

Beyond the crossing

FEMALE GENITAL MUTILATION ACROSS BORDERS

Ethiopia, Kenya, Somalia, Tanzania and Uganda



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CONTENTS

FOREWORD	4
CHAPTER 1	
WHAT ARE THE DATA TELLING US?	6
1.1 Key facts	6
1.2 the geography of female genital mutilation and ethnicities	7
1.3 Age-specific risks of female genital mutilation	8
1.4 Cross-border dynamics of age-specific risk of female genital mutilation: the Somali community	18
1.5 The number of girls at risk by 2030.....	21
CHAPTER 2	
SOCIAL FACTORS AND DYNAMICS OF FEMALE GENITAL MUTILATION ACROSS THE BORDERS	22
2.1 Socio-Economic determinants of female genital mutilation	23
2.2 Types of female genital mutilation performed.....	23
2.3 Medicalization of female genital mutilation.....	24
2.4 Evidence of cross border practice of female genital mutilation.....	25
2.5 Key factors driving cross border female genital mutilation practice	25
CHAPTER 3	
LEGAL AND POLICY FRAMEWORKS ON FEMALE GENITAL MUTILATION AND ITS CROSS-BORDER PRACTICE	26
3.1 Regional and sub regional frameworks	27
3.2 National legislations & policies.....	27
3.3 Positive trends in programming.....	29
3.4 Example of law enforcement achievements.....	29
CHAPTER 4	
WHAT ARE THE CHALLENGES IN TACKLING THE CROSS BORDER FEMALE GENITAL MUTILATION PRACTICE?	30
CHAPTER 5	
CONCLUSION.....	33
CHAPTER 6	
RECOMMENDATIONS	34
ANNEX	
SUMMARY OF FEMALE GENITAL MUTILATION RELATED LEGAL, POLICY AND COORDINATION FRAMEWORKS.....	36

LIST OF FIGURES

Figure 1. Prevalence of female genital mutilation among women aged 15 to 49, latest available survey	7
Figure 2. Single year risk of female genital mutilation in Ethiopia, among women and girls who will eventually undergo.....	9
Figure 3. Ethiopia - percentage of women age 15-49 who have undergone female genital mutilation, by ethnicity [%]	9
Figure 4. Single year risk of female genital mutilation, among women and girls who will eventually undergo female genital mutilation, by ethnicity.....	10
Figure 5. Single year risk of female genital mutilation, among women and girls who will eventually undergo female genital mutilation in Kenya.....	12
Figure 6. Kenya - percentage of women age 15-49 who have undergone female genital mutilation, by ethnicity.....	13
Figure 7. Single year risk of female genital mutilation, among women and girls who will eventually undergo female genital mutilation, by ethnicity.....	14
Figure 8. Single year risk of female genital mutilation, among women and girls who will eventually undergo the practice in Tanzania.....	16
Figure 9a. Single year risk of female genital mutilation, among women and girls who will eventually undergo female genital mutilation in Somaliland	17
Figure 9b. Single year risk of female genital mutilation, among women and girls who will eventually undergo female genital mutilation in Somalia North East Zone	17
Figure 10. Cross-boundary dynamics of female genital mutilation - example: Somali community	18
Figure 11. Single year risk of female genital mutilation, among all women and girls, among Somali women and girls in Kenya, Ethiopia and Somalia.....	19
Figure 12. Number of girls at risk of Female Genital Mutilation, 2015-2030, by country and in thousands.....	21
Figure 13. Types of female genital mutilation in Ethiopia, Kenya, Tanzania	23
Figure 14. Frequency of visits in Kenya for female genital mutilation services by interviewed women (percentage)	25
Figure 15. Law enforcement in Ethiopia and Kenya between 2015-2018	29



FOREWORD

Globally, it is estimated that at least 200 million girls and women alive today have undergone female genital mutilation (FGM) in 30 countries, including Ethiopia, Kenya, Somalia, Tanzania and Uganda.

The practice is generally rooted in traditional beliefs, values and attitudes and is valued in many countries as a rite of passage into womanhood and child marriage.

Yet, FGM is one of the manifestations of gender inequality and human rights violations and has adverse effects on women and girls' health, especially sexual and reproductive health, education and empowerment. The practice can cause short and long-term health complications, including chronic pain, infections, increased risk of HIV transmission, anxiety and depression, birth complications, infertility and, in the worst cases, death. It is internationally recognized as an extreme violation of the rights of women and girls.

In 2012, the United Nations General Assembly unanimously adopted the first-ever resolution calling for intensified global efforts for the elimination of FGM. Ending FGM is also a fundamental step towards achieving the Sustainable Development Goals (SDGs). In 2015, FGM was included in the [Sustainable Development Goals](#) under Target 5.3, which calls for the elimination of all harmful practices, including FGM. Ending this harmful practice can accelerate progress in other SDGs that focus on good health and well-being, safe motherhood, quality education, inclusive societies and economic growth.

While there are clear evidences of social norms changes due to efforts by stakeholders, there are still challenges to address if we are to end FGM. The cross-border practice of FGM is one of these challenges.



Photo: Narok, Kenya – Georgina Goodwin for UNFPA

The cross-border practice is common in the East Africa Region, in particular in Ethiopia, Kenya, Somalia, Tanzania and Uganda (in some sub national areas), where there is still a high prevalence of FGM. These countries share borders and have, in some areas, the same communities and ethnic groups, which leads to cross-border practices of FGM.

This report brings to light the cross-border dimension of FGM. It describes the practice, as well as the socio factors and dynamics that contribute to FGM across borders, and presents the legal and policy frameworks, as well as the positive trends in programming aimed at eliminating FGM. The report concludes by suggesting a series of recommendations to address cross-border FGM practice, which requires bringing together regional-level solutions and inter-country programmes.

On the pathway to achieving the Sustainable Development Goals, UNFPA is committed to help countries delivering three transformative results: ending maternal deaths; addressing unmet need for family planning; and ending harmful practices, including FGM. The growing number of public commitments to end FGM as well as its abandonment by communities show that it is possible to abandon FGM.

We hope that this report can inform further interventions and efforts to address FGM globally so the practice can indeed become a vestige of the past.

Benoit Kalasa

Director, Technical Division, UNFPA

1

WHAT ARE THE DATA TELLING US?

1.1 KEY FACTS

ETHIOPIA

- 65 per cent of girls and women aged 15 to 49 who have undergone FGM (DHS 2016).
- Secular decline: half of girls aged 15 to 19 (47 per cent) have undergone FGM compared to three quarters of women older than 30 (DHS 2016).
- Prevalence in rural area (68 per cent) is higher than in urban area (54 per cent) (DHS 2016).
- Recent estimates indicate that between 2015 and 2030, about 6.3 million girls are at risk of undergoing FGM (UNFPA 2018).
- Among women who have heard of FGM, 24 per cent believe that the practice is required by their religion, and 18 per cent believe that the practice should be continued (DHS 2016).

KENYA

- 21 per cent of girls and women aged 15 to 49 years have undergone FGM (DHS 2014).
- Prevalence of FGM varies in the country and is concentrated in the Eastern regions of the country.
- The practice of FGM seems to undergo rapid changes, with decreased prevalence by 72 per cent between the women aged 45 to 49 and girls aged 15 to 19 years old (DHS 2014).
- Recent estimates indicate that between 2015 and 2030, about 800,000 girls are at risk of undergoing FGM (UNFPA 2018).
- 11 per cent or less of women and men believe that the practice should continue (DHS 2014).

SOMALIA

- FGM remains near universal in the country, with 98 per cent of girls and women aged 15 to 49 years having undergone FGM (MICS 2006).
- Recent estimates indicate that 2.2 million girls are at risk of undergoing FGM between 2015 and 2030 (UNFPA 2018).

TANZANIA

- In the 2015-2016 DHS, 10 per cent of women aged 15 to 49 reported FGM, a decline from 18 per cent compare to 1996 (DHS 1996).
- The prevalence in rural areas (13%) is more than double that in urban areas (5%) (2015-16 DHS).
- The highest percentages of circumcised women are in Manyara and Dodoma regions (58 per cent and 47 per cent, respectively, 2015-16 DHS).
- Recent estimates indicate that between 2015 and 2030, about 140,000 girls are at risk of undergoing FGM (UNFPA 2018).
- 95 per cent of the women who have heard of FGM, believe that the practice is not required by their religion and should not be continued (2015-16 DHS).

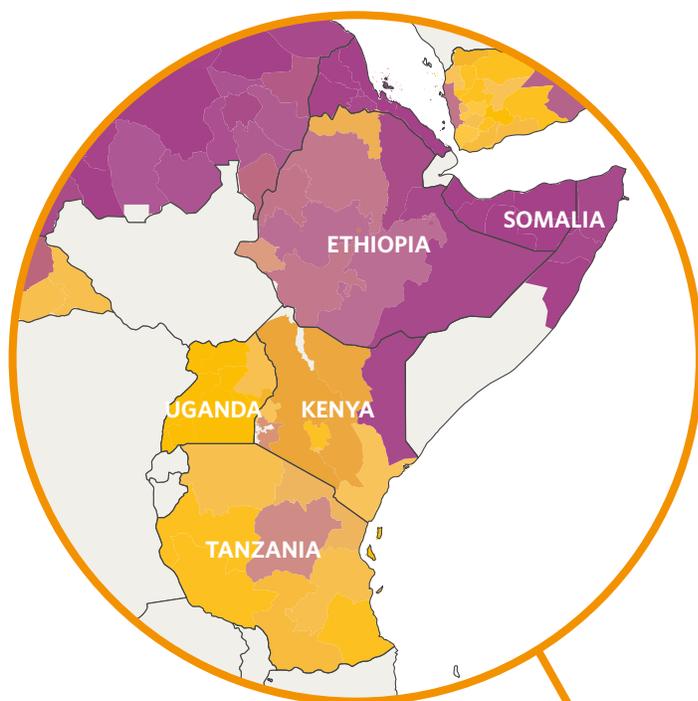
UGANDA

- While nationally, 0.3 per cent of girls and women aged 15 to 49 years have undergone FGM according to the DHS (2016), the FGM survey report/UBOS (2017) indicate a 26.7 per cent rate in the two practicing regions (Karamoja and Sebei) and goes up to 67 per cent in Tapac sub-county (Moroto District)
- 94.8 per cent of interviewed women believe that the practice should not be continued (DHS 2016).
- As age of cutting has not been recorded in the case of Uganda, no incidence estimates and number of girls at risk of undergoing FGM can be provided.

1.2 THE GEOGRAPHY OF FEMALE GENITAL MUTILATION AND ETHNICITIES

The practice of FGM cuts across national borders. In the case of East Africa, highlighted in figure 1, regions with high prevalence are often concentrated in areas that span several countries such as the border areas of Kenya Ethiopia and Somalia, Kenya and Tanzania, Ethiopia and Sudan, as well as Ethiopia, Djibouti and Eritrea.

Figure 1. Prevalence of female genital mutilation among women aged 15 to 49, latest available survey

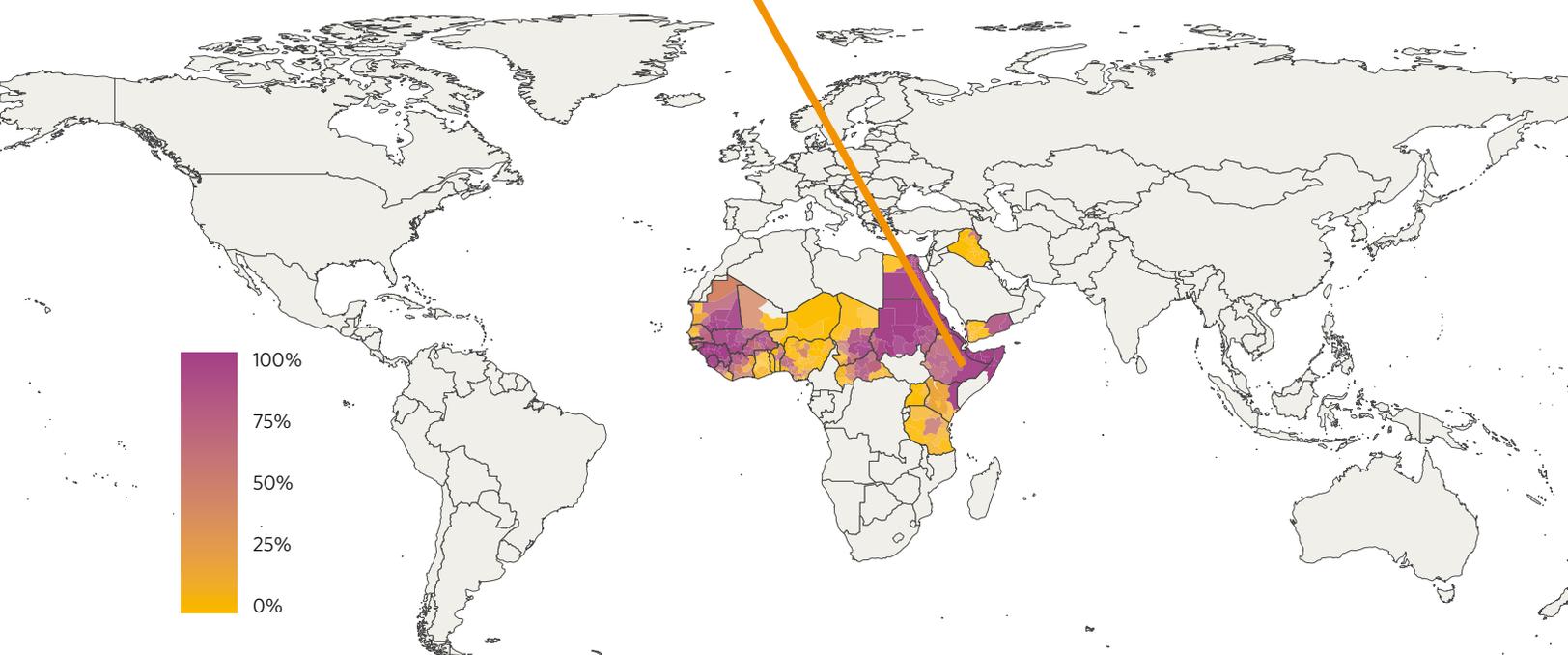


Source: Latest available nationally representative household survey if conducted in the last 10 years. The source of the shape files are:

