HAWASSA UNIVERSITY

COLLEGE OF MEDICINE AND HEALTH SCIENCES

SCHOOL OF PUBLIC HEALTH

INTENTION TOWARDS FEMALE GENITAL MUTILATION AMONG WOMEN OF REPRODUCTIVE AGE GROUP, USING BEHAVIORAL INTENTION APPROACH ATOTEHULO DISTRICT, HALABA ZONE, CENTRAL ETHIOPIA, 2024

BY: DAGMAWIT GIRMA (BSC.)

RESEARCH THESIS SUBMITTED TO THE SCHOOL OF PUBLIC HEALTH HAWASSA UNIVERSITY FOR PARTIAL FULFILLMENT FOR THE REQUIREMENT OF MASTER OF PUBLIC HEALTH DEGREE IN REPRODUCTIVE HEALTH

JUNE, 2024

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DECLARATION

I, Dagmawit Girma, hereby declare that this MPH in reproductive health thesis is my original work (except where acknowledgements indicate otherwise) and has not been presented for a degree in this or any other university, and all sources of material used for this thesis have been duly acknowledged. Moreover, the undersigned agree to accept all responsibilities for the scientific and ethical conduct of the research project. I will provide timely progress report to my advisors and seek the necessary advice and approval in the course of the research.

Signature: _____

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We, the undersigned, members of the Board of examiners of the final open defense by _____ have read and evaluated her thesis entitled "intention towards female genital mutilation/cutting among women of reproductive Age group at AtoteHulo District, Halaba Zone, Central Ethiopia, 2024" This is, therefore, to certify that the thesis has been accepted in partial fulfillment of the requirements for the degree of Masters of public health in reproductive health.

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Stamps of the SGS date----------

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List of Acronyms and Abbreviations

AOR	Adjusted Odds Ratio
CI	Confidence Interval
COR	Crude Odds Ratio
EDHS	Ethiopian demographic health survey
FGM/C	Female genital mutilation/cutting
HTPs	Harmful traditional practice
IDI	In-depth interview
PI	Principal investigator
SDGs	Sustainable developmental goals
SPSS	Statistical packages social science
UNICEF	United nations international children's emergency fund
WHO	world health organization

Abstract

Introduction: female genital mutilation /cutting are a deeply rooted harmful traditional practice, affecting millions of girls and women globally which have serious physical and psychosocial consequences. Understanding the intentions and attitude towards Female genital mutilation among women of reproductive age is crucial however there is only limited research in Ethiopia to have comprehensive understanding of the problem. Therefore, this study was aimed to asses intention towards Female genital mutilation is highly valuable.

Methods and materials: Embedded mixed study design was conducted among reproductive age group between April 1 and April 30, 2024. A total 497 women were selected for the quantitative data using a multi-stage sampling procedure. Data was collected using a structured questionnaire with Kobo collect application. Then, SPSS version 25 was used to clean, to code and analyze of the data. Variables that had a p-value of less than 0.25 in the bivariable logistic regression were selected as candidate variables for the multivariable logistic regression model, and a P value of less than 0.05 at a 95% confidence interval was considered statistically significant. Finlay, the findings were presented using tables, charts and graphs accordingly, for qualitative data, semi structured interview was used among 8 participants and thematic analysis was done by using ATLAS ti.version 24 software

Result: - prevalence of intention towards the practice in this study was 54.1%. the odds of intention to continue were 2 times higher on women who had Favorable attitude than their counterparts (AOR= 2.4: 95% CI= 1.37-4.3: P=0.002), odds of Favorable subjective norm (AOR=4.91, 95%CI: 2.76-8.63, P=0.000)were about 5 times higher intend to continue than their counterparts also, Circumcision history of women (AOR=2.76, 95%CI=1.2-6.3, P=0.017) and Child with circumcision (AOR= 5.75, 95% CI= 2.2-14.7, P=0.000) were found to be significantly associated with intention. For qualitative part 3 themes were extracted from total respondents including, attitude, subjective norm and intention to continuation.

Conclusion: According to this study 54.1 of the participant had intended to continue the practice. Attitude, subjective norm, child circumcision history, mother circumcision history as a child was associated with intention. For qualitative part. Participant's attitude, Subjective norm and intention to continue were the themes extracted from analysis, which support our quantitative findings.

Key words: - intention, Female genital mutilation, reproductive age group, Ethiopia

Chapter 1 Introduction

1.1 Background

The term "female genital mutilation(FGM)/cutting" refers to any non-medical practice that involves the partial or complete removal of external female genitalia or any other damage to the female genital organs(1). This practice is a deeply rooted traditional practice, rooted in religious, personal, and societal beliefs within a frame of psychosexual and social reasons, against girls and women that has serious physical and psychosocial consequences which adversely affect health (2, 3).

The Joint Declaration classified FGM/C into four categories. Type I: clitoridectomy, in which the prepuce and/or clitoris are removed entirely or partially. Type II: partial or total excision of the clitoris and labia Minora, or with or without of the labia Majora. Type III: Narrowing of the vaginal opening, with or without clitoris removed (infibulation), and labia Minora and/or Majora sliced and positioned to form a covering seal. Type IV: Unclassified refers to any additional hazardous non-medical operations that are applied including cauterization, pricking, piercing, incising, and scraping(1).

An estimated of 200 million girls and women in 30 countries have been subjected to the FGM/Cutting. Of these 200million more than half live in Indonesia, Egypt and Ethiopia, while 44 million are girls below 15 years (4).

Female genital mutilation is performed on communities for a number of reasons. These include adherence to social norms, respect to customs and traditions, rites of passage of womanhood, increased fertility, marriage prospects, virginity assurance, chastity and faithfulness, cleanliness and beauty, femininity and religious beliefs(5). The practice is primary found in area where there is high poverty, child mortality, illiteracy, poor sanitation and access to modern health care facilities. Religion, tradition, poor economic and social status of women are among the most common factors reported to play a role for the practice to continue and exist(6)

FGM/C performed on children by traditional circumcisers, or traditional birth attendants. The procedure is typically performed in an unsanitary setting by an operator who lacks basic surgical training and awareness of the anatomy of the female genitalia. As a result, the child's health will

undoubtedly suffer grave difficulties, even leading to death. And faces significant impairments that have an impact on their long-term mental, physical, and reproductive health(7).

Any type of FGM is also considered as a violation of the human rights of girls and women, it is known to be harmful to girls and women in many ways; the removal of or damage to healthy, normal genital tissue interferes with the natural functioning of the body and causes several immediate and long-term physical, psychological and sexual consequences(8).Women who have had FGM/C may face complication ranging from immediate issues such as shock, bleeding, and infection to long-term effects such as chronic pain, miscarriage, stillbirth, primary infertility, and psychological suffering such as post-traumatic stress disorder(9).

Theory of reasoned action is one of Behavioral Intention approach developed by Fishbein and Ajzen in 1970's in the field of social psychology, provides understanding and predicting human behavior(10).

Behavioral intention is the central construct and the most immediate determinants of behavior. It's defined as people readiness to perform behavior thus intention is assumed to capture the motivational factors that influence the behavior: they are indication of people's willingness to try and the amount of work they intend to put in to carry out the behavior (11).

This theory posits that individual intention to perform a behavior is strong predictors of the actual behavior influenced by their attitudes, subjective norms. Attitude refers to people's positive and negative evaluation towards that specific behavior. Subjective norm refers as perceived social norms to perform or not to perform the behavior.as general rule, the more favorable the attitude and the subjective norm the stronger the intention to engage in the behavior .It suggests that these determinants play a crucial role in shaping individuals intention towards engaging in or rejecting specific behavior (10, 12, 13).Each indicator contributes independently to intention to carry out or not to carry out FGM(14).

1.2Statement of the problem

Globally around 200 million girls and women in 30 countries have been subjected to the FGM/Cutting, including parts of Africa and the Middle East. Accessible information from extensive representative surveys indicates the practice is extensively concentrated in a region spanning from the Atlantic coast to the Horn of Africa(4, 15).

FGM is most prevalent in parts of Asia, the Middle East, and Africa, as well as among some immigrant populations in North America and Europe, even though that it has been observed worldwide(16).

The prevalence of FGM according to figures from African countries shows a prevalence of more than 70% in Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Guinea, Mali, Mauritania, Northern Sudan, and Somalia. However, there is great variation in prevalence between and within countries, reflecting ethnicity and tradition (8). Egypt is the country with the highest number (27.2 million) of women undergone FGM/C while, Somalia has the highest prevalence rate (98%) of FGM.in Ethiopia around 23.8 million girls and women also undergone FGM/C(15).

According to EDHS, 65 percent of reproductive aged women 15 to 49 years have been exposed to FGM; whereas 47 percent of adolescents aged 15 to 19 have been subjected to the procedure. (17). In some Ethnic groups the prevalence of FGC was higher than the national level. For instance, Somalia (99%), Afar (91%), and 92% in wolaita, Other nearby studies conducted in the southern Ethiopian Hadiya zone (82.2) conclude that FGM is still highly prevalent(17, 18).

