



# Key message

This study found changes in social norms in the cross-border communities investigated indicating that the practice of female genital mutilation (FGM) can be eradicated.

Effective interventions to end FGM need to be tailored to communities' belief systems if they are to be "owned" by and mobilize the communities to change their culture. An opinion leader from Kenya put it like this:

**WE NEED TO WIN HEARTS  
AND MINDS TO END FEMALE  
GENITAL MUTILATION**

getting married, but the other one thinks you should

# Introduction

FGM, or female circumcision, is practised in around 30 countries in Africa, the Middle East and Asia. Globally, it is estimated that over 200 million girls and women alive today have undergone FGM.

The World Health Organization defines four types of FGM:

- **Type I: clitoridectomy**  
removing part or all of the clitoris.
- **Type II: excision**  
removing part or all of the clitoris and the inner labia.
- **Type III: infibulation**  
cutting and repositioning the labia to narrow the vaginal opening, with or without clitoridectomy.
- **Type IV:**  
any other harmful procedure carried out on the female genitalia for non-medical reasons.

Twenty-eight of the 30 countries where FGM is prevalent are in Africa. In the five countries studied in East Africa and the Horn of Africa, the prevalence of FGM among girls and women aged 15–49 years old ranges from 98 per cent in Somalia through 65 per cent in Ethiopia, 21 per cent in Kenya and 10 per cent in Tanzania to 0.3 per cent in Uganda. However, within countries, there are areas where the prevalence is higher than the national average, particularly in the border areas of Ethiopia, Kenya, Tanzania and Uganda.

There is legislation in place prohibiting FGM in all of the study countries apart from Somalia. However, legislation and policy differs between the countries, and the lack of a common regional legislative framework makes it difficult for individual countries to enforce their laws governing the practice.

There has been little research on the movement of traditional practitioners of FGM or families seeking FGM across borders, which reduces the deterrent effect of the law. Therefore, much remains unknown about the practice of cross-border FGM, particularly about gaps in existing policy and legislation for managing it, and so it is not clear whether the interventions in the cross-border areas are sufficiently targeted to bring about changes in the social norms perpetuating the practice. This movement of traditional practitioners and families across national borders presents a complex challenge for initiatives to end the practice of FGM. Understanding cross-border FGM is essential to ensure that the countries can cooperate in enforcing compliance with the laws protecting girls and women from this harmful practice.

The overall aim of the 32nd African Union Heads of State and Government Summit, held in February 2019 in Addis Ababa, Ethiopia, was to strengthen collaboration between countries

on addressing FGM in the border areas, share good practices and set out the way forward for preventing cross-border FGM. During the summit, member states committed to ending FGM in Africa and endorsed an African Union social marketing campaign addressing the cross-border practice of FGM. The campaign aims to eliminate FGM globally by 2030, and it provided the rationale for the commissioning of this study. The aims of the study were also premised on the resolutions of the Regional Interministerial Meeting to End Cross-border FGM, held 15–17 April 2019 in Mombasa, Kenya.

Accordingly, this study set out to investigate the factors affecting the prevalence of the practice among cross-border communities in East Africa and the Horn of Africa and the extent to which people cross borders to practise or undergo FGM and the effects of the practice on the women and girls in those communities.

## Aims and objectives

To support the campaign, the study's overall aim was to assess the status of FGM in the cross-border areas and inform the regional End Cross-border Female Genital Mutilation Action Plan. The specific objectives of the study were as follows:

- To identify the gaps in existing policy and legal frameworks and the social dynamics, determinants and drivers of the practice of FGM in the cross-border communities
- To finalize the regional End Cross-border Female Genital Mutilation Action Plan
- To examine the sociocultural, health, political and economic effects of FGM on cross-border communities, particularly on women and girls
- To map the institutions and organizations engaged in preventing and responding to FGM and the types of interventions undertaken in the border areas, including referring women and girls to health and psychosocial services or reporting practitioners and families to the police
- To explore the social norms and practices around FGM and the extent to which these are upheld or contested by cross-border communities.

# Methodology

The research team drew up a survey questionnaire informed by desk research and used it to collect quantitative data. The researchers also collected qualitative data from interviews with key informants, focus group discussions and targeted observations at border points. Table 1 shows the number of contacts the team had with survey respondents and key informants and the number of focus group discussions facilitated.