- a) the latest DHS survey (Benin, Burkina Faso, Chad, Cote d'Ivoire, Egypt, Eritrea, Ethiopia, Ghana, Guinea, Kenya, Liberia, Niger, Nigeria, Senegal, Sierra Leone, Tanzania, Gambia, Togo, Uganda, Yemen),
- b) the MIS (Mali) or OCHA's data base on administrative boundaries (Guinea-Bissau, Sudan, Iraq, Central African Republic, Mauritania, Somalia-Northeast Zone and Somalia - Somaliland), available at: <https://data.humdata.org/>

Disclaimer: The designations employed and the presentation of material on this map do not imply the expression of any opinion whatsoever on the part of UNFPA concerning the legal status of any country, territory, city or area or its authorities, or concerning the delimitation of its frontiers or boundaries.

Note: In 2011, a MICS was conducted separately in both Somalia Northeast Zone and Somaliland.



This observed geographic distribution of FGM is tightly linked to the distinct patterns of ethnicities that reside in the region. Many ethnic groups inhabit East Africa, and not all practice FGM. Recent household surveys allow analyzing subnational differences in the practice of FGM and revealing significant diversity across ethnicities. In Kenya, where the largest variations is observed, FGM prevalence rates range from almost universal (nine out of ten Samburu and Somali women reported FGM in 2014) to virtually non-existent (0.2 % report FGM among the Luo in 2014).

Many of these ethnicities predominantly reside in one single country such as the Amhara in Ethiopia, Kisii and Rendille in Kenya or the Chagga in Tanzania. While residing in one single country, other practicing ethnicities are leaving at the border with the other countries such as the Burji in Ethiopia or the Sabiny in Uganda. However, there are five ethnic groups that reside in more than one country in the region, the Kikuyu, Kurya/Kuria, Maasai, Pokot and Somalis (table 1). These communities do not only share borders, but also traditions and cultures, including the practice of FGM.

The next section, analyzes the practices around FGM in Ethiopia, Kenya, Somalia, and Tanzania and study the age at which FGM occurs which is of particular relevance for programmatic interventions and allows us to derive year-by-year risk patterns for young girls and adolescents. This method will be used to derive an estimate of the number of girls at risk in each country and to analyze key subnational variations across ethnicities.

Subsequently, a case study will be provided on the Somali community who resides in three countries in the region and is captured in nationally representative surveys in each of them. This will underline the consequences of shared practices and social norms and their implications on the risk of FGM and cross-border cooperation and interventions.

1.3 AGE-SPECIFIC RISKS OF FEMALE GENITAL MUTILATION

The age at which FGM is practiced is an important variable in order to plan programmatic interventions, as it indicates decision-making structures. When girls are subjected to FGM a young age, interventions have to target their parents, community leaders and health facilities. Where FGM is performed on girls in their early adolescence or later, giving girls the information and means to stand up for themselves through girls' empowerment activities is crucial. As practices are similar across bordering regions, knowing how to intervene is an important aspect of cross border cooperation.

In addition, knowing the year-by-year risk structure of FGM is also important as demographic dynamics result in large youth cohorts and rapid population growth in some countries where FGM is practiced. These dynamics are a critical factor in the estimation of the number of girls at risk of FGM. This section will provide an estimate of the number of girls at risk based on the risk that girls and adolescents face at each year of their life.

In order to derive the annual risk structure of FGM, a survival analysis will be used. This method has particular advantages in analysis FGM, as it takes into account that girls or women who have not yet experienced the practice are still at risk of experiencing FGM at a later age. The level of this risk is determined by the overall age structure of FGM in a particular country or community.

In the following sections, general information on FGM is presented per country with figures displaying risk of FGM following the ages of girls and women who have experienced FGM.

Table 1. Ethnic groups living in at least two of the five countries

Ethnic groups	Ethiopia	Kenya	Somalia	Tanzania	Uganda
Kikuyu		●		●	
Kurya/ Kuria		●		●	
Maasai		●		●	
Pokot		●			●
Somali	●	●	●		

Ethiopia

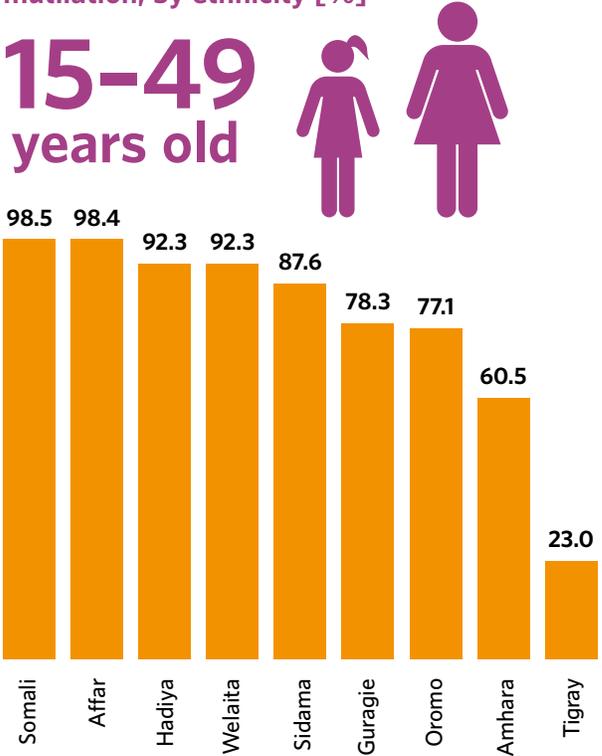
Figure 2 demonstrates the risk of FGM at each year of life among girls who will eventually undergo FGM. It has the shape of a step function, as they grow older more and more girls are subject to FGM. The higher the step, the larger the number of girls who have experienced FGM at a specific year of their life and the more the overall curve drops.

Ethiopia’s curve indicates a significant risk of FGM in infancy, i.e. in the first year of their life. 25 per cent of girls experience FGM by age one, and by age 2, 50 per cent of all girls who are eventually experiencing FGM have already undergone the practice.

As girls grow older, there is still a risk of FGM if they do not undergo the practice. Nevertheless, as the height of the steps decreases so does the risk. By age 18, the curve is virtually flat.

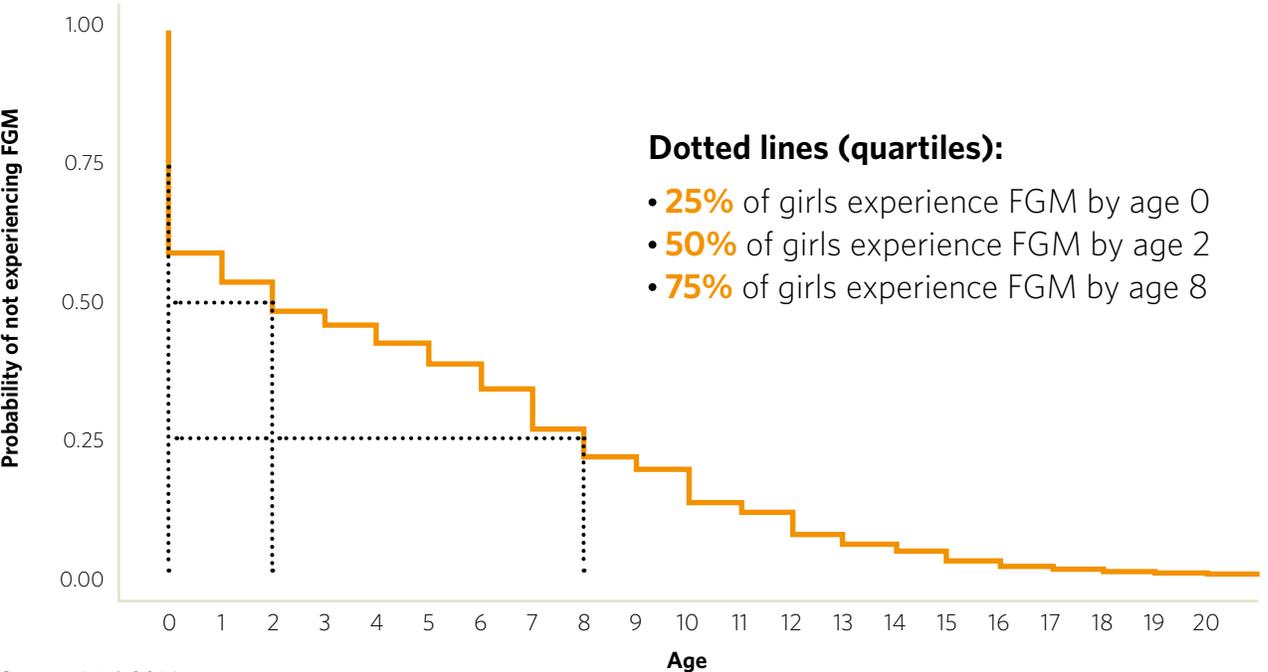
This curve, as well as all other national statistics, mask substantial subnational differences in the practice. In the 2016 DHS in Ethiopia, Somali and Affar women reported the highest prevalence of FGM at 99%. Further, 92% of Hadiya, and Welaita women reported FGM, compared to 88% of Sidama women (see figure 3). This is almost four times higher than the prevalence recorded for the Tigray ethnicity (23%).

Figure 3. Ethiopia - percentage of women age 15-49 who have undergone female genital mutilation, by ethnicity [%]



