ERADICATING FEMALE GENITAL MUTILATION

RESOURCE BOOK

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OPERATIONAL DEFINITION OF TERMS

Circumciser/mutilator- A person who carries out the mutilation of female genitalia.

Community - A social group of any size whose members reside in a specific locality and often have a common cultural and ethnic heritage.

Harmful Cultural Practices - particular forms of violence against women and girls which are defended on the basis of tradition, culture and religion.

Law enforcement Officer - Individuals and agencies responsible for enforcing laws prohibiting female genital mutilation.

Misconception - View or opinion that is incorrect because it is based on faulty thinking or understanding.

Myth - A widely held but false belief or idea.

Perpetrator - A person who commits an illegal, criminal, or evil act.

Perpetuator - A person who allows and/or facilitates continuity of something.

Physical integrity - the wholeness of the body that should not be interfered with.

Social Status - The position of an individual in relation to another or others, especially in regard to female genital mutilation.

ABBREVIATIONS

ACRWC:	African Charter on the Rights and Welfare of the Child
AFGMB:	Anti-Female Genital Mutilation Board
AMREF:	African Medical and Research Foundation
ARP:	Alternative Rights of Passage
CEDAW:	Convention on the Elimination of all Forms of Discrimination against Women
FAWE:	Forum for African Women Educationists
FGC:	Female Genital Cutting
FGM:	Female Genital Mutilation
GBV:	Gender Based Violence
GoK:	Government of Kenya
HIV:	Human Immunodeficiency Virus
ICL:	I Choose Life-Africa
ICT:	Information Communication Technology
IEC:	Information Education and Communication
KCPE:	Kenya Certificate of Primary Education
KDHS:	Kenya Demographic and Health Survey
KICD:	Kenya Institute of Curriculum Development
KNH:	Kenyatta National hospital
KNP:	Kabete National Polytechnic
NCCK:	National Council of Churches of Kenya
NPA:	National Plan of Action
ODPP:	Office of the Director of Public Prosecution
PTSD:	Post Traumatic Stress Disorder
UN:	United Nations
UNFPA:	United Nations Population Fund
UNICEF:	United Nations Children Fund
WHO:	World Health Organisation

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I believe this Resource Book will provide relevant information that will lead to the eradication of FGM.

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FOREWORD

Female genital mutilation (FGM) is not only a global issue but also an international concern. Due to the prevalence and adverse effects of the practice on communities, there has been a pressing need to address the issue in Kenya. This resource book is therefore an effort to provide accurate and appropriate information on female genital mutilation to the user.

The book is written by a team of experts in educational curriculum development, gender and development and members of the civil society with extensive knowledge and experience on FGM matters.

The book puts together key information on FGM in the country, bringing international, regional as well as national perspectives on the approach towards eradication of FGM. It informs the reader on the current situation of the practice, as well as interventions against FGM and provides valuable content to users in schools, for field intervention and for progressing research on FGM and general information.

I hope that the book will serve as a solid base for boosting the campaign against the practice and for transforming the lives of women and girls and ultimately entire communities.

Bernadette Loloju (Mrs.)
Chief Executive Officer
Anti-FGM Board Kenya

CHAPTER 1: FEMALE GENITAL MUTILATION

1.0 Introduction

Female genital mutilation (FGM), also known as female genital cutting (FGC), is defined as all procedures involving the partial or total removal of the external female genitalia, or any other injury to the female genital organs for non-medical reasons (WHO, 2008, The Prohibition of Female Genital Mutilation Act, 2011).

FGM is generally practised on girls and women of different ages. In some cultures, it is performed from as early as a few days after birth to shortly before marriage. It is one of the most severe forms of gender based violence (GBV). It is estimated that over 200 million girls and women worldwide have undergone FGM. This chapter examines the origin, trends and cultural practices associated with FGM.

1.2 Origin of FGM

FGM was practised by the Phoenicians, Hittites, Ethiopians and Egyptians as early as 5 B.C. Historical evidence points to Egypt as the origin of FGM before it spread to countries in Sub-Saharan Africa, Asia and the Middle East. As a result of immigration, FGM spread to Europe, Australia and the United States. In these regions some immigrant families take their daughters and relatives to Africa and Asia to undergo the procedure due to stringent laws that criminalise the practice.

1.3 Status of FGM

Despite efforts to eradicate the practice, 3 million girls and women are at risk of undergoing FGM every year (WHO, 2016). FGM is common in the Middle East, Asia and 28 African countries. There is a wide variation in the percentage of girls and women who have undergone the practice. In Kenya, five ethnic communities have not practised it, namely, the Luo, Luhya, Teso, Pokomo and Turkana.

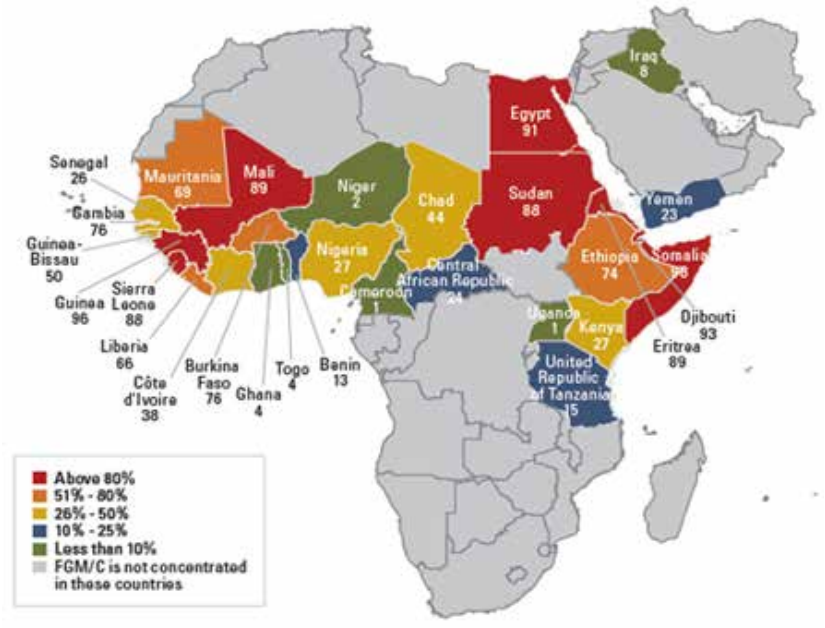


Figure 1: Percentage of Girls and Women aged 15 to 49 who have undergone FGM by Country in Africa
Source: https://www.unicef.org/esaro/FGCM_Brochure_Hi_res.pdf

According to the Kenya Demographic and Health Survey (KDHS, 2014), 21 per cent of women aged 15-49 years reported to have been circumcised by 2014, compared to 27 per cent in 2008/2009 and 32 per cent in 2003. Majority of the circumcised women (87 per cent) had a cut with flesh removed, 9 per cent reported that their genital area had been closed by stitching (a procedure known as infibulation) while 2 per cent were cut without removing any flesh. According to the report:

- Girls aged 0-14 years are more likely to be circumcised if their mother is circumcised. Likewise, girls aged 0-14 years are more likely to be infibulated if their mother is infibulated;
- Eight (8) per cent of girls aged 0-14 years have had their genital area stitched-closed;
- Eleven (11) per cent or less of women and men believe that the practice of FGM is required by their community or their religion, or that the practice should continue.

