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A 14-year-old girl who spends her days doing household chores, Somali, Ethiopia © Nathalie Bertrams/GAGE 2024

FGM and child marriage in Ethiopia's Afar and Somali regions

Patterns, risks and priority entry points for change

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Introduction

The Ethiopian government is committed to ending female genital mutilation (FGM) and child marriage. The country has a strong legal framework, which outlawed both practices two decades ago, as well as multiple policies and strategies designed to eliminate these harmful practices (28toomany and Orchid Project, 2023). Despite these commitments, and the sustained efforts of the government and its development partners, progress remains highly uneven and too slow to meet targets. Although prevalence rates of both FGM and child marriage are falling at the national level,[1] the absolute number of girls at risk continues to rise, due to population growth (ibid.; UNICEF, 2023). Girls in the pastoralist regions of Afar and Somali are at especially high risk. According to the most recent Ethiopian Demographic and Health Survey (EDHS), rates of FGM among girls aged 15–19 years in both regions are over 90%[2] and static, with most girls subject to the most severe type of FGM – infibulation (Central Statistical Agency of Ethiopia (CSA) and ICF, 2017). Rates of child marriage are also very high. Among young women aged 20–24 years, 67% in Afar and 49% in Somali had been married prior to age 18

1 Between 2005 and 2016, the percentage of girls aged 15–19 years who had undergone FGM fell from 65% to 52% (Elezaj et al., 2019). Between 2005 and 2016, the percentage of young women who married prior to age 18 fell from 49% to 40% (Erulkar, 2022).

2 In Afar, 91% of all women aged 15–49 years had undergone FGM. With the caveat that few girls aged 15–19 were included in the sample, of those girls, 91% had undergone FGM. In Somali, 99% of all women aged 15–49 years had undergone FGM. With the caveat that few girls aged 15–19 were included in the sample, 95% had undergone FGM. Regional figures for girls aged 15–19 are authors' own calculations, using unweighted EDHS data.

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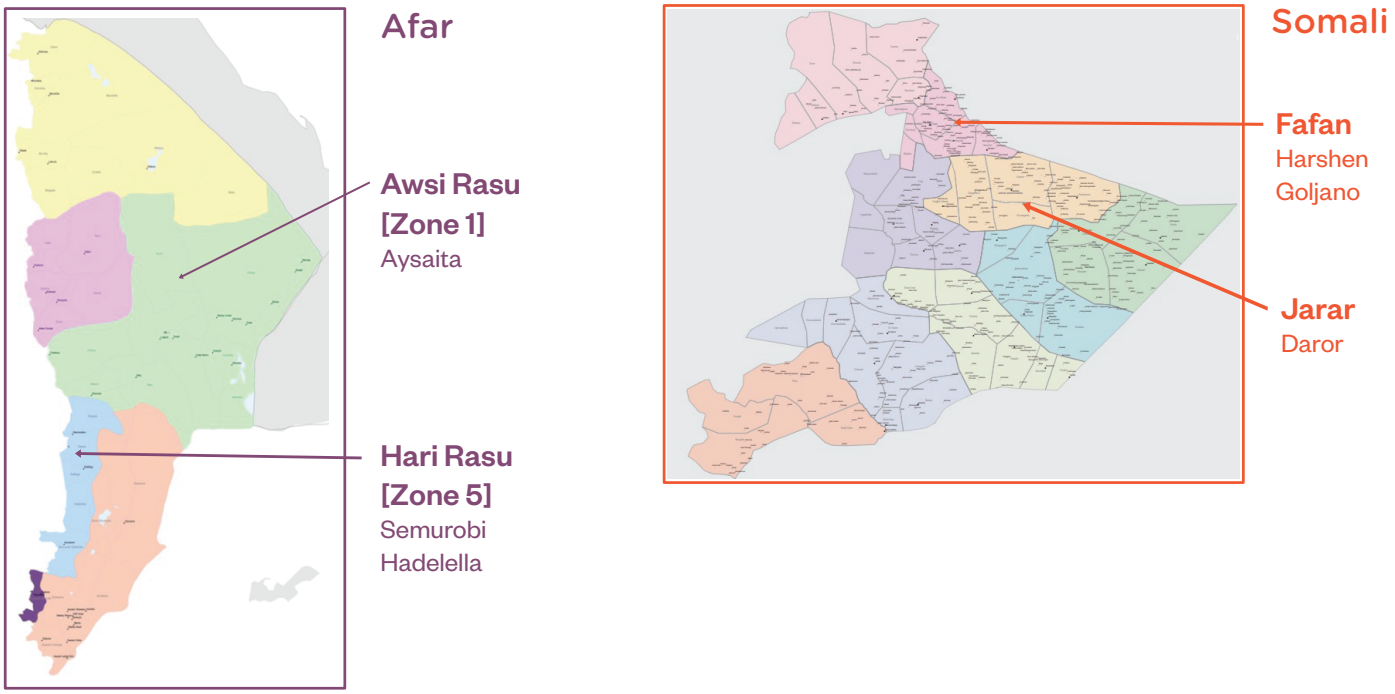
Figure 1: Research locations



(ibid.; Erulkar, 2022). Indeed, despite national-level progress, it appears that in both Afar and Somali child marriage may be becoming more common (CSA and ICF, 2017; Elezaj et al., 2019; Erulkar, 2022).

This policy brief draws on data collected in 2024, in two zones of Afar and two zones of Somali, as part of an Irish Aid-funded multi-year, mixed-methods longitudinal study designed to explore girls' and women's social and economic empowerment, especially regarding the risks of FGM and child marriage. It builds on baseline research conducted in 2022 (see Endale et al., 2022), and summarises the findings of a longer report (Endale et al., 2025). The brief begins with an overview of our research methodology, then turns to our main findings on FGM and child marriage. We conclude with implications for fast-tracking policy and practice changes in line with the Ethiopian government's commitment to the Sustainable Development Goal (SDG) 5 target to eradicate FGM and child marriage by 2030.

Research methodology

The Gender and Adolescence: Global Evidence (GAGE) programme undertook mixed-methods research in early 2024 in Afar and Somali regions (see Figure 1). In each region, data was collected in three *woredas* (districts), in two zones. The GAGE midline quantitative sample included 1,881 adolescents and young adults (aged between 12 and 21 when surveyed) and 1,912 caregivers (see Table 1). Surveys were administered in respondents' native language (Afar Af' and Somali respectively), and included modules on FGM, child marriage, education, livelihoods, sexual and reproductive health, mobility and decision-making and gender norms. It is important to note that adolescent girls were surveyed only about their own experiences (including with FGM), while caregivers were surveyed about the experiences (including with FGM) of all females in the household. Our qualitative sample was also drawn equally across regions. It included 65 adolescent girls and young women, 67 adolescent boys and young men, 102 caregivers, and 113 key informants from *kebele* (community), *woreda* (district) and regional levels (see Table 2).

Table 1: Quantitative sample

		Afar	Somali	Total
Young people	**Total**	**961**	**920**	**1881**
	Female	824	705	1529
	Male	137	215	352
Caregivers	**Total**	**976**	**936**	**1912**
	Female	897	833	1730
	Male	79	103	182

Table 2: Qualititative sample

	Afar	Somali	Total
Girls and young women	33 (half married)	32 (half married)	65
Boys and young men	32 (half married)	35 (half married)	67
Mothers	36	34	70
Fathers	16	16	32
Key informants	58	55	113
Total	**175**	**172**	**347**

Findings

Female genital mutilation

Incidence, type and age of practice

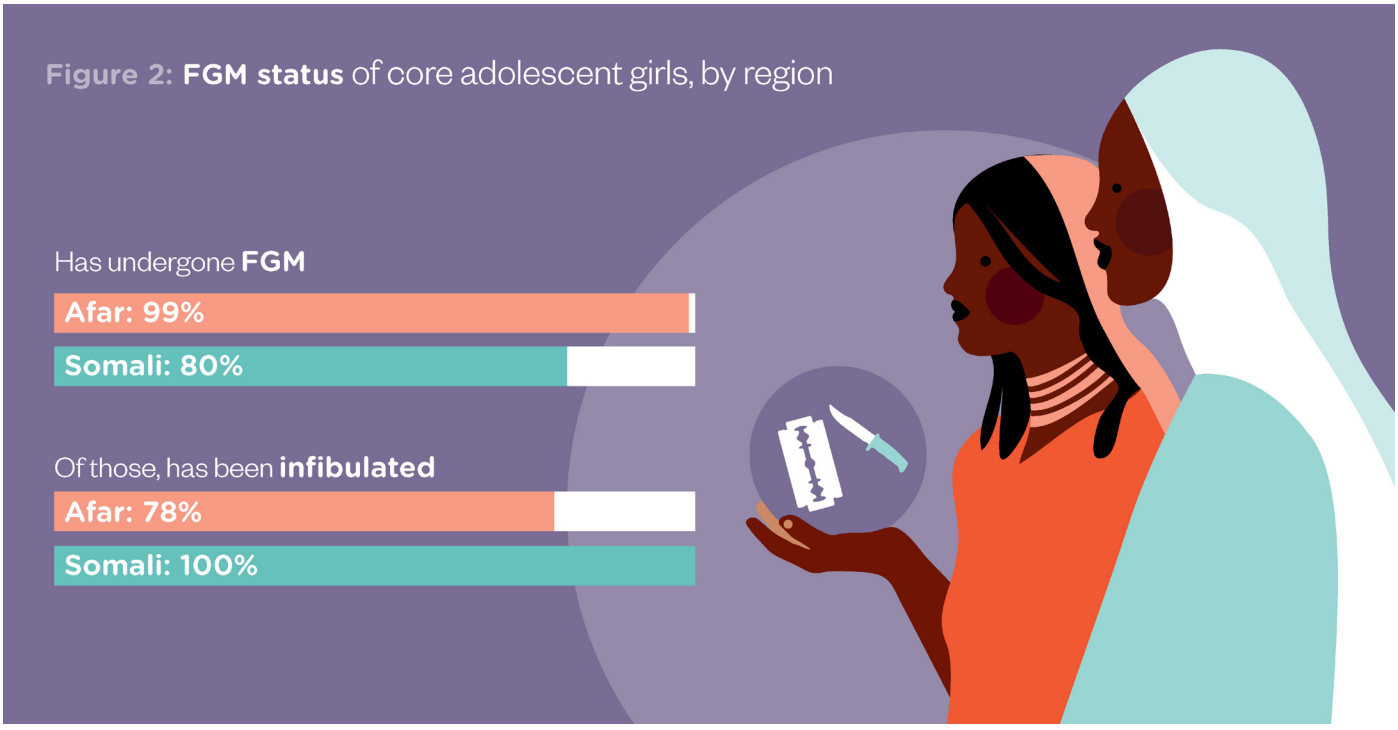
The survey found that of core adolescent girls and young women, 99% of those in Afar study sites and 80% of those in Somali study sites had undergone FGM (see Figure 2). Differences in rates reflect differences in the timing of the practice: in Afar, girls undergo FGM in infancy or toddlerhood, depending on which *woreda* they live in (mean age of 2 years); in Somali, where the age of FGM is dropping in tandem with the age of marriage (because girls who are found to be uncut at the time of marriage are shamed, alongside their families), girls typically undergo FGM between middle childhood and middle adolescence (mean age of 9.3 years), meaning that the young adolescent girls who have not yet undergone FGM still have time to do so in the future.