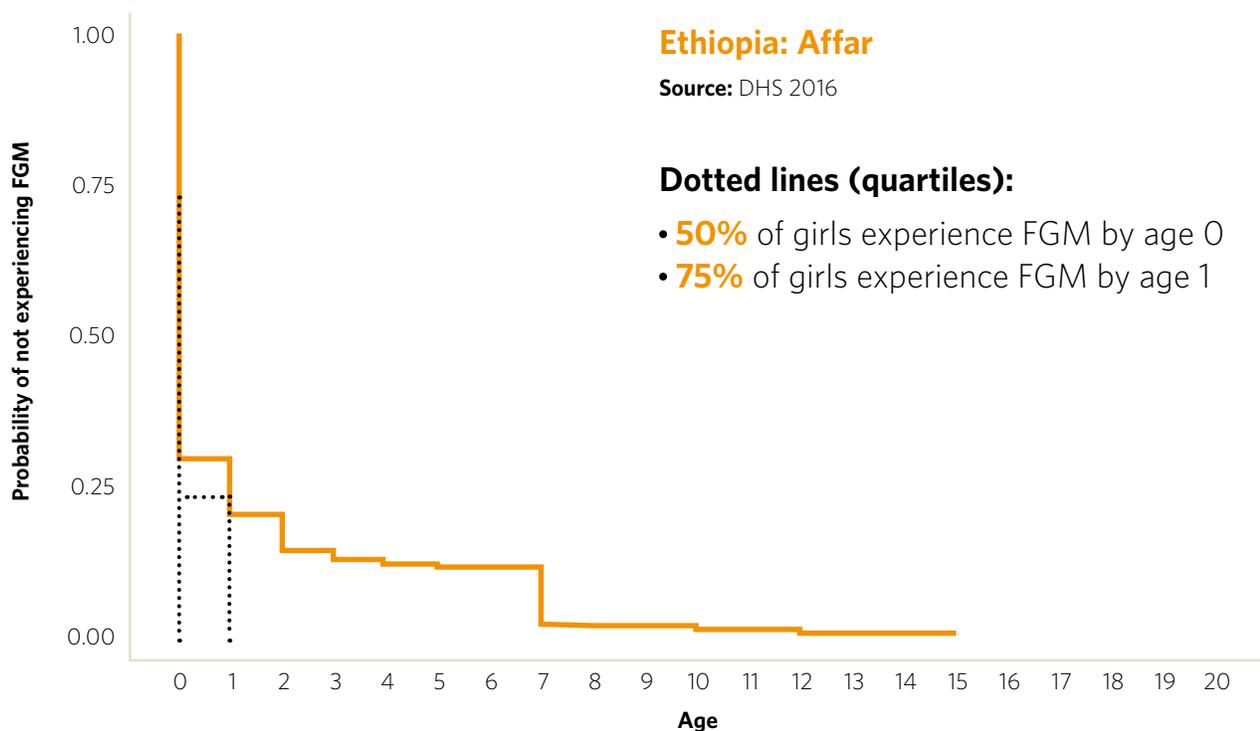
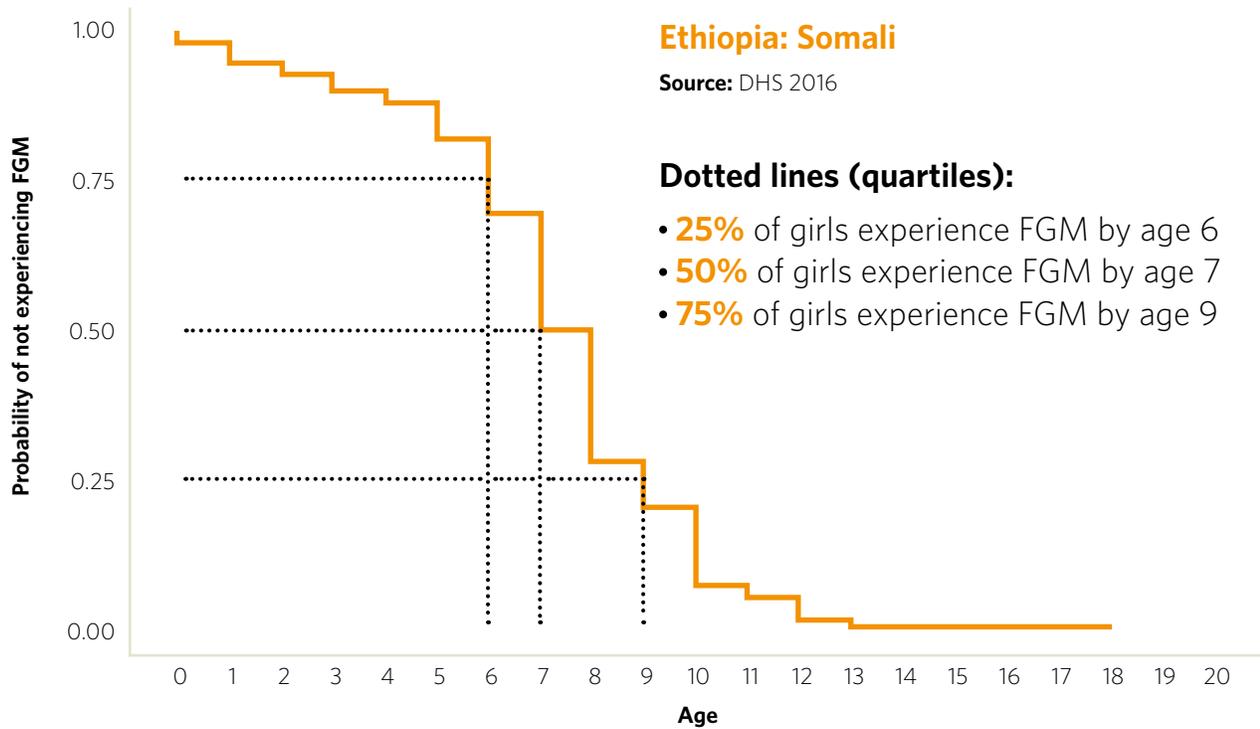
Source: Ethiopia DHS 2016

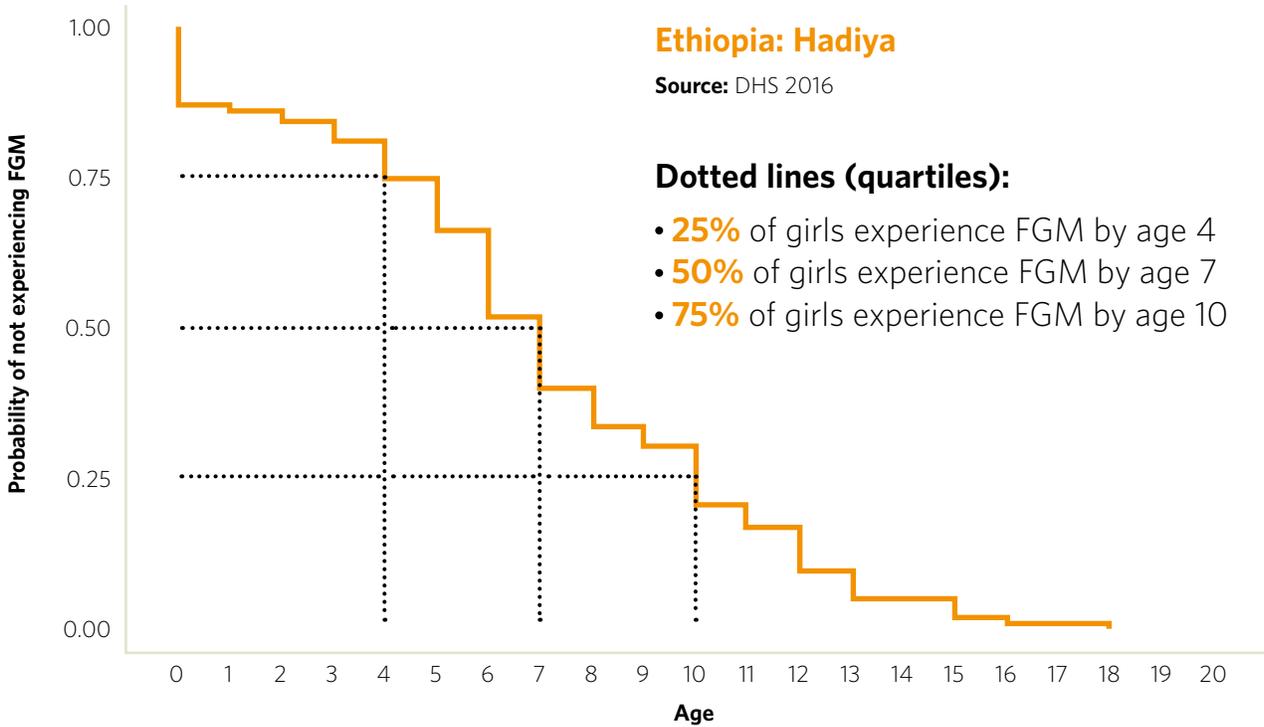
Figure 2. Single year risk of female genital mutilation in Ethiopia, among women and girls who will eventually undergo female genital mutilation



Source: DHS 2016

Figure 4. Single year risk of female genital mutilation, among women and girls who will eventually undergo female genital mutilation, by ethnicity





Different ethnicities do not only vary in terms of overall prevalence, but also in terms of practice around FGM. Figure 4 demonstrates the vast subnational differences with respect to age patterns of FGM. While girls from the

Afar ethnicity face FGM typically in the very first year of their life, the age patterns of girls in the Somali and Hadiya groups indicate a later age-at-FGM, particularly among the Hadiya where girls are at risk until the late adolescence.



Photo: Ethiopia - Luca Zordan for UNFPA

Kenya

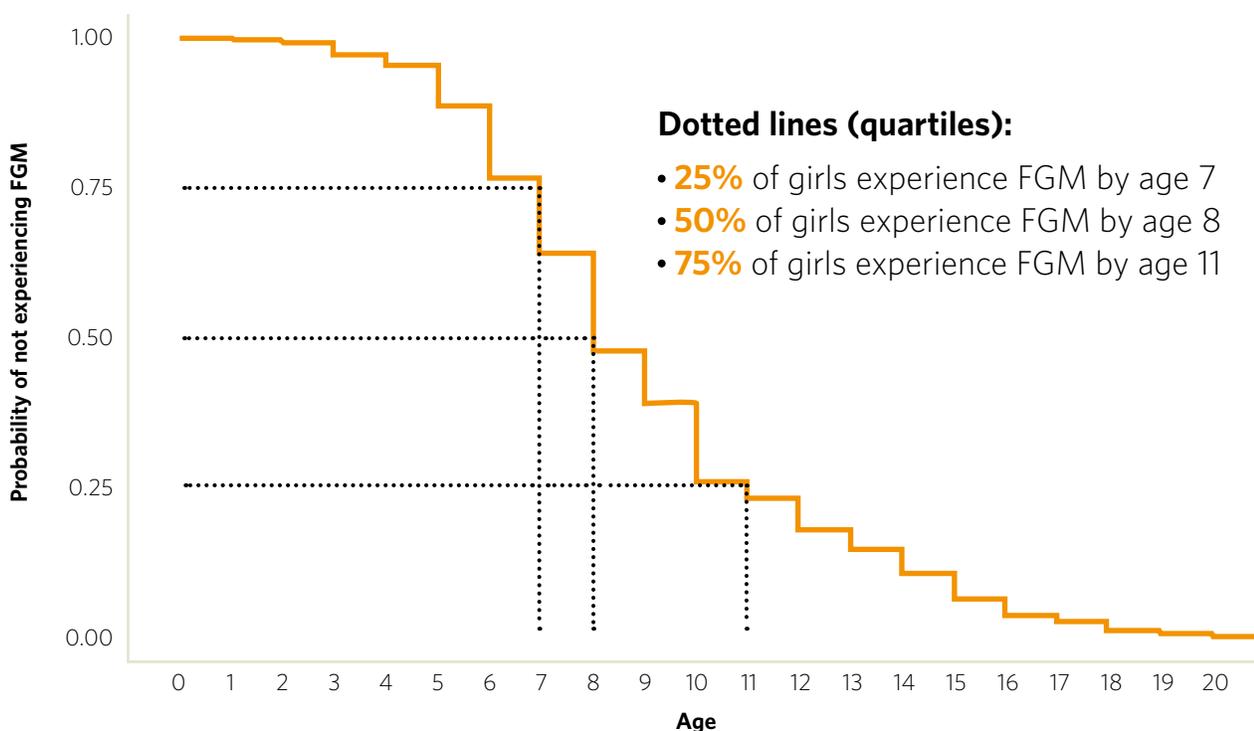
While half of girls and women in Kenya who eventually experience FGM are subjected to FGM before age of 8, the practice seems to continue until the ages of 19 or 20, which starkly distinguishes the pattern in Kenya from other countries in the region. In Kenya, girls are less exposed to FGM before age 7 and most of them are subjected to FGM at the beginning of their adolescence, between the ages of 8 to 15 years of age.

As in the case of Ethiopia, the national pattern observed in Kenya also masks significant subnational differences across ethnicities. There are 44 ethnic communities in Kenya. Only five are not practicing FGM including Pokomo, Luhya, Luo, Turkana and Teso¹. Data from the 2014 DHS in Kenya, for example, demonstrate that the proportion of women who are subjected to FGM varies significantly by ethnic group, from almost universal FGM among Somalis, Samburu and Kisii to a number

of ethnicities that do not practice FGM such as the Luo, Luhya, Turkana and Mijikenda/Swahili (see figure 6). The baseline study realized in 2017² revealed that respondents with Somali origins (76%) largely perform FGM on their daughters when under 10 years old, while a majority of surveyed girls and women of Maasai (97%), Samburu (90%), Pokot (100%) and Rendille (77%) origins perform FGM on their daughters from age 10 to 14 years old. Similarly, Muslim communities (76%) in the study locations generally practice FGM on girls when aged under, while girls in communities professing Protestant (94%) and Catholic (91%) faiths generally undergo the practice from 10 years when aged 10 and above.

These subnational diversities translate further into differences in the practice of FGM. In the case of the Somali and Kisii communities, FGM occurs in late childhood and is performed on girls by age 10, while in Samburu and Maasai girls are more likely to experience FGM in their early teens (Figure 7 a-d).

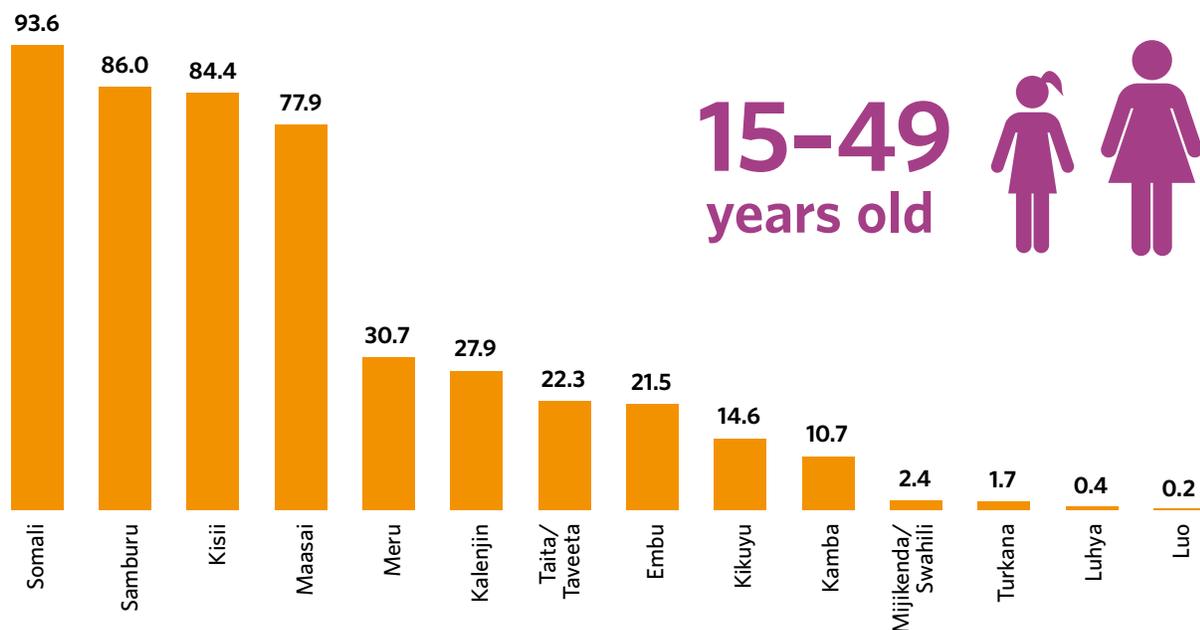
Figure 5. Single year risk of female genital mutilation, among women and girls who will eventually undergo female genital mutilation in Kenya



Source: DHS 2014

1 Kenya Ministry of Gender presentation during the Regional Inter-Ministerial End FGM Cross Border meeting in Nairobi, 15th to 17th April 2019.
 2 Baseline Study Report: Female Genital Mutilation/ Cutting and Child Marriage among the Rendille, Maasai, Pokot, Samburu and Somali Communities in Kenya, 2017.

