

# COUNTRY PROFILE: FGM IN KENYA

MAY 2013



**28 TOOMANY**  
FGM...  
let's end it.



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## FORWORD

In organisations, annual appraisals and monitoring and evaluation reports show a measure of progress towards a goal. With an aim to eliminate a harmful traditional practice such as FGM which has been in existence across Africa for over 2000 years, it is hard to assess measures of progress.

This country report into FGM across Kenya shows FGM in 15-49 year olds reducing from 37.6% (1998) to 32.2% (2003) to 27.1% (2008-9). This is measurable progress and around 10% over 10 years. However, measuring changes in attitudes and belief is difficult, and there is still much to do.

FGM affects the physical and psychological health of girls and women; decreases their attendance and performance at school; fails to meet their gender equality rights; and risks their lives at the time of FGM, at marriage and during childbirth. FGM affects up to 3 million girls a year, one every 10 seconds. On behalf of them, we have created this charity, 28 Too Many, to speak out and engage with the global campaign to end FGM.

FGM also has a relationship with other issues such as girls not completing their education and having poor literacy; early or arranged marriage; the spread of HIV AIDS and poor access to physical health and psychological health care.

FGM is practised for a variety of reasons – sometimes at a certain age or alternatively as a rite of passage, often at puberty which is a time of vulnerability and change. Many young women are affected by HIV/ AIDS and many others marry early which leads to early childbirth, with resulting complications for many of obstetric fistula.

Having first visited Kenya in 2003, I have seen significant change in many development indicators in the dozen trips I have made there. It was in 2005 that I first came across FGM whilst working in North Sudan, and then worked in an Internally Displaced People (IDP) Camp in Dadaab, North

East Kenya in 2008, with over 250,000 Somali IDPs. This led to my research paper that was published in March 2012 (Wilson, 2012).

Having seen first-hand over 10 years the trauma, pain and health consequences of FGM, we are pleased 28 Too Many has been able to undertake this research and see progress. The photograph below shows a Maasai community that used to practice FGM but has now abandoned it. This was due to two older girls attending school and joining a health club. They then ran away to avoid FGM, and as they were reunited with their parents via an aunt and grandma, then educated their community on the harm caused by FGM. Since then, no girl has been cut for seven years.

This community experience helps me see how change can happen. We are always seeking new partners, FGM collaborators, research volunteers and donors to help us end FGM across Africa and the diaspora. My dream is that a woman does not cut her daughter; then as a mother that daughter does not cut her own daughter; and as a grandmother, that she will not cut her granddaughter/others in the community, and over 3 generations (36 years) major change can happen; over 5 generations (60 years) FGM could be eradicated. Meanwhile, 28 Too Many plans to create reports on the 28 countries in Africa as a resource tool to the FGM and development sector, government, media and academia. With your partnership, we can make these useful and often accessed reports which share good practice.

**Dr Ann-Marie Wilson**

**28 Too Many Executive Director**

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## BACKGROUND

28 Too Many is an anti-female genital mutilation (FGM) charity, created to end FGM in the 28 African countries where it is practised and in other countries across the world where members of those communities have migrated. Founded in 2010, and registered as a charity in 2012, 28 Too Many aims to provide a strategic framework, where knowledge and tools enable in-country anti-FGM campaigners and organisations to be successful and make a sustainable change to end FGM. We hope to build an information base including providing detailed reports for each country practising FGM in Africa and the diaspora, and develop a network of anti-FGM organisations to share knowledge, skills and resources. We also campaign and advocate locally and internationally to bring change and support community programmes to end FGM.

## PURPOSE

The prime purpose of this report is to provide improved understanding of the issues relating to FGM in the wider framework of gender equality and social change. By providing a country profile, collating the research to date, this report can act as a benchmark to profile the current situation. As organisations send us their findings, reports, tools and models of change, we can update these reports and show where progress is being made. Whilst there are many challenges to overcome before FGM is eradicated in Kenya, many programmes are making positive active change and government legislation offers a useful base platform for deterring FGM practice.

## USE OF THIS REPORT

Extracts from this publications may be freely reproduced, provided the due acknowledgement is given to the source and 28 Too Many. 28 Too Many invites comments on the content, suggestions on how it could be improved as an information tool, and seeks updates on the data and contacts details.

## ACKNOWLEDGEMENTS

28 Too Many is extremely grateful for all the FGM practising communities, local NGOs, CBOs, faith-based organisations, international organisations, multilateral agencies, members of government and media in Kenya, who have assisted us in accessing information to produce this report. We thank you, as it would not have been possible without your assistance and collaboration. 28 Too Many carried out all its work as a result of donations, and is an independent objective voice not being affiliated to any government or large organisations. That said, we are grateful to the many international organisations that have supported us so far on our journey and the donations that enabled this report to be produced. Please contact us on [info@28toomany.org](mailto:info@28toomany.org).

## THE TEAM

Producing a report such as this is a collaborative process. We are very grateful to the following key contributors:

**Katherine Allen** is a Research Intern for 28 Too Many and a DPhil (PhD) student in the history of medicine and science at the University of Oxford.

**Kelly Denise** is a Research Volunteer for 28 Too Many who has lived and worked in Kenya and Uganda for over 2 years.

**Vanessa Diakides** is a Research Volunteer for 28 Too Many and is studying an MA in Women and Child Abuse at the Child and Women Abuse Studies Unit (CWASU) at London Metropolitan University.

**Johanna Waritay** is Research Coordinator for 28 Too Many. Prior to this, she worked for 13 years as a lawyer at a leading international law firm in London. She has carried out research in three countries that practice FGM in the last year.

**Ann-Marie Wilson** founded 28 Too many and is its Executive Director. She has travelled to Kenya many times over the last 11 years and published

her paper this year on ‘Can lessons by learnt from eradicating footbinding in China and applied to abandoning female genital mutilation in Somalia? A critical evaluation of the possibilities offered for developing strategies to expand current promising practice’ in the Journal of Gender Studies.

**Rooted Support Ltd** – For donating their time through its director Nich Bull in the design and layout of this report, [www.rootedsupport.co.uk](http://www.rootedsupport.co.uk).

We are grateful to the rest of the **28 Too Many Team** who have helped in many ways.

Photograph on front cover: *Samburu girls ready for wedding – Kenya* © [www.lafforgue.com](http://www.lafforgue.com)

## LIST OF ABBREVIATIONS

**ARP** – Alternative Rites of Passage

**CBO** – Community-Based Organisation

**DHS** – Demographic Health Survey

**FGM** – Female Genital Mutilation

**GBV** – Gender-based violence

**MDG** – Millennium Development Goal

**NGO** – Non-Governmental Organisation

**WHO** – World Health Organisation

## EXECUTIVE SUMMARY

In Kenya, according to the most recent Demographic Health Survey (DHS), the estimated prevalence of FGM in girls and women (aged 15-49 years) is 27.1% (DHS 2008-09). This represents a steady decrease from 37.6% in 1998, and 32.2% in 2003. There are significant regional variations, with prevalence ranges from 0.8% in the west to over 97% in the north-east (DHS 2008-09).

Kenya has great ethnic and cultural diversity, as reflected in the differing rates of FGM across the ethnic groups, as well as the type of FGM performed and the underlying reasons for practising it. Somalis who live predominantly in the North Eastern province practice FGM at a rate of 97.7%, with 75% having undergone the most severe Type III infibulation. The next highest prevalence is found among the Kisii (also known as the Abagussi or Gusii) at 96.1% and the Maasai at 73.2%. The Kisii and Maasai practice Type I clitoridectomy and Type II excision respectively. By contrast, the Luhya and Luo have the lowest rates of less than 1%. (DHS 2008-09)

The most common type of FGM is 'flesh removed' which accounts for 83% of women who have been cut. Type III infibulation accounts for 13% and 'nicked, no flesh removed' 2% (DHS, 2008-09)

In Kenya, FGM is performed mostly on girls aged between 12 and 18. Some studies have shown that girls are now being cut earlier, between the ages of 7 and 12. It is thought that the decrease is to avoid detection as a response to legislation banning the practice. The proportion of women who have undergone FGM declines with age, indicating a decline in the popularity of the procedure in the younger generations.

FGM is a deeply rooted cultural practice, although the reasons vary between ethnic groups. For some, such as the Meru, Embu and Maasai, it is an important rite of passage. FGM is closely tied to marriageability for some ethnic groups, such as the Maasai. For some ethnic groups such as the Somali, FGM is linked to concepts of family honour and the need to preserve sexual purity. Along the Kisii, FGM is believed to be necessary to control women's sexual desires and distinguishes them from their neighbouring Luo ethnic group.

The medicalisation of FGM in Kenya has been a trend that has been documented, particularly among the Kisii. In 2003, 46% of Kenyan daughters had FGM performed by a health professional (up from 34.4% in 1998). However, the latest DHS puts the figure at 19.7% overall or 27.8% in urban areas.

At the end of 2011, the existing anti-FGM law was replaced by the more robust Prohibition of Female Genital Mutilation Act 2011. This closed loop holes in the previous law, criminalising all forms of FGM performed on anyone, regardless of age, aiding FGM, taking someone abroad for FGM and stigmatising women who have not undergone FGM.

There are many local NGOs, CBOs, faith-based organisations, international organisations and multilateral agencies working in Kenya to eradicate FGM. A broad range of initiatives and strategies have been used. Among these are: health risk/harmful traditional FGM practices approach; addressing the health complications of FGM; educating traditional FGM practitioners and offering alternative income; alternative rites of passage (ARPs); religious-oriented approach; legal approach; human rights approach; intergenerational dialogue; promotion of girls' education to oppose FGM and supporting girls escaping from FGM/child marriage. (Population Council, 2007)

Due to the diversity in underlying ethnic and cultural traditions and beliefs that underpin FGM, organisations need to tailor anti-FGM initiatives and strategies accordingly. Programmes have worked best in Kenya when they are cooperative and inclusive. There are still many challenges to overcome before FGM is eradicated in Kenya, but with new legislation and active anti-FGM programmes progress continues in a positive direction. We propose the measures relating to:

1. Sustainable funding.
2. Considering FGM within the framework of the millenium development goals.
3. Facilitating education on health and FGM.
4. Improvements in managing health complications of FGM, tackling the medicalisation of FGM, more resources for sexual and reproductive health education, as well as research and funding on the psychological consequences of FGM.
5. Increased advocacy and lobbying.
6. Increased law enforcement and equipping of law enforcement agencies.
7. Increased use of media.
8. Recognising role of faith-based organisations.
9. Greater use of partnerships and collaborative research.

## INTRODUCTION

*‘Even though cultural practices may appear senseless or destructive from the standpoint of others, they have meaning and fulfil a function for those who practise them. However, culture is not static; it is in constant flux, adapting and reforming. People will change their behaviour when they understand the hazards and indignity of harmful practices and when they realise that it is possible to give up harmful practices without giving up meaningful aspects of their culture’ (WHO, 1997)*

Female genital mutilation (sometimes called female genital cutting and female genital mutilation/cutting) is defined by the WHO as referring to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. FGM is a form of gender-based violence and has been recognised as a harmful practice and a violation of the human rights of girls and women. Between 100 and 140 million girls and women in the world are estimated to have undergone such procedures, and 3 million girls are estimated to be at risk of undergoing the procedures every year.

FGM has been reported in 28 countries in Africa and occurs mainly in countries along a belt stretching from Senegal in West Africa, to Egypt in North Africa, to Somalia in East Africa and the Democratic Republic of Congo (DRC) in Central Africa. It also occurs in countries in Asia and the Middle East and among certain diaspora communities in North America, Australasia and Europe. As with many ancient practices, FGM is carried out by communities as a heritage of the past and is often associated with ethnic identity. Communities may not even question the practice or may have long forgotten the reasons for it.

The WHO classifies FGM into four types:

<b>Type I</b>	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
<b>Type II</b>	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). Note also that the term ‘excision’ is sometimes used as a general term covering all types of FGM.
<b>Type III</b>	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
<b>Type IV</b>	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

(WHO 2008)

FGM is often motivated by beliefs about what is considered appropriate sexual behaviour, with some communities considering that it ensures and preserves virginity, marital faithfulness and prevents promiscuity/prostitution. There is a strong link between FGM and marriageability with FGM often being a prerequisite to marriage. FGM is sometimes a rite of passage into womanhood, and necessary for a girl to go through in order to become a responsible adult member of society. FGM is also considered to make girls ‘clean’ and aesthetically beautiful. Although no religious scripts require the practice, practitioners often believe the practice has religious support. Girls and women will often be under strong social pressure, including pressure from their peers and risk victimisation and stigma if they refuse to be cut.

FGM is always traumatic (UNICEF, 2005). Immediate complications can include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue. Long-term consequences can include recurrent bladder and urinary tract infections; cysts; infertility; an increased risk of childbirth

complications and newborn deaths; the need for later surgeries. For example, Type III infibulation needs to be cut open later to allow for sexual intercourse and childbirth. (WHO, 2013)

The eradication of FGM is pertinent to the achievement of four millennium development goals (MDGs): MDG 3 - promote gender equality and empower women; MDG 4 - reduce child mortality, MDG 5 - reduce maternal mortality and MDG 6 - combat HIV/AIDS, malaria and other diseases.

In Kenya, an estimated 27.1% of girls and women aged 15-49 years have undergone FGM (DHS 2008-09), a figure that has decreased from 37.6% in 1998, and 32.2% in 2003. There are significant regional variations, with prevalence ranges from 0.8% in the west to over 97% in the north-east (DHS 2008-09). The practice is particularly among the Somalis in the North Eastern province practice (97.7%), with 75% having undergone Type III infibulation. The prevalence is also highest among the Kisii (96.1%) and the Maasai (73.2%). FGM is a deeply rooted cultural practice, although the reasons vary between ethnic groups. For some, it is an important rite of passage, for others it is closely tied to marriageability or the concepts of family honour and the need to preserve sexual purity. Among some communities, there has been a trend towards the medicalisation of FGM with the procedure being carried out by medical professionals. At the end of 2011, the government passed the Prohibition of Female Genital Mutilation Act 2011 to replace the existing law. There are many local NGOs, CBOs, faith-based organisations, international organisations and multilateral agencies working in Kenya to eradicate FGM using a broad range of approaches.

The vision of 28 Too Many is a world where every woman is safe, healthy and lives free from FGM. A key strategic objective is to provide detailed, comprehensive country reports for each of the 28 countries in Africa where FGM is practised. The reports provide research into the situation regarding FGM in each country, as well as providing

more general information relating to the political, anthropological and sociological environments in the country to provide a contextual background within which FGM occurs. It also offers some analysis of the current situation and will enable all those with a commitment to ending FGM to shape their own policies and practice to create conditions for positive, enduring change in communities that practice FGM. We recognise that each community is different in its drivers for FGM and bespoke, sensitive solutions are essential to offer girls, women and communities a way forward in ending this practice. This research report provides a sound knowledge base from which to determine the models of sustainable change necessary to shift attitude and behaviour and bring about a world free of FGM.

From our research, we have met many anti-FGM campaigners, CBOs, policy makers and key influencers. We wish to help facilitate in-country networking to enable information sharing, education and increased awareness of key issues, enabling local NGOs to be part of a greater voice to end FGM, locally and internationally.

## RESEARCH METHODOLOGY

28 Too Many aims to provide research on FGM across the 28 countries in African in which it is practised, by providing a strategic framework, knowledge and tools to enable in-country anti-FGM campaign and organisations to be successful and make a sustainable change to end FGM.