**Table 1: Number of interviews and focus group discussions conducted**

Data collection method	Number
Survey respondent interview	1,480*
Key informant interview	143
Focus group discussion	63

*\*48 per cent male and 52 per cent female.*

The study sites were on the following borders:

- **Kenya–Tanzania border**  
respondents from the Maasai community in the Transmara region and the Kuria in Isebania–Tarime, Migori County (Kenyan side of the border only).
- **Kenya–Ethiopia border**  
respondents from the Borana community in Moyale subcounty and the Turkana (both Kenya) and the Oromo community in Oromia, Moyale subcounty, and the Dasenach in Omorate (both Ethiopia).
- **Kenya–Uganda border**  
respondents from the Pokot community in Amudat district and the Sabiny community in the Sebei region (both Uganda) and the Pokot community in West Pokot and the Sabaot in Mt Elgon (both Kenya).
- **Kenya–Somalia border**  
respondents from the Somali community in the Mandera border area in north-eastern Kenya and the Somali community in Bula Hawa (Somalia).

# Key findings

## Legal and policy frameworks to prevent female genital mutilation

Ethiopia, Kenya, Tanzania and Uganda have national legislation prohibiting FGM. Somalia currently has no national legislation, but its constitution prohibits the practice. Only Kenya and Uganda have comprehensive legislation that defines the practice of FGM, sets out penalties for seeking or practising it and provides for extraterritorial jurisdiction.

An understanding of the laws can act as a deterrent where the law is rigorously enforced. However, in many cases, the implementation of the law is weak or lacking entirely, and there is widespread resistance to it. For example, the law is perceived to be particularly weak among Somali respondents in Mandera (Kenya, 78 per cent) and among Kuria respondents in Isebania–Tarime (Kenya, 83 per cent). The reasons for this include a lack of knowledge of the law and the penalties, low numbers of reported cases, lack of capacity (training) and resources to implement the law, the remoteness of and poor infrastructure in the border areas, and some cross-border communities' refusal to accept existing national laws, partly because of a lack of ownership of the laws in practising communities. The result is that the practice is driven underground, encouraging some families to cross the border to have their daughters circumcised. As one key informant, a prosecutor in Kenya, put it:

*Mostly the practice is conducted in secret and hence [there is] no reporting.*

As the borders are porous, it is easy for people to cross undetected at many of the border points.

The results of the study indicate a clear need to harmonize legislation to allow cross-border collaboration on anti-FGM activities and to empower women and girls to make independent decisions that will help to end FGM in the cross-border communities.

The authors therefore recommend developing a legal and policy framework that addresses cross-border FGM activities. The main regional bodies – the East African Community (EAC) and the Intergovernmental Authority on Development (IGAD) – have existing frameworks for cross-border programmes on other topics, and these would be a good starting point for developing a regional framework for tackling cross-border FGM.

Although there is no regional legislation prohibiting FGM, the EAC has a draft bill, Prohibition of FGM in the East African Community, 2016. This bill was passed by the Third Assembly in 2017, but it was not assented to by the Heads of State, and thus needs to be revived. The EAC has a Gender Policy, 2018, and Child Policy, 2016, both of which address FGM. The EAC also has a policy to tackle cross-border violations of children's rights, including FGM. Nonetheless, the lack of regional legislation prohibiting FGM makes

collaborative initiatives to eliminate the practice in individual countries difficult, because perpetrators can easily enter and leave different jurisdictions, thereby escaping the law.

## Social and cultural drivers of female genital mutilation

There are still many sociocultural and religious drivers promoting the practice of FGM in the cross-border communities. Overall, 65 per cent of respondents cited culture and religion as the main reasons for continuing FGM. Gender identity is particularly significant – what it means to be a girl or woman and what she needs to do to realize that identity. FGM is seen as a way of increasing a young woman’s social capital and bringing her influence and prestige in the community. The sociocultural and religious beliefs and norms around the practice put girls and women under pressure to conform with tradition, as the following extract from an interview with a Maasai headteacher in Kenya shows:

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

Sociocultural drivers include perceptions of ethnic identity, familial honour and respect, a girl’s marriageability and bride wealth (payment made by the bridegroom or his kin to the bride’s family) and preserving a girl’s virginity to assure the husband’s sexual pleasure and satisfaction (common among the Kuria, Maasai, Oromo, Pokot and Somalis). FGM is also seen as a rite of passage (among the Kuria, Maasai and Pokot) and a religious requirement (common on the Somali and Ethiopian borders), as the following extracts from interviews with key informants in Kenya and Somalia, respectively, show:

*FGM was a sign of transition of girl[s] from childhood to adulthood and so it came in as a way of ushering them to womanhood and freedom to get married. It was also viewed as a rite of passage that allowed suitors to pursue them.*

*The reason for practising circumcision in general both for men and women is to fulfil a religious obligation as we have been commanded by God.*

