

# **Final Report**

## **Feasibility Study on Programme to Stop FGM/C: Our Body, Our Rights in Guinea and Kenya**



**Submitted to**

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## List of Acronyms

ACHPR	African Charter for Human and Peoples' Rights
AU	African Union
AULO	African Union Liaison Office of Plan International
CBOs	Community-based organizations
CEDAW	Convention on the Elimination of all forms of Discrimination against Women
CIDA	Canadian International Development Agency
CREAW	Centre for Rights Education and Awareness
EAC	East African Community
ECOWAS	Economic Community of West African States
FGD	Focus Group Discussions
FGM/C	Female Genital Mutilation/Cutting
GN	Guinea
GNO	German National of Plan International
GPS	Global Positioning System
ICCPR	International Covenant On Civil And Political Rights
ICESCR	International Covenant On Economic, Social And Cultural Rights
IPD	Institute for Peace and Development
KIIs	Key Informant Interviews
KN	Kenya
NGEC	National Gender and Equality Commission
NGO	Nongovernmental Organization
OECD	Organization for Economic Cooperation and Development
OHCHR	Office of the High Commissioner on Human Rights
PESTEL	Political, Economic, Social, Technological, Environmental, and Legal
RBM	Results-Based Management
RBM	Results-Based Management
SDG	Sustainable Development Goals
SGBV	Sexual and Gender-Based Violence
ToR	Terms of Reference
UDHR	Universal Declaration on Human Rights
UNCRC	United Nations Convention on the Rights of the Child
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund

## Executive Summary

The practice of FGM has been going on for centuries around the world. The practice is particularly endemic in Africa, which hosts more than 80% of the estimated 200 million cases worldwide. Prevalence rates of the practice, however, differ across the continent with communities on the Eastern flanks of the continent, such as Egypt, Sudan, Eritrea, Djibouti, Ethiopia, Kenya, Somalia, and Tanzania hosting hotspots of the practice. In West Africa, the practice is prevalent in Burkina Faso, Guinea-Bissau, Mali, Senegal, Sierra Leone, and the Gambia having enclaves of practices. Other parts of the continent have varying degrees of the prevalence of the practice.

The fight to eradicate FGM has run for more than a century. Colonial and postcolonial governments have tried various means to end the practice (Sanogo and Pusumane, 2021; Berer, 2015; Boyes, 2014; Gust, 2014; Smith, 2011; and Gachiri, 2000), given the physical and psychosocial harm it has on women who are victims. In recent times, the African Union, and its regional bodies such as the East African Community (EAC) and the West African Economic Community (ECOWAS) have adopted and urged their constituent member states to domesticate the international treaties and conventions in national policies and laws in attempts to stop the practice. Local and international development agencies and civil society organizations have supported the fight to end the practice through the implementation of various interventions based on the particular tilts of their institutional mandates and funding sources and priorities. While some interventions have supported the criminalization and the use of security and judicial approaches to enforce bans, others have adopted persuasive approaches that seek to change perceptions, attitudes, beliefs, values, behaviors, and practices in the practicing communities as preferred routes to ending the practice. Other anti-FGM/C groups have used a combination of both approaches to dissuade and persuade communities to abandon the practice. Additionally, the fight to end FGM has gone on under the banner of health, human rights, women's empowerment, equity and social justice, among others.

Plan International has been at the forefront of this fight to end FGM/C and has used the combination approach in several countries in Africa. In Guinea and Kenya Plan International Germany has worked with its country offices and partners to promote different approaches to end FGM/C across Africa. In Guinea, Plan International and its partners have supported initiatives in 12 administrative districts in the Guéckedou and Kissigoudou areas over the last 14 years. It has since extended the interventions to Coyah and Conakry, enabling it to cover more than 50 districts overall. Plan International's interventions in Guinea target the engagement and education of community leaders, the gatekeepers of customs and traditions that enforce customary beliefs and practices, as well as FGM/C practitioners to promote knowledge, perception, and behavioral changes that support the abandonment of the practice. The strategy also includes the promotion of alternate rituals and the use of positive deviance models such as uncut girls to demonstrate the feasibility and desirability of abandoning the practice. In Kenya, GNO and Plan Kenya interventions seek to enhance the capacity of adolescent girls against sexual and gender-based violence (SGBV); protection of the economic security of women through savings and loans activities, and stimulation of discussions to raise awareness of the dangers of FGM/C and the prevention of early childhood marriages.

Despite some achievements in abetting or slowing down the practice in some countries, FGM/C remains a prevalent, intractable, endemic in some countries, thereby weakening the resolve of the continent, through the African Union to put an end to it. Guinea and Kenya represent the two ends of the continuum. The practice remains high in Guinea despite its ban since 1965 and the adoption or amendment of laws and regulations, and the establishment of various enforcement regimes to end it. Kenya, on the other hand, has witnessed the abandonment of the practice in some communities, even though others have remained recalcitrant. A common thread that links both Guinea and Kenya are that the criminalization of FGM through the adoption of policies and legislation to enforce the ban has driven the practice underground in practicing communities. The practice continues to thrive in communities that believe in it through several channels such as the non-public performance of the practice; cross-territorial access of services; changes in methods of cutting; and changes in the timing and the age at which the cut is inflicted to focus on either older women during childbirth or children as young as five years and under. All these changes are designed to circumvent the ban or to conceal the practice.

The persistence of the practice despite the risks of arrests, conviction, imprisonment, fines or both suggests that communities practicing FGM perceive some value or benefits in the practice that is worth or exceed the risk. The increase in medicalization, cross-border trade in FGM/C services and the patronage of FGM/C by the diaspora who return to their native countries or other safer places for the cut testifies to the presence of an active and persistent demand for FGM/C services in communities where it is practiced. It also suggests a disconnect between the realms of policy and practice; a situation in which the adoption and implementation of proscriptive policies, laws, and regulations have no relevance in influencing changes in perceptions, attitudes, behaviors, and practices of those who believe in the FGM. For such communities, the perceived social value or benefits of participation in the practice outweighs the risk of sanctions that the State can inflict on them.

To overcome the persisting challenges to the eradication of FGM/C Plan International and its country partners intended to launch a set of innovative interventions that go beyond the traditional country-specific and isolated approaches to fighting FGM/C. Instead, Plan International seeks to galvanize continental, regional, national, and subnational level policy and decision-makers; managers and activists in the anti-FGM/C space for synergistic engagements. The intent is to maximize coherence, efficiency, and effectiveness between the different decision-makers, resource managers; and duty-bearers to make a concerted push for ending FGM/C on the continent. Plan International seeks to support advocacy for the promulgation, amendments, or enforcement of policies and laws that support the effective ban of FGM/C Guinea and Kenya. The interventions in Guinea and Kenya will serve as pilots from which lessons learned will be applied to adapting and/or scaling up the interventions to other countries.

This study was commissioned to assess the feasibility of the interventions that Plan International has conceptualized. The scope of the study covered the analysis of the intervention contexts in both countries; the identification of and analysis of stakeholders at the continental, regional, national, and subnational levels, alongside their respective strengths, weaknesses, opportunities, and threats (SWOT); and the assessment of the risks and the framework for operationalizing the Do No Harm principle. It aimed to establish the validity and relationship of the problem analysis and to conceptualize solutions proposed in the project's concept paper; assess the potential political, technical and social barriers that can affect the interventions; conduct a gap analysis in the project implementation processes, etc. to determine the feasibility of the envisaged interventions in both Guinea and Kenya. The findings will inform the fine-tuning of the project interventions.

The study used a mixed method approach to collect data from multiple sources. The desk study of Plan International's concept notes, documents, and reports of current and past projects, as well as relevant literature from relevant sources informed the design of study instruments and the interpretation of the findings from primary sources. Key informant interviews used three-tier protocols to target respondents at the continental level (African Union), regional levels (EAC and ECOWAS), and the national and subnational level actors in Guinea and Kenya. Focus Group discussions targeted community level men, women, youth, and other identifiable groups involved in pro and anti-FGM/C activities. The survey collected data on community level respondents' perceptions, knowledge, attitudes, behaviors, and practices related to the practice of FGM/C in their respective communities. Data collected, using mainly the Kobotool online data collection portal was cleaned and analyzed after downloads using Excel and SPSS, as appropriate.

The findings from the primary and secondary data sources indicate that while the AU, EAC, and ECOWAS may have adopted and domesticated international conventions, treaties, and protocols aimed at fighting FGM/C, such measures have a modeling and persuasive effect only, as these continental and regional bodies lack the capacity to enforce the bans in their member states. The domestication and operationalization of international treaties are within the exclusive authority of member states; they decide the pace and nature of actions. Hence, while the engagement of these institutions for policy and legislative directions is important, it is not sufficient to transform country-level legal and administrative frameworks that make the ban work.

At the country levels, there is evidence that the governments of Guinea and Kenya have demonstrated political commitments through the adoption and domestication of laws and programs to end FGM/C; the

setting up of national and subnational structures for the enforcement of the ban; and the promised or actual allocation of resources to support the operationalization of the legal and administrative frameworks to stop the practice of FGM/C. However, respondents believe that they have not shown enough political will to carry through their declared commitments. In the view of respondents in both countries, resource allocations for the enforcement of the ban are inadequate; interagency coordinating mechanisms for the prevention of the practice are weak; and commitments of individual political leaders, especially those at lower levels, to take action to end the practice are weak or ambivalent in some instances. Respondents reported that while some politicians shy away from pursuing rigorous enforcement of the law in their constituencies because of the fear of losing electoral votes and favors, others are reported to silently support the practice, and have been known to subject members of their families to FGM/C because they are not convinced about the arguments against it. In sum, there is a gap between declared and enacted political wills. Politicians may not be practicing what they preach. This creates a credibility challenge for constituents on the reasons advanced for the banning of the practice.

Diminished political will and commitment apart, the enforcement of anti-FGM/C laws in both countries are lax, largely because of funding, staffing, and logistical constraints. Respondents also cited interference in judicial processes by local influential persons, who intervene to have cases stopped at the courts. As a result, law enforcement agencies and the courts have not been able to hold violators of the prohibitions on FGM/C practice to account. Therefore, the deterrent and punitive value of the laws are greatly diminished. This has bred a culture of impunity as people who break the law are never arraigned before a court, and the few that have been sent to court were left off with light sentences.

Besides the laxity in implementing legal regimes to deter and punish offenders, there is considerable resistance to the ban on FGM/C. Either the bans have been challenged in court (albeit unsuccessfully) or are being undermined through increasing medicalization of the practice, which amounts to a subversion of the ban. Communities that support the ban have also developed cultures of silence around the practice – refusing to report cases of breach of the law. This has permitted the practice to be carried out clandestinely in various ways.

The emergence of cross-border trade in the services and the patronage of FGM/C services by highly educated persons and members of diaspora communities do not only debunk the view that demand for FGM/C is a phenomenon cherished by poor, rural, uneducated citizens; it demonstrates that there is a real demand for the services. The patronage by local and diaspora better educated, and resource persons provide critical funding and legitimacy to support the continuation of the practice.

The lessons to be learned from the findings are that punitive approaches to stopping FGM/C have failed over the centuries. This is because banning the practice emphasizes a supply side approach as it aims to deter and punish recalcitrant service providers. But as respondents in this study have noted, in the face of continued perception of the relevance and value of FGM/C in some communities and associated high demand of services that satisfy that demand suppression of the supply of the services alone is not enough to stop the practice. Laws and policies establish boundaries of action and prescribe penalties for infringement. However, they are not enough to dissuade those who hold high value for FGM/C services from seeking alternate routes to access the service. To be useful in ending the practice, laws and policies must institutionalize actions that permeate and influence beliefs, attitudes, behaviors, and practices in communities of the practice to make change happen. Change will not happen if policies trigger or reinforce insular responses that do not only reinforce the perceived value of the practices, they seek to change but take the practices beyond the purview and reach of the regime of policy and regulatory control and sanctions.

The three-tier recommendations of this study target Plan International's engagements at the macro, meso, and micro level. At the Macro level, the study recommends Plan International's engagement at the AU, EAC, ECOWAS, and national government levels to trigger actions that i) mobilize and invest adequate resources and efforts in mindset transformation using culturally appropriate approaches; ii) support initiatives that foster holistic approaches to understanding and addressing other factors using an intersectionality approach; iii) engagement with the diaspora community through international partners to elicit their support for the end to FGM/C; iv) need to harmonize and share FGMP/C prevention capacities; v) work with member countries to design and implement interventions across borders to stop the trade; and vi) promote

policies and action frameworks that support innovative and inclusive approaches that eliminate the cut in all forms while preserving community values in order to bring onboard community members to end FGM/C:

Meso level recommendations direct Plan International and its partners to i) harness and work with champions of change or voices of reason from among community leaders (chiefs, religious leaders, elders, women and youth leaders) and government leaders who have voiced support for the end of FGM/C to advance the agenda for change; ii) expand to also reach the under-served but highly FGM/C practice endemic communities in places that are difficult to reach; iii) adopt a multiplicity of approaches that offer holistic opportunities for change. These recommendations recognize that community leaders have the power, authority, and legitimacy to convene their members to make and interpret local customs and traditions, and where they have the credibility, can influence change directly and subtly too. They need to be in the driving seat for change to happen.

Respondents also noted that the practice of FGM/C is more endemic in isolated rural communities that have not been touched by the anti-FGM/C service providers. Advocacy for specialized funding and programs to reach these areas will greatly support the ending of the practice. Finally, single-strand approaches such as a human rights, gender, health, or justice-focused analysis of the FGM/C problem and generation of solutions often miss community perspectives on what it would take to get them to stop the practice. More inclusive and holistic approaches will allow community views to inform intervention designs, efficiency and effectiveness of the implementation, impact, and sustainability. Finally, findings point to a blame game in which men and women shift blame for who is responsible for sustaining the practice of FGM/C. It is essential that Plan International and national partners institutionalize action research interventions to better understand who the sustainers of the practice are. This will enable Plan International and its partners to design and target behavior and practice change messaging to the right audiences.

Finally, diasporan communities wield a lot of influence in their home communities. They have money, exposure, and access to networks in and out of their home countries that make them respected voices in their home communities. Their return home to patronize FGM/C does not only validate and legitimize the continuation of the practice in the eyes of the home community, but they also provide an important source of income that supports the existence of the service market. Many are role models to the youth in their home communities. However, they remain an untapped pool of champions of change within the diasporan community and back home. To leverage their influence, we recommend that Plan International and its partners consider working with national governments, civil society groups, and identity-based associations of Guineans and Kenyans in the diaspora to promote their championship of the anti-FGM/C agenda among their members and then with their home communities.

Recommendations for the micro level engagements point to the need for Plan International and partners to i) place communities in the driving seat while bringing all key stakeholders on board; ii) the need to involve both women and men to highlight shared interests and benefits accruable from the stoppage of the practice; iii) meaningfully engage FGM cutters in different ways; and iv) advocacy to ensure mobilization and allocation of adequate resources for the enforcement of laws and regulations. Putting communities in the driving seat will enable them to identify collective interests founded on visions of a future without the FGM/C cut. Once convinced about such futures and the benefits, they will lead the action to eliminate the cut. The use of inclusive and collaborative approaches that involve men, women, cutters, and law enforcement agencies in fora that lead to collectively agreed platforms of action will generate locally developed and contextualized alternatives for ending the cut. This will lead to more impactful and sustainable interventions and outcomes for ending FGM/C.

Two cross-cutting recommendations advise anti-FGM/C activists and programs at all levels to leverage what already exists instead of spending time and efforts to tweak or reinvent the wheel on intervention mixes that have been tried and proved to have worked or failed. Much time and resources could be released for direct community level engagements if they are not spent on experimentation. Also, we recommend investment in advocacy for the mobilization and allocation of resources for engagements at the grassroots where the change needs to happen to make FGM/C practice disappear.

## I. Introduction

### 1.1 Background to Study

Although the practice of Female Genital Mutilation/cutting takes place on other continents, Africa remains an intransigent hotspot for the practice, with 80% of the estimated 200 million cases worldwide taking place in Africa (Reliefweb, 2021). The African Union (AU) approximates that “more than 50 million girls in Africa under the age of 15 years are at risk of being subjected to female genital mutilation by 2030” (Africa Union, 2019). UNFPA estimates a potential “two (2) million additional cases of female genital mutilation [...] by 2030” (UNFPA, 2020) as a result of the Covid-19 pandemic that has stalled progress towards its elimination. The incidence and intensity of the practice, however, differ widely within and across regions and countries. While some regions and countries have lower prevalence rates, others are experiencing declines from initial high rates, with a third category being trapped in stagnation or a decline in progress toward the elimination of the practice.

In Africa, East Africa hosts hotspots for the practice of FGM/C. Egypt, Sudan, Eritrea, Djibouti, and Somalia, all in the north-eastern flanks of the continent, have the highest prevalence rate for FGM/C. Five countries in East Africa (namely: Ethiopia, Kenya, Somalia, Tanzania, and Uganda) account for 25% of reported global cases of FGMC. That translates to “nearly 50 million girls and young women from this region [having] undergone FGM” (UNFPA and UNICEF, 2022, n.p.). In West Africa, Sierra Leone, Guinea, Burkina Faso, and Mali have the highest prevalence rates for the practice of FGM/C.

This feasibility study supports Plan International’s interventions for the eradication of FGM/C in Guinea and Kenya – two countries that fall within different categories in the FGM/C incidence and practice continuum. While Kenya is listed among “countries with a significant decline in prevalence”, Guinea is counted among countries that have witnessed “no significant change in prevalence” (Africa Union, 2022, p. 3). In Guinea, the practice is almost universal among girls and women between the ages of 15-49 with a national average prevalence rate of 94.5% but with rates going as high as 98.4% in Kindia and other regions (UNICEF, 2022). The prevalence rate of FGM/C practice in Kenya, on the other hand, ranges from 21% on average among girls and women aged 15 to 49 years nationally. However, prevalence rates are reaching 98% in the Northeastern region. The Western Region has the lowest prevalence rate of 1% (Plan International, ToR, p. 2ff).

While the African Union and its member states have instituted various measures to eliminate the practice, the intensity of engagement and success rates vary widely. At least 25 of the 29 countries in Africa with high prevalence rates<sup>1</sup> of FGM/C practice have adopted laws that ban the practice of FGM/C. However, there has been little progress in reducing the practice for a broad range of reasons. Guinea and Kenya, for instance, both have clear legislation against FGM/C, with clearly defined punitive measures against infractions, but both still have challenges or have made little progress in reducing FGM/C practice. Guinea, for instance, has a comprehensive legal framework that prescribes sanctions ranging from several months and up to twenty (20) years of imprisonment and/or cash penalties of several thousand to millions of GNF for infringements of the law.

### 1.2 Contributions of Plan towards ending FGM/C

Plan International Germany (called German National Organisation – GNO) has supported initiatives to stop FGM/C in several countries across Africa, including Egypt, Ethiopia, Burkina Faso, Guinea-Bissau, Mali, Senegal, Sierra Leone, and Sudan. Plan GNO is currently running community-based projects in six (6) other countries in West Africa. In Guinea, GNO supported initiatives in 12 administrative districts in the Guéckedou and Kissigoudou areas for over 14 years. The second wave of interventions expanded the

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<sup>1</sup> UNICEF classifies high prevalence rate of FGM/C in countries with cases ranging from 65.2% (Ethiopia) to 99.2% (Somalia). In between are Burkina Faso, Mali, Guinea, Sierra Leone, in the West and Egypt, Sudan and Eritrea in the East, with various percentages within the Ethiopia and Somalia range – see map at <https://data.unicef.org/topic/child-protection/female-genital-mutilation/>.

geographical scope of GNO's support against FGM/C beyond Guéckedou and Kissigoudou to Coyah and Conakry, covering 50 to 80 districts overall.

Plan International Guinea has used the whole-community approach to advance its objectives of stopping FGM/C in the country. The strategy is built around educating community gatekeepers such as opinion leaders including traditional and religious leaders, cutters, and uncut girls to demonstrate the feasibility and desirability of abandoning the practice. The strategy emphasizes the creation of new rituals that avert the cut; celebration and protection of uncut girls, and the use of separate meetings between men, women, elders, and the youth to galvanize support for the stoppage of the practice. Plan International leverages the presence and capacities of local NGOs and CBOs to access and work with the communities it engages.

In Kenya, GNO and Plan Kenya are implementing a Sexual and Gender-Based Violence project that seeks to enhance the agency of adolescent girls in exercising their rights to education and protection from SGBV. Additionally, Plan International Kenya created Village Savings and Loans Associations (VSLAs) to provide women with economic security so they can sustain themselves and contribute to their household finances. These groups are also platforms through which women discuss issues that affect them and their families such as FGM/C and early child marriages. Plan International Kenya uses these groups in the Maasai region to create awareness of FGM/C practice which is predominant in the region. This forum is also used to protect the rights of girls and also create a communication channel for engaging the communities. Plan International Kenya's work with Maasai communities in Kajiado West and Kajiado Central areas has seen the development of alternative rites of passage as a substitute for FGM. They are working with Maasai Warriors and elders to sensitize the communities on the harmful effects of FGM/C.

### ***1.3 Purpose, Objectives, and Scope of Feasibility Study***

a) Purposes of Feasibility Study: Plan International and its partners in Guinea and Kenya intend to capitalize on their experiences and lessons learned from these years of work in the sector to design and launch a set of innovative interventions that harness the power of youth, families, CBOs, and key decision makers to influence policies, programs, and promote joint learning in ways that build capacities that stimulate systematic changes at national, regional, and possibly continental levels through replication of lessons learned in other countries (Plan International, ToR, 2022).

To support the design of the new interventions, Plan International and its partners in Guinea and Kenya have commissioned this feasibility study to provide data that would ground the interventions in evidence that would ensure the activities of the project would contribute to the stoppage of FGM/C in the two countries. The results of the study will enable Plan International, its Country Offices and local partners to fine-tune interventions to ensure that key policies, legislation, programs, and other decisions are made at local, national, regional, and continental levels to support the stoppage of FGM/C in targeted districts/counties of Guinea and Kenya respectively and contribute to the global effort for the eradication of the practice.

b) Study Objectives and deliverables: In summary, the objectives of the feasibility study are:

- i) "...assess whether the original problem analysis and the solution approaches based on it are appropriate, valid and whether the formulated intervention logic can thus lead to the envisaged changes".
- ii) "...investigate the political, technical and social barriers on the different levels with a special focus and emphasis on barriers on the national level in both Guinea and Kenya".
- iii) "...assess capacities and identify capacity gaps among higher-level stakeholders and institutions and indicate whether the planned interventions are suitable to address the gaps and if necessary, make recommendations for alternative measures".
- iv) "...analyze whether the interaction and expected results between the work in Guinea and Kenya will bring the expected added value to the impact and outcomes of the project".

c) Expected Outcomes of Study: The expected deliverables of the study are:

- i) Provide concrete recommendations that "...provide Plan Kenya, Plan Guinea, Plan Germany, and Plan's African Union Liaison Office with a well-founded basis for the further adaptation of the project concept, in which the prerequisites, opportunities and risks have all been clarified.

- ii) Provide a realistic view on whether the envisaged changes can be implemented within the project period and with the budget available.

d) *Geographic and Thematic Scope of Assignment*

While Plan International and its partners will focus their interventions in the Macenta, Nzérékoré, and Yomou districts of Guinea, and the Kajiado and Tharaka Nithi districts of Kenya, data collection for this study covered actors and institutions at the i) Continental level, focusing on key policy and decision-makers at the African Union, and Plan's AU Liaison Office in Addis Ababa; ii) regional economic and political offices covering the two project countries, namely - ECOWAS officials in Abuja and other regional offices in respect of Guinea, and officials of the East African Community (EAC) in Arusha, Tanzania and elsewhere in respect of Kenya; iii) national and district levels in the target areas, and iv) community-level for selected communities in the project districts. The three-tier data collection scope is designed to meet Plan International's envisaged interventions at the macro, meso, and micro-levels. While engaging with continental, regional, and national level (governmental) actors and institutions will generate findings that guide the design of engagement with macro level policy and decision-makers, data for meso level engagements will come from the data collected through engagement with national and subnational actors, civil society, business, faith-based leaders and institutions. The study at the community-level will generate data for micro-level engagements.

Thematically, the study explored a broad range of contextual factors that underpin the prevalence and persistence of FGM/C practices in the targeted study communities, using the PESTEL framework. The PESTEL analytical framework assesses the potential influence of external factors on program design, implementation, and outcomes. It is a precursor tool for identifying potential elements that guide an in-depth SWOT analysis. For this study, it allowed for a thorough consideration of the political, economic, social, technological, environmental, and legal frameworks that different categories of actors used to define, institutionalize, enforce, and sustain collective knowledge, perceptions, attitudes, beliefs, and behaviors that drive acceptance and practice of FGM/C. The social dimensions explored covered the roles of culture, religion, and gender in the perpetuation of the practice.

The study also ascertained the nature, extent, and distribution of gaps or missing/weak points in i) the legal and regulatory frameworks (laws, conventions, regulations), within and between countries and respective regional organizations to ensure the eradication of FGM/C practices; ii) the direction of flow and strength of linkage of policies and programs from the continental through the regional to community-level for the eradication of the practice of FGM/C, and iii) gaps in institutional capacities of different agencies and groups intervening in the FGM/C eradication sector that Plan and its partners need to be aware of and possibly consider in the design of their interventions. The latter component included an examination of the structure and envisioned operation of the project coordination mechanisms at the national, intermediate-regional and operational (community) levels. In addition to assessing the feasibility of the envisioned interventions per the OECD Criteria, the study assessed the extent to which the cross-cutting aspects of the intervention such as consideration of marginalized/discriminated girls and disabilities are taken into account in the project design. Findings from these thematic engagements provide the backdrop for assessing the adequacy or otherwise of the set of interventions Plan International and country partners have proposed to combat FGM/C.

#### ***1.4 Conceptual Frame of Study***

Appendix 1 details the conceptual framework that underpinned the design and conduct of the study. Essentially the framework is comprised of:

- ***Results-Based Management (RBM) conceptual frame*** grounded in the feasibility of using multi-stakeholder action and engagement platforms running from the community through the district, national, regional, and continental actors and institutions that allowed for different stakeholders to critically assess how Plan's intended interventions would contribute, directly or indirectly, to the achievement of project objectives

- **Lines of Enquiry built on the OECD** project design, performance, and evaluation criteria to facilitate the assessment of the relevance, coherence, efficiency, effectiveness, sustainability, and potential impact of the planned interventions.
- **Engagement Approaches that emphasized i)** Participatory strategies that involved a broad range of participants at continental, regional, national, and subnational levels; **ii)** Multi-tier data collection processes reaching out to different categories of people to provide a broad range of perspectives on the findings; **iii)** Nested approaches to facilitate seamless integration of data collection and analysis

### **1.5 Brief Description of Study Methodology**

Desk Review: The eradication of FGM/C has attracted high visibility and attention from political actors, ranging from the UN to the World Bank, continental, and regional political institutions such as the EAC and ECOWAS, as well as different governments of member states of these bodies. Consequently, there is an abundance of literature that detail the commitments, investments, and outcomes of interventions that different actors have engaged directly in or in support of partners in the design and execution of initiatives to end FGM/C. These sources have a wealth of information on what has worked and what has not in different contexts in the eradication of the practice of FGM/C. Additionally, Plan International, its country offices in Guinea and Kenya, as well as other civil society organizations have accumulated considerable experience in the development, management, and reporting of interventions to stop FGM/C in Africa in general, and more specifically in Guinea and Kenya.

IPD, therefore, sought out, collected, and reviewed pertinent documents detailing conventions and protocols such as the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol on Women's Rights); the African Charter on the Rights and Welfare of the Child; the Convention on Elimination of All Forms of Discrimination against Women; and the Beijing Declaration and Platform for Action among others that state parties have signed and committed to stopping the practice of FGM/C; intervention proposals and associated monitoring and evaluation reports for lessons learned. The literature search included reviewing legal documents, including court decisions that have bearing on the policy and legal frameworks underpinning decisions and actions of government, etc. The outcome of the desk reviews informed the conceptual design of the study and, in particular, the range and substance of the questions used in the various data collection instruments. The desk review also allowed IPD to establish what commitments various agencies at the continental, regional, and country levels have made towards the eradication of FGM/C; what follow-through actions they have undertaken; the gaps in commitment versus actions, and constraints have stalled the implementation of decisions made to end FGM/C at different levels.

Sample frame and Size: The study set out to engage at least 580 individuals located at the Continental level (AU staff and personnel of Plan International's AU Liaison Office); Regional levels (ECOWAS in Abuja and ECA in Arusha, Tanzania); and at the national and district, prefecture, our county levels in Guinea and Kenya. Additionally, the study targeted to interview 475 individuals at the community-level in the five participating districts (three in Guinea and two in Kenya) using a combination of key informant interviews, focus group discussions, and surveys. Table 1 below presents the distribution of study participants by type of data collection protocols, level of engagement, and country of study.

**Table 1: Distribution of Study Participants by Type of Data Collection Protocols, Level of Engagement, and Country of Study**

Instruments	Plan International Levels	Kenya	Guinea	Totals
KII_01: Community-level Participants	<b>Micro:</b> Community leaders (chiefs, elders, Leaders of Community-based and Faith-based organizations)	54	79	133
KII_02: National and District Level Participants	Covers <ul style="list-style-type: none"> <li>• <b>Macro:</b> participants (Government Officials in Ministries, Departments and Agencies)</li> <li>• <b>Meso:</b> participants – leaders of CSOs, national leaders of Faith-based organizations, Associations, etc.</li> </ul>	186	88	274
KII_03:	<b>Macro:</b> AU, EAC, ECOWAS, Representatives of foreign embassies and Development partners; UN and other international Agencies	10	14	24
Survey	<ul style="list-style-type: none"> <li>• <b>Micro:</b> Community leaders (chiefs, elders, Leaders of Community-based and Faith-based organizations)</li> <li>• <b>Meso:</b> participants – leaders of CSOs, national leaders of Faith-based organizations, Associations, etc.</li> </ul>	113	151	264
FGD	Micro: Men, women, and mixed groups	45	64	109
<b>Total Participants</b>		<b>408</b>	<b>396</b>	<b>804</b>

**Table 2: Gender of Survey Respondents By Country of Study**

Gender	Country		Total
	Guinea	Kenya	
Male	75	52	127
	49.7%	46.0%	48.1%
Female	76	61	137
	50.3%	54.0%	51.9%
Total	151	113	264
	100.0%	100.0%	100.0%

Instrumentation:

**KII\_01** protocol collected data from the following category of respondents: Community-level custodians of the institution and practices FGM/C (i.e., traditional leaders - chiefs, elders, queens) religious leaders (Priests, Pastors, Imams, Traditional priests, leaders of sacred or initiated societies), FGM/C service providers, women who are 18 years or older; women leaders; youth leaders (male and female). It aimed to assess participants' knowledge, perceptions, attitudes, behaviors, and practices that drive or can stop the practice of FGM/C. It includes the collection of data to allow for factors and actors identification and analysis, as well as change process analysis.



**KII\_02** protocol targeted elected/appointed political officeholders (Mayors, Governors), senior civil and public servants in government ministries, departments, and agencies responsible for Health, Social Welfare, Women’s Affairs, etc. It also covered senior government officials at Municipal, District, National, and regional/provincial levels; leaders of faith-based organizations (Pastors, Imams, Traditional priests) and civil society organizations at local and national governance levels. The instrument focused on collecting data on the existence, nature, and functioning of legal and regulatory frameworks governing the practice of FGM/C in their respective spheres of influence. It also permitted the collection of data to assist in the identification of and analysis of stakeholders as well as capacity and gap analyses at the respective levels.



**KII\_03** was designed to collect data from regional and continental officeholders and duty bearers at AU, ECA, and ECOWAS Levels; as well as regional and continental civil society actors on FGM/C. The tool was also meant for use with key staff of Plan International’s Liaison Office to the African Union (Plan AULO). The instrument aimed to collect data on the legal and regulatory frameworks at various levels for facilitating the elimination of FGM/C, as well as stakeholder analysis, capacity, and gap analyses at those levels.



The **Survey tool** solicited views from traditional leaders (chiefs, elders, queens), women leaders; youth leaders (male and female); elected/appointed political officeholders (mayors, governors); senior civil and public servants in ministries, departments, and agencies responsible for Health, Social Welfare, Women’s Affairs, etc.; Senior government officials at Municipal, District, and regional/provincial levels of government; Leaders of faith-based organizations (Pastors, Imams, Traditional priests).

The **Community Focus Group Discussion Guide** was used to collect data from Community-level custodians of the institution and practices of FGM/C (i.e., traditional leaders - chiefs, elders, queens) religious leaders (Pastors, Imams, Traditional priests, leaders of sacred or initiated societies); FGM/C service providers, women who are 18 years or older, women leaders; and youth leaders (male and female). It aimed to collect data to complement and validate findings from the other instruments through triangulation of views from ‘group debates’ on the factors, actors, and sustainers of the FGM/C practice at the community-level.



*Data Collection Process:* Data collection instruments were mounted on the Kobo tools platforms. Trained data collection agents used android smartphones to access links to the questions and upload completed data sets. The IPD team monitored and checked the data for quality and engaged field coordinators in Guinea and Kenya to ensure accuracy, completeness, and timely upload.

*Data Analysis:* The data downloaded in Excel format was checked, cleaned, and readied for analysis. Data from the qualitative component i.e., KIIs and FDGS were coded and analyzed using Excel, while the survey data was exported into SPSS for analysis.

Appendix 2 provides an outline of the methodology while Appendix 3 details the different instruments used for the collection of the data.

## 1.6 Structure of Report

The structure of this report follows the outline of the lines of enquiry established in the ToR of the assignment. This ensures that the report responds to the objectives of the study. In terms of substance, the blends data from the desk reviews, surveys, key informant interviews, and focus group discussions to provide a seamless overview of the findings. It uses the *viva voce* approach to ensure that the reviews and voices of respondents or secondary sources of data give life and meaning to the findings.

Where direct quotes from primary data are used, the following source coding protocol allows for the disaggregation of findings by country and the study instruments used. For instance, data reference such as GN\_KII\_02\_XXXX indicates the data referenced comes from the Guinea segment of the study, using the KII\_02 instrument. The numbers correspond to the last four digits of the system-generated identity of the particular respondents. For KII\_03, where much of the data did not pass through the Kobotool to allow for the generation of the data identification numbers, the organizations or locations of the interview are used as the suffixes to provide the unique data source identification. This makes it easy to trace and verify the specific respondent who made the statement when the need arises.

## 1.7 Limitations of Study

*Time constraints:* Due to several hitches between the contract negotiation and receipt of the first tranche of funds, the launch of fieldwork for data collection was delayed by several weeks. This significantly truncated the time effectively available for the collection and analysis of the data.

*Nonavailability of respondents:* The timing of field work close to the Christmas and New Year holiday seasons made it difficult to access certain categories of respondents, especially those at the regional and continental levels. Most of those we tried to contact for interviews were either out on business travels or already starting their end of year vacations. Despite efforts to reach them through alternate means (phone calls, direct email messaging, abbreviation, and relaunch of shorter versions of the KII\_03 protocol that targeted them) the response rate was very low. Some individuals who engaged us but could not participate in the interviews explained that they needed to clear some bureaucratic hurdles in their respective workplaces to get permission to participate in the study; and this could not be done during the holiday period. As a result, the study was able to secure the participation of 24 out of the estimated 80 interviews planned for the AU, ECOWAS, and EAC levels.

## II. Context Analysis

### 2.1 Political and Legal Context

#### 2.1.1 The Political Context

##### a) Political Commitment at the African Union (AU) Level:

Eradication of female genital mutilation is a high political priority for a broad range of interest holders ranging from the United Nations and its affiliate agencies (UNICEF, WHO); to intergovernmental organizations, national governments, and civil, community-based, and faith-based organizations among others. Spurred on by global condemnation, the African Union, regional bodies and national governments have subscribed to protocols, conventions, and other international agreements that provide frameworks or spell out commitments to work towards the eradication of the practice in their respective spheres of influence. National governments have gone further to criminalize the practice through the passage of laws and other regulatory instruments that ban the practice and prescribe punitive measures for violators.

The African Union recently reasserted that its commitment to “...ending female genital mutilation is an urgent priority [and its] Saleema Initiative on Eliminating Female Genital Mutilation works to catalyse regional and national level efforts towards the complete elimination of the harmful practice within a generation” (African Union, 2022, p.2). The Saleema initiative responds to the fact that a major obstacle to the fight

against FGM/C in communities where the practice is entrenched is the social pressures (stigmatization, ostracization, pejorative name-call, etc.) that girls and women who have not taken the cut face from community members. In other words, girls who receive the cut are valued and branded higher socially than those who have not. The Saleema initiative, therefore, aimed to reconstruct narratives around uncut girls and women to change social norms and values attached thereto and help rebrand uncut girls and women as equal, if not of a higher, value than their uncut counterparts. It harnessed both conventional and contemporary social media platforms to create and disseminate alternate narratives beliefs, values, norms, perceptions, attitudes, behaviors, and practices on staying uncut or “uncutness”. Data from a two-year phase of initiative implementation in Sudan (2015-2017) show positive correlations between exposure to Saleema interventions and reductions in pro-FGM social norms for people who have participated in the project (Evans et. al, 2019). Initially designed for Sudan, the African Union adopted and encouraged member states to sign unto the program (AU, (2019).

The AU’s treaties and other agreements between member states against the practice of FGM/C include but are not limited to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (Maputo Protocol on Women’s Rights); the African Charter on the Rights and Welfare of the Child; its recognition of the Convention on Elimination of All Forms of Discrimination against Women; and the acceptance of the Beijing Declaration and Platform for Action. Together, the commitment to these protocols and convention signal the political will and collective commitment of AU member states to see to the eradication of the practice of FGM/C within their frontiers. In particular, “Article 21 of the African Charter on the Rights and Welfare of the Child mandates governments to make every effort possible to stop harmful social and cultural practices such as FGM/C that affect the welfare and dignity of girls” (Republic of Kenya, 2019b, p. 9). This has provided a comprehensive umbrella under which member states are encouraged to develop their own consonant national legislative, policy, and programming frameworks to operationalize the elimination of FGM/C among member states. The AU’s directorate for Women, Gender and Youth has oversight for the development and coordination of policy responses of member states for the elimination of all forms of gender-based discrimination, including the elimination of institutionalized forms of violence against women, such as the practice of FGM/C.

