a communal decision leading to a ban of this practice among community members in Erbore. In so doing, it could be possible to eradicate FGM also from Dassenech.

Milk Teeth Extraction

Milk teeth extraction is one of the common HTPs in the study area among all the native and non-native ethnic groups. They apply milk teeth extraction when children face diarrhea. They extract the milk teeth with in six months to one year period of time. From the literature, both at regional and national levels the practice of milk teeth extraction has serious risks that results in immediate and long-term health problems on children. At first, it affect child suffers from severe pain, bleeding and shock that result from the painful operation that is carried out without using anesthesia. Severe bleeding might result in blood loss and even death. Other harmful effects of milk teeth extraction include swelling of the mouth, problem in chewing food and suckling the breast. Most traditional healers use un-sterilized tools that may result in the transmission of infections including HIV. For the second set of (permanent) teeth to grow properly the child's mouth should be free from infection. In the process of performing MTE there is also the possibility of extracting sound and healthy teeth. In addition, no teeth growth, wrong teeth position (deformity), rotten teeth and misplaced teeth are other possible effects of MTE. At times germs may be carried by the blood stream and enter into the bone where the blood circulation is sluggish. As a result an abscess is formed and the pus may spread the infection causing swelling and bone destruction. Considering all these harmful effects in the face of low attitude among community members to support eradication of this HTP, there is a need for concentration of the program to design an appropriate intervention against this practice.

Early Marriage and Marriage by Abduction

Early marriage and marriage by abduction are the two national priority HTPs, which are also identified as the second group priority in the project area. As identified by FGD participants the process of early marriage varies at different places. Marriage in the project area is not the arranged type done by parents, as is the case in other parts of the country. It

is rather the accord built between of the boy and the girl during the cultural dancing events of *Evangadi* that will draw the marriage arrangement to a close.

As indicated in literature, before the age of 18, girls can be seen physically mature but they are not psychologically ready to conceive the formation of family. In many instances, however, girls aged 12-15 years old are confronted with their first pregnancy and related medical problems. Studies indicate a close correlation between childbearing before the age of 18 years and the health risks to both the mother and the fetus.

Some of the major risks of early marriage and abduction are sexual abuse, early pregnancy, early childbearing, unwanted pregnancy, risk to the baby and maternal death. The major harmful effect of early marriage is fistula due to obstructed labor following early pregnancy and early child bearing. Some of the social effects of early marriage include broken marriage, school dropouts, and rural-urban migration. In general early marriage has devastating effects on the girl child, on the family, and on the community at large. Understanding this harmful effect of early marriage and having the highest popular support for eradication intensive intervention in the project area with mass education and legal support assist to bring it to an end of early marriage.

The form of marriage by abduction also varies from area to area. For example, in South Omo Zone among the Ari ethnic group abduction is performed to married women of somebody's wife as a sign of braveness. In this project area the major reasons similar to the other parts of the country and the region.

In general, abduction is unlawful and forceful kidnapping or carrying away of a girl/women for marriage. In almost all cases, rape follows abduction since this is a guarantee that the abductor will most likely succeed in marrying the girl after negotiation, and paying some ransom to the parents through local elders.

Rape which happens in almost in all abductions is the most humiliating and degrading experience to girls and women. Nowadays this act is becoming common in all parts of the country. Rape violates women's rights in all aspects of their life. Victims of rape lose their right to life, dignity, privacy, health, education and security. Their reproductive rights and many other rights are violated. They may *be* exposed to unwanted pregnancy that could lead to illicit abortion, psychological and health problems such as the acquisition of sexually transmitted diseases and HIV/AIDS. Victims of rape will be hopeless, remain lonely and develop psychological problems.

Since abduction also has serious negative effects, it needs serious strategic intervention in the project area using mass sensitization of the community on the legal framework and its application by all concerned.

E. Opinion of children on Priority HTP

As shown in the previous section children who are the victims of major HTP in the project area have identified ‘’*mingi*’’, the issues related to cattle jumping , MTE and others as a common practice in their community. More importantly they Stressed to get the information through the school clubs. This is an important indication as children can protect themselves from different violence if they get the information adequately. They are also the future mothers and fathers who can protect their children to end HTP in the future generation. The idea of multiplication of information was also forwarded during the PAR. This must be encouraged and children found in the school can share their knowledge among the school community and tell their parents on the negative effect of HTP during their day to day routine discussions at each household. This clearly shows that the project can invest to produce a user friendly IEC materials mainly leaflets to distribute for students that can serve them as reference materials.

5.2 Water, Sanitation, and Hygiene

General

Field based empirical evidences conducted at various time depicted that approximately 3.1% of death worldwide relates to unsafe water, sanitation and hygiene practices. Compared to other regions Africa carries the large burden with 4-8% of the share of all diseases related to unsafe water, sanitation and hygiene (USAID, 2008).