Our work is initially focussed on research and analysis as we believe it is essential to build up knowledge of the current situation and an evidence base that will make a difference. We aim to update these over time so progress can be made.

We strive to remain objective in providing this information, while maintaining the position that FGM is an inherent violation of human rights

and needs to be ended. Our intent is to avoid victimising language and passing judgement on cultural practices, while focusing on the statistics behind FGM and the progress of anti-FGM programmes. We generally use the term FGM, as opposed to alternatives such as female circumcision or female genital cutting (FGC), to emphasise the gravity of the practice, following the approach of the WHO. The information in this document comes from reports available online, as well as scholarly articles and general literature on FGM. We provide a comprehensive overview of each country’s current socio-economic, cultural, religious, and political conditions and the current state of FGM. Moreover, we focus on the rights, education, health and safety of girls and women. Our reports summarise past and current work on the elimination of FGM in Africa and document progress already made to end FGM.

Since the early 1990s, data on FGM have been collected through a separate module of the Demographic and Health Surveys (DHS) implemented by Macro International. The FGM module has yielded a rich base of data. We wish to thank the DHS project for this data. Data have also been collected through the Multiple Cluster Indicator Surveys (MICS) using a module similar to that of DHS. The MICS FGM module has been adjusted to the DHS module and was implemented during the third round of surveys (MICS-3) in 2005-6.

To compliment this research and research from other sources, we provide first-hand accounts of FGM practices and programmes aimed to eradicate FGM within each country at a community level. We aim to achieve this by questionnaires for NGOs and community mapping. This information enables us to understand the challenges and successful strategies associated with ending FGM at a grass-roots level. Additionally, in-country research provides new information which has not yet been published and gives us valuable insight for recommending future action plans. Finally, we set out our conclusions, based on the evidence

gathered, on how to accelerate progress to eradicate FGM.

The objective of our work is to provide a concise report for each country to be freely available for use by governments, NGOs, charities, media, academics and other groups so that we can work collaboratively on ending FGM.

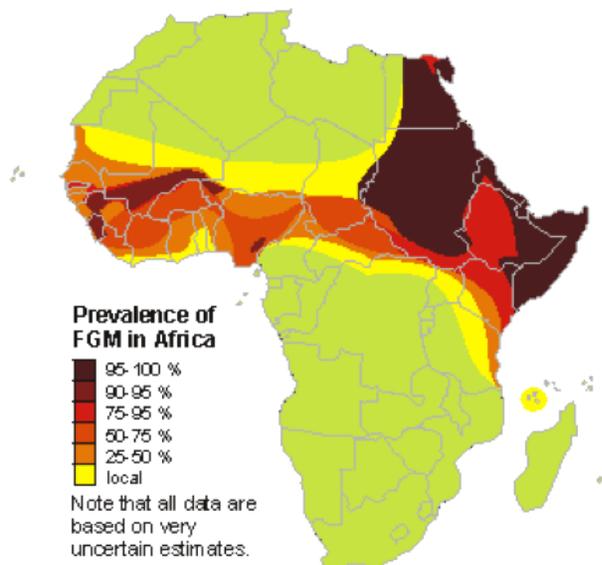
## INTRODUCTION TO FGM

See Introduction above for details of types of FGM.

## HISTORY OF FGM

FGM has been practiced for over 2000 years (Slack, 1988). Although it has obscure origins, there has been anthropological and historical research on how the practice came about. It is found in traditional group or community cultures that have patriarchal structures. Although FGM is practised in some communities in the belief that it is a religious requirement, research shows that FGM pre-dates Islam and Christianity. Some anthropologists trace the practice to 5th century BC Egypt, with infibulations being referred to as ‘Pharaonic circumcision’ (Slack, 1988). Other anthropologists believe that it existed among Equatorial African herders as a protection against rape for young female herders; as a custom amongst stone-age people in Equatorial Africa; or as ‘an outgrowth of human sacrificial practices, or some early attempt at population control’ (Lightfoot-Klein, 1983). There were also reports in the early 1600s of the practice in Somalia as a means of extracting higher prices for female slaves, and in the late 1700s in Egypt to prevent pregnancy in women and slaves. FGM is practiced across a wide range of cultures and it is likely that the practice arose independently amongst different peoples (Lightfoot-Klein, 1983), aided by Egyptian slave raids from Sudan for concubines and maids, and traded through the Red Sea to the Persian Gulf (Mackie, 1996). (Sources referred to by Wilson, 2012)

## FGM – GLOBAL PREVALENCE



### Prevalence of FGM in Africa (Afril News)

FGM has been reported in 28 countries in Africa, as well as in some countries in Asia and the Middle East and among certain immigrant communities in North America, Australasia and Europe.

## NATIONAL STATISTICS

### GENERAL STATISTICS

#### POPULATION

43,013,341 (July 2012 est.)

Median age: 18.8 years

Growth rate: 2.444% (2012 est.) (World Factbook)

#### HUMAN DEVELOPMENT INDEX

Rank: 145 out of 186 in 2013 (UNDP)

#### HEALTH

Life expectancy at birth (years): 57.7 (UNDP) or 63.07 (World Factbook)

Infant mortality rate (per 1,000 live births): 43.61

Maternal mortality rate 360 deaths / 100,000 live births (2010); country comparison to the world: 29th

Fertility rate, total (births per women): 3.98

(2012 est.)

HIV/AIDS – adult prevalence rate: 6.3% (2009 est.)

HIV/AIDS – people living with HIV/AIDS: 1.5 million (2009 est.); country comparison to the world: 4th

HIV/AIDS – deaths: 80,000 per annum (World Factbook)

### LITERACY (AGE 15 AND OVER WHO CAN READ AND WRITE)

Total population: 87.4%

Female: 84.2%; male: 90.6% (2010 est.) (World Factbook)

Female youth (15-24 years): 93.6%; male youth: 91.7% (2009) (World Bank)

### MARRIAGE

Girls aged 15 - 19 who are married, divorced, separated, or widowed: 11.7% (DHS 2008-09)

Married girls or women who share their husband with at least one other wife: 14.9% (DHS 2008-09)

### GDP

GDP (official exchange rate): US\$41.84 billion (2012 est.)

GDP per capita: US\$1,800 (2012 est.)

GDP (real growth rate): 5.1%

### URBANISATION

Urban population: 22% of total population (2010)

Rate of urbanisation: 4.2% annual rate of change (2010-15 est.)

### ETHNIC GROUPS

Kikuyu 22%, Luhya 14%, Luo 13%, Kalenjin 12%, Kamba 11%, Kisii 6%, Meru 6%, other African 15%, non-African (Asian, European, and Arab) 1%

## RELIGIONS

Christian 82.5% (Protestant 47.4%, Catholic 23.3%, other 11.8%), Muslim 11.1%, Traditionalists 1.6%, other 1.7%, none 2.4%, unspecified 0.7% (Census, 2009)

## LANGUAGES

English (official), Kiswahili, and numerous indigenous languages

## MILLENNIUM DEVELOPMENT GOALS

The eradication of FGM is pertinent to a number of the UN's eight Millennium Development Goals (MDGs).

### GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

The aim of this MDG is to eliminate all gender disparity in primary and secondary education no later than 2015. This is highly relevant given that FGM is a manifestation of deeply entrenched gender inequality and constitutes an extreme form of discrimination against women. Moreover there is a correlation between the level of a woman's education and her attitude towards FGM. See section on FGM and Education.

### GOAL 4: REDUCE CHILD MORTALITY

FGM has a negative impact on child mortality. A WHO multi-country study, in which over 28,000 women participated, has shown that death rates among newborn babies are higher to mothers who have had FGM. See section on Women's Health and Infant Mortality

### GOAL 5: IMPROVE MATERNAL HEALTH

This MDG has the aim of reducing maternal mortality by three quarters between 1990 and 2015. In addition to the immediate health consequences arising from FGM, it is also associated with an increased risk of childbirth complications. See section on Women's Health and Infant Mortality.

### GOAL 6: COMBAT HIV/AIDS, MALARIA AND

## OTHER DISEASES

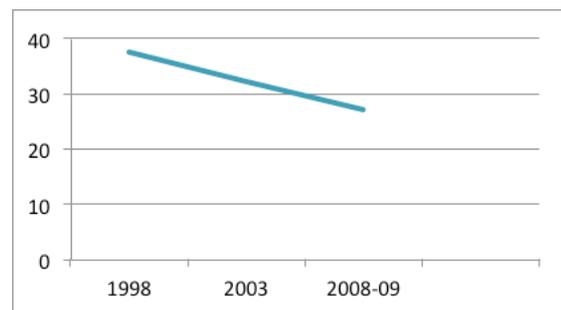
Although the correlation between HIV and FGM is not as direct as some research has previously claimed, there are a number of potential sources of HIV transmission associated with FGM and its consequences. See section on HIV/AIDS and FGM.

## NATIONAL STATISTICS RELATING TO FGM

Statistics on the prevalence of FGM are compiled through large scale household surveys in developing countries – the Demographic Health Survey (DHS) and the Multiple Cluster Indicator Survey (MICS). All statistics below are derived from the Kenyan DHS.

### PREVALENCE OF FGM IN KENYA BY AGE %

The estimated prevalence of FGM in girls and women (15-49 years) is 27.1% (DHS 2008-09). This has reduced from 37.6% in 1998 (DHS 1998) and 32.2% in 2003 (DHS 2003).



Prevalence of FGM in women and girls aged 15-49 (%) (DHS 1998, 2003, 2008-09)

**FGM in Kenya has shown a decline from almost 40% in 1998 to 27% in 2008-09 (DHS)**

	1998	2003	2008-09
15-19	26.0	20.3	14.6
20-24	32.2	24.8	21.1
25-29	40.4	22.0	25.3
30-34	40.9	38.1	30.0
35-39	49.3	39.7	35.1
40-44	47.4	47.5	39.8
45-49	47.5	47.7	48.8
<b>Total</b>	<b>37.6</b>	<b>32.3</b>	<b>27.1</b>

Prevalence of FGM in women and girls by age (%)  
(UNICEF 2005; DHS 1998, 2003, 2008-09)

### PREVALENCE OF FGM IN KENYA BY PLACE OF RESIDENCE %

Women and girls in rural areas are more likely to undergo FGM. The variation of prevalence based on place of residence is 'probably rooted in such factors as the area's ethnic composition, neighbouring countries, dominant religious affiliation, and level of urbanization' (Carr, Dara 1997).

URBAN	RURAL	LOWEST REGION	HIGHEST REGION
16.5	40.6	0.8	97.5

Prevalence of FGM by place of residence (%) (PRB, based on DHS 2008-09)

### PREVALENCE OF FGM IN KENYA BY HOUSEHOLD WEALTH %

The DHS breaks down the population into quintiles from the richest to the poorest, using information such as household ownership of certain consumer items and dwelling characteristics.

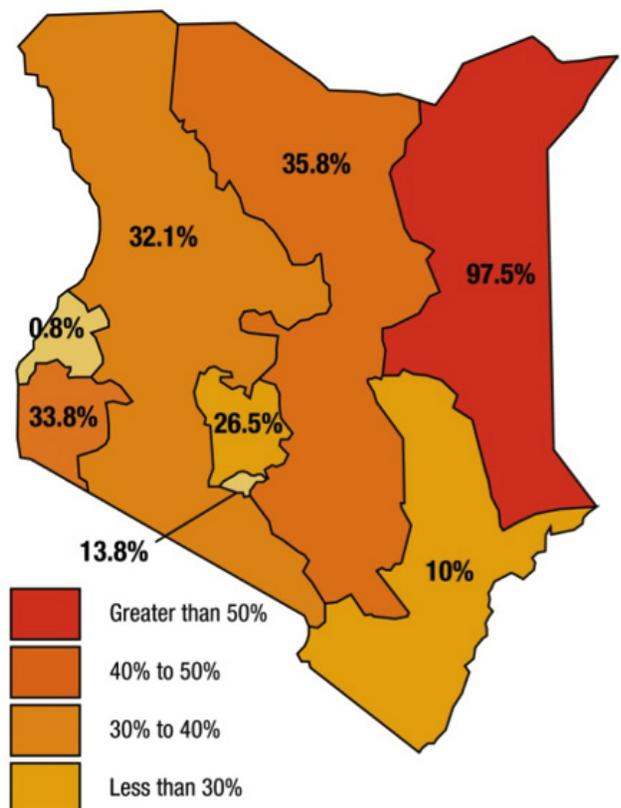
WEALTH INDEX QUINTILE				
POOREST	SECOND	MIDDLE	FOURTH	RICHEST
40	31	29	26	15

Prevalence of FGM by household wealth (%) (DHS 2008-09)

## REGIONAL STATISTICS

Kenya is classed by UNICEF as a Group 2 Country, where FGM prevalence is intermediate and only certain ethnic groups practise FGM, at varying rates. (UNICEF 2005)

Kenya has significant regional variations in FGM, with prevalence ranges from 0.8% in the west to over 97% in the north-east of Kenya. These regional differences are reflective of the diverse ethnic communities; prevalence of FGM within individual communities is discussed below in section on FGM in Kenya by Ethnicity.



FGM by province (DHS 2008-09)

## POLITICAL BACKGROUND

### HISTORICAL

The first inhabitants of present-day Kenya were hunter-gatherer groups. Kenya was later populated by Cushitic-speaking people around 2000 BC before being colonised through trade activity by Arab and Persian settlers in the eighth century. Bantu and Nilotic peoples subsequently moved into the region during the first millennium AD, though Arab dominance continued until the Portuguese arrived in 1498. The region was established by Britain as the East African Protectorate in 1895, which encouraged European settlement of agricultural communities in the highlands. Kenya was made a British colony in 1920 and Africans gained political participation and representation in 1944.

From 1952 to 1959, Kenya was under a state of emergency during the Mau Mau Rebellion against British rule. The main areas involved were the central highlands of the Kikuyu people, tens of thousands whom died during the conflict. Kenya gained independence on 12 December 1963 and joined the Commonwealth the next year. The first president was Jomo Kenyatta, of Kikuyu ethnicity and leader of the Kenya African National Union. Kenyatta died in 1978 and was succeeded by Daniel arap Moi who ruled as President 1978-2002. Minority parties were unsuccessful in gaining power and in June 1982 the constitution was amended making Kenya a one-party state. Following this amendment there was a violent coup by military officers attempting to overthrow the one-party government. The coup resulted in the repeal of the one-party section rule in December 1991, with multi-party elections held the following year. In 1997, Kenya had its first coalition government. In October 2002 the opposition parties formed the National Rainbow Coalition and their candidate Mwai Kibaki was elected as Kenya's third president. From 2003 to 2005 there were internal government conflicts, resulting in a re-drafting of the constitution. In 2007, the presidential elections took place amidst serious irregularities. Kibaki was declared

president and this resulted in a violent crisis with 1,300 deaths and 500,000 people displaced; UN negotiations were needed to restore order.