In both regions, FGM remains all but universal. A Somali *kebele*-level Women's Affairs key informant stated: '*It is unthinkable that a girl would not undergo circumcision.*' In Somali study sites, 100% of girls and young women who reported having undergone FGM stated that they had undergone Type 3/infibulation and had been sewn shut with stitches or thorns. A 19-year-old Somali young woman reported of her experience, '*They sew the body part with thorns after cutting… Healing took more than a month.*' In Afar study sites, and with the caveat that the vast majority of girls undergo FGM when they are very young, 80% of girls and young women reported having been infibulated – with scar tissue rather than stitching. Of Afar girls and young women who had not been infibulated, nearly all reported Type 2/excision. An Afar father explained traditional practices:

> *They first remove the girl's clitoris from its base and then they will also cut the flesh in the right and left of the girl's clitoris. After they remove the clitoris and the entire flesh, they will tie the girl's thighs using rope so as to make the cut organ stuck with blood and to close or tighten their genital hole.*

Age-related trends in FGM practice

The caregiver survey asked caregivers about the FGM status of all females living in the household. Three findings stand out. First, nearly all (96%) Somali girls aged 15–17 years were reported as having undergone FGM. Second, even though FGM has traditionally been practised in very early childhood in Afar, girls aged 6–8 (86%) and 9–11 (91%) were less likely to have undergone FGM than those aged 12–17 (97%). Although these figures must be interpreted with caution,[3] they suggest that rates of FGM may be declining in Afar. Third, while the prevalence of Type 3/infibulation (among those who have undergone FGM) is largely static across age groups in both Afar and Somali, it appears that the extent to which girls' genitalia are removed prior to closure has slowly reduced over the past few years. In Afar study sites, of girls and women aged 9 and over who had undergone FGM, just over three-quarters were reported as being infibulated. Of girls aged 8 and under who had undergone FGM, the rate was nearly as



3 This is because there are relatively fewer younger girls living in sampled households (due to sample construction, which was focused on adolescents).

high – just under three-quarters. However, although 56% of Afar women over the age of 18 and 48% of Afar girls aged 12–17 had had their inner and outer labia removed prior to closure, the same was true of '*only*' 35% of Afar girls aged 8 and under. Similar shifts are evident in Somali study sites. Although 90% of all females in the household who had undergone FGM were reported as infibulated, regardless of age group, there was a slow decline in the percentage who had had their inner and outer labia removed prior to closure: 51% of adults aged 18 and over, 44% of girls aged 12–14, and 37% of girls aged 6–11.

Qualitative research suggests that it is premature to interpret declining FGM rates across age cohorts in Afar study sites as a sign that the practice is becoming less common. Although several respondents reported that there is a growing cohort of younger girls who have not undergone FGM, this was primarily attributed to women being materially rewarded for eschewing the practice – and also linked to shifts in when FGM is carried out. A 15-year-old boy from Afar explained:

> *I have a 7-year-old sister who is not circumcised. She also has many uncircumcised friends… We will do it in the future.*

With the caveat that respondents in both regions often consider only traditional (more invasive) practices to constitute FGM, and even more often consider any deviation from those traditional practices to constitute *sunna* (permitted), qualitative research did find evidence of shifts towards '*milder*' forms of FGM, albeit mostly in more urban areas. In Afar study sites, respondents reported that younger girls have less flesh removed and/or that girls' legs are tied together for less time after the procedure, resulting in less scar tissue. A father from Afar stated, of his daughters:

> *My first daughter was circumcised in the old way, and my other daughters are not circumcised… My first daughter has suffered a lot due to her circumcision. After I had observed her pain, I decided to circumcise my other daughters in a new way.*

In Somali study sites, respondents reported that younger girls have less flesh removed and/or that girls are stitched only once or twice, rather than six or seven times. A 22-year-old Somali young woman stated that only the degree of stitching varies: '*Sunna varies only with the sewing. Removing the genital organ is the same.*'

Awareness of legal prohibitions against FGM

Awareness of legal prohibitions against FGM also differs significantly across and within Ethiopia's regions. The survey found that young people (52%) and caregivers (61%) in Afar study sites were far more likely than young people (18%) and caregivers (27%) in Somali study sites to be aware that there is a national law[4] prohibiting FGM (see Figure 3). That said, during qualitative interviews, it was not uncommon for respondents in both regions to identify penalties (aimed at traditional cutters and parents who practice infibulation) as the reason why FGM practices are shifting. A 17-year-old girl from Somali reported that traditional cutters are no longer stitching girls with five to seven stitches because they are afraid of going to jail:

> *No circumciser wants to stitch girls. If they are found doing that, they will be taken to the woreda town and imprisoned there.*

In Afar study sites – where exposure to other cultures is more common, where health extension workers are more willing to tackle FGM, and where more gender-focused non-governmental organisations (NGOs) have been more active for longer – respondents also reported that these have contributed to shifts.

Religious and cultural beliefs underpinning FGM

Most respondents, however, were forthright that although legal and health messaging has been important in encouraging change on FGM, the linchpin to nascent progress has been religious leaders' preaching. The main message from faith leaders is that while infibulation must be abandoned, removal of the clitoris is allowed – or even required – by Islam.[5] A father from Afar explained, '*We accepted that teaching since it was in line with what our religion, Islam, says about the practice of circumcision.*'

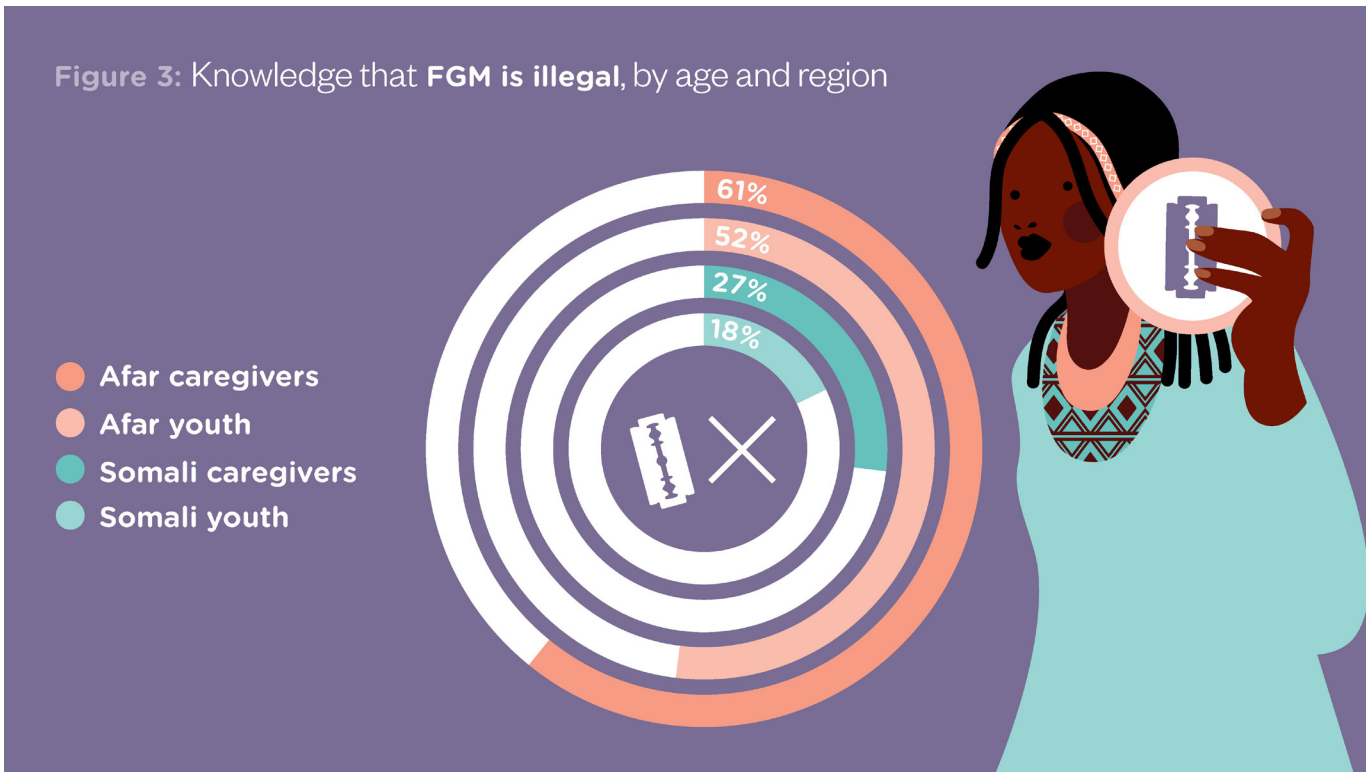
Beliefs about the relationship between FGM and religion are complex and difficult to disentangle, given that milder forms of FGM are sometimes not conceptualised as FGM, and given that Islam is seen as a core feature of both Afar and Somali culture. In Afar study sites, where respondents were more likely to recognise that clitorectomy is a form of FGM, because of their exposure to neighbouring Amhara customs, most young people (66%) and caregivers (76%) reported that FGM is required by religion (see Figure 4). A 22-year-old mother stated:

> *I didn't want my daughter to be uncircumcised… It is very bad. If she dies, she will not get into heaven if she is not circumcised.*

4 Neither Afar nor Somali have ratified the national law. At the regional level, FGM remains legal.

5 There are four main schools of thought regarding Islam and FGM. For details, see Islamic Relief Worldwide (2018) *One cut too many*: Islamic Relief policy brief on female genital mutilation/cutting. In Somali, regional faith leaders issued a ruling in 2023 that came out strongly against infibulation.