In Ethiopia, the situation of access and equity in terms of safe drinking water, sanitation and hygiene practices is very low compared to many African countries. Safe water and sanitation- related diarrhea accounts for approximately 20% of all deaths in children under the age of five, taking the lives of close to 100,000 children annually. Thirty-two percent of this diarrhea could be prevented by improving sanitation interventions such as pit latrines, septic tanks and composting toilets. According to the 2005 Ethiopian Demographic and Health Survey, only 8% of Ethiopian households have water on their premises and only 38% have a toilet. Studies have shown that poor water and sanitation is the source for many health problems including chronic intestinal parasites that attribute to high prevalence of malnutrition, anemia and retarded growth. Poor water and sanitation are also major causes of blinding trachoma in Ethiopia (DHS, 2005).

Knowledge related to Water, sanitation and hygiene

In the present survey it seems most community members of the study area have very low awareness about the link between drinking safe water, sanitation and hygiene practices with communicable disease although the knowledge level various among community members in terms of their educational status, sex, ethnicity and woredas.

The government of Ethiopia has been undertaking health extension program having 16 health packages including water, sanitation and hygiene. In line with this Ethiopia Ministry of health has introduced new sanitation and hygiene strategy, this strategy that has been tried in Amhara region and it had has brought significant improvement in improving sanitation and hygiene practices and also in improving the knowledge of the community. The approach shifted from the production and distribution of latrine slabs to social marketing. Increasing community knowledge and understanding of sanitation and its linkages to health created demand for improved services and resulted in behavior changes. Working in an integrated manner with local leaders and extension agents, and using schools as the focal points for change helped to increase access and stimulate demand. The project focus was not just on individual behavior change but on social change of the entire population, resulting in full coverage (UINCEF and WHO, 2006). Accordingly, it would be vital to understand the variation in level of knowledge among the community members in the study area concerning not only the link between sanitation and hygiene with disease transmission, but also link with communicable disease prevention for the wellbeing of the household in terms of health and social wellbeing.

Several studies indicated that unprotected water source and contamination of food that served to the household are the source of disease and illness that can be prevented through simple sanitation and hygiene exercises such as using latrine, washing hand after toilet, washing hand before eating, preparing food, and feeding children, boiling water for 20 minutes, separating human and domestic animal living etc. The common communicable disease transmission methods identified in the study area relates with environmental and personal hygiene, drinking non boiled milk, open birthing among patients of various diseases, mosquito and dust particles since the study area landscape is characterized by arid landscape with full of dust particles especially along the routes of water and pastor.

It was found out that majority of the community members in the study area do not have adequate knowledge on advantage and disadvantage of protecting water source and using latrine for prevention of communicable disease prevention through simple sanitation and hygiene exercises in its household and surrounding environment as a norm or standard behavior of action in its day to day activities. It is evident both in the household survey and key informant and FGD discussion that Hamer and Nyagatom community members has relatively better know how on importance of protecting water sources and using latrine than Karo, Erbore, Murle, and Muguji. The main reason the key informant and FGD discussant argued is that the former are more cosmopolitan and closer to urban health extension program and other intervention than the later.

Attitude and Practices related to water, sanitation and Hygiene

The current baseline survey found out that majority of the community members in the study area does not have favorable attitude to protection of water points, construction of latrine and washing hand before eating to prevent themselves and their household member from communicable disease although they have got relatively more favorable attitude towards water points protection as compared to washing hand before eating. The logic and philosophy behind this attitude according to the key informant and FGD discussant is that the communities have very low awareness about the link between sanitation and hygiene practices and communicable practices. Some of these practices have been the norm and culture of the society since antiquity and they do not consider it as way of safeguarding their health. Practices like eating without washing hand has been internalized by most members of the community and they do not consider it as an aspect of sanitation and hygiene. Thus, about 88 percent of the household in the study area does not protect water point. In line with this, majority of the community does not have access to potable water services as result about 64 percent of the household use river water and about 9 percent of the household use *Chirosh* as source of both drinking and cooking water in their daily subsistence.

One of the major activities that help household and community to protect water points from contamination and to keep the environmental sanitation and hygiene is construction of latrine with locally available material with water services after toilet but the survey baseline found out that 64 percent of the household does not have latrine and 72 percent of the households are not using latrine. This shows the gap between the availability of latrine and the usage. It is clear that majority of the household does not have latrine and some of those who constructed latrine are not using it. There are many reasons that associate with this phenomenon:

1. Low knowledge about importance of latrine for disease prevention and how to construct latrine;
2. Bad stench occurred due to poor latrine management;
3. Established social norms about latrine. It is considered as taboo, and
4. Wrong perception and misconceptions like if human feces are collected in one place it would cause a serious disease/outbreak.