The health of women and girls may be affected by female genital mutilation or cutting. Severe pain, severe bleeding, shock, wound infection, trauma, difficult urination, tetanus and other infectious diseases, and/or death may occur immediately following the cutting. Long-term complications may include depression, anxiety, difficulties having sex, painful menstrual cycles, fistula, and difficulties during and after childbirth(9).

It was commonly reported that most of those who went through the process FGM and the public at large claim to know about the problem entailed in FGM and disapprove of the practice; nevertheless, recent studies shows that despite relatively widespread awareness about consequences of FGM and disapproving attitude, four in five women reported having circumcised

their daughters. Besides, still, there are mothers, who come out proactively to support the practice in connection to sanitary reasons, to avoid shame, and to respect cultures (19). Only a few had tried to stop the practice and the majority had taken no steps to do so. This may be attributable to the fear of becoming alienated from the cultural system and fear of isolation (20).

The nationwide research shows that support for the practice of female genital mutilation dropped from 42.8% (no education) to 2.0% (higher education). Additionally, showed that support to continue the practice going ranged from 76.0% in Somalia and 69.0% in Afar to 13.3% in Dire Dawa and 5.9% in Addis Ababa, respectively(21).

FGM/C is Also human rights issue that affects girls and women worldwide thus; elimination is a global concern. In September 2015, the United Nations General Assembly adopted new sets of development objectives on the SDGs, including targets under five goals to eliminate all harmful practices, such as child, early and forced marriage, and FGM/C. By the year 2030(4).

Over the last two decades in general, Ethiopia has significant legal, policy, and programmatic measures to eliminate FGC. The country has also developed a national Harmful traditional practice (HTPs) strategy that aims to take a three pillar approach (prevention, provision, and protection) to fulfilling its commitment to ending FGM/C and early/child marriage practice. Additionally, Ethiopia has criminalized code, revised in 2005. To end, a mix of prevention and provisional intervention are under implementation at different levels by government(22).

Despite numbers of many interventions FGM practice persist in the country with different magnitude. Although there are several studies that applied behavioral intention approach explain health-related behaviors, no studies applied behavioral intention approach with mixed design to assess intention towards FGM/C in Ethiopia. As central Ethiopia has multiethnic group with varying socio-cultural contributing factors for FGC. It's unlikely to end FGM without considering the opinion of mothers regarding the practice. Thus, this study will display intentions toward FGM among reproductive age women Atotehulo district, Halaba zone, central Ethiopia.

1.3 Significance of the study

FGM is a deeply ingrained practice in some communities, causing lasting physical and psychological harm to women and girls. This study can shed light on the underlying motivations and factors influencing its continuation, paving the way for targeted interventions and awareness campaigns.

By exploring personal attitudes and intentions towards FGM, the study can contribute to breaking the cycle of silence and empowering women to make informed choices about their own bodies and their daughters' well-being.

Addressing FGM effectively requires a nuanced understanding of the cultural context and the complex reasons behind its persistence. This study can provide valuable insights into the specific attitudes and motivations within a particular community, informing culturally sensitive approaches to prevention and support.

Furthermore, it is anticipated that the outcomes of this research will serve as valuable input for district health care planners and program managers. This input can aid them in developing targeted and scientifically grounded interventions to address the identified gap.

2. Literature Review

2.1 overview of Female genital mutilation

FGM/C is practiced all over the world. Around 30 countries mostly in East and West Africa and parts of the Arabian Peninsula. As a result of migration from these areas, it is now also practiced in Europe, Australia, and the United States of America(4).

There are several regions in Africa, Asia, and the Middle East where FGM/C is practiced; however, the highest prevalence was found in Horn Africa, where it accounts for over 99% of cases; the prevalence of FGM varies throughout Africa, ranging from 2% to 95%, Egypt is the country with the highest number of women undergone FGM/C while, Somalia has the highest prevalence rate (98%) of FGM(15).

As a systematic analysis of secular trends done for prevalence of FGM among 0-14 aged girls from 29 countries from Africa, and two countries from Western Asia, the overall prevalence decreased from 71.4% in 1995 to 8.0% in 2016 in East Africa, the prevalence decreased from 57.7% in 1990 to 14.1% in 2015 in North Africa, the prevalence decreased from 73.6 % in 1996 to 25.4% in 2017 in West Africa. The trend analysis showed that a significant reduction rate of FGM prevalence in East Africa followed by North Africa then followed by West Africa(23).

According to EDHS 65% females have undergone FGM, statistics from the survey revealed that prevalence ranges from 27.1% in the Gambella region to 99.7% in the Somali region, and to more than 50% in the capital city of Addis Ababa(17).According to a research conducted in the Bale zone of the Oromia region with a sample size of 634 women and girls of reproductive age group, the overall prevalence of FGM was 78.5%(24).

The study conducted in southern Ethiopia, which involved 780 high school girls and women in the Hadiya zone, 82.2% of the participants had undergone FGM at a mean age of 11 years old, and over 50% said that the procedure is being carried out in their village(25).

2.2 Magnitude of intention towards Female genital mutilation

The DHS's women's survey revealed that 58% of Egyptian girls, 63% of Guinean girls, 16% of Kenyan girls, 72% of Malian girls, 3% of Niger girls, 23% of Senegalese girls, and 52% of Sierra Leonean girls supported the continuance of FGM(26). And other related study conducted in Nigeria showed that 21% claims they will continue FGM on their children(27). In contrast, study conducted in Nigeria showed that 70% of respondents did not intend to circumcise their daughter for the future(28).

A community-based cross-sectional study design conducted in bale zone revealed that 26.7% of the respondents had intention towards FGM continuation and 27.3% of the respondents reported that they support FGM to be continued on their daughters(24).related study conducted in kersa showed that 26.7% of the respondents had an intention for the continuation of FGM(29).

The nationwide research shows that support for the practice of female genital mutilation dropped from 42.8% (no education) to 2.0% (higher education). Additionally, results indicated that support for keeping the practice going ranged from 76.0% in Somalia and 69.0% in Afar to 13.3% in Dire Dawa and 5.9% in Addis Ababa, respectively(21).

2.3 socio-demographic characteristics of intention towards FGM.

Secondary in-depth analysis of EDHS data in Mauritania revealed that both female and male (64% and 70%) Favor continuation and 71 % continue circumcise their daughters but varied depending on ethnicity(30)

A study conducted in the Jigjiga district of eastern Ethiopia showed that the prevalence of FGM was associated with the level of education, age of participants, and their occupations. The prevalence of FGM was found to be high among older age groups. Those women whose age is below 25 years were about 35% less likely to undergo FGM compared to their counterparts(31).

Compared to younger mothers, older mothers have more positive attitudes($p <. 001$) toward FGM, perceive themselves as having more control over their behavior and demonstrate a greater intention to allow their daughter to undergo FGM(32).

Study conducted in south west, jimma zone showed that Compared to their male counterparts, female adolescents were 36% less likely (P<0.01) to favor the continuation of FGM (AOR: 0.64; 95%CI: 0.49, 0.83)(33).other related study conducted showed that being female was less likely to support a continuation of FGM (AOR:0.07 CI:0.05-0.88)(34).

A study conducted at the national level is revealed that the support for the continuation of females genital mutilation decreased from 42.8% among Females with no education to 2.0% among Females with higher education (35). study conducted at Kersa district showed that parents with less educational level(under high school)were more likely to cut their girls (AOR = 2.04; 95% CI: 1.25, 3.09)(35).another study also showed that moms who were less educated had a more positive attitude towards FGM practice and felt more societal pressure(32).

Those living in semi-urban and rural regions were 1.46 and 1.52 times more likely, respectively, to have a positive attitude towards the practice of FGM continuing than those living in urban areas (P 0.05) (33).other related study also support living in rural had positive Towards FGM(32).

2.4 Circumcision history

Compared to parents who had a history of female genital mutilation, those who had none were 3.39 times more likely to say they had no intention of performing FGM on their daughters (OR = 3.39; CI = 2.62–4.39)(36). There is a significant variation in the degree of support for circumcision among women who have had one or more of their daughters circumcised than women who hadn't(37).

Women who are genitally mutilated are more likely to genitally mutilate their daughters (AOR = 28.732, 95% CI = 6.171–133.768), and those who have previously genitally mutilated their daughters have greater intention to genitally mutilate future ones (AOR = 141.786; 95% CI = 9.584–209.592)(38).

2.5 Theory of Reasoned action characteristics of intention towards FGM

Study conducred in ravansar showed that attitude is the strongest predictor (p <.001) of mothers' intentions to allow their daughters to undergo FGM, followed by subjective norms. Thus, mothers who had a positive attitude and felt greater social pressure from significant persons in their lives

were more likely to intend to mutilate their daughters(32). other institutional based cross-sectional study conducted in Dunna districts south ethiopia, Primary school girls' intention towards FGC increased by 0.18 units for every positive unit change in referents' acceptability of circumcision(P = 0.039)(39).