### CURRENT POLITICAL CONDITIONS

Under Kibaki, Kenya has been a republic with a strong president and prime minister, however both had unclearly defined executive powers (US Department of State, 2011). In February 2008 President Kibaki and Ralia Odinga, leader of the opposition party Orange Democratic Movement, signed a power-sharing agreement creating a prime minister position for Odinga. This agreement also expanded the cabinet to 42 members with proportional representation in parliament. The new government's aim was to create a new constitution with a focus on economic development and increased accountability for corruption and political violence. The new constitution was approved by referendum on 4 August 2010. The World Bank's 2010 Worldwide Governance Indicators stated that corruption remains a severe problem in all levels of Kenya's legal system (Human Rights Report, 2011). In the March 2013 elections, Uhuru Kenyatta was elected as president.

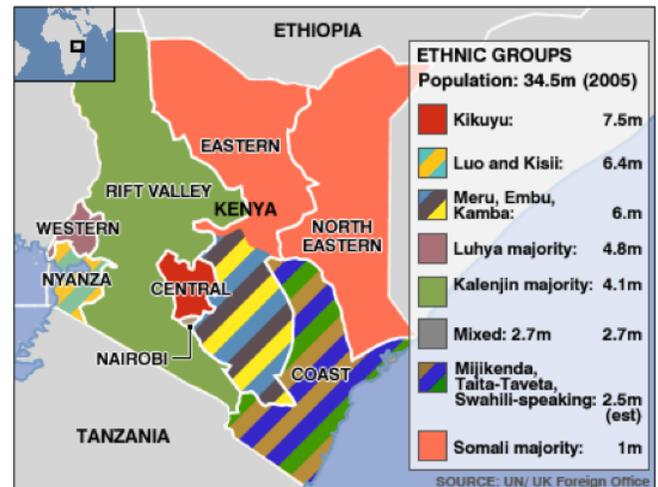
## ANTHROPOLOGICAL BACKGROUND

### ETHNIC GROUPS

Kenya has great ethnic, cultural, religious and linguistic diversity. The peoples of Kenya are roughly divided into three initial sub-groups based on shared languages and related histories: the Bantus, the Nilotes and the Cushites. These groups are further divided into a variety of ethnic groups, the largest of which are as follows: Embu, Kalenjin, Kamba, Kikuyu, Kisii, Luhya, Luo, Maasai, Meru, Mijikenda/Swahili, Somali, Taita/Taveta and Turkana. There are huge variations in the languages and cultures between the various ethnic groups, although they often intermingle and absorb practices from each other.

Ethnic/national minorities, such as the Nubians and Somalis, are not recognised as such by the Kenyan government and have problems accessing citizenship documents. Political conflict along ethnic lines has increased dramatically in recent years, exacerbated by economic decline and divisive politicians. Agriculturalists and pastoralists often have competing claims to land, and nomadic pastoralists are in ceaseless conflict with the authorities, most of whom come from farming tribes. Although the relationship has generally been one of tolerance, divisions between Christians and Muslims are of growing significance. No ethnic grouping is dominant in terms of size, although the Kikuyu, who make up 22% of the population, have tended to dominate politics in the post-independence era. Competition for power and exclusion from power on an ethnic basis has been a major source of tension in Kenya. Particularly vulnerable minorities include Muslims, such nomadic pastoralists as Somalis and Maasai, and hunter-gatherers such as the Ogiek and Aweer. (Minority Rights Group International, 2012).

For more details on ethnic groups, see FGM by Ethnicity below.



Geographic distribution of the major ethnic groups in Kenya (UK Foreign Office)

### COUNTRYWIDE TABOOS AND MORES

Kenya has a patriarchal society and there are moral and cultural restrictions on women and their behaviour. One prominent religio-social taboo that impacts FGM is the belief against women achieving sexual pleasure. Unplanned pregnancies are also considered taboo and there are many taboos and rituals associated with the childbirth process. Coinciding with the cultural mores surrounding reproduction is the taboo of openly discussing sex and sexuality. Studies have shown that Kenyan mothers are struggling to overcome cultural restrictions to teach their daughters about sexual maturation, abstinence, and contraceptives (Crichton et al. 2012). Sexual education for young children is important for communicating the issues surrounding HIV and AIDS, and safe sexual practices in general (Mbugua, 2007). Moreover, there are significant taboos associated with HIV and AIDS and this plays a role in the stigma against homosexuality, which is illegal in Kenya (Human Rights Report, 2011). Finally, FGM practices can result in post-traumatic stress disorder and depression (Berg et al., 2010). This health area is often overlooked, in part because depression and suicide are religious and cultural taboos (Ndetee et al., 2010).

## SOCIOLOGICAL BACKGROUND

### ROLE OF WOMEN

Kenya was ranked 46 out of 86 in the 2012 OECD Social Institutions and Gender Index (SIGI).



Woman gathering wood © 28 Too Many

According to SIGI, women face equality challenges in the following areas:

#### DISCRIMINATORY FAMILY CODE:

- Although the minimum age for marriage is 18, and the Children's Act of 2001 forbids early or forced marriage, many marriages are not officially registered, or are performed under customary or Islamic law, which have no age restriction.
- Polygamy is forbidden in statutory marriages but exists in customary or Muslim marriages, which constitute approximately 60% of all marriages.
- Kenyan women often face inequality through inheritance court cases, despite the Law of Succession Act enforcing gender equality.

#### RESTRICTED PHYSICAL INTEGRITY:

- There is a high incidence of domestic violence against women and there is no specific law against domestic violence. A majority of Kenyans consider partner violence culturally acceptable.
- There is a high incidence of rape without prosecution. Police are reluctant to investigate rape cases because victims need to be examined by police and this procedure clashes with a prominent cultural taboo that prohibits discussion of sex. Rape and sexual assault, much

of it ethnically driven, were widespread during the post-election crisis in 2008.

#### RESTRICTED RESOURCES AND ENTITLEMENTS:

- The Kenyan Constitution ensures equality of ownership rights. In practice, women are restricted by customary law, which prohibits women from owning or inheriting land or property.

### HEALTHCARE SYSTEM

Kenya's healthcare system is structured by hierarchy according to the severity of cases and treatment and is run by both the government and the private sector. Basic healthcare is carried out at government run dispensaries and private clinics. Government health centres focus on preventative care and also provide comprehensive primary care. More complicated health concerns and surgeries are dealt with at sub-district and district hospitals. Kenya also has eight provincial hospitals and two national hospitals which offer intensive care and specialised treatment. The Kenyan Ministry of Public Health and Sanitation offers free primary health care and their three highest priorities are: improving immunisation coverage for children, ensuring that most deliveries are conducted under the care of skilled health attendants, and reducing morbidity and mortality from malaria, HIV/AIDS, tuberculosis and non-communicable diseases. Kenya has a mental health programme and it is gaining attention, but treatment is sparse and not covered by general health insurance.



Health clinic © 28 Too Many

## EDUCATION

The Kenyan education system is structured as an 8-4-4 curriculum and is controlled by the Ministry of Education. Children enter the formal education system at age six and remain in the 'primary' stage for eight years. They then spend four years in the 'secondary' stage and, upon a satisfactory completion of their exams, are awarded a Kenya Certificate of Secondary Education (KCSE) and can move into higher education at a university. Since 2003, education in public schools has been free and compulsory at 'primary' level. Early Childhood Development and Education (ECDE) is available through NGOs, local authorities and private funding, although these can cost money and are not universally attended (World Data on Education, 2010-11). The Ministry of Gender, Children and Social Development is in charge of implementing adult education and literacy programs.

In 2002 the primary education curriculum underwent reforms intending to promote the teaching of, amongst other issues, gender equality. The implementation of this has not, however, been fully achieved for a variety of reasons (World Data on Education, 2010-11). Gendered division of labour, early marriage and pregnancy, and negative/hostile learning environments affect girls' attendance and performance at school. General poverty is also a factor (Onsomu et al, 2005; Hungi and Thukub, 2010). See section on Education and FGM below.



Kenyan school ©28 Too Many

## RELIGION

Freedom of religion is guaranteed by Kenya's constitution and the government generally respects this freedom in practice. According to the Bureau of Democracy, Human Rights and Labor, approximately 80% of the Kenyan population is Christian; 58% being Protestant and 42% Roman Catholic (note that these figures differ from those cited above sourced from the World Factbook). Christianity was introduced to Kenya in the fifteenth century by the Portuguese, and Christian contact was subsequently revived and flourished at the end of the nineteenth century. Today there are a number of syncretic faiths, which borrow from Christian and indigenous African religious practices, as well as a number of independent churches. Between 1-2% of the population adheres to indigenous faiths, or are Hindus, Sikhs, Baha'is, Jews or Jains. Faith-based NGOs and Christian missionaries are heavily involved with early childhood education, medical care and community-wide events. In particular, inter-faith organisations are noted for working together to combat social issues like HIV/AIDS. See section on Religion and FGM below.

Around 10% of the population is Muslim and there are provisions in the 2010 constitution to provide for Islamic law Kadhis' courts, though the secular High Court has overall jurisdiction. Recently there has been religious and ethnic tensions related to government military action relating to the Somali terrorist group al-Shabaab's attacks in Kenya. Some Muslims, including ethnic Somalis, have accused the government of profiling and targeting Islamic NGOs. There have been reports of discrimination and societal abuses against Muslims by Christian community leaders and, conversely, Christian discrimination in historically Muslim areas of the country (International Religious Freedom Report, 2011).

Witchcraft remains an influential aspect of indigenous cultures in Kenya, though it is a criminal offence. In 2011, there were multiple reports from the Kisii and Kuria districts and Nyanza, Coast and

Western provinces of abuse and killings of persons suspected of practicing witchcraft, however these incidents were often motivated by neighbour or family disputes (International Religious Freedom Report, 2011).

## MEDIA

### PRESS FREEDOM

- Media in Kenya is regulated by the Media Council of Kenya. In 2008, the government passed the ICT Bill, or ‘Media Act’, which regulates media and the conduct of journalists and imposes heavy fines and prison sentences for press offences. The ICT Bill gives the government authority over the issuing of broadcast licences; it handles media complaints and has been known to invoke restrictions on journalists reporting on politically centred court cases. Reporters Without Borders ranked Kenya 84th out of 179 countries in its 2012 global Press Freedom Index.
- The Internet is widely used Kenya and there are no restrictions on the freedom of communicating news and other information.
- According to the Committee to Protect Journalists (CJP), one journalist has been killed in Kenya since 1992. Every year there are reports of threats of violence against journalists in Kenya and many threats have been followed by direct attacks.
- In the on-going crisis in East Africa, Somali journalists have become refugees, forced into exile due to threats of violence. Many of these journalists have sought refuge in Kenya.

## MAIN NEWSPAPERS IN KENYA

### DAILIES (MAINLY PUBLISHED IN NAIROBI):

*Daily Nation, The Standard, The Star, East African, Financial Standard, Taifa Leo.*

### WEEKLIES:

*Coastweek (published in Mombassa), African Science News Service (internet only)*

## TRENDS IN MEDIA

- Nation Media Group has a monopoly in media.
- The Kenya Broadcasting Corporation is state run and is the main source for TV and radio.
- TV is the main news source in cities and towns, while radio is the main medium in rural areas (for the majority of Kenyans).
- Social media is popular, with many Kenyans preferring to use Facebook over email for communicating.

## FGM PRACTICES IN KENYA

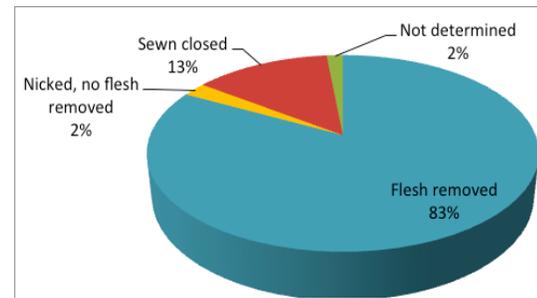
### TYPE OF FGM

#### PREVALENCE OF FGM IN KENYA BY TYPE %

The most prevalent type of FGM practised within Kenya is 'flesh removed' (Types I and II). The Kisii and Kikuyu ethnic groups practise Type I clitoridectomy, the Maasai and Meru practise Type II excision, and the Somali, Borana, Rendille and Samburu Type III infibulations. There is a trend to cut less flesh. For example, among Somali women there was a reported decline in the severity of the cut among younger girls (Population Council 2007) and a similar trend was also observed among the Abagusii, where there has been an increasing trend to carry out a symbolic pricking or nicking

of the clitoris, mostly carried out by medical professionals (Population Council 2004).

The following data from the DHS 2008-09 shows the prevalence of FGM by type of FGM performed, as a total and according to other characteristics, and by practitioner.



Total prevalence of FGM by type (DHS, 2008-09)

Province	Type				
	% Women cut	Flesh removed	Nicked, no flesh removed	Sewn closed	Not determined
Nairobi	13.8	70.8	17.1	12.0	0.1
Central	26.5	75.6	2.0	17.2	5.2
Coast	10.0	49.4	2.4	34.9	13.3
Eastern	35.8	88.6	0.9	8.5	2.0
Nyanza	33.8	98.0	0.1	1.9	0.0
Rift Valley	32.1	93.1	2.3	3.9	0.6
Western	0.8	*	*	*	*
North Eastern	97.5	14.2	2.8	82.5	0.5

Prevalence of FGM by type and province (DHS, 2008-09)

	Traditional circum-ciser	Traditional birth attendant	Health professional	Don't know/missing
1998	50.3	11.9	34.4	3.3
2003			46.0	
2008-09	74.7	3.4	19.7	2.2

Prevalence of FGM by type of practitioner (DHS, 2008-09)

A traditional practitioner could be a community wise woman, herbal woman, or a nomadic cutter who comes in to the community once a season. These women normally have high social status.

### MEDICALISATION OF FGM

The medicalisation of FGM has grown in Kenya in recent years. Despite being illegal this means that the procedure takes place in a hospital or

clinic and is done by medical professionals using surgical instruments and anesthetics. In a 2003 survey, 46% of Kenyan daughters underwent FGM via medicalisation, meaning the majority of girls are still cut by traditional practitioners, but that the rates FGM performed via medicalisation increased. The increased medicalisation of FGM was also confirmed by a study by the Population Council of the Abagusii in Nyanza Province, as well

as by PATH and MYWO. Among the Abagussi, FGM has become a popular means of additional income for nurses and midwives (Population Council, 2004). According to the 2008-09 figures, however, this trend appears to have been reversed.

Although medicalisation decreases the negative health effects of the procedure, this has led to a misconception that hospital/clinic FGM is a benign and acceptable form of the practice. According to UNICEF and other NGOs, medicalisation obscures the human rights issues surrounding FGM/C and prevents the development of effective and long-term solutions for ending it (UNICEF, 2005). Research has shown that changing the context of FGM or educating about the health consequences does not necessarily lessen the demand for it (Shell-Duncan et al, 2000). Furthermore, there is concern from older and more traditional members of communities that performing the surgery in a health facility with anaesthetic takes much of the

meaning out of the ritual (i.e., the need for the strength to endure the pain) (Christoffersen-Deb 2005).

The Ministry of Health Reference Manual for Health Service Providers developed in collaboration with the Population Council, contains recommendations to curb the sustained involvement of health personnel in the performance of FGM (Ministry of Health, undated).

### FGM BY ETHNICITY

Ethnicity appears to be the most determining influence over FGM within a country (UNICEF, 2005). The prevalence of FGM varies hugely within ethnic groups. The table below lists percentages pertaining to FGM by ethnicity and indicates knowledge of FGM, percentages of women who have been cut, and the type of circumcision.