## **b) Political Commitment at the Regional Levels (ECOWAS and EAC)**

### *i) East Africa Community (EAC)*

The sub-regional bodies of the Economic Community of West African States (ECOWAS) and the East African Community (EAC) acknowledge the practice of FGM/C as a crime against girls and women which dehumanizes and infringes on their human rights (ECOWAS Commission (2020); African Union (2019); East African Community (2017). In light of this, the regional bodies are joining the continental and global bodies to fight to eradicate FGM/C.

To combat FGM/C, the East African Legislative Assembly (which includes Kenya, South Sudan, Tanzania and Uganda) 2016 enacted the East African Community Prohibition of Female Genital Mutilation Act (EAC Act). The objective of the act is to “prohibit the practice of Female Genital Mutilation ..., promote cooperation in the prosecution of perpetrators of female genital mutilation and develop common measures, strategies and programmes for the effective implementation...”(Dora Christine Kanabahita Byamuka (2016). This establishes a basis for members of EAC to liaise with and prosecute culprits through the coordination of laws, strategies, and policies to eradicate FGM/C in the region. It further provides a platform for the dissemination and sharing of data, research, and information to facilitate raising awareness of the harmful nature of FGM/C.

### *ii) Economic Community of West Africa (ECOWAS)*

The 2010-2020 gender strategy that the ECOWAS Parliament developed in collaboration with the Parliamentary Centre and funded by the Canadian International Development Agency(CIDA) had no single mention of FGM/C as an issue that the strategy needs to take on board. In ECOWAS’ Child Policy 2019-2030. ECOWAS Member States merely accepted the African Union’s Common Position to “eradicate all

forms of violence against women and children, and harmful practices such as female genital mutilation (FGM) and early marriage” which aligns with the AU Child Marriage Campaign launched in 2014” (ECOWAS Commission, 2019, p. 11). The Policy document recognizes the prevalence of the practice of FGM within its member states in stating that “...more than 46 million women and girls have undergone some form of FGM/C in West Africa [with] the percentage of girls aged 15 - 19 who have undergone FGM/C [...] estimated at 23 percent, [noting further that] the prevalence in West Africa varies widely from 94 percent in Guinea, 88 percent in Mali and 76 percent in the Gambia, to 74 percent in Sierra Leone” (ECOWAS Commission, 2019, p. 20). Beyond this recognition, however, neither the Gender Strategy nor the Child Policy Document indicated any concrete actions that ECOWAS and its member states envisaged to end the practice of FGM/C beyond an intent to “Enhance the participation of youths in eradicating violence against children and GBV, in particular, child marriage and FGM/C” (ECOWAS Commission, 2019, p.18) as part of the strategic objective of increasing the participation of children in decision-making and governance.

Unlike the East African Legislative Assembly which enacted the East African Community Prohibition of Female Genital Mutilation Act (EAC Act) (Byamuka, 2016), ECOWAS has not yet adopted any legislative framework against FGM/C despite the urging of First Ladies of the region on it to do so (Economic Community of West African States (2017). In the absence of a regional legal framework to guide, encourage, and enforce the commitment of member states to adopt legislation that ends the practice, the duty has fallen on non-state actors such as civil society organizations to take recalcitrant ECOWAS member states such as Mali to court to compel them to promulgate legislation that bans the practice (Equality Now, 2021; Radio France International, RFI, 2021; Reuters, 2021).

### c) Political Commitment and Environment in Kenya:

Kenya has been politically stable since 2008 and has recently organized highly contested elections with a peaceful transition of power from one government to another. This political stability has contributed to legal and policy stability and continuity in the fight against FGM/C. The stability of democratic and peaceful transitions has ensured leadership upholds Kenya’s commitments to international conventions and protocols that call for the proscription of FGM/C in all its forms. Under Article 2 of the Constitution of Kenya, the country’s ratification of international conventions such as the Universal Declaration on Human Rights (UDHR, 1948), International Covenant on Civil and Political Rights (1966), International Covenant on Economic, Social and Cultural Rights (1966), the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW, 1979), the Convention Against Torture and other Cruel and Inhuman or Degrading Treatment or Punishment (1984) and the United Nations Convention on the Rights of the Child (UNCRC, 1989), among others, automatically makes them parts of Kenya’s laws. According to Article 2 (6) of the Kenyan Constitution “Any treaty or convention ratified by Kenya shall form part of the law of Kenya under this Constitution” and, by extension, are enforceable instruments for the eradication of FGM/C and all other forms of harmful practices and discrimination against women and girls.

In June 2019, President Uhuru Kenyatta affirmed his commitment to end FGM before leaving office (see section 2.3.2 for details). In line with that, those contesting to replace him announced similar commitments but in less forceful ways. Of the seven (7) commitments to women the United Democratic Party in its manifesto, the Kenya Kwanza Plan, FGM is mentioned only twice in one sentence in the 65-page document that announced the party’s commitment to implementing the national ban on FGM through resourcing the police and the Anti-Female Genital Mutilation (FGM) Board with the human and financial resources they need to “fully Implement the Anti FGM Law” (Kenya Kwanza, 2022, p. 53). Similarly, the Azimio La Umoja One Kenya Alliance’s singular mention of FGM in its manifesto is shrouded in one statement in which the party commits to “enhance security and street lighting around the country to provide a safe environment and strive to end FGM and Gender based violence” (Azimio, 2022, p. 32). No further elaboration of how this would happen was offered.

Although Kenya has signed the Convention on the Elimination of all forms of Discrimination against Women (CEDAW), she has not assigned the associated Optional Protocol, effectively signalling that Kenya does not recognize the competence of the governing Committee of this Convention to hear complaints or investigate breaches raised by individuals. Similarly, Kenya has signed the Convention on the Rights

of the Child (1989) but not the Optional Protocol II to the Convention on the Rights of the Child (2000). At the regional levels, Kenya has signed the following AU Charters: i) Protocol on the Rights of Women in Africa (2005) ii) Protocol on the establishment of an African Court on Human and Peoples' Rights (1997); iii) African Charter on the Rights and Welfare of the Child (1990); and iv) African Charter on Human and Peoples' Rights (ACHPR, Banjul, 1981) – all of which have different provisions offering protection to women and girls against harmful practices (Kenya Human Rights Commission (2010).

Kenya is struggling to contain the activities of Violent Extremism within and across its borders with Somalia, which require the investment of greater amounts of resources in security operations. Much of the FGM/C practices in Kenya also occur in the mega-size refugee camps in the country hosting ethnic groups such as the Somalis who cherish the practice of FGM/C. Incidentally, the presence of native Somali Kenyans and Somali refugees in refugee camps who subscribe to the practice of FGM/C in their communities compound Kenya's struggle to curb the practice as well (Hazel, Bedri, and Krishnapalan, 2021).

#### **d) Political Commitment and Environment in Guinea:**

Despite its political upheavals Guinea has maintained in print its very early political commitment to the eradication of FGM/C. Guinea has signed onto at least 11 international protocols and agreements that ban the practice of FGM/C (Barbière, 2017)). She has also ratified the African Charter on the Rights and Welfare of the Child which enjoins signatory States to take all actions to “eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child”, particularly “customs and practices prejudicial to the health or life of the child” and “those customs and practices discriminatory to the child on the grounds of sex or other status” (OHCHR, 2016, p.1). As part of its commitment to the eradication of FGM/C, the Government of Guinea has recognized and collaborates with the Cellule de Coordination sur les Pratiques Traditionnelles Affectant la Santé des Femmes et des Enfants (CPTAFE)<sup>2</sup> through the Department of Health and Social Affairs and Women's Affairs. This collaboration led to the inclusion of articles in “...the Guinean Constitution that upholds the right to physical integrity of the person and condemns all forms of inhumane treatment” (US Department of State, 2001, p.1).

Asked about what affects Guinea's ability to operationalize the various conventions and treaties the country has signed up to, a senior official at the Presidency of Guinea indicated cited the difficulty government faces in aligning the provisions of certain conventions with their national laws as a major factor that inhibits rapid domestication of the international commitments (GN\_KII\_03\_GO1).

Beyond the legal and constitutional matters, Guinea is also grappling with political unrest and uncertainties related to multiple civil dissatisfactions with the economic and political leadership. This has led to recurrent military coup d'états that have culminated in the suspension of Guinea as a member state of ECOWAS (Aljazeera, 2021). In the midst of the political turbulences, it is not clear what priorities are accorded the fight against FGM/C. Guinea also suffered the resurgence of Ebola virus disease in 2021 that also put pressure on already limited resources.

#### **2.1.2 The Legal Context**

##### **a) Consolidation of Legal Framework for Action Across Africa**

The AU has adopted various international conventions, treaties, and protocols that criminalize the practice of FGM/C and has encouraged member states to do the same. In 2004, the AU merged the African Court on Human and Peoples' Rights and the Court of Justice of the African Union into the African Court of Justice and Human Rights (ACJHR) to provide a comprehensive framework for handling cases beyond the purview of member states. At regional levels, the East Africa Community established the East African Court of Justice (EACJ) in 2001 (Gathii, 2130), while ECOWAS established the ECOWAS Community Court of Justice (ECCJ) with jurisdiction over all human rights cases over their respective member states (Alter et. al, 2013). At the country level, Guinea has had anti-FGM legislation in place since 1965, while Kenya more

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<sup>2</sup> In English, CPTAFE stands for Coordinating Body on Traditional Practices Affecting the Health of Women and Children  
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recently doubled its efforts to put in place a strong legal framework to buttress its fight against the practice of FGM/C.

With respect to testing the robustness and resolve of the continental, regional, and country level legal institutions in the fight against FGM/C, two classical cases in East and West Africa provide pathways for enforcing the ban on FGM/C. They have provided grounds for different individuals and civil society groups to test the legality of the proscription or non-proscription of the practice of FGM/C in Africa in separate landmark court cases. In West Africa, civil society groups in Mali challenged the failure of the Malian government to enact laws that criminalize the practice of FGM/C in that country at the ECOWAS Court of Justice in Abuja. While the case is yet undecided, it shows how nonstate actors have the legal bases to hold state parties to account in the ECOWAS Court for their neglect to create the environments that support the eradication of FGM/C. In East Africa, an individual sued the Government of Kenya for its indiscriminate and total ban on the practice of FGM/C. Ironically, both cases cited human rights violations as the basis for the reliefs they sought.

Unlike the case against the government of Mali, which is still undecided, the High Court in Kenya upheld the criminalization and ban on the practice of FGM/C. The High Court ruled that “...the practice of FGM/C violates a woman’s right to health, human dignity and in instances when it results in death, the right to life, adding that the practice also undermines international human rights standards” (African Union, 2021a, n.p.). The Kenyan Court further found that Kenya’s National Policy on the Abandonment of Female Genital Mutilation which was approved in June 2010 was inconsistent with the provisions of Kenya’s Constitution, the Prohibition of Female Genital Mutilation Act, 2011, other pieces of legislation, lacked compliance with the UN’s Sustainable Development Goals (SDGs)<sup>3</sup>, (Republic Of Kenya (2019a ). The Court ordered the Attorney General of Kenya to initiate actions to amend the Constitution and all existing laws and regulations that are inconsistent with the protocols and conventions of the AU and other bodies that Kenya has signed onto. Existing laws did not impose a total ban on the practice of FGM/C and did not offer adequate protection for girls against the practice of FGM/C. The Attorney General of Kenya submitted a petition to Parliament on 24th July 2017 to amend Kenya’s Prohibition of Female Genital Mutilation Act to protect all women, including young girls from the practice of FGM/C. Kenya’s Prohibition of Female Genital Mutilation Act has since been promulgated to protect all women, including young girls from the practice of FGM/C. This demonstrated Kenya’s commitment to respect the rule of law and take actions that ensure the enforcement of the rights of women against FGM/C and other forms of gender-based discrimination. In other words, the Court did not only restrict itself to the human rights issues brought before it, but it also waded into constitutional matters, providing a pathway for citizens’ groups to challenge the constitutionality of provisions that infringe on the rights of citizens, including on cases on FGM/C.

The decision of the Kenyan High Court and the subsequent amendments of the law have underscored the fact that the prohibition of FGM/C in Kenya does not undermine the freedom of choice or rights of access to health of women in Kenya. It has also sustained the constitutionality of banning FGM/C, not only in Kenya but in other jurisdictions across the continent. It provides a stronger legal grounding for advocacy for the abolition of the practice in Kenya. In addition, even though the Kenyan High Court has no jurisdiction over other members States of the African Union, the ruling has persuasive force, especially in countries that subscribe in various degrees to the British Common Law traditions of legal precedence under which decisions in one Common Law Country are frequently used in legal arguments in third country court cases.<sup>4</sup> Among the common law countries, decided court cases in one jurisdiction are frequently used in legal arguments in other Common Law member countries and by judges to support their decisions. Hence, the Court’s decision also provides a strong basis for different stakeholders, and all interested parties in member states to engage in actions that create the policy, program, and operational environments for ending FGM/C. The decisions of the Court further established that legal Kenya’s framework respects the rule of law, which allowed an

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<sup>3</sup> While the UN’s Sustainable Development Goals (SDGs) are not binding on any member State, they are key reference points and aspirational guides that all member states are expected to own and use for the development actionable frameworks that contribute to the achievement of the UN’s goals.

<sup>4</sup> At least 16 member countries of the AU (namely Botswana, Cameroun, Eswatini, The Gambia, Ghana, Kenya, Liberia, Malawi, Nigeria, Sierra Leone, South Africa, Sudan, Tanzania, Uganda, Zambia, and Zimbabwe subscribe to the use of the Common Law in their legal systems in various mixed forms – see <https://worldpopulationreview.com/country-rankings/common-law-countries>.

individual to challenge the constitutionality of the ban on FGM/C. Plan International and its Country Offices and partners in Kenya are therefore on solid grounds in seeking to promote macro, meso, and micro-level engagements for the stoppage of FGM/C practice in the target communities.

The AU has embraced the ruling of the Kenyan High Court as a demonstration of “... commitment by member states to shun practices that violate international human rights” (African Union, 2019a, p.1). The embrasure is a policy indicator of what direction a similar case that rises to the AU Court might run. The AU’s embrasure of the ruling also signals to other non-Common Law member States that this is a blueprint to follow. The AU, therefore, declared that the “ruling [of the Kenyan court] is not only a win for Kenya, but for all African women and girls” since it amounted to the courts saying that they “...will not allow African women and girls to be subjected to these dreadful practices under any circumstance”. Effectively, the ruling advanced the operationalization of the AU’s Saleema initiative, as it lends judicial force to an otherwise persuasive policy statement that could not be enforced it AU member states. It also created platforms for the operationalization of the AU Strategy for Gender Equality and Women’s Empowerment, and Aspiration 6 of the AU’s Transformative Agenda 2063 aims to end all forms of gender-based violence, including female genital mutilation across the continent.

### 2.1.3 *The Gap Between Political Commitment, Law, And Practice*<sup>5</sup>

a) *Gap Between Political Commitment and Willingness to take Action - Kenya*: To gauge perceptions on the level of political will to implement measures to end FGM/C in their respective countries, respondents in this study were asked to indicate their assessment of the extent to which political leaders at the National and Sub National government levels are willing to end FGM/C. In response to the question, some respondents, mainly national (macro and meso level) actors believed that **some political leaders have the will to ensure FGM comes to an end**. They make commitments on their manifestos and have called for more investment in “...education and literacy on FGM/C as a way to curb FGM/C and wipe out harmful cultural practices(KN\_KII\_02\_2244) while others are “encouraging women to stand and speak for themselves” (KN\_KII\_02\_9242). Others make public statements in the media to condemn the practice. Some respondents in this category argue that political leaders “are trying their best to make sure that laws are developed, and FGM/C come to end, however, communities are ignorant” (KN\_KII\_02\_7773). Others believe that despite the high level of willingness on the part of politicians to stop FGM/C “communities have their stand and reasons for practicing FGM/C” (KN\_KII\_02\_5314). In sum, political leaders are perceived to have goodwill but need further and better information on the practice and dangers of FGM/C or its magnitude to enable them to champion the relevant policies and programs for its eradication (KN\_KII\_02\_8237; KN\_KII\_02\_2244).

Limited or no political will was cited several times (31/73 cases) as the reason for limited achievement in the fight against FGM/C in Kenya. Respondents said that **political leaders have zero or a very low level of political will in championing the eradication of FGM/C** either because they “have never seen them handling this issue with seriousness” (KN\_KII\_02\_3126) or “heard of any political leader discussing the matter [or] bringing the motion to the parliament to be debated” (KN\_KII\_02\_3351; KN\_KII\_02\_4179). This is partly because “many times they don’t want to talk openly about FGM/C” (KN\_KII\_02\_4076) either because of their lack of education on the subject or the electoral risks associated with the issue. As one respondent put it: “Politicians are not willing [to take on the issue] because they are not aware of what is going on about FGM/C since no evidence has been sufficiently shared with them while some appreciate it as a culture and therefore this weakens in their willingness to end FGM/C” (KN\_KII\_02\_5977; KN\_KII\_02\_8172). In other words, either some politicians are not educated on the

#### **Textbox 1:**

##### **FGM/C as a Political Weapon**

“Political leaders to me they are after votes, or retention of their political position, anything that can course rift with community they serve they can’t pursue it. Therefore, FGM is one of it. They are reluctant to preach against their FGM culture just to remain peaceful with their electorate” (KN\_KII\_02\_1862)

<sup>5</sup> We define **political commitment** as the expressed intent to take and sustain action that lead to the elimination of FGM/C while **political will** relates to the demonstration of a willingness to commit resources, including time, money, and materials to contribute to the elimination of FGM/C, even if that comes at a cost e.g., the cost of losing an election.

harmful effect of FGM/C, or they are simply unwilling to take on the challenge of championing change because of the fear of electoral costs. Table 1 sums up the views of respondents who believe political leaders instrumentalize the issue of FGM/C for electoral purposes. Table 3 below presents a sample of views from national-level interviews from Kenya.

**Table 3: Views on Instrumentalization of FGM/C in Politics in Kenya**

**Question: What is your assessment of the extent to which political leaders at the National and Sub National government levels are willing to end FGM/C?**

KN_KII_02_1862	“Political leaders, to me, they are after votes, or retention of their political position, anything that can cause rift with community they serve they can’t pursue it. Therefore, FGM is one of them. They are reluctant to preach against their FGM culture just to remain peaceful with their electorate”.
KN_KII_02_4273	“The political leaders are driven [by] what the community want...”
KN_KII_02_9935	“Yes and No Political leaders do not circumcise their children [but]they go against their will to ensure that they guard votes and [so] promote FGM. In Baringo politicians circumcise children [but] in Kisii they don’t”
KN_KII_02_1401	“Politicians are not willing to take deliberate steps to formulate and speak against FGM as this would cost them their political fortunes”
KN_KII_02_6023	“Political leaders are always in constant fear of community repercussions that may make them lose their seat”
KN_KII_02_5836	Political leaders are elected by electorates who are the same community members practicing FGM; leaders fear going against their culture and the will of the people for fear of not being elected again in the future.
KN_KII_02_2617	FGM isn’t a priority. Supporting Anti FGM campaigns is like committing political suicide

Others believe there is a gendered aspect to the lack of political will to fight against the elimination of FGM/C. In Kenya, respondents believed **there is reluctance in the male-dominated structures of government to create and implement regulatory frameworks** and resource allocation mechanisms that advance the fight against FGM/C because they are not directly affected by the practice.

Some **political leaders also attempt to monetize their role in ending FGM/C** by seeking monetary rewards as a precondition for their engagement in actions that contribute to ending the practice. As one respondent put it: “The Members of parliament don’t feel obligated to do their role. They would demand money [ask you] to pay at least \$200 for them to attend a meeting by CSOs to address policy issues [...] on FGM and other advocacy agenda” (KN\_KII\_02\_5168).

**Textbox 2**  
**Gender and Political Will**

"I would say NO because a majority of the parliamentarians are male and have not been at the forefront in fighting for the female gender. Indeed, the women leaders have attempted to try however their efforts are still very low"  
KN\_KII\_02\_1423

In sum, respondents in the Kenyan component of the study believe that political leaders are the products of their communities. Therefore, they are not homogenous in their levels of education and worldviews on social issues nor are they always neutral or objective. On the contrary, “some are highly influenced by cultural beliefs and practices [while] some do not have adequate information to address the FGM issues” (KN\_KII\_02\_6993).

b) *Gap Between Political Commitment and Willingness for Action - Guinea.*

In Guinea, the practice of FGM/C has been illegal under a national decree since 1965. This legal commitment was reaffirmed in 2000 with an amendment of the law and enshrined in Article 265 of the Penal Code. Punishment for infractions of this article "...is hard labor for life and if death results [from the practice] within 40 days after the crime, the perpetrator will be sentenced to death" (United States Department of State (2001, p.1)<sup>6</sup>. However, despite the coexistence of this constitutional provision and the high cases of FGM/C practice across all of Guinea, "No cases regarding this practice under the law have ever been brought to trial" (United States Department of State (2001, p.1). When cases were brought to the attention of the courts "between 2010 and 2015 [...] the courts were lenient and did not apply the full penalties to circumcisers or members of women's families" (Barbière, 2017, p1). The government and judiciary have had to tread carefully with enforcing the full rigor of the law because of "the risk of the population rising up and demonstrating against such a judicial decision" (Barbière, 2017, p1). Hence, contrary to the global downward trend, the practice of FGM/C in Guinea is reported to be on the rise (United Nations and United Nations Human Rights, 2015, p.1). This epitomizes the gulf between law and practice; between the will to write laws and the will to implement them; or the will to conform to international laws in proscribing FGM/C and the desire to enforce such proscriptions at the national and local levels.

**Textbox 3**  
**FGM/C Politics in Guinea**

"Governments are shy in enforcing laws and regulations concerning FGM/C because they are directly affected within their community and find it difficult to speak out against FGM/C" (GN\_KII\_02\_1131)

Asked about what national policies or laws are in place to regulate the practice of FGM/C, 50/62 KII\_02 respondents in Guinea indicated they were aware of the existence of various laws and penal codes that ban the practice of FGM/C in the country. However, opinions varied on the relevance and effectiveness of the policies, laws, and regulations governing the practice of FGM/C. Respondents cited the existence of "articles 259, 260 and 261 of the penal code related to the repression against FGM/C" (GN\_KII\_02\_3823; also, GN\_KII\_02\_5441; GN\_KII\_02\_5625; GN\_KII\_02\_5703, among others). They were aware of the punishments associated with infractions of these regulations, as they pointed out "article 259 on FGM provides for a penalty of 3 months to 2 years and a fine of 500,000 to 2,000,000 gnf. (GN\_KII\_02\_9424; also GN\_KII\_02\_8141; GN\_KII\_02\_6080). In addition to the "existence of provisions in the legal texts (civil code, penal code, reproductive health law), the national strategy on FGM/C, the national gender policy" (GN\_KII\_02\_1131), respondents also cited the "labor code [and the] code of good conduct for civil servants" (GN\_KII\_02\_9047; GN\_KII\_02\_6357) as the legal and policy frameworks that demonstrate political commitment to fighting the practice of FGM/C. The aim of these frameworks "... is to put an end to this practice" (GN\_KII\_02\_0500) and so those who fail to respect them are punishable under the law (GN\_KII\_02\_1689; GN\_KII\_02\_4847; GN\_KII\_02\_7321; GN\_KII\_02\_8556).

Respondents were, however, skeptical about the effectiveness of the measures to curb the practice of FGM/C in Guinea, pointing out that beyond the "joint declaration of the ministries of social action and justice and national strategy committee" (GN\_KII\_02\_9562), "the policy put in place to remedy this practice is the sensitization carried out in the media by certain authorities of the country and religious" (GN\_KII\_02\_7611). Additionally, "to regulate this policy or laws community sensitizations are carried out to make citizens understand that a law has been passed to ban the practice and that anyone who falls foul with it will answer before law courts" (GN\_KII\_02\_2367). The strategy to raise community awareness involves working "through the groups and associations in place to make the disadvantages of this practice understood" (GN\_KII\_02\_5665; GN\_KII\_02\_5147; GN\_KII\_02\_5236; GN\_KII\_02\_1177), as well as "raising awareness by involving women leaders, young people and elders GN\_KII\_02\_61312)

Several respondents, however, opined that Guinea's response to the call to ban the practice of FGM/C in the country is mere "politics: only whispers but no reaction and as far as the law is concerned none" (GN\_KII\_02\_6161). As other respondents summed it, "there is the law, but it is not applied" (GN\_KII\_02\_5233" because of "politics in the children's code" (GN\_KII\_02\_6638) or "no practice policy" (GN\_KII\_02\_9425) to ensure enforcement of the legal regimes in place. As a result, "no law is applicable"

<sup>6</sup> Since the passage of the anti FGM/C law, Guinea has since abolished the death penalty for all crimes – see <https://deathpenaltyinfo.org/policy-issues/international/countries-that-have-abolished-the-death-penalty-since-1976> .

(GN\_KII\_02\_6209) as far as the ban on FGM/C practice is concerned. Calling for the political will to ensure enforcement, one respondent concludes that “we need punishment in our country” (GN\_KII\_02\_1862).

b) *Gap Between Legal Reforms and Eradication of FGM: Kenya* has demonstrated strong leadership in its legal framework and decided court cases against the practice of FGM/C. However, community reactions to the Kenyan High Court decision and subsequent legislative amendments in taking the practice of FGM/C underground or across frontiers show that the declaration of political commitments, the promulgation of legislation, and the enforcement of judicial actions and processes alone are not enough to curb the practice of FGM/C. While the legal approach criminalizes the supply side of the FGM/C enterprise by sanctioning those caught promoting or practicing the act, it does little to stem the demand for FGM/C services. While laws and other legal frameworks do set boundaries of acceptable conduct in respect of the practice of FGM/C, they cannot automatically translate into changed behaviors and practices unless a critical number of the target population accept that compliance with the legal frameworks “is the right thing to do” (Plan International and 28 Too Many, 2022, p. 8).

The gulf between awareness of legal boundaries for behaviors on FGM/C and compliance with the law exists because the practice of FGM/C is rooted more strongly in the socio-cultural perceptions, beliefs, values, attitudes, behaviours, and practices of practicing communities more than it is grounded in any medical, health, or any other life-enhancing outcomes for the women subjected to it.

Asked to indicate what they think are the factors that would make it difficult to stop the practice of FGM/C in their communities and beyond, most respondents mentioned “respect for culture”, cultural belief, and the need to preserve their customs, among others as the challenges facing the eradication of FGM/C. In the words of one respondent, “It was an ancestral practice that was inked in the minds of women from generation to generation” (KN\_KII\_02\_0438). This is because, in most practicing societies, FGM/C practice is a “rite of passage or to preserve virginity for marriage” (Republic of Kenya, 2019a, p.10). Accordingly, women are socially pressured to submit to the cut because “failure to undergo the cut subjected one to ridicule, stigmatization and risks of being ostracized” (AU, 2021a). Hence, as the Kenyan experience suggests, proscription alone of FGM/C practices can drive the enterprise underground, with those seeking the services and those willing to offer them finding different ways to keep the practice alive.

In Kenya, the political, legal, and policy efforts to eradicate FGM/C have triggered the adaptation of various strategies in practicing communities to circumvent the prohibitions. To avoid visibility, detection, and possible sanctions, some communities have either i) reduced the age at which girls are subjected to the practice from 15-19 years to 5-9 years; ii) made use of different methods of cutting from Type I to other less conspicuous types of cutting; iii) increased use of traditional, less visible FGM/C service providers; iv) abandoned public celebration of FGM/C events in favor of private and covert ones; v) made use of transborder service providers, and vi) recourse to medical professions for services to professionalize and legitimize the practice under the claim of reducing pain, bleeding; and infections (medicalization). At least four of the seven adaptation strategies to the ban of FGM/C point to its persistence despite its criminalization, which may be due more to demand-driven phenomena than supply-side factors. As a government report notes “Kenyans from FGM practicing communities living abroad also return to Kenya to obtain the cut for their female relatives” (Republic of Kenya, 2019b, p. 12). UNICEF acknowledges the futility of ending the practice of efforts to end FGM/C by 2030 without strategies to effectively engage the diaspora and other actors involved in cross-border service provision and access (UNFPA and UNICEF, 2022).

**Textbox 4**  
**Drivers of Demand for FGM/C**

FGM is perpetuated for family pride, prestige, community acceptance, marriageability, and inclusion among other factors. Rejecting FGM has social, cultural, economic, and political consequences including stigmatization and discrimination. FGM is also considered a cultural identifier

Republic of Kenya (2019b, p. 13)

Long held and deeply engrained socio-cultural and religious beliefs, values, and practices drive demand for FGM/C services. For instance, the perceived value of FGM/C practice as the rite of passage from childhood to womanhood or as a deeply significant religious observance for women comes with rewards or sanctions that make acceptance or rejection of the practice a critical determinant of belongingness or exclusion;

embasement or ostracization; dignity and respect or stigmatization and outcast for young women (Elnakib and Metzle, 2022). Consequently, despite the preponderance of the evidence of the medical and health risks that women undergoing FGM/C face, some who oppose the abolition of the practice have often grounded their arguments on perceptions of "...clash of cultures [in which] circumcising communities are discriminated against and forced to adopt the culture of non-circumcising communities" (Republic of Kenya, 2019a, p. 37). This perception of a cultural war between the state and the practicing communities sets a narrative of the oppressed which in turn drives the practice underground rather than creating an open space for frank and genuine dialogue that leads to change that is owned and led by those who subscribe to the practice of FGM/C.

**Guinea:** Asked about how these laws are enforced in their respective districts, counties, or areas, 24/62 of the KII\_02 respondents from Guinea said in various ways that "the laws there are applied in case of violations" (GN\_KII\_02\_5441; GN\_KII\_02\_6638; GN\_KII\_02\_5147; GN\_KII\_02\_4850). They are either "enforced administratively and [through] NGO intervention" (GN\_KII\_02\_0564)" or through the courts (GN\_KII\_02\_8141; GN\_KII\_02\_6080). Others believe the enforcement is through self-censorship in which the "laws are enforced at the practitioner level" (GN\_KII\_02\_4850; GN\_KII\_02\_9305; GN\_KII\_02\_9568). The degree of self-censored compliance is, however, dependent on the extent to which they are willing to "follow the education related to the harms of FGM" (GN\_KII\_02\_2389). On the other hand, 11/62 respondents believed that the law is only very weakly applied to enforce the ban on FGM/C in Guinea. In their views there is "very little reinforcement" (GN\_KII\_02\_5290" of the laws because they are weakly or moderately enforced (GN\_KII\_02\_3847; GN\_KII\_02\_8556; GN\_KII\_02\_9425; GN\_KII\_02\_7582, and six others).

Of the 18/62 respondents who believed that the laws have not been enforced, several indicated that nothing is happening by way of enforcement "...because there really is no law" (GN\_KII\_02\_6161) since "these laws are left or kept in cabinets and are never enforced" (GN\_KII\_02\_61312). While one respondent believed "it is the non-application of the law that makes people not respect this law" (GN\_KII\_02\_1862), a colleague argued that the "laws are not respected because of membership at the community-level" (GN\_KII\_02\_1131). In other words, due to local systems of solidarity, members of communities protect each other against the law i.e., do not report cases to the police or other law enforcement agencies. This makes reporting the practice to law enforcement agents difficult or unsafe. The unwillingness to expose practitioners who "continue to exercise this practice underground" (GN\_KII\_02\_5665) or those in whose view "...this practice continues in the community in secret" (GN\_KII\_02\_2367) are often scared to even mention that the practice exists (GN\_KII\_02\_6209). This is "because people are afraid of the consequences for those who know them" (GN\_KII\_02\_3823).

One respondent, however, takes a demand-side view on why the practice of FGM/C continues in Guinea despite the existence of legal frameworks to ban it. In the respondent's view, FGM/C practice will continue, openly or in secret, "in so far as demanding women refuse to recognize the consequences of FGM" (GN\_KII\_02\_8287). In other words, unless the demand side for the FGM/C services is effectively addressed through impacting changes in perceptions, values, and beliefs of the communities to change their personal and collective attitudes, behaviors, and practices, Guinea will continue to have the situation "this law is not respected" (GN\_KII\_02\_1689).

#### 2.1.4 Socio-economic Context

The effect of socioeconomic contexts on the prevalence and persistence of FGM/C in practicing communities remains an unsettled question, as the effect of socio-economic factors such as income, wealth, educational levels, place of residence, and occupation, as direct causal effects on the prevalence or otherwise of the practice of FGM/C remain an open question. Within the anti-FGM/C literature, various statements have been made to suggest that poverty is a major driver of the practice of FGM/C. For instance, in Guinea, Fell (2021) asserts that "... the practice of FGM is inextricably linked with poverty" (Fell, 2021, p. 1). Fell cited an unreferenced UNICEF source which purportedly "...states that 56% of mutilated Guinean girls aged 0-14 fall in the most impoverished economic quintile [...] a clear intersectional overlap between gender and class" (Fell, 2021, p. 1). For Kenya, anti-FGM/C activists have linked the poverty incentive to the prospects of bride prices paid to families of girls who have undergone the cut (Girls Not Brides, 2022) and argued that

“...it will be impossible to eradicate FGM if the government does not address a root cause of its prevalence in the rural Kuria community: poverty” (The Guardian, 2020, n.p).

In field interviews for this study, little was said about differences in socio-economic contexts as drivers for the practice of FGM/C. In particular, poverty or income differentials were sparsely mentioned as push factors for the persistence of the practice of FGM/C in both Guinea and Kenya. For instance, in Kenya the word poverty was not mentioned in all 44 community-level key informant interviews and the word “poor” was mentioned only in reference to “poor transport network to areas doing” (KN\_ (KII\_01\_9119) FGM/C. In FGDs, when ‘poverty’ was mentioned in one case in Kajuki community in Kenya, it was in reference to the inability of families to afford education, not as a push factor for engagement in FGM/C. The participant in a FGD said there was a need to “empower the community because most of these families are languishing in poverty [and] educating the children is never a priority when food and other basic needs are not available” (KN\_FGD\_Kajuki\_-12-12-2022). In Guinea, the word “poverty” came up 15 times in the community-level interviews, with one case indicating that the existence of “practices FGM [is] because of the poverty of the excising women of the community” (GN\_KII\_02\_1862). Another cited “...customary weight and poverty” (GN\_KII\_02\_0564) as a cause of the practice.

Despite these references to poverty as a causal factor, there is, however, a dearth of strong empirical evidence to establish poverty as a driver for the existence or persistence of FGM/C practice. On the contrary, available empirical evidence suggests that FGM/C is neither provided in only poor communities nor is it patronized by only the poor. The practice takes place in a wide range of socio-economic settings, ranging from advanced countries to lower-middle income and low-income countries alike. Morhason-Bello et. al., (2020)<sup>7</sup> have amply demonstrated that FGM/C is neither the practice for the poor nor any longer exclusively restricted to low-income countries. They have demonstrated statistically that the demand for medicalized FGM/C services, for instance, “...increased with the wealth status of the household of the woman, with 29%, 45%- and 75%-times higher odds in the middle, richer and richest household wealth quintiles, respectively than those from the poorest households”. Given the *p*-values of < 0.05 in their study, such findings cannot be wished away as accidental.

This study confirms the practice and patronage of FGM/C services are not the preserve of the poor. For instance, in Guinea, where the practice of FGM/C is nearly universal, its patronage cuts across all socio-economic strata. In Kenya, the most prominent advocates for the maintenance of practice are not poor, uneducated, rural women who practice FGM/C as their source of livelihood. The demand for the service comes from persons of different social strata, including those living abroad. Elsewhere, Akindola and Abiola (2019) also found no conclusive evidence that socioeconomic differentials such as poverty are push factors for the persistence of the practice of FGM/C in Nigeria. Similarly, Batyra et. al. (2020) buttresses this view with their findings that socio-economic differences have little to do with the prevalence of and support for FGM/C practices. On the contrary, they ask FGM/C change agencies “...to realize that different communities practice FGM/C in different social contexts, and that each context presents specific challenges for reformers” (Batyra et. al, 2020, p. 13). The socio-economic status of individual women is not also a determinant of their acceptance or otherwise of FGM/C practice as some “...women with some education (or living in urban areas) can have higher average prevalence rates” (Batyra et. al, 2020, p. 13). UNICEF also unequivocally states that in Guinea, for instance, the practice of FGM/C is universal, cutting across all socio-economic strata (UNICEF, 2014).

In sum, the wide distribution of the practice in both urban and rural areas; patronage of the services across different socioeconomic strata (the poor and the rich, the educated and uneducated, different cultures); the increase in cross-border FGM/C service access circumvent national bans on the practice; the patronage of the service by diaspora communities; and the increasing medicalization of the service as a means to professionalize and justify the provision of the services, all point to other factors, not poverty, as the push factor for the persistence of the practice of FGM/C. Cultural beliefs and values, not poverty, are the major drivers for the demand and supply of FGM/C services. While the deterrent and punishment effects of policies and legislation do impose or increase costs on the provision and access to the FGM/C services (i.e., it is more

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<sup>7</sup> Guinea and Kenya were among the 13 countries included in this study.

expensive to access services clandestinely locally or across frontiers and medicalization increases costs), the fact that demand for the services persists shows the policy and legal routes to imposing economic costs are not deterrent enough. Only changes in the cultural beliefs and views systems can lead to downward changes in demand to end the practice. This buttresses the recommendation of Morhason-Bello et. al., (2020) to agencies seeking to end the practice to pursue "... a culturally sensitive policy that will discourage perpetuation of FGM" while proposing that future studies delve more into "...identifying drivers of FGM among the high social class families in the society in SSA." (Morhason-Bello, 2020, p. 1).

