SUPPORT TO THE AFRICA-LED MOVEMENT TO END FEMALE GENITAL MUTILATION (FGM)

Political Economy Analysis, Kenya

Submitted by:

Options

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amref health africa

ORCHID PROJECT
WORKING TOGETHER TO END FEMALE GENITAL CUTTING

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AFRICA CO-ORDINATING CENTRE FOR THE ABANDONMENT OF FGM/C

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List of Abbreviations

ALM	Africa-led Movement
AUU	African Union
CSO	Civil Society Organisation
DHS	Demographic and Health Survey
EAC	East African Community
FCDO	Foreign, Commonwealth and Development Office
FGM/C	Female Genital Mutilation/Cutting
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GNI	Gross National Income
HDI	Human Development Index
IMF	International Monetary Fund
INGO	International Non-Governmental Organization
PEA	Political Economy Analysis
SDG	Sustainable Development Goal
TGG	The Girl Generation
TMB	Treaty Monitoring Body
ToC	Theory of Change
UPR	Universal Periodic Review
UN	United Nations

1. Introduction

1.1 The Africa-led Movement

The UK Government (Foreign, Commonwealth and Development Office - FCDO) has a vision of a world free from Female Genital Mutilation/Cutting (FGM/C) by 2030, in line with the Sustainable Development Goals (SDGs). The importance of eliminating FGM/C is reflected in Target 5.3 of the SDGs: "Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilations." A programme has been established entitled 'Support to the Africa-led movement (ALM) to end FGM/C' to contribute to global efforts to achieve that vision.

Building on the foundations of the first five-year investment (2013-2018) of the Department for International Development, this programme will focus on **accelerating the pace of change** and achieving results to contribute to the vision in the SDGs of a world free of FGM/C by 2030. More specifically, this program will support and build the capacity of the ALM to end FGM/C at **multiple levels and at scale**. The ALM is the anti FGM/C movement and a community of activists at all levels whose efforts are complementing the work of UN agencies (such as UNFPA-UNICEF Joint Programme), Saleema initiative, other alliances (such as Girls not Brides, She Decides, FEMNET, Global Citizen, One Campaign) and grassroot Civil Society Organisations (CSOs), women's and girls' movements, etc.

Phase II is composed of two consortia working in close collaboration. Options has engaged with Amref Health Africa, ActionAid UK, Shujaaz Inc/Well Made Strategy, Orchid Project, ACCAF and University of Portsmouth to implement the 'Support to the ALM to End FGM/C' in cooperation with Population Council and Greenmash which is implementing 'The FGM Data Hub: Data and Measurement Support to the ALM to end FGM/C' (hereafter: 'FGM Data Hub).

1.2 Political Economy Analysis

Political Economy Analysis (PEA) is about understanding the political dimensions of a context and actively using this information to inform programming. In order to be able to achieve sustainable results, due consideration of the political realities is really important. We believe that an informed understanding of the national political economy can improve the effectiveness of a programme at all stages and will lay the foundations for a second stage PEA at sub-national level.

"Political economy analysis aims to situate development interventions within an understanding of the prevailing political and economic processes in society – specifically, the incentives, relationships, and distribution and contestation of power between different groups and individuals. Such an analysis can support more politically feasible and therefore more effective development strategies by setting realistic expectations of what can be achieved, over what timescale, and considering the risks involved."[1]

Specifically, this PEA aims to look at the interaction of political and economic processes on FGM/C that create and transform the power and gender dynamics that sustain FGM/C over

[1] Mcloughlin, C. (2014). *Political economy analysis: Topic guide* (2nd ed.) Birmingham, UK: GSDRC, University of Birmingham.

time.[2,3] This will help us to define structural gendered power dynamics that influence how and by whom decisions on girls' sexuality, rights, health and wellbeing are made. The PEAs will include context analysis, highlighting policies in place, prevalence data etc. and intersectional gender analysis (to map the beliefs and norms underpinning FGM/C). This will facilitate our team's, and Civil Society Organisations (CSOs) (through the grants mechanism), to 'think and work politically', recognising that achieving change is both a technical and political process.

Adapted from DFID's commission report of the drivers of pro-poor change in Kenya,[4] we will analyse the linkages between:

- **Context:** long-term processes of social, gendered, political and economic change.
- **Institutional:** changes in the workings of institutions and the accountability and effectiveness of good governance structures.
- **Change agents:** Key actors motivated to see change and able to make it happen. This needs to include analysis into how free and supportive media outlets are and whether they represent effective drivers of change.

There are important linkages between these three aspects. This PEA will capture data and insights across all three and then inform an evidence-based decision-making process around which the ALM should work, and *how* the ToC might be operationalised successfully. In order to support this goal, we will add a fourth strand:

- **Evidence and understanding of what works' best to end FGM/C.** We need to ensure the PEA process brings us to conclusions around what, represents the best opportunities for change and where.

Aims of the National Level PEA:

- To provide a detailed national level political-economic-social country analysis including a narrative analysis of different media actors and their relative influence over public and political opinion.
- To focus on documenting the gendered environment and conditions that may support or block the efforts of the ALM to end FGM/C.
- To break down prevalence into regions to provide a rigorous picture of where FGM/C is seen more acutely.
- To identify key national change agents, specific opportunities/entry points to leverage momentum for change, and map each context against the change continuum as outlined in the ToC (to help us understand how far away it is from the point of accelerated change).

Objective:

- To inform both the sub-national PEAs and the design of country level ToCs.
- To map the existing actors and stakeholders already active in the ALM, their respective strengths, priorities, and gaps, so that this programme can be informed by and constructively collaborate with them.
- To support the site/region selection for implementation.
- To support the embedding of an ongoing process of identifying and maximising opportunities to leverage influence.

[2] DFID (2009). Political Economy Analysis How to Note. A DFID practice paper.
[3] Collinson (2003). Power, livelihoods and conflict: case studies in political economy analysis for humanitarian action. HPG Report 13. Overseas Development Institute.
[4] http://www.gsdrc.org/docs/open/DOC24.pdf.

- Support a capacity development assessment so that resources can be targeted to strengthen the ALM in Kenya.

1.3 Methodology

The PEA approach will combine a central gendered feminist lens with the components of the drivers of change approach (contextual factors, institutional environment and change agents, evidence of what works). Once the second stage sub-national PEA is complete, we will then be able to map our analysis across the levels in the ecology model (as detailed in the ToC) (National, District, Community, Household and Individual) providing a comprehensive understanding of where momentum for change is most intense, what works where and why and the remaining challenges.

The approach taken involved the following methods:

a. **Desk based country profile analysis** including political power analysis. This provided an overview of the political system, relevant legislative provision, gender index and data on VAWG including FGM/C and evidence for why FGM/C occurs.
b. **Prevalence data mapping.** What is there and what does it tell us? Where are the gaps? What does it tell us about regional diversity? Intersectional analysis will help us understand who are the most vulnerable and the level of risk.
c. **Stakeholder and Movement Mapping**: This helped to map the **Institutional Landscape** and an analysis into how inclusive it is/gauge the appetite for change at this political level. This involved (through power analysis) identifying stakeholders that may pose challenges. Which are the key government departments and agencies? The mapping identified **agents of change capturing the extent and strength of civil society** and the activities and effectiveness of International Non-Governmental Organizations (INGOs) as well as individual change agents who are working to promote gender equality and more specifically ending FGM/C.
d. **Intervention mapping:** The findings were taken from the end FGM/C repository of FGM/C-related programmes implemented in different countries between the year 2000 and August 2016. The repository has been brought up to date for the purposes of this PEA analysis.
e. **Media:** A list of keywords (FGM, End FGM, FGM/C, FGC, Female Genital Mutilation) was created and hashtags were identified (e.g. #EndFGM #EndFGMinKenya #FGMinKenya #AntiFGM #PamojaTukomesheUkeketaji) for searches online. Data from Ipsos, the Kenya Audience Research Foundation and the Media Council of Kenya provided background to the media landscape in Kenya. Below are highlights of what was learned.

Data collection: Twenty stakeholders were interviewed covering relevant government departments, national organisations, and civils society organisations, and additionally some key religious actors. The interview tool and research protocol were reviewed by the Ethics Committee of the Faculty of Humanities and Social Sciences at the University of Portsmouth and clearance granted. All interview transcripts were transcribed verbatim in English and anonymised. Secure data management and access is being facilitated by the University of Portsmouth in line with United Kingdom Research and Innovation (UKRI) guidelines on data usage and storage. The interview transcripts were hand coded thematically into a table and the findings were drawn from it. The headings used below represent the key findings. It should be stressed that this was a qualitative study and as such is not quantitatively exhaustive. However, within the dataset we did reach a saturation point whereby themes and patterns were consistently repeated across those interviewed. We are therefore confident that the findings are robustly evidenced by the dataset.

The report ends with a set of conclusions, including important considerations, opportunities, and next steps for the sub-national PEA to follow.

1.4 Impact of COVID-19

The emergence of the COVID-19 pandemic may hamper progress towards ending FGM/C by 2030, even in countries that have experienced a decline in the practice.[5] Measures to contain the spread of the pandemic such as restrictions on movement and social distancing affect implementation and scaling up of interventions to eliminate the practice, including community empowerment and sensitisation programmes. It has, for instance, been projected that scaling up FGM/C prevention programmes could reduce new cases by 5.3 million between 2020 and 2030,[6] a milestone that may not be achieved due to scaling down of programmes as a result of COVID-19. Anecdotal and media reports further indicate that school closures to prevent the spread of the pandemic have put many girls at risk of FGM/C, with some reports indicating that parents in practicing communities have their girls cut and marry them off as a means of coping with the economic hardships brought about by the pandemic.[7] UNFPA states that as a result of COVID-19; "it is anticipated that 2 million cases of FGM will occur between 2020 and 2030 that could have been averted, resulting in a 33 per cent reduction in the progress toward ending this harmful practice."[8] The sudden surge in FGM/C is attributed to COVID-19 containment measures such as movement restrictions and night curfews, school and medical centre closures and the fact that community and health workers are no longer able to move around freely educating communities and supporting and protecting vulnerable girls.

Across all the interviews, the consensus emerged that COVID-19 had set back gains in ending FGM/C. One stakeholder answered in the following way, the sentiments expressed here were commonly expressed; *"remember there was the curfew there was limitation people could actually not travel, so the children who actually transported to the other country or the other county because in Garissa for example and Wajir there is a border to Somalia girls are taken across the border, cut brought back and nobody can tell because there is a lockdown and there is no school the children is not missing school so the teacher will not know if the child is sick or what so we feel like during COVID-19 the cases of FGM have really shoot up."*

Another stakeholder expressed the need to build in activities to prevent set-backs due to crises. *"If you are doing FGM programming and you don't have a sustainability plan for the gains you would have made then they can easily be done away with by an emergency."*

Clearly, the already urgent need to accelerate progress towards FGM/C abandonment is even more pertinent in the context of COVID-19.

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[5] Orchid Project, *Policy Briefing: Impacts of COVID-19 on Female Genital Cutting* (Orchid Project 2020) available at https://www.orchidproject.org/wp-content/uploads/2020/11/COVID_female_genital_cutting_FGC_policy_briefing_Orchid_Project_FINAL.pdf [Last Accessed 22 February 2021].

[6] UNFPA, *Interim Technical Note: Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage* (UNFPA 2020) available at https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_impact_brief_for_UNFPA_24_April_2020_1.pdf [Last Accessed 22 February 2021].

[7] See, for instance, N. Bhalla, 'COVID-19 Threatens Kenya's Goal to End Female Genital Mutilation by 2022', *Global Citizen*, 18 June 2020, available at https://www.globalcitizen.org/en/content/covid-19-school-closures-end-FGM/C-in-kenya/ [Last Accessed 22 February 2021].

[8] UNFPA, *Interim Technical Note: Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage*, UNFPA 2020, available at https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_impact_brief_for_UNFPA_24_April_2020_1.pdf [Last Accessed 22 February 2021].

2. Country Characteristics

2.1 Population

The Kenya population in 2019 was estimated at 47,564,296 (of which 23,548,056 were males and 24,014,716 were females).[9] The census indicators can be found in Table 2.1.

Table 2.1: Kenya Population and Housing Census (2019)

Indicator	2019
Population Size	47,564,296
- Male	23,548.056
- Female	24,014,716
- Intersex	1,524
Sex Ratio (No. of Males per 100 Females)	98.1
Population Density (No. per sq. Km)	82
Number of Households	12,1143,913
Average Household Size	3.9
Intercensal Growth Rate (%)	2.2

2.2 Languages, ethnic backgrounds, and religion

Kenya has a very diverse population that includes many ethnic, racial, and linguistic groups. The national language of the Republic is Kiswahili and the official languages are Kiswahili and English. Kenya's largest ethnic groups are the Kikuyu, Luhya and Kalenjin (Table 2.2).

Table 2.2: Ethnic groups in Kenya

Ethnic Group	Population	% of population
Kikuyu	8,148,668	17.13%
Luhya	6,823,842	14.35%
Kalenjin	6,358,113	13.37%
Luo	5,066,966	10.65%
Kamba	4,663,910	9.81%
Somalis	2,780,502	5.85%
Kisii	2,703,235	5.68%
Mijikenda	2,488,691	5.23%
Meru	1,975,869	4.15%
Maasai	1,189,522	2.50%
Turkana	1,016,174	2.14%

The predominant religion in Kenya is Christianity at 85.5% of the total population, of which 60.8% are Protestants, 20.6% Catholics and 4.1% other Christian religion. Islam is the second-largest religion in Kenya, practiced by 10.91% of Kenyans. In total, 1.8% of the population reported themselves as having an 'other religion' (for example Hinduism), 1.6% as having 'no religion' and

[9] 2019 Kenya Population and Housing Census Results, November 2019, available at https://www.knbs.or.ke/?p=5621 [Last Accessed 21 February 2021].

0.7% traditional faiths (such as the traditional Kikuyu religion or the traditional Mijikenda religion).[10]

2.3 Political system

The Republic of Kenya is a unitary State divided into **47 counties**. The county is run by the National Government and 47 county governments. Since 1992, Kenya has been a multi-party democracy. The president is elected for a five-year term by the people.

On 27 August 2010, a **new Constitution** for Kenya was promulgated. The aims of the new Constitution include improved transparency and accountability within government and the creation of an independent judiciary.

The Parliament of Kenya is a bicameral house consisting of the National Assembly and the Senate. The **National Assembly** has 349 members plus the Speaker, who is an *ex officio* member.[11] The new Constitution specifies in Article 97 that the National Assembly should consist of 47 women, "each elected by the registered voters of the counties, each county constituting a single member constituency." The **Senate** consists of 67 members plus the Speaker, who is also an *ex-officio* member. Similarly, Article 98 of the Constitution establishes that the Senate shall consist of "sixteen women members who shall be nominated by political parties according to their proportion of members of the Senate […]."

The new Constitution also created a Bill of Rights (Chapter Four)[12] with special provisions for women and children's equality and freedom from discrimination.

[10] 2019 Kenya Population and Housing Census Volume IV: Distribution of Population by Socio-Economic Characteristics, Kenya National Bureau of Statistics, available at https://www.knbs.or.ke/?wpdmpro=2019-kenya-population-and-housing-census-volume-iv-distribution-of-population-by-socio-economic-characteristics&wpdmdl=5730&ind=7HRl6KateNzKXCJaxxaHSh1qe6C1M6VHznmVmKGBKgO5qIMXjby1XHM2u_swXdiR [Last Accessed 21 February 2021].
[11] Art. 95 and 97 of the Constitution (2010).
[12] Kenya Law Reform Commission, Chapter Four – The Bill of Rights, available at https://www.klrc.go.ke/index.php/constitution-of-kenya/110-chapter-four-the-bill-of-rights [Last Accessed 21 February 2021].

3. Development indicators

3.1 Gross Domestic Product

According to the International Monetary Fund (IMF), the Gross Domestic Product (GDP) of Kenya is $101.048 billion (nominal) and $243.137 billion (PPP).[13] Kenya ranks **62 out of 195 countries** in the IMF GDP ranking, 66th according to the World Bank and 65th according to the UN. The GDP growth was 6.3% in 2018, 5.6% in 2019 and 1% in 2020. The GDP per capita was $2,075 in 2020 (nominal) and $4,993 (PPP).

3.2 Human Development Index

According to the 2020 Human Development Report, Kenya ranks **143 out of 189 countries** in the Human Development Index (HDI), positioning the country in the medium human development category. The HDI is a summary measure for assessing long-term progress in three basic dimensions of human development: a long and healthy life, access to knowledge and a decent standard of living (Table 3.2).

Some important trends can be observed over time: between 1990 and 2019, Kenya's HDI value increased from 0.482 to 0.601 (an increase of 24.7%). Between 1990 and 2019, Kenya's life expectancy at birth increased by 9.3 years, meaning years of schooling increased by 2.8 years and expected years of schooling increased by 2.3 years. Kenya's Gross National Income (GNI) per capita increased by about 37.1% between 1990 and 2019.[14]

Table 3.2: Human Development Index

Dimension	Indicator	Rate
Health	**Life expectancy at birth (years)**	**66.7**
	- female (years)	69.0
	- male (years)	64.3
	Life expectancy index	0.718
	Mortality rate	
	- female adult (per 1,000 people)	195
	- infant (per 1,000 live births)	30.6
	- male adult (per 1,000 people)	265
	- under-five (per 1,000 live births)	41.1
Education	**Expected years of schooling (years)**	**11.3**
	- Education index	0.534
	- Expected years of schooling, female (years)	11.0
	- Expected years of schooling, male (years)	11.7
	- Government expenditure on education (% of GDP)	5.3
	- Gross enrolment ratio, pre-primary (% of preschool-age children)	76
	- Gross enrolment ratio, primary (% of primary school-age population)	103

[13] World Economic Outlook Database, International Monetary Fund, October 2020, available at https://www.imf.org/en/Publications/WEO/weo-database/2020/October/weo-report?c=664,&s=NGDPD,PPPGDP,NGDPRPPPPC,NGDPDPC,PPPPC,&sy=2018&ey=2025&ssm=0&scsm=1&scc=0&ssd=1&ssc=0&sic=0&sort=country&ds=.&br=1 [Last Accessed 21 February 2021].

[14] UNDP, Human Development Report 2020, The Next Frontier: Human Development and the Anthropocene, available at http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/KEN.pdf [Last Accessed 26 January 2021].

	- Gross enrolment ratio, secondary (% of secondary school-age population)	n.a.
	- Gross enrolment ratio, tertiary (% of tertiary school-age population)	11
	- Literacy rate, adult (% ages 15 and older)	81.5
	- Mean years of schooling (years)	6.6
	- Mean years of schooling, female (years)	6.0
	- Mean years of schooling, male (years)	7.2
	- Percentage of primary schools with access to the internet	n.a.
	- Percentage of secondary schools with access to the internet	n.a.
	- Population with at least some secondary education (% ages 25 and older)	35.2
	- Population with at least some secondary education, female (% ages 25 and older)	29.8
	- Population with at least some secondary education, male (% ages 25 and older)	37.3
	- Primary school dropout rate (% of primary school cohort)	7.0
	- Primary school teachers trained to teach (%)	97
	- Pupil-teacher ratio, primary school (pupils per teacher)	31
	- Survival rate to the last grade of lower secondary general education (%)	81
Income	**Gross national income (GNI) per capita (constant 2017 PPP$)**	**4,244**
Inequality	**Inequality-adjusted HDI (IHDI)**	**0.443**
Gender	**Gender Development Index (GDI)**	**0.937**
	- Adolescent birth rate (births per 1,000 women ages 15-19)	75.1
	- Antenatal care coverage, at least one visit (%)	93.7
	- Child marriage, women married by age 18 (% of women ages 20–24 who are married or in union)	23
	- Contraceptive prevalence, any method (% of married or in-union women of reproductive age, 15–49 years)	60.5
	- Female share of employment in senior and middle management (%)	n.a.
	- Gender Inequality Index (GII)	0.518
	- Human Development Index (HDI), female	0.581
	- Human Development Index (HDI), male	0.620
	- Mandatory paid maternity leave (days)	90
	- Maternal mortality ratio (deaths per 100,000 live births)	342
	- Prevalence of female genital mutilation/cutting among girls and women (% of girls and women ages 15–49)	21.0
	- Proportion of births attended by skilled health personnel (%)	61.8
	- Share of employment in nonagriculture, female (% of total employment in nonagriculture)	42.4
	- Share of graduates from science, technology, engineering, and mathematics programmes in tertiary education who are female (%)	30.7
	- Share of graduates from science, technology, engineering, and mathematics programmes in tertiary education who are male (%)	69.3
	- Share of graduates in science, technology, engineering and mathematics programmes at tertiary level, female (%)	11.2
	- Share of graduates in science, technology, engineering and mathematics programmes at tertiary level, male (%)	20.84
	- Share of seats held by women in local government (%)	33.5
	- Share of seats in parliament (% held by women)	23.3
	- Total unemployment rate (female to male ratio)	1.12
	- Unmet need for family planning (% of married or in-union women of reproductive age, 15–49 years)	14.9
	- Violence against women ever experienced, intimate partner (% of female population ages 15 and older)	40.7

	- Violence against women ever experienced, nonintimate partner (% of female population ages 15 and older) - Women with account at financial institution or with mobile money-service provider (% of female population ages 15 and older) - Youth unemployment rate (female to male ratio)	n.a. 77.7 1.01
Poverty	**Population in multidimensional poverty, headcount (%)**	**38.7**
Work, employment, and vulnerability	**Employment to population ratio (% ages 15 and older)** - Labour force participation rate (% ages 15 and older), female - Labour force participation rate (% ages 15 and older), male	**72.7** 72.1 77.3
Human Security	**Homicide rate (per 100,000 people)**	**4.9**
Trade and Financial Flows	**Exports and imports (% of GDP)**	**33.4**
Mobility and Communication	**Internet users, total (% of population)** - Internet users, female (% of female population) - Mobile phone subscriptions (per 100 people)	**17.8** 13.5 96.3
Environmental sustainability	**Carbon dioxide emissions, production emissions per capita (tonnes)**	**0.4**
Socio-economic sustainability	**Skilled labour force (% of labour force**	**40.5**

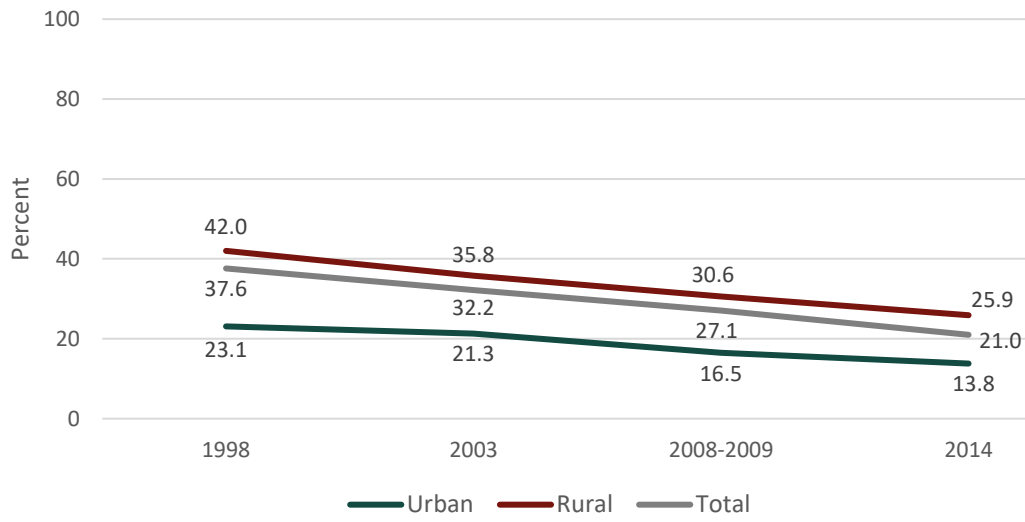
4. FGM/C prevalence

4.1 National prevalence

Nationally representative data on FGM/C in Kenya is available from the Demographic and Health Surveys (DHS). Information on FGM/C was collected in Kenya for the first time in 1998,[15] and in subsequent surveys in 2003,[16] 2008-2009[17] and 2014.[18]

Data from the 2014 DHS[19] show that the national prevalence of FGM/C among women aged 15-49 in Kenya is 21.0%.[20] The prevalence of FGM/C in Kenya declined by about 17 percentage points over the past two decades, from 37.6% in 1998 to 21.0% in 2014 (Figure 4.1). Girls and women in rural areas are more likely to undergo FGM/C than those in urban areas (Figure 4.1).

Figure 4.1: National trends in FGM/C prevalence among women aged 15-49

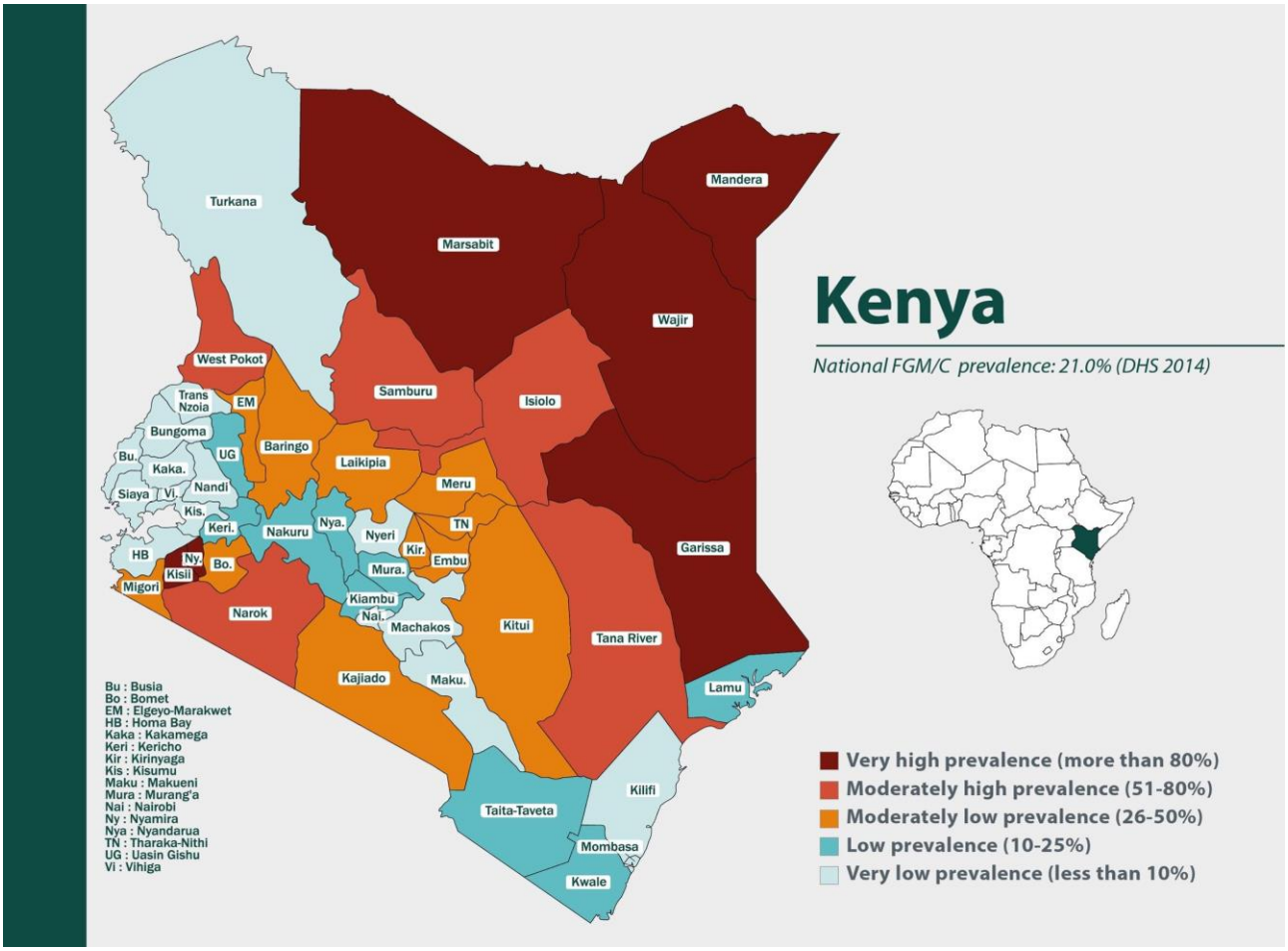


[15] National Council for Population and Development (NCPD), Central Bureau of Statistics (CBS) (Office of the Vice President and Ministry of Planning and National Development) [Kenya], and Macro International Inc. (MI). 1999. Kenya Demographic and Health Survey 1998. Calverton, Maryland: NDPD, CBS, and MI, available at https://dhsprogram.com/pubs/pdf/FR102/FR102.pdf [Last Accessed 17 February 2021].
[16] Central Bureau of Statistics (CBS) [Kenya], Ministry of Health (MOH) [Kenya], and ORC Macro. 2004. Kenya Demographic and Health Survey 2003. Calverton, Maryland: CBS, MOH, and ORC Macro, available at https://dhsprogram.com/pubs/pdf/FR151/FR151.pdf [Last Accessed 17 February 2021].
[17] Kenya National Bureau of Statistics (KNBS) and ICF Macro. 2010. Kenya Demographic and Health Survey 2008-09. Calverton, Maryland: KNBS and ICF Macro, available at https://dhsprogram.com/pubs/pdf/FR229/FR229.pdf [Last Accessed 17 February 2021].
[18] Kenya National Bureau of Statistics (KNBS) and ICF Macro. 2014. Kenya Demographic and Health Survey 2014. Calverton, Maryland: KNBS and ICF Macro, available at https://dhsprogram.com/pubs/pdf/FR308/FR308.pdf [Last Accessed 17 February 2021].
[19] The statistics presented on the national FGM/C prevalence need to be interpreted with caution as the reality might be more nuanced. First of all, the most recent data is 7 years old (and does therefore not reflect recent trends/changes including COVID-19) and second of all, the DHS is based on self-reports by women interviewed. See also Yoder, P. Stanley, and Shanxiao Wang. 2013. Female Genital Cutting: The Interpretation of Recent DHS Data. DHS Comparative Reports No. 33. Calverton, Maryland, USA: ICF International, available at https://dhsprogram.com/pubs/pdf/cr33/cr33.pdf [Last Accessed 17 February 2021].
[20] DHS 2014, p. 331.