Ethnicity % cut	Type of FGM (2008-09)						
	1998	2003	2008-09	Flesh re- moved	Nicked, no flesh removed	Sewn closed	Not deter- mined
Embu	52.4**	43.6	51.4	86.5	2.8	8.4	2.3
Kalenjin	62.2	48.1	40.4	92.6	2.5	4.4	0.5
Kamba	33.0	26.5	22.9	91.1	1.0	5.7	2.1
Kikuyu	42.5	34.0	21.4	80.7	5.0	11.3	3.0
Kisii	97.0	95.9	96.1	97.0	1.1	1.4	0.5
Luhya	1.6	0.7	0.2	*	*	*	*
Luo	1.2	0.7	0.1	*	*	*	*
Maasai	88.8	93.4	73.2	95.5	2.0	2.4	0.0
Meru	52.4**	42.4	39.7	97.7	0.0	2.2	0.1
Mijikenda/ Swahili	12.2	5.8	4.4	21.1	3.4	75.1	0.4
Somali	-	97.0	97.6	21.1	3.4	75.1	0.4
Taita/Taveta	-	62.1	32.2	44.2	0.0	19.4	36.4
Turkana	-	12.2	-	-	-	-	-
Kuria	-	(95.9)	-	-	-	-	-
Other	19.2	17.6	38.9	76.0	2.7	17.4	3.9

Prevalence of FGM by type and ethnicity (DHS, 1998, 2003, 2008-09)

\* denotes less than 25 cases, \*\* this figure was jointly given for Embu/Turkana, () are based on 25-49 unweighted cases

## **BORANA**

The Borana are a traditionally nomadic people residing in and around Isiolo, Tana River, Garissa, Moyale and Marsabit Districts. Although more and more Borana are choosing to be more permanently settled. The men's duty is to care for the cattle, while the women raise the children, build the houses and relocate the villages. The Borana perform FGM for religious reasons. Most Borana are Muslims, although some still practice the traditional religion which worships a supreme being known as Waqa.

## **EMBU**

The Embu are Bantu peoples closely related to the Kikuyu and the Mbeere. They are agricultural and mostly Christians and inhabit the Embu District, Eastern Province. For the Embu, FGM is part of a rite of passage to adulthood, and is usually done around the onset of puberty. It is estimated that 51.4% of Embu women have undergone FGM (DHS, 2009-9). One survey from 2008 reported that FGM prevalence in Embu women was highest in groups with low income and minimal education. When asked if the practice of FGM should continue, only 12.2% of women aged 15-49 years who knew of FGM said it should be continued. Moreover, it appears that attitudes towards FGM is generational in that for women aged 35-49, 16.9% had at least one daughter with a form of FGM, whereas for women aged 25-34 it was only 1.7%. Nearly 7% of women have had Type III infibulation whereas 91.9% had 'flesh removed' and 0.8% were nicked. (Embu Report, 2008).

## **KALENJIN**

The Kalenjin are a group of related Nilotic tribes which came under the single name 'Kalenjin' during the British colonial era. They live in the highlands of the Rift Valley and are mostly Christian. They live in highly patriarchal family structures and are famous for their running ability. Women who have not been cut are seen as promiscuous, immoral and imitators of Western culture (Cheserem, 2010). It is estimated that approximately 40.4%

of Kalenjin women have undergone FGM (DHS, 2008-09).

## **KAMBA**

The Kamba are Central Bantu people who are agriculturalists, and they inhabit areas in south-central Kenya, Machakos and Kitui Districts. Their languages are Kamba and Swahili and approximately 60% are Christian, 39% traditional religion, and 1% Muslim. The Kamba culture is most noted for its highly athletic traditional dance (Immigration and Refugee Board of Canada, 1998). It is estimated that approximately 23% of Kamba women have undergone FGM (DHS, 2008-09).

## **KIKUYU**

The largest ethnic group in Kenya is the Kikuyu from the Bantu group, and they comprise approximately one fifth of the total population. Despite their large population, the Kikuyu own little land, and are concentrated in a small central region around Mount Kenya. They are heavily involved in the infrastructure of the country. It is estimated that approximately 21.4% of Kikuyu women have undergone FGM (DHS, 2008-09). The most common type of cutting by a large majority (over 80%) within the Kikuyu is 'flesh removed' (DHS, 2008-09) or clitoridectomy (Population Council, 2007). Concern exists around the banned Kikuyu sect the Mungiki, a large, violent, political organisation which actively rejects all Western influence. They are known to force women to undergo FGM, in particular, the wives, partners, children and other female family members of those men who have taken the Mungiki oath (UK Border Agency, 2008).

## **KISII**

The second highest prevalence of FGM (at 96.1%) is found in the Kisii, who are also known as the Abagusii or just the Gusii (DHS, 2008-09). The Kisii inhabit Kisii and Nyamira Districts in Nyanza Province, Western Kenya. These Bantu peoples have fertile lands and are considered one of the more economically active groups in Kenya. Over

the past two decades the Kisii have focused on schooling their children and are relatively well educated, making the sustained presence of FGM unusual. They are historically farmers but many live in urban areas. A significant minority (up to 20%, exact data unclear) still practice a monotheistic religion that pre-dates colonialism and the arrival of missionaries. The majority (around 80%) are Christian, with influences from traditional indigenous religion remaining. FGM continues because of tradition and a sense of community, particularly as it distinguishes minority Kisii from their historically hostile neighbours the Luo, who do not practice it. FGM is stated as a necessity to be marriageable, to gain the respect, to control sexual desires before marriage and ensure fidelity (especially within polygamous marriages) and that it is fundamental to cleanliness and hygiene. Cutting was done with celebration, but has recently become secretive due to prohibition of FGM under law. Traditionally FGM was performed from 15 years in preparation for marriage but it now typically performed on girls aged 8-10 years. The most common form of FGM is Type I. (Population Council, 2004 and 2007).

**KURIA**

The Kuria are mainly agriculturists and live in the west and east districts of Nyanza Province in south-west Kenya. They are closely related to the Kisii people. FGM is performed on girls around the age of puberty (Feed the Minds, 2010) to curb their sexual desires and make them faithful wives; parents of girls are keen to have their daughters undergo FGM to increase their dowry. The dominant religion practised by the Kuria is non-

denominational Christianity.

**LUHYA**

FGM is rarely practiced by this ethnic group.

**LUO**

FGM is rarely practiced by this ethnic group.

**MAASAI**

The Maasai are semi-nomadic, pastoral Nilotic peoples. They are cattle herders however environmental stresses and the fall-out from intrusive colonial initiatives have meant their traditional way of life has had to be adjusted. Attempts by governments and NGOs to convince them to abandon their lifestyle and settle in one place have been met with fierce resistance and no success (IRIN, 2005). In Maasai culture there is a legend that a girl called Napei once had intercourse with an enemy. To punish her and suppress her sexual desire, Napei was subjected to FGM. FGM takes place once a year for all girls in the appropriate age group, usually between the ages of 12 and 14 (prior to marriage), and the celebration is an important rite of passage into womanhood. The procedure is often done during school holidays and also involves having their hair shaved as part of the womanhood ritual (Equality Now, 2011). FGM is performed by the Massai to mark a girl's transition to womanhood and readiness for marriage, as well as to gain the community's respect, ensure sexual purity and chastity and be taught the ways of the community (Coexist, 2012). The most common type of cutting in the Maasai is Type II excision (Population

Maasai community © 28 Too Many



Council, 2007). Although the Maasai are proud of their culture and are typically deliberately resistant to outside influence, they have shown willingness to adjust their practices, including using a different blade for each girl to minimise infection (IRIN, 2005). There has been a slight but encouraging reduction in FGM prevalence rates, decreasing from 93.4% to 73.2% (DHS, 2003 and 2008-09).

### **MERU**

The Meru are Bantu people. They live in central Kenya around Mount Kenya. The Meru language is closely related to that of the Kikuyu and Embu tribes, and the three have historically been aligned. They are predominantly Christian and missionary schools have contributed to their education. Meru groups have strict patriarchal societies that are both age and gender-segregated, and male and female circumcision is related to adulthood and marriage rituals. It is estimated that approximately 39.7% of Meru women have undergone FGM (DHS, 2008-09). The most common type of cutting among the Meru is Type II excision (Population Council, 2007). On 29th August 2009, the Njuri Ncheke Supreme Council of Elders (the highest tier in Meru society) publically condemned FGM, introduced fines on communities found practising it, and vowed to use their power to influence change. A signed declaration of their commitment was given to a minister from the Ministry of Gender, Children and Social Development. However, the Maendeleo ya Wanawake organisation has challenged the Njuri Ncheke council of elders to step up its sensitisation programme saying that the declarations effects were yet to be felt at the grassroots (FGM Network, 2011).

### **POKOT**

The Pokot are split into two groups, around half are semi-nomadic, semi-pastoralists and lowlands west and north of Kapenguria and throughout Kacheliba Division and Nginyang Division, Baringo District, the other half are agriculturists and live wherever conditions allow farming. The Pokot have a tense relationship with neighbouring Turkana

people which is fraught with conflict. Social status in the Pokot tribe is associated with age sets; progression through the age sets is determined by certain initiation rituals, including FGM around the age of 12 for girls. Around 85% of Pokot still follow their traditional religion which involves animal sacrifice and sees the sky (Yim) as God. The remaining 15% are thought to be Christians.

### **RENDILLE**

Originating in Ethiopia, the Rendille migrated to the area between the Marsabit hills and Lake Turkana in North Kenya after constant conflict with the Oromo tribe. Social status for men is based on a well defined system of age sets, initiation ceremonies symbolise the transition between age sets and take place every 7 to 14 years. Women's status is much simpler as they are either married women or unmarried girls. FGM is sometimes performed the morning of the wedding and symbolises the girl's transition into womanhood. The Rendille practice Type III infibulation (Population Council) although other commentators report the less severe Type I (Shell-Duncan, 2001). Men often 'book' girls they wish to marry at a very young age, the marriage often takes place when the girl is around 10-12 years old.

### **SAMBURU**

The Samburu are semi-nomadic pastoralists who live in the Rift Valley province; they are closely related to the Maasai. The Samburu people have a tempestuous relationship with the police, there has been alleged violence from both sides, with Samburu people claiming to have been abused, beaten and raped by police over land disputes and deadly attacks on the police being blamed on the Samburu. The Samburu traditionally live in groups of five to ten families, the men's roles are to take care of cattle and protect the rest of the tribe, the women are expected to gather vegetation, collect water, raise the children and keep the homes clean. FGM is considered a passage into womanhood and is usually performed on girls as young as 12 in preparation for marriage. They

practice Type III infibulation (Population Council, 2007). The Samburu traditionally worship a God named Nkai/Ngai though many modern Samburu are Christians or Muslims.

**SOMALI**

The Somali are Eastern Cushites originating from Somalia and have inhabited Kenya for around two hundred years. They live in the North Eastern Province, and are mostly Muslim herdsman. 97.7% of all the women have undergone FGM, with 75% having undergone Type III FGM (infibulation) (DHS, 2008-09). The tradition of FGM was brought from Somalia. For Kenyan Somalis, tradition is cited as the strongest factor for the perpetuation of FGM, with cultural values around virginity and marriageability a close second, and belief that it is a necessary procedure to be a proper Muslim woman is the third reason. It is believed that an uncut girl will be sexually promiscuous and unsuitable as a wife, bringing shame to the family. Cutting is enforced via peer pressure amongst young girls at school and by social stigma, and it is usually carried out by traditional practitioners (Population Council, 2005). Girls in the North Eastern region (the Somalis) are typically circumcised at a young age, with two thirds being cut between the ages of 3 and 7 (DHS, 2008-09).

**SWAHILI**

FGM is not widely practiced in this ethnic group.

**TAITA/TAVETA**

The Taita are Bantu people who inhabit the Taita-Taveta District in Coast Province and they historically migrated to Kenya from Tanzania. The Taita people have many dialects and are noted for their sacred Mbanga cave burials. The Taveta are Bantu people who live between the Tsavo National Park and the Tanzanian border up the slopes of Mount Kilimanjaro. They are mostly Christian, although approximately 10% are Muslim. It is estimated that 32.3% of Taita/Taveta women have undergone FGM (DHS 2008-09).

**TURKANA**

The Turkhana are a nomadic, pastoral people inhabiting semi Desert Turkana District in the Rift Valley province of Kenya, where they migrated to from Eastern Uganda. With a population of around 250,000 people, the Turkhana are the second largest pastoral community in Kenya. They rely heavily on their livestock for both food and income, as do many other tribes in the area, this often leads to tribal conflicts and cattle rustling, with the increase of small arms this has become more dangerous and the Kenyan government has had to intervene. The DHS 2003 states that 12.2% of Turkana have undergone FGM although there is no data for the Turkana in the most recent DHS of 2008-09. They practise Type III infibulation (Brockman, 2004).



Turkana mother and child © 28 Too Many

**REFUGEE POPULATIONS**

Kenya hosts over 240,000 refugees, from Sudan, Somalia, Ethiopia and Eritrea with these groups practising Type II excision or Type III infibulation (Population Council 2007). This figure has increased and in Dadaab refugee camp in the North East Region, the world's largest refugee camp, there are estimated to be over 500,000 refugees (UNHCR, 2012).

## REASONS FOR PRACTISING FGM

FGM is a sociocultural tradition, often enforced by community pressure and the threat of stigma. Although every community in which FGM is found in Kenya has different specifics around the practice, there are several unifying rationales/beliefs. FGM is considered necessary for a girl to become a woman. It is often done as part of an initiation into womanhood ritual. FGM is claimed to preserve a girl's virginity and protects her from promiscuity and immoral behavior. For some ethnic groups, an uncut girl is considered to be sexually promiscuous and not marriageable. Finally, FGM is associated with sexuality and the aesthetic appearance of the female body; uncut genitalia can be considered unclean or too masculine.

For some ethnic groups, such as the Embu, Kalenjin, Maasai and Meru, FGM is considered a rite of passage and necessary for a girl to go through in order to become a responsible member of society. Girls who have not undergone FGM are often stigmatised. There is a strong link between FGM and marriageability, especially among the Massai and Samburu, with ability to attract a higher bride price for a girl who has been cut being significant for the latter.

FGM is often motivated by beliefs about what is considered appropriate sexual behaviour, with some communities considering that it ensures and preserves virginity, marital faithfulness and prevents promiscuity/prostitution. This is true among the Somali, where having FGM is seen to preserve a family's honour through the preservation of girls' virginity and chastity. The Kisii believe that FGM will control a girl's sexual desires and ensure marital fidelity, especially within polygamous marriages.

Sometimes FGM is performed by communities as a religious requirement. This is true of the Somali, Borana, Orma and Boni, who believe FGM constitutes an Islamic requirement.

FGM is perhaps first and foremost a deeply

rooted cultural practice, with tradition being a powerful driver. (Population Council, 2004 and 2007).