Figure 6. Kenya - percentage of women age 15-49 who have undergone female genital mutilation, by ethnicity

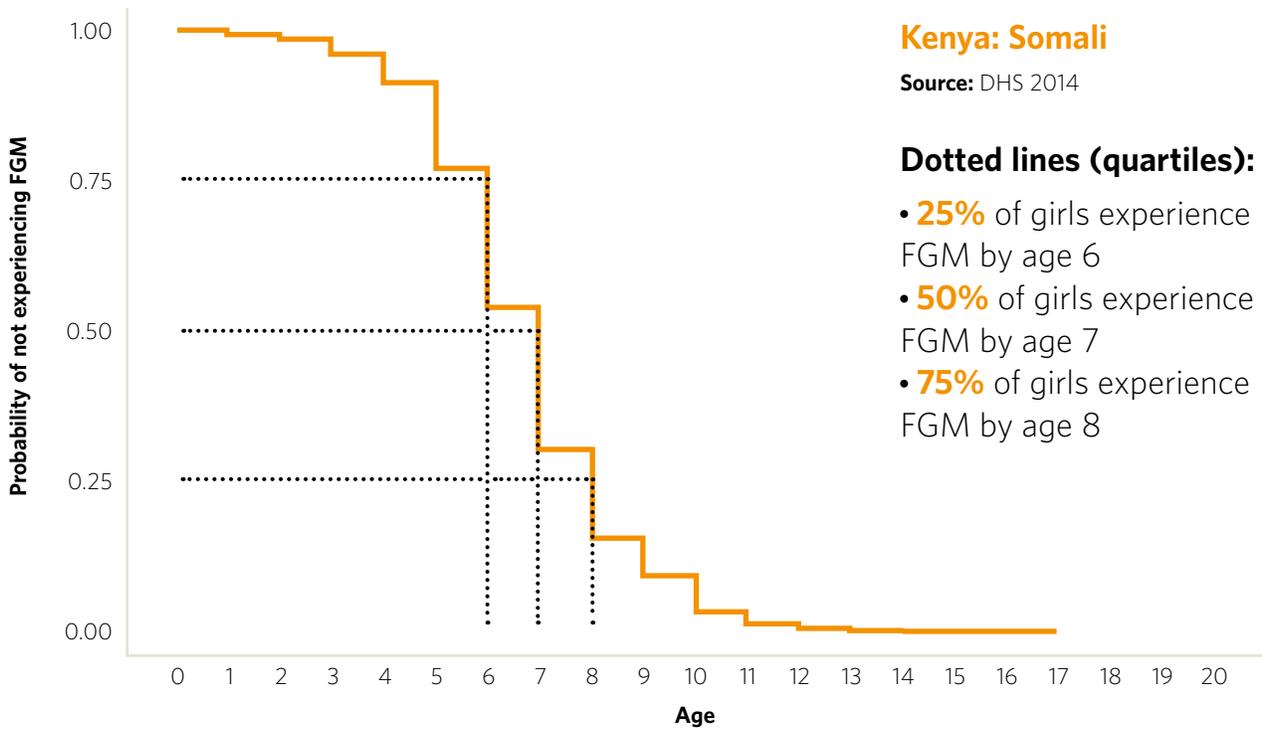


Source: Kenya DHS 2014

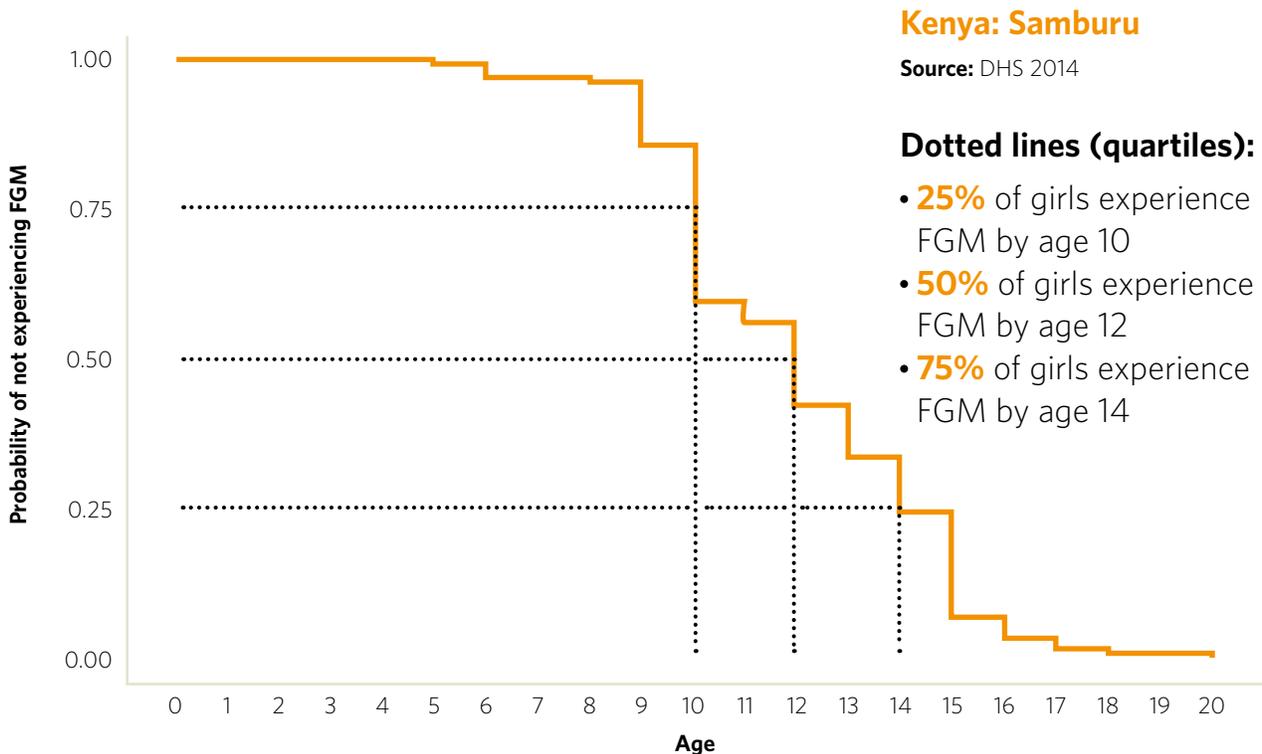


Photo: Narok, Kenya - Georgina Goodwin for UNFPA

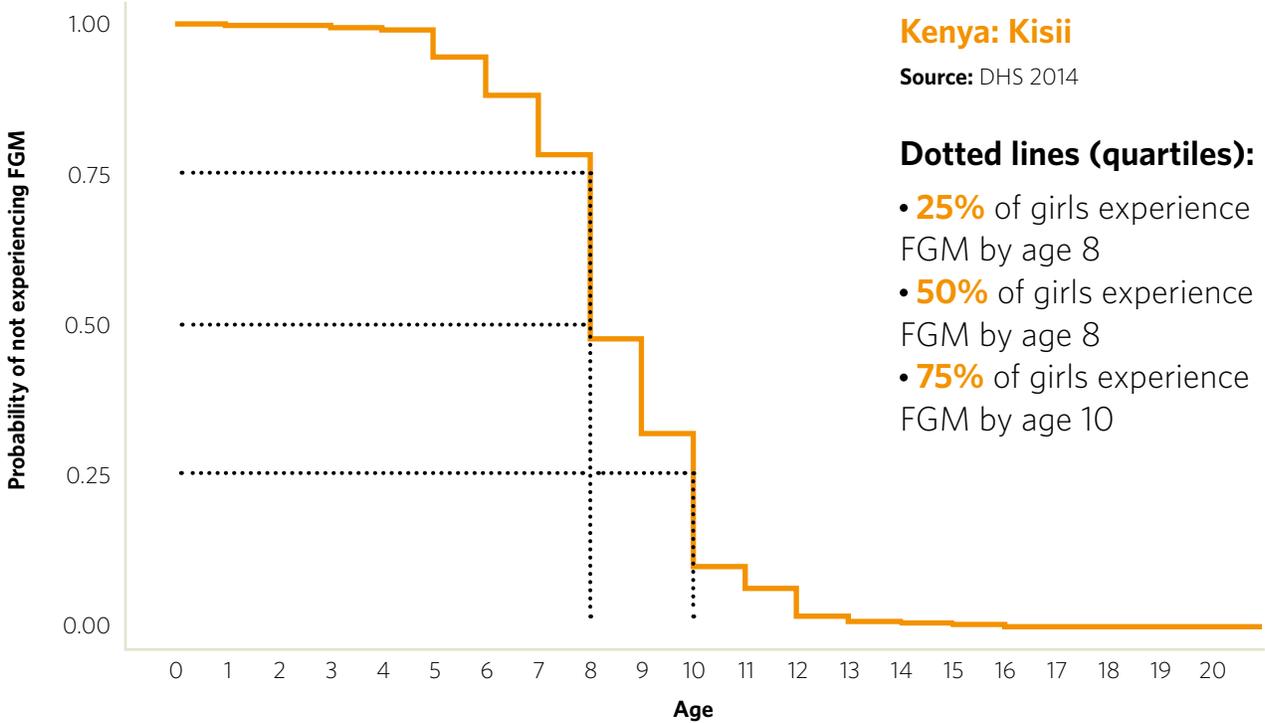
Figure 7. Single year risk of female genital mutilation, among women and girls who will eventually undergo female genital mutilation, by ethnicity



