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

Political Economy Analysis, Kenya

Short version

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Options

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amref health africa

ORCHID PROJECT
WORKING TOGETHER TO END FEMALE GENITAL CUTTING

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

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Contents

List of Abbreviations

ALM	Africa-led Movement
CSO	Civil Society Organisation
DHS	Demographic and Health Survey
FCDO	Foreign, Commonwealth and Development Office
FGM/C	Female Genital Mutilation/Cutting
GDP	Gross Domestic Product
HDI	Human Development Index
IMF	International Monetary Fund
PEA	Political Economy Analysis
SDG	Sustainable Development Goal

Introduction

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

Why do we need a Political Economy Analysis and how will we approach it?

Political Economy Analysis (PEA) draws out the political and intersectional dimensions of a context and then actively uses this information to inform programming. PEA analysis is necessary at the start of a programme to ensure that interventions are designed to maximize opportunities (e.g. government buy-in and civil society organisation (CSO) infrastructure) and think through how to navigate challenges. This PEA is focused on mapping the landscape in relation to ending FGM/C in Kenya. This PEA answers questions around: the level and extent of government commitment; the existence and effectiveness of legislation and policies; prevalence rates and diversity (religion, ethnicity, age, type, socio economic factors and triggers); the capacity and resources of civil society as a vehicle to end FGM/C; and the nature and number of end FGM/C interventions in existence. The insights in this detailed PEA will enable the programme to make strategic and evidence-based decisions around where to work, and which interventions should be resourced because they are most likely to work.

Country Profile

Summary

Population: The Kenya population is in 2019 estimated at 47.6 million (of which 23.5m were males and 24.0m were females).[1]

Languages, ethnic backgrounds and religion: Kenya has a very diverse population that includes many ethnic, racial and linguistic groups.

Political System: The Republic of Kenya is a unitary State run by the National Government and **47 county governments**.

Economic and Development Status: According to the International Monetary Fund (IMF), the Gross Domestic Product (GDP) of Kenya is $101 billion (nominal) and $243 billion (PPP).[2]

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[1] 2019 Kenya Population and Housing Census Results, November 2019, available at https://www.knbs.or.ke/?p=5621 [Last Accessed 21 February 2021].

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

Kenya ranks **62 out of 195 countries** in the IMF GDP rank, 66th according to the World Bank and 65 according to the UN. According to the 2020 Human Development Report, Kenya ranks **143 out of 189 countries** in the Human Development Index (HDI), positioning the country in the medium human development category.

National prevalence of FGM/C and Diversity

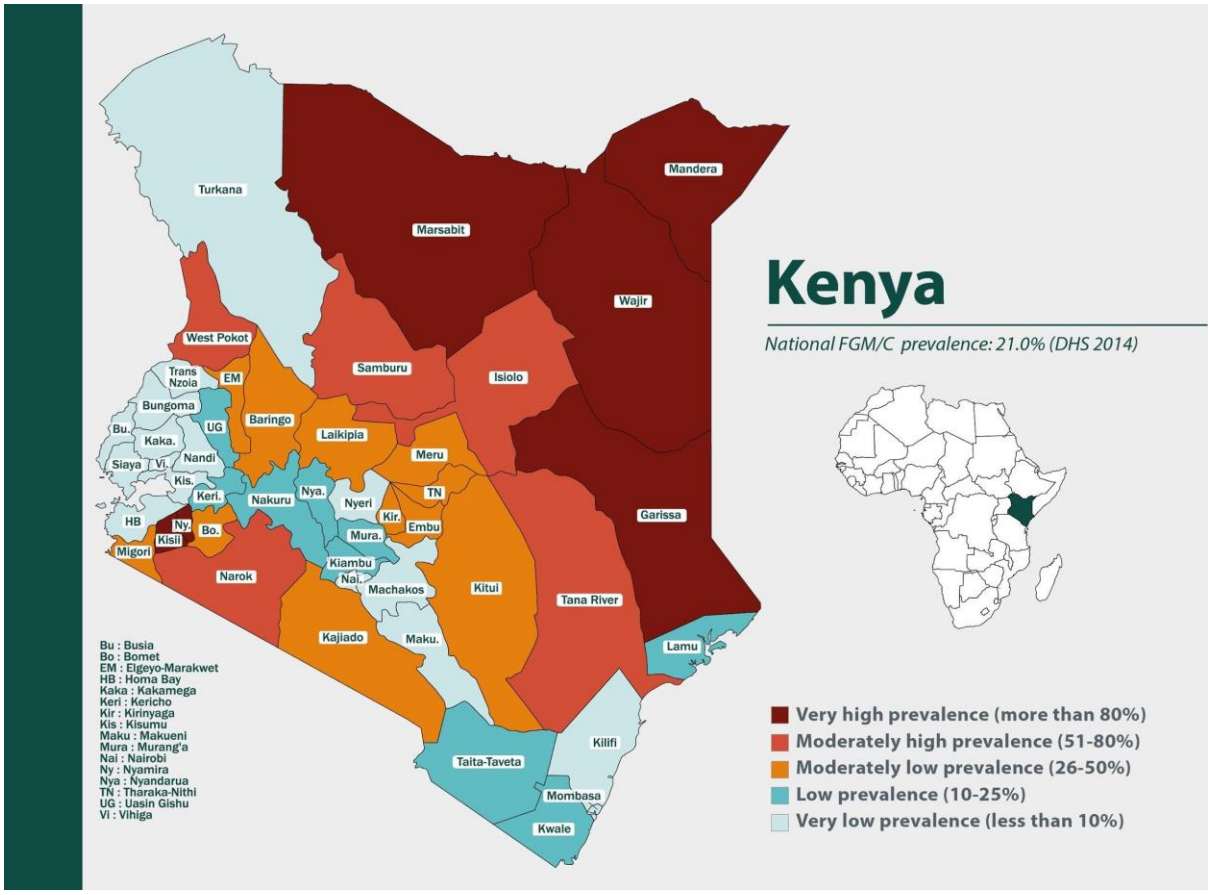
Nationally representative data on FGM/C in Kenya is available from the Demographic and Health Surveys (DHS). Data from the 2014 DHS[3] show that national prevalence of FGM/C among women aged 15-49 is 21.0%.[4] Prevalence declined by about 17 percentage points over the past two decades, from 37.6% in 1998 to 21.0% in 2014. Girls and women in rural areas are more likely to undergo FGM/C than those in urban areas.

County variations: The prevalence of FGM/C in Kenya varies greatly among the 47 counties (Annex I). In some counties, such as Mandera, Wajir, Garissa, Marsabit and Nyamira, the prevalence is very high (more than 90%). In other counties, the prevalence is very low (less than 2%), for example in Siaya, Kisumu, Bungoma and Kakamega (see Figure 1, below).

Figure 1. Geographic variations in FGM/C prevalence, Kenya (2014)

[3] The statistics presented on the national FGM/C prevalence need to be interpreted with caution as the reality might be more nuanced. First of all, the most recent data is 7 years old (and does therefore not reflect recent trends/changes) and second of all, the DHS is based on self-reports by women interviewed. See also Yoder, P. Stanley, and Shanxiao Wang. 2013. Female Genital Cutting: The Interpretation of Recent DHS Data. DHS Comparative Reports No. 33. Calverton, Maryland, USA: ICF International, available at https://dhsprogram.com/pubs/pdf/cr33/cr33.pdf [Last Accessed 17 February 2021].

[4] DHS 2014, p. 331.



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

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

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

Age of cutting: Distribution of women by age of cutting shows that 2.3% underwent FGM/C before the age of 5, 26.6% at age 5-9, 42.6% at age 10-14, and 26.9% at age 15 or older. There is some evidence of a trend over time suggesting that girls are undergoing FGM/C at a younger age in Kenya.

Estimates of the number of girls at risk of FGM/C in Kenya: Despite important progress made in the past two decades in Kenya, and declining in FGM/C prevalence, a considerable number of girls and young women remain at risk. Approximately 911,000 girls alive today in Kenya are estimated to be at risk of FGM/C before they reach the age of 18 years.

The impact of Covid-19: Emerging data indicates that Covid-19 has had a detrimental impact on declining rates of FGM/C. UNFPA states that as a result of Covid-19; *"it is anticipated that 2 million cases of FGM will occur between 2020 and 2030 that could have been averted, resulting in a 33 per cent reduction in the progress toward ending this harmful practice*."[5] Key local stakeholders interviewed for this PEA also confirm an increase in girls being cut as a direct result of Covid-19 measures.

Root Causes: The root causes for FGM/C in Kenya differ. All are manifestations of the control that society exercises over women in stark comparison to men, whether the reasons for FGM/C revolve around the perceived need to preserve girls' virginity or to control female sexuality; social expectations associated with family honour; anticipation of higher dowries for females perceived as 'beautiful' or 'chaste' due to their FGM/C status; or the fact that anti-FGM/C laws are not enforced.[6] The societal incentives and repercussions associated with FGM/C help perpetuate the practice and the inequalities it engenders.[7]

Ratifications of human rights treaties: The Kenyan government has ratified all treaties that are relevant to the elimination of FGM/C, including the CEDAW Convention, the CRC Convention and the Maputo Protocol.

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[5] UNFPA, UNICEF (2020) (n. 13)

[6] WHO (2008). *Eliminating Female Genital Mutilation: An Interagency Statement*, WHO, Geneva, available at https://apps.who.int/iris/bitstream/handle/10665/43839/9789241596442_eng.pdf?sequence [Last Accessed 13 November 2020].

[7] Ibid.

Legislation and Policies

National Law: In 2011, Kenya adopted a law prohibiting FGM/C nationwide: the **Prohibition of Female Genital Mutilation Act 2011**.[8] Anyone who performs any type of FGM/C (including when it is done by medical professionals) commits an offence, regardless of the age or status of a girl or woman. While some arrests have been made and **cases brought to court in Kenya** since the introduction of the Act in 2011, generally, the implementation of the law and its enforcement remain a challenge.

National Policies: Various policies and Action Plans have been set up to address FGM/C. The Kenyan government adopted **The National Policy for the Abandonment of Female Genital Mutilation** in June 2010. The policy was instrumental in the formulation of the Prohibition of Female Genital Mutilation Act 2011. The National Policy was revised in 2019 because of "*the need to address emerging trends that have contributed to the slow decline in practice of FGM*."[9]

Over the past few years, the Anti-FGM Board adopted two **Strategic Plans** covering the periods 2014-2018 and 2019-2023 that set out the Board's direction and aim.

East African Community Prohibition of Female Genital Mutilation Bill: In 2015, the East Africa Community[10] took the initiative to develop a regional law on FGM/C to promote cooperation in the prosecution of perpetrators of FGM/C. In August 2016, the East African Community Prohibition of Female Genital Mutilation Bill (EAC Bill) went through the Legislative Assembly.[11]

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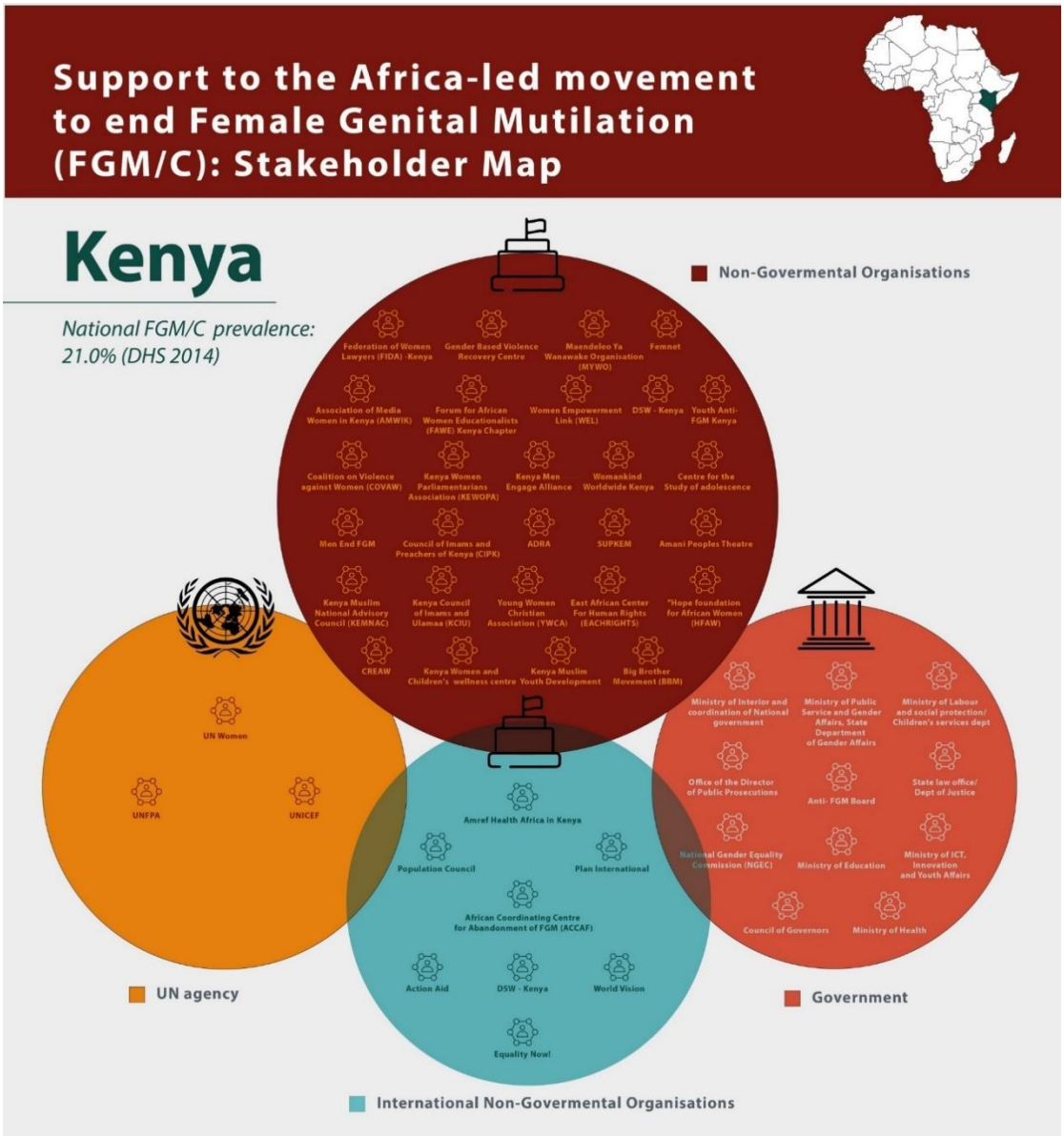
[8] Although other national laws are relevant in relation to FGM/C as well, such as the Children Act 2001 (revised in 2016), the Protection Against Domestic Violence Act (2015) and the Penal Code (revised in 2014), we focus on this PEA only on the Prohibition of FGM Act 2011 (revised in 2012).

[9] Republic of Kenya, National Policy for the eradication of Female Genital Mutilation, Sessional Paper No. 3, January 2019, p. 7-8, available at https://gender.go.ke/wp-content/uploads/2019/10/NATIONAL-POLICY-FOR-THE-ERADICATION-OF-FEMALE-GENITAL-MUTILATION-.pdf [Last Accessed 22 February 2021].

[10] The East Africa Community is a regional intergovernmental organization including six partner states: Burundi, Kenya, Rwanda, South Sudan, Tanzania, and Uganda. For more information, see: East African Community, *Overview of EAC*, available at https://www.eac.int/overview-of-eac [Last Accessed 22 February 2021].

[11] East African Community, *The East African Community Prohibition of Female Genital Mutilation Bill 2016*, 19th August 2016, available at http://www.eala.org/uploads/Geni_14-Sep-2016_10-31-04.pdf [Last Accessed 22 February 2021].

Mapping the Stakeholder landscape



Government departments working to end FGM/C

Anti-FGM work in Kenya is housed under the Ministry of Public Service and Gender and specifically under the State Department for Gender. *The Prohibition of Female Genital Mutilation Act No.32 of 2011* that was revised in 2012 established the Anti-Female Genital Mutilation Board (Anti-FGM Board) that came into being in 2014 as a Semi-Autonomous Government Agency (SAGA) under the Ministry of Public Service and Gender. The Board consists of appointees by both the President and Cabinet Secretary, and representatives from

Gender, Finance, Health, Youth, Education and is headed by a Chief Executive Officer. The Board has the key functions of designing programmes to eradicate FGM, advising the Government on matters of FGM, providing technical support to institutions engaged in end FGM initiatives as well as coordinating awareness programmes, among others.

In 2019, the President made a declaration that FGM should end in Kenya by the year 2022. This led to the development of *The President's Acceleration Plan to End FGM by 2022* and the formation of a multi-agency technical committee with representatives drawn from 10 Government Ministries and State Offices considered pivotal in ending FGM, namely, the Ministry of Public Service and Gender, Ministry of Interior and Coordination of National Government, Ministry of Education, Science and Technology, Ministry of East African Community and Regional Development (cross border initiatives), Ministry of Labour and Social Protection/Children's Department, Ministry of ICT, State Law office/Department of Justice, and the National Treasury.

The Multi-Agency Technical Committee sits at the national level but is replicated at county level through the County Anti-FGM Steering Committees that are co-chaired by the County Commissioner and the National Gender Officers. All non-state actors working at county level on FGM are supposed to report their activities quarterly through this entity at County level.

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

Partner Presence

Amref: Amref has extensive presence in Kenya, covering all 47 countries. Amref is currently implementing specific end-FGM/C programming in three counties: Kajiado, Marsabit and Samburu. Amref also implements programmes that do not specifically focus on FGM/C (but for example on SRHR, Youth advocacy, WASH and Nutrition), but that an FGM/C component (in Migori, Narok and West Pokot).

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

Evidence on Interventions: What Works?

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

FGM/C-related interventions in Kenya: These findings, mapping current and past programming in Kenya, are drawn from the End FGM/C repository of FGM-related programmes implemented in different countries between August 2016 and 2000. The repository has been brought up to date for this PEA analysis. In Kenya, the compendium captured a total of 51 programmes, of which 12 were national/regional. Although these programmes were implemented within the wider Kenyan jurisdiction, one in every three programmes (33.3%) specifically targeted communities living in the North Eastern corridor. These programmes can be broken down into 13 thematic areas. The interventions/themes spanned from legislation, human rights, capacity building, advocacy, awareness creation, community dialogues and behavioral change communication among others. Of the themes, capacity building (66.7%) and awareness creation (58.3%) were most commonly implemented across the programmes. Female empowerment (8.3%) and engagement with religious leaders (8.3%) were the least implemented across the programmes.

Legislative: A total of four studies assessed the impact of legislation on FGM/C in Kenya; two were of moderate quality and two of high quality. Study findings showed that enforcement of the anti-FGM law has been a challenge in ensuring that the law deters people from performing FGM/C (Meroka-Mutua et al., 2020; P; OBS; ↑, Nambisia, 2014; P; OBS; →). The introduction of laws against cultural practices such as FGM/C that are strongly valued by community members has led to the practice being conducted in secret, at younger ages and supposedly

less severe types of FGM/C rather than abandonment (Buttia, 2015; S, OR; →, Matanda et al., 2018; P; OBS; ↑, Meroka-Mutua et al., 2020 ; P; OBS; ↑). A combination of legislation, enforcement and other interventions are likely to be more effective in reducing FGM/C prevalence through changing the drivers of FGM/C including knowledge, attitudes, and norms.

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

Formal education: Five studies, two of high quality and three of moderate quality, evaluated the effectiveness of formal education on the practice of FGM/C in Kenya. Most of the studies used educational attainment as a proxy intervention but no direct educational intervention on FGM/C was implemented and assessed. Study findings showed that formal education exposes girls to new information including health risks/consequences of FGM/C as well as on the illegal status of FGM/C and therefore plays a significant role in the abandonment of the practice (Buttia, 2015; P; OBS; →, Berg and Denison 2013; S, SR; ↑, Nambisia, 2014; P; OBS ; →, Equality Now, 2011; P; OBS; →). School-based health education was impactful in improving the knowledge of girls, and changing the attitude of female students towards FGM/C (Berg and Denison 2013; S; SR; ↑).

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

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

Rescue centers: Four studies assessed the effectiveness of rescue centers as an approach to end FGM/C in Kenya; three were of moderate quality and one of high quality. Notably, most of the studies included rescue centers among multiple other interventions with limited information on assessment of rescue centers as an independent intervention. Research has shown that rescue centers face challenges such as limited resources and lack of recognition as an alternative ritual and hence there has been limited evidence on their effectiveness

(Buttia, 2015; S; OR; →, Van Bavel, 2020; P, OBS; ↑). A study that evaluated a project that used a mix of interventions including safe houses/rescue centers to protect girls from FGM/C showed that their sensitization campaigns were successful since they empowered girls to say no to the practice, with many seeking refuge in safe houses or being able to report cases of attempts to be cut to the police for prosecution (Equality Now, 2011; P; OBS; →). A review of successful interventions including safe houses among the Maasai, Kisii and Kuria communities in Kenya suggested that the rescue centers approach can be successful if integrated with other interventions to eradicate FGM/C (Buttia, 2015; S; OR; →).

Media / social marketing campaigns / communication: Two high quality studies and three moderate quality studies assessed the impact of media, social marketing campaigns and communication on FGM/C abandonment. Most of the interventions focused on using various media platforms to disseminate messages on negative health consequences of FGM/C. Study findings showed that the use of media can be an effective tool in the push towards FGM/C abandonment (Kaunga, 2014; P; OBS; →). Mainstream newspapers and television reports, SMS messaging and the full range of social media, theatre productions, television and radio melodramas, can shape conversations about FGM/C and accelerate the shift in social norms (UNFPA, 2017; S; OR; →). Effective sensitization campaigns have empowered girls to refuse FGM/C and to report to relevant authorities when at risk (Buttia, 2015; S; SR →). As a result of awareness campaigns in 17 program countries, a study by UNFPA showed that disapproval of the practice had increased **(**UNFPA,2017; S; SR →). A systematic review by Berg and Denison (2013) observed that the driving force for changing FGM/C related behaviour lies in the dissemination of information. There was evidence of a shift in perspective regarding FGM/C through the provision of knowledge and the actions of some which spread to others through social networks (Berg and Denison, 2013; S; SR; ↑). Nonetheless, other evidence suggests that interventions which only supply information, education and campaigns (IEC) to increase FGM/C awareness are not sufficient to change behaviour (WHO, 2011; P; OBS; →, Cloward, 2014; P; OBS; ↑).

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

Findings by Nambisia (2014) showed that the majority of respondents supported public ceremonies where girls were celebrated as they transitioned into womanhood without necessarily going through FGM/C (Nambisia, 2014; P; OBS; →). The ARP approach seems to be most effective when it takes place at the end of a structured girls empowerment programme and involves a community ceremony that is explicitly recognized as an alternative to undergoing FGM/C. Mepukori (2016) examined the effectiveness of ARP implemented as a single intervention among the Samburu community in Kenya, and found that ARP had no effect on reducing FGM/C as a single intervention (Mepukori 2016, P; OBS; ↑). One of the recommendations from the study was that for ARP to be effective, it should be implemented

in combination with other approaches such as community awareness-raising initiatives. Oloo et al (2011) equally recommends that ARP should involve intensive community sensitisation about FGM/C combined with a public declaration ceremony, fully integrated into a girl's empowerment programme can be effective in encouraging abandonment in rural communities (Oloo et al, 2011; P; OBS; ↑). Mwendwa and colleagues (2020) argue that for ARPs to be effective, it will require a combination of behaviour change support at the community level, law enforcement and monitoring, and open and persistent advocacy by diverse representatives of communities (Mwendwa et al, 2020; P; OBS; ↑).

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

Mapping the evidence to the interventions

Comparing what stakeholders are doing and what they feel works against the evidence base summarised above reveals some gaps. For example, interventions are not embedded within programmes focused on the empowerment of women and girls, yet the evidence shows this is necessary in order to drive sustainable change. Work specifically with girls is limited: a girl-focused approach is not widely talked about apart from by women-led/girl focused organisations. The attention, across actors, is being placed on community dialogues and harnessing the support of chiefs and religious leaders. ARPs are seen as crucial in marking shifts in attitudes at community level. However, the evidence that they work is limited, particularly when not embedded in a more holistic gender empowerment approach.

The education of girls and boys is strongly evidenced as a successful approach in challenging and reducing child-marriage and FGM/C, yet few of those interviewed make this link. It is likely that it is known that educating girls is important but in programming terms may be seen as a separate set of interventions from those designed to end FGM/C. Mainstreaming FGM/C across different gender programmes may help to bring a more holistic and multi stranded approach together.

Media campaigning, especially social media, was mentioned by a number of stakeholders and the evidence is very strong that such approaches are effective. Interestingly, a number of CSOs interviewed did acknowledge the importance of using social media platforms to engage young people, but very few actually pursued these activities. There is certainly room to explore how to develop media interventions in a more systematic and widespread way.

Media Analysis

Radio is the media that most people access on a regular basis and 65% of radio listeners are found in rural areas. There is no dominant national station. Citizen has 13% of the average national daily reach, and the top ten stations in Kenya, in the table below[12], have close to half of the national listenership. Other local, vernacular and community radio stations share the remaining 50% of the country's listeners. This is still a large number of people and it is important to note if using radio for audiences in specific regions with high prevalence of FGM/C. Radio is more frequently accessed by women and girls than TV and newspapers[13].

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

Facebook and WhatsApp are the most popular social media channels in Kenya. 36% get information from WhatsApp, 35% from Facebook, 10% Twitter, 9% Instagram and 7% from YouTube[14]. Facebook tends to be more popular in rural areas while people in towns and cities are more active on Instagram. People use both traditional media and social media to access the news but **social media's prime role for Kenyans is networking[15]**. When building movements and campaigns online there must be a recognition that networking drives social media engagement for Kenyans. Social media use is also influenced by gender and age, with more boys than girls online and usage

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

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

[12] Ibid.

[13] Kenya Audience Research Foundation (2018) Audience Tracker Q4

[14] Media Council of Kenya (2020) Status of the Media Report

[15] Ibid.

Cross Border: Emerging challenge

The United Nations has highlighted cross-border FGM/C as one of the emerging challenges that needs to be addressed in order to eradicate FGM/C.[16] However, that said there is relatively little research that gives us a nuanced and detailed picture of the extent of cross border movement, why it happens and how it might best be responded to. Most of the research has been conducted by international agencies and published as grey literature.

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

Conclusions

The purpose of this PEA was to gather comprehensively information and data to support key decisions at the national level. The research process behind the PEA was designed to identify gaps and where more data is needed. Lastly, it aimed to produce an accurate map of where Kenya is positioned at the moment in terms of achieving the Presidential goal of ending FGM/C by 2022.

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

The approaches to end FGM/C reviewed in this PEA clearly suggest that there is not a one-size fits all model for how to end FGM/C. Arguably there is opportunity for the programme to create a holistic girl-centered and gender transformative approach that places the abandonment of FGM/C as a priority. This may well represent a new more integrated model for ending FGM/C that draws on a number of interventions where the evidence suggests putting them together is likely to bring the best results. For example, social media and local radio campaigns coupled with opening access to these technologies to girls and boys; integrating end FGM/C and gender norm change into school curriculums; working with key local influencers including religious leaders to engage communities in dialogue to end harmful behaviors and to hold them accountable when they break the law; ARPs and a targeting of important groups such as young men about to marry and parents of young girls.

Opportunities for mainstreaming FGM/C also seem critical. The integration of ending FGM/C activities into programmes with a strong gender focus seem to offer value for money and potentially will help to accelerate abandonment. The resources of the programme will only support a certain number of bespoke holistic interventions. Opportunities to grow the movement and see impact deepen must involve other gender programmes. **In parallel the ALM to end FGM/C needs to align more closely with feminist and women's organizations**. Whilst they may be closely related, the integration of the ALM into the wider movement for women's rights holds potential to embed FGM/C as a central and urgent issue.

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