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LEARNING BRIEF

Lessons and approaches from end FGM programming within a conflict.

Combatting FGM in Conflict Zones of Ethiopia and Somaliland

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actionaid

Lessons and Approaches from programming within a conflict situation-Ethiopia and Somaliland (ActionAid Ethiopia & ActionAid Somaliland)

Combatting FGM in Conflict Zones of Ethiopia and Somaliland

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INTRODUCTION

This learning brief brings together evidence from Somaliland and Ethiopia to examine how conflict shapes community responses to female genital mutilation (FGM) and affects the ability of programmes to support abandonment. It explores how social norms, service access, and community-led action are affected when instability disrupts everyday life, and identifies the adaptations that enable local actors to continue protecting girls and sustaining awareness despite insecurity.

The brief focuses on community-level interventions implemented under The Girl Generation: Support to the Africa-Led Movement to End FGM/C (TGG-ALM), a multi-country, five-year programme operating in Ethiopia, Somaliland, Kenya, and Senegal. TGG-ALM aims to accelerate the decline of FGM through a girl-centred, community-led, and gender-transformative approach that places power in the hands of local actors and grassroots networks. Its Theory of Change is grounded in the socio-ecological model and interconnected pathways of change, recognising that meaningful and lasting progress requires shifts at household, community, institutional, and system levels. This process is often non-linear, especially in volatile settings such as conflict-affected areas.

The insights presented here are intended to guide programme teams, policymakers, and partners in designing approaches that remain effective, relevant, and community centred during periods of conflict.

BACKGROUND

East Africa remains a region with a high prevalence of Female Genital Mutilation (FGM), though significant change is underway. According to the Somaliland Ministry of Planning and National Development, Central Statistics Department (2020), female genital mutilation is nearly universal in Somaliland, with 98.1 percent of women aged 15 to 49 reporting that they have undergone the practice.[1] In contrast, the Ethiopian national prevalence is approximately 65% among women =aged 15-49, according to the 2016 Demographic and Health Survey (DHS).[2] However, these national averages mask deep regional disparities. Prevalence remains historically high in the Somali (99%) and Afar (91%) regions, whereas the Amhara region reports a prevalence of 61.7%, compared with significantly lower rates in regions such as Tigray (24%).[3]

Whereas in Ethiopia, there has been a decline even in high-prevalence settings, with the rate of FGM dropping to 47% among adolescent girls (aged 15-19) compared to higher rates in older generations.[4] While this downward trend demonstrates that change is possible, the current pace is uneven. UNICEF reports indicate that progress needs to be accelerated significantly, by some estimates, at least eight times faster to meet the Sustainable Development Goal (SDG) of eliminating the practice by 2030.[5]

THE IMPACT OF CONFLICT AND CRISIS

Conflict and humanitarian crises threaten to reverse hard-won gains in the region. When families are displaced or destitute due to fighting, they often resort to harmful practices as coping mechanisms.

Conflict-induced economic hardship: In conflict-affected regions, economic collapse drives alarming spikes in child marriage and FGM. In Northern Ethiopia, the conflict destabilized household finances, causing child marriage rates to rise as families married off daughters to secure dowries or reduce their economic burden.[6]

Similarly, in Somaliland, the conflict in Las Anod (Sool region) displaced

1 Somaliland Ministry of Planning & National Development, Central Statistics Department. (2020). Somaliland Health and Demographic Survey (SLHDS) infographics. https://www.somalilandcsd.org/wp-content/uploads/2021/08/SLHDS-infographs_web.pdf

2 Demographic and Health Survey (EDHS) 2016: The most recent comprehensive national survey places prevalence at 65.2%. Available at: dhsprogram.com/pubs/pdf/FR328/FR328.pdf

3 UNICEF Ethiopia (2020): A Profile of Female Genital Mutilation in Ethiopia. See page 2 for regional breakdowns. Available at: data.unicef.org/wp-content/uploads/2020/02/A-Profile-of-FGM-in-Ethiopia_2020.pdf

4 UNICEF Ethiopia (2020): A Profile of Female Genital Mutilation in Ethiopia. See page 1 ("FGM is less common today... now affecting 5 in 10 adolescent girls").

