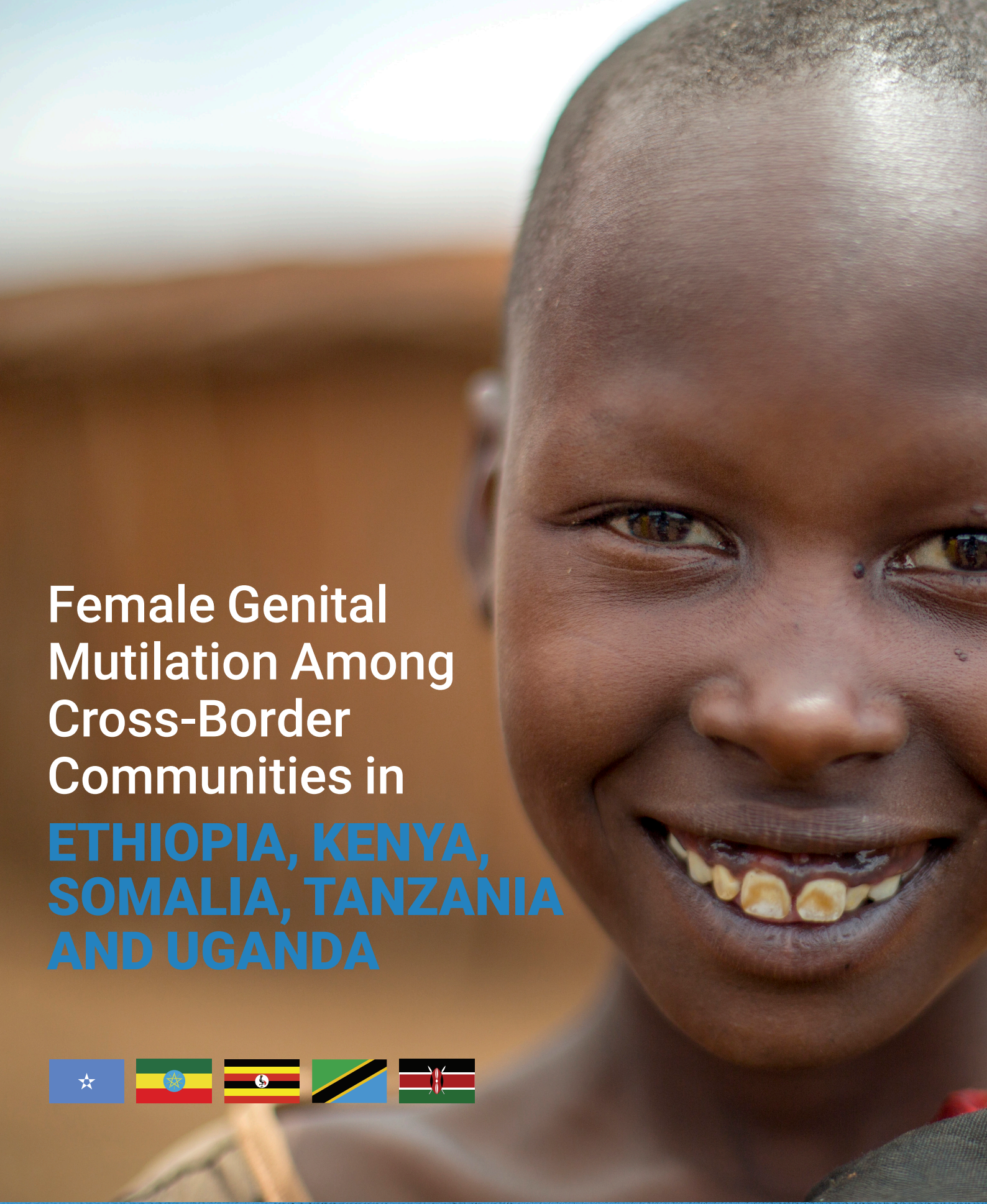
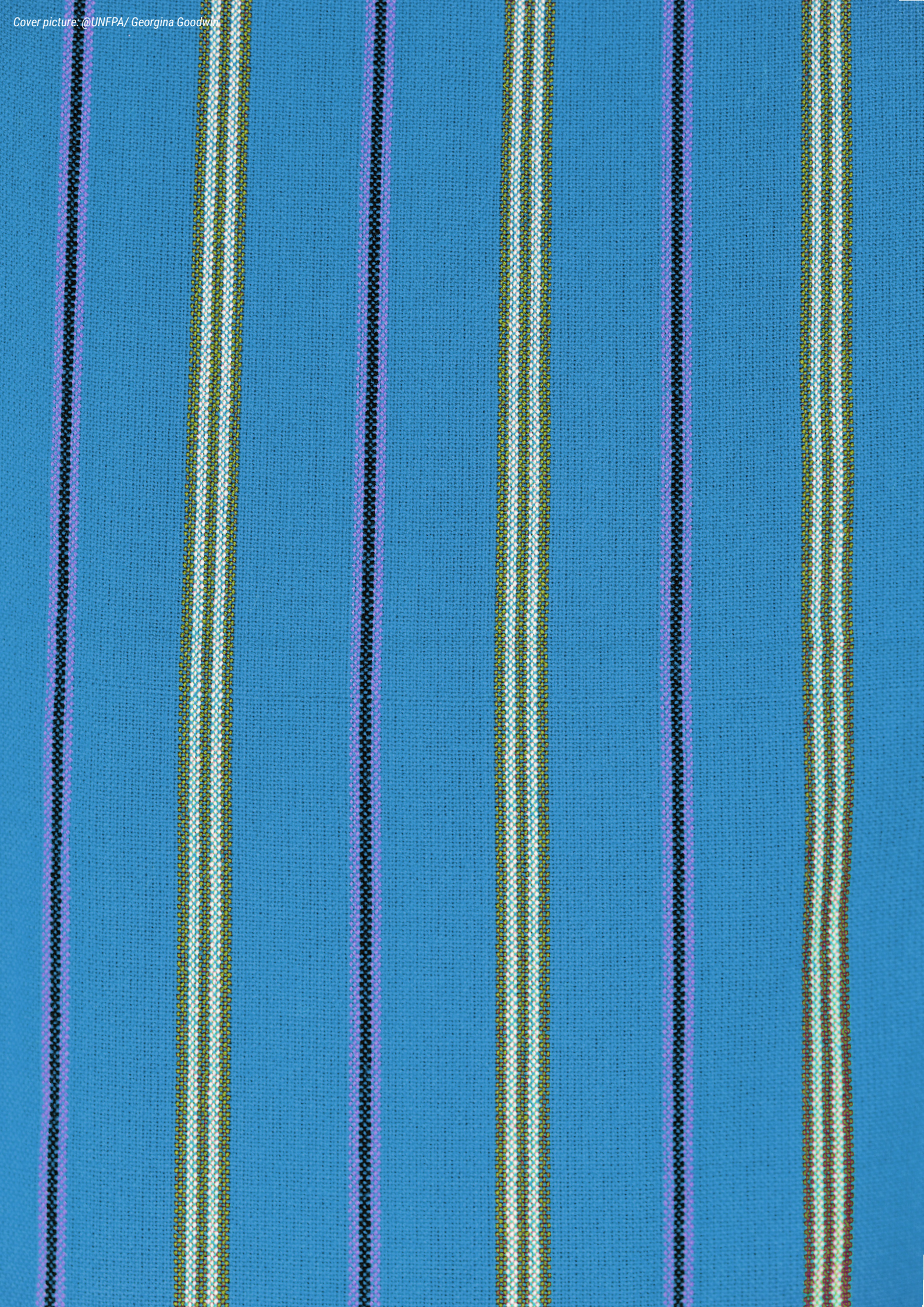


Female Genital Mutilation Among Cross-Border Communities in

ETHIOPIA, KENYA, SOMALIA, TANZANIA AND UGANDA


Cover picture: @UNFPA/ Georgina Goodwin

ACKNOWLEDGEMENT

We wish to acknowledge the leadership of the ministers from the Federal Democratic Republic of Ethiopia, the Republic of Kenya, the Federal Republic of Somalia, the United Republic of Tanzania, and the Republic of Uganda for their leadership in the development and finalisation of this research.

United Nations Population Fund (UNFPA) Kenya County Office has led the development of an institutional partnership between these countries in collaboration with the United Nations Children's Fund (UNICEF) Kenya Country Office and we would like to acknowledge the leadership of Dr. Ademola Olajide, Representative of UNFPA in Kenya and contributions of Caroline Murgor and technical specialists from the UNFPA Country Offices in Ethiopia, Somalia, the United Republic of Tanzania, and Uganda.

We also wish to acknowledge the technical support of Nafissatou J. Diop, Chief Gender and Human Rights Branch, Berhanu Legesse, Technical Specialist, and Thierno Diouf, Monitoring & Evaluation Specialist from the Gender, Human Rights and Culture Branch.

Much appreciation to the crucial roles played of Julie Diallo and Grace Uwizeye from UNFPA East and Southern Africa Region (ESAR) for their contribution to the report under the guidance of Beatrice Mutali, Deputy Regional Director, UNPFA ESAR and Dr Bannet Ndyanabangi, Regional Director of UNFPA ESAR.

We also wish to thank the support from UNICEF East and Southern Africa Office.

Author: Dr Meseret Kassahun

Editor: Prepress Projects Ltd: December 2021

Suggested citation: Female genital mutilation among cross-border communities in Ethiopia, Kenya, Somalia, Tanzania, and Uganda.

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ABBREVIATIONS AND ACRONYMS

ADRA	Adventist Development And Relief Agency
AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical And Research Foundation
CBO	Community-Based Organization
EAC	East African Community
EDHS	Ethiopia Demographic Health Survey
ESRC	Ethics And Scientific Review Committee
FBO	Faith-Based Organization
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
GBV	Gender-Based Violence
GEM	Africa Gender & Media Initiative
HIV	Human Immunodeficiency Virus
IGAD	Intergovernmental Authority On Development
KDHS	Kenya Demographic Health Survey
KII	Key Informant Interview
MIS	Management Information System
MOH	Ministry Of Health
NCA	Norwegian Church Aid
NGO	Non-Governmental Organization
SEDHURO	Socio-Economic Development And Human Rights Organization
STD	Sexually Transmitted Disease
TDHS	Tanzania Demographic Health Survey
TVET	Technical And Vocational Education And Training
UDHS	Uganda Demographic Health Survey
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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FOREWORD

Through the Sustainable Development Goals, the world made a strong commitment to end female genital mutilation (FGM) by 2030. The fight to end FGM is at a tipping point, and undeniably we have made progress with the ambitious regional End Cross-border Female Genital Mutilation Action Plan in our countries.

Delivering the ambitious goal of ending FGM by 2030 will require ambition, decisiveness and a sense of urgency. This will translate into putting more efforts into harmonizing national laws and scaling up capacity-building efforts and the quality of services for women and girls.

This research is the first-ever regional research in East and Southern Africa that highlights the extent of FGM within the cross-border communities in Ethiopia, Kenya, Somalia, Tanzania and Uganda. The findings show yet again how intergovernmental collaboration is critical in the journey to end FGM by 2030.

The findings provided in this report are invaluable in the effort to end FGM, because they push us to act and provide a baseline from which we can measure the scale and effectiveness of interventions. The findings will influence the development of strategic investments, policy and programmes to end FGM at regional and national levels.

This study establishes that there is need to intensify our efforts to end FGM within the border communities, which will contribute to reinforcing the gains made at national levels. This calls for intercountry collaboration and coordination if it to be more impactful and scalable. This research is a strategic intervention that will inform the regional action plan.

Federal Democratic Republic of Ethiopia
Ministry of Women and Social Affairs,
Minister Hon. Dr. Ergogie Tesfaye

Federal Republic of Somalia
Ministry of Women and Human Rights Development
Minister, Hon. Hanifa Mohamed Ibrahim Habsade

Republic of Kenya
Ministry of Public Service, Gender, Senior Citizens Affairs and Special Programmes Cabinet Secretary,
Professor Margaret Kobia, PhD, MGH

United Republic of Tanzania
Ministry of Health, Community Development, Gender, Elders and Children Minister,
Hon. Dr Dorothy O.Gwajima

Republic of Uganda
Ministry of Gender, Labour and Social Development
Minister of State for Gender and Culture Affairs, Hon. Mutuuzo Peace Regis (MP)

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EXECUTIVE SUMMARY

Cross-border female genital mutilation (FGM) practices were found to be prevalent and to hinder the proper control of criminal activities along the borders of Ethiopia, Kenya, Somalia, Tanzania and Uganda. The lack of a common regulatory regime and laws make it difficult for the individual countries to ensure compliance with their respective laws governing the practice. Understanding the cross-border dynamics is important to ensure that the countries cooperate and find mutual ways of ensuring compliance with the various laws that protect girl children and women against harmful cultural practices.

Despite the existence of criminal law, which is an important aspect of anti-FGM policies and programmes, there is not much research on the effects of cross-border practices that invalidate the law as a deterrent. Much remains unknown about the practice of cross-border FGM, specifically about gaps in existing policy and legislation for managing cross-border FGM, as well as whether the existing interventions in the cross-border areas are sufficiently targeted to facilitate changes in social norms.

The movement of families and traditional practitioners across national borders for the purpose of practising or undergoing FGM has been a complex challenge for the campaign to end the practice. At the 32nd African Union Heads of State and Government Summit, member states adopted a declaration “Galvanizing Political Commitment towards the Elimination of Female Genital Mutilation in Africa” and endorsed an African Union continent-wide social marketing campaign that focuses on addressing the cross-border practice of FGM. This campaign, which has a global target of eliminating FGM by 2030, formed the basis for the commissioning of this exercise.

The overall objective of the regional interministerial meeting was to strengthen intercountry collaboration on FGM in border areas, share good practices and chart a way forward in response to cross-border FGM. To this end, this study had several objectives. The overall objective was to assess the status of FGM in the cross-border areas in order to finalize the regional End Cross-border Female Genital Mutilation Action Plan. Specifically, the study aimed to:

- Identify the social dynamics of the practice of FGM in these communities and the gaps in existing policy and legal frameworks and finalize the regional End Cross-border Female Genital Mutilation Action Plan
- Examine the sociocultural, health, political and economic effects of FGM on cross-border communities, particularly on women and girls
- Establish determinants and drivers of cross-border FGM among communities in Ethiopia, Kenya, Somalia, Tanzania and Uganda
- Map out institutions and organizations engaged in FGM prevention and response and the types of interventions in the border areas, including referring women

and girls to health and psychosocial services or reporting practitioners and families to the police

- Explore the social norms and practices related to FGM and the level to which these are upheld or contested by cross-border communities in the four borders studied between Ethiopia, Kenya, Somalia, Tanzania and Uganda.

The study used a mixed methods cross-sectional design, which allowed us to collect quantitative and qualitative data simultaneously. Desk review formed the basis for the formulation of research questions. Apart from the questionnaire survey, the study used other qualitative methods, which included key informant interviews, focus group discussions and targeted observations at the border points. A total of 1,480 respondents were interviewed, comprising 704 (48 per cent) males and 776 (52 per cent) females. The researchers also reached out to 143 key informants and conducted 63 focus group discussions. Qualitative data were analysed using Stata 14.2, while the qualitative data were analysed with QSR Nvivo 12 iteratively and later thematically.

The study sites included the following common borders:

- Kenya–Tanzania border (i.e. the Maasai community in the Transmara region and the Kuria in Isebania, Migori County)
- Kenya–Ethiopia border (i.e. the Borana community in Moyale subcounty and the Ommo and Turkana communities)
- Kenya–Uganda border (i.e. the Pokot community in the Karamoja region and the Sebei in Uganda and the Sabaot in Mt Elgon region, Kenya)
- Kenya–Somalia border (i.e. the Somali community in the Mandera border area in north-eastern Kenya and Somalia).

The results of the study indicate that there is great need to harmonize legislation to allow cross-border collaboration on anti-FGM activities and to empower women and girls to make independent decisions that will change the trends in FGM in the focus communities.

In terms of the current gaps in the legal and policy provisions on cross-border FGM, all of the countries studied except Somalia have anti-FGM laws, although their implementation is still weak or non-existent and resistance to the laws is widespread. This is because of a number of factors, including lack of knowledge of the law and the penalties, limitations in and lack of proper implementation of the laws within the respective jurisdictions, and in some cases failure to accept existing national laws by some border communities. Currently, there is no specific legislation at the regional level that prohibits FGM, making collaborative efforts to eliminate FGM in the individual countries using legal and policy measures difficult. This lack of harmonized laws between the countries has been a hindrance to law enforcement in the efforts to apprehend perpetrators who can easily enter and leave different jurisdictions. The study recommends the development of a legal and policy framework that addresses cross-border FGM activities.

The study notes that there are still many sociocultural and religious drivers that promote the practice of FGM among the border communities. Gender identity is particularly significant – what it means to be a girl and what she requires to become a "complete human being". Culture is closely tied to marriageability, familial honour, bride wealth at marriage, preventing promiscuity, preserving virginity and assuring the husband's sexual pleasure and satisfaction (common among the Maasai, Pokot, Kuria, Somali and Oromo). FGM is a rite of passage (among the Maasai, Kuria and Pokot) and a religious requirement (common on the Somali and Ethiopian borders). In all of the study communities, the girl's parents only become "real people" in the community after subjecting their daughter to FGM. Otherwise they are "outcasts" and not allowed to participate in communal rituals and related ceremonies.

The study recommends upscaling engagement with the custodians of culture to promote understanding of FGM as a violation of the rights of women and girls and as a means of subordination. This will involve more detailed understanding and appreciation of the approach to changing social norms and creating the critical mass necessary to change the social and cultural environment.

The study concludes that FGM violates the dignity of the individual and compromises their autonomy to exercise their sexual and reproductive rights, educational rights, economic rights and their liberties. The impact and consequences of FGM are both short term and long term. The impacts reported in the study include health consequences such as excessive bleeding, pain, potential spread of diseases, childbirth complications (e.g. obstructed labour), obstetric complications, retention of menstrual blood, development of fistulas and death. There are also psychological impacts such as trauma, emotional effects, depression, stigmatization and at times domestic violence. Sexual malfunction, painful intercourse, decreased sexual satisfaction, fear of intercourse and lack of enjoyment were reported to be some of the sexual effects of FGM.

In addition, FGM compromises women and girls developing the capacity to emancipate themselves. Some of the notable impacts of FGM include increased school drop-out rates after cutting, frequent absenteeism from school, increased rates of early or child marriages or forced adulthood, retardation of women's economic development, and increased medical expenses and related costs for the family. All of this has ensured the continued insubordination of women and girls and their increased dependency, leading to less productivity. All these impacts have adverse effects on the quality of life of women and girls in particular and the community in general.

The study found that there are a good number of organizations along common borders that work on ending FGM, albeit with some variation in the areas of engagement. The organizations range in scope from community based to international. Those reported included several community-based organizations, several non-governmental organizations, the United Nations Population Fund, United Nations Children's Fund, Socio-Economic Development and Human Rights Organization, Action Aid, World Vision, Habiba International, Save the Children, Population Council, several government agencies, and faith-based organizations, among them the Adventist Development and

Relief Agency, Norwegian Church Aid, Pentecostal churches, Catholic churches and mosques. There are also individual human rights activists, the political class, women's networks, judicial officers, the police and local administrators. The duties they perform include training and sensitization, awareness-raising activities, survivor support, providing shelters and rescue centres, spearheading cross-border engagements, organizing cross-border meetings, capacity-building campaigns, supporting medical referrals and expenses, providing psychological support to survivors, supporting schooling programmes and organizing campaigns to change social norms. The study recommends that their actions and activities should be coordinated to avoid duplication and competition that may hamper their effectiveness.

Regarding the prevalence of cross-border FGM, the borders were found to be too porous and hence easily crossed back and forth. Generally, no law exists at these common borders to regulate the practice of FGM. For instance, a family in the Maasai, Kuria, Borana or Somali community may have parts of the nuclear family on either side of the border, so, depending on their perception of which side has the less prohibitive anti-FGM laws, they would cross at will to perform the act and return. The similarity in the traditions, languages, cultures and resistance to the "imposed" laws are some of the reasons for the continuing practice of cross-border FGM. Apart from the cultural uniformity, other reasons for the rampant practice of cross-border FGM include the ability to avoid arrest, as a result of the remoteness and the lack of infrastructure such as roads on the borders, the availability of experienced circumcisers who are believed to reside on the Kenyan side of the border, common hostility between neighbouring countries at the political level that ensures minimal collaboration in apprehending cultural offenders, and the absence of a regional mechanism that enables neighbouring countries to forge a common front to handle FGM.

Moreover, the study found that communities still conform to traditional views on the practice of FGM and are compelled to act like all those around them. There are very few people who have abandoned the practice, and unfortunately they have not reached the critical mass needed to tilt the scale against circumcision as the norm. There are, however, changes that have been observed in the practice of FGM. These include younger girls being mutilated, a limited number of actors involved, changes in the timing of mutilation, minimal celebrations compared with those in previous times, and reduced severity of mutilation, as most people now prefer type I FGM over type III, which was common among some communities. Some simply say that they nowadays just "prick" the clitoris as a way of demonstrating cutting. There are also instances of medicalization of the process as a way of ensuring "safety". The lack of proximity of the of the border points to the cities and the lack of social amenities that expose people to different lifestyle may be preventing people from developing self-awareness. This limits the ability of individuals to see their situation differently, and often it is learned helplessness that makes them conform to FGM as a way of gaining social acceptance.

Opportunities to eradicate the practice of FGM exist, since communities speak highly of empowered women and all parents would want to see their daughters develop and achieve their maximum potential as human beings. The problem is that many of them

do not seem to see that FGM is a stumbling block to achieving that emancipation. The study recommends that organizations working in these areas should work very closely with the custodians of culture and religious leaders to develop a participatory process towards achieving grassroots-driven change. They should create the necessary awareness and identify model families and individuals with the power and the will to drive change from a communal perspective. The organizations could also identify and work with reformed circumcisers, who wield the power to be at the forefront of preaching the "new normal", and liaise with Governments to open up the infrastructure to ease communications and increase engagement between communities.

Drawing on the major findings of the study, the following specific recommendations on legal and policy frameworks, anti-FGM programmes and research are made.

A. Legal and policy frameworks

LEGISLATIVE

- National legal pluralism should be addressed to provide guidance on how to deal with the inherent conflict between the formal law on the one hand and religious and customary rules on the other to achieve social legitimacy within the formal criminal law.
- A regional law that prohibits FGM is needed and should consider provisions that:
  - Harmonize the offences and minimum penalties to eliminate the need for people to cross borders to face less punitive penalties
  - Capitalize on local and religious rules and laws that prohibit the practice of FGM
  - Protect those who report or are witnesses in FGM cases
  - Address emerging issues such as the medicalization of the practice and self-mutilation.
- A robust policy structure with accompanying plans of action is needed at regional level, providing minimum standards while allowing countries to integrate these policy provisions to reflect their unique situations.
- These policy provisions should address:
  - Implementation strategies with dedicated budgetary allocations
  - A monitoring and evaluation framework to track progress throughout the border communities
  - Standard operating procedures on how to deal with FGM cases in each jurisdiction in the region

Other complementary polices that address interrelated issues, such as health and psychosocial support for survivors of FGM and re-admission to school for girls who are survivors of FGM and child marriage.

CAPACITY BUILDING

- Train all law enforcement officials on the practice of FGM and the anti-FGM laws. Joint training sessions would be ideal to ensure uniformity of understanding of the practice of FGM and the law.
- We hope that the findings of the study will contribute to enlarging the evidence base for anti-FGM planning, budgeting and decision-making, to realize our ambitious goal. It is our wish that it will translate into sustainable action that will make a difference to the lives of women in the region.
- Improve the ability of law enforcement officials to arrest perpetrators and continue to raise awareness of FGM and the law within their communities by improving the infrastructure and other resources such as cars to increase their mobility within their administrative areas.
- Increase awareness of the existence of the national laws banning FGM, and the associated penalties, in particular along the Kenya–Ethiopia border among the Dasenach (Ethiopia), Borana (both Kenya and Ethiopia) and Somalis in Mandera (both Kenya and Somalia). Awareness-raising among community members is needed: including key community players such as religious and cultural leaders is important, as this encourages buy-in from community members and increases compliance with the law.
- Make extensive use of local media outlets and accessible social media platforms to raise awareness of FGM, including the support services available in the cross-border areas.

B. Preventive and response programmes on anti-FGM practice should be scaled up

- Intensify advocacy and awareness-raising activities throughout the border areas. Such activities should be designed to address specific drivers in the different communities and other harmful practices such as child marriage.
- Provide comprehensive health services, including psychosocial support, to help survivors deal with FGM-related complications, such as fistulas, in the cross-border areas.
- Exploit the influence of religion in eradicating the practice by promoting the correct religious teachings and using religious leaders as agents of change. The definition of FGM should be aligned with the World Health Organization's definition. This would eliminate the defence that certain types of acts are religious or cultural and therefore are not regarded as FGM, for example the Sunna type of circumcision.

- Institute an accountability mechanism to prevent medical professionals from engaging in any form of FGM. In addition to criminalizing the medicalization of the practice, medical institutions should have policies for dealing with medical professionals who perform FGM.
- Tailor interventions to specific communities' belief systems in the cross-border areas to ensure that social change is community driven and participatory and to give the people more say in transforming their traditions towards a new reality.
- Introduce evidence-based social norm change models to allow community members to come up with community consensus on alternative rites of passage ceremonies while abandoning the practice of FGM completely.
- Map out organizations engaged in FGM prevention and response activities and services to improve the distribution of these services and establish referral systems among the various organizations in collaboration with Government departments.

C. Related research

- There was no baseline study with which to compare the major findings from the current study and discuss the social changes in FGM practice occurring in the cross-border areas. Hence, we recommend process evaluation research to capture new trends, measure changes in practice and develop interventions that are informed and effective.
- The research failed to capture the situation on the Tanzanian side of the border as a result of the necessary approval processes and the COVID-19 pandemic. There is a need to repeat the survey when time allows to find out the views of the Maasai and Kuria communities on the Tanzanian side of the border.
- There may also be a need to further interrogate the political processes and diplomatic dimensions that hinder neighbouring countries from taking a common approach, since this may delay the development of joint action against FGM.
- There may be a need to understand the effects of the current political and diplomatic standoff between Kenya and Somalia and how this may hamper the development of common laws against FGM.

1 Introduction

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1.1 Background

Female genital mutilation (FGM), also commonly referred to as female circumcision, comprises all procedures that intentionally alter or cause injury to the female genital organs (WHO, 2018). According to the World Health Organization (WHO, 2018) classification, there are four main types of FGM: 1) clitoridectomy; 2) excision; 3) infibulation; and 4) all other forms of harmful procedures to the female genitalia for non-medical purposes. The first type refers to a partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris). Whereas excision is the partial or total removal of the clitoris and the labia minora (the inner folds of the vulva), with or without excision of the labia majora (the outer folds of skin of the vulva), infibulation involves the narrowing of the vaginal opening by creating a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris (clitoridectomy).

FGM is largely understood as a medically unjustified modification of women's genitalia (Wagner, 2015). Globally, it is estimated that more than 200 million girls and women alive today (UNICEF, 2016) have undergone FGM in 30 countries in Africa, the Middle East and Asia where the practice is concentrated (UNICEF and UNFPA 2019). Without concerted and accelerated actions, another 68 million girls are likely to undergo FGM by 2030 in these same countries (UNFPA, 2018). A total of 28 countries out of the 30 countries where FGM is prevalent are in Africa. In East Africa and the Horn of Africa, the prevalence of FGM among women aged 15–49 years in Ethiopia is 65 per cent (Ethiopia Demographic and Health Survey [EDHS]), 2016; see Central Statistical Agency and ICF, 2016), Kenya 21 per cent (Kenya Demographic and Health Survey [KDHS], 2014; see Kenya National Bureau of Statistics and ICF Macro, 2015), Somalia 98 per cent, Tanzania 10 per cent (Tanzania Demographic and Health Survey [TDHS]/MIS, 2015–16; see Ministry of Health et al., 2016) and Uganda 0.3 per cent (Uganda Demographic and Health Survey [UDHS], 2011; see Uganda Bureau of Statistics and ICF, 2012). Although Somalia remains one of the countries with the highest prevalence of FGM in the world, there are areas in the other countries where the prevalence is higher than the national averages, especially in the border areas of Ethiopia (EDHS, 2016), Kenya and Uganda (UDHS, 2011) and Tanzania (TDHS/MIS, 2015–16). In most cases, the ethnic groups or communities involved live on both sides of the borders, in border towns, and share a common culture, language and customs. The five countries listed above account for almost one quarter (an estimated 48.5 million) of the girls and women who have undergone FGM globally (UNICEF, 2016). This is an alarming number, and it requires a comprehensive international intervention to end the decades of suffering among women and girls because of this harmful cultural practice.

The movement of families and traditional practitioners across national borders for the purpose of performing or undergoing FGM or female circumcision (FGM/C) remains a complex challenge for the campaign to end the practice, and women and girls living in border communities can be particularly vulnerable. At the 32nd African Union Heads of State and Government Summit, in Addis Ababa, Ethiopia, in February 2019, member states adopted a declaration "Galvanizing Political Commitment towards the Elimination of Female Genital Mutilation in Africa" and endorsed an African Union continent-wide social marketing campaign that focuses on addressing the cross-border practice of FGM. The global target of eliminating FGM by 2030 will be achieved only if efforts to address the problem are intensified, especially across the borders.

A study commissioned by Kenya Country Office of the United Nations Children's Fund (UNICEF) in 2017, in collaboration with the Kenya Anti-FGM Board (UNICEF, 2017), shows the influence of the border communities on the prevalence of FGM in both those who supply the services and those who demand them. The findings show that approximately 60 per cent of respondents from Ethiopia, 14 per cent from Somalia, 17 per cent from Tanzania and 71 per cent from Uganda travelled to Kenya to undergo FGM. Specifically, approximately 4 per cent of the women surveyed indicated that they had visited Kenya only once, 8 per cent had always visited Kenya for FGM and 30 per cent stated that they visited Kenya occasionally for FGM. By country, 54 per cent of women surveyed from Ethiopia, 50 per cent from Somalia and 22 per cent from Uganda visited Kenya at least three times for FGM. Approximately, 46 per cent of women surveyed from Ethiopia, 50 per cent from Somalia, 100 per cent from Tanzania and 77 per cent from Uganda visited Kenya once or twice for FGM. This shows that the survey respondents who had visited Kenya more than once for FGM may have been involved in securing repeated FGM procedures in Kenya for their relatives and friends. The reasons given by respondents for crossing over to Kenya for FGM included affordability (48 per cent), quality of FGM procedures (41 per cent), fear of arrest in their native country (37 per cent) and lack of proximity to circumcisers in their native country (15 per cent). Much remains unknown about the practice of cross-border FGM, specifically about gaps in existing policy and legislation for managing cross-border FGM, as well as whether the existing interventions in the cross-border areas are targeting changes in social norms.

To end cross-border FGM, representatives of the gender ministries from Kenya, Tanzania and Uganda, together with their counterparts from the United Nations Population Fund (UNFPA) and UNICEF Joint Programme to Eliminate Female Genital Mutilation, met officially in Burkina Faso during an international conference to end FGM in 2018. During the meeting, the representatives agreed to set up a tripartite initiative to end cross-border FGM in Kenya, Tanzania and Uganda . However, subsequent discussions in Kenya, between the Kenya Ministry of Gender, UNFPA and UNICEF concluded that it would be imperative to have Ethiopia and Somalia on board. Subsequently, a regional interministerial meeting was held from 15 to 17 April 2019 in Mombasa, Kenya. The overall objective of the interministerial meeting was to strengthen intercountry collaboration on FGM in border areas, share good practices and chart a way forward in response to cross-border FGM.

As part of the recommendations from the Burkina Faso meeting and specifically pillar 4 of the interministerial meeting – Action plans on evidence, research and data – this study was commissioned to provide detailed information on the current trends and patterns in the practice of FGM among communities living in border areas of Ethiopia, Kenya, Somalia, Tanzania and Uganda.

1.2 Objectives of the study

The overall objective of this research was to assess the status of FGM in the cross-border areas of Ethiopia, Kenya, Somalia, Tanzania and Uganda in order to finalize the costed regional Action Plan to End Cross-border Female Genital Mutilation. Specifically, the study aims were as follows:

- Identify the social dynamics of the practice of FGM in these communities and the gaps in existing policy and legal frameworks and finalize the regional End Cross-border Female Genital Mutilation Action Plan
- Examine the sociocultural, health, political and economic effects of FGM on cross-border communities, particularly on women and girls
- Establish determinants and drivers of cross-border FGM among communities in Ethiopia, Kenya, Somalia, Tanzania and Uganda
- Map out institutions and organizations engaged in FGM prevention and response and the types of interventions in the border areas, including referring women and girls to health and psychosocial services or reporting practitioners and families to the police
- Explore the social norms and practices related to FGM and the level to which these are upheld or contested by cross-border communities in the four borders studied between Ethiopia, Kenya, Somalia, Tanzania and Uganda.

2 Female Genital Mutilation In The Cross-Border Areas

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Drivers, consequences, social norm change and availability of legislative and policy frameworks

The study reviewed the various aspects of the practice of cross-border FGM, among them the sociocultural drivers, the effects of the practice, the issues of norm change, and the legal and policy context around the practice.

2.1 Sociocultural drivers of female genital mutilation

Evidence available on the drivers of FGM show that multifaceted sociocultural factors contribute to the sustenance of the practice in many societies in Africa (UNFPA and UNICEF, 2019; WHO, 2016). These reports also single out certain sociocultural requirements and considerations that enhance the continuation of the practice: among them, issues related to marriageability, maintenance of family honour and respect, community acceptance and ethnic identity, the ritual marking of the transition to womanhood, improvement of hygiene, and religious and cultural requirements are major drivers.

Wagner (2013) used cross-sectional data from 13 African countries and explored why FGM persists, and her analysis revealed that the sociocultural significance and reputation gained contributes to the persistence of the practice of FGM. Furthermore, the same study shows that being cut increases a young woman's marriage prospects by almost 40 per cent. The practice of FGM is deeply rooted within the social and cultural identity of the practising communities. Evidence also shows that FGM is strongly associated with increasing the social capital of young women and bringing power and prestige (Refaei, Aghababaei, Pourreza and Masoumi, 2016). The prevailing beliefs and norms around the practice of FGM have been attracting girls and may make a woman willing to undergo FGM as part of conforming to prevailing cultural requirements. This is because the practice is perceived to allow members of the society to continue to enjoy a sense of belonging within their community. Rafaei et al. (2016) also argue that women and girls who decide not to conform to the practice of FGM would experience social consequences, such as harassment, ridicule and social stigma, forcing women and girls to undergo FGM even in circumstances where their knowledge does not support the practice.

2.2 Health and socioeconomic effects of female genital mutilation

Evidence on the effects of FGM show that many communities consider the practice to be normal cultural and traditional practice (WHO, 2016). However, FGM has both short- and long-term effects on the women and girls who undergo the procedure (Reisela and Creighton 2015). The short-term consequences of FGM include traumatic bleeding and infection, including wound infection, septicaemia, gangrene and tetanus. The long-term gynaecological complications include infection, scarring and keloid, menstrual difficulties, urinary symptoms and infertility. FGM also has psychological effects, including challenges in sexual functioning (Reisela and Creighton, 2015; WHO, 2008). Based on cross-sectional data from 13 African countries, Wagner (2015) also found that cut women with long-term health impairments have a 24 per cent higher odds of contracting sexually transmitted infections and a 15 per cent increase in genital problems.

Based on a qualitative study that looked at the consequences of FGM on girls' schooling in Tanzania, Pesambili (2013) found that uncircumcised girls experience significant isolation, stigmatization, lack of support in education, forced circumcision and forced marriages. Refaei et al. (2016) also found that the social consequences of FGM include identity-based harassment of uncircumcised girls and women, exclusion from the adult community and communal events, discrimination by peers, social rejection, loss of social status, and increasing isolation. Although the effect of FGM on the economic and political well-being of women and girls has not been adequately studied, it is obvious that FGM is mostly used as a rite of passage that automatically changes the status of girls to that of women. As a result, cut girls and older women are likely to get married and drop out of school, which in turn affects their ability to pursue a career and significantly reduces their likelihood of entering the labour market. This affects women's economic development and hinders their emancipation. It disempowers them from being active participants in the politics of their country, given their limited capacity.

2.3 Legal and policy frameworks

FGM has become illegal, as countries in the Horn of Africa have instituted various laws and policies with one strategy, namely, to end the practice. These national laws' and policies' provisions vary in content and scope. The countries in this study are signatories to several international and regional treaties that identify FGM as a serious violation of the human rights of women and girls, with negative health, social and economic consequences, which should be eliminated. With the exception of Somalia, all the other countries have ratified the Convention on the Elimination of All Forms of Discrimination against Women and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), Somalia has, however, not signed the Maputo Protocol. Despite the availability of laws in the

individual countries apart from Somalia, the practice of FGM persists, and research shows that border areas in these countries report higher levels of the practice than their national averages (UNICEF, 2017).

While there are national laws and policies to tackle FGM within the respective jurisdictions, this is lacking at the regional level. A proposed bill on the prohibition of FGM in the East African Community was passed by the Assembly in 2017 but is yet to be assented to by heads of state. Enactment of a law that prohibits FGM at the East African Community level would allow cooperation on the uniform implementation of FGM legislation in the borders of Kenya, Tanzania and Uganda. The Intergovernmental Authority on Development does not have any mandate to address issues such as FGM, yet of all its member states have high levels of FGM being practised within their borders. The evaluation report on the joint UNFPA and UNICEF anti-FGM programme shows that poor implementation of laws is a major barrier to reducing FGM (UNFPA, 2019). The use of legislation has gained momentum over the years as a strategy for eliminating FGM; however, various limitations, gaps and challenges have been identified. For example, there is no evidence showing the extent to which the practice of cross-border FGM has been targeted by existing laws and policies.

2.3.1 Kenya

Unlike most practising countries, in Kenya FGM has been in steady decline since the 1960s, according to data from the Demographic Health Survey (Engelsma, Mackie and Merrell, 2019). The development of laws and policies to address the practice of FGM started in the late 1980s with President Daniel arap Moi issuing two decrees banning the practice and forbidding it in Government-controlled health facilities. A national plan of action was launched in 1999, followed in 2001 by a criminal law that prohibited FGM for girls under 18 years old. Section 14 of that Act declared that “no person shall subject a child to female circumcision”, and Section 20 imposed criminal penalties on any person who wilfully or by culpable negligence violates the child’s right not to be cut. Reportedly, there was little enforcement and little effect.

Presently, Kenya has a mixed legal system comprising English common law, Islamic law and customary law. The country has a quasi-federal structure with two distinct but interdependent tiers of government at national and county levels. The Constitution of Kenya (Kenya, 2010) assigns all criminal law to the national Government. National law supersedes any laws made at the county level and applies when there is no county legislation on a matter. Although the constitution does not explicitly refer to FGM, Article 29(c) provides the right not to be “subjected to any form of violence” or (f) “treated or punished in a cruel, inhuman or degrading manner”. Article 44(3) states that “a person shall not compel another person to perform, observe or undergo any cultural practice or rite”. In addition, Article 53(d) protects every child from “abuse, neglect, harmful cultural practices, all forms of violence, inhuman treatment and punishment ...”.

In 2011, a more comprehensive law prohibiting FGM (Prohibition of Female Genital Mutilation Act) which, applies to all ages and with stronger penalties, was enacted.

The law at Article 2 defines FGM and Articles 19–25 outline the offences related to FGM; it penalizes those who perform (including medical practitioners), aid, abet, counsel or procure another person to perform FGM (even outside the Kenyan jurisdiction) or anyone who fails to report an act of cutting to the law enforcement agency. Interestingly, it also penalizes the stigmatization of women who have not undergone FGM, in order to undermine it as a social norm (Prohibition of Female Genital Mutilation Act, 2011). The Children's Act (2001) at Section 14 specifically prohibits FGM and allows for the issuance of a protection order by the court where a female child is likely to be subjected to FGM at Section 119(1)(h). The Protection against Domestic Violence Act (2015) defines domestic violence under Section 3(a)(ii) to include "female genital mutilation" and under Article 19(1)(g) it provides the facility to set up protection orders covering potential victims against engagement, or threats to engage, "in cultural or customary rites or practices that abuse the protected person". Lastly, Kenya's Penal Code (revised 2014) under Section 4 outlaws the deliberate infliction of "grievous harm", which includes "any permanent or serious injury to any external or internal organ, membrane or sense".

In addition to substantive legislation, there are several policy provisions for the response to and management of FGM; these include the National Policy for the Eradication of Female Genital Mutilation of 2019 (Kenya, 2019), the National Adolescent Sexual and Reproductive Health Policy of 2015, the National School Health Policy of 2018 and the National Plan of Action for Children in Kenya (Kenya, 2015), all of which recognize FGM as having negative health consequences for girls and as a violation of their human rights (National Plan of Action, 2015–2022). Kenya also has a coordinating body (the Kenya Anti-FGM Board) with a state budget for its anti-FGM activities. The country has also built-up response capacity in the criminal justice system, whereby a special unit to prosecute FGM cases was established but later disbanded and merged into a general gender-based violence unit. A richer account of the law in Kenya can be found in Shell-Duncan, Gathara and Moore (2017, 9–11).

With particular regard to cross-border FGM, Sections 21 and 28(1) of the Prohibition of Female Genital Mutilation Act 2011 criminalizes cross-border FGM by stating that it is an offence for any citizen or permanent resident of Kenya to "take another person from Kenya to another country or arrange for another person to be brought into Kenya from another country" for the purposes of FGM. Article 28(2) further qualifies that a person may not be convicted of the offence if such a person has already been acquitted or convicted in the country where the offence was committed. However, the practice continues to thrive along the border areas as communities try to evade legal penalties in their respective jurisdictions (Mafabi, 2018; Migiro Omwancha, 2012).

2.3.2 Tanzania

Like some neighbouring countries, Tanzania has recorded a steady decline in FGM within its borders, with the latest data pegging the practice at a prevalence of 10 per cent (TDHS/MIS, 2015–16). Although the Constitution of the United Republic of Tanzania (1977) does not directly refer to harmful practices or FGM, Article 9 imposes an obligation on the State to respect and preserve human dignity and rights, to accord men and women equal rights and to eradicate all forms of discrimination. Article 13 addresses equality further and states that "all persons are equal before the law and are entitled, without any discrimination, to protection and equality before the law" and charges the State with implementing procedures that take into account that "no person shall be subjected to torture or inhuman or degrading punishment or treatment". Article 16 also states, "Every person is entitled to respect and protection of his person" and "privacy of his own person". The main law criminalizing FGM in Tanzania is Article 21 of the Sexual Offences Special Provisions Act 1998, which inserted a new section, Section 169A (1), into the Penal Code prohibiting FGM on girls under the age of 18 years (Sexual Offence Special Provisions Act 1998). The Act provides penalties for performing and procuring FGM in Section 169A (2) of the Penal Code with specific reference to guardians or those who have custody of children. In addition, the Law of the Child Act (2009) protects people under the age of 18, and Article 13(1) makes it a criminal offence to "subject a child to torture, or other cruel, inhuman punishment or degrading treatment including any cultural practice which dehumanizes or is injurious to the physical and mental well-being of a child". Article 18 also allows the court to issue a care order or an interim care order to remove a child from any harmful situation.

The Sexual Offences Special Provisions Act, under Section 169A, does not refer to FGM carried out by health professionals or in a medical setting. In 1995, the Medical Association of Tanzania published *Guiding Principles on Medical Ethics and Human Rights in Tanzania* (1995). This document notes under principle 7 (on medical care for vulnerable and disadvantaged groups) that "hazards to the health of the girl child include adverse traditional practices such as genital mutilation" and requires doctors to "expose the dangers of such practices with the aim of changing such beliefs and attitudes which support them". Further to this, a reference to physicians' responsibilities to prevent FGM is made at principle 11 (on health promotion and preventive medicine', which states that they should "seek, through community for participation, to modify adverse social behaviour such as early marriage, female genital mutilation, that have a deleterious effect on women's health".

Section 169A of the Penal Code does not also address cross-border FGM practices carried out on or by Tanzanian citizens in other countries. However, Article 6(b) of the Tanzanian Penal Code does state that the jurisdiction of the Courts of Tanganyika for the purposes of the code extends to "any offense committed by a citizen of Tanganyika, in any place outside Tanganyika". While the police are working with their Kenyan counterparts to tackle this movement (e.g. in the Tarime/Rorya special zone), the current national legislation in Tanzania fails to support these efforts by not addressing cross-border FGM.

2.3.3 Ethiopia

In Ethiopia, FGM is widely acknowledged as a violation of human rights and a public health concern because of its role in serious medical complications. The legal and policy framework in the country encourages and supports the eradication of the practice within its borders. The Constitution of the Federal Democratic Republic of Ethiopia while not directly addressing FGM, contains several provisions relevant to the practice: Article 35(4) asserts that "The State shall enforce the right of women to eliminate the influences of harmful customs. Laws, customs and practices that oppress or cause bodily or mental harm to women are prohibited." Article 36 sets out the "Rights of Children" and states that all actions "shall be in the best interest of the child" (Ethiopia, 1995).

The main law governing FGM in Ethiopia is Proclamation No. 414/2004, the Criminal Code (Ethiopia, 2005). This is a federal act that makes it a criminal offence to perform or procure FGM in Ethiopia. In addition, as well as being a criminal offence, performing any action that causes bodily harm is a civil offence under the Ethiopian Civil Code (Ethiopia, 1960). The Criminal Code at Chapter III, Articles 561–570, specifically deals with "Crimes Committed Against Life, Person and Health through Harmful Traditional Practices". It criminalizes the performance and procurement of FGM in Ethiopia but does not provide a clear definition of the practice. In addition to performing and procuring FGM, the code also criminalizes supporting the practice but does not criminalize failure to report it. However, more generally, Article 443 sets out the punishments for failing to report certain crimes whose penalty is death or imprisonment (which would include FGM). The Criminal Code also fails to protect uncut women (and their families) from verbal abuse or exclusion from society, which is included in the laws of some other neighbouring countries such as Kenya and Uganda. The medicalization of FGM has not been addressed by the Criminal Code and the practice does not appear to be significant across most of Ethiopia, as according to recent data only 1 per cent of women aged 15–49 years who have undergone FGM are reported to have been cut by a health professional. However, among girls aged 0–14 years, the percentage is slightly higher, at 1.9 per cent (28 Too Many, 2013a; EDHS, 2016). Generally, given the wide scope of Articles 561–570, the law does appear to apply universally and thus could encompass all medical practitioners who perform harmful practices.

As part of Ethiopia's ambition to become a middle-income country by 2026, the Government of Ethiopia indicated its commitment to end any form of gender-based violence and any forms of socioeconomic discrimination in its second growth and development plan. In July 2014, the Government of Ethiopia galvanized its commitment to ending FGM and child marriage by 2025 by implementing an integrated intervention, that is, a three-pillar approach of prevention, provision and protection to end the practice altogether or decrease it to 10 per cent prevalence (CSA and ICF, 2016). The strategic plan is to be released as part of the national child policy. According to the Central Statistical Agency report, the use of legislative and policy normative frameworks, as well as well-coordinated and integrated approaches to end FGM, has helped to increase the awareness of Ethiopian society of the negative

effects on the health and socioeconomic status of women and girls. Evidence from the Ethiopia's 2016 Demographic and Health Survey (EDHS, 2016) shows that the practice has been on the decline for the past two decades, particularly among younger age groups. To accelerate the efforts to end FGM/C, Ethiopia has launched a fully costed national roadmap to end child marriage and FGM for 2020–2024. The roadmap has five major strategies: 1) empowering adolescent girls and their families; 2) community engagement (including faith and traditional leaders); 3) enhancing systems, accountability and services across sectors; 4) creating and strengthening an enabling environment; and 5) increasing the generation and use of data and evidence.

While the law in Ethiopia does not directly address cross-border FGM, Articles 11–22 of the Criminal Code deals with crimes specified in the code that are carried out by either a foreigner acting in Ethiopian territory or nationals acting in another country. Specifically, Article 11 states, "This Code shall apply to any person whether a national or a foreigner who has committed one of the crimes specified in this Code on the territory of Ethiopia." Article 18 states that the code applies to any person who commits a crime outside Ethiopia against an Ethiopian national and to any Ethiopian national who commits a crime under the code outside Ethiopia, and it makes provision for extradition.

Ethiopia shares borders with several other countries where the existence and enforcement of laws on FGM varies widely, including Kenya, which has a comprehensive FGM law, and Somalia, where currently there is no legislation in place to prohibit FGM. The free movement of people across borders to perform FGM remains a complex challenge for the eradication of the practice. Unlike across the Kenyan, Tanzanian and Ugandan shared borders, there has been no known cooperation between law enforcement officials along Ethiopia's borders with Kenya or Somalia to tackle the practice of cross-border FGM.

2.3.4 Somalia

Somalia's legal system is a combination of civil law, Islamic law and customary law. The country is divided into three zones, Puntland, South–Central zone and Somaliland. (Somaliland has its own government, but its self-declared independence remains unrecognized by the United Nations, and Somalia continues to consider Somaliland as a federal member state.) In each of the zones, there are key ministries concerned with activities to end FGM: the ministries concerned with women, namely the Ministry of Labour and Social Affairs in Somaliland, the Ministry of Women's Development and Family Affairs in Puntland, and the Ministry of Women and Human Rights Development in the South–Central zone. The Ministry for Religious Affairs and Endowment (all zones) and the Ministry of Health (all zones) are also involved, in partnership with the Ministry of Youth.

The new Constitution of the Federal Republic of Somalia, promulgated in 2012, outlaws all forms of FGM. Article 4 states that "After the Shari'ah, the Constitution of the Federal Republic of Somalia is the supreme law of the country." It protects human dignity and equality under Articles 10 and 11, respectively, and, most significantly in

relation to FGM, sets out under Article 15(4) that "Circumcision of girls is a cruel and degrading customary practice, and is equivalent to torture. The circumcision of girls is prohibited." Article 29(2) further states, "Every child has the right to be protected from mistreatment, neglect, abuse or degradation." There is no definition of FGM in either the constitution (in which it is referred to as "circumcision of girls") or in the religious fatwa, which simply states that it "bans all forms of female genital mutilation (FGM)". There is no reference to whether the prohibitions cover only those who perform FGM, or if they could also include those who plan, procure, aid or assist acts of FGM, or who fail to report FGM that has already taken place or is due to take place.

There is currently no national legislation in Somalia that criminalizes and punishes the practice of FGM. The Somali Penal Code, Law No. 05/19623 (Penal Code, 1964), is applicable to all jurisdictions in Somalia (and Somaliland) and makes it a criminal offence to cause hurt to another and sets out the associated punishments. Under Article 440(3), hurt is deemed "very grievous" if it results in (b) "loss of a sense" or (c) "loss of a limb, or a mutilation which renders the limb useless, or the loss of the use of an organ or of the capacity to procreate". Under Article 440(1) of the Penal Code, the penalty for causing hurt to another is imprisonment for three months to three years. Where the hurt is deemed to be "grievous", the penalty is imprisonment for three to seven years, rising to six to twelve years where the hurt is deemed to be "very grievous". In 2015, it was reported that work had started to initiate a bill that would ban FGM across all of Somalia, and the Ministry of Women and Human Rights Development has announced its willingness to introduce laws to eradicate FGM in Somalia; however, no specific bill has yet been passed. Puntland has made much more progress in addressing FGM; specifically, FGM legislation is expecting parliamentary approval (Shiino, 2014), and in 2016 the Sexual Offences Act was passed, which demonstrates commitment to addressing harmful practices (UNFPA, 2016). An Islamic ruling (fatwa) against FGM has also been signed in Puntland. Despite reports of the increase in medicalized FGM throughout Somalia, there are no data available on the number of women and girls who have been cut by a health professional.

The medicalization of FGM has not been addressed in Somalia's national legislative or policy provisions. Nonetheless, in Puntland, an interministerial decree against FGM, developed by the Ministry of Health and signed in 2014, states that there will be no medicalization of FGM, and the ministry has the authority to shut down clinics and hospitals that continue the practice, arrest perpetrators, and cancel the licences of medical professionals who practise FGM in their clinics. This interministerial policy is now being disseminated by stakeholders, but currently it lacks an implementation plan and accountability framework. Similarly, in Somaliland, the Ministry of Religious Affairs issued a religious fatwa banning the practice of FGM and vowing to punish violators. The fatwa allows victims to claim compensation but is not clear whether this will be paid by the Government or the violators of the ban (Ahmed, Abdi and Maruf, 2018). Curiously, the fatwa forbids the performance of any circumcision that is contrary to the religion, which involves cutting and sewing up, such as pharaonic circumcision, or infibulation, the implication being that some types of FGM may be allowed as a religious practice under shariah law, which is supreme over the Constitution of Somalia.

Although the Constitution of Somalia prohibits FGM, there is no specific law or provision that establishes punishment for breach of the constitution. There are currently no penalties set out in the law of Somalia for practising FGM. In the absence of national legislation on FGM, there are no reported cases of arrest or court proceedings in Somalia. There have been cases in which girls have bled to death or experienced adverse side effects following medicalized FGM, but it seems that such cases were settled secretly between the medical practitioner and the family. It has also not been possible to obtain any details of a formal Government strategy to end FGM across the whole of Somalia.

Somalia shares borders with countries where the prevalence of FGM and the existence and enforcement of anti-FGM laws vary, including Ethiopia and Kenya. There are many Somalis living in the border regions of Ethiopia and Kenya, and the absence of national legislation banning FGM in Somalia allows the practice to continue, as families move across borders to avoid prosecution. There are no accurate data on the number of girls who are taken across borders to be cut. It is also suggested that many Somali women and girls from the Western diaspora (e.g. in the United States of America, Australia, the United Kingdom and other European countries) are taken to Somalia for FGM, because there is no risk of prosecution (28 Too Many, 2019), compounding the response needed to address the elimination of FGM using legislation and policy as a strategy.

2.3.5 Uganda

Leveraging international and regional instruments prohibiting FGM, Uganda has put in place a comprehensive legal and policy framework to eliminate the practice of FGM and ensure that the rights of women and girls are not violated through the practice. These principles are enshrined in the supreme law of Uganda, the Constitution of the Republic of Uganda (Uganda, 1995). Although FGM is not specifically prohibited under the constitution, it protects women and their rights under Article 33 and specifically prohibits under Article 33(6) “Laws, cultures, customs or traditions which are against the dignity, welfare or interest of women or which undermine their status ...”. Furthermore, Article 44 states that no person shall be subjected to any form of “torture and cruel, inhuman or degrading treatment”.

The substantive law prohibiting FGM in the country is the Prohibition of Female Genital Mutilation Act (Uganda, 2010). The Act provides a clear definition of FGM and associated offences, prosecution, punishment of offenders, and the protection of victims.

The Act penalizes the performance, procurement, aiding and abetting, and failure to report FGM, and the practice of FGM by medical professionals. The Act at Section 15 crucially provides for extraterritorial jurisdiction (cross-border) where the victim is a resident of Uganda but does not detail how this is to be implemented. In addition to the Act, Uganda has several policy provisions: the Prohibition of Female Genital Mutilation (FGM) Regulations (Uganda, 2013), the National Policy on Elimination of Gender-based Violence (Uganda, 2016b), and the National Action Plan for Child Well-being 2016–2021 (Uganda, 2017), which integrates FGM and provides 0.63 per cent

of its budget specifically for FGM therein. Moreover, Section 7 of the Children's Act 1997 (as amended by the Children (Amendment) Act 2016; Uganda, 2016a) prohibits and punishes harmful customary or cultural practices as follows: "A person shall not expose a child to any customary or cultural practice that is harmful to his or her health, wellbeing, education or social-economic development." The Penal Code Act (Uganda, 1950) also provides under Section 219 that any person who unlawfully does grievous harm to another commits a serious crime subject to punishment. Medicalization of FGM is specifically prohibited under Section 3(m) of the Prohibition of Female Genital Mutilation Act 2010 which states that, if FGM is carried out by a "health worker", it is classified as "aggravated FGM", and the perpetrator is liable on conviction to life imprisonment. "Health worker" is defined as a person qualified in the promotion of health, the prevention of disease and the care of the sick and who is registered and enrolled under the Medical and Dental Practitioners Act, the Nurses and Midwives Act or the Allied Health Professionals Act. The use of the law combined with other interventions, including extensive sensitization and community dialogue, has contributed to a remarkable reduction in the prevalence of FGM in the country from a high of 1.4 per cent (Uganda Bureau of Statistics and ICF, 2012) to 0.3 per cent (UDHS, 2016).

Despite this success, the elimination of FGM is threatened by the high prevalence of the practice along Uganda's borders with its neighbouring countries, Kenya, Tanzania and South Sudan. Section 15 (extraterritorial jurisdiction) of the Prohibition of Female Genital Mutilation Act 2010 criminalizes cross-border FGM by stating that the offences and punishments set out in the Act apply equally when "committed outside Uganda where the girl or woman upon whom the offense is committed is ordinarily resident in Uganda". Therefore, Ugandan nationals who are members of these border communities and who cross the national boundary for FGM are subject to punishment under the 2010 Act. The strength of the law in Uganda is, therefore, being undermined by women crossing, or being taken across, the border into Kenya to be cut in secret (Mafabi, 2018).

2.3.6 Specific regional legislation and policy on female genital mutilation

There is currently no specific legislation at the regional level that prohibits FGM, making collaborative efforts to eliminate the practice within the various countries using legal and policy measures difficult. The countries that this study focused on are collectively part of one or both of the main East Africa and Horn of Africa regional bodies that are organized mainly around the economic development and peace and security of the region, that is the East African Community (EAC) and Intergovernmental Authority on Development (IGAD). These bodies have over the years expanded their mandate to incorporate social issues such as gender equality, health, education, peace and justice and strong institutions in recognition of the importance of social development in ensuring and sustaining economic integration and development in line with the Sustainable Development Goals.

2.3.6.1 The East African Community

The EAC comprises Burundi, Kenya, Rwanda, South Sudan, Tanzania and Uganda and was established by the Treaty for the Establishment of the East African Community of 1999. The treaty is a binding document and provides articles that can be effectively used to eliminate cross-border FGM. In this regard, the relevant articles of the treaty include:

- Article 6(d) under the fundamental principles of the Community, which encompass peaceful coexistence and good neighbourliness, good governance, including adherence to the principles of rule of law, social justice, gender equality … in accordance with the African Charter on Human and Peoples' Rights

- Article 7(2) under the operational principles of the Community, including a commitment to abide by the principles of maintenance of universally accepted standards of human rights

- Article 121(b) under the role of women in socioeconomic development, which obliges partner states to enact appropriate and other measures – abolish legislation and discourage customs that are discriminatory against women

- Article 124(5) under regional peace and security, which commits partner states to enhancing cooperation in handling cross-border crime, providing mutual assistance in criminal matters, including the arrest and repatriation of fugitive offenders, and exchanging information on national mechanisms for combating criminal activities.

The EAC has been very cognizant of the fact that FGM poses a threat to its mission by undermining the health, education and, ultimately, human capital capacity of its citizens, who collectively contribute to the integration and development of the Community as a whole, especially given the porous borders in the region and the large number of refugees from within the region present in every country. To this end, the EAC has developed several legislative and policy provisions that specifically address FGM. In 2016, a bill (the Prohibition of Female Genital Mutilation Bill) was introduced and passed by the East African Legislative Assembly; however, this is still pending because it has not yet been assented to by EAC Heads of State. Such a law would greatly enhance the practical implementation of the existing policies and frameworks, allowing partner states to take more practical and concrete steps towards the elimination of FGM within each country's borders and the region.

The policy framework within the EAC is well developed. The East African Community Child Policy (EAC, 2016), noting the negative consequences of FGM, is specific in its aim of addressing FGM as a cross-border violation of children's rights and provides for integrated and collaborative child protection and legislative, judicial and programmatic interventions to tackle FGM in all partner states. The East African Community Gender Policy (EAC, 2018) notes that FGM continues to be one of the hindrances to the role of women in the socioeconomic development in the partner states. Collaboration

on various issues is not new among the EAC partner states: for example, Kenya and Uganda already collaborate on other cross-border crimes such as cattle rustling and people trafficking, and Kenya and Tanzania collaborate on wildlife conservation initiatives along their borders. The EAC has an extradition agreement among partner states, which is concerned with organized crime and corruption but could be an entry point to address cross-border FGM and child marriage. These initiatives can collectively provide lessons that can be applied to addressing FGM.

2.3.6.2 Intergovernmental Authority on Development

The IGAD member states are Djibouti, Eritrea, Ethiopia, Kenya, Somalia, Sudan, South Sudan and Uganda. The Authority states that its mission is to "promote regional cooperation and integration to add value to Member States' efforts in achieving peace, security and prosperity". Its mission includes social development, with one of its main divisions working on health and social development, which includes initiatives on cross-border cooperation and programmes on nutrition, tuberculosis and education for refugees who are found in all member countries. The Authority does not work on FGM, which is practised in all of its member states. Given the existing structural capacity around social development, with initiatives such as cross-border collaboration programmes and strategic plans to address nutrition and tuberculosis, these can be used to address pertinent issues such as FGM, which have been proven to be a barrier to development in all of the study countries (WHO, 2020).

2.4 Ending female genital mutilation: a social norm change process

FGM is a social convention (WHO, 2016), and several sociocultural factors are used to justify its relevance in all of the practising communities. Women and girls are socially pressurized to conform with the practice in order to be accepted socially and to increase their marriageability. These socially constructed beliefs around FGM are strong motivations for many community members to perpetuate the practice, despite FGM being declared a criminal act in many African countries. As a harmful practice, FGM is sustained by social norms and collective beliefs about what people expect from each other (Cislaghi, Denny, Cissé, Guaye *et al*., 2019).

Evidence from various studies on FGM and evaluation of anti-FGM programmes shows that efforts that are designed to facilitate changes in social norms are an effective approach to significantly reducing the practice. This implies that any intervention to reduce FGM needs to systematically transform the prevailing belief systems, including beliefs about the perceived benefits of FGM (Coyne and Coyne, 2014). There is evidence of successful interventions targeting changes in social norms. For instance, a non-governmental organization (NGO) called KMG was able to eliminate FGM in the Kembatta community, Ethiopia, using an approach to change social norms (28 Too Many, 2013a). In their analysis, Cislaghi *et al*. (2019) indicate that a normative shift is important to ensure the elimination of harmful traditional practices such as FGM.

The important consideration in the changing social norms process is that there has to be a critical mass of adopters of change who encourage other people to do so. The change must provide alternatives and create environment that enables the adopters to be socially accepted and their new identities to be the new norm. This requires the interventions to be community driven and participatory, giving the people more say in transforming their traditions towards a new reality. One stumbling block to this process is that matters of sexuality that mainly touch on women receive minimal attention in our patriarchal environment.

@UNFPA/ Luis Tato

3 Methodology

@UNFPA/ Luca Zordan

In this section, the overall methodology adopted to achieve the five research objectives is discussed. Specifically, the design of the study, the study setting, data collection methods and tools, data analysis, the procedures used to ensure the reliability and validity of data, and the ethical procedures followed during data collection are presented and discussed in detail.

3.1 Study design setting

The study used a mixed methods cross-sectional design. The design helped to collect quantitative and qualitative data simultaneously in one phase.

The study was conducted in the following areas:

- Kenya–Tanzania border (i.e. the Maasai community in the Transmara region and the Kuria in Isebania, Migori County) but only on the Kenyan side
- Kenya–Ethiopia border (i.e. the Borana community in Moyale subcounty and the Moyale area of Ethiopia, as well as the Turkana and the Ommo communities)
- Kenya–Uganda border (i.e. the Pokot community in the Karamoja region in Uganda and the West Pokot region in Kenya, and the Sebei in Uganda and the Sabaot in Mt Elgon region, Kenya)
- Kenya–Somalia border (i.e. the Somali community in the Mandera border area in north-eastern Kenya and Somalia).

3.2 Sampling

In this study, obtaining or developing a sampling frame including a list of possible subjects was not possible, as many of the cross-border communities live in remote areas of the five countries. Hence, a purposive/convenience sampling technique was used to guide the process of selecting the regions to be studied, which had to be the border communities listed above. To select the respondents for the quantitative survey, the study used a clustered and stratified random approach to narrow down both the male and female participants for the study. Further, purposive sampling was used to select the key informants (KIs) and the focus group discussion (FGD) participants for the qualitative arm of the study. The key informants took part in different aspects of the research, while the focus group discussion participants were grouped according to gender and age.

For the quantitative data, respondents were sampled through a multi-stage, clustered and stratified process. The study had intended to sample 1,400 respondents from the seven targeted regions as follows: 100 respondents from each side of the border consisting of 50 men and 50 women. This means that, from each of the borders, there were supposed to be 200 respondents. Hence, the respondents were clustered by regions and ethnicity and stratified by gender. A random sampling approach was used to select the individual man or woman to be interviewed in the community. To maximize the variation in the samples, the study team, in collaboration with local officials, mapped out the area where cross-border communities were residing and took note of the residential patterns. From a specific point in the villages, assistants recruited people randomly at intervals of two households as they moved in either direction, ensuring that they observed the 50:50 ratio for women to men, as well as a range of ages. This approach ensured representativity and the potential of including a wide range of participants.

For the qualitative data, the study used purposive sampling. Key informants consisted of a number of actors, among them community gate keepers, national Government representatives, local/county government representatives, civil society representatives (e.g. NGOs, community-based organizations (CBOs), faith-based organizations (FBOs), media), religious leaders and women's leaders, among others. The rationale for choosing the above actors is that each and every community has different principal players when it comes to FGM matters. For instance, the civil society actors are the main players in anti-FGM programming, while the religious leaders are key messengers in the Islamic world in influencing behaviour patterns. For cultural matters, the elders and other traditional gate keepers are crucial actors, and understanding their views is crucial for any possible intervention. The study conducted four focus group discussions at each site on either side of the border to cover the young men, young women, older men and older women as follows: one focus group discussion each with women aged 18–34 years, men aged 18–34 years, women 35 years and over and men 35 years and over. This process enabled the research to unpack the generational and gendered differences in the FGM debate. The research was able to contextualize the views of both men and women and to tease out where interventions should possibly be targeted and why.

3.3 Data collection methods and tools

Both primary and secondary data sources were used. For secondary data, the literature was reviewed from reports, journal publications, books, legal and policy documents, and web-based literature. For primary data, quantitative and qualitative data were collected using a survey, in-depth interviews and focus group discussions.

3.3.1 Literature/document review

A critical review was conducted of the existing regional and national policy frameworks, national-level regulations and legislation relevant to FGM/C and the status of their implementation in Ethiopia, Kenya, Somalia, Tanzania and Uganda. In addition, secondary sources were used to document the profile and prevalence of cross-border FGM/C and to assess the determinants of cross-border FGM/C practices. Relevant national- and county-/district-level reports from Governments and development partners were also reviewed.

3.3.2 In-depth interviews

In-depth key informant interviews (KIIs) were conducted with relevant national- and local-level stakeholders on cross-border FGM/C issues. The stakeholders interviewed included:

- Government actors (national and local government officials, including administrators in health, education and social development/protection, police officers, prosecution officers, members of the judiciary, ministry officials in charge of gender/women, anti-FGM/C board members, representatives from the Office of the Director of Public Prosecutions, local-level immigration officers)
- Non-State actors (NGOs, CBOs and FBOs working on women rights/FGM/ gender-based violence/safe houses, media, community mobilizers and paralegals)

Community-level actors (circumcisers, community gate keepers, including village elders, chiefs/assistant chiefs, *Aba Gaddas*,1 *kraal*)

Other local-level actors, among them elders (men and women), *moran*, young men and women, religious leaders).

Accordingly, a total of 143 key informants participated in the in-depth interviews (see Table1).

1 Abba Gaddas are the older men in Borana who are the cultural leaders of their community.

Table 1: Number of key informant interviews by study site

Key informants	Ethiopia	Kenya	Somalia	Uganda	Total
National-level experts	5	1		1	
Regional bureaux	6	N/A	2	1	
Kenya 1 Moyale	12	12		8	32
Kenya 2 Turkana	15	7		10	32
Kenya 3 Maasai		7			
Kenya 4 Kuria		14			14
Kenya 5 Pokot		14			14
Kenya 6 Sebei		12			12
Somalia 1 Mandera			8		8
Somalia 2 Bula Hawa			8		8
Total	**38**	**67**	**18**	**20**	**143**

3.3.3 Focus group discussions

To gain insight on cross-border FGM overall and its effects on women and girls, focus group discussions were conducted at all the study sites involving both young and adult men and women. In the focus group discussions, participants' ideas on the most common types of FGM practices, the acceptability of the practices among their communities, the social norms around FGM and the effects of the practice were discussed. A total of 63 focus group discussions were conducted (see Table 2 for the total number of groups that participated in each country).

Table 2: Focus group participants

FGD participants	Ethiopia	Kenya	Somalia	Uganda	Total
Female-only youth group (18–34 years old)	2	10	2	2	16
Male-only youth group (18–34 years old)	2	10	2	2	16
Women-only group 35 years and over	2	10	2	2	16
Men-only group 35 years and over	1	10	2	2	15
Total	**7**	**40**	**8**	**8**	**63**

3.3.4 Survey

Assessing the profile and determinants of the practice of FGM across the borders, as well as the effects of FGM on women's and girls' sociocultural, economic and political participation requires quantitative information on the types of FGM and the factors that determine its practice. The study team used household surveys to generate comprehensive numerical data. The survey instrument included both open and closed questions that identify types of FGM, factors associated with the practice of FGM, effects of the practice on women's and girls' sociocultural, economic and political participation, the cross-border practices, and preventive and response services and service providers, including financial resources. The survey questionnaire was developed and used after obtaining approval from the Institutional Review Board (IRB) on the protection of human subjects from the African Medical and Research Foundation Kenya and the National Commission for Science, Technology and Innovation (see Annex for IRB certificates). The questionnaire also included issues of social norms on the practice and possible interventions. The questionnaire had several sections based on the study objectives and ensured that each of the objectives was exhaustively teased out.

The data collectors in each country were selected from individuals with experience in field research and knowledge of the requisite languages. The research assistants lived locally in the communities concerned and had to have a good command of the local languages. The data collectors recruited for this study were trained on the research topic, objectives, study instruments, informed consent procedures, and the importance of protecting the confidentiality of the research findings. A pilot test was carried out in each data collection site and adjustments were made to the questionnaires before the actual data collection. Following this, data collectors were deployed to undertake the interviews using the survey questionnaire.

The meeting points for the survey were households. Accordingly, a total of 1,480 respondents, 776 (52 per cent) female and 704 (48 per cent) male participated in the study. Disaggregated by country, 754 (50.8 per cent) of the respondents were interviewed on the Kenyan side of all the borders (55 per cent female), 108 (7 per cent) on the Somalian side of the border (49 per cent female), 417 (28 per cent female) on the Ugandan side of the border (50 per cent female) and 202 (14 per cent) on the Ethiopian side of the border (47 per cent female) (see Table 3).

Table 3: Number (and percentage) of survey participants

Country	Male	Female	Total
Kenya	335 (47.6)	419 (53.8)	754 (50.8)
Uganda	208 (29.6)	209 (26.8)	417 (28.1)
Somalia	55 (7.8)	53 (6.8)	108 (7.3)
Ethiopia	106 (15.1)	95 (12.2)	201 (13.6)
Total	704	776	1,480

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3.4 Data analysis

The data gathered from the quantitative survey, qualitative key informant interviews, focus group discussions and observations, as well as data from secondary sources, were analysed rigorously using different approaches.

3.4.1 Quantitative data analysis plan

After the survey, the data cleaning involved the cross-checking of all entries by a team of data clerks under the supervision of the lead data analyst and working closely with the research team. Data were then entered into the statistical software Stata 14.2 for processing based on the set themes. Data were analysed using descriptive statistics reporting summary statistics, including mean and standard deviation or median and interquartile range, as appropriate for continuous variables. Associations between continuous variables were tested using two-sample *t*-test statistics. For all categorical variables, counts and proportions are reported, and associations or correlations tested using chi-squared or Fisher's exact tests, as appropriate.

Perceptions on the health and psychological effects of FGM were measured using a five-point Likert scale coded as follows: strongly disagree (1), disagree (2), neutral (3), agree (4) and strongly agree (5). To ensure the reliability and internal consistency of the scale, Cronbach's alpha coefficient was estimated. To measure the overall level of agreement with the different statements under each aspect measured on the Likert scale, a composite summary score was computed by summing the responses to each of the statements for each respondent and dividing by the total number of items under the aspect being measured. These scores were then compared using independent-sample *t*-tests by sex and by cross-border to assess whether there were any significant differences by sex and on either side of the borders surveyed.

3.4.2 Qualitative data analysis

All interviews were tape recorded with the consent of participants. The recorded interviews were transcribed verbatim, translated into English where necessary, and exported into QSR Nvivo 12 for analysis. A thematic framework approach was used to classify and organize the data into key themes. Emergent categories were identified during analysis. An iterative analysis process was followed to develop a coding framework and later a tentative thematic framework was developed. Analysis charts were prepared for each theme and category of participants. These charts were used to identify common themes across different participants and sites. The interpreted qualitative data and the described quantitative data were integrated during the analysis, so that the data final presented were corroborated by the facts generated from both sources. However, distinct cases of qualitative information have been presented independently, such as quantitative figures. Lastly, the data were interpreted based on the identified themes and categories of the qualitative data and the Stata 14.2 analysis of the quantitative data.

3.5 Reliability and validity of quantitative data and trustworthiness of qualitative data

Quantitative data were collected on paper using structured questionnaires and administered by trained research assistants. All completed questionnaires were serialized and entered on a pre-programmed data entry screen in EpiData version 3.1. Data entry was done by trained data clerks under the supervision of a senior data manager, who provided overall guidance on how to enter and code responses appropriately and in preparation for data quality assurance. Data quality assurance was done at two levels: 1) at the point of data entry, where any obvious mistakes, including wrongly coded values and mislabelled entries, were flagged up by the data entry clerks and raised with the data manager, who resolved the obvious ones and escalated those that required more consultation to the study team; 2) during data cleaning, which involved checking for missing data, data consistencies and validation, including checking for obvious data entry errors that may have been missed at the first level. Lastly, to ensure the reliability of the data collection instrument, an inter-item correlation test was computed using Cronbach's alpha coefficient of inter-item scale reliability (i.e. internal consistency). There was high internal consistency, with an alpha score for all scale sub-scales used to measure sociocultural effects of 0.88, effects of religious norms of 0.75 and effects of FGM of 0.75.

Ensuring trustworthiness in qualitative data analysis means ensuring the credibility, transferability, dependability and conformability of the data, which is largely related to the issue of presentation (Lincoln and Guba, 1985). To ensure the credibility, dependability and conformability of qualitative data, triangulation by data sources and data types, as well as negative case analysis, was undertaken. Accordingly, findings from the key informant interviews were compared with the findings obtained from the focus group discussions. Ideas that differed from the majority views were also presented.

3.6 Data presentation

Quantitative data were presented in tables and graphs where appropriate. Qualitative data were presented using quotes arising from the key informant interviews and focus group discussions. Triangulation methods helped in contextualizing the findings of each and adding additional voices to the quantitative data.

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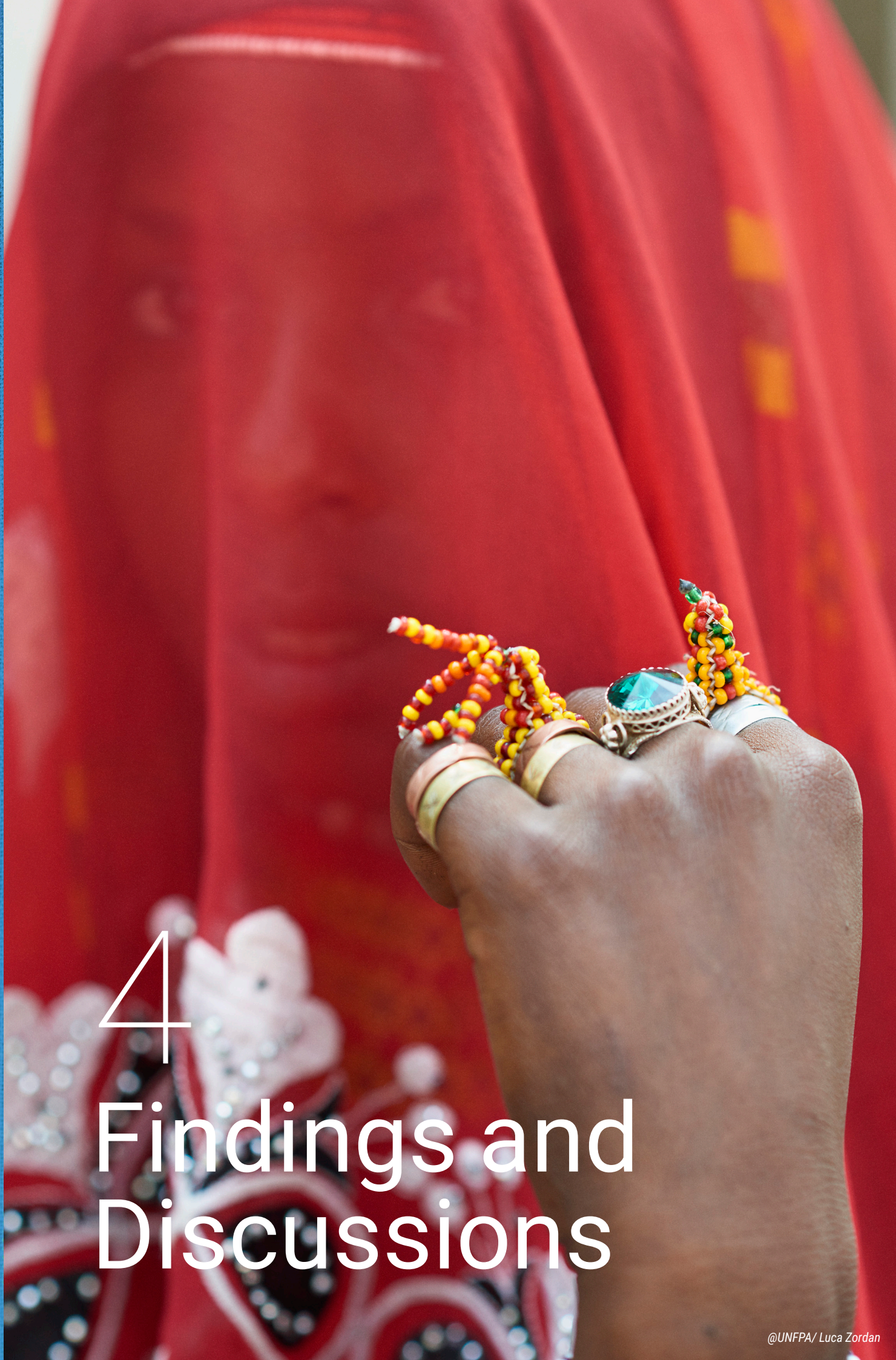
4 Findings and Discussions



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This study explored gaps in policy and legislation on FGM, identified the sociocultural drivers of FGM, the effects of FGM on girls and women, preventive and response-related services, and the changes in social norm processes around the practice of FGM in the cross-border areas of Ethiopia, Kenya, Somalia, Tanzania, and Uganda.

4.1 Current gaps in the legal and policy provisions on cross-border female genital mutilation

KEY FINDINGS

- All the countries have laws prohibiting FGM in one form or another, be it constitutional provisions or specifically enacted national legislation.
- FGM is not defined in every country's laws. Only Kenya and Uganda have legislation that comprehensively defines FGM and the various types.
- There is no regional law prohibiting FGM, but there is a draft bill awaiting adoption by the EAC legislative assembly. There is, however, an EAC child policy on tackling the cross-border violation of children's rights, including FGM.
- Knowledge of the existing legal provisions and policies within the countries studied is varied, and some communities in remote borders areas have little knowledge of the laws prohibiting FGM.
- Knowledge of laws acts as a deterrent in some instances, mainly where the law is well known and there is relatively strong implementation. However, there is also defiance of the laws, mainly based on cultural and religious beliefs around FGM.
- There are existing frameworks within the two main regional bodies – IGAD (e.g. cross-border programmes on nutrition) and EAC (e.g. cross-border cooperation on cattle rustling) – which can be used as a starting point to develop regional cooperation to tackle cross-border FGM.

4.1.1 Available policies and legislation on female genital mutilation

The countries included in this study all have in place some form of legal and policy provisions that prohibit some aspects of FGM within their borders. Some of these legal and policy provisions go further and provide frameworks for how to address FGM-related issues such as health complications. However, defiance of the law continues to be observed in the communities living along the borders of the countries as the practice continues to thrive. The findings show that several factors contribute to the continuance of the practice despite the law: lack of knowledge of the law and its penalties, apathy towards the law, where it is considered of less consequence than defying of social, cultural and religious norms that dictate the practice of FGM, and the limitations of and lack of proper implementation of the laws within the countries' jurisdictions.

4.1.2 Effectiveness of legislation and policy in reducing/preventing female genital mutilation in cross-border areas

Enactment and enforcement of criminal laws to prohibit the practice of FGM has been a common policy response in the efforts to eliminate the practice. This section looks at the findings of this study to draw conclusions on the effectiveness of legislation in reducing and/or preventing the practice of FGM in the border areas of the study countries by looking at various parameters: knowledge of the law and its sanctions, compliance with the law, implementation of the law, and associated successes and challenges.

4.1.2.1 Knowledge of laws prohibiting female genital mutilation

The findings show that there is general awareness of the existence of national laws banning the practice of FGM and the associated penalties, but there are gaps in people's knowledge. Overall, slightly less than half (48 per cent) of all respondents (50 per cent male, 46 per cent female) surveyed said that they were aware of the existence of a law that prohibits the practice of FGM, with 40 per cent having ever heard of someone being penalized for breaking the law. Over 1 in 4 (28 per cent) knew what the penalty for the offence was compared with 72 per cent who did not know what the penalty was. Table 4 shows the results for awareness of the law disaggregated by sex.

Table 4: Respondents' level of awareness of the law prohibiting FGM disaggregated by sex

Items	Male (*n* = 704)	Female (*n* = 779)	Total (*n* = 1,483)	*p*-value
Are you aware of the existence of laws that prohibit FGM practice?				
Yes	348 (49.8)	359 (46.2)	707 (47.9)	
No	351 (50.2)	418 (53.8)	769 (52.1)	0.169
Have you ever heard of a person being penalized for breaking the law prohibiting FGM practice?				
Yes	279 (42.0)	284 (38.5)	563 (40.1)	
No	386 (58.0)	454 (61.5)	840 (59.9)	0.185
Do you know the penalty in FGM law?				
Yes	171 (27.1)	201 (27.8)	372 (27.5)	
No	459 (72.9)	521 (72.2)	980 (72.5)	0.775
What can be done to those who practise FGM?				
Arrest them	178 (52.4)	163 (42.7)	341 (47.2)	
Penalize them (fine)	32 (9.4)	30 (7.9)	62 (8.6)	
Jail/take them to prison	62 (18.2)	127 (33.3)	189 (26.2)	
Advise them	7 (2.1)	9 (2.4)	16 (2.2)	
Educate the parent/girl	61 (17.9)	53 (13.9)	114 (15.8)	0.000

Items	Male (*n* = 704)	Female (*n* = 779)	Total (*n* = 1,483)	*p*-value
Families that practise FGM do not face any legal repercussions in cross-border areas				
Yes	412 (59.5)	430 (56.9)	842 (58.1)	
No	280 (40.5)	326 (43.1)	606 (41.9)	0.306
In your opinion, which are the three most important strategies to reduce FGM?				
Enforcing the anti-FGM laws	537 (85.0)	544 (77.5)	1,081 (81.0)	0.001
Educating a girl child	454 (72.5)	539 (76.3)	993 (74.5)	0.110
Reducing early child marriages	215 (35.8)	271 (39.9)	486 (37.9)	0.133
Increasing knowledge of FGM practice in the community	242 (39.8)	307 (44.0)	549 (42.0)	0.127
Seeking other ways of initiating girls into adulthood	82 (14.2)	70 (10.6)	152 (12.2)	0.053
Providing another source of income for circumcisers	138 (23.0)	118 (17.4)	256 (20.0)	0.013

Differences in awareness of the existence of anti-FGM laws are evident in the border areas. Although not statistically significant, differences were observed in the following border areas: along the Kenya–Uganda border with 39 per cent of the Sabaot in Mt Elgon (Kenya) compared with 59 per cent among the Sebei (Sabiny) in Uganda, and 64 per cent among the Pokot in West Pokot (Kenya) compared with 81 per cent among the Pokot in Amudat in Uganda; along the Kenya–Somalia border with 15 per cent of the Somalis in Mandera (Kenya) compared with 6 per cent among the Somalis in Bula Hawa (Somalia); and along the Kenya–Ethiopia border with 12 per cent of the Turkana (Kenya) compared with 68 per cent of the Dasenach (Ethiopia). On the Kenya–Tanzania border, 64 per cent in the Transmara region and 24 per cent in the Isebania–Tarime region also said that they were aware of the existence of the law prohibiting FGM. Figure 1 shows the proportion of respondents who were aware of the existence of laws that prohibit the practice of FGM by border site.

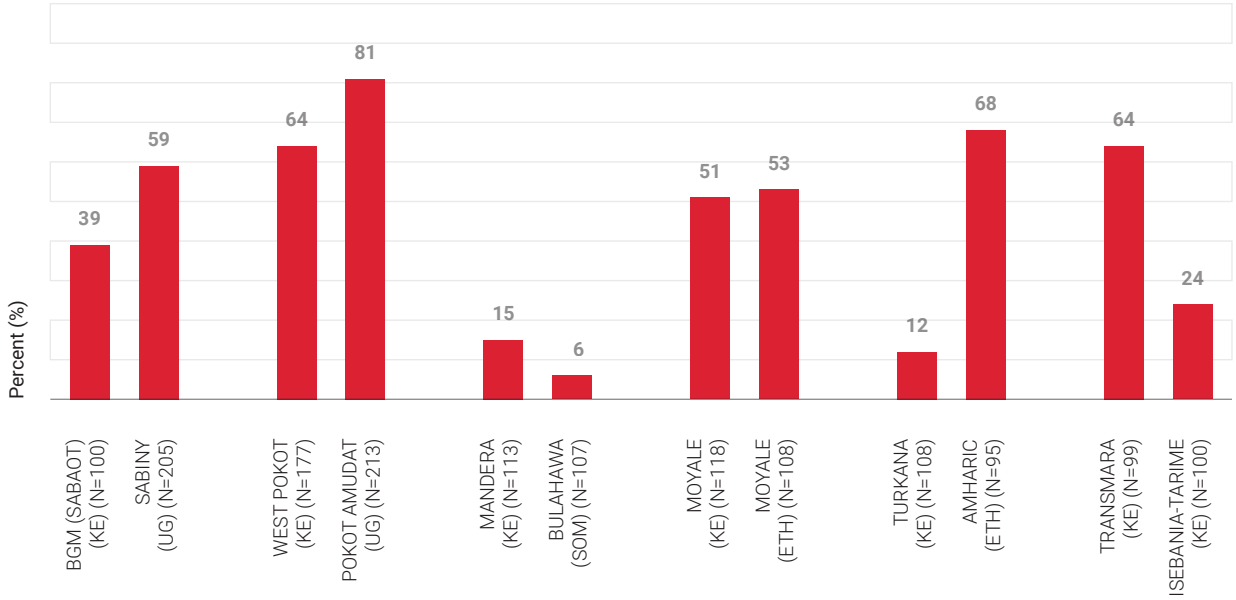

Figure 1: Proportion of respondents aware of the existence of the law prohibiting FGM by cross-border site.

While the data show a general knowledge of the existence of the law, except in Somalia, the findings also show that a lack of awareness of the law is still relatively high across all border areas, with just as much variation between them as in those who reported being aware of the law.

At the Kenya–Uganda border, awareness was 61 per cent among the Sabaot in Mt Elgon (Kenya) compared with 41 per cent among the Sabiny in Uganda, and 40 per cent among the Pokot in West Pokot (Kenya) compared with 19 per cent among the Pokot in Amudat in Uganda; along the Kenya–Somalia border awareness was 85 per cent among the Somalis in Mandera (Kenya) compared with 94 per cent among the Somalis in Bula Hawa (Somalia); along the Kenya–Ethiopia border awareness was 88 per cent among the Turkana (Kenya) compared with 32 per cent among the Dasenach (Ethiopia), and 73 per cent in Moyale (Kenya) compared with 80 per cent in Moyale (Ethiopia). Along the Kenya–Tanzania border, 36 per cent of respondents in the Transmara region and 76 per cent in the Isebania–Tarime region said that they were not aware of the existence of the law prohibiting FGM. The high variations, such as in the Turkana and Somalis, can be attributed to the fact that the Turkana do not practise FGM, while in Somalia there is no specific national legislation banning the practice.

Responses from the focus group participants and key informants also confirm the general awareness of the existence of laws prohibiting the practice of FGM and the associated penalties, as shown by the following excerpts:

> *Yes, laws are there, it clearly states that, when you are found circumcising a girl, you will be arrested and jailed. We also heard that the circumciser's hands are chopped off in Uganda.*
>
> (Female FGD participant over 35 years old, Pokot, Uganda)

We just know that the FGM is against the law, uncut girls have been married and have children and that is enough for us. We don't know anything else. (Male FGD participant over 35 years old, West Pokot, Kenya)

The anti-FGM law that was enacted in 2011 says that if you are caught maybe preparing a girl for FGM or you bought her anything or you have given out space for FGM, you will be arrested and imprisoned for three years or a fine of Ksh. 200,000 or both.
(Male FGD participant under 35 years old, Kuria, Kenya)

We were told that if caught the parents will be jailed for ten years each and the circumciser will be jailed for forty years and her hands will be cut from the wrist. (Male FGD participant under 35 years old, Maasai, Kenya)

In Somalia there is no law, but in Kenya, Mandera, it is there. Most of the members of the community in the border will cross over for circumcision because there are no laws which are now governing the practice, we know the laws are there but they are not [enforced] on the ground because it requires to be strengthened through [the] assistant chief to the county commissioner. (KII, activist, Bula Hawa, Somalia)

Nonetheless, similar to the survey findings noted above, some respondents stated that they were not aware of any law, (see Figure 1), in particular along the Kenya–Ethiopia border among the Dasenach (Ethiopia), Borana (Moyale, Ethiopia) and Somalis in Mandera (both Kenya and Somalia), where some respondents pointed to being aware of cultural or customary laws set by cultural leaders rather than national criminal laws:

There is a law which is prepared locally by Abba Gaddas, but the law is not prepared for FGM alone, it is prepared to abandon harmful traditional practices ... According to Borana culture, the higher [authority] personnel are Abba Gaddas. (KII, health worker, Dasenach (Omorate), Ethiopia)

Participant: "No written laws prohibiting FGM …" Interviewer: "No written laws in your office?" Participant: "There is written criminal law in our office. But at the community level, there is custom law [rather] than written legal provision to prevent against FGM. (KII, children and women's security officer, Moyale, Ethiopia)

Yes, I have. There is currently the Sharia law which is derived from the Holy Book and the teachings of the prophet (SAW) which is used by the Islamic courts. The law states that if a girl is cut the one who did

it should be fined up to 50 camels. There is also a law currently being worked on to be implemented this 2020, hopefully, that outlines the procedures and the punishments for the people who do FGM.
(KII, NGO liaison officer, Bula Hawa, Somalia)

No, there is no law, only the religious leaders used to create awareness about it not practising firaun [pharaonic] type of circumcision but there is no law in our country. … There is no law; the religion says the Sunnah should be practised only.
(Female FGD participant under 35 years old, Moyale, Kenya)

In view of the general level of awareness of the law, the study followed up on where people got their information pertaining to the law. Participants pointed to various sources of information about the law, noting that stakeholders such as local government officials like chiefs, CBOs and international organizations that have anti-FGM interventions are the major sources of their knowledge. The media, particularly television and radio programmes, were other sources of information on the law. Social media platforms such as Facebook were also mentioned as a forum where people discussed the subject of FGM, condemning the practice and emphasizing the seriousness of the law and the charges associated with violating it:

Yes, I have heard, and different people from Government and NGOs come to each us every now and then and the laws are very strict … Yes, I have heard in the radio that some cutters were arrested in Sebei land – over 20 and above cutters. (KII, Pokot, Uganda)

I heard through the press, and as an activist I have also attended many workshops concerning female genital mutilation; for example, as women for peace they have been doing it, and also there was a time when Islamic Relief was also handling those things.
(KII, activist, Bula Hawa, Somalia)

I have heard about anti-FGM law from training by Save the Children through the ministry of health; two, I have heard also through Action Aid which resulted [in] forming paralegals, Gender-based actors, CBOs and KEVIADO [a local CBO]. (KII, CBO, Bungoma, Kenya)

I have heard many times of anti-FGM prohibition law, for example in the news, television, also media services like Facebook; majority of people talk about it, how it affects the community and also in the newspapers.
(KII, CBO, Mandera, Somalia)

4.1.2.2 Compliance with laws prohibiting female genital mutilation

Evidence from the current study shows that there is evidence of compliance with the law prohibiting FGM, mostly attributed to fear of the penalties and awareness of the negative consequences of the practice of FGM. The following accounts from all cross-border study sites demonstrate these two reasons for compliance with the law:

> *The Government ordered the chiefs and assistant chiefs to arrest those who practise FGM, no one is practising because of fear of being arrested.* (Female FGD participant over 35 years old, Bungoma, Kenya)

> *Yes, there was a time when I personally decided to take my daughter to get circumcised secretly, I knew it is against the law. We went to the bush with my colleagues. When we got there, we heard that the village elders and Nyumba Kumi chairperson are coming for us, everyone ran, and we left the knives and everything there. So, I think the laws will help to end the practice. The fear created ensured that we did not try it again.* (Woman FGD participant over 35 years old, Maasai, Kenya)

> *It's the Government who are concerned [with] the laws because if any[one] is caught doing that act you suffer the consequences.* (Female FGD participant under 35 years old, Pokot, Uganda)

> *People fear the law [more] than anything. Having awareness of FGM someone can practise FGM. But if there is law, he will be afraid of the law. Moreover, if you penalize someone because of FGM that person will become the role model for others.*
> (KII, local administrator, Moyale, Ethiopia)

For some participants, while their compliance is still largely determined by the legal repercussions, it is also informed by their awareness of the negative consequences of the practice:

> *We know that there are consequences of or effects of FGM, that there are complications associated with the cut, like during childbirth. So those are the reasons why the Government is fighting the practice, they are saying that people can die due to the cut and other complications associated with it.* (Male FGD participant over 35 years old, Maasai, Kenya).

The findings from both the quantitative survey and the qualitative studies show that, although people are aware of the law and the legal penalties for performing FGM, as well as the negative consequences of the practice, that knowledge does not fully act as a deterrent.

4.1.2.3 Non-compliance with laws prohibiting female genital mutilation

Despite awareness of the legal sanctions for breaking the law on FGM, as demonstrated by the results of the survey, the findings from the focus group discussions and key informant interviews show that the communities in the border areas still largely continue to engage in the practice. Several reasons were identified: limited awareness of the laws, some community members not accepting the existing national laws, FGM being viewed as an integral part of the community's culture and religion, and perceptions of the level of implementation of the law in border areas. According to participants, implementing the law through force, instead of consensus-building and understanding the community's needs, was a major contributing factor to failure to comply with the law.

4.1.2.4 Female genital mutilation as a cultural and religious practice

For the Muslim communities along the Kenya–Ethiopia and Kenya–Somalia borders, FGM is of great importance as both a cultural and a religious norm. The community believes that FGM is a practice required by Islam and one that has been practised by generations of its ancestors that no law can stop. The community's perceived implications of failure to undergo the cut are unbearable compared with legal sanctions:

> *Because culture has a great impact. The impact of culture is more than everything. Culture has a great impact. Before prophet Mohammed sent a female to be buried with her life in their culture.*
> (KII, religious leader, Dasenach (Omorate), Ethiopia)

> *The law that is prepared across the country cannot be applied in all areas similarly because the culture and norm of the peoples are different. So, the law must be locally adapted. The penalty also must be in the way the community believes and agrees upon it.*
> (KII, police officer, Dasenach (Omorate), Ethiopia)

> *Because of our religion and norm. They said that our ancestors passed on the culture to us and we must pass it on to the next generation. So, what has happened today for us to stop our culture?*
> (KII, health official, Moyale, Kenya)

Along the Kenya–Uganda and Kenya–Tanzania borders, FGM is a strongly upheld cultural practice, and staunch supporters of it feel that the law is an affront to their culture. Community expectations and beliefs force members to pursue the practice regardless of legal penalties; their conformity with their culture is largely based on the fear of being sanctioned and discriminated against by fellow community members as opposed to being criminalized by the law. The Kuria elders are also known to curse anyone who has rebelled against their culture, thus creating fear among the people:

The locals also defy the law simply because they are rooted to the culture of FGM, which they claim they have been practising since time immemorial. (KII, judge, West Pokot, Kenya).

You see this is an issue of culture versus law: which one will people be faithful to? The law that prohibits FGM was not made with consultation of the communities that practise FGM; it was a law that was made in parliament. And therefore, to this people it is an affront to their culture, so to them those of us who are against FGM are the ones [in] the wrong they don't understand. (KII, children's officer, Maasai, Kenya)

I think that it is the culture becoming stronger than the law; they fear the culture more than the way they fear the law. So that's why I said that if we want this thing to end, total abandonment can be reached through a collective approach where there is a total shift, because if you want to make those people who understand the law to not do the practice, that is where you find the stigma, but when there is a collective shift [it] will not be lurking behind, having people who respect the law and having people who respect the culture and then having the fear of the law and having the fear of the culture. (KII, activist, Maasai, Kenya)

They defy it because they see like it's their culture and they are being attacked – that is one; some have put it in their minds that they must be circumcised so that they can live well and be respected in the community. (KII, health officer, Kuria, Kenya)

First of all the challenges may be quite many, but first of all the resistance in the community, some of them are still so entrenched in the practice that they even don't want to report the practice, they also hide the practice in a way like at cultural galas, they also say some of the TBAs [traditional birth attendants] are participants in these and even other qualified doctors are participants.
(KII, district police commander, Sabiny, Uganda)

The study findings show that, even when someone reported the practice or tried to comply with the law, they were threatened, intimidated and discriminated against, which meant they also became complicit in defying the law:

I will not be in the position to report FGM cases for safety purposes. I do not wish to be discovered by the victims of female genital mutilation or [be] named a traitor and an enemy of the people. I do not wish to live in

anxiety because of reporting cases of FGM because they might come after me. (Male FGD participant under 35 years old, West Pokot, Kenya)

The challenge they face in enforcing anti-FGM laws is witchcraft, we have witnessed many people who have tried to oppose FGM, especially chiefs, we have seen some of them break legs, another one had his leg broken by a tree after a curse from the elders and therefore all the challenges they face is because of witchcraft.
(Male FGD participant under 35 years old, Kuria, Kenya)

4.1.2.5 Limited involvement of key community players in formulating laws

Lack of or limited involvement of key community actors during the making and amendment of the laws contributes to a lack of compliance; participants expressed the feeling that these laws were imposed on them, and hence there was a need for them to be involved. The discussions from the focus groups show that FGM practising communities along the borders relate more to local leaders who understand them better than State legal actors:

In my opinion, the gap that is found in anti-FGM law is that the law does not consider the real situation of the community. The law that is prepared across the country cannot be applied in all areas similarly because the culture and norm of the peoples are different. So, the law must be locally adapted. The penalty also must be in the way the community believes and agrees upon it. (KII, community elder, Kuria, Kenya)

Authorities have not focused on it because that authority is still the community. The authority that is supposed to be involved, like chiefs, are gotten from those communities that practise FGM. So, it is like they are threatened, or they still know it is their tradition and they are not willing to cooperate. Or there is something in their customs that prevents them. (KII, police officer, Maasai, Kenya)

These community representatives are supposed to know the existing laws, criminality and penalty related to FGM while taking training. Despite frequent attempts to raise community awareness, yet the community has requested permission to cut the upper part of clitoris to meet the requirements of the existing cultural beliefs. The officials reject such community's request because, as stipulated in the law, any form of FGM is considered as a crime against human rights and security. (KII, chief, Maasai, Kenya).

4.1.2.6 Magnitude of penalties

Of the respondents surveyed, while there was a much higher awareness of the existence of a law banning FGM, awareness of the penalties was much lower and varied among the border communities. Awareness was particularly low along the Kenya–Somalia border, at over 90 per cent. compared with the Kenya–Uganda border, where on average only over 50 per cent said that they were not aware of the penalties. The lack of awareness, coupled with the perception that the penalties for breaking the law are trivial, contribute to the failure to comply with the law. Participants reported that little was done to penalize those who defy the law, giving them no incentive to comply with it. Over half of the respondents (58 per cent) perceived that families that practise FGM do not face any legal repercussions in the cross-border areas. Respondents also pointed to a weak and corrupt system of implementation by the administration, which enables people to find ways to circumvent the law, as demonstrated by the following participants' responses:

> *There is a man who was arrested the same day his daughter went for FGM; she was taken to a rescue centre and the father was taken to court and was released on bond and he is continuing with the act.*
> (Male FGD participant under 35 years old, Kuria, Kenya)

> *The gap in the law is that the penalty is not satisfactory. At least if the penalty is 1,000 or 1,500 birr, the community may not afford to pay that money. But since the penalty is 500 birr or three months' period in the jail, the community can assume that if I practise FGM, I will pay the money or I will stay only three months in the jail. If it is possible the proclamation has to improve in [such a] way that the penalty deters the individual from practising FGM.*
> (KII, police officer, Dasenach (Omorate), Ethiopia)

> *Still we haven't seen anyone penalized for breaking anti-FGM law. Since they consider it as their tradition, religious activity, they hide even if something bad happens to their child. So no one brings it to the law.*
> (KII, health official, Moyale, Ethiopia)

4.1.2.7 Perceptions of strength and weakness of laws along the border

Perceptions on the strength or weakness of laws along borders countries also contributes to the movement of people across borders in search of FGM services in defiance of the law. The survey findings show that there is significant variation among the border sites in how people perceive the strength of the law in the border area and whether or not it holds people accountable in the different countries (Table 5). The perceived weakness of the law was particularly high among the Somalis in Mandera (Kenya) at 78 per cent and among the Kuria in Isebania (Kenya) at 83 per cent. This

perceived weakness was sufficient encouragement for some to cross borders in search of FGM services.

Table 5: Respondents' perceptions of the strength of anti-FGM laws in the cross-border areas

	Sabaot in Mt Elgon (KE)	Sabiny (UG)	West Pokot (KE)	Pokot in Amudat (UG)	Somalis in Mandera (KE)	Somalis in Bula Hawa (SOM)
Is the FGM law in the cross-border area weak and does not hold people who practise FGM accountable?						
Yes	28 (29.2)	96 (48.7)	34 (30.1)	61 (32.4)	88 (77.9)	49 (45.8)
No	68 (70.8)	101 (51.3)	79 (69.9)	127 (67.6)	25 (22.1)	58 (54.2)
Is it [easy or] difficult to have a girl circumcised on the Kenyan side of the border?						
Yes	39 (39.4)	114 (57.0)	50 (45.5)	55 (28.1)	48 (42.5)	28 (26.2)
No	60 (60.6)	86 (43.0)	60 (54.5)	141 (71.9)	65 (57.5)	79 (73.8)

	Turkana (KE)	Dasenach (ETH)	Borana in Moyale KE)	Oromia Moyale (ETH)	Maasai in Transmara (KE)	Kuria in Isebania–Tarime (KE)
Is the FGM law in the cross-border area weak and does not hold people who practise FGM accountable?						
Yes	26 (27.4)	55 (59.8)	57 (49.1)	34 (31.5)	63 (64.9)	80 (82.5)
No	69 (72.6)	37 (40.2)	59 (50.9)	74 (68.5)	34 (35.1)	17 (17.5)
Is it easy or difficult to have a girl circumcised on the Kenyan side of the border?						
Yes	25 (25.5)	29 (33.3)	62 (52.5)	54 (52.9)	37 (39.4)	76 (83.5)
No	73 (74.5)	58 (66.7)	56 (47.5)	48 (47.1)	57 (60.6)	15 (16.5)

4.1.3 Implementation of anti-female genital mutilation laws and policies

The survey found that 79 per cent of the respondents favoured implementing anti-FGM laws as the most viable strategy for reducing FGM among the border communities. Forty-seven per cent of respondents favoured the arrest and imprisonment of perpetrators. Regarding whether people had heard of anyone being penalized for breaking anti-FGM laws, the survey found that this relatively few respondents had heard of anyone being penalized for breaking anti-FGM laws, especially in Bula Hawa (Somalia) at 54 per cent (see Table 14). Consistent with the quantitative data, conversations during the focus groups and key informant interviews reveal that, despite the existence of and general awareness of the law, its implementation faces several challenges that undermine its use as a deterrent to the practice of FGM among border communities. Social, cultural and religious beliefs have a stronger influence than the law, and therefore community members tend to view FGM in terms of its benefits to the community as opposed to the requirements of the law. This in turn makes it challenging to arrest and prosecute offenders because of the limited numbers of cases reported and the lack of witnesses. Furthermore, inadequate training, lack of resources, corruption and hesitance or reluctance of law implementers, and the lack of cross border anti-FGM laws make it difficult to use the law effectively as a strategy for the elimination of FGM.

4.1.3.1 Low numbers of reported cases of female genital mutilation

Participants noted that there were several reasons for the lack of reporting: communities still greatly value FGM as a cultural and religious practice, and the law is viewed as interfering with it; this has resulted in it being performed in secrecy, making it difficult for local law enforcement agencies to apprehend perpetrators:

> *Mostly, the practice is conducted in secret and hence no reporting.* (KII, prosecutor, Kuria, Kenya)

> *The report[ing] is very limited because it is made in hidden ways. For instance, only one case was reported this year. Yet the community believes that if girls are left uncircumcised, the family will be cursed which leads to extinction due to God's punishment. The community often tries to negotiate with legal bodies to get permission to cut only the upper part of clitoris.* (KII, police officer, Dasenach, Ethiopia)

> *We have less cooperation from the people in general and since FGM is not an open affair, it is hard to follow up on cases. We hope to improve that with awareness creation and bringing the people together in the fight against FGM.* (KII, chief, Bula Hawa, Somalia)

Other participants said that their fear of reporting the practice is based on traditional beliefs such as witchcraft. It is believed that those who report FGM activities are the target of witchcraft, which leads to misfortune befalling them:

> *No, people fear that they will be bewitched. The best thing to do is maybe going secretly to the authorities like the chief and inform them not to mention your name when arresting the perpetrators. ... they are not helping in implementing this law at all because they fear being bewitched by the council of elders.* (Male FGD participant over 35 years old, West Pokot, Kenya)

> *When you hear [of] a girl being circumcised, you cannot report someone. When you report somebody, you can be bewitched, even if she will be arrested you can still be bewitched.* (Female FGD participant over 35 years old, West Pokot, Kenya)

In addition, those who report the practice are said to be alienated within the community. According to participants, those who reported or were witnesses in FGM cases were considered cultural betrayers or traitors. Some respondents stated that one risked being summoned by the council of elders, while in other cases parental support would be withdrawn from girls who reported FGM; such consequences made people afraid to report:

> *When you report, the entire village wants to turn against you because they think they are doing a bad thing.* (Male FGD participant under 35 years old, Sabiny, Uganda)

> *I cannot report because I fear that there will be follow up from the council of elders.* (Male FGD participant over 35 years old, Kuria, Kenya)

> *I have never heard anyone reporting such a case because girls do fear and worry about where they will go thereafter because the parents threaten not to pay school fees for them, and the entire community becomes hostile.* (Female FGD participant over 35 years old, Kuria, Kenya)

> *Most challenges in these cases are mainly in terms of witnesses; no one is ready to be a witness, and again they choose to settle these cases domestically.* (KII, judge, West Pokot, Kenya)

4.1.3.2 Poor infrastructure and limited resources

The border areas considered in this study are very remote and far removed from road networks and other social amenities such as hospitals, police stations and courts. The inaccessibility of these areas is because of the poor road networks, lack of means of transport and limited specialized personnel. This makes it challenging for local administrators to implement anti-FGM laws effectively, not only to make arrests but also to disseminate information on FGM. Law enforcement personnel lament the challenges they face:

> *I don't have my motorbike; the other challenge is that there are no roads to most parts, [or] now the means to reach there. The other challenge is the fact that there is a lot of secrecy in the community, but I am a bit relieved there because I have some informers within every location and every village. So those are the only challenges that I feel could prevent me.* (KII, chief, Maasai, Kenya)

> *We also have the challenge of accessibility; the topography of the areas where we have rampant FGM practices is so rugged.* (KII, judge, West Pokot, Kenya)

> *Poor roads also make our work difficult to go and make an arrest.* (KII, police officer, Turkana, Kenya)

> *I want to believe that the same law is also in the neighbouring countries, but like I said before the law might be good but the modes of implementation … areas where FGM is carried out both in Uganda are very remote areas where disseminating information is very hard.* (KII, political leader, Sabiny, Uganda)

> *We don't have a gender desk. But normally the gender desk at the police … here it is remote. It should be involved. It is like a station within another station. So those ones are in levels like subcounty, or county-level stations. This one is a police post. We don't have those services. A female officer has to be specifically assigned. So we don't have[one] here.* (KII, police officer, Maasai, Kenya)

4.1.3.3 Reluctance among law implementers

Some participants felt that the implementers of the law – police, prosecutors and judges – lack commitment in enforcing the law:

Aaah, I have not seen the law enforcers dealing with the issue, ... law enforcers do not help us at all; if they were assisting FGM will have come to an end. They only announce for two days that we have stopped FGM practices, they say like this, but it ends there. The law enforcers are very silent and do not act. (KII, children's officer, Kuria, Kenya)

Lack of commitment in implementing what is written [in] the law to the real ground is another challenge of preventing FGM.
(Female FGD participant under 35 years old, Moyale, Kenya)

There is not much enforcement [of] the law here. Yes, it is there, and many don't even know it is there…
(KII, gender and child officer, Bula Hawa, Somalia)

Participants attributed this lack of commitment and reluctance on the part of some law enforcers to various reasons. Some law officers, such as chiefs, are members of the practising communities they serve and still believe in the practice; because of the strongly held cultural beliefs about the practice, law officers may receive threats of witchcraft and physical harm. Even in situations in which a case reaches the courts, some magistrates are reluctant to give custodial sentences if the perpetrator is the family's sole breadwinner:

Authorities have not focused on it because that authority is still the community. The authority that is supposed to be involved, like chiefs, are gotten from those communities that practise FGM. So, it is like they are threatened, or they still know it is their tradition, and they are not willing to cooperate. (KII, police officer, Maasai, Kenya).

Yes, matters to do with witchcraft, like there is a district officer who went and arrested a parent to a child who had been circumcised. When he arrested the parents they also went and arrested the circumciser; nobody knows how the circumciser disappeared from prison. The district officer was a man from the Luo community who traditionally do not circumcise even their men; they caught him and circumcised him forcefully. He did not make it; he died, and this is a true story. (KII, health officer, Kuria, Kenya)

Charging the parents becomes difficult; this is because they are the breadwinners so once you lock them up, their children fail to go to school. In a lot of instances, children do not want to incriminate their parents for this reason and so the cases collapse.
(KII, magistrate, Kuria, Kenya)

4.1.3.4 Inadequate training of law enforcement officers

Despite several law enforcement officers reporting having received training on the anti-FGM law, some reported not having received any training. This gap in training of law enforcement personnel undermines the ability of these officers to enforce the law as attested to by some participants:

> *Secondly, awareness about the law is not spread so much; most of the would be implementers of the law are not aware of the law and its provisions so it becomes a challenge because you cannot implement what you're not aware of.* (KII, district police commander, Sabiny, Uganda)

> *I am aware of the law, but I have not received any training on it. I have never heard that there was any training since I would have attended it and, in case of any training, I will go for it.*
> (KII, immigration officer, Sabiny, Uganda)

> *No, we have never been invited for such trainings.*
> (KII, prosecution and judges, Sabiny, Uganda)

4.1.3.5 Lack of cross-border laws prohibiting female genital mutilation

While there are laws and/or policies that prohibit FGM within the jurisdictions of the study countries, these laws do not extend to non-citizens. All of the study sites have very porous borders, most people do not use official border crossings and people move freely from one country to another daily with little to no restrictions. With the exception of the Kenya (Turkana) and Ethiopia (Dasenach) border, the communities that live along these borders are the same ethnic communities, and they have similar if not identical social, cultural and religious practices; to them, the borderlines are artificial, as family members live on either sides of the official boundaries. This porosity of the borders allows people to move from one country to another to perform or acquire FGM services where the enforcement of the law is perceived to be more stringent in one country than in the other. Of the respondents surveyed, slightly less than half (47 per cent) agreed, while about one third (34 per cent) disagreed, with 18 per cent being uncertain about whether or not it was much easier to perform FGM in the neighbouring country and no difference between the sexes. Sixty-one per cent of respondents in all border areas agreed that the anti-FGM laws in Kenya were much stricter than those in the other study countries:

> *The border is generally porous and enables easy movement of people thus leading to the continuation of the FGM practice within the community.* (KII, police officer, Mandera, Kenya)

> *The border is like the thorny fence in our villages. People cross over at any time and at any point.*
> (Male FGD participant under 35 years old, Maasai, Kenya)

> *Whether on motorcycle, vehicle, foot … the problem of Moyale is that we have a lot of routes whereby people move across small rivers which separate the two countries. The only official route is one at the immigrations [border crossing]. So, most of the people who do illicit acts move across the other routes.* (KII, activist, Moyale, Kenya)

The lack of jurisdiction to enable law enforcement officers to arrest and prosecute perpetrators on either side of the borders was cited as a barrier to effective enforcement of the law:

> *The other challenge is being at the border where they cross to the other side of Kenya, they participate in the activity and then cross back, and you cannot really trace it out.* (KII, district police commander, Sabiny, Uganda)

Apart from the general lack of common laws that might enable cross-border collaboration on anti-FGM activities, there is a general hostility between these neighbouring countries emanating from trade and related misunderstandings that deters collaboration on many issues. This currently seems to be the case between Kenya and Tanzania, Kenya and Uganda, Somalia and Ethiopia and Kenya and Somalia. It may be important for these countries to put their diplomatic relations in order so that the law enforcement agents can act in unison for the common good.

4.2 Social and cultural drivers of female genital mutilation

KEY FINDINGS

- Major drivers of FGM include certain sociocultural requirements and considerations that encourage the continuation of the practice, including issues related to marriageability; maintenance of family honour and respect; community acceptance and ethnic identity; ritual marking of the transition to womanhood; improvement of hygiene; and religious and cultural requirements.
- FGM is seen as a way of increasing young women's social capital that brings power and prestige.
- The prevailing beliefs and norms around the practice of FGM attract girls and women and make them willing to undergo the practice to conform with prevailing cultural requirements.
- Women and girls who decide not to conform to the practice of FGM experience social consequences, such as harassment, ridicule and social stigma forcing them to undergo FGM even in circumstances where their knowledge does not support the practice.
- Circumcised girls and their families are more likely to be respected and accepted in the communities that practise FGM than uncut girls who are usually ridiculed and discriminated against.
- FGM is perpetuated by illiteracy and ignorance, and it is much more prevalent in remote areas where literacy levels are low as a result of few schools and a lack of proper sensitization against the practice.

The study examined the sociocultural drivers of the practice of cross-border FGM among communities living along the borders of Ethiopia, Kenya, Somalia, Tanzania and Uganda. It found that there are various factors driving communities to continue the practice, including tradition/culture, religion, ignorance and medical reasons.

4.2.1 Culture and traditions

The main driver of the practice of FGM is culture and/or traditions. Many communities believe that FGM is a tradition or culture passed on to them through the generations and that they are compelled to follow the dictates of their forefathers. Tradition in this context refers to beliefs held or customs performed in the past, and culture represents

the shared norms, values, traditions and customs of a group that typically define and guide appropriate and inappropriate attitudes and behaviours. Traditions are bearers of value systems and standards. They are often culture dependent and are not static or ossified but dynamic structures that are constantly subjected to rational enquiry and critical evaluation. Traditions help form the structure and foundation of our families and our society, and they remind us that we are part of a history that defines our past and shapes who we are today and who we are likely to become. Sonnenberg (2014) notes that once we ignore the meaning of our traditions, we are in danger of damaging the underpinning of our identity. This is because traditions reinforce values and enable us to showcase the principles of our founding fathers, celebrate our diversity and unite us as a people or entity. Maybe the best illustration of the role of tradition and its persistence comes from the work of the renowned moral philosopher, Alasdair Macintyre, who wrote:

A living tradition … is an historically extended, socially embodied argument, and an argument precisely in part about the goods which constitute the tradition. Within a tradition the pursuit of goods extends through generations, sometimes through many generations. Hence, the individual's search for his or her good is generally and characteristically conducted within a context defined by those traditions of which the individual's life is part, and this is true of both goods which are internal to practices and of the goods of a single life. (Macintrye, 1985, 222)

The reasons why FGM is performed vary from one region to another and over time, and they include a mix of sociocultural factors within families and communities. The most often cited reasons are marriageability, familial honour, increased bride wealth and marriage prospects, preserving virginity, limiting a woman's sexuality, preventing immorality and enhancing the husband's pleasure. Related to these are strong feelings that compel individuals to accept and conform with their culture. In some instances, religion, which is part of the culture, reinforces obligations that ensure that individuals act in ways that increase their sense of belonging and show respect for those who have gone before them.

4.2.2 Religion

Overall, 65 per cent of respondents mentioned culture and religion as the main reasons for continuing FGM. At the border community level, 91 per cent the Sabaot in Mt Elgon (Kenya), 84 per cent of the Sabiny in Uganda, 68 per cent of the Pokot in West Pokot (Kenya), 83 per cent of the Ugandan Pokot in Amudat, 99 per cent of the Kenyan Somalis in Mandera, 95 per cent of the Somalis in Bula Hawa (Somalia), 86 per cent of the Borana in Kenya, 49 per cent of the Borana in Ethiopia, 92 per cent of the Maasai in Transmara (Kenya), and 85 per cent of the Kuria in Isebania–Tarime (Kenya) all mentioned culture and religion as the major reason for continuing FGM.

As shown in Figure 2, respondents ranked the various cultural reasons as follows: tradition/culture in the general sense was mentioned by 58 per cent of respondents, while religion was mentioned by 20 per cent, mainly by the Somali and Ethiopian border communities, where in many cases it is considered part of culture. Better marriage

prospects was mentioned by 6 per cent of respondents, familial honour by 5 per cent and increasing bride wealth by 4 per cent.

On the sexual front, preserving virginity was mentioned by 3 per cent of respondents, limiting a woman's sexual desires by 4 per cent, preventing immorality by 5 per cent and enhancing the husband's pleasure by 2 per cent. These data show clearly that the centre of attention in the process of perpetuating the practice of FGM is that the man and woman, through learned helplessness, have continued in the hope of being accepted within their cultural.

Other reasons for continuing FGM included lack of knowledge about its harmful nature (6 per cent) and for health (3 per cent).

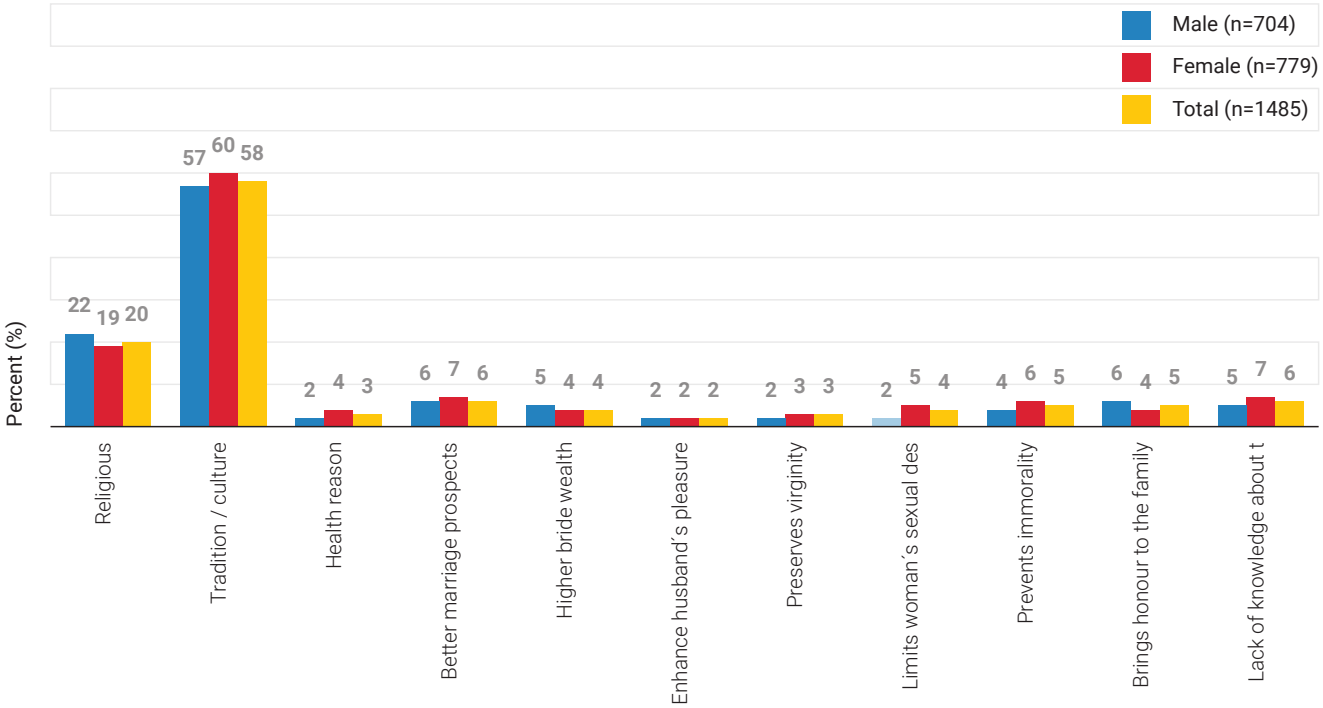

Figure 2: Reasons respondents gave for having their daughters undergo FGM.

To determine the drivers of FGM, the respondents were requested to respond to various statements in order to gauge the extent to which they agreed or disagreed with them. The statements were used to interrogate the degree to which the social, religious and moral norms contributed to the continuation of the practice. These included whether FGM marks the transition of a girl from childhood to adulthood (rite of passage); it is a religious duty to perform FGM; it teaches girls to be obedient; it has always been part of their traditions; it is recommended or endorsed in the Hadith of the Prophet Muhammad; it does not cause any problems; it shows respect for elders; it prepares girls for future childbirth; it ensures that girls remain pure before marriage; it ensures that girls retain their femininity; it teaches girls to be respectful; it is a completely safe practice; it helps a girl stay a virgin until she marries; it makes a girl

clean; it is a form of violence against women; and it is safer if done by a trained medical professional.

As to whether the practice is seen as a rite of passage, the following responses were obtained:

- 82 per cent of the Sabaot (Kenya), 67 per cent of the Sabiny (Uganda), 79 per cent of the Pokot (Kenya) and 62 per cent of the Pokot in Amudat (Uganda) agreed that FGM is a rite of passage that propels the circumcised to adulthood.
- Only 38 per cent of the Somalis in Mandera (Kenya) and 5 per cent of their kin living in Bula Hawa in Somalia saw the practice as a rite of passage.
- About two thirds (66 per cent) of the Dasenach (Ethiopia) believe that FGM is a rite of passage, while only 17 per cent of the sample in the Turkana region agreed.
- 78 per cent of the Borana in Moyale (Kenya) and 43 per cent of the same community on the Ethiopian side of the border considered FGM a rite of passage.
- 90 per cent of the Maasai in Transmara and 59 per cent of the Kuria in Isebania–Tarime region (both in Kenya) also saw the practice as a rite of passage.

The above results show that FGM is performed as a rite of passage, a transition from childhood to womanhood. A circumcised girl is considered an adult who can make decisions, is ready for marriage and can even vie for leadership positions in the community. On the other hand, a girl who is not circumcised is considered a child regardless of her age. The perception that FGM is a rite of passage from childhood to adulthood persists, even though most of communities in this study practise FGM before girls are 18 years old.

Information on the age at which girls undergo FGM reveals that the Maasai perform it between the ages of 12 and 14 years, the Kuria between 8 and 20 years, the Sabiny before 15 years of age, the Sabaot around the age of 15 years, the Pokot between 6 and 14 years, the Ethiopians before the age of 4 years, and the Somalis perform FGM from days after birth to puberty with the majority mentioning 6–10 years. In addition to this, treating a girl child as an adult on the basis that she has undergone FGM was noted to fuel “child marriages”, which are punishable by law.

The finding that FGM is performed as a rite of passage from childhood to adulthood was further cemented by the voices of several key informants and focus group participants at the various study sites. The following selection highlight the issues:

Mmmh, okay [there] are quite a number of people saying people who have undergone FGM are much more trained to be wisely responsible women in the society; aaah, during the seclusion, that period when they are put [confined]; eeeh, information is instilled that will help them grow to be responsible women and mothers in the society; that is the main reason they are advised, and in any case it also marks the rite of passage from childhood to adulthood after one has gone through the rite of passage; she is now considered mature, somebody who can now start a family and even can make decisions.
(KII, immigration officer, Kuria, Kenya)

This community believes that it is a rite of passage when now maybe a girl is transitioning to womanhood or something like that. It is a passage that they must undergo for them to be accepted as women who can bear children or something like that and they take it as a cleansing, maybe, practice. (KII, medical practitioner Maasai, Kenya)

FGM was a sign of transition of a girl from childhood to adulthood and so it came in as a way of ushering them to womanhood and freedom to get married. It was also viewed as a rite of passage that allowed suitors to pursue them. There are people who take prestige in it. It was believed that a woman who did not undergo FGM was looked at as an outcast, and some girls could look up to it out of the fear of being looked at as outcasts. (KII, opinion leader, Sabaot, Kenya)

Yes, FGM was very acceptable in the Pokot community because it was showing that [an] uncut child is still very young but when she is cut it's a sign of adulthood. (Female FGD participant under 35 years old, Pokot, Uganda)

As to whether religion is connected to the continuation of FGM, about 72 per cent of the respondents (72 per cent male, 71 per cent female, $p = 0.806$) disagreed that it is a religious duty to perform FGM, while 26 per cent agreed. Close to three quarters of the respondents (71 per cent; 68 per cent male, 74 per cent female, $p = 0.021$) disagreed that the Bible contained verses that make FGM obligatory, compared with only 18 per cent who agreed. About one third (27 per cent male, 34 per cent female) agreed that FGM is recommended or endorsed in the Hadith of the Prophet Mohammad. In respect to whether the Hadith makes it obligatory for a girl or woman to undergo FGM, 27 per cent of the respondents agreed, and 48 per cent disagreed.

It was notable that a sizeable proportion of respondents along the Kenya–Somalia border (47 per cent among the Somalis in Mandera, Kenya, vs 31 per cent among the Somalis in Bula Hawa, Somalia) and on the Kenya–Ethiopia border (64 per cent in the

Kenyan side of Moyale vs 53 per cent in the Ethiopian side) agreed that it is a religious duty to perform FGM.

The findings show that, to some extent, it is widely believed among Muslims that it is a sin for a girl not to be circumcised, as she will be going against the teaching of the Islamic religion. In this way, FGM is perceived to be a religious obligation for Muslims, and a girl who is not circumcised is perceived to be unclean and cannot fast in the month of Ramadan. Shariah law is also perceived as a basis for the Sunna type of FGM, which is the cut most performed among Muslims, who believe that when the Sunna type of FGM is practised, blood is shed to appease their God.

The following participant's responses reinforce the findings on the use of religion as a basis for the practice of FGM:

> *There is an attitude in the community that their God will punish them unless they cut their girls. They are afraid of its punishment, which they believe that it can be death penalty.*
> (KII, health worker, Dasenach (Omorate), Ethiopia)

> *The reason for practising circumcision in general both for men and women is to fulfil a religious obligation as we have been commanded by God.* (KII, circumciser, Bula Hawa, Somalia)

> *As a Muslim, circumcision is Sunna and everyone does it.*
> (Male FGD participant under 35 years old, Bula Hawa, Somalia)

> *It is traditional and Islamic. If a girl is not cut, she is considered as a dirty person. We believe that a girl should be cut at some certain age. A girl who is not circumcised is not considered clean and cannot fast during the month of Ramadan. If a girl is not circumcised, she will be desperate for a man.* (KII, assistant chief, Moyale, Kenya)

> *A big problem came because the Government is trying to tell us to defy our religion which is impossible, but if they say we should abandon the firaun [pharaonic] practice and continue practising the Sunna, that one is well and good but we can't stop the whole practice … Bringing up a girl child without undergoing the FGM practice is not making sense to us.*
> (KII, leader, Moyale, Ethiopia)

The sanctions imposed culturally and religiously in most communities bar women from participating in many communal activities. The voices of several key informants and focus group participants captured most of the fears:

> *In some extreme cases, an uncircumcised girl is not allowed to perform duties such as opening the gate for the father or father-in-law or even serving their husbands meals. If you are uncircumcised, there are some farms you cannot even pass because the crops will dry up. So, they feel like outcasts. They are also not allowed to access the granaries without any sanctions.* (KII, NGO, Kuria, Kenya)

> *… uncircumcised girls were considered as children. They were not allowed to fetch water from the water points with other women, they were not supposed to bathe with other women. The uncircumcised women were not allowed to milk cows or even serve their husband's meals. They were really undermined, and this pressure forced them to go through circumcision.*
> (Female FGD participant over 35 years old, West Pokot, Kenya)

There were also questions about whether the practice teaches a girl to be respectful and obedient to the elders and other people in the community. The results show that 84 per cent from the Sabaot (Kenya), 38 per cent among the Sabiny (Uganda), 51 per cent of the Pokot in West Pokot (Kenya) and 85 per cent among the Pokot in Amudat (Uganda) agreed that FGM teaches a girl to be respectful. On the other borders, 50 per cent of the Somalis in Mandera (Kenya), 7 per cent among the Somalis in Bula Hawa (Somalia), 12 per cent of the Turkana (Kenya), 46 per cent of the Dasenach (Ethiopia), 64 per cent of the Borana in Kenya, 41 per cent of the Borana in Ethiopia, 39 per cent of the Maasai in Transmara and 24 per cent of the Kuria in Isebania–Tarime (both Kenya) all agreed that FGM teaches a girl to be respectful.

The voices of a focus group participant and a key informant reinforce the respect and pride associated with the practice of FGM:

> *Clean and proud of the culture … respected … circumcision calms down the girl.* (Male FGD participant over 35 years old, Borana, Kenya)

> *A circumcised girl does not run after men; she is respectful and never roams around looking for men like those who are never cut.*
> (KII, elderly man, Kuria, Kenya)

On the idea that FGM propels a girl to adulthood and subsequent motherhood, the researchers asked whether FGM prepares a girl for childbirth in the cultural sense. The results show that 55 per cent of the Sabaot in Mt Elgon (Kenya), 21 per cent of the Sabiny (Uganda), 9 per cent of the Pokot in West Pokot (Kenya), 18 per cent of the Pokot in Amudat (Uganda), 42 per cent of the Somalis in Mandera (Kenya), 7 per cent of the Somalis in Bula Hawa (Somalia), 12 per cent of the Borana on the Kenyan side of Moyale, 46 per cent of the Borana in Ethiopia, 63 per cent of the Maasai in

Transmara and 29 per cent of the Kuria in Isebania–Tarime (both Kenya) agreed that FGM prepares a girl for childbirth:

> *FGM is mainly cultural and prepares a girl to have a legitimate child. Any woman who gives birth before circumcision is considered a child and her motherhood is in vain. She has to be circumcised during delivery to make the child and the mother acceptable members of the community.*
>
> (KII, health worker, Dasenach (Omorate), Ethiopia)

Study participants across all sites reported that circumcised girls and their families are more likely to be respected and accepted in the communities that practise FGM than uncut girls who are mostly ridiculed and discriminated against. In most circumcising communities, girls who are not circumcised are considered immature and thus do not command respect and, in some cases, they are considered loose and are excluded from key roles in the community, such as fetching water or milking cows, and also denied access to services. The social sanctions are overbearing and make individuals very fearful and compels them to conform despite their individual beliefs.

Regarding marriage prospects following FGM, all communities seem to agree that the practice prepared a girl for marriage and conferred some level of communal maturity. Marriageability, therefore, emerged as a key factor that drives the practice of FGM in the communities under study. The findings show that most parents took their daughters for circumcision to increase their daughters' chances of getting married, as circumcised girls are valued more highly than uncircumcised girls. In addition, the bride wealth paid for a circumcised girl is substantially higher than that paid for a girl who has not undergone FGM. The difference in bride wealth motivate parents to take their daughters for FGM.

There were respondents who indicated that girls who have not undergone FGM are less likely to be married within the community and that most of them end up getting married outside the community. In their opinion, a girl who has undergone FGM is a better homemaker, since she has been mentored on how to live and retain a husband. The voices of key informants and focus group participants highlight some aspects of the community's position:

> *Any girl who hasn't been circumcised is a loose girl. Traditionally, when a girl is married and she isn't circumcised, men would make a hole on the seat that the mother-in-law has gifted them with. He would make a hole in the middle of the seat and keep it outside for the people to see, without talking. That sends a message to all that the girl had an open vagina and she wasn't a virgin as she should be.*
>
> (KII, gender and child officer, Bula Hawa, Somalia)

There could be some economic reasons for the parents since the cut girls fetch more bride wealth when they are married than the uncut in the community. (KII, anti-FGM activist, West Pokot, Kenya)

In the recent past, if you were not circumcised then you were not allowed in the community. I had a sister from the other side of Bukusu and she got married this side, she was forced to get circumcised otherwise she would have left her marriage. If you are not circumcised, you get divorced. (KII, children's officer, Bungoma, Kenya)

Circumcision is a measure of a girl's value. Circumcised girls are more valuable than uncircumcised girls. The degree of marriageability of a circumcised girl is high as compared to an uncircumcised girl. Less cattle are given for dowry for an uncircumcised girl and the vice versa applies to the circumcised girl.
(Male FGD participant under 35 years old, West Pokot, Kenya)

In the past they used to say that if a child is not cut it shows that the child has not grown and it is not ready for marriage; that is why Pokots used to take it as a priority because it would show a boy of the next neighbourhood that there is grown-up girl there who needs to be married. (Female FGD participant under 35 years old, Pokot, Uganda)

We have to cut girls because they get married and go to families where … you're even told that you cannot pass the same gate as the man of the house. That is why we keep cutting girls. Also, it helps you to graduate from being a child to be an adult. … As the Kuria, when an uncircumcised girl is pregnant, she is kicked out to a different community and a different place that is far away from her home, she cannot be married among the Kuria people. She is ferried to a different place in a different community and dumped there.
(Female FGD participant under 35 years old, Kuria, Kenya)

According to the traditions of the Maasai community, like, if you are uncircumcised, they say that you are still a girl and not a woman, you will not get a husband, because, there is something they call "entoopai", which is the name they give to a girl who gets pregnant before they are circumcised. It is a taboo to give birth before being circumcised, and therefore you will not get a husband. There are families who will never marry a girl who has given birth before being circumcised, there are those families who marry them, but they are few. (KII, chief, Maasai, Kenya)

There seem to be other related economic benefits that the fathers of the circumcised girls derive from the act. They get gifts from their peers, relatives and friends during the ceremony:

> *The other beneficiary is the father; you know you will call your friends and when they come for the celebration, they will not just come empty-handed. They will bring gifts, cows, goats and sheep. So, the father of the girl also benefits. And now when there is no more practice of FGM that benefit ends for the father.*
>
> (Male FGD participant over 35 years old, Maasai, Kenya)

The need to control sexuality also emerged as an important driver for the practice of FGM. Respondents noted that FGM is commonly performed to control a woman's sexual desire (female sexuality). The results of the study show that most pastoral communities found FGM favourable in marriage because men could go away for long periods in search of pasture. FGM was thus performed to tame women to deter them from adultery. Some members of pastoral communities believe that a girl who has undergone FGM is more desirable for marriage because she is more likely to be faithful to her husband, unlike an uncut girl who is viewed as being loose or even equivalent to a prostitute. Some of the pastoral communities living in the borders where the study was conducted include the Borana, Kuria, Maasai, Pokot, Sabaot and Sabiny. These pastoral communities still cross borders in search of pasture but, whereas in the past pastoral communities spent a long time away from their homes in search of pasture, this is no longer the case. Therefore, the reason for practising FGM to "control women's sexuality or domesticate women" no longer holds and yet FGM persists. According to the findings of the study, pastoral communities that live astride the borders have very close kinship ties and are in close contact and jointly cherish their culture and traditions, which potentially has sustained cross-border FGM. The key informants and the focus group participants noted the following:

> *The reason [for] cutting in Pokot is to reduce the libido of a woman/ reduce the sexual desire because a word came from our grandfathers who said that men could go very far to graze animals for over five months and above so by the time they come back, they find that the women have misbehaved with other men; then people said we should cut off that thing [clitoris] to stop women from moving to other men.*
>
> (KII, elder, Pokot, Uganda)

> *FGM represents culture and here in Kapweno village the old men said that if a woman is cut, it reduces on the appetite which reduces on issues of adultery. Secondly, traditionally once a woman was cut, she could not move from one marriage to another.*
>
> (Male FGD participant under 35 years old, Sabiny, Uganda)

So, they also believe that when a girl is not circumcised, she is promiscuous, so they say she has to be circumcised to reduce the sexual urges. They also believe that an uncircumcised girl is a prostitute because her sexual urges are at the peak. So, they say that a circumcised girl will wait for her husband to come back if he is away for a few days because they believe it reduces her sexual urges.
(KII, assistant chief, Kanyerus, West Pokot, Kenya)

In the past it was that men took their cows very far for grazing to a place called "Nagurebul" and when they came back, they would find their women pregnant and they would ask themselves how and why? So as they went on investigating, they found that the clitoris is the one that made them so crazy so men called a surgeon to do something by cutting all the women and this helped so much in reducing the sexual desires of women and that is how FGM started but now we no longer want it because it has costed us a lot.
(KII, local councillor one (LC1), Kara Pokot, Uganda)

In the Sabaot community, that is a male elders' driven vice. To me when elders say by circumcising a girl it reduces sexual urge, then to them they believe it is a vice to domesticate this woman so that she does not leave. Sabaots are pastoralists and move from one place to another. So, they leave and go to the forest and they have that fear of who they will leave back at home. So, the only way that they could domesticate women to ensure that she doesn't leave the homestead and go somewhere else is to circumcise. (KII, anti-FGM activist, Chepkube, Bungoma, Kenya).

Related and closely linked to sexuality and sexual control is the issue of virginity and cleanliness as a motivation for the continuing the practice. About 59 per cent of the Sabaot in Mt Elgon (Kenya), 28 per cent of the Sabiny (Uganda), 9 per cent of the Pokot in West Pokot (Kenya), 14 per cent of the Pokot in Amudat (Uganda), 49 per cent of the Somali in Mandera (Kenya), 17 per cent of the Somali in Bula Hawa (Somalia), 53 per cent of the Dasenach (Ethiopia), 18 per cent of the Maasai in Transmara and 13 per cent of the Kuria in Isebania–Tarime (both Kenya) reported that virginity was a key consideration for the practice.

A similar pattern as above was observed in the proportion of respondents who thought that FGM makes a girl clean. The study findings reveal that some communities view an uncut girl as being "impure" and/or "dirty". As a result, many communities ensure that their daughters undergo FGM to make them clean and improve hygiene. Some of the voices of the key informants and focus group participants affirm this perception:

Yes, and that clitoris also grows as the girl grows because it's just part of the body and the friction of the thighs make it even longer so it will be painful as you walk unless you don't walk a lot. You know the clitoris has an opening on top so when I help the uncut girls to deliver it has a very bad smell. (KII, traditional circumciser, Mandera, Somalia)

First, it was a cultural practice and part of traditions of the Pokot community. There is a belief associated with it that the uncircumcised girls are smelly (dirty) and lazy. Circumcision was therefore, meant to purify a girl and to make them clean.
(Male FGD participant under 35 years old, West Pokot, Kenya)

Women say that cut organs are easier to clean than the uncut ones.
(Male FGD participant over 35 years old, Maasai, Kenya)

Apparently, notions of cultural identity feature prominently in communal discussions regarding the practice of FGM. This is more prevalent in communities neighbouring those that do not practise FGM. It is not just a matter of identity but one of cultural pride. This is common among the Kuria to distinguish themselves from their Luo neighbours, the Sabaot to distinguish them from their Bukusu neighbours, and so forth. Most communities see FGM as a tradition that has been passed to them through generations and believe that abandoning it amounts to cultural suicide. The practice confers on them a sense of belonging and bragging rights. Most of the key informants observed that the reason they practise FGM is because they had been brought up witnessing women being cut and that they also need to avoid the consequences of failing to adhere to long-standing practices such as FGM. The participants' voices below amplify this notion:

Our ancestors were subjected to the same. Even when we came of age it was said it's time to mutilate the village kids and around five of us were taken to an old woman and were subjected to the act. Therefore, it is like a traditional/cultural trend that is inherited from one generation to another. (KII, school administrator, Moyale, Somalia)

Yah, these reasons are especially strongly attached to … let's say traditional affiliations; for one they usually say it is their cultural practice; since time immemorial it has been there so there is no way to get rid of them because their forefathers and everybody else went through it and practised it. Who are they to leave it? Because it has been practised since time immemorial and it is their way of life. (KII, headteacher, Maasai, Kenya)

Circumcision has always been a very important occasion ever since, we have grown up seeing and celebrating it, it has been there since our great grandparents' time. This is something that is handed over, you can't just go to the shop and buy it, it is inherited from generation to generation. How else would you distinguish a Luo from a Kuria?
(KII, circumciser, Kuria, Kenya)

Demi is a treasured cultural ceremony in Ethiopia which precedes circumcision and any girl who doesn't observe it is considered a sinner. "Demi" ceremony is the reason behind [the] community's continuation of FGM. Culturally, the community believes that if a girl doesn't pass through the "Demi" ceremony, she and her family will be recused. The community considers refusal [to] celebrat[e] "Demi" as committing sin that leads to extinction of family and the clan.
(KII, elder (Omorate) Dasenach, Ethiopia)

Furthermore, the study findings reveal that undergoing FGM is a way of averting bad omens, as uncircumcised girls are seen as a bad omens. There are fears that, if a girl is not cut, evil will befall her, and her husband and all her family members will die as a result. In Ethiopia and bordering communities, it is believed that a family that does not organize and celebrate the Demi ceremony loses its existence on the Earth. The Maasai and Kuria communities also believe that the practice is a way of casting out demons:

Refusing celebration of Demi ceremony causes mass child mortality and extinction of the family. (Male FGD participant, Omorate, Ethiopia)

You see, traditionally, people say that uncircumcised girls are not allowed to attend cultural practices. They also believe that such people give birth to demonic children … That is why most of the people have the notion believing you have become demonic/unclean and none would want to touch your blood. Your firstborn child will be inflicted with bad luck and so will your second born; in fact, the second born will carry all the evil remaining. Nobody will be willing to marry you.
(KII, CBO officer, Maasai, Kenya)

There are traditional beliefs that if, for example, if I marry an uncircumcised girl and I am circumcised myself, then I will die. That the husband will die because of marrying an uncut girl. So that is the main source of fear for many people in this community: that people say that women must be cut to save their husbands from death.
(KII, chief, Maasai, Kenya)

Socially in this community, all men believe that when you marry a cut girl then you will be blessed by your parents and no evil will befall you.
(KII, school administrator, Kuria, Kenya)

Apart from the strong mythical beliefs that reinforce the need for compliance with the practice, some participants noted that the upholding of cultural practices such as FGM is influenced by illiteracy and ignorance. In their opinion, FGM is more rampant in remote areas where literacy levels are low as a result of few schools and lack of awareness of the harm caused by the practice. The situation in most of the border sites is that they are remote, far removed from the centres of each country's administration and at times very difficult to access as a result of rugged terrain and impassable roads. This was voiced by key informants as follows:

The main activity of … the people along the Kenyan border are mainly nomads. I think these are people who have been left behind and have been neglected; they are still in total darkness and thus have continued to uphold strong cultural practices and beliefs.
(KII, nursing officer, West Pokot, Kenya)

Okay, as I said again the most important aspect is education; as people's level of literacy goes up, they start seeing such activities as outdated and useless. Let people embrace education and go to school. Let us have a high literacy level. You never see them going to do those kinds of things. (KII, immigration officer, Kuria, Kenya)

We live-in far-removed places from the centres of civilization. We have no police stations, few schools and, if anything, we only have our culture to hold on to. The day we will also be included as part of the country, then we may reconsider our practices. (KII, village elder, interior of Maasailand)

Given the myths and cultural reinforcement in the communities, when the study posed questions about whether FGM should continue, the responses indicated that there are those in the communities who have yet to accept change. They still believe that the practice provides them with anchorage and the desired identity in their community. Those who reportedly wanted FGM to continue were as follows: 47 per cent of the Sabaot in Mt Elgon (Kenya), 28 per cent of the Sabiny (Uganda), 11 per cent of the Pokot in West Pokot (Kenya), 23 per cent of the Pokot in Amudat (Uganda), 50 per cent of the Somalis in Mandera (Kenya, 12 per cent of the Somalis in Bula Hawa (Somalia), 37 per cent of the Dasenach (Ethiopia), 50 per cent of the Borana in Kenya, 44 per cent of the Borana in Ethiopia, 38 per cent of the Maasai in Transmara and 22 per cent of the Kuria in Isebania (both Kenya). These large numbers show that the efforts to eradicate FGM must be upscaled and, where possible, the approach changed. There seems to be a large proportion of people who still strongly believe that the drivers of FGM are too strong for them to become part of a critical mass of individuals who can drive change.

4.3 Effects and consequences of female genital mutilation

KEY FINDINGS

- FGM has short-term and long-term health consequences, among the former excessive bleeding, pain, infection and death. The long-term consequences include risks of childbirth, fistulas, newborn deaths, HIV and AIDS, and menstrual problems.
- There are sexual consequences of FGM, for instance painful intercourse, vaginal problems, decreased sexual satisfaction and reduced sexual desire.
- There are also psychological and emotional effects resulting in low self-esteem, bitterness and regret throughout the woman's life.
- FGM leads to socioeconomic retardation, resulting from a lack of livelihood opportunities. This is brought about by early marriage, low levels of schooling and the continuing subordination of women in most of the practising communities.
- The practice also violates the rights of the women and girls and compromises their dignity and right to self-autonomy.

This section discusses the impacts and consequences of FGM as noted in the study. The findings show that FGM has long-term and short-term effects, ranging from sexual, health, and psychological effects to educational and socioeconomic effects. In all the border sites studied, respondents noted that women with severe FGM, that is, type III or infibulation, were exposed to a considerable risk compared which those with practised Sunna or types I and II FGM.

4.3.1 Health effects of practising female genital mutilation

4.3.1.1 Immediate complications

Circumcised girls face a myriad of health challenges. The procedure is performed by traditional practitioners without the use of anaesthesia; thus, the immediate consequences include excessive bleeding, excessive pain during and after the procedure, infection and death as a result of the trauma.

Participants also told of being afraid to seek help from health services in the event of complications or delayed referral after the cut because FGM is outlawed.

Overall, 93.5 per cent of respondents agreed that FGM causes health problems. Figure 3 shows the proportion of respondents who believe that FGM has health consequences, disaggregated by sex and by each of the cross-border sites.

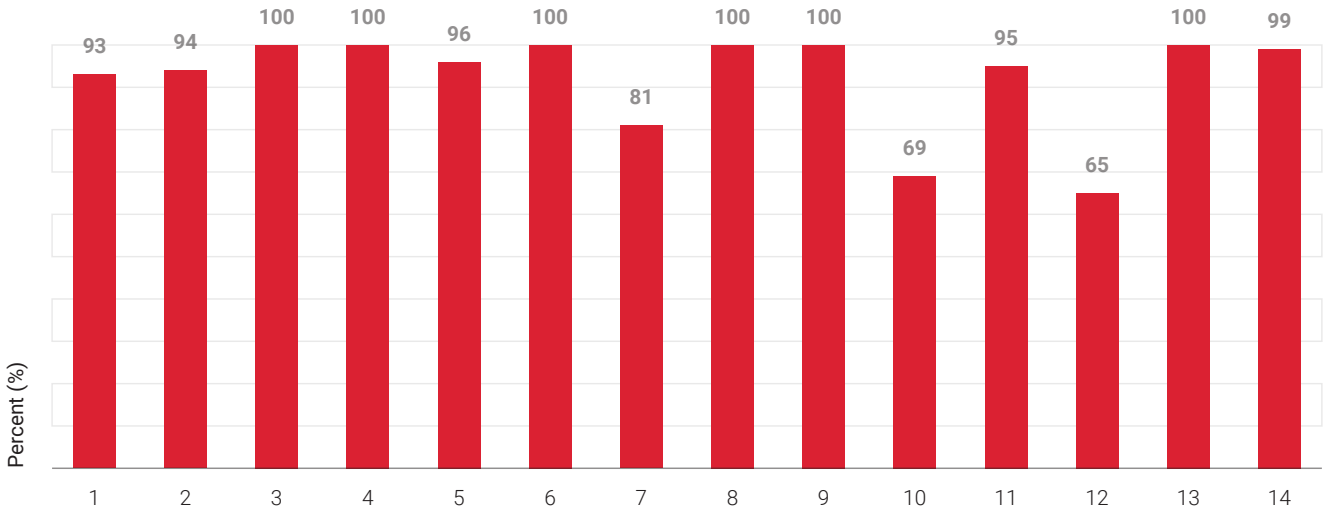

Figure 3: Proportion of respondents who believe that FGM has health consequences by sex and by cross-border site.

As shown in Table 6, about 9 in 10 (93 per cent) of the respondents (93 per cent male, 94 per cent female) thought that FGM has some health consequences, and 87 per cent agreed or strongly agreed that FGM causes a person to bleed, 70 per cent agreed that FGM causes death; on whether FGM spreads HIV and AIDS and other sexually transmitted diseases (STDs), 65 per cent agreed or strongly agreed, while 22 per cent disagreed or strongly disagreed. FGM can lead to pain in the genitalia and cause urinary tract infections, according to over two thirds (70 per cent) of the respondents, whereas 22 per cent of them disagreed. About half of the respondents (61 per cent) agreed or strongly agreed that FGM causes vaginal problems (discharge, itching and other infections) and 26 per cent of respondents disagreed with this. In the opinion of 57 per cent of the respondents, FGM contributes to sexual problems, which include pain during intercourse and decreased sexual satisfaction, while 27 per cent thought it does not. In the view of 65 per cent of the respondents, FGM increases the risk of childbirth complications, and newborn deaths and 58 per cent thought it reduces sexual desire.

Table 6: Respondents' opinions on whether FGM has any health consequences, disaggregated by sex

	Male (*n* = 704)	Female (*n* = 779)	Total (*n* = 1,485)	*p*-value
Composite score: mean (standard deviation)	33.6 (8.1)	33.0 (8.4)	33.3 (8.3)	0.177
D02 FGM can cause a person to bleed, n (%)				
Disagree	51 (8.0)	50 (7.1)	101 (7.5)	0.242
Neutral	25 (3.9)	41 (5.8)	66 (4.9)	
Agree	561 (88.1)	614 (87.1)	1,175 (87.6)	
D03a FGM causes death, n (%)				
Disagree	125 (19.7)	161 (22.8)	286 (21.3)	0.193
Neutral	48 (7.6)	63 (8.9)	111 (8.3)	
Agree	462 (72.8)	481 (68.2)	943 (70.4)	
D03b FGM can spread HIV and AIDS and other STDs, n (%)				
Disagree	128 (20.3)	158 (23.0)	286 (21.7)	0.026
Neutral	69 (10.9)	102 (14.8)	171 (13.0)	
Agree	435 (68.8)	427 (62.2)	862 (65.4)	
D04 FGM can lead to pain in the genitalia and cause urinary tract infections/problems, n (%)				
Disagree	94 (14.8)	146 (20.9)	240 (18.0)	0.001
Neutral	95 (15.0)	69 (9.9)	164 (12.3)	
Agree	446 (70.2)	484 (69.2)	930 (69.7)	
D05 FGM causes vaginal problems (discharge, itching and other infections), n (%)				

	Male (*n* = 704)	Female (*n* = 779)	Total (*n* = 1,485)	*p*-value
Disagree	119 (19.0)	180 (25.7)	299 (22.5)	
Neutral	121 (19.4)	96 (13.7)	217 (16.4)	0.002
Agree	385 (61.6)	425 (60.6)	810 (61.1)	
D06 FGM causes menstrual problems (painful menstruation, difficulty in passing menstrual blood), n (%)				
Disagree	149 (25.0)	260 (38.0)	409 (31.9)	
Neutral	147 (24.6)	101 (14.7)	248 (19.3)	0.000
Agree	301 (50.4)	324 (47.3)	625 (48.8)	
D07 FGM contributes to sexual problems (pain during intercourse, decreased satisfaction)				
Disagree	154 (25.4)	180 (26.2)	334 (25.8)	
Neutral	104 (17.2)	115 (16.7)	219 (16.9)	0.945
Agree	348 (57.4)	393 (57.1)	741 (57.3)	
D08a FGM increases the risk of childbirth complications and newborn deaths, n (%)				
Disagree	139 (22.1)	168 (23.9)	307 (23.0)	
Neutral	87 (13.8)	80 (11.4)	167 (12.5)	0.354
Agree	404 (64.1)	456 (64.8)	860 (64.5)	
D08b FGM reduces sexual desire, n (%)				
Disagree	171 (27.4)	167 (24.0)	338 (25.6)	
Neutral	105 (16.8)	106 (15.2)	211 (16.0)	0.181
Agree	349 (55.8)	424 (60.8)	773 (58.5)	

Disaggregated by side of the cross-border, significant differences in the mean scores for opinions on whether FGM had health consequences were observed across all borders except for the Kenya–Somalia border. In the Kenya–Uganda border sites, the Sabaot in Mt Elgon on the Kenyan side had 53 per cent of respondents likely to agree compared with the Sabiny on the Uganda side who had about 78 per cent likely to agree. Similarly, among the Pokot in West Pokot (Kenyan side), 71 per cent of respondents agreed, compared with 82 per cent l among the Pokot in Amudat (Uganda side of the border). There was

no significant difference in the responses for the Kenya–Somalia border. However, there was a significant difference in the mean score by sex in Mandera on the Kenyan side of the Kenya–Somalia border, with females (87 per cent) more likely to agree than male (73 per cent) respondents. Significant differences by sex within each border were also observed for the Kuria in the Isebania–Tarime region along the Kenya–Tanzania border with males (89 per cent) more likely to agree than female (69 per cent) respondents. The observed differences could result from learned helplessness and the degree to which some communities see the problems as a given rather than as the result of FGM.

The data on the health complications were reinforced by the voices of key informants and the focus group participants, as the following extracts show:

> *The first effect of FGM is bleeding to death, girls failing to give birth, fainting during circumcision because of the pain, someone may be cut too much such that the nerves are affected, and the woman can become insane. These are the things that I have witnessed, in fact three days ago a 12-year-old girl died because she was circumcised.*
> (KII, Komesi CBO, West Pokot, Kenya)

> *There is a lot of bleeding, we have fistula cases common among women who have undergone FGM, they experience complications which can lead to death. They get complication[s], like women sometimes develop growth[s], so those are some of the health effects that a woman undergoes.* (KII, anti-FGM activist, West Pokot, Kenya)

> *… there is the risk of transmitting disease, including HIV and others. This is because of using this one tool to cut several girls. The other effect is that even sexual stimulation will go down, because the girl's sensitivity will decrease, so those are my views on the effects of cutting a girl. Ooh, there is another one, I can say, it could even cause fistula.*
> (KII, chief, Maasai, Kenya)

> *First of all, the girl is circumcised and stitched up without use of anaesthesia. The pain she goes through is extreme and that affects her physically and psychologically. During her healing, she goes to pee and it is not washed for the fear of the stitches opening. That brings a lot of infections due to the continued urine dirt. Later, as she grows up, she gets her periods which come out in very small bit.*
> (KII, gender and child officer, Bula Hawa, Somalia)

> *I have witnessed one and they go through a lot of pain especially when urinating, they do it while standing because they believe that if the*

urine meets the wound it fastens [hastens] the healing. There is a lot of bleeding in case of anything small; they cannot do any work.
(Female FGD participant under 35 years old, Sabiny, Uganda)

It can cause bleeding and even death. They can use one blade to cut many children so this can transmit disease like HIV. It can also cause different infection. For example, if bleeding occurs, they don't take them to hospital because the practice is hidden. They use traditional medicine and this traditional medicine can cause different infections since it [is] applied in [a] sensitive area. (KII, local administrator, Moyale, Ethiopia)

The respondents further noted that the various traditional ways of managing excessive bleeding cause more harm. The ways devised to treat wounds or improvised local anaesthesia are thought to expose the victims to more severe infections. The use of herbs, cow dung and raw eggs to treat the wound make them more vulnerable to infections or further complications:

The girl bled for a long time; she was given traditional herbs. Apparently, the blood wasn't getting out of her body, instead it moved back, and it was getting into the stomach. It became a problem considering that she was circumcised, and it is against the law. They decided to take this girl to the hospital; on their way to hospital, they met an old woman who offered to help. She took a certain herb, squeezed the sap out and dropped it to the girl's vagina. After some time, the blood came out in form of thick blood clots. I came to learn that FGM is a very serious practice. The girl could have died because of excessive bleeding and the parents could have been arrested.
(Female FGD participant over 35 years old, West Pokot, Kenya)

After circumcising a girl, we put her on bed rest then bring out blood from a cow; usually they shoot [it] on the neck, the pierce oozes blood then some cow dung is smeared on the spot to stop the bleeding and [the girl] drinks it [the blood].
(Female FGD participant over 35 years old, Maasai, Kenya)

Circumcisers from Gari of Somali have a syringe and they inject something like anaesthesia [in]to the girl who is going to be circumcised. This makes the girl to faint and as a result, during circumcision, the girl does not feel any pain. Immediately after circumcision, the circumciser breaks an egg and adds the broken egg to the wounded part of clitoris as part of the cure to the wound.
(KII, prosecutor Dasenach, (Omorate), Ethiopia)

4.3.1.2 Long term reproductive health complications

Furthermore, long-term health effects as a result of the scarring include obstetric complications, retention of menstrual blood and fistulas. From the results of the study, circumcised women are more likely to experience delivery complications: prolonged labour, tearing and Caesarean delivery (CS); such complications can lead to maternal or infant mortality. Respondents described the long-term consequences as follows:

> *The CS alone gives her too much pain and the fact that the blood keeps remaining in her every month, exposes her to many risks and diseases.*
> (KII, gender and child officer, Bula Hawa, Somalia)

> *Other effects include persistent pain during her periods which [is] as a result of blood passing out slower than it is supposed to. We destroyed those girls completely and I highly regret it.*
> (KII, circumciser, Bula Hawa, Somalia)

> *It will be complicated for her during childbirth. You know where there is a scar, there is no elasticity during birth; another effect could be, and you know that Maasai could use one razor blade to cut more than one girl. They could also use the traditional blade to cut even twenty girls.*
> (KII, chief, Maasai, Kenya)

> *I would like FGM to end because when a girl has been circumcised, during child delivery it becomes very hard because they tend to heal attached or connected and, in most cases, they rupture or tear. That place becomes very bad and these wounds can even develop into cancer. In some cases, one grows extra tissue, and this calls for an operation.* (Female FGD participant under 35 years old, Kuria, Kenya)

> *I was circumcised, I got married and got pregnant. When the time for delivery came, I had a prolonged labour and when midwives came, they helped me but it was very hard for my child to come out because of the big scar left during circumcision; they were forced to tear my private area to expand so that the child may come out. This procedure was done wrongly such that my urinal part joined with the anal region. This was a very painful experience; I was rushed to Kapenguria hospital where I was assisted.* (Female FGD participant under 35years old, West Pokot, Kenya)

> *This leads the mother to develop [a] fistula during delivery. There were cases which were referred to Yirgalem hospital for fistula cases*

because the elasticity of the genital organ decreases because of the scar formed during FGM.
(KII, local administrator Dasenach (Omorate) Ethiopia)

We receive them during delivery periods; when you are conducting deliveries, you're in [a] position to tell a woman who went through FGM. In most cases, when they are delivering they get tears compared to those who did not go through it and even most cases of fistula are from women who went through FGM.
(KII, senior nursing officer, midwifery, Sabiny, Uganda)

I am one of those who underwent FGM and since that time, when I get married and during each pregnancy, I normally undergo prolonged labour for one week until I feel my legs are paralysed and when it reaches time of delivery, I am cut inside my private part thoroughly and feel a lot of pain that I even curse myself.
(Female FGD participant over 35 years old, Kara Pokot, Uganda)

4.3.1.3 Sexual functioning complications (sexuality)

Removal of sexual tissues and/or the clitoris can lead to scar formation and traumatic memories associated with the cut. FGM can lead to sexual dysfunction, reduced sexual satisfaction and lack of sexual desire due to the pain associated with penetration:

A lot, you know this is something that we have done in some years, and we have really done investigations on the ground and I think you understand keloids, they develop in the private parts of the cut women or girls and that makes her unable to do sex. There are also those ones who have been affected by the scar, and when they give birth there is a lot of pain which has been developed because of that, so having sex is a problem, it is something that we know, we know people suffering of that problem, yes. (KII, activist, Maasai, Kenya)

They have serious challenges and they don't enjoy sex the way it's supposed to be and as a result the men go out again to the new women who are not circumcised. (KII, NGO actor, Sabiny, Uganda).

Because their husbands do not feel happy with them, they do not enjoy sex with them because the sensitive part of their organ that is the clitoris has been cut and therefore, they do not enjoy sex, are you seeing that? So, there has been [an] escalated divorce rate, separation rate and violence as a result of FGM issues. (KII, CBO, Kuria, Kenya)

Pokots cut the clitoris, remove the walls of the vagina and the girl is told to close her legs to heal, leaving a small opening for urination. When the girl is married, the husband struggles hard to get in, and when she is giving birth, the sides of vagina [are] cut to expand, but care is taken so that the vagina doesn't join the anus.
(Male FGD participant over 35 years old, West Pokot, Kenya)

Later on, the girl gets married. She cannot have sex due to the pain associated with it. If the man is able to break her virginity, then the girls even run away breaking the homes because of the pain he caused them. FGM has broken many families, I know. Finally, when it is time for the girl to be a mother and give birth, her entire vagina cuts off and joins the anus, making the whole process of giving birth a problem, and the man leaves her because she is not attractive any more and her expenses are excess[ive] now due to the numerous medical bills involved. It's very bad. (KII, gender and child officer, Bula Hawa, Somalia)

4.3.2 Psychological and emotional well-being

Lifelong trauma, depression and stigma are some of the psychological and emotional distress that circumcised girls face. In addition, the fear of intercourse due to reduced sexual desire and the pain associated with sex makes the act unpleasant for most circumcised girls, and this can lead to divorce. Circumcised girls are also likely to have low self-esteem due to discrimination, and consequently some girls end up living with bitterness and regret throughout their lives.

Respondents were asked to give their opinions on four effects of FGM: whether it causes depression, increases anxiety, causes post-traumatic stress disorder and reduces self-esteem. A composite score was computed by adding all the responses to these statements for each individual respondent. The score ranged from 4 (disagree with all four statements) to 16 (agree with all statements). Figure 4 shows the results for respondents' opinions on the psychological effects of FGM disaggregated by sex. Overall, on whether FGM causes depression, responses across the scale were uniformly distributed, with 38 per cent of the respondents disagreeing or strongly disagreeing, 32 per cent agreeing or strongly agreeing and 18 per cent indifferent. FGM increases anxiety and post-traumatic disorder according to 44 per cent of the respondents. In the opinion of 42 per cent of the respondents, FGM reduces self-esteem. There were no significant differences by sex in either the overall proportion or the composite score for all the statements used to measure opinions on whether FGM causes any psychological problems. The overall mean score was 12 (± 1), which represented about 60 per cent of respondents likely to agree that FGM causes psychological problems.

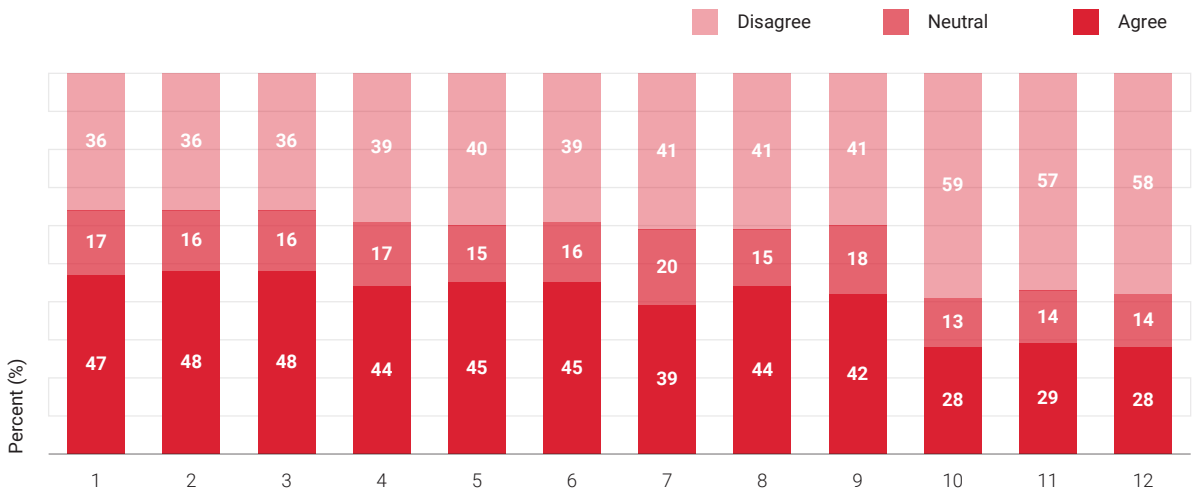

Figure 4: Respondents' opinions on whether FGM causes any psychological problems, disaggregated by sex.

Disaggregated by side of the border, significant differences in the mean score for opinions on whether FGM caused psychological problems were observed across all borders except the Kenya–Somalia border and the Kenya–Ethiopia border involving the Turkana from Kenya and the Amhara from Ethiopia. On the Kenya–Uganda border, the Sabiny on the Ugandan side had about 60 per cent likely to agree compared with the Sabaot in Mt Elgon on the Kenyan side, who had about 45 per cent likely to agree. Similarly, among the Pokot in West Pokot (Kenyan side), 55 per cent of the respondents were likely to agree, compared with 60 per cent likely to agree among the Pokot in Amudat (Ugandan side).

Other scores disaggregated by sex on each side of the Kenya–Somalia border had females at 65 per cent likely to agree compared with males at 60 per cent. Similar percentages were observed in the Somalis in Bula Hawa (Somalia). Significant differences by sex within each border were also observed among the Kuria in the Isebania–Tarime region along the Kenya–Tanzania border, with 70 per cent of male respondents likely to agree compared with 50 per cent of female respondents.

The overall picture is that respondents agreed that FGM causes psychological trauma and has long-term effects on individuals' relationships. The qualitative information reinforced the quantitative findings, and several respondents' voices captured the essence of the psychological effects of FGM in communities, including the following:

There are psychological effects where the girl develops permanent shock [such] that she will have the remembrance of what she has undergone forever, and that can be traumatizing. There is also the emotional effect that has developed in the girl: the girl will develop a lot of fear because of what has happened, she cannot even talk in bigger forums because there is that emotion, she will develop self-denial because you know what you have undergone, you don't have the courage to say that [I] am a survivor, you will tend to say that [you are] not cut and yet you are cut and that those are the effects.
(KII, activist, Maasai, Kenya)

Girls who have undergone FGM mostly live a life of bitterness because, for example, you were circumcised and you developed [a] fistula, your husband ran away, you cannot go to the farm, you live a traumatized life and in that state your level of education is low; it's a big challenge, life becomes hard, you can't access anything including information and you are undermined and you also don't know what to do when you are violated. (KII, CBO, Sabaot, Kenya).

Then the psychological effects are trauma; I can remember when I was growing up, when the girl undergoes FGM, after she has had the first cut you would find people saying that she is brave, but right now there are those who get nightmares because of FGM, they cannot go back to the same stat;, at times you talk to them and you notice that they are not there. (KII, anti-FGM activist, West Pokot, Kenya)

A girl who has undergone FGM has her dignity and self-esteem lowered because, during that time of the clitoris being cut, it is done in front of many people who undress her to see her nakedness and later despise her based on her courage; for that reason, her dignity is heavily compromised. (KII, chief, Kuria, Kenya)

No because it affects the lady; the lack of sexual desires leads to relationship break-ups, divorce and mental torture where the girls wonder what is wrong with them and why they cannot keep men.
(KII, activist Moyale, Ethiopia).

In general, the practice of FGM poses great risks to the mental health of the women who are survivors, and it will be crucial for communities to develop ways of understanding their plight. Too many women are suffering emotional violence in silence.

4.3.3 Socioeconomic impacts of practising female genital mutilation

Generally, FGM has several socioeconomic consequences for the individual woman or girl as well as on the overall community. Respondents noted that FGM affects girls' education, promotes early marriages or early adulthood, retards women's economic empowerment, and increases medical expenses and costs for the family. It also puts a considerable burden on the health systems and economies of countries and leads to the continued subordination of women, as their potential livelihood is cut short and they must depend on their husbands for survival. Overall, over one third of the respondents (39.2 per cent) said that, following FGM, girls would not continue with their education, and 76.2 per cent said that the cut girls would most probably get married. According to 42 per cent of the respondents, a girl who has undergone FGM will be forced to get married, and about one third (30 per cent) thought that, in their community, uncut girls were not considered marriageable. Forty-two per cent of respondents said that uncut girls do not have a good image, while 41 per cent thought that circumcision retards a girls' economic empowerment and development. Over half of the respondents (59 per cent) thought that the best a girl can do is to get married, while, according to 55 per cent, FGM increases medical costs for the family and the husband as a result of frequent infections and the need for Caesarean sections due to obstructed labour as a result of FGM (see Table 7).

Table 7: Respondents' opinions on whether FGM has socioeconomic effects, disaggregated by sex, n (%)

Items	Male (n = 704)	Female (n = 779)	Total (n = 1,485)	p-value
After FGM, girls would continue their education				
Yes	351 (56.4)	416 (59.9)	767 (58.2)	0.373
No	256 (41.2)	260 (37.4)	516 (39.2)	
Don't know	15 (2.4)	19 (2.7)	34 (2.6)	
After FGM, cut girls remain unmarried				
Yes	128 (20.1)	153 (21.7)	281 (20.9)	0.709
No	492 (77.2)	531 (75.3)	1023 (76.2)	
Don't know	17 (2.7)	21 (3.0)	38 (2.8)	
FGM forces girls to get married				

Items	Male (n = 704)	Female (n = 779)	Total (n = 1,485)	p-value
Yes	280 (44.2)	283 (40.2)	563 (42.1)	0.329
No	338 (53.4)	403 (57.2)	741 (55.4)	
Don't know	15 (2.4)	18 (2.6)	33 (2.5)	
In my community, uncut girls are not wanted for marriage				
Yes	159 (25.2)	243 (34.2)	402 (30.0)	0.001
No	460 (73.0)	459 (64.6)	919 (68.6)	
Don't know	11 (1.7)	8 (1.1)	19 (1.4)	
In my community, uncut girls do not have a good image				
Yes	222 (35.0)	344 (48.2)	566 (42.0)	0.000
No	403 (63.5)	359 (50.4)	762 (56.5)	
Don't know	10 (1.6)	10 (1.4)	20 (1.5)	
Circumcision retards a girl's economic empowerment/development				
Yes	265 (42.1)	286 (40.6)	551 (41.3)	0.460
No	345 (54.8)	403 (57.2)	748 (56.1)	
Don't know	19 (3.0)	15 (2.1)	34 (2.6)	
Once circumcised, the best a girl can do is to get married				
Yes	373 (59.0)	416 (59.2)	789 (59.1)	0.791
No	247 (39.1)	277 (39.4)	524 (39.3)	
Don't know	12 (1.9)	10 (1.4)	22 (1.6)	
FGM increases medical costs for the family and the husband as a result of frequent infections and Caesarean sections due to obstructed labour resulting from FGM				
Yes	354 (56.0)	386 (55.3)	740 (55.6)	0.755
No	264 (41.8)	300 (43.0)	564 (42.4)	
Don't know	14 (2.2)	12 (1.7)	26 (2.0)	

As shown above, significant differences by sex were observed in the proportions of those who thought that uncut girls are not wanted for marriage in the community (25 per cent male, 34 per cent female) and those who thought that uncut girls do not have a good image (35 per cent male, 48 per cent female). This is supports the concept of learned helplessness, in which the urge to adhere to long-held traditions has prevented individuals from exercising their human rights and perpetuated the belief that FGM is the key to a better future.

In terms of the cross-border differences, significant differences were observed along the Kenya–Uganda border on respondents' opinions on whether girls would continue their education after FGM, with 82 per cent of the Sabaot in Mt Elgon, Kenya, and 34 per cent of the Sabiny in Uganda noting that FGM does not interfere with schooling. In the Kenya–Somalia border areas, a high proportion in both Mandera, Kenya (96 per cent), and Bula Hawa, Somalia (97 per cent), also thought that girls would continue with their education after FGM. Eighty per cent of respondents from the Sabaot in Mt Elgon and 94 per cent from the Sabiny did not think that girls remain unmarried after FGM. Actually, over three quarters (79 per cent) of respondents from the Sabiny thought that FGM forces girls to get married, with 29 per cent from the Sabaot in Mt Elgon having a similar opinion. A high proportion (74 per cent and 64 per cent, respectively) of respondents from the Pokot in West Pokot (Kenya) and Amudat (Uganda) also thought that FGM forces girls to get married. This opinion was also held by 21 per cent of the Turkana respondents and 11 per cent of the Dasenach in Ethiopia, as well as 65 per cent and 56 per cent of the Maasai (in Transmara) and Kuria (in Isebania–Tarime), respectively, on the Kenya side of the Kenya–Tanzania border. Information provided by the key informants suggests otherwise in terms of the number of girls who continue their schooling after being cut. The majority are said to drop out, and the evidence available from the schools paints a grim picture.

4.3.3.1 Negative implication of female genital mutilation for girls' education

FGM is associated with considerable negative impact on girls' education. Poor performance and low retention rates among girls in school are largely associated with psychological trauma, frequent absenteeism related to the cut-healing process and other health effects, and early marriage. Inasmuch as the findings show that there are a number of interventions put in place at the school level to decrease dropout rates, the study participants argued that the influence of key players (parents) and religious and cultural practices remains a strong factor in hindering the abandonment of FGM and thus little change is being seen.

4.3.3.2 Dropout rates among girls

Across all sites, there is a high dropout rate among girls in upper-level classes compared with boys. The drastic change in retention rates is highly associated with the practice of FGM; most school administrators stated that girls in classes 5–6 (about 12–15 years old) are likely to drop out of school as a result of FGM. A high proportion of girls going through puberty are also said to drop out due to painful menses:

When they reach class 5, their numbers dramatically decrease. In some places in first cycle (1–4) [the] number of female students [is] even greater than male students, but this changes after class 5. For example, where I taught in 2006, all female students didn't attend grade 5. In grade 4, out of 154 students 86 were females. This means that all the 86 girls either dropped out, got married or transferred to other schools, which was most unlikely. (KII, school supervisor, Dasenach (Omorate), Ethiopia)

Last year we had 10 girls and 13 boys … I think they all went; you know, the cutting happens when the girls are in class 5 and class 6, class 7 a little bit. After those classes there is relief that they have escaped the act. (KII, Government rescue centre, West Pokot, Kenya)

From class 4 the number of girls starts going down; by the time they are in class 8, the number of boys is higher than the number of girls. When girls are circumcised, they rarely return to school, they are married off, they end up living a miserable life and end up being economically poor. (KII, headteacher, West Pokot, Kenya)

A very small number transition, like you can have out of those 25 being enrolled in first grade not all of them go to high school, like 4 to 5 out of the 25. (KII, headteacher, Maasai, Kenya)

The girl child has got a lot of challenges, like if you have 80 girls you can lose like 10 of them; not all of them will progress because of a lot of challenges, like some of them get married at an age of 18 or less. (KII, school administrator, Sabiny, Uganda)

Many girls drop out of school to help the parents; some get married before they finish school because of FGM-related effects. Girls go through FGM at an early age of 6–8 years. They are still [too] young to feel the effects directly at the time. It's when they reach adolescence and puberty that the problem starts. They go through painful periods and eventually after missing out so much in school, they quit and head on to other matters of their life. (KII, school administrator, Bula Hawa, Somalia)

The girls who have undergone FGM are not okay mostly mentally and they have a poor self-esteem to begin with. In class they are not as active, and their performance is very poor. This is because the girls spend about a week at home because of the pains during their periods and that takes them back a lot. (KII, gender and child officer, Bula Hawa, Somalia)

Apart from the high dropout rates, FGM is also correlated with poor performance among those girls who remain in school. The findings show that FGM makes it difficult for girls to concentrate in class, which results in poor grades and high dropout rates due to girls losing interest in school.

In most communities, circumcision is seen as a rite of passage that marks transition from childhood to adulthood. Cut girls are considered mature, and school heads reported that, after being circumcised, girls no longer respected teachers and would become strong willed as a result of the perception that they are adults and no one can rightfully ask them to do anything:

> *… a few who will manage to come back to school after circumcision, their performance will be very poor, because they no longer respect teachers and treat their teachers as their agemates.*
> (KII, headteacher, West Pokot, Kenya)

> *Because girls who are circumcised think about marriage and forget about school, their school performance goes down. Before she is circumcised, she is told adult issues. She is told you are no longer a child and you have become a grown-up. She is seen as mature and education deteriorates. Even if you tell them things to do with school, she tells you I am also big enough for marriage and she will not study.*
> (KII nurse, Bungoma, Kenya)

Furthermore, circumcision spells the end of education and its replacement with marriage. Most circumcised girls, because of their circumstances, view school as a waste of time and are fully geared towards marriage. This situation results in the value accorded to girls in most of the communities studied: girls are seen as an extension of the herd. They are destined for marriage and seen as a source of additional livestock. In some instances, they are married off directly after the ceremony with little or no option to go back to school. It is not uncommon to hear statements such as “educated girls are difficult to tame” or “they are unmarriageable”. The conservative elders who remain very important in decision-making in these communities present a challenge to women’s and girls’ progress:

> *Moreover, according to the attitude of the society, once a girl is circumcised, they think that she is ready for marriage. So, she is forced to drop out of her education. She is forced to marry, so she cannot complete her education. Statistics show that female students still have not graduated [at] degree level. There are males who graduated [at] master’s levels but there is no female in this community who graduated with a degree.* (KII, health worker, Dasenach (Omorate), Ethiopia)

Yes, a lot; FGM affects girls education in my community; the reason, because you understand Maasai culture, there is the age group, when the girl is circumcised, she believes that she is a woman and she will approach different people not as a child but as an adult, including the teachers, so that child has a mindset that she is now an adult by doing so you don't expect her to concentrate in class, so obviously academic side is affected. (KII, activist, Maasai, Kenya)

So, when a girl is circumcised, she knows that she has become a woman. So, in her state she thinks, or she feels, there is no point in continuing with her education because she feels that she has become a woman and she could get married and go to her homestead at any time. So, we have lost many girls because they drop out of school immediately after FGM is performed. She feels if she goes to school people will think of her as a child and yet she has become a woman because she has been circumcised.
(KII, assistant chief, Kanyerus, West Pokot, Kenya)

4.3.3.3 Increased absenteeism

Circumcised girls tend to experience prolonged and consistently painful menses, which makes them lose interest in and miss school more often. In some communities, for instance in Ethiopia, it is noted that the circumcision ceremony (Demi) seems to last for a long period, which can eat into their school-attending period:

During the ceremony of FGM they spend more than two months out of school. So, this absenteeism has a great negative impact in their education. (KII, health worker, Dasenach (Omorate), Ethiopia)

The many teachings or cultural indoctrination in many communities during the seclusion period also adds additional responsibilities to the girls, hence distracting their attention from schooling. In fact, the practice robs the girls of their childhood and ushers them to unknown territory that is simply beyond their mental capacity.
(KII, anti-FGM activist, West Pokot, Kenya)

Despite the above, some respondents felt that FGM does not hinder a girl from continuing with her education, as a girl can be circumcised over the school holidays and still go on with her studies when the schools reopen. This opinion was expressed by older men and circumcisers, and it could be a defence mechanism to justify the practice:

> *No, not really. You see being cut does not prevent them from going to school. So school is not a hindrance to FGM: a girl just goes to school, [and] when she reaches the age of being cut, she goes through that and goes back to school.* (Male FGD participant over 35 years old, Maasai, Kenya)

> *About 5,000 girls whom I circumcised almost all of them went to school and gave birth successfully. FGM does not hinder [a] girl child from studying; as long as she is fed properly and well taken care of, eventually she would study well.* (KII, circumciser Bungoma, Kenya)

> *No, it does not, this entirely depends on the child; we have a lot who are well educated, and they were circumcised. They have jobs. This is a child's decision. You can find an uncircumcised girl who is a dropout and a circumcised one who is still in school and will eventually be employed.* (KII, circumciser, Kuria, Kenya)

The observations made by these key actors may be true, but they are not the norm. The nature of communal practices that see the girl as a potential wife and not as a potential professional in the formal economy has a lot to do with the mindset that pushes circumcised girls into marriage and motherhood at tender ages.

4.3.4 Socioeconomic effects of female genital mutilation

FGM has also been shown to have a negative effect on the economic development and empowerment of women and the entire community. Given that circumcised girls are married off at a young age, they end up dropping out of school, getting married and becoming housewives without the skills or knowledge to engage in the formal economy as trained professionals. They are mainly concentrated in the informal economy, where the skill set needed is limited and the returns are used for basic household survival.

Because of a lack of education, which directly hampers her chances of earning a decent living from the formal economy, a girl ends up depending on her husband for everything, unless she is entrepreneurial and has the option of engaging productively in the informal economy. Because of pain and associated complications, a circumcised woman is less productive economically than an uncircumcised woman. The other challenge already observed is the value placed on women in these communities. Given their remoteness and being distant from urban centres, it is difficult for women to get involved in small-scale trading. The cattle economy is unfortunately male driven, and women may have access rights only to small ruminants:

> *When girls are married at [a] tender age, this means they drop out of the school, this means that there are not girls who are employed in formal economy, and unemployment will greatly affect the economic status*

of the community. These married young girls completely depend on their husbands for financial support and provision of basic needs like clothing, food, shelter, medication and education for their children, their living standard is very low, and they live in very miserable conditions. The husbands may not be able to provide for the family because of the polygamous nature of the community; because of these, women are forced to cut trees and sell charcoal and firewood so that they can get money to fend for their children. (KII, headteacher, West Pokot, Kenya)

Now she will be under him, and there is no work that she is going to do; you just have to look after this old man's sheep or cows. And there is no business that he will let you do, and even the day that you will receive your national identity card, you have no right to carry it. This identity card, you will have to give it to that man to carry it. So, at the time you will need anything, be it food, be it clothing, it is him. Even if he denies you, you have no option but to just be there. That is why you see they really have a problem. (KII, hospital, in charge, Maasai, Kenya)

… resulting from the lack of education, women suffer from generational poverty, from one generation to another. It will not stop, as long as we link FGM to early marriages and lack of formal training.
(KII, medical practitioner, Maasai, Kenya)

Most girls only reached class 4, so what chances of getting employed do such people have? Opportunities are very limited for young girls who are disempowered and are not even able to be in a position to make decisions in the society. (KII, immigration officer, Kuria, Kenya)

Generally, most circumcising communities are patriarchal and place a lot of emphasis on marriage and domestic chores as the best work for women; the whole notion of female empowerment and giving women an opportunity to work outside the homestead is limited.

4.3.4.1 Economic burden of medical expenses

The findings also show that Somali women who have been infibulated must be de-infibulated during childbirth and re-infibulated after delivery or else they will be divorced or abandoned by their husbands. Failure to carry out the above procedures lead to tears that ultimately culminate in either vesicovaginal fistulas or rectovaginal fistulas. Generally, circumcised girls and women end up spending a lot of money on medical treatment if the practice goes wrong, while they also have to spend more during childbirth, as the majority will end up delivering through Caesarean section. The practice leads to generational poverty, since the circumcised woman is very likely to

circumcise her daughters at a young age, and so the cycle continues. In addition, the country incurs a lot of costs in ensuring that such women are taken care of and are given the necessary medical attention when they suffer from fistulas, keloids, cysts, obstructed labour and other related complications occasioned by FGM. Above all, women reported that their husbands opt to marry women from the coastal region, since, although they are Muslims, the coastal communities in Kenya do not circumcise their girls as the Somali community does. Eastleigh in Nairobi has become a hub of what one described as medical tourism, since women are brought from as far away as Somalia to deliver their babies under the care of medical personnel who can de-infibulate and re-infibulate to ensure the husbands' continued enjoyment:

> *Women cannot move ahead because of the pain they experience their whole life. Their money goes to [pay] medical expenses as opposed to developing themselves. That alone makes them less empowered. As I have said also, those many FGM-related deaths also cut the lives of otherwise prominent and helpful women who would have made a big impact in the world.* (KII, NGO liaison officer, Bula Hawa, Somalia)

> *The challenge is that when a child is going to deliver the path is so tight and this leads to Caesarean section and spending a lot of money.*
> (KII, elder and NGO monitor, Pokot, Uganda)

> *There are referrals during delivery resulting from FGM that makes poor people suffer a lot. The process of de-infibulation and possible re-infibulation after delivery are costly and traumatizing.*
> (KII, school leader, Moyale, Ethiopia)

> *When a woman who has been infibulated is expecting, she is taken to Eastleigh in Nairobi where doctors in those clinics de-infibulate you to ease the delivery process. The unfortunate thing is that he must re-infibulate you or else you have no husband. Men claim that they cannot imagine sleeping with a "wide woman" who has no taste. If you do not want to lose your husband, then you must abide.*
> (KII, anti-FGM crusaders, Mandera, Kenya)

Furthermore, the costs arising from FGM, although not well elaborated, are thought to be very high. The family has to spend a lot of its resources feeding the community during the traditional ceremony, buying gifts for the girl and paying the traditional surgeon. The ceremony is only conducted during harvest when there is enough food. For instance, a Demi ceremony lasting for three to six months could have huge economic implications for the family of the girl undergoing the cut:

Due to the cutting, you spend a lot of resources like selling of the animals at home so as to take this child to the hospital for treatment as well as feeding the community who come to witness the practice. There are also the gifts to be given, which is burdensome to the parents and other relatives. (KII, local council, Pokot, Uganda)

I see at times a lot of resources are used during FGM, such as maize amounting to 15 bags can be used, and at the end of it all, there are debts. There are examples where a goat or sheep can be taken on credit so as to be paid back later and this becomes a problem. Besides slaughtering livestock, we also pay the surgeons for the practice they have done and in all those things if that money had been kept it would have helped in other things for example to educate the children and handle any problem in the family.
(Female FGD participant under 35 years old, Sabiny, Uganda)

Demi is done before the FGM. During Demi there is drink and meal. They stay there like in a wedding dancing, eating drinking. The ceremony can take from three to six months but varies from tribe to tribe. But it is a holiday for them. During their stay, there is feasting throughout the period … Do they have resources for this ceremony? The father of girls has to do this ceremony in order to get respect from the community.
(KII, women, child and youth affairs officer, Dasenach (Omorate), Ethiopia)

4.3.4.2 Violation of human rights

Study participants indicated that, since FGM is mostly done to minors who cannot give informed consent, this is a human rights violation; the act was forceful; they tied the victims with ropes just to have the cut done. This practice also goes against the constitutions of the countries and the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women and the Universal Declaration of Human Rights of 1947, among others:

In fact, it is a gross human rights violation because it is against this human being's right. They have not consented; you subject a child to be circumcised and what the law says when this child has been defiled is another thing. What is the difference between defilement and FGM? It is the same. When you say a man has defiled this child, meaning he has defiled her without her consent, what about this FGM? You have done the same. So, what is the difference? It is a human rights violation.
(KII, anti-FGM activist, Bungoma, Kenya)

Yes, it is a violation against human rights because, when practice is being done on a person, she doesn't have a choice and our constitution has a whole article which should be respected by all people in the country. (KII, prosecutor, Moyale, Kenya)

It's a violation of human rights because first getting misinformed is a violation of human rights; in fact, it is a very heinous crime. When you know you are telling someone something because of their ignorance and you are giving them information which will come to haunt them later. So, this FGM is becoming, or was, or still is a violation of human rights … I will give definition, in fact I will say it is both because you will find that someone has been informed but still undergoes the cut. Why? Because of the misinformation or the indoctrination that she has gone through, so still it will just go back to the human rights, why is somebody agreeing to get the cut, it is because of the misinformation … Something that is against the constitution and is a violation of that person's rights. If the law says this is a repugnant law or a repugnant practice and somebody still undergoes it or somebody forces someone to undergo it that goes back to human rights, what we call the rights to privacy, the rights to health, rights to decency and rights to personal autonomy; so all of [these] are denied to that person. (KII, lawyer, West Pokot, Kenya)

I think that is already a violation, and not even just that. They are causing bodily harm, you see, it's complete violation of the dignity of the girl and giving you scars that you will live with forever. To me if that is not violation, I think it should be, but it's a complete violation of your medical right, your human right. I think everything is taken [away] by these people when they do the FGM to this little girl.
(KII, medical practitioner, Maasai, Kenya)

It's a violation. It's a violation because most of the ladies are forced, some end up bleeding, leading to death, and others are tortured mentally because you get, they are forced, they are not willing to do it, so it's just violence. (KII, health officer, Kuria, Kenya).

Furthermore, during the process of FGM, victims can be exposed as other members of the community watch and cheer during the process, thus infringing the victims' right to privacy and bodily integrity:

> *Girls are circumcised at the cowshed. During the cutting process, the people of the community stand aside watching the cutting process. Women whistle and shout as a sign of happiness for the success of the whole process.* (Female FGD participant under 35 years old, West Pokot, Kenya)

However, a few informants felt that it's not a human rights violation, since the children agreed to this act. This agreement seems to be part of the learned helplessness that women are mostly subjected to in patriarchal societies in the name of cultural preservation:

> *Female genital mutilation does not pin down a person's rights. I hear that you people exaggerate information on female genital mutilation as if what we did was a mistake. Circumcision only proved that a girl was old enough to be married and the willingness to be circumcised is a product of their conscience.* (KII, reformed circumciser, West Pokot, Kenya)

Previous studies have reported a myriad of physical health complications arising from FGM. Some of these include infections, urine retention, difficult births, excessive bleeding and at times death (Government of Kenya, UNFPA and UNICEF, 2008; Morison *et al*., 2001; UNICEF, 2005; WHO, 2016).

Other complications are psychological, such as anxiety, depression, memory loss, post-traumatic stress, intense fear, feelings of helplessness and horror, the complications of severe pain and sexual complications (Anderson, Rymer, Joyce, Momoh *et al*., 2012; Behrendt and Moritz, 2005). Other psychological effects include being uncommunicative, withdrawn, emotionally distant, flashbacks, sleep disorders, social isolation, somatization and distrustfulness (Burage, 2015). WHO (2008) reported that immediate psychological trauma may stem from the pain and shock and the use of physical force by those performing FGM. Furthermore, Rodgers (2015) notes that some women suffer from cognitive dissonance because of conflicting beliefs and actions. This is relevant to the study's findings, as some women who are circumcised are forced to undergo the practice against their wishes and despite their knowledge of the effects of the practice.

Reisela and Creighton (2015) observe that there is increasing evidence that FGM impairs sexual function as a result of the damage to a sexually sensitive organ such as the clitoris. Furthermore, Berg and Denision (2012) note that women who have undergone FGM experience painful intercourse, reduced sexual satisfaction and reduced sexual desire. Women may also experience more difficulty reaching orgasm and shame or embarrassment about intimacy (Burage, 2015). The British Medical Association (2011) observed that the narrowing of the vaginal opening may make intercourse painful for both partners and that women who have undergone FGM experience dyspareunia. Just as noted in this study, lack of sexual pleasure for both parties can lead to husbands having extramarital affairs with women who have not undergone the cut (FORWARD, 2002; Whitehorn, Ayonrinde and Maingay, 2002).

The WHO (2006) study in six African countries found that women who have undergone FGM have a strong likelihood of having a Caesarean delivery and increased risk of giving birth to a baby who requires intensive care and that their children have a higher mortality rate both before and after birth. Similar findings were reported by Jaldesa, Askew, Njue *et al*. (2005) who noted the life-threatening episodes emanating from FGM.

On the socioeconomic front, previous research has documented the negative effects of FGM. The practice leads to early marriage and parents' adopting a negative attitude to girls' education. Girls also change their attitude following FGM and lose interest in schooling, which leads to poor educational achievement in many ways. Girls who undergo FGM are often married off young, hence limiting their education and future prospects. This entrenches poverty in communities and seriously holds back countries' economic development. The effects on school attendance and work opportunities radically undermines the ability of women and girls to fulfil their potential.

It has been noted that, because a significant number of women experience FGM health-related issues through adulthood, labour and overall economic productivity fall short in societies that subscribe to the procedure. While women are spending time dealing with such issues, the economy is missing their contribution to the production process either through the marketplace or through home production.

FGM violates a series of well-established human rights principles, norms and standards, including the principles of equality and non-discrimination on the basis of sex, the right to life, the right to freedom from torture and cruel inhuman or degrading treatment or punishment and the rights of the child (Reza, Mercy and Krug, 2001; WHO, 2008). The practice has also been shown to violate the fundamental human rights of women and girls by depriving them of their physical and mental integrity, of their rights to a life free from violence and discrimination, and, in the worst case, of life itself (WHO, 2006). Oloo, Wanjiru, Newell-Jones and Minds (2011) observe that FGM as a rite of passage to womanhood can enhance the gender power imbalance, as women are taught to be subservient to men. The practice is seen as a major indicator of gender inequality and is linked to child marriage, forced sexual debut and health complications across women's life courses (Williams-Breault, 2018). Although research has not given much attention to documenting the economic impacts of FGM, apart from the economic gains made by the circumcisers and the councils of elders, which are indirect beneficiaries of the practice, this study documents the long-lasting adverse economic consequences that FGM places on the shoulders of women and girls. Deprived of education and forced into early marriage, women are perpetually constrained to the lowest wealth quantile in communities. Their power to negotiate for better life prospects is seriously curtailed and the cycle becomes ever downwards.

4.4 Prevention and response-related services on female genital mutilation along Kenya's border with Ethiopia, Somalia, Tanzania and Uganda

KEY FINDINGS

- In the cross-border areas, CBOs and INGOs, such as UNFPA, UNICEF, NCA, SEDHURO, Action Aid, World Vision, Habiba International, Save the Children, ADRA, and the Population Council, and FBOs, such as Catholic and Pentecostal churches and mosques, are working to end the practice of FGM.
- Training of local practitioners such as health workers, raising awareness among the community and local government officials, and capacity-building efforts are the major preventive interventions.
- Supporting FGM survivors, providing shelters and rescue centres, supporting medical referrals and expenses, and providing psychological support for survivors are the major response-related interventions.
- More work is needed to enhance the capacities of religious leaders and local government organizations.
- More focused intervention is required in the communities to define the practice of FGM as a morally wrong and illegal criminal activity.

The study assessed community members' knowledge of any anti-FGM programmes in their area, the institutions providing preventive and response related programmes and the gaps in existing anti-FGM programmes. This section discusses the findings obtained from quantitative and qualitative data.

4.4.1 Knowledge of anti-female genital mutilation programmes

From the survey of members of communities along Kenya's borders with the other three countries, it was established that over half of the respondents (55 per cent) were aware of anti-FGM programmes being undertaken in their communities to try to end FGM. The results also differ across border sites, as lower proportions of community members from the Kenyan side of the border with Uganda (Sabaot 35 per cent vs Sabiny 63 per cent), Somalia (Mandera 29 per cent vs Bula Hawa 44 per cent) and Ethiopia (Turkana 8 per cent vs Dasenach 98 per cent) confirmed that they were aware of anti-FGM programmes being undertaken in their community to try to stop the practice. On the other hand, a high percentage of respondents among the Pokot on either side of Kenya's border with Uganda (West Pokot 68 per cent vs Amudat 73 per cent) said that they were aware of anti-FGM programmes.

Table 8 presents the results disaggregated by cross-border site.

Table 8: Respondents' awareness of anti-FGM programmes in the community, n (%)

Cross-border site	Yes	No
Sabaot in Mt Elgon (KE)	34 (35.1)	63 (64.9)
Sabiny (UG)	129 (62.9)	76 (37.1)
West Pokot (KE)	80 (68.4)	37 (31.6)
Pokot in Amudat (UG)	151 (72.9)	56 (27.1)
Somalis in Mandera (KE)	33 (29.2)	80 (70.8)
Somalis in Bula Hawa (SOM)	47 (43.9)	60 (56.1)
Turkana (KE)	8 (8.3)	88 (91.7)
Dasenach (ETH)	91 (97.8)	2 (2.2)
Borana in Moyale KE)	46 (39.0)	72 (61.0)
Oromia Moyale (ETH)	55 (50.5)	54 (49.5)
Maasai in Transmara (KE)	83 (83.8)	16 (16.2)
Kuria in Isebania–Tarime (KE)	47 (47.0)	53 (53.0)

4.4.2 Institutions and organizations involved in cross-border anti-female genital mutilation programmes

From the qualitative data, it was established that several interventions by different institutions and stakeholders to end FGM are in place across the study sites. Key among the stakeholders in anti-FGM programmes are the Governments through various law enforcement agencies, CBOs and NGOs, the political class, human rights activists and religious institutions or FBOs. These anti-FGM interventions are classified as either preventive or response related. Preventive interventions are those aimed at protecting girls and women from undergoing the practice, while response-related interventions are aimed at rehabilitating girls and/or promoting ending the practice in the future. The study participants mentioned a number of organizations that work on different preventive and response-related approaches in cross-border anti-FGM programmes as shown in Tables 9 and 10.

Table 9: Organizations and institutions involved in cross-border anti-FGM prevention intervention programmes

Cross-border site	Preventive anti-FGM intervention	Organization/institution
Kenya–Somalia (Mandera/ Bula Hawa)	Works with religious leaders and Government agencies to conduct awareness-raising and capacity-building campaigns against FGM	UNICEF, NCA, SEDHURO, Trocare
	Community mobilization and sensitization on the effects of FGM Provides sanitary pads and clothing for girls	Habiba International
Kenya–Somalia (Turkana/Dasenach)	Creates awareness to stop FGM and other harmful traditional practices Works with local communities at the village level to increase response to FGM/C cases; supports referral to health facilities and expenses related to health care for victims Provides psychosocial support for the victims	Save the Children/UNICEF
Kenya–Tanzania (Kuria/Tarime)	Rescues girls at risk of FGM, supports continuation of their education, and links them with other like-minded organizations across the border	ADRA, Population Council and Mutiniti cross-border anti-FGM programme
	Mobilizes girls through school clubs Provides sensitization on the effects of FGM	Kenyan Government through Anti-FGM Board
Kenya–Uganda (Mt Elgon/Sabiny)	Spearheads cross-border engagements on FGM	UNFPA
	Sensitization on the dangers of FGM	Komesi Women's Network, World Vision and Action Aid
	Provides refuge and shelter facilities for victims	Pentecostal churches

Cross-border site	Preventive anti-FGM intervention	Organization/institution
Kenya–Uganda (West Pokot/Amudat)	Organizes and facilitates anti-FGM cross-border sensitization meetings Provides rescue centres for girls at risk of FGM	Catholic church
	Sensitizes the community to the dangers of FGM	POZIDEP

ADRA, Adventist Development and Relief Agency; NCA, Norwegian Church Aid; POZIDEP, Pokot Zonal Integrated Development Programme; SEDHURO, Socio-Economic Development and and Human Rights Organization; UNFPA, United Nations Population Fund; UNICEF, United Nations Children's Fund.

Table 10: Organizations and institutions involved in cross-border anti-FGM response-related intervention programmes

Cross-border site	Response-related anti-FGM interventions	Organization/institution
Kenya–Somalia (Mandera/Bula Hawa)	Supports medical referrals and expenses for victims who have been taken to hospital due to complications related to FGM	UNICEF, NCA, SEDHURO, Trocare
	Community mobilization and sensitization on the effects of FGM Provides sanitary pads and clothing for girls	Habiba International
Kenya–Somalia (Turkana/Dasenach)	Provides school subsidies and scholastic materials; supports living expenses for victims; supports their reintegration into the community; and supports their access to health services Creates awareness to stop FGM and other harmful traditional practices Works with local communities at the village level to increase responses to FGM cases; supports referral to health facilities and expenses related to health care for victims Provides psychosocial support for the victims	Save the Children/UNICEF
	Provides psychosocial support to survivors; supports referral to health care; provides non-food items such as dignity kits; provides economic support for households	Government of Kenya/UNICEF
Kenya–Tanzania (Kuria/Tarime)	Rescues girls at risk of FGM, supports continuation of their education and links them with other like-minded organizations across the border	ADRA, Population Council and Mutiniti cross-border anti-FGM programme

Cross-border site	Response-related anti-FGM interventions	Organization/institu
Kenya–Uganda (Mt Elgon/Sabiny)	Spearheads cross-border engagements on FGM	UNFPA
	Reintegrates victims in the community, including schools and vocational skills training places	Komesi Women's Network, World Visio Action Aid
Kenya–Uganda (West Pokot/Amudat)	Provide rescue centres for FGM victims	Catholic church

ADRA, Adventist Development and Relief Agency; NCA, Norwegian Church Aid; POZIDEP, Pokot Zonal Integrated Development Programme; SEDHURO, Socio-Economic Development and and Human Rights Organization; UNFPA, United Nations Population Fund; UNICEF, United Nations Children's Fund.

The study established that various organizations and institutions were involved in anti-FGM intervention programmes across the different study sites with varied outcomes. As Tables 9 and 10 above show, key anti-FGM interventions include in-school and community-level sensitization on the dangers of FGM for girls and women, cross-border joint stakeholder meetings and other activities spearheaded by various NGOs and religious institutions, involving community leadership in spearheading behaviour change and communications about ending the practice of FGM, and setting up rescue centres for girls and women at risk of FGM in the communities where it is very prevalent. These initiatives empower girls to act when threatened with the risk of FGM. Increased collaboration with other anti-FGM stakeholders across the borders ensures concerted efforts towards eradicating FGM, as the excerpts below demonstrate:

> *Our work as a CBO for gender-based violence for example, we have networks in various places to preach the end of FGM that is a past practice and that it has no value today.* (KII, CBO, Bungoma, Kenya)

> *We visit the villages, majorly we talk to them about the importance of this FGM education to the child, and then we also go to deal with the chief whereby they help us to mobilize the community; also we go to the victims who endured the FGM and then they become witness[es] whereby we educate and mobilize through the community; also we educate the girl child on the effect of FGM [on] their bodies, [on] their health, on their schooling and how it affects [the] majority of them.*
> (KII CBO, Mandera, Somalia)

These interventions are usually provided through different pathways, as discussed below.

4.4.2.1 Interventions through educational institutions

Government organizations and NGOs are involved in anti-FGM programmes targeting young girls through learning institutions with different interventions and approaches. To prevent new cases of FGM among schoolgirls and young women, various NGOs and Government agencies support schools to set up anti-FGM clubs across different study sites. These clubs are then used to educate girls on the effects of FGM while mobilizing the teachers to play a role in empowering the girls to say no to FGM. Furthermore, from the study, girls and boys attending school have counselling in separate sessions. The counselling and life skills sessions are meant to advise students on the risks of undergoing FGM and of associated complications, the consequences of early marriage and the importance of education for both girls and boys. These clubs help provide information that is critical for changing attitudes and behaviours towards the abandonment of FGM and have been shown to be successful in reducing the number of cases of FGM in the community and hence reducing the rates of school dropouts:

> *A number of NGOs like Adventist Development Relief Agency (ADRA) in collaboration with NGOs like Population Council, my CBO that I founded – Mutiniti cross-border programme – the Government of Kenya and the GEM [Africa Gender & Media Initiative] board, we all had programmes in the community. Since its inception, the Anti-FGM Board has partnered with us and we've been having programmes, mobilizing girls, teaching girls against FGM, teaching girls on the effects of FGM, forming anti-FGM clubs in various schools to sensitize the girls and boys.*
> (KII, CBO, Kuria, Kenya)

> *I do rescue young girls who are at risk, who are subjected to FGM that is after every three years in Kuria. They normally run to me, to seek refuge in my home. I educate them, I source for resources for their education, educate them personally because [I] am trained on FGM/C issues … I do link them to other CBOs addressing the same, the same issue against FGM that is across the Kenya–Tanzania border; for instance there is an NGO in Tanzania called Anti FGM Association for the Termination of FGM at Masanga in Tanzania, where those cases that needs to be addressed in the other side; I do collaborate with the Tanzanian government, that is through the local administrator based within the Kenya–Tanzania borders in Kuria, … they seek refuge and take part in education till when schools are reopened and [girls] are taken back to school.* (KII, CBO, Kuria, Kenya).

We have clubs that help in passing information to girls [on] issues related to FGM and early marriages and at times we receive visitors like health workers, NGOs asking children about those related issues, and our children are well informed, they know the impacts, the causes among others and I don't think at this level our children can think of FGM since they know the implications. It's there but the government should put FGM in the curriculum not just [be] pushing [it] in clubs.
(KII, FGM monitor, Pokot, Uganda)

Yes, in this school we have Boys and Girls Forum. It is only in this school that we have had such a forum in these rural schools. We choose a female patron for the girls and a male patron for the boys. We have our own calendar where on a weekly basis, girls come for the forum and are taught the effects of FGM while the boys on the other side are also taught the effects of FGM. FGM is one of the major topics that are taught in the forum. Other topics that are taught are life skills.
(KII, headteacher, West Pokot, Kenya)

For example, this issue is addressed under anti-HIV club, club of women affair, club of natural science. About impact of FGM, transmission of HIV ... (KII, school leader, Moyale, Kenya)

In terms of responding to the needs of girls in school, some NGOs support trauma and psychosocial counselling for girls who have either undergone the practice or who nearly underwent the practice to help them deal with the possible negative consequences of such traumatizing experiences. This is done in the context of anti-FGM clubs in schools or one-to-one sessions with girls who are being rehabilitated in rescue centres but being supported to continue with their education. The support also includes economic support. The schools also provide a platform where the girls who have undergone FGM can be referred to health care services, especially where complications are reported:

The bureau supports the students especially psychologically in appreciating and helping them economically in collaboration with Save the Children NGO. We buy them necessary material for their living and education, and we convince their families to live together with them. The other is when girls who are circumcised come to work corporately with different health stations so that they can get treatment. There are volunteers who work on FGM and help victims of FGM.
(KII, women and child rights and security officer, Dasenach (Omorate), Ethiopia)

You know education goes hand in hand with counselling; in the school we do counselling sessions like twice in the term and we also have individual counselling; at times these girls may be tempted to go for FGM to feel different like to be women and no longer girls and so these counselling sessions help them. (KII, school head, Sabiny, Uganda)

4.4.2.2 Interventions through religious institutions

Religious practices and beliefs play a big role in continuing the practice of FGM. In terms of anti-FGM cross-border prevention interventions, the study established that NGOs play a critical role in demystifying myths, misconceptions and beliefs around FGM by creating awareness and by building the capacity of religious leaders to be able to convey key messages on the consequences of FGM as well as the correct religious teachings around the practice. The focus of these interventions is to promote behaviour and attitude change that will go a long way towards abandoning the practice. Furthermore, religious leaders catalyse the ending of FGM through religious institutions by providing refuge to those at risk of FGM. This they do by setting up and supporting rescue centres for the girls and women at risk while time supporting their integration into the community:

Yes, we work with NCA [Norwegian Church Aid] and SEDHURO [Socio-Economic and Development and Human Rights Organization] and I am their liaison [with] the government and the community. We do awareness creation and capacity-building campaigns and we work with religious leaders, the government and the community at large in stopping the practice. (KII, NGO liaison officer, Bula Hawa, Somalia)

My responsibility is teaching the harm of the FGM. My responsibility is trying to change the attitude of the comsmunity while I teach the Qur'an.
(KII, religious leader, Dasenach (Omorate), Ethiopia)

The other thing that is bringing great change is the church. The church is educating the community concerning this issue. The church is highlighting the effects and negative issues of FGM.
(Male FGD participant under 35 years old, Maasai, Kenya)

In terms of responding to the needs of those that have already undergone FGM, religious institutions across the four borders work with other development partners to provide refuge and shelter facilities for the victims as well as spearheading cross-border engagements on FGM that enable the smooth return and reintegration of the girls and women who have been rescued post FGM.

I also want to credit another group of religious leaders: the churches have really played a big role; the Pentecostal churches were the first

people to bring refuge to the girls who were victims.
(KII, DCAO, Sabiny, Uganda)

… we have some churches like the Catholic churches who always take part in that. We always have FGM cross-border meeting, [where] we sit down with religious leaders and they help. In fact, most of the rescue centres are being sponsored by some churches so they are always taking part. (KII, officer commanding station, West Pokot, Kenya)

4.4.2.3 Interventions through health services

A common approach used in anti-FGM programmes is to train health workers, such as doctors, nurses and midwives, on the harms and illegality of the practice so that they can help in health education about the long-term health consequences of the practice. They are also trained to be able to provide medical support, especially when women experience complications post FGM. The study established that there are several NGOs that have adopted this approach across all the study sites. In terms of prevention interventions in health-care settings, health-care workers are supported to conduct outreach meetings at which they sensitize the community members, girls and women on the health complications associated with the practice. They also support the anti-FGM campaigns by sensitizing clients visiting health facilities on the harmful effects of FGM by integrating anti-FGM messages with information on antenatal care (ANC) at the mother and child health clinics:

Yes, there are two organizations that deal with FGM and general GBV [gender-based violence] issues. They conduct trainings and create awareness on the effects of FGM. They also help with the medical referrals and expenses for victims who have been taken to hospital because of over-bleeding and other FGM-related complications. They are SEDHURO, Trocare and NCA. (KII, school administrator, Bula Hawa, Somalia)

Yes, there are a lot of NGOs who train on FGM such as UNICEF and CARE. They use projectors to display their information. They give examples of children harmed by fistula and infections due to FGM.
(KII, school leader, Moyale, Kenya)

One is ECO Social Support; there are other support depending on the survivor's condition. If the survivor is physically abused, we refer them to health facility, we also have a wellness centre within Lodwar referral hospital that deals with cases of GBV. FGM is part of GBV so this is where these cases are handled. We also have non-food items such as dignity kits. With support from UNICEF, we have given some of these survivors' household economic support.
(KII, children's officer, Turkana, Kenya)

NGOs across the study sites facilitated referral of FGM survivors by taking care of the related medical expenses. Health facilities also act as a link between the victim and the law enforcement agencies. After examining the survivors, the health providers report the cases to the chief who follows them up to ensure that the perpetrators are convicted. Part of the health interventions that these NGOs provide is trauma and psychosocial support or counselling to help those that have gone through that experience deal with it more easily. In addition, health-care providers also treat girls who come because of excess bleeding and repair fistulas in circumcised mothers who experience tears during delivery. Severe cases of excess bleeding and fistulas are usually referred to higher level health facilities:

> *Yes, we do awareness [with] them like when they come for child clinic ANC and even the time they come to deliver we talk to them on the dangers of FGM. Even before the government had put programmes on FGM, NGOs would go down to the community to talk to them but since it's a strong cultural practice you find that mothers are still cut.*
> (KII, nurse, Pokot, Uganda)

> *As I told you, cases such as fistula come to us. People who [develop] fistula come to our health stations. And after health professionals recognize it as fistula, they will be referred to Yirgalem [hospital]. The other case is if they caught infection during the circumcision, they will come to health stations.* (KII, health officer, Dasenach (Omorate), Ethiopia)

> *Not so frequent. I once was brought a girl who was cut and over-bled, as one of her arteries was cut during FGM. I had to work on her to stop the bleeding. I recently got a case of a girl who gave birth and her vagina got torn all the way towards her anus. It is very rare to get FGM-related cases, as many hide and prefer not to come to a health facility … I do record them normally with the others. There is no special book for FGM cases only.* (KII, health worker, Bula Hawa, Somalia)

> *First you make sure she is telling the truth so you should do a physical examination; after that when you are sure it has been done to her, that is if she has come when she's stable; but when she comes bleeding of course you can tell that something has been done to her then you will take the details of the person, you find one who gives you the chief's number, the chief of the area where she comes from. She comes without the parents; the chief follows up with the patient's parents and then you go to the police and try to report. The parents are followed up and arrested if it's the parents or the guardian or the people who forced*

her, those who were involved, they are followed up and reported and a case is opened in the court. (KII, health officer, Kuria, Kenya)

4.4.2.4 *Interventions through local community leadership*

Community leaders wield the power of influence in the communities that they lead. On the other hand, community members play a big role in the continuance of the practice of FGM. They are the ones who perpetuate discrimination against and stigmatization of girls who are uncircumcised by perceiving them as unmarriageable. This pressurizes community members to continue FGM in the interest of making their daughters and sisters marriageable despite the clear physical health and psychological risks arising from the practice. Community leaders, therefore, are a critical cog in the wheel of pushing for the abandonment of FGM at various levels. They create awareness of and sensitize the community against FGM, support community programmes that are aimed at eradicating the practice and provide role models by not engaging in the practice themselves. The political leaders interviewed stated that they contribute to the fight against FGM by advocating against it and by engaging in community sensitization against the practice and the formulation of anti-FGM policies at the national level:

I have explained to them the laws from the government pertaining to FGM. I encouraged them to leave FGM and stay well; I told them about other tribes like the Bagisu who are not circumcised and yet they give birth normally. (KII, political leader, Sabiny, Uganda)

On my side, we are continuing to teach people. I would give myself as an example: I talked to my daughters until they were convinced not to undergo FGM. As we speak, one is a teacher, the other one is in the university. Girls who have been circumcised, and the ones that are not, think very differently. The one who is circumcised thinks of getting married, but the other one thinks of education. So [I] am also in the teaching program on FGM. (KII, opinion leader, Kuria, Kenya)

We are trying to make that belief about faithfulness a myth. There is no evidence that FGM brings fidelity so at the county level, we meet the youths and we talk about this thing; we compare faithfulness and unfaithfulness among the practising communities and those that do not practise, and we found that there is no scientific relationship between FGM and fidelity. (KII, children's officer, Maasai, Kenya)

My role as an elder of this village is to report such cases to the police or to the chief. (KII, elder, Kanyerus, West Pokot, Kenya)

Our leaders from both sides should address this issue and become an agent of anti-FGM; both countries have laws that prohibit FGM and leaders work in unity. Strengthening the anti-FGM champions since they are directly or indirectly affected. Create more desks for reporting cases. (KII, police officer, Turkana, Kenya)

We call upon the government, NGOs like POZIDEP [Pokot Zonal Integrated Development Programme] to sensitize the youth, mothers, fathers, the elderly in every village in different days and this will help the children understand that FGM is not good.
(Female FGD participant under 35 years old, Pokot, Uganda)

As a political leader, we participate a lot in most of these community events. We use that time to mainstream and sensitize the community about FGM. As leaders, we are part of this discussions at district, regional and national level. At community mobilizations we come in because the community listens more to the politicians than the technical people. We basically use any available forums including radio stations. (KII, political leader, Sabiny, Uganda)

Our role as the political leadership of Mandera County is to campaign against the practice of FGM. We have been using various modes of communication including the local media to campaign against the practice. Myself, I haven't let my daughters go through the cut, and I have been leading as an example … At my level, and the county at large, we have been working on a policy to curb FGM and we are currently drafting a bill that will go to the County Assembly to be put into law. It is going to be used as a tool to enforce and act against anyone practising FGM. (KII, Mandera, Bula Hawa, Somalia).

4.4.2.5 Interventions through legal actors (judicial officers and the police)

The study established the existence of anti-FGM laws across the five countries of interest. Legal actors include the police and judicial officers who are involved in the enforcement of these anti-FGM laws. These legal actors sensitize community members on these laws. They educate community members through various platforms on the legal consequences of engaging in the practice of FGM while working with the different organizations to find alternative sources of income for the circumcisers:

We went to Kanyerus border in Kenya, we went there with a team from the district and we talked about it and [the] people of Kenya responded

and promised to sensitize their people to stop. We encouraged them to take children to school and we warned them never to try because we are on the ground both in Uganda and Kenya. (KII, police officer, Sabiny, Uganda)

Our work is to sensitize the community about FGM, and its dangers, and we also support the alternative rites of passage that [are] carried out by some other organizations. We also have the supporting action where, if there is an issue of reporting, we support action against perpetrators. We have so many cases that we have facilitated right from the ground; as I had told you the community would see it and the whistle blowers will let us know and we take these cases to court and we have so many cases that are ongoing in court. We also facilitate support for the victims when we rescue them because it's also part of our work. You take a child from her home and that means you are prosecuting the parents, so you remove her from that environment because she is a State witness and take her to a rescue centre.
(KII, children's officer, Maasai, Kenya)

What we always do, because some of them flee to Uganda, we work together with Uganda authorities as long as they have identified where somebody is; we go with Uganda police and they help us make arrest and we bring them to Kenya. Some flee from Uganda to Kenya, we make arrest and the person is taken back to Uganda. That is why we come together in eradication of FGM. (KII, OSC, West Pokot, Kenya)

Also, as an activist, I call out on other people, other partners and the stakeholders, the county government, the authorities, and other organizations to ensure that we are championing the eradication of FGM. And then also as an activist individually, I also rescue girls [in my house] who have run away from FGM. So I always move up and down in the community fighting with the police that they are not doing their job. But I am very grateful to them, they have been very supportive, we have a very good relationship and even the leaders at the county, we have to push them around. You know as an activist you must ensure that justice is always served, because if you don't ask these people to do it, they will not do it. (KII, anti-FGM activist, West Pokot, Kenya)

In terms of responding to the survivors that have already gone through FGM, the legal actors work with chiefs and anti-FGM activists from the community to apprehend the perpetrators while linking FGM survivors and potential victims with shelters. They ensure that the cases that are reported are prosecuted in court and the perpetrators jailed as per the existing laws.

4.4.2.6 Interventions through local administration (chiefs)

Local administrators are employees of the central Government under the provincial administration in Kenya and at the same time are members of their respective communities and are bound by the same culture and traditions. They include actors such as the chiefs and assistant chiefs who are salaried and the *Nyumba Kumi*, or village heads, who assist the assistant chiefs in discharging their duties. They are heavily involved in anti-FGM campaigns at the community level. As part of their involvement in taking preventive measures against FGM, they use various community forums such as barazas (public meetings) to enlighten the community and create awareness of the harms caused by FGM. They also encourage members of the community to report incidences of FGM and to support prosecutors to gain evidence that can be used to put up a watertight case against the perpetrators and their accomplices. Furthermore, they work with the directorate of children's services to ensure that the rights of children, and specifically girls put through FGM, are upheld by ensuring that they are rehabilitated and helped through their post-FGM experiences:

> *I think what the rest have said is true, the Government has done campaigns against the cut, they have also arrested one or two people, there has been collaboration between the government and the village elders and the chiefs and the traditional leaders. They also take a pivotal part of the community's leadership. There was one huge campaign that was done here some time back that involved all these leaders.*
> (Male FGD participant over 35 years old, Maasai, Kenya)

> *I call for a meeting when they instruct me; I call mothers, fathers, and tell them that there is news here that there is something they have to abandon and as they continue hearing they find that what the government has brought is true and find that this act has brought laws.*
> (KII, local council, Pokot, Uganda)

> *I have also held public barazas in every village to tell the community members that FGM is illegal. So, the agenda has been to address the issues on early marriages and other things making sure that the parents are sensitized on the issue and making sure that all the children are taken to school. I have also been inviting facilitators, like the World Vision who come, and they spent a whole day in the community sensitizing them and explaining the dangers of performing FGM.*
> (KII, assistant chief, Kanyerus, West Pokot, Kenya)

> *The law announced by chiefs and sub-chiefs in barazas and funerals saying that if you see any homestead performing that thing come and report, and when you report they act and forward the cases to the*

relevant authorities. The girl's parents and circumciser will be arrested. The law has helped. (KII, nurse, Bungoma, Kenya)

There are only two ways that can help us; we usually do public barazas here, we discourage girls by telling them that it will be difficult for them to deliver if cut. There is also transmission of HIV/AIDs and other sexually transmitted diseases. So as chiefs, when we have public barazas, there is no day that I will not mention that agenda of FGM …
(KII, chief, Maasai, Kenya)

Chiefs as local administrators are the major actors in this FGM. We must act in unison with the assistant chiefs and village elders to ensure that our community protect[s] the girls and women. To this end, I have monthly meetings in the community and we often deliberate on cultural issues. It is a form where we have made a lot of changes and helped to create awareness on FGM and other harmful practices.
(KII, chief, Pokot, Kenya)

4.4.3 Gaps in cross-border anti-female genital mutilation programmes

From the survey across different study sites, a number of gaps were found in cross-border anti-FGM programmes, as demonstrated by the respondent's sentiments regarding differences in the ease of conducting FGM between one country and another and the differences in the desire among community members to have their daughters or their female relatives undergo FGM.

Table 11: Respondents' answers to the question "Is it difficult to circumcise a girl on the Kenyan side of the border?"

	Number of respondents (%)	
Cross-border site	**Yes**	**No**
Sabaot in Mt Elgon (KE)	39 (39.4)	60 (60.6)
Sabiny (UG)	114 (57.0)	86 (43.0)
West Pokot (KE)	50 (45.5)	60 (54.5)
Pokot in Amudat (UG)	55 (28.1)	141 (71.9)
Somalis in Mandera (KE)	48 (42.5)	65 (57.5)
Somalis in Bula Hawa (SOM)	28 (26.2)	79 (73.8)
Turkana (KE)	25 (25.5)	73 (74.5)
Dasenach (ETH)	29 (33.3)	58 (66.7)
Borana in Moyale KE)	62 (52.5)	56 (47.5)
Oromia Moyale (ETH)	54 (52.9)	48 (47.1)
Maasai in Transmara (KE)	37 (39.4)	57 (60.6)
Kuria in Isebania–Tarime (KE)	76 (83.5)	15 (16.5)

As Table11 shows, the proportion of the respondents who felt that it was difficult to have a girl circumcised on the Kenyan side of the border were as follows: Kenya–Uganda border (Sabaot 39 per cent vs Sabiny 57 per cent; West Pokot 45 per cent vs Pokot in Amudat 28 per cent), Kenya–Somalia border (Mandera 43 per cent vs Bula Hawa 26 per cent), Kenya–Ethiopia border (Turkana 26 per cent vs Dasenach 33 per cent; Borana in Moyale 53 per cent vs Oromia Moyale 53 per cent) and finally Kenya–Tanzania border (Maasai in Transmara 39 per cent) and Isebania–Tarime (84 per cent), both on the Kenyan side.

Table 12: Respondents' answers to the question "Do people cross easily to have their daughters circumcised across the border?"

	Number of respondents (%)	
Cross-border site	**Yes**	**No**
Sabaot in Mt Elgon (KE)	28 (28.6)	70 (71.4)
Sabiny (UG)	115 (57.2)	86 (42.8)
West Pokot (KE)	35 (30.7)	79 (69.3)
Pokot in Amudat (UG)	35 (17.3)	167 (82.7)
Somalis in Mandera (KE)	84 (74.3)	29 (25.7)
Somalis in Bula Hawa (SOM)	36 (33.6)	71 (66.4)
Turkana (KE)	7 (7.1)	91 (92.9)
Dasenach (ETH)	28 (31.5)	61 (68.5)
Borana in Moyale KE)	69 (59.0)	48 (41.0)
Oromia Moyale (ETH)	51 (48.1)	55 (51.9)
Maasai in Transmara (KE)	37 (39.4)	57 (60.6)
Kuria in Isebania–Tarime (KE)	87 (87.9)	12 (12.1)

As Table 12 shows, a similar pattern is also seen in the proportions of those who felt that people can cross easily to have their daughters or other kin circumcised across the border. The proportions are distributed as follows: in the Kenya–Uganda border area, 29 per cent of the respondents from the Sabaot in Mt Elgon (Kenya) compared with 57 per cent among the Sabiny (Uganda) and 31 per cent among the Pokot in West Pokot (Kenya) compared with 17 per cent among the Pokot in Amudat (Uganda); in the Kenya–Somalia border area, 74 per cent of the Somalis in Mandera (Kenya) compared with 34 per cent among the Somalis in Bula Hawa (Somalia); in the Kenya–Ethiopia border area, 7 per cent of the Turkana (Kenya) compared with 32 per cent of the Dasenach (Ethiopia) and 59 per cent of the Borana in the Kenyan side of Moyale compared with 48 per cent on the Ethiopian side; and in the Kenya–Tanzania border area, 39 per cent of the Maasai in Transmara and 88 per cent in Isebania Tarime, both on the Kenyan side.

Table 13: Respondents' answers to the question "Is it your intention to have your daughter, or your other female relatives, circumcised?"

	Number of respondents	
Cross-border site	**Yes**	**No**
Sabaot in Mt Elgon (KE)	32 (32.7)	66 (67.3)
Sabiny (UG)	31 (16.1)	161 (83.9)
West Pokot (KE)	12 (10.3)	104 (89.7)
Pokot in Amudat (UG)	0 (0.0)	6 (100.0)
Somalis in Mandera (KE)	63 (55.8)	50 (44.2)
Somalis in Bula Hawa (SOM)	14 (13.1)	93 (86.9)
Turkana (KE)	9 (9.2)	89 (90.8)
Dasenach (ETH)	41 (44.1)	52 (55.9)
Borana in Moyale KE)	51 (43.2)	67 (56.8)
Oromia Moyale (ETH)	38 (35.8)	68 (64.2)
Maasai in Transmara (KE)	24 (26.4)	67 (73.6)
Kuria in Isebania–Tarime (KE)	22 (22.2)	77 (77.8)

On future intentions to practise FGM (see Table 13), there were also differences observed across the borders. The proportions of those who intended to have their daughters or other female relatives circumcised are distributed as follows: in the Kenya-Uganda border area, 33 per cent among the Sabaot in Mt Elgon (Kenya) compared with 16 per cent among the Sabiny (Uganda) and 10 per cent among the Pokot in West Pokot (Kenya) compared with less than1 per cent among the Pokot in Amudat (Uganda); in the Kenya–Somalia border area, over half (56 per cent) of the Somalis in Mandera (Kenya) compared with 13 per cent among the Somalis in Bula Hawa (Somalia); in the Kenya–Ethiopia border area, 9 per cent of the Turkana (Kenya) compared with 44 per cent of the Dasenach (Ethiopia) and 43 per cent of the Borana in the Kenyan side of Moyale compared with 36 per cent in the Ethiopian side. In the Kenya–Tanzania border, 26 per cent of the Maasai in Transmara and 22 per cent in Isebania–Tarime region (both on the Kenyan side) also intended to have their daughters or other female relatives circumcised, and a similar pattern can be seen in those who intended to have their wives circumcised if they were not already circumcised.

Table 14: Respondents' opinion on the statement "FGM law in the cross-border area is weak and does not hold people who practise FGM accountable"

	Number of respondents (%)	
Cross-border site	**Yes**	**No**
Sabaot in Mt Elgon (KE)	28 (29.2)	68 (70.8)
Sabiny (UG)	96 (48.7)	101 (51.3)
West Pokot (KE)	34 (30.1)	79 (69.9)
Pokot in Amudat (UG)	61 (32.4)	127 (67.6)
Somalis in Mandera (KE)	88 (77.9)	25 (22.1)
Somalis in Bula Hawa (SOM)	49 (45.8)	58 (54.2)
Turkana (KE)	26 (27.4)	69 (72.6)
Dasenach (ETH)	55 (59.8)	37 (40.2)
Borana in Moyale KE)	57 (49.1)	59 (50.9)
Oromia Moyale (ETH)	34 (31.5)	74 (68.5)
Maasai in Transmara (KE)	63 (64.9)	34 (35.1)
Kuria in Isebania–Tarime (KE)	80 (82.5)	17 (17.5)

Finally, there were also significant differences in respondents' perceptions of whether the law was weak in the cross-border area and did not hold people accountable (Table 14). This was evidenced by the proportions reported as follows: in the Kenya–Uganda border area, 29 per cent of the respondents from the Sabaot in Mt Elgon (Kenya) compared with about half (49 per cent) among the Sabiny (Uganda) and 30 per cent among the Pokot in West Pokot (Kenya) compared with 32 per cent among the Pokot in Amudat (Uganda); in the Kenya–Somalia border area, 78 per cent of the Somali in Mandera (Kenya) compared with 46 per cent among the Somali in Bula Hawa (Somalia); in the Kenya–Ethiopia border area, 27 per cent of the Turkana (Kenya) compared with 60 per cent of the Dasenach (Ethiopia) and 49 per cent in the Kenyan side of Moyale compared with 32 per cent in the Ethiopia side; and in the Kenya–Tanzania border area, 65 per cent of the Maasai in Transmara and 83 per cent in Isebania–Tarime region (both in Kenya).

From the key informant interviews and the focus group discussions, it was also noted that some gaps still existed in the anti-FGM programmes across different countries. For instance, some participants in Kuria, along Kenya's border with Tanzania, felt that some religious leaders are not practising what they preach, as they end up marrying circumcised girls:

> *As I see churches are the ones having great ideas that girls should be cut; why do I say that, I have seen many people especially pastors, youths saying that FGM should end but you have never seen a pastor marrying uncut girls; when he wants to engage a girl, he does so with one who has undergone FGM, So if he had been a good example to us, he should engage an uncut girl so as to inspire confidence in his congregation and as a way of publicly declaring that this FGM should end.* (Male FGD participant under 35 years old, Kuria, Kenya)

Moreover, some community leaders seem to have contrary views on the abandonment of FGM: a participating community leader stated the need for the Government to exercise the law in accordance with the willingness of the community members. However, he also said that FGM is still practised especially in rural areas. Another issue is that FGM is considered a cultural practice and hence any attempt to abandon it is construed as implying communities being stripped of their identity, as illustrated by the excerpts below:

> *I think the law should be optional to protect those who don't want it as well as protect those who want to do it, but education is the key thing because FGM is still being practised only among the very remote and in deep villages [where people] have not gotten the chance to go to school.* (KII, elder, Amanang village, Sabiny, Uganda)

> *We would love as elders to be informed so that we advise on how to conduct the circumcision. We can then push for the Sunna type which is not harmful to the girls.* (KII, elder, Bula Hawa, Somalia)

> *It can never be stopped because you'd be stripping the community of their identity as Muslims and as Somalis.* (KII, community leader, Mandera, Kenya)

Also in relation to religion, some Muslim leaders continue teaching the importance of circumcision in Islam and advocate type I FGM. This has the effect of encouraging circumcision among Muslims.

There is also a general feeling among some participants that most politicians fear speaking out against FGM for fear of losing votes during elections, and hence they do not play an active role in condemning the act:

Politically, it is not accepted by the politician since, if you support the abandonment of FGM, you will lose votes or even friends and probably fight your family, therefore in my opinion they are not willing to sensitize on matters FGM since they are more interested [in] their votes.
(KII, CBO officer, Maasai, Kenya)

Yeah, I am a politician, but am saying we cannot depend on politicians on this thing. Some of [these] politician[s] and we have seen some in some areas, they even promote it so long as they get votes. But you see they cannot tell their people the dangers of this thing.
(KII, lawyer, West Pokot, Kenya)

Yah, but in my opinion, politics has always been compromising; therefore, it is not the best approach because they have their interests, they don't want to touch some of the things because they know the numbers and that it can affect their next elections.
(KII, headteacher, Maasai, Kenya)

There is a belief that it is against their culture and that it is a curse to the community to be led by a non-cut woman so it's difficult for such a woman to manoeuvre politically and nowadays, they say that political leaders who will come out clearly and defend the community on continuing with FGM will command [the] majority of the votes.
(KII, school administrator, Kuria, Kenya)

Through the UNFPA programme, we have had engagements with leaders from within and even across the border. The message is stop FGM because we are aware; we no longer have surgeons here, the surgeons we get in come from across the border especially Pokot and Trans-Nzoia side. We have the law both in Uganda and Kenya and the Kenyan implementation is still weak and that is why we still have surgeons coming in. We have always discussed the role of bodaboda [motorbike]smuggling surgeons here; we still want to emphasize that the Kenyan enforcement is letting us down and they need to up their game. (KII, DCAO, Sabiny, Uganda)

In terms of response, there are gaps in the capacity of local organizations to intervene comprehensively because limited resources make them refer or release girls who go back to homes where they face the perpetrators, and this exacerbates the mental torture of the survivors:

We don't have much capacity to take them in ourselves and even the NGOs they just provide treatment and counselling only as opposed to taking them in and protecting them from their people. (KII, gender and child officer, Bula Hawa, Somalia)

One challenge facing health-care workers is that communities generally hide girls with complications for fear of being apprehended for practising FGM and thus opt to use traditional medicine to control FGM-related complications and only take the girls to hospital when the complications are severe. The study also established that there were low levels of awareness in communities about the impact of FGM; hence, it is still being practised secretly, making it hard to arrest the perpetrators.

4.5 Social norm practices and changes in cross-border areas

KEY FINDINGS

- Social norms around FGM are a major driver for families to continue the practice as a way of maintaining their social status and acceptance within their community.
- Despite the deep-rooted understanding of FGM as part of social and cultural identity among many cross-border communities, there is evidence that social norms are beginning to change. In many communities, FGM is no longer a publicly celebrated ceremony.
- Changes have been observed in the following: the type of cut (i.e. from removing large parts of the clitoris to a type I cut); the role of community members; where the cut takes place; the time and season of cutting; and the age when girls are cut.
- There is no disagreement among community members with the preventive interventions and messages that are focused on transforming the sociocultural and religious norms related to the practice of FGM.

Strong cultural, religious and moral norms have been identified as influencing the continuation of FGM in the cross-border areas. Specifically, adherence to the practice of FGM is often perpetuated by societal views and perceptions about the differences between cut and uncut girls and women. These beliefs and norms are multifaceted

and put a lot of pressure on girls and their families to practise FGM. Stigmatizing uncut girls' as unclean, unmarriageable and outcasts from the community puts such pressure on girls that they choose to be cut despite their knowledge of the consequences. Sociocultural and religious norms, coupled with the narrative of traditions, have been used to shape girls' own beliefs such that they opt for FGM. In addition, the social norms around FGM have been forcing families to maintain their social status by continuing the practice to maintain their acceptance within their community.

This study did not find any disagreement with the sociocultural and religious norms related to the practice of FGM. The preventive and response-related anti-FGM programmes, however, have been identified as instrumental in facilitating some form of change in social norms . The following section discusses the social norm-related changes that have been observed among communities practising FGM in the cross-border areas.

4.5.1 Changes in social norms relevant to female genital mutilation

Evidence from both qualitative and quantitative data show that FGM is deeply embedded in the cross-border area communities' social identity. Hence, FGM is completely associated with societal expectations based on different ethnic groups' identities, sociocultural beliefs and religious practices. Community upholding of the practices results in social benefits and avoids social repercussion and the fear of being sanctioned in the event of deviating from the norm. The fear of social exclusion, belief in curses, and fear of stigma and being unable to find their daughters suitable marriage partners has pushed community members into continuing the practice of FGM. As a result, FGM remains an ongoing practice that is largely condoned and accepted. Data from the qualitative study revealed that some participants felt the need to continue FGM because of moral, cultural and religious requirements. As a result of the introduction of anti-FGM laws in each country, however, it was observed that, in some areas, the practice is being carried out secretly and fuelled by cross-border practice. In a few areas, medical practitioners are providing an alternative and safe option to the traditional way of carrying out FGM. Moreover, the various communities have transitioned into doing circumcision in different and more discreet ways to avoid being sanctioned. Previously, circumcision was a communal ceremony sanctioned by cultural merrymaking and with defined roles for the various actors. It also marked an important transition to adulthood, but all these have changed as a result of the new regulations and laws, which have seen the practice go underground without any public celebration.

More importantly, this study identified changes in the types of cut, where the cut takes place, the age when girls are cut, how FGM is celebrated, the time and season of cutting, and changes in the role of the actors. These changes have come about because of the existing anti-FGM interventions. The following sections discusses these changes.

4.5.1.1 Changes in type of circumcision

The findings suggest that, because of increased awareness of the negative effects of FGM, the severity of the cut has changed. Accordingly, the narratives of study participants indicate that, in the past, they used to remove larger parts of the genitalia in either type II or type III (infibulation) FGM. Currently, the most frequently mentioned type of cut is type I (Sunna) which was described as the "slight cut done now":

> *Previously they totally removed the outer part of female genital organ but now they cut the tip of clitoris. The community is aware of the impact of FGM on women.* (KII, health officer, Dasenach (Omorate), Ethiopia)

> *In Kuria, traditionally, they used to cut deeply but now they just cut the tip, not like the earlier days. They used to cut to the extent that a girl could not walk but, nowadays, a girl could be cut, and you would not know she is cut. She will just be walking normally.*
> (KII, opinion leader, Kuria, Kenya)

> *… then the last type is where they slightly prick or cut the tip of the clitoris to make it bleed slightly only. This last type is the one called "Sunna" and is the one we recommend as religious leaders and members of the Islamic courts.* (KII, legal actor, Bula Hawa, Somalia)

> *Back then it used to take a bit longer to heal. Unlike nowadays, today they perform the slight cut and tomorrow you are up and walking. This is the reason why we have accepted the slight cut since some girls fight to be circumcised kisasa [in the modern way]; in the past girls used to cry so much, but with this new cut girls don't.* (KII, CBO officer, Maasai, Kenya)

The drastic change in the type of cut was reported to be due to sensitization and awareness of the community about the health consequences associated with FGM types II and III. It seems that there has been a consensus on adopting a harm reduction strategy but, at the same time, still holding on to the traditional practice.

4.5.1.2 Changes in celebrations

As FGM is a social norm, it was celebrated openly, involving immediate family members or clan members. The ceremony had a defined time and season known to the community; all community members were involved, and their roles were clearly defined. However, following several interventions and the mobilization of the community to abandon FGM, as well as the introduction of anti-FGM laws, community members are no longer openly celebrating and undertaking the cut. This is because of their fear of being arrested. As a result, communities have come up with mechanisms

to divert the attention of the law enforcers while undertaking FGM. The following participants' voices show how this change is occurring:

> *These days they don't do it in cowshed but rather inside houses because they know it is illegal. The girls are given pep talks by their mothers to be strong since there is no celebrations and songs to give them strength.*
> (Male FGD participant, over 35 years old, Maasai, Kenya)

> *Yes, the practice has really changed: there are no more traditional dances, no more singing around the village inviting friends and relatives, this will alert law enforcers and anti-FGM activists who are against the practice. In the past, circumcision was accompanied by a lot of preparations and was done openly during the day. However, nowadays it is done secretly during the night and far away from homes because it is prohibited.* (Female FGD participant under 35 years old, West Pokot, Kenya)

> *Yes, nowadays there is no prize and even songs being sung is immoral; the activity is mostly performed in secret without the cultural pomp associated with the past.*
> (Male FGD participant under 35 years old, Bungoma, Kenya)

4.5.1.3 Changes in place of circumcision

Unlike in the past, when FGM ceremonies were conducted in defined spaces, study participants stated that there is currently no specific place for such practices. Hence, FGM occurs in hidden places such as in bushes, along the river, in families' own homes or houses and at times in the homes of the traditional circumcisers, where the girls stay until they heal. This is to hide them from law enforcers. The following accounts indicate how FGM is carried out in hiding from law enforcers:

> *Because of the penalty they would face, now FGM procedure is performed in the bushes. Not in the cowshed or homestead as it used to be.*
> (Male FGD participant, under 35 years old, West Pokot, Kenya)

> *They perform FGM [on] the other side, the interior, in the forest. This side they are a bit enlightened, but [on] the other side where even the Government cannot access them. So, there they cannot be reached, you cannot even get that information that such a practice is taking place. Even the Government getting there is hard, the roads are bad.* (KII, children's officer, Chepkube, Bungoma, Kenya)

No the place is already set and the cutter is aware of their coming and they do the cutting at night along the river where no one sees them, but these days the cutter is monitored properly in that in the day she is not at home they just know she has gone somewhere to cut children so the responsible people go searching for her.
(Female FGD participant under 35 years old, Sabiny, Uganda)

Since awareness is created as FGM is an illegal activity, it is difficult to know the right time when FGM happens in Demi. It may happen in different places prepared for this activity or in the bushes. But we cannot say that Demi is the ceremony of FGM alone … The first one is that old women circumcise girls in the house and the girls stay hidden until their wounds are healed.
(KII, women and child rights and security officer, Dasenach (Omorate), Ethiopia)

4.5.1.4 Changes in time and season of circumcision

Like the change in the where the cut takes place, the time and season of cutting has also changed. Previously most communities practised FGM when there was plenty of food, and they had traditional seasons for conducting the cut; however, because of the changes in the law, it is said that FGM is now mostly practised during the school holidays. This change is meant to give girls time for healing and avoid arousing suspicion by being absent from school. Furthermore, the "Demi" ceremony that was conducted during circumcision in Ethiopia has become significantly shorter as opposed to what happened previously, when it could last up to six months.

The study participants also stated that the cut is mostly done during the night, unlike in the past when it was done in broad daylight and community members could witness it and celebrate.

When the school is closed, FGM happens in the houses where many people do not live around. Because no one will report it to authorities. They [associate] the pain of the children with other disease so no one will know it. (KII, school leader, Moyale, Ethiopia)

FGM is often practised during the Demi ceremony. Demi takes up to six months … after the intervention made by the Government, they reduced it to less than three months.
(KII, local administrator, Dasenach (Omorate), Ethiopia)

Previously, December was the month that most children got cut. But now we have the other vacations as well due to school breaks like the April holiday and the August holiday; they can have [it] during these holidays. (Female FGD participant under 35 years old, Maasai, Kenya)

4.5.1.5 Changes in role of female genital mutilation actors

The role of important actors in the family is also changing. For instance, in the past the roles were well segregated by gender. Men were regarded as key decision makers on FGM, since they determined when their daughters were set to undergo circumcision. Women, on the other hand, were responsible for preparing the circumcision ceremony, while the role of their peers, neighbours and relatives was to participate in the FGM ceremony and to cheer, support and encourage the girl during circumcision. This has changed now. First, there is no celebration and thus community members have limited roles to play during the cut. Perhaps the only significant role remaining is to act as spies on behalf of the legal actors during the process, as discussed above. The role of men is unclear. However, women have been left with key responsibilities in FGM; they make decisions and also facilitate the process:

> *The father will be informed by his wife when the cut has been done; the father will look for his friend and they come to cast the spirits if any and pray [to] the gods to protect the girl. It is very secret. The girl wears clothes and not skin as it used to be and no seclusion is done to avoid [it] being noticed that the act was done.*
>
> (Male FGD participant over 35 years old, Maasai, Kenya)

> *These days, men have no role in the circumcision exercise. Because it's the mothers who are in control of circumcision of the girl … The mother of the girl is the decision maker when it comes to circumcision. The mother is in control; the man has no powers in determining whether the girl should be circumcised or not.*
>
> (Male FGD participant under 35 years old, Bula Hawa, Somalia)

The accounts of study participants suggest that men's power in relation to reinforcing the practice of FGM has been declining, suggesting a decline in the importance of gendered power on the continuance of the practice. This finding is also consistent with the findings obtained from quantitative data. As Table 15 shows, male respondents had a lower average score (2.7) than female participants (2.8), indicating that male respondents were more likely to disagree with the cultural and religious justification for continuing FGM than the female study participants. These findings illuminate the negative impact of gendered power on FGM and the importance of women's and girls' empowerment in fully eradicating the practice from the cross-border areas.

4.5.1.6 Changes in age of circumcision

FGM was practised as a rite of passage in most communities, and age was used as a factor to determine when a girl was set to undergo the cut. In the Kuria and Maasai communities, the cut was undertaken from the age of 18 years. However, some girls are now said to undergo the cut at a very tender age: a key respondent stated that it is done to young girls because they are vulnerable and are not able to give informed

consent due to a lack of information. They are also still too young to complain or refuse to be cut, as is happening in some communities where girls are reporting their parents to the authorities or to the many anti-FGM actors at the community level. The following accounts show how the age of circumcision has changed:

> *Yes, they have changed with time, age has been lowered; in the past it was over the age of fifteen but now it has come down to nine years or below to about thirteen years old.*
> (Male FGD participant over 35 years old, Kuria, Kenya)

> *I was observing some of my girls here and it's like they do it as early as the girl is in class 3, class 2, at a very tender and young age. Why, because they know [that] when a girl is mature, especially a girl that is through school, [she] will know a lot of things about FGM, and she will tend to stand against it. So, they do it at a very tender age to avoid any possible rebellion.* (KII, headteacher, Maasai, Kenya)

The quantitative data also confirm that social norms are changing in the cross-border areas. To understand the direction of change, the study compared the findings by age and gender in the cross-border areas. Accordingly, responses to 15 statements were used to measure participants' opinions on social norms, using a Likert scale, ranging from strongly disagree (1) to neutral (3) to strongly agree (5).

As shown in Table 15, younger respondents aged under 35 years old were more likely to disagree with statements justifying the importance of FGM based on tradition, culture and religious norms than those aged 35 years or older. These results varied by border. Overall, participants from the Kenya side of the borders had higher scores than those from the other side of the border, apart from the Kenya–Ethiopia border area, where the Turkana in Kenya had a score of 2.2 compared with the Dasenach in Ethiopia with a score of 3.0. Particularly, in the Kenya–Uganda border area, the Sabaot in Mt Elgon had an average score of 3.8, indicating agreement with sociocultural norms, with males (4.0) more likely to agree than females (3.4) and those aged 35 years or above (4.0) more likely to agree than the younger participants (3.3). Participants from the Sabiny in Uganda had a score of 2.5, indicating overall disagreement. There was no significant difference by sex, but those under 35 years old were more likely to disagree (2.3) compared with the older respondents (2.8). The Pokot in Kenya had a score of 2.6 compared with 2.2 among the Pokot in Amudat in Uganda, indicating that the Pokot in Uganda were more likely to disagree with sociocultural norms than those in Kenya.

A similar pattern is observed in the Kenya–Somalia border area, where the Somali participants in Mandera (Kenya) had a higher score of 3.2 than those in Bula Hawa (Somalia) at 2.4 and in the Kenya–Ethiopia border area, where the Borana on the Kenyan side of Moyale had a higher score (3.2) than those in Oromia on the Ethiopian side of Moyale (2.9). In the Kenya–Tanzania border area, the Maasai from the Transmara region had a higher score (3.1) than the Kuria in the Isebania–Tarime region (2.3).

Table 15: Respondents' scores for agreement with sociocultural norms by age, sex and border area

	Participant score, mean (standard deviation)				
Cross-border area	**Under 35 years**	**35 years or older**	**Male**	**Female**	**Overall**
Overall	2.6 (0.8)	2.8 (0.9)	2.7 (0.9)	2.8 (0.9)	2.7 (0.9)
Kenya–Uganda					
Sabaot in Mt Elgon (KE)	3.3 (0.9)	4.0 (0.7)	4.0 (0.8)	3.4 (0.8)	3.8 (0.7)
Sabiny (UG)	2.3 (0.9)	2.8 (1.0)	2.5 (1.0)	2.5 (1.0)	2.5 (1.0)
Pokot in West Pokot (KE)	2.3 (0.5)	2.6 (0.8)	2.4 (0.7)	2.6 (0.7)	2.6 (0.9)
Pokot in Amudat (UG)	2.2 (0.4)	2.2 (0.6)	2.2 (0.5)	2.2 (0.5)	2.2 (0.5)
Kenya–Somalia					
Somalis in Mandera (KE)	3.2 (0.7)	3.2 (0.9)	2.7 (0.6)	3.6 (0.8)	3.2 (0.8)
Somalis in Bula Hawa (SOM)	2.5 (0.4)	2.4 (0.4)	2.4 (0.5)	2.5 (0.3)	2.4 (0.4)
Kenya–Ethiopia					
Borana in Moyale (KE)	3.2 (0.7)	3.1 (0.8)	3.3 (0.6)	3.2 (0.7)	3.2 (0.7)
Oromia Moyale (ETH)	2.9 (0.7)	3.1 (0.8)	3.0 (0.8)	2.8 (0.7)	2.9 (0.8)
Turkana (KE)	2.1 (0.9)	2.3 (1.1)	2.2 (1.0)	2.2 (1.0)	2.2 (1.0)
Dasenach, Ethiopia	3.2 (0.4)	3.2 (0.3)	3.0 (0.5)	3.0 (0.5)	3.0 (0.5
Kenya–Tanzania					
Maasai in Transmara (KE)	3.0 (0.8)	3.2 (0.9)	3.0 (0.9)	3.3 (0.7)	3.1 (0.9)
Kuria in Isebania–Tarime (KE	2.3 (1.0)	2.4 (0.9)	2.2 (0.9)	2.5 (1.0)	2.3 (0.9)

5 Conclusions and Recommendations

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This study sought to understand the legislative and policy frameworks available in relation to FGM in the cross-border areas in Ethiopia, Kenya, Somalia, Tanzania and Uganda. It also identified major drivers of FGM and the social, economic, health and political effects of FGM. The study also looked at the available preventive and response-related interventions in the border areas and the efforts to change social norms that have helped to transform the sociocultural and religious norms around practising FGM among communities in the border areas. Both quantitative and qualitative data were collected from communities in 12 cross-border areas from both sides of the Kenya–Uganda, Kenya–Somalia and Kenya–Ethiopia borders and from the Kenyan side of the Kenya–Tanzania border. This section provides the conclusions and recommendations. The conclusions are drawn from the findings based on triangulation. This section also highlights the key elements pertinent to the way forward for eliminating FGM in the cross-border areas in the study countries.

5.1 Conclusions

The conclusions are drawn from the major findings of the study. Accordingly, the study highlights the fact that there is currently no specific legislation at the regional level that prohibits FGM, making collaborative efforts to eliminate FGM in the various countries using legal and policy measures very difficult. As discussed in section IV, the countries that this study focuses on are collectively part of one or both of the main regional bodies that are organized mainly around promoting economic development, peace and security within the region, that is, IGAD and EAC. Both regional organizations have expanded their mandates to work on social issues and have been implementing several initiatives in areas such as health and education with the aim of sustaining economic integration. This study also found that there is presently a draft Prohibition of Female Genital Mutilation Bill pending enactment by the EAC Parliament, an initiative that would greatly enhance the practical implementation of the existing policies and frameworks and allow partner states to take more practical and concrete steps towards eliminating FGM within each country's borders and the region.

The findings also show that the countries in the cross-border areas of Ethiopia, Kenya, Somalia and Uganda to varying degrees have laws and policies that are aimed at ending the practice of FGM within their respective jurisdictions. However, non-compliance with the laws is relatively high. This can be explained by the widespread lack of awareness of the existing laws and policies, duplication and contradiction between national and cultural laws, the strong values placed on FGM as a sociocultural and religious norm, ineffective implementation of the laws and lack of ownership of the laws by the practising communities. The findings from this study also highlight that there is insufficient reporting of FGM cases when they happen, a lack of and unwillingness of witnesses to testify, corruption within the institutions in the criminal justice system, a lack of capacity among law enforcement officers, and difficult terrain

and poor logistics hindering law enforcers. All of these are major factors contributing to the poor implementation of existing legal frameworks, which hinders officers from monitoring and apprehending offenders.

The laws and policies in the study countries vary significantly in terms of the definition of FGM, the offences and penalties imposed and the implementation strategies. Furthermore, the study shows that the lack of harmonized laws between the countries sharing a border with Kenya has been a hindrance for law enforcement officers in their efforts to apprehend perpetrators who can easily enter and leave the different jurisdictions. Despite the many challenges, the study showed that there is support for the use of legal measures to curb the practice of FGM.

The current study identified sociocultural traditions and considerations related to marriageability, maintenance of family honour and respect, community acceptance and ethnic identity, the ritual marking of the transition to womanhood, improvement of hygiene, and religious and cultural requirements as major drivers. Furthermore, the prevailing beliefs, rituals and ceremonies around the practice of FGM have been attracting girls and encouraging women to undergo the practice. This can be explained in terms of young girls conforming with the prevailing cultural requirements, as the practice allows their families to continue enjoying a sense of belonging in their community. This study also found that, because of the national laws prohibiting FGM, in most places FGM has gone underground: it is still practised in a clandestine manner and porous borders are used to evade the law. It was observed that in many if not all of the border areas, be it among the Maasai or Kuria (Kenya–Tanzania), Pokot or Sabaot (Kenya–Uganda), Borana or Dasenach (Kenya–Ethiopia) or Somalis (Kenya–Somalia), people easily and freely crossed border points.

The current study found a myriad of social and economic effects of FGM. In relation to the social effects, health complications arising from FGM are widely reported. Infections, urine retention, difficult births, excessive bleeding and at times death, as well as psychological effects, were identified as major health effects. A significant number of women experience FGM health-related issues throughout adulthood. When it comes to the effects of FGM on the economic well-being of women and girls, this study found that overall economic productivity falls short in societies that subscribe to the procedure. While women are spending time dealing with such issues, the economy is missing their contribution to the production process, either through the market place in the formal economy or through home production. FGM also has a considerable negative impact on girls' education. Poor performance and low retention rates among girls in school are largely associated with psychological trauma, frequent absenteeism related to the cut-healing process and other health effects, and early marriage. Generally, most circumcising communities are patriarchal and place a lot of emphasis on marriage and domestic chores as the best work for women. Hence, the notion of female empowerment and giving women an opportunity to work outside the homestead is limited.

Furthermore, FGM violates a series of well-established human rights principles. The practice of FGM is seen as a major indicator of gender inequality and is linked

to child marriage, forced sexual debut and health complications across women's life courses. On the economic effect of FGM, apart from the economic gains made by the circumcisers and the council of elders, who are indirect beneficiaries of the practice, this study documents the adverse long-lasting economic consequences that FGM places on the shoulders of women. Deprived of education and forced into early marriage, women are perpetually constrained to the lowest wealth quantile in communities. Their power to negotiate for better life prospects is seriously curtailed and the cycle becomes ever downwards.

This study also found that there are institutions that are undertaking anti-FGM programmes focused on prevention and responding to the needs of survivors of FGM along Kenya's borders with Ethiopia, Somalia, Tanzania and Uganda. However, almost half of community members living in the cross-border areas are not aware of those services. Various organizations have been involved in anti-FGM programmes targeting young girls through learning institutions, in which they set up anti-FGM clubs where the effects of FGM are discussed. These interventions are targeted and provide information to help change attitudes and behaviours towards the abandonment of FGM.

Some organizations support schools to set up anti-FGM clubs, sensitizing and creating awareness among girls and teachers on the consequences of the practice of FGM, and provide capacity-building opportunities for local administrators. Furthermore, the anti-FGM service providers are also working to enhance the role of religious leaders as catalysts in the process of ending the harmful practice of FGM. Churches and mosques are also providing refuge to victims and sponsoring rescue centres. However, some Muslim leaders continue to teach the importance of circumcision in the Muslim religion and advocate type I FGM, otherwise known as Sunna.

Health-care providers also closely work to enhance their clients' awareness of the harmful effects of FGM. Health-care providers also treat girls who come to them as a result of excessive bleeding and repair fistulas in circumcised mothers who experience tears during delivery. Because FGM is criminalized, community members often hide girls with complications as a result of the cut for fear of being apprehended for practising FGM, thus opting to use traditional medicine to treat the complications and only take the girls to hospital when the complications are severe.

The study also highlights some gaps in the anti-FGM programmes across the different countries. For instance, in the Kuria community, along Kenya's border with Tanzania, it was reported that some religious leaders are not practising what they preach, as they end up marrying circumcised girls. This gives a licence to community members to continue practising FGM. Community leaders seem to have contrary views on the abandonment of FGM. Hence, community members receive contrasting messaging from anti-FGM campaigners such as NGOs and from traditional and religious leaders, who unfortunately have the greatest influence. This is explained in terms of the cultural norm, and hence an attempt to abandon the practice is construed as communities being stripped of their identity, as illustrated below. The rituals associated with the

practice, and the fact that girls who are not cut are ostracized, also makes girls comply with FGM as a result of learned helplessness.

The study finds that FGM is justified using sociocultural norms and religious arguments. In all scenarios, women and girls are pressurized to undergo the cut in order to be accepted socially and to increase their marriageability. Furthermore, FGM continues because of the fear of being rejected by community members and the need to maintain families' social status and gain the respect of elders. However, because of the anti-FGM interventions in the cross-border areas, these socially constructed beliefs are having a declining influence on the practice of FGM. As a result, practising community members are resorting to less dangerous forms of the cut (i.e. type I) and the medicalization of FGM. This is happening despite FGM being declared a criminal act in the cross-border communities in the countries neighbouring Kenya.

Strong belief systems were observed in practically all the communities studied. For instance, among the Dasenach and the Kuria communities, not circumcising girls is associated with curses, which ensures compliance. Some communities see the practice as a form of cultural purity and a way of preserving their identity and religion, which is prevalent among the Somali community. Despite this, existing anti-FGM interventions have helped to increase communities' awareness of the harms caused by FGM and to view the practice as a violation of rights and a form of violence against women and girls. The important consideration in the process of changing social norms is that there must be a critical mass of adopters of change who have the ability to encourage other people to do so. This calls for assertive targeted interventions in the cross-border areas to give communities the necessary knowledge and mental strength to abandon the practice of FGM. Hence, interventions tailored to specific communities' belief systems will be needed in the cross-border areas to ensure that the change is community driven and participatory and gives people more say in transforming their traditions towards a new reality.

5.2 Recommendations

This study finds that, despite the availability of preventive and response-related programmes on FGM and changing social norm in the cross-border areas, and the attendant level of achievements made, much still remains to be done by the Governments of Ethiopia, Kenya, Somalia, Tanzania and Uganda to ensure that local policies and legislation are properly implemented in the cross-border areas. In addition, a bilateral agreement needs to be initiated to strengthen cross-border efforts to end FGM. Drawing on the major findings of the study, the following specific recommendations on legal and policy frameworks, capacity-building, anti-FGM programmes targeting changes in social norms, and research are suggested.

A. Legal and policy frameworks

- National legal pluralism should be addressed to provide guidance on how to deal with the inherent conflict between the formal law on the one hand and religious and customary rules on the other to achieve social legitimacy within the formal criminal law.
- A regional law that prohibits FGM is needed and should consider provisions that:
  - Harmonize preventive measures, offences and minimum penalties to eliminate the need for people to cross borders to face less punitive penalties and escape from the law
  - Capitalize on local and religious rules and laws that prohibit the practice of FGM
  - Protect those who report or are witnesses in FGM cases
  - Address emerging issues such as the medicalization of the practice and self-mutilation.
- Enhanced intergovernmental collaboration to develop a robust policy structure with accompanying evidence-based multisectoral plans of action is needed at regional level, providing minimum standards while allowing countries to integrate these policy provisions to reflect their unique situations.
- These policy provisions should address:
  - Implementation strategies with dedicated budgetary allocations
  - A monitoring and evaluation framework to track progress throughout the border communities
  - Standard operating procedures on how to deal with FGM cases in each jurisdiction in the region
  - Other complementary polices that address interrelated issues such as health and psychosocial support for survivors of FGM and re-admission to school for girls rescued from FGM and child marriages.

B. Capacity-building

- Train all law enforcement officials on the practice of FGM and the anti-FGM laws. Joint training sessions would be ideal to ensure uniformity of understanding of the practice of FGM and the law.
- Improve the ability of law enforcement officials to arrest perpetrators and continue to raise awareness of FGM and the law within their communities by improving the infrastructure and other resources such as cars to increase their mobility within their administrative areas.

- Increase awareness of the existence of the national laws banning FGM, and the associated penalties, in particular along the Kenya–Ethiopia border among the Dasenach (Ethiopia), Borana (both Kenya and Ethiopia) and Somalis in Mandera (both Kenya and Somalia). Awareness-raising among community members is needed. Including key community players such as religious and cultural leaders is important, as this encourages buy-in from community members and increases compliance with the law.
- Make extensive use of local media outlets and accessible social media platforms to raise awareness of FGM, including the support services available in the cross-border areas.

C. Preventive and response programmes on anti-FGM practice should be scaled up

- Intensify advocacy and awareness-raising activities throughout the border areas. Such activities should be designed to address specific drivers in the different communities and other harmful practices such as child marriage.
- Provide comprehensive health services, including psychosocial support, to help survivors deal with FGM-related complications, such as fistulas, in the cross-border areas.
- Exploit the influence of religion in eradicating the practice by promoting the correct religious teachings and using religious leaders as agents of change. The definition of FGM should be aligned with the WHO definition. This would eliminate the defence that certain types of acts are religious or cultural and therefore are not regarded as FGM, for example the Sunna type of circumcision.
- Institute an accountability mechanism to prevent medical professionals from engaging in any form of FGM. In addition to criminalizing the medicalization of the practice, medical institutions should have policies for dealing with medical professionals who perform FGM.
- Tailor interventions to specific communities' belief systems in the cross-border areas in order to ensure that social change is community driven and participatory and to give people more say in transforming their traditions towards a new reality.
- Introduce evidence-based social norm change models with indicators to allow community members to come up with community consensus on alternative rites of passage ceremonies while abandoning the practice of FGM completely.
- Map out organizations engaged in FGM prevention and response activities and services to improve the distribution of these services and establish referral

systems among the various organizations in collaboration with Government departments.

- Establish an FGM database system, in particular at the country borders, to record more data on population movements related to cross-border FGM, and promote information-sharing among countries.

D. Related research

- There was no baseline study with which to compare the major findings from the current study and discuss the social changes in FGM practice occurring in the cross-border areas. Hence, we recommend process evaluation research to capture new trends, measure changes in practice and develop interventions that are informed and effective.

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ANNEX I
DATA COLLECTION TOOLS (SURVEY, KEY INFORMANT INTERVIEW AND FOCUS GROUP DISCUSSION GUIDES)

I. Survey instrument

Understanding the impact of FGM amongst practising communities across Kenyan, Ugandan, Tanzanian, Somali and Ethiopian borders

General introduction

Welcome. Thank you for being here. My name is _____ and I am part of a research team working with NEEMA COASTAL and GEM. We are trying to understand the impact of FGM amongst practising communities across Kenyan, Ugandan, Tanzanian, Somali and Ethiopian borders. The information you provide will be used to develop or improve health programmes as well as other interventions for young girls at the risk of FGM amongst cross-border communities in the five countries. We will not use your names or otherwise identify you personally in the analysis and reporting of the results of our discussion today.

Before you decide whether to participate, you need to understand why the research is being done and what it would involve. Please take the time to read or to listen as I read the following information. You may talk to others about the study if you wish. Please ask me if there is anything that is not clear, or if you would like more information. When all of your questions have been answered and you feel that you understand this study, you will be asked if you wish to participate in the study, and if yes to sign this informed consent form. You will be given a signed copy to keep.

Investigators

The study investigators are Meseret Kassahun, Owuor Olungah, Dora Kanabahita Byamukama, Esther Njenga and Sadia Isaack.

Study location

The study is being conducted across the borders of five countries: Kenya, Uganda, Tanzania, Somalia and Ethiopia.

Purpose of the research

What is the study? The purpose of the proposed study is to understand the impact of FGM amongst practising communities across Kenyan, Ugandan, Tanzanian, Somali and Ethiopian borders.

Why have I been invited to take part? You have been invited to participate in the study because you hold an important position in the community and you live in one of the countries we have selected. You might

also have important information about the cross-border practices and how the law works at the local level and how the practice of FGM affects the girl child/women.

Description of the research

What will happen if I take part? If you agree to take part in the study, we will ask you to sign this form. You will also be asked to participate in an interview about your views and experiences on the research topic.

How long will the interview last? The interview will last up to one hour.

Risks

What are the risks of the study? A risk may be a breach of confidentiality (something you say or data are accidentally provided to others) but we will take precautions to minimize this. You may also feel uncomfortable giving your views on FGM/C. You are free to ask me to stop or decline to answer any questions that you are uncomfortable with. An inconvenience may be the time and effort you take to participate in the study.

Benefits

What are the benefits of participating? There are no direct benefits to you for participating in the study. You may find an indirect benefit in knowing that you participated in an important study that could inform programmes working in communities practising FGM/C in the region.

Confidentiality

Will my participation in the study be kept confidential? The interview with you is confidential and will be conducted in private. We will not record your name on the interview form. In addition, your responses will be combined with responses from other community members and service providers. This form will be kept under lock-and-key. The information gathered will be stored in a password-protected computer in NEEMA COASTAL's office in Nairobi that only the study team can access. Your signature at the bottom of this form will not be used for any other purpose apart from proving that you have read or have been read to the information and that you have understood this information.

Voluntariness

What are my rights as a research participant/subject? Your participation in this study is completely voluntary. If you decide not to participate, you will not lose any existing benefits to which you are entitled. Refusing to participate will not affect your employment status. If you agree to participate in this study, you may end your participation at any time without penalty or loss of existing benefits to which you are entitled. You are free to withdraw from the study at any time.

Additional information

What will I receive for participating? You will not receive any compensation for participating in the study.

What will happen to the results of the research study? The results of the study will be presented to organizations that implement FGM/C programmes, the Governments of the five countries and

international actors. The study findings are expected to inform programmes/interventions aimed at ending FGM/C in the region.

Anonymized data will be made publicly available to publish the knowledge gained as a result of this study, which means it could be used in future research without additional consent. Any report or data that is made available to the public will not include your name or any other individual information by which you could be identified.

Who has reviewed the study for ethical issues? The Institutional Review Board of AMREF Health Africa in Kenya ESRC.

Contacts

What if I need more information? If you have a concern about any aspect of the study, you should ask to speak to the researchers, who will do their best to answer your questions. You may call any of the core team members listed below.

Meseret Kassahun, PhD, P.O. Box 30577-00100, Nairobi, Kenya; Tel: +254715542562; Email: Meseretkassahun@gmail.com

Charles Owuor Olungah, PhD, MPhil, BA, University of Nairobi, P.O. Box 30197-00100, Nairobi, Kenya; Tel: +254722217132; Email: owuorolungah@gmail.com

Hon. Dora Kanabahita Byamukama, LAW-Uganda, P.O. Box 1032, Kampala, Uganda; Tel: +256772507047; Email: dkanabz@gmail.com

Esther Njenga, MA, BA, Law University of London, Institute of Advanced Studies, P.O Box 175-00515, Nairobi, Kenya; Tel: +254701154487; Email: kirigonjenga@gmail.com

Sadia Isaack, MPH University of Nairobi, BSc Nursing International University of Sudan, P.O. Box 17643-00500 Nairobi, Kenya; Tel:+254722235777; Email: sadia.isaack12@gmail.com

What if there is a problem? Any complaint about the way you have been treated during the study or any possible harm you might suffer will be addressed. Please contact:

AMREF Health Africa in Kenya
Ethics and Scientific Review Committee
P.O. Box 30125-00100
Nairobi, Kenya
Tel: +254(0)206994000
Or
National Commission for Science Technology and Innovation
off Waiyaki Way, Upper Kabete
P. O. Box 30623-00100
Nairobi, Kenya
Land line: 020 400 7000, 020 224 1349, 020 331 0571, 020 800 1077
Wireless: 020 267 3550
Mobile: 0713 788 787/0735 404 245
WhatsApp: 0792 746282

Do you have any questions?

Yes ☐ No ☐

If yes, note the questions below:

_____

_____

_____

_____

Would you be willing to participate in the study?

Yes ☐ No ☐

Respondent's statement: I have read or have been read to the above considerations regarding my participation in the study. I have been given a chance to ask any questions and my questions have been answered to my satisfaction. I understand that the information I give will be kept private. I understand that I may withdraw from this study any time. My withdrawal from the study or my refusal to participate will in no way affect my employment status. I agree to participate in this study as a volunteer.

_____ _____

Signature of respondent Date

A study on cross-border FGM/C on women and girls amongst border communities in Kenya, Uganda, Ethiopia, Somalia and Tanzania

The survey questionnaire has EIGHT sections. The first section explores the socioeconomic profile. The second section assesses the knowledge of FGM/C. Social, cultural and religious-related norms are teased out in the third section, and the fourth section assesses the effects of FGM/C (health, psychological, socioeconomic, and political). Abandonment of FGM/C is the fifth; access to preventive and response-related services is sixth; cross-border FGM/C practices is the seventh and assessment on awareness of FGM/C law is the eighth.

SECTION A: SOCIOECONOMIC PROFILE

No.	Question	Responses/choices	Values
A01	Sex of respondent	Male	1
		Female	2
A02	Age of respondent	Type the age (Should be 18 years and above)	
A03	Marital status of the respondent	Single	1
		Married	2
		Separated/divorced	3
		Widowed	4
		Don't know	98
		Refused to answer	99
A04	Educational level of respondent	Illiterate (Do not know read and write)	1
		Church/Qur'an education	2
		Adult literacy	3
		Elementary (1–8)	4
		High school (9–12)	5
		TVET diploma	6
		Diploma	7
		First degree (BA/BSc)	8
		Don't know	98
		Refused to answer	99
A05	Ethnic background	Type in the ethnic group	
A06	Religious background	Muslim	1
		Christian	2
		Traditional religion	3
		Don't know	98
		Refused	99

B07	What is your main source of income/livelihood?	Unskilled wage labour	1
		Private sector employment	2
		Public sector employment	3
		Business owner	4
		Small and micro business (informal)	5
		Farmer	6
		Pastoralist	7
		Don't know	98
		Refused to answer	99
A08	Average monthly income	Below 1,000	1
		1,000–2,500	2
		2,500–5,000	3
		5,001–10,000	4
		Above 10,000	5
A09	How many children do you have?		
A10	Do you have daughters	Yes	1
		No	2
		Refused to answer	99
		If no, skip questions D05 and D06	
A11	Number of females circumcised in your household (write the number of daughters circumcised)	None of them are circumcised	1
		Don't know	98
		Refused to answer	99
		(If none of your daughters are circumcised, skip D06 and D07)	
A12	At what age were your daughters when they passed through the FGM/C ritual	Write the age of circumcised daughter/s	98
		Don't know	99
		Refused to answer	
A13	What was your reason for making your daughter to go through FGM/C	Religious	1
		Tradition/culture	2
		Health reason	3
		Better marriage prospects	4
		Higher bride wealth	5
		Enhance husband's pleasure	6
		Preserves virginity	7
		Limits woman's sexual desire	8
		Prevents immorality	9
		Brings honour to the family	10
		Lack of knowledge about the harmful nature of FGM/C	11
		Don't know	98
		Refused to answer	99

SECTION B: KNOWLEDGE OF FGM/C

No.	Item	Answers	Value
B01	How many different forms of FGM/C are there in your community? (If need to clarify, say How many different ways can the procedure be performed?)	Enter numeric response (start with 0) Don't know Refused to answer	98 99
B02	Can you describe the different ways a girl can be cut? (Use diagram of external genitalia) (Multiple responses are possible)	Partial or total removal of the clitoris and/or prepuce (type I) Partial or total removal of the clitoris and labia minora (type II) Infibulation; excision of the clitoris and sewing the labia minora and/or labia majora shut to form a small opening (type III) Nicking and pricking; cut without the removal of flesh (type IV) Other (please specify) _____ Don't know Refused to answer	1 2 3 4 5 98 99
B03	What is the nature/behaviour of cut girls? What do you think?	She is calm/not restless She is not very fast She is patient She is weak She doesn't break things/household utensils No tendency or interest to mix and play with boys It is impossible to know Other, please specify_____ Don't know Declined to answer	1 2 3 4 5 6 7 98 99
B04	From your observation, who has the MOST influence in encouraging the persistence of practice of FGM/C?	Mothers Fathers Girls themselves Grandmothers Grandfathers Uncles Aunties Siblings Relatives Religious leaders Elder women Don't know Refused to answer	1 2 3 4 5 6 7 8 9 10 11 98 99

No.	Item	Answers	Value
B05	In your community who are the circumcisers? (Multiple answers are possible)	An influential elderly woman	1
		An influential elderly man	2
		A nurse	3
		Mothers	4
		Fathers	5
		Grandmothers	6
		Doctors	7
		Health officers	8
		Don't know	98
		Refused to answer	99
B06	In your community What is the appropriate age for a girl to go through FGM/C	List the responses	

SECTION C: SOCIAL, RELIGIOUS AND MORAL NORMS

Using a scale of 1 to 5, with 1 being strongly disagree and 5 strongly agree, to what extent do you agree or disagree with the following statements?

		Strongly disagree	Disagree	Neutral	Somewhat agree	Strongly agree
No.	**Item**	**1**	**2**	**3**	**4**	**5**
C01	FGM/C marks the transition of a girl from childhood to being identified as an adult	1	2	3	4	5
C02	It is a religious duty to perform FGM/C	1	2	3	4	5
C03	FGM/C teaches girls to be obedient	1	2	3	4	5
C04	FGM/C has always been a part of our traditions	1	2	3	4	5
C05	The Bible contains verses that make FGM/C obligatory	1	2	3	4	5
C06	FGM/C is recommended/ endorsed in the Hadith of the Prophet Muhammad (SAW). So it is “Sunna” to perform FGM/C	1	2	3	4	5
C07	FGM/C does not cause any problems	1	2	3	4	5
C08	FGM/C shows respect to our elders	1	2	3	4	5
C9	FGM/C prepares girls for future childbirth	1	2	3	4	5
C10	FGM/C ensures that girls remain pure before marriage	1	2	3	4	5
C11	FGM/C ensures that girls retain their femininity	1	2	3	4	5

		Strongly disagree	Disagree	Neutral	Somewhat agree	Strongly agree
No.	**Item**	**1**	**2**	**3**	**4**	**5**
C12	The Hadith of the Prophet makes for a woman/ girl to undergo FGM/C obligatory	1	2	3	4	5
E13	FGM/C teaches girls to be respectful	1	2	3	4	5
E14	FGM/C is a completely safe practice	1	2	3	4	5
C15	FGM/C helps a girl stay a virgin until she marries	1	2	3	4	5
C16	FGM/C makes a girl clean	1	2	3	4	5
C17	FGM/C is a form of violence against women	1	2	3	4	5
C18	FGM/C is safer if done by a trained medical professional					

SECTION D: EFFECTS/CONSEQUENCES OF FGM/C

No.	Items	Responses/choices	Values	Skip
D01	Do you think FGM/C has health consequences?	Yes No Don't know Refused to answer	1 2 98 99	If no, skip F02; if yes, proceed to answer D02

For items beginning with D02, please tick the appropriate answer						
	Items	1 = Strongly isagree	2 = Disagree	3 = Neutral	4 = Agree	5 = Strongly agree
D02	FGM/C can cause a person to bleed	1	2	3	4	5
D03	FGM/C causes death	1	2	3	4	5
	FGM/C can spread HIV and AIDS and other STDs	1	2	3	4	5
D04	FGM/C can lead to pain in the female genitalia and cause urinary tract infections/problems	1	2	3	4	5
D05	FGM/C causes vaginal problems (discharge, itching and other infections)	1	2	3	4	5
D06	FGM/C causes menstrual problems (painful menstruations, difficulty in passing menstrual blood)	1	2	3	4	5
D07	FGM/C contributes to sexual problems (pain during intercourse, decreased satisfaction)	1	2	3	4	5
D08	FGM/C increases the risk of childbirth complications and newborn deaths	1	2	3	4	5
D09	FGM/C reduces sexual desire	1	2	3	4	5

Psychological problems						
D10	FGM/C causes depression	1	2	3	4	5
D11	FGM/C increases anxiety and post-traumatic stress disorder	1	2	3	4	5
D12	FGM/C reduces self-esteem	1	2	3	4	5
D13	Uncut girls are isolated					
Socioeconomic consequences Please use a "Yes" and "No" answer .Yes = 1, No = 2, Don't know = 98 and Refused to answer = 99						
D13	After FGM/C, girls drop out of school?	Yes No	1 2			
D14	After FGM/C, cut girls remain unmarried	Yes No	1 2			
D15	FGM/C forces girls to get married	Yes No	1 2			
D16	No one wants to marry uncut girls	Yes No	1 2			
D17	In my community, uncut girls are not wanted for marriage	Yes No	1 2			
D18	In my community, uncut girls do not have a good image	Yes No	1 2			
D19	Circumcision retards a girls economic empowerment/ development	Yes No	1 2			
D20	Once circumcised, the best a girl can do is to get married	Yes No	1 2			
D21	FGM/C increases medical costs for the family and the husband as a result of frequent infections and Caesarean section due to obstructed labour resulting from FGM/C	Yes No	1 2			

Political consequences Please use a "Yes" and "No" answer. Yes = 1, No = 2, Don't know = 98 and Refused to Answer = 99				
D22	Uncut girls are not allowed to participate in school-related clubs	Yes No Don't know Refused to answer	1 2 98 99	
D23	Uncut women are not allowed to participate in community meetings/ gatherings	Yes No Don't know Refused to answer	1 2 98 99	
D24	Uncut women are not allowed to participate in community-level participation	Yes No Don't know Refused to answer	1 2 98 99	
D25	Uncut women cannot run as a politician	Yes No Don't know Refused to answer	1 2 98 99	

SECTION E: DETERMINANT OF ABANDONMENT OF FGM/C

No.	Item	Answers	Value
E01	Do you think that FGM/C should be continued, or should it be abandoned?	Continued Abandoned Other (please specify) _____ Don't know Refused to answer	1 2 98 99
E02	Who should be involved in the programmes on the abandonment of FGM/C in your community? (Multiple answers are possible)	Myself Girls and women Men and boys Everyone in the community Community leaders Local government Teachers Local NGOs NGOs/UN agencies (e.g. UNICEF, UNFPA) Federal government Ministry of women's and children's affairs Ministry of health Other (please specify) _____ Don't know Refused to answer	1 2 3 4 5 6 7 8 9 10 11 12 13 98 99

Using a scale of 1 to 5, with 1 being strongly disagree and 5 strongly agree, to what extent do you agree or disagree with the following statements?

		1	2	3	4	5
E03	Men are key players in FGM/C practice	1	2	3	4	5
E04	Anti-FGM/C laws should be implemented in all countries	1	2	3	4	5
E05	The anti-FGM/C activities in this community are helping to reduce FGM	1	2	3	4	5
E06	It is much easier to perform FGM across the border	1	2	3	4	5
E07	Anti-FGM/C laws are stricter in Kenya/stricter in this area than across/cross-border	1	2	3	4	5

SECTION F: ACCESS TO PREVENTIVE AND RESPONSE-RELATED SERVICE DETERMINANT OF ABANDONMENT OF FGM/C

No.	Item	Answers	Categories	
			Yes [1]	No [2]
F01	What are some of the ways that can lead to the abandonment of FGM/C practice in your community?	Awareness raising/community sensitization Women/girl child education Alternative rights of passage (ARPs) Alternative economic activities for the circumcisers Other (specify)……		
F02	In your opinion, are the services helping the community change the social beliefs and values attached to FGM/C?	Elders have decided to stop the practice of FGM/C Circumcisers are refusing to cut girls Community members have started celebrating uncut girls Boys are promoting anti-FGM/C messages		
F03	In your community, what are some of the response-related services on FGM/C	Law enforcement Public declarations Health services Institutional care Psychosocial support (PSS) Referral Legal aid		
F03	Who are the formal service providers (preventive and response) (Allow participants to list service providers)	Community-based organizations NGOs Government Religious organizations Any other response		

SECTION G: CROSS-BORDER FGM/C PRACTICE

No.	Item	Categories	
		Yes [1]	No [2]
G01	Are you aware of any anti-FGM/C programme being taken in this community to try and stop the practice of FGM/C?	Yes No	1 2
G02	Is it easy or difficult to have a girl circumcised on the Kenyan side of the border?	Yes No	1 2
G03	Do people cross easily to have their daughters/kin circumcised across the border?	Yes No	1 2
G04	Do you intend to have your daughter, or your other female relatives, circumcised?	Yes No	1 2
G05	Do you intend to have your wife circumcised, if not done already?	Yes No	1 2
G06	Is FGM/C law in the cross-border area weak and does not hold people who practise FGM/C accountable?	Yes No	1 2
G07	Families that practise FGM/C do not face any legal repercussions in cross-border areas	Yes No	1 2

SECTION H: ASSESSMENT ON AWARENESS OF FGM/C LAW

No.	Item	Categories		
		Yes [1]	No [2]	
H01	Are you aware on the existence of laws that prohibit FGM/C practice?	Yes No	1 2	If yes, answer H02
H02	If you are aware, please list how the law prohibits FGM/C_____			
H03	Can you tell us what the existing law misses? _____			
H02	Have you ever heard of a person being penalized for breaking the law prohibiting FGM/C practice?	Yes No	1 2	
H03	If yes, how was the person/ family penalized? List			
H04	Do you know the penalty in FGM/C law?	Yes No	1 2	
G05	If yes to question H04, list them			
G06	What can be done to those who practise FGM/C? List			
G06	Families that practice FGM/C do not face any legal repercussions in cross-border areas			
G07	In your opinion, which are the three most important strategies to reduce FGM/C?	Enforcing the anti-FGM/C laws Education of a girl child Reduce early/child marriage Increasing knowledge on FGM/C practice in the community Seeking other ways of initiating girls into adulthood Providing another source of income to circumcisers Others (specify)_____		

End time_____ Thank you

II. Key informant interview guide

Informed consent form: key informant interviews

Understanding the impact of FGM/C amongst practising communities across Kenyan, Ugandan, Tanzanian, Somali and Ethiopian borders

General introduction

Welcome. Thank you for being here. My name is _____ and I am part of a research team working with GEM. We are trying to understand the impact of FGM/C amongst practising communities across Kenyan, Ugandan, Tanzanian, Somali and Ethiopian borders. The information you provide will be used to develop or improve interventions for women and young girls at the risk of FGM/C amongst cross-border communities in the five countries. We will not use your names or otherwise identify you personally in the analysis and reporting of the results of our discussions today.

You have been invited to take part in a research study as part of the key informants. Before you decide whether to participate or not, you need to understand why the research is being done and what it would involve. Please take time to read or to listen as I read the following information. You may talk to others about the study if you wish. Please ask me if there is anything that is not clear, or if you would like more information. You will be asked for your consent to enable audio-recording of the conversation. When all of your questions have been answered and you feel that you understand this study, you will be asked if you wish to participate in the study, and if yes to sign this informed consent form. You will be given a signed copy to keep.

Investigators

The study investigators are Meseret Kassahun, Owuor Olungah, Dora Kanabahita Byamukama, Esther Njenga and Sadia Isaack.

Study location

The study is being conducted across the borders of five countries: Kenya, Uganda, Tanzania, Somalia and Ethiopia.

Purpose of the research

What is the study? The purpose of the proposed study is to understand the impact of FGM/C amongst practising communities across Kenyan, Ugandan, Tanzanian, Somali and Ethiopian borders.

Why have I been invited to take part? You have been invited to participate in the study because you hold an important position in the community and you live in one of the countries we have selected. You might also have important information about the cross-border practices and how the law works at the local level and how the practice of FGM/C affects women, girls and other community members.

Description of the research

What will happen if I take part? If you agree to take part in the study, we will ask you to sign this form. You will also be asked to participate in an interview about your views and experiences on the research topic. We will audio-tape the interview so that the researcher does not have to write everything down.

How long will the interview last? The interview will last up to one hour.

Risks

What are the risks of the study? A risk may be a breach of confidentiality (something you say or audio-recorded data are accidentally provided to others) but we will take precautions to minimize this. You may also feel uncomfortable giving your views on FGM/C. You are free to ask me to stop or decline to answer any questions that you are uncomfortable with. An inconvenience may be the time and effort you take to participate in the study; however, this inconvenience is mitigated by the fact that this study on the impact of cross-border FGM/C will inform future programmes and interventions, which are for the well-being of all persons and the community as a whole.

Benefits

What are the benefits of participating? There are no direct benefits to you for participating in the study. You may find an indirect benefit in knowing that you participated in an important study that could inform programmes working in communities practising FGM/C in the region.

Confidentiality

Will my participation in the study be kept confidential?

The interview with you is confidential and will be conducted in private. We will not record your name on the interview form. In addition, your responses will be combined with responses from other service providers. This form will be kept under lock-and-key. The information gathered will be stored in a password-protected computer in GEM's office in Nairobi that only the study team can access. Your signature at the bottom of this form will not be used for any other purpose apart from proving that you have read or have been read to the information and that you have understood this information.

Voluntariness

What are my rights as a research participant/subject? Your participation in this study is completely voluntary. If you decide not to participate, you will not lose any existing benefits to which you are entitled. Refusing to participate will not affect your status in any way.

If you agree to participate in this study, you may end your participation at any time without penalty or loss of existing benefits to which you are entitled. You are free to withdraw from the study at any time.

Additional information

What will I receive for participating?

You will not receive any compensation for participating in the study.

What will happen to the results of the research study? The results of the study will be presented to organizations that implement FGM/C programmes, the Governments of Kenya, Uganda, Ethiopia, Somalia and Tanzania and international partners who support activities to end FGM/C. The study findings are expected to inform programmes/interventions aimed at ending FGM/C in the region.

Anonymized data will be made publicly available to publish the knowledge gained as a result of this study, which means it could be used in future research without additional consent. Any report or data that is made available to the public will not include your name or any other individual information by which you could be identified.

Who has reviewed the study for ethical issues? The Institutional Review Board of AMREF Health Africa in Kenya ESRC.

Contacts

What if I need more information? If you have a concern about any aspect of the study, you should contact the researchers, who will do their best to answer your questions. Information on researchers and their contacts is provided as follows:
Meseret Kassahun, PhD, P.O. Box 30577-00100, Nairobi, Kenya;
Tel. +254715542562; Email: Meseretkassahun@gmail.com
Charles Owuor Olungah, PhD, MPhil, BA, University of Nairobi, P.O. Box 30197-00100, Nairobi, Kenya; Tel: +254722217132; Email: owuorolungah@gmail.com
Hon. Dora Kanabahita Byamukama, LAW-Uganda, P.O. Box 1032, Kampala, Uganda; Tel: +256772507047; Email: dkanabz@gmail.com
Esther Njenga, MA, BA, Law University of London, Institute of Advanced Studies, P.O Box 175-00515, Nairobi, Kenya; Tel: +254701154487; Email: kirigonjenga@gmail.com
Sadia Isaack, MPH University of Nairobi, BSc Nursing International University of Sudan, P.O. Box 17643-00500 Nairobi, Kenya; Tel:+254722235777; Email: sadia.isaack12@gmail.com

What if there is a problem?

Any complaint about the way you have been treated during the study or any possible harm you might suffer will be addressed. Please contact:
AMREF Health Africa in Kenya
Ethics and Scientific Review Committee
P.O. Box 30125-00100
Nairobi, Kenya
Tel: +254(0)206994000
Or
National Commission for Science Technology and Innovation
off Waiyaki Way, Upper Kabete
P. O. Box 30623-00100
Nairobi, Kenya
Land line: 020 4007000, 020 2241349, 020 3310571, 020 8001077
Wireless: 020 267 3550
Mobile: 0713 788 787/0735 404 245
WhatsApp: 0792 746282

Do you have any questions?

Yes ☐ No ☐

If yes, note the questions below:

_____

_____

_____

_____

Would you be willing to participate in the study?

Yes ☐ No ☐

Respondent's statement: I have read or have been read to the above considerations regarding my participation in the study. I have been given a chance to ask any questions and my questions have been answered to my satisfaction. I understand that the information I give will be kept private. I understand that I may withdraw from this study any time. My withdrawal from the study or my refusal to participate will in no way affect my employment status. I agree to participate in this study as a volunteer.

_____ _____

Signature of respondent Date

Interviewer's declaration: I, _____, have explained to the respondent in a language she or he understands the procedures to be followed in this study, and the risks and benefits involved.

_____ _____

Signature of interviewer Date

_____ _____

Signature of witness (if any) Date

KII GUIDING QUESTIONS: SPECIFIC ACTORS

A.	**National-level actors (Gender ministry, Prosecution)**	**Issues that require more probing**
	What issues in your opinion arise from the regional and national anti-FGM laws and policies that hinder their use in eradicating FGM/C?	Probe (Any gaps in the law and policy? What challenges are there both legal and practical?)
	Given your national reach and perspective on the FGM/C issue, what have you noticed are the drivers that perpetuate the continuance of this practice?	Probe (Look out for social, cultural and economic drivers with specific interest in border communities)
	What in your observation has been the impact of FGM/C on women and girls in this community?	Probe (Effects on health, education, social and economic participation, community status among others; How do these manifest?)
	What interventions are in place to address FGM/C? (especially along border communities)	Probe (Most common types of interventions? Their success rate? What informs/indicates success? What other interventions are needed? Are there any national government interventions?)
	What changes if any have you noticed in the practice of FGM/C within border communities?	Probe (Time of the year the practice takes place, practitioners, type of FGM/C? What can the change be attributed to? Look out for change in opinions among community members, legal sanctions, etc.)
	What has been your experience or knowledge if any of cross-border FGM/C?	Probe (Why do people choose to cross the border? Look out for legal, social and/or cultural reasons)
B.	**Local State legal actors (Chiefs/police/prosecutors/ judges/immigration officers)**	
	Are you aware of any regional or national laws and policies about FGM/C?	Probe(Which ones and from where? If yes, any training given (by whom)? Any training needed? Any concerns with the law/policy, e.g. gaps, challenges with practical application (evidence etc.? If, yes, what can be done?)
	In your opinion what is the level of knowledge about the law in the community?	Probe (How do they know? Do they understand the law? Has knowledge of the law aided in abandonment of the practice? If no, why the defiance? How can they use the law for abandonment?)
	Do you think a law/policy that allows you to take action on perpetrators of cross-border FGM/C would be helpful in tackling the practice?	Probe (How would it be helpful? What would be its practical application? Arrest, prosecution, sentencing, etc.)

	Have you dealt with any FGM/C cases and in particular cross-border cases?	Probe (How do you deal with them? Any referral system? If yes, how does it work? Any challenges and how can these be overcome? Any opportunities that have helped, e.g. collaborative efforts? What reasons do people give for crossing the border for FGM/C services? Experience with regard to evidence, witnesses, etc? Do you have the mandate to take action on cross-border FGM cases? Any referral or collaborative efforts?)
	Through your work what reasons for practising FGM/C have been mentioned to you by community members?	Probe (Social, cultural and economic reasons; Connection with sanctions/benefits)
	What community activities if any do you undertake to address FGM/C abandonment?	Probe (Are there actors trying to intervene? Who are they and what are they doing? Are the activities successful?)
	What in your observation has been the impact of FGM/C on women and girls in this community?	Probe (Effects on health, education, social and economic participation, community status among others)
	What changes if any have you noticed in the practice of FGM/C within the community?	Probe (Time of the year the practice take place, practitioners, type of FGM/C?)
	Are there actors or organizations dealing with FGM/C and in particular cross-border FGM/C?	Probe (Who are they and where are they? What types of interventions? Levels of success? Weaknesses and strengths of the interventions and how they can be scaled up?)
C.	**Local political leaders or anti-FGM activists**	
	What do you think is the role of politicians/ influencers like yourself in the FGM/C discussion?	Probe (Their influence in changing behaviour in the community? Their role in continuity on the practice?)
	What is your opinion on the law banning FGM/C?	Probe (Knowledge of law? Opinion on content, any gaps or disagreeable provisions Opinion on regional law and coordination)
	Why does the community continue to practise FGM/C?	Probe (Social, cultural and economic reasons? Benefits/sanctions associated with adherence?)
	What changes if any have you seen in how the community practises FGM/C?	Probe (Form of practice, time, place, celebrations, etc.)
	Do you think that the community in general expects you to continue or abandon FGM/C as their leader?	Probe (Why? What would be the consequence of non-compliance with the common position?)
	As a member of this community what have you noticed as being the impact of FGM/C on women and girls?	Probe (Education, economic, social status, health, etc.)

	Thinking back 5 years, are the cases of FGM/C fewer or more presently?	Probe (Reasons for any variation in numbers. Looking for change in behaviour/attitude and what has facilitated the change)
	How, if at all, have the opinions of people in your community changed on the practice of FGM/C over the past 12 months/year?	Probe (What do you think has contributed to this change?)
	What is your view on cross-border FGM/C practices?	Probe (If it happens? What is encouraging it? How can it be handled? Legal sanctions, etc.? Who is to blame?)
	What organizations if any have FGM/C interventions in this area?	Probe: (What kind of interventions? By whom and where? What is your view on their work? Weaknesses, strengths, improvements, etc.)
	What is the best way to deal with FGM/C in the community?	Probe (What interventions are presently working? What could be done to make it work? Cultural changes that may be necessary? Shift in social norms? Any other suggestions?)

D. Non-State community-level actor (circumciser/ elders, male and female)

	Who do you think is responsible for tackling the issue of cutting in your community?	Probe (Look out for community influencers and authority holders)
	What is your opinion on the use of the law to address FGM/C?	Probe (Benefits, shortcomings? Is it a deterrent, is there defiance? Community members' views? Do they know and understand the law? Have they used it?)
	Do you personally think that FGM/C should be continued, or should it be abandoned?	Probe (Look for reasons given: social, cultural and economic. Look out for benefits/sanctions)
	Do you think that the community expects you to continue or abandon FGM/C?	Probe (Why and what would inform their decision?)
	Are there cases of cross-border FGM/C practices in the community?	Probe (Frequency of cross-border FGM/C? Who crosses, where and why? What can be done about the crossings and who is responsible?)
	What are the risks associated with undergoing FGM/C?	Probe (Look for knowledge on negative consequences on health and well-being, etc.)
	As a member of this community what have you noticed as being the impact of FGM/C on women and girls?	Probe (Education, social, economic impact, etc.)
	How, if at all, have the opinions and practices of people in your community changed on the practice of FGM/C over the past 5 years?	Probe (Time, place, practitioner, numbers, celebrations, age of cutting, benefits/sanctions, etc.)

	Do you personally know of anybody that has not cut their daughter?	Probe (How is the family treated by the community? How is the girl/woman treated by the community?)
	Are there organizations in the community that are campaigning against FGM/C?	Probe (Which organizations? Where they are located? What types of interventions/activities they undertake; Success or not of their operations? Community views of these interventions? etc.)
	What would be the best approaches to end FGM/C?	Probe (The social norms and their impacts; People-driven approaches; Community empowerment; Legal sanctions, etc.)
	Is there any other issue in the community regarding FGM/C practice and abandonment that you may wish to let us know?	

F. Community-based organizations (NGO, CBO or FBO)

	What is your role in addressing FGM/C in this community?	Probe (Types of interventions, where, success, etc? Look out for behaviour change interventions; Have economic interventions had an effect on FGM/C?)
	From your interventions with the community what are the reasons given for the continuation of FGM/C?	Probe (For social, cultural and economic reasons; Sanctions/benefits)
	Have you dealt with any cross-border FGM/C instances?	Probe (How this knowledge came to their attention? Action taken? Reasons given for crossing the border? Effects of the crossings Consequences on their programming?)
	What do you think needs to be done to address cross-border FGM/C?	Probe (For legal and policy, e.g. gaps identified, implementation, etc.; Service provision, e.g. health, education, etc.; Interventions that address social norms)
	Have you noticed any changes in the practice of FGM/C within this community?	Probe (Prevalence, time, place, age of cutting, practitioner, ceremonies, change in attitude/ behaviour, etc.)
	How would you rate the success of your interventions?	Probe (Indicators of success; Difficulties experienced; Change in social norms in the community; Change agents noted among others)
	As a principal actor in the anti-FGM/C activities, what should be done differently to achieve desired results?	Probe (New approaches; Lessons learnt; Strengths and weaknesses of approaches)
	Is there any other issue you would wish to have us know regarding the anti-FGM/C approaches in this community and in cross-border activities?	

G.	School administrators (Government schools)	
	What is the average number of girls enrolling in school at first grade in this area?	Probe (In comparison to boys)
	Do these girls all transition to high school?	Probe (If no, why? If FGM is mentioned, probe on drivers and effects of FGM on education; Are there any girls who return to school after undergoing FGM? Percentage?)
	Do you have any anti-FGM programmes within the school curriculum/activities?	Probe (What kind and why those particular interventions?)
	Have you noticed any changes in how FGM is practised within this community?	Probe (Prevalence, time, place, practitioner, ceremonies etc.)
	Are there girls who cross the border to undergo FGM/C?	Probe (What reasons are given for crossing the border? What reasons are given for undergoing FGM/C? Social, cultural, etc.)
	Do you see FGM/C practices as hindering the development and empowerment of girls/women in this community?	Probe (Effects on educational attainment; Effects on economic empowerment; Effects in general emancipation)
	From your perspectives, how best can we deal with the practice of FGM/C in this community?	Probe (On social norms change; Education as the best route; Community economic empowerment; Community dialogues among others)
	Is there any other issue that you may consider important regarding the practice of FGM/C and its effects on girls that you would want to share with us?	

H.	Health centre (government facility)	
	Do you receive cases of FGM/C-related complications? What interventions do you think would help stop FGM/C in this area?	Probe (What sort of cases? What are the effects of FGM/C on the victims? Estimation of how many cases per day/week)
	Do you have a procedure to record FGM/C-related cases?	Probe (How is this information used? Referrals to law enforcement, other health services?)
	Do you have cases of cross-border referrals?	Probe (On cases attended to that come across the border; People demanding for services from across the border; Nature of border practices in relation to health seeking patterns)
	Do you have awareness/education sessions for girls and women on the health consequences of FGM/C?	Probe (Any reasons/opinions raised by women and girls as to why they undergo FGM/C? Any changes in the practice that you have observed in terms of severity?)

	Are there people demanding for medical services in the practice of FGM/C?	Probe (Medicalization of FGM/C; Reasons for medicalization; Practices in the facilities among others)
	What changes have you observed in the practice of FGM/C in this community?	Probe (Time, place, practitioner, age of cutting, numbers, etc.)
	From a medical perspective, what would be the best way to eradicate FGM/C in the community?	Probe (Current practices in interventions that are successful; Possible scale-up; Role of social norms change? And how to achieve this)
	Is there any other concern that you would wish to raise regarding the link between FGM/C in the community and the health-care system?	

III. Focus group discussion guide

Informed consent form: focus group discussion interviews

Understanding the impact of FGM/C amongst practising communities across Kenyan, Ugandan, Tanzanian, Somali and Ethiopian borders

Let's start by going around the circle and having each person introduce himself/herself.

(Members of the research team should also introduce themselves and describe each of their roles.)

<table>
<tr><td>Use this section to guide the discussion</td><td colspan="3">Day: [___|___] Month: [___|___] Year: [___|___|___|___]</td></tr>
<tr><td>Country/border</td><td colspan="3"></td></tr>
<tr><td>Venue of interview</td><td colspan="3"></td></tr>
<tr><td>Time
[24-hour]</td><td colspan="2">Start:
Hour: [___|___]
Minute: [___|___]</td><td>End:
Hour: [___|___]
Minute: [___|___]</td></tr>
<tr><td rowspan="13">Participants' characteristics</td><td>Participant No.</td><td>Gender
(Male – M;
Female – F)</td><td>Estimated age
(in complete years)</td></tr>
<tr><td>1</td><td></td><td></td></tr>
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<tr><td>12</td><td></td><td></td></tr>
<tr><td>Name of note taker</td><td colspan="3">_____</td></tr>
<tr><td>Name of facilitator</td><td colspan="3">_____</td></tr>
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General introduction

Welcome. Thank you for being here. My name is _____ and I am part of a research team working with GEM. We are trying to understand the impact of FGM/C amongst practising communities across Kenyan, Ugandan, Tanzanian, Somali and Ethiopian borders. The information you provide will be used to develop or improve interventions for women and young girls at the risk of FGM/C amongst cross-border communities in the five countries. We will not use your names or otherwise identify you personally in the analysis and reporting of the results of our discussions today.

You have been invited to take part in a research study as part of the key informant. Before you decide whether to participate or not, you need to understand why the research is being done and what it would involve. Please take time to read or to listen as I read the following information. You may talk to others about the study if you wish. Please ask me if there is anything that is not clear, or if you would like more information. You will be asked for your consent to enable audio-recording of the conversation. When all of your questions have been answered and you feel that you understand this study, you will be asked if you wish to participate in the study, and if yes to sign this informed consent form. You will be given a signed copy to keep.

Investigators

The study investigators are Meseret Kassahun, Owuor Olungah, Dora Kanabahita Byamukama, Esther Njenga and Sadia Isaack.

Study location

The study is being conducted across the borders of five countries: Kenya, Uganda, Tanzania, Somalia and Ethiopia.

Purpose of the research

What is the study? The purpose of the proposed study is to understand the impact of FGM/C amongst practising communities across Kenyan, Ugandan, Tanzanian, Somali and Ethiopian borders.

Why have I been invited to take part? You have been invited to participate in the study because you hold an important position in the community, and you live in one of the countries we have selected. You might also have important information about the cross-border practices and how the law works at the local level and how the practice of FGM/C affects women, girls and other community members.

Description of the research

What will happen if I take part? If you agree to take part in the study, we will ask you to sign this form. You will also be asked to participate in an interview about your views and experiences on the research topic. We will audiotape the interview so that the researcher does not have to write everything down.

How long will the interview last? The interview will last up to one hour.

Risks

What are the risks of the study? A risk may be a breach of confidentiality (something you say or audio-recorded data are accidentally provided to others) but we will take precautions to minimize this. You may also feel uncomfortable giving your views on FGM/C. You are free to ask me to stop or decline to answer any questions that you are uncomfortable with. An inconvenience may be the time and effort you take to participate in the study; however, this inconvenience is mitigated by the fact that this study on the impact of cross-border FGM/C will inform future programmes and interventions, which are for the well-being of all persons and the community as a whole.

Benefits

What are the benefits of participating? There are no direct benefits to you for participating in the study. You may find an indirect benefit in knowing that you participated in an important study that could inform programmes working in communities practising FGM/C in the region.

Confidentiality

Will my participation in the study be kept confidential?

The interview with you is confidential and will be conducted in private. We will not record your name on the interview form. In addition, your responses will be combined with responses from other service providers. This form will be kept under lock-and-key. The information gathered will be stored in a password-protected computer in GEM's office in Nairobi that only the study team can access. Your signature at the bottom of this form will not be used for any other purpose apart from proving that you have read or have been read to the information and that you have understood this information.

Voluntariness

What are my rights as a research participant/subject? Your participation in this study is completely voluntary. If you decide not to participate, you will not lose any existing benefits to which you are entitled. Refusing to participate will not affect your status in any way.

If you agree to participate in this study, you may end your participation at any time without penalty or loss of existing benefits to which you are entitled. You are free to withdraw from the study at any time.

Additional information

What will I receive for participating?

You will not receive any compensation for participating in the study.

What will happen to the results of the research study? The results of the study will be presented to organizations that implement FGM/C programmes, the Governments of Kenya, Uganda, Ethiopia, Somalia and Tanzania and international partners who support activities to end FGM/C. The study findings are expected to inform programmes/interventions aimed at ending FGM/C in the region.

Anonymized data will be made publicly available to publish the knowledge gained as a result of this study, which means it could be used in future research without additional consent. Any report or data that is made available to the public will not include your name or any other individual information by which you could be identified.

Who has reviewed the study for ethical issues? The Institutional Review Board of AMREF Health Africa in Kenya ESRC.

Contacts

What if I need more information? If you have a concern about any aspect of the study, you should contact the researchers, who will do their best to answer your questions. Information on researchers and their contacts is provided as follows:

Meseret Kassahun, PhD, P.O. Box 30577-00100, Nairobi, Kenya;

Tel. +254715542562; Email: Meseretkassahun@gmail.com

Charles Owuor Olungah, PhD, MPhil, BA, University of Nairobi, P.O. Box 30197-00100, Nairobi, Kenya; Tel: +254722217132; Email: owuorolungah@gmail.com

Hon. Dora Kanabahita Byamukama, LAW-Uganda, P.O. Box 1032, Kampala, Uganda; Tel: +256772507047; Email: dkanabz@gmail.com

Esther Njenga, MA, BA, Law University of London, Institute of Advanced Studies, P.O Box 175-00515, Nairobi, Kenya; Tel: +254701154487; Email: kirigonjenga@gmail.com

Sadia Isaack, BSc Nursing, MPH, P.O. Box 17634-00500, Nairobi, Kenya; Tel: +25472223577; Email: sadia.isaack12@gmail.com

What if there is a problem?

Any complaint about the way you have been treated during the study or any possible harm you might suffer will be addressed. Please contact:

AMREF Health Africa in Kenya

Ethics and Scientific Review Committee

P P.O. Box 30125-00100

Nairobi, Kenya

Tel: +254(0)206994000

Or

National Commission for Science Technology and Innovation
off Waiyaki Way, Upper Kabete
P. O. Box 30623-00100

Nairobi, Kenya

Land line: 020 4007000, 020 2241349, 020 3310571, 020 8001077
Wireless: 020 267 3550
Mobile: 0713 788 787/0735 404 245

WhatsApp: 0792 746282

Do you have any questions?

Yes ☐ No ☐

If yes, note the questions below:

_____

_____

_____

_____

Would you be willing to participate in the study?

Yes ☐ No ☐

Respondent's statement: I have read or have been read to the above considerations regarding my participation in the study. I have been given a chance to ask any questions and my questions have been answered to my satisfaction. I understand that the information I give will be kept private. I understand that I may withdraw from this study any time. My withdrawal from the study or my refusal to participate will in no way affect my employment status. I agree to participate in this study as a volunteer.

_____ _____

Signature of respondent Date

Interviewer's declaration: I, _____, have explained to the respondent in a language she or he understands the procedures to be followed in this study, and the risks and benefits involved.

_____ _____

Signature of interviewer Date

_____ _____

Signature of witness (if any) Date

What are the drivers of cross-border FGM/C practices among communities living along the borders of Kenya, Uganda, Tanzania, Ethiopia and Somalia?	
Which communities reside here and what is your opinion about the practice of FGM/C among communities living here?	Probe (What makes people living here practise FGM/C? Who practises FGM/C? Which part of the border is FGM/C most common? Why do you say so? What types of FGM/C are practised by communities living here? Who performs the FGM/C? At what age do women undergo FGM/C? What is happening currently in as far as FGM/C practices is concerned? Is the FGM/C practice increasing or decreasing? What are the reasons for the changes? What are the benefits of FGM/C if it is done on either side of the border?)
What is involved in the practice of FGM/C among the communities in this border?	Probe (What does FGM/C mean for communities living here? What is required to be available before, during and after the actual cut? Where is the practice conducted? Have these changed over time? If yes, in what ways have these changed over time?)
In your opinion, who is involved in FGM/C practices on either side of the border?	Probe (Who are directly involved and why? Who is indirectly involved and why? What are the specific roles of people involved in FGM/C? How have the roles of people involved in FGM/C changed over time? What may be the reasons for such changes in roles? What are the roles of men in FGM/C? What are the roles of women in FGM/C? What are the roles of parents in the FGM/C process?)
What motivates communities living in this border point to practise FGM/C?	Probe (What are the social or cultural practices that encourage FGM/C? Prestige, fame, social status, "real woman feeling", etc}.?What are the social or cultural benefits of FGM/C among communities living here? What religious practices encourage FGM/C? What are religious benefits among communities living here? What are the economic/financial benefits of FGM/C? How does each of these motivators manifest in either of the sides of the border? Are there changes in the trends for these motivators? If yes, describe the changes in trends and the possible reasons for these? Explore implementation of anti-FGM legislation and interventions/ education and changes in perspectives of perpetrators)
What should be done to stop this practice among the cross-border communities here?	Probe (Specific action and why the actions are recommended? Are the actions the same for men, women, girls, elders, religious leaders? Healthcare providers, the police and courts of law?)
Has your daughter/wife undergone this practice?	Probe (How this has affected her and how this has affected you? What is your role in ending FGM/C as the man of the house? (question for male FGD participant)
Are there girls in this community who have not undergone FGM/C?	Probe (Description of the girls/women? Possible reasons for them stopping the practice? How does the community view them? How does the community living here perceive girls who do not undergo FGM/C? What challenges do people who decline FGM/C face? How do these differences manifest across both sides of the border?)
Are there people from across the border who prefer/have it done here?	Probe (In your opinion why do they prefer it done here? What drives them across? Are more people crossing to Kenya or the other country?)
What enhances/increases the rate of the practice here?	Probe (Role of the community in enhancing the practice; Social, economic and psychological drivers; Social norms and related concerns)

Knowledge of existing national and regional legislative and policy frameworks relevant to FGM and status of the implementation	
Do you consider FGM/C legal or illegal in this country?	Probe (Why do you consider it illegal/legal? What happens in this community if anyone is caught practising FGM/C in this area? What are your thoughts about laws existing to ban FGM/C in this country/the other country?)
What laws or regulations and institutions are available to fight against FGM/C in this country?	Probe (Which ones are you aware of? Ask separately for each of the provisions or laws cited, what is the legislation/law about? How is it being implemented currently in this region? Who implements it? What are the successes or failures/challenges in its implementation in fighting FGM/C in this community? What can be done to improve/sustain its implementation in your area? What do you think government should do to end FGM/C?)
Are you aware about any anti-FGM campaigns or non-FGM/C campaign that has influenced FGM/C?	Probe (Description of some of the campaigns? The people involved (government, CSOs, community members, religious leaders, etc.? The extent to which such campaigns influenced FGM in the target communities and services delivered to the community? Successes and failures of the campaigns?)
What is the impact of FGM/C on women's and girls' health, social and economic status in the border communities?	
Are women/girls in this community allowed to engage in socioeconomic activities such as work, income generating activities, business, public events, politics, etc.?	Probe (If yes, what is the extent of their involvement in these activities? If no, what are the reasons for their lack of involvement? Has the level of involvement in this area changed over time? How have they changed? What is the community's general perception of this kind of change?)
Does undergoing FGM/C affect girls' education and participation in social and economic activities?	Probe (How does this manifest? How can this be reversed? Is education seen in this community as desirable for girls?)
How much does it cost one to have FGM/C done in your community and across the border?	Probe (In your opinion do we have differences in price? What other forms of payments are undertaken?)
What do you think are some of the effects of FGM/C to the victims/ parents and the community at large?	Probe (State the effects; How do these effects manifest in the life of the victim and in the community at large? Are these effects immediate or long term? Probe social, health and economic effects)
What are the social norms and practices related FGM/C and the level to which these are upheld or contested by cross-border communities in Kenya, Uganda, Tanzania, Ethiopia and Somalia?	
What are the changes in the practice of FGM/C?	Probe (Changes in severity of the cut, age of the cut, medicalization, abandonment of the practice; What has brought about the changes noted?)
Do you know of anybody who has abandoned the practice?	Probe (Attitude of the community towards abandonment; Barriers to abandonment; Consequences of continuing or abandoning? What are the characteristics of abandoning families?)

Would you wish FGM/C for a daughter/granddaughter?	Probe (Why?)
What is the best way in this community to deal with FGM/C?	Probe (Acceptable strategies; Cultural strategies and what may change the norms; Legal strategies and shortcomings; Community-driven empowerment)
Do you have any other issue that the community deems important regarding the FGM/C practice?	

Closing

Thank you very much for sharing your time and helping us understand the practice and the impact of FGM/C from the context of cross-border communities found in this region. The information you have shared will help people here in your community and throughout the entire region develop and improve interventions aimed at eradicating FGM/C among the cross-border communities in the five countries where this study is being conducted. As a reminder, we will not share the discussion with anyone outside the study team and you will not be identified in any results we share with others. Remember to not share the information we've discussed today with anyone outside of this group, so we keep everyone's opinions private. Thank you for participating in the discussion today.