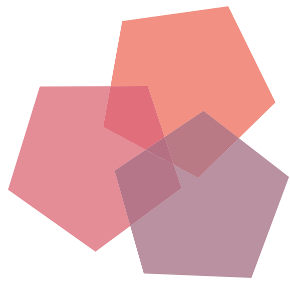

Gaining insight into the magnitude of and factors influencing child marriage, female genital mutilation/ cutting and teenage pregnancy in Ethiopia

Baseline Report
August 2018

by

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Preface

YES I DO. is a strategic alliance of five Dutch organizations which main aim is to enhance the decision making space of young women about if, when and whom to marry as well as if, when and with whom to have children. Funded by the sexual and reproductive health and rights policy framework of the Ministry of Foreign Affairs of the Netherlands, the alliance is a partnership between Plan Nederland, Rutgers, Amref Flying Doctors, Choice for Youth and Sexuality and the Royal Tropical Institute. Led by Plan, the alliance members have committed to a five-year programme to be implemented between 2016 and 2020 in seven countries: Ethiopia, Indonesia, Kenya, Malawi, Mozambique, Pakistan and Zambia.

The YES I DO Alliance partners and the Ministry of Foreign Affairs of the Netherlands acknowledge that child marriage, teenage pregnancy and female genital mutilation/cutting are interrelated issues that involve high health risks and human rights violations of young women and impede socioeconomic development. Therefore, the YES I DO programme applies a mix of intervention strategies adapted to the specific context of the target countries. The theory of change consists of five main pathways: 1) behavioural change of communities and gatekeepers, 2) meaningful engagement of young people in claiming for their sexual and reproductive health and rights, 3) informed actions of young people on their sexual health, 4) alternatives to the practice of child marriage, female genital mutilation/cutting and teenage pregnancy through education and economic empowerment and 5) responsibility and political will of policymakers and duty bearers to develop and implement laws towards the eradication of these practices.

The programme includes a research component to investigate the interlinkages between child marriage, female genital mutilation/cutting and teenage pregnancy and look at what works, how and why in the specific country contexts. The research focuses on testing the pathways of the theory of change, underlying assumptions and interventions, as well as on looking for mechanisms triggering change and enhancing programme effectiveness. To that end, the research component of YES I DO started with a baseline study in each of the seven countries where the programme is implemented.

The aim of the baseline studies is to provide a contextualized picture of the prevalence, causes and consequences of child marriage, teenage pregnancy and female genital mutilation/cutting (where applicable) in the intervention areas of the YES I DO programme. Also, the studies aim to act as a reference point for the monitoring and evaluation of the YES I DO programme throughout its implementation. In four of the seven countries, the baseline studies included control areas. Each baseline study was conducted in close collaboration with local research partners.

The present report details the baseline study conducted in Ethiopia. The report draws on literature about child marriage, teenage pregnancy and female genital mutilation/cutting in Ethiopia, details the methodology used, presents the main results and provides general recommendations for policy and practice on child marriage, teenage pregnancy and female genital mutilation/cutting in Ethiopia. The study report aims to be a tool for the different stakeholders working in the YES I DO programme as well as in other programmes on sexual and reproductive health and rights of young people.

ACKNOWLEDGEMENTS

The research team thanks:

Amhara region community members of the four kebeles in Qewet woreda of north Shewa zone (Yelen, Sefiberet, Medina, Abayatir) and of the four kebeles in Bahirdar Zuria woreda of west Gojjam zone (Robit, Chenta Sosetu, Latamba, Yigoma Huletu).

Woreda, Kebele, school and health officials as well as representatives of women and youth associations who collaborated by providing information and by facilitating contacts with the study communities.

Research assistants who actively participated in the collection of the baseline data; namely Dereje Tesema, Belayneh Worku, Semehar Tesfatsion, Selamawit Zigita, Tsion Amdework, Sonan Daniel, Berket Sisay, Kokob Hailemichael, Meseret Tadesse, Alemnew Berhanu and Meskrem Ababaw.

In country partner organizations and those who collaborated with the research team, namely: Amref Ethiopia, Plan Ethiopia, TaYA and DEC.

Consortium partners in the Netherlands: Plan Nederland, Amref, Choice for Youth and Sexuality, Rutgers and the Royal Tropical Institute (KIT), in particular Maryse Kok for all her constructive feedback in shaping the report.

The two ethical clearance boards, namely: Amhara Region Health Bureau and KIT's Research Ethics Review Committee.

Table of contents

LIST OF TABLES AND FIGURES 5

ABBREVIATIONS AND KEY TERMS 6

EXECUTIVE SUMMARY 7

1. INTRODUCTION 10
 1.1 The Ethiopian context of child marriage, teenage pregnancy and female genital mutilation/cutting 10
 1.2 The Yes I Do programme in Ethiopia 13
 1.3 The research component 14

2. METHODOLOGY 15
 2.1 Study areas 15
 2.2 Quantitative methods 17
 2.3 Qualitative methods 18
 2.4 Data collection 19
 2.5 Data analysis 20
 2.6 Ethical considerations 20
 2.7 Study limitations 20

3. RESULTS 21
 3.1 Characteristics of the respondents 21
 3.2 Child marriage 23
 3.3 Teenage pregnancy 28
 3.4 Female genital mutilation/cutting 31
 3.5 Community context 34
 3.6 Sexual and reproductive health information and service utilization 40
 3.7 Youth economic empowerment 43
 3.8 Policies and legal issues 46

4 DISCUSSION 48
 4.1 Child marriage 48
 4.2 Teenage pregnancy 49
 4.3 Female genital mutilation/cutting 50
 4.4 Sexual and reproductive health services and information 51
 4.5 Policy and legal issues 51

5 CONCLUSION 53

6 RECOMMENDATIONS FOR YES I DO 54

7 ISSUES FOR FURTHER RESEARCH 57

8 REFERENCES 58

List of tables and figures

LIST OF TABLES

Table 1: FGM/C prevalence rate by age groups and type of FGM/C (CSA 2016) 12
Table 2: Area, population and livelihood features of the study woredas 16
Table 3: Distribution of sample population by woreda and sex 17
Table 4: Number and distribution of qualitative interviews 19
Table 5: Types of respondents' households 21
Table 6: Respondent´s level of education at the time of the survey respondents 22
Table 7: Child marriage rates among young women aged 18-24 by woreda 23
Table 8: Culture/tradition for a girl to marry young 24
Table 9: Culture or tradition for a boy to marry young 24
Table 10: Underage marriage for a girl is mostly due to love 25
Table 11: Pressured into marriage by family/friends 25
Table 12: Child marriage has disadvantages for underage girls 26
Table 13: Girls and boys who dropped out of school due to marriage 27
Table 14: Forms of marriage by gender and woreda 28
Table 15: Young women (20-24 years) who experienced teenage pregnancy 29
Table 16: Discussed methods of prevention of pregnancy with family 29
Table 17: Have you been circumcised? 31
Table 18: Knowledge and attitude towards FGM/C 34
Table 19: Community expectations regarding girls and boys 35
Table 20: Easy to talk with parents/care givers about marriage and sexuality 36
Table 21: Have you discussed with your parents about marriage? 37
Table 22: Sources of sexual and reproductive health information 40
Table 23: Respondents' knowledge of pregnancy prevention methods 41
Table 24: Appropriate for a girl to propose condom use? 41
Table 25: Difficult to access contraceptives in your area 42
Table 26: Do you have SRHR entitlements as a young person? 42
Table 27: Economically active outside the household 43
Table 28: Employment status among those who experienced child marriage 44
Table 29: Economic empowerment is a solution to the problem of child marriage 45
Table 30: Worried about various aspects of life 46
Table 31: Respondents knowledge about the legal minimum age for marriage 47

LIST OF FIGURES

Figure 1: The YES I DO Ethiopia Theory of Change 13
Figure 2: Location map of the study communities 15
Figure 3: FGD Pre-testing exercise with boys ages 15-24, Fito kebele, north Shewa zone, July 2016 18
Figure 4: A partial view of participants of the research assistants' training workshop held in Mosaic Hotel, Addis Ababa, July 2016 19
Figure 5: Two brothers (22, 18) collecting citrus fruit from farmers to be transported to Gondar, Yigoma Huletu Kebele, Bahirdar Zuria woreda, July 2017 43

Abbreviations and key terms

LIST OF ACRONYMS

DEC	Development Expertise Center
DHS	Demographic and Health Survey
FDRE	Federal Democratic Republic of Ethiopia
FGD	Focus Group Discussion
FGM/C	Female Genital Mutilation/Cutting
GDP	Gross Domestic Product
IDI	In-Depth Interview
KII	Key Informant Interview
NGO	Non-Governmental Organization
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
TaYA	Talent Youth Association

GLOSSARY

Adolescents	Boys and girls aged 10 to 19 years old
Child marriage	Legal or customary union involving a boy or girl below the age of 18
Female genital mutilation / cutting	Procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons
Teenage pregnancy	Pregnancy before the age of 20 (age 15-19 in this study)
Young people/youth	Boys and girls aged 15 to 24 years old in this study

Executive summary

INTRODUCTION

This baseline study of the Yes I Do Ethiopia programme was conducted in Amhara region where child marriage, female genital mutilation/cutting (FGM/C) and teenage pregnancy are widespread and affecting the lives of young girls and boys. The study aimed to provide a picture of the prevalence of child marriage, FGM/C and teenage pregnancy in the Amhara region as well as contextualized insights of the interrelated causes and effects of all three issues, that would serve to optimize the YES I DO intervention strategies and the monitoring and evaluation of the programme.

METHODOLOGY

The study was conducted in the Amhara region, more specifically in two intervention woredas (districts) of the YES I DO programme in Ethiopia: Qewet woreda from north Shewa zone and Bahirdar Zuria woreda from west Gojjam zone. In each woreda, four intervention kebeles (lowest administrative units or wards) were selected, namely Yelen, Medina, Sefeberet and Abayatir from Qewet, and Robit, Chenta Sosetu, Latamba and Yigoma Huletu from Bahirdar Zuria.

A mixed methods design was used to collect and analyse quantitative and qualitative data. A survey was administered to 1,602 respondents from the study areas (71% girls and 29% boys aged 15-24). In addition, qualitative data was collected from young people, parents, community leaders, local officials, school and health officials, and youth and women representatives using in-depth and key informant interviews as well as focus group discussions. Quantitative data were analysed with descriptive statistics in SPSS and STATA and a thematic content analysis was conducted for the qualitative data using a coding framework in Nvivo. Triangulation was done during the analysis to present the results in an integrated manner in this baseline report.

RESULTS

EDUCATION AND EMPLOYMENT SITUATIONS OF RESPONDENTS

The majority of the respondents had completed some kind of education (41.6% grades 5-8, 21.2% grades 1-4 and 16.5% grades 9-10) while about 13.5% of the respondents had not received any type of education. School drop-out was common, as 49% and 43% of the female and male respondents respectively indicated to have ever dropped out of school. In relation to respondents' employment status, data indicate that 33.5% were students, 14.4% did subsistence farming, 16% were unemployed, 11.6% self-employed, 6.3% with casual, daily labour and 16.4% performed unpaid work (e.g. homemaker/housewife). That is, 47% of the respondents had some form of employment. The primary sources at the household level was mostly agriculture including agriculture-related trade (e.g. contractual work for onion farmers).

PREVALENCE OF CHILD MARRIAGE, FEMALE GENITAL MUTILATION/CUTTING AND TEENAGE PREGNANCY

The baseline data indicate that 23% of all respondents had ever married, of which more than half (56%) did so below the age of 18 years. Child marriage was more common among young women; the mean age of first marriage among married female respondents was 16 years while among married male respondents it was 19 years. The child marriage rate among respondents aged 18 to 24 was 37.5% among females and 1.8% among males. The teenage pregnancy rate was slightly lower than the child marriage rate; 33% of the female respondents aged 20 to 24 had had a pregnancy under the age of 20. Both the child marriage and teenage pregnancy rate were found to be higher in Qewete than in Bahirdar Zuria. Female genital mutilation/cutting had the highest prevalence. Among all female respondents, 54% affirmed to have been circumcised with little differences between the districts. As for the rest of the sample, 22% had not been circumcised and 24% reported to not know whether they were circumcised.

DRIVERS OF CHILD MARRIAGE, FEMALE GENITAL MUTILATION/CUTTING AND TEENAGE PREGNANCY

In relation to child marriage, the study identified the fears that parents harbour about their daughters as well as the benefits that parents get from marrying off their daughters young as the main drivers. Some of the most mentioned fears were that daughters do not get husbands if they grow older, engage in pre-marital sex, get pregnant before

marriage, fall in a secret love and ultimately run away from home, or that the school environment exposes them to sex early, and consequently it would be more difficult to find a husband because of having been seen going out with other men. As for the perceived benefits of marrying daughters young, the most mentioned were that child marriage helps to cement relationships between the two marrying families, protects the family from shame and loss of reputation which are likely to result from a daughter giving birth to a child outside marriage, parents to fulfil their social obligations by organizing weddings and inviting relatives, neighbours and friends to the wedding, and that through child marriage young women then get trained about their future family.

The practice of FGM/C, though declining in recent years, was found to be common, an accepted social norm, and was seen as a foundation for marriage that makes girls to be good wives. The practice of FGM/C was influenced by several myths, such as that there is no stable marriage without it, it is needed to curve perpetual sexual desire since FGM/C is believed to make girls less sexual aggressive, it helps girls to keep a hygienic vagina or that uncircumcised girls tend to have a vagina that is more difficult to penetrate during sexual intercourse. At the same time, respondents also agreed that FGM/C causes a number of problems for girls. Data indicate that the problems that most respondents agreed to be causes of FGM/C were problems with labour (60.2%), menstrual problems (53.7%), fertility problems (40.7%) and sexual problems (38.5%).

Teenage pregnancy was found to be closely related to marriage. Data indicate that 35% of all married female respondents had had a teenage pregnancy and teenage pregnancies generally occurred after or in the same year as marriage (77% and 19% respectively). Among all female respondents who had both a teenage pregnancy and a child marriage, only 2% had the pregnancy before marrying. Most of them had the teenage pregnancy within marriage (83%) and some had both in the same year (15%). Pregnancies outside marriage were rare, seen as a family dishonour and feared by especially parents. Therefore, the fear for teenage pregnancy was a driver of child marriage, as preventing teenage pregnancies outside marriage was a reason for parents to marry their daughters earlier. Research participants recognized various negative consequences of teenage pregnancy such as social isolation and stigma from family members, friends and the community in general; health problems such as fistula and bleeding in cases of unsafe abortion; psychological traumas and sometimes long-lasting emotional disturbances; school drop-out with limited possibilities to go back to school for some girls; unplanned and hurried-off marriages forcing young women to marry someone they may not like as a husband; or running away from home and migrating to towns and cities.

SEXUAL AND REPRODUCTIVE HEALTH SERVICES

The study found that young people were using different sources of SRHR information. Radio was the most mentioned source (31%) followed by TV (13%). All respondents indicated to know at least one method to prevent pregnancies, of which injections were mentioned the most (21%). Condoms were reported by only 2% of the respondents, although 29% of the respondents said that it is appropriate for a girl to propose the use of condom when specifically asked about this. The majority of the respondents (64%) did not believe that it is difficult to access contraceptives in their area.

CONCLUSIONS

The results of this baseline study show that child marriage and FGM/C are prevalent and deeply rooted in the culture of the studied communities. Multiple drivers of both issues are intertwined in the local beliefs, social norms and practices and particularly perceptions of what are the important qualities of a good girl or wife. Most marriages were arranged and not legally registered. Marriages, including child marriage, performed social and economic functions, e.g. wedding was a social event for relatives and neighbours to intermingle and marriage allowed parents to shift the responsibility of supporting daughters onto husbands. At the same time, child marriage was sometimes seen as a way to prevent pre-marital pregnancies which was one of parent's main fears. Teenage pregnancies within marriage seemed to be accepted. The practice of FGM/C has been maintained by various myths on supposedly beneficial functions of the practice. Parents, assisted by a network of family members, relatives, friends as well as community or religious leaders were key decision makers in the practice of FGM/C and child marriage. Therefore, interventions designed to reduce and ultimately eliminate child marriage and FGM/C should also focus on parents, who have a strong influence on young people who generally avoid confronting or rejecting parent's decisions.

RECOMMENDATIONS

Taking into account the theory of change of the YES I DO programme and based on the results of this baseline study, the following recommendations for interventions are made:

- **Engage parents.** Changing community and gate keepers' attitudes towards child marriage, FGM/C and teenage pregnancy requires a focus on parents who are key decision makers in the practice of child marriage and FGM/C.
- **Engage young people directly.** Young people should be able to take informed actions in relation to their sexual and reproductive health and rights (SRHR). Through trainings and conversations young women and men can strengthen their knowledge on sexuality related themes and build skills to more openly improve the relations and communication with their parents about their futures, including SRHR issues.
- **Engage young people via significant others.** Role models such a brothers, peer students or teachers can have a strong influence on young people and can be important agents of change regarding child marriage, FGM/C, and teenage pregnancy within home and school environments.
- **Empower girls through education.** Education not only provides young people information on SRHR issues but can also diminish the power of social norms that sustain child marriage and FGM/C. Education efforts should focus on rural girls to increase their access to primary and secondary education as well as facilitate that they retain retention in school after enrolment.
- **Empower young people through employment creation.** Education should open up opportunities for jobs and income in order for young people to see the benefits of attending and finishing school. Young people's educational and economic empowerment would increase their ability to postpone marriage. At the same time, only availability of jobs that do not require higher education can be a reason for school drop-out, because of prioritization of earlier access to income.
- **Educate communities via demonstrations.** Promote actions with a stronger advocacy focus where young women can share personal stories on the negative effects of FGM/C and child marriage by strengthening girls' clubs, school mini-media and facilitating the use of multiple communication channels (TV, internet, radio).
- **Enforce the laws.** The federal and state family codes provide legal backing for interventions aimed at eliminating child marriage and FGM/C which are generally known by the communities. Interventions aimed at improving the enforcement of these frameworks should also direct efforts to strengthen the professionalism of local officials (e.g. police) through continuous training and engagement.
- **Engage religious leaders** in strategies to reduce child marriage as they often have a strong general influence in their communities and play a key role giving (or not) their blessing for underage marriages.
- **Improve sexual and reproductive health (SRH) infrastructure.** In this study, the respondents identified rural health posts as main sources of sexual and reproductive health information. However, the health extension programme is not keeping up with demand for better health services, as health centres often run out of medicines and some health workers do not adhere to office working hours. Therefore, health posts should be strengthened (e.g., more drugs, more consultation hours) so that they can address young people's critical SRH needs.
- **Enhance political will and commitment.** The key policy officers for addressing child marriage and FGM/C are those at the level of the community and it is at this level that strong commitment and dedication is most needed. The woreda women's affairs office, kebele administration, woreda administration, health extension workers, and school teachers are all involved in varying degrees in the fight against child marriage and FGM/C. These local-level official duty-bearers, working hand in hand with the communities and non-governmental organizations (NGOs), can bring about meaningful changes (if fully committed) in the lives of young girls affected by the plight of child marriage and FGM/C.

1. Introduction

Child marriage, female genital mutilation/cutting (FGM/C) and teenage pregnancy are manifestations of deeply rooted gender inequality and social norms, poverty and limited economic perspectives, inadequate access to comprehensive sexuality education and adolescent sexual and reproductive health (SRH) services, and voiceless youth. Child marriage, FGM/C and teenage pregnancy are interrelated issues that involve high health risks and human rights violations of young women, and impede socio-economic development in many developing countries. Besides sharing common causes and consequences, these three issues can be mutually reinforcing: child marriage can increase the likelihood of teenage pregnancy as well as the other way around (Williamson 2012). FGM/C and child marriage are also linked to each other: in many areas where FGM/C is practiced this is a prerequisite for marriage (World Vision 2014).