In line with this it was found out that majority of the household does not wash hand either by soap or ash before eating and about 73 percent of them simply threw both solid and liquid west materials in the field although the practices various from community to community, among male and female and place of residence.

In order to reverse and/or halt these actions and to change community behavior and practices various stakeholders including government and nongovernmental organizations have made a range of interventions ranging from community awareness raising activities

up to latrine construction, distributing soup, septic tank and water treating chemicals. However, this endeavor is surrounded by several challenges: The key challenges identified by key informant and FGD discussant are:

1. Low community awareness about the link between safe water, sanitation and hygiene and communicable diseases;
2. Poor implementation capacity by the public sector;
3. Services related to WASH is limited to urban and surrounding community
4. In areas where latrine is constructed without adequately convincing the community it has exposed the community to communicable disease like diarrhea, and
5. Low literacy rate in the area to deploy community health promoters and health extension workers.

6. CONCLUSION

6.1 Harmful Traditional Practices

Ethiopia is a country of nations and nationalities with colorful cultural practices and diversified socio-economic situation. The country has tremendous beneficial traditional practices such as breast feeding, settling quarrels and conflict management system, social gathering and others that can be examples for the rest of the world. On the other hand, there are also harmful traditional practices that affect the health and social well-being of women and children in various parts of the country and among various communities. Some of these practices include female genital mutilation, early marriage, abduction, milk teeth extraction, uvulectomy, bloodletting and others that seriously affect the health of children and contribute for the transmission of HIV/AIDS (NCTPE, 1998).

Women and children who constitute the vast majority of the population in the country suffer from various types and forms of harmful traditional practices, absence of potable water services, poor sanitation and hygiene practices, work stereotypes and gender inequality. Harmful traditional practices are the most humiliating and degrading experiences to girls and women. Female Genital Mutilation (FGM), marriage by abduction, milk teeth extraction, uvulectomy, tonsillectomy, soiling the umbilical cord, incision and others are the common HTPs that affect children in Southern Nations, Nationalities and people regional State (The Bureau of Statistics and Population of SNNPR, 2005) where more than 56 ethnicity of Ethiopia live with wide range of harmful traditional practices and poor water, sanitation and hygiene services as compared to many African countries and other regions of Ethiopia. Traditional practices vary by it form and type among these ethnic group in South Nations, Nationalities and peoples state (SNNP).

In South Omo Zone alone there are 16 different types of ethnic group residing in different districts of the zonal administration. Among these almost half, about 7 of them are residing in Hammer, Dassenech, and Nyangtom districts where the present study has been conducted. These 7 ethnic groups have different traditional practices. Hence the main objective of the current study to generate a baseline indicator that can serve as a benchmark and to identify current activities and gaps to suggest future interventions of the project in the three districts in the area of HTP and WASH programs. In line with this detail information on knowledge, attitude and intention indicators have been collected from 1208 respondents. Based on this information the following points are concluded:

- Concerning Information Coverage the majority of the respondents (74.8%) got information on marriage by abduction followed by inheritance marriage (67.2%) and not washing under the waist (62.4%). The major source of information are meeting place followed by health facilities;
- The differentials of information coverage by districts showed that Hamer is in a

better position on MTE, forced abortion, whipping during cattle jumping, excessive feast and *Mingi* while it is in a better position in Dassenech district on FGM, UC, EM, MBA, inheritance marriage, and not washing under waist;

- Above 60% of the respondents consider the 9 HTPs as harmful (knowledge) except MTE and whipping women during cattle jumping. This goes in line with the qualitative information where most key informants and FGD participants consider MTE as beneficial for permanent cure and most suggested that the community is not convinced to leave whipping and cattle jumping;
- Again over 60% of the respondents support eradication of 9 HTPs (Attitude) except MTE and whipping. The same is true for those who promised not to perform (Intention)
- In the case of whipping, milk teeth extraction and widows' inheritance though higher information coverage is documented, the knowledge and the attitude of who support eradication is lower than the priority HTPs. This is also witnessed by the qualitative information and respondents as some community members still consider them as beneficial.

Among the different HTPs identified as priority in the project area the magnitude and prevalence differ in the three districts. In Hamer, forced abortion, *Mingi* and whipping are dominant and unique HTP while FGM prevalence is significantly higher and sever in Dassenech districts. Inheritance marriage is higher in Nyangtom including robbery/quarrelling.