## RELIGION AND FGM

	Muslim	Protes- tant	Roman Catholic	None
1998	28.3	35.9	44.2	38.1
2003	49.6	29.5	33.2	39.6
2008	51.4	23.5	29.1	38.3

### Prevalence of FGM by religion (%) (DHS 2008-09)

Province	Percentage who believe FGM is required by their religion
Nairobi	4.3
Central	3.6
Coast	5.8
Eastern	5.0
Nyanza	13.5
Rift Valley	4.1
Western	0.8
North Eastern	86.5

### Belief that FGM is a religious requirement (DHS 2008-09)

In Kenya, the role of religion in the practice of FGM is complex, and often intersects with ethnicity. Of the women surveyed in one study, only 7% felt that FGM is required by their religion. Those who were already circumcised were more likely to believe it is required by their religion (DHS, 2008-09). Of the two ethnic groups with the highest percentage of women circumcised, one (the Somali peoples) is predominantly Muslim and the other (the Kisii) is predominantly Christian. The proportion of women in the North Eastern province (home of the Somalis who practice near universal FGM who believe cutting is required by Islam is extremely high, at 86.5% (DHS, 2008-09). This, in part, explains the resistance to ending FGM in some groups (Population Council, 2009). The percentage of Muslim women circumcised (44.4%) is nearly double to that of Christian women (17.7%). However, the same survey suggests that more Christian women (26%) are in favour of continuing FGM than Muslim women

(15%). Religious groups and officials are involved in the eradication of FGM. In general, there is some preliminary evidence that taking a religion-based approach in such communities may be a more successful technique than traditional strategies (Population Council 2009).

## WOMEN'S HEALTH AND INFANT MORTALITY

There are numerous health concerns associated with FGM. Immediate complications can include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue. Long-term consequences can include recurrent bladder and urinary tract infections; cysts; infertility; an increased risk of childbirth complications and newborn deaths; the need for later surgeries. For example, Type III infibulation needs to be cut open later to allow for sexual intercourse and childbirth. (WHO, 2013). A study of 1,222 women in four Kenyan districts indicated that 48.5% of the women experienced haemorrhage, 23.9% infection, and 19.4% urine retention at the time of the FGM operation (MYWO, 1993). There are reports that women who have undergone FGM have reduced sexual desire, pain during intercourse, and less sexual satisfaction (Berg and Denison, 2011). In relation to psychological issues surrounding FGM data suggests that following FGM, women were more likely to experience psychological disturbances (have a psychiatric diagnosis, suffer from anxiety, somatisation, phobia, and low self-esteem) (Berg and Denison, 2010). More research is needed to understand better the relationship between FGM and consequential psychological, social and sexual problems (Berg and Denison, 2011).

In relation to the increased risk of birth complications, a WHO multi-country study, in which over 28,000 women participated, confirmed that women who had undergone FGM had a significantly increased risk of adverse events during childbirth. Higher incidences of caesarean section and post-partum haemorrhage were found

in the women with Type I, II and III FGM compared to uncut women and the risk increased with the severity of the procedure. The consequences for women not giving birth in a hospital setting are likely to be even more severe. (WHO, 2006). The high incidence of postpartum haemorrhage is particularly concerning where health services are poor or inaccessible. (WHO, 2008).

The WHO also showed that death rates among newborn babies are higher to mothers who have had FGM. There was an increased need to resuscitate babies whose mothers had had FGM (66 per cent higher in women with Type III). The death rate among babies during and immediately after birth was also much higher for those born to mothers with FGM: 15 per cent higher in those with Type I; 32 per cent higher in those with Type II; and 55 per cent higher in those with Type III. The study estimated that FGM leads to an extra 1 to 2 perinatal deaths per 100 deliveries (WHO, 2006).

Another WHO-sponsored study is examining the association between FGM and obstetric fistulae. The pilot study indicated that there may be an association but the final results are not expected until the end of 2013. In addition, a multi-country modelling study was set up to estimate the increased costs in obstetric care due to increased obstetric complications as a result of FGM. The annual costs was estimated to be US\$ 3.7 million and ranged from 0.1 to 1% of government spending on health for women aged 15-45 years. (WHO, 2011)

## EDUCATION AND FGM

In many cases, FGM has a negative impact on a girl's education. Girls are taken out of school to be cut and the healing time takes several weeks, resulting in further school absence. Moreover, as FGM is considered by many groups to be a rite of passage into womanhood, it is likely that a girl's education will end in order for her to be married. Moreover, studies have shown that education influences perceptions of FGM and that

educated women are more aware of the health consequences. There is, therefore, a general correlation that the higher a woman's education level is, the less likely she is to be in favour of FGM (Population Reference Bureau, 2001).

No education	Primary incomplete	Primary complete	Secondary +
53.7	28.8	26.4	19.1

**Prevalence of FGM by education (% women aged 15-49) (DHS 2008-09)**

## AGE

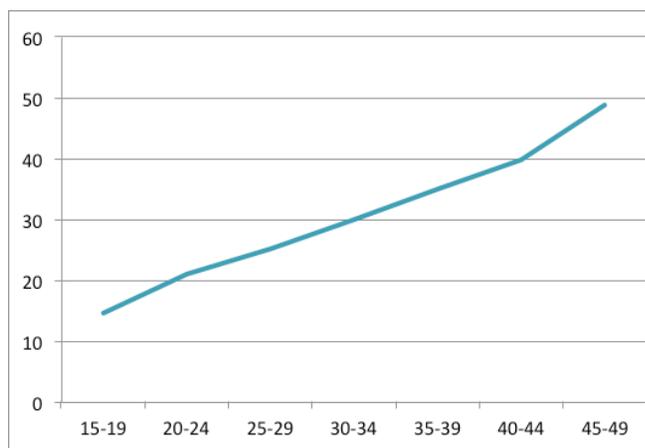
In Kenya, FGM is performed most often on girls and young women, with the majority of girls being cut between the ages of 12 and 18. Other studies have shown girls are now being cut at earlier ages with girls being cut between the ages of 7 and 12. It is thought that the decrease in age is to avoid detection in response to legislation banning the practice. Another factor for why FGM is performed on young girls is that they are dependent and less aware of the health implications of FGM. The proportion of women circumcised increases with age, indicating a gradual decline in popularity of the procedure in younger generations (DHS,

	Total	15-19	20-24	25-29	30-34	35-39	40-44	45-49
<b>1998</b>	37.6	26.0	32.2	40.4	40.9	49.3	47.4	47.5
<b>2003</b>	32.2	20.3	24.8	33.0	38.1	39.7	47.5	47.7
<b>2008-09</b>	27.1	14.6	21.1	25.3	30.0	35.1	39.8	48.8

**Prevalence of FGM in women and girls by age (%) (UNICEF 2005; DHS 1998, 2003, 2008-09)**

Age	Percentage of women who have heard of FGM	Percentage of women who have had FGM
<b>15-19</b>	93.3	14.6
<b>20-24</b>	96.2	21.1
<b>25-29</b>	97.1	25.3
<b>30-34</b>	96.9	30.0
<b>35-39</b>	96.8	35.1
<b>40-44</b>	97.4	39.8
<b>45-49</b>	96.9	48.8

**Knowledge and prevalence of FGM by age (%) (DHS 2008-09)**



**Prevalence of FGM by age (%) (DHS 2008-09)**

2008-09). With increased education and anti-FGM initiatives, girls are less inclined to undergo the procedure. (UNICEF 2005 and UNICEF 2010).

In communities where FGM is performed as a rite of passage into adulthood (e.g. the Meru and Embu), girls are cut around the age of puberty. In communities where FGM is carried out to demonstrate marriageability (e.g. the Maasai and Samburu) girls undergo FGM after puberty. In other communities, girls aged 6-10 years undergo FGM (e.g. Somali, Kisii, Borana) and the Taita perform FGM on infants (Population Council 2007).

## PUBLIC ATTITUDES TO FGM

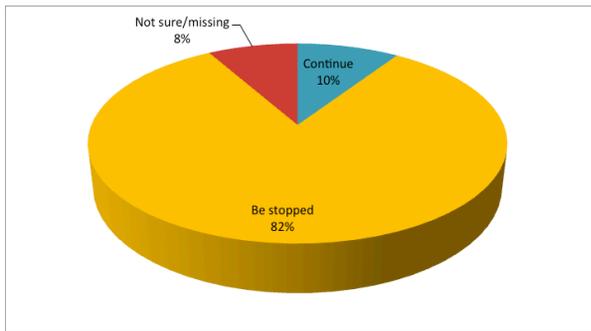
There are conflicting reports on the perception of FGM amongst women. In one report, 42% of women surveyed believe FGM is a good tradition (UNICEF, 2005). In contrast, another survey stated that most women in Kenya aged 15-49 have heard of female circumcision (96%), and the majority believe that the practice should be stopped (82%) (DHS 2008-9). Among women who have been cut, 59% say they do not see any benefit to the practice (DHS 2008-9). However, in the North Eastern province most women defend FGM (Somalis), with 90% supporting its continuation, compared to 9% overall (DHS 2008-09). Men's attitudes seem to be changing with there being an increasing trend among young men to publicly announce their preference to marry uncut girls (UNFPA/UNICEF, 2011). One study among the Massai found that a significant proportion of unmarried boys (46%) had a preference for uncut girls or stated that a girl's circumcision status did not matter, compared to 68% of all respondents stating that they wanted FGM to continue (Coexist, 2012).

Perceived benefit of FGM	Women who have had FGM	Women who have not had FGM
<b>No benefits</b>	58.6	89.1
Cleanliness/hygiene	6.9	0.8
Social acceptance	23.7	1.9
Better marriage prospects	8.7	0.8
Preserve virginity/prevent premarital sex	15.6	1.5
More sexual pleasure for the man	2.4	0.4
Religious approval	5.3	0.3
Reduce promiscuity/reduce sex drive	3.7	0.3
Reduce STD and HIV/AIDS	0.1	0.6
Other	31.8	18.9

Women who cite benefits that girls get if they are circumcised according to circumcision status (%) (DHS 2008-09)

Background characteristic	Distribution by whether practice should be continued or stopped		
	Continue	Be stopped	Not sure/missing
<b>Age</b>			
15-19	8.8	80.0	11.3
20-24	9.9	82.7	7.5
25-29	9.9	82.7	7.4
30-34	8.4	85.0	6.6
35-39	9.8	82.0	8.2
40-44	9.6	82.7	7.6
45-49	10.0	81.3	8.8
<b>Residence</b>			
Urban	7.6	85.9	6.4
Rural	10.0	81.0	8.9
<b>Province</b>			
Nairobi	5.7	88.5	5.8
Central	5.2	91.8	3.0
Coast	4.0	74.1	21.0
Eastern	9.0	87.7	3.2
Nyanza	16.7	66.4	16.9
Rift Valley	6.4	87.7	5.8
Western	1.6	90.5	7.9
North Eastern	89.8	7.3	2.9
<b>Education</b>			
No education	33.9	47.6	18.5
Primary incomplete	8.1	79.8	12.0
Primary complete	6.7	86.8	6.6
Secondary +	6.3	89.9	3.7
<b>Circumcision status</b>			
Circumcised	28.9	67.5	3.6
Uncircumcised	2.2	87.8	10.1
<b>Wealth quintile</b>			
Lowest	17.6	67.0	15.4
Second	9.4	82.0	8.5
Middle	9.3	83.5	7.3
Fourth	6.6	86.3	7.2
Highest	6.6	88.0	5.3
Total	9.4	82.3	8.3

Percentage of women who believe FGM should be continued or stopped (%) (DHS 2008-09)



**Percentage of women who believe FGM should be continued or stopped (%) (DHS 2008-09)**

## HIV/AIDS AND FGM

The 2011 Human Rights Report stated the following concerning HIV/AIDS: ‘Societal discrimination against persons with HIV/AIDS was a problem. Stigmatisation of HIV/AIDS made it difficult for many families to acknowledge that a member was HIV-positive, and no socially or politically prominent individual admitted being HIV-positive. Violence against persons with HIV/AIDS occurred.’

The link between HIV and FGM is a complex and contested issue amongst researchers. The WHO multi-country study found that although no studies link HIV/AIDS and FGM directly, haemorrhaging subsequent to the operation, bleeding during sexual intercourse as a result of lasting damage to the genital area and anal intercourse where infibulations prevent or impede vaginal intercourse are all potential sources of HIV transmission (WHO, 2006). Using data from the DHS 2003 report on FGM in Kenya, one study suggested that circumcised male and female virgins were substantially more likely to be HIV infected than uncircumcised virgins. The authors concluded that HIV transmission may occur through circumcision-related blood exposure (Brewer et al., 2007).

A further study reported that a plausible mechanism of HIV transmission for females was through the use of a non-sterilized ceremonial knife on several girls, where one of the girls was infected with HIV through a non-sexual mechanism before undergoing FGM (Pépin et al., 2006). However, the correlation between HIV and FGM is not as direct as some research has previously claimed. Some

research suggests that there is an indirect, rather than direct, association between HIV and FGM through a number of different pathways. These pathways could include a first sexual experience at a young age, divorce and being widowed, and whether or not the woman engages in risky sexual activity (Yount & Abraham, 2007).

A more recent study therefore argues that there is a behavioural pathway of association between HIV and FGM, and there is a complex interplay of bio-behavioral and social variables that are important for disentangling the association of HIV with FGM. Their study found that girls with FGM and young first time partners had a higher risk for HIV than girls without FGM. Yet, in girls with FGM and older first time partners had lower odds of having HIV than those without FGM (Maslovskaya et al., 2009). Although it is important that communities and girls are educated on the dangers of HIV and FGM, including sharing contaminated tools and post-procedure infections, this does not mean that FGM will always result in HIV. Anti-FGM activists need to be aware of the complex cultural issues surrounding both HIV/AIDS and FGM and tailor their programmes appropriately.

## LAWS RELATING TO FGM

### INTERNATIONAL & REGIONAL TREATIES

Kenya has signed several international human rights conventions, which provide a strong basis for the characterisation of FGM as a violation of international human rights:

- Convention on the Elimination of Discrimination Against Women (CEDAW)
- Convention on the Rights of the Child (CRC)
- International Covenant on Economic, Social and Cultural Rights (ICESR)
- African Charter on the Rights and Welfare of the Child.
- Maputo Protocol to the African Charter on Human and Peoples’ Rights on the Rights of the Women in Africa (the ‘Maputo Protocol’).
- African Charter on Human and People’s Rights (the ‘Banjul Charter’).
- The African Union declared the years from 2010 to 2020 to be the Decade for African Women and Kenya is expected to continue its commitment to promote and protect the rights of women.
- In December 2012, the UN passed an historic resolution, calling on countries to eliminate FGM, and in 2013 the 57th UN Convention on the Status of Women’s agreed conclusions included a reference to the need of states to develop policies and programmes to eliminate FGM as well as other forms of violence against women (UN, 2012).

The CEDAW and the CRC clearly prohibit traditional practices that discriminate against women and harm children. Article 2 of CEDAW directs ‘State Parties...(f) To take all appropriate measures, customs and practices which constitute discrimination against women.’ Additionally, Article 5 states, ‘State Parties shall take all

appropriate measures: (a) to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes...’. Article 24(3) of the CRC states that, ‘State Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children’. In addition, Article 19(1) provides that ‘State Parties shall take all appropriate legislative, administrative, social, and educational measures to protect the child from all forms of physical or mental violence, injury, or abuse’. Kenya therefore has a responsibility under CEDAW and CRC to prevent harmful practices such as FGM.

Under the ICESCR, FGM is a violation of the right to health. Article 12(2) provides that ‘[t]he steps to be taken by State Parties to the present Covenant to achieve the full realization of [the right to health] shall include those necessary for: (a) The provision for...healthy development of the child’. ‘Health’ is defined so as to include ‘maturity, reproductive and sexual health’. FGM thus violates the convention due to the numerous health consequences, as discussed in the section Women’s Health and Infant Mortality above.