5 UNICEF (2020): A Profile of Female Genital Mutilation in Ethiopia. See "Accelerating Action" section.

6 UNICEF (2022). Child marriage on the rise in Horn of Africa (Conflict and Crisis Context). Link to Report.

an estimated 185,000 to 200,000 people, 89% of whom were women and children.[7] UNFPA reported that these newly displaced families faced severe economic shocks and a loss of essential shelter, increasing the risk of "negative coping strategies" including forced marriage.[8] In this context, where FGM is culturally viewed as a prerequisite for marriageability, the economic pressure to marry daughters directly increases the risk of them being cut, even amidst active fighting.

Protection Vacuums: In conflict zones, community protection systems are often upended. In Northern Ethiopia, social workers and community educators, critical for FGM prevention were themselves displaced during the fighting, leaving a dangerous "protection vacuum" for vulnerable girls.[9]

In Somaliland, this vacuum is exacerbated by the withdrawal of humanitarian actors and weak legal frameworks. During the height of the Las Anod violence, medical and protection agencies were forced to withdraw due to insecurity, removing a critical safety net for girls.[10]

Displacement and Identity : Research suggests that displacement into camps can reinforce harmful norms. In Somaliland, where conflict has swelled Internally Displaced Persons (IDPs) settlements, camp conditions pose severe risks. A recent review found that 92% of IDP settlements in Somaliland lack gender-segregated sanitation and sufficient lighting, creating an environment rife with sexual violence and harassment.[11] In these insecure settings, some families cling to FGM as a way to "protect" their daughters' chastity or preserve cultural identity while living in temporary shelters.[12]

These factors highlight why anti-FGM programming must be adaptable in conflict settings. While East Africa is mobilizing against FGM, the convergence of political instability and displacement risks stalling progress if not proactively addressed.

THE GIRL GENERATION PROGRAMME IN ETHIOPIA AND SOMALILAND

TGG-ALM has operated in Ethiopia and Somaliland since 2021, mainly in conflict zones. In northern Ethiopia, the April 2023 conflict in Amhara

7 Amnesty International (2023). Somaliland: Urgent investigation needed as fighting takes heavy toll on civilians in Las Anod. Link to Report

8 UNFPA Somalia (2023). Las Anod Crisis: UNFPA Raises Alarms on the Devastating Impact on Women and Girls. Link to Statement

9 ReliefWeb (2022). Ethiopia: Gender-Based Violence in Conflict-Affected Regions. Link to Report

10 Human Rights Watch (2024). World Report 2024: Somalia/Somaliland (MSF Withdrawal). Link to Report

11 ResearchGate (2024). Gender-Based Violence in Somaliland: An Integrative Review (IDP Camp Conditions). Link to Study

12 Forced Migration Review. Conflict, gender inequalities, and local response in Somalia/Somaliland. Link to Article

worsened conditions for women and girls. The programme was adapted by customising interventions and partnering with community groups to safely reach at-risk girls. Supporting local women's and youth networks has been key to sustaining anti-FGM efforts amid security issues.

In January 2023, conflict in Sool, Somaliland, intensified due to long-standing territorial and governance disputes. Despite this, TGG-ALM kept advocating against FGM with civil society and government partners. These efforts resulted in Somaliland's first national Anti-FGM Policy in 2024, reflecting years of advocacy and a more substantial commitment to ending FGM amid ongoing humanitarian issues.

The programme's experience in both countries highlights the importance of flexibility, local ownership, and a clear "Do no harm" approach in conflict zones. Limited access, safety risks, and shifting priorities required ongoing adjustments. Progress was achieved by leveraging community resilience. In Somaliland, efforts included strengthening school youth clubs, training teachers, and supporting women's groups to run awareness campaigns. Local champions, religious leaders, and women's groups were vital, especially when rising insecurity required discreet outreach, WhatsApp use, or reliance on community members when external staff couldn't travel. In Ethiopia's Guna and Farta, implementation involved trained community volunteers, health workers, teachers, and women's groups conducting dialogues, conferences, home visits, and school sessions.

DATA AND EVALUATION METHODOLOGY

This brief draws on qualitative data from Somaliland and Ethiopia, collected in November 2025, to examine how conflict affects FGM practices, services, and programme adaptation in unstable environments. Data were gathered through focus group discussions (FGDs) and key informant interviews (KIIs) in conflict-affected districts, engaging community members, frontline actors, and programme staff to explore how conflict disrupts decision-making, service delivery, and programme reach.