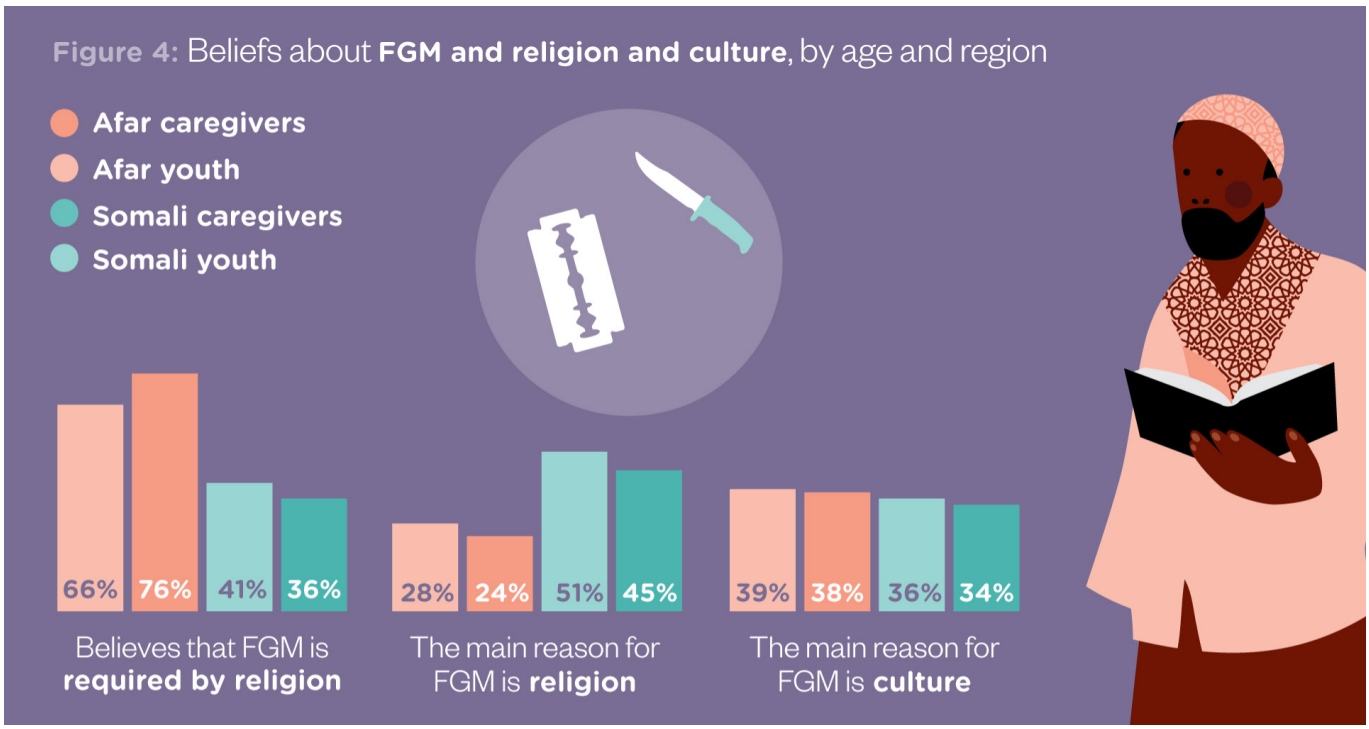
Figure 3: Knowledge that **FGM is illegal**, by age and region



That said, when asked to identify the *main* reason for FGM, Afar respondents were more likely to report cultural identity than religion (e.g. 39% versus 28% for young people). A mother expressed pride that FGM – and infibulation – sets Afar culture apart from those around it: '*We are circumcised and that's why we circumcise our children. No one else has this culture except us.*' In Somali study sites, where respondents were particularly likely to consider only traditional infibulation as FGM, a minority of caregivers (35%) and young people (41%) reported that FGM is required by religion. However, when asked to identify the *main* reason for FGM, both groups of respondents were more likely to choose religion than culture (e.g. 45% versus 34% for caregivers). An educator from Somali explained:

> *With regard to the religion, it is a direction given, that a person should start prayers from the age of 10. As per the religion, girls should get cut at that age. Otherwise, the prayers of the girls may not be accepted by God. That is the belief among the community.*

Figure 4: Beliefs about **FGM and religion and culture**, by age and region



A 20-year-old young man clarified that Islam requires only FGM, not infibulation – which continues to be seen by many, especially in more rural areas, as a cultural requirement: *'The religion tells us only about circumcision but not about stitching the girl… It is because of the culture.'*

Benefit-risk calculi about FGM

The survey found that in study sites in both regions, it was common for young people and caregivers to believe that FGM has social benefits. Rates ranged from a low of 35% for young people in Somali to a high of 52% for caregivers in Afar (see Figure 5). The reported benefits of FGM varied by region and, in Somali, by gender. In Afar study sites, the primary benefit ascribed to FGM – by respondents other than girls and young women, who often admitted that they had merely heard that there were benefits but did not personally believe them – was managing girls' (and women's) sexuality. A father stated:

> *If girls are not circumcised, they will have high sexual desire and will not stay only with one man/husband and will engage in adultery or they will start sexual intercourse before marriage.*

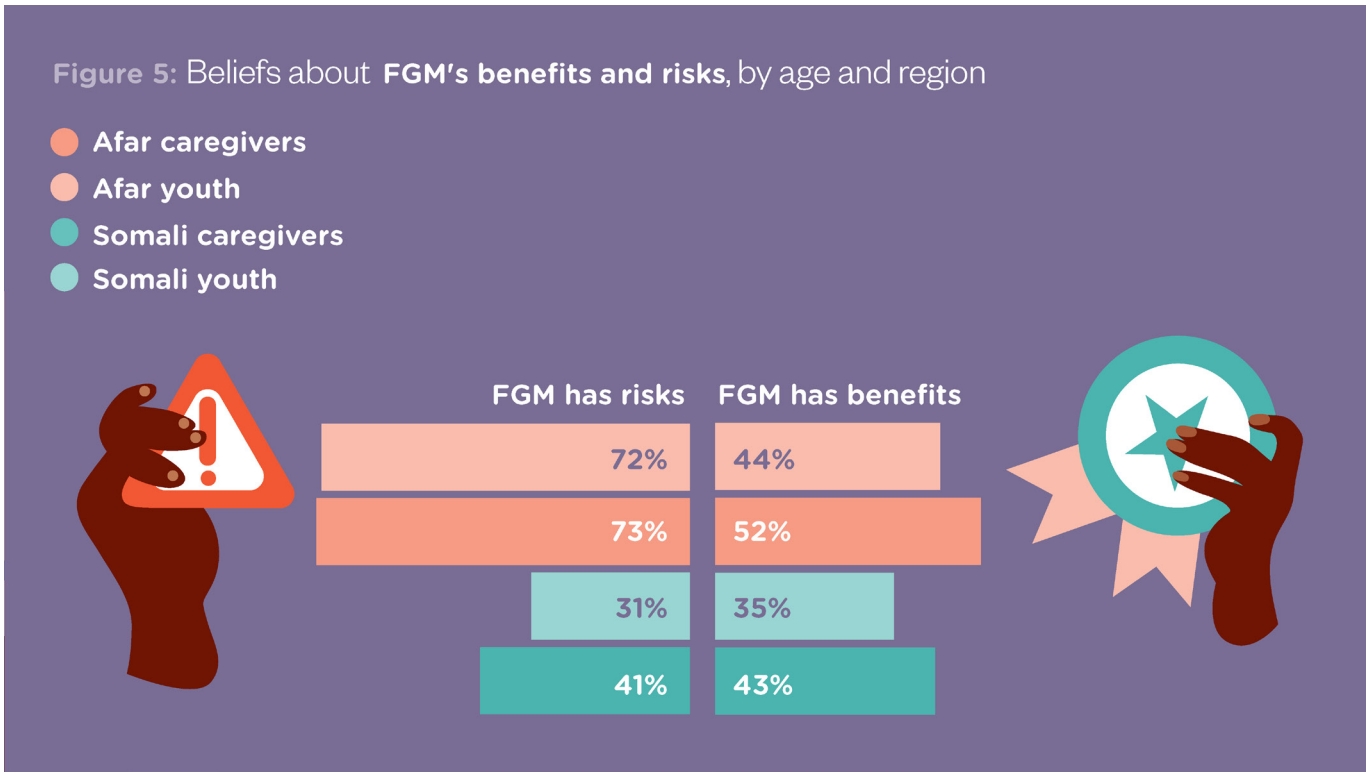
In Somali study sites, female respondents most often spoke of FGM as necessary to girls' (and mothers') place in the community. A mother explained:

> *It is shameful for us not to be circumcised. Since I am Somali, she should be circumcised. If I do not circumcise my girl, others insult me, labelling me as a woman who does not circumcise her daughter. Moreover, the girl will be harassed and labelled as the one who is not circumcised.*

Boys and men, on the other hand, emphasised that FGM is required for girls to be marriageable, because it ensures girls' virginity. A 15-year-old boy stated, *'Female children will not marry if they didn't perform FGM.'* In both regions, FGM was also perceived to protect girls from rape (by effectively closing their vaginas).

