

Descriptive Baseline Report for Save the Children USA Transformation to Food Security Development Food Aid program (in Pastoral and Agro-pastoral Areas, Ethiopia)

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List of Acronyms

AIDS	Acquired Immunity Deficiency Syndrome
CDC	Center for Disease Control
CMW	Currently Married Women
CRS	Catholic Relief Service
CSA	Central Statistical Authority
CSI	Copping Strategy Index
DFAP	Development Food Aid Program
DHS	Demographic and Health Survey
ENA	Essential Nutrition Action
ESDP	Education Sector Development Program
FANTA	Food and Nutrition Technical Assistance
FC	Female Circumcision
FFP	Food for Peace
FH	Food for Hungry
GER	Gross Enrollment Ratio
HDDS	Household Dietary Diversity Score
HH	Household
HHS	Household Hunger Scale
HIV	Human Immune Virus
IPTT	Indicators Performance Tracking Table
IR	Intermediate Result
MHH	Male Head of Household
MoE	Ministry of Education
MoH	Ministry of Health
PPS	Probability Proportional to Size
PSNP	Productive Safety Net Program
REST	Relief Society of Tigray
SCUS	Save the Children USA
SD	Standard Deviation
SO	Specific Objective
SoC	Scope of Work
SPSS	Statistical Package for Social Science
T2FS-DFAP	Transformation to Food Security -Development Food Aid Program
UNICEF	United Nations Children's Fund
USAID	U.S Agency for International Development
WHO	World Health Organization

Executive Summary

This baseline survey was conducted in five woredas (4 in Somali and 1 in Oromia regions) for the Transformation to Food Security -Development Food Aid Program (T2FS-DFAP) in Ethiopia implemented by Save the Children USA (SCUS). The purpose of the survey is to collect data and provide values for program impact and outcome indicators. This executive summary presents the findings of the survey in relation to the program indicators (Annex 1).

Food security

Household dietary diversity score (HDDS), household hunger scale (HHS), food insecurity strategy (CSI), and number of months with adequate food provisioning were the four indicators used for measuring the outcomes of DFAP. The baseline values of these indicators in SCUS operational areas were:

- Average HDDS = 5.87
- HHS, percentage of HHs with moderate to severe hunger = 67.6%
- Mean household CSI score = 22.7
- Average number of months with adequate food provisioning(PSNP and Non- PSNP beneficiaries households) = 3.8 months

Access to improved sanitation facilities and drinking water sources

DFAP considers improved sanitation and clean drinking water sources as crucial to reducing diseases and improving health, nutrition and style of living of households in the target areas. Based on the findings of the baseline survey only about 1.5% of sample households have access to improved sanitation facilities unshared with neighbors. Likewise 22.4% and 15.6% of households reported access to improved drinking water sources during dry and wet seasons, respectively.

Household asset holdings

The DFAP indicator on household asset is stated as percentage of households whose asset levels are stable or increasing. This indicator is expected to measure asset stability or change over the program life time, i.e. between baseline and final evaluation time. Thus, from the baseline survey we can only tell the average asset holding per household. Based on this, the average value of assets owned currently by households is Birr 38,922.

Gender and social perspectives

Gender and social perspective indicators included in the DFAP mainly focus on decision-making roles of women and men on household assets, female circumcision, and health service seeking. The baseline values of these indicators are as follows.

- Percentage of women reported to have jointly decided on purchase and/or sale of assets:

	Women alone	Men alone	Women/men jointly
Camel	6.0%	12.5%	81.5%
Cattle	5.4%	23.5%	71.1%
Sheep/Goat	5.8%	22.4%	71.8%
Donkey	6.0%	28.1%	65.8%
Horse	1.1%	8.0%	90.9%
Mule	2.3%	6.8%	90.9%
Cereals	41.5%	7.7%	50.8%
Pulses	57.4%	6.4%	36.2%

- Percentage of men head of households who believe that the practice of female circumcision should be stopped = 78.1%
- Percentage of married women who believe that the practice of female circumcision should be stopped = 79.1%
- Percentage of currently married women aged from 15 - 49 years that decide independently or jointly with their spouses on seeking health services for either themselves or their children = 81%

Persons living with disabilities

DFAP, as part of the Productive Safety Net Program (PSNP) in Ethiopia, has the strategy to provide direct support for the chronically food insecure people with disabilities. Currently only about 35.3% of persons with disabilities are getting PSNP transfer in the SCUS operational areas.

Social services

DFAP has outcome indicators on access to primary schools and health posts as per the government standards, duration of availability of domestic water from improved structures, and percentage of girls attending schools constructed by the program (PSNP). However, according to the government standards access to primary schools and health posts are not measured by distance from service users and percentage of households. Therefore, the values for the indicators on the two social services are just reported by considering the average distance from the sample households. Based on this, the following are calculated as the baseline values of the social service indicators.

- Average one-way distance of primary schools (first cycle, grades 1-4) = 2.2 km
- Average one-way distance of health posts = 4.4 km
- Average months in a calendar year of water availability at improved water structures = 4.53 months
- Percentage of households using improved drinking water sources for livestock = 45%

Nutritional status of children

DFAP has three indicators on nutritional status of children. The baseline survey has found out the following levels of malnutrition as per the program indicators for children between the ages of 6 to 59.9 months.

- Percentage of underweight (WAZ<-2) children aged 6-59 months: boys = 31.8%, girls = 25.6% and total = 28.5%
- Percentage of stunted (HAZ<-2) children aged 6-59 months: boys = 35.5%, girls = 27.4% and total = 31.2%
- Percentage of wasted children 6-59 months: boys = 19.0%, girls = 16.1% and total = 17.5%

1. INTRODUCTION

1.1 Overview of DFAP

This baseline survey is conducted for the Development Food Aid Program (DFAP) in Ethiopia implemented by SCUS in four woredas of Somali and one woreda of Oromia regions. The program is funded by U.S. Agency for International Development/Food for Peace (USAID/FFP) and will cover approximately the period between October 2011 and September 2016 with a final goal of “Chronic Food Insecurity of 112,688 PSNP beneficiaries in five woredas of Somali and Oromia regional States Reduced.” The program is designed with a specific objective (SO) of “Community and Household Resilience to Stress Periods Improved.” Moreover, the program has the following intermediate results (IR) to indicate its outcomes in relation with the SO:

- IR 1.1: Timeliness, appropriateness and predictability of food transfers improved;
- IR 1.2: Depletion of productive assets reduced;
- IR 1.3: Natural resource assets and their management improved;
- IR 1.4: Social service community assets developed; and
- IR 1.5: Community and government management of PSNP improved.
- IR 1.6: Women empowerments

The baseline survey is designed to collect data on the indicators for the above SO and IRs. The survey results show the current status of communities and households in relation with identified indicators, and will help to measure changes during future evaluation episodes.

1.2 Objectives of the Baseline Survey

The DFAP baseline survey is designed not only for SCUS operational areas but also for other three DFAP Awardees, namely CRS, FH and REST, operating in the highland areas of Oromia, Amhara and Tigray regions, respectively. The baseline survey for these organizations is jointly conducted in terms of indicator selection and methodological approach. The report for SCUS is prepared separately to show the peculiar nature of lowland areas without mixing the survey results with the highland areas. The field data collection in SCUS operational areas was conducted in February 2012. Dadimos Development Consultants PLC was contracted by the Awardees to conduct and prepare the baseline survey reports.

The joint baseline survey has a common objective for the four Awardees. This common objective is to generate statistically valid information that will serve as the bases for comparison with the same type of information collected during the final evaluation. In addition, the scope of the joint baseline survey has defined the following specific objectives:

- Determine the baseline values of key impact and outcome level indicators for the four awardees;
- Collect data compatible with the final evaluation and which enable to determine the level of changes on impact and outcome indicators between baseline and final evaluation;
- Collect data that will allow for bivariate and multivariate analysis required for FFP indicators; and
- Help establish annual and end-line targets for those indicators, as applicable.

1.3 Methodology of the Survey

1.3.1 Types of Evaluation Designs

Three main types of designs may be used in pre/post evaluation studies: Adequacy (Simple before/after comparisons); Plausibility (Before/after comparisons with controls) and Probability (Causal analysis of before/after differences) (Habicht and Victora, 1999). Preliminary consultations between the Awardees and Dadimos about the Scope of Work (SoW) for this assignment led to the selection of an “adequacy” evaluative model in which only outcome data are collected. These outcome data are expected to be collected before and after the program intervention for comparison. For this comparison, the same households will participate in the baseline and final evaluation surveys. This suggests collection of evaluation survey data at the end of the program from the same randomly selected households during the baseline survey. For this reason Dadimos will provide the names of sample households interviewed during this survey to SCUS with appropriate information useful for finding them from the sample kebeles.

1.3.2 Sampling

The survey was conducted on sample households selected from the sampling frame based on the total population of the target woredas. From SCUS operational areas 5 woredas were included in the sample. The sampling strategy was a two-stage sampling in which the primary units (clusters) were kebeles selected using Probability Proportional to Size (PPS), and the secondary units were households selected from the sample kebeles using systematic random sampling technique.

The sample size determination was jointly made by the four DFAP implementing agencies on the basis of prevalence of child stunting as an outcome indicator of the program. Based on the SoW which outlines the sampling methodology and sample size determination, with the exception of exclusive breast-feeding, the sample size required to measure the expected change in stunting satisfies the sampling requirements for all other indicators that allow detection of planned changes at Awardee level (See Annex 1 for the SoW).

Based on this sampling strategy, a total of 1,540 households, including 10% additional households to account for attritions and non-response cases were included per Awardee. The SoW also suggested 35 clusters (kebeles) per Awardee and made the sample 35X44 by considering 44 households per cluster. Using PPS method this sample size is distributed in the five woredas as presented in the table below.

Table 1: Geographic distribution of sample areas

Woreda	Regional state	Number of sample kebeles	Number of HHs interviewed
Arero	Oromia	4	176
Bare	Somali	8	352
Dollo Ado	Somali	7	308
Dollo Bay	Somali	6	264
Filtu	Somali	10	440
Total		35	1540

Exceptionally, getting an accurate list of households in each kebele was difficult to randomly select households using household rosters. Therefore, SCUS and Dadimos agreed that the enumeration teams apply a “bottle spinning method” to randomly select the 44 sample households from each sample kebele.

1.3.3 Indicators and Questionnaire Design

One particular feature of this survey is that it was jointly undertaken by four different development organizations known as Awardees. Since not all parties have the same data needs, between-program differences were accommodated by designing the survey questionnaire in a modular form so that each Awardee could select and implement the set of modules that would best suit its particular needs. To this end, list of indicators were prepared by awardees indicating for which organizations each indicator is applying. From the total 34 list of indicators, 20 were applicable for SCUS (Annex 1).

The survey questionnaire is designed mainly using Food for Peace (FFP) Standard Indicators Methodology Guide (2011). The questions and indicator formulation methods for 18 indicators out of 34 were taken from this guide. The rest of the indicators were either prepared by the consultant team or taken from other widely applied instruments developed by FANTA and others. Please see Annex 2 for the household questionnaire applied for the baseline survey.

1.3.4 Data Entry and Analysis

The raw data was entered into a computerized database system using the CSPro 4.0 program specifically designed for this baseline survey. As part of the data quality control mechanism, a portion (10%) of the data was entered using a double entry protocol. In addition, random visual comparisons between the original forms and the computer database were performed after the data was entered on the data that had not been double entered. Once all the data entry and cleaning were completed, the data was then exported to SPSS (v15.0) for analysis. Further data cleaning was made using SPSS by looking into frequency distributions and cross tabulations to identify outlier cases. In addition to this, the ENA for SMART (Nutrisurvey) software was used to derive the Z-scores¹ that were used to compare each child’s anthropometric measurements to the CDC/NCHS/WHO reference standards.

¹ The Z-score is defined as the deviation of the value of an individual child from the median value of the reference population, divided by the standard deviation for the reference population (CDC, 1978).

2 POPULATION AND HOUSEHOLD CHARACTERISTICS

The baseline survey is conducted in 1,540 sample households, of which 176 households are in Oromia region and 1,364 households in Somali region where SCUS implements DFAP. In total, about 93.8% of sample households are led by male and the remaining 6.2% by female (Table 2). As the table below shows the proportion of female headed households in Oromia is about one in five of the sample households. This is a bit higher as compared to the case in Somali region where only about 4.5% sample households are headed by female. The higher proportion of female headed households in Oromia region might be associated with the uncommon feature of remarrying widows by close relatives of former husbands unlike in Somali region where it is practiced widely.

The survey data reveal that the male-female ratio of the people in the sample households is almost proportional, constituting 51.6% males and 48.4% females. As indicated in Table 2, at an average the family size in the sample areas is about 6.3 persons per household, which is relatively higher in these lowland areas when compared to the national average rural family size of 4.9 persons according to the 2007 census report of the Ethiopia Central Statistical Agency (CSA). As commonly expected in rural areas, households are largely formed from nucleus family members constituting household heads (15.8%), spouses (15.3%) and sons or daughters (63.7%). (See Table 3)

Table 2: Demographic structure of sample households

	Oromia N=174 hhs N=1235 persons		Somali N=1364 hhs N=8548 persons		Total N=1538 hhs N=9783 persons	
Sex of HH members	Male	Female	Male	Female	Male	Female
Proportion of surveyed household heads (N= HHS)	79.9%	20.1%	95.5%	4.5%	93.8%	6.2%
Proportion of population (N= persons)	49.3%	50.7%	52.0%	48.0%	51.6%	48.4%
Mean number of person per household (male and female)	7.1		6.3		6.3	

Table 3: Household structure and members' relation to the household head

	Oromia			Somali			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Head of household	11.3%	2.8%	14.1%	15.4%	0.7%	16.1%	14.8%	1.0%	15.8%
1st wife	0.2%	11.1%	11.3%	0.4%	15.1%	15.5%	0.3%	14.6%	14.9%
2nd or 3rd wife		0.6%	0.6%		0.4%	0.4%		0.4%	0.4%
Son or daughter	34.3%	32.1%	66.4%	33.9%	29.4%	63.3%	34.0%	29.7%	63.7%
Son/daughter-in-law	0.1%	0.2%	0.3%	0.4%	0.3%	0.7%	0.3%	0.2%	0.5%
Grandson/daughter	0.6%	0.4%	1.0%	0.2%	0.2%	0.4%	0.2%	0.2%	0.4%
Mother or father	0.2%	1.1%	1.3%	0.2%	0.8%	1.0%	0.2%	0.8%	1.0%
Father/mother-in-law	0.1%		0.1%	0.0%	0.1%	0.1%	0.1%	0.1%	0.2%
Brother or sister	2.0%	1.1%	3.1%	0.6%	0.4%	1.0%	0.8%	0.5%	1.3%
Other relatives	0.2%	0.2%	0.4%	0.5%	0.4%	0.9%	0.5%	0.3%	0.8%
Adopted child, custody	0.2%	0.9%	1.1%	0.2%	0.1%	0.3%	0.2%	0.2%	0.4%
No relationship		0.2%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Stays here			0.0%	0.3%	0.1%	0.4%	0.2%	0.1%	0.3%
Total	49.3%	50.7%	100.0%	52.1%	47.9%	100.0%	51.7%	48.3%	100.0%

The data on age distribution of persons in the sample households shows that economically inactive individuals under 15 years old account for 54.1% of the population. Thus, a majority of the population, including individuals under 15 years old and over 60 years old at 55.9% of the total population collectively, are economically dependent on the remaining 44.1% active labor segment of the population (See Table 4).

Table 4: Age and labor distribution of household members

Age range		Oromia		Somali		Total	
		Count	Table %	Count	Table %	Count	Table %
< 15 years	Male	338	27.4%	2396	28.1%	2734	28.0%
	Female	364	29.5%	2182	25.6%	2546	26.1%
	Total	702	57.0%	4578	53.7%	5280	54.1%
15 - 60 Years	Male	251	20.4%	1947	22.8%	2198	22.5%
	Female	242	19.6%	1865	21.9%	2107	21.6%
	Total	493	40.0%	3812	44.7%	4305	44.1%
> 60 years	Male	19	1.5%	87	1.0%	106	1.1%
	Female	18	1.5%	54	.6%	72	.7%
	Total	37	3.0%	141	1.7%	178	1.8%
All ages	Male	609	6.2%	4443	45.4%	5052	51.6%
	Female	626	6.4%	4105	42.0%	4731	48.4%
	Total	1235	12.6%	8548	87.4%	9783	100.0%

According to Table 5, the mean age of household heads in the survey area is about 42 years. In Oromia region the mean age of household heads was found to be 45 years and 41 in Somali.

Table 5: Mean age of household heads in years

Sex	Oromia	Somali	Total
Male	44	41	42
Female	55	37	42
Total	45	41	42

As indicated in Table 6 below, about 95.3% of household heads are married while about 2.9% are widows or widowers. Interestingly, about 12% of sample households in Oromia reported to be widowed.

Table 6: Marital status of sample household heads (% of HHs)

Region	Marital status	Sex				Total	
		Male HHs		Female HHs		Count	Table %
		Count	Table %	Count	Table %		
Oromia	Married	112	78.9%	9	6.3%	121	85.2%
	Single	2	1.4%			2	1.4%
	Divorced or separated			2	1.4%	2	1.4%
	Widowed	2	1.4%	15	10.6%	17	12.0%
	Total	116	81.7%	26	18.3%	142	100.0%
Somal	Married	1253	94.9%	20	1.5%	1273	96.4%
	Single	9	.7%	3	.2%	12	.9%
	Divorced or separated	3	.2%	6	.5%	9	.7%
	Widowed	1	.1%	24	1.8%	25	1.9%
	Total	1266	95.9%	54	4.1%	1320	100.0%
Both regions	Married	1365	93.4%	29	2.0%	1394	95.3%
	Single	11	.8%	3	.2%	14	1.0%
	Divorced or separated	3	.2%	8	.5%	11	.8%
	Widowed	3	.2%	39	2.7%	42	2.9%
	Total	1382	94.5%	80	5.5%	1462	100.0%

Educational status of members of sample households is analyzed and reported in Table 7. The table shows that about 53.5% of household heads are literate and able to read and write in any one of the languages. Household heads literacy rates are 59.4% and 6.9% in Somali and Oromia regions, respectively. The high literacy rate in Somali region might be associated with the religious education widely given in Arabic letters through traditional schools.

Literacy rate among school age children, 7-14 years old, in the sample areas was found to be about 60%. This means two in five school age children are not able to read and write. When these data are examined by region, the number of literate school-age children in Oromia is low (20.3%) as compared to Somali Region (66.9%). According to the survey finding about 67.5% and 21% of school age children have been literate by attending in first cycle primary schools and religious/traditional schools, respectively.

Table 7: Educational status of people in the sample households

Education		Oromia	Somali	Total		
				Male	Female	Total
Education of all HH heads				N=174	N=1349	N=
1426 N= 94 N= 1520						
Literate		6.3%	59.5%	55.8%	19.1%	53.5%
Highest grade completed	Church/mosque school/traditional	79.2%	84.4%	84.5%	72.4%	84.1%
	Literacy or other program	-	-	-	-	-
	First cycle primary (1 st grade to 4 th grade)	15.1%	5.7%	5.9%	17.2%	6.3%
	Second cycle primary (5 th grade to 8 th grade)	5.7%	7.9%	7.8%	6.9%	7.7%
	Secondary level education (9 th grade to 10 th grade)	-	1.5%	1.3%	3.4%	1.4%
Above 10 th grade		-	0.5%	0.5%	-	0.5%
Education of all HH members, 7 years old and above		N=888	N=3407	N= 2183	N= 1370	N= 3553
Literate		17.9%	57.1%	61.6%	41.7%	52.0%
Highest grade completed	Church/mosque school/traditional	45.8%	43.4%	47.0%	38.2%	43.6%
	Literacy or other program	-	-	-	-	-
	First cycle primary (1 st grade to 4 th grade)	25.8%	38.8%	33.4%	44.6%	37.8%
	Second cycle primary (5 th grade to 8 th grade)	21.4%	15.1%	16.3%	14.7%	15.7%
	Secondary level education (9 th grade to 10 th grade)	5.0%	2.2%	2.7%	2.1%	2.4%
Above 10 th grade		2.0%	0.4%	0.7%	0.4%	0.6%
Education of all HH members 7-14 years old		N=359	N=2041	N= 1255	N= 1128	N= 2383
Literate		20.3%	66.9%	63.2%	56.5%	60.0%
Highest grade completed	Church/mosque school/traditional	33.9%	20.2%	21.7%	20.5%	21.2%
	Literacy or other program	-	-	-	-	-
	First cycle primary (1 st grade to 4 th grade)	41.3%	69.7%	66.7%	68.5%	67.5%
	Second cycle primary (5 th grade to 8 th grade)	23.1%	9.6%	10.9%	10.5%	10.8%
	Secondary level education (9 th grade to 10 th grade)	1.7%	.4%	.5%	.4%	.5%
Above 10 th grade		-	.1%	.1%	-	.1%

3. FOOD SECURITY – MODULE C

3.1 Food Access (HDDS and HHS) – Module C.1

Household dietary diversity score (HDDS) is the sum of food groups consumed by households within 24 hours prior to the interview. According to FFP Standard Indicators Methodology Guide issued in 2011, HDDS is considered as a proxy indicator of household socio-economic status. It is also seen as important indicator of food access at household level calculated from the number of food groups consumed by households.

The dietary diversity indicator uses 24 hours recall on consumption of food from twelve food groups that are recommended as being important contributors to the nutritional quality of a diet. The food groups included in the dietary diversity score of this baseline study were cereals, roots and tubers, pulses/legumes/nuts, vegetables, milk and milk products, fruits, fish, meat and poultry, sugar/honey, eggs and others miscellaneous foods. Foods consumed by the respondent households during the 24 hours preceding the survey are presented in Table 8. Almost all households (94.7%) reported the consumption of coffee and tea, followed by sugar/honey (89.7%). Then cereals, milk /milk products as well as oil/fat were part of the diet for about 81.0%, 70.8% and 69.8% of households, respectively.

Table 8: Households' consumption of foods

	Region				Total	
	Oromia		Somali		Count	%
	Count	%	Count	%		
Cereals	162	92.0%	1086	79.6%	1248	81.0%
Root crops	14	8.0%	357	26.4%	371	24.3%
Vegetables	3	1.7%	342	25.3%	345	22.6%
Fruits	9	5.1%	370	27.4%	379	24.9%
Meat, poultry	26	14.8%	565	41.6%	591	38.6%
Eggs	4	2.3%	268	19.8%	272	17.8%
Fish	2	1.1%	152	11.2%	154	10.1%
Pulses/legumes/nuts	2	1.1%	688	50.8%	690	45.1%
Milk and milk products	106	60.2%	974	72.1%	1080	70.8%
Oil/fat	39	22.4%	1033	75.9%	1072	69.8%
Sugar/honey	92	52.6%	1279	94.5%	1371	89.7%
Miscellaneous (coffee or tea)	168	96.0%	1275	94.6%	1443	94.7%

Average dietary diversity score is a standard indicator for measuring the outcome of DFAP in terms of measuring changes in household access to food over the program life time. As the survey data summarized in Table 9 below indicate, the average HDDS in SCUS operational areas is estimated at 6 (5.87). This means at an average households have reported the consumption of half of the 12 food groups within the 24 hours recall during the survey season, which is

Table 9: Average household dietary diversity score

Gender of HH Head	Somali	Oromia	Both
MHH	6.19	3.55	5.93
FHH	5.75	3.63	5.03
Total	6.16	3.56	5.87

commonly characterized as dry and hungry season². There is no significant difference in the average HDDS between male and female headed households. However, this value is high in Somali Region (6.16) as compared to Oromia (3.56). This is largely associated with higher proportion of households consuming diverse food groups, including root crops, vegetables meat, pulses, milk and oil/fat in Somali region as opposed to Oromia.

3.2 Household Hunger Scale – Module C.2

Household Hunger Scale (HHS) is the second important indicator applied in DFAP to measure access to food at household level. It measures the percentage of households with moderate or severe hunger. This indicator is based on three variables showing the food access situation of households throughout the four weeks prior to the interview date. These variables are posed to the respondents as follows:

- i) In the past [4 weeks/30 days] was there ever no food to eat of any kind in your house because of lack of resources to get food?
- ii) In the past [4 weeks/30 days] did you or any household member go to sleep at night hungry because there was not enough food?
- iii) In the past [4 weeks/30 days] did you or any household member go a whole day and night without eating anything at all because there was not enough food?

The detailed analysis methodology for HHS as an outcome indicator is done on the basis of FFP Standard Indicators Methodology Guide (2011). The findings of the baseline survey data analysis presented in Table 10 show that about 67.6% of households lived in moderate or severe hunger in SCUS operational areas during the survey season. The hunger level was also high among female headed households in which about 82.2% were moderately or severely hungry as compared to 66.6% in the case of male headed households. Likewise, the result of the survey indicates that hunger is more rampant in the Oromia sample areas (79.5%) than in Somali (66.1%).

Table 10: Percentage of households by HHS

Household Hunger Score	Household Hunger Categories	Region		Sex		Total (N=1532)
		Oromia (N=176)	Somali (N=1359)	MFF (N=1425)	FHH (N=107)	
0-1	Little to no hunger in the household	20.50%	33.90%	33.50%	17.80%	32.40%
2-3	Moderate hunger in the household	53.40%	58.60%	57.80%	60.70%	58.00%
4-6	Severe hunger in the household	26.10%	7.50%	8.80%	21.50%	9.60%
Indicator value: Percentage of HHS with moderate to severe hunger		79.50%	66.10%	66.60%	82.20%	67.60%

² The survey was conducted from February 20 to March 10, 2012.

3.3 Household Food Insecurity Coping Strategy – Module C.3

The concept of coping strategy is defined as the behavior that households revert to when food is in short supply to meet their needs during the food shortage period. The sample households were asked to report on what coping strategies they used during the last 7 days, if there have been shortages of food or money to buy food. Coping strategies included relying on less preferred foods, reducing the number of meals eaten per day, restricting consumption of adults so as children can eat normally, borrowing food/money from friends and relatives, limiting portions at mealtime. Summary of the responses of respondents on how often they practiced each coping strategy are provided in Table 11.

Table 11: Frequency of food insecurity coping behaviors

Coping strategies	Never	1 day/week	2-3 days/week	4-6 days/week	Daily
Eating less-preferred foods	32.90%	8.60%	24.20%	13.40%	20.90%
Borrowing food/money from friends and relatives	22.10%	7.70%	37.20%	19.20%	13.80%
Limiting portions at mealtime	21.40%	9.10%	34.00%	19.30%	16.20%
Limiting adult intake	23.10%	12.70%	30.00%	17.80%	16.40%
Reducing number of meals per day	22.10%	12.50%	25.40%	15.80%	24.00%

Overall the three major households coping strategies which are commonly practiced by the surveyed households in their order of priorities include reducing the number of meals per day, limiting adult intake and borrowing food/money from friends and relatives. Over half of the households (67.1%) responded that they relied on less preferred foods at least once in a week during the last 7 days. More importantly, 77.9% of households reduced the number of meals they eat at least once per week, while 24% of the households reduced the number of meals they eat every day. Some of the households (16.4%) also regularly reduces the amount of food for adults so that children can eat.

Average coping strategy index (CSI) is considered as an outcome indicator for DFAP. To estimate the average CSI in the program areas, a reduced household CSI Score developed by CARE, USAID and TANGO, and which is applicable to the Ethiopian context, was used (Maxwell and *et.al*, 2008). Based on the survey data, the average coping strategy index for surveyed areas was estimated at 22.7 (Table 12). Sever CSI score was reported in Oromia (31.4) as compared to Somali areas covered by the study (21.3). These results indicate the presence of significant difference in their CSI score between the survey areas of the two regions (p-value <0.01). Gender wise the analysis of CSI shows that male headed households have a significantly lower coping strategy index (22.3) as compared with female headed households (26.3) with p- value <.01).

Table 12: Mean score per coping strategy index by survey regions

Coping Strategy	Oromia	Somali	Total
a) Eating less-preferred foods	2.3	2.6	2.7
b) Borrowing food/money from friends and relatives	6.6	5.5	5.6
c) Limiting portions at mealtime	4.4	2.7	2.9
d) Limiting adult intake	13.1	7.7	8.4
e) Reducing the number of meals per day	5.0	2.8	3.1
Mean of coping strategy index score	31.4	21.3	22.7

Note: The following universal severity weights were applied: a = 1, b =2, c =1, d =3 and e = 1

In order to help implementing entities plan for change in CSI targets we have presented percentage distribution of sample households by level of severity of CSI in Table 13. Based on our own categorization of CSI scores by severity level, about one in three households (37.1%) have high CSI score which implies the severity food insecurity at the time of this survey. Particularly, severe food insecurity is prevalent in Oromia sample woredas in which about 74.4% of households fall under high CSI score compared to 32.1% in Somali region.

Table 13: Percentage distribution of HHs by level of CSI in 2011/12 and by regions

CSI Level	Oromia	Somali	Total
Low CSI		11.0	9.7
Moderate CSI	25.6	56.8	53.2
High CSI	74.4	32.3	37.1

Low CSI = Below 5 CSI score; Moderate CSI = 6 - 25 CSI score; and High CSI = Over 25 CSI score

3.4 Number of Months with Adequate Food Provisioning – Module C.4

This section discusses the adequacy of food access at household level in survey areas during the last one year, i.e. from February 2011 to January 2012. The sample households were asked whether they had enough food to cover their needs on a month by month basis during the reference period. The summary of their responses in terms of number of months with adequate food supply is presented in Figure 1. Based on this, households in the SCUS operational areas had enough food for about 4 months (3.84) per year. This means at an average

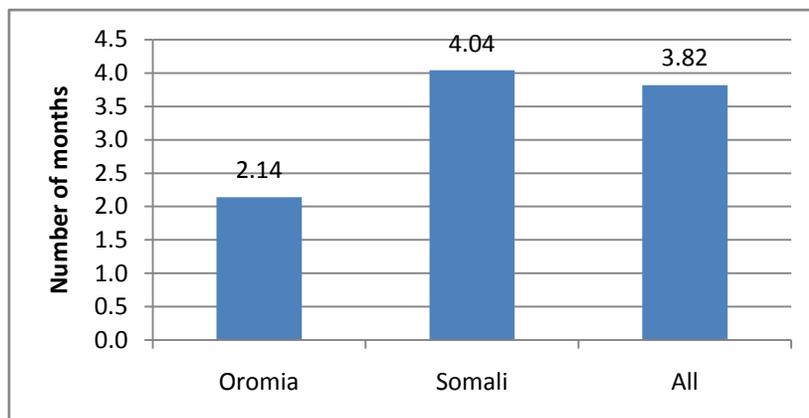


Figure 1: Number of months with enough food

households faced food shortages for about 8 months

per year. Regionally, households had two and four months of enough food to cover their needs in Oromia and Somali, respectively, in the reference one year period.

As the household food access situation presented in Table 14 indicates only a little above a quarter of households (27 %) had enough food to eat at all times during last year. About 11.6% of the sample households [9.8% in Oromia and 11.8% in Somali] reported to have insufficient food throughout the year. Only about 2.3% percent of the sample households reported to have access to adequate food from different sources during the reference period.

Table 14: Percentage of households by number of months with enough food during 2011/12 year

Number of months with enough food	% of HHs that had enough food to cover all needs		
	Oromia	Somali	All
0 month	9.8	11.8	11.6
1 month	19.1	2.5	4.4
2 months	29.5	11.2	13.3
3 months	30.6	20.1	21.3
4 months	10.4	14.8	14.3
5 months	0.0	13.0	11.5
6 months	0.6	11.4	10.2
7 months	0.0	7.0	6.2
8 months	0.0	3.5	3.1
9 months	0.0	1.3	1.1
10 months	0.0	0.6	0.5
11 months	0.0	0.3	0.2
12 months	0	2.6	2.3

4. ACCESS TO IMPROVED SANITATION AND DRINKING WATER SOURCES

Access to improved sanitation facilities and clean drinking water are crucial to bringing about reduction in diseases and improving the overall health, nutrition and style of living of household members. This is done by breaking the cycle of disease transmission and reducing the exposure risks. Diseases like diarrhea are mainly water-borne and rampant in lowland areas because of favorable temperatures for multiplication of micro-organisms. This is aggravated by living conditions like improper excreta disposal which worsens the situation. Reductions in morbidity are expected to improve productivity and nutritional status by reducing the effects of dehydration, fever and mal-absorption of nutrients. Water, if not purified, can carry dangerous diseases and consequently cause considerable morbidity and mortality.

4.1 Improved Sanitation Facilities – Module F

Based on FFP Standard Indicators Methodology Guideline (2011) a sanitation facility is considered improved when an improved toilet is used without being shared with other households. As indicated in Table 15 there two types of improved toilet facilities, including ventilated improved pit latrines and pit latrines with slab used by about 10% sample households in SCUS operational. Majority of these improved toilet facilities are shared among neighboring households. Therefore, only 1.5% of the total sample households have access improved sanitation facilities in the survey areas. The survey result also came across no households using improved sanitation facilities in Oromia while only 1.7% of households in Somali region reported to have access to improved sanitation facilities as per the definition of this indicator (Table 16). According to the DHS 2011, 90.6% of the households in the rural parts of Ethiopia do not have access to improved sanitation facilities, which is higher than the results from the program area.

Table 15: Percentage of households by type of sanitation facilities

Improved and unshared	Oromia	Somali	Total
Non-improved	100.0%	98.3%	98.5%
Improved	0.0%	1.7%	1.5%
Total	100.0%	100.0%	100.0%

Table 16: Percentage of households by type of toilet facilities

	Improved		Non – improved				
	Ventilated improved pit latrine	Pit latrine with slab	Pit latrine with no slab/ open pit	No facility	Composting toilet	Hanging toilet	Others
Somali (n= 1311)	0.7	10.9	10.1	75.0	3.0	0.2	0.2
Oromia (n= 175)	2.9	0.6	2.9	93.7	0.0	0.0	0.0
Total (n= 1486)	0.9	6.7	9.3	72.7	2.6	0.1	0.1
Total	10.6%		90.4%				

4.2 Access to Improved Drinking Water Sources – Module G

Access to improved drinking water is one of the livelihood impediments in lowland areas of Ethiopia. As Tables 17 and 18 indicate about 22.4% and 15.6% of the households in the SCUS program areas have access to improved sources of drinking water during the dry and wet seasons, respectively. Compared to the DHS 2011³ findings which states that nationally some 41.7% of the rural households have access to improved drinking water sources, these results from the program areas are very low.

In the survey areas, access to improved water sources is low during the wet season when compared to the dry season as the people resort to short distance unprotected surface water sources that are easily available during the rainy seasons. During the wet season, river/stream (44.8%) remains to be the most common source of water for Somali areas while pond/lake (91.0%) is the most common source for Oromia areas included in the baseline survey.

Table 17: Percentage of households with access to improved drinking water sources during dry season

	Sources of drinking water	Somali (n=1364)	Oromia (n = 175)	Total (n= 1539)
Improved	Piped into dwelling	0.1	1.1	0.2
	Piped into yard/plot	0.1	0.0	0.1
	Public tap	9.1	13.1	9.6
	Protected well in dwelling	0.4	0.0	0.3
	Protected public well	7.2	0.6	6.4
	Tube well/borehole	3.0	6.3	3.4
	Protected spring	0.3	1.1	0.4
	Rain water protected	0.2	0.0	0.2
	Water vendor	0.4	0.0	0.4
	Birka protected	0.5	3.4	0.8
	Protected well in yard/plot	0.1	0.6	0.2
	Canvases tank	0.4	0.0	0.4
	Total		21.8	26.2
Unimproved	Open well in dwelling	0.8	5.1	1.3
	Open well in yard/plot	0.8	0.6	0.8
	Open public well	25.0	16.0	24.0
	Unprotected Spring	0.1	72.0	8.3
	River/stream	36.4	0.0	32.3
	Birka unprotected	0.7	2.9	0.9
	Pond/lake	6.0	0.6	5.4
	Dam	2.3	0.0	2.0
	Rain water harvesting unprotected	2.1	1.1	2.0
	Others	20.7	1.7	18.5

³ Ethiopian Demographic and Health Survey, 2011

Table 18: Percentage of households with access to improved drinking water sources during wet season

	Sources of drinking water	Somali (n=1364)	Oromia (n = 175)	Total (n= 1539)
Improved	Piped into dwelling	0.1	0.0	0.1
	Piped into yard/plot	0.1	0.0	0.1
	Public tap	7.8	6.9	7.7
	Protected well in dwelling	0.1	0.0	0.1
	Protected public well	4.7	0.0	4.2
	Tube well/borehole	1.8	0.6	1.7
	Protected spring	0.7	0.0	0.6
	Rainwater protected	0.4	0.0	0.4
	Birka protected	0.4	0.0	0.3
	Protected well in yard/plot	0.0	0.0	0.0
	Canvas tank	0.4	0.0	0.4
	Total	16.5	7.5	15.6
Unimproved	Open well in dwelling	1.1	4.0	1.4
	Open well in yard/plot	0.5	0.0	0.5
	Open public well	21.3	7.4	19.8
	Un protected Spring	5.0	8.6	5.4
	Birka unprotected	0.5	1.1	0.6
	Pond/lake	12.2	90.9	21.1
	Dam	2.5	0.0	2.2
	Rain water harvesting unprotected	11.4	40.0	14.7
	River/stream	44.4	2.9	39.7
	Water vendor	1.8	0.0	1.6
	Others	17.7	0.0	15.7

5. HOUSEHOLD ASSET HOLDINGS – MODULE H.2

5.1 Average Value of Household Asset Holding

According to the survey data, the total asset value owned per household for the surveyed areas is Birr38,922. The most important asset holding of the sample households reported is livestock, which accounts for 97.2% of the total asset value followed by household goods (1.4%). The result of the survey also shows that the total asset value owned per household in Oromia is Birr 28,050 while it is Birr 40,325 in Somali region (Table 19). This indicates that households in Somali region are relatively better off than their counterparts in Oromia region.

Table 19: Current mean asset holding per household (in Birr), 2012

	Oromia	Somali	Total	Percentage
Livestock ⁴	27,754	39136	37,833	97.20%
Productive assets	33	369	331	0.85%
Household goods	0	627	558	1.43%
Consumer products	263	193	200	0.52%
Total	28,050	40,325	38,922	100.0%

The direction of the national Food Program in Ethiopia is to stabilize and increase the value of households' asset over time. The survey attempted to compare values of household asset holdings at the time of the survey period and a year ago. The mean asset value owned per household was found to be Birr 38,922 during the survey time (2012) and Birr 56,844 a year ago (2011). Surprisingly, the trend of asset value indicates a reduction by 31.5% (Birr 17,922) per household. The reduction in mean household asset was mainly due to

Table 20: Mean asset holding per household (in Birr)

Region	Asset type	Current	A year ago	Change, %
Oromia	Livestock	27,754	75,619	-63.3%
	Productive assets	33	79	-58.3%
	Household goods	0	0	0.0%
	Consumer goods	263	168	56.7%
	Sub-total	28,051	75,866	-63.0%
Somali	Livestock	39,136	53,287	-26.6%
	Productive assets	369	355	4.1%
	Household goods	627	574	9.2%
	Consumer goods	193	165	16.7%
	Sub-total	40,325	54,381	-25.8%
All	Livestock	37,833	55,845	-32.3%
	Productive assets	331	323	2.4%
	Household goods	558	511	9.2%
	Consumer goods	200	165	21.1%
	Total	38,922	56,844	-31.5%

reduction in value of livestock asset ownership. As indicated in Table 20, the mean livestock asset holding per household has shown a reduction by 32% over one year period. The higher mean asset value reduction is observed in Oromia (by 63%) than in Somali region (26%).

⁴ Please refer to Annex 2 for the details on the types of livestock households own.

Sample households were further asked the reasons for the reduction of household assets. The summary of those responses indicate that 34.1% households stated livestock died or were slaughtered due to droughts and livestock diseases. Likewise, about 21.8% and 11% of households reported forced sale in order to buy food and exchange the livestock with food, respectively (Table 21).

Table 21: Main reasons for household asset reduction (% of households)

	Oromia	Somali	Total
Livestock died or was slaughtered	52.2	28.6	34.1
We were forced to sell the asset to buy food	23.6	21.3	21.8
We were forced to exchange the asset for food		14.8	11.3
We were forced to sell the asset to pay for health expense	2.3	2.5	2.5
We had to sell the asset to meet social obligation	2.7	0.6	1.1
We used the asset in a social occasion		0.6	0.5
The asset was stolen	13.6	3.3	5.7
Livestock was sold to generate income	0.3	2.0	1.6

5.2 DFAP indicator on household asset

DFAP, as one of its indicators, uses “percentage of households whose asset levels are stable or increasing”. This indicator can be calculated by tracking change in asset values owned by households during the baseline survey and final evaluation. As this is the time for baseline survey, however, it is not possible to provide percentage of households with stable or increased asset levels. Therefore, the current mean value of asset ownership should be seen as a baseline and the indicator value to be calculated at the end of the program by comparing mean asset holding through conducting the final evaluation among the same households interviewed during the baseline survey.

6. GENDER AND SOCIAL PERSPECTIVES

Available literatures indicate that pastoralist women (including women in Borena and Somali) are victims of social, economic and political marginalization, and they also suffer inequality in accessing resources, social services and participation in decision-making⁵. Although there are cross cultural variations, the overall pattern of gender relations favors men in the distribution of resources, opportunities, power and access to and control over resources. In general, men dominate the political, economic, and social arena in all cultures. Factors that determine gender roles, access to and control over resources and decision-making power at the household and public domains include general economic conditions, institutional structures, socio-cultural factors, social norms, attitudes, legal systems, policies, education and training as well as political events⁶.

The DFAP implemented by SCUS in lowland areas has four outcome indicators to measure its contributions to women's empowerment of the program over its five years life time. These indicators are:

1. Proportion of women who reported to have jointly decided on purchase and/or sale of asset (cattle, camel, shots, pack animals and agricultural produces) with their husbands/partners;
2. Proportion of currently married women who believe that the practice of female circumcision should be stopped;
3. Proportion of male head of households who believe that the practice of female circumcision should be stopped; and
4. Percentage of currently married women aged from 15-49 reporting that they make decisions independently or jointly with their spouses with regard to seeking health services.

6.1 Women's decisions on purchase and sale of household assets

For the purpose of DFAP, the indicator on household assets focuses on the decision-making role of married women only. So a question was posed to married women in the sample households as to who makes decisions on household assets, including livestock and agricultural products purchase and sale. The question was posed only to those married women in the household who had sold or bought these assets. The result of the survey data shows that in most cases joint decision-making by men (household heads) and women (spouses) on purchase and/or sale of household assets (livestock and agricultural produces) is a common phenomenon in the survey areas (Table 22). As per the program indicator, the proportion of currently married women that jointly made decision on purchase and/ or sale of camel, cattle and sheep/goat are 81.5%, 71.1% and 71.1%, respectively. Likewise, about 65.8% of the currently married women were reported to have jointly decided on the purchase of donkeys. In the case of horses and mules, about 90.9% of the women acknowledged similar joint decision-making process. About half (50.8%) of the women made decisions jointly with their husbands on the purchase and/or sale of cereals while 36.2% of them did the same in pulses.

⁵ Naomi Kipuri and Andrew Ridgewel (2008): A Double Bind: The Exclusion of Pastoralist Women in the East and Horn of Africa

⁶ Almaz (1991): Perspectives on Gender and development in Gender Issues in Ethiopia (ed. Tsehai Berhane-Selassie) IES.

Table 22: Proportion of currently married women who make decisions independently or jointly on purchase and/or sale of assets

Items	Purchase			Sale			Purchase and/or Sale		
	Women alone	Men alone	Women/men Jointly	Women alone	Men alone	Jointly	Women alone	Men alone	Women/men jointly
Camel	3.7%	18.2%	78.1%	5.2%	12.6%	82.2%	6.0%	12.5%	81.5%
Cattle	4.5%	28.6%	66.9%	6.6%	21.2%	72.2%	5.4%	23.5%	71.1%
Sheep/Goat	7.0%	27.8%	65.2%	3.9%	24.1%	72.0%	5.8%	22.4%	71.8%
Donkey	5.2%	29.2%	65.6%	7.1%	25.9%	67.0%	6.0%	28.1%	65.8%
Horse	1.2%	5.8%	93.0%	0.0%	50.0%	50.0%	1.1%	8.0%	90.9%
Mule	2.4%	7.1%	90.5%	0.0%	2.9%	97.1%	2.3%	6.8%	90.9%
Cereals	44.9%	8.4%	46.7%	33.4%	10.0%	56.6%	41.5%	7.7%	50.8%
Pulses	59.5%	7.4%	33.1%	44.5%	7.3%	48.2%	57.4%	6.4%	36.2%

The manner of asset disposal and acquisition seems to depend upon the values of the assets under discussion. For instance, women’s independent decision on livestock that represent the principal economic output of the pastoralist economy and serve as a sign of prestige and social status is insignificant, while women have high independent decision-making power on the sale and purchase of less valued assets (mainly for household consumption good such as cereals and pulses) like pulses and cereals.

As shown in Table 22, only insignificant proportion of women decides independently to purchase camel (6.0%), cattle (5.4%), sheep/goat (5.8%), donkey (6), horse (1.1%) and mule (2.3%). Contrary to these, women have more independent decision-making autonomy over marketing of food crops. Nearly 12.5% of women respondents acknowledged that they have the power to independently decide on the purchase and/or sale of cereals independently. Similarly, almost 57.4% of the study participants responded positively as regards to their independent decisions on the purchase/sales of pulses.

6.2 Female Circumcision

The World Health Organization defines female circumcision (FC) as, “all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons. It is a deeply rooted traditional practice which is one form of violence against girls and women that has serious physical consequences that adversely affect health. Furthermore it is a reflection of discrimination against women and girls”.⁷

The practice of female circumcision (FC) is widespread in Ethiopia, particularly in the study areas⁸. Studies indicate that 74 % of girls and women in Ethiopia have undergone female

⁷ WHO, 1996, Toubia,1999

⁸ NCTPE, Old Beyond Imaginings: Ethiopia Harmful Traditional practices,

circumcision and the practice is almost universal in Somali region⁹. FC has harmful consequences to women's health and wellbeing. Hemorrhage, infections, women's infertility, obstetric complications (including fistula) and the possibility of HIV/AIDS transmission are the major health hazards related to FC.

The main purpose of the study was to find out mainly the proportion of currently married women (CMW) and male heads of households (MHH) who believe that the practice of female circumcision should be stopped as one of the program outcome indicator. CMW and MHH in the sample households were independently asked about their current stand on the practice. As can be seen from Table 23, nearly four in five people believe that the long established practice of female circumcision should be stopped. Specifically, 79.1% of CMW and 78.1% MHH of proclaimed the need for stopping the practice. Regional and gender variations were insignificant in this respect. Some 81.3% of CMW in Oromia and 78.9% in Somali believed that the practice is harmful and should be abandoned. On the other hand, 81.6% of MHHs in Oromia and 77.7% in Somali said that the practice should be stopped.

Apart from the program indicator requirement, the study has examined the prevalence of female circumcision among households with girls. In order to determine the prevalence of the practice in the study areas, currently married women and male heads of households were asked whether any of their daughters have undergone circumcision. As clearly shown in Table 24, high variations were witnessed in the two study regions with regard to the prevalence of female circumcision. Surprisingly, the overwhelming majority (well over 80%) of respondents, both currently married women (CMW) and male household heads (MHH), in Oromia region claimed that their daughters have not undergone circumcision. In Somali, 34.4% of MHHs and 38.5% of CMW reported that their daughters were not circumcised. The current study disclosed that the number of girls affected by the practice of female circumcision has been reducing significantly in the study areas, particularly in Oromia.

Table 23: Proportion of CMW and MHHs who believe that female circumcision should be stopped

Responses	Currently Married Women			Male Household Heads		
	Oromia	Somali	Total	Oromia	Somali	Total
<i>It should be stopped</i>	81.3%	78.9%	79.1%	81.6%	77.7%	78.1%
It should continue	18.8%	20.9%	20.7%	17.8%	21.6%	21.2%
I have no idea or am indifferent		.2%	.2%	.6%	.7%	.7%
Total	100	100	100	100	100	100

Table 24: Proportion of CMW and MHHs with circumcised daughters

Responses	Currently Married Women (CMW)			Male Household Heads (MHHs)		
	Oromia	Somali	Total	Oromia	Somali	Total
No	82.9%	33.6%	38.5%	83.6%	34.4%	40.1%
Yes	17.1%	66.4%	61.5%	16.4%	65.6%	59.9%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

⁹ 2005 Demographic and Health Survey (EDHS)

As cited above, literatures on the practice of female circumcision have documented that FC is pervasive and widespread in the two study sites. The findings of this survey, however, do not tally with the findings of previous studies. This deviation could partially be attributed to respondents' denial to provide the real picture and/or awareness raising campaigns waged against the practice by different state and non-state actors are paying off. In order to corroborate the findings of the present quantitative study, there may be a need to call for a qualitative study in the future.

However, the preference of high proportion CMW and MHH respondents to stop female circumcision indicates the positive supports from the community against this practice which denies the right of girls and women. The study findings also show that only a fifth of the study participants supported the continuity of female circumcision in Oromia and Somali regions. The findings suggest that there is a change of attitude towards the deeply rooted traditional practice of female circumcision. It was also found that the present survey finding is in conformity with other previous studies. For instance, a study indicated that out of 15,000 women surveyed across Ethiopia only 25.5 percent still supported FC, down from 60 percent five years ago. A number of factors may be at work for the increasing opposition against the long established cultural practice in the study areas. Better educational attainment of girls, anti-FC laws and awareness-raising efforts are some of the contributing factors for the increasing opposition of the practice.

In addition to the information regarding the program outcome indicators, the study has also attempted to identify decision makers on female circumcision practice in and outside of the household. In both regions, predominantly mothers alone or jointly with fathers of the girls make decisions on female circumcision (Table 25). According to 41.1% and 44.3% of CMW and MHH, respectively, mothers decide to circumcise their daughters. Likewise, 44.4% of CMW and 45.2% of MHHs reported such decisions to be jointly made by mothers and fathers of the girls. Insignificant (less than 1%) proportion of CMW and MHH reported that decisions on circumcision are made by the girls themselves.

Table 25: Responses of women and men on who makes decisions on FGM

Decision makers	Currently married women			Male household heads		
	Somali	Oromia	All	Somali	Oromia	All
Father alone	14.6%	4.2%	13.5%	10.6%		9.4%
Mother alone	42.1%	31.3%	41.1%	45.6%	34.7%	44.3%
Father and mother jointly	42.8%	59.0%	44.4%	43.4%	58.8%	45.2%
Children themselves	.3%	5.6%	.8%	.2%	6.5%	.9%
Don't know	.2%		.2%	.2%		.1%
Total	100.0%	100%	100.0%	100.0%	100.0%	100.0%

As mentioned above, the main thrust of the study is to identify the proportion of women who jointly decide on matters pertaining to their daughters' circumcision. The data on this variable is disaggregated by the study areas so as to help make comparative analysis. As shown in Table 24 above, the vast majority of men and women respondents in the two regions mentioned both mothers' independent and joint decisions in girls' circumcision. In Somali, 42.8% of MHHs

reported joint decision while 42.1% of them mentioned mothers' independent decisions on matters pertaining to female circumcision. Regional variations were observed on men's responses. In Oromia, a third of men respondents mentioned mothers' independent decision-making power, whereas 59% acknowledged joint decision-making exercise on female circumcision.

The reasons for the prevalence of female circumcision vary cross culturally. Several studies show that the pervasiveness and persistence of the practice of female circumcision can be explained by psychosexual, social, hygienic, aesthetic and religious reasons.¹⁰ This study also tries to find out the reasons for the practice in the two study areas. As depicted in the following table, the highest proportion (60%) of men's respondents in the two study areas mentioned religious and ritual (cultural) reasons for the practice of female circumcision. About 34.7% of men respondents also cited the issue of proving to be marriageable (FC is viewed as a prerequisite for an honorable marriage) as a reason for the pervasiveness and persistence of the tradition. Significant variations were not recorded in the two study sites. As regards to women's respondents, the finding of the study shows similar trend to that of men respondents. In the two study sites nearly 60% of women respondents indicated religious and/ or ritual reasons for the practice of FC. Being marriageable is also cited by almost a third of the study participants as a reason for the practice. In general, as the finding of this study revealed, there are no significant variations on gender and study areas as regards to reasons for the practice of FC. Overall, nearly 60%, 27% and 8% of the study participants mentioned religious/ritual obligations, girls' suitability for marriage and reducing females' sexual desires, respectively, as reasons for the prevalence of the harmful traditional practice (Table 26).

Table 26: Reasons of parents for perpetrating female circumcision on their children

Reasons	Men			Women			Both gender
	Somali	Oromia	All	Somali	Oromia	All	
Religious/ ritual	63.2%	75.8%	60.0%	63.4%	67.7%	59.3%	59.3%
Marriageability	36.6%	15.9%	34.7%	27.9%	16.8%	26.8%	26.8%
Reduce the females' sexual desires	11.7%	13.6%	11.9%	7.7%	11.0%	8.1%	8.1%
Maintain cleanness and provide aesthetic appearance	4.7%		4.2%	2.4%		2.2%	2.2%
Other	.1%		4.4%		.6%	4.6%	4.6%
Total	100	100	100		100	1000	100

6.3 Women's Decision on Seeking Health Services

The study has attempted to determine the decision-making power of women in seeking health services for themselves and their children. In order to capture data related to women's independent or joint (with her spouse) decisions on matters pertaining to their own health and the health of their children, currently married women aged between 15 and 49 were asked about their decisions on seeking health services. The DFAP indicator states that "percentage of currently married women age 15-49 reporting that she makes decisions either by herself or

¹⁰ NCTPE, Old Beyond Imaginings: Ethiopia Harmful Traditional practices,

jointly with her spouse regarding seeking health services for her own health or for their own children.” Based on this, about 81% of currently married women reported that they make decisions for their own or their children’s either by themselves and or jointly with their spouses (See Tables 26 and 27).

As the data obtained from the two study areas indicates (Table 27), the majority of the respondents (72.6%) mentioned that decisions are made jointly by women and men (spouses) on seeking health services for the female partner. Analysis by region shows that almost 80% of the interviewees in Oromia mentioned joint decisions while nearly 72% of respondents in Somali indicated joint decisions. As compared to the case in Somali (20.2%), only 3.7% of the respondents in Oromia identified that men (husbands) decide on seeking health services for their wives. This finding indicates that women in Oromia seem to be more empowered than their counterparts in Somali in terms of making decisions of seeking health services.

Table 27: Percentage of women reported decision makers on seeking health services for themselves

Responses	Somali	Oromia	Both
Woman alone	8.0%	11.8%	8.5%
Husband/partner alone	20.2%	3.7%	18.3%
Woman and her husband/partner jointly	71.8%	79.5%	72.6%
Others		4.9%	.6%
Total	100.0%	100.0%	100.0%
Either by women and/or her spouse (DFAP indicator)	79.8%	91.3%	81.1%

As regards decisions pertaining to seeking health services for their children, respondents were asked whether women decide independently or jointly on seeking health services during their children’s illness. As Table 28 clearly indicates, the finding on who decides in seeking health services for women is almost similar to that of the children. The majority of the study participant women (72.4%) in the two study areas mentioned that decisions are passed jointly, while 18.5% of the respondents disclosed men’s independent decisions on seeking health services for their children. Men’s independent decision on seeking health services for children appears to be lower (3.7%) in Oromia than in Somali (20.4%).

Table 28: Percentage of women reported decision makers on seeking health services for their children

Responses	Somali	Oromia	Both
Women alone	8.1%	11.8%	8.5%
Husband/partner alone	20.4%	3.7%	18.5%
Husband/partner and women jointly	71.6%	79.5%	72.4%
Other		4.9%	.6%
Total	100.0%	100.0%	100.0%
Either by women and/or her spouse (DFAP indicator)	79.70%	91.30%	80.90%

7. PERSONS LIVING WITH DISABILITIES BENEFITING FROM THE PSNP - MODULE J

In the Productive Safety Net Program (PSNP) chronically food insecure persons with disabilities are entitled to direct support. These people are expected to get food transfer from PSNP without labor contribution. In order to measure the support of DFAP to these people in the baseline survey households were interviewed for the availability of and access to transfer by people with disabilities. In the baseline survey questionnaire, disabilities were defined as **physical, cognitive, mental, sensory, emotional, and developmental or some combination of these observed on people within sample households. Old age members were not considered as persons with disability. This definition was well explained to respondents in the time of interviews.**

As shown in Table 29 from the 1540 sample households, the presence of 131 people with disability was reported. Of these, about 47 people or about 35.3% of are receiving PSNP transfer. Respondents were further asked as to why the people with disabilities in the households were not receiving PSNP transfer at the time of this survey. As indicated in Table 29, about 39.1% of respondent households reported loss of interest to register persons with disabilities in PSNP due to fear of social stigma and discrimination by others within their communities. Similarly, about 39.1% of households reported lack of recognition for the persons with disabilities as needy people by the PSNP targeting bodies. These entail the need to work on building awareness in avoidance of stigma and discrimination on disabled people in the targeting process, and help them or their households to bring the cases to the PSNP targeting bodies.

Table 29: Persons living with disabilities that receive PSNP

	Oromia	Somali	Total
Total people with disability (N)	12	121	133
People with disability receiving PSNP (N)	2	45	47
Percent of Person with disability receiving PSNP (%)	16.7%	37.2%	35.3%

Table 30: Percentage of households living with persons with disability not receiving PSNP support and the reasons

Reasons for not Receiving PSNP	%
Person(s) with disabilities is/are not recognized as a needy person(s) by the targeting body	39.1%
Person/s with disability or the household head had no interest to get registered as PSNP beneficiary	39.1%
Disability happened to the person(s) after the process of targeting completed	11.6%
Person(s) with disability came to PSNP beneficiary HH after completion of the process of targeting	10.1%
Total	100

8. SOCIAL SERVICES – MODULE K

The SCUS DFAP program has four indicators that measure the program outcome in relation with its interventions to expand social services. These indicators are:

- i) Percentage of HHs in PSNP woredas report improved access to primary schools as per government standard;
- ii) Percentage of HHs in PSNP woredas report improved access to health posts as per government standard;
- iii) Average months in a calendar year of water availability at improved water structures;
- iv) Percentage of households using improved drinking water sources for livestock; and
- v) Percentage of girls attending schools constructed by the program.

8.1 Access to primary schools and health posts

The first two indicators are supposed to be seen in terms of distance between the residence of households and the services, i.e., primary schools and health posts. The average travel distance or the time taken to reach these services as means to measure these indicators is stated in the Indicators Performance Table of the program as prepared by SCUS.

The baseline survey team made a review of different government documents on ways of measuring access to primary schools and health posts. It found out that access to primary schools, according to the government's approach, is measured by school enrolment rates in a particular administrative boundary such as region or national level. The IV Education Sector Development Program (ESDP) indicates the general enrolment rate for primary school for Somali region will increase from 63.8% in 2009/10 to 100% in 2014/15 (MoE, 2010). Similarly the consultants came to know that access to health posts are planned in such a way that a health post can serve about 5,000 people in surrounding villages and two female health extension workers are employed at one health post (MoH, 2005). In both cases, the government standards do not formally measure access in terms of distance and percentage of households.

Therefore, the baseline survey asked households within the walking distances of the two services from their residences and summarized the responses in Table 30 as per the program IPTT of SCUS. Although this approach cannot help in comparing the survey results with the government standard, it can easily measure the change in access to services as a result of the program interventions, if the same baseline survey questions are used during the evaluation time. The average one-way distance of first cycle primary schools in the DFAP area where SCUS operates is about 2.2 km from the residential places of the sample households. The children in Oromia have to travel two-fold to three-fold distances than that of the children in Somali to access first cycle primary schools. Similarly, sample households have to cover 4.4 km to reach to the nearest health post facility. Households in Oromia are required to travel over five times distance than those in Somali region to reach health posts (Table 31).

These data show that efforts should be exerted to reduce the distances of primary schools and health posts from households in Oromia, while more attention would be required in terms of improving quality of infrastructures in both regions through PSNP public work activities.

Table 31: One-way walking distance of primary schools and health posts from residential places

		1 st Cycle Primary Schools			Health Posts		
		Oromia	Somali	Total	Oromia	Somali	Total
% of HHs	30 min or less	63.8%	91.8%	88.5%	19.8	80.2	73.3
	30.1 - 60.0 min.	5.2%	5.4%	5.4%	2.4	9.9	9.1
	60.1- 90.0 min.	4.6%	1.4%	1.7%	1.2	3.8	3.5
	90.1 - 120.0 min.	4.0%		0.5%	3.6	0.5	0.9
	120.1 - 150.0 min.	9.2%		1.1%	9.0	1.7	2.5
	Above 150 min.	13.2%	1.4%	2.8%	64.1	3.9	10.7
Average distance in min.		75	20	26	185.0	36.0	53.0
Average distance in km		6.2	1.7	2.2	15.4	3.0	4.4

8.2 Access to Domestic Water Sources

The DFAP intends to improve access to domestic water from improved water sources for human consumption. Consensuses have been reached between the baseline study team and SCUS to consider two water sources (*birka* and hand dug well) that will be promoted by the program for measuring access to domestic water sources. In addition, the indicator also states the duration of the use of improved water sources during a normal rainy year. Normal rainy year is considered mainly because access to water from the improved structure can be ensured only when the rain season is appropriate. In the case of households reported concurrently using both structures as source of water, the study considered the structure with longer duration of service to calculate the average duration of access to the improved structures.

Table 32 shows the average duration of rainy seasons and the use of water from improved structures after the end of the rainy seasons. In the survey areas there are two rainy seasons. According to the survey respondents, the two rainy seasons last for three and half (3.44) months every year. The same households in both regions also reported the use of improved water sources for about four and half (4.53) months per year after the secession of the rainy seasons.

Table 32: Duration of rainy seasons and access to improved water sources

	Duration of normal rainy season	Duration of domestic water access from improved structures after the rainy seasons
Oromia	3.72	3.00
Somali	3.41	4.84
All	3.44	4.53

8.3 Improved water sources for livestock

Basically, the baseline data was collected on sources of water for livestock both during the dry and rainy seasons from the sample respondent households. However, livestock owners do not largely worry during rainy season where to provide drinking water for their animals as they can

obtain water from different surface water sources. During this occasion, people do not normally look for improved water sources. Therefore, the consultants calculated the indicator value on access to improved water sources for livestock only for the dry season. As indicated in Table 33, about 45% of sample households reported to have access to improved water sources for their animals at the time of this survey. The improved water sources include ponds, *birkas* and hand dug wells – all with cattle trough. Likewise, about 43% of the households use unimproved water sources. Nearly 11% of the households also reported not to have livestock and no need for water sources for animals. Relatively, households in Oromia (57.7%) have better access to improved water sources as compared to Somali region (44.2%).

Table 33: Percentage of households by sources of water for livestock

	Oromia (N = 175)	Somali (1,365)	Total (1,540)
Have no livestock	1.7	12.4	11.2
<i>Improved livestock water sources</i>	57.7	43.4	45.0
Unimproved livestock water sources	40.6	44.2	43.8

9. NUTRITIONAL STATUS OF CHILDREN – MODULE L

Nutrition plays a critical role in economic and human development. Appropriate nutrition actions in general and that of children under five in particular enable the creation of a healthy and productive labor force which is vital to ensuring rapid social and economic development. Good nutritional status is a cornerstone to the health of all people, enabling them to reach their full potential as individuals and societies. Accordingly, nutrition has long been recognized as a fundamental human right enshrined in key international conventions. The right to nutritional security is also upheld by the Ethiopian Constitution, entrusting the government to act appropriately to ensure that these nutritional rights are adequately protected, especially among the most vulnerable – children, women, the elderly, and the infirm.

According to the global conceptual framework developed by UNICEF¹¹, nutritional status in children is the result of a long sequence of interconnected events that are classified as the immediate, the underlying and the basic causes or determinants of malnutrition. Inadequate dietary intake and disease are considered the most significant immediate causes of malnutrition of children. The underlying causes for inadequate dietary intake and diseases are insufficient food availability and access, inadequate care for children, and insufficient health services as well as inadequate provision of a healthy environment. Finally, the basic or structural causes of malnutrition include economic, technological, political, cultural, and institutional structures and processes, the means of control of physical resources, and the level of human development.

The data on weight and height of children aged from 6-59 months were used to calculate three summary indices of nutritional status (according to WHO child growth standard), which affects susceptibility to disease and their chance of survival. These indices are height-for-age, weight-for-height, and weight-for-age. The three nutritional status indices are expressed in standard deviation (SD) unit (z-score) from the median for the international population. Children, who fall more than 2 standard deviations below the reference median, are considered to be malnourished, while those who fall more than 3 standard deviations units below the reference median are considered to be severely malnourished.

Each of the indices provides somewhat different information about the nutritional status of children. The height-for-age index measures linear growth retardation among children. Children who are more than 2 SD below the median of the reference population in terms of height-for-age are considered short for their age or *stunted (chronically malnourished)*. The weight-for-height index measures body mass in relation to body length. Children who are more than 2 SD below the median of the reference population in terms of their weight-for-height are considered to be *thin or wasted (acutely malnourished)*. Weight-for-age is a composite measure which takes into account both chronic and acute under-nutrition. Children who are more than 2 SD below the reference median on this index are considered *underweight*.

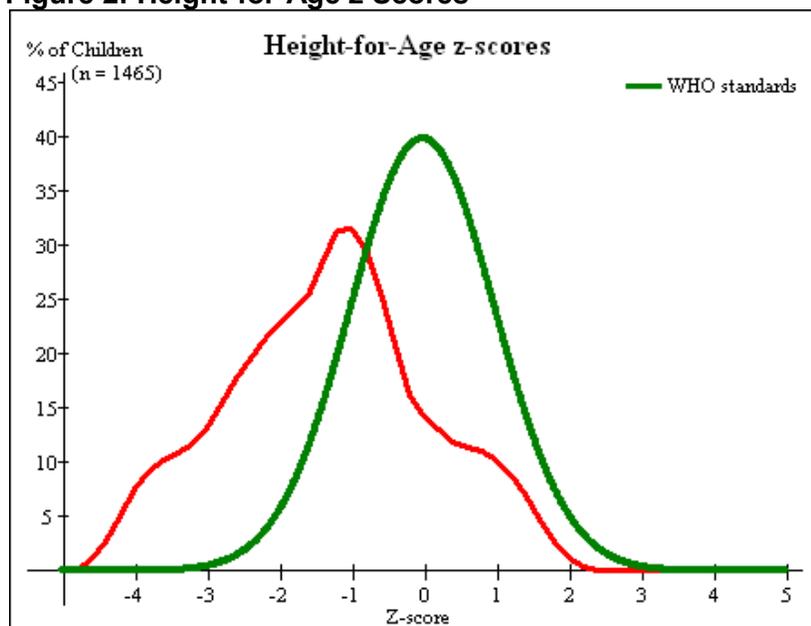
Table 34 presents the nutritional status for children aged between 6 and 59 months for stunting. Among children 6-59 months, the proportion of children stunted (<-2SD) were 31.2% in the program area. The prevalence of global malnutrition (moderately stunted children) in both survey regions is further analyzed by the respective regions as displayed in Table 33. The survey shows nutritional problem is very common all project regions, slightly higher rate of stunting(31.75) is recorded in Oromia while 31.3% found in Somali region. This indicates that in both surveyed areas children have been suffering from chronic malnutrition in the past.

¹¹ UNICEF, 1990

Table 34: Prevalence of stunting based on height-for-age z-scores for children aged 6 to 59 months

Height-for-Age			
Region	Gender	Stunting (<-2 z-score)	Severe stunting (<-3 z-score)
Somali	Boys (n=592)	34.8% (28.7-40.9 C.I.)	13.5% (7.7-19.3 C.I.)
	Girls (n=692)	28.3% (22.0-34.7 C.I.)	11.3% (7.4-15.2 C.I.)
	Total (n=1284)	31.3% (25.7-36.9 C.I.)	12.3% (6.8-17.9 C.I.)
Oromia	Boys (n=81)	42.9% (32.2-53.5 C.I.)	23.1% (3.2-43.0 C.I.)
	Girls (n=85)	21.1% (14.9-27.2 C.I.)	9.5% (2.7-16.2 C.I.)
	Total (n=166)	31.7% (25.0-38.5 C.I.)	16.1% (4.7-27.6 C.I.)
Total	Boys (n=681)	35.5% (30.0-41.1 C.I.)	14.4% (9.1-19.7 C.I.)
	Girls (n=784)	27.4% (21.6-33.3 C.I.)	11.0% (7.4-14.5 C.I.)
	Total (n=1465)	31.2% (26.1-36.3 C.I.)	12.6% (7.5-17.6 C.I.)

Figure 2: Height-for-Age z Scores



Compared to the 2011 Ethiopian Demographic and Health Survey (DHS)¹² which showed that 44.4% and 20.6% of children under-five in Ethiopia were stunted and severely stunted, the corresponding prevalence in the program area was lower, i.e. 31.2% and 12.6%, respectively.

As indicated in Table 35, the proportions of children 6 to 59 months who were underweight (<-2SD) and severe underweight (<-3SD) was 28.5% and 10.2%, and the corresponding proportions in EDHS 2011 were 28.7% and 8.8%, respectively. The prevalence in the program area is the same as the national figure.

Table 35: Prevalence of underweight by age based on weight-for-age z-scores for children aged 6 to 59 months

Region	Gender	Weight-for-Age	
		Underweight (<-2 z-score)	Severe underweight (<-3 z-score)
Somali	Boys (n=722)	33.4% (24.8-42.0 C.I.)	11.2% (7.2-15.2 C.I.)
	Girls (n =813)	27.4% (19.7-35.1 C.I.)	11.3% (7.1-15.6 C.I.)
	Total (n=1535)	30.2% (22.1-38.4 C.I.)	11.3% (7.5-15.0 C.I.)
Oromia	Boys (n=106)	22.6% (12.7-32.6 C.I.)	5.7% (2.2- 9.2 C.I.)
	Girls (n=106)	13.2% (4.7-21.7 C.I.)	3.8% (-0.1- 7.7 C.I.)
	Total (n=2120)	17.9% (9.4-26.4 C.I.)	4.7% (1.5- 7.9 C.I.)
Total	Boys (n=825)	31.8% (24.0-39.6 C.I.)	(84) 10.2% (6.7-13.7 C.I.)
	Girls (n =917)	25.6% (18.4-32.8 C.I.)	(94) 10.3% (6.3-14.2 C.I.)
	Total (n=1742)	28.5% (21.1-36.0 C.I.)	10.2% (6.9-13.5 C.I.)

¹² Ethiopian Demographic and Health Survey, 2011

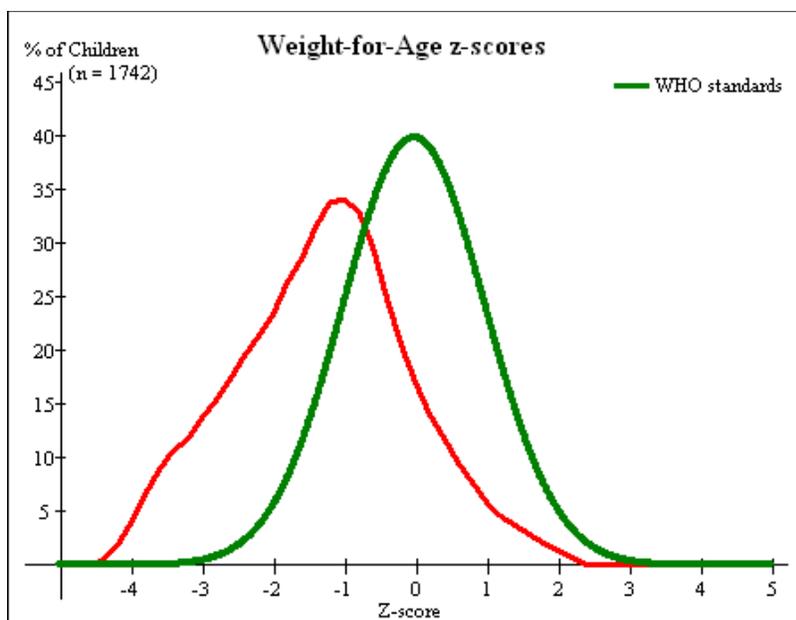


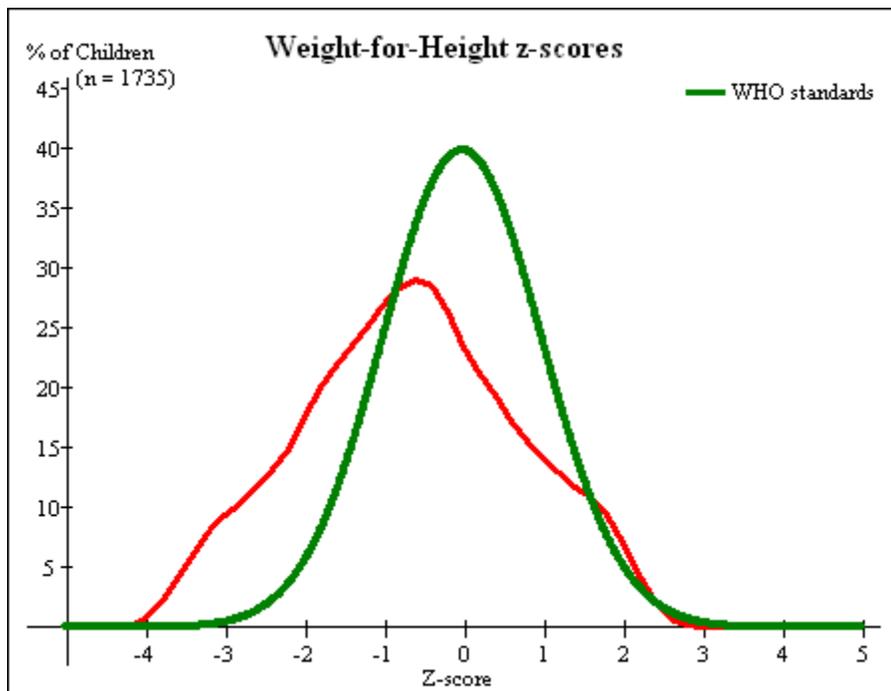
Figure 3: Weight-for –Age z–scores

As indicated in Table 36, the proportion of children who were wasted and severely wasted in the program area was 17.5% and 5.5%, respectively. Compared to the EDHS 2011 where the corresponding proportion was 9.7% and 2.8%, the prevalence in the program area is higher.

Table 36: Prevalence of wasting based on weight-for-height z-scores for children aged 6 to 59 months

Weight-for-Height			
Region	Gender	Wasting (< -2 z-score)	Severe wasting (< -3 z-score)
Somali	Boys (n=739)	21.4% (16.3-26.5 C.I.)	6.8% (4.2- 9.4 C.I.)
	Girls (n =801)	18.1% (13.3-22.9 C.I.)	5.2% (3.4- 7.1 C.I.)
	Total (n=1540)	19.7% (15.4-24.0 C.I.)	6.0% (4.4- 7.6 C.I.)
Oromia	Boys (n=101)	3.0% (-0.7- 6.6 C.I.)	0.0% (0.0- 0.0 C.I.)
	Girls (n=104)	3.8% (1.3- 6.4 C.I.)	0.0% (0.0- 0.0 C.I.)
	Total (n=205)	3.4% (2.1- 4.7 C.I.)	0.0% (0.0- 0.0 C.I.)
Total	Boys (n=836)	19.0% (14.1-23.9 C.I.)	5.7% (3.4- 8.1 C.I.)
	Girls (n=899)	16.1% (11.7-20.6 C.I.)	4.2% (2.7- 5.8 C.I.)
	Total (n=1735)	17.5% (13.4-21.6 C.I.)	5.0% (3.4- 6.5 C.I.)