### 2.1.5 Socio-cultural Context

#### a) *Different Locales, Different FGM/C Practices*

Participants reported different determinants of the nature, type, prevalence, and intensity of FGM/C practices in the study communities. In Guinea and Kenya, the age at which FGM/C is applied varies from as low as five years into adulthood (UNICEF, 2014). The criminalization of the practice further broadens the range of ages at which the practice is inflicted, as communities seek to hide the practice from the law. The type of cutting, as well as the intensity of practice also vary according to religion, ethnicity, and geography. For instance, while type 1 and type 2 are the most common in Kenya, type 3 is practiced mainly in communities along the border with Somalia (US Department of State, 2009). In Guinea, all types 1, type 2, and type 3 are practiced in various degrees around the country without distinction between ethnicity, religion, and location. Some families are now opting for type 4, which is a symbolic incision (US Department of State, 2009). A distinction is also made between the traditional methods of practice and medicalized FGM/C practices performed by medical professionals such as doctors, nurses, midwives, or other health professionals) in both Guinea and Kenya. As an Officer of the National Anti-FGM Board in Kenya observed, there are "emerging trends in the practice of FGM, medicalization of FGM where medical practitioners are now engaged in FGM and becoming a major issue in all over the country" (KN\_KII\_03). Even as far back as 2014, as much as 15% of cases were handled by professionals (KNBS, 'Kenya DHS 2014' (Table 18.7), December 2015).

Asked what they think about the practice of FGM/C in their communities, FGD participants in both countries acknowledged they had conflicted views on the subject. In Kenya, FGD participants shared that:

- "There's a mixed feeling among us because some of us and other women have undergone the same. Though this FGM/C is losing its meaning in the urban setting, it's still widespread and practiced secretly in the remote areas of the county because it's still valued as a tradition and a practice" (KN\_FGD\_Kathwana/Kajiambao Village, 2022-12-17).
- "Some of us feel that it's important that the community members are given the opportunity to either chose to cut or not to cut because it is what our fore elders did for a very long time, and we appreciate the culture because it helps our girls to complete school for instance without being so sexually active and be disrupted" (KN\_FGD\_Kathwana/Kajiambao Village, 2022-12-17).
- "On the contrary, the majority also perceive that this practice is outdated, and it needs to be undone. It's very harmful to our young girls"(KN\_FGD\_Kathwana/Kajiambao Village, 2022-12-17)
- "From the multiple sources of information received, we think this practice is harmful [to] circumcised, women, young girls" (GN\_FGD\_3418\_Gbanakoly, 17-12-11\_.
- "It is not good at all, but the community practices it" (GN\_FGD\_2475\_Mohomou, 18-12-11.
- It has no advantage for the person experiencing it" (GN\_FGD\_4094\_Pela, 18-12-11)

The figures from Table 4 confirm the ambivalence in community perceptions about the importance of FGM/C practice in both Guinea and Kenya. The findings in the table show the perceived importance of the practice of FGM/C in targeted districts of Kenya and Guinea. Half of the respondents, constituting 48.9% (129/264 respondents) consider the practice of FGM/C unimportant to the customs and traditions of their society. Disaggregated by country, however, while 43.7% of Guinean respondents considered the practice unimportant to their customs and traditions, Kenya had 55.8% of respondents who said the practice is unimportant. Critically, however, 29.6% (88/264) of respondents across both countries said the practice was either very important or important practice for their customs and traditions. The rest of the respondents are uncertain of its importance (9.8%) or do not know(11.7%).

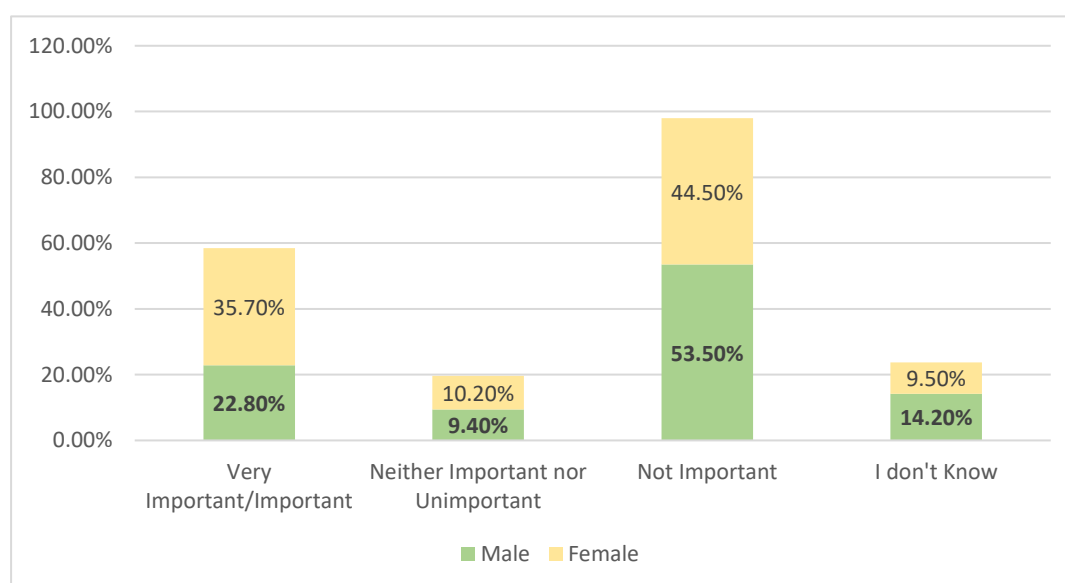
**Table 4 Percentage Distribution of Perceived Importance of FGM/C by Country of Study and by Gender**

Country of Study Level of Important	Guinea		Kenya	
	Male	Female	Male	Female
Very Important/Important	25.4	34.3	19.5	37.7
Neither Important nor Unimportant	8	11.8	11.5	8.2
Not Important	46.7	40.8	63.5	49.2
I don't Know	20	13.3	5.8	4.9

The Chi-Square test value of .017 (see Table 1, Appendix 4), however, shows this result is significant. In other words, the finding that close to 30% of respondents in both countries still find the practice of FGM/C to be important to their customs and traditions is not accidental. There must be driving factors that sustain this perception.

Disaggregated by gender, figure 1 below indicates that 35.7% of female respondents said FGM/C is very important or important to their customs and traditions while only 22.8% of males said the practice was important to their way of life. While 53.5% of male respondents across the two countries indicated that FGM/C was not important, only 27.7% of female respondents could say the same thing. The findings are, however, not significantly important, given the average Chi-Square value of 6360 with a two-sided significance of 0.174 for the two countries.

**Figure 1: Perception of Importance of FGM/C by Gender**



*b) Factors Constraining the Abolishing FGM/C*

Participants in the FGD and KIIs provide perspectives to explain the persistence of the practice of FGM/C, despite its dwindling popularity in both Guinea and Kenya, as indicated in the levels of perceived importance of the practice in both countries above. Apart from the attachment to cultural and religious values, participants noted that the eradication of the practice is being hampered by the approaches of some of the interventions that seek its abolition. An example cited is the double-barrel messaging that often occurs in advocacy campaigns for FGM/C eradication where health, education, and human rights issues are often comingled with issues of sex education. As a participant in one FGD summed it up:

“Yes, FGM is not good at all. It should be abolished however the government should not use its power to harass people. FGM should be abolished, however, a mechanism to pass good virtues to girls should be developed because it is important as they transition to adulthood. We have players in this town who have girl’s programs, but they teach girls about sex which we think teaching pre-teen sex is not the right thing to do. I wish they would focus on good moral values and not just sex education and academics” (KN\_FGD\_Kajuki Elders; Kajuki Community, 2022-12-12).

Participants associate the sex education components with increasing teenage pregnancies, single parenthood, and the abandoning of children to the care of the elderly. As one participant noted: “Initially they [young girls] used to focus on their education and becoming great people in the society but nowadays they are into early sexual behaviour and leave us with the kids and travel to other towns like Nairobi ”(KN\_FGD\_Kajuki Elders, Kajuki Community, 2022-12-12)

Participants in this study also noted that although the practice of FGM/C is waning in importance, it persists in some communities for several reasons. In Kenya, participants in FGD said that:

"FGM/C is losing its original meaning nowadays but it’s still taking place in a majority of the villages in Tharaka Nithi. FGM/C is important to the community as envisaged in the communal traditions and beliefs. It is assumed that when women and girls are cut then they will not be able to be sexually active and therefore this will reduce their sexual hunger and definitely we have women and wives who are faithful to the community. It’s also a way in which most women and girls see it as a rite of passage from being a girl to a woman and ready for marriage. It is assumed that when women are cut then they become clean as opposed to women who are uncut seem to be dirty" (KN\_FGD\_Kathwana/Kajiambao Village, 2022-12-17).

Participants in another FGD in Guinea agreed that the practice of FGM/C has lost its initial significance as an initiation or educational process that allowed young girls to graduate into womanhood. Today, they pointed out, it has no importance except for the service providers (GN\_FGD\_Gbanakoly, 2022-12-16). Participants in Mohomou community added that the practice of FGM/C today serves only as a source of income for the practitioners (GN\_FGD\_Mohomou, 2022-12-15).

The social pressures that sustained the practice of FGM/C, despite the awareness of its health hazards, included the perceived social cost of being uncut. As one group of women noted, “Women who have not undergone the cut have faced serious stigmatization especially when the family is pro-FGM/C. Women have mimicked the women who are uncut and have even caused husbands to reject such wives in the community. Women who are uncut have on the flip side [have] been able to maintain their husbands because of sexual activeness" (KN\_FGD\_Kathwana/Kajiambao Village, 2022-12-17).

The prevalence of the practice due to social reasons is further buttressed when respondents were asked to select all the possible reasons that made the practice of FGM/C important in their communities. Overall, cultural beliefs were selected 215 times representing 44.70% of all total selections – Table 5. Respondents also selected “social reasons” in 10.81% (52/481) of cases. In other words, in 55.5% of cases, sociocultural factors account for the persistence of the practice of FGM/C in the respondents’ communities. It is only in 16.42% i.e. 79/481) of cases that respondents said the persistence of the practice of FGM/C is because it represents a “source of income for circumcisers.” This is insightful because it downplays the instances where circumcisers who financially benefit from the activity either as the main or supplementary income source are perceived as the push agents for the sustenance of the practice.

**Table 5: Respondents' Multiple Choice of Factors That Make The Practice Of FGM/C Important for Your Community**

Factors Mentioned	Frequency	Valid Percent
Cultural Beliefs	215	44.70
Religious	31	6.44
Social Reasons	52	10.81
Sources of Income for Circumcisers	79	16.42
Inhibiting women's sexual feeling	48	9.98
Peer pressure	48	9.98
Other	8	1.66
Total	481	100.00

Table 6 below disaggregates the responses to the question by county of study and by gender. It shows that more than 70% of both male and female respondents in the two study countries cited cultural beliefs as the main reason for the prevalence and sustenance of the practice of FGM/C in their respective communities. Beyond the consensus on culture as a push factor for FGM/C practice, the opinion of respondents varied on what factors make the practice of FGM/C important in their respective communities. While 48.0% of men in Guinea said FGM/C practice is important because it is a source of income for the circumcisers, only 19.2% of their counterparts in Kenya agreed with that conception; and only 32.9% of female respondents in Guinea and 13.1% of their counterparts in Kenya said FGM/C practice in their communities is important because it is a source of income for the circumcisers. Male respondents in Kenya saw the inhibitive effect of FGM/C on the sexual feelings of women (34.6% of mention by Kenyan males) and peer pressure (36.5% mention) as important factors sustaining the practice in their respective communities. Less than 5% of women respondents in Kenya (3.3%) agreed with the sexual inhibition view. However, more women respondents in Kenya (21.3%) said peer pressure is of major importance for the sustenance of the practice in their communities. Details for each category are available in Appendix 5.

**Table 6: Summary Responses to question by Gender and Country of Study:  
What are the things that make the practice of FGM/C important for your community?**

Country of Study	Guinea		Kenya		Overall Total	
	Male	Female	Male	Female	Male	Female
Gender of Respondents/ Factors Mentioned						
Cultural Beliefs	73.3	77.6	84.6	93.4	78.0	84.7
Religious	17.3	17.1	3.8	4.9	11.8	11.7
Social Reasons	34.7	25.0	11.5	1.6	25.2	14.6
Sources of Income for Circumcisers	48.0	32.9	19.2	13.1	36.2	24.1
Inhibiting women's sexual feeling	22.7	14.5	34.6	3.3	27.6	9.5
Peer pressure	12.0	9.2	36.5	21.3	22.0	14.6
Other	5.3	3.9	1.9	0.0	3.9	2.2

c) *Sustaining Forces of FGM/C*

The conflicting perspectives community-level participants in the study have shared point to the fact that it would take more than the translation of conventions and protocols into policies laws, rules, and regulations, and the application of sanctions to end the practice of FGM/C in both Guinea and Kenya. In particular, initiatives that criminalize rather than encourage adherents of FGM/C practice will not only drive the practice underground, as participants have stated; their antagonistic nature can only breed intransigent positions among believers and practitioners of FGM/C. Change has to come from within, not without. Accordingly, local leaders must be in the lead in the search for pathways of change, all forms of support for eradicating the practice must support, not lead them. Otherwise, campaigns led from the outside (i.e. not designed and initiated by community members and/or from the top (i.e. by state and supra-state level actors will be seen

as a challenge to the cultural beliefs and identity of the communities and lead to reactions that, as witnessed before “...ultimately prevented the effectiveness of top-down approaches in changing the minds of communities who practice FGC” (Knox, 2021; also see Shell-Duncan and Hernlund 2000; see Breitung 1996).

The need for policymakers and implementers to use non-adversarial or confrontational approaches to promoting the end of FGM/C is evidenced by the critical challenge that some respondents voiced in the course of this study. As part of the process for seeking informed consent for participation in the survey, respondents were asked if they had any questions regarding the study before they participated. Of the 34 out of 151 survey participants who asked questions, fifteen (15) of them questioned the motives of Plan and other agencies for meddling with their customs and traditions in seeking to end FGM/C. Thirteen of the 15 respondents were under the age of 50 - See Appendix 6 for their questions. While the female questioners (8/15) were between 28-46 years old, the male questioners (7/15) ranged from 33 to 76 years. In other words, most of the questioners were younger females – a factor that illustrates the power of socialization in sustaining buy-ins and support for the perpetuation of the practice. The findings in this study are consistent with findings from other studies that confirm that “Girls and women are more likely to support the continuation of the practice than boys and men” (UNICEF, 2014, p. 3). In another study, 74% of girls and women aged 15 to 49 years in Guinea indicated that they were willing to adhere to the practice of FGM/C in Guinea, compared to 21% of the same-age cohort of study respondents in Kenya (UNICEF, 2013).

The foregoing indicates the problem of FGM/C persists in the social realm, more than in the political. Therefore, there is a need to focus on issues that attract the interests of both women and men, rather than pitch one gender category against the other. It is essential, therefore, not to over-problematize the issue of FGM/C by loading the analysis with multiple dimensions that, though pertinent, would alienate one category of gender. For instance, a focus on FGM/C as an issue that affects only women risks alienating men or generating blame for which one takes responsibility. As one KII\_03 respondent pointed out the fight against FGM/C requires the “engagement of men both young and elderly who are custodians of culture” (Officer, Tharaka Nithi Anti-FGM Board). Also, see Text Box 5. Instead, problem analysis and the search for solutions should emphasize issues of common interests to both genders. For instance, an emphasis on the consequences of FGM/C on the physical and psychosocial health of women and relationships between men and women in marital relationships might help encourage greater dialogue between men and women on finding solutions to the problem.

**Textbox 5**  
**The Blame Game**

Men blame women, women blame men and then they all blame culture and religion and justify the practice on the basis of its functionalism and control of female sexuality. KN\_KII\_03\_Prof, University of Nairobi.

On the contrary, while “...strengthening the human rights of girls and women to life, equality, freedom from discrimination, education and welfare and promotes their social, societal, political and economic participation” (GIZ 2020, n.p) is valid and important to pursue an emphasis on these issues, leads to reliance on legal and punitive ways of preventing FGM/C in communities that find value in it, would not only breed alienation and resistance; it will drive the practice underground and, therefore, make it harder to eliminate, as has been amply demonstrated in this study. As one macro-level respondent noted, extensive use of force and the law has failed terribly” (KN\_KII\_03\_Prof, University of Nairobi) to curb the practice of FGM/C. Similarly, building on Wade (2011), Knox (2021) points out that the focus on human rights, equality and emancipation of women, [and] freedom from discrimination among others rather on human interests dimensions of FGM/C such as improving the health and well-being of women, promoting healthier marital relationships between men and women, recognizing, valuing, and providing alternative pathways for preserving traditional education and rites of passage celebrations evokes a Western ‘anti-FGM’ campaigning discourse [that] has at times strengthened the resolve of communities to continue cutting” (p. 2).

Against this background, some respondents believed that the practice of FGM/C will end someday but on its terms. They “...feel that communities had significant reasons to keep these cultures and so this shouldn’t be stopped but rather people should be educated and be allowed to make choices if whether they want to practice it or not” (KN\_FGD\_Kathwana/Kajiambao Village, 2022-12-17). Interventions must pursue engagement from the demand side beyond hoping that the legislation and punitive measures can dissuade people from demanding the services. Hence, rather than use aggressive approaches to compel compliance

and abandonment of the practice, community engagement is necessary to secure compliance with the laws. As one respondent put it: “you need a friendly face to talk to the affected communities; the judiciary officers like the court clerks and probation officers should engage with communities and teach the communities on laws and policies implemented by the government on chief barazas” (KN\_KII\_02\_9147).

### **Macro-level Capacity Analysis**

**Lack of Capacity for Rule and Law Enforcement:** The AU, ECOWAS, and EAC may champion the framing and promulgation of laws and policies that create the enabling environment for championing the eradication of FGM/C. However, they lack the legal and administrative capacities to enforce their own rules on member states. Article 4g of the Constitutive Act of the African Union, for instance, clearly states the principle of “...non-interference by any Member State in the internal affairs of another. Article 23 of the Act prescribes sanctions for member states that fail to comply with decisions of the AU. However, as Maluwa, clarifies in respect of the enforcement of international treaties, “...the AU lacks the power to compel member states to ratify, domesticate and comply with treaty provisions [because] the decision to ratify treaties ultimately remains within the sovereign purview of individual states” (Maluwa, 2012,p.35). Additionally, its capacity to monitor post-ratification compliance with treaties by member states is limit to “the three treaties with treaty bodies: the Child Charter, the Convention on Corruption and the Human and Peoples’ Rights Charter” (Maluwa, 2012, p. 35). Even then, the inability of the AU’s Commission on the African Charter for Human and Peoples Rights (ACHPR) to deliver on its mandate despite the many human rights issues in member states to enforce “...compliance with their treaty obligations and the ACHPR’s recommendations, clearly reveals the limitations of the AU’s power and capacity to compel compliance” (Maluwa, 2012, p. 35).

ECOWAS and the EAC fail similar limitations in their legal and operational setups. This is why when Mali failed to enact national laws and other legal frameworks to regulate the practice of FGM/C, ECOWAS was powerless in compelling Mali to comply with the regional protocols, neither through sanctions nor legal enforcement. It took a coalition of civil society actors to institute legal action to compel Mali to meet its commitments to the international treaties it signed on its own in association with ECOWAS or the AU. . In principle a decision in favor of the Civil Society Coalition that successfully compels the Government of Mali to domesticate national laws to ban the practice of FGM will set a precedent for the application of the decision in other countries that show resistance in banning FGM. In practice, however, there is no guarantee Mali can be compelled to implement a decision of the ECOWAS court in favor of the applicants (i.e., the Civil Society alliance), since member states reserve the power to enforce the judgment. For instance, as of March 2022, only 30% of the decisions of the ECOWAS Court had been implemented in member states. This emphasizes the powerlessness of continental and regional bodies such as the AU, EAC, and ECOWAS to compel member states into compliance with supranational level policies, laws, and decisions without the full cooperation of the member states (Akufo-Addo, 2022).

**Absence/Weak Inter-state Coordination Mechanisms:** To avoid being caught by national laws, both practitioners and clients seek safe spaces of practice across borders of neighboring countries either because the legal regimes and/or supervisory and enforcement services are more lax or the areas of practice are beyond the easy reach of the law from both sides. For instance, the governments of Uganda, Somalia, and Tanzania are unable to pursue, prevent, or prosecute their nationals who cross the border into Kenya to clandestinely seek FGM/C services. As a senior official of the national Anti-FGM Board in Kenya noted “Cross boarder FGM [involves] taking girls from Kenya to neighboring countries like Tanzania, Uganda, Ethiopia for the cut” (KN\_KII\_03\_Nairobi; see also UNFPA and UNICEF, 2022). The practice is, however, a two-way traffic. While “many [Kenyan] girls run to Uganda for the cut [...] many girls from Amudat, Moroto and Sebei region [of Uganda] cross to some areas in Kenya for the cut” (Shanzu, 2022, p. 1).

In the West, Guineans are also able to access services in neighboring Guinea Bissau. While Inter-state coordination and collaboration mechanisms exist to prevent the practice of FGM/C across countries, they are weak and often underfunded. Consequently, national bans on the practice do not effectively discourage access as long as they can access the services beyond the reach of the state.

**Nebulous Legal Frameworks:** In Guinea, the nebulous nature of the legal regime covering transborder access to FGM/C services is the killer of any effort to enforce the law. The Guinean law against FGM/C

does not directly criminalize transborder access to FGM/C services. Criminality is however inferred through other articles in the penal codes which rest on two conditions i.e., that the type of FGM/C practices accessed abroad is punishable by law a) in Guinea and b) in the country where the services are accessed (Plan International, 2021).

**Disconnected Capacity Building Initiatives:** A major challenge toward capacity building for eradicating FGM/C within and across countries is that capacity building efforts are siloed by country, by agency, and by types of intervention objectives pursued by the different intervention sponsors and implementors. Cross-country and cross-agency collaboration and cross-fertilization of ideas, or the leverage of the capacities and intervention platforms of different actors are either very limited or absent altogether. This is because different actors are doing different things, with the potential of double-crossing strategies.

Young (2015) lists six different and noncomplementary approaches to fighting FGM/C such as “cultural absolutism, cultural relativism, health education, feminism, human rights legislation, and psychosocial approaches” (p.5) all of which have proven unsuccessful. While the policy and legal approaches that criminalize and punish apprehended practitioners of FGM/C often pay little attention to the educational aspects of the practice, other Alternative Rite of Passage (ARP) approaches emphasize the education of the girls and the preservation of cultural values “...such as sexuality education, blessings by elders, and keeping girls in schools” (Amref, 2022). On the other hand, Both Amref and Christian approaches aim to avert the cut while equipping the girls with life skills training for their adult life. The ARP approach takes away the cut while retaining important aspects such as sexuality education, blessings by elders, and keeping girls in schools. It preserves and protects the good cultural values of communities. It provides much-needed life skills to the girls while giving them a future. The Christian initiation approaches, on the other hand, offer “many rituals and teachings that replace outdated values, practices and concepts [inherent in] the many traditional rites of passage and their rituals” (Gachiri, 2006, p. 11) In other words, it covers alternate norm formation that aims to normalize non-cutting.

However, the fact that the practice of FGM/C is prevalent despite the existence of the ban, as well as the Amref and Christian approaches such as the existence of a missing link between what the anti-FGM actors offer and what would make practicing communities buy into the idea of abandoning their practice. This highlights the need for service providers to initiate packages that lead practicing communities out of their zones of fear into ones where they see affirmation of what is good in their culture and to feel comfortable with giving up what hurts them, individually or collectively. This calls for further thought in the repackaging of interventions to elicit the response of community actors.

**No Centralized Resource Mobilization and Allocation Mechanisms:** The African Union does not have a centralized resource mobilization and allocation mechanism in support of the fight of its member countries against FGM/C. The AU’s accountability framework for the elimination of harmful practices, including FGM/C relies on member states to mobilize “...domestic resources to provide adequate funding to programmes for ending harmful practices”. However most African countries are juggling numerous, pressing, and competing priorities that tend to push the FGM/C agenda to be back burner. In addition to the destabilizing effects of the Covid19 pandemic and the War in Ukraine on their economies and resources, both Guinea and Kenya have to deal with many internal governance and security challenges that require the retooling of substantial resources to finance them

## ***2.2 Activities of Other Donors***

### ***2.2.1 Current State of Interagency Collaboration on Anti-FGM/C Activities***

The multi-dimensionality of the FGM/C phenomenon as a health, human rights, educational, and socio-economic development issue attracts a plethora of local and international actors who source funding from different donors to invest in an equally wide range of interventions to end the practice in ways that are consistent with their institutional mandates and the angles from which they perceive the issue. Hence, while the WHO and UNFPA see and address the practice FGM/C as a health issue, UNICEF focuses on the implication of the practice from child rights and safety dimensions with an emphasis on its implication for

the education of the girl-child. GIZ and other agencies see and address the FGM/C issue as a human rights issue. Others such as the World Bank prioritize legal training for state actors to develop, enact, and enforce laws that prohibit FGMC (Abrantes and Hélder). Many of the donors fund projects in silos with little to no opportunities for leveraging, layering on, or dovetailing interventions and funding areas to create synergies that optimize resource injections beyond the lifespan of a single project.

In cases where joint programming is attempted, a cocktail of intervention objectives from different agencies may coexist in the same project intervention. For instance, in the UNFPA-UNICEF Joint Programme on Eliminating Female Genital Mutilation: Accelerating Change that covered both Guinea and Kenya, UNFPA's focal objective was to ensure that "Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian setting [through] "Strengthened response to eliminate harmful practices, including child, early and forced marriage, female genital mutilation and son preference", UNICEF focused on its Strategic Plan 2018-2021 Goal 3 which aimed to ensure that "...girls are reached with UNICEF-supported multisectoral at-scale programmes to address harmful practices, namely [female genital mutilation] and child marriage" UNFPA and UNICEF (2017, p.2).

International development planning and implementation agencies such as Plan International and its affiliates serve largely holding and pass-through agencies for funds from multilateral and bilateral donor agencies such as the World Bank, BMZ, and GIZ destined to support specific activities in specified countries that fall within the country and thematic priorities of the donors. Activities are also carried out over specified periods based on the budget cycles and funding capacities of donors. Some projects have follow-on activities to consolidate gains made or right wrongs in previous; others do not. In contexts where funding is sourced from different donors, appropriate tilts in programmatic and locational choices are made to match the priorities of the donors. In the process, the same project may address multiple dimensions of the FGM/C question. For instance, the €5,000,000 funding that Plan International expects to access from BMZ (75% of the total budget) is destined to support women and girls' rights, health, and sexual and reproductive rights interventions in Guinea and Kenya over 36 months covering 2023 -2026 (Plan International, 2022.<sup>8</sup> Others such as the European Union (EU) view FGM/C as a gender issue and so recommend a focus on gender mainstreaming as a prerequisite for empowering women and eliminating all forms of discrimination, including harmful practices such as FGM/C (EU, 2019). In Guinea, the World Bank supported the development of manuals to create awareness of the existence of these sanctions (Banque Mondiale (2022).

No doubt, the FGM/C problem is multifaceted and requires multi-dimensional and multi-sectoral approaches to dealing with it. However, coordination of interventions and resource injections is essential to ensuring relevance, coherence, efficiency, effectiveness, impact and sustainability of the contributions of the different donors. A lack of synergy between different interventions can be counterproductive in the fight against FGM/C. As different participants in this study observed, uncoordinated cocktail approaches to funding FGM/C activities lead to splintered and siloed interventions by FGM/C advocacy coalitions and movements as a result of the limited cooperation, coordination, and collaboration among anti-FGM/C networks. The isolated nature of interventions translates into inadequate leveraging of the capacities and resources of agencies working in the same terrain on FGM/C. The "poor coordination of actors [leads to] lack of sufficient funding" (KN\_KII\_02\_9119) for sustained programming for most intervention agencies. Additionally, the "inadequate funding for the activities that specifically target FGM/C" (KN\_KII\_02\_4273) creates a discontinuity in the FGM/C interventions which creates dissonance, credibility challenges, and even opportunities from "resistance from practicing communities" (KN\_KII\_02\_9119) against the interventions. The limited coordination and continuity in anti-FGM/C interventions also lead members of participating communities to wonder why Plan and other NGOs are always carrying out research and activities on FGM/C issues but no one sees any results (GN\_Survey\_2274)<sup>9</sup> or why such institutions always come to start such

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<sup>8</sup> Reference Plan International (2022) Global FGM Programming Conceptual Note, on background document files provided to consultant.

<sup>9</sup> « Pourquoi êtes-vous chaque fois sur ces mes choses mais jamais on ne voit le résultat ? »

studies but never seem to follow through to the end of the interventions as it should (GN\_Survey\_3101”<sup>10</sup>, as respondents in Guinea’s component of the survey of this research questioned when asked if they had any questions before participating in the survey.

### 2.2.2 *Opportunities and Comparative Advantage for Engagement of Plan and Partners*

The multiplicity of actors, actions, and the apparent lack of effective coordination between them at all levels present Plan International and its partners with a unique opportunity to contribute effectively to the anti-FGM agenda. In the words of one respondent, “there is a lack of commitment and a lack of a coordination framework to harmonize efforts. If there are frameworks, they must be revitalized” (GN\_KII\_02\_9424). In the void of effective coordination of policies and actions at all levels in the anti-FGM space, Plan International’s presence and operations at the macro, meso, and micro-levels position it to be an effective facilitator of spatial and thematic coordination of actors and actions at the continental, regional, and country levels. Plan International’s liaison office at the AU Headquarters provides it access to decision-making centers on anti-FGM activities at the highest level on the continent; and an opportunity to network with other agencies such as Civil Society and Faith-based organizations working on or have potential interests in the anti-FGM agenda who also have representation at the AU level. Plan International also has connections with regional bodies such as EAC and ECOWAS where similar anti-FGM interest groups are present. At the national level, Plan International and its partners have been working in both Guinea and Kenya, and more specifically, on anti-FGM issues in endemic practice communities for a while. Plan and its partners, therefore, have access to local networks that understand the terrain and are willing to work with Plan. The local networks also grant Plan and partners access to insights into the issues that create and sustain resistance to change in the practice of FGM.

The presence of Plan in the macro, meso, and micro-level spaces of decision-making and action; the opportunities to build networks and alliances with other CSO and FBO actors; and the ability to bring community-level voices into decision-making and action at the national, regional, and continental levels through its network of partners from the community to the continental levels create unique opportunities for Plan to bridge the gap in the coordination of policies and actions in the anti-FGM space. Concrete actions suggested for Plan International’s attention at the continental level is the recommendation that Plan International and its partners champion initiatives to “revise the texts [of policies, conventions, and laws] to adapt them to present realities” (GN\_KII\_02\_3823)

At the micro-level, Plan International and its partners have another unique opportunity to influence the substance and direction of anti-FGM/C interventions in the Plan ecosystems within and across countries, as well as, through reaching out with lessons learned to other stakeholders. Plan International and its partners have presence and legitimacy through the many years of development work they have done in the target communities. As one respondent in Guinea noted, Plan International and its partners have had several interventions in the area over the years, which gives it easy access to the communities (GN\_KII\_02\_2469; GN\_KII\_02\_3320; GN\_KII\_02\_2825; GN\_KII\_02\_7582; GN\_KII\_02\_4282, GN\_KII\_02\_1862). Therefore, Plan has an opportunity to champion transformational leadership by leveraging the years of experience and legitimacy it gained in promoting community approaches to galvanize multi-stakeholders to promote anti-FGM/c interventions “centered on respect for the rights of women and girls” (GN\_KII\_02\_5292) without alienating their respective communities.

Study participants in Guinea, for instance, recommended a focus of Plan International’s initiatives on “the policy of involving the community in its project and of funding circumcisers to ensure their autonomy” (GN\_KII\_021625, GN\_KII\_02\_1862). This should include emphasizing “participatory processes that involve everyone” (GN\_KII\_027582; GN\_KII\_02\_4252); and creating opportunities for “the involvement of local actors in the establishment of local policies” (GN\_KII\_02\_3669). In furtherance of this, people, and community-centered approaches, one study participant noted variously that a great “...opportunity that Plan International has is that excision is not at all liked by certain authorities, executives, leaders, spiritual supervisors, parents of families, so they can go through them to achieve their goals”(GN\_KII\_02\_3320).

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<sup>10</sup> « Pourquoi chaque fois les institutions viennent débiter quelques études mais ne termine pas comme il le faut ? »

Hence, Plan and its partners have a chance to identify, mobilize, and build alliances across a broad range of community-level voices of reasons to promote whole-of-community change processes that lead to the ending of the practice of FGM. Plan International and its partners can leverage the willingness and participation of such the groups on the ground to put an end to this practice” (GN\_KII\_02\_2376). It will be especially important to pass interventions through “the old women who do this by promising them a better future when they stop doing this and helping them financially” (GN\_KII\_02\_3320).

Some participants have, however, warned that Plan International and its partners “have little chance of success unless the justice system, the police, and gendarmerie play their part (GN\_KII\_02\_6721). Hence, building bridges and partnerships with state institutions and actors to ensure collaboration and synergy between different actors to make change happen.

## ***2.3 National Sector Priorities***

### ***2.3.1 Guinea National Sector Priorities***

**Legal Framework:** Guinea has signed the Maputo Protocol and CEDAW. Additionally, Guinea has had the 1965 Penal Code prohibiting FGM since that time, even though the country’s constitution does not specifically mention this prohibition. Several provisions of the Guinean constitution and a labyrinth of laws enjoin the State to guarantee the equality of all citizens, respect and protect the rights of citizens and ensure no one is subjected to harmful practices or forms of torture and pain that degrade their dignity, health, or wellbeing. Provisions signal Guinea’s prioritization and commitment to fighting FGM. However, the suspension of Guinea’s constitution following the military takeover in March 2020 effectively puts any protections against FGM/C under the constitution in abeyance, making it difficult for anyone to invoke the constitution as the basis for enforcing any prohibitions against FGM. Even though the interim Prime Minister of the Transitional Government signed two agreements with UNICEF to guarantee the rights of women and girls, including the prohibition of FGM (UNICEF, 2021), such agreements do not replace the need for strong constitutional commitments to the citizens of the country to protect their rights and dignity. The agreement is a bilateral arrangement between the government of Guinea and an international agency, not the citizens of Guinea.

Besides the Constitution, multiple grey areas in Guinea’s sleuth of laws provide murky grounds for holding persons providing or accessing FGM services, whether domestically or across Guinea’s borders, accountable for punishable offenses. The legal regime of the country comprises “...three types of law – customary, religious and statutory – which undermine the respect for women’s rights” (European Union, 2019, pg.). In the competition of which legal regime is applicable in the predominantly illiterate, remote, and rural environments in which most of Guinea’s population live, religious and customary laws<sup>11</sup>are bound to trump statutory and constitutional frameworks on FGM/C practice (UNICEF, 2014). As one respondent noted, because “there is also a high level of illiteracy [it is difficult] to change the cultural beliefs in the society” GN\_KII\_01\_5713; see also GN\_KII\_02\_4847). As another added:

cultural beliefs are very strong in this community and therefore sometimes it's difficult for the community to forego these cultures, Secondly, the enforcement of laws has not been so effective because the resources available are not adequate enough, Lack of accountability mechanisms for government officers charged with enforcement of the law (GN\_KII\_01\_1983).

**Law Compliance and Enforcement:** Even though Guinean Law No. 2016/059/AN (the Criminal Code 2016) specifically prohibits FGM/C, however, carried out, and Articles 405–410 of Law L/2008/011/AN (the Children’s Code 2008) criminalize FGM and other forms of violence against children (Thomson Reuters Foundation and 28 Too Many, 2018), “...they are often poorly applied, meaning that women have no

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<sup>11</sup> Whereas statutory laws are enacted by the state legislatures or by executive instruments and decrees of government and are applicable within large political jurisdictions, customary law are context specific as they are derived from and govern relationships of people within a specific ethnic or religious community. They are not usually codified or written, and their interpretations are subject to wide changes depending on the context. In most countries in Africa, customary law co-exists with statutory law with their applications restricted to the specific ethnic groups from which they emanate.

recourse when their rights are violated” (European Union, 2019, pg.). Third, the existing laws do not specifically criminalize the failure to report incidents of FGM or the practice of cross-border access of FGM” (Thomson Reuters Foundation and 28 Too Many, 2018, p. 2). This inadvertently encourages the hiding of FGM/C practices in communities to accept it.

Respondents in this study indicated awareness of the existence and importance of these constitutional laws for regulating the practice of FGM/C in Guinea. In particular, they cited Articles related to the repression against FGM/C (GN\_KII\_02\_3823); Art 259, which prescribes penalties of 3 months to 2 years and a fine of 500,000 to 2,000,000 GNF and 260 and 261 of the penal code that prescribes aggravated penalties in the event of death of people (GN\_KII\_02\_9424). They also recognize the “existence of provisions in the legal texts (civil code, penal code, reproductive health law), the national strategy on FGM/C, the national gender policy” (GN\_KII\_02\_1131) as well as the “labor code, code of good conduct for civil servants” (GN\_KII\_02\_9047) and the “reproductive health law of 2000” (GN\_KII\_02\_5292). This has contributed to increasing awareness of the law on FGM/C and the consequences of breaching them.

With respect to actions, however, several respondents in Guinea argued that the “Government has not done enough to stop FGM [because] the programs that have been done to stop FGM have not been sustainable enough to curb the practice” (GN\_KII\_01\_5713). As a respondent observed, there is “Laxity in the judiciary system, personally as Senior assistant chief I have no idea the status of the cases I have taken to court” (GN\_KII\_01\_5719). In general, “prosecutions against FGM are rare in Guinea. A few cases have been reported” (Thompson Reuters Foundation, 2018, p. 5). For instance, from 2001 to 2009, “No cases regarding the practice under the law [were] ever [...] brought to trial” (US Department of State, 2009). The few cases that have been brought to the courts were treated leniently with the courts “giving only suspended sentences and/or small fines” (Thompson Reuters Foundation, 2018, p. 5).

**Health Sector:** The Health Sector in Guinea is expected to champion anti-FGM campaigns, providing essential education on the harm that the practice causes to the health and well-being of women. The sector has good penetration and presence throughout the country with different categories of health facilities present at national, regional, district, and community levels. Therefore, health professionals have access to large segments of the population for the diffusion of messages on the harmful effects of FGM/C on girls and women. Article 410 of the Criminal Code 2016 requires that all public and private health facilities report cases of FGM to relevant public authorities (Thompson Reuters Foundation, 2018). Article 13 of Law/010/2000/AN of July 2000 on Reproductive Health in the Republic of Guinea criminalizes all forms of FGM/C in the country. Incidentally, much of the increases in FGM/C cases that Guinea has witnessed in recent times have been performed by “...health professionals (mainly nurses and midwives)[who] cut about 15% of women overall (aged 15–49) and about 30% of girls (aged 0–14)” (Thompson Reuters Foundation, 2018, p. 3). By 2020, “Medicalised FGM was found to be highest in Guinea, where nearly all women had FGM among which a fifth was medicalised” (Morhason-Bello, 2020, p. 7).