4.2 County variations

The prevalence of FGM/C in Kenya varies greatly among the 47 counties (Annex I). In some counties, such as Mandera, Wajir, Garissa, Marsabit and Nyamira, the prevalence is very high (more than 90%). In other counties, the prevalence is very low (less than 2%), for example in Siaya, Kisumu, Bungoma and Kakamega (Figure 4.2). This can be explained by the ethnic, religious, socio-economic backgrounds of people living in these geographical areas (see next sections).

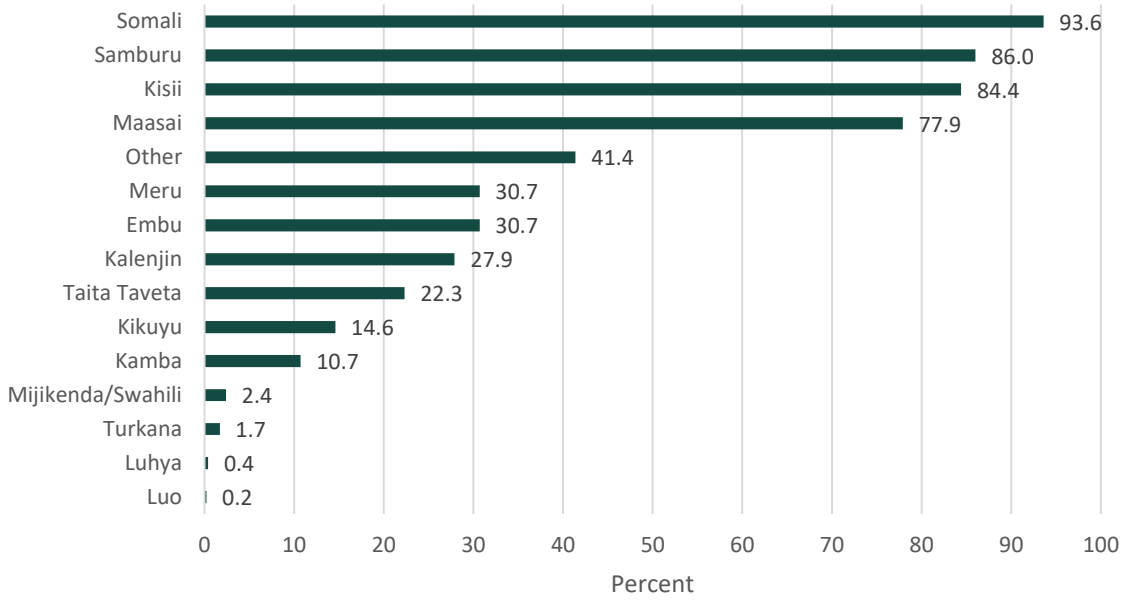
Figure 4.2: FGM/C prevalence by county



4.3 Ethnic variations

The proportion of women aged 15-49 who have undergone FGM/C varies significantly by ethnic group, with the majority of women of Somali (93.6%), Samburu (86%), Kisii (84.4%), and Maasai (77.9%) ethnic backgrounds having undergone FGM/C (Figure 4.3). In contrast, less than 3% of women from Luo, Luhya, Turkana, and Mijikenda/Swahili ethnic groups have undergone FGM/C (Figure 4.3).

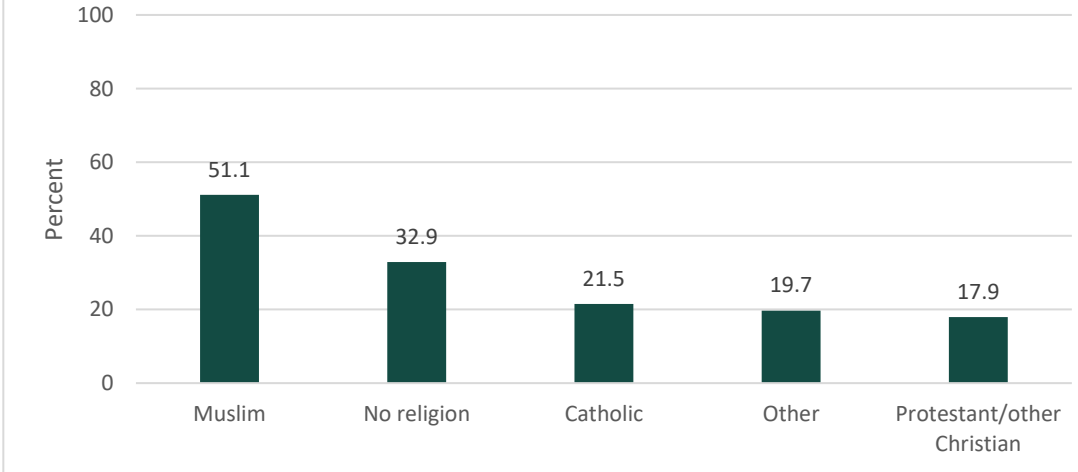
Figure 4.3: Ethnic variations in FGM/C prevalence



4.4 Religious affiliation

The proportion of women aged 15-49 who have undergone FGM/C varies significantly by religious affiliation. It is nearly three times higher among Muslim women compared to women from Protestant or other Christian denominations (51% and 18%, respectively; Figure 4.4).

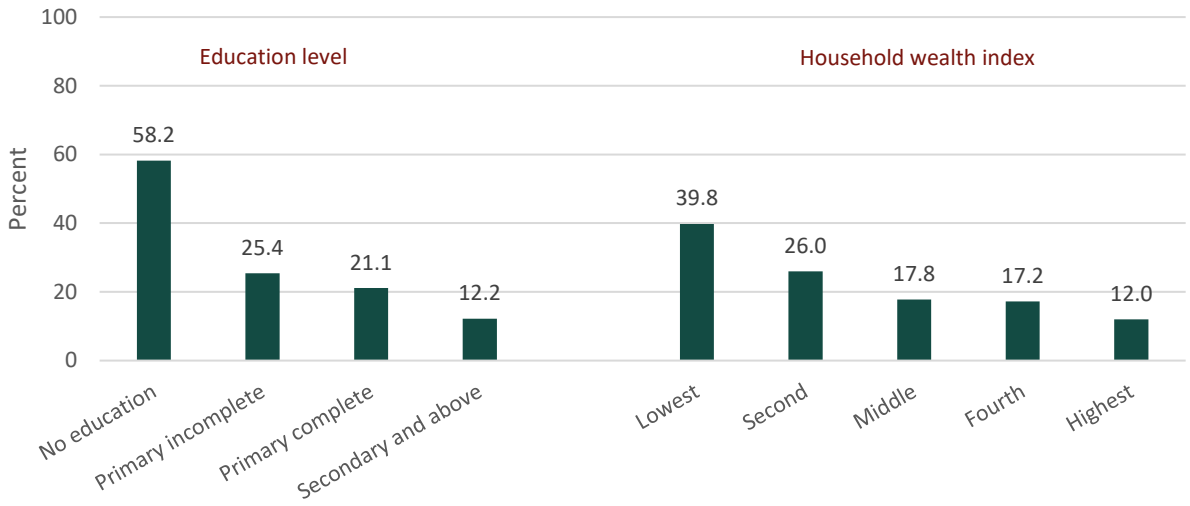
Figure 4.4: FGM/C prevalence by religious affilation



4.5 Socio-economic indicators

FGM/C prevalence among women aged 15-49 declines markedly with higher levels of socio-economic status. It is nearly five times as high among women with no education compared to women with secondary or higher levels of education (58% and 12%, respectively; Figure 4.5). It is also more than three times higher among women from the poorest households compared to those from the richest households (40% and 12%, respectively; Figure 4.5).

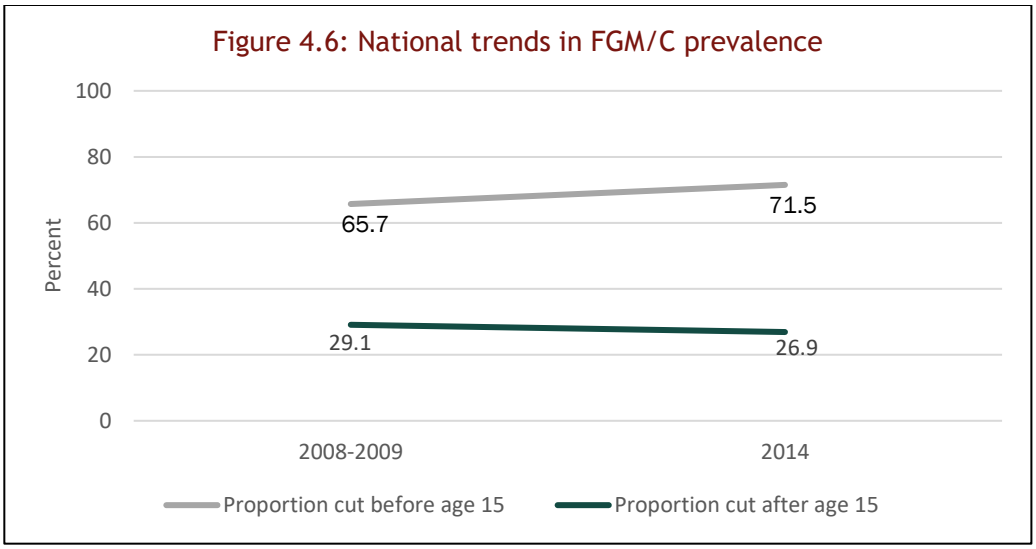
Figure 4.5: FGM/C prevalence by socio-economic indicators



4.6 Age of cutting

Distribution of women by age of cutting shows that 2.3% underwent FGM/C before the age of 5, 26.6% at age 5-9, 42.6% at age 10-14, and 26.9% at age 15 or older.

There is some evidence suggesting a trend over time of girls undergoing FGM/C at a younger age in Kenya. For instance, the proportion of women aged 15-19 who underwent FGM/C at age 5-9 is more than twice the proportion of those aged 45-49 who were cut at that age (46% and 17%, respectively). In addition, the proportion of women aged 15-49 who were cut before the age of 15 increased from 65.7% in 2008-2009 to 71.5% in 2014 (Figure 4.6). Similarly, the proportion of women aged 15-49 who were cut at the age of 15 or higher slightly declined from 29% in 2008-2009 to 27% in 2014 (Figure 4.6).



4.7 Type of FGM/C and practitioners

The majority of women who have undergone FGM/C in Kenya (87.2%) had a cut with flesh removed, while 9.3% reported that their genital area had been sewn closed (also known as infibulation), and 1.6% were cut with no flesh removed. Of girls aged 0-14, 7.8% have had their genital area sewn closed. The data shows that girls are more likely to be infibulated if their mother was also infibulated.

FGM/C in Kenya continues to be carried out predominantly by traditional practitioners (83.3%). Medical professionals carried out 14.8% of the FGM/C cases that were reported in 2014. On the one hand, there does not seem to be a trend towards medicalization since the proportion of cases carried out by medical professionals in 2014 was lower than in 2008-2009 (14.8% and 19.7%, respectively). On the other hand, when analysing the 'daughter data', there seems to be an **increase in medicalization among the younger generation**. In 2014, 19.7% of girls aged 0-14 was cut by a medical professional, while only 14.8% of women aged 15-49 (Table 4.7).

Table 4.7: Person who performed FGM/C

Person who performed FGM/C	Girls age 0-14 (daughters)	Women age 15-49 (mothers)
Traditional agent	74.9%	83.3%
Medical professional	19.7%	14.8%

4.8 Attitudes towards FGM/C

Data from the DHS 2014 shows that knowledge about FGM/C in Kenya is high: 96.8% of women and 97.6% of men across all ethnic groups have heard about the practice. Among both women and men, knowledge of FGM/C generally increases with increasing education and household wealth status.

Only a small proportion of women and men who have heard of FGM/C believe that it is **required by religion** (4.5% and 5.5%, respectively). However, there are strong variations by ethnic group. For example, the majority of Somali women (82.3%) and men (83.4%) believe that FGM/C is required by religion. In addition, women (35.5%) and men (37.4%) with no education are more likely to report that FGM/C is required by their religion than those with some formal education. In addition, women (15.4%) and men (13.9%) from the poorest households are most likely to believe that FGM/C is a religious requirement than those from richer households.

Only 7.9% of women and 10.6% of men who have heard of FGM/C believe that it is **required by their community**. Variations by ethnic group, education level and household wealth status mirror those of the belief related to FGM/C and religion.

The proportion of women and men who have heard of FGM/C who believe that **FGM/C should continue** is also low (6% and 9%, respectively). The overwhelming majority of women (92.5%) and men (88.8%) believe that FGM/C should end. There is a slight decline in the proportion of women who have undergone FGM/C who believe that the practice should continue, from 28.9% in 2008-2009 to 23% in 2014.

5. Girls at risk of FGM/C

5.1 Introduction

Despite the important progress that has been made in the past two decades in Kenya and the trend towards a decline in FGM/C prevalence, a considerable number of girls and young women remain at risk of the practice. UNFPA estimates that globally, 68 million girls are at risk of FGM/C by 2030, if no concerted and accelerated action is taken to end the practice.[20] In this section, we estimate the absolute number of girls at risk of FGM/C in Kenya.

5.2 Methodology

While acknowledging that every approach to estimate the absolute number of girls at risk of FGM/C has its own limitations, we used the method proposed by the European Institute for Gender Equality (EIGE)[21] to estimate the number of girls at risk of FGM/C in Kenya. This approach uses FGM/C prevalence among girls 15-19 years and the number of girls who have reached the median age of cutting. We computed the median age of cutting and FGM/C prevalence among girls 15-19 years in each region and county from the 2014 DHS. We then determined the number of girls who have reached the median age of cutting in each region and county from the 2019 Kenya Population and Housing Census data. We calculated the number of girls at risk of FGM/C as the product of the number of girls who have reached the median age of cutting and FGM/C prevalence among girls 15-19 years in each region and county. The estimates show that the number of girls at risk of FGM/C at the start of the programme mirror prevalence of the practice, that is, very high in counties where the practice is high and very low in counties where the practice is low (Table 5.3).[22]

5.3 Estimates of the number of girls at risk

Table 5.3: Estimates of the number of girls at risk of FGM/C in Kenya

	Number of girls (0-18 years)	Median age of cutting	Number of girls within median age of cutting	FGM/C prevalence among girls 15-19	Number of girls at risk of FGM/C
	(2019 CENSUS)	(KDHS 2014)	(2019 CENSUS)	(DHS 2014)	
Coast	**1,034,505**	**8**	**523,234**	**5.6**	**29,301**
Kilifi	374,254	9	202,370	0.0	0
Kwale	230,313	8	117,236	0.0	0
Lamu	33,248	9	18,375	11.4	2,095
Mombasa	237,208	10	150,980	2.4	3,624
Taita Taveta	71,344	0	3,895	0.0	0
Tana River	88,138	9	51,884	56.4	29,263

[21] European Institute of Gender Equality, Estimation of girls at risk of Female Genital Mutilation in the European Union: Belgium, Greece, France, Italy, Cyprus and Malta, EIGE Report, 2018, available at https://eige.europa.eu/publications/estimation-girls-risk-female-genital-mutilation-european-union-report-0 [Last Accessed 18 February 2021].

[22] These figures may need to be interpreted with caution and the reality could be higher, given the data is some years old and doesn't account for more recent trends or impacts of COVID-19.

North Eastern	**728,820**	**7**	**332,334**	**99.7**	**331,337**
Garissa	217,038	7	92,462	99.3	91,815
Mandera	287,526	8	160,573	100.0	160,573
Wajir	224,256	7	101,178	100.0	101,178
Eastern	**1,523,860**	**12**	**1,035,390**	**12.0**	**124,247**
Embu	119,450	12	80,373	17.5	14,065
Isiolo	70,814	9	40,248	65.1	26,201
Kitui	281,238	9	134,083	8.2	10,995
Machakos	287,617	9	146,859	0.0	0
Makueni	219,120	7	79,024	0.0	0
Marsabit	126,075	12	93,237	90.1	84,007
Meru	336,654	14	269,026	16.6	44,658
Tharaka Nithi	82,892	15	55,835	8.2	4,578
Central	**1,062,038**	**14**	**852,619**	**1.7**	**14,495**
Kiambu	458,207	13	351,038	2.6	9,127
Kirinyaga	110,971	14	87,586	0.0	0
Muranga	211,003	14	169,313	0.0	0
Nyandarua	142,005	14	111,905	3.8	4,252
Nyeri	139,852	13	103,583	1.1	1,139
Rift Valley	**3,198,567**	**14**	**2,623,187**	**8.5**	**222,971**
Baringo	176,197	15	153,739	9.6	14,759
Bomet	223,501	16	204,579	4.0	8,183
Elgeyo Marakwet	116,750	14	94,910	0.0	0
Kajiado	256,015	12	190,130	46.0	87,460
Kericho	218,564	16	199,192	1.0	1,992
Laikipia	118,388	13	90,008	12.3	11,071
Nakuru	496,957	14	403,775	1.2	4,845
Nandi	216,018	17	207,073	0.8	1,657
Narok	329,087	14	280,365	25.1	70,372
Samburu	88,292	14	74,667	57.1	42,635
Trans Nzoia	259,615	14	209,711	4.4	9,227
Turkana	247,630	10	155,917	7.4	11,538
Uasin Gishu	265,754	15	226,955	0.0	0
West Pokot	185,799	15	166,837	24.5	40,875
Western	**1,336,816**	**13**	**997,827**	**0.0**	**0**
Bungoma	458,021	14	370,476	0.0	0
Busia	239,675	8	107,747	0.0	0
Kakamega	492,946	8	218,927	0.0	0
Vihiga	146,174	8	63,174	0.0	0
Nyanza	**1,618,031**	**10**	**932,520**	**26.6**	**248,050**
Homa Bay	307,435	12	216,469	0.0	0

Kisii	316,309	9	157,564	84.3	132,826
Kisumu	282,575	8	128,899	0.0	0
Migori	312,390	12	223,278	25.0	55,820
Nyamira	146,719	10	80,998	78.2	63,340
Siaya	252,603	10	145,056	0.0	0
Nairobi	**816,927**	**12**	**596,397**	**4.5**	**26,838**
Kenya	**11,319,564**	**12**	**7,990,885**	**11.4**	**910,961**

Note: Estimates of median age of cutting are based on weighted sample sizes of less than 30 in 16 counties: Kwale, Kilifi, Lamu, Taita Taveta, Machakos, Makueni, Nyeri, Turkana, Nandi, Kakamega, Vihiga, Bungoma, Busia, Siaya, Kisumu, and Homa Bay. In addition, estimates of FGM/C prevalence among girls 15-19 years are based on weighted sample sizes of less than 30 in 15 counties: Tana River, Lamu, Taita Taveta, Wajir, Mandera, Marsabit, Isiolo, Tharaka Nithi, Nyandarua, Nyeri, Kiambu, West Pokot, Samburu, Elgeyo Marakwet, and Nyamira.

6. International Commitments

6.1 Ratifications human rights treaties

The Kenyan government has ratified all treaties that are relevant to the elimination of FGM/C, including the Convention on the Elimination of All of Discrimination against Women (CEDAW) Convention, the Convention on the Rights of Children (CRC) and the Maputo Protocol (Table 6.1) However, the Kenyan government made an important reservation in relation to the Maputo Protocol. More specifically, the government does not consider itself to be bound upon the provisions of Article 10(3) and Article 14(2)(c), as it the government claims that these provisions are "*inconsistent with the provisions of the Laws of Kenya on health and reproductive rights.*" This means that the government is not bound by the provision on the promotion of women and there is no international legal obligation to take measures to establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding.

Table 6.1: International Commitments

Treaty	Abbreviation	UN / AU	Ratified	Date
International Covenant on Civil and Political Rights	ICCPR	UN	Yes	1 May 1972
International Covenant on Economic, Social and Cultural Rights	ICESCR	UN	Yes	1 May 1972
Convention on the Elimination of All Forms of Discrimination Against Women	CEDAW	UN	Yes	9 Mar 1984
Convention on the Rights of the Child	CRC	UN	Yes	30 July 1990
African Charter on Human and Peoples' Rights	ACHPR	AU	Yes	23 Jan 1992
Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa	Maputo Protocol	AU	Yes	25 Nov 2005
African Charter on the Rights and Welfare of the Child	ACRWC	AU	Yes	25 Jul 2000
African Youth Charter	AYC	AU	Yes	23 Jan 2014

6.2 Recommendations from Treaty Monitoring Bodies

When a state signs and ratifies a treaty, it is obliged to periodically report progress made on the implementation of the substantive treaty provisions to the Treaty Monitoring Bodies (TMB). Independent experts assess what has been achieved and what more needs to be done to promote and protect human rights. FGM/C has been a topic discussed in-depth by the TMB over the past years, including in the Kenyan context.

In 2016, the **Committee on the Rights of the Child** welcomed the enactment of the Female Genital Mutilation Act, but at the same time the committee expressed its concern that – despite its legal prohibition - FGM/C is still persistent in Kenya. Therefore, the Committee urged the Kenyan government to *"Enforce effectively the prohibition of female genital mutilation, including that practised by health practitioners, child marriage, and other forms of harmful practices; (b) Continue efforts to address the root causes of such practices and implement culturally appropriate measures to eliminate them; (c) Prohibit any out-of-court settlements in cases of harmful practices."*[23]

[23] Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, CRC/C/KEN/CO/3-5, 21 March 2016, available at

In 2017,[24] the **CEDAW Committee** expressed its concern about the persistence of discriminatory stereotypes with regard to the roles and responsibilities of women and men in the family and in society, as well as harmful practices, such as FGM/C in Kenya. It recommended to the Kenyan government to provide systematic training for judges, prosecutors, legal professionals, law enforcement officials and medical personnel on the strict application of criminal law provisions to punish FGM/C, and raise awareness about the criminal nature of such practices and their adverse effect on women's rights. In addition, the CEDAW Committee recommended the Kenyan government to ensure that women who are victims of harmful practices can file complaints without fear of retribution or stigma and have access to effective remedies and victim support, such as legal, social, medical and psychological assistance and shelters.

More specifically in relation to FGM/C, the CEDAW Committee recommended that the Kenyan government ensures that the Prohibition of Female Genital Mutilation Act is widely known and implemented, and that perpetrators of FGM/C, including medical practitioners, are prosecuted and adequately punished. Furthermore, the Committee recommended the Kenyan government to take measures to eradicate FGM/C, including through increased awareness-raising among religious and traditional leaders and the general public, in cooperation with civil society, about the criminal nature of the procedure, its adverse effect on the human rights of women and the need to eradicate it and its underlying cultural justifications. Lastly, the Committee specifically recommended to update the 2010 Female Genital Mutilation policy.

6.3 Recommendations from the Universal Periodic Review

The Universal Periodic Review (UPR) is a process which involves a review of the records of all UN Member States. It is a state-driven process, under the umbrella of the Human Rights Council. The UPR is an opportunity for states to explain what actions they have taken to improve the human rights situation in their respective countries and to fulfil their human rights obligations. Kenya was reviewed for the first time in 2010, for the second time in 2015 and the third time in January 2020. During this recent review, various countries raised concerns, asked questions, and made recommendations to the Kenyan government in relation to FGM/C (Table 6.3).

Table 6.3: Comments and Recommendations UPR

Country	Comments
Canada	welcomed the commitment by Kenya to eradicating female genital mutilation by 2022.
Costa Rica	expressed concern about child and forced marriage, female genital mutilation, murders, mutilations, kidnappings, rapes, and trafficking in persons and in the body parts of persons with albinism.
Estonia	welcomed the commitment to eradicating female genital mutilation, while expressing concern about the high level of gender-based violence.
Slovenia	urged Kenya to adopt a comprehensive strategy to eliminate harmful practices, including forced marriage and female genital mutilation.
Country	**Recommendations (that enjoy the support of Kenya):**
Angola	Make an effort to implement existing legislation to end female genital mutilation.
Austria	Continue efforts to end female genital mutilation and harmful practices such as child marriage, in close collaboration with civil society.

https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2fKEN%2fCO%2f3-5&Lang=en [Last Accessed 20 February 2021].

[24] Committee on the Elimination of Discrimination Against Women, Concluding Observations on the eight periodic report of Kenya, CEDAW/C/KEN/CO/8, 22 November 2017, available at https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW%2fC%2fKEN%2fCO%2f8&Lang=en [Last Accessed 20 February 2021].

Belgium	Ensure that the Prohibition of Female Genital Mutilation Act is widely known and implemented, and that perpetrators of female genital mutilation, including medical practitioners, are prosecuted, and adequately punished.
Brazil	Redouble efforts to provide training to medical, security and justice professionals on the application of its criminal law punishing harmful practices such as child, early and forced marriage, female genital mutilation, and girl “beading”.
Burkina Faso	Adopt a national policy aimed at eliminating female genital mutilation and increase the resources allocated to the council for combating female genital mutilation.
Cabo Verde	Enforce the prohibition of female genital mutilation and child rape (“beading”).
Eritrea	Take measures to fully abolish female genital mutilation through a public campaign on the new legislation.
France	Put an end to violence against women and girls and eradicate female genital mutilation.
Georgia	Strengthen its efforts to fully implement the Prohibition of Female Genital Mutilation Act of 2011.
Ghana	Continue efforts to ensure the full implementation of legislation to eradicate the harmful practice of female genital mutilation.
Ireland	Develop and implement a comprehensive strategy to eliminate harmful practices and ensure that perpetrators are held accountable and that victims have access to effective remedies.
Italy	Continue efforts to eradicate all harmful practices against women and girls, including female genital mutilation and child, early and forced marriage, and to combat violence against women, including by enhancing access to justice.
Maldives	Take measures to eradicate female genital mutilation, through increased awareness-raising among all groups.
Namibia	Develop and implement a comprehensive strategy to eliminate harmful practices and stereotypes that discriminate against women and girls.
Nepal	Continue to take measures to eradicate the harmful practices of female genital mutilation and other sexual and gender-based violence.
New Zealand	Actively implement the positive measures to end gender-based violence and harmful practices, including through recent legislative frameworks, a pledge to end female genital mutilation, and its commitment to reduce maternal deaths.
Costa Rica	Redouble efforts to eradicate the harmful practice of female genital mutilation, through the dissemination of the Law on the Prohibition of Female Genital Mutilation and prosecute and subsequently punish those responsible for carrying out this practice.
Philippines	Continue to implement its inclusive national framework on preventing and addressing sexual and gender-based violence.
Senegal	Complete the procedure for examining a national policy to end female genital mutilation.
Spain	Effectively implement the strategy for the eradication of female genital mutilation and forced child marriage.
Sweden	Adopt and implement a national policy on the eradication of female genital mutilation.
Ukraine	Adopt the necessary measures aimed at eliminating harmful practices, such as child and forced marriage, FGM/C, and others.
Zimbabwe	Streamline the ongoing programmes aimed at eliminating sexual and gender-based violence and female genital mutilation.