FGDS were held separately with men, women, girls, boys, and mixed youth groups to create safe spaces for honest discussions on conflict's influence on FGM decisions, risks, community norms, and access to services. Eight FGDs were conducted in Somaliland (Aynaba and Eel-Afwayn) with a total of 70 participants, comprising men (n=26), women (n=26), boys (n=14), and girls (n=14). Six FDGs in Ethiopia (Guna and Farta Woredas) with 66 participants, comprising men (n=12), women (n=18), boys (n=18), and girls (n=18).

KIIS complemented FGDs, gathering perspectives from health workers, teachers, religious leaders, facilitators, programme staff, community champions, and frontline workers on service challenges, programme adaptations, institutional constraints, and opportunities for anti-FGM efforts. Eight KIIs were conducted in each country.

Respondent selection employed purposive sampling to ensure diverse representation of programme participants, non-participants, affected groups, young people, women, frontline workers, and traditional influencers, thereby reducing potential bias. This methodology enabled triangulation across community experiences, local systems' responses, and programme strategies, revealing how conflict affects norms and systems and informs programme decisions.

FINDINGS

1. CONFLICT, SOCIAL NORMS AND CHANGE

1.1 Conflict as total disruption of social life

Participants across Somaliland (Aynaba and Eel-Afwayn) and Ethiopia (Farta and Guna woredas) described conflict as a disruption that overturned daily life and dismantled key social, economic, and institutional structures. In both settings, conflict was not experienced as a single event but as a collapse of normal social functioning. Women in Aynaba explained that "*there were no gatherings or social interactions at all; the town was completely divided and isolated,*" while boys described how "*people were afraid to move freely to villages and towns, which has led to food shortages and loss of income.*" Ethiopian participants expressed similar fears, noting that "*leaving home and moving freely has become risky because no one knows when fighting may break out,*" and described how armed groups frequently seized household food supplies, making daily consumption difficult and leaving farmland "non-functional."

Social cohesion weakened markedly in both contexts. Women in Aynaba described how "*people became completely separated and lived in isolation,*" while youth in Eel-Afwayn emphasised that "*there was no crossing over between the two sides of the town.*" Ethiopian participants also reported reduced social interaction due to uncertainty and fear, noting threats to both economic activities and community life.

Young people faced heightened risks across both settings, though the nature of the pressures varied. In Somaliland, youth described isolation and restricted mobility, whereas in Ethiopia the risks were more direct, with one participant explaining that "*youths are suffering intensely, as government forces often pressure them to identify opposing groups and subject them to arrest, insults, and torture if they refuse.*" Families in Ethiopia became afraid to send children to community discussions or training sessions because of unpredictable violence.

1.2 Knowledge of FGM: shifts in awareness

Across Somaliland and Ethiopia, participants demonstrated strong awareness of FGM and its harmful effects, with many describing the practice in detail and emphasising both physical and psychological consequences. In both settings, participants commonly defined FGM as the cutting of female genitalia and recognised it as harmful, with Ethiopian respondents describing it as "*a human rights violation,*" and boys in Aynaba referring to it as "*the*

harmful practice of cutting or injuring the female genitals for non-medical reasons… not a religious command… causes many immediate and long-term health problems." Girls in Somaliland also characterised it as a violent practice that results in "*physical and psychological harm,*" while women and men in Ethiopia and Somaliland similarly referred to a range of health and social consequences.

In both countries, conflict did not appear to diminish community understanding of the harms associated with FGM. Ethiopian participants consistently stated that awareness has remained strong even during instability, with health workers noting that "the community still believes and understands that FGM harms their daughters," and that people do not revert to the practice "*even when supervision is limited.*" A similar pattern emerged in Somaliland, where participants explained that people's knowledge of the dangers of FGM has increased over time.

One difference that emerged relates to community attitudes toward specific forms of cutting. In Somaliland, some men in Eel-Afwayn criticised the most severe forms while indicating that Sunna remains socially acceptable. This distinction did not appear in the Ethiopia, which focused more uniformly on the harms of all forms of cutting.