Asked what makes it difficult for the state to live up to its commitments to roll out policies, programs, and justice frameworks to conform to its international and national commitments to end FGM/C, a senior national level official interviewed in this study said the FGM/C problem was cultural and recommended the roll-out of “a cultural program in which they should involve the community [through] raising awareness with concrete evidence to touch their sensitivity” (GN\_KII\_03\_2416). However, the complicity of health professionals in legitimizing FGM through its medicalization breeds “the lack of legitimacy of the actors involved in raising awareness” (GN\_KII\_03\_7965). On the other hand, when asked what other actors and institutions could support the fight against FGM/C, respondents in Guinea identified several community-level actors and institutions that would have the legitimacy to play strong roles in the fight against FGM/C. These included the Community or village health committees, Youth platforms, NGO networks, Networks of women, women's groups, the alliance of religious leaders, religious associations, Alliance of Christians, girl leaders, women leaders, traditional leaders, Local radios stations, media, social networks, and even “model families without excision” (GN\_KII\_02\_2022).

**Education Sector:** UNICEF (2014) reports an inverse correlation between the number of years of education of a mother to the likelihood that they would subject their daughters to the cut in Guinea. The tendency to subject daughters aged 0 to 14 years to FGM/C reduced from 48% of mothers with no education to 35% of

mothers with a primary school education, and further down to 28% for mothers with a secondary school education or higher. Similarly, the likelihood that women aged 15 to 49 years would have heard about FGM/C and think the practice should continue reduced from 85% for those who have not been to school to 75% for women in the age cohort who had completed primary school and then to 55% for those who have had secondary school education or higher (UNICEF, 2014).

For this reason, Guinea's offer of compulsory and free education to kids between ages 7 and 13, which covers the first 6 years of primary school education provides a good starting point for institutionalizing an education-based reprogramming of social norms and values that would contribute to ending FGM/C in the country. Unfortunately, Guinea faces hitches with the free, compulsory basic education system. First, urban-rural differentials in coverage exist as "...in practice many rural children never even get this far" (Scholaro database, 2023, p.1). There are also large gender-based differences in the participation rates in the educational system. In 2020, of the 302,477 Guinean children of school-going age who were reported to be out of school, 73.3% (i.e., 221,655/302,477) were girls. This compares to the 80,822 (i.e., 26.6%) boys of school-going age who were reported to be out of school (UNESCO Institute of Statistics, 2020). For girls who manage to go to school, progression rates are also low. In an 18-country study on gender bias in schooling decision-making, Guinea is among the four countries where "the proportion of girls that attend secondary school is significantly lower than the proportion of boys" (Koissy-Kpein, 2015, p. 11)

Participants in this study variously called for the adaptation of Guinea's educational curricula to incorporate education on FGM/C and its harm on women and girls and ensure educational sector actors "teach them in private and public schools" GN\_KII\_02\_5703; also, GN\_KII\_02\_2022; GN\_KII\_02\_5665). Such a move would emulate Burkina Faso, which has successfully integrated anti-FGM/C education into its school curricula.

### **2.3.2 Kenya National Sector Priorities**

**Legal Regime:** Kenya enacted the Prohibition of FGM Act in 2011. In apparent response to the limited achievement of the Act since its passage, former President Uhuru Kenyatta in June 2019 made a public declaration of his firm commitment to put an end to female genital mutilation (FGM) by the year 2022" (UNFPA, 2020, p.1). Pursuant to this, Kenya witnessed substantial progress in the establishment of administrative frameworks and institutional structures, including the Anti-FGM Board and Secretariat, to advance the fight against FGM/C. The State, in collaboration with Development Partners, Research Institutions, and implementers commissioned various studies to increase knowledge on the nature and incidence of FGM/C practice and the challenges confronting its eradication. This has contributed to open evidence-based public discourse across multiple traditional (radio, print media, television) and social media platforms on options for ending FGM/C. As the Saleema Initiative has shown, increased social, community, and public dialogue has contributed to reducing tolerance for FGM/C in many ways among the general population. (Evans et. al, 2019).

In addition to the development of the National Policy For The Eradication Of Female Genital Mutilation, the enactment of the Prohibition of Female Genital Mutilation Act of 2011 and the establishment of the Anti-FGM Board and Secretariat that oversees the implementation of the Act and the National Plan of Action (NPA), and the multi-agency technical committee to accelerate the #EndFGM, several Counties have their policies and plans of action for the eradication of FGM. Within the decentralized levels in the Counties, there is a robust child justice system, with the National Council for Children's Services (NCCS) and the Area Advisory Councils, now known as Children Advisory Committees, being active players in the operations of these systems.

Beyond the Counties, there are various measures and structures at the community-levels to address issues of FGM, which include safe places for survivors; helplines for reporting including the toll-free 116 for children; alternative rites of passage; involvement of gatekeepers in the fight against FGM; guidelines for the adoption of the former President's declaration of the country's commitment to end FGM by 2022; and the establishment and training of anti FGM committees within the hot-spot counties and sub-counties. Various FGM awareness and action campaigns have led to the mobilization of communities in FGM hotspots to act

against the menace. The establishment of the Youth Anti-FGM network in Kajiado; forum with college and university students to end FGM; meetings and strategy planning with communities across the Kenyan and Tanzanian borders; supporting the communities to establish alternative rites of passage; and strengthening roles of local leaders in ending FGM are examples of a few of the efforts being made to stop FGM.

**Law Compliance and Enforcement:** Despite the declaration of commitment at the highest level of government in 2019, and the mobilization to reform legislative and policy measures to prohibit the practice of FGM/C, the practice persists in certain communities; and Kenyans are realizing that statement of priorities do not always translate into actions to that carry them through. This is evidenced by the responses that participants in the study to the question of the level of commitment of Kenya to fulfilling its obligations under international protocols and conventions to end FGM/C that she signed onto.

Asked to what extent their respective countries were compliant with international treaties and commitments their governments signed, one group of respondents from Kenya believed “the government of Kenya has been compliant to the international treaties and commitment to a large extent” (KN\_KII\_02\_8297). Such respondents cited the open declaration of President Kenyatta in 2019 to end FGM/C and the financial support the government has received from partners such as the UN agencies “to ensure [the government can] fund and implement laws and programs to stop FGM” (KN\_KII\_02\_8237). However, 15/78 respondents were categorical that they did not know if the government of Kenya was compliant or not.

Others believed Kenya is compliant with international laws and conventions to a very high extent on paper or “... in terms of being compliant to international law in writing the law [but is compliant] to a very low extent in implementation. The gap is that we have a very poor implementation of the same treaties” (KN\_KII\_02\_5168). As a result, “Kenya is not very compliant with these laws. They should actualize the commitments by an implementation which is not happening” (KN\_KII\_02\_7666). In the view of another respondent, Kenya is “committed in word but not in deeds; we are lagging behind in actualization” of the international protocols and conventions to end FGM/C. Hence, Kenya’s commitment “maybe on media but on the ground, things are different” (KN\_KII\_02\_9267). Respondents, therefore, assessed that overall, Kenya’s “compliance with international law is weak because the laws are written in compliance [with demands of the international community but there is] very limited implementation” (KN\_KII\_02\_5977). In the view of other respondents, Kenya is struggling to comply to treaties that have been signed [due to] the challenge [of] resource allocations for programmes” (KN\_KII\_02\_5314; KN\_KII\_02\_3387).

As a result, despite the enactment of the Prohibition of FGM Act, 2011 and the public declaration of former President Uhuru Kenyatta in June, 2019 of a firm commitment to put an end to female genital mutilation (FGM) by the year 2022” (UNFPA, 2020, p.1), the practice of FGM/C persists to date. This highlights a distinction between making commitments and pursuing priorities. While Kenya may have declared its intent to end FGM/C, it is struggling to achieve that aim because the intent has not been translated into the full range of actions that would make the intent a reality. For instance, between 2019/2020 only 85 cases of FGM/C offenses were brought to the courts for prosecution, and only 41 convictions were recorded, representing a 48% conviction rate (United Kingdom Home Office, 2021). The number of cases brought to the court and the convictions issued pale in comparison to the thousands of cases of girls and women who are cut every year.

**Health Sector:** As with Guinea, the Prohibition of FGM Act, 2011 forbids all forms of FGM/C practices in the country. The health sector has a responsibility for ensuring that the ban is communicated and enforced within and outside of its facilities. However, the health sector scarcely provided information, education, and communication (IEC) materials to inform women of the health hazards of submitting to FGM/C and “few (16%) health facilities and workers explained the negative consequences of FGM/C and the need for stopping it (15.3%). Health facilities also had little to no data on FGM/-related service delivery. Contrary to being the stoppers of FGM/C, health professionals have replaced traditional practitioners that have taken their practice underground, as “medicalized FGM [which] is largely performed by clinical officers, nurses, and midwives. Doctors and other health professionals are also involved in this vice” (UNFPA, 2021, p. 22). It is widely practiced in private clinics as well as in public health facilities, where authorities would tell health professionals working in such places who wish to carry out the practice “Just do it, but if you’re caught, you’re on your own.” (Kimeu, 2022, p.1). Hence, rather than being a facilitator for the stoppage of FGM/C, the health sector

is the facilitator for its continuation. Not surprisingly, community, subnational, and national level participants in this study did not mention the health sector nor its actors as possible agents of change for the stoppage of FGM/C.

**Education Sector in Kenya:** As in Guinea, Kenya’s policies on gender equality in access to education are not translating into practice. In conformity with the national constitution and its commitments to international treaties, Kenya has enacted legislation for the establishment of the National Gender Equality Commission, Kenya National Human Rights and Equality Commission, and instituted the Low-Cost Boarding Schools and Mobile Schools in Arid and Semi-Arid Lands (ASALs), Free Primary Education (FPE) policy, and the Free Day Secondary Education (FDSE) policies. In addition, Kenya has a policy that allows girls to return to school after they drop out due to pregnancies. She also has “...affirmative action in the allocation of bursaries, admission of girls in universities...” (Government of Kenya, 2015, p.1), all in attempts to create even playing fields that foster equal participation of the genders in education. These measures notwithstanding, girls in Kenya’s educational system tend to peter out in their progression from primary school to the secondary school level or higher (Akala, 2019). While the lag of girls in their educational progression is a countrywide challenge, girls in FGM/C practicing communities face a greater risk of being forced to drop out of school, once they have gone through the cut and are considered mature enough to get married (UNFPA, 2019). There is little to no opportunity for them to return to school once they become wives or mothers. Consequently, in some practicing communities, “female genital mutilation has derailed the pursuit of education for many young girls” (UNFPA, 2019, p. 10). Incidentally, the country’s Education and Training Sector Gender Policy has no provisions for addressing the issues of girls whose educational journeys have been cut short by submission to FGM/C and its social and health consequences.

### 2.3.3 Limited Demonstration of Commitment to Resource Allocation

Priorities are underscored by the allocation of resources to achieve them. In 2021, the Government of Kenya announced it would allocate US\$23 million to the fight against GBV in 2022, and work to increase the allocation to US\$50 million by 2026. In particular, it committed to sustain an investment of US\$2.7 million for GBV and FGM in 2021 and incrementally increase that investment to US\$5 million in out years. Additionally, the government would invest US\$1 million annually in GBV research over the period (Equality Now, 2021). For 2021/2022 the government allocated 129 million Kenyan Shillings (Generation Equality Forum and Amref Health Africa, 2022), equivalent to US\$ 1,188,326 as of June 1, 2021<sup>12</sup> for GBV/FGM programming. This was about 44% of the US\$2.7 million promised.

**Textbox 6**  
**Inadequate Resource Allocation for**  
**Anti-FGM/C Activities - Kenya**

“The national polices plans and budgets have not adequately addressed the issue of FGM/C. There’s however the ANTI FGM board which was established but has not significantly been able to address the issues. It’s time for a holistic approach to reevaluate and review the policies and programs around FGM/C and see whether they can lead to the impact that is desired”  
KN\_KII\_02\_1401

In field interviews, the study sought to establish the adequacy and distribution of budgetary allocations for FGM eradication as reflected in the policies and plans of the government at the District/prefecture, County, and national levels of the two countries. In response to the question, respondents noted the gap that exists between declared and enacted political wills. In their view, politicians may not be practicing what they preach. This creates a credibility challenge for constituents. In particular, study participants reiterated the lack of commitment to allocate resources for the implementation of FGM/C interventions to support the view that the governments of Guinea and Kenya are not serious about prioritizing the end of FGM/C practices in the countries. In Kenya, the majority of respondents said they had “no clue”, “no idea” or “don’t know” if/how funding is allocated for anti-FGM/C activities at the national and sub-national levels. Asked whether national or county/district governments have specialized funds that support policies and programs to end FGM/C at their respective levels, the majority (78/78) gave a categorical “no” answer to the question.

<sup>12</sup> June 1, 2021, is used as the reference date for computing the USD equivalent of the KES committed, given the report date of the source document. Computations of rate based on oando.com

Some respondents who were uncertain about funding being budgeted for FGM/C activities believed that budgetary allocations for FGM/C prevention and elimination are incorporated into national plans. However, the allocations are subsumed under the general budget of the ministry responsible for children's affairs, even though that budget in itself is very small (KN\_KII\_02\_9935; KN\_KII\_02\_8297; KN\_KII\_02\_2625). As a result, it appears there are no specific budgets for FGM initiatives (KN\_KII\_02\_5977; KN\_KII\_02\_2212). As a result, the Anti-FGM board that Government established is cash-strapped and "has not significantly been able to address the issues" (KN\_KII\_02\_7714) because "...the Anti-FGM/C Board does not have adequate funds" (KN\_KII\_02\_7666) to operate. The situation is much worse at the subnational level as the small budgetary allocations at the national do not percolate to the county levels. Hence, even though Counties have FGM/C eradication activities incorporated into their "Mid-term Plans, County Integrated Plans, Annual Plans, [and] Budgeting processes" (KN\_KII\_02\_8297), they seldom receive the funding to carry them out.

Others believe that at County levels there are no plans or budgets or policies to tackle FGM/C seriously (KN\_KII\_02\_7666; KN\_KII\_02\_5977; KN\_KII\_02\_3536; KN\_KII\_02\_1423). Hence, FGM/C is not adequately and specific in the county plans addressed (KN\_KII\_02\_2244) either because "FGM/C has not been prioritized by the Government at National and Sub National levels" (KN\_KII\_02\_2244) or because of the usurpation of government duties and responsibilities or the displacement of government funding for FGM/C prevention and eradication by NGOs. As a result, the "Government has a laxity to plan and budget because the NGOs have been supporting these districts" (KN\_KII\_02\_9935). This translates into a lack of urgency to push for legislation that mandates the allocation of resources to the counties (KN\_KII\_02\_2625). Consequently, Counties are yet to customize their policies to incorporate the need to secure funding from government sources to support their programming (KN\_KII\_02\_3536).

In sum, even though in Kenya "there's a will to stop FGM [the level of effort is] not satisfactory; budgetary allocations are very limited; in some counties, the interventions are not happening; No specific medication for FGM survivors" (KN\_KII\_02\_8237). A respondent believes the apparent lack of will to adequately fund FGM/C eradication initiatives is because "Civil Societies have not taken the budgetary advocacy for FGM seriously; plans are at the national level though they need to be reviewed' counties need to step up planning and implementation of FGM initiatives" (KN\_KII\_02\_5977).

In Guinea, 14/62 respondents indicated they were aware that budgetary allocations for FGM/C are made with another 9/62 indicating variously that "We hear about it but I have never experienced facts" (GN\_KII\_02\_8287); "I have no idea about that" (GN\_KII\_02\_) or that even if such allocations are made "these budgets did not arrive at the destination to compensate [actors] for this practice" (GN\_KII\_02\_2367). A significant share of the respondents (24/62) said there is "no annual country budget for this practice" (GN\_KII\_02\_1862) or that they had not heard of such allocations.

### **III. Stakeholder Mapping and Analysis**

#### ***3.1 Identification and Analysis of Stakeholders***

Stakeholder identification and analysis of this study are based on data from documentary reviews and respondents' perspectives from the study. Documentary sources included materials obtained from Plan International and other print and electronically published resources accessed through web searches. Data from the research component came through the use of three questions in the KIIs and FGDs to assess the type, distribution, interests, influence, and potential contribution of stakeholders in the efforts to eliminate FGM/C in the respective geographical spheres of respondents. These included enquiries on

- persons or institutions that respondents believed to have the power and influence to stop or make contributions to the stoppage of the practice of FGM/C in their community or district
- key actors that can make and/or implement policies on FGM/C at the continental and regional levels that Plan International and its partners must involve to ensure the right policies, programs and legislative frameworks are in place to support their work in Guinea and Kenya.
- other groups, networks, or alliances that respondents believed can play important roles at the continental or regional levels to advance the agenda of eliminating the practice of FGM/C.

Based on these sources, this section identifies and maps out the different categories of stakeholders in the FGM/C field at the macro, meso, and micro-levels. Specifically, it identifies the FGM/C interest holders and duty bearers at community, district, national, regional levels, and continental levels and explores their motivations for sustaining or working against the practice. It includes the analysis of the levels of power and influence each stakeholder or duty bearer has over the making and implementation of policies, programs, and rules and regulations that can stop the practice of FGM/C in their respective areas of purview.

Essentially, the stakeholder identification, mapping, and analysis exercise produced a wide range of actors, groups, and institutions at the district, county/provincial, and national levels that Plan and its partners need work to ensure the right policies, programs and legislative frameworks are in place to advance the anti-FGM/C agenda. Appendices 7a to 7c provide an overview of stakeholder identification and analysis. The analysis in 5a lists the different categories of stakeholders, where they are spatially located, the roles they play in the field of FGM/C practice, their interests and the nature and sources of the authority, power, and influence they have to contribute to the advancement of the anti-FGM/C agenda. The impact column putatively rates the expected impact each stakeholder can have on the role of Plan's FGM/C agenda in Guinea and Kenya, while the "other observations" column provides notes to guide the design of engagements in the project.

Appendices 7b and 7c dispense with the column on location since they capture community-level stakeholders in Guinea and Kenya respectively. Instead, two sub-columns that capture potential risks of including or not including the listed stakeholders are included to provide to guide project designers on what to look out for in incorporating interventions to mitigate the identified risks.

### ***3.2 SWOT Analysis of Stakeholders***

The study conducted analyses of the strengths, weaknesses, opportunities, and threats associated with the engagement of the different stakeholders at different levels. Appendix 8a and 8b provide respectively provide overviews of the SWOT for country-level stakeholders for Guinea and Kenya. Where applicable, notes have been included to provide further guidance.

An essential point to note is that some stakeholders are viewed as double-edge swords, individually or as a group. Perceived roles and contributions to Plan's interventions may also differ between the two countries. For instance, while the inclusion of celebrities as key stakeholders with considerable opportunity to shape public opinion on FGM/C in Kenya, there is considerable caution and concern about the role of celebrities in doing the same in Guinea. This is because of the negative image Guinean society attaches to the concept of celebrities. Similarly, youth leaders can work for or against change in the practice of FGM/C. In Guinea, religious leaders carry more weight as a go-to source of guidance than traditional and political leaders, irrespective of the creed of the religious leader. Hence, even though Guinea is a predominantly Muslim country (85%+ of the population is Muslim), Christian pastors are highly respected opinion leaders because they are believed to be more educated and therefore highly intellectual in their engagements on issues. .

These nuances provide an important guide in programming decision-making. In particular they provide caution against homogenizing members of any stakeholder category. Project designers and implementors will have to engage frequently with identified stakeholders to determine their moods and preferences at all times to decide when it is best to engage them in anti-FGM/C activities.

### ***3.3 Capacity Assessment of Stakeholders***

Plan International and its partners have experience and competencies in developing and delivering advocacy initiatives in diverse sectors, including the field of FGM/C. As one respondent observed: "I really don't expect that Plan International will face challenges because they have been here with other almost similar programs before" (KN\_KII\_01\_2814). A colleague echoed that: "I don't see any challenges because Plan has been here, and it enjoys a wide range of acceptance" (KN\_KII\_01\_8103).

Plan International and its partners can leverage their collective experience, expertise, and goodwill from their previous work in the communities for the delivery of their interventions in Guinea and Kenya. They can also build on the foundations that other actors have already established. This includes exploring the possibility of supporting “more sensitization in communities to inform communities that FGM is a violation of human rights” (KN\_KII\_02\_5314). In particular, civil society organizations have ensured continued sensitization and campaigns against FGM. In some places in Kenya, the government has arrested some culprits to serve as deterrence (KN\_KII\_02\_1401). Hence, awareness of the judicial risks of the practice is high in most communities. Building on this preexisting local knowledge to promote the abandonment of the practice of FGM/C will not only be an efficient and effective way to go; the continuity that it brings will contribute to sustaining the initiatives in the participating communities. Leveraging its access to communities, Plan International should consider adopting a community-based approach to design policies and ensure the communities are highly involved in decision-making on FGM issues. [For this to happen] leaders at all levels need to be involved as agents of change (KN\_KII\_02\_8297).

In Guinea, respondents in the KII\_02 component of the study cited different permutations of local, national, and international state and civil society actors acting in the FGM/C space at the district, county or national level that are advocating for policies and budgets to end FGM/C. The different combinations of actors include community level networks comprising “...alliances of women leaders, the network of CSOs for the fight against FGM and the network of Centers for Listening to Advice and Orientation for Young People (CECOJE)” (GN\_KII\_02\_6357). There are also “youth associations [working with] NGOs and national and international institutions” (GN\_KII\_02\_2367). At the national level, the Ministry in charge of women and children; the NGO Forum for Development which constitutes a database of organizations (GN\_KII\_02\_6209; GN\_KII\_02\_8103; GN\_KII\_02\_1689; GN\_KII\_02\_9305); bilateral intergovernmental development partners such as GIZ; , multinational agencies such as “UNFPA, UNICEF, [and others such as] Terres des Hommes, TOSTAN, FGM Coalition, religious leaders, associations of girls, women and young people, modern and traditional communicators” GN\_KII\_02\_5292) are playing various roles at different levels to support the fight against FGM/C– see also Textbox 7. These organizations are involved in “the organization of advocacy sessions, digital campaigns on FGM, the organization of awareness sessions etc.” (GN\_KII\_02\_6357) including “...organizing theater sessions on the harmful effects associated with FGM” (GN\_KII\_02\_2389). Collectively, the NGOs and civil society activists in particular have larger footprints and penetrations as “they go to small villages to raise awareness with t-shirts bearing the image of a knife on which we see the red cross” (GN\_KII\_02\_9425).

**Textbox 7**

**Three Levels of Actors in Guinea**

“Three levels of actors: state level (with the Ministries of Social Action, Justice, judicial police officers, juvenile courts, and the program to fight against FGM/C), the non-state level with medical (CPTAFE), human rights and other (Tostan) NGOs, and at the institutional level with funding development partners (UNICEF, UNFPA, GIZ)”.

GN\_KII\_02\_4180

The broad range of actors and activities in both Guinea and Kenya present a stock of knowledge, experience, and expertise on which Plan International and its partners can graft their interventions to reach scales and depths that, acting alone, they would not be able to reach. However, this stock of prior experience and expertise notwithstanding, the capacity to deliver services for stopping FGM/C goes beyond the ability to mobilize financial, technical, material, human, and other resources. Cultural awareness and competencies, appreciation and incorporation of indigenous knowledge systems and institutions into program design and service delivery, access to and leveraging of local networks, and the ability to use people-centered rather than problem-centered approaches to engagement are key to gaining trust and cooperation for effective and efficient service delivery. Interventions must also fit the local contexts and reality. As noted by a KII\_03 respondent in Kenya FGM/C, “... is

**Textbox 8**

**Exploring Non-Legal Pathways**

“Culturally appropriate approaches and indulging the church and the Sheikhs will yield better outcome. Whether we want to go the Mujwa Catholic Women group way in Meru, or the Alternative Rite of Passageway of the Tasaru in Narok or the education way of the Maasai Educational Trust or the SDA way, what matters is the proper identification of the site of power and what each community believes is the progressive way to cultural change”.

(KN\_KII\_03\_Prof, University of Nairobi)

practiced by different communities for different reasons and blanket solutions, therefore, cannot work” (KN\_KII\_03\_PoP Council). Against this background and based on findings from the study, our capacity assessment focuses on the following:

*Ability to Recognize that the FGM/C Field is Dynamic, not static:* Plan International’s capacity to deliver on its commitments in this project will depend on its ability to appreciate and deal with every changing dynamics of the FGM/C sector. As reported above, the use of the policy and legal routes to ban the practice of FGM/C has not only driven the practice underground and dispersed access through trans-frontier operations, but it has also occasioned the emergence of medicalized FGM/C service providers which, to all intents and purposes, represent more professional commercialization of the service provision sector. Medicalization does not only sustain the provision of FGM/C services, it attempts to legitimize it through the claims of providing access to less harmful services. Providing FGM/C services out of state-recognized health facilities by licensed health service providers represents an attempt to institutionalize and normalize the practice – a process that makes it more difficult to advocate a complete ban. The medicalization process also lends credibility and support to those who argue for the sustenance of the practices based on culture and other norms. The fact that the Kenyan High Court overruled the cultural and traditional justifications for the practice in favor of the health and human rights arguments does not settle the question for those intent in pursuing the practice. Plan International and its partners will have to confront and deal with the reality that as long as there is a demand for the service, providers will find orthodox and unorthodox ways to meet the needs of those who demand the services.

*Recognize that Governments Have Competing Priorities:* Respondents have noted limited access to funds as a major challenge to operationalizing existing laws and policies. In the midst of competing priorities, “the government won’t be easily willing to put specific funds to this [fight against FGM/C] as it is not considered a priority” (KN\_KII\_01\_5713). Plan International may therefore find it tough to convince governments to allocate adequate resources from public funds to support subnational-level initiatives.

*Local Needs Drive Engagement and Acceptance of Change:* Some of the areas that Plan envisages working in are hard to reach, poor, and often confronted with dire survival needs due to agro-climatic changes that destabilize their livelihood systems. In such places the urge to survive takes precedence over anything else. As one respondent noted in the case of one operational area in Kenya “Sometimes Tharaka gets dry, and people are so much into looking for food than going to listen to Plan international intervention. Community members have become money minded and so in many meetings Plan will spend much to reimburse the community” (KN\_KII\_01\_3399). In such circumstances, survival programming for behavior change might require complementary programming that addresses the survival needs of the participants as well. Hence, the adoption of holistic and integrated approaches would be preferable to single-strand approaches. In addition to a focus on the banning of FGM/C through the making and enforcement of laws and regulations, which represents a supply-side approach to addressing the FGM/C challenge, a more holistic approach that incorporates demand-side programming would include interventions that address the cultural, psychosocial, religious, and other needs and factors that push people to want have FGM/C, despite knowing about the health hazards associated with it. Such interventions would aim to change the minds and hearts of those seeking the services rather than seeking to prevent them from accessing a service they cherish through bans. The extent to which can Plan do this all by itself or leverage the resources and capacities of other service providers will determine its success in achieving its primary objective – putting a stop to FGM/C.

*Strong Leadership and Coordination of Efforts is necessary:* Irrespective of their best interventions, most actors in the FGM/C space tend to act in silos. At the same time, the state, which has a wider purview in its interventions, has its own programs and strategies to implement at national and district levels. Respondents in both Guinea and Kenya attributed identified challenges to FGM/C advocacy coalitions and movements such as the resistance and hostility from practitioners, community rejection, inadequate funding and support, limited co-operation, coordination and collaboration among anti-FGM/C networks, as issues directly related to the lack of effective coordination of interventions between actors. In Guinea, for instance, respondents noted that while “the state is implementing programs and strategies [at the national level] NGOs [...] are on the ground [carrying out] training and awareness-raising [that] trained the religious who give their Friday sermons based on discussions with them” (GN\_KII\_02\_4180). However, there is limited coordination of actions between the government and the NGOs, in some instances. This lack of strong leadership and coordination creates

cracks in the spatial and thematic coverage of interventions that pro-FGM/C activists often exploit to perpetuate the practice (GN\_KII\_02\_0701).

In Kenya, respondents similarly noted that “Some of the challenges encountered [in the fight against FGM/C] include poor coordination of activities between different stakeholders (KN\_KII\_02\_4949). This “poor coordination among the coalitions and actors [creates] inconsistencies in the interventions that are executed [consequently] the application of the laws across is not universal [as] different people and groups interpret the law differently” (KN\_KII\_02\_1401; see also KN\_KII\_02\_9119; KN\_KII\_02\_7374). The lack of proper coordination mechanisms leads to a lack of monitoring and evaluation systems and the inability to successfully mobilize and effectively use resources for their programs. This, in part, creates the financial constraints, competition, and conflicts of programming interests between the different actors (KN\_KII\_02\_7374; KN\_KII\_02\_4949; GN\_KII\_02\_3823; GN\_KII\_02\_5625).

## IV. Do No Harm Analysis

### 4.1 General Cautions

*Kenya: Narrative of the Oppressed and Saboteur Strategies:* The practice of FGM/C is rooted more in the sociocultural perceptions, beliefs, values, attitudes, behaviours, and practices of practicing communities than it is grounded in any medical, health, or any other live-enhancing outcomes for the women subjected to it. In most practicing societies, FGM/C is practiced as a “rite of passage or to preserve virginity for marriage” (Republic Of Kenya, 2019a, p.10). Accordingly, women are socially pressured to submit to the cut because “failure to undergo the cut subjects one to ridicule, stigmatization and risks of being ostracized” (AU, 2014). Placing a ban on the practice without finding alternate, harmless processes of socialization and training of young girls is not only the factor driving resistance to change; the success of a complete ban without an alternative could have long- term psychosocial and cultural repercussions that are yet unknown (Ukagba, Des-Obi, and Nwankor, 2010). For communities that view the practice of FGM/C as a graduation point of the educational process, attempts to ban it in its entirety without appreciating the noncut aspect of the process is seen as an attempt to erase their values and beliefs and replace them with those of the orthodox world (Republic of Kenya, 2019a). However, practicing communities have very strong feelings and attachments to the practice because it means more than the cut. For instance, in Guinea, FGM/C is a cherished route to the intergenerational transmission of knowledge and life skills. As respondents in this study noted variously in respect of the importance of FGM/C to their societies, “Since ancient times it was a means of education and protection of children” (GN\_KII\_02\_0564); “For them, this practice is a means of education for the future life of a woman” (GN\_KII\_02\_2389); and “According to practitioners, the importance of this practice for girls is for the education of girls, respect for customs and mores, reduction of sexual desire.” (GN\_KII\_02\_6209).

For both Guinea and Kenya, care must be taken not to replace violence against women with a form of cultural violence against entire communities. For instance, respondents in this study have asserted that girls who refuse the cut are exposed to psychosocial traumas in their communities because they will face stigmatization, they are usually sidelined and mimicked by other girls. They are also “perceived to be smelly” (KN\_KII\_01\_1563; KN\_KII\_01\_8102); or “they are not regarded as women that matter and can give their opinion to elderly, they basically do not get recognized by the elderly” (KN\_KII\_01\_5719). In Guinea, such girls will face “segregation, humiliation, limitation of access to certain community events, health” (GN\_KII\_01\_1301).

#### Textbox 9 Importance of FGM/C to Communities

FGM/C is “Very important. Our parents think it's a social norm that people follow, a duty to elders. The term is not mutilation, if a woman circumcises her daughter, it is a duty to which she complies, but not mutilation. It is practiced in all communities and religions, and it has no borders”

(GN\_KII\_03\_1850\_LCSO)

*Driving a Harmful Practice Underground Could Make It More Harmful:*

The political, legal, and policy efforts to eradicate FGM/C in both Guinea and Kenya have triggered the adaptation of various strategies in practicing communities to circumvent the prohibitions. To avoid visibility, detection, and possible sanctions, some communities have either i) reduced the age at which girls are subjected to the practice from 15-19 years to 5-9 years; ii) use different methods of cutting from Type I to other less conspicuous types of cutting; iii) increased use of traditional, less visible FGM/C service providers; iv) abandonment of public celebration of FGM/C events in favor of private and covert ones; v) use of transborder service providers; and vi) recourse to medical professions for services to professionalize and legitimize the practice under the claim of reducing pain, bleeding, and infections. /as a respondent in Guinea noted, despite the ban on FGM/C, “this practice continues in the community in secret” (GN\_KII\_02\_2367).

**Textbox 10**  
**Changing Ages**

“Emerging trends, they used to do it for marriage but now it’s being done to babies and girls of less than five years just to evade the law.

UNFPA, Officer 1, Nairobi.

**Mitigation Measures:** De-emphasize criminalization, prosecutions, and punitive measures. Instead, encourage open, consultative, and educational approaches that win hearts and minds to stop the demand for FGM/C services.

*Stoking A Cultural War Won’t Help The Cause:*

At least four of the seven adaptation strategies to the ban of FGM/C point to its persistence despite its criminalization, which may be due to more demand-driven phenomena than supply-side factors. It is noted, for instance, that “Kenyans from FGM practicing communities living abroad also return to Kenya to obtain the cut for their female relatives”<sup>13</sup> (Republic of Kenya, 2019b, p. 12). Long held and deeply engrained socio-cultural and religious beliefs, values, and practices drive demand for FGM/C services. For instance, the perceived value of FGM/C practice as the rite of passage from childhood to womanhood or as a deeply significant religious observance for women come with rewards or sanctions that make acceptance or rejection of the practice a critical determinant of belongingness or exclusion; embrasure or ostracization; dignity and respect or stigmatization and outcast for young women. Consequently, despite the preponderance of the evidence of the medical and health risks that women undergoing FGM/C face, some who oppose the abolition of the practice often ground their arguments on perceptions of a cultural impositions that want to force practicing communities to adopt the culture of non-circumcising communities (Republic of Kenya, 2019a, p. 37). This perception of a cultural war between the state and the practicing communities sets a narrative of the oppressed which in turn drives the practice underground rather than creating an open space for frank and genuine dialogue that leads to change that is owned and led by those who subscribe to the practice of FGM/C.

**Textbox 11**  
**Drivers of Demand for FGM/C**

FGM is perpetuated for family pride, prestige, community acceptance, marriageability, and inclusion among other factors. Rejecting FGM has social, cultural, economic, and political consequences including stigmatization and discrimination. FGM is also considered a cultural identifier

Republic of Kenya (2019b, p. 13)

**Mitigation Measures:** Emphasize the health and hygiene implications of FGM/C for women over human rights issues to achieve the end goal of supporting the practices. Create opportunities for local ownership and leadership in the fight against FGM/C to dispel the perception of external imposition and cultural warfare arguments. Also, identify, validate, and build on positive indigenous educational components of the practice without the harmful component of the cut.

*Be careful Not to Drive the Professionalization and Institutionalization of FGM/C:* The emergence of medicalized FGM/C service providers portends a risk of legitimizing rather than delegitimizing the practice through the involvement of medically trained professionals who may have a stronger voice and better access to power to counter the calls for complete ban on the practice. As established in this report, medicalization is emerging strongly because there is demand for FGM/Cs, despite the efforts to ban and penalize offenders. Consequently, unless the demand-side factors that make people seek out FGM/C services are

<sup>13</sup> Unfortunately, because of the clandestine nature of this practice there is currently no data available to establish the magnitude of the diaspora return phenomenon.

comprehensively addressed, both traditional and medicalized FGM/C service providers will offer the services, overtly or covertly, as long as there are people to patronize the services. The involvement of health professionals in advocating for the unbanning of the FGM/C practice or in offering services to clients directly challenges the expert authority of those seeking to ban the practice on health grounds. Plan International, therefore, needs to engage in the fight against FGM/C from a much broader perspective than focusing on the policy and legal advocacy perspectives. It needs to create spaces of dialogue that build a much broader consensus on the subject.

**Mitigation Measures:** Medicalization is a counter-eradication and an economic, not a medical response to the ban on FGM/C. It represents attempts to cash in on the real demands for FGM/C services in the face of suppressed supply due to the fear of prosecution. Medicalization attempts to eliminate only some aspects of the harmful practice – hygiene. Eliminating demand for the services through education and changing perceptions, beliefs, and values will debunk the medicalization argument and eliminate the practice naturally.

#### ***4.2 Potential harm to victims and witnesses***

*Risk of Re-traumatization FGM/C Survivors or Victims:* Plans advocacy efforts may involve engaging persons that have experienced or witnessed the practices as witnesses or spokespersons. Apart from reliving traumatic experiences that are better forgotten, such persons may be subjected to ridicule or other forms of adversarial engagements that deepen their loss and push them into more psycho-traumatic experiences. Where psychosocial support services are not available, participating in the initiatives could create more harm than good.

*Risk of Exposing Whistle blowers to Harm:* Respondents also cited the lack of support for anti-FGM/C champions, especially young girls/women who are ready to denounce/evade the practice (KN\_KII\_02\_9119). Besides being another obstacle to the fight to eliminate the practice of FGM/C, the absence of protection for whistleblowers puts them in harm's way, especially in communities where the practice is tolerated.

## **V. Risk Analysis**

*Political Risks:* The political risks associated with Plan International's envisaged interventions relate largely to the perceived inconsistencies in the political will of leaders to carry through actions needed to facilitate and sustain actions to end the practice of FGM/C. Participants in the study noted, for instance, that there is "Political resistance [to implementing relevant laws]. The politicians are not at all supportive of efforts being made by non-state actors to stop FGM; a good example is when the Kajiado County Anti-FGM Policy was being developed the Members of the County Assembly did not support it. We had to call for the Governor to intervene" (KN\_KII\_02\_3375). This is partly because "many times they don't want to talk openly about FGM" (KN\_KII\_02\_4076) either because of their lack of education on the subject or the electoral risks associated with the issue. They fear the "resistance from practicing community" (KN\_KII\_02\_9119; also KN\_KII\_02\_2244:) will translate into electoral losses, should they champion an agenda against the wishes of their constituents. In the words of another respondent, "some politicians [...] do not want to challenge FGM. They promote FGM so that they cannot be rejected and lose their positions" (KN\_KII\_03\_Plan staff).

