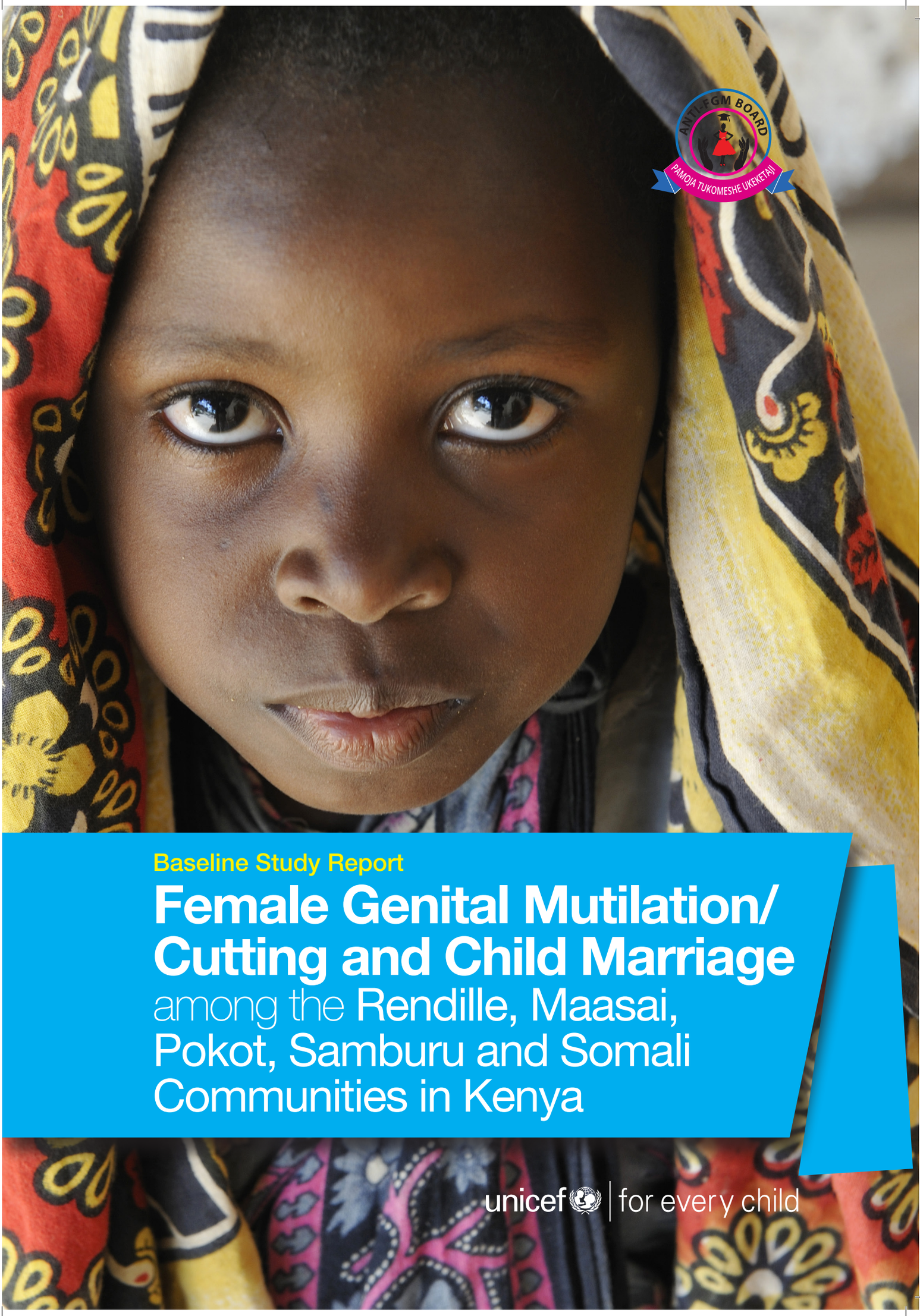

Baseline Study Report

Female Genital Mutilation/ Cutting and Child Marriage among the Rendille, Maasai, Pokot, Samburu and Somali Communities in Kenya

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Baseline Study Report: Female Genital Mutilation/ Cutting and Child Marriage among the Rendille, Maasai, Pokot, Samburu and Somali Communities in Kenya

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Foreword

In recognition that Female Genital Mutilation (FGM) is not only a harmful practice but a violation of human rights, Kenya has adopted a robust legal framework. The country has ratified several international legal instruments that have become part of the Kenyan law as provided for in Article 2 of the constitution. Further to the provisions of the constitution, the government has enacted the Prohibition of Female Genital Mutilation Act, 2011. The law provides the framework for public engagement and advocacy for accelerating the eradication of FGM. The Children's Act, 2001, S (14) criminalizes subjecting a child to harmful cultural practices. This provision of statute gives parents the responsibility of ensuring the safety and security of the child. The Penal Code, Chapter 63, also provides offences under which the circumcisers can be charged. The Protection against Domestic Violence Act, 2015 classifies FGM as violence. The Act provides for protective measures for survivors and victims of domestic violence including FGM.

The Vision 2030 and the second Medium Term Plan (MTP II) for the period 2013-2017 both address FGM, under the Gender, Youth and Vulnerable Groups sector of the social pillar. MTP II targets the creation of public awareness campaigns for the eradication of FGM and the creation of a critical mass at the same time.

As part of the response plan to FGM, Anti-FGM Board in collaboration with relevant stakeholders including UNICEF and other partners, continue to strengthen the base for evidence as a matter of having a sound and an informed programming at national and county level. The baseline report is incredibly thorough, systematically arranged on topical issues surrounding FGM as well as it is based on a logical methodology.

It is my hope that this baseline study report on Female Genital Mutilation/Cutting and Child Marriage among the Rendille, Maasai, Pokot, Samburu and Somali Communities in Kenya will provide much understanding to relevant policy makers, programme planners and community members on FGM trends, analysis, knowledge, attitudes, behaviour and practices of all the five selected communities.

This baseline report must translate to a sound and an informed based programming in all the five selected counties so the cited area/communities' specific prevalence are reduced. To achieve that the Anti-FGM Board will continue to support and coordinate FGM programmes in Kenya.

We thank UNICEF for this great initiative and collaboration with the anti-FGM Board. The board will continue working with other partners to undertake baseline survey in counties that have not been covered by this report. The Anti-FGM Board in collaboration with donor agencies and other development partners are committed to the protection of girls from undergoing FGM.

Yours Sincerely,

Bernadette Loloju
Chief Executive Officer
Anti-FGM Board.

Acknowledgements

This baseline study report on female genital mutilation/cutting (FGM/C) and child marriage among the Rendille, Maasai, Pokot, Samburu and Somali communities in Kenya is the outcome of extensive interviews and discussions with community members—including community leaders, representatives of young people and women in the target sub-counties and divisions, national government ministries, departments and agencies, county government ministries and departments, local and international non-governmental organizations, faith-based organizations and community-based organizations.

Our gratitude goes to all who contributed to the baseline study, including various stakeholders, such as the national government and county authorities, chiefs and assistant chiefs, community leaders, religious leaders, community organizations (including women's organizations and youth groups), traditional birth attendants, traditional circumcisers, and international and local organizations including child protection working groups and UNICEF's partners—who provided valuable feedback and shared their strategies, experiences and challenges in the campaign against FGM/C and child marriage. UNICEF recognizes the contribution of all other stakeholders not specifically mentioned here.

The work of the consultants, Information Research Solutions (IRS), under the leadership of Mr. Tobias Odhiambo and supported by Mr. George Otieno and Mr. David Kamau, is duly recognized.

Finally, special thanks go to those who worked long hours to provide essential administrative and technical support to ensure the successful completion of this exercise, including everyone who provided valuable comments around the report, and those whose wisdom is incorporated in it.

Werner Schultink
Representative, UNICEF Kenya

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Abbreviations

ACK	Anglican Church of Kenya
ACRWC	African Charter on the Rights and Welfare of the Child
ADS	Anglican Development Services
AGM	Annual General Meeting
AMWIK	Association of Media Women in Kenya
BIDII	Benevolent Institute of Development Initiatives
CBO	community-based organization
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CIPD	County Integrated Development Plan
CRC	Convention on the Rights of the Child
CSO	Community Service Officer
DCS	Department of Children's Services
EA	Enumeration Area
FBO	Faith-Based Orgnization
FGD	Focus Group Discussion
FGM/C	Female Genital Mutilation/Cutting
GAMCOTRAP	Gambia Committee on Traditional Practices Affecting the Health of Women and Children
IBEC	Independent Electoral and Boundaries Commission
ICESR	International Covenant on Economic, Social and Cultural Rights
IGA	income-generating activity
IRS	Information Research Solutions
KDHS	Kenya Demographic Health Survey
KNBS	Kenya National Bureau of Statistics
KII	Key Informant Interview
KEWOPA	Kenya Women's Parliamentary Association
NACOSTI	National Commission for Science, Technology and Innovation
NGO	Non-Governmental Organization

ODPP	Office of the Director of Public Prosecutions
OHCHR	Office of the United Nations High Commissioner for Human Rights
PCEA	Presbyterian Church of East Africa
PPS	Population Proportional to Size (PPS)
PSU	Primary Sampling Unit
SDG	Sustainable Development Goal
SNNP	Southern Nations, Nationalities and Peoples' (region)
SGBV	Sexual and Gender-Based Violence
RFSU	Swedish Association of Sexuality Education
TISA	The Institute for Social Accountability
ToRs	Terms of Reference
TSC	Teachers Service Commission
UDHR	Universal Declaration of Human Rights
WEL	Women's Empowerment Link

Executive summary

In line with the 1997 interagency statement, *Eliminating Female Genital Mutilation* (WHO et al., 2008), the United Nations Population Fund (UNFPA) and United Nations Children's Fund (UNICEF) launched a joint programme in 2007 entitled Female Genital Mutilation/Cutting: Accelerating Change, with the objective of contributing to the accelerated abandonment of female genital mutilation/cutting (FGM/C) in one generation, with demonstrated success[1] in 17 countries in Africa by 2012. The programme seeks to contribute to the overall goal, set by the 1997 interagency statement and reaffirmed by the 2012 United Nations General Assembly (UNGA) Resolution (UNGA, 2012), to intensify global efforts to eliminate FGM/C.

In Kenya, the joint programme was launched in 2008 in a collaborative effort with the Ministry of Gender, Children and Social Development and various non-governmental organizations (NGOs). Phase I, which ended in 2014, focused on the districts of Tana River, Garissa, Isiolo, Marsabit, Marakwet, Kuria, Migori, Naivasha and Mount Elgon, and achieved impressive results, with the formulation of a national policy on the abandonment of FGM/C, enactment of the Anti-FGM Act 2011 and upscaling of community-led actions against FGM/C and child marriage practices.

Analysis of data from over 70 nationally representative household surveys undertaken in the 29 countries where FGM/C is concentrated (UNICEF, 2013) shows that its continued practice is due to the perception of FGM/C as a social obligation, intertwined with tradition and religion. However, the data indicates that in many countries, prevalence has decreased, and across the majority of countries, including some of the high-prevalence countries, support for FGM/C is declining and the majority of the population wants the practice to end.

In the light of knowledge gained during phase I, including research and programmes supported by UNFPA, UNICEF and their partners, and based on the recommendations stemming from the evaluation of phase I (UNFPA–UNICEF, 2014), phase II of the joint programme was launched in 2014 and will run until 2017 in line with the strategic plans of UNICEF and UNFPA (UNFPA–UNICEF, 2016).

Phase II focuses on strengthening the enabling environment and increasing the demand side. The programme advocates and supports enforcement of the legal and policy framework, including standardising jointly developed guidelines relating to FGM/C. Additionally, the programme will focus on strengthening coordination between actors at a national level. Furthermore, the programme will continue to work with communities, focusing on children in and out of schools, and identify and train community change agents to hold community dialogues that are expected to contribute towards public declarations on the abandonment of FGM/C.

It is against this background that UNICEF Kenya commissioned a baseline study on FGM/C and child marriage among the Rendille, Maasai, Pokot, Samburu and Somali communities in Kenya. The main objectives were to establish the prevalence of FGM/C

1. "Demonstrated success" refers to a 40% reduction in prevalence among daughters (0–15 years) over a five-year period, in specific areas of the programme's implementation, and cannot be extrapolated to an entire country or region. The figure of 40% is based on evidence from specific fieldwork where community-led approaches were implemented. Egypt and Senegal are good examples of demonstrated success.

and child marriage among five ethnic communities in the following six study locations: Garissa (Balambala); Wajir South (Habaswein); Kajiado Central; Marsabit (Laisamis); Samburu (Wamba); and West Pokot (Sook).

The bases of selection for assessment of these communities, together with the target age cohorts of girls and women aged 10–49 and boys and men aged 15–49, were that: all the target communities have high FGM/C and child marriage prevalence rates in Kenya and are pastoral communities with low levels of education, especially among girls; the target areas were the new locations selected for FGM/C and child marriage interventions in 2014–2017; and the selected communities share traditions, cultures and borders with neighbouring countries including Tanzania (Maasai), Somalia (Somali), Ethiopia (Rendille) and Uganda (Pokot).

The study was conducted between December 2016 and March 2017 and adopted a mixed-method approach entailing desk review, and quantitative and qualitative design. In drawing up the sample for the quantitative design, random and systematic sampling was adopted. Out of a target total sample of 6,100 household interviews, 6,648 interviews comprising 1,357 boys and men aged 15–49 and 5,291 girls and women age 10–49 were successfully completed. In addition, a total of 133 interviews out of a total target of 250 were successfully completed with border communities. The qualitative design entailed use of focus group discussions (FGDs) and key informant interviews (KIIs) and adopted a purposive sampling approach due to the need for targeted and relevant interviews. All the targeted 24 FGDs were successfully conducted and 60 of the targeted 71 KIIs were successfully conducted.

During fieldwork, the study team visited Kajiado Central, Balambala, Habaswein, Laisamis, Sook and Wamba and interviewed community members and a broad range of key informants drawn from county and national governments, community-based organizations, NGOs, faith-based organizations and community leaders.

It is expected that the study findings presented in this report will provide the basis of interventions in the target sub-counties and divisions towards ensuring accelerated abandonment of the twin practices of FGM/C and child marriage.

Major findings and key results

I. Female genital mutilation/cutting

A. Prevalence of FGM/C and age of undergoing FGM/C

1. The FGM/C prevalence rates among all girls and women aged 10–49 in the target study areas are: Habaswein sub-county (98%); Balambala sub-county (94%); Laisamis sub-county (78%); Sook division (74%); Wamba division (71%); and Kajiado Central sub-county (51%). Surveyed girls and women of Somali origin recorded an FGM/C prevalence rate of 96%, while girls and women from Samburu, Pokot and Rendille communities recorded prevalence rates of 72%, 74% and 78% respectively. Surveyed girls and women of Maasai origin recorded the lowest prevalence rate of 51%. Surveyed girls and women professing the Muslim faith recorded a prevalence rate of 95%, while those of Protestant and Catholic orientation recorded prevalence rates of 65% and 69% respectively. In the 18–49 age cohort, FGM/C prevalence rates of surveyed girls and women are near universal: Balambala and Habaswein regions are 97% and 98% respectively; 89% in Kajiado Central; 100% in Laisamis;

94% in Sook; and 95% in Wamba. By ethnicity, FGM/C prevalence rates of surveyed women in the 18–49 age cohort are: 89% among Maasai women; 98% among Somali women; 95% among Samburu women; 94% among Pokot women; and 100% among Rendille women. In the 10–17 age cohort, FGM/C prevalence rates are: 93% in Balambala; 98% in Habaswein; 28% in Kajiado Central; 62% in Laisamis; 62% in Sook; and 57% in Wamba. By ethnicity, FGM/C prevalence rates of surveyed girls in the 10–17 age cohort are: 28% among Maasai girls; 95% among Somali girls; 57% among Samburu girls; and 62% among both Pokot and Rendille girls.

2. A significantly lower proportion of surveyed girls and women and boys and men of Maasai extraction, compared to the Somali, Pokot, Rendille and Samburu, believe that uncut girls and women will undergo circumcision now and in the future. The belief that girls and women in the target communities will be cut in the future is mainly fuelled by three key consequences in the event that a girl or woman is not circumcised: ostracism occasioned by exclusion and rejection by boys, men, family and the larger community; ineligibility for marriage and hence difficulty in finding a spouse; and subjection to ridicule by peers and the wider community.
3. Evidence of expected future circumcision of girls and women in the target communities exists. Approximately 32% of surveyed mothers/caregivers in Balambala, 47% in Kajiado Central, 19% in Habaswein, 38% in Laisamis, 46% in Sook and 51% in Wamba have daughters who are uncut since they are still considered not ready for cutting, in addition to those refusing to undergo circumcision. Of the surveyed mothers with uncut daughters, approximately 63% in Balambala, 25% in Kajiado Central, 84% in Habaswein, 27% in Laisamis, 38% in Sook and 43% in Wamba intend to circumcise their uncut daughters. Intent to have FGM/C performed on uncut daughters decreases with increasing level of education: significantly more mothers with no education (48%, $p < 0.05$), compared to 29% with primary-level education and 7% with secondary-level education, intend to have FGM/C performed on their uncut daughters in the future. A universal reason offered by surveyed mothers for intending to perform FGM/C on their uncut daughters is to preserve their long-held traditions. This is due to the deep-rooted nature of the practice, which is mainly attributed to traditions passed from one generation to the next without question.
4. A trend analysis of change in the prevalence rates of FGM/C over a period of 10 to 40 years preceding the survey reveals three patterns: little to no change in prevalence rates over the last 10 to 40 years, as observed in Balambala, Habaswein and Laisamis; a sharp decline in prevalence rates over the last 20 years, as observed in Kajiado Central and Wamba; and a steady, near-linear decline in prevalence rates over the last 30 years, as observed in Sook. This is mainly attributed to intensified anti-FGM/C campaigns by state and non-state actors in the two study locations of Wamba division and Kajiado Central.
5 In Balambala (82%) and Habaswein (69%), a majority of girls undergo FGM/C when under 10 years old. However, in Kajiado Central (97%), Laisamis (75%), Sook (100%) and Wamba (91%), a majority of girls undergo FGM/C from age 10 and above. Thus survey respondents with Somali origins (76%) largely perform FGM/C on their daughters when under 10 years old, while a majority of those of Maasai (97%), Samburu (90%), Pokot (100%) and Rendille (77%) origins perform FGM/C on their daughters from age 10 to 14 years old. Similarly, Muslim communities (76%) in the study locations generally cut their daughters when aged under 10, while communities professing Protestant (94%) and Catholic (91%) faiths generally cut their daughters when aged 10 and above.

B. Knowledge and perceptions of FGM/C

6. The perceived level of practice of FGM/C in the target study areas is higher, compared to the actual prevalence rates of FGM/C in the target study areas, especially in Laisamis, Sook and Wamba. This may indicate under-reporting of the prevalence of FGM/C or the possibility of currently uncut girls and women undergoing cutting in the future.
7. Among the Pokot in Sook and the Samburu in Wamba, compared to the Somali in Balambala and Habaswein, the Maasai in Kajiado Central and the Rendille in Laisamis, FGM/C is mostly associated with marriage. A significantly higher proportion of circumcised girls and women surveyed in Sook (83%) and Wamba (77%), compared to 53% in Balambala, 58% in Habaswein and 47% in Kajiado Central, were married off before reaching the age of 18. Circumcised girls are more likely to have had little to no education compared to their uncircumcised counterparts. Approximately 73% of circumcised girls and women with no education were married before reaching the age of 18, compared to 54% of those with primary-level education, 24% with secondary-level education and 20% with college or higher level education.
8. In order of popularity, common reasons for the practice of FGM/C, which vary across study locations, are tied to four key factors: marriageability entailing readiness for marriage and prevention of premarital sex; social acceptance; personal hygiene (including enhanced attractiveness if cut); and religious identity. Marriageability is the chief reason for practising FGM/C in Sook and Wamba, while the Muslim communities of Balambala and Habaswein practise FGM/C mainly for reasons of personal hygiene. In Kajiado Central and Laisamis, social acceptance is the most popular reason for practising FGM/C. While marriageability, personal hygiene and social acceptance remain causal elements for practising FGM/C across all study locations, assessment of FGM/C as a religious requirement is evident among the Somali (32%) (largely resident in the study locations of Balambala and Habaswein), compared to 10% and 4% of surveyed girls and women professing the Protestant and Catholic faiths respectively and who are resident in other study locations.
9. Awareness of the risks associated with FGM/C is low. FGM/C is associated with health-related risk factors as well as social factors: health-related factors are mainly bleeding, and difficulty during childbirth, infection, pain during sex and reduced sexual satisfaction and even death; social factors relate mainly to dropping out of school and child marriage. Significantly low awareness levels of the risks of FGM/C were observed among surveyed girls and women and boys and men in Wamba, Balambala, Kajiado Central and Habaswein, compared to Laisamis and Sook. This observation is reflected across the target ethnic communities in the study locations: the Maasai (mainly in Kajiado Central), the Somali and the Samburu have significantly lower levels of awareness of the risks of FGM/C compared to the Pokot and the Rendille, who are mainly resident in Sook and Laisamis respectively.
10. Awareness of the prohibition on FGM/C in Kenya is average to good. Surveyed girls and women as well as boys and men in Balambala and Habaswein recorded significantly lower levels of awareness of the ban of FGM/C in Kenya, compared to their counterparts in Kajiado Central, Laisamis, Sook and Wamba. A similar trend is observed across ethnic communities in the study locations where the Somalis (largely resident in Balambala and Habaswein) recorded a lower level of awareness of the ban on FGM/C in Kenya, compared to the Maasai (mainly in Kajiado Central), the Pokot (in Sook), the Rendille (in Laisamis) and the Samburu (mainly in Wamba). Compared to surveyed girls and women as well as boys and men of Catholic and Protestant orientation, who recorded higher levels of awareness of the ban on FGM/C in Kenya, significantly lower proportions of Muslims, largely resident in Balambala and Habaswein, are aware that FGM/C has been outlawed in Kenya.

11. There is a general perceived decrease in the practice of FGM/C, as reported by 72% of all girls and women surveyed and a near-equal proportion of boys and men surveyed (73%). Significantly lower proportions of surveyed girls and women as well as boys and men in Balambala and Habaswein, compared to those in Kajiado Central, Laisamis, Sook and Wamba, believe that there is a reduction in the practice of FGM/C in their respective communities. The reduction is mainly attributed to: intensive anti-FGM/C interventions by state and non-state actors that have been ongoing in the study locations over the last 10 to 20 years; fear of arrest; and enhanced knowledge among parents/caregivers, daughters and sons in their respective communities on FGM/C and its effects.

C. Type of FGM/C, circumciser and tools for carrying out FGM/C

12. Performing FGM/C is largely the preserve of traditional circumcisers, as reported by virtually all surveyed girls and women in Balambala (99%), Kajiado Central (97%), Habaswein (95%) and Wamba, Sook and Laisamis (all 100%). The survey results reveal some limited role of healthcare professionals in performing FGM/C in the target communities: 3% of surveyed girls and women in Habaswein, 5% in Kajiado Central, 1% in Balambala and 0% in Wamba, Sook and Laisamis reported that healthcare professionals are involved in the practice of FGM/C in their respective regions. However, it was noted that this involvement is largely limited to the administration of pain relief and is done in secrecy to protect the professional and also the girls and the family from ridicule since they will be considered "weak". What is clear is that healthcare professionals are mostly involved in the case of complications arising from FGM/C performed by traditional practitioners.
13. Further study findings show that traditional practitioners use crude tools, such as a razor blade or knife for cutting, herbal medicine for reducing pain, horn to enlarge the vaginal opening and ropes to tie girls undergoing circumcision. Depending on the ethnic community, there is use of tea leaves and breast milk to alleviate pain during circumcision, and the use of modern medicine, including paracetamol for pain, anti-tetanus injections to prevent infection and antibiotics such as penicillin for healing the wound after circumcision.
14. Removal of flesh from the genital area is the main type of FGM/C performed on girls and women, as reported by approximately 90% of surveyed girls and women, while nicking of the genital area without removing any flesh was reported by 6% of all girls and women surveyed. Removal of flesh in the genital area as a type of FGM/C is predominant in Laisamis (100%), Sook (94%), Wamba (98%) and Kajiado Central (89%). While removal of flesh from the genital area is the most common type of FGM/C performed on girls and women in Balambala (73%) and Habaswein (67%), nicking of the genital area without removing any flesh was reported by approximately 24% and 30% of surveyed respondents from Balambala and Habaswein respectively. Infibulation, typically involving stitching to close the genital area, was least evident, as reported by 1% of surveyed girls and women in Balambala, Kajiado Central and Sook and 0% in Laisamis, Habaswein and Wamba.

D. Support for continuation of FGM/C

15. A significant proportion of surveyed girls and women in Balambala (73%, $p < 0.05$), compared to 7% in Kajiado Central, 37% in Habaswein, 28% in Laisamis, 24% in Sook and 35% in Wamba, support the continuation of FGM/C in their respective communities. In addition, a significantly higher proportion of surveyed girls and women of Somali extraction (55%, $p < 0.05$), compared to 7% of the Maasai, 27% of the Samburu, 25% of the Pokot and 27% of the Rendille, support the

continuation of the practice of FGM/C in their respective communities. Except for surveyed girls and women of Rendille origin, significantly more women aged 18–49, compared to girls aged 10–17 in all target ethnic communities, support the continuation of FGM/C in their respective communities. Significantly more surveyed girls and women with no education, compared to 21% with primary-level education, 19% with secondary-level education and 11% with college or higher level education, support the continuation of FGM/C in their respective communities. Across all study locations, survey results show that significantly more girls and women who have undergone FGM/C, compared to their uncut counterparts, support the continuation of FGM/C. In Balambala, 74% of girls and women who have undergone FGM/C, compared to 18% who are not cut, support the continuation of FGM/C; and this result is reflected for Kajiado Central (12% of cut girls and women compared to 2% of uncut girls and women); Habaswein (38% of cut girls and women compared to 11% of uncut girls and women); Laisamis (32% of cut girls and women compared to 8% of uncut girls and women); Sook (29% of cut girls and women compared to 12% of uncut girls and women); and Wamba (31% of cut girls and women compared to 19% of uncut girls and women) support continuation of FGM/C.).

16. With regard to surveyed boys and men, significantly more of them in Balambala (60%, $p < 0.05$), compared to 5% in Kajiado Central, 39% in Habaswein, 25% in Laisamis, 33% in Sook and 37% in Wamba, support the continuation of FGM/C. By ethnicity, a significantly higher proportion of surveyed boys and men of Somali origin (49%), compared to 34% of the Samburu and Pokot and 33% of the Rendille, support continuation of the practice of FGM/C. While no significant differences were observed in the level of support for the continuation of FGM/C among urban and rural samples, significantly more surveyed boys and men of Muslim orientation (48%), compared to 18% of Protestants and 25% of Catholics, support continuation of the practice of FGM/C. Furthermore, among boys and men, support for the continuation of FGM/C reduces with increasing levels of education: approximately 39% of surveyed boys and men with no education, compared to significantly lower proportions of respondents with primary-level education (20%), secondary-level education (17%) and college or higher level education (16%) support continuation of the practice of FGM/C. A universal reason, provided by surveyed girls and women as well as boys and men, for supporting the continuation of FGM/C was “preservation of our culture”.

II. Child marriage

A. Prevalence of child marriage and age at marriage

17. Survey data from all girls aged 10–17 and boys aged 15–17 shows very low child marriage prevalence rates. Approximately 15% of girls aged 20–24 in Balambala, 28% in Kajiado Central, 58% in Habaswein, 44% in Laisamis, 64% in Sook and 22% in Wamba reported being married before reaching the age of 18. By ethnicity, 28% of the surveyed girls of Maasai origin, 38% of Somali origin, 17% of Samburu origin, 64% of Pokot origin and 54% of Rendille origin got married before reaching the age of 18. Approximately 30% of boys aged 20–24 in Balambala, 1% in Kajiado Central, 0% in Habaswein and Wamba, 3% in Laisamis and 38% in Sook got married before reaching the age of 18. By ethnicity, 1% of the surveyed boys aged 20–24 of Maasai origin, 14% of Somali origin, 0% of Samburu origin, 4% of Rendille origin and 38% of Pokot origin got married before reaching the age of 18.
18. The median age at marriage of girls and women in Balambala is 17.5 years old, and for the other study areas the median age was: 18 years old in Kajiado Central; 17 years old in Habaswein and Laisamis; 15 years old in Sook; and 16 years old

in Wamba. Approximately 68% of all married/once married girls and women were married off when aged under 18. This comprises 46% of married girls and women in Kajiado Central, 50% in Balambala, 58% in Habaswein and Laisamis, 76% in Wamba and 82% in Sook. Approximately 70% of all mothers surveyed married their daughters off when the latter were aged under 18. This comprises 20% in Kajiado Central, 75% in Balambala, 63% in Habaswein, 78% in Laisamis, 96% in Sook and 80% in Wamba. Among surveyed boys and men, 30% in Balambala, 4% in Kajiado Central, 6% in Habaswein, 20% in Laisamis, 30% in Sook and 8% in Wamba first got married when aged under 18.Among boys aged under 18 who were married at the time of the survey or were once married, approximately 18% in Balambala first got married when aged 10–14, while 82% were married when aged 15–17. In Habaswein and Sook, all boys aged under 18 who were married at the time of the survey or were once married first got married from around the age of 15.

B. Knowledge and perceptions of child marriage

19. Common reasons for practising child marriage include: personal choice of girls themselves; better bride price; existing poverty and hardship; traditional requirements; social pressure ("other girls are doing it"); and pressure from the father. A majority of surveyed girls and women in Balambala (60%) and Habaswein (59%) and a considerable proportion in Kajiado Central (44%) and Sook (36%) believe that the practice of child marriage is mainly driven by the girls themselves who demand to be married off before reaching the age of 18, possibly in following established norms. In Laisamis (73%), Sook (52%) and Wamba (42%), the practice of child marriage is believed to be influenced by the opportunity to obtain a better bride price, possibly driven by existing hardship and poverty in these regions. Similar observations were made by surveyed boys and men. A majority of surveyed boys and men in Laisamis (66%), Sook (61%) and Wamba (47%) believe that child marriage is practised in their respective communities since "younger girls" fetch a better bride price. This could be influenced by poverty, which was cited by a considerable proportion of surveyed boys and men in Laisamis (46%), Sook (37%) and Wamba (48%). In Balambala (60%), Kajiado Central (52%) and Habaswein (53%), a majority of respondents indicated that child marriage is mainly driven by the girls themselves, possibly due to the fact that it is the norm, as reported by 30%, 10% and 27% of respondents in Balambala, Kajiado Central and Habaswein respectively. The influence of fathers in pressurizing their daughters to get married before reaching the age of 18 is considerably evident in Kajiado Central, Sook and Wamba.
20. Awareness of the risks of child marriage is moderate in Laisamis, Sook and Wamba and low in Balambala, Kajiado Central and Habaswein. Awareness of the risks associated with child marriage increases with increasing levels of education. Approximately 40% of surveyed girls and women with no education, compared to 46% with primary-level education, 62% with secondary-level education and 65% with college or higher level education, reported having knowledge of the risks associated with child marriage. With regard to surveyed boys and men, approximately 43% of them with no education, compared to 54% with primary-level education, 50% with secondary-level education and 53% with college or higher level education, reported having knowledge of the risks associated with child marriage.
21. Knowledge of the prohibition on child marriage in Kenya is high among surveyed girls and women and boys and men. Approximately 53% of surveyed girls and women in Balambala, 85% in Kajiado Central, 58% in Habaswein, 91% in Laisamis, 59% in Sook and 88% in Wamba indicated that the practice is outlawed in Kenya. By ethnicity, approximately 85% of surveyed girls and women of Maasai origin, 55%

of the Somali, 89% of the Samburu, 59% of the Pokot and 90% of the Rendille are aware that the practice of child marriage is outlawed in Kenya. Approximately 54% of surveyed boys and men in Balambala, 91% in Kajiado Central, 69% in Habaswein, 90% in Laisamis, 77% in Sook and 90% in Wamba are aware that child marriage is illegal in Kenya. By ethnicity, approximately 91% of surveyed boys and men of Maasai origin, 61% of the Somali, 90% of the Samburu, 77% of the Pokot and 90% of the Rendille are aware that the practice of child marriage is outlawed in Kenya.

C. Support for the continuation of child marriage

22. Support for the continuation of child marriage in the target communities is low. However, more boys and men, compared to girls and women, support the continuation of child marriage in their respective communities. Significantly lower proportions of surveyed girls and women from Kajiado Central (2%), compared to respondents in Balambala (34%), Habaswein (15%), Laisamis (15%), Sook (15%) and Wamba (12%), believe that the practice of child marriage should continue in their respective communities. By ethnicity, approximately 2% of surveyed girls and women of Maasai origin, 26% of the Somali, 12% of the Samburu, 15% of the Pokot and 17% of the Rendille believe that the practice of child marriage should continue in their respective communities. Higher proportions of surveyed boys and men in Balambala (33%), Sook (33%), Habaswein (25%) and Laisamis (24%), compared to 2% in Kajiado Central and 15% in Wamba, support the continuation of child marriage in their respective communities. By ethnicity, higher proportions of surveyed boys and men of Pokot (33%), Rendille (26%) and Somali origin (29%), compared to approximately 2% of surveyed boys and men of Maasai origin and 14% of the Samburu, believe that child marriage should continue in their respective communities.
23. The belief that other girls and women will get married before reaching the age of 18 is significantly higher among surveyed girls and women in Balambala (39%), Habaswein (29%), Laisamis (38%), Wamba (35%) and Sook (45%), compared to only 4% of surveyed girls and women in Kajiado Central. By ethnicity, approximately 4% of surveyed girls and women of Maasai origin, compared to the Somali (35%), the Samburu (33%), the Pokot (45%) and the Rendille (42%), strongly believe that girls in study locations will get married before reaching the age of 18. This belief is more pronounced among girls and women who were married when under 10 years old (67%) and when aged 10–14 (30%), compared to 13% of those married at 15–17 years old and 7% married when at least 18 years old, with the former two cohorts expressing the view that girls and women will be punished if they do not get married before reaching the age of 18. The conviction that other girls will get married before reaching the age of 18 is driven by the perceived consequences of not getting married before reaching the age of 18, which, as cited by survey respondents across all study locations, were: ridicule by fellow girls and women; shunning and rejection of older girls by boys and men; difficulty in finding a husband; and rejection by parents, including banishment.

III. Influence of border communities on the continuity and prevalence of harmful practices

24. Approximately 71% of respondents from Uganda, 14% from Somalia, 60% from Ethiopia and 17% from Tanzania had visited Kenya for FGM/C services: approximately 4% of surveyed females indicated that they had visited Kenya only once, 8% had always visited Kenya when in need of FGM/C services and 30% stated that they had visited Kenya occasionally to seek FGM/C services. Specifically, approximately 54% of surveyed women from Ethiopia, 50% from Somalia and 22% from Uganda

had visited Kenya at least three times to seek FGM/C services. Approximately 77% of surveyed women from Uganda, 50% from Somalia, 46% from Ethiopia and 100% from Tanzania had visited Kenya once or twice for FGM/C services. This suggests that survey respondents who had visited Kenya more than once for FGM/C services might be involved in securing repeated FGM/C services in Kenya for their relatives and friends.

25. Approximately 40% of surveyed women from Ethiopia, 50% from Somalia and 50% from Uganda reported having secured FGM/C services in Kenya for at least three females. Approximately 10% of surveyed respondents from Uganda, 50% from Somalia, 20% from Ethiopia and 0% from Tanzania indicated that they had brought at least six females to Kenya to obtain FGM/C services. Specifically, approximately 67% of all persons brought to Kenya to undergo FGM/C are close relatives of the surveyed women, comprising daughters (47%), sisters (30%) and nieces (30%), while approximately 33% comprise friends and other relatives. Intermarriage (63%) is one of the main driving factors when seeking FGM/C services in Kenya. Other reasons cited for seeking FGM/C services in Kenya include: affordability (48%); quality of FGM/C services (41%); fear of arrest in native country (37%); and lack of proximity to circumcisers in native country (15%).

IV. Enforcement of laws prohibiting FGM/C and child marriage

26. Key concerns in respect of the enforcement of FGM/C and child marriage laws include: 1) inadequate knowledge of the laws and their requirements by the general public, which has posed a key barrier to the enforcement of laws on FGM/C and child marriage; 2) victims conniving with perpetrators of child abuse, thus frustrating enforcement of these laws; 3) community members' fear of attack and retaliation and hence reluctance to testify in court on cases of FGM/C and child marriage; 4) politicians interfering with enforcement of the existing laws, including bailing out perpetrators of FGM/C and child marriage, possibly for short-term gains in elections; and 5) most importantly, lack of infrastructure, both hard and soft and including human and financial resources, to enable the enforcement of laws prohibiting FGM/C and child marriage. Specifically, a lack of child protection officers in some of the study locations such as Balambala, the limited availability of courts and so increased costs of seeking justice, and a shortage of rescue centres to host children at risk of FGM/C and child marriage are key areas that frustrate enforcement of the laws addressing FGM/C and child marriage in Kenya.

Conclusions

27. Despite relatively high levels of awareness and knowledge of the risks resulting from undergoing FGM/C, as well as average to good levels of awareness of the prohibition on FGM/C in Kenya, the survey recorded high FGM/C prevalence rates among surveyed girls and women of Maasai, Pokot, Samburu and Rendille origins found in the study locations of Kajiado Central sub-county, Sook division, Wamba division and Laisamis sub-county respectively, and near-universal FGM/C prevalence rates among surveyed girls of Somali origin, largely resident in the study locations of Balambala and Habaswein.

28. The preservation of long-held traditions passed from one generation to the next is the most singular reason identified by the survey in the practice of FGM/C and in support for its continuation in the study locations. The perceived consequences of not undergoing FGM/C, such as ostracism occasioned by exclusion and rejection by boys, men, family and the wider community, ineligibility for marriage and hence difficulty in finding a spouse, and subjection to ridicule by peers and the wider community, are grounded in respect and fulfilment of these long-held traditions. Across all study locations, the power of these traditions is manifested, for example through the high levels of intent among surveyed mothers/caregivers to perform FGM/C on uncut daughters in the future.
29. Across all study locations, a majority of surveyed girls and women and boys and men had only attained primary-level education or none at all. However, in virtually all measurement areas,[2] the survey data reveals that positive dispositions of respondents on these measurement areas towards support for accelerating the abandonment FGM/C and child marriage increases with increasing levels of education and vice versa. Consequently, the role of education in supporting efforts towards accelerating abandonment of the practice of FGM/C and child marriage in the study locations cannot be overemphasized.
30. While marriageability is still central to the practice of FGM/C, the current practice of undergoing FGM/C at younger ages (especially among surveyed girls of Somali origin in Balambala and Habaswein, reflected by near-universal FGM/C prevalence rates among girls aged 10–17 in these two locations), or in later years beyond the ages where girls are considered ready for marriage (especially among the Pokot, Samburu, Maasai and Rendille), has changed the matrix of FGM/C practice. Survey results show that the cause and effect relationship between FGM/C and marriage is diminishing, mainly due to the increased awareness on the part of target communities regarding the prohibition on FGM/C and child marriage, and the intensified efforts by state and non-state actors towards accelerating their abandonment. Thus, increasingly, other factors such as social acceptance and cleanliness are gaining ground. This is supported by study results that show that the driving force behind the current practice of FGM/C in the study locations is girls and women themselves, supported by boys and men.
31. While rare, it is important to note the role played by healthcare professionals in the practice of FGM/C. Incorporation of modern medicine such as the use of pain relief prescribed or administered by healthcare professionals prior to girls and women undergoing FGM/C points to possible evolution into a larger role for the healthcare professionals, such as performing FGM/C.
32. While more research is required in assessing the role of border communities in perpetuating harmful practices such as FGM/C and child marriage, study data from surveyed members of border communities and key informants mainly in the Office of the Director of Public Prosecutions (ODPP) reveals that communities along the borders of Uganda, Ethiopia, Somalia and Tanzania may be involved in supporting the continuation of FGM/C and child marriage, mainly among the Pokot, the Rendille, the Somali and the Maasai in that order. A key driving factor in the cross-border practice of FGM/C is shared culture, mainly intermarriage, which may therefore play an indirect role in perpetuating FGM/C and child marriage practices in target communities.

2. Measurements areas include prevalence rates, intention to perform FGM/C on uncut daughters in the future and the marriage of daughters before the age of 18, the belief that FGM/C and child marriage will continue in the future, awareness of the prohibition on FGM/C and child marriage and of the risks associated with child marriage and FGM/C, and support for the continuation of FGM/C and child marriage.

33. While existing laws that prohibit FGM/C and child marriage are considered adequate, all the documented challenges faced in enforcing these laws directly point to capacity issues of the institutions entrusted with accelerating the abandonment of FGM/C and child marriage. Enumerated challenges such as interference by politicians, connivance between victims and perpetrators, community members' reluctance to testify in a court of law due to fear of attack by perpetrators, and lack of the necessary infrastructure such as offices and courts, and inadequate or total lack of personnel such as child protection officers, all translate into a lack of capacity involving human and financial resources, investigations and successful arrests, and witness protection.

Recommendations

34. Enhance sensitization and educational campaigns to equip girls and women as well as boys and men with the correct information about FGM/C and child marriage and their attendant effects. A key outcome of this study should include development of a comprehensive communication strategy to address identified gaps in knowledge, misconceptions and underlying reasons for the practice of FGM/C and child marriage.
35. One of the emerging issues in the study is the effect of school attendance on the practice of FGM/C and child marriage. There is anecdotal evidence that increased enrolment of girls in school is likely to reduce cases of child marriage and FGM/C. It is therefore imperative that efforts are also directed towards increasing school attendance to reduce the prevalence of FGM/C and child marriage. A key entry point is the establishment or strengthening of existing school clubs for child protection issues, training teachers in the areas of harmful practices, and creating links between schools and child protection actors, such as the police, provincial administration resources and rescue centres through encouraging schools to join these networks to fully benefit from interventions in the areas of FGM/C and child marriage, and supporting these child protection networks.
36. It is important to reach out to men, including fathers, to use their power and authority in support of accelerating the abandonment of FGM/C and child marriage in the study locations. Efforts should be directed towards positively channelling their power as key influencers and enforcers with regard to compliance with long-held traditions on FGM/C and child marriage practices towards accelerating the abandonment of FGM/C and child marriage. A key entry point is the establishment of community groups or strengthening of existing community groups to support advocacy on the abandonment of FGM/C and child marriage, including incorporating livelihood interventions such as income-generating activities (IGAs) and group saving and loan schemes to address the key area of poverty, which the study has revealed as a key driver in the practice of child marriage, including FGM/C, where the two go together.
37. It is important that awareness and knowledge of FGM/C and child marriage, including the attendant risks associated with these harmful practices, are enhanced among healthcare professionals in the target study locations. This should also cover legal and policy frameworks touching on harmful practices, including areas such as sexual and gender-based violence (SGBV).

38. It is also important that policy frameworks and mechanisms that address the medicalization of FGM/C are strengthened, including collaboration between target communities, healthcare facilities, police and provincial administration services, reporting protocols, and investigation and prosecution of cases involving healthcare professionals in the practice of FGM/C.
39. There is a need for capacity-building among key individuals and institutions charged with responsibility for implementing child protection activities in the study locations, as well as enforcing existing laws that address FGM/C and child marriage. Capacity-building must also involve support towards enhancing human and financial resources, including key infrastructure such as offices. However, it is important that a comprehensive organizational capacity assessment is carried out to identify successes to build on and the capacity needed to support the abandonment of FGM/C and child marriage.
40. It is recommended that community leaders (mainly chiefs, village elders, teachers and religious leaders) are brought on board in accelerating the abandonment of FGM/C and child marriage since they are considered by surveyed communities to be the most important source of information on FGM/C and child marriage. However, this must be complemented by other sources of information such as NGOs and officials of faith-based organizations, parents/caregivers and mass media (mainly TV, radio, newspapers, social media and the internet) to expand the reach to all target populations. Due consideration must also be given to effective channels of communication since separate target groups are likely to identify with different spokespeople. It is therefore important to segment the target population by effective sources of information; in many places, young people may respond to messages given by their peers rather than to messages given by adults or providers.

Chapter 1
Baseline study background

This chapter covers the insights and context under which the baseline study was undertaken. It comprises background information, and the purpose and research objectives of the baseline study.

1.1 Introduction

In line with the 1997 interagency statement Eliminating female genital mutilation (WHO et al., 2008), the United Nations Population Fund (UNFPA) and United Nations Children's Fund (UNICEF) launched a joint programme in 2007 entitled Female Genital Mutilation/Cutting: Accelerating Change, with the objective of contributing to the accelerated abandonment of FGM/C in one generation, with demonstrated success[3] in 17 countries in Africa by 2012. The programme seeks to contribute to the overall goal set by the interagency statement of 1997, reaffirmed by the 2012 United Nations General Assembly (UNGA) Resolution (UNGA, 2012) to intensify global efforts to achieve the elimination of FGM/C.

In Kenya, the joint programme was launched in 2008 in a collaborative effort with the Ministry of Gender, Children and Social Development and various NGOs. Phase I, which ended in 2014 and focused on the districts of Tana River, Garissa, Isiolo, Marsabit, Marakwet, Kuria, Migori, Naivasha and Mount Elgon, achieved impressive results, with the formulation of a national policy on the abandonment of FGM/C, enactment of the Anti-FGM Act 2011, and upscaling of community-led actions against FGM/C and child marriage practices.

Analysis of data from over 70 nationally representative household surveys undertaken in the 29 countries where FGM/C is concentrated (UNICEF, 2013) shows that its continued practice is due to the perception of FGM/C as a social obligation, intertwined with tradition and religion. However, the data indicates that in many countries, its prevalence has decreased and across the majority of countries, including some of the high-prevalence countries, support for FGM/C is declining and the majority of the population wants the practice to end.

In the light of knowledge gained during phase I, including through research and programmes supported by UNFPA, UNICEF and their partners, and based on the recommendations stemming from its evaluation (UNFPA–UNICEF, 2016), phase II was launched in 2014 and will run until 2017, in line with the strategic plans of UNICEF and UNFPA.

Phase II focuses on strengthening the enabling environment and increasing the demand side. The programme advocates and supports enforcement of the legal and policy framework, including standardising jointly developed guidelines relating to FGM/C.

3 "Demonstrated success" refers to a 40% reduction in prevalence among daughters (0–15 years) over a five-year period, in specific areas of the programme's implementation, and cannot be extrapolated to an entire country or region. The figure of 40% is based on evidence from specific fieldwork where community-led approaches were implemented. Egypt and Senegal are good examples of demonstrated success.

Additionally, the programme will focus on strengthening coordination between actors at a national level. Furthermore, the programme will continue to work with communities, focusing on children in and out of schools, and will identify and train community change agents to hold community dialogues that are expected to contribute towards public declarations on the abandonment of FGM/C. The joint programme in Kenya is contributing to achieving the following outputs:

1. Strengthened implementation of legislative frameworks at national and regional levels
2. Increased awareness and endorsement of the UNGA Resolution (UNGA, 2012) on FGM/C at global, continental, regional and national levels
3. Increased knowledge of the benefits of the abandonment of FGM/C and related adverse gender norms in the population
4. Increased accessibility, acceptability and quality of relevant prevention, protection and care services addressing FGM/C
5. Strengthened synergistic national and decentralized coordination addressing FGM/C and related adverse gender norms
6. Enhanced national and subnational systems for the generation of monitoring and evaluation data on FGM/C for continuous programme improvement
7. Strengthened dissemination, appropriation and visibility of evidence-based programme research and learning generated by the joint programme.

1.2 Purpose and objectives of the baseline study

While the social drivers and circumstances of FGM/C are similar in Kenya to those in other countries, no county- or sub-county-specific data is available on the prevalence rates and trends in FGM/C in the target communities under phase II of the joint programme. Thus, in addition to obtaining such data, the baseline study is expected to contribute to the following programme areas:

- **UNICEF Country Programme Document (CPD) for 2014–2018 Child Protection Outcome 4:** By 2018, children, families and communities utilize child protection services, underscored by a functional child protection system that prevents and responds to violence, family separation and harmful practices in regular and emergency situations at national and county levels, including in vulnerable urban areas.
- **Output 4:** Children, families and communities are able to reject harmful practices and respond to violence and family separation and to adopt positive social norms, and utilize child protection services.
- **Activity 1.4.2.** Provide technical and financial support to raise awareness among children, families and communities to prevent and respond to child protection violations.

The main objective of the baseline study was to establish the prevalence of FGM/C in the targeted counties and sub-counties. Specifically, the baseline study aimed to:

- establish the attitudes of parents/caregivers, men, women, boys and girls, adolescents and youth (male and female) and community leaders (including religious and political leaders) in the selected communities about FGM/C and child marriage
- assess the changing community patterns of parents/caregivers, men, women, boys and girls, adolescents and youth (male and female) and community leaders (including religious and political leaders) about FGM/C and child marriage
- establish the prevalence of FGM/C on girls aged between 10 and 17 years and child marriage on girls aged between 10 and 17 years
- assess the knowledge of parents/caregivers, men, women, boys and girls, adolescents and youth (male and female) and community leaders (including religious and political leaders) in the selected communities on FGM/C and child marriage
- explore to what extent bordering countries, including Somalia, Uganda, Ethiopia and Tanzania, may have influenced the continuity and prevalence rates of the harmful practices in the selected communities
- undertake a stakeholder mapping and analysis by creating an inventory of the interventions currently being implemented for the abandonment of FGM/C and child marriage in the locality, and map the gaps, previous interventions, strategies and key stakeholders to work with in order to inform the partnership and programming work of UNICEF in respect of FGM/C and child marriage.

1.3 Scope of the baseline study

The baseline study covered five ethnic communities in the following six study locations: Garissa (Balambala), Wajir South (Habaswein), Kajiado Central, Marsabit (Laisamis), Samburu (Wamba) and West Pokot (Sook). The bases for selection of these communities, together with the target age cohorts to participate in the baseline study, were as follows:

- All the target communities have high FGM/C and child marriage prevalence rates and are pastoral communities with low levels of education, especially among girls.
- The target areas are the new locations selected for FGM/C and child marriage interventions in the period 2014–2017 under the joint programme.
- The selected communities share traditions, culture and borders with neighbouring countries including Tanzania (Maasai), Somalia (Somali), Ethiopia (Rendille) and Uganda (Pokot). In the sub-counties close to the borders with Somalia, Ethiopia, Uganda and Tanzania, there is anecdotal evidence that the prevalence of FGM/C is higher than in other areas.

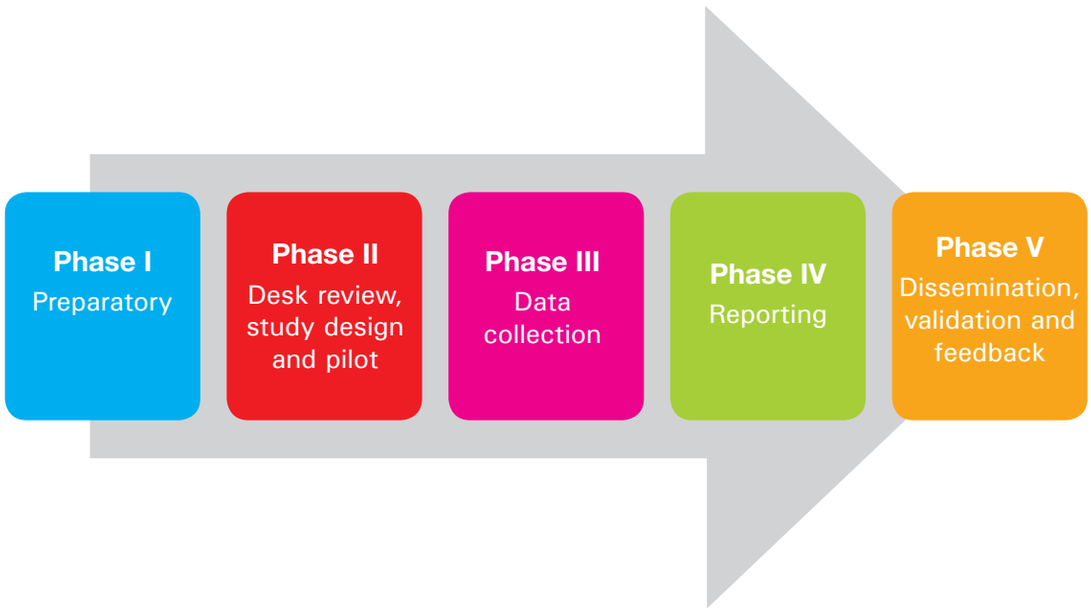
Chapter 2
Methodology

This chapter deals with the methodology used to carry out the baseline study. More specifically, it describes in detail the various approaches used in conducting the study and the respective samples achieved for each approach used. In addition, justifications for the adoption of various methodologies used are provided.

2.1 Baseline study process

As shown in Figure 1, implementation of the baseline study consisted of five sequential phases, namely: preparatory phase; desk review, study design and pilot phase; data collection phase; reporting phase; and dissemination, validation and feedback phase.

Figure 1: Phases of baseline study process



2.1.1 Phases of baseline study process

Details of each phase are as follows:

a. **Phase I: Preparatory:** During this phase, UNICEF and the consultants, Information Research Solutions (IRS), undertook several activities with a view to preparing the ground for implementation of the baseline study. These activities included addressing contractual issues, clarifying the terms of reference (ToRs), providing necessary literature for the preparation of the inception report and study tools, and recruitment of the data collection team.

b. **Phase II: Desk review and study design:** In this phase, a literature review largely on FGM/C and child marriage was carried out by the consultants to guide the development of an inception report with a key focus on refining the methodology to ensure that the data and study findings matched the study objectives and study outcome and output indicators. In addition, the desk review was vital in preparing the study tools, and establishing the type and level of analysis of baseline data, and in reporting on the study findings.

   UNICEF review teams provided substantive comments and feedback on the inception report and study tools. The consultants then proceeded to train the data collection team using the draft tools, and to pre-test and validate core elements of the inception report (mainly the methodological approach), and to test the study tools under similar field conditions as those in the targeted sub-counties and divisions. Following the pilot mission, a revised inception report and study tools incorporating the pre-test findings were submitted to the UNICEF review teams for substantive comments and feedback. The comments and feedback were incorporated in the inception report and study tools and a final set submitted to UNICEF for approval and use.

c. **Phase III: Data collection:** Following approval of the inception report and study tools, the consultants proceeded to the field to carry out data collection in the target sub-counties and divisions for a period of approximately one month. Prior to commencement of data collection proper, the data collection team was debriefed accordingly to ensure that any changes in the methodology and content of the study tools were understood.

d **Phase IV: Reporting:** Using the collected baseline data, the consultants prepared three draft baseline study reports: 1) a full and main report; 2) a summarized version of the full report; and 3) a child-friendly version of the full report. These were submitted to the UNICEF review teams for substantive comments and feedback, which were incorporated into second drafts, which were subsequently submitted to the review team for further comments and feedback. All these procedures ensured that the baseline study report complied with professional standards while meeting the study objectives and information needs of its intended users.

e **Phase V: Dissemination, validation and feedback:** Dissemination and validation sessions were incorporated into the study design to allow for maximum feedback and learning. The first drafts were presented to the UNICEF teams and substantive feedback was provided and subsequently incorporated into the second drafts. The second draft was subjected to a validation exercise with child protection working groups, community members and children in all the study locations. This was to ensure that the findings of the study harmonised with the positions of the validation exercise participants with regard to the twin issues of FGM/C and child marriage in their respective communities.

2.2 Survey design

The baseline study adopted a mixed-method approach, entailing desk review, and quantitative and qualitative designs. This ensured that the baseline study benefited from the triangulation of data sources, so ensuring reliable and valid study estimates, based on results, and conclusions drawn using data obtained by deploying the three different methodologies.

To obtain quantitative measures of the baseline indicators, questionnaire surveys were used to obtain data at household level, while focus group discussions (FGDs) and key informant interviews (KIIs) were employed to obtain qualitative measures of the baseline indicators, and to contextualize the quantitative study findings and provide further discourse on the established outcome indicators.

2.2.1 Desk review

Guided by the baseline study objectives, the desk review as a secondary source of data involved analysis and review of available literature on FGM/C and child marriage in Kenya and beyond. Key documents that were reviewed include: UNFPA–UNICEF joint programme documents on FGM/C and child marriage; legislation, policies and action plans on FGM/C and child marriage; county integrated development plans (CIDPs); reports covering situation analyses, baseline studies and evaluations of FGM/C and child marriage; and other relevant literature on FGM/C and child marriage.

Data obtained through the desk review was used to: prepare a literature review on FGM/C and child marriage among the Rendille, Maasai, Pokot, Samburu and Somali communities in Kenya; streamline the baseline study methodology; guide preparation of the baseline study tools; and assist in the writing of the baseline study report.

2.2.2 Qualitative design

The qualitative design entailed use of predominantly semi-structured KIIs and unstructured FGD guides to provide a more in-depth analysis of the baseline study measurement areas.

Guided by the baseline study ToRs and objectives, the KIIs targeted key informants at national, county and sub-county levels, with community-level informants purposively identified and included in the baseline sample. Furthermore, informants' respective positions of influence and expertise with regard to FGM/C, child marriage and child-related rights programmes[4] were a key determinant in their selection. Focus group discussions targeted key populations of the target communities of Rendille, Maasai, Pokot, Samburu and Somali: adult women and men, including youth, parents/caregivers aged 18–49, and girls and boys, including adolescent girls aged 10–17 years. A breakdown of the FGD target sample composition is detailed in Table 1.

4 UNICEF Kenya Child Protection team staff were key in the identification of, and communication with, key informants to participate in the baseline study.

Table 1: Focus discussion group sample

Category	Sex	Age (years)	Number of FGDs	Expected sample size per FGD*	Description	Actual sample size achieved per FGD
Parents	Females	18–49	6	48–72	At least one FGD in each of the six target communities (Balambala, Habaswein, Central, Laisamis, Wamba and Sook)	6 (60 females)
	Males	18–49	6	48–72	At least one FGD in each of the six target communities (Balambala, Habaswein, Central, Laisamis, Wamba and Sook)	6 (60 males)
Girls and boys	Girls	15–17	6	48–72	At least one FGD in each of the six target communities (Balambala, Habaswein, Central, Laisamis, Wamba and Sook)	6 (60 girls)
	Boys	15–17	6	48–72	At least one FGD in each of the six target communities (Balambala, Habaswein, Central, Laisamis, Wamba and Sook)	6 (60 boys)
Total			**24**	**192–288**		**24 (240 females and males)**

Note: * Each FGD comprised a minimum of 8 participants and a maximum of 12.

2.2.3 Quantitative design

The sample design features for this baseline study included target sample size, sample allocation, sampling frame, choice of domains, sampling stages, stratification and the calculation of sample weights.

The primary objective of the quantitative sample design for this baseline study was to produce statistically reliable estimates of key indicators at community level in the target sub-counties/divisions: Balambala sub-county in Garissa County; Habaswein sub-county in Wajir County; Sook division in West Pokot sub-county in West Pokot County; Wamba division in Samburu East in Samburu County; Laisamis sub-county in Marsabit County; and Kajiado Central sub-county in Kajiado County. Where applicable, urban and rural areas in each of the six sub-counties/divisions were defined and used as the sampling strata.

2.2.3.1 Sampling frame and selection of clusters

The most recent national sample master frame developed by the Kenya National Bureau of Statistics (KNBS) was used to define the sample. The frame is based on the 2009 Kenya Population and Housing Census and enabled the selection of household-based samples that are representative of the actual demographic profile of the study locations. In developing the frame, the sub-county, which in Kenya is an administrative boundary, was utilized by segmenting sub-counties into urban and rural components. For the target sub-counties/divisions, the frame has a total of 540 enumeration areas (EAs), with urban and rural strata for each sub-county/division as applicable. The distribution of EAs in the study areas is shown in Table 2.

Table 2: Distribution of EAs in the target sub-counties/divisions

Region	Sub-region	Population size	Number of households	Number of EAs			Total number of EAs
				Rural	Urban	Peri-urban	
Garissa	Balambala	30,655	4,503	47	0	0	47
Waji South	Habaswein	35,974	5,460	35	9		44
Kajiado Central	Central	59,632	13,120	134	61	1	196
Marsabit	Laisamis	18,253	4,424	42	8	0	50
Samburu East	Wamba	37,614	8,470	80	10	6	96
West Pokot	Sook	29,916	5,896	107	0	0	107
Total		**212,044**	**41,873**	**445**	**88**	**7**	**540**

Source: 2009 Kenya Housing and Population Census

Using this frame, a household survey approach was adopted and typically assumed a three-stage design based on a multi-stage, stratified cluster sampling where the selection of clusters (EAs) as the primary sampling units formed the first stage of sampling, while selection of the elementary units (i.e. households) formed the second stage of sampling. The selection of EAs to form clusters employed the use of population proportional to size (PPS) sampling methodology, suitably stratified at sub-county/division level. The second stage of sampling entailed selecting a random (first household selected) and systematic (subsequent households selected) sample of a fixed number of households within the randomly selected EAs.

Finally, using random selection by way of last birthday rule, the final unit (i.e. eligible persons) was selected within the randomly selected household to participate in the baseline study. Two eligible household members aged 10–49 were selected to participate in the baseline study. The inclusion criteria in selected households entailed first randomly selecting one female household member aged 10–17 among all female household members and then randomly selecting any other household member aged 15–49.

2.2.3.2 Sample size computation and sample allocation

The computed total sample size for this baseline study was 3,050. Using FGM/C prevalence in Kenya as the main indicator, the estimation formula below was utilized to compute the sample size:

$$\mathbf{n} = \left[\frac{(z^2)*(r)*(1-r)*(f)*(k)}{(p)*(\check{n})*(e^2)} \right]$$

where:

n *is the parameter to be calculated and is the sample size in terms of number of households to be selected*

z *is the statistic that defines the level of confidence desired (1.96 for 95% level of confidence)*

r *is an estimate of a key indicator to be measured by the survey (it is estimated that approximately 21% of the female population have undergone FGM/C)*

f *is the sample design effect, deff, assumed to be 2.0 (default value)*

k *is a multiplier to account for the anticipated rate of non-response (approximately 20% in sensitive surveys in Kenya)*

p *is the proportion of the total population accounted for by the target population and upon which the parameter, r, is based (approximately 19% of the Kenyan female population constitutes girls aged 10–17 years)*

ň *is the average household size (number of persons per household) (approximately 6.0 in households in North Eastern and Rift Valley regions)*

e *is the margin of error to be attained (recommended to be set at 10% of r, i.e. e = 0.1r)*

Substituting the recommended values:

$$\mathbf{n} = \left[\frac{(1.96^2)*(0.21)*(1-0.21)*(2)*(1.2)}{(0.91)*(\check{}6)*(0.021^2)} \right] = 3{,}402 \approxeq 3{,}050$$

Thus, a total of 3,050 households drawn from the target sub-counties/divisions was included in the baseline study sample.

The number of households allocated to each randomly selected cluster was determined as 25 households. This was based on a number of considerations, including the design effect, and available financial, human and time resources. To compute the required number of clusters, the computed household sample size was divided by the cluster size. Thus a total of 122 clusters each comprising 25 households was computed.

PPS sampling methodology was employed to proportionally allocate sample households to each strata (sub-counties/divisions). This entailed allocating sample EAs to the sub-counties/divisions depending on the actual[5] number of EAs in each sub-county/division, thus ensuring that 'large' sub-counties/divisions had the same probability as 'smaller' sub-counties/divisions of being included in the sample. Using the inclusion criteria mentioned previously, two eligible household members in each randomly selected household were selected to participate in the baseline study. Thus, a total of 6,100 eligible household members were targeted for inclusion in the baseline study sample.

5 As per the 2009 Kenya Housing and Population Census

The allocation of the computed number of EAs, number of households and number of eligible household members to the target sub-counties/divisions is provided in Table 3.

Table 3: Sample allocation of EAs, households and eligible household members

Region	Sub-region	Total number of EAs	Selected number of EAs	Selected number of EAs			Total number of target households	Expected maximum sample size of eligible units
				Rural	Urban	Peri-urban		
Garissa	Balambala	47	11	11	0	0	265	531
Waji South	Habaswein	44	10	8	2	0	249	497
Kajiado Central	Central	196	44	30	14	1	1,107	2,214
Marsabit	Laisamis	50	11	9	2		282	565
Samburu East	Wamba	96	22	18	2	1	542	1,084
West Pokot	Sook	107	24	24	0	0	604	1,209
Total		**540**	**122**	**100**	**20**	**2**	**3,050**	**6,100**

2.2.3.3 Calculation of sample weights

While use of the PPS procedure ensured that the computed sample size was allocated to target sub-counties/divisions based on their actual size, the sample was not self-weighting at individual sub-county/division level. Specifically, the application of a multi-stage sampling methodology instead of a simple random sampling afforded the baseline study the following benefits: practicality, through computing and having previous knowledge of the number of EAs to be covered in the survey; the ability to link the household variables to other important higher order variables such as EAs, rural–urban; and ensuring a less costly approach to data collection. However, the household selection procedure, through the multi-stage sampling method, had affected the characteristics and properties of the household sample. Thus the households did not have the same probability of selection and without taking into account these varying probabilities, the baseline study data might have returned biased results.

To compensate for the varying probabilities in the selection of households, baseline data was weighted through computation of sample weights which were used in subsequent analyses. As mentioned, the baseline study employed a multi-stage sampling approach at three levels: sub-county/division entailing sampling of EAs; within EAs entailing sampling of households; and within households entailing selection of eligible respondents.[6] Thus the major component of the weight is the reciprocal of the sampling fraction employed in selecting the number of sample households in sub-county/division *h* and EA *i*:

$$W_{hi} = \frac{1}{p_{hi}}$$

where p_{hi}, the sampling fraction of the i-th sample EA in the sub-county/division, is the product of probabilities of selection at every stage in each sub-county/division:

6 These are girls and women aged 10–49 and boys and men aged 15–49. The 2009 Kenya Housing and Population Census was used to derive the distribution of these population categories as part of the weighting procedure.

$$p_{hi} = q_{1hi} \times j_{2hi} \times k_{3hi}$$

where q_1 is the first stage of selection, j_2 is the second stage of selection and k_3 is the third and final stage of selection. Based on the above sample design, these probabilities were defined as follows:

- The probability of selecting the *i-th* EA in the target sub-county/division is given by:

  $$q_{1hi} = \frac{e_i}{E_i}$$

  where e_i is the target number of EAs in the i-th EA and E_i is the total number of EAs in the *i-th* sub-county/division.

- The probability of selecting the i-th household in the i-th EA is given by:

  $$j_{1hi} = \frac{h_i}{H_i}$$

  where h_i is the target number of households in the *i-th* EA and H_i is the total number of households in the i-th EA.

- The probability of selecting the i-th household member of the required age cohorts in the i-th household is given by:

  $$k_{1\text{hi}} = \frac{m_i}{HS_i}$$

  where m_i is the target number of household members in the *i-th* household and HS_i is the total number of household members in the *i-th* household. The household size in any EA is derived by dividing the total population in the *i-th* EA by the total number of households in the *i-th* EA:

  $$HS_i = \frac{p_{ti}}{H_{ti}}$$

  where HS_i is the average household size of the *i-th* EA, p*ti* is the total population of *i-th* EA and H_{ti} is the total number of households in the *i-th* EA.

The computed weights were appended in the appropriate data files and activated for analysis.

2.3 Sample coverage and respondent characteristics

Out of the targeted 6,100 sampled household interviews, 6,648 interviews were successfully completed, yielding an overall response rate of approximately 101%. Of the successfully completed interviews, a total of 1,357 were boys and men aged 15–49 and 5,291 were girls and women aged 10–49.

Out of the total of 5,291 successfully completed interviews with girls and women, 3,300 were carried out with girls aged 10–17, while 1,991 were carried out with women aged 18–49. Out of the successfully completed 1,357 interviews with boys and men, a total of 1,093 were completed with men aged 18–49, while a total of 264 were completed with boys aged 15–17 (as captured in Table 4).

Table 4: Sample coverage

Sub-county/ division	Residence	Sampled number of interviews	Completed number of interviews by sex		Total completed number of interviews	Completed number of interviews by age				Total completed number of interviews	Response rate (completed no. of interviews/ sampled no. of interviews)
			Male	Female		15–17 yrs (boys)	18–49 yrs (men)	10–17 yrs (girls)	18–49 yrs (women)		
Balambala sub-county	Urban	0	0	0	0	0	0	0	0	0	0
	Rural	550	176	433	176	29	147	270	163	609	1
	Total	**550**	**176**	**433**	**176**	**29**	**147**	**270**	**163**	**609**	**1**
Kajiado Central sub-county	Urban	700	55	337	55	7	48	211	126	392	1
	Rural	1,550	454	1,613	454	125	329	1,027	586	2,067	1
	Total	**2,250**	**509**	**1,950**	**509**	**132**	**377**	**1,238**	**712**	**2,459**	**1**
Habaswein sub-county	Urban	100	28	55	28	12	16	34	21	83	1
	Rural	400	130	269	130	38	92	169	100	399	1
	Total	**500**	**158**	**324**	**158**	**50**	**108**	**203**	**121**	**482**	**1**
Laisamis sub-county	Urban	100	18	92	18	3	15	53	39	110	1
	Rural	450	81	368	81	18	63	216	152	449	1
	Total	**550**	**99**	**460**	**99**	**21**	**78**	**269**	**191**	**559**	**1**
Sook division	Urban	0	0	0	0	0	0	0	0	0	0
	Rural	1,200	245	1,003	245	16	229	622	381	1,248	1
	Total	**1,200**	**245**	**1,003**	**245**	**16**	**229**	**622**	**381**	**1,248**	**1**
Wamba division	Urban	100	34	195	34	6	28	108	87	229	1
	Rural	950	136	926	136	10	126	590	336	1,062	1
	Total	**1,050**	**170**	**1,121**	**170**	**16**	**154**	**698**	**423**	**1,291**	**1**
Total	Urban	1,000	135	679	135	28	107	406	273	814	1
	Rural	5,100	1,222	4,612	1,222	236	986	2,894	1,718	5,834	1
	Total	**6,100**	**1,357**	**5,291**	**1,357**	**264**	**1,093**	**3,300**	**1,991**	**6,648**	**1**

Demographic analysis of surveyed girls and women shows that 8% were from Balambala sub-county, 37% from Kajiado Central sub-county, 6% from Habaswein sub-county, 9% from Laisamis sub-county, 19% from Sook division and 21% from Wamba division. Of these, 37% were of Maasai origin, 14% were Somalis, 22% were Samburus, 19% were Pokots and 8% were Rendilles.

A majority of surveyed girls and women were aged 10–17 (62%), while those aged 18–24 comprised 6%, 25–29 (8%), 30–34 (7%), 35–39 (8%), 40–44 (5%) and 45–49 (4%). Of the surveyed girls and women, 66% were single and 31% were married; 4% were either divorcees or widows. A majority of surveyed girls and women had attained only primary-level education (52%), while 8% had attained secondary-level education and 2% had attained college or higher level education. Approximately 36% had no education at all.

A higher proportion of surveyed girls and women (48%) were of Protestant orientation, while 33% were Catholics and 15% professed the Muslim faith.

Table 5 summarises respondent characteristics.

Table 5: Respondent characteristics of surveyed girls and women aged 10–49 and boy and men aged 15–49

Category	Demographic variable	Girls and women		Boys and men	
		Count	%	Count	%
Sub-county	Balambala	433	8.2%	176	13.0%
	Kajiado Central	1,950	36.9%	509	37.5%
	Habaswein	324	6.1%	158	11.6%
	Laisamis	460	8.7%	99	7.3%
	Sook	1,003	19.0%	245	18.1%
	Wamba	1,121	21.2%	170	12.5%
	Total	**5,291**	**100.0%**	**1,357**	**100.0%**
Age groups	(10–17 yrs, females) and (15–17, males)	3,300	62.4%	264	19.5%
	18–24 yrs	321	6.1%	275	20.3%
	25–29 yrs	407	7.7%	163	12.0%
	30–34 yrs	370	7.0%	146	10.8%
	35–39 yrs	426	8.1%	200	14.7%
	40–44 yrs	260	4.9%	178	13.1%
	45–49 yrs	207	3.9%	131	9.7%
	Total	**5,291**	**100.0%**	**1,357**	**100.0%**

Category	Demographic variable	Girls and women		Boys and men	
		Count	%	Count	%
Marital status	Single	3,470	65.6%	534	39.4%
	Married	1,658	31.3%	786	57.9%
	Cohabiting	1	.0%	3	.2%
	Divorced	44	.8%	8	.6%
	Separated	23	.4%	9	.7%
	Widow	95	1.8%	0	0.0%
	Widower	0	0.0%	17	1.3%
	Total	**5,291**	**100.0%**	**1,357**	**100.0%**
Education	None	1,891	35.7%	526	38.8%
	Pre-school	119	2.2%	22	1.6%
	Primary	2,744	51.9%	360	26.5%
	Secondary	417	7.9%	340	25.1%
	College or higher	94	1.8%	92	6.8%
	Adult education	26	.5%	17	1.3%
	Total	**5,291**	**100.0%**	**1,357**	**100.0%**
Residence	Urban	679	12.8%	189	13.9%
	Rural	4,612	87.2%	1,168	86.1%
	Total	5,291	100.0%	1,357	100.0%
Ethnicity	Maasai	1,950	36.9%	509	37.5%
	Somali	757	14.3%	332	24.5%
	Samburu	1,182	22.3%	183	13.5%
	Pokot	1,004	19.0%	246	18.1%
	Rendille	398	7.5%	87	6.4%
	Total	**5,291**	**100.0%**	**1,357**	**100.0%**
Religion	Muslim	787	14.9%	340	25.1%
	Protestant	2,520	47.6%	556	41.0%
	Catholic	1,742	32.9%	433	31.9%
	Other	242	4.6%	28	2.1%
	Total	**5,291**	**100.0%**	**1,357**	**100.0%**

Further, demographic analysis of surveyed boys and men shows that 13% were from Balambala sub-county, 37% from Kajiado Central sub-county, 12% from Habaswein sub-county, 7% from Laisamis sub-county, 18% from Sook division and 12% from Wamba division. Of these, 37% were of Maasai origin, 24% were Somalis, 13% were Samburus, 18% were Pokots and 6% were Rendilles.

Surveyed boys and men aged 15–17 formed 19% of the sample, while those aged 18–24 comprised 20%, 25–29 (12%), 30–34 (11%), 35–39 (15%), 40–44 (13%) and 45–49 (10%). Of the surveyed boys and men, 39% were single and 58% were married; 3% were either divorcees or widowers. Just over a quarter of surveyed boys and men had attained only primary-level education (26%), while 25% had attained secondary-level education and 7% had attained college or higher level education. Approximately 39% had no education at all.

A slightly higher proportion of surveyed boys and men (41%) were of Protestant orientation, while 40% were Catholics and 25% professed the Muslim faith.

2.4 Data analysis

Data collected through the quantitative approach was analysed using IBM SPSS Statistics Version 23. Sample proportions of key attributes were computed and tests of group differences, especially with regard to gender, age, level of education, religion, ethnicity and residence, were measured using z-test and adjusted for all pairwise comparisons using the Bonferroni correction.

Data collected using the qualitative approach underwent analysis through grouping collected information by themes to facilitate content analysis. This entailed first identifying the common themes guided by the study indicators around which the analysis should be carried out. Exploratory analysis of the qualitative data was then carried out and this entailed structural coding and partitioning of data in line with the identified themes. Finally, extraction of the data for further analysis was carried out to ensure that each thematic area was comprehensively addressed.

2.5 Training

Prior to carrying out a pre-test of the survey tools and the data collection proper, a total of 120 research assistants comprising 55 women and 65 men were trained on specific areas that included: familiarization with the baseline study ToRs; survey questions and questionnaire flow; recording of information; household selection; interview administration and techniques; integrity during data collection; informed consent, confidentiality and gender considerations as key components of research ethics as well as familiarity with the UNICEF child protection policy and manual.

2.6 Ethical considerations

As part of implementation of the baseline study, reference was made to the WHO *Ethical and Safety Recommendations* (WHO, 2007a). At the core of the ethical principles deployed during the baseline study was the need to always do good and do no harm. Ethical considerations as part of ensuring successful execution of the baseline study included the following:

1. For the purposes of conducting this baseline study, ethical clearance was sought from the National Commission for Science, Technology and Innovation (NACOSTI).
2. Prior to conducting interviews with all target respondents, written and oral consents were sought and obtained from literate and illiterate[7] respondents respectively, after

7 For illiterate parents/guardians who had consented, either their thumbprints were taken or a witness was asked to sign on their behalf.

they had been apprised of the purpose of the study in a language that they fully understood.[8] In the case of child participants, consent was sought from either the parents or guardians prior to selecting them for inclusion in the study sample. Further, study participants were informed of their right not to answer any questions they were not comfortable with and to terminate the interview at any time they deemed fit.

3. Participation in the baseline study was voluntary and based on informed consent, which entailed providing study participants with information about the study and its approach, their role in the study, the roles of the survey team and the attendant personal benefits, both directly and indirectly.
4. All interactions between the survey team and participants, as well as among study participants, were based on mutual respect and trust. Confidentiality and anonymity regarding the data collected were ensured through the following means:
   - Safeguards to ensure confidentiality during data processing and reporting entailed not making or implying precise references to study participants or statements made by particular study participants.
   - Data from KIIs were processed void of personal information.
   - For all study approaches, personal information was not collected.
   - To ensure network security, computer systems had a firewall and were password protected.
   - Safe and secure storage of master copies of data collected, together with back-up files on password-protected hard drives and CDs, was implemented. The stored data underwent verification and validation at regular intervals to ensure its integrity in the long term.
   - Non-disclosure agreements were imposed on, and signed by, the consultants that had access to the stored data.
   - Survey data was only shared with UNICEF and designated persons in the consultant team.
   - Confidentiality of survey participants during dissemination of the study findings was enforced through written confidentiality agreements by all participating researchers.
5. Sensitive questions were de-personalized or scenarios were provided as a prompt for discussion.
6. Deliberate matching of respondent and interviewer by gender was carried out during data collection to elicit sensitive information.
7. Posing questions in the third person to avoid the risk of respondents looking for a "correct" answer or feeling threatened by direct questioning was carried out and enforced throughout the study.
8. Video recording of interviews and FGDs was not carried out. Only note-taking and audio recording was carried out.

While obligations to baseline study participants were clearly spelled out, a number of challenges were encountered during the pre-test and the data collection proper. Table 6 lists all the ethical issues encountered during the execution of the baseline survey and the accompanying solutions.

8 The main languages used were Somali, Rendille, Maasai, Pokot and Samburu.

Table 6: Ethical issues encountered during pre-test exercise and data collection and accompanying solutions

Ethical issue	Solution
1. In Kajiado Central sub-county, enumerators of Maasai origin indicated that culturally, it is a taboo to collect information/ask questions within one's clan on sensitive topics such on FGM/C, such as the type of FGM/C practised and related procedures. Indeed, this was confirmed during the pre-test exercise where a number of households declined to respond to the said questions since the enumerator was their clan member and therefore well known to them.	To be mindful of the potential implications of this challenge, such as hostility to enumerators and non-response, enumerators of Maasai origin in Kajiado Central sub-county were reorganized to collect data from other clans away from their own clans to ensure respect for differences in culture and customs.
2. During the pre-test and data collection, only female parents/caregivers were at home in a majority of households and hence the only target group available to participate in the baseline study when individual consent was successfully obtained. However, children had either gone to school or were carrying out chores such as herding or fetching water and so could not be adequately covered as desired. Male parents/caregivers were equally affected.	To ensure fair representation and consequently meet sample requirements, care was taken to ensure that relatively "hard-to-reach" or potentially excluded groups were represented in the study. This was done through call-backs, where enumerators returned to the affected households late in the evening to carry out planned interviews of selected household members.

Ethical issue	Solution
3. Some of the respondents, especially male parents/caregivers, were concerned that giving out information on respected traditions such as FGM/C was tantamount to being traitorous and so could attract negative consequences from other community members.	As part of the study during the pre-test and actual data collection, respondents were furnished with adequate information about the study so as to make an independent decision on whether or not to participate in the study without fear of penalty, thus ensuring that their right to self-determination was respected. However, respondents' right to provide information in confidence was respected while making known to the respondents the scope and limits of the principle of confidentiality. To ensure that any sensitive information was not traced to the sampled households, respondents' contact details were not recorded in any form, thus protecting them from negative consequences. In addition, respondents were given sufficient information on how to seek redress for perceived negative consequences suffered as a result of participating in the study, including how to report a complaint regarding the conduct of an enumerator/ supervisor or Information Research Solutions (IRS) as the contracted firm.
4. Due to the heightened crackdown on harmful practices such as FGM/C and child marriage, communities, especially in Kajiado Central sub-county where heightened interventions on FGM/C and child marriage were recorded, numerous instances of potential but hostile respondents were reported. Respondents were suspicious of anyone asking questions regarding FGM/C and child marriage and so declined to invite enumerators into their homes or ejected them from their homes midway through the interview.	
5. As a consequence of fear of possible reprisal/arrest, a high number of negative responses on key indicators such as FGM/C prevalence against set expectations were recorded in the target sub-counties/divisions during the first week of data collection. After subjection to quality assessment, the collected data was discarded.	
6. Interviews targeting key informants could not be completed on time for two key reasons: objections raised by sampled key informants with regard to a lack of adequate and timely communication regarding the impending study, and lack of time to participate in the study.	To ensure respect for stakeholders' right to privacy in addition to getting the most out of the available time while keeping any disruptions to a minimum, target stakeholders were provided anew with notice requesting their participation in the study and allowed to give an appropriate time and place to participate.
7. Some of the key informants raised concerns about possible misrepresentation by the consultants (IRS) of community positions on FGM/C and child marriage practices.	The evaluation findings were subjected to a validation exercise through presenting and discussing key findings with relevant groups at the target sub-county/division level, including child protection working groups, community members and children. This enabled stakeholders to see first-hand the study findings and to have the opportunity to either adopt or reject the findings before the baseline report was completed and published.

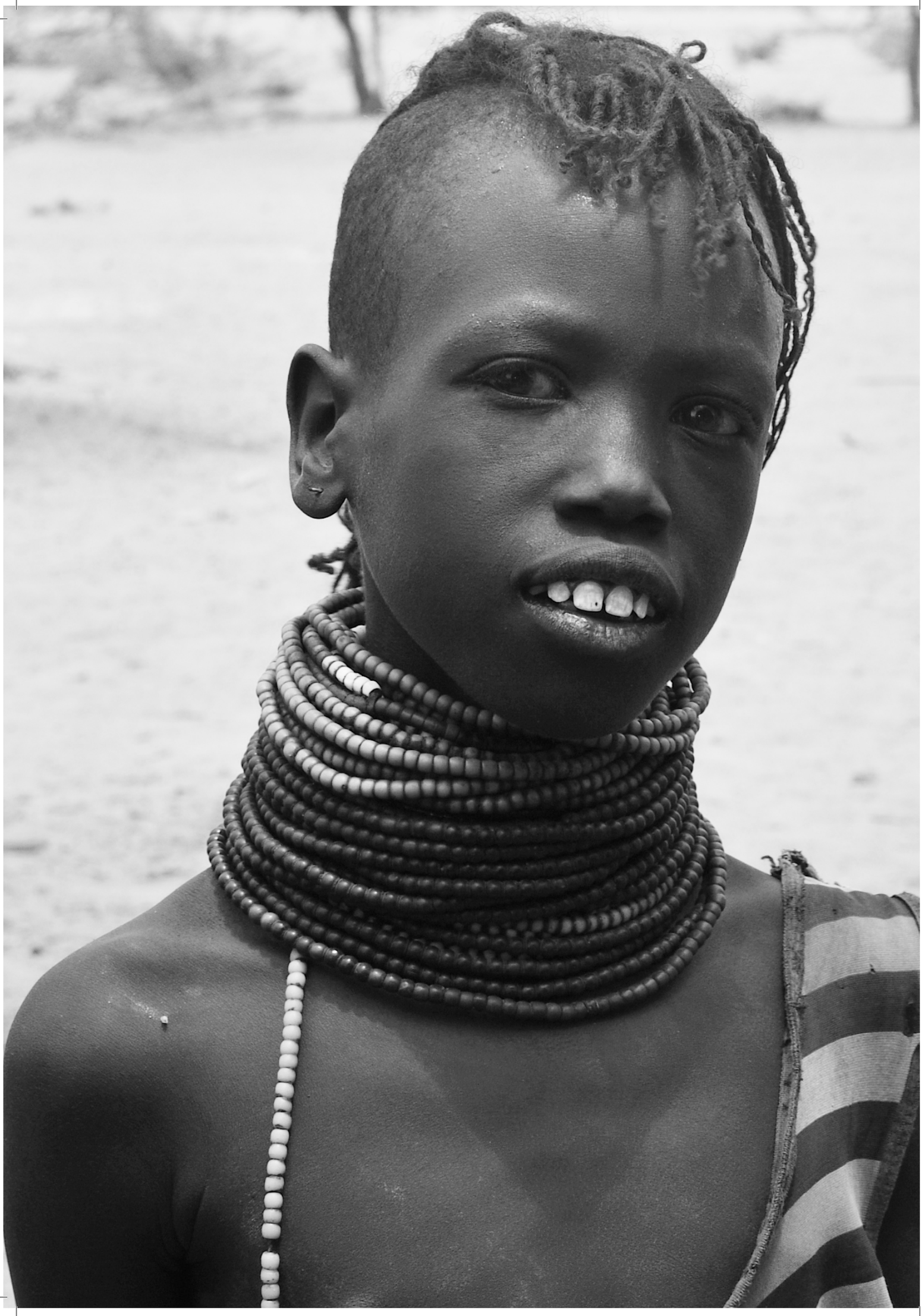
2.7 Limitations of the survey

During the pre-test and data collection proper, a number of challenges were encountered. A detailed account of these challenges and mitigating strategies are provided in Table 7.

Table 7: Challenges and mitigation strategies during pre-test and fieldwork proper

No.	Challenge	Mitigation strategy
1	The majority of surveyed respondents, especially women, did not feel comfortable in responding to certain modules of the study tool, especially questions related to sharing their own personal experiences of FGM/C. Further, during the first week of data collection, approximately 750 interviews were discarded after undergoing quality assessment due to the high number of negative responses regarding key indicators such as FGM/C prevalence against set expectations.	Transitional statements before the questions that were considered highly sensitive were introduced in the tools to improve the response rate for affected questions. The identified sensitive questions on FGM/C were rephrased from direct questions to respondents to experiences of their peers. Village elders and chiefs were incorporated into the study to increase target community buy-in and therefore increase survey participation. Throughout the study period, enumerators, with the support of supervisors and coordinators, continuously built rapport with respondents for ease of conducting interviews.
2.	Respondents were expecting incentives at the end of the interview, mainly observed in Balambala and Sook.	During the introduction session at the household, enumerators stated that no incentives were to be provided for participation in the survey.
3.	In Kajiado, numerous instances of potential but hostile respondents were reported where respondents would not allow enumerators into their homes or chased away enumerators midway through the interview.	Village elders and chiefs were incorporated into the study to support community buy-in and increase survey participation.

No.	Challenge	Mitigation strategy
4.	It was noted during data collection that in many households reached, children had gone to school or were carrying out chores such as herding while only female parents/caregivers were at home and so available to participate in the baseline study if individual consent was successfully obtained.	A majority of interviews with children were carried out late in the evening when they were available in their homes.
5.	At the time of survey, Balambala and Habaswein were experiencing drought, including harsh climatic conditions. These harsh conditions hampered the data collection exercise, mostly in the afternoons.	Each day of the data collection exercise commenced very early in the morning to cover the day's quota.



Chapter 3
Study findings

3.1 Global, regional and national status of female genital mutilation/cutting

The joint statement on female genital mutilation issued by WHO, UNICEF and UNFPA (WHO et al., 1997) defines female genital mutilation (FGM), also known as female genital cutting (FGC), as comprising all procedures involving "partial or total removal of or injury to the external female genitalia performed for non-therapeutic reasons" (WHO, 1997, p.1) and classified FGM/C into four broad categories.

As shown in Table 8, WHO reviewed the wording of the classification typologies (WHO, 2014, 2007b), which was modified and subdivisions created to capture varieties of procedures involved in FGM/C.

Table 8: FGM/C classification

WHO modified typology (WHO, 2007)
Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy). When it is important to distinguish between the major variations of Type I mutilation, the following subdivisions are proposed: Type I a, removal of the clitoral hood or prepuce only; Type I b, removal of the clitoris with the prepuce.
Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). When it is important to distinguish between the major variations that have been documented, the following subdivisions are proposed: Type II a, removal of the labia minora only; Type II b, partial or total removal of the clitoris and the labia minora; Type II c, partial or total removal of the clitoris, the labia minora and the labia majora. Note also that, in French, the term 'excision' is often used as a general term covering all types of female genital mutilation.
Type III: Narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation). When it is important to distinguish between variations in infibulations, the following subdivisions are proposed: Type III a: removal and apposition of the labia minora; Type III b: removal and apposition of the labia majora.
Type IV: Unclassified: all other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterization.

UNICEF estimates that at least 200 million girls and women alive today have been subjected to FGM/C in 30 countries in Africa, the Middle East and Asia where FGM/C is concentrated, with 3 million girls and women remaining at risk of the procedure each year. With regard to child marriage, the 2014 UNICEF estimates showed that more than 700 million women alive worldwide were married before their 18th birthday, while more than one in three (about 250 million) entered into union before the age of 15, with projections showing that if there is no reduction in the practice of child marriage, up to 280 million girls alive are at risk of becoming brides by the time they turn 18; due to population growth, this number will approach 320 million by 2050.

According to the 2014 Kenya Demographic Health Survey (KDHS), 21% of the female population of child-bearing age (15–49 years old) reported having undergone FGM/C, with the Somali (94%), Samburu (86%), Kisii (84%), Maasai (78%), Embu (31%), Meru (31%), Kalenjin (28%) and Taita Taveta (22%) communities recording the highest FGM/C prevalence rates. Thus FGM/C prevalence rates vary considerably, with ethnicity being a key decisive factor. Compared to prevalence rates of 27% in 2008–2009, 32% in 2003 and 38% in 1998, a steady decline in the practice is observed. With regard to child marriage, the 2014 KDHS data shows that marriage occurs relatively early in Kenya. Among women aged 25–49, 29% were married by age 18 and 9% were married by age 15, while among women aged 20–49, 7% were married by age 15, while 27% were married by age 18. Of the girls and women aged 15–19, approximately 2% were married by age 15. Thus, the 2014 prevalence rate of child marriage in Kenya is approximately 23%.[9]

The consequences of FGM/C and child marriage are grave and imperil the realization of sustainable development goals (SDGs). Child marriage is associated with a range of poor health and social outcomes and other negative consequences. Specifically, child marriage results in early and frequent pregnancies and forced continuation of pregnancy closely linked to high maternal and infant morbidity and mortality rates and can have an adverse effect on girls' sexual and reproductive health, including obstetric fistula developed during adolescence, preterm birth, low birthweight and asphyxia, school dropout and subsequent lower educational attainment, and lack of decision-making including on their sexual and reproductive health. According to WHO (2006), FGM/C contributes to a number of maternal and neonatal outcomes among girls and women who have undergone FGM/C: increased risk of maternal death, and adverse obstetric outcomes including caesarean section and post-partum haemorrhage, increased need to resuscitate babies whose mothers had undergone FGM/C and higher death rates among new-born babies.

In the target ethnic communities comprising the Pokot, the Maasai, the Rendille, the Samburu and the Somali, the impacts of FGM/C and child marriage as cultural practices (including others, such as cattle rustling) have been documented, namely: poor educational outcomes, including low primary and secondary school enrolment rates, high dropout rates, poor primary to secondary transition rates and high illiteracy rates; and poor health outcomes, including poor reproductive health and increased rates of HIV infection. Further, the role of migrant communities with regard to perpetuating FGM/C and child marriage practices has also been documented. FGM/C can be adopted in various situations: by new groups or areas as a result of migration and displacement (Abusharaf, 2007, 2005); neighbouring groups influencing other communities to adopt the practice (Leonard, 2000; Dellenborg, 2004); in religious or traditional revival movements (Nypan, 1991); and through intermarriage involving communities widely practising FGM/C (Shell-Duncan and Hernlund, 2006). It is instructive to note the effect of border countries with high FGM/C prevalence rates, mainly Somalia and Ethiopia, on Kenyan communities, especially those bordering these countries: the Rendille bordering Oromiya and the Southern Nations, Nationalities and Peoples' (SNNP) regions with FGM/C prevalence rates of 87% and 71% respectively; the Somali in Wajir and Garissa counties bordering Juba and Gedo regions in Somalia where FGM/C is near universal (98%), with affected women having been subjected to Type III or pharaonic circumcision, the most drastic form (World Bank and UNFPA, 2004); the Maasai bordering Arusha and Kilimanjaro regions in Tanzania, with estimated FGM/C prevalence rates of 57% and 22% respectively; and the Pokot bordering Karamoja region in Uganda with an FGM/C prevalence rate of 5%.

9 Analysis by Information Research Solutions based on 2014 KDHS data, taking into account all surveyed girls and women aged 15–49.

Thus, FGM/C and child marriage are human rights issues that affect girls as well as women worldwide. A number of international and regional human rights treaties and consensus documents provide protection and contain safeguards against harmful practices including FGM/C and child marriage, key among which are the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the United Nations Declaration on the Elimination of Violence Against Women and the United Nations Convention on the Rights of the Child (CRC), which call for eradication of harmful traditional practices including FGM/C and child marriage. Other international and regional human rights treaties and consensus documents providing protection and containing safeguards against harmful practices, including FGM/C and child marriage, are: the Universal Declaration of Human Rights (UDHR); Convention relating to the Status of Refugees; Protocol relating to the Status of Refugees; International Covenant on Civil and Political Rights; International Covenant on Economic, Social and Cultural Rights; Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; European Convention for the Protection of Human Rights and Fundamental Freedoms; American Convention on Human Rights; African Charter on Human and Peoples' Rights (Banjul Charter); African Charter on the Rights and Welfare of the Child (ACRWC); and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol).

Kenya is party to several of the aforementioned international human rights conventions, which provide a strong basis for the characterisation of FGM/C and child marriage as violations of international human rights:

- Convention on the Rights of the Child (CRC), in which State Parties are directed under: Article 6.2 to ensure survival and development of the child; Article 24(3) to take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children; and Article 19(1) to take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse.
- Convention on the Elimination of Discrimination Against Women (CEDAW) in which State Parties are directed under: Article 2 to take all appropriate measures to eliminate all customs and practices that constitute discrimination against women; Article 5 to take all appropriate measures to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes; Article 16.1 to eliminate discrimination in marriage by providing that men and women have the same right to enter into marriage and the same right to freely choose a spouse and to enter into marriage only with their free and full consent; and Article 16.2 that marriage of a child shall have no legal effect.
- International Covenant on Economic, Social and Cultural Rights (ICESR) in which: Article 1 provides for the right to freely pursue economic, social and cultural development; Article 3 calls for equal rights for men and women in economic matters; Article 12.2 provides that steps be taken by State Parties to achieve the full realization of the right to health which shall include those necessary for provision for healthy development of the child. "Health" is defined so as to include "maturity, reproductive and sexual health". FGM/C thus violates the Convention due to the numerous negative health consequences.

- Convention on the Consent to Marriage, Minimum Age for Marriage and Registration of Marriage calls upon parties to eliminate the marriage of girls under the age of puberty and requires that States stipulate the minimum age of marriage under: Article 1 that no marriage shall be legally entered into without the full and free consent of both parties, such consent to be expressed by them in person.... as prescribed by law; Article 2 that State Parties to the Convention shall specify a minimum age for marriage; and Article 3 that all marriages shall be registered in an appropriate official register by the competent authority.
- African Charter on the Rights and Welfare of the Child, which requires Member States of the African Union to abolish customs and practices harmful to the "welfare, dignity, normal growth and development of the child and in particular: (a) those customs and practices discriminatory to the child on the grounds of sex or other status". It calls State Parties under: Article 6 to ensure right to liberty and security of person; and Article 17 to ensure right to education; and Article 29 to ensure right to harmonious development of family.
- Maputo Protocol to the African Charter on Human and Peoples' Rights on the Rights of the Women in Africa (the Maputo Protocol) explicitly refers to FGM under Article 5, which directs State Parties to prohibit and condemn through legislative measures backed by sanctions all forms of FGM/C, scarification and para-medicalisation of FGM/C and all other practices in order to eradicate them. Further, it provides under: Article 2 for commitment by State Parties to modify harmful traditional practices; Article 5 for prohibition of all practices that negatively affect the human rights of women; and Article 6 for prohibition on non-consensual marriage, the minimum age of marriage for women being 18 years.
- African Charter on Human and People's Rights (the Banjul Charter) provides for the right to health (Article 16) and right to physical integrity (Articles 4 and 5).

  Cairo Declaration for the Elimination of FGM/C 2003 explicitly calls for governments to recognize and protect the human rights of women and girls in accordance with the aforementioned human rights documents and to implement legislation to criminalize and prohibit FGM/C.
- The 1998 Banjul Declaration on Violence against Women, Inter-African Committee on Traditional Practices and the Gambia Committee on Traditional Practices Affecting the Health of Women and Children (GAMCOTRAP) strongly condemns the practice of FGM/C and the misuse of religious argument to promote the practice.
- The African Union declared the years from 2010 to 2020 to be the Decade for African Women and Kenya is expected to continue its commitment to promote and protect the rights of women.
- On 20 December 2012, the UN General Assembly adopted Resolution A/RES/67/146, which "calls upon States, the United Nations system, civil society and all stakeholders to continue to observe 6 February as the International Day of Zero Tolerance for Female Genital Mutilation and to use the day to enhance awareness- raising campaigns and to take concrete actions against female genital mutilations". In 2013, the conclusions of the 57th UN Commission on the Status of Women agreed to include a reference to the need for States to develop policies and programmes to eliminate all forms of violence against women including FGM/C (UN, 2013).

In Kenya, the Prohibition of Female Genital Mutilation Act 2011 and the Marriage Act 2014 are the key national laws that directly address FGM/C and child marriage. The Kenya Women's Parliamentary Association (KEWOPA), with support from the Parliamentary Council, the National FGM/C Secretariat and the UNFPA–UNICEF joint programme on FGM/C drafted the Prohibition of Female Genital Mutilation Act 2011, which was passed by Parliament on 30 September 2011 and signed into law on 6 October 2011. An Anti-FGM and child marriage Prosecution Unit was subsequently set up in the Office of the Director of Public Prosecutions (ODPP). To coordinate the implementation of the Act, the Anti-FGM Board was subsequently operationalized and resources allocated to it by the government, including receiving technical and financial support from the UNICEF–UNFPA joint programme, for the organization of an FGM/C strategic development forum and development of the Anti-FGM Board strategic plan.

In addition, advocacy for abandonment of FGM/C has received continued support from high government officials such as the President of Kenya and the First Lady, including establishment of an Anti-FGM Unit and an FGM/C and child marriage hotline in order to streamline the prosecutorial management of FGM/C cases in Kenya and to facilitate the reporting of cases for timely intervention respectively.

The Prohibition of Female Genital Mutilation Act 2011 criminalises all forms of FGM/C performed on anyone, regardless of age or status, including training to become an FGM/C practitioner, causing death as a result of performing FGM/C, aiding and abetting FGM/C, procuring of a person to perform FGM/C in another country, use of premises to perform FGM/C, possession of tools or equipment for purposes connected to performing FGM/C, failure to report an offence of FGM/C and use of derogatory or abusive language intended to ridicule, embarrass or harm a girl or woman for not having undergone FGM/C or a man for marrying or supporting a girl or woman who has not undergone FGM/C. On conviction, these offences attract imprisonment for a minimum term of three years, or a fine of not less than 200,000 Kenyan shillings, or both.

Other recent key developments in national legislation and policies with regard to child protection are: Article 53 (1) d of the Constitution of Kenya 2010; the Kenya Citizens and Foreign Nationals Management Service Act 2011; the Counter Trafficking in Persons Act 2010; the 2010 Constitution, which prohibits marriage of persons under the age of 18; and the Marriage Act 2014, which consolidates all marriage laws in Kenya to remove any discriminatory provisions with respect to boys and girls (e.g. different ages for marriage).

With the United Nations General Assembly adopting a milestone Resolution in 2012 calling on the international community to intensify efforts to end all harmful practices and more recently, the 2015 SDGs aiming to eliminate all harmful practices, such as child, early and forced marriage and FGM/C by 2030, the elimination of these practices is indeed a global endeavour.

Recent years have seen various developments at the international level to eliminate FGM/C and child, early and forced marriage. In 2012 and 2013, the General Assembly adopted Resolutions aimed at intensifying global efforts for the elimination of FGM/C and child, early and forced marriage. The Resolutions call upon States to take a number of measures, including enhancing awareness-raising efforts and the engagement of keys actors, including healthcare providers, teachers, community leaders and religious leaders, and girls and boys, to revise school curricula to include programmes of zero tolerance for violence against women including FGM/C, and to create national action plans and strategies to end FGM/C and child, early and forced marriage.

Submissions[10] to the Office of the United Nations High Commissioner for Human Rights (OHCHR) show six key strategies deployed by States, including Kenya, United Nations agencies, funds and programmes, civil society and other relevant stakeholders, towards preventing and eliminating FGM/C and child, early and forced marriage (OHCHR, 2014, 2015). These are: legislative measures, policies, action plans and coordination mechanisms; education and awareness-raising; engagement of religious and traditional leaders and service providers; education and empowerment of girls and women; protection and support measures; and promoting alternative rites of passage.

However, the OHCHR submissions from several countries reveal a number of constraints and challenges that States face in their efforts to meet their obligations to respect, protect and fulfil the rights of women and children to live free from FGM/C and child marriage. These are: lack of effective enforcement of existing and adequate legislation prohibiting these practices due to support by existing customary, traditional or religious norms which are deeply rooted; gaps in protection afforded by existing legal frameworks, including lack of consideration of the mobile, transnational character of practising communities; the increasing incidence of medicalization of FGM/C, including genital surgery for non-therapeutic reasons; the absence of systematic free and compulsory marriage and birth registration in an official registry; and the absence of compulsory registration of customary and religious marriages. These are major stumbling blocks for the implementation of existing child protection legislation. Poverty, time limitations on petitions for annulment and other technicalities such as a girl being a "minor" and so unable to submit a petition serve as key legal and practical barriers to accessing remedial action.

3.2 Female genital mutilation/cutting

3.2.1 Knowledge, practice, perceptions and experiences of FGM/C

3.2.1.1 Prevalence of FGM/C and age of undergoing FGM/C

Key findings

- Awareness of FGM/C as a concept is virtually universal among surveyed girls and women and boys and men in the target study areas. Survey data shows that the perceived level of practice of FGM/C in the target study areas is higher than the actual prevalence rates of FGM/C in the target study areas, especially in Laisamis, Sook and Wamba. This may indicate under-reporting of FGM/C prevalence or the possibility of currently uncut girls and women undergoing cutting in the future.
- The FGM/C prevalence rates of all girls and women aged 10–49 in the target study areas are: Habaswein sub-county (98%) and Balambala sub-county (94%), Laisamis sub-county (78%), Sook division (74%), Wamba division (71%) and Kajiado Central sub-county (51%). Surveyed girls and women of Somali origin recorded a prevalence rate of 96%, while Samburu communities, Pokot communities and Rendille communities recorded prevalence rates of 72%, 74% and 78% respectively. Surveyed girls and women of Maasai origin recorded the lowest prevalence rate of 51%. Communities in the target study areas professing the Muslim faith recorded a prevalence rate of 95%, while Protestant and Catholic communities recorded prevalence rates of 65% and 69% respectively.

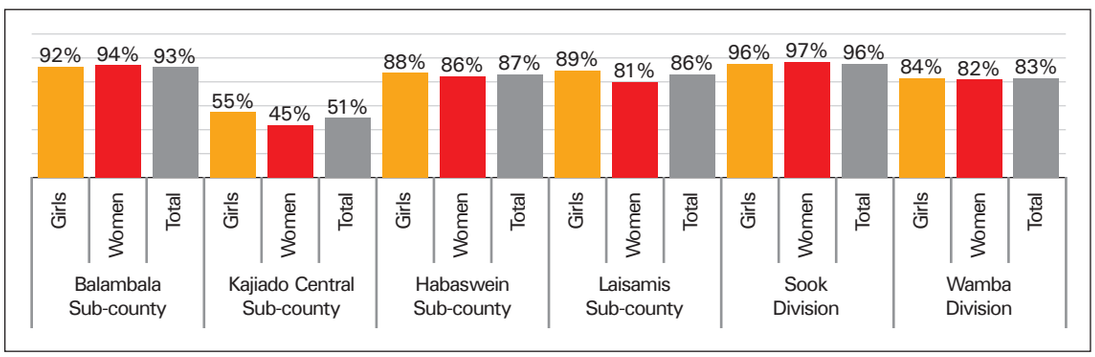
10 OHCHR solicited inputs on FGM/C and child, early and forced marriage from Member States, United Nations agencies, funders and programmes, special procedures mandate holders, treaty bodies, civil society organizations and other relevant stakeholders. Submissions are available at www.ohchr.org/EN/Issues/Women/WRGS/Pages/W RGSIndex.aspx and www.ohchr.org/en/issues/women/wrgs/pages/eliminate female genital mutilations.aspx

- In the 18–49 age cohort, FGM/C prevalence rates of surveyed girls and women are near universal: Balambala and Habaswein regions are 97% and 98% respectively; 89% in Kajiado Central; 100% in Laisamis; 94% in Sook; and 95% in Wamba. By ethnicity, the FGM/C prevalence rates of surveyed women in the 18–49 age cohort are: 89% among Maasai women; 98% among Somali women; 95% among Samburu women; 94% among Pokot women; and 100% among Rendille women. In the 10–17 age cohort, the FGM/C prevalence rates of surveyed girls are: 93% in Balambala; 98% in Habaswein; 28% in Kajiado Central; 62% in Laisamis; 62% in Sook; and 57% in Wamba. By ethnicity, the FGM/C prevalence rates of surveyed girls in the 10–17 age cohort are: 28% among Maasai women; 95% among Somali women; 57% among Samburu women; and 62% among both Pokot women and Rendille women.
- A trend analysis of the change in prevalence rates of FGM/C over a period of 10 to 40 years preceding the survey reveals three patterns: little to no change in prevalence rates over the last 10 to 40 years as observed among the Somali and Rendille in Balambala, Habaswein and Laisamis; a sharp decline in prevalence rates over the last 20 years as observed among the Maasai and the Samburu in Kajiado Central and Wamba; and a steady, near-linear decline in prevalence rates over the last 30 years as observed among the Pokot in Sook.

In the context of this study, knowledge about FGM/C refers to possessing specific factual information about the concept of FGM/C, its procedure and effects, which may or may not influence attitudes towards it. Assessment of knowledge of FGM/C and subsequently raising awareness about it is an important first step in its eradication. To assess knowledge of FGM/C for this study, survey respondents were asked four questions relating to: awareness of FGM/C as a concept and its practice in their communities; whether surveyed girls and women have undergone FGM/C and the risks faced by girls and women who undergo FGM/C; FGM/C as a religious requirement; and the legality of FGM/C in Kenya.

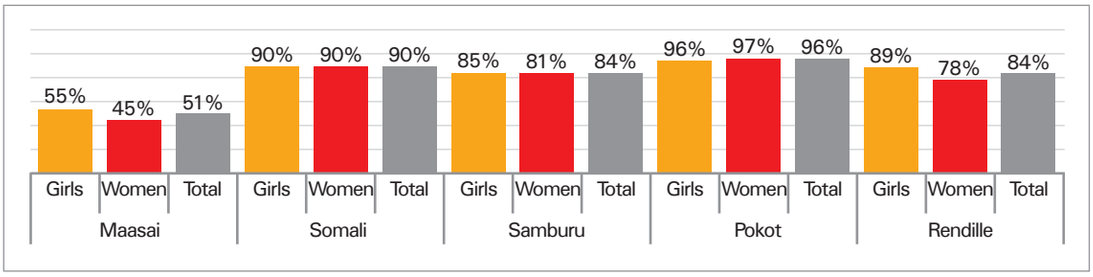
Survey data from girls and women aged 10–49 and boys and men aged 15–49 shows that FGM/C is a common practice across all the six study locations, and knowledge of its existence is near universal. As shown in Figure 2, 93% of all girls and women surveyed in Balambala sub-county, 51% in Kajiado Central sub-county, 87% in Habaswein sub-county, 86% in Laisamis sub-county, 96% in Sook division and 83% in Wamba division believe that FGM/C is practised in their respective sub-counties/divisions.

Figure 2: Belief by girls and women aged 10–49 that FGM/C is practised in their sub-counties/divisions by region (N = 5,291)



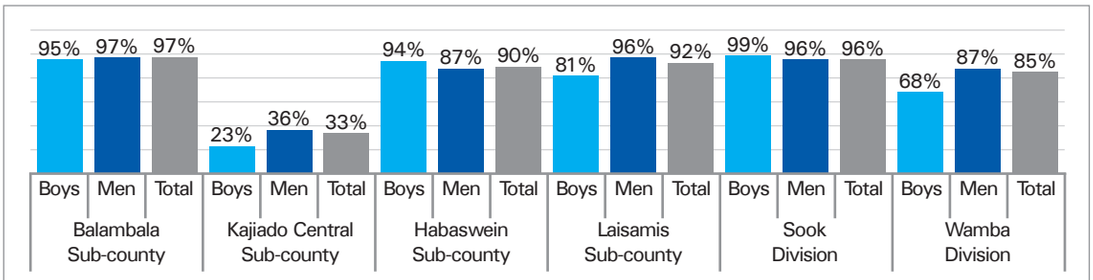
A similar trend is observed across ethnic communities (Figure 3), where 51% of surveyed girls and women respondents of Maasai origin, 90% of the Somali, 84% of the Samburu, 96% of the Pokot and 84% of the Rendille believe that FGM/C is practised by their respective ethnic communities.

Figure 3: Belief by girls and women aged 10–49 that FGM/C is practised in their communities by ethnicity (N = 5,291)



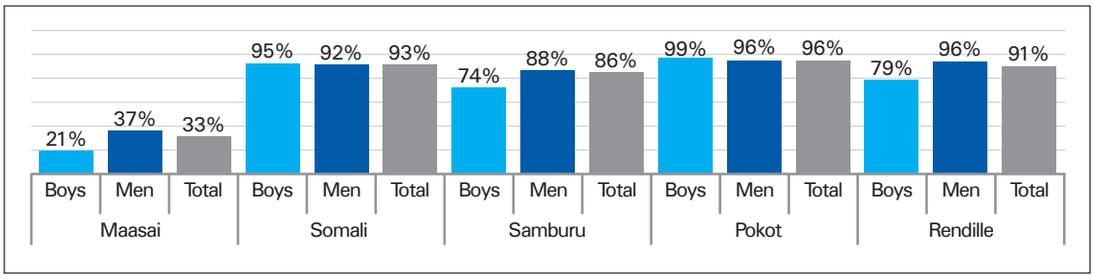
Survey data from boys and men aged 15–49 (Figure 4) shows that 97% of all surveyed boys and men in Balambala sub-county, 33% in Kajiado Central sub-county, 90% in Habaswein sub-county, 92% in Laisamis sub-county, 96% in Sook division and 85% in Wamba division believe that FGM/C is practised in their respective sub-counties/divisions.

Figure 4: Belief by boys and men aged 15–49 that FGM/C is practised in their sub-counties/divisions by region (N = 1,357)



Analysis by ethnic community (Figure 5) shows that 33% of all surveyed boys and men of Maasai origin, 93% of the Somali, 86% of the Samburu, 96% of the Pokot and 91% of the Rendille believe that FGM/C is practised by their respective ethnic communities.

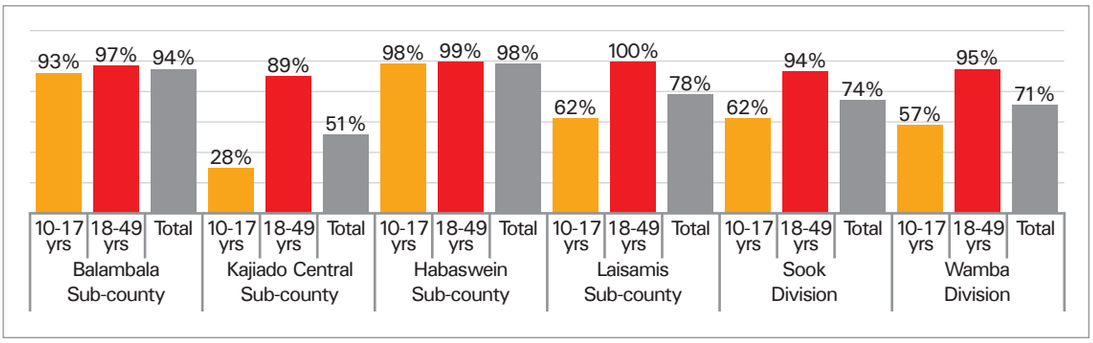
Figure 5: Belief by boys and men aged 15–49 that FGM/C is practised in their communities by ethnicity (N = 1,357)



A key objective of the baseline study was to measure the prevalence of FGM/C in the target sub-counties/divisions. Computation of FGM/C prevalence rates as well the distribution of the practice is vital in estimating the number of girls and women affected by the practice or at risk at any given point, and provides a further basis for targeted intervention.

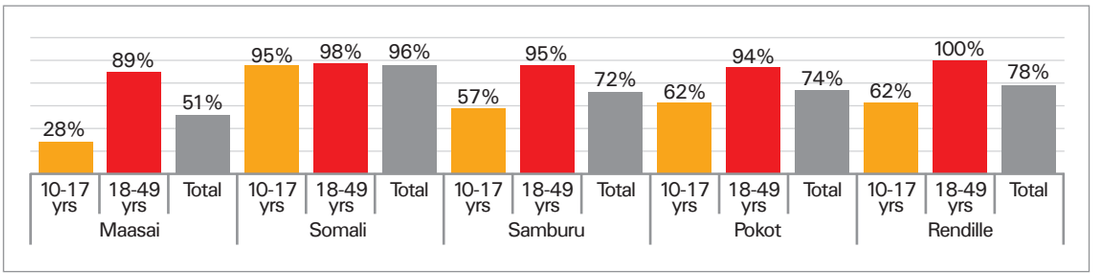
In this study, prevalence rates of FGM/C were computed using the ratio of respondents who reported that they had undergone circumcision (numerator) to the total number of respondents surveyed (denominator). Accordingly, survey data from all girls and women aged 10–49 indicates prevalence rates ranging from a high of 98% to a low of 51%. As shown in Figure 6, Habaswein and Balambala sub-counties recorded the highest prevalence rates of 98% and 94% respectively, compared to Laisamis (78%), Sook (74%) and Wamba (71%). Kajiado Central sub-county recorded the lowest FGM/C prevalence rate of 51%.

Figure 6: Prevalence of FGM/C among girls and women aged 10–49 by region (N = 5,291)



As expected, analysis by ethnicity (Figure 7) shows that surveyed girls and women of Somali origin recorded a prevalence rate of 96% while Samburu communities, Pokot communities and Rendille communities recorded prevalence rates of 72%, 74% and 78% respectively. Surveyed girls and women of Maasai origin recorded the lowest prevalence rate of 51%.

Figure 7: Prevalence of FGM/C among girls and women aged 10–49 by ethnicity (N = 5,291)

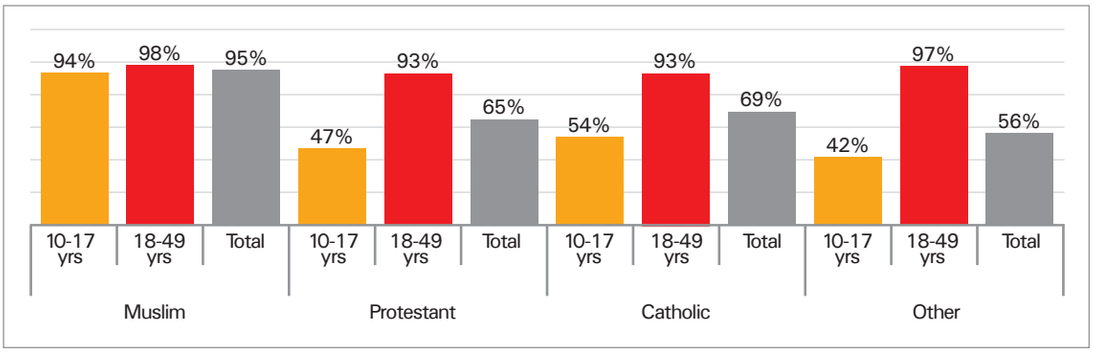


In the 18–49 age cohort, FGM/C prevalence rates of surveyed girls and women are near universal. The FGM/C prevalence rates of surveyed girls and women in Balambala and Habaswein region is 97% and 98% respectively, 89% in Kajiado Central, 100% in Laisamis, 94% in Sook and 95% in Wamba. By ethnicity, the FGM/C prevalence rate of surveyed women in the 18–49 age cohort among Maasai women is 89%, 98% among Somali women, 95% among Samburu women, 94% among Pokot women and 100% among Rendille women.

In the 10–17 age cohort, the FGM/C prevalence rates of surveyed girls in Balambala and Habaswein region is 93% and 98% respectively, 28% in Kajiado Central, 62% in Laisamis, 62% in Sook and 57% in Wamba. By ethnicity, the FGM/C prevalence rates of surveyed girls in the 10–17 age cohort among Maasai women is 28%, 95% among Somali women, 57% among Samburu women, and 62% among Pokot women and Rendille women.

Analysis by religion (Figure 8) shows that communities in the target study areas professing the Muslim faith recorded a prevalence rate of 95%, while Protestant and Catholic communities recorded prevalence rates of 65% and 69% respectively.

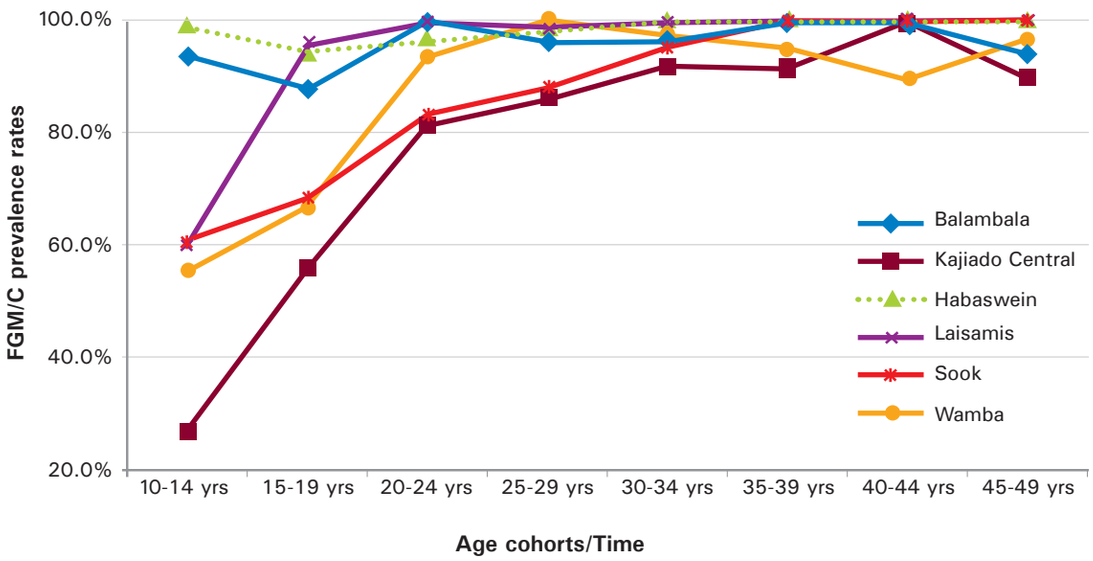
Figure 8: Prevalence of FGM/C among girls and women aged 10–49 by religion (N = 5,291)



To establish evidence of possible changes in prevalence rates of FGM/C over time, analysis of the prevalence of FGM/C by age cohorts was carried out. Specifically, this entailed carrying out a trend analysis using FGM/C prevalence rates in five-year intervals over a period of 10 to 40 years preceding the survey.

As observed in the trend analysis shown in Figure 9, three patterns emerge: little to no change in prevalence rates over the last 10 to 40 years, as observed among the Somali in Balambala and Habaswein and the Rendille in Laisamis; a sharp decline in prevalence rates over the last 20 years, as observed among the Maasai and the Samburu in Kajiado Central and Wamba respectively; and a steady, near-linear decline in prevalence rates over the last 30 years, as observed among the Pokot in Sook.

Figure 9: FGM/C prevalence rates among girls and women aged 10–49 by age cohort (N = 4,959)



A detailed distribution of FGM/C prevalence rates by region across age cohorts is provided in Table 9.

Table 9: FGM/C prevalence rates across age cohorts by region

Region	Age cohorts (years)							
	10–14 n = 2698	15-19 n = 459	20–24 n = 191	25–29 n = 387	30–34 n = 351	35–39 n = 419	40–44 n = 254	45–49 n = 200
Balambala n = 382	93.6%	87.8%	100.0%	96.1%	96.4%	100.0%	100.0%	94.4%
Kajiado Central n = 1752	26.9%	55.9%	81.6%	85.9%	91.7%	91.4%	99.1%	89.8%
Habaswein n = 301	99.0%	94.6%	96.8%	98.4%	100.0%	100.0%	100.0%	100.0%
Laisamis n = 441	60.5%	96.0%	100.0%	99.1%	100.0%	100.0%	100.0%	100.0%
Sook n = 990	61.3%	68.6%	83.4%	88.2%	95.5%	100.0%	100.0%	100.0%
Wamba n = 1093	55.3%	66.8%	93.5%	100.0%	97.7%	94.9%	89.5%	96.6%

Similar trends as those observed in FGM/C prevalence rates by study areas across age cohorts are also evident when analysing FGM/C prevalence rates by ethnicity across age cohorts. As presented in Table 10, a sharp decline in prevalence rates over the last 20 years by the Maasai and by the Samburu over the last 10 years is observed. Further, there is little to no change in prevalence rates over the last 10 to 40 years among the Somali and Rendille and a near-linear decline in prevalence rates over the last 30 years among the Pokot. However, it is important to note that in the last 10 to 14 years, no clear observable trend is apparent among the Rendille (largely located in Laisamis sub-county) since the decline from 96% in the 15–19 age cohort to 61% in the 10–14 age cohort could be a result of timing of FGM/C; i.e. girls in this cohort are yet to reach what is considered the right age for undergoing FGM/C; only then can a trend be established.

Table 10: FGM/C prevalence rates across age cohorts by ethnicity

Ethnicity	Age cohorts (years)							
	10–14 n = 2698	15–19 n = 459	20–24 n = 191	25–29 n = 387	30–34 n = 351	35–39 n = 419	40–44 n = 254	45–49 n = 200
Maasai n = 1752	26.9%	55.9%	81.6%	85.9%	91.7%	91.4%	99.1%	89.8%
Somali n = 683	96.1%	91.5%	98.0%	97.1%	98.0%	100.0%	100.0%	95.6%
Samburu n = 1151	55.5%	66.8%	95.0%	100.0%	97.7%	95.2%	91.2%	96.7%
Pokot n = 991	61.3%	68.6%	83.4%	88.2%	95.5%	100.0%	100.0%	100.0%
Rendille n = 382	60.9%	96.0%	100.0%	99.0%	100.0%	100.0%	100.0%	100.0%

While the study has established the FGM/C prevalence rates of the target communities, including those for girls and women aged 10–17, it is important to note that these are considered the prevailing as opposed to final statuses. As earlier noted, the final FGM/C status of girls aged under 18 is largely unknown since that category of girls may not have reached the age at which FGM/C is carried out, depending on the region. However, survey data can be used to establish the proportion of girls and women likely to undergo FGM/C in the future.

The terms of reference for this study identify girls aged 10–17 as the main cohort whose FGM/C prevalence rates should be measured. Tied to this is the proportion of girls and women in the 10–17 age cohort that has not been subject to FGM/C, which is important in establishing the proportion of uncut girls and women likely to undergo FGM/C in the future. Using the 18–24 age cohort as the proxy and upper limit for the prevalence of girls and women aged 10–17 (see Yoder, Wang and Johansen, 2013), the proportion of uncircumcised girls and women likely to undergo FGM/C after reaching the age of 18 is provided in Table 11.

Specifically, nearly all uncut girls and women aged 10–17 in Balambala (96%), Habaswein (98%) and Laisamis (100%) are likely to undergo FGM/C after reaching 18 years old. Further, 82% of uncut girls and women aged 10–17 in Kajiado Central and 82% in Sook and Wamba are likely to undergo circumcision after reaching the age of 18.

Table 11: Proportion of uncircumcised girls and women aged under 18 that are likely to be circumcised

Region	Median age of circumcision (years)	FGM/C prevalence rate of age cohort 18–24	Proportion of surveyed uncut girls and women aged under 18 likely to be cut in the future
Balambala sub-county	7.0	95.9%	95.9%
Kajiado Central sub-county	14.0	82.3%	82.3%
Habaswein sub-county	7.0	98.2%	98.2%
Laisamis sub-county	10.0	100.0%	100.0%
Sook division	13.0	81.6%	81.6%
Wamba division	13.0	81.9%	81.9%

However, this analysis must be carried out in combination with the trend analysis of FGM/C prevalence rates as presented in Figure 9 above. Beyond the numbers, the likelihood of uncut girls and women undergoing FGM/C is dependent on a number of factors, key among which is the current trend of prevalence rates in the study locations. Thus while 82% of uncut girls and women in Kajiado Central aged under 18 are likely to undergo FGM/C in the future, the downward FGM/C prevalence trend in Kajiado Central shows that a lower proportion than that computed may undergo FGM/C. Conversely, due to the little to no change in FGM/C prevalence in the last 10 to 40 years observed in Balambala and Habaswein, there is a very high probability that the whole proportion of uncut girls and women aged under 18 in Balambala (96%) and Habaswein (94%) will undergo FGM/C.

As presented in other sections of this report, other factors likely to influence the likelihood of uncut girls aged under 18 undergoing FGM/C after reaching the age of 18 include: change in the circumcision calendar, meaning girls and women undergo FGM/C earlier or later than initially practised; FGM/C ceremonies reduced or completely avoided; and girls running away from the procedure due to fear or enhanced knowledge of FGM/C and its effects.

Group discussions with girls and women as well as with boys and men corroborate the above study findings. In Kajiado Central, it was noted that while the practice of FGM/C still exists, it has lessened in the recent past. A key factor is that now, more than ever, society has enhanced knowledge of FGM/C and its effects. A key outcome of this is that girls have more control with regard to decision-making on undergoing FGM/C.[11] Some discussion points on the practice of FGM/C as provided by FGD participants aged 18–49 are presented below.

> Our culture as Maasai still remains the same. We do circumcise children, both boys and girls, though girls' circumcision has diminished in the recent past… during our time, girls' circumcision was mandatory. It wasn't an option unlike now when girls choose whether or not to get cut.
>
> **FGD respondent, female 33 years old, Kajiado Central**
>
> I tell you it has reduced drastically. Maybe in the next five years it will be a story to be told to young children… surely that is something we never thought could come to an end, but it has finally come to its end.
>
> **FGD respondent, female 40 years old, Kajiado Central**

In Balambala, group discussions with women aged 18–49 reveal that FGM/C is still widely practised if not by all. Respondents cited FGM/C, marriage and religion as cultural practices that were dear to them and still practised. Asked which cultural practices are most valued by their society, all participants in the Balambala FGDs cited FGM/C, which was attributed to culture and religion. However, as revealed by respondents, it is apparent that FGM/C is not immediately linked to marriage since a majority of girls are cut when aged approximately five to seven years old.

> We mostly value FGM/C as a practice… every girl is circumcised – this is because it is good for the culture and our religion… it is hard to find an uncircumcised female praying.
>
> **FGD respondent, female 37 years old, Balambala**
>
> If a girl is not circumcised, there are consequences… the girl will not be allowed to pray since circumcision is part of the religion… she will be chased away from the community, she will become an outcast,
>
> **FGD respondent, female 29 years old, Balambala**

While it was noted by all respondents that the practice of FGM/C among the Samburu has currently changed, it still widely practiced since marriage and FGM/C go together.

11 This may include girls running away from FGM/C.

Specifically, one is allowed to marry only if he or she has undergone FGM/C, and in other cases, FGM/C is immediately followed by marriage. With girls now attending school, it was noted that the society has relaxed its traditions. A key consequence of this is more liberal attitudes coupled with enhanced knowledge of FGM/C and its effects due to increased FGM/C interventions in Wamba. Similar observations were also made among the Pokot in Sook and the Rendille in Laisamis.

> We practise [FGM/C]… our culture nowadays allows girls to go to school and if they don't want to be circumcised it is okay; also if the man wants to marry them without them being circumcised it is also fine.
>
> **FGD respondent, female 36 years old, Wamba**
>
> If a girl is not circumcised, there is nothing that can be done to them… only that she will be socially unacceptable and lose her friends. She will be alienated. The girl will tell her parents how she is being treated and will pressure them to circumcise her for acceptance purposes.
>
> **FGD respondent, female 44 years old, Wamba**
>
> The neighbours will be laughing at them, saying that that girl from that manyatta is not circumcised and the family will not be allowed to attend certain functions. They become isolated by the people in the community.
>
> **FGD respondent, female 30 years old, Wamba**

3.2.1.2 Reasons for practising FGM/C

Key findings

- In order of popularity, common rationales for the practice of FGM/C are tied to four key factors: marriageability entailing readiness for marriage and the prevention of premarital sex; social acceptance; personal hygiene (including enhanced attractiveness if cut); and religious identity.
- Rationales for the practice of FGM/C vary across study locations. Marriageability is the chief reason for practising FGM/C in Sook and Wamba, while the Muslim communities of Balambala and Habaswein practise FGM/C mainly for reasons of personal hygiene. In Kajiado Central and Laisamis, social acceptance is the most popular reason for practising FGM/C.
- While marriageability, personal hygiene and social acceptance remain causal elements for practising FGM/C across all study locations, assessment of FGM/C as a religious requirement is evident among the Somali (32%), who are largely resident in the study locations of Balambala and Habaswein, compared to 10% and 4% of surveyed girls and women professing the Protestant and Catholic faiths respectively and who are resident in other study locations.

Analysis of drivers of the practice of FGM/C in the study locations shows that FGM/C is a manifestation of gender inequality and is embedded in complex social, cultural, economic, political and religious structures. A closer look at rationales for practising FGM/C in all study locations reveals a "reward–punishment" system that is central to the practice and its continuation. Specifically, avoiding this system has attendant negative outcomes in the form of punishment through condemnation, ridicule and ostracism, while acceptance and adherence to the requirements of the system are rewarded through recognition, celebrations and approval at community, social and religious levels, as well as through personal and social benefits such as perceived coming of age, pride, marriageability, attractiveness, cleanliness and chastity. Clearly, the practice of FGM/C in the study locations is mostly associated with benefits as opposed to demerits.

> No because even after circumcision, men remain unmarried for quite some time.
> **FGD respondent, female 26 years old, Kajiado Central**
>
> No man is allowed to marry unless he is circumcised. But it doesn't imply that once a boy is cut he should marry immediately.
> **FGD respondent, female 48 years old, Kajiado Central**

As shown in Table 12, the practice of FGM/C occurs for a number of reasons that vary across study locations and cultures. Despite the variations, study results reveal that common rationales for the practice are tied to four key factors: marriageability entailing readiness for marriage and to prevent premarital sex; social acceptance; hygiene (including enhanced attractiveness if cut); and religious identity.

Table 12: Reasons provided by girls and women aged 10–49 for the practice of FGM/C in their respective communities by region (N = 3,818)

Perceived reasons for practising FGM/C	Region					
	Balambala sub-county	Kajiado Central sub-county	Habaswein sub-county	Laisamis sub-county	Sook division	Wamba division
For the girl to be ready for marriage	60%	58%	43%	53%	80%	71%
Cleanliness, hygiene	66%	22%	64%	18%	45%	41%
Social acceptance	39%	63%	27%	70%	50%	53%
Preserve virginity, prevent premarital sex	5%	1%	33%	4%	8%	11%
More sexual pleasure for the man	3%	3%	14%	0%	2%	4%
For religious approval	33%	18%	30%	1%	7%	3%
To aid future childbirth	4%	7%	2%	0%	1%	1%
They are more attractive	0%	0%	0%	0%	1%	1%

As mentioned earlier, rationales for the practice of FGM/C vary across regions and cultures. As shown in Table 12 above, personal hygiene and cleanliness were cited by 66% and 64% of surveyed girls and women respondents drawn from Balambala and Habaswein respectively, while marriageability was the second most common reason cited by 60% and 43% of respondents from Balambala and Habaswein in that order. Balambala and Habaswein are predominantly inhabited by Somali of Muslim orientation.

The most common reason for practising FGM/C in Wamba and Sook was to ensure eligibility for marriage, as reported by 71% and 80% of respondents in Wamba and Sook respectively, followed by social acceptance, as reported by 53% and 50% of respondents in Wamba and Sook in that order. In Laisamis, largely inhabited by the Rendille, FGM/C was reported as mainly carried out for social acceptance, as reported by 70% of girls and women surveyed, while marriageability and personal hygiene were the second and third most common reasons for practising FGM/C respectively. Further analysis by ethnicity is provided in Table 13.

Table 13: Reasons provided by girls and women aged 10–49 for the practice of FGM/C in their respective communities by ethnicity

Perceived reasons for practising FGM/C	Ethnicity				
	Maasai	Somali	Samburu	Pokot	Rendille
For the girl to be ready for marriage	58%	52%	71%	80%	51%
Cleanliness, hygiene	22%	65%	40%	45%	17%
For social acceptance	63%	33%	51%	51%	76%
Preserve virginity, prevent premarital sex	1%	17%	11%	8%	4%
More sexual pleasure for the man	3%	8%	3%	2%	0%
For religious approval	18%	32%	3%	7%	1%
To aid future childbirth	7%	4%	1%	1%	0%
They are more attractive	0%	0%	1%	1%	0%

Group discussions with women aged 18–49 confirm the above findings. As earlier discussed, FGM/C, as practised in Laisamis, Sook and Wamba, is an antecedent event of marriage, while among the Somali in Balambala and Habaswein, FGM/C is largely carried out to ensure personal hygiene and allow the circumcised girl to engage in prayers. As earlier noted, a majority of the Somali cut their daughters when very young (at age five to seven), and hence not for marriage. However, FGM/C is a condition that must be met for a girl to be married.

Social acceptance as a key reason for practising FGM/C was also noted across all study locations. This is closely linked to the continued practice of FGM/C as a long-held culture that must be sustained. Also connected to social acceptance is the ability to perform and participate in certain activities. For example, group discussions with respondents of Pokot extraction revealed that uncut girls and women are not allowed to milk cows while among the Somali, and that cut girls and women are allowed to pray. Among the Rendille and the Samburu, only cut girls and women are allowed to participate in social activities.

Other key reasons mentioned in group discussions included: a rite of passage signalling transition from childhood to adulthood that readies the girl for marriage; to ensure purity before marriage through preservation of virginity and therefore ensure family honour and dignity; to reduce sexual urges and prevent premarital sex; and in some cases to reduce the likelihood of acquiring HIV.

> It is done so that they can be married.
>
> **FGD respondent, male 29 years old, Laisamis**
>
> [FGM/C] reduces sexual urges. A girl who is not circumcised has a lot of sexual urges… but it has been there for a long time and as much as it reduces sexual urges, it is our culture.
>
> **FGD respondent, male 42 years old, Laisamis**
>
> An uncircumcised girl is not allowed to interact with other women in the society… she is not allowed to address people… a circumcised girl is respected in the community.
>
> **FGD respondent, female 41 years old, Sook**

> It was also a rite of passage that marks transition from childhood to adulthood. It prepared one for future responsibilities as a woman.
>
> **FGD respondent, male 44 years old, Kajiado Central**
>
> We like it because it brings about cleanliness in the genital area, it prevents too much wetness that is unhygienic… it also prevents infections and it is also believed that one can easily acquire HIV/AIDS if that flesh is not removed.
>
> **FGD respondent, female 28 years old, Wamba**

The silent role of family members, especially the father, was noted as a key reason for the practice of FGM/C and its continuation. While respondents in all group discussions cited mothers as the custodian of matters relating to FGM/C, it became apparent that fathers must be consulted in any decision on FGM/C, especially where it is carried out as a rite of passage. Where a girl is not married after reaching the "age of maturity", her family bears the blame, including possible ostracism of the girl and her family. The father, as the head of the household, therefore holds the responsibility of upholding existing norms on FGM/C including marriage.

> The father of the girl definitely is the one who gives out the girl to get married and is the one who gives out the order for the girl to be circumcised, you see… so when she has already been given out, that is a must. If it is marriage, that's the rite of passage. There is no debate about that. She must be circumcised for her to be married.
>
> **Key informant interview, administration official, Wamba**
>
> Okay, culturally, people believe that an uncircumcised girl is a taboo and she will not be married if she is not circumcised. It also shows that if a girl is not married, her family have not taken good care of her. If a woman is not circumcised, she becomes a prostitute, according to the belief of the people. She will have that urge when not cut.
>
> **Key informant interview, administration official, Balambala**
>
> Let's say that my family says a girl will not be cut, according to the community, my family will be an outcast and that girl will not be married, culturally that is what they believe. My family will be different from other families, I will be like an outcast, and you know, I will look like a different person from the rest… fellow men look at me just the same, they will not sit with me, they will not interact, just because my girl is not circumcised. No single man will come for my girl for marriage.
>
> **Key informant interview, administration official, Habaswein**

Similar observations are also observed among surveyed boys and men across study locations, where 84% and 74% of surveyed boys and men in Sook and Wamba respectively cited marriageability as the chief reason for the practice of FGM/C in their respective communities. Further, respondents in Balambala (68%) and Habaswein (59%) mentioned personal hygiene, while those in Kajiado Central (76%) and Laisamis (67%) cited social acceptance as the most popular reason for the practice of FGM/C in their respective communities.

Again, compared with Kajiado Central (3%), Laisamis (0%), Sook (2%) and Wamba (4%), religious identity as a key reason for practising FGM/C is largely evident in the Muslim regions of Balambala and Habaswein, as reported by 35% and 28% of surveyed boys and men respectively. Further analysis is provided in Table 14.

Table 14: Reasons provided by boys and men for the practice of FGM/C in their respective communities by region

Reasons for practising FGM/C	Region					
	Balambala sub-county	Kajiado Central sub-county	Habaswein sub-county	Laisamis sub-county	Sook division	Wamba division
For the girl to be ready for marriage	58%	64%	40%	51%	84%	74%
For social acceptance	39%	76%	28%	67%	40%	63%
Cleanliness, hygiene	68%	18%	59%	14%	39%	35%
They are more attractive	0%	2%	0%	0%	2%	12%
Preserve virginity, prevent premarital sex	1%	2%	37%	8%	7%	9%
For religious approval	35%	3%	28%	0%	2%	4%
More sexual pleasure for the man	0%	1%	15%	0%	5%	3%
To aid future childbirth	6%	7%	7%	0%	0%	2%
Other	0%	1%	1%	0%	2%	5%

Thus, while marriageability, personal hygiene and social acceptance remain causal elements for the practice of FGM/C across all study locations, assessment of FGM/C as a religious requirement is evident among the Somali (32%) who are largely resident in the target sub-counties of Balambala and Habaswein, compared to 3% and 1% of surveyed girls and women who are resident in the other study locations.

Compared to other study locations, significantly more surveyed girls and women ($p < 0.05$) from Balambala (34%) and Habaswein (28%) who are predominantly of Somali origin and Muslims cited religious identity and approval more commonly as a reason for practising FGM/C. Further analysis by religion is provided in Table 15.

Table 15: Reasons provided by girls and women for the practice of FGM/C in their respective communities by religion

Perceived reasons for practising FGM/C	Religion			
	Muslim	Protestant	Catholic	Other
For the girl to be ready for marriage	48%	69%	75%	74%
Cleanliness, hygiene	62%	25%	33%	42%
For social acceptance	33%	63%	51%	57%
Preserve virginity, prevent premarital sex	19%	5%	7%	12%
More sexual pleasure for the man	8%	4%	2%	0%
For religious approval	31%	3%	1%	4%
To aid future childbirth	6%	3%	1%	0%
They are more attractive	0%	0%	6%	11%
Other	1%	1%	2%	7%

An attempt to understand the rationale and significance attached to the practice of FGM/C within the target communities over time shows that eligibility for marriage, social acceptance and personal hygiene have been static over the last 40 years. As shown in Table 16, there are no significant differences among age cohorts in the target communities when assessing marriageability as a key driver for practising FGM/C. Further, while small differences exist between different age cohorts, social acceptance and personal hygiene as key factors in the practice of FGM/C have also remained more static as opposed to dynamic over the 40-year period.

Table 16: Reasons provided by girls and women for the practice of FGM/C in their respective communities by age cohort

Reasons for practising FGM/C	Age cohort (years)							
	10–14 n = 2106	15–19 n = 366	20–24 n = 136	25–29 n = 270	30–34 n = 263	35–39 n = 322	40–44 n = 211	45–49 n = 144
For the girl to be ready for marriage	63%	60%	69%	67%	62%	67%	69%	59%
Cleanliness, hygiene	43%	44%	49%	31%	44%	40%	50%	43%
For social acceptance	50%	41%	48%	52%	51%	59%	53%	55%
Preserve virginity, prevent premarital sex	9%	12%	8%	7%	12%	12%	7%	9%
More sexual pleasure for the man	5%	4%	3%	2%	3%	2%	4%	1%
For religious approval	15%	17%	11%	16%	17%	7%	11%	8%
To aid future childbirth	3%	4%	2%	1%	1%	2%	3%	2%
They are more attractive	0%	1%	2%	1%	1%	1%	1%	1%
Other	2%	2%	0%	1%	2%	1%	3%	7%

A cross-analysis of region by religious identity as a key factor in the practice of FGM/C shows that a significant proportion of younger girls and women in Kajiado (27%, $p < 0.05$), compared to older women are now citing religious identity as a key reason for practising FGM/C. This reveals a shift in the influence of religion where the practice of FGM/C is now closely linked to religious identity. Further analysis is provided in Table 17.

Table 17: Influence of religion on the practice of FGM/C reported by girls and women by region

Region	Age cohort (years)							
	10–14 n = 2106	15–19 n = 366	20–24 n = 136	25–29 n = 270	30–34 n = 263	35 – 39 n = 322	40–44 n = 211	45–49 n = 144
Balambala	31%	26%	34%	47%	43%	16%	33%	65%
Kajiado	27%	7%	3%	0%	0%	1%	0%	0%
Habaswein	29%	37%	5%	35%	31%	54%	27%	19%
Laisamis	0%	0%	0%	0%	4%	2%	8%	0%
Sook	4%	19%	16%	8%	7%	5%	8%	0%
Wamba	2%	2%	0%	10%	9%	2%	3%	3%

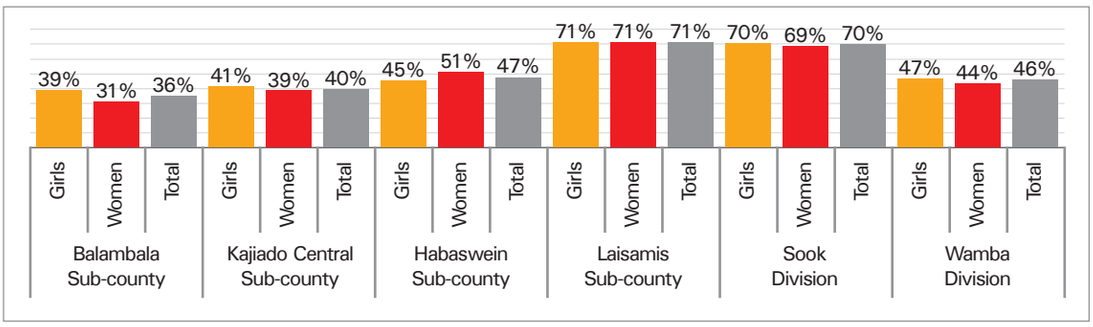
3.2.1.3 Awareness of risks of FGM/C

Key findings

- Significantly low levels of awareness of the risks associated with FGM/C ($p < 0.05$) were observed among surveyed girls and women and boys and men in Wamba, Balambala, Kajiado Central and Habaswein, compared to Laisamis and Sook. This observation is reflected across the target ethnic communities in the study locations: the Maasai mainly in Kajiado Central, the Somali and the Samburu have significantly lower levels of awareness of the risks of FGM/C ($p < 0.05$), compared to the Pokot and the Rendille who are mainly resident in Sook and Laisamis respectively. However, no significant differences were observed across rural and urban areas.
- FGM/C is mainly associated with health-related factors as well as social factors: health-related factors include bleeding, difficulty during childbirth, infection, pain during sex and reduced sexual satisfaction and even death; and social factors include dropping out of school and child marriage.

Survey results (Figure 10) show that among surveyed girls and women aged 10–49, approximately 36% in Balambala, 40% in Kajiado Central, 47% in Habaswein, 71% in Laisamis, 70% in Sook and 46% in Wamba are aware of the risks that girls and women face as a result of FGM/C. The lower levels of awareness of the risks of FGM/C observed in Balambala, Kajiado Central, Wamba and Habaswein are reflected across ethnic communities in these study locations, namely the Maasai (40%), the Somali (41%) and the Samburu (46%). Similarly, high levels of awareness of risks of FGM/C were observed among the Pokot (70%) and the Rendille (74%).

Figure 10: Proportion of girls and women aged 10–49 aware of risks associated with FGM/C by region (N = 4,959)



The level of education is confirmed by the survey results as key in having knowledge about the risks associated with FGM/C. Survey data from girls and women in the study locations shows that awareness of risks associated with FGM/C increases with increasing level of education: 43% of surveyed girls and women with no education, compared to 55% with primary-level education and 62% with secondary-level education, college or higher higher level education reported being aware of the risks associated with the practice of FGM/C (Table 18).

Table 18: Influence of education on awareness of risks of FGM/C, reported by girls and women by region

Aware of risks of FGM/C	Level of education			
	No education	Primary education	Secondary education	College or higher
Yes	43.0%a	54.7%b	61.9%c	60.7%c
No	57.0%a	45.3%b	38.1%c	39.3%c

Note: Values in the same row and sub-table not sharing the same subscript are significantly different at p< .05 in the two-sided test of equality for column proportions. Cells with no subscript are not included in the test. Tests assume equal variances.

Note: Tests are adjusted for all pairwise comparisons using the Bonferroni correction. Cell counts of some categories are not integers. They were rounded to the nearest integers before performing column proportion tests.

Group discussions with community members confirm that they are aware of the risks associated with FGM/C. Respondents cited a number of possible risks of FGM/C that they have observed in girls and women who have undergone FGM/C. These included health-related complications: excessive bleeding immediately after FGM/C, lasting on average for one to two days; infections if the wound is not cared for properly, including acquiring HIV where circumcision tools are shared; excessive pain during menstruation; impaired sexual satisfaction; complications during childbirth, especially in cases involving infibulation; trauma and depression; and death. Social consequences included missing school for long periods or dropping out altogether since healing could take nearly two weeks or longer where infections had set in.

> Complications during menstruation, complications during birth, suffering during the process of circumcision, it is painful, and there is loss of a lot of blood.
>
> **FGD respondent, female 22 years old, Habaswein**
>
> The girl may stop attending school… many men will disturb her after circumcision… which will divert her mind from school… she becomes confused and a man will easily win her.
>
> **FGD respondent, female 34 years old, Sook**
>
> The risks are some get a disease or an infection because the woman at times uses one razor blade to circumcise two girls… they have abdominal pain during menstruation.
>
> **FGD respondent, female 33 years old, Habaswein**
>
> During giving birth she faces complications… during the monthly period, they get problems after circumcision that is done badly… also a circumcised girl disturbs the man since when the man is sleeping with her she doesn't feel anything, making it hard for the man to enjoy the intercourse. It is just like sleeping with a sack full of potatoes.
>
> **FGD respondent, male 31 years old, Balambala**

Survey data confirms the above findings from FGD respondents and key informants. Specifically, it shows that negative outcomes of the practice of FGM/C are broad, spanning health complications and social consequences. Specifically, key associated risks of FGM/C as reported by surveyed girls and women include: health complications (mainly continuous bleeding and death); difficulty during childbirth; infections; pain during sex; impaired sexual satisfaction; and depression as a result of feeling incomplete; and social consequences such as child marriage and dropping out of school. Further analysis is provided in Table 19.

Table 19: Perceived risks associated with FGM/C reported by girls and women by region

Perceived risks associated with FGM/C	Study location					
	Balambala sub-county	Kajiado Central sub-county	Habaswein sub-county	Laisamis sub-county	Sook division	Wamba division
Continuous bleeding	88%	69%	91%	95%	79%	74%
Infection	34%	15%	45%	8%	36%	44%
Difficulty during childbirth	24%	50%	58%	40%	47%	45%
Pain during sex	15%	3%	32%	28%	20%	6%
Death	6%	7%	2%	2%	48%	27%
Dropping out of school	2%	19%	6%	2%	49%	21%
Child marriage	2%	12%	2%	1%	25%	15%
Feeling of incompleteness	2%	7%	3%	4%	14%	3%
Impaired sexual satisfaction	1%	8%	10%	17%	10%	6%

Survey results from boys and men in the study locations also show that boys and men are equally aware of the risks of FGM/C on girls and women. Specifically, significantly low awareness levels ($p < 0.05$) were observed among surveyed boys and men in Wamba (39%), Balambala (43%), Kajiado Central (40%) and Habaswein (49%), compared to Laisamis (62%) and Sook (69%). Similarly, analysis by ethnic communities in these study locations shows that the Maasai (40%), the Somali (46%) and the Samburu (40%) have significantly lower levels of awareness of the risks of FGM/C, compared to the Pokot (69%) and the Rendille (62%).

While a higher proportion of surveyed boys and men residing in urban areas (47%), compared to their rural counterparts (42%) are aware of FGM/C, no significant differences were observed. Further analysis is provided in Figure 11.

Figure 11: Proportion of boys and men aged 15–49 aware of risks associated with FGM/C by region (N = 1,243)

Surveyed boys and men mainly associate FGM/C with six key factors: health-related factors (mainly bleeding); difficulty during childbirth; infection; pain during sex; and impaired sexual satisfaction and even death. Social factors cited were mainly dropping out of school and child marriage. Further analysis is provided in Table 20.

Table 20: Perceived risks associated with FGM/C reported by boys and men by region

Perceived risks associated with FGM/C	Study location					
	Balambala sub-county	Kajiado Central sub-county	Habaswein sub-county	Laisamis sub-county	Sook division	Wamba division
Continuous bleeding	86%	77%	86%	94%	75%	76%
Infection	34%	16%	37%	9%	24%	42%
Difficulty during childbirth	45%	43%	67%	47%	52%	57%
Pain during sex	13%	4%	43%	29%	20%	15%
Death	6%	6%	4%	4%	45%	27%
Dropping out of school	1%	9%	4%	4%	44%	35%
Child marriage	4%	3%	2%	5%	16%	23%
Feeling of incompleteness	0%	2%	0%	13%	13%	6%
Reduced sexual satisfaction	0%	4%	7%	20%	11%	13%

3.2.1.4 Knowledge of the prohibition on FGM/C in Kenya

Key findings

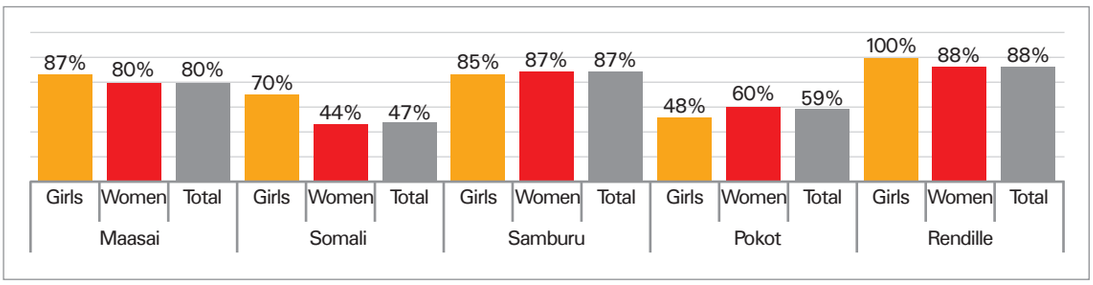
- Surveyed girls and women as well as boys and men in Balambala and Habaswein recorded significantly lower levels of awareness of the ban on FGM/C in Kenya, compared to their counterparts in Kajiado Central, Laisamis, Sook and Wamba. A similar trend is observed across ethnic communities in the study locations where the Somalis, largely resident in the study locations of Balambala and Habaswein, recorded a lower level of awareness of the ban on FGM/C in Kenya, compared to the Maasai resident mainly in Kajiado Central, the Pokot in Sook, the Rendille in Laisamis and the Samburu mainly in Wamba.
- Compared to surveyed girls and women and boys and men of Catholic and Protestant orientation who recorded higher levels of awareness of the ban on FGM/C in Kenya, significantly lower proportions of Muslims, largely resident in the study locations of Balambala and Habaswein, are aware that FGM/C has been outlawed in Kenya.
- A significantly lower proportion of surveyed girls and women and boys and men in Balambala, compared to Kajiado Central, Habaswein, Laisamis, Sook and Wamba agree that girls have a right to resist FGM/C. Similarly, significantly lower proportions of surveyed girls and women and boys and men of Somali extraction, compared to the Maasai, the Samburu, the Pokot and the Rendille, agree that girls and women have a right to resist FGM/C.
- Higher proportions of girls and women and boys and men of Protestant and Catholic orientation, compared to significantly lower proportions of respondents professing the Muslim faith, agree that girls and women have a right to resist FGM/C.

  Significantly more urban residents, compared to their rural counterparts, believe that girls and women have a right to resist FGM/C.

FGM/C as a violation of the human rights of girls and women is recognized in numerous international, regional and national human rights instruments, which provide a foundation for the right of girls and women to be free from practices such as FGM/C and child marriage. The broader categories of these rights include: the rights of the child; the right to health; the right to be free from all forms of discrimination against women; and the right to life and physical integrity, including freedom from violence. The survey sought to measure awareness among girls and women and boys and men in the study locations regarding the prohibition of the practice of FGM/C in Kenya.

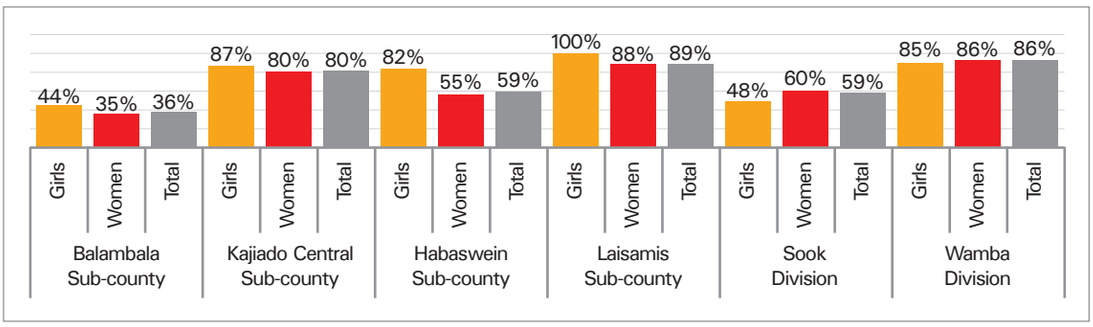
When asked if they were aware of the ban on the practice of FGM/C, a significantly lower proportion of surveyed Somali girls and women (47%, $p < 0.05$), compared to the Pokot (59%), Maasai (80%), Samburu (87%) and Rendille (88%) replied in the affirmative (Figure 12).

Figure 12: Proportion of girls and women aged 10–49 aware that FGM/C has been abolished in Kenya by ethnicity (N = 2,085)



This observation is also evident at study location level, where 36% and 59% of surveyed girls and women from Balambala and Habaswein respectively affirmed that they are aware that the government of Kenya has banned the practice of FGM/C. In Laisamis, approximately 89% of surveyed girls and women are aware of the ban on FGM/C, as are 80% of surveyed girls and women in Kajiado Central, 86% in Wamba and 59% in Sook (Figure 13).

Figure 13: Proportion of girls and women aged 10–49 aware that FGM/C has been abolished in Kenya by region (N = 2,085)



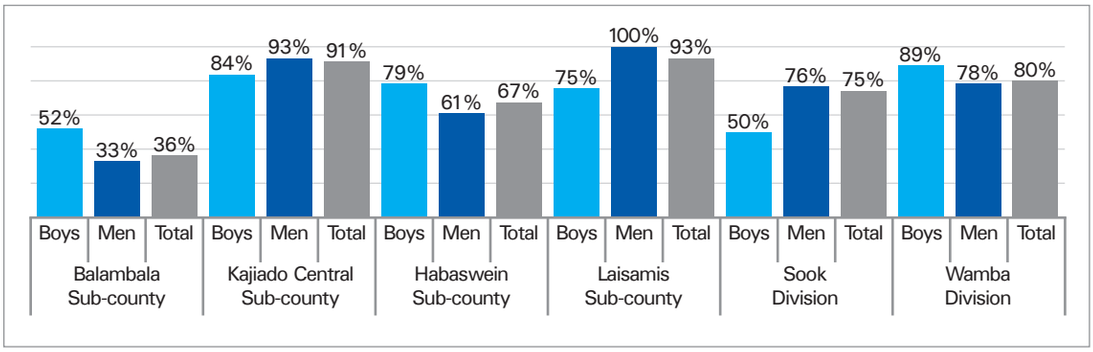
Compared to surveyed girls and women of Catholic (82%) and Protestant (82%) orientation, analysis by religion shows that significantly less proportion of Muslims (49%, $p < 0.05$), largely resident in the study locations of Balambala and Habaswein have the lowest level of awareness as far as prohibition of FGM/C in Kenya is concerned.

The level of awareness of the abolition of FGM/C in Kenya increases with the level of education: 65% of surveyed girls and women with no education, compared to 79% and 87% of those with primary-level and secondary- or higher level education respectively are aware of the ban on FGM/C.

A look at survey data derived from boys and men in the study locations shows that 81% of them are aware that FGM/C has been outlawed by the government of Kenya. However, across study locations, ethnic communities and religion, significant differences are observed in the level of awareness of the ban on FGM/C in Kenya. As shown in Figure 14, a significantly lower proportion of surveyed boys and men in Balambala (40%, $p < 0.05$), compared to in Kajiado Central (93%), Habaswein (67%), Laisamis (96%), Sook (81%) and Wamba (86%) are aware that FGM/C has been outlawed in Kenya.

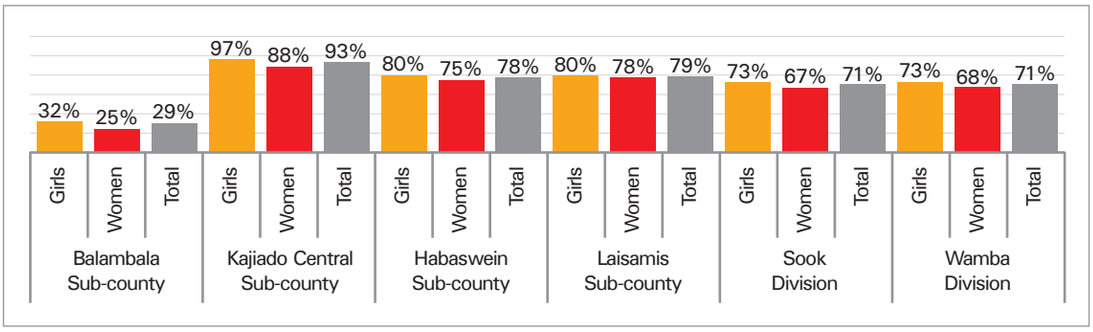
Similarly, surveyed boys and men of Somali extraction, mainly resident in the study locations of Balambala (36%) and Habaswein (67%), have a lower awareness of the ban on FGM/C, compared to the Maasai (91%), the Samburu (80%), the Pokot (75%) and the Rendille (93%). Furthermore, survey respondents of Muslim orientation, largely the Somali, recorded significantly lower levels of awareness (54%, $p < 0.05$), compared to survey respondents of Protestant (88%) and Catholic (84%) orientation.

Figure 14: Proportion of boys and men aged 15–49 aware that FGM/C has been abolished in Kenya by region (N = 1,243)



To assess attitudes towards the practice of FGM/C on girls and women, surveyed girls and women were asked whether a girl or woman has a right to resist FGM/C. While study data reveals that the common position that a girl or woman does have a right to resist FGM/C, supported by a majority of girls and women surveyed in Kajiado Central (93%), Laisamis (79%), Habaswein (78%), Sook (71%) and Wamba (71%), a significantly lower proportion ($p < 0.05$) of surveyed girls and women in Balambala (29%) represented this position. Similar observations were made across surveyed ethnic communities, in particular the Somali, where approximately 52% of surveyed girls and women do not agree that girls and women have a right to resist FGM/C. Further analysis is provided in Figure 15 below.

Figure 15: Proportion of girls and women aged 10–49 that think a girl or woman has a right to resist FGM/C by region (N = 5,291)

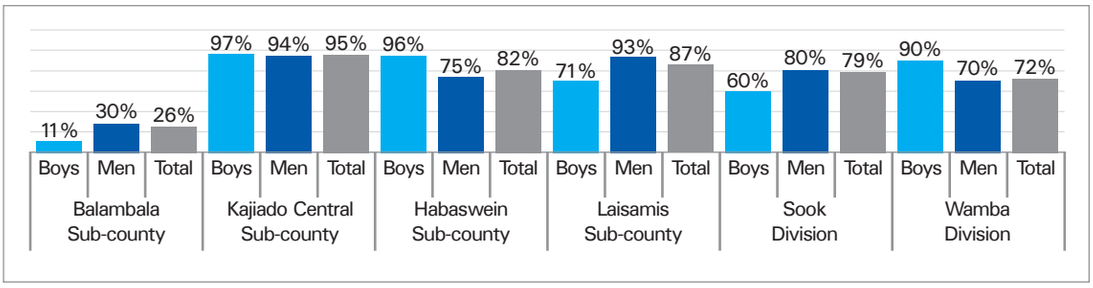


Analysis by religion also shows that a significantly lower proportion of the survey respondents of Muslim orientation (52%, $p < 0.05$), compared to Protestants (84%) and Catholics (75%) believe that girls and women have a right to resist FGM/C.

In addition, analysis by level of education shows that the higher the level of education, the higher the agreement with the view that girls and women have a right to resist FGM/C. Specifically, 60%, 85% and 91% of surveyed girls and women with no education, primary-level education and secondary- or higher level education were in agreement that women and girls have a right to resist FGM/C.

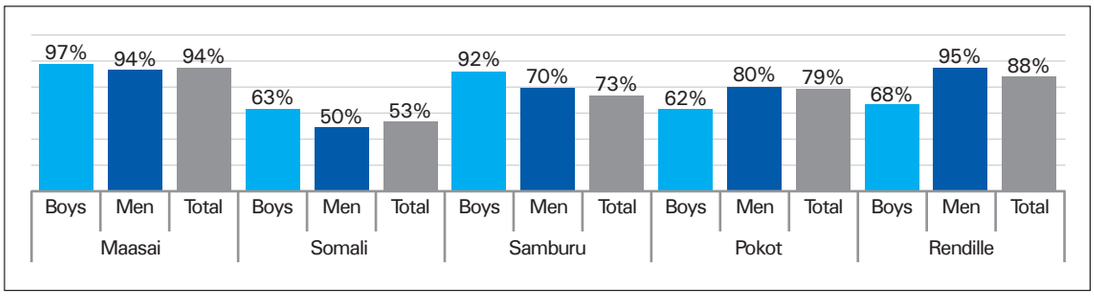
A similar trend is observed among surveyed boys and men in the study locations, where a significantly lower proportion of surveyed boys and men in Balambala (26%), compared to Kajiado Central (95%), Habaswein (82%), Laisamis (87%), Sook (79%) and Wamba (72%) believe that girls have a right to resist FGM/C (Figure 16).

Figure 16: Proportion of boys and men aged 15–49 that think a girl or woman has a right to resist FGM/C by region (N = 1,347)



Across ethnic communities in the study locations, 51% of surveyed boys and men of Somali extraction, compared to the Maasai (94%), the Samburu (72%), the Pokot (82%) and the Rendille (89%) reported that they believe that girls and women have a right to resist FGM/C (Figure 17).

Figure 17: Proportion of boys and men aged 15–49 that think a girl or woman has a right to resist FGM/C by ethnicity (N = 1,347)



A look at data from group discussions and key informant interviews reveals diverse positions regarding the legality of FGM/C and the right of a girl or woman to resist FGM/C. Virtually all FGD participants cited long-held traditions, and not existing laws outlawing the practice of FGM/C, as the main defining factor in the practice and its continuation. In addition, parents were cited as the main custodians of these long-held traditions and therefore as having responsibility for enforcing them. This is couched as respect for parents and linked to religion, which must be upheld at all times without question.

> No… they do not have a right… according to the community, they must be circumcised.
> **FGD respondent, male 43 years old, Laisamis**
>
> The right to resist circumcision… no and yes. Children are not allowed to disobey their parents. It is against the culture and the religion. Girls don't even know when they are supposed to be circumcised. At a tender age, girls cannot refuse to be cut. And yes, because it concerns her body and future life.
> **FGD respondent, male 25 years old, Balambala**

Of interest is the role of key persons and institutions charged with enforcing existing anti-FGM laws. Study data shows that key persons such as administration officials who are expected to be at the forefront in the fight against FGM/C also perceive FGM/C as a cultural practice that must be respected. This is especially so among community leaders, mainly chiefs and village elders and administration officials, covering the Somali communities in the study locations of Habaswein and Balambala.

> On the right to resist circumcision… you know we are Muslims, and community members will be surprised with that kind of a girl and even consider her to be out of the religion. The parents will be blamed for not circumcising their daughter. Whoever wants to seek her hand in marriage will have second thoughts due to the missing cultural practice of circumcision. Even the girl herself will not be comfortable when she is not circumcised since her peers went through the cutting. Others will despise her… so she has no right.
> **Key informant interview, village elder, Balambala**

Further analysis of FGD data shows religion as one of the main driving factors for the practice of FGM/C and its continuation in the study locations of Habaswein and Balambala, such that administration officials (chiefs) are not able to execute their mandate objectively. As natives and professing the Muslim faith, chiefs are compromised in carrying out their duties as far as addressing FGM/C issues in their jurisdictions is concerned, since they too believe that FGM/C is a religious requirement and must be observed. In addition, as members of the target community, they too have practised or continue practising FGM/C and are thus conflicted in their roles as custodians of the existing laws.

> No, even our religion accepts that a girl should be circumcised and therefore she will not be able to decline what the religion commands… a girl will have the right to refuse to be cut in the wrong way involving cutting and stitching, but with the normal circumcision, she will never have the right to do so.
> **FGD respondent, male 18–49, Balambala**

3.2.1.5 Belief that other girls and women will undergo FGM/C in the future

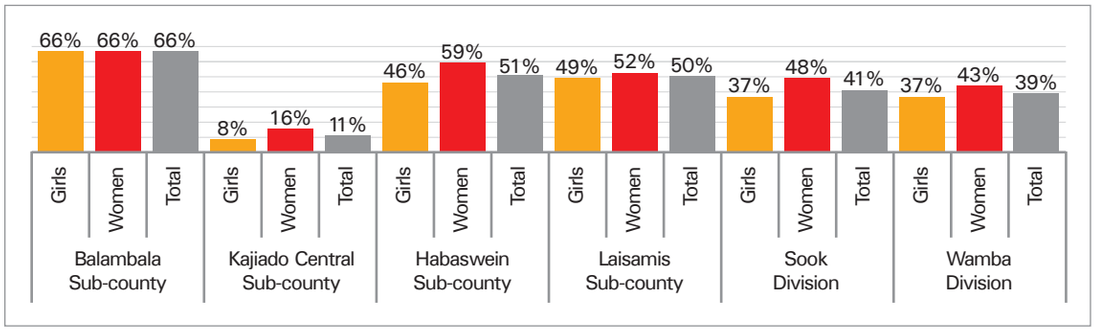
Key findings

- A significantly lower proportion of surveyed girls and women and boys and men of Maasai extraction, compared to the Somali, Pokot, Rendille and Samburu, believe that uncut girls and women will undergo FGM/C now and in the future. A significantly higher proportion of surveyed girls and women and boys and men of Muslim orientation (largely made up of respondents drawn from Balambala and Habaswein), compared to the Catholic and Protestant faithful (mainly from Kajiado Central, Laisamis, Sook and Wamba) believe that uncut girls and women will undergo circumcision in the future.

- Significantly more surveyed boys and men from Balambala (43%) and Sook (56%), compared to 13% from Kajiado Central, 28% from Habaswein, 33% from Laisamis and 34% from Wamba affirmed that there are consequences faced by uncut girls and women in their respective communities. Approximately 22%–27% of boys and men aged 15–29, compared to approximately 35%–37% of men aged 30–49 years believe that consequences abound for uncut girls and women in their respective communities. On a similar note, significantly more boys and men with no education (42%), compared to 26% with college or higher level education held the same belief.
- The belief that girls and women in the target communities will be cut in the future is mainly fuelled by four key consequences in the event that a girl or woman is not circumcised: ostracism occasioned by exclusion and rejection by boys, men, family and the wider community; ineligibility for marriage; hence difficulty in a finding a spouse; and subjection to ridicule by peers and the wider community.
- Evidence of future circumcision of girls and women in the target communities exists. Approximately 32% of surveyed mothers/caregivers in Balambala, 47% in Kajiado Central, 19% in Habaswein, 38% in Laisamis, 46% in Sook and 51% in Wamba reported that they have daughters who are uncut, mainly attributed to the immaturity of their daughters at the time of the survey and refusal of their daughters to undergo circumcision. Of the surveyed mothers with uncut daughters, approximately 63% in Balambala, 25% in Kajiado Central, 84% in Habaswein, 27% in Laisamis, 38% in Sook and 43% in Wamba affirmed that they intend to circumcise their uncut daughters who were yet to undergo circumcision at the time of the survey.
- Presented with three stark choices of having a cut girl/woman or uncut girl/woman or both, a majority of surveyed boys and men (59%) exclusively value cut girls and women over the remaining two choices, with significantly more surveyed boys and men in Balambala (80%), Habaswein (83%), Laisamis (84%) and Wamba (73%), compared to 37% in Kajiado Central and 54% in Sook, preferring cut girls and women to uncut girls and women.
- Significantly lower proportions of boys and men aged 15–17 (40%), compared to 56% of 18–24 year-olds and 61%–70% of 25–49 year-olds exclusively prefer cut girls and women to uncut girls and women. However, the survey data shows decreasing proportions of surveyed boys and men preferring cut over uncut girls and women as respondents' level of education increases.
- Readiness for marriage (50%), aesthetics through personal hygiene (42%), social acceptance (56%) and religious identity (15%) are the core reasons for boys' and men's preference for cut girls and women over their uncut counterparts.
- In Balambala and Habaswein (which are largely inhabited by the Somali of Muslim orientation), personal hygiene and religious requirements are the core reasons for preferring cut girls and women over their uncut counterparts. In Laisamis, inhabited by the Rendille, respondents mainly cited readiness for marriage (64%) and social acceptance (57%) as the core reasons for preferring cut girls and women over their uncut counterparts. In Sook and Wamba divisions, readiness for marriage, social acceptance and personal hygiene are the main reasons for preferring cut girls and women to their uncut counterparts. In Kajiado Central 72% cited social acceptance, while 31% indicated that only cut girls are ready for marriage.

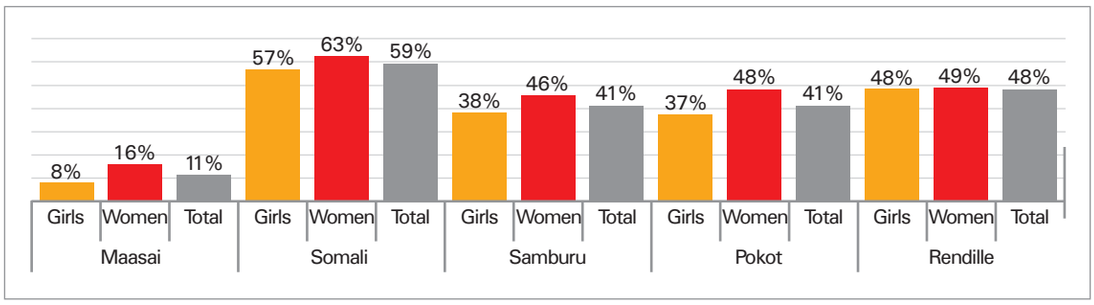
The survey results show that surveyed girls and women in Balambala (66%), Habaswein (51%), Laisamis (50%), Wamba (41%) and Sook (39%), compared to only 11% of surveyed girls and women in Kajiado Central, believe that uncut girls and women will undergo circumcision in the future. Further analysis is provided in Figure 18.

Figure 18: Proportion of girls and women aged 10–49 who believe that others girls and women in their respective communities will get cut now and in the future by region



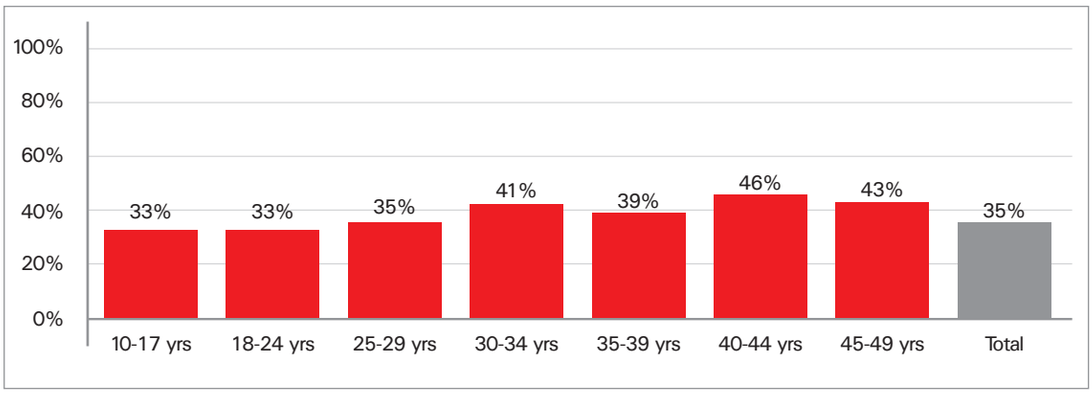
As depicted in Figure 19, similar observations are found among the Maasai (11%), who showed less belief compared to the Somali (59%), Pokot (41%), Rendille (48%) and Samburu (41%). The Muslim population (58%) in the study locations, largely made up of girls and women drawn from Balambala and Habaswein, have a firmer conviction than the surveyed respondents professing Catholic (39%) and Protestant (26%) faiths in the belief that girls and women in their respective communities will be cut in the future. A significant proportion of rural girls and women (37%), compared to 23% of surveyed girls and women from urban areas, believe that girls and women in their respective communities will be cut in the future.

Figure 19: Proportion of girls and women aged 10–49 that believe that others girls and women in their respective communities will get cut now and in the future by ethnicity (N = 4,959)



A look at the age cohorts of surveyed girls and women (Figure 20) shows that significant proportions of surveyed girls and women aged 10–17 (33%) are less convinced, compared to their older counterparts aged 18–49 of the belief that girls and women in their respective communities will be cut in the future. Analysis of data from group discussions with girls and women shows that a majority of older women, compared to younger women and girls strongly believe in FGM/C as a cultural practice since virtually all of them are cut. In addition, a majority of older women, compared to younger women, unquestioningly believe that FGM/C was practised by their ancestors and has survived many generations and so must be sustained.

Figure 20: Proportion of girls and women aged 10–49 that believe that others girls and women in their respective communities will get cut now and in the future by age cohort (N = 4,959)



When asked whether there are consequences for girls and women in their respective communities who refuse to undergo circumcision, approximately 42% of all surveyed girls and women replied in the affirmative. A significant proportion of surveyed girls and women from Balambala (59%), Sook (62%) and Wamba (49%), compared to Kajiado Central (27%), Habaswein (26%) and Laisamis (26%), reported that there are consequences for girls and women who refuse to undergo FGM/C. Similarly, a significant proportion of survey respondents from rural areas (44%), compared to those from urban areas (28%), also believe in the existence of the consequences.

Thus the belief that girls and women in the target communities will be cut in the future is mainly fuelled by four key consequences in the event that a girl or woman is not circumcised: ostracism occasioned by exclusion and rejection by boys, men, family and the wider community (69%); ineligibility for marriage; hence difficulty in a finding a spouse (60%); and subjection to ridicule by peers and the wider community (55%). Further analysis is provided in Table 21.

Table 21: Perceived consequences for a girl/woman who refuses to get circumcised reported by girls and women by region

Consequences for a girl/woman who refuses to get circumcised	Sub-county					
	Balambala n = 68	Kajiado Central n = 185	Habaswein n = 29	Laisamis n = 46	Sook n = 211	Wamba n = 213
She will not easily find a husband to marry her	71%	42%	62%	87%	60%	66%
Other girls and women will laugh at her	49%	72%	31%	35%	70%	34%
Boys and men will avoid such a girl	60%	28%	41%	48%	60%	29%
Her parents will chase her away	7%	17%	3%	24%	9%	56%
She could be rejected by the community	6%	5%	7%	7%	20%	42%
Her parents will curse her	6%	8%	14%	4%	8%	30%

Consequences for a girl/woman who refuses to get circumcised	Sub-county					
	Balambala n = 68	Kajiado Central n = 185	Habaswein n = 29	Laisamis n = 46	Sook n = 211	Wamba n = 213
Her family will be shamed by the community	3%	1%	0%	0%	11%	16%
Community leaders could curse her	1%	0%	0%	0%	2%	15%
Her family will be fined by the community leaders	1%	1%	0%	0%	3%	2%
Nothing will happen to her	0%	2%	0%	0%	0%	0%

One of the questions asked of the surveyed mothers/caregivers to further understand the depth of the conviction with regard to future circumcision of girls and women in the target communities concerned their intent to circumcise their uncut daughters in the future. Survey data shows that approximately 42% of surveyed mothers/caregivers reported that they have daughters who are uncut. This was largely attributed to two things: the status of their daughters, who were considered immature for circumcision at the time of the survey (48%), and the refusal of their daughters to undergo circumcision (20%).

Out of this category of surveyed mothers/caregivers, approximately 40% affirmed that they intend to circumcise their remaining daughters who were yet to undergo circumcision at the time of the survey. This intent is more pronounced in Balambala (72%), Habaswein (80%) and Wamba (47%), where significantly more survey respondents ($p < 0.05$) compared with those from Kajiado Central (25%), Laisamis (22%) and Sook (37%) indicated that they plan to circumcise their uncut daughters in the future. A similar trend is observed among ethnic communities from the study locations. Further analysis by location of survey respondents shows that more surveyed rural mothers (41%),compared to surveyed urban mothers (32%) with uncut daughters intend to cut their daughters in the future.

The role of men in the practice of FGM/C in their respective communities was also assessed in this study. In response to the question, "Do you think that other girls and women in your community will get cut now and in the future?", rejection and shunning of uncut girls by boys and men and as a consequence difficulty in finding a husband, as well as perceived ridicule of uncut girls and women by their cut counterparts were reported by sampled boys and men across all study locations as the main perceived consequences faced by uncut girls and women. In addition, the survey results also show that a majority of surveyed boys and men prefer cut girls and women to their uncut counterparts.

These aggregated responses by surveyed boys and men reveal three things: through indicating that uncut girls will face rejection from boys and men and ultimately not find husbands, boys and men play a silent role in perpetuating the practice of FGM/C in their respective communities; men's preference for cut girls and women over their uncut counterparts is exposed; boys' and men's discriminatory attitudes and prejudices towards uncut girls and women are indirectly manifested through indicating that other cut girls and women will ridicule their uncut counterparts.

The belief in the existence of consequences as reported by surveyed boys and men increases with the age of respondent and reduces with increasing levels of education of the respondent. However, of those who believe that there are consequences faced by uncut girls and women in their respective communities, both old and young as well as those who are highly educated or with little to no education, consistently cite the above consequences faced by uncut girls and women. This reveals the deep-rooted nature of the practice of FGM/C in the target communities and the role of boys and men in its continuation.

Analysis of data from group discussions with men and women aged 18–49 supports the above deductions. Group respondents consistently cited deep-rooted cultures as key drivers of the practice of FGM/C and the belief that other girls are likely to be cut now and in the future. For example, in Kajiado Central, circumcision of boys and men is not a sufficient factor to be married and so circumcision does not automatically lead to marriage. However, boys and men were not allowed to marry if uncut and, notably, they were not allowed to marry an uncut girl or woman. Some of the FGD respondents had this to say:

> A girl could not get married unless she gets cut. Also, no husband was allowed to marry an uncircumcised girl.
>
> **FGD respondent, female 37 years old, Kajiado Central**
>
> It is an offence to bring someone's daughter and make her a wife without consultation between the two families. Also, young men must accumulate some wealth before marriages to enable him to take care of his family after marriage.
>
> **FGD respondent, male 38 years old, Kajiado Central**

Group discussions in Laisamis with men aged 18–49 shows that boys and men can marry any girl or woman at whatever age so long as she is circumcised. A key process during arranging a marriage is that boys and men are allowed identify an uncircumcised girl for marriage. However, she must be circumcised before marriage.

> You chose one who is not circumcised and get her circumcised when you want to marry her. It depends on the love between the two… it is a disgrace and our culture does not allow one to mingle with her or come close to her.
>
> **FGD respondent, male 29 years old, Laisamis**
>
> According to the culture of Samburus and Rendille, they want the uncircumcised ones and later get her circumcised so that they can get married… even staying with her or impregnating her is a disgrace. It does not portray a good picture.
>
> **FGD respondent, male 26 years old, Laisamis**

A look at the practices of the Pokot, as revealed in group discussions with men aged 18–49, shows that they also carry out male circumcision. However, it is not tied to marriage. FGM/C is also practised among the Pokot and while it is a cultural requirement that boys and men marry only circumcised girls or women, group discussions with men revealed that some boys and men are now marrying uncircumcised girls and women, possibly due to enhanced knowledge on the effects of FGM/C. However, uncircumcised girls and women are still stigmatized by the society. Some of the FGD respondents had this to say about the practice of male circumcision and FGM/C among the Pokot.

Male circumcision is done in order to be like other men, friendship, to be considered an adult… it does not show that once a boy is circumcised he is ready to marry… it just for pleasure and proudness.

FGD respondent, male 23 years old, Sook

Boys and men cannot marry an uncircumcised girl or woman… An uncircumcised girl is still considered a child… but now some men marry uncircumcised girls… by now some men are regretting why they married circumcised girls since uncircumcised girls do not get complications during birth.

FGD respondent, male 40 years old, Sook

Uncircumcised girls or women are stigmatized and they are not allowed to interact with other members of the society… people will laugh at her, she is referred as a coward… a group of women will talk ill of her. They can't even assist her when giving birth. Again she is not allowed to milk cows and no one wants to eat her food when she cooks.

FGD respondent, male 30 years old, Sook

Among the Samburu in the target region of Wamba, similar observations were made. Group discussions with men aged 18–49 also showed that FGM/C is mandatory for a girl to be married, otherwise, she is considered a child and not a "woman" and is subject to stigmatization. It was further revealed that some girls and women, in some cases with the support of their respective families, are now rejecting FGM/C due to enhanced knowledge of its effects. However, these girls and women, together with their unborn children, face stigmatization from society and are sometimes forced to comply by undergoing circumcision during childbirth.

Some of the FGD respondents had this to say about the practice of male circumcision and FGM/C among the Samburu.

We have to circumcise girls, because if a male is circumcised and a woman is not, you cannot marry her because she is considered a child. So that's why the Samburu do that.

FGD respondent, male 18–49, Wamba

Another important reason apart from marriage is circumcision is like a lifestyle, so if a girl is not circumcised and she gives birth, the children will be made inferior to the rest and both she and the children will not be valued in the community because she is still seen as a girl and not a woman.

FGD respondent, male 18–49, Wamba

Almost all of the girls but not all are circumcised… our cultures nowadays allow girls to go to school and if they don't want to be circumcised it is okay, also if the men wants to marry them without them being circumcised it is also fine… but right now in the Samburu culture you can be married without being circumcised, but once you get pregnant you are taken back to your home to be circumcised before giving birth.

FGD respondent, female 18–49, Wamba

It happens, especially these days where there are a lot of campaigns against FGM/C and also girls are now going to school. Some girls refuse to get circumcised. There is nothing that can be done to the family or even the girl, but if she decides to get married, some rituals that are performed by the parents during the wedding ceremony will not be done and that by itself is a problem because the rituals are the ones that unite the two families.

FGD respondent, male 18–49, Wamba

Likewise, among the Somali in the study locations of Balambala and Habaswein, group discussions with men aged 18–49 also showed that FGM/C is mandatory and is demanded by culture and religion. Respondents indicated that all girls and women are cut since it is a taboo for a boy or man to marry an uncut girl or woman. Uncut women also face rejection, shunning, ridicule and even banishment from the community. Some of the FGD respondents had this to say.

> If a girl is circumcised, she is considered a complete woman… Circumcision is based on religion and culture and no one will be comfortable having uncut woman in the community
>
> **FGD respondent, male 18–49, Balambala**
>
> She will be kept isolated and everybody in the community will come to know her. The community will most likely reject her in all possible ways since culture demands that a girl must be circumcised.
>
> **FGD respondent, male 18–49, Habaswein**
>
> People in the community will talk about her and her family and this will make them separate from the entire community. Their role in the community will be at stake unless they do what the community is known to do.
>
> **FGD respondent, male 18–49, Balambala**

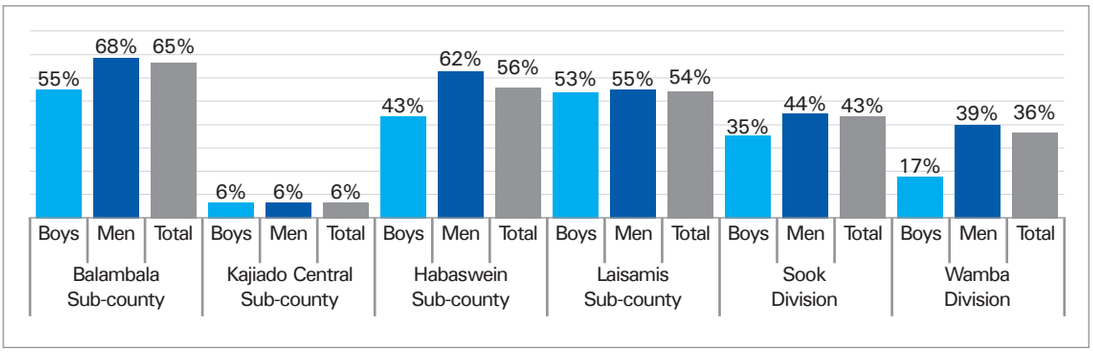
Thus, while girls' readiness for marriage is arbitrarily determined using for example age- and maturity-related bodily changes and other factors outside the girls' control such as poverty,[12] boys' and men's readiness for marriage includes the accumulation of wealth and, recently, completion of school. This demonstrates how the practice of FGM/C is embedded in complex socio-cultural, economic and political structures and is a manifestation of gender inequality.

A look at the study results shows that higher proportions of surveyed boys and men in Balambala (65%), Habaswein (56%) and Laisamis (54%), compared to Sook (43%), Wamba (36%) and Kajiado Central (6%) believe that girls and women in their respective communities will get cut now and in the future. Across target ethnic communities in the study locations, a similar trend is observed, where a higher proportion of respondents of Somali extraction (60%) and of Rendille extraction (55%), compared to a lower proportion of the Maasai (6%), the Samburu (37%) and the Pokot (43%) reported that girls and women in their respective communities will get cut now and in the future.

Further analysis is provided in Figure 21.

12 See Section 3.3.2.1: Reasons for practising child marriage. Marriage of girls is linked to FGM/C, especially in Laisamis, Sook and Wamba, and a key factor in early child marriage is a better bride price, possibly to alleviate existing hardship and poverty.

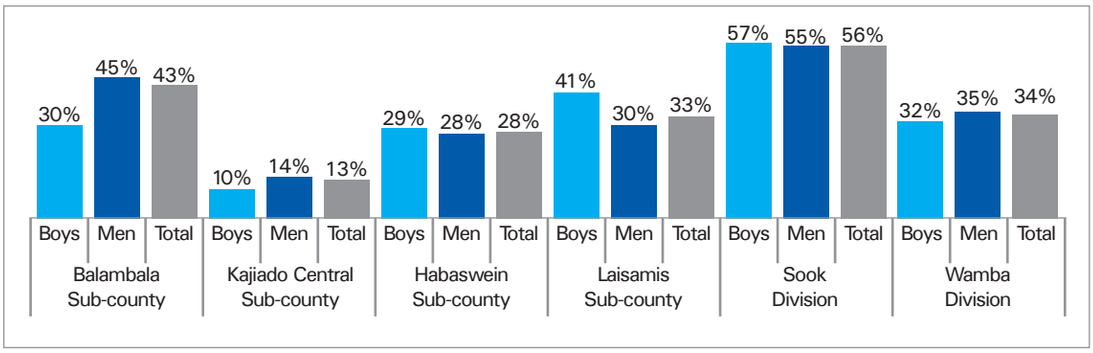
Figure 21: Proportion of boys and men aged 15–49 that believe that girls and women in their respective communities will get cut now and in the future by region (N = 1,243)



While no significant differences were observed across rural and urban populations, significantly more respondents of Muslim orientation (63%), compared to 21% and 29% of respondents of Protestant and Catholic orientation respectively, believe that girls and women in their respective communities will get cut now and in the future.

When asked whether there are perceived consequences faced by uncut girls and women in their respective communities, significantly more surveyed boys and men from Balambala (43%) and Sook (56%), compared to 13% from Kajiado Central, 28% from Habaswein, 33% from Laisamis and 34% from Wamba, affirmed that there are consequences faced by uncut girls and women in their respective communities.

Figure 22: Proportion of boys and men aged 15–49 affirming the existence of consequences for girls and women who refuse to be cut by region (N = 1,243)



Analysis by ethnic communities shows that significantly fewer respondents of Maasai origin (13%), compared to 55% of the Pokot, 35% of the Somali, 34% of the Samburu and 33% of the Rendille, believed that there are consequences faced by uncut girls and women in their respective communities.

Further, belief in the existence of consequences reported by surveyed boys and men increases with the age of respondent and reduces with the increasing level of education of respondent. Approximately 22% to 27% of boys and men aged 15–29, compared to approximately 35% to 37% of men aged 30–49 years believe that consequences exist for uncut girls and women in their respective communities. On a similar note, significantly more boys and men with no education (42%), compared to 26% with college or higher level education, bore the same belief.

Table 22 shows the distribution of perceived consequences faced by uncut girls and women in the study locations, as reported by surveyed boys and men. Specifically, approximately 70% of all surveyed boys and men cited difficulty in finding a husband

as a key consequence faced by uncut girls and women, mainly fuelled by rejection and shunning of uncut girls by boys and men (55%). In addition, a considerable proportion of all boys and men surveyed (44%) indicated that uncut girls and women would be ridiculed by their cut counterparts, besides being cursed by their parents/caregivers (10%) or community leaders (3%), rejected by the community as a whole (16%), and their families shamed by their respective communities (7%).

Table 22: Perceived consequences for a girl/woman who refuses to get circumcised reported by boys and men by region

Perceived consequence	Sub-county						
	Balambala n = 78	Kajiado Central n = 443	Habaswein n = 144	Laisamis n = 98	Sook n = 243	Wamba n = 166	Total N = 1,243
Nothing will happen to her	14.1%$_{a,c}$	50.0%$_{b}$	22.2%$_{a,b}$	3.2%$_{a,c}$	4.5%$_{c}$	3.8%$_{a,c}$	14.1%
She will not easily find a husband to marry her	76.9%$_{a,b}$	53.8%$_{a}$	63.9%$_{a,b}$	93.5%$_{b}$	68.9%$_{a,b}$	69.8%$_{a,b}$	70.2%
Boys and men will avoid such a girl	65.4%$_{a,b}$	63.5%$_{a,b}$	55.6%$_{a,b}$	35.5%$_{a,c}$	64.4%$_{b}$	18.9%$_{c}$	55.0%
Other girls and women will laugh at her	47.4%$_{a}$	25.0%$_{a,b}$	11.1%$_{b}$	19.4%$_{a,b}$	70.5%c	26.4%$_{a,b}$	43.7%
Her parents will curse her	9.0%$_{a,b}$	21.2%$_{a,c}$	8.3%$_{a,b,c}$	0.0%[1]	2.3%$_{b}$	30.2%$_{c}$	10.5%
Her parents will chase her away	9.0%$_{a,b}$	17.3%$_{a,c}$	0.0%[1]	3.2%$_{a,b}$	4.5%$_{b}$	39.6%$_{c}$	11.5%
She could be rejected by the community	10.3%$_{a}$	7.7%$_{a}$	2.8%$_{a}$	6.5%$_{a,b}$	21.2%$_{a,b}$	34.0%$_{b}$	16.0%
Community leaders could curse her	0.0%1	1.9%$_{a}$	5.6%$_{a}$	0.0%[1]	4.5%$_{a}$	7.5%$_{a}$	3.4%
Her family will be shamed by the community	1.3%$_{a}$	3.8%$_{a}$	2.8%$_{a}$	3.2%$_{a}$	11.4%$_{a}$	11.3%$_{a}$	6.8%
Her family will be fined by the community leaders	0.0%[1]	0.0%[1]	0.0%[1]	0.0%[1]	0.8%$_{a}$	0.0%[1]	.3%

Note: Values in the same row and sub-table not sharing the same subscript are significantly different at $p < .05$ in the two-sided test of equality for column proportions. Cells with no subscript are not included in the test. Tests assume equal variances.[2]

1 This category is not used in comparisons because its column proportion is equal to zero or one.
2 Tests are adjusted for all pairwise comparisons using the Bonferroni correction.

To further assess attitudes towards the practice of FGM/C, the survey sought to measure predispositions of boys and men in the target communities with regard to favouring uncut or cut girls and women. Presented with three stark choices of having a cut girl/woman or uncut girl/woman or both, a majority of surveyed boys and men (59%) exclusively value cut girls and women over the remaining two choices.

As detailed in Figure 23, significantly more surveyed boys and men ($p < 0.05$) in Balambala (75%), Habaswein (82%), Laisamis (78%) and Wamba (71%), compared to 38% in Kajiado Central and 54% in Sook, prefer cut girls and women to uncut girls and women.

Figure 23: Proportion of boys and men aged 15–49 exclusively showing preference for cut girls and women by region (N = 1,243)

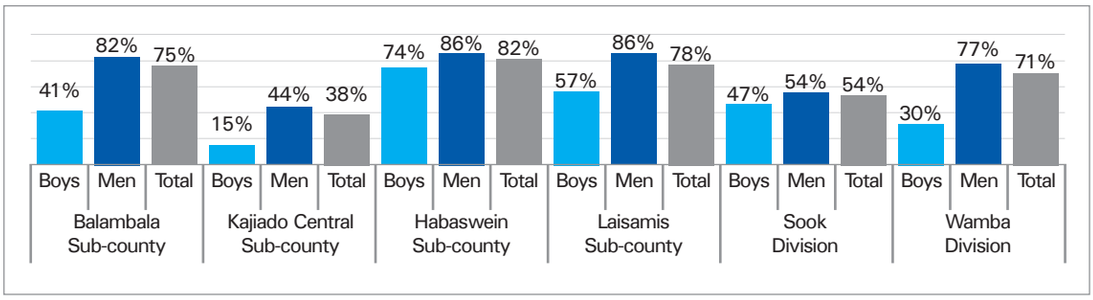
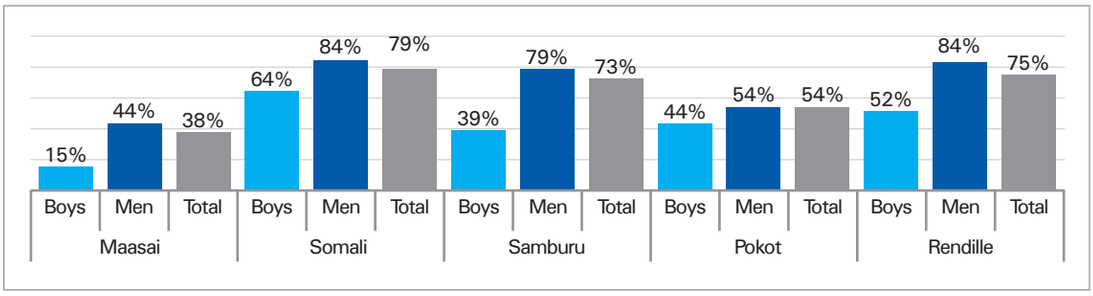


Figure 24 shows that significantly fewer respondents of Maasai (38%) and Pokot (54%) origins, compared to 79% of the Somali, 73% of the Samburu and 75% of the Rendille, prefer cut girls and women to uncut girls and women. Further, while no significant differences exist between urban and rural populations, significantly more Muslims (78%), compared to 61% and 48% of the Catholic and Protestant orientation respectively, prefer cut girls and women to uncut girls and women.

Figure 24: Proportion of boys and men aged 15–49 exclusively showing preference for cut girls and women by ethnicity (N = 1,243)



Further analysis by age shows that significantly lower proportions of boys and men aged 15–17 (45%, $p < 0.05$), compared to 61% of 18–24 year-olds and 63% to 70% of 25–49 year-olds, exclusively prefer cut girls and women to uncut girls and women. Further analysis is presented in Table 23 and Table 24.

Table 23: Proportion of boys and men aged 15–49 exclusively showing preference for cut girls and women by age (N = 1,243)

Category	Age (years)						
	15–17	18–24	25–29	30–34	35–39	40–44	45–49
Exclusive preference for cut girls and women over uncut girls and women	$46.9\%_{a}$	$61.5\%_{b}$	$67.5\%_{c,e}$	$63.3\%_{b,c}$	$76.6\%_{d}$	$67.7\%_{c,e}$	$70.2\%_{e}$

Note: Values in the same row and sub-table not sharing the same subscript are significantly different at $p < .05$ in the two-sided test of equality for column proportions. Cells with no subscript are not included in the test. Tests assume equal variances.[1,2]

1 Tests are adjusted for all pairwise comparisons using the Bonferroni correction.

2 Cell counts of some categories are not integers. They were rounded to the nearest integers before performing column proportion tests.

Further, analysis by level of education (Table 24) reveals decreasing proportions of surveyed boys and men preferring cut over uncut girls and women as their level of education increases. Specifically, a significantly higher proportion of surveyed boys and men with no education (74%), compared to 55% with primary-level education and secondary-level education and 51% with college or higher level education, prefer cut girls and women to uncut girls and women.

Table 24: Proportion of boys and men aged 15–49 exclusively showing preference for cut girls and women by level of education (N = 1,243)

Category	Level of education			
	No education n = 531	Primary education n = 325	Secondary education n = 302	College or higher education n = 85
Exclusive preference for cut girls and women over uncut girls and women	74.1%$_a$	55.3%$_b$	55.2%$_b$	51.2%$_b$

Note: Values in the same row and sub-table not sharing the same subscript are significantly different at $p < .05$ in the two-sided test of equality for column proportions. Cells with no subscript are not included in the test. Tests assume equal variances. Tests are adjusted for all pairwise comparisons using the Bonferroni correction.

While different reasons for the preference for cut girls and women over their uncut counterparts abound in each of the study locations surveyed, readiness for marriage, and hence marriageability (50%), aesthetics through personal hygiene (42%), social acceptance (56%) and religious identity (15%) are the core reasons for the preference for cut girls and women over their uncut counterparts.

As presented in Table 25, and corroborating the initial findings in earlier sections of this report, surveyed boys and men drawn from Balambala and Habaswein, which are largely inhabited by the Somali of Muslim orientation, mainly cited personal hygiene and religious requirements as the core reasons for preferring cut girls and women over their uncut counterparts. A majority of surveyed boys and men in Laisamis, inhabited by the Rendille, mainly cited readiness for marriage (64%) and social acceptance (57%) as the core reason for preferring cut girls and women over their uncut counterparts. In Sook and Wamba divisions, surveyed boys and men stated that readiness for marriage, social acceptance and personal hygiene are their main reasons for preferring cut girls and women to uncut girls and women. A majority of surveyed boys and men from Kajiado Central (72%) cited social acceptance as the main reason, while 31% indicated that only cut girls are ready for marriage. Further analysis is provided in Table 25.

Table 25: Perceived reasons provided by boys and men for preference for cut girls and women over uncut girls and women by region (N = 1,243)

Reasons for preference	Age	Only circumcised girls/women are ready for marriage	They are clean, hygienic	For social acceptance	They are virgins	More sexual pleasure for the man	For religious approval	They do not have complications during childbirth	They are more attractive
Balambala sub-county	Boys	39%	45%	30%	0%	0%	36%	11%	0%
	Men	58%	67%	39%	1%	1%	47%	2%	0%
	Total	**56%**	**65%**	**38%**	**1%**	**1%**	**45%**	**3%**	**0%**
Kajiado Central sub-county	Boys	32%	5%	64%	0%	0%	6%	15%	5%
	Men	31%	11%	75%	2%	0%	7%	1%	0%
	Total	**31%**	**10%**	**74%**	**2%**	**0%**	**7%**	**3%**	**1%**
Habaswein sub-county	Boys	17%	50%	42%	17%	18%	36%	5%	0%
	Men	36%	57%	28%	20%	18%	41%	5%	0%
	Total	**30%**	**55%**	**33%**	**19%**	**18%**	**39%**	**5%**	**0%**
Laisamis sub-county	Boys	70%	5%	53%	11%	0%	0%	0%	0%
	Men	62%	15%	59%	14%	2%	1%	1%	0%
	Total	**64%**	**13%**	**57%**	**14%**	**2%**	**1%**	**1%**	**0%**
Sook division	Boys	26%	56%	16%	0%	14%	0%	0%	16%
	Men	72%	70%	53%	3%	16%	4%	1%	3%
	Total	**69%**	**70%**	**51%**	**3%**	**16%**	**4%**	**1%**	**4%**
Wamba division	Boys	57%	22%	57%	0%	0%	0%	0%	29%
	Men	63%	36%	65%	3%	1%	2%	2%	14%
	Total	**62%**	**35%**	**65%**	**3%**	**1%**	**1%**	**2%**	**15%**

3.2.1.6 Perceived changes in the practice of FGM/C

Key findings

- There is a general perceived decrease in the practice of FGM/C, as reported by 72% of all girls and women surveyed and a near equal proportion of boys and men surveyed (73%).
- Significantly lower proportions of surveyed girls and women as well as boys and men in Balambala and Habaswein, compared to those in Kajiado Central, Laisamis Sook and Wamba, believe that there is a reduction in the practice of FGM/C in their respective communities.
- Fear of being arrested (74%), enhanced knowledge of effects of FGM/C (39%), and the perception that community leaders are now supporting the elimination of FGM/C are the main perceived reasons for the perceived reduction in the practice of FGM/C as reported by surveyed girls and women.
- Data from group discussions with girls and women respondents also attributes the reduction to intensive anti-FGM/C interventions by state and non-state actors that have been ongoing in the study locations over the last 10 to 20 years, fear of arrest, and enhanced knowledge among parents/caregivers, daughters and sons in their respective communities on FGM/C and its effects.
- Key perceived changes reported by surveyed girls and women with regard to the practice of FGM/C are: reduction in the number and magnitude of ceremonies, especially those involving all community members (33%); change in the cutting season, including time and date (32%); enlightened girls running away from the cut (28%); and girls getting cut at a younger age (24%).
- A look at individual regions shows contrasting reasons for the perceived changes related to FGM/C that have occurred: in Kajiado Central and Wamba, a key changed observed is that girls are now running away from the cut (39%); in Balambala (56%) and Habaswein (48%), girls are now getting cut at a younger age; in Sook (56%) and Laisamis (52%), ceremonies involving community members have reduced, the timing has changed or ceremonies have been altogether avoided.

While there may be cases of under-reporting of FGM/C, especially among girls and young women, further analysis of survey data from girls and women indicates a general perceived decrease in the practice of FGM/C as reported by 72% of all women surveyed (Balambala (11%), Kajiado Central (84%), Habaswein (44%), Laisamis (83%), Sook (83%) and Wamba (67%)).

The above findings from surveyed girls and women are corroborated by surveyed boys and men from the study locations. Approximately 73% of surveyed boy and men believe that there is a reduction in the practice of FGM/C in their respective communities. However, significantly lower proportions of surveyed boys and men in Balambala (13%) and Habaswein (44%), compared to Kajiado Central (90%), Laisamis (83%), Sook (86%) and Wamba (78%), believe that there is a reduction in the practice of FGM/C in their respective communities. Further analysis is provided in Table 26.

Table 26: Perceived change in the practice of FGM/C reported by boys and men by region

Perceived change	Sub-county						Total N = 1,243
	Balambala n = 149	Kajiado Central n = 443	Habaswein n = 144	Laisamis n = 98	Sook n = 243	Wamba n = 166	
Increased	65.1%$_{a}$	0.0%$_{1}$	10.4%$_{b}$	13.3%$_{b}$	2.1%$_{c}$	0.6%$_{c}$	10.5%
Remained the same	15.4%$_{a}$	7.0%$_{b}$	13.2%$_{a,b}$	4.1%$_{a,b}$	8.6%$_{a,b}$	13.9%$_{a,b}$	9.7%
Reduced	13.4%$_{a}$	90.5%$_{b}$	43.8%$_{c}$	82.7%b,d	86.0%$_{b,d}$	77.7%$_{d}$	72.6%
I don't know	6.0%$_{a,c}$	2.5%a	32.6%$_{b}$	0.0%1	3.3%$_{a,c}$	7.8%$_{c}$	7.1%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

1 This category is not used in comparisons because its column proportion is equal to zero or one.

Asked about possible changes that have occurred in their respective communities that could be attributed to changes in the practice of FGM/C, three key reasons emerge from the data from girls and women: fear of being arrested (74%); enhanced knowledge of the effects of FGM/C (39%); and the perception that community leaders are now supporting the elimination of FGM/C. This is shown in Table 27, which provides further reasons for the perceived reduction in the practice of FGM/C.

Table 27: Perceived reasons for reduction in the practice of FGM/C reported by girls and women by region

Perceived reason for reduction in the practice of FGM/C	Study location						Total N = 2,085
	Balambala n = 156	Kajiado Central n = 728	Habaswein n = 127	Laisamis n = 193	Sook n = 403	Wamba n = 478	
Fear of being arrested	58%	67%	76%	93%	78%	77%	74%
Increased knowledge of effects of FGM/C	49%	52%	46%	21%	34%	25%	39%
Community leaders are now supporting elimination of FGM/C	22%	25%	28%	17%	35%	23%	26%
Traditional circumcisers are afraid of being arrested	13%	9%	10%	9%	31%	32%	19%
Pressure from NGOs in the community	10%	6%	4%	4%	25%	8%	10%
Pressure from government officials in the community	8%	9%	7%	3%	19%	14%	11%
I don't know	6%	0%	7%	0%	3%	9%	4%

Data from group discussions with women respondents validated the above study findings. They mainly attributed the perceived reduction in the practice of FGM/C to intensive anti-FGM/C interventions by state and non-state actors that have been ongoing in the study locations over the last 10 to 20 years, fear of arrest and enhanced knowledge among parents/caregivers, daughters and sons in their respective communities of FGM/C and its effects.

A look at the perceived changes in the practice of FGM/C reveals three emerging issues. Firstly, there is a change in the age at circumcision, where some households in the target communities are now circumcising their daughters at an earlier age. The net effect of this action is that where FGM/C is practised as a rite of passage culminating in marriage, it is disconnected from the latter because the cut girl is still considered too "immature" for marriage. Secondly, the type of circumcision has changed in some of the study locations. Specifically, among the Somali in the study locations of Habaswein and Balambala, infibulation has virtually been abandoned and replaced by nicking of the genital area or removal of flesh from the genital area. The change in cutting has been consistently linked to religion and hence goes against the teachings of Islam and reduces the health complications observed in the past. Thirdly, while not common, healthcare professionals are now becoming involved in the practice of FGM/C through offering complementary services to those offered by traditional practitioners. This typically includes the provision of painkillers and antibiotics before and after circumcision. However, this is mostly carried out in secrecy. Finally, there has been a change in the tools used for circumcision. Study results show that in the past, a common cutting tool such as a razor or knife was used to cut all the girls. By contrast, "one cutting tool, one girl" is the current practice to ensure a reduced risk of infection.

Key discussion areas on the perceived changes in the practice of FGM/C are provided in the quotes below.

> Before, we used to have early marriages and circumcision for both boys and girls, but after 2012 it drastically reduced because the government has enforced the laws at the grassroots level, prohibiting early child marriage and FGM/C. It has reduced to let's say 20% and it is barely practised. We have a group called the Women Network, where some women are chosen from this community to track where these practices are being carried out. Since the formation of the Women Network, the practices have ended. So if the practices continue at all – and I believe they don't – it's a very small fraction which I haven't myself witnessed.
>
> **Key informant interview, village elder, Kajiado Central**
>
> We no longer use circumcision as an indicator for marriage… girls used to be circumcised when aged 12 to 14 but that has changed now… there are some who run away for rescue but sometimes they return home afterwards at an older age like 25 years and demand to be cut.
>
> **FGD respondent, male 35 years old, Kajiado Central**
>
> It has reduced because of sensitization from [the Christian charity] World Vision. But now that World Vision has reduced its services, many people are tending go back to cutting their daughters… going back to our tradition.
>
> **FGD respondent, woman 33 years old, Sook**

In line with the perceived reduction in the practice of FGM/C in target communities reported by survey respondents, the data reveals a number of perceived changes in the respective communities as far as FGM/C is concerned, key of which are: reduction in the number and magnitude of ceremonies, especially those involving all community members (33%); the cutting season, including time and date, having been changed (32%); enlightened girls running away from the cut (28%); and girls getting cut at a younger age (24%).

A look at the individual regions shows contrasting reasons for the perceived changes relating to FGM/C that have occurred: in Kajiado Central (38%) and Wamba (39%), a key changed observed is that girls are now running away from the cut; in Balambala (56%) and Habaswein (48%), girls are now getting cut at a younger age; and in Sook (35%) and Laisamis (49%), ceremonies involving community members have reduced, the timing has changed or ceremonies have been avoided altogether. A detailed analysis is provided in Table 28.

Table 28: Perceived changes in the practice of FGM/C reported by girls and women by region

Perceived changes to practice of FGM/C	Sub-county						Total N = 2,085
	Balambala n = 156	Kajiado Central n = 728	Habaswein n = 127	Laisamis n = 193	Sook n = 403	Wamba n = 478	
Girls are being cut at a younger age	56%	30%	48%	29%	9%	7%	24%
The cutting season has been changed	49%	15%	42%	17%	38%	11%	23%
Ceremonies involving community members have reduced or are avoided	31%	31%	17%	49%	35%	35%	33%
The time of the day or night for conducting the ceremony has been changed	8%	4%	2%	3%	21%	12%	9%
Girls are running away from getting circumcised	4%	38%	3%	16%	19%	39%	28%
Girls are now being cut at home	3%	2%	0%	1%	6%	1%	2%
Girls are now being cut in hospitals	1%	0%	5%	0%	1%	1%	1%
Girls are now being cut by healthcare professionals	1%	1%	4%	0%	0%	0%	1%
No changes have occurred	16%	6%	17%	6%	5%	22%	11%

As mentioned above, the support of community leaders in the elimination of FGM/C in the study locations, fear of arrest and enhanced knowledge of FGM/C and its effects and hence the likelihood of the practice being rejected have led to a reduction in the practice of FGM/C in the study locations.

Though marginal, a key concomitant outcome of these perceived changes in the practice of FGM/C, together with its reduction in the respective study locations, is movement across bordering communities to seek FGM/C services.

As reported by 5% of all girls and women surveyed, female members of other communities visit their respective communities to obtain FGM/C services. Conversely, approximately 3% of all girls and women surveyed indicated that they are aware of girls and women from their communities visiting bordering communities for FGM/C services. Depending on the accessibility to the target region and other factors such as shared traditions (e.g. marriage), key communities that visit the study locations for FGM/C services are: the Samburu visiting Balambala and Habaswein regions and vice versa; the Somali visiting Laisamis and Sook regions and vice versa; and the Pokot, Samburu, Akamba and Ameru visiting the Wamba region and vice versa.

3.2.2 Current trends in the practice of FGM/C

3.2.2.1 Type of FGM/C performed

Key findings

- A majority of surveyed girls and women (90%) indicated that removal of flesh from the genital area is the main type of FGM/C performed on girls and women in their respective communities, while nicking of the genital area without removing any flesh was reported by 6% of all girls and women surveyed. Removal of flesh in the genital area as a type of FGM/C is predominant in Laisamis (100%), Sook (94%), Wamba (98%) and Kajiado Central (89%). While removal of flesh from the genital area is also the most common type of FGM/C performed on girls and women in Balambala (73%) and Habaswein (67%), nicking of the genital area without removing any flesh was reported by approximately 24% and 30% of surveyed respondents from Balambala and Habaswein respectively. Infibulation, typically involving stitching to close the genital area , was least evident, as reported by 1% of surveyed girls and women in Balambala, Kajiado Central and Sook and 0% in Laisamis, Habaswein and Wamba.
- Indirect support for continuation of the practice FGM/C is evident in the measurement of the preference for the type of FGM/C, where approximately 83% of all surveyed girls and women mentioned one type of FGM/C that they prefer. A majority of surveyed girls and women (60%) preferred removal of flesh from the genital area while 20% prefer nicking of the genital area without removing any flesh. Stitching to close the genital area was the least preferred, as reported by 1% of surveyed girls and women. Only 17% of all surveyed girls and women do not prefer any form of FGM/C, which breaks down as 36% from Kajiado Central (the Maasai), 0% in Balambala and Habaswein (Somali), 9% in Laisamis (Rendille) and Sook (Pokot) and 10% in Wamba (Samburu).
- The main motivations behind preferences for the different types of FGM/C are: community preference and approval (64%) in all study locations; religious requirement (17%) (largely in Balambala and Habaswein); and less pain (16%) in all study locations.

While FGM/C is classified into the four broad categories presented previously (WHO, 1996), a key limitation of the study identified during the baseline study pre-test exercise

was the inability of participating girls and women to state the type of circumcision performed on them. Subsequently, and guided by the FGM/C Demographic Health Survey (DHS) module, the type of FGM/C was classified into three simple categories: genital area nicked without removing flesh; flesh removed from genital area; and genital area stitched to close it.

When asked how girls and women known to them in their respective communities were circumcised, a majority of those surveyed indicated that they had had flesh removed from their genital area. Survey results show that removal of flesh in the genital area as a type of FGM/C is predominant in Laisamis (100%), Sook (94%), Wamba (98%) and Kajiado Central (89%). However, while removal of flesh from the genital area is also the most common type of FGM/C performed on girls and women in Balambala (73%) and Habaswein (67%), approximately 24% and 30% of surveyed respondents from Balambala and Habaswein respectively indicated that some circumcised girls and women in their respective communities were nicked in their genital area without removing any flesh.

Infibulation, typically involving stitching to close the genital area, was least evident, and reported by 1% of surveyed girls and women in Balambala, Kajiado Central and Sook, and 0% in Laisamis, Habaswein and Wamba. Further analysis is provided in Table 29.

Table 29: Proportion of girls and women reporting the type of FGM/C performed on girls and women known to them by region

FGM/C category	Sub-county						Total n = 3432
	Balambala n = 364	Kajiado Central n = 903	Habaswein n = 293	Laisamis n = 354	Sook n = 746	Wamba n = 772	
Genital area nicked without removing any flesh	24%	2%	30%	0%	2%	2%	6%
Flesh removed from genital area	73%	89%	67%	100%	94%	98%	90%
Genital area stitched closed	1%	1%	0%	0%	1%	0%	1%
I don't know	2%	8%	3%	0%	2%	0%	3%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Assessment of preference for any type of FGM/C corroborates the above findings and further shows how rooted the practice is in the study locations and communities. When asked which type of FGM/C they prefer, a majority of surveyed girls and women preferred removal of flesh from the genital area while the second most preferred was nicking the genital area without removing any flesh. Stitching to close the genital area was the least preferred.

Only 17% of all surveyed girls and women indicated that they do not prefer any method. Specifically, a significant proportion (36%, $p < 0.05$) of surveyed respondents from Kajiado Central (the Maasai), compared to 0% in Balambala and Habaswein (Somali), 9% in Laisamis (Rendille) and Sook (Pokot) and 10% in Wamba (Samburu) stated that they do not prefer any form of FGM/C. Further analysis is provided in Table 30.

Table 30: Proportion of girls and women reporting the type of FGM/C they prefer by region

FGM/C category	Sub-county						Total n = 2085
	Balambala n = 156	Kajiado Central n = 728	Habaswein n = 127	Laisamis n = 193	Sook n = 403	Wamba n = 478	
Nicking genital area without removing any flesh	26.3%$_{a}$	13.0%$_{b}$	53.5%$_{c}$	20.7%$_{a,b}$	7.2%$_{d}$	30.5%$_{a}$	20.1%
Removing flesh from genital area	71.8%$_{a}$	49.7%$_{b}$	44.1%$_{b}$	69.9%$_{a}$	74.7%$_{a}$	57.7%$_{b}$	59.6%
Stitching to close the genital area	1.9%$_{a}$	0.5%$_{a}$	1.6%$_{a}$	0.0%1	1.2%$_{a}$	0.4%$_{a}$	0.8%
All types of FGM/C	0.0%[1]	1.0%$_{a}$	0.0%[1]	0.0%[1]	8.2%$_{b}$	1.0%$_{a}$	2.2%
I don't prefer any	0.0%[1]	35.7%$_{a}$	0.8%b	9.3%$_{c}$	8.7%$_{c}$	10.3%$_{c}$	17.4%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Note: Values in the same row and sub-table not sharing the same subscript are significantly different at $p < .05$ in the two-sided test of equality for column proportions. Cells with no subscript are not included in the test. Tests assume equal variances.[2]

1 This category is not used in comparisons because its column proportion is equal to zero or one.

2 Tests are adjusted for all pairwise comparisons using the Bonferroni correction.

A look at the motivations behind preferences for the different types of FGM/C reveals three beliefs: community preference and approval was cited by 64% of survey respondents across all study locations and mainly associated with "removal of flesh from the genital area" as a form of FGM/C; religious requirement was cited by 17% of survey respondents, largely from Balambala and Habaswein and mainly associated with both "nicking of the genital area without removing any flesh" and "removal of flesh from the genital area" as forms of FGM/C; and less pain was mentioned by 16% of survey respondents from all target regions and associated with "nicking of the genital area without removing any flesh" as a form of FGM/C. Further analysis is provided in Table 31.

Table 31: Reasons provided by girls and women for preferring a given type of FGM/C

Reason for preference	Type of FGM/C					Total n = 2085
	Nicking genital area without removing any flesh n = 419	Removing flesh from genital area n = 1242	Stitching to close the genital area n = 16	All types of FGM/C n = 45	I am not sure n = 363	
It is what the community favours	34.8%$_{a}$	85.1%$_{b}$	43.8%$_{a,c}$	88.9%$_{b}$	22.3%$_{c}$	63.8%
It is what my religion favours	16.5%$_{a,b}$	20.8%$_{a}$	37.5%$_{a}$	2.2%$_{b,c}$	4.7%$_{c}$	16.8%
It is less painful	44.2%$_{a}$	10.0%$_{b}$	25.0%$_{a,b}$	6.7%$_{b,c}$	4.1%$_{c}$	15.9%
It ensures a girl remains a virgin or avoids premarital sex	10.5%$_{a,c}$	5.2%$_{b}$	25.0%$_{a}$	2.2%$_{b,c,d}$	0.6%$_{d}$	5.5%
It does not result in future health complications	21.2%$_{a}$	2.4%$_{b}$	6.2%$_{a,b}$	6.7%$_{a,b}$	4.1%$_{b}$	6.6%
It is what my husband prefers	1.4%$_{a}$	2.7%$_{a}$	0.0%[1]	2.2%$_{a}$	2.8%$_{a}$	2.4%
It is what is easier to carry out	10.7%$_{a}$	3.5%$_{b}$	12.5%$_{a,b,c}$	28.9%$_{c}$	0.3%$_{d}$	5.0%
It is easier to heal	14.1%$_{a}$	3.1%$_{b}$	18.8%$_{a}$	24.4%$_{a}$	2.8%$_{b}$	5.8%
Other	0.7%$_{a}$	0.8%$_{a}$	6.2%$_{a}$	2.2%$_{a}$	64.5%$_{b}$	11.9%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Note: Values in the same row and sub-table not sharing the same subscript are significantly different at $p < .05$ in the two-sided test of equality for column proportions. Cells with no subscript are not included in the test. Tests assume equal variances.[1]

1 Tests are adjusted for all pairwise comparisons using the Bonferroni correction.

Data from group discussions with community members reveals a number of things about respondents' knowledge and practice regarding FGM/C. Among the Somali community in the study locations of Balambala and Habaswein, respondents consistently regard infibulation as the only harmful form of FGM/C, while other forms such as nicking the genital area or removal of flesh from the genital area are referred as "normal types". Secondly, they consistently link FGM/C to the teachings of Islam. Thirdly, data obtained from community members and key informants in the study locations of Balambala and Habaswein reveals that infibulation as a form of FGM/C is no longer practised and is considered as going against the teachings of Islam.

Key discussion points from key informants and community members are provided in the quotes below.

> Yes, they remove flesh… they remove flesh around the vagina, the vulva… circumcisions are different. There are two types of circumcision; the "suna" one which the girl will not be sewn and the other one we call the "firauni", after removing the part, they sew… we only practise the "suna" one, there is no issue of sewing.
>
> **FGD participant, female 15–17, Habaswein**
>
> There are ways that girls should be circumcised in regard to the religion of Islam. Even mutilation is not there nowadays. Cutting the body of a human being is not accepted anywhere. Just cutting or scratching a small part is allowed. You know Arabs, they don't cut their girls, but they just cut a small part… but the Somali way of cutting is the worst, including one similar to that in other communities like the Samburu, Maasai, Kikuyu and Turkana, and it is such practices that make a girl's life very bad. People with cows and camels and without farming are the ones making things complicated for their girls, and currently Kikuyus are stopping the practise.
>
> **Key informant interview, village elder, Balambala**
>
> Circumcision is categorised into two ways and the Somali community mostly don't follow the right procedure in doing the practice. Genital mutilation has been used previously, but currently nothing of that sort happens. Just the upper part is scratched.
>
> **FGD respondent, male 31 years old, Balambala**
>
> Only part of the female genitalia is scratched… in the olden days, mutilation and stitching of the female genital was practised. Such practice greatly reduced after people discovered the complications of such kinds of cutting.
>
> **FGD respondent, male 33 years old, Balambala**

Study data also shows that the type of FGM/C is also influenced by the girl undergoing circumcision. For example, it was widely noted across group discussion that girls are able to choose the type of FGM/C to undergo. What is of interest is that at times, they make "wrong choice", only to later request the "right" type of FGM/C. This change of mind is always informed by peer pressure, including ridicule from other girls who have noticed that a girl has not been circumcised the "right way" as they are. A key example is provided in the following quote.

> It all depends on the girl. If she wants the whole flesh to be taken out or just a small part ("suna") that is what will be done… there was a girl who was circumcised the suna way (removing just part of the flesh) and when they went to bathe in the river with the other girls, they laughed at her that she had not been circumcised the right way. When she went back home she told her parents to circumcise her like the other girls.
>
> **FGD respondent, female 38 years old, Wamba**

3.2.2.2 Performance of FGM/C

Key findings

- As reported by virtually all surveyed girls and women in the study locations of Balambala (99%), Kajiado Central (97%), Habaswein (95%) and Wamba, Sook and Laisamis (all 100%), FGM/C is mainly performed by traditional practitioners, specifically traditional circumcisers and traditional birth attendants.

- Survey results reveal some role of healthcare professionals in FGM/C in target communities. Only 1% of all surveyed girls and women comprising 3% in Habaswein, 5% in Kajiado Central, 1% in Balambala and 0% in Wamba, Sook and Laisamis reported that healthcare professionals are involved in the practice of FGM/C in their respective regions, mainly through administration of pain relief to girls and women prior to undergoing FGM/C. However, healthcare professionals are mostly involved in case of complications arising from FGM/C performed by traditional practitioners.
- Key complications as a result of performing FGM/C on girls and women include: continuous bleeding (77%); difficulty during childbirth (52%); infection (30%); pain during sex (25%); impaired reduced sexual satisfaction (9%); relationship problems with the husband (14%); and feelings of incompleteness (13%).
- Complications arising from FGM/C performed on daughters are mainly referred to traditional practitioners (54%) (comprising traditional circumcisers, traditional birth attendants and traditional healers) and healthcare professionals (46%).

Across all target counties, performing FGM/C is mainly a preserve of traditional circumcisers, as reported by virtually all surveyed girls and women in the study locations of Balambala (95%), Kajiado Central (97%), Habaswein (95%), Wamba (100%) and 99% in both Sook and Laisamis. Further analysis is provided in Table 32.

Table 32: Identity of persons performing FGM/C by region

Circumciser	Sub-county					
	Balambala sub-county n = 364	Kajiado Central sub-county n = 903	Habaswein sub-county n = 293	Laisamis sub-county n = 354	Sook division n = 746	Wamba division n = 772
Traditional circumciser	95%	97%	95%	100%	99%	99%
Traditional birth attendant	4%	1%	0%	0%	1%	1%
Doctor – healthcare professional	1%	2%	3%	0%	0%	0%
Nurse midwife – healthcare professional	0%	0%	2%	0%	0%	0%

The role of healthcare professionals in FGM/C in target communities is low. Only 1% of all surveyed girls and women comprising 3% in Habaswein, 5% in Kajiado Central, 1% in Balambala and 0% in Wamba, Sook and Laisamis reported that healthcare professionals perform FGM/C in their respective regions.

Further, there are no observable differences in the identity of the person performing FGM/C in rural and urban areas. As shown in Table 33, both rural and urban residents who participated in the baseline study reported that traditional circumcisers and traditional birth attendants perform FGM/C in virtually all cases.

Table 33: Identity of persons performing FGM/C in study locations by residence

Circumciser	Residence		
	Urban n = 393	Rural n = 3039	Total N = 3,432
Traditional circumciser	96%	98%	98%
Traditional birth attendant	1%	1%	1%
Doctor – healthcare professional	3%	1%	1%
Nurse midwife – healthcare professional	0%	0%	0%
Other	0%	0%	0%
Total	**100%**	**100%**	**100%**

However, what is evident from the survey data is that healthcare professionals are mostly involved in cases of complications arising from FGM/C performed by traditional practitioners. Survey results show that these complications mainly include continuous bleeding (77%), difficulty during childbirth (52%), infection (30%), pain during sex (25%), relationship problems with the husband (14%), feeling of incompleteness (13%) and impaired sexual satisfaction (9%).

As shown in Figure 18, complications as a result of FGM/C performed on daughters are mainly referred to traditional practitioners (54%) (comprising traditional circumcisers, traditional birth attendants and traditional healers) and healthcare professionals (46%).

Significantly more surveyed mothers in Balambala (71%) and Habaswein (69%), compared to Kajiado Central (50%), Laisamis (60%), Sook (26%) and Wamba (48%), had referred their circumcised daughters to traditional practitioners. By contrast, significantly more surveyed mothers in Sook (74%), compared to Balambala (29%), Habaswein (31%) Kajiado Central (50%), Laisamis (40%) and Wamba (52%) referred their sick daughters to healthcare professionals.

Significantly more surveyed mothers living in urban areas (64%), compared to those residing in rural areas (45%), referred their sick daughters to healthcare professionals. Further analysis is provided in Table 34.

Table 34: Proportions of girls and women who referred their circumcised daughters with complications to a practitioner

Practitioner	Region						Total n = 409	Residence		Total N = 409
	Balambala n = 96	Kajiado Central n = 50	Habaswein n = 80	Laisamis n = 47	Sook n = 96	Wamba n = 40		Urban n = 33	Rural n = 376	
Traditional circumciser	77%	48%	70%	55%	23%	53%	55%	39%	56%	55%
Traditional birth attendant	30%	2%	1%	9%	13%	0%	11%	0%	13%	11%
Traditional healers	20%	0%	0%	0%	5%	3%	6%	0%	7%	6%
Healthcare professional at home	25%	8%	6%	21%	43%	10%	22%	33%	20%	22%
Healthcare professional in the hospital	26%	42%	26%	19%	74%	43%	40%	36%	40%	40%
Community healthcare worker	0%	0%	0%	2%	0%	8%	1%	0%	1%	1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Study findings from group discussions and interviews with key informants corroborate the above findings. Specifically, and as presented in the quotes below, group participants cited an elaborate strategy when performing FGM/C in the target counties, complete with roles and responsibilities.

> The father gives permission to the girl so that she gets circumcised, brings the circumciser and looks for maize for making beer… mothers milk cows, prepare food and look for grass that her daughter will lie on as her wound is healing… brothers and sisters fetch water and assist their mother in food preparation… community leaders find a place where the circumcision process will take place… religious leaders bless the initiates… and community members come for celebration.
>
> **FGD respondent, female 40 years old, Sook**

Traditional practitioners (mainly traditional circumcisers or traditional birth attendants) from within the community are charged with the responsibility of performing FGM/C. They are usually older village women and in some cases wives of well-known village elders. Depending on the circumstances surrounding the circumcision, traditional practitioners have well-delineated responsibilities. During the usual circumcision of girls when they come of age, both the traditional circumciser and traditional birth attendant are involved in performing FGM/C. However, during childbirth emanating from premarital pregnancies involving uncut girls or pregnancies of returning "old" uncut girls, traditional birth attendants are charged with the responsibility of performing FGM/C prior to birth delivery.

> Okay, this circumcision is normally done by women, me as father am not even told, and men don't even do that, only mothers do it. I will see when the girl has been circumcised.
>
> **Key informant interview, administration official, Balambala**
>
> Culture has it that one cannot get married before going through FGM and in fact for those girls who evade the cut, when they go through marriage, before child-bearing they have to be cut. They are so entrenched in the culture about the cut that it's a taboo to give birth before you get circumcised.
>
> **Key informant interview, Department of Children Services, Kajiado County**

Further study findings show that traditional practitioners use crude tools such as a razor blade or knife for cutting and herbal medicine reducing pain, horn to enlarge the vaginal opening, ropes to tie girls undergoing circumcision, and, depending on the ethnic community, there is use of tea leaves and breast milk to alleviate pain during circumcision, or use of modern medicine including paracetamol for pain, anti-tetanus injections to prevent infection and antibiotics such as penicillin for healing the wound after circumcision.

Discussion points are provided in the quotes below.

> A traditional circumciser circumcises the girl… they come from the community within our villages… they use a knife and locally we drop breast milk on the wound to relieve pain… it works effectively.
>
> **FGD respondent, female 18–49, Sook**
>
> The flesh is removed. Thereafter the legs are tied together. If the vagina is sealed at the end, it is enlarged using a special type of horn… no the wound is not sewn, the legs are just tied together.
>
> **FGD respondent, female aged 18–49, Sook**

> To perform the circumcision, they use a razor blade… they also use tea leaves to stop the bleeding. After [she has been] cut, tea leaves are placed on the cut to stop bleeding… they also use an injection of tetanus before being circumcised. Beforehand, we inject the girl with the tetanus injection that may reduce the pain, and after we can use the capsules, medicine that heals the injured part like Amoxil, or even Panadol, are used which may reduce the pain and which mostly takes two to three days and the bleeding… it depends on one's body, some may bleed for a day others for just 30 minutes. But what takes time is the healing.
>
> **FGD participant, female 18–49, Habaswein**

As noted above, there is anecdotal evidence from group discussions on the possible use of healthcare professionals to carry out FGM/C in the target communities. However, it was noted that this is largely limited to administration of pain relief and is done in secrecy to protect the professional and also the girls and the family from ridicule since they will be considered "weak".

> Traditional women in the community carry out FGM/C… a razor blade is used… each uses her own blade for hygiene purposes: there is no way they will share because of infections and diseases… we just do it like that without any pain relief, but there are cowards whose use pain relief… those educated mothers, when their girls are being circumcised, they bring a nurse who injects a girl with pain relief before she goes to get circumcised, but that is done in secrecy between the mother, nurse and the girl.
>
> **FGD respondent, female 18–49, Wamba**

3.2.2.3 Intention to have daughters undergo FGM/C

Key findings

- Evidence of future circumcision of girls and women in the target communities exists. Approximately 32% of surveyed mothers/caregivers in Balambala, 47% in Kajiado Central, 19% in Habaswein, 38% in Laisamis, 46% in Sook and 51% in Wamba reported that they have daughters who are uncut, which was mainly attributed to the immaturity of their daughters at the time of the survey and refusal of their daughters to undergo circumcision. Of the surveyed mothers with uncut daughters, approximately 63% in Balambala, 25% in Kajiado Central, 84% in Habaswein, 27% in Laisamis, 38% in Sook and 43% in Wamba affirmed that they intend to circumcise their uncut daughters who were yet to undergo circumcision at the time of the survey.
- A lower proportion of surveyed mothers of Rendille origin (25%) and Maasai origin (25%), compared to 38% of the Pokot, 42% of the Samburu and 69% of the Somali stated that they intend to cut their uncut daughters in the future. Further, 67% of respondents of Muslim orientation, compared to 35% of both Catholics and Protestants, indicated that they intend to have their uncut daughters undergo FGM/C in the future.
- Intent to have FGM/C performed on uncut daughters decreases with increasing level of education; significantly more mothers with no education (48%, $p < 0.05$), compared to 29% with primary-level education and 7% with secondary-level education intend to have FGM/C performed on their uncut daughters in the future.

To assess dispositions towards the abandonment of FGM/C in the study locations, the baseline study sought to establish the proportion of mothers aged 15–49 that intend to have their uncircumcised daughters undergo FGM/C in the future. This indicator also contributes to the measurement of public acceptance and support for abandonment of the practice of FGM/C in the study locations.

Evidence of future circumcision of girls and women in the target communities exists. Approximately 32% of surveyed mothers/caregivers in Balambala, 47% in Kajiado Central, 19% in Habaswein, 38% in Laisamis, 46% in Sook and 51% in Wamba reported that they have daughters who are uncut, which was mainly attributed to the immaturity of their daughters at the time of the survey and refusal of their daughters to undergo circumcision. Of the surveyed mothers with uncut daughters, approximately 63% in Balambala, 25% in Kajiado Central, 84% in Habaswein, 27% in Laisamis, 38% in Sook and 43% in Wamba affirmed that they intend to circumcise their uncut daughters who were yet to undergo circumcision at the time of the survey.

Further analysis by ethnicity shows that a lower proportion of surveyed mothers of Rendille origin (25%) and Maasai origin (25%), compared to 38% of the Pokot, 42% of the Samburu and 69% of the Somali, stated that they intend to cut their uncut daughters in the future. Further, 67% of respondents of Muslim orientation, compared to 35% of both Catholics and Protestants, indicated that they intend to have their uncut daughters undergo FGM/C in the future.

In addition, intent to have FGM/C performed on uncut daughters decreases with increasing level of education. As shown in Table 35, significantly more mothers with no education (48%, $p < 0.05$), compared to 29% with primary-level education and 7% with secondary-level education, intend to have FGM/C performed on their uncut daughters in the future.

Table 35: Proportion of mothers who intend/do not intend to have FGM/C performed on their uncut daughters by level of education

Intention to have uncut daughters undergo FGM/C in the future	Level of education			
	No education	Primary education	Secondary education	College or higher
Yes	48.1%a	29.0%b	7.0%c	0.0%1
No	43.8%a	60.5%b	81.5%c	100.0%1
I am not sure	8.1%a	10.5%a	11.5%a	0.0%1

Note: Values in the same row and sub-table not sharing the same subscript are significantly different at p< .05 in the two-sided test of equality for column proportions. Cells with no subscript are not included in the test. Tests assume equal variances.[2]

1 This category is not used in comparisons because its column proportion is equal to zero or one.

2 Tests are adjusted for all pairwise comparisons using the Bonferroni correction.

Group discussions and interviews with key informants corroborate the above survey findings. A universal reason offered by community members in group discussions for intending to perform FGM/C on their uncut daughters in the future is to preserve their long-held traditions. This is supported by data from key informants in the target region, which shows that the practice is likely to be performed on uncut daughters in the future due to the deep-rooted nature of the practice, which is mainly attributed to the traditions passed from one generation to the next without question.

> Yes, we do talk about FGM/C as women… we discuss that we will circumcise our girls now and in the future… and it's a must.
>
> **FGD respondent, female 43 years old, Wamba**
>
> Yes, the practice will continue in the future… we need to convince them to stop the practice. That is where we want to struggle: although it is difficult to make them understand the issue, it is important for those in rural areas to be given more information concerning leaving the harmful practice of female genital mutilation. Some persist in doing it.
>
> **Key informant informant, CBO official, Balambala**

However, a considerable proportion of group discussion participants and key informants believe that due to the enforcement of anti-FGM laws in the study locations, the likelihood that daughters will be circumcised in the future is reduced. Key examples are the study locations of Kajiado Central and Wamba division, where key informants alluded to intensive enforcement of the anti-FGM laws, including interventions by state and non-state actors to eliminate the practice. As discussed in later sections of this report, a sharp decline in prevalence rates was observed in the two regions over the last 20 years.

> I said before… even if it is still there (of which am sure it has ended)… we have the Women Network who have dedicated themselves to stopping it. We had a case in Kenkue of a girl who was circumcised and she passed away. The Women Network reported the case and the parents were arrested and taken to court and I don't think the case is over. Since then, people have become very much afraid… so it will not be happening in future.
>
> **Key informant interview, village elder, Kajiado Central**

3.2.2.4 Age at undergoing FGM/C and marriage

Key findings

- Communities in Balambala (82%) and Habaswein (69%) reported that a majority of girls get circumcised when under 10 years old. However, communities in Kajiado Central (97%), Laisamis (75%), Sook (100%) and Wamba (91%) reported that a majority of girls are circumcised from age 10 and above. A majority of survey respondents with Somali origins (76%) indicated that they cut their daughters when under 10 years old, while a majority of surveyed Maasai (97%), Samburu (90%), Pokot (100%) and Rendille (77%) circumcise their daughters from 10 to 14 years old. Similarly, Muslim communities (76%) in the study locations generally cut their daughters when aged under 10, while communities professing Protestant (94%) and Catholic (91%) faiths generally cut their daughters when aged 10 and above.
- FGM/C is mostly associated with marriage in the Pokot in Sook and the Samburu in Wamba, compared to the Somali in Balambala and Habaswein, the Maasai in Kajiado Central and the Rendille in Laisamis. A significantly higher proportion of circumcised girls and women surveyed in Sook (83%) and Wamba (77%) ($p < 0.05$), compared to 53% in Balambala, 58% in Habaswein and 47% in Kajiado Central, were married off before reaching the age of 18. Further, 73% of circumcised girls and women with no education, compared to 54% with primary-level education, 24% with secondary-level education and 20% with college or higher level education were married before reaching the age of 18.

This study sought to estimate the age at which girls and women across the six study locations are circumcised. This is important in understanding the behaviour and practices of communities in the study locations regarding FGM/C.

As shown in Table 36, there are differences in the timing of circumcision. Communities in Balambala reported that a majority of girls (82%) are circumcised when under 10 years old: 69% when between 6 and 9 years old and 13% when under 5 years old. A similar scenario is observed in Habaswein sub-county. However, communities in Kajiado Central (97%), Laisamis (75%), Sook (100%) and Wamba (91%) reported that a majority of girls are circumcised from age 10 and above.

Table 36: Age at circumcision by region

Age at which daughters are circumcised	Sub-county					
	Balambala sub-county	Kajiado Central sub-county	Habaswein sub-county	Laisamis sub-county	Sook division	Wamba division
Under 5 yrs old	13%	0%	7%	0%	0%	0%
6–9 yrs old	69%	3%	62%	25%	0%	9%
10–14 yrs old	6%	59%	23%	36%	75%	63%
15–17 yrs old	8%	20%	3%	32%	24%	25%
Over 18 yrs old	4%	18%	4%	7%	1%	4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Analysis by ethnicity (Table 37) reveals a similar picture. A majority of survey respondents with Somali origins (76%) indicated that they cut their daughters when under 10 years old, while a majority of surveyed Maasai (97%), Samburu (90%), Pokot (100%) and Rendille (77%) circumcise their daughters from the age of 10 to 14 years old. Similarly, Muslim communities (76%) in the study locations generally cut their daughters when aged under 10, while communities professing Protestant (94%) and Catholic (91%) faiths generally cut their daughters when aged 10 and above.

Table 37: Age at circumcision by ethnicity

Age at which daughters are circumcised	Ethnicity				
	Maasai	Somali	Samburu	Pokot	Rendille
Under 5 years old	0%	10%	0%	0%	0%
6–9 years old	3%	66%	10%	0%	23%
10–14 years old	59%	14%	60%	75%	38%
15–17 years old	20%	6%	26%	24%	30%
More than 18 years old	18%	4%	3%	1%	8%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Further analysis of survey data from girls and women corroborates the above findings. For example, a look at the absolute median age at which girls are cut shows that in Habaswein, girls are cut at a median age of 6.5, while in Kajiado Central, girls are circumcised at a median age of 13.5. This is shown in Table 38 and Table 39, which the distribution of median ages at which daughters in Kajiado Central are circumcised. This picture is replicated across Laisamis, Sook and Wamba, which recorded median ages at circumcision of 10, 13 and 13 respectively.

Table 38: Median age at circumcision in Habaswein sub-county

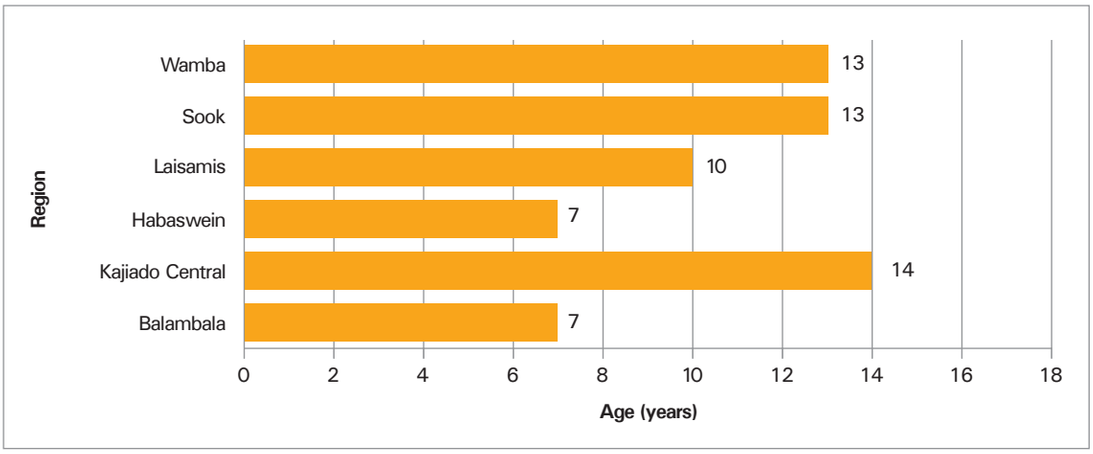
Measure	Daughters in Habaswein sub-county						Overall median age at circumcision (years)
	1st born daughter n = 72	2nd born daughter n = 37	3rd born daughter n = 11	4th born daughter n = 5	5th born daughter n = 2	6th born daughter n = 1	
Median age at circumcision	8.0	8.0	7.0	6.0	5.5	5.0	6.5

Table 39: Median age at circumcision in Kajiado Central sub-county

Measure	Daughters in Kajiado Central								Overall median age at circumcision (years)
	1st born daughter n = 176	2nd born daughter n = 108	3rd born daughter n = 50	4th born daughter n = 21	5th born daughter n = 11	6th born daughter n = 2	7th born daughter n = 1	8th born daughter n = 1	
Median age at circumcision	12.0	13.0	13.0	13.0	14.0	15.0	15.0	15.0	13.5

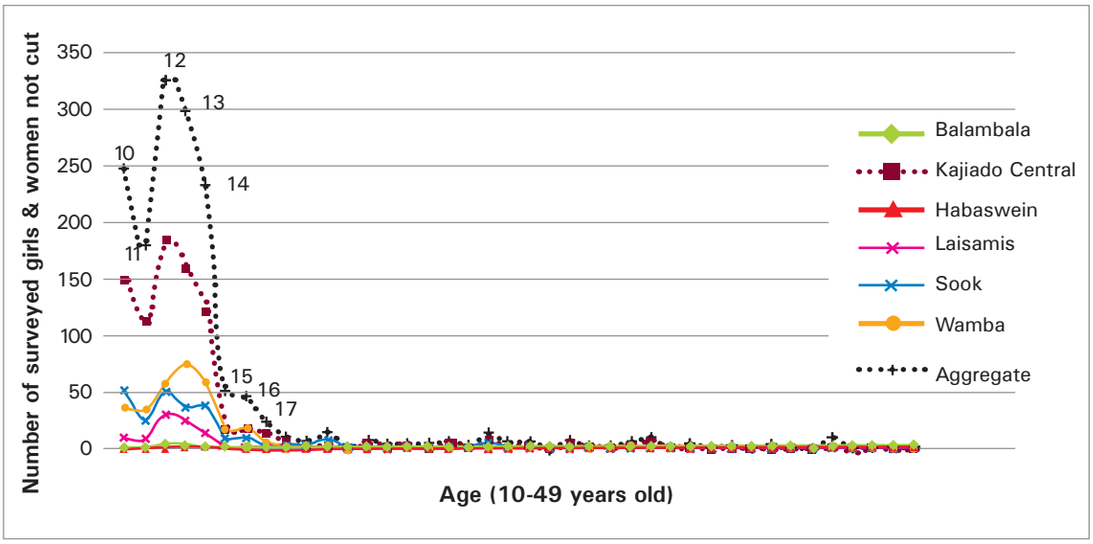
Overall, as presented in Figure 25, analysis of survey data shows that the median age of circumcision in the study locations ranges from approximately 7 years old in Balambala and Habaswein to a maximum of 14 years old in Kajiado Central.

Figure 25: Median age of circumcision in the study locations



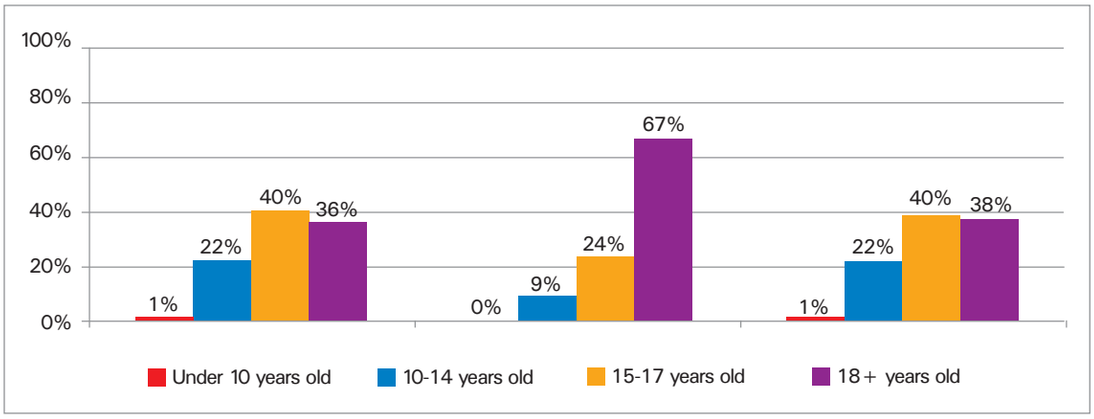
The study has thus established that girls in the study locations generally undergo circumcision when aged 0 to 15. This is further validated by the trend analysis as shown in Figure 26, which indicates a rapid decline to age 15 in the number of uncircumcised girls and plateauing from age 15 onwards. Subsequently, it can be assumed that the likelihood of an uncircumcised girl or woman undergoing circumcision after the age of 15 diminishes.

Figure 26: Trend analysis of proportion of girls and women that are uncircumcised across all ages from 10 to 49 (N = 1,527)



An analysis of the survey data to investigate the link between FGM/C and age at marriage was carried out. As shown in Figure 27, a significant proportion of cut girls and women (64%, $p < 0.05$) got married before reaching the age of 18, compared to only 33% of uncut girls and women.

Figure 27: Analysis of age at marriage of cut and uncut girls and women



Regional analysis shows that a significantly higher proportion of circumcised girls and women surveyed in Sook (83%) and Wamba (77%) ($p < 0.05$), compared to 53% in Balambala, 58% in Habaswein and 47% in Kajiado Central, were married off before reaching the age of 18.

Analysis of the survey data by level of education shows that 73% of circumcised girls and women with no education, compared to 54% with primary-level education, 24% with secondary-level education and 20% with college or higher level education were married before reaching the age of 18.

3.2.2.5 Support for continuation of FGM/C

Key findings

- A significant proportion of surveyed girls and women in Balambala (73%, $p < 0.05$), compared to 7% in Kajiado Central, 37% in Habaswein, 28% in Laisamis, 24% in Sook and 35% in Wamba, support the continuation of FGM/C in their respective communities. In addition, a significantly higher proportion of surveyed girls and women of Somali extraction (55%, $p < 0.05$), compared to 7% of the Maasai, 27% of the Samburu, 25% of the Pokot and 27% of the Rendille, support the continuation of the practice of FGM/C in their respective communities. Except for surveyed girls and women of Rendille origin, significantly more women aged 18–49, compared to girls aged 10–17 in all target ethnic communities, support continuation of FGM/C in their respective communities. Significantly more surveyed girls and women with no education, compared to 21% with primary-level education, 19% with secondary-level education and 11% with college or higher level education support the continuation of FGM/C in their respective communities.
- Across all study locations, survey results show that significantly more girls and women who have undergone FGM/C, compared to their uncut counterparts, support continuation of FGM/C. In Balambala, 74% of girls and women who have undergone FGM/C, compared to 18% who are not cut, support continuation of FGM/C. Figures for the remaining regions are: Kajiado Central (12% of uncut girls and women compared to 2% of uncut girls and women); Habaswein (38% of uncut girls and women compared to 11% of uncut girls and women); Laisamis (32% of uncut girls and women compared to 8% of uncut girls and women); Sook (29% of uncut girls and women compared to 12% of uncut girls and women); and Wamba (31% of uncut girls and women compared to 19% of uncut girls and women) supporting continuation of FGM/C.

- Significantly more boys and men surveyed in Balambala (60%, $p < 0.05$), compared to 5% in Kajiado Central, 39% in Habaswein, 25% in Laisamis, 33% in Sook and 37% in Wamba, support the continuation of FGM/C. With regard to ethnicity, a significantly higher proportion of the Somali (49%), compared to 34% of the Samburu and Pokot and 33% of the Rendille, support continuation of the practice of FGM/C. While no significant differences were observed in the level of support for continuation of FGM/C among urban and rural samples, significantly more surveyed boys and men of Muslim orientation (48%), compared to 18% of Protestants and 25% of Catholics, support the continuation of the practice of FGM/C. Among boys and men, support for the continuation of FGM/C reduces with increasing level of education: approximately 39% of surveyed boys and men with no education, compared to significantly lower proportions of respondents with primary-level education (20%), secondary-level education (17%) and college or higher level education (16%) support continuation of the practice of FGM/C.
- Key characteristics of surveyed girls and women who support the continuation of FGM/C in their respective communities are: they are largely from Balambala (70%), mainly of Somali extraction (55%), are largely of Muslim orientation (54%, $p < 0.05$), compared to Catholics (25%) and Protestants (16%); and largely, they have little to no education, as shown by 39% of survey respondents with no education ($p < 0.05$), 20% with primary-level education, 17% with secondary-level education and 16% with college or higher level education supporting continuation of FGM/C. They are mostly circumcised and older.

  Key characteristics of surveyed boys and men who support the continuation of FGM/C in their respective communities are: they are largely from Balambala (60%), mainly of Somali extraction (49%), mostly of Muslim orientation (48%, $p < 0.05$), compared to Catholics (25%) and Protestants (18%), and largely, they have little to no education, as shown by 43% of surveyed respondents with no education, compared to 23% with primary-level education, 24% with secondary-level education or 23% with college or higher level education.
- A universal reason provided by surveyed girls and women (as well as boys and men) for support of the continuation of FGM/C is “preservation of our culture”.

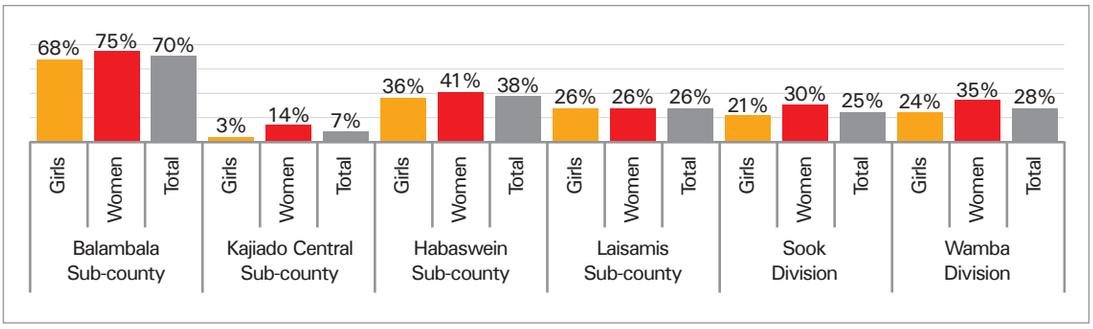
To assess support for the abandonment of FGM/C, respondents were asked whether they think that FGM/C should be continued. Across all study locations, survey results show that significantly more girls and women who have undergone FGM/C, compared to their uncut counterparts, support the continuation of FGM/C. In Balambala, 74% of girls and women who have undergone FGM/C, compared to 18% who are not cut, support continuation of FGM/C. For the remaining regions the comparative figures are: Kajiado Central (12% of uncut girls and women compared to 2% of uncut girls and women); Habaswein (38% of uncut girls and women compared to 11% of uncut girls and women); Laisamis (32% of uncut girls and women compared to 8% of uncut girls and women); Sook (29% of uncut girls and women compared to 12% of uncut girls and women); and Wamba (31% of uncut girls and women compared to 19% of uncut girls and women) supporting the continuation of FGM/C. Further analysis is provided in Table 40.

Table 40: Proportion of girls and women aged 10–49 supporting the continuation of FGM/C by status of FGM/C

Study locations	Category of respondents	Support continuation of FGM/C	
		Undergone FGM/C	Not undergone FGM/C
Balambala sub-county	Girls	72%	19%
	Women	76%	12%
	Total	**74%**	**18%**
Kajiado Central sub-county	Girls	6%	2%
	Women	15%	7%
	Total	**12%**	**2%**
Habaswein sub-county	Girls	37%	14%
	Women	42%	0%
	Total	**38%**	**11%**
Laisamis sub-county	Girls	38%	8%
	Women	26%	0%
	Total	**32%**	**8%**
Sook division	Girls	26%	13%
	Women	32%	5%
	Total	**29%**	**12%**
Wamba division	Girls	26%	20%
	Women	36%	0%
	Total	**31%**	**19%**

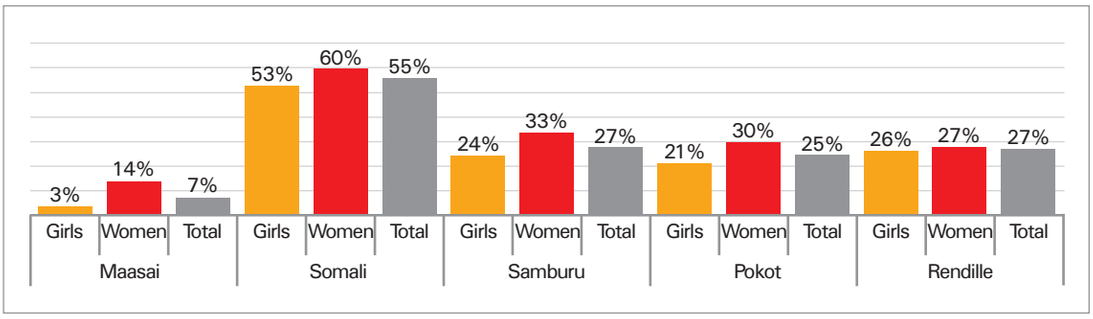
Specifically, a look at study locations and ethnic communities reveals that the practice of FGM/C is still deeply rooted. In Balambala, compared to other regions (including Habaswein, with which it shares cultural and religious values), 70% ($p < 0.05$) of all girls and women support continuation of the practice of FGM/C, compared to 7% in Kajiado Central, 38% in Habaswein, 26% in Laisamis, 25% in Sook and 28% in Wamba. Further analysis is shown in Figure 28.

Figure 28: Proportion of girls and women aged 10–49 supporting continuation of FGM/C by region



A similar observation is made at community level (Figure 29), where significantly higher proportions of surveyed girls and women of Somali extraction (55%, $p < 0.05$), compared to 7% of the Maasai, 27% of the Samburu, 25% of the Pokot and 27% of the Rendille, support continuation of the practice of FGM/C in their respective communities. Except for surveyed girls and women of Rendille origin, significantly more women aged 18–49, compared to girls aged 10–17 in all target ethnic communities, support continuation of FGM/C in their respective communities.

Figure 29: Proportion of girls and women aged 10–49 supporting continuation of FGM/C by ethnicity



As shown in Table 41, analysis by level of education shows that significantly more surveyed girls and women with no education, compared to 21% with primary-level education, 19% with secondary-level education and 11% with college or higher level education support the continuation of FGM/C in their respective communities.

Table 41: Proportion of girls and women aged 10–49 supporting continuation of FGM/C by education

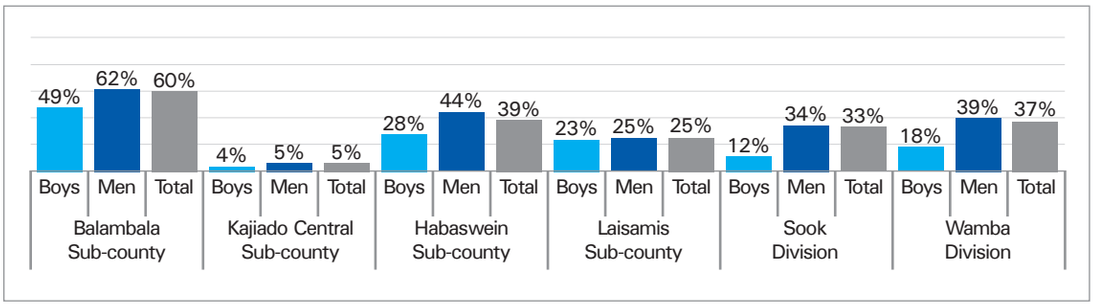
Support continuation of FGM/C	Level of education			
	No education	Primary education	Secondary education	College or higher
Yes	39.5%a	20.8%b	19.2%b	11.2%c
No	52.5%a	68.4%b	74.7%c	84.1%d
I am not sure	8.0%a	10.8%b	6.1%c	4.7%c

Note: Values in the same row and sub-table not sharing the same subscript are significantly different at $p < .05$ in the two-sided test of equality for column proportions. Cells with no subscript are not included in the test. Tests assume equal variances.[1]

1 Tests are adjusted for all pairwise comparisons using the Bonferroni correction.

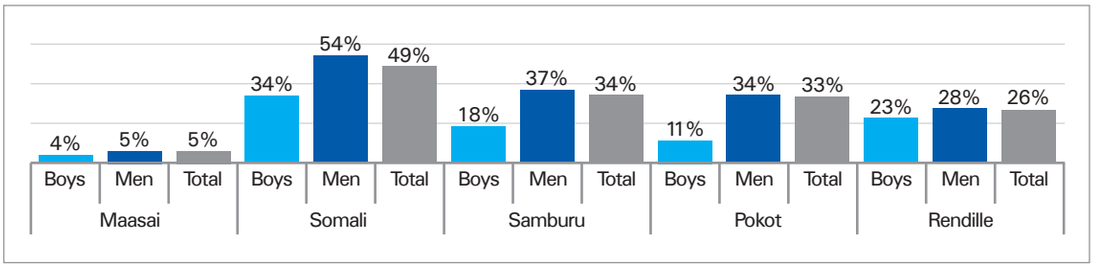
A look at data derived from surveyed boys and men (Figure 30) shows that significantly more respondents in Balambala (60%, $p < 0.05$), compared to 5% in Kajiado Central, 39% in Habaswein, 25% in Laisamis, 33% in Sook and 37% in Wamba, support the continuation of FGM/C.

Figure 30: Proportion of boys and men aged 15–49 supporting continuation of FGM/C by region



Analysis by ethnic communities shows that a significantly higher proportion of the Somali (49%), compared to 34% of the Samburu and Pokot and 33% of the Rendille, support continuation of the practice of FGM/C (Figure 31). While no significant differences were observed in the level of support for continuation of FGM/C among urban and rural samples, significantly more surveyed boys and men of Muslim orientation (48%), compared to 18% of Protestants and 25% of Catholics, support the continuation of the practice of FGM/C.

Figure 31: Proportion of boys and men aged 15–49 supporting continuation of FGM/C by ethnicity



Analysis by level of education shows that support for the continuation of FGM/C reduces with increasing level of education of surveyed boys and men. Approximately 39% of surveyed boys and men with no education, compared to significantly lower proportions of respondents with primary-level education (20%), secondary-level education (17%) and college or higher level education (16%), support continuation of the practice of FGM/C.

Analysis of the perceived reasons for supporting the continuation of FGM/C, as provided by surveyed boys and men, corroborates findings from the data for girls and women. The preservation of traditions is the universal reason provided for supporting the continuation of the practice, as indicated by 88% of surveyed boys and men in Balambala, 90% in Kajiado Central, 87% in Habaswein, 88% in Laisamis, 92% in Sook and 98% in Wamba. Further analysis is provided in Table 42.

Table 42: Reasons provided by boys and men aged 15–49 to support continuation of FGM/C by region

Reason for supporting continuation of FGM/C	Sub-county					
	Balambala sub-county	Kajiado Central sub-county	Habaswein sub-county	Laisamis sub-county	Sook division	Wamba division
To preserve our tradition	88%	90%	87%	88%	92%	98%
To ensure girls do not engage in premarital sex	23%	2%	22%	11%	13%	11%
Circumcised girls are clean, hygienic	56%	16%	35%	0%	44%	16%
Circumcised girls are mature and responsible	16%	13%	11%	11%	43%	22%
Circumcised girls do not have difficulty giving birth	1%	3%	7%	0%	0%	1%
Circumcised girls are religiously pure	21%	0%	17%	4%	1%	1%
Other	1%	2%	0%	0%	0%	0%

Group discussions with both women and men in the study locations support the above findings. As earlier discussed, group discussions revealed that FGM/C among the Maasai, the Pokot, the Samburu and the Rendille is mainly practised as a rite of passage signalling the transition from childhood to adulthood and so prepares the girl for marriage. However, when asked why they support continuation of the practice of FGM/C in their respective communities, FGD respondents mainly cited preservation of their long-held cultures passed to them from one generation to the next. One of the participants aptly captured this:

> Yes it should continue... It should continue because when the time comes for me to get married, my culture will not allow me to marry one who is not circumcised... culture has to be followed.
>
> **FGD respondent, male 40 years old, Laisamis**
>
> That is a bit difficult to answer because circumcision is part of culture that we inherited from our forefathers. So we are just continuing what we found... in fact it is difficult to trace the origin of circumcision.
>
> **FGD respondent, female 43 years old, Kajiado Central**
>
> As a father I will not allow a man to marry my daughter if she is not circumcised... mothers authorize circumcision, for example if all the girls have been circumcised, she says the daughter should also be circumcised.
>
> **FGD respondent, male 44 years old, Laisamis**
>
> Religious leaders also support FGM/C... even a pastor cannot marry one who is not circumcised.
>
> **FGD respondent, male 38 years old, Laisamis**

Other key reasons mentioned in group discussions include: a rite of passage signalling the transition from childhood to adulthood and hence readiness of the girl for marriage; to ensure purity before marriage through preservation of virginity and therefore family honour and dignity; and to reduce sexual urges and prevent premarital sex.

However, the effect of the existing anti-FGM laws and their enforcement was noted. A majority of respondents opposed to the continuation of the practice of FGM/C cited fear of arrest as key reason. This was largely recorded among respondents in Kajiado Central and Wamba, where it seems a lot of effort has been expended by the state in enforcing existing laws through intensive sensitization campaigns and education.

3.3 Child marriage

Key findings

- Approximately 18% of surveyed girls and women in Balambala and 19% in Habaswein provided the correct definition of a child, compared to 68% in Kajiado Central, 70% in Laisamis, 58% in Sook and 50% in Wamba, who correctly defined a child as a person who is aged under 18. However, a considerable proportion of surveyed girls and women defined a child in a number of incorrect ways including: being aged under 15, 10, 5 or 1; a person who is not circumcised; a person who is under the care of his/her parents/caregivers; a person who still goes to school; and a person who is not married or has not completed school. Knowledge of the definition of a child increases with increasing level of education, where significantly more secondary-level educated respondents (73%) and college-educated respondents (85%) ($p < 0.05$), compared to 40% of respondents with no education and 61% of respondents with primary-level education, correctly defined a child in line with the Convention on the Rights of the Child and the Children Act.
- A majority of surveyed boys and men in Kajiado Central (81%), Laisamis (77%), Sook (66%) and Wamba (62%) correctly defined a child, while significantly lower proportions of surveyed boys and men in Balambala (19%) and Habaswein (21%) ($p < 0.05$) provided the correct definition of a child. Among surveyed boys and men in Balambala and Habaswein, varied definitions of a child are evident. In Balambala, a child is mostly defined as a person who is under 1 year old (32%), while other definitions include one who is under 10 years old (16%), one who is not circumcised (13%), one who is under 15 years old or under 5 years old (10%). Nearly one half of surveyed boys and men in Habaswein (48%) define a child as a person who is under 5 years old, while 25% believe a child is one who is under 10 years old.

In the context of this study, knowledge about child marriage refers to possessing specific factual information about the concept of child marriage and its effects, which may or may not influence attitudes towards it. Key thematic areas covered in the baseline study to assess knowledge of child marriage are: definition of a child and adulthood; indicators for determining readiness for marriage; risks faced by girls due to child marriage; child marriage as a religious requirement; and the legality of child marriage in Kenya.

Survey data from girls and women aged 10 to 49 shows that approximately 18% of surveyed girls and women in Balambala and 19% in Habaswein provided the correct definition of a child, compared to 68% in Kajiado Central, 70% in Laisamis, 58% in Sook and 50% in Wamba, who correctly defined a child as a person who is aged under 18. However, as shown in Table 43, a considerable proportion of surveyed girls and women defined a child in a number of incorrect ways, including: being aged under 15, 10, 5 or 1; a person who is not circumcised; a person who is under the care of his/her parents/caregivers; a person who still goes to school; and a person who is not married or has

not completed school. In general, surveyed respondents from Balambala believe that a child is a person who is less than 1 year old (34%), while others believe that a child is a person aged under 15 (16%), under 10 (16%) or under 5 (8%). In Habaswein, almost half of girls and women surveyed (45%) define a child as a person who is under 5 years of age. Further analysis is provided in Table 43.

Table 43: Definition of a child by girls and women by region

Perceived definition of a child	Study location					
	Balambala sub-county n = 433	Kajiado Central sub-county n = 1950	Habaswein sub-county n = 324	Laisamis sub-county n = 460	Sook division n = 1003	Wamba division n = 1121
A child is a person who is under 1 year old	34%	7%	3%	20%	2%	2%
A child is a person who is under 5 years old	8%	1%	45%	6%	8%	1%
A child is a person who is under 10 years old	16%	6%	30%	2%	14%	7%
A child is a person who is under 15 years old	16%	11%	2%	0%	11%	12%
A child is a person who is under 18 years old	18%	68%	19%	70%	58%	50%
A child is a person who still goes to school	0%	4%	0%	0%	2%	1%
A child is a person under the care of his/her parents/ caregivers	0%	2%	1%	2%	2%	10%
A child is a person who is not circumcised	7%	0%	0%	0%	3%	15%

The above observation is consistent with results from analysis by ethnic communities in the study locations, where significantly fewer Somali respondents (17%, $p < 0.05$), compared to the Maasai (67%), the Samburu (46%), the Pokot (63%) and the Rendille (69%), correctly defined "a child". The Muslims mainly associated with the Somalis have less understanding of the definition of a child (19%, $p < 0.05$), compared to other respondents of Protestant (67%) and Catholic (54%) orientation.

Further analysis of the definitions of a child by level of education shows that knowledge of the correct terminology increases with the level of education. Specifically, survey data shows significant differences between secondary- or college-educated respondents and respondents with primary-level or no education. Significantly more secondary-educated respondents (73%, $p < 0.05$) and college-educated respondents (85%), compared to

40% of respondents with no education and 61% of respondents with primary-level education, correctly defined a child in line with the Convention on the Rights of the Child and the Children Act.

There are significant differences between urban and rural residents with regard to knowledge of the correct definition of a child. Significantly more surveyed girls and women residing in urban areas (70%, $p < 0.05$), compared to 52% of rural-based respondents, correctly defined a child.

Significant differences were also observed between circumcised and uncircumcised girls and women, revealing a possible link between the practice of FGM/C and child marriage. Specifically, significantly more uncircumcised girls and women (62%, $p < 0.05$), compared to their circumcised counterparts, (52%) provided a correct definition of a child.

Significant differences were also observed between girls and women married off when aged over 18 and under 18, with analysis of the survey data showing that knowledge of the definition of a child increases with age at marriage: 45% of surveyed girls and women married when aged 10–14, compared to 51% married at 15–17 years old and 68% married when at least 18 years of age, correctly defined a child.

A look at survey data from boys and men in the study locations shows that a majority of surveyed respondents in Kajiado Central (81%), Laisamis (77%), Sook (66%) and Wamba (62%) correctly defined a child, while significantly lower proportions of surveyed boys and men ($p < 0.05$) in Balambala (19%) and Habaswein (21%) provided the correct definition. Among surveyed boys and men in Balambala and Habaswein, varied definitions of a child are evident. In Balambala, a child is mostly defined as a person who is under 1 year old (32%), while other definitions include one who is under 10 years old (16%), one who is not circumcised (13%), and one who is under 15 years old or under 5 years old (10%). Nearly one half of surveyed boys and men in Habaswein (48%) define a child as a person who is under 5 years old, while 25% believe a child is one under 1 year old.

Analysis of data from group discussions with girls and women and boys and men confirms the above findings. While a majority of FGD participants indicated that a child is anyone aged under 18, a considerable number of respondents across all regions had varied definitions of a child depending on existing or past traditions affecting children. Practices such as FGM/C, child marriage and therefore physical signs of maturity, or the ability to perform certain tasks, influence the definition of a child where anyone, whether aged below or above 18 who is not circumcised is considered a child. In addition, the first menstruation of a girl signals adulthood, and only then is a girl considered an adult, thus influencing other practices such as child marriage and FGM/C.

This is aptly captured in the discussion quotes below:

> A child is a person who is not circumcised. Even if you are old and haven't been circumcised you are still a child… even in men.
>
> **FGD respondent, male 32 years old, Laisamis**
>
> A child is from zero years to 14 years. Even a boy who is below 14 years is a child and cannot be circumcised. If a boy can carry a calf from the bush where it is being delivered to the homestead then he is good to go, he is a man.
>
> **Key informant interview, village elder, Kajiado Central**

3.3.1 Prevalence of child marriage

Key findings

- Survey data from all girls aged 10–17 and boys aged 15–17 shows high child marriage prevalence rates. Approximately 15% of girls aged 20–24 in Balambala, 28% in Kajiado Central, 58% in Habaswein, 44% in Laisamis, 64% in Sook and 22% in Wamba reported being married before reaching the age of 18.. By ethnicity, 28% of the surveyed girls of Maasai origin, 38% of Somali origin, 17% of Samburu origin, 64% of Pokot origin and 54% of Rendille origin got married before reaching the age of 18.
- Approximately 30% of boys aged 20–24 in Balambala, 1% in Kajiado Central, 0% in Habaswein and Wamba, 3% in Laisamis and 38% in Sook got married before reaching the age of 18. By ethnicity, 1% of the surveyed boys aged 20–24 of Maasai origin, 14% of Somali origin, 0% of Samburu origin, 4% of Rendille origin and 38% of Pokot origin got married before reaching the age of 18.

In this study, regional prevalence rates of child marriage were computed using the ratio of surveyed girls and women aged 20–24 or boys aged 20–24 who reported that they were married/once married (numerator) to the total number of surveyed girls and women aged 20–24 or surveyed boys aged 20–24 (denominator).

Accordingly, survey data from all girls and women aged 20–24 indicates high prevalence rates of child marriage. As shown in Figure 32, approximately 15% of girls aged 20–24 in Balambala, 28% in Kajiado Central, 58% in Habaswein, 44% in Laisamis, 64% in Sook and 22% in Wamba reported being married before reaching the age of 18.

Figure 32: Prevalence of child marriage among girls and women aged 10–49 by region (N = 3,300)

Sub-county/ Division	Age group (years old)	Marital status			Total
		Never married	Married when less than 18 years old	Married when aged at least 18 years old	
Balambala sub-county	10—17	96.2%	2.5%	1.3%	100.0%
	18—19	41.0%	29.8%	29.2%	100.0%
	20—24	8.4%	15.2%	76.5%	100.0%
	25—49	5.8%	45.9%	48.4%	100.0%
Kajiado Central sub-county	10—17	99.7%	.3%	0.0%	100.0%
	18—19	75.1%	13.9%	11.0%	100.0%
	20—24	36.2%	27.6%	36.1%	100.0%
	25—49	4.4%	43.3%	52.3%	100.0%
Habaswein sub-county	10—17	99.1%	.9%	0.0%	100.0%
	18—19	50.5%	49.5%	0.0%	100.0%
	20—24	33.4%	57.8%	8.8%	100.0%
	25—49	23.3%	37.9%	38.8%	100.0%
Laisamis sub-county	10—17	99.0%	.7%	.3%	100.0%
	18—19	78.1%	0.0%	21.9%	100.0%
	20—24	25.0%	44.5%	30.4%	100.0%
	25—49	8.3%	52.5%	39.2%	100.0%

Sub-county/ Division	Age group (years old)	Marital status			Total
		Never married	Married when less than 18 years old	Married when aged at least 18 years old	
Sook Division	10—17	98.7%	1.3%	0.0%	100.0%
	18—19	42.5%	57.5%	0.0%	100.0%
	20—24	21.4%	64.1%	14.5%	100.0%
	25—49	2.0%	78.5%	19.5%	100.0%
Wamba Division	10—17	98.4%	1.6%	0.0%	100.0%
	18—19	70.6%	29.4%	0.0%	100.0%
	20—24	71.4%	22.1%	6.5%	100.0%
	25—49	7.8%	69.9%	22.2%	100.0%

Analysis by ethnicity (Figure 33) shows that 28% of the surveyed girls of Maasai origin, 38% of Somali origin, 17% of Samburu origin, 64% of Pokot origin and 54% of Rendille origin indicated that they got married before reaching the age of 18.

Figure 33: Prevalence of child marriage among girls and women aged 10–17 by ethnicity (N = 1,257)

Ethnicity	Age group	Marital status			Total
		Never married	Married when less than 18 years old	Married when aged at least 18 years old	
Maasai	10—17	99.7%	.3%	0.0%	100.0%
	18—19	75.1%	13.9%	11.0%	100.0%
	20—24	36.2%	27.6%	36.1%	100.0%
	25—49	4.4%	43.3%	52.3%	100.0%
Somali	10—17	97.5%	1.8%	.7%	100.0%
	18—19	45.3%	38.7%	16.0%	100.0%
	20—24	21.8%	38.0%	40.2%	100.0%
	25—49	13.0%	42.6%	44.4%	100.0%
Samburu	10—17	98.5%	1.5%	0.0%	100.0%
	18—19	70.6%	29.4%	0.0%	100.0%
	20—24	77.6%	17.3%	5.1%	100.0%
	25—49	9.1%	67.6%	23.3%	100.0%
Pokot	10—17	98.7%	1.3%	0.0%	100.0%
	18—19	42.5%	57.5%	0.0%	100.0%
	20—24	21.4%	64.1%	14.5%	100.0%
	25—49	2.0%	78.6%	19.5%	100.0%
Rendille	10—17	98.9%	.8%	.3%	100.0%
	18—19	78.1%	0.0%	21.9%	100.0%
	20—24	8.9%	54.1%	37.0%	100.0%
	25—49	5.5%	54.3%	40.2%	100.0%

A look at the data for surveyed boys and men shows that 30% of boys aged 20–24 in Balambala, 1% in Kajiado Central, 0% in Habaswein and Wamba, 3% in Laisamis and 38% in Sook indicated that they got married before reaching the age of 18.

Figure 34: Prevalence of child marriage among boys and men aged 20–24 by region (N = 1,251)

Sub-county/Division	Age group (years old)	Marital status			Total
		Never married	Married when less than 18 years old	Married when aged at least 18 years old	
Balambala sub-county	10—17	77.5%	15.0%	7.5%	100.0%
	18—19	44.7%	36.3%	19.0%	100.0%
	20—24	19.2%	30.1%	50.7%	100.0%
	25—49	9.3%	18.0%	72.7%	100.0%
Kajiado Central sub-county	10—17	100.0%	0.0%	0.0%	100.0%
	18—19	100.0%	0.0%	0.0%	100.0%
	20—24	90.8%	1.1%	8.1%	100.0%
	25—49	12.8%	3.4%	83.7%	100.0%
Habaswein sub-county	10—17	97.9%	2.1%	0.0%	100.0%
	18—19	83.3%	5.9%	10.8%	100.0%
	20—24	97.2%	0.0%	2.8%	100.0%
	25—49	27.9%	1.6%	70.4%	100.0%
Laisamis sub-county	10—17	100.0%	0.0%	0.0%	100.0%
	18—19	100.0%	0.0%	0.0%	100.0%
	20—24	93.4%	3.3%	3.3%	100.0%
	25—49	12.2%	13.0%	74.8%	100.0%
Sook Division	10—17	94.1%	5.9%	0.0%	100.0%
	18—19	69.8%	15.7%	14.4%	100.0%
	20—24	38.7%	38.1%	23.3%	100.0%
	25—49	3.8%	24.5%	71.8%	100.0%
Wamba Division	10—17	100.0%	0.0%	0.0%	100.0%
	18—19	100.0%	0.0%	0.0%	100.0%
	20—24	76.9%	0.0%	23.1%	100.0%
	25—49	5.2%	7.5%	87.3%	100.0%

Analysis by ethnicity (Figure 35) shows that 1% of the surveyed boys aged 20–24 of Maasai origin, 14% of Somali origin, 0% of Samburu origin, 4% of Rendille origin and 38% of Pokot origin stated that they got married before reaching the age of 18.

Figure 35: Prevalence of child marriage among boys and men aged 20–24 by ethnicity (N = 1,251)

Ethnicity	Age group (years old)	Marital status			Total
		Never married	Married when less than 18 years old	Married when aged at least 18 years old	
Maasai	10—17	100.0%	0.0%	0.0%	100.0%
	18—19	100.0%	0.0%	0.0%	100.0%
	20—24	90.8%	1.1%	8.1%	100.0%
	25—49	13.5%	3.4%	83.1%	100.0%
Somali	10—17	90.1%	7.0%	2.9%	100.0%
	18—19	61.9%	22.7%	15.4%	100.0%
	20—24	61.6%	13.7%	24.7%	100.0%
	25—49	16.6%	11.3%	72.1%	100.0%
Samburu	10—17	100.0%	0.0%	0.0%	100.0%
	18—19	100.0%	0.0%	0.0%	100.0%
	20—24	81.8%	0.0%	18.2%	100.0%
	25—49	5.0%	7.3%	87.7%	100.0%
Pokot	10—17	94.5%	5.5%	0.0%	100.0%
	18—19	69.8%	15.7%	14.4%	100.0%
	20—24	38.7%	38.1%	23.3%	100.0%
	25—49	3.8%	24.5%	71.8%	100.0%
Rendille	10—17	100.0%	0.0%	0.0%	100.0%
	18—19	100.0%	0.0%	0.0%	100.0%
	20—24	95.6%	4.4%	0.0%	100.0%
	25—49	12.9%	13.7%	73.3%	100.0%

3.2.2 Practice, perceptions and experiences of child marriage

3.2.2.1 Reasons for practising child marriage

Key findings

- Common reasons for practising child marriage include: personal choice of girls themselves; a better bride price; existing poverty and hardship; traditional requirements; social pressure ("other girls are doing it"); and pressure from the father.
- A majority of surveyed girls and women in Balambala (60%) and Habaswein (59%) and a considerable proportion in Kajiado Central (44%) and Sook (36%) believe that the practice of child marriage is mainly driven by the girls themselves who demand to be married off before reaching the age of 18, possibly in following established norms. In Laisamis (73%), Sook (52%) and Wamba (42%), the practice of child marriage is believed to be influenced by the opportunity of obtaining a better bride price, possibly driven by existing hardship and poverty in these regions.

- A majority of surveyed boys and men in Laisamis (66%), Sook (61%) and Wamba (47%) believe that child marriage is practised in their respective communities since "younger girls" fetch a better bride price. This could be influenced by poverty, which was cited by a considerable proportion of surveyed boys and men in Laisamis (46%), Sook (37%) and Wamba (48%). In Balambala (60%), Kajiado Central (52%) and Habaswein (53%), a majority of respondents indicated that child marriage is mainly driven by the girls themselves, possibly due to the fact that it is the norm, as reported by as reported by 30%, 10% and 27% in Balambala, Kajiado Central and Habaswein respectively.
- The influence of fathers in pressurizing their daughters to get married before reaching the age of 18 is considerably evident in Kajiado Central, Sook and Wamba.

Analysis of drivers of the practice of child marriage in the study locations shows that child marriage is also a manifestation of gender inequality and embedded in complex socio-cultural, economic and political structures. Similar to the practice of FGM/C, child marriage as practised in the study locations is mostly associated with benefits both to the girl and her family, which is essential to its continuation.

A closer look at the reasons for practising child marriage in all study locations reveals a practice perpetuated by the girl and her parents, especially the father, boys and men, other girls and women, and the community at large. As shown in the quotes below, peer pressure from married girls is one of the chief reasons for the practice of child marriage and its continuation. Consequently, through influence exerted by married girls, unmarried girls pressure their parents to be married off, thus perpetuating the practice of child marriage.

> It is due to peer influence that some decide to get married early... When a girl has married friends, she also wants to get married.
>
> **FGD respondent, female 18–49, Balambala**

Just as with the practice of FGM/C, child marriage is perpetuated through negative outcomes in the form of punishment through condemnation, ridicule and ostracism, and positive outcomes through rewards in the form of recognition, celebrations and approval at community and social levels, as well as through personal and social benefits such as "following the norm", a better bride price and alleviation of poverty for the parents.

As shown in Table 44, the practice of child marriage occurs for a number of reasons that vary across study locations and cultures. Despite the variations, study results reveal that common reasons for the practice are tied to four key factors: personal choice of girls themselves; a better bride price; existing poverty and hardship; traditional requirements; social pressure ("other girls are doing it"); and pressure from the father.

A majority of surveyed girls and women in Balambala (60%) and Habaswein (59%) and a considerable proportion in Kajiado Central (44%) and Sook (36%) believe that the practice of child marriage is mainly driven by the girls themselves who demand to be married off before reaching the age of 18. This could be attributed to the existing norm where girls are married off before reaching the age of 18, as reported by considerable proportions of respondents in Balambala (28%), Habaswein (23%) and Sook (23%).

In Laisamis, Sook and Wamba, the practice of child marriage is mainly believed to be influenced by the opportunity for obtaining a better bride price, as reported by 73%, 52% and 42% of surveyed respondents in these three study locations respectively.

This could be driven by existing hardship and poverty in these regions, as reported by a considerable proportion of surveyed girls and women in Laisamis (40%), Sook (41%) and Wamba (49%).

The influence of fathers was considerably evident in Kajiado Central, Sook and Wamba, as reported by 14%, 15% and 19% of surveyed respondents in these three regions respectively. Further analysis is provided in Table 44.

Table 44: Reasons provided by girls and women for the practice of child marriage in their respective communities by region

Reasons for practising child marriage	Study location					
	Balambala sub-county n = 433	Kajiado Central sub-county n = 1950	Habaswein sub-county n = 324	Laisamis sub-county n = 460	Sook division n = 1003	Wamba division n = 1121
Personal choice of girls to get married	60%	44%	59%	22%	36%	12%
Because other girls in the community are married/get married before reaching the age of 18 years	28%	8%	23%	9%	23%	9%
For a better bride price	32%	23%	19%	73%	52%	42%
Due to hardship, poverty	16%	22%	15%	40%	41%	49%
Traditional culture demands it	20%	30%	12%	15%	32%	34%
Daughters want to get married	2%	7%	0%	0%	10%	1%
Pressure from father	6%	14%	1%	0%	13%	19%
Pressure from mother	5%	1%	0%	0%	9%	6%
Pressure from husband	5%	6%	0%	0%	4%	3%
Pressure from brothers, sisters	0%	1%	0%	0%	4%	3%
Pressure from friends	0%	7%	0%	0%	7%	3%
To gain respect in the community	1%	5%	9%	0%	4%	8%
Religion demands it	2%	3%	14%	0%	1%	1%
Lack of knowledge of child rights	6%	7%	7%	0%	6%	9%
Lack of knowledge of effects of child marriage on girls	5%	6%	7%	0%	6%	7%
Protecting girls from premarital sex/ pregnancy	2%	0%	9%	0%	1%	4%
Men's preference for pure girls, virgins	0%	0%	1%	0%	1%	1%

Data obtained from boys and men in the study locations corroborates the above survey findings. According to surveyed boys and men, girls are married mainly for four reasons: personal choice of girls in the target communities; to fetch a better bride price; to alleviate poverty for girls' parents; and as demanded by traditions and culture; and because of social pressure ("other girls are doing it").

A majority of surveyed boys and men in Laisamis (66%), Sook (61%) and Wamba (47%) believe that child marriage is practised in their respective communities since younger girls fetch a better bride price. This could be influenced by poverty, which was cited by a considerable proportion of surveyed boys and men in Laisamis (46%), Sook (37%) and Wamba (48%).

In Balambala (60%), Kajiado Central (52%) and Habaswein (53%), a majority of respondents indicated that child marriage is mainly driven by the girls themselves, possibly due to the fact that it is the norm, as reported by 30%, 10% and 27% in Balambala, Kajiado Central and Habaswein respectively. Further analysis is provided in Table 45.

Table 45: Reasons provided by boys and men for the practice of child marriage in their respective communities by region

Reasons for practising child marriage	Study location					
	Balambala sub-county n = 176	Kajiado Central sub-county n = 509	Habaswein sub-county n = 158	Laisamis sub-county n = 99	Sook division n = 245	Wamba division n = 170
Personal choice of girls to get married	60%	52%	53%	26%	25%	14%
Because other girls in the community are married/get married before reaching the age of 18 years	30%	10%	27%	10%	17%	19%
For a better bride price	40%	17%	37%	66%	61%	47%
Due to hardship, poverty	18%	22%	26%	46%	37%	48%
Traditional culture demands it	26%	25%	15%	16%	29%	27%
Daughters want to get married	2%	5%	0%	3%	9%	2%
Pressure from father	6%	5%	1%	1%	9%	23%
Pressure from mother	5%	0%	1%	3%	7%	3%
Pressure from husband	1%	5%	0%	1%	3%	5%
Pressure from brothers, sisters	0%	0%	0%	0%	5%	6%
Pressure from friends	0%	2%	0%	0%	7%	6%
To gain respect in the community	1%	1%	8%	2%	3%	11%

Reasons for practising child marriage	Study location					
	Balambala sub-county n = 176	Kajiado Central sub-county n = 509	Habaswein sub-county n = 158	Laisamis sub-county n = 99	Sook division n = 245	Wamba division n = 170
Religion demands it	1%	1%	9%	0%	0%	0%
Lack of knowledge of child rights	4%	2%	10%	8%	5%	17%
Lack of knowledge of effects of child marriage on girls	4%	2%	8%	1%	6%	15%
Protecting girls from premarital sex/ pregnancy	2%	0%	5%	0%	1%	6%
Men's preference for pure girls, virgins	0%	0%	3%	1%	1%	1%

Group discussions and interviews with key informants reveal similar reasons for the practice of child marriage. Peer pressure from married girls was the most cited reason in all group discussions, thus attributing the practice and its continuation to the girls themselves. Also commonly cited in the group discussions was pressure from family members due to fear of "revenge missions" carried out by other potential families with daughters for marriage. Specifically, failing to accept a proposition from one family for your daughter's hand in marriage might in future have similar consequences for both your sons and daughters alike.

> Once you come to ask for my daughter and I refuse for you to marry her, tomorrow, if somebody in my family asks for a girl to marry, he will be rejected. By refusing my daughter today because she has not reached the age of 18 years, somebody from my family will suffer because of that.
>
> **Key informant interview, administration official, Balambala**

Poverty as a key reason for practising child marriage is historical. In Kajiado Central, a key informant traced the rampant practice of child marriage to the drought that hit Kenya in 1984 or thereabouts, when communities lost livestock. As a coping mechanism, very young girls were married off, thus attracting a better bride price in form of livestock and so restoring the status of the girls' families.

Across all study locations, poverty, closely linked to a better bride price, was cited as a key reason for practising child marriage, in addition to peer influence, fear of revenge and as a requirement of the prevailing culture.

In 1984, we were hit by a severe drought that affected us greatly. We lost cows and goats and this led to poverty. So those who had girls in their family gave them out for marriage so as to get a dowry which was in the form of cows and goats. It became so rampant and that's how early child marriage erupted. Before that, the Maasai did not circumcise small girls and boys. A boy was circumcised at 20 years and for a girl, the mother had to see that she was ready. But because of the poverty levels at that time, things changed. That's from 1984 to 2000.

Key informant interview, village elder, Kajiado Central

Well, it is because of poverty, school dropout or even pregnancy of an orphan child and there is no one to take care of them but we have tried a lot to return these girls to school and they have advanced well and that is the trend we are pushing forward.

Key informant interview, administration official, Wamba

Poverty… the girl would like to get married before the age of 18 because back home she may have a problem, maybe she has lost her mother, she is not with a good parent to take care of her so she is forced to get married so that she can find someone to care for her.

FGD respondent, woman 32 years old, Habaswein

Because you get a young clean woman who is not used up… and also a man should marry a girl below his age. It's not a must they are of the same age.

FGD respondent, man 28 years old, Laisamis

3.3.2.2 Awareness of risks of child marriage

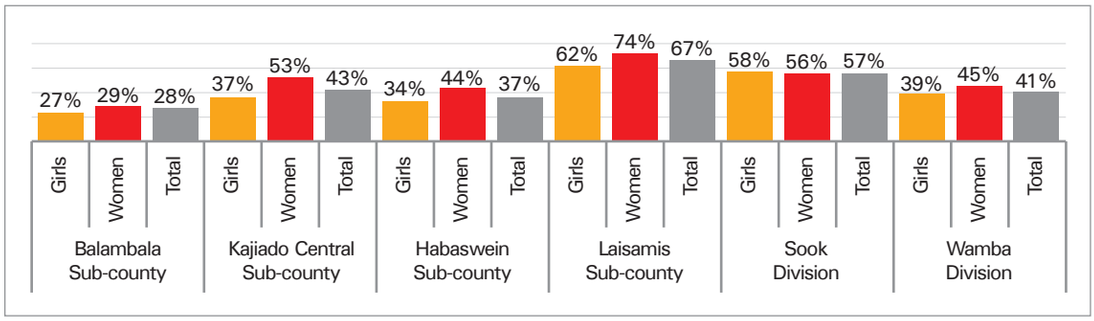
Key findings

- Risks of child marriage include health complications and social consequences: specific health complications cited were mainly fistula, death of mother and of new-born, pre-term birth, difficulty during childbirth, pain during sex and the risk of infections. Social consequences included dropping out of school, lack of general decision-making ability in the household due to being of a young age and key consequences such an increased number of pregnancies.
- Approximately 28% of surveyed girls and women in Balambala, 43% in Kajiado Central, 37% in Habaswein, 67% in Laisamis, 57% in Sook and 41% in Wamba are aware of the risks that girls and women face as a result of child marriage. Significantly higher proportions of surveyed girls and women of Pokot (68%), Laisamis (60%), Maasai (43%) and Samburu (40%) extraction, compared to the Somali (29%), have knowledge of the risks associated with child marriage. Slightly more respondents living in urban areas (52%), compared to their rural counterparts, are aware of the risks of child marriage.
- A majority of surveyed boys and men in Laisamis (63%) and Sook (62%), compared to 34% in Balambala, 46% in Kajiado Central, 48% in Habaswein and 47% in Wamba, were aware of the risks of child marriage. Further, 61% of surveyed boys and men of Pokot origin, 60% of the Rendille, 52% of the Samburu, 46% of the Maasai and 41% of the Somali reported being aware of the risks of child marriage.
- Awareness of the risks associated with child marriage increases with increasing level of education. Approximately 40% of surveyed girls and women with no education, compared to 46% with primary-level education, 62% with secondary-level education and 65% with college or higher level education, reported having

knowledge of the risks associated with child marriage. With regard to surveyed boys and men, approximately 43% of them with no education, compared to 54% with primary-level education, 50% with secondary-level education and 53% with college or higher level education reported having knowledge of the risks associated with child marriage.

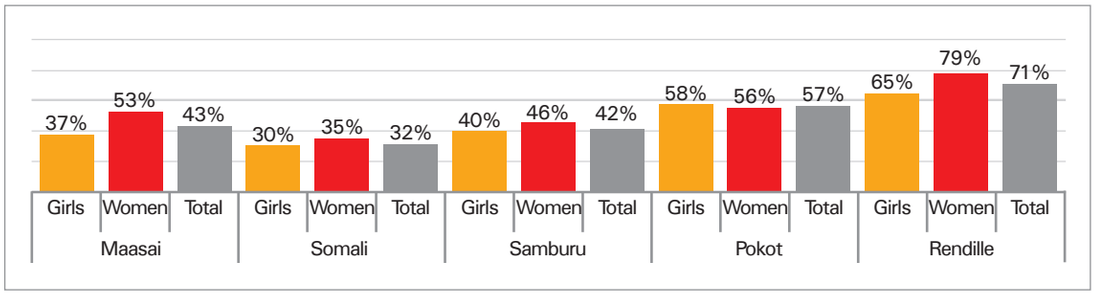
As shown in Figure 36, survey results show that approximately 28% of surveyed girls and women in Balambala, 43% in Kajiado Central, 37% in Habaswein, 67% in Laisamis, 57% in Sook and 41% in Wamba are aware of the risks that girls and women face as a result of child marriage.

Figure 36: Proportion of girls and women aged 10–49 aware of risks of child marriage by region



Analysis by ethnicity shows that significantly higher proportions of surveyed girls and women of Pokot (68%), Laisamis (60%), Maasai (43%) and Samburu (40%) extraction, compared to the Somali (29%) have knowledge of the risks associated with child marriage (Figure 37). Slightly more respondents living in urban areas (52%), compared to their rural counterparts, are aware of the risks of child marriage.

Figure 37: Proportion of girls and women aged 10–49 aware of risks of child marriage by ethnicity



Awareness of the risks associated with child marriage increases with increasing level of education of surveyed girl or woman. Approximately 40% of surveyed girls and women with no education, compared to 46% with primary-level education, 62% with secondary-level education and 65% with college or higher level education, reported having knowledge of the risks associated with child marriage.

Table 46: Awareness of risks associated with child marriage reported by girls and women by level of education

Aware of risks of child marriage	Level of education			
	No education	Primary education	Secondary education	College or higher
Yes	39.9%a	46.4%b	61.6%c	65.3%c
No	60.1%a	53.6%b	38.4%c	34.7%c

Note: Values in the same row and sub-table not sharing the same subscript are significantly different at p< .05 in the two-sided test of equality for column proportions. Cells with no subscript are not included in the test. Tests assume equal variances.[1,2]

1 Tests are adjusted for all pairwise comparisons using the Bonferroni correction.

2 Cell counts of some categories are not integers. They were rounded to the nearest integers before performing column proportions tests.

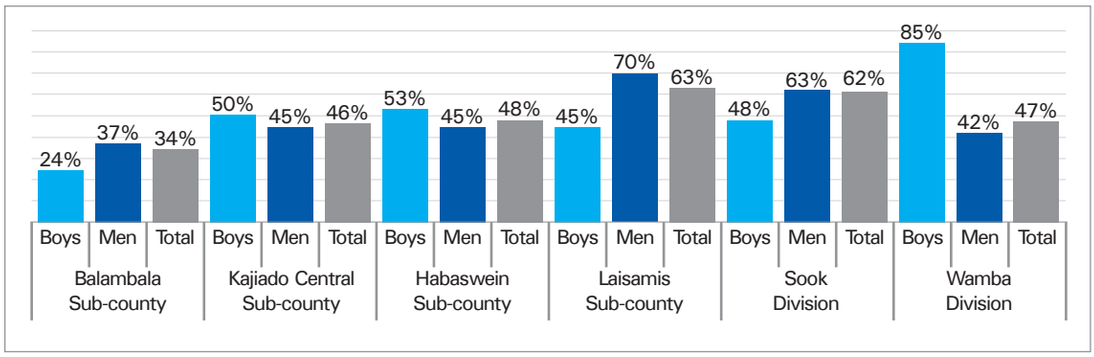
As reported by surveyed girls and women, survey data shows that the risks of child marriage are broad, spanning health complications and social consequences. Specifically, key associated risks of child marriage include: health complications, mainly fistula and death of mother and of new-born, pre-term birth, difficulty during childbirth, pain during sex and risk of infection; and social consequences such as dropping out of school, lack of general decision-making ability in the household due to being of a young age and coming with key consequences such as an increased number of pregnancies and violence. Further analysis is provided in Table 47.

Table 47: Awareness of risks associated with child marriage reported by girls and women by region

Perceived risks associated with child marriage	Sub-county					
	Balambala sub-county n = 109	Kajiado Central sub-county n = 832	Habaswein sub-county n = 109	Laisamis sub-county n = 306	Sook division n = 605	Wamba division n = 442
Death of mother as a result of pregnancy	35%	17%	16%	32%	48%	51%
Death of new-born	45%	4%	12%	45%	30%	28%
Increased number of pregnancies	77%	18%	44%	13%	17%	24%
Pre-term birth	1%	7%	36%	1%	17%	7%
Fistula	2%	3%	39%	0%	49%	3%
Lack of decision-making in the household because of young age	22%	55%	51%	20%	41%	30%
Difficulty during childbirth	16%	43%	21%	22%	25%	32%
Pain during sex	8%	1%	4%	4%	14%	4%
Risk of infection	0%	3%	2%	0%	15%	17%
Dropping out of school	7%	17%	6%	3%	38%	23%

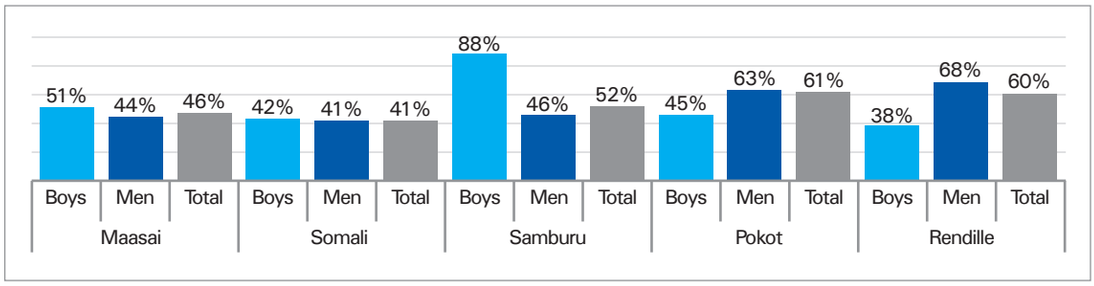
Equally, a majority of surveyed boys and men in Laisamis (63%) and Sook (62%), compared to 34% in Balambala, 46% in Kajiado Central, 48% in Habaswein and 47% in Wamba, are aware of the risks of child marriage. Further analysis is provided in Figure 38.

Figure 38: Proportion of boys and men aged 15–49 aware of risks of child marriage by region



Survey results show that 61% of surveyed boys and men of Pokot origin, 60% of the Rendille, 52% of the Samburu, 46% of the Maasai and 41% of the Somali reported being aware of the risks of child marriage (Figure 39).

Figure 39: Proportion of boys and men aged 15–49 aware of risks of child marriage by ethnicity



Awareness of the risks associated with child marriage increases with increasing level of education of surveyed boy or man. Approximately 43% of surveyed boys and men with no education, compared to 54% with primary-level education, 50% with secondary-level education and 53% with college or higher level education, reported having knowledge of the risks associated with child marriage.

Table 48: Awareness of risks associated with child marriage reported by boys and men by level of education

Awareness of risks of child marriage	Level of education			
	No education	Primary education	Secondary education	College or higher level education
Yes	43.4%$_{a}$	53.8%$_{b}$	50.2%$_{c}$	53.0%$_{b,c}$
No	56.6%$_{a}$	46.2%$_{b}$	49.8%$_{c}$	47.0%$_{b,c}$

Note: Values in the same row and sub-table not sharing the same subscript are significantly different at $p < .05$ in the two-sided test of equality for column proportions. Cells with no subscript are not included in the test. Tests assume equal variances.[1,2]

1 Tests are adjusted for all pairwise comparisons using the Bonferroni correction.

2 Cell counts of some categories are not integers. They were rounded to the nearest integers before performing column proportions tests.

Largely, surveyed boys and men believe that child marriage causes difficulty during childbirth. Other perceived risks of child marriage include pain during sex, death and dropping out of school by the affected girl. Further analysis by study location is provided in Table 49.

Table 49: Awareness of risks associated with child marriage reported by boys and men by region

Perceived risks associated with child marriage	Study location					
	Balambala sub-county n = 60	Kajiado Central sub-county n = 234	Habaswein sub-county n = 71	Laisamis sub-county n = 61	Sook division n = 146	Wamba division n = 71
Difficulty during childbirth	72%	85%	88%	92%	80%	78%
Pain during sex	48%	5%	65%	34%	19%	10%
Death	38%	9%	10%	6%	38%	40%
Dropping out of school	45%	25%	33%	29%	69%	55%

Group discussions and interviews with key informants corroborate the above study findings. Specifically, discussion participants and key informants all agreed that child marriage has attendant risks which are health related as well as affecting the married girl socially. Largely, surveyed informants and group participants cited complications during childbirth, including post-birth complications such as fistula, and dropping out of school as the main consequences of child marriage.

> The risks are a lot. This is a small girl and when she gets pregnant and her hips are small therefore she will get problems when carrying the pregnancy. She has not learned how to keep her husband. In our community, mothers teach their daughters how to keep their families; she has not been taught that since she is still a child. So she faces a lot of problems, this being one of them.
>
> **Key informant interview, administration official, Balambala**
>
> They get problems while giving birth because their bodies are not well developed… when giving birth they give birth usually through operation.
>
> **FGD respondent, female 34 years old, Habaswein**
>
> It is reported that a girl may run away and sometimes suffer from depression, which could lead to family breakup. The girl may suffer complications during giving birth also. In our area, most young mothers deliver through C-section, which is contributed by early child marriage.
>
> **Key informant interview, CBO official, Balambala**
>
> Yes, they find it hard to give birth in a normal way… fistula. No more breaks, urine just falls as she feels the urge.
>
> **FGD respondent, female 38 years old, Sook**

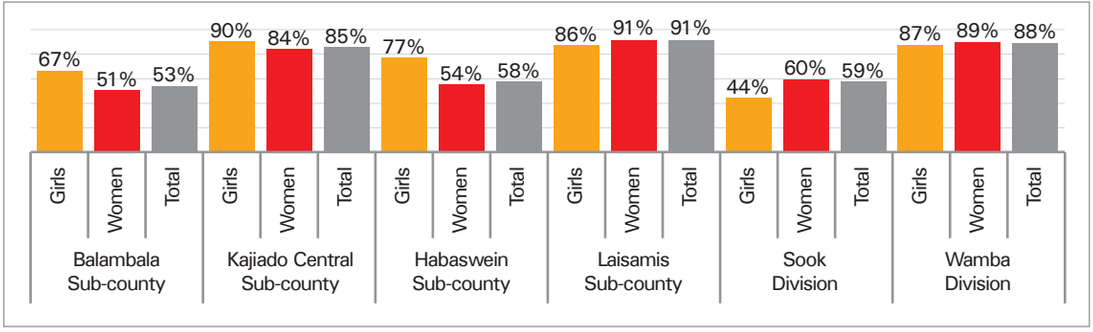
3.3.2.3 Knowledge of prohibition of child marriage in Kenya and support for continuation of child marriage

Key findings

- Approximately 53% of surveyed girls and women in Balambala, 85% in Kajiado Central, 58% in Habaswein, 91% in Laisamis, 59% in Sook and 88% in Wamba indicated that the practice is outlawed in Kenya. By ethnicity, approximately 85% of surveyed girls and women of Maasai origin, 55% of the Somali, 89% of the Samburu, 59% of the Pokot and 90% of the Rendille are aware that the practice of child marriage is outlawed in Kenya.
- Approximately 54% of surveyed boys and men in Balambala, 91% in Kajiado Central, 69% in Habaswein, 90% in Laisamis, 77% in Sook and 90% in Wamba are aware that child marriage is illegal in Kenya. By ethnicity, approximately 91% of surveyed boys and men of Maasai origin, 61% of the Somali, 90% of the Samburu, 77% of the Pokot and 90% of the Rendille are aware that the practice of child marriage is outlawed in Kenya.
- A significantly lower proportion of surveyed girls and women from Kajiado Central (2%), compared to respondents in Balambala (34%), Habaswein (15%), Laisamis (15%), Sook (15%) and Wamba (12%), believe that the practice of child marriage should continue in their respective communities. By ethnicity, approximately 2% of surveyed girls and women of Maasai origin, 26% of the Somali, 12% of the Samburu, 15% of the Pokot and 17% of the Rendille believe that the practice of child marriage should continue in their respective communities.
- A higher proportion of surveyed boys and men in Balambala (33%), Sook (33%), Habaswein (25%) and Laisamis (24%), compared to 2% in Kajiado Central and 15% in Wamba, support the continuation of child marriage in their respective communities. By ethnicity, a higher proportion of surveyed boys and men of Pokot origin (33%), Rendille origin (26%) and Somali origin (29%), compared to approximately 2% of surveyed boys and men of Maasai origin and 14% of the Samburu, believe that child marriage should continue in their respective communities.

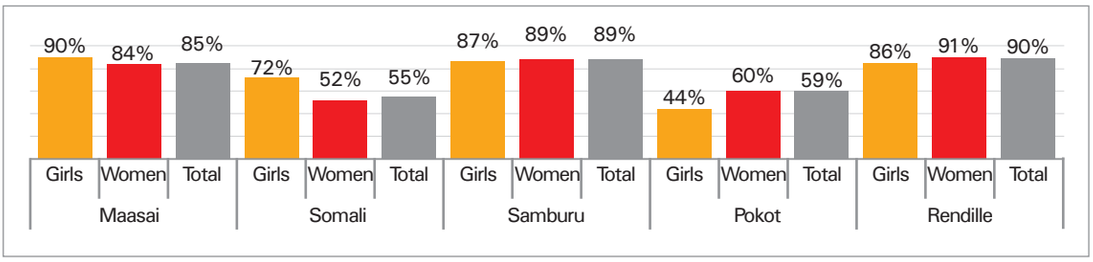
To test the knowledge of surveyed girls and women aged 10–49 on the legality of child marriage in Kenya, they were asked whether the practice of child marriage has been abolished by the government. As shown in Figure 40, approximately 53% of surveyed girls and women in Balambala, 85% in Kajiado Central, 58% in Habaswein, 91% in Laisamis, 59% in Sook and 88% in Wamba indicated that the practice is outlawed in Kenya.

Figure 40: Proportion of girls and women aged 10–49 who believe that the practice of child marriage has been abolished in Kenya by region



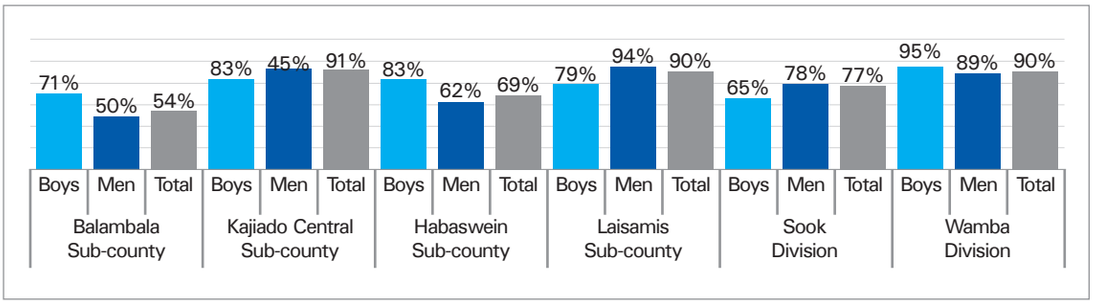
Analysis by ethnicity (Figure 41) shows that approximately 85% of surveyed girls and women of Maasai origin, 55% of the Somali, 89% of the Samburu, 59% of the Pokot and 90% of the Rendille are aware that the practice of child marriage is outlawed in Kenya.

Figure 41: Proportion of girls and women aged 10–49 who believe that the practice of child marriage has been abolished in Kenya by ethnicity



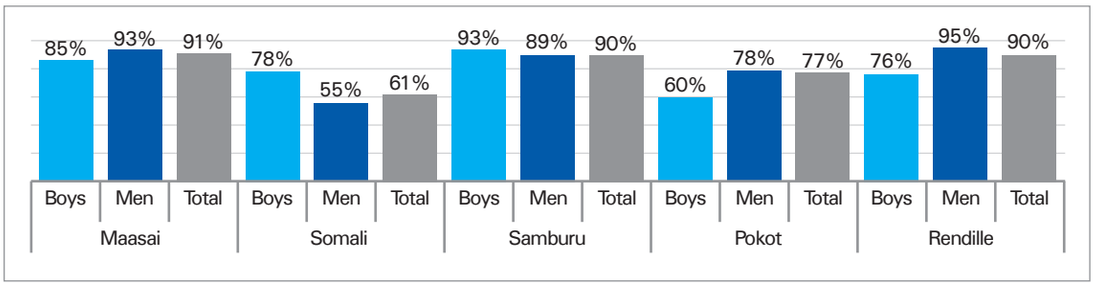
A look at survey data from boys and men (Figure 42) shows that approximately 54% of surveyed boys and men in Balambala, 91% in Kajiado Central, 69% in Habaswein, 90% in Laisamis, 77% in Sook and 90% in Wamba are aware that child marriage is illegal in Kenya.

Figure 42: Proportion of boys and men aged 15–49 who believe that the practice of child marriage has been abolished in Kenya by region



Analysis by ethnicity (Figure 43) shows that approximately 91% of surveyed boys and men of Maasai origin, 61% of the Somali, 90% of the Samburu, 77% of the Pokot and 90% of the Rendille are aware that the practice of child marriage is outlawed in Kenya.

Figure 43: Proportion of boys and men aged 15–49 who believe that the practice of child marriage has been abolished in Kenya by ethnicity



Findings from group discussions show that most community members are indeed aware that the practice of child marriage has been outlawed by the Government of Kenya.

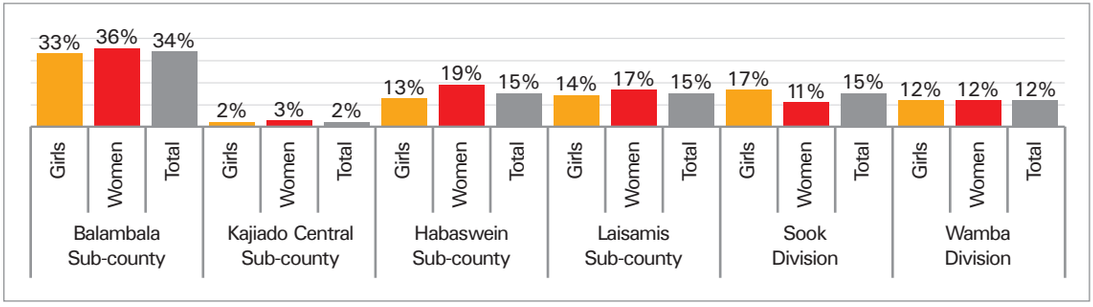
However, the practice is deep rooted in the study locations and has well-understood and respected punishment connotations surrounding any defiance from the girl or her family with regard to child marriage. Thus the prevailing culture and these considerations over-ride the laws that prohibit child marriage.

Study findings show that according to tradition girls must submit to instructions or advice from their parents when a decision is made on marriage. Where defiance is observed, curses follow. In addition, there is the matter of prevailing culture being passed from one generation to the next. This has influenced the practice of child marriage in other ways, such as peer pressure where girls in groups demand to be married off to be "like other girls in the community".

> Yes, the laws on children are there, but people carry on with the cultural practices… If the girl has a complaint, she will tell her father that she has not reached the age to be married, but even the girl herself is ready to be married, so in such situation what do you do? At seven years, she gets what women get and she is ready for marriage. In the past, you could see a girl who is over 20 years and still not married, but nowadays you will not be surprised to see small girls who want to get married.
>
> **Key informant interview, village elder, Balambala**
>
> Girls below 18 years get married in this community to a very large extent… this is because of the cultural belief among the community. It is cultural belief, if a lady stays more at home, she is regarded as a woman who has been rejected, so the earlier she gets married the better. Those are cultural beliefs; the early marriage is going at higher rate… If a girl is not married early like other girls, other girls will see her as somebody who has been rejected by the community because once a man has refused to marry her, they start teasing her. It will make her feel ashamed.
>
> **Key informant interview, administration official, Balambala**

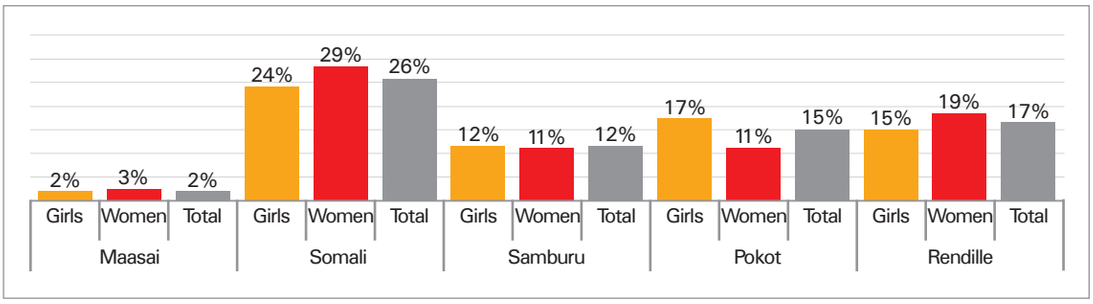
Regarding support for the continuation of child marriage, a significantly lower proportion of surveyed girls and women from Kajiado Central (2%), compared to respondents in Balambala (34%), Habaswein (15%), Laisamis (15%), Sook (15%) and Wamba (12%), believe that the practice of child marriage should continue in their respective communities.

Figure 44: Proportion of girls and women aged 10–49 who believe that the practice of child marriage should continue in their communities by region



Analysis by ethnicity (Figure 45) shows that approximately 2% of surveyed girls and women of Maasai origin, 26% of the Somali, 12% of the Samburu, 15% of the Pokot and 17% of the Rendille believe that the practice of child marriage should continue in their respective communities.

Figure 45: Proportion of girls and women aged 10–49 who believe that the practice of child marriage should continue in their communities by ethnicity



Significantly higher proportions of girls and women with no education (19%), compared to those with primary-level education (11%), secondary-level education (6%) and college or higher level education (3%), support the continuation of child marriage in their respective communities.

Table 50: Support for continuation of child marriage reported by girls and women by level of education

Support continuation of child marriage	Level of education			
	No education	Primary education	Secondary education	College or higher
Yes	19.3%a	10.7%b	6.0%c	2.6%d
No	68.9%a	78.8%b	87.9%c	88.4%c
Don't know	11.7%a	10.5%b	6.1%c	9.0%a,b

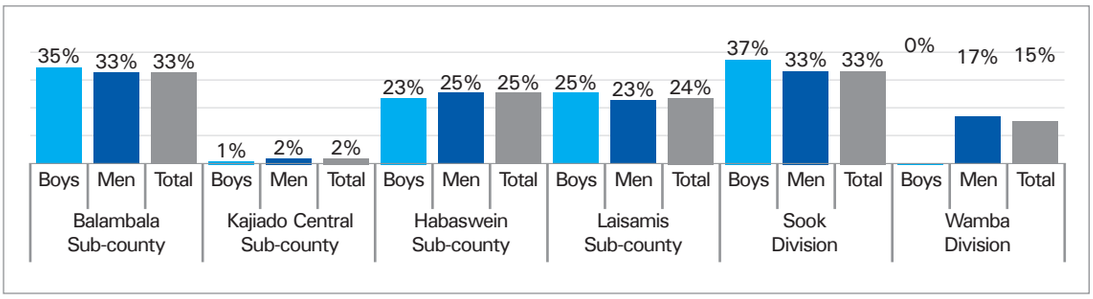
Note: Values in the same row and sub-table not sharing the same subscript are significantly different at p< .05 in the two-sided test of equality for column proportions. Cells with no subscript are not included in the test. Tests assume equal variances.[1,2]

1 Tests are adjusted for all pairwise comparisons using the Bonferroni correction.

2 Cell counts of some categories are not integers. They were rounded to the nearest integers before performing column proportion tests.

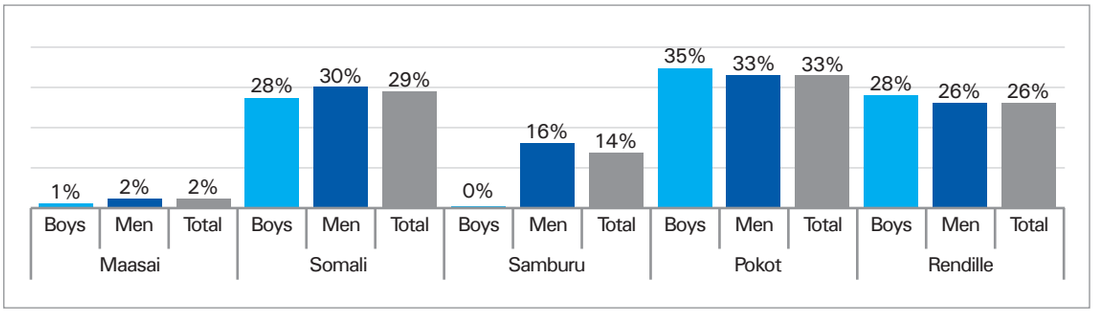
A look at the survey data from boys and men (Figure 46) shows that a higher proportion of surveyed boys and men in Balambala (33%), Sook (33%), Habaswein (25%) and Laisamis (24%), compared to 2% in Kajiado Central and 15% in Wamba, support the continuation of child marriage in their respective communities.

Figure 46: Proportion of boys and men aged 15–49 who believe that the practice of child marriage should continue in their communities by region



Analysis by ethnicity (Figure 47) shows that a higher proportion of surveyed boys and men of Pokot origin (33%), Rendille origin (26%) and Somali origin (29%), compared to approximately 2% of surveyed boys and men of Maasai origin and 14% of the Samburu, believe that child marriage should continue in their respective communities.

Figure 47: Proportion of boys and men aged 15–49 who believe that the practice of child marriage should continue in their communities by ethnicity



Further, significantly higher proportions of surveyed boys and men with no education (27%), compared to those with primary-level education (22%), secondary-level education (14%) and college or higher level education (4%), support the continuation of child marriage in their respective communities (Table 51).

Table 51: Support for continuation of child marriage reported by boys and men by level of education

Support continuation of child marriage	Level of education			
	No education	Primary education	Secondary education	College or higher education
Yes	$26.9\%_{a}$	$21.7\%_{b}$	$14.5\%_{c}$	$4.4\%_{d}$
No	$61.8\%_{a}$	$71.8\%_{b}$	$80.3\%_{c}$	$83.1\%_{c}$
I don't know	$11.4\%_{a}$	$6.5\%_{b}$	$5.3\%_{b}$	$12.5\%_{a}$

Note: Values in the same row and sub-table not sharing the same subscript are significantly different at $p < .05$ in the two-sided test of equality for column proportions. Cells with no subscript are not included in the test. Tests assume equal variances.[1,2]

1 Tests are adjusted for all pairwise comparisons using the Bonferroni correction.

2 Cell counts of some categories are not integers. They were rounded to the nearest integers before performing column proportions tests.

The above study findings are congruent with data obtained through group discussions and from key informants. As earlier discussed, peer pressure is one of the possible key drivers for the continuation of child marriage. However, nearly all FGD participants and key informants are in agreement that child marriage is anchored in prevailing norms passed from one generation to the next, so driving the practice and support for its continuation. Consequently, when asked about possible reasons for supporting the continuation of the practice of child marriage, nearly all cited "to preserve our traditions". Other popular reasons included: to preserve family honour through the marriage of "pure and clean girls" whose virginity is intact; to prevent premarital sex, including possible prostitution; to respect one's parents and elders; and to bestow responsibility on children at a younger age to ensure early maturity.

No, she cannot refuse because of the culture and traditions… It's something that was there… it is our culture… so we can continue to marry before she reaches the age of 18.

FGD respondent, male 41 years old, Laisamis

Yes, we support it to continue… when a girl reaches adolescence, some become very stubborn and say they want a husband… It is better if she gets married rather than going out and becoming immoral… we do not entertain that.

FGD respondent, male 32 years old, Balambala

No, she has no right to resist child marriage… we are the parents and the child belongs to us. So we decide for her whether or not she will get married.

FGD respondent, female 31 years old, Balambala

All of us support that this child marriage should be stopped… girls have a right to resist it… but a parent can say you don't have a right because he is your parent and you must take his orders and that's the only way.

FGD respondent, female 35 years old, Habaswein

However, a majority of community members do not support the continuation of the practice of child marriage. As mentioned earlier, poverty is a key reason for the practice of child marriage. Nevertheless, data from group discussions with community members shows that they place a value on the education of their daughters and count on education as key factor in reducing the practice of child marriage in their respective communities.

When asked to explain why they support abandonment of the practice of child marriage, nearly all indicated that stopping it will ensure that all their daughters attend school and do not drop out of school. In addition, they are aware of the rights of a child, including a right to be involved in decision-making, a right not to be discriminated against and a right to freedom from violence, which they link with existing laws that ban child marriage and seek to protect children. They also believe that the abandonment of child marriage will ensure that health complications arising from child marriage are eliminated.

I'd say it shouldn't continue because you see if you marry an 11-year-old, she cannot be a wife. You will have denied her her youth and she cannot be a wife because she has no experience in handling some things. Also the government does not allow a girl below the age of 18 to get married. You can be arrested… it is the girls' right.

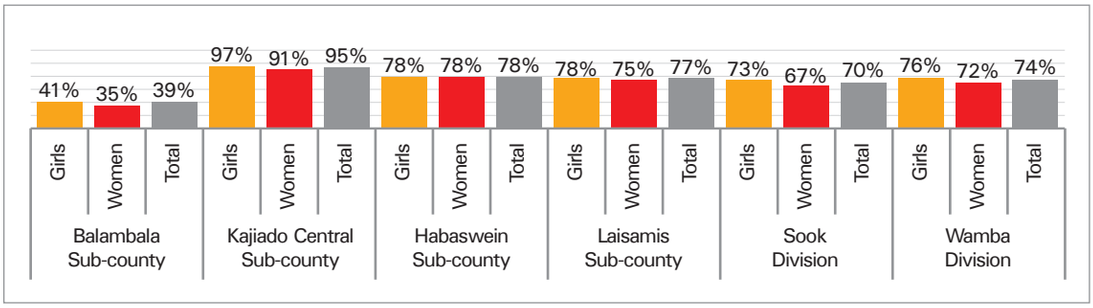
FGD respondent, male 31 years old, Laisamis

We girls have a right to resist child marriage…it should be abolished… we need a better life for our daughter, we want our daughters to proceed with her education… stop those health problems because of child marriage

FGD respondent, male 25 years old, Sook

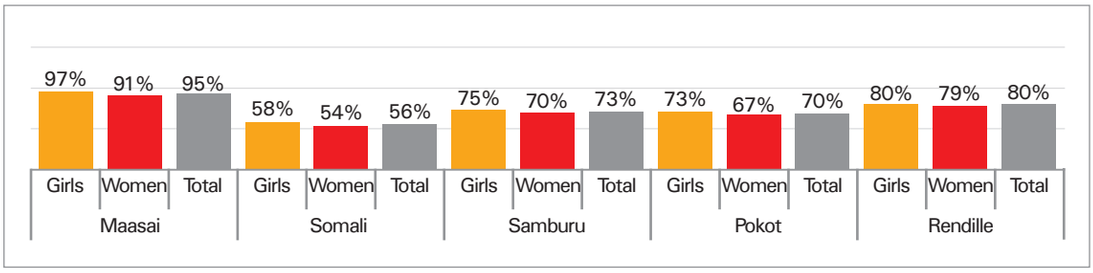
To further assess attitudes towards child marriage, surveyed girls and women were asked whether a girl has the right to resist child marriage. Study data (Figure 48) shows that a lower proportion of surveyed girls and women in Balambala (39%), compared to girls and women in Kajiado Central (95%), Laisamis (77%), Habaswein (78%), Sook (70%) and Wamba (74%), believe that a girl or woman has a right to resist child marriage.

Figure 48: Proportion of girls and women aged 10–49 that believe that a girl or woman has a right to resist child marriage by region (N = 5,291)



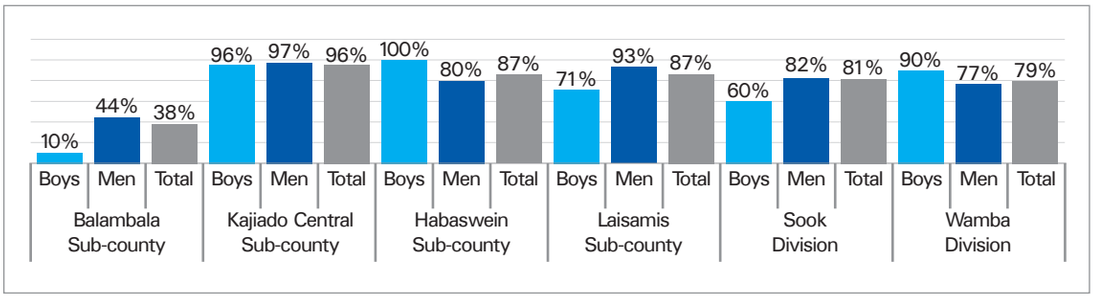
Similar observations were made across surveyed ethnic communities where a lower proportion of surveyed girls and women of Somali origin (56%), compared to 95% of respondents of Maasai origin, 73% of the Samburu, 70% of the Pokot and 80% of the Rendille, believe that a girl or woman has a right to resist child marriage.

Figure 49: Proportion of girls and women aged 10–49 that believe that a girl or woman has a right to resist child marriage by ethnicity (N = 5,291)



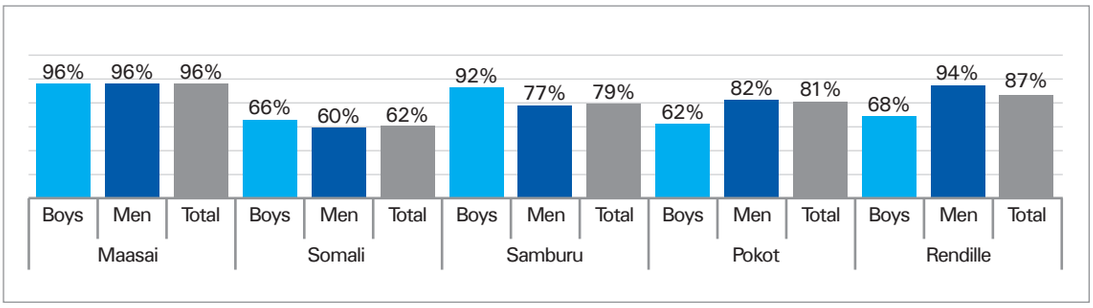
A look at study data from surveyed boys and men (Figure 50) shows that lower proportions of surveyed boys and men in Balambala (38%), compared to boys and men in Kajiado Central (96%), Laisamis (87%), Habaswein (87%), Sook (81%) and Wamba (79%), believe that a girl or woman has a right to resist child marriage.

Figure 50: Proportion of boys and men aged 15–49 that believe that a girl or woman has a right to resist child marriage by region (N = 1,243)



Across target ethnic communities, lower proportions of surveyed boys and men of Somali origin (62%), compared to 96% of respondents of Maasai origin, 79% of the Samburu, 81% of the Pokot and 87% of the Rendille, believe that a girl or woman has a right to resist child marriage (Figure 51).

Figure 51: Proportion of boys and men aged 15–49 that believe that a girl or woman has a right to resist child marriage by ethnicity (N = 1,243)



3.2.2.4 Age at marriage

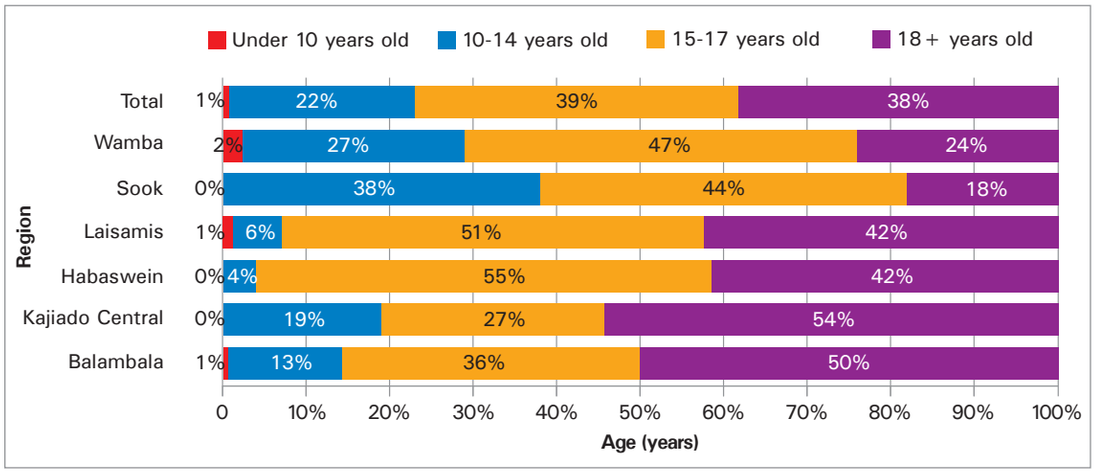
Key findings

- The median age at marriage of girls and women in Balambala is 17.5 years old, and 18 years old in Kajiado Central, 17 years old in Habaswein and Laisamis, 15 years old in Sook and 16 years old in Wamba.
- Approximately 68% of all married/once married girls and women comprising 46% of married girls and women in Kajiado Central, compared to 50% in Balambala, 58% in Habaswein and Laisamis, 76% in Wamba and 82% in Sook, were married off when aged under 18.
- Only 30% of all surveyed mothers in the study locations, comprising 25% in Balambala, 80% in Kajiado Central, 37% in Habaswein, 22% in Laisamis, 4% in Sook and 20% in Wamba, married off their daughters when aged at least 18.
- Approximately 70% of all mothers surveyed, comprising of 20% of surveyed mothers in Kajiado Central, 75% in Balambala, 63% in Habaswein, 78% in Laisamis, 96% in Sook and 80% in Wamba, married off their daughters when aged under 18.

This study also sought to estimate the age at which girls and women across the six study locations get married. According to survey data from married girls and women, the median age at marriage of girls and women in Balambala is 17.5 years old, 18 years old in Kajiado Central, 17 years old in Habaswein and Laisamis, 15 years old in Sook and 16 years old in Wamba.

As shown in Figure 52, approximately 68% of all married/once married girls and women surveyed in the study locations reported that they were married off when aged under 18. Across all study locations, 46% of married girls and women in Kajiado Central, compared to 50% in Balambala, 58% in Habaswein and Laisamis, 76% in Wamba and 82% in Sook, reported that they were married at an average age of under 18 years old. Further analysis by region is provided in Figure 52.

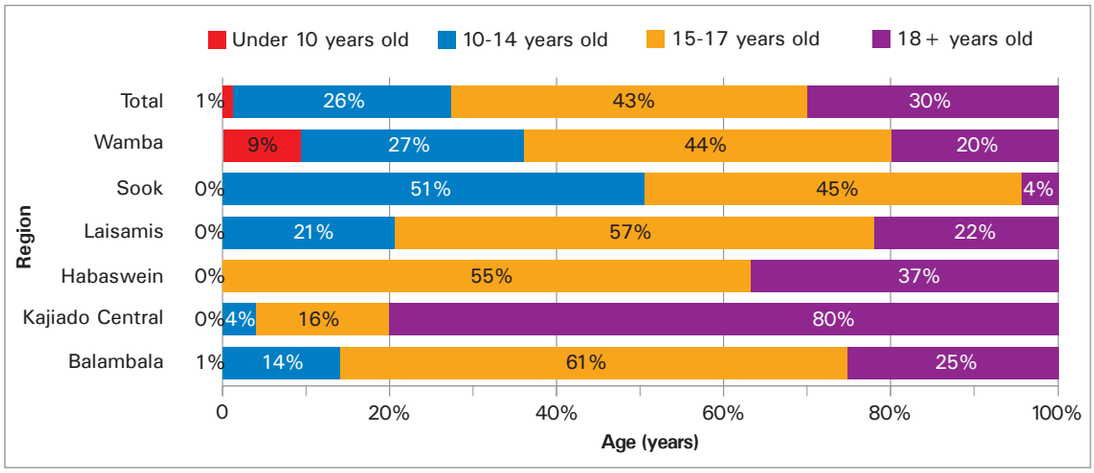
Figure 52: Age at marriage reported by surveyed mothers by region (N = 547)



Further, of all survey respondents who are currently married or were once married, 67% have no education, 21% have primary-level education, 9% have secondary-level education and 3% have college/higher level education. A similar trend is observed among respondents who were married before reaching the age of 18: 71% have no education; 53% have primary-level education and 20% and 26% have secondary and college or higher education respectively.

Further investigation to understand the dynamics of child marriage in the study locations shows that only 30% of all surveyed mothers in the study locations indicated that they had married off their daughters when aged at least 18. Across all study locations, only 20% of surveyed mothers in Kajiado Central, compared to 75% in Balambala, 63% in Habaswein, 78% in Laisamis, 96% in Sook and 80% in Wamba, reported that they had married off their daughters at an average age of under 18 years old. Further analysis is provided in Figure 53.

Figure 53: Age at marriage of daughters of surveyed mothers by region (N = 547)



Survey data from surveyed boys and men shows that 30% of all boys and men in Balambala, 4% in Kajiado Central, 6% in Habaswein, 20% in Laisamis, 30% in Sook and 8% in Wamba first got married when under 18 years old.

Table 52: Age at marriage reported by boys and men by region (N = 1,257)

Age at first marriage	Study location					
	Balambala sub-county	Kajiado Central sub-county	Habaswein sub-county	Laisamis sub-county	Sook division	Wamba division
Under 10 years old	0%	0%	0%	0%	0%	0%
10–14 years old	2%	1%	0%	5%	6%	2%
15–17 years old	28%	3%	6%	15%	24%	6%
18+ years old	70%	96%	94%	80%	71%	91%

However, among boys aged under 18 who are currently married or were once married, approximately 18% in Balambala first got married when aged 10–14, and 82% when aged 15–17. In Habaswein and Sook, all boys aged under 18 who are currently married or were once married first got married from around the age of 15 years.

Table 53: Age at marriage reported by boys aged 15–17 by region

Age at first marriage	Balambala sub-county	Kajiado Central sub-county	Habaswein sub-county	Laisamis sub-county	Sook division	Wamba division
Under 10 years old	0%	0%	0%	0%	0%	0%
10–14 years old	18%	0%	0%	0%	0%	0%
15–17 years old	82%	0%	100%	0%	100%	0%

3.2.2.5 Belief that other girls and women will get married in the future

Key findings

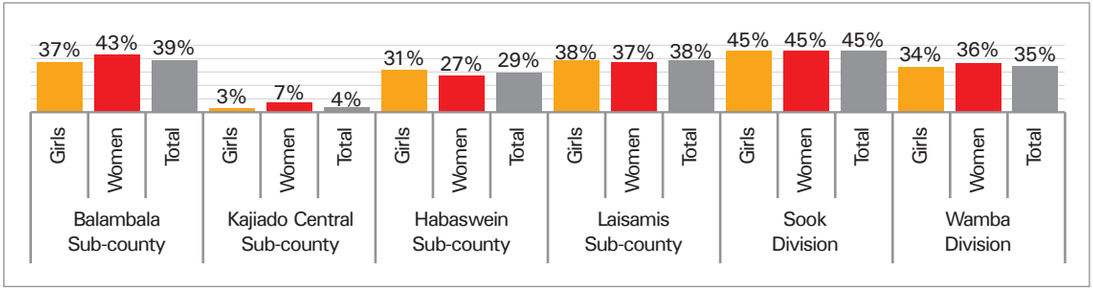
- The belief that others girls and women will get married before reaching the age of 18 is significantly pronounced among surveyed girls and women in Balambala (39%), Habaswein (29%), Laisamis (38%), Wamba (35%) and Sook (45%), compared to only 4% of surveyed girls and women in Kajiado Central. By ethnicity, approximately 4% of surveyed girls and women of Maasai origin, compared to the Somali (35%), Samburu (33%), the Pokot (45%) and the Rendille (42%) strongly believe that girls will get married before reaching the age of 18.
- Key consequences of not getting married before reaching the age of 18, as cited by respondents across all study locations, are: ridicule from fellow girls and women; shunning and rejection of older girls by boys and men; difficulty in finding a husband to be married to; and rejection by parents, including banishment.

To assess perceptions on the likely continuation of the practice of child marriage in the study locations, survey respondents were asked whether they believe that other girls and women in their respective communities will get married before reaching the age of 18. Survey data shows that approximately 30% of surveyed girls and women believe that that others girls and women in their respective communities will get married before reaching the age of 18.

However, a cross-analysis by age at marriage shows that this conviction gets stronger as age at marriage decreases. Specifically, data from surveyed girls and women shows that significantly more girls and women married off at under 10 years old (75%) and 10–14 years old (40%) have a stronger feeling, compared to girls and women married off at 15–17 years old (33%) and when at least 18 years old (19%), with regard to the belief that girls and women in their respective communities will get married before reaching the age of 18.

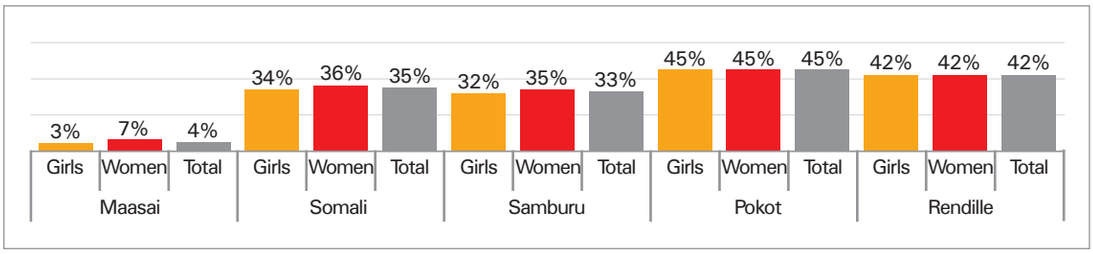
At study location level, this conviction is stronger among surveyed girls and women in Balambala (39%), Habaswein (29%), Laisamis (38%), Wamba (35%) and Sook (45%), compared to only 4% of surveyed girls and women in Kajiado Central (Figure 54).

Figure 54: Proportion of girls and women believing that girls will get married before reaching the age of 18 by region



Further analysis by ethnicity shows that approximately 4% of surveyed girls and women of Maasai origin, compared to the Somali (35%), Samburu (33%), the Pokot (45%) and the Rendille (42%), believe that girls in study locations will get married before reaching the age of 18 (Figure 55).

Figure 55: Proportion of girls and women believing that girls will get married before reaching the age of 18 by ethnicity



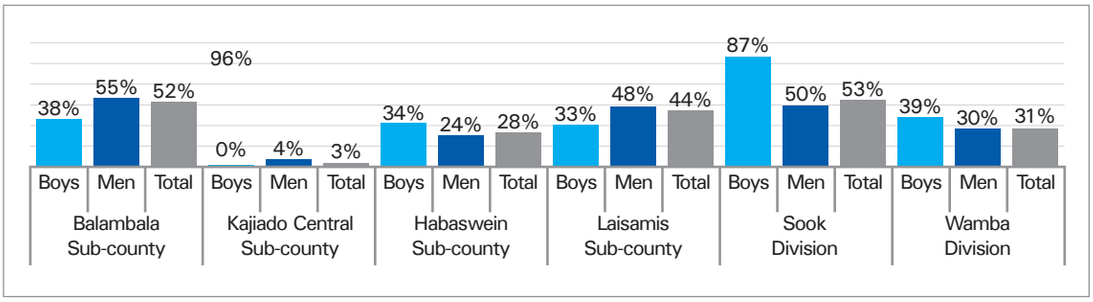
Further analysis shows that significantly more girls and women ($p < 0.05$) who married when under 10 years old (67%) and when aged 10–14 (30%), compared to 13% married off at 15–17 years old and 7% married when at least 18 years old, expressed the view that girls and women will be punished if they do not get married before reaching the age of 18. Three key consequences were cited by the surveyed girls and women across all study locations: ridicule from fellow girls and women (44%); rejection by boys and men (46%); and hence not able to find a husband (23%). This is shown in Table 54.

Table 54: Perceived consequences of not getting married before reaching the age of 18, reported by girls and women aged 15–49 by region

Consequences of not getting married before reaching the age of 18	Sub-county					
	Balambala n = 71	Kajiado Central n = 57	Habaswein n = 55	Laisamis n = 54	Sook n = 338	Wamba n = 176
Nothing will happen to them	22%	9%	14%	10%	22%	5%
They will not find a husband to marry	48%	24%	21%	32%	21%	15%
Boys and men will avoid them	70%	17%	63%	67%	50%	26%
Other girls and women will laugh at them	22%	29%	7%	17%	74%	24%
Their parents will curse them	8%	18%	9%	0%	5%	40%
Their parents will chase them away	3%	17%	0%	14%	4%	40%
The community leaders will curse them	6%	3%	4%	2%	3%	32%
They will be rejected by the community	4%	8%	4%	2%	15%	37%

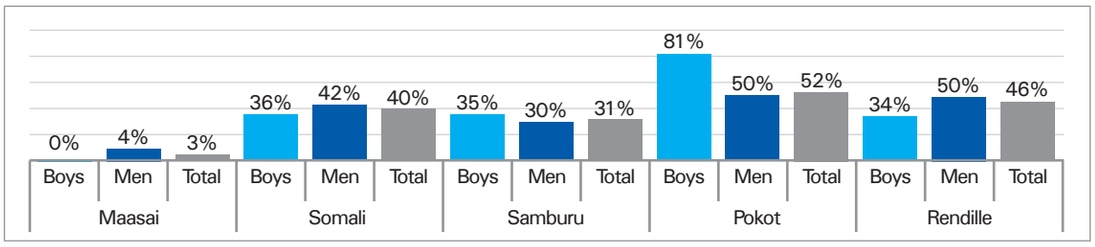
A look at data obtained from surveyed boys and men in the target study locations (Figure 56) shows that the conviction that girls in their respective communities will get married before reaching the age of 18 was less pronounced in Kajiado Central (3%), compared to 52% in Balambala, 28% in Habaswein, 44% in Laisamis, 53% in Sook and 31% in Wamba.

Figure 56: Proportion of boys and men aged 15–49 that believe that girls will get married before reaching the age of 18 by region (N = 1,357)



Further analysis by ethnicity shows that approximately 3% of surveyed boys and men of Maasai origin, compared to the Somali (40%), Samburu (31%), the Pokot (52%) and the Rendille (46%), strongly believe that girls in study locations will get married before reaching the age of 18 (Figure 57).

Figure 57: Proportion of boys and men aged 15–49 that believe that girls will get married before reaching the age of 18 by ethnicity (N = 1,357)



While approximately 18% of surveyed boys and men believe that nothing will happen to girls that do not get married before reaching the age of 18, a majority of the respondents believe that there are consequences. Largely, these are: difficulty in finding a husband; shunning and rejection of older girls by boys and men; ridicule from other girls and women; and rejection by parents, including banishment. Further analysis is provided in Table 55.

Table 55: Perceived consequences of not getting married before reaching the age of 18, reported by surveyed boys and men aged 15–49 by region

Consequences for not getting married before reaching the age of 18	Study location					
	Balambala sub-county	Kajiado Central sub-county	Habaswein sub-county	Laisamis sub-county	Sook division	Wamba division
They will not find a husband to marry	84%	17%	83%	72%	37%	38%
Boys and men will avoid them	66%	17%	70%	50%	57%	16%
Nothing will happen to them	45%	49%	5%	27%	10%	23%
Other girls and women will laugh at them	20%	16%	9%	17%	72%	16%
Their parents will curse them	3%	11%	0%	0%	7%	8%
Their parents will chase them away	6%	8%	0%	0%	5%	46%
The community leaders will curse them	0%	8%	0%	0%	8%	26%
They will be rejected by the community	13%	13%	0%	0%	5%	23%

Notwithstanding the perceived consequences of not getting married before reaching the age of 18, the study findings from group discussions and interviews with community members and key informants respectively show little belief that other girls in the target communities will get married in the future before reaching the age of 18. Surveyed respondents believe that the enforcement of existing laws on free and compulsory primary-level education and increased enrolment of girls in school will increase in the future. Analysis of data from parents across all study locations shows that children in school, including girls, are allowed to proceed with school despite prevailing cultures such as FGM/C and child marriage. For example, in Balambala and Habaswein, FGM/C is mainly carried out during school holiday periods, thus allowing girls to have adequate time to heal.

Thus while marriage automatically spells doom for school-going children, there is considerable evidence from study respondents from Sook, Wamba and Kajiado Central that attending school could be a major turning point for the practice of child marriage. However, all are agreed that there is a high likelihood of increased child marriage for girls who are out of school as soon as they are "mature".[13] Key discussion points are provided in the quotes below.

> A girl getting married before attaining the age of 18 years was there, but today it is rare. Most of the girls in this community are in school… but those who dropped out of school do get married before reaching the age of 18 years.
>
> **FGD respondent, male 18–49, Sook**
>
> Yes, we believe girls in this community will continue getting married before reaching the age of 18, but mostly those who are not in school."
>
> **FGD respondent, female 18–49, Balambala**
>
> Our culture nowadays allows girls to go to school and if they don't want to be circumcised, it is okay, also if the man wants to marry them without them being circumcised it is also fine.
>
> **FGD respondent, female 18–49, Wamba**
>
> A girl who doesn't want to get married before reaching 18 years old… she cannot refuse, especially when she lives in a place like Sirata and she doesn't go to school. She will just be forced into marriage, even with someone you don't know.
>
> **FGD respondent, female 15–17, Wamba**
>
> In terms of education, currently, many parents take their children to school and the practise has decreased greatly regarding education, and therefore, I can say that early child marriage has reduced… but for girls not attending school, it will increase.
>
> **Key informant interview, CBO official, Balambala**

3.2.2.6 Perceived changes in the practice of child marriage

Key findings

- A majority of surveyed girls and women in Kajiado Central (87%), Laisamis (75%), Sook (83%) and Wamba (76%), compared to 18% in Balambala and 38% in Habaswein, believe that the practice of child marriage has reduced in their respective communities.
- Fear of being arrested, enhanced knowledge of the effects of child marriage and the perception that community leaders are now supporting the elimination of child marriage are the main reasons attributed to the perceived reduction in the practice of child marriage.

A majority of surveyed girls and women in Balambala (54%), compared to Kajiado Central (0%), Habaswein (15%), Laisamis (15%), Sook (0%) and Wamba (1%), believe that child marriage has increased in their respective communities. Conversely, a majority of surveyed girls and women in Kajiado Central (87%), Laisamis (75%), Sook (83%) and Wamba (76%), compared to 18% in Balambala and 38% in Habaswein, believe that the practice of child marriage has reduced in their respective communities (Table 56).

13 As earlier noted, transition from childhood to adulthood among girls is influenced by FGM/C and observable physical body changes change such as the development of breasts and first menstruation.

Table 56: Proportion of girls and women who believe that child marriage has reduced in their respective communities by region (N = 2,186)

Perceived change in the practice of child marriage	Study location					
	Balambala sub-county	Kajiado Central sub-county	Habaswein sub-county	Laisamis sub-county	Sook division	Wamba division
Increased	54%	0%	15%	15%	0%	1%
Remained the same	13%	9%	10%	10%	9%	13%
Reduced	18%	87%	38%	75%	83%	76%
I don't know	14%	4%	37%	0%	7%	11%

The above study findings are corroborated by focus group participants and key informants interviewed across the study locations. Largely, group discussion participants and key informants in the study locations of Wamba, Laisamis, Kajiado Central and Sook indicated that the practice of child marriage had reduced.

While increased school enrolment, as earlier discussed, could change the key dynamics surrounding the practice of child marriage in the study locations, evidence of intensive anti-FGM and anti-child marriage interventions abound in the group discussions and interviews with community members and key informants respectively. In addition, factors such as rural–urban migration and increased liberal attitudes of girls as a result of education and sensitization were also mentioned as possible causes of a reduction in the incidence of child marriage.

Regarding the matter of anti-FGM interventions, study data in the latter sections of this report shows that the practice of FGM/C has changed in many ways, including the age at circumcision. Considering that FGM was carried out in the study locations of Kajiado Central, Laisamis, Wamba and Sook mostly as a rite of passage and mainly leading to marriage, a change in the age at circumcision as a result of prevailing circumstances such as enforcement of anti-FGM laws means that FGM/C is carried out at an early age when the girls is considered "not ripe" for marriage or during latter years of growth of the girl. This uncouples the practice of FGM/C from child marriage.

Further, evidence exists of cases where girls return home for the cut in later years after the prescribed age for circumcision or prior to giving birth due to fear of the "curse" from parents or community leaders. Put together, these factors have contributed to the reduction in the incidence of child marriage in the study locations.

> People are migrating from rural to town centres and it has influenced [it] a lot. In terms of education, currently, many parents take their children to school and the practice has decreased greatly regarding education, and therefore, I can say that early child marriage has reduced… Girls in school are in safe hands while those in rural settings are prone to early child marriage… to avoid early pregnancy and adultery… is also something which has been in practice. If a girl is mature [she] is ready to get married… if the monthly period starts it means the girl is ready for marriage.
>
> **Key informant interview, CBO official, Balambala**

However, a number of respondents feel that girls have become more emboldened, to the extent that they demand to be married off in line with their respective traditions. This perceived change is a result of peer pressure and girls desiring to be "just like other girls in the community". Parents mostly attribute this to a possible increase in the practice of child marriage.

> A long time ago, girls were shy about getting married… these days, they themselves look for a husband, they want to get married.
>
> **FGD respondent, female aged 18–49, Balambala**
>
> We support the continuation of child marriage… when a girl reaches adolescence, some become very stubborn and say they want a husband… It is better if she gets married rather than going out and becoming immoral… we do not entertain that.
>
> **FGD respondent, male 32 years old, Balambala**

Asked about possible reasons that can be attributed to the reduction in the practice of child marriage in their respective communities, three key reasons emerge: fear of being arrested (63%); enhanced knowledge of the effects of child marriage (18%); and perception that community leaders are now supporting the elimination of child marriage (8%). Further analysis is shown in Table 57.

Table 57: Perceived reasons for reduction in practice of child marriage reported by girls and women by region

Perceived reason for reduction in practice of child marriage	Study location					
	Balambala n = 89	Kajiado Central n = 474	Habaswein n = 73	Laisamis n = 136	Sook n = 225	Wamba n = 276
Fear of being arrested	42%	51%	62%	88%	67%	75%
Increased knowledge of effects of child marriage	44%	37%	6%	4%	7%	4%
Community leaders are now supporting elimination of child marriage	6%	8%	12%	6%	13%	2%
Pressure from NGOs in the community	0%	2%	3%	2%	10%	1%
Pressure from government officials in the community	1%	1%	0%	0%	1%	7%
I don't know	7%	2%	17%	0%	3%	11%

3.4 Influence of border communities on the continuity and prevalence of harmful practices

3.4.1 Introduction

The role of migrant communities in the prevalence of FGM/C has also been documented. Some studies (Diop et al, 2009; Equality Now, 2009; Leye et al, 2007) have noted that the movement of individuals and families practising FGM/C – both those who supply the service and those who demand it – across national boundaries to more lenient countries is a direct result of the criminal sanctions imposed on those who practise it. It is documented that FGM/C can be adopted in various situations: by new groups or areas as a result of migration and displacement (Abusharaf, 2007, 2005); through neighbouring groups influencing other communities to adopt the practice (Leonard, 2000; Dellenborg, 2004); in religious or traditional revival moments (Nypan, 1991); and through intermarriage involving communities widely practising FGM/C (Shell-Duncan and Hernlund, 2006). In fact, according to the International Organization for Migration (IOM), the migration of populations who practise FGM/C to other countries has added a new dimension to the issue of "integration". Difficulties in integration have led to the stricter application of cultural practices among migrant communities as a means of distinguishing themselves from the "receiving" society and preserving their ethnic identity. Addressing FGM/C in receiving countries has particular challenges, since initiatives that promote the abandonment of FGM/C can be perceived as judgemental or morally offensive and result in negative reactions in migrant communities (IOM, n.d., p. 2).

The OHCHR submissions from several countries reveal a number of constraints and challenges that States face in their efforts to meet their obligations to respect, protect and fulfil the rights of women and children to live free from FGM/C and child marriage. One of the challenges is presented by a gap in the protection afforded by existing legal frameworks. Most States have criminalised FGM/C when it takes place on national territory or when a girl is taken abroad for mutilation if she is a citizen or permanent resident of the State. This fails to recognize the obligation of States to protect all children within their jurisdiction and does not take into consideration the mobile, transnational character of practising communities. A further challenge is insufficient collaboration among governments across borders. Girls living near border areas are most vulnerable, particularly if they are living next to countries with weaker legislation against the practice than their own.

Through Article 21 of the Prohibition of Female Genital Mutilation Act, 2011, which criminalises cross-border practice of FGM/C, Kenya added an extraterritoriality clause in its law, thus making performing female genital mutilation outside its border a criminal offence for Kenyans. In addition, Kenya has established mechanisms to monitor progress in elimination efforts of FGM/C and has allocated resources for implementation, including equipping relevant officials with the requisite personnel, and financial, technical and other resources. Through the Anti-FGM Act, an Anti-FGM board has been established to provide an operational and advisory role, including for securing adequate resources for combating FGM/C. In addition, an Anti-FGM and Child Marriage Prosecution Unit has been established in the Office of the Director of Public Prosecutions (ODPP) to prosecute FGM/C cases.

It is instructive to note the effect of border countries with high FGM/C prevalence rates, mainly Somalia and Ethiopia, on Kenyan communities, especially those bordering these countries: the Rendille bordering Oromiya and SNNP regions with FGM/C prevalence rates of 87% and 71% respectively (Central Statistics Agency, 2006);[14] the Somali in Wajir and Garissa counties bordering Juba and Gedo regions in Somalia where FGM/C is universal (98%) (World Bank and UNFPA, 2004; Population Reference Bureau, 2014), with affected women having been subjected to Type III or pharaonic circumcision, the most drastic form (World Bank and UNFPA, 2004); the Maasai bordering Arusha and Kilimanjaro regions in Tanzania with estimated FGM/C prevalence rates of 57% and 22% respectively (National Bureau of Statistics, 2010);[15] and the Pokot bordering the Karamoja region in Uganda with a FGM prevalence rate of 5% (Uganda Bureau of Statistics, 2011).[16]

3.4.2 Accessing FGM/C services

Key findings

- Approximately 71% of respondents from Uganda, 14% from Somalia, 60% from Ethiopia and 17% from Tanzania have visited Kenya for FGM/C services. Specifically, approximately 4% of surveyed women indicated that they had visited Kenya only once, 8% have always visited Kenya when in need of FGM/C services and 30% stated that they have visited Kenya occasionally to seek FGM/C services: 54% of surveyed women from Ethiopia, 50% from Somalia and 22% from Uganda have visited Kenya at least three times to seek FGM/C services. Approximately 77% of surveyed women from Uganda, 50% from Somalia, 46% from Ethiopia and 100% from Tanzania have visited the Kenya one to two times for FGM/C services. This shows that survey respondents who have visited Kenya more than once for FGM/C services may be involved in securing repeated FGM/C services in Kenya for their relatives and friends.
- Approximately 60% of surveyed women from Ethiopia, 50% from Somalia and 50% from Uganda have secured FGM/C services in Kenya for at least four females, while approximately 50% of surveyed respondents from Uganda, 50% from Somalia, 40% from Ethiopia and 33% from Tanzania indicated that they had brought approximately one to three females to Kenya to obtain FGM/C services. Specifically, approximately 67% of all persons brought to Kenya to undergo FGM/C are close relatives of the surveyed women, with daughters comprising 47%, sisters comprising 30% and nieces comprising 30%. Approximately 33% comprise friends and other relatives.
- Intermarriage (63%) is one of the main driving factors when seeking FGM/C services in Kenya. Other reasons cited for seeking FGM/C services in Kenya include: affordability (48%); quality of FGM/C services (41%); fear of arrest in native country (37%); and lack of proximity to circumcisers in their native countries (15%).

The survey team visited communities bordering the Pokot in Uganda, the Maasai in Tanzania, the Somali in Somalia and those bordering Oromiya and SNNP regions in Ethiopia. Survey results show that approximately 42% of the women interviewed have visited Kenya at least once to seek FGM/C services. As shown in Table 58, approximately 71% of respondents from Uganda, 14% from Somalia, 60% from Ethiopia and 17% from Tanzania have visited Kenya for FGM/C services.

14 Ethiopia Demographic Health Survey 2005 at http://www.dhsprogram.com/pubs/pdf/FR179/FR179[23June2011].pdf

15 Tanzania Demographic Health Survey 2010 http://dhsprogram.com/pubs/pdf/FR243/FR243%5B24June2011%5D.pdf

16 Uganda Demographic Health Survey 2011 at https://dhsprogram.com/pubs/pdf/FR264/FR264.pdf

Specifically, approximately 4% of surveyed women indicated that they had visited Kenya only once, 8% had always visited Kenya when in need of FGM/C services and 30% stated that they had visited Kenya occasionally. This shows that survey respondents who have visited Kenya more than once for FGM/C services may be involved in securing repeated FGM/C services in Kenya for their relatives and friends.

Table 58: Frequency of looking for FGM/C services in Kenya reported by girls and women from bordering communities

Frequency of looking for FGM/C services in Kenya	Respondent's country						Total N = 71
	Uganda n = 14	Somalia n = 14	Ethiopia n = 25	Tanzania n = 18	Kenya n = 0	Other n = 0	
Yes, always	7%	7%	16%	0%	0%	0%	8%
Just this once	14%	0%	4%	0%	0%	0%	4%
Not always	50%	7%	40%	17%	0%	0%	30%
I have never come to look for circumcision services in Kenya	29%	86%	40%	83%	0%	0%	58%

Further analysis (Table 59) shows that 54% of surveyed women from Ethiopia, 50% from Somalia and 22% from Uganda have visited Kenya at least three times to seek for FGM/C services. Approximately 77% of surveyed women from Uganda, 50% from Somalia, 46% from Ethiopia and 100% from Tanzania have visited the Kenya one to two times for FGM/C services.

Table 59: Number of times surveyed girls and women from bordering communities have visited Kenya to seek FGM/C services

Frequency of looking for FGM/C services in Kenya	Respondent's country				Total N = 30
	Uganda n = 10	Somalia n = 2	Ethiopia n = 15	Tanzania n = 3	
1 time	44%	50%	15%	50%	31%
2 times	33%	0%	31%	50%	31%
3–5 times	11%	50%	23%	0%	19%
More than 5 times	11%	0%	31%	0%	19%

When asked how many females they have brought to Kenya to obtain FGM/C services, approximately 40% of surveyed women from Ethiopia, 50% from Somalia,50% from Uganda and 33% from Tanzania had secured FGM/C services in Kenya for not more than three females. Approximately 10% of surveyed respondents from Uganda, 50% from Somalia, 20% from Ethiopia and 0% from Tanzania indicated that they had brought at least six females to Kenya to obtain FGM/C services (Table 60).

Table 60: Number of females brought to Kenya for FGM/C, reported by girls and women from bordering communities

Number of females brought to Kenya for FGM/C	Respondent's country				Total N = 30
	Uganda n = 10	Somalia n = 2	Ethiopia n = 15	Tanzania n = 3	
1–3 females	50%	50%	40%	33%	40%
4–5 females	20%	0%	13%	0%	13%
6–10 females	10%	50%	20%	0%	17%
More than 10 females	0%	0%	13%	0%	7%

As shown in Table 61, approximately 67% of all persons brought to Kenya to undergo FGM/C are close relatives of the surveyed women, with daughters comprising 47%, sisters comprising 30% and nieces comprising 30%. Approximately 33% comprise friends and other relatives.

Table 61: Persons brought to Kenya for FGM/C reported by girls and women from bordering communities

Person brought to Kenya to undergo FGM/C	Respondent's country				Total N = 30
	Uganda n = 10	Somalia n = 2	Ethiopia n = 15	Tanzania n = 3	
My daughter	50%	0%	60%	0%	47%
My sister	40%	0%	33%	0%	30%
My niece	10%	0%	47%	33%	30%
My female friend	30%	0%	33%	0%	27%
Other friends and relatives	20%	100%	13%	67%	27%

Interviews with key informants in the study locations confirm the above study findings. Specifically, data from county-based offices of the Director of Public Prosecutions shows that suspects believed to be involved in cross-border perpetuation of FGM/C have been apprehended in the past.

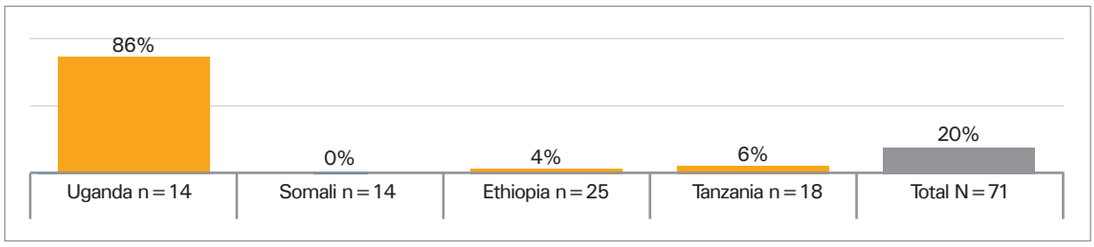
As reported by 63% of surveyed women, intermarriage is one of the main driving factors when seeking FGM/C services in Kenya. Other reasons cited for seeking FGM/C services in Kenya include: affordability (48%); quality of FGM/C services (41%); fear of arrest in native country (37%); and lack of proximity to circumcisers in native countries (15%).

Table 62: Reasons provided for seeking FGM/C services in Kenya reported by girls and women from bordering communities

Reasons for seeking FGM/C services in Kenya	Respondent's country				Total N = 30
	Uganda n = 10	Somalia n = 2	Ethiopia n = 15	Tanzania n = 3	
We also come here to marry	20%	100%	85%	100%	63%
It is more affordable here	10%	0%	69%	100%	48%
FGM/C is performed in a better way in Kenya	20%	0%	46%	100%	41%
Fear of arrest my community	70%	0%	0%	100%	37%
There are not enough circumcisers in our communities	10%	0%	0%	100%	15%
The authorities in Kenya are not as strict as back at home	10%	0%	0%	67%	11%
In Kenya, FGM/C is not illegal	0%	0%	0%	33%	4%

When asked whether they were aware of Kenyan nationals who visit their countries for FGM/C services, approximately 20% (comprising 86% from Uganda, 4% from Ethiopia and 6% from Tanzania) replied in the affirmative (Figure 58).

Figure 58: Proportion of girls and women from bordering communities who are aware of Kenyans visiting their countries to seek FGM/C services



A majority of surveyed respondents (86%) mainly from Uganda (92%) and Tanzania (100%) believe that fear of arrest in Kenya is the main reason why a majority of Kenyan nationals visit their bordering countries for FGM/C services (Table 63).

Table 63: Reasons for Kenyan nationals seeking FGM/C services in bordering countries reported by girls and women from bordering communities

Reasons for seeking FGM/C services in bordering countries	Respondent's country				Total N = 71
	Uganda n = 14	Somalia n = 14	Ethiopia n = 25	Tanzania n = 18	
Fear of arrest in Kenya	92%	0%	0%	100%	86%
They also go to my country to marry	0%	0%	100%	100%	14%
It is a tradition	17%	0%	0%	0%	14%
There are not enough circumcisers here	0%	0%	0%	100%	7%
FGM/C is performed in a better way in my country	0%	0%	0%	100%	7%
In my country, FGM/C is not illegal	8%	0%	0%	0%	7%

3.4.3 Birth registration in the study locations

Birth registration is the continuous, permanent and universal recording within the civil registry of the occurrence and characteristics of birth, in accordance with the national legal requirements. It establishes the existence of a person under law, and lays the foundation for safeguarding civil, political, economic, social and cultural rights.[17] Article 7 of the Convention on the Rights of the Child and Article 24, paragraph 2 of the International Covenant on Civil and Political Rights recognizes birth registration as a fundamental right.

The fulfilment of the right to be registered at birth is linked to the realization of many other rights; it allows a child to prove who and how old they are, helping to protect against child labour and child marriage. It grants them a national identity, making it easier to fight abuse and child trafficking, and gives access to social services, such as education and healthcare (Plan International, n.d). Indeed, the Human Rights Committee (HRC, 1994), in its general comment No. 17 on the rights of the child, directly expresses that Article 24, paragraph 2 of the International Covenant on Civil and Political Rights should be interpreted as being closely linked to the right to special measures of protection and that the main purpose of the obligation to register children after birth is to reduce the danger of abduction, sale of, or traffic in children, or of other types of treatment that are incompatible with the enjoyment of the rights provided for in the Covenant. In this regard, if birth registration is not methodically carried out, the child's socio-economic rights are at risk and the protection of the child is therefore endangered.

As part of a wider civil registration system that entails recording of the occurrence and characteristics of key population and other civil status events, this study mainly dwelled on births within the context of awareness and practices regarding birth registration: the importance of birth registration and certification; awareness, access to and barriers to birth registration services; and media and communication. Further, in a broader context, the records of key population and other civil status events are the main source of statistics, and so the complete coverage, accuracy and timeliness of civil registration system are paramount. Taking account of this, the study further sought to assess the civil registration system as a whole, since increasing demand for birth registration requires an improved and efficient civil registration and statistics systems and processes.

To assess birth registration as a key outcome of the civil registration and statistics systems and processes, a study of prevailing practices with regard to birth registration in Balambala, Habaswein, Kajiado Central, Laisamis, Sook and Wamba was carried out. The immediate purpose of this activity was to inform a possible community campaign to create awareness of birth registration and increase demand for birth registration services.

To assess the actual use of birth registration services, respondents were asked where their children, both boys and girls, are officially registered at birth. Approximately 31% of the surveyed parents/caregivers indicated that all their children were registered at birth, comprising 17% in Balambala, 49% in Kajiado Central, 57% in Habaswein, 26% in Laisamis, 8% in Sook and 27% in Wamba. However, further interrogation showed that only 57% of them, comprising 46% in Balambala, 59% in Kajiado Central, 95% in Habaswein, 74% in Laisamis, 30% in Sook and 50% in Wamba, provided physical proof of registration of all their officially registered children at birth.

Surveyed parents/caregivers who had not registered their children at birth offered various reasons for this, namely: lack of awareness of the importance of registration at birth (38%); registration offices are far away (35%); prohibitive costs associated with birth registration process (4%); lack of knowledge of the importance of a birth certificate (6%);

17 www.unicef.org/protection/57929_58010.html

lack of knowledge of the location of registration offices (4%); and other reasons, mainly lack of knowledge of the registration process, gave birth at home, lack of assistance, loss of notification of birth, the child died, I was sick, I was busy etc. Further analysis by region is provided in Table 64.

Table 64: Reasons provided by girls and women for not registering all of their children at birth by region

Reasons for non-registration of child at birth	Sub-county						Total
	Balambala	Kajiado Central	Habaswein	Laisamis	Sook	Wamba	
Registration offices are far away	63.6%	10.8%	8.3%	26.0%	34.7%	64.6%	35.4%
I don't think a birth certificate is important	7.6%	33.6%	33.3%	22.1%	13.2%	6.2	18.6%
It costs a lot of money to get a birth certificate	7.6%	2.1%	8.3%	1.9%	5.4%	4.4%	4.0%
I did not want to pay a fine	0.0%	0.7%	8.3%	0.0%	0.0%	0.0%	.3%
I don't know where the registration offices are	10.6%	2.1%	0.0%	1.9%	2.5%	6.2%	3.7%

3.4.4 Existing laws to address female genital mutilation/ cutting and child marriage and their enforcement

Key findings

- Key informants reported that laws to address harmful practices such as FGM/C and child marriage are in existence and are well formulated, but that there are challenges with regard to enforcing them.
- The chief concern of key informants was inadequate knowledge of the laws and their requirements by the general public, which has posed a key barrier to their enforcement. It was noted that through acts of omission and commission (including cases of victims conniving with perpetrators of child abuse), enforcement of the laws has been frustrated. Fear of attack and reluctance on the part of community members to testify in court in cases of FGM/C and child marriage were also highlighted. The net result is an inability to successfully prosecute child abuse cases, and so permitting the continued harmful practices of FGM/C and child marriage.
- The role of some politicians in interfering with law enforcement, including influencing the prosecution of perpetrators, was highlighted. Despite politicians playing a role in formulating the laws addressing harmful practices such as FGM/C and child marriage, respondents indicated that some politicians in the study locations had frustrated the enforcement of the same laws for short-term gains, such as election. This has played a key part in supporting the practice of FGM/C and child marriage and their continuation.

As stated earlier, FGM/C and child marriage are violations of the human rights of girls and women, as recognized in numerous international and regional human rights instruments which provide a foundation for the right of girls and women to be free from practices such as FGM/C and child marriage. The broader categories of these rights include: the rights of the child; the right to health; the right to be free from all forms of discrimination against women; and the right to life and physical integrity, including freedom from violence.

Over and above recent key developments in Kenya in respect of national legislation and policies, action plans and coordination mechanisms for child protection, special laws are in existence that address harmful practices involving FGM/C and child marriage in Kenya. These are the Prohibition of Female Genital Mutilation Act, 2011, the Children Act 2001 and the Marriage Act 2014; the 2010 Constitution (which prohibits marriage of persons under the age of 18); and the Penal Code, mainly Sections 234, 250 and 251.

Key informants surveyed reported that these laws are well formulated to address the study areas of FGM/C and child marriage. Study results show that the police, children's officers and probation officers in the Department of Children's Services (DCS), the provincial administration and the judiciary are the key institutions in Kenya charged with responsibility for implementing these laws in Kenya. However, it was noted by all key informants that there are challenges with regard to enforcing the laws prohibiting FGM/C and child marriage.

The chief concern of key informants was inadequate knowledge of the laws and their requirements by the general public, which has posed a key barrier to their enforcement. In general, key informants corroborated the initial study findings that the level of awareness of existing laws on FGM/C and child marriage by the general public was average to good. It was noted that through acts of omission and commission (including cases of victims conniving with perpetrators of child abuse), enforcement of these laws has been frustrated. Fear of attack and reluctance on the part of community members to testify in court in cases of FGM/C and child marriage were also highlighted. The net result is an inability to successfully prosecute child abuse cases, and so permitting the continued harmful practices of FGM/C and child marriage.

> The main cause that has made FGM continue is lack of education. The people here are illiterate, like myself; I have been working with NGOs for quite some time but when I came here, I didn't have knowledge on the bad and the good of FGM but I underwent training both visual and other. That is where I got help. That is where I came to realize it is a very bad thing so there is an information gap. I was not convinced, even if had heard it before, it hadn't sunk into my mind and… I had done a lot of work in the community for quite a long time. I was part of those people condemning it but myself, it had not sunk in, but now there is no problem. I have education now, and I have changed.
>
> **Key informant interview, administration official, Wamba**

Further, the role of some politicians in interfering with law enforcement, including influencing the prosecution of perpetrators, was highlighted. Despite politicians playing a role in formulating the laws addressing harmful practices such as FGM/C and child marriage, respondents indicated that some politicians in the study locations had frustrated the enforcement of the same laws for short-term gains, such as election. This has played a key part in supporting the practice of FGM/C and child marriage and their continuation.

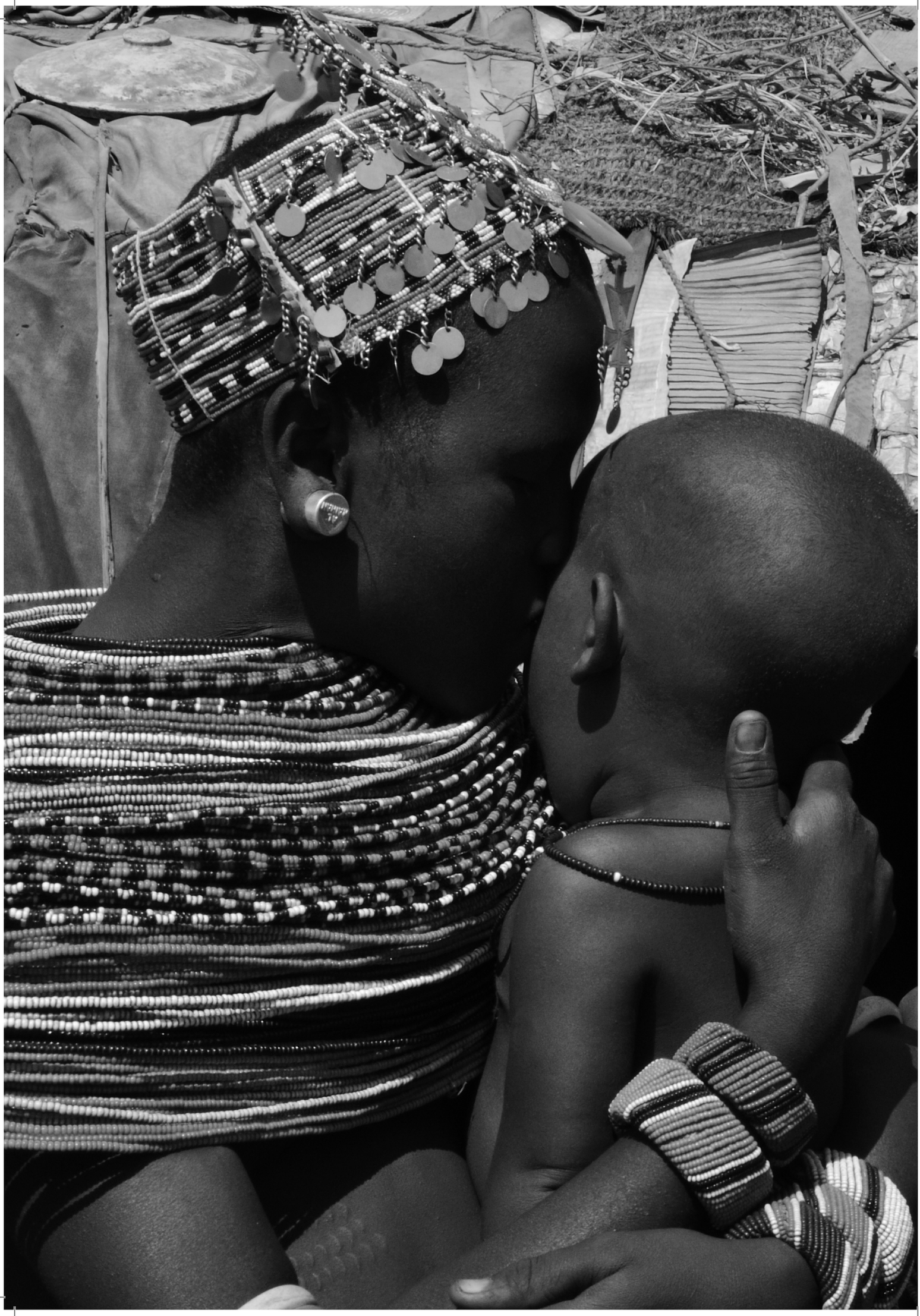
> Another thing that has made FGM [continue] is politicians. Some of them have become barriers to change in this community… at the implementation stage of some of the county laws, people will differ, because you know that some of them are against some cultural practices for that community so instead of the politician standing and saying the truth, you will find that they are the ones who even go to get those we have arrested out of prison. The same people who pass the laws are the same people who fight it. They are the ones who make us as administrators fight until the community starts seeing us as bad people. Right now, our lives are threatened. Some of us have been beaten. They just fight for their votes. They say, "If I go back to parliament, I will put that issue to an end."
>
> **Key informant interview, administration official, Wamba**

In addition, a lack of infrastructure, both hard and soft and including human and financial resources to enforce the laws prohibiting FGM/C and child marriage, was noted. Specifically, informants reported a lack of children officers in some of the study locations such as Balambala, a lack of courts and hence increased costs of seeking justice and a lack of rescue centres to host children at risk of FGM/C and child marriage.

> Awareness has not been done, especially for these amended laws of 2016. More awareness needs to be done. In sub-counties we are supposed to have children officers who are supposed to create awareness in the community but here we don't have them. So not much awareness has been done. The only children officers we have are in Garissa township.
>
> **Key informant interview, administration official, Balambala**
>
> I have no problem with the laws. I have a problem with the way they have been implemented. Every location, every sub-county should have a children's office. That's the first thing. Secondly, put a child rescue centre in every sub-county. Avoid mobile courts. Every sub-county should have a normal operational court, so that such cases are not taken far or lack means. There are some cases now, like the day before yesterday, there is a woman who was cut but because she didn't have money to pay the doctor, she couldn't take that person to court. The cost of seeking justice for most of them is a problem. Do not think people who live here are rich. The majority are poor. 60% or even 70% so that's what I was telling you, if those offices are built and those rescue centres, normal courts that are near, then that's the only way you can implement these rights. These days, you couldn't find a place to take a mutilated girl. If I don't do anything when we have police and whatever around us, what of the man in the interior? And he has no police like me! He has no car, no nothing. It is him alone versus those I was telling you about. He won't make it. He'll keep quiet and of course, they might also blame him. The pressure will be too much.
>
> **Key informant interview, administration official, Wamba**

3.4.5 Sources of information of female genital mutilation/ cutting and child marriage

Survey data from girls and women as well as boys and men shows that community leaders (mainly chiefs, village elders, teachers and religious leaders) are the most important source of information on FGM/C and child marriage, as reported by 24% of all respondents surveyed. In Balambala, fathers (35%) and mothers (35%) are the most important source of information on FGM/C and child marriage while in Habaswein (37%) and Laisamis (38%), mothers are. In Wamba, survey data shows that community leaders (41%) (mainly village elders, chiefs and teachers) are the most important source of information on FGM/C and child marriage while in Sook, most survey respondents cited NGO officials as their most important source of information on FGM/C and child marriage.



Chapter 4
Conclusions and recommendations

4.1 Survey conclusions

1 Despite relatively high levels of awareness and knowledge of the risks resulting from undergoing FGM/C, as well as average to good levels of awareness of the prohibition on FGM/C in Kenya, the survey recorded high FGM/C prevalence rates among surveyed girls and women of Maasai, Pokot, Samburu and Rendille origins in the study locations of Kajiado Central sub-county, Sook division, Wamba division and Laisamis sub-county respectively, and near-universal FGM/C prevalence rates among surveyed girls of Somali origin largely resident in the study locations of Balambala and Habaswein.

2 Preservation of long-held traditions passed from one generation to the next is the most singular reason identified by the survey in the practice of FGM/C and support for its continuation in the study locations. Perceived consequences of not undergoing FGM/C, such as ostracism occasioned by exclusion and rejection by boys, men, family and the larger community; ineligibility for marriage and hence difficulty in a finding a spouse; and subjection to ridicule by peers and the larger community, are grounded in respect and fulfilment of these long-held traditions without which such consequences impact upon girls and women who have not undergone FGM/C. Across all study locations, the power of these long-held traditions is for example manifested through a high level of intent among surveyed mothers/caregivers to perform FGM/C on uncut daughters in the future.

3 Across all study locations, a majority of surveyed girls and women and boys and men have only attained primary-level education or none at all. However, in virtually all measurement areas including prevalence rates, the intention to perform FGM/C on uncut daughters in the future and the marriage of daughters before reaching the age of 18, the belief that FGM/C and child marriage will continue in the future, awareness of the prohibition on FGM/C and child marriage and the risks associated with child marriage and undergoing FGM/C, and support for continuation of FGM/C and child marriage, survey data reveals that positive dispositions of respondents on these measurement areas towards support for accelerating abandonment FGM/C and child marriage increase with increasing level of education and vice versa. Thus the role of education in supporting efforts towards accelerating the abandonment of the practice of FGM/C and child marriage in the study locations cannot be overemphasized.

4 While marriageability is still central to the practice of FGM/C, the current practice of undergoing FGM/C at younger ages (especially among surveyed girls of Somali origin in the target study locations of Balambala and Habaswein, as reflected by near-universal FGM/C prevalence rates among girls aged 10–17 in these two locations), or at later years beyond ages where girls are considered ready for marriage (especially among the Pokot, Samburu, Maasai and Rendille) has changed the matrix of FGM/C practice. Survey results show that the cause and effect relationship between FGM/C

and marriage is diminishing mainly due to increased awareness of target communities regarding the prohibition of FGM/C and child marriage and intensified efforts by state and non-state actors towards accelerating abandonment FGM/C. Thus, increasingly, other factors such as social acceptance and cleanliness are gaining ground. This is supported by study results that show that the driving force behind the current practice of FGM/C in the study locations is girls and women themselves, supported by boys and men.

5 While rare, it is important to note the part played by healthcare professionals in the practice of FGM/C. The incorporation of modern medicine such as use of pain relief prescribed or administered by healthcare professionals prior to girls and women undergoing FGM/C points to possible evolution into a larger role of the healthcare professionals, such as performing FGM/C.

6 While more research is required in assessing the role of border communities in perpetuating harmful practices such as FGM/C and child marriage, study data from surveyed members of border communities and key informants mainly in the Office of the Director of Public Prosecutions (ODPP) reveals that communities along the borders of Uganda, Ethiopia, Somalia and Tanzania may be involved in supporting the continuation of FGM/C and child marriage, mainly among the Pokot, the Rendille, the Somali and the Maasai in that order. A key driving factor in the cross-border practice of FGM/C is shared culture, mainly intermarriage, which may therefore play an indirect role in perpetuating FGM/C and child marriage practices in the target communities.

7 While existing laws that prohibit FGM/C and child marriage are considered adequate, all the documented challenges faced in enforcing these laws directly point to capacity issues of institutions entrusted with accelerating the abandonment of FGM/C and child marriage. Enumerated challenges such as interference by politicians, connivance between victims and perpetrators, community members' reluctance to testify before a court of law due to fears of attack by perpetrators, and a lack of the necessary infrastructure such as offices and courts, and inadequate or total lack of personnel such as children officers, translate into a lack of capacity involving human and financial resources, investigations and successful arrests, and witness protection.

4.2 Survey recommendations

1 Enhance sensitization and educational campaigns to equip girls and women as well as boys and men with the correct information about the FGM/C and child marriage and their attendant effects. A key outcome of this study should include development of a comprehensive communication strategy to address identified gaps in knowledge, misconceptions and underlying reasons for the practice of FGM/C and child marriage.

2 One of the emerging issues in the study is the effect of school attendance on the practice of FGM/C and child marriage. There is anecdotal evidence that increased enrolment of girls in school is likely to reduce cases of child marriage and FGM/C. It is therefore imperative that efforts are also directed towards increasing school attendance to reduce the prevalence of FGM/C and child marriage. A key entry point is the establishment or strengthening of existing school clubs on child protection, training teachers in the areas of harmful practices, and creating links between schools and child protection actors such as the police, provincial administration and rescue centres and through encouraging schools to join these networks to fully benefit from interventions in the areas of FGM/C and child marriage, and in supporting these child protection networks.

3 It is important to reach out to men, including fathers, to use their power and authority to support the accelerated abandonment of FGM/C and child marriage in the study locations. Efforts should be directed towards positively channelling their power as key influencers and enforcers with regard to compliance with long-held traditions on FGM/C and child marriage practices. A key entry point is the establishment of community groups or through strengthening existing community groups to support advocacy on FGM/C and child marriage, including incorporating livelihood interventions such as income generating activities (IGAs) and group saving and loan schemes to address poverty, which the study revealed as a key driver in the practice of FGM/C and child marriage where the two go together.

4 It is important that awareness and knowledge of FGM/C and child marriage, including the attendant risks associated with these harmful practices, are enhanced among healthcare professionals in the target study locations. This should also cover the legal and policy framework touching on harmful practices, including areas such as sexual and gender-based violence (SGBV).

5 It is also important that policy frameworks and mechanisms that address the medicalization of FGM/C are strengthened, including collaboration between target communities, healthcare facilities, police and provincial administration, reporting protocols, and investigation and prosecution of cases involving healthcare professionals in the practice of FGM/C.

6 There is need for capacity-building of key persons and institutions charged with responsibility for implementing child protection activities in the study locations as well as enforcing existing laws that address FGM/C and child marriage. Capacity-building must also involve support for enhancing human and financial resources, including key infrastructure such as offices. However, it is important that a comprehensive organizational capacity assessment is carried out to identify successes to build on and the capacity needed to support the abandonment of FGM/C and child marriage.

7 It is recommended that that community leaders (mainly chiefs, village elders, teachers and religious leaders) are brought on board in accelerating the abandonment of FGM/C and child marriage since they are considered by surveyed communities as the most important source of information on FGM/C and child marriage. However, this must be complemented by other information sources such as NGO and FBO officials, parents/caregivers and mass media (mainly TV, radio, newspaper, social media and the internet) to expand the reach to all target populations. Due consideration must also be given to effective channels of communication since separate target groups are likely to identify with different spokespersons. It is therefore important to segment the target population by effective sources of information; in many places, young people may respond to messages given by their peers rather than to messages given by adults or providers.

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Annex I
Stakeholder mapping

1. Anti-FGM Board

Name of strategy	Inclusion of FGM content in the curriculum
Year of implementation	2016 to date
Target group	Primary school pupils, secondary school pupils, Teachers Service Commission – Kenya, Kenya Institute of Curriculum Development
Source of funding	Partner support
Amount of funding	38,048,300 Kenyan Shillings
Partners	UNFPA, AMREF Health Africa
Successes	The curriculum development is in the matrix stage
Challenges	Not many challenges have been experienced because the project is in its development stage.

2. Association of Media Women in Kenya (AMWIK)

Name of strategy	Stopping FGM on FM
Year of implementation	2015
Target group	Radio journalists
Source of funding	AIDOS
Amount of funding	$41,000
Partners	Anti-FGM Board, media
Successes	12 journalists skilled in radio production
Challenges	FGM prevalence still high nationally at 21%, and in specific communities
	Medicalization and reducing age of circumcision
	Strong cultural demand and lack awareness of the law against FGM and related practices such as early marriage.
Name of strategy	**Dealing with the media – prevention of FGM targeting high-prevalence areas**
Year of implementation	2006/07
Target group	Print journalists
Source of funding	AIDOS, RAINBOW, UNICEF
Amount of funding	–
Partners	Media, anti-FGM stakeholders, KEWOPA
Successes	Well-informed articles for print on FGM and better understanding of the issue
Challenges	FGM prevalence still high nationally at 21%, and in specific communities in some communities
	Medicalization and reducing age of circumcision
	Strong cultural demand and lack awareness of the law against FGM and related practices such as early marriage.

Name of strategy	Media campaign to create awareness of Anti-FGM Bill
Year of implementation	2010
Target group	General public
Source of funding	–
Amount of funding	–
Partners	Media
Successes	Increased awareness among the public on effects of FGM
	Enactment of Prohibition of FGM Bill into law (2011).
Challenges	Entrenched cultural beliefs supporting FGM
	Inadequate awareness of the effects of FGM.
Name of strategy	**Awareness of reproductive health issues among 13–19 year-old boys and girls**
Year of implementation	2015–2016
Target group	Parents, teachers and 13–19 years-old boys and girls across 12 schools in Nairobi
Source of funding	Swedish Association of Sexuality Education (RFSU)
Amount of funding	700,000 Swedish Krona
Partners	Media, Ms Koch, Nairobi Family Support Services, Gender Violence Recovery Centre
Successes	Increased awareness of effects of early pregnancies, FGM, HIV/AIDS, peer pressure, early sexual debut etc.
	Reduced levels of child pregnancies in the targeted schools
	Better child–parent communication/engagement.
Challenges	Poverty, which increases demand for reimbursement from beneficiaries.
Name of strategy	**Using community media and dialogue forums to promote behavioural change**
Year of implementation	2017
Target group	Young men, women, elders and FGM survivors
Source of funding	Girl Generation
Amount of funding	$50,000
Partners	Anti-FGM Board, media
Successes	Still at the onset stage
Challenges	–

3. Presbyterian Church of East Africa (PCEA)

Name of strategy	Mother Esther Children Rescue Center
Year of implementation	2015
Target group	Young children 3–18 years old
Source of funding	Local PCEA funding and some international funding
Amount of funding	About 5 million Kenyan Shillings so far
Partners	Outreach Foundation
Successes	Over 50 girls now rescued and in a fairly stable infrastructure with classes and dormitories, where there was nothing before
Challenges	Financial challenges
	Negative cultural beliefs.

Name of strategy	Retoire Girls Rescue Center
Year of implementation	2011
Target group	Girls under 18 years old
Source of funding	PCEA funding, donors and local fundraising
Amount of funding	Over 5 million Kenyan Shillings
Partners	Outreach Foundation
Successes	Over 100 girls rescued and now in the school
Challenges	Financial challenges
	Negative cultural beliefs.
Name of strategy	**Imbirikani Girls School**
Year of implementation	2002
Target group	Girls who have completed class 8
Source of funding	PCEA, partners and school fees
Amount of funding	Over 80 million Kenyan Shillings
Partners	Highland Park Presbyterian Church, Texas
Successes	Over 400 girls rescued and now transforming the community
Challenges	Financial challenges
	Negative cultural beliefs
	Community hostility.

4. World Vision Kenya – Wajir Area Programme

Name of strategy	Bring Back Out-of-school Children
Year of implementation	2016/17
Target group	Children who have dropped out of school
Source of funding	UNICEF
Amount of funding	–
Partners	World Vision Kenya, UNICEF, District Education Offices
Successes	4,000 children enrolled so far.
Challenges	Vast area
	Nomadic set-up.
Name of strategy	**Child Protection and Rights**
Year of implementation	Since 2010 – integrated within the project
Target group	Children
Source of funding	World Vision Korea
Amount of funding	–
Partners	Benevolent Institute of Development Initiatives (BIDII) (community-based organisation), MEMA
Successes	Formation of Children Parliament
Challenges	–

5. Kadhi's Court, Republic of Kenya (Habaswein)

Name of strategy	Denial of Marriage Certificates for Under-age Girls
Year of implementation	2014
Target group	Young girls aged under 18 years and community at large
Source of funding	–
Amount of funding	–
Partners	National Registration Bureau
Successes	Enabled to deny marriage certificates to under-age girls.
Challenges	The same girls go ahead to marry at the mosques through imams and sheikhs.

6. Bidii Youth Welfare Organization (Habaswein)

Name of strategy	Child Protection
Year of implementation	2014/2015
Target group	School children
Source of funding	World Vision
Amount of funding	150,000 Kenyan Shillings
Partners	World Vision, Schools (primary, secondary and madrassa)
Successes	Many young girls educated on health implications of circumcision.
Challenges	Most target groups were not in school.

7. Sub-county Children's Department (West Pokot)

Name of strategy	Formation of area advisory councils in all sub-counties
Year of implementation	2016/2017
Target group	Community members, government departments, NGOs
Source of funding	World Vision
Amount of funding	–
Partners	–
Successes	Area advisory councils have been able to address the issues in different forums.
Challenges	Lack of funds.
Name of strategy	**Formation of Child Protection Network**
Year of implementation	2015/2016
Target group	All stakeholders
Source of funding	World Vision
Amount of funding	–
Partners	–
Successes	Different stakeholders are able to address the issue at different levels.
Challenges	Lack of funds for sustainability.

8. Child supplementary feeding programme (West Pokot)

Name of strategy	Awareness Creation
Year of implementation	–
Target group	Youth
Source of funding	World Vision and Ministry of Health
Amount of funding	–
Partners	World Vision
Successes	Girls forced into marriage rescued and a rescue centre established
	Girls able to go through a rite of passage in different ways. They received teaching and advice in a shared place, and a ceremony was organized during their graduation without getting cut.
Challenges	Resistance from community because circumcision of girls is a source of income for old women
	Channels of communication and reporting unclear for a child forced to get circumcised
	Fear from neighbouring communities.

9. UDO Program (West Pokot)

Name of strategy	Radio Call Shows, Community Awareness Creation
Year of implementation	2015, 2014, 2016
Target group	Elders, youth, general public
Source of funding	Girl Generation, Canadian Embassy
Amount of funding	1.5 million Kenyan Shillings
Partners	Other anti-FGM crusaders in West Pokot
Successes	Thousands of anti-FGM messages printed and distributed to those who can read
	Community members aware of harmful effects of FGM and where to report cases.
Challenges	–

10. World Vision Kenya – Sook ADP (West Pokot)

Name of strategy	Alternative Rite of Passage
Year of implementation	2008–2016
Target group	Boys and girls
Source of funding	World Vision, UNFPA, community
Amount of funding	1.5 Million Kenyan Shillings
Partners	CBOs, Daughters of Charity
Successes	FGM prevalence reduced from 96% to 74%.
Challenges	Lack of funding and some continue practising FGM after the project.

11. Sub-county Children's Department (Garissa)

Name of strategy	Community Dialogue on FGM at Sankumi division
Year of implementation	2016–2017
Target group	Children, youth, elders and religious leaders
Source of funding	UNICEF, Womankind Kenya
Amount of funding	–
Partners	UNICEF, Womankind Kenya
Successes	Holding community dialogue sessions
	Celebration of zero-tolerance to FGM during national celebrations February 2016 and 2017.
Challenges	People have not really changed their mind-set
	Uncooperative political class.

12. Anglican Development Services (ADS)

Name of strategy	Increasing Women's Participation in Elective Leadership
Year of implementation	2012–2013
Target group	Female aspirants in central and coast regions of Kenya (Kirinyaga, Muranga, Mombasa, Kilifi and Taita Taveta counties)
Source of funding	United Nations
Amount of funding	5,998,040 Kenyan Shillings
Partners	ADS Pwani and ADS Mount Kenya region
Successes	Enhanced knowledge on electoral process and devolved governance
	Increased participation of targeted congregations and communities in civic and voter education, resulting in more women voting and vying for elective positions in the targeted areas in coast and central regions
	At least 200 volunteer church leaders in the four targeted Anglican Church of Kenya (ACK) dioceses in the two regions actively facilitating civic and voter education.
Challenges	The country was divided between two main political parties with cut-throat competition for party nominations. This affected women aspirants as they were disadvantaged in violent and confrontational circumstances.
Name of strategy	**Empowering the Church to Support Women's Leadership**
Year of implementation	2011–2015
Target group	Women in leadership and girls in schools
Source of funding	Norwegian Church Aid
Amount of funding	8,500,000 Kenya Shillings
Partners	ADS Eastern, ACK Kajiado Diocese

Successes	ACK developed and disseminated its gender policy.
	The percentage of women participating in the ACK annual general meeting (AGM) increased to 22%, and the ratio of women to men was 1:5.
	The number of female board members for ADS Kenya increased to 30% in 2013 and 40% in 2014.
	ACK Wathini Church recorded a 40% increase in the number of women represented on the Church Council.
	The number of female clergy in ACK Kajiado Diocese increased by 40% in 2014.
	Working relationships between ADS Kenya and stakeholders in Kajiado and Makueni counties were strengthened.
	New working relationships were formed between ADS Kenya with the Independent Electoral and Boundaries Commission (IBEC), The Institute for Social Accountability (TISA) and Women's Empowerment Link (WEL).
	ACK Kajiado started an anti-FGM campaign and adult literacy classes through the church structures.
	ACK Kajiado Diocese established a mentorship programme for up to 400 girls in Meto primary and secondary schools to curb early marriages and FGM.
	A village savings and loan scheme was launched through ACK Wathini Church, bringing together 18 groups.
	The county government in Kajiado has started enforcing implementation of the anti-FGM Act and several people have been apprehended and taken to court.
Challenges	Some community leaders were still inclined to traditional and harmful cultural practice that promote FGM and early child marriage.
	The low-literacy level, especially in Kajiado, hampered effective engagement of women and girls in leadership and governance.

13. Women's Empowerment Link (WEL)

Name of strategy	**Girls Alive Advocacy (GAA)**
Year of implementation	2017
Target group	Young women in informal settlements in Nairobi and Kisumu County
Source of funding	Plan International
Amount of funding	4,800,000 Kenyan Shillings
Partners	Plan International community services officers (CSOs) working in the communities where the program is being implemented, schools
Successes	Program is in the inception stages
Challenges	–

Annex II: Estimates of sampling errors for selected indicators of interest

Sampling errors are calculated for indicators of primary interest for age cohorts of 10–17 and 18–49 among surveyed girls and women. The following sampling error measures are presented in this annex for each of the selected indicators:

i Standard error (se): Standard error is the square root of the variance of the estimate. The Jack-knife repeated replications method has been used for standard error estimation.

ii Confidence limits are calculated to show the interval within which the true value for the population can be reasonably assumed to fall, with a specified level of confidence. For any given statistic calculated from the survey, the value of that statistic will fall within a range of plus or minus two times the standard error (r + 2.se or r – 2.se) of the statistic in 95% of all possible samples of identical size and design.

A. Balambala sub-county

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q18. Do you think that other girls and women in your community will get cut now and in the future?	**Females**	10–17 yrs	Yes	66.2	.0	.8	64.5	67.6
			No	31.1	.0	.8	29.9	32.5
			I am not sure	2.7	.0	.3	2.3	3.2
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	66.1	.0	.9	64.2	67.9
			No	28.9	.0	.9	27.2	30.7
			I am not sure	5.1	.0	.5	4.3	5.8
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	55.0	.0	2.5	50.2	59.4
			No	40.1	.0	2.4	35.9	44.8
			Not sure	5.0	.0	1.1	3.5	6.7
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	67.4	.0	1.1	65.1	69.6
			No	29.4	.0	1.1	27.5	31.5
			Not sure	3.1	.0	.4	2.4	4.0
			Total	100.0	0.0	0.0		
Q22. Have you yourself been circumcised?	**Females**	10–17 yrs	Yes	92.6	.0	.4	91.7	93.4
			No	7.4	.0	.4	6.6	8.2
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	97.2	.0	.3	96.6	97.8
			No	2.8	.0	.3	2.2	3.5
			Total	100.0	0.0	0.0		

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q56. Are you aware of risks that girls/women face due to circumcision?	**Females**	10–17 yrs	Yes	38.8	.0	.8	37.4	40.3
			No	61.2	.0	.8	59.6	62.7
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	30.8	.0	.9	28.9	32.7
			No	69.2	.0	.9	67.3	71.0
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	24.3	.0	2.1	20.3	28.5
			No	75.7	.0	2.1	71.8	79.2
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	46.5	.0	1.1	44.5	48.9
			No	53.5	.0	1.1	51.2	55.5
			Total	100.0	0.0	0.0		
Q69. Do you think female circumcision should be continued?	**Females**	10–17 yrs	Yes	67.8	.0	.7	66.3	69.3
			No	30.4	.0	.7	29.0	31.7
			I am not sure	1.8	.0	.2	1.5	2.3
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	74.6	.1	.9	72.9	76.6
			No	22.8	.0	.8	21.1	24.3
			I am not sure	2.6	.0	.3	2.0	3.2
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	48.5	.0	2.5	44.1	53.0
			No	45.5	.0	2.4	41.1	50.0
			I am not sure	5.9	.0	1.2	4.0	8.2
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	62.3	.0	1.1	60.3	64.4
			No	34.7	.0	1.1	32.7	36.9
			I am not sure	2.9	.0	.4	2.3	3.6
			Total	100.0	0.0	0.0		

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q93. Do you think that other girls and women in your community will get married before reaching the age of 18?	**Females**	10–17 yrs	Yes	41.7	.0	.8	40.2	43.3
			No	45.0	.0	.8	43.4	46.5
			I am not sure	13.3	.0	.5	12.3	14.3
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	48.7	.0	1.0	46.8	50.5
			No	38.7	.0	1.0	36.9	40.9
			I am not sure	12.6	.0	.7	11.3	13.9
			Total	**100.0**	**0.0**	**0.0**		
	Males	15–17 yrs	Yes	45.0	.0	2.5	40.1	49.3
			No	49.0	.0	2.5	44.3	53.5
			I am not sure	5.9	.0	1.2	3.7	8.4
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	60.0	.0	1.1	57.8	62.0
			No	31.4	.0	1.1	29.3	33.5
			I am not sure	8.7	.0	.6	7.5	10.0
			Total	**100.0**	**0.0**	**0.0**		
Q106. Are you aware of risks that girls/women face due to child marriage?	**Females**	10–17 yrs	Yes	22.8	.0	.7	21.5	24.2
			No	77.2	.0	.7	75.8	78.5
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	24.3	.0	.9	22.6	26.2
			No	75.7	.0	.9	74.0	77.3
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	29.7	.0	2.3	25.5	33.9
			No	70.3	.0	2.3	66.1	74.5
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	34.0	.0	1.1	32.1	36.0
			No	66.0	.0	1.1	63.8	68.1
			Total	100.0	0.0	0.0		

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q114. Do you think child marriage should be continued in your community?	**Females**	10–17 yrs	Yes	38.0	.0	.8	36.5	39.6
			No	50.9	.0	.8	49.4	52.4
			Don't know	11.1	.0	.5	10.2	12.0
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	40.8	.0	1.0	38.9	42.7
			No	51.5	.1	1.0	49.4	53.5
			Don't know	7.7	.0	.6	6.6	8.7
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	40.1	.0	2.5	35.4	44.6
			No	59.9	.0	2.5	55.2	64.9
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	37.4	.0	1.1	35.5	39.5
			No	56.7	.0	1.1	54.5	58.9
			I don't know	5.9	.0	.5	4.9	6.8
			Total	100.0	0.0	0.0		
Q132. Do you think a girl has a right to resist female circumcision?	**Females**	10–17 yrs	Yes	29.0	.0	.8	27.6	30.5
			No	71.0	.0	.8	69.4	72.5
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	20.5	.0	.8	19.0	22.1
			No	79.5	.0	.8	77.9	81.0
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	10.9	.0	1.6	8.2	14.1
			No	89.1	.0	1.6	86.1	91.6
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	25.8	.0	1.0	23.9	27.6
			No	74.2	.0	1.0	72.4	76.0
			Total	100.0	0.0	0.0		
Q133. Do you think a girl has a right to resist child marriage before the age of 18?	**Females**	10–17 yrs	Yes	38.8	.0	.8	37.2	40.4
			No	61.2	.0	.8	59.7	62.7
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	30.8	.0	.9	29.0	32.7
			No	69.2	.0	.9	67.3	71.0
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	9.9	.0	1.5	7.2	12.6
			No	90.1	.0	1.5	87.1	93.1
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	41.0	.0	1.1	38.7	43.1
			No	59.0	.0	1.1	57.0	61.2
			Total	100.0	0.0	0.0		

a. Unless otherwise noted, bootstrap results are based on 1,000 bootstrap samples

B. Habaswein sub-county

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q18. Do you think that other girls and women in your community will get cut now and in the future?	Females	10–17 yrs	Yes	46.2	.0	.9	44.7	47.8
			No	19.4	.0	.7	18.2	20.7
			I am not sure	34.4	.0	.8	32.9	35.8
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	58.5	.0	1.1	56.2	60.6
			No	19.4	.0	.9	17.9	21.1
			I am not sure	22.1	.0	.9	20.5	23.9
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	43.4	.0	1.7	40.3	46.7
			No	26.9	.0	1.4	24.3	29.6
			Not sure	29.7	.0	1.5	26.5	32.6
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	62.2	.0	1.1	60.1	64.4
			No	16.1	.0	.9	14.2	17.9
			Not sure	21.8	.0	1.0	19.8	23.6
			Total	100.0	0.0	0.0		
Q22. Have you yourself been circumcised?	Females	10–17 yrs	Yes	97.9	.0	.2	97.4	98.3
			No	2.1	.0	.2	1.7	2.6
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	99.1	.0	.2	98.7	99.4
			No	.9	.0	.2	.6	1.3
			Total	100.0	0.0	0.0		
Q56. Are you aware of risks that girls/women face due to circumcision?	Females	10–17 yrs	Yes	44.7	.0	.9	42.8	46.5
			No	55.3	.0	.9	53.8	56.8
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	51.2	.0	1.2	49.0	53.6
			No	48.8	.0	1.2	46.5	50.9
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	49.1	.0	1.6	46.1	52.1
			No	50.9	.0	1.6	48.0	53.8
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	49.6	.0	1.2	47.4	52.0
			No	50.4	.0	1.2	48.1	52.6
			Total	100.0	0.0	0.0		

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q69. Do you think female circumcision should be continued?	Females	10–17 yrs	Yes	36.1	.0	.8	34.5	37.8
			No	39.2	.0	.8	37.6	40.9
			I am not sure	24.7	-.1	.7	23.4	26.0
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	41.1	.0	1.1	39.1	43.4
			No	32.4	.0	1.0	30.6	34.1
			I am not sure	26.5	.0	1.0	24.6	28.5
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	28.0	.0	1.5	25.3	30.7
			No	54.1	.0	1.7	50.6	57.5
			I am not sure	17.9	.0	1.2	15.6	20.3
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	44.3	.0	1.2	41.8	46.6
			No	37.2	.0	1.2	34.8	39.5
			I am not sure	18.5	.0	1.0	16.7	20.4
			Total	100.0	0.0	0.0		
Q93. Do you think that other girls and women in your community will get married before reaching the age of 18?	Females	10–17 yrs	Yes	32.5	.0	.8	30.8	34.1
			No	41.2	.0	.8	39.5	43.0
			I am not sure	26.3	.0	.7	24.9	27.6
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	29.1	.0	1.1	27.0	31.2
			No	48.7	.0	1.1	46.6	51.1
			I am not sure	22.1	-.1	1.0	20.4	23.8
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	32.5	.0	1.5	29.9	35.4
			No	45.9	.0	1.6	42.4	49.3
			I am not sure	21.6	.0	1.3	19.0	24.1
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	26.6	.0	1.1	24.7	28.7
			No	50.9	.0	1.2	48.8	53.1
			I am not sure	22.4	.0	1.0	20.3	24.5
			Total	100.0	0.0	0.0		

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q106. Are you aware of risks that girls/women face due to child marriage?	Females	10–17 yrs	Yes	35.9	.0	.8	34.1	37.4
			No	64.1	.0	.8	62.7	65.7
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	47.5	.0	1.2	45.3	49.9
			No	52.5	.0	1.2	50.1	54.7
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	54.9	.0	1.6	51.9	57.7
			No	45.1	.0	1.6	42.1	48.2
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	49.4	.0	1.2	46.9	52.0
			No	50.6	.0	1.2	48.3	52.8
			Total	100.0	0.0	0.0		
Q114. Do you think child marriage should be continued in your community?	Females	10–17 yrs	Yes	13.2	.0	.6	12.2	14.4
			No	60.0	.0	.8	58.5	61.7
			Don't know	26.7	.0	.8	25.3	28.2
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	20.8	.0	1.0	19.1	22.6
			No	53.9	.0	1.2	51.5	56.0
			Don't know	25.4	.0	1.0	23.3	27.5
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	24.0	.0	1.4	21.4	26.8
			No	62.9	.0	1.6	59.7	66.0
			I don't know	13.1	.0	1.1	11.2	15.2
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	27.8	.0	1.1	25.7	30.1
			No	56.8	.0	1.2	54.3	59.1
			I don't know	15.4	.0	.9	13.7	17.0
			Total	100.0	0.0	0.0		
Q132. Do you think a girl has a right to resist female circumcision?	Females	10–17 yrs	Yes	82.6	.0	.6	81.2	83.9
			No	17.4	.0	.6	16.2	18.6
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	79.8	.0	.9	78.1	81.7
			No	20.2	.0	.9	18.4	21.8
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	95.4	.0	.7	94.0	96.7
			No	4.6	.0	.7	3.4	5.9
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	80.8	.0	.9	79.1	82.6
			No	19.2	.0	.9	17.5	20.8
			Total	100.0	0.0	0.0		

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q133. Do you think a girl has a right to resist child marriage before the age of 18?	Females	10–17 yrs	Yes	81.0	.0	.7	79.6	82.3
			No	19.0	.0	.7	17.7	20.3
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	83.9	.0	.8	82.3	85.6
			No	16.1	.0	.8	14.3	17.8
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	100.0	0.0	0.0		
		18–49 yrs	Yes	86.5	.0	.8	85.0	87.9
			No	13.5	.0	.8	11.9	15.1
			Total	100.0	0.0	0.0		
a. Unless otherwise noted, bootstrap results are based on 1,000 bootstrap samples								

C. Kajiado Central sub-county

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q18. Do you think that other girls and women in your community will get cut now and in the future?	Females	10–17 yrs	Yes	8.2	.0	.3	7.6	8.8
			No	67.4	.0	.6	66.4	68.4
			I am not sure	24.4	.0	.5	23.4	25.3
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	16.0	.0	.5	15.0b	17.0
			No	70.0	.0	.7	68.7b	71.3
			I am not sure	14.0	.0	.5	13.0b	15.0
			Total	100.0	0.0	0.0	100.0b	100.0
	Males	15–17 yrs	Yes	6.1	.0	.9	4.5	7.7
			No	78.8	.0	1.5	75.9	81.6
			Not sure	15.1	.0	1.3	12.7	17.6
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	6.6	.0	.5	5.7	7.6
			No	84.6	.0	.7	83.2	85.9
			Not sure	8.8	.0	.5	7.8	9.9
			Total	100.0	0.0	0.0		
Q22. Have you yourself been circumcised?	Females	10–17 yrs	Yes	28.7	.0	.5	27.7	29.8
			No	71.3	.0	.5	70.2	72.3
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	89.5	.0	.5	88.6b	90.4
			No	10.5	.0	.5	9.6b	11.4
			Total	100.0	0.0	0.0	100.0b	100.0

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q56. Are you aware of risks that girls/women face due to circumcision?	Females	10–17 yrs	Yes	41.0	.0	.6	39.8	42.1
			No	59.0	.0	.6	57.9	60.1
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	39.4	.0	.7	38.0b	40.7
			No	60.6	.0	.7	59.3b	62.0
			Total	100.0	0.0	0.0	100.0b	100.0
	Males	15–17 yrs	Yes	60.7	.0	1.8	57.4	64.0
			No	39.3	.0	1.8	36.0	42.6
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	33.9	.0	1.0	32.1	35.8
			No	66.1	.0	1.0	64.2	67.9
			Total	100.0	0.0	0.0		
Q69. Do you think female circumcision should be continued?	Females	10–17 yrs	Yes	3.0	.0	.2	2.6	3.4
			No	83.6	.0	.4	82.8	84.4
			I am not sure	13.4	.0	.4	12.7	14.2
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	13.9	.0	.5	12.9b	15.0
			No	77.8	.0	.6	76.5b	79.0
			I am not sure	8.3	.0	.4	7.5b	9.1
			Total	100.0	0.0	0.0	100.0b	100.0
	Males	15–17 yrs	Yes	3.9	.0	.7	2.8	5.1
			No	92.2	.0	1.0	90.2	94.1
			I am not sure	4.0	.0	.7	2.8	5.4
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	5.6	.0	.4	4.8	6.4
			No	89.0	.0	.6	87.7	90.1
			I am not sure	5.5	.0	.4	4.7	6.3
			Total	100.0	0.0	0.0		

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q93. Do you think that other girls and women in your community will get married before reaching the age of 18?	Females	10–17 yrs	Yes	2.6	.0	.2	2.3	2.9
			No	76.1	.0	.5	75.3	76.9
			I am not sure	21.2	.0	.4	20.4	22.2
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	7.1	.0	.4	6.3b	7.8
			No	76.9	.0	.6	75.6b	78.0
			I am not sure	16.0	.0	.5	15.0b	17.1
			Total	100.0	0.0	0.0	100.0b	100.0
	Males	15–17 yrs	Yes	.4	.0	.2	.0b	1.0
			No	78.1	-.1	1.5	75.2	80.9
			I am not sure	21.5	.1	1.5	18.6	24.5
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	4.2	.0	.4	3.5	5.0
			No	88.0	.0	.6	86.8	89.2
			I am not sure	7.8	.0	.5	6.7	8.8
			Total	100.0	0.0	0.0		
Q106. Are you aware of risks that girls/women face due to child marriage?	Females	10–17 yrs	Yes	39.9	.0	.5	38.9	40.9
			No	60.1	.0	.5	59.0	61.2
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	53.7	.0	.7	52.3b	55.2
			No	46.3	.0	.7	44.8b	47.7
			Total	100.0	0.0	0.0	100.0b	100.0
	Males	15–17 yrs	Yes	58.9	.1	1.8	55.4	62.6
			No	41.1	-.1	1.8	38.1	44.2
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	46.7	.0	1.0	44.7	48.7
			No	53.3	.0	1.0	51.4	55.2
			Total	100.0	0.0	0.0		

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q114. Do you think child marriage should be continued in your community?	Females	10–17 yrs	Yes	2.1	.0	.2	1.8	2.4
			No	91.5	.0	.3	90.9	92.1
			Don't know	6.4	.0	.3	5.9	6.9
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	2.6	.0	.2	2.1b	3.0
			No	91.4	.0	.4	90.6b	92.1
			Don't know	6.1	.0	.3	5.4b	6.8
			Total	100.0	0.0	0.0	100.0b	100.0
	Males	15–17 yrs	Yes	1.2	.0	.4	.7	1.9
			No	90.5	.0	1.1	88.3	92.6
			I don't know	8.3	.0	1.0	6.6	10.0
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	1.9	.0	.3	1.5	2.4
			No	94.8	.0	.4	93.9	95.7
			I don't know	3.3	.0	.4	2.7	4.0
			Total	100.0	0.0	0.0		
Q132. Do you think a girl has a right to resist female circumcision?	Females	10–17 yrs	Yes	96.9	.0	.2	96.5	97.3
			No	3.1	.0	.2	2.7	3.5
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	87.1	.0	.5	86.2b	88.1
			No	12.9	.0	.5	11.9b	13.8
			Total	100.0	0.0	0.0	100.0b	100.0
	Males	15–17 yrs	Yes	99.6	.0	.3	99.2	99.9
			No	.4	.0	.3	.0b	1.0
			Total	100.0	-5.5	22.8	.0b	100.0
		18–49 yrs	Yes	94.7	.0	.4	93.9	95.5
			No	5.3	.0	.4	4.4	6.1
			Total	100.0	0.0	0.0		

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q133. Do you think a girl has a right to resist child marriage before the age of 18?	Females	10–17 yrs	Yes	97.6	.0	.2	97.3	97.9
			No	2.4	.0	.2	2.1	2.7
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	90.9	.0	.4	90.0b	91.7
			No	9.1	.0	.4	8.3b	10.0
			Total	100.0	0.0	0.0	100.0b	100.0
	Males	15–17 yrs	Yes	98.1	.0	.5	97.1	99.0
			No	1.9	.0	.5	1.2	2.8
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	96.5	.0	.3	95.9	97.2
			No	3.5	.0	.3	2.8	4.2
			Total	100.0	0.0	0.0		

a. Unless otherwise noted, bootstrap results are based on 1,000 bootstrap samples

b. Some results could not be computed from jack-knife samples, so this confidence interval is computed by the percentile method rather than the BCa method.

D. Laisamis sub-county

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q18. Do you think that other girls and women in your community will get cut now and in the future?	Females	10–17 yrs	Yes	48.7	.0	1.0	46.8	50.7
			No	43.1	.0	.9	41.2	45.0
			I am not sure	8.2	.0	.5	7.3	9.1
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	52.0	.0	1.1	50.0	54.0
			No	46.4	.0	1.1	44.3	48.5
			I am not sure	1.6	.0	.3	1.2	2.1
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	52.7	.0	2.6	47.9	57.6
			No	44.8	.0	2.6	40.0	49.7
			Not sure	2.4	.0	.9	1.2	3.9
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	54.2	.0	1.6	51.2	56.9
			No	42.7	.0	1.6	39.7	46.0
			Not sure	3.1	.0	.6	2.0	4.2
			Total	100.0	0.0	0.0		

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q22. Have you yourself been circumcised?	Females	10–17 yrs	Yes	61.6	.0	.9	59.8	63.4
			No	38.4	.0	.9	36.7	40.1
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	99.7	.0	.1	99.5	99.9
			No	.3	.0	.1	.1b	.5
			Total	100.0	-.4	6.3	100.0b	100.0
Q56. Are you aware of risks that girls/women face due to circumcision?	Females	10–17 yrs	Yes	71.2	.0	.8	69.5	73.0
			No	28.8	.0	.8	27.3	30.3
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	71.1	.0	1.0	69.1	73.1
			No	28.9	.0	1.0	27.2	30.7
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	59.4	.0	2.8	53.9	64.5
			No	40.6	.0	2.8	35.8	46.1
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	63.0	.0	1.6	59.9	66.0
			No	37.0	.0	1.6	34.1	40.0
			Total	100.0	0.0	0.0		
Q69. Do you think female circumcision should be continued?	Females	10–17 yrs	Yes	26.2	.0	.8	24.8	27.7
			No	68.9	.0	.8	67.1	70.5
			I am not sure	5.0	.0	.4	4.2	5.8
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	26.1	.0	.9	24.4	27.7
			No	73.9	.0	.9	72.1	75.7
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	23.3	.0	2.3	18.8	27.9
			No	76.7	.0	2.3	72.4	80.6
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	25.2	.0	1.5	22.4	27.9
			No	74.2	.0	1.5	71.2	77.1
			I am not sure	.7	.0	.3	.3	1.0
			Total	100.0	0.0	0.0		

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q93. Do you think that other girls and women in your community will get married before reaching the age of 18?	Females	10–17 yrs	Yes	40.4	.0	.9	38.6	42.3
			No	54.3	.0	.9	52.5	56.0
			I am not sure	5.3	.0	.4	4.5	6.2
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	38.9	.0	1.1	36.7	41.0
			No	60.5	.0	1.1	58.5	62.5
			I am not sure	.6	.0	.2	.4	1.0
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	33.3	.0	2.6	28.2	38.5
			No	66.7	.0	2.6	62.4	71.2
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	48.4	.0	1.6	45.7	51.4
			No	47.5	.0	1.6	44.1	50.6
			I am not sure	4.1	.0	.7	2.9	5.5
			Total	100.0	0.0	0.0		
Q106. Are you aware of risks that girls/women face due to child marriage?	Females	10–17 yrs	Yes	65.6	.0	.9	63.9	67.3
			No	34.4	.0	.9	32.7	36.1
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	75.6	.0	1.0	73.8	77.6
			No	24.4	.0	1.0	22.6	26.1
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	44.8	.0	2.8	39.7	50.3
			No	55.2	.0	2.8	50.1	60.0
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	69.5	.0	1.5	66.6	72.2
			No	30.5	.0	1.5	27.7	33.5
			Total	100.0	0.0	0.0		

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q114. Do you think child marriage should be continued in your community?	Females	10–17 yrs	Yes	15.0	.0	.7	13.6	16.4
			No	79.9	.0	.8	78.6	81.3
			Don't know	5.1	.0	.4	4.3	5.8
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	17.1	.0	.8	15.6	18.6
			No	82.0	.0	.8	80.3	83.6
			Don't know	1.0	.0	.2	.6	1.3
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	25.5	.0	2.4	20.9	30.0
			No	74.5	.0	2.4	70.0	79.1
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	23.1	.0	1.4	20.4	25.7
			No	71.4	.0	1.5	68.5	74.2
			I don't know	5.5	.0	.8	4.2	7.1
			Total	100.0	0.0	0.0		
Q132. Do you think a girl has a right to resist female circumcision?	Females	10–17 yrs	Yes	81.9	.0	.7	80.5	83.3
			No	18.1	.0	.7	16.7	19.4
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	79.7	.0	.8	78.0	81.5
			No	20.3	.0	.8	18.7	21.7
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	70.9	.0	2.4	66.4	75.2
			No	29.1	.0	2.4	24.8	33.6
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	92.9	.0	.9	91.1	94.7
			No	7.1	.0	.9	5.7	8.5
			Total	100.0	0.0	0.0		
Q133. Do you think a girl has a right to resist child marriage before the age of 18?	Females	10–17 yrs	Yes	78.7	.0	.8	77.3	80.2
			No	21.3	.0	.8	19.7	22.9
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	76.7	.0	.9	75.0	78.4
			No	23.3	.0	.9	21.6	24.9
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	71.5	.0	2.4	67.0	75.8
			No	28.5	.0	2.4	23.9	33.0
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	92.5	.0	.9	90.6	94.2
			No	7.5	.0	.9	6.1	9.1
			Total	100.0	0.0	0.0		

a. Unless otherwise noted, bootstrap results are based on 1,000 bootstrap samples

E. Sook sub-county

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q18. Do you think that other girls and women in your community will get cut now and in the future?	Females	10–17 yrs	Yes	37.1	.0	.6	35.9	38.2
			No	42.6	.0	.7	41.3	44.0
			I am not sure	20.4	.0	.5	19.3	21.3
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	48.4	.0	.9	46.8	50.1
			No	32.1	.0	.8	30.6	33.7
			I am not sure	19.5	.0	.7	18.1	20.8
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	34.8	.0	3.6	28.6	41.6
			No	24.8	.0	3.4	19.4	30.4
			Not sure	40.4	.0	3.9	33.5	47.8
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	43.6	.0	1.0	41.7	45.5
			No	39.5	.0	1.0	37.6	41.5
			Not sure	16.8	.0	.8	15.4	18.4
			Total	100.0	0.0	0.0		
Q22. Have you yourself been circumcised?	Females	10–17 yrs	Yes	61.9	.0	.6	60.7	63.1
			No	38.1	.0	.6	36.8	39.4
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	93.7	.0	.4	92.9	94.4
			No	6.3	.0	.4	5.6	7.1
			Total	100.0	0.0	0.0		
Q56. Are you aware of risks that girls/women face due to circumcision?	Females	10–17 yrs	Yes	69.9	.0	.6	68.7	71.1
			No	30.1	.0	.6	28.9	31.2
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	68.6	.0	.8	67.1	70.1
			No	31.4	.0	.8	29.9	33.0
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	59.0	.0	3.8	52.2	65.8
			No	41.0	.0	3.8	34.2	47.8
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	69.5	.0	1.0	67.5	71.5
			No	30.5	.0	1.0	28.7	32.4
			Total	100.0	0.0	0.0		

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q69. Do you think female circumcision should be continued?	Females	10–17 yrs	Yes	21.0	.0	.6	19.9	22.2
			No	70.7	.0	.6	69.5	71.9
			I am not sure	8.2	.0	.4	7.5	9.0
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	30.3	.0	.8	28.8	31.8
			No	59.4	.0	.9	57.8	61.1
			I am not sure	10.3	.0	.5	9.3	11.3
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	11.8	.0	2.5	7.5	16.1
			No	38.5	.0	3.7	32.3	44.7
			I am not sure	49.7	.0	3.9	43.5	56.5
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	34.3	.0	1.0	32.2	36.3
			No	58.2	.0	1.0	56.4	60.2
			I am not sure	7.5	.0	.5	6.6	8.6
			Total	100.0	0.0	0.0		
Q93. Do you think that other girls and women in your community will get married before reaching the age of 18?	Females	10–17 yrs	Yes	45.1	.0	.7	43.9	46.4
			No	32.2	.0	.6	31.0	33.4
			I am not sure	22.7	.0	.6	21.8	23.8
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	44.8	.0	.9	43.1	46.5
			No	35.2	.0	.8	33.6	36.7
			I am not sure	20.1	.0	.7	18.8	21.4
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	87.0	.0	2.7	81.4	91.9
			No	6.2	.0	1.9	3.1	9.3
			I am not sure	6.8	.0	2.0	3.7	9.9
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	49.7	.0	1.1	47.7	51.7
			No	34.8	.0	1.0	32.8	36.9
			I am not sure	15.5	.0	.8	14.1	16.9
			Total	100.0	0.0	0.0		

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q106. Are you aware of risks that girls/women face due to child marriage?	Females	10–17 yrs	Yes	58.7	.0	.7	57.5	60.0
			No	41.3	.0	.7	40.0	42.5
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	56.1	.0	.8	54.6	57.7
			No	43.9	.0	.8	42.2	45.6
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	47.2	.0	3.8	40.4	54.0
			No	52.8	.0	3.8	46.0	59.6
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	62.3	.0	1.0	60.2	64.3
			No	37.7	.0	1.0	36.0	39.5
			Total	100.0	0.0	0.0		
Q114. Do you think child marriage should be continued in your community?	Females	10–17 yrs	Yes	17.5	.0	.5	16.6	18.5
			No	65.9	.0	.6	64.7	67.2
			Don't know	16.5	.0	.5	15.6	17.5
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	11.2	.0	.5	10.1	12.2
			No	76.6	.0	.7	75.3	77.9
			Don't know	12.2	.0	.6	11.1	13.3
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	36.0	.0	3.7	29.2	42.9
			No	51.6	.0	3.8	45.3	57.8
			I don't know	12.4	.0	2.6	8.1	16.8
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	32.8	.0	1.0	30.9	34.6
			No	61.0	.0	1.0	59.2	63.0
			I don't know	6.2	.0	.5	5.4	7.0
			Total	100.0	0.0	0.0		
Q132. Do you think a girl has a right to resist female circumcision?	Females	10–17 yrs	Yes	73.2	.0	.6	72.2	74.2
			No	26.8	.0	.6	25.5	27.8
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	66.7	.0	.8	65.2	68.2
			No	33.3	.0	.8	31.7	34.9
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	60.9	.0	3.7	54.7	66.5
			No	39.1	.0	3.7	31.7	47.2
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	80.2	.0	.8	78.6	81.6
			No	19.8	.0	.8	18.1	21.6
			Total	100.0	0.0	0.0		

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q133. Do you think a girl has a right to resist child marriage before the age of 18?	Females	10–17 yrs	Yes	72.8	.0	.6	71.8	73.9
			No	27.2	.0	.6	26.1	28.3
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	66.3	.0	.8	64.8	67.8
			No	33.7	.0	.8	32.2	35.3
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	60.9	.0	3.7	54.7	66.5
			No	39.1	.0	3.7	31.7	47.2
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	82.1	.0	.8	80.7	83.5
			No	17.9	.0	.8	16.4	19.4
			Total	100.0	0.0	0.0		
a. Unless otherwise noted, bootstrap results are based on 1,000 bootstrap samples								

F. Wamba sub-county

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q18. Do you think that other girls and women in your community will get cut now and in the future?	Females	10–17 yrs	Yes	36.9	.0	.6	35.8	38.1
			No	52.9	.0	.6	51.7	54.0
			I am not sure	10.2	.0	.4	9.4	11.1
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	43.2	.0	.8	41.5	44.8
			No	49.2	.0	.8	47.6	51.0
			I am not sure	7.6	.0	.4	6.8	8.4
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	16.9	.0	2.8	12.2	22.1
			No	67.4	.0	3.5	61.6	73.3
			Not sure	15.7	.0	2.7	11.5	20.9
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	38.9	.0	1.4	36.4	41.6
			No	33.8	.0	1.4	31.1	36.4
			Not sure	27.3	.0	1.3	24.8	29.8
			Total	100.0	0.0	0.0		

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q22. Have you yourself been circumcised?	Females	10–17 yrs	Yes	56.8	.0	.6	55.6	58.0
			No	43.2	.0	.6	41.9	44.5
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	94.7	.0	.4	94.0	95.4
			No	5.3	.0	.4	4.6	6.0
			Total	100.0	0.0	0.0		
Q56. Are you aware of risks that girls/women face due to circumcision?	Females	10–17 yrs	Yes	47.1	.0	.7	45.8	48.4
			No	52.9	.0	.7	51.5	54.3
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	43.6	.0	.8	42.2	45.3
			No	56.4	.0	.8	54.7	57.8
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	78.5	.0	3.1	72.7	83.7
			No	21.5	.0	3.1	16.3	27.4
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	32.7	.0	1.4	30.2	35.5
			No	67.3	.0	1.4	64.7	69.7
			Total	100.0	0.0	0.0		
Q69. Do you think female circumcision should be continued?	Females	10–17 yrs	Yes	23.7	.0	.5	22.7	24.7
			No	69.8	.0	.6	68.6	70.8
			I am not sure	6.6	.0	.3	5.9	7.2
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	34.6	.0	.8	33.0	36.0
			No	62.1	.0	.8	60.6	63.8
			I am not sure	3.3	.0	.3	2.8	3.9
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	18.0	.0	2.9	13.4	23.3
			No	82.0	.0	2.9	76.7	87.2
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	39.1	.0	1.4	36.6	41.4
			No	43.0	.0	1.5	40.1	46.0
			I am not sure	17.9	.0	1.1	15.7	20.0
			Total	100.0	0.0	0.0		

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q93. Do you think that other girls and women in your community will get married before reaching the age of 18?	Females	10–17 yrs	Yes	33.8	.0	.6	32.8	34.9
			No	54.7	.0	.6	53.5	55.9
			I am not sure	11.4	.0	.4	10.6	12.3
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	36.3	.0	.8	34.7	37.9
			No	52.2	.0	.8	50.7	53.7
			I am not sure	11.5	.0	.5	10.4	12.6
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	39.0	.0	3.8	32.0	45.9
			No	61.0	.0	3.8	54.7	67.4
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	29.6	.0	1.3	27.0	32.1
			No	38.4	.0	1.4	35.7	41.3
			I am not sure	32.0	.0	1.3	29.6	34.4
			Total	100.0	0.0	0.0		
Q106. Are you aware of risks that girls/women face due to child marriage?	Females	10–17 yrs	Yes	40.3	.0	.7	39.1	41.5
			No	59.7	.0	.7	58.4	61.0
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	45.7	.0	.8	44.0	47.5
			No	54.3	.0	.8	52.7	55.9
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	84.9	.0	2.7	79.7	89.5
			No	15.1	.0	2.7	10.5	20.3
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	40.9	.0	1.4	38.2	43.5
			No	59.1	.0	1.4	56.5	61.9
			Total	100.0	0.0	0.0		

Indicator of interest	Sex of respondent	Age cohort		Indicator value	Bootstrap for per cent[a]			
					Bias	St. error	BCa 95% Confidence interval	
							Lower	Upper
Q114. Do you think child marriage should be continued in your community?	Females	10–17 yrs	Yes	12.2	.0	.4	11.4	13.0
			No	79.4	.0	.5	78.4	80.5
			Don't know	8.4	.0	.4	7.7	9.1
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	11.0	.0	.5	10.1	12.0
			No	85.1	.0	.6	83.9	86.3
			Don't know	3.9	.0	.3	3.3	4.4
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	No	94.8	.0	1.7	91.9	97.1
			I don't know	5.2	.0	1.7	2.9	8.1
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	16.9	.0	1.1	15.1	18.8
			No	66.8	.0	1.3	64.2	69.5
			I don't know	16.3	.0	1.0	14.4	18.4
			Total	100.0	0.0	0.0		
Q132. Do you think a girl has a right to resist female circumcision?	Females	10–17 yrs	Yes	73.0	.0	.6	71.9	74.2
			No	27.0	.0	.6	25.9	28.0
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	68.9	.0	.8	67.3	70.5
			No	31.1	.0	.8	29.6	32.7
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	90.1	.0	2.3	86.0	93.6
			No	9.9	.0	2.3	6.4	14.0
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	70.7	.0	1.3	68.5	73.0
			No	29.3	.0	1.3	26.9	31.7
			Total	100.0	0.0	0.0		
Q133. Do you think a girl has a right to resist child marriage before the age of 18?	Females	10–17 yrs	Yes	75.9	.0	.5	74.8	77.0
			No	24.1	.0	.5	23.1	25.1
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	72.8	.0	.8	71.4	74.3
			No	27.2	.0	.8	25.7	28.6
			Total	100.0	0.0	0.0		
	Males	15–17 yrs	Yes	90.1	.0	2.3	86.0	93.6
			No	9.9	.0	2.3	6.4	14.0
			Total	100.0	0.0	0.0		
		18–49 yrs	Yes	77.0	.0	1.2	74.8	79.4
			No	23.0	.0	1.2	20.5	25.3
			Total	100.0	0.0	0.0		

a. Unless otherwise noted, bootstrap results are based on 1,000 bootstrap samples

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