In all of the study communities, a girl’s parents are truly accepted by the community only after their daughter has undergone FGM. Otherwise, they are treated as outcasts and excluded from communal rituals and other ceremonies. The girls and women who refuse to conform and undergo FGM are also treated as outcasts and subject to harassment, ridicule and discrimination. They are often excluded from holding key positions in the community and from earning a livelihood, as explained by a key informant from a non-governmental organization (NGO) working in Kenya:

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

The practice of FGM is perpetuated by illiteracy and ignorance. It is most prevalent in remote areas with low literacy levels where ignorance thrives as a result of a lack of awareness of the law and the harm caused by FGM. A key informant from West Pokot, Kenya, put it like this:

*... the people along the Kenyan border are mainly nomads. I think these are people who have been left behind and have been neglected; they are still in total darkness and thus have continued to uphold strong cultural practices and beliefs.*

The authors recommend engaging the “custodians of culture” (community and religious leaders and elders) in the campaign to end FGM to promote an understanding of FGM as a violation of women’s and girls’ rights and as a means of subordinating them. The custodians are widely respected and have the power to influence social norms. Engaging them will need a greater appreciation of the approach to changing social norms and achieving the critical mass necessary to change the social and cultural environment.

## Consequences of female genital mutilation

Overall, 94 per cent of respondents agreed that FGM causes health problems in girls and women. The short-term physical consequences include pain, excessive bleeding, infection and even death. This is illustrated by an extract from a key informant from a community-based organization in West Pokot, Kenya:

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

The long-term consequences include menstrual problems, increased risks of complications during childbirth and newborn deaths, and developing fistulas, HIV infection and AIDS. A key informant from Bula Hawa, Somalia, expressed remorse:

*Other effects include persistent pain during her periods which [is] as a result of blood passing out slower than it is supposed to. We destroyed those girls completely and I highly regret it.*



The sexual consequences include painful intercourse and reduce sexual desire and satisfaction. Such problems may contribute to domestic violence and divorce. A key informant from a community-based organization in West Pokot, Kenya, put it like this:

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

The psychological and emotional effects of FGM can lead to low self-esteem, post-traumatic stress disorder, depression and women living with bitterness and regret for the rest of their lives. Overall, over 30 per cent of respondents agreed that FGM causes depression, over 40 per cent agreed that it increases anxiety and post-traumatic stress disorder and reduces self-esteem, and 60 per cent agreed that it is likely to cause psychological problems overall.

Undergoing FGM retards girls' education and women's socioeconomic development and capacity to emancipate themselves. They are denied the opportunity to earn a livelihood as a result of increased absences from school, dropping out of school, early marriage and childbirth. Most practising communities are patriarchal and still consider marriage and domestic chores as the best outcome for women. This is illustrated by an extract from a key informant interview with a Dasenach health worker in Ethiopia:

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

This perpetuates the subordination of women in practising communities, increasing their dependency and reducing their productivity. Their families may have to face considerable medical expenses. All of these consequences adversely affect the achievements and quality of life of women and girls and thereby reduce the economic productivity of the community as a whole. A Maasai medical practitioner from Kenya explained it like this:

*... women suffer from generational poverty, from one generation to another. It will not stop, as long as we link FGM to early marriages and lack of formal training.*

The authors conclude that FGM violates the dignity of girls and women and compromises their independence and capacity to exercise their sexual and reproductive rights, educational rights, economic rights and liberties. Depriving girls and women of education and forcing them into early marriage traps them in poverty and curtails their ability to negotiate better life chances.

## Prevention and response-related services in the border areas

A number of organizations are working to end the practice of FGM in the border areas, for example community-based organizations, such as women's networks, and international NGOs, such as the United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), Socio-Economic Development and Human Rights Organization, Action Aid, World Vision, Habiba International, Save the Children and the Population Council. Several Government agencies are also engaged in this work, as are faith-based organizations, such as the Adventist Development and Relief Agency, Norwegian Church Aid, Pentecostal churches, Catholic churches and mosques. They are supported by human rights activists, judicial officers, police officers, politicians and local administrators.

However, almost half of immigration officials and local government administrators (45 per cent) were not aware of such initiatives in their communities.

The main preventive interventions are training local health workers, raising awareness of the law and the harm caused by FGM among the community and local government officials, capacity-building initiatives, organizing cross-border initiatives and meetings, supporting school programmes and campaigning for changes in social norms. These initiatives empower girls and women to resist FGM and mobilize the community to end the practice.