The African Charter on the Rights and Welfare of the Child requires members states of the African Union to abolish customs and practices harmful to the ‘welfare, dignity, normal growth and development of the child and in particular: (a) those customs and practices discriminatory to the child on the grounds of sex or other status’.

The Maputo Protocol explicitly refers to FGM. Under Article 5, ‘state parties shall prohibit and condemn...through legislative measures backed by sanctions, (b) all forms of female genital mutilation, scarification and para-medicalisation of female genital mutilation and all other practices in order to eradicate them’.

The Banjul Charter includes provisions related

to the right to health (Article 16), right to physical integrity (Articles 4 and 5).

Unless otherwise stated, all references in this sub-section are to Mgbako et al, 2010.

## NATIONAL LAWS

### AGE OF SUFFRAGE, CONSENT AND MARRIAGE

In Kenya, the age of suffrage is 18 and the age of consent is 16. The minimum age for marriage is 18, and the Children's Act of 2001 forbids early or forced marriage, however many marriages are not officially registered, or are performed under customary or Islamic law, which have no age restriction.

### HISTORIC POSITION

Historically, there was little political will to outlaw FGM with Kenyatta, Kenya's first president, being a strong proponent of the practice, which he used as mobilising agent around cultural rights. In addition, historically, many MPs in the post-independence era have either chosen to be neutral or on the subject or have supported FGM in order to retain their political position (FIDA, 2009).

### 1ST ANTI-FGM ACT (2001)

Prior to the passing of Kenya's first anti-FGM legislation, then President Daniel arap Moi issued two presidential decrees banning FGM and prohibiting government-controlled hospitals and clinics from performing FGM (FIDA, 2009). In 1999 the Ministry of Health launched a National Plan of Action for the Elimination of Female Circumcision in Kenya was launched by the Ministry of Health in 1999 detailing the government's commitment to ending the practice. This was followed in 2001 by the passing of the Children's Act (which came into force in 2002) which made FGM illegal for girls under 18. The penalties under the act for anyone subjecting a child to FGM were 12 months' imprisonment and/or a fine of up to fifty thousand shillings (approximately US\$600). There were however few reported cases and there was widespread criticism that the Act offered

inadequate protection, did not apply to adult women, was poorly implemented and failed to curb FGM (Feed the Minds, 2010).

In terms of the effectiveness of the 2001 Act, FIDA found that communities (in Samburu and Garissa districts) were aware of the law and the protection it afforded to children at risk, but that as a result FGM was being done more in secret to avoid prosecution, and that cultural concerns and, in Muslim areas, religious beliefs had more weight than the fact that FGM was now illegal. In addition, those entrusted to enforce the Act conspire with perpetrators to defeat the cause of justice (FIDA, 2009).

### 2ND ANTI-FGM ACT (2011)

On 30 September 2011 the Prohibition of Female Genital Mutilation Act 2011 was passed by parliament and was signed into law on 6 October 2011. The Act was drafted by the Kenya Women's Parliamentary Association (KEWOPA) with support from the Parliamentary Council, the National FGM Secretariat and the UNFPA/UNICEF Joint Programme.

The Act criminalises all forms of FGM performed on anyone, regardless of age or status, and banned the stigmatizing of a woman who had not undergone FGM in an attempt to tackle social pressure. It also made it illegal to aid someone in performing FGM, taking them abroad to have the procedure done, failing to report to the authorities if the individual was aware it had taken place or carrying out FGM on a Kenyan abroad.

The punishment with this act is much more severe than the 2001 Act, and can apply to a wider range of perpetrators. The penalties include three-seven years' imprisonment, or life imprisonment for causing death by performing FGM and fines of nearly US\$6,000.

Under the National Policy for the Abandonment of FGM, capacity-building of those responsible for upholding the new law has taken place. In 2011, nearly 800 police officers, probation officers,

community leaders and others were trained to implement the new legislation.

The new law was praised by NGOs and others opposed to FGM, however FGM continues to be practiced widely, particularly in rural areas (Human Rights Report, 2011).

The University of Melbourne is publishing a Gender Equality Study at the end of 2013 which focuses on the effects of the anti-FGM law (28 Too Many in-country research).

To date, there have only been three successful prosecutions under the 2011 Act (Office of the Attorney General, Interview 2013).

Unless otherwise stated, all references in this sub-section are to UNFPA/UNICEF, 2011.

## INTERVENTIONS AND ATTEMPTS

### TO ERADICATE FGM

#### HISTORICAL OVERVIEW

Looking at the international picture, there were early attempts to persuade communities to abandon FGM, first by Christian missionaries and colonial authorities in the early 20th century and later by Western feminists in the 1960s and 1970s. These attempts were largely considered to be western imperialism and something imposed on communities by outsiders. The International Conference on Population and Development in 1994 and the Fourth World Conference on Women in Beijing in 1995 marked a turning point. FGM was now being discussed in terms of health and human rights and it was acknowledged that efforts to eradicate FGM needed to be locally-led initiative with the communities, health professionals and policy makers involved (Feed the Minds, 2010)

Efforts to stop FGM began in Kenya in the early 20th century, with Christian missionaries denouncing FGM as ‘barbaric’ and it was banned. However nationalist and cultural support for FGM dampened these initiatives and FGM became

a symbol of African tradition, with Kenya’s first President, Kenyatta, a strong proponent of the practice. During the UN Decade for Women in 1976 – 1985, the Kenyan government participated in a series of conferences and efforts to eradicate FGM were renewed. The movement to eradicate FGM continued with local partner, government ministries, national and international NGOs and the UN all involved. (UNICEF, 2010).

## GOVERNMENT POLICY

A National Action Plan for Accelerating the Abandonment of FGM/C in Kenya (2008-2012) was launched by the Ministry of Gender, Children and Social Development. The National Policy calls on the government to take concrete steps to promote the abandonment of FGM through legislation, public education and outreach programmes, advocacy, media coverage, the empowerment of women and access to reproductive health and other support services (UNFPA/UNICEF, 2007). The Ministry of Health has also published a Reference Manual for Health Service Providers on the management of complications of FGM (Ministry of Health, undated).

## OVERVIEW OF INTERVENTIONS

A broad range of interventions and strategies have been used by different types of organisations to eradicate FGM:

1. Health risk/harmful traditional practice approach
2. Addressing the health complications of FGM
3. Educating traditional FGM/C practitioners, offering alternative income
4. Alternative rites of passage
5. Religious-oriented approach
6. Legal approach
7. Human rights approach

8. Intergenerational dialogue
9. Promotion of girls' education to oppose FGM
10. Supporting girls escaping from FGM/child marriage
11. Media Influence

These interventions tend to be isolated and uncoordinated which makes assessing their impact difficult (Population Council, 2007).

**HEALTH RISK / HARMFUL TRADITIONAL PRACTICE APPROACH**

Strategies that include education about the negative consequences of FGM have been the most frequently used globally for the eradication of FGM, and is a common element of programmes within Kenya. Research has shown that this approach in itself is not sufficient to eradicate FGM and can have the negative consequences of encouraging the medicalisation of the FGM. (Population Council, 2007).

**ADDRESSING THE HEALTH COMPLICATIONS OF FGM**

As a response to health professionals being asked to re-infibulate women after childbirth among Somalis, the Population Council and others have implemented a training programme with the Ministry of Health in North Eastern Province to sensitise and train health care providers not to re-infibulate. (Population Council, 2007)

**EDUCATING TRADITIONAL FGM/C PRACTITIONERS AND OFFERING ALTERNATIVE INCOME**

Educating traditional practitioners about the health risks and providing them with alternative means of income as an incentive to stop practising FGM has not been as beneficial as expected. Although such a strategy may encourage some practitioners to stop, they have virtually no effect on the demand for FGM and circumcisers often

return to cutting (Population Council, 2007). 28 Too Many's in-country research, for example, found that in one programme run by Sentinelles in West Pokot, seeking to provide income generating activities for circumcisers was unsuccessful as it encouraged more women to become circumcisers in order to achieve financial assistance (28 Too Many in-country research, 2012).

**ALTERNATIVE RITES OF PASSAGE (ARPS)**

For those ethnic groups where FGM is part of a rite of passage initiating girls into adulthood, one approach that has shown some success in Alternative Rites of Passage (ARPs). ARPs substitute the cutting part of the ceremonies with alternative rituals that preserve the cultural traditions while eliminating the cutting. ARPs have been implemented with varying degrees of success. The success of APRs depends on the community practising FGM as part of a community ritual such as a rite of passage. In addition, ARPs will have limited impact unless they are accompanied by education which engages the whole community in collective reflection and leads to changes in the expectations of community members. Initiatives which engage only girls who are at risk of FGM rather than the entire community did not change the social norm and the community continued to practice FGM. (Population Council, 2007). These finding were also supported by research by UNICEF (UNICEF, 2010). Also supporting these conclusions are Feed the Minds who conducted research among the Kuria and Kisii, who found that ARPs had been successful in Kisii where residential ARP camps had been used in addition to girls empowerment programmes and intensive community awareness encouraging the local community to accept the ARP as an alternative to FGM. In Kuria, however, there had been a greater emphasis on rescuing girls at risk of FGM during the cutting season. Although the rescue camps were accompanied by girls' education and an ARP graduation ceremony, the local community did not fully accept the ARP. (Feed the Minds, 2010).

## RELIGIOUS ORIENTED APPROACH

A religious oriented approach refers to approaches which demonstrate that FGM is not compatible with the religion of a community and thereby lead to a change of attitude and behaviour. This has been used among both Muslim and Christian communities.

The Population Council has been developing a religious-oriented approach to work with the predominantly Muslim Somalis in the North Eastern Province (as part of the Frontiers in Reproductive Health Project). The purpose of this approach is to educate the community on the harm of FGM from a religious and medical perspective, to generate discussion in relation to the correct position of Islam on FGM and build consensus amongst religious scholars. The Population Council found that religious scholars are instrumental as they command respect and are opinion leaders. They are crucial in correcting misconceptions surrounding the Islamic position on FGM and can then educate the community. Community members expressed a willingness to listen to religious scholars who prescribed to a different view of FGM than what was commonly believed. Some religious leaders, scholars and community members openly declared their opposition to FGM and many more opposed FGM in private although they were unwilling to speak about the issue publicly. It is thought this technique will be far more successful than other interventions (such as Alternative Rites of Passage (ARPs)). The Population Council recommends continuing with religious clarifications, mainstreaming FGM in other development programmes, strengthening partnerships especially with Islamic Faith-based Organisations, targeting the whole community, especially youths and use of mass media. (Population Council, 2009).

A religious oriented approach has also been used within the Christian community, with the Seventh Day Adventist church run sensitisation programmes as to the health risks to churchgoers in Kisii, accompanied by the message that FGM

is against the Bible (28 Too Many, in-country research 2012).

The UNFPA/UNICEF report that in Kenya, 23 Muslim scholars and two Christian leaders made public declarations delinking FGM from religion (UNFPA/UNICEF, 2011).

## LEGAL APPROACH

Please refer to Laws relating to FGM above, under section on National Laws. Although legislation theoretically offers protection for girls and women and a deterrent to families and circumcisers, it can be difficult to enforce and does not in itself change beliefs and behaviour (Population Council, 2007). It is most effective when accompanied by awareness raising and community dialogue. If anti-FGM laws are introduced before society has changed its attitudes and beliefs or is not accompanied by the requisite social support, it may drive the practice underground, encourage people to cross the border to undergo FGM in a neighbouring country (UNICEF, 2005) and prevent people seeking medical treatment for health complications (WHO, 1999 quoted by Population Council, 2007). Commentary on Kenya's first anti-FGM law suggest that it forced the issue underground (FIDA, 2009).

As far as the Somali community is concerned, international, regional and national laws etc. are considered man-made, and are therefore superseded by beliefs in divine laws (Population Council, 2007).

## HUMAN RIGHTS APPROACH, INCLUDING PUBLIC DECLARATIONS

A human rights approach acknowledges that FGM is a violation of women's and girls' human rights. This approach is sometimes used alongside other strategies to eradicate FGM based on the social abandonment theory of FGM (derived from the social change theory behind foot-binding in China). The components of this theory include (i) a non-judgemental human rights approach; (ii) community awareness raising of the harmfulness

of the practice; (iii) a decision to abandon FGM that is a collective decision by the entire community; (iv) the requirement of community public affirmation of abandonment; (v) intercommunity diffusion of the decision and (vi) a supportive change-enabling environment, including the commitment of the government. This approach was pioneered by Tostan in Senegal. (UNICEF, 2005a).

The Fulda-Mosocho Project, launched in 2002 in Kisii and Nyanza, adopted a human rights approach. The project's aim was to create a safe environment that supports individuals to make their own decision to abandon FGM. The project engaged the whole community, and the participating NGOs built a communication and health centre. The project identified key local leader interested in community programmes addressing sexual and reproductive health and rights. They embarked on a three-and-a-half year programme covering sexual and reproductive health and rights, HIV and AIDS, hygiene, human rights, the effects of FGM as well as encouraging reflection on underlying gender structures. This was done in a non-judgmental manner and participants were encouraged to reach their own decision in a non-coercive environment. Over 200 teachers participated in the initial educational programme. Halfway through the programme the teachers decided to organise a large public event to celebrate the acceptance of 2,000 uncut girls as full members of Kisii community, culminating in a ceremony attended by 10,000 people. During the ceremonies girls were given certificates that are greatly prized. In 2005, nearly 50 former circumcisers publicly declared to stop practising FGM and founded an organisation called FOCUM to motivate others to abandon FGM. By 2009, evidence suggests that 16,500 at-risk girls had not been cut. (UNICEF, 2010).

Public declarations to abandon FGM have been made by the Pokot Council of Elders in 2011, which is significant given that the prevalence is especially high within the Pokot (the community concerned had a prevalence rate of 73%) (UNFPA/

UNICEF, 2011). In addition, in August 2009, the Njuri Ncheke Supreme Council of Ameru Elders condemned FGM and resolved to impose a fine on any community member on any Meru district (Eastern Province) found to have conducted or participated in FGM (UNICEF, 2010). In addition, a trend has been emerging of young men playing a role in increasingly speaking out publicly to announce their preference to marry women who have not undergone FGM (UNFPA/UNICEF, 2011).

### **INTERGENERATIONAL DIALOGUE**

This approach is based on the principle of listening and questioning between different generations, aided by a facilitator. It enables participants to reflect on their values, customs, traditions and expectations and to consider whether, when, how and under what conditions change should take place. This approach adopted by GIZ has had some success. (GIZ, 2011).

### **PROMOTION OF GIRLS' EDUCATION TO OPPOSE FGM**

There is a strong link between FGM and early marriage among some ethnic groups, such as the Maasai. Girls are cut prior to getting married and often drop out of school following being cut. This approach encourages the girls to remain in education and in some cases encourages them to speak out against FGM.

FAWE has adopted this approach. FAWE is a pan-African NGO working in 32 African countries to empower girls and women through gender-responsive education, founded in 1992 by five African women ministers of education. FAWE has developed the Centre of Excellence (COE) model through which ordinary schools are transformed into gender-responsive schools that offer quality education and pay attention to the physical, academic and social dimensions of girls' and boys' education. It aims to tackle those issues that prevent girls completing their schooling, including FGM. FAWE's Tuseme Youth Empowerment Program currently runs in two schools in Kenya: AIC Girls' Primary Kajiado, Kajiado District and

Athwana High School, incorporating raising awareness on sexual maturation and FGM. The programme runs a 'Let us speak out' project that allows girls to speak out against FGM using the medium of drama. There are also media programmes carrying out sensitization on FGM in the two areas. The Kajiado school also has a rescue centre for girls fleeing FGM. Both schools have experienced an increase in the retention rates for girls of over 90% as well as improvements in other indicators. (28 Too Many in-country research and FAWE website).