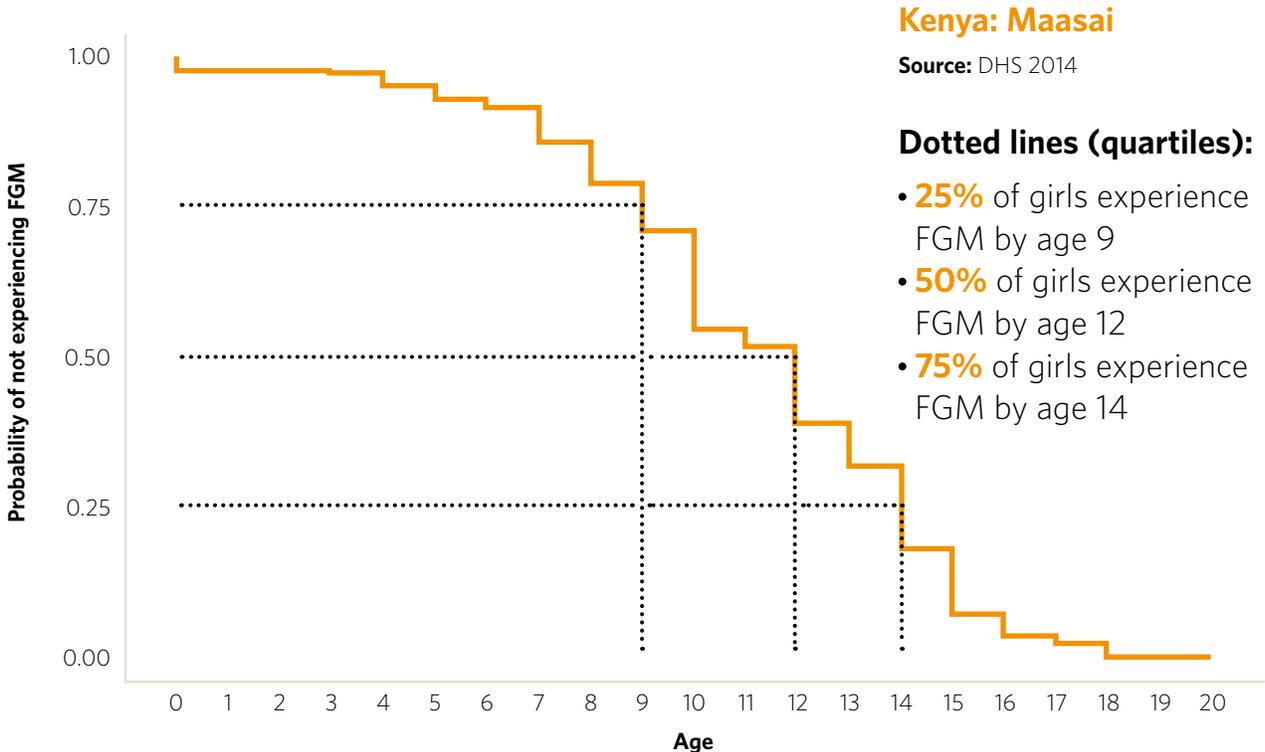
Source: DHS 2014



Source: DHS 2014



Source: DHS 2014



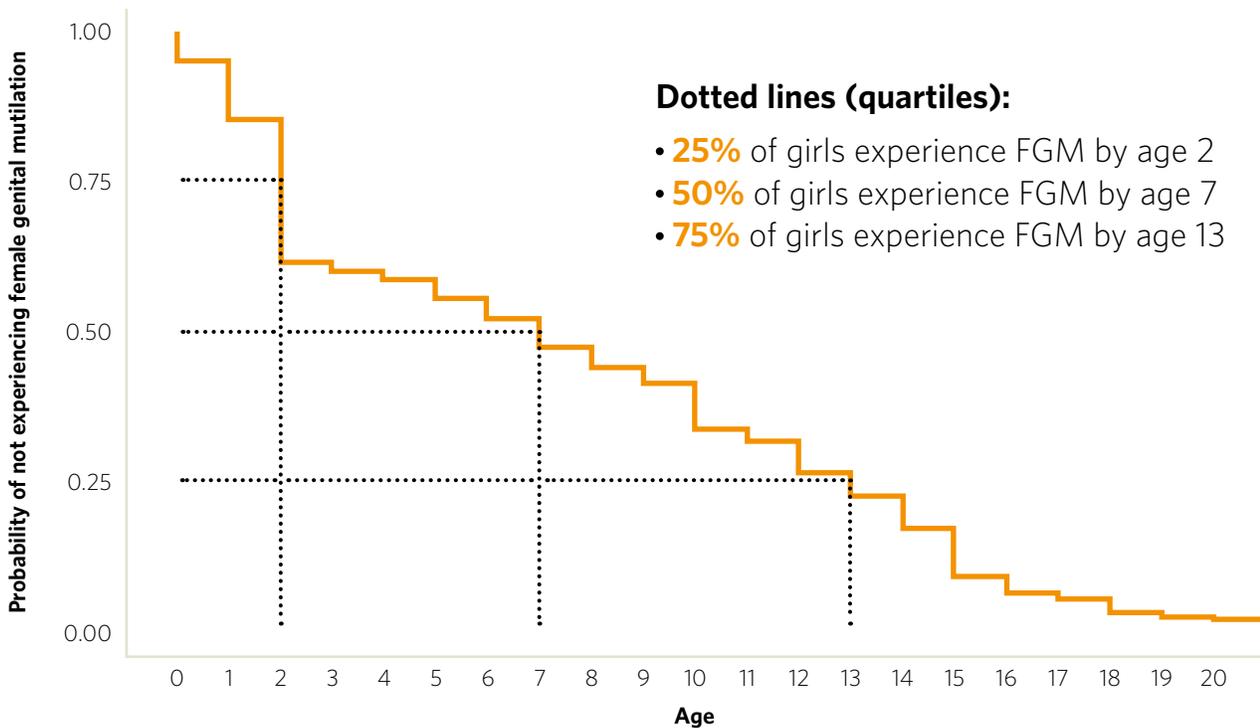
Source: DHS 2014

United Republic of Tanzania

In the case of Tanzania, around 25 per cent of all girls who experience FGM undergo the practice by age two. Especially from the second to the third years of their lives, girls seem to bear a large level of risk.

Nevertheless, there is still significant risk of undergoing FGM at later ages, as 25 per cent of girls who will eventually undergo FGM are subject to the practice after age 13. The risk continues up to 20 years of age.

Figure 8. Single year risk of female genital mutilation, among women and girls who will eventually undergo the practice in Tanzania



Source: DHS 2015

While this pattern might be related to different practices across communities and/or ethnic groups in Tanzania, a breakdown by ethnicity in Tanzania is not possible, this variable was not recorded in the 2015 DHS.



Somalia

As Somalia's North East Zone and Somaliland were surveyed separately in 2011, Figure 9a and Figure 9b below show the analysis for each region of the country separately. Nevertheless, the shape of the curves is very similar, indicating similar FGM practices. In both areas, the curves are flat in the beginning of girls' adolescence

indicating little risk of FGM before age 10. There is, in contrast, a high probability of experiencing FGM for girls aged 7 to 9 or 10. These are the years in which 50% of girls in Somaliland and in Somalia's North East Zone undergo FGM.

As in the case of Tanzania a breakdown by ethnicity is not possible due to data limitations.

Figure 9a. Single year risk of female genital mutilation, among women and girls who will eventually undergo female genital mutilation in Somaliland

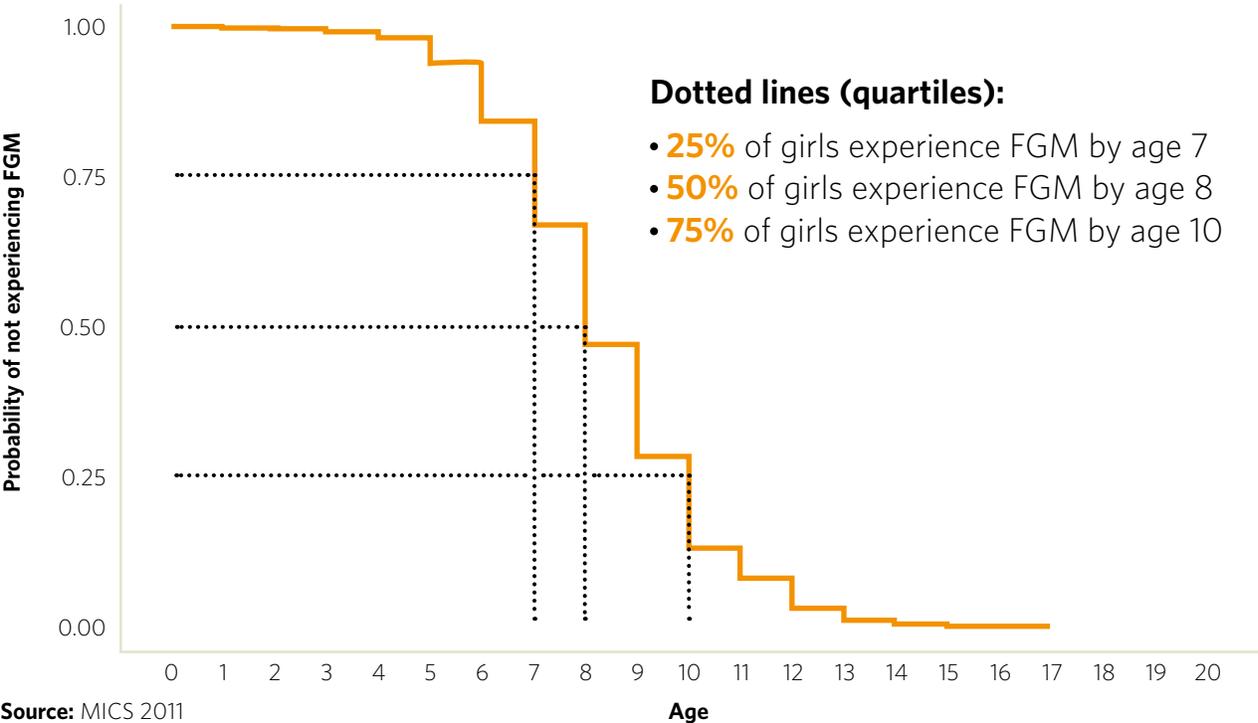
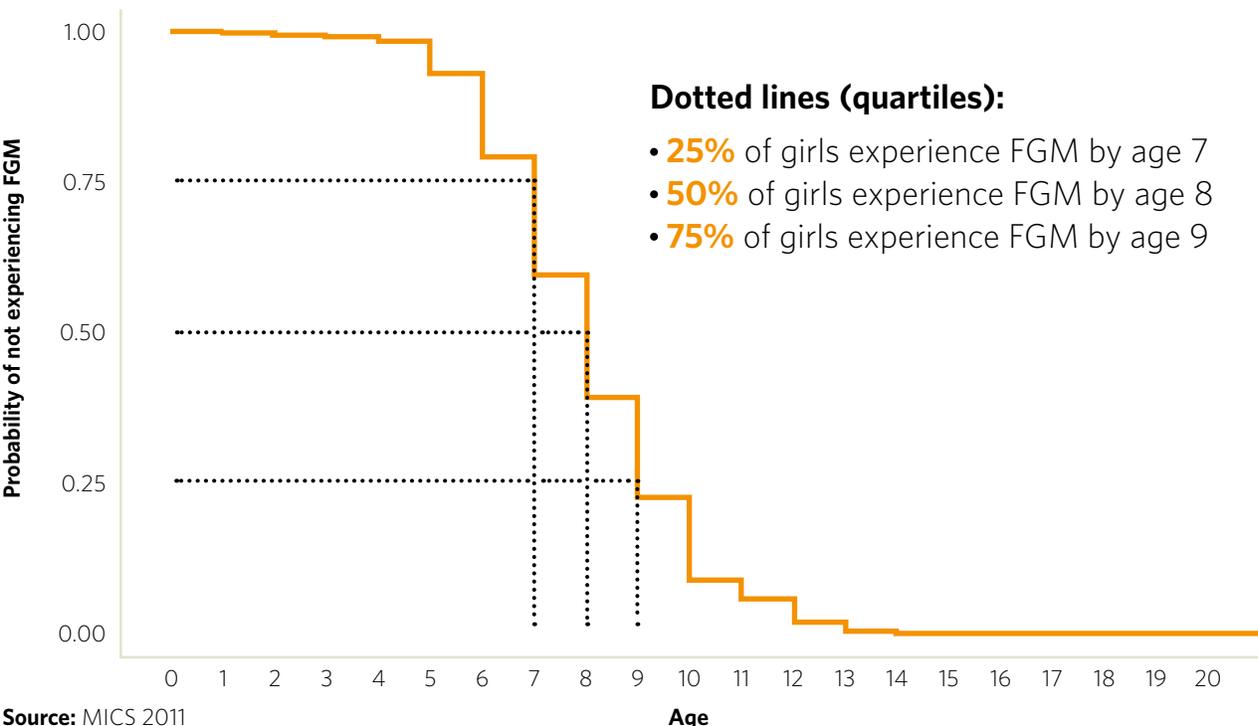


Figure 9b. Single year risk of female genital mutilation, among women and girls who will eventually undergo female genital mutilation in Somalia North East Zone



1.4 CROSS-BORDER DYNAMICS OF AGE-SPECIFIC RISK OF FEMALE GENITAL MUTILATION: THE SOMALI COMMUNITY

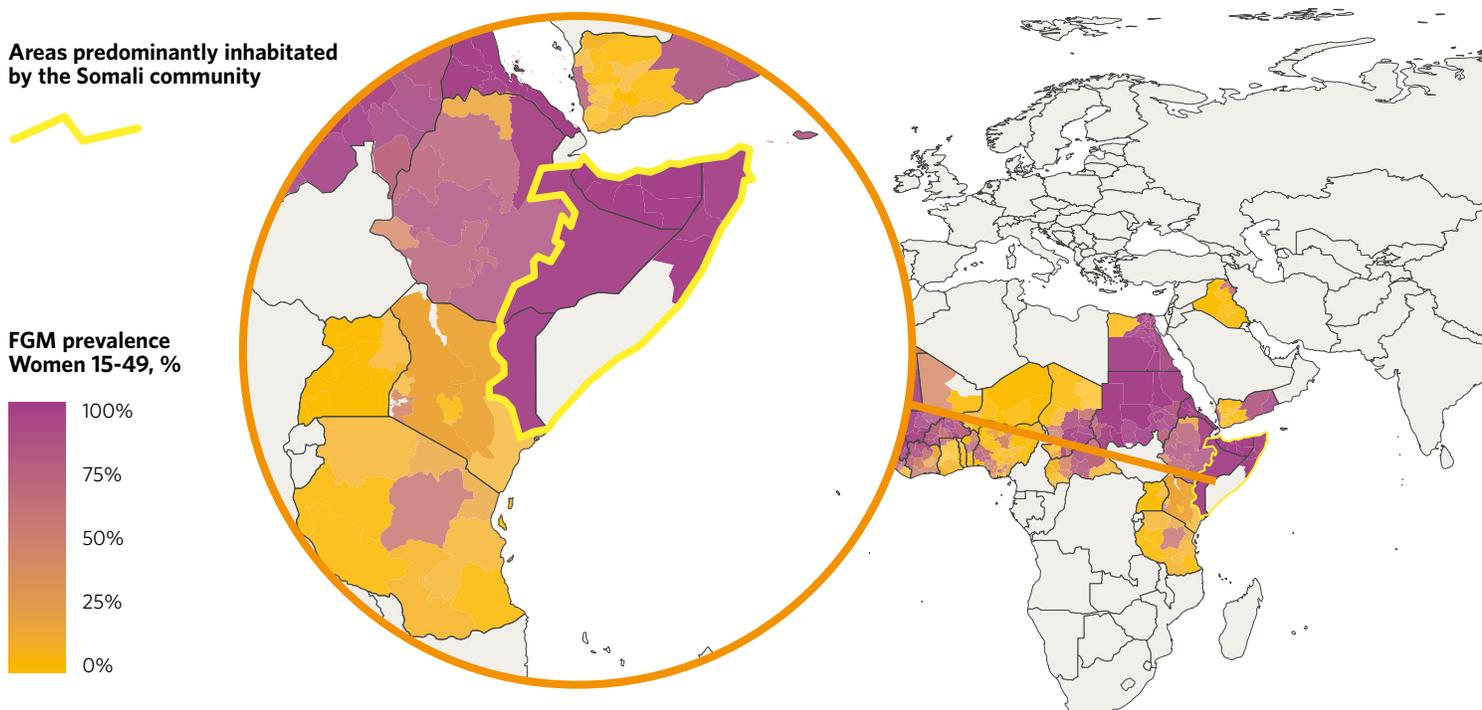
The previous sections have outlined that there are significant differences in the practice of FGM - particularly the age at which it occurs - across and within countries across Eastern Africa. In contrast to this diversity of practices, similarities around FGM span across borders.