As noted earlier in the report, participants also believe that some political leaders are floppy on the issue – they would speak against the practice in public but subject their female relatives to the cut in secret. As one other respondent in Guinea said: "The authorities themselves are part of these FGM in secret" (GN\_KII\_02\_6161). Another in Kenya concluded that: "some politicians like in Tharaka are pro FGM so there could be [source of] resistance" (KN\_KII\_01\_1983). Similar sentiments were expressed in Guinea where a participant noted that "the big challenge [facing the eradication of FGM/C] is the resistance and illiteracy of the population" and the practitioners (GN\_KII\_01\_1325; (GN\_KII\_01\_2629; (GN\_KII\_01\_1998).

Another risk that participants identified relates to the role that NGOs play versus that of the government in the same Anti-FGM/C programming space. There are two dimensions to this. First, there is the risk of

competition for space and influence between nonstate and state actors when NGOs and governments champion similar or even different interventions using different, uncoordinated strategies. As participants observed in the stakeholder risk assessment table, NGOs that are better resourced and are working to deliver services within short time frames tend to adopt aggressive engagement strategies that can alienate other actors. Alternatively, better-resourced NGOs risk usurping the functions and responsibilities of relevant government departments and agencies through displacement in the areas they work in. Government agencies may also tend to relinquish their responsibilities to NGOs. (KN\_KII\_02\_9935; KN\_KII\_02\_2625).

Political corruption and self-centered policy making were also cited as some of the political factors that beset the FGM/C space in both Guinea and Kenya. Corruption was mentioned 14 times in community-level interviews in Kenya. A respondent in Kenya noted, for instance, that several political figures and public sector actors come into the intervention arena with high levels of conflict of interest, (KN\_KII\_02\_7374). Plan International Kenya staff in Kajiado also observed that “Some Government people are the ones who refuse to interview without any sitting allowance”. Other sample statements made on this issue in community-level interviews in Kenya are listed below:

- “The cases are rampant because the corruption of law enforcement agencies is very high [as well as] corruption from the local administration” (KN\_KII\_01\_8102).
- “It is very secretive nowadays and the rampant corruption for those charged with the responsibility of enforcing the law against it” (KN\_KII\_01\_2094)
- Corruption of government officials especially the local leaders and the enforcement agencies (KN\_KII\_01\_2094)
- Corruption among the officers to deal with FGM/C and the practice nowadays is done in a very secretive way” (KN\_KII\_01\_2094)
- “High levels of corruption from local administrators to police to the judiciary. The act is being done at night or in hidden places” (KN\_KII\_01\_8081)
- “Financial constraints and conflict of interest among different actors” (KN\_KII\_02\_7374)

Community, district, and national level participants in Guinea expressed similar sentiments, with one participating noting that one of the great barriers to fighting FGM is “...the corruption done to those circumcised on promises given to them [but not fulfilled, and] also the misappropriation of funds that comes for these circumcised” (GN\_KII\_01\_2566). Textbox 11 captures the sentiments of the other respondents, which highlights the source of the corruption challenge in Guinea. The same can be said of Kenya where, as previously indicated, health professionals subvert the ban on FGMC practice to offer services for a fee, sometimes using public facilities at state ran hospitals.

**Textbox 12**  
**Self-Centered Policymaking**

“The bulk of the challenges is that many of the executives of this country think of their own interests, so wanting to think about helping the government would mean enriching them, you have to know how to sensitize the government to think about the lives of citizens”  
GN\_KII\_7611.

The persistence of corruption constitutes a risk for Plan International’s planned interventions because of the potential of subverting resource mobilization and usage in the fight against FGM/C. Not only will persistent corruption divert and dissipate government-allocated resources, but it would also constitute a major obstacle to enticing donor funding to support the initiatives.

**Socio-economic Risks:** The major social risk associated with efforts to stop FGM is cultural resistance. Societies that practice FGM/C have strong belief systems that root the practice. They have “Strong cultures and it takes time to change the perceptions and behaviors” (KN\_KII\_02\_8237). These cultures come with institutional actors and processes that uphold and defend the values and beliefs of the cultures. Traditional authorities such as chiefs, elders, headsmen and women leaders and religious leaders, including those superintending traditional religious practices hold and interpret the rules that govern society. They are gatekeepers who manage how changes in beliefs, values, and practices can happen. They are the custodians of socialization processes and practices. Under their watch, women are socially pressured to submit to the cut because “failure to undergo the cut subjected one to ridicule, stigmatization and risks of being ostracized” (AU, 2014).

Sustainable changes in the perceptions, attitudes, beliefs, values, and practices governing FGM/C are possible if only these gatekeepers lead the change process. However, interventions that focus on the macro-level run the risk of excluding and alienating such agents of change. This is why a respondent cautioned that it is essential to “Start with the elders to sensitize and push [them] to stop” (KN\_KII\_01\_5518) the practice of FGM/C within their areas of purview. Without their leadership, overt and covert subversion of efforts to stop the practice will persist.

Due to stigmatization and fear of the law, some communities, such as the Massai, have adopted lock-in attitudes that make it difficult for non-indigenes to access their social networks for any FGM engagements. They also breed a “culture of silence in terms of reporting FGM activities” (KN\_KII\_03\_UNFPA),

**Logistics:** accessing some communities that practice FGM can be a challenge, given their remote locations. Road networks are bad, distances long and often lonely, raising security risks, especially in areas with active violent extremist activities. Concerns of “insecurity in the areas where this FGM is practiced” (KN\_KII\_02\_1401) are genuine. Some of the communities are inaccessible; others are very far from Plan’s operational centers in the regions and counties, while others, such as the itinerant herder communities are constantly on the move and difficult to track down.



There is also the challenge with communication due to limited or poor cellphone coverage in some areas. This significantly restricts possible the use of emerging information technologies such as social media platforms for engaging different stakeholder groups in dialogues and discussions that can lead to change. A strength of the Saleema Initiative is its leverage of social media platforms for information dissemination and stakeholder engagements. That success in turn depends on access to reliable cellphone and internet connectivity. Our team experienced this in both Guinea and Kenya when field data collectors could not upload collected data from some locations. They had to wait to get back to cell phone and internet coverage areas.

**Textbox 13**  
**Confronting Logistical Challenges**

“There are 22 FGM hotspot counties in Kenya – probably to expand geographical scope and reach more people [...] We could add more wards in this county but not go to another county. We work in only in 2 out of 5 wards and only one sub county. We can’t cover the entire ward; hard to reach areas like Torosei was removed [from] area of operation in Kajiado” – Group Discussion, Kadijajo

Asked what Plan International should do or seriously think about as it plans to expand the outcomes or scope of its projects to prevent or stop FGM in hotspots in Kenya such as Kajiado, Tharaka Nithi, Tana River and the national levels, field staff of Plan International Kenya in Kajiado shared the logistical challenges that they anticipate in reaching some of the hotspots of FGM/C in Kenya as captured in textbox 12.

**Environmental risks:** Environmental risks are largely related to the social environment in which FGM/C is practiced in both Guinea and Kenya. Strongly held beliefs, strong socialization practices, peer pressure, and the strong desire to respect, protect, and honor traditions in deference to ancestors create the psychosocial environment within which communities that practice FGM/C live. As participants in Kenya noted: “We have a strong culture and traditions especially in the last decade. It’s a practice that is associated with the maturity of women/girls; it’s a practice that was believed to keep homes safer from sexual immorality and break ups. It was also a ceremony to bring people together and [for] socialization” (KN\_KII\_01\_3132). Members of this social environment strongly believe that practicing FGM/C “... is our culture and we cannot abandon it. If we do that, we will be cursed” (KN\_KII\_01\_2255). Accordingly, “the social environment and particularly parents have placed value in this practice and therefore forcing many girls and women compliance to this practice” (KN\_KII\_01\_4470). In return, “The community perceives FGM/C girls and women who are cut are respectful” (KN\_KII\_01\_1301; KN\_KII\_01\_1325). Community-level respondents expressed

similar views, stressing that: “The community perceives FGM/C girls and women who are cut as respectful . It is a cultural tradition that has existed for very many years and widely accepted [as] a rite of passage from childhood to adulthood” (GN\_KII\_01\_5518; also, GN\_KII\_01\_1983; GN\_KII\_01\_5713; and GN\_KII\_01\_8958).

Within this social environment, there is considerable “peer pressure” (KN\_KII\_01\_5414) on girls to conform to the cut. Otherwise, “What they earn are the insults from others who have been in the excision camp; and in relation to the loss if you have a problem you go to a marabout you will not have a favorable follow-up because you're not excised” (GN\_KII\_01\_0036). This pressure that women and girls in practicing communities face to conform to the practice must be understood within the context of the socioeconomic environment as well. In predominantly rural and economically depressed environments, membership in social groups often translates into opportunities for inclusion in economic groups, and by extension, access to economic resources. Government and NGO support for women’s poverty alleviation and income generation activities are usually passed through pre-existing or socially homogenous groups. This makes the need for acceptance, belongingness, and inclusion in groups important routes to accessing development resources. Hence, the exclusion of women from groups on account of the cut can often translate into exclusion from social and even political spaces and opportunities. In the case of their later, the voices and views of excluded women will not be heard in decision-making processes. Respondents in Guinea captured the political and economic exclusion of uncircumcised women aptly: “They are marginalized and do not participate in decision-making” (GN\_KII\_01\_7982) or considered “...not socialized and we forget them in the community” (GN\_KII\_01\_3793).

**Specific Stakeholder Associated Risks:** The study explored the risks associated with Plan’s envisaged initiatives to advocate for the stoppage of FMG/C in the targeted districts. It explored the nature of the risks and sources of the risks; who is at risk; and why identified risks are important. Since the potential risks arise from the mix of actors and agencies engaged in the FGM/C arena at different levels, the assessment of the risks was directly matched with the different stakeholders identified in the study. Accordingly, columns 7 and 8 of Appendices 5b and 5c detail some of the risks associated with the inclusion or non-inclusion of different stakeholders in Plan’s initiatives. Appendix 9 expands on this to provide a more holistic overview of potential risks that the project can encounter.

**Increased Risks From Underground FGM/C Service Access:** The study has already identified and discussed the risk of driving the practice of FGM/C underground with attendant higher risks of harmful effects as service providers cash in on persisting demand for the services that can only be provided in obscurity or procured across other frontiers. Banning the practice does not remove the social pressures for girls to undergo FGM. Girls forced to access such services clandestinely may fall into the hands of charlatan service providers seeking to cash in on the suppressed demands for the services. Such girls may find themselves facing exposure to more harmful services than would otherwise have been provided by experienced or trained hands.

**Risk of Entrenching Ignorance and Deepening Alienation:** Respondents in this study have already indicated that part of the challenges for stimulating the acceptance of change in the practice of FGM/C lies in how the “lack of awareness” (KN\_KII\_02\_2625) or “ignorance of the law plays a major part” (KN\_KII\_02\_4949) in non-conformity with the law. This, in part, is due to the delivery approaches of behavior change messages because “...the manner in which the regulatory framework is delivered is not result-based or oriented [and limits] inclusivity of other actors in the process of FGM” (KN\_KII\_02\_1862). Part of that is the technical nature of jargons used in the framing, presentation, and interpretation of the policies, laws, and regulatory frameworks on the ban of the practice. This is further complicated by the “differentiated interpretations of the same law” (KN\_KII\_02\_0302).

**Textbox 14**  
**Inaccessible Language of FGM/C Policies**

“Technicality of the law and policies makes it difficult for people to understand and follow [due to] high rates of illiteracy [plus] differentiated interpretations of the same law. Voluminous law. They are not simplified or abridged KN\_KII\_02\_2244

**Risk of Entrenching Impunity:** Another obstacle to behavior and practice change is the absence or non-deterrent nature of sanctions applied to persons who violate the laws or policies. However, respondents believed that the “unwillingness by law enforcement to enforce” [the law] (KN\_KII\_02\_4949) or the “lenient punishment to offenders (KN\_KII\_02\_9119) are not deterrent enough to discourage the practice. The non-deterrent application of the laws is either because of the “lack of political good will” (KN\_KII\_02\_4949) or “law enforcers lack logistical support to respond and bring perpetrators to book” (KN\_KII\_02\_2625). Plan International and its partners have no mandate to enforce the law. However, at the macro level Plan International and partners will bring together high level multi-stakeholders to identify and share ideas on how to bridge implementation gaps and law enforcement. It will also support community members who see that infractions of the law are not punished may abandon attempts to reform and follow the law.

**High rate of civic distrust can hamper community uptake of policies and regulations:** Community-level policy uptake is essential for the success of Plan International’s macro and meso-level policy engagement and advocacy efforts. The practice of FGM/C will only end when community members buy into, respect, and comply with the policy and legal outcomes of Plan’s intervention. Respondents have already signaled the disconnect between existing policies, laws, and regulatory frameworks and the attitudes, behaviors, and practices of FGM/C at the community-levels. Community members’ acceptance and compliance with rules, regulations, policies, and other regulatory injunctions from the national, regional, and continental levels will depend greatly on the degree of respect, confidence, and credibility they accord to different stakeholders and duty-bearers vested with formal or informal authority and responsibilities to stop the practice of FGM/C.

To ascertain the level of civic trust respondents had in the ability of different actors to contribute to the stoppage of the FGM/C practice in their respective communities, respondents were asked to indicate the extent to which they believed the following categories of persons have the power and influence to stop the practice of FGM/C in their community or district:

- Government Officials at the Municipal/ District Levels
- Government Officials in the Health Sector
- Government Official at the Educational Sector
- Security Agencies such as the police and military
- Traditional Leaders such as chiefs and elders
- Religious Leaders
- Women Leaders
- Youth Leaders
- Community Members who provide FGM/C Services
- Youth of the Community
- Others

Table 7 below presents a summary of the results of Likert scale responses selected by level of agreement or disagreement. The results show that while more than 60% of respondents in Guinea consistently had a higher level of confidence in all the categories of stakeholders and duty bearers listed to be able to influence the elimination of FGM/C in their communities or countries, not more than 38.3% of respondents from Kenya had similarly high levels of confidence and trust in the same categories of people to make any impactful change in the practice of FGM/C in their communities or country.

**Table 7 Percentage of Respondents with High Levels of Trust in Stakeholders to stop FGM/**

Stakeholder/Duty bearer	Level of Agreement	Guinea		Kenya	
		Male	Female	Male	Female
Government Officials at the Municipal/ District Levels	To a Very Large Extent, To a Large Extent	84.0%	72.4%	61.5%	36.1%
	Some extent, low extent, very low extent, I don't know	16.0%	27.6%	38.5%	63.9%
Government Officials in the Health Sector	To a Very Large Extent, To a Large Extent	88.0%	71.1%	48.1%	36.0%
	Some extent, low extent, very low extent, I don't know	12.0%	28.9%	51.9%	64.0%
Government Official at the Educational Sector	To a Very Large Extent, To a Large Extent	84.0%	61.8%	42.3%	37.8%
	Some extent, low extent, very low extent, I don't know	16.0%	38.2%	57.7%	62.2%
Security Agencies such as the police and military	To a Very Large Extent, To a Large Extent	74.7%	61.9%	50.0%	32.8%
	Some extent, low extent, very low extent, I don't know	25.3%	38.1%	50.0%	67.2%
Traditional Leaders such as chiefs and elders	To a Very Large Extent, To a Large Extent	68.0%	57.9%	50.0%	49.2%
	Some extent, low extent, very low extent, I don't know	32.0%	42.1%	50.0%	50.8%
Religious Leaders	To a Very Large Extent, To a Large Extent	80.0%	69.7%	55.8%	67.2%
	Some extent, low extent, very low extent, I don't know	20.0%	30.3%	44.2%	32.8%
Women Leaders	To a Very Large Extent, To a Large Extent	77.3%	73.6%	34.6%	57.4%
	Some extent, low extent, very low extent, I don't know	22.7%	26.4%	65.4%	42.6%
Youth Leaders	To a Very Large Extent, To a Large Extent	72.0%	59.2%	25.0%	27.9%
	Some extent, low extent, very low extent, I don't know	28.0%	40.8%	75.0%	72.1%
Community Members who provide FGM/C Services	To a Very Large Extent, To a Large Extent	74.7%	60.6%	26.9%	50.8%
	Some extent, low extent, very low extent, I don't know	25.3%	39.4%	73.1%	49.2%
Youth of the Community	To a Very Large Extent, To a Large Extent	69.3%	65.8%	26.9%	18.0%
	Some extent, low extent, very low extent, I don't know	30.7%	34.2%	73.1%	82.0%
Others	To a Very Large Extent, To a Large Extent	58.7%	57.9%	15.4%	11.5%
	Some extent, low extent, very low extent, I don't know	41.3%	42.1%	84.6%	88.5%

The level of distrust expressed in the survey reflects the skepticism that participants in the community-level KIIs (KN\_KII\_01) expressed when asked about the gatekeepers of change in respect of FGM/C in their respective communities. They noted that the gatekeepers of change who ensure the continuation of FGM/C are diverse including but not limited to community leaders, opinion leaders, village elders, clan elders, councils of elders, traditional leaders, elderly people, women, and mothers, practicing communities and families, etc. Specifically listed are:

- “Traditional leaders are in support of it because they perform FGM, community members also support, encourage and transport their girls in Tanzania to go through FGM because in Kenya the laws are very punitive” (KN\_KII\_02\_3387)
- Traditional leaders and those who underwent the same and still practicing. Affected people, community leaders, like-minded partners, (KN\_KII\_02\_7672)
- The mothers are the ones who propagate it with the fear that if their girls do not undergo FGM/C then they are likely to be secluded and remain unmarried. Cross border Counties also propagate it, A good example is girls from West Pokot would be ferried to Uganda to undergo the cut (KN\_KII\_02\_1494)

Plan International and its partners will have to deal with this kind of civic distrust to be able to move communities to accept change. This cannot be done through policy advocacy or the enforcement of laws, rules, and regulations. It is going to have to involve community engagements that win hearts and minds.

## VI. Project Feasibility Assessment using OECD Criteria

### 6.1 Plan International's Envisaged Interventions for ending FGM/C

To overcome the challenges besetting current initiatives to end FGM/C in Guinea and Kenya, Plan International and its partners intend to launch three tier integrated engagement to influence changes at the systemic, strategic, and operational levels within the anti-FGM/C spheres of action. At the systemic level, Plan International and its partners intend to work with **macro level** key decision makers, institutional actors, and nonstate groups working in the anti-FGM/C space at continental, regional, and national levels to promote policies and legislation that support systemic changes that lead to the eradication of FGM/C in member states of the African Union, EAC, and ECOWAS. Interventions at this level will create spaces of engagement for “high-level peers, stakeholders, civil society and government agencies to exchange on how to effectively enable the implementation of high-level laws and policies” (Plan International, 2022, p.4) within and across member states.

The AU, ECOWAS, and EAC have already expressed their commitments to eradicating FGM/C within their respective purviews. They have adopted several protocols and instruments that enjoin member states to take action to end the practice. Plan International will engage the AU, EAC, and ECOWAS to continue to encourage and support their respective member states to move along with domesticating and operationalizing these commitments through the enactment of appropriate laws and regulatory frameworks; setting up and resourcing relevant institutions to enforce the commitments; and creating enabling environments for other state and nonstate actors to support the push to end FGM/C.

As a complement to these **strategic level engagements** for systemic change at the macro level, Plan International and its partners intend to deploy various **meso-level operational interventions** that aim to create, support, leverage, and/or sustain local national and subnational levels capacities for operationalizing anti-FGM/C policies and programs at district or county levels. In furtherance of this local capacity building initiative, Plan International and its partners also aim to secure commitments for resource allocations from national governments and relevant stakeholders to support the operationalization of laws, regulations, and the effective function of enforcement agencies to advance the eradication of the practice of FGM/C in Guinea and Kenya. The initiatives will seek to enforce accountability of service providers and promote effective coordination of actions, using multistakeholder platforms to facilitate the exchange of information, ideas, and other resources that create synergies for efforts to end FGM/C. Plan International and partners will also identify implementation gaps and build capacity to effectively implement national legislation in the local (rural) contexts.

At the micro-level, Plan International and its partners propose to leverage the different influence and power bases of a broad range of actors to stimulate intergenerational dialogues and actions that shift positions on the norms rooting the practice in their respective communities. Accordingly, planned interventions will mobilize and engage community leaders, local police, elders and grandmothers, religious leaders, parents (men and women) as well the youth within the targeted communities, among others in discussions and action programs that aim to: “Shift normative expectations associated with FGM/C within the community; reduce sanctions and stigma on those who decide not to exercise FGM/C; [and ] challenge the personal beliefs and attitudes of key influencers and decisionmakers that support the continuation of the practice” (Plan International, Concept Note, 2022, p. 5).

The feasibility of the planned interventions contributing to achieving change where other interventions have not been so successful depends on target communities’ assessment of the relevance, coherence, effectiveness, efficiency, impact, and sustainability of the envisaged interventions to make change happen and in a sustained manner within their respective jurisdictions. The assessment of this feasibility must be carried out through the findings of this research and lessons learned from other interventions and jurisdictions that have invested in similar interventions to end FGM/C.

## ***6.2 Views on Feasibility of Plan International's Proposed Project***

The study assessed the feasibility of Plan's intended interventions through the lenses of the OECD criteria for project design and evaluation. The assessment of feasibility relied on the perceptions, knowledge, and experiences of respondents in the various sections of the study. The assessments are therefore based largely on descriptive statistics and qualitative data from interviews and focus group discussions with respondents. It was beyond the scope of this study to use econometric analysis to establish the level of effectiveness, efficiency, impact, and sustainability of the interventions. The scope of reference for the definition of and assessments based on the OECD criteria are outlined in Appendix 10 and summarized below:

**Relevance:** The broad question this component of the survey sought to answer was: To what extent are the planned interventions the right ones to contribute to the stoppage of FGM/C in Guinea or Kenya? Accordingly, the study sought out respondents' views i) in what ways the planned interventions will contribute to the stoppage of the practice of FGM/C in Guinea and Kenya; ii) to what extent community level actors see the planned interventions as important to helping them stop the practice of FGM/C; and how effective the different levels of engagement will be in promoting changes in attitudes, behaviors, and practices at the community level for the elimination of FGM/C practices.

**Coherence:** The study aimed to find out participants' views on how well the planned continental, regional, and national levels engagements fit with the understanding of community-level actors on how the practice of FGM/C can be stopped in Guinea and Kenya. Hence, the questions sought the perspectives of respondents on: i) how consistent regionally determined policies and programs for stopping FGM/C are with the political, cultural, and religious and other country specific contexts of Guinea and Kenya; ii) how policies, programs, and laws determined at national levels would fit the worldviews, beliefs, and practices of communities that practice FGM/C; and iii) how the planned interventions align with what other actors are doing to stop the practice of FGM/C in the targeted communities.

**Effectiveness:** The broad question for this component was: How effective will the planned interventions be in helping Plan International achieve its objectives of stopping FGM/C in Guinea and Kenya? Under this, the component sought respondents' view on i) the extent to which planned interventions would lead to the achievement the desired objectives of stopping FGM/C in target countries; and ii) what in the planned interventions will contribute to concrete, verifiable changes in perceptions, attitudes, behaviors, and practices that lead to verifiable change in the practice of FGM/C at the community level.

**Efficiency:** The assessments gauged respondents' views on the most efficient way to achieve the objectives of stopping FGM/C in Guinea and Kenya, using the resources available to Plan International and its partners. Therefore, guiding questions included, but not limited to i) what levels of engagement (macro, meso, and micro) have the potential to yield the largest and most sustainable changes that sustain the stoppage of FGM/C? ii) which categories of actors should Plan International and partners focus attention on to elicit the greatest benefit to achieving the objectives of the study? iii) what opportunities exist for networking with and leveraging the resources and capacities of other actors to create synergies that result in a larger and more sustainable outcomes than Plan International and its partners alone would have achieved.

**Impact:** The study sought to find out participants' views on i) what difference the interventions of Plan International and its partners will make to the stoppage of the practice of FGM/C in the targeted communities; ii) at what level in the chain of responsibilities will critical change happen to trigger a cascade of changes at other levels; iii) how well suited are the chosen activities in Plan International current design to make the desired change happen; and iv) what needs to be tweaked or eliminated in that plan to ensure maximum impact?

**Sustainability:** The key question on sustainability was: to what extent will the benefits of the interventions be in ensuring that the stoppage of FGM/C practices in the project communities last beyond the life of the project? Hence, the study sought respondents' opinions on i) how the outcomes of the interventions be sustained; ii) what will make participating communities sustain the stoppage of the practices; iii) what

structures and systems they believe will Plan International, and its partners will leave behind to ensure communities do not revert to the practice of FGM/C once the project is ended.

The above questions were explored with participants in the survey and qualitative data collection components of the study. For the survey component, the study used a 7-point Likert scale ranging from agreement to a very large extent to “I do not know” and “I am not sure” to gauge the extent to which respondents assessed the various statements attached to the independent variables. To assess the reliability of the measures for the dependent variable (i.e. the various statements associated with the measures), an internal consistency reliability test for the variables relevance, coherence, effectiveness, efficiency, impact, and sustainability was conducted, using Cronbach’s Alpha. Burns and Burns (2008) indicate that “an Alpha of 0.8 or above is regarded as highly acceptable for assuming homogeneity of the items (p.417). Table 8 below indicates an Alpha of 0.892, which confirms a high degree of homogeneity or internal reliability of the scales used.

**Table 8 Cronbach’s Reliability Test Statistics**

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.892	.892	6

*General Overview of Project Feasibility per OECD Criteria:* Table 9 presents the case selection of responses to questions on the different dimensions for accessing the feasibility of Plan International’s proposed interventions, using the OECD criteria. Overall, respondents indicated the planned interventions are relevant, coherent, and will be effective in contributing to the stoppage of FGM/C in their respective communities in our counties. Consistently, more than 60% of respondents (n=264) indicated that the interventions Plan International and partners have envisaged i) are the right ones to contribute to the stoppage of FGM/C in Guinea or Kenya (*Relevance*); ii) fit with the understanding at community-level actors on how the practice of FGM/C can be stopped in Guinea and Kenya (*Coherence*); iii) will help Plan International achieve its objectives of stopping FGM/C in Guinea and Kenya (*Effectiveness*); iv) represent the most efficient way to achieve the objectives of stopping FGM/C in Guinea and Kenya (*Efficiency*); v) will make an impact on the stoppage of the practice of FGM/C in the targeted communities (*Impact*); iv) will ensure that the stoppage of FGM/C practices in the project communities last beyond the life of the project (*Sustainability*).

**Table 9: Case Selection Of Perceptions On Feasibility Planned Interventions Using OECD Criteria**

Criteria	Broad Question Asked	Case Selection of Responses	Count (n=264)	Percentage
<b>Relevance</b>	To what extent are the planned interventions the right ones to contribute to the stoppage of FGM/C in Guinea or Kenya?	Very Large + Large Extent	169	64
<b>Coherence</b>	How well do you believe these planned continental, regional, and national levels engagements fit with the understanding community-level actors on how the practice of FGM/C can be stopped in Guinea and Kenya?	Very Strongly + Strongly Believe	201	76.1
<b>Effectiveness</b>	How effective will the planned interventions be in helping Plan International achieve its objectives of stopping FGM/C in Guinea and Kenya?	Very Effective + Effective	204	77.3
<b>Efficiency</b>	How are the intended use of resources available to Plan International and its partners for the interventions above the most efficient way to achieve the objectives of stopping FGM/C in Guinea and Kenya?	Very Efficient + Efficient	193	73.1
<b>Impact</b>	what difference will the interventions of Plan International and its partners make on the stoppage of the practice of FGM/C in the targeted communities?	Very Impactful + Impactful	190	72
<b>Sustainability</b>	To what extent will the benefits of the interventions be in ensuring that the stoppage of FGM/C practices in the project communities last beyond the life of the project?	Very + High Extent	202	76.5

*Perceptions of Feasibility per OECD Criteria by Country:* Table 10 presents a summary of the results from the crosstabulation of the selected cases of responses to the different questions disaggregated by country of study. The table shows the variations in perceptions on the feasibility of the project based on respondents' experiences in their respective countries. The selected responses represent case selection of positive ratings of the different criteria.

Respondents from Guinea were more optimistic of the feasibility of the project, based on all six (6) OECD criteria than their counterparts in Kenya. Except for the assessment of the potential impact of the planned interventions, only about a third of the respondents from Kenya said the interventions are relevant to efforts to stop FGM/C in their communities; would be effective in doing so, or that the approaches would be the most efficient and sustainable ways to achieve the objective of bringing an end to FGM/C. Additionally, 41.6% of Kenya's respondents said the planned interventions would have impact on the fight to end FGM/C. In contrast, except for the assessment of the impact of the interventions, more than 65% of respondents from Guinea consistently said the planned interventions would be relevant, coherent, effective, efficient, impactful, and sustainable initiatives for putting an end to the practice of FGM/C in their respective communities.

**Table 10: Summary of Responses to Feasibility Assessment Criteria by Gender**

OCED Criteria	Selected Response Range	Country			
		Kenya (n =113)		Guinea (n=151)	
		Count	%	Count	%
Relevance	To a very large extent and a large extent	49	29	120	71
Coherence	Very Strongly and Strongly Believe	65	32.3	136	67.7
Effectiveness	Very Effective and Effective	68	33.3	136	66.7
Efficiency	Very Efficient and Efficient	66	34.2	127	65.8
Impact	Very Impactful and Impactful	79	41.6	111	58.4
Sustainability	To a Very High Extent and High Extent	70	34.7	132	65.3

*Perception of Feasibility per OECD Criteria by Gender:* Table 11 presents a gender disaggregation of the responses to the same question. It shows that female respondents were slightly more positive in their ratings of the relevance, coherence, effectiveness, and efficiency of the proposed interventions than their male counterparts. Male respondents were, however, more optimistic about the impact of the planned interventions in contributing to the end of FGM/C in the targeted communities. Male and female respondents were evenly split (50% on both sides) on sustainability the planned interventions.

**Table 11: Summary of Responses to Feasibility Assessment Criteria by Gender**

OCED Criteria	Summarized Range of Responses	Gender			
		Male (n=127)		Female (n=137)	
		Count	%	Count	%
Relevance	To a very large extent and a large extent	84	49.7	85	50.3
Coherence	Very Strongly and Strongly Believe	98	48.8	103	51.2
Effectiveness	Very Effective and Effective	101	49.5	103	50.5
Efficiency	Very Efficient and Efficient	92	47.7	101	52.3
Impact	Very Impactful and Impactful	97	51.1	93	48.9
Sustainability	To a Very High Extent and High Extent	101	50	101	50

### Criterion Specific Assessment

**Relevance:** The findings in the table reflect the views of respondents in the KIIs and FGDs in respect of the feasibility of the planned macro and meso-level interventions. In general, respondents see relevance in the planned interventions because the practice of FMG/C remains entrenched in some communities in Guinea and Kenya. An African Union level respondent pointed out that interventions for the eradication of FGM/C is a priority because of “50 million girls at risk of being subjected to FGM in Africa; an additional 2 million at risk as a result of COVID 19 impact [hence, ending FGM/C is] “...a high priority [...] in Agenda 2063, and is covered by AU Human Rights instruments” (KII\_03\_AU). However, respondents cautioned that time and duration of interventions are critical to enhancing the relevance of the interventions. As one senior official of Kenya’s National Anti-FGM board put it, the practice of FGM/C is rooted in “entrenched social norms, since FGM is a cultural issue so communities have been brainwashed. By the time you convince a community to abandon FGM, it takes a process like many, many years” (KN\_II\_03\_National Anti-FGM Board). The complications with expecting large changes with short term interventions is further articulated by another respondent as follows:

Rejecting FGM has social, cultural, economic and political consequences including stigmatization and discrimination. FGM is also considered a cultural identifier among the practicing communities distinguishing their daughters from neighboring communities who do not circumcise girls and women. The cutting of girls remains a norm in practicing communities to the extent that there is acceptance for continuation and support for the practice (KN\_KII\_03\_CREAW)

Respondents believed therefore that the level of engagement of Plan International and partners (i.e. the macro, meso, and micro levels) is critically important for the relevance of the proposed interventions. Asked at what level of engagement (district, county, national, regional, or continental) will the interventions of Plan International and its partners make the greatest impact in contributing to the stoppage of the practice of FGM/C in Guinea and Kenya, a respondent from the AU placed emphasis on devolution to local levels in stating that interventions should be: “At the sub-national, national, as well as in the region the countries are located [while sharing] capacity with other stakeholders, and at level of the continent as part of efforts led by the African Union” (KII\_03\_AU),

Commenting on what works best in the fight against FGM/C, another respondent called for the devolution of activities to the community levels, pointing out how the “community empowerment approach tried in Senegal has been lauded as a success [as] culturally appropriate approaches which includes involving the church and the Sheikhs will yield better outcome” (KN\_KII\_03\_ University of Nairobi). Responding to a question on what may have worked or failed in actions and interventions to prevent or stop FGM, another respondent with the National Population Council in Kenya observed that “We should have leveraged on existing community structures such as AACs/CACs to advance the fight against FGM seeing that the Anti FGM Board only has a national secretariat and no staff beyond” (KN\_KII\_03\_PoP Council). Similarly, respondents in Guinea emphasized the need to mobilize and engage community level actors such as religious leaders, traditional leaders, girl leaders GN\_KII\_02\_4847; GN\_KII\_02\_5292; GN\_KII\_5233) and “the alliances of women leaders, the network of CSOs for the fight against FGM” (GN\_KII\_02\_6357), as well as, NGOs and development institutions and members of women's groups (GN\_KII\_02\_5665) as more relevant actors to champion the fight against FGM/C, given their rootedness in the knowledge, cultures, and practices of their respective communities.

**Coherence:** The study aimed to find out from the perspective of respondents i) how consistent regionally determined policies and programs for stopping FGM/C are with the political, cultural, and religious and other country specific contexts of Guinea and Kenya; ii) how policies, programs, and laws determined at national levels would fit the worldviews, beliefs, and practices of communities that practice FGM/C; and iii) how the planned interventions align with what other actors are doing to stop the practice of FGM/C in the targeted communities.

Although overall 76.1% (201/2640) of the respondents in the survey said they very strongly or strongly believed that the interventions that Plan International and partners have envisaged at the planned continental, regional, and national levels engagements fit with the understanding of community-level actors

on how the practice of FGM/C can be stopped in Guinea and Kenya, there are important country and gender level differences, as exemplified in Table 11 above. Notably, more respondents in Guinea than in Kenya acknowledged that the planned interventions are coherent with the intents and strategies of governmental and non-governmental organizations at the continental, national, and subnational levels to the extent that they all seek to enforce changes in behaviors and practices that lead to the stoppage of the practice. The planned multilevel nature of the interventions also fills an important need – the need for a unified model that connects engagements of different actors from the community to the continental levels. For instance, at the continental and regional levels, as well as, in both Guinea and Kenya, different agencies are already engaged in the fight to end FGM/C from different angles. However, as noted earlier in this report, mechanisms to coordinate interventions across levels and between different actors in the same regions or countries are weak. This is because no agency focuses on both vertical (community, district/county to national, regional, and continental engagements) and horizontal engagements i.e., collaborative engagements between two different countries at the same. Even within countries, “the FGM framework at the National and the County levels is inadequate and generally lacks strong coordination including in the education, health, culture, legal, policy and economic segments” (KN\_KII-03\_ CREAM). As a result of these institutional and programmatic disconnections and the absence of model for coordinated actions, there are “gaps in policy and legislative frameworks” (KII\_03\_AU) that make it difficult to have concerted approaches to fighting FGM/C.

Thematically too, actors engaged in the FGM/C field focus on different things. As noted when asked what specific issues related to the eradication of FGMC that Plan International and its partners in Guinea and Kenya need to pay attention to in order to accelerate the elimination of FGM in Guinea and Kenya, one participant summarized the needs as: “legal framework strengthening, domestic resource allocation, cross-border FGM, leadership among others” (KII\_03\_AU). This suggests a broad array of needs that run from the community to the continental levels. This calls for a concerted effort to coordinate the efforts actors to ensure success (GN\_KII\_03\_French Embassy). Therefore, Plan International has an opportunity to provide transformational leadership in the FGM/C space (GN\_KII02\_5292) for galvanizing a broad base of support that ensure collaboration, cooperation, and the creation of synergies that make a big push to end FGM/C.

**Effectiveness:** This component sought respondents’ view on i) the extent to which planned interventions would lead to the achievement the desired objectives of stopping FGM/C in target countries; and ii) what in the planned interventions will contribute to concrete, verifiable changes in perceptions, attitudes, behaviors, and practices that lead to verifiable change in the practice of FGM/C at the community level? Table 11 shows that just about 50% of both male and female respondents in the survey (49.5% male and 50.5% female) said that the planned interventions would have observable impact on ending FGM/C.

The evidence from this study points to the fact Plan’s interventions will be effective if targeted emphases, rather than blank interventions, are directed at the macro, meso, and micro levels. At the macro levels, participants want to see emphasis placed on engaging national governments to speed up the mobilization, and above all allocation of funding to support the work of community level actors working to stop the practice. At the meso level, civil society actors must increase collaboration with government and other organizations to dovetail their engagements to create synergies, maximize use of resources, and eliminate discordant competition between actors.

Most participants, however, argue that the bulk of Plan International’s interventions should be directed at the *micro-levels*, where effective change can be generated. They point out that the most effective way to make change happen is to leverage the indigenous institutional structures and knowledge systems of the communities where the practice of FGM/C is prevalent. This is because the people and institutions that have real power and influence to stop the practice of FGM/C are found in the communities, or districts. As was observed in the case of “Kenya what works well is the chief who has a strong voice; they should be engaged and involved; even when there

**Textbox 15**  
**A Voice from the AU on Effectiveness**

“Work with affected communities, with particular emphasis to engage opinion leaders, community groups - especially women and youth, sub and national leaders, be part of national coordination and investment efforts; champion evidence and data in driving interventions and local work, and help to strengthen legal and policy frameworks, and service delivery”.  
KII\_03\_AU

is an emergency, they call a chief” (KN\_KII\_03\_ Plan Field Office). It is therefore essential to “Support Community Based Organizations (CBOs) in affected areas [through] engagement of men both young and elderly who are custodians of culture” (KN\_KII\_03\_ Tharaka Nithi Anti FGM Board). This is critically important because “at the community level, apart from the religious leaders and the elders, the women who are the victims are also the actors (the old ones in the communities, they can negatively impact the new generation). We must cut the cord” (GN\_KII\_02\_8349) by converting them into active supporters of the stop FGM/C movement.