Across both contexts, community learning played an important role in shaping attitudes. Somaliland participants frequently credited programme activities for shifts in knowledge, with boys in Aynaba noting that they "*only learned the true dangers of FGM from the training sessions conducted by TGG-ALM,*" and girls explaining that before awareness sessions "*we believed FGM was normal and religious, but now people's knowledge is very different from before.*" Similar learning processes were described in Ethiopia, where participants highlighted examples such as a former practitioner who publicly stopped performing FGM and began teaching others that it is a harmful practice.

1.3 Drivers of FGM

Across Somaliland and Ethiopia, participants described FGM as driven by long-standing cultural norms and expectations about purity, honour, and marriageability. In Somaliland, boys in Aynaba explained that FGM is a "*deep-rooted tradition and social pressure to ensure that girls are seen as pure, faithful and marriageable so the family avoids shame,*" while women recalled being told that a girl who has not undergone FGM was "*unclean, haram, and cannot marry.*" Girls and women in both Aynaba and Eel-Afwayn described the practice as

historically justified by the belief that it "*protects the girl's honour.*" Similar ideas were reflected in Ethiopia, where participants noted that families believe "*if a girl has not undergone FGM, she will not get married, she cannot give birth, she cannot adapt to her husband," and that "a girl who has not undergone FGM cannot become the wife of a priest.*"

Beliefs about behaviour and sexuality appeared in both settings. Ethiopian participants explained that many families think a girl who has not undergone FGM "*would have a strong sexual desire and might seek multiple sexual partners,*" while Somaliland participants linked FGM to expectations around modesty and moral behaviour. In Ethiopia, some also associated FGM with making a woman a "*good wife*" and easing intercourse.

Economic factors were mentioned more strongly in Somaliland. Men in Aynaba stated that girls who have undergone FGM "*bring a higher bride price,*" and in Eel-Afwayn, men noted that practitioners may resist change because "*you are taking away their livelihood unless you replace it with another job.*" This economic aspect was absent from the Ethiopian accounts; they focused more on cultural continuity.

1.4 Conflict's effect on FGM Practice

Across Somaliland and Ethiopia, participants described how conflict altered the practice of FGM, though in different ways. In Somaliland, participants in Aynaba and Eel-Afwayn consistently reported that FGM declined during conflict because families were focused on survival, and normal ceremonies could not take place. Women in Aynaba explained that "*during the conflict, FGM was not practised; the situation was too severe, and each family was focused on survival,*" and girls noted that "*during conflict, people don't focus on FGM. They are preoccupied with life and death. So FGM decreases significantly.*" In Eel-Afwayn, respondents agreed that movement restrictions and safety concerns made FGM difficult to carry out; however, families intend to resume the practice when peace returns, suggesting that the decline was driven by logistical barriers rather than a shift in attitudes. Some programme staff also observed that conflict could heighten pressures to perform FGM. They described how pauses in programming sometimes created space for peer discussions that reintroduced doubts about anti-FGM messages.

Similarly, in Ethiopia, respondents stated that conflict had not changed community attitudes, noting that people continue to believe that FGM harms girls. As one participant explained, "*there has been no change in the community's attitude or practice*

regarding FGM due to the conflict," adding that "*the community still believes and understands that FGM harms their daughters.*" Unlike Somaliland, however, participants in Ethiopia reported that the conflict affected how FGM is practised. However, movement restrictions and weakened monitoring systems increased the likelihood of FGM occurring in secret. A teacher in Awuzet Kebele described how "*an FGM practitioner from another kebele had been secretly performing FGM in Awuzet kebele during the conflict,*" which was uncovered only after questioning students. Some respondents expressed concern that instability might create opportunities for practitioners, explaining that "*the number of FGM practitioners may be increased due to the best situation of the conflict for them,*" particularly when "*there is no structure to enforce the rules.*" Health workers also noted that when pregnant women returned to their families in other kebeles, "*their families may push the mothers to do FGM on their daughters,*" although movement restrictions limited their ability to observe cases directly.

ANALYTIC REFLECTION: SOMALILAND AND ETHIOPIA

A key finding is that conflict undermines systems, not necessarily beliefs. In Somaliland, FGM declined temporarily due to families prioritising survival and restricted mobility, not to changes in attitudes; noting some members of the community planned to resume FGM once stability returns. In Ethiopia, attitudes stayed stable, largely rejecting FGM due to prior awareness, with conflict not reversing this. Weakened structures allowed hidden practices to persist, and some practitioners became more active as monitoring systems collapsed.