There were stark regional differences in beliefs about the risks of FGM, with respondents in Afar study sites approximately twice as likely to report risks as those in Somali study sites (among young people, 73% and 41% respectively) (see Figure 5). Respondents in Afar often reported that FGM results in excruciating pain for girls, can result in a lifetime of urinary and gynaecological infections, makes sexual intercourse painful (for women and men alike, given that grooms are expected to defibulate their wife on the wedding night, in effect battering the vagina open – and even calling on male peers to assist if the process is protracted in the first week(s) of marriage), and makes childbirth difficult and dangerous for the mother and baby. By contrast, their peers in Somali regularly denied that the practice entails any risks at all. A 21-year-old young woman from Somali, when asked if she had suffered health consequences because of infibulation, responded, '*There are none… It was good for us.*' Somali young men were especially oblivious to the risks of FGM. A Somali young man, aged 21, who expressed anxiety over the caesarean

Figure 5: Beliefs about **FGM's benefits and risks**, by age and region



birth of his child, reported that there was no association with FGM:

> *My child was born via surgery. I was in a very serious worry at that moment... My sister has given birth to seven children. In all cases, she went for surgery. It is normal to go for surgery.*

Interestingly, given regional discrepancies in awareness of the risks of FGM, it was only in Somali study sites that we found evidence of emergent medicalisation of the practice. Although the survey found that most girls in Somali, like their peers in Afar, undergo FGM at the hands of traditional cutters, some Somali qualitative research participants reported that girls are increasingly cut by health care workers, who perform Type 1/ clitorectomy to prevent girls being subject to Type 3/infibulation by traditional cutters. Other Somali respondents reported that traditional cutters are now providing girls with painkillers and antibiotics when they undergo FGM, and again when they marry and must be defibulated with a knife in the hours before they are expected to begin conjugal relations.

Young males' support for FGM

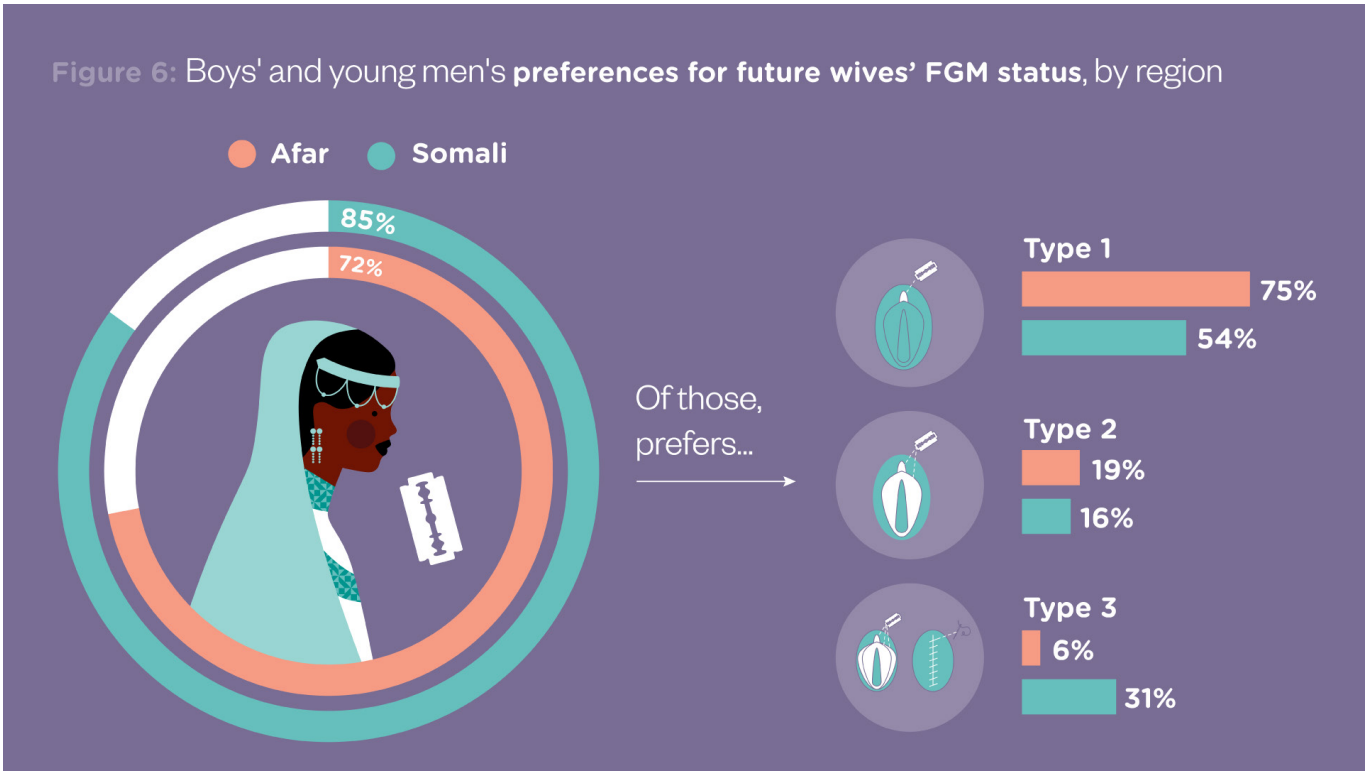
FGM also has complex associations with notions of traditional masculinity. In both Afar (72%) and Somali (85%) study sites, most boys and young men reported that they prefer to marry a wife who has undergone FGM (see Figure 6). In Afar, where young males' dominant preference is for a wife who has undergone Type 1/clitorectomy, preferences aligned with broader beliefs about the benefits of FGM and were almost entirely driven by beliefs about girls' (and women's) hyper-sexuality. A 22-year-old young man explained that:

> *Currently boys/men in our locality are well aware about the effects of practising the previous type of FGM, so that they can marry girls whose clitoris is cut. But no one can marry a girl who is not circumcised at all. Because, cutting the clitoris of the girls benefits girls to reduce their sexual desire.*

In Somali study sites, where 31% of young males reported preferring a wife who has undergone Type 3/infibulation, preferences were again aligned with broader beliefs about the benefits of FGM and were driven by concerns about girls' premarital sexuality. A 19-year-old young man explained, '*She'll be considered as a divorcee* [if she is not sewn]... *Men want a virginal woman*.' Another Somali young man the same age added that while he and his peers prefer an infibulated wife, their commitment to infibulation pales beside their mothers' commitment to the practice: '*Men don't want the girl to be open, but it's the mothers who are the number one supporters.'*

Attitudes towards continuation of FGM

Unsurprisingly, given interwoven beliefs about religion, culture and girls' sexuality, support for the continuation of FGM is high – particularly in Somali study sites, where awareness of the risks of the practice appears to be low. In Afar, 30% of surveyed young people and 38% of surveyed caregivers reported that FGM should continue



(see Figure 7). Analogous figures in Somali were 54% and 55% respectively. Interestingly, when asked if they plan to subject their own future daughters to FGM, young people's answers did not align with their preferences for continuation of the practice. In Afar study sites, young people were more likely to report that they intend to practice FGM on their own daughters than they were to support continuation (40% versus 30%) (see Figure 8). In Somali study sites, the reverse was true, with young people less likely to report that they intend to practice FGM on their own daughters than they were to support continuation (46% versus 54%). As was the case with boys' and young men's preferences for their future wife, surveyed young people in Afar overwhelmingly (92%) reported intention to practice Type 1/clitorectomy on their future daughters. In Somali, most young people reported their intention to choose either Type 2/excision (39%) or Type 3/infibulation (20%).

Figure 7: Support for the continuity of FGM, by age and region

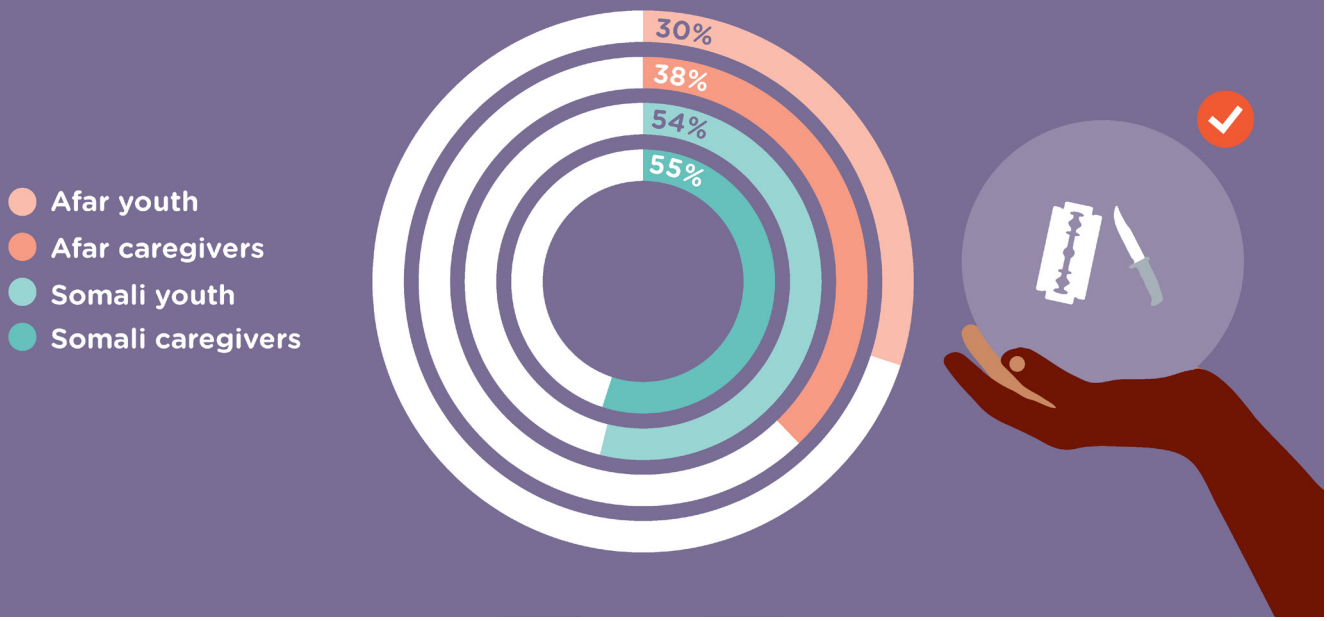
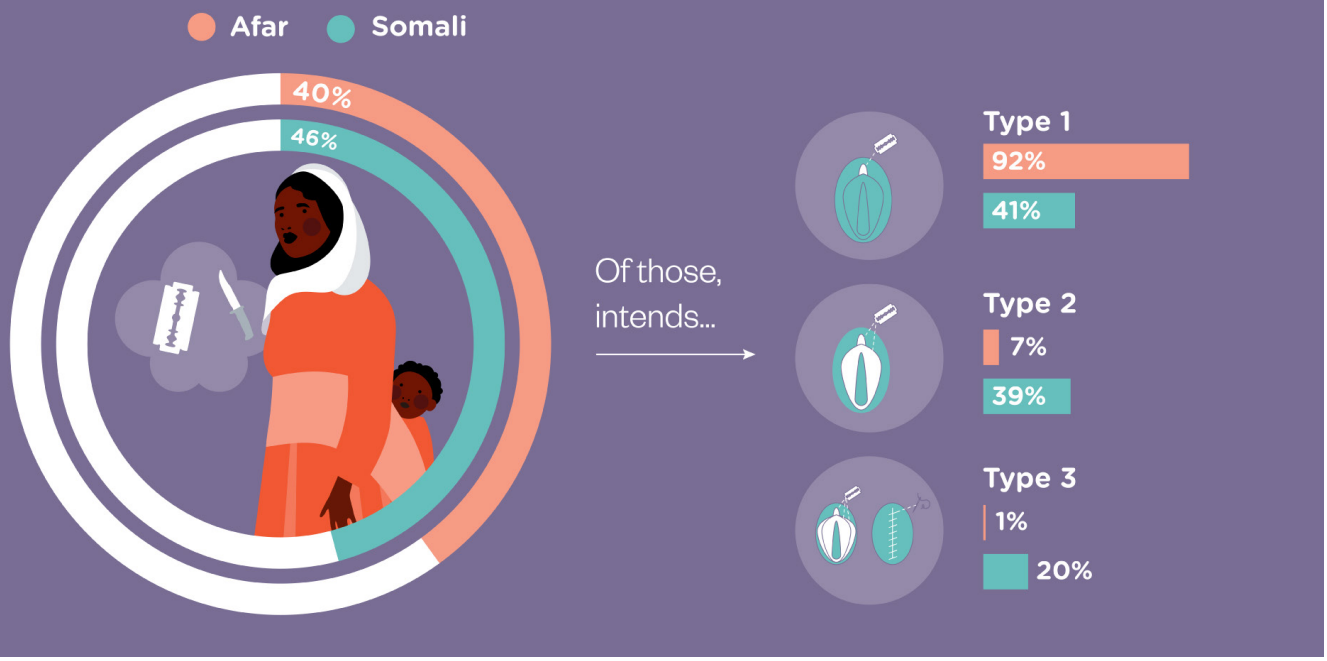