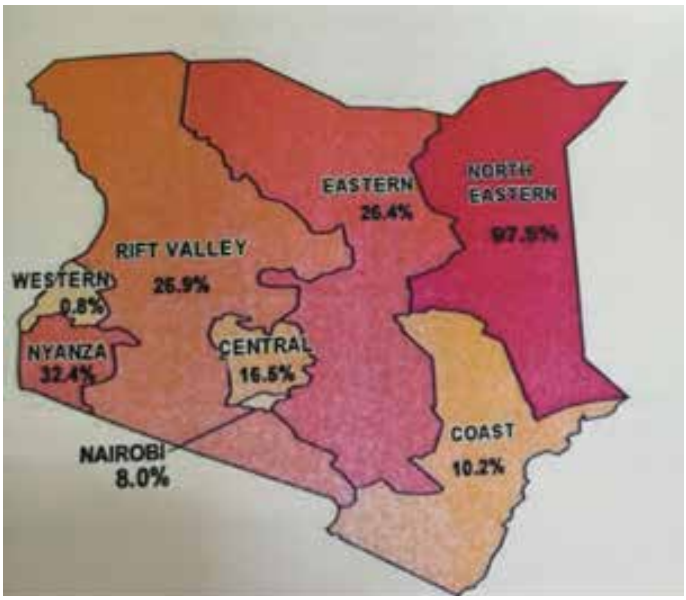


Figure 2: Regional Distribution of FGM in Kenya
Source: Communication and Media Strategy 2016-2018. Ant-FGM Board, Ministry of Public Service, Youth and Gender Affairs

The Kenya Demographic and Health Survey, (2014), reports that about 9.3 million girls and women in Kenya have been subjected to FGM. The prevalence of FGM is still high especially among the Somali (94 per cent), Samburu (86 per cent), Kisii (84 per cent) and Maasai (78 per cent).

The report shows that Nairobi, Central, Eastern, Nyanza and Rift Valley regions have shown a slight decline in FGM prevalence. However, there is a marginal increase in the prevalence from 10 per cent to 10.2 per cent for women and girls aged 15-49 years in the Coast region. The prevalence in North-Eastern region has remained high at 97.5 per cent.

1.4 Trends of FGM in Kenya

There are emerging trends with regard to FGM due to a number of factors. Some of these trends include:

a) Lower Age of Circumcision: There is an increasing trend to have girls undergo FGM at a younger age in order to conceal the practice from law enforcement officers.

b) Change in the Type of FGM: There is a growing tendency by some communities especially those that practice type III (infibulation) to change to type II (excision) or I (clitoridectomy). Other communities that practice type I or II are changing to pricking.

c) Increased Demand for Traditional Circumcisers' Services: According to KDHS (2014), the proportion of women aged 15-49 years who have undergone FGM through a traditional mutilator has increased from 75 per cent in 2008/2009 to 80.5 per cent in 2014. The number of mutilators has reduced as a result of enforcement of the law and voluntary eradication by some of them, raising the demand for their services.

d) Increased Secrecy in Female Genital Mutilation: The practice of FGM has become secretive among many communities. Girls and women undergo FGM privately as opposed to having elaborate communal celebrations and festivities that traditionally used to accompany the practice. This is attributed to arrests by law enforcement officers.

e) Cross-border Cutting: This is common among FGM-practising communities that live in border counties such as the Maasai, Pokot, Somali and Kuria who seek FGM services in the neighbouring countries such as Uganda and Tanzania to evade the law enforcers.

Also, some Kenyans living abroad especially in Europe and America bring back their daughters and relatives to undergo FGM.

f) Medicalization: Some families in Kenya prefer to use medical professionals to perform FGM in order to reduce cases of severe pain, bleeding and infection. These medics perform FGM procedures in disregard of their professional code of conduct and the relevant laws. Traditional circumcisers have also resorted to the use of surgical blades, gloves and anaesthesia among others in the belief that it makes the practice safer.

g) Increased Cost: FGM is an income-generating activity for certain sections of the practising communities. Due to interventions against FGM, the cost of performing the procedure has gone up due to increased risk of arrest and prosecution.

h) Legal Action: The government has established the Anti-FGM Prosecution Unit in the Office of Director of Public Prosecution (ODPP) to investigate and prosecute cases of FGM.

1.5 Cultural practices associated with FGM

Several cultural practices are closely linked to FGM. These practices may negatively affect survivors of FGM, the communities and the nation. Some of the practices include:

a) Child Marriages: In some communities, FGM is viewed as a prerequisite for marriage. The need to have girls married off at an early age increases their chances of undergoing FGM.

b) Beading: Beading is a community-sanctioned pre-marital sexual relationship between young men and young girls who are not yet eligible for marriage. In some communities, beading is practised to prepare young girls for FGM and subsequently marriage. This may entail building a hut for the girl who is thereafter expected to engage in a sexual relationship so as to break her virginity. This practice may result to child pregnancy and subsequent forced abortions since girls are not allowed to bear children before undergoing FGM.