1.1. THE ETHIOPIAN CONTEXT OF CHILD MARRIAGE, TEENAGE PREGNANCY AND FEMALE GENITAL MUTILATION/CUTTING

With a population of 95.5 million, Ethiopia is the second most populated country in Africa (after Nigeria). According to the 2007 population and housing census, 20.5% of the population is between the age of 15-24 (57.7% of this group is 15-19 years of age) and girls aged 15-24 constitute 10.3% of the total population of the country (CSA 2007). The 2014 mini demographic and health survey (DHS) indicates that 21.5% of young women aged 15-24 did not have any kind of education, 46.9% had some primary education and 16.4% had some secondary education. Literacy among women (15-49) was 41% and showed significant variation by age, from 18% among women aged 45-49 to 70% among women age 15-19 (CSA 2014). This shows that illiteracy is prevalent among women in general but also among young people, though the proportion of women (15-49) with no formal education has declined by 35% since 2000, according to data from the Mini DHS, 2014.

Agriculture is the most important economic activity contributing to 80% of the employment, 84% of the exports and half of the gross domestic product (GDP). In recent years, Ethiopia is among the fastest growing non-oil economies in the world, with an annual growth of 10.8% in 2017[1]. The agriculture development-led industrialization and successive poverty reduction (2002-2010) and growth-oriented programmes (2010/11-2014/15) have contributed to rapid economic growth. As a result, Ethiopia's GDP per capita income has increased from 164 in 1992 to 486 in 2015 and poverty has been reduced from 44% in 2000 to 30% in 2015. This has positive impacts on the health and education sub-sectors with life expectancy, infant mortality, maternal mortality, primary school enrolment and primary school completion rates all showing progress, leading to Ethiopia being on the way towards the attainment of the global sustainable development goals by 2030. For example, primary school completion rates have increased from 35% in 2004 to 58% in 2011.

Women have equal rights in marriage as compared to men as prescribed by the Federal Democratic Republic of Ethiopia (FDRE) Constitution (FDRE 1995). A national policy of women was announced in 1993 to institutionalize women's economic, political and social rights by creating opportunities that would allow women's participation in government institutions and public offices (Emirie 2005). Both the Family Code and Penal Code have been revised in 2000 and 2005 respectively so as to make marriage and divorce procedures reflect gender equality and to make FGM/C illegal. Besides, the Ministry of Agriculture's Federal Rural Land Administration Law gives equal rights to women to receive, transfer and use land (ECA 2009).

Despite legal and policy changes favourable to women and girls, these two groups remain vulnerable to constrained life choices. They are less likely to have access to and complete formal education, more likely to be married as children (to men who are, on average, five years older), and are growing up in a culture in which gender discrimination permeates social institutions (Jones et al. 2014). The Gender Development Index puts Ethiopia 129th out of 136 counties while Ethiopia's rank on the Social Institutions and Gender Index is 64th out of 86 countries. Practices of child marriage and FGM/C are prevalent in most parts of Ethiopia, though there have been reports of a decline of the practices, especially for FGM/C, in recent years (CSA 2016).

1. www.statista.com/statistics/455074/gross-domestic-product-gdp-growth-rate-in-ethiopia.

1.1.1 CHILD MARRIAGE

Child marriage is a harmful practice that is prevalent in Ethiopia. It is a deep rooted tradition in many Ethiopian communities, perpetuated by poverty, lack of education and economic opportunities, and social customs limiting rights of women and girls (Girls Not Brides 2015). The 2011 Ethiopia Demographic and Health Survey (DHS 2011) reveals that the median age at marriage was 16.5 years, and over 41% of women aged 20-24 reported that they were married by the age of 18. This figure shows a slight improvement from the 16.1 years reported in the 2005 DHS. Data from the 2011 DHS show that 27% of women aged 20–29 had married by the age of 15 (Erulkar 2013).

Child marriage prevalence varies by region and is highest in Amhara region (44.8%), followed by Tigray (34.1%), Benishangul Gumuz (31.9%) and Addis Ababa (32.3%). In comparison to the other eight regions of Ethiopia, Amhara had the lowest median age at first marriage. A study by Pathfinder International (2006) noted that 15% of ever-married women in Amhara were married before the age of 12 years. The mean age at first marriage was 14.5 years, and about 44% of urban and 53% of rural ever-married women were first married between 12 and 15 years. Only 16.2% of rural women and 26.6% of urban women married at the age of 18 or older and more than half of child marriages were arranged with a man who was at least 10 years older than the girl (Pathfinder 2006:27). While prevailing norms influencing early marriage persist, there has been an increase in the average age of marriage, from 4-12 years in the previous two generations to 10-plus years in the current generation (Jones et al. 2015).

The Pathfinder International 2006 findings are corroborated by the 2011 DHS that found the median age at first marriage for women aged 25-49 to be the lowest in Amhara region (14.7 years), which is significantly lower than the national average (CSA 2012). The practice of early marriage in Amhara is reported to be widespread in many of the administrative zones and woredas (districts). Data from the Ethiopia Youth Adult Survey 2010 conducted in seven regions revealed that two in five girls in Amhara (39%) are married by the age of 15. While 18% of Amhara boys were married by age 18, 63% of the girls were married by the same age. Almost all early marriages are arranged by parents (94%), and most planning related to early marriages takes place without the girl's knowledge or consent (Erulkar et al., 2010). A survey conducted by the Ethiopian Committee against Harmful Traditional Practices (Mekonnen and Aspen 2009) in Amhara Region revealed that the problem of child marriage is much more serious in western Amhara (which includes East Gojam, West Gojam, Awi, North Gonder, and South Gonder) than in eastern Amhara (Wag Himira, North Wollo and South Wollo). In north Shewa, too, child marriage is a conspicuous problem (Pathfinder 2006).

According to a study by the Overseas Development Institute, multiple factors contribute to child marriage in Ethiopia (Jones et al. 2015). Young women and girls who are uneducated, poor and living in rural areas tend to marry significantly earlier than their peers who are educated, economically better off and living in urban areas (CSA 2012). Women with no education married at a median age of 15.9 years, those with primary education married nearly two years later (17.5 years) and those with secondary education seven years later (22.8 years). Women aged 25-49 who lived in urban areas married at a median age of 18.1 years, compared to 16.3 years for women who lived in rural areas. The wealth quintile had no significant impact on marriage age until the top quintile. Women in the bottom 80% married at approximately the same age: slightly after age 16. The wealthiest women (the upper 20%) married at a median age of 17.9 years. This may reflect Ethiopia's extremely flat income structure (Jones et al. 2014) but may also reflect the fact that national-level statistics tend to hide local differences in the social drivers of child marriage.

Ethiopia's approach to child marriage is guided by the National Strategy and Action Plan on Harmful Traditional Practices against women and children. A National Alliance to End Child Marriage was established in 2013 to coordinate actions against child marriage of governmental and non-governmental actors. Recent trends indicate that child marriage is on decline as manifested among other things by an increase in the average age of marriage (Jones et al. 2014) resulting from the combined efforts of legislative, civil society and non-governmental organizations' interventions. The government has set a target that by 2025, child marriage should be eliminated.

1.1.2 TEENAGE PREGNANCY

In Ethiopia, teenage pregnancy is directly related to child marriage; underage married girls are likely to give birth before they turn 18 years (Mekonnen 2013). According to the data of the DHS 2016, 13% of young women aged 15-19 years had begun childbearing; 10% had had a live birth, and 2% were pregnant with their first child at the time of the survey. The proportion of women aged 15-19 years who had begun childbearing increased with age, from 2% among young women aged 15 years to 28% among those aged 19 years. Teenage childbearing was higher in rural than in urban areas (15% versus 5%). It was also higher in the regions of Afar and Somali (23% and 19% respectively) than in Addis Ababa (3%). The proportion of teenagers who had started childbearing decreased with increasing level of education: 28% of teenage women with no education had begun childbearing compared with 12% of those who had attained primary education and 4% of those who had attained secondary education. Studies show that teenage pregnancy among school girls forces them to drop out of school. Consequently, pregnant teenage girls' chances of graduating from high school and proceeding onto higher education are reduced and this in turn reduces their chances of accessing formal employment and earning regular income (Tefera et al. 2013).

1.1.3 FEMALE GENITAL MUTILATION/CUTTING

Over the past years, FGM/C has decreased in Ethiopia from 80% in 2000 to 74% in 2005 and 65% in 2016 (CSA 2016). At the same time, it is one of the most prevalent harmful traditional practices and Ethiopia has one of the highest FGM/C rates in Africa. The most common type of FGM/C involves cutting as well as removal of flesh. Parents consider it their responsibility to arrange FGM/C to be performed on their daughters before they reach puberty stage, hence it is mostly carried out on girls between the ages of 0 and 15 years. However, occasionally, adult and married women are also subjected to the procedure. FGM/C is more prevalent among older age groups (Table 1).

Table 1 **FGM/C prevalence rate by age groups and type of FGM/C (CSA 2016)**

Age group	% of women circumcised	Type of cutting/circumcision		
		Cut, not flesh removed	Cut, flesh removed	Genital sewn closed
15-19	49.1%	3.0%	72.0%	47.1%
20-24	58.6%	3.1%	79.4%	6.8%
25-29	67.6%	2.2%	80.7%	5.7%
30-39	75.8%	2.4%	81.6%	5.7%
40-49	75.3%	3.1%	79.5%	8.1%

While FGM/C is prevalent in all regions and among many ethnic groups of Ethiopia, its prevalence rate, according to the 2016 DHS, is highest in Somali region (98.5%), followed by Afar region (91.1%). Tigray and Gambella regions had the lowest prevalence rates, 24.2% and 33.0% respectively, while the prevalence rate in Amhara region is 61.7%. FGM/C was lower among educated women with secondary level of education (50%) compared to women with no education (73%); and lower among urban residents (54%) compared to women in rural areas (68%) (CSA 2016).

The Ethiopian government has recognized the negative impacts of FGM/C on women. Various measures have been introduced to reduce the prevalence of FGM/C, including prohibition of the practice of FGM/C by the FDRE Constitution which states that 'the state shall enforce the rights of women to eliminate the influences of harmful customs. Laws, customs and practices that oppress or cause bodily or mental harm to women are prohibited'. A national committee to eliminate harmful traditional practices (EGLDAM) has been established to coordinate government and NGO activities against harmful traditional practices, including FGM/C. A National FGM/C Network, managed by a seven member executive committee and chaired by the Ministry of Women, Children and Youth Affairs, has been established to mobilize actors and increase coordinated participation of governmental and civil society organizations to bring broad social change through collective action and voice (28 Too Many 2013).

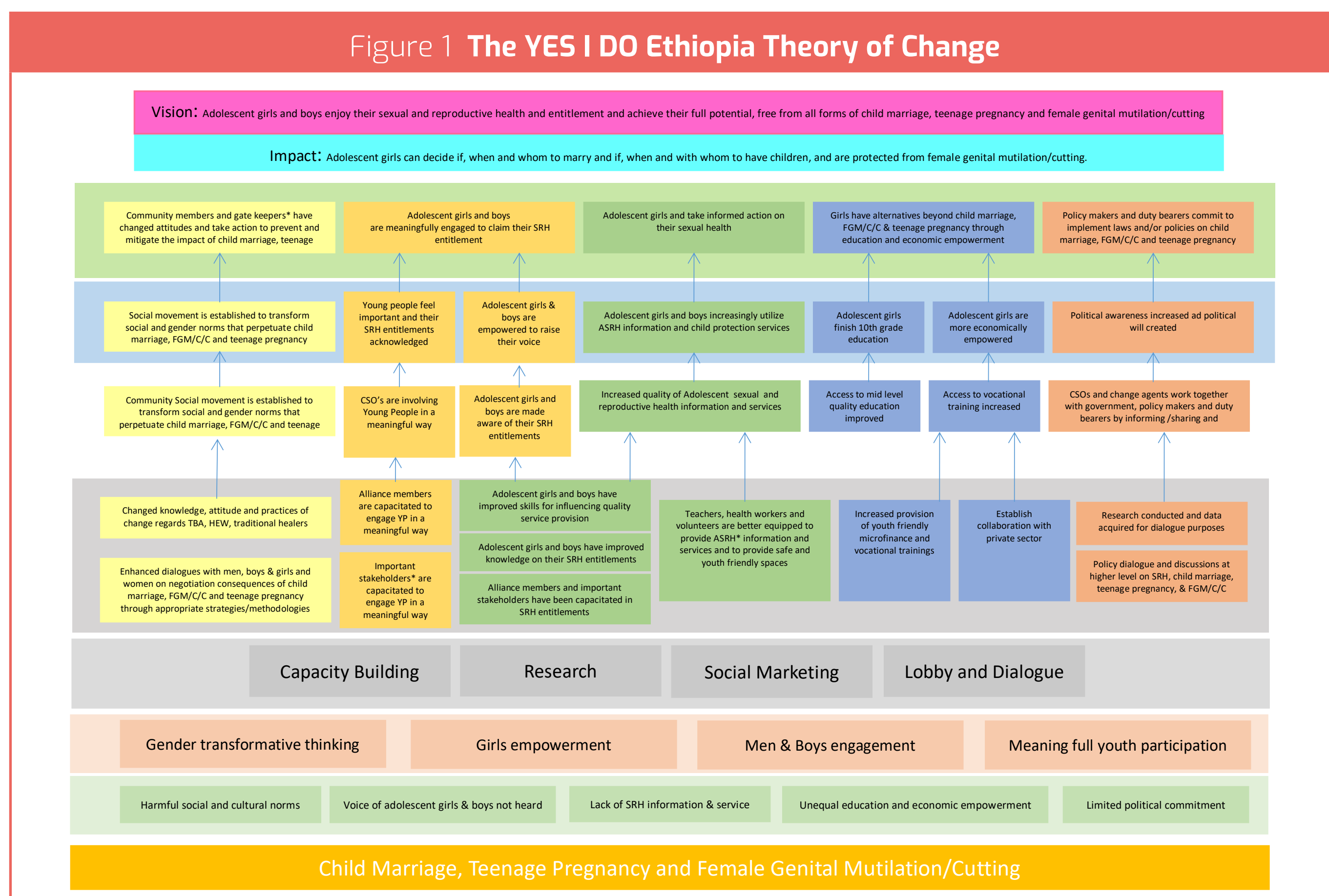
1.2 THE YES I DO PROGRAMME IN ETHIOPIA

The YES I DO Programme was rolled out in November 2016 in Bahirdar city. The implementing partners in Ethiopia are Amref Health Africa Ethiopia, Plan Ethiopia, Development Expertise Center (DEC), and Talent Youth Association (TaYA). The YES I DO programme aims to contribute to a world in which adolescent girls can decide if, when and with whom to marry and have children, and are protected from FGM/C. This requires innovative intervention strategies which address child marriage, teenage pregnancy and FGM/C in a combined and holistic manner in Ethiopia. The programme's theory of change has five strategic goals (Figure 1):

- Community members and gate keepers have changed attitudes and take action to prevent and mitigate the impact of child marriage, FGM/C and teenage pregnancy
- Adolescent girls and boys are meaningfully engaged to claim their SRH (sexual and reproductive health) entitlements
- Adolescent girls and boys take informed action on their sexual health
- Girls have alternatives beyond child marriage, FGM/C and teenage pregnancy through education and economic empowerment
- Policy makers and duty bearers commit to implement laws and policies on child marriage, FGM/C and teenage pregnancy

The five goals are related to five intervention strategies, illustrated by the interrelated boxes in Figure 1. The intervention strategies focus on forming a social movement, empowering and meaningfully engage young people, improving access to information and services, stimulating education and economic empowerment for girls and enhancing evidence-based lobby and advocacy for improved legal and policy frameworks. These intervention strategies follow experiences of Alliance partners and global evidence available on what works in trying to reduce child marriage, teenage pregnancy and FGM/C (OHCHR and UNDP 2008; Malhotra et al. 2011; Williamson 2012; Loaiza and Liang 2013).

Figure 1 **The YES I DO Ethiopia Theory of Change**



1.3 THE RESEARCH COMPONENT

The overall goal of the study is to provide insight into the (interrelated) causes and effects of child marriage, teenage pregnancy and FGM/C and the extent to which these causes and effects, and the three problems themselves, are present in the intervention areas of the YES I DO programme. In addition, the study aims to provide insight into different pathways of change, thereby testing the theory of change, and unravel why and how the YES I DO interventions strategies do or do not contribute towards improved outcomes related to the five strategic goals, and ultimately a decrease in child marriage, teenage pregnancy and FGM/C.
The specific objectives of this baseline study are:

1. To explore attitudes of community members and gate keepers[2] around child marriage, teenage pregnancy and FGM/C, whether and to what extent they take action to prevent the three issues and which factors influence this and how
2. To determine the level of meaningful engagement of young women and men in community activities, programmes and policies – thereby claiming their entitlements- and which factors influence this and how
3. To explore and analyse whether and to what extent young people take informed action on their sexual and reproductive health and which factors influence this and how
4. To explore and analyse whether and to what extent education and economic empowerment of girls provides them with alternatives beyond child marriage, teenage pregnancy and FGM/C
5. To provide insight into commitment to implement laws and policies on child marriage, teenage pregnancy and FGM/C
6. To contribute to the evidence on effective and context specific intervention strategies to eliminate child marriage and FGM/C and reduce teenage pregnancy

2 Gatekeepers: caretakers; family members such as grandmothers, mothers in-law; health and social workers; teachers; traditional and religious leaders and peers, who influence girls' situation in relation to child marriage, FGM/C and teenage pregnancy.

2 METHODOLOGY

The study was based on a mixed-method research design with a quantitative and qualitative complementary strand. This section details the methodology used to collect and analyse primary data.

2.1 STUDY AREA

Ethiopia, officially known as the Federal Democratic Republic of Ethiopia, has a federal structure comprising of the federal government, nine regional states and two city administrations (Addis Ababa and Dire Dawa). The regions are divided into zones, woredas and kebele administrations, this being the lowest administrative structure or ward. The Amhara National Regional State is situated in the northwest, northeast and north central part of the country. The Amhara people (numbering approximately 20 million) comprise one of the nine ethnic divisions of Ethiopia, and are predominantly engaged in agriculture. The region is characterized by high levels of food insecurity due to recurrent drought and deforestation, low health coverage, and low educational attainment (for example, more than 60% of women over the age of 15 have never been to school) (CSA 2012). This baseline study was conducted in two woredas: Qewet woreda in north Shewa zone and Bahirdar Zuria woreda in west Gojjam zone (Figure 2).