Participants also noted that indigenous communication systems and networks are equally important players in the education of people to change their values, beliefs, and practices. However, these pre-existing, effective, and relatively cheaper communications channels are not fully harnessed in the fight against FGM/C. As one respondent observed, despite the influence they wield, “traditional communicators [such as griots, town criers, singers and songstresses] are sidelined but they are good and can help us (NGOs) in the fight” (GN\_KII\_02\_4870). This is in spite of the fact that such people are “model women and men, model religious men, people who can decide and impose themselves on everyone in families. NGOs and resource persons” (GN\_KII\_02\_0701).

The extent literature supports the view of respondents that engagement at the community levels will be more effective in stopping FGM/C than others. Easton, Monkman, & Miles, (2003) have documented how externally led approaches such as the use, “legislation, medicalization (training health professionals to perform the procedure under sanitary conditions), religious condemnation, information, ‘just-say-no’ campaigns, educational efforts, and attempts to institute alternative rituals” (p. 446). Referencing findings from Mackie (2000), they point out that few of these interventions “have had widespread or locally sustained effects because in many cases such strategies have failed to recognize the need for locally generated initiatives to reform such social conventions” (p.446). Building on the observations of Easton, Monkman, & Miles, Kay (2015) attributes such failures, in part, to the “cultural absolutism, cultural relativism, health education, feminism, human rights legislation, and psychosocial approaches” (p. 5) rooted in external worldviews of “outsiders from the global North” (Kay, 2015, p. 5) that fail to consider the real and felt needs of community members. As a respondent in Kenya observed from lived experiences as an anti-FGM/C: “we go to fields with our own plans of what to do and then community surprise us about what they want which is not even what we want” (KN\_KII\_03\_ Plan Field Office). Besides, communities have widely different cultural beliefs and values that sustain the practice.

In parallel, Easton, Monkman, & Miles, (2003) outline two community-based approaches to engineering “social change from the bottom up” (p.446). They highlight, for instance the Tostan approach rooted in the indigenous knowledge, decision-making, and action systems through working “...with rural women to identify their felt needs, to develop and test curricula that reflected their concerns and used language and cultural forms familiar to the participants, and to anchor the approach in a Senegalese version of ‘women’s ways of knowing’ (Belenky et al. 1986 in Easton, Monkman, & Miles, 2003, p.447).

Similarly, the leadership of traditional leaders, rather than state-led processes, in initiating voluntary abandonment of FGM/C practice by cutters in Liberia signals the effectiveness of community-led approaches to ending the practice. Liberia, which shares a 590 kilometers borders and spillovers of cultural similarities with Guinea, is one of only three countries in West Africa that does not have a national law prohibiting FGM/C. As late as last year, (2022) attempts to pass a “...a bill in the Legislature to ban the practice [did] not have enough support to pass [because] traditional leaders, who derive their income from fees paid for bush schools, had threatened lawmakers not to pass the bill” (Jlogbe, 2023, n.p). However, in a ceremony to mark the International Day of Zero Tolerance for Female Genital Mutilation on February 6, 2023, the association of FGM/C circumcisers publicly declared their stoppage of the practice. The decision of cutters to down their tools and close down the “bush school [...]comes after years of failed bans, moratoriums and promises but this was the first time zoes have surrendered their tools. The zoes took that major step under the direction of Zanzan Karwor, head of the National Council of Chiefs and Elders of Liberia (NACCEL)” (Jlogbe, 2023, n.p.). This formal declaration of abandonment was, in part triggered by “a three-year moratorium announced by traditional leaders a year ago”[on the practice of FGM/C following which the practice was] quickly abandoned by practitioners across the country [and]

Sande<sup>14</sup> membership has plummeted from 83 percent in 2007 to 35 percent in 2020 according to Demographic and Health Surveys” (Jlogbe, 2023, n.p).

Besides highlighting the important role that traditional leaders can play in stemming the practice of FGM/C among their citizens, it demonstrates that changing of hearts and minds is the most effective way to induce abandonment of the project. The chiefs who once opposed the ban of the practice through legislation have become champions of that ban through the use of their traditional authority. The Liberian example also highlights how demand for FGM/C drives the persistence of the practice. The Zoes were only willing to consider alternative sources of earning income because the moratorium the chiefs placed on the practice stemmed the flow of demand for their services. As Jlogbe notes, the “Zoes here have not been persuaded by arguments that FGC is harmful for girls despite well documented evidence of its long term physical and psychological impacts. They have agreed to end the practice only after promises from UN Women and others that their lost income will be replaced by strong economic empowerment projects” (Jlogbe, 2023, p.1).

**Efficiency:** The study assessed participants’ views on how efficient they believed are the intended use of resources available to Plan International and its partners for the multi-level and multi-country interventions the most efficient way to achieve the objectives of stopping FGM/C in Guinea and Kenya. Under this broad frame, the study explored questions such as i) What, in the view of respondents, are the best ways to make large-scale change happen quickly and with the resources at the disposal of Plan International and partners? ii) How are the planned interventions (by type and level of engagement) the best way to use the resources available to Plan International and its partners to achieve the objectives of stopping FGM/C?

In response to the questions, respondents noted that there is already a lot happening in the anti-FGM/C space in both Guinea and Kenya. Different actors approach the design and implementation of interventions from the perspectives of their peculiar institutional mandates and priorities of their funding agencies. As one macro-level respondent from Kenya noted “Stakeholders are of diverse shape and proper screening will be necessary before we get it right” (KN\_KII\_03\_University of Nairobi). Unfortunately, there is a “lack of proper coordination mechanisms [or even a joint] monitoring and evaluation systems” (KN\_KII\_02\_7374) to ensure concerted efforts in the FGM/C fight between actors in the different actors in the anti-FGM space at all levels. Consequently, the opportunities to make large scale change happen quickly through networking, leveraging, layering, and dovetailing of interventions of the different actors to create synergies that extend the reach of the resources at their disposal are lost. This in part, answers the question of the respondent in Guinea who wanted to know “why do we receive multiple institutions and NGOs in relation to FGM but the objectives are never achieved?” (GN\_Survey\_7604). Another respondent recognized that in the fight to eradicate FGM/C “There is a lack of commitment and a lack of a coordination framework to harmonize efforts. If there are frameworks, they must be revitalized” (GN\_KII\_2\_9424). This observation is a pointer to how efficiency in the FGM/C may be achieved.

Respondents said Plan International need to champion the rallying of the multiplicity of power and gate keepers (male and female traditional, religious, and other group leaders) in every community to maximize efficiency of its investments for putting an end to FGM/C in Guinea and Kenya and beyond. The problem of “inadequate resources to accelerate the eradication of FGM” (KN\_KII-03\_ CREAM; KN\_KII\_02\_7374) is echoed throughout the different categories of respondents. In the words of respondent from Guinea, “the scarcity of resources means that [fighting FGM/C] does not become a priority for governments and [hence] the non-adherence of communities” (GN\_KII\_02\_9562) to the policies and laws. To achieve large scale and lasting change in the practice of FGM/C, there is the need to “...support the mobilization of resources at several levels (national, regional and continental) (GN\_KII\_02\_9424), alongside the “coordination of actions and human and financial resources” (GN\_KII\_02\_9562). Hence, in addition to investing their own resources from the planned project, Plan International and partners will also need to leverage the human, material, financial, technical, capacities of other actors, as well as harness community level structures to advance the achievement of the collective objectives of stopping FGM/C.

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<sup>14</sup> Sande is the women’s secret society in Liberia that trains and initiates young girls into adulthood, including inflicting the cut of FGM/C. Poro is the male equivalent

As most community level actors are unable to mobilize resources for their interventions, Plan International and partners already anticipate engagements at the continental, regional, and national levels to promote the adoption of policies and programs that support resource mobilization for subnational level operations. However, respondents in this study are not only worried about the amount of money allocated, but also whether or not the allocated resources do reach down to the subnational levels for them to access and use for their activities. As one respondent in Guinea summed it:

“...we are talking about gender-sensitive budgeting and there is an increase in the budget compared to the finance law which has just been passed. However, there are no resources dedicated solely to FGM/C. The gross amount is known but the disaggregated is unavailable. There is an increase in the budget of the Ministry in the Interim Program on the issue of women's rights but there is a gap in the field” (GN\_KII\_02\_4180).

Respondents highlighted corruption in the use of allocated budgetary resources for FGM/C as another major source of concern (GN\_KII\_02\_1789; GN\_KII\_02\_8414; GN\_KII\_02\_6080; GN\_KII\_02\_0570). As two respondents summed it, Corruption has a role to play” (GN\_KII\_02\_1652) in the limited success in fighting FGM/C because “...even if there are funds if there is corruption the funds are not well managed (GN\_KII\_02\_4870). In Kenya, concerns over corruption focused on “the rampant corruption of those charged with the responsibility of enforcing the law against [FGM/C] (KN\_KII\_01\_2094; also, KN\_KII\_01\_5713; KN\_KII\_01\_8081; KN\_KII\_01\_9185). The level of corruption in the anti-FGM/C space extends to “Corruption of government officials especially the local leaders and the enforcement agencies” (KN\_KII\_01\_2094). The endemic nature of the phenomenon undermines the efforts to fight it (KN\_KII\_01\_3132).

The foregoing suggests that, to be effective, investments in resource mobilization and allocation initiatives must go beyond securing promises, policies, and programs, to supporting the institutionalization of mechanisms that ensure that allocated resources are not only adequate, but do reach the target communities. Plan International and partners must pay attention to initiatives that help fight corruption and ensure available resources are transparently allocated and judiciously used in the fight against FGM/C. Investments that build community capacities to participate in budget preparation and to establish and use budget tracking systems will be worthwhile.

**Impact:** The study sought to find out what difference the interventions of Plan International and its partners will make to the stoppage of the practice of FGM/C in the targeted communities; ii) at what level in the chain of responsibilities will critical change happen to trigger a cascade of changes at other levels; iii) how well suited are the chosen activities in Plan International current design to make the desired change happen; and iv) what needs to be tweaked or eliminated in that plan to ensure maximum impact?

The section on effectiveness above points to the fact that any expected impact of the planned interventions must derive directly from the effectiveness of the interventions. To this extent, and as already highlighted, participants have pointed out that project interventions will be most effective in bringing a stop to the practice of FGM/C if targeted to changing hearts and minds of practicing communities to stem the demand for FGM/C services. However, FGM/C is practiced in predominantly communitarian settings where collective values and social pressures mandate “...the subordination of individuals’ personal interests in favor of the welfare of families/collectives [with] the existence of a punishment system, in the form of stigmatization and exclusion, aimed at promoting compliance with the FGM tradition” (Doucet et. al, 2020, p.10). Hence, the decision to submit to the cut is a communitarian rather than an individual choice, since it is an important inclusion criterion or membership of lifelong socio-economic groups. Age-cohorts of girls who are cut stick together as social and economic groups throughout life and women who do not undergo FGM/C “they lose sense of belonging” KN\_KII\_01\_ 9456. In the words of another respondent, women and girls who fail to take the cut “... are excluded and stigmatized when you fail to do so in the family and community. Other women will speak against you” (KN\_KII\_01\_ 8102).

In Guinea, the “...practice is widespread, as it is applied by all communities and all women/girls suffer from it” (GN\_KII\_02\_ 6357). This is “because they think doing it makes them important to other girls (GN\_KII\_02\_ 2825). Besides, social costs to non-circumcision can be very high as “girls who are not

circumcised end up suffering the stigma of the community (no marriage, insulted)” (GN\_KII\_02\_ 8711). Hence, while it is often argued that “the importance of this practice for girls is for the education of girls, respect for customs and mores, reduction of sexual desire” (GN\_KII\_02\_ 6209), patronage of the service despite the health and psychological trauma that comes with it is because “Women insist on circumcising girls to avoid stigmatization” (GN\_KII\_02\_ 9562).

The foregoing suggests that achieving impact therefore mandates greater investment at the community levels than at the national and continental levels. Policies and laws may create state-centered deterrence, punishment, and rewards systems, but that would not be enough to convince communities that attach strong values and beliefs to the practice to abandon it. To induce lasting abandonment of the practice, therefore requires a whole-of-the-community approach to changing mindsets in ways that translate into changing the systems of beliefs, values, and narratives that drive the demand for the service. Otherwise, “It is utopian to say that we are going to put an end to the practice. Contributions to reducing prevalence can be made, but through the efforts of a whole range of actors, not just government” (GN\_KII\_02\_4180).

**Sustainability:** The study sought respondents’ opinions on i) how the outcomes of Plan International’s interventions can be sustained; ii) what structures and systems will Plan International, and its partners leave behind to ensure communities do not revert to the practice of FGM/C once the project is ended iii) what changes due to the interventions of Plan International and partners in the proposed project will make participating communities sustain the stoppage of the practices.

Respondents from Guinea support the view that since the practice is rooted in “a strong culture that has lasted for over 100 years, it is hard to bring it down” (GN\_KII\_01\_0278) within the short life cycle of a project. Respondents have also witnessed how such “programs that have been done to stop FGM have not been sustainable enough to curb the practice” (GN\_KII\_01\_5713). In the view of one respondent from Kenya, “The programs that have been done to stop FGM have not been sustainable enough to curb the practice (KN\_KII\_01\_5713). Therefore, to ensure “...sustainable and adequately funded sensitization and campaigns [Plan International and partners need to place] more emphasis on demand for accountability for enforcement of laws and policies in the community by the government” (GN\_KII\_01\_1983).

Beyond the efforts of governments and external partners, lasting change that ends the practice of FGM/C must come from within the practicing communities, not without. Accordingly, the outcomes of the Plan International’s project will be sustainable if the interventions lead to changes in beliefs, values, behaviors, and practices associated with FGM/C within the communities that participate in the project. As one respondent noted: “Community based organizations with support from partners have been implementing programmes to address FGM at the community level with probable sustainability of interventions as a result of community ownership and leadership” (KN\_KII-03\_ CREAW).

Plan International’s multi-layered approach from the macro through to the micro-level, and the intent to use multi-stakeholder platforms of engagement create windows of opportunities for sustaining the activities and outcomes of the project. Respondents, for instance, endorsed the proposed “multisectoral approach and collaboration [involving the] pooling resources together (KN\_KII\_01\_1563) and the creation of spaces of “Working together , and involving the communities in all the aspects of the intervention” (KN\_KII\_01\_5518). However, to achieve this, Plan International and partners will have to actively seek out partnerships and leveraging opportunities that ensure that others are picking up where Plan International’s inventions end. To achieve this, Plan International and partners will have to “put in place an effective structure to fight against these practices in collaboration with the authorities at all levels” (GN\_KII\_01\_8556)

### **6.3 Summary of Key Findings**

*i. Existence of disconnect between policymaking and policy enactment:* The section on capacity assessment above has already outlined the existence of gaps between the knowledge of policies and programs initiated at the macro and meso-levels and their impact on community-level attitudes, behaviors and practices. The apparent disconnect between policymaking and policy enactment suggests a need for stronger interconnection between policymakers and implementors at all levels – community, local government, national and regional governmental institutions, and continental policy and decision-makers.

Respondents in this study have already confirmed the observation in documented sources that the criminalization of FGM through policies, legislation, and case law has driven the practice of FGM underground through several channels i.e. non-public performance of the practice, cross-territorial access of services, changes in methods of cutting, changes in the timing of cutting, etc.; all of which are designed to conceal the practice (Population Reference Bureau, 2010; Boddy, 1998). Secondly, it is evident that simply ‘challenging patriarchal power relations’ and ‘empowering women’ in response to FGMC may be oversimplifying a complex situation derived from multiple factors at multiple levels. Understanding the constraints that dominated the consciousness of the people is useful but insufficient to comprehend the “intricacies of power relations and their continuous reproduction and transformation” (Boddy 1998:97).

For instance, despite the existence of laws that ban the practice of FGM/C in Kenya, the country is the destination for cross-border access to FGM services, with 70% of respondents in a recent survey from Uganda and 60% from Ethiopia indicating that they traveled to Kenya to access the services (UNFPA and UNICEF, 2022). In Guinea, women participants in an FGD in Nzérékoré noted that although the practice of FGM is harmful, it is still practiced in their community in different forms – partial cutting, and deep cuts with suturing, among others. They believe that the practice will end someday, but patience is needed to get there. The practice continues now because of economic reasons, inadequate education, and the protection of cultural values and beliefs. They are aware of the existence of national laws that ban the practice but say the laws do not work simply because people disregard them with impunity as the prescribed sanctions are not applied. Asked about what suggestion they can offer for a definite end to the practice, they responded: “*Aucune suggestion, elle se pratique dans nos communautés malgré les efforts de Plan et ses partenaires*” to wit: we have no suggestions, the practice continues in our communities despite the efforts of Plan and its partners” (GN\_FGD\_Nzérékoré)

The foregoing suggests a disconnect between the realms of policy and law making and community-level perceptions, attitudes, behaviors, and practice; a situation in which the adoption and implementation of proscriptive policies, laws, and regulations have had limited impact in influencing changes in perceptions, attitudes, behaviors, and practices of those who believe in the FGM. For such communities the perceived social value or benefits of participation in the practice outweighs the risk of sanctions that the state can inflict on them. Policies must permeate and influence beliefs, attitudes, behaviors, and practices to make change happen. Change will not happen if policies trigger or reinforce insular responses that do not only reinforce the perceived value of the practices, they seek to change but take the practices beyond the view and reach of the regime of policy and regulatory control and sanctions. As one KII respondent concluded, “We have not used the right strategy to address FGM/C [because] most strategies have not been well-thought out. They are usually not sustainable and do not adequately involve the people” (GN\_KII\_01\_1563).

ii. **AU, EAC, and ECOWAS have persuasive, not enforcement powers:** While these strategy levels engagements are all worthwhile, Plan International and its partners need to recognize that the AU, ECOWAS, and EAC do not have the power to compel their respective member states to ratify and comply with any international treaty or agreements. Even when the AU and the regional bodies have adopted such international treaties, and developed protocols, policies, and regulations to make them their own, they cannot impose timelines for the acceptance of these protocols within their respective member states. Member States are free to domesticate such protocols, laws, policies, and programs at their own pace. This limitation must guide the expectations from engaging these institutions. In other words, while consultations and consensus building at the continental and regional levels on what needs to be done to end FGM/C are important and necessary in pushing the agenda to end FGM/C continentally and within member states, they are not sufficient to make change happen at the community-levels where the practice of FGM/C are carried out.

iii. **Proscriptions Set Boundaries of Acceptable Behavior But Do Not Change Minds and Hearts:** Plan International’s intent to support policy and legislative forms supports the call on State Parties to “take measures to modify or abolish existing laws, customs and practices which constitute discrimination against women” (CEDAW, Article 2). The push for legislative reforms is grounded in the conviction that laws and policies trigger changes in behaviors that alter practices from undesirable to more desirable ones. An inherent assumption is that “all law exists to effect changes in human behavior” (Jones and Goldsmith, Institute for Peace and Development - Feasibility Study on Female Genital Mutilation/Cutting, Guinea and Kenya pg. 54

2005, p. 412); hence, changes in laws can automatically induce changes in behavior to conform with the laws. However, the fact that “...law still struggles to induce people to behave more constructively” (Jones and Goldsmith, 2005, p. 408) signals that compliance with policies and laws is determined by a myriad of human, social, economic, cultural, and other contextual factors that may be unrelated or contradictory to the dictates of the policy and legal frameworks enforce. Hence, while the promulgation and implementation of laws and policies are necessary ingredients to modifying behaviors in respect of FGM/C, they are not in themselves sufficient to make that change happen. The primary and secondary data in this study have amply demonstrated how different groups are finding ways to circumvent the laws and regulations, through resort to underground and cross-border access to services, among others.

iv. **Proscription May Discourage But Does Not Eliminate Demand For A Service:**

Proscription and sanctions may have a deterrent effect and impose costs that may change the structure and operations of the market for a product or service. However, it is not always sufficient to change the values that underpin the demand and supply of the product or service. On the contrary, in accordance with the law of supply and demand, proscription or attempts to control access to a high-value product or service merely drives the market for the product or service underground, as both clients and suppliers find creative ways to circumvent the law and avoid sanctions. For as long as there is a demand for FGM/C services, there will always be suppliers – both old and new ones. Proscription then may not only defeat the purpose of stopping FGM/C practice; it makes it harder to access and engage the service providers and clients in constructive ways that change the value systems to make desired changes in perceptions, values, attitudes, behaviors, and practices related to the supply and demand for the product or service happen.

**Textbox 16**  
**Demand Drives Service Provision**

“She will not stop doing it but if anyone wishes to terminate the practice [...] let the person go to the parents who bring the girls to her of their own accord. She does not go for them in their homes” (Gachiri, 2000., p 42).

v. **Punitive Measures Harden Hearts and Resolves:** Jones and Goldsmith have observed that “...law [is] effective when it gets its job done, and efficient when it does so with minimum waste” (Jones and Goldsmith, 2005, p. 413). Since the promulgation of new laws and the enforcement of the existing and new laws will not automatically lead to changes in behaviors that stop FGM/C, the questions that Plan International and its partners have to grapple with is how much effort should be put into supporting the macro and meso-level initiatives that aim at promoting legal and regulatory reforms? The observed failure of the legal and policy regimes in both Kenya and Guinea to end the practice of FGM/C suggest that interventions that seek to effect changes in perceptions, attitudes, behaviors, and practices that contributed to real and sustainable changes in the practice of FGM/C must either include or leverage a cocktail of other interventions in the spheres of behavioral biology, cultural, economic, social, and other spheres to induce embrasure of and lasting change. Gachiri (2000) details how even extreme forms of sanctions under the law and by governments did not succeed in breaking the resolve or repressing the practice among circumcisers but rather had the opposite effect of increasing the practice spatially and in the extent of the cut inflicted on girls and young women.

**Textbox 17**  
**Sanctions, Resolve, and Irrepressibility**

“We were beaten very much, spent many nights standing on wet floors, in the swamps of rice fields for two weeks. We promised the government that we would never circumcise girls again [but] after that we tool hold of many young women and taught them how to perform the operation secretly everywhere, day and night. We swore to do it even more extensively than before. We circumcised everywhere even in the forests, in banana plantations and in homestead” (Gachiri, 2000., p 42).

vi. **Top-Down Approaches Create New Forms of Resistance To Change:** The proscription of the practice of FGM/C is occasioning the emergence of new forms of intellectualized and professionalized resistance to the calls for the abandonment of the practice of FGM/C. Such resistance and attempts to frustrate the banning of the practice may be summarized as follows:

- *Medicalization is a form of resistance* – Medicalization of FGM/C practice is not a new phenomenon. On the contrary, it has roots in colonial history that introduced and legitimized it. Gachiri (2000) recounts how the colonial government in Kenya allowed female circumcision “...in hospitals as a lesser evil

[when] done without heathen ceremonies and in private, with Christian supporters” (2000, p.2). This, together, with the demonization of the practice by missionaries who told “converts that all traditions of the people [including FGM/C] were evil and from the devil” (Gachiri, 2000, p. 41) set the stage for resistance and counter-narrative constructions that sort to validate and reestablish the practice as a genuine African practice of value.

However, the current entry of medical professionals into the FGM/C service provision space represents attempts to counter the health hazard and harmful practice narrative used to justify the ban. Through the provision of presumably more professional and less harmful practices, medicalized service providers offer a counter-narrative that aims to eliminate the health and harm argument and provide alternatives that effectively counter-argue that there are safe and unharmed ways to maintain the practice. This counter-narrative is what made medicalization an alternate route to side-stepping the ban, even though medicalized FGM/C is itself included in the ban. Medicalization also represents an attempt to cash in on the unmet demands in the FGM/C service market, as explained elsewhere in this report.

- *Legal and Anti-colonial Counter Resistance Movement*: The Kenyan Court case represents not only a legal form of resistance to the outlawing of the practice, but also casts the debate on the push to abolish FGM/C within the discourse of coloniality and issues of cultural imperialism that sets up a cultural warfare over whose values matter in the discourse (Catterson, 2022; Kwamboka, 2016; Kwamboka, 2016). This argument is bound to continue in the debate over whose perceptions of rights trump in the fight to end FGM/C. The subalterns i.e., those whose voices are suppressed in the discourse are bound to find alternate ways of living out their culture, as the various forms of evading the law and law enforcement captured in this study signal.
  - *Human Rights Counter-narrative*: Emerging voices on counter-human rights arguments emphasizing a two-sided pro-choice contestation i.e., the right to choose to be cut or not. Pro-FGM/C advocates have counter-argument that women have the right to choose whether they should be cut or not. Such counter-arguments effectively weaken the human rights approach to calling for the ban on FGM/C, since the same arguments that advance the logic of non-cutting i.e. it is a violation of the human rights to inflict a cut on an unwilling woman, it is equally a violation of the rights of a willing woman to be denied the cut. The High Court in Kenya may have overruled the latter argument, but the question remains unsettled.
- vii. *Need to adopt whole-of-community developmental approaches to ending FGM/C*: In contrast to the women’s human rights and health approaches, participants in this study have called for comprehensive all-of-community developmental approaches to bringing an end to FGM/C. Such approaches will create different paradigms and narratives that support inclusive programming in which all segments of the community – men, women, the youth, circumcisers, etc. lead the charge because they can see or have experienced tangible benefits from the stoppage of the practice. Developmental approach entails the development and implementation of whole-of-community intervention strategies that include, but are not limited to the following:
- sponsorship of income generation activities for ex-circumcisers (GN\_KII\_02\_8414; GN\_KII\_7582).
  - Support for the interventions that create immediate and tangible benefits to families of those who resist the uncut e.g., support for the education of uncut girls, training and skills development for uncut girls or women who cannot go back to school
  - Promotion of family enterprises for men agreeing to value and marry uncut girls
  - Community development initiatives such as the building of educational and health facilities, support for communal infrastructure (building of roads, construction of bridges, provision of water sources for human and animal consumption and for productive economic activities such as gardening, etc. for communities that abandon the cut.

### *viii Weak Coordination of actions hamper effectiveness:*

Respondents in this study have cited how weak coordination of actions between different stakeholders and even within government establishments charged with overseeing the end of FGM/C have created loopholes in the fight. In particular macro level actors have noticed the existence of “weak coordination and collaboration between actors “ (GN\_KII\_03\_Ministry of Health and Public Hygiene) and the need for “real systems of coordination of efforts (GN\_KII\_03\_German Embassy) between the actors. In Kenya, also, it is noted that “the FGM framework at the National and the County levels is inadequate and generally lacks strong coordination including in the education, health, culture, legal, policy and economic segments” (KN\_KII\_03\_NGEC); despite the awareness that an effective “Coordination and team work will help to develop common approaches and build synergies to fight this FGM/C” (KN\_KII\_03\_3132). Textbox 18 provides an example of what the lack of coordination means on the ground and how that hampers the fight against FGM/C. In sum, actors in the anti-FGM/C space need to “establish coordination [mechanisms] that can allow harmonization and collaboration between the actors” (GN\_KII\_03\_Ministry of Health and Public Hygiene).

#### **Textbox 18 Non-institutionalization of Frameworks of Action against FGM/C**

“when you look at the county, various technical working groups like the gender sector, like the court users’ committees, there isn’t that institutionalization in the government agencies. It purely depends on the goodwill of the person that is in the office. For instance, for a court user to be very supportive with FGM prosecution [...], it purely depends on the magistrate that is sitting in that court. There isn’t that kind of deliberate commitment by say the judiciary that “our officers must end FGM”. Every stake holder must work around FGM. It is so personalized” (KN\_KII\_03\_UNFPA).

### **6.4 Discussion of Findings**

Interventions to end the practice of FGMC date back to colonial times, with the full range of intervention options in force today having been tried before. For instance, Gachiri (2000) discusses how, since the 19<sup>th</sup> Century, the colonial government and missionaries in Kenya used bans, severe sanctions, education, and even authorization of presumably less harmful methods through medicalization and supervision of circumstances, as means to enforce bans or persuade practicing communities to give up the practice. Contemporary interventions to stop the practice are rooted in global efforts to promote systemic reforms through securing commitments from continental, regional, and national governments and their respective agencies to adopt legislative and policy reforms, as well as, implement commitments on setting up and resourcing relevant agencies to monitor and prevent the practice or sanction errant persons who perpetuate the practice.

Despite the great visibility created on the issue and the sleuth of conventions, protocols and treaties rolled out and adopted at the international and national levels to stop it, FGM/C remains an entrenched practice that is using creative ways to evade the sanctions of the law. Regional and national governments have adopted laws and put in place regulations that ban the practice within their jurisdiction. Yet, little if any commitment is often shown to demonstrate progress towards the achievement of their national and collective global goals. Reductions in the practice are faster in some countries than others, with significant pockets of resistance in some regions within practicing countries. Guinea and Kenya represent two ends of the success stories of FGM eradication. While the practice is still widespread in Guinea, despite the existence of a ban since the 1960s and considerable investments by national and international agencies to effect the ban. Kenya, on the other hand, has witnessed significant reductions in the practice over the years, although high prevalence still exists in different geo-ethnic pockets of the country. In both countries, combinations of different factors undergird the slow pace of or resistance to change.

The findings of the study suggest that the feasibility of the planned interventions will be enhanced through a combination of top-down and bottom-up interventions that bring policy makers, implementers, and the community-level actors into the same spaces for open and frank dialogues for decisions and actions that reflect the interests of all. It is only when community members are convinced of the need for change and see that such change preserves or enhances their interests will they lead the process to make change happen. This requires a careful balancing of the macro, meso, and micro-level interventions to ensure the relevance, coherence, effectiveness, efficiency, and impactful investments of the time and resources of the project to achieve sustainable outcomes. Such a balance must respond to the observation that: “The most effective way to end FGM is through education, information, and advocacy that will raise public awareness and bring about changes in attitudes within communities where FGM is practiced [...] Countries may pass laws to eradicate FGM, but legal instruments by themselves cannot end the practice since traditions and beliefs are strong and deeply rooted in societies” (Population Reference Bureau, 2010, p.1). In such circumstances, top-down approaches will not work; instead, they would breed resistance. People obey laws that they agree with – see textbox.

**Textbox 19**  
**Views from Guinea whether people respect the laws banning FGM/C**

“They don't respect and that's the problem with the law. The law is like a project, you have to start at the base. If it's not sensitive, it becomes complicated. You need a bottom-to-top approach otherwise the application becomes problematic”  
 (GN\_KII\_03\_8349\_IO)

“Everything comes from the conception of the law, for me before imposing a law you have to work at the base. If everyone understands that the practice is dangerous and harmful for the woman and the child, they will be able to respect it. If the base adheres, there will be more denunciations.”  
 (GN\_KII\_03\_8144\_SNRCS)

To achieve a good balance between the macro, meso, and micro-level interventions requires a recalibration of the intervention outlooks and strategies of Plan international and its partners to take the following factors into account:

*i) Intervention paradigms and narratives focus on women, not all-of-community development approaches:* Part of the stalemate comes from the fact that not much has been done to shift the paradigm and narratives that define the call for the ban on FGM/C. Conception of the FGM/C problem remains focused on the health, rights, and well-being of women only, not the wider beneficial interests of families and communities. The focus on women rather than the whole society leads to an inability to stimulate discussions that generate wider societal paradigms that change narratives to incorporate the interests of a broader range of interest holders in the community such as men whose sexual and social pleasures the practice of FGM/C seems designed to fulfill. This has resulted in the adoption of adversarial rather collaborative postures that leverage whole community approaches to tackling the problems. Consequently, except under the Saleema Initiative, most continental, regional, national, and county/district strategies to combat the practice of FGM/C emphasize punitive measures as deterrents rather than adopting holistic development approaches to promoting the abandonment of the practice. As one respondent in Guinea noted, current national and subnational anti-FGM/C interventions prioritize punishments in the penal code with articles that specify clear punitive sanctions for those who offer or receive FGM/C services.

**Textbox 20**  
**The Need for a New Paradigm**

Men remain the decision-makers.  
 “So, we need to do more in terms of male engagement, we need to reach out more to men, we have specialized a lot to women and girls, and we need to be able to penetrate that kind of patriarchal kind of setup we need to engage men at various levels and also strengthen that kind of commitment from the male counterpart both from the highest to the lowest level.  
 KN\_KII\_03\_UNFPA

Hence, the emphasis is “not on development plans but regulatory framework” (GN\_KII\_02\_9424). Besides generating and sustaining the resistance to change, the inordinate focus on criminalizing and pushing offenders leaves the fight against FGM/C trapped in circular victim-offender narratives that entrench the punitive legal processes of the State against the recalcitrant resolve and resistance from the practicing communities; thereby creating the “hostility from communities practicing it” (KN\_KII\_02\_9331) or “rejection by some of the community leaders who believe in FGM/C” (KN\_KII\_02\_7400; KN\_KII\_02\_2244; KN\_KII\_02\_9119).

ii) **Multiple Actors, Muddled Objectives:** The multiplicity of actors coming from different ideological backgrounds – health, human rights, women’s empowerment, etc. – advance different programmatic approaches that, in the eyes of practicing communities, tend to muddle the real objective of the call for the ban. The calls for total bans through laws and sanctions often amount to throwing the baby out with the bathwater, since they fail to see the cherished dimensions of the practice to those who believe in it – the educative and adulthood socialization processes involved in the FGM/C practice. This, in part, triggers resistance and sabotage, as practicing communities see it as an attempt to usurp or replace their traditional educational systems with foreign ones.

Another challenge with the over concentration of actors in certain geographical zones is the risk of overlap or even double-crossing of activities that may have countervailing strategies. Multiple actors working on different projects or using different intervention strategies can create cognitive dissonance among participating communities who struggle to understand what all the actors want. For instance, interventions that focus on the use of the law to identify, arrest, prosecute and punish offenders will be counterproductive to ones that emphasize promoting alternative rites of passage approaches that affirm the non-cutting aspects of the FGM/C practice. Communities that receive messages from such different actors have difficulty understanding what the agencies want from their search to ban the practice, as respondents in Guinea questioned.

iii) **Externalization of the Fight Discourages Local Ownership and Participation:** Third, practicing communities see that it is external agents who directly engage or sponsor local counterparts to champion the calls for the bans. Therefore, they do not understand the rationale for the call to end FGM/C, as exemplified by the questions survey respondents in Guinea raised – see Appendix 6. Besides, since the interventions are led by external actors, community members do not own the process for effecting it. Building on the observations of Monkman, & Miles, (2003), Young (2015) makes the point poignantly in observing that:

Outsiders from the global North have tried many approaches to end FGC, including “legislation, medicalization (training health professionals to perform the procedure under sanitary conditions), religious condemnation, information, ‘just-say-no’ campaigns, educational efforts, and attempts to institute alternative rituals”—all with little effect

As community-level participants in this study in Guinea observed the lack of progress in the fight against FGM/C is partly because “We have not used the right strategy to address FGM/C. Most strategies have not been well thought of. They are usually not sustainable and do not adequately involve the people” (GN\_KII\_01\_1563). Recalling the external nature of interventions, another participant attributes the limited progress to the fact that the “...community was not consulted on why they should fight female genital mutilation. Secondly the government and non-governmental organizations have used the top-down approach” (GN\_KII\_01\_2814).

iv) **Distributional Disparities and Ineffective Coverage of FGM/C Hotspots:** Logistical, budgetary, and time constraints tend to direct intervening agencies to concentrate in specific geographical enclaves to the exclusion of other endemic FGM/C practicing areas. Findings under the logistical risk factors above highlight how decisions to invest in some FGM/C endemic areas and not in others are made. As a result, such considerations (difficulty of access; staffing and budgetary limitations) while some zones witness a near saturation of agencies promoting anti-FGM/C activities, other

**Textbox 21**

**Go Where the Need is, not where it is convenient to be in**

“Go to counties which do not have partners, we have partners who are only concentrated in one county or two or three while we have other counties which do not even have a single partner. A county like Bomet, Nyamira, like UNICEF is in Kisii and Migori but not in Nyamira. I would recommend if they would do some mapping to determine where to set up the partners, then spread out to the rest of the country. **The war Against FGM cannot be won if these organizations are concentrated in one area yet we have the practice going on in almost 20 different counties**” (our emphasis).

KN\_KII\_03\_National Anti-FGM Board

areas have literally no presence of such agencies. The textbox highlights the implications of such uneven coverage of endemic areas in the fight against FGM/C. Concentrating the fight in one place to the neglect of other endemic areas is what creates the loopholes that permit FGM/C service seekers to move between the cracks to access services where prevention activities are absent.

### **6.5 Lessons Learned and Implications for Plan's Intervention Designs and Management**

Based on findings from the experiences of participants in the study, as well as insights from the extant literature reviewed in the course of this study, we draw out the following lessons to guide Plan International and its partners in the design and implementation of their interventions:

1. **Do not support extensive use of force and the law.** While it is known that the law can make others refrain from practices which are categorized as illegal; this does not always work in areas which touch on deep-seated cultural beliefs and practices. In the case of FGM, the forceful use of the law has led to communities migrating across borders to perform FGM and keeping secrecy about where FGM takes place. Communities also threaten the security of those who report FGM cases. The practice of FGM is transforming into a more concealed underground manner.
2. **Do not employ strategies or messages that are generic and not targeted.** In cases whereby, general awareness has been shared with the whole community using a standard generic strategy or message; there has not been substantial evidence that this approach works to deter communities from practicing FGM. When strategies and messages are generic and imposed from one community to another, then in many cases the communities will just listen and watch but still not stop the practice of FGM. This is because the overwhelming pressure of factors like their socio-cultural beliefs, ignorance and poverty could be keeping them from responding to what is being advised. It is noted that awareness creation and public education for FGM in Kenya should have been more targeted and customized in a special manner that effectively reaches the children, parents, leaders, and community members.
3. **Do not disregard existing structures by reinventing new ones.** While the move to establish the anti-FGM/C Board is a positive demonstration of Government political goodwill, there have not been enough resources for the board to reach down to the decentralized levels. The board, therefore, remains at the national level where it has a secretariat with national staff with limited visibility and impact at decentralized levels. It would have perhaps been better to leverage previously existing structures for HIV and AIDS like Constituency AIDS Committees (CACs) to advance the fight against FGM. Stakeholders could have assisted the Board to decentralize its functions to the county and community levels while using existing structures.
4. **Do not design short and under-funded interventions.** It is noted that to eliminate FGM a whole transformation of mindset is required among all the key stakeholders in the communities. As such it has been noted that, unlike some health and education projects, FGM control takes a much longer duration of many years and requires enough resources to constantly reach out and engage all spheres of community members. Therefore, short, and under-funded projects have often come to an end before the practice of FGM is eradicated from the communities. The three-year time i.e., 36 months between 2023 –2026 anticipated in Plan International's proposed interventions is therefore inadequate to significant and lasting transformational changes. This timeframe and the funding available can, however, make significant contributions to the fight against FGM/C if devoted to strengthening and harnessing the capacities of subnational level structures to initiate and follow through activities that trigger and sustain changes in beliefs, values, and mindsets that make the demand for FGM/C services irrelevant.

