

WOMEN'S AND GIRLS' EMPOWERMENT PROJECT

Funded by
The David and Lucile Packard Foundation

Implemented by
Pathfinder International-Ethiopia
and
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ONGOING MONITRING & EVALUATION FINAL REPROT



Prepared by

Addis continental Institute of Public Health
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Women's and Girls' Empowerment Project
Ongoing Monitoring and Evaluation Final Report

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ACRONYMS

ACIPH	Addis Continental Institute of Public Health
AIDS	Acquired Immune deficiency syndrome
ANC	Ante-Natal Care
DHS	Demographic and Health Survey
ECS	Ethiopian Catholic Secretariat
FGM	Female Genital Mutilation
FHAPCO	Federal HIV/AIDS Prevention and Control Office
FP	Family Planning
GBV	Gender Based Violence
HIV	Human Immune Deficiency virus
HTP	Harmful Traditional Practices
IPOs	Implementing Organizations
NGOs	Non Governmental Organizations
PMTCT	Prevention of Mother to Child Transmission
RH	Reproductive Health
STAR	Sexuality Teaching in the context of Adult Responsibility
TOT	Training of Trainers
VCT	Voluntary Counseling and Testing
YMCA	Young Male Christian Association

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Executive summary

Women's and girls' empowerment project is funded by Packard foundation and implemented by pathfinder international Ethiopia in Amhara, Oromia and Addis Ababa regions from 2007- 2009. Five implementing organization were involved in the implementation of the project. Increasing awareness of reproductive health issues, advocating for the elimination of harmful traditional practices and increasing access and utilization of youth friendly services are among the major strategies of the project.

A baseline survey was conducted in May 2007 and ongoing monitoring and evaluation was performed through out the project period. End project survey is conducted in May 2009 and changes in selected indicators were compared with the results of the baseline study.

Awareness, attitude and utilization of reproductive health services

A total of 6,780,345 women and girls were addressed with messages on reproductive health issues. Awareness about almost all reproductive health issues is found to be persistently high both during the baseline and end line surveys. Use of modern family planning methods has increased from 24.7% to 34.9% ($P=0.001$) in the project areas. In line with that the proportion of women and girls who has looked for FP methods and couldn't obtain has decreased significantly during the project period from 10.9% to 3.3% ($p=0.001$).

Awareness about ANC is found to be more than 90% both during the baseline and end line surveys. Willingness to attend ANC services has significantly increased from 96.6% to 98.9% with ($p=0.001$) throughout the three regions. These two factors may have contributed to the increase in ANC service utilization. In general ANC visit has increased from 51.9% to 67.9% ($p=0.001$) with a significant change registered in Amhara region when the data is analyzed at the regional level.

HIV/AIDS and VCT

The proportion of women and girls who have ever been tested has changed from 25.5% to 51.5% in the three years of the project. This major change could be as a result of the Millennium AIDS Campaign in which a lot of people have been tested in a short period of time. Intention to be tested again has been found to be lower.

Harmful Traditional Practices

An increased awareness about harmful traditional practices is registered. There is no significant change registered when it comes to attitude towards selected harmful traditional practices. Only 70% know the correct legal age at marriage. More than 4000 early marriages have been cancelled during the project period.

Adolescent reproductive health

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Peer education and teen STAR programs are the major strategies used to approach young people with reproductive health messages. More than 10, 189 young people have been trained on sexuality and reproductive health issues by the teen STAR program. Parents and adult community members were also approached with information on youth friendly services. Special youth groups like housemaids and out of school youths are also approached with peer education. Youth centres are upgraded and health professionals were trained to provide youth friendly services. As upgrading and setting up a youth friendly clinic takes time there was a delay in providing services in Youth Friendly Reproductive Health Clinics.

Conclusions and Recommendation

In general the project has achieved its goal. Most target plans have been achieved at the end of the project period. For majority the activities were equally distributed through out the project period. This gives adequate time for activities to bring the expected changes. However some of the activities have not been started in the first year of the project. Early implementation of activities contributes to better out come. It is recommended that there should be more efficient project planning and implementation in the future. Awareness and attitude towards most reproductive health issue is high both during the baseline and end line surveys. Future projects should focus on changing the behaviour of beneficiaries.

1 Background

The estimated adult point prevalence of HIV/AIDS in Ethiopia for the year 2009 is 2.3% with a prevalence of 8.5, 2.8 and 1.5% in Addis Ababa, Amhara and Oromia regions. In the year 2009 the estimated number of HIV positive pregnancies is 84,189 with 14,140 HIV positive births. The incidence of HIV is higher in the cities as compared to the rural parts of the country (FHAPCO, 2007). Every year more women acquire new infection. Females accounted for 54.5% of AIDS deaths and 53.2% of new infections in 2005 (Federal Ministry of health/ National HIV/AIDS prevention and control office, 2006).

Ethiopia is one of the countries with high fertility rate and low contraceptive prevalence rate. Knowledge of any modern contraceptive method among currently married women was 87% while the current use of any contraceptive method among women and girls in the reproductive age group was 10.7% during the 2005 Demographic and Health Survey (DHS). 34% of the married women had unmet need, a figure which hasn't changed in 5 years from the 2000 DHS (FHAPCO, August 2006).

Utilization of reproductive health services remained low in the country. The baseline survey for the project has shown that institutional delivery was 10% in the project implementation areas (Addis Continental Institute of Public Health, 2006).

Early marriage followed by teenage pregnancy and child bearing is a common problem in most rural parts of Ethiopia. The median age of child birth is 19.2 years and 17% of adolescents (15-19) have already given birth or were pregnant during the 2005 survey (FHAPCO, August 2006). In Amhara region around 34% of the population doesn't know the legal age of marriage correctly. In 2007 15% of adolescent girls have been promised into marriage, 12% had even been formally engaged and 13 % had been ever married in Amhara region. Early marriage has consequences like dropping out of school, unwanted pregnancy, early child bearing and delivery complications including fistula. Early marriage prevention program that use School girls' clubs have played important role in preventing and stopping significant number of early marriages (Berhane, et al., April 2009)

Domestic violence is accepted by the society to some degree. 81% of women believed that a husband is justified in hitting his wife for at least one reason. Only 39% of the women have autonomous decision on their own income (FHAPCO, August 2006). Both sexual and physical violence have been found to be high. In the province of Ethiopia around 71% of the population has experienced at least physical or sexual violence or both (WHO, 2005). Awareness raising activities about domestic violence are going on by the Ethiopian government and NGOs in recent years. The revised Ethiopian Family Code which improves the right of women has a positive contribution in changing the situation of violence. The revised code also paves the way in implementing interventions that are geared towards improving the status of women. (Federal Negarit Gazette, 2000).

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The 'Women's and Girls' empowerment project' is a three year project funded by the David and Lucile Packard Foundation and operates in selected communities in Addis Ababa, Oromia, and Amhara regional states. The project is implemented by Pathfinder International in collaboration with five of its implementing partners - Addis Ababa Women's Association, Amhara Women's Association, Oromia Women's Association, Young Men's Christian Association Bahir Dar branch and the Ethiopian Catholic Secretariat. The project addresses some of the factors that lead to women vulnerability to HIV/AIDS and reproductive health problems. To achieve the project goal the implementing organizations used various strategies such as community mobilization, referral to services, and training of health professionals as depicted in table 1

Table 1: Implementing organizations' strategies

Focuses and strategies
<ul style="list-style-type: none"> • Increase awareness of reproductive health (RH) among girls and women through community education using community conversation, sensitization program, organizing mass rally, panel discussion and edutainment program
<ul style="list-style-type: none"> • Providing girls with scholarship opportunities for education, development of leadership and life skill
<ul style="list-style-type: none"> • Advocating for the elimination of HTPs and GBV affecting the reproductive health and rights of women and girls through community education using community conversation sessions sensitization programs, mass rally, panel discussion and edutainment programs and forming community action committees
<ul style="list-style-type: none"> • Increasing awareness if reproductive health among youth through community education using community conversation, club members, peer education and edutainment
<ul style="list-style-type: none"> • Increasing the awareness of reproductive health among young boys and girls (10-19) teen STAR program in schools, out of school teen STAR program and school clubs • Providing training of natural family planning method for health professionals and religious leaders • Increase access and utilization of youth friendly services

ACIPH facilitated the regular recording of activities, best practices and lessons learned during the implementation of the project to identify changes resulting from the interventions. A comprehensive Monitoring and Evaluation plan which clearly depict the activities and procedures to document results was developed and adapted at the beginning of the project with full participation of the implementing agencies. Accordingly a baseline survey was conducted in April/May 2007. During the implementation period ongoing monitoring and evaluation reports were generated by implementing agencies and feedbacks were provided timely. First year and second year monitoring and evaluation reports were delivered to the funding agency as well as implementing organizations. The end line survey was conducted in the same manner as the baseline to detect major changes in the implementation areas.

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2 Objectives

The main objective of the end line survey was to document changes in the major project indicators which are listed in table 2:

Table 2: list of selected project indicators

S. No	Indicators	Strategies used
1.	% of women and girls who know modern FP methods	Community education
2.	% of women and girls with desired attitude towards modern family planning	
3.	% women and girls who know the benefit of ANC	Community education
4.	% of women and girls who have desired attitude towards ANC	
5.	% women and girls who know the benefit of facility based delivery	Community education
6.	% of women who have desired attitude towards facility based delivery	
7.	% women and girls who got VCT services	Community education
8.	% women and girls who use any modern FP methods	Community education, provision of condom and oral contraceptive pills
9.	% women and girls who use ANC services	Community education
10.	% of young girls (15-24) who know about youth friendly services	Community education, peer education, upgrading health facilities to provide YFSs
11.	% of young girls(15-24) who use YFSs	
12.	% women and girls who used nearby health facility for delivery	Community education
13.	# of clubs established and their members trained on RH issues	Teen STAR program, girls club formation

3 Methods

Study Design

A cross sectional community based survey was conducted to collect relevant information on the awareness knowledge and practice of reproductive health and rights issues among women and girls

Study population

Women and girls in the age group of 15-49 and who are permanent residents of the area were eligible respondents for the survey.