Figure 8: Intention to practice **FGM on future daughters**, by region



Caregiver beliefs and decision-making about FGM for daughters

Programming designed to eliminate infibulation and, eventually, FGM, must take account of regional differences in mothers' and fathers' beliefs about FGM. In both Afar and Somali study sites, mothers – whose own social status is tied to their adherence to FGM customs and who were more aware that their daughters would be socially isolated were they to eschew FGM – were 10 percentage points more likely than fathers to report that FGM has benefits and is required by religion (see Figure 9). In Afar, where several fathers reported that they had insisted on less invasive FGM for younger daughters after observing the suffering their older daughters had experienced due to being cut, mothers were 14 percentage points less likely than fathers to report that FGM entails risks (71% versus 85%).

FGM decision-making also varied by region. In Afar study sites, respondents reported that while mothers –and maternal grandmothers – were responsible for determining when and by whom daughters would undergo FGM, fathers have some input into the type of FGM their daughters undergo. This implies that it is vital to target fathers and future fathers, in addition to mothers and future mothers, with awareness-raising about all aspects of FGM. In Somali study sites, on the other hand, respondents agreed that FGM decision-making is the realm of mothers, with fathers and grandmothers excluded from decision-making. This suggests that programming in this region should focus on mothers and future mothers, and how mothers shape and perpetuate their sons' preferences for the FGM status of any future wife. A Somali mother reported that:

> *In Somali culture, women are the decision-makers regarding female circumcision… Even if the husbands do not allow the girls to get circumcised, the mothers will force them to be circumcised… I circumcised two of my girls when my husband went to another place. Had he been here, he would not allow me to perform the procedure… He was really angry with me!*

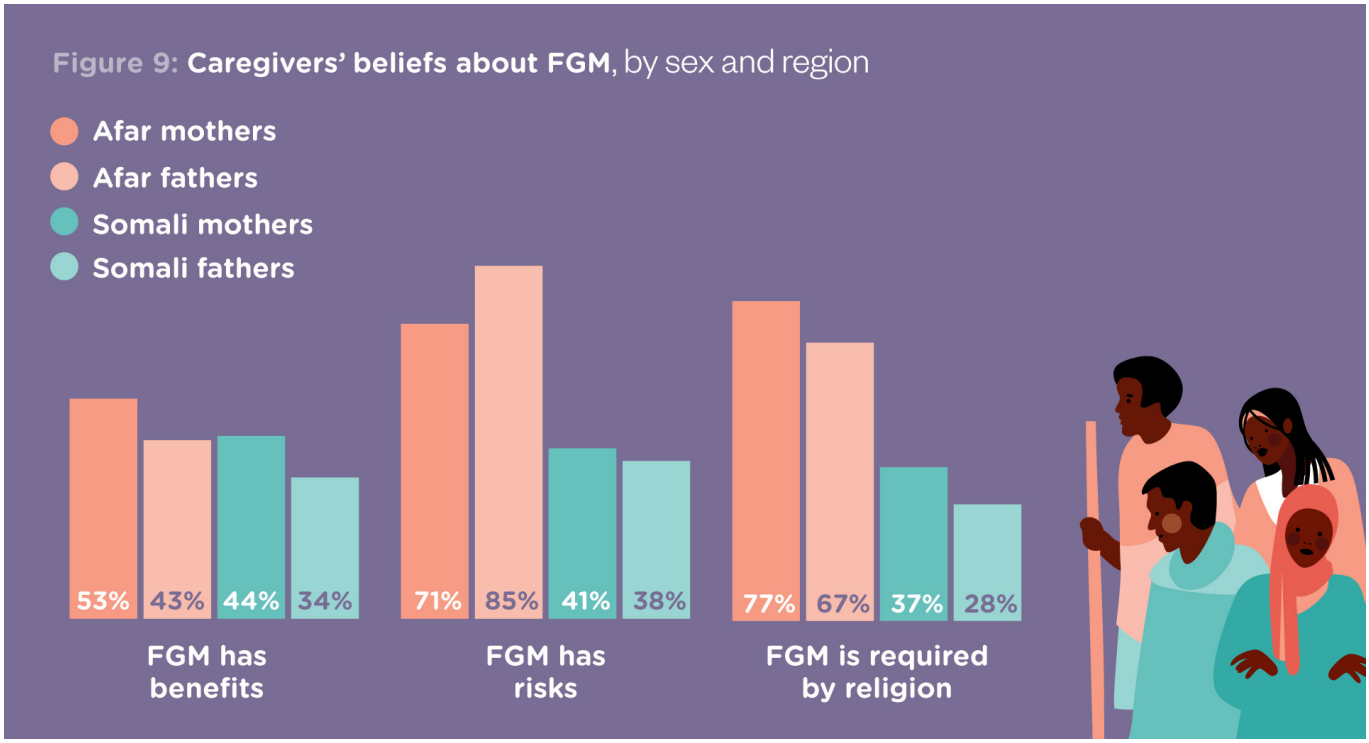
Child marriage

Age at marriage, and type of marriage

Because the average sampled young female was only in middle adolescence at the time of midline data collection (mean age of 16 years in Afar and 15.7 years in Somali), it was rare for respondents to have been married. In both regions, only 5% of surveyed young females had ever been married. In Afar, girls who had married had done so at a mean age of 17.3 years, to men on average 4.6 years older. Nearly all Afar brides (95%) reported that their marriage had been arranged by their parents following the *absuma* custom, which dictates that marriage partners are maternal cousins; girls have no input in the choice of spouse or timing of the marriage. A 21-year-old Afar mother recalled:

> *I only heard about marrying him [her husband] on the day of the marriage ceremony. They caught me and informed me about it on that very day… It was my father who decided that I should marry.*

In Somali, where marriage customs are very different, of girls who had married, marriage took place earlier (mean age of 16 years), age gaps between partners were smaller



(mean of 2.2 years), and nearly all marriages (94%) were decided by the two young partners themselves. An 18-year-old Somali young woman, who married at age 15, stated of her choice to marry, *'My family didn't know anything about it. I decided on my own.'*

Trends in child marriage practices

Although at midline it was rare for girls and young women to have been married, the survey found that in study sites in both regions, child marriage is believed to be not only common, but typical. In Afar (84%) and Somali (83%), just over four-fifths of caregivers reported that most girls in the community marry prior to age 18 (see Figure 10). In Somali, nearly as many young people (75%) agreed. Afar young people were less likely to believe that child marriage is typical, with 'only' 60% believing that most girls marry prior to age 18.

Beliefs about the prevalence of child marriage are especially interesting when juxtaposed with mothers' own experiences: in Afar study sites, 88% of mothers had married prior to age 18; in Somali study sites, that figure was only 58%. The survey also found that beliefs about the prevalence of child marriage are relatively unencumbered by knowledge that child marriage is illegal under national law,[6] especially in Somali, where only 13% of young people reported being aware of the law (see Figure 11).