The main response-related interventions are supporting the survivors of FGM by providing shelters and rescue centres, supporting medical referrals and helping meet medical expenses, and providing psychological support and counselling.

Respondents identified some gaps in cross-border anti-FGM programmes and in anti-FGM programmes within countries. For instance, respondents from the Kuria community along the Kenya–Tanzania border reported that some religious leaders are not practising what they preach. Community members reported receiving contrasting messages from anti-FGM NGOs and traditional and religious community leaders. Unfortunately, the community leaders have more influence, and attempts to end FGM can be construed as stripping communities of their identity.

Some respondents also raised concern about the lack of resources in local organizations that prevents them from supporting survivors of FGM effectively, as a gender and child officer from Somalia explained:

*We don't have much capacity to take them in ourselves and even the NGOs they just provide treatment and counselling only as opposed to taking them in and protecting them from their people.*

The authors recommend that these organizations' actions and activities are coordinated to avoid any duplication and competition for resources that could reduce their effectiveness. More work is needed to increase the capacities of community and religious leaders and local government organizations to bring about changes in social norms. And more focused interventions are needed in the remote border areas to raise awareness that the practice of FGM is not only illegal but also morally wrong.

## Changes in social norms in the border areas

FGM is understood as an important part of many cross-border communities' social and cultural identity. Similarities in the traditions, languages and cultures and shared resistance to the laws in these communities are some of the reasons for continuing the practice of cross-border FGM. Moreover, because the borders are porous they are easily crossed, and there is no regional law in force to regulate the practice of FGM. For instance, a family in the Maasai, Kuria, Borana or Somali community may have relatives on either side of the border, and family members may choose to have their daughters circumcised on the side of the border perceived to have the less prohibitive laws against FGM.

Other reasons for the prevalence of cross-border FGM include the ease of avoiding arrest, because of the remoteness of the border areas and the lack of transport infrastructure, the availability of experienced circumcisers, who are mainly on the Kenyan side of the border, frequent political hostility between neighbouring countries, which prevents collaboration on ending the practice of FGM, and the absence of any regional initiative enabling countries to collaborate on enforcing their laws against FGM.

The social norms associated with the practice are a strong incentive for families to continue having their daughters circumcised to maintain their social status and acceptance in their communities. Few people have abandoned the practice, and unfortunately the number of those who have done so has not reached the critical mass needed to change the perception of circumcision as the norm. Despite this, existing anti-FGM interventions have helped communities to become more aware of the harms caused by the practice and to see it as a violation of the individual's rights and a form of violence against women and girls. There is evidence that social norms are beginning to change: for example, FGM is no longer publicly celebrated in many communities, as explained by a focus group participant from Bungoma, Kenya:

*Yes, nowadays there is no prize and even songs being sung is immoral; the activity is mostly performed in secret without the cultural pomp associated with the past.*

Changes have been observed in the following areas:

- Age of circumcision: there is a tendency for girls to be circumcised at younger ages, which some attribute to younger girls being less able to give informed consent or to question the practice.
- The type of circumcision: type III FGM, in which large parts of the genitalia are removed or repositioned, has largely been replaced by type I FGM, in which part of the clitoris is removed. Some practitioners say that nowadays they simply "prick" the clitoris as a way of demonstrating that a girl has been circumcised.
- Time and season of circumcision: FGM used to be celebrated by the community as a girl's rite of passage and was undertaken after harvest when food was plentiful. Public celebrations are much less common now, and girls tend to be circumcised in the school holidays to allow time for healing and avoid raising suspicion.

- Other circumstances: circumcision in a public place has been replaced by girls being circumcised in their own homes or in the circumciser's home. Whereas men used to be the key decision makers and women organized the ceremony, women are now the decision makers and there is no public ceremony.
- Medicalization of the practice: this is seen as a way of reducing the risks of the practice and ensuring its "safety".

Overall, members of the cross-border communities do not disagree with the messages of the campaigns and interventions aimed at transforming the sociocultural and religious norms associated with FGM. However, the distance of the border areas from cities and the communities' lack of exposure to different lifestyles may prevent them from developing self-awareness. This limits individuals' ability to see their situation differently, and often it is "learned helplessness" that leads them to conform with traditional practices as a way of being socially accepted.

## Conclusions

There is an opportunity to eradicate the practice of FGM, as the cross-border communities hold empowered women in high regard, and all parents will wish to see their daughters realize their full potential as human beings. The problem is that many community members do not see FGM as a barrier to achieving that emancipation.