An interagency statement described that most children or women are circumcised by local women and traditional midwives often the intervention is part of cultural rituals that make the transition to womanhood and preparation for marriage(16).

A study conducted by the community society reveals that 39% of the women continued FGM/C because of custom. About 60% of respondents said that FGM/C was religious practices, while 15%–25% refused to express an opinion. 72% of husbands prefer wives who have undergone circumcision. Of those, 45% think it stopped adultery(40).

A study conducted in Egypt showed that, although concerned about the possible effects on their daughter, they support FGM/C, claiming it as a way to protect their daughter's virginity, preserve her femininity and marriageability, and preserve community identity(41). A study in Ethiopia that 26.7% of the respondents had an intention for the continuation of FGM. Religion, safeguarding virginity, tradition, and social values were the major reasons for the perpetuation of this practice(20).

In a qualitative study carried out in the Hababo Guduru District of the Oromia region of Western Ethiopia, the key informants most commonly stated that the purpose of FGC was to prepare daughters for marriage, to avoid shame, and to reduce their daughters' sexual desire(42).another qualitative study conducted in Hadiya and Wolaita zone showed that social and cultural acceptability of the practice, influences from peers, families, future marriage partners , the community(poor awareness and positive attitude towards continuation) were among reason for perpetuation of FGM practice(43, 44).

A cross-sectional mixed study carried out in the Jigjiga district of eastern Ethiopia showed that maintaining virginity, gaining social acceptability, having improved marriage prospects, receiving religious approval, and maintaining good cleanliness were among the potential justifications for FGC practice. The most important factors that predicted FGC were religion, place of residence,

respondents' educational attainment, mother's education, attitude, and belief in religious requirements.(45).

A study conducted in Somalia, 96% of males said they would rather marry women who have had FGM/C. Still, 85% of respondents preferred the Sunna form and it's for religious purposes (AOR=16.5 CI: 2.43-112). Only two people agreed that all FC should be discontinued. 96% of males said that FC was necessary for their religion(34)

2.3 Conceptual framework

The conceptual framework in this Study illustrated multiple factors affecting intention towards Female genital mutilation

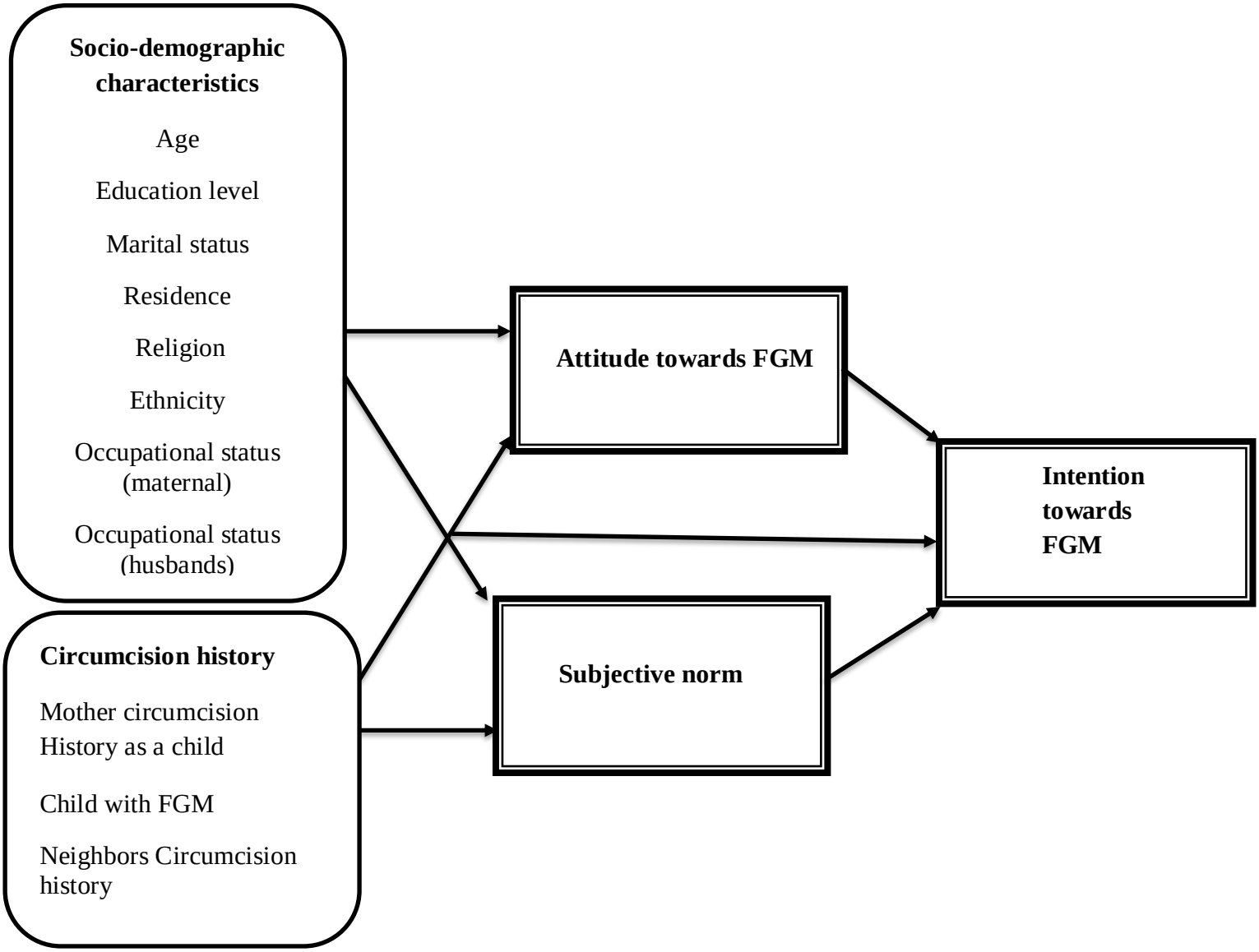

Figure 1conceptual framework Adapted from ajzen and other shows intention towards Female genital mutilation among reproductive age group, behavioral intention approach AtoteHulo District, Halaba zone, Ethiopia 2024(14, 32, 46).

3. Objectives of the study

3.1 General objectives

- To assess intention towards Female genital mutilation among women of reproductive age group in Atotehulo district, Halaba zone, central Ethiopia 2024.

3.2 Specific objectives

- To assess the level of intention towards FGM among women of reproductive-age group in Atotehulo district, Halaba zone, central Ethiopia 2024.
- To identify factors associated with that intention to continue FGM among women of reproductive-age group in Atotehulo district, Halaba zone, central Ethiopia 2024.
- To explore the subjective norms and attitudes for perpetuation of FGM in Atotehulo district, Halaba Zone, Central Ethiopia 2024.

4. Method and Materials

4.1 Study area and period

The study was conducted in Atotehulo district, Halaba zone, central Ethiopia, which is located 242 kilometers south of the capital Addis Ababa. Based Atotehulo district health department report, there are 3 health centers and 21 health post serving 21 kebeles with an estimated total population of 86,228 from which female were 43,977.From this Child bearing age mothers in the district are 20,091 and it has a total of 17,597households. Majority of the resident of the districts are Halaba in ethnicity followed by kembata. The source of income of the community is based on croup production, coffee, chat farm and Trading. The study was conducted from April/1/-April/30/2024

4.2 Study design

Cross sectional quantitative and phenomological qualitative study (A mixed methods design) was employed to achieve the study objectives. From mixed, concurrent mixed was used. Concurrent mixed design is a research methodology that combines elements of both qualitative and quantitative research approaches simultaneously. Then triangulation will be involves to enhance the validity and reliability of finding **(47)**.

4.3 population

4.3.1 Source of population

All women of the reproductive age group (15-49 years old) who were living in the AtoteHulo district.

4.3.2 Study population

For quantitative:-

Randomly Selected Women of the reproductive age group were available during the data collection period and met the inclusion criteria in the selected kebeles.

For qualitative study participant

Women of reproductive age group, who believed to be best informant of the topic and

strong public speaker with health extensions recommendations, were chosen purposely for in-depth interviews in selected area.

4.4 Eligibility criteria

4.4.1 Inclusion criteria

- Women of reproductive age group (15-49 years) who lived in Atoteullo district, for six months and more
- Women of reproductive age group lived in AtoteHulo who had uncircumcised daughter.

4.4.2 Exclusion criteria

- Women of reproductive age group who are critically and mentally ill.