Figure 2 **Location map of the study communities**

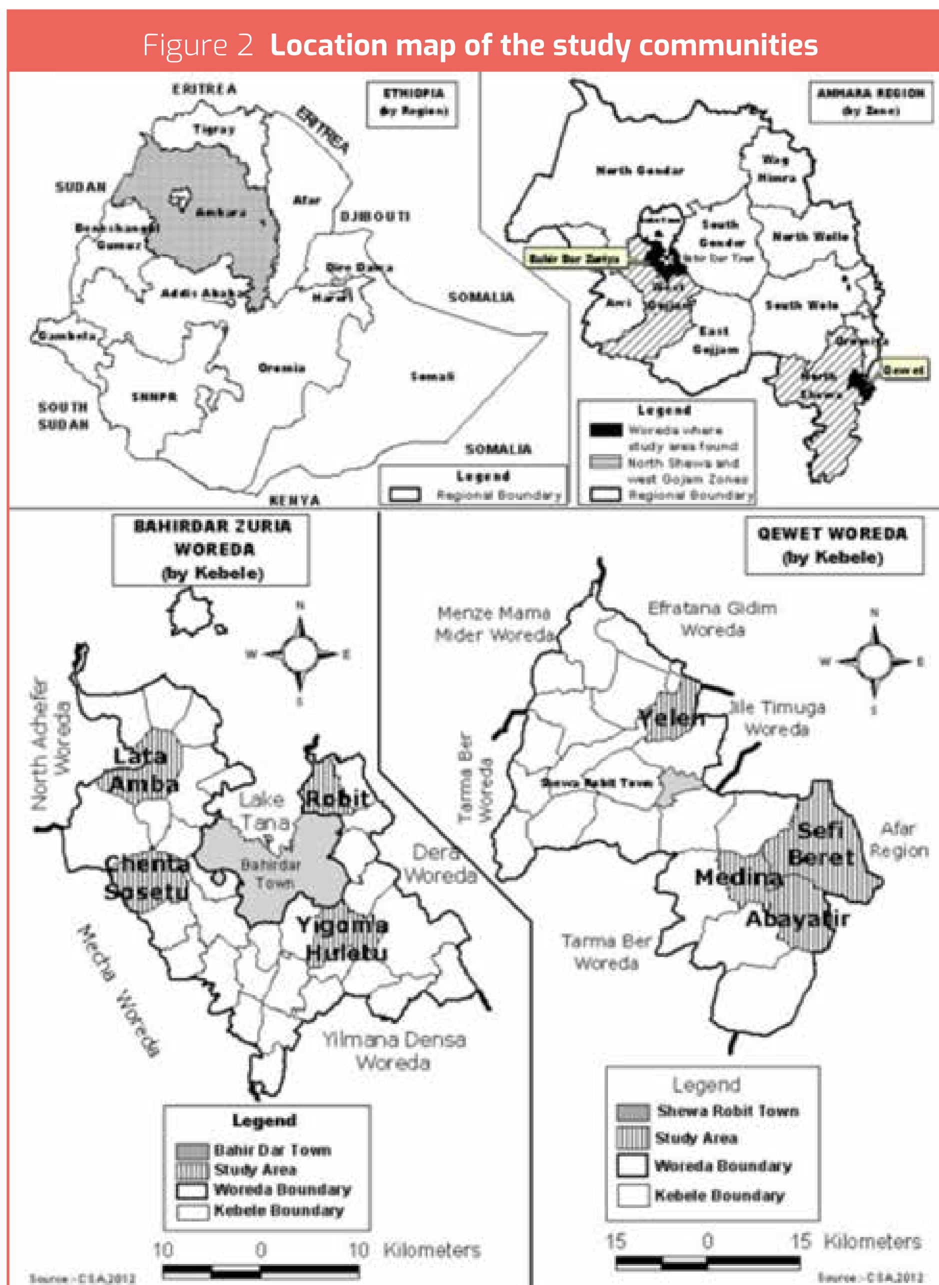


Table 2 **Area, population and livelihood features of the study woredas**		
Key features	Bahirdar Zuria woreda	Qewet woreda
Area (km^2)	1143.37	785.85
GPS coordinates	11º14'60.00 N 37º09'60.00 E	10º09'60.00 N 39º44'59.99 E
Population	182,730	118,381
Pop density	126.60	150.64
No of HHs	40,893	29,058
HH size	4.47	4.07
Major social organizations	Orthodox Christianity	Orthodox Christianity, Moslem and Protestant
Livelihood	Crop-cum-livestock farming (major crops: maize, teff, khat and fruit crops of mango,	Crop-cum-livestock farming (major crops: maize, teff, sorghum, tomato, khat)
Economic opportunities	High irrigation potential using Andasa Dams and Abbay River	Small-scale irrigation using river diversions, dairy potential, international migration, etc.

BAHIRDAR ZURIA WOREDA IN WEST GOJJAM ZONE

The West Gojjam zone is located in southwest Amhara. According to the 2007[3] Census conducted by the Central Statistical Agency its total population is 2,106,596 and is 99% Ethiopian Orthodox Christian (CSA 2007). Bahirdar Zuria woreda is located in the northern part of the zone and has a population of 182,730 (Table 2). The population's main livelihood is farming where maize, finger millet and teff are produced. Khat has also become a major source of livelihood especially for young people who are routinely engaged in contractual khat farming by taking khat plots from farmers and harvesting green leaves for a fixed amount. The crop has increasingly become an important cash source mostly displacing crop fields and young people are seen working on khat fields and transporting them to local selling points located on the Bahirdar-Gondar highway. In a good year, a kilo of khat could fetch up to 250 Birr but at the time of the survey it was selling Birr 50, because of the abundance of khat in the rainy season. Irrigation using water pumps is used in 10 of the 32 kebeles in the woreda, but mostly devoted to the cultivation of khat fields. Young people also migrate to Humera, Awi zone and neighbouring areas of the Oromiya region (e.g. Wollega) in search of jobs. Migration into the woreda is almost non-existent. The woreda consists of 32 surrounding rural kebeles of the state capital – Bahirdar city. The baseline study was conducted in four rural kebeles: Robit, Chencha Sostu, Leta Amba and Yigoma Huletu kebeles (Figure 2).

QEWET WOREDA IN NORTH SHEWA ZONE

North Shewa zone is located in southern Amhara. In the 2007 Census, the zone's population was 1,431,305. The communities in north Shewa are predominantly Amhara (96%), but also other ethnic groups such as Afar (3%) and Argoba (1%) live there. Qewet woreda is located in the northeast part of the zone and has a population of 118,381 (Table 2). In terms of religion, 83.3% practice Orthodox Christianity, 13% are Muslim and 2% Protestant. The woreda is prone to frequent rain shortages characterized by late start or early cessation of the main rain season (June-August), though a significant part of the area also receives small rains during from January till March. In the 2015/16 production season, the woreda was affected by drought resulting in people being dependent on food aid provided by the government and NGOs. Malaria is a significant health problem in 11 out of the 18 kebeles. A recent study by Getaneh (2016) found that there is no malaria risk-free kebele in the woreda, with 70% of it being classified as high risk or very high risk. The baseline study was conducted in four kebeles, namely Yelen, Medina, Sefeberet and Abayatir (Figure 2).

2 The 2007 census is the latest population and housing census to date. The next planned Census is in 2018.

2.2 QUANTITATIVE METHODS

The quantitative strand of the study was based on a household survey administered to young people aged 15 to 24. A generic survey for the multi-country YES I DO research programme was developed using a tablet-based structured questionnaire based on available literature and existing and validated tools of Plan International. This generic survey was adapted to the Ethiopian context by incorporating inputs from the national stakeholder's theory of change design workshop in March, 2016, inputs from the research assistants' training workshop in July 2016, and from a short desk review. The adjusted questionnaire was pre-tested in a community located in north Shewa on the Addis Ababa-DebreBirhan road for final adjustments. The survey included multiple questions about child marriage, teenage pregnancy and FGM/C as well as questions related to community norms and values around sexuality and reproduction, young people's ability to claim SRH rights, education and economic empowerment.

2.2.1 SAMPLING

The sample size calculation was based on being able to detect a reduction of 10% over the period of five years of the programme in the percentage of women aged 20 to 24 who were married by the age of 18. As according to the 2011 DHS 41% of young women aged 20 to 24 were married by the age of 18, the following parameters were used for the calculation of the sample size: proportion at baseline 41%, proportion at end-line 31%, confidence interval 95% and a power of 80%. On top of that, a male sample was added using a ratio of 1 male per three females. Finally, as the study used clustered sampling, this female and male sample was multiplied by 1.5 to take into account possible design effects. That lead to a sample size of 716 per area so a total of 1,432. However, the study aimed for a total of 1,600 respondents.

The sampling aimed for an equal proportion of respondents in each study area (Qewet 50%, Bahir Dar 50%) as well as a similar number of respondents aged 15-18 and 19-24, with a division of 25% males and 75% females (Table 3 shows the results of the sampling).

Table 3.1 **Types of education**

	Age group	Female		Male		Total	
		n	%	n	%	n	%
Bahir Dar	15-18	294	51.1%	89	38.9%	383	47.6%
	19-24	281	48.9%	140	61.1%	421	52.4%
	Total	575	100.0%	229	100.0%	804	100.0%
Qewet	15-18	349	63.2%	129	53.8%	478	60.4%
	19-24	203	36.8%	111	46.2%	314	39.6%
	Total	552	100.0%	240	100.0%	792	100.0%
Total	15-18	643	57.1%	218	46.5%	861	53.9%
	19-24	484	42.9%	251	53.5%	735	46.1%
	Total	1,127	100.0%	469	100.0%	1,596[ϕ]	100.0%

ϕ six respondents are missing throughout variables where age is considered as their ages were not recorded at the time of the survey. Otherwise, the total sample size is 1,602

Young women and men were randomly selected through two-stage cluster sampling. In the first stage, villages separated by roads or clusters of settlements were randomly selected. Then, within the selected clusters, households with young people aged 15-24 were randomly selected using the roaster provided by the respective kebele administration.

In locating and contacting respondents, research assistants were assisted by two guides: an employee of the woreda women's affairs office who had good knowledge of the study kebeles and a local guide assigned by the respective kebele administrations, to help making contact and arranging interviews with the respondents. In situations where randomly selected potential respondents were not found, after repeated attempts failed (e.g. in Medina kebele), research assistants were advised to employ availability sampling. The presence of the local guide at all times (throughout the data collection period) helped to ensure that respondents accessed using availability sampling method were within the age group of 15-24 and were residents of the kebele.

2.3 QUALITATIVE METHODS

The qualitative methods used were focus group discussions (FGDs), in-depth interviews (IDIs) and Key Informant Interviews (KIIs). Generic topic guides for each method were developed for all countries and adjusted to the Ethiopian context based on the input from the stakeholder workshop, training of research assistants and desk review. These guides were pretested together with the survey questionnaire for final adjustments (Figure 3).

Figure 3 **FGD Pre-testing exercise with boys ages 15-24, Fito kebele, north Shewa zone, July 2016**

A total of six FGDs were conducted with young women aged 15-24 (one), young men aged 15-24 (three) and with mothers/grandmothers (two). In total, 50 individuals participated in the six FGDs, with an average of eight members per group. These FGDs provided information about joint or diverging views, community norms and values about SRHR, child marriage, teenage pregnancy and FGM/C and influencing factors. Also, 11 IDIs were held with young women and men aged between 15-19 and 20-24 years as well as parents or caregivers. These IDIs provided in-depth information about the causes and consequence of child marriage, teenage pregnancy and FGM/C as well as experiences, opinions and feelings towards these three issues. Finally, KIIs were held with local officials, religious leaders and health and school professionals. These KIIs intended to obtain their views regarding the pathways in the theory of change, particularly regarding the strategic goal 5 which states that '*policy makers and duty bearers commit to implement laws and/or policies on child marriage, FGM/C and teenage pregnancy*'. Table 4 provides an overview of the total number of FGDs, IDIs and KIIs conducted.

Table 4 **Number and distribution of qualitative interviews**											
	Young women 15-24		Boys 15-24		(Grand) Parents/ caregivers		Religious leaders		Others*		Total
	BD	Q	BD	Q	BD	Q	BD	Q	BD	Q	
FGDs		1	1	2	1	1					6
KII							1	2	1	2	6
IDIs	2	2	2	3	1	1					11
Total											23

*Woreda women's affairs head, health extension worker, teacher, and kebele chairperson. Bahir Dar (BD), Qewet (Q).

All participants were purposefully selected by the research team, with help from Amref Ethiopia staff (Qewet woreda) and Plan Ethiopia staff (Bahirdar Zuria woreda) as well as with the support of the woreda women's affairs office.

2.4 DATA COLLECTION

Ten research assistants (six females and four males) were recruited for the data collection which started with a research workshop. This workshop was conducted in July 2016 and was designed to introduce the YES I DO Ethiopia programme and to provide training about quantitative and qualitative data collection, including how to use tablets in completing the quantitative survey questionnaire, how to conduct qualitative interviews (FGDs, KIIs, SSIs) and ethical considerations. The workshop ended with a pre-test of all the tools which served to gain practical experience and get insights about necessary adjustments. The workshop was organized by two KIT researchers in collaboration with the national researcher (Figure 4).

Figure 4

A partial view of participants of the research assistants' training workshop held in Mosaic Hotel, Addis Ababa, July 2016

Fieldwork started in July 2016 and two teams were deployed: one in Qewet and one in Bahir Dar Zuria. Each team consisted of four research assistants (three females, one male) and one supervisor (male). Before each team's departure to the field, supervisors were sent four days in advance to make preparations and conduct background work (e.g. making contacts with local officials, vising survey kebeles and preparing a list of study participants). The national researcher, Dr Abeje Berhanu, closely supervised both research teams by visiting each team at different times.

In Qewet, data collection was completed between July and August 2016 in two short rounds. The first round took place from July 27 to August 12 and was interrupted during one week because of mass demonstrations in the Amhara region. Fieldwork re-started on August 19 and was completed by the end of the month (August 27). The Bahirdar team stayed in the field until August 11, 2016 collecting data in two kebeles (Robit and Chencha). Then fieldwork had to stop because of the deteriorating security situation in Bahirdar city. The data collection in Bahir Dar resumed in July 2017 leading to the completion of the data collection in the remaining two kebeles (Lata Amba and Yigoma Huletu).

During fieldwork, daily review evening meetings were held with research assistants to identify emerging themes, to check completeness of work and possible inconsistencies resulting from the day's fieldwork. Lessons learned during the day were shared among research assistants.

2.5 DATA ANALYSIS

The quantitative analysis was based on descriptive statistics using SPPSS and STATA, consistently disaggregating data by sex and study area. Several standard indicators were calculated. All qualitative data were transcribed, translated simultaneously into English and coded using a coding framework based on the topic guides, in which new and more specific sub-themes were added. Preliminary results were discussed during an analysis workshop that took place in November 25-27, 2016 were research assistants also shared fieldwork experiences, perspectives, lessons learned, and unique stories. Workshop minutes were recorded on a daily basis and the themes/issues contained in the minutes were later incorporated into the data analysis. The triangulation of qualitative and quantitative data was done to present all data in an integrated manner in the report.

2.6 ETHICAL CONSIDERATIONS

Recognizing the importance of ethics in research, the study took into account the basic principles of autonomy, doing no harm, beneficence and justice. Respondents and participants received forms outlining the purpose of the study, voluntary nature of participation, and confidentiality of the information collected. Adult participants received a consent form to sign and for minors assent forms were used together with consent forms for their parents or caregivers. Interviews and FGDs were recorded only after having obtained approval from participants. All data collection instruments were translated from English into Amharic to ensure that the research participants understood the questions and that their opinions/views were recorded correctly. The research proposal, research instruments with Amharic translation and associated consent/accent forms (also with Amharic translation) were submitted to and approved by the Ethical Review Committee of the Amhara Regional State Health. The study was also granted Ethical approval by KIT's Ethical Review Committee.

2.7 STUDY LIMITATIONS

One limitation of the study is that the difficulty for some study participants to openly discuss the addressed topics could have led to incomplete information. As adolescent sexual and reproductive health is a sensitive social and cultural issue, the research team tried to use a variety of approaches to ensure that participants felt comfortable and free to express what they genuinely believed (e.g. reminding their views would be kept confidential) and the researchers explicitly focused on eliciting in-depth genuine responses to the questions. The research team was trained to listen and observe intently without displaying any judgmental attitude towards information they received from the participants. In situations when young people showed persistent resistance to cooperate (e.g. lack of knowledge on the issues raised or for some other reasons) the research assistants were advised to stop interviewing such people and look for a replacement instead.

Ultimately, data quality depends on the ability of the interviewers and FGD facilitators as well as the willingness and ability of participants to collaborate. Due to language-related challenges, despite preparations of materials and training of involved researchers, some data contents could have been lost during translation and transcription. The research team addressed this by working closely with all researcher assistants during the data analysis workshop to obtain a deeper understanding of the scenes, contexts and situation of the qualitative interviews and also by double-checking the collected qualitative notes as well as audio records.

The interruption in data collection also results in a limitation, as a (smaller) part of the data were collected a year later, when YES I DO intervention had already started.

3 Results

In this section the main study findings are presented, integrating quantitative and qualitative data. The characteristics of the respondents are described, followed by subsections on child marriage, teenage pregnancy, FGM/C, community context, SRHR, youth economic empowerment and policy and legal issues.

3.1 CHARACTERISTICS OF THE RESPONDENTS

Respondents' households were diverse, the most common being households were mother, father, brother and sister lived together (21.3%) followed by husband-wife type of households (Table 5). The respondents' household size ranged from 1-2 members (17.3%) to 3-5 (44%) and 6-8 (35.1%) members. Respondents' religious background was mainly Orthodox Christian (85%) followed by Muslim (12.4%) and Protestant (2.6%).

Table 5 **Types of respondents' households**

	Bahir Dar		Qewet		Total	
	n	%	n	%	n	%
Mother-Father-Brother-Sister	83	10.3%	258	32.5%	341	21.3%
Husband-Wife	171	21.2%	105	13.2%	276	17.2%
Mother-Father	103	12.7%	9	1.1%	112	7.0%
Alone	60	7.4%	32	4.0%	92	5.7%
Mother-Father-Brother	6	0.7%	46	5.8%	52	5.8%
Mother-Sister-Brother	6	0.7%	46	5.8%	52	3.2%
Mother-Father-Sister	6	0.7%	39	4.9%	45	2.8%
Mother-Brother	4	0.5%	26	3.3%	30	1.9%
Mother only	14	1.7%	13	1.6%	27	1.7%
Husband-Wife-Others	12	1.5%	44	5.5%	56	3.5%
Mother-Others	4	0.5%	29	3.7%	33	2.1%
Mother-Father-Others	7	0.9%	54	6.8%	61	3.8%
Father-Others	40	5.0%	21	2.6%	61	3.8%
Others	287	35.5%	67	8.4%	354	22.1%
Father only	5	0.6%	5	0.6%	10	0.6%
Total	808	100.0%	794	100.0%	1,602	100.0%

The majority of the respondents (87.4%) had received some form of education and primary education was the education level of most of them (25.6% grades 1-4 and 27.6% grades 5-8). Twelve percent of the respondents who had received some form of education where in secondary education grades 9-10 and 6.5% in secondary education grades 11-12. The level of education seemed to be slightly higher among males and among Qewet respondents. In general, primary education was the most common education level. However, among females and Bahir Dar respondents the percentage of those in grades 1-4 was the highest and among male and Qewet respondents grades 5-8 was the most reported education level. Also, the percentage of respondents in secondary education was slightly higher among males than among females as well as slightly higher in Qewet than in Bahir Dar (Table 6).

Table 6 **Respondent´s level of education at the time of the survey respondents**

	Gender n (%)		Woreda n (%)		Total n (%)
	Female	Male	Bahir Dar	Qewet	
Primary (grades 1-4)	301 (30.8%)	57 (13.5%)	188 (28.1%)	170 (23.3%)	358 (25.6%)
Primary (grades 5-8)	262 (26.8%)	124 (29.4%)	154 (23%)	232 (31.8%)	386 (27.6%)
Secondary (grades 9-10)	113 (11.6%)	60 (14.2%)	59 (8.8%)	114 (15.6%)	173 (12.4%)
Secondary (grades 11-12)	62 (6.3%)	29 (6.9%)	40 (6%)	51 (7%)	91 (6.5%)
University	14 (1.4%)	12 (2.8%)	8 (1.2%)	18 (2.5%)	26 (1.9%)
Vocational	15 (1.5%)	5 (1.2%)	17 (2.5%)	3 (0.4%)	20 (1.43%)
Completed	13 (1.3%)	6 (1.4%)	14 (2.1%)	5 (0.7%)	19 (1.4%)
Other	198 (20.3%)	129 (30.6%)	190 (28.4%)	137 (18.8%)	327 (23.4%)
Total	978 (100%)	422 (100%)	670 (100%)	730 (100%)	1400 (100%)

It appears that dropping out of school was a widespread phenomenon: 49% of the female respondents and 43% of the male respondents had ever dropped out of school due to various reasons. For young women, getting married, heavy domestic workload and illness were identified as the main reasons for dropping out of school while for young men heavy workload in the family, lack of support and illness were found to be contributing factors for school dropout. The majority of the respondents had parents who did not have education at all, which according to some participants explained why young people dropped out of school. As a 21 year-old FGD participant male from Yelen kebele, Qewet woreda, explained:

> *"Illiterate or 'mahaim' parents do not understand the value of education. They are not willing to support their children with education materials. Instead, they prefer boys to work on the farms and girls to stay at home and get married at early age."*

On the other hand, parents blamed lack of employment opportunities for young people as a factor discouraging them from investing in the education of their children. Many parents cited the cases of grades 10 and 12 national exams, but in the former in particular, in which many students often failed and ended up going back to their parents' household with little appetite to work on farms. The experience of children not successfully passing grade 10 national exam, which too often happens to many parents, and living in the family with younger siblings who aspire to go to school, was mentioned by a 47 year-old father from Robit kebele, Bahirdar Zurai woreda.