**SUPPORTING GIRLS ESCAPING FROM FGM/  
CHILD MARRIAGE**

Rescue centres which shelter girls who are running away from FGM and/or child marriage, particularly in communities where there is a strong link between FGM and child marriage. For example, Tareto Maa, in Kajiado district, a grass-roots organisation founded in 2007 by members of the local community ( Tareto meaning 'help' and Maa meaning 'Maasai' in the Maasai language) is a rescue centre although it is planning to expand its scope and adopt a wider community approach. When girls come to the rescue centre, they are registered with the police as being circumcised or uncircumcised. Meetings with the parents are then established to try to reunite the girl with her family. The parents are informed about the anti-FGM law and that, if at any time in the future their daughter is found to have undergone FGM, they will be liable to prosecution. They try to find a solution, working closely with the civil society in Kigoris, the local congregation of the African Inland Church and the local authorities. If no satisfactory solution can be found, the girl is admitted to the rescue centre. They also inform the public about child rights, child health and sexual and reproductive health. Members of the group go into schools as well as into community assemblies, and raise awareness on the effects of FGM and the importance of school education for girls. Tareto Maa takes care of the costs for food, clothes and education. As the majority of the population of Kajiado are Christian, the close

links with the church and assistance of pastors in meetings with parents have been found to be very useful. Tareto Maa's first alternative rites of passage (ARP) ceremony for girls in their care took place in December 2012. Tareto Maa has observed that people are beginning to rethink their attitudes to FGM (28 Too Many in-country research, 2012).

**MEDIA INFLUENCE**

In a 2011 report by the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting discussed their third goal concerning media campaigns and other forms of communication to spread the message of ending FGM. As a participating country, Kenya reportedly had 122 radio and/or TV programmes covering FGM. The Joint Programme continues to support the Kenya Media Network on Population and Development (KEMEP) to develop media coverage of the campaign to end FGM. Across most participating African countries, the use of press, television, radio, film, and social media is vital to educating the public on the dangers of FGM and increasing awareness of abandonment campaigns. (UNFPA/ UNICEF, 2011). In Kenya, radio was ranked as the second highest source of anti-FGM messages. (Chege et al., 2004).



Rescue home Tareto Maa, Kajiado District © 28 Too Many

## INTERNATIONAL ORGANISATIONS

Bilateral and multi-lateral agencies working against FGM include USAID, UNFPA/UNICEF, Programmes for Appropriate Technology in Health (PATH) and GTZ (from Germany). The Inter-African Committee on Traditional Practice (IAC) is also present in Kenya.

Please see Appendix for full list of organisations.

### USAID

The US government, via USAID, funded PATH to work with MYWO in introducing Alternative Rites of Passage for girls. In the 1990s they funded Womankind, an NGO working on women's issues, including FGM, and funded the Federation of Women's Groups of Nyamira that trains the community and develops ARPs. USAID also supports the DHS and conducts research via the Population Council. (Population Council, 2007)

### UNFPA/UNICEF

The UNFPA-UNICEF Joint Programme for ending FGM was founded in 2008 and has been extended to December 2013. The Joint Programme supported the NGO Women Empowerment Link (WEL) to conduct a training session for 31 primary school teachers on how to work with students and parents to prevent FGM. Similarly, they provided support to The Catholic Diocese of Nakuru to train 80 teachers in educating about FGM.

The UNFPA-UNICEF Joint Programme supported a forum of 32 Christian leaders in the Rift Valley region where they received training in human rights, FGM and FGM legislation.

The UNFPA-UNICEF group reported that there was a rise in public declarations of their commitment to abandon FGM, with 15 communities announcing their abandonment of FGM in 2011. There is an increase in young men speaking out publicly announcing their choice to marry uncut girls and women (UNFPA-UNICEF, 2011).

## POPULATION COUNCIL / FRONTIERS

The Population Council has also been developing a religious-oriented approach to work with the predominantly Muslim Somalis in the North Eastern Province (as part of the Frontiers in Reproductive Health Project). See discussion above on this approach.

## FORUM ADVOCACY WOMEN EDUCATIONALISTS (FAWE)

FAWE is a pan-African NGO working in 32 African countries to empower girls and women through gender-responsive education, founded in 1992 by five African women ministers of education. FAWE has developed the Centre of Excellence (COE) model through which ordinary schools are transformed into gender-responsive schools that offer quality education and pay attention to the physical, academic and social dimensions of girls' and boys' education. It aims to tackle those issues that prevent girls completing their schooling, including FGM. FAWE's Tuseme Youth Empowerment Program currently runs in two schools in Kenya: AIC Girls' Primary Kajiado, Kajiado District and Athwana High School, incorporating raising awareness on sexual maturation and FGM. The programme runs a 'Let us speak out' project that allows girls to speak out against FGM using the medium of drama. There are also media programmes carrying out sensitisation on FGM in the two areas. The Kajiado school also has a rescue centre for girls fleeing FGM. Both schools have experienced an increase in the retention rates for girls of over 90% as well as improvements in other indicators. (28 Too Many in-country research).

## WORLD VISION

World Vision is a Christian humanitarian organisation working in nearly 100 countries worldwide. The organisation is dedicated to working with children, families, and their communities worldwide to reach their full potential by tackling the causes of poverty and

injustice. They undertake anti-FGM programmes in Narok, Kajiado Central, West Pokot, East Pokot, Baringo and Naivasha. Methods include:

- Facilitating dialogue and non-judgmental discussions with the elderly, youth and children.
- Supporting Alternative Rights of Passage (ARP).
- Using role models or positive deviancy during the training that forms part of the ARP.
- Supporting alternative employment opportunities for traditional practitioners.
- Supporting Girl Child Education Projects.
- Organising media advocacy activities in local languages.
- Working with partners to influence policies for the abandonment of FGM.

World Vision reports that programmes run through community-based organisations are the most effective in terms of sustainability. World Vision reports that ARPs are still not fully accepted by elders and parents, and girls may still be cut after the ARP. In some communities, the elders sometimes call for a circumcision ceremony very soon after the ARP. They are also publishing guidelines for anti-FGM programmes.

### LOCAL ORGANISATIONS

Local organisations working to eradicate FGM are varied and include national NGOs, CBOs and faith-based organisations. Most are heavily dependent on funding from international donors. Larger organisations tend to have programmes covering several districts and target different demographic groups within society. (Population Council, 2007).

Please see Appendix for full list of organisations.

#### AID KENYA FOUNDATION

AID Kenya Foundation is an NGO whose mission is to mobilise voluntary humanitarian aid and development assistance to orphaned and vulnerable children, teenage mothers and disenfranchised populations in rural-urban Kenya. The organisation’s Stop FGM Now campaign commenced in 2008 and focuses on the Maasia in rural Kisii areas and in Narok. The programme seeks to offer community dialogue, support and counselling for women and girls who have had FGM and vocational training for ex-circumcisers. The community dialogue provides a platform from which girls and women who have undergone FGM can speak out against FGM. AID Kenya Foundation has found that the most effective means of convincing parents to abandon FGM is to hold private meetings in homes. The subject of FGM is raised with the community elders gently via men raising the issue of male circumcision. The involvement of church leaders was found to have limited impact on rates of FGM within the church. Large group discussions have initially been encouraging, with the majority condemning FGM, however follow-up sessions with individuals found that most still supported FGM privately (28 Too Many in-country research, 2012).

#### BOGORIA NETWORK MINISTRIES (BNM)

BNM is a small missionary organisation established in 2006 and registered in both Kenya and Germany. It offers refuges for girls fleeing FGM and support girls in paying school fees. They currently house a small number of girls who have fled from FGM. The organisation has reported that a challenge is determining which girls are actually in fear of FGM and which are simply taking advantage of school fee support. (28 Too Many in-country research, 2012).

#### COEXIST INITIATIVE

The Coexist Initiative was founded in 2002 and officially registered in 2005 as a non-profit network for men and boys organisations that work in the areas of sexual and gender-based violence (SGBV), FGM and child marriage in Kenya. The organisation’s main focus groups are

communities, men and boys. Women and girls also form a key constituent of their work. They have among the Kisii and Kuria in Nyanza province, the Maasai and Samburu in the Rift Valley, the Panjuni and Rendile on the Coast, the Meru and Tharaka in Central province, and the Somali in North Eastern Kenya. They have adopted grass-root initiatives to FGM, using a human rights-based approach. This involves emphasising the responsibilities of everyone in society to ensure women's and girl's rights and freedoms in the local context. Their FGM projects are participatory in nature and utilize the expertise and tools that are respected by the target community. Currently, the Coexist initiative has reached over 25,000 men in each of the communities that they have worked with. FGM rates have steadily decreased in the areas they work with a 35% reduction among the Kisii and the Kuria. They continue to formulate and disseminate various FGM related tools and resources. Their FGM programs mainly focus on men, boys and communities with the aim of building competences, raising the levels of awareness, influencing attitude/behaviour change and objectively providing information.

### **EDUCATION CENTRE FOR THE ADVANCEMENT OF WOMEN (ECAW)**

ECAW was established in 2006 to address the challenges faced by women and girls, including lack of education, violence, early marriage and FGM. The organization runs girls' empowerment camps for around 200 girls during the school vacations which coincide with the cutting season. The camps provide education in health, GBV and FGM, including strategies for the girls to deal with stress and stigmatisation when they return home. They also provide alternative rights of passage (ARP). Law enforcers often visit the girls' homes after the camps and inform the parent that they are liable to prosecution if their daughters are found to have been cut at a later date; they also provide security for the camps and engage with traditional leaders. ECAW also carries out school outreach during the school year and community dialogue with police, social workers and traditional leaders. ECAW

reports that community dialogue seems to have been the most successful strategy. (28 Too Many in-country research, 2012).

### **KEPSTENO ROTWO TIPIN ('SAY NO TO CIRCUMCISION OF GIRLS') (KRT) & BEYOND FGM - POKOT**

KRT is a grassroots organisation made up of approximately 20 community members who are advocating against FGM and acting as role models in refusing to cut their daughters, working in collaboration with UK NGO Beyond FGM. The organisation approaches parents on an individual household basis and educates and sensitises them against FGM. Alternative rites of passage (ARPs) are arranged for the girls. The ARPs are community-wide celebrations and include health education, cultural events, the girls and public commitments by young males to marry only uncut girls. Girls who have been rescued from FGM are sponsored by group members. So far the programme has been very successful with reportedly only six girls out of over 600 reportedly have been cut after graduating during the past three graduations, with an MP from a neighbouring area requesting that the programme be extended to that area. (28 Too Many in-country research, 2012).

The UK umbrella group Beyond FGM facilitated a documentary called 'Abandon the Knife' (available on You Tube), about two girls in West Pokot who parents were forcing them to undergo FGM. The film follows the girls as they desperately try to convince their parents to allow them to continue with their education instead.

### **MAENDELEO YA WANAWAKE (MYWO)**

Maendeleo Ya Wanawake (MYWO) has been conducting research into FGM in rural areas of Kenya for 20 years. From the data they have collected they developed intervention techniques appropriate for specific regions. These have included the use of education through school or media, role models and community debates. The areas they have worked in are the Kisii, Nyambene, Samburu, Meru, Tharaka Nithi, Meru South, Narok,

Muranga and Nandi districts. They have claimed successes through sensitisation, education, publicity through traditional and modern media, and getting the issue raised in parliament. Working with the Programme for Appropriate Technology in Health (PATH), they were able to produce and implement an alternative rite of passage in certain small regions. These are known as the ‘Ntanira na Mugambo’ or ‘Circumcision Through Words’, which aim to keep the significance and celebration behind the ritual intact without the physical damage of FGM. This has been adopted and worked well in areas where circumcision is part of a coming-of-age or marriage passage that is deeply entrenched into the culture. The success is due to the projects being developed within communities after substantial research into understanding the cultural significance of the ritual in each particular community.

**MASSAI EVANGELISTIC ASSOCIATION (MEA)**

MEA is a religious organisation based in Narok district that was established in 1996. It offers girls under threat of FGM sanctuary in church and provides education in schools and churches, facilitated by medical workers. The girls are placed with Christian families and retained in education by means of child sponsorship. MEA work with the families from which the girls have fled to bring about reconciliation and reintegration where possible. Due to the polygamous nature of the Maasai, many men marry Maasai women for their first marriage but marry Luo women for subsequent marriages. The Luo do not practice FGM and so the men are aware that FGM damages women sexually. The church demonstrates its anti FGM stance by prohibiting men who allow their daughters to be cut from participating in church activities. Narok town council has awarded MEA two acres of land and they plan to build a permanent rescue centre for girls fleeing FGM, with capacity for 144 girls. MEA do not currently conduct Alternative Rights of Passage (ARP) although this is planned for when the permanent rescue centre is established. (28 Too Many in-country research, 2012).

**NASERIAN GIRLS RESCUE INITIATIVE**

The Naserian Girls Rescue Initiative is based in Kilgoris, in the Rift Valley. As part of their Women Empowerment and Girl Child Education programme, the organisation provides a place of refuge and contributes towards school fees for 58 Maasai girls aged between 13 and 18 who are fleeing FGM. In the future, the organisation hopes to acquire the funding to provide permanent accommodation, offer alternative rites of passage and educational programmes for the communities and practitioners (28 Too Many in-country research, 2012).

**NTANIRA NA MUGAMBO THARAKA WOMEN’S WELFARE PROJECT (TWWP)**

Ntanira Na Mugambo Tharaka Women’s Welfare Project (TWWP), is a community-based organisation established in 1995 that aims to eradicate FGM in the Eastern Province. It works in partnership with Women’s Global Education Project (WEGP). Called Circumcision with Words, TWWP’s programme incorporates the themes of girls’ education, empowerment and the eradication of FGM and offers alternative rights of passage (ARP) ceremonies. They provide:

- Community awareness workshops and events for parents and community members of both sexes to explore the harmful effects of FGM and early marriage.
- Outreach to village leaders and chiefs to encourage them to lead and support the efforts to eradicate FGM in their community.
- Curriculum on FGM awareness, women’s rights and the importance of girls’ education in their adult literacy classes, health workshops and clubs for boys and girls.
- Promotion of the value of educating girls and delaying marriage until after girls finish their education.

- Awareness workshops for girls age 12-17 and their families about FGM and the option of participating in their alternative rite of passage.
- An alternative rite of passage where girls are 'secluded' for one week for empowerment workshops with their mothers and other female role models. At the end of the week, family and community members gather to celebrate the girls' passage into adulthood. The girls perform uplifting songs and dances, and local leaders, especially women, give speeches. And, instead of genital cutting, a cake is cut to celebrate the girls entering womanhood.

Since being adopted by WGEP in 2007, the Circumcision With Words programme has helped 425 girls and their families abandon FGM (WGEP's website).