4.5 Sample size determination

4.5.1 Quantitative Data

The sample size for the first objective was determined using a single population proportion formula calculated by Epi-info version 7.2 by considering the following assumptions: proportion of intention (26.7%) towards continuation among reproductive age women(24), 95% level of confidence, 5% precision, and 10 % non-response rate.

$$\frac{(Z\frac{\alpha}{2})^2 \text{ X } P(1-P)}{d^2}$$

$$(Z\frac{\alpha}{2})^2 = 1.96$$

$$\alpha = 0.05$$

d= the margin of error is = 0.05

$$n = \frac{(Z\frac{\alpha}{2})^2 \text{ X } 0.267(1-0.267)}{d^2}$$

$$n = \underline{(1.96)^2 \text{ x } 0.267(0.733)}$$

$$(0.05)^2$$

$$n = \underline{3.84\text{x } 0.196}$$

$$0.0025$$

$$n = \underline{0.75}$$

0.0025

N=301

With 10% non-response rate (331) and multiplying with 1.5 design effect the total sample size will be =497

The second objective was calculated used with the following statically function by epi infoversion7.2 with the assumption of type one error of 0,5 and 80%, previous similar literature is referred and the proportion of associated factors among non-exposed groups reviewed and taken. For each factors power of 80%CI of 95% and 1:1unexposed to exposed ratio is considered**.**

Table 1 Sample size determination for the second objectives based factors from other studies

Factors	Proportion among non-exposed	AOR	CI	10% Non-response rate	Sample size with 1.5 D.Effect	Reference
Education	6.8	7.58	(3.47,16.54)	4.4	72	(24)
Parent circumcised	6.8	2.89	1.33, 6.20)	9	146	(24)
Religion	18.5	1.46	(0.45, 4.71)	16.8	284	(31)

The factors the one which gives larger sample size in which 284 was taken. By comparing with sample size of specific objectives the larger sample which is 497 from specific objective one was taken as a final sample size.

4.5.2 for qualitative data

In-depth interviews (IDI) session was carried out to address the qualitative study portion. 8 IDI participants' sessions were held. The sample adequacy was determined by data saturation and obtaining no new information.

4.6 Sampling technique and procedure

4.6.1 for quantitative Data

To select the study participants' multi-stage sampling technique was used. First, simple random sampling was used to select the district from the 3 district found in halaba zone and then five from a total of 21kebeles in the selected district. The selected 5 kebeles has total 4728 households. The calculated sample size was allocated proportionally to the size of populations in each selected kebeles, and sampling frame was extracted using family folder from health extension workers to identify women who fulfill the inclusion criteria. Then, simple random sampling technique (computer generated table of random number) was used to select the study units from households who fulfill the inclusion criteria. In case of more than one reproductive age women who fulfill the inclusion criteria found in selected households, the data collectors selected one woman by lottery method. Women who will not exist during the visit time were revisited until three times and move to the next household. The sampling procedure is presented diagrammatically as follows (figure2)

4.6.2 for Qualitative

Some district of kebeles were used to select women for IDI sessions using purposive sampling method that fulfills the inclusion criteria, based on their knowledge and information towards female genital mutilation, . Data were gathered from 8 IDI participants who known by the community as best informant and public speaker. The sample size was determined based on data saturation and obtaining no new information

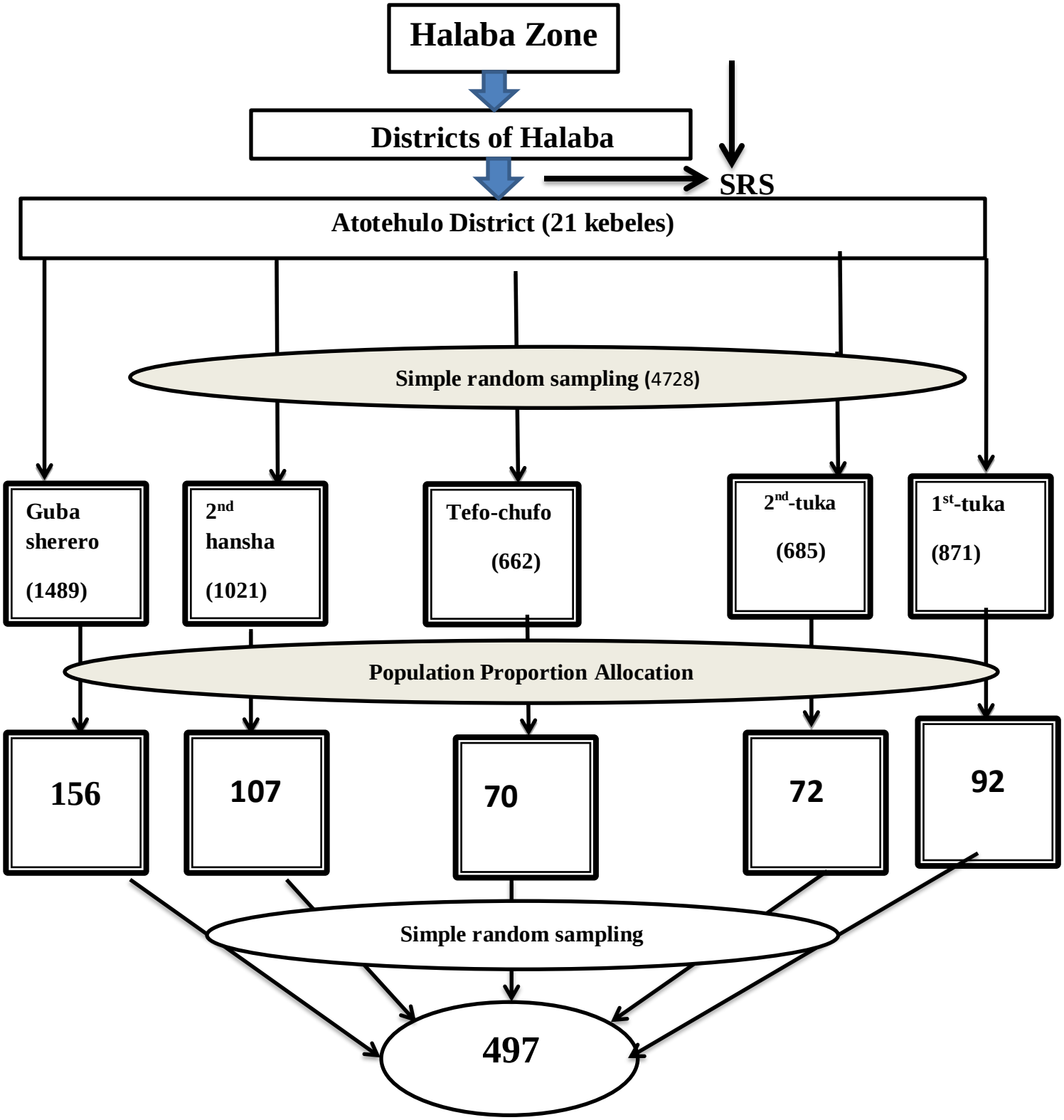

Figure 2 Schematic presentation of sampling procedure for intention towards FGM among reproductive age women in Atotehulo District, Halaba Zone, Ethiopia

4.7 Study variable

4.7.1 Dependent variable

Intentions towards FGM/C (intend to Continue or intend not to continue FGM/C)

4.7.2 Independent variable

Socio-demographic variables: Age, marital status, educational status, husband educational status, religion, ethnicity, residence, child circumcision history**,** mother circumcision history, neighbor's circumcision History.

Constructs of Theory of Reasoned action

Attitude, subjective norm and behavioral intention

4.8 Operational definitions

FGM/Cutting: to any non-medical practice that involves the partial or complete removal of external female genitalia or any other damage to the female genital organs(1)

FGM types: There four types of FGM according to WHO classification

- Type I(Clitoridectomy)
- Type II (removal of clitoris and labia Minora)
- Type III (infibulation)
- Type II (incising, scraping, and cauterizing the genital area.)(1).

Behavioral Intention: Intention refers to an individual's conscious decision and motivation to perform a specific behavior. It reflects the individual's readiness to engage in the behavior(10).

Attitude: the individual's positive or negative evaluation of perception of a particular behavior, including about its consequences, importance and moral considerations(10, 12).

Subjective norm: Subjective norms refer to an individual's perception of what others think they should do. They take into account the influence of social norms, the expectations of important others, and the desire for social approval(10, 12).

Construct of behavioral intention approach measurement

Intention: Three question items was used to assess participants' intentions: whether they intended, will try, or plan to circumcise their daughter or practice FGM. Each of the 4 questions included a 5-point rating scale, with 1 “strongly disagree" and 5 “strongly agree." To ensure that all aspects of the respondents' intentions were recorded and sums of the mean was computed for analysis. Reliability of the item was good(r= 0.9).

Attitude: mothers attitude towards FGM of direct measures was assessed by asking respondents to respond to nine questions (e.g. “is FGM performed for religious reasons”).a 5 point Likert-scale , with;1(strongly dis agree) and 5(strongly agree) was used to asses items and once items transform to composite variable, means were computed for analysis. Those scored above the mean was labeled as favorable attitudes and those scores below the mean value was labeled as unfavorable attitude towards FGM. Reliability of the item was good(r= 0.94).

Subjective norms: direct measures of subjective norm was measured with 3 items; whether the respondents think important others (spouse, family, friend, community leaders) wanted them to practice FGM or whether the respondents feel societal pressure to practice or think it will be expected of them to practice. 5 point Likert-scale with; 1(strongly dis agree) and 5(strongly agree) were used to assess items. once items transform to composite variable, means were computed for analysis Those scored above the mean was labeled as the favorable subjective norm and those scores below the mean value was labeled as unfavorable subjective norm towards FGM. The reliability of the item was good(r= 0.92).

