Policy Brief

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Ten-year-old girl who goes to school and helps her mother with housework, Afar region, Ethiopia © Nathalie Bertrams/GAGE 2022

Fast-tracking progress towards eliminating FGM/C and child marriage in pastoralist Ethiopia: priorities for policy and programming

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Overview

Child marriage and female genital mutilation/cutting (FGM/C) have far-reaching consequences throughout the life course and across generations. As such, tackling these harmful practices has increasingly become a development priority. Two of the targets for Sustainable Development Goal 5 (gender equality) directly address these practices – 5.3.1 (eliminating child marriage) and 5.3.2 (eliminating FGM/C). Ethiopia has made rapid progress in tackling child marriage and FGM/C over the past 20 years (UNICEF, 2020). Despite this, it is still one of the top five countries globally in terms of absolute numbers of girls who married as children. In addition, it is home to an estimated 25 million girls and women who have experienced FGM/C – the largest absolute number of any country in eastern and southern Africa (ibid.).

1 The first five authors are listed alphabetically as all have contributed significantly to the analysis underpinning the policy brief.

2 The second group of authors are also listed alphabetically and were involved in both data collection and preliminary data analysis. A full list of acknowledgements is included in the longer report upon which this policy brief is based.

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Rates of child marriage and FGM/C vary widely across the country, with some regions showing significant reductions and others yet to experience progress. Afar and Somali regional states have the highest rates of FGM/C in Ethiopia (91% and 99% respectively of all women aged 15-49); Afar's median age of first marriage is lower than the national average (16.4 years compared to 17.5 years) (CSA and ICF, 2017). In line with Ethiopia's National Costed Roadmap to End Child Marriage and FGM/C (2020–2024), as well as the country's commitment to achieving the SDG targets, a new research project was launched by the Government of Ireland. The project aims to provide evidence on the current levels and drivers of FGM/C and child marriage in pastoral communities as well as, over time, to evaluate a multicomponent programme implemented by Save the Children and aimed at eliminating FGM/C and child marriage (see Box 1).

This policy brief summarises findings from mixed-methods research carried out in early 2022 (see Endale et al., 2022). It also sets out the implications of those findings for policy and programming, including the implementation of the National Costed Roadmap. It should be noted that the recommendations are not derived from an analysis of Save the Children progamme impacts as this round of research is meant to serve as a baseline. Instead, recommendations are based on the study's broader findings on FGM/C and child marriage norms and practices.

Background context

Child marriage and FGM/C have been illegal in Ethiopia since 2000 and 2005 respectively. The government's efforts to eliminate both these harmful practices have been reflected in national policy frameworks over the past decade. In 2013, the Ministry of Women, Children and Youth launched the National Strategy and Action Plan on Harmful Traditional Practices against Women and Children, followed in 2019 by the National Costed Roadmap to End Child Marriage and FGM/C by 2025.

Buttressed by these strong legal and policy frameworks, Ethiopia has made notable progress, at the national level, towards eliminating child marriage and FGM/C. According to the Ethiopia Demographic and Health Survey (EDHS), in 2000, 14% of adolescent girls were married before the age of 15, and 49% of young women were married before the age of 18 (CSA and ORC Macro, 2001). By 2016, these rates had fallen to 6% and 40% respectively (CSA and ICF, 2017). The 2000 survey reported that 71% of adolescent girls aged 15-19 had undergone FGM/C (CSA and ORC Macro, 2001). By 2016, this had fallen to 47% (CSA and ICF, 2017). However, as already noted, this progress has been uneven when seen across regional states. In Ethiopia's 'emerging' regions – which include pastoralist Afar and Somali – rates of FGM/C remain static, while rates of child marriage appear to be increasing (CSA and ORC Macro, 2001; CSA and ICF, 2017; Elezaj et al., 2019). Both regional governments are also yet to ratify the national Family Law which bans FGM/C and child marriage. Unsurprisingly, given the links between harmful traditional practices and conservative gender norms, these are also the regions where girls and women have especially limited opportunities for education and employment (Presler-Marshall et al., 2022). Shaped by the framing of the Sustainable Development Goals, which focus on those most at risk of being 'left behind', the Ethiopian government and its partners have recently stepped up efforts to eliminate these harmful practices in the emerging regions.

Box 1: Empowering women and girls to reduce child marriage and FGM/C in Afar and Somali regions: a new programming initiative

The Government of Ireland, in partnership with Save the Children, supports a five-year, €7.8 million programme called 'Supporting women and girls in Ethiopia's lowlands to realise their rights, and live healthy and productive lives free from violence and abuse'. It aims to empower girls and young women, economically and socially, and reduce the negative impact of harmful gender norms and practices – especially FGM/C and child marriage – on their lives.

The programme is being implemented in three *woredas* in two zones in Afar region (Aysaita *woreda* in zone 1 and Semurobi and Hadelella *woredas* in zone 5) and three *woredas* in two zones in Somali region (Daror *woreda* in Jarar zone and Harshen and Goljano *woredas* in Fafan zone). Its six workstreams will focus not only on girls and young women, but also on local service providers, boys and men, and communities. The workstreams are: (1) economic empowerment, including cash and asset transfers, access to savings and credit opportunities, and support for self-employment; (2) material support to help out-of-school girls enrol, and tutorial support to improve girls' academic success; (3) women's and girls' engagement, including leadership training and girls' clubs so that women and girls can advocate more effectively for their rights; (4) protection against gender-based violence, including supporting survivors to access protection and sexual and reproductive health (SRH) services; (5) community engagement, including working with men and boys in male-only spaces led by men, as well as holding structured community conversations led by clan and religious leaders; and (6) capacity-building and coordination, including training for local leaders and service providers.

Research methods

This policy brief draws on findings from a mixed-methods baseline assessment exploring the patterning and drivers of child marriage and FGM/C in Afar and Somali regions. The baseline is part of a longitudinal research evaluation that includes three rounds of quantitative and qualitative data collection in 2022, 2024 and 2026. The research team is led by the Gender and Adolescence: Global Evidence (GAGE) programme and ODI, in partnership with researchers at Addis Ababa University and Quest Consulting. The team includes researchers from both Afar and Somali regions.