Figure 11 underlines the importance of the cross-border nature of FGM with the example of the Somalis who reside in Ethiopia, Kenya and Somalia. In addition, the community is captured in the latest household surveys for all three countries which allows for closer examination of its practices around FGM.

The map in figure 10 demonstrates that the four sub regions which are predominantly inhabited by Somalis (Somaliland, Somalia North East Zone, Somali in Ethiopia, and the North Eastern region of Kenya) are also areas with high prevalence of FGM. In addition, these four sub-regions are geographically connected to each other and only separated by national boundaries between Kenya and Ethiopia, as well as Ethiopia and Somaliland/Somalia North East Zone³.

This example demonstrates that the geography of FGM and the distribution of communities and ethnic groups are inextricably linked and determine the distribution of FGM across the region.

Figure 10. Cross-boundary dynamics of female genital mutilation - example: Somali community



Source: Latest available nationally representative household survey if conducted in the last 10 years. The source of the shape files are: a) the latest DHS survey (Benin, Burkina Faso, Chad, Cote d'Ivoire, Egypt, Eritrea, Ethiopia, Ghana, Guinea, Kenya, Liberia, Niger, Nigeria, Senegal, Sierra Leone, Tanzania, Gambia, Togo, Uganda, Yemen), b) the MIS (Mali) or OCHA's data base on administrative boundaries (Guinea-Bissau, Sudan, Iraq, Central African Republic, Mauritania, Somalia-Northeast Zone and Somalia - Somaliland), available at: <https://data.humdata.org/>

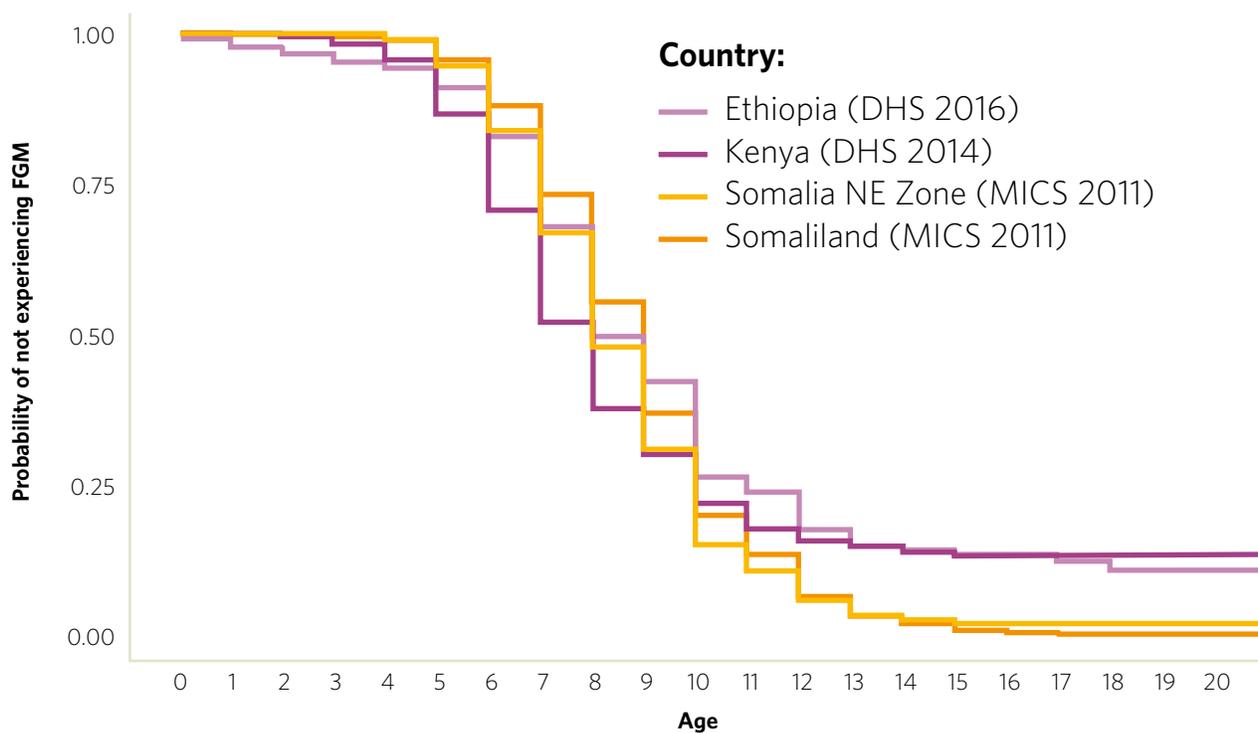
Disclaimer: The designations employed and the presentation of material on this map do not imply the expression of any opinion whatsoever on the part of UNFPA concerning the legal status of any country, territory, city or area or its authorities, or concerning the delimitation of its frontiers or boundaries.

³ Note that the remaining areas of Somalia were not included in the 2011 MICS - thus no data is shown in the map and this part of Somalia is not included in the analysis.

The figure below shows the survival curves for the Somali ethnic group living in Ethiopia and Kenya next to the survival curve for Somaliland and Somalia's North East Zone. These four curves show similar patterns for age-at-FGM as they largely overlap and resemble each other in shape.

While the survival curves for Ethiopia and Kenya flatten out at a higher level, indicating lower overall risk of FGM, it is important to note that the surveys in Ethiopia and Kenya have been conducted three and five years after the 2011 MICS in Somaliland and Somalia North East Zone. As the practice is far from static in the region, this

Figure 11. Single year risk of female genital mutilation, among all women and girls, among Somali women and girls in Kenya, Ethiopia and Somalia



temporal lag could explain the differences in levels of the survival curves.

In the previous sections, the survival curve analysis allowed to examine the age patterns of FGM and to take into account that at any given age girls who have not previously experienced FGM are still at risk. Even married women can be forced to undergo FGM due to ever-increasing pressure and discrimination from communities and society⁴. This analysis has been conducted to support programmatic intervention as age

patterns reflect decision-making structures around FGM and provide programmatic intervention with entry points for interventions.

These analyses reveal that there are significant differences across countries. In Ethiopia, a large part of girls is at risk in the first years of their life, in Tanzania girls seem to be at a particular risk between the second and third year of their life, while in Kenya and Somalia, FGM seems to be practiced in early adolescence and

⁴ <https://www.pri.org/stories/2018-07-20/tens-thousands-married-women-uganda-are-secretly-undergoing-cut>
<https://www.nation.co.ke/news/africa/Uganda-married-women-undergoing-circumcision/1066-4269734-6wsagyz/index.html>



Photo: Somaliland – Georgina Goodwin for UNFPA



beyond. However, these national figures mask vast variation and diversity in practices around FGM.

At the same time, age-risk-patterns of FGM are similar across national borders, where ethnic groups not only share borders, but also traditions and cultures. This is highlighted with the example of similar age pattern of FGM among Somalis in Kenya and Ethiopia, as well as in Somaliland and Somalia’s North East Zone.

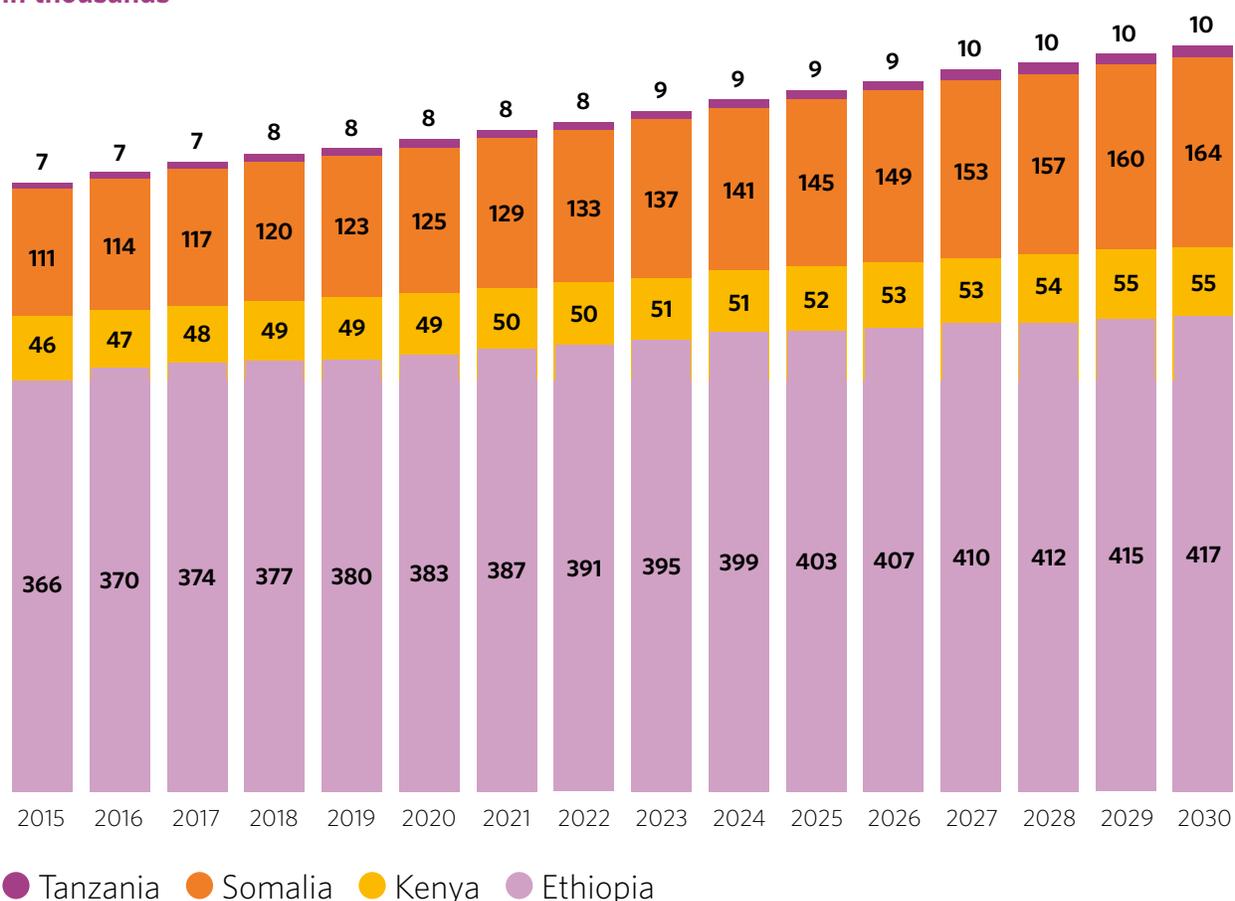
1.5 THE NUMBER OF GIRLS AT RISK BY 2030

The analysis of age-specific risk of FGM in single years of age allows to estimate the number of girls who are at risk at every given year of their lives and to incorporate the changing age structures and population dynamics into global estimates. These incidence estimates are

derived from survival analysis and combined with single year population projections from the United Nations. By directly estimating the risk at each given age and combining it with the corresponding population projection, a higher level of granularity and precision than previous estimates can be seen.

The figure below shows the number of girls at risk of experiencing FGM, if current age-specific FGM risks persist throughout 2030. It demonstrates the importance of demographic dynamics. If the current trend of the FGM incidence remains unchanged, it is expected that the number of girls who are at risk every year is set to increase continuously throughout 2030. Overall, around 9,410,000 girls in Ethiopia, Kenya, Somalia and Tanzania will be at risk of experiencing FGM from 2015 to 2030 if nothing is done (see figure 12).

Figure 12. Number of girls at risk of Female Genital Mutilation, 2015-2030, by country and in thousands



Source: 2018 UNFPA analysis based on latest available household survey.