Table 2 Measurement scale

SN	**Attitude/SN/BI**	**Assigned score**
1	**Strongly disagree**	**1**
2	**Disagree**	**2**
3	**Neutral**	**3**
4	**Agree**	**4**
5	**Strongly agree**	**5**

4.9 Data collection procedures and tools

4.9.1 For Quantitative data

Based on ajzen and other colleague recommendation (14, 32, 46).structured interview questionnaire was prepared and kobo collect mobile application was used for data collection. The questionnaire contained socio-demographic characteristics and attitude and subjective norm items. The questionnaire was developed in English and translated to local languages by language expert (Halabiafo) and was translated back to English. To collect the data 5 BSc nurse who are fluent in speaking local language were recruited as data collectors, while one public health officer and 1 MPH who have experiences in data collection supervised the whole data collection process. The data were collected from respondents through face-to-face interview with selected participant at their home. In case of more than one reproductive age women who fulfill the inclusion criteria found in selected households, the data collectors were selected one woman by lottery method. Women who did not exist during the visit time were revisited until three times and move to the next household.

4.9.2 for Qualitative Data

Data collection was conducted through In-depth interview using in-depth interview guide to gain deep understanding related to participant intention, attitude and subjective norm. Before interview, the interviewer and the note-taker were discuss in each question to exclude any differences. Face to face interview was employed for 8 IDI sessions for about 30-40 minutes each. With participant's verbal consent, the assistant data collector was recording audio and the principal investigator was take note to capture participant's response, the assistant data collector will help the participant whenever there is language barrier. At the same time, the audio was transcribed word by word and was used as primary data source. IDI was taken in a quiet and private room in order to preserve participant's safety

4.10 Data quality assurance

4.10. Quantitative

The questionnaire was first developed in English then translated in to Halabi-afo and retranslated back in to English for checking the consistence. Detail training for data collectors and supervisors was given on the objectives of the study and how to interview, how to fill the questionnaire using

kobo tools and handle questions asked by respondents during interviewing by the principal investigator for 4 days. Furthermore, feedback and correction on daily basis for the data collectors was deployed to the field and completeness, accuracy, and clarity of the collected data was checked carefully and performed by the principal investigator and supervisor. Before the actual data collection, pre-test was carried out on 5% of the sample size and modification was done. Also, Reliability of the data collection tool for TRA items was checked by Cronbach's alpha test. (a= 0.94).

4.10.2 for qualitative Trust worthiness of data

Credibility

To ensure credibility the researchers were ensured prolong engagement on the data and were discussed data coding, analysis and interpretation throughout the process of the research with advisor's and other researchers who have experience with qualitative research.

Transferability

To establish transferability the investigator was provided detail explanation of the whole research process from the data collection to final report. A participant statement was quoted directly and, detail definition was developed between the studied contexts and studies itself.

Dependability

The finding of the research was audited and verified by the advisors to examine the data. The audio records, notes and process during the analysis were kept for cross-checking.

Confirmability

To establish confirmability the participants own word was used instead of interviewer opinions eliminate biases throughout the procedure.

4.11 Data Analysis

Quantitative Data

After the collected data checked for consistency and completeness, Data was cleaned, coded and analyzed using SPSS version 25 statistical software. Cross tabulation was done among dependent variable and independent variables. Intention was dichotomized and bivariate logistic regression

was conducted to see the association of each independent variable to the outcome variable. Variables with p-values of up to 0.25 in the bivariate logistic regression analysis was identified and fitted to the multiple logistic regression analysis to identify the independent effects of each variable to the outcome variable. The model fitness test was checked by Hosmer and Lemeshow model fitness test. Also an Adjusted Odds Ratio with 95% confidence intervals (CI) was computed to identify the presence and strength of associations, and $p < 0.05$ was taken as statistically significant.

Qualitative Data

For qualitative study, first, the researcher managed the data by creating and organizing files through data collection, translation and transcription, so that it was accessed easily for analysis. Then the researcher read and reread the transcriptions to detect emerging themes, making notes in the margins of the phenomena, the concepts, or themes. Lastly, researcher was interpreting the theme to reveal core meanings of the experiences and presenting the discoveries of the study**.**

Specifically, thematic analysis technique was used to analyze the data. The interview was transcribed, and was performed by the researcher. Data transcribed by principal investigator was read several times to critically evaluate and get the concept and group in to themes based on the concept they contain. So that responses was categorized under each theme. And an investigator was analyzing data to answer study objective and write report based on categorized themes. Quotes were used to highlight each category and show association with each theme. The researcher discussed and agrees with supportive advisor on the final themes analysis. ATLAS ti software version 24 was used to facilitate data analysis.

4.12 Ethical considerations

Ethical clearance was obtained from Hawassa University, College of Health and Medical Sciences and Formal letter also was submitted to all concerned authorities through process. The participants were informed about the purpose of the study and written informed consent was obtained from participants to confirm willingness. They were notified that they have the right to refuse or terminate at any point of the interview. Confidentiality of the information was secured throughout the study process.

4.13Dissemination of Results

The findings will be presented to the Hawassa University scientific community and submitted to Hawassa University School of Public health. The findings will also be communicated to local health planners and other relevant stake holders at Zonal level in the area to enable them take recommendations in to consideration during their planning process. It can also be communicated to health planners and managers at regional level through Hawassa University website and library. Efforts will also be made to publish in peer reviewed national and International journals.

5. Result

5.1 Quantitative result

5.11 Socio-demographic characteristics

The study involved a total of 497 participants with 100% response rate. The median age of a participants were 27 years with IQR of 24 to 30. Majority of the respondents 441(88.7%) were Muslim by religion, and 371(74.6%) had Halaba Ethnic background. About 2/3 (70.2 %) of participants were rural residents. Most of the respondents 416 (83.7 %) were married. Regarding occupation status of the women 2/3 of the respondents or 318 (64 %) were housewives. whereas, more than half 269 (54.1%) husbands' occupation were farmers. In terms of educational achievement 221(44.5%) were unable to read and write, while 18 (3.6 %) attended diploma and above education. Over 94% of mothers, 77.5% of children, and nearly 90% of neighbors had a history of circumcision (table 3)

Table 3 Socio demographic characteristics of reproductive age group mothers in Halaba District, Ethiopia 2024

Variables	Category	Frequency N=497, (%)
Age	18-27 28-37 ≥38	261 (52.5) 204 (41.0) 32 (6.4)
Ethnicity	Halaba Kembata Silte Welayita Other	371 (74.6) 56 (11.3) 43 (8.7) 23 (4.6) 4 (8.0)
Religion	Muslim Orthodox Protestant	441 (88.7) 25 (5.0) 31 (6.2)
Residence	urban Rural	148 (29.8) 359 (70.2)
Marital status	Single Married Divorced Widowed	32 (6.4) 416 (83.7) 30 (6.0) 19 (3.8)

Educational status	Cannot read and write Can read and write primary education (1-8) secondary education (9-12) diploma and above	221 (44.5) 99 (19.9) 123 (24.7) 36 (7.2) 18 (3.6)
Occupational status (mothers)	Farmer Housewife Civil servant Merchant Student	40 (8) 318 (64) 31 (6.2) 57 (11.5) 51(10.3)
Occupational status (husband) ***n=416***	Farmer Daily laborer Civil servant Merchant	269 (64.7) 27 (6.5) 31(7.5) 89 (21.4)
Mother circumcision	Yes No	467(94.0) 30 (6.0)
Child circumcision	Yes No	385 (77.5) 112 (22.5)
Neighbor circumcision	Yes No	447 (89.9) 50 (10.1)

5.12 Attitude measures, Constructs of TRA

A study revealed a range of views on female genital mutilation (FGM); Over half (57.5%) believed it is a good tradition. However, for other reasons like religion (34.6%), marriage prospects (49.5%), social acceptance (52.7%), or a rite of passage (35.0%), less than half agreed.