Study area

To detect changes brought by the project survey areas that are included during the base line and the end line survey were the same. Table 3.1 shows the list of Woredas and kebeles included in the surveys

Table 3 list of Woredas and Kebeles included in the studies

Region	Woreda	Kebele
Addis Abab	Kolfe	02/03,06,07,12,13/14
	Gulele	07/17,08/16,09/15,10/11/12,18
Amhara	Awabel	Wejel,Enebe,Shebla Abkestit, Zindaye Gider
	Debrebirhan	04,05,06,09
	Dessie Zuria	Abso qotu, Gelbuti, Anto meshal, Atari mesk
	Gondar Zuria	Zangaj,Lamba arbayitu,Debre selam, Debsa tekare
	Sekella	Telm mentadber,Sangle, Kolkolcha, Gulle/01
Oromia	Gorro	Finchir,Chersa,Degma,Chancho syema, Goro, Gorora
	Kuyu	Amemo wechale, Rope kolate, Daro tatetsa, Harezo chali, Dewcha trnas, Sanbise rogi
	Menna	Dawa , Harro, Meti/ Kellaguda, Gudeta bula/Yebu, Simido /Hundae tolle, Atisa guda/Henda Keneni
	Shashemane	Keji dema, Hugugeta tule, Feje sile, Feje gole, Awash denki, Qore brojeta

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Sample size is calculated for each implementation regional state: Amhara, Oromia and Addis Ababa. During sample size calculation it is assumed that there will be a 50% relative increase in contraceptive prevalence after three years intervention in Amhara and Oromia regions, and a 40% relative increase in Addis Ababa. Relatively small change is expected in Addis Ababa because unmet need for family planning is lesser in Addis Ababa compared to the other two regions. The other assumptions used to calculate sample size include: 80% power to detect difference on the prevalence of modern contraceptive between baseline and end project surveys, a 5% alpha error, a 10% non-response rate, and a design effect of 2 to accommodate the multi-stage nature of the sampling. The sample size is calculated using the following formula:

$$n = \frac{D \left[Z_{1-\alpha/2} \sqrt{2P(1-P)} + Z_{1-\beta} P_1 \sqrt{(1-P_1)+P_2(1-P_2)} \right]^2}{(P_1 - P_2)^2}$$

Where:

n= sample size

α= 95%

β= 80%

D= design effect

P₁= prevalence at base line

P₂= prevalence at the end of the third year

P= (P₁+P₂)/2

Based on the formula the total sample size for the surveys is 2596.

Table 4: sample size calculation for the end line survey

Region	Prevalence at base line: assumptions based on EDHS 2005	Expected prevalence after three years (based on the assumption)	Required Sample size for baseline and end line each
Amhara	15.7	23.6	926
Oromia	12.9	19.4	1173
Addis Ababa	45.2	58.8	497
Total			2596

Sampling stages

A three stage cluster sampling strategy was used to identify households for the base line and end line surveys;

Primary sampling: in each implementing zone one woreda (two woredas if more than five implementing woredas exist per zone) was selected randomly.

Secondary sampling: the total number of sample size for each region was divided by the number of woredas selected. The Woreda Sample sizewere divided by 50 to estimate the number of Kebeles that will be participating in the survey. After excluding non implementing kebeles, then study kebeles were selected randomly.

Tertiary sampling: In each Kebele 50 households were systematically selected for the study.

Data Collection

Data collection has taken place at two phases.

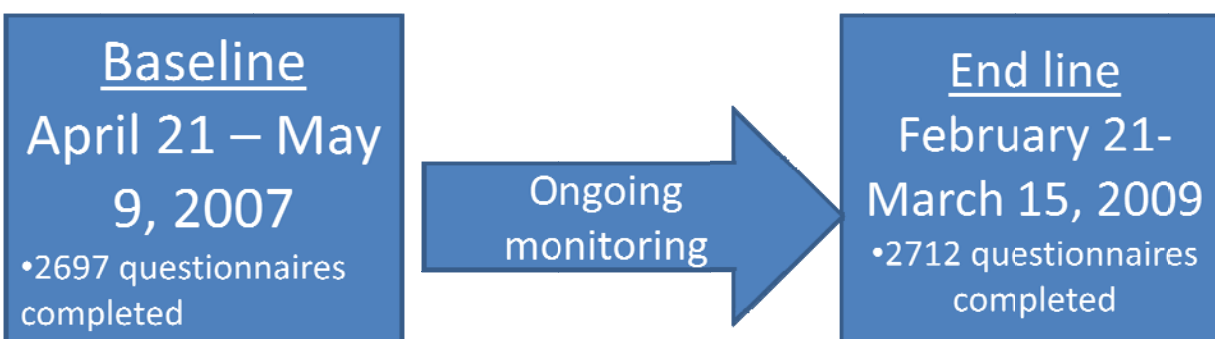


Figure 1: Data collection period for baseline and end project assessment

A structured questionnaire was used to collect information on socio demographic characteristics, reproductive health issues, HIV/AIDS, Gender Based Violence and Youth Friendly Services. The same instrument that have been developed and tested during the baseline survey was used during the end line assessment. This enables to detect changes in the reproductive health and right issues that may have been brought by the project. The instrument was initially developed in English then translated into Amharic by expert panels for use in the field.

Data collection was conducted in all the Kebeles listed in table 3.1. Women age between 15-49 and permanent residents of the Kebeles were recruited for the survey through a house-to-house visit. The participants were beneficiaries and non beneficiary community members of the implementation area.

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Data collectors were recruited from the pool of Addis Continental Institute of Public Health data collectors. They were trained for five days at ACIPH. The pretest of the questionnaire developed for the baseline assessment was used for the end line survey.

The training of data collectors and field supervisors included basics of interviewing skills as well as detailed discussion on the data collection instrument. Multiple methods were used to train the data collectors including lectures, small group discussion, role plays, and paired-interviews. Along with the interviewers, supervisors have attended the training for the data collectors. Additional session on field supervision is provided for the supervisors. At the end of the training interviewers and supervisors were selected for the actual field work based on their performance during the training. Only those who have attended all the training days and performed top in the standardized interviews were included for the field survey.

Data Quality

Data quality was maintained by providing extensive training for the data collectors and supervisors on the survey instrument and interviewing skills. Extensive field supervision was done by field supervisors who have stayed with data collector through out the data collection period. Expert supervision was provided intensively in addition to the field supervisors. Data were entered in the institute computer system by trained and well experienced data clerks using templates that have checks for valid values.

4 Results

During the end line survey a total of 2715 households were contacted to participate in the survey out of which 2712 has consented giving a 99.9% response rate. The reasons for not participating were: respondent were not at home (1) and refusal (2). The project indicators are calculated and compared against the baseline survey. Indicators are also calculated for each region.

The overall result shows awareness and positive attitude for most reproductive health and right issues remained high during both the baseline and end line assessments. Positive changes towards major reproductive health indicators are also registered during the end line survey. The findings are put thematically in the document.

4.1 Family Planning

The project has planned to reach 6 million women with a message of reproductive health issues including family planning. The project was successful in achieving its target plan through timely implementation of awareness raising activities (Refer to table 8). Awareness about family planning remained high among women and girls both during the baseline and end line survey. The proportion of women and girls who have received information about FP in the last 12 months has also remained high. In Oromia region women and girls who have received messages on reproductive health issues in the last 12 months has shown significant increase; from 82.6% to 87.7% with $p=0.001$. Use of modern family planning methods has shown a significant change; 24.7% to 34.9% ($P=0.001$). While Amhara and Ormoia regions have shown a significant change in modern contraceptive use, the change in Addis Ababa is not statistically significant. Positive attitude towards the use of modern FP method has remained high during the baseline and end line survey; 93.8% vs 95.1% $p=0.046$. The persistent high level of awareness and positive attitude towards the use of modern contraceptive methods may have contributed to the significant changes registered in practice.

Similarly the proportion of women and girls who has looked for FP methods and couldn't obtain has decreased significantly during the project period from 10.9% to 3.3% $p=0.001$. This shows that women and girls are aware of where to obtain FP methods when they want to use one. The other factor that may contribute to this change is increased availability of FP methods through different health service delivery systems including health extension program along with high level of awareness.