These patterns show that conflict can influence FGM prevalence through system breakdowns, not value shifts. Whether prevalence decreases or practices go underground, the driver is system failure, highlighting the need to distinguish prevalence from attitudes. Additionally, social norms around FGM are highly resilient under pressure. In both countries, even deep disruption did not alter norms related to purity, protection, honour, and marriageability.

2. CONFLICT-DRIVEN DISRUPTIONS TO ESSENTIAL SERVICES AND ANTI-FGM PROGRAMMING

2.1 Disruptions to Programming due to Conflict

Across Somaliland and Ethiopia, participants reported that conflict severely restricted access to awareness activities and programmes. In both settings, movement became dangerous, gatherings were no longer possible, and the presence

of armed actors or insecurity made routine mobilisation unsafe. Girls in Aynaba explained that "*discussions and awareness completely stopped once the conflict began,*" while boys noted that NGOs and government workers "*can no longer visit us safely… it is too dangerous to gather.*" Similar patterns were reported in Ethiopia, where women in Guna Woreda stated that "*it is difficult to reach and gather the community,*" and that armed actors sometimes "*consider it a political gathering*" unless they could present training documents.

Across both countries, school closures created significant barriers to programmes. In Somaliland, respondents explained that awareness activities from "*all the International and Local Organisations stopped when conflict broke out.*" In contrast, teachers in Ethiopia reported that students were absent because they feared travelling long distances to reach temporary safe areas. Health workers in both contexts noted similar constraints. In Somaliland, staff were unable to enter neighbourhoods and public spaces safely, and in Ethiopia, a health extension worker explained that "*our movement has been highly restricted, making it difficult to travel from place to place to create awareness or report cases.*"

Programme coverage also became highly uneven. In Somaliland, several planned districts including Lasanood, Adhi-Adeye, Samakaab, parts of Eel-Afwayn and Erigavo became unreachable, with authorities designating some as "*red zones,*" forcing organisations to withdraw. In Ethiopia, access varied kebele by kebele depending on the presence of armed groups and localised insecurity, which often stopped peer discussions, community meetings, and school-based activities. Despite these challenges, respondents in both settings described adaptation strategies that allowed some activities to continue. In Somaliland, women in Aynaba reported shifting to discreet household visits: "*We went house to house because gathering was dangerous, and we talked to mothers individually.*" Boys described taking on a more active role by placing "*banners and stickers in public places and talking to neighbours ourselves.*" Local champions received materials through WhatsApp when external actors could not travel, and Women Safe Spaces became important locations for continuing sessions.

Comparable approaches emerged in Ethiopia. Community initiatives within each kebele helped "*cascade FGM messages, even when free movement is difficult,*" relying on religious leaders, youth groups, women's groups, and volunteer facilitators. Health workers integrated FGM messaging

into routine maternal and child health visits, noting that pregnant mothers attending services "*learn about FGM alongside other health packages.*" Remote communication, including phone calls, became a key supervision and support mechanism "*when people are unable to be present physically.*"

2.2 Limited Access To Services

Across Ethiopia and Somaliland, conflict severely reduced access to education, health and psychosocial services, leaving women and girls at heightened risk. In Ethiopia, women reported that "*ambulance services have been discontinued,*" that families using stretchers "*were beaten by soldiers,*" and that women "*were forcibly turned back by armed forces while attempting to reach hospitals.*" Girls also avoided care because "*they fear being stopped or harmed by armed forces,*" and health workers noted that "*when there is an active war, the health centre may be closed totally.*" Psychosocial support was largely absent, with participants stating, "*there is no intentionally established or functional psychosocial treatment centre.*"

In Somaliland, similar barriers emerged. Women recalled that "*pregnant women could not reach hospitals at night because ambulances could not move,*" and girls and health workers described how "*hospitals were overwhelmed with war injuries… some women gave birth at home and suffered serious bleeding or even died.*" Rural communities faced even greater shortages, with boys stating that "*outside the town, there are virtually no services available now for implications caused by FGM for pregnant women,*" and girls reporting that "*some girls died on the way to the hospital because the injection to stop bleeding after FGM was not available.*" Psychosocial support was also lacking. KIIs of AAIS Community Mobiliser and the health worker in Aynaba emphasised elevated levels of psychological distress, especially among displaced families, yet noted an absence of formal psychosocial services dedicated to FGM survivors.