**Textbox 22**  
**The Ratchet of Influence that Sustain FGM/C Practice**

“Many NGOs aim their work at mothers, but they are wrong. Mothers have no power to stop this tradition. Only the father has the power to make that decision. And he is under pressure from his sisters, because traditionally under Guinea’s patriarchal system, girls belong to the father’s family” (Barbière, 2017, p1).

5. ***Do not leave behind the children and their families:*** In many cases, mostly due to resources constraint, some FGM interventions have not been rolled to personally engage children, their families, and couples within households. The most critical dilemmas, decisions and actions concerning FGM take place within the family. For instance, it is very critical for the projects to fully understand and address the connection between household poverty, FGM/C and subsequently marrying off daughters for the benefit of bride price. Therefore, when projects have been placed at national and county levels without any strong linkage to the community and subsequently households; then it proved to be hard for these projects to change the minds, beliefs and practices of families as relates to FGM.
6. ***Do not nurture any tension between women and men:*** FGM has caused a situation whereby men blame women and women blame men, while the practice continues to be harmful to girls and women. In some cases where projects opted to leave out men and work with women alone, then the fight against FGM/C could not succeed since men are often the gatekeepers and decision-makers at home and within communities. Antagonizing the genders has not worked well, and projects that succeeded were that that nurtured more meaningful engagement and collective action of couples within their households and community groups.

## VII. Conclusion

Efforts to end the practice of FGM/C in Guinea and Kenya, and for that matter, other parts of Africa have gone on for decades. The persistence of the practice is testimony to the inability of interventions to date to effectively address the entrenched nature of the practice. Since colonial times, efforts to abolish the practice have focused on the promulgation and enforcement of laws that punish offenders, especially those carrying out the excision. The focus on criminalization of the practice direct intervention attention to the supplier side of the FGM/C service market. The persistence of the practice, however, show that what supply side interventions have been offered, such as the creation of awareness of the harmful effects of the practice have not done much to change the minds and hearts of individuals and communities who find value in accessing the service. The recourse to underground and cross-frontier service provision and access; the medicalization of the practice, the observed instances of “girls cutting themselves” (Olajide and Zaman, 2021, p.1), and the readiness of diasporan communities to invest in travels to get the cut for their girl-children underscore the fact that the demand outweighs the supply. It also reveals the limitations in using proscription and law enforcement as an instrument to ending FGM/C.

Plan International and its partners envisage launching innovative interventions at the macro, meso, and micro-levels that harness the power of youth, families, CBOS, and key decision makers to influence policies, programs, and promote joint learning in ways that build capacities that stimulate systemic changes at national, regional, and possibly continental levels through replication of lessons learned in other countries. Envisaged interventions include support for macro level engagement to promote and/or accelerate policy and legal reforms that create enabling environments for meso and micro-level actors to take brave and sustained actions to end FGM in targeted communities within selected endemic districts and counties in Guinea and Kenya respectively. This multi-tier, multi-stakeholder approach seeks to mobilize and galvanize different stakeholder groups (government actors, leadership of civil and faith-based organizations, as well as, community-based organizations and actors) to engage synergistically to advance the end to FGM/C practice in Guinea and Kenya.

This research was commissioned to examine the feasibility of the proposed interventions based on an assessment of a broad range of contextual and technical factors underwriting the practice of FGM/C in both Guinea and Kenya. The findings and recommendations of this study are based on the review of a broad range of extant literature from different stakeholder sources; a three tier sets of interviews with an equally broad range of stakeholders in the FGM/C space at the continental, regional (EAC and ECOWAS levels), and at national, district, and community-levels within Guinea and Kenya. Participating communities were selected from the districts or counties Plan International has targeted for the interventions under the anticipated project.

While welcoming the interventions that Plan International and its partners envisage in the new project, participants in this study have made a distinction between form and substance in their assessment of the feasibility of the planned interventions. They recognized the existence of continental legal and institutional frameworks and domesticated laws and regulations, with accompanying implementing institutions in several member states of the African Union, the EAC, and ECOWAS. However, they noted that having the right laws and institutions in place does not necessarily mean countries or communities are engaging effectively to end FGM/C. They pointed out that the focus on banning the practice of FGM/C through legislation and punitive actions does not work and may, in some cases, have become counterproductive as it has either increased resistance or driven the market for FGM/C service provision underground. Similarly, a focus on building capacities of macro and meso-level actors to enact and enforce legal frameworks that ban the practice is not efficient, effective, impactful, nor will it be sustainable. The approach is also not consistent or coherent with the world views of practicing communities on what needs to be done to stop the practice. The solution to ending FGM/C practice is not with preventing the supply of FGM/C services by criminalizing it and identifying and punishing downstream service providers and end-users; the solution lies in upstream initiatives that eliminate the demand for the service in the first place. As the quote from Gachiri (2000) intimated, as long as there is a demand for FGM/C services, there will be service providers to meet that need.

Transformational and sustainable change is only possible through persuasion, not dissuasion. Genuine, embraced, and sustainable change happens when people see that the change serves their best interest. Therefore, efforts to engineer change must be rooted in helping communities realize their interest are served better when they embrace the desired change. Change that is perceived to go against the best interest of people will be resisted.

Respondents have also pointed out centuries-old beliefs, values, and practices cannot be changed overnight with the promulgation of a law and/or a burst of activities that take place within a short span of time. Changing minds and hearts to change values and practices takes time. As one KII\_03 respondent noted: “By the time you convince a community to abandon FGM, it takes a process like many, many years” (KN\_KII\_03\_National Anti FGM). Therefore, anti-FGM/C activists need either measure the expectations of their interventions or plan for the long haul to wait out the slow processes of transformation that changes in perceptions, norms, behaviors, and practices require.

## **VIII. Recommendations**

### ***8.1 Reflections on Planned Activities and Recommendations for Macro-level Engagements***

#### ***8.1.1 Planned Activities at Macro Level***

Per the Concept Note, Plan International’s macro level interventions aim to contribute to ending FGM/C in Guinea and Kenya through triggering “systemic change in the implementation of FGM/C laws and policies” (Plan International, 2022, p. 3). To achieve this, Plan International’s AU/LO and Civil Societies Organizations will engage political actors at the AU level “...to advocate for implementation of laws, increased accountability, and realistic resourcing, particularly in the COVID19 context” (Plan International, 2022, p. 3). Plan International also hopes to facilitate high-level engagements of peers, stakeholders, civil society, and government agencies at regional and national levels promote exchanges on how to effectively end the practice of FGM/C. This will include facilitating engagements between National Anti-FGM/C boards of Guinea and Kenya, Members of Parliament, equivalent government departments and agencies of the two countries to share experiences and best practices that contribute to eradicating FGM/C in both countries. Through the exchanges, implementing partners would identify bottlenecks in the eradication of FGM/C “that require national or AU level Advocacy” (Ibid). Macro level engagements will also “Create a digital platform for long term exchange and learning” (ibid).

#### ***8.1.2 Reflections based on Findings:***

Findings from this study have established that the AU, ECOWAS, and EAC already have expressed commitments to eradicate FGM/C within their respective purviews. They have adopted several protocols

and instruments that enjoin member states to take action to end the practice. However, as confirmed in the findings, the AU, ECOWAS, and EAC do not have the power to compel their respective member states to ratify and comply with any international treaty or agreements, even if the AU and the regional bodies have adopted them as their own policies and programs. Secondly, part of Plan International's envisaged interventions in the project seek to facilitate systemic change through advocacy and engagement with high level decision makers and other actors at macro level to influence the making or enforcement of laws and resource allocation to support the fight against FGM/C.

The study has established that the main challenge to ending FGM has been the mindset of communities. As illustrated in this report, even some well-educated national leaders and health professionals support the continuation of the culture of FGM/C. Eradicating FGM/C requires changes in the mindsets of whole communities. Mindsets do not change overnight; it requires a long-haul engagement that goes beyond the cycles of projects and programs. Similarly, as with the AU and regional bodies, this study has also established that national consultations are important and necessary but not sufficient to make change happen at the community levels where the practice of FGM/C is carried out, unless the interventions lead to changes in beliefs, values, minds, and hearts that change demand for the service. Hence, while legal, structural, and resource allocation reforms for the fight against FGM/C are necessary, they are not sufficient to make changes in perceptions, beliefs, values, and practices happen at the microlevel, unless such efforts are owned, implemented, and sustained at the community levels. In other words, large-scale and sustainable change for the eradication of FGM/C will happen only when practicing communities are *convinced*, not *compelled*, to embrace change.

Third, Guinea has been suspended from membership of the AU since 2021, following the military coup d'état that truncated the rule of a democratically elected government. At its plenary meeting in February 2023, the AU renewed its indefinite suspension of Guinea from its membership. Therefore, it is not evident that the AU will have any persuasive force on the internal policies of Guinea in respect of the eradication of FGM/C until the country is readmitted to the AU membership. Consequently, advocacy with the AU in respect of Guinea in this project, while desirable, may be ineffective. These limitations must guide the expectations from engaging these institutions.

### **8.1.3 Recommended Actions**

In the light of the findings, we recommend that macro-level engagements in both Guinea and Kenya should be directed at encouraging stakeholders and duty bearers at the AU, EAC, ECOWAS, and national levels to prioritize policies and programs that enable meso and micro level actors to:

**1) Focus Advocacy at the Macro level to trigger increased investment of adequate resources and efforts in mindset transformation using culturally appropriate approaches:** To achieve the objectives of ending FGM/C, we recommend that Plan International advocates with the AU, regional bodies, and governments to invest in longer-term, adequately funded, and sustainable programs that work on transforming mindsets over the years. This will require working with national governments, donor agencies, and other meso and micro level actors to devise and institutionalize mechanism for mobilizing and sustaining the flow of resources to support long term microlevel engagements that allow Plan International and its partners to have a full understanding of the reasons behind people's values. This immersed understanding of what underpins the practice of FGM/C would enable Plan International and partners to work with community resource persons to agree on what interventions work well within their unique context to trigger the whole-scale change required to end FGM/C. The process of engineering change must be culturally responsive, respectful, sensitive, inclusive, and demonstrate a commitment to long-term engagement with the communities to work through their challenges. It should also include a will to empower communities to identify and adopt their non-harmful alternative rites of passage which work well within their unique context and needs.

*This recommendation is applicable to both Guinea and Kenya.*

2) **Fully understand and address other factors using an intersectionality approach:** the analysis of the socio-economic context supporting the practice of FGM/C in both Guinea and Kenya have cited poverty as one of the drivers of the FGM/C practice from both the demand and supply side. In Kenya, it is blamed as one of the key factors that push parents to take their children to participate in FGM and so that they can quickly marry them off. However, poverty is multi-dimensional in its origin and manifestations. Besides, poverty alone does not explain why well-educated professionals, such as those in the health sector, as well as citizens in the diaspora support and patronize the practice.

To fully understand what sustains the practice of FGMC, we recommend that Plan International and its partners adopt an intersectionality approach that track and analyze the broader range of factors that underpin the demand and supply of services to perpetuate the practice of FGM/C. A comprehensive approach should enable Plan International and partners to identify and customize interventions that address different needs for different communities or groups. Such an intersectional programming approach could enable Plan International and partners to identify and prioritize in its interventions that include support for the strengthening of local and family livelihoods; improving knowledge and practices that lead to the abandonment of FGM/C; promoting interventions for retaining girls in school; initiatives for rescuing girls and helping them rebuild their lives through transit safe houses; and providing legal aid to those who need it.

*This recommendation is applicable to both Guinea and Kenya.*

3) **Engage the Diaspora:** Though not anticipated in the intervention design in Plan International's Concept Note, the findings of this study highlight the critical role of diaspora communities in supporting the continuation of FGM/C in their home countries and elsewhere. Incidentally, most diasporan communities tend to self-organize around different associations directly linked to their native countries, regions of origin, ethnic groups, or alumni associations of the high schools, colleges, or universities they attended. In some places, umbrella associations such as the Guinea Diaspora Association in the USA or the Kenya Diaspora Association in the Netherlands provide entry point to reaching other associations.

Diaspora communities wield considerable influencing power in their native communities. The exposure of this group of citizens to the outside world and their relative wealth makes them influential stakeholders in multiple domains in their home countries and communities. Most African governments are actively courting partnership with their respective diaspora as key stakeholders in their development efforts through the creation of physical and virtual platforms of engagement. For instance, the government of Guinea has a Division for Guineans abroad within its Ministry of Foreign Affairs, even though most members of Guinea's diaspora are unaware of the existence of this interface point. However, development agencies have demonstrated the influential power of this diaspora when, for instance, "Members of the Guinean diaspora living in the ECOWAS region were mobilized to give training in the creation and management of micro-enterprises to a group of beneficiary women" (IOM, 200-4, p. 8). In 2022, the Government of Kenya formalized the creation of the State Department for Diaspora Affairs "to engage the Kenyan Diaspora in a more constructive and productive manner to unlock and unleash their full potential" (Government of Kenya, 2022, n.p). Other governments are offering dual citizenship and other engagement programs to entice the return or engagement of their diaspora.

Both Guinea and Kenya have substantial numbers of their citizens in the diaspora within Africa and beyond, who play an influential role in perpetuating the practice of FGM/C through their patronage of the services since their patronage of the FGM/C services lends some credence and legitimacy to the practice. The monies they spend on accessing the services sustains the supply chain. Besides, diaspora communities have access to information channels that they can use to influence changes in perceptions, attitudes, and behaviors in their native communities. Diasporan communities can be engaged in dialogues that change their own perceptions and embrasure of anti-FGM/C. They can champion change first among the diasporan community and then with their home relations. Just as their continued patronage of FGM/C validates the practice, their willingness to be voices of change will influence perceptions of their home communities on the practice.

To succeed in ending the practice of FGM/C, Plan International and its partners need to find ways to engage diasporan groups who bring their girl children back to their respective home countries for the cut. Plan International and partners therefore need to engage this critical constituency if the fight against FGM/C is to succeed. To harness the influence and resources of Guinea and Kenya diaspora to make change happen in respect of ending the practice of FGM/C we recommend that:

- i) *For Supra-national level diaspora engagements:* Plan International and partners within and outside Africa engage their respective continental bodies such as the AU and the European Union (EU) to explore ways to engage diasporan communities in dialogues and actions that discourage their patronage of FGM/C within their membership and in their home countries. Plan International and partners should also engage the Embassies, High Commissions, and other foreign representations of the governments of Guinea and Kenya to explore ways to engage their respective diasporan communities for dialogue and action that make them champions of change for ending FGM/C.
- ii) *For national level diaspora engagements:* Plan International identifies and works with organized and visible diasporan associations as the entry point for mobilizing national diasporan associations to commit to supporting the fight against FGM/C among their members and within their home communities, leveraging their individual and collective influences they have back home. An entry point would be for Plan International and its partners to work with the national governments of Guinea and Kenya to see what channels they already have for engaging the diaspora and to use same to establish collaborative engagements with diaspora communities to promote the end to the harmful effects of FGM/C. The engagement should involve the identification of influential diasporans who can serve as champions of change in their home communities and leverage the influence of such persons to influence changes in minds and hearts that would lead to the abandonment of FGM/C.

*This recommendation is applicable to both Guinea and Kenya.*

**4) Need to Harmonize and Share FGMP/C Prevention Capacities:** The evidence adduced in this study suggests that multi-sectoral, multi-tier, and multi-national approaches are required for effective tackling of the practice of FGM/C. The ability to effectively coordinate policies and actions across all these levels must be built around harmonized policies and action plans; shared approaches to policy and program implementations; coordinated systems; and shared resources. The latter includes shared intelligence gathering and action, especially at the interstate levels to deal with the issue of cross border access to FGM/C services. Currently, however, capacity building efforts concentrated within countries and specific government departments and agencies directly engaged in the prevention of FGM/C. There is little inter-ministerial and much less inter-state coordination of interventions that build capacities across board. For instance, GIZ found out that in its support for FGM/C prevention capacity building in Ethiopia, Somalia, and Sudan, "... there is a lack of regional coordination: key actors cannot implement preventative measures adequately" (GIZ, 2020, p.)

Plan International already anticipated the creation of multi-stakeholder platforms that bring together "together anti-FGM/C boards from both countries to exchange and learn lessons from other successful strategies like Saleema Initiative and the UNICEF\_UNFPA Joint Programme" (Plan International, 2022, p. 4). It also anticipates support for "high level Inter- Country peer to peer exchanges between Members of Parliament, national Anti-FGM/C Board as well as relevant ministries e.g. (ministries of health, justice, law enforcement) (ibid) to facilitate learning and coordination of action. However, in consonance with the findings of this study that the outcomes of high-level engagements seldom percolate to community levels where the change that would stop FGM/C resides.

This study has highlighted how the cross-border transactions in FGM/C service provision and access have thwarted efforts to end the practice through bans in neighboring countries. At the same time, there are success stories of how FGM/C has been stopped across the borders of both Guinea and Kenya. Guinea, for instance, stands to gain a lot more from the positive deviance stories across their borders in Senegal and Liberia where communities have willingly abandoned the practice of FGM/C. Kenya can also learn from the success of the Saleema project in Sudan. The similarity in cultural and socio-economic contexts make cross-learning from such neighborhood initiatives hold greater potential for impacting change than through high level to cross-regional peer to peer engagements envisaged in the project.

We recommend that Plan International and its partners consider stepping down the level of engagements for peer learning to the level of intra-regional cross border engagements in lieu of the continental level engagements envisaged in the project.

*This recommendation is applicable to both Guinea and Kenya.*

**5) Implement interventions across borders:** Plan International and its partners have envisaged supporting the sharing of experience, best practices, and other resources between National Anti-FGM/C boards of Guinea and Kenya, Members of Parliament and corresponding government departments and agencies of Guinea and Kenya to facilitate the identification of common challenges that can be addressed through advocacy initiatives at national or AU levels. However, the study has established that in both Guinea and Kenya, people often migrate across neighboring borders to receive or provide FGM/C services. This is done to evade falling foul of the law in their home countries. The ethnic, cultural, and linguistic similarities between frontier communities and the porous nature of national borders make it easy to mask the cross-border transactions in FGM/C services.

Peer learning and action is easiest when the peers share common backgrounds such as language, cultural beliefs, values, and practices. Such common bases make engagements and learning less intimidating and facilitates the identification of shared interests and common challenge. Sharing physical and socio-economic spaces facilitates collaboration in finding solutions to common problems. Language barriers to learning and action are minimized through the use of native languages or shared lingua franca used between different communities that regularly engage in trade and other transactions. Kenyans will find it easier to engage neighbors in East Africa through the use of Swahili than they would, trying to communicate with their counterparts in Guinea. Rural communities in Guinea and Liberia can communicate in Kpelle and Mano, while communities in Senegal can communicate in Pulaar or Mandingo with their neighbors in Guinea. The existence of these common cultural and linguistic bases come handy in enabling Guinea and Kenya to learn from the more contextually appropriate success stories of their neighbors.

*Hence, rather than investment in cross-frontier learning initiatives between Guinea and Kenya, we recommend that Plan International and its partners emphasize investments that promote cross border learning and action between the two countries and their respective contiguous neighbors within their regions. The promotion of multi-stakeholder engagements between Kenya, Uganda, and Sudan on the one hand, and between Guinea, Liberia, Senegal, and Sierra Leone, for instance, would be more beneficial to promoting the end to FGM/C than cross continent engagements between Kenya and Guinea.*

We note that with the suspension of Guinea from membership of the AU and ECOWAS, engagement at governmental level between state agencies of Guinea and its neighbors may not be feasible. However, national civil society groups and NGOs have affiliations with or are members of local and/or regional associations and networks that offer contacts between key actors in subregions, and possibly with ECOWAS and the AU respectively. Multi-country non-state actor groups within the Mano River Union countries of Côte d'Ivoire, Guinea, Liberia, and Sierra Leone, such as the Mano River Women's Peace Network (<https://www.peacewomen.org/civil-society-organisation/mano-river-womens-peace-network>) and the Mano River Union Civil Society Organization Platform (<https://mrucsoplatform.org/>) provide important interface points and outlets for anti-FGM agents in Guinea and the subregion, if properly engaged. *We therefore recommend that Plan International and partners pay greater attention to identifying and harnessing the coverage and capacities of such cross-national networks to further elimination of FGM/C.*

**6. Promote Policies and Programs that Support Innovative and Inclusive Approaches:** To bring community members fully onboard in the fight, it is essential to adopt more inclusive approaches to defining the problem and articulating the solutions. In particular, identifying, valuing, and supporting approaches that eliminate the harmful aspects of FGM/C such as the cut, while preserving the educational and life skills training component of the practice will win the support of members of practicing communities over time. To initiate, this, it is recommended that Plan International and its partners engage and encourage the AU, regional bodies, and national governments to adopt policies, programs, and fund initiatives that:

- i) Emphasize collaborative rather than antagonistic approaches to ending the practice of FGM/C. Such approaches should include the use of participatory problem analysis and decision-making processes that put the interests, not the guilt of communities at the center. This requires a conscious effort to identify and highlight the positive elements of the FGM/C and to demonstrate how the communities'

interests will be best served with the adoption of practices that eliminate the cut while valuing and supporting the educative aspects of the rite of passage.

- ii) Recognize that true and sustainable change comes from within, not without, and that transformative and sustainable change happens within a context, not outside of it. Therefore, Plan International and partners need to emphasize whole-of-community approaches to social transformation that encourage personal as well as community-wide intrinsic or internalized changes<sup>15</sup> in perceptions, attitudes, beliefs, values, behaviors, and practices that abolish FGM/C.
- iii) Demonstrate substantial and tangible benefits for individuals and communities that abandon the practice. This could include the award of tangible community benefits such as partial or full funding of community-identified infrastructure e.g., schools, health facilities, water sources for domestic and productive use, construction of roads and bridges, etc. Such reward systems would not only demonstrate tangible dividends of the abandonment of FGM/C, collaborative work on building such infrastructure would enhance social cohesion to preserve the collective resolve to stop the practice.

**7. Adopt Holistic Systems Approaches to Stakeholder and Influencer Mobilization:** Sustainable change happens only when structures and systems change. Structures represent the institutions and actors that make and sustain the rules and regulations governing the condition that needs to be changed. Conversely, the systems relate not only to the policies, rules, and regulations, but also the beliefs, values, and practices that give meaning and life to the conditions that need to be changed. Within this frame, findings from this study suggest that current three-tier intervention design of the Plan International initiative focuses more on the structural side, with its targeting of community influencers, grandmothers, religious leaders, local police, former circumcisers, youth and parents and family members at the *micro level*; key stakeholders (health, social, protection, legal services), local authorities, youth associations, CBOs and local media at the *Meso level*; and National, pan-African civil society networks, Anti-FGM/C Boards, Members of Parliament, national governments, Ministries, media at the *macro level* with the objective of influencing changes in the creation or enforcement of laws, policies, and programs to ban FGMC/C. However, interventions that directly address the cultural, psychosocial, and religious beliefs, values, and practices, and other intangible factors that drive the demand for FGMC do not come up strongly in the Concept Note as areas the project needs to address. But as indicated throughout this report, sustainable stoppage of FGM/C can only happen when practicing communities change their beliefs, values, and narratives that encourage and sustain the practice.

*We therefore recommend that Plan Integrational and partners seek ways to invest strongly in community engagement and dialogue processes in which the communities recognize the need for, and champion the changes that eliminate the demand for FGM/C services.*

## **8.2 Reflections on Planned Activities and Recommendations for Interventions at Meso level:**

### **8.2.1 Planned Activities at Meso Level**

Meso level interventions of the Concept Note anticipate facilitating intra-country peer to peer and multistakeholder dialogue engagements between CBOs, traditional authorities, criminal justice (police/judiciary), county/provincial governmental agencies and actors, healthcare professionals, and religious leaders to enhance coordination of actions that support the eradication of FGM/C practices within their respective spheres of authority and influence. The engagements will also facilitate the sharing of lessons learned and best practices between the different communities, institutional actors such as provincial/county governments, traditional authorities, judiciary, police, religious leaders, medical professionals, and other civil society groups engaged in the fight against FGM/C. Collaborative action between community actors, civil society leaders, government agents and the judicial services is expected to bridge the gaps in enforcement of legislation and promote local support for the implementation of the laws

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<sup>15</sup> Intrinsic change happens because individuals and communities are convinced that change is needed and are motivate to engage in actions that lead to the change. Internalized change occurs when people, out of conviction of the need for change, voluntarily institutionalize mechanisms (changes in structures, rules, regulations, and enforcement procedures) to make the desired change happen.

and programs to end FGM/C. Plan International and partners also anticipate providing capacity strengthening support to local authorities, the criminal justice system, CBOs and other key stakeholders to enhance effective participation and coordination of actions between the different actors for effective implementation of laws and program to end FGM/C

### ***8.2.2 Reflections based on Findings***

The envisaged creation and leverage of multi-stakeholder platforms at national and subnational levels to coordinate actions for ending FGM/C is commendable and highly encouraged. However, the study established that some outlier communities or districts are often at risk of being excluded from participation in the anti-FGM/C programs. And yet, the practice of FGM/C is usually more endemic in such communities. By their exclusion, they offer spaces for the perpetuation of the practice, as both locals and outsiders can access the services there. Similarly, the study highlighted the need for holistic and livelihood systems approaches that address the interests and needs of practicing communities comprehensively. Practicing communities will only embrace change and abandon the practice when they see that their greater interests are best served through such actions.

The study also notes the crucial role that indigenous authority and knowledge systems can play in promoting full community cooperation with project interventions and their engagement in actions for the abandonment of the FGM/C practice. While engagement of traditional dialogue processes with other stakeholders is important, it is not enough to make them effective instruments for ending FGM/C. Traditional leaders must have the spaces, support, and resources to directly engage with key actors within their communities or spheres of influence to make change happen.

### ***8.2.3 Recommendations for Meso Level Engagements***

To achieve the Meso-level objectives of the planned interventions, we suggest that Plan International and partners consider the adoption of the following recommendations to fine-tune the envisaged interventions.

**1) Harness and work with champion torch bearers among community elders and Government leaders:** In Kenya, the Presidential directive of Uhuru Kenyatta, the former President of Kenya, to end FGM by 2022 created an enabling political environment and policy impetus for scaling up FGM work in the country. The current President has committed to continuing with the effort to end FGM/C in the country. This was a new beginning from when politicians never talked about FGM for fear of losing elections. The government of Guinea has also made similar commitments through the proscription of the practice and investments in setting up commissions and committees at the national and subnational levels to oversee upholding of the ban. In addition to the 1965 law and its amended versions that banned the practice of FGM/C, in 2020 former President Alpha Condé inserted a provision in the new constitution that placed “a total ban on Female Genital Mutilation (FGM) of Guinean girls” (Sakor, Sacko, and Soko, 2021, n.p). The Military who took over from Konté chose a prominent anti-FGM/C campaigner as Foreign Minister – putatively an endorsement of her work and a commitment to working to ban the practice (AFP, 2020).

We encourage Plan International to leverage the opportunities that these high-profile declarations of support to ending FGM/C create to work with local and national leaders like Chiefs, County Governors, First Ladies, Parliament, Cabinet, Judiciary, and all others as champion torchbearers against FGM. However, the Liberian example cited in this report point to how traditional leaders can be obstacles to or influencers of change, depending on whether and how they are engaged. Hence, in addition to engaging chiefs through the multi-stakeholder platforms that the project has envisaged, we recommend that Plan International and Partners seek out alternative platforms to specifically engage local, regional, and national opinion leaders such councils of chiefs and traditional rulers, the associations of circumcisers as in the Sande group in Liberia, as well as, local influential religious leaders who can use their voices and spaces of influence to engineer and champion changes at the community levels to the practice of FGM/C.

2) **Network to Expand Anti-FGM/C Activities to under-served communities in targeted and other counties:** Kenya has 22 counties which are identified as FGM hotspots. While Plan International currently works on FGM in Tharaka Nithi, Kajiado and Tana River counties; it is noted that its work even within counties still leaves out some villages and sub-counties where FGM is still being practiced. In addition to the targeted counties, there are also some areas which have not been reached at all by FGM interventions such as Bomet and Nyamira counties and generally across Northeastern Kenya which is riddled with insecurity. Similarly unreached communities exist in Guinea as well.

We recognize that Plan International and its partners alone cannot realistically cover all communities that need to be reached with anti-FGM/C services. However, findings of the study indicate the tendency of multiple service providers to concentrate in specific areas to the neglect of others. For purposes of efficiency and effectiveness in the utilization of available resources, we recommend that Plan International works with national, provincial/county, and local government structures to establish national coordination mechanisms for anti-FGM/C actors to ensure the equitable spread of interventions to communities that need the services most. Effective coordination will create synergies through layering, leveraging, and sequencing of interventions that enable different actors to build on, expand, or deepen the interventions of previous, concurrent, or future actors. Plan International and partners could, for instance, leverage micro-enterprise activities of one agency to address the health, education, or livelihood security needs of communities participating in anti-FGM/C initiatives. Such complementarity of interventions will ensure no gray areas are left in the spatial and thematic coverage in the targeted areas.

3) **Adopt a Multiplicity of approaches:** The anti-FGM/C space attracts different actors and types of activities. As noted in the findings of this study, activities of agencies may be complementary or contradictory and create dissonance for communities receiving different anti-FGM/C services from the different actors. Essentially, the range of interventions that anti-FGM/C actors are sponsoring cover:

- a) Awareness creation and public education.
- b) Active collaboration and coordination with stakeholders. This should include regularly mapping stakeholders to reassess or adjust roles.
- c) Engaging mass and social media in championing the fight against FGM.
- d) Supporting the development and implementation of required policies, laws, and guidelines.
- e) Generation of real-time data related to FGM prevalence, incidence, as well as Knowledge Attitudes Practices and Behavior (KAPB).
- f) Supporting girls to enroll and be retained in school.
- g) Support the relevant state and nonstate institutions to strengthen positive parenting and family interventions on FGM.
- h) Support Judiciary and law enforcement organs including police and immigration to address and contain FGM in line with laws and policies.
- i) Support the work Anti-FGM agencies in both Guinea and Kenya to: a) expand awareness of the laws and regulations that forbid the practice of FGM/C; b) increase awareness of the harmful effects of FGM/C among children through the development and launch of both in and out of school programs that meet the needs of the age, gender differences, and educational level of the children.

Of the list, Plan International's current set of envisaged interventions does not cover the need to generate real-time to support the prevention of FGM/C; support to enroll and keep girls in school and need to support state institutions in Kenya to create and sustain awareness of the dangers of FGM/C to encourage its stoppage. While Plan International and partners are not expected to cover the full gamut of interventions, the adoption of the multi-stakeholder approaches to programming should enable them to co-opt the expertise and resources of other players within their spheres of operation to advance their mutual objectives. To do this, however, Plan International and partners would need to have a broad frame of reference in the design of their activities.

To achieve this, we recommend that Plan International and partners adopt multi-sectoral approaches in the conceptualization of project interventions in order to identify niches in which they can engage different actors that can provide complementary services to what they have on offer. The multi-sectoral approaches recognizes that some of the approaches could be directly implemented by Plan International, while others could be done in collaborative partnerships.

Community actions are often organic, taking on different shapes and directions as the engagements evolve, as the Tostan example cited in this study demonstrates. Hence, the adoption of multiple approaches would also be better served if Plan International makes available resources to support unplanned but desirable interventions that evolve from the engagement of different actors. To sustain community motivation and engagements, therefore, we recommend that Plan and International and partners set aside a contingency fund that supports unplanned but innovative approaches that contribute to the ending of FGM/C. It will be essential to have clearly defined criteria for CBOs and Civil Society partners to access such funding. Clear guidance would also provide motivation for communities to strive for excellence in innovation and creativity in bringing an end to FGM/C

**4) Institutionalize Action Research Portfolios in Community-level Interventions:** Plan International’s Concept Note anticipates promoting long term learning on actions that promote the end of FGM/C. However, Plan International envisaged promoting such learning through the physical and digital engagement of different stakeholders. While this is commendable, it is also noteworthy that there are several issues pertinent to the ending of FGM/C that require more structured and conventional research and learning approaches. For instance, The survey results reported in Table 4 indicate that more women respondents in both Guinea and Kenya considered the practice of FGM/C as very important or important, compared to their male compatriots. Additionally, the quote in Textbox 14 above shows that although men are presumed to be the deciders on the maintenance of FGM/C practice in Guinea, in reality it is the women who push the men to make the decisions that sustain the practice. The incipient dynamics between positional and power, as well as formal and informal power and influence in the decision-making processes for the maintenance of FGM/C in practicing communities was not fully explored in this study and we have not encountered other studies that fully explore these dynamics of front stage and backstage decision-making processes.

In particular the backstage influences that women, as wives, mothers, sisters, or cutters exert on community decisions to continue the practice needs to be fully understood if the change in collective community perceptions, attitudes, behaviors, and practices on FGM/C practice and its eradication is to happen. Otherwise, initiatives to address visible gender inequalities in access to power and decision-making such as making structural changes such as increasing the presence and participation of women in hitherto male-dominated community decision-making structures alone will not lead to meaningful and lasting change.

To fully understand the factors that facilitate or hinder the fight to end FGM/C, we recommend that Plan International and its country partners institutionalize action research portfolios within their interventions to track and collect data that allow them to better understand the power dynamics that influence change or lack of it in respect of the practice of FGM/C within their jurisdictions.

**Textbox 23**  
**FGM/C and Men’s World**

“They have a very strong kind of patriarchy set up where women and girls are not very well strengthened. Men still have the upper hand on deciding on their body autonomy and all that”.

KN\_KII\_03\_UNFPA

### ***8.3 Reflections on Planned Activities and Recommendations for Micro-level Engagements***

#### ***8.3.1 Planned Activities at Micro-level***

Plan International and partners recognize that the practice of FGM/C is rooted in entrenched social norm is that require sustained engagement with key stakeholders at the micro level to make any meaningful and sustainable shift happen. Making that change happen in the practice of FGM/C requires thorough analyses and understanding of the power and authority structures that underpin the making of decisions that create and enforce the norms, beliefs, and values that guide and sustain the practice. This entails close and sustained engagement of community level actors such as traditional chiefs and elders, women leaders, religious leaders, and youth in targeted communities. To achieve this, Plan International and partners propose a set of activities that raise awareness and promote intergenerational dialogue on the harmful

effects of FGM/C. The interventions also seek to protect children through the economic empowerment of women in the target communities. Interventions will also aim to mentors anti-FGM/C advocates at the community levels to support their initiatives. Implementing partners will also use participatory approaches to build the capacity of youth groups , especially in the use of local and social media tools to amplify the messages of change for the abandonment of FGM/C. Plan International and partners will bring up generative issues and themes emerging from community level engagements that require policy actions to appropriate fora at the meso level for redress.

### ***8.3.2 Observations based on Findings on Micro Level:***

This study has established that whole-scale and lasting change in the practice of FGM/C can only happen when citizens of practicing communities embrace change. Therefore, Plan International and partners must endeavor to deepen the reach of the interventions beyond the influential voices at the community level to engage those whose lives and livelihood systems will be directly impacted by the continuation or stoppage of the practice of FGM/C. The use of community empowerment and community-led approaches has been lauded for success in reducing FGM/C in various communities in Kenya and Africa at large. The success of community-based approaches in the fight against FGM/C in Senegal provide pointers to the feasibility of similar interventions in Guinea, given the cultural similarities that fuel the practice in both countries. Plan International is advised to make sure that its FGM project clearly defines roles and brings all stakeholders on board, especially community level actors in the target regions of Guinea and Kenya.

Intergenerational dialogue approaches in Guinea have led to tangible results at the community level. Community level engagements involving men and women in FGDs have contributed to breaking gender and communication barriers that have allowed FGM/C issues to be discussed in the open. However, traditional leadership structures are fixed and age and gender-based power differentials still exist in most communities. Elderly men still make and enforce rules and regulations in respect of the maintenance of customs and traditions in most communities. Externally led project interventions that have sought to empower women often create positions for the youth and women, but do not give power and authority in decision-making processes. Although change in these structures is possible, it has to come from within, not without. Powerholders in communities will self-initiate change when see that the change required serves the larger and best interests of the communities, as demonstrated in the case of Liberia cited in this study, where traditional leaders who once fought off the banning of FGM/C became the champions for its stoppage. In support of endogenous change processes that scale up and deepen community leadership to end the practice of FGM/C, we recommend, in addition to what Plan International and partners have planned, the following areas of emphasis:

### ***8.3.3 Recommended Actions on Micro Level***

**Place the communities in the driving seat while bringing all key stakeholders on board:** We recommend the use of multi-tiered dialogue circles in which elderly men and women and young men and men have opportunities to separately discuss issues around FGM/C, identify benefits and risks, and map out action plans to end the practice of cutting with minimal collateral damage to the ways of life of the community. A second level of engagement would bring representatives of young men and women together, as well as, older men and women, to share the outcomes of their deliberations and build consensus on what needs to be done to end the practice of FGM/C. A final step will be to bring gender-balanced representatives of the youth and elderly groups together for community action planning engagements that map out ways in which the communities can bring FGM/C to an end. This approach would place the communities in the lead for identifying all needs and risks for ending FGM/C and designing ways in which the project would address them. It will help mobilize whole communities to overcome the obstacles and resistances to change. It enables communities to create collective and inspirational visions of a future without FGM/C - visions rooted in the collective interests and expressed needs of the community that inspire collective action for their realization. Where multi-stakeholder approaches involving non-community members (e.g., civil society and local government actors) are already in use, it will be essential to have another level of engagement to share community interests and agreed pathways to ending FGM/C. This will broaden the scope of interests and engagement of other stakeholders to support the community efforts to end FGM/C.