2

SOCIAL FACTORS AND DYNAMICS OF FEMALE GENITAL MUTILATION ACROSS THE BORDERS



2.1 SOCIO-ECONOMIC DETERMINANTS OF FEMALE GENITAL MUTILATION

Research and assessments have shown that in the five countries, FGM operates as a social norm stemming from gender inequality⁵.

The cultural anxiety over the loss of virginity or pregnancy before marriage for girls encourages the practice of FGM by communities as an effective sexual control measure. It is linked with the assurance of girls' or women's social status, chastity or marriageability. In practicing communities in the region, there is a collective negative image of girls and women who have not undergone FGM. They are considered "not marriable" and suffer from stigma, with exclusion from social functions and mockeries from both men and women. This compels some of them to endure the pain of the "knife".

Beyond the traditional aspect, the perception of FGM is often linked to religious reasons in some communities although there is no reference to the practice in their main religion. FGM is considered as part of raising a girl properly and preparing her for marriage/adulthood. In Kenya particularly and among Rendille, Maasai, Pokot, Samburu and Somali, Muslim communities generally subject their daughters to FGM when aged under 10 while communities professing Protestant and Catholic faiths generally subject their daughters to FGM when aged 10 and above⁶. In communities like the Maasai, Pokot or Sabinu (Kenya, Tanzania, Uganda), FGM appears as a cultural practice perpetuated by ancestors and linked with girls' passage to womanhood. Hence, it is often practiced through ceremony of rite of passage.

An analysis conducted on socioeconomic status and FGM in 17 African countries, including Kenya and Somalia, shows that the risk is most often higher in very poor households than in rich households⁷. Among other factors, the practice of FGM varies with ethnicity (or geographic origin), level of education, place of residence (urban/rural), income and age. Girls in rural areas are more likely to undergo FGM than those living in urban areas⁸.

Investing in women and girls' health, education and empowerment as key determinants of sustainable economic and social growth are essential to eliminate FGM and achieve their rights.

2.2 TYPES OF FEMALE GENITAL MUTILATION PERFORMED

There is a clear linkage between the type of FGM performed and the communities or ethnic groups.

WORLD HEALTH ORGANIZATION (WHO) CLASSIFICATION

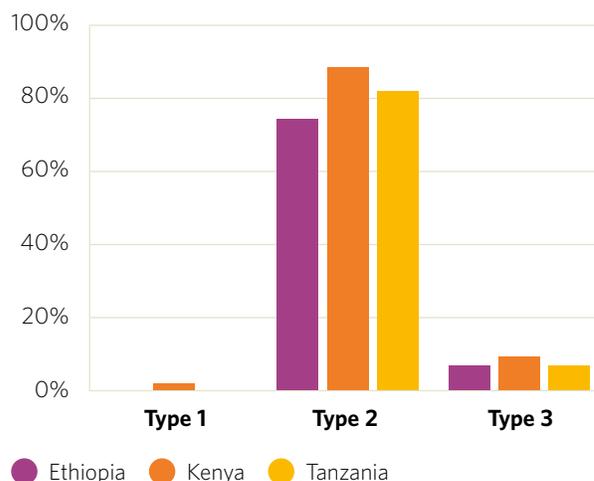
TYPE 1: Clitoridectomy - partial or total removal of the clitoris.

TYPE 2: Excision - partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.

TYPE 3: Infibulation - Narrowing of the vaginal orifice with creation of a covering seal by cutting and a positioning the labia minora and/or the labia majora, with or without excision of the clitoris.

TYPE 4: All other harmful procedures to the female genitalia for non- medical purposes, for example, pricking, piercing, incising, scraping and cauterization.

Figure 13. Types of female genital mutilation in Ethiopia, Kenya, Tanzania



Sources: DHS Kenya (2014) and DHS Ethiopia (2016), DHS/MIS Tanzania (2015-16).

5 UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation: Accelerating Change, Proposal for Phase III, 2018.

6 Baseline Study Report: Female Genital Mutilation/ Cutting and Child Marriage among the Rendille, Maasai, Pokot, Samburu and Somali Communities in Kenya, 2017.

7 The normal and the aberrant in female genital cutting: shifting paradigms. *HAU: Journal of Ethnographic Theory* 6(2): 41-69, 2016

8 Female genital mutilation overview and current knowledge; by Armelle Andro, Marie Lesclingand Translated by Madeleine Grieve and by Paul Reeve, I.N.E.D | « Population » 2016/2 Vol. 71 | pages 239-248.

Overall, in the region, the type 2 of FGM appears to be the most practiced, followed by the infibulation (type 3). However, there are specificities. For instance in Kenya, Sunna circumcision equated to clitoridectomy (Type 1) is carried out among the Somali including in the border areas, with a religious justification. Qualitative data suggests that the most severe form-infibulation or 'pharaonic' type of FGM- has been practiced for years on women and girls in Somalia. However, stakeholders have noticed a shift to type 1 and 2. This suggests a relative difference of practices in Somali communities depending of the country ⁹.

All the types 1,2,3 and 4 are practiced in Uganda depending of the ethnic group: Sabiny practice types 1 and 2, the Pokot practice type 3¹⁰ and Baganda mainly practice other types (type 4).

2.3 MEDICALIZATION OF FEMALE GENITAL MUTILATION

The growing trend of medicalization of FGM is one of the greatest threats to its abandonment. "Medicalization" of

FGM refers to situations in which FGM is practiced by any category of health care provider, whether in a public or a private clinic, at home or elsewhere. It also includes the procedure of re-infibulation at any point in time in a woman's life¹¹. This tendency remains a reality in the region even if there is a disparity of prevalence: 14.8 per cent in Kenya, 1 per cent in Ethiopia, 1 to 2 per cent in Tanzania. There is limited information for Uganda, as well as for Somalia where the increase of medicalized FGM has been reported¹².

The rationale of the medicalization of FGM is based on the fact health care providers are perceived to be more cautious, more knowledgeable and hygienic; and can provide more options in cases of complications. Most health- care providers who perform FGM are themselves part of practicing communities. However, medicalized FGM is not necessarily safer and it still ignores the long-term sexual, psychological and obstetrical complications of the practice¹³.

These geographical, cultural and ethnical differences highlighted call for adapted and not generalized strategies to end FGM.



Photo: Somaliland – Georgina Goodwin for UNFPA

9 UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation: Accelerating Change, Proposal for Phase III, 2018. p. 91

10 Country profile: FGM in Uganda, 28 Too Many, July 2013, p.9.

11 Global strategy to stop health-care providers from performing female genital mutilation, WHO 2010.

12 Somalia and the law, 28 Too Many report, July 2018.

13 Njue C, Askew I. Medicalization of female genital cutting Among the Abagusii in Nyanza Province, Kenya. Population Council, Frontiers in Reproductive Health Program, New York, NY, 2004. Engaging midwives in the Global Campaign to End Female Genital Mutilation, UNFPA, p.5.

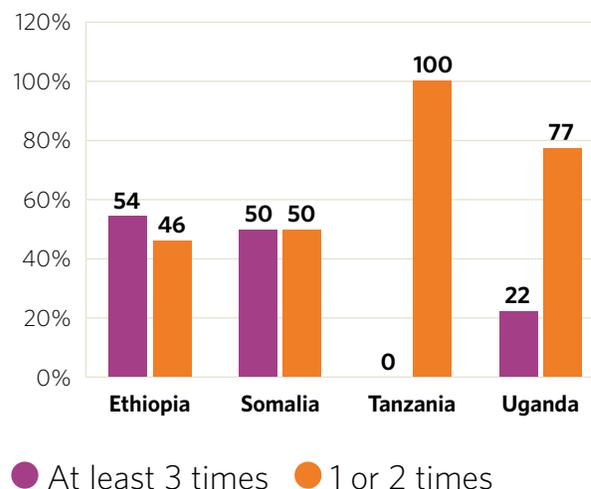
2.4 EVIDENCE OF CROSS BORDER PRACTICE OF FEMALE GENITAL MUTILATION

The Kenyan baseline study commissioned by the Anti-FGM Board and UNICEF in 2017 shows the influence of border communities on the prevalence of FGM-both those who supply the service and those who demand it. The figure below shows that a high percentage of interviewed women have visited Kenya from bordering countries for FGM related services.

The cross border practice is most of the time based on existing relationships. Approximately 67 per cent of all persons brought to Kenya to undergo FGM are close relatives of the surveyed women, comprising daughters (47 per cent), sisters (30 per cent) and nieces (30 per cent), while 33 per cent comprise friends and other relatives. Even if there are missing data from the other countries, different stakeholders reported the cross border practice as a common reality.

For instance, a trend for married women from Uganda to be taken across the border into Kenya into Kenya to undergo FGM secretly is reported. FGM is reported. Not only women and girls are moving to undergo FGM; circumcisers from Kenya are also being brought into Uganda to perform FGM.

Figure 14. Frequency of visits in Kenya for female genital mutilation services by interviewed women (percentage)



Sources: Kenya Baseline study report on FGM, Anti FGM Board- UNICEF 2017

2.5 KEY FACTORS DRIVING CROSS BORDER FEMALE GENITAL MUTILATION PRACTICE

The main reason of the cross-border practice is the fact that FGM is deeply rooted as a social norm. This cross-border practice is one of the strategies for communities to ensure that the FGM is done in secret or without risks of prosecution. Key factors reported in the Kenyan baseline survey and by stakeholders in the countries include:

- **Shared traditions, especially intermarriage that contributes to perpetuate FGM and child marriage**
- **Fear of arrest in native country and feeling of limited prosecution in neighboring countries**
- **Lack of proximity to circumcisers in native countries**
- **Quality and affordability of FGM services in the neighboring country**
- **Income sources for circumcisers encouraging them to continue**

- **Absence of strong regional monitoring mechanisms for reporting**

A multisectoral approach, intergovernmental initiatives/collaboration in addition to community level engagements are required to address these factors.

Photo: Uganda - Edward Echwalu for UNFPA



3

LEGAL AND POLICY FRAMEWORKS ON FEMALE GENITAL MUTILATION AND ITS CROSS-BORDER PRACTICE



In line with the global frameworks such as the CEDAW, UN resolutions on FGM¹⁴ and the SDGs, FGM issue has been integrated in different regional and national frameworks with some specific provisions.

3.1 REGIONAL AND SUB REGIONAL FRAMEWORKS

The following frameworks call African States for concerted drive towards the elimination of FGM.

- **African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol 2003)**¹⁵; ratified by Kenya, Tanzania and Uganda, only signed by Ethiopia and Somalia.
- **African Union Agenda 2063 "The Africa we want" (aspiration 6-priority 51)**¹⁶.
- **"African Union Initiative on Eliminating Female Genital Mutilation" or «Saleema»** (January 2019), and its related Declaration on **"Galvanizing Political Commitment towards the Elimination of Female Genital Mutilation"**¹⁷.

Two frameworks clearly address the cross border FGM aspect:

- **Pan African Parliament action plan to end FGM in Africa (2016)**; it highlights the need for initiatives to strengthen actions against cross border FGM¹⁸.
- **East African Community (EAC) Prohibition of FGM Bill (2016)**¹⁹, enacted by the East African Legislative Assembly, which includes Kenya, South Sudan, Tanzania and Uganda. This act is unique in the sense that it contains provisions for the definition and prosecution of FGM cross border offences, applicable in all states members. It calls for establishing a sub-regional coordination mechanism and for catalyzing efforts to eliminate FGM".

3.2 NATIONAL LEGISLATIONS & POLICIES

Ethiopia, Kenya, Tanzania and Uganda have national legislations on FGM and specific budget lines, while Somalia constitutes an exception. The five countries have integrated FGM prevention, response and care into sectorial policies related to health, sexual and reproductive health, youth, gender- based violence and harmful practices. In some contexts, there is a specific FGM national policy or strategy with an action plan. There are specific FGM coordination bodies (See annex). In the case of Somalia, there is not yet a national law on FGM, however, in 2014 a zero tolerance FGM fatwa was released in Puntland and a draft of zero tolerance FGM Bill in Federal Government of Somalia (FGS), Somaliland and Puntland are available²⁰.

Despite efforts to have FGM related legislation, it is important to note that there are no harmonized provisions for the five countries. This can be a reason for the practice of cross border for community members moving from high penalties countries to low penalties one.

The East African Community FGM Bill provides a minimum penalty for offence of FGM at **"not less than 3 years"**. This is harmonized with the laws in Kenya and Tanzania, where the lower penalty is respectively stated at 3 and 5 years. Uganda did not specify a minimum but should comply with the Bill, which states that it **'takes precedence over other Partner state laws to which its provision relate'**. Out of East African Community, the lowest penalty for FGM offence in Ethiopia is 3 months imprisonment while it is not specifically defined in Somalia.

Regarding the fines, there is also a huge difference between the countries. Some just defined a minimum rate going from US\$17 for Ethiopia (500Birr) to US\$218 for Tanzania (500.000TZS) and US\$1935 in Kenya (200.000KES)²¹. Uganda just defined a maximum rate at US\$910 (168-currency points/3360000UGX).