In the three projects area different activities in the area of HTP have been started by GOs, NGOs and community members. The main focus is information dissemination through different outlets to the community members. Legal application is at its minimal and initial stage. There is no attempt to identify victims and perpetrators in the three districts. There is HTP task force or committee in some limited member of kebeles. On the other Coordination, networking and mainstreaming are at initial stage in the project area. In line with this the key informants and FGD participants have identified gaps and recommended to fill the gaps in the area of BCC, victims, legal application, perpetrators and capacity building. These idea must get due consideration during the intervention program by the project

6.2 Water, Sanitation, and Hygiene

In the present study the following major findings can be drawn from the baseline survey: These include:

1. In general terms it found out that the communities in the study area have very low understanding about water, sanitation and hygiene practices for prevention of communicable disease and social wellbeing with considerable knowledge difference between the three woredas, ethnicity, educational status and sex.

2. It is possible to say that the majority of the communities in the study area do not know if contaminated food and unprotected water sources are major mode of disease transmission with significant difference among woredas, educational status and ethnicity. The common communicable disease transmission methods identified by the key informants in the three woreda of the study area are:
    a. Open Breathing;
    b. Environmental and personal hygiene;
    c. Mosquito;
    d. Drinking milk without boiling;
    e. Unprotected sexual intercourse; and
    f. Dust particles.
3. The household survey revealed that majority of the community member in the study area do not know the advantage of protecting water source and using of latrine for communicable diseases prevention with considerable knowledge difference among woredas, educational status and sex. Based on key informant and focus group discussants all the community under this study has low knowledge about communicable disease in general term. However, the level of knowledge varies across the community. Karo, Erbore, Kore, Murele, and Muguji communities have relatively low understanding about communicable disease that relates to water, sanitation and hygiene as compared to Hamer and Nyangatom.
4. It is possible to concluded that majority of the community members in the study area do not support protection of water point, construction of latrine and washing hand as means of disease prevention with various degree of attitude for each of the parameters having relatively favorable attitude towards water point protection and less favor arable attitude towards washing hand for disease prevention.
5. The major source of drinking water is river and *chirosh*, it literally means shallow and temporary bore hole over sandstone. The household survey depicted that 63.7% of the household use river water and 9% of the household in the study area uses *chirosh* as major source drinking and cooking water. In addition, 88% of the population does not use protected water source.
6. It is found out that 64 percent of the population does not have latrine, 72 percent of the population does not use latrine and about 61 percent of the population does not wash hand after toilet and 61 percent of the household does not wash hand before eating with soap or ash. It is found out that majority of the population, 73 percent, threw solid and liquid west materials in to open fields. It is possible to conclude that majority of the population does not have latrine and even those who have reported to have latrine does not use it with significant variation between place of residence, ethnicity and woredas.

    The major reason the key informant and FGD discussant revealed for not using latrine in the study area are:

    - Low knowledge about importance of using latrine;

- They perceive if they use latrine it would bring bad stench;
- Luck of experience and knowledge on how to construct latrine;
- Established social norm about latrine. They consider that using latrine in one place is a taboo;
- They perceive that it may cause a disease if human feces is gathered in one area and
- Since they are mobile pastoral community they cannot find latrine everywhere as required

7. In general term children does not have any role in household health and sanitation issues. However, there are difference among ethnicity, woreda and place of residence.
8. Some of the major interventions undertaken by various stakeholders including Government and NGOs in relation to water, sanitation and hygiene activities/program are:
   - Awareness raising and community sensitizations activities were done although it was not in a continuous manner
   - Community health promoters who are supposed to train and mentor the community on WASH has been trained and deployed by Health extension workers but not actively engaging
   - Rewarding households who have started WASH practices system established
   - Soup, water collecting tank and water treating chemicals were distributed in some localities and in few localities water taps were constructed

   As a result of these interventions the following results were achieved:
   - Few latrine were built in some areas;
   - Number of household who construct latrine increased every year;
   - In few areas like Hamer using latrine has started;
   - Few household have started taking sick child to health facilities and
   - Washing hand before eating started in some area like Hamer
9. Major challenges and gaps associated with water, sanitation and hygiene practices among the community in the study area:
   - Low communities awareness on the link between water, sanitation and hygiene with their health;
   - Absence of solid and liquid waste disposable place;
   - Serious potable water shortage;
   - Poor implementation capacity by public sector;
   - Services related to water, sanitation and hygiene is limited to urban and surrounding areas;
   - Underutilization of available services like latrine;
   - Improper utilization of services like water points;
   - Persistent child illness;
   - High prevalence of malaria;

- In some areas where latrine is built diarrhea and other health problem has occurred due to improper utilization of the latrine.
- Majority of community members do not accept WASH education given by health extension workers and other coordinators.
- Absence of committed leadership in the program;
- Low attention to WASH program by government;
- Knowledge gap by most community members about WASH;
- Difference in level of knowledge among communities, community members and households about WASH practices;
- Low literacy rate in the area, it is difficult to get educated community coordinator and committee leader or health promoters;
- Luck of knowledge about how to construct latrine among most community members;
- Low follow up and supervision by health extension workers;
- Most government build health facilities (health posts) are not functional;
- Luck of sufficient drug supply.