The results on Female Genital Mutilation (FGM) showed a mixed view. While over half (50.5%) of respondents expressed a favorable attitude towards FGM, a huge portion disagreed with reasons commonly cited for the practice. Disagreement was strong on specific justifications: around 40-45% rejected beliefs that FGM is important, pleasurable, promotes chastity, or guarantees virginity (Table 4)

Table 4 attitude of reproductive age women towards intention of FGM in Halaba, Atotehulo district, Ethiopia 2024

	Category, N=497, Frequency (%)

Items of Attitude		Strongly Disagree	Disagree	Neutral	Agee	Strongly Agree
Is female circumcision a good tradition?		91(18.3%)	61(12.3%)	19(3.8%)	286(57.5%)	40(8%)
Is female circumcision being important?		104(20.9%)	200(40.2%)	16(3.2%)	133(26.8%)	44(8.9%)
Is female circumcision being pleasant?		133(26.8%)	221(44.5%)	10(2.0%)	97(19.5%)	36(7.2%)
Is female circumcision performed for religious reason?		129(26.0%)	55(11.1%)	111(22.3%)	172(34.6%)	30(6.0%)
Is female circumcision good for chastity and faithfulness?		108(21.7%)	212(42.7%)	34(6.8%)	94(18.9%)	49(9.9%)
Is female circumcision increase chance of marriage?		68(13.7%)	96(19.3%)	6(1.2%)	246(49.5%)	81(16.3%)
Is female circumcision preserve virginity until marriage?		103(20.7%)	214(43.1%)	30(6.0%)	96(19.3%)	54(10.9%)
Does female circumcision increase social acceptability?		59(11.9%)	63(12.7%)	23(4.6%)	262(52.7%)	90(18.1%)
Is female circumcision rite passage to womanhood?		84(16.9%)	145(29.2%)	37(7.4%)	174(35.0%)	57(11.5%)
Attitude	Favorable	**251(50.5%)**				
	Unfavorable	**246(49.5%)**				

5.13 Subjective norm, constructs of TRA

The majority, 145(29.25 %), 153(30.8 %) of the respondent strongly Agree with the question asked whether people who are important to me puts me under pressure and wants me to make my daughter(s) undergo FGM, respectively. Most 136 (27.3 %) of the respondents agreed with the question that my referents expect me to make my daughter(s) undergo FGM. In addition, the computed (composite variable) subjective norm measures show that 276 (55.5%) of the respondents had a favorable subjective norm. (Table 5)

Table 5 subjective norm among women of reproductive age group, Halaba zone, Atotehulo District, 2024

subjective norm items	**Category, N=497, Frequency (%)**				
	Strongly Disagree	**Disagree**	**Neutral**	**Agee**	**Strongly Agree**
Most people who are important to you put you under pressure to make your daughter(s) undergo FGM.	78(15.7%)	139(28.0 %)	32(6.4 %)	103(20.7 %)	145(29.2 %)
Most of your referents expect you to make your daughter(s) undergo FGM.	66(13.3 %)	135(27.2 %)	31(6.2 %)	136(27.4 %)	129(26.0 %)
Most people who are important to you want you to make your daughter(s) undergo FGM.	62(12.5 %)	109(21.9 %)	60(6 %)	143(28.8%)	153(30.8%)
Subjective norm	**Favorable SN**		**Unfavorable SN**		
	276**(55.5 %)**		221**(44.5 %)**		

5.14. Behavioral Intention measures, constructs of TRA

More than 1/3 (35.6%), 151 (30.4%), and 152 (30.6%) of the respondents agreed with the question of whether they intended, had a plan, or would you make your daughter circumcised, respectively. (Table 7)

Table 6 behavioral intention among women of reproductive women, halaba zone, Ethiopia. 2024

Behavioral intention Items	**Category, N=497, Frequency (%)**				
	Strongly Disagree	**Disagree**	**Neutral**	**Agee**	**Strongly Agree**
Did you intend to make your daughter undergo circumcision?	82(16.5 %)	88(17.7 %)	54(10.9 %)	177(35.6 %)	96(19.3 %)

Do you a have plan to make your daughter undergo circumcision?	84(16.9 %)	102(20.5 %)	57(11.5 %)	151(30.4 %)	103(20.7 %)
Would you allow your daughter to undergo circumcision	84(16.9 %)	99(19.9 %)	69(13.9)	152(30.6)	93(18.7)

Intention towards Female genital mutilation

In addition, 269 (54.1%) of respondents intended to continue the practice while 228(45.9 %) participant not intended to continue the practice (Figure 3).

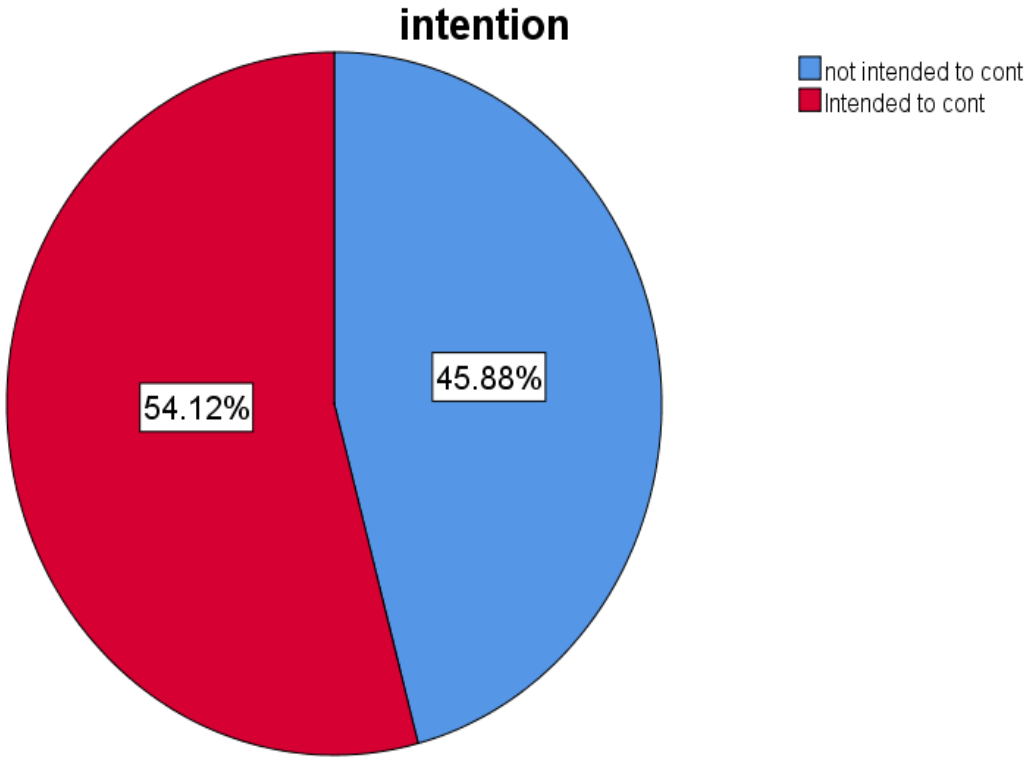

Figure 3 intention towards female genital mutilation among reproductive age group Halaba zone, Atotehulo district, Ethiopia, 2024

Factor associated with intention towards female genital mutilation in binary and multivariable logistic regression.

In the Bivariable logistic analysis age, educational status, participant residence, mother occupation status, husband occupational status, mother circumcision history in the family as a child, child circumcision history, neighbors circumcision history, subjective norm, attitude were found to have association with intention toward FGM at a p-value ≤0.25(Table 3).

All variables with p-value <0.25 at bivariable logistic regression were included in the multivariable logistic regression, in the final model four variables including Attitude of the participant, subjective norm ,mothers history of circumcision, and Child circumcision history were significantly associated with p-value <0.05. Accordingly, women who had favorable attitude towards female genital mutilation were nearly 2 times higher odd to intend to continue the practice compared to their counter parts **(AOR=2.4: 95% CL=(1.37-4.31: P=0.002)**. Participant who had favorable subjective norm were nearly five times **(AOR=4.91, 95%CI: 2.76-8.63, P=0.000)** higher odd intended to continue the practice compared to their counter parts. Women who had experienced circumcision as a child were about 2.8 times **(AOR=2.76, 95%CI=1.2-6.3, P=0.017**) higher odd to intend practicing FGM.

Women who had circumcised child had 5.7 times higher odd intended to continue the practice **(AOR= 5.75, 95%CL= 2.2-14.7, P=0.000)** (Table 8)

Table 7 factors associated with intention towards FGM practice in binary and multivariable logistic regression, Atotehulo district, Halaba zone, Ethiopia.2024

Variable		Intention		95% CI		p-value
		Intended	Unintended	COR	AOR	
Age	18-27	124	137	**1**	**1**	
	28-37	128	76	1.86(1.28-2.7)	1.4(0.82-2.6)	0.2
	≥38	17	15	1.25(0.6-2.6)	0.98(0.27-3.5)	0.97
Educational status	No formal education	205	115	8.9(4.21-18.9)	1.07(0.2-6.65)	0.93
	Primary	55	68	4.04(1.82-9.0)	1.05(.17-6.6)	0.95
	Secondary and above	9	45	**1**	**1**	
Residence	Urban	92	56	**1**	**1**	
	Rural	177	172	0.63(0.43-0.93)	0.698(0.37-1.33)	0.27
Mother 0ccupation	Farmer	21	19	1.57(0.68-3.64)	2.30(0.43-12.44)	0.33
	Housewife	209	109	2.73(1.49-5.01)	3.39(0.83-13.92)	0.09
	C. Servant	1	30	0.048(0.01-0.4)	0.34(0.012-9.59)	0.53
	Merchant	17	40	0.61(0.27-1.35)	2.71(0.52-14.25)	0.23
	Student	21	30	**1**	**1**	
Father occupation	C. Servant	10	21	**1**	**1**	
	Merchant	26	63	**.**0.87(0.86-2.09)	1.42 (.41-4.8)	0.57
	D. Laborer	6	21	0.6(0.18-1.95)	3.9(.67-23.2)	0.13
	Farmer	180	89	4.25(1.91-9.4)	1.87(0.61-5.77)	0.27
Mother circumcision	Yes	249	169	**4.35(2.52-7.48)**	**2.76(1.2-6.3)**	**0.017**
	No	20	59	**1**		
Child circumcision	Yes	258	127	**18.65(9.66-36.0)**	**5.75(2.24-14.7)**	**0.000**
	No	11	101	**1**	**1**	
Neighbor circumcision	Yes	263	184	10.48(4.38-25.11)	1.08(0.32-3.67)	0.89
	No	6	44	**1**	**1**	
Attitude	Negative	81	165	**1**	**1**	
	Positive	188	63	**6.08(4.12-8.97)**	**2.4(1.37-4.31)**	**0.002**
Subjective Norm	Un Favorable favorable SN	66	155	**1**	**1**	
		203	73	**6.53(4.41-9.67)**	**4.9(2.76-8.63)**	**0.000**