> *"I have two children, a son and a daughter, who failed in grade 10. They are living with us now. They are harvesting khat leaves like me and my 12 year-old boy who is also a drop-out from grade 4. The younger brother is not motivated to go to school because he saw education is not making a difference in his older siblings' lives. I cannot force him. Education is no good if it does not reward after years of hard toil."*

In relation to respondents' employment status, data indicate that 33.5% were students, 14.4% did subsistence farming, 16% were unemployed, 11.6% self-employed, 6.3% with casual, daily labour and 16.4% performed unpaid work (e.g. homemaker/housewife). That is, 47% of the respondents had some form of employment. The primary sources at the household level was mostly agriculture including agriculture-related trade (e.g. contractual work for onion farmers).

Respondents were also asked to estimate their households' monthly income and for the majority it was difficult to give figures (hence the results are not computed) principally for two reasons: (1) children have very little knowledge of their parents' income from different sources, and (2) most of these income sources (e.g. farm produce,) are difficult to convert into cash income as most of it is consumed at home.

3.2 CHILD MARRIAGE

Data from the baseline survey show that 37.4% of the young women (aged 18-24) had experienced child marriage (Table 7). Disaggregation of the data by woreda shows that child marriage was more prevalent in Qewet woreda (48.2%) compared to that of Bahirdar Zuria woreda (30%). The majority of the child marriages were among female respondents; only six males had experienced child marriage, with five being from Bahirdar Zuria woreda.

Table 7 **Child marriage rates among young women aged 18-24 by woreda**

	Bahir Dar Zuria		Qewet		Total	
	n	%	n	%	n	%
Child marriage	124	30.0	136	48.2	260	37.4
Marriage 18 and above	289	70.0	146	51.8	435	62.6
Total	413	100.0	282	100.0	695	100.0

3.2.1 REASONS FOR CHILD MARRIAGE

A number of (interrelated) factors were found to contribute to the practice of child marriage in the study communities. Some of these are cultural (e.g. parents have been doing it), social (e.g. fulfilling social responsibilities) or economic (e.g. daughters bring bride wealth).

Mismatch between the law and community perception. Although the law states that the minimum age to marry is 18, the study found that there was a belief in the communities that young women are ready for marriage starting 14/15 years of age and should not marry later than 20 years. Parents arrange marriage in hidden way to escape the supervision of law enforcement bodies such as police. This indicates that even if the community members recognize the legal age of marriage they want to maintain the age-old practice.

Fear that daughter might get pregnant outside marriage. Most parents were concerned that teenage daughters engage in sexual relationships and subsequently become pregnant before getting married. The stigma associated with teenage pregnancy out of wedlock made some parents to prefer marrying off their daughters before they engage in pre-marital relationships.

Tradition/culture to marry girls young. Young women were reported to marry young because of the culture or tradition in the community. Nearly three-fourth of the respondents agreed that it is culture/tradition for a girl to get married young, with a higher proportion among respondents in Qewet (76.6%) than in Bahir Dar (71.7%) (Table 8). At the same time, a smaller proportion of the respondents (45.3%) agreed that it is custom/culture for a boy to get married young with a strong difference between the two woredas, ranging from an agreement level of 28.1% for Qewet and 62.3% for Bahirdar respondents (Table 9). This shows varying degrees of cultural expectations for females

and males in the two study communities, with Qewet communities appearing less strict towards what is considered an appropriate age at which males are expected to marry as compared to girls. This can be related to information from an FGD held with young men in Abayatir kebele, where expectations related to sex were linked to marriage.

> *"Legally children are expected to start sex at age 18, but the community expects them to be sexually active for girls age 15 and boys 18. However, in practice boys start sex as young as 16 and girls as young as 13."*

Table 8 **Culture/tradition for a girl to marry young**

	Bahir Dar Zuria		Qewet		Total	
	n	%	n	%	n	%
Agree	579	71.7%	608	76.6%	1187	74.1%
Neutral	7	0.9%	5	0.6%	12	0.7%
Disagree	214	26.5%	174	21.9%	388	24.2%
Don't know	8	1.0%	7	0.9%	15	0.9%
Total	808	100.0%	794	100.0%	1602	100.0%

Table 9 **Culture or tradition for a boy to marry young**

	Bahir Dar Zuria		Qewet		Total	
	n	%	n	%	n	%
Agree	503	62.3%	223	28.1%	726	45.3%
Neutral	15	1.9%	19	2.4%	34	2.1%
Disagree	280	34.7%	548	69.0%	828	51.7%
Don't know	10	1.2%	4	0.5%	14	0.9%
Total	808	100.0%	794	100.0%	1602	100.0%

Failure at school. Parents seemed to see marriage as an option when their daughters failed in school. When young women do not pass grade 8 or 10 examination, parents saw in marriage a better option for their daughters.

Fulfilling social responsibility. In some cases, weddings enabled parents to pay off their social debts. Parents who have been attending weddings organized by relatives and neighbours are under social pressure to organize a wedding for their daughter. A 22 year-old female from Sefiberet kebele made the following observation:

> *"In our community girls cannot reject a marriage proposal. Forced marriage is practiced to strengthen the family bond. Pressure to marry is on the girl, not the boy. If a girl is over age 15, she has no value in the community."*

Economic necessity. Some participants mentioned that parents who are not economically well-off and hence cannot support their daughter may decide to give her to marriage. This reduces the economic burden of supporting the daughter by shifting the responsibility onto husband/his family. Payment of bride wealth may also be an incentive for some parents to decide to marry daughter off to a relatively well-to-do family.

Mutual love between would-be-spouses. In some instances, child marriage was reported to occur because of genuine love between the would-be-spouses. A good example is a couple residing in Robit kebele (Bahirdar Zuria woreda) who were happily married (girl 15, boy 16) and are currently living with the husband's mother. They had already built their own house and planned to move in when the young man would reach 18 years. This is also supported by results of the survey which shows that 41.1% of the respondents agreed that underage marriage for girls is mostly due to love (Table 10). It appears that female respondents (37.7%) were less optimistic about the role of love in the practice of child marriage compared to males (49.4%) who viewed love as a reason for girls to get married young.

Table 10 **Underage marriage for a girl is mostly due to love**

	Female		Male		Total	
	n	%	n	%	n	%
Agree	427	37.7%	232	49.4%	659	41.1%
Neutral	7	0.6%	5	1.1%	12	0.7%
Disagree	674	59.5%	228	48.5%	902	56.3%
Don't know	24	2.1%	5	1.1%	29	1.8%
Total	1132	100.0%	470	100.0%	1602	100.0%

3.2.2 DECISION MAKING ABOUT CHILD MARRIAGE

The study found that young women often felt pressured into marriage by parents, relatives and/or friends. Data indicate that the pressure was felt more by younger women aged 15-18 (57.2%) than among older ones aged 19-24 (30.3%). On the other hand, males felt more pressure into marriage as they grew older (Table 11).

Table 11 **Pressured into marriage by family/friends**

Age at first marriage	Pressured into marriage by family/friends	Female		Male		Total	
		n	%	n	%	n	%
15-18	No	125	42.1%	2	33.3%	127	41.9%
	Not sure	2	0.7%	0	0.0%	2	0.7%
	Yes	170	57.2%	4	66.7%	174	57.4%
	Total	297	100.0%	6	100.0%	303	100.0%
19-24	No	98	69.0%	22	44.9%	120	62.8%
	Not sure	1	0.7%	0	0.0%	1	0.5%
	Yes	43	30.3%	27	55.1%	70	36.6%
	Total	142	100.0%	49	100.0%	191	100.0%
Total	No	223	50.8%	24	43.6%	247	50.0%
	Not sure	3	0.7%	0	0.0%	3	0.6%
	Yes	213	48.5%	31	56.4%	244	49.4%
	Total	439	100.0%	55	100.0%	494	100.0%

Table 12 **Child marriage has disadvantages for underage girls**						
	Bahirdar		Qewet		Total	
	n	%	n	%	n	%
Disagree	45	5.6%	96	12.1%	141	8.8%
Neutral	5	0.6%	4	0.5%	9	0.6%
Agree	740	91.6%	675	85.0%	1415	88.3%
Don't know	18	2.2%	19	2.4%	37	2.3%
Total	808	100.0%	794	100.0%	1602	100.0%

The pressure from parents, relatives and the community is so high that most young women agreed to marriage proposals. Parents, especially fathers, were said to try to pursue daughters by resorting to tradition, family background (e.g. spouse comes from a respectable family) or referring to their daughter's futures. When young women were not convinced some parents seemed to use negative sanctions such as cursing or disavowing their daughter: *'You are not my daughter'. 'Do not ever call me father', 'I am not your father'*. In interviews and FGDs, young people argued that nowadays some young women refuse to marry young, resulting from education and awareness-raising activities. Some of the reasons for refusing were wanting to continue school, not wanting to marry the boy and having plans to migrate (e.g. in Medina kebele).

In rare situations, some young women themselves took the decision to get married. In these cases, they sometimes also sought parental approval. This was the case with a 22 year-old woman from Sefiberet who got married at the age of 14. In her own words:

> *"I married at the age of 14. No one pressured me to marry at the time..., getting married is a golden opportunity for girls, whether they are students or not. After the age of 15, no girl refuses to marry."*

In the same line, a 15 year-old girl from Abayatir kebele was confident that she should be married at age 15. The girl felt it was the right time that she got married. She was able to express herself well and seemed to understand and accept the responsibilities that accompany underage marriage.

In general, whether a young woman under 18 years of age should get married or not seemed to be mostly a matter decided by parents. Parents did not equally participate in child marriage decisions. The young woman's father was generally the one approached by the father of the male, and took marriage decisions in consultation with close relatives, often the maternal uncle. The wedding date was decided in consultation with bride's mother who is responsible for planning the wedding. Community members also participated in the marriage by offering advice and contributing resources for the wedding. In some cases where the bride was under the age of 18, the wedding ceremony was attended only by the local community without the spouses being present, because of fear of the police. Child marriage, like any other marriage, was found to be both a family and community affair.

3.2.3 CONSEQUENCES OF CHILD MARRIAGE

Study participants reported both advantages and disadvantages of child marriage for the young woman as well as for her family. However, the disadvantages (especially for females) outweighed the advantages or benefits; data show that 88.3% of the respondents agreed that child marriage has disadvantages for girls (Table 12). Only 12.1% of the Qewet woreda respondents and 5.6% for Bahirdar Zuria woreda did not consider child marriage a disadvantage for girls. The negative impact on young women´s education was one of the most highlighted consequences (93%). Teenage pregnancy was rarely mentioned as a consequence of child marriage, only a few participants argues that married young women could have birth complications such as obstetric fistula. During a focus group discussion a male participants argued on divorce the following:

> *"Most of child marriages end in divorce even with in less than a year. I am surprised that some of the girls I know divorced with in less than six months. Some migrate to Saudi Arabia after divorce. Most of the girls marry under pressure and deceived by their parents that marriage is good but it is not. When they taste the true nature of marriage, it is difficult that is why they divorce"*

The study found several factors contributing to the prevalence of child marriage in the Amhara region. Parent´s fear that their daughters got pregnant outside marriage, poor school results, financial burden, family bonds and community pressure were some of the main drivers which were often interlinked. Related to these drivers, young women and men perceived that child marriage could have some advantages, such as providing young women security, resolving family disputes or protecting family´s honour.

Respondents seemed to agree that underage marriage for males had less disadvantages. The impact of marriage on school drop-out is shown in Table 13 below. Overall, 8.7% of the respondents indicated that they ever dropped out of school due to marriage, and 99% were females. The percentage was much higher in Qewet (15.2%) than in Bahir Dar (2.6%). It needs to be taken into consideration that the number in Table 13 could be higher, as marriage was just one of the answer options for reasons for school drop-out, and the answer options were not read out loud to the respondents.

Table 13 **Girls and boys who dropped out of school due to marriage**

		Female		Male		Total	
		n	%	n	%	n	%
Bahirdar	Yes	15	2.6%	0	0.0%	15	1.9%
	No	564	97.4%	229	100.0%	793	98.1%
	Total	579	100.0%	229	100.0%	808	100.0%
Qewet	Yes	84	15.2%	1	0.4%	85	10.7%
	No	469	84.8%	240	99.6%	709	89.3%
	Total	553	100.0%	241	100.0%	794	100.0%
Total	Yes	99	8.7%	1	0.2%	100	6.2%
	No	1033	91.3%	469	99.8%	1502	93.8%
	Total	1132	100.0%	470	100.0%	1602	100.0%

Some child marriages end up in divorce. In the qualitative interviews, some mothers explained that they were divorced twice and that the first divorce was experienced after a child marriage. The link between child marriage and divorce was also evidenced in an interview with a 29 year-old male agricultural extension worker in Yigoma Huletu kebele (Bahirdar Zuria woreda) who explained:

> *"I got married when I was 4. By then my wife was 2. We both enrolled in school. But my then wife dropped out of school and got remarried as she grew fast. I was very young to take care of her and hence her parents decided to remarry her to another man. I continued my education and finished high school and went to college. Now, I am remarried to another woman. My sister also got married when she was 6 but soon divorced because her husband was not going to school and hence she did not want to live a farm life. She is now remarried to another man from town."*

3.2.4 FORMS OF MARRIAGE (INCLUDING CHILD MARRIAGE)

Two major types of marriage were observed in the study communities: traditional (marriage without the involvement of religion and registration) and religious marriages. The latter are of two types: marriage performed under the guidance of the church (both Orthodox and protestant churches) and marriage performed under the guidance of mosques, being practiced mostly in Qewet woreda. As Table 14 details, 81.5% of all young women's marriages were religious followed by no registration or traditional marriages (17.1%). Religious marriage was more common in Bahir

Dar where 90.0% occurred under the auspices of the Orthodox Tewahedo Church – the single dominant religion in the area – compared to Qewet where 72.4% of the marriages were reported as being religious marriage representing the three religions in the area – Orthodox Christianity, Moslim and Protestant. Marriage by government registration represented only 1.4% of all marriages which might be influenced by the non-existence of public institutions such as a city council or civil registration office in most of these rural areas. Even in Yelen where the town is inhabited by around 11,000 people, the Yelen kebele administration was just building a proper office at the time of the baseline study in July 2016, evidencing that services for registering vital events such as marriage are underdeveloped.

Table 14 **Forms of marriage by gender and woreda**

		Female		Male		Total	
		n	%	n	%	n	%
Bahirdar	Gov. registration	4	1.7%	0	0.0%	4	1.5%
	No registration	19	8.3%	4	10.0%	23	8.6%
	Religious registration	206	90.0%	36	90.0%	242	90.0%
	Total	229	100.0%	40	100.0%	269	100.0%
Qewet	Gov. registration	2	1.0%	1	6.7%	3	1.3%
	No registration	56	26.7%	2	13.3%	58	25.8%
	Religious registration	152	72.4%	12	80.0%	164	72.9%
	Total	210	100.0%	15	100.0%	225	100.0%
Total	Gov. registration	6	1.4%	1	1.8%	7	1.4%
	No registration	75	17.1%	6	10.9%	81	16.4%
	Religious registration	358	81.5%	48	87.3%	406	82.2%
	Total	439	100.0%	55	100.0%	494	100.0%

3.3 TEENAGE PREGNANCY

For the communities in the study areas, teenage pregnancy was seen as a curse that should be avoided. Especially if it happens outside marriage, it brings shame and dishonour for the family. Therefore, some parents preferred opting for an abortion or rejecting their daughters rather than accepting a pregnancy out of wedlock. In the words of a young man during a focus group discussion:

> *"I know a girl who got pregnancy while she was in grade 8. Her parents immediately forced her to try abortion but health extension workers declined the proposition because the pregnancy exceeded 3 months. After she gave birth, she left the keblele. Her parents are wealthier who support even other people but could not accept her status as a pregnant teenager."*

Regarding the prevalence of teenage pregnancy, results of the baseline survey show that 32.6% of the female respondents (20-24 years) had their first child when they were below 20 years. As can be seen in Table 15, teenage pregnancy among respondents aged 20-24 was higher in Qewet (39.7%) than in Bahir Dar (28.0%).

Table 15 **Young women (20-24 years) who experienced teenage pregnancy**						
	Bahirdar		Qewet		Total	
	n	%	n	%	n	%
No teenage pregnancy	168	72.0%	94	60.3%	262	67.4%
Experienced teenage pregnancy	65	28.0%	62	39.7%	127	32.6%
Total	233	100.0%	156	100.0%	389	100.0%

3.3.1 CIRCUMSTANCES OF GETTING PREGNANT

Sexual relations preceding teenage pregnancy occurred in various settings such as in and around school, at home, the work place, or in the community. Forced sexual relationship or rape can also lead to teenage pregnancy as was the case of one young woman in Bahir Dar Zuria woreda who had a three years old son, because she was raped by a construction worker while returning from school.

As shown in Table 16, 54.3% of the respondents indicated familiarity with pregnancy prevention methods through discussion with their family members. Female respondents were more likely to discuss pregnancy prevention methods with family members than males (57.6% and 46.5% respectively).

Table 16 **Discussed methods of prevention of pregnancy with family**							
		Female		Male		Total	
		n	%	n	%	n	%
15-18 years	No	286	44.5%	136	62.4%	422	49.0%
	No answer	1	0.2%	3	1.4%	4	0.5%
	Not sure	4	0.6%	4	1.8%	8	0.9%
	Yes	352	54.7%	75	34.4%	427	49.6%
	Total	643	100.0%	218	100.0%	861	100.0%
19-24 years	No	185	38.2%	97	38.6%	282	38.4%
	No answer	0	0.0%	2	0.8%	2	0.3%
	Not sure	2	0.4%	9	3.6%	11	1.5%
	Yes	297	61.4%	143	57.0%	440	59.9%
	Total	484	100.0%	251	100.0%	735	100.0%
Total	No	471	41.8%	233	49.7%	704	44.1%
	No answer	1	0.1%	5	1.1%	6	0.4%
	Unknown	6	0.5%	13	2.8%	19	1.2%
	Yes	649	57.6%	218	46.5%	867	54.3%
	Total	1127	100.0%	469	100.0%	1596	100.0%

Because the circumstances under which teenage pregnancy occurs are often hidden, the involvement of the public and local officials in dealing with teenage pregnancy appears to be limited. The issues surrounding establishing the identity of the impregnator, negotiations regarding marriage and other related matters were often discussed and settled locally using elders as mediators with limited involvement of law enforcement. Institutions such as the police and courts seem to have very limited presence in the rural study communities.

3.3.2 MARITAL STATUS AND TEENAGE PREGNANCY

Data on the interlinkage between child marriage and teenage pregnancy in the Amhara region indicate that teenage pregnancy generally occurred within marriage. Among all female respondents who had both a teenage pregnancy and a child marriage, only 2% had a pregnancy before marrying. Most of them had the teenage pregnancy within marriage (83%) and some had both in the same year (15%). Pregnancies outside marriage were rare, seen as a family dishonour and feared by especially parents. Therefore, the fear for teenage pregnancy was a driver of child marriage, as preventing teenage pregnancies outside marriage was a reason for parents to marry their daughters earlier.

3.3.3 CONSEQUENCES OF TEENAGE PREGNANCY FOR YOUNG WOMEN

Teenage pregnancy negatively affects the young woman in relation to social relationships, health, education, and life chances. Pregnant teenage girls who were not married faced social isolation and stigma from friends, family members and the community at large. They lose respect and their social status within their family and community. Therefore, taking refuge in an aunt's or uncle's home was said to sometimes be the only avenue to escape widespread condemnation by parents and relatives. Teenage pregnancy out of wedlock is likely to leave a deep and permanent psychosocial scar if the pregnancy leads to the birth of a child. This results from the labels given to such girls as bad, disobedient, or asadage yebedelat (in Amharic). Some study participants mentioned that teenage pregnancy can also result in physical health damages such obstetric fistula resulting from protracted labour.

Another consequence of teenage pregnancy for young women highlighted by interview and FGD participants was school drop-out. When a pregnant teenage girl is in school she will most likely stay at home for the rest of the pregnancy period or migrate to another city or town. Gossips and rumours play their part in keeping the pregnant teenage girl away from school. The fact that most primary schools in rural areas do not have counselling services leaves pregnant teenage girls little choice besides abandoning school or hiding.

Generally, pregnant unmarried teenage girls face an uncertain feature. Once they become mothers, they have a slim chance of resuming school partly because of bad experiences in school when they were pregnant (e.g. rumour, gossip, finger pointing) or because of lack of support from parents and relatives. The notion of having a child outside marriage carries a social liability, for which salvation can be found only when the impregnator agrees to marry the girl. Those pregnant girls who migrate often end up in domestic and child labour, street life and even prostitution. In the opinion of a 25 year-old informant from Chenta Sosetu, pregnant teenage girls who run away from home often face poverty as they lose social and economic support from parents.

Teenage pregnancy outside of wedlock did not seem to be a main concern in the community studies. During an interview, a young woman argued:

> *"Most families allow their females to marry before they engage in deviant behaviour such as teenage pregnancy which end up in revulsion and disgust to the parent and her kin. What can parents do if the girl herself want to marry? Just allowing her to engage."*

This quote shows that marriage was seen as a solution to avoid a pregnancy out of wedlock suggesting that if the pregnancy occurred within marriage it was not seen as an issue.

3.3.4 CONSEQUENCES FOR THE BOYS FATHERING CHILDREN

Teenage pregnancy out of wedlock is not as consequential for males as it is for females. The impregnator does not receive as much blame and shame for his action from his parents and the community. He does not have to drop out from school, if he is in school. He does not have to hide himself from friends and community. He does not have to face migration to escape shame and humiliation. However, the issue he might face is pressure to marry the pregnant girl and to accept the position of impregnator, which most young boys often deny but through time relent due to pressure from parents and close confidents, as the following narrative from a 15 year-old girl in Abbayatir (Qewet woreda), illustrating her friend's experience, shows:

> *"There was my friend who was in grade 9 and had a boyfriend. She was living with her mother as her father died. Although she was using injectables to prevent pregnancy, she got pregnant at the age of 15. She had a plan to abort but the health extension worker told her that it was too late to carry out safe abortion. Her boyfriend married her after long hesitation and negotiations between the girl's and boy's parents. She is now a mother and no longer attending school."*

Males who impregnate teenage girls use various strategies to lessen the consequences of their action including denying fatherhood, refusing to marry and threatening the girl not to disclose his identity. There hardly exist local enforcement mechanisms, laws or customary practices to hold the males accountable for impregnating a teenage girl, including providing child support if the marriage proposal fails. Therefore, the burden of responsibility often rests on the teenage mother.

3.4 FEMALE GENITAL MUTILATION/CUTTING

FGM/C is one of the harmful traditional practices that is present in varying degrees in the context of the study communities, though the FDRE Constitution explicitly states that 'laws, customs and practices that oppress or cause bodily harm or mental harm to women are prohibited'. Among all female respondents, 53.6% affirmed to have been circumcised with little differences between the districts. As for the rest, 24.4% had not been circumcised and 21.9% reported not to know whether they were circumcised (Table 17).

Table 17 **Have you been circumcised?**

	n	%
No	276	24.4%
Do not know	248	21.9%
Yes	607	53.6%
No answer	1	0.1%
Total	1,132	100%

The evidence from the medical field, as confirmed by a health extension worker from Chenta Sosetu kebele (Bahirdar Zuria woreda), suggests that FGM/C causes physical injury, psychological trauma and health problems. A number of interrelated factors are responsible for the continued existence of FGM/C. These are embedded in the cultural, customary and belief systems of the study communities and collectively constitute what we may call myths about FGM/C. This section presents the different myths that sustain FGM/C, circumstances under which FGM/C is executed; FGM/C's interlinkage with teenage pregnancy, young women's perception of FGM/C, consequences of FGM/C and other related issues.

3.4.1 MYTHS AND FACTS ABOUT FEMALE GENITAL MUTILATION/CUTTING

Rural communities in the study areas held different myths that serve to perpetuate the practice of FGM/C, despite a wave of anti-FGM/C campaigns and activities undertaken by governmental and non-governmental organizations.

Myth 1: Uncircumcised girls do not grow to become good wives. This view was repeatedly raised and discussed by informants of all groups, young people, grandparents, religious leaders and local officials. It is said that uncircumcised girls are unruly and disobedient to their husbands. They tend to be aggressive and hot-tempered. The common expression is that the girl is restless and is not fit to be a wife. One informant said 'she breaks glasses', referring to how mentally and emotionally unsettled the girl would be if not circumcised.

Myth 2: Uncircumcised girls suffer from perpetual sexual desire. This is grounded in the notion that FGM/C helps to regulate the sexual desire of girls. This myth is in turn related to the notion that girls with unstable sexual desires are likely to sleep with other men, or are likely to run away from home and demand divorce. The 49 year old-priest from Chenta Sosetu kebele recounted the story of his niece who got divorced three times and then found a stable marriage after FGM/C was performed on her.

Myth 3: The story of "chincha". Men who got married to uncircumcised girls often find it very difficult to penetrate the girl's vagina – hence the Amharic expression 'chincha'. The boys who participated in FGDs in Yelen kebele (Qewet woreda) stressed that no man wishes to marry a chincha girl since it poses hard physical labour for the man to penetrate the vagina.

Myth 4: Uncircumcised girls have an unhygienic vagina. The argument is that as a portion of the clitoris which should have been removed grows and covers the opening of the vagina, it prevents fresh air from entering the vagina. This causes bad smell and odour inside and outside the vagina with depressing effects on the husband's sexual desire.

Myth 5: FGM/C as the foundation of marriage. A 75 year-old grandmother from Robit (Bahirdar Zuria woreda) considered FGM/C as the foundation of marriage since without it men run away from marriage. Parents are terrified at the thought of their daughter not being able to get or keep a husband because FGM/C was not performed.

Myth 6: With FGM/C delivering a child is easy. It is believed that girls who did not undergo FGM/C often face long hours of labour during delivery. Therefore, it is argued that it is in the interest of girls to allow FGM/C on their body so that they would not suffer during delivery later. However, the extension worker from Chenta Sosetu countered this argument by saying that FGM/C does in fact cause physical harm and often causes complications during child delivery.

Fact: FGM/C is a social norm. The community believes that FGM/C serves an important social function by preparing girls for marriage. Even the young generation seems to accept the view that FGM/C is a social norm that is widely accepted and practised by the community, as 47% of the respondents agreed that FGM/C is a social norm. More males than females agreed with the statement that FGM/C is a social norm (69.7% versus 37.4%).

3.4.2 RELIGION AND FEMALE GENITAL MUTILATION/CUTTING

Generally, FGM/C appears to have a limited base in religion. Three religious leaders – Orthodox, Muslim and Protestant – were interviewed about their respective religion's position on the subject. All agreed that there is no religious support for FGM/C. According to the 54 year-old Muslim leader from Yelen kebele (Qewet woreda), Islam does not support FGM/C; in his own words:

> *"In the past, some people tried to base their evidence on the Holy Koran for FGM/C but there is no verse which orders FGM/C. This helped us to challenge those people who used to justify the practice with religion."*

As a member of the committee to eliminate harmful traditional practices, the Muslim leader was actively involved in teaching people about the complete absence of religious justification for the continued practice of FGM/C. However, he indicated that the practice is common despite the continuous teaching regarding its harmful consequences on the girls' physical, psychological and mental conditions. Similarly, the Orthodox priest from Chenta Soesstu kebele (Bahir Dar) stressed that the Church does not support FGM/C and as member of the committee, he teaches his followers about the negative consequences of FGM/C for the girls during church services.

3.4.3 YOUNG WOMEN'S PERCEPTIONS AND KNOWLEDGE ABOUT FEMALE GENITAL MUTILATION/CUTTING

It seemed that most young women had limited knowledge about FGM/C. Almost one-fourth of the respondents did not know if they have been circumcised and this clearly indicates that some women have limited knowledge of their status with regard to circumcision, or on how it was performed. This seemed to have various reasons. First, FGM/C was performed on girls at early age and as there are no records kept on how it was performed, girls could not know about it. When female respondents were asked when FGM/C was performed no specific age was reported. The most common answers were 'when I was a child/infant', 'some days/weeks after having born' (7, 6, 9, 20, 40 days where some of the answers) or 'I don't know/don't remember'. Second, more recently, FGM/C is performed secretly underground to avoid official sanctions from local authorities and hence little information circulates about the practice of FGM/C in the community. Third, it is considered a taboo for a girl to ask if she has been circumcised as this would be seen as showing interest in sexual intercourse. However, there are situations where young women sought information about their FGM/C status, for example, if it is rumoured that she is not circumcised, often referred in Amharic "woshella". This labelling is an insult for young women, which prompts them to actively inquire information about her status.

Results of in-depth interviews with young people indicate that the younger generation is likely to abandon FGM/C. The change in attitude on the part of the younger generation is attributed to the education given to students at school about the negative effects of FGM/C (though this education is not mainstreamed as part of the academic curriculum) and the important role being played by girls' clubs in promoting anti-FGM/C campaigns through, for example, school mini-media activities (e.g. drama) and also because of the anti-FGM/C campaign being waged by the government (e.g. women's affairs office), NGOs (e.g. Plan in Bahirdar Zuria woreda) and indigenous organizations (e.g. Finot Hiwot in Bahirdar Zuria woreda).

3.4.4 CONSEQUENCES OF FEMALE GENITAL MUTILATION/CUTTING

Data indicate that the in study communities, both negative and positive consequences of FGM/C were reported. Study participants argued that FGM/C causes body harm and leaves permanent scars on girls, some pointed out that FGM/C might lead to fistula. Others mentioned that it is also against girls' rights to perform FGM/C on them, because of the deep psychological and health problems it results in. However, there also seemed to be a general perception that girls benefitted from FGM/C. As Table 18 shows, the negative impact of FGM/C on the menstrual cycle (53.7%) and labour (60.2%) were most reported. Few respondents agreed that FGM/C causes early marriage (11.0%) and school dropout (8.9%). Respondents appeared to be more concerned about the linkage between FGM/C and sexual (38.5%) and fertility (40.5%) problems.

Table 18 **Knowledge and attitude towards FGM/C**			
	Female n (%)	Male n (%)	Total n (%)
FGM/C causes early marriage:			
Yes	93 (8.2%)	84 (17.9%)	177 (11.0%)
No	910 (80.4%)	265 (56.4%)	1,175 (73.3%)
Do not Know	129 (11.4%)	121 (25.7%)	250 (15.6%)
FGM/C causes fertility problems:			
Yes	442 (39.0%)	207 (44.0%)	649 (40.5%)
No	480 (42.4%)	133 (28.3%)	613 (38.3%)
Do not know	210 (18.6%)	130 (27.7%)	340 (21.2%)
FGM/C causes menstrual problems:			
Yes	702 (62.0%)	158 (33.6%)	860 (53.7%)
No	154 (13.6%)*	91 (19.4%)	245 (15.3%)
Do not know	276 (24.4%)	221 (47.0%)	497 (31.0%)
FGM/C causes problems with labour:			
Yes	669 (59.1%)	296 (63.0%)	965 (60.2%)
No	302 (26.7%)	69 (14.7%)	371 (23.2%)
Do not know	161 (14.2%)	105 (22.3%)	266 (16.6%)
FGM/C causes school drop-out:			
Yes	38 (3.4%)	105 (22.3%)	143 (8.9%)
No	971 (85.8%)	281 (59.8%)	1,252 (78.2%)
Do not know	123 (10.9%)	84 (17.9%)	207 (12.9%)
FGM/C causes sexual problems:			
Yes	397 (35.1%)	219(46.6%)	616(38.5%)
No	474(41.9%)	116(24.7%)	590(36.8%)
Do not know	261(23.1%)	135(28.7%)	396 (24.7%)
FGM/C is a social norm:			
Yes	317 (28.0%)	262 (55.7%)	579 (36.1%)
No	667 (58.9%)	148 (31.5%)	815 (50.9%)
Do not know	49 (4.3%)	24 (5.1%)	73 (4.6%)

The figures presented in Table 18 show that more males than females reported to agree with the statements about FGM/C causing sexual problems, school drop-out, problems with labour, fertility problems, and early marriage. The percentage of agreement was higher among female respondents only for the statement that FGM/C causes menstrual problems. This suggests that young women have a more positive perceptions on FGM/C than young men.

3.5 COMMUNITY CONTEXT

The main community attributes discussed here include social norms, intergenerational communication and the role of religious leaders, schools/teachers and health workers.

3.5.1 SOCIAL NORMS

Every community has social norms which are considered appropriate for people, including young males and females, to follow. The universal social norms that govern parent-child relationships (love, respect, obedience, helping parents) existed in varying degrees in the study communities. Generally, girls and boys were held for different standards, though there was an emphasis on good conduct and obedience to parental authority for all – two important hallmarks of successful child socialization and parental upbringing (Table 19). Girls tend to be disciplined more strictly, often confined at home and doing domestic chores while boys can spend their time outside and socialize with other boys as long as they do not offend local authorities or elders by engaging in 'antisocial' behaviours as drinking alcohol and smoking cigarettes.

Table 19 **Community expectations regarding girls and boys**		
Key issues	Girls	Boys
Social norms	Respectful of and obedient to parents, willing to help mother at home, show love for family members, obedient and loyal to husband, not hanging out with boys, not talkative.	Respectful of and obedient to parents, not causing trouble with authorities, high academic achiever, okay to hang out with other boys, not expected to do household chores.
Age at marriage	Expected to be ready for marriage starting age 15, lower age is preferred to prevent girls from having sex before marriage.	Expected to be ready for marriage after 18, but preferred age to start family is around 22, boys expected to be mature later (by an average of 4 years) than girls, to be able to lead a family.
Sexual conduct	'Messing' with boys is strictly forbidden, not expected to be expressive of sexual behaviour, not allowed to have boyfriend.	'Messing' with girls is somewhat condoned, okay to have girlfriend, pre-marital sex is tolerated.

There was the notion that a girl is safe if she stays at home, while a boy can broaden his experience in the community as long as he stays out of trouble. A 59 year-old male informant from Yelen kebele (Qewet woreda) reported:

> *"Daughters are prone to sexual harassment or even rape if they sit outside the home and may even end up giving birth to an illegitimate child. But sons are free from these risks and hence their outside exposure may not pose as much risk for the family. Parents may even encourage their sons to interact with the wider community (ye'adebabi sew indihonu[4]) but they have to remain peaceful and respectful of others."*

The above also finds support from the results of the survey, in which a good proportion of the respondents (39.4%) agreed (including strongly agreed) that marrying girls at young age prevents sexual violence like sexual harassment and rape. Similarly, a third of the respondents expressed agreement that marrying girls young provides security (e.g. social acceptance). Older girls risk missing out husbands and hence the Amharic expression '*kumo ker*' applies to them. According to some study participants, there is no more humiliating experience for a woman than to be labelled as kumo ker[5] (unable to find a husband) as this caries the social stigma of being unwanted by men.

Results of interviews show that children are expected to obey parents and display good manners not only with family members but also with neighbours and kinship members (grandparents, aunts and uncles). Failure to conform to parents' wishes/desires can result in parents denouncing their children and sometimes resorting to cursing: 'He/she is not my son/daughter. I do not know her/him. Let him/her go hell'. Young people fear that cursing by parents will lead to social stigma in the community and children try hard not to offend their parents. As a 21 year-old informant from Chenta Sosetu kebele (Bahirdar Zuria woreda) said:

> *"A child who is not blessed by his parents is not a good child. He/she cannot be successful in life."*

There is this belief, however, that good behaviour starts at home and children who do not behave well with parents and other members of the family cannot be expected to show respect for the community in general, according to a 52 year-old man from Yelen kebele (Qewet woreda):

> *"If my children do not respect me, their mother and their brothers and sisters, how can they be good for neighbours and at school. Good behaviour starts in the family. We (parents) are responsible for what our children will be. If we want them to turn out good, we have to be good towards them as well. We have to treat them with respect. There is this saying 'as you sow, so shall you reap.'"*

4 To be known in the community, to be a public figure, to be able to represent the family and carry the family name in the community and beyond.
5 The age limit varies from place to place but generally if a girl passes 20, she is kumo ker (girls in school are not included).

3.5.2 INTERGENERATIONAL COMMUNICATION

Interaction between young people and parents, care givers and grandparents affect how young people deal with SRH issues or problems. The study explored this issue by examining respondents' thoughts concerning how easy was it for young people to talk with parents or care givers about sexuality and marriage issues.

Data show that 27.4% of the respondents agreed that it is easy to talk with parents or care givers about sexuality and marriage (Table 20). Further analysis of the responses by sex, age and woreda shows that relatively younger respondents (15-18) felt less at ease (26.1%) compared to the respondents belonging to the 19-24 age group (29.0%). Also young men felt more at ease (33.5%) than girls (24.9%), and that Bahir Dar respondents felt relatively more at ease (29.3%) than Qewet respondents (25.4%) in discussing with parents or care givers about issues of marriage and sexuality.

Table 20 **Easy to talk with parents/care givers about marriage and sexuality**

		Female		Male		Total	
		n	%	n	%	n	%
15-18 years	No response	5	0.8%	14	6.4%	19	2.2%
	No	469	72.9%	148	67.9%	617	71.7%
	Yes	169	26.3%	56	25.7%	225	26.1%
	Total	643	100.0%	218	100.0%	861	100.0%
19-24 years	No response	7	1.4%	13	5.2%	20	2.7%
	No	365	75.4%	137	54.6%	502	68.3%
	Yes	112	23.1%	101	40.2%	213	29.0%
	Total	484	100.0%	251	100.0%	735	100.0%
Total	No response	12	1.1%	27	5.8%	39	2.4%
	No	834	74.0%	285	60.8%	1119	70.1%
	Yes	281	24.9%	157	33.5%	438	27.4%
	Total	1127	100.0%	469	100.0%	1596	100.0%

In a related question, respondents were asked if they have discussed with parents/caregivers specifically about marriage issues (Table 21). Overall, 38.0% of the respondents acknowledged that they had discussed with their parents about marriage. Such a relatively low figure (i.e.; below 50%) suggests that most underage marriages take place with limited or little consultation between parents and their daughters. On the other hand, no noticeable differences were observed between age groups or sex in terms of respondents' experience in discussing issues of marriage with parents.