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Table 5: baseline and end line comparison of major family planning indicators

Indicator	Region	Baseline (%)	End line (%)	p- value
Heard about reproductive health issues	Addis Ababa	94.2	99.0	0.001
	Amhara	94.2	98.2	0.001
	Oromia	94.1	98.6	0.001
	Total *	94.0	98.4	0.001
Heard about family planning	Addis Ababa	98.0	96.9	0.365
	Amhara	98.4	97.6	0.303
	Oromia	96.1	98.0	0.008
	Total *	97.3	97.7	0.470
Heard about FP in the last 12 months	Addis Ababa	85.0	86.0	0.719
	Amhara	86.4	88.3	0.237
	Oromia	82.6	87.7	0.000
	Total *	84.3	87.6	0.001
Approve use of modern contraceptive methods	Addis Ababa	96.8	96.8	0.862
	Amhara	93.3	94.2	0.417
	Oromia	93.3	95.0	0.071
	Total *	93.8	95.1	0.046
Ever used any FP method	Addis Ababa	41.8	46.6	0.142
	Amhara	41.6	51.3	0.001
	Oromia	30.5	44.0	0.001
	Total *	36.6	47.2	0.001
Used any FP method in the last 12 months	Addis Ababa	28.3	34.9	0.120
	Amhara	29.0	37.6	0.004
	Oromia	19.8	32.5	0.001
	Total *	24.7	34.9	0.001
Looked for FP but couldn't obtain	Addis Ababa	9.6	2.7	0.001
	Amhara	11.2	3.7	0.001
	Oromia	11.3	3.3	0.001
	Total *	10.9	3.3	0.001

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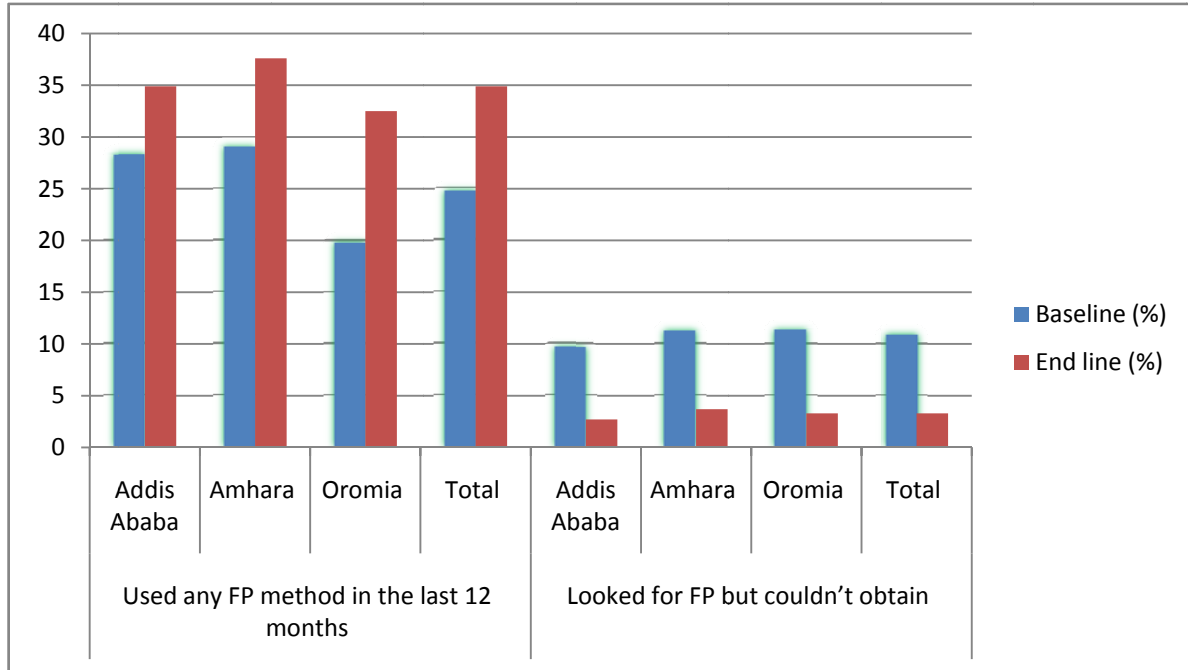


Figure 2: Comparison of family planning use and difficulty of obtaining family planning methods during baseline and end line survey

4.2 ANC, Delivery and post natal care

High proportion of women and girls believe that ANC is beneficial both during the baseline and end line survey, 95.6% and 96.6% respectively. Willingness to attend ANC has significantly increased from 96.6% to 98.9% with $p=0.001$ throughout the three regions. These two factors may have contributed to the increase in ANC service utilization. In general ANC visit has increased from 51.9% to 67.9% with $p=0.001$). However inter-regional variation is seen in the change. A significant change is registered in Amhara region while the change in Oromia and Addis Ababa remained statistically insignificant. The health extension program and increased construction of health posts at kebele level is generally believed to increase access to ANC and delivery services in the community. It should be noted that the small sample size of ANC visitors, as depicted in table 6, may have contributed to the failure in detecting the true change especially in Addis Ababa.

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Table 6: baseline and end line comparison for major indicators for delivery and ANC

Indicator	Region	Baseline (%)	End line (%)	p- value
Visit ANC service in the last 12 months among women who are currently pregnant or who have been pregnant in the last 12 months	Addis Ababa	80(*12)	97.1(*34)	0.075
	Amhara	33.9 (*21)	62.8 (*76)	0.000
	Oromia	64.8(*35)	66.8(*147)	0.906
	Total	51.9	67.9	0.001
Willing to attend ANC service if pregnant in the future	Addis Ababa	96.8	97.8	
	Amhara	92.6	94.4	
	Oromia	92.8	96.2	
	Total	96.6	98.9	0.001
Believe that ANC is beneficial	Addis Ababa	98.8	99.4	
	Amhara	94.6	93.5	
	Oromia	95.3	98.2	
	Total	95.6	96.6	0.076
Institutional delivery is beneficial	Addis Ababa	99.4	99.8	
	Amhara	91.4	91	
	Oromia	93.1	96.4	
	Total	93.6	94.9	0.040
Home delivery	Addis Ababa	26.6 (*7)	13.7(*7)	0.591
	Amhara	90.3(*112)	80.6 (*104))	0.045
	Oromia	90.3(*196)	80.6 (*141)	0.009
	Total	84	71.5	0.001

* Number of respondents

The project has used awareness raising activities to give information for women and girls about reproductive health issue. Message on the antenatal care and delivery services are delivered along with other reproductive health issues for more than 6 million women (Refer table 8).

4.3 HIV/AIDS and VCT

Although the proportion of women and girls who are aware of HIV/AIDS has been high during the baseline survey awareness has even increased significantly from 95% to 98.6% p=0.001. This near to 100% awareness level can indicate the beginning of reduction in vulnerability. Along with high awareness level the proportion of women and girls who have ever been tested has increased from 25.5% to 51.5% with p=0.001. This major change could be as a result of the Millennium AIDS Campaign in which large number of people has been tested in a short period of time. Intention to be tested in the future has slightly decreased from 72.8% to 70.3% p=0.001. This may indicate the need of emphasising on the benefit of repeated HIV testes in the future IEC/BCC programs.

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Proportion of women and girls who know that HIV can be transmitted from mother to child has decreased from 92.6% to 87.2% with $p=0.001$. However among those who believe that HIV could be transmitted from mother to child, the proportion who believe the transmission could be reduced has increased from 68.8% to 82.3% with $p=0.001$.

Table 7: Baseline and end line comparison for major HIV/AIDS indicators

Indicator	Region	Baseline	End line	p- value
Ever heard about HIV/AIDS	Addis Ababa	99.2	99.8	0.374
	Amhara	94.7	98	0.001
	Oromia	93.8	98.7	0.001
	Total *	95%	98.6%	0.001
Have you ever been tested for HIV	Addis Ababa	50.9	67.4	0.001
	Amhara	22.1	49.2	0.001
	Oromia t	19.1	47.3	0.001
	Total *	25.5%	51.5%	0.001
Wish to be tested in the future	Addis Ababa	89.8	85.9	0.290
	Amhara	60.8	56.6	0.159
	Oromia	77.9	77.4	0.887
	Total *	72.8%	70.3%	0.000
Believe HIV is transmitted mother to child	Addis Ababa	95.3	97.4	0.116
	Amhara	88.7	82.7	0.001
	Oromia	93.8	86	0.001
	Total	92.6%	87.2%	0.001
It is possible to reduce HIV transmission from mother to child	Addis Ababa	92.1	97.7	0.001
	Amhara	67.9	82.1	0.001
	Oromia	59.2	75.7	0.001
	Total *	68.8%	82.3%	0.001

To bring changes in HIV/AIDS and VCT as well as other reproductive health issues awareness and practice the project has used multiple strategies through out the project period. The project has reached women and girls with repeated messages about reproductive health and right through different strategies and opportunities in the early phase of the project implementation. Although the first year achievement was encouraging, it can be seen that in the second year the project achievement has been excellent. By the end of the second year of the project period 88% of target plan for the three year have been achieved.

Multiple messages including family planning, ANC, HIV/AIDS, VCT, harmful traditional practices and gender based violence are disseminated. Public holidays and events where large numbers of people are potentially gathered together have been effectively used to reach the target population.

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The strategies used in the project and timely implementation of awareness raising activities have contributed in the positive changes registered in reproductive health and right issues during the end line survey.

Table 8: performance achievements of activities that helped to change awareness of reproductive health and right issues (Family planning, ANC, delivery, HIV/AIDS, VCT and PMTCT)

Project Objective	Indicators	Target	1st year achievement	2nd year achievement	+3rd year achievement
Increasing awareness of RH among girls and women through outreach and education and improve access to quality service	# of women and girls reached with information on RH and reproductive rights	6,000,000 women and girls reached	2,095,730	3,174,089	1,510,526
	# of girls accessing YFS	5000 women accessing YFS (through referral)	-	11,300 referred	6,755 referred
	# of providers trained in YFS	355 providers trained	116	162	-

⁺ the third year report includes achievements for only the first three quarters

Best practices from the field activities are communicated through different stages and publications. The regular newsletter by pathfinder international publishes outstanding best practices and case reports. Movies and press releases are among the major strategies pathfinder has used to communicate its best practices. Donors and other implementing organizations have the opportunity to learn from the experience of the project and replicate some of the project strategies that enabled pathfinder to bring changes in community.

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Figure 3: samples of news letters with best practice issues from the project

4.4 Harmful Traditional Practices

One of the major objectives of the project was to advocate the elimination of harmful traditional practices and gender based violence that affect the reproductive health and rights of women and girls. Besides raising awareness through community education programs, community action committees were formed under the regional women associations. Community action committees are composed of local administrative bodies, women's association representatives, legal bodies including judges and police force, local leaders and women. The community action committee has helped in raising awareness about HTPs in the society as well as helping women and girls in finding solution for challenging HTPs that affect their day to day life. A number of early marriages have been cancelled and rape and domestic violence victims were assisted to get justice.