Figure 4: Weight-for-Height z-scores



10. CONCLUSIONS AND POSSIBLE PROGRAM IMPLICATIONS

10.1 Household Food Security

Households in SCUS operational areas could obtain adequate food access from all sources for approximately 3.82 months per year. In addition, the proportion of food self-sufficient households throughout the year in the surveyed woreda stands at 2.3% of the total sample households from the surveyed areas. Households that are female headed tend to have more months without enough food than male-headed households. On average the number of months without enough food for female-headed households is nine while the average number of months for male-headed households is eight.

The average coping strategy index for the entire surveyed areas was found to be 22.7. The majority of households mentioned the following strategies for dealing with food insecurity: eating fewer meals per day, reducing the quantity of food per meal, borrowing cash or grain, and eating food they do not normally eat according to their order of priority.

The sample households were asked on the type of different food groups they consumed using a 24 hour recall period to calculate household dietary diversity score (HDDS). The overall mean HDDS in the SCUS program area was thus found to be about 5.87 (i.e. 3.56 for Oromia and 6.16 for Somali). This means that, on average, households had consumed about five to six different food groups. With regard to household hunger scale (HHS) about 67.6% households in the survey areas are with moderate or severe hunger.

Based on the above indicators, the prevalence of household food insecurity is high in the program areas. Households led by female are the relatively affected by food insecurity. Thus, reduction of food insecurity through PSNP transfers and longer term development interventions such as household asset protection (mainly livestock) and development of locally appropriate production strategies such as irrigation facilities should continue to be the focuses of DFAP. Moreover, development interventions that focus on female-headed household should be the priority of the woreda development plan.

10.2 Asset Holdings

The average asset value owned by households for the baseline year was found to be Birr 41,256. Livestock appears to be the most important wealth accumulation strategy for most of the population in all the survey areas, accounting for about 97% of the total value of the average household assets followed by household goods at 1.4% and productive assets at about 1% of the total mean household asset value. About 28% of household asset reduction was reported by the sample households in one year period prior to the survey due to drought and livestock diseases. Thus, a program intervention that facilitates in enhancing feed and water availability and animal health can help these communities secure their livelihoods and improve their capacity for adapting to the impacts of climate change. Furthermore, strategies for diversification of assets, other than livestock, at the household level must be explored by the DFAP.

10.3 Gender and Social Perspectives

The study found that the highest proportion of currently married women (CMW) decided jointly to purchase and/or sale livestock. About 90.9%, 81.5%, 71.1% and 71.1%, 65.8% of currently married women reported to have jointly decided on the purchase and/or sale of horse and mule, camel, cattle, sheep/goat and donkey, respectively. As the survey findings indicated, the existing gender-based decisions on agricultural produces seem to be slightly different from decisions on livestock. The majority of women respondents reported that they independently decide on the purchase and/or sale of cereals (41.5%) and pulses (57.4%).

The study also found that the overwhelming majority of CMW (79.1%) and MHH (78.1%) included in the study opposed the practice of female circumcision (FC) and claimed that it should be stopped. As regards to the decisions on girls' circumcision, 80% and 72% of the interviewees reported that they decided jointly on matters related to female circumcision in Oromia and Somali, respectively. The findings of the study also show that the majority of respondents (72.6%) reported that decisions are made jointly by women (wives) and men (husbands) on seeking health services for women and children.

These findings on gender highlight the need for further enhancement of women's decision-making power at the household level in the program intervention areas. Besides, the result of the survey signifies the need for tailored health care services for girls and adult women who have already undergone FC and also calls for systematic actions to prevent the practice of this harmful tradition.

10.4 Persons Living With Disability

DFAP considers target beneficiaries' disability status in its Productive Safety Net Program targeting. One of the thrust of this study is to determine the prevalence of disability of different forms in the study areas. The study revealed that 8.5% of the sample households reported the presence of people living with disability. Out of the people with disability, only 35.3% reported to have received PSNP transfer. As to the reasons for not receiving the transfer, 39.1% of respondents reported that they did not register persons living with disabilities for fear of stigma and discrimination, and 39.1% of households reported lack of recognition of the persons with disabilities as needy people by the PSNP targeting bodies. The findings of the study on disability warrant the need for increasing awareness creation and sensitization efforts to avoid stigma and discrimination against people living with disability and PSNP targeting bodies should well consider the disability status of individuals during the targeting process.

10.5 Access to Social Service

More than 77.6 % of the population in the sample area did not have a year round protected water source, 80.1% did not use toilet facilities at all and many said that they used the nearby bush for defecation. Thus, interventions in this area should focus on improving proper hygiene and sanitation knowledge and practices at household level. Reduction in the incidence of communicable diseases and an overall improvement in hygienic practices, such as hand washing at appropriate times, should be highlighted.

10.6 Nutritional Status of Children

In this survey, anthropometric data on height and weight, including age and sex, were collected from all children aged between six and fifty nine months in the sample households to determine their nutrition status. Based on these measurements, the prevalence of stunting was 31.9% and 31.4% and that of severe stunting was 13.6% and 16.2%; the prevalence of underweight was 33.0% and 19.0%, and severe underweight was 14.3% and 5.7%: and the prevalence of wasting 19.4% and 3.4% and that of severe wasting was 6.0% and 0.0% in Somali and Oromia Woredas respectively. These rates were close to the regional averages for Somali Woredas and are lower for the Oromia Woredas than the regional averages as reported in EDHS 2011.

The survey results showed that nutritional problem is very common in all project areas. This has implications for the designing of programs which improve health and nutrition as important components of the food security framework and stress the need for appropriate “utilization” of foods as well as sanitation and hygiene at the household level. Nutritional status is a function of food security, caring practices (behavior) especially of the mother and a healthy environment, and not just a mere absence of food, and hence improvement in nutritional status requires a multi-faceted response. Implementing partners need to work closely with the ministry of health and the ministry of agriculture at all levels. Thus, efforts are due to provide the necessary information on exclusive breastfeeding through provision of information via different channels and continuous and targeted counseling during pregnancy, child birth and within the first two years following birth are needed. These interventions aimed at improving infant and young child feeding practices need to be coupled with efforts to reduce major child health problems in the area through increasing household access to toilet facilities and vaccination coverage, and improving treatment seeking behaviors for sick children are critical. The health extension program needs to be supported in the implementation of the community-based nutrition program through facilitation of trainings, and organizing various community discussion fora.

As part of the multifaceted interventions, improving household food security, the provision of appropriate complementary feeding and meeting the minimum dietary diversity, and meal frequency, among others is highly recommended. Implementing partners need to work closely with the ministry of agriculture in improving the problems of food diversity through supporting agricultural interventions geared towards diversification of food production in the study areas. We also believe that the lack of dietary diversity may well be attributed to lack of women's and community's knowledge on how to prepare food for children from different food groups. Targeted interventions that focus on behavior change communication and educating mothers on food preparation from locally available resources are among the important intervention strategy.

Annex 1: Indicators of DFAP Ethiopia in the SCUS operation areas

Ind #	List of Indicators	Indicator value	Module in the Survey Questionnaire
1	Percentage of underweight (WAZ<-2) children aged 6-59 months (sex disaggregated)	Boys = 31.8% Girls = 25.6% Total = 28.5%	L
2	Percentage of stunted (HAZ<-2) children aged 6-59 months (sex disaggregated)	Boys = 35.5% Girls = 27.4% Total = 31.2%	L
3	Percentage of wasted children 6-59 months (sex disaggregated)	Boys = 19.0% Girls = 16.1% Total = 17.5%	L
11	Percentage of households with access to an improved sanitation facility	19.9%	F
12	Percentage of households using an improved drinking water source	22.4% during dry season 15.6% during wet season	G
13	Average Household Dietary Diversity Score (HDDS)	5.87	C.1
15	Household Hunger Scale (HHS): Percentage of households with moderate or severe hunger	67.6	C.2
16	Percentage of people with disabilities in PSNP woredas that are served by the program	35.3%	J
17	Copping Strategy Index (CSI)/resilience indicator	22.7	C.3
18	Average months of adequate food provisioning from all sources	3.8	C.4
19	Proportion of women who reported to have jointly decided on purchase and/or sale of asset (cattle, Camel, shots, pack animals and agricultural produces) with their husbands/partners during the last 12 months	Camel = 81.5% Cattle = 71.1% Sheep/Goat = 71.8% Donkey = 65.8% Horse = 90.9% Mule = 90.9% Cereals = 50.8% Pulses = 36.2%	I.1
24	Proportion of male head of households who believe that the practice of female circumcision should be stopped.	79.1%	I.4
25	Proportion of currently married women who believe that the practice of female circumcision should be stopped	78.1%	I.4
26	% of households whose asset levels are stable or increasing	% of HHs is reported during the final evolution by comparing with baseline data. The mean asset value during the baseline is estimated at = ETB 41,256 per household	H.2

27	Percentage of currently married women age 15-49 reporting that she makes decisions either by herself or jointly with her spouse regarding Seeking health services for her own health or for their own children	81.1%	1.5
30	Percentage of HHs in PSNP woredas report improved access to primary schools as per government standard	% of HHs is not a way government standard is measured. Thus we present the mean distance of primary schools (grade 1-4) in the program area. This is 2.2 km.	K
31	Percentage of HHs in PSNP woredas report improved access to health posts as per government standard	% HHs is not the way the government standard is reported. Rather it states one health post per 5,000 people. Thus we have considered average distance to correspond with this indicator which equals to 4.4 km.	K
32	Average months in a calendar year of water availability at improved water structures	3.8 months	K
33	% of households using an improved drinking water sources for livestock	45.5%	K
34	% of girls attending in schools constructed by the program	So far we got data from one woreda (Arero). Two woredas (Filtu and Bare) have no schools constructed through PSNP. We are still waiting secondary data from Dolo Ado and Dolo Bay.	Secondary data

Annex 2: Mean livestock asset owned per household (in Birr)

	Oromia		Somali		Total	
	Current (2012)	A year ago (2011)	Current (2012)	A year ago (2011)	Current (2012)	A year ago (2011)
Cattle	11,249	37,410	11,210	17,955	11,267	20,596
Sheep/goat	4,882	9,947	11,183	14,824	10,452	14,136
Equines	840	1,375	1,133	1,330	1,091	1,272
Camel	10,540	26,109	15,536	19,089	14,954	19,764
Poultry	243	778	73	89	88	106
Total	27,754	75,619	39,136	53,287	37,833	55,874