AOR with bold indicate variables with P value <0.05

5.2 Qualitative Result

A total of 8 participants were involved in the study .found between 20 and 45 age range. The entire participants were Muslim and married. Regarding educational status half of the participants were secondary level (table 9)

Table 8 socio-demographic characteristics of participant, (N=8)

code	Age	Educational status	Marital status	Religion	employment	Child status
001	32	Primary	Married	Muslim	merchant	Yes
002	20	Secondary	Married	Muslim	House wife	Yes
003	34	Secondary level	Married	Muslim	Farmer	Yes
004	25	Secondary Level	Married	Muslim	Merchant	Yes
005	45	Primary level	Married	Muslim	Housewife	Yes
006	25	Primary level	Married	Muslim	Civil servant	Yes
007	34	Primary level	Married	Muslim	Housewife	Yes
008	34	Secondary	Married	Muslim	Business woman	Yes

3 themes were emerged from the analysis of the interview. Those themes were attitude towards FGM, subjective norm and intention of continuation towards FGM.

Theme1: subjective norm

This study found that Female genital mutilation practice is not merely a personal choice but heavily influenced by the expectation and pressure exerted by culture, family pressure, peers pressure, religious beliefs, and societal norm plays a powerful role to perform or not to perform

circumcision. Among the participants most of them responded that Female genital mutilation is enriched as a cultural norm, perceived as essential for maintain social acceptance and fulfilling community tradition. Participant frequently highlighted that circumcision is a mandatory cultural practice, with a significant social repercussions for who do not conform. The fear of social ostracism and belief in continuing culture heritage were common responses of the most.

A 20 years old participant said that "Female circumcision is seen as a culture, as it is seen as a culture, it is obligatory in this area, woman should be circumcised before she reaches the age of 15. It's believed that we must continue this culture" (**code01**).

Many respondents noted that they were pressured by family members, including parents and spouses to circumcise their daughters. This pressure ensures the influential family member's decision-making, often overriding individual preferences. And peers pressure contributes significantly to the continuation. Uncircumcised women often facing obstacization and bullying from their peers.

A 20 years old participant said that "Well, I remember when I was a child, my grandmother beat my mother and took me to circumcision. It is impossible to leave. They force me because they want me to be circumcised**" (code 2).**

A 45 years participant said "When my daughter turned 16, she used to trouble me to circumcise her because of, her friends were belittled her. Then one day she came and cried, saying if I wasn't circumcised, I wouldn't ever go outside. Then we just said okay, and her father took her too undergone circumcise**" (Code 05).**

Religious beliefs justify circumcision as religious obligation and marker of purity reinforcing its continuation.

A 30 years participant said that "The religion also permits women to have minor skin cuts, known as Sunna, in order to protect them from the negative expectations of society. If not, it is not permissible for a girl to offer **Salat** because they are deemed to be impure (**Nejasa)**" **(code03**)

Broader societal expectations further reinforce the practice. The fear of social exclusion and the desire for social acceptance compel many to continue the practice. Community members often perceive circumcised women as more respectable, obedient, and suitable for marriage

A 45 years participant said that “our society won't accept it they'll put fingers on the one who said I am not circumcised so it's a must that she has to circumcised only the circumcised woman will be able to have a husband**” (code 6).**

Theme 2 Attitude of the participant

Attitudes towards female genital mutilation (FGM) are complex and multifaceted, encompassing both positive and negative perspectives that influence the continuation or rejection of the practice. Respondents maintained a positive attitude towards female circumcision, viewing it as beneficial for social behavior and religious conformity.

These participants believed that circumcision helps girls become more respectful, calm, and acceptable in society.in contrast there are also negative attitudes towards FGM, centered on its harmful health impacts. Many respondents pointed out the physical and psychological dangers associated with the practice, including complications during childbirth, excessive bleeding, and reduced sexual satisfaction

45 years old participant said “I encourage my daughter to circumcise, to study the Quran, as she is not to be isolated from her religion. Uncircumcised women claimed to be impure. So It helps her to become calm, a woman and polite**” (code 5).**

A 34 years participant said “When she was circumcised, the part of the flesh that was cut was huge and caused her prolonged labor and caused her to bleed and death” When we hear such accidents, our stomachs fill up with mattresses” **(code 3).**

Theme 3 intention to continuation of the Practice

The intention to circumcise future daughters remains strong among many respondents due to ingrained cultural beliefs and the perceived social benefits. This intention despite, knowing the effects of circumcision is often motivated by the desire to avoid social stigma and ensure better marriage prospects for their daughters.

A 34 years old participant said that “Despite being aware issue that she faces, I would still circumcise my daughter out of concern for the psychological effects of discrimination from peers, the community, and her religion. I don't want her to lose her opportunity to get married, so I can't bear to watch her suffer. Therefore, I'll circumcise her” **(code 8).**

And another 20 years participant said “I want it to continue, it's a culture, and it’s hard to leave a culture alone It's better to be circumcised and look alike. I don't want them to be embarrassed. Even if I don't want to circumcise my daughter, society, family and my husband would make my daughter circumcised**” (code 2).**

6. Discussion

In this study we assessed intention towards female genital mutilation (FGM/C). The findings showed that over half (54.1%) of the studied population intend to continue the practice.

Quantitatively, the study identified four key factors influencing this intention: The women's own attitudes towards FGM, Social pressure from their community and significant others (subjective norm), circumcision of another child, and whether the woman herself had undergone FGM as a child. And qualitative findings from this study underscore the pervasive of cultural, familial, and religious pressures on intention towards continuation.

This study showed that 54.1% of women intended to perpetuate female genital mutilation on their daughters. This result is higher than the national Ethiopian demographic survey (EDHS) report (18 %), in Iraq (32.2%), in Nigeria, two studies (21% and 30.1%), as well as other regional studies in Ethiopia, specifically Oromia and southern Ethiopia show that lower intention at 26.7% and 44.1%, respectively (17, 24, 32, 36, 38, 39). This study also lower than the study conducted in Egypt (86.1%), in Mauritania (64%), and in eastern Ethiopia (84%) (30, 48). The difference in prevalence across studies could be explained by socio-demographic feature of the study participants which is attributed to localized cultural norms and social pressure.

This study reveals that, women circumcised as a child were two times more likely to develop intention towards continuation of FGM compared to women who had not circumcised. This finding aligns with previous research in Nigeria and the Bale Zone of Ethiopia, which suggests a social learning process. Girls who experience FGM themselves may be more likely to view it as a normal or even necessary part of growing up increasing the chance they will continue the practice on future generations. Our Qualitative finding also support the Quantitative finding in which women who have experience with FGM intend to continue the practice due to broader societal expectations and benefits she got when she circumcised (24, 36, 38).

This might be explained by the fact that Women who have been mutilated may harbor erroneous beliefs and perceive it as tradition. In a world where female genital mutilation (FGM) is an accepted social norm or standard, the practice is strongly encouraged by social pressure to follow the practice set by others, the need to fit in, and the fear of rejection from the community. It is frequently seen as an essential component of a girl's womanhood and marriage and is challenging

to leave behind (5, 38). and also women who were genitally mutilated did not see any harm from being genitally mutilated, suggests a victim-precipitated action (49).

This study also reveals that respondents Women who had circumcised their child were 5 times more likely intended to continue the practice. Similar result observed in previous related study conducted in Nigeria(38). There is a significant variation in the degree of support for circumcision among women who have had one or more of their daughters circumcised than women who hadn't. Although our qualitative findings do not support or contradict previous studies conducted by the Population Reference Bureau, they are consistent with our findings. (37).

Mother attitudes also was another factor which significantly affects intention towards female genital mutilation, in this study women who had favorable attitude towards FGM were 2 times more likely intend to continue the practice to their daughter in the future. Those finding was consistent with previous study conducted in Ravansar, Iraq and UNICEF (32, 50). This could be explained by the strength of their attitude towards FGM, which influenced the likelihood of their intention. Mothers with a stronger attitude were more inclined to have intentions. Suggesting that that the intensity of attitude plays a crucial role in shaping individual behaviors to engage the practice in which individual attitudes towards the practice are influenced by cultural beliefs, religious norms, awareness, and perceived benefits of the practice.(3, 10, 11, 24, 32, 36, 51, 52).