Education was severely affected in both countries. Girls in Aynaba recalled, "*while we were in class, we used to hear gunshots and run away… at one point we stopped schooling completely,*" and in Eel-Afwayn they reported that "*schools were closed for several months*" when fighting intensified. In Ethiopia, participants described widespread damage to schooling infrastructure. They explained that "*two schools had been destroyed,*" and that the elementary school in Mogish Kebele "*was demolished, the teaching radio had been broken, and farmers' routine activities had been disrupted.*" Others added that "*school materials such as radios, textbooks, blackboards, and whiteboards were damaged and are now out of service.*"

Overall, both contexts show that conflict increases FGM-related risks while destroying the systems needed to manage complications, with Ethiopia experiencing more direct military obstruction and Somaliland experiencing more service overload and displacement-related gaps.

ANALYTIC REFLECTION

Across Somaliland and Ethiopia, conflict significantly disrupted anti-FGM programs and services. It affected access to information, education, and health care. Program delivery became uneven and dependent on local conditions such as road access, control, and community tolerance. Different areas experience varying levels of disruption, from complete withdrawal in Somaliland's 'red zones' to ongoing suspicion issues in Ethiopia. Program design acknowledged the fragmentation and included flexible outreach methods. Community actors such as women's groups, youth, religious leaders, volunteers, and health workers became vital when formal systems stalled, emphasising the importance of investing in local leadership in advance.

Disrupted healthcare exacerbated FGM risks; with limited access, complications turn life-threatening, especially where health facilities are partially or fully closed, or mobility is impeded. In Somaliland, women could not access care; in Ethiopia, health system failures and checkpoints worsen dangers. Routine system collapse heightened harm, requiring risk communication and support adjustments during crises.

3. ROLES, ADAPTATION AND SUPPORT SYSTEMS

3.1 Programme-level adaptation and safety strategies

Across Somaliland and Ethiopia, programme teams and community actors described a wide range of adaptations that enabled anti-FGM work to continue despite insecurity, movement restrictions, and the collapse of formal structuresAcross locations, discreet or low-visibility approaches became essential. In Somaliland, women explained that "*we went quietly from house to house to talk to mothers so that the awareness did not stop,*" while in Ethiopia, health extension workers integrated FGM messages into routine maternal and child health visits, newborn follow-ups, and vaccination schedules - activities that could continue even when larger gatherings were unsafe. In both contexts, gender dynamics shaped who could move safely. Women, particularly health extension workers, women's watch groups and voluntary community facilitators, were often more able to move without attracting suspicion, even

though they still faced significant protection risks during the conflict. Participants explained that women could continue household visits, small group discussions and follow-up of newborn girls, while men risked interrogation or violence. This made women indispensable to maintaining programme continuity.

Community dialogues also adapted to shifting security dynamics. In Somaliland, youth placed banners, stickers and used social media to spread messages when gatherings were impossible, and decentralised structures such as Women Safe Spaces and community committees helped sustain engagement. In Ethiopia, participants described rescheduling meetings at short notice, shifting to safer locations, and engaging religious leaders to legitimise discussions and reduce suspicion from armed actors.

Remote communication emerged as a shared strategy across both settings. Somaliland champions received materials via WhatsApp when external staff could not travel, while Ethiopian facilitators and teachers used phone calls to supervise activities, coordinate with volunteers, follow up on cases, and maintain contact when movement was unsafe.

Local safety protocols were another common feature. Somaliland implementers used pre-travel risk assessments and avoided areas classified as red zones, where organisations were required to withdraw entirely. In Ethiopia, communities sought permission from local armed actors before meeting, gathered discreetly outdoors when tensions were high, and shortened sessions if movement became risky.

Despite these efforts, respondents in both countries pointed to significant barriers. In Somaliland, families sometimes responded that "*our lives are at risk, and you are talking about FGM,*" highlighting how survival concerns overshadowed prevention efforts. In Ethiopia, similar dynamics emerged as people questioned the relevance of awareness activities amid displacement, food insecurity and the presence of armed groups. Both contexts also faced limitations when implementers could not intervene in planned FGM or early marriage because travel routes were unsafe, schools were closed or government structures had collapsed.

