ORCHID PROJECT

WORKING TOGETHER TO END
FEMALE GENITAL CUTTING








Female genital cutting in Kenya

A baseline review of attitudes and behaviours in Kuria, Narok and Loita Hills

FEBRUARY – MARCH 2018

Contents

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Acronyms

ARP
Alternative Right of Passage

CBO
Community-based organisation

COVAW
Coalition on Violence Against Women

ECAW
Education Centre for the Advancement of Women

YWCA
Young Women's Christian Association

FFVAWG
Freedom from Violence Against Women and Girls

FGC
Female genital cutting; this term is used interchangeably with cutting

HIV/AIDS
Human immunodeficiency virus infection and acquired immune deficiency syndrome

KDHS
Kenya Demographic Health Survey

TBA
Traditional birth attendant

WHO
World Health Organisation

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WORKING TOGETHER TO END FEMALE GENITAL CUTTING

Orchid Project is a UK-based NGO that is catalysing the global movement to end female genital cutting (FGC). FGC is a human rights violation that harms the lives of girls, women and their communities. Orchid Project partners with pioneering grassroots organisations around the world, and shares knowledge and best practice to accelerate change. Orchid Project also advocates among governments and global leaders to ensure work to end FGC is prioritised.

Executive summary

In Kenya, the national prevalence rate of female genital cutting (FGC) is 21%[1], which has seen a decline in recent years (27.1% in 2008-9, 32.2% in 2003 and 37.6% in 1998)[2]. This community-based review took place in early 2018 in three areas of Kenya where Orchid Project has been working with community-based partners to end FGC. In each of these areas the prevalence remains significantly higher than the national average yet there is a limited number of studies on FGC prevalence.

One of Orchid Project's strategic objectives is to support the growing body of evidence and research on FGC, with specific emphasis on local level and locally owned data. Through the generation of more localised data and evidence, organisations can increasingly share and learn from one another, and strengthen the movement to end FGC. We hope that this baseline review will support grassroot organisations in the review and adaptation of their own FGC interventions, and in the development of new FGC interventions.

This baseline review was carried out to:

- provide evidence on attitudes and behaviours in relation to FGC to inform project design and implementation
- provide baseline data in specific communities against which progress can be measured in the future
- contribute to the wider national and international discourse on FGC in Kenya

This review was carried out by Orchid Project in communities across 3 key areas: Narok with Coalition on Violence Against Women (COVAW); in Kuria in collaboration with the Education Centre for Advancement of Women (ECAW); and in Loita Hills with SAFE Maa. Within these three areas the two predominant ethnic groups are Kuria and Maasai, although not exclusively, as detailed later within the Limitations Section. This review additionally provided an opportunity for COVAW, ECAW and SAFE Maa to gain experience of community-based research in order to enhance their own work at the grassroots level.

The approach used was a multiple-choice community survey, developed collaboratively with the partners, based on their experience and related to their programmes. The survey targeted a wide range of community members, including mothers, fathers, youth, teachers, health professionals, religious leaders and law enforcement officials. A total of 2,112 interviews (60% female, 40% male) took place in the local languages of Kuria, Swahili and Maa, in 14 communities in Kuria, Narok and Loita Hills. This data was collected by local community researchers using mobile phone technology and uploaded to the data platform, Ona.

Prevalence of FGC within families

Overall, 49% of survey participants in the targeted communities said that girls are cut in their extended family, which is more than twice the national figure. The targeted area in Loita Hills appears to have the highest perceived prevalence, with 62% of participants reporting that cutting happens in their families, while in the targeted areas in Kuria and Narok this figure was 36% and 45% respectively. Perceived prevalence in individual communities varies considerably from 21% in Masaba Town, Kuria, to 92% in Imartin, Loita Hills. Girls were reported as being cut predominantly between the ages of 12 and 14 years, primarily by traditional cutters or traditional birth attendants (TBAs), with mothers being the primary decision-makers. The traditional cut (loosely defined as WHO type II) is still practised in all three areas, although there is evidence of a move from the traditional cut (WHO type II) to the kisasa, snip or prick (WHO type I or type IV). Traditionally, preparation for marriage has been seen as a key reason for girls to be cut, however, this is now cited as the main reason by only 30% of participants, with culture being the more predominant reason behind the cut in the targeted communities in Kuria, Narok and Loita Hills.

[1]DHS 2014, available at: https://dhsprogram.com/publications/publication-FR308-DHS-Final-Reports.cfm

[2]28 Too Many, Country profile: FGM in Kenya, (2013)

Knowledge, education and intention to cut

Across all participants, just over half are aware that all forms of FGC are illegal under Kenyan law. A third of participants are not aware of the health risks of FGC, or did not make the connection between FGC and health problems experienced by girls and women. There appears to be a correlation between education levels (i.e. school attendance), awareness of issues associated with FGC and future intentions in relation to FGC. Those who have attended school are more likely to have knowledge about the complications of cutting, the rights of women and girls and the Kenyan law on FGC. They are also more likely to come from extended families which do not cut and are less likely to intend to cut their daughters in the future. Half of unmarried men who have not been to school would prefer to marry a cut woman, as opposed to just 9% of unmarried men who have attended school.

Support for abandonment

Overall, 69% of those surveyed want to see the abandonment of all types of cutting.

In the targeted communities in Kuria there is evidence of a strong desire to see the abandonment of FGC. The majority of those surveyed would like to see the abandonment of all types of cutting (80%) with a similar percentage (83%) saying they do not intend to cut their daughters in future.

In targeted communities in Narok, the evidence of a desire for change in relation to FGC is weaker. Although 76% of those surveyed would like to see the abandonment of all types of cutting, 42% said they intended to cut their own daughters in the future.

In targeted communities in Loita Hills, there is evidence of a strong desire to see a reduction in the use of the traditional cut. This is demonstrated by over 80% of participants wanting to see change, with 45% wanting to see the abandonment of **all** types of FGC.

Roles within the movement to end FGC

i. Health professionals

The role of health professionals in relation to FGC is complex. The majority surveyed in this baseline review (87%) would like to see the abandonment of all types of cutting, including the kisasa, snip or prick. Conversely, the data confirms that some nurses, midwives and doctors are involved in practising cutting, particularly in communities in Kuria and Narok where medicalisation of cutting is strongest at 17% and 21% respectively. Anecdotally, in Loita Hills, parents have indicated that they would like to have their daughters cut by nurses or midwives, but there are few health facilities.

Currently, health professionals are not seen by those surveyed as influential in ending FGC and not identified by the survey participants as among those opposing cutting or having responsibility to end FGC. For example, less than 10% of teachers surveyed invite health professionals to their schools to talk to pupils or parents about FGC and only 16% of women surveyed stated having consulted with a health professional on FGC. There is potential for supporting health professionals in developing their role in ending FGC and developing the relevant skills and knowledge.

ii. Religious leaders

Less than 2% of survey participants across all targeted communities see religion as a driving factor for FGC. Overall, those religious leaders surveyed are well informed on FGC, have a strong commitment towards the abandonment of all types of cutting and are the group most seen by the community as opposing FGC. All religious leaders surveyed know that all types of cutting are illegal in Kenya and 80% are aware of the complications for women and girls. There is therefore the potential for greater use of religious leaders in initiatives to end FGC.

iii. Teachers

Teachers, in all targeted communities, are most in favour of abandoning FGC amongst those surveyed. They tend to be well informed about the complications of FGC, are aware of the law on FGC, the Rights of the Child and the right to Freedom from Violence Against Women and Girls, they do not intend to cut their daughters and leave their sons to decide whether they marry a cut or uncut woman.

Currently, however, teachers are not seen by others surveyed in the community as strong opposers of FGC and are not seen as having responsibility to end FGC. Less than half of teachers surveyed are approached by girls and parents in relation to FGC with almost twice as many female as male teachers being approached. The advice given by teachers has a strong focus on the illegality of FGC. Whilst it is correct that FGC is illegal, teachers appear to be missing opportunities to engage parents in dialogue, to listen to their concerns or to advise them to seek the advice of religious leaders, health professionals or others who also support abandonment. There is potential for the extension of the role of schools and the capacity building of teachers to play a stronger role in ending FGC.

iv. Young people (15-24 years)

Young people appear to be stepping into roles as decision-makers as they become the parents to the next generation of girls. This is just one of the reasons why young people are key stakeholders to engage with when working to end FGC. However, this survey indicates that currently young people are not seen as key opponents of FGC and are seen by less than 20% of others surveyed as having responsibility for change. Despite this, the young people surveyed as part of this baseline review, both female and male, are more aware of their human rights and the law on FGC than older people in communities. They are more in favour of change in relation to FGC and show a greater interest in being involved in activities to end FGC. There is scope to engage more with young people in communities to support them in leading initiatives that engage others in their community.

Gender

FGC is often considered an issue which concerns primarily women, and that men are not well informed or involved. However, this review indicates that the men surveyed in the targeted communities in Kuria, Narok and Loita Hills are interested, involved and possibly more ambitious for change in relation to FGC than women, with 71% of men and 68% of women wanting to see the abandonment of all types of cutting. Additionally, over two thirds of unmarried men would prefer to marry an uncut woman. Similar proportions of women and men (66%) recognise that women suffer complications of cutting, however, women more often cite severe bleeding, severe pain and difficulties in childbirth, and men more often cite marital relationships as being affected and challenges conceiving.

According to this baseline review, both women and men surveyed are involved in conversations with different people about FGC, with women more likely to speak to a health professional than men. However, more men

(47%) than women (40%) said they have spoken to others about FGC in the last year. Based on the survey sample, women appear to be the main decision-makers about whether their daughters undergo FGC, however, anecdotal evidence suggested that men are increasingly becoming involved in this process, especially in targeted communities in Kuria and Narok. Similar numbers of men and women (38%) surveyed are involved in activities to end FGC currently. In contrast, in schools, activities relating to FGC tend to involve mainly girls, with limited opportunities for boys.

Dialogue

FGC remains a subject which many people do not openly talk about. Less than half of those participating in this baseline review have spoken with someone about FGC in the last year, and less than half are aware of FGC ever being mentioned in public gatherings in their community. Only 9% of parents surveyed have talked to their spouse about FGC, with the majority of conversations taking place with other family members and friends. Less than 20% of parents talk to their daughters and sons, or to professionals, such as teachers, health workers, law enforcers or community leaders about cutting.

One activity which organisations working to end FGC could do is to promote dialogue involving all community members at family, neighbourhood and community levels. Evidence suggests[3] that this is a key way in which community members can increase their awareness of the health risks associated with FGC, the law on FGC in Kenya, and the experiences, preferences and intentions of family members, neighbours and others across the community. At community forums, it is important for community members to hear the opinions of religious leaders, community leaders, teachers, health professionals and law enforcers, as well as having opportunities to share their own experiences. Equally important are the conversations between spouses, and also between parents and grandparents and their children.

Conclusion

This survey has provided a rich picture of the knowledge, attitudes and beliefs of a wide range of community members in relation to FGC across 14 communities in Kuria, Narok and Loita Hills. The evidence suggests that there is potential in all three regions, with large numbers of participants stating their desire to see some form of change towards abandonment happening in their community. This baseline review also found that while individual knowledge of the practice and support for abandonment appeared high, community and family dialogue was low. The risk here is that if spaces are unavailable for community members to engage in dialogue, ask questions and share their intentions and beliefs, the practice will continue, with community members unable to publicly express their appetite for change. As this critical mass of people wanting change continues to build in each of the three areas, it will be important to ensure that space is created to ensure that community members are engaging with one another and that health workers, teachers, religious leaders and cultural leaders are engaging in the dialogue.

[3]Vaitla, Bapu, Alice Taylor, Julia Van Horn, and Ben Cislaghi. 2017. 'Social Norms and Girls' Well-Being: Linking Theory and Practice.' Washington, D.C.: Data2X.

Introduction

What is FGC?

Female genital cutting (FGC) is a harmful practice involving the full or partial removal of, or injury to, a girl's external genitals. On average, globally, girls are cut before the age of 5[4], although this varies between different communities and can happen at any time from a girl's birth to her adolescence.

FGC is not an obligation of any religion and has no known health benefits. Far from it, the practice can cause long-lasting physical and psychological damage for the more than 200 million women and girls who are affected worldwide. In some cases, this can include death[5].

FGC is commonly referred to as a social norm.[6] Social norms are behavioural rules shared by people in a given society or group; they define what is considered "normal" and appropriate behaviour for that group.[7] It has been suggested that successful approaches towards ending FGC should recognise the practice as a social norm and develop interventions and models that are community-led, and focus on shifting social norms at community level and empowering women.[8]

FGC in Kenya

In Kenya the national FGC prevalence rate is 21%[9], which shows a decline in recent years (27.1% in 2008-9, 32.2% in 2003 and 37.6% in 1998)[10]. Prevalence varies between regions and ethnic groups, with the regions in which this baseline review took place having significantly higher prevalence of FGC than the national rates. Among the Maasai, which includes Narok and Loita Hills areas with multiple smaller communities within, the prevalence rate for FGC in 2014 was 78%[11]. In Kuria, southwest Kenya, FGC prevalence was 96%[12] in 2009.

In recent years, Orchid Project has significantly increased its focus in the Kenyan movement to end FGC. This is following a research project that identified Kenya as an area for potential acceleration of abandonment[13]. Orchid Project has established key strategic partnerships with three organisations working at the community level to bring an end to the practice:

1. Coalition on Violence Against Women (COVAW) – an organisation working in nine regions in Kenya, focused on ending all forms of violence against women through programmes and advocacy at local, national and international levels. COVAW works at the community level, engaging community members in open dialogue on the harmful effects of FGC and supporting communities to reach a collective decision to end the practice. Orchid Project has been supporting their FGC work in Narok since January 2018.

2. Education Centre for the Advancement of Women (ECAW) - a grassroots organisation working for the rights and empowerment of girls and women in Kuria in southwest Kenya. Orchid Project supported ECAW's Girls Empowerment programme in partnership with **Feed The Minds** and **Young Women's Christian Association** between 2016 and 2019. Within this programme, peer educators and paralegals engaged in community dialogue and workshops with youth, and older community members, to raise awareness of girls' rights.

3. SAFE Maa - working with Maasai communities in the Loita Hills region, focusing on HIV/AIDS, FGC and the environment. SAFE Maa's approach uses traditional Masaai culture including songs and dance to share messages related to FGC and HIV/AIDS and open up dialogue with community members on these issues. Orchid Project has been supporting SAFE Maa's FGC work since 2014, and in 2017 developed a three-year programme focused on FGC.

[4]UNFPA-UNICEF, 2014, "UNFPA-UNICEF Joint Programme On Female Genital Mutilation/Cutting: Accelerating Change' Summary Report of Phase I 2008 – 2013"

[5]www.orchidproject.org

[6]Mackie, G. & Moneti, F., What are social norms? How are they measured?, UNICEF (2015)

[7]Heise, L. & Cislaghi, B., Measuring social norms: A learning report, London School of Hygiene and Tropical Medicine (2016)

[8]McChesney, K.Y., Successful approaches to ending female genital cutting, Journal of Sociology and Social Welfare (2015)

[9]DHS 2014, available at: https://dhsprogram.com/publications/publication-FR308-DHS-Final-Reports.cfm

[10]28 Too Many, 2013 'Country profile: FGM in Kenya'

[11]Kenya Demographic and Health Survey 2014 https://dhsprogram.com/pubs/pdf/FR308/FR308.pdf

[12]Feed the Minds, 2014 'Female Genital Mutilation practices in Kenya: The role of alternative rite of passage: A case study of Kisii and Kuria districts'

[13]Orchid Project & hera, 2017 "Research on opportunities for investment on FGC abandonment in Africa"

1. Coalition on Violence Against Women (COVAW)
2. Education Centre for the Advancement of Women (ECAW)
3. SAFE Maa

Through working in collaboration with these organisations, it has been increasingly apparent that there is a data gap at the community level, with community-based organisations (CBOs) having limited capacities to conduct systematic data collection on FGC. Recognising the vital role data has in measuring impact, informing programmes, influencing national discourse and ensuring accountability between organisations and the communities in which they work, Orchid Project recommended conducting a community-led baseline review. This review was carried out with these partners in a sample of targeted communities in the three regions where they work to end FGC, using a similar approach to a previous study Orchid Project conducted in Somaliland[14].

Key to this baseline review was that it be community-led, with researchers identified from the local context. This was recognising the sensitivity of the issue and the increased likelihood of more open discussion between community members. Community ownership was also critical to ensure the baseline data is used by the local CBOs working to end FGC, supporting them to inform programme design.

The objectives of this community baseline review were to:

- Provide an evidence base on attitudes and behaviours in relation to FGC to inform project design and implementation of ECAW, COVAW and SAFE Maa
- Provide baseline data against which progress can be measured in the future
- Contribute to the wider national and international discourse on FGC in Kenya

This report outlines the methodology adopted in this community-led baseline review, a summary of the key findings, key recommendations for partner organisations and specific summary sheets for each of the areas where the study took place.

[14]Orchid Project, 2017 'Female genital cutting in Somaliland: A baseline study'

Methodology

The baseline review was carried out by three teams of community researchers in targeted communities in Kuria, Narok and Loita Hills. The Kuria team was coordinated by ECAW and YWCA, the Narok team by COVAW and the Loita Hills team by SAFE Maa. Each team consisted of 5 community researchers, 3 women and 2 men, all of whom lived in the communities, together with 1 or 2 field coordinators provided by the local organisation.

The project involved a mixed-methods approach, combining both quantitative and qualitative approaches. The data collection was primarily quantitative using an online survey with 'best fit' answers (see appendix). Additional qualitative information was included through open responses, quotations from participants and discussions with the community researchers and local partners ECAW, YWCA, COVAW and SAFE Maa.

The survey was developed in partnership between Orchid Project and the local organisations. Care was taken to avoid questions which invited people to admit to breaking the Kenyan law on FGC which might result in inaccurate data. Consequently, the prevalence of cutting was estimated at the family level by asking all participants whether or not FGC was practised in their extended family. It is recognised, however, that this may have led to some under reporting (see limitations) and additionally means this review and report does not show specific prevalence in regions, but rather perception of prevalence amongst community members in a sample of targeted communities.

The data platform, Ona was used to develop and collect survey information, with questions and answers translated into Maa, Swahili and Kurian and made available on mobile phones which were provided for the community researchers. Community researchers held face-to-face interviews, asking questions and digitally recording answers in their own language. The Ona site does not require access to internet connection at the point of data collection and so data was uploaded once a week when connectivity was available. This allowed community researchers to use mobile phone technology to survey individuals in remote areas without internet connectivity.

Prior to data collection, the community researchers and coordinators participated in a two-day training workshop on ethical research. This was developed on the back of a similar workshop conducted in Somaliland. The workshop enabled the teams to develop skills in sampling techniques, informed consent, sensitive interviewing, accurate data collection and security of data handling and uploading to the Ona open source website where the data was stored securely. After the workshops, each team piloted the tools, practising their interview techniques and checking the technology, with feedback from Orchid Project.

Data collection took place over a period of 12 days at the end of February/early March 2018. Six communities were surveyed in Kuria, selected by ECAW and YWCA; three in Narok, selected by COVAW; and five in Loita Hills, selected by SAFE Maa (chart 1). There was a slightly lower number of communities targeted in Narok recognising the higher population density in the communities. Partner organisations picked the communities based on their experience of working in these regions, and aimed to select a mix of communities, from those that had been targeted through projects for a range of time periods.

During the training workshop, participant targets were identified in collaboration with partners and researchers. The group aimed to select a target that could give a strong indication of knowledge, attitudes and practice among the wider community, recognising limitations in time for data collection. Participants in each targeted community were selected based on a random methodology using a dice. This was to avoid researcher bias in whom they interviewed in each community.

Once all data was uploaded, an initial analysis was carried out by Orchid Project. Following this a further two-day workshop took place in Narok, during which the community researchers and coordinators examined the initial findings. They were then able to contribute to the process of data analysis and enhance their own understanding of attitudes and behaviours in relation to FGC in their own communities.

Sample size and composition

A total of 2,112 interviews took place in 14 communities, referred to throughout the report as "targeted communities":

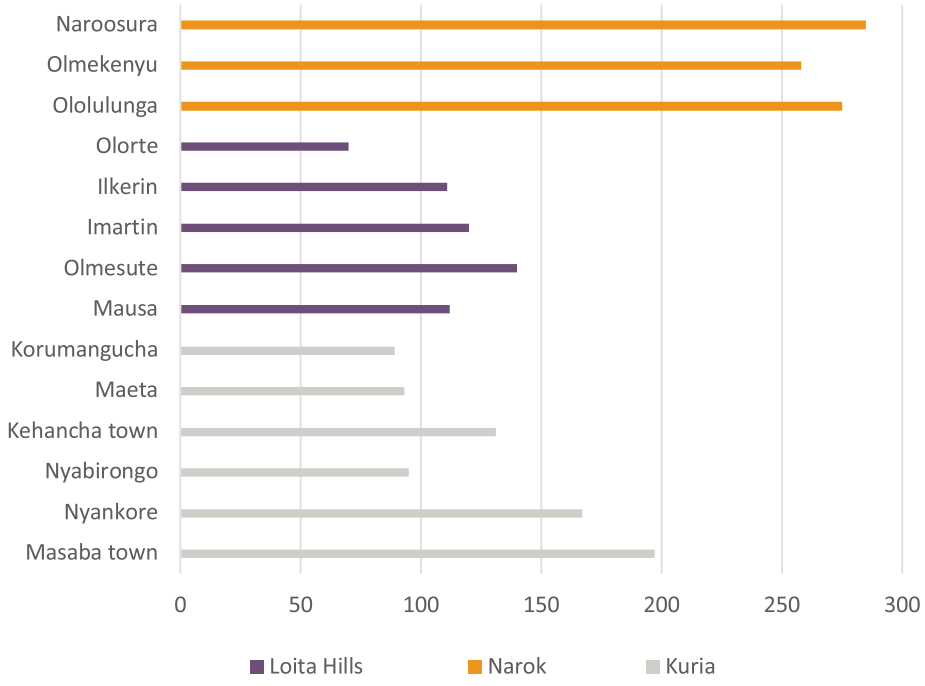
- 772 in Kuria across 6 communities
- 818 in Narok across 3 communities
- 556 in Loita Hills across 5 communities[15]

Researchers in Loita Hills had a lower target, recognising the lower population density and recognising the poor infrastructure and time it takes to travel from one community to another on foot.

It is important to note that while Loita Hills is an area in and of itself, it is part of the wider Narok county. The communities reached in Loita Hills by SAFE community researchers were distinctly separate to the communities reached in Narok through COVAWs community researchers, to ensure there was no cross over or duplication.

1,277 (60%) of the survey participants were female and 835 (40%) were male. The majority of the participants were married (73% in Kuria, 56% in Narok and 87% in Loita Hills).

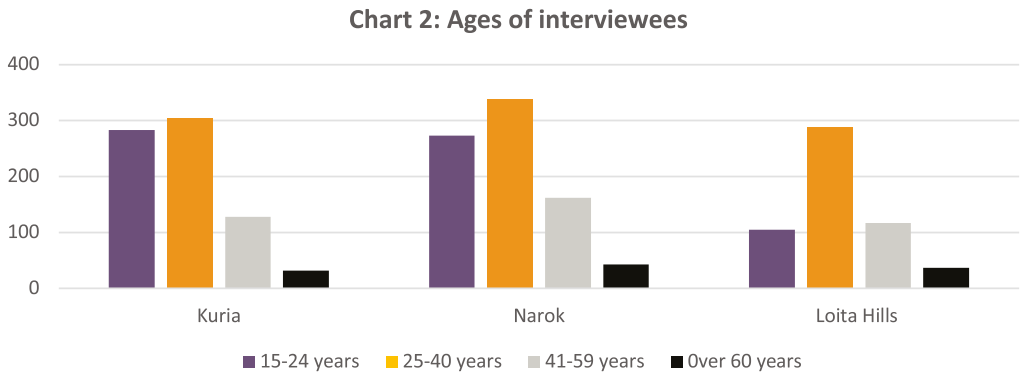
Chart 1: Number of interviews per community in Kuria, Narok and Loita Hills



[15]It's important to note that Mausa is a rural village within Olorte and Imartin is a rural village within Olmesutie

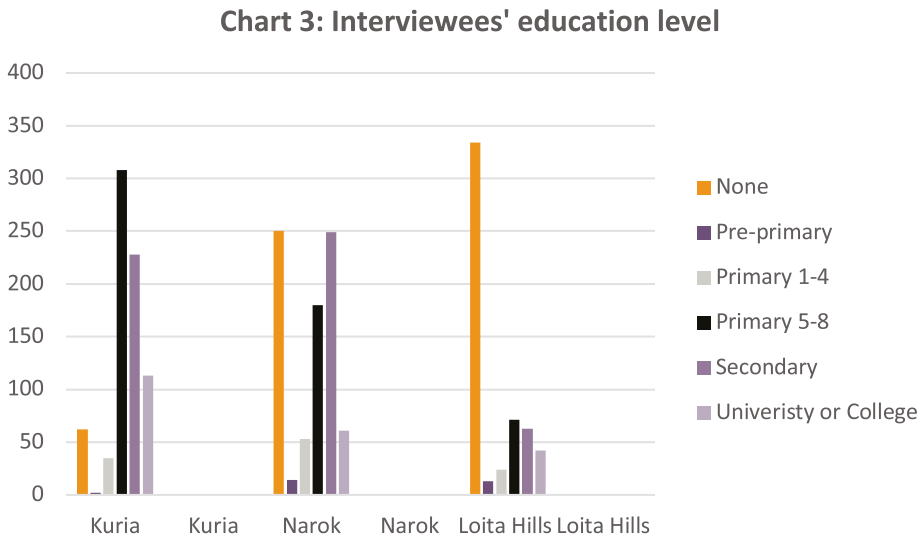
Age

Overall, 75% of the participants were under 40 years old. The age profile differed between the regions (chart 2), with a lower proportion of young people (15-24 years) being surveyed in Loita Hills, due to the distances many of the young people have to travel to look after their livestock in this rural area.



Education

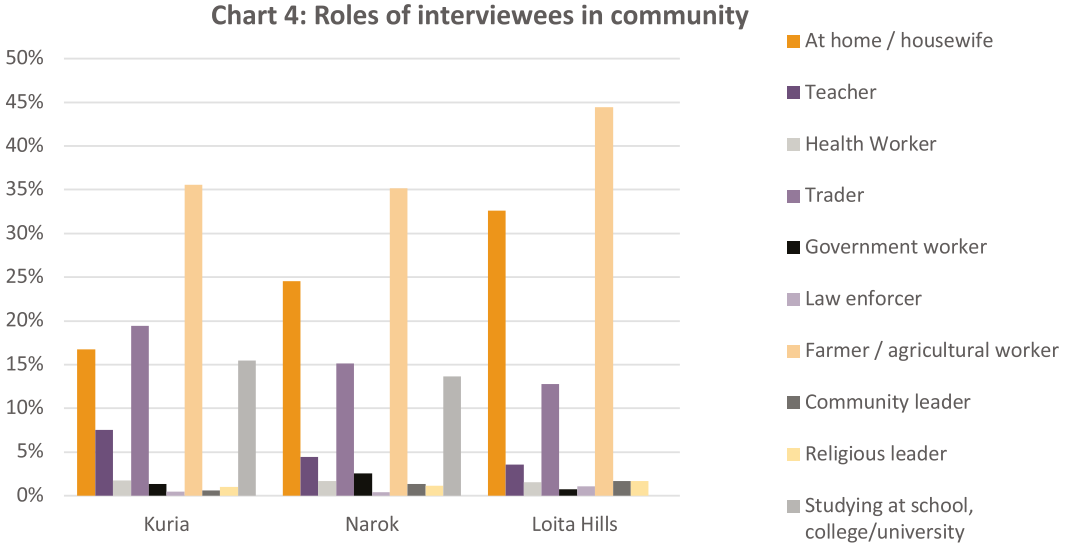
The education profile of the communities in Kuria, Narok and Loita Hills differs considerably with 61% of participants having had no formal education, in comparison to 32% in Narok and just 8% in Kuria (chart 3).



Livelihoods

Farming and agriculture are the most common means of earning a living in all of the targeted communities (chart 4). In the communities reached in Loita Hills, there appeared fewer professional people (health workers, teachers and law enforcers) and fewer people studying at college or university than in communities in Kuria or Narok.

Chart 4: Roles of interviewees in community



Limitations and considerations for data

The baseline survey was the first systematic community research with which COVAW, ECAW and SAFE Maa had been involved. One of the aims was for each organisation to increase their capacity to carry out community research in the future and to adapt their approach to working with communities in light of the findings.

Influence of FGC law in Kenya

The survey asked community members about their knowledge, attitudes and intentions in relation to FGC, rather than gathering direct information on whether or not individuals are cut. This was in recognition of the national law prohibiting the practice of FGC and wanting to ensure that participants felt no risk of being later prosecuted by taking part in the baseline review. It should be acknowledged however, that there may be some under reporting of people's intentions to cut, or the type of cut they would use, as a result of the law.

Perception of prevalence

The survey used for this review focused on questions on perception of prevalence in a community and within a family. It did not ask direct questions similar to Demographic Health Surveys (DHS) related to whether a person is cut, what type of cut etc. Therefore, this study is focused on the perception of the practice within a community and whether the practice is happening at the family level.

Defining FGC

There may also be some under reporting of people's intentions to cut as a result of what community members perceive to be FGC. In some cases, only the traditional cut (WHO type II[16]) is considered FGC, while the kisasa, snip or prick (WHO type I or type IV) is not considered FGC. While community researchers tried to ask follow up questions to avoid the latter under reporting, it is likely to have been only partially successful.

[16]World Health Organization, available at: http://www.who.int/reproductivehealth/topics/fgm/overview/en/

The World Health Organization (WHO) classifies female genital cutting (FGC) into four different types, however community-to-community, there are likely to be variations that lie in between these classifications. Community members' understanding of what constitutes FGC and/or the different types of cut is also likely to vary person-to-person.

Type I: The clitoris or clitoral hood is partially or fully removed (clitoridectomy). Within this baseline study, type I is referred to as "kisasa, snip or prick".

Type II: As well as the clitoris, the labia minora are partially or fully removed. The labia majora may also be cut. Within this baseline study, type II is referred to as "the traditional cut".

Type III: The clitoris, labia minora and labia majora are cut away, and the remaining skin is sewn or sealed together leaving a tiny hole for menstrual blood and urine (infibulation). Within this baseline study, some community members' understanding of "the traditional cut", which we have categorised as type II, may sit between type II and type III.

Type IV: All other harmful procedures to the female genitals including pricking, piercing, rubbing and scraping. Within this baseline study, type IV is also referred to as "kisasa, snip or prick".

Ethnic groups

In Narok, there is a significant Kalenjin community who have different practices from the local Maasai community, e.g. the Kalenjin practice FGC, but age of cutting is significantly higher than amongst the Maasai. This was not identified as an important factor in advance and so it was not possible to disaggregate the data by ethnic group.

Gender

It was intended that community members would be surveyed by community researchers of the same gender. However, this was not always the case, although some were offered a choice as to whom would interview them. It is possible, therefore, that some people felt uncomfortable with the gender of the person interviewing them and this might have influenced their responses. Community researchers felt confident that most people were open to being interviewed by a person of the opposite sex.

Community researcher selection and community selection

In this review each partner organisation carried out research in communities in which they lived and worked, in order to gain a deeper understanding about how their communities felt about FGC. With this method comes potential risk of researcher bias, as well as people being surveyed by people they know. This was mitigated by providing training in advance on random participant selection methods. Having now carried out the baseline review, there is increased awareness amongst all three grassroot partners of the importance of avoiding interviewing in communities where you are known.

Payment

Some people declined to be interviewed due to a lack of payment or because they were unsure who the information would benefit.

Safeguarding

Community researchers also faced the challenge of being asked for support in avoiding being cut by some girls. Researchers had been informed, during the ethical research 2-day training, on how to manage these scenarios and cases were referred to the local partner organisation who followed up after the community survey had been completed.

Comparable Data

Throughout this report, attempts have been made to draw comparisons between the data from the community survey used in this study, and the Demographic Health Survey (DHS). It is important to note however that direct comparisons are challenging as the DHS data does not disaggregate to the detail at which the survey does. We have therefore looked at comparisons related to ethnicity (e.g. Maasai and Samburu) and wherever possible geographical regions.

Sample size

Community researchers surveyed 2,112 community members in 14 targeted communities in Narok, Kuria and Loita Hills. It is recognised that this sample size is not representative of the whole communities, or indeed the 3 regions.

Literacy

The community survey used for this baseline review was translated into local languages, and a “best-fit” approach was used. Furthermore, participants were interviewed by a community researcher from the local area who could speak the same language. Researchers were trained in using probing questions to clarify their understanding. However, it is recognised that despite these mitigating factors, limited literacy in each of the targeted communities may have affected some participants understanding and interpretation of the questions and responses.

Summary Findings

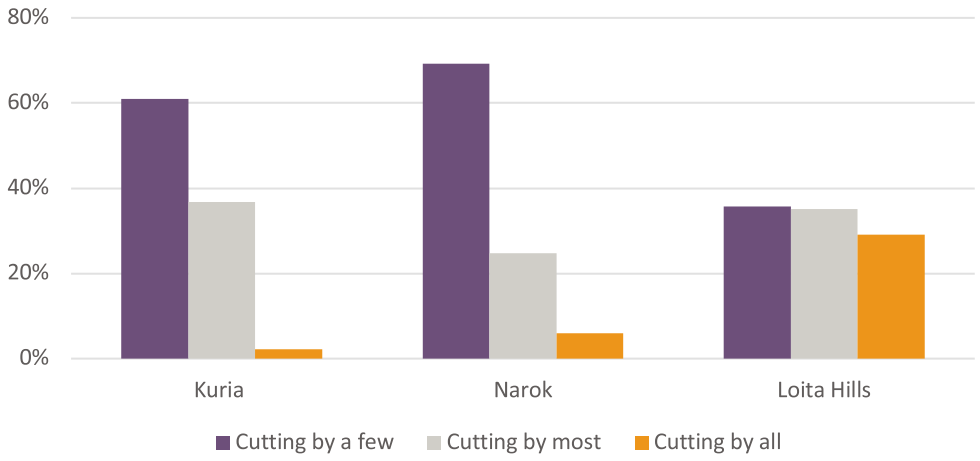
1. Perceptions of FGC practices at community level

Individuals' perceptions of their community and their peers' attitudes, behaviours and beliefs often impacts their own individual beliefs and practices. This thinking forms the basis of social norm theory and interdependent action and is applicable to FGC. This baseline review sought to understand participants' beliefs about their peers and communities, and how this impacts their decision-making processes in regard to FGC.

1.1 Perception of community prevalence of FGC in Kuria, Narok and Loita Hills

Overall, 80% of participants across the 14 communities surveyed said that FGC takes place in their communities. In targeted communities in Kuria and Narok, the majority of people surveyed believe that cutting is carried out by a few families within their community, while in the communities in Loita Hills the majority of people surveyed believe FGC is practised in most or all families (chart 5). These figures, recognising participants were not directly asked if they were cut themselves or have cut their daughters, are significantly higher than the national average according to Kenya Demographic Health Survey (KDHS) statistics (21%). However, these baseline figures appear to be generally in line with prevalence within ethnic groups from the 2014 KDHS, with Maasai prevalence at 77.6%. There is no comparison available for the Kuria or Narok regions.[17]

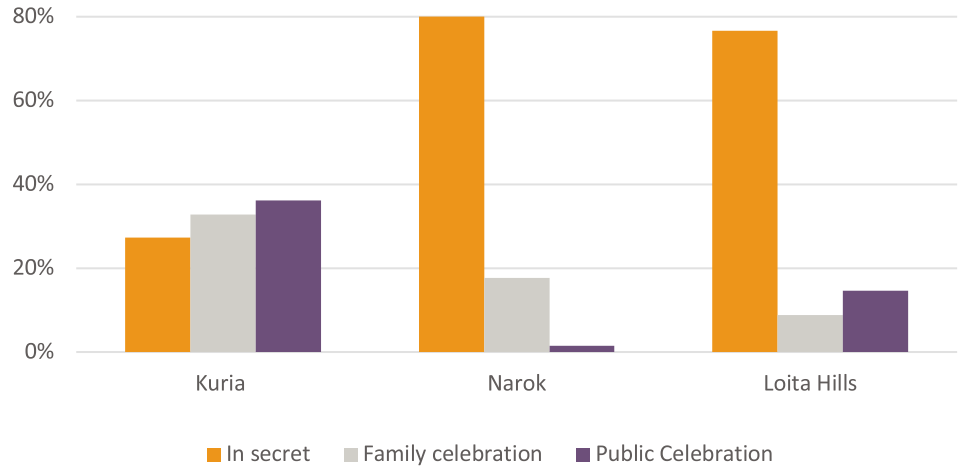
Chart 5: Reported prevalence of cutting in Kuria, Narok, Loita Hills communities



According to those surveyed in targeted communities in Loita Hills and Narok, cutting primarily takes place in secret. However, in targeted communities in Kuria those surveyed identified cutting as being practised in public and family celebrations in which most of the families that cut their girls are involved (chart 6).

[17]DHS 2014, available at: https://dhsprogram.com/publications/publication-FR308-DHS-Final-Reports.cfm

Chart 6: How cutting is carried out - in secret, family celebration or public celebration

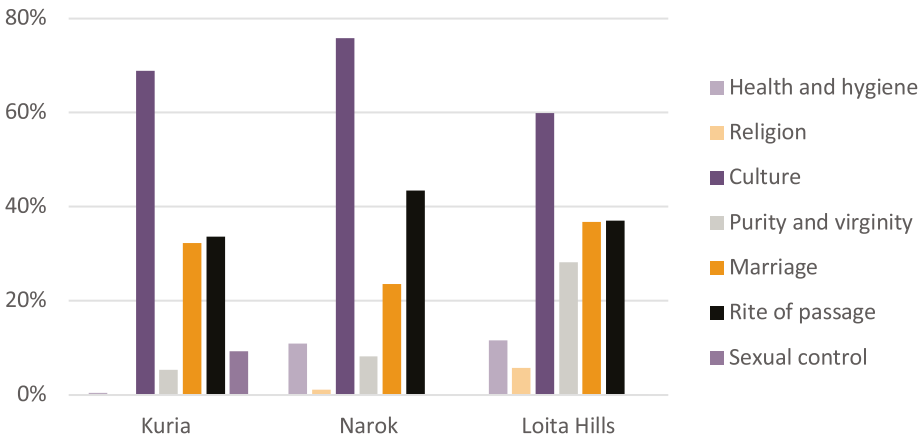


1.2 Reasons why FGC takes place

Across all targeted communities, culture is identified by those surveyed as the strongest reason that FGC takes place (chart 7). Rite of passage and marriage are also seen as significant reasons why girls are cut. In targeted communities in Loita Hills, ensuring purity and virginity are also cited by survey participants as important factors. Across all targeted communities, religion is cited by only 2% of participants as the reason for cutting.

In the targeted communities in Narok and Loita Hills, health and hygiene are cited by 11% of participants as reasons for continuation of the practice. In communities in Kuria, where the impact of cutting on girls' libido is discussed by the local partner (ECAW), 9% of participants identified control over the sexual libido of girls and women as one of the reasons girls are cut.

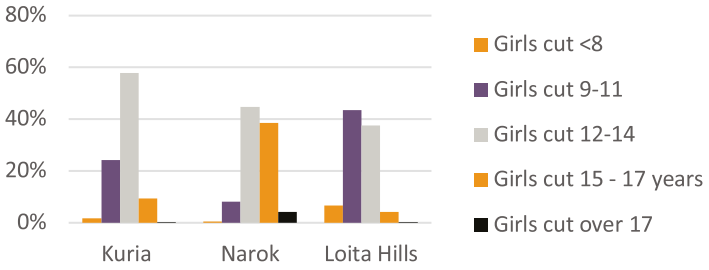
Chart 7: Why girls are cut in Kuria, Narok, Loita Hills communities



1.3 Age of cutting

Overall, according to those surveyed, the most common age for girls to be cut is 12-14 years, however there are some differences between regions (chart 8). In targeted communities in Narok, girls are being cut at a slightly older age, between 12 and 17 years. Community researchers in Narok suggested that this is possibly due to some participants coming from the Kalenjin community in Narok, who tend to cut their daughters when they are slightly older (15-17 years). In targeted communities in Loita Hills, girls are cut at a slightly younger age, between 9 and 14 years.

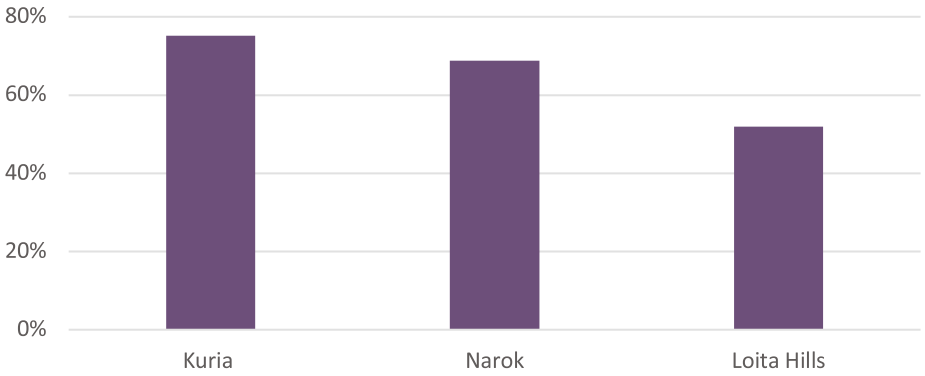
Chart 8: Age of cutting in Kuria, Narok, Loita Hills communities



1.4 Complications associated with FGC

Of the participants who stated that FGC takes place either in the family or in their community, the majority (66%) believe that girls and women who are cut suffer from complications (chart 9). This belief is most widely held in targeted communities in Kuria, where 75% of those surveyed recognise there are complications. In contrast, in targeted communities in Loita Hills, 52% of participants think that women and girls suffer complications from cutting.

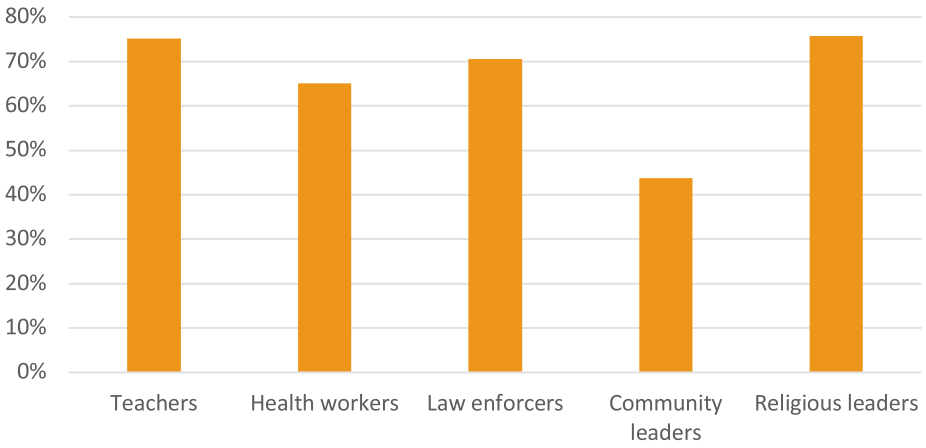
Chart 9: Percentage of people who feel women and girls suffer complications from FGC, by region



Young people surveyed, aged between 15-24, were more likely to feel that girls and women suffer from complications (73%), than 25-40 years olds (67%) or those over 40 years old (57%).

Professionals surveyed (health professionals, teachers and law enforcers) are significantly more aware that girls and women suffer complications as a result of FGC (chart 10), with community leaders being less knowledgeable than the professionals.

Chart 10: Percentage of people who feel women and girls suffer complications from FGC, by role



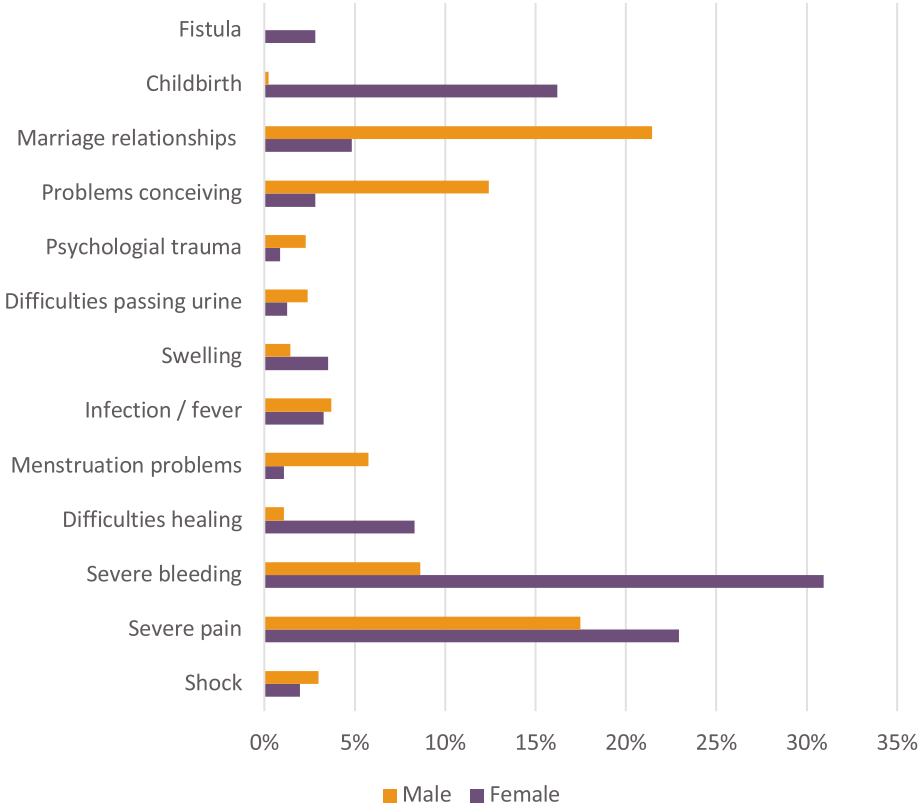
Of those participants who have attended school, 69% felt that girls and women suffer complications from FGC, as opposed to just 39% of those who have not attended school.

Participants identified a wide range of complications caused by FGC. There are slight differences between the answers given by participants from the different regions, however there are more striking differences between these complications disaggregated by gender (chart 11).

Women surveyed identified severe bleeding after cutting, severe pain, difficulties healing and difficulties in childbirth. Men surveyed identified difficulties within marital relationships, severe pain and problems conceiving.

Less than 10% of participants mentioned problems with menstruation, difficulties passing urine, swelling, infections or fever, which suggests that participants may not know about these issues or do not directly associate these with FGC.

Chart 11: Complications by gender



1.5 Conclusion:

Across all targeted communities, the majority of participants (80%) are aware that FGC is taking place in their communities. There are, however, differences in participants' perceptions of how widespread FGC is. In the targeted communities in Kuria and Narok, most participants think that cutting is carried out by the minority of families in their community, while in the communities reached in Loita Hills, surveyed participants believe cutting is practised in most or all families. This suggests that the social norm and expectation in the communities reached in Loita Hills is for girls to be cut, with less expectation of the cut in the communities reached in Narok and Kuria.

The way in which the practice is carried out varies between the communities reached, with participants identifying FGC as happening mostly "in secret" in targeted communities in Narok and Loita Hills but more likely to involve public celebration in targeted communities in Kuria. It has been suggested by grassroot organisations that FGC happening "in secret" could be in response to increased awareness of the FGC law and fear of prosecution.

The survey results are supported by external research, which shows that FGC is practised as a public celebration[18] in Kuria, whereas in Loita Hills and Narok, FGC is more likely to be carried out in secret.

Culture is cited as the main reason for the continuation of practice by survey participants, followed by FGC as a rite of passage, preparation for marriage, and ensuring purity and virginity. Less than 2% of participants identified religion as the reason for the cut.

The majority of participants recognise that women and girls suffer complications from FGC. This is slightly higher among male participants (54%) than female participants (48%). There is a difference in the complications identified by men and women surveyed. Women identified bleeding, severe pain and difficulties at birth, while men identified problems within marital relationships and difficulties conceiving children. This significant difference between those complications identified by men and women could suggest that there is limited

[18]https://www.feedtheminds.org/wp-content/uploads/2014/09/FGM-July-Report.pdf

dialogue on complications between genders, or that those interventions specifically focused on discussing impacts of FGC are not reaching both men and women equally.

Generally speaking, in the targeted communities in Narok and Loita Hills, the age of cutting is in line with KDHS statistics of the Maasai ethnic group from 2014.[19] In Kuria, while there is no specific KDHS data available (Kuria ethnic group not included), a Feed The Minds study from 2014 found that the age of cutting was 8-9 years of age[20]. This baseline review therefore suggests that the age of cutting has shifted slightly upwards in the targeted communities in Kuria, though there is some anecdotal evidence emerging from grassroot organisations on the ground of girls sometimes being cut at a lower age.

There does appear to be a correlation between the level of education, the level of understanding of complications associated with FGC, prevalence of FGC and intention to cut future daughters. Looking, for example, in communities targeted in Kuria, where the majority of participants have attended school, more people recognise that FGC leads to health complications.

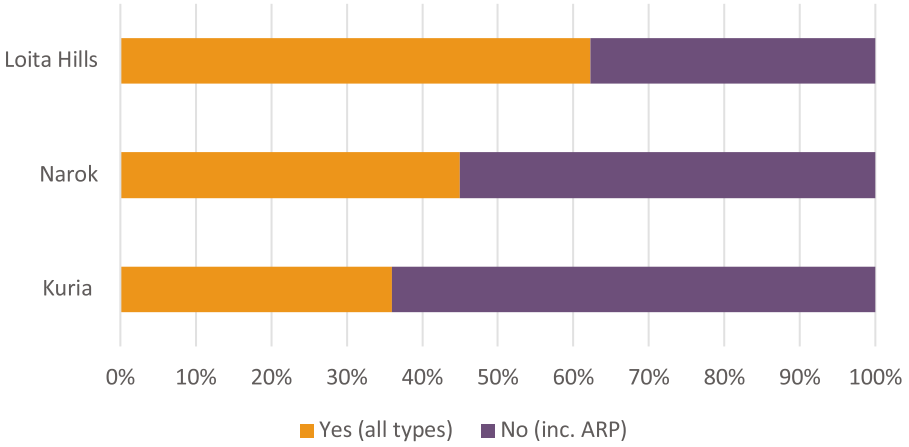
2. Perceptions of FGC practices within their extended family

Considering Kenya's national law against FGC, it was important not to directly ask participants whether they were cut or had cut their daughter/s to avoid collecting of inaccurate information and to protect the validity of the data. Instead participants were asked broader questions about the practice of FGC within their extended family.

2.1 Estimated prevalence of FGC within people's extended families

Overall, 49% of participants said that girls are cut in their extended family. Communities targeted in Loita Hills has the highest perceived prevalence with 62% of participants stating cutting takes place in their family, while in targeted communities in Kuria and Narok this figure was 36% and 45% respectively (chart 12). The perceived prevalence rates in individual targeted communities vary considerably, from 21% in Masaba Town, Kuria, to 92% in Imartin, Loita Hills.

Chart 12: Reported prevalance of cutting in Loita Hills, Narok and Kuria



Use of an Alternative Rite of Passage (ARP) ceremony within families is not reported by any survey participants in targeted communities in Kuria. In targeted communities in Loita Hills and Narok 7% and 4% of participants, respectively, report ARP happening within their extended families. There is additional evidence from SAFE Maa's team that indicates awareness and use of the ARP amongst SAFE's targeted communities in Loita Hills is significantly higher. A 2017 evaluation of the SAFE Maa programme found that 33% of community members are now using the ARP model in Loita Hills.[21] The discrepancy between this baseline review's figures and SAFE's internal evaluation could relate to the factors described in the limitations section.

[19]DHS 2014, available at: https://dhsprogram.com/publications/publication-FR308-DHS-Final-Reports.cfm

[20]Feed the Minds, 2014 'Female Genital Mutilation practices in Kenya: The role of alternative rite of passage: A case study of Kisii and Kuria districts'

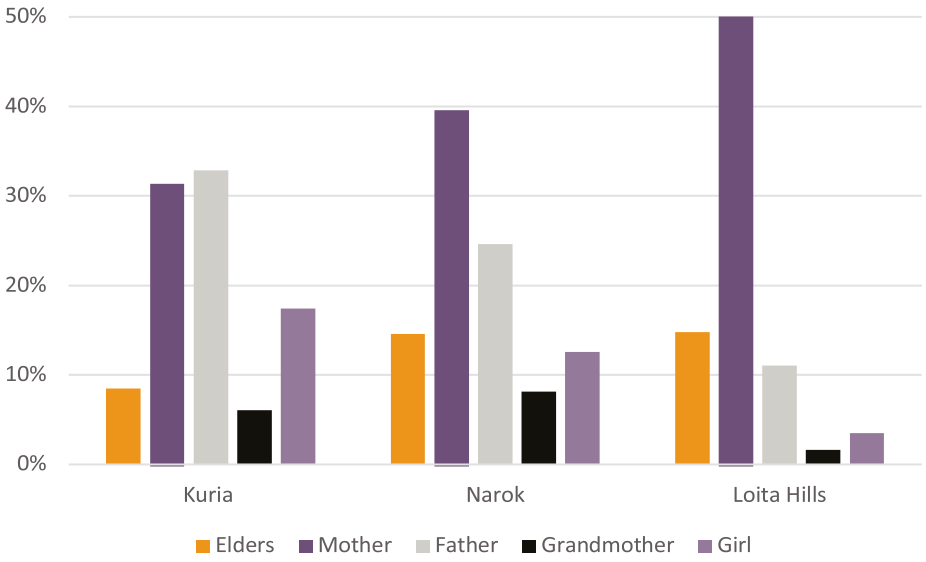
[21]SAFE Maa "Ending FGC in Loita Hills" programme evaluation report (2017) – showed 33% or participants aware of and using ARP IN 2017

2.2 Who is deciding whether a girl should be cut or not?

In the targeted communities in Narok and Loita Hills, the mother is identified by survey participants as the primary decision-maker in relation to whether girls are cut (chart 13). This is especially the case in communities in Loita Hills with over four times as many participants saying the mother decides compared to those saying the elders make the decision.

In targeted communities in Kuria, it appears that decision-making is shared more between mothers and fathers with equal numbers of participants saying fathers and mothers are responsible for the decision. In targeted communities in Kuria and Narok, 17% and 13% of participants perceive girls as now the main decision makers.

Chart 13: Who decides whether a girl is cut, by region

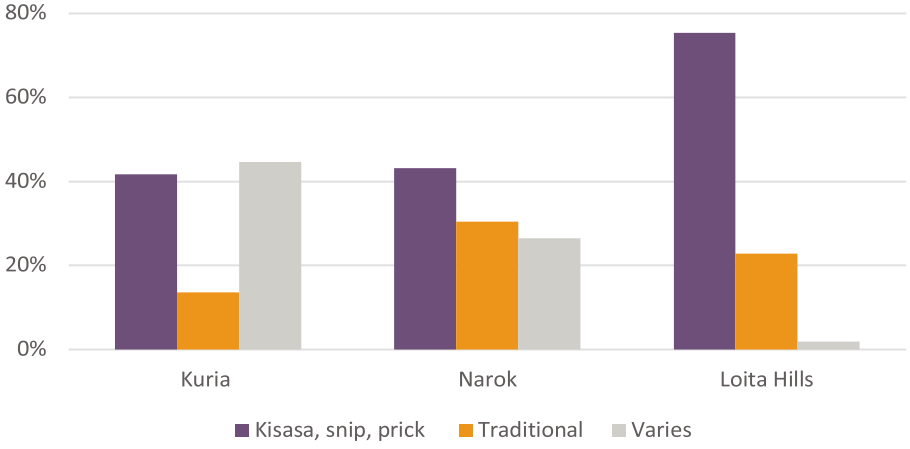


2.3 Types of cut used

Participants identified the kisasa, snip or prick as being the most common types of cut being practised amongst families that continue FGC (chart 14). However, the perceived prevalence of the traditional type is significant in all three areas, and practised by at least 14% of families who cut in targeted communities in Kuria, 30% and 23% in targeted communities in Narok and Loita Hills respectively.

In the targeted communities in Kuria and Narok it is quite common for the type of cut used to vary from one girl to another within an extended family, making it difficult to state the precise ratio of girls undergoing the traditional cut or the kisasa, snip or prick.

Chart 14: Types of cut used, by region

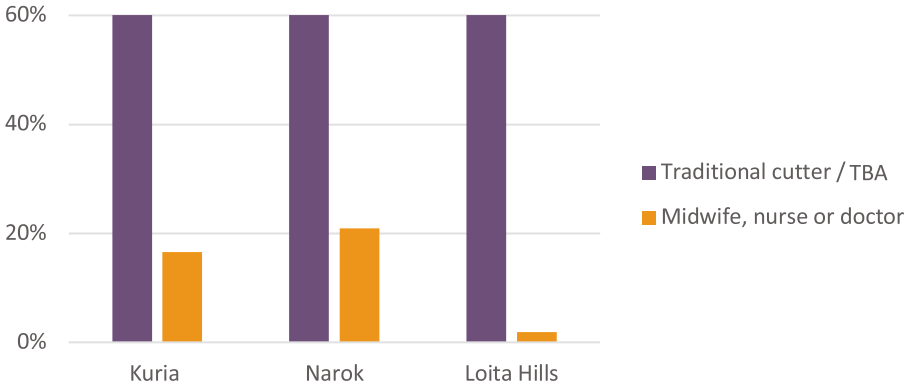


2.4 Who is carrying out the cut

Across all targeted communities, where cutting takes place, survey results show that the majority (86%) is undertaken by traditional birth attendants (TBAs) or traditional cutters (chart 15). However overall, of those participants that said cutting happens within their extended family, 14% said that girls are cut by health professionals (e.g. nurses, midwives and doctors).

A number of participants surveyed in targeted communities in Kuria and Narok identified health professionals as carrying out the cut (17% and 21% respectively). In targeted communities in Loita Hills, this number was significantly lower (1%). This is likely due to there being fewer local health facilities in Loita Hills and hospitals are a considerable distance away.

Chart 15: Who performs the cut, by region



2.5 Conclusion

Overall, 49% of survey participants said that FGC takes place in their extended family, with the perceived prevalence being higher in Loita Hills (62%) than in Narok (45%) and Kuria (36%). An ARP celebration is not widely recognised as common practice by those surveyed in any of the targeted communities.

Mothers are seen by those surveyed as the key decision makers by the majority of participants with regard to the cut, especially in communities targeted in Loita Hills. In the communities targeted in Kuria, and to some extent in Narok, surveyed participants identified fathers as playing a more significant role in relation to FGC. Also, in communities in Kuria, girls were seen more as the main decision-makers. While this cannot be directly compared due to limited data, this could suggest youth empowerment, and specifically girls' empowerment, initiatives are influencing the perceived role of young people in these communities.

Traditional cutters and TBAs are identified by survey participants as key individuals carrying out the cut in all targeted communities, identified as undertaking 86% of the cutting. However, in 14% of families where FGC takes place, participants stated that it was carried out by health professionals (nurses, midwives and doctors). This is more common in the communities targeted in Kuria and Narok than in Loita Hills, probably due to access to medical services being limited in the Loita area.

This baseline review supports the growing evidence[22] showing trends away from the type of cut perceived to be 'more harmful', and towards other forms of cutting. This could suggest that interventions focused on health impacts of FGC have played a role in shifting the form of cutting from the traditional cut to kisasa, snip or prick. However, caution is needed here to recognise this shift may lead to legitimisation of some forms of FGC, including medicalised cutting, making total abandonment of FGC more difficult.

[22]https://www.popcouncil.org/uploads/pdfs/2019RH_FGMC-MedicalisationKenya_brief.pdf

3. Knowledge of human rights and laws in relation to FGC

In recent years there have been increasing efforts within Kenya, and in the East Africa region more broadly, to establish national laws prohibiting the practice, including the Kenyan Children's Act 2001, the Kenyan Prohibition of Female Genital Mutilation Act 2011 (establishing the Kenya Anti-FGM Board) and the East Africa Community Prohibition of FGM Act 2016[23]. FGC prevalence rates in Kenya have fallen from 38% in 1998 to 21% in 2014 (KDHS 2014) and it has been suggested that having an enforced national law can play a role in contributing to FGC abandonment when implemented alongside other interventions supporting social change[24]. Nonetheless, in the case of Kenya, the FGM Act 2011 has not been effectively implemented due to ambiguity within the act itself, lack of accessibility at local level and lack of capacity to effectively implement the law. There appears to be a distinct disconnect between local CBOs and national efforts[25].

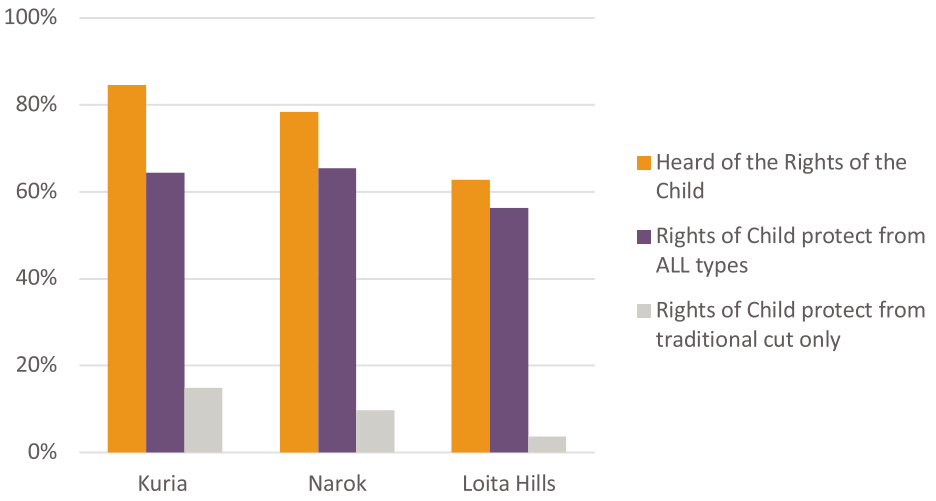
There have been increasing efforts to approach the issue of FGC from a human rights and child rights perspective, suggesting confidence in the approach of increasing awareness of human rights in order to shift attitudes towards the practice[26]. Therefore, this baseline review aimed to understand participants' understanding of the national law, human rights and communities' perceived link, if any, between human rights and FGC.

3.1 Knowledge of the Rights of the Child

Overall, 77% of surveyed participants have heard about the Rights of the Child (chart 16). Most think that the Rights of the Child should protect girls from all types of cutting. Awareness was highest in targeted communities in Kuria (84%), followed by communities in Narok (78%), where awareness raising has been taking place for some time, and a higher proportion of people have attended school. Awareness was lowest in the targeted communities in Loita Hills (62%), although almost all those who have heard of the Rights of the Child also know it should protect girls from all types of cutting.

Younger survey participants from all communities have a greater awareness of the Rights of the Child and the implications for FGC than older participants.

Chart 16: Knowledge of Rights of the Child, by region



Virtually all teachers (99%), health workers (94%) and law enforcers (100%) surveyed are aware of the Rights of the Child with over 80% knowing that it should protect girls from all types of cutting. Surveyed community leaders appear to be slightly less aware with 71% knowing that it should protect girls from all types of FGC.

[23]https://www.28toomany.org/static/media/uploads/Law%20Reports/kenya_law_report_v1_(may_2018).pdf

[243]https://www.unicef.org/media/files/UNICEF_FGM_report_July_2013_Hi_res.pdf

[25]https://www.28toomany.org/static/media/uploads/Law%20Reports/kenya_law_report_v1_(may_2018).pdf

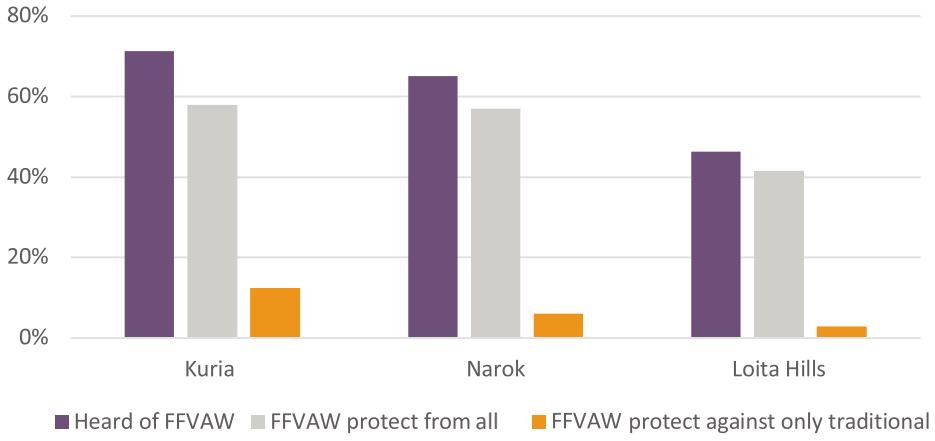
[26]https://www.unicef.org/media/files/UNICEF_FGM_report_July_2013_Hi_res.pdf

3.2 Knowledge about the Right to Freedom from Violence Against Women and Girls

Compared to knowledge of the Rights of the Child, overall, slightly fewer participants (62%) have heard of the Right to Freedom from Violence Against Women and Girls (FFVAWG). However, similar to knowledge of the Rights of the Child (above), there is a pattern showing that most of those who have heard of the Right to Freedom from Violence Against Women and Girls feel that it should protect girls from all types of cutting (chart 17).

Once again, those from targeted communities in Loita Hills are less aware than those in targeted communities in Kuria and Narok, and younger participants are more likely to be aware of the Right to Freedom from Violence than their older community members.

Chart 17: Knowledge of Freedom from Violence Against Women and Girls, by region

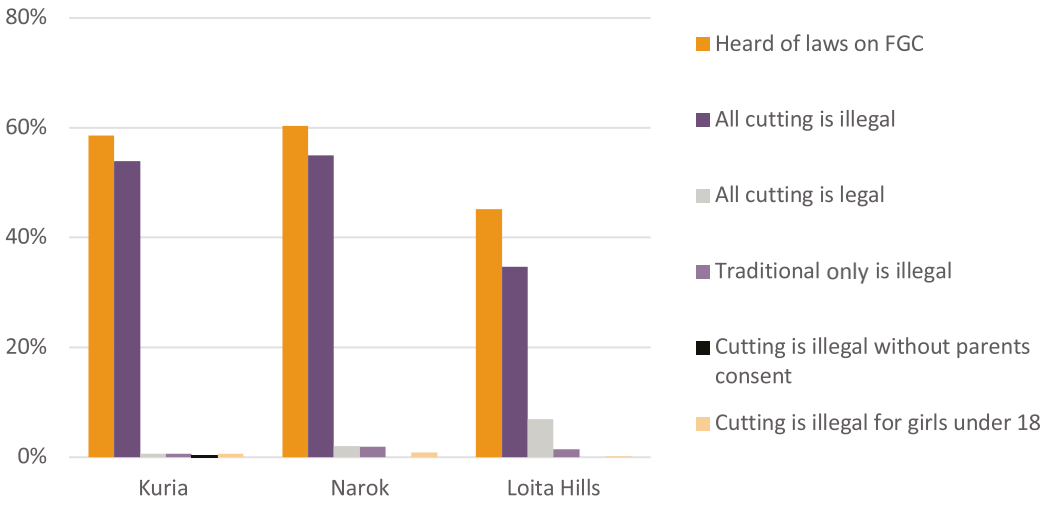


A high level of awareness is shown among teachers (88%), health workers (87%) and law enforcers (100%) surveyed, with over 75% of all professionals combined knowing that FFVAWG should protect girls from all types of cutting. Surveyed community leaders appear to be slightly less aware with 64% knowing that it should protect girls from all types of FGC.

3.3 Knowledge about the law on FGC in Kenya

Overall, 56% of participants know that there is a law on FGC in Kenya and most of those who have heard of it also know that it aims to protect girls and women from all types of cutting (chart 18). Awareness is greatest among targeted communities in Kuria and Narok and least in Loita Hills.

Chart 18: Knowledge of the law on FGC, by region



There is a clear link between the level of education and knowledge of the law. 69% of those who have attended school are aware of the law on FGC, as opposed to 39% of those who have not attended school.

A high level of awareness of the law is shown among surveyed teachers (79%), health workers (84%), law enforcers (89%) and community leaders (79%).

3.4 Conclusion

The majority of participants (77%) have heard of the Rights of the Child, with highest awareness in targeted communities in Kuria. Of those that have heard of the Rights of the Child, the majority believe it should protect girls from all forms of FGC. A smaller majority (62%) have heard of the FFVAWG, however, again, the majority of those aware of this right feel it should protect a girl from all types of FGC. Knowledge of the national law on FGC is slightly lower (56%) than knowledge of Rights of the Child and FFVAWG and lowest in the more remote areas of Loita Hills, where only 35% of participants know that all types of FGC are illegal.[27] The lower level of awareness of the law is in contrast to other anecdotal and research evidence emerging now to suggest that wide knowledge of the law is potentially pushing the practice underground.[28] Access to education appears to be a factor in participant's understanding of the international rights and national law, with 69% of participants with some educational background having heard of the laws as opposed to 39% of participants who have never attended school.

Professionals (teachers, health workers and law enforcers) and community leaders surveyed tend to have higher levels of awareness and knowledge on the Rights of the Child, FFVAWG and the law on FGC than the community as a whole. However, there are some within all of these groups who lack accurate information and could benefit from dialogue and exchange with their peers.

4. Future intentions in relation to FGC

When communities begin to abandon FGC, the overall prevalence rates decrease relatively slowly. This is because change primarily affects the prevalence among the younger generation, yet women who have already been cut continue to be included in the data. Therefore, future intentions, in terms of whether or not daughters will be cut and preferences about future wives or daughters-in-law, provides another possible way of identifying attitudinal change in relation to FGC.

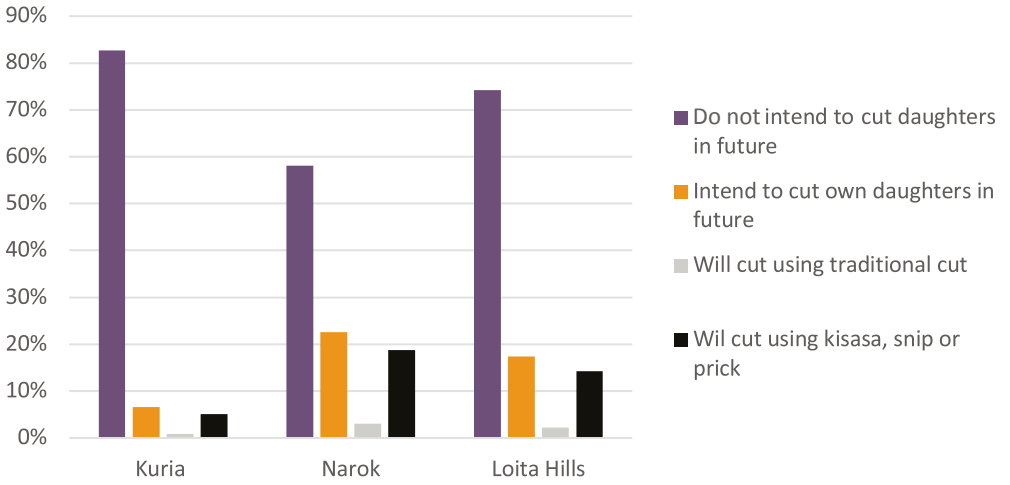
[27]There could be scenarios where an individual knows that the practice is illegal but is unaware of specific laws related to FGC. The lived experience of SAFE Maa supports other anecdotal and research evidence (see footnote 26) whereby the widespread police crackdown on FGC in 2018 pushed FGC underground, indicating that people are aware of the illegality of the law even though they are not aware of specific laws on FGC. This will be interrogated further in a follow up study in 2021.

[28]Matanda, D., Okondo, C., Kabiru, C.W. & Shell-Duncan, B., Tracing change in female genital mutilation/cutting: shifting norms and practices among communities in Narok and Kisii counties, Kenya, Population Council (2018)

4.1 Intentions in relation to future daughters

Overall, 71% of community members surveyed said they do not intend to cut their daughters in the future (chart 19). In the targeted communities in Narok, a greater number (42%) of participants intend to cut their daughters, as opposed to in Kuria (17%) and Loita Hills (26%), respectively. This difference may be because of the significant Kalenjin community in Narok who, anecdotal evidence suggests, are more traditional in their attitudes towards cutting, than the Maasai or Kurian communities.

Chart 19: Future intentions to cut daughters, by region

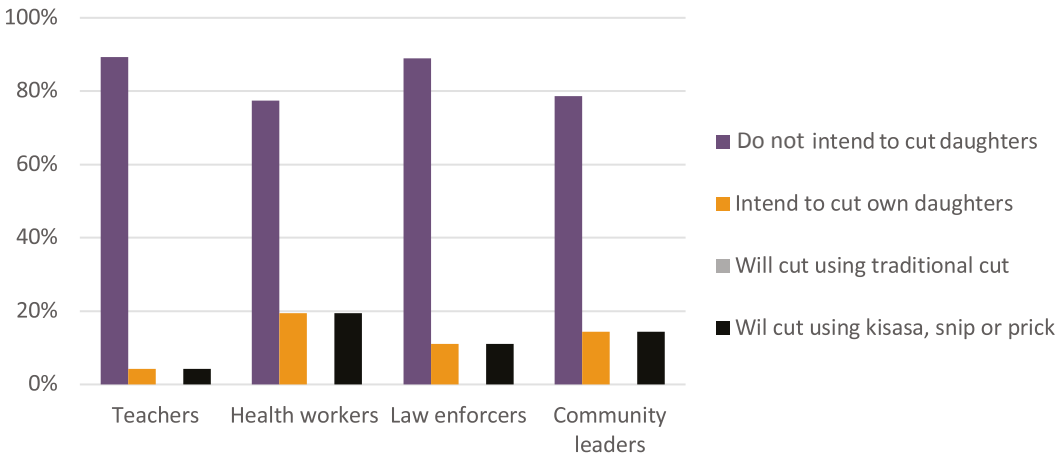


There is no significant difference between the intentions of men and women surveyed. However, age does appear to be a factor, with 87% of young participants, aged 15-24, not intending to cut in the future, as opposed to 80% of those participants over 40 not intending to cut their daughters in the future.

The majority of professionals surveyed do not intend to cut their daughters. However, a small percentage of teachers (4%), health workers (19%), law enforcers (11%) and community leaders (14%) intend to cut their daughters using the kisasa, snip, or prick (chart 20).

Overall, 62% of participants who intend to cut their daughters are aware that all forms of FGC are illegal in Kenya.

Chart 20: Intentions for own daughters, by role

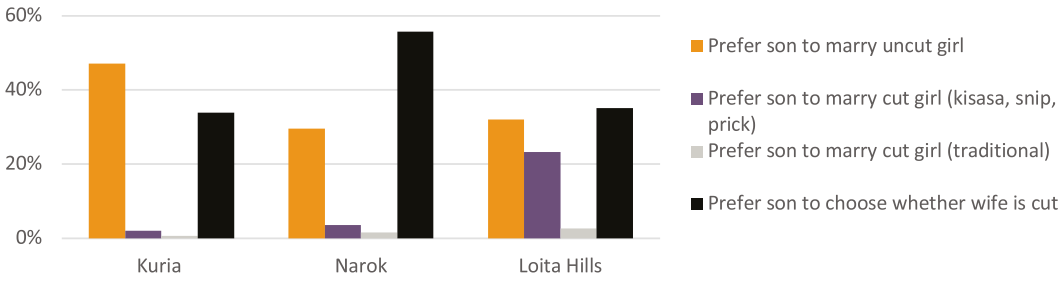


4.2 Preferences for future daughters-in-law

Overall, 36% of participants would prefer their son to marry an uncut woman (chart 21). This figure is higher in targeted communities in Kuria (47%) than in Narok (30%) and Loita Hills (32%). A significant percentage (35%) of participants, especially in the communities in Narok, prefer to allow their son to choose who to marry (cut or uncut).

In the targeted communities in Loita Hills, 26% of participants would prefer their son to marry a cut woman, with almost all of these preferring her to have undergone the kisasa, snip or prick.

Chart 21: Preferences for daughters-in-law, by region

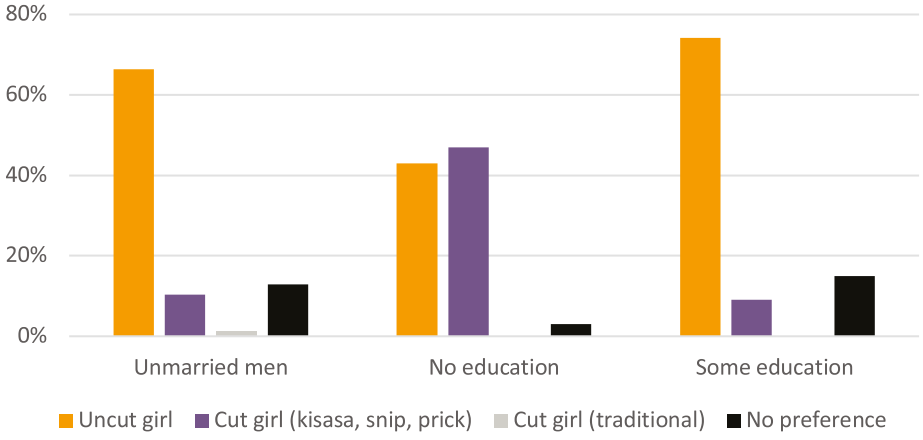


4.3 Preferences of unmarried men

Chart 22 shows surveyed unmarried men's preferences for their future wives across the three areas. Overall, two thirds of surveyed unmarried men would prefer to marry an uncut woman with an additional 15% having no preference.

There is a marked difference in preferences between those unmarried men who have attended school and those who have not. 47% of unmarried men who have not been to school would prefer to marry a cut woman, as opposed to just 9% of those who have attended school, even if only early primary classes.

Chart 22: Preference for future wife of unmarried men, by education



4.4 Conclusion

Overall, 71% of participants do not intend to cut their daughters in the future. Where there is an intention to cut, most people across all communities intend to use kisasa, snip or prick. This figure needs to be interpreted carefully, as in some cases this represents a future intention or preference, rather than a firm commitment, as demonstrated by a woman in Loita Hills who said:

> ***"I don't intend to cut my daughter but it will depend on the community as the community has more power."***

The intentions of surveyed women and men in relation to the cutting of their daughters in future are similar. However, young people surveyed aged 15-24 years, appear less inclined to cut their daughters than older people.

The majority of professionals surveyed do not intend to cut their daughters in the future. However, despite high education and knowledge levels, 20% of health workers and 11% of law enforcers intend to cut their daughters (kisasa, snip or prick). Teachers (4%) are the least likely to cut future daughters, which could be correlated with teachers being the main group aware of the complications that girls face during school.

Overall, 36% of survey participants would prefer their sons to marry an uncut woman, although a trend for sons choosing who they would like to marry is common, particularly in the targeted Narok communities. Most unmarried men surveyed want to marry an uncut woman, although this is less the case among unmarried men who have not attended school.

There appears to be a link between the level of education, knowledge of complications of cutting and participants' intentions to cut. Those who have had access to education tend also to have a higher awareness of the complications of cutting, greater knowledge of the law and fewer intent to cut their daughters.

5. Movement towards abandonment

With an active civil society and a recent decline in national prevalence of FGC (27.1% in 2008-9, 32.2% in 2003 and 37.6% in 1998) , Kenya is often looked to internationally as an example of significant change and movement towards ending the practice. Therefore, this study sought to understand what kind of conversations are taking place in relation to FGC currently at the local level, who is perceived to be opposing and supporting FGC and whether people would like to see and be involved in the abandonment of FGC in the future.

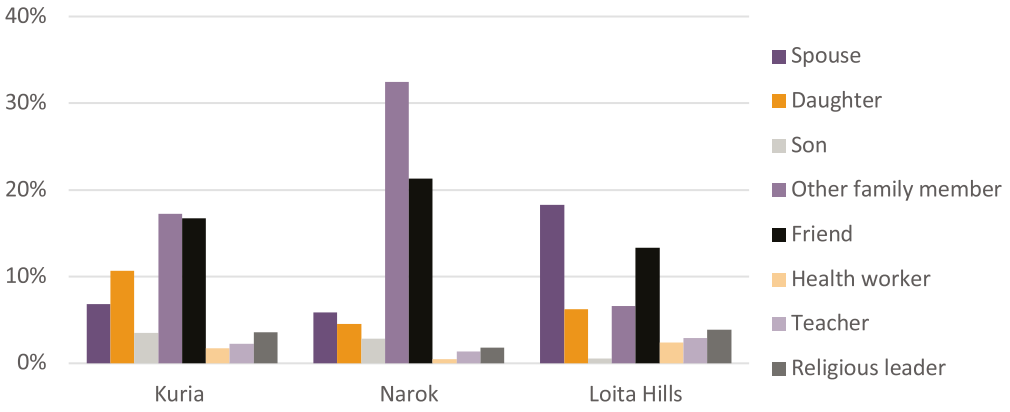
5.1 Talking to others about FGC

Overall, only 43% of participants said they had talked to someone about FGC in the last year (chart 23). In all areas, the majority of these conversations took place within the extended family, with few taking place with health workers, teachers, religious leaders.

In the targeted communities in Loita Hills, these conversations mainly took place with a spouse and/or friends, whereas in Narok they took place mainly with other family members. Sons have only been part of these conversations occasionally, and hardly involved at all in Loita Hills.

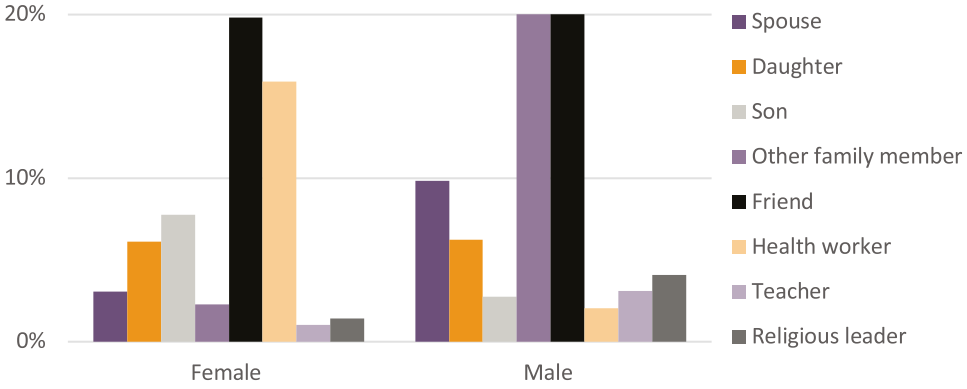
[29]Country profile: FGM in Kenya, 28 Too Many 2013, available at: https://www.28toomany.org/static/media/uploads/Country%20Research%20and%20Resources/Kenya/kenya_country_profile_v3_(july_2017).pdf

Chart 23: Talking to others about FGC, by region



The survey results showed there is a difference between the types of people that participating women and men talk to about FGC (chart 24). Male participants are more likely to talk about FGC with a friend, a family member or their spouse. They are more likely to talk to their daughter/s than their son/s. Female participants are more likely to talk about FGC to a friend or a health worker. They appear to be more likely to talk to their son/s than their daughter/s.

Chart 24: Talking to others about FGC, by gender

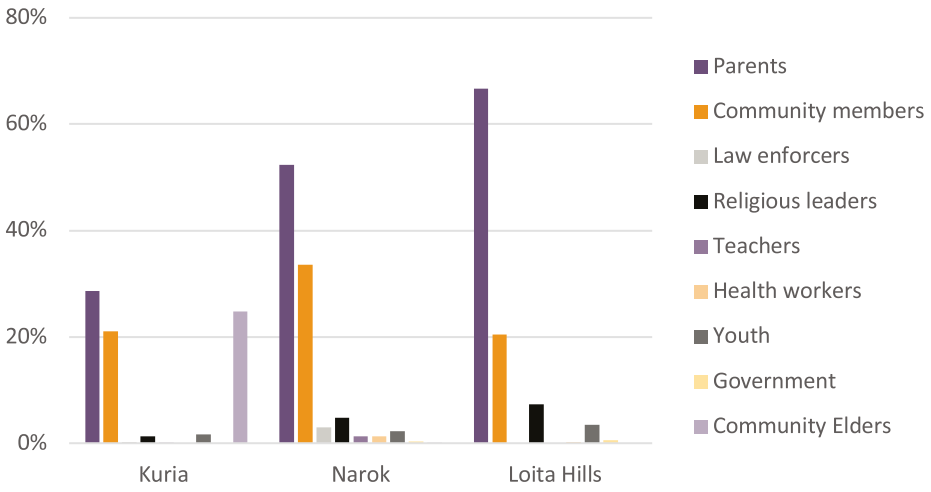


5.2 Perceptions of who supports and who opposes FGC

Across all targeted communities, the principal individuals who are seen to support FGC are parents and community members (chart 25). In targeted communities in Kuria, where the Council of Elders decides on the timing of the cut , participants also identified community elders as supporters of the practice.

[30]https://www.feedtheminds.org/wp-content/uploads/2014/09/FGM-July-Report.pdf

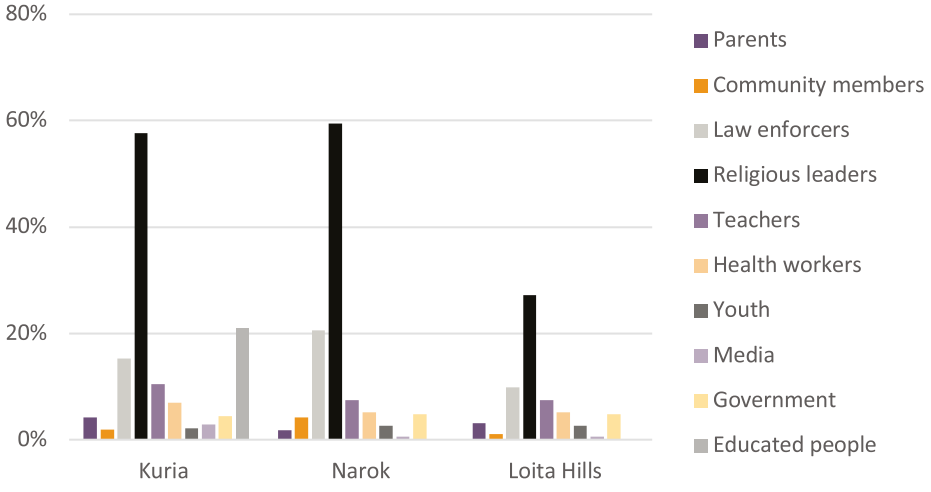
Chart 25: Who supports FGC, by region



Survey participants regard religious leaders as the group of people most strongly in opposition of FGC in all three area, especially in targeted communities in Kuria and Narok (chart 26).

In targeted communities in Kuria, educated people are the second most mentioned group by survey participants, whereas in communities in Narok and Loita Hills participants identified law enforcers as the second most mentioned group. Teachers, health workers, youth, government and media were all mentioned by less than 10% of participants as opposing FGC.

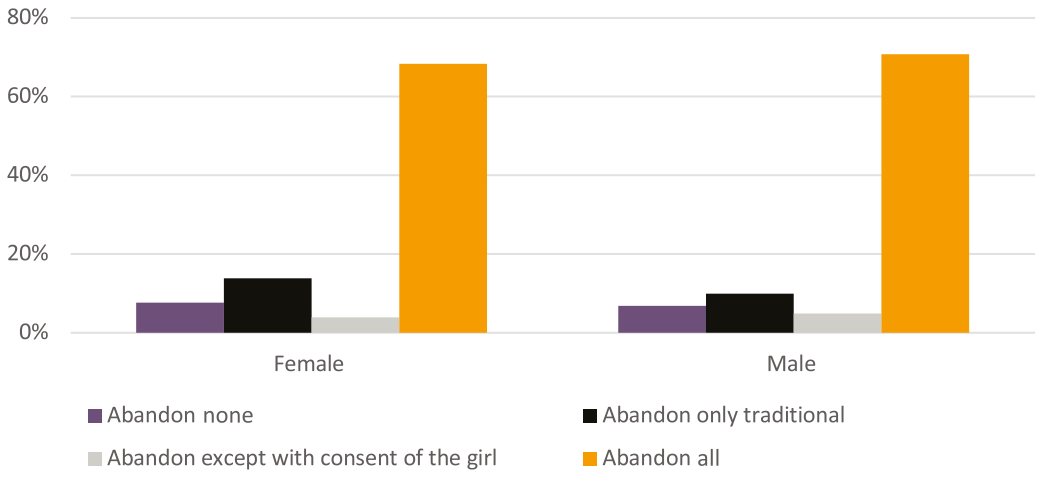
Chart 26: Who opposes FGC, by region



5.3 Support for abandonment

Overall, 69% of those surveyed would like to see abandonment of all types of cutting (chart 27). Female participants appear slightly less ambitious for change with more women (14%) than men (10%) wanting to see the abandonment of only the traditional cut (i.e. more women are supportive of continuing some form of cutting than men).

Chart 27: Preferences for abandonment, by gender



Greater numbers of younger people (15-24 years) surveyed are ambitious for change with 76% wanting to see the abandonment of all types of cutting (chart 28). In contrast, only 62% of participants aged over 40 years want to see the abandonment of all types and 14% of this age group do not want to see the abandonment of even the traditional cut.

Chart 28: Preferences for abandonment, by age

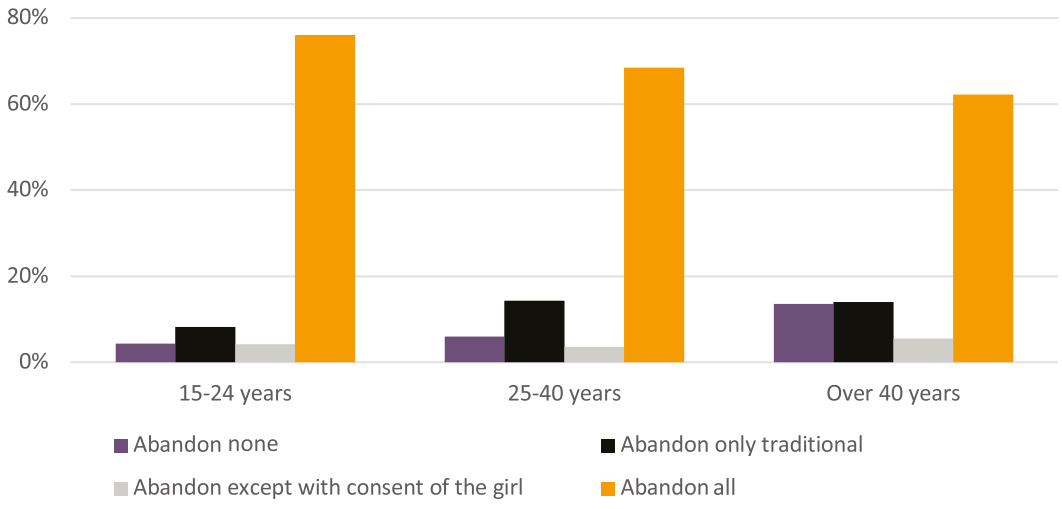
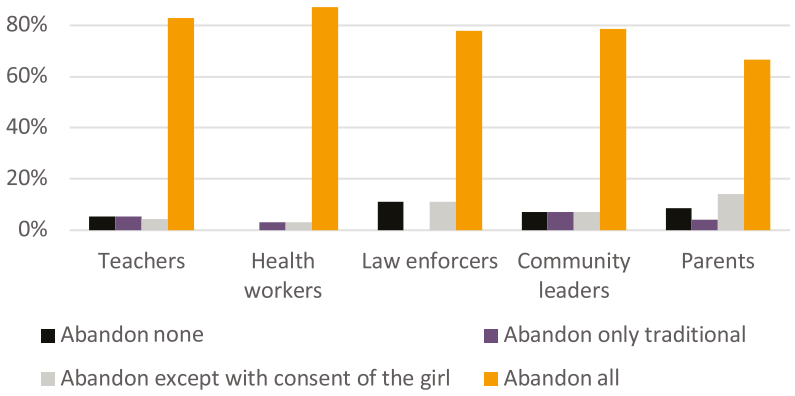


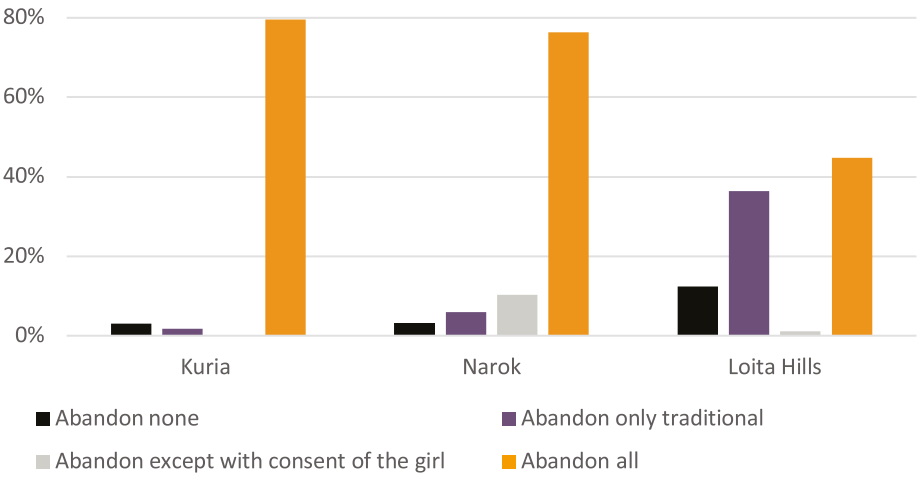
Chart 29 indicates that 67% of parents surveyed want to see the abandonment of all types of cut. Participating health workers, teachers, community leaders and law enforcers are slightly more likely to want to see the abandonment of all types of cutting than parents. However, there are some law enforcers that do not want to see the abandonment of any types of cutting.

Chart 29: Preferences for abandonment, by role



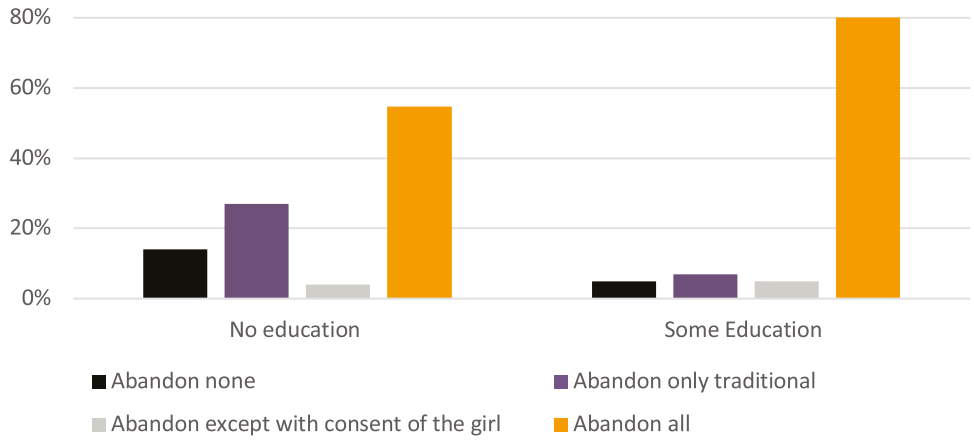
The majority of participants in the targeted communities in Kuria and Narok said they would like to see the abandonment of all types of cutting (chart 30). However, in communities in Loita Hills, 45% of participants would like to see the abandonment of all types of cutting, whilst 12% would like to see no abandonment of any type of cut, and 36% would like to see abandonment of the traditional cut only.

Chart 30: Preferences for abandonment, by region



Access to formal education, even the first years at primary school, appears to have a significant impact on participants attitude to FGC abandonment (chart 30). Overall, 82% of those surveyed that have attended some education would like to see the abandonment of all types of cutting, whereas only 55% of those who have not been to school at all want the same. 14% of those with no educational background want all types of cutting to continue, including the traditional cut. This links with the relative lack of knowledge about the law and human rights among those who have not attended school.

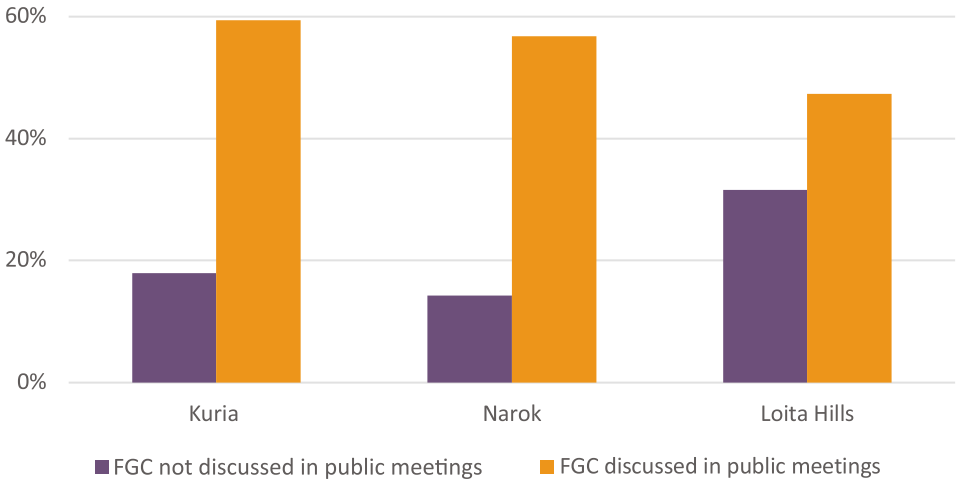
Chart 31: Preferences for abandonment, by formal education



5.4 Public dialogue about FGC

Overall, approximately half of the survey participants said that FGC had been mentioned in public meetings in their communities (chart 32). This was slightly higher amongst the survey respondents in Kuria (59%) as compared with Loita Hills (47%).

Chart 32: Public dialogue about FGC, by region

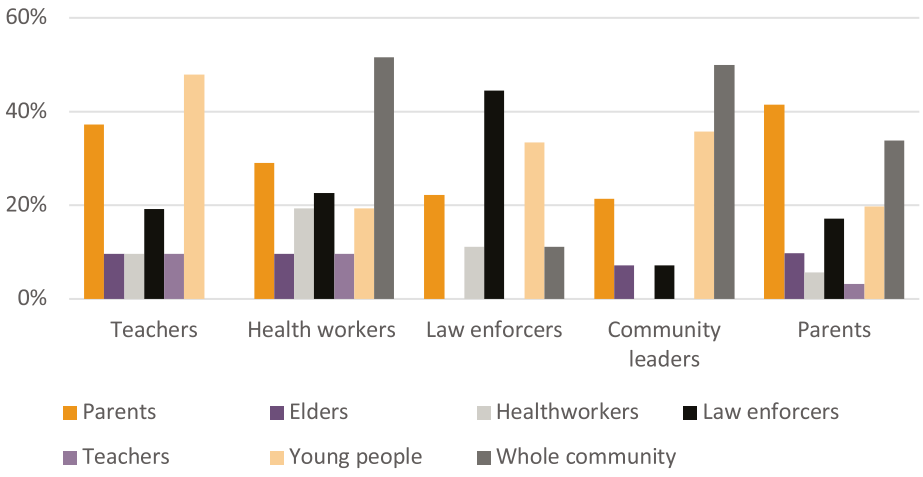


5.5 Responsibility to end FGC

Different groups of surveyed community members had quite different opinions on whose responsibility it is to end FGC (chart 33 and 34). Generally, the groups that participants feel have responsibility for ending FGC are parents, young people and the whole community. Overall, a small number of participants feel that teachers and health workers have a responsibility for ending FGC (3% and 5% respectively).

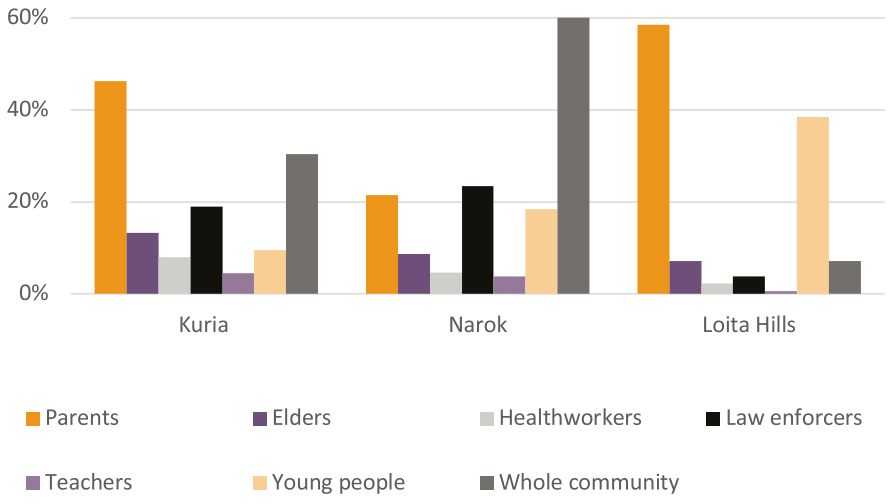
In targeted communities in Kuria, survey participants see parents and the whole community as having responsibility to end FGC, supported by law enforcers. The picture is similar in the targeted communities in Narok with increased mention of youth. However, in the communities targeted in Loita Hills, participants see parents holding most of the responsibility along with young people, with very few people seeing responsibility as being held by the whole community.

Chart 33: Whose responsibility to end FGC, by role



Surveyed teachers tend to think that parents and young people are those with the greatest responsibility to abandon FGC, whereas health workers place a greater responsibility on the whole community, parents, law enforcers, health workers and youth. Law enforcers see themselves as those most responsible, followed by youth and parents. Community leaders, like health workers, take a more collective view and see the whole community as responsible for bringing about change.

Chart 34: Whose responsibility to end FGC, by region

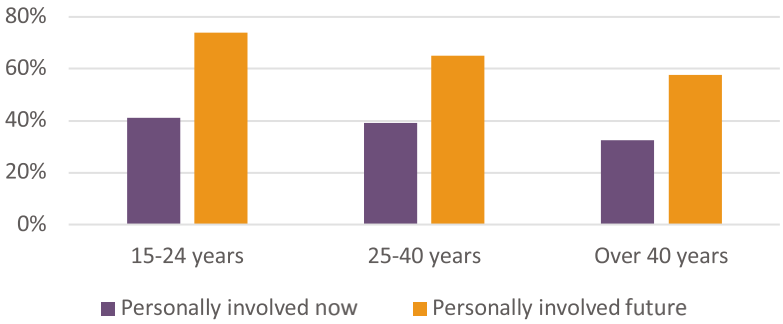


5.6 Involvement in activities to end FGC

Overall, 38% of surveyed community members are currently involved in activities to end FGC (chart 35). Surveyed teachers, law enforcers, health workers and community leaders are almost twice as likely to be involved in such activities, which primarily includes advising parents and talking in schools and churches.

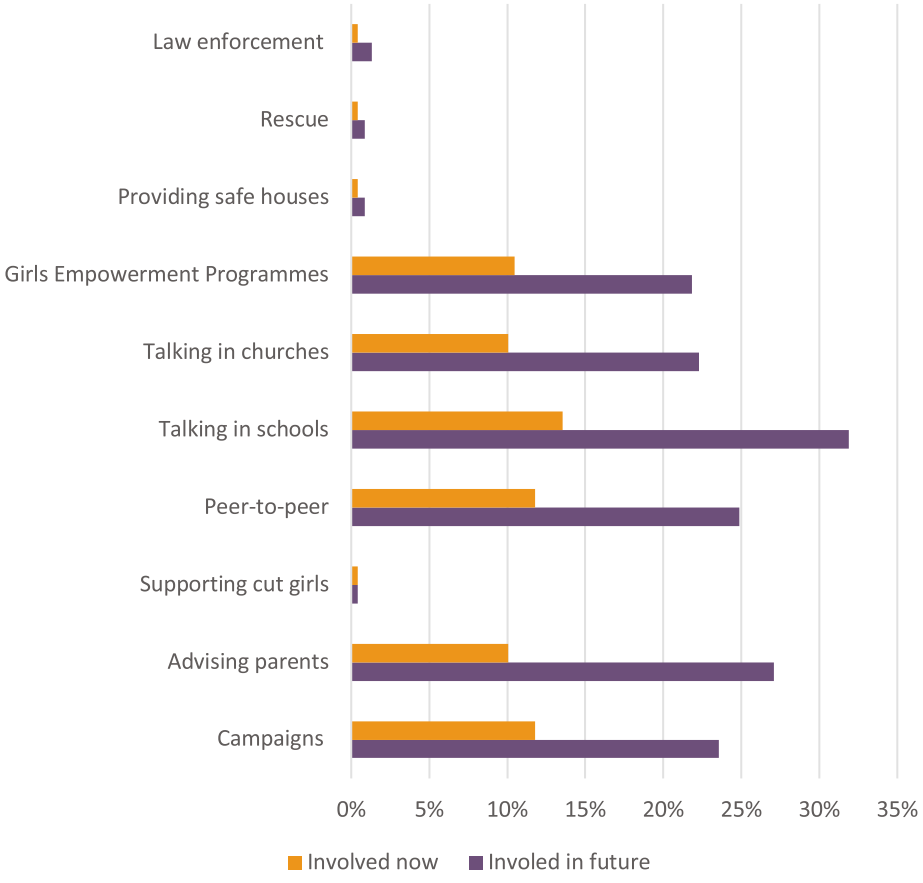
Many more participants said they would like to get involved in activities to end FGC in the future than are involved currently. This is most marked among young people where 41% are involved currently but 74% would like to be in the future (chart 35).

Chart 35: Involvement in activities to end FGC, by age



Young people surveyed said they are currently involved in girls' empowerment programmes, talking in churches, talking in schools, peer-to-peer education, advising parents and campaigns, with twice as many wanting to be involved in each of these in the future (chart 36). In addition to the other activities, they want to get involved in peer support and girls' empowerment programmes.

Chart 36: Involvement of young people (15-24 years) now and in the future in activities to end FGC



5.7 Conclusion

The majority of people surveyed (69%) want to see an end to all types of FGC, with this figure highest amongst young people. Preference for total abandonment is highest in the targeted communities in Kuria (80%) and Narok (76%), in comparison to Loita Hills (45%) where almost as many participants would prefer to only see the abandonment of the traditional cut. These figures are, as expected, lower than the national KDHS figures for Kenya[31] which shows approximately 90% of people think all types of FGC should be abandoned.

Health workers and teachers are not considered by survey participants to have much responsibility for ending FGC, despite both these groups having high preferences for total abandonment and being in professions that engage with both youth and parents.

As seen in the sections above, educational attainment appears to play a role in people's preference for abandonment, with 82% of those surveyed who've had some level of formal education in favour of total abandonment as opposed to 55% of those without formal education in favour of abandonment.

Parents, followed by the community, are seen as the biggest supporters of the practice across all three areas, yet 67% of surveyed parents stated they would want to see abandonment of all types of cutting. Religious leaders are perceived as the biggest group that opposes the practice, followed by law enforcement, teachers and health workers. Parents and the community are also identified by survey participants as those most responsible for bringing change in all three areas.

Engaging in community dialogue on the issue of FGC does appear to be happening in all three regions. However, conversations with health workers, teachers and religious leaders do not appear to be common. Participants are more likely to speak to a friend or extended family member than a health worker, teacher, religious leader or spouse.

What the data appears to show is that participants' internal preferences are not known to others in the community. This is particularly true of parents who are perceived to be primarily in favour of the practice, but with 67% of surveyed parents stating that they want to see abandonment of all types. With less than half of the participants sharing they had been involved in community dialogue on FGC, there is opportunity here to ensure spaces are created where individuals in the community can safely share their beliefs, preferences and intentions with one another.

6. Attitudes and actions of teachers in relation to FGC

Schools are influential organisations in Kenyan communities, so it is important to know about the attitudes of teachers in relation to FGC. Therefore, teachers were asked additional questions related to what they believed their role was, if any, in relation to FGC, what conversations they are involved in regarding FGC at school and whether parents or pupils were approaching them on the issue. A total of 94 teachers were interviewed in 33 schools across the three regions (table 1). In the targeted communities in Loita Hills, there are no secondary schools, so researchers only visited primary schools.

Table 1. Numbers of schools visited and teachers interviewed

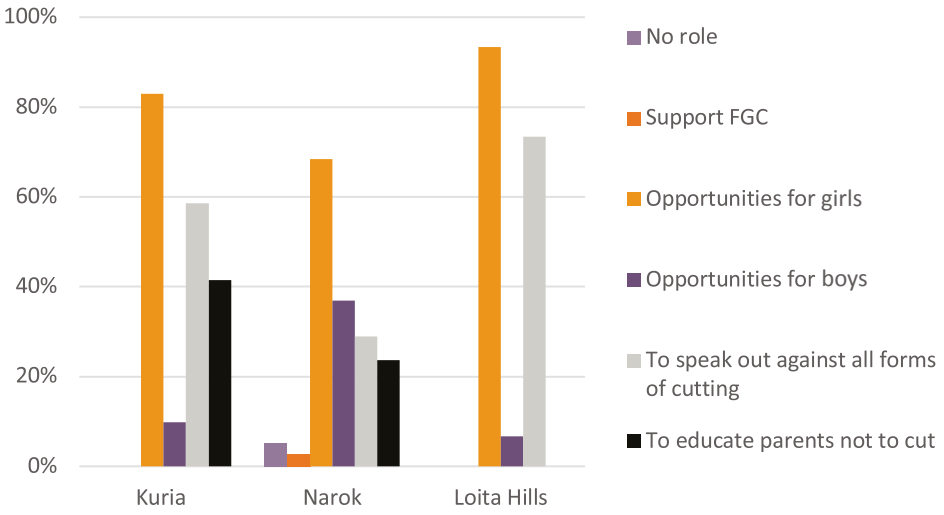
Region	Number of teachers interviewed	Number of schools visited
Kuria	41 teachers interviewed 21 female / 20 male	11 school visited - 8 primary (including 1 early child development (pre-primary) / 3 secondary
Narok	38 teachers interviewed 18 female / 20 male	9 schools visited - 4 primary, 5 secondary
Loita Hills	15 teachers interviewed 4 female / 11 male	13 schools visited - all primary

[31]https://dhsprogram.com/pubs/pdf/FR308/FR308.pdf

6.1 Roles of schools and colleges on FGC

Virtually all teachers surveyed (97%) feel that there is a role for schools and teachers to play in relation to FGC. Some teachers speak of multiple roles for schools. Overall, half identified this role as speaking out against all forms of cutting (chart 37). The teachers surveyed feel the main roles of schools is in providing opportunities for girls to learn about FGC (chart 37). In targeted communities in Narok, a higher percentage of teachers (37%) than in Kuria and Loita Hills feel that schools should provide opportunities for boys to learn about FGC. In targeted communities in Kuria and Narok a third of teachers surveyed feel schools have a role to play in educating parents, while in the communities targeted in Loita Hills teachers felt this was less of a priority. There is a similarity in views between male and female teachers surveyed in this baseline review.

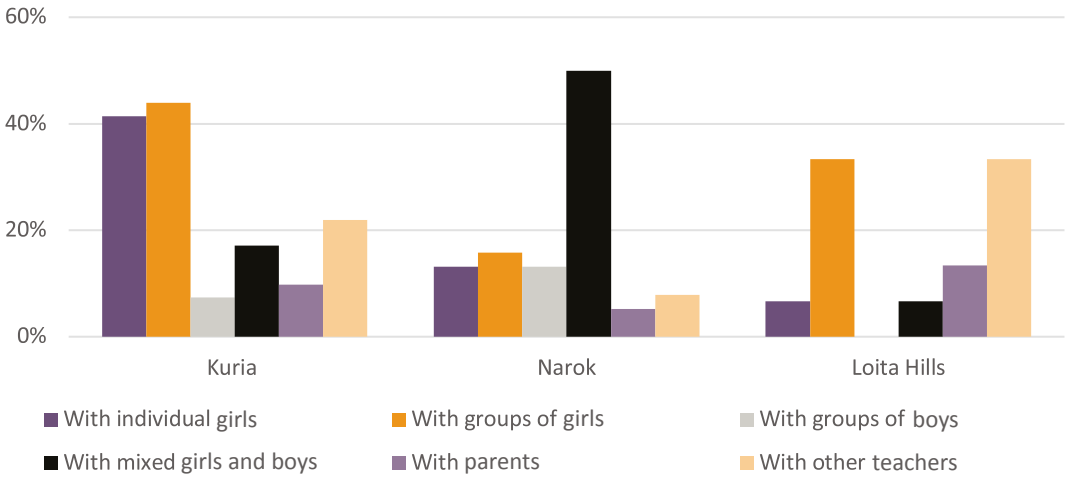
Chart 37: Role of schools and colleges, by region



6.2 Conversations taking place in schools on FGC

Most teachers (95% female and 82% male) surveyed talk about FGC in schools, however the types of conversations differ in the three regions (chart 38). In targeted communities in Kuria, conversations are more likely to take place with individual girls, or groups of girls. However, in the targeted communities in Narok, conversations tend to take place with mixed groups of girls and boys. In the targeted communities in Loita Hills the focus is on groups of girls and teachers talking to other teachers. Overall, only 9% of teachers surveyed, mainly female, talk to parents about FGC.

Chart 38: Teachers talking about cutting in schools, by region

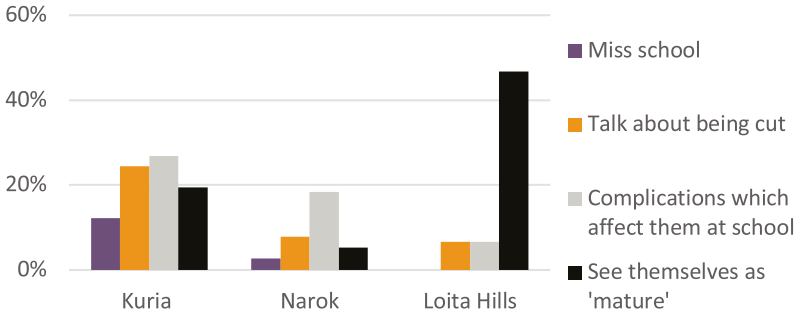


6.3 How teachers know girls have been cut

Overall, 51% female teachers and 37% male teachers surveyed think they know when individual girls have been cut. In the targeted communities in Kuria, girls seem to talk about being cut and teachers are aware of the complications (chart 39). In the targeted communities in Narok, dealing with complications alerts teachers to those girls who have been cut. However, in the targeted communities in Loita Hills, teachers report that girls see themselves as being mature, as equals to teachers, and more difficult to manage in the classroom.

"When she is cut she will see herself as equal to the female teachers and will have difficulties following instructions at school."

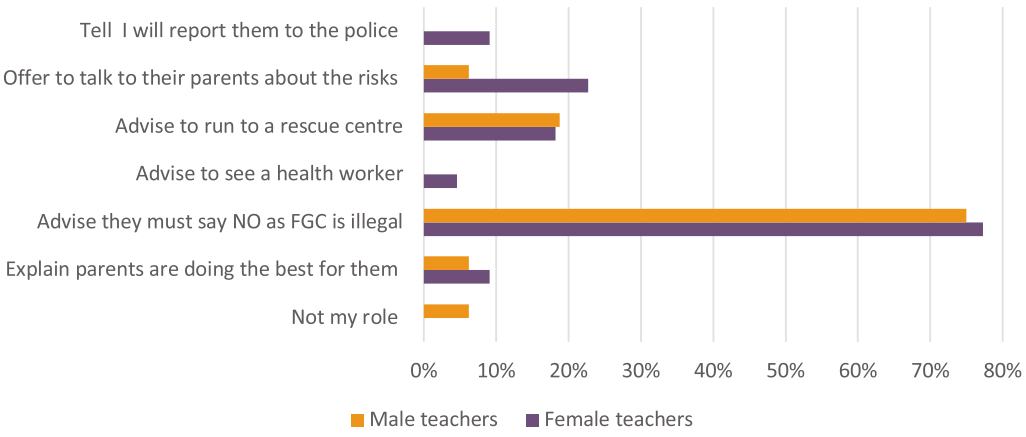
Chart 39: How teachers know girls have been cut, by region



6.4 Advice given to girls and parents on FGC

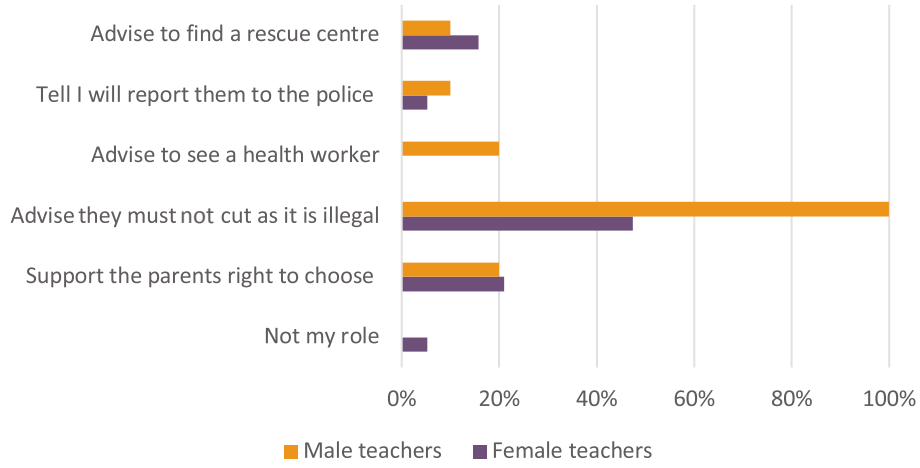
Overall, 51% of the female teachers and 31% of the male teachers surveyed have been asked for advice on FGC by girls at school. The vast majority advise the girls to say "no" to being cut, as FGC is illegal (chart 40). Less than a quarter offer other advice, although a small number offer to speak to the girls' parents.

Chart 40: Advice given to girls, by gender



Overall, 44% of female teachers surveyed have been approached by parents for advice on FGC, as opposed to 20% of male teachers. All male and half of female teachers advise parents that cutting is illegal (chart 41). In addition, 20% of teachers also support a parents' right to choose for their daughter.

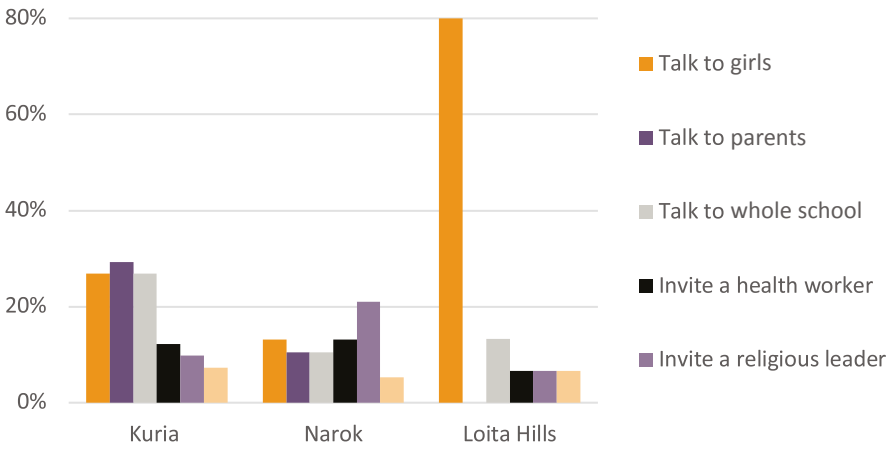
Chart 41: Advice given to parents, by gender



6.5 Actions taken on FGC by teachers before school holiday

Overall, more than half of teachers surveyed take some action on FGC before school holidays when cutting is most likely to take place (chart 42). In the communities targeted in Loita Hills, 80% of teachers talk to girls but no teachers talk to parents. In targeted communities in Kuria and Narok, a wider range of activities takes place, although with relatively few teachers involved in each. The female teachers are more likely to invite health workers to the school, whereas the male teachers are more likely to invite a religious leader.

Chart 42: Actions taken on FGC before school holidays, by region



6.6 Conclusion

The majority of the teachers surveyed feel that the school and teachers have a role to play in ending FGC. In all three areas, speaking out against the practice with pupils and also creating space and opportunities for girls are seen as the two key activities in which schools currently engage. There are differences at the community level in how these opportunities and spaces are created. In the targeted communities in Kuria, participants identify that conversations are likely to be at the individual level or amongst groups of girls, while in the targeted communities in Narok, conversations tend to be with mixed groups.

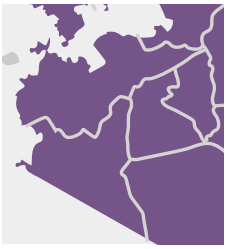
It is worth noting that while the majority of the teachers surveyed are in support of ending all types of FGC, 4% actually reported that they intend to cut their own daughters in future and 17% do not want to see all types of cutting abandoned in the future in their communities.

The most common advice that teachers involved in this baseline review offer students is to say “no” to the cut and tell them that it is illegal. Engagement between teachers and other key decision makers or stakeholders within the community appears limited, according to the survey results. For example, only 9% of teachers surveyed speak with parents and less than 20% of teachers surveyed have engaged health workers in school activities on the issue.

There is an opportunity to review the type of advice and action taken by teachers in the community. They are currently the largest group that state they want to see abandonment of all types, and have the highest intention to not cut their own daughters. However, teachers, as previously mentioned are not seen by others in the community as being opposed to the practice. This baseline review shows that only a small number of teachers are pro-actively speaking with parents (9%) and more often than not wait to be approached by parents. Furthermore, the advice provided by the teachers surveyed (telling girls to say “no”) does not take into consideration who key decision makers are regarding FGC in the community, i.e. parents and community members.

Regional differences and profiles

This survey was carried out across 14 communities in three areas in Kenya, Kuria, Narok and Loita Hills and does not attempt to be wholly representative of the entire community and all communities in each area. There appear to be key similarities in the practice of FGC across the three areas, however, this survey also indicates some significant differences, which suggests that different approaches are more likely to be successful in moving towards total abandonment of all types of cutting. FGC continues to be practised in each area with perceived prevalence rates in individual communities varying from 21% in Masaba Town, Kuria, to 92% in Imartin, Loita Hills. Girls are being cut predominantly between the ages of 12 and 14 years, primarily by traditional cutters or TBAs, with the mother being the primary decision-maker. This section below gives a brief overview of each area, drawing attention to the nuances identified by the survey results that were observed through the data collected.



Kuria (6 communities)

The overall perceived prevalence rate of FGC amongst the targeted population in Kuria is 36%, with significant differences between communities, from 21% in Masaba Town to 64% in Korumangucha.

The communities in Kuria appear to have a strong involvement in the FGC process, with the Council of Elders having a significant influence, for example by deciding the timing for cutting to begin. Parents, elders and community members emerged strongly as main supporters of FGC, as indicated by those surveyed, with religious leaders, educated people and law enforcers seen as those most strongly opposing it. Mothers and fathers are seen equally by those surveyed as the main decision-makers, with daughters being involved to some extent. According to the survey data, most FGC involves family or community celebrations with less than a third taking place in secret. Participants identified that girls are primarily cut aged 12-14 years, with the type of cut varying, with both the traditional cut and kisasa, snip, or prick being practised. Cutting is mainly carried out by traditional cutters or traditional birth attendants (TBAs)s, however, 17% of participants stating FGC is being carried out by health professionals (nurses, midwives or doctors).

Only 8% of participants in Kuria had not attended formal education at all. Awareness of the Rights of the Child, the Right to Freedom from Violence Against Women and Girls and knowledge of the law on FGC is reasonably high.

Narok (3 communities)

The perceived prevalence rate of FGC is 45% in Narok, which is consistent across the three communities surveyed. Parents and community members are seen by those surveyed as the main supporters of FGC, with religious leaders and law enforcers seen as those most strongly opposing it. There is evidence of a strong desire to see a reduction in FGC in the targeted communities in Narok. The majority of those surveyed would like to see the abandonment of all types of cutting (80%) while a similar percentage (83%) said they do not intend to cut their daughters in future.

According to participants, FGC is carried out primarily in secret, with a few family celebrations. Mothers are seen by those surveyed as the main decision-makers in relation to FGC, although fathers, elders and daughters are involved to some extent. Participants identified that girls are cut between the ages of 12 and 17 years, possibly with Maasai girls being cut aged 12-14 years and Kalenjin girls being cut aged 15-17 years and the type of cut varies between and within families, with

at least a third of girls undergoing the traditional cut. Cutting takes place mainly by traditional cutters or TBAs, although, medicalisation is significant with 21% of participants stating FGC is being carried out by health professionals (nurses, midwives or doctors).

A third of participants in the communities targeted in Narok had not attended any formal education. Awareness of the Rights of the Child, the Right to Freedom from Violence Against Women and Girls and knowledge of the law on FGC is reasonably high.

In the three communities in Narok, there is evidence of action towards change in relation to FGC is weak. Although, 76% of those surveyed would like to see the abandonment of all types of cutting, only 58% do not intend to cut their own daughters in the future, highlighting the strength of FGC as a social norm at community level.

Note: Narok's population primarily consists of Maasai people and also a large Kalenjin community. The survey did not distinguish between Maasai and Kalenjin practices in relation to FGC as there was no question asking participants to identify their ethnicity, although the COVAW team are aware of differences in practice between the two ethnic groups.

Loita Hills (5 communities)

The overall perceived prevalence rate of FGC is 62% in the 5 communities targeted in Loita Hills. The perceived prevalence rate varies considerably between the different communities reached, from 92% in Imartin, where the strength of the norm appears to be more significant, compared to 25% in Ilkerin, where the norm appears to be less valued.[32]

Parents are seen by those surveyed as the main supporters of FGC, with religious leaders seen as those most strongly opposing it. Participants identify that FGC is carried out mainly in secret, although a quarter of families are involved in family or public celebrations. Mothers are seen by those surveyed as the main decision-makers in relation to FGC, with some involvement from elders and fathers. Participants state that girls are between the ages of 9 and 14 years. The type of cut varies between and within families. Three quarter of girls are cut using the kisasa, snip or prick and a quarter using the traditional cut. Health facilities are scarce in rural parts of Loita Hills. Cutting takes place almost entirely by traditional cutters or TBAs, with some participants saying they go to health professionals to cut their daughters in Mausa and Olorte.

Almost two thirds of participants in the 5 communities targeted in Loita Hills had not attended any formal education. However, over half of participants were aware of the Rights of the Child, with fewer being aware of the Right to Freedom from Violence Against Women and Girls. Conversely, only 35% knew that all forms of cutting are illegal.

There is evidence of a strong desire to reduce the use of the traditional cut in Loita Hills. This is demonstrated by over 80% of participants wanting to see change, but only 45% wanting to see the abandonment of all types of FGC. Conversely, 74% said they do not intend to cut their daughters in future, although as one woman explained this 'intention' is more of a preference than a definite commitment as she would also need to take the views of the community into account. There is further additional evidence from the SAFE team to suggest that this intention is gradually being translated to action through the increased use of an Alternative Rite of Passage. The data from this survey suggests that 7% of community members are aware of this ARP, while a SAFE evaluation suggests this figure is now closer to 33%.

[32]This is one possible explanation, among others, as to why perceived prevalence is low. The lived experience of SAFE Maa suggests that the prevalence in Ilkerin is on par with the rest of Loita Hills, so this will need to be examined further in future studies

Emerging themes and recommendations

This section looks at key themes emerging from the data, highlighting some of the differences between the communities targeted in Kuria, Narok and Loita Hills, together with specific recommendations relevant to each region.

7.1 Clarity about what constitutes FGC

Orchid Project, COVAW, ECAW and SAFE Maa are working towards the abandonment of all types of female genital cutting (FGC), including the kisasa, snip or prick. It was clear from community researchers that some community members see the movement to end FGC as referring only to the traditional cut and supporting the continuation of kisasa, snip or prick, as demonstrated by this woman from Kuria who said,

> ***"I have campaigned against FGM and all my girls are cut with just the kisasa. I wish for my sons to marry those that are cut like this also."***

This interpretation of FGC is likely to result in some under reporting of prevalence. Additionally, opportunities may be missed to engage community members in dialogue about what total abandonment means, resulting in implied or assumed support for other types of cutting and the kisasa, snip or prick continuing to be seen by many as a practice that does not constitute/fall under the term FGC.

RECOMMENDATION:

COVAW, ECAW and SAFE Maa and other local organisations should:

- Be explicit about working to end all types of cutting, including the kisasa, snip or prick (WHO I and VI) and that this becomes part of the community dialogue. This is especially relevant among communities where the traditional cut is still practised, where other forms of cutting are not seen as FGC.

7.2 Support for abandonment

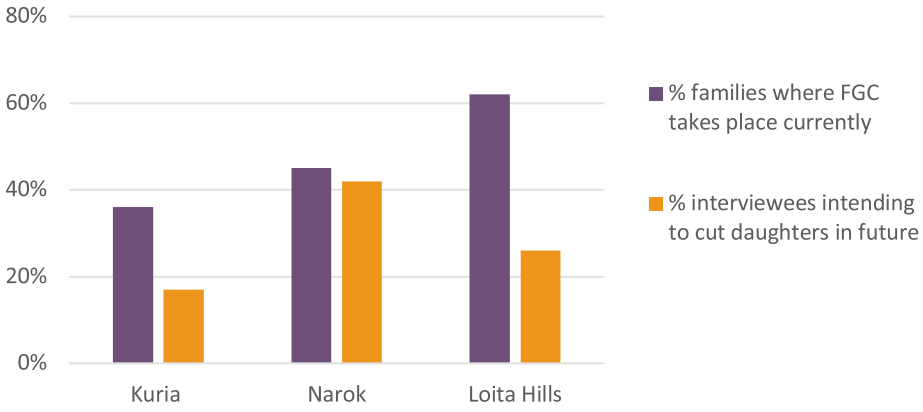
This study provides additional evidence of change in attitudes and beliefs in relation to FGC, especially in the targeted communities in Kuria and Loita Hills.

Overall, 69% of those surveyed want to see the abandonment of all types of cutting. The commitment for abandonment appears highest among surveyed health workers, teachers, law enforcers, community leaders and young people and also higher among those who have attended school.

Approximately half (49%) of participants stated that FGC takes place in their extended families, whereas only 29% indicated that they intend to cut their daughters in the future. Care has to be taken when comparing these figures, as current practice refers to people's extended families, whereas future intentions are about their own daughters i.e. their immediate family. However, the suggestion is that FGC prevalence could reduce further in the next generation.

This pattern is most marked in Loita Hills and Kuria (chart 43), where the differences between current perceived prevalence and future intentions are substantial.

Chart 43: Comparison of current practice of FGC and future intentions, by region



In the targeted communities in Kuria where the current FGC perceived prevalence is 36%, with most participants believing that FGC is carried out by only a minority of families, the data suggests that prevalence could halve in the next generation to 17%.

In the targeted communities in Loita Hills the expected reduction is even more dramatic. The current perceived prevalence rate is 62% with the majority of participants believing that most families cut their daughters. The data suggests that only 26% of participants intend to cut their daughters in the future, which, if this happens, could change the community to one where cutting is carried out by a minority of families, thus potentially shifting the social norm. Intentions need to be interpreted carefully, as in many cases they represent a preference, rather than a definite commitment, as demonstrated by a woman in a community in Loita Hills who said,

> ***"I don't intend to cut my daughter but it will depend on the community as the community has more power."***

This woman and others like her, are more likely not to cut their daughters if they know that other parents around her would also prefer not to cut their daughters.

In both Loita Hills and Kuria the priority, therefore, for community activity in relation to FGC should be to support people to follow through with their intentions, or preferences, not to cut their daughters. Research suggests that community dialogue, creating spaces for people to talk openly and share their concerns and intentions, is a successful programme model.[33]

In the communities targeted in Narok, the situation appears to be quite different, with the difference between the current perceived prevalence and future intentions being relatively small (3%), suggesting that change is taking place much more slowly and that almost all families that practice FGC now intend to continue to do so in the future. A different type of approach might be required among Narok communities, exploring in greater depth, perhaps, the parts of the community who are cutting, the reasons why they intend to continue and their levels of knowledge on the law, rights and health complications of FGC.

RECOMMENDATIONS:

- In the communities in Kuria and Loita Hills, to focus community dialogue on sharing the message with enough people that change is happening and that most people do not intend to cut their daughters in the future. Change is most likely to result from people discovering this through dialogue with their peers and neighbours, and from hearing it in community forums and from professionals and leaders in the community.
- In Narok, to identify those parts of the community where FGC is continuing and to provide opportunities for them to increase their knowledge on human rights, the law and health consequences of cutting, and also to engage in community dialogue in relation to FGC.

[33]UNICEF (2007), CoordInated strategy to ending FGM in one generation – technical note

7.3 Medicalisation and knowledge of health risks of FGC

While there is widespread knowledge of the health complications associated with FGC, 66% of participants across all areas remain unaware of the health risks of FGC, or perhaps have not made the connection between FGC and the health problems experienced by girls and women. Further dialogue among community members, especially those who have not attended school, and increased involvement of health professionals in dialogue about FGC with individual women and in community forums might help increase the level of awareness across the community.

However, the role of health professionals in relation to FGC is complex. This survey indicates that most health professionals would like to see the abandonment of all types of cutting, including the kisasa, snip or prick (chart 26). This suggests they would be a key target group to engage in increasing the level of awareness of the health risks of FGC. Conversely, Kenya is listed in the top 5 countries with the highest level of medicalised FGC (15%)[34] which is most commonly practised in Nyanza and Rift Valley Province[35], where Narok and Kuria lie. The data from this survey confirms that some nurses, midwives and doctors are clearly involved in cutting, particularly in Kuria and Narok where medicalisation of cutting is strongest (chart 15). Anecdotally, in Loita Hills parents have indicated that they would like to have their daughters cut by nurses or midwives, although they cannot as there are so few health facilities.

It is not surprising, therefore, that health professionals are currently not seen by those surveyed in this baseline review as influential in the move towards ending FGC, as they are not perceived as opposers of cutting (chart 31). This also potentially accounts for our findings that less than 10% of teachers surveyed invite health professionals into their schools (chart 41) and that health professionals were not identified as a group with responsibility to end FGC (charts 32 & 33). Conversely, 16% of women surveyed do appear to be consulting health professionals on FGC (chart 23).

Currently health professionals do not have a clear role in relation to FGC and it cannot be assumed that all health professionals already have the skills or motivation required to promote the abandonment of FGC.

The extent to which FGC is included in the initial training curricula for health professionals varies considerably and tends to focus on difficulties experienced in childbirth. Midwives and nurses are the subject of anti-medicalisation initiatives by the Ministry of Health, although these tend to focus on the law and responsibilities of health professionals rather than developing the skills to deal with the pressure they face in relation to FGC.

In conclusion, health professionals are well-placed to play a positive role in promoting abandonment of all types of FGC. However, first they will need to be supported in:

- Developing skills to being more explicit and proactive in their commitment to total abandonment of FGC
- Responding to requests to carry out FGC
- Facilitating dialogue with individuals and groups to promote health seeking behaviour in relation to FGC
- Supporting girls and women who have undergone FGC

RECOMMENDATIONS:

COVAW, ECAW and SAFE Maa and other local organisations should:

- Engage with health professionals to understand the challenges they face with regard to FGC and to support them in developing a positive role in relation to FGC.
- Engage in increased community dialogue among community members on the health risks of FGC, specifically focusing on them sharing their experiences and helping them to make the connections between their health challenges and the cut they underwent.

  Note: It is especially important that this information is accurate and relates directly to the lives of women in the community. It should not include the use graphic stories or videos[36] that aim to shock[37], but should focus on allowing community members to share the complications they have and how they are best managed.

[34]http://www.popcouncil.org/uploads/pdfs/2017RH_MedicalizationFGMC.pdf

[35]http://www.popcouncil.org/uploads/pdfs/2017RH_FGMCKenyaChange.pdf

[36]Health Poverty Action, A Practical Guide for Communicating Global Justice & Solidarity, (2019)

[37]End FGM European Network, How to talk about FGM, (2016)

7.4 Knowledge of rights and the law

Even in communities that are most informed on rights and the law, just over half of community members surveyed were aware of that all forms of FGC are illegal under Kenyan law. Levels of awareness of the Rights of the Child and the Right to Freedom from Violence Against Women and Girls (FFVAWG) were slightly higher. Knowledge of the law is not in itself sufficient to change attitudes, indicated by the high proportion (62%) of community members surveyed who intend on cutting their daughters and are also aware that FGC is illegal. However, knowledge of the Rights of the Child and FFVAWG are key elements of using a rights-based approach to ending FGC.

RECOMMENDATION:

COVAW, ECAW and SAFE Maa and other local organisations should:

- Encourage community members to discuss the legal status of FGC in Kenya, the Rights of the Child and the Right to FFVAWG in community forums, bazaras (community gatherings) and workshops, and through this share knowledge and increase the levels of awareness.

7.5 The role of community leaders and religious leaders

Over 80% of participants said that FGC continues because it is deeply embedded in the culture of communities in Kuria, Narok and Loita Hills, as demonstrated by a man in Kuria who said,

"It has been done by our forefathers, why should we change our culture?"

Despite such beliefs, over 80% of community leaders surveyed want to see the abandonment of all types of cutting (chart 26). Community leaders surveyed included quite a diverse group of men and women with a wide range of roles in the community. They tended to be less well informed than health professionals, teachers and law enforcers on the law and the Rights of the Child and many might benefit from support to deepen their understanding of FGC and to build their capacity to engage the community in dialogue and exchange.

Overall, religious leaders were the most well informed group of people surveyed, with 80% being aware of the health complications (chart 11), all religious leaders surveyed knowing that all types of cutting are illegal in Kenya and all having a strong commitment to the abandonment of all types of cutting. Less than 2% of participants think that FGC is a religious practice.

In addition, religious leaders are identified by survey participants as the single group most likely to oppose FGC across all regions (chart 31). However, few programmes to end FGC engage fully with religious leaders in programmatic activities.

RECOMMENDATION:

COVAW, ECAW and SAFE Maa and other local organisations should:

- Engage with community leaders and religious leaders to enable them to play a stronger role in working towards ending FGC.

7.6 The role of schools and teachers

Overall, teachers are among those most committed of those surveyed to the abandonment of FGC in communities in Kuria, Narok and Loita Hills. The teachers surveyed in this baseline review tended to be well informed about the complications of FGC (chart 11), the law on FGC, the Rights of the Child and the Right to Freedom from Violence against Women and Girls (FFVAWG). They also do not intend to cut their daughters (chart 19) and will leave their sons to decide whether they marry a cut or uncut woman.

However, less than 5% of community members surveyed talk to teachers about FGC (chart 22), teachers are not seen in the community as strong opposers of FGC (chart 31) and are not seen by many as having responsibility to end FGC (chart 32 & 33).

The male and female teachers surveyed in this review have similar ideas on the role of schools in ending FGC (chart 36) with 80% seeing the primary role being to provide girls with opportunities to learn about FGC. In the targeted communities in Kuria and Loita Hills, teachers also identified speaking out against all forms of FGC as a key role for teachers and schools. The importance of educating parents also featured strongly in answers from teachers in Kuria and Narok. Emphasis on providing opportunities for boys was low in the communities in Kuria and Loita Hills, although a third of teachers surveyed in Narok saw this as part of their role (chart 36).

Currently, less than half of the teachers surveyed are approached by girls and parents in relation to FGC with almost twice as many of the female as male teachers being approached. The advice given focuses strongly on informing girls and parents that FGC is illegal (charts 39 & 40). This is especially true of the male teachers when talking to parents. Whilst it is correct that FGC is illegal, the teachers surveyed appear to be missing opportunities to engage parents in dialogue, to listen to their concerns or to advise them to seek the advice of religious leaders, health professionals or others who support abandonment.

RECOMMENDATION:

COVAW, ECAW and SAFE Maa and other local organisations should:

- Increase work with schools and teachers to include:

  (a) developing whole school policies on FGC

  (b) supporting teachers in developing skills and confidence to engage parents and pupils on FGC and provide a range of advice supporting abandonment of all types of cutting

  (c) developing approaches to engage the whole school in dialogue about FGC throughout the year, with pupils of varying age ranges and genders.

7.7 Non-school attendees

Across the all communities targeted in this baseline review there is a link between the level of education (i.e. school attendance), awareness and future intentions in relation to FGC. Those participants who have attended school, even if only for primary school, are more likely to have knowledge about the complications of cutting, the rights of women and girls and the Kenyan law on FGC. They are more likely to come from extended families that do not cut and are less likely to intend to cut their daughters in the future. The preferences of unmarried men surveyed demonstrates this difference clearly. 47% of unmarried male survey participants who have not been to school would prefer to marry a cut woman, as opposed to just 9% of unmarried male participants who have attended school.

This poses a particular challenge to organisations working to end FGC. As discussed in section 7.6, schools see themselves as playing a significant role in ending FGC and provide an opportunity to engage with large numbers of children and their parents. However, engagement with those who have not attended school and who appear to be most resistant to change in relation to FGC also needs to be considered.

RECOMMENDATION:

COVAW, ECAW and SAFE Maa and other local organisations should:

- Explore ways of engaging those who have not attended school in community forums and workshops in order to enable them to increase their knowledge and engage in more informed decision-making.

7.8 Youth engagement

The results from this survey indicate that currently, young people are not seen by survey participants as key opponents of FGC and are viewed as having responsibility for change by less than 20% of those surveyed. However, the data shows that young people surveyed, both female and male, are more aware of their human rights and the Kenyan law on FGC than older people in communities in Kuria, Narok and Loita Hills. They are more in favour of change in relation to FGC, show a greater interest in being involved in activities to end FGC and also will be the decision-makers as parents for the next generation of girls.

RECOMMENDATION:

COVAW, ECAW and SAFE Maa and other local organisations should:

- Identify ways of increasing the involvement of young people at every stage from planning, implementation and monitoring of activities to end FGC. Young people should become, not only recipients of knowledge on FGC or participants in workshops, but also an informed and committed stakeholder group that is willing and able to lead initiatives to engage others in their communities.

7.9 Gender and the role of men in the abandonment of FGC

FGC is often considered an issue which primarily concerns women and that men are not well informed or involved. However, this baseline review indicates that men surveyed in communities in Kuria, Narok and Loita Hills are interested, involved and are possibly slightly more ambitious for change in relation to FGC than the women, with 71% male survey participants and 68% of female survey participants wanting to see the abandonment of all types of cutting. More male survey participants (47%) than female (40%) have spoken to others about FGC in the last 2 years, although only 9% of parents surveyed have had these conversations with their spouse. Women were identified by survey participants as the main decision-makers about whether their daughters undergo FGC, however, men are increasingly becoming involved in this process, especially in communities in Kuria and Narok. Traditionally, marriage is seen as a key reason for girls to be cut, however, this is now cited as the main reason by only 30% of participants. Over two thirds of unmarried men surveyed would prefer to marry an uncut woman. Similar numbers of men and women (38%) surveyed are involved in activities to end FGC currently. In contrast, in schools, activities relating to FGC tend to mainly involve girls, with limited opportunities for boys.

There are differences in the way women and men surveyed are involved in conversations about FGC, for example, the female teachers who participated in this survey are more likely to be approached by girls or parents than the male teachers, and women are more likely to speak to a health professional than men. In addition, while similar proportions of female and male participants (66%) recognise that women suffer complications of cutting, there is a difference in the types of complications they identified with women more often citing severe bleeding, severe pain and difficulties in childbirth, while men more often cite marital relationships as being affected and challenges conceiving.

RECOMMENDATIONS:

COVAW, ECAW and SAFE Maa and other local organisations should:

- Involve both women and men, girls and boys in activities relating to FGC, including providing opportunities for them to engage in dialogue with each other.
- Men and boys should be encouraged to understand their role in FGC, both in the way that cutting is still perceived by some as being required for marriage and also in overcoming the stigma associated with not being cut which persists in some communities.

7.10 Opportunities for dialogue

As a social norm, peoples' decisions whether or not to cut are dependent to some extent on their perceptions of other peoples' opinions and intentions relating to FGC. As opinions change and people in communities abandon FGC, it is important for them to know others' attitudes and intentions around FGC, and to be engaged in dialogue about the changes taking place. This is especially true for parents who are in the process of making decisions about their own daughters.

Although more than two thirds of those surveyed would like to see the abandonment of all types of cutting, the data confirms that FGC remains a subject which many people do not openly talk about.

Less than half of those surveyed have spoken to anyone about FGC in the last year and less than half were aware of FGC ever being mentioned in public gatherings in their community. Only 9% of parents surveyed have talked to their spouse about FGC, with the majority of conversations taking place with other family members and friends. Few parents talk to their daughters and sons about cutting, or to professionals, such as teachers, health workers, law enforcers or community leaders.

One of the key activities that organisations working to end FGC can do is to promote dialogue involving all community members at family, neighbourhood and community levels. In this way, community members will increase their awareness of the health risks associated with FGC, the law on FGC in Kenya, the experiences, preferences and intentions of family members, neighbours and others across the community. At community forums, it is important for community members to hear the opinions of religious leaders, community leaders, teachers, health professionals and law enforcers, as well as having opportunities to share their own experiences. Equally important are the conversations between husband and wife, as well as between parents and grandparents and their children.

RECOMMENDATIONS:

COVAW, ECAW and SAFE Maa and other local organisations should:

- Encourage the inclusion of FGC in existing community events such as barazas (community gatherings), and to promote specific community forums where community members can explore rights-based issues relating to women and girls, including early marriage, girls' education, FGC and domestic violence.
- Place dialogue at the centre of their workshops, forums and other activities on FGC, ensuring that even where expert advice is provided, space is also given for exchange and dialogue among participants.

CONCLUSIONS

This baseline review has been able to confirm existing evidence while also providing new data for areas that have previously been under researched. Organisations and communities in Narok, Loita Hills and Kuria can use this report as a baseline to inform new and ongoing programmatic activities.

The data shows that change is happening in regard to prevalence and type of cut in the targeted communities Narok, Loita Hills and Kuria, which confirms a shift from the traditional cut to the kisasa, snip or prick. There has also been a decline in perceived prevalence in these communities compared to previous studies, with the overall perceived prevalence now being 49%. While this is still more than twice the national average (21%), this decline is significant as previous studies showed prevalence rates of 96% in Kuria and 78% for Maasai communities, including Narok and Loita Hills.

There are considerable differences in the perceived prevalence of FGC between the three areas and between different communities. The communities in Loita Hills have the highest perceived prevalence with 62% of survey participants stating cutting takes place in their families, while the communities surveyed in Kuria and Narok showed lower rates of 36% and 45% respectively. Perceived prevalence in individual targeted communities varies considerably from 21% in Masaba Town, Kuria, to 92% in Imartin, Loita Hills.

The majority of community members surveyed are aware of the harmful effects of FGC (66%), though this varies considerably between regions; from 75% in communities in Kuria to 52% in communities in Loita Hills. However, overall, the data suggests that awareness-raising activities have been somewhat successful in connecting health complications and social barriers to FGC in community.

This baseline review found that dialogue on FGC remains low, with less than half of those interviewed having talked to anyone about FGC in the last year and less than half were aware of FGC being mentioned during public gatherings in their communities. We also found that those most in favour of abandonment (teachers, religious leaders and health workers) are not being engaged in dialogue either at the individual family level or at the wider community level. This low level of public community dialogue could be hindering the movement to abandon FGC at community level, given that one person's decision to cut will be significantly influenced by their peers. Open, non-judgemental dialogue is widely recognised as a critical step in enabling others to see perceptions shifting and to feel more comfortable in shifting their own perceptions as a result[38].

Finally, and perhaps most interestingly, this study found that there is a significant opportunity in all three areas to build critical mass and shift the social norm towards abandonment of FGC. The data shows that while FGC is prevalent in all targeted communities, the intention to cut is lower than the current prevalence. For example, in the communities reached in Loita Hills where the perceived prevalence of FGC is 62%, intention to cut in future is below 30%. If those who have stated they do not intend to cut their daughters in the future receive support to commit to this intention through sharing their preferences and beliefs in open non-judgemental community spaces, there could be a significant reduction in FGC in the next generation.

[38]UNICEF, Coordinated strategy to end female genital mutilation/cutting in one generation – A human rights based approach to programming, (2007)

APPENDIX

Kenya baseline questionnaire 2018

The questions were translated into Kuria, Swahili and Maa and interviews took place in the local language.

Introduction
Date of interview
Organisation conducting interview
Community researcher
Community name
If other, please give name
Is this a rural or urban community?

Consent questions
Has the purpose of the interview been explained to you?
Are you willing to continue with the questions?

Personal information
Male or female
Age
Did you attend school? If yes, how long did you continue?
Are you married?
Are you a parent?
What do you do? (role in the community, e.g. health worker, farmer etc.)
This survey is about female genital cutting
Have you heard about the cutting of girls' genitalia?
Do you know that girls can be cut in different ways?
If yes, can you describe the different types?

Female genital cutting in your community
Does female genital cutting take place in your community?
If yes, is it by a few, some or all?
If yes, is it mainly carried out in secret, as a family celebration or as a community celebration?
At what ages are most girls cut in your community?
What are the main reasons why young girls are cut in your community? (select two maximum)
Do girls and women suffer complications from being cut?

If yes, what kind of complications?

Is female genital cutting discussed in public meetings in your community?

What kind(s) of people support female genital cutting in your community?

What kind(s) of people do not cut their daughters or support abandonment of the practice?

Prevalence

Are you willing to answer some more personal questions about FGC?

Is female genital cutting practised in your extended family?

If yes, who cuts?

Who decides whether your daughter is cut? (select 1 or 2 only)

Intentions

Do you intend to cut any daughters you have in the future?

If yes, which type of cut?

What kind of woman would you prefer your son to marry? (cut/uncut/no preference)

If cut, which type?

As an unmarried man, which kind of woman would you prefer to marry? (cut/uncut/no preference)

If cut, which type?

Support for abandonment

Do you know of any other community nearby that supports abandonment of all types of female genital cutting?

If yes, has anyone from this community spoken publicly about this with your community?

Have you talked to anyone else about female genital cutting in the last year?

If yes, who?

In the future, which types of female genital cutting do you think should be abandoned in your community?

Whose role is it to end the practice of female genital cutting?

Are you involved in any activities against female genital cutting in your community?

If yes, what kind of activity?

Would you like to be involved in activities against female cutting in the future?

If yes, what kind of activities?

Knowledge of the law

Have you heard of the Rights of the Child?

If yes, do you think the Rights of the Child should protect girls from female genital cutting?

Do you think female genital cutting goes against a girls' rights?

Have you heard of the Right to Freedom from Violence?

If yes, do you think the Right to Freedom from Violence should protect girls from female genital cutting?

Do you know of any laws about female genital cutting in Kenya?

If yes, what does the law say?

Questions for school teachers

What do you see as the role of schools and colleges in relation to female genital cutting?

Do you talk about female genital cutting in your school or college?

If yes, with whom?

Do you know whether individual girls in your school have been cut?

If so, how?

Do girls ever come to you as a teacher for advice or support on female genital cutting?

If yes, what kinds of advice are you able to offer?

Do parents ever come to you as a teacher for advice or support on female cutting?

If yes, what kinds of advice are you able to offer?

Before the school holidays when girls are cut, do you take any action to protect girls?

If yes, what type(s) of action?

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