7. National Legal Framework

7.1 National Law

In 2011, Kenya adopted a law - the **Prohibition of Female Genital Mutilation Act 2011** - that prohibited FGM/C nationwide (Annex II).[25] Anyone who performs any type of FGM/C (including when it is done by medical professionals) commits an offence, regardless of the age or status of a girl or woman. The minimum sentence is three years and/or a minimum fine of 200.000 shillings. If FGM/C is carried out and causes death, the perpetrator will be liable to imprisonment for life (Article 19). Not only the person who performs FGM/C is liable in Kenya, but also a person who aids, abets, counsels or procures commits an offence (Article 20). The Act also criminalizes cross-border FGM/C. Or in other words: if a person who takes another person from Kenya to another country, or arranges for another person to be brought into Kenya from another country, with the intention of having that other person to be subjected to FGM/C is also liable (Article 21). In addition, the failure to report FGM/C to the authorities is also an offence. Article 24 explicitly states the following: *"A person commits an offence if the person, being aware that an offence of female genital mutilation has been, is in the process of being, or intends to be, committed, fails to report accordingly to a law enforcement officer."* Lastly, the law also prohibits the use of derogatory or abusive language that is intended to ridicule, embarrass or otherwise harm women for not having undergone FGM/C, with a minimum prison sentence of six months (and/or a minimum fine of 50.000 shillings). The law also has extraterritorial jurisdiction, which means that if a Kenyan citizen or permanent resident commits FGM/C outside Kenya, this person can still be prosecuted in Kenya under the Act.

The Act also established the **Anti-Female Genital Mutilation (FGM) Board**, which came into being in 2014 as a Semi-Autonomous Government Agency (SAGA) under the Ministry of Public Service and Gender. Its functions are set out under Article 5: to design, supervise and co-ordinate public awareness programmes against FGM/C in the country; to advise the Government on matters relating to FGM/C and the implementation of the law; to design and formulate a policy on the planning, financing and coordinating of all activities relating to FGM in the country; to provide technical and other support to institutions, agencies and other bodies engaged in the programmes aimed at eradication of FGM/C; to design programmes aimed at the elimination of FGM/C; and to facilitate resource mobilization for the programmes and activities. Furthermore, the Anti-FGM Board requires that necessary measures be taken by the government of Kenya to protect women and girls from FGM/C; to provide support services to victims of FGM/C; and to undertake public education.

While some arrests have been made and **cases brought to court in Kenya** since the introduction of the Act in 2011, generally, the implementation of the law and its enforcement remain a challenge. A study on the implementation of the law in Kenya concluded: "This is largely due to a lack of resources, difficulties reaching remote rural areas and the limited capacity of law-enforcement agents. Evidence suggests that judges are often reluctant to respect the statutory minimum custodial sentence provided by the law, and sentences are routinely being reduced or

[25] Although the Constitution and other national laws are relevant in relation to FGM/C as well, such as the Children Act 2001 (revised in 2016), the Protection Against Domestic Violence Act (2015) and the Penal Code (revised in 2014), we focus on this PEA only on the Prohibition of FGM Act 2011 (revised in 2012).

quashed on appeal."[26] This is also confirmed in the National Policy for the eradication of FGM. One of the challenges highlighted in this policy is the weak enforcement of the laws relating to FGM/C.[27] More specifically, law enforcement officers, survivors and witnessing communities where FGM/C is practiced are threatened by members of the community and sometimes harmed for reporting incidences effectively hampering the enforcement of the laws. In addition, some communities have come out publicly to resist the implementation of the law and claim that the law encroaches on their cultural identity and rights.[28]

7.2 National Policies

Various policies and Action Plans have been set up to address FGM/C. The Kenyan government adopted **The National Policy for the Abandonment of Female Genital Mutilation** in June 2010. The policy was instrumental in formulation of the Prohibition of Female Genital Mutilation Act 2011. The National Policy was revised in 2019 because of "the need to address emerging trends that have contributed to the slow decline in practice of FGM."[29]

Other policies that are relevant in relation to FGM/C in Kenya are the following:

- National Reproductive Health Policy (2007)
- **National Plan of Action for the Elimination of Female Genital Mutilation in Kenya** (2008-2012)
- Adolescent and Reproductive health Policy and Plan of Action (2005-2015)
- National Policy for Prevention and Response to Gender Based Violence (2014)
- National Adolescent Sexual and Reproductive Health Policy (2012)
- National Gender and Development Policy (2019)

Over the past few years, the Anti-FGM Board adopted two **Strategic Plans** covering the periods 2014-2018 and 2019-2023 that sets out the direction and aim which the Board wish to achieve.

In 2019, the President made a declaration that FGM/C should end in Kenya by the year 2022 that led to the development of the **President's Acceleration Plan to End FGM by 2022**[30] and the formation of a multi-agency technical committee with representatives drawn from 10 government ministries and state offices.[31]

[26] 28TooMany, Kenya: The Law and FGM, May 2018, p. 6, available https://www.28toomany.org/static/media/uploads/Law%20Reports/kenya_law_report_v1_(may_2018).pdf [Last Accessed 22 February 2021].
[27] Republic of Kenya, National Policy for the eradication of Female Genital Mutilation, Sessional Paper No. 3, January 2019, p. 14, available at https://gender.go.ke/wp-content/uploads/2019/10/NATIONAL-POLICY-FOR-THE-ERADICATION-OF-FEMALE-GENITAL-MUTILATION-.pdf [Last Accessed 22 February 2021].
[28] Dr. Tatu Kamau (a female physician from Kenya), who also held a number of high-level positions at the Ministry of Health filed a case at the Machakos High Court seeking to have FGM/C legalized for adult women who – to her mind - should have the right to freely choose FGM/C. She claims that the legal ban on FGM/C in Kenya is unconstitutional and argues that females, especially adult women should have the freedom to consent to the practice and have the right to be cut under the supervision of a medical practitioner.
[29] Republic of Kenya, National Policy for the eradication of Female Genital Mutilation, Sessional Paper No. 3, January 2019, p. 7-8, available at https://gender.go.ke/wp-content/uploads/2019/10/NATIONAL-POLICY-FOR-THE-ERADICATION-OF-FEMALE-GENITAL-MUTILATION-.pdf [Last Accessed 22 February 2021].
[30] President's national address on ending FGM in Kenya, available at: http://www.antifgmboard.go.ke/download/president-uhuru-kenyatta-national-address-on-ending-fgm-in-kenya-at-statehouse-nairobi-in-nov-2019/ [Last Accessed 22 February 2021].
[31] For more information, please see section 8.2 of this PEA.

7.3 East African Community Prohibition of Female Genital Mutilation Bill

In 2015, the East Africa Community[32] took the initiative to develop a regional law on FGM/C to promote cooperation in the prosecution of perpetrators of FGM/C. In august 2016, the East African Community Prohibition of Female Genital Mutilation Bill (EAC Bill) went through the Legislative Assembly.[33] The Bill proposes harmonization of laws, policies and strategies to eliminate FGM across the region, recognizing that it's practiced for different reasons including cultural and religious beliefs by several communities including immigrants. The EAC Bill sets out its objectives in Article 3, which include: prohibiting FGM/C as a 'trans-national crime'; providing a minimum penalty for the offence of FGM/C; establishing institutions to foster cooperation in the prosecution of offenders, prevention of FGM/C and provision of services of victims and girls at risk of FGMC; and developing and harmonizing policies, laws, strategies and programmes to prevent FGM/C, to prosecute offenders and provide services to victims and girls at risk of FGM/C. Cross-border FGM/C is also criminalized in Article 6: *"A person commits an offence if the person takes another person from a Partner State to another Partner State or another country, or arranges for another person to be brought into a Partner State from another country with the intention of having that other person subjected to female genital mutilation."*

The EAC Bill is a good example of a regional mechanism attempting to tackle cross-border FGM. However, although the EAC Bill went through the regional Assembly in 2016, it has not been signed into a law yet, as it did not receive assent from the Heads of State within the required time.

Over the past few years, several initiatives have been taken to push for the revival of debate and assentation of the EAC Bill, for example by women rights' groups,[34] UNFPA-UNICEF Joint Programme and governments.[35]

7.4 Stakeholder reflections on legal framework

Across all the stakeholders interviewed the view was shared that the **legal and policy frameworks were robust, but it is the implementation of them that remains a problem**. It was also felt by a considerable number that the presidential decree that FGM/C is to be ended by 2022 has made a big difference in terms of making the criminality of FGM a more visible issue. One CSO stakeholder shared; "*Kenya has very strong legal and policy framework – the problem is in implementation for the same. Until the president decreed FGM banned in Kenya, civil servants and ministries did not have it as a matter of concern."*

Several CSO's shared that successful implementation of the law relied strongly on seeing sanctions being applied when it is broken. One government official gave an example of sanctions clearly being seen through. *"The sacking of chiefs in Kuria due to community parading girls who had been cut was a shock to many – now they know the government can act if they are not*

[32] The East Africa Community is a regional intergovernmental organization including six partner states: Burundi, Kenya, Rwanda, South Sudan, Tanzania, and Uganda. For more information, see: East African Community, *Overview of EAC*, available at https://www.eac.int/overview-of-eac [Last Accessed 22 February 2021].
[33] East African Community, *The East African Community Prohibition of Female Genital Mutilation Bill 2016*, 19th August 2016, available at http://www.eala.org/uploads/Geni_14-Sep-2016_10-31-04.pdf [Last Accessed 22 February 2021].
[34] M. Havyarimana, *Women decry delay in assenting to regional anti-FGM Bill*, The East African, 6 November 2018, available at https://www.theeastafrican.co.ke/news/ea/Women-decry-delay-in-signing-anti-FGM-Bill-into-law/4552908-4839818-se9yngz/index.html [Last Accessed 22 February 2021].
[35] M. Xuequan, *East African states unite to eradicate female genital cut*, Xinhua, 18 April 2019, available at http://www.xinhuanet.com/english/2019-04/18/c_137985796.htm [Last Accessed 22 February 2021].

working to stop FGM." Legislation has to happen alongside sensitisation. As one CSO stakeholder shared; "*We know we cannot win this by using law alone."*

Concerns were expressed by some CSO stakeholders that **the way in which the law is enacted in relation to processes for prosecution adds to the vulnerability of girls.** For example, in one interview it was shared; "*Girls are arrested as part of the prosecution process in order to stop them running away and ensuring that they give their testament."* Another CSO stakeholder gave further insight into the challenges of implementation; "*The paperwork is very good but the problem is implementation even judges who are sitting in the bench then come from these communities which circumcise and when they are handling the cases they are very careful, we have evidence and very few people have been convicted."* In another interview again with a CSO stakeholder a similar view was shared; *"law enforcers are from same communities and they hold same beliefs, so they sympathise with those that they are supposed to punish."*

The **lack of support offered to girls through the process of prosecution** was also highlighted by a number of women-led CSOs. In the passage below the tensions between the application of the law and traditional customary approaches to justice is highlighted. "*The first challenge I can talk about is access to legal services because we have girls who actually report the cases and we cannot be everywhere as an organization. For example, in the whole of North Eastern a girl has been defiled or a girl was rescued from FGM and the case was reported so because of "Maslaha" whereby it is a local system, an alternative dispute resolution system that is normally used, you find that this girl does not get justice. So, this one is a major hindrance to justice amongst the girls especially the survivor and this one actually contributes a lot to girls and young women not wanting to report because they say if I report tomorrow the same man will be outside (released) and nothing will happen and I will not get justice, so one is the access to the legal justice services."*

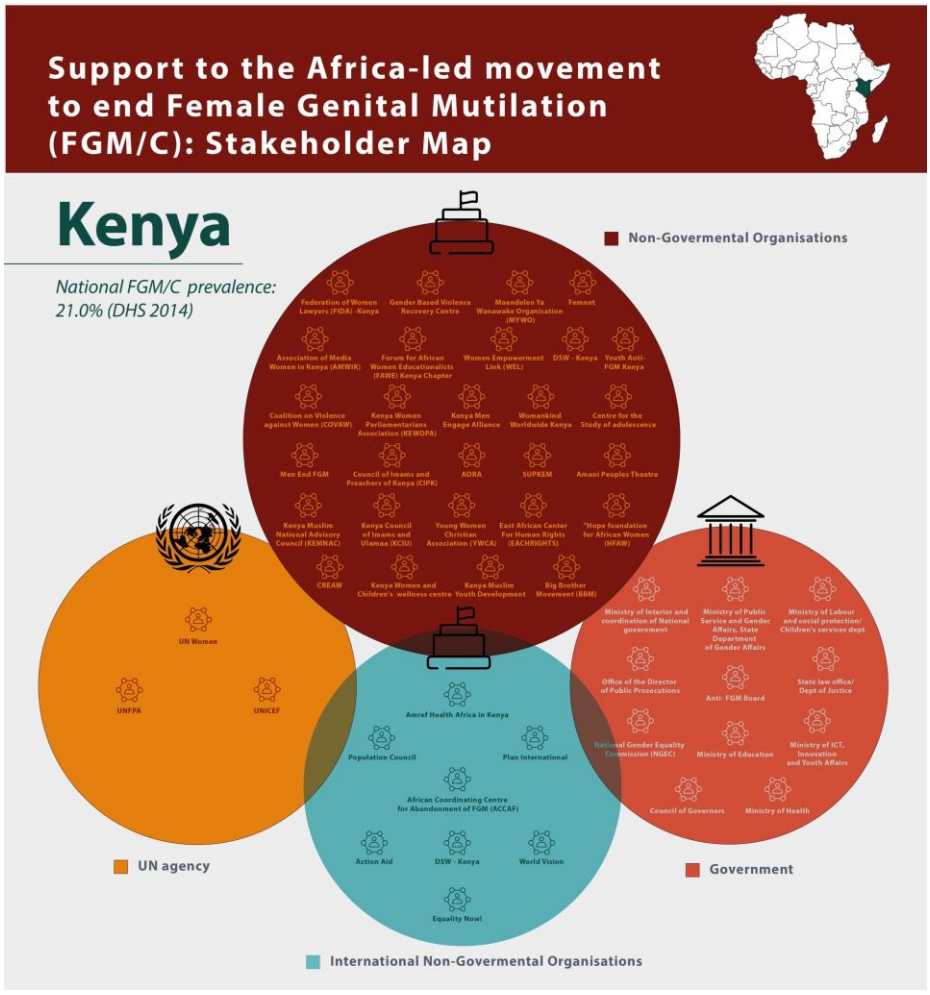
Some stakeholders both government officials and CSOs highlighted that the **practice of cross-border FGM/C to avoid the law in Kenya** was growing as an issue of concern. The need to work better regionally was highlighted.

8. Stakeholder mapping

8.1 Methodology

There are many stakeholders with interests in the anti FGM/C and gender equality space in Kenya ranging from government entities, UN agencies, bi-lateral donors, international and national non-governmental organisations, community-based organisations, faith-based organisations, and individual change agents. This exercise sought to map key institutions and change agents that are working towards the abandonment of FGM/C at the national level. While identifying key government stakeholders and UN agencies was not challenging because these are clearly defined, INGO and CSOs tend to not have interventions nationally even when their registration gives them this mandate. Many organisations, while having their main offices in Nairobi, have interventions in specific regions or a few counties across the country, while others may only have interventions in one county. Therefore, for purposes of this PEA exercise, only international and national organisations with FGM/C activities in multiple counties were mapped (Figure 8, Annex III and VII).

Figure 8.1: Stakeholder Map



8.2 Government stakeholders

Anti-FGM/C work in Kenya is housed under the Ministry of Public Service and Gender and specifically under the State Department for Gender. As described in the previous section, the prohibition of Female Genital Mutilation Act established the Anti-FGM Board that consists of appointees by both the president and the cabinet secretary as well as representatives from the relevant ministries and departments namely: – Gender, Finance, Health, youth, education and is headed by a Chief Executive Officer.

Following the declaration of the President that FGM/C should end in Kenya by the year 2022, a multi-agency technical committee was formed with representatives drawn from 10 government ministries and state offices considered pivotal in ending FGM/C namely, Ministry of Public service and gender (special programmes for women empowerment, gender mainstreaming in other ministries and domestication of relevant international and regional treaties and conventions), Ministry of Interior and Coordination of National government (responsible for enforcement of the Prohibition of FGM Act and creating awareness and registering cases of FGM/C), Ministry of Health (handling health component of FGM/C, training professionals, integrating FGM/C in medical school curriculum), Ministry of education, science and technology (including anti-FGM/C content in the school curriculum, strengthening school clubs to address child protection, FGM/C and gender issues, enforcement of prohibition among others), Ministry of East African Community and regional development (cross-border initiatives), Ministry of labour and social protection/children's department (implementation of the Children Act 2001, child protection, livelihoods for FGM/C survivors), Ministry of ICT, Innovation and Youth Affairs (promoting youth empowerment and youth engagement, integrating FGM/C messages in youth training, development of ICT materials including Apps that can be used to report Gender-Based Violence (GBV) cases), Office of the director of public prosecution (Prosecution and collection of relevant data), State Law office/Department of Justice (enhancing legal interpretation of FGM/C cases, taking courts closer to communities, educating the public on GBV cases including FGM/C), the National treasury (FGM/C resource allocation). The National Gender Equality Commission is also a member of the multi-agency technical committee with the responsibility of promoting and ensuring gender equality as provided by the Constitution of Kenya 2010, reduce gender inequalities and discrimination against all persons, receiving and investigating violations regarding sexual and reproductive health (including FGM/C)[36].

The Multi-Agency Technical Committee sits at the national level but is replicated at county level through the County Anti-FGM Steering Committees that are co-chaired by the County commissioner and the national gender officers. All non-state actors working at country level on FGM/C are supposed to report quarterly of their activities through this entity at County level.

8.3 Other (non-state) stakeholders

Besides government stakeholders, there are other non-state actors active in the anti-FGM/C space in Kenya. These include **UN agencies** namely, UNFPA, UNICEF and UN Women that support the government and other development practitioners in the sectors of health and human rights (including children's rights) and specifically in policy formulation, elimination of discrimination against women and girls, achievement of equality between men and women, child protection, health systems strengthening, peace among others. UNFPA and UNICEF have

[36] Ministry of gender affairs, Government of Kenya. National policy on eradication of Female genital mutilation. Nairobi, Kenya: Government of Kenya; 2019.

implemented the 'UNFPA-UNICEF Joint Programme on Eliminating Female Genital Mutilation: Accelerating Change' in Kenya since 2008. The main objective is to accelerate the abandonment of FGM/C through partnership with the government, civil society, social movements, religious leaders, and communities. The programme focuses on strengthening policy development and implementation, improving access to quality health care, protection and legal and social services and engages communities to transform social norms from within and to ensure that girls have access to quality services for child protection and sexual and reproductive health.[37]

There also exists a strong body of **international and national non-governmental organisations**, civil society (consisting of women and youth organisations) as well as religious actors and activists active in the anti-FGM/C space in Kenya (Annex III and IV).

8.4 Findings Key Informant Interviews

8.4.1 Government Commitment to see change

There was consensus across the interviews that government commitment to end FGM/C exists. Many of those interviewed highlighted the Presidential commitment to end FGM/C in Kenya by 2022. Whilst there was a significant amount of doubt expressed particularly by INGOs and national CSOs that this would be achieved, the declaration and subsequent steps taken by the government in developing the *President's Acceleration plan to end FGM by 2022* was seen as a positive step.

One government official stated; "*Political will is more than 100% the Anti FGM board is a state agency and shows the commitment of government to end FGM" w*hile another senior official in one of the ministries indicated; "*At the national level, we have the best political goodwill both in terms of the composition of the multi-agency team, the presidency, the internal security teams and the ministries are on board. I think for me the national level commitment is just on top gear. However, there's of course need to see that this is strongly cascaded and operationalized at the county level*."

One member of the government multi-agency team shared that he felt the infrastructure was in place to see effective implementation of the law. He described the links between different levels of government from the anti FGM board down to provincial commissioners, district commissioners and community elders and chiefs. He was clear that all needed to work together to deter and educate communities on the criminality of performing FGM/C and more robust reporting of breaches were still needed. In reality, government stakeholders admitted that even with this infrastructure the embedded norms around FGM/C meant that chiefs and other local leaders often switch from condoning the practice to observing it and argued that much more requires to be done.

One government official talked of the need for a holistic approach with different CSOs and government stakeholders working together. CSOs, he stated, *"need to pool their resources"* and focus on talking directly with communities about the negative impact of FGM/C on the lives of girls. The official went on to say; *"There is political goodwill at county level, of course, and I will give an example of Kajiado county… the office of the governor is a very strong office to work with because of the first lady in that office when they support something they have a big following*

[37] United Nations Population Fund, UNFPA-UNICEF Joint Programme on Female Genital Mutilation, available at: https://www.unfpa.org/unfpa-unicef-joint-programme-female-genital-mutilations [Last Accessed 22 February 2021].

behind them." Some CSOs were critical stating that the government needed to do more to coordinate activities. For example, one stakeholder shared; "*We need more direction and coordination from government."*

It was commonly shared across interviews that relevant ministries are working well together via the national anti-FGM board. Reporting structures exist linking the national board with county steering committees. However, successful operationalisation of these structures still needs work. For example, one CSO stakeholder shared; "*There is a difference between theory and practice"* and claimed that children's officers still do not work much on FGM/C, which seemed strange to this stakeholder.

There is some disagreement between CSO and government stakeholders over what ails efforts to end FGM/C in the country, even as government officers decried inadequate resourcing for anti FGM/C work from the government exchequer. For some of the government officials, CSOs are not coordinating and pooling resources in a way that will successfully implement the policies and laws. For CSO and INGO stakeholders, the government needs to do more especially in ensuring that the law and policies are implemented. For example, one CSO stakeholder shared; "*The government is supporting us in a way, yes, but the government is also failing us in another way. The policies if they are there we need to implement them. If the policies are not there, we need to have the policies and the government should source resources and allocate the right resources to end FGM."*

8.4.2 Interventions that are thought to work

The national stakeholders interviewed specialising in ending FGM/C talked of **community-based approaches** as the most effective. In particular 'sensitisation approaches and community dialogues' were commonly referred to. One CSO stakeholder shared; "*The anti FGM war is changing – being taken to the communities, the villages not boardrooms or hotels and that is good for the communities."* There is clear consensus across stakeholders that focus has to be at community level and solutions need to include community voices, with members of the various FGM/C practicing communities being at the forefront and supported to come up with workable, socially and culturally acceptable solutions. Working with survivors of FGM/C was also, according to a number of stakeholders, an approach worth investing in as they can speak from their own experiences, influence young girls and boys and promote understanding of the negative effects of FGM/C hence tip the scale in favour of abandonment. A stakeholder who is also a survivor had this to say; "*We are survivors, we have decided to have our voices come out because people have been thinking this thing about women suffering is a myth. The moment I became serious and said women just stand up and say, yes I was cut and these are the problems I am going through, they are personal but you know, in our society culturally we were not allowed to talk sexuality…"*

Alternative rites of passage (ARP) were used by a number of the organisations we spoke with. There was the feeling that it was critical to offer a replacement for FGM/C amongst communities that practice FGM/C as a rite of passage. FGM/C in the words of one stakeholder; "*is not just about cutting. Girls are also educated about how to be a good wife and mother. It also marks the transition into womanhood. It needs to be understood that not everything about the ritual of FGM is bad. The cutting part needs to stop but the preparation for being a wife and mother still needs to remain."* For other stakeholders, alternative rites of passage along with community declarations were important indicators that a tipping point had been reached. It needs to be noted that whilst these approaches are popular the evidence base suggests their success in achieving long-term change is limited if they are not part of a much broader set of targeted activities. There is tension

therefore between the evidence on what works and common belief repeated in many of the interviews that ARP are a critical intervention in drive to end FGM/C. For example, one stakeholder offered the following elaboration: "*Tostan has taught us how to fight it from within. You need champions, you need staff who are champions from those communities to go in and talk to them in a language they understand. So, if we must end FGM then we cannot ignore those counties, but the design of the program should be a fight from within approach. Alternative rite of passage is the fourth most effective effort of ending FGM of course in addition to other methods … And then information you know from qualified anthropologists that we want to end a practice and it is a principle in anthropology that you can't kill a practice so quickly without a suitable alternative because FGM in its self has very good intentions only that some inhuman practice was introduced. It is a rite of passage but can girls go through that rite of passage without the cut? … and that is why we designed the alternative with the community, they tell us then what do we do in place of FGM and we ask them what do you want to do within. We guide the community with a structure to select the girls who will go through the alternative rite of passage. The ARP needs to truly have meaning to girls who are not circumcised."* Another stakeholder in supporting replacement rites argued that abandonment of FGM/C efforts fail because "*may be what we present to them (communities) takes away what value they get from that cultural norm. So, for example, is it the cutting we don't want or is it the whole FGM ceremony? … from an anthropological point of view, do they get anything from that process even if it's not the cutting and how do we preserve that.... we have made it very modernized, the approach, that the community doesn't see why we don't see that they need to have celebrations for example, why can't they have transition celebrations.*

Working with local leadership and especially changing the views of chiefs was seen as critical. Also thought to be important was harnessing the support of religious leaders and community elders. One stakeholder from a CSO claimed; "*Religious leaders already have a platform and can use them to campaign to end FGM so important to engage with them."* Another stakeholder highlighted how they were working with religious leaders and elders in Samburu, northern Kenya and Pokot to change attitudes and have communities abandon FGM/C. One religious actor interviewed shared the difficulty of changing the minds of communities who saw FGM/C as a religious requirement. In fact, he felt it to be too great a challenge to achieve in one stage and instead advocated in a first step the shift to Sunna. He claimed, "*it is difficult for people to just change from the worst form to total abandonment - a small cut as a symbol as people get ready to abandon."*

Interviews with representatives of youth organisations and networks offered optimism that the **younger generation has appetite and drive to change**. The engagement of young people, both boys and girls was seen as critical by all those interviewed and across CSO and government. In particular examples were shared in a number of interviews of working with the Morans of the Maasai (young men approaching marriage) who are being targeted for awareness in FGM/C in the hope that they accept it is not a requirement for a 'good' wife and mother and that uncut girls can make good wives and mothers as well. One stakeholder, in acknowledging the potential of young people in the abandonment of FGM/C indicated: "W*e need to make FGM not an elderly people's agenda, but a young people's agenda, because they could be key agents of change and could create a movement that may be different from thinking that it's an agenda for older people… Why not raise a generation of young people who are just going to disrupt this?" she posed.* Youth networks such as the one supported by The Girl Generation (TGG) were considered to have national visibility by a number of stakeholders. Some also felt that young female activists existed but more so at a community level. Despite this acknowledgement of the importance of engaging young people, the department of Youth Affairs which is part of the multi-agency technical

committee was not seen by stakeholders as taking a very active role in galvanising youth to end FGM/C other than inviting the AFGMB to run sensitisation sessions during its events.

Bringing men and boys into the discussion is seen as a gap that now needs to be filled challenging the idea that FGM/C is a woman's issue of no concern to men. One representative of a male-led organisation stated, **"***There is a gap with very few male-led organisations, most organisations focus on girls only. -I Need to connect better male and female led organisations. Men need safe spaces too to talk about FGM."* The importance of men and women working together to end FGM/C was widely endorsed and emphasised across interviews. Stakeholders from both the government and civil society acknowledged that there is great value in involving men and boys in end FGM/C efforts especially considering their decision-making roles in patriarchal communities and the fact that FGM/C is tied to marriageability in many communities and if more young men accepted to marry uncut girls, that would be instrumental changing community perceptions about uncut girls.

