



# Exploring the patterning and drivers of FGM/C and child marriage in pastoralist Ethiopia

## Baseline report from Afar and Somali regions

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## Acronyms

CG	caregiver
CSA	Central Statistical Agency of Ethiopia
CR	core respondent
DHS	Demographic and Health Survey
EDHS	Ethiopia Demographic and Health Survey
ESS	Ethiopia Statistics Service
ESSSWA	Ethiopian Sociologists, Social Anthropologists and Social Workers Association
FGM/C	female genital mutilation/cutting
FHH	female-headed household
FGD	focus group discussion
GAGE	Gender and Adolescence: Global Evidence
GBV	gender-based violence
GER	gross enrolment rate
GTP	Growth and Transformation Plan
HH	household
MHH	male-headed household
MHM	menstrual hygiene management
NGO	non-governmental organization
ONLF	Ogaden National Liberation Front
PSNP	Productive Safety Net Programme
SGBV	sexual and gender based-violence
SRH	sexual and reproductive health
SDG	Sustainable Development Goal
TPLF	Tigray People's Liberation Front
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

# Executive summary

## Introduction and report aims

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 (SDG) 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.).

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. This report, which is aimed at informing a broad audience – including Ethiopian government stakeholders, national and international researchers and non-governmental organisations (NGOS), as well as, as well as donors – summarises findings from mixed-methods research carried out in early 2022. It also sets out the implications of those findings for policy and programming, including the implementation of the National Costed Roadmap.

## Research methods

This report draws on findings from a mixed-methods baseline assessment that explored the patterning and drivers of child marriage and FGM/C in Afar and Somali regions, to identify possible entry points to fast-track change for girls, their families and communities. The baseline is part of a longitudinal research evaluation that includes three rounds of data collection in 2022, 2024 and 2025. 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 Afar and Somali regions.

The quantitative sample includes 2,042 households, split equally between Afar and Somali. In each region, data was collected in 9 *kebeles* (communities) where programming will be implemented, and 9 *kebeles* that will receive no programming. In each household (HH), a caregiver and an adolescent between the ages of 10 and 19 were surveyed. The qualitative sample includes a sub-sample of adolescents (n=295) and their caregivers (n=166) who participated in individual and group interviews, as well as key informant interviews (n=84) with regional and district-level government officials, clan and religious leaders, and service providers.

## 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 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



Adolescent boys from Afar region, Ethiopia © Nathalie Bertrams/GAGE 2022



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 HH livelihoods. In Afar, FHH are significantly more likely than MHH 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 MHH, FHH 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, FHH have approximately half as much land as MHH. 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 HH 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.

### 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 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.
- Support for FGM/C depends on awareness of risks, and beliefs about benefits and religious mandate.
- 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.
- 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.

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%).<sup>1</sup> Noting that it is difficult to disentangle culture and religion, especially given the heightened import of culture in today’s Ethiopia, Afar girls in our sample cited cultural identity (65%) and religion (21%) as the main drivers of the practice in their community.

<sup>1</sup> 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.

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 Ethiopia Demographic and Health Survey (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.

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. 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



An illiterate pastoralist mother who has three children, Afar region, Ethiopia © Nathalie Bertrams/GAGE 2022

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. 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 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.

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. 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<sup>2</sup> 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.

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<sup>3</sup> 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 HH resources are more than three times more likely to support FGM/C than those who report less control. In addition, greater HH 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.

<sup>2</sup> There is a marginal effect ( $p < .1$ ) for girls in Somali.

<sup>3</sup> Self-efficacy refers to an individual's confidence in their ability to carry out a task successfully.

## 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 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. 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 HH 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, and policy and programming implications

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 at 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 practice and religious leaders are increasingly aware of the dangers of infibulation vs. 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 disjoint 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.

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 big. Efforts must be at scale, mainstreamed into sectoral plans, coordinated across sectors and levels of government, draw upon the expertise of child- and gender focused NGOs, engage with traditional and religious leaders, and recognise that all community members – adult women and men and adolescents 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 penalise those who violate it:** Efforts to scale up, promote and enforce national laws are critical, given that research participants report that knowledge of FGM/C and child marriage laws is limited and enforcement is all but non-existent.

**Work with girls and women, in regionally tailored ways, to shift the gender norms and practices that limit their lives:** Because restrictive gender norms prevent girls and women from accessing education, employment or decision-making – and drive FGM/C and child marriage – it is critical for the Women and Social Affairs Bureaux to invest in programming to directly tackle these beliefs and practices with adolescents, caregivers, and religious and community leaders, making sure to focus on risks, perceived advantages, and actual advantages of eschewing current practices.

**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.

**Work with clan and traditional leaders to raise awareness among communities to shift the practices and gender norms that disadvantage girls and women:**

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 clan leaders to shift the beliefs and practices that disadvantage girls and women through regular, focused and structured awareness-raising sessions.

**Make sure that all girls have access to education, at least until the end of intermediate school but ideally through to completion of secondary school:**

Because girls are far more likely to be excluded from education than boys, and because education appears protective against child marriage and FGM/C in Afar (and is likely to deliver over time in Somali), the education sector should redouble its efforts to make sure that all girls have access to education, at least through to the end of intermediate school (8<sup>th</sup> grade) but ideally through to completion of secondary school (12<sup>th</sup> grade).

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

Because education is protective of girls – and has cascading benefits across generations – use social protection to incentivise families to educate girls and delay marriage. Support should include: school feeding programmes with supplementary take-home rations for girls; cash and asset transfers to support girls' education, ideally tied to girls' attendance and continued unmarried status, and their participation (with parents too) in gender-focused programming.

**Work with health 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 in pastoralist communities 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. Efforts must be carefully paired with awareness

raising, given findings that women's control over resources increases their support for FGM/C.

**Ensure that the medicalization of FGM/C does not progress:** Educate health care practitioners about the FGM/C law – and penalize those who violate the law.

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

Because Afar and Somali are not yet evidencing the progress on reducing child marriage and FGM/C shown by other regions, it is critical to involve regional government leaders in championing the end of child marriage and FGM/C and supporting coordinated cross-sectoral efforts. Tackling harmful practices could be framed as critical to not only improving women's and girls' lives – but also in advancing the regions' broader development outcomes.

**Engage religious leaders to help eradicate FGM/C and child marriage and to shift the gender norms that lead to SGBV:**

Because FGM/C is seen as a religious mandate, especially in Somali, and child marriage is seen as religiously acceptable – and even preferable – it is vital that government and non-government actors work closely with religious leaders to eradicate these practices by sensitising communities to the fact that the practice is not religiously sanctioned.

**Encourage non-governmental organisations (NGOs) to 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 communities' and leaders' capacity to recognise and address these norms, it is vital that child- and gender-focused NGOs work with adolescents and adults (traditional and community leaders, service providers, and caregivers) to shift beliefs and practices and to develop local capacity. Also, Because the Alliance to End Child Marriage and FGM/C is uniquely positioned to continue and accelerate efforts towards eradication, it must continue to open new change pathways and identify new champions at all levels.

**Scale up investment in efforts to eradicate both practices, informed by robust longitudinal evaluations:**

Because eradicating FGM/C and child marriage will be resource-intensive and a long-term process, development partners must scale up their investments and assess impacts through robust longitudinal and mixed-methods research evaluations.

# 1 Introduction

Eliminating ‘harmful traditional practices’ – a rubric that includes child marriage and FGM/C – has moved up the development agenda in recent years given mounting evidence that the costs of such practices go far beyond the lives of individual girls and women, to affect national economies (Wodon et al., 2018; WHO, 2020). Policy attention is evident in the international commitments made by governments, including SDG 5 – achieving gender equality and empowering all women and girls. Target 5.3 explicitly calls for the elimination of ‘all harmful practices, such as child, early and forced marriage and FGM’. In Ethiopia, during the past decade, child marriage and FGM/C (which have been illegal since 2000 and 2005 respectively) have also become highly visible in the country’s national-level policy framework. In 2013, the then Ministry of Women Children and Youth created a National Strategy and Action Plan on Harmful Traditional Practices against Women and Children, and in 2019 launched its National Costed Roadmap to End Child Marriage and FGM/C by 2025.

Driven by these strong legal and policy frameworks (see Figure 1), Ethiopia has made notable progress at the national level towards eliminating child marriage and FGM/C. In 2000, according to the EHDS, 14% of adolescent girls (aged 10–19) had married before the age of 15 and 49% of young women (20–25) had married before the age of 18 (Central Statistical Agency of Ethiopia (CSA) and

ORC Macro, 2001). By 2016, these rates had fallen to 6% and 40% respectively (CSA and ICF, 2017). In 2000, 71% of adolescent girls had undergone FGM/C (CSA and ORC Macro, 2001), but this had dropped to 47% by 2016 (CSA and ICF, 2017). However, this progress has been highly uneven, with some of the country’s ‘emerging’ regions (including Afar and Somali) lagging far behind. Rates of FGM/C in those regions are static, and rates of child marriage appear to be increasing (CSA and ORC Macro, 2001; CSA and ICF, 2017; Elezaj et al., 2019). Unsurprisingly, given the links between harmful traditional practices and gender norms, these are also the regions where girls and women have very few opportunities for education and employment. In line with the framing of the SDGs, which focus on those most at risk of being ‘left behind’, donors and international NGOs have recently stepped up their efforts to accelerate progress on reducing child marriage and FGM/C in Ethiopia’s emerging regions (see Box 1).

This report draws on mixed-methods research conducted in two zones of Afar and two zones of Somali in early 2022, exploring women’s and girls’ situation, especially in regard to FGM/C and child marriage. The research also establishes a baseline against which the impact of Save the Children’s programming can be assessed (future rounds of data collection are planned for 2024 and 2026). Our sample of 4,084 adolescents and caregivers (2,042 households in each region), and more

## Box 1: Programming to tackle child marriage and FGM/C in Afar and Somali

Efforts to tackle child marriage and FGM/C in Afar and Somali include new programming funded by the Government of Ireland and implemented by Save the Children. The programme, *Supporting women and girls in Ethiopia’s lowlands to realise their rights, and live healthy and productive lives free from violence and abuse*, aims to empower girls and young women and reduce the impacts of restrictive gender norms – especially around FGM/C and child marriage – that limit their lives.

The programme has six workstreams that focus not only on girls and young women, but also on local service providers, boys and men, and communities: (1) economic empowerment (including cash and asset transfers, access to savings and credit opportunities, and support for self-employment); (2) material support to enrol out-of-school girls and tutorial support to improve girls’ academic success; (3) women’s and girls’ engagement (including leadership training and girls’ clubs to enable women and girls to advocate for their rights); (4) GBV protection (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 structured community conversations led by clan and religious leaders, and radio listening groups for women where participants discuss issues related to broadcasted messages on child marriage and FGM/C); and (6) capacity-building and coordination (including training for local leaders and service providers).

The programme will complement efforts by local and international NGOs, including CARE Ethiopia, AMREF Health Africa, Concern Ethiopia and GIZ, and the United Nations Children’s Fund (UNICEF) and United Nations Population Fund (UNFPA) joint Global Programme to End Child Marriage.





A 16-year-old girl, with her 12-year-old cousin, standing by the house in Ber'aano Woreda, Somali region, Ethiopia ©UNICEF Ethiopia/2015/Ose

**Figure 1: Timeline of Ethiopia’s national laws and policies addressing child marriage and FGM/C**



than 100 key informants, is far larger than the 2016 EDHS regional samples (see discussion below). The sample was carefully constructed to allow us to track whether rates of child marriage and FGM/C are changing – and, if so, in response to which elements of programming.

This report begins with a background section that introduces the Afar and Somali contexts (particularly as

they relate to the risks and disadvantages facing girls and women), and provides a brief overview of the design of Save the Children’s programming. It then discusses the conceptual framing of our research, and the research methods, before presenting our findings. It concludes with the implications of those findings for programming and policy.



## 2 Background

Afar and Somali have seen very little focused research. This is partly because they have sparse, mobile populations; partly because they are relatively side-lined within Ethiopia as ‘emerging’ regions; and partly because their populations remain difficult to disentangle from broader populations of Afars (in Djibouti and Eritrea) and Somalis (in Somalia, Somaliland, Djibouti and Kenya). These evidence gaps are also shaped by the recurrent drought and conflict that afflicts both regions. Indeed, there is reason to believe that even large-scale national surveys – including the census and the EDHS – do not accurately capture the realities of people living in Afar and Somali because of sampling and enumerating difficulties.<sup>4,5</sup> Even less is known about the age- and gender-specific vulnerabilities affecting girls and women living in the two regions. Owing to restrictions on their mobility, their extremely low literacy rates, and social norms that restrict their voice and agency, girls and women in Afar and Somali are less likely to be included in research and almost certainly less likely to answer questions accurately and candidly.

Bearing in mind concerns about evidence gaps and evidence quality, this section contextualises our findings by briefly describing the two regions, highlighting the special challenges facing girls growing up there. We describe broader socioeconomic patterns before turning to opportunities for girls and women for education and employment. We then hone in on the patterning and drivers of FGM/C and child marriage. This section also introduces Save the Children’s programming in the regions to reduce FGM/C and child marriage by empowering girls and young women. A more complete review of the evidence on Afar and Somali girls’ and women’s empowerment can be found in the companion evidence synthesis report (Presler-Marshall et al., 2022b).

### 2.1 Pastoral realities

Afar and Somali regions have much in common. Both are primarily desert and home to pastoralists who engage in seasonal migration shaped by rainfall patterns. After

millennia during which inhabitants successfully adapted their livelihoods to environments, both regions are now seeing those livelihoods – and food security – devastated by recurrent climate change-driven drought and invasive species (Oxfam, 2016; UNICEF, n.d.a; n.d.b; Management Entity, 2021; UNOCHA, 2022). Both regions are almost exclusively Muslim, are experiencing very high and increasing population growth, and lag considerably behind the rest of the country in terms of access to basic services and infrastructure (World Bank, 2020b; UNICEF, n.d.a; n.d.b). Due to resource constraints (primarily water, grazing land and trade routes), both regions are also impacted by recurrent clan and ethnic violence that has displaced tens of thousands of people in recent years (Clugston and Fraser, 2022; UNOCHA, 2022; UNOCHA, 2021, cited in Addis Standard, 2021; UNICEF, n.d.a; n.d.b; Ethiopia Peace Observatory, n.d.; Tadesse et al., 2015). In terms of gender dynamics, both regions have skewed gender ratios that are yet to be explained. While the most recent census was conducted 15 years ago, the 2021 Labour Force and Migration Survey estimates that in Afar, there are 106 males for every 100 females, and in Somali, the ratio is estimated at 110:100 (Ethiopia Statistics Service (ESS), 2021). By contrast, at the national level, there are equal numbers of females and males.

In other ways, the two regions are dissimilar. Somali is Ethiopia’s second largest region, and considerably larger than Afar. It also has a larger population (6.6 million compared to 2 million) (ESS, 2021) and is substantially less urbanised (15% compared to 21%) (ibid.). Also, although poverty rates in both regions fell between 2011 and 2016<sup>6</sup> – from 36% to 24% in Afar and from 33% to 23% in Somali – the patterning of progress differs (World Bank, 2020b). In Afar, all progress was made in urban areas, with rural poverty rates unchanged, which meant that inequality grew rapidly (Gini of 37) (ibid.). In Somali, by contrast, all progress in reducing poverty was made in rural areas, largely due to improvements in the agricultural sector and the rural population engaging in trading activities, while

<sup>4</sup> In the case of Somali region, this included conflict between the Liyu regional special forces and the separatist Ogaden National Liberation Front (ONLF) at the time of the census. A peace deal was signed in 2018 ending hostilities in the region.

<sup>5</sup> The 2016 EDHS sampled 549 women aged 15–49 in Afar; in Somali, it sampled 685 women of the same age group.

<sup>6</sup> The most recent Welfare Monitoring Survey was completed in 2015–2016.

urban poverty rates remained unchanged. This meant that in 2016, Somali was the region with the lowest rate of inequality (Gini of 26.2) (ibid.).

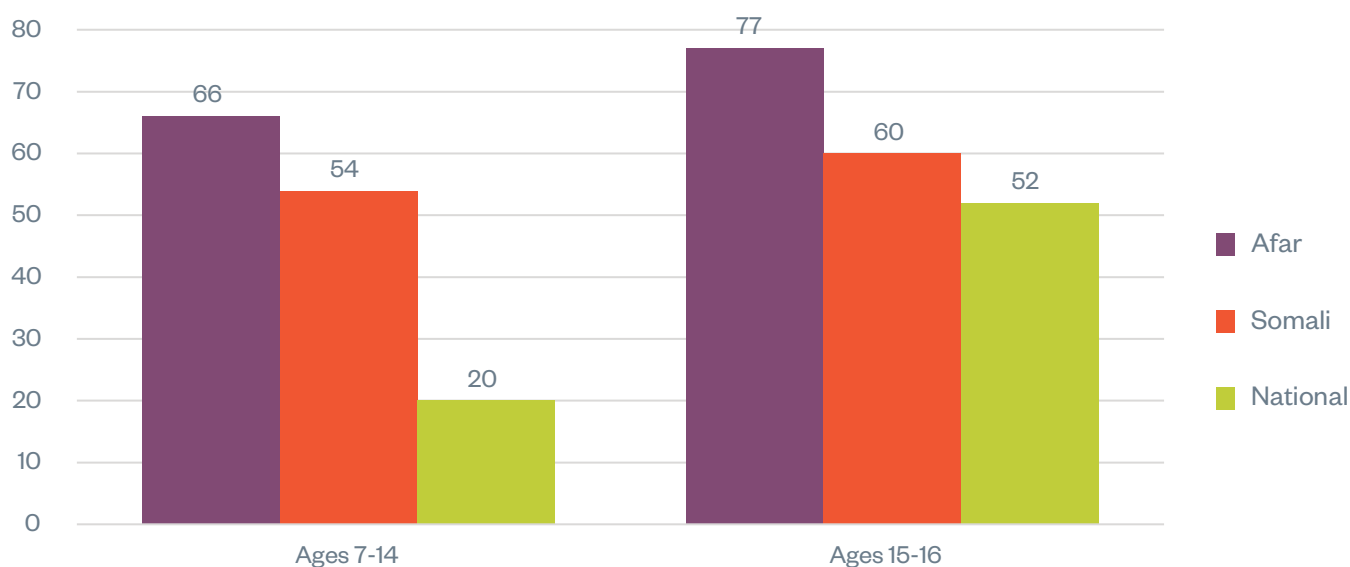
## 2.2 Access to education

Access to education in Afar and Somali has long lagged compared to Ethiopia's other regions, largely because populations are sparse and nomadic, which both complicates the delivery of formal schooling and suppresses demand for it (Woldesenbet, 2015; Jackson, 2011; Muhumed, 2017; Wodajo, 2014; Alemu and Solomon, 2019). Many remote communities do not have schools, and many of those that do have schools lack teachers, learning materials and drinking water (Woldesenbet, 2015; Jackson, 2011; Presler-Marshall et al., 2021; Muhumed, 2017; Wodajo, 2014; Alemu and Solomon, 2019). Parents and students also consider the school calendar to be too rigid – both in terms of hours per day (to accommodate herding) and weeks per year (to accommodate migration) – and the curriculum irrelevant to pastoralist realities (Jackson, 2011; Muhumed, 2017; Wodajo, 2014; Alemu and Solomon, 2019; Woldesenbet, 2015). The situation is especially acute in Afar, because instruction is often not in students' native tongue (there are too few teachers able to speak Afar-af). Although educational provisioning and uptake

are improving, with Elezaj et al. (2019) calculating that enrolment tripled between 2000 and 2016, recent figures underscore the continuing disadvantage experienced by children in both regions. The Ministry of Education (2021) reports that of 7–14-year-olds, 54% of those in Somali and 66% of those in Afar are out of school – compared to a national average of 20% (see Figure 2). Older adolescents (15–19) are even more likely to be out of school: 60% in Somali and 77% in Afar.

Girls in both regions have less access to education than boys, due to complex interactions between cultural, economic and structural factors that leave them both less likely to enrol and more likely to drop out (Goshu et al., 2021; Muhumed, 2017; Wodajo, 2014; Dessalegn et al., 2020; Jackson, 2011). This is because culturally, families do not see girls as worth the investment, as they will eventually marry and leave the household. Girls are also disproportionately burdened with housework and caring for others; they lack female role models; they have few opportunities for paid work; and they marry (and have children) years earlier than the national average (Presler-Marshall et al., 2021; Tiruneh et al., 2021; Jackson, 2011; Wodajo, 2014; Woldesenbet, 2015). The Ministry of Education (2021) reports that in 2021, net enrolment rate<sup>7</sup> in Afar at primary level (grades 1–6) was 48% for girls and 56% for boys (see Figure 3). Rates were

Figure 2: Children out of school, by location and age



Source: Ministry of Education, 2020

<sup>7</sup> Gross enrolment figures, which include students who are over age for grade, are higher than net enrollment figures. In Afar, the primary gross enrolment rate (GER) is 70 for boys and 59 for girls. At middle school level, the GER is 30 for boys and 23 for girls. At secondary level, the GER is 18 for boys and 13 for girls. In Somali, the primary GER is 114 for boys and 86 for girls. The middle school GER is 43 for boys and 32 for girls. The secondary school GER is 29 for boys and 22 for girls. We have reported net enrolment rates rather than GERs in the main text because GERs can be well over 100 and are difficult to interpret.

far lower at middle school level (grades 7–8), with only 12% of girls and 14% of boys enrolled. Only 1 in 10 adolescents in Afar were enrolled at the correct grade for their age at secondary level (grades 9–12) (9% of girls and 11% of boys). Although enrolment rates are generally higher in Somali than Afar, girls’ disadvantage is far starker. The Ministry of Education (2021) reports that while 84% of primary school-aged boys in Somali were enrolled in 2021, only 64% of girls were enrolled. At the secondary level, rates plummet; 23% of boys and 16% of girls are enrolled. High rates of truancy and grade repetition mean that even those who are enrolled tend to make limited academic progress. The Ministry (2021) also reports that although on a national level, girls are more likely to complete primary school than boys (88% compared to 64%), this is not the case in Afar and Somali.

### 2.3 Girls’ and women’s economic empowerment

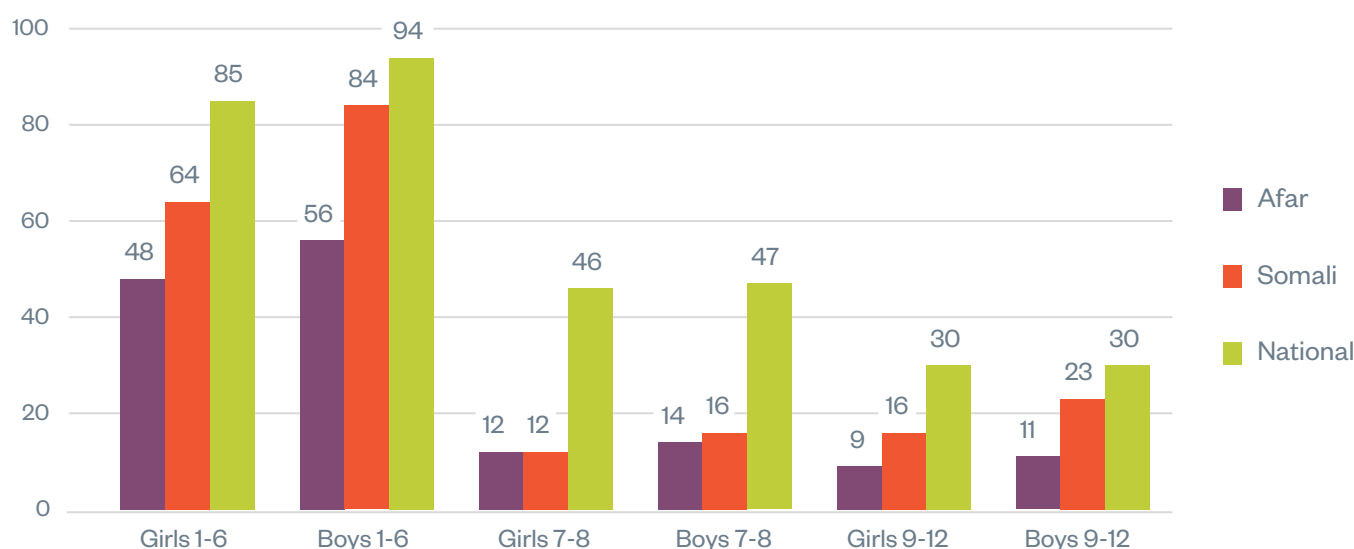
The economic empowerment of girls and women in Afar and Somali is broadly shaped by pastoralism and government efforts to sedentarise populations in river basins where access to irrigation for crop farming – and makes it easier and more efficient to deliver services (Abebe, 2014; Haji and Legesse, 2017; Mahamoud and Ahmed, 2019). In pastoralist areas, females’ access to income is almost exclusively related to livestock (especially small ruminants) and livestock products (especially milk) (Inkermann, 2015; Dessalegn et al., 2020; Ridgewell and Flintan, 2007). In agro-pastoralist areas, where communities are less mobile, women’s livelihood strategies revolve around trading as well as livestock. Their incomes,

while small, can be more dependable than men’s, given that men are more likely to rely solely on livestock (Gurmu, 2018; Balehey et al., 2018; Tekla et al., 2019; Mahamoud and Ahmed, 2019; Oxfam, 2016; United States Agency for International Development (USAID), 2021).

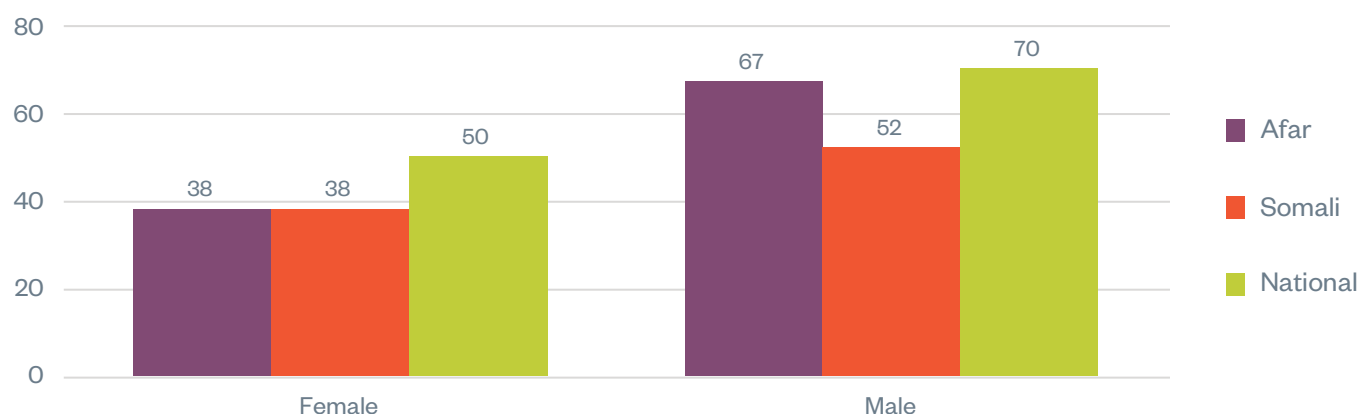
As is common across the country – and indeed sub-Saharan Africa – gender norms that leave Afar and Somali girls and women time poor also limit their economic empowerment (Dessalegn et al., 2020; Inkermann, 2015; Gurmu, 2018; Balehey et al., 2018; Ridgewell and Flintan, 2007). Every day, girls and women must spend amount of time collecting water and fuelwood, which is challenging given the desert conditions and poor water infrastructure – a situation that is also significantly exacerbated by climate change-related drought (Balehey et al., 2018; Oxfam, 2016; Hutchings et al., 2022). It is not unusual for women to spend more than 4 hours each day collecting water (Whitley et al., 2019). They are also tasked with tending smaller livestock that are cared for locally, as well as preparing food, and building, maintaining and cleaning their housing (UNICEF, n.d.a; n.d.b; Dessalegn et al., 2020; Inkermann, 2015; USAID, 2021). Girls and women are also responsible for care work in the context of extremely high fertility rates. Because of how domestic and care work is allocated in pastoralist households, many girls and women do not have time to earn.

There is a wealth of research highlighting the disadvantage experienced by Ethiopian girls and women – including those in Afar and Somali – in terms of their access to productive inputs (including livestock, education and training), their opportunities to save and borrow, and even

**Figure 3: Net enrolment rate, by grade, sex, and location**



Source: Ministry of Education, 2021

**Figure 4: Employment to population ratio, by sex and location**

Source: ESS, 2021

their own earnings (Ayele, 2019; Inkermann, 2015; Gurmu, 2018; Dessalegn et al., 2020; Balehey et al., 2018; USAID, 2021). This gender disparity starts at birth, when girls are given fewer livestock by their parents than boys because girls will ultimately marry out of the family and take their assets with them, and continues into adulthood. Divorcees often get no share of marital assets; widowed female heads of households are especially likely to be poor (particularly if they have only daughters, as men's assets are passed solely to sons and other male relatives); and females are granted less of an inheritance from their parents than males (Dessalegn et al., 2020; Balehey et al., 2018; Teka et al., 2019; USAID, 2021; Fenta, 2017).

Girls' and women's time poverty and limited access to productive assets are reflected in their employment rates, which in Afar and Somali are markedly lower than national averages. With the caveat that it also captures child labour, the 2021 Labour Force and Migration Survey reports that only 38% of females over the age of 10 are employed in both regions, compared to a national average of 50%<sup>8</sup> (see Figure 4) (ESS, 2021).

## 2.4 FGM/C

FGM/C is nearly universal in both Afar and Somali. The most recent EDHS<sup>9</sup> found that of females of reproductive age (15–49 years), 91% in Afar and 99% in Somali had undergone FGM/C (CSA and ICF, 2017) (see Figure 5).

With the caveat that the number of girls sampled in Afar and Somali is small<sup>10</sup>, the rates for adolescent girls (aged 15–19) were nearly as high – 91% and 95% respectively.<sup>11,12</sup>

Among women and girls aged over 15, infibulation (see Box 2) was the most common form of FGM/C practised in both Afar (64%) and Somali (73%) (CSA and ICF, 2017). Despite some recent smaller-scale studies finding that clitoridectomies are replacing infibulation in both regions (Presler-Marshall et al., 2022a; Mehari et al., 2020; Abebe et al., 2020; Getanehe, 2017; Gebremariam et al., 2016; Hussein et al., 2013), the most recent EHDS reports that of girls aged 14 or younger who have undergone FGM/C, shifts towards 'less invasive' types are evident only in Somali region. Indeed, in Afar, girls under 15 are just as likely to be infibulated as girls and women aged over 15 (68% compared with 64%) (CSA and ICF, 2017). In Somali, where Mehari et al. (2020) found that nearly absolute resistance to ending FGM/C has resulted in government officials actively promoting clitoridectomy as an alternative, the EDHS reports that 'only' 33% of out girls aged 14 or younger have been sewn closed (compared to 73% of women) (CSA and ICF, 2017).

The age at which girls are cut varies by region and has important implications for programming. In Afar, cutting is traditionally practised during infancy and early childhood. Although several studies have found diversity across households and communities (Presler-Marshall et al.,

<sup>8</sup> Employment to population ratio of persons over the age of 10.

<sup>9</sup> Data is still being collected for the 2021–2022 EDHS.

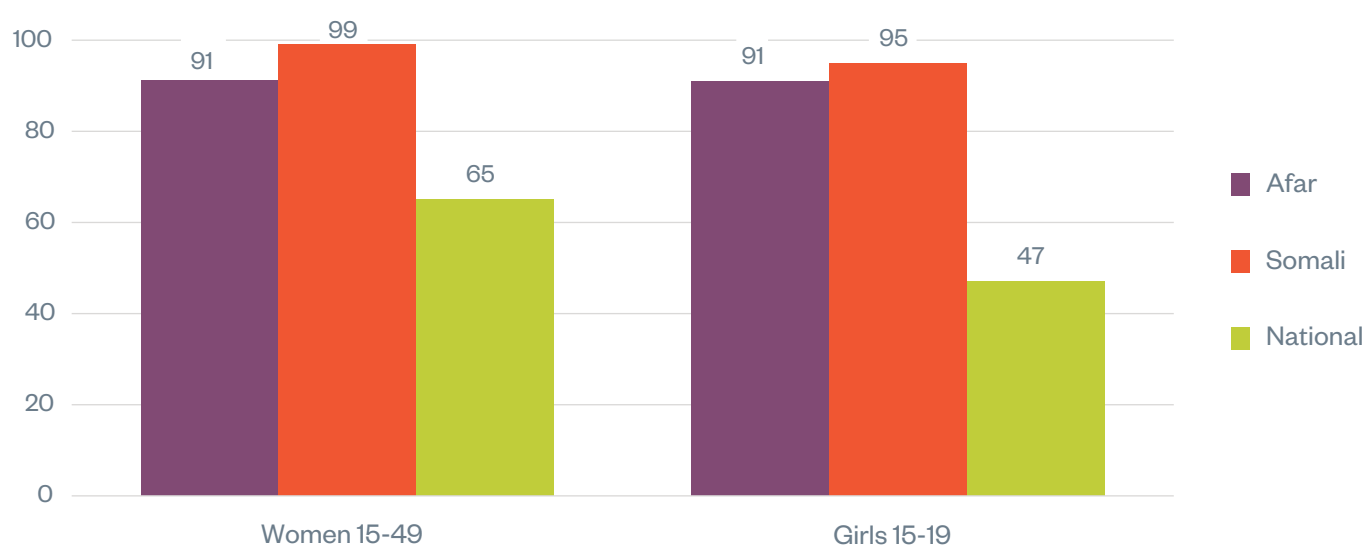
<sup>10</sup> The total number of girls aged 15–19 who were asked questions about FGM/C on the 2016 EDHS was only 139 in Afar and 152 in Somali.

<sup>11</sup> Regional figures for girls aged 15–19 are author's own calculations using unweighted DHS data.

<sup>12</sup> Because in Somali many girls undergo FGM/C in early or even mid-adolescence, the proportion of girls aged 10–14 who have been cut does not necessarily speak to current prevalence. Of girls in that age group, female caregivers report that 86% of those in Afar and 70% of those in Somali have undergone FGM/C (CSA and ICF, 2017).



**Figure 5: Women who have undergone FGM/C by age and location (%)**



Source: CSA and ICF, 2017

### Box 2: Types of FGM/C

World Health Organization (2020) delineates four major types of FGM/C:

- Type 1, often called clitoridectomy, consists of the partial or total removal of the clitoris and/or the clitoral hood. In Ethiopia, this is often called ‘*sunna*’, which has the connotation of being religiously sanctioned. In Arabic, ‘*sunnah*’ means following the path or way of the Prophet Mohammed (Asmani and Abdi, 2008).
- Type 2 consists of the partial or total removal of the clitoris and labia minora, with or without the removal of the labia majora.
- Type 3, often called infibulation, involves the narrowing of the vaginal opening – sometimes with stitching and other times by repositioning flesh until it fuses with scar tissue. Type 3 includes procedures that remove the clitoris as well as those that do not. In Ethiopia, this is sometimes called ‘pharaonic’ cutting.
- Type 4 refers to all other harmful procedures (this type is extremely rare in Ethiopia).

In Ethiopia, it is common for people to refer to FGM/C as ‘female circumcision’. We acknowledge that male circumcision has medical benefits whereas FGM/C has only risks and where the word ‘circumcision’ is used, in quotes by research participants, it is not meant to equate practices, only to be faithful to word choice.

2022a; Andarge, 2014), the EDHS reports that on a regional basis, approximately 85%<sup>13</sup> of older girls aged 15–19 had undergone FGM/C before the age of 5 and UNFPA (2019) reports that of Afar girls living in Ethiopia<sup>14</sup>, 75% were cut by the age of one. In Somali, FGM/C is primarily practised during middle childhood. Of girls aged 15–19, 63% reported having been cut between the ages of 5 and 9, with the remainder more likely to be cut in early adolescence (aged 10–14) than in early childhood (ibid.). Across regions, the EDHS and other research has found that FGM/C is most commonly carried out by traditional cutters, who also generally serve as birth attendants.

In both Afar and Somali, where Islam is the most common religion, there is strong normative and religious

attachment to the practice of FGM/C (see Asmani and Abdi, 2008). The EDHS reports that over half of girls and women in Afar and Somali believe that FGM/C is required by religion and that the practice should therefore continue. Girls’ and women’s support for FGM/C is generally not due to ignorance of the risks involved. Indeed, many studies have found that the risks are relatively well-understood – but are simply perceived as less salient than the social risks of eschewing FGM/C or the advantages of perpetuating it. For example, in Afar’s Zone 5, the GAGE survey found that 44% of older girls and 46% of female caregivers were able to identify at least one risk of FGM/C – the most commonly cited risks being birthing difficulties, infection, and sexual dysfunction. However, an even larger

<sup>13</sup> Authors’ own calculations using unweighted DHS data.

<sup>14</sup> While most Afar girls live in Afar, not all do. UNFPA is reporting by ethnicity, not residence location.

proportion – 56% (girls and caregivers) – reported that FGM/C has advantages (Presler-Marshall et al., 2022a). Girls and women most often said that it improves girls' behaviour (specifically that it lowers their sex drive, leaves them more tractable, and more capable and less clumsy in performing domestic responsibilities. Abdisa et al. (2017) found similar results in Somali. Specifically, although 91% of their sample knew that FGM/C carries health risks – primarily bleeding (36%) and difficult birthing (32%) – 62% believed that FGM/C has the advantage of preserving girls' virginity. Critically, in both Afar and Somali, FGM/C is seen as being a prerequisite for marriage (Presler-Marshall et al., 2022a; Andarge, 2014; Abebe et al., 2020; Abathun et al., 2016, 2018; Gebremariam et al., 2016; Getanehe, 2017; Flintan, 2008; Adinew and Mekete, 2017; Mohamud et al., 2016). Uncut girls are seen as sexually promiscuous – and thus undesirable for marriage. And those who are uncut and unmarried are shamed and ostracised by the community (ibid.).

## 2.5 Child marriage

Afar and Somali are unique among Ethiopia's regions in that they have not yet revised their Family Code to outlaw child marriage<sup>15</sup> (McGavock, 2021). Reluctance to do so is evident in the very high rates of child marriage in both regions. Of women aged 20–24 years at the time of the 2016 DHS, UNICEF reports that 67% of those in Afar and 55% of those in Somali were married before the age of 18, compared to only 40% nationally (see Figure 6) (UNICEF, n.d.a; n.d.b). That same survey, and with caveats about data quality, found that girls in Afar marry earlier than their peers in Somali. The median age at first marriage for women aged 15–49 in Afar was 16.4 years – compared with 18.1 years in Somali (CSA and ICF, 2017).

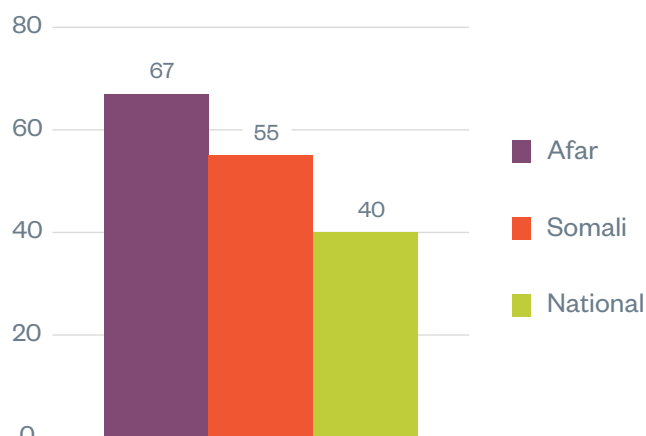
Somewhat worryingly, Elezaj et al. (2019) calculate, using DHS data, that while the incidence of child marriage among girls aged 15–17 is declining nationally, it appears to be increasing in Afar and Somali (see Figure 7). In 2000, at the national level, 20% of girls aged 15–17 were married; by



An adolescent girl with her five-day-old baby in Afdler, Somali region, Ethiopia © UNICEF Ethiopia/2022/Mulugeta Ayene

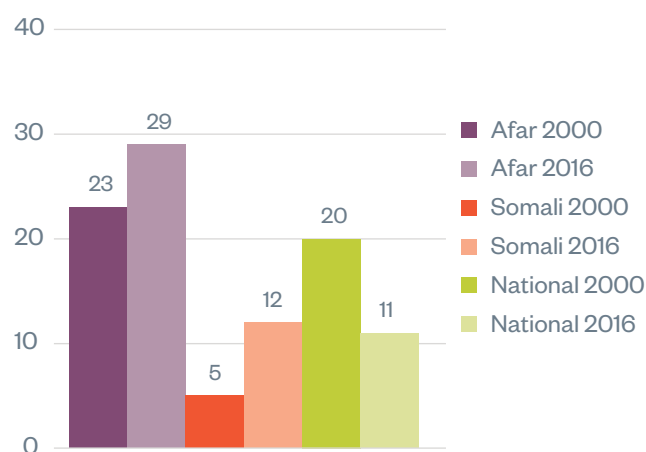
<sup>15</sup> Regional resistance to revising the Family Code is not solely about child marriage; it is also due to polygamy and inheritance law.

**Figure 6: Women aged 20–24 who were married by age 18, by location (%)**



Source: CSA and ICF, 2017

**Figure 7: Incidence of child marriage for girls aged 15–17, by location and time (%)**



Source: Elezaj et al., 2019.

2016, that proportion had almost halved, to 11%. In Afar and Somali, on the other hand, the rate of child marriage had climbed by six and seven percentage points respectively. Although the rate of child marriage in Somali remains far below that in Afar, it is worth noting that it has more than doubled between 2000 and 2016. Rates of adolescent motherhood track rates of child marriage and in Afar are the highest in the country – and climbing. The most recent DHS reports that of girls aged 15–19 in Afar, 23.4% had begun childbearing (CSA and ICF, 2017). In Somali, this figure was 18.7%. Elezaj et al. (2019) note that in 2000, rates were ‘only’ 21% and 13% respectively.

The form that child marriage takes appears to differ starkly across regions. In Afar, a girl traditionally marries an *absuma* (maternal cousin) (Jones et al., 2016; Presler-Marshall et al., 2020; Dessalegn et al., 2020). Girls do not

have any say about when and which cousin they will marry, and some marry men 10 years or more older than they are. In Somali, although Woldesenbet (2015) reports that some parents force girls to marry soon after puberty in order to collect bride price, most girls reportedly marry when and to whom they choose (albeit with pressure to marry early). These different traditions are reflected in the DHS data. In Afar, of married girls aged 15–19, 89% reported that their parents had decided on their marriage (CSA and ICF, 2017). This proportion – like the proportion of girls who marry before the age of 18 – has been static across generations, because *absuma* marriage customs are considered central to reinforcing clan ties (CSA and ICF, 2017; UNICEF, n.d.a; Dessalegn et al., 2020). In Somali, on the other hand, of married girls aged 15–19, 64% reported that they had decided on their own marriage (CSA and ICF, 2017). This proportion has also been static across generations. We found only one study on the drivers of child marriage in Somali, and it cited the reasons for girls’ early marriage as poverty, limited access to education and work, and social pressure (Lelieveld, 2011).

## 2.6 Save the Children programming

Programming to tackle child marriage and FGM/C in Afar and Somali has been expanding over the past decade, in part galvanised by the Action Plan to End Child Marriage and FGM/C. One new initiative, funded by the Irish Embassy in Ethiopia and implemented by Save the Children, is the multi-component programme entitled ‘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 and reduce the impacts of the restrictive gender norms – especially around FGM/C and child marriage – that limit their lives and life choices. The programme is being implemented in three *woredas* (districts) 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). Districts and *kebeles* (community) were chosen, in consultation with regional officials, because of their high rates of FGM/C and child marriage. The programme aims to benefit more than 42,000 individuals, at least 70% of them women and girls.

Drawing on Save the Children’s theory of change for the programme, which recognises the complex interplay between economic conditions and restrictive gender



norms, programming takes an integrated approach, comprising six overlapping workstreams (see Figure 8). These include: (1) supporting girls to access education and training (including school supplies and tutorial support); (2) engaging with girls and women on gendered topics (including through girls' clubs and leadership training); (3) supporting girls and women who are experiencing GBV to access justice and health services; (4) engaging with communities – including boys and men – to address harmful gender norms (through radio listening groups and in partnership with religious and clan leaders); (5) empowering girls and women economically (including through cash transfers and opportunities to save); and (6) capacity-building and coordination to improve services that can support girls to thrive. In each district, the programme is coordinated by Save the Children in partnership with local government officials and service providers, particularly the Bureau of Health and the Bureau of Agriculture and Pastoralists.

**Figure 8: Save the Children programming workstreams**



An unmarried adolescent girl, with her sister, who wishes to complete school before getting married Afar region, Ethiopia © Nathalie Bertrams/GAGE 2022



## 3 Conceptual framing

Informed by the emerging evidence base on adolescent well-being and development captured in the GAGE conceptual framework (GAGE consortium, 2019), this research takes a holistic approach. It pays careful attention to the interconnectedness of what we call the '3 Cs' – capabilities, change strategies and contexts – to understand what works to support and empower adolescent girls to develop their full capabilities, both now and in the future. This framing recognises that social and economic empowerment are inextricably intertwined. It also acknowledges that contexts shape adolescent girls' risks and opportunities, as well as the strategies for promoting change.

The capabilities approach is core to this framing. It was championed originally by Amartya Sen (1984; 2004) and nuanced to better capture complex gender dynamics at intra-HH and societal levels by Martha Nussbaum (2011) and Naila Kabeer (2003). The approach has evolved as a broad normative framework exploring the kinds of assets (economic, human, political, emotional and social) that expand the capacity of individuals to achieve valued ways of 'doing and being'. At its core is a sense of competence and purposive agency; it goes beyond a focus on a fixed bundle of external assets, instead emphasising investment

in an individual's skills, knowledge and voice. Importantly, the approach can encompass relevant investments in girls with diverse trajectories, including the most marginalised and 'hardest to reach' such as those who are disabled or are already mothers.

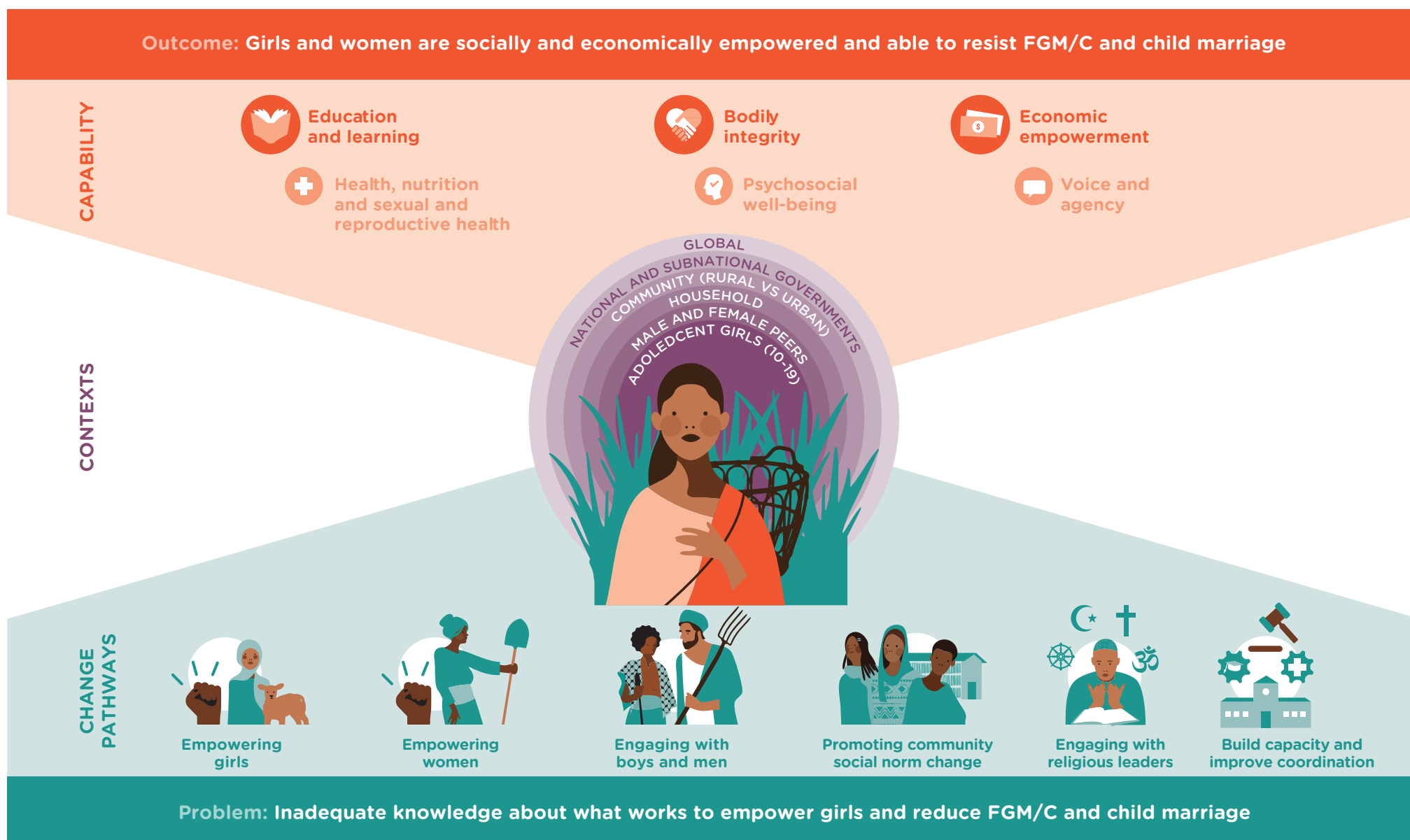
The second building block of our conceptual framework is context. Our model situates girls socio-ecologically and recognises not only that adolescent girls at different stages in the life course have different needs and constraints, but that these are also highly dependent on girls' contexts at the family/HH, community, subnational and national levels.

The third and final building block – change strategies – acknowledges that girls' contextual realities not only shape the pathways through which they develop capabilities but also determine the change strategies open to them to improve their outcomes. Our socio-ecological approach emphasises that to nurture transformative change in girls' capabilities and broader well-being, change strategies must simultaneously invest in integrated intervention approaches at different levels, weaving together policies and programming that support girls, their families and their communities while also working to effect change at the systems level.



Wishing to attend the university and become a teacher, a fourteen-year-old girl from Afar region, Ethiopia © Nathalie Bertrams/GAGE 2022

Figure 9: Conceptual framework



This report focuses on three of the six human capabilities explored through the GAGE programme (see Figure 9): education and learning; bodily integrity (which includes protecting girls from FGM/C and child marriage as well as from age- and gender-based violence); and economic empowerment. In line with GAGE's broader framework,

we recognise that these three capabilities do not stand alone, and that for girls to develop these capabilities they must also be supported to develop good health (including SRH), voice and agency, and psychosocial well-being (Baird et al., 2021).

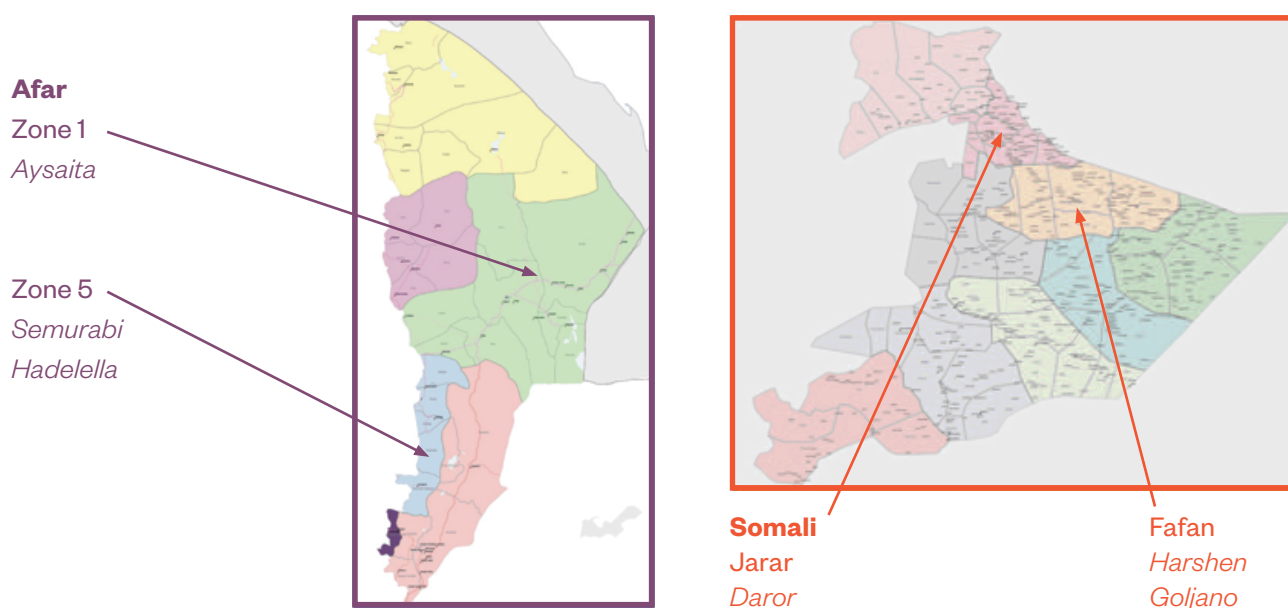
## 4 Methods

This report draws on mixed-methods research undertaken between January and April of 2022 with 2,042 adolescents and their primary caregivers, as well as approximately 100 key informants from *kebele* to regional level. Research was conducted in Afar (Zones 1 and 5) and Somali (Fafan and Jarar) (Figure 10) and has two aims: to build the evidence base on FGM/C, child marriage and girls' empowerment in these two under-researched regions; and to provide a baseline against which to evaluate impacts of Save the Children's programming. Future rounds of research are planned for 2024 and 2026, and will explore how programming is being rolled out and whether and how it might contribute to change. This baseline round of research included quantitative and qualitative research which we now describe in more detail.

### 4.1 Quantitative

We fielded two face-to face tablet-based quantitative surveys that were given in participants' homes, one with adolescents, the other with their primary caregiver. Our sample of 2,042 households – which was calculated to be large enough to allow us to detect a 10% change in the prevalence of FGM/C and child marriage (see Annex 1) – was equally split between Afar and Somali, and targeted 18 rural<sup>16</sup> *kebeles* in each region. We surveyed girls and boys aged 10–19, making sure to include those in and out of school. We surveyed adolescents' primary caregivers in male-headed, female-headed and polygamous households. To allow us to explore the impacts of access to services, half of the sampled *kebeles* were relatively near the *woreda* town (<15 km) and half were remote (up to 50 km). To track

Figure 10: Research locations



<sup>16</sup> All *kebeles* included in our research are considered rural by regional governments. In Somali, several *kebeles* (Lankyrta in Harshen *woreda*, and Abekor, Rabaso, and Waba'ado in Daror *woreda*) have semi-urban features, such as secondary schools and health centres. In Afar, only one *kebele* (Korodora in Aysaita *woreda*) has these features.

**Figure 11: Quantitative sample**

	Treatment		Control	
	Adolescents and caregivers are both participating in programming	Caregivers are participating, adolescents are not	Adolescents are participating, caregivers are not	Adolescents and caregivers are not participating
<b>Total</b>	340 households (HHs) across 6 <i>kebeles</i>	340 HHs across 6 <i>kebeles</i>	340 HHs across 6 <i>kebeles</i>	1,020 HHs across 18 <i>kebeles</i>
<b>Somali</b>	170 HHs across 3 <i>kebeles</i>	170 HHs across 3 <i>kebeles</i>	170 HHs across 3 <i>kebeles</i>	510 HHs across 9 <i>kebeles</i>
<b>Afar</b>	170 HHs across 3 <i>kebeles</i>	170 HHs across 3 <i>kebeles</i>	170 HHs across 3 <i>kebeles</i>	510 HHs across 9 <i>kebeles</i>

the impacts of Save the Children programming over time, our sample has 9 treatment communities and 9 control communities. Households in the treatment (programming) communities are further subdivided into three categories: (1) those where adolescents and caregivers are participating in programming; (2) those where adolescents are participating in programming but caregivers are not; and (3) those where caregivers are participating in programming but adolescents are not. The control communities will not receive programming (see Figure 11 and Table 1). In treatment communities, participating households were randomly drawn from programme beneficiary lists provided by Save the Children and *woreda* officials.

The round 1 caregiver and adolescent surveys (which can be found in full here and here), covered eight themes:

1. Adolescent girls' experiences of FGM/C
2. Adolescents' experiences of marriage and relationships
3. Adolescents' access to education
4. Adolescents' experiences with paid work and access to financial services, credit and savings
5. Adolescents' mobility, involvement in decision-making, and presence of role models
6. Adolescents' SRH, including menstrual health management

7. Personal gender attitudes and community gender norms
8. Programme participation

The caregivers' survey also included questions on HH socioeconomic conditions, including whether the HH was participating in the government's flagship social protection scheme – the Productive Safety Net Programme (PSNP) – which is aimed at vulnerable households in food insecure *woredas* and is meant to prioritise FHH in recognition of their greater vulnerability.

In terms of the quantitative analysis, while descriptive methods such as mean differences are useful in examining how the outcome variable varies according to different explanatory variables, such methods do not help in identifying the relative importance of specific covariates. Thus, descriptive analyses need to be supported by regression analysis to draw important conclusions and policy lessons. The estimation method depends on the nature of the outcome variables. In this section we have identified three outcome variables: (1) caregivers' and adolescents' beliefs about whether FGM/C should continue; (2) caregivers' and adolescents' views about delaying child marriage until secondary school completion; and (3) adolescents' preference for marriage in adulthood.

**Table 1: Breakdown of quantitative sample by gender and participant**

	Afar		Somali		Total
	Control	Treatment	Control	Treatment	
Caregivers	516	506	509	511	2042
Female caregivers	449	474	430	454	1807
Male caregivers	67	32	79	57	235
Adolescents	516	506	509	511	2042
Adolescent girls	442	435	395	391	1663
Adolescent boys	74	71	114	120	379



All of these outcome variables are dummy variables<sup>17</sup> and the most common method of estimating dummy dependent variables is a probit model, which assumes a normal distribution of the error term. Thus, the probit model is employed to estimate the correlation of the covariates with the outcome variables, controlling for other factors. We report the marginal effects of the covariates in the tables below. Robust standard errors are reported and *kebele* (community-level) dummies are included in each regression to account for *kebele*-specific effects. Due to differences in marriage arrangement types, age at the time of FGM/C, and FGM/C types between Afar and Somali regions, the regressions are performed separately for each region.

## 4.2 Qualitative

Our qualitative sample was purposively selected from the larger quantitative sample. It includes 522 individuals in 8 rural *kebeles* in 4 *woredas*, split equally between regions and treatment/control groups (see Figure 12 and Tables 2a, 2b and 2c). In each *kebele*, we conducted focus group discussions (FGDs) – some with adult women and men, and others with married and unmarried adolescent girls and boys of varying ages. We also conducted key informant interviews (KIIs) with teachers, health extension workers, and development agents. At the district and regional levels, we interviewed government officials, service providers, clan and religious leaders, and sectoral staff from key bureaux. Interviews explored the prevalence and patterning of child marriage and FGM/C as well as the structural factors and actors working to promote – or inhibit – changes in girls’ lives and were conducted either in participants’ homes or places of work (in the case of key informants).

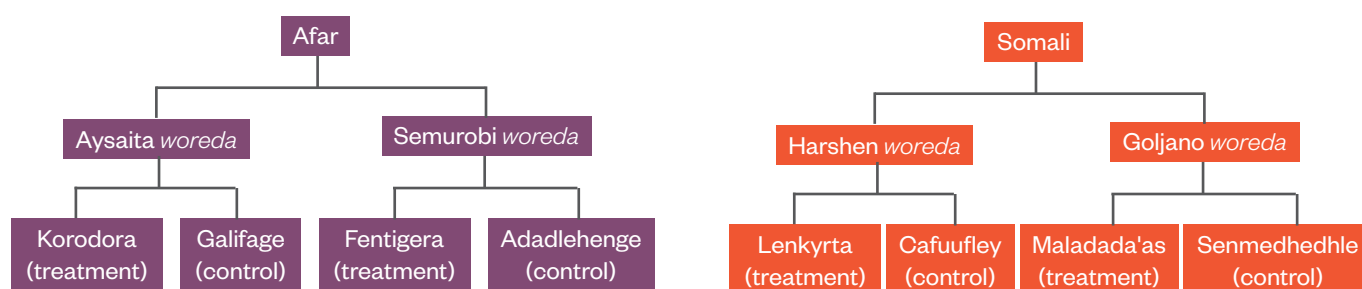
diverse norms and practices in each community. Tools focused on FGM/C (using pictures to aid conversations about the different types of cutting practised, see Figure 13), child marriage, and opportunities for girls and women to access education and employment. They also explored girls’ and women’s opportunities to influence personal and HH decision-making, and their experiences of SRH (including menstrual health management), and SGBV. In treatment communities, tools also addressed exposure to programming (of participants and implementers) and any early impacts thereof.

In terms of the qualitative data analysis, all interviews were transcribed and translated, and then coded in the qualitative software package, MAXQDA, following a thematic code book, informed by the conceptual framework discussed above.

## 4.3 Research ethics

Before research commenced, ethical clearance was received from the Research Ethics Committee of the Ethiopian Sociologists, Social Anthropologists and Social Workers Association (ESSSWA), a Ministry of Science and Innovation-accredited body to carry out national research ethics reviews. All interviewers were trained to interact appropriately with vulnerable adolescents and adults, including on sensitive topics such as FGM/C. Before interviews commenced, participants were informed of their right to refuse to participate – including to withdraw consent at any time during the interview – and about confidentiality and data security protocols. Informed assent (for minors under age 18) and informed consent (for adults aged 18 and over) was then obtained from all participants.

Figure 12: Qualitative sampling frame



<sup>17</sup> Adults’ and adolescents’ views about the desirability of FGM/C and child marriage were captured on a three-point scale: should continue, should not continue, and ‘it depends’. Answers were overwhelming clustered around responses 1 and 3. Adolescents’ preference for adult marriage was constructed based on their numeric responses for marriage before age 18 (child marriage) and 18 or above (adult marriage).

**Table 2a: Qualitative sample with adolescents, caregivers and community leaders**

	Afar		Somali		Total
	Control	Treatment	Control	Treatment	
<b>FGD girls</b>	6 (6 people for each group)	6 (6 people for each group)	5 (6 people for each group)	6 (6 people for each group)	<b>2042</b>
<b>FGD boys</b>	6 (6 people for each group)	6 (6 people for each group)	6 (6 people for each group)	6 (6 people for each group)	<b>1807</b>
<b>Total adolescents</b>	24	23	79	57	<b>235</b>
<b>FGD women</b>	2 (6 people for each group)	2 (6 people for each group)	2 (6 people for each group)	2 (6 people for each group)	<b>2042</b>
<b>FGD men</b>	2 (6 people for each group)	2 (6 people for each group)	2 (6 people for each group)	2 (6 people for each group)	<b>1663</b>
<b>Total caregivers</b>			114	120	<b>379</b>
<b>FGD community leaders</b>	2 (4 people for each group)	2 (4 people for each group)	2 (4 people for each group)	2 (4 people for each group)	
<b>Total community leaders</b>					
<b>IDI girls (10–14 years)</b>	-	11	-	10	
<b>IDI girls (15–19 years)</b>	-	9	-	9	
<b>IDI girls (married)</b>	-	1	-	-	
<b>Total IDI girls</b>	20	19			
<b>Total IDI women</b>	19	19			

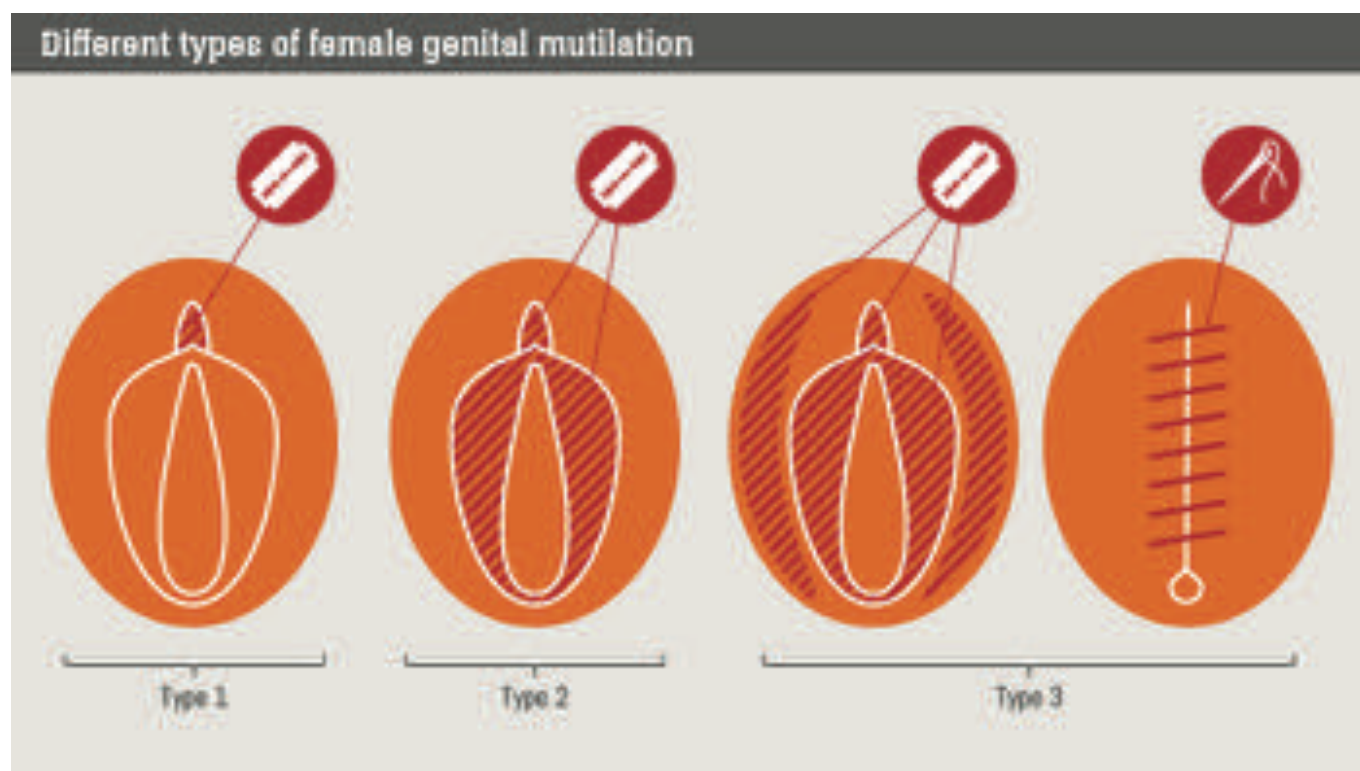
**Table 2b: Qualitative sample with key informants at community level**

Research site		Health extension worker	Traditional cutter	Teacher	Women Affairs Bureau	Religious leader	Clan leader	School principal	Development agent	Kebele chair	Total
<b>Afar</b>	Fentigera		1	1	1	1	1	1			6
	Adadelhengeg		1	1		1					3
	Koro Dora		1	1	1	1	1	1	1	1	9
	Galifage		1		1					1	4
<b>Somali</b>	Lankyrta		1		1		1	1	2	1	8
	Afufuley		1		1						3
	Melkadaas			1	1	1	1	1			6
	Senmededhele		1								2
<b>Total</b>		<b>7</b>	<b>2</b>	<b>6</b>	<b>4</b>	<b>4</b>	<b>4</b>	<b>5</b>	<b>3</b>	<b>6</b>	<b>41</b>

**Table 2c: Qualitative sample with key informants at district and regional levels**

Research site		Save the Children Programme Officer	Bureau of Women and Social Affairs	Bureau of Health	Bureau of Justice	Bureau of Education	Bureau of Agriculture	Sharia court	Religious council	Total
<b>Afar</b>	Semurobi	1	1	1	1	1	1	1	1	8
	Aysaita	1	1	1	1	1	1	1	1	7
	Semera / regional	1	1	1	1	1	1	1	1	7
<b>Somali</b>	Harshin	1	1		1			1	1	6
	Goljano	1	1	1	1	1		1		6
	Jigjiga / Regional	1	1	1	1	1		1		6
<b>Total</b>		<b>6</b>	<b>6</b>	<b>5</b>	<b>6</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>2</b>	<b>40</b>

**Figure 13: Pictorial representation of types of FGM/C used by researchers to help guide sensitive conversations**



# 5 Findings

## 5.1 Background characteristics of households and adolescents

### Key findings

- Most households are large, dependent on livestock, and very remote.
- Few caregivers – especially female caregivers – have ever attended formal education or are literate.
- Households in Afar are far more likely to depend on livestock than households in Somali.
- Reporting of polygamy varies by region – in Somali, many caregivers in polygamous households report that the HH is female-headed.
- Afar households are more likely than Somali households to have ever received PSNP.

Across regions, sampled households have much in common. They are typically large, remote, and headed by an adult who is illiterate (see Table 3). Many households are polygamous, though how that is reported by caregivers varies by region and may have implications for other more

domain-specific findings. Those in Afar are more likely to admit to polygamy and those in Somali are more likely to report being female-headed. However, there are also important differences between the two regions that shape adolescents' lives. For example, HH heads in Somali are far more likely to be literate than those in Afar (25% vs. 11%) and livelihoods in Afar are far more likely to be shaped around rearing livestock than those in Somali (71% vs. 42%) – where common livelihoods also include sales/retail. Also, although households in Afar are no more likely than those in Somali to be currently benefiting from the PSNP (7% vs. 10%) – and are indeed better off based on a wealth index<sup>18</sup> – they are far more likely to have done so historically. Nearly half (49%) of Afar households reported having ever benefited from the PSNP, compared to only 13% of Somali households. Adolescents, whose average age was 13.2, are also similar across regions, although the Afar sample includes more girls than the Somali sample (86% vs. 77%).

Survey findings also highlight intra-regional differences that shape adolescents' lives (see Table 4). In Afar, heads of households in *kebeles* closer to the *woreda* town were significantly more likely to have ever attended formal education than HH heads in more distant communities (11% vs. 7%;  $p < .05$ ). The reverse was true in Somali, with HH heads in more distant communities more likely to have attended school than those in *kebeles* closer to the *woreda* town (18% vs. 13%). However, the qualitative findings indicate that this was because of the proximity of these communities to the main road, which meant that although they were further from the district town, they had relatively good access to education services. We also found that some communities in Goljano district, although close to the district town, had only been able to access education quite recently due the protracted conflict with the ONLF. The patterning of polygamy was similar. In Afar, polygamous households were concentrated in more distant communities (18% vs. 12%). In Somali, and with the caveat that our qualitative research suggests the opposite, they were concentrated in communities closer to

**Table 3: Sample characteristics, by region**

Characteristic	Afar	Somali
HH size	6.5 members	7.1 members
<i>Kebele</i> distance from <i>woreda</i> town	32 km	35 km
Literacy of HH head	11%	25%
HH head ever attended formal education	9%	16%
Polygamous HH	16%	7%
Female-headed HH	20%	60%
HH livelihoods depend on livestock	71%	42%
HH currently receiving PSNP	7%	10%
HH ever received PSNP	49%	13%
Mean age of adolescents	13.3 years	13.1 years
Adolescent participants: female	86%	77%

<sup>18</sup> Wealth index is a relative measure of wealth status which is created from households' ownership of HH assets, livestock and land using principal component analysis. Based on the wealth index scores, households are categorised into five quintiles: poorest, poor, medium, wealthy and wealthiest. For details see Fry et al. (2014) and World Food Programme (2017).



**Table 4: Sample characteristics, by region and distance from *woreda* town (%)**

Characteristic	Afar		Somali	
	Close	Far	Close	Far
HH head ever attended formal education	11	7	13	18
Polygamous HH	12	18	10	6
HH head primary activity is livestock	60	81	Not significant	
HH currently receiving PSNP	10	5	3	13
HH ever received PSNP	53	46	4	17

the district town (10% vs. 6%). In Afar, households living in communities closer to town were more likely to have ever benefited (and to be currently benefiting) from the PSNP than those in more remote communities. Kalls suggested this could be a result of poor targeting as well as neglect of remote *kebeles*. In Somali, the reverse was true, with households in communities far from the town significantly more likely to have ever benefited from (or be currently benefiting from) the PSNP. In Afar, but not Somali, tending livestock was more common in *kebeles* far from town (81% vs. 60%).

The qualitative findings also highlight these intra-regional differences and the impact they have on adolescents' lives. In Afar, in *Aysaita woreda* (in Zone 1), which is more urbanised and (according to key informants) more politically powerful, access to services is better. *Semurobi woreda* (in Zone 5), however, is not only more remote and politically marginalised but has seen livelihoods recently decimated by an invasion of locusts, compounded by conflict with the Tigray People's Liberation Front (TPLF). In Somali, those living in Daror and Harshin *woredas* regularly move back and forth across the border into Somaliland, given their close clan ties. There, they access education and work, with little attention paid to citizenship. In Goljano, protracted conflict has limited children's and adolescents' access to education.

Across both regions, we found some differences between treatment and control communities that are worth noting because they are likely to affect our future findings. In Afar, households in control communities are more remote (34 km vs. 30 km), less likely to be headed by a woman (16% vs. 25%), but also less poor – based on the wealth index – than those in treatment communities. In Somali, households in control communities are significantly

less likely to be headed by a literate HH head (17% vs. 32%), more likely to be engaged in rearing livestock (53% vs. 33%), less remote (34 km vs. 37 km), and poorer than those in treatment communities. All differences were significant at least at the  $p < .01$  level.

## 5.2 Access to education and learning

### Key findings

- A large minority of adolescents have never enrolled in school.
- Adolescents in Somali are less likely to have been enrolled than their peers in Afar.
- Across regions, girls are less likely to have enrolled than boys, primarily due to conservative gender norms – the gender gap is especially large in Somali.
- Across regions, girls are more likely than boys to have already dropped out of school – due to concerns about their safety en route to school, limited school wash facilities, and child marriage.
- Across regions, adolescents are years over age for grade.
- Access to education raises adolescents' aspirations.

In line with existent evidence, and with implications for how to best reach adolescents with programming, our research found that adolescents' access to education in both regions is poor (see Table 5). A staggering 39% of young people in the Somali sample, and 27% of the Afar sample, reported having never been enrolled – and 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. In Somali, 10% of ever enrolled girls were not currently enrolled, compared to only 5% of boys; in Afar, the figures were 10% and 4% respectively. For the young people who were enrolled at the time of our survey, nearly all were over age for grade. Adolescents who are aged 13 should be in 6<sup>th</sup> or even 7<sup>th</sup> grade. Those in our sample, however, had (on average) only recently begun 4<sup>th</sup> grade. In Afar, as might be expected, adolescent girls and boys in more remote communities have significantly ( $p < .05$ ) more limited access to education than those in *kebeles* closer to the *woreda* town. For example, only 16% of girls in communities close to the town had never enrolled,

**Table 5: Access to education, by region and gender and distance to woreda town**

	Afar		Somali		
	Girls	Boys	Girls	Boys	
Never enrolled	27%	23%	43%	27%	
Close/ far	16%	38%	17%	29%	not significant
Already dropped out	10%	4%	10%	5%	
Close/ far	7%	13%	4%	5%	not significant
Mean grade of those enrolled	4.3	4.6	4.5	3.7	

compared to 38% of those in more remote communities. Girls in more remote communities are also more likely to have already dropped out than those living closer to the woreda town (13% vs. 7%). In Somali, distance to the woreda town was not significant.

Our qualitative work identified multiple and intersecting barriers to accessing education. 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 – all fundamentally related to the fact that girls' education is less valued by families and communities than boys'. Barriers 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 (see Box 3); and lack of safe transport to secondary school. In Afar, families' preferences that girls marry young in order to ensure that they agree to an arranged marriage and produce children for the clan is also a powerful driver. As a 15-year-old adolescent girl from kebele A (Afar) noted: *'The mother becomes afraid of her as she grows older because the mother feels like the girl will say no to her family [i.e. their request to marry an absuma or maternal cousin]'*. In Somali,

the worry that girls might have sex before marriage and bring shame to the family is similarly a powerful barrier to continuing school attendance, especially as girls age. *'They [parents] arrange marriage for girls to prevent harms that happen. She may become sexually active before marriage and perform things that are not allowed by religion,'* explained a 15-year-old adolescent girl from kebele E (Somali). Respondents in Somali also reported that school feeding had, in the past, encouraged enrolment, but after it was discontinued, enrolment began to decline.

In-school girls underscored the importance of addressing these barriers to girl's education to reducing FGM/C and child marriage. A 15-year-old girl from kebele A in Afar explained that she and her peers had learned about both at school – and that they were disseminating lessons to their mothers:

*We tell them [our mothers] that what we heard and how its not good for her to be circumcised. We do tell them not to get married their daughters to fathers [old men] too.... Previously they didn't listen but now they hear us out...They recognise our education.*

A 17-year-old girl from kebele E in Somali added:

*The guy from the Education Bureau told us about the FGM and early marriage. He advised us to continue our education and it will also lead to physical pain....I agree with him because FGM leads to too much pain, bleeding and may even lead to death during baby delivery.*

Our survey also found that access to education raises adolescents' aspirations for future employment (see Table 6). Of the adolescents in our sample in Afar, the most common aspirations among young people who had never attended school were to be a housewife (41%), farmer (13%) or housemaid (9%). Of those who had ever enrolled, however, approximately half aspire to a professional job, with the top choices being teaching (18%) and salaried work in business management and accounting (18%). Patterning

**Table 6: Top occupational aspirations of adolescents, by region and enrolment status (never or ever)**

Afar		Somali	
Never enrolled	Ever enrolled	Never enrolled	Ever enrolled
<ul style="list-style-type: none"> <li>• 41% housewife</li> <li>• 13% farmer</li> <li>• 9% housemaid</li> </ul>	<ul style="list-style-type: none"> <li>• 18% teacher</li> <li>• 18% salaried worker in business management and accounting</li> <li>• 11% government employee</li> <li>• 10% health extension worker</li> <li>• 4% farmer</li> </ul>	<ul style="list-style-type: none"> <li>• 13% farmer</li> <li>• 13% housewife</li> <li>• 13% teacher</li> <li>• 12% doctor</li> <li>• 12% own shop</li> </ul>	<ul style="list-style-type: none"> <li>• 30% teacher</li> <li>• 20% doctor</li> <li>• 14% health extension worker</li> <li>• 10% government employee</li> <li>• 2% farmer</li> </ul>

### Box 3: Managing menstruation

The survey found interesting regional differences in how girls manage their periods. In our sample, girls in Somali (aged 13 years on average) had started their periods a full year before their peers in Afar (14.1 years) (see Table 7). Somali girls also had more limited access to disposable period products and were more likely to report that their normal activities are restricted by menstruation (24% vs. 14%). In Somali, girls were most likely to report menstruation-related restrictions around taking part in religious worship or activities. In Afar, girls reported restricted access to school and work.

**Table 7: Girls' experiences with menstruation, by region**

	Afar	Somali
Girls already menstruating	32%	47%
Mean age of menarche	14.1 years	13 years
Type of period product used		
Cloth/non-reusable rags	53%	62%
Home-made reusable pads/cloths	20%	27%
Disposable pads	31%	12%
Activities restricted by menstruation	14%	24%
What activities? (of these reporting)	School 40% Work 28%	Fasting 79% Mosque 38%

Across both regions, only a small minority of enrolled girls reported that their school has facilities or resources to help girls manage menstruation (see Table 8). Girls in Somali (72%) were more likely than their peers in Afar (46%) to report that their school has separate toilets for girls and boys. They were also, however, more likely to report that their school has no toilets at all (12% vs. 4%).

**Table 8: School facilities by region (%)**

	Afar	Somali
Schools has menstrual hygiene management (MHM) facilities	13%	12%
Schools has separate toilets for boys and girls	46%	72%
Schools has no toilets	4%	12%

is similar in Somali: of those who have ever enrolled, nearly three-quarters have professional aspirations, with top choices being medicine (34%) and teaching (30%). Of those who have never enrolled, only one-quarter have professional aspirations. All reported differences are significant at least at the  $p < .05$  level.

As with pastoralist adolescents taking part in GAGE research, very few adolescent survey respondents who were ever enrolled in formal education aspire to become farmers of any sort (4% in Afar and 2% in Somali). Climate change plays a large role in this, as young people can see that regardless of the stable livelihoods it used to provide in the past, pastoralism is becoming untenable.

Adolescents' aspirations reflect contextual differences between Afar and Somali. On the whole, we found that aspirations are 'lower' among adolescents in Afar. This is because access to education remains more challenging there, and young people have fewer educated role models to inspire them. In Somali, adolescents' aspirations are often highly unrealistic, with even those who have never attended school reporting aspiring to become a doctor. Somali's trading culture is also reflected in adolescents' aspirations, with 12% of uneducated adolescents aspiring to open their own shop. In Afar, less than 4% of adolescents aspired to do the same.

## 5.3 FGM/C

### Key findings

- Across regions, most girls have undergone FGM/C.
- More girls in Afar than Somali have already undergone FGM/C – but this is because of differences in the way FGM/C is practiced.
- In Afar girls are cut as infants; in Somali, they are cut in late childhood.
- Mothers are the primary deciders of if and when girls will undergo FGM/C.
- Nearly all girls are cut by traditional cutters – but there is growing evidence of medicalisation in Somali.
- Across regions, participants highlight cultural identity as the primary driver of FGM/C.
- Somali participants are more likely to report a religious mandate for FGM/C than Afar participants.
- Participants are more likely to report that FGM/C has benefits – primarily controlling girls' sexuality and ensuring their marriageability – than risks.
- A majority of respondents agree that FGM/C should continue.
- Knowledge of the law criminalising FGM/C is low overall; caregivers in Somali have less accurate knowledge of the law than those in Afar.
- FGM/C is not a 'one off' event – it results in a lifetime of pain and trauma.

### 5.3.1 Incidence and timing

In Afar, nearly all girls (96%) have heard of FGM/C (see Table 9). In Somali, where it is taboo to discuss topics that touch on sexuality, more than a fifth of girls (22%) purported not to have heard of the practice. Across regions, most girls who had heard of FGM/C admitted to having been cut. Using the full sample, rates are far higher in Afar (97%) than Somali (72%). This should not, however, be interpreted as evidence that Somali is making more progress towards eliminating FGM/C than Afar. Rather, it highlights differences in how FGM/C is practiced. Whereas in Afar, nearly all girls are cut during infancy (in our sample around their first birthday), in Somali, girls are cut any time up until right before marriage. This means that many girls in our Somali sample who have not yet been cut will likely undergo the practice in the coming years. A 13-year-old girl from *kebele* G in Somali emphasised that her experience was very painful and that her suffering was not unusual but rather commonplace for girls in her community. She recalled:

*They tied me up in a rope for 10 days and I had to lie down on my side so I could pee. I was in a lot of pain and it was very troublesome... It wasn't just me who went through that pain and trouble a lot of girls went through it as well.*

Although our survey found that approximately one-third of Somali girls have input into the timing of FGM/C, which has implications for programming aimed at elimination, another girl the same age from *kebele* E reported this is uncommon in her community. She said:

*No girl refuses circumcision. The decision about FGM/C is made by mothers, and mothers are the one that decide about the practices. Parents are concerned about criticism from the community for not allowing the girl to get circumcised. No one asks the girl's opinion when they plan to circumcise her.*

**Table 9: FGM/C practices, as reported by adolescent girls, by region (and distance to *woreda* town)**

	Afar	Somali
Have heard of FGM/C	96%	78%
Have been cut (of those who have heard)	97%	72%
Close/ far	Not significant	63% 76%
Mean age of FGM/C (of girls who have been cut)	1 year	9 years
Input into timing (of cut)	Not applicable	33%

In Somali, girls in more remote communities are significantly more likely to have been cut than their peers living in *kebeles* closer to the *woreda* town (76% vs. 63%;  $p < .01$ ). This is not the case in Afar. Although our midline and endline research will confirm whether this is because girls in more central communities are cut when they are older – or are less likely to be cut due to exposure to education and programming – our baseline qualitative research strongly suggests the former, with girls effectively unable to avoid being cut. As a 16-year-old girl from *kebele* A noted:

*If a girl refused to be cut or her mother refused, she will experience FGM even if she doesn't want to because the other women will do it forcedly. The mother also believes it's mandatory religiously to cut the clitoris so she will not refuse.*

A 13-year-old girl from the same community added that even if FGM/C is delayed in Afar – and girls are cut in early adolescence rather than in infancy as it is common – girls still have extremely limited agency. She noted:

*No one discuss FGM/C with girls. Girls may run away, if they heard they are going to experience it. Parents call a boy that hold the girl then they tie to limit her movement and perform FGM/C... They will tie her leg and hands, and someone will sit on her stomach and the circumciser do the circumcision then.*

With the caveat that a single point in time does not allow us to disentangle the effects of age and recent progress – because older girls may be at greater risk of FGM/C because of their age (and impending marriage) and/or because their birth cohort pre-dates government efforts to eliminate FGM/C – comparing younger girls (age 10–14) and older girls (age 15–19) in Somali provides a different lens through which to view the region's 'progress' (see Table 10). Compared to older girls, younger Somali girls

**Table 10: FGM/C practices in Somali, as reported by adolescent girls, by age cohort**

	Somali girls (age 10–14)	Somali girls (age 15–19)
Have heard of FGM/C	74%	86%
Have been cut (of those who have heard)	65%	85%
Mean age of FGM/C (of girls who have been cut)	9 years	9.7 years
Input into timing (of girls who have been cut)	28%	40%



are significantly less likely to have heard of FGM/C (74% vs. 86%;  $p < .01$ ) and to have been cut (65% vs. 85%). However, our qualitative findings suggest that this may represent under-reporting, as it is not socially acceptable to discuss SRH issues in Somali (in Afar, by contrast, adolescent and caregiver respondents discussed such issues more openly). Younger girls in Somali were also cut at a younger age (see Box 4) and were less likely to have had input into timing (28% vs. 40%). As a 15-year-old girl from *kebele* G (Somali), who had been cut at age 8 explained:

*First of all, the lady [circumciser] came and they called me... I didn't know that there was a circumcision, my mother and her sister, my aunt caught me then once they had made sure I couldn't move anymore, she started cutting off my organs. After she is done with cutting, she put some medicine on the wound and tied my legs together and that is all I can remember.*

Our key informant interviews underscore that it will be extremely difficult to completely eliminate FGM/C in Afar and Somali. Stakeholders reported that regional officials are willing to accept donor money for this purpose – but are not committed to it – and that within the Bureaux of Women Affairs, women's voices are sidelined. They also noted that past efforts to address FGM/C have faded in recent years. A key informant from *kebele* G (Somali), explained:

*From the past four years, there is no information about girls' circumcision and whether it has been eradicated or they are hiding. No one knows. Five years ago, we from school, health workers, kebele leaders and other members of the community used to create awareness on girls'*

*circumcision. There was an incident where a woman in this kebele that was circumcising girls was caught and arrested. Before, because of the awareness, the information of girls' circumcision was available, but now there is no awareness and no information about circumcision.*

Save the Children staff in Somali region reported that it is not possible to engage in conversations about eliminating FGM/C there as the practice is simply too entrenched.

### 5.3.2 Perpetrators

In both Afar (89%) and Somali (83%), based on female caregivers' responses, our survey found that girls most often undergo FGM/C by traditional cutters. In Afar, these women are generally unpaid or paid very little and perform their 'service' as part of cultural responsibilities. As a 15-year-old girl from *kebele* C (Afar) noted, 'There is a circumciser and this is her role in the community; she is paid just 100 [Ethiopian] birr [1.83 Euros] for doing FGM/C.' In Somali, however, cutters are paid quite well – providing them with economic reasons for resisting change. A 13-year-old girl from *kebele* G said:

*The circumciser came from a different village. She came bringing needle; anaesthesia and thread, if the mother chose the area to get sewed by thread or it to be done by thorn, the mother brings thorns... Mothers pay 250 birr to circumciser... the community values circumcision very much.*

Survey results indicate that nearly all girls who are not cut by traditional cutters are cut by their mothers. However,

#### Box 4: Marrying at a younger age, and being cut younger, go in tandem in Somali region

Our qualitative findings show that due to the fast increase in adolescent-driven 'love' marriages in the Somali region, the age of marriage is coming down – with some girls marrying at age 12 or 13. Because of this, some parents (especially mothers) start to fear that their daughter may elope with her boyfriend before she is cut. As marriage without FGM/C is shameful for parents, mothers are increasingly having their daughters cut at an earlier age than was common in the past (8, 9 or 10 years). A key informant in *kebele* A noted that girls should be cut between the ages of 8 and 11 because if they are uncut beyond 11, there is a greater chance that they might marry uncut, which is taboo. When asked whether it would be possible to delay FGM/C – and, by implication, marriage – until after 14 years, the same key informant said this was not possible because the girl would be 'a woman' by this age and if she is 'open' and not sewn closed, she could begin a sexual relationship with a boy and bring shame on the family.

The head of the Bureau of Women Affairs in *kebele* G reported that recently a 14-year-old girl had eloped with a boy. When the news reached her family, the girl's mother fainted because she knew her daughter had not been cut. When the girl was taken to a traditional cutter for defibulation, which is often carried out immediately after marriage, it became known that she was still uncut. Amid much secrecy, the girls' relatives discussed the situation and the girl was immediately cut. If this had not happened, the only choice would have been for the groom to return the girl to her family, which would have been a serious insult to the girl's mother. The key informant said that the problem happens because of a growing trend of adolescent-driven marriages, which parents are unable to control.



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 *kebele* A (Afar) stated, ‘My sister is 10 years old. She is not in school and she was circumcised in a hospital. They took her to hospital and the nurse did the circumcision.’ A father from *kebele* E (Somali) added:

*They – girls and boys – are being taken to the hospitals and health centres to be cut... Those working in the health centres, female doctors. They assist women during delivery – how can they not be involved in circumcising?’*

A *kebele* chairperson from Somali noted that medicalisation is linked to efforts to promote the ‘*sunna*’ type [Type 1] of FGM/C rather than infibulation. He explained:

*In previous times, they were forced to commit circumcision 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 way of doing it. Even the traditional ladies are being trained by non-governmental organisations about the importance of the sunna and the magnitude of danger that the pharaonic method [Type 3] poses for the young girls’ lives.*

### 5.3.3 Type of FGM/C

Despite efforts to promote Type 1 over infibulation, our survey found little evidence that the type of FGM/C

practised is changing. Across both regions, nearly all girls who had been cut – regardless of age – reported having been infibulated (see Table 11). In Somali, although the DHS reports that infibulation is becoming less common (see Box 5) and a teacher from *kebele* F stated that FGM/C ‘is not the suturing, like the past’, all girls who had been cut reported having been sewn shut. As a 13-year-old girl from *kebele* G (Somali) explained:

*Our culture does not accept another type of FGM/C, sewing is the type of FGM/C that the community practices here, no other type of FGM/C... I think it is good to stop this type of FGM/C... it is harmful. I was circumcised when I was 8 years old. The area was sewn by thorns, not thread. I suffer pain during menstruation; it does not flow well and is very painful. I do not know what I will experience in the future because of FGM/C.*

In Afar, 85% of girls reported having been ‘closed’ with scar tissue. Participants in our qualitative work explained that this is accomplished by tying girls’ legs together

**Table 11: Type of FGM/C, by region, of adolescent girls who admit to having undergone FGM/C**

	Afar	Somali
Type 3 (infibulation)	85% – with scar tissue	100% – sewn shut
Type 2 (excision)	10%	
Type 1 (clitorrectomy)	5%	

### Box 5: Comparing our data to the 2016 Ethiopia Demographic and Health Survey data

Our baseline data does not neatly align with those of the 2016 EDHS due to sampling differences. Our sample was selected on the basis of girls' vulnerability to FGM/C and child marriage and is not meant to be representative of the broader population in Afar and Somali. That said, the 2016 Ethiopia DHS samples in Afar and Somali were small and as a result may also not be representative. As noted above, the 2016 EDHS sampled 549 women aged 15–49 in Afar; in Somali, it sampled 685 women of the same age group. The DHS also asks mothers to report on the FGM/C status of daughters aged 0–14 only, whereas our survey asks female caregivers to report on all female children in the HH, including older adolescent girls still resident in the HH.

Looking at caregivers' responses to FGM/C questions, we note three primary differences in findings (see Table 12). First, with the caveats above, our survey finds far higher rates of FGM/C in both Afar (93% vs. 78% in the DHS) and Somali (55% vs. 26% in the DHS). Second, our survey finds rates of infibulation far higher than stated in the DHS. In Afar, female caregivers reported that 83% of female children have been infibulated (with scar tissue), whereas the DHS reports a rate of 68%. While the DHS reports an infibulation rate of 'only' 33% in Somali, 100% of caregivers (and girls) in our Somali sample reported that girls have been infibulated. With the additional caveat that our sample includes only female caregivers when asking about preferences for continuation of the practice – whereas the DHS also includes adolescent girls aged 15–19 as well as adult women who are not yet mothers – our survey also found that caregivers are more likely to believe that FGM/C should continue. In Afar, the difference is 9 percentage points (66% vs. 55%) and in Somali, 17 percentage points (69% vs. 52%).

**Table 12: Comparison of results from the 2016 EDHS to our baseline survey, by region (%)**

	Afar		Somali	
	DHS – mothers reporting on daughters under 15	Our survey – female caregivers reporting on all female children in the HH	DHS – mothers reporting on daughters under 15	Our survey – female caregivers reporting on all female children in the HH
Reporting girls have been cut	78	93	26	55
Reporting girls have been infibulated	68	83	33	100
Believe FGM/C should continue*	55	66	52	69

\*DHS figures for this row include all women aged 15-49

Looking at the responses of girls aged 15-19, we note myriad differences between our findings and those of the 2016 EDHS (see Table 13). Looking first at Afar, girls in our sample are more likely to have undergone FGM/C than girls the same age sampled for the DHS (97% vs. 91%). Girls in our sample are also more likely to have been infibulated (83% vs. 67%). Interestingly, girls in our sample are far less likely than their peers sampled for the DHS to believe that FGM/C is a religious mandate (18% vs. 56%), though that may be because our survey also included cultural identity as a driver whereas the DHS does not.

Looking at Somali, older girls in our sample are far less likely to have heard of FGM/C (86% vs. 97%) and to admit to having been cut (85% vs. 95%) than those sampled for the DHS. This may be because our sample is drawn from more rural areas where taboos about sexual topics are stronger. Girls in our sample are far more likely to have been infibulated (100% vs. 57%) and to believe that FGM/C should continue (67% vs. 51%). They are, as in Afar, less likely to report that FGM/C is a religious mandate.

**Table 13: Comparison of results from the 2016 EDHS to our baseline survey, by region – for girls 15-19 only**

	Afar		Somali	
	DHS girls 15-29	Our survey girls 15-19	DHS girls 15-19	Our survey girls 15-19
Have heard of FGM/C	100	98	97	86
Have been cut	91	97	95	85
Have been infibulated	67	85	57	100
FGM/C is a religious mandate	56	18	61	36
FGM/C should continue	51	53	51	67

for weeks after first removing the inner and outer labia. Those participants also clarified that in the Afar context, clitorectomies are rare and girls who are not infibulated are still primarily subjected to Type 2 FGM/C. Several religious leaders who previously advocated for 'sunna' to replace infibulation confessed that they now regretted that tactic – as it has not resulted in a switch from Type 3 to Type 1 – and were instead calling for elimination of the practice. In Afar, FGDs with men also indicated that men with multiple wives reflected positively on the effects of Type 1 FGM/C on their sexual relationship compared to Type 3. This may be a possible entry point for shifting support towards Type 1 cutting, which at least has fewer detrimental health and psychological impacts on girls and women.

### 5.3.4 Drivers of FGM/C

Adolescent girls and female caregivers reported similar drivers of FGM/C (see Table 14). Caveating that ethnic and cultural identity has taken on ever more freighted importance in Ethiopia in recent years – when asked to identify the main reason for cutting, cultural identity was the most common response. Two-thirds of girls (65%) and female caregivers (67%) in Afar, and half of girls and female caregivers (54%) in Somali, chose this survey response. When asked if she would cut her daughter in the future, a 19-year-old girl from *kebele C* (Afar) replied:

*I may not cut her if the culture does not inhibit me... If I get more information on FGM/C I may stop it but if the culture still considers it [important] then I will circumcise her.*

Noting that it is difficult to disentangle culture and religion, religious mandate was a more common response in Somali than Afar, with one-third of girls and two-fifths of caregivers choosing that response. Across regions, religious mandate was also especially important to male caregivers (see Box 6).

Interesting differences emerge when splitting the sample by distance to *woreda* town, which suggests the need to carefully tailor messaging (see Table 14). In Afar,

there are trade-offs between cultural identity and religious mandate. Compared to their peers in more remote communities, girls and female caregivers who live in more central communities – where access to information and exposure to different customs is more common – are significantly ( $p < .05$ ) more likely to report that the primary reason for FGM/C is cultural identity, and less likely to report that it is religious mandate. For example, of girls in Afar, 72% of those in more central communities – compared with 58% of those in remote communities – report cultural identity as the main driver. In Somali, on the other hand, girls and female caregivers in more central communities are less likely to report that FGM/C is required by culture than their peers in more remote communities (38% vs. 59% for girls) – but there is no trade-off with other explanations. This is highlighted in the following explanation by a 12-year-old girl from *kebele G* (Somali):

*Unless a girl is circumcised, she does not pray, not go to mosque, not go to wedding places and she does not engage in dance. She has a body part which is Haram, she needs to stay at home until that part gets cut.*

### 5.3.5 Beliefs about the risks and benefits of FGM/C

Underscoring how difficult it will be to eliminate FGM/C in Afar and Somali, girls and female caregivers were far more likely to believe that FGM/C has benefits than they were to believe that it carries risks (see Table 16). In Afar, and using the full sample, 23% of girls reported that FGM/C has benefits (primarily ensuring girls' good behaviour) and only 6% that it has risks. A 13-year-old from *kebele A* (Afar) explained, 'The girl that's not circumcised brings shame to the family... Circumcision doesn't bring any bad thing for her.' Of the small number of girls who reported that FGM/C is risky, concerns centred on difficult childbirth (67%) and painful sex (35%). Female caregivers, who were more aware of risks because they had personally experienced sexual intercourse and childbirth, had a more balanced

**Table 14: FGM/C drivers, by region and type of respondent and distance to *woreda* town (%)**

	Afar				Somali			
	Girls		Female caregivers		Girls		Female caregivers	
Cultural identity	65		67		54		54	
Close/far	72	58	76	60	38	59	47	57
Religious mandate	21		17		33		38	
Close/far	14	27	11	24	not significant		not significant	
Ensure girls' good behaviour	10		10		3		3	



## Box 6: Boys' and men's perspectives on FGM/C

With the caveat that a small minority (~10%, see Figure 11) of caregivers are male, male and female caregivers identified disparate primary drivers of FGM/C (see Table 15). Across regions, men were more significantly likely than women to report that FGM/C is a religious mandate. In Afar, 29% of male caregivers and 17% of female caregivers responded in this way. In Somali, figures were 55% and 38% respectively. Male caregivers were correspondingly less likely to prioritise cultural identity or 'girls' good behaviour' than female caregivers.

Male and female caregivers were similarly likely to believe that FGM/C has benefits – and identified relatively similar benefits (e.g. ensuring girls' good behaviour and attracting a husband). Interestingly, however, in Afar, male caregivers were far more likely than female caregivers to understand that FGM/C has risks (65% vs. 40%) and far less likely than female caregivers to believe that FGM/C should be continued (41% vs. 66%). While males and females were similarly likely to understand that FGM/C makes sex and childbirth difficult, male caregivers were more likely than female caregivers to report that infection is a risk of FGM/C (38% vs. 18%, not shown). In Somali, the reverse was true – female caregivers were more likely than males to understand that FGM/C has risks (37% vs. 24%). Of those who reported risks, male caregivers were more likely than female caregivers to emphasise difficult sex (46% vs. 32%) and difficult childbirth (66% vs. 51%). In Somali, male and female caregivers were equally likely to believe that FGM/C should continue.

**Table 15: Caregiver beliefs about FGM/C, by sex and region (%)**

	Afar		Somali	
	Male caregivers	Female caregivers	Male caregivers	Female caregivers
Cultural identity	62	67	42	54
Religious mandate	29	17	55	38
Ensure girls' good behaviour	4	10	1	3
FGM/C has benefits	44	46	67	68
FGM/C has risks	65	40	24	37
FGM/C should be continued	41	66	68	69

In FGDs, men – like women – emphasised that FGM/C is central to cultural identity. Specifically, they reported that it is not possible for girls to marry if they have not undergone FGM/C. A father in *kebele* E (Somali) for example, when asked if an uncut girl could marry, replied:

*No, not at all. If she marries uncircumcised, she spoils out culture. We will not all girls to marry uncut. It is also part of an honour of the family and a respect for the mother of the daughter.*

Adolescent boys taking part in our qualitative research in *kebele* G Somali agreed with men that FGM/C is required for marriage and noted that cultural identity and religious mandate cannot be disentangled in the minds of most people. One boy explained:

*Boys want to marry a circumcised girl and no one will marry an uncircumcised 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 types.*

The boys then added that the mandate for infibulation is so absolute that when a local religious leader (who had tried to lead his community to abandon FGM/C by leaving his own daughters uncut) married off his daughters, they were returned to him by husbands who refused to accept them. The man and his daughters were so marginalised by the community that they all eventually migrated to Djibouti.

view, with 46% citing benefits and 40% risks. Female caregivers in Afar, like adolescent girls, believe the primary benefit of FGM/C is that it ensures girls' good behaviour (91%) – which in their minds means preventing premarital sex and ensuring girls' docility. Several mothers added that while they had delayed cutting their daughters, sometimes due to NGOs handing out bars of soap in exchange for an agreement to not eschew FGM/C, they would still carry through with custom, as FGM/C is required for girls to be considered marriageable. The primary risks of the

practice, according to caregivers in Afar, were difficult childbirth (95%) and painful sex (50%).

Somali girls were also more likely to report that FGM/C has benefits (55%) than risks (22%) (see Table 16). Of the one-fifth who reported risks – and reflecting the fact that Somali girls are cut when they are old enough to be aware of what is happening – concerns overwhelmingly centred on infection (91%), and daily bleeding in the weeks after cutting (29%). Benefits centred on ensuring girls' good behaviour (83%,) which in Somali means preventing

**Table 16: Perceived benefits and risks of FGM/C, by region and type of respondent (%)**

	Afar		Somali	
	Girls	Female caregivers	Girls	Female caregivers
FGM/C has benefits	23	46	55	68
Attract husband	28	39	27	46
Ensures girls' good behaviour	89	91	83	78
Other	5	5	7	10
FGM/C has risks	6	40	22	37
Infection	29	18	91	94
Difficult sex	35	50	17	32
Difficult childbirth	67	95	33	51
Bleeding	14	N/A	29	N/A
Other	6	2	4	2

premarital sex. Somali female caregivers' beliefs mirror those of their daughters. More than two-thirds (68%) report believing that FGM/C has benefits, compared with only one-third reporting risks (37%). Like their peers in Afar, Somali caregivers were most likely to believe (78%) that FGM/C ensures girls' good behaviour. Like their daughters, however, Somali caregivers were more likely to report infection (94%) as a risk than they were difficult childbirth (51%).

Differences also emerge when the sample of adolescent girls is split by age cohort (see Table 17). In Afar, and compared to older girls, younger girls are significantly ( $p < .05$ ) less likely to report that FGM/C has benefits (21% vs. 28%) and risks (4% vs. 11%). This speaks to older girls' 'better' socialisation, and also to their life experiences. In Somali, younger and older girls are equally likely to report

that FGM/C has benefits, but older girls – who are more likely to have already experienced FGM/C and sexual intercourse – are far more aware of risks (28% vs. 18%).

Location differences in reported benefits and risks of FGM/C emerge when the sample is split not only by region, but by distance to *woreda* town (see Table 18). Compared to their peers in remote communities, adolescent girls in Afar and Somali and female caregivers in Afar are significantly ( $p < .05$ ) less likely to believe that FGM/C has benefits if they live in *kebeles* close to the *woreda* town. For girls in Afar, for example, the gap is 9 percentage points (19% vs. 28%). Female caregivers in Afar who live in communities close to the town are also more likely to believe that FGM/C has risks than their peers in remote communities (44% vs. 37%;  $p < .05$ ). In Somali, the reverse is true: girls and caregivers who live in remote communities are significantly more likely to believe that FGM/C has risks than their peers in communities close to the *woreda* town (40% vs. 32% for female caregivers;  $p < .05$ ). This is because they are more cognisant of the risks of childbirth. Of Somali girls who report that FGM/C has risks, 37% of those in remote communities but only 13% of those in communities close to the town reported that FGM/C increases the risks of difficult childbirth. For female caregivers, rates were 55% and 40% respectively.

**Table 17: Risks and benefits of FGM/C, by region and age cohort (girls, %)**

	Afar		Somali	
	Girls aged 10–14	Girls aged 15–19	Girls aged 10–14	Girls aged 15–19
FGM/C has benefits	21	28	Not significant	
FGM/C has risks	4	11	18	28

**Table 18: Risks and benefits of FGM/C, by region and type of respondent and distance to *woreda* town (%)**

	Afar				Somali			
	Girls		Female caregivers		Girls		Female caregivers	
	Close	Far	Close	Far	Close	Far	Close	Far
FGM/C has benefits	19	28	41	50	48	57	NS	
FGM/C has risks	NS		44	37	15	25	32	40

### 5.3.6 Beliefs about whether FGM/C should be continued

Unsurprisingly, given the perceived benefits of FGM/C, especially that it is required for marriage, most adolescent girls and female caregivers responded to our surveys that the practice should continue (see Table 19). In Afar, 59% of girls responded in favour of continuation, as did 66% of female caregivers. Caregivers in the most remote communities were a significant 12 percentage points more likely than those in communities close to the *woreda* town to report that it should continue ( $p < .01$ ). This finding was mirrored among girls, with 65% of those in more remote communities and 53% of those in communities close to the *woreda* town reporting that FGM/C should continue ( $p < .01$ ). The qualitative findings underscored that girls who did not get cut would be subject to insults from peers and the community. As a 12-year-old girl from *kebele* A (Afar) explained:

*It is good to get circumcised. We all get circumcised; my younger siblings also experience it. There are people that teach the community to stop circumcising girls. When a girl left uncircumcised her husband calls her Kintram, I do not want you, and leave her... Also, if a girl not circumcised, children insult her calling Kintram (you have clitoris)... It is bad to be called Kintram... When a girl disagrees with some children and she is uncircumcised they insult her as Kintram.*

Survey respondents in Somali were even more in favour of continuation than their peers in Afar, with 68% of girls and 69% of female caregivers supporting its continuation. The qualitative findings indicated that in some cases Somali girls may even seek out the traditional cutter on their own accord, such is the social pressure to be cut. As a 16-year-old girl from *kebele* G (Somali) explained:

*There are kids who go to The Old Woman [the traditional cutter] by their own choice... They think well my peers and those that are younger than me have already done it so why can't I do it too. She thinks that If it happens and I am married to a guy and the old lady is called to open me up and they find out that I haven't undergone FGM, that would bring shame.*

For Somali caregivers, there were no differences linked to distance from the town. For Somali girls, on the other hand, there was a 7-percentage point difference, with girls in remote communities more likely to support continuation. This difference was not significant, however.

### 5.3.7 Caregivers' knowledge of the law regarding FGM/C

Although FGM/C has been illegal in Ethiopia since the early 2000s, a minority of caregivers reported that they were aware of the law surrounding FGM/C (see Table 20). In Afar, only 42% said they were aware of the law, falling to 34% in Somali. In Afar, caregivers living in *kebeles* closer to the *woreda* town were significantly more likely to be aware of the law (51% vs. 34%). Among the minority of caregivers who reported being aware of the law, understandings varied. In Afar, most caregivers (64%) correctly identified that all types of FGM/C are illegal. In Somali, however, most caregivers (80%) reported believing that Type 1 is a legal form of the practice. This may be the result of government efforts to prevent infibulation by actively promoting 'less invasive' forms for FGM/C. Caregivers were even less clear about who can be penalised under the law. Of caregivers who reported being aware of the law, fewer than a fifth in Afar (19%) and Somali (16%) correctly identified that the law penalises both cutters and parents. Our qualitative research suggests that caregivers' limited legal awareness is in large part because awareness-raising tends to focus only on the risks of FGM/C, rather than addressing the law (or perceived benefits).

There were some gender differences in caregivers' awareness and understanding of the law regarding FGM/C. In Somali, female caregivers were nearly twice as likely as male caregivers to have heard of the FGM/C law (34% vs. 18%) – although this could simply reflect men's unwillingness to admit to knowledge which might then expose them to prosecution. They were also significantly ( $p < .01$ ) more likely to believe that Type 1 is legal than their male peers (81% vs. 60%). In Afar, although male and female caregivers were equally aware of the law, men's knowledge was more accurate, likely because of their greater mobility

**Table 19: FGM/C should continue, by region, respondent type, and distance to *woreda* town (%)**

		Afar		Somali			
		Female caregivers		Girls	Female caregivers		
		59%	66%	68%	69%		
Close	Far	Close	Far	Close	Far	Close	Far
53	65	60	72	62	69	68	70

**Table 20: Caregivers' awareness of the FGM/C law, by region and distance to woreda town (%)**

	Afar		Somali	
	Close	Far	Close	Far
Heard of law	42		34	
	51	34	37	33
Believes FGM/C is legal	2		2	
Believes only Type 1 is legal	10		80	
Believes FGM/C is illegal	64		21	
Believes only the cutter is penalised	30		10	
Believes only the parents are penalised	13		11	
Believes cutters and parents are penalised	19		16	

and exposure to information. Of those who reported having heard of the law, 33% of male caregivers but only 17% of female caregivers accurately identified that both cutters and parents are liable to be prosecuted.

### 5.3.8 Life course consequences of FGM/C

Our qualitative research suggests 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 FGD 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.

## 5.4 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.
- In Somali, most marriages are adolescent-driven.
- Few adolescents are aware that there is a legal minimum age for marriage.
- Across regions, most adolescents report that the ideal age for marriage is greater than 18 years.

### 5.4.1 Marriage practices of female caregivers

Because the average age of adolescents in our sample is only 13, relatively few girls are already married. The experiences of female caregivers, however, speaks to how normalised child marriage is. In Afar, nearly 90% of female caregivers had married before age 18 (see Table 21), with the average at marriage being 16.2 years. Nearly one-eighth (14%) of caregivers in Afar had married before the age of 15. In Somali, the survey findings suggest that



**Table 21: Female caregivers' marriage practices, by region**

	Afar	Somali
Average current age of the CG	37	38
Mean age at marriage	16.2 years	17.4 years
Married before age 18	88%	58%
Married before age 15	14%	8%
Marriage arranged by parents	97%	74%
Felt ready to marry at the time	38%	77%

child marriage is – or at least was – less common and that girls marry later in adolescence or as young women. Just over half (58%) of caregivers were married before age 18, with the average age at marriage being 17.4 years. Only 6% of caregivers had married before age 15. Husbands in both regions were, on average, 5 years older than their wife. Caregivers' marriage type also varied by region. In Afar, in line with the *absuma* custom, nearly all marriages (97%) were arranged by parents, with less than half of female caregivers (42%) reporting being ready to marry when they did. In Somali, 'only' 74% of caregivers' marriages were arranged by parents (with the remainder decided by partners themselves) and three-quarters of caregivers (77%) reported being ready to marry when they did. There were no statistically significant differences between treatment and control communities on caregivers' marriage practices.

### 5.4.2 Marriage practices of adolescent girls

Of the adolescent girls in our sample, only a small minority were already married – 3% in Afar (23 girls) and 4% in Somali (32 girls), although ever married rates were one percentage point higher (see Table 22). Of this small number of girls, marriage was very early – often before age

**Table 22: Marriage practices of adolescent girls in the sample, by region**

	Afar	Somali
Ever married	3%	4%
Mean age at marriage (among married)	15.8 years	15.6 years
Married before age 18 (among married)	87%	88%
Married before age 15 (among married)	22%	22%
Marriage arranged by parents (among married)	87%	21%
Felt ready to marry at the time (among married)	36%	97%

15 (22%), because clan leaders in Afar actively promote child marriage (so that couples produce many children to benefit the clan) and because religious leaders in Somali often encourage marriage immediately after menarche (first occurrence of menstruation). Of married girls, the average age at marriage was under 16 years in both regions.

In Afar, of the 23 girls who were already married, our survey found that nearly all child marriages (87%) were arranged by parents, and only a third (36%) of girls reported feeling ready to marry when they did. Indeed, our qualitative research found that it is common for friends of the groom to actively monitor engaged girls, to prevent them from escaping. There are also signs – albeit nascent and from a low base – that pressure to abandon *absuma* marriage is building. 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, there were multiple accounts of girls reporting impending marriages to Bureau of Woman and Social Affairs office at the *woreda* level, to teachers, or (in the case of more urbanised Aysaita) to the Sharia court. A 16-year-old girl from *kebele* A 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.*

In Somali, and with the caveat that our qualitative work suggests that the incidence rate of child marriage may be far higher than survey results suggest, especially in remote communities where schooling is not available, our survey found that only 21% of child marriages had been arranged by parents and nearly all of the 32 married girls (97%) felt ready to marry when they did. Our qualitative work found competing explanations for these patterns – all of which underscore how girls' 'choices' are shaped by their environments. Adults expressed concern that child marriage is increasing, and that the age at which girls marry is getting lower. Some blamed sedentarisation for this, because with less migration, it is easier for adolescents to meet partners – especially at school. Others blamed mobile phones for facilitating adolescent relationships that result

in marriage, given that premarital sex is taboo. A religious leader from *kebele* G stated, 'I think early marriage has increased now because of irresponsible adolescents.' With the caveat that our survey found 100% of girls in Somali are still infibulated, several key informants also blamed less severe forms of FGM/C for increases in child marriage – because girls' have more sexual desires when they are not infibulated. A school director from *kebele* E observed:

*Both circumcision and early marriage are interconnected. Early marriage is new to us and started now... The sunna type of circumcision may be the reason... Previously, child marriage was not that much practised in real life, and the community believed that they should wait till they are responsible and old enough.*

Adults also reported that mothers, who can be left in penury if their husbands decide to take another wife, sometimes drive child marriage – pushing their sons to marry early to prevent land from being shared out. There were also reports that some mothers encourage their daughters to get married at a young age to better-off traders from Jijjiga and the Somali diaspora, who lure rural girls into marriage with promises of material comforts.

Adolescent girls in Somali, while agreeing with their parents that most child marriages are adolescent-driven, reported that some girls are 'pushed' into marriage by their parents. In some cases, mothers buy mobile phones for their daughters, so that daughters can communicate with suitors. In other cases, girls are forced to marry. A 14-year-old girl from *kebele* E explained that, 'If a mother wants her daughter to marry but the daughter refuses, she would be pressured to marry... And if the girl refuses adamantly, they might beat her up.'

Caregivers and adolescents agreed that recurrent drought has reshaped marriage practices over the last generation. Whereas in the past young men could not seek a bride without providing bride wealth to the bride's parents, today this is impossible for most, at least in the zones of Somali in which our research is taking part. With bride wealth, and the traditional rituals of marriage, unavailable – adolescents marry whom and when they please.

### 5.4.3 Norms surrounding child marriage

Pervasive social norms about marriageability also shape these 'choices'. Our survey found that most adolescents



An adolescent boy with his parents sitting in front of their house, Afar region, Ethiopia © Nathalie Bertrams/GAGE 2022

**Table 23: Agree with the statement ‘Most girls in my community marry before age 18’, by region, respondent type, and respondent sex (%)**

Afar				Somali			
Adolescents		Caregivers		Adolescents		Caregivers	
Girls	Boys	Female	Male	Girls	Boys	Female	Male
83	73	87	69	54	65	79	77

and caregivers – across both regions and in treatment and control communities – believe that child marriage is typical (see Table 23). In Afar, a large majority of female caregivers (87%) and girls (83%) reported that most girls in their community marry before the age of 18. For caregivers, distance to the *woreda* town matters. Those in more remote communities – where child marriage genuinely is more common because girls lack other options – were significantly more likely to agree that child marriage is normal than those in *kebeles* closer to the *woreda* town (93% vs. 82%;  $p < .01$ ). Boys (73%) and male caregivers (69%) in Afar also agree that child marriage is typical for girls in their communities, but they are significantly ( $p < .01$ ) less likely to agree than girls and female caregivers, perhaps because they are not living with constant worries about being ‘left on the shelf’ – because unlike girls, boys and men do not become ‘too old’ to marry. In Somali, where child marriage is less common, there is a gap between female caregivers’ and girls’ reports: while nearly four-fifths of female caregivers (79%) report that most girls marry before age 18, fewer than three-fifths (54%) of adolescents agree. Interestingly, in Somali, boys are significantly more likely than girls to report that most girls marry before age 18 (65% vs. 54%;  $p < .01$ ). There is no statistically significant difference between male and female caregivers.

In Somali, but not Afar, there are differences between treatment and control communities that may affect future results. Specifically, primary caregivers in Somali who live

in treatment communities are significantly less likely to report that most girls in their community marry before age 18 (75% vs. 82%;  $p < .05$ ).

#### 5.4.4 Adolescents’ knowledge of the marriage law

Our survey found that despite government efforts to inform the public about the legal age of marriage, it is vanishingly rare for Afar and Somali adolescents to admit knowing that the national law stipulates 18 years (see Table 24). In Somali, only 2% of adolescent girls and boys reported knowing the law, and of those, only half (56%) had accurate knowledge. In Afar, only 7% of adolescent girls and boys reported knowing the law, but of those, nearly all (93%) accurately identified 18 as the legal age for marriage.

#### 5.4.5 Adolescents’ ideal age for marriage

Across both regions over half of adolescents in our sample reported that the ideal age of marriage for girls was 18 or over (see Table 25). This was true of 64% of those

**Table 24: Adolescents’ knowledge of the marriage law, by region**

	Afar	Somali
Reports knowing the legal age of marriage	7%	2%
Accurately identifies 18 as the legal age	93%	56%

**Table 25: Adolescents’ ideal age of marriage, by region**

	Afar	Somali
Believes that the ideal age of marriage >18	64%	53% (no gender differences)
	62% of girls 82% of boys	
Believes that the ideal age of marriage <18	27%	10% (no gender differences)
	29% of girls 13% of boys	
Mean ideal age of marriage	19 years	20.7 years
Reasons for ideal age choice	<ul style="list-style-type: none"> <li>• 38% physical and mental maturity</li> <li>• 37% to finish education</li> <li>• 16% others marry by this age</li> </ul>	<ul style="list-style-type: none"> <li>• 34% to finish education</li> <li>• 25% physical and mental maturity</li> <li>• 19% others marry by this age</li> </ul>

in Afar and 53% of those in Somali. Although only 10% of adolescents in Somali reported that the ideal age of marriage was under age 18, with no gender differences, in Afar, 27% of adolescents expressed a preference for child marriage. Despite survey findings that most married girls were not ready to marry when they did, girls in Afar were more than twice as likely as boys to support child marriage (29% vs. 13%). When asked to choose between reasons for their preferences, adolescents in both regions cited allowing girls to finish their school and to mature, physically and mentally.

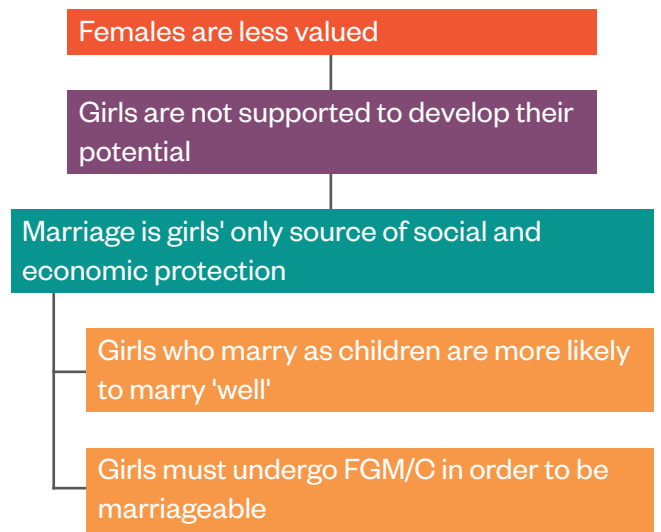
### 5.5 Gender norms

**Key findings**

- Caregivers report that community gender norms disadvantage girls and women.
- Caregivers hold deeply inequitable personal beliefs about gender roles.
- Men tend to be more conservative than women in regard to gender.
- Adolescents' personal beliefs about gender are deeply inequitable – but gender differences are fairly small.

Restrictive gender norms – and what people believe is (and is not) appropriate behaviour for girls and boys, and women and men – underpin the limits on girls' and women's lives in the two regions, and drive the harmful practices of FGM/C and child marriage. Girls are valued less than boys, and are not supported to develop their potential, so marriage is, in many contexts, girls' (and women's) main source of a family's social and economic protection. This

**Figure 14: Gender norms drive child marriage and FGM/C**

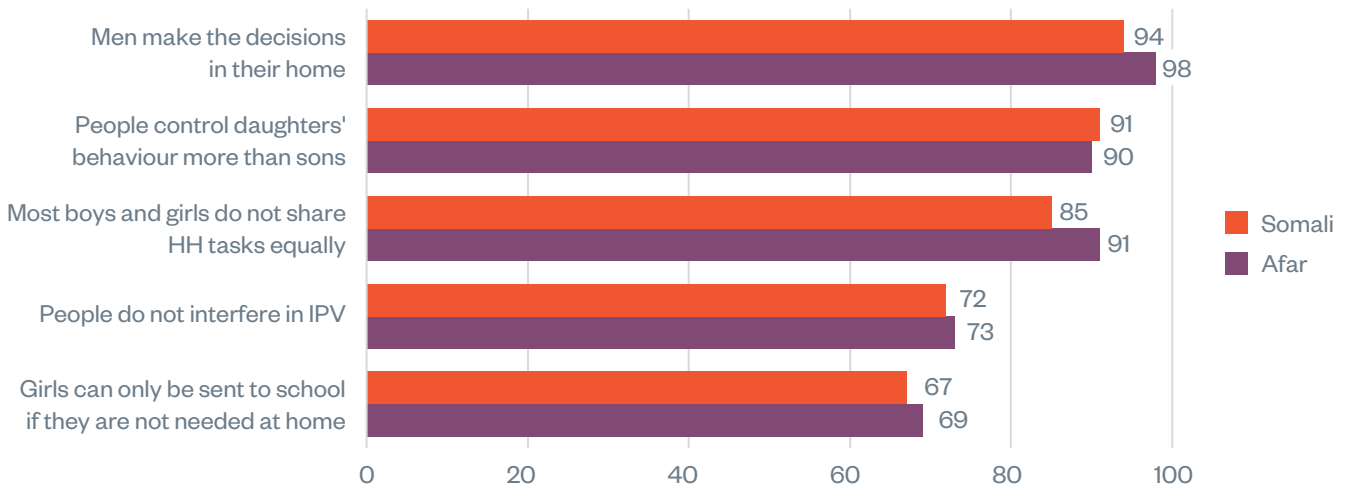


leaves families, and even girls themselves, reluctant to abandon the practices that have ensured they can marry – and marry as ‘well’ as possible (see Figure 14). Because of the strength of restrictive gender norms, our survey included a wide variety of questions designed to uncover what people believe about how women and men, and girls and boys, should behave.

#### 5.5.1 Caregivers

Caregivers reported that gender norms in their communities are very restrictive (see Figure 15). Nearly all caregivers, in Afar and Somali, agreed (at least in part) that in their communities: men make HH decisions (94% and 98% respectively); parents control girls' behaviour more than they do boys' (91% and 90% respectively); and girls and boys do not equitably share HH tasks (85% and 91% respectively). A large majority of caregivers reported

**Figure 15: Caregiver responses regarding community gender norms**





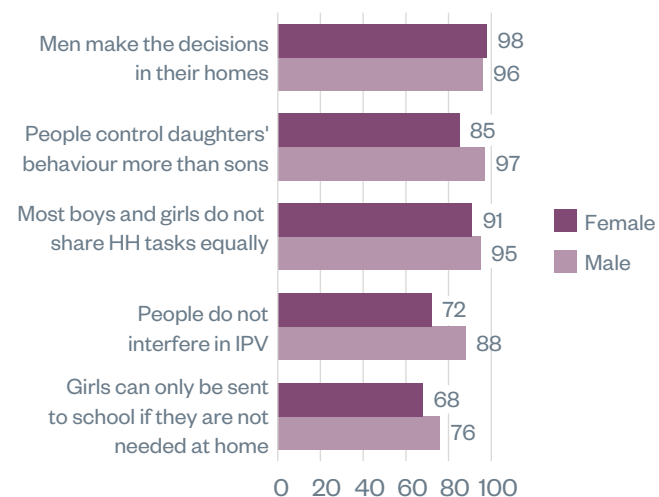
that people in their community do not interfere in spousal violence (72% and 73% respectively) and that girls are only sent to school if they are not needed at home (67% and 69% respectively).

Across regions, and again with the caveat that only a small minority of caregivers (~10%) in our sample are male, male and female caregivers' reports of community gender norms evidence some differences. Men tend to report more conservative norms than women. For example, in Afar (see Figure 16), men are more likely than women to report that people control daughters' behavior more than sons' (97% vs. 85%) and that girls can only be sent to school if they are not needed at home (76% vs. 68%). In Somali (see Figure 17), gender differences are in the

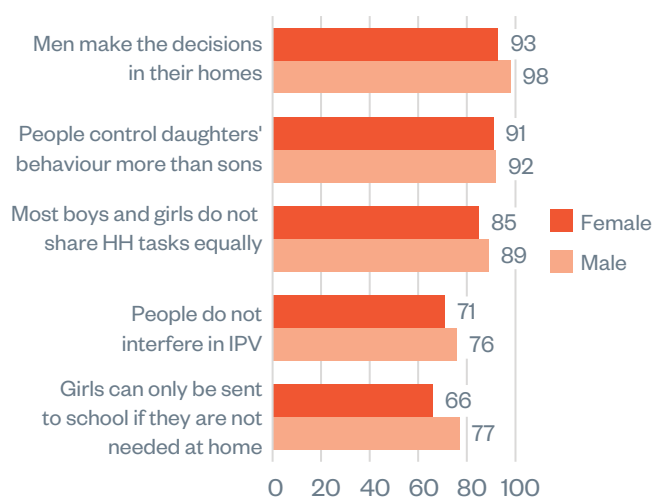
same direction but are more muted. Compared to female caregivers, Somali men – like their peers in Afar – are more likely to agree that girls should only be sent to school if they are not needed at home (77% vs. 66%).

Unsurprisingly, given these norms, most caregivers reported holding deeply inequitable personal beliefs about most gender roles (see Figure 18). This was especially the case in Afar, where 97% of caregivers reported that a woman's main role is to care for her home and 98% agreed that a woman should obey her husband in all things. Echoing the findings from the 2016 DHS, caregivers' support for spousal violence is also higher in Afar (74%) than in Somali (54%). Caregivers hold gendered beliefs about childrearing as well. Approximately 9 in 10, in both Afar and Somali,

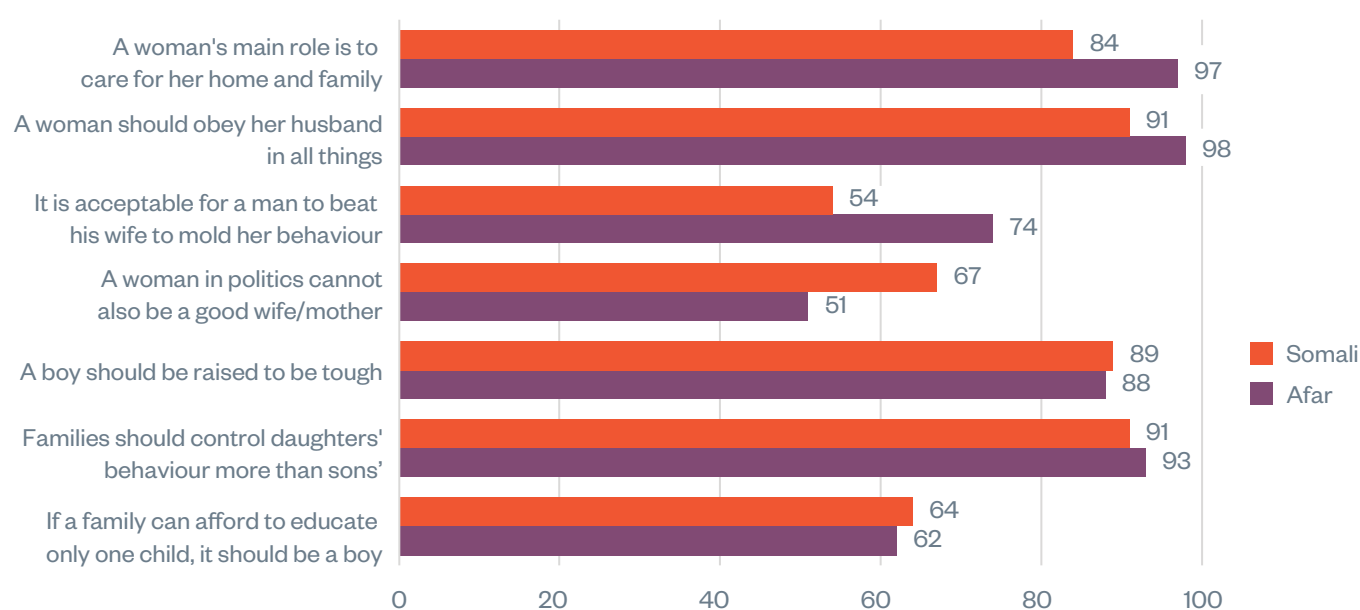
**Figure 16: Afar caregiver responses regarding community gender norms, by sex**



**Figure 17: Somali caregiver responses regarding community gender norms, by sex**



**Figure 18: Caregiver personal beliefs about gender roles**



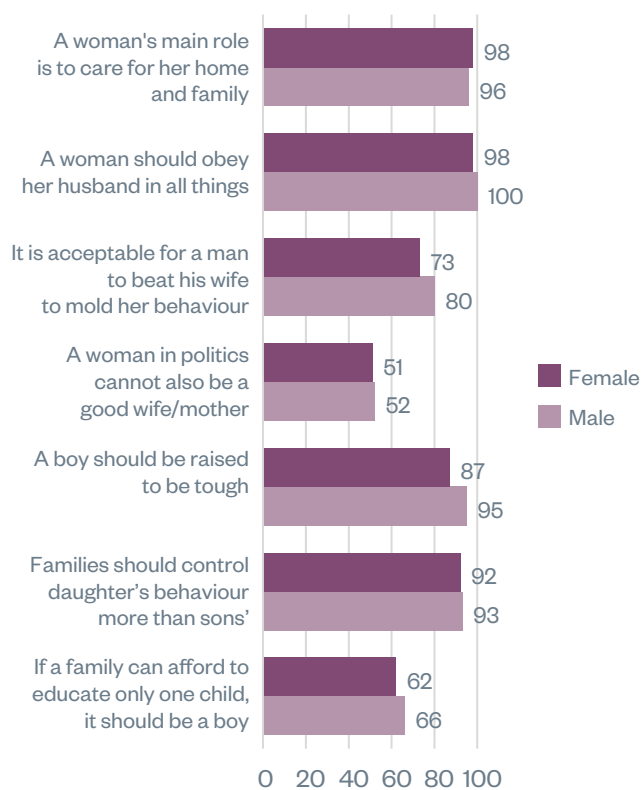
report that boys should be raised to be 'tough' and girls should be controlled more than boys. Nearly two-thirds of caregivers agreed that if only one child should be sent to school, it should be a boy.

Male and female caregivers' personal beliefs about gender roles also evidence some differences – albeit generally smaller than for community gender norms. Again, men's responses tend to be more conservative than women's. For example, in Afar, male caregivers are more likely than female caregivers to believe that men

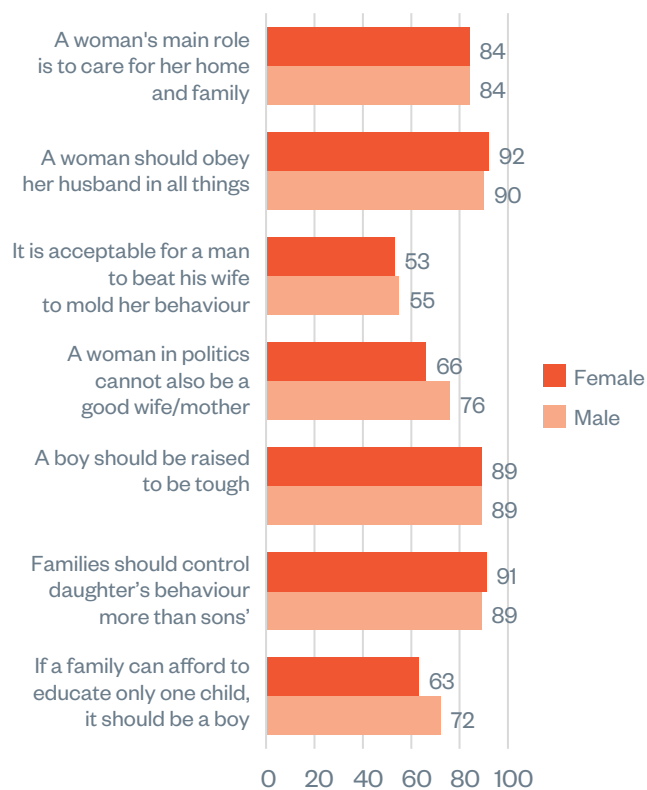
have a right to beat their wife (80% vs. 73%) and that boys should be raised to be tough (95% vs. 87%) (see Figure 19). In Somali, male caregivers are more likely than female caregivers to believe that a women cannot be a good mother if she is in politics (76% vs. 66%) and that if a family can afford to educate only one child, it should be a boy (72% vs. 63%) (see Figure 20).

Survey evidence on caregivers' awareness of gender norms is mixed (see Figure 21). On the one hand, when asked whether they had ever thought about gender

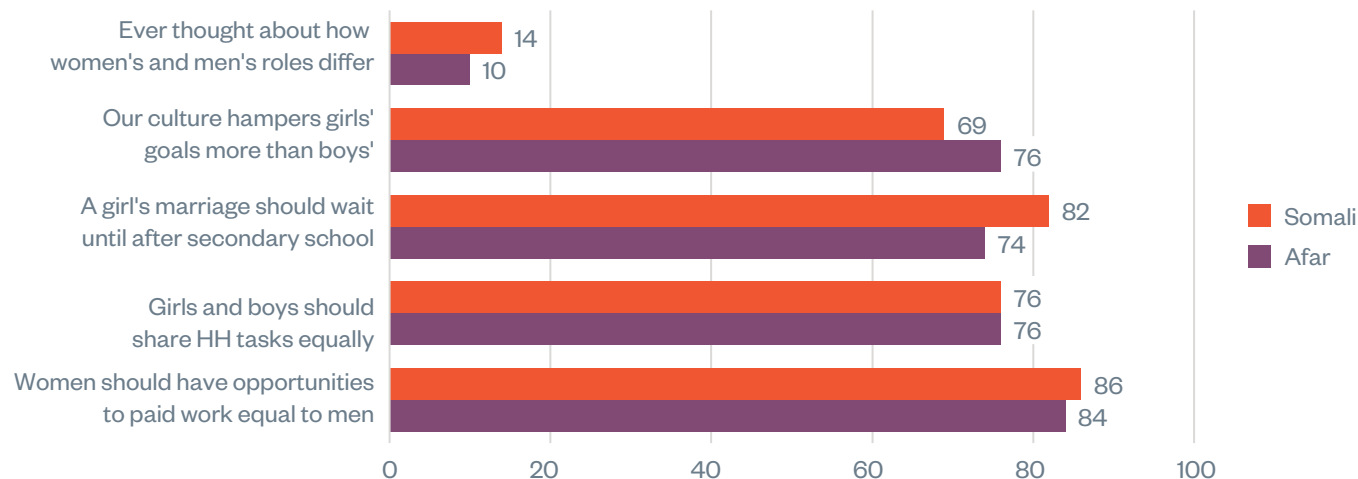
**Figure 19: Afar caregivers' personal beliefs about gender roles, by sex**



**Figure 20: Somali caregivers' personal beliefs about gender roles, by sex**



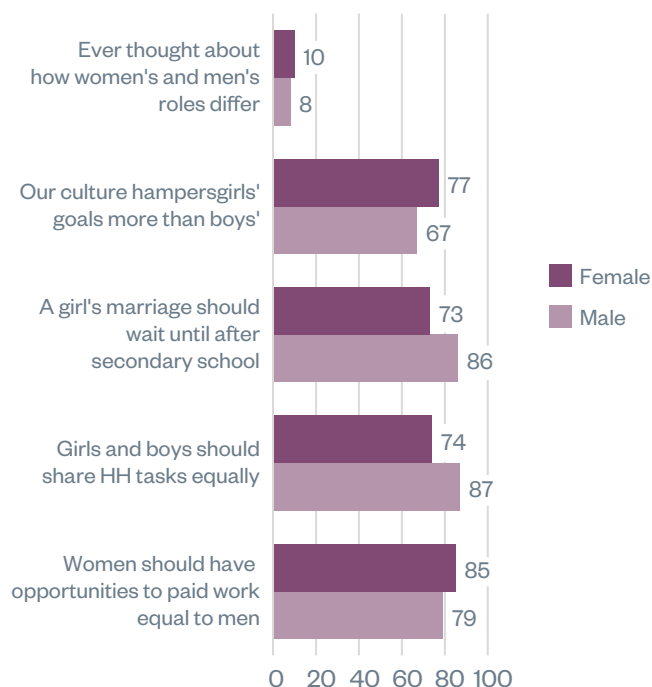
**Figure 21: Caregiver awareness of gender norms**



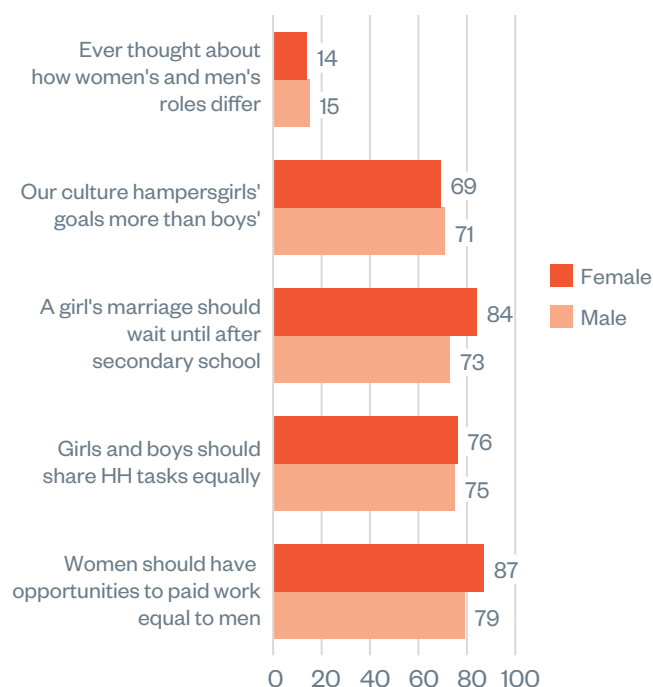
roles, and how women's and men's and girls' and boys' roles vary in the HH and community, a small minority of caregivers answered that men and women should have different roles. Only 14% of those in Somali and 10% of those in Afar admitted to having considered gender roles. On the other hand, a majority of caregivers in Afar (76%) and Somali (69%) reported that: culture hampers girls' ability to achieve their goals more than boys'; that girls' marriage ought to be delayed until after secondary school; that domestic work ought to be more equitably distributed between daughters and sons; and that women ought to have the same opportunities to work outside the home as men.

Across regions, male and female caregivers are similarly unlikely to have thought about gender roles. In Afar, 10% of women and 8% of men report having thought about how women's and men's roles differ (see Figure 22). In Somali, figures are 14% and 15% respectively (see Figure 23). Interesting, men and women in Afar are sensitive to different gender norms. Namely, while female caregivers in Afar are more likely than male caregivers to agree that culture hampers girls' goals more than boys' (77% vs. 67%) and that women should have the same opportunities as men to pursue paid work (85% vs. 79%), male caregivers are more likely than female caregivers to agree that girls' marriage can wait until after secondary school (86% vs. 73%)

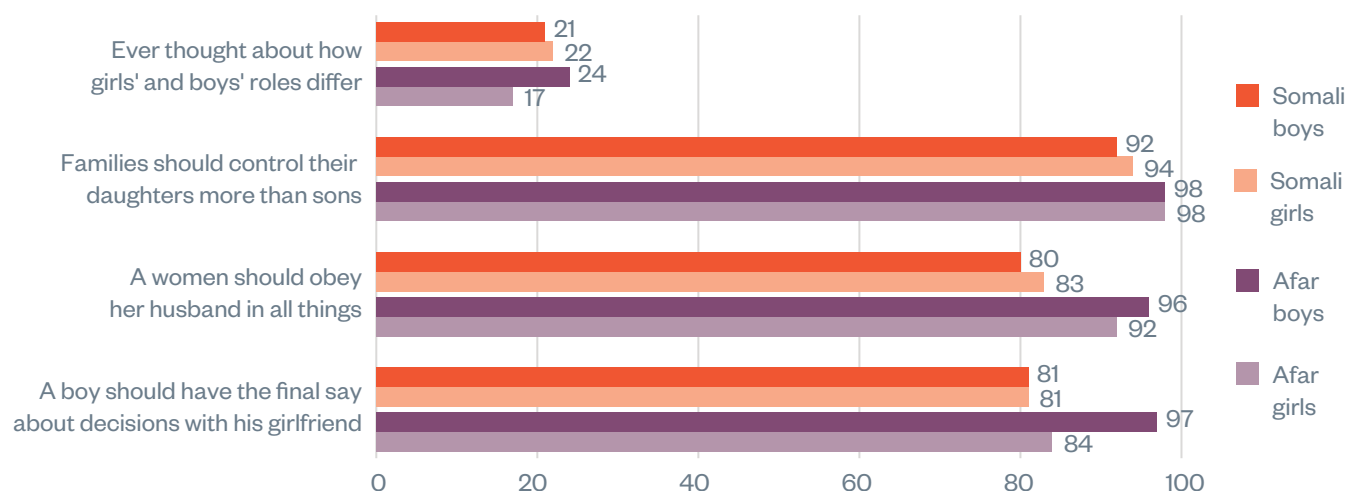
**Figure 22: Afar caregiver awareness of gender norms, by sex**



**Figure 23: Somali caregiver awareness of gender norms, by sex**



**Figure 24: Adolescents' personal beliefs about gender roles**



vs. 73%) and that girls and boys should share HH tasks (87% vs. 74%). In Somali, where there are gender gaps in awareness of gender norms, female caregivers are more sensitive than male caregivers. For example, women are more likely to support women’s access to paid work (87% vs. 79%) and to agree that girls’ marriage can wait until after secondary school (84% vs. 73%).

### 5.5.2 Adolescents

Our survey found that adolescents, like their parents, hold deeply inequitable beliefs about gender roles, and that few have even contemplated these (see Figure 24). Across both regions, nearly all young people agree that parents should control their daughters more than their sons. They also agree that a woman should obey her husband in all things and that a boy should have the final say in decisions with his girlfriend. Adolescents in Afar are more likely to agree with these statements than their peers in Somali. In both regions, girls and boys hold similar beliefs, except on the question about boyfriends and girlfriends. Boys in Afar are much more likely to believe that boys should have the final say than are girls (97% vs. 84%).

In Afar, our survey asked adolescents whether they believed that it was acceptable to tease boys who act like girls and vice versa. Boys were much less likely than girls to report that teasing was OK. Only about a third of boys but half of girls agreed that teasing was OK.

## 5.6 Economic empowerment

### 5.6.1 Adolescents’ occupational aspirations

Our survey found that adolescents’ aspirations vary by where they live and whether they are girls or boys (see Table 26). Unsurprisingly, only girls expressed a preference for becoming a housewife. Interestingly, however, girls in Afar were more than twice as likely as their peers to Somali

#### Key findings

- Adolescents’ occupational aspirations vary by gender and region – but few adolescents prefer traditional livelihoods.
- Women are less likely to see themselves as earner than men.
- Women own fewer productive assets than men.
- Women have less input into financial decision-making than men, especially in Afar.
- Somali women report that they engage in more independent financial decision-making than Afar women.

(21% vs. 8%) to aspire to become a housewife – despite Afar girls’ relatively better access to education. Indeed, although more than 40% of adolescent girls in Somali had never been to school, nearly that many aspired to become a teacher (21%) or a doctor (18%). While no girls aspired to become herders, even boys were unlikely to prefer this pathway. Only 8% of boys in Afar and 6% of boys in Somali expressed an interest in tending livestock as an adult. Most boys – like most girls in Somali – wish to become salaried workers of some sort.

### 5.6.2 Caregiver livelihoods

Again with the caveat that we surveyed relatively few male caregivers (~ 10%, see Table 1), male and female caregivers reported different primary economic activities (see Table 27). Across both regions, and as noted earlier, most caregivers tend livestock to earn a living. Men are significantly more likely to do so than women, with the gender gap especially large in Somali (53% vs. 34%;  $p < .01$ ). Although crop farming is a less common means of livelihood than tending livestock, because Afar and Somali are primarily desert and crop farming is only possible in river basins, it is far more male-dominated. In Somali, 19% of men but just 6% of women reported engaging in crop

**Table 26: Adolescents’ top occupational aspirations, by region and gender**

Afar		Somali	
Female	Male	Female	Male
<ul style="list-style-type: none"> <li>• 21% housewife</li> <li>• 13% salaried worker in business management and accounting</li> <li>• 13% teacher</li> <li>• 10% government job</li> </ul>	<ul style="list-style-type: none"> <li>• 19% salaried worker in business management and accounting</li> <li>• 15% teacher</li> <li>• 11% skilled worker</li> <li>• 10% doctor</li> <li>• 9% own commercial/financial business (other than retail)</li> <li>• 8% herder</li> </ul>	<ul style="list-style-type: none"> <li>• 21% teacher</li> <li>• 18% doctor</li> <li>• 12% health extension worker</li> <li>• 8% housewife</li> <li>• 8% own retail shop/business</li> </ul>	<ul style="list-style-type: none"> <li>• 29% teacher</li> <li>• 11% doctor</li> <li>• 9% government employee</li> <li>• 8% skilled worker</li> <li>• 7% health extension worker</li> <li>• 6% herder</li> <li>• 6% religious leader</li> </ul>



**Table 27: Primary economic activity of caregiver, by caregiver sex and region (%)**

	Afar		Somali	
	Male	Female	Male	Female
Tend livestock	61	47	53	34
Crop farming	11	2	19	6
Own shop	1	0	8	15
Homemaker	0	44	0	31
Wage employment in crop farming	10	2	2	1

farming, with 11% and 2% respectively in Afar. Women were quite likely (34%) to report being homemakers – which, in both regions, generally involves tending livestock (no male caregivers reported being a homemaker). In Somali, women were twice as likely as men to report earning an income through having their own shop (15% vs. 8%;  $p < .05$ ), whereas in Afar, this livelihood activity was rare either for men or women. Wage employment in crop farming was reported only by male caregivers in Afar (10%).

Sources of HH income differ between MHHs and FHHs (see Table 28). In Afar, FHHs are significantly more likely to rely on livestock than MHHs (77% vs. 69%) ( $p < .05$ ). They are also significantly more likely to rely on petty trading (6% vs. 1%), but significantly less likely to rely on producing crops (12% vs. 22%) ( $p < .01$ ). In Somali, patterning is markedly different. FHHs are marginally less likely to rely on livestock than households headed by men (38% vs. 43%) ( $p < .1$ ). Petty trading is especially common among FHHs in this region, with nearly 1 in 4 relying on it as a source of income, compared to only 14% of MHH ( $p < .01$ ). Wage and salary work is uncommon in both regions, and almost non-existent in FHHs compared to MHH ( $p < .01$ ).

Table 28 also highlights that location shapes livelihoods in ways that interact with gender. In Afar, in both male- and FHHs, crop farming is significantly more common in the *kebeles* closer to the *woreda* town, primarily because of larger investments in infrastructure and the greater

presence of development agents. For example, 36% of MHHs in communities close to the town depend on crops, compared with 10% of those in more distant communities ( $p < .01$ ). Figures for FHH are 17% and 8% respectively ( $p < .05$ ). For MHH, but not FHH, there is a corresponding drop in depending on livestock (54% vs. 83%,  $p < .01$ ). In Somali, this pattern holds only for FHHs, with 34% of those living closer to town depending on crops compared with 18% of those in more distant communities ( $p < .01$ ). FHHs in Somali in more remote communities are more likely to rely on petty trading than those in communities closer to the *woreda* town (27% vs. 12%) ( $p < .05$ ).

### 5.6.3 Male- and female- heads' control of productive assets

Our survey found that FHHs have approximately half as much land as MHHs (see Table 29). In Afar, MHHs have an average of 0.85 hectares of total farmland, whereas FHHs have only 0.49 ( $p < .01$ ). In Somali, the figures are 1.3 and 0.7 hectares respectively ( $p < .01$ ).

Across regions, our survey also found that FHHs own fewer livestock than MHHs (see Table 30). In Afar, the only significant difference is in regard to oxen (.97 vs. .63,  $p < .01$ ). In Somali, and in line with reported income streams, gaps favouring MHHs are generally larger and more often significant. For example, compared to FHH, MHH own significantly ( $p < .01$ ) more oxen (.25 vs. .6), donkeys (.5 vs.

**Table 28: Primary source of HH income, by region, sex of HH head, and distance to *woreda* town (%)**

	Afar				Somali			
	MHH		FHH		MHH		FHH	
Livestock (%)	69		77		43		37	
close/far	54	83	74	80	36	46	35	39
Crops (food and cash)	22		12		19		22	
close/far	36	10	17	8	22	18	34	18
Petty trading	1		6		14		23	
close/far	1	1	4	8	12	14	12	27
Wage/ salary	5		1		6		2	
close/far	6	4	1	1	3	7	1	2

**Table 29: Farmland by region and sex of HH head (in hectares)**

	Afar		Somali	
	MHH	FHH	MHH	FHH
Total farmland	0.85	0.49	1.3	0.7

.3), cattle (1.8 vs. 1), and goats (14.8 vs. 12.2). However, given that FHHs may in practice be part of a polygamous HH, further explanation will be needed in subsequent rounds to tease out the drivers of these dynamics.

#### 5.6.4 Caregivers' financial decision making

Across both regions, our survey found that women are also disadvantaged compared to men regarding financial decision-making. The specifics of women's disadvantage, however, vary by location, and only come into sharp focus when women's and men's survey responses are compared side-by-side. Caregivers were asked who has the final say over six aspects of financial decision-making: (1) use of own income; (2) use of spouse's income; (3) sale of HH assets; (4) major HH purchases; (5) HH food purchases; and (6) opening a bank account. In nearly all cases, male and female caregivers' responses were significantly different from one another.

##### Afar

In Afar, most female caregivers (approximately three-quarters) reported shared decision-making for every aspect (see Figure 25 in the left column). Of those that did not report shared decision-making, women's responses were fairly equally split between their own role and their husband's role as the final decider. For example, on use of own income, 72% of female caregivers reported shared decision-making, 17% reported that they alone decided, and 11% reported that their husband alone decided. Responses from male caregivers in Afar were similar in that they agreed that decision-making is primarily shared between husbands and wives (see Figure 25 in the right column). However, their responses

were markedly different from women's in two regards: how much individual financial power male caregivers claimed for themselves; and how little individual financial power they allocated to their wives. For example, 17% of male caregivers reported that they had the final say over asset sales, and only 2% reported that their wife had the final say. This is markedly different from female caregivers' reports (14% said husbands have the final say, 13% said wives have the final say). Men's and women's responses to the question about food purchases provide the single point of agreement: approximately three-quarters shared decision-making, one-eighth reported decisions were made by wives only and one-eighth by husbands only.

Our qualitative findings suggest that in Afar, whereas men are responsible for selling larger livestock (cows, oxen and camels), women have the right to sell small ruminants and they can control the profits from those sales. Women also fully control firewood and charcoal sales and use the money they make for HH expenses. In areas like Aysaita district, where the credit and saving culture is very strong, most of those in the community-based saving and credit services are women, who use loans to buy livestock and open small shops. By contrast, men are not as strong on financial management and decisions.

##### Somali

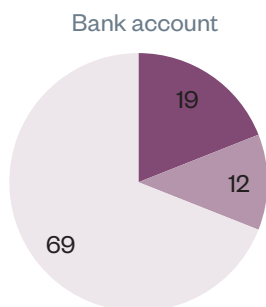
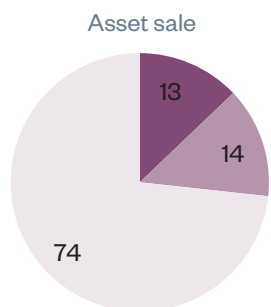
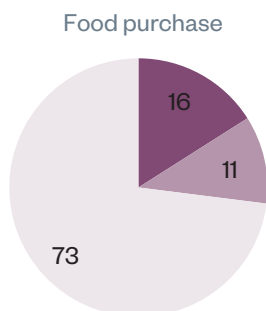
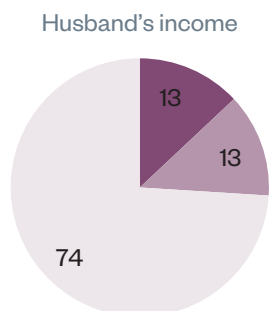
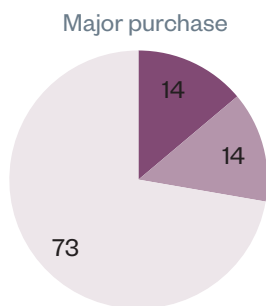
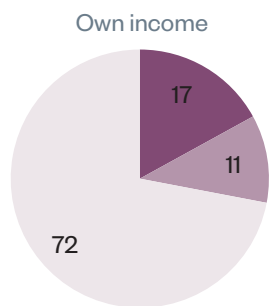
Viewed from one perspective, financial decision-making is markedly different in Somali. Female (and male) caregivers are far more likely than their counterparts in Afar to report individual rather than shared financial decision-making. For example, 50% of female caregivers in Somali reported that they alone control how their income is used – and only 38% report sharing the decision with their husband (see Figures

**Table 30: Livestock holdings, by region and sex of HH head (in headcount)**

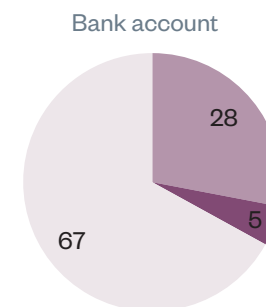
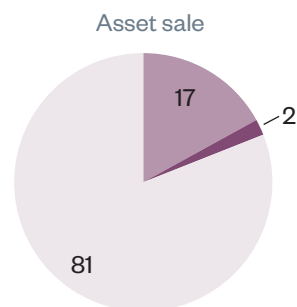
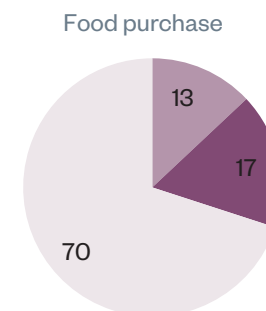
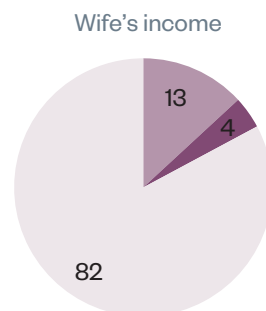
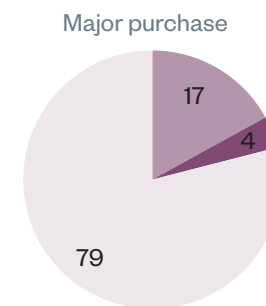
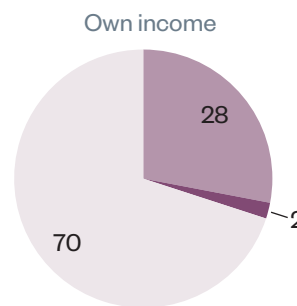
	Afar		Somali	
	MHH	FHH	MHH	FHH
Oxen	.97	.63	.6	.25
Camels	3	2.2	1.6	1.4
Donkeys	.83	.7	.5	.3
Cattle (other than oxen)	6.2	5.5	1.8	1
Goats	16.5	15.8	14.8	12.2
Sheep	3.5	3.1	8.9	6.3

Figure 25: Afar caregivers' reported decision-making

Female caregivers' report



Male caregivers' report



I alone (wives)  
 My husband alone  
 Shared

I alone (husbands)  
 My wife alone  
 Shared



Adolescent boys from Afar region, Ethiopia © Nathalie Bertrams/GAGE 2022

26 in the left column). Similarly, 32% of female caregivers reported that they alone decide about asset sales, and 45% reported shared decision-making with their husband. In another way, however, the patterning of responses echoes that in Afar: male caregivers claim more financial decision-making for themselves and allocate less to their wife (see Figures 26 in the right column). For example, 53% of male caregivers reported that they alone decide about asset sales; and only 12% reported that their wife decides alone. Compared to female caregivers in Somali, men claim 30 percentage points more own power (53% vs. 23%) and allocate women 20 percentage points less (12% vs. 32%). In Somali, most male caregivers claimed to have final say in decision-making even over food purchases.

Our qualitative findings are in line with survey results and suggest that in Somali culture, women have a great deal of say in HH decision-making, including the control of assets and spending. Interviews with multiple Somali men indicate that while men have the final say about the seasonal sale of large animals, women control the sale of small ruminants (goats, sheep, chickens), which provide households' regular income. Several men added that women have the right to not to share the income from sales of these animals, whereas men are required to share the income they earn from selling larger livestock. One of the key informants in *kebele* E noted that it is not even culturally acceptable for man to ask how much his wife earned from a sale – or how she spent it – because men recognise that

women are better at financial management. In *kebele* G, a married adolescent boy in a FGD, when asked whether he knew what his wife earned from the sale of a goat or sheep, said, 'No, I do not, and I do not ask her.' He did, however, explain, 'But I know and trust my wife that she fully uses the money for HH expenses. It is not a culture here to control how she spends it.' Somali women's control over financial assets has significant implications for FGM/C, as it means that women can afford to have their daughters cut. It also side lines husbands and leaves them with less space to refuse to have their daughters cut.

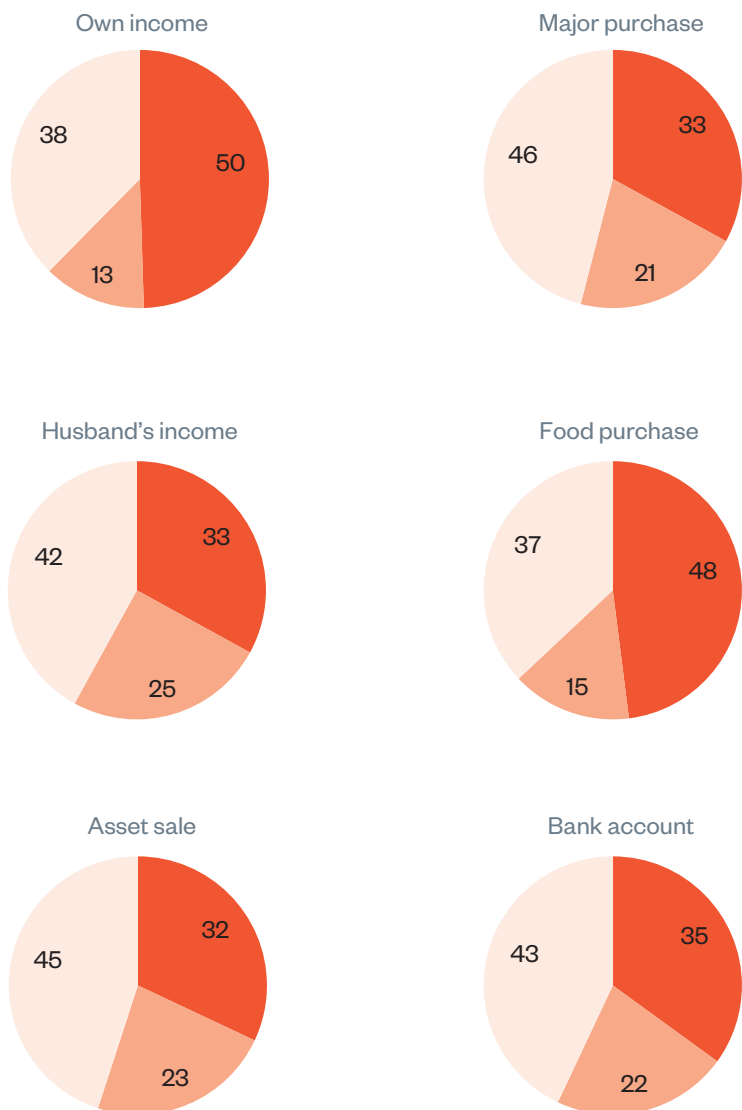
### 5.6.5 Households' access to social protection

Our survey found evidence that social protection is being differently targeted in Afar and Somali (see Table 31). In Afar, we found few differences between male- and FHHs; approximately half had ever received PSNP or other assistance (such as a waiver for healthcare). This is in line with previous GAGE research and indicates that the PSNP is being targeted to communities as a whole rather than to households on the basis of HH level poverty. In Somali, on the other hand, FHHs are significantly more likely to have received all forms of assistance than MHHs ( $p < .01$ ). For example, 13% of FHHs but just 5% of MHHs are currently receiving support from the PSNP. This is to be expected, given that the PSNP programme is weighted towards FHHs.

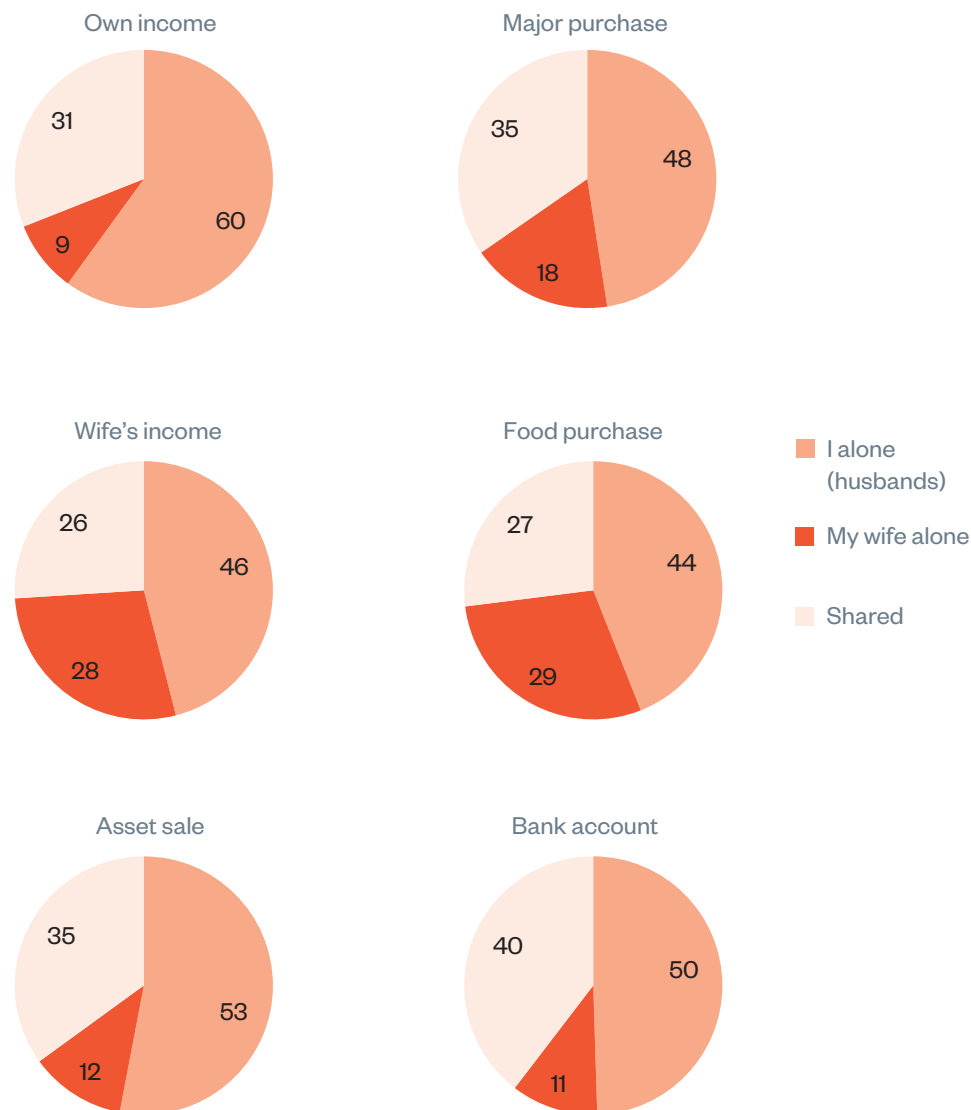


Figure 26: Somali caregivers' reported decision-making

Female caregivers' report



Male caregivers' report



**Table 31: Receipt of social protection, by region and sex of HH head (%)**

	Afar		Somali	
	MHH	FHH	MHH	FHH
Ever received PSNP	50	46	9	16
Currently receiving PSNP	7	6	5	13
Other assistance (e.g. health waiver)	45	44	8	12

## 5.7 Roll out of Save the Children's programming

### Key findings

- Roll out appears more challenged in Somali than Afar.
- Across regions, most people who are taking part in programming have received either cash (adults) or school materials (adolescents); a minority have taken part in activities meant to shift gender norms or directly address FGM/C or child marriage.

### 5.7.1 Exposure to programming

Our caregiver survey found that Save the Children's programming rollout has varied across regions (see Table 32). Looking only at treatment communities, more of those living in Afar than Somali have heard about – and participated in – programming. The specifics of programming have also varied. For example, more caregivers in Afar (80%) than Somali (57%) reported receiving cash transfers (which were provided in both regions for six months to mitigate the effects of the Covid-19 pandemic) and more of those in Somali (31% vs. 21%) reported taking part in self-help groups aimed at economic empowerment. A small minority in both regions reported attending radio listening groups aimed at exposing women to ideas about gender equality.

Our adolescent survey found similar patterns (see Table 33) – albeit with interesting gender differences. Girls and boys in treatment communities in Afar were more likely to have heard of programming, and to have participated in programming, than their peers in Somali. The qualitative interviews in Afar suggest that there has been intensive

training for government officials and experts both at *woreda* and *kebele* levels, including religious leaders, and that these people have been visiting the community several times to discuss the programme's intentions. This has a positive impact in terms of raising awareness; for example, both adolescents and adults in *kebele* A knew about the programme. In Somali, by contrast, although training was provided to officials at both levels, the follow-up and supervision was apparently so poor that many adolescents were not aware of the programme. In some areas, they only knew that education materials were given to them through the school administration, but did not know which organisation had funded this. For example, a 17-year-old girl in *kebele* E (Somali) noted that programming in her community was very ad hoc and disorganised:

*There is an anti FGM club which has been established in 2021. I am a member of it. But it is not that much active and we have do not have any activities. There was a guy from the Education Bureau and he taught us about FGM and that is it... The leader is from the primary school... teachers from our school are not involved but there was one teacher from the primary school... The club was only for girls...*

In both regions, boys were significantly more likely to have heard of programming than girls, presumably because of their greater mobility and exposure to information. Support in the form of school materials was the most commonly reported programme element among girls and boys in both regions. At the time of the survey, rates of participation in the gender clubs were low, especially among boys as the targeting appeared to focus on girls.

**Table 32: Caregivers' awareness of programming, and which elements they participated in, by region**

	Afar	Somali
Have heard of programming	80%	68%
Of those who have heard of programming, participated in it	90%	85%
Of those who have participated in the programming, which element?	<ul style="list-style-type: none"> <li>• 80% cash transfer</li> <li>• 21% self-help group</li> <li>• 14% school material support</li> <li>• 2% radio listening group</li> </ul>	<ul style="list-style-type: none"> <li>• 57% cash transfer</li> <li>• 31% self-help group</li> <li>• 5% school material support</li> <li>• 14% radio listening group</li> </ul>

**Table 33: Adolescents' awareness of programming, and elements participated in, by region and adolescents' sex**

	Afar		Somali	
	Girls	Boys	Girls	Boys
Have heard of programming	59%	76%	42%	70%
Of those who have heard of programming, have participated in it	84%	26%	84%	85%
Of those who have participated in programming, which element?	<ul style="list-style-type: none"> <li>• 88% school material</li> <li>• 12% gender club</li> </ul>	<ul style="list-style-type: none"> <li>• 71% school material</li> <li>• 7% gender club</li> </ul>	<ul style="list-style-type: none"> <li>• 84% school material</li> <li>• 19% gender club</li> </ul>	<ul style="list-style-type: none"> <li>• 99% school material</li> <li>• 4% gender club</li> </ul>

### 5.7.2 Reactions to programming

Caregivers' reactions to programming are primarily positive, but far more so in Afar, where 93% reported liking everything the programme had to offer (see Table 34). In Somali, only 62% of caregivers reported the same. Caregivers particularly enjoyed the social aspects of programming, though some also enjoyed learning new life skills and contributing to social change in the community. Complaints about programming were far more common in Somali, where one-eighth of caregivers reported not learning anything useful and that meetings were at inconvenient locations.

Adolescents' views on programming largely mirrored those of their female caregivers (see Table 35). Those living in Afar were extremely positive, with 94% reporting that they liked everything. The social aspects were what adolescent girls and boys enjoyed most – with no gender differences (hence the lack of gender disaggregation in the table). In Somali, only half (52%) of adolescents reported that they liked everything, and complaints about the programme were more common. There were also important gender differences. For example, 17% of girls and 29% of boys reported that they did not learn anything useful, while some girls (8%) and boys (7%) reported that topics were inappropriate. This highlights how deeply

entrenched norms are in this region, and suggests it will be difficult to promote change. A teacher in Somali added that progress in that region is likely to be further slowed by Save the Children's limited follow-up. They stated:

*Save the Children provided training to teachers and headteachers on how to strengthen gender clubs and to create awareness of the risks of FGM/C. However, there is very little supervision and follow-up. Because of that, we also do not give attention to what we learned during the training.*

### 5.7.3 Differences between treatment and control communities

Our survey found some significant differences between treatment and control communities that may be due to programme impacts, to pre-existing differences between communities, or to some combination of the two. For example, school enrolment rates were found to be higher in treatment communities. In Afar, 77% of girls in treatment communities had ever enrolled in school, vs. only 68% of those in control communities (see Figure 27,  $p < .05$ ). Girls in control communities were also more likely to have already left school than those in treatment communities (15% vs. 5%;  $p < .01$ ). In Somali, differences between treatment and control communities were even more marked (see

**Table 34: Caregivers' reactions to programming, by region (participants only)**

	Afar	Somali
Liked everything	94%	52%
Liked aspects	<ul style="list-style-type: none"> <li>• 49% enjoyed time with peers</li> <li>• 32% liked making new friends</li> <li>• 22% liked getting out of the house</li> <li>• 21% liked contributing to community change</li> <li>• 20% liked learning new life skills/subjects</li> </ul>	<ul style="list-style-type: none"> <li>• 54% enjoyed time with peers</li> <li>• 32% liked learning new life skills/subjects</li> <li>• 28% liked making new friends</li> <li>• 22% liked contributing to community change</li> <li>• 18% liked getting out of the house</li> </ul>
Disliked aspects	<ul style="list-style-type: none"> <li>• 2% disliked any aspect</li> </ul>	<ul style="list-style-type: none"> <li>• 14% felt they did not learn anything useful</li> <li>• 13% reported meetings were at inconvenient locations</li> <li>• 10% reported they did not feel safe at meeting locations</li> </ul>

**Table 35: Adolescents' reactions to programming, by region (participants only)**

	Afar	Somali	
Liked everything	94%	52%	
	Girls and Boys*	Girls	Boys
Liked aspects	<ul style="list-style-type: none"> <li>• 36% enjoyed time with friends</li> <li>• 20% liked making new friends</li> <li>• 14% of girls liked getting out of the house (vs. 7% of boys)</li> <li>• 12% liked learning new life skills/subjects</li> </ul>	<ul style="list-style-type: none"> <li>• 51% enjoyed time with friends</li> <li>• 18% liked making new friends</li> <li>• 16% liked learning life skills/subjects</li> </ul>	<ul style="list-style-type: none"> <li>• 63% enjoyed time with friends</li> <li>• 14% liked making new friends</li> <li>• 8% liked learning life skills/subjects</li> </ul>
Disliked aspects	<ul style="list-style-type: none"> <li>• 7% of boys reported not learning anything useful</li> </ul>	<ul style="list-style-type: none"> <li>• 17% reported learning nothing useful</li> <li>• 9% topics were inappropriate</li> <li>• 7% inconvenient locations</li> </ul>	<ul style="list-style-type: none"> <li>• 29% reported learning nothing useful</li> <li>• 7% topics were inappropriate</li> <li>• 3% inconvenient locations</li> </ul>

\*Because responses from girls and boys were so similar, we have presented both together.

Figure 28). In treatment communities, 81% of girls had ever attended school, compared with just 34% in control communities ( $p < .01$ ). As with their peers in Afar, girls in Somali control communities were also more likely to have already dropped out (21% vs. 6%) ( $p < .01$ ). A school principal in Somali reported that he attributed at least some recent progress to Save the Children's distribution of school supplies. He said:

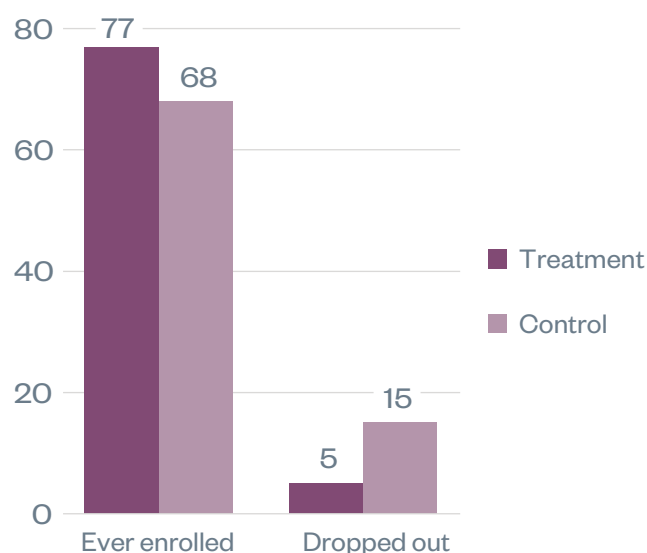
*Save the Children distributed education materials to all students, both in primary and secondary. After this, many students, especially girls, have continued to attend, and we observed that the number of female students in both primary and secondary has been increasing this year.*

In Somali, but not Afar, there were stark differences in the grade attainment of enrolled girls in treatment vs.

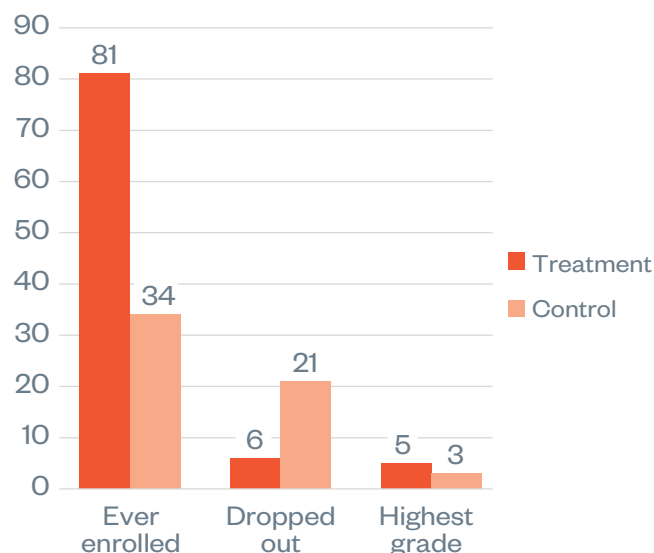
control communities – differences so large that they cannot be attributed to Save the Children programming. Those in control communities had completed, on average, only 2.9 grades, compared with 5.1 for girls in treatment communities. This will need to be borne in mind in terms of disentangling programming impacts over time.

With the important caveat that differences between treatment and control communities may be pre-existing – due to exposure to awareness raising activities by both government and NGOs in the past and also to better access to mobile technology and other media – there are a few significant differences between communities in terms of adolescents' beliefs about child marriage and FGM/C that should be noted. For example, in Afar, girls in treatment communities are 11 percentage points less likely to report that FGM/C has advantages (see Figure 29,  $p < .01$ ), and 10

**Figure 27: Educational differences for adolescent girls by community treatment status, Afar**



**Figure 28: Educational differences for adolescent girls by community treatment status, Somali**





percentage points less likely to report that FGM/C should continue ( $p < .01$ ). In both Afar and Somali, adolescents in treatment communities are more likely to prefer delaying marriage until adulthood than those in control communities. Differences are at least 10 percentage points and are significant at least at the  $p < .01$  level. In Somali, adolescents in treatment communities are also significantly more likely to know the legal age for marriage – though it should be noted that the overall percentage remains extremely low, at just 4% (see Figure 30).

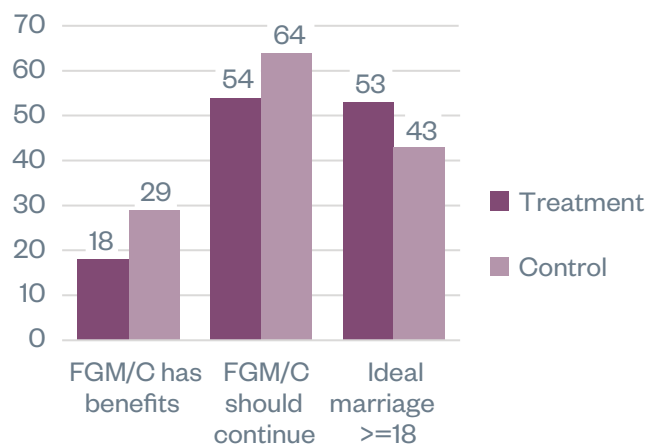
Again with the caveat that differences between treatment and control communities may be pre-existing, there are also some significant differences between communities in terms of primary caregivers' beliefs about FGM/C. For example, in Afar, caregivers in treatment communities are less likely to believe that FGM/C should continue than those in control communities (59% vs. 68%,  $p < .01$ ) (see Figure 31). Those in treatment communities are also less likely to believe that FGM/C is a religious mandate (16% vs. 22%,  $p < .01$ ) and more likely to believe that it is required by culture (71% vs. 64%,  $p < .01$ ). There are fewer

significant differences between treatment and control communities in Somali (see Figure 32). However, primary caregivers in treatment communities are more likely to report that FGM/C has risks (40% vs. 31%) and to have heard of the law regarding FGM/C (40% vs. 28%) ( $p < .01$ ).

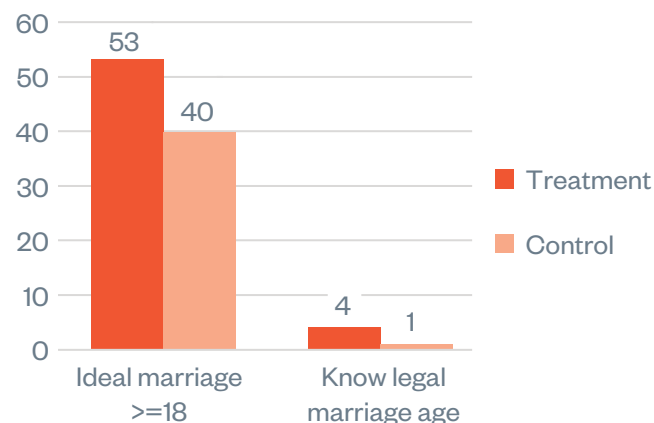
## 5.8 Regression results

To explore the factors associated with caregivers' and adolescents' beliefs about FGM/C and child marriage, and to help identify entry points for programming to begin shifting those beliefs, we ran a variety of probit regressions. In the discussion of our findings, we employ the term 'significant' to refer to statistical significance and indicate the level of significance in brackets in the text, and by using stars in the tables. We report findings for statistical significance at the 10% (\*), 5% (\*\*) and 1% (\*\*\*) levels. In the tables in the main text, to highlight the findings that are statistically significant we only include values for those variables that are significant. However, in the annexes, we report the full findings for all variables.

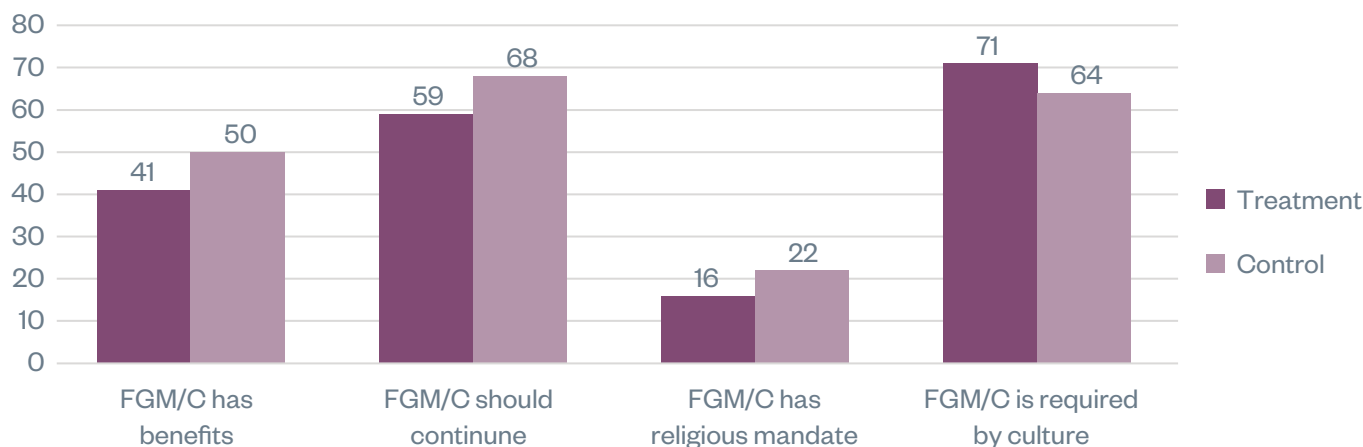
**Figure 29: Differences in adolescent girls' beliefs by community treatment status, Afar**



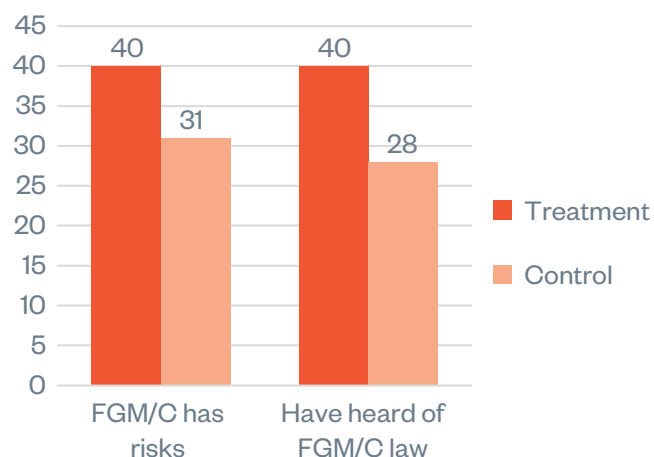
**Figure 30: Differences in adolescent girls' beliefs by community treatment status, Somali**



**Figure 31: Differences in caregivers' beliefs about FGM/C, by community treatment status, Afar**



**Figure 32: Differences in caregivers' beliefs about FGM/C, by community treatment status, Somali**



Results were markedly different for FGM/C and child marriage. With some exceptions, results were also markedly different for Afar and Somali regions, suggesting that programming needs to be carefully tailored to each region to optimise efficacy.

### 5.8.1 FGM/C

To explore the factors associated with support for FGM/C, we used survey responses to the question, ‘Should FGM/C be continued?’ Results are presented below first by region and then by participant type with results for caregivers presented first, followed by results for adolescents.

#### Afar

##### Key findings

- Across regions, awareness raising – about risks, perceived benefits, and religious tenets – appears critical to encouraging elimination.
- Economic empowerment is the least likely pathway to change – and may indeed further entrench FGM/C.
- In Afar, but not Somali, education is a promising pathway.
- In Somali, but not Afar, raising adults’ legal awareness may help.

In Afar, caregivers’ preferences for the continuity of FGM/C are not related to age, literacy, HH wealth, gender, gender of HH head, major source of HH income, or knowledge of the law on FGM/C (see Table 36). That is, caregivers are equally likely to believe that FGM/C should be continued regardless of whether they are older or younger, literate or

not, better off or poorer, female or male, living in a male-headed or female-headed HH, derive their income from livestock or crop farming or petty trading, or know that parents and cutters can be prosecuted for FGM/C under national law.

Preferences are, however, significantly ( $p < .01$ ) related to caregivers’ beliefs about the risks and benefits of FGM/C, beliefs about whether FGM/C is required by religion, caregivers’ control over own earnings, and adolescents’ enrolment in school and self-efficacy. Unsurprisingly, female and male caregivers who believe that FGM/C has risks (in terms of sexual intercourse and childbirth) are less likely to support continuation than those who do not believe that FGM/C has risks. Those who believe that FGM/C has benefits (in terms of controlling girls’ behaviour, marriageability and respecting social customs) are correspondingly more likely to support continuation of the practice. Female and male caregivers who believe that FGM/C is mandated by religion are also more likely to support continuation. Caregivers with adolescents enrolled in school and with higher scores for adolescent self-efficacy are also less likely to support continuation of FGM/C. Caregivers from households with a large number of cut girls are more likely to support continuation of the practice, although the effect is only marginally significant ( $p < 0.1$ ).

Perhaps the most interesting finding is that in Afar, female caregivers (regardless of whether they live in MHHs

**Table 36: Average marginal effects from probit model of Afar caregivers’ support for the continuation of FGM/C**

Independent variables	All-caregivers	Female caregivers
Believes FGM/C has risks	-.23***	-.24***
Believes FGM/C has benefits	.34***	.32***
Believes FGM/C is required by religion	.28***	.26***
Caregiver controls earned money	.19***	.21***
Caregiver shares control of earned money	.16***	.17***
Adolescent respondent is enrolled in school	-.11***	-.10***
Adolescent respondent’s self-efficacy score	-.08***	-.08***
Proportion of girls in HH who have been cut	0.16*	0.18*
Observations	839	782

(\*= $p < .1$ , \*\*= $p < .05$ , \*\*\*= $p < .01$ )

or FHHs) who have control over earnings are more likely to support continuation than those who have no control over earnings. This suggests that for mothers, ensuring that their daughters are cut is sufficiently important that when they do control resources, they prioritise FGM/C.

Looking only at adolescent girls in Afar who reported having been cut, our regression results primarily speak to the need for awareness raising of all sorts (see Table 37). Girls' support for the continuation of FGM/C is significantly ( $p < .01$ ) and positively related to believing that FGM/C has benefits and is required by religion. It is significantly ( $p < .01$ ) and negatively related to believing that FGM/C has risks. Girls are also significantly ( $p < .01$ ) less likely to support continuation if they have ever been enrolled in school and when they have relatively higher levels of self-efficacy, both of which speak to pathways for intergenerational progress (given the age at which girls are cut in Afar). There is a marginal negative relationship between support for continuation and girls' age ( $p < .1$ ), with older girls perhaps less likely to support continuation than younger girls. Mirroring findings for caregivers, perhaps the most interesting finding is regarding the relationship between HH wealth and girls' support for continuation. Girls who live in better off households are significantly ( $p < .05$ ) more likely to support continuation than those who live in less well-off households – again perhaps because there are resources available to support the practice.

## Somali

In some ways, Somali caregivers' support for the continuation of FGM/C mirrors that of their peers in Afar (see Table 38). For example, there is no relationship between support and caregiver age, caregiver sex, or HH size or wealth. There are, however, significant ( $p < .01$ )

**Table 37: Average marginal effects of probit model of cut Afar girls and their support for the continuation of FGM/C**

Independent variables	
Age of adolescent	-.02*
HH wealth	.03**
Adolescent ever enrolled	-.14***
Believes FGM/C has risks	-.32***
Believes FGM/C has benefits	.26***
Believes FGM/C is required by religion	.20***
Adolescents' self-efficacy score	-.01***
Observations	649

(\*= $p < .1$ , \*\*= $p < .05$ , \*\*\*= $p < .01$ )

**Table 38: Average marginal effects from probit model of Somali caregivers' support for the continuation of FGM/C**

Independent variables	All-caregivers	Female caregivers
Literate	.08**	
HH income from crop farming	.13***	.13***
HH income is from wage employment	.08**	
HH income from trading	.06**	.07**
HH income from other than livestock	.06**	.06**
Knows parents and cutters legally liable	-.19*	-.22**
Believes FGM/C has risks	-.34***	-.34***
Believes FGM/C has benefits	.41***	.39***
Believes FGM/C is required by religion	.14***	.16***
Observations	812	712

(\*= $p < .1$ , \*\*= $p < .05$ , \*\*\*= $p < .01$ )

relationships between caregivers' support for continuation and their beliefs about the risks and benefits of FGM/C and its religious underpinnings. Those who perceive risks are less supportive, and those who perceive benefits or believe that FGM/C is required by religion are more supportive.

In other ways, Somali and Afar caregivers' support for the continuation of FGM/C is quite different. For example, in Somali, literate caregivers are significantly ( $p < .05$ ) more likely to support continuation than their illiterate counterparts. This effect is only for male caregivers and may be related to their having become literate at Islamic schools. However, this finding was not borne out in the qualitative data and this is an area that we will need to probe in more depth in subsequent data collection rounds in order to better understand the interplay between education, cultural pride and religious mandates in shaping the practice of FGM/C. In addition, and perhaps because there is more variation in Somali livelihoods than Afar livelihoods, among caregivers in Somali, support for continuation of FGM/C varies with the source of HH income. Specifically, despite hypothesising that livelihood diversification might lead to improved income and then better access to education – which might then reduce support for FGM/C – caregivers whose households depends on crop farming or trading or other livelihood sources are significantly more likely to support the continuation of FGM/C than those that depend on livestock ( $p < .01$  for crop farming and  $p < .05$  for other activities). Interestingly, caregivers' control over

income is not significant in Somali (though it was in Afar). Also in contrast to Afar, in Somali – and more so for female caregivers – knowledge of the national law on FGM/C is associated with significantly ( $p < .05$ ) less support for continuation. In Somali, unlike in Afar, adolescents' school enrolment and self-efficacy is not related to caregivers' support for FGM/C.

Although our Somali sample includes significantly fewer girls who have already undergone FGM/C – a fact that may obscure patterning – girls' support for the continuation of FGM/C largely mirrors that of caregivers' (see Table 39). For example, girls whose caregivers are literate are significantly ( $p < .05$ ) more likely to support continuation than girls with illiterate caregivers. This is also the case with girls who believe that FGM/C has benefits or is required by religion ( $p < .01$ ). Girls who believe that FGM/C has risks are correspondingly less likely to support continuation ( $p < .01$ ). As with caregivers, there is no relationship between Somali girls' school enrolment and their support for FGM/C. In other ways, girls' and caregivers' support varies. For instance, while Somali caregivers who report other HH livelihoods (such as transportation service, transfers, and casual employment) are more likely to support the continuation of FGM/C, this is not the case for adolescent girls. Already cut girls who live in households with other livelihoods (i.e. other than farming, wage employment, petty trading, and livestock) are marginally ( $p < .1$ ) less likely to support continuation than those who live in households that depend on livestock – even with controls for education. There is also a marginal negative relationship ( $p < .1$ ) between girls' self-efficacy and support for FGM/C that does not exist for caregivers and for girls only, support for FGM/C decreases with HH size.

**Table 39: Average marginal effect from probit model of cut Somali girls' support for continuation of FGM/C**

Independent variables	
HH literate	.10**
HH size	-0.02**
Others HH income (other than livestock)	-.19*
Believes FGM/C has risks	-.43***
Believes FGM/C has benefits	.24***
Believes FGM/C is required by religion	.25***
Adolescents' self-efficacy score	-.005*
Observations	318

(\*= $p < .1$ , \*\*= $p < .05$ , \*\*\*= $p < .01$ )

## 5.8.2 Child marriage

### Key findings

- Across regions, awareness raising – about risks, perceived benefits, and religious tenets – appears critical to encouraging elimination.
- Economic empowerment is the least likely pathway to change – and may indeed further entrench FGM/C.
- In Afar, but not Somali, education is a promising pathway.
- In Somali, but not Afar, raising adults' legal awareness may help.

To explore the factors associated with support for child marriage, we used survey responses to two questions. For caregivers and adolescents, we used responses to the statement, '*Girls' marriage can wait until have they have completed secondary school*'. For adolescents, we also used the statement, '*The ideal age of own marriage is 18 or greater*'. Results are presented below first by region and then by participant type, with results for caregivers presented first, followed by those for adolescents.

### Afar

In Afar, among male and female caregivers, support for delaying girls' marriage until after secondary school is not related to age, age or literacy of the HH head, whether the caregiver was married before age 18, HH wealth, whether HH major livelihoods are derived from crop farming or wage employment, caregiver's control over own income, or adolescent's school enrolment or self-efficacy score (see Table 40). Literate caregivers were marginally more likely to approve of delayed marriage than their illiterate peers, though this effect is only of limited significance ( $p < .1$ ), likely due to the small number of caregivers who are literate (and indeed the effect disappears for female caregivers, who are vanishingly unlikely to be literate). It is also unclear whether support for delayed marriage is related to girls' preference for ideal age at marriage or their completion of secondary school.

Caregivers whose own marriages included a bridal payment are significantly ( $p < .01$ ) less likely to support delaying marriage than those whose marriages did not include such a payment. Although caregivers' support for FGM/C did not vary according to gender, this is not the case for caregivers' support for delayed marriage. Female caregivers were marginally less likely to support delayed marriage than male caregivers ( $p < .1$ ). Caregivers living



**Table 40: Average marginal effects from probit model of Afar caregivers' support for delaying girls' marriage until after secondary school**

Independent variables	All-caregivers	Female caregivers
Literate	.11*	
Bridal payment for caregivers' marriage	-.09***	-.09***
Female	-.10*	na
HH head is female	.10**	.11**
HH income is petty trading	.17***	.19***
Believes most girls in the community marry before 18	-.08**	-.07*
Adolescent supports delaying girls' marriage until after secondary school	.22***	.23***
Observations	900	821

(\*= $p < .1$ , \*\*= $p < .05$ , \*\*\*= $p < .01$ )

in FHHs, however, were significantly ( $p < .05$ ) more likely to support delayed marriage than those living in MHHs. Caregivers living in households that derive livelihoods from petty trading, rather than livestock, were also significantly

( $p < .01$ ) more likely to support delayed marriage. Male and female caregivers who believe that most girls in the community marry before the age of 18 are (unsurprisingly) significantly ( $p < .05$ ) less likely to support delayed marriage. Caregivers' support for delayed marriage is significantly ( $p < .01$ ) and positively associated with their adolescent's support for delayed marriage, highlighting important intergenerational effects.

As noted above, for adolescents, we estimated two models – the first based on adolescents' general support for delaying girls' marriage until after secondary school (mirroring the caregiver model), and the second based on adolescents' personal preference for marriage at 18 or above. As Table 41 shows, results were often markedly different – which suggests that adolescents may have been focusing more on girls' completion of secondary school and less so on age at marriage, in the first question. In Afar, this is especially evident regarding the relationship between adolescents' marital status and the dependent variables. Adolescents who married before age 18 are significantly ( $p < .01$ ) less likely to see adult marriage as ideal, but significantly ( $p < .01$ ) more likely to support delaying girls' marriage until after they complete secondary school.

**Table 41: Average marginal effects from probit models of Afar adolescents' support for delaying girls' marriage until after secondary school and beliefs about the ideal age of marriage**

Independent variables	Girls' marriage (in general) should be delayed until after secondary school		Ideal age of marriage for the respondent is 18 or older	
	All adolescents	Girls	All adolescents	Girls
Age of adolescent			.05***	.06***
Female			-.19***	na
Adolescent ever enrolled	.13***	.11***	.14***	.13***
Adolescent married before 18	.21***	.19***	-.50***	-.46***
Adolescent is aware of legal age of marriage	.11**	.11*	.20***	.20***
Adolescent believes most girls marry before 18			-.20***	-.22***
Adolescent participated in traditional dance	.08**	.09**		
Literate HH head			.14***	.16***
HH head is female				
Caregiver married before 18			-.09*	
Bridal payment in caregiver's marriage	-.13***	-.15***	-.09**	-.11**
HH income from crop farming	.07*	.09**	.09*	.09*
HH income from petty trading	-.28*	-.29*		.22*
HH income other than livestock	.18***	.18***		
HH wealth index			-.03**	-.03***
Caregiver supports delaying girls' marriage until after secondary school	.22***	.20***		
Observations	901	708	924	808

(\*= $p < .1$ , \*\*= $p < .05$ , \*\*\*= $p < .01$ )

Adolescents' age is not associated with their support for delaying girls' marriage until after secondary school. It is, however, associated with the ideal age of marriage being in adulthood. Older adolescents, closer to marriageable age, were significantly ( $p < .01$ ) more likely than younger adolescents to prefer marriage in adulthood. The same is true for literacy of the HH head, which is not associated with adolescents' support for delayed marriage, but adolescents living in households where the head is literate were significantly ( $p < .01$ ) more likely to see marriage in adulthood as ideal. Adolescents' gender, their beliefs about how common child marriage is in the community, and HH wealth were also associated with the ideal age for marriage, but not support for delayed marriage until finishing secondary school. Specifically, girls were significantly ( $p < .01$ ) less likely to prefer marriage in adulthood than boys, and adolescents who believe that most girls marry as children were significantly ( $p < .01$ ) less likely to report wanting to marry at 18 years or older than those who do not hold those beliefs. Adolescents in better-off households were also significantly ( $p < .05$ ) less likely to prefer marriage in adulthood than those in less well-off households. On the other hand, adolescents who have taken part in cultural dances for adolescents ( $p < .05$ ) or who have caregivers who support delaying girls' marriage until after the completion of secondary school ( $p < .01$ ) were significantly more likely to support delaying girls' marriage until after secondary school, but this did not affect their preference for marriage in adulthood. In the case of participation in the saddah traditional dance, our qualitative findings suggest that because those who participate have an opportunity to interact in an adolescent-only space with adolescents of the opposite sex – including, according to some reports, engaging in sexual activity with non-*absuma* partners – they may feel less compelled to marry at an early age.

Other variables were similar across models. For example, adolescents who have ever been enrolled in school were both significantly ( $p < .01$ ) more likely to support delaying girls' marriage until after secondary school and to see marriage in adulthood as ideal for themselves. Findings were similar for adolescents' knowledge of the marriage law: those who know that the legal age of marriage is 18 or above were significantly more likely to support delay ( $p < .05$ ) and to see marriage in adulthood as ideal ( $p < .01$ ). As noted above for caregivers, bridal payments were negatively associated with support for delayed marriage – and preferences for marriage in adulthood. Adolescents whose caregiver's marriage involved bridal payment were

significantly ( $p < .01$ ) less likely to agree that girls should delay marriage until after they have completed secondary school and less likely to see marriage in adulthood as ideal. Adolescent girls living in households whose major source of income is crop farming were more likely to prefer delayed marriage until after secondary school completion and to have a personal preference for marriage in adulthood. HH reliance on petty trading, on the other hand, was negatively associated ( $p < .01$ ) with delaying marriage until after secondary school completion but marginally positively associated ( $p < .01$ ) with adolescent girls' (not boys) preference for marriage in adulthood.

### Somali

In Somali, where girls are especially unlikely to have ever enrolled in formal education, caregivers' support for delaying girls' marriage until after the completion of secondary school is not related to age, age of the HH head, literacy, caregiver's age at marriage, bridal payments, gender, HH wealth, caregiver's control over money or adolescent's school enrolment (see Table 42). Caregivers' support for delayed marriage is, however, positively related to literacy of the HH head ( $p < .05$ ), female-headed HH ( $p < .1$ ), and adolescents' support for delaying girls' marriage until after secondary school ( $p < .1$ ) – although it should be noted that several of these relationships are only statistically significant at 10%. For female caregivers only, support for delaying marriage is also significantly ( $p < .01$ ) associated with deriving an income from petty trading. Caregivers' support for delaying girls' marriage until after

**Table 42: Average marginal effects from probit models for Somali caregivers' support for delaying girls' marriage until after secondary school**

Independent variables	All-caregivers	Female caregivers
Literate HH head	.09**	.07**
HH head is female	.07*	
HH income is farming	-.17***	-.13***
HH income is petty trading		.06***
Believes most girls in the community marry before 18	-.09***	-.07***
Adolescent supports delaying girls' marriage until after secondary school	.07*	.08**
Adolescents' self-efficacy score	.004**	
Observations	819	706

(\*= $p < .1$ , \*\*= $p < .05$ , \*\*\*= $p < .01$ )

the completion of secondary school is negatively ( $p < .01$ ) associated with beliefs that most girls in the community marry before age 18 – and for households whose main income is from crop farming. Crop farmers, who are more likely to be sedentary, are less likely than pastoralists to support delaying girls' marriage.

As noted above, for adolescents we estimated two models – the first based on their support for delaying girls' marriage until after secondary school (mirroring the caregiver model), and the second based on their personal preference for marriage at age 18 or older (see Table 43). In Somali, compared to boys, girls were significantly ( $p < .05$ ) more likely to support delaying marriage until after secondary school completion but significantly ( $p < .05$ ) less likely to have a personal preference for marriage in adulthood.

As was the case in Afar, older adolescents in Somali were significantly ( $p < .01$ ) more likely to prefer marriage in adulthood than younger adolescents, and adolescents who married before age 18 were significantly ( $p < .01$ ) less likely to, suggesting either that they are satisfied

with their choice to marry as a child – or that they are justifying their choice to reduce cognitive dissonance. Neither age nor marriage before age 18 were associated with adolescents' preferences for delaying girls' marriage until after secondary school. Receipt of bridal payment in caregiver's marriage was also negatively ( $p < .05$ ) associated with adolescent preferences for marriage in adulthood. This may be because girls and their families who are recipients of such payments can use the money as a coping mechanism during shocks, whereas boys who customarily provided the payments may recognise that it is necessary to reach adulthood in order to accumulate the livestock to afford such payments. This variable is again not associated with support for delaying girls' marriage until after secondary school. Adolescents' beliefs that most girls marry before age 18, and residence in a female-headed household (MHH), are also significantly related to preference for marriage in adulthood, but only marginally, and for girls only – related to support for delayed marriage until the completion of secondary education. Adolescents



Local boys in Degheh Bur, Somali region, Ethiopia © UNICEF Ethiopia/2017/Mersha

who believe most girls marry before age 18 are significantly ( $p < .01$ ) more likely to prefer marriage in adulthood; adolescents living in a FHH are significantly ( $p < .05$ ) less likely to see marriage in adulthood as the ideal. HH wealth ( $p < .01$ ) and caregivers' support for delayed marriage ( $p < .05$ ), on the other hand, are significantly associated with adolescents' preference for delaying marriage until after completion of secondary school, but not with the ideal age of marriage being in adulthood.

Several variables are similar across models (see also Table 43). For example, and in line with caregivers' beliefs, adolescent girls are significantly ( $p < .01$ ) less likely to support delaying girls' marriage and less likely to see marriage in adulthood as ideal if they live in a HH

that engages in crop farming rather than herding – likely because sedentarisation facilitates girls' engagement to be married and the marriage process, especially if access to education is limited. Petty trading, on the other hand, is significantly ( $p < .01$ ) associated with more support for both delayed marriage until after secondary school completion and for marriage in adulthood. Adolescent's self-efficacy score is positively associated ( $p < 0.01$ ) with preference for marriage in adulthood. Adolescent's school enrolment and awareness of the marriage law, literacy of the HH head, and caregiver's age at marriage are not statistically significantly associated with either support for delayed marriage or ideal age at marriage being in adulthood.

**Table 43: Average marginal effects from probit models of Somali adolescents' support for delaying girls' marriage until after secondary school and beliefs about the ideal age of marriage**

Independent variables	Girls' marriage should be delayed until after secondary school		Ideal age of marriage is 18 or older	
	All adolescents	Girls	All adolescents	Girls
Age of adolescent			.03***	.03***
Female	.08**	Na	-.1**	na
Adolescent married before 18			-.30***	-.30***
Adolescent is aware of legal age of marriage				
Adolescent believes most girls marry before 18		.06*	.26***	.26***
Self-efficacy score			.01***	.01**
HH head is female		-.06**	-.08*	-.11**
Caregiver married before 18				
Bridal payment in caregiver's marriage			-.11**	-.10*
HH income from crop farming	-.14***	-.14***	-.19***	-.17***
HH income is from petty trading	.07**	.08***	.16***	.19***
HH wealth index	.05***	.04**		
Caregiver supports delaying girls' marriage until after secondary school	.08**			
Observations	819	598	851	649

(\*= $p < .1$ , \*\*= $p < .05$ , \*\*\*= $p < .01$ )



# 6 Conclusions, and policy and programming implications

## 6.1 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 at which girls are marry 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 practice and religious leaders are increasingly aware of the dangers of infibulation vs. 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 disjoint 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.

### 6.8.1 FGM/C

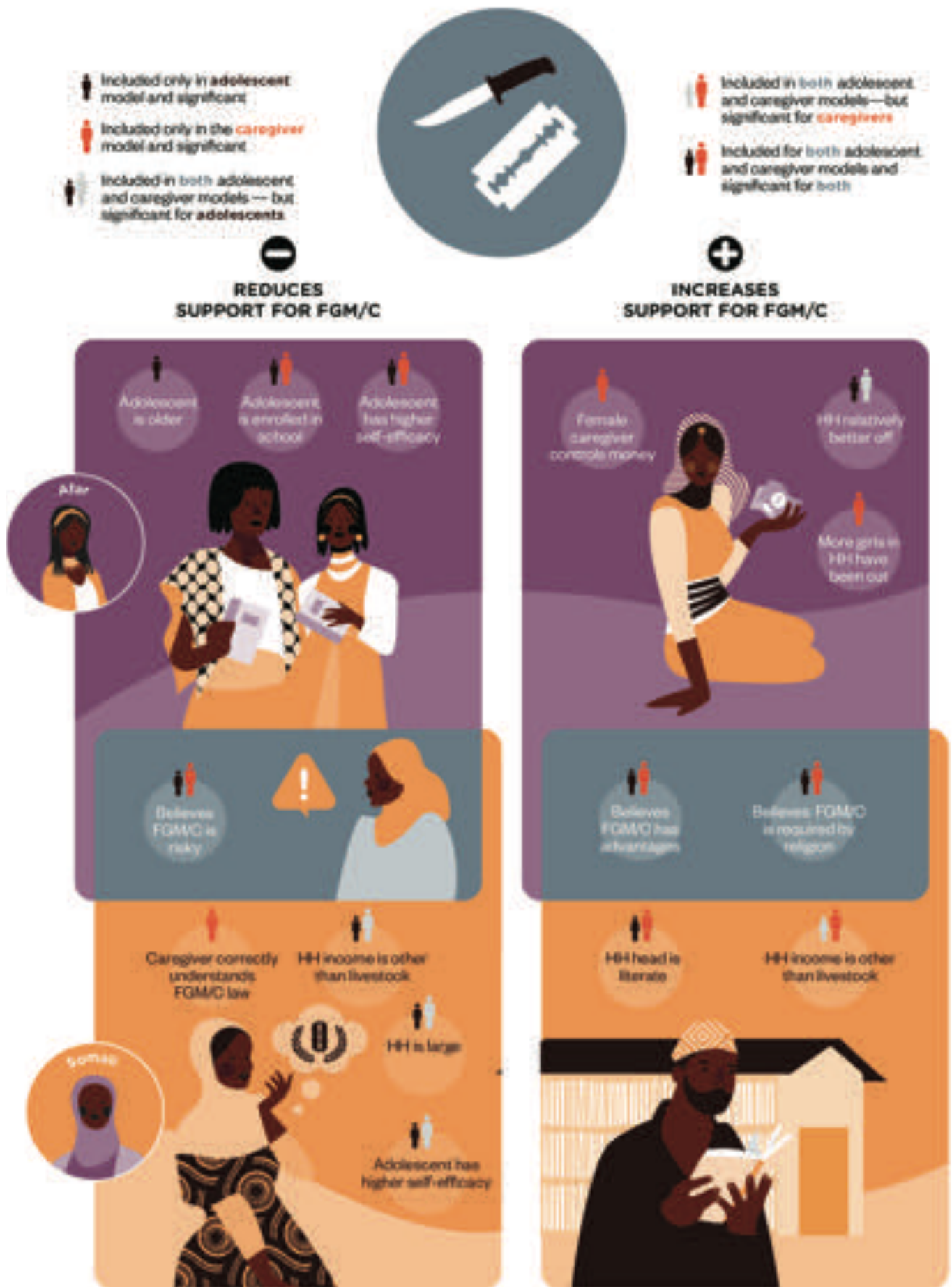
As highlighted in Figure 33 below, our research is finding that there are both similarities and differences in regards to how and why FGM/C is practiced in Afar and Somali.

Regression modelling also suggests that efforts to eliminate FGM/C must be tailored to regional realities. In Afar, as can be seen in Figure 34, programming to reduce FGM/C should include awareness-raising – for adults and adolescents – that addresses the risks of FGM/C, the perceived benefits of FGM/C, and the actual benefits of not cutting girls. Programming should also work closely with religious leaders, to disseminate messages that decouple religion and FGM/C. Supporting adolescents to attend school may also have an impact on the beliefs of caregivers and girls (although, as noted earlier, the negative relationship between enrolment and support for continuation of harmful practices may reflect pre-existing differences between households that do and do not send their children to school, rather than uptake of schooling itself). Programming, either in school or out of school, that promotes girls' self-efficacy will also be important to change – as self-efficacy is positively associated with support to discontinue FGM/C and today's adolescent girls will soon be mothers choosing whether to have their own daughters cut. Critically, our model suggests that

Figure 33: Summary of research findings regarding FGM/C



Figure 34: Summary of regression modelling for support for the continuation of FGM/C





empowering women economically is not likely to reduce FGM/C in Afar. Indeed, it may even increase it, as women's control over their own and their spouse's earnings is associated with greater support for continuation of FGM/C – presumably because women then have the resources they need to demonstrate loyalty to their culture and clan.

In Somali, as in Afar, regression results suggest that programming to reduce FGM/C should include awareness-raising for adults and adolescents that addresses the risks of FGM/C, its perceived benefits, and the actual benefits of not cutting girls (see also Figure 34). It should also include engagement with religious leaders to disseminate messages that de-couple religion and FGM/C. In contrast to Afar, our model for Somali suggests that efforts to raise women's awareness of the national law on FGM/C may also reduce support for continuation of the practice. Programming in Somali may need to confront intergenerational trade-offs in terms of supporting households to diversify their livelihoods (taking up other productive activities in addition to livestock). Such efforts appear to increase adults' support for continuing FGM/C but decrease girls'. In Somali, our results suggest that supporting adolescent girls to attend school is unlikely to shift caregivers' or girls' support for FGM/C – though efforts may pay out over the longer-term – but that because girls'

self-efficacy is marginally correlated with lower levels of support for continuing the practice, programming that supports girls' agency may have their lower support for FGM/C.

### 6.8.2 Child marriage

As highlighted in Figure 35, our research is also finding regional similarities and differences in child marriage practices in Afar and Somali.

In Afar, as can be seen in Figure 36, in our regression models suggest that if programming is to shift preferences for child marriage (and girls' education), it should combine awareness-raising, programming aimed at supporting girls to attend school, and support for livelihood diversification. Awareness-raising should target adults and adolescents, and focus on the risks of child marriage, the perceived advantages of child marriage, and the actual advantages of adult marriage. It should also include information about the legal age of marriage and, where possible, provide local role models that have thrived despite (or because of) eschewing child marriage. Adolescent girls and boys should be supported to attend school, both for their own sake and to encourage intergenerational change, perhaps through stipends or material support. Because households who have incomes derived from activities other than livestock may have more financial leeway to



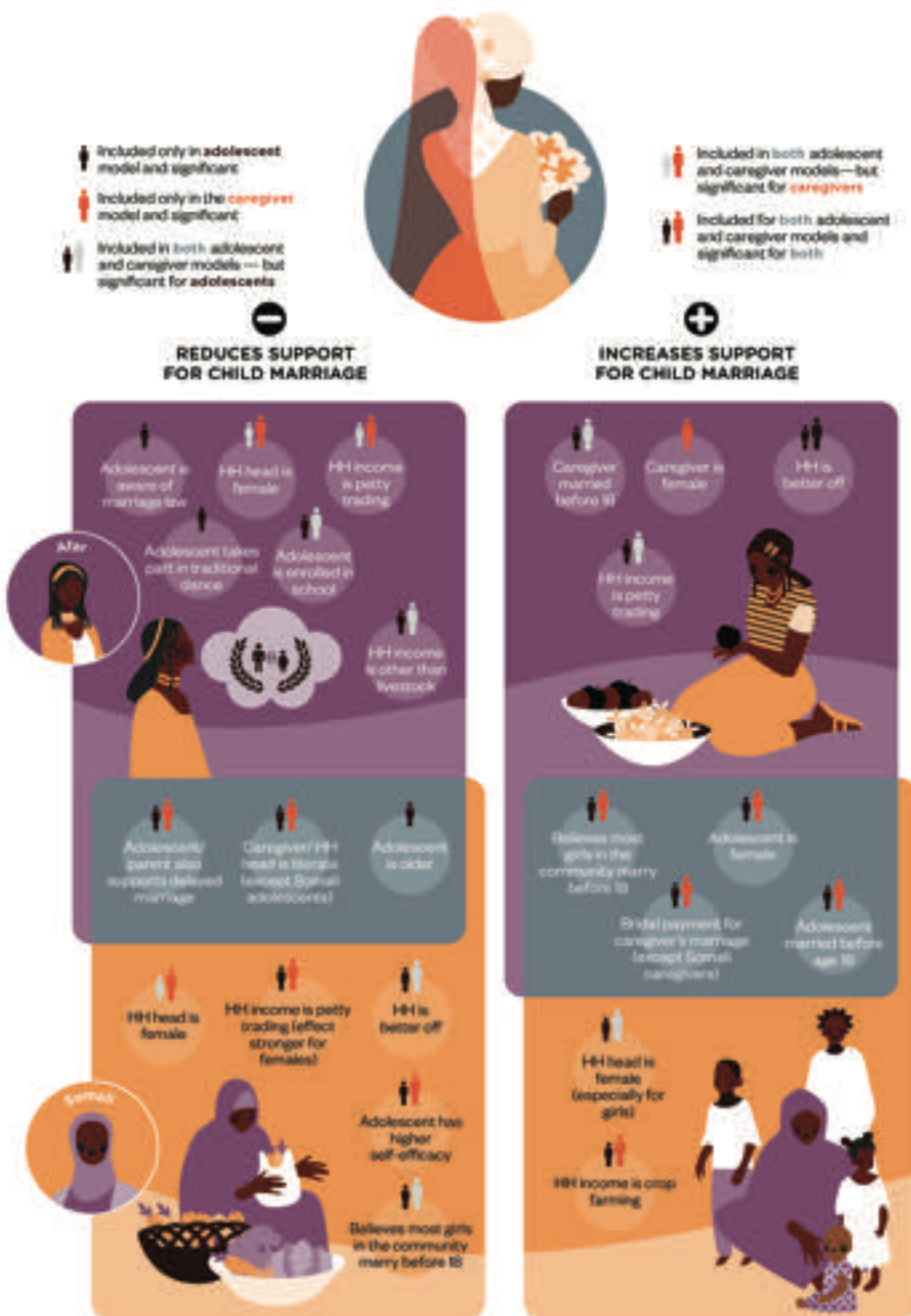
Sisters who have never been to school, Dollo zone, Somali region, Ethiopia © UNICEF Ethiopia/2017/Nahom Tesfaye



Figure 35: Summary of research findings regarding child marriage



Figure 36: Summary of regression modelling for support for child marriage



educate daughters, it is important to support livelihood diversification – although it should be noted that this may come with costs, as adolescents in better off households are more likely to support child marriage than their peers in less well-off households (and women with more control of financial resources are more likely to support FGM/C). Outlawing bridal payments may also shift views about the ideal age for marriage, at least over time – but given that the reverse appears to be happening in Somali (with the abandonment of bride wealth increasing child marriage), this approach would require careful monitoring.

In Somali, as can be seen in Figure 36 (and again with the caveat of trade-offs in regard to beliefs about FGM/C), support for families to engage in trading rather than farming (livestock or agriculture), and for adolescents only greater HH wealth, is associated with support for delayed/adult marriage – perhaps due to greater exposure to urban life. Although our regression model finds a positive correlation between bridal wealth in caregivers' marriages and support for child marriage, suggesting that outlawing bride wealth may reduce support, our qualitative research strongly suggests the reverse. In contrast to Afar, regression models in Somali do not suggest that improved access to education is likely to shift preferences for child marriage, at least in the shorter term. However, given that adolescents' self-efficacy is associated with reduced support for child marriage, it is possible that investments in participatory programming in school – for example, through gender clubs that promote girls' empowerment and agency and boys' rethinking of masculinity – could result in reduced support for child marriage over time.

## 6.1 Policy and programming implications

Given our broader research findings, we suggest the following priority actions for the Ethiopian government and its partners if the goals of the National Costed Roadmap to End Child Marriage and FGM/C are to be achieved. We highlight the range of actors needed to fast-track change for adolescent girls and young women, and the specific actions within their mandate, while recognising that efforts need to be well coordinated and are interdependent:

**Because knowledge of the law banning FGM and child marriage remains limited, and enforcement appears all but non-existent, the justice sector needs 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.

**Because restrictive gender norms prevent girls and women from accessing education, employment or decision-making – and drive both FGM/C and child marriage – the Women and Social Affairs Bureaux must prioritise efforts 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';
- 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 SGBV;
- 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.

**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 HH decision-making and less violent masculinities, including how fathers can bring up their sons differently.

**Because the gender norms that limit girls' and women's lives also limit communities' and leaders' capacity to recognise and address these norms, it is vital that child- and gender-focused NGOs 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;

- developing a cadre of role models;
- working alongside local leaders and service providers to raise awareness about the risks of FGM/C and child marriage.

**Because girls are far more likely to be excluded from education than boys, the education sector must redouble efforts to ensure that all girls have access to education, at least through the end of intermediate school – and ideally through to completion of 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 SGBV;
- greater provisioning of school supplies for students from poorer households;
- stepped up investments in school feeding programmes, school WASH (water, sanitation and hygiene) and MHM 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.

**Because global evidence suggests that the best way to prevent child marriage is to keep girls in school as long as possible, social protection should be used 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.



**Because girls and women in pastoralist communities have extremely limited 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.

**Because of the growing trend of medicalisation of 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, in line with the 2017 Ministry of Health guidance (see Background Context discussion).

**Because Afar and Somali are not yet evidencing the progress shown by other regions in reducing FGM/C and child marriage, regional government leaders should invest in promoting the social change that will improve girls' and women's lives, as well as the country's 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.

**Because FGM/C is seen as a religious mandate, and child marriage is seen as religiously acceptable – and even preferable – it is vital that government and**

**non-government actors work closely with religious leaders to promote abandonment of 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;
- providing 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.

**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 need to work closely with clan leaders to shift the beliefs and practices that continue to 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.

**Because the National Alliance to End FGM/C and Child Marriage is uniquely positioned to continue and accelerate efforts towards eradication, it is vital that Alliance members collectively continue to open new change pathways and identify new champions to support eradication efforts 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.

**Because eliminating FGM/C and child marriage will be resource-intensive and require consistent long-term interventions, development partners must scale up investment in programming.** 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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# 7 Annex

**Annex Table 1: Descriptive Statistics of outcome and independent variables**

Variables	Afar			Somali		
	Obs	Mean	Std. Dev.	Obs	Mean	Std. Dev.
<b>Caregiver (CG) and HH characteristics</b>						
CG's attitude towards delaying girls' marriage until secondary school completion (=1)	1019	0.74	0.44	1017	0.82	0.38
There was bridal payment when CG married (=1)	937	0.49	0.50	884	0.68	0.47
CG knows that most girls in community married before 18 (=1)	943	0.86	0.35	888	0.79	0.41
CG married before 18 (=1)	1006	0.83	0.38	990	0.52	0.50
CG favors continuation of FGM/C (=1)	941	0.69	0.46	945	0.74	0.44
Proportion girls in HH who have been cut	959	0.93	0.20	925	0.55	0.40
CG thinks FGM/C is risky (=1)	1013	0.43	0.50	1015	0.36	0.48
CG thinks that FGM/C has benefits (=1)	1011	0.45	0.50	1014	0.68	0.47
CG knows parents and cutters will be penalized (=1)	1022	0.08	0.27	1019	0.06	0.23
FGM/C is required by religion (=1)	974	0.78	0.41	994	0.65	0.48
Age of CG	1022	38.07	9.76	1015	38.58	10.98
Female CG (=1)	1022	0.90	0.30	1020	0.87	0.34
Literate CG (=1)	1022	0.06	0.24	1018	0.19	0.39
CG control own money by self (=1)	1021	0.29	0.45	1019	0.57	0.50
CG control own money mutually with spouse (=1)	1021	0.62	0.49	1019	0.32	0.47
CG has no control own money (=1)	1021	0.09	0.29	1019	0.11	0.32
Age of the HH head	1022	44.18	10.82	1001	40.86	11.38
FHH (=1)	1022	0.20	0.40	1020	0.61	0.49
Literate HH head (=1)	1022	0.11	0.31	1018	0.25	0.43
HH size	1022	6.48	2.12	1020	7.06	2.45
Ever participated in PSNP (=1)	1022	0.49	0.50	1018	0.13	0.34
Wealth index	1022	-0.06	1.83	1018	-0.01	1.74
Major HH income is from livestock (=1)	1022	0.71	0.46	1020	0.40	0.50
Farming income as a major source of HH income (=1)	1022	0.20	0.40	1020	0.21	0.41
Wage Employment as a major source of HH income (=1)	1022	0.04	0.21	1020	0.03	0.18
Petty Trading as a major source of HH income (=1)	1022	0.02	0.14	1020	0.19	0.40
Other major sources of HH income (=1)	1022	0.02	0.15	1020	0.14	0.34
<b>Core adolescent respondents (CR)</b>						
Age CR	1022	13.33	2.40	1020	13.10	2.67
Female CR (=1)	1022	0.86	0.35	1020	0.77	0.42
CR attended formal education (=1)	1022	0.73	0.44	1020	0.61	0.49
CG's attitude towards delaying girls' marriage until secondary school completion (=1)	995	0.73	0.44	970	0.81	0.39
CR's preference for adult marriage/marriage at 18 and older (=1)	1022	0.65	0.48	1020	0.53	0.50
CR married before 18 (=1)	1022	0.02	0.14	1020	0.03	0.17

Variables	Afar			Somali		
	Obs	Mean	Std. Dev.	Obs	Mean	Std. Dev.
CR knows most girls in community marries before 18 (=1)	1022	0.82	0.39	1020	0.56	0.50
CR knows the legal age of marriage (=1)	1022	0.07	0.25	1020	0.02	0.15
CR ever participate in traditional dance (=1)	1022	0.28	0.45	1020	0.03	0.16
CR favors FGM/C has to continue (=1)	737	0.65	0.48	395	0.76	0.43
CR thinks FGM/C is risky (=1)	806	0.06	0.24	441	0.22	0.42
CR thinks FGM/C has benefits (=1)	742	0.26	0.44	431	0.56	0.50
CR thinks FGM/C is required by religion (=1)	769	0.68	0.47	419	0.73	0.44
CR's self-efficacy score	1022	25.22	6.59	1020	24.69	6.81



**Annex Table 2: Marginal effects on the average from probit regressions of caregivers' attitude towards delaying girls' marriage until they finish secondary school**

Variables	Both female and male caregivers		Only female caregivers	
	Afar	Somali	Afar	Somali
Age of CG	-0.00105 (0.00274)	-0.00295 (0.00262)	-0.000949 (0.00299)	-0.00293 (0.00255)
Female CG (=1)	-0.0981* (0.0514)	0.0238 (0.0515)		
CG married before 18 (=1)	-0.0480 (0.0419)	0.0164 (0.0275)	-0.0585 (0.0458)	0.0182 (0.0264)
Literate CG (=1)	0.105* (0.0603)	-0.0956 (0.0779)	0.0982 (0.0700)	-0.0562 (0.0727)
Age of the head	-0.00235 (0.00235)	0.00112 (0.00250)	-0.00211 (0.00248)	0.000329 (0.00235)
FHH (=1)	0.0970** (0.0429)	0.0698* (0.0394)	0.111** (0.0455)	0.0649 (0.0397)
Literate head (=1)	0.0785 (0.0488)	0.0871** (0.0406)	0.0764 (0.0528)	0.0695** (0.0353)
HH size	-0.00638 (0.00830)	0.00461 (0.00526)	-0.00654 (0.00919)	0.00349 (0.00529)
Ever participated in PSNP (=1)	0.00356 (0.0339)	0.00696 (0.0447)	0.00892 (0.0379)	-0.0239 (0.0443)
Wealth index	-0.00930 (0.00847)	-0.00981 (0.00872)	-0.0116 (0.00971)	-0.00900 (0.00866)
Major HH income is from farming (=1)	0.0660 (0.0415)	-0.173*** (0.0488)	0.0717 (0.0447)	-0.133*** (0.0496)
Major HH income is from wage employment (=1)	0.0339 (0.0656)	0.0644 (0.0537)	0.0238 (0.0729)	0.0879*** (0.0267)
Major HH income is from petty trading (=1)	0.173*** (0.0610)	0.0438 (0.0316)	0.188*** (0.0642)	0.0599** (0.0274)
Major HH income is from other sources other than livestock (=1)	0.0659 (0.0883)	-0.0797* (0.0468)	0.0665 (0.0937)	-0.0698 (0.0450)
CG control own earned money by self (=1)	0.00191 (0.0578)	0.0553 (0.0436)	-0.0249 (0.0643)	0.0405 (0.0409)
CG control own earned money mutually with spouse (=1)	0.0618 (0.0530)	0.0314 (0.0404)	0.0567 (0.0555)	-0.00221 (0.0402)
There was bridal payment during CG's marriage (=1)	-0.0913*** (0.0326)	-0.0239 (0.0286)	-0.0909*** (0.0350)	-0.0174 (0.0275)
CG knows most girls in his/her community married before 18 (=1)	-0.0799** (0.0349)	-0.0856*** (0.0240)	-0.0720* (0.0400)	-0.0650*** (0.0235)
CR agrees that girls' marriage should be delayed until they complete secondary education (=1)	0.223*** (0.0381)	0.0654* (0.0366)	0.225*** (0.0406)	0.0825** (0.0396)
CR's Self Efficacy score	0.00209 (0.00235)	0.00384** (0.00192)	0.00184 (0.00252)	0.00270 (0.00184)
CR attended formal education (=1)	0.0198 (0.0363)	-0.0306 (0.0276)	0.0135 (0.0386)	-0.0408 (0.0264)

Variables	Both female and male caregivers		Only female caregivers	
	Afar	Somali	Afar	Somali
Observations	900	819	821	706
Kebele dummies	Yes	Yes	Yes	Yes

(Robust standard errors in parentheses, \*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.1$ )

**Annex Table 3: Marginal effects on the average from probit regressions of caregivers' attitude towards the continuity of FGM/C**

Variables	Both female and male caregivers		Only female caregivers	
	Afar	Somali	Afar	Somali
Age of CG	3.90e-05 (0.00268)	-0.00375 (0.00247)	0.00147 (0.00280)	-0.00230 (0.00262)
Female CG (=1)	0.0453 (0.0692)	0.0464 (0.0595)		
Literate CG (=1)	0.00554 (0.0699)	0.0786** (0.0349)	0.0644 (0.0580)	0.0595 (0.0419)
Age of the head	-0.000410 (0.00219)	0.00410 (0.00250)	-0.000734 (0.00223)	0.00313 (0.00248)
FHH (=1)	0.0134 (0.0559)	0.0187 (0.0417)	-0.00543 (0.0576)	0.0105 (0.0427)
Literate head (=1)	-0.0495 (0.0611)	-0.0801 (0.0640)	-0.0216 (0.0602)	-0.0798 (0.0689)
HH size	0.00183 (0.00813)	0.00216 (0.00553)	0.00250 (0.00861)	-0.00258 (0.00632)
Ever participated in PSNP (=1)	0.0301 (0.0377)	-0.0368 (0.0622)	0.0160 (0.0398)	-0.0413 (0.0666)
Wealth index	0.00663 (0.0105)	0.00364 (0.00908)	0.0133 (0.0109)	-3.23e-05 (0.00997)
Major HH income is from farming (=1)	-0.0663 (0.0542)	0.132*** (0.0224)	-0.0819 (0.0551)	0.132*** (0.0255)
Major HH income is from wage employment (=1)	0.0326 (0.0751)	0.0804** (0.0338)	0.0608 (0.0680)	0.0649 (0.0528)
Major HH income is from petty trading (=1)	-0.100 (0.148)	0.0641** (0.0285)	-0.0912 (0.154)	0.0660** (0.0313)
Major HH income is from others other than livestock (=1)	0.000701 (0.122)	0.0602** (0.0294)	-0.00836 (0.127)	0.0631** (0.0310)
CG controls own earned money by self (=1)	0.192*** (0.0447)	0.0208 (0.0428)	0.206*** (0.0438)	0.0175 (0.0472)
CG control own earned money mutually with spouse (=1)	0.162*** (0.0575)	0.0306 (0.0396)	0.170*** (0.0571)	0.0476 (0.0418)
Proportion of girls in HH who have been cut	0.156* (0.0875)	-0.0569 (0.0353)	0.179** (0.0883)	-0.0617 (0.0410)
CG believes that FGM/C is Risky (=1)	-0.229*** (0.0392)	-0.338*** (0.0430)	-0.240*** (0.0409)	-0.336*** (0.0455)
CG believes that FGM/C has benefits (=1)	0.335*** (0.0303)	0.409*** (0.0463)	0.315*** (0.0313)	0.387*** (0.0503)
CG knows parents and cutters will be penalized (=1)	-0.0666 (0.0665)	-0.190* (0.0974)	-0.0662 (0.0697)	-0.222** (0.108)
FGM/C is required by religion (=1)	0.279*** (0.0485)	0.140*** (0.0373)	0.261*** (0.0504)	0.160*** (0.0402)
CR's self-Efficacy score	-0.00860*** (0.00278)	0.000443 (0.00210)	-0.00818*** (0.00283)	0.00220 (0.00239)

Variables	Both female and male caregivers		Only female caregivers	
	Afar	Somali	Afar	Somali
CR attended formal education (=1)	-0.106*** (0.0357)	-0.00372 (0.0302)	-0.102*** (0.0363)	-0.0286 (0.0312)
Observations	839	812	782	712
<i>Kebele</i> dummies	Yes	Yes	Yes	Yes

(Robust standard errors in parentheses, \*\*\* $p < 0.01$ , \*\* $p < 0.05$ , \* $p < 0.1$ )



**Annex Table 4: Marginal effects on the average from probit regressions of adolescents' attitude towards delaying girls' marriage until they finish secondary school**

Variables	Both female and male adolescents		Only female adolescents	
	Afar	Somali	Afar	Somali
Age of CR	0.000967 (0.00760)	0.00382 (0.00518)	0.00237 (0.00826)	0.00271 (0.00563)
Female CR (=1)	0.0465 (0.0559)	0.0862** (0.0368)		
CR married before 18 (=1)	0.209*** (0.0356)	0.0496 (0.0661)	0.194*** (0.0498)	0.0329 (0.0693)
CR knows most girls in his/her community married before 18 (=1)	-0.0188 (0.0389)	0.0488 (0.0299)	0.00317 (0.0441)	0.0595* (0.0344)
CR attended formal education (=1)	0.133*** (0.0409)	-0.000344 (0.0292)	0.112*** (0.0433)	-0.00847 (0.0311)
CR's Self Efficacy score	0.00181 (0.00251)	-0.00158 (0.00220)	-0.000200 (0.00271)	-0.00189 (0.00241)
CR knows the legal marriage age of woman (=1)	0.114** (0.0554)	-0.0104 (0.0950)	0.107* (0.0607)	
Ever participated in traditional Dance (=1)	0.0800** (0.0343)	0.0544 (0.0646)	0.0852** (0.0373)	
Age of the CG	-0.00281 (0.00258)	-0.00265 (0.00249)	-0.00439 (0.00278)	0.00110 (0.00263)
Literate CG (=1)	-0.0471 (0.0823)	-0.0494 (0.0639)	-0.0818 (0.0963)	-0.128 (0.0844)
CG married before 18 (=1)	0.00658 (0.0439)	0.00253 (0.0274)	0.0468 (0.0505)	-0.0104 (0.0293)
CG agrees that girls' marriage should be delayed until they complete secondary education (=1)	0.220*** (0.0385)	0.0765** (0.0383)	0.199*** (0.0404)	0.0667 (0.0421)
There was bridal payment when CG married (=1)	-0.127*** (0.0337)	0.0311 (0.0331)	-0.152*** (0.0359)	0.0397 (0.0371)
Age of the head	0.00210 (0.00223)	0.00111 (0.00243)	0.00280 (0.00231)	-0.00184 (0.00246)
FHH (=1)	0.0362 (0.0446)	-0.0316 (0.0290)	0.0723 (0.0453)	-0.0638** (0.0305)
Literate HH head (=1)	-0.0547 (0.0572)	-0.0644 (0.0590)	-0.0361 (0.0582)	-0.0254 (0.0558)
HH size	-0.00807 (0.00746)	-0.000635 (0.00487)	-0.00494 (0.00803)	-0.000781 (0.00519)
Ever participated in PSNP (=1)	0.0515 (0.0353)	0.0139 (0.0466)	0.0697* (0.0391)	0.0534 (0.0426)
Major HH income is from farming (=1)	0.0719* (0.0421)	-0.139*** (0.0447)	0.0908** (0.0433)	-0.136*** (0.0522)
Major HH income is from wage employment (=1)	-0.0337 (0.0706)	0.0290 (0.0588)	-0.0190 (0.0702)	0.0299 (0.0624)
Major HH income is from petty trading (=1)	-0.277* (0.163)	0.0694** (0.0312)	-0.285* (0.172)	0.0828*** (0.0283)
Major HH income is from others other than livestock (=1)	0.175*** (0.0618)	0.0335 (0.0345)	0.176*** (0.0663)	0.00830 (0.0416)

Variables	Both female and male caregivers		Only female caregivers	
	Afar	Somali	Afar	Somali
Wealth index	0.000122 (0.0104)	0.0504*** (0.0109)	0.00441 (0.0110)	0.0434*** (0.0139)
Observations	901	819	788	598
Kebele dummies	Yes	Yes	Yes	Yes

(Robust standard errors in parentheses, \*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.1$ )

**Annex Table 5: Marginal effects on the average from probit regressions of adolescents' personal preference for adult marriage (marriage at 18 years old and above)**

Variables	Both female and male adolescents		Only female adolescents	
	Afar	Somali	Afar	Somali
Age of CR	0.0509*** (0.00837)	0.0286*** (0.00849)	0.0563*** (0.00935)	0.0306*** (0.00947)
Female CR (=1)	-0.192*** (0.0438)	-0.0976** (0.0460)		
CR married before 18 (=1)	-0.502*** (0.135)	-0.304*** (0.0932)	-0.455*** (0.153)	-0.303*** (0.0943)
CR knows most girls in his/her community married before 18 (=1)	-0.203*** (0.0366)	0.259*** (0.0412)	-0.220*** (0.0428)	0.263*** (0.0487)
CR attended formal education (=1)	0.140*** (0.0437)	0.0228 (0.0465)	0.132*** (0.0474)	0.0111 (0.0526)
CR's Self Efficacy score	0.00106 (0.00289)	0.0118*** (0.00339)	0.000123 (0.00321)	0.00795** (0.00387)
CR knows the legal marriage age of woman (=1)	0.196*** (0.0622)	0.175 (0.146)	0.199*** (0.0749)	-0.0339 (0.168)
Ever participated in traditional Dance (=1)	-0.0336 (0.0420)	0.00153 (0.114)	-0.0119 (0.0457)	-0.0296 (0.152)
Age of the CG	-0.000309 (0.00298)	-0.00233 (0.00397)	-0.00189 (0.00317)	-0.00369 (0.00434)
Literate CG (=1)	0.0877 (0.0762)	0.105 (0.0905)	0.120 (0.0787)	0.0265 (0.103)
CG married before 18 (=1)	-0.0851* (0.0452)	-0.0456 (0.0425)	-0.0795 (0.0535)	-0.0813* (0.0480)
CG agrees that girls' marriage should be delayed until they complete secondary education (=1)	0.0181 (0.0386)	0.0827 (0.0517)	0.00984 (0.0424)	0.0558 (0.0598)
There was bridal payment when CG married (=1)	-0.0897** (0.0379)	-0.112** (0.0493)	-0.114*** (0.0420)	-0.103* (0.0564)
Age of the head	0.00147 (0.00248)	-0.00145 (0.00374)	0.00236 (0.00259)	-0.00188 (0.00410)
FHH (=1)	0.0167 (0.0529)	-0.0828* (0.0471)	0.0660 (0.0568)	-0.111** (0.0550)
Literate HH head (=1)	0.143*** (0.0498)	-0.117 (0.0850)	0.162*** (0.0546)	0.0328 (0.0920)
HH size	-0.000704 (0.00918)	0.00458 (0.00790)	0.00793 (0.0104)	0.00343 (0.00903)
Ever participated in PSNP (=1)	-0.0351 (0.0396)	0.0281 (0.0701)	-0.0144 (0.0447)	0.105 (0.0799)
Major HH income is from farming (=1)	0.0868* (0.0475)	-0.194*** (0.0526)	0.0916* (0.0529)	-0.173*** (0.0634)
Major HH income is from wage employment (=1)	-0.0107 (0.0875)	0.0588 (0.100)	-0.000709 (0.0922)	-0.0124 (0.115)
Major HH income is from petty trading (=1)	0.100 (0.128)	0.158*** (0.0551)	0.222* (0.114)	0.193*** (0.0618)
Major HH income is from other sources other than livestock (=1)	-0.135 (0.127)	-0.0277 (0.0595)	-0.0688 (0.129)	-0.0611 (0.0687)

	Both female and male adolescents		Only female adolescents	
	Afar	Somali	Afar	Somali
Wealth index	-0.0252** (0.0104)	0.0172 (0.0142)	-0.033*** (0.0126)	-0.000591 (0.0177)
Observations	924	851	808	649
Kebele dummies	Yes	Yes	Yes	Yes

(Robust standard errors in parentheses, \*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.1$ )

**Annex Table 6: Marginal effects on the average from probit regressions of cut adolescent girls' attitude towards the continuity of FGM/C**

Variables	Afar	Somali
Age of CR	-0.0188* (0.00979)	-0.00985 (0.00747)
CR attended formal education (=1)	-0.138*** (0.0451)	-0.0234 (0.0469)
Proportion of girls in the HH who have been cut	-0.156 (0.144)	-0.00418 (0.0604)
CR believes that FGM/C is risky (=1)	-0.320*** (0.104)	-0.428*** (0.109)
CR believes that FGM/C has benefits (=1)	0.263*** (0.0375)	0.237*** (0.0488)
CR thinks that FGM is required by religion (=1)	0.197*** (0.0497)	0.251*** (0.0702)
CR's self-efficacy score	-0.010*** (0.00380)	-0.005* (0.00297)
Age of the CG	0.000351 (0.00381)	0.00114 (0.00309)
CG is literate (=1)	-0.139 (0.110)	-0.116 (0.0957)
Age of the HH head	0.00299 (0.00307)	0.00307 (0.00298)
FHH (=1)	0.0214 (0.0632)	0.00337 (0.0432)
Head is literate (=1)	-0.0706 (0.0756)	0.0979** (0.0440)
HH size	-0.00514 (0.0106)	-0.0196** (0.00783)
Ever participated in PSNP (=1)	0.0899* (0.0505)	0.0867** (0.0419)
Major HH income is from farming (=1)	0.00928 (0.0646)	-0.00397 (0.0635)
Major HH income is from wage employment (=1)	-0.0535 (0.0927)	-0.0912 (0.130)
Major HH income is from petty trading (=1)	0.0284 (0.162)	0.0747 (0.0464)
Major HH income is from sources other than livestock (=1)	-0.183 (0.186)	-0.193* (0.109)
Wealth index	0.0287** (0.0137)	0.0133 (0.0132)
Observations	649	318
Kebele dummies	Yes	Yes

(Robust standard errors in parentheses, \*\*\* $p < 0.01$ , \*\* $p < 0.05$ , \* $p < 0.1$ )





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## **About GAGE**

Gender and Adolescence: Global Evidence (GAGE) is a nine-year longitudinal research programme generating evidence on what works to transform the lives of adolescent girls in the Global South. Visit [www.gage.odi.org.uk](http://www.gage.odi.org.uk) for more information.

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Front cover: An adolescent girl who helps her mother with the housework, Afar region, Ethiopia © Nathalie Bertrams/GAGE 2022