ANALYTIC REFLECTION

In both countries, decentralised, locally driven systems enabled prevention work to continue, and the two contexts share patterns that highlight the centrality of local actors and decentralised systems.

1. **Local champions expand their roles during conflict, often beyond what programmes originally envisioned.**

Across both contexts, local actors took on roles such as mediating safety with armed groups, delivering awareness, monitoring at-risk girls, and integrating FGM messaging into services like Somaliland's Women Safe Spaces or Ethiopia's maternal health visits. These roles arose organically from insecurity, not through formal design. Champions often made risk-sensitive decisions, such as shifting discussions to safer locations, altering schedules, or using discreet channels. Programme teams continued remote supervision, shared materials via WhatsApp and phone, guided safety protocols, and supported community work. Local actors, embedded and mobile, carried out on-ground tasks, but their efforts were supported and coordinated by programme staff. This shows that programme continuity depends on adaptive community leadership and that training must prepare local actors to deliver content and to navigate risks and suspicions from the armed forces.

2. **Religious leaders hold unique catalytic power in both contexts, though for different reasons**

In Somaliland, religious leaders were decisive in countering religious rationales for FGM and opening space for families to rethink the practice. In Ethiopia, religious leaders were central because they maintained influence during conflict, had trusted access to families during key life events, and could reinforce messages even when public gatherings were unsafe. In both settings, religious actors were among the few who retained mobility and trust. This reinforces the strategic importance of faith-aligned messaging and long-term engagement with religious institutions, particularly in contexts where access is volatile.

3. **Adaptation is hyper-local, creative, and shaped by gendered safety dynamics**

Both countries demonstrated similar adaptive patterns: discreet household visits, peer-led awareness, shifting venues, phone-based supervision and reliance on small groups or one-to-one engagement. These approaches allowed anti-FGM work to continue when movement was restricted and formal systems were disrupted.

A shared and notable theme is that women often moved more safely than men. In both settings, women delivered messaging in spaces where men could not, either because men were at higher risk of being stopped, questioned, or associated with conflict. This did not make women "safe," but it meant they could

sometimes carry out low-visibility activities that men could not, such as quiet household visits or informal discussions.

This nuance is important for programming: it does not suggest shifting responsibilities onto women or relying on them in ways that increase their exposure to harm. Instead, it highlights the need for conflict-sensitive planning that recognises how gendered mobility operates in practice, ensures robust protection measures for all community actors, and avoids assuming that any group is inherently safe to mobilise during periods of insecurity.

CROSS-COUNTRY DISCUSSION AND CONCLUSION

The comparison of Somaliland and Ethiopia shows that while conflict dynamics differ, both contexts face structural constraints that shape how communities engage with anti-FGM work. Conflict influences what people can do more than what they believe. Attitudes toward FGM, whether shifting or deeply rooted, do not change simply because conflict occurs. What changes are the conditions, such as restricted mobility, disrupted services and the loss of safe spaces for dialogue, that determine whether families can act on their beliefs or access support.

Across both countries, community systems proved more resilient than formal structures. Women's groups, youth networks, religious leaders, health workers and volunteer facilitators continued their roles even when external teams could not reach communities. Their embedded presence allowed awareness, follow up and referral efforts to continue in forms that matched local realities. This reinforces that the strength of anti-FGM work in conflict settings comes from community-rooted systems rather than the continuous physical presence of external organisations.

Adaptation emerged organically from necessity. In both contexts, flexible and hyper-local approaches, such as shifting venues, discreet household visits, small-group dialogue, altered schedules, using phone communication and peer-led messaging, allowed prevention activities to continue. Programmes that relied on fixed delivery models struggled. Programmes grounded in strong community relationships were able to adjust. Planning for conflict therefore requires designing programmes that assume disruption rather than adding adaptation only after instability occurs.

Conflict also significantly weakened health and psychosocial systems in both settings, heightening the risks associated with FGM. Even when awareness efforts continued,

families struggled to reach health facilities and specialised psychosocial support was largely unavailable. This reinforces the need to strengthen referral pathways and ensure that prevention messages are linked to realistic access to care, especially when health systems are unreliable.