1) ***Involve both women and men:*** Mechanisms that emphasize the leadership role of men (old and young) either as heads of families and clans, traditional leaders, religious leaders, or leaders of other identity groups is critical to ensuring they champion the changes required to stop FGM/C. However, women are the survivors of FGM as well as mothers and cutters; while men are the ones who give final permission or order for FGM to take place. Therefore, involving men and women in the fight to control FGM is critical. Plan International should support the empowerment and agency of women through education, leadership positions and livelihood opportunities as this works well in safeguarding women's rights. Social and economic empowerment of women to lead the charge for ending FGM/C is possible, if the process and outcomes are perceived to provide tangible contributions to improved livelihoods of families and communities. It is essential, therefore, that the project focuses on the social and economic empowerment of women and girls, as socially and economically empowered women gain greater degrees of respect and admission to decision-making circles in their families and communities. As indicated in the preceding recommendation, change in power dynamics must be induced, not forced.

In addition, it will be critical for Plan International to harness and magnify the voices of girls and women who have survived FGM/C to use their lived experiences in discouraging FGM within communities. Particular attention needs to be paid to girls who are out of school and often are left out in FGM programs which take place within educational institutions. At the same time, men as gatekeepers cannot be left behind in this pursuit of ending FGM in both Guinea and Kenya.

2) **Meaningfully engage FGM cutters in different ways:** FGM cutters are some of the main opponents to the stoppage of this practice. It is recommended that Plan International works with cutters to support their alternative income or livelihood efforts and to maintain their relevance and respect in communities by supporting them to become anti-FGM campaigners and educators. This has worked well in communities in Northern Tanzania, Senegal, and Liberia where the cutters put the knife down after being reassured that their income and social status will not be adversely affected if they stop the practice. For instance, due to the success of a re-skilling program that trained cutters on entrepreneurial skills, provided them with startup capital and supported them to access financial services, two well-established cutters that had separately cut 600 and 800 girls in 2016, abandoned their trade and applied to join the reskilling program (Chambua, G. et al, 2019). This, alongside other programs contributed to Tanzania's ability to reduce FGM/C prevalence rates from 15% in 2010 to 10% in 2015.

3) **Support the enforcement of laws and regulations:** Without prejudice to the recommendation to de-emphasize deterrent and punitive measures, and irrespective of the success of such programs, there will always be some people with criminal intent who perpetrate the practice in criminal ways such as the use of crude practices that endanger the lives of clients. It is essential therefore, that the laws be applied to the full to hold such persons accountable for their acts. To achieve this, we recommend the following:

*i. Make Law on FGM/C Accessible to Citizens:* This study encountered complaints about the legal jargons that make the law banning FGM/C incomprehensible to ordinary citizens. While ignorance of the law is not an excuse, it is the duty of government and law makers to ensure that the text of the law is accessible in languages and forms that ordinary citizens can understand. For instance, in Kenya, when asked what, in their opinion are the factors that (would) make it difficult to stop the practice of FGM/C in their community and beyond, respondents noted that "illiteracy levels are high in areas that practice FGM KN\_KII\_01\_9185; KN\_KII\_01\_8102). As a result, "there is ignorance of the law and little efforts are being made to ensure people fully understand the law" (KN\_KII\_01\_8102). In the view of another respondent, the main challenges, obstacles, or barriers that made their community fail to succeed in ending FGM/C is that "the law and policy are not specific and understood by the consumers" (KN\_KII\_01\_1983). Asked whether people in their communities generally follow the existing laws (including by-laws), policies, guidelines, regulations, or prescribed alternative rites to end FGM/C, the answer, as summed up by one respondent is: "to smaller extent yes, however the majority of cases no. This is because there's limited knowledge on the law and policies" (KN\_KII\_01\_1983). Hence, when asked what changes they would propose to make the laws more effective in ending FGM/C a respondent bluntly said: "I'm not aware of these laws , policies , guidelines because they have not been disseminated to us" (KN\_KII\_01\_10). It is therefore essential that Plan International and its partners support the translation and simplification of the law

to make it accessible in all local languages to all members of society/community. This should include considerations for the “dissemination of texts and laws at the central and community-level, organize mobile courts and properly train lawyers so that they can apply the laws to the height of the offences committed” (GN\_KII\_03\_0701\_SNRCS).

- ii) Reinforce Capacity of Law Enforcement Agencies:* In addition to funding and logistical challenges confronting the law enforcement agencies, this study has encountered instances where interference with law enforcement by the local elites weakens the deterrent and punitive functions of the law. In Guinea, KII\_03 respondents noted for instance that the “Laws are not adapted and punishments are not applied [so there is] impunity” (GN\_KII\_03\_3802\_SGO); or when they are applied, they are “not systematically [applied because] when there are arrests, the notables (elites) get involved, and the cases are not condemned or repressed [and not enforced] to the degree of the offense committed” (GN\_KII\_03\_0701\_SNRCS). In some cases, “some judges do not even want to touch the question [because] imprisoning an old woman is difficult [hence] the penalties remain fines and suspended sentences” (GN\_KII\_03\_8349\_IO). In Kenya, respondents also observed that there are fairly well “... written law and policies but to some extent the implementation but is still far from actualization” (KN\_KII\_01\_1563). This is partly because there is “lack of enforcement of these laws and policies to a greater extent [as] the government is only reactive to a few cases” (KN\_KII\_01\_5518) This is because of the “lack of accountability mechanisms for government officers charged with enforcement of the law” (KN\_KII\_01\_1983). As a result, “the [FGM/C] cases are rampant because corruption of law enforcement agencies is very high” (KN\_KII\_01\_8102) As respondent concluded on how the practice of FGM/C might be brought to an end “ When government will take its roles seriously including creation of awareness and strictly enforcing the law then we are definitely sure that we can have the issues of FGM/C addressed” (KN\_KII\_01\_8081).

In addition to strengthening the capacities of judges (justice) and members of the forces of law and order (police and gendarmerie) for the enforcement of laws and regulations, we recommend Plan International, and partners consider support for:

- a) Community courts built around indigenous structures and procedures of justice to empower communities to deal with non-criminal dimension of the infringement of the rules on FGM/C. Such courts could be empowered to deal with disputes arising in families on whether to cut or not cut girl-children; infringement of rules and regulations determined and imposed by the communities; enforcement of rules for the protection of survivors; adjudication on minor infringements that do not involve serious injury or death of victims
- b) the organization of mobile courts with trained judges to the communities to increase access to speedy resolution of cases criminal cases deriving from infringement of the law, rules, and regulations
- c) the promotion of educational programs that dissuade interference with law enforcement for those who breach the FGM/C laws.
- d) Training on community-policing, as well as community-police relationships to enhance collaboration on surveillance and enforcement of the bans.

**4) Support community education and dialogue:** Active communication, information sharing, and dialogues will create spaces for dispelling misconceptions, reinforcing positive knowledge, and encouraging behaviors and practices that support positive deviance, especially for girls and families that want to end the cut but could be under social pressure to conform with their traditions. To support the development and enrichment of open dialogue initiatives, we recommend that Plan International and its partners consider support for the following:

- i. *Develop new strategies to get individuals to listen collectively or individually to radio programs related to anti-FGM/FGC activities.* For example, in addition to using local languages, Plan International and partners could support interactive radio programs that encourage audience participation using call-ins, SMS or WhatsApp texts/audio messages, Facebook engagements, among others at the end of hosted programs that discuss different aspects of the need to end FGM/C. Monthly competitive

quizzes that reward winners with token prizes (certificates, trophies, cash) would encourage listenership and promote greater participation in the radio-based educational programs.

- ii. *Promote country-wide dialogue of generations initiatives:* We have already recommended the use of intra-community generational dialogue circles that bridge the decision gaps between age and gender categories. In addition to that, it will be essential to extend intergenerational dialogue beyond participating communities to generate a nation-wide discourse and agreements on ways to end FGM/C. This could be expanded into cross-frontier dialogues with generational groups in neighboring communities, as well as those in the diaspora through harnessing the power of the internet and social media platforms. The dialogues should be organized as intra and inter gender sessions, creating space for broader circles of community members to participate in reshaping the paradigms that govern the practice of FGM/C in their respective communities.

In furtherance of this, we recommend that, where county/provincial, or national platforms of generational dialogue are already in place, Plan International and partners consider support initiatives that expand and deepen such dialogues in ways that help communities to collectively reconstruct the narratives around FGM/C. In particular, interventions should focus on helping the older and younger generations to isolate and discard the harmful practices while preserving the aspects that enhance the life and well-being of the individuals and the society at large.

For cross-frontier generational dialogues, including those that engage corresponding generations groups in the diaspora, Plan International and its partners should consider sponsoring virtual platforms of engagement that allow young people across different ethnic, national, regional, and even continental boundaries to constructively engage in moderated conversations that culminate in gathering structured lessons that can be used to influence policy making at different levels. Participating countries should not be restricted to Guinea and Kenya, but open to all countries to encourage cross-fertilization of ideas from different experiences.

- iii. *Promote intra-generational dialogue among the youth:* most young people congregate now in cyberspace, using self-select groups as points of interface. Cyberspace comes with the added advantage of affording transnational engagements within membership ecosystems. It therefore affords Plan International and its partners the opportunity to create and support youth-led and cyber-based engagement fora to share experiences and support each other in their fight to end FGM/C. Despite the language divide, the youth can be creative in using other forms of communication including songs, clips, and other audio-visuals to communicate with each other across language and distance divides between Guinea and Kenya.

**5) Monitor and maintain the safety and security of advocates and Whistleblowers:** Since FGM/C is a sensitive matter in some of these communities, it will be critical to pay attention to the safety and security of champions who campaign against FGM/C in some communities. In remote and highly traditional communities, some of the champions are scared that they could be bewitched or cursed for fighting against FGM/C, considered an ancestral tradition that must be protected. In some cases, champions who report when FGM/C takes place are threatened with assault and told that their houses could be burnt down. Plan International should monitor security risks within its working environment and make sure that any possibility of danger is adequately mitigated. The training of community police, as recommended above, would be one way to institutionalize community safety and security surveillance system for whistleblowers.

#### **8.4 Cross-cutting recommendations are applicable at all levels – macro, meso, and micro.**

- 1) ***Work with what already exists and do not reinvent the wheel:*** In both Guinea and Kenya, there are structures like the committees and other state and non-state organizations which already exist in communities and at national levels to support the implementation of laws, policies, and programs to stop the practice of FGM/C. This study has noted that such structures may not be operating optimally due to technical inadequacies and/or resource constraints. Nonetheless, they are known in the communities and at the national levels to represent structures dedicated to ending FGM/C. Instead of spending much-needed resources and efforts in creating new mechanisms of work, Plan International and partners should identify and work through what exists. Project investments would then focus on revamping and resourcing such structures to up their game in their respective functions to end FGM/C. Attention should be paid to how to help such structures institutionalize and sustain their operations beyond the support of Plan International and partners. For instance, opportunities that exist for institutionalizing anti-FGM/C messaging could include supporting the Government to mainstream FGM/C education and campaigns in learning and education curricula in schools, colleges, and in-service and pre-service training platforms for teachers, security services agencies such as the military, police, and other duty bearers in the two countries.
  
- 2) ***Advocate for Resource Mobilization and Allocation for FGM/C Eradication:*** The need to advocate for uncompelled resource mobilization, allocation, and usage has already been raised above. In addition to promoting voluntary initiatives that mobilize and deliver resources for anti-FGM/C initiatives, Plan International and partners should consider sponsorship of advocacy that emphasize the creation of legislative frameworks that impose obligations and establish monitoring mechanisms to ensure specific budgetary allocations to County and other Subnational level activities for the eradication of FGM/C. Opportunities for legally obligated budgetary allocations for FGM/C initiatives could include specific provisions in national revenue management laws (e.g. natural resource, including mining and petroleum revenue laws) that allocate specified percentages to county and provincial budgets for anti-FGM/C activities. Having such specificity on the source and amount of funding expected from national allocations would allow communities to monitor how much actually comes into their community and how it is used in the fight against FGM/C.

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## Appendices

### *Appendix 1: Conceptual Frame for Feasibility Study*

This inception report outlines the steps IPD, and its partners will take to deliver the results that provide Plan International and its partners greater clarity on the potential enablers and inhibitors in the implementation and outcomes of the planned interventions. Built on the technical proposal that IPD submitted, it also incorporates decisions that Plan International, the Country Offices of Guinea and Kenya, and IPD made during the several rounds of discussions on the technical and financial proposals that the latter submitted and leading up to the award of the contract to IPD for the conduct of the study.

#### **a. Use of Results-Based Management Conceptual Frame**

Consistent with the technical proposal that IPD submitted, this study will use the Results-Based Management (RBM) conceptual frame for the design and execution of all phases of the feasibility study. The RBM conceptual framework is best suited for examining the feasibility of using multi-stakeholder action and engagement platforms that comprise the community, district, national, regional, and continental actors, and action nodes that Plan International and its partners intend to deploy in their intervention's zones in both Guinea and Kenya. This is because RBM allows the different stakeholders to critically examine and determine how their decisions and actions contribute, directly or indirectly, to the achievement of project objectives. It provides a transparent framework for coordinating intervention processes and outcomes to ensure greater inclusivity, accountability, and ownership of the results at the outputs, outcomes, and impact levels. The increased transparency of actors and actions through the RBM lens allows for more efficient coordination and leveraging of capacities across the multiple actors to create synergies that would otherwise be lost. It also sets up Plan International and its partners for the design of comprehensive and inclusive planning, execution, monitoring, and evaluation processes across different levels and countries for assessing the success or otherwise of the planned interventions.

#### **b. Lines of Enquiry**

It places emphasis on the use of the OECD project design, performance, and evaluation criteria of relevance, coherence, efficiency, effectiveness, sustainability, and impact as filters for ascertaining the feasibility of the planned interventions. Specific lines of enquiry that the study will pursue to determine the feasibility of planned interventions include, but are not limited to the following:

##### ***Relevance –***

- In what ways will the planned interventions contribute to the stoppage of the practice of FGM/C in Guinea and Kenya?

To what extent do community-level actors see the planned interventions as important to help them stop the practice of FGM/C?

- How effective will the different levels of engagement be in promoting changes in attitudes, behaviours, and practices at the community level for the elimination of FGM/C practices?

##### ***Coherence –***

- How consistent are regionally determined policies and programs for stopping FGM/C with the political, cultural, religious, and other country-specific contexts of Guinea and Kenya?
- How would policies, programs, and laws determined at national levels fit the worldviews, beliefs, and practices of communities that practice FGM/C?
- How do the planned interventions align with what other actors are doing to stop the practice of FGM/C in the targeted communities?

##### ***Effectiveness –***

- To what extent will planned interventions achieve the desired objectives of stopping FGM/C in target countries?
- What in the planned interventions will contribute to concrete, verifiable changes in perceptions, attitudes, behaviours, and practices that lead to a verifiable change in the practice of FGM/C at the community-level?

### ***Efficiency –***

- What, in the view of respondents, are the best ways to make large-scale change happen quickly and with the resources at the disposal of Plan International and its partners?
- How are the planned interventions (by type and level of engagement) the best way to use the resources available to Plan International and its partners to achieve the objectives of stopping FGM/C?

●

### ***Impact –***

- What difference will the interventions of Plan International and its partners make to the stoppage of the practice of FGM/C in the targeted communities?
- At what level in the chain of responsibilities will critical change happen to trigger a cascade of changes at other levels?
- How well-suited are the chosen activities in Plan International's current design to make the desired change happen?
- What needs to be tweaked or eliminated in that plan to ensure maximum impact?

### ***Sustainability –***

- How will the outcomes of the interventions be sustained?
- What will make participating communities sustain the stoppage of the practices?
- What structures and systems will Plan International and its partners leave behind to ensure communities do not revert to the practice?

## **c. Engagement Approaches**

Given the geographic and thematic scope of the study, IPD proposes the use of:

- a) Participatory approaches that encompass the following: i) involvement of a Broad range of participants at continental, regional, national, and subnational levels; ii) use of Multiple data collection approaches to ensure access to a variety of views, and iii) Working closely with Plan staff in both countries to ensure they are onboard at all times and can provide guidance to ensure outcomes meet Plan's needs
- b) Nested approaches to data collection that involve the use of data collection instruments that i) dovetail into each other, ii) allow us to seamlessly collect data on different aspects of the study; iii) Limit replication or use of multiple tools or iv) Limits they need to engage the same respondents multiple times
- c) Multi-tier data collection processes that ensure that i) Data is collected at different levels from different people to provide a broad range of perspectives on the findings; ii) the same instruments are adapted to different levels without losing the substance of the data collected; iii) Multiple perspectives emerge on the same issues

## ***Appendix 2: Summary of Study Approach and Methodology***

### ***a) Study Approach:***

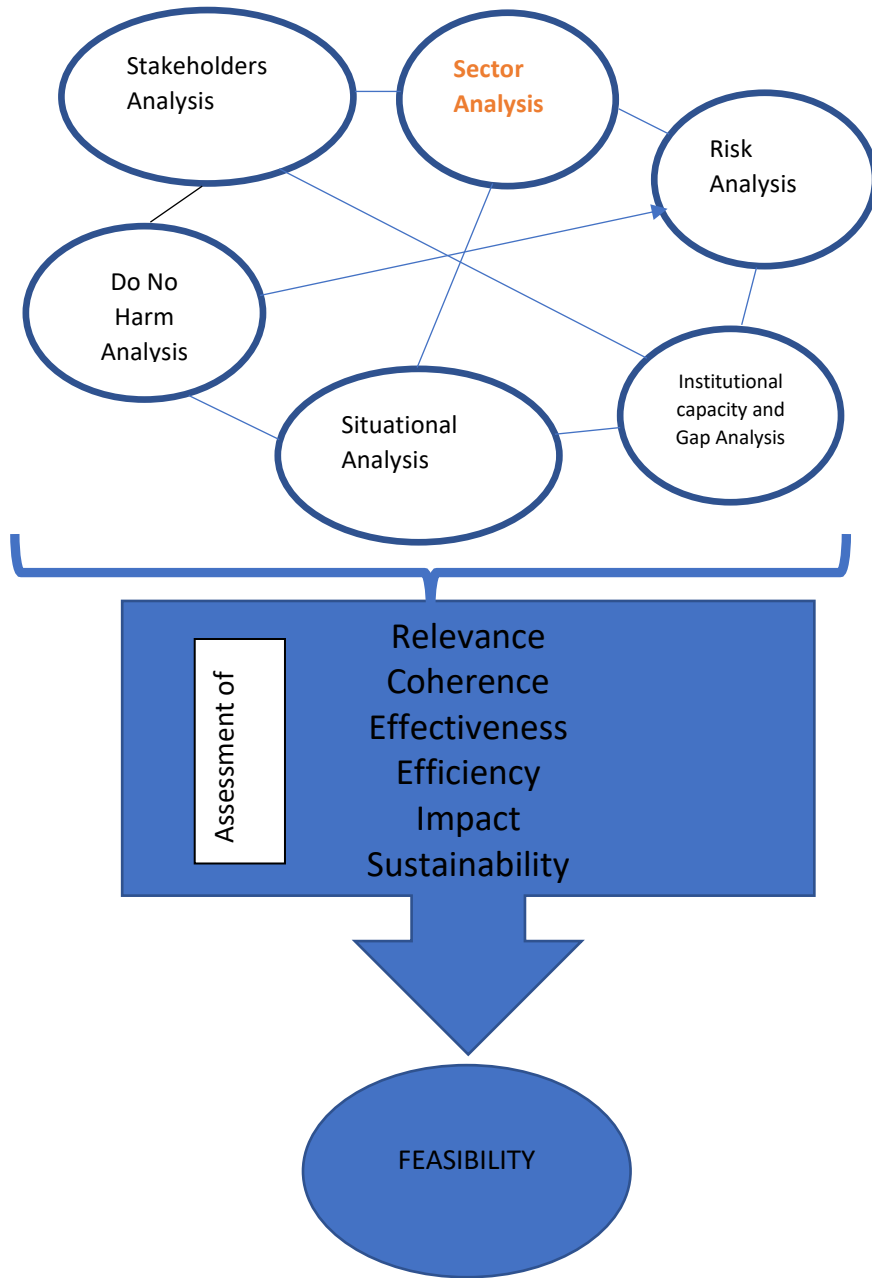
We will use nested, multi-layered, utilization-focused, participatory, and mixed methods approach to ensure that the voices and views of all stakeholder categories count in the insights generated from the study. Hence, we will use a combination of frameworks and tools designed to provide a comprehensive view of the contextual factors that underpin the prevalence and persistence of FGM/C practices in the targeted study communities. Within this frame, the study will use

- ***Nested approaches*** to data collection, analysis, and reporting. The nested approach means we will ensure that data collection instruments dovetail into each other to allow us to seamlessly collect data on different aspects of the study while limiting the replication or use of multiple tools or having to engage the same respondents multiple times. Appendix 1 provides a summary framework for data collection in different components of the study

The figure below illustrates how the nested approach would work. We will start with a desk review of documents available to feed into the design and conduct of specific component analysis, running from the situational/context assessment to sector, stakeholders, Do No Harm, Risk and institutional capacity and gap analysis. The outcome from these component analyses will inform the assessment of Plan International's planned interventions, using the OECD program and strategy evaluation criteria i.e., relevance, coherence, effectiveness, efficiency, impact, and sustainability.

- ***Multi-tier approaches*** to data collection will ensure that we collect data at different levels with different people, using the same instruments adapted to different levels without losing the substance of the data collected. This allows for the collection of data across a broader range of participants to provide multiple perspectives on the same issues.
- ***Utilization-focused*** – ensures that data collected, and the outcomes of the study provide concrete, concrete and actionable insights and recommendations grounded in the evidence collected in the course of the study. Findings will be matched to the different needs of Plan International and partners for the fine-tuning or revision of planned interventions to achieve maximum results.
- ***Participatory process*** means that right from the structure of the sampling process to the data collection, the study will create opportunities for a broad range of participants at all levels to have their views captured and counted in the (re)design of planned interventions. The use of open-ended questions in qualitative instruments such as Key Informant Interviews and Focus Group Discussions affords the different categories of respondents the opportunity to express themselves frankly on the issues under research. The participatory approach also means that IPD will work closely with Plan International's focal teams responsible for the study to ensure that they are on board with the study processes at all times; are able to provide guidance to ensure the study stays on course; and have the opportunity to input into the outcomes before the finalization of the study report.
- ***Mixed methods approach*** – means the study will use both quantitative and qualitative instruments in the collection and analysis of the data. Findings from the qualitative and quantitative This will ensure that the outcomes of the study blend the results from both components into a comprehensive overview of the issues and what needs to be done to address them

**Figure A: Illustration of The Interlinked Nested Approach to Study**



***b) Sample Frame and Sample Size***

In compliance with the requirement of Plan International to refocus the study at the supra-community-levels, the bulk of our engagements will be at the national, regional, and continental levels, with minimal engagements at the community levels in Guinea and Kenya. Table 2 presents the scope and size of the proposed participants at each of the levels.

**Table A: Distribution and Size of Samples for Continental, Regional, and National Level KIIs**

Level of Engagement		Number of Possible Interviews
Continental (AU staff and personnel of Plan International's AU Liaison Office)		30
Regional (ECOWAS) in Abuja and ECA in Arusha, Tanzania)		50
National (Guinea and Kenya)		380
District/ Prefecture	<ul style="list-style-type: none"> <li>● Guinea: Macenta, Nzérékoré, and Yomou districts</li> <li>● Kenya: Kajiado and Tharaka Nithi Counties</li> </ul>	120
Total		580

After the approval of the technical proposal, IPD has since learned that the planned project will take place in three new prefectures in Guinea, namely: Macenta, Nzérékoré, and Yomou, instead of the original two districts of Guekedou and Kissidougou. Coverage of the three instead of two prefectures in Guinea translates into increases in sample sizes, even if originally planned contacts per district are maintained. To accommodate the expected increase in contact points while ensuring the minimal contacts that Plan International anticipates, IPD proposes a readjustment of the sample frame and sizes to refocus data collection as follows:

**Table B: Size and Distribution of Proposed Samples for Community-level Engagements**

Country	District	# of Communities	5 KIIs/Community	2 FGD/District x 10 participants	5 communities x 10 Surveys /community	Total Participants
	Macenta	5	25	20	50	95
Guinea	Nzérékoré	5	25	20	50	95
	Yomou	5	25	20	50	95
<i>Total for Guinea</i>		<i>15</i>	<i>75</i>	<i>60</i>	<i>150</i>	<i>285</i>
Kenya	Kajiado	5	25	20	50	95
	Tharaka Nithi	5	25	20	50	95
<i>Total for Kenya</i>		<i>10</i>	<i>50</i>	<i>40</i>	<i>100</i>	<i>190</i>
Grand Total		25	125	100	250	475

The adjustments above led to an increment of the total number of community-level contacts for data collection in the two countries to 475 in five (5) participating districts/counties instead of the agreed 400 in 4 districts/counties. The sample frame for the community-level engagement is representatives of the community-level actors such as traditional leaders, religious leaders, leaders of Community-based organizations (CBOs) involved in FGM/C initiatives; Youth Leaders; Women leaders; Leaders of men's groups) as available.

#### a. Instrumentation

We will use a mixed methods data collection process that involves i) the use of both quantitative and qualitative instruments in the collection and analysis of the data; ii) triangulation of findings from the qualitative and quantitative data sources; iii) blending of the results from both components into one comprehensive overview of the issues and what needs to be done to address them. In furtherance of this, we have designed customized protocols for the collection of data germane to the placement and levels of competency on the subject matter for different categories of stakeholders and duty-bearers in the FGM/C sector. Below are summaries of the targets and rationale for the various instruments.

**Key Informant Interviews 01 (KII\_01) target** community-level custodians of the institution and practices FGM/C (i.e., traditional leaders - chiefs, elders, queens) religious leaders (Priests, Pastors, Imams, Traditional priests, leaders of sacred or initiated societies), FGM/C service providers<sup>16</sup>, women who are 18 years or older; women leaders; youth leaders (male and female). Its focus is to ascertain participants' knowledge, perceptions, attitudes, behaviors, and practices; as well as identify and analyze community-level Factors, Actors, and change processes that can impact, positively or negatively, the implementation of Plan International's interventions.

The **Key Informant Interview 02 (KII\_02)** targets the following categories of participants at the district, county, and national levels: Elected/appointed Political officeholders (Mayors, Governors); Senior civil and public servants in Ministries, departments, and agencies responsible for Health, Social Welfare, Women's Affairs, etc.; Senior government officials at Municipal, District, National, and regional/provincial levels of government; Leaders of faith-based organizations (Pastors, Imams, Traditional priests) and Civil society organizations at these levels. Its focus is to assess the legal and regulatory frameworks; stakeholder analysis; capacity and gap analysis; as well as the identification and analysis of district, county, and national level factors and actors that can impact the implementation and outcomes of Plan's interventions, positively or negatively.

**Key Informant Interview 03 (KII\_03) targets** Regional and Continental level officeholders at AU, ECA, and ECOWAS Levels; Regional and Continental Civil Society Actors on FGM/C; Plan International Liaison Office to the African Union (Plan AULO) who have responsibility for the design and implementation of legislative frameworks, policies, and programs that support member countries to implement relevant conventions and agreements for the eradication of FGM/C within their respective jurisdictions. Hence, the focus of this instrument is on the legal and regulatory frameworks; Stakeholder Analysis; Capacity and Gap Analysis at the regional and continental levels that support the design and **effective implementation of interventions for the stoppage of FGM/C.**

The **Focus Group Discussions will engage community-level** custodians of the institution and practices FGM/C (i.e., traditional leaders - chiefs, elders, queens); religious leaders (Pastors, Imams, Traditional priests, leaders of sacred or initiated societies), FGM/C service providers, women who are 18 years or older; women leaders; youth leaders (male and female), among others. Societies in Guinea and Kenya are communitarian in their structure and operations, and collective decisions often drive individual and community actions. Change in entrenched customary practices will be difficult to achieve without engaging with the collective worldviews and decision-making processes. Accordingly, the focus group discussions aim to assess the collective knowledge, perceptions, behaviors, practices, and attitudes that drive group actions for or against the practice of FGM/C.

The **Survey component** will be administered to a cross-section of Traditional leaders (chiefs, elders, queens), women leaders; youth leaders (male and female); Elected/appointed Political officeholders (Mayors, Governors); Senior civil and public servants in Ministries, departments, and agencies responsible for Health, Social Welfare, Women's Affairs, etc.; Senior government officials at Municipal, District, and regional/provincial levels of government; Leaders of faith-based organizations (Pastors, Imams, Traditional priests). It aims to quantitatively assess the presence, depth and spread of the knowledge, perceptions, attitudes, behaviors, and practices of different categories of persons that have bearings on the existence and persistence of the practice of FGM/C in their respective jurisdictions.

Table 3 below provides a summary of the levels of engagement, target categories of respondents, and the data collection instruments that we would use.

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<sup>16</sup> Service providers include cutters, conventional and traditional post-operative treatment services, suppliers of instruments and medications, etc.

**Table C: Matrix of Levels of Engagements, Categories of Respondents, and the Data Collection Instruments**

Level of Engagement	Categories of Participants	Data Collection Instruments
<b>Community-level Engagement</b>	<ul style="list-style-type: none"> <li>● community-level custodians of the institution and practices FGM/C (i.e., traditional leaders - chiefs, elders, queens)</li> <li>● religious leaders (Priests, Pastors, Imams, Traditional priests, leaders of sacred or initiated societies),</li> <li>● FGM/C service providers<sup>17</sup>,</li> <li>● women who are 18 years or older</li> <li>● women leaders; youth leaders (male and female).</li> </ul>	<ul style="list-style-type: none"> <li>i. Key Informant Interviews 01 (KII_01)</li> <li>ii. Survey</li> <li>iii. FGD (for a subsample)</li> </ul>
<b>District, County, And National Levels</b>	<ul style="list-style-type: none"> <li>● Elected/appointed Political officeholders (Mayors, Governors).</li> <li>● Senior civil and public servants in Ministries, departments, and agencies responsible for Health, Social Welfare, Women’s Affairs, etc.; Senior government officials at</li> <li>● Municipal, District, National, and regional/provincial levels of government.</li> <li>● Leaders of faith-based organizations (Pastors, Imams, Traditional priests)</li> <li>● Leaders of Civil society organizations at these levels.</li> </ul>	<ul style="list-style-type: none"> <li>i. Key Informant Interview 02 (KII_02)</li> <li>ii. Survey</li> </ul>
<b>Regional and Continental level officeholders at AU, ECA, and ECOWAS Levels</b>	<ul style="list-style-type: none"> <li>● Regional and Continental Civil Society Actors who responsible for the design and implementation of legislative frameworks, policies, and programs that support member countries to implement relevant conventions and agreements for the eradication of FGM/C within their respective jurisdictions.</li> <li>● Senior staff of Plan International Liaison Office to the African Union (Plan AULO)</li> </ul>	Key Informant Interview 03 (KII_03) targets

**b. Data Collection Processes**

We used an integrative model for the collection of data. While the Key Informant Interviews and Focus Group discussions were administered to discrete groups of participants, the survey questions bridged several of these groups. Since the questions in the different instruments were cross matched to a large extent, administering the survey across all categories of participants in the qualitative data collection processes provided a pathway for quantitatively synthesizing the diversity of views that participants hold on the subject. Figure A above presents an illustration of the integrative model we used for the collection and blending of data from multiple sources.

<sup>17</sup> Service providers include cutters, conventional and traditional post-operative treatment services, suppliers of instruments and medications, etc.

## Appendix 3: Study Protocols

### Appendix 3.1 Interview Guide for KII-01 – Community-level Participants

INSTITUTE FOR PEACE AND DEVELOPMENT

**Plan International , Germany**

**Plan Guinea      Plan Kenya**

Feasibility Study On Interventions To Stop Female Genital Mutilation/Cutting In Guinea And Kenya

#### Key Informant Interview 01 (KII\_01) Interview Guide

#### Community-level Participants

**Target Participants:** Community-level custodians of the institution and practices FGM/C (i.e., traditional leaders - chiefs, elders, queens) religious leaders (Priests, Pastors, Imams, Traditional priests, leaders of sacred or initiated societies), FGM/C service providers, women who are 18 years or older; women above the age of 18, women leaders; youth leaders (male and female).

Focus: Participants' knowledge, Perceptions, Attitudes, Behaviors and Practices; • Factor Analysis: • Actor Analysis, • Change process analysis

**Interview Number:**      **Date of Interview:** \_\_\_\_\_ **Time Started:** \_\_\_\_\_ **Time Ended:** \_\_\_\_\_

#### Introduction

My name is \_\_\_\_\_. I am here on behalf of the Institute for Peace and Development (IPD) and its partners. I am part of a team that is conducting feasibility studies for interventions that aim to contribute to stopping the practice of female genital mutilation or cutting (FGM/C). The findings of this study will enable Plan International and its affiliate offices in Guinea and Kenya to design more effective interventions to reduce the practice of FGM/C.

We do not promise that you will personally benefit from the research. However, your participation in the study will help Plan International and its country level partners design interventions that may benefit your community and others.

We will treat the answers that you provide in this research as confidential. We will keep a list of the people we interviewed in case we need to come back and clarify some information from you. However, the list will not be shared with anyone. It will be kept under lock at IPD offices in Ghana and will be destroyed after the analysis is done. We will not mention your name in the report. If we need to quote something that you have said word for word during the interview, we will use a different description so that no one knows who made the statement. You may choose not to have your name written. Do we have your permission to write your name on the list of participants? **Yes** [ ] **No** [ ]

Your participation in the research is voluntary. You may choose to withdraw at any point during the interview. If you decide not to participate or choose to stop your participation, you will not suffer any repercussions as a result. Do you accept to participate in this study? **Yes** [ ] **No** [ ]

Do you have any questions about the study? **Yes** [ ] **No** [ ]

Name of Interviewee \_\_\_\_\_ Phone #1 \_\_\_\_\_ 2. \_\_\_\_\_

Name of Interviewer \_\_\_\_\_ Supervisor \_\_\_\_\_

If you have any concerns about this study, you may contact directly of the following persons:

Hippolyt Pul Executive Leader, Institute for Peace, and Development. Lead Study Researcher	A55 Gumani Rice City, P O Box TL1799 Tamale, NR, Ghana Tel: +233 (0) 244 311 098 Email: Hippolyt. <a href="mailto:pul@ipdafrica.org">pul@ipdafrica.org</a>
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## **Geo location of Data Collection Sites - GPS Location of Interview (automatic)**

1. In which country is the data being collected?
  1. Guinea
  2. Kenya
  3. Ethiopia (AU office, AU Liaison Office)
  4. Tanzania ECA Office, Arusha
  5. Nigeria ECOWAS Office, Abuja
  6. Other (Specify) : \_\_\_\_\_
  
2. In which of the targeted districts for Plan's FGM/C activities is the data being collected
  1. Macenta, Guinea
  2. Nzérékoré, Guinea
  3. Yomou, Guinea
  4. Kajiado County, Kenya
  5. Tharaka Nithi County, Kenya
  6. None of the above

### **Section 1: Profile of Respondents**

I would now like to begin by getting to know you better. Would you mind if I ask:

3. To which gender category would you say you belong?
  - 1) Male [ ]
  - 2) Female [ ]
  - 3) Others (specify) \_\_\_\_\_ [ ]
  
4. How old were you on your last birthday?
  1. (Write age down in years) \_\_\_\_\_
  2. I do not know my age (please mark) [ ]
  
5. What is the highest level of education you attained? (Check one)
  7. Never been to school [ ]
  8. Less than six years of Primary Education [ ]
  9. Primary Education up to Middle School/Junior Secondary School [ ]
  10. Completed secondary school [ ]
  11. Completed Teacher/Nursing/Vocational Training College [ ]
  12. Tertiary Institution up to Diploma/Higher National Diploma [ ]
  13. University Degree up to bachelor's level [ ]
  14. University Degree up to the master's level [ ]
  15. University Degree up to the Doctorate level [ ]
  16. Others (specify) \_\_\_\_\_ [ ]
  
6. How would you describe the place where you normally live?
  1. Village
  2. Town/city
  3. Regional Capital
  4. National Capital
  5. Other (please specify) \_\_\_\_\_
  
7. How would you describe your status of employment?
  1. Not employed [ ]
  2. Self-employed [ ]
  3. Employed in the private sector [ ]
  4. Employed in the government sector [ ]
  5. Still in school or under training [ ]
  6. Other [ ] (Specify) \_\_\_\_\_

8. If you are employed, how would you describe the kind of work you do?
  1. Public Servant (Appointed government official at the regional, district or local level)
  2. Civil Servant (an employee hired by the government such as doctors, nurses, teachers, etc. on government payrolls)
  3. Security Services (Military, Police, Immigration, Customs, Fire Service etc.)
  4. Work for an NGO/Civil Society
  5. Businessperson (storeowner, mechanic, construction, manufacturing, etc.) .
  6. Hospitality (owner/manager of hotel, motel, restaurant, drinking bar, etc.)
  7. Farmer, Herdsman,
  8. Stay-at-home spouse
  9. Other (Specify) \_\_\_\_\_
  
9. What role do you play in your community?
  1. Community leaders (chiefs, youth, and women leaders) [ ]
  2. Religious Leader – Priest, Pastor, Imams, Rev. Sister, Nun, etc., Spiritualist). [ ]
  3. Elected or appointed Municipal, district, or regional local government representative [ ]
  4. None [ ]
  5. Other (Specify) \_\_\_\_\_ [ ]

**Knowledge, Perceptions, Attitudes, Behaviors**

10. How important is the practice of FGM/C to the customs and traditions of your community? (Provide options) : Very [ ] Moderate [ ] Not important [ ]
11. What are the things that make the practice of FGM/C important for your community?
12. In your opinