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"Towards Zero: Understanding the limitations of the UNFPA-UNICEF Joint Program to Eliminate Female Genital Mutilation, a case study of Kenya"


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## Abstract

Female genital mutilation (FGM), or female circumcision, effects more than 200 million women and girls worldwide, and since the 1990s has been classified as violence against women and a human rights violation. It is estimated that three million more girls are threatened to be subject to FGM every year, and that is why hundreds of organizations all over the world have formed to try and put a stop to it. The largest effort is the UNFPA/UNICEF Joint Program to Eliminate Female Genital Mutilation, which works in 17 countries to put an end to the practice worldwide by 2030. The Joint Program, however, is limited. By examining the top-down approach, awareness campaigns, and the extent of coordination with other organizations, both at an international level and within Kenya, this thesis aims to explain why the Joint Program is limited, and therefore, ineffective.

## Abstract (Deutsch)

Weibliche Genitalverstümmelung (FGM) oder weibliche Beschneidung betrifft weltweit mehr als 200 Millionen Frauen und Mädchen und wird seit den 1990er Jahren als Gewalt gegen Frauen und Menschenrechtsverletzung eingestuft. Es wird geschätzt, dass jedes Jahr drei Millionen weitere Mädchen von FGM bedroht sind, und deshalb wurden Hunderte von Organisationen weltweit gegründet, um zu versuchen, dem Einhalt zu gebieten. Die größte Anstrengung ist das gemeinsame Programm von UNFPA und UNICEF zur Beseitigung der Genitalverstümmelung von Frauen, das in 17 Ländern arbeitet, um die weltweite Praxis bis 2030 zu beenden. Das gemeinsame Programm ist jedoch begrenzt. Durch die Untersuchung des Top-down-Ansatzes, der Sensibilisierungskampagnen und des Ausmaßes der Koordinierung mit anderen Organisationen sowohl auf internationaler Ebene als auch innerhalb Kenias soll erklärt werden, warum das gemeinsame Programm begrenzt und daher ineffektiv ist.

## Pledge of Honesty

*On my honour as a student of the Diplomatic Academy of Vienna, I submit this work in good faith and pledge that I have neither given nor received unauthorized assistance on it.*

*Marissa Miller*

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## Introduction

The practice of female genital mutilation (FGM), also known as female circumcision, effects more than 200 million women and girls worldwide. It is a human rights violation and perpetuates issues like violence against women and children, gender discrimination, and has significant negative health effects. Therefore, the efforts to eradicate the practice are pressing. The research and statistics produced on the subject are numerous, attempting to convey the necessity of its end everywhere in the world and striving to educate the globe's citizens on the negative consequences of FGM. The issue has been at the forefront of Kenyan society and politics for the last 100 years, but measures against the practice have been implemented and revoked, spoken out against and shut down, as in many other countries where the practice is prevalent. With legislative action taken in numerous countries, the numbers have dropped, but nearly 30 years since FGM's recognition by UN member states as a human rights violation, the issue still persists.

The main driver for change has been the United Nations, especially through the United Nations Population Fund (UNFPA) and the United Nations International Children's Fund (UNICEF) in their Joint Program, formed to combat FGM globally, along with partnerships with the World Health Organization (WHO) and Demographic and Health Surveys (DHS). After the World Conference on Human Rights in 1993, where FGM first became recognized as violence against women, and therefore also a human rights violation, research into the practice soared. In 2015, FGM eradication saw a new push when it was explicitly made a part of Sustainable Development Goal 5, and as a result, the goal of worldwide eradication became the year 2030. While the UNFPA and UNICEF led the charge, after the launch of the UNFPA/UNICEF Joint Program, dozens of other organizations – international and local – followed suit. Today, the number of organizations working to combat FGM is not a recorded, official number, but based on resources like The Girl Generation, the number is likely over 1000.[1]

Kenya has taken several legislative steps in the last 20 years to commit to FGM's complete eradication among its citizens. In 2011, the state banned FGM and imposed a fine and jailtime for breaking that law. The national percentage of girls subject to FGM has decreased from 48% (estimated in 1999 by DHS) to 21% in 2014,

[1] "Impact Report 2017-2018," *The Girl Generation*, 2018.

which is seen as a relative success. While this decline should not be denigrated, in some Kenyan counties, the number is upwards of 90% of girls – nowhere near the deceiving 21%. Most efforts to spread awareness comes from grassroots organizations and NGOs, not necessarily the government itself. These organizations aim to educate whole communities on the health risks of the procedure, amid a growing number of circumcisions being medicalized or outsourced across country borders. In areas that have been harder to reach, they have created new types of "coming-of-age" rituals that focus on health and education. However, there is an overall lack of resources and lack of enforcement by the Kenyan government that can inhibit continued progress.

The eradication of FGM has only come more into focus in present day. In 2019 in Narok County, Kenya, the Commissioner issued the directive to have all schoolgirls tested for FGM and pregnancy in order to crack down on violators and solve the problem of high rates of teen pregnancy.[2] Not only does this present more human rights issues, but it was heavily critiqued as only potentially worsening the issue, not stopping it. In Meru County, Kenya, the death of a young girl in early 2019 due to the procedure and multiple arrests made later in the year sparked outcry from anti-FGM groups across Kenya. For an area that has been at the forefront of awareness-raising and politics around the subject for decades, these events indicate that the move toward complete eradication is far from over.

While the UN organizations have joined together in the fight against FGM, they are falling short of being on track for complete eradication by 2030. Only working in 17 of the approximately 30 countries where the practice is prevalent – not including where the practice has spread in diaspora regions around the world – even if the UNFPA/UNICEF Joint Program is completely successful in its program areas, these others will still remain. The Joint Program, however, is not reaching the levels it needs to be at, even within the program countries. Contrary to statements claiming lack of funding and resources as the main reason, this thesis seeks to analyze three reasons that limit the international method from being effective: the top-down approach, awareness campaigns, and (lack of) coordination between efforts.

[2] Nita Bhalla, "School girls in Kenya undergo compulsory tests for pregnancy, female genital mutilation," *Reuters* online, last modified January 4, 2019.

In order to answer why it is that the international approach is ineffective, it is crucial to analyze the current methods and strategies used on an international, national, and local level. Since the latter two levels differ significantly by country, a single case study will be used. A single case study offers a more specific approach to a topic that encompasses various regions and circumstances. By addressing one country, in this case Kenya, more attention can be devoted to the details of various programs and organizations and how their approaches are affecting communities rather than a global context. Additionally, now that there are two decades of implemented measures to reflect on, the emphasis should no longer be on the big picture, but rather on the effects on single states or groupings of people. This differs from academic research that has already been done, which overwhelmingly draws on larger themes and then gives specific examples from various locations; this discourse will be discussed further in Chapter 1. Furthermore, due to a lack of ability for the author to conduct her own field research on the topic of FGM, available quantitative data as well as the author's own gathered data will be utilized in order to do a qualitative analysis, thus drawing a conclusion.

For each level of analysis, there will be two different approaches used in order to analyze each organization or program's methods and their effectiveness, first from an overarching global perspective and then from a single perspective, in this case of Kenya. After an overview of FGM, the following chapters will delve into three different aspects to analyze the international and local efforts: the top-down approach; awareness raising, specifically through social media; and the coordination between efforts. The top-down approach looks at the history of the FGM movement on an international scale, including the first actions taken by governments. The main international effort comes from the UNFPA/UNICEF Joint Program, and this section will break down the stated and intended goals of the program from its outset and utilize its own reports and project analyses to evaluate progress. The same will then be done but specifically regarding the program's effects within Kenya. The analysis of awareness raising will follow, and it will be done through social media, specifically regarding the engagement with the organization or program and the successfulness of social media campaigns, in order to give insight on the reach of the organizations' efforts.

Regarding Chapter 3, the awareness section, original research will be used as a main part. The research was conducted on Twitter and is an evaluation of various hashtags, mentions, and retweets of the organizations and programs which are analyzed in this thesis. This section focuses less on the data itself, and instead on the outcomes represented by this data. Since there is no open data analysis of Twitter available, the data used here is from the author's own gathering. Three elements were evaluated by four different criteria, and the first was the number of post mentions/times a tag was used throughout a year. Because of the lack of available analytics, this was done manually through sampling. For each year, the post mentions/tags were counted from November 1st to 15th and multiplied by two to represent a month-long sample. November was chosen because it does not contain either of the two international days directly pertaining to FGM and is otherwise random. Therefore, when reading the corresponding graphs to the first element, Figure 1 is representative of the number of post mentions/tag uses throughout the month of November of the marked year.

The second element of data comes from direct engagement with posts made by others. This was done based on the number of retweets a post received, and each data point represents the average number of retweets on posts pertaining to the search term. For each year and each term, the top 30 posts that were generated by the Twitter algorithm were used. The total number of retweets of all 30 posts were added together and divided by the total number of posts (30) to get the average. It is important to note that these are not the top 30 posts by highest number of likes or retweets, but rather the top 30 generated by Twitter that appear under the "Top" tab as the first 30 posts shown to viewers when searching for the term. Because this is based on Twitter's own algorithm, all data was gathered by the author on the same day – May 25, 2020 – as it is possible the search term could return different results to different users on different days. This data collection is represented in Figure 2.

The third element looked at which types of accounts were represented in the top 30 posts (by the same top 30 definition as in the second element). This was done by recording which accounts had a total of two or more posts within the top 30 posts each year. The accounts were then categorized by whether they were an international or governmental organization, a non-governmental organization, or a local or personal account. To determine the correct category, a verification check was done, and if it

was not a verified account, then it was based on the description of the account and any available links to websites.

For the data pertaining to Kenya, in order to get a more accurate and local picture of Twitter feeds, the data in this section was collected using a virtual private network (VPN) connected to Nairobi.

All this original data is subject to human error, though all counts were done three times each in order to assure the most accurate reporting. However, taken as an approximation, the data is used to find trends and evaluate engagement, and therefore a small amount of error will not significantly impede the analysis and/or conclusions drawn.

## Chapter 1: An overview of FGM globally and within Kenya – research and efforts towards eradication

Female genital mutilation (FGM), or female circumcision, is defined by the World Health Organization (WHO) as, "All procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons."[3] The term and its definition are broad, so a further categorization is used which divides the procedure into four different types:

> Type I: Clitoridectomy (the partial or total removal of the clitoris and/or the prepuce)
>
> Type II: Excision (partial or total removal of the clitoris and labia minora, with or without the labia majora)
>
> Type III: Infibulation (narrowing of the vaginal orifice with creation of a covering seal by cutting and positioning the labia minora and/or the labia majora, with or without excision of the clitoris)
>
> Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping or cauterization.[4]

The WHO and the United Nations further classify FGM as both a public health issue and a violation of human rights as defined in the Universal Declaration of Human Rights. There are no health benefits to the practice, regardless of which type. Following various medical studies, the UN/WTO interagency statement concludes that any procedure as outlined in the four categories interferes with the body's natural functions and "causes several immediate and long-term health consequences."[5] The immediate negative health effects of FGM include infection, swelling, hemorrhage, abscesses, and acute urinary retention. The long-term negative health effects can vary by the type that was performed and are more likely after undergoing type two or three. These long-term consequences include cysts, urinary tract infections, painful menstruation, and for women who become pregnant, there is a significantly increased

[3] "Eliminating Female genital mutilation: an interagency statement," *WTO Press*, 2008.
[4] *Ibid*.
[5] *Ibid*.

likelihood of perineal tears, excessive bleeding, needing a caesarean section, and even death.[6] For women and girls living in rural areas with a lack of access to hospitals and trained physicians, these consequences to their short- and long-term health are even more exacerbated. The psychological effects the procedure has on women and girls are also detrimental to their long-term health.

**Discourse on FGM**

Since the 1990s, the literature on FGM has increased dramatically. The task to identify and explain FGM was taken up not only by health professionals and feminists, but by anthropologists, sociologists, and even economists. The main debates around FGM are on how it should be approached. Continuing publications of the effects of FGM on reproductive health demonstrate the negative consequences that can result, and this has been tied to the practice's role in society. The result is a variety of publications which analyze FGM as a practice from several angles. In the *African Journal of Reproductive Health*, Finke writes about FGM reducing female pleasure as an expression of power structures, saying that FGM cannot come to an end without the improvement of economic and legal rights for women and the establishment of gender equality.[7] Finke suggests that FGM is linked to not only to women and children's rights, but that it is impossible to eliminate FGM without addressing these issues first.

The topic of FGM is also extensively written about in the field of human rights. Williams-Breault argues that eradication should come on the grounds of human rights-based legislation, as this is something that a majority of countries have committed to since the Universal Declaration of Human Rights was established. She says that the most effective way to combat this gender inequality is through education and empowerment (Williams Breault 2018).[8] Although Williams-Breault addresses FGM from a human rights perspective when suggesting the best way to combat FGM is through education, the educational approach is by far the most widely written about and accepted as the way to most effectively eradicate FGM. One author in particular,

[6] "Eliminating Female genital mutilation: an interagency statement," *WTO Press*, 2008.
[7] Emanuela Finke, "Genital Mutilation as an Expression of Power Structures: Ending FGM through Education, Empowerment of Women and Removal of Taboos," *African Journal of Reproductive Health / La Revue Africaine De La Santé Reproductive* 10, no. 2 (2006): 13-17.
[8] Beth D. Williams-Breault, "Eradicating Female Genital Mutilation/Cutting: Human Rights-Based Approaches of Legislation, Education, and Community Empowerment," *Health and Human Rights* 20, no. 2 (2018): 223-34.

Dorkenoo, discusses the turn of the millennia, during the height of the NGO push, that strong community outreach and increased education of women are the keys to a long-term elimination strategy.[9] These two different angles both favor the educational approach demonstrate the continued emphasis on education over two decades.

It is also generally accepted among the literature that FGM is a crucial part of a young woman's identity. This is due to the correlation between the practice and initiation rites. Many societies view circumcision as a crucial part of initiation and as vital to becoming a woman in their respective society. Without it, a girl cannot become a woman and an active member of the community, and the girls who do not go through the procedure are often casted out. The research of Coyne et al. provides a quantitative approach in a cost-benefit analysis of ethnic identity and its influence on the participation of the practice. They consider FGM to be a rational practice, and under this assumption, undergoing FGM is directly related to being suitable for marriage, being a member of any social group (religious, non-religious, or otherwise), and being a good parent. All of these factors lend to an overall strengthening of identity. Therefore, a change in practices required by banning means a change in (perceived) identity, and any law will be ineffective if there is no change in the view of one's identity.[10] Coyne's conclusion is similar to that of Finke; both authors view laws as ineffective if there is no critical change to how women are perceived in society.

Lynn Thomas's book, *Politics of the Womb: Women, Reproduction, and the State in Kenya*, is the most comprehensive and in-depth work as a specific case study of Kenya. Thomas discusses the history of reproductive rights including female initiation, abortion, premarital pregnancy, and childbirth, specifically regarding the Meru population. Beginning with the colonial influence of the British Empire and the church missions they brought with them, through the Mau Mau rebellion, and after independence, she asserts that controversies surrounding gender and reproduction have challenged, but also constructed, social hierarchies. The interplay between the external actors like development aid agencies, intergovernmental organizations, and colonial/post-colonial relationships have various effects on the independent Kenyan state. Thomas also sheds light on the relationship between aid given specifically by

[9] Efua Dorkenoo, "Combating Female Genital Mutilation: An Agenda for the Next Decade," *Women's Studies Quarterly* 27, no. 1/2 (1999): 87-97.
[10] Christopher J. Coyne, Rachel L. Coyne, "The Identity Economics of Female Genital Mutilation," *The Journal of Developing Areas* 48, no. 2 (2014): 137-152.

the United States through the US Agency for International Development and pressure on the Kenyan government to comply with certain standards, at the risk of not receiving the promised – and relied upon – aid. She draws the connection between these two areas and asserts that because of the international attention drawn to FGM in the early 1990s, there was pressure for the Kenyan government to comply so that they would continue to receive aid from countries in Western Europe and the United States. In 1990, the US had already pulled funding for six months due to human rights abuses of the Kenyan government; therefore, it is credible that they, and others, could do this once again.[11] Thomas's book, however, was written in 2003, just after Kenya passed its first legislation banning FGM on women under 18 years of age. Since then, there has not been any further research published by her or others in her field on the impact of external influence on decisions made on the national level in Kenya, even though there have been significant developments on the matter.

As demonstrated, the extent of the research done is largely focused on anthropological approaches of analysis, identifying one reason that there is still hold-out, and proposing the best way to address the issue of FGM in countries. The current literature largely only exists in the context of all cases of FGM, with the statistics often being the only indicator of differentiation among regions or countries. The situation and reasons for the practice of FGM, however, varies by state – and even drastically within states – and an overview-style analysis does not do justice to the matter. Moreover, the current research strongly focuses on the role of FGM within societies in an over-arching cross-border context, while the discussion of methods used is nearly non-existent outside of NGO and international aid programs' reports. Not only does this over-arching concept fail to address what is largely a localized issue, it does not leave room for a discussion of effectiveness that lies beyond a mere proposal of implementing methods. The academics discussed here have merely been a basis for the methods that have been implemented during the last 15 years. While this is a crucial aspect and undoubtedly had a significant impact on how these methods and strategies were created, there is little follow-up research done on an academic level regarding the progress after these ideas were implemented by the UN and others. The more recent research, such as by Williams-Breault, is an all-inclusive overview; the

[11] Lynn M. Thomas, *Politics of the Womb: Women, Reproduction, and the State in Kenya,* University of California Press, 2003.

reality, though, is that different countries and different communities treat FGM and respond to eradication measures in different ways. Now that there are two decades of implemented measures to reflect back on, the emphasis should no longer be on the big picture, but rather on the effects on single states or groupings of people.

**FGM around the world**

It is estimated that around 200 million girls have undergone FGM, and three million are subject to the practice each year – that is one girl every 10 seconds. The practice predominantly takes place in 28 African countries, Indonesia, and Yemen, but it is also carried out in immigrant communities in Europe, the United States, Canada, and Australia, among others. The reasons FGM is practiced varies by country and regional/ethnic group, but the most cited reasons are related to religious or cultural practices. While 90% of the cases worldwide are of Type I, II, or IV, infibulation (Type III) is the most severe and is still found in 10% of total cases. This severe form is generally practiced in countries in the north-east of Africa like Djibouti, Ethiopia, and Somalia. In western Africa, Type I and II are the most commonly practiced.[12] The prevalence of girls and women aged 15-49 who have undergone some type of FGM procedure varies greatly by country, and sometimes even within individual countries. The countries where the practice is most widespread include Egypt, Somalia, Mali, and Guinea, each seeing rates of over 85%; in Guinea, this number is upwards of 95%. In other places such as Uganda and Niger, the prevalence is less than 1% and 2%, respectively.[13]

While the last 30 years has seen an overall decline in the practice of FGM, from 49% to 34% in girls aged 15-19, the downward trend is not a universal one. Some countries have seen quick and significant decline, some a slow and steady one, and others a decline followed by the threat of stagnation or increase. Even though significant progress is being made, the pace at which progress comes is significantly varied.[14] For example, in Guinea-Bissau, the overall prevalence among girls and women aged 15-49 has remained at 45% from 2006 to 2014, but the percentage of those girls and women who think FGM should continue has decreased significantly

[12] "Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change: Annual Report," *UNFPA/UNICEF*, 2010, pp. 42.
[13] "Female genital mutilation (FGM)," *UNICEF Data*, February 2020.
[14] *Ibid.*

from 28% to 13% over the same time period.[15] In Tanzania, the percentage who think FGM should continue has remained relatively unchanged (at 3-5%), and the prevalence of the practice from 1996 to 2016 has decreased steadily from 18% to 10%.[16] In Niger on the other hand, where the prevalence has been consistently low, dropping from 4% to 2% over the period from 1998 to 2012, the percentage of the girls and women in the same age group who think FGM should continue is higher, at 6% in 2012. [17] Therefore, with such a wide-ranging prevalence, a country-by-country approach provides a better way of viewing the situation, as opposed to overall world statistics. The overall progress is important, but it encompasses only a glimpse at the trends throughout the world.

Additionally, although progress towards the eradication of FGM is being seen, one major factor that threatens the continued decline of FGM rates is population growth. The countries with the highest prevalence of FGM are also those facing the highest population growth rates in the world. Tanzania and Senegal, whose FGM rates are currently some of the lowest, are experiencing population growth at 2.8%, with the female population aged 25-29 accounting for 8% of the total female population in both countries, threatening the persistence of the low FGM rates.[18] This is a concern for all effected countries, as it makes progress toward the practice's continuing decline even more challenging, especially considering the current state of progress.

**FGM in Kenya**

The prevalence of FGM in Kenya has been on the decline since the practice came to international attention in the 1990s. Demographic and Health Surveys (DHS) data shows that the country-wide percentage of women and girls (aged 15-49) who have undergone FGM has decreased from 27.1% in 2008 to 21% in 2014. In the age group 15-19, the total dropped from 14.6% to 11.4% during the same surveys. The majority (87.2%) of those who have undergone FGM have experienced Type II, with

[15] "Guinea-Bissau: Statistical Profile on Female Genital Mutilation," *UNICEF Data*, January 2020.
[16] "United Republic of Tanzania: Statistical Profile on Female Genital Mutilation," *UNICEF Data*, January 2020.
[17] "Niger: Statistical Profile on Female Genital Mutilation," *UNICEF Data*, January 2020.
[18] "Population growth (annual %)," *World Bank Group*, 2019.

Type III being the next most common procedure, effecting 9.3% of circumcised women and girls.[19]

These numbers showing low rates and steady decline are rather disproportionate, however, when broken down by region or ethnic group. While ethnic groups such as the Luo and Luhya have rates of 0.2% and 0.4%, respectively, rates among the Kisii, Maasai, Somali, and Samburu are significantly higher – 84.4%, 77.9%, 93.6%, and 86.0%, respectively. Ethnic group breakdown accounts for the largest disparity between demographic groups regarding FGM, more so than religion, education, or wealth. Islam is the third largest religion in Kenya, and it also is where the highest occurrence of ties between religion and FGM occur. Among Muslim women, 43.7% believe female circumcision is required by their religion, whereas this number is 2.5% among Roman Catholic women. While it is evident that the lower categories of education and wealth tend to have higher rates of FGM, women and girls in this category are only minimally less aware of female circumcision, ranging from 92.3% among those with no education to 98.6% among those with secondary+ education. The factor of those who have heard of female circumcision also is mostly tied to region and ethnic group over their education and wealth levels. Generally speaking, almost all of the ethnic groups show a rate in the 95-100% range; however, among the Mijikenda/Swahili group, only 83.1% have heard of female circumcision.[20]

As stated, the practice of FGM in Kenya is overall not a religious tradition. It is generally only believed to be required by religion among Muslims, who make up just 10.9% of the total population (and of those, only half believe in its requirement).[21] The practice instead, among the majority of ethnic groups, is a sociocultural tradition. FGM is part of the initiation ritual, or rite of passage, which signifies the transition to womanhood. Just one part of the entire rite of passage, female circumcision is considered a necessary part of a girl becoming a woman and is linked to marriage and promiscuity. In many ethnic groups, especially those still with the highest rates of FGM like the Maasai and Samburu, those who are not cut are not eligible for marriage, and therefore cannot become a true member of society, leaving them as outcasts. This

[19] "Kenya Demographic and Health Survey 2014," *DHS Final Reports, Kenya DHS: Nairobi,* December 2015.
[20] *Ibid.*
[21] "Africa: Kenya," *The World Factbook 2020*, 2020; "Kenya Demographic and Health Survey 2014," *DHS Final Reports, Kenya DHS: Nairobi,* December 2015.

social pressure to be cut is one of the most prominent reasons for the continuation of the practice.

In some ethnic groups, such as the Kikuyu, female circumcision has historically been tied to colonialism and Christian mission churches during the era of the British empire. In the 1920s, the Church of Scotland, appalled by the practice, denied schooling and being part of the church to anyone who participated. Angered by this, many political groups were formed in defiance, and leaders like Jomo Kenyatta who was the representative of the Kikuyu Central Association at the time, used this opportunity to speak out. He utilized the tensions to provoke the Church and the British government and to arouse a sense of nationalism among the people. For many decades after, effectively until Kenyan independence in 1963, the insistence of the colonial powers to end female circumcision was viewed as a way for Western ideals and practices to be imposed on African societies.[22]

For the Samburu ethnic group, located in Samburu County, formerly known as the Rift Valley Province, FGM is intertwined with the practice known as "beading." According to the KIOS Foundation,

> "…the warriors (Morans) are allowed to have a temporary marital relationship with a very young girl from the same clan as the warrior…since the moran and his beaded girl are relatives, and the girl is uncircumcised, both marriage and pregnancy are forbidden. In case of a pregnancy, the pregnancy has to be terminated through cruel abortion…if the beaded girl gives birth, the child has to be killed through herbs poisoning."[23]

Most often, girls are beaded between 9 and 15 years of age, before the time when they would become marriageable (circumcised) and then unfit to be beaded. This has led to some families circumcising girls at a younger and younger age in order to prevent them from being beaded. However, being circumcised at a younger age also means that the girls are fit to be married at a younger age as well, persisting both the

[22] Marissa Miller, "The Role of Missionaries in the Rise of Kikuyu Nationalism," 2019.
[23] Jane Meriwas, "Hidden tradition – girl child beading in Samburu communities," *KIOS Foundation* online, last modified March 8, 2017.

problem of early child marriage and FGM, at the expense of avoiding a different cultural practice.[24]

Girls who are cut are also less likely to finish their schooling, and this is another of the major problems in Kenya. Not only are girls taken out of school for the procedure to be done and for the weeks following for recovery, they are also unlikely to go back to school at all. Because of the social and traditional link between female circumcision and marriage, once girls have become women, they are often married not long after having completed initiation. Therefore, they are removed from school in order to take care of the home and start a family. Here, the correlation between more education and lower FGM rates has an influence on the continuation of the practice.

As FGM is increasingly under scrutiny, there has been an increase in the number of procedures being done outside the country, such as in bordering Tanzania. There has also been an increasing fear that the practice will continue to be pushed underground and being performed by those who are "untrained," and thus posing more health risks. Despite these worries, however, many girls in Kenya are undergoing alternative rites of passage, where the rite of passage ritual can still be a part of society, but instead of being cut, the focus is on health education and finding other representative ways of coming of age. Overall, though, the alternative rites of passage has not been the emphasis of many organizations or movements.

Although FGM prevalence in Kenya has declined significantly, the disparities between counties and ethnic groups distorts the big picture. A rate of 21% nationwide, and 11% among 15 to 19-year-olds, is promising but deceiving. Like many other countries where FGM is practiced, Kenya has a very young population with approximately one-third of people being 13 years of age or younger. As girls in this age group come of age in larger numbers than in previous years, it becomes difficult to predict how FGM rates will be influenced. Therefore, even with continued positive progress in the direction of eradication, it is crucial that this continue to be the case over the coming generation.

[24] Jane Meriwas, "Hidden tradition – girl child beading in Samburu communities," *KIOS Foundation* online, last modified March 8, 2017.

## Chapter 2: Top-down approach

### Into the international spotlight

Although FGM has been practiced for millennia, it has only come into the international spotlight within the last thirty years. Around the same time, uncoincidentally, was when human rights and women and children's rights also became the focus of the international community. What began as a feminist movement in the 1970s, gained traction by the late 1980s as a global trend for women's rights.

As early as the 1950s, the WHO denied that FGM was in their realm of activity after being asked to look into it by the United Nations. However, by the 1970s, NGOs in Senegal brought the issue of FGM to the public attention, around the same time that the first academic article was written on the subject and referred to the practice for the first time as "genital mutilation" rather than "circumcision." Following the new attention to the practice, at the first International Women's Day held in Burkina Faso in 1975, the details and the negative health impacts of FGM were expressed and made it into popular media for the first time. The articles and figures that followed not only highlighted FGM as having negative health effects, but it was also taken up by feminists, particularly Fran Hosken who published *The Hosken Report: Genital and Sexual Mutilation of Females* in 1979. Hosken's report called out FGM as violence against women and a practice that enables this kind of violence. Earlier that year, FGM was included for the first time in a WHO seminar, and UNICEF released its first FGM-related statement.[25] Using the Hosken Report – which also gave a country-by-country estimations of the prevalence of FGM – the UN bodies continued to discuss the topic, and in the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) adopted by the UN General Assembly in 1979, violence against women was first recognized as a violation of human rights. From then on, FGM became a progressively more prominent part of the worldwide conversation. There was little information or data on FGM during these early stages of international recognition, so the compilation of research quickly hastened. In 1984, African NGOs formed the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, and as women's groups began coming together to push for laws

[25] "Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change," *UNICEF*, 2013.

prohibiting FGM, the decade culminated with the Convention on the Rights of the Child (CRC), adopted by the UN General Assembly in 1989. As more information was slowly becoming available, the CEDAW laid out in more detail its provisions concerning FGM. Three years following, in 1993, at the World Conference on Human Rights, FGM was explicitly recognized as a form of violence against women, an issue that itself was recognized at the Conference as being a human rights violation. In turn then, FGM was now classified as a human rights issue and there was a call for the complete end to the practice.[26] This was the first time that FGM was acknowledged as a human rights issue, instead of a health or medical issue. The movement to formally end the practice had now fully commenced, and this started with pressure on national governments to respond to the fact that letting FGM continue was now equated to a violation of internationally recognized human rights.

International and national attention to FGM ramped up considerably after the Conference in 1993 and the practice's new association as a violation of human rights. Not only did this new association call for the invocation of the CEDAW, but due to the practice mostly effecting children and it being detrimental to their health, FGM also violates the Convention on the Rights of the Child. This put pressure on the national governments where the practice is performed – even if in a small minority – to act in accordance with the international treaties. One of the first countries to act after the recognition of FGM as a human rights violation was Burkina Faso. In 1996, a national law was passed that specifically outlines the prohibition and punishment for those who practice FGM under an amendment to the government's penal code. This remains the principal legislation in Burkina Faso still today. These conventions adopted by the UN General Assembly became the catalysts for the movement and for countries around the world to outlaw the practice of FGM.

**Action by the international community**

In 1997, another international milestone unfolded. The first joint statement was published by the WHO, together with UNICEF and UNFPA, explicitly against FGM. This document not only outlines the negative health effects and cultural reasons for the practice, but it calls for a multidisciplinary approach of national and local action.

[26] "Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change," *UNICEF*, 2013.

Some of their recommendations include an increase in research regarding all aspects of the practice, an emphasis on outreach and communication, and a call for clear national policies on the practice's abolishment.[27] Not long after this joint statement was released, data acquisition – largely by Demographic and Health Surveys (DHS) – began on a large scale, in order to gather a better understanding of how widespread the practice is within the concerned countries. The DHS began including questions on FGM in Egypt in 1995 and introduced them in other countries such as Kenya and Burkina Faso in 1998.[28]

In 2000, at the Millennium Summit, the UN adopted the United Nations Millennium Declaration. Signed by 189 member states, the Declaration aims to combat poverty through dealing with hunger, gender discrimination, and disease, among others, by setting eight goals. Of the eight goals, two of them are commonly associated with FGM:

> Goal 3: Promote gender equality and empower women.
> Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015.
>
> Goal 5: Improve maternal health.
> Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.
> Target 5.B: Achieve, by 2015, universal access to reproductive health.[29]

While these goals do not specifically address FGM, they are still closely tied. Promoting equality in education and empowering women is one of the steps in the action plan outlined in the Joint Statement by the WHO/UNFPA/UNICEF. Additionally, as medical research has shown, complications during and after birth can arise due to the lasting effects of FGM. Improving the care and awareness around maternal health would therefore also encompass reducing the number of women who suffer from complications due to FGM. Because girls' education and women's health are so

[27] World Health Organization, "Female genital mutilation: A Joint WHO/UNICEF/UNFPA Statement," *World Health Organization*, 1997, pp. 13-16.
[28] "Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change," *UNICEF*, 2013.
[29] "Millennium Development Goals (MDG) monitoring," *UNICEF* online, December 31, 2014.

closely tied to the practice, by addressing these issues, FGM will consequently be addressed as well. By 2013, the result of Goal 3 was determined a relative success. Overall, most countries had eliminated gender disparity in primary and secondary education and there was a 6-percent increase of women in the workforce from 1990-2013. Additionally, the number of women in parliamentary positions doubled over the same period. As for Goal 5, the maternal mortality rate decreased almost 50% during this period as well.[30] Because of the direct correlation drawn between education, health, and FGM, these were considered good progress indicators for a declining rate of FGM.

In 2012 the UN began to ramp up the push for awareness and to further make FGM a more explicit priority, especially compared to its vague reference within the Millennium Development Goals. At the 67th session of the General Assembly, Resolution 67/146 was adopted. Recalling on earlier resolutions, A/RES/67/146 called for "Intensifying global efforts for the elimination of female genital mutilations." The Resolution calls for states to, among other things, fulfill their obligations under the Convention on the Rights of the Child, the CEDAW, and other international commitments; to condemn harmful practices; and to implement measures and action plans with a target of eliminating FGM within their borders.[31]

The Millennium Development Goals framework expired in 2015, and they were replaced by the Sustainable Development Goals (SDGs) which are the current framework in place until 2030. All the goals are interconnected to one another, and together, they were created to address some of the most pressing global challenges. While the MDGs consisted of eight rather broad goals and a few sub-targets, the SDGs consist of 17 separate goals, each with multiple targets. Similar to the MDGs, the SDGs cover the education and health aspects that are a concern for eradicating FGM. However, Goal 5 of the SDGs is Gender Equality and directly refers to FGM in its targets. It reads:

Goal 5: Achieve gender equality and empower all women and girls.

[30] "Millennium Development Goals and Beyond 2015," *UN* online, accessed May 15, 2020.
[31] General Assembly resolution 67/146, *Intensifying global efforts for the elimination of female genital mutilations*, A/RES/67/146, March 5, 2013.

> 5.3: Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.[32]

Not only did this make FGM eradication an explicit goal, but it shifted the narrative from urging national governments to abolish the practice to a global commitment of ending the practice completely throughout the world – and doing so by 2030.

With more data becoming available, and more and more programs being launched by groups across the world, the global awareness of FGM also began to increase. From 1990 to 2010, the global percentage of girls aged 15-19 who have undergone FGM decreased from 49% to 42%, and since 2010, this number has dropped to an estimated 34%.[33] In order to completely eradicate FGM by 2030 though, efforts need to be accelerated even further. Over the last decade hundreds of NGOs and local groups have sprung up to take part in the fight against FGM. Whether through communication strategies, lobbying, or helping fund education, these organizations have played a crucial role in the process. The international treaties and campaigns, however, have been the driving force as far as building the framework and guidelines, and together with DHS, the data used to proceed forward.

**UNFPA/UNICEF Joint Program**

The international community has been one of the main driving forces in the fight to end FGM. Through the creation and undertaking of various campaigns, UN agencies and states at the international level have taken a stand. The methods implemented by the international community, however, vary by organization and over time. This section will provide an overview of the main international methods that have been used over the last 25 years as well as why they were implemented. After analyzing the progress of the global movement as a whole, the limitations and successes of the methods will be discussed.

About five years after the UN took an official stand against FGM, the UN bodies of the WHO, UNICEF, and UNFPA together released their first statement promising to begin a global effort to eradicate the practice. This first document, the Joint Statement on Female Genital Mutilation published in 1997, outlined the organizations' proposed

[32] "Sustainable Development Goals: Goal 5," *UN* online, accessed May 15, 2020.
[33] "Female genital mutilation (FGM)," *UNICEF Data*, February 2020.

actions and first steps in the process. Specifically, it covers raising awareness among all influential leaders, assisting authorities and groups in developing policies, providing support to community initiatives, and helping to revise school curricula on their portrayal of women and girls. Each organization concerns itself with a different area of expertise in the action plan with the WHO focusing on continued research on FGM's health impact and properly training medical professionals regarding complications that may arise after undergoing the practice; UNICEF focusing on supporting community efforts of education and communication, as well as generally raising awareness; and UNFPA as a channel of advocacy related to law and policy, and a focus on data collection. By following this coordinated campaign structure, the action plan states that it "should bring about a major decline in female genital mutilation in 10 years and lead to its elimination within three generations."[34]

The next joint inter-agency statement was in 2008, this time with the commitment of 10 UN agencies, and was the follow-up to the launch of UNFPA/UNICEF's Joint Program on Female Genital Mutilation/Cutting: Accelerating Change. Implemented in 15 countries in Africa, the five year "Phase I" was developed to accelerate the progress toward abandonment of FGM through a human rights approach. The program emulated the Millennium Development Goals in that it focused on the empowerment of women and girls and slowly changing how women and girls are valued in society through education. Primarily funded by Austria, Iceland, Italy, the UK, Switzerland, Norway, Ireland, and Luxembourg, the first phase focused on five key parts: strengthening the global movement, collaborating with national actors, integrating prevention and care into health services, fostering local commitments, and monitoring and research. Over the period 2008-2013, quantifiable progress was made. The broad strategy of encouraging public declarations against the practice saw a total of 12,573 communities (representing approximately 10 million people) across the 15 program countries publicly commit to ending FGM.[35] In hindsight, Phase I was rightly named, as it served as the launchpad for growth of the programs, most reaching their peak in 2013, and therefore being carried over into Phase II. The culmination of the first phase came during the Global Conference "Intensifying Actions to Eliminate

[34] "Female genital mutilation: A Joint WHO/UNICEF/UNFPA Statement," *World Health Organization*, 1997, pp. 17.
[35] "Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change: Summary Report of Phase I, 2008-2013," *UNFPA/UNICEF*, 2014.

Female Genital Mutilations" which was held by the Joint Program and the Italian government in Rome, where planning for Phase II initially took place. Under strengthening the global movement, advocacy and education implementation were focused on, where the Joint Program advocated for the UN resolutions that passed in 2012 and the International Day of Zero Tolerance of FGM to be implemented. Additionally, the launch of an Africa Coordinating Centre for the Abandonment of FGM/C was established in Nairobi.

On a national level, the first phase of the Joint Program mostly contributed to advocacy for the implementation of laws and policies regarding FGM. During the five years of the initiative, 10 countries saw either decrees, draft legislation, or adoption of legislation concerning FGM, and in the case of Senegal, the inclusion of FGM related health protocols introduced in their Division of Reproductive Health in the Ministry of Health. The second part of this was turning the laws into a plan of action. While more cases of enforcement were seen after the introduction of the Joint Program, most of these were in just one program country – Burkina Faso – and the Program subsequently steered in the direction of strengthening the capabilities of the states.[36]

The third part of the Joint Program's efforts focused on integrating health services in the program countries. Including training medical staff and occasionally introducing FGM into the education system, over the five years, a total of 5571 health facilities had incorporated FGM in their ante- and post-natal care. Aside from this, the program supported the effort to stop the medicalization of FGM (health workers performing the practice). The support was limited in this case, however, to only five of the program countries and largely centered around providing education materials and advocacy.[37]

Fostering local commitments brought out the Joint Program's aim to take into account the varying national factors. They focused on four main factors to "personalize" their efforts: the extent to which FGM was linked to religion, at what age FGM was generally performed, the extent of existing legal framework on FGM, and the extent to which a movement toward FGM abandonment was established. For example, in Sudan, the Saleema Initiative, which was created to reshape the language

[36] "Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change: Summary Report of Phase I, 2008-2013," *UNFPA/UNICEF*, 2014.
[37] *Ibid.*

surrounding FGM and those who were uncircumcised, was already in full swing by 2008. The Joint Program then provided support to this existing initiative which in turn attracted more awareness and funding to it. Where religious leaders hold significant influence over populations, the program concentrated on working with these leaders on education and urging them to inform their followers that FGM is not a religious obligation. By 2013, 20,941 religious leaders made such a public declaration.[38] Along the lines of public declaration, using TV, radio, and newspapers to promote abandonment rose significantly, as did discussion of FGM via social media. The Joint Program actively promoted and facilitated the use of these channels.

The final part of the first phase of the Joint Program was monitoring and evaluation (M&E). In 2010, partnered with the Harvard School of Public Health, the initial indicators and framework were substantially revised and restructured and were implemented for use starting in 2011. Besides the annual reports that they produced, four country case studies were published as well as an external evaluation commissioned by UNICEF and UNFPA. The conclusions of Phase I state the need for further funding and information about FGM, and the need for "further development of programmatic and research evidence about the effectiveness of national efforts and specific strategies across time."[39]

Phase II of the Joint Program was conducted from 2014-2017. The biggest shift that can be initially seen with the second phase is the structure of their performance report. The report emphasizes a holistic approach, that focuses less on broadly specific goals and more on the empowerment of girls and women and global aspects of the FGM movement. They did so by strengthening and amplifying those who already committed to the end of FGM in order to empower others, creating a type of snowball effect. With the new Sustainable Development Goals specifically discussing FGM, the legitimacy and commitment of 193 countries were a significant part of growing the global movement for FGM's abandonment. While Phase I had to focus on the beginning steps of how to lead a program such as this one, Phase II was able to embody the "acceleration" part of the program's goal and make it the priority. One of the biggest achievements of Phase II was the growth of the FGM-related database.

[38] "Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change: Summary Report of Phase I, 2008-2013," *UNFPA/UNICEF*, 2014.
[39] *Ibid.*

Studies looked at whether populations were experiencing a shift in social norms and how the practice varied across villages within the same country.

The three main areas of focus for Phase II were helping develop and support legal frameworks, provide education about prevention and care practices regarding health, and to promote further declaration to denounce FGM at the community level. Of these priorities, 56% of allocations were spent on education and mobilizing social change, which includes public declarations and increased communication to normalize the shift toward complete abandonment of the practice. The indicator used was the "Number of communities making public declarations of abandonment of FGM." The target number for the period 2014-2017 was 5946 communities, but by 2017 the total was 8963 communities.[40]

The final section discusses the lessons needed to move forward with the Joint Program into Phase III, and it emphasizes the need to hold national governments accountable for their legislation and putting even more focus on the empowerment of women and girls, including those who are living with FGM by not isolating them. This last statement acknowledges not only the need to focus on abandoning the practice, but also ensuring that those who are continuing to be subject to it have the proper care and support available.

Since the launch of the UNFPA/UNICEF Joint Program, 13 countries have developed legal and policy framework that bans FGM. All 17 of the program countries have mechanisms regarding FGM in place at the national level, and 12 of them have national funding that goes specifically towards FGM-related programs. Through the program's community engagement efforts, over 31 million people have made public statements about ridding FGM as a practice. Phase III of the Joint Program is ongoing since 2018 and continues to push for the completion end to FGM by 2030, in line with SDG 5.3. Over time, as the Joint Program has more resources and data available to them, increased attention has been given to individual countries and they now produce case files for each of the program countries. Seen through this country by country analysis, progress varies drastically across the program countries.

[40] "Performance Analysis for Phase II," *UNFPA/UNICEF Joint Programme on Female Genital Mutilation*, 2018.

**Effects in Kenya**

As one of the Joint Program's countries from the beginning, Kenya has benefitted greatly from the efforts and funding of the international community. Since independence, Kenya has been an active member of the United Nations, acceding to the CEDAW in 1984 and ratifying the CRC in 1990. They have also acceded to the African Charter on the Rights and Welfare of the Child in 2000 and ratified the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol) in 2010.[41]

The movement to eliminate FGM in Kenya by the Kenyan state began in the 1980s, when President Moi publicly condemned the practice and continued to make public appeals for the practice's end throughout 1980s and 1990s. In 2001, seven years after FGM was recognized as a human rights violation and four years after the first joint statement, Kenya's Parliament passed the Children's Act, where the criminalization of FGM on girls under 18 years of age is included. Then in 2008, the same year that the UNFPA/UNICEF Joint Program was launched, the Ministry of Gender, Children and Social Development launched their action plan for accelerating the elimination of the practice nationwide.[42]

In the Joint Program's third year, the Prohibition of FGM Act 2011 was adopted. This was an update to the Children's Act, and a more comprehensive stance against FGM in light of the new constitution which was adopted the year before. With the adoption of the Prohibition of FGM Act 2011, all forms of FGM became criminalized for all ages, and the Anti-FGM Board was established and is responsible for the implementation of the Act. Article 29 of the Act sets out the penalties for all offences: imprisonment for a minimum of three years and/or a minimum 200,000 shilling ($1953) fine. Additionally, if the procedure results in death, the perpetrator could face up to life imprisonment.[43] The most recent legislation passed was through the East African Community, called the EAC Prohibition of Female Genital Mutilation Act, enacted in 2016 to further commit and provide for the sharing of information and research within the Community. A year later, the National Policy on the Elimination of FGM (2016-

[41] "Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change," *UNICEF*, 2013.
[42] *Ibid.*
[43] "Kenya: The Law and FGM, May 2018," *Thomas Reuters Foundation* and *28 Too Many*, 2018, pp. 5.

2020) was introduced, followed by a statement in 2019 by President Uhuru Kenyatta where he committed to eliminating FGM in Kenya by 2022, a goal eight years ahead of the one set by the UN's Sustainable Development Goals.[44]

Despite these laws and stated commitment by the president, though, implementation has been limited. A network of various organizations, including the Joint Program, have been working with the government departments to address issues regarding implementation and effectiveness. Some examples, laid out by the Thomas Reuters Foundation include:

> "The law has not been translated into local languages, and the language in the law is not easy to understand.
>
> …There have been few successful prosecutions to date.
>
> …Both the judiciary and police need more training on how to handle FGM cases, and more support and funding is needed from the county governments.
>
> …Medicalized FGM is increasing at an alarming rate in some part of Kenya, and the law is not proving effective in bringing the perpetrators to court."[45]

During the first three years after the FGM Act was enacted, only 71 cases were reported, and of these, only 16 resulted in convictions. This increased slightly in 2016, where the Joint Program reported 75 cases and ten convictions in that year alone. In 2017, there were 76 cases.[46]

The lack of effectiveness of the law largely results from a lack of resources and limited capacities of the state of Kenya. While the Anti-FGM Board was established after the law's passing, the state still does not allocate the capacity and capability needed for stronger enforcement. Whether this is due to a lack of their ability or a lack of their willingness is unable to be determined.

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[44] Nita Bhalla, "Kenya pledges to end FGM by 2022 – ahead of global target," *Reuters* online, last modified November 12, 2019.
[45] "Kenya: The Law and FGM, May 2018," *Thomas Reuters Foundation* and *28 Too Many*, 2018, pp. 8-9.
[46] *Ibid.*

Overall, Phase II of the Joint Program saw considerable progress in Kenya. Regarding the legal aspects, the Joint Program focused on the training of officials on the Standard Operating Procedures of FGM prosecution and successfully trained 40 staff members of the Office of the Director of Public Prosecution. In addition, 515 teachers were trained on the physical and mental health consequences, as well as human rights violations, of FGM. Of all the services provided, it is estimated that over 6500 girls were rescued from undergoing FGM through the services provided by the Joint Program throughout Phase II.[47]

[47] "Performance Analysis for Phase II," *UNFPA/UNICEF Joint Programme on Female Genital Mutilation*, 2018.

## Chapter 3: Awareness

Raising awareness about an issue is often the most difficult, yet crucial part of any cause, and this is no different for FGM. Awareness of the practice throughout the world is a main priority, and raising awareness through education and communication has been one of the main aspects of the movement toward eradication within countries who practice FGM. Within the last decade, a large part of the communication strategy has not only been done in-person but also through social media. Although the internet penetration in Africa was very low in the early 2000s, in certain countries like Kenya, the penetration rate has been growing significantly over the last ten years. Digital Reportal data shows a 16% annual growth rate of internet users in Kenya, with 43% of the population being an internet user.[48] These statistics are highly varied, however, as the International Telecommunications Union reports that only 17.83% of Kenyans were internet users in 2017. Additionally, data from the Communications Authority of Kenya's third quarter statistics from January to March 2020 states that by March 2020 the total internet subscriptions in Kenya stood at 39.3 million.[49] While subscriptions do not directly translate to users, the local data suggest that the percentage may be closer to the number reported by Digital Reportal.

Dubbed the heart of the "Silicon Savannah," Nairobi is home to a booming tech industry, with thousands of young people aiming to improve and advance Kenyan development through Africa-born technology.[50] Combined with an increasingly growing young population and internet usage, a large portion of the population has access – and will only increasingly gain access – to the internet as a communication tool, and this will be assessed in the following sections.

### International awareness campaigns and engagement

The main focus of the UNFPA-UNICEF Joint Program Phase II was the area of "education, values deliberations, mobilization and consensus building activities," where 56% of program allocations were spent. The two other areas – "policy and legal

[48] Simon Kemp, "Digital 2020: Kenya," *Data Reportal*, last modified February 18, 2020; Important to note is that approximately one-third of the Kenyan population is under 13 years old.
[49] "Third Quarter Sector Statistics Report for the Financial Year 2019/2020 (January – March 2020)," *Communications Authority of Kenya*, 2020.
[50] Laura Mallonee, "The Techies Turning Kenya Into a Silicon Savannah," *Wired*, last modified August 12, 2018.

framework" and "access to prevention, protection and care services" – only receive 26% and 18%, respectively.[51] The Phase II report states mass and social media as playing central roles in achieving the "education, …" outcome, in order to raise large-scale awareness of FGM. The first section will focus on the types of communication campaigns introduced by the UN organizations, followed by a more detailed look at the social media campaigns in action through data presentation. Then an in-depth look at how and which social media is used in Kenya, followed by a discussion of data on the social media campaigns within Kenya, will provide a further look into the reach and effectiveness of this area of the Joint Program.

Since promoting dialogue and communication are one of the main aims of the international programs, the UN has launched social advocacy campaigns to raise global awareness. Since 2012, International Day of the Girl has been celebrated on October 11. The UN often declares international days as an advocacy tool, and International Day of the Girl is no different. Under a different theme each year for the last eight years, "the day aims to highlight and address the needs and challenges girls face, while promoting girls' empowerment and the fulfillment of their human rights."[52] The day of recognition and celebration coincides with the Sustainable Development Goals that were adopted in 2015 – specifically Goal 5 – and through media campaigns has contributed to raising awareness of gender inequality in the world by celebrating the achievements that have been made and using empowerment as a tool for further achievement. The International Day of the Girl has over 150,000 post mentions on Instagram, and it has been used in advertisements for companies like Adidas to promote girls in sports.

[51] "Performance Analysis for Phase II," *UNFPA/UNICEF Joint Programme on Female Genital Mutilation*, 2018.
[52] "International Day of the Girl Child, 11 October," *United Nations* online, accessed May 25, 2020.

There is also an international day specifically for FGM, however. The International Day of Zero Tolerance for Female Genital Mutilation was also created in 2012 and is marked on February 6 each year. While not as catchy for company ads, the Day gets more recognition for also being the launch of the #EndFGM. To date, the hashtag has been used over 115,000 times on Twitter alone, with the top 30 posts of 2019 receiving an average of 23 retweets. The use of the hashtag has recently seen a lot of growth. Compared to the launch in 2012 where about 25 posts were made per month using the hashtag – with nearly all the top posts coming from the United Nations and US Department of State accounts – as seen in the figure below, this number sharply rose two years later, and, until 2019 had stagnated. Over the entire period of 2012-2019, the engagement with the top 30 posts remained relatively the same. However, the accounts that constituted these top posts shifted from mainly the UN and UN organizations (such as UNICEF, UNFPA, and UN Women) to mainly NGOs such as the Orchid Project and The Girl Generation. By 2019, these top posts were largely made up of personal accounts, such as Dr. Leyla Hussein. Therefore, a relative

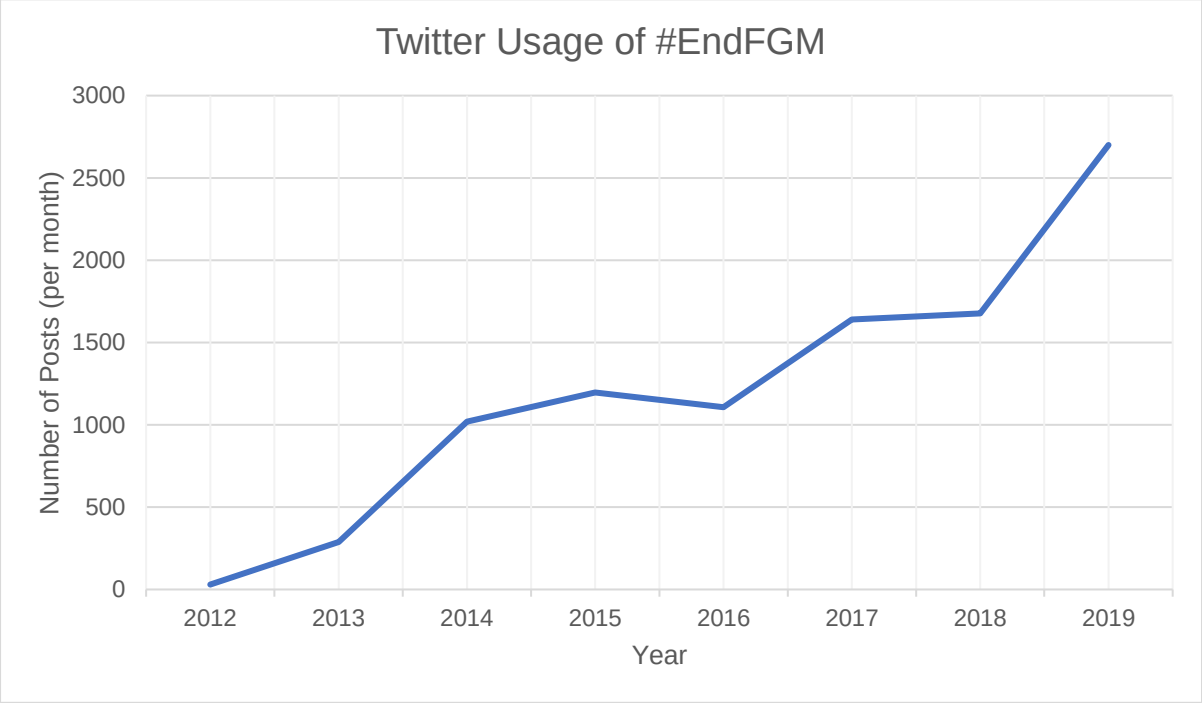


Figure 1: Twitter Usage of #EndFGM
*The number of posts is the count over the month of November of the corresponding year, not of the entire year. The number is representative of a monthly average. Refer to methodology.

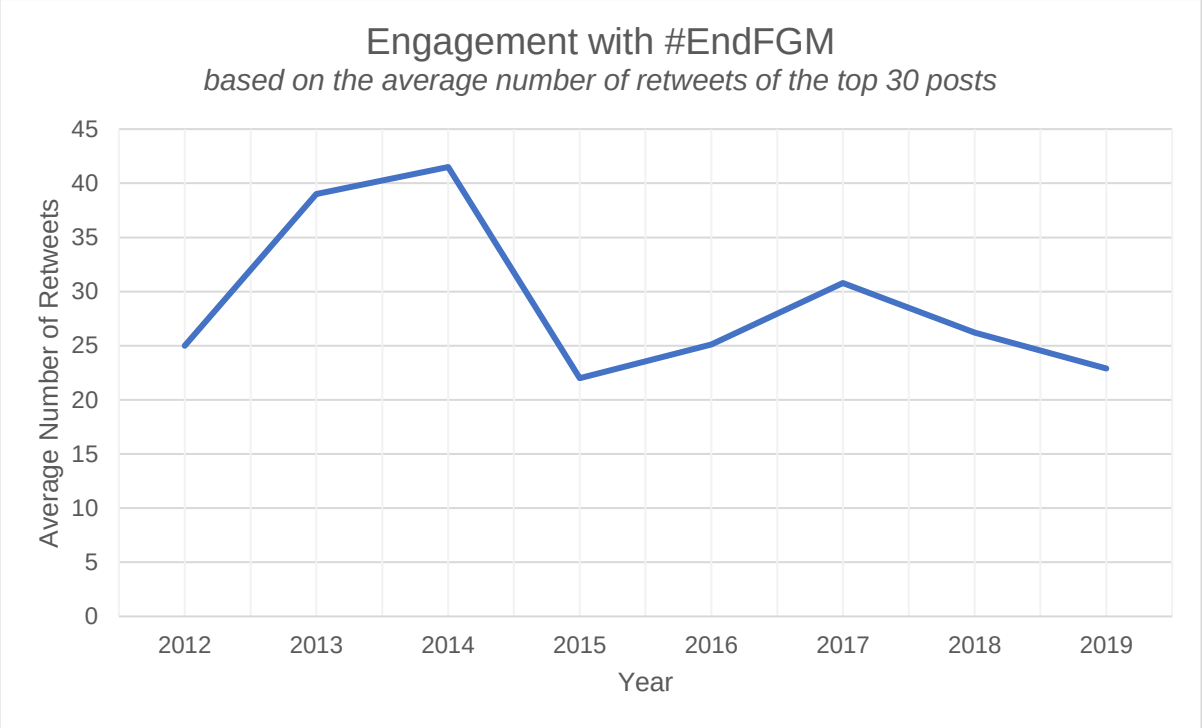


Figure 2: Engagement with #EndFGM
* The average number of retweets is of the top 30 posts in the month of November of the corresponding year, not of the entire year. The number is representative of a monthly average. Refer to methodology.

success of #EndFGM can be seen. While the engagement does not show any change, the total number of mentions has increased. Not only that, but what had started as only being led by the United Nations is now being taken up by individual users, meaning that the campaign indeed reaches a broader and more local base. The top results belonging to individuals can also account for the lack of increased engagement – a personal account is less likely to have as high of a following as an organization's account.

Whereas gender inequality affects all corners of the world and therefore people are more likely to experience it in their lifetime, FGM does not have this same recognition. Less about empowerment of girls and more about the education and empowerment of both men and women to take a stand, the #EndFGM campaign is truly about awareness. The more people who become aware of the consequences of gender disparity and FGM, the more who will become advocates for change. This is the goal of these international days – to get more people to advocate for change in their local communities, and if possible, by supporting change and the empowerment of girls in other communities. Stemming from the joint statement's and UN resolutions,

these campaigns are in line with their action plan. For only an eight-year-long movement, International Day of the Girl, International Day of Zero Tolerance, and #EndFGM have received a large audience across the globe.

**Engagement with the campaigns in Kenya**

In 2019, the SIMElab (Social Media Lab Africa), partnered with the United States International University – Africa and the US Embassy Nairobi, released the study, Social Media Consumption in Kenya: Trends and Practices. It is one of the most comprehensive studies on this subject done to date and was conducted from December 2018 to March 2019. The study received 3166 responses across eight different counties, one from each of the eight former provinces. Social media use was broken down into nine platforms. It found that overall, the most common social media used is Facebook at 88.5% of all social media users. Twitter is ranked sixth most popular with 27.9% of social media users being active on an account. However, in the age groups 21-25 and 26-35, Twitter is ranked third, and among first degree graduates, it is the second most popular. These age groups also show the largest percentage of people who have participated in an online debate nine or more times. This demographic information is significant because of the aforementioned young population and worldwide trends of social media use. Addressing an urban vs rural divide, the study found that the Twitter usage distribution is 43% rural and 57% urban populations, suggesting that this factor does not have such a significant impact when it comes to Twitter.[53]

As far as what Kenyans use social media for, the study looked at a few different areas. One aspect was the overall purpose of social media for individuals, which found that the most common reason for social media use among Kenyans generally is for the acquisition of information, clarified as news, knowledge, and exploration (32%). Additionally, the study also inquired about the specific issues of focus regarding each social media channel. For this they used nine categories of issues: education, entertainment, environment, family, job-related, political, religious, social, and sports. Regarding political issues, Twitter is the most commonly used platform, with 36% of Kenyans using Twitter for these issues; the next most common is Facebook at 18%.

[53] "Social Media Consumption in Kenya: Trends and Practices," USIU Africa: SIMElab, 2020.

Twitter is also the third most used platform for social issues at 41% of users, which is the highest percentage garnered by Twitter on any one issue.[54]

Taking into account all nine categories of issues, FGM fits into the political and social issues the most. Therefore, if Kenyans were to interact or discuss the topic of FGM, they would be most likely to do so on Twitter compared to other forms of social media. For this reason, the data collected here is done solely with Twitter, as it will provide the most comprehensive and accurate depiction of online engagement with the topic of FGM.

When looking specifically at Kenya, the data from Twitter shows a slightly different story compared to the international usage. For example, the use of #EndFGM within Kenya did not become significant until 2019. In 2012 and 2013, during the start of the hashtag campaign, there were zero posts. By 2015 this picked up to 11 posts, stagnating until 2019 where the number increased dramatically to 241 posts over the year. The same can be said of any discussion of FGM through #FGM; posts were stagnant at a very low level until 2019 where they jumped to 82. A majority of the top

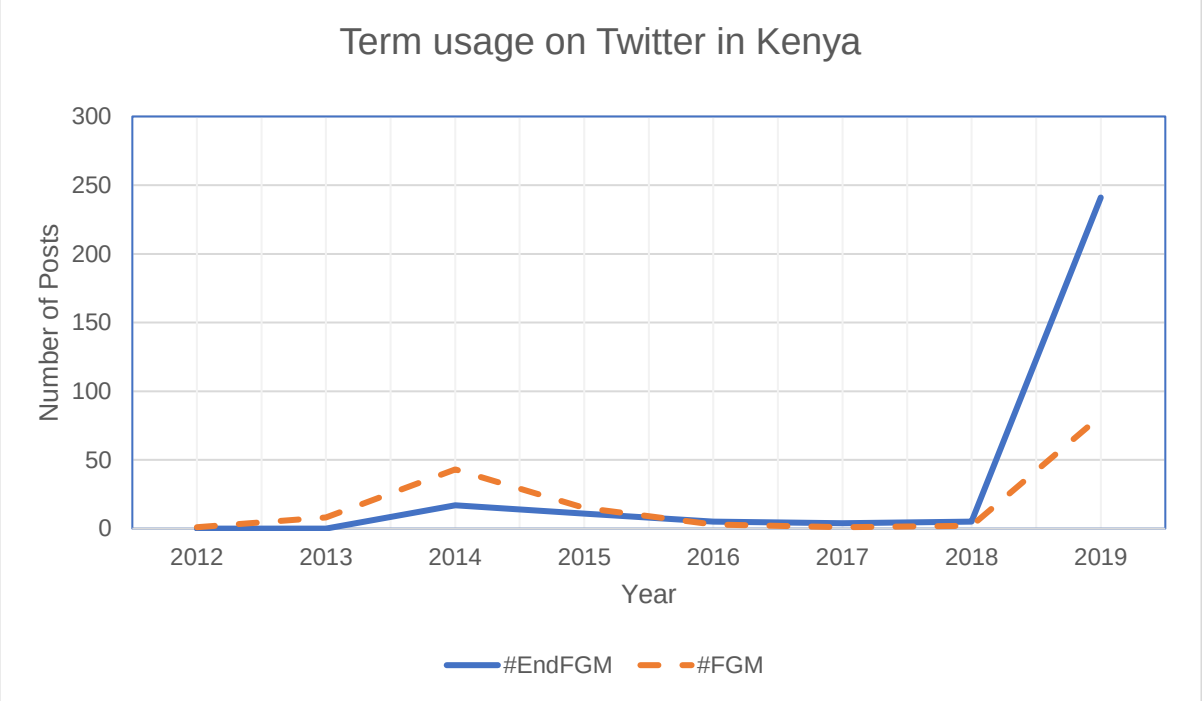


Figure 3. Term usage on Twitter in Kenya

Usage on Twitter over the course of the whole year of each indicated year. Results shown for Nairobi server, status "Location: near you"

[54] "Social Media Consumption in Kenya: Trends and Practices," USIU Africa: SIMElab, 2020.

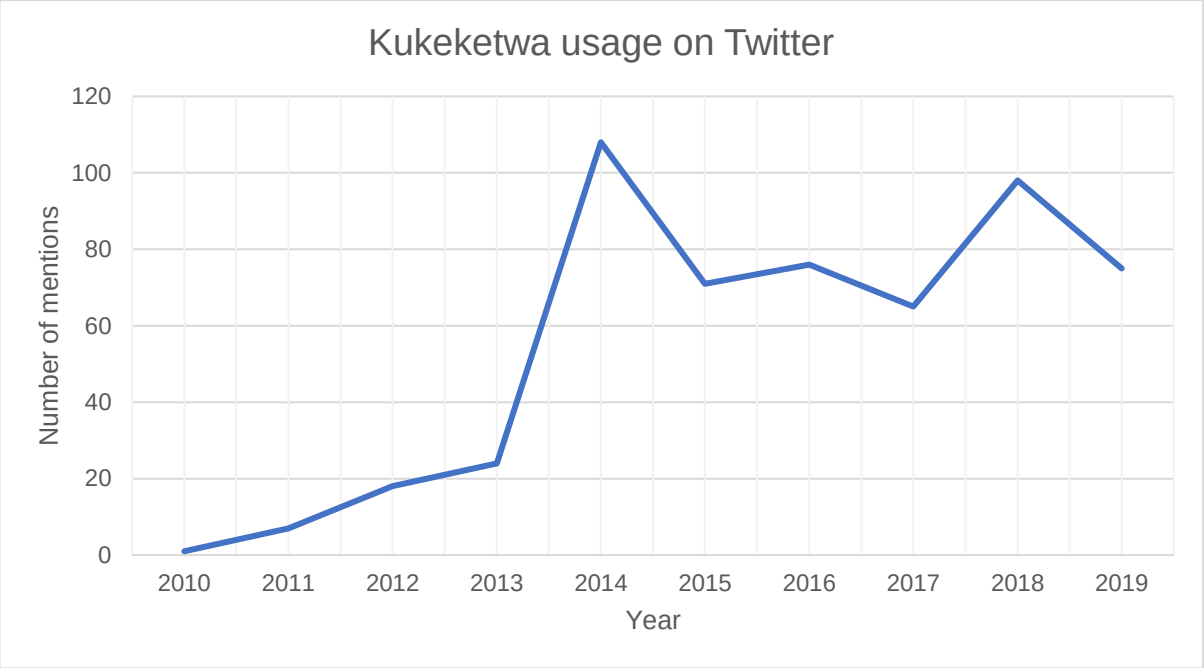


Figure 4. Kukeketwa usage on Twitter

Usage on Twitter over the course of the whole year of each indicated year. Results are shown for Nairobi server, status "Location: anywhere"

posts using either or both of these hashtags were from Action Aid Kenya (the Kenyan branch of an international women's rights organization), John Miano (a Kenyan digital communications consultant and human rights activist), the Ifrah Foundation (organization focused on FGM eradication in Somalia and beyond), and the UNFPA-UNICEF JP to End FGM (account created in September 2019). Additionally, the Anti-FGM Board account (@AFGMBoard) which has been active since 2015, received no replies or mentions until 2019, where there were 47 over the whole year.

Since Swahili is the most prominent language in Kenya, a second set of data was collected using Swahili vocabulary, including kukeketwa (female circumcision), tohara kwa wanwake (circumcision of women), and kutairi was ichana (circumcision of girls).[55] Searching for these terms on Twitter produced the results in Figure 4, as a total number of posts mentions of these terms over the whole year. The outlier of 2014 is due to a press release stating that ISIS ordered the circumcision of girls and most post mentions occurred over the few days following this news. Taking into account this outlier, while the total mentions show a steady increase, it also stagnates similarly to the international data and even drops in 2019.

[55] "Traditional Terms for Female Genital Mutilation," *National FGM Centre*, accessed June 13, 2020.

While the international campaign can be viewed as a relative success even though stagnation has occurred, the reach within program countries is not as broad. According to the UNFPA-UNICEF Joint Program's Phase II Performance Report, 56% of Joint Program allocations were spent on "education, values deliberations, social mobilization and consensus building activities." Although the scope of this focus area encompasses more than just social media, the main stated goal of it is to use "various media and communication tools to raise awareness about FGM on a large scale."[56] As seen from the SIMElab study, Twitter is used most often for discussing political and social issues. Although the #EndFGM campaign began in 2012, its lack of traction in the Kenyan social media sphere until 2019 indicates a gap in outreach success for this particular form of media. Even with the contribution of factors like the increased youth population and the ever-growing access to the internet and social media, the data presented here shows both minimal engagement and minimal growth in engagement on topics of FGM within Kenya over the last ten years. Given that increased awareness is part of the high-focus areas in the initiative, it is concerning that there is little to no evidence for the Joint Program's effectiveness in raising awareness through social media outreach within Kenya. For the last five years, Kenya has been referred to as the "Silicon Savannah," and the impact this has, and will continue to have, should not be underestimated, but rather, taken advantage of.

[56] "Performance Analysis for Phase II," *UNFPA/UNICEF Joint Programme on Female Genital Mutilation*, 2018.

## Chapter 4: Coordination between efforts

The UNFPA-UNICEF Joint Program is the largest and most comprehensive effort to eradicate FGM, but it is not the only one. There are many local, national, and international organizations that focus on the various aspects of achieving eradication such as health, education, and legal rights. Although a few existed before the Joint Program, there has been a significant increase in organizations and mobilized efforts since 2008, when the Joint Program's first phase was implemented.

### Prominent NGOs in Kenya

There are a host of organizations, both international and national, working to end FGM worldwide and within their respective program areas. The same is true in Kenya, where there are over 200 different organizations working for women and children's rights, and as a result are either directly or indirectly working to combat FGM, whether on a legal, social, or educational level.

In general, there are a few different categories of organizations and how they approach the goal of ending FGM: working on legal frameworks and policy advocation, focusing on empowerment and communication, focusing on education, focusing on research, and focusing on human rights. Occasionally, some of these organizations focus on two or more of these areas, but typically only if they are larger, i.e. have more resources at their disposal. For example, the Hope Foundation for African Women is an organization that works mostly within Kenya, but also throughout East Africa, particularly in rural communities. Their key aims surrounding FGM include viewing FGM through a human rights lens and focusing on education and leadership trainings in the communities they support. These trainees are then ready to educate their communities further on the negative effects of FGM and how to reshape social norms.[57] On the other hand, Samburu Women Trust works within the Samburu and other pastoralist communities in Kenya to help build up leadership among women, with the ultimate goal of bolstering their capacity to influence both decision-making processes and the policies that impact their lives, such as bringing attention to FGM and the harmful practice of beading within their communities.[58]

[57] "About Us," Hope Foundation for African Women, accessed July 6, 2020.
[58] "Samburu Women Trust," *Namati* online, accessed July 6, 2020.

On an international level, there are two leading organizations: 28 Too Many and The Girl Generation. 28 Too Many is an English charity that currently works in some capacity in all 28 African countries where FGM is prevalent. Their mission encompasses significant amounts of research, primarily Country Profile Reports, and using this research to engage with both activists/influencers and local organizations. Engagements by 28 Too Many are all based on the research that has been conducted in their program countries. The country profiles comprise a detailed overview of FGM in the country and overall trends regarding all aspects of gender equality such as women's advancements in business, politics, and their physical health. Overall, 28 Too Many seeks to compile all research and data on FGM within each country and present it in an attempt to raise awareness. One of their latest projects, completed in 2018, was done through a partnership with the Thomas Reuters Foundation, and culminated in the report *The Law and FGM*. The report acts as a comprehensive guide and one of the first resources of its kind, clearing laying out the legal frameworks and progress made in Kenya since the FGM Act 2011.

The Girl Generation is "an African-led global collective of members and partners brought together by a shared vision that FGM can – and must – end in this generation."[59] A five-year project funded by the UK Department for International Development, The Girl Generation is the largest collaborative organization working to end FGM in the world. Their focus is on growing the movement in Africa by engaging African-led organizations and by "strengthening social change communications, sharing inspirational stories of change, and leveraging resources." Starting in 2014, they have worked to amplify the voices of smaller organizations in order to spread a positive message to others across the continent. They believe it is crucial to "galvanize, catalyze, and amplify" the *African-led* movement. The organization operates in 10 African countries with over 900 member organizations, 91% of which are from the African continent. Of these 900+ organizations, 141 members are in Kenya. The Girl Generation operates within six "themes": social change in focal countries, greater connectivity within the movement to end FGM, youth activation,

[59] "The Africa-led movement to end Female Genital Mutilation (FGM)," *The Girl Generation*, accessed July 6, 2020.

changing how we communicate about ending FGM, inspiring action, and activating grassroots action.[60]

The main achievement within The Girl Generation community is the introduction of their Do No Harm principle. The Do No Harm principle is a part of their social change communications strategy which focuses on what is said about FGM and *how* it is said. By using positive language and an inclusive approach, instead of focusing on negative health impacts and legal implications, they have reported a better response in communities and significantly increased engagement.[61]

Additionally, The Girl Generation provides End FGM Grants to local groups for them to implement social change initiatives and for capacity building. Over two years, 104 grants were awarded to groups in The Gambia, Nigeria, and Kenya, for a total of $850,483. In 2018, they supported the Kenyan Women and Children Wellness Center with one of these grants that helped make the Anti-FGM Board in Kenya more sustainable. Since it is one of the key duties of the Anti-FGM Board to bring together all stakeholders in the movement, the grant allowed the two organizations to work together in mapping the organizations that are working across Kenya, in order to be better informed of projects and increase Kenya-wide communication.[62]

Overall, organizations like The Girl Generation act as a type of middle-man – lifting the small voices and projecting them to larger audiences while also taking the larger funding and dispersing it amongst local groups – and show a shift away from programs like UNFPA/UNICEF that can display tangible change in the very short term.

**Relationship between agencies and organizations**

The Joint Program itself partners with governmental and civil society partners in Kenya, including World Vision, Womankind Kenya, Africa Institute for Development Policy, Kenya Red Cross Society, the Federation of Women Lawyers Kenya, the Anti-FGM Board, and the Ministry of Public Service Youth and Gender Affairs, along with the University of Nairobi. During Phase II, from 2014 to 2017, the total expenditure on the Kenyan programs amounted to $6.3 million.[63] While many NGOs and other

[60] "Impact Report August 2016 – July 2017," *The Girl Generation*, 2017.
[61] "Do No Harm," *The Girl Generation* (infographic), accessed July 7, 2020.
[62] "Impact Report 2017-2018," *The Girl Generation*, 2018.
[63] "Performance Analysis for Phase II," *UNFPA/UNICEF Joint Programme on Female Genital Mutilation*, 2018.

organizations as described above also contribute to the mission of FGM elimination, there is no evidence of direct coordination other than those stated above. The organizations often utilize the data and research done through UNICEF and DHS, but no organization mentions a collaboration except for The Girl Generation, who briefly cite the Joint Program, but only insofar as its relationship with the UK Department for International Development, particularly regarding legislation and policy. As demonstrated, however, organizations like The Girl Generation are not focused on making an impact on legislation, unlike the stated goals of the Joint Program. Moreover, while the majority of the Joint Program's partners in Kenya are government or law-based, this is not reflected in their program allocations, with only 26% being allocated to this area.

The extent to which the Joint Program is involved in coordinating between multiple organizations is therefore unclear, as only those listed above are mentioned as partners. The overall stated aims and focuses of both the Joint Program and The Girl Generation (as a key example due to the organization's large capacity) are not that different; however, the resources and tools they utilize are different indeed. Because of the larger capabilities of the Joint Program, the lack of coordination within Kenya in particular is a critical flaw. With The Girl Generation, which built itself on a foundation of increased collaboration leading to better coordination, coming to an end in 2019, there is an even larger gap left to fill.

## Conclusion

The international movement toward FGM abandonment has been accelerating over the last 12 years, starting with the launch of the Joint Program by UNICEF and UNFPA. However, while some countries progress quicker than others, all progress is threatened by population growth, something that also effects each country differently. Throughout Phase II of the Joint Program, a stronger focus was given to individual countries, but there is still significant progress to be made to reach full abandonment by 2030. Moreover, the Joint Program does not engage with 11 of the 28 countries in Africa where FGM is still prevalent, which puts even more pressure on such a short-term goal. What went from being a goal to eliminate FGM in three generations as announced in the first Joint Statement in 1997 has quickly developed into ending it within this generation. Examining such a goal, and if it is attainable, is difficult when addressing the whole world, though. As the international community has tried to bridge this gap, it becomes clearer that they may not have the capacity to do so. Therefore, various local organizations have sprung up that aim to contribute to FGM's end as well.

After tracing the history of the FGM movement and the efforts of the Joint Program, some important successes can be seen. A topic of which details were largely unknown until about 30 years ago has been brought to the attention of the international audience and became part of the 17 Sustainable Development Goals that guide the United Nations. There have been many achievements of the Joint Program since its launch in 2008, and these should not be overlooked. As this research has pointed out though, there are significant limitations and shortcomings of the Joint Program. It has struggled to demonstrate the continued exponential progress necessary to achieve FGM eradication, especially by 2030. The top-down approach, the demonstrated lack of discussion and awareness raising via social media in-country, and the lack of coordination with local organizations all present concerns regarding the Joint Program. While the Joint Program overall states a success, this success is limited when presented on a per country basis and when compared next to other organizations.

Because the situation varies significantly by country and by ethnic group, a one size fits all approach is simply not the best strategy. As discussed in Chapter 1, how different groups react and respond to the push to eliminate FGM can vary and are particularly dependent on the circumstances. For example, for the Samburu people,

increased FGM rates are the result of trying to turn away from other harmful social practices. This is just one example where a local organization is able to produce more effective change than the Joint Program, whom in their country reports has not mentioned circumstances like the Samburu.

Without a coordinated platform that is clearly aware of who is responsible for the progress being made and how it was done (what type of education program, which strategies for which types of communities), it will become increasingly difficult to proceed in the future. With more and more organizations joining the movement, one comprehensive system is needed that is connected between the national and local levels, even if the individual strategies vary – in fact, especially then. What can be seen now is a myriad of people trying to work toward the same goal; but to do so, the focus needs to be taken away from the top-down and uncoordinated approach, and move toward one that utilizes technology and catalyzes the small movements. The international program is limited in its current strategy to be able to effectively implement these changes, but the work that has been done by The Girl Generation shows that it may be possible to move past the current limitations.

Further research is necessary to analyze the extent to which the research done in this thesis holds true in other countries. The points made here about the limitations of the Joint Program's approach in ending FGM are applicable to further studies, and it would prove beneficial to the future of the movement to carry out the single case analysis for all countries where FGM is prevalent, but especially in the program countries of the UNFPA/UNICEF Joint Program. Without adaptation and continued research into the effectiveness of programs – international, national, and local – FGM will be a lasting practice that will continue to inhibit the human rights of women and girls. Momentum cannot afford to be lost for the world to achieve the 2030 goal and to see worldwide eradication of FGM in this generation.

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