Our qualitative finding also found Attitude as one the theme in which, Participant who held favorable attitude, perceiving it as a culture, religious obligation, enhancing purity, rite passage to woman hood and marriage prospect have the intention to engage to practice. Which support our quantitative study finding and align with other related studies (5, 24, 32, 38, 39).

This study also showed a significant association between subjective norm and intention. In which women who had favorable subjective were 5 times more intended than their counter parts. This study is consistent with study conducted in Ravansar, Nigeria, and other studies (32, 36, 39, 50). This could be explained by social pressure and moral judgment associated with key determinants of both continuation and discontinuation of the practice; the stronger or more favorable the subjective norm, the more likely it is to be intended(10, 11, 50). This suggests that individuals are often motivated to comply with social norms to gain approval, acceptance, or to avoid social

sanctions. Mothers may feel compelled to adhere to social norms endorsing the practice; this compliance with perceived social norms influences their intentions regarding circumcision (3, 32, 36, 39).

In our qualitative study finding, subjective norm also emerges as a power full theme on the decision towards female genital mutilation that participant felt compelled to continue the practice due to societal, family, peers, religious expectation and fear of social ostracism. Which support our quantitative study finding and consistent with other studies (5, 39, 42-44, 53). This aspect could be explained the fact that individual behavior is effected by perceived social pressure, people who are significant to them think they should engage in the behavior and cultural expectation affect individual decision making. In which the stronger the pressure and expectation, the stronger engagement in the practice (3, 5, 11, 12).

7. Strength and limitation of this study

7.1 strength

- Using mixed design
- To the best of our knowledge, there is scarce study conducted in Ethiopia that assessed intention toward FGM/C by implementing theoretical perspectives.

7.2 Limitation of the study

This study has some limitations. First, it only looks at a single point in time, so it can't say for sure what causes what. Second, the study was only done in one location, so the findings may not apply to everyone. Finally, due Intention-behavior Gap not all intention leads to behavior some might be withdrawer.

8. Conclusion

Prevalence of intention towards FGM/C among reproductive age group was high than the national survey (EDHS) implying that attitude and subjective norm is high to stop the practice which is also supported by the qualitative part. Notably, four key factors emerged as significant influences on this intention: the women's personal views on FGM, the social pressures exerted by their family and communities, prior experience with FGM on another child, and their own history of undergoing FGM and for the qualitative part attitude, subjective norm and intention towards continuation were the themes identified from the analysis, Which is consistent with the quantitative findings. These findings underscore the critical need for targeted interventions that address these specific factors.

9. Recommendation

Community Education and Awareness Programs:

Implement comprehensive educational campaigns that focus on the harmful effects of FGM. Provide accurate information about the medical, psychological, and social risks associated with FGM to counteract the traditional beliefs and misconceptions that perpetuate the practice.

Strengthening Legal and Policy Frameworks: Ensure strict enforcement of existing laws with local authorities to monitor and penalize those who perform or facilitate FGM, creating a deterrent effect.

Engagement with Influential Community: Engage and train influential community members, including elders, religious leaders, and educators, to advocate against FGM. Their endorsement can significantly influence public opinion and behavior. Promote alternative rites of passage that can replace FGM, maintaining cultural traditions without the associated health risks.

Support Systems for Women and Girls: Develop support networks for women and girls who resist FGM, including counseling, shelters, and educational opportunities to protect them from familial and societal pressure. Encourage peer support groups where women who have not undergone FGM or who oppose the practice can share their experiences and provide mutual support.

Behavior Change Communication: Utilize behavior change communication strategies to shift societal norms and attitudes. This includes mass media campaigns, community dialogues, and storytelling that highlight the negative consequences of FGM and promote gender equality.

Research and Monitoring: Conduct ongoing research to monitor the prevalence of FGM and the effectiveness of interventions, allowing for data-driven adjustments to strategies.

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APPENDICES

Annex 1 information sheet

My name is _____ (Interviewer). I am working as data collector in the research conducted by investigator **Dagmawit Girma**, who is conducting research for the partial fulfillment of his Master degree in Reproductive health in Hawassa University. Trying to assess intention towards Female genital mutilation/Cutting among Reproductive women Atotehulo districts central Ethiopia and you are one of the participants who have been selected randomly to participate in this study. The responses that you provide to the questions are very essential, not only, for the successful accomplishment of the study, but also for producing relevant information which will be helpful in the planning and implementation of intervention activities.

Risk and Benefits: By participating in this study, you may feel that it has some discomfort especially on wasting time about 20-30 minutes. There is no risk in participating in this research. For participation in this study, there may not be direct benefit to you. Ultimately, this will help us to identify the gap and take the appropriate intervention by the authorized stakeholder. You will not be provided any incentive or payment for taking part in this study.

Confidentiality: The information collected from this study will be kept confidential and will be stored in a file, without your name, but a code number assigned to it. In addition, it will not be revealed to anyone except the investigator and will be kept locked with key.

Right to refuse or withdraw: You have full right to refuse or to withdraw from this study at any time you wish, without losing any of your right. You can choose not to respond to some or all questions if you do not want to give your response.

Persons to contact: If you have any question to ask, please contact

Dagmawit Girma Tel: 0945382880: email dagmawitshu@gmail.com

Annex ii: - Consent form

I undersigning this document, I am giving my consent to participate in the study entitled "to identify intention towards FGM/C.I have been informed about the purpose of this study. I have understood that participation in this study is entirely voluntarily. I have been told that my answers to the questions will not be given to anyone else and no reports of this study ever identify me in any way. I have also been informed that my participation or non-participation or my refusal to answer questions will have no effect on me. I understood that participation in this study does not involve risks and Dagmawit Girma is the contact person if I have questions about the study or about my rights as a study participant.

Are you voluntary to respond to the questions?

Yes; proceed with the interview

No; thank him/ her and End.

Signature: _____ Date: ___

Result: Questionnaire completed ————

Questionnaire partially completed ———

Participant refused ———

Checked by supervisor: Name _____Signature _____Date _____

Annex_ iii English questionnaire

Date _____ Hospital _____

Name of data collectors _____ ID of the questionnaire_____

Socio-demographic characteristics Questionnaire

No	Variables	Response option	Skip
101	Age	_____years	
102	Religion	1.Muslim 2.Orthodox 3.Protestant	
103	Ethnicity	1. Halaba 2. Kembata 3. Silte 4. Welayita 5. Other	
104	Residence	1. Urban 2. Rural	
105	Marital status	1.Single 2.Married 3.Divorced 4.Widowed	
106	Educational status	1.Cannot read and write 2.Can read and write 3. primary education (1-8) 4. secondary education (9-12) 5.Diploma and above	
107	Occupational status (mother)	1.Farmer 2.Housewife 3.Civil servant 4.Daily laborer 5.Merchant 6.Student 7.Others(specify _____	
108	Occupational status (Husband)	1.Farmer 2.Daily laborer 3.Civil servant 4.Merchant 5. other	
109	Parent(mother)circumcision history	1.Yes 2. No	
110	Child with circumcision in	1. Yes	

	the family	2. No	
111	Neighbor circumcision history	1.Yes 2.No	

Constructs of behavioral intention (TRA)

S/No	Attitude	Response options				
		SD 1	D 2	N 3	A 4	SA 5
201	Female circumcision is good tradition					
202	Female circumcision is important					
203	Female circumcision is pleasant					
204	Female circumcision is performed for religious reason					
205	Female circumcision is good for chastity and faithfulness					
206	Female circumcision increase chance of marriage					
207	Female circumcision preserve virginity/premarital sex					
208	Female circumcision increase social acceptability					
209	Female circumcision is rite passage to womanhood					
	Subjective norms					
210	Most people who are important to you put you under pressure to make your daughter(s) undergo FGM.					
211	Most of your referents expect you to make your daughter(s) undergo FGM.					
212	Most people who are important to you want you to make your daughter(s) undergo FGM.					
	Behavioral intention					
213	Did you intend to make your daughter undergo circumcision?					
214	Do you a have plan to make your daughter undergo circumcision?					

215	Would you make your daughter undergo circumcision soon					

In-depth interview Guide for the qualitative part

1. How do you perceive female genital mutilation? What does it look like in your area?

2. What do you think are the major factors contributing to female circumcision practice in your area?

3. Do you think that female genital mutilation is important? Why? Why not?

4. Do you think that circumcised females face some problems? If yes, what type?

5. Do you support the continuity of female circumcision? Why? Why not?

6. Would u make your daughter circumcised (if any)? Why? Why not?

7. Did the community, spouse or family support you to continue or to discontinue? Why? Why not? And what's your action towards that?

8. Suggest the points of entry for stopping the practice if you believe in stopping the practice.

If you need to give or suggest any comment on the practice of FGC, you are welcomed.

Thank you for participating on the discussion!

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Annex IV: - □□□ □□

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