Table 21 **Have you discussed with your parents about marriage?**							
		Female		Male		Total	
		n	%	n	%	n	%
15-18 years	No	290	45.1%	113	51.8%	403	46.8%
	Yes	248	38.6%	79	36.2%	327	38.0%
	Don't Know	105	16.3%	26	11.9%	131	15.2%
	Total	643	100.0%	218	100.0%	861	100.0%
19-24 years	No	185	38.2%	68	27.1%	253	34.4%
	Yes	172	35.5%	108	43.0%	280	38.1%
	Don't Know	127	26.2%	75	29.9%	202	27.5%
	Total	484	100.0%	251	100.0%	735	100.0%
Total	No	475	42.1%	181	38.6%	656	41.1%
	Yes	420	37.3%	187	39.9%	607	38.0%
	Don't Know	232	20.6%	101	21.5%	333	20.9%
	Total	1127	100.0%	469	100.0%	1596	100.0%

The results of qualitative interviews held with parents and young people also corroborated the above findings. Young people mostly complained about parents not showing love, not understanding young people's concerns, and not willing to help them with their education. This was the case with a 16 year-old boy from Yelen kebele who blamed his parents for him dropping out of school because of their unwillingness to provide education materials. There was a general sense of disinterest of parents, according to interviewed young people, in issues affecting young people. Especially, issues dealing with sexuality and dating were not accepted for discussion between parents and children.

Parents, on the other hand, complained that young people do not respect their parents and do not listen to their advice. They are not willing to help their parents with, for example, farm activities. However, for the children, working on the farm makes them lag behind their education. Parents were critical of children who frequented towns that exposed them to 'anti-social behaviours' such as drinking alcohol and smoking cigarettes. These tensions, resulting from parents' desire to nurture their children according to the culture and norms of the community, on the one hand, and children's desire to adapt to the fast-moving changes taking place around schools and towns, on the other hand, contributed to the deteriorating relationships between them.

It would be however wrong to assume that a sense of doom prevails about parent-child relationships. Some positive stories also exist in the study communities. The case of a 52 year-old Protestant pastor and Yelen kebele chairman illustrates this. He said to be passionate about the education of his five children and regularly holds family discussions about issues that affect the family. His children accompany him to church and he spends time with them listening to their needs and concerns. He strongly believes that children learn from their parents the qualities of a good person. For that, he sets a good example for his children to follow. Similarly, an Orthodox priest in Chenta Sosetu kebele talked about his good relationships with his children, attributing this to his willingness to listen to them and fulfil their needs – for example, he bought shoes for his two sons and plans to buy clothes for them so that they are protected from cold while tending cattle or helping him with the farms. Holding open and frequent discussions with children is the key for a successful child-parent relationship, according to the 49 year-old priest.

3.5.3 ROLE OF RELIGIOUS LEADERS

Religious leaders are important members of the community and play a key role in shaping communities' attitudes towards FGM/C, child marriage and teenage pregnancy. Religious leaders in Qewet woreda comprise Orthodox Christians, Moslems and Protestants. In Yelene kebele, for example, a group of leaders of these three religions are represented in the community, though Orthodox Christian leaders are the majority as the residents are mostly followers of Orthodox Christianity. In Bahirdar Zuria woreda, especially in Chenta Sosetu and Robit kebeles, Orthodox

priests are the single most important religious leaders who command a great deal of respect especially among the parents' generation, though their influence on the younger generation seemed somewhat waning. Parents looked for guidance from religious leaders especially when they face problems with their children.

A 49 year-old priest from Chenta Soset kebele (Bahirdar Zuria woreda) who participated as a key informant believed that his community is deeply religious and that involving religious leaders in issues affecting young people (e.g. FGM/C, child marriage) can bring positive results in terms of creating community awareness and consequently abandoning harmful cultural practices. As members of the committee who deal with FGM/C, child marriage and teenage pregnancy, religious leaders have been instrumental in invoking religious explanations against, for example, child marriage: '*God Bless marriage that occurs at the appropriate age*' or '*a blessed marriage is one that is established through consensus*'. These are some of the mottos written down on the inside wall of the office of the committee against harmful traditional practices in Robit kebele (Bahirdar Zuria woreda). The priest from Chenta Sosetu, however, noted that the lack of critical support from the local administration was undermining religious leaders' role in the fight against harmful traditional practices. For instance, he mentioned that priests were not often invited to participate in awareness-creating workshops focusing on harmful traditional practices.

According to a Protestant pastor in Yelen kebele (Qewet woreda), one of the ways religious leaders can play a powerful positive role in the fight against FGM/C or child marriage is for them to set an example.

> *"If they do not let FGM/C practiced on their daughters, or if they do not force their daughters marry while young, then they can teach the community by example and people will definitely listen to them."*

This view was also echoed by the priest from Chenta Sosetu (Bahirdar Zurai woreda) who persuaded his sister not to give her 13 year-old daughter to marriage. The priest said that 'we all have to be vigilant in our efforts to not only condemn FGM/C and child marriage but also to stop them from occurring in our communities'. This shows that religious leaders are increasingly becoming aware of the harmful effects of FGM/C and child marriage and it is vital to spread this energy and enthusiasm into the wider community so that the YES I DO interventions will have meaningful impact in reducing FGM/C, child marriage and teenage pregnancy.

3.5.4 ROLE OF HEALTH WORKERS

There are two groups of health workers in the communities: health extension or community health workers and mid-level health professionals (e.g. nurses, laboratory technicians). The first category of health workers provide health education (e.g. maternal health services like antenatal and postnatal care) and family planning services mostly at the level of primary health care unit or health post. They are stationed in the community with health posts as their focal points while health professionals work in clinics and health centres and provide curative health care services. The advantages of health extension workers, compared to health care providers in clinics and health centres, is that they work in the community and cover as many families and communities as possible.

The results reveal that in both Qewet and Bahirdar Zuria woredas, there is a shortage of health workers, kebeles are mostly served by a health post staffed by two health extension workers. Yelen informants argued that their kebele (with a population of 11,000) is served by a nurse and a health assistant. The health centre that used to be located in Yelen town moved to Terra kebele (5 km west of Yelen) due to shortage of health workers. Inadequate health services characterized by frequent staff turnover and shortage of medical supplies such as medicines and medical equipment was affecting the delivery of health services to the community.

Health workers served in committees to eliminate harmful traditional practices and were involved in awareness creating activities through meetings and workshops. Health extension workers also collaborated with schools by involving school girls in the production of mini-media information (e.g. drama) focusing on harmful effects of FGM/C and child marriage. In Chenta Sosetu, the health extension worker had been helping girls' clubs to help school girls on issues related to reproductive health and sexual rights. As a member of the Finot Hiwot committee against harmful traditional practices, the health extension worker had been instrumental in preventing six planned child marriages in 2014/15.

However, health extension workers' contribution to the anti-harmful traditional practices effort has been impeded by the multiple and competing responsibilities they face including recordkeeping, reporting, managing family folders, travel time to and from work activities, attending clients' requests at health posts, conducting community and resource mapping and building relationships in the community. There were reports (e.g. in Yelen kebele) that some health extension workers have collaborated with parents by providing false age certificates so that parents could give their underage daughters to marriage. Some members of the local police were also found to be part of the scheme by abetting parents to circumvent the law against underage marriage.

3.5.5 ROLE OF SCHOOLS AND TEACHERS

The expansion of education in rural areas in recent years has opened opportunities for children to attend school. However, the evidence suggests that school attendance is often high in the 1st cycle (1-4 grades) and 2nd cycle (5-8 grades) of the education system, with 3rd cycle (9-10 grades) and 4th cycle (11-12 grades) showing a steep decline in student enrolment. This is also true in the study communities, all of which are served by only up to grade 8 schools. In Yelen (Qewet woreda), for example, there is only a primary school (grades 1-8) after which students would have to travel to Shewa Robit (13 km) to continue school. It is because of this that children, girls in particular, cannot proceed with their education, as parents cannot support them to go to Shewa Robit by providing food and renting dormitories. Similarly in Chenta Sosetu (Bahirdar Zurai woreda) there is only one primary school after which students would have to enrol in Bahirdar (15 km) or stop going to school.

Especially young women are more likely to discontinue their education because of lack of secondary schools in their communities. Those who would manage to continue are thought to be vulnerable to various kinds of gender-based violence (e.g. rape) while travelling from and to home or living in dormitories. Some try to support themselves by working as daily labourers (further exposing them to sexual harassment) or even by engaging in prostitution. Therefore, girls are most affected by the absence of secondary schools in the area, contributing to either early marriage or migration to Arab countries. Teenage girls in Medina and Yelen kebeles make no secret of their dream of migration to Saudi Arabi, especially when they do not succeed in the grade 10 national examination. They try to avoid child marriage via migration – though the principal reason for their migration is economic, not avoidance of child marriage (Box 1).

BOX 1: MIGRATION AS A STRATEGY TO ESCAPE CHILD MARRIAGE

The youth in Medina kebele, especially young girls, have increasingly taken migration as a means of empowering them economically and also a means of avoiding child marriage. Many of the migrant girls aspire to work in the Arab countries, though boys are also participating in internal migration by taking up contractual work such as harvesting onions and tomatoes. Migrant girls' families have benefited from remittance accruing from the Mideast countries. Many of these girls have renovated their parents' houses or built new ones and established small businesses in their rural home town after returning. They are now looked upon by other girls and are regarded as role models for girls to follow their footsteps. They are highly sought by men who are looking for potential wives who can command cash to start small businesses. They are very selective in their choice of husbands and require a matching fund to start a new family in an urban setting. Many of these girls are school drop-outs or failed in national exams and hence the human capital of these communities is likely to deteriorate further as more and more girls quit school and take up migration as strategy to escape rural poverty and through this, child marriage.

Because of their strategic position in the communities, schools can play a positive role in efforts to reduce child marriage, FGM/C and teenage pregnancy. As providers of information for young people, schools can stress the negative effects of harmful traditional practices, though school curricula do not emphasize these subjects. One of the areas where schools have helped young girls is the establishment of girls' clubs. These clubs have been instrumental

in teaching members about how to protect their sexual and reproductive rights, both in in- and off-school situations. For example, the active participation of members in the girls' club in Chenta Sosetu has helped to stop six planned child marriages. The chairperson of the girls' club is a member of the committee against harmful traditional practices where information about FGM/C and child marriage is communicated with a view to prevent these practices from happening.

Teachers were also reported to sometimes conduct Saturday and Sunday classes as part of extra-curriculum activities to teach about harmful effects of FGM/C, child marriage and teenage pregnancy. Schools (through teachers and parents' committees) also teach parents about FGM/C and child marriage and have helped to prevent child marriage by conducting follow-ups on female students who are suspected of being about to be married off (e.g. repeated absenteeism from class can be a symptom that child marriage is about to happen). In Medina, Sefiberet and Abayatir kebeles, teachers have been actively supporting efforts by the Woreda Women's Affairs Office and Women Support Association to empower schools girls with knowledge and awareness about the harmful effects of FGM/C, child marriage and teenage pregnancy.

3.6 SEXUAL AND REPRODUCTIVE HEALTH INFORMATION AND SERVICE UTILIZATION

Young people can be prepared to better deal with issues related to their sexual and reproductive rights if they have information and means of accessing SRH services. In this section, we present, based on results of the survey, the status of SRH information and services in the study communities as assessed by young people themselves.

3.6.1 SOURCES OF SEXUAL AND REPRODUCTIVE HEALTH INFORMATION

Respondents were asked about sources from which they often get SRH information. Radio was mentioned most (31%), followed by TV (13.3%) and a combination of radio, TV and phone (Table 22). It seemed that young women used radio more often than young men to obtain SRH information, while the use of other sources such as newspapers was more common among male respondents. The use of modern media (phone, SMS and internet) was generally low suggesting a poor state of information infrastructure in the study communities.

Table 22 **Sources of sexual and reproductive health information**

	Female		Male		Total	
	n	%	n	%	n	%
Radio	385	34.0%	111	23.6%	496	31.0%
TV	163	14.4%	50	10.6%	213	13.3%
Phone (SMS)	66	5.8%	16	3.4%	82	5.1%
Internet	4	0.4%	6	1.3%	10	0.6%
A combination of radio, TV and phone	461	40.7%	240	51.1%	701	43.8%
Other (magazine, newspaper, etc.)	53	4.7%	47	10.0%	100	6.2%
Total	1,132	100.0%	470	100.0%	1602	100.0%

In a related question, the respondents were asked about their preferred source of information and the majority referred to health centres, followed by schools. Additional preferred sources of SRH information included, in no particular order: friends, home, TV, church and youth centres.

3.6.2 KNOWLEDGE AND ATTITUDES TOWARDS SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Knowledge about the existence of various SRH services can affect young persons' access and utilization of SRH services. The study particularly explored one important component of the SRH services – that is, respondents' knowledge of various pregnancy prevention methods. Accordingly, the respondents were asked what pregnancy prevention methods they knew and the responses are shown in Table 23. All of the respondents (1,601) indicated that they know at least one method to prevent pregnancy and the most popular method was injection (20.6% of the respondents mentioned this). The knowledge about condoms was negligible and this might be due to shortage of them in rural areas, poor marketing strategies or a combination of both.

Table 23 **Respondents' knowledge of pregnancy prevention methods**

	Bahir Dar		Qewet		Total	
	n	%	n	%	n	%
Abstinence	9	1.1%	11	1.4%	20	1.2%
Birth control pill	19	2.4%	8	1.0%	27	1.7%
Injection	67	8.3%	263	33.1%	330	20.6%
Condom	23	2.8%	10	1.3%	33	2.1%
Combination of the above methods	656	81.2%	456	57.4%	1112	69.4%
Others (withdrawal, breastfeeding, post pill)	34	4.2%	44	5.5%	78	4.9%
Total	808	100.0%	794	100.0%	1602	100.0%

It is important to note that attitudes toward SRH services (e.g. condom use) have a gender dimension. Males were relatively at ease to buy condom and initiate its use as compared to females. In this regard, respondents were asked if it is appropriate for a girl to propose condom use and about 29% of the respondents agreed it is okay for a girl to propose condom use during a sexual encounter (Table 24). Thirty-one percent (31.1%) of the females agreed, against 23.5% of the males. The respondents were also asked if it is easy for boys to propose condom use and the majority of the respondents (58.5%) agreed that it is easy for a boy to propose condom (data not displayed in the Table).

Table 24 **Appropriate for a girl to propose condom use?**

		Female		Male		Total	
		n	%	n	%	n	%
15-18 years	Agree	220	34.2%	50	22.9%	270	31.4%
	Disagree	310	48.2%	110	50.5%	420	48.8%
	Don't know/ no response	113	17.6%	58	26.6%	171	19.9%
19-24 years	Agree	131	27.1%	60	23.9%	191	26.0%
	Disagree	273	56.4%	150	59.8%	423	57.6%
	Don't know/ no response	80	16.5%	41	16.3%	121	16.5%
Total	Agree	351	31.1%	110	23.5%	461	28.9%
	Disagree	583	51.7%	260	55.4%	843	52.8%
	Don't know/ no response	193	17.1%	99	21.1%	292	18.3%

3.6.3 ACCESS AND UTILIZATION OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Availability and accessibility of SRH services directly affects their utilization. First, we look at what respondents thought about accessibility of the services and then we explore if they have used any of these services at least once. In this regard, respondents were asked if they thought it would be difficult for them to access contraceptives. The majority (64.8%) did not believe that it is difficult for the youth to access contraceptives in their neighbourhoods (Table 25). Boys disagreed by 49.0% to the statement 'it is difficult for the youth to access contraceptives' compared to 71.4% of the girls. The two age groups (15-18, 19-24) did not show marked difference in terms of their views of whether or not it is difficult to access contraceptives, though the younger age group appeared less optimistic about accessing contraceptives in their communities compared to the older age group who scored a relatively high disagreement response of 69.1% with the statement 'it is difficult for the youth to access contraceptives' in this community (as compared to 61.2% among those ages 15-18).

Table 25 **Difficult to access contraceptives in your area**

		Female		Male		Total	
		n	%	n	%	n	%
15-18 years	Agree	152	23.6%	79	36.2%	231	26.8%
	Disagree	424	65.9%	103	47.2%	527	61.2%
	Don't know/ no response	67	10.4%	36	16.5%	103	12.0%
19-24 years	Agree	73	15.1%	107	42.6%	180	24.5%
	Disagree	381	78.7%	127	50.6%	508	69.1%
	Don't know/ no response	30	6.2%	17	6.8%	47	6.4%
Total	Agree	225	20.0%	186	39.7%	411	25.8%
	Disagree	805	71.4%	230	49.0%	1035	64.8%
	Don't know/ no response	97	8.6%	53	11.3%	150	9.4%

Issues of access and utilization of SRH services are also related to respondents' perception of SRHR and therefore respondents were asked if they thought they have SRHR entitlements as a young person. The majority of the respondents (62.8%) answered affirmatively – that is, 'yes' they have SRHR as young persons (Table 26). Female respondents appeared more aware of their SRHR entitlements (68.6%) compared to males (48.7%), which could be related to the fact that young women tended to access SRH services more frequently than young men and that SRH services have different impacts on the two groups, with girls affected the most by issues of availability and accessibility of SRH services.

Table 26 **Do you have SRHR entitlements as a young person?**

	Female		Male		Total	
	n	%	n	%	n	%
No	238	21.0%	163	34.7%	401	25.0%
Yes	777	68.6%	229	48.7%	1006	62.8%
Don't know/ no response	117	10.3%	78	16.6%	195	12.2%
Total	1,132	100.0%	470	100.0%	1602	100.0%

3.7 YOUTH ECONOMIC EMPOWERMENT

Empowering young people economically is one of the strategic objectives of the YES I DO programme. As presented under employment data, the study found most of the respondents were students and some were farmers, self-employed or working in casual jobs (e.g. working at onion or khat farms) and hence did not have formal jobs, but jobs in the informal sector.

Generally, the majority considered themselves as having some kind of work that generated income for the family. This is evident from respondents' responses to the question whether they were economically active outside the household, as 73.4% answered 'yes' (Table 27). It should be noted that as the period of fieldwork for the survey coincided with a long school vacation, most of the respondents (including student respondents) were doing some kind of work to support themselves and their families. This could be one of the explanations for the presence of apparently high economic activities among the youth.

Table 27 **Economically active outside the household**

Age group	Employed?	Female		Male		Total	
		n	%	n	%	n	%
15-18 years	No	158	24.6%	33	15.1%	191	22.2%
	Yes	485	75.4%	185	84.9%	670	77.8%
19-24 years	No	190	39.3%	29	11.6%	219	29.8%
	Yes	294	60.7%	222	88.4%	516	70.2%
Total	No	348	30.9%	62	13.2%	410	25.7%
	Yes	779	69.1%	407	86.8%	1186	74.3%

Results of qualitative interviews and FGDs with young men in Latamba and Yigoma Huletu revealed that they are also engaged in fattening activities (goats, sheep), cultivation of fruits (e.g. mango) using the Abbay wetlands in Latamba Andasa and irrigation schemes in Yigoma Huletu and also in the sale of various wood and grass products harvested in and around the Abbay river. Especially in Yigoma Huletu, there were irrigation opportunities (because of the presence of Andasa I and II dams) which provide all-year-round irrigation water for residents. Because of the availability of water, young people are engaged in the cultivation of various farm products (including sugar cane, pepper, tomato, mango, citrus fruit, coffee and papaya) and supply markets in Bahirdar and as far as Gonder (e.g. citrus fruit) (Figure 5). In Robit and Chenta Sosetu, too, young men are highly involved in khat cultivation and also in harvesting (on contract basis) and selling of the green leaf, which has become a source of cash income for the communities concerned.

Figure 5

Two brothers (22, 18) collecting citrus fruit from farmers to be transported to Gondar, Yigoma Huletu Kebele, Bahirdar Zuria woreda, July 2017

Male respondents (86.8%), as compared to female respondents (69.1%), reported relatively higher economic participation and young people aged 15-18 also showed higher economic participation (77.8%) compared to those aged 19-24 (70.2%). The least economic participation was reported by young women of 19-24 ages (60.7%). This relatively low participation by young women could be partially explained by the negative impact of child marriage on the economic participation of young women. Young women who experienced child marriage were less likely to work outside the household than those who did not experience child marriage. This can be seen from Table 28, which shows that 50.8% of young women who experienced child marriage did not have a job compared to 80.3% of the young women who did not have a child marriage. A low economic participation was reported by young women from Qewet woreda where only 23% of young women who experienced child marriage reported to be employed compared to 78.9% of young women who went through child marriage in Bahir Dar.

Table 28 **Employment status among those who experienced child marriage**

Child marriage?	Employed?	Bahirdar		Qewet		Total	
		n	%	n	%	n	%
No	No	119	17.9%	137	21.6%	256	19.7%
	Yes	547	82.1%	496	78.4%	1043	80.3%
Yes	No	30	21.1%	124	77.0%	154	50.8%
	Yes	112	78.9%	37	23.0%	149	49.2%
Total	No	149	18.4%	261	32.9%	410	25.6%
	Yes	659	81.6%	533	67.1%	1192	74.4%

Young women's lower economic participation could be also explained by the fact that they are often tasked with helping their mothers with domestic work (e.g. food preparation, cleaning). However, the situation in Latamba (Bahir Dar) was different because young women constituted 70% of the workforce of the Tana Flower Farm. The farm is the only source of formal employment for the surrounding communities and young women, many of whom are out of school, are the major labour pool for the company. Some parents and community leaders are worried that the availability of work at the Tana Flower Farm is negatively affecting the education of young women as most either drop out of school or do not start school at all to get employment in the farm, as the following case illustrates (Box 2).

BOX 2: IMPACT OF YOUTH EMPLOYMENT ON YOUNG WOMEN'S EDUCATION*

The Tana Flower Farm, located 23 km west of Bahirdar on the way to Zege, provides employment for young people from Latamba kebele, Bahirdar Zuria woreda. Over 900 young people (70% of them are girls) work in the farm. They work six days per week and earn 750 to 950 birr per month. Many of them are out-of-school girls, or are not enrolled in school at all, who have been persuaded by their parents to work on the farm and earn money to support their families, but also to save money for marriage. Although the company has a policy of not hiring people under 18 year of age, some are underage (based on consultation with the payroll officer and also looking at the girls' slim and tender physical appearance). They produce fake kebele IDs to prove that they are 18. While the farm provides jobs for young people where opportunities for formal employment are almost non-existent, its effect on education is negative. The girls complained about difficult working conditions (e.g. heavy workload covering large sheds, hot temperature, removing of flood water due to heavy rains), unsafe transport service (e.g. ISUZU trucks are main means of transport) and health risks resulting from the use of chemicals contributing to irregularity of menstruation, headache and dizziness.

(Latamba kebele, Bahirdar Zuria woreda)

The responsibilities of looking after the household, pregnancy and raising children prevent teenage girls from actively seeking a job or working outside the domestic unit. Young women who experienced child marriage tended to have lower education and consequently more limited possibilities of getting a job. Therefore, curbing child marriage and teenage pregnancy is an important step towards strengthen young women's education and empowering them economically – as the two are closely linked. This is also reflected in the responses that respondents gave to the statement: 'economic empowerment is a solution to child marriage' with which more than 63.5% agreed (Table 29).

Table 29 **Economic empowerment is a solution to the problem of child marriage**

	Female		Male		Total	
	n	%	n	%	n	%
No	303	26.8%	146	31.1%	449	28.0%
Yes	734	64.8%	284	60.4%	1018	63.5%
Don't know/ not sure	95	8.4%	40	8.5%	135	8.4%
Total	1,132	100.0%	470	100.0%	1,602	100.0%

3.7.1 WORRIES ABOUT EDUCATION AND WORK

For young people, the future is full of uncertainties and anxieties. A number of questions were posed to the respondents to get a sense of what they thought about their future – school, relationships, SRH and other related issues. Most respondents (60.5%) reported to be worried about dropping out of school (Table 30). Females appeared less worried about the possibility of dropping out of school (59.0%) compared to males (64.3%). Results of qualitative interviews and FGDs held with young men and in-depth interviews conducted with parents showed that young men are expected to succeed in education, while young women are not expected to have the same level of success in education. If a young women fails in education, she can always fall onto marriage as an option to live her future life. Young men feel that they face greater risks if they fail in school and the pressure to do well with education is higher for them as compared to young women.

Another area of worry for the respondents was whether they would be able to decide who to date. Overall, the issue of who to date seemed of less a concern for the respondents; 40.9% agreed and 57.9% disagreed that they were worried about being able to decide who to date with similar results among female and male respondents. The fear of becoming pregnant (females) or making someone pregnant (males) was expressed by 55.7% of the respondents. Female respondents (60.2%) appeared more concerned about the possibility of getting pregnant compared to boys (45.1%) who appeared less concerned about making girls pregnant early. When the respondents were asked whether they worried about being unable to access contraceptives, 38.9% expressed agreement, with girls (43.2%) appearing more concerned about the issue of accessing contraceptives as compared to boys (28.5%) (Table 30).

Table 30 **Economically active outside the household**							
		Female		Male		Total	
		n	%	n	%	n	%
Dropping out of school	Agree	668	59.0%	302	64.3%	970	60.5%
	Disagree	443	39.1%	162	34.5%	605	37.8%
	Don't know/ no answer	21	1.9%	6	1.3%	27	1.7%
Unable to decide who to date	Agree	454	40.1%	192	40.9%	646	40.3%
	Disagree	663	58.6%	264	56.2%	927	57.9%
	Don't know/ no answer	15	1.3%	14	3.0%	29	1.8%
Early pregnancy/ impregnation	Agree	681	60.2%	212	45.1%	893	55.7%
	Disagree	444	39.2%	234	49.8%	678	42.3%
	Don't know/ no answer	7	0.6%	24	5.1%	31	1.9%
Unable to access contraceptives	Agree	489	43.2%	134	28.5%	623	38.9%
	Disagree	618	54.6%	270	57.4%	888	55.4%
	Don't know/ no answer	25	2.2%	66	14.0%	91	5.7%

3.8 POLICIES AND LEGAL ISSUES

Protection of the rights of children is well documented in the FDRE Constitution. Article 36 (1) (d) states that children must be protected against exploitative practices. Regarding marriage, Article 34 (2) states that marriage shall be based on the free and full consent of the intending spouses. The Revised Family Law also contains articles which are designed to ensure the rights and welfare of children. According to Article 7 of Ethiopia's Revised Family Code of 2000, no marriage may be concluded between a man and a woman who have not attained the full age of 18. Similarly, the revised Penal Code makes FGM/C illegal. Article 568 contains provisions that stipulate penalty for circumcision of a girl ranging from three months to three years imprisonment and a fine of up to 10,000 Birr, or both. Article 18 of the Amhara National Regional State's Family Code of 2003 states: '*Neither a man nor a woman who has not attained the full age of eighteen years shall conclude marriage. However the Justice Bureau of the Region may, on the application of the future spouses, of the parents or the guardian of one of them, for a serious cause, grant dispensation of not more than two years.*' This means that marriage is allowed at the age of 16 if approved by the Justice Bureau of the Region as a response to a submitted application by one of the spouses or their parents.

At the local level, various governmental and non-governmental organizations have been working to promote girls' and women's rights with respect to sexual and reproductive health issues. For example, the woreda women affairs offices were closely working with kebele administration, health, and education sector offices to create community awareness about the negative impacts of child marriage, teenage pregnancy and FGM/C on young girls and women. In Qewet, the women's affairs office had actively intervened to stop child marriages, though child marriages were often executed underground to avoid scrutiny by local officials. The office chairs the committee for the prevention of harmful traditional cultural practices and, in Chenta kebele, Bahirdar Zuria woreda, the committee has helped to stop six planned child marriages in one year. In Qewet woreda, the Muluwongel Ethiopia Child Development Project and Women's Support Development Association (supported by Norway Development Fund) were helping young girls and women to become economically self-sufficient through various income generating activities with a view to curb child marriage. In Bahir Dar, Plan Ethiopia is helping the Fenot Hiwot Committee (in collaboration with the committee for the prevention of harmful traditional cultural practices) to stop child marriage. The police and health offices of the respective woredas were working together to monitor ages of brides who are suspected to be underaged, though cases of falsifying girls' ages by health professionals were reported in Yelen kebele. Health workers are the ones who normally do the age estimation of girls to see whether they are indeed 18 and above. Participants however indicated that some health workers collaborated with parents and certified girls of under 18 as if they were above 18 to allow marriage.

Concerted interventions by government, community and non-governmental organizations have resulted in increased community awareness about laws and policies dealing with child marriage, teenage pregnancy and FGM/C. Results of qualitative interviews held with young people, parents, community leaders and local officials show that people are aware of the 'do-not-laws' of FGM/C and child marriage. Most people have knowledge of the fact that marriage below the age of 18 and practicing FGM/C are illegal. This is also supported by results of the survey, where 57.7% of the respondents indicated that they have knowledge of the legal minimum age for marriage. Female respondents (60.6%) compared to male respondents (50.6%) appeared more knowledgeable about the existence of the law and this increased knowledge on the part of the girls can be attributed to the fact that the law is more consequential for girls as it protects them from child marriage and FGM/C (Table 31).

Table 31 **Respondents knowledge about the legal minimum age for marriage**

	Female		Male		Total	
	n	%	n	%	n	%
No	62	5.5%	31	6.6%	93	5.8%
Yes	686	60.6%	238	50.6%	924	57.7%
Don't Know/ not sure	384	33.9%	201	42.8%	585	36.5%
Total	1132	100.0%	470	100.0%	1602	100.0%

However, knowing the law is different than enforcing it. Parents, elders, young people, the police, health workers and kebele officials were knowledgeable about the law. They had been enlightened through education and various awareness-raising campaigns conducted by schools, churches, kebele administration, women's affairs office and NGOs. However, few programme interventions had stopped parents from circumventing the law. Key informants argued that lack of coordination among different sector offices and lack of integration of the different activities related to FGM/C and child marriage is part of the problem. For example, woreda women's affairs, youth affairs, woreda administration, the police and kebele administration each assume some responsibilities in efforts to prevent FGM/C and child marriage. However, none of these institutions is fully charged with the task of prevention/elimination of FGM/C and child marriage. This has created an institutional vacuum in the fight against harmful cultural practices. In addition, the communities are often told to abandon practices, but are rarely engaged in dialogue with the law and government policies, for example, on why child marriage and FGM/C are harmful. Parents had multiple concerns and worries (e.g. the need for more local job creation, alternative income generation) that influenced their decisions regarding child marriage, which government policies should (try to) address.

4 DISCUSSION

This report has presented the main results of a baseline study that was conducted in two intervention woredas of the YES I DO programme in Amhara national regional state – Qewet woreda in north Shewa zone and Bahirdar Zuria woreda in west Gojjam zone. The main purpose of the study was to give insights into the magnitude and the factors influencing child marriage, FGM/C and teenage pregnancy and their interlinkages. A mix of quantitative and qualitative data were collected from diverse groups of research participants comprising of young women and men aged 15-24, parents/care givers, local officials, community leaders, religious leaders, health extension workers and teachers.

4.1 CHILD MARRIAGE

In Amhara region, the high prevalence of child marriage is well documented (Workineh et al. 2015; Pathfinder 2006; Assefa et al. 2005), though a recent study shows somewhat declining trends (Jones et al. 2015). Child marriage is a major issue affecting young women, with 37.0% of the girls aged 18-24 in the sample having married below the age of 18. Generally, Ethiopian girls and young women marry much earlier than males and child marriage among males is a rare phenomenon (Jones, et al., 2015). Finally, baseline data reveal that child marriage among females aged 18 to 24 years was higher in Qewet than in Bahir Dar (48% and 30% respectively).

The study found that multiple factors were contributing to the practice of child marriage in the Amhara region. One of the most important factors is the widely held social norm that girls should maintain sexual purity and be socialized properly to become a good future wife. Through the practice of the 'wife in training' and under the guidance and protection of the groom's family, the child bride develops socially and emotionally learning the basic skills of becoming a good wife and mother. Our findings support the argument that social norms that focus on girls' sexual purity push both parents and girls towards child marriage (Jones et al., 2015). Related to this is parents' fear that their daughters are developing sexually too fast and if not managed via marriage, might engage in pre-marital sex potentially leading to teenage pregnancy and to out-of-wedlock birth, thereby dishonouring family tradition.

Communities in the study area seem to disapprove child marriage but in practice most rural parents are eager to marry off their daughters before the minimum legal age of 18 years. Everyone – young or old, educated or uneducated – appears to be knowledgeable about the marriage law but the practice has not ended. The law has not addressed parents' fear that daughters who are not wanted by men will continue to be a burden for parents and this fear is exacerbated by girls who return to their communities after they have failed in grade 10 or grade 12 national examinations and who by then become 'old' to get a husband. In an effort to circumvent the law, some parents organize 'ghost weddings' where guests are invited to a secret wedding in the absence of the bride and groom so that their identities are kept secret especially from outside guests such as local officials.

Most marriages, in the study communities, are arranged and executed under the influence of social customs and religion provides moral backing – this observation is supported by the finding that 406/494 of all marriages were religious marriages and only seven marriages were approved by government vital registration office. Therefore, the absence of a vital registration service in rural areas is undermining efforts to reduce/eliminate child marriage. Besides, marriages including child marriage perform a social function (wedding is a social event for maintaining interactions among relatives and neighbours) and an economic function (parents are relieved because they can now shift the responsibility of supporting daughters economically onto husbands). As indicted before, parents also see child marriage as a strategy to prevent daughters from becoming a victim of pre-marital sexual relationship and also to protect them from teenage pregnancy before marriage. Parents seem to fear that schools, because of their weak disciplining approach toward students, tend to create conducive environment for school girls to start their sexual debut early and hence become pregnant before marriage. This fear increases as girls complete primary school, and move to bigger towns like Bahirdar and Shewa Robit to attend secondary education as such schools are non-existent in rural areas.

Skill training institutes designed to prepare young girls for various hands-on jobs so that they can be empowered economically to resist the temptation of child marriage are not available in rural areas. In the FGD held with parents in Chenta Sosetu kebele, some parents expressed interest in establishing small businesses (e.g. coffee shops) for their daughters but shortage of working space is a hurdle to overcome.

The presented results also reveal that in the study areas child marriage was a main driver (rather than a consequence) of teenage pregnancy. Although both issues were mutually reinforcing, data indicate that among all female respondents who had both a teenage pregnancy and a child marriage, only 2% had a pregnancy before marrying. Most of them had the teenage pregnancy within marriage (83%) and some had both in the same year (15%). Besides, as multiple studies have highlighted, child marriage was found to be a major contributing factor to young women's school drop-out. In this study, 6.2% of the respondents reported to have ever dropped out of school because of marriage, a percentage that was much higher among female respondents (8.7%) than among male respondents (0.2%). This result shows a significant improvement from Pathfinder's 2006 study which found that 27% of the girls dropped out of school to get married, however, the way the question was asked in our survey could have resulted in underreporting. After marriage, young girls' access to formal and non-formal education is severely limited because of their domestic burden, childbearing and social norms that view marriage and schooling as incompatible (ICRW 2006, cited in Tefere et al. 2013).

Generally, in the two study areas, child marriage is seen as having both advantages and disadvantages. Data show that young people's general perspective on child marriage is that the disadvantages for girls outweigh the advantages they may derive from being married young; 88% of the respondents agreed that marrying young has disadvantages. The study found that especially young female respondents aged 15 to 18 indicated to feel pressured by parents or family members into marriage although, at the same time, most female respondents (57.9%) were not worried about being unable to decide who to date. Refusal of (child) marriage proposals was generally rare, although some participants argued that there is an increasing number of cases of young women refusing (child) marriage proposals. However, young women are often pushed towards accepting child marriage because they do not want to offend their parents, or do not want to miss the opportunity of getting a husband on time or do not have other options such as employment or a combination of all of these factors. Child marriage is also a means of creating social bonds and kinship alliances with respected families. Parents view child marriage as a means of achieving social security as families believe their son-in-law and grandchildren will be able to take better care for them when they get older.

4.2 TEENAGE PREGNANCY

In Ethiopia, young women are pushed to have children relatively at younger age especially if they are married (Yalemzewud 2010). In this study, 32.6% of young women aged 20 to 24 years had had a pregnancy before turning 20. Of all this cases, 98% had ever married and only 2% were pregnant before marriage. This shows that the large part of the teenage pregnancy occurred within marriage evidencing the linkage between marriage and teenage pregnancy.

The DHS conducted in 2005 revealed that 17% of the adolescent girls had a child or were currently pregnant at the time of the survey (DHS 2005). According to the 2011 DHS, 12% of women aged 15-19 had already started childbearing and 34% of women were either mothers or were pregnant with their first child by age 19 (CSA 2012). Amhara region's teenage pregnancy rate was 12%. A study conducted among students aged 15-49 indicated that 50% of teenage girls had had a pregnancy at least once in Koladiba (north Gondar), 15% in Harar and 18% in Addis Ababa (Alemayehu et al. 2010). Another study conducted in east Go jam among out of school teenager girls revealed 43% of them had had at least one pregnancy. Overall, in Ethiopia teenage pregnancy has been on decline from 2000 to 2005 and 2011.

In the study areas, teenage pregnancy out of wedlock often led to school drop-out and isolation of the pregnant teenage girl from friends, family members, and the community. Therefore, some young women decide to run away from home to protect family honour, to escape gossip and stigma. Health consequences such as obstetric fistula and risks related to unsafe abortion were also mentioned consequences of teenage pregnancy. Study participants showed good knowledge about the harms of teenage pregnancy. A study by Alemayehu et al. (2010) observes that 'adolescent fertility is associated with adverse maternal and child health outcomes including obstructed labour, low birth weight, foetal growth retardation, and high infant and maternal mortality rate'.

Factors that have been identified as contributors of a decline of teenage pregnancy include increased knowledge and use of contraceptives; increased number of girls enrolled and staying in schools; education and awareness raising activities undertaken by community, governmental and non-governmental organizations regarding the negative

consequences of teenage pregnancy, and young girls are now increasingly taking SRH issues into their own hands. According to the 2014 mini DHS, overall knowledge of contraceptive methods has increased among women (for example, knowledge of any contraceptive method increased from 8% in 2000 to 42% in 2014) and 40.1% of currently married women ages 15-19 used at least one contraceptive method.

Baseline data show that 92% of the respondents knew at least one way how to prevent pregnancy and the most reported method was injection. In addition, most respondents were not worried about being unable to access contraceptives, although more females (43%) than males (29%) reported this concern. However, the use of contraceptives among non-married teenagers could be lower as married people feel more at ease to access contraceptives compared to non-married teenage girls, according to the findings of this study. Providing girls access to education is one of the mechanisms to reduce teenage pregnancy as educated girls are more likely to make conscious choices regarding when, how and with whom to get a child (CSA 2012).

4.3 FEMALE GENITAL MUTILATION/CUTTING

FGM/C, despite being labelled as a harmful cultural practice and being prohibited by Ethiopian law, is strongly supported by social norms, customs and traditions. In our survey, 36.1% of the respondents acknowledged FGM/C to be a social norm. FGM/C is interwoven with social acceptability, marriageability and beliefs about what is normal and healthy (28 Too Many 2013). The UN General Assembly, in its 2009 resolution stated: 'It is now widely acknowledged that FGM/C functions as a self-enforcing social convention or social norm. In societies where it is practiced it is a socially upheld behavioural rule. Families and individuals uphold the practice because they believe that their group or society expects them to do so. Abandonment of the practice requires a process of social change that results in new expectations on families' (UN General Assembly, 2009, cited by 28 Too Many, 2013).

FGM/C's social acceptability in the study area is evident in the fact that 54% of the female respondents reported to be circumcised and only 24% reported they were not. The rest (22%) did not know if they had been circumcised. Amhara region as a whole has the 2nd highest FGM/C rate (47.2%) after Afar region (59.8%) among ages 0-14, while the national average is 23%, according to the 2011 DHS. A study conducted in six woredas of north Gondar by Amare and Aster (2006) found an overall FGM/C prevalence rate of 35.7%, with striking variations between woredas from 1.4% in Dabat to 72.3% in Misrak Belesa. In a nation-wide study conducted by Save the Children Denmark and covering students, teachers and parents, it was found that FGM/C is recognized as a form of violence committed against school girls – among students (43.5%), teachers (59.6%) and parents (46.3%).

In our study communities, FGM/C was performed during the first few days of birth, although some participants pointed at the fact that young women who missed out circumcision might be subject to it at later ages, for example before marriage and if husbands believe the vagina will be difficult to penetrate. FGM/C is performed by traditional birth attendants or mostly elderly women who have acquired the skills to perform FGM/C. Some parents who participated in the qualitative interviews also believed that health workers working in health institutions perform FGM/C. This thought, however, is not without evidence, because in Addis Ababa, 20% of the FGM/C was performed by health workers (CSA, 2012).

Several myths contribute to uphold FGM/C. These include myths are associated with maintaining vaginal hygiene, enforcing 'proper' behaviour on girls and making them good wives, controlling girls' 'excessive' sexual desires, and making vaginal penetration easy for the future husband. Evidently, these benefits are intended for men, not for women. Therefore, FGM/C is another manifestation of a patriarchal structure that is imposed on women and girls in the context of the study communities. Parents fear that if daughter is not circumcised, the groom will return the bride to her parents' house and this becomes an embarrassment for her and for the family as a whole. Gossip and rumours feed into stories of grooms returning brides to their parents' homes because they found them uncircumcised. Women as mothers, grandmothers and performers of FGM/C, are responsible for its execution.

Various influential community groups – parents, religious leaders, local officials, health workers, police – who publicly oppose FGM/C, can at the same time practice it secretly, or assist its practice or show complicity towards its continued

practice. The opposition is not so much because most of them are committed to its abandonment, but because of fear of its illegality and liability to punishment if caught by the law performing FGM/C or assisting its practice. The study showed that while some religious and community leaders are raising awareness about the negative consequences of FGM/C and the non-relation between the practice and religion, others are contributing to its prevalence by helping relatives to perform FGM/C or allowing FGM/C on their daughters. This is a testimony to the widespread ambivalence of the community toward FGM/C and hence lending continued social acceptance for FGM/C. There is a strong link between FGM/C and education in that mothers who do not have education are more likely to perform FGM/C on their daughters than those who have some kind of education (UNICEF, 2013).

A key factor in the fight against FGM/C, as emphasized by study participants, is the importance of social and political commitment among various stakeholders. They pointed out that a number of local government institutions (e.g. women's affairs office, the police, kebele administration etc) are involved in anti-FGM/C campaigns. Parents, teachers, religious leaders and health workers are also involved as members of the committee to eradicate FGM/C and associated harmful cultural practices. NGOs (e.g. Plan Ethiopia, Amref Ethiopia, DEC and TaYA) are also engaged in activities designed to free girls from FGM/C. Nationally, there are over 82 NGOs which are working in the area of prevention of FGM/C and other harmful traditional practices (28 Too Many, 2013). Equally important, as noted, is the presence of strong political commitment as expressed in the allocation of budget for anti-FGM/C-focused activities at local levels, genuine engagement of the local community in demythologizing the social and normative basis of FGM/C and promotion of broad-based anti-FGM/C coalition comprising young people, citizens, community groups, schools, mass media and law enforcement agencies. The resource and coalition mobilization can be effective if there is 'strong coordination of the activities of various stakeholders that are engaged in the fight against FGM/C, including various government sectors, non-governmental organizations and community based organizations' (MOFED & UNICEF, 2012).

4.4 SEXUAL AND REPRODUCTIVE HEALTH SERVICES AND INFORMATION

Schools and health institutions have been oriented to support anti-FGM/C and anti-child marriage efforts. For example, in the study communities, girls' clubs and school mini-media centres have been established to encourage school girls discuss issues related to SRHR and to keep an eye on harmful traditional cultural practices (e.g. child marriage) that hinder girls from continuing their education. Health posts and health centres have served as important sources of information on SRH and also provided young girls with SRH services including contraceptives and education on SRH. However, some of these health institutions (e.g. Yelen Health Post) are not well equipped to meet the growing demand for SRH services because of insufficient budgetary allocations, shortage of well-trained health professionals, and distance. In Yelen kebele there is no health centre. The community has to travel for an hour to access health centre in Tare kebele. This is difficult during summer because there is a river between the two kebeles. As a result, people including adolescents rely on private clinic which require higher fee as compared to public health centre.

The findings of this study show that the media such as radio and TV provide important sources of information for young people. However, use of TV as source of SRH information is negligible as most rural parents cannot afford to buy TV and also most rural areas are not yet provided with electricity. The use of mobile phones, print media (e.g. newspapers and magazines) and electronic media (e.g. internet) to access SRH information is also limited, though these communication channels will be gradually taken-up by young people as information infrastructure and electricity expand in rural areas.

4.5 POLICY AND LEGAL ISSUES

The government has put in place anti-FGM/C and child marriage laws to protect girls and women from abuse and exploitation. The FDRE Constitution (1995), the revised family code (2000) and revised criminal code (2005) contain anti-FGM/C provisions and have served legal instruments in the fight against FGM/C and child marriage. However, the problem is a lack of law enforcement, especially at the local level where means of enforcing laws (e.g. financial resources, law enforcement professionals, institutional support mechanisms) are lacking. Consequently, young people

are sometimes left to their own devices to deal with consequences of FGM/C and child marriage with little help from standard duty-bearers.

On the institutional front, the Ethiopian government has created federal, state and local level institutions to foster efforts to eradicate FGM/C. For example, the Federal Ministry of Women and Children Affairs and Federal Ministry of Youth and Sports and the respective sector offices are responsible for coordinating anti-FGM/C and child marriage efforts at federal, state and local levels. In addition, there are also supporting ministries (e.g. Ministries of Health, of Education and of Social Affairs) which are actively involved in anti-FGM/C campaigns by working directly with young people on issues related to health, education and employment opportunities.

The Ethiopian government has also initiated and actively supported the creation of national and local level coalitions devoted to elimination of FGM/C and child marriage. To this end, the National Alliance to End Child Marriage, National Network to End FGM/C, Ethiopian Association to Eliminate Harmful Traditional Practices, and National Strategy and Action Plan on Harmful Cultural Practices have been initiated to coordinate efforts against FGM/C and child marriage. Ethiopia's strategic approach to end FGM/C and child marriage has been guided by the national strategy and action plan to end FGM/C and child marriage and is coordinated by the Federal Ministry of Women and Children's Affairs.

Enforcement of anti-FGM/C and anti-child marriage laws is inadequate at local level, not only because of shortage of law enforcement personnel in rural areas. Shortage of health institutions in nearby areas is discouraging young girls from seeking SRH services, including safe abortion, contraceptives and pre-post-natal counselling and education services for mothers. Schools do not have resources to undertake anti-FGM/C activities (e.g. drama) on a regular basis. Parents and community leaders cannot engage in continuous dialogue and discussion with responsible government bodies (e.g. women's affairs, health workers, police) to develop agreed-upon strategies and action plans to eliminate FGM/C and child marriage once and for all, because resources allocated for such activities are often scattered and limited.

5 CONCLUSION

Ethiopia is a patriarchal society where females hold a subordinate position. This is evident in the socialization of sex roles and gender-based responsibilities which tend to favour men at the expense of women. Child marriage and FGM/C in particular, are reflections of social norms that give preferential treatment of men. However, in recent years attitudes opposing harmful practices such as child marriage and FGM/C are growing. There is a fairly high level of knowledge and awareness among community members regarding the negative effects of harmful traditional practices on young women, but this knowledge is often not backed by action. Narrowing the gap between the two is one of the biggest challenges of interventions aimed at reducing FGM/C and child marriage. The qualitative and quantitative evidence presented in this baseline report suggest that education of young woman and continuous engagement of the community hold the key to the success of anti-FGM/C and anti-child marriage efforts.

Data from qualitative interviews held with parents, community and religious leaders, local officials and young people show that the continued existence of FGM/C, child marriage and partly teenage pregnancy depends on the support and guidance provided by the community. Parents assisted by a network of relatives and friends are responsible for practicing FGM/C and child marriage. For example, most decisions about marriage in general and child marriage in particular are made by parents, especially by fathers, with the help of relatives such as uncles and aunts. Elders and religious leaders are involved in child marriage as witness when a teenage girl and a boy are joined by marriage, and religion provides moral force for the union. Like child marriage, FGM/C is also a community affair where parents, grandparents, relatives and traditional health attendants are involved in the execution of FGM/C. There is another way in which health professionals and the police also aide FGM/C and child marriage – that is, by producing false document about girls' ages. This shows that the structural basis of FGM/C and child marriage extends beyond the local community and includes government health and law enforcement institutions. Therefore, future programme interventions should address all these complex and interlinked issues of FGM/C and child marriage.

The existence of a relatively high level of knowledge about the existence of the anti-FGM/C and anti-child marriage family code, school girls increasingly vocal and active role in the fight against child marriage, positive role played by school teachers and school officials in helping school girls develop confidence to resist child marriage (e.g. via drama and role plays), the pro-active role being demonstrated by woreda women's affairs office in aggressively raising community awareness about FGM/C and child marriage, and grassroots action being undertaken by various empowerment (e.g. Muluwengel Ethiopia Child Development project in Abbayiter and Women's Support Association in Sefiberet) and anti-FGM/ child marriage (e.g. Fenot Hiwot Committee in Chenta Sosetu) groups, all point to the inevitability of change and gradual erosion of the normative and cultural basis of FGM/C and child marriage. The YES I DO programme should capitalize on these positive developments.

6 RECOMMENDATIONS FOR YES I DO

The theory of change is the cornerstone of the YES I DO programme. Through change in beliefs and convictions, people will gradually but surely abandon FGM/C and child marriage. But changing deeply-held beliefs about the supposed benefits of FGM/C and child marriage is not something that will occur overnight. It requires sustained engagement, conversation and dialogue with all stakeholders and duty-bearers about the pros and cons of FGM/C and child marriage. For a productive and effective engagement of people at all levels, the views and perspectives of the communities concerned should be the starting point. Bearing in mind how important it is to take the local perspective on child marriage, FGM/C and teenage pregnancy into account, the following recommendations are forwarded.

Engage parents directly. Changing community and gate keepers' attitude towards child marriage, FGM/C and teenage pregnancy, as envisaged in **Strategic Goal 1**, should start with parents who represent the critical group behind the continued existence of FGM/C and child marriage. They initiate, plan, approve, execute and oversee the whole process from beginning to end. They represent a critical group which should be engaged directly and not via proxies. Therefore, having honest and sustained conversations and dialogue with parents about the pros and cons of FGM/C and child marriage is critical. There is a need to address parents' fears about delaying marriage and encourage them to have good relations and open discussion with their children so that they can build a non-FGM/C world for their daughters. Bringing parents and children together to discuss openly about FGM/C and child marriage is a good place to start, and no intervention is going to be successful if it does not engage parents in a continuous and holistic manner; addressing their fears, beliefs and mythologies underpinning FGM/C.

Engage young people directly, actionably. As set out in the theory of change, one of the long-term strategic goals of the YES I DO programme is to engage young people meaningfully so that they can claim their sexual and reproductive entitlements (**Strategic Goal 2**). As young people, especially teenage girls, are victims of FGM/C and child marriage, they have to be involved directly in efforts to reduce/eliminate these harmful practices. Through training and education, young girls need conversation and confidence building skills designed to increase their abilities to openly discuss and dialogue with their parents about what is good for their future. Communication between parents and young people on issues that affect the latter (e.g. dating, prevention of pregnancy, marriage, education) is weak and the growing education gap between parents (being uneducated) and children (being relatively educated) is regarded as main communication barrier. However, it is important that young people understand that parents make sacrifices in sending children to school while this chance was not available to them when they were young. Building good relations between parents and children can pave the way for an effective engagement of young people in anti-FGM/C and anti-child marriage activities, because when parents approve their children's participation, the latter would be encouraged to get involved more and to bring positive change.

Engage young people via significant others. Again, the theory of change emphasizes the importance of engaging young people in matters that affect their sexual and reproductive lives so that they take informed actions on their sexual health entitlements (**Strategic Goal 3**). One strategy is to use role models to bring about positive changes in the attitude of young people. In the family, elder brothers can be a positive force in motivating siblings to adopt pro-active behaviour towards preventing child marriage and teenage pregnancy and also in negotiating with parents about daughters' marriage and other related issues. In school, trusted girl friends can have a positive influence on their peers and especially school girls who are involved in girls' clubs and school mini-media activities can have a positive impact on other girls. Female teachers often maintain good relations with their female students and so do some male teachers who are respected and listened to by school girls and boys. These groups can be important agents of change regarding preventing FGM/C, child marriage and teenage pregnancy within the home and school environments.

Empower girls through education. Providing young people with opportunities for education and employment is another strategic goal (Strategic Goal 4). Education has the effect of undermining and diminishing the power of social norms that sustain FGM/C and child marriage. Educated girls may less easily fall victim of child marriage and teenage pregnancy compared to less educated ones. Girls in rural areas need increased access to education and efforts should be made to retain them in school once they are enrolled. Through education, girls can develop confidence and acquire knowledge about various SRHR issues. Educated girls who protect themselves from child marriage and teenage pregnancy can be role models for other young girls. Giving girls increased access to secondary school

education by upgrading existing primary schools to secondary school in rural areas is critical, as many girls drop out of grade 8 because of lack of support.

Empower young people through employment creation. For education to be viable and attractive, it must open opportunities for jobs and income. If young people see the benefits of attending school (in terms of increasing access to jobs and income), they would be motivated to stay in and finish school. This is also an incentive for parents who would like to see returns from investment in their children's education. Therefore, through the benefits from attending school young people would be empowered educationally and economically and hence their power to 'say no' to child marriage increases. Girls are vulnerable to child marriage and teenage pregnancy if they are unemployed and hence do not have economic independence. However, it should be noted that availability of jobs for young people can sometimes take them away from education (as observed in Latamba kebele of Bahirdar Zuria woreda) by directing their attention to casual/contract jobs designed to generate income to support parents and also to save money for marriage.

Educate communities via demonstrations. Actions are more powerful than words and this was highly stressed by parents and community leaders who argued that summoning parents and lecturing them about the negative effects of FGM/C, child marriage and teenage pregnancy could not have the desired effect of reducing these practices. People are keen to see real consequences of these harmful traditional practices through drama, storytelling and sharing of experiences of girls who went through FGM/C or child marriage. Girls and women could be willing to tell stories of how they have been affected by the negative effects of FGM/C and child marriage and in this way other girls, boys and communities will learn real effects. This requires other supporting services such as strengthening girls' clubs, school mini-media, and more importantly access to electricity so that TV programmes dedicated to the anti-FGM/C and child marriage activities can reach young people in locations (e.g. small rural town centres) where young people frequently hang out.

Enforce the laws. Both the federal and state family codes provide legal backing for interventions aimed at reducing/ eliminating FGM/C, child marriage and teenage pregnancy. These laws are well known by the communities practicing FGM/C and child marriage, but they have not been as effective in preventing harmful practices as they are poorly enforced. There are not enough police officers in rural areas and some tend to conform to social norms and community views rather than aggressively enforcing the laws. The police should see it as their professional duty to stop FGM/C and child marriage because both practices are illegal. To develop a sense of duty and professionalism in the police, continuous training and engagement are critical. This recommendation is related to **Strategic goal 5**.

Engage religious leaders. In the study communities, religious leaders are well respected and their moral guidance is often sought by their respective followers. The fact that most child marriages receive the blessing of religion shows the important role religion plays in sustaining child marriage. If religious leaders are on board in the fight against child marriage, they can withhold their blessing for underage marriages and this will discourage parents from practicing child marriage as this would be interpreted as not obeying their religious leaders. Therefore, the challenge is to convince religious leaders (through continuous dialogue) so that they would say no to child marriage when they are approached for approval by their followers.

Improve SRH infrastructure. Ethiopia's rural health infrastructure based on the health extension programme is a key aspect of the country's SRH infrastructure. In this study, the respondents identified rural health posts as main sources of SRH information. However, the health extension programme is not fully keeping up with demand for better health services. Young people would be discouraged to visit health posts and seek SRH services (e.g. pregnancy prevention methods) if medicines are not available or if extension workers are not there. Therefore, health posts should be strengthened (e.g. more health professionals, drugs, longer consultation hours) so that they can address young people's critical SRH needs. Schools can also support the existing SRH infrastructure by educating their students about SRH issues, including pregnancy prevention. Using youth-friendly radio (e.g. Yegna drama) and TV programmes, transmitting SRH messages can increase young people's access to SRH information.

Enhance political will and commitment. In the political arena, the anti-FGM/C and anti-child marriage field consists of diverse groups of actors whose presence extends from federal to state and woreda/kebele levels. Winning the

support of policy makers especially at highest level of government (federal and regional) is part of Strategic Goal 5 of the YIDA programme, which is critical to enforce the laws. However, the most critical to the anti-FGM/C and anti-child marriage efforts are those which are found closer to the community and it is at this level that strong commitment and dedication is needed. The woreda women's affairs office, kebele administration, woreda administration, health extension workers, religious leader, police and teachers should all be involved in the fight against FGM/C and child marriage. However, not all of them show the same level of commitment or effort, and especially those with some resources at their disposal (e.g. woreda administration) should take a leading role in coordinating efforts among different stakeholders. These duty bearers (through their influence on the community) working hand in hand with the communities and NGOs can bring about meaningful changes in the lives of young girls affected by the plight of FGM/C, child marriage and teenage pregnancy.

7 ISSUES FOR FURTHER RESEARCH

This baseline study has identified the following issues as areas for further research.

- Interventions aiming at improving parent-child relationships and the involvement of grandparents, uncles and aunts, and attempts to address the collective social norms that allow relatives to participate in decision making related to FGM/C and child marriage should be studied, to shed light on main lessons learned in this regard.
- Education is a powerful weapon against harmful traditional practices and it is essential that girls in rural areas are encouraged to stay in school. It would be advisable to follow interventions aiming to retaining girls in school, to assess what works best, how and why.
- The link between rural transformation (e.g. electrification, emerging rural towns) and harmful traditional practices should be explored in detail, as evidence from this baseline study seems to suggest that the power of child marriage, FGM/C and teenage pregnancy may decline under the influence of these transformations (e.g. improved health and road infrastructure, increased population movement).
- The impact of migration on child marriage is another area that needs further research, as young girls are taking up migration as a strategy to escape rural poverty, thereby also delaying marriage, though, the long-term impact of migration on the social and human capital of rural communities is likely to be negative and this too needs serious attention.
- The political economy of child marriage as it relates to government's land tenure policy, rural investment policy, education and workforce training policy needs to be explored further, to understand the impact of these policy-related contextual factors on young people's vulnerability and exposure to child marriage, FGM/C and teenage pregnancy.
- Improved access to health infrastructure is likely to prevent teenage pregnancy, however, social norms (e.g. lack of openness about SRH, community perceptions of a good girl) can act as barriers against (unmarried) girls' ability to access contraceptive services and hence future research should focus on interventions involving the development of life skills (e.g. assertiveness, dialogue, self-esteem, communication) among girls living in rural areas, to assess whether this contributed to increased access to contraceptives.

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