The presence of the community action committees and the visible positive changes observed in the judiciary system has given women and girls a sense of security. The proportions of women and girls who believe that the common harmful traditional practices are a serious problem in their locality have decreased significantly. This may be attributed to the multi component activities by community action committees that address harmful traditional practices. The activities by the committees as described above are visible and the actions taken may have given safety and direction to the women and girls in the project area.

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Table 9: women and girls who believe that common traditional practices are serious problems in their locality

Indicator	Region	Baseline	End line	p- value
FGM	Addis Ababa	88.8	56.6	0.001
	Amhara	77.4	56.4	0.001
	Oromia	87.6	60.8	0.001
	Total *	84%	58.3%	0.001
Early marriage	Addis Ababa	95.5	57.6	0.001
	Amhara	85.7	65.1	0.001
	Oromia	90.9	67.3	0.001
	Total *	88.8%	64.5%	0.001
Abduction	Addis Ababa	89.8	57.2	0.001
	Amhara	85.6	60.9	0.001
	Oromia	91.3	64.5	0.001
	Total *	88.9%	61.9%	0.001
Rape	Addis Ababa	92.6	69.4	0.001
	Amhara	88.4	69.3	0.001
	Oromia	91.8	66.6	0.001
	Total *	90.6%	68.1%	0.001

4.4.1 Female Genital Mutilation

Awareness about female genital mutilation has increased from 88.3% to 92.2% with $p=0.001$. Around 95% of women and girls believe that FGM should be stopped. 0.2% (6) and 0.8% (23) women and girls have reported that they have gone under FGM during baseline and end line survey. While 3.3% (89) and 2.5% (68) women and girls have reported that at least one family member have undergone FGM in the last 12 months.

4.4.2 Early Marriage

Prevention and cancellation of early marriage was one of the project major activities. Awareness about early marriage has been increased from 85.7% to 90.9%. Women and girls who stated that the legal age of marriage is below 18 years has decreased from 16.5% to 11.6% with $p=0.001$. Similarly women and girls who correctly identified the minimum legal age of marriage as 18 years has increased from 63.9% to 69.8% ($p=0.001$). This result is similar to the finding during the 2007 study of early marriage where 34% of adults were not able to state the legal age of marriage correctly (Berhane, et al., April 2009)

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¹Early marriage cancellation has been done mainly through school girls' clubs and local community action committees. More than 4023 early marriage cases have been cancelled during the project period. Victim girls and their colleagues have played a role in the marriage cancellation by providing information for school girls' clubs and community action committees. Girls whose marriage has been cancelled have been provided legal protection from their threatening family members and would-have-been-in-laws.

Table 10: major indicators of early marriage

Indicator	Baseline	End line	p- value
Heard about early marriage	85.7%	90.9%	0.001
Early marriage is a serious problem	88.8%	64.5%	0.001
Early marriage should be stopped	99.4%	99.4%	0.114
Has experienced early marriage in the last 12 months	0.3%(9)	0.8%(23)	0.125
Know a family member who has experienced early marriage in the last 12 months	2.4% (64)	1.2%(33)	0.002

The policing activities to prevent early marriage activities are strong. Legal bodies including the police, the judiciary system, and women association have worked strongly to present perpetrators of early marriage to the court. During field visits, it was noted that most community members, especially parents of girls whose marriage has been cancelled, have been giving false information to protect themselves. Some of the parents have reported that they have come to the women's association to report the case while the women association has informed the evaluation team that they are telling the opposite, fearing that they might be brought to the court if they admit arranging marriage for their under-aged girls².

Although information given by most adult community members was meant to build a positive image rather than their true belief about early marriage, the evaluation team has observed a strong change of attitude among adolescents. The girls' club coordinating school teachers have reported that they get most of the information about early marriage from the students. Girls who have come to know about their arranged weddings, brothers of victim girls, and other students who have come to know about arranged early marriage in their village come to the school teachers with the information. The teachers who are mostly coordinators of the girls' clubs in the

¹ A girl whose marriage has been cancelled has expressed their challenge after the marriage cancellation. They have reported that they are blamed for exposing their parents. Some of the girls have said that they will not be able to continue their education as their families are not willing to cover their school expenses after the marriage cancellation. One girl has indicated that she may consent in future marriage proposal as her families have threatened to disown her.

² The delegates of the women association working at Kebele level have reported that some parents use other religious and social events as cover to marry their under-aged children. It is through the information obtained from girls and other young people that early marriages are exposed most of the time.

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school in turn report the cases for the kebele administration and community action committees. Girls whose marriage has been cancelled have also reported that when they become aware of their wedding arrangements they have gone to the school girls club to give information. This could be a sign of a beginning of social change where the society takes ownership of the problem. Such social changes will bring desired long term sustainable changes in the elimination of early marriage.

4.4.3 Fistula case detection

One of the consequences of early marriage is fistula following teenage pregnancy and child birth. Due to the nature of the condition Fistula cases suffer from social isolation and psychological consequences. Limited availability of treatment for the cases has contributed to accumulation of the fistula victims in the community. In recent years the Addis Ababa Fistula hospital has opened branches in regions to allow all women suffering from fistula to get treatment. The Women's and Girls' Empowerment Project has used this opportunity to inform the community the availability of treatment.

In addition to giving information about fistula hospitals, the project through the women's associations has been identifying cases and referring them to the nearest fistula treatment site. The association focal persons at Woreda/ sub city level take the responsibility of making sure that fistula cases go to the right health facility to get treatment. In the first two years of the project more than 250 fistula cases have been identified and referred for medical treatment. Most of the Fistula cases are identified from Amhara region where early marriage is abundant followed by Oromia region. Fistula cases have also been identified from Addis Ababa where institutional delivery is the highest in the country. This could be used as indicator of the depth of maternal health problems in the country.

“ALEM[♦], 23, has dropped out of school to get married when she was 12. After 7 years of her marriage she becomes pregnant. The labor took days with out delivery. Finally was taken to hospital only to be told that her child is dead. After the still birth she was unable to control her urine. She was isolated from social life because of the bad odor. Her husband has left her to marry another woman. ALEM has heard about fistula hospital first on radio. Then she was heard that the women association could help her to get to the hospital. She travelled from Amba Giorgies to Woreta to meet the women's association representative. She has stayed with the representative overnight and was brought to the. Now she is admitted and waiting for operation”.

When we meet ALEM she was unstable and the answers she gave us were inconsistent. She was very worried about what may be her operation out come and if she would be normal again.

[♦] Names have been changed for confidentiality

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“DENIKE[♦] married at the age of 17 and gave birth to her first child at the age of 21. The labor took six days and ended up in still birth. She had four other pregnancies in which all end up in still births. The labor for the consecutive pregnancies lasted one to three days. DENIKE recognized that she was unable to control urine after her first delivery before 10 years. She has suffered social consequences in the last 10 years as a result of her condition. Even though she wants to have active social participation the negative feedback she got from other people has degraded her self-confidence. No one was willing to associate with her. “When people know that I am around they cover their nose or change a place”. Although now she is leaving with her husband, he has left her in between and has married another woman. He has a daughter from his second wife. When his wife died and he come back to her she was more that happy to accept him and her step daughter. No one in her family has ever believed that her illness has a cure. She has visited health facilities at different times to get the same response; nothing can be done for her. One day she was approached by a member of a woman association with the information of this hospital (Felegehiwot Fistula Ward). DENIKE was not convinced that she can be cured but the repeated visit from the woman has made her consider the offer. She is brought to the hospital by the Women Association Delegate. After observing other fistula victims in the hospital, she is filled with hope. She is determined to tell women that there is cure for fistula when she went back to her village.”

4.4.4 Domestic violence

To assess the level of domestic violence in the community, question on physical violence and decision making in household matters have been asked. Most women believe that joint decision should be made in household matters including; large household purchases, family visits, the number and timing of children. At the same time large number of women and girls believe that joint decision should be made on the income of the woman. Women and girls should be oriented that they should have the power to decide how to use their own income.

Tolerance for physical violence hasn't changed much. As can be seen in table 11, women and girls believe that a man is justified to beat his wife/partner for one or more reasons listed in the table. There still exists high level tolerance of domestic violence among women. Even in urban settings where women have the opportunity to fight against violence and where assistance is provided, women still tend to accept domestic violence. Studies have found that acceptance of violence is higher among women with past experience of violence. Through their past violence experience women learn to accept violence and consider it as the right thing for a man to act (WHO, 2005).

[♦] Names have been changed for confidentiality

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Most harmful traditional practices, including domestic violence and early marriage, are deep rooted and culturally accepted. For such kind of health issues behavioural changes in the society are not expected to occur in such short time. Awareness raising and change in attitude towards HTPs should proceed before true significant change in practice is observed. This was also observed in the history of child immunization in Ethiopia. At the initial phase of immunization program there was a strong commitment from the government. Women were forced to vaccinate their children to get their basic needs like food. This made women to accept vaccination with out resistance leaving the question of social sustainability in question. When the reinforcement was lifted during the transitional government in 1991 immunization coverage has dropped to less than 30% from the universal coverage (Immunization in Ethiopia: Acceptance, Coverage and Sustainability, 2000).

Table 11: selected indicators on domestic violence

Indicator	Baseline (%)	End line (%)	p- value
A man is justified to beat his wife for the following reasons			
If she leaves the house without his consent	33.0	35.8	0.217
If she neglects the children	31.6	34.5	0.202
If she argues	26.8	34.5	0.015
A man is justified to do the following things if his wife refused to have sex with him			
Beat her	19.4	14.3	0.005
Stop giving money	6.0	7.6	0.174
Force her physically to have sex	9.8	6.8	0.058
Have sex with other women	3.9	5.0	0.294

Community sensitization was the major strategy to increase the awareness of women and girls about gender based violence and harmful traditional practices. Public events like March 8 have been used to organize mass rallies and seek the attention of the public and decision makers.