7. RECOMMENDATION

7.1 Harmful Traditional Practices

About 11 different gaps have been identified by the key informants and FGD participants in the area of BCC, care, legal application and capacity building. Hence, the following points are recommended in these five thematic areas to be applied by the current project.

I. General in the five thematic areas

A. Behavioral Change Communication (BCC) (Prevention component)

- As suggested by the FGD participants and Key informants the awareness raising program should continue in a consistent and sustainable manner and further reach grassroots level. To this end, indigenous communication mechanisms could be adopted to reach the remotest PAs of the study area through community members at market places, religious institutions and CBO like *Debo* or *Jege*. The common religious institutions found in the project area are Catholic and protestant in the rural community. In the district capitals Demeka and Turmi there are Orthodox followers. Community promoters, club members and CBRH workers could be encouraged to pass the information to grassroots level.
- Interpersonal communication in the form of peer education has the power to bring attitudinal change among individuals. This must be initiated and encouraged among youth, women and farmer groups in the rural and urban communities at the project area. For example, the youth can be approached by forming in and out of school youth clubs and the women groups through peer education during coffee ceremony. In the project area the coffee ceremony is called *Shoforo* where many villagers sit together to discuss common issues.
- Both the quantitative and the qualitative evidence form the current study clearly show that most community members are willing to reduce or eradicate HTPs like forced abortion by massaging the abdomen, *Mingi*, whipping women during cattle jumping, widows' inheritance and milk teeth extraction. The effort must be to gather consensus both at individual and community levels of decisions. For this an appropriately designed community conversation or community dialogue should be implemented at PA levels in the project area of the two Woredas.
- In the process of sustained and consistent education, an intervention project can use:
    - Health facilities and workers to play an important role in awareness raising and in other responses to HTPs especially in the area of widows' inheritance, illegal abortion, milk teeth extraction and on further investigation of improving safety, quality and effectiveness of traditional medicines. To this end, it is advisable, to support efforts in keeping health workers up to date with developments in the effort to eliminate HTPs and to improve the application of traditional medicines in the study area.

- Support to school based initiatives (clubs, teachers against HTPs, pupils/students against HTPs…) including provision of updated education materials appropriate to school youth. It is important to involve more and more schools in HTP networks and advocate for strengthening curricular material on HTP and traditional medicines both for students and teachers' trainings.

B. Perpetrators of HTPs (Prevention component)

- It has to be understood that one important strategy in the reduction of HTP should be to attempt the interruption of the supply side. This leads us to focus our attention on perpetrators of different HTPs like circumcisers, teeth extractors, uvula cutters, TBA that massage the abdomen for forced abortions, elders that arrange marriage related HTPs etc. For this focus the qualitative respondents have forwarded different points. In this effort, it is advisable to:
- Establishing and continuously updating a registry of practitioners in the community and following them up
- Informing them on the laws regarding HTPs
- Providing HTP practitioners with training for alternative employment and/or income generating activities
- Encouraging them to serve as change agents
- Taking legal measures on recalcitrant practitioners; those who do it secretly in particular

C. Legal Application (Prevention component)

Based on the suggestion of respondents one potential area of the intervention could be the maximum application of the available laws in the area of HTPs focusing on early marriage, widows' inheritance, marriage by abduction, whipping women during cattle jumping and *Mingi*. In connection with this it is advisable:

- Relating, as much as possible, formal legal provisions with traditional/customary laws/norms to make them easily accessible and acceptable to the communities and more easily implemented
- Educating the population in general about the legal provisions
- Reinforcing mechanisms to strengthen law enforcement by individuals and community/civil society organizations
- Informing the law enforcement agencies (police, prosecutors, courts on the new legislations from the point of view of HTP
- Advocacy to strengthen the implementing capacity of law enforcement authorities

D. Assisting Victims of HTPs (the care component)

The above three recommendations mainly focus on the prevention component by trying community members to bring behavioral change, perpetrators to stop doing the practice and to apply the law who violate the rights of women and children on parents and perpetrators in the name of tradition. This cannot continue for generation affecting the health of children must be prevented at some point using the different strategy methods. The other targets who are forgotten by most actors are the victims of HTP who are suffering by its complications. This group must be assisted physically, physiologically, mentally, socially and economically and must share their experience to serve as change agents. In line with this and as suggested by the FGD participants and key informants, it is advisable to give legal, medical, psychological and economic support as required and feasible to victims of HTPs like women who faced fistula and complications of illegal abortion, widows' inheritance. This also assists to bring practical behavioral change if the project mobilizes victims as change agents and invite them to share their experience for community members it will be worthy to apply the following strategies:

- Identify victims
- Assist them by refereeing to health facilities
- Support them with IGA program after returning home
- Provide them training on the negative effect of HTP
- Encourage them to teach the community by sharing their experience on the negative effect of HTP

E. Capacity building (Capacity and sustainability component)

One of the important areas of future intervention identified by the respondents is capacity building of partners to assist during the implementation of the project and to take over the project during the exit strategy for sustainability. In line with this important activities like giving training, experience sharing, coordination, networking and mainstreaming should be encouraged in the project areas. It is also advisable to establish committee or task force at kebele level on HTP, link them with school clubs, establish HTPs task force at district level to follow the kebele task force and establish reporting system with the kebele task force

II. Specific to unique or different HTPs

A. Forced abortion by massaging the abdomen and *Mingi*

- These two priority HTPs that are interlinked and that have similarity in different indicators and are common in Hammer district must get serious attention for intervention

- Appropriate educational materials must be prepared on these two HTPs and continuous education must be given for the community by addressing the negative effect and the legal issues related to the criminal act associated with *Mingi*.
- FP practice must be promoted in the project area extensively to reduce the two practices significantly as the cause for illegal abortion is fear of *Mingi* and one of the reasons for the classifying a child as *Mingi* is when s/he is born outside of marriage, without fulfilling the *Denb* and in a short time interval following another birth.
- Concerning *Mingi* the long-term solution should be to demystify the belief associated with children classified as *Mingi* through various community awareness creation and consensus building activities. Where as in the short term it is advisable to give an option for elders of the community to transfer children to government and non-government organizations who can assist in their upbringing instead of killing, throwing to the hill or abandoning them outside of their areas.

B. Widows' Inheritance, whipping and milk teeth extraction

- These are the other two priority HTPs with reasonable information coverage but high resistance among community members to accept them as harmful. Due to this, appropriate educational materials must be developed on these two HTPs to gradually convince community members especially elders and tribal leaders.
- Perpetrators especially milk teeth extractors must be sensitized to give up the practice and to serve as change agents in the overall effort to putting an end to this serious harmful practice in these communities.
- It is very important to integrate the issues of marriage through widows' inheritance and milk teeth extraction with efforts of preventing HIV transmission

As a long term solution the practice of widows' inheritance must be removed from the community. Interventions should aim at eradication of the practice. But, as suggested by the FGD participants, as a short term solution it is advisable to teach people take HIV test before this marriage.

C. Whipping women and excessive feast

- Substitute the expression of love during cattle jumping by local dances instead of whipping;
- Develop appropriate educational materials against the negative effects of whipping (including the potentials for HIV transmission);
- Educate the harmful effects of the bad belief associated with wasteful expenses for rituals in regard of a dead person in family, like *Gelo*.

D. Early Marriage and Abduction

These practices are part of a complex social relationship related to family formation and perpetuation of ethnic groups. Studies on marriage are numerous but often fail to incorporate these HTPs in a holistic picture of the place of marriage in family formation, community building, the role and process of these HTPs, and the relationship between the different HTPs. Further studies elucidating the underlying factors are required.

For the most part, the underlying factors will be related to underdevelopment, poverty and the low status of women. Any intervention project should, therefore, elaborate strategies to strengthen its ties (Networks) with those working in similar fields to have an impact on the process of accelerated socio-economic development in general and the empowerment of women in particular. More specifically, measures should be taken to promote:

- Community collective decision on these practices through community dialogue
- Girls' education (high enrollment, low drop out…).
- Status of women

FGM

- Encourage total eradication instead of harm reduction in Erbore Ethnic group;
- Use Community Conversation among the Erborie and Dassenceh Ethnic group;
- Encourage the community from non-FGM areas to share their experience for Erbore and Dassenech Community members;
- Involve the young boys to declare marriage with uncircumcised girls as FGM is performed around marriage in the study area particularly in Erbore and Dassenech.

7.2 Water, Sanitation, and Hygiene

Based on the finding and conclusion given under chapter 5 and 6 the consulting firm would like to recommend the following points in relation to improving water, sanitation and hygiene practices/programming in the study area:

- As the major finding of this baseline survey is related with knowledge gap among majority of the community members it is vital to design program that improve the knowledge gap of the community like adult education, continuous awareness raising forums using evidence based, targeted and multi-channel behavioral change intervention
- In order to ensure the sustainability of water, sanitation, and hygiene practices it is recommendable to strengthen the public sector working on WASH program like the health extension program who are in charge of training and supervising community health promoters who directly work with the community with help of both interpersonal communication and group dynamics since the study area

community are leading more of communal life and are egalitarian. Thus, it would be also advisable to associate any of WASH program intervention with community structures and community/opinion leader to challenge established pattern of behaviors or social norms related with WASH for sustainable program intervention.

- It is highly recommendable to build the capacity of public sector such as zonal and woreda health office on the following issues:
  - Program management, Supportive supervision and data management to build their capacity on program monitoring and the use of data for decision making and
  - Train health extension supervisors and health extension workers on water, sanitation and hygiene practices based on the national WASH guide to reach the remote rural community.
- It would be vital to design community based WASH program in which the community would identify its WASH related program, plan interventions and implement and evaluation the program using participatory review and reflection process (PRRP). For example, if the program has intended to avail potable water services, the community need to identify the problem, select construction site, establish committee to run the construction process and take the responsibility of water point maintenance and protection. It would also be vital to empower women in this issue since it is women and children who are in charge of this vital resource for the household. One of type of community based WASH program is Community Led Total Sanitation (CLTS). It is an approach that facilitates a process of empowering local communities to completely eliminate open defecation and build and use latrine without any external hardware support. Communities conduct their own appraisal and analysis of open defecation and take their own action to become open defecation free. By raising awareness that as long as even a minority continues to defecate in the open everyone is at risk of disease, CLTS triggers the community's desire for change, propels them into action and encourages innovation, mutual support and appropriate local solutions, thus leading to greater ownership and sustainability

Note: The activities planned under the current project are more or less in agreement with the current finding especially on BCC and Capacity building thematic areas. We suggest the program will be more fruit full if it includes the issue of assisting victims, perpetrators and somehow introduce legal application for grave HTPs like whipping women during cattle jumping, forced abortion, old man marrying young girls (*yalachagabecha*) and others in due course of time.

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ANNEXES – DATA COLLECTION INSTRUMENTS

Annex A: Quantitative Questionnaire (Q1A)

Section One: address & identification

No.	Question/variable	Responses	Skip
101	Address	Woreda Kebele	
102	Sex	1) Male 2) Female	
103	Age in Years	_____Years	
103	Marital Status	1) Never married/single 2) Currently Married 3) Divorced 4) Widowed 5) Others	
104	Religion	1) Orthodox 2) Protestant 3) Muslim 4) Catholic 5) Others	
105	Ethnic group	1)Amhara 2) Hamer 3) Karo 4) Erbore 5) Dassench 6) Nyangtom 7) Muguji 8) Murelie 9) Others	
106	Education	77) Illiterate 66) Reading and writing 78) Grade completed.	
107	Occupation	1) Pastoralist 2) Farmer 3) House wife 4) Merchant 5) Others (specify)___.	

Section Two: Information, Source, Knowledge, Attitude, Intention on HTP

Major HTP	Information 1. Yes 2. No	If Yes, source 1. Radio 2. HF 3. School 4. Meeting 5. Others	Is it performed on you	Do you think that it is harmful? 1. Yes 2. No 3. DNK	Do you support Eradication? 1. Yes 2. No 3. DNK	Will you perform in the future? 1 Yes 2. No 3. DNK	Experience in the last five years 1. Yes 2. No 3. DNK
201. FGM							
202. Uvulectomy							
203. Milk teeth extraction							
204. Marriage <15 years							
205. Forced abortion							
206. Whipping a women							
207. Inheritance marriage							
208. Excessive feast							

209. MBA							
210. Not washing Under the waist							
211 *Mingi*							

Section Three: Prevalence of Priority HTP

No	Name	Relation	Sex	Age	Eth.	Religion	FGM	MTE	UVL	Forced abortion	W	I
301												
302												
303												
304												
305												
306												
307												

W = Whipping of women during cattle jumping I = Inheritance marriage

Status of Mingi in the HHD for the past five years - Has there been a death of child less than five years in the HHD? 1) Yes 2) No

If yes what was the cause of the death? 1) DDs 2) Mingi 3) Others (specify)...

If *Mingi* what was the reason 1) Wrong teeth growth 2) Fulfillment of ceremonial blessing by the clan leaders 3) Pregnancy before marriage 4) Others (specify)

Section Four: KAP on WASH

No.	Question/variable	Responses
401	Have you got information on DDs	1) Yes 2) No
402.	Modes of DDs Transmission	1) Contaminated food 2) Unprotected water source 3) Others
403.	Major disease transmitted by unprotected water source	1) ARI 2) Intestinal parasite 3) DDs 4) Malaria 5) Others (SP)
404	Major diseases transmitted through feces	1) ARI 2) Intestinal parasite 3) DDs 4) Malaria 5) Others (SP)
405	What is the major advantage of protected water source or pipe	1) Near to house 2) Free from germs 3) Can drink good test water 4) Others (specify)