Motivation to engage shifted during conflict. Families facing displacement, food insecurity or violence found it harder to prioritise FGM unless it was framed in relation to immediate protection and wellbeing. Integrating FGM discussions into routine health contacts, humanitarian assistance and trusted community platforms improved relevance and reach.

Conflict did not eliminate risk but changed its form. In Somaliland, reduced FGM practice reflected the prioritisation of survival rather than a shift in beliefs. In Ethiopia, weakened oversight increased the possibility of hidden or opportunistic FGM. These patterns highlight the need to distinguish between changes in practice and changes in norms, especially in volatile settings.

Overall, the experiences of Somaliland and Ethiopia point to a shared conclusion. Sustainable progress in ending FGM during conflict depends on the strength of local systems, the adaptability of delivery models and the ability to connect prevention to broader protection and wellbeing. Community-led structures, supported by flexible programme approaches and strengthened service pathways, create the foundations for resilience and continuation even in the most challenging circumstances.

LESSONS LEARNED/ LEARNINGS

Key Takeaways and Actionable Insights

For programme designers and implementers

- **Plan for disruption, not linear progress.** Conflict interrupts access, halts activities and limits community engagement. FGM may pause for practical reasons, but underlying norms remain unchanged. Programmes must be designed so they can stop and restart without losing momentum.
- **Local actors are the foundation of programme continuity.** Women's groups, youth, teachers, health extension workers, religious leaders, and volunteer facilitators sustained anti-FGM activities in both countries when external actors could not access communities. Localisation must be built in from the beginning.
- **Build capacity before instability intensifies.** Champions need training, mentoring and materials early. Once conflict escalates, it becomes difficult to support them remotely. Preparatory work strengthens their ability to continue independently during crisis. They need ongoing mentoring, simple teaching tools, facilitation support, and regular communication.
- **Integrate anti-FGM work with basic needs support.** In both contexts, communities prioritised safety, food, and health. Standalone awareness activities lost relevance when families were facing displacement or insecurity. Linking FGM messaging to broader protection, health and humanitarian assistance increases engagement.
- **Provide multiple delivery pathways from the start.** Household visits, peer discussions, small group meetings, health facility contacts, phone calls, WhatsApp resources, local radio, and safe community spaces helped sustain activities when gatherings were unsafe or movement was restricted.
- **Tailor approaches to gendered safety dynamics.** In both contexts, women, especially health workers and members of women's groups, were sometimes able to move more safely than men. Programmes should be sensitive to who can travel and engage without drawing suspicion.
- **Expand and sustain safe community spaces. Women Safe Spaces, youth clubs, and girls' groups became hubs for dialogue, support, and referrals during**

instability. These spaces are essential and should be prioritised in programme design.

For health and protection systems

- **Strengthen emergency referral pathways.** Conflict disrupted ambulance services, transport, and facility access in both countries. This increased the danger for girls and women facing FGM complications or childbirth risks. Reliable emergency pathways save lives when normal systems collapse.
- **Integrate psychosocial support into trusted spaces. Emotional distress increased sharply in both contexts, especially among girls and displaced families.** Formal psychosocial services were often unavailable. Existing platforms such as Women Safe Spaces, mothers' groups, youth groups, and health posts offer practical entry points for support.
- **Invest in routine health contacts as a platform for prevention.** In Ethiopia, maternal and child health visits provided one of the few consistent opportunities for FGM messaging. Similar opportunities exist in Somaliland through Women Safe Spaces and community health workers.

For policy and coordination actors

- **Do not interpret reduced reporting as reduced practice.** In both settings, limited access, fear, and system disruptions made it harder to monitor cases. Low reporting does not necessarily indicate progress.
- **Coordinate around security realities.** Areas classified as insecure or difficult to reach often had the greatest need but the least coverage. Joint planning, shared access assessments and coordinated risk management can reduce geographic inequity.
- **Engage religious leaders systematically.** Their influence shaped acceptance of anti-FGM messages in both countries. Consistent engagement helps align community beliefs with health and rights-based perspectives.
- **Strengthen collaboration between health, protection, and education systems.** Teachers, health workers, and protection actors played complementary roles. Formal mechanisms for joint action improve reach and responsiveness during conflict.

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