8.4.3 The challenges of achieving abandonment

Persistent social and cultural norms are embedded because of the links between different practices (polygamy, bride-price, child-marriage) and poverty. The links between multiple practices and realities were spoken about by a number of representatives from female led organisations. For example, in one interview the complex intersections between child-marriage, FGM/C, bride-price, family wealth and climate change were outlined, all made worse by COVID-19. Climate change is plunging communities into deeper vulnerability making them even more dependent on bride-price, as cattle die due to drought. In one interview the stakeholder stated, *"Girls are willingly making the sacrifice to marry young out of respect for their fathers."*

In a number of interviews, it was acknowledged that the belief is still strong that FGM/C is needed to make girls into women with a view that it is chiefs in particular who are still advocating for the practice. "*The challenges are at the ground level and with the community elders. The elders hold the view that campaigners are "stumbling on their culture."*

Stakeholders shared that communities are finding ways of circumventing the changes brought by interventions such as the empowerment of girls and the existence of safe houses that they can flee to: "*Progress is slow. The social norms are so embedded. Changes in how it is practiced have been introduced to circumvent measures to end FGM. The age has lowered from 13-14 to 5-9. It is no longer a big celebration but happens now at night. Young girls can't run away as haven't yet been empowered.*

Measuring sincere attitude change is seen as highly challenging not least because communities sometimes see participating in anti FGM/C activities as an opportunity to gain resource. "*People expect to be paid to participate in anti-FGM efforts".* The same stakeholder went on to say, *"what is needed is people who are committed and are willing to make sacrifices from the sake of ending FGM."* Stakeholders also made a case for longer term and sustained multi-prong interventions within communities for change to happen and be sustained as opposed to a few activities over a shorter period of time that almost always result in communities going back to their old ways when the interventions end and the 'change agents' leave. As a sustainability measure, organisations supporting communities to end FGM were also encouraged to hire local staff and train community champions and FGM/C survivors who would always live in the community and continue working regardless of external circumstances.

8.4.4 Is there a movement?

Interestingly, very few of those interviewed felt there existed a visible and connected movement to end FGM/C. Some felt a movement can be seen in a localised way and where CSOs are working well with communities and are concentrated. However, connectivity between different levels of organisations and with the government could not be seen. A stakeholder from a CSO shared "*There is no vibrant/active movement – there are laws and policies and some top government officers are involved, but this does not mean there is a movement."*

There is perception that what can be seen as a movement has been introduced from the outside by westerners. Stakeholders across groups did not feel there was a visible cohesive movement. There is the beginning of a youth movement at the national level, credited to efforts by TGG to galvanise youth momentum through supporting national youth networks and even though this floundered with the ending of TGG, some structure still exists but the development of county chapters is needed. Girls were also mobilised particularly in relation more generally to GBV rather than just FGM/C. Activism at a local level was identified as more movement like rather than there existing a nationally coordinated network. *"The movement should be at the community level – with women and youth groups and activists but not there yet. No movement - national forums happen but they do not constitute a movement. After these forums, not much else happens to keep momentum going." We need to map out organisations working in the 22 hotspot counties so that they can group and build networks that bring about movement."* Many of those interviewed felt that competition for space and resources between organisations is hindering the development of a movement.

Another stakeholder shared; "*Yes there is a movement but not an active one. There is a movement that was established way back I think 2017, 2016 around there but I cannot say it is quite active and secondly, we have so many other organisations and networks that have joined. We also have people who would like to join the movement as individuals so that is why as an organization we have started, supported by Action Aid, the Garissa youth hub. This a small hub where youths are able to meet and talk about all issues affecting them including and giving a priority to the harmful cultural practices like FGM. But we need to revive and maybe if there is any other partner that is coming on, I think the idea of coming back with a hope and strengthening the existing work will be wonderful to bear fruit."*

Another stakeholder indicated there this lack of capacity for a strong movement by saying *"I think investment in strengthening capacity… and systems that would then entrench a more organized movement, would be critical; investing in that would be very important. And then having just people tasked to strengthen that, you know, like technical assistance, remember these are CBOs … they are not necessarily technical."*

8.4.5 Mapping to the Evidence

Comparing what stakeholders are doing and what they feel works against the evidence base reveals some gaps. For example, interventions are not embedded within programmes focused on the empowerment of women and girls, yet the evidence shows this is necessary to drive sustainable change. Activities on their own will not galvanise an acceleration of abandonment. Work specifically with girls is limited. A girl focused approach is not widely talked about and only by women-led/girl focused organisations. The attention across actors is being placed on community dialogues and harnessing the support of chiefs and religious leaders. ARP are crucial in marking shifts in attitudes at community level. However, the evidence that they work is limited particular when not embedded in a more holistic gender empowerment approach.

The **education of girls and boys** is strongly evidenced as a successful approach in challenging and reducing child-marriage and FGM/C and a majority of stakeholders seemed to support this. For other stakeholders, it is likely that it is known that educating girls is important but in programming terms may be seen as a separate set of interventions from those designed to end FGM/C. Mainstreaming FGM/C across different gender programmes may help to bring a more holistic and multi stranded approach together and some stakeholders emphasized an integrated approach that would ensure that FGM/C is looked at in the context of other existing gender inequalities exist.

There was little mention of the **use of media** in campaigning especially social media, yet the evidence is very strong in relation to effectiveness of these approaches. Interestingly, several CSOs interviewed did acknowledge the importance of using social media platforms to engage young people, but very few pursued these activities. There is certainly room to explore how to develop media interventions in a more systematic and widespread way.

8.4.6 Summary conclusion

There is widespread consensus that a national infrastructure to support an end to FGM/C is emerging but is not yet operationalised in an effective way. Tensions between government and CSOs in terms of whose responsibility it is to effectively implement policies and laws exist. Government agencies are hampered by a lack of resourcing and this is thought to be the main barrier for effective implementation. There is also concern across stakeholders that not enough donor funding reaches the community level. The lack of a sense of belonging to a joined up and visible movement could well be a critical issue preventing better coordination of efforts. Youth networks seem to be growing and showing promising signs of being able to mobilise into an effective national presence stretching and linking local activists. Young people at community level are becoming mobilised but clearly need to be connected and supported by a stronger enabling movement.

9. Partner presence

9.1 Introduction

Our consortium partners ActionAid and Amref will be implementing projects in Kenya. Amref will lead the majority of the community work with potential for ActionAid to build upon its existing end-FGM/C community work. The total budget allowance for each country will determine how many counties our partners will be able to implement in.

9.2 Amref presence

Amref has extensive presence in Kenya, covering all 47 countries. Amref is currently implementing specific end-FGM/C programming in three counties, namely: Kajiado, Marsabit and Samburu. In addition, Amref also implements programs that do not specifically focus on FGM/C (but for example on SRHR, Youth advocacy, WASH and Nutrition), but that do have a component of FGM/C in it. This is the case in the following counties: Migori, Narok and West Pokot. Table 9.2 and Figure 9.4 below provide an overview of the above.

Table 9.2: presence Amref Kenya

Amref presence in Kenya	End-FGM/C specific programming	Programs with a component of FGM/C
All 47 counties	Kajiado	Migori
(see figure 9.4)	Marsabit	Narok
	Samburu	West Pokot

9.3 ActionAid presence

ActionAid Kenya is currently present in 15 out of 47 counties in Kenya, including Baringo, Embu, Garissa, Homa Bay, Isiolo, Kajiado, Kakamega, Kilifi, Kitui, Makueni, Migori, Mombasa, Nairobi, Taita Taveta and West Pokot. Of these 15 counties, ActionAid Kenya is implementing end-FGM/C specific programming in 8 counties (see table 9.3 below).

Table 9.3: presence ActionAid Kenya

ActionAid presence in Kenya	End-FGM/C specific programming	Programs with a component of FGM/C
Baringo	Baringo	N/A*
Embu	Embu	
Garissa	Garissa	
Isiolo	Isiolo	
Kajiado	Kajiado	
Migori	Migori	
Taita Taveta	Taita Taveta	
West Pokot	West Pokot	
Homa Bay		
Kakamega		
Kilifi		
Kitui		
Makueni		
Mombasa		
Nairobi		

** The programming in the field of FGM/C of ActionAid Kenya can be classified as end-FGM/C specific programming (including the girls groups and safe spaces programming) as the overall objective of the project was to challenge violence against women and girls and harmful traditional practices such as FGM/C and improve girls' access to education. The programming focused on tackling barriers to girls' education and ending FGM/C through working with girls and girls' networks to create a supportive environment where they can demand and exercise their rights to live free from violence, as well as on creating awareness of the laws protecting women and girls' rights through advocacy and pushing for policy implementation. As part of AA's human rights-based approach, the project looked holistically at the issues affecting girls and therefore included interventions which address the broader themes around empowerment and agency, including providing life skills, advocacy trainings, and dialogue spaces for girls.*

9.4 Where partners intend to work under ALM

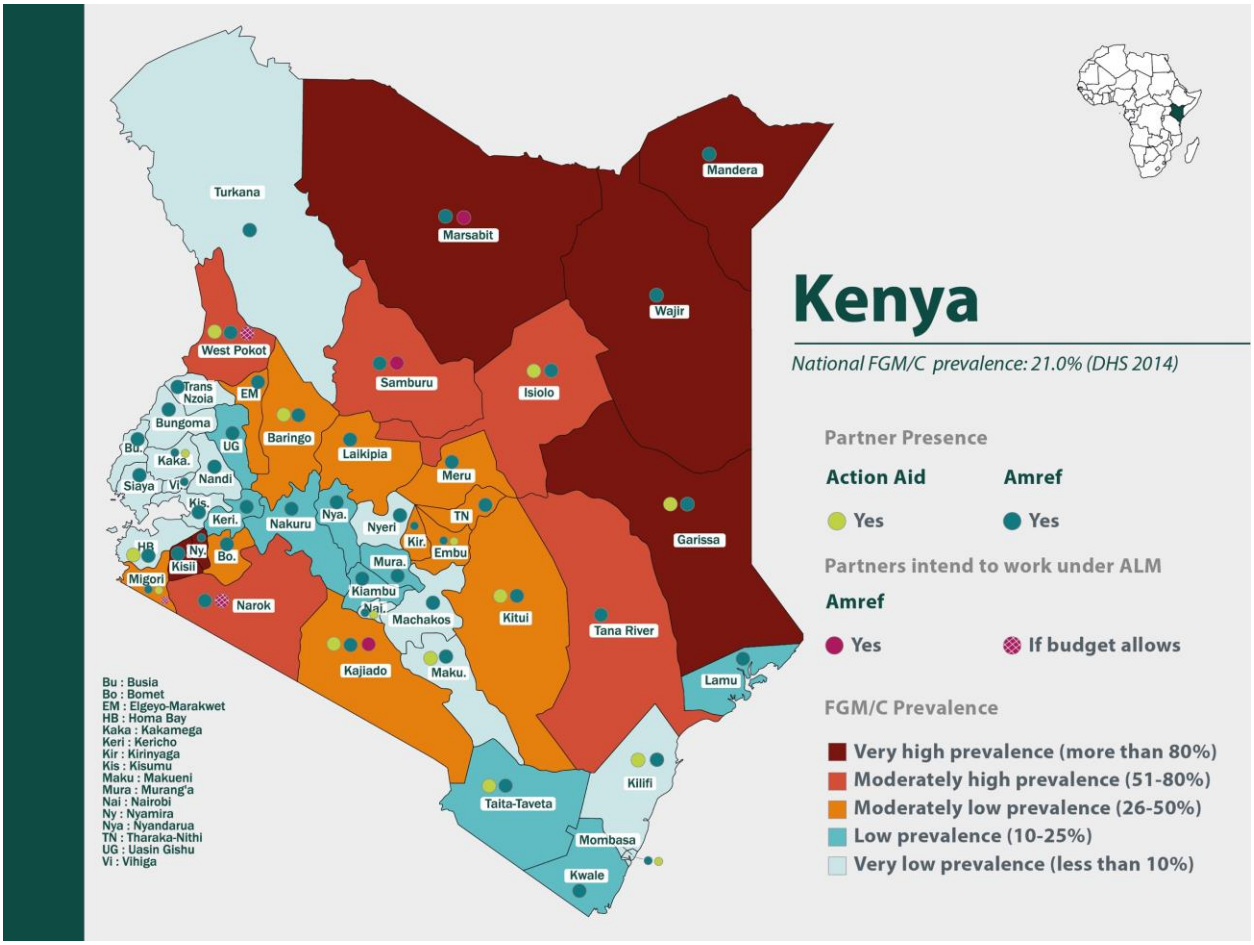
Amref is well placed to support implementation in many counties. However, in terms of regions where Amref plans program implementation under ALM, it is the preference of Amref to leverage the momentum gained on their existing programmes in three counties: Marsabit, Samburu, Kajiado if limited funds were available. If budget allows, Amref would welcome the opportunity to expand their reach particularly in Narok, Migori and West Pokot counties where Amref has new ongoing end FGM/C projects and could partner with AA through their contacts and offices on the ground (see Figure 9.4).

Amref has shared a preliminary situational analysis and county contexts which have been the basis for the proposed Amref's ALM counties. The rationale for selection of these counties has taken into consideration current prevalence rates, emerging trends, ARP success, cross-border dimensions, presence of UNJP and spotlight end FGM/C projects, existence of strong youth movements, similarities of culture and religion, similarities and differences in interventions, Amref's strategic presence, capacity and availability, community readiness, enthusiasm and political support and in-county partnerships and connections.

Apart from Samburu County, all the proposed counties are border counties – therefore, this will provide a seamless entry into those counties by Amref to promote transnational cooperation in ending cross-border FGM/C which is a key focus area for Amref and also, within the ALM programme. Amref's current end FGM/C work in Kajiado, Narok and Migori counties will provide a strong basis for cross-border collaboration along the Kenya-Tanzania border while interventions in Marsabit and West Pokot counties will enhance cross-border work along the Kenya-Ethiopia and Kenya-Uganda borders respectively.

As mentioned in the previous paragraph, **ActionAid** has end-FGM/C specific programming in 8 counties. There is a possibility (if budget allows) to implement the support to the ALM to end FGM/C in these counties. In addition, ActionAid also has a strong track record on policy and advocacy at a national level, advocating for effective response by duty bearers in implementing laws and policies to eradicate FGM/C as well as documenting and sharing best practice on end-FGM/C programming. Depending on budget and in partnership discussions with Amref, ActionAid would welcome building upon these interventions under this programme.

Figure 9.4: Overview of partner presence in Kenya:[38]



[38] Please note that all the above is tentative at this stage and is subject to change based on the findings of the PEAs as well as being budget dependent.

10. Root cause analysis

10.1 Introduction

As with other parts of the world, FGM/C in Kenya occurs for reasons that are rooted in notions of inequality between females and males.[39] These notions and beliefs are deeply embedded in sociocultural, economic, and political structures, as outlined below.

10.2 Sociocultural reasons

Studies across various Kenyan communities[40,41,42] provide insights into the sociocultural reasons for the practice. A common reason stems from the belief that female libido must be moderated in order to stave off premarital sex, and ensure morality and fidelity in the context of marriage.[43] FGM/C is seen as instrumental in achieving these goals, given its role in diminishing female sexual desire.

Furthermore, for many Kenyan communities, the practice of FGM/C is also rooted in the importance of a sense of belonging. In community-oriented societies such as Kenya, a sense of belonging is a powerful construct that can impose a 'group effect' on community members, resulting in unquestioned conformity to group behaviours. This construct helps to solidify group identity through various practices, such as FGM/C. Among the Abagusii in Kisii, for instance, the act of FGM/C serves as a distinguishing factor, setting this ethnic group apart from its non-FGM/C-practicing neighbours.[44] Closely related to the construct of belonging is the fact that FGM/C is considered as a rite of passage in some Kenyan communities, including Narok, Kuria, and Kisii.[45] The Kuria, for instance, devote public ceremonies to this rite, further solidifying a sense of belonging among girls subjected to FGM/C and their families. As this rite of passage marks girls' transition from childhood to womanhood, the practice of FGM/C is automatically connected to, and has implications for, other desirable sociocultural accomplishments in FGM/C-practicing contexts in Kenya. For instance, it is often regarded as a pre-requisite for marriage, and therefore as an indicator of marriageability[46] in settings where marriage is highly valued. While this notion has weakened somewhat in Narok and Kisii, for example,[47] FGM/C nonetheless persists in these communities for other related reasons.

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[39] WHO (2008). *Eliminating Female Genital Mutilation: An Interagency Statement*, WHO, Geneva, available at https://apps.who.int/iris/bitstream/handle/10665/43839/9789241596442_eng.pdf?sequence [Last Accessed 13 November 2020].
[40] Matanda, Dennis, Okondo, Chantalle, Kabiru, W. Caroline and Shell-Duncan, Bettina. 2018. "Tracing Change in Female Genital Mutilation/Cutting: Shifting Norms and Practices among Communities in Narok and Kisii Counties, Kenya." Evidence to End FGM/C: Research to Help Girls and Women Thrive. New York: Population Council.
[41] Kimani S, Kabiru CW, Muteshi J, Guyo J (2020) Female genital mutilation/cutting: Emerging factors sustaining medicalization related changes in selected Kenyan communities. PLoS ONE 15(3): e0228410. https://doi.org/10.1371/journal. pone.0228410.
[42] Mose B,G. (2008). Thinking the Gusii Way: Insider Perpectives on Female Genital Mutilation (FGM)/Cutting and Strategies for Change. Saarbrucken, Germany: VDM Verlag Dr. Muller.
[43] Ibid.
[44] Matanda, Dennis, Okondo, Chantalle, Kabiru, W. Caroline and Shell-Duncan, Bettina. 2018. "Tracing Change in Female Genital Mutilation/Cutting: Shifting Norms and Practices among Communities in Narok and Kisii Counties, Kenya." Evidence to End FGM/C: Research to Help Girls and Women Thrive. New York: Population Council; Kimani S, Kabiru CW, Muteshi J, Guyo J (2020) Female genital mutilation/cutting: Emerging factors sustaining medicalization related changes in selected Kenyan communities. PLoS ONE 15(3): e0228410. https://doi.org/10.1371/journal. pone.0228410.
[45] Ibid.
[46] Kimani S, Kabiru CW, Muteshi J, Guyo J (2020) Female genital mutilation/cutting: Emerging factors sustaining medicalization related changes in selected Kenyan communities. PLoS ONE 15(3): e0228410. https://doi.org/10.1371/journal. pone.0228410.
[47] Matanda, Dennis, Okondo, Chantalle, Kabiru, W. Caroline and Shell-Duncan, Bettina. 2018. "Tracing Change in Female Genital Mutilation/Cutting: Shifting Norms and Practices among Communities in Narok and Kisii Counties, Kenya." Evidence to End FGM/C: Research to Help Girls and Women Thrive. New York: Population Council.

For instance, the construct of respect is deeply entangled with FGM/C and the rationale for its practice. The complexity of respect as it is understood by FGM/C-practicing communities is demonstrated by the fact that it manifests on several different levels, and in various ways. Respect for a community's forefathers (from whom community members also derive their sense of belonging) is one level of manifestation. Community members are obligated to perform FGM/C in order not to violate respect for their forefathers (e.g., among the Abagusii, Somali and Kuria).[48] Respectability is also bestowed on girls and women who have been cut (in Kisii, for example), as they are held in high esteem by their peers, family, and wider community following FGM/C.[49] Furthermore, such girls and women are considered as being respectful – a desirable trait in this context – unlike their uncut peers.[50] A female's respectability as a result of FGM/C spills over to her family – a notion which further perpetuates the practice. Although attitudes are changing, social sanctions still remain for uncut girls, who may be subject to ridicule by their communities, and even regarded as outcasts.[51] The risk of social sanctions has its impact on families, resulting in pressure to perpetuate FGM/C.[52]

Among the (primarily Islamic) Somali community in Kenya FGM/C's basis is found in religion, and the practice is therefore regarded by most as obligatory. However, some Somali community members are of the opinion that Islam and the Quran prohibit FGM/C and have therefore abandoned the practice.[53] The practice also occurs for aesthetic reasons among the Kenyan Somali community.[54]

10.3 Economic reasons

Economic reasons also play a role in the occurrence of FGM/C in Kenya. In the rural community of Kuria, for instance, Kenyan activists point to poverty as the root cause of the high prevalence of FGM/C.[55] The monetary and other material gifts presented by the community to cut girls serve as a powerful incentive to continue the practice in this context. Over time, these gifts have apparently increased in value to include mattresses in poor communities were girls typically sleep on bare floors.[56]

As FGM/C becomes increasingly medicalized in Kenya, it is simultaneously becoming more commercialized. Medical practitioners are also being incentivised by community members to perform FGM/C at health facilities or elsewhere and are discovering lucrative careers as professional cutters who are gradually replacing traditional cutters.[57]

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[48] Kimani S, Kabiru CW, Muteshi J, Guyo J (2020) Female genital mutilation/cutting: Emerging factors sustaining medicalization related changes in selected Kenyan communities. PLoS ONE 15(3): e0228410. https://doi.org/10.1371/journal. pone.0228410.
[49] Matanda, Dennis, Okondo, Chantalle, Kabiru, W. Caroline and Shell-Duncan, Bettina. 2018. "Tracing Change in Female Genital Mutilation/Cutting: Shifting Norms and Practices among Communities in Narok and Kisii Counties, Kenya." Evidence to End FGM/C: Research to Help Girls and Women Thrive. New York: Population Council.
[50] Ibid.
[51] Ibid.
[52] Kimani S, Kabiru CW, Muteshi J, Guyo J (2020) Female genital mutilation/cutting: Emerging factors sustaining medicalization related changes in selected Kenyan communities. PLoS ONE 15(3): e0228410. https://doi.org/10.1371/journal. pone.0228410.
[53] Ibid.
[54] Ibid.
[55] Muiruri, P. (2020). Kenyan efforts to end FGM suffer blow with victims paraded in 'open defiance.' *The Guardian* October 21, 2020, https://www.theguardian.com/global-development/2020/oct/21/kenyan-efforts-to-end-fgm-suffer-blow-with-victims-paraded-in-open-defiance.
[56] Ibid.
[57] Parsitau, D.S. (2018). How outlawing FGM in Kenya has driven it underground and led to its medicalization. *Education Plus Development*, https://www.brookings.edu/blog/education-plus-development/2018/06/19/how-outlawing-female-genital-mutilation-in-kenya-has-driven-it-underground-and-led-to-its-medicalization/; Bettina Shell-Duncan, Carolyne Njue, and Zhuzhi Moore "The Medicalization of Female Genital Mutilation /Cutting: What do the Data Reveal?" February 2017," *Evidence to End FGM/C: Research to Help Women Thrive.* New York: Population Council.

10.4 Political reasons

The reasons for the practice of FGM/C also need to be understood within the political context in which FGM/C occurs.[58] As Akinyemi explains: "[I]n Africa, the political responsibility of the practice of FGM/C lies more within the control of indigenous political structures and systems because it is under this system that most Africans define their social, political, and cultural identities."[59]

This description holds true for Kenya. Among the Kuria, for instance, dates for community-wide, public FGM/C ceremonies are decided upon by the Council of Elders – an indigenous group of local leaders.[60] Recently in the Kuria community, 10 local chiefs and their assistants faced interdiction for abetting FGM/C in their communities.[61] The strong influence of local political systems on daily activities in Kenya (despite the country's anti-FGM/C law) is therefore a further reason for the perpetuation of the practice.

10.5 Final word

Whether the reasons for FGM/C in Kenya revolve around the perceived need to preserve girls' virginity, the need to control female sexuality, social expectations associated with family honour, anticipation of higher dowries for females perceived as 'beautiful' or 'chaste' due to their FGM/C status, or the fact that anti-FGM/C laws are not enforced, they are all manifestations of the control that society exercises over women in stark comparison to men.[62] The societal incentives and repercussions associated with FGM/C help perpetuate the practice and the inequalities it engenders.[63]

[58] Akinyemi, R. (2000) Political dimensions of FGM in Africa, http://www.african-women.org/documents/political-dimensions.pdf.
[59] Ibid., pp. 1-2.
[60] Kimani S, Kabiru CW, Muteshi J, Guyo J (2020) Female genital mutilation/cutting: Emerging factors sustaining medicalization related changes in selected Kenyan communities. PLoS ONE 15(3): e0228410. https://doi.org/10.1371/journal. pone.0228410.
[61] Muiruri, P. (2020). Kenyan efforts to end FGM suffer blow with victims paraded in 'open defiance.' *The Guardian* October 21, 2020, https://www.theguardian.com/global-development/2020/oct/21/kenyan-efforts-to-end-fgm-suffer-blow-with-victims-paraded-in-open-defiance.
[62] WHO (2008). *Eliminating Female Genital Mutilation: An Interagency Statement*, WHO, Geneva, available at https://apps.who.int/iris/bitstream/handle/10665/43839/9789241596442_eng.pdf?sequence [Last Accessed 13 November 2020].
[63] Ibid.

11. Programme Mapping

11.1 Methodology

The findings presented here mapping current and past programming in Kenya have been taken from the end FGM/C repository coordinated by ACCAF and Population Council[64] of FGM-related programmes implemented in different countries between the year 2000 and August 2016.[65] The repository has been brought up to date for the purposes of this PEA analysis.

11.2 Categories of implemented FGM/C-related interventions in Kenya

In Kenya, the compendium captured a total of 51 programmes out of which 12 were national/regional. Although these programmes were implemented within the wider Kenyan jurisdiction, 1 (33.3%) in every 3 programmes specifically targeted communities living in the North Eastern corridor. These programmes can be broken down into 13 thematic areas (Table 11.2). The interventions/themes spanned from legislation, human rights, capacity building, advocacy, awareness creation, community dialogues and behavioural change communication among others. Of the themes, capacity building (66.7%) and awareness creation (58.3%) were most commonly implemented across the programmes. Female empowerment (8.3%) and engagement with religious leaders (8.3%) were the least implemented across the programmes.

Table 11.2: FGM/C interventions categorized according to themes

S/N	FGM/C-related thematic interventions	Frequency (n)	Percent (%)
1	Legislation	2	16.7
2	Legal approach	3	25.0
3	Promotion of human rights	2	16.7
4	Capacity building	8	66.7
5	Alternative rite of passage	2	16.7
6	Advocacy	3	25.0
7	Public declaration	2	16.7
8	Awareness creation	7	58.3
9	Women empowerment	1	8.3
10	Engagement with religious leaders	1	8.3
11	Community education	1	8.3
12	Community dialogues	3	25.0
13	Behavioural/attitude change	2	16.7

11.3 FGM/C-related interventions targeted various groups in Kenya

The FGM/C-related programmes implemented in Kenya since 2000 were shown to have targeted different stakeholders (target groups) (Table 11.3). Most of the programmes targeted the policy makers (58.3%), religious leaders (41.7%), community members (33.3%) and health workers

[64] Population Council. Evidence to end FGM/C Compedium. 2016.
[65] Matanda D, Meroka A, Kimani S. Evidence Summary: Lessons from a five-year research programme on FGM/C and their relevance for policy and programmes in Kenya Overview. 2020;(July 2020):1–26, available at https://www.popcouncil.org/uploads/pdfs/synthesisreportfgmresearchkenya_final_.pdf [Last Accessed 22 February 2021].

(33.3), respectively. The stakeholders' least targeted through the anti FGM/C-related interventions included: traditional leaders (8.3%), and men (8.3%), Women (8.3%) as community level, teachers (8.3%) and law enforcers (8.3%), respectively. The list of target groups shows that the programmes were comprehensive enough but missed on targeting male politicians.