No.	Question/variable	Responses
406	Major advantage of latrine	1) Very near to the house during night 2) Prevents the transmission of communicable diseases 3) others
407	Do you support the protection of water sources	1) Yes 2) No If yes, why If yes, which source
408	Do you support the construction of latrine	1) Yes 2) No If yes, reason
409	Do you support washing hands before eating	1) Yes 2) No If yes, reasons
410.	Water source	1) *Chiroshe* 2) Protected well 3) Unprotected well 4) Protected spring 5) Unprotected spring 6) Pond 7) River
411	How far is the water source	1) Half an hour 2) One hour 3) >1 hour
412	Do you have latrine	1) Yes 2) No If yes, a) private b) shared c) public
413	Do you use latrine	1) Yes 2) No
414	Do you wash your hands after using toilet?	1) Yes 2) No
415	Where do you throw your waste material	1) Private refuse pit 2) Publicpit 3) others.
416	Do you wash your hands with soap or ash before eating regularly	1)Yes 2) No
417	Do your children have any role in your household health and sanitation matters?	1) Yes 2) No

Note: In the above questions, it is possible to have multiple responses. In such situation it is possible to circle more than one choice.

Annex B: Key Informant In-depth Interview Questionnaire (KIIQ)

Section One: Address

Region Zone Woreda PA

Section Two - Identification and other questions

a. Identification

1. Sex a) Male b) Female
2. Age

3. Religion a) Orthodox b) Catholic c) Protestant d) Muslim e) Other (specify)
4. Ethnic Group
5. Occupation
6. Education 88) Literate 77) Illiterate 66) grade completed
9. Marital status a) Single b) Marred c) Divorced d) Widowed e) Other (specify
10. Age at first marriage

b. Other Questions

1. Is there a minimum age for marriage? 1) Yes 2) No 3) Do not know
2. If yes, what is the minimum age?
3. Is there a law against FGM? 1) Yes 2) No 3) Do not know

Section Three: Traditional Practices

a. Identification

1. What are the common beneficial or good traditional practices in this kebele/Woreda? Please list them.
2. What are the common harmful traditional practices (HTP) in this Kebele or Woreda? Please list.
3. What are the top five HTP among the above list?

b. Activities Performed and gaps observed

1. What are the major activities performed in relation to HTP?
2. What were the major achievements or results?
3. What were the problems encountered and solutions attempted?
4. What were the lessons learnt?
5. Was there any behavioral change?
6. Gaps observed?

c. Future interventions suggested

1. To bring behavioral change
2. To assist victims
3. Related to perpetrators
4. Related to legal application
5. Capacity Building

Section Four: Opinion on WASH

1. What are the major communicable diseases?
2. Do the community members know the modes of transmission of these major diseases? If yes, what do they think are the most common modes of transmission of the major communicable diseases perceived by the community?
3. What do they think are the most common modes of prevention of the major communicable diseases perceived by the community?
4. What are the major sources of water?
5. Do the majority of the community members use latrine? If yes, what type? If no why?
6. What are the major activities performed in relation to WASH and child nutrition program in the community?
7. What are the problems faced and solution undertaken?
8. What are the major achievements, lessons learnt and best practices regarding WASH?
9. What are the major gaps in relation to WASH and suggested intervention to fill the gap?
10. Recommendation in the future in general.

Annex C: Focus Group Discussion Points (FGDP)

Section One: Address

Region Zone Woreda PA

Section Two: Background of FGD Participants

Register all FGD participants by age, sex, religion, occupation in a Table.

Section Three: Traditional Practices

a. Beneficial and Harmful Traditional Practices

1. List all the beneficial traditional practices in the PA/Woreda.
2. List all harmful traditional practices (HTP) in the PA/Woreda.

b. Priority HTP

Write the top five priorities HTP from the above list.

c. For each priority ask the following

1. Distribution
2. Process
3. Reasons

4. Harmful effect
5. Major activities performed, Problems and solutions attempted
6. Major outcome, lessons and best practices
7. Observed gaps and suggested future intervention strategies

Section Four: Opinion on the WASH situation

1. What are the major communicable diseases in the community?
2. Do the community members know that major communicable diseases are transmitted through infected water sources, defecting and throwing refuse every where?
3. Do they wash their hands before eating using soap and ash?
4. What are the major water sources in the community?
5. Do the community support protection safe water sources, construction of latrine and refuse pits?
6. Activities performed in relation to WASH and Hygiene.
7. Problem faced and solutions undertaken.
8. Achievements, lessons learnt and best practices.
9. Gaps and future intervention.
10. Others.

Annex D: checklist for the PAR

1. Introduction with the children by telling names of the students and the organizers
2. The major objective of the visit is to assess the situation of grave HTPs including water and sanitation in their area.
3. What are the major HTP in their community?
4. What are the reasons for performing them including their harmful effect?
5. How is the situation of water and sanitation in their community
6. What future intervention strategies do you suggest? For HTP and WASH
7. What is expected from children?
8. Any other issues