14 2012 (A/RES/67/146), 2014 (A/69/150), 2016 (resolution 2135) and 2018 (A/HRC/38/L.1/Rev.1)

15 <http://www.achpr.org/instruments/women-protocol/>

16 <https://www.un.org/en/africa/osaa/pdf/au/agenda2063.pdf>

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18 <https://kenya.unfpa.org/sites/default/files/pub-pdf/UNFPA-PAP%20Workshop%20on%20Ending%20FGM%20FINAL%20Report%20%281%29.pdf>

19 <http://www.eala.org/documents/view/the-eac-prohibition-of-female-genital-mutilation-bill2016>

20 UNFPA-UNICEF Joint Programme on FGM, Performance analysis for phase II, 2018

21 Ethiopia Penal Law 2004, art 565-570/ Tanzania Children Act 2009, art. 158/ Uganda Children Amendment Act 2016, art.6/ Kenya FGM Act 2011, Art 29

As positive achievements, in Kenya and Uganda laws, there are specific provisions for cross border FGM offences, applying to both nationals and foreign residents; being committed within or out of the country. In Ethiopia, it is covered under the Criminal Code as other crimes.

While harmonizing laws is a necessity, the enforcement of the laws remains another challenge that needs to be addressed.



Photo: G. Bell for UNFPA



3.3 POSITIVE TRENDS IN PROGRAMMING

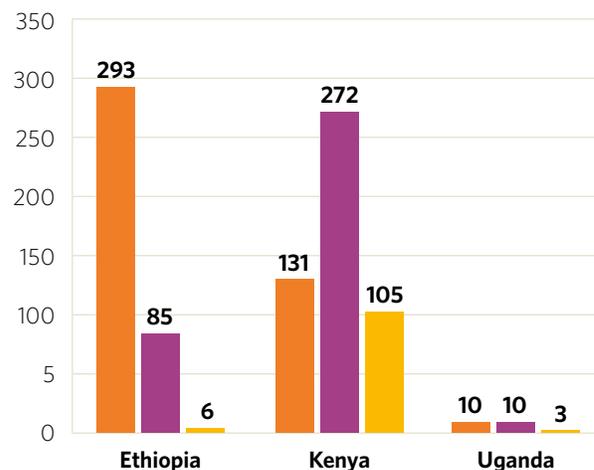
The governments of Ethiopia, Kenya, Somalia, Tanzania and Uganda and stakeholders are implementing various initiatives and strategies to end FGM. This includes:

- **Strengthening of legal and policy frameworks and law enforcement on female genital mutilation, with governmental and parliamentarians' engagements.**
- **Empowering girls and women to exercise their rights, including through education and income generating activities.**
- **Engaging men and boys within communities and through youth programmes, gender hubs.**
- **Empowering young people through social platforms, children/youth clubs. (Somaliland Y-PEER Facebook, U-report in Uganda).**
- **Surveys, researches and the Data-for-All (DFA) of the Joint Programme on female genital mutilation for comprehensive programming data.**
- **Engaging media (radio talk show and spots, TV programmes, articles, social media).**
- **Integration of female genital mutilation into sexual reproductive health services package for prevention through sensitization of women during pregnancies**
- **Community engagement for public declarations of female genital mutilation abandonment and alternative rites of passage in partnership with traditional/religious leaders and faith-based organizations.**
- **Promoting community surveillance for female genital mutilation prevention through monitoring, alerting and referring cases for care services.**
- **Advocacy and resources mobilization to sustain the results achieved.**
- **Setting up coordination mechanisms at national and local levels.**

These initiatives reflect a good dynamic, nevertheless more remain to be done.

3.4 EXAMPLE OF LAW ENFORCEMENT ACHIEVEMENTS

Figure 15. Law enforcement in Ethiopia and Kenya between 2015-2018



- Number of arrests
- Number of cases brought to court
- Number of convictions

Sources: UNFPA-UNICEF Joint Programme on FGM

FROM 2014 TO 2018:

1,204,541 GIRLS AND WOMEN BENEFITED from health, social and legal services related to FGM in Ethiopia, Kenya, Somalia and Uganda.

AT LEAST 1,932 COMMUNITIES made public declarations of FGM abandonment involving more than 9,656,807 individuals in Ethiopia, Kenya, Somalia and Uganda.

AT LEAST 22,347 GIRLS PARTICIPATED in Alternative Rites of Passage in Kenya, avoiding undergoing FGM.

4

WHAT ARE THE CHALLENGES IN TACKLING THE CROSS BORDER FGM PRACTICE?

Photo: Somaliland - Georgina Goodwin for UNFPA





Photo: Somaliland – Georgina Goodwin for UNFPA

Despite the evident progress in social norms change and the commitment from stakeholders (governments, parliamentarians, United Nations, civil society, leaders and members of the communities, media practitioners), there are different challenges impacting on the change in FGM norms. It remains social norms that require time and persistence for change. The gaps and challenges faced include the followings:

- **Social and economic benefits for families of victims, traditional leaders and excisors, making the practice difficult to abandon.**
- **Changing tactics of FGM- hiding in caves, disguised with other ceremonies (such as traditional marriages, overnights, fellowships, fundraisings), mothers subjected to female genital mutilation during delivery by traditional birth attendants, medicalization, etc.**
- **Strong social bonds within communities making the reporting difficult, especially for relatives²².**
- **Movements of mobile cross border communities -pastoralists -facilitating cross border movements of excisors and girls.**
- **Same people visiting each other (dual citizenship) with difficulties to detect if there is a motive for female genital mutilation.**
- **Porous borders, with limited surveillance.**
- **Limited access to basic services, including schools, health facilities, police stations and courts for most practicing communities.**
- **Insufficient prosecutions of cases, particularly the cross-border ones less reported.**
- **National legislations not harmonized in the region and insufficient allocated resources.**
- **Lack of a regional monitoring and data mechanism on the cross-border practice, limiting the comprehension of the situation and evidence-based programming.**
- **Lack of uniform and joint coordination mechanism between the countries in the region.**

22 Driving Forces in Outlawing the Practice of Female Genital Mutilation/Cutting in Kenya, Uganda and Guinea-Bissau, UNFPA.

MEET THE CHALLENGE OF TACKLING CROSS-BORDER FEMALE GENITAL MUTILATION: PROMISING INITIATIVES

1 “Run to end female genital mutilation”

The Archbishop of the Church of Uganda, Most Rev. Stanley Ntagali, together with the Ministry of Gender, Labor and Social Development (MGLSD), UNFPA, and other stakeholders from Uganda and Kenya, organizes an annual anti FGM marathon in the Sabei region (Kapchorwa, Kween and Bukwo). Bringing together participants from both countries, this marathon creates awareness among the cross border communities (Pokot and Sabinu). The strong message disseminated is “ *We can give up FGM without giving up our culture*”. It involves high-level political and religious representatives in the focus areas. Started in 2015, this initiative has moved forward with Ethiopia that joined in 2017 where more than 1,200 athletes attended the competition. This good practice shows that the commitment of the religious leaders should go across the borders.

2 Specific provisions on cross border female genital mutilation practice in national laws

Kenya and Uganda FGM acts have specific provisions for cross-border practice of FGM. Through Article 21, the Prohibition of Female Genital Mutilation Act, 2011, criminalizes cross-border FGM by stating that “*it is an offence for any citizen or permanent resident of Kenya to ‘take another person from Kenya to another country, or arrange for another person to be brought into Kenya from another country’ for the purposes of FGM*” (Articles 21 and 28). The Ugandan FGM Act 2010 specifies that it applied to offences ‘*committed outside Uganda where the girl or woman upon whom the offence is committed is ordinarily resident in Uganda*’ (Section 15 on Extra-territorial jurisdiction). Therefore, Ugandan and Kenyan nationals, as well as foreign residents who cross the national boundary for FGM are subject to punishment. Nevertheless, there is a need to improve by taking in consideration the foreigners who are not residents.

3 Realized female genital mutilation baseline study among cross borders communities

The Kenyan Anti FGM Board in collaboration with UNICEF realized in 2017 a baseline study on “Female Genital Mutilation/ Cutting and Child Marriage among the Rendille, Maasai, Pokot, Samburu and Somali communities in Kenya”. These communities are living in the borders with Ethiopia, Somalia, Tanzania and Uganda. It’s the first survey that clearly addresses the cross border issue of FGM practice in the region. The report provides informative data on reported frequency, prevalence and reasons for Kenyan seeking FGM services in bordering countries and bordering communities seeking these services in Kenya



5 CONCLUSION

Considering the differences and the particular ethnic and cultural traditions and beliefs that underpin FGM in the region, it is important to tailor the initiatives and strategies accordingly. As per the age risk analysis, strategies should be adapted to the FGM dynamics per country and per community. For instance, where girls are subjected to FGM in their early age (1 to 2 years) the alternative rite of passage (ARP) wouldn't be appropriate. Parents, especially mothers or caregivers should be better targeted for interventions. Where adolescents and young girls are mostly subjected to FGM beyond that ages, the ARP and girls empowerment are strategies to be considered. And where the medicalization of FGM is increasing, specific interventions should target health care providers. There are no exhaustive interventions; adapting the strategies to the specificity of each context is key.



6

RECOMMENDATIONS

To effectively tackle the cross-border practice of FGM, it is important to strengthen the current national initiatives that have produced and continue to produce positive results, while integrating the cross border and specific communities' dynamics (age, ethnicity, type of practice). Yet, more initiatives need to be developed.

Photo: Somaliland – Georgina Goodwin for UNFPA



- 1 Realize regional research highlighting specific social and ethnic drivers of female genital mutilation and its cross-border practice, and adapt programming in the five countries in line with the sociocultural specificities.
- 2 Develop and implement a comprehensive regional action plan, harmonized with the East African Community female genital mutilation Bill, including Ethiopia and Somalia.
- 3 Set up a regional monitoring and accountability mechanism with periodic reviews and reports on female genital mutilation.
- 4 Harmonize national legislations and policies to include female genital mutilation cross border practice where missing.
- 5 Strengthen law enforcement with a strong collaboration between cross border security and judiciary actors.
- 6 Integrate the cross border female genital mutilation related indicators in national databases and monitoring mechanisms and in the Data-for- All.
- 7 Strengthen community awareness and surveillance, considering the cross-border aspect.
- 8 Strengthen the capacities of stakeholders (including services providers, media actors and leaders of the communities) for interventions sensitive to the cross-border issue.
- 9 Ensure the availability of appropriate protection measures to facilitate protection for survivors and witnesses in female genital mutilation cases, including through safe spaces.
- 10 Allocate adequate resources for joint and coordinated regional efforts.
- 11 Develop/strengthen strategic partnerships (national, regional and with donors).

“THE HIGH-LEVEL COMMITMENT AND THE DEVELOPMENT OF A STRONG COLLABORATION BETWEEN THE FIVE GOVERNMENTS REMAIN THE FIRST IMPORTANT ACTIONS REQUIRED TO ADDRESS THE CROSS-BORDER ISSUE OF FEMALE GENITAL MUTILATION.”

A NNEX: SUMMARY OF FEMALE GENITAL MUTILATION RELATED LEGAL, POLICY AND COORDINATION FRAMEWORKS

Photo: Uganda - Edward Echwalu for UNFPA



Countries	Legislation with specific provision on FGM	Legislation with provision linked to FGM	Integration into sectorial policies	Specific budget line	Coordination & accountability mechanisms
Ethiopia	Yes Criminal Code (2004)	Constitution (1995) referring to 'bodily harm'	National strategy and action plan on harmful practices (2013) Growth and Transformational Plan (GTP II 2016-2020) National Adolescent and Youth Health Strategy (2016-2020) National Women Policy	Yes	National Alliance to End FGM and Child Marriage
Kenya	Yes FGM Act 2011 Revised Children Act (2016) Protection Against Domestic Violence Act (2015) Penal Code (revised 2014)	Constitution (2010)	National policy on the elimination of FGM (2010) National Adolescent Sexual and Reproductive Health Policy (2012) National Policy for Prevention and Response to Gender Based Violence, 2014 National Plan of Action for Children	Yes	Anti-FGM Board (National)
Somalia	No at federal level but Zero tolerance FGM fatwa enacted for Puntland in 2014	Constitution 2012, referring to the 'protection of human dignity and equality' Penal Code 1962, referring to 'hurt to another that results in physical or mental illness' Sexual Offences Law for Puntland (2016)	FGM policy for Puntland (2014) w	No	Inter-ministerial FGM Task force established in Puntland. FGM Task Force in Mogadishu, Somaliland and Puntland,
Tanzania	Yes Sexual Offences Special Provisions Act 1998 (SOSPA) amending the section 169 of the Penal Code. Child Act 2009	Constitution 1977, referring to 'inhuman or degrading punishment or treatment'	National Plan of Action (NPA) to End Violence against Women and Children (2017/18 - 2021/22) Women and Gender Development Policy 2000 Child Development Policy 2008 Education and Training Policy 2014	Yes	Social Norms and Values Thematic Working Group (national level) Women and Children Protection Committees Complaint mechanism of the Commission of Human Rights and Good Governance
Uganda	Yes FGM Act 2010+ Children Amendment Act passed into Law (2016)	Penal Code 1950 referring to 'grievous harm' Domestic Violence Act 2010 and its regulations	Strategy to end CEFM and teenage pregnancy, National policy on GBV (2016) + Action Plan (2016-2021)	Yes	National and districts FGM Alliances

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