The quantitative sample includes 2,042 households (2,042 adolescents aged 10-19 years and 2,042 caregivers), split equally between the two regions. The sample size was determined in such a way as to detect a reduction in FGM/C and early marriage indicators by 10 percentage points, with 95% power. The sample size was increased by 15% to account for attrition. In each region, we collected data from 9 *kebeles* (communities) where programming will be implemented and 9 *kebeles* that will receive no programming. All *kebeles* are rural, though some are more remote than others. The qualitative sample included a sub-sample of adolescents (n=295) and their caregivers (n=166), who took part in individual and group interviews. It also included key informant interviews with community (*kebele*), district and regional level government officials, clan and religious leaders, service providers and Save the Children staff at district and regional levels (n=84).

Key findings

Education

Key findings

- Nearly one third of adolescents in the study have never been enrolled, while among those enrolled in school the large majority are over-age for grade.
- Girls' access to education is worse than boys' – especially in Somali – due to conservative gender norms, poor WASH facilities at school and limited safety en route to school.

Approximately two-fifths (39%) of young people in the Somali sample, and one-quarter (27%) of those in the Afar sample, reported having never been enrolled. Among these, most were girls. In Somali, 43% of girls had never been enrolled, compared to 27% of boys. In Afar, the gender gap was smaller, but boys were still 5 percentage points more likely than girls to have been enrolled (27% vs. 32%). Girls were also more likely than boys to have already dropped out of school. For the young people who were enrolled at the time of our survey, nearly all were years over age for grade.

Our qualitative work identified multiple and intersecting barriers to accessing education, which were largely similar across regions. For girls and boys alike, these include: long travel times to school (especially at intermediate and secondary levels); schools that lack drinking water (especially given long commutes across desert areas); teachers who are often absent; and low-quality education. Girls face additional barriers. These include arduous domestic responsibilities that can lead to late enrolment, regular absenteeism, and early dropout; limited access to menstrual hygiene products and private toilet/washing facilities in schools; and lack of safe transport to secondary school. Child marriage also emerged as a critical factor in explaining girls' school dropout, especially in upper primary and secondary education. Respondents in Somali reported that school feeding had, in the past, encouraged enrolment, but after it was discontinued, enrolment began to decline. They added that many caregivers refuse to allow their daughters access to school, for fear that girls may engage in inappropriate sexual relationships with boys.

Economic empowerment

Key findings

- Women are less likely to see themselves as 'earners' than men – they also own fewer productive assets.
- Somali women have more diverse livelihoods than Afar women.
- Women have more limited input into financial decision-making than men, especially from men's perspective and especially in Afar.
- Somali women report that they engage in more independent financial decision-making than Afar women.

Unsurprisingly, since a large minority of female caregivers in Afar (44%) and Somali (31%) identify themselves as homemakers, men are more likely than women – in both Afar (72% vs. 49%) and Somali (72% vs. 40%) – to report that farming (livestock and crops) is their primary activity. Differences in men's and women's primary activities impact household livelihoods. In Afar, female headed households are significantly more likely than male headed households to rely on livestock (77% vs. 69%) and petty trading (6% vs. 1%). They are less likely to rely on crop farming (12% vs. 22%). In Somali, patterning is different. Compared to male headed households, female headed households are more likely to rely on petty trading (23% vs. 14%), but equally likely to rely on crop farming (22% vs. 19%), and livestock (38% vs. 43%). Across regions, female headed households have approximately half as much land as male headed

households. They also own fewer livestock of all types.

Women's access to financial decision-making varies by region, but is generally lower than men's. In Afar, approximately three-quarters of female caregivers report sharing decisions with their husbands. In Somali, on the other hand, approximately four-fifths of female caregivers report that they alone make financial decisions (without their husbands). Critically, in both regions, our survey found that male caregivers report that women have far less input into financial decisions than women perceive themselves to have.

Our qualitative findings nuance and extend survey findings. In Afar, respondents reported that whereas men are responsible for selling larger livestock (cows, oxen and camels), women have the right to sell small ruminants and can control the profits from those sales. Women also fully control firewood and charcoal sales and use the money they make for household expenses. In areas like Aysaita district, where the credit and saving culture is very strong, most of those using community-based saving and credit services are women. In Somali, women not only decide whether and when to sell the small ruminants that provide households' regular income, but they are not required to share this income with their husbands. Interestingly, men are required to share their incomes with wives. Women's control over financial assets has significant implications for FGM/C, as it means that women can afford to have their daughters undergo FGM/C. It also side lines husbands and leaves them with less space to refuse to have their daughters cut.

The patterning and drivers of FGM/C

Our findings show that across regions, most of the 10-19-year-old girls in our sample have undergone FGM/C. Practices, however, are starkly different and speak to a need to carefully tailor interventions.

In Afar, of the 96% of girls who had heard of FGM/C, 97% had already been cut, mostly by the age of one. In terms of the type of cutting, 85% of these girls reported infibulation with scar tissue. The remainder reported having undergone Type 2 (10%) or Type 1 (5%).[3] Noting that it is difficult to disentangle culture and religion, especially given the heightened import of culture in today's Ethiopia, Afar

Dreaming of reaching out to her community by becoming a health professional, an adolescent girl from Somali region, Ethiopia © UNICEF Ethiopia/2015/Bindra

3 There are four main types of FGM/ C. Type 1 (clitoridectomy) refers to removing part or all of the clitoris. Type 2 (excision) involves removing part or all of the clitoris and the inner labia (the lips that surround the vagina), with or without removal of the labia majora (the larger outer lips). Type 3 (infibulation) refers to the narrowing of the vaginal opening by creating a seal, formed by cutting and repositioning the labia either by suturing or scar tissue. Type 4 refers to other harmful procedures to the female genitals, including pricking, piercing, cutting, scraping or burning the area.

Key findings

- In Afar, girls are cut as infants. In Somali, they are cut in late childhood, sometimes with girls' input on timing.
- Mothers are the primary deciders of if and when girls will undergo FGM/C.
- A large majority of girls are cut by traditional cutters – but in Somali in particular there is growing evidence of medicalisation.
- Across regions, study participants highlight cultural identity as the primary driver of FGM/C.
- Somali study participants are more likely to report a religious mandate for FGM/C than Afar participants.
- Study participants are more likely to report that FGM/C has benefits – primarily controlling girls' sexuality and ensuring their marriageability – than risks.
- FGM/C is not a 'one off' event – it results in a lifetime of pain and trauma.
- Knowledge of the law criminalising FGM/C is low overall; caregivers in Somali have less accurate knowledge of the law than those in Afar. In Somali, raising legal awareness may reduce support.
- Support for FGM/C depends on awareness of risks, and beliefs about benefits and religious mandate.
- In Afar, but not Somali, educating girls may be a promising strategy to reduce support for FGM/C – but economically empowering women may increase support for the practice.

girls in our sample cited cultural identity (65%) and religion (21%) as the main drivers of the practice in their community.

In Somali region, 78% of the 10–19-year-old girls in our sample reported having heard of FGM/C, and of these, 72% admitted to having been cut. Girls who admitted to having undergone FGM/C were cut at an average age of 9 years, and one-third reported having had some say in the timing. Similar to Afar, girls identified cultural identity (54%) and religion (33%) as the main drivers of the practice. The FGM/C prevalence rate in our Somali sample is not only markedly lower than in our Afar sample, but is also lower than the 95% of girls aged 15-19 reported cut in the 2016 EDHS. This should not, however, necessarily be interpreted as evidence of progress. Rather, it highlights the importance of attending to differences in how FGM/C is practiced and how this makes comparing different samples difficult. Because girls in Somali are cut at any age – up until the time of marriage – many of the girls in our sample, who were on average only 13-years-old at the time of data collection, will likely be cut in the next few years. Moreover, all the girls in our research sample in Somali region who had undergone FGM/C were subject to Type 3/infibulation with suturing. One of the key findings of our qualitative research and stakeholders' meeting was that being uncut renders a girl unmarriageable. During a focus group discussion involving unmarried boys, one participant said:

> *Boys want to marry a cut girl and no one will marry an uncut girl because of our religious views. Girls who are sewed are good, boys want them, believe that her dignity is protected and that of her family, since it is closed. We disregard sunna*[4] *types.*

Traditional cutters (women who may also work as birth attendants) are still the main perpetrators of FGM/C: about 89% of girls in Afar and 83% in Somali had been cut by traditional cutters. A further 10% of girls in Afar and 15% of girls in Somali reported that their mother had cut them. However, our qualitative research suggests that while mothers may hold girls down, they do not cut them. What girls are trying to say is that mothers are the primary deciders of FGM/C and arrange for girls to be cut – increasingly by health professionals. A 13-year-old girl from Somali explained, '*The decision about FGM/C is made by mothers, and mothers are the one that decide about the practices*.' In line with their daughters' reports, and with the caveats mentioned above, caregivers reported that the main reason for perpetuating the practice is cultural identity (67% and 52% in Afar and Somali respectively), religion (19% and 41% respectively), and to control girls' behaviour (10% in both regions).

A minority of caregivers are aware that FGM/C carries risks. Only 42% of those in Afar and 36% of those in Somali report that there are risks to the practice. Delineated risks are similar across regions – but are weighted differently. In Afar, caregivers emphasise more difficult childbirth (95%) and more painful sex (50%) over infection (21%). In Somali, they emphasise infection (95%) and more difficult childbirth (53%) over more painful sex (33%). Awareness of risks – rather than leading to a reduction of FGM/C – is resulting in some communities in medicalisation of the practice (see Box 2). In addition, caregivers are quite likely to report that FGM/C has benefits – especially in Somali (68% vs. 45% in Afar). Delineated benefits include ensuring that girls behave well (79% and 91% respectively) and that they can attract a good husband (50% and 37% respectively).

Although we found that FGM/C can result in a lifetime of physical and psychosocial trauma (see Box 3), relatively few girls reported that FGM/C entails risks. In Afar, where girls are cut in infancy, only 6% of girls reported that FGM/C has risks. In Somali, 22% of girls reported risks. In addition, girls – like their caregivers – were far more likely to report

4 'Sunna' translates as 'sanctioned' and is often used to refer to Type 1 FGM/C.

Box 2: Growing trend of medicalization of FGM/C

Although the Ministry of Health banned medical professionals from undertaking FGM/C in 2017, due to concerns that if the practice becomes medicalised it will be more difficult to eliminate, our research found that especially in Somali, FGM/C is becoming medicalised. Some respondents report that cutting increasingly takes place in health centres and private clinics. For example, a *kebele* chairperson from Somali region, noted:

In previous times, they were forced to commit FGM/C in a hidden way but now they do it publicly in the health centres and even the community health workers are responsible for the sunna [Type 1] way of doing it. Even the traditional ladies are being trained by non-governmental organisations about the importance of the sunna [Type 1] and the magnitude of danger that the pharaonic method [non-Type 1] pose for young girls' lives.

A father in a group discussion in Somali similarly reported that healthcare providers were increasingly getting involved in carrying out the practice:

Previously, even boys were taken to the forests to be circumcised there, but now instead they – girls and boys – are being taken to the hospitals and health centres to be cut… Those working in the health centres, female doctors [are doing it]. They assist women during delivery – how can they not be involved in FGM?*

In addition, some respondents reported that private pharmacies are providing training to traditional cutters (in a hidden way) on how to use painkillers and that nurses and midwives sometimes visit girls' homes to carry out FGM/C there.

* *We are aware that male circumcision has medical benefits whereas FGM/C has only risks and do not mean to equate the practices. Many Ethiopians use the word circumcision to refer to both male circumcision and FGM/C.*

Box 3: The physical and psychological trauma caused by FGM/C across the life course

Our qualitative research finds that FGM/C is not a one-off painful experience for girls and women, but instead begins a lifetime of ill health and suffering. Infibulated girls reported painful urination and menstruation. Many reported deliberately dehydrating to reduce the need to urinate and repeated urinary tract infections.

Married girls and young women added that the defibulation (re-opening) required at marriage, to allow sexual intercourse, is another source of trauma. In Somali, it is often carried out by traditional cutters, although healthcare workers have been getting involved more recently. This was reported to be an unintended consequence of NGOs training local cutters and healthcare workers to use anaesthetics to reduce pain. Girls who have been cut open are expected to have sex immediately thereafter. In Afar, where respondents report that it is common for husbands to use violence to defibulate their wives, often effectively battering their wives open while friends hold wives down, boys admit that defibulation is even painful for men. An older boy in a focus group discussion reported:

During the time of their first sex girls face severe pain when the boy/man struggle to dis-virgin her… Newly married grooms have also been suffering a lot when they dis-virgin girls, because the hole is too narrow, and the scar is also very strong to dis-virgin, bride grooms were limping for three or four days after they dis-virgin their wives, because of the pain due to the friction while struggling to dis-virgin girls.

It was also reported in Afar that some husbands take Viagra, to improve their 'stamina' and allow them to consummate the marriage; that some husbands ask their friends to rape their new wife, because they cannot tolerate her cries; and that some husbands resort to using knives, which can lead to haemorrhaging and even death.

Girls and women who have been infibulated also experience trauma, and increased risk of fistula and death, during childbirth. This may be especially the case in Afar, where respondents report that women are resealed with scar tissue through their fourth pregnancies.

benefits than risks. Almost a quarter of girls in Afar (23%) and more than half (55%) in Somali reported advantages of FGM/C. Girls primarily cited FGM/C's perceived effects on girls' good behaviour (89% and 84% in Afar and Somali respectively) and attracting a desirable husband (28% and 27% respectively). Our qualitative interviews confirmed these sentiments. A 13-year-old girl from Afar explained, '*The girl that's not cut brings shame to the family… Cutting doesn't bring any bad thing for her*.'

While there is strong support by caregivers for the continuity FGM/C (63% in Afar and 69% in Somali), there is some awareness that it is illegal at the national level (42% of caregivers in Afar and 34% in Somali). Of those who report knowing about the law on FGM/C, 10% in Afar but a markedly higher 80% in Somali incorrectly believe that Type 1 is allowed – perhaps due to government efforts to reduce infibulation by promoting 'less invasive' types of FGM/C. Caregivers have extremely poor knowledge about the specifics of legal penalties delineated by the law. Fewer than one-in-five correctly reported that both parents and cutters are held liable (19% in Afar and 16% in Somali). The remainder reported that only the cutter is penalised (30%

in Afar and 10% in Somali) or that only the parents are penalised (13% in Afar and 11% in Somali).

When looking at the factors most closely associated with caregivers' and adolescents' beliefs that FGM/C should be continued, our regression analysis found evidence of both similarities and differences between regions (see Figure 1). Again, with the caveat that it is difficult to disentangle religion and culture, the belief that FGM/C is religiously mandated is a key driver of the practice in both regions – as is cultural continuity. Awareness about the risks of FGM/C discourages its continuation in both regions, while the belief that it offers benefits serves to encourage the practice in both regions. Despite beliefs that income diversification might result in improved ability to resist social norms – as households become more economically stable or are better able to access services (especially education) and information simply by dint of where they live – in neither region does a shift away from livestock (to crop farming, wage employment or petty trading) appear to significantly reduce caregivers' or girls' support for the continuation of FGM/C. Indeed, in Somali such shifts appear to increase the caregivers' support for the continuation of FGM/C.

As also captured in Figure 1, our regression analysis provides further evidence of the need to regionally tailor approaches to the elimination of FGM/C. For example, it found that girls' access to education was associated with less support for FGM/C in Afar, but not in Somali region. Similarly, girls' self-efficacy was more closely associated with lower support for FGM/C in Afar than Somali, which has important implications for future generations, given high rates of child marriage and adolescent motherhood. Caregivers' knowledge of the law, on the other hand, was important in Somali and not Afar. More legally aware Somali caregivers were less likely to support continuation than their less aware peers. In Somali, literate caregivers were more likely to support continuation. Regional differences in economic factors are especially interesting. In Afar, but not Somali, mothers who report more control over household resources are more than three times more likely to support FGM/C than those who report less control. In addition, greater household wealth is associated with Afar girls' – but not Somali girls' – support for continuation.

Taken together, regression results suggest that changing preferences for FGM/C will require more awareness-raising about the risks involved, efforts to shift norms around male preferences for cut brides, and legal enforcement. Results strongly suggest that economically empowering women and households is unlikely to support abandonment – and indeed may, especially in Afar, encourage retrenchment by providing women with resources they then allocate to FGM/C.

The patterning and drivers of child marriage

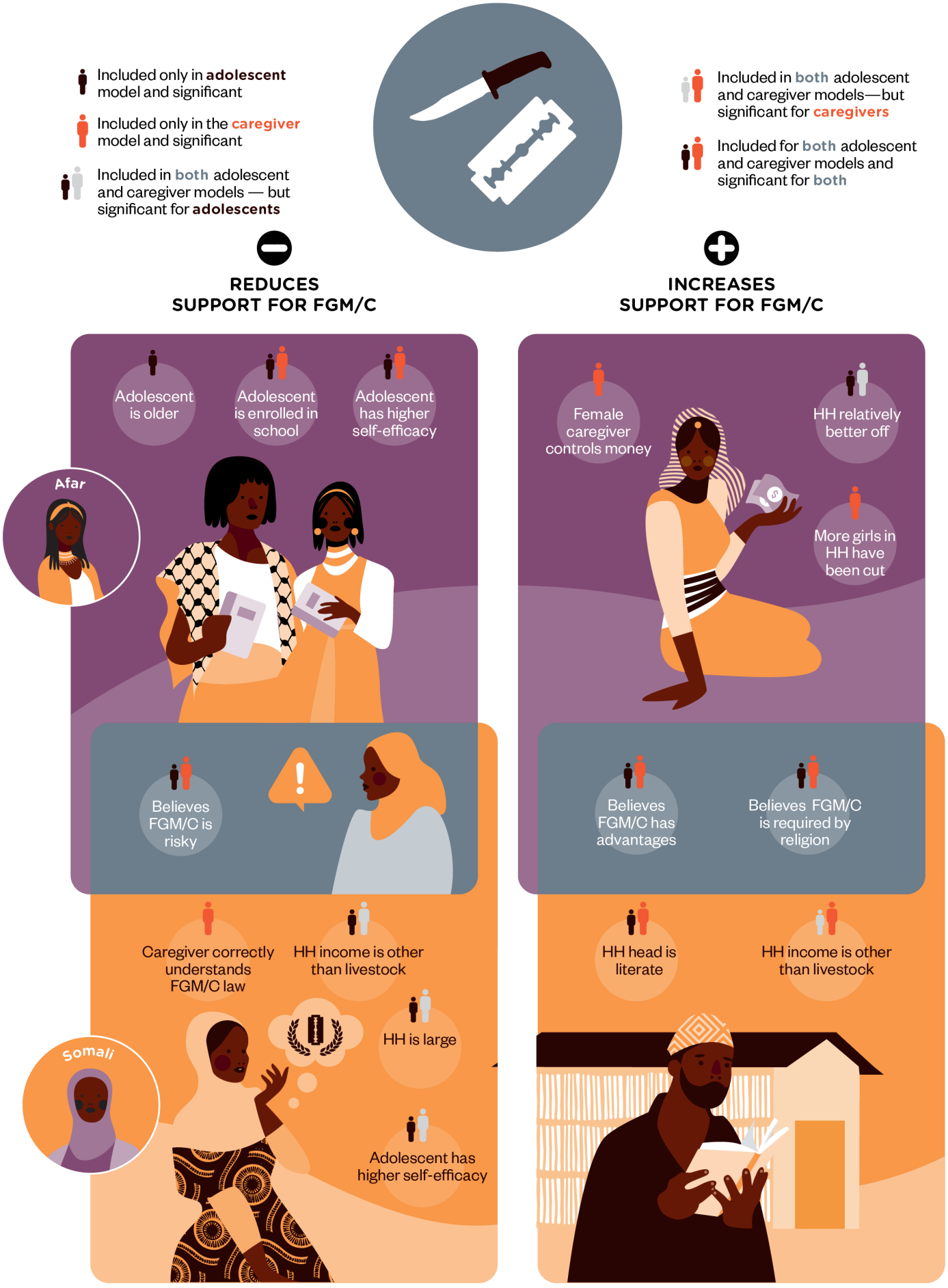
Key findings

- Few girls in our sample are already married, because most are too young – but child marriage is seen as normal in both contexts.
- Arranged marriage is common in Afar; most girls do not want to marry when they do. By contrast, in Somali, most marriages are adolescent-driven.
- Few adolescents are aware that there is a legal minimum age for marriage, but across regions, most adolescents report that the ideal age of marriage is greater than 18.
- Girls are more likely to support child marriage than boys.
- Support for child marriage is shaped by community norms – where respondents believe it to be common, they are more likely to support it.
- Caregiver literacy reduces support for child marriage.
- There are intergenerational synergies – adults' and adolescents' beliefs about child marriage reinforce one another.
- Access to education reduces support for child marriage in Afar but not in Somali.
- In Somali, better off households are less likely to support child marriage – the reverse is true in Afar.
- In Somali, higher adolescent self-efficacy reduces support for child marriage.

Because the average age of girls in our sample was 13, only 3% in Afar and 4% in Somali had ever been married (2% and 3% currently married respectively and 1% previously married but now divorced). Of these girls, the average age at marriage was similar – 15.8 years in Afar and 15.6 years in Somali. More than a fifth (22%) were married before age 15 in both regions. However, the type of marriage differed significantly across regions. In Afar, 87% of girls had an arranged marriage according to the *absuma* tradition (maternal cousin marriage designed to preserve clan unity), and only just over a third (36%) reported that they felt ready to marry at the time (see Box 4). In Somali, by contrast, only 21% of married girls reported a parentally arranged marriage. With the caveat that very few girls in our sample are already married, almost all married girls in Somali (97%) evidence the limited options available to girls in their environments and reported that they felt ready to marry when they did.

Among caregivers, significantly more women in Afar (88%, compared to 58% in Somali) had been married before age 18, with the average age at marriage of 16.2 years (compared to 17.3 years in Somali). Almost all

Figure 1: Regression results for beliefs about the desirability of FGM/C



Box 4: Changes in child marriage in Afar

Whereas previous research highlighted the ubiquity of *absuma* marriages in Afar (Jones et al., 2019; Presler-Marshall et al., 2020), our qualitative findings reveal some changes – albeit nascent and from a low base. Some parents appear to be giving girls more say in marriage decisions, primarily due to increased awareness of intimate partner violence and to rising divorce rates. Some religious leaders (interviewed as key informants) also highlighted that there is nothing in the Qur'an that endorses *absuma* marriage. In addition, we heard several reports of girls resisting an *absuma* marriage, and reporting an impending marriage either to the Bureau of Women and Social Affairs office at *woreda* (district) level, to teachers, or (in the more urbanised district of Aysaita) to the Sharia court. As a 16-year-old girl noted:

Nowadays, absuma marriage culture is declining... The process is like, if a girl reaches puberty, then the parent will start looking for a guy that can marry their child. They support (the groom and bride) if they are first cousins but if it is marriage by love; it will be arranged between the girl and the guy who wants her. And then the parents are usually not involved.

Despite some evidence that *absuma* marriage is becoming less universal, religious leaders are still advocating for child marriage. They encourage girls to marry immediately after menarche (the onset of menses), typically around 15, because early and frequent childbearing is seen as desirable for the greater good of the clan.

caregiver marriages in Afar (97%) were arranged by parents, compared to 74% in Somali. Unsurprisingly, there were significant differences in the proportion of women who reported that they felt ready to marry at the time – less than half (38%) in Afar, compared to more than three-quarters (77%) in Somali.

Social norms play an important role in perpetuating child marriage. In both regions, most caregivers (87% in Afar and 79% in Somali) and adolescents (87% and 54% respectively) believed that it is normal for a girl to marry before age 18. Moreover, very few adolescents (7% in Afar and 2% in Somali) reported being aware that marriage under 18 is illegal. Despite this, adolescents reported a preference to marry as an adult. The average ideal age for marriage was reported as 19 years in Afar and 20.7 years in Somali. Furthermore, almost two-thirds of adolescents (64%) in Afar and just over half (53%) in Somali said that the ideal age for marriage was 18 years or older. Adolescents reported that their ideals were shaped by allowing girls to complete their education, be more physically prepared for marriage, and be more mentally prepared.

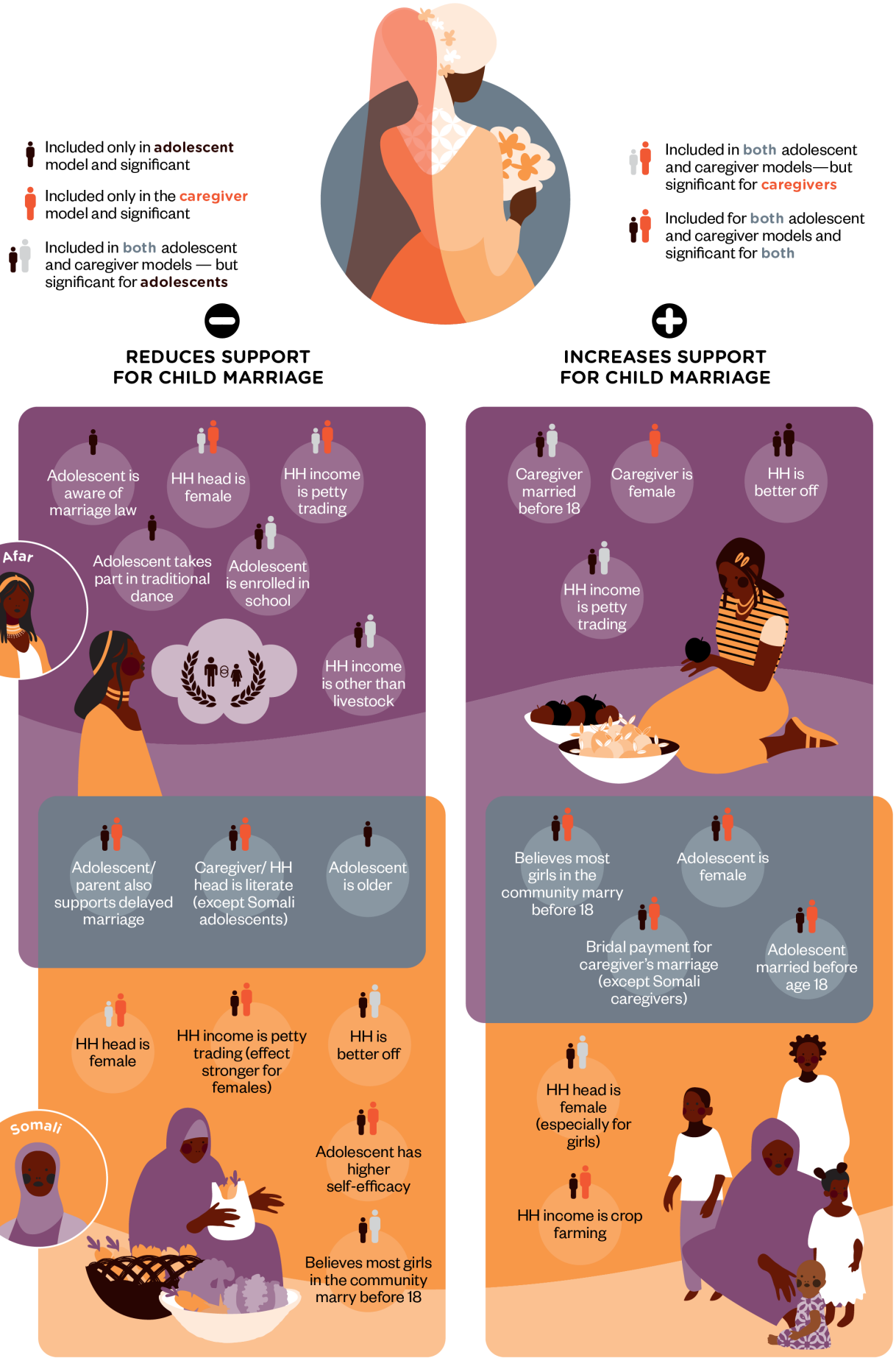
When looking at the factors most closely associated with continued support for child marriage, our regression analysis found almost unrelenting evidence of a need to carefully tailor interventions around local practices (see Figure 2). For example, and in line with findings for FGM/C, it found that adolescents' access to education was associated with less adolescent support for child marriage in Afar – but not Somali. Similarly, adolescents' knowledge of the legal age of marriage and participation in traditional dances were found to reduce support for child marriage, but only in Afar. On the other hand, adolescents' self-efficacy was associated with lower levels of support for child marriage in Somali, but not in Afar. In terms of economic factors, patterning across regions is diametrically opposed – likely because in Afar, wealthier households tend to live in rural whereas in Somali they tend to be more urban and exposed to the possibilities that urbanisation engenders. In Somali, greater household wealth (as measured by an index of assets) was found to be protective against child marriage. In Afar, the reverse was true. Similarly, in Afar, shifts from livestock to crop farming were found to reduce support for child marriage, whereas in Somali this led to greater support. Shifts from livestock to petty trading were found to be protective against child marriage for girls in Somali; in Afar, the reverse was true.

Conclusions

Our research highlights that there is still much to be done by the Ethiopian government and its development partners to fast-track delivery on its commitment to eliminate FGM/C and child marriage. Indeed, in the Afar and Somali communities where we conducted our research, we find no evidence that FGM/C is becoming seen as less desirable, no evidence that it is becoming less common, and little to no evidence that infibulation is being replaced by less invasive forms of cutting. We even find some evidence of entrenchment in medicalisation. Moreover – and in line with existing evidence – our research also suggests that in Somali child marriage may be becoming more common and the age of which girls marry is dropping. These harmful traditional practices are under-pinned and reinforced by restrictive gender norms that value girls and women exclusively for their reproductive capacities, and which serve to limit their access to education, paid work, and decision-making. The refusal of the regional governments in Afar and Somali to approve the Ethiopian Family Law, which states that both FGM/C and child marriage are illegal, has contributed to the continuation of these practices.

That said, our research also finds some glimmers of progress and hope. Regarding FGM/C, adults are slowly becoming more aware of national laws that prohibit the

Figure 2: Regression results for beliefs about the desirability of child marriage



practice and religious leaders are increasingly aware of the dangers of infibulation versus clitorectomies. Regarding child marriage, girls in both Afar and Somali are increasingly able to marry a partner of their own choosing (rather than a partner chosen by their parents) and adolescents are beginning to prefer marriage after the age of 18 – despite some evidence of practices to the contrary.

Critical to future progress, our research highlights that if FGM/C and child marriage are to be eliminated, it is important to focus on both similarities and differences. This includes similarities and differences in how FGM/C and child marriage practices vary across regions – as well as similarities and differences in the drivers of FGM/C and child marriage within regions. For example, although our research finds that FGM/C (and indeed infibulation) remains the norm in both Afar and Somali – and suggests that awareness raising (about risks, perceived benefits, and the law) is critical to reductions in both regions, it also suggests that that awareness raising needs to be carefully tailored to account for different practices and pathways. This includes the age at which girls undergo FGM/C (infancy in Afar and late childhood in Somali) and the finding that education reduces support for FGM/C in Afar but not Somali. In addition, although FGM/C and child marriage are in some ways two sides of the same coin, in that both reflect deep-seated beliefs that girls' value is limited to marriage and motherhood, our research underscores that pathways to elimination are largely divergent and that FGM/C is likely to be far harder to eliminate than child marriage. Indeed, although economically empowering women and their households may reduce girls' risk of child marriage, it may come at the cost of further entrenching FGM/C.

Policy and programming implications

Although future rounds of research will provide further insight into the most effective pathways through which to effect change, our baseline research findings – combined with our review of the existing evidence – leads us to suggest that if the Ethiopian government and its development partners are to fast-track progress on the National Costed Roadmap to End Child Marriage and FGM/C and achieve SDG targets, they must think ambitiously. Efforts must be at scale, mainstreamed into sectoral plans, coordinated across sectors and levels of government, draw upon the expertise

Wishing to go to university and work before getting married, a 15-year-old girl from Afar region © Nathalie Bertrams/GAGE 2022

of child- and gender focused NGOs, engage with traditional and religious leaders, and recognise that all community members – adult women and men and adolescent girls and boys – have a role to play in eliminating FGM/C and child marriage. We suggest the following priority actions:

Raise awareness of the law and prosecute those who violate it

Because knowledge of the national law is reported as limited – and enforcement even more so – we urge the justice sector to scale up efforts to promote and enforce national laws on harmful practices. This should include:

- working with traditional and community leaders to make sure that communities know that all forms of FGM/C and child marriage are illegal;
- working with Sharia courts – to improve girls' and women's rights to education, inheritance, and freedom from violence – and enhancing cooperation between Sharia courts and the formal courts and justice system;
- establishing anonymous reporting mechanisms (perhaps at school) that can be used to prevent planned FGM/C and child marriages taking place;
- working with communities to set enforceable penalties for violations and strengthening mechanisms and oversight at the *kebele* level;
- working with girls and women, to make them more aware of their rights and how to claim them;
- working with boys and men, to make them more aware of the law and penalties for violation;
- advocating with regional governments for regional laws to be harmonised with national laws banning both FGM and child marriage, and to ratify the Family Law so that these practices are criminalised.

Work with girls and women to shift the gender norms and practices that limit girls' and women's lives and life choices

Because the same restrictive gender norms that drive FGM/C and child marriage also prevent girls and women from accessing education and employment, and having a say in decision-making, we urge the Bureaux of Women and Social Affairs to directly tackle these beliefs and practices. This should include:

- greater efforts to raise women's awareness of their own (and their daughters') rights and how to report violations;
- creating avenues and opportunities through which women (and girls) can develop their own skillsets, including, for those denied access to formal education, literacy and numeracy;
- working with mothers to empower their daughters and encourage their sons to adopt alternative masculinities including eschewing norms that render uncut girls as 'unmarriageable';

16-year-old standing in front of her house in Ber'aano *Woreda* in Somali region, Ethiopia © UNICEF Ethiopia/2015/Ose

- working with communities to raise awareness about the importance of girls' education and how to practically support it;
- addressing FGM/C and child marriage in a regionally tailored way to account for decision-making (e.g. girls have more input in Somali) by educating girls and families and communities about their risks, challenging their perceived advantages, and raising awareness about the real advantages of eschewing norms;
- strengthening services (including rehabilitation centres) for those who have experienced sexual and gender-based violence;
- working with the Bureaux of Health to ensure that girls who have been cut have access to appropriate healthcare at different stages of their life.

Work with boys and men to raise awareness of gender norms and to encourage the adoption of alternative masculinities

Because fathers, brothers, male peers, boyfriends and husbands are complicit in perpetuating the broader gender norms that disadvantage girls and women, including the FGM/C that is almost exclusively considered the purview of women, government and non-government actors need to collaborate to shift male attitudes and practices. This should include:

- helping fathers and brothers to see how they could better support wives and sisters to free up girls' time to study;
- educating boys and men on why it is not important to marry a cut girl, and on how boys and men can protect their sisters and daughters and prevent further injury to their wives;
- working to decouple men's status in the community from daughters' sexual purity and 'successful' marriage;
- educating boys and men about the practical advantages of an adult wife (e.g. better helpmeet) – and the disadvantages of marrying a child;
- encouraging more equitable household decision-making and less violent masculinities, including how fathers can bring up their sons differently.

Within the wider community, work with adults and adolescents to shift the gender norms and practices that limit girls' and women's lives

Because the gender norms that limit girls' and women's lives also limit the ability of other community members and leaders to recognise and address these norms, child- and gender-focused NGOs must work with adolescents and adults to shift beliefs and practices, and to develop local capacity. Interventions should be scaled for impact, so that tipping points are timely, and should include:

- supporting girls to access and excel in education;
- engaging with adolescents on FGM/C and child marriage to shift current practices or encourage intergenerational change (depending on context);
- supporting women to learn about their (and their daughters') rights and how to access them;
- providing parent education courses for mothers and fathers that directly address gender norms and how these harm girls and women;
- strengthening school-based girls' and gender clubs;
- supporting role models and working alongside local leaders and service providers to raise awareness about the risks of FGM/C and child marriage.

Make sure that all girls have access to education, up to the end of secondary school

Because girls are far more likely to be excluded from education than boys, we urge the education sector to redouble its efforts to ensure that all girls have access to education, at least through the end of intermediate school – and ideally through secondary school. This should include:

- making sure that all communities (including nomadic pastoralists) have schools that offer quality mother-tongue education through to at least 6th grade – including adult education for the older girls and women previously denied access to school;
- door-to-door outreach to enrol those children who are out of school, combined with fines for parents of truant children, as appropriate;
- expanded curricular and extra-curricular education on gender norms, including direct attention to FGM/C, child marriage, and sexual and gender-based violence;
- greater provisioning of school supplies for students from poorer households;
- stepped up investments in school feeding programmes, school WASH (water, sanitation and hygiene) and menstrual hygiene management supplies, participatory girls'/gender clubs, and tutorial support;
- safe and affordable boarding options for students in intermediate and secondary school;
- more supervision by *woreda*-level education offices, using incentives for teachers as necessary to reduce turnover and absenteeism.

Use social protection to incentivise uptake of education – and to delay child marriage

Because global evidence suggests that the best way to prevent child marriage is to keep girls in school for as long as possible, use social protection to incentivise families to educate girls and delay marriage. This should include:

- start/resume school feeding programmes, with supplementary take-home rations for girls;

- cash and asset transfers to support girls' education, ideally conditional both on girls' attendance and continued unmarried status, and parents' and adolescents' participation in gender-focused programming;
- asset transfers to support girls and women to earn their own incomes;
- challenge stigma and discrimination, one option would be to provide legal support and social protection to families who actively resist undertaking these harmful practices. Those families could also serve as role models to others.

Work with heath care providers to prevent medicalisation

Because there is evidence that health care workers are perpetrating FGM/C, Bureaux of Health at the regional and district levels must provide training for health professionals to make sure they know about the Family Law's ban on FGM/C, and should enforce penalties for any health professional found to practice it.

Work with women and girls to improve their livelihood options

Because girls and women have very few opportunities to earn their own incomes, the agricultural and labour sectors should scale up efforts to expand and diversify females' livelihood options. These should be paired with awareness raising, to ensure that girls' and women's improved access to finance does not further entrench FGM/C and should include:

- community-based female-only literacy and numeracy courses, to offset girls' and women's much more limited access to formal education;
- the development of skills and training courses for older girls and women, including animal husbandry and other culturally acceptable occupational skills, alongside life skills and financial/business skills;
- more opportunities for older girls and women to access formal savings and credit institutions.

Work through regional government leaders in Afar and Somali regions to promote social and legal change for girls and women

Because Afar and Somali are not yet evidencing the progress shown by other regions, we urge regional government leaders to promote the social and legal changes that will improve girls' and women's lives – as well as broader development outcomes. This should include:

- efforts to identify champions (particularly among clan and religious leaders) willing to encourage change;
- the development of a coalition to advocate for harmonising regional legal codes with national ones;
- allocating sufficient human and financial resources to tackle the gender norms and practices that prevent girls and women from accessing their rights;
- and investing in evidence-based monitoring and evaluation of programming designed to tackle FGM/C and child marriage, focusing on the remote communities where prevalence is highest.

Engage religious leaders to encourage people to abandon harmful practices and to shift the gender norms that underpin sexual and gender-based violence

Because FGM/C is seen as a religious mandate, and child marriage is seen as religiously acceptable – and even preferable – it is vital that all actors (government and non-government) work closely with religious leaders to eliminate these harmful practices. This should include:

- raising religious leaders' awareness of the fact that it is illegal for them to advocate for FGM/C and child marriage, and that they can be prosecuted for officiating a child marriage;
- education about the risks of FGM/C (especially infibulation) and child marriage and the advantages of delaying marriage until adulthood;
- addressing misconceptions that FGM/C and child marriage are required/permitted by Islam, and developing persuasive religious-based arguments in favour of ending the practices (including addressing beliefs that girls must be cut in order to enter mosques and/or pray);
- building support for girls' education, for the sake of girls themselves and for future generations;
- addressing broader gender norms, including recognising the value that girls and women add to families and communities, and the importance of teaching boys and men to eschew violence and treat female family members well.

Engage clan and traditional leaders to encourage people to abandon harmful practices

Because clan and culture are central to Afar and Somali identities – and to the perpetuation of FGM/C and child marriage – government and non-government actors must work closely with traditional leaders to begin to shift the beliefs and practices that disadvantage girls and women. This should include:

- promoting girls' education;
- raising awareness about the risks of FGM/C, especially infibulation;

- raising awareness of the risks of child marriage and the advantages of delaying marriage until adulthood;
- making sure that communities – especially traditional cutters and mothers – know that all forms of FGM/C are illegal and subject to fines and imprisonment.

Continue and expand efforts to open change pathways and support champions at all levels

Because the Ethiopian Alliance to End Child Marriage and FGM/C is uniquely positioned to continue and accelerate efforts towards eradicating these harmful practices, it must continue to open new change pathways and identify and support champions at all levels. The Alliance should:

- work with regional officials, to advocate for harmonising national and regional laws; sub-regional officials, to raise awareness and improve enforcement; local officials, to strengthen commitment to eliminating the practices and to oversight at the *kebele* level to support that; and with religious and clan leaders, to develop tailored and actionable plans;
- work with line ministries (especially health, education and justice) to mainstream child marriage and FGM/C prevention in government sectoral plans including stepping up efforts to keep girls in school, supporting the expansion of girls' and gender clubs; and tackling the medicalisation of FGM/C;
- support capacity-building for journalists and media producers to report on girls' and women's empowerment in order to inform and inspire adolescent girls and their caregivers about their potential to eschew discriminatory gender norms and to lead empowered and independent lives.

Scale up investment in efforts to eliminate both practices, informed by robust longitudinal evaluations

Because eliminating FGM/C and child marriage will be resource-intensive and a long-term process, development partners should scale up investment and robustly assess impacts through longitudinal and mixed-method research evaluations. This should include:

- investing in education for all children, including those in remote pastoralist communities;
- scaling up social protection for the most vulnerable households, leveraging this where possible to improve girls' education (and reduce child marriage);
- strengthening sub-national capacity to improve local services;
- investing in programming to shift restrictive gender norms;
- improving and fine-tuning programmes to maximise context specificity;
- investing in robust longitudinal monitoring, evaluation and research to track progress, inform how best to deploy scarce resources given context specificity, and how to promote effective programming at scale.

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