Table 11.3: The target groups for anti-FGM/C related interventions in Kenya

S/N	FGM/C interventions target group	Frequency (n)	Percent (%)
1	Policy makers	7	58.3
2	Government departments	3	25.0
3	Ministry of Health officials	1	8.3
4	Health workers	4	33.3
5	Administrators	1	8.3
6	Teachers	1	8.3
7	Law enforcers	1	8.3
8	Community health workers	1	8.3
9	Media practitioners	3	25.0
10	Civil society organization	3	25.0
11	Community members	4	33.3
12	Community leaders	2	16.7
13	TBAs	1	8.3
14	Religious leaders	5	41.7
15	Youth	2	16.7
16	Traditional leaders	1	8.3
17	Somali speaking Horn of Africa people	1	8.3
18	FGM/C survivors	2	16.7
19	Circumcisers	2	16.7
20	Girls	2	16.7
21	Women	1	8.3
22	Men	1	8.3
23	Communities	2	16.7

11.4 The anti-FGM/C programmes implemented from 2016

On further analyses, several FGM/C related programmes were identified to have been implemented in Kenya from 2016 to date. The programmes include:

- The evidence to end FGM/C a national/regional project that was aimed at generating research to inform FGM/C-related programming, policies, and investments.
- East African Community anti-FGM bill aimed at addressing cross-border FGM/C practices[66]
- The anti-FGM board developed tools and resource materials for addressing abandonment of FGM/C including emerging challenges such as medicalization and cross-border FGM/C.[67] These tools include the eradicating FGM/C resource book, a community engagement tool for conducting effective dialogue on FGM/C, anti-FGM board strategic plan, and national policy for the eradication of FGM/C. Furthermore, the anti-FGM board spearheaded the participation, assurance, pronouncement, and commitment

[66] East African Legislative Assembly. EAC prohibition of FGM Act 2016.pdf [Internet]. 2016, available at https://www.eala.org/index.php/documents/view/the-eac-prohibition-of-female-genital-mutilation-bill2016 [Last Accessed 22 February 2021]. See also section 7.3 of this PEA for more information.
[67] Anti FGM Board. Anti FGM Board [Internet]. Government of Kenya. 2021, available at http://www.antifgmboard.go.ke/contact-us/ [Last Accessed 22 February 2021]. See also section 7.1 and 7.2 of this PEA for more information.

of religious and cultural leaders from the twenty-two counties with high prevalence of FGM/C in supporting the presidential decree of ending FGM/C by 2022.

- There has been commencement of Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change Phase III covering interventions in Kenya, Somalia and Ethiopia building on the success and lessons learnt in phase I and II.

11.5 Discussion

11.5.1 Bilaterally or multilaterally funded programmes have wide geographic reach

Our findings showed that there are a number of FGM/C related programmes with national and regional reach, most of which are funded by bilateral partners (e.g. USAID, DFID (now FCDO)) or multilateral organizations such as the UN agencies (e.g. UNFPA and UNICEF). This is mainly because of the huge requirement for resources and stable financial investments. In addressing FGM/C, the partners are critical stakeholders in promoting human rights and addressing violation associated with FGM/C in line with their country's values. The programming and funding process also involves full support and knowledge of the host government administration strengthening the relationships between local partners and government. Therefore, considerations must be put into place when ALM end FGM/C programme is implementing projects in the target countries to understand what FGM/C programs are already in place in order to identify synergy, avoid duplication and leverage on political goodwill of the existing projects. This can be promoted through stakeholder engagements and communications to help understand what partners are implementing which projects. Such engagement offers the ALM an opportunity for shared learning, collaboration, promotion of evidence communication and uptake from countrywide projects and/or research. There is also possibility to leverage on development agenda/programmes supported by the partners to infuse human rights/health issues like FGM/C into WASH projects funded by bilateral and multilateral partners.

11.5.2 Programmes with regional reach can offer platforms for addressing cross-border FGM/C

The programmes with regional reach had their focus on Kenya, Ethiopia, and Somalia. These are some of the target countries for the ALM end FGM/C programme. This is an indication that working in the identified block of countries could be a feasible and efficient way to addressing the common challenges of ending FGM/C. The regional extent of the FGM/C programmes is of interest to ALM strategy given the cross-border FGM/C activities between Kenya-Ethiopia, Kenya-Somalia and the triad of Kenya, Ethiopia, and Somalia. The cross-border FGM/C activities are promoted by several factors namely; cultural and ethnic lineage/similarities between the cross-border communities; similar in social norms; existence of custodians of culture for the communities on both sides of the countries; existence of porous/imaginary borders between the countries that host same clans in both countries; lack of or non-enforcement of FGM/C prohibition laws in border countries. Although cross-border FGM/C is a challenge, it offers an opportunity for block legislation, for example the EAC FGM prohibition Act 2016 covers FGM/C issues for Kenya, Uganda, and Tanzania. This is an example of a block legislation that can be developed and adopted for Kenya, Ethiopia, and Somalia. This offers opportunities for community dialogues and engagements for clans across the countries.

11.5.3 Mapping to the evidence base

The evidence review presented in this PEA focused on what seems to work best to end FGM/C. It identified media campaigns, education, engagement of religious and cultural leaders (where religion is cited as a reason), women and girls empowerment programme as the most effective approaches. It stressed that legislation and policy alone have little chance of triggering sustainable change. The same can be seen with replacement rites. A holistic approach is clearly needed that integrates interventions (e.g. ARPs) within an ongoing programme of community engagement, media campaigns at multiple levels and female empowerment. What has emerged in this mapping of interventions presented here are clear gaps or rather a mismatch between what the evidence tells us works best and what seems to be funded. The model of implementing FGM/C interventions in the communities living in the northern corridors of Kenya needs rethinking and reengineering given the substantial investments compared to the decline in FGM/C prevalence. This could also mean devising more innovative ways to measure the effectiveness of FGM/C programmes and adapting interventions in line with the emerging evidence. It also strongly suggests the need to take a holistic approach and embed FGM/C more widely in gender transformation programmes.

So far, we see very few women and girl empowerment programmes specifically focused to end FGM/C. We see no medium to long-term national and local level media campaigns. We do see resources focused on capacity development of organisations and in building the legislative and policy frameworks. It seems reasonable to conclude that certain activities are needed to build the enabling environment to support more targeted and holistic interventions. Without policy and legal frameworks and government structures to enforce them community engagement initiatives are unlikely to lead to long-term changes in behaviour. Similarly, without sufficient organisational capacity at national and local levels within civil society it is not possible to design and implement the kind of holistic programming the evidence tells us works best to end FGM/C. The challenge for Kenya then is to move in a coordinated way out of a framework and capacity building phase into strategic evidence-based programming.

12. Evidence on interventions

12.1 Methodology

This chapter assessed the impact of FGM/C interventions in Kenya and presents the results of moderate and high-quality studies. We defined an 'FGM/C intervention' as any form of action or process of intervening, a deliberate process to interfere with, modify or change people's (both women's and men's) thoughts, feelings, knowledge or behaviours to reduce the prevalence, lead to the abandonment of FGM/C, or offer health care and other services to girls, women, and those indirectly affected by the practice (including men). The inclusion and exclusion criteria were established a priori and included studies that assessed FGM/C interventions from January 2008 to August 2020.

The key words used in the literature search were: ("female genital mutilation" OR "female genital cutting" OR "female genital mutilation/cutting" OR "FGM" OR "FGC" OR "FGM/C" OR "female circumcision" OR "FGM gash" OR "female genital distortion" "female sexual mutilation" OR "clitoridectomy") AND "interventions". We conducted a systematic search of literature in scientific databases EBSCO (social sciences database, CHW Wilson, gender studies database, MEDLINE, CINAHL Plus and ERIC), JSTOR, Knowledge Commons, PubMed, SAGE journals, Web of Science and WILEY. Literature was also searched from websites of institutions or organisations that have been involved in FGM/C work (45 websites). Additional literature was identified by hand searching references of retrieved studies and suggestions from experts in the FGM/C field.

To assess the quality of studies, we used the DFID (2014) How to Note guidelines to first categorise studies as either primary (studies which observe a phenomenon first hand, collecting, analysing or presenting raw data) or secondary (studies that interrogate primary research studies, summarizing and interrogating their data and findings). Primary and secondary studies were then individually scored using quality principles following the How to Note guidelines.

Studies are described using the format prescribed in the How to Note guidelines i.e. '<Author Name Year>, <Study type>';'<Quality of evidence>'. The summary arrow descriptors have been used to denote the quality of studies i.e. ↑ signifying high quality, and → signifying moderate quality.

12.2 Legislative interventions

A total of four studies assessed the impact of legislation on FGM/C in Kenya; two were of moderate quality and two of high quality (Table 12.2). Study findings showed that enforcement of the anti-FGM law has been a challenge in ensuring that the law deters people from performing FGM/C (Meroka-Mutua et al., 2020; P; OBS; ↑, Nambisia, 2014; P; OBS; →). The introduction of laws against cultural practices such as FGM/C that are strongly valued by community members has led to the practice being conducted in secret, at younger ages and supposedly less severe types of FGM/C rather than abandonment (Buttia, 2015; S, OR; →, Matanda et al., 2018; P; OBS; ↑, Meroka-Mutua et al., 2020 ; P; OBS; ↑). A combination of legislation, enforcement and other interventions are likely to be more effective in reducing FGM/C prevalence through changing the drivers of FGM/C including knowledge, attitudes, and norms.

Table 12.2: Studies that have assessed effectiveness of legislative interventions in Kenya

Study	Intervention focus	Effect on FGM/C	Quality
Nambisia EM. 2014. Measures Influencing Eradication of Female Genital Mutilation Practices Among the Maasai Community in Maparasha Constituency Kajiado County, Kenya. University of Nairobi (UoN)	Multiple interventions including legislation	Poor enforcement making the law not effective	→
Matanda et al. 2018. Tracing change in female genital mutilation/cutting: Shifting norms and practices among communities in Narok and Kisii counties, Kenya. Population Council.	Multiple interventions including legislation	Laws led to changes in FGM/C practice: secretive, FGM/C on younger girls and medicalization.	↑
Meroka-Mutua AK; Mwanga D; Olungah CO. 2020. Assessing the role of law in reducing the practise of FGM/C in Kenya. Population Council.	Extent to which people obey the law on FGM/C	FGM/C conducted in secrecy due to fear of the law. Conflict between custom and the law results to non-compliance.	↑
Buttia C. 2015. Investigation of successful interventions in mitigation of female genital mutilation /cutting (FGM/C) among selected Kenyan communities: Maasai, Kisii and Kuria (Master thesis, Hochschule für angewandte Wissenschaften Hamburg).	Review of multiple interventions including legislation	Law effective where it is integrated with other interventions. FGM/C practice increasingly performed in secret.	→

12.3 Training health care providers

Three studies assessed the effectiveness of training providers/enhancing the health system with the aim of ending FGM/C in Kenya. Two of the studies were of high quality and one of moderate quality (Table 12.3). Most of the interventions focused on imparting knowledge and skills to health care providers either to act as agents of change in the prevention of FGM/C or to offer quality services to clients seeking health services post FGM/C. Evidence showed that training can be effective in imparting knowledge to health care workers (Kimani et al., 2018; P; OBS; →). Using an online UNFPA training module, Kimani and colleagues (2018) established that comprehensive knowledge, and competencies on FGM/C among providers was critical for rejecting/preventing FGM/C. However, a systematic review of multiple interventions including training of health personnel in several countries (Kenya included) showed that training health personnel produced no effects in knowledge or beliefs/ attitudes about FGM/C. The study noted weak quality of evidence (Denison et al., 2009; S; SR; ↑).

An improved health care system should have the capacity to manage and provide optimal services to clients that have undergone FGM/C and prevent the practice from occurring among those at risk of undergoing FGM/C. A study by Kimani and Okondo (2020) found limited capacity of the Kenyan health care system to prevent FGM/C and provide quality health services to those who have complications related to FGM/C (Kimani and Okondo, 2020, P; OBS; ↑).

Table 12.3: Studies that have assessed effectiveness of training of health care providers/ capacity building of the healthcare system in Kenya

Study	Intervention focus	Effect on FGM/C	Quality
Kimani S et al. 2018. Female Genital Mutilation/Cutting: Innovative Training Approach for Nurse-Midwives in High	Training nurse-midwives using an electronic tool derived	Substantial FGM/C-related knowledge demonstrated by nurse-midwives. Challenges in preventing	→

Prevalent Settings. Obstetrics and Gynaecology International	from a paper-based quiz on FGM/C	medicalization with knowledge gaps concerning sexual and social complications	
Kimani S; Okondo C. 2020. A diagnostic assessment of the health system's response to female genital mutilation/cutting management and prevention in Kenya. Population Council.	Health system capacity to handle FGM/C	The Kenyan health-sector response to FGM/C prevention and management is anchored in legal and policy instruments. Although the instruments are well understood by policy actors, few healthcare providers appear to be aware of these instruments. This limited awareness has a negative impact on the quality of care received by women and girls.	↑
Denison E et al. 2009. Effectiveness of Interventions Designed to Reduce the Prevalence of Female Genital Mutilation/Cutting. Norwegian Knowledge Centre for the Health Services	Review of multiple interventions including training of health personnel	Training health personnel likely produced no effects in knowledge or beliefs/ attitudes about FGM/C. Notes weak evidence base.	↑

12.4 Health education

Intervention activities under health education were mostly educational campaigns for awareness creation delivered either in the community or at the institutional level. One high quality study described the effects of health education on various aspects of FGM/C including awareness, beliefs, and practices (Table 12.4). While the effects of health education appear impressive, literature and findings from multifaceted interventions suggest that health education can be more effective in an environment where context is considered and other interventions are also implemented (Waigwa et al, 2018; S, SR; ↑).

Table 12.4: Studies that have assessed effectiveness of health education interventions in Kenya

Study	Intervention Focus	Effect on FGM/C	Quality
Waigwa et al. 2018. Effectiveness of health education as an intervention designed to prevent female genital mutilation/cutting (FGM/C): a systematic review. Reproductive Health.	Systematic review of health education interventions to prevent FGM/C	Effectiveness depends sociodemographic factors; traditions and beliefs; intervention strategy, structure, and delivery	↑

12.5 Formal education

Five studies; two of high quality and three of moderate quality evaluated the effectiveness of formal education on the practice of FGM/C in Kenya (Table 12.5). Most of the studies used educational attainment as a proxy intervention but no direct educational intervention on FGM/C was implemented and assessed.

Study findings showed that formal education exposes girls to new information including health risks/consequences of FGM/C as well as on the illegal status of FGM/C and therefore plays a significant role in the abandonment of the practice (Buttia, 2015; P; OBS; →, Berg and Denison 2013; S, SR; ↑, Nambisia, 2014; P; OBS ; →, Equality Now, 2011; P; OBS; →). School-based health education was impactful in improving the knowledge of girls and changing the attitude of female students towards FGM/C (Berg and Denison 2013; S; SR; ↑).

A study by Buttia et al (2015) reported that secondary education was associated with a four-fold increase in disapproval of FGM/C (Buttia, 2015; S; OR; →). Evidence from another study that assessed the effect of educating mothers on the prevalence of FGM/C of their eldest daughters showed that additional year of schooling led to a decrease in the likelihood of FGM/C among daughters (Bø Nesje, 2014; P; OBS; ↑).

A review of interventions designed to eradicate FGM/C in several African countries (Kenya included) showed a paucity of high-quality evidence regarding the effectiveness of interventions to prevent FGM/C and concluded that the evidence base was insufficient to draw solid conclusions. However, the effect estimates suggest that educating female students may have led to a small increase in knowledge/awareness about FGM/C. The authors note that the low quality of the body of evidence affected the interpretation of results and raised doubts about the validity of the findings (Denison et al., 2009; S; SR; ↑).

Table 12.5: Studies that have assessed effectiveness of formal education interventions in Kenya

Study	Intervention Focus	Effect on FGM/C	Quality
Equality Now. 2011. Protecting Girls from Undergoing Female Genital Mutilation: The Experience of Working with the Maasai Communities in Kenya and Tanzania. Equality Now	Multiple interventions including promotion of girls' education	Girls empowered to say no to FGM/C	→
Berg RC; Denison EM. 2013. A realist synthesis of controlled studies to determine the effectiveness of interventions to prevent genital cutting of girls. Paediatrics and International Child Health	Systematic review of multiple interventions including formal education	Education of female students increased students' knowledge of the likely complications of FGM/C	↑
Nambisia EM. 2014. Measures Influencing Eradication of Female Genital Mutilation Practices Among the Maasai Community in Maparasha Constituency Kajiado County, Kenya. University of Nairobi (UoN)	Multiple interventions including promotion of girl child education	Girl-child education had significantly contributed to the eradication of FGM/C among the Maasai.	→
Buttia C. 2015. Investigation of successful interventions in mitigation of female genital mutilation /cutting (FGM/C) among selected Kenyan communities: Maasai, Kisii and Kuria (Master thesis, Hochschule für angewandte Wissenschaften Hamburg).	Review of multiple interventions including promotion of girl education	Successful where interventions were integrated. FGM/C was also increasingly performed in secret	→
Bø Nesje FH. 2014. Effects of Schooling on Female Genital Cutting: The Case of Kenya. Master thesis, University of Oslo.	Effect of educating mothers on the prevalence of FGM/C of their eldest daughters	Additional year of schooling led to a decrease in the likelihood of FGM/C among daughters	↑

12.6 Religious/cultural leaders

There was one moderate quality study that assessed the effectiveness of using religious or cultural leaders as an intervention to end FGM/C (Table 12.6). The study discusses the potential usefulness of religious leaders and provides examples of the involvement of religious leaders in declaring edicts, or publicly stating their stand on FGM/C. The study showed that religious/cultural leaders can be effectively used to pass on messages to the community especially in communities where religion and culture play a significant role in driving FGM/C. Religious leaders can be at the forefront in questioning the religious underpinnings of the practice and in publicly declaring opposition to the practice (Abdi and Askew, 2009; P; OBS; →).

Table 12.6: Studies that have assessed effectiveness of using religious/cultural leaders in Kenya

Study	Intervention Focus	Effect on FGM/C	Quality
Abdi M and Askew I. 2009. A religious oriented approach to addressing female genital mutilation/cutting among the Somali community of Wajir, Kenya, *Population Council*	Discussion topics with religious leaders	Some religious scholars and community members openly declared their opposition to FGM/C	→

12.7 Conversion of excisors

Table 12.7 summarizes the two studies that assessed effectiveness of using excisors[68] in efforts to end FGM/C. Intervention activities involved either working with former excisors who have abandoned performing FGM/C or providing an alternative income to active excisors so that they stop providing FGM/C services. Evidence showed that efforts to convert and provide excisors with alternative sources of income have not been successful. In most cases it resulted in increased secrecy in conducting the practice (Buttia, 2015; P, OR; →, Van Bavel, 2020; P, OBS; ↑).

Table 12.7: Studies that have assessed effectiveness of conversion of excisors

Study	Intervention Focus	Effect on FGM/C	Quality
Buttia C. 2015. Investigation of successful interventions in mitigation of female genital mutilation /cutting (FGM/C) among selected Kenyan communities: Maasai, Kisii and Kuria (Master thesis, Hochschule für angewandte Wissenschaften Hamburg).	Review of multiple interventions including engaging former excisors	FGM/C performed in secret, where excisors have publicly declared support for abandonment	→
Van Bavel H. 2020. At the intersection of place, gender, and ethnicity: changes in female circumcision among Kenyan Maasai. Gender, Place & Culture	Multiple interventions including engaging excisors	FGM/C conducted in secret, where excisors have been reached with interventions	↑

12.8 Rescue centres

There were four studies that assessed the effectiveness of rescue centres as an approach to end FGM/C in Kenya; three of which were of moderate quality and one of high quality (Table 12.8). Notably, most of the studies included rescue centres among other multiple interventions with limited information on assessment of rescue centres as an independent intervention.

Rescue centres or safe houses aim to provide protection and refuge for girls who are at risk of FGM/C during the cutting period. Apart from providing shelter to girls running away from FGM/C, rescue centres also provide education to girls on the health risks of FGM/C, its illegality and its violation of human rights (Nambisia, 2014; P; OBS; →). Research has shown that rescue centres face challenges such as limited resources and lack of recognition as an alternative ritual and hence there has been limited evidence on their effectiveness (Buttia, 2015; S; OR; →, Van Bavel, 2020; P, OBS; ↑).

A study that evaluated a project that used a mix of interventions including safe houses/rescue centres to protect girls from FGM/C showed that their sensitization campaigns were successful since they empowered girls to say no to the practice, with many seeking refuge in safe houses or

[68] Excisors (or 'cutters') are traditionally the women who perform FGM/C on girls.

being able to report cases of attempts to be cut to the police for prosecution (Equality Now, 2011; P; OBS; →). A review of successful interventions including safe houses among the Maasai, Kisii and Kuria communities in Kenya suggested that the rescue centres approach can be successful if integrated with other interventions to eradicate FGM/C (Buttia, 2015; S; OR; →).

Table 12.8: Studies that have assessed effectiveness of rescue centres

Study	Intervention Focus	Effect on FGM/C	Quality
Equality Now. 2011. Protecting Girls from Undergoing Female Genital Mutilation: The Experience of Working with the Maasai Communities in Kenya and Tanzania. Equality Now	Assessed multiple interventions including rescue centres	Girls have been empowered to say no to FGM/C	→
Van Bavel H. 2020. At the intersection of place, gender, and ethnicity: changes in female circumcision among Kenyan Maasai. Gender, Place & Culture	Assessed multiple interventions including rescue centres	Limited effectiveness of rescue centres	↑
Nambisia EM. 2014. Measures Influencing Eradication of Female Genital Mutilation Practices Among the Maasai Community in Maparasha Constituency Kajiado County, Kenya. University of Nairobi (UoN)	Assessed multiple interventions including rescue centres	Challenges with reconciliatory efforts between the rescued girls and their parents	→
Buttia C. 2015. Investigation of successful interventions in mitigation of female genital mutilation /cutting (FGM/C) among selected Kenyan communities: Maasai, Kisii and Kuria (Master thesis, Hochschule für angewandte Wissenschaften Hamburg).	Review of multiple interventions including rescue camps	Limited impact when implemented in isolation	→

12.9 Media / social marketing campaigns / communication

Two high quality studies and three moderate quality studies assessed the impact of media, social marketing campaigns and communication on FGM/C abandonment (Table 12.9).[69] Most of the interventions focused on using various media platforms to disseminate messages on negative health consequences of FGM/C.

Study findings showed that the use of media can be an effective tool in the push towards FGM/C abandonment (Kaunga, 2014; P; OBS; →). Mainstream newspapers and television reports, SMS messaging and the full range of social media, theatre productions, television and radio melodramas, can shape conversations about FGM/C and accelerate the shift in social norms (UNFPA, 2017; S; OR; →). Effective sensitization campaigns have empowered girls to refuse FGM/C and to report to relevant authorities when at risk (Buttia, 2015; S; SR →). As a result of awareness campaigns in 17 program countries, a study by UNFPA showed that disapproval of the practice had increased (UNFPA,2017; S; SR →).

A systematic review by Berg and Denison (2013), observed that the driving force for changing FGM/C related behaviour lies in the dissemination of information. There was evidence of a shift in perspective regarding FGM/C through the provision of knowledge and the actions of some which spread to others through social networks (Berg and Denison, 2013; S; SR; ↑). Nonetheless, evidence shows that interventions which only supply information, education and campaigns (IEC) to increase FGM/C awareness are not sufficient to change behaviour (WHO, 2011; P; OBS; →, Cloward, 2014; P; OBS; ↑).

[69] It should be noted that the 2017 is the most recent study.

Table 12.9: Studies that have assessed effectiveness of media / social marketing campaigns / communication interventions

Study	Intervention focus	Effect on FGM/C	Quality
Kaunga S. 2014. Media strategies and their influence in communicating information on Female Genital Mutilation: a case of Meru community in Tharaka District (Doctoral dissertation, University of Nairobi).	Media strategies and communicating information on FGM/C	Use of media and local language was effective in influencing effective communication on FGM/C	→
UNFPA. 2017. 17 ways to end FGM/C. UNFPA.	Review of multiple interventions including mass communication	Reduced incidences of FGM/C	→
Buttia C. 2015. Investigation of successful interventions in mitigation of female genital mutilation /cutting (FGM/C) among selected Kenyan communities: Maasai, Kisii and Kuria (Master thesis, Hochschule für angewandte Wissenschaften Hamburg).	Reviewed multiple interventions including communication interventions	Increased awareness of consequences of FGM/C and reduced prevalence of FGM/C	→
Cloward K. 2014. False Commitments: Local Misrepresentation and the International Norms Against Female Genital Mutilation and Early Marriage.	Transnational activism/campaigns led by international actors	Campaigns can lead to concealment of real behaviour and changes in attitudes	↑
Berg RC; Denison EM. 2013. A realist synthesis of controlled studies to determine the effectiveness of interventions to prevent genital cutting of girls. Paediatrics and International Child Health	Systematic review of multiple interventions including media communication, outreach, and advocacy	Change in attitude regarding FGM/C through knowledge acquisition	↑

12.10 Alternative rites of passage

Three high quality studies and four studies of moderate quality assessed the effectiveness of alternative rites of passage (ARP) as a strategy to end FGM/C in Kenya (Table 12.10). Alternative rituals to FGM/C allow girls to undergo training and graduate to womanhood without the cut. During this process, girls are also educated on different topics like human rights, adverse effects of FGM/C, and are encouraged to abandon the practice (Buttia, 2015; S; SR; →). Among groups that had dedicated training on the harmful effects of FGM/C, ARP increased reproductive health knowledge, and in some instances the training led to not necessarily abandonment of FGM/C but rather changes in the practice—from severe to less severe cuts (Mepukori, 2016; P; OBS; ↑).

Findings by Nambisia (2014) showed that majority of the respondents supported public ceremonies where girls were celebrated as they transitioned into womanhood without necessarily going through FGM/C (Nambisia, 2014; P; OBS; →). The ARP approach seem to be most effective when it takes place at the end of a structured girls empowerment programme and involves a community ceremony that is explicitly recognized as an alternative to undergoing FGM/C. Mepukori (2016) examined the effectiveness of ARP implemented as a single intervention among the Samburu community in Kenya. Study findings showed that ARP had no effect on reducing FGM/C when implemented as a single intervention (Mepukori 2016, P; OBS; ↑). One of the recommendations from the study was that for ARP to be effective, it should be implemented in combination with other intervention approaches such as community awareness-raising initiatives. Oloo et al (2011) equally recommends that ARP that involves intensive community sensitisation about FGM/C combined with a public declaration ceremony fully integrated into a girl's empowerment programme can be effective in encouraging abandonment in rural communities (Oloo et al, 2011; P; OBS; ↑). Mwendwa and colleagues (2020) argue that for ARPs to be effective, it will require a combination of behaviour change support at the community level,

law enforcement and monitoring, and open and persistent advocacy by diverse representatives of communities (Mwendwa et al, 2020; P; OBS; ↑).