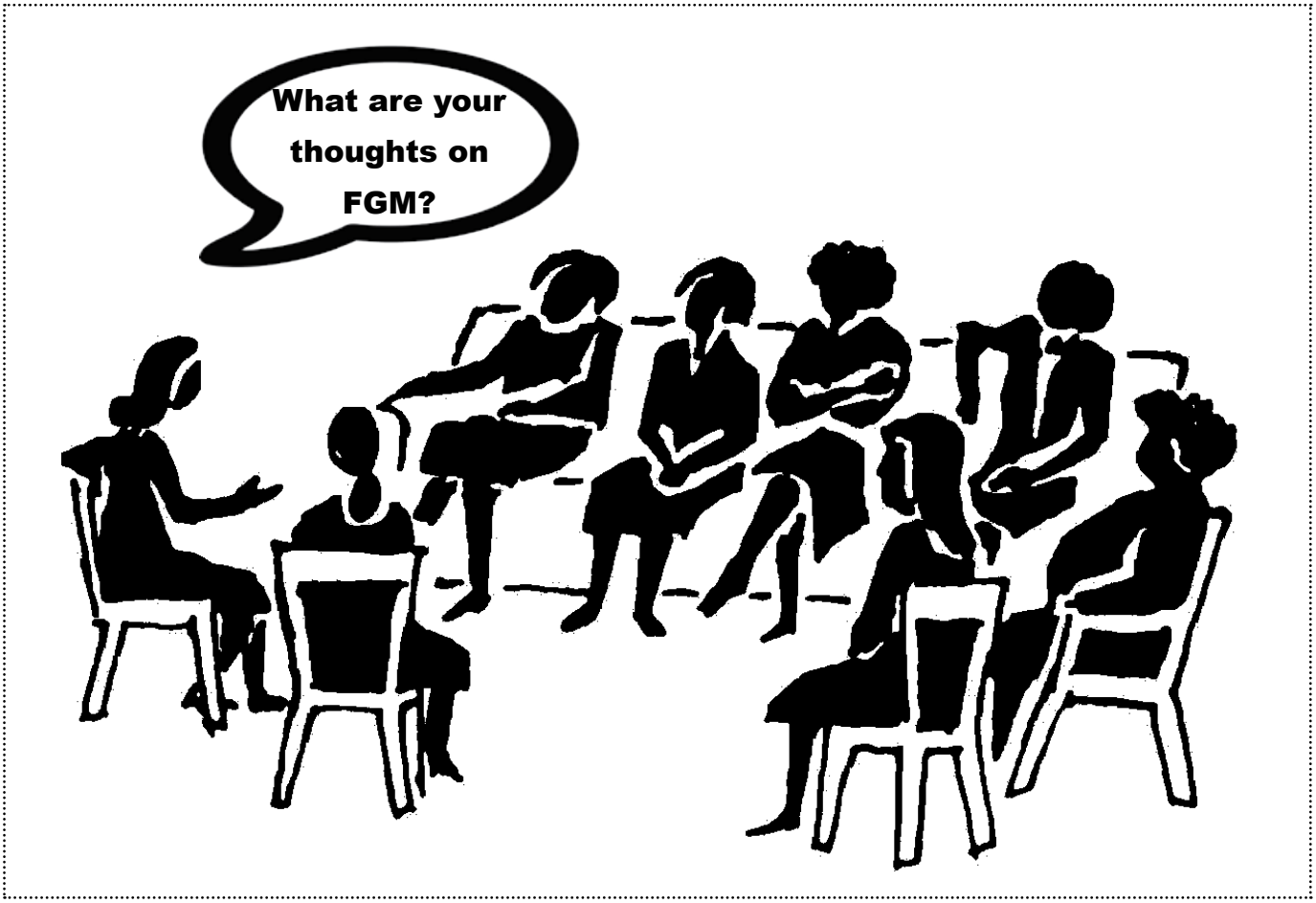
c) Cattle Raids: Cattle raids among some pastoral communities are closely linked to FGM. In these communities, young men organize raids in order to acquire cattle and other livestock to pay dowry.

d) Ceremonies: FGM is characterized by cultural ceremonies performed before, during and after the procedure. The ceremonies which involve feasting, exchange of gifts, dancing and music are accorded great value.

e) Male circumcision: In some communities, a mother cannot participate in the celebration of her son's circumcision and other traditional rituals unless she has undergone FGM. Traditional male circumcision therefore may increase demand for FGM among women.

ACTIVITY

Discuss how FGM is perceived in your community.



CHAPTER 2: REASONS FOR FGM

2.0 Introduction

FGM is widely practiced in Kenya. This chapter explores why communities practice FGM and the roles played by different actors in perpetuating it.

2.1. Reasons advanced by communities

Communities practise FGM for various reasons ranging from socio-cultural, to economic and religious. Myths, misconceptions and stereotypes also reinforce the practice.

2.1.1. Socio-cultural reasons

The socio-cultural reasons include:

a) Rite of passage: Some communities practise FGM as a rite of passage to signify transition from childhood to adulthood.

b) Delayed sexual debut and preservation of virginity: In some communities, girls are not expected to engage in sex before marriage. It is considered an abomination to the family for a girl to become pregnant before undergoing FGM. Some communities value virginity of girls before marriage and believe that FGM ensures its preservation.

c) Prerequisite for marriage: Some communities practise FGM as a way of preparing girls for marriage. In such communities, once a girl undergoes FGM, she is married off irrespective of her age.

d) Social acceptance, identity and status: Communities that practice FGM believe that the practice contributes to their cultural identity and social acceptance of the initiates and their families. Girls and women who do not undergo FGM are stigmatized and considered social misfits. They are often barred from important community roles and ceremonies. In these communities, FGM earns girls respect, increases their potential to get married and enables them to participate in social functions.

e) Control of sexual desire: Some communities believe that the sexual desire of girls and women can be controlled by FGM thereby preventing promiscuity.

2.1.2 Economic reasons

FGM is a source of income to the perpetrators and perpetuators. While the perpetrators are paid a fee for performing FGM, the perpetuators mobilise, persuade and at times intimidate families to undertake the practice since they receive a token from the girl's family. In some communities, girls are treated as 'property' and are married off after undergoing FGM, thereby attracting a higher bride price for the parents. Girls who undergo FGM receive gifts including money. These rewards may motivate some girls to undergo FGM.

2.1.3 Religious reasons

Some communities practise FGM to purportedly fulfil 'religious' requirement although there is no documented evidence that FGM is supported by any religion.

2.1.4 Myths and misconceptions

The practise of FGM is attributed to myths and misconceptions among different communities, as shown in Table 1.

Table 1: Myths and Misconceptions that perpetuate FGM

MYTH	FACT
A girl or woman who has not undergone FGM will become promiscuous and have uncontrollable sexual desire.	FGM makes no difference to a woman's sexual desire but may hinder her enjoyment and satisfaction. Sexual desire mainly arises from hormones secreted by glands in the brain.
If the clitoris is not cut, it will continue to grow	The clitoris stops growing after puberty.
If the clitoris is not cut, it will harm the baby during delivery	The clitoris causes no harm to the foetus, the baby or the mother. On the contrary, FGM may cause serious complications during childbirth.
If the clitoris is not cut, it will harm the man during sexual intercourse	The clitoris gives a woman sexual pleasure and does not cause harm to either the woman or the man.
If a woman does not undergo FGM, she will not be able to conceive.	FGM may lead to infertility due to possibility of infections caused by damage to the female reproductive organs.
If a woman does not undergo FGM, her genitalia will smell.	FGM does not make the female genitalia cleaner. In fact, type III FGM makes the female genitalia less hygienic due to urine retention and restrained menstrual flow.
A girl or woman who has not undergone the cut attracts calamity or bad omen.	There is no link between FGM and calamity or bad omen.

2.2 Roles played by perpetuators of FGM

There is considerable pressure on families and communities that practise FGM to ensure girls and women undergo the procedure. FGM is perpetuated by different actors who include mutilators, cultural leaders, parents, girls, women, men and some healthcare workers as shown in the following Table.

Table 2: Roles of Perpetuators of FGM

ACTOR	ROLE IN PERPETUATING FGM
Mutilators	They are paid a fee for performing FGM. They encourage the practice for economic gain and the conviction that they are promoting the community's culture.
Girls	Some girls 'willingly' undergo the cut while others comply for fear of stigmatization and rejection. Some girls also exert pressure on their peers to undergo FGM in order to be accepted.
Parents	Some parents perpetuate FGM for economic reasons and to avoid stigmatization.
Women	Women who have undergone FGM justify it and motivate young girls to undergo the procedure. They instil fear and discriminate against uncut girls.
Men	Men in some communities have been socialized to marry girls who have undergone FGM for fear of being ridiculed and abused by their peers.
Community Elders and Opinion Leaders	Elders in some communities get special prizes and rewards hence their motivation to perpetuate the practice. They elders encourage FGM and view it as a social activity that propagates their culture.
Healthcare Workers	Some unethical healthcare practitioners secretly perform FGM for economic gain.
Family	Grandmothers, aunties, in-laws among others persuade and secretly procure FGM for girls and women. Others threaten the girls with curses and intimidate parents who refuse to subject their daughters to FGM.

Suggested Activities

a) Role plays depicting reasons for practising FGM in some communities.
b) Discussion groups on the roles played by different actors in perpetuating FGM.

Suggested Key Inquiry Questions

a) Explain why the reasons given by communities for undertaking FGM are not justifiable.
b) In what ways can the community protect girls from undergoing FGM?

CHAPTER 3: TYPES AND CONSEQUENCES OF FGM

3.0 Introduction

Different communities perform FGM in diverse ways. The practice has far-reaching effects on the survivor. This chapter examines the different parts of the external female genitalia and their functions. It also discusses different types of FGM and their consequences.

3.1 Parts and functions of the external female genitalia

The external female genitalia comprise different parts which perform different functions in the body. Being knowledgeable of these parts and their functions enables one to understand the harm caused to a girl or woman who has undergone FGM. The parts and functions of the external female genitalia are as shown in the following Table.

Table 3: Parts and functions of the external female genitalia

PART	FUNCTION(S)
Vagina	Allows for sexual intercourse and delivery. It also serves as a conduit for menstrual flow.
External urethral orifice	It is the point where urine exits the urethra.
Clitoris	It provides sexual pleasure and satisfaction.
Perineum	It separates the vagina from the rectum.
Labia majus (majora)	It covers and protects the inner, more delicate and sensitive structures of the vulva e.g. labia minora, clitoris, urinary and vaginal orifice from mechanical stress and friction.
Labia minus (minora)	It has protective structures that surround the clitoris, urinary orifice and vaginal orifice.

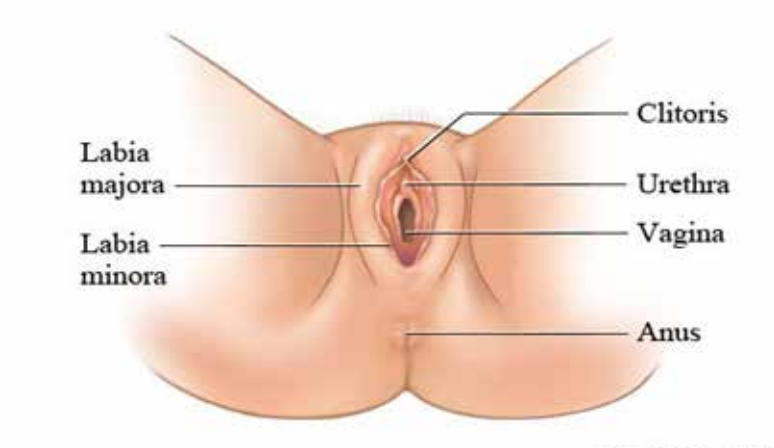
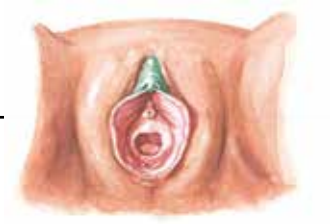


Figure 3: Anatomy of the external female genitalia

3.2 Types of FGM

According to WHO, there are four types of FGM each with varying degrees of clitoral and genital skin removal and health complications. Table 4 describes these types as practised by different communities.

Table 4: Types of FGM

TYPE	DESCRIPTION	DIAGRAM
Type 1: Clitoridectomy	This is the partial or total removal of the clitoris or the prepuce.	
Type 2: Excision	This is the partial or total removal of the clitoris or the prepuce and the labia minora, with or without excision of the labia majora.	
Type 3: Infibulation	This is narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and labia majora with or without excision of the clitoris.	
Type 4: Others	This is the pricking, piercing, incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice or cutting of the vagina; introduction of corrosive substances or herbs into the vagina to cause bleeding or for purpose of tightening.	

Difference between FGM and male circumcision

The procedure of FGM is different from that of male circumcision. FGM involves partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. However, male circumcision involves the removal of the foreskin but never amputating the entire organ.

3.3 Consequences of FGM

FGM has physical, psychological, socio-economic and educational consequences. Table 5 enumerates the consequences of FGM.

Table 5: Consequences of FGM

Physical	• Severe pain • Injury • Severe bleeding. In some cases, this can lead to death • Increased risk of infections e.g. vaginal, uterus, pelvic infections, HIV and tetanus • Soft tissue swelling • Poor wound healing • Urine retention and difficulties in menstruation • Complications in pregnancy and childbirth - stillbirth and neonatal death. • Increased risk of fistula • Incontinence • Keloids / Scars • Increased risk of infertility due to infections
Psychological	• Shock • Sexual phobia • Post-traumatic stress disorder – flashbacks, nightmares, anxiety and depression • Anger, bitterness and resentment • Sleeplessness • Emotional distress • Low self-esteem
Socio-economic	• Stigma and discrimination • Estrangement from significant others • Strained relationships • Family break-ups • Early marriages and pregnancy • Huge expenses incurred by families in preparation for FGM ceremonies • Financial burden in the management of health complications • Reduced productivity as a result of health complications
Educational	• Poor academic performance. • Indiscipline • School dropout. • Absenteeism from school. • Low transition rate from primary to secondary level of education.

Activity

Case Study Analysis

Read the case study given in this section and answer the questions that follow.

The Tribulations of Sophia

Sophia, a bright and hard-working pupil, was forced to undergo FGM by her mother and aunt at 11 years. After the cut, she bled profusely and became unconscious. She was hospitalized for two days. The wound became septic causing her to miss school for a month. This led to poor academic performance and strained relationship with her mother and aunt.

Despite her predicament, Sophia continued to work hard. She sat for the Kenya Certificate of Primary Education (KCPE) and emerged top in the county. Subsequently, she was admitted to a national school. While in Form I, some girls got to know she had undergone the cut and they began to isolate and ridicule her. This stressed her a lot and she dropped out of school.

Sophia got married to an elderly man as a third wife at the age of 15 and soon after got pregnant. During delivery she experienced obstructed labour. Although she delivered a baby girl whom she named 'Bahati', she unfortunately developed fistula.

Due to the incontinence resulting from fistula, she was abandoned by her husband and friends.

Answer the following questions

1. Discuss the consequences of female genital mutilation depicted in the case study.
2. How can Sophia be assisted?
3. If you were Sophia, what would you have done differently?

CHAPTER 4: PREVENTION AND MANAGEMENT OF FGM

4.0 Introduction

The state and non-state actors have come up with interventions to eradicate female genital mutilation and mitigate its effects. These interventions are geared towards protection of girls and women from FGM and to help survivors manage their situation. This chapter examines the interventions, their successes and challenges. It also outlines the role played by various actors and makes recommendations that could be considered in future.

4.1 Interventions

a) Legislations
The Constitution of Kenya under the Bill of Rights accords women and children the right to be free from all forms of discrimination and the right to dignity and physical integrity including protection from FGM. The Prohibition of Female Genital Mutilation Act, 2011 and the Children Act, 2001 both outlaw FGM.

b) Affirmative action: The Office of the Director of Public Prosecutions (ODPP) has established a Prosecution Unit to handle FGM cases. Further, content on gender based violence (GBV) including FGM, has been introduced into the police service training curriculum.

c) The Anti-FGM Board: The Anti-FGM Board was inaugurated following the enactment of the Prohibition of Female Genital Mutilation Act No. 32 of 2011. It is mandated to design, supervise and coordinate the campaign against FGM among other functions.

d) Marking of international days and events: The days and events observed include:

- International Day of Zero Tolerance to FGM - 6th of February;
- The International Women's Day - 8th of March;
- The Day of the African Child - 16th of June;
- The International Day of the Girl Child -11th of October,
- Sixteen Days of Activism against Gender Based Violence - 25th of November to 10th of December

e) School-Based Interventions: Education equips individuals with knowledge, skills, attitudes and values necessary for the eradication of FGM. Anti-FGM interventions that target boys and girls, parents, teachers and school boards of management have been designed and implemented in schools. The interventions make use of the i) formal school curriculum, ii) non-formal curriculum including sports, clubs and societies, music and drama festivals and iii) informal curriculum which includes the use of posters, murals and day-to-day interaction with resource persons among others. Age-appropriate anti-FGM content has also been integrated in the competence based curriculum.

f) Public Education: Public education is used to inform communities on the consequences of FGM. The campaign takes place during barazas (community meetings), sports tournaments, music and drama festivals and road shows among others. At these fora, duty bearers, advocates, role models, celebrities and champions sensitize communities on the need to abandon FGM.

g) Community Dialogues: Community dialogues entail interactive engagement among members of the community. Dialogues are structured to create a conducive environment for free interaction among community elders, men, women, mutilators, boys and girls.

A facilitator who is well versed with the culture of the community guides the dialogue to lead to a resolution to abandon FGM. Participants trace the origin of FGM; reflect and debate on the myths, misconceptions, beliefs, values and stereotypes used to perpetuate the practice. The community may resolve to declare the abandonment of FGM and persuade men to accept to marry women who have not undergone the practice.

h) Changing the mind-set of mutilators: Changing the mind-set of mutilators plays a crucial role in the eradication of FGM. It entails sensitising them on the consequences of FGM, introducing them to alternatives rites of passage and converting them into anti-FGM agents.

i) Alternative Rites of Passage: Alternative Rites of Passage (ARP) is an approach that marks the transition from childhood to womanhood without the cut. An ARP is characterised by celebrations, exchange of gifts, teachings on cultural and societal values, health and contemporary issues.

j) Mentorship Programmes: Mentorship programmes aim at inspiring girls to realise their full potential in life. Mentors are role models who may or may not have undergone FGM that the community identifies with and emulates. They share their experiences and success in life to motivate the girls to set goals and work towards their attainment. The programme helps to correct the misconception that defying FGM attracts calamities and other negative happenings. Girls who have undergone FGM are encouraged to continue with education and become anti-FGM champions.

k) Community Exchange Visits: Exchange visits enhance learning through benchmarking between two or more communities that share a similar culture but are at different stages in the eradication of FGM. Communities pick out the best practices to inform their strategies for abandonment of FGM.

l) Media Campaigns: Communities are educated on the consequences of FGM through the print, electronic and social media. The media includes newspapers, journals, newsletters, radio, television, mobile phone, Facebook, twitter, blogs, WhatsApp, Instagram, e-social learning, YouTube and chat forums.

m) Capacity Building: Different actors are trained on FGM matters. The training enhances collaboration, networking and partnerships in the campaign against FGM among duty-bearers like the police, administrators, healthcare workers, the judiciary, political leaders, communities and civil society organisations.

n) Safe Havens: The safe havens, also known as rescue centres, are either private or public shelters where girls who are at risk of FGM seek refuge. Food, clothing and psychosocial support are provided through individuals, corporates and anti-FGM partners. The rescue centres eventually re-integrate the girls into their families.

o) Other Support Services: The Government in collaboration with non-state actors implements joint programmes geared towards the eradication of FGM. These include:

- Legal aid and legal education;
- Medical services and psychosocial support;
- Funding of anti-FGM interventions.

4.2 Value-based life skills for prevention and management of FGM

Life skills refer to psycho-social abilities that help individuals cope with challenges. Values are moral standards and principles within which individuals base their reasoning, decisions and actions. Equipping girls and women with value-based life skills empowers them to evade FGM and help those who have undergone the practice to manage its effects. Life skills programmes can be conducted in learning institutions, communities and through other interventions. Some of the life skills and values that help address FGM are presented in Table 6.

Table 6: Life skills and values that help address FGM

LIFE SKILL	APPLICATION	ASSOCIATED VALUES
Self-awareness and self-esteem	Self-awareness helps individuals understand and appreciate who they are and set goals and aspirations. They develop a clear sense of their physical, social, sexual and economic identity. They are also aware of the possible risks and challenges that FGM may pose to the achievement of their goals. Self-esteem allows individuals to develop a healthy sense of worth and value without influence of external factors. High self-esteem enables one to resist the pressure to undergo FGM and other social practices set by the community.	• Respect and tolerance for self and others. • Responsibility for one's choices and actions.
Coping with emotions and stress	Coping with emotions and stress enables an individual to deal with challenges and pressure in life such as those associated with FGM.	• Responsibility, patience and tolerance.
Assertiveness and negotiation	Assertiveness refers to the ability to stand firm in one's belief and resolve, and communicate the same while respecting the views of others without being aggressive. Resisting FGM and other harmful socio-cultural practices demands that one learns to be assertive. This process calls for the individual to possess good negotiation and effective communication skills.	• Freedom to make choices and stand by them. • Respect for the opinions of others. • Responsibility for choices made.
Peer pressure resistance	The need to belong and conform leads individuals to identify, develop and maintain relationships. However, some relations may influence individuals to engage in activities that are against their wishes. Resisting peer pressure is critical in the campaign against FGM.	• Responsibility, • Respect for diversity, • Honesty, cooperation, unity, • Tolerance • Being accommodative.
Empathy and peaceful conflict resolution skills	Conflicts result from differences in opinions, interests and preferences. Individuals and communities collectively seek to understand the effects of FGM and come up with programmes that support girls who have gone through the practice. Empathy is demonstrated through giving psychosocial and medical support to enable the girls continue with education.	• Care • Confidentiality, • Respect, • Unity • Tolerance.
Critical and creative thinking skills, problem solving and decision making	Managing difficult situations requires patience and careful analysis of the challenge and the available alternatives. It calls for making rational decisions. Interventions against FGM need to help individuals and communities reflect on beliefs, myths, stereotypes, convictions and practices in order to eradicate the practice.	• Freedom to think rationally, • Objectivity, • Patience, • Responsibility and tolerance.

4.3 Successes of Interventions towards Eradication of FGM

Various success stories have been documented in the campaign against FGM. The following are some of the milestones made:

a) Increased awareness: There has been an increase in the level of awareness about FGM and related issues. The Kenya Demographic and Health Survey (KDHS 2014) placed the levels of awareness at 98 per cent, an improvement from 96 per cent as reported in the KDHS, (2009). Increased discussions and conversations around FGM will further hasten the eradication of the practice.

b) Reduction in prevalence: The various interventions have led to a decline in the national prevalence of FGM from 27 per cent in 2008/2009 to 21 per cent in 2014.

c) Establishment of the Anti-FGM Prosecution Unit: The Office of the Director of Public Prosecutions (ODPP) has established the Anti-FGM Prosecution Unit. Prosecution officers deployed to the Unit have been trained on FGM prevention and response in order to handle cases appropriately.

d) Enhanced community dialogues: Through dialogue, community members have discussed and debated freely on the possibility of abandoning FGM and accepting uncircumcised girls and women in their community. Vernacular radio stations have provided a platform for sensitization and dialogue on the eradication of FGM in the practising communities.

e) Increased school retention and transition: The Anti-FGM campaigns have contributed to an increase in girls' retention in school and transition to higher levels of education. This implies that many girls who do not undergo FGM and child marriage stand a great chance of completing their education and becoming role models.

f) Abandonment of FGM: Interventions have resulted to some female genital mutilators deserting their role in FGM and adopting alternative sources of livelihood. Some have openly campaigned against the practice. Some videos on the desertion of FGM by female genital mutilators are available on: ***www.https:/youtube/fnUmDJnAybA / https://youtu.be/y1QXDfFMxOY / https://www.YouTube.com/watch?v+1sApjyaGUNY***

g) Anti-FGM Declarations: The campaign against FGM has been greatly boosted by men who openly declare their intention to marry uncircumcised girls. This is seen as a big stride given that marriage has been cited as the reason girls undergo FGM in some communities. Videos on men campaigning against FGM are available on: https://www.YouTube.com/watch?v=aAcQDX6dTCI

4.4 Challenges in the anti-FGM campaign

The campaign against FGM has encountered a number of challenges. Some are enumerated below:

a) Weaknesses in the enforcement of Anti-FGM laws: There is a weakness in the enforcement of the laws prohibiting FGM. Complainants or survivors and witnesses are threatened by other members of the community not to report incidents of FGM to law enforcement officers or testify in a court of law. Communities and other actors do not have adequate knowledge and expertise on evidence preservation; which is critical for successful prosecution and conviction of perpetrators.

b) Inadequate resources to campaign against FGM: The campaign against FGM requires concerted effort, structures and resources at all levels especially at the grassroots. However, there are constraints in financial and human resource to sustain the campaigns.

c) Resistance and hostility: FGM is a deeply entrenched practice in some communities. Advocates against it have often faced resistance and hostility.

d) Insecurity and poor infrastructure: Campaigns against FGM are hampered by insecurity, rough terrain and poor communication networks making it hard to access some communities.

e) Changes in the practice of FGM: There are changes in the practice of FGM that make it difficult to trace and arrest perpetrators. Such changes include the lowered age at which girls are cut, secrecy due to lack of public celebrations and medicalization of FGM.

f) Gaps in the design and implementation of interventions: Despite anti-FGM interventions, the practice still persists. This may be partly attributed to poorly designed programmes and projects. Some programmes and projects do not consider the views of the public; resulting into their rejection and failure.

g) Commercialization of FGM: Some unscrupulous non-state actors have mobilized resources under the guise of campaigning against FGM. A number of them have been unable to account for the resources.

4.5 Role of various actors in the eradication of FGM

Various actors play different roles in the campaign against FGM, as outlined in Table 7.

Table 7: Role of various actors in the eradication of FGM.

ACTOR	ROLES
Government	Policy formulation and implementation / Legislation / Enforcement of the law / Design anti-FGM programmes / Regulation, supervision and coordination of actors / Resource mobilization and allocation / Provision of platforms for information sharing/ Technical support to institutions and agencies / Encouraging citizen participation in campaigns against FGM / Provision of medical and psycho-social support / Research, monitoring & evaluation
Public Benefit Organizations (PBOs)	Advocacy and lobbying / Awareness creation / Resource mobilization and allocation / Capacity development / Design, implementation, monitoring and evaluation of the anti FGM programmes / Conducting research
Council of elders	Offering guidance and direction on social, spiritual, cultural and political matters related to FGM / Conflict resolution
Communities	Embrace all girls and women unconditionally / Denouncing FGM / Recognizing and adhering to laws and policies / Actively participating in anti-FGM campaigns / Protecting girls and women / Reporting cases of FGM
Boys and girls	Reporting cases of FGM / Saying no to FGM / Participating in the anti-FGM campaigns
Corporate bodies	Resource mobilization in support of campaigns against FGM / Contributing towards capacity development in the prevention and management of FGM
Faith Based Organizations (FBOs)	Guidance on FGM based on religious teachings / Preaching against the practice / Initiating conversations on FGM / Being role models / Collaborating with other actors in the campaign against FGM.
Educational and research institutions	Provision of updated data on trends and prevalence of FGM through research / Disseminating research findings / Developing FGM content / Capacity building of stakeholders / Monitoring the delivery of FGM content / Reviewing of FGM content
Celebrities	Motivating and inspiring communities to embrace change / Being role models / Leading and participating in campaigns against FGM / Mentoring young people
Mutilators	Making public declarations against FGM / Joining anti-FGM campaigns / Finding alternative sources of livelihood

The Teachers' Service Commission	Monitoring and reporting what is happening to school girls in relation to FGM / In-servicing teachers
The media	Enlightening the public on the consequences of FGM / Providing timely and accurate information on anti-FGM campaigns
Safe havens/rescue centres	Providing security to girls and women / Collaborating with relevant authorities in the provision of support to girls and women / Providing basic necessities
Partners	Mobilising and allocating resources to address FGM

4.6 Recommendations for future interventions

To fast-track the eradication of FGM, it is recommended that interventions should:

a) Enhance security in and accessibility to hard-to-reach areas
b) Capacity build the communities to address FGM
c) Engage stakeholders at all levels of the interventions
d) Be community led and driven especially ARPs
e) Offer support to youth-led campaigns
f) Ensure sustainability of ARPs
g) Use media to pass anti-FGM messages
h) Enhance collaboration of actors to create synergy
i) Empower communities to evaluate their values, beliefs and practices
j) Document and share lessons learnt and best practices
k) Share information among stakeholders
l) Offer psycho-social support to prevent and manage FGM

Activity

Case Study

Read the following case study on community learning exchanges and answer the questions that follow.

Community Learning Exchange Visit

Milimani and Mpakani communities have been carrying out campaigns to end FGM. The campaign focuses on sensitising and persuading custodians of culture to abandon FGM and accept women who have not undergone FGM for marriage. Over time, the campaigns in Mpakani have borne fruit. Their cultural elders mobilise and lead the community to embrace the change. Female genital mutilators have denounced the practice and adopted alternative sources of livelihood and acquired status change agents. Men are openly and consistently declaring their resolve to marry women who have not been cut and their commitment to support the campaign against FGM. Further, girls boldly come out to inform their peers that it is possible to be accepted, married and live happily without FGM. The community celebrates the girls and contributes resources towards their alternative rites of passage.

In contrast, most of the community members in Milimani do not welcome the idea of abandoning FGM. They conceal the identity of female genital mutilators. The few girls who have escaped the cut report high level of stigmatization and fear rejection.

The community leaders in both communities agreed to have a learning exchange visit. The Milimani community selected a team to represent them in a visit to Mpakani. The team included local government officers, cultural elders, female genital mutilators, women, boys and girls. During the exchange visit, both communities shared their experiences.

Answer the following questions

1. Identify some of the successes that the Mpakani community might have shared during the visit.
2. What do you think are some of the challenges faced by communities advocating against FGM?
3. How can exchange visits help communities learn from each other to eradicate FGM?

Discussion Questions

1. How can you contribute towards eradication of FGM?
2. How would you help an individual who has been affected by FGM?

CHAPTER 5: LEGAL & INSTITUTIONAL FRAMEWORK ON PROHIBITION OF FGM

5.0 Introduction

The Government of Kenya has ratified several conventions and treaties on children and women rights. This chapter outlines various international treaties and conventions that Kenya has ratified, the legislations enacted, and the policies developed towards the eradication of female genital mutilation. These include: Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), 1990; The Nairobi Forward Looking Strategies,1985; African Charter on the Rights and Welfare of the Child (1990) which came into force in 1999; African Charter on Human and Peoples' Rights and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol), 2003; The Constitution of Kenya, 2010; The Children Act, 2001; The Prohibition of Female Genital Mutilation Act, 2011; Kenya Vision 2030 and The National Plan of Action for the Elimination of Female Genital Mutilation,1999. The treaties and conventions, the legislations and policies are discussed in the following sub-section.

5.1 Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)

General recommendation No. 14, ninth session, 1990 on female circumcision, recommends that State parties take appropriate and effective measures with a view to eradicating the practice of female circumcision.

5.2 African Charter on the Rights and Welfare of the Child

The African Charter was adopted by the Assembly of Heads of State and Government of the Organization of African Unity, at its Sixteenth Ordinary Session in Monrovia, Liberia in 1979. The African heads of state recognized the need to take appropriate measures to promote and protect the rights and welfare of the African Child.

Article 16 Protects the Child against Abuse and Torture; it states:

1. States Parties to the present Charter shall take specific legislative, administrative, social and educational measures to protect the child from all forms of torture, inhuman or degrading treatment and especially physical or mental injury or abuse, neglect or maltreatment including sexual abuse, while taking care of the child.

Article 21 Protects against Harmful Social and Cultural Practices; it states:

1. States Parties to the present Charter shall take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child and in particular:
   (a) Those customs and practices prejudicial to the health or life of the child; and,
   (b) Those customs and practices discriminatory to the child on the grounds of sex or other status.

5.3 The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa

This protocol also referred to as Maputo Protocol, 2003 was necessitated by the need to have a regional instrument that adequately protects the rights of women which is culturally relevant to the Africa context. The Protocol was adopted in Maputo, Mozambique in July 2003. It was entered into force in 2005. Article 5 of the Protocol guarantees women the right to an end to female genital mutilation. The article entitled 'Elimination of Harmful Practices' observes that:

> States Parties shall prohibit and condemn all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognised international standards. States Parties shall take all necessary legislative and other measures to eliminate such practices, including:
>
> a) Creation of public awareness in all sectors of society regarding harmful practices through information, formal and informal education and outreach programmes;
>
> b) Prohibition, through legislative measures backed by sanctions, of all forms of female genital mutilation, scarification, Medicalization and para-medicalisation of female genital mutilation and all other practices in order to eradicate them;
>
> c) Provision of necessary support to victims of harmful practices through basic services such as health services, legal and judicial support, emotional and psychological counselling as well as vocational training to make them self-supporting;
>
> d) Protection of women who are at risk of being subjected to harmful practices or all other forms of violence, abuse and intolerance.

5.4 The Constitution of Kenya 2010

The Constitution of Kenya guarantees human rights to all citizens and protection of their dignity as stipulated in the following articles;

Article 44 on language and culture, sub section 3 states that a person shall not compel another person, to perform, observe or undergo any cultural practice or rite.

Article 53 provides, among others, that every child has a right to be protected from abuse, harmful cultural practices, all forms of violence and inhuman treatment.

Article 55 provides, among others, that the state shall take measures to ensure that the youth are protected from harmful cultural practices and exploitation.

5.5 Prohibition of Female Genital Mutilation Act, 2011

The Act prohibits the practice of female genital mutilation and safeguards against violation of a person's mental or physical integrity through the practice and connected purposes. The act further established the Anti-FGM Board to campaign for the eradication of FGM.

5.5.1 Functions of the Anti-FGM Board

The functions of the Board are:

1. Design, supervise and co-ordinate public awareness programmes against the practice of female genital mutilation;
2. Generally advise the Government on matters relating to female genital mutilation and the implementation of this Act;
3. Design and formulate a policy on the planning, financing and co-ordinating of all activities relating to female genital mutilation;

4. Provide technical and other support to institutions, agencies and other bodies engaged in the programmes aimed at eradication of female genital mutilation;
5. Design programmes aimed at eradication of female genital mutilation;
6. Facilitate resource mobilization for the programmes and activities aimed at eradicating female genital mutilation; and
7. Perform such other functions as may be assigned by any written law.

5.5.2 Offences under the Act

Part IV of the Act outlines the offences that constitute female genital mutilation and the penalties upon conviction.

Section 19: Offence of female genital mutilation:

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

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

3. No offence under subsection (1) is committed by an approved person who performs—
   (a) A surgical operation on another person which is necessary for that other person's physical or mental health; or
   (b) A surgical operation on another person who is in any stage of labour or has just given birth, for purposes connected with the labour or birth.

4. The following are, for the purposes of this Act, approved persons—
   (a) in relation to an operation falling within paragraph (a) of subsection (3), a medical practitioner;
   (b) In relation to an operation falling within paragraph (b) of subsection (3), a medical practitioner, a registered midwife or a person undergoing a course of training with a view to becoming a medical practitioner or midwife.

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

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

Section 20: Aiding and abetting female genital mutilation:
A person who aids, abets, counsels or procures—
(a) A person to commit an offence under section 19; or
(b) Another person to perform female genital mutilation on that other person commits an offence.
Section 21: Procuring a person to perform female genital mutilation in another country

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

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

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

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

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

Part v of the act provides miscellaneous information as follows:

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

Section 27: Measures by Government
The Government shall take necessary steps within its available resources
to;

(a) Protect women and girls from female genital mutilation;
(b) Provide support services to victims of female genital mutilation; and
(c) Undertake public education and sensitise the people of Kenya on the dangers and adverse effects of female genital mutilation.

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

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

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

5.6 The Children Act, 2001

This Act provides for parental responsibility, fostering, adoption, custody, maintenance, guardianship, care and protection of children; and of children's institutions.

Section 13 of the Act stipulates that;
(1) A child shall be entitled to protection from physical and psychological abuse, neglect and any other form of exploitation including FGM, trafficking or abduction by any person.
(2) Any child who becomes the victim of abuse, in the terms of subsection (1), shall be accorded appropriate treatment and rehabilitation in accordance with such regulations as the Minister may make.
Section 14 states that no person shall subject a child to female circumcision, early marriage or other cultural rites, customs or traditional practices that are likely to negatively affect the child's life, health, social welfare, dignity or physical or psychological development.

Section 15 protects a child from sexual exploitation and use in prostitution, inducement or coercion to engage in any sexual activity, and exposure to obscene materials.

5.7 National Policies

These are plans of action that have been approved by the government towards eradication of FGM. Two policies discussed in this chapter are Kenya Vision 2030 and National Plan of Action for the Elimination of Female Genital Mutilation in Kenya 1999–2019.

5.7.1 Kenya Vision 2030

The Vision 2030 goal for vulnerable groups is to minimise vulnerabilities through prohibition of retrogressive practises including Female Genital mutilation.

5.7.2 National Plan of Action for the Elimination of Female Genital Mutilation in Kenya 1999–2019

This plan of action is published by the Ministry of Health. The Plan describes the sensitive and responsive interventions and strategies for achieving the goal of reducing the number of girls, women and families affected by female genital mutilation.

5.8 Enforcement of Prohibition of FGM law

Any offence or suspected offence under the law should be reported to law enforcement officers that include; police officer, member of the provincial administration, children's officer, probation officer, gender and social development officer and cultural officer.

Activity

Case study

Read the following case study on family dilemma and answer the questions that follow.

Family Dilemma

Jones and Jonathan are brothers who have recently married from their local community where FGM is prevalent. Jonathan`s wife has undergone FGM while Jones` wife, Sarah has not. Sarah's mother-in-law wants her to undergo FGM as she considers Sarah a child. Jones and Sarah object. They are ridiculed and discriminated against. Jones works far away from home. Sarah feels she cannot withstand the pressure and gives in. Her mother in-law and Jonathan's wife sneak Sarah to Jones' aunt to undergo FGM. Upon return, Jones finds out that his wife has undergone FGM.

Questions

a) What options are available to Jones?
b) What offences have been committed and by who?

Key Inquiry Questions

1. Why is FGM prohibited?
2. What are the offences according to the prohibition of FGM Act?
3. What is the role of a citizen in enforcing the laws against FGM?
4. What is the role of the community in enforcing the laws against FGM?

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