### **ORGANISATION OF AFRICAN INSTITUTED CHURCHES (OAIC)**

The Organization of African Instituted Churches (OAIC), founded in 1978, is the representative body that brings together African Independent and Instituted Churches. The OAIC is currently involved in anti-FGM projects in Maasai and Pokot districts. They influence religious groups to abandon FGM by educating pastors of the negative effects of FGM and training them to promote health and human rights through biblical teaching. They facilitate culturally appropriate community dialogues, including working with men and community elders, which can result in community-driven proposals to stop FGM. The OAIC does not arrange its own alternative rite of passage (ARP) ceremonies but supports the Catholic church in so doing. Difficulties have been experienced in convincing families to educate their daughters, as girls are perceived to take the educational gains with them to benefit their new families after marriage. (28 Too Many in-country research, 2012).

### **SENTINELLES – WEST POKOT**

Sentinelles is a rescue programme dealing with

the problems of FGM and forced marriage, the organisation speaks with the parents of girls at risk, gets them to sign a written agreement that the girls are safe from FGM and then conducts follow up appointments to ensure the continued welfare of the girls. The organisation also runs advocacy programmes addressing different groups according to demographic. Girls also benefit from week long, sensitisation workshops and school advocacy is offered to both boys and girls at primary and secondary levels. Medical treatment is provided for women suffering or at risk of fistula as a consequence of having undergone FGM, the women are gifted two goats after treatment to enable them to earn a living, they are asked to gift the offspring of the goats to other women in need. Trying to provide income generating activities for circumcisers was unsuccessful as it encouraged more women to become circumcisers in order to achieve financial assistance. Sentinelles are currently linking with other organisations who are able to supply homes for girls in danger. (28 Too Many in-country research, 2012).

### **SEVENTH DAY ADVENTIST CHURCH – KISII**

As the mother is usually the one deciding whether a child should be cut or not, this organisation runs community workshops for women to sensitise and raise awareness of the negative effects of FGM. There is also a rescue home for girls fleeing FGM currently under construction. Religious leaders in the area are against FGM and promote sensitisation programmes to churchgoers. (28 Too Many in-country research, 2012).

### **TARETO MAA**

Tareto Maa, in Kajiado district, is a grass-roots organisation founded in 2007 by members of the local community (Tareto meaning 'help' and Maa meaning 'Maasai' in the Maasai language). It is primarily a rescue centre although it is planning to expand its scope and adopt a wider community approach. When girls come to the rescue centre, they are registered with the police as being circumcised or uncircumcised. Meetings with the parents are then established to try to reunite the

girl with her family. The parents are informed about the anti-FGM law and that, if at any time in the future their daughter is found to have undergone FGM, they will be liable to prosecution. They try to find a solution, working closely with the civil society in Kigoris, the local congregation of the African Inland Church and the local authorities. If no satisfactory solution can be found, the girl is admitted to the rescue centre. They also inform the public about child rights, child health and sexual and reproductive health. Members of the group go into schools as well as into community assemblies, and raise awareness on the effects of FGM and the importance of school education for girls. Tareto Maa takes care of the costs for food, clothes and education. As the majority of the population of Kajiado are Christian, the close links with the church and assistance of pastors in meetings with parents have been found to be very useful. Tareto Maa's first alternative rites of passage (ARP) ceremony for girls in their care took place in December 2012. Tareto Maa has observed that people are beginning to rethink their attitudes to FGM (28 Too Many in-country research, 2012).

### **TASARU NTOMONOK INITIATIVE (TNI)**

Tasaru Ntomonok Initiative was established in 1999 for Kenya's Maasai communities to promote awareness of women's rights issues and to fight for the elimination of all social and cultural practices that are harmful to girls and women. The TNI is based in the Narok District in the rift valley and they have one rescue centre in Narok South, which opened in 2000, and a second centre in Narok North, which opened in 2009. These facilities house girls who have fled threats of FGM and provide counselling, life and marriage skills, education, and an alternative rite of passage ceremony at the end to mark their passage into womanhood. The aim is to return the girls to their communities safe, strong, educated, and confident women. The TNI works closely with men and boys because it is a patriarchal society and they ultimately decide to accept and marry uncircumcised women. Furthermore, the TNI

holds separate seminars for women and men to allow participants to speak freely. Religious leaders are engaged in the campaign to end FGM and educate on the dangers of FGM during church functions. The TNI also trains police on FGM and cooperates with the Narok Police who patrol during the cutting season. The building of the safe houses and the funding of the project comes from UNFPA. The founder was Masai activist Agnes Pareyio (Equality Now Report, 2011).

## CHALLENGES FACED BY

### ANTI-FGM INITIATIVES

There are still many challenges anti-FGM initiative face.

A government report indicates some major challenges to eradicating FGM (Population Council, 2007):

- Cultural sensitivities surrounding FGM and the difficulty with identifying appropriate entry points into communities.
- Entrenched religious and cultural beliefs.
- High level of illiteracy, making dissemination of information challenging.
- Difficulties covering the vast geographical areas and remote populations.
- Lack of adequate rescue homes for run-away girls.
- The issue of medicalisation.
- Lack of support from politicians that represent communities that practise FGM for fear of losing seats.
- Lack of national coordination of anti-FGM activities.

There are reports that refugee communities (Somalis) sometimes targeted opponents of FGM, including NGO staff (Human Rights Report, 2011).

Entrenched positions by elders and traditional leaders within communities, who are often highly influential, can be a challenge to eradication efforts. In 2011, for example, some churches and NGOs provided shelter to girls who fled home to avoid FGM and some communities instituted 'no cut' initiation rituals as an alternative to FGM. There were some reports that community elders interfered with this initiatives (Human Rights Report, 2011).

## CONCLUSIONS

28 Too Many recognises that each country where FGM exists requires individualised plans of action for elimination to be successful. In Kenya's case, attention to specific needs including health, education, religious beliefs and cultural mores is pertinent on ethnic and regional levels, as well as on a community level. We propose the following general conclusions which are applicable within the wider scope of international policy and regulation, but we also include conclusions that are specific to Kenya.

### SUSTAINABLE FUNDING

Programmes and research studies concerned with the elimination of FGM require sustainable funding in order to be effective. Continued publicity of current FGM practices at a global level, particularly through the UN and WHO, is crucial for ensuring that NGOs and charities are given support and resources long term. Prioritising charitable aid and grant funding is inherently challenging, and programmes for ending FGM are given less attention than those related to the health and poverty crises. However, as is discussed in this report, FGM is a focal issue connected to these crises and directly relates to several of the millennium development goals.

### FGM AND THE MILLENNIUM DEVELOPMENT GOALS

Considering FGM within the larger framework of the millennium development goals conveys the significant negative impact FGM makes on humanity. FGM is connected to promoting gender equality, reducing child mortality, improving maternal health, and combating HIV/AIDS. Relating FGM to wider social crises is important when creating grant proposals and communicating anti-FGM initiatives to a wider audience because it highlights the need for funding anti-FGM programmes and research for broader social change. Post the UN global ban on FGM in December 2012, it is important that violence against women and girls, including FGM,

is reflected in the post millennium development goals.

**FGM AND EDUCATION**

Education is a central issue in the elimination of FGM. Illiteracy remains at a critical level in Kenya and the lack of basic education is a root cause for perpetuating social stigmas surrounding FGM as they relate to health, sexuality and women’s rights. FGM hinders girls’ ability to obtain basic education and prevents them from pursuing higher education and employment opportunities. This lack of education directly relates to issues surrounding child marriage. Anti-FGM programmes need to be focused on advocating for girl’s education, but educating men and boys on FGM is equally crucial.

**FGM , MEDICAL CARE AND HEALTH EDUCATION**

The medicalisation of FGM is a global issue and one that has been documented in Kenya. Health providers need to be better trained to manage complications surrounding FGM. Moreover, there needs to be more education for health providers on the consequences of their role in medicalised FGM. Following this, the authorities need to prosecute health providers carrying out FGM. Finally, more resources are needed for sexual and reproductive health education, and more research and funding is needed on the psychological consequences of FGM.

**FGM, ADVOCACY AND LOBBYING**

Advocacy and lobbying is essential to ensure that recent legislative and policy changes introduced by the Kenyan government are properly implemented and that the momentum gained by such changes is sustained.

**FGM AND THE LAW**

Kenya now has more robust legislation against FGM and while its success has not yet been fully assessed, it is recommended that further prosecutions under the new law are necessary across a wide range of geographical regions. We welcome the capacity building that has already

taken place among those responsible for upholding the new law. We recommend that such capacity building is increased to assist prosecutions and overcome a prevailing social stigma against matters relating to sexuality and women’s equality.

**FGM IN THE MEDIA**

Media has proven to be an effective tool against FGM and in advocating for women’s rights. More effort is needed to incorporate FGM in public discourse. Diverse forms of media should be used (including formal and informal media) to promote awareness of FGM and advocate for women’s rights targeting grassroots communities.

**FGM AND FAITH-BASED ORGANISATIONS**

With over 80% of the population in Africa attending a faith building at least weekly, religious narratives and references are essential for personal understanding, family and society. Faith-based organisations are a major agent of change, and their international, regional, national, and local presence and structures offer platforms for teaching, education, support and health provision regarding issues such as FGM. They can also work with global bodies such as the UN and its agencies. Just as governments work closely with NGO’s and bi-laterals, it is important to include all faith groups and those of no faith in policy development and dialogue, as they have an important role to play in supporting the delivery of key messages and programme deliverables to their communities.

**PARTNERSHIPS AND COLLABORATIVE RESEARCH FOR ENDING FGM**

There are many successful anti-FGM programmes currently in place in Kenya with much of the progress beginning at the grassroots level. These initiatives would be more effective if programmes communicate their efforts to each other more publicly and collaboration at a project level. A coalition against FGM will be a stronger voice in terms of lobbying and will be more effective in obtaining sustainable funding and achieving programme success.

**APPENDIX I – LIST OF INTERNATIONAL AND NATIONAL ORGANISATIONS CONTRIBUTING TO EFFORTS FOR THE ABANDONMENT OF FGM IN KENYA**

28 Too Many	tion Awareness (CREAW)	Advancement of Women (ECAW)	Jali Africa Group
7th Day Adventist Church	Centre for the Study of Adolescence (CSA)	EMACK	Juliekei
7th Day Adventist Rehab and Ed Center	Center for Minority Rights Development (CEMIRIDE)	ELAND	Kenyan Arab Friendship Society – National
Action TIME Family Care (ATFC)	Child Rights Advisory Documentation and Legal Centre (CRADLE)	El-Taller International	Kenya Alliance for the Advancement of Rights of Children (KAARC)
Action Aid International	Child Welfare Association	Equality Now	Kenya Assembly Church of Kenya
ADRA Kenya	Children’s Legal Action Network (CLAN)	Ewangan Nadede Advocacy Initiative (ENAI) Africa	Kenya Youth Education and Community Development Programme (KYECDP)
Africa Hope	Christian Community Services	Family Guidance Association	Kenya Female Advisory Organization (KEFEADO)
African Medical Research Foundation (AMREF)	Christian Children’s Fund (CCF)	Family Health Options of Kenya (FHOK)	Kenya Children’s Home
African Network for the Prevention and Protection against Child Abuse and Neglect (ANPPCAN)	Christian Missionary Fellowship (CMF)	Federation of Women Lawyers (FIDA)	Kenya Child Welfare Association
Aid Kenya Foundation	Church World Service (CWS)	Feed the Minds	Kenyan National Council on Traditional Practices (KNCTP)
AIC Kajiado Girls Primary School	Coalition on Violence Against Women (COVAW)	FHI 360	Kuria Child and Development Program (KCDP)
Al Falal	Coast Development Authority (CDA)	Free Pentecostal Fellowship	Konrad Adenauer Foundation
Alton Maasai Project	Coexist Initiative	Friends of Nomad International (FONI)	Kenya Arab Friendship Society
Anglican Church of Kenya	Community Integrated Development Project (CIPED)	Friends of UNFPA	LMAA Care Foundation
Association of Media Women In Kenya (AM-WIK)	Community Relief Services (CRS)	Full Gospel Church of Kenya	Lutheran Outreach
Basonga Community Health Outreach	Consortium for Empowerment and Development of Marginalized Communities (CEDMARC)	Forum for African Women Educationalists (FAWE)	Maasai Evangelistic Association
Beyond FGM	Council of Imams and Preachers of Kenya (CIPK)	German Development Cooperation (GTZ)	Maendeleo ya Wanawake Organization (MYWO)
Bogoria Network Ministries	CIWIT (Hope for yourself, Jitengeme)	Health Unlimited	MAIKOO ATE (Maasai people’s program)
British High Commission	DFID	Igoma Vision Women Group	Maranatha Faith Assemblies
Campaign on Accelerated Reduction of Maternal, Newborn and Child Mortality in Africa (CARMMA)	Daraja Community Based Organization	Inter-African Committee on Traditional Practices (IAC) - Kenya	Methodist Church
Catholic Dioceses of Nakuru and Meru	Education Centre for the	IPPF	MERLIN International
Canadian International Development Agency (CIDA)		International Labor Organization (ILO/IPEC)	Ministry of Justice and Constitutional Affairs
CARE Kenya		Isiolo Youth against AIDs Program (IYAAP)	
Centre for Rights Educa-		IKWIP	

Ministry of Education  
 Ministry of Gender, Children and Social Development  
 Ministry of Public Health and Sanitation  
 Ministry of Home Affairs  
 Muslim Consultative Council (MCC)  
 National Coordinating Agency for Population & Development (NCPD)  
 National Council of Churches of Kenya (NCCK)  
 National Council of Women of Kenya (NCWK)  
 NACC  
 Naserian Girls Rescue Initiative  
 Norwegian People's Aid  
 Northern Aid  
 Norwegian Embassy  
 Ogiek Welfare community  
 Orchid Project  
 Organisation of African Instituted Churches (OAIK) - Kenya  
 Organisation of African Youth  
 Oxfam  
 Partners for Progress (PFP)  
 Pastoralists Girl Initiative (PLI)  
 Pioneers  
 PLAN International  
 Program for Appropriate Technology in Health (PATH)  
 Population Council  
 Practical Solution (PRA-SO)

Presbyterian Church of East Africa (PCEA)  
 Ripples International  
 Rural Women's Peace Link (RWPL)  
 Royal Netherlands Embassy  
 Samaritan Purse Relief International  
 Samburu Girls Foundation  
 Save the Children Canada  
 Sentinelles  
 SNV Kenya (Netherlands Development Organization)  
 SDA rural project  
 St. Martins Friends of the Youth  
 Socially organized education team (SOET)  
 Soila Maasai Children's Home  
 SIMAHO  
 Supreme Council of Kenya Muslims (SUPKEM)  
 Tasaru Ntomonok Initiative (TNI)  
 Tigania Cultural Development Association  
 Tareto Maa  
 Tasaru Girls Rescue Center  
 Trans-World Radio (Twr) Kenya  
 United Nations Children's Fund (UNICEF)  
 United States Agency for International Development (USAID)  
 UNIFEM  
 United Nations Population Fund (UNFPA)  
 UNHCR

UNFPA  
 Voices of Hope  
 Volunteers Children's Officers Association (VOS)  
 Vivid Communication with Women in their Culture (VividCom)  
 WAFNET  
 Women Empowerment Link (WEL)  
 Womankind Kenya (Wokike)  
 Women's Global Education Project  
 Women's Rights Awareness Programme (WRAP)  
 World Health Organization (WHO)  
 Woman Concern  
 Women Department Initiative  
 World Relief  
 World Vision  
 Young Women's Christian Association (YWCA)

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