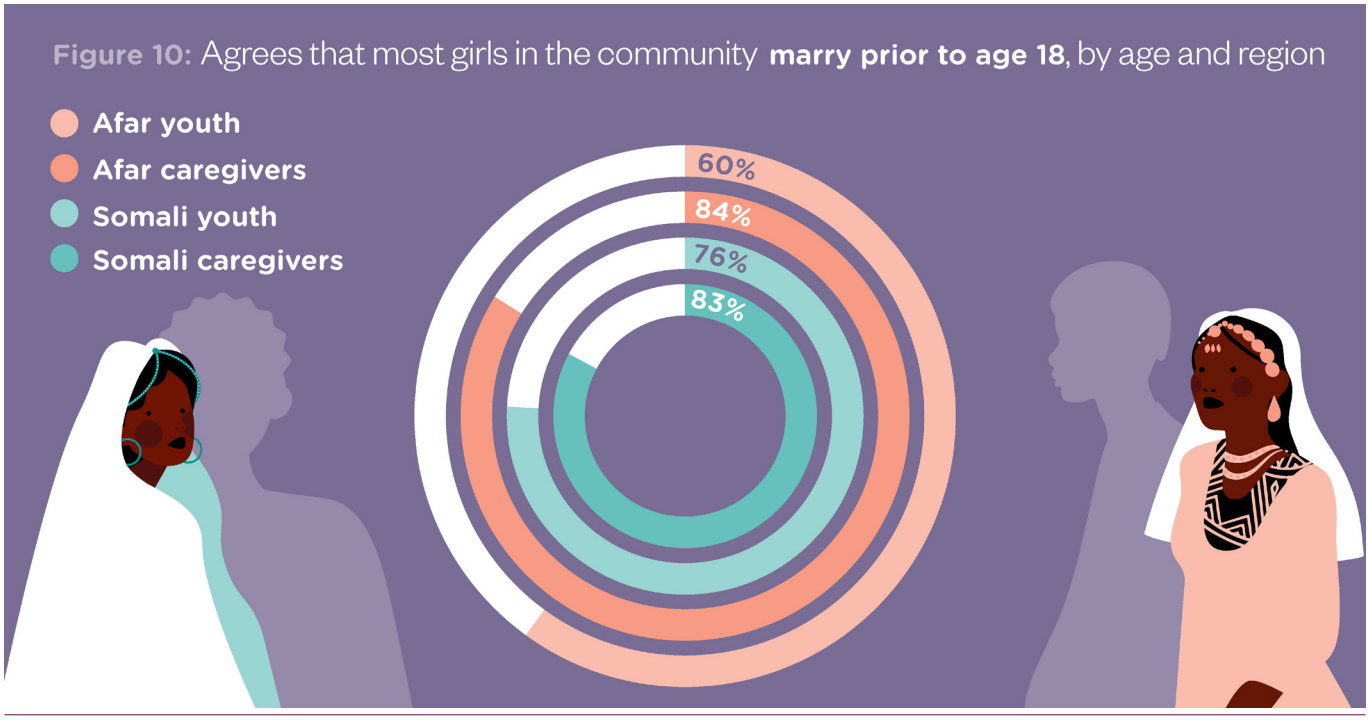
Qualitative research adds nuance to these survey findings. In Somali study sites, where less than half of young females (47%) have ever been enrolled in school (because not all rural communities have a school, because girls are responsible for fetching water, and because parents often think that, according to one mother, '*sending the girls to school turns them into a whore')*, respondents reported that not only has child marriage become more common in recent years, but that the age at marriage has also plummeted as young people have taken over marriage decision-making. A clan leader from Somali reported that:

> *Most girls are usually married before they turn 18… I would estimate that 70% of marriages involve individuals under 18 years old.*

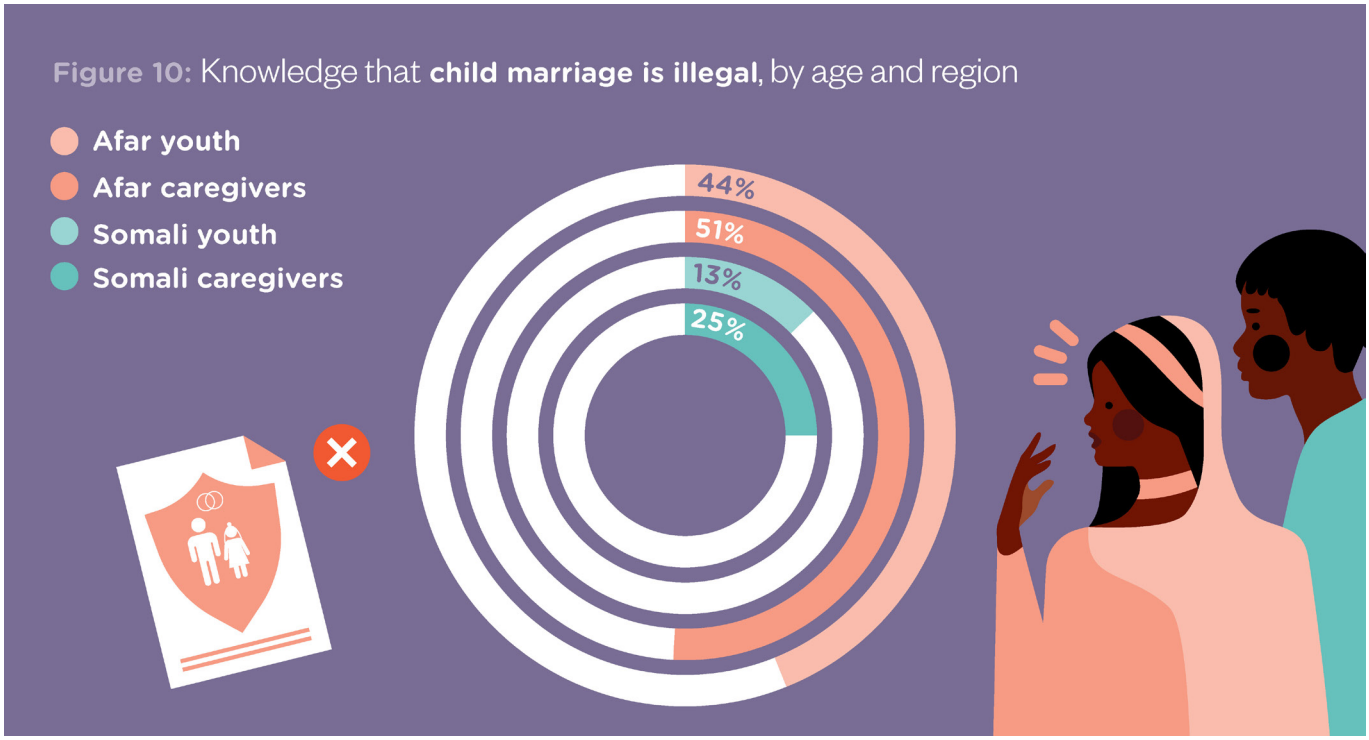
A *kebele* chairperson from that region added, '*I have seen girls as young as 10, 12 and 13 getting married.*' In Afar study sites, on the other hand, while many girls do marry prior to adulthood (especially in more rural areas, where parents focus on '*the girl's physical growth, if she is starting menstruating',* according to one father), the age of marriage in study sites is generally creeping up in tandem with girls' enrolment (67%) and parents' awareness of the risks. An 18-year-old young man from Afar explained that:

> *During the previous time, girls in our locality got married at a young age, like 13, 14 or 15… But now, because of the effort that has been done by NGOs, religious leaders and the Sharia men, the age of marriage for girls has been raised a bit, and now, girls here get married after they turned age 17.*

Afar respondents noted that girls' access to education has been especially important to recent progress on reducing child marriage. Schools teach girls that child marriage



6 Regional governments have not yet ratified this law.



is illegal, that they have a right to refuse, and that early pregnancy is dangerous. They also afford young people a venue for reporting planned marriages in time to have them cancelled by the authorities, and situate girls as students, rather than potential brides. An 18-year-old unmarried young woman from Afar described how:

> *They asked me to marry starting from when I was in 9th grade. They had been asking me to marry for three years but my father is not willing to marry me off. He said that since I am a student, he wants me to marry after completing my education.*

Several respondents in Afar also lauded the efforts of religious leaders to prevent child marriage, especially when girls are resisting. Indeed, in a more urban area, one respondent reported that a religious leader had worked with *woreda* officials to have a girl's parents – and the *kebele* leaders –imprisoned for their role in forcing the child to marry.

Adolescent preferences for age at marriage

Despite believing that most girls marry prior to adulthood, a large majority of surveyed young people in both Afar (88%) and Somali (84%) reported that they personally prefer to marry as adults. In Afar, this preference largely follows from how marriages are transacted. Girls who are married in adolescence have no input into decision-making; they marry who and when their parents (usually their father) decide and are not uncommonly made to leave school to do so. Girls who marry in young adulthood, on the other hand, not only avoid the risks of pregnancy before their body is mature, but have more of a say in which cousin they will marry. A father explained that girls often refuse much older cousins:

> *Currently, girls and women are aware about their rights so that if an old man who is the girl's absuma wants to marry a girl, she will refuse him... Girls now want to marry young boys who are their age mates.*

In Somali study sites, young people's reported preferences for adult marriage stand out in stark opposition to broader narratives, which underscore that even when parents try to intervene to delay marriage, adolescents refuse to listen, largely because they see it as the best route to claiming adult status among their peers. A 20-year-old young woman, who married at age 15, recalled that she had ignored her parents:

> *My parents told me I should not have married early as I can marry when I grow well... I told my parents marriage happens with the will of God. Marriage is decided by God...*

A 20-year-old young man, who married at age 11 to a girl a year younger, explained that his choice had been shaped by watching his peers: *'We know that marriage is a good thing. Everyone knows that. We see people getting married and we attended weddings before.'* Unlike in Afar, we found no evidence in qualitative research that religious leaders in Somali intervene to prevent child marriage. Indeed, several insisted that they would never try to dissuade young couples from a hasty marriage because they believe that child marriage is preferable to premarital sex.

Conclusions

In line with existing research, GAGE research finds that FGM remains effectively universal for girls in Afar and Somali study sites, although because of variation in *when* girls undergo FGM, not all adolescent girls in our Somali sample had yet undergone the procedure.

The type of FGM girls undergo is a matter of some debate in both regions, because current practices are understood by respondents predominantly in relation to traditional practices, which are extremely invasive, and because respondents (especially those in more urban areas) are anxious to frame current practices as *sunna* (permitted). Although a large majority of girls in both regions have been subjected to genital narrowing, the amount of flesh removed prior to narrowing, and the degree of narrowing itself, appears to be very slowly 'improving' over time, due to cooperative efforts by the government, NGOs, and religious leaders – who advocate for clitorectomy rather than infibulation.

Differences between regions notwithstanding – with respondents in Afar study sites generally more aware of risks, less likely to support continuation of the practice, and more open to 'milder' types of FGM than their peers in Somali – in study sites in both regions, support for the practice remains strong. This is due to beliefs that FGM is required by religion, is necessary for the replication of culture, and controls girls' sexuality and makes them fit for marriage. Indeed, in Somali study sites, we found that adult women and future grooms often expressed not only support for FGM, but specifically for infibulation, which they identified as the only way to ensure that a bride was a virgin. In Somali, we also found some evidence of medicalisation (of both FGM and defibulation), and that adults and young people agree that FGM is entirely the purview of women. In Afar, we found that fathers had more of an input into what type of FGM their daughters undergo, and some willingness to abandon the practice entirely.

As the average young person in our sample had not yet turned 16 years old when surveyed at midline, few had been married. We expect this to change by endline, given widespread agreement in both regions (and especially in more remote *kebeles*) that girls' risk of child marriage climbs sharply during middle adolescence, once they begin menstruating or turn 15. Critically, while girls in study sites in both Afar and Somali are at high risk of child marriage, the reasons *why* they are at risk are very different. In both regions, adults and young people had only limited awareness of the marriage law. In Afar, respondents reported that child marriage remains common due to parents, who still primarily follow *absuma* marriage customs. There is, however, growing space (due to girls' improved access to formal education) for girls (and their teachers) to advocate for delayed marriage and for girls to choose a preferred partner. In Somali, where religious leaders stated that they have the right to approve marriage even if girls are still legally children, respondents agreed that child marriage is becoming more common for girls and boys, and that the age at marriage is declining, on account of the growing phenomenon of adolescent-driven child marriages.

Implications for policy and programming

Our research findings point to a range of key priority actions for the Ethiopian government and its development partners if they are to achieve the goals of the National Costed Roadmap to End Child Marriage and FGM/C, and of SDG target 5.3 on eliminating harmful practices. Here, we highlight the range of actors needed to fast-track change for adolescent girls and young women, and the specific actions within their mandate, while recognising that efforts need to be well coordinated across sectors and are interdependent.

Women and Social Affairs sector

Because the regional governments of Afar and Somali have yet to adequately invest in ending FGM and child marriage and the justice sector has not sufficiently prioritised initiatives to tackle Harmful Traditional Practices, the Women and Social Affairs sector should convene and oversee a new cross-sectoral government body – comprised of gender experts from the justice, education, health, agriculture and disaster risk management sectors – to develop and oversee regionally tailored plans for ending these practices.

Because restrictive gender norms limit girls' and women's access to education, employment and decision-making, and ultimately drive both FGM and child marriage, all levels of the Women and Social Affairs sector must prioritise efforts to directly tackle these beliefs and practices. This should include:

- creating and strengthening (depending on context) venues through which girls and women can confidentially report rights violations;
- prioritising efforts to raise girls' and women's awareness of their own and their (future) daughters' rights and how to (confidentially) report violations (e.g. to educators, Women's Affairs, police and justice officials);
- creating avenues through which girls and women can develop their own skillsets, including (for those denied access to formal education) literacy and numeracy;

An Afar bride and her friend © Nathalie Bertrams/GAGE 2025

- working with mothers, including through parenting education courses, to empower their daughters and to encourage their sons to adopt alternative masculinities, including eschewing norms that render uncut girls as '*unmarriageable*';
- working with communities to raise awareness about the importance of girls' education and how to practically support their learning, including managing demands on their time and cooperating with other families to arrange safe passage to school (e.g. walking in groups or with an adult);
- working to decouple women's status in the community from daughters' sexual purity and 'successful' marriage;
- addressing FGM and child marriage in a regionally tailored way to account for decision-making (e.g. girls have more input in Somali because FGM is carried out later and marriages in that region are often adolescent-led, while grandmothers have more sway over FGM in Afar) by educating girls, their families and communities about the risks of both harmful practices, challenging their perceived advantages, and raising awareness about the real advantages of eschewing norms;
- developing a cadre of role models – both educated girls and women, and progressive boys and men – who can work as champions of change in the community and through social media;
- expanding the 'one-stop' centres that offer support for violence and raising community awareness of their existence so that they can better support survivors of sexual and gender-based violence, prioritising conflict-affected areas, and also working with service providers at one-stop centres so that they can widen their remit to also support those at risk of impending child marriage and FGM;
- collaborating with other government sectors to harmonise national and regional laws and strengthen and extend the 2023 *fatwa* against infibulation to include language that specifies that no part of the female body is *haram.*

Because fathers, brothers, male peers, boyfriends and husbands are complicit in perpetuating the broader gender norms that disadvantage girls and women, including FGM (which is framed as the purview of women), the Women and Social Affairs sector should collaborate with the education sector and child- and gender-focused NGOs to use school- and community-based engagement sessions and media campaigns to shift male attitudes and practices. This should include:

- raising awareness among fathers and brothers as to how they could better support wives and sisters to free up girls' time to study;
- educating boys and men on why it should not be important to marry a girl who has undergone FGM, and on how boys and men can protect their sisters and daughters and prevent further FGM-related injury to their wife;

- working to decouple men's status in the community from daughters' sexual purity and 'successful' marriage;
- educating boys and men about the practical advantages of an adult wife (e.g. better helpmeet, fewer risks during childbirth), and the disadvantages of marrying a child (e.g. greater likelihood of early divorce, challenges in child-rearing, risk of sexual incompatibility);
- encouraging more equitable household decision-making and workloads, and rejecting violent masculinities.

Because FGM is seen as a religious mandate in Afar and Somali regions, and child marriage is seen as religiously acceptable – and even preferable – it is vital that the Women and Social Affairs and justice sectors collaborate with non-government actors to work closely with religious leaders to promote harm reduction in the short term and, eventually, the abandonment of these harmful practices. This should include:

- raising religious leaders' awareness of the fact that it is illegal for them to advocate for FGM and child marriage, and that they can be prosecuted for officiating a child marriage/approving the *nikah* [Sharia marriage certificate] of girls under the age of 18;
- encouraging religious leaders to seek young females' active consent to marriage, rather than accepting their silence;
- providing education about the risks of FGM (especially infibulation) and of child marriage, and the advantages of delaying marriage until adulthood;
- educating communities about which practices constitute *sunna* and which practices extend to *haram*;
- convening a national dialog to clarify the religious dimensions of FGM and child marriage, building consensus on how to tackle these practices (including by arranging tours in Muslim-majority countries where FGM is not prevalent), and developing unified advocacy strategies aimed at elimination;
- building support for girls' education, for the sake of girls themselves and for future generations;
- addressing broader gender norms, including recognising the value that girls and women add to families and communities, and the importance of teaching boys and men to eschew violence and treat female family members with kindness and respect.

Because clan and culture are central to Afar and Somali identities, and also to the perpetuation of FGM and child marriage, the Women and Social Affairs sector should collaborate with the education sector and child- and gender focused NGOs to work closely with clan leaders to shift the beliefs and practices that continue to disadvantage girls and women. This should include:

- promoting girls' education;
- raising awareness about the risks of FGM, especially infibulation, in an integrated manner, including through radio, social media, television, community conversations, in school-based gender clubs, and through door-to-door visits by health extension workers;
- raising awareness of the risks of child marriage and the advantages of delaying marriage until adulthood;
- making sure that communities – especially traditional cutters and mothers – know that all forms of FGM are illegal and subject to fines and imprisonment.

A 15-year old Afar girl making coffee © Nathalie Bertrams/GAGE 2025

A *kebele* manager in a Somali health post © Nathalie Bertrams/GAGE 2025

Justice sector

Because knowledge of the law banning FGM and child marriage remains limited, as does enforcement, the justice sector needs to scale up efforts to promote and enforce national laws on harmful practices. This should include:

- working with rights-based organisations (including the Ethiopian Human Rights Commission and the Ethiopian Women Lawyers Association) to advocate with regional officials and legislators for regional laws to be harmonised with national laws banning both FGM and child marriage, and to ratify the Family Law so that these practices are criminalised;
- working with Sharia courts to improve girls' and women's rights to education, inheritance, and freedom from violence – including FGM, child marriage, and intimate partner violence– and enhancing cooperation between Sharia courts and the formal courts and justice system;
- working with other government sectors, the National Alliance to End FGM and Child Marriage and the Ethiopian Religious Council to extend the 2023 fatwa against infibulation to include language that specifies that no part of the female body is *haram;*
- working with traditional and community leaders to make sure that communities know that all forms of FGM are illegal, emphasising that in the short term the focus needs to be on harm reduction, and in the longer term to move towards eradicating the practice, recognising that this is likely to be a lengthy and non-linear process;
- working with traditional and community leaders to make sure that communities know that all forms of child marriage – even those initiated by adolescents – are illegal; they pose health risks for adolescents and any future children they may have, they heighten the risk of early divorce and associated stigma, and they preclude better educational and, in turn, economic futures;
- establishing anonymous reporting mechanisms, at schools and other community venues, which can be used to prevent planned FGM and child marriages taking place and to cancel recently transacted child marriages;
- working with communities to set enforceable penalties – for parents, traditional cutters, adult husbands, and marriage officiators – for violations, even those that take place in other locations, and strengthening mechanisms and oversight at the *kebele* level;
- working with girls and women to make them more aware of their rights and those of their (future) daughters, and how to claim those rights, and working with mothers to make them aware of the penalties for FGM;
- working with men and boys to make them more aware of the law and penalties for violation for FGM (fathers) and child marriage (adult husbands and fathers).

Because FGM is seen as a religious mandate, and child marriage is seen as religiously acceptable – and even preferable – it is vital that the justice and Women and Social Affairs sectors collaborate with non-government actors to work closely with religious leaders to promote harm reduction in the short term and, eventually, the abandonment of these harmful practices. This should include:

- raising religious leaders' awareness of the fact that it is illegal for them to advocate for FGM and child marriage, and that they can be prosecuted for officiating a child marriage/ approving the *nikah* [Sharia marriage certificate] of girls under the age of 18;

A 15-year-old girl Somali girl fetching water © Nathalie Bertrams/GAGE 2025

- providing education about the risks of FGM (especially infibulation) and of child marriage, and the advantages of delaying marriage until adulthood;
- educating communities about which practices constitute *sunna* and which practices extend to *haram*;
- addressing misconceptions that FGM and child marriage are required/permitted by Islam, and developing persuasive religious-based arguments in favour of ending the practices (including addressing beliefs that girls must be cut in order to enter mosques and/or pray);
- building support for girls' education, for the sake of girls themselves and for future generations;
- addressing broader gender norms, including recognising the value that girls and women add to families and communities, and the importance of teaching boys and men to eschew violence and treat female family members with kindness and respect.

Education sector

Because girls are far more likely than boys to be excluded from education, and because girls' education is central to empowering girls and ending FGM and child marriage, the education sector must redouble efforts to ensure that all girls have access to education, at least through to the end of middle school, and ideally through to completion of secondary school. This should include:

- making sure that all communities (including nomadic pastoralists) have schools that offer quality education through to at least 6th grade, and expanding opportunities for the older girls and women (who were previously denied an education) to achieve literacy and numeracy;
- door-to-door outreach to enrol those children who are out of school, or who are regularly absent, combined with fines for parents of truant children, as appropriate;
- expanded curricular and extra-curricular (e.g. through girls' and gender clubs) education on gender norms, including direct attention to the stigma that surrounds menstruation and toileting, FGM, child marriage, and sexual and gender-based violence;
- hiring more female teachers so that girls have access to positive role models;
- ensuring greater provisioning of school supplies for students from poorer households;
- prioritising stepped-up investments, across all grade levels, in school feeding programmes, WASH (water, sanitation and hygiene) and menstrual hygiene management (MHM) supplies, participatory girls' clubs/gender clubs, textbooks and libraries, and tutorial support;
- constructing more middle schools and secondary schools in rural areas and investing in safe and affordable boarding options for students (especially girls) in the interim;
- ensuring more supervision by *woreda*-level education offices, using incentives for teachers as necessary to reduce turnover and absenteeism.

Because fathers, brothers, male peers, boyfriends and husbands are complicit in perpetuating the broader gender norms that disadvantage girls and women, including FGM (which is framed as the purview of women), the education sector should collaborate with the Woman and Social Affairs sector and child- and gender focused NGOs actors to use school- and community-based

engagement sessions and media campaigns to shift male attitudes and practices. This should include:

- helping fathers and brothers to see how they could better support wives and sisters to free up girls' time to study;
- educating boys and men on why it should not be important to marry a girl who has undergone FGM, and on how boys and men can protect their sisters and daughters and prevent further injury to their wife;
- working to decouple men's status in the community from daughters' sexual purity and 'successful' marriage;
- educating boys and men about the practical advantages of an adult wife (e.g. better helpmeet, fewer risks during childbirth), and the disadvantages of marrying a child (e.g. greater likelihood of early divorce, challenges in child-rearing, risk of sexual incompatibility);
- encouraging more equitable household decision-making and workloads, and rejecting violent masculinities.

Because clan and culture are central to Afar and Somali identities, and to the perpetuation of FGM and child marriage, the education sector should collaborate with the Women and Social Affairs sector and NGOs to work closely with clan leaders to shift the beliefs and practices that continue to disadvantage girls and women. This should include:

- promoting girls' education;
- raising awareness about the risks of FGM, especially infibulation, in an integrated manner, including through radio, social media, television, community conversations, in school-based gender clubs, and through door-to-door visits by health extension workers;
- raising awareness of the risks of child marriage and the advantages of delaying marriage until adulthood;
- making sure that communities – especially traditional cutters and mothers – know that all forms of FGM are illegal and subject to fines and imprisonment.

Non-governmental organisations

Because the gender norms that limit girls' and women's lives also limit communities' and leaders' capacity to recognise and address these norms, it is vital that child- and gender-focused NGOs collaborate with the Women and Social Affairs and education sectors to work with adolescents and adults to shift beliefs and practices, and to develop local capacity to promote more equitable gender norms. Interventions should be scaled for impact, so that tipping points are timely, and should include:

- supporting girls to access and succeed in education;
- strengthening school-based girls' clubs and gender clubs;
- helping fathers and brothers to see how they could better support wives and sisters to free up girls' time to study;
- engaging with adolescent girls and boys on FGM and child marriage to shift current practices or encourage intergenerational change (depending on context);
- providing parent education courses for mothers and fathers that directly address gender norms and how these harm girls and women;
- supporting women to learn about their (and their daughters') rights and how to access them;
- encouraging men to reject violent masculinities and adopt more equitable household decision-making and workloads;
- working to decouple parents' status in the community from daughters' sexual purity and 'successful' marriage;
- developing a cadre of role models – both educated girls and women, and progressive boys and men – who can work as champions of change in the community and through social media;
- working alongside local leaders and service providers to raise awareness about the harmful effects of discriminatory gender norms and the benefits at all levels (individual, family and community) of educated and economically empowered girls and women;
- collaborating with the Woman and Social Affairs and education sectors to educate religious and clan leaders about the harmful effects of FGM and child marriage.

Agriculture, labour and disaster risk management sectors

Because global evidence suggests that the best way to prevent child marriage is to keep girls in school for as long as possible, the agriculture sector and the disaster risk management and food security sector should collaborate with the education sector to use social protection to incentivise families to educate girls and delay marriage. This should include:

- starting/resuming/continuing school feeding programmes, with supplementary take-home rations for girls;
- investing in cash and asset transfers to support girls' education – ideally conditional on girls' attendance and continued unmarried status, and on parents' and adolescents' participation in gender-focused programming; and, where practicable, leveraging the existing Productive Safety Net Programme (PSNP) platform to facilitate targeting and implementation.

Because girls and women in pastoralist communities have extremely limited opportunities to earn their own incomes, the agricultural and labour sectors should scale up efforts to expand and diversify females' livelihood options, to

provide them with an alternative to child marriage and to give them an alternative way to accrue status in the community. These should be paired with awareness raising, to ensure that girls' and women's improved access to finance does not further entrench FGM. This should include:

- developing skills and training courses (designed to take account of climate change and invasive species) for older girls and women, including animal husbandry, crop farming, trading and other culturally acceptable occupational skills, alongside life skills and financial/ business skills;
- more opportunities for older girls and women to access formal savings and credit showcasing women who are successful agricultural entrepreneurs (e.g. in dairy, beekeeping, or poultry) though radio programs and local fairs to inspire young girls and challenge traditional gender roles.

Health sector

Because girls and women who have undergone FGM often face a lifetime of pain and infection, because of the growing trend of medicalisation of FGM, and because it is possible to decouple child marriage and adolescent pregnancy, the Bureaus of Health at the regional and district levels must redouble efforts to ensure that health care workers play their part in reducing harmful practices.

This should include:

- training health extension workers and other health care providers about the physical and psychological risks of FGM;
- educating community members (including during antenatal and child vaccine visits, and contextualising to take account of local beliefs and practices) about the different types of FGM (including which practices do and do not fall under the rubric of *sunna*) and the lifecourse consequences of FGM;
- enlisting health extension workers to monitor shifting practices and regularly communicating these to both the Bureaus of Health and Bureau of Women and Social Affairs officials in order to better tailor messaging and programming;
- ensuring that girls and women who have been cut have access to appropriate health care at different stages of their life;
- training health professionals to make sure they know about the Family Law's ban on FGM, and enforcing penalties for any health professional found to practice it (including after childbirth), in line with the 2017 Ministry of Health guidance. This should include clear guidance from regional Bureaus of Health down to *woreda* and *kebele* levels about the prohibition on health professionals carrying out the practice, and

A group of Afar girls © Nathalie Bertrams/GAGE 2025

related sanctions should there be evidence of such involvement;
- supporting health extension workers to advocate – even in areas where demand is low – for married girls to use contraception until their body is mature;
- engaging with the East Africa platform that the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) have established, and of which the Ministry of Women and Social Affairs is a part, to cooperate across borders in order to tackle the practice of FGM, including sharing evidence at the annual meetings that have been established to inform strategic actions.

Regional governments

Because Afar and Somali are not yet evidencing the progress shown by other regions of Ethiopia in reducing FGM and child marriage, regional government leaders should invest in promoting the social change that will improve girls' and women's lives, as well as broader development outcomes. This should include:

- efforts to identify champions (particularly among clan and religious leaders, traditional cutters, and women whose own lives or whose daughters' lives were adversely impacted by FGM or child marriage) willing to encourage change;
- ratify the national level Family Law that prohibits FGM and child marriage;
- allocating sufficient human and financial resources to tackle the gender norms and practices that prevent girls and women from accessing their rights;
- monitoring sector-level actors to ensure that they are fulfilling their mandates vis-à-vis FGM and child marriage;
- investing in evidence-based monitoring and evaluation of programming designed to tackle FGM and child marriage, focusing on the remote communities where prevalence is highest.

National Alliance to End FGM and Child marriage

Because the National Alliance to End FGM and Child Marriage is uniquely positioned to continue and accelerate efforts towards eradication, it is vital that Alliance members collectively continue to open new change pathways and identify new champions to support eradication efforts at all levels. The Alliance should:

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

Donors

Because eliminating FGM and child marriage will be resource-intensive and require consistent long-term interventions, development partners must scale up – and sustain – investment in evidence-informed programming. This should include:

- investing in education for all children, including those in remote pastoralist communities, not only by building schools, but by supporting the teacher training and school feeding that results sustainable impacts;
- scaling up social protection for the most vulnerable households, leveraging this where possible to improve girls' education (and reduce child marriage);
- strengthening sub-national capacity to improve local services;
- investing in programming to shift restrictive gender norms;
- improving and fine-tuning programmes to maximise context specificity;
- investing in robust longitudinal monitoring, evaluation and research to track progress, and inform how best to deploy scarce resources given context specificity, as well as how to promote effective programming at scale.

A 20-year-old Somali mother of three © Nathalie Bertrams/GAGE 2025

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