Risk of exclusion, perceived loss of cultural identity, changing meanings ascribed to cultural practices, lack of precise knowledge about subjective sexual experience and negative stereotyping are some of the reasons that can limit the success of the ARP programmes commonly implemented in Kenya (Graamans et al, 2019; P, OBS; →). A study by UNICEF observed limited impact of ARP in facilitating FGM/C abandonment as the approach was curtailed by communities cutting girls at younger ages with less ceremony and ritual

Table 12.10: Studies that have assessed effectiveness of alternative rites of passage

Study	Intervention focus	Effect on FGM/C	Quality
Buttia C. 2015. Investigation of successful interventions in mitigation of female genital mutilation /cutting (FGM/C) among selected Kenyan communities: Maasai, Kisii and Kuria (Master thesis, Hochschule für angewandte Wissenschaften Hamburg).	Reviewed multiple interventions including alternative rites of passage	Reduced prevalence of FGM/C. ARP considered effective in influencing girls to reject FGM/C	→
Mepukori DN. 2016. Is alternative rite of passage the key to abandonment of female genital cutting? A case study of the Samburu of Kenya. Duke University.	Encourage/ train communities to maintain the cultural ceremonies and rites surrounding female initiation whilst getting rid of FGM/C	Some change in attitudes. Community disagreements with some of the approaches	↑
Oloo H et al. 2011. Female genital mutilation practices in Kenya: The role of Female genital mutilation practices in Kenya: The role of alternative rites of passage. A case study of Kisii and Kuria alternative rites of passage. A case study of Kisii and Kuria districts. Population Council	ARP focusing on community sensitization, training on family life education, and public graduation ceremony	Reduction in FGM/C prevalence but context specific -Positive changes in Kisii but not in Kuria	↑
Graamans EP, et al. 2019. Lessons learned from implementing alternative rites in the fight against female genital mutilation/cutting. The Pan African Medical Journal.	Amref Health Africa's efforts to end FGM/C through ARP	Limited effectiveness. Risk of exclusion, perceived loss of cultural identity, changing meanings ascribed to cultural practices, lack of precise knowledge about subjective (sexual) experience and negative stereotyping	→
Nambisia EM. 2014. Measures Influencing Eradication of Female Genital Mutilation Practices Among the Maasai Community in Maparasha Constituency Kajiado County, Kenya. University of Nairobi (UoN)	Assessed multiple interventions including alternative rites of passage	ARP considered a vital FGM/C eradication measure. Public ceremonies held to celebrate girl's entry into womanhood without FGM/C	→
Mwendwa P, et al. 2020. "Promote locally led initiatives to fight female genital mutilation/cutting (FGM/C)" lessons from anti-FGM/C advocates in rural Kenya. Reproductive Health.	Assessed perceived effectiveness of FGM/C interventions including ARP - training of girls and community sensitization	Substantial shift in the culture of FGM/C with decrease in FGM/C prevalence	↑
UNICEF Innocenti Insight. 2010. The dynamics of social change towards the abandonment of female genital mutilation/cutting in five African countries. The UNICEF Innocenti Research Centre	Assessed multiple interventions including ARP in Kenya – preserving coming-of-age ceremonies and initiation rites while eliminating FGM/C	Limited impact. Curtailed by communities cutting girls at younger ages with less ceremony and ritual	→

13. Media Analysis

13.1 Methodology

A list of keywords (FGM, End FGM, FGM/C, FGC, Female Genital Mutilation) was created and hashtags were identified (e.g. #EndFGM #EndFGMinKenya #FGMinKenya #AntiFGM #PamojaTukomesheUkeketaji) for searches online. Data from Ipsos, the Kenya Audience Research Foundation and the Media Council of Kenya provided background to the media landscape in Kenya. Below are highlights of what was learned.

13.2 Overview of media in Kenya

Over recent years TV and online have become more popular in Kenya but radio remains dominant. 43.2% of Kenyans report that they watch TV, 67.4% listen to the radio, 25.9% use social media and 9.5% read the newspapers[70]. There are close to 300 radio stations, nearly 400 TV stations (66 local) and 44 newspapers registered in Kenya. Despite these significant numbers, there are only a few that command the mainstream media.

The Nation (daily circulation of 180,000) and the Standard (daily circulation of 150,00) capture around 90% of all newspaper readership. The East African (weekly paper, regional business focus), The Star, The People, Taifa Leo (Nation Media Group's Kiswahili daily) and several other smaller, local papers, complete the market. Readers are found in both rural and urban areas, with 65% of them in Nairobi, Central[71], the Rift[72] and Western[73] regions. Readership is very low in the northern areas of Kenya. Newspaper readership is predominantly male in Kenya with only 20% of readers being women[74]; readers are mostly older, decision makers, politicians and people in formal employment.

TV is popular in both rural and urban areas. More viewers are men (57%) than women (43%). The most popular TV station in Kenya is **Citizen TV** with 37.6% of the share. The station's commitment to local content and programmes has allowed it to lead the pack for the last 10-15 years. Other major TV stations are **KTN Home** (10.1%), **NTV** (9.5%), **KTN News** (9.4%), **Inooro** (9.4%, vernacular Kikuyu) and **K24** (5.8%)[75]. All carry news programmes in Kiswahili and English, apart from Inooro.

Radio is the media that most people access on a regular basis and 65% of radio listeners are found in rural areas. There is no dominant national station. Citizen has 13% of the average national daily reach, and the top ten stations in Kenya, in the table below[76], have close to half of the national listenership. Other local, vernacular and community radio stations share the remaining 50% of the country's listeners. This is still a large number of people and is important to note if using radio for audiences in specific regions with high prevalence of FGM/C. Radio is the media that more women and girls access compared to TV and newspapers[77].

[70] IPSOS (2020) Kenya Audience Measurement Survey
[71] Includes the counties of Kiambu, Kirinyaga, Laikipia, Muranga, Nakuru, Nyandarua, Nyeri
[72] Includes the counties of Baringo, Bomet, Elgeyo Marakwet, Kericho, Nandi, Narok, Uasin Gishu, Kajiado
[73] Includes the counties of Bungoma, Busia, Kakamega, Trans-Nzoia, Kakamega, West Pokot
[74] IPSOS (2020) Kenya Audience Measurement Survey
[75] Media Council of Kenya (2020) Status of the Media Report
[76] Ibid.
[77] Kenya Audience Research Foundation (2018) Audience Tracker Q4

	Radio station	Language	Reach
1	Citizen	Swahili	13%
2	Jambo	Swahili	7%
3	Maisha	Swahili	6.8%
4	Inooro	Kikuyu	5%
5	Kameme	Kikuyu	3.5%
6	Milele	Swahili	3.2%
7	Ramogi	Luo	3%
8	Taifa	Swahili	2.9%
9	Classic	English	2%
10	Kass	Kalenjin	1.8%

Facebook and WhatsApp are the most popular social media channels in Kenya. 36% get information from WhatsApp, 35% from Facebook, 10% Twitter, 9% Instagram and 7% from YouTube[78]. Facebook tends to be more popular in rural areas while people in towns and cities are more active on Instagram. People use both traditional media and social media to access the news but **social media's prime role for Kenyans is networking[79]**. When building movements and campaigns online there must be a recognition that networking drives social media engagement for Kenyans. Social media use is also influenced by gender and age, with more boys than girls online and usage increasing with age[80]. It is important to note that girls are disproportionately excluded from technologies making access to these platforms problematic.

13.3 How FGM/C is covered in the Kenyan media

The two main newspapers in Kenya, **The Standard** and **The Nation** cover FGM/C more regularly than other newspapers. Over the last twelve months both papers had a story or feature on FGM/C at least once a month. Articles tend to become more frequent around specific key dates related to FGM/C, such as the International Day for Zero Tolerance for FGM on February 6th. In February 2021, the Standard has published four articles on FGM/C[81]. From these articles, it is clear that institutions, such as UN bodies, the Anti FGM board and CSOs are driving the agenda to end FGM/C in the mainstream written media. Coverage of FGM/C was found on **KTN News, Citizen TV, NTV News and KBC**, during news programmes[82], related to international days on FGM/C and gender-based violence. These stations capture the majority of TV news viewing. There is an opportunity here to place articles and segments about FGM/C around times relevant to Kenyans rather than the UN. Much coverage is paid for but interventions around the various cutting seasons could be very effective.

It is more difficult to get accurate information on the coverage of FGM/C on radio stations, but it is widely recognised that radio can play a key role in a country such as Kenya where radio remains king. In this analysis we found some content on FGM/C on Capital FM, which is an urban (Nairobi) station, in English, catering to the middle class. Star Media in the northern region[83] carries content on FGM/C, but mostly when this is sponsored. Star Media broadcasts in Somali in both radio and TV in northern Kenya and into Somalia. It has around 40% of the radio listenership in that region. On Mayian FM (a Kimaa station in Kajiado/Narok) there is a weekly programme looking at different aspects of FGM/C, sharing stories and sparking debate. Vernacular Egesa FM in Kisii also

[78] Media Council of Kenya (2020) Status of the Media Report
[79] Ibid.
[80] Shujaaz Knowledge and Learning team
[81] https://www.standardmedia.co.ke/kenya/article/2001402823/board-four-million-women-girls-living-with-fgm-in-kenya; https://www.standardmedia.co.ke/opinion/article/2001403203/survivors-would-make-great-anti-fgm-champions; https://www.standardmedia.co.ke/opinion/article/2001402502/lets-work-together-to-end-fgm; https://www.standardmedia.co.ke/health/article/2001402746/study-fgm-still-practised-by-kenyans-but-across-the-border
[82] https://www.youtube.com/watch?v=e7IcwsTxKxw https://www.youtube.com/watch?v=D5ps37zx3cw
[83] Includes the counties of Garissa, Mandera, Wajir, Marsabit, Turkana, Samburu

broadcasts periodic features on FGM/C. Egesa is popular locally, in the South Nyanza region[84] with 36% share. In previous work, WMS has partnered with local and vernacular radio stations through identifying stations that connect with the local audience we are targeting, building strong relationships with the station, with training and support, that helps to steer impactful broadcasts that reach the right audience. It is common practice in Kenya for CSOs, or any other institution, to pay for radio airtime. It is often expensive, and CSOs have to negotiate corporate deals with broadcasters.

Social media is a huge opportunity for creating campaigns that bring people into conversations, rallying calls for change and for influencing specific audiences. Most social media activity in Kenya around FGM/C is found on Facebook and Twitter and mirrors that of traditional media by focusing on key international days. Activists and individuals create a buzz around an international day and then posts fizzle out, or they move on to another issue. CSOs show more consistency and tend to frame FGM/C in the wider context of the challenges that girls face such as staying in school, access to opportunities, girl empowerment and child marriages etc. This allows them to share more content, more frequently and to keep the issue alive and in conversations. Hashtags that were found related to increasing awareness on FGM/C and Kenya include #FGM, #antiFGM, #Humanrights, #KataaKatishaZui, #EndFGM, #16daysofActivism2020, #16daysofActivismagainstgbv, #EndFGM, #Act2EndFGM, #zerotoleranceforfgm.

13.4 Themes

Themes that turned up consistently in our analysis of the traditional media were:

- End FGM/C, progress on FGM/C in Kenya, COVID impact on FGM/C
- Community action and stories, such as a push for alternative rites of passage, calls for men to support, the link between early marriage and FGM/C
- Legal/consequences such as public servants fired for aiding/abetting FGM/C practice, government regulations and action taken on those who perform the act
- Information on FGM/C (dangers, myths)
- Medicalisation of FGM/C
- International Day for Zero Tolerance of FGM/C
- Provision for reconstructive surgery

As FGM/C is illegal in Kenya it is no surprise that most stories focus on ending FGM/C and the challenges associated with the fight to end the practice. However, in conversations with journalists they expressed views that some people in the media can be reluctant to cover FGM/C, for different reasons. They shared that some would argue that it is a cultural practice that people still value. Others suggested that there is a prevailing view that if it is secretly practiced, there's no need to highlight it. They had also heard of cases where whistle-blowers were threatened in their communities, and there was unease about putting people at risk. The media only very rarely covers stories that are supportive of FGM/C. In 2019, Dr Tatu Kamau was seeking to have FGM/C legalised through the courts, a case that was covered by KTN news. The media might not openly refuse to carry stories on FGM/C but, at the same time, they might not actively seek to cover it.

[84] Includes the counties of Kisii, Nyamira

13.5 Voices

These are the voices that have been heard most in the last six months, in mainstream media in Kenya:

- Bernadette Loloju, CEO Anti-FGM board[85],
- Gladwell Cheruiyot, Baringo Women Rep[86],
- Alice Masinte, Activist Anti-FGM campaigner[87],
- Tony Mwebia, Men end FGM[88],
- Dr. Josephine Kulea, Samburu Girl's Foundation[89],
- Agnes Pareiyo, Anti FGM board Chair[90]
- Ademola Olajide, UNFPA Representative[91].

Other influencers found in the mainstream media in the last six months are Maniza Zaman (UNICEF), Ann Marie Wilson (28 too many), Angelina Cikanda (CREAW), Fatuma Gedi (Wajir Woman Rep (Survivor)), Hamisi Kirenga (Spread Truth Africa), Aisha Hussein (Anti FGM/C Youth Activist), Patrick Makau (Mavoko MP), Leah Chebet Psiya (Pokot women's empowerment organization), Robi Marwa (Anti FGM/C Campaigner), Domitilah Chesang (IREP, West Pokot), Samuel Ole Tunai (Narok County Governor), Natalie Robi Tingo (Msichana Empowerment), Dr. Dennis Matanda (Population Council), Ibrahim Guyo (SASA), Sadia Hussein (Anti FGM activist Dayaa Women's group), Talaso Gababa (Anti FGM/C Activist), Esther Injema (community mobilizer).

There are many voices from Kenya on social media that are contributing to global conversations, sharing stories from the community and personal journeys that highlight the need to end FGM/C. These include local organisations such as Youth Anti–FGM network KE, Samburu Girls Foundation, MenEndFGM, Fida Kenya, broader networks such as The Girl Generation Kenya, FEMNET, Global Media Campaign to End FGM, Feminists in Kenya, UN agencies such as UNFPA Kenya, UNICEF, UN Women and international organisations such as Equality Now-End FGM campaign, Save the Children and consortium members Orchid Project and Amref Health Africa. Social media, especially twitter and Instagram, are used by activists and activist networks such as @cdomtilla,@Shujaa Sadia Hussein @pitamarsh, https://www.instagram.com/scarletudaan/ Kulamo Rend, Abdi Safia- https://www.instagram.com/ms._abdi_safia/?igshid=yhtz4ttj7k7b. Many levels of government in Kenya are found on social media including Parliamentarians (Rachel Shebesh), County governments e.g. West Pokot, Narok, national government e.g. Anti FGM board, Ministry of Health.

Again, it should be noted that the visibility of girl activists through national media platforms if virtually non-existence. In implementing a girl-centered approach this will be important to address.

[85] https://nation.africa/kenya/videos/news/anti-fgm-board-chairperson-ms-agnes-blames-politicians-from-kuria-for-promoting-fgm-1270114
[86] https://www.standardmedia.co.ke/the-standard-insider/article/2001394672/men-support-fgm-but-seek-uncut-mipango-second-wives
[87] https://www.standardmedia.co.ke/ktnnews/video/2000205233/campaign-against-fgm-discussion-with-end-fgm-activist-alice-masinte
[88] https://www.reuters.com/article/us-kenya-women-fgm-trfn-idUSKBN1XM2GN
[89] https://www.theeastafrican.co.ke/tea/magazine/one-woman-s-race-to-save-girls-from-the-cut-early-marriage-1441706
[90] https://nation.africa/kenya/gender/joint-initiative-in-laikipia-north-to-wipe-out-fgm-233224
[91] https://nation.africa/kenya/ademola-olajide-287420

13.6 Potential Target Audience

When the programme begins to develop communications strategies, the consortium will need to delve deeper into the audiences it wants to target (girls) and the media that these audiences most engage with. The table below gives a snapshot of some of the expected audiences in Kenya, the media that they use and voices that they may listen to.

Table 13.6: Potential Target Audience

Potential Target Audience	Influential media	Influential personality	Rationale
National policy makers	Mainstream print media National TV & Radio stations. Citizen, KTN, NTV, KBC Twitter	Uhuru Kenyatta, President; Ukur Yattani, CS Treasury and planning; Rachel Shebesh, CAS Gender & youth affairs; Supreme Council of Kenyan Muslims (SUPKEM); National Council of Churches of Kenya (NCCK)	They watch, listen, read for the news; they listen to people with influence and power in their circles; religion is important
Community leaders	National Radio (Citizen, Radio Maisha, Radio Taifa (northern region), TV Community (vernacular) radio e.g. Star FM, Meru FM, Muuga FM, Egesa FM, Kass FM, Chamgei FM	Boran, Maasai, Pokot, Tana Delta, Loita Maasai, Council of Elders; Jacob Narengo, Wajir County commissioner; Boaz Cherutich, Migori county commissioner; Local/Community media personalities; Local politicians/administrators	Radio and TV dominate. They listen to elders and county government leaders
Young girls/adolescents	National radio, local (vernacular) community radio; TV; social media (older girls with smart phones)	Parents; Aspirational community and youth personalities; teachers; Religious leaders	Complex community – growing social media use, could be used for specific messaging BUT more research needed on girls in e.g. northern region: do they have smart phones? (often not, in our experience_
Young boys/adolescents	National radio, local (vernacular) community radio; TV; social media	Parents; Aspirational community and youth personalities; teachers; Religious leaders	Similar to girls – more research on smart phone access
Mothers/women in the community	National, vernacular, community radio; TV	Political leaders; Religious leaders; Cultural leaders; Socially progressive personalities;	Especially in rural areas, news, discussion and entertainment

14. Cross-border FGM/C

14.1 Emerging challenge

The United Nations has highlighted cross-border FGM/C as one of the emerging challenges that needs to be addressed in order to eradicate FGM/C.[92] However, there is relatively little research that gives us a nuanced and detailed picture of the extent of cross-border movement, why it happens and how it might best be responded to. Most of the research has been conducted by international agencies and published as grey literature.

Several organisational reports have been commissioned that capture the triggers and drivers for cross-border cutting in Kenya.[93] According to these reports the border areas with the highest FGM/C prevalence rates are with Somalia and Ethiopia. Kenyan communities affected are the Rendille bordering Oromiya and "the Southern Nations, Nationalities and Peoples' (SNNP) regions with FGM/C prevalence rates of 87% and 71% respectively; the Somali in Wajir and Garissa counties bordering Juba and Gedo regions in Somalia where FGM/C is near universal (98%)".[94] In regard to the Somalia border communities, these comprise of women who have been subjected to Type III or pharaonic circumcision.[95] Other country border communities include the Maasai bordering Arusha and Kilimanjaro regions in Tanzania, with estimated FGM/C prevalence rates of 57% and 22% respectively; and the Pokot bordering Karamoja region in Uganda with an FGM/C prevalence rate of 5%.[96]

14.2 Main drivers

In terms of understanding why it happens we know relatively little compared to what we understand internally. The main driver is the need for both cutters and families to move to avoid prosecution. Cutters move across borders to families requesting their services. Families move across borders to procure services of cutters. This movement is also driven by the affordability and availability of cutters. It is not just avoiding prosecution.[97] However this is likely not the only reason with kin groups, intermarriage and family networks also likely drivers. Extended families separated by a border may move either side to come together to perform FGM/C on their girls collectively. In other words: cultural, ethnic and family ties need to also be drivers.

Girls living in these areas are highly vulnerable. Media reports state that girls living near borders are most vulnerable to being forcibly moved, particularly if they are living next to countries with

[92]UNFPA (2019). Beyond the crossing: Female Genital Mutilation Across Borders, Ethiopia, Kenya, Somalia, Tanzania and Uganda. United Nations Population Fund, New York UNFPA-UNICEF, 2019) UNFPA-UNICEF (2019). Accelerating Change: Annual report 2018. UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation.

[93]"Baseline Study Report: Female Genital Mutilation/ Cutting and Child Marriage among the Rendille, Maasai, Pokot, Samburu and Somali Communities in Kenya. United Nations Children's Fund (UNICEF), Nairobi, 2017", UNFPA (2019). Beyond the crossing: Female Genital Mutilation Across Borders, Ethiopia, Kenya, Somalia, Tanzania and Uganda. United Nations Population Fund, New York. Walela Nasimiyu Stella (2020). Assessment of international laws on female genital mutilation and its implications on the East African region: a case study of Namanga, Kenya-Tanzania border. University of Nairobi. UNFPA-UNICEF (2019). Accelerating Change: Annual report 2018. UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation. 28 Too Many (2018). The Law and FGM: An Overview of 28 African Countries (September 2018). Available at https://www.28toomany.org/Law

[94] Baseline Study Report: Female Genital Mutilation/ Cutting and Child Marriage among the Rendille, Maasai, Pokot, Samburu and Somali Communities in Kenya. United Nations Children's Fund (UNICEF), Nairobi, 2017".

[95] (World Bank and UNFPA, 2004);

[96] Ibid

[97] (Building Bridges to End FGM, 2019) Building Bridges to End FGM (2019). Cross Border Female Genital Mutilation. Available at: https://copfgm.org/cross-border-fgm

weaker anti-FGM/C legislation as compared to their countries of residence.[98] We might arguably say that this is the case particularly in regard to the border between Kenya and Somalia. Once more though it is important to note that very little peer reviewed research has been conducted to help us understand these trends and how common they are.

14.3 Tackling cross-border FGM/C

Currently there are several efforts to tackle cross-border FGM/C including regional cooperation, action plans, national laws and policies, international declarations and extraterritorial provisions in FGM/C laws. Stopping cross-border FGM/C requires a regional approach and the engagement of intergovernmental organizations through multilateral collaboration on policies and legislation, and the development of joint communication strategies that discourage individuals and families from crossing borders for FGM/C.[99]

There are various regional and sub-regional frameworks that generally call African States for a concerted approach towards the elimination of FGM/C. These include the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol 2003) ratified by Kenya, Tanzania and Uganda but signed by only Ethiopia and Somalia; African Union Agenda 2063 "The Africa we want" (aspiration 6-priority 51; "African Union Initiative on Eliminating Female Genital Mutilation or Saleema" (January 2019), and its related declaration on "Galvanizing Political Commitment towards the Elimination of Female Genital Mutilation".[100]A report by the UNFPA report notes that the Pan African Parliament action plan to end FGM/C in Africa recommends the need for initiatives to strengthen actions against cross-border FGM/C.[101] The East African Community (EAC) Prohibition of FGM Bill (2016) enacted by the East African Legislative Assembly is another form of legislation that contains provisions for the definition and prosecution of cross-border FGM/C offences, applicable in all member states. The legislation also calls for establishment of a sub-regional coordination mechanism to catalyse efforts to end FGM/C.[102]

14.4 Challenges in tackling cross-border FGM/C

Several factors make it difficult to address cross-border FGM/C. For instance, movements of mobile cross-border communities such as pastoralists in search of pastures and water for their animals facilitates cross-border FGM/C; dual citizenship which allows people to visit each other makes it difficult to detect if there is a motive for FGM/C; and the porous borders with limited surveillance facilitates the practice. Other challenges include: insufficient prosecutions of cross-border FGM/C cases which are less reported, lack of harmonization of national legislations, insufficient resources, and lack of a regional monitoring and data mechanism on the cross-border practice which limits the comprehension of the situation and evidence-based programming.[103]

[98] IRIN (2020, (Kimani et al., 2018). Kimani, Samuel and Caroline W. Kabiru (2018). Shifts in female genital mutilation/cutting in Kenya: Perspectives of families and health care providers. Evidence to End FGM/C: Research to Help Girls and Women Thrive. New York: Population Council.
[99] UNFPA-UNICEF (2019). Accelerating Change: Annual report 2018. UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation.
[100] UNFPA (2019). Beyond the crossing: Female Genital Mutilation Across Borders, Ethiopia, Kenya, Somalia, Tanzania and Uganda. United Nations Population Fund, New York.
[101] UNFPA 2016
[102] UNFPA 2019 ibid
[103] UNFPA 2019

There is difficulty in prosecuting cases where there are no extraterritorial laws.[104] In most extraterritorial cases, double criminality proves to be an impediment. Double criminality means that people can only be punished for actions that are considered a crime in both countries.[105] For example in Tanzania where FGM/C is illegal only for girls below 18 years and as such women above 18 can undergo if they consent to it. Consequently, this lenient legal environment aids cross-border FGM/C to flourish. Tanzania is also a dualist state, and international and regional laws such as The East African Prohibition of Female Genital Mutilation Bill (2016) and many others must be domesticated to be enforced. Failure by the authorities to act as expected, and the lack of elaborate legal mechanisms and structures to extradite perpetrators of FGM/C from Tanzania to face criminal proceedings for cross-border FGM/C related offences has proven to be a challenge for Kenyan authorities.[106]Important to note is that most anti-FGM/C laws in Africa do not specifically address the issue of cross-border FGM/C making this a potential focus for advocacy.[107] The fact that some African countries have no legislation against FGM/C provides the possibility for communities in neighbouring communities to freely travel and practice FGM/C where it is legal.[108]

14.5 Knowledge gaps

Clearly this review of evidence has revealed significant gaps when it comes to understanding around the main drivers and what will work best to end FGM/C in border regions. Operational research to guide a more comprehensive evidence base is highly recommended which should focus on; a more detailed mapping of trends in terms of the age of the girls most vulnerable and a spectrum understanding of the main drivers (is it availability of cutters, cost of cutting, prosecution or a mixture?) The influence of ethnic cross border family factors also needs to be measured and captured in more detail. With this greater understanding more effective and targeting programming becomes possible. What seems apparent is that girls in these areas are marginal and extremely vulnerable to FGM/C not least because most activity and resource to end FGM/C is focused internally rather than around these more mobile communities.

[104] (Leye, 2007 Leye Els, Deblonde Jessika, García-Añón José, Johnsdotter Sara, Kwateng-Kluvitse Adwoa, Weil-Curiel Linda and Temmerman Marleen (2007). An analysis of the implementation of laws with regard to female genital mutilation in Europe. Crime Law Soc Change (2007) 47:1–31 DOI 10.1007/s10611-007-9055-7.; Vanhoof, 2011)
[105] Leye at al 2007 Leye Els, Deblonde Jessika, García-Añón José, Johnsdotter Sara, Kwateng-Kluvitse Adwoa, Weil-Curiel Linda and Temmerman Marleen (2007). An analysis of the implementation of laws with regard to female genital mutilation in Europe. Crime Law Soc Change (2007) 47:1–31 DOI 10.1007/s10611-007-9055-7.
[106] Walela Nasimiyu Stella (2020). Assessment of international laws on female genital mutilation and its implications on the East African region: a case study of Namanga, Kenya-Tanzania border. University of Nairobi.
[107] (Building Bridges to End FGM, 2019 Building Bridges to End FGM (2019). Cross Border Female Genital Mutilation. Available at: https://copfgm.org/cross-border-fgm
[108] ibid

15. Conclusions

15.1 Aim of this PEA

As stated in the introduction, the purpose of this Political Economy Analysis was to understand the political dimensions of a context and actively using this information to inform programming. In this document, we comprehensively gathered at national level all information and data needed to support key decisions. The research process behind the PEA was designed to identify gaps and questions where more data is needed. Lastly, to produce an accurate map of where Kenya is positioned at the moment in terms of achieving the presidential goal of ending FGM/C.

15.2 Girl-centered approach

What is clear from the data, and the analysis of it, is that **a girl-centered approach is still not the dominate lens through which interventions and policies are currently framed and implemented**. More thinking is needed in terms of what a girl-centered approach should look like and how it can drive activities. Cultural contextualization is also needed in terms of how the term 'girl' is understood at community level. In a context where child-marriage is prevalent girls become women from a very young age.

The approaches to end FGM/C reviewed in this PEA clearly suggest that there is not a one-size-fits-all model for how to end FGM/C. The evidence in terms of the interventions that works best also point to the need to take a **multi-layered approach**. For example, ARPs are popular, and stakeholders believe them to work however the evidence suggests that they do not work if implemented on their own. ARP only work when they form part of a wider programme of gender transformation. Arguably, there is opportunity for the programme to create a holistic girl-centred approach to gender transformation that places the abandonment of FGM/C as a priority. This may well represent a new model more integrated model for ending FGM/C that will draw on a number of interventions where the evidence suggests putting them together is likely to bring the best results. For example, social media and local radio campaigns coupled with opening access to these technologies to girls and boys. Integrating end FGM/C and gender norm change into school curriculums, working with key local influencers including religious leaders to engage communities in dialogue to end harmful behaviours and to hold them accountable when they break the law and targeting important groups such as young men about to marry and parents of young girls. Alongside this holistic girl-centered approach a robust monitoring and evaluative framework is needed to provide further evidence around what works and to support adaptive programming.

This PEA and the sub-national PEA to follow clearly reveals that any transformative model needs to be designed at the grassroots and with the involvement of different groups of actors' specifically young people. Internal diversity in prevalence, type of cutting age and vulnerabilities as well as the root causes all need to guide this model.

15.3 Mainstreaming FGM/C

Opportunities for mainstreaming FGM/C also seem critical. The integration of FGM/C activities into programmes with a strong gender focus seem to offer value for money and potentially will help to trigger with greater intensity acceleration to abandonment. The resources of the programme will only support a certain number of bespoke holistic interventions.

Opportunities to grow the movement and see impact deepen must involve other gender programmes. **In parallel the ALM to end FGM/C needs to align more closely with feminist and women's organizations**. Whilst they may be closely related the integration of the ALM into the wider movement for women's rights holds potential to embed FGM/C as a central and urgent issue.

Decisions need to be made over where the programme should concentrate its resources.

15.4 Important considerations

This PEA draws out several important questions for the consortium to answer:

- Should activities be focused in areas of already intense effort and to trigger faster accelerated transformation toward change?
- If decisions are made to work in areas where interventions and organizational presence is limited: what are the security risks, and can they be mitigated?
- In areas where the challenges to gender equality may be greater combined with other issues such as security risks? Do these areas still present opportunities for change (even if it cannot be triggered to the same degree as elsewhere?)
- To what extent should we apply a strict 'leave no one behind' approach and be systematic in working in areas where interventions have been scarce but where the prevalence need is high? E.g. border area with Somalia?

Other questions for the sub national PEA:

- Who do we need to work with? Clearly working closely with members of the Anti/FGM board is critical. There is need for the programme to align and support the implementation of the new FGM/C strategy, but more careful thought is needed over how this should effectively happen?
- Who are the other critical gatekeepers? The most visible activists and key feminist groups (who may not focus on FGM but who might be willing to).
- What is the relationship (if any) between the women's movement in general in Kenya and the ALM to end FGM/C?
- What, at national level seem like the most likely entry points for change?

15.5 Next steps

Work to be carried out as part of the sub-national process: The national PEA process has largely taken the approach of evidence synthesis and existing data analysis and has been instrumental in providing a comprehensive overview of the trends, successes and challenges in ending FGM/C to date. Moving to the sub-national process the voices of women and girls will guide a more in-depth analysis. It will explore the existence and effectiveness of activism at country and community level (in the target areas). In analysing this data conclusions need to be drawn around the connectivity of the local level movement with national platforms and recommendations drawn on how best to bridge them.

More in-depth mapping of interventions and where they are fielded will again guide the decision-making process in terms of where to target programme resources.

The sub national PEAs need to go as far as they can in beginning the process of filling the evidence gaps: what primarily is driving cross border FGM/C and does this also differ according

to which border? We can see from the evidence presented in this national PEA that stopping cross-border FGM/C requires a regional approach. Different legislation regimes across countries and law enforcement practices present challenges to FGM/C eradication. Alternative strategies/interventions that consider the communities that live across such borders as one need to be explored this should also be applied to cross-border advocacy.

To what extent has knowledge and understanding around the existence of FGM/C legislation been communicated, received and taken on board at a community level and how much of a deterrent are the punishments? Is there any evidence that the law is in applied?

How effective are key professionals in implementing the law? For example; health professionals are key to successful prosecutions; what more can be done to capacity build this group and others (police, teachers) to be more confident and effective in this role.

Annex I

FGM/C prevalence at county-level

Prevalence rate	No. of counties	County-level Prevalence			
		County	**Prevalence**	**County**	**Prevalence**
Very high prevalence (more than 80%)	6	Mandera	99.7%	Marsabit	94.4%
		Wajir	98.6%	Nyamira	91.3%
		Garissa	95.1%	Kisii	89.6%
Moderately high prevalence (51-80%)	5	Samburu	79.2%	Narok	62.3%
		West Pokot	71.8%	Tana River	57.2%
		Isiolo	68.2%		
Moderately low prevalence (26-50%)	11	Bomet	41.9%	Kirinyaga	28.5%
		Tharaka-Nithi	39.9%	Baringo	28.4%
		Embu	36.6%	Elgeyo Marakwet	27.7%
		Kajiado	36.1%	Laikipia	27.0%
		Meru	35.5%	Migori	25.3%
		Kitui	29.6%		
Low prevalence (10-25%)	9	Murang'a	25.0%	Lamu	17.1%
		Kericho	23.3%	Kiambu	13.8%
		Taita Taveta	22.8%	Uasin Gishu	13.4%
		Nyandarua	18.5%	Kwale	10.3%
		Nakuru	17.8%		
Very low prevalence (less than 10%)	16	Trans Nzoia	9.2%	Makueni	2.6%
		Nandi	8.7%	Siaya	1.9%
		Nairobi	8.1%	Kisumu	1.5%
		Mombasa	7.5%	Bungoma	1.2%
		Machakos	7.1%	Kakamega	0.8%
		Nyeri	4.7%	Kilifi	0.6%
		Turkana	3.7%	Busia	0.4%
		Homa Bay	2.9%	Vihiga	0.3%

Annex II

The Prohibition of Female Genital Mutilation Act (2011)

THE PROHIBITION OF FEMALE GENITAL MUTILATION ACT, 2011

No. 32 of 2011

Date of Assent: 30th September 2011
Date of Commencement: 4th October 2011

ARRANGEMENT OF SECTIONS

Section

PART I — PRELIMINARY

PART II – THE ANTI-FEMALE GENITAL MUTILATION BOARD

THE PROHIBITION OF FEMALE GENITAL MUTILATION ACT, 2011

AN ACT of Parliament to prohibit the practice of female genital mutilation, to safeguard against violation of a person's mental or physical integrity

through the practice of female genital mutilation and for connected purposes

ENACTED by the Parliament of Kenya, as follows—

PART I - PRELIMINARY

Short title.

1. This Act may be cited as the Prohibition of Female Genital Mutilation Act, 2011.

Interpretation.

2. In this Act, unless the context otherwise requires—

"Board" means the Anti-Female Genital Mutilation Board established under section 3;

"female genital mutilation" comprises all procedures involving partial or total removal of the female genitalia or other injury to the female genital organs, or any harmful procedure to the female genitalia, for non- medical reasons, and includes—

(a) clitoridectomy, which is the partial or total removal of the clitoris or the prepuce;

(b) excision, which is the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora;

(c) infibulation, which is the narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora or the labia majora, with or without excision of the clitoris,

but does not include a sexual reassignment procedure or a medical procedure that has a genuine therapeutic purpose;

"law enforcement officer" includes a police officer, a member of the provincial administration, a children's officer, a probation officer, a gender and social development officer and a cultural officer; and

"medical practitioner" means a person registered as such under the Medical Practitioners and Dentists Act;

Cap. 253

Cap. 257

"midwife" means a person registered as such under the Nurses Act;

"sexual reassignment procedure" means any surgical procedure that is performed for the purposes of altering (whether wholly or partly) the genital appearance of a person to the genital appearance (as nearly as practicable) of a person of the opposite sex;

"support services" includes the provision of shelter, medical services, legal education, training of service providers and advocates against female genital mutilation, and the provision of psycho-social support.

PART II – THE ANTI-FEMALE GENITAL MUTILATION BOARD

Establishment of the Board.

3. (1) There is established a board to be known as the Anti-Female Genital Mutilation Board.

(2) The Board is a body corporate with perpetual succession and a common seal and shall, in its corporate name, be capable of—

(a) suing and being sued;

(b) taking, purchasing or otherwise acquiring, holding, charging or disposing of movable and immovable property;

(c) borrowing money or making investments;

(d) entering into contracts; and

(e) doing or performing all other acts or things for the proper performance of its functions under this Act which may lawfully be done or performed by a body corporate.

Composition of the Board.

4. (1) The Board shall consist of—

(a) a chairperson appointed by the President;

(b) the Principal Secretary of the Ministry for the time being responsible for matters relating to

gender or a representative duly appointed in writing;

(c) the Principal Secretary of the Ministry for the time being responsible for matters relating to finance or a representative duly appointed in writing;

(d) the Principal Secretary of the Ministry for the time being responsible for matters relating to health or a representative duly appointed in writing;

(e) the Principal Secretary of the Ministry for the time being responsible for matters relating to education or a representative duly appointed in writing;

(f) the Principal Secretary of the Ministry for the time being responsible for matters relating to youth affairs or a representative duly appointed in writing;

(g) three other members appointed by the Cabinet Secretary; and

(h) the Chief Executive Officer.

(2) A person appointed as a member of the Board under this Act, other than an *ex officio* member, shall serve for a single term of six years and shall not be eligible for re-appointment.

Functions of the Board.

5. The functions of the Board shall be to—

(a) design, supervise and co-ordinate public awareness programmes against the practice of female genital mutilation;

(b) generally advise the Government on matters relating to female genital mutilation and the implementation of this Act;

(c) design and formulate a policy on the planning, financing and coordinating of all activities relating to female genital mutilation;

(d) provide technical and other support to institutions, agencies and other bodies engaged in the programmes aimed at eradication of female genital mutilation;

(e) design programmes aimed at eradication of female genital mutilation;

(f) facilitate resource mobilization for the programmes and activities aimed at eradicating female genital mutilation; and

(g) perform such other functions as may be assigned by any written law.

Powers of the Board.

6. The Board shall have all powers necessary for the proper performance of its functions under this Act and in particular, but without prejudice to the generality of the foregoing, the Board shall have power to—

(a) enter into contracts;

(b) manage, control and administer its assets in such manner and for such purposes as best promote the purpose for which the Board is established;

(c) determine the provisions to be made for capital and recurrent expenditure and for the reserves of the Board;

(d) receive any grants, gifts, donations or endowments and make legitimate disbursements therefrom;

(e) enter into association with such other bodies or organizations within or outside Kenya as it may consider desirable or appropriate and in furtherance of the purposes for which the Board is established;

(f) open such banking accounts for its funds as may be necessary;

(g) invest any funds of the Board not immediately required for its purposes; and

(h) undertake any activity necessary for the fulfilment of any of its functions.

Conduct of business and affairs of the Board.

7. (1) The conduct and regulation of the business and affairs of the Board shall be as provided in the Schedule.

(2) Except as provided in the Schedule, the Board may regulate its own procedure.

Delegation by the Board.

8. The Board may, by resolution either generally or in any particular case, delegate to any committee or to any member, officer, employee or agent of the Board, the exercise of any of the powers or the performance of any of the functions or duties of the Board under this Act or under any other written law.

Chief Executive Officer.

9. (1) There shall be a Chief Executive of the Board who shall be appointed by the Board.

(2) The Chief Executive Officer shall hold office for a period of not more than five years, on such terms and conditions of employment as the Board may determine, and shall be eligible for re-appointment.

(3) The Chief Executive Officer shall be an *ex-officio* member of the Board but shall have no right to vote at any meeting of the Board.

(4) The Chief Executive Officer shall—

(a) subject to the direction of the Board, be responsible for the day to day management of the Board;

(b) in consultation with the Board, be responsible for the direction of the affairs and transactions of the Board, the exercise, discharge and performance of its objectives, functions and duties, and the general administration of the Board; and

(c) be the secretary of the Board.

Staff.

10. The Board may appoint such officers, agents and other staff as are necessary for the proper and efficient

discharge of the functions of the Board under this Act, upon such terms and conditions of service as the Board may determine.

The common seal of the Board.

11. (1) The common seal of the Board shall be kept in the custody of the Chief Executive Officer or of such other person as the Board may direct, and shall not be used except upon the order of the Board.

(2) The common seal of the Board, when affixed to a document and duly authenticated, shall be judicially and officially noticed, and unless the contrary is proved, any necessary order or authorisation by the Board under this section shall be presumed to have been duly given.

(3) The common seal of the Board shall be authenticated by the signature of the chairperson of the Board and the Chief Executive Officer.

(4) The Board shall, in the absence of either the chairperson or the Chief Executive Officer, in any particular matter, nominate one member of the Board to authenticate the seal of the Board on behalf of either the chairperson or the Chief Executive Officer.

Protection from personal liability.

12. (1) No matter or thing done by a member of the Board or by any officer, member of staff, or agent of the Board shall, if the matter or thing is done *bona fide* for executing the functions, powers or duties of the Board under this Act, render the member, officer, employee or agent or any person acting on their directions personally liable to any action, claim or demand whatsoever.

(2) Any expenses incurred by any person in any suit or prosecution brought against him in any court, in respect of any act which is done or purported to be done by him under the direction of the Board, shall, if the court holds that such act was done *bona fide*, be paid out of the general funds of the Board, unless such expenses are recovered by him in such suit or prosecution.

Liability for damages.

13. The provisions of section 12 shall not relieve the Board of the liability to pay compensation or damages to any person for any injury to him, his property or any of his interests caused by the exercise of any power conferred by

this Act or any other written law or by the failure, wholly or partially, of any works.

PART III – FINANCIAL PROVISIONS

Funds of the Board.

14. The funds and assets of the Board shall consist of—

(a) such gifts as may be given to the Board; and

(b) all moneys from any other lawful source provided, donated or lent to the Board.

Financial year.

15. The financial year of the Board shall be the period of twelve months ending on the thirtieth June in each year.

Annual estimates.

16.(1) At least three months before the commencement of each financial year, the Board shall cause to be prepared estimates of the revenue and expenditure of the Board for that year.

(2) The annual estimates shall make provision for all estimated expenditure of the Board for the financial year and in particular, the estimates shall provide for the—

(a) payment of the salaries, allowances and other charges in respect of members and staff of the Board;

(b) payment of pensions, gratuities and other charges in respect of members and staff of the Board;

(c) proper maintenance of the buildings and grounds of the Board;

(d) maintenance, repair and replacement of the equipment and other property of the Board; and

(e) creation of such reserve funds to meet future or contingent liabilities in respect of retirement benefits, insurance or replacement of buildings or equipment, or in respect of such other matter as the Board may deem appropriate.

(3) The annual estimates shall be approved by the Board before the commencement of the financial year to

which they relate and, once approved, the sum provided in the estimates shall be submitted to the Cabinet Secretary for approval.

(4) No expenditure shall be incurred for the purposes of the Board except in accordance with the annual estimates approved under subsection (3), or in pursuance of an authorization of the Board given with prior written approval of the Cabinet Secretary.

Accounts and audit.

17. (1) The Board shall cause to be kept proper books and records of accounts of the income, expenditure and assets of the Board.

(2) Within a period of three months after the end of each financial year, the Board shall submit to the Auditor-General, the accounts of the Board together with—

(a) a statement of the income and expenditure of the Board during that year; and

(b) a balance sheet of the Board on the last day of that year.

(3) The accounts of the Board shall be audited and reported upon in accordance with the provisions of the Public Audit Act, 2003.

No. 12 of 2003.

Investment of funds.

18.(1) The Board may invest any of its funds in securities in which for the time being trustees may by law invest trust funds, or in any other securities or banks which the Treasury may, from time to time, approve for that purpose.

(2) The Board may place on deposit, with such bank or banks as it may determine, any moneys not immediately required for the purpose of the Board.

PART IV - OFFENCES

Offence of female genital mutilation.

19.(1) A person, including a person undergoing a course of training while under supervision by a medical practitioner or midwife with a view to becoming a medical practitioner or midwife, who performs female genital mutilation on another person commits an offence.

(2) If in the process of committing an offence under subsection (1) a person causes the death of another, that person shall, on conviction, be liable to imprisonment for life.

(3) No offence under subsection (1) is committed by an approved person who performs—

(a) a surgical operation on another person which is necessary for that other person's physical or mental health; or

(b) a surgical operation on another person who is in any stage of labour or has just given birth, for purposes connected with the labour or birth.

(4) The following are, for the purposes of this Act, approved persons—

(a) in relation to an operation falling within paragraph (a) of subsection (3), a medical practitioner;

(b) in relation to an operation falling within paragraph (b) of subsection (3), a medical practitioner, a registered midwife or a person undergoing a course of training with a view to becoming a medical practitioner or midwife.

(5) In determining, for purposes of subsection (3)(a), whether or not any surgical procedure is performed on any person for the benefit of that person's physical or mental health, a person's culture, religion or other custom or practice shall be of no effect.

(6) It is no defence to a charge under this section that the person on whom the act involving female genital mutilation was performed consented to that act, or that the person charged believed that such consent had been given.

Aiding and abetting female genital mutilation.

20. A person who aids, abets, counsels or procures—

(a) a person to commit an offence under section 19; or

(b) another person to perform female genital mutilation on that other person,

commits an offence.

Procuring a person to perform female genital mutilation in another country.

21. A person commits an offence if the person takes another person from Kenya to another country, or arranges for another person to be brought into Kenya from another country, with the intention of having that other person subjected to female genital mutilation.

Use of premises to perform female genital mutilation.

22. A person who knowingly allows any premises, for which that person is in control of, or responsible for, to be used for purposes of performing female genital mutilation commits an offence.

Possession of tools or equipment.

23. A person who is found in possession of a tool or equipment for a purpose connected with the performance of female genital mutilation, commits an offence

Failure to report commission of offence.

24. A person commits an offence if the person, being aware that an offence of female genital mutilation has been, is in the process of being, or intends to be, committed, fails to report accordingly to a law enforcement officer.

Use of derogatory or abusive language.

25. Any person who uses derogatory or abusive language that is intended to ridicule, embarrass or otherwise harm a woman for having not undergone female genital mutilation, or a man for marrying or otherwise supporting a woman who has not undergone female genital mutilation, commits an offence and shall be liable, upon conviction, to imprisonment for a term not less than six months, or to a fine of not less than fifty thousand shillings, or both.

PART V - MISCELLANEOUS

Entry into premises.

26. A law enforcement officer may, without a warrant, enter any premises for the purposes of ascertaining whether there is or has been, on or in connection with such premises any contravention of this Act.

Measures by Government.

27. The Government shall take necessary steps within its available resources to—

(a)protect women and girls from female genital mutilation;

(b) provide support services to victims of female genital mutilation; and

(c) undertake public education and sensitise the people of Kenya on the dangers and adverse effects of female genital mutilation.

Extra-territorial jurisdiction.

28. (1) A person who, while being a citizen of, or permanently residing in, Kenya, commits an act outside Kenya which act would constitute an offence under section 19 had it been committed in Kenya, is guilty of such an offence under this Act.

(2) A person may not be convicted of an offence contemplated in subsection (1) if such a person has been acquitted or convicted in the country where that offence was committed.

Penalty for offences.

29. A person who commits an offence under this Act is liable, on conviction, to imprisonment for a term of not less than three years, or to a fine of not less than two hundred thousand shillings, or both.

SCHEDULE (S. 7 (1))

PROVISIONS AS TO THE CONDUCT OF BUSINESS AND AFFAIRS OF THE BOARD

Tenure of office.

1. Any member of the Board, other than an *exofficio* member shall, subject to the provisions of this Schedule, hold office for a single term of six years, on such terms and conditions as may be specified in the instrument of appointment, and shall not be eligible for reappointment.

Vacation of office.

2. A member of the Board, other than an *ex-officio* member, may –

(a) at any time resign from office by notice in writing to—

(i) in the case of the chairperson, the President; and

(ii) in any other case, the Cabinet Secretary; or

(b) be removed from office by the Cabinet Secretary if the member—

(i) has been absent from three consecutive meetings of the Board without the permission of the chairperson;

(ii) is convicted of a criminal offence and sentenced to imprisonment for a term exceeding six months or to a fine exceeding ten thousand shillings;

(iii) is convicted of an offence involving dishonesty or fraud, or an offence under the Anti-Corruption and Economic Crimes Act;

(iv) is adjudged bankrupt or enters into a composition scheme or arrangement with his creditors;

(v) is incapacitated by prolonged physical or mental illness or is deemed otherwise unfit to discharge his duties as a member of the Board; or

(vi) fails to comply with the provisions of this Act relating to disclosure.

Meetings.

3. (1) The Board shall meet not less than four times in every financial year and not more than four months shall elapse between the date of one meeting and the date of the next meeting.

(2) Notwithstanding the provisions of subparagraph (1), the chairperson may, and upon requisition in writing by at least five members shall, convene a special meeting of the Board at any time for the transaction of the business of the Board.

(3) Unless three quarters of the total members of the Board otherwise agree, at least fourteen days' written notice of every meeting of the Board shall be given to every member of the Board.

(4) The quorum for the conduct of the business of the Board shall be five members including the chairperson or the person presiding.

(5) The chairperson shall preside at every meeting of the Board at which he is present but, in his absence, the members present shall elect one of their numbers to preside, who shall, with respect to that meeting and the business transacted thereat, have all the powers of the chairperson.

(6) Unless a unanimous decision is reached, a decision on any matter before the Board shall be by a majority of votes of the members present and voting and, in the case of an equality of votes, the chairperson or the person presiding shall have a casting vote.

(7) Subject to subparagraph (4), no proceedings of the Board shall be invalid by reason only of a vacancy among the members thereof.

Disclosure of interest by Board members.

4. (l) If a member is directly or indirectly interested in any contract, proposed contract or other matter before the Board and is present at a meeting of the Board at which the contract, proposed contract or other matter is the subject of consideration, that member shall, at the meeting and as soon as practicable after the commencement thereof, disclose the fact and shall not take part in the consideration or discussion of, or vote on, any questions with respect to the contract or other matter, or be counted in the quorum of the meeting during consideration of the matter:

Provided that, if the majority of the members present are of the opinion that the experience or expertise of such member is vital to the deliberations of the meeting, the Board may permit the member to participate in the deliberations subject to such restrictions as it may impose but such member shall not have the right to vote on the matter in question.

(2) A disclosure of interest made under this paragraph shall be recorded in the minutes of the meeting at which it is made.

(3) A member of the Board who contravenes subparagraph (1) commits an offence and is liable to imprisonment for a term not exceeding six months, or to a fine not exceeding one hundred thousand shillings, or both.

Execution of instruments.

5. Any contract or instrument which, if entered into or executed by a person not being a body corporate, would not require to be under seal, may be entered into or executed on behalf of the Board by any person generally or specially authorized by the Board for that purpose.

Minutes.

6. The Board shall cause minutes of all resolutions and proceedings of meetings of the Board to be entered in books kept for that purpose.

Annex III

Mapping - Stakeholders

Stakeholder Name	Summary of Activities/Focus	Geographical reach
Ministry of Public Service and Gender Affairs **State Department of Gender Affairs**	Overall leadership in implementation of the FGM Policy and resource mobilization Gender Policy Management, Special Programmes for Women Empowerment, Gender Mainstreaming in Ministries/ Departments/Agencies, Community Mobilization, Domestication of International Treaties/Conventions on Gender and Policy and Programmes on Gender Based Violence (GBV)	National
Anti-FGM Board	Mandate: • Design, supervise and co-ordinate public awareness programmes against the practice of female genital mutilation. • Coordinate, monitor and evaluate implementation of all anti-FGM related activities. • Facilitate implementation of the FGM policy through institutional capacity strengthening (Formulation of an integrated strategic plan, this Policy Action Plan, regulate and coordinate FGM related training activities and coordinate donor activities). • Provide technical and other support to institutions, agencies and other bodies engaged in the programmes aimed at eradication of female genital mutilation; • Facilitate resource mobilization for the programmes and activities. • Design programmes aimed at eradication of female genital mutilation. • Facilitate experience sharing, exchange of best practices, approaches and lessons learnt as well as guidelines for accelerating the eradication of FGM for replication within the various communities. • Establish data bank on FGM, coordinate reporting from state and non-state actors.	National
Ministry of Health	Mandate in regard to FGM/C: • Health policy formulation, National referral Health facilities management Regulate the health component of FGM services. • Train health professionals to handle complications suffered by FGM survivors. • Address FGM as a reproductive health issue. • Integrate FGM in the curriculum of the medical schools in Universities and colleges. • Capacity building and Technical assistance to Counties	National
Ministry of Education	• Include anti-FGM content in the school curriculum. • Strengthen school clubs for child protection, FGM and gender issues. • Engage girl guides and scouts movement in the campaign against FGM • Enforcement of the Prohibition	National

Ministry of Interior and coordination of National government	• Enforcement of the Prohibition of Female Genital Mutilation Act,2011 • Create Public awareness on FGM and ensure that Chiefs and Assistant Chiefs register all cases of FGM in their area.	National
Ministry of Labour and social protection / Children's services dept	• Implementation of the Children Act, 2001. • Protect PWDs against harmful cultural practices and trafficking. • Ensure greater livelihood for FGM survivors. • Initiate FGM cross-border initiatives.	National
Office of the Director of Public Prosecutions	• Prosecution - Institute and prosecute criminal matters - including those related to FGM. • Collection of relevant data on the prosecution FGM related matters.	National
State law office/ Dept of Justice	• Develop jurisprudence-to enhance legal interpretation of cases related to FGM. • Organize service week to attend to matters that deal with gender-based violence related cases including FGM. • Strengthen mobile courts that bring services closer to the community. • Enhance partnership with court users' committees for case follow up. • Educate the Public on availability and services provided by free legal aid/clinics.	National
National Gender Equality Commission (NGEC)	•promote and ensure gender equality, principles of equality and non-discrimination for all persons in Kenya as provided for in the Constitution of Kenya 2010 with a focus on the following Special Interest Groups Goal is to contribute to the reduction of gender inequalities and discrimination against all Investigate violations regarding sexual and reproductive health (including FGM) rights • Receive complaints on violation of sexual and reproductive health rights (including FGM)	National
Ministry of ICT, Innovation and Youth Affairs	Promote Youth Empowerment. Mainstream Youth in National Development. Harnessing and Development Youth Talents for National Development. Managing and Promoting Engagement with Youth for National Development. Collaborating and Overseeing stakeholders engaged in Youth Promoting Activities.	
Council of Governors	The Council of Governors comprises of the Governors of the forty-seven Counties. main functions are the promotion of visionary leadership; sharing of best practices and; offer a collective voice on policy issues; promote inter – county consultations; encourage and initiate information sharing on the performance of County Governments with regard to the execution of their functions; collective consultation on matters of interest to County Governments.	47 County Governments
UNICEF	UNICEF works to promote and protect the rights of every child. UNICEF is mandated by the United Nations General Assembly to advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential. Works closely with governments to fulfil its mandate. • UNFPA-UNICEF Joint Programme on Female Genital Mutilation as mentioned above.	National

	Others include - Education, child protection, Health, Emergencies, Nutrition, HIV/AIDS and WASH	
UN Women	• The main roles of UN Women are: To support inter-governmental bodies, such as the Commission on the Status of Women, in their formulation of policies, global standards and norms. • Grounded in the vision of equality enshrined in the UN Charter, UN Women, among other issues, works for the: • elimination of discrimination against women and girls; prevention of FGM, empowerment of women; and achievement of equality between women and men as partners and beneficiaries of development, human rights, humanitarian action, and peace and security	National
UNFP	• UNFPA helps strengthen health services to prevent FGM and to treat the complications it can cause. • UNFPA works with civil society organizations that engage in community-led education and dialogue sessions on the health and human rights aspects of the practice. The Fund works with religious and traditional leaders to de-link FGM from religion and to generate support for abandonment. • UNFPA also works with media to foster dialogue about the practice and to change perceptions of girls who remain uncut. UNFPA-UNICEF Joint Programme On FGM in Kenya - Key areas - Enabling environment, advocacy, policy dialogue; Knowledge management; Service delivery/ community education, mechanisms of prevention/ protection /care and Partnerships incl. South-South cooperation, regional dynamics, cross-border FGM • Supports implementing partners working with the youth, male champions, survivors of FGM, artists in the creative industry, as well as duty bearers such as teachers, healthcare workers, and other accountability partners to build strong surveillance and response systems towards ending FGM. • Engages with faith-based organisations and cultural institutions to work against female genital mutilation (FGM), child marriage and other harmful cultural practices.	National
Amref Health Africa in Kenya	Aspire for lasting health change in Africa through increasing access to sustainable health care by communities in Africa through solutions in human resources for health, health service delivery and investments in health with four cross-cutting themes of Gender, Research, Advocacy & Policy and Innovation	47 Counties in Kenya. FGM Intervention in Samburu, Marsabit and Kajiado Counties
Action Aid	• VAWG - Establishing and strengthening girls and women's institutions and solidarity groups to challenge VAWG of all forms. Tackling Barriers to Girls' Education (TBGE) - to enable over 2,000 girls to challenge violence and overcome the barriers that prevent them from achieving their potential, with a focus on female genital mutilation (FGM). • Constructed a Sh7.5 million fully equipped safe house for girls in North Eastern - protection against FGM and early marriage. Civic education targeting women - leadership and governance Supports youth networks to lobby issues affecting them - using digital platforms to build movements	Baringo, Garissa, Kajiado, Embu, Isiolo, Taita Taveta, Migori and West Pokot

African Coordinating Centre for Abandonment of FGM (ACCAF)	• Identifies knowledge gaps and supports and stimulates research in the field of female genital mutilation /cutting (FGM/C) • Supports networking and knowledge exchange between researchers, health professionals and community workers on the abandonment of FGM/C • Improves health care for women and children who have undergone FGM/C • Advocates, educates and creates a supportive environment for cultural change	National
Population Council	Research Organisation: Some recent studies that included Kenya:- A national situation analysis of interventions that supported the MoH in developing national service guidelines for the management of the medical complications of FGM (Kenya specific) Building the evidence base on where, when, why FGM is practiced through quant and qual data analysis Assessing interventions to address FGM abandonment Understanding the wider impacts of FGM on the lives of girls, women, their families, gender norms, and other harmful practices (early marriage, GBV)	Kenya, Egypt, Ethiopia, Nigeria, Senegal, Somalia, Sudan, Burkina Faso and Mali, Somalia
World Vision	Accelerating Abandonment of Female Genital Mutilation and Child Marriage Project. Empowers faith leaders to become child protection change agents among their congregants, and use their influence to bring to an end to the FGM practice. Community Dialogues, ARP. Implement development projects in; Education & Child Protection, Water, Sanitation & Hygiene (WASH), Women and governance, Livelihoods & Resilience, Health & Nutrition and Disaster Management	Narok, Migori, Kakamega, Kajiado, West Pokot, Turkana, Elgeyo Marakwet, Samburu, Isiolo, Marsabit, Wajir, Taita Taveta, Kilifi, Kitui, Nyamira, Nakuru, Lamu, Homabay, Elgeyo Marakwet, Nairobi and Samburu FGM project being implemented in Kajiado, West Pokot, Marsabit and Samburu
Plan International	• End female genital mutilation (FGM) in Africa within a generation project in Kenya, Sudan, Egypt and Ethiopia. • Working alongside the Njuri-Ncheke elders from the Ameru community to challenge the stereotypes that lead to FGM in Meru • Plan International is leading a group of 5 partner organisations on the Yes I Do programme which is tackling FGM, child marriage and teenage pregnancy in 7 countries in Africa and Asia. In Kenya the project is implemented in Kajiado and involves; • Developing an alternative rite of passage for girls in their transition to womanhood • Capacity building of FGM champions. • Young warriors - work well with the elders to speak against FGM (2016 -2020 programme) Others: Child protection, Education, WASH, ASRH and disaster risk management	Nairobi, Machakos, Kajiado, Tharaka Nithi, Kilifi, Kwale, Bondo, Homabay, and Kisumu FGM projects in Tharaka Nithi and Kajiado Counties.

DSW - Kenya	Works mostly with and for young people: creating demand for and access to health information, services and supplies for the youth, and to securing their right for a brighter future. Advocacy, capacity development, and family planning initiatives, to ensure the youth are empowered to lead healthy and self-determined lives.	Bungoma, Embu, Homa Bay, Kakamega, Kilifi, Kwale, Laikipia, Meru, Mombasa, Nairobi, Nakuru, Nandi, Nyandarua, Trans Nzoia, Uasin Gishu, and West Pokot.
Equality Now!	Accountability to eliminating harmful practices such as Female Genital Mutilation; child marriage (SDG5.3); and sexual violence (SDG5.2). - Use regional and international instruments that Kenya is party to end FGM, child marriage and sexual violence against women and girls - Their partners include: Hope Beyond Foundation, I'llaramatak Community Concerns and Tasaru Ntomonok Initiative (FGM)in Kajiado and Narok; Sauti Ya Wanawake Kwale to end child marriage Others: Legal Equality, sexual violence, sex trafficking, rural education and economic enhancement	Narok, and Kajiado Counties (FGM), Kwale (Child Marriage), Kisumu, Busia and Makueni (Sexual Violence), Naivasha and Kilifi (Sex Trafficking)
Federation of Women Lawyers (FIDA) -Kenya	• Ending FGM and early marriage project in Kajiado and Transnzoia working with Womankind. • Key activities carried out include spreading information and legal aid to women facing violence and discrimination; train women leaders as ambassadors to campaign against Harmful Traditional Practices, including Female Genital Mutilation (FGM) and other forms of violence; • Work with the police, chiefs, community elders and medical professionals to raise awareness of the violence faced by women and girls, and the laws that are in place to protect them; also provides legal aid, family mediation and counselling; • training women to be champions against FGM/early marriage.	National FGM- Kajiado & Samburu
Gender Based Violence Recovery Centre	GVRC's main purpose is to bring back meaning to the lives and families of survivors of sexual and gender-based violence by providing free medical treatment and psychosocial support Prevention focuses on creating awareness that facilitates behaviour change. Target groups are engaged through community and media awareness initiatives as well as innovative child participatory processes. The centre builds the capacities for service providers on GBV management and the community through trainings.	Nairobi, Eldoret , Mombasa, Taita taveta, Makueni
Maendeleo Ya Wanawake Organisation (MYWO)	Supporting activities aimed at enactment of laws that address harmful practices particularly FGM/C and early marriage. • Scaling up sensitization of community leaders on the need to abandon FGM/C and early marriage • Implements 'The gender equality programme' supported by the GOK/UNFPA/UNICEF • Supporting the promotion of gender equality through advocacy and community involvement including participation of males. Others: Women and development, Civic education, Gender and governance, Girls education promotion	For FGM specific: Samburu, Baringo, Mt. Elgon, West Pokot, Kuria, Migori, Moyale, Isiolo, Garissa, Meru and Tana River

Forum for African Women Educationalists (FAWE) Kenya Chapter	Empower women and girls through gender responsive education. Work with community activists to rescue girls from harmful cultural practices like FGM and early marriages, enrol them in school and retain them so that they can go through the cycle of education. They also provide youth friendly services that enables girls and women access accurate sexual and reproductive health information	47 Counties
Association of Media Women in Kenya (AMWIK)	Partner of TGG: The Girl Generation Inter-generational dialogue to stem FGM in Kuria project, use of media - talk shows and radio listening clubs, Sauti ya Boke project. • Part of a regional project in Africa 'Stop FGM/C' that aims to build a cultural and social environment allowing and facilitating the choice for communities and individuals to abandon FGM/C. Others: SRHR, Network of Women in Media; Women Economic Empowerment (Financial Literacy, Accountability and Social Justice) and Children Engagement, Health, Gender and governance	Members in 40 Counties
Women Empowerment Link (WEL)	Facilitated the development of home grown measures for combatting FGM - WEL in collaboration with the Catholic Diocese of Nakuru developed a documentary on the developments within the Ilchamus community since the Anti-FGM Declaration in 2011 Others: sGBV, Economic empowerment for sustainable livelihoods, , HIV/AIDS, transformative leadership and governance	Nairobi, Nakuru-Naivasha, Mombasa and Baringo
Coalition on Violence against Women (COVAW)	Access to justice for children in Kenya by offering legal representation - cases relating to FGM, Early marriage, child labour, trafficking and all other forms of violence and violations against children. Advocacy	Narok, Kajiado
Kenya Women Parliamentarians Association (KEWOPA)	The Kenya Women Parliamentary Association (KEWOPA) is a membership association of all women parliamentarians drawn from across all political parties both elected and nominated in the Senate and National Assembly. They aim to strengthen the participation of women in all spheres through capacity development, partnership building and strategic community engagement.	47 Counties in Kenya
Kenya Men Engage Alliance	Global alliance made up of dozens of country networks spread across many regions of the world, hundreds of non-governmental organizations, as well as UN partners. Men Engage members work collectively and individually toward advancing gender justice, human rights and social justice to achieve a world in which all can enjoy healthy, fulfilling and equitable relationships and their full potential.	National
Womankind Worldwide Kenya	Project: *Catalysing a new generation of activists to challenge FGM and child marriage in Kenya and Uganda*- Project focuses on instilling girls with the confidence and leadership skills to be able to challenge FGM and CEFM by creating their own campaigns to raise awareness and engage parents and leaders from a position of agency. Others: Education, Child protection	Garissa, Tana River and Wajir
Men End FGM	Involved in rallying men and boys to join the quest to end FGM/C, Child marriages and other forms of SGBV	National

ADRA	ADRA recognises that securing the future for girls in Kenya, means tackling FGM from multiple angles, and this is exactly how ADRA Kenya's Anti-FGM project works. School fees for runaway and vulnerable girls, works with religious entities to introduce anti - FGM messaging in teachings and services, works with the Area Advisory Councils and local county authorities in educational workshops, and alternative rites of passage ceremonies	Nyamira, Kisii Central, Kisii South, Gucha, Kuria East & West and Transmara Districts, Western Kenya (Kisii, Kuria, Kipsigis and Masaai communities
Council of Imams and Preachers of Kenya (CIPK)	To empower and capacity build the Muslim community and consolidate inclusive and integrated approaches that will embrace their fundamental and constitutional rights and privileges through Dialogue, Policy influence, Advocacy and Empowerment.	47 Counties in Kenya
SUPKEM	Represent Muslims in all areas of interest. Also has operations in areas of Health, education.	47 Counties in Kenya
Kenya Muslim National Advisory Council (KEMNAC)	Brings Muslims to work with Government on development; Gender, End-FGM interventions, Education, WASH, Drug Abuse Rehabilitation and food relief	47 Counties in Kenya
Young Women Christian Association (YWCA)	Runs an Anti-FGM project in Kuria *Positive Minds, End FGM/C.* Peer education, attitude change campaigns through engagement of clan elders, community outreaches, engaging medical professionals, media, parents, school clubs, youth and community forums. girl's empowerment program, ARPs	Kuria, Kisii
Kenya Council of Imams and Ujamaa (KCIU)	Health projects - including FGM/C and education projects	Narok, Kajiado, Koibatek, Samburu, Laikipia, Baringo, Uasin Gishu, Molo, Naivasha and Turkana Counties
CREAW	National feminist women's right Non-Governmental Organization whose vision is a just society where women and girls enjoy full rights and live in dignity. Programmes - Ending VAWG, Economic and cultural social -cultural discrimination, promoting effective participation of women and girls, access to SRHR, leadership and governance and Advocacy.	Nairobi, Meru, Narok, Kilifi
Kenya Women and Children's wellness centre	Addresses Gender Based Violence prevention to including ending FGM. The implementation activities are geared towards behaviour change in order to entrench a culture that respects the sanctity and dignity of human beings irrespective of gender.	Nairobi and Kajiado
Femnet	Feminist Organisation that facilitates dialogue around critical issues on women's human rights. Intentional about influencing decisions to ensure African women voices are amplifies and their needs, priorities and aspirations are prioritized in key policy dialogues and outcomes	49 African countries
DSW - Kenya	Works mostly with and for young people: creating demand for and access to health information, services and supplies for the youth, and to securing their right for a brighter future. Advocacy, capacity development, and family planning initiatives, to ensure the youth are empowered to lead healthy and self-determined lives.	Bungoma, Embu, Homa Bay, Kakamega, Kilifi, Kwale, Laikipia, Meru, Mombasa, Nairobi, Nakuru, Nandi, Nyandarua, Trans Nzoia, Uasin Gishu, and West Pokot.

Centre for the Study of adolescence	Adolescent health - promoting the health and development of young people.	Kisii, Kajiado West, Mt. Elgon Narok-Transmara West
Amani Peoples Theatre	Awareness creation on FGM work, rights of the girl child - using theatre to respond to conflict	West Pokot , Kuria, Kajiado-North
Hope foundation for African Women (HFAW)	Committed to women and girl's empowerment, their sexual and reproductive health and human rights as well as elimination of gender disparities, and ending of FGM practices in all our communities.	Kisii, Kajiado
Big Brother Movement (BBM)	The BBM support the Big Sister Movement (BSM) and other national & international stakeholders in their commitment to prevent and eradicate violence against women and girls (VAWG), including FGM/C, gender based violence (GBV), honour based violence/abuse (HBV/A), and other harmful practices inflicted on women and girls by 2030.	Kajiado, Kisii , Kuria
East African Centre For Human Rights (EACHRIGHTS)	Organization seeks to promote, protect and enhance human rights in East Africa with an emphasis on economic and social rights among vulnerable and marginalized groups. It implements projects that are aimed at ending FGM.	Kajiado, Marsabit , Garissa
Youth Anti-FGM Kenya	Initiated by The Girl Generation - Works to end FGM and early/child marriage in Kenya	National
Kenya Muslim Youth Development	Kenya Muslim Youth Development Organization - KMYDO is a national youth led Muslim youth organization that engages in health programs. Advocacy on FGM issues-targeting Muslim scholars, women and girls.	Kilifi , Mombasa, Lamu, Kwale Wajir, Garissa

Annex IV

Mapping - Actors

Name of Actor	Category – Rel/Pol or activist	Summary of Activities/Focus	Geographical reach
Agnes Pareiyo	Chairperson Anti - FGM Board	Women's rights Activist- vocal on matters FGMC long before appointment to chair the Anti-FGM Board. Also a politician	National
Hon. Linah Jebii Kilimo	Former Chairperson Anti - FGM Board (now in government CAS)	Activist and long term anti-FGM crusader - long before being the first Chair of the Anti-FGMB. Pushed for the anti-FGM Act Also a politician	National
Hon. Rachel Shebesh	CAS- State Department of GENDER	Vocal on matters of GBV and FGM Politician who is now a Cabinet secretary	National
Agnes Leina	Exec Director Il'laramatak Community Concerns (ICC), Samburu	Activist and anti-FGM crusader - as well as working to restore dignity among Indigenous people, with special emphasis on Girls and Women envisioning society that is free from all forms of discrimination.	Sub- regional
George Natembeya	Rift Valley Regional Commissioner	Very vocal on matters of GBV and FGM	National
Naisola Likimani	Team Leader, She Decides	Feminist and Team leader of the She Decides Movement -	
Mr. Rashid Ali Omar	Religious leader	Anti-FGM Board Drirector Former deputy Kadhi	National
Tony Mbebia	Male Activist & Executive Director, Men End FGM	Activist, ED and Founder of Men End FGM. Advocates against FGM, child marriage ad all harmful cultural practices	National/sub
Sadia Abdi	Activist		Isiolo
Dr Ahmed Omar	County Commissioner- Elgeyo Marakwet County	Vocal on matter of GBV and FGM	
Dr. Josephine Kulea	CEO Samburu Girls Foundation & Aspiring Women Rep, Samburu County	Women's rights Activist and Founder of Samburu Girls Foundation - Anti- child marriage, FGM and VAWG crusader. Rescues girls at risk of marriage and FGM.	Samburu County
Rev Timothy Njoya	Religious leader and Activist, Author	Campaigns for human rights and Women's right to control their own bodies free of FGM	National
Hon. Mary Simat	Member of County Assembly		National

Hon. Nuria Gollo	Political Aspirant - Marsabit		Sub national
Hon. Denitta Ghati	Member of Parliament - Migori		National
Natalie Robi Tingo	Exective Director & Founder, Msichana Empowerment, Kuria	Girls empowerment, including FGC, child marriage and girl's education	Sub regional
Nice Naliankai		Works for AMREF as a project officer in Narok. **Was recognised by Time Magazine as one of the 100 most influential people in 2018 for her work with girls in Narok**	Narok
Shinina Shani	Individual	She rescues girls that are at risk of undergoing FGM- they voluntarily call/reach out to her seeking help to avoid the cut.	Narok
Patrick Ngigi	Religious Leader	Runs a safe house in Narok that shelters girls that run away from the practice of FGM	Narok

Bibliography

- 2019 Kenya Population and Housing Census Results, November 2019, available at https://www.knbs.or.ke/?p=5621
- 2019 Kenya Population and Housing Census Volume IV: Distribution of Population by Socio-Economic Characteristics, Kenya National Bureau of Statistics, available at https://www.knbs.or.ke/?wpdmpro=2019-kenya-population-and-housing-census-volume-iv-distribution-of-population-by-socio-economic-characteristics&wpdmdl=5730&ind=7HRl6KateNzKXCJaxxaHSh1qe6C1M6VHznmVmKGBKgO5qIMXjby1XHM2u_swXdiR
- 28TooMany, Kenya: The Law and FGM, May 2018, p. 6, available https://www.28toomany.org/static/media/uploads/Law%20Reports/kenya_law_report_v1_(may_2018).pdf [Last Accessed 22 February 2021].
- Akinyemi, R. (2000) Political dimensions of FGM in Africa, http://www.african-women.org/documents/political-dimensions.pdf.
- Anti FGM Board. Anti FGM Board [Internet]. Government of Kenya. 2021, available at http://www.antifgmboard.go.ke/contact-us/ [Last Accessed 22 February 2021].
- Baseline Study Report: Female Genital Mutilation/ Cutting and Child Marriage among the Rendille, Maasai, Pokot, Samburu and Somali Communities in Kenya. United Nations Children's Fund (UNICEF), Nairobi, 2017", UNFPA (2019). Beyond the crossing: Female Genital Mutilation Across Borders, Ethiopia, Kenya, Somalia, Tanzania and Uganda. United Nations Population Fund, New York. Walela Nasimiyu Stella (2020). Assessment of international laws on female genital mutilation and its implications on the East African region: a case study of Namanga, Kenya-Tanzania border. University of Nairobi. UNFPA-UNICEF (2019). Accelerating Change: Annual report 2018. UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation. 28 Too Many (2018). The Law and FGM: An Overview of 28 African Countries (September 2018). Available at https://www.28toomany.org/Law
- Building Bridges to End FGM, 2019 Building Bridges to End FGM (2019). Cross Border Female Genital Mutilation. Available at: https://copfgm.org/cross-border-fgm

- Central Bureau of Statistics (CBS) [Kenya], Ministry of Health (MOH) [Kenya], and ORC Macro. 2004. Kenya Demographic and Health Survey 2003. Calverton, Maryland: CBS, MOH, and ORC Macro, available at https://dhsprogram.com/pubs/pdf/FR151/FR151.pdf
- Collinson (2003). Power, livelihoods and conflict: case studies in political economy analysis for humanitarian action. HPG Report 13. Overseas Development Institute.
- Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, CRC/C/KEN/CO/3-5, 21 March 2016
- DFID (2009). Political Economy Analysis How to Note. A DFID practice paper.
- DHS 2014, p. 331.
- East African Community, *The East African Community Prohibition of Female Genital Mutilation Bill 2016*, 19th August 2016, available at http://www.eala.org/uploads/Geni_14-Sep-2016_10-31-04.pdf].
- East African Legislative Assembly. EAC prohibition of FGM Act 2016.pdf [Internet]. 2016, available at https://www.eala.org/index.php/documents/view/the-eac-prohibition-of-female-genital-mutilation-bill2016.
- http://www.gsdrc.org/docs/open/DOC24.pdf.
- https://nation.africa/kenya/ademola-olajide-287420
- https://nation.africa/kenya/gender/joint-initiative-in-laikipia-north-to-wipe-out-fgm-233224
- https://nation.africa/kenya/videos/news/anti-fgm-board-chairperson-ms-agnes-blames-politicians-from-kuria-for-promoting-fgm-1270114
- https://www.reuters.com/article/us-kenya-women-fgm-trfn-idUSKBN1XM2GN
- https://www.standardmedia.co.ke/health/article/2001402746/study-fgm-still-practised-by-kenyans-but-across-the-border
- https://www.standardmedia.co.ke/kenya/article/2001402823/board-four-million-women-girls-living-with-fgm-in-kenya;
- https://www.standardmedia.co.ke/ktnnews/video/2000205233/campaign-against-fgm-discussion-with-end-fgm-activist-alice-masinte
- https://www.standardmedia.co.ke/opinion/article/2001402502/lets-work-together-to-end-fgm;
- https://www.standardmedia.co.ke/opinion/article/2001403203/survivors-would-make-great-anti-fgm-champions;
- https://www.standardmedia.co.ke/the-standard-insider/article/2001394672/men-support-fgm-but-seek-uncut-mipango-second-wives

- https://www.theeastafrican.co.ke/tea/magazine/one-woman-s-race-to-save-girls-from-the-cut-early-marriage-1441706
- https://www.youtube.com/watch?v=e7IcwsTxKxw
- https://www.youtube.com/watch?v=D5ps37zx3cw
- IRIN (2020, (Kimani et al., 2018). Kimani, Samuel and Caroline W. Kabiru (2018). Shifts in female genital mutilation/cutting in Kenya: Perspectives of families and health care providers. Evidence to End FGM/C: Research to Help Girls and Women Thrive. New York: Population Council.
- Kenya Law Reform Commission, Chapter Four – The Bill of Rights, available at https://www.klrc.go.ke/index.php/constitution-of-kenya/110-chapter-four-the-bill-of-rights
- Kenya National Bureau of Statistics (KNBS) and ICF Macro. 2010. Kenya Demographic and Health Survey 2008-09. Calverton, Maryland: KNBS and ICF Macro, available at https://dhsprogram.com/pubs/pdf/FR229/FR229.pdf
- Kimani S, Kabiru CW, Muteshi J, Guyo J (2020) Female genital mutilation/cutting: Emerging factors sustaining medicalization related changes in selected Kenyan communities. PLoS ONE 15(3): e0228410. https://doi.org/10.1371/journal. pone.0228410.
- Leye, 2007 Leye Els, Deblonde Jessika, García-Añón José, Johnsdotter Sara, Kwateng-Kluvitse Adwoa, Weil-Curiel Linda and Temmerman Marleen (2007). An analysis of the implementation of laws with regard to female genital mutilation in Europe. Crime Law Soc Change (2007) 47:1–31 DOI 10.1007/s10611-007-9055-7.; Vanhoof, 2011
- M. Havyarimana, Women decry delay in assenting to regional anti-FGM Bill, The East African, 6 November 2018, available at https://www.theeastafrican.co.ke/news/ea/Women-decry-delay-in-signing-anti-FGM-Bill-into-law/4552908-4839818-se9yngz/index.html
- M. Xuequan, East African states unite to eradicate female genital cut, Xinhua, 18 April 2019, available at http://www.xinhuanet.com/english/2019-04/18/c_137985796.htm
- Matanda D, Meroka A, Kimani S. Evidence Summary: Lessons from a five-year research programme on FGM/C and their relevance for policy and programmes in Kenya Overview. 2020;(July 2020):1–26, available at https://www.popcouncil.org/uploads/pdfs/synthesisreportfgmresearchkenya_final_.pdf
- Matanda, Dennis, Okondo, Chantalle, Kabiru, W. Caroline and Shell-Duncan, Bettina. 2018. “Tracing Change in Female Genital Mutilation/Cutting: Shifting Norms and

Practices among Communities in Narok and Kisii Counties, Kenya." Evidence to End FGM/C: Research to Help Girls and Women Thrive. New York: Population Council; Kimani S, Kabiru CW, Muteshi J, Guyo J (2020) Female genital mutilation/cutting: Emerging factors sustaining medicalization related changes in selected Kenyan communities. PLoS ONE 15(3): e0228410. https://doi.org/10.1371/journal.pone.0228410.

- Mcloughlin, C. (2014). Political economy analysis: Topic guide (2nd ed.) Birmingham, UK: GSDRC, University of Birmingham.
- Ministry of gender affairs, Government of Kenya. National policy on eradication of Female genital mutilation. Nairobi, Kenya: Government of Kenya; 2019.
- Mose B,G. (2008). Thinking the Gusii Way: Insider Perpectives on Female Genital Mutilation (FGM)/Cutting and Strategies for Change. Saarbrucken, Germany: VDM Verlag Dr. Muller.
- Muiruri, P. (2020). Kenyan efforts to end FGM suffer blow with victims paraded in 'open defiance.' The Guardian October 21, 2020, https://www.theguardian.com/global-development/2020/oct/21/kenyan-efforts-to-end-fgm-suffer-blow-with-victims-paraded-in-open-defiance.
- N. Bhalla, 'COVID-19 Threatens Kenya's Goal to End Female Genital Mutilation by 2022', Global Citizen, 18 June 2020, available at https://www.globalcitizen.org/en/content/covid-19-school-closures-end-FGM/C-in-kenya/
- National Council for Population and Development (NCPD), Central Bureau of Statistics (CBS) (Office of the Vice President and Ministry of Planning and National Development) [Kenya], and Macro International Inc. (MI). 1999. Kenya Demographic and Health Survey 1998. Calverton, Maryland: NDPD, CBS, and MI, available at https://dhsprogram.com/pubs/pdf/FR102/FR102.pdf [Last Accessed 17 February 2021].
- Orchid Project, Policy Briefing: Impacts of COVID-19 on Female Genital Cutting (Orchid Project 2020) available at https://www.orchidproject.org/wpcontent/uploads/2020/11/COVID_female_genital_cutting_FGC_policy_briefing_Orchid_Project_FINAL.pdf [Last Accessed 22 February 2021].
- Parsitau, D.S. (2018). How outlawing FGM in Kenya has driven it underground and led to its medicalization. Education Plus Development, https://www.brookings.edu/blog/education-plus-development/2018/06/19/how-outlawing-female-genital-mutilation-in-kenya-has-driven-it-underground-and-led-to-its-medicalization/; Bettina Shell-Duncan, Carolyne Njue, and Zhuzhi Moore "The

Medicalization of Female Genital Mutilation /Cutting: What do the Data Reveal?" February 2017," Evidence to End FGM/C: Research to Help Women Thrive. New York: Population Council.

- Population Council. Evidence to end FGM/C Compedium. 2016.
- President's national address on ending FGM in Kenya, available at: http://www.antifgmboard.go.ke/download/president-uhuru-kenyatta-national-address-on-ending-fgm-in-kenya-at-statehouse-nairobi-in-nov-2019/ [Last Accessed 22 February 2021].
- Republic of Kenya, National Policy for the eradication of Female Genital Mutilation, Sessional Paper No. 3, January 2019, available at https://gender.go.ke/wp-content/uploads/2019/10/NATIONAL-POLICY-FOR-THE-ERADICATION-OF-FEMALE-GENITAL-MUTILATION-.pdf [Last Accessed 22 February 2021].
- The East Africa Community is a regional intergovernmental organization including six partner states: Burundi, Kenya, Rwanda, South Sudan, Tanzania, and Uganda. For more information, see: East African Community, Overview of EAC, available at https://www.eac.int/overview-of-eac [Last Accessed 22 February 2021].
- UNDP, Human Development Report 2020, The Next Frontier: Human Development and the Anthropocene, available at http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/KEN.pdf [Last Accessed 26 January 2021].
- UNFPA (2019). Beyond the crossing: Female Genital Mutilation Across Borders, Ethiopia, Kenya, Somalia, Tanzania and Uganda. United Nations Population Fund, New York
- UNFPA, Interim Technical Note: Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage (UNFPA 2020) available at https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_impact_brief_for_UNFPA_24_April_2020_1.pdf [Last Accessed 22 February 2021].
- UNFPA-UNICEF (2019). Accelerating Change: Annual report 2018. UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation.
- United Nations Population Fund, UNFPA-UNICEF Joint Programme on Female Genital Mutilation, available at: https://www.unfpa.org/unfpa-unicef-joint-programme-female-genital-mutilations [Last Accessed 22 February 2021].
- Walela Nasimiyu Stella (2020). Assessment of international laws on female genital mutilation and its implications on the East African region: a case study of Namanga, Kenya-Tanzania border. University of Nairobi.

- WHO (2008). Eliminating Female Genital Mutilation: An Interagency Statement, WHO, Geneva, available at https://apps.who.int/iris/bitstream/handle/10665/43839/9789241596442_eng.pdf?sequence [Last Accessed 13 November 2020].
-
- World Economic Outlook Database, International Monetary Fund, October 2020, available at https://www.imf.org/en/Publications/WEO/weo-database/2020/October/weo-report?c=664,&s=NGDPD,PPPGDP,NGDPRPPPPC,NGDPDPC,PPPPC,&sy=2018&ey=2025&ssm=0&scsm=1&scc=0&ssd=1&ssc=0&sic=0&sort=country&ds=.&br=1 [Last Accessed 21 February 2021].
- Yoder, P. Stanley, and Shanxiao Wang. 2013. Female Genital Cutting: The Interpretation of Recent DHS Data. DHS Comparative Reports No. 33. Calverton, Maryland, USA: ICF International, available at https://dhsprogram.com/pubs/pdf/cr33/cr33.pdf [Last Accessed 17 February 2021].