The authors recommend that the organizations working in these areas cooperate closely with the custodians of culture to bring about community-led change. Robust, targeted interventions tailored to communities' belief systems will be needed to ensure that the change is community driven and participatory and to give people a say in adapting their traditions to the new reality. The organizations could identify model families and individual "anti-FGM champions" with the influence and the will to drive change and involve the whole community. They should also identify and work with reformed circumcisers, who have a unique ability to advocate the "new normal". And the organizations will need to liaise with Governments to improve the infrastructure in the border areas to ease communications and increase engagement between cross-border communities and between those communities and the rest the country.

Much remains to be done to ensure that national policies and legislation are fully implemented in the border areas. A regional legislative and policy framework will be key to strengthening cross-border initiatives to tackle FGM and to achieving the African Union's aim of ending the practice by 2030.

# Recommendations

Drawing on the major findings of the study, the authors propose the following specific recommendations.

## A. Legal and policy frameworks

- Address national legal pluralism to provide guidance on how to deal with the inherent conflict between the formal law on the one hand and religious and customary rules and practices on the other in order to achieve social legitimacy within the criminal law.
- Introduce a regional law prohibiting FGM, which should include provisions for:
  - Harmonizing the offences and minimum penalties to eliminate the need for people to cross borders to face less prohibitive laws and less punitive penalties
  - Capitalizing on local and religious rules and laws that prohibit the practice of FGM
  - Protecting those who report or are witnesses in FGM cases
  - Addressing emerging issues, such as the medicalization of the practice and self-mutilation.
- Develop a robust policy structure with accompanying plans of action at regional level, providing minimum standards while allowing countries to integrate these policy provisions into their own policy and reflect their unique situations.
- Ensure that these policy provisions address:
  - Strategies for implementation with dedicated budgetary allocations
  - A monitoring and evaluation framework to track progress throughout the cross-border communities
  - Standard operating procedures on how to deal with FGM cases in each jurisdiction in the region
  - Other complementary policies that address interrelated issues, such as health and psychosocial support for survivors of FGM and re-admission to school for girls who are survivors of FGM and child marriage.

## B. Capacity-building

- Train all law enforcement officials on the practice of FGM and the anti-FGM laws. Joint training sessions would be ideal to ensure uniformity of understanding of the practice of FGM and consistency in enforcing the law.
- Improve the ability of law enforcement officials to arrest perpetrators and continue to raise awareness of FGM and the law within their communities by improving the infrastructure and other resources such as transport to increase their mobility within their administrative areas.
- Increase awareness of the existence of the national laws banning FGM, and the associated penalties, in particular along the Kenya–Ethiopia border among the Dasenach (Ethiopia), Borana (both Kenya and Ethiopia) and Somalis in Mandera (both Kenya and Somalia). Awareness-raising among community members is needed: including key community players such as religious and cultural leaders is important, as this encourages buy-in from community members and increases compliance with the law.
- Make extensive use of local media outlets and accessible social media platforms to raise awareness of FGM, including the support services available in the cross-border areas.

## C. Scale up FGM preventive and response programmes

- Intensify advocacy and awareness-raising activities throughout the border areas. Such activities should be designed to address specific drivers in the different communities and other harmful practices such as child marriage.
- Provide comprehensive health services, including psychosocial support, to help survivors deal with FGM-related complications, such as fistulas, in the cross-border areas.
- Exploit the influence of religion in eradicating the practice by promoting the correct religious teachings and engaging religious leaders as agents of change. The definition of FGM should be aligned with the World Health Organization's definition. This would invalidate the defence that certain types of acts are religious or cultural and therefore not regarded as FGM, for example the Sunna type of circumcision.
- Institute an accountability mechanism to prevent medical professionals from engaging in any form of FGM. In addition to criminalizing the medicalization of the practice, medical institutions should have policies for dealing with medical professionals who practise FGM.
- Tailor interventions to specific communities' belief systems in the cross-border areas to ensure that social change is community driven and

participatory and to give the people more say in transforming their traditions towards a new reality.

- Introduce evidence-based social norm change models to allow community members to come up with community consensus on alternative rites of passage ceremonies while completely abandoning the practice of FGM.
- Map organizations engaged in FGM prevention and response activities and services to improve the distribution of these services and establish referral systems among the various organizations in collaboration with Government departments.

#### D. Related research

- There was no baseline study with which to compare the major findings from the current study and discuss the social changes in the practice of FGM occurring in the cross-border areas. Hence, we recommend process evaluation research to capture new trends, measure changes in practice and develop interventions that are informed and effective.
- There may also be a need to further interrogate the political processes and diplomatic dimensions that hinder neighbouring countries from taking a common approach, as this could delay the development of joint action against FGM.

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