Community action committees that are formed at each kebele in the project implementation area have also played a significant role in advocating the issues and changing some of the community practices. Harmful traditional practices including early marriage, gender based violence and rape were among the major areas the community action committees have worked on. Besides advocating the issues the community action committees have shown women and girls where to go and what to do when they face gender based violence. Perpetrators of rape and domestic violence were brought before court and justice have been passed.

In all community action committees men were involved in advocating the illumination of gender based violence. These men has played role in changing the attitude of fellow men. Their role as a community and religious leader has given men the opportunity of changing others' attitudes towards harmful traditional practices and gender based violence in their community. Men and

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women members of community action committees agree that involving men is instrumental to eliminate harmful traditional practices and gender based violence. A priest, who is a member of community action committee in Addis, explained his involvement as follows:

“A lot of abused women came to us (religious institutions) to make confessions and get relief but they want their issues to be kept confidential. They do not want others to know. It is my duty to keep their secret but at the same time it is also my duty to convince them to take the case to court. Most of the time I succeed in convincing the women to do the right thing but sometimes it is impossible to make the woman see her situation. I remember a widow who had a house and some money when she met an HIV positive partner. She was not aware of his status at first. The man was after her money and her properties. Once they started to live together he started to beat her constantly. One day she came to me with a broken leg. She told me that she is separated with her husband because of the continuous violence. I had a very long discussion before she was willing to come to the committee and press charges. We reported the case to police. But at the end she dropped the charges to be with him. Since neighbors know that I work with the committee, many people including children call me during the night to report abuse and violence. For example there was a man who was trying to kill his wife with a knife in the middle of the night. She locked herself in the house and gave me a call. I went to the house with a police and he was caught and taken to court.”

To facilitate the elimination of Harmful traditional practices and gender based violence law enforcement officials have been trained on the interpretation of the laws and legal procedures of female genital mutilation, early marriage and gender based violence.

Table 12: performance achievements of activities that helped to change awareness and practices harmful traditional practices and Gender based violence

Project Objective	Indicators	Target	1st year achievement	2nd year achievement	+3rd year achievement
Advocate elimination of harmful traditional practices and gender based violence affecting the reproductive health and rights of women	*Number of community members sensitized about HTP, GBV and women’s right	2,000,000 community members sensitized	2,015,000	2,75,379	1,132,500
	Number of law enforcement officials trained and sensitized on law against FGM, early marriage and GBV	750 officials trained	530	657	175
	Number of cancelled cases of early marriage	4,000 early marriage cancelled	1365	1170	1488

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* Includes awareness creating activities provided on Youth Friendly Services

+ The third year report includes achievements for only the first three quarters

4.5 Strategies targeted to address the youth

4.5.1 Youth Friendly Services³

Awareness about youth friendly services has increased among girls in Addis Ababa and Amhara regions. Knowledge about a nearby youth friendly services has also been increased in the two regions. However utilization of youth friendly services doesn't show any change. Especially in Oromia regions the quantitative indicators show that awareness and utilization of youth friendly services hasn't shown any improvement when compared to the baseline survey. The proportions of young girls (15-24) who know a nearby youth friendly services are very low.

Table 13 : awareness and utilization of youth friendly services among girls 15-24

Indicator	Region	Baseline (%)	End line (%)	p- value
Heard about youth friendly services	Addis Ababa	56.3	70.5	0.001
	Amhara	29.6	38.1	0.009
	Oromia	27.9	28.4	0.898
Know a nearby youth friendly service	Addis Ababa	21.7	35.9	0.000
	Amhara	14.5	22.2	0.004
	Oromia	5.0	6.7	0.293
Ever used a nearby youth friendly service	Addis Ababa	46.6	28.6	0.044
	Amhara	47.1	44	0.820
	Oromia	55.6	45.5	0.604
Heard about girls club	Addis Ababa	42.3	54.7	0.072
	Amhara	24.1	33.3	0.003
	Oromia	19.2	18.2	0.731
Girls club member	Addis Ababa	7.7	10	0.467
	Amhara	8.1	11.2	0.158
	Oromia	5.5	5.6	0.938

YMCA and ECS are the two most important implementing organizations in implementing youth friendly strategies. Unfortunately their implementation areas are not included in the baseline and end line surveys as their involvement in the project was late. Thus the areas included in the survey don't include areas where youth friendly activities are implemented. Table 4.9 doesn't represent all the youth friendly intervention of the project and thus underestimate the project real achievement. However it should be noted that even among the implementing organization in the survey areas the implementation of youth friendly services have been delayed. This is due to delayed project planning and implementation at the IPOs level. The other reason is the process of

³ The two major implementing organizations that work on youth friendly services are YMCA and ECS. These two IPOs have not been included in the baseline survey. Any result from the surveys regarding youth friendly services utilization doesn't reflect the true effects of the two IPOs. Thus it should be noted that the true effects of the project could be underestimated in the quantitative results.

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establishing youth friendly services takes time. Youth friendly service provision has started after the establishment of the youth friendly reproductive health clinics.

4.5.2 Teen STAR program (Sexuality Teaching in the context of Adult Responsibility)

Teen STAR program is implemented by the Ethiopian Catholic Secretariat (ECS) in the Addis Ababa and Oromia region schools around Addis Ababa. The objective of the program is to make girls self assertive by increasing their awareness about their reproductive system physiology and functions as well as decision making on sexuality issues. The program will help adolescent girls to have a healthy transition to adulthood.

During the first year of the program 1,339 students were enrolled in the program and the number of students enrolled has been increasing every year during the project period. A total of 10,189 students were trained through teen STAR program during the project period.

In some of the teen STAR program areas exponential effects of the program has been observed. Wonji area could be good example where every teen STAR program graduate student goes out in the community and recruit other five peers who are in different school or out of school. The recruited teens couldn't get the chance to be trained by the teen STAR program. The recruiters will provide them with information on sex, sexuality and reproductive health information they obtained from their training as a teen STAR student. The students' effort of reaching other young people with the teen STAR message is appreciated by school teachers and parents. During a teen STAR students graduation ceremony at Wonji on March 9, 2008 teachers and parents expressed their gratitude for the students' effort of reaching out for their peers. At the same time they have promised to support the students with all the necessary material and technical support they need for their activity.

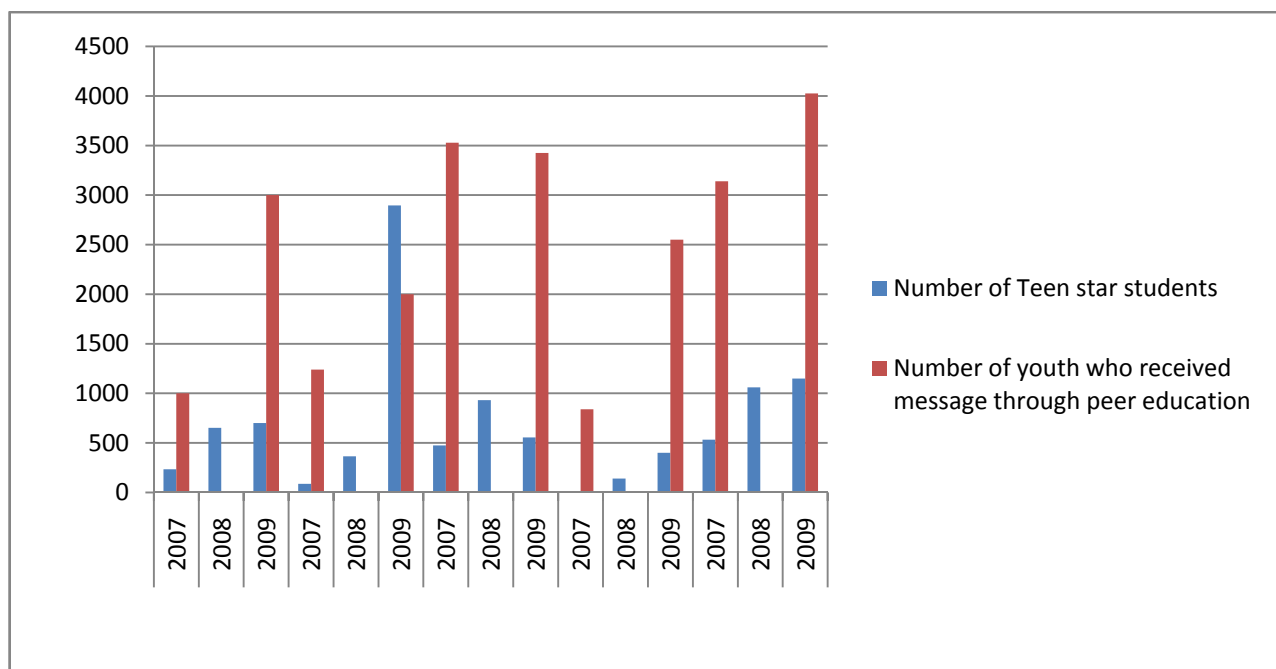
Adults including parents, teachers and health professionals have promised to help teen STAR students. In Mojo health professionals have been invited for teen STAR graduation and they have presented themselves and promised to help the students. These volunteer health workers have told the students to come to health institutions if they ever need counselling services on HIV/AIDS, traditional harmful practices and reproductive health issues. They have reminded the students to encourage their friends to come to the health professionals if they encounter any problem or if they need advise. The students were promised that their issues will be kept confidential.

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Table 14: Young people addressed though Teen STAR program over the project period

Site	Year	Number of Teen star students	Number of youth who got peer education training	* Number of youth who received message through peer education
Addis Ababa	2007	234	20	1000
	2008	652	250	N/A
	2009	700	242	3000
Debrezeit	2007	87	125	1239
	2008	365	105	N/A
	2009	2896	200	2000
Modjo	2007	475	400	3529
	2008	932	200	N/A
	2009	555	250	3425
Adama	2007	10	50	840
	2008	140	250	N/A
	2009	400	200	2550
Wonji	2007	533	450	3139
	2008	1061	300	N/A
	2009	1149	350	4025

* The messages include Harmful traditional practices, drug abuse, abortion, HIV/AIDS and STI



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Figure 4: Teen STAR students and youth approached by volunteer teen STAR students by program area

Although teen STAR program mainly addresses students in school, it has also included out of school youth in some of the sites. In Debrezeit town adolescents were approached through the Catholic Church. The church has given support by making available training venue and training materials. During the graduation of these students the church representatives were present and advised the students to make use of their training.

Teen STAR program has extended its activities to universities, a different site than the usual high schools and junior schools. In 2009 a total of 83 instructors in Adama and Hawassa University have received training on Teen STAR program.

Parents' commitment to teen star program

Parents of teen STAR students have expressed their positive attitude towards the program. Most parents said that the program has helped them to open up with their girls and have a positive discussion regarding their reproductive health and other sensitive issues. Parents have also said they are learning a lot from their children.

'This is an act of saving a generation and must continue'

'We are happy to see our children learning new life and communication skills'

There is a repeated request to include boys in the teen STAR program. There were requests from parents in Addis Ababa as most schools enroll only girls in the program. Accordingly some schools have started to include boys in the teen STAR program. Some parents have volunteered to take a training of trainers (TOT) and provide the training free of charge for the teens. Some also promised to contribute financially if requested.

Although parents have expressed their positive attitude towards the program it was not smooth at the beginning.

'The girls were being kept late in school and we were not comfortable with that arrangement. We thought that they may engage in bad behavior if they stay in school after class.'

The teen STAR program has communicated with parents and community members to give information about the program. At the beginning of a teen STAR training for new students their parents are invited for discussion. Consent was taken from the parents to enroll the students. After hearing the purpose of the training almost all parents have agreed to let their teens to participate in the program.

Teachers' attitude

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Teachers are the core for the teen STAR program. Introductory briefings were given for teachers and school staffs when teen STAR program starts in a new school. These introductions have created a common understanding of the program. Teachers have volunteered to take a TOT and lead the program in their respective schools. Most teachers have expressed that are happy to have the program in their school

'It helps us to communicate with our students in a friendly manner'

Students also agree that the program has helped them to communicate with their teachers openly. Some teachers have said that the program is supplementing to their lessons in the classrooms (especially biology class).

4.5.3 Empowering girls through educational opportunities

To improve the status of girls in the community the project has provided scholarship opportunity for 70 economically disadvantage girls at the beginning of the project period. The support has continued for three years. This will help the girls to finish high school and move on to the next level. The scholarship targets girls who have achieved high in their earlier classes. The scholarship covers basic living costs for students that couldn't finance their high school or preparatory school education.

The project has also planned to provide 300,000 girls with professional role models. The role model presentations inspire girls to strive more in their educational life. In the first year of the project 69% of the target was achieved and at the end of the 2nd year of the project life more than 100% of the project target has been achieved. The role models are women who have successfully achieved their higher education studies including graduate level studies. The women visit school girls to share their life experience on how they have overcome challenges they have faced during their earlier educations. The role models are mostly from the same background as the students. Girls are inspired and motivated by what they hear from their role models. Some girls have expressed their wish of continuing their education to become like that of their role models.

4.5.4 Strategies used to improve awareness and utilization of youth friendly services

The project has used multi-component strategies to boost awareness and utilization of youth friendly services. School girls club and peer educators have been portals for the message. Health professionals have been trained on YFS starting from the first year of the project. It was planned that 5000 young women would receive referrals to YFS. Although referral activities haven't started on the 1st year of the project life, the numbers of referrals made during the 2nd year of the project alone were more than twice that of the total target plan (Refer to table 8).

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Health facilities have been upgraded to create a comfortable youth friendly environment. Upgrading the health centres included constructing additional blocks in the existing health centres, equipping the youth friendly clinics with youth friendly facilities and deploying specially trained health professionals to deliver youth friendly services. The upgrading of the health centres has come true with a matching fund from USAID Ethiopia⁴. Peer educators are found around youth friendly clinics to give guidance and encourage for their peers.

Creative approaches have been used by YMCA to address all sectors of the youth. The peer educators trained by the implementing organization have approached youth in the school and out of school. Sunday schools, market places and community gatherings have been used to raise awareness about youth friendly services. Vulnerable youth like house maids, disabled youth and Sunday school students have been approached with the information on reproductive health and harmful traditional practices.



Figure 5: peer education for deacons and Sunday school students at Bahir Dar

Out of school young people engaged in the car washing around Abay River, Bahir Dar town, have been approached and trained on reproductive health issues. Members of the car washing club has testified that their life style has changed a lot since they have received the training by

⁴ talk with program coordinator at pathfinder Ethiopia

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YMCA. Most of them have admitted that before getting the training they were engaged in risky sexual behaviours. One of the members described how he benefited from YMCA as follows:

“I used to have a lot of girlfriends at a time; one from a student and one from the village. No girl is allowed to say no to me if I want to have sex with her. I never used condom. The training I got from YMCA has changed my life a lot. When they told as the facts about HIV/AIDS, I realized that what I have been doing was wrong. That was the first time I was scared of becoming HIV positive. I was scared to get the test but fortunately I turned HIV negative. That changed my life a lot”

The car washing group members provide information on HIV/AIDS and reproductive health issues for their clients. They give referrals for clients who want to have HIV test or need to visit health services for reproductive health issues. In addition they distribute condom and for ‘shy’ people they leave condom during the evenings in a box under a tree shade.



a b c
Figure 6: a. Activities at Abay Dar car wash b. outdoor condom box at Abay Dar car wash service
c. Abay Dar car wash service Reproductive Health information centre

5 Major successes and challenges of the project

5.1 Major successes of the project

- Most planned activities have been accomplished successfully and performance indicators show more than 100% achievement (refer to table 8 and 12).
- Significant positive changes have been registered in family planning, VCT and perception about harmful traditional practices in the survey areas.
- Project achievement could be partially attributed to matching funds used to boost some of the project activities including awareness rising and upgrading of youth friendly services.
- Application of multiple strategies simultaneously may have contributed to the changes detected in family planning, VCT, harmful traditional practices and gender based violence although the contributions of other stakeholders towards the observed changes cannot be ruled out.
- The involvement of men in community action committees was instrumental in effectively advocating against harmful traditional practices and gender based violence; they used their influence over fellow men.

5.2 Major challenges of the project

- The process of design and implementation of the program lacks timeliness. Timely project implementation has impact on the outcome of the project. An activity that has started earlier in a project life has a better out come
- Some activities especially those on youth reproductive health issues have not been implemented in the first year of the project. Training of health professionals on youth friendly services is not achieved as planned. Especially most activities by the Ethiopian Catholic Secretariat have not started to be implemented until the second year of the project. Delayed project implementation will create a gap in the monitoring and evaluation of projects. This may have attributed to the insignificant changes exhibited in the utilization of youth friendly reproductive health services
- During several field visits the M&E team from ACIPH has noted that a lot of activities that could be demonstrated as best practices remained unreported/ underreported despite the availability of the case reporting and best practice format developed by the institute. The unreported activities will understate the extra efforts that are made by the implementing organizations and pathfinder international

6 Major conclusions and recommendations

- The prevalence of FP method use has significantly increased in all the three implementation areas presumably due to the interventions. Further interventions that focus specifically on changing the behaviour and practice of women and girls towards utilization of modern contraceptive methods can result in greater use of the methods.
- Proportion of women and girls who have ever been tested for HIV has increased significantly but intention for repeated test has not been observed as much as the initial test. Future behavioural change communication should emphasize the benefit of repeated tested so that people will not take a single test for granted and risk HIV infection.
- The utilization of youth friendly services has remained the same through out the project period. Delayed implementation of youth friendly strategies can be one of the reasons for the low utilization of youth friendly services; most services require time to reach a pick utilization level. The delay could also be attributed to delayed planning and implementation at the initial phase of the project.
- Although pathfinder has communicated its best practices through publications and on workshops, the evaluation team believe that there remain equally important best practices that are left unreported. This is specially observed during several field visits of the team. The unreported activities will understate the extra efforts that are made by the implementing organizations and pathfinder.

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Annex

Annex 1: Best Practice Reporting Format

Name of Implementing Organization _____

Activity: _____

Beneficiaries: _____

Date: _____

Name of Project Implementation Area: Region: _____

Zone: _____

Woreda: _____

Kebele: _____

My name is [NAME] I am working with [IMPLEMENTING ORGANIZATION]. I will be interviewing you to document the BEST PRACTICES of [specific program] that is implemented by [IMPLEMENTING ORGANIZATION]. By BEST PRACTICE we mean any activity or programmatic approach which brought about a significant outcome/ change in achieving the project's objectives and that could possibly be innovative and can be replicable to other project implementation sites or even to other parts of the country. The purpose of documenting this best practice is to provide information for others on the achievement of specific activities. The information you give us will be very important in identifying the lessons learned and challenges of the program. Your identity will be kept confidential unless you give us permission. You can escape a question you not want to answer or you can stop the interview at any time.

Are you willing to participate? No_____ ->stop here

Yes_____ -> sign and proceed (the interviewer will sign if the participant gives consent

Name of interviewer _____

Date _____

Beneficiaries

1. Tell us about your self. How long have you lived in this area?
2. Tell us about [IMPLEMENTING ORGANIZATION] activities in your area regarding [SPECIFIC ACTIVITY]
3. who can benefit from this [SPECIFIC ACTIVITY]
4. How did you become a beneficiary of [SPECIFIC ACTIVITY]?
5. What did you gain from the program?
6. What do you like most from the program? Why?
7. What are the things you don't like from the program? Why?
8. What things do you think should be improved in the program? Why?
9. Do you have anything you would like to tell us?

Non Beneficiaries

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1. Tell us about yourself. How long have you lived in this area?
2. Have you ever heard [IMPLEMENTING ORGANIZATION] activities on women and girls' in your area?
3. How do you hear about [SPECIFIC PROGRAM]?
4. What do you know about the program?
5. Who can benefit from this program? (What is the criteria to participate in the program)
6. Why didn't you participate in the specific program?
7. Have you ever been approached participate by any one? If yes, who approached you? What was the information you were provided?
8. If similar programs are available would you like participate in the future?
9. Is there anything you would like to tell us?

Staff/program coordinators

1. How long have you been coordinating the program?
2. Tell us about the program(brief description)
3. What problem or issues do you address through your program?
4. Please give a brief summary of the practice (set of actions or what you are doing to address the identified problem and that have been successful and/or innovative).
5. What are the key activities related to this practice?
6. Describe any lessons-learned, obstacles and how you overcome them and also what specifically has changed since the practice /approach /tool has been introduced, attitude, service utilization
7. In your opinion, what was / were the most important factors for the success of this best practice?
8. What are the limitations of the program?

Name, position and signature of the person who compile the form

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Annex 2: Questionnaire

Women's and Girls' Empowerment Project, End line survey
Addis continental institute of public health

Informed consent

“Hello, my name is _____. I am working with [name of implementing organization] here in [CITY, REGION, and SITE]. We are interviewing many people like you in order to find out about your knowledge, practice and attitudes related to RH/HIV/STI/GBV and the availability of services like youth friendly services and girls clubs in your locality. Beside to assess whether there is /are organizations who teach the community about RH/HTPs/STI/GBV. The results of this baseline study will be used to better understand the knowledge, practice and attitudes of people like you related to RH/HIV/STI/ GBV and to start implementing various interventions to educate the community with regard to the mentioned issues/ problems. “If you agree to participate in the survey, your honest answers are very important to help us understand the needs of people in [NAME OF THE LOCALITY]. Your answers are completely confidential. Your name will not be written on any form and none of the information will ever be linked back to you or anyone you mention during the interview. You do not have to answer any question you don't want to and you can end the interview at any time. The interview will take about 20 - 25 minutes. “We would greatly appreciate your help in responding to this survey, even though we are not able to financially compensate you for this interview. Beside, I assure you that being involved in the survey don't cause any harm.

Do you agree to participate in the survey?”

If she does not agree agrees ----- End

If the respondent agrees, then sign the form (the interviewer signs the form, not the respondent) as noted, certifying that informed consent has been given verbally by respondent

Interviewer name Interviewer Signature Date

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Part I Background information

101	How long have you lived here in this area/town?	-----/-----/ years 98 since birth 00 if less than 1 year 99 No response	
102	Age at last birth day	-----/-----/ years 88 = Don't know	
103	What is your religion?	Orthodox1 Muslim2 Catholic3 Protestant4 Traditional5 Have no religion6 Others (specify) _____	
104	What is your main occupation?	Unemployed (have no source of income).....1 Self employed2 Employed (private /government)3 Business venture4 Farming/ Ploughing5 Daily laborer6 Housewife.....7 Other, specify9	
105	Can you read and write?	Yes.....1 No2	
106	Have you ever attended school?	Yes.....1 No2 skip to Q 109	
107	Are you currently attending school?	Yes1 No2	
108	Please tell me your level of education which you have already completed.	----- / -----grade	
109	What is your current marital status?	Never married1	
		Married2	
		Divorced3	
		Separated4	
		Widowed4	
		Non-marital partnership6	
ONLY FOR THOSE WHO ARE MARRIED OR LIVED WITH THEIR PARTNER			
110	Can you tell me your husband/partner age	-----/-----/ years Don't know88	

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111	If married or living with partner; what is your husband main occupation?	Unemployed1 Self employed2 Employed.....3 Business venture.....4 Farming/ Ploughing 5 Daily laborer.....6 Other, specify..... 9	
112	Does your husband or partner can read and write?	Yes 1 No 2	
113	Has he ever attended school?	Yes 1 No 2 Don't know..... 88	
114	Is he you currently attending school?	Yes 1 No 2	
115	Please tell me his level of education which he has already completed. .	----- / -----grade Don't know 88	
ONLY for those living with parents/guardians			
116	With whom are you living?	With both of my parents 1 With my mother.....2 With my father 3 With my guardians 4 With other relatives5	
117	Do your parents or guardians can read and write?	Both can read and write 1 My mother / female guardian only can read and write..... 2 My father / male guardian only can read and write 3 Both can read and write.....4	
Part 2: Questions related to RH/FP question 201 – 719			
S#	Variables	Response categories	
201	Have you ever received/seen information about reproductive health issues? Probe: use the terms stated in question 202	Yes 1 No 2 skip to Q 205	
202	If yes, about which of the following programs have you heard/see/read?		
	About which of the following issues have you heard/see/read?	If yes, what was your main source of information?	

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A	Family Planning	Yes No	Radio01 Television02 IEC materials03 Community meeting04 CBRHAs 05 Health facility workers 06 Women association07 Youth center 08 ' idirs'09 Among family members 10 Other 99
B	Anti Natal Care	Yes No	Radio01 Television02 IEC materials03 Community meeting04 CBRHAs 05 Health facility workers 06 Women association07 Youth center 08 ' idirs'09 Among family members 10 Other 99
C	Delivery service	Yes No	Radio01 Television02 IEC materials03 Community meeting04 CBRHAs 05 Health facility workers 06 Women association07 Youth center 08 ' idirs'09 Among family members 10 Other 99
D	Post Natal Care	Yes No	Radio01 Television02 IEC materials03 Community meeting04 CBRHAs 05 Health facility workers 06 Women association07 Youth center 08 ' idirs'09 Among family members 10 Other 99

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E	Post Natal Care	Yes No	Radio01 Television02 IEC materials03 Community meeting04 CBRHAs 05 Health facility workers 06 Women association07 Youth center 08 ‘ idirs’09 Among family members 10 Other 99
F	Post Abortion Care	Yes No	Radio01 Television02 IEC materials03 Community meeting04 CBRHAs 05 Health facility workers 06 Women association07 Youth center 08 ‘ idirs’09 Among family members 10 Other 99
G	HIV/AIDs	Yes No	Radio01 Television02 IEC materials03 Community meeting04 CBRHAs 05 Health facility workers 06 Women association07 Youth center 08 ‘ idirs’09 Among family members 10 Other 99
H	STI	Yes No	Radio01 Television02 IEC materials03 Community meeting04 CBRHAs 05 Health facility workers 06 Women association07 Youth center 08 ‘ idirs’09 Among family members 10 Other 99

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I	Traditional practices	Yes No	Radio01	
			Television02	
J	Gender based violence	Yes No	IEC materials03	
			Community meeting04	
			CBRHAs 05	
			Health facility workers 06	
			Women association07	
			Youth center 08	
			' idirs'09	
			Among family members 10	
			Other 99	
			Radio01	
			Television02	
IEC materials03				
Community meeting04				
CBRHAs 05				
Health facility workers 06				
Women association07				
Youth center 08				
' idirs'09				
Among family members 10				
Other 99				
203	In general, do you believe that the information you have received/seen about RH issues is adequate or not?		Adequate1 Partially adequate2 Partially inadequate3 Inadequate4 Other (specify)5	
204	In the last 12 months have you seen/heard/read messages about FP/modern contraceptive methods? PROBE: WHAT CONTRACEPTIVE MEANS. IT IS A WAY THAT HELPS TO PREVENT BIRTH.		Yes 1 No 2 skip to Q 207	
205	If yes, Which methods of contraception have you heard about?	a. Female Sterilization	Yes	No
		b. Male Sterilization	1	2
		c. Pill	1	2
		d. IUD	1	2
		e. Injectables (Depo)	1	2
		f. Implants	1	2
		g. Condom	1	2
		h. Diaphragm/Foam Jelly	1	2
		i. Standard Days Method	1	2
		j. Lactation Amen Method	1	2
		k. Rhythm Method	1	2
		l. Withdrawal	1	2
		m. Other(Specify) _____	1	2
	ONLY WHO SAID YES FOR Q 204.	health facility/ FP worker1 CBRHAs 2		

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206	What was your main source of information?	Health extension workers3 Girls club4 other (specify) 9	
207	Were you ever told about methods of FP that you could use?	Yes.....1 No2	
208	Do you know of a place where you can obtain FP services in your area?	Yes1 No 2	
209	If yes, please tell me the most convenient place to obtain FP, if needed.	_____ _____	
210	Do you approve or disapprove the use of modern contraceptive methods?	Approve1 Disapprove2 Indifferent3	
211	Have you ever used anything or tried in any way to delay or avoid getting pregnant?	Yes 1 No 2skip to Q 213	
212	In the past 12 months, have you ever used anything or tried in any way to delay or avoid getting pregnant?	Yes1 No2 Not relevant / not want to use3	
213	In the last 12 months, was there a time you wanted to use contraception but could not obtain what you wanted?	Yes1 Don't look for it2 No3	
214	Are you currently doing something or using any method to delay or avoid getting pregnant?	Yes 1 No 2 Not relevant / not want to use.....3	
215	If no, do you think that you will use a contraceptive method to delay or avoid pregnancy at any time in the future?	Yes 1 No 2 skip to Q 217	
216	If you don't want to use modern family planning methods in the future; would you mind if you tell me your main reason?	no sex0 Infrequent sex 1 Menopausal / hysterectomy.....2 Wants as many children as possible 3 usband / partner opposition 4 Religious prohibition 5 Knows no method 6 Knows no source7 Fear of side effects8 Lack of access / too far 9 Other (specify)99	

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217	In your opinion, whom do you think can decide whether the women to use family planning methods or not?	Only the women1 Mainly Husband/Partner.....2 Joint Decision3 other (Specify)_____9
Part 3 : Questions related to ANC		
S#	Variables	Response categories
301	Do you think that having medical follow up during pregnancy (Ante Natal Care) is beneficial?	Yes 1 No 2 Don't know 3
302	Have you been pregnant in the last 12 months or are you currently pregnant?	Yes 1 No 2--- skip to Q 307
303	Are you currently pregnant?	Yes 1 No 2
304	If 'yes' for Q 302 Or 303, did you see anyone for ANC for this pregnancy?	Yes 1 No 2
305	If 'yes', whom did you see?	Health Professional1 TBA2 CBRHA3 HEW4 Relative/neighbor5 Other (Specify)_____9
306	How many times did you receive ANC during this pregnancy?	Number of ANC visits ----- (help her to guess if she cant remember the exact number of times)
307	Are you willing to attend ANC follow ups if you get pregnant in the future?	Yes 1 No 2
Part 4: Delivery service		
S#	Variables	Response categories
401	Do you think that giving birth at health facilities is beneficial or not?	Yes 1 No 2
402	Have you given birth in the last 12 months?	Yes 1 No 2 skip to Q 406 Can't give birth - ----- skip to Q 501

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403	If 'yes', where did you give birth to that child?	Home1 Gov't Hospital2 Gov't health center3 Gov't Health Post4 NGO Health Facility5 Private Health facility6 Other (Specify)_____9	
404	Who assisted your last delivery?	Home1 Gov't Hospital2 Gov't health center3 Gov't Health Post4 NGO Health Facility5 Private Health facility6 Other (Specify)_____9	
405	What was the outcome of the pregnancy?	Live child1 Abortion2 Preterm3 Still birth4 Other (specify) -----	
406	If you are currently pregnant, where do you intend to deliver?	Home1 Gov't Hospital2 Gov't health center 3 Gov't Health Post 4 NGO Health Facility 5 Private Health facility6 Other (Specify)_____9	
407	If you don't intend to deliver in health facilities, why?	Cost too much 1 Facility not open 2 Too far / no transportation 3 Poor quality service 4 No female provider5 Husband / family don't allow 6 Since health workers don't welcome well ...7 Not customary 8 I want to give birth at home 9 Other (specify) 99	
Part 5 : HIV/AIDS The following questions are related to the prevention ,transmission and control of HIV/AIDS			
			Skip To
S#	Variables	Response categories	

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501	Have you ever heard of an illness called HIV/AIDS?	Yes1 No2 --- skip to Q 601			
502	The following questions are about the prevention of HIV/AIDS. Read the questions (A - H) to the respondent and circle the number written on the right column based on the respondent response				
		1. true	2. False	3. Don't Know	
A	Can people reduce their chances of getting the AIDS virus by having just one sex partner who is not infected and who has no other partners?	1	2	8	
B	Can people get the AIDS virus from mosquito bites?	1	2	8	
C	Can people reduce their chances of getting the AIDS virus by using a condom every time they have sex?	1	2	8	
D	Can people get the AIDS virus by sharing food with a person who has AIDS?	1	2	8	
E	Can people reduce their chance of getting the AIDS virus by abstaining from sexual intercourse? PROBE: EXPLAIN WHAT ABSTAIN MEANS.	1	2	8	
F	Can people get the AIDS virus because of the curse of God or other supernatural means?	1	2	8	
G	Is there anything else a person can do to avoid or reduce the chances of getting the AIDS virus?	1	2	8	
H	Is it possible for a healthy-looking person to have the AIDS virus?	1	2	8	
503	How can one tell that whether a person has got AIDS virus in his blood or not? CIRCLE ALL THAT APPLY	By Blood Test1 By looking at his appearances2 If repeatedly sick 3 Other (Specify)_____9			
504	I don't want to know the result, have you ever been tested for HIV/AIDS?	Yes 1 skip to Q 506 No..... 2			

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505	If no, do you wish to have an HIV test in the future?	Yes1 No2 Not sure3 Other (Specify)_____9		
506	Do you know of a place where people can go to get tested for the virus that causes AIDS?	Yes1 No2		
507	Can the virus that causes AIDS be transmitted from a mother to her baby?	Yes1 No2		
508	If yes, how can it be transmitted?		Yes	No
		A. During pregnancy	1	2
		B. During delivery	1	2
		C. During breast feeding	1	2
509	Are there any treatment that a health worker (doctor or a nurse) can give to a woman infected with the AIDS virus to reduce the risk of transmission to the baby?	Yes1 No2		
Section II.5 HTP and GBV				
S#	Variables	Response categories		
601	Have you heard/seen/read about the traditional practices in the last 12 months? Probe : traditional practices using the terms stated on 602	Yes1 No2 skip to Q 603		
602	If yes, about which of the following?		Yes	No
		FGM	1	2
		early marriage	1	2
		abduction	1	2
		Rape	1	2
other (specify)-----				
603	Have you experienced any one of the following traditional practices in the last 12 months? [FGM/ early marriage/ abduction/ rape]		Yes	no
		FGM	1	2
		Early marriage	1	2
		Abduction	1	2
		Rape	1	2
		other (specify)-----		
604	Have the member of your household experienced any one of the HTPS in the last 12 months? Probe: FGM/ early marriage/ abduction/ rape etc MEANS.		yes	No
		FGM	1	2
		Early marriage	1	2
		Abduction	1	2
		Rape	1	2
other (specify)-----				
605	In your opinion, which of the following is a serious		Yes	No

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	problem in your area?	FGM	1	2		
		Early marriage	1	2		
		Abduction	1	2		
		Rape	1	2		
606	Do you think that HTPs like (FGM, abduction, rape, early marriage and so on) should be discontinued?		SA	A	D	SD
		A. Rape	1	2	3	4
		B. FGM	1	2	3	4
		C. Early marriage	1	2	3	4
		D. Abduction	1	2	3	4
607	Are there any organization/ concerned groups who have taught the community as they have to stop any of the HTPs?	Yes1 No2 skip to Q 609 don't know 3 skip to Q 609				
608	If yes, who are they? Name the main two organizations:	1 _____ 2 _____				
609	Do you know that involvement in HTPs such as FGM and early age marriage in any way could make someone penalized by the law?	Yes1 No2 Do not know -----8				
610	What is the commonest age of marriage for a girl in this community?	-----/-----/ Years of Age				
611	What is the legal age at marriage for a girl in Ethiopia?	-----/-----/ Years of Age Don't know ----- 88				
Gender issues						
Now I would like to ask you a few questions regarding relationships between men and women						
612	In a couple, who do you think should have the greater say in each of the following decisions: the husband, the wife or both equally:	Husband	Wife	Both equally	Don't know	
A	Making large household purchases?	1	2	3	88	
B	Deciding when to visit family, friends or relatives?	1	2	3	88	
C	Deciding what to do with the money she earns for her work?	1	2	3	88	
D	Deciding how many children to have and when to have them?	1	2	3	88	
613	Sometimes a husband is annoyed or angered by things that his wife does. In your opinion, is a husband justified in hitting or beating his wife in the following situations:	Yes	No	Don't Know		

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A	If she goes out without telling him? GOES OUT	1	2	88
B	If she neglects the children? NEGLECT CHILDREN	1	2	88
C	If she argues with him? ARGUES	1	2	88
D	If she refuses to have sex with him? REFUSES SEX.	1	2	88
E	If she burns the food? Burns food	1	2	88
614	Husbands and wives do not always agree on everything. Please tell me if you think a wife is justified in refusing to have sex with her husband when:	yes	No	Don't Know
A	She knows her husband has a sexually transmitted disease? Has STD	1	2	88
B	She knows her husband has sex with other women? Other women	1	2	88
C	She is tired or not in the mood? Tired/not in a mood	1	2	88
D	Other (specify)			
615	Do you think that if a woman refuses to have sex with her husband when he wants her to, he has the right to	Yes	No	Don't know Depends
A	Get angry and reprimand her?	1	2	88
B	Refuse to give her money or other means of financial support?	1	2	88
C	Use force and have sex with her even if she doesn't want to?	1	2	88
D	Go and have sex with another woman?	1	2	88
616	When a wife knows her husband has a disease that can be transmitted through sexual contact, is she justified in asking that they use a condom when they have sex?	Yes1 No2 DK ----- 8		
617	Are there any organization/ concerned groups who have taught the community about gender based violence?	Yes1 No2		
PART 7: availability of services (FOR AGE GROUP 15-24 YEARS)				
701	Have you heard about what is called youth friendly services?	Yes1 No2		
702	Are there youth centers in your locality?	Yes1 No2 skip to Q 704		

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703	If yes, do you use that service?	Yes1 No2	
704	In your opinion, do you think that the presence of youth centers in your locality have an importance?	Strongly agree 1 Agree2 Disagree 3 Strongly disagree 4	
705	Have you heard about girls club?	Yes1 No2 skip to Q 707	
706	If yes, what kinds of activities are the club members undertaking?	1. _____ 2. _____ 3. _____	
707	If yes, do you think the presence of these services are useful?	Strongly Agree..... 1 Agree2 Disagree3 Strongly disagree4	
ONLY FOR THOSE IN THE AGE GROUP OF 15 – 24			
708	Are you the member of the girls club?	Yes1 No2	
709	If not member of the girls club; what is your reason	Have no reason 1 I'm not interested2 Family influence3 They refused4 Don't know about the service5 The service is not available in our locality 6 Other (specify9	
Now I have finished the interview. I really appreciate your voluntary cooperation for giving response for the above questions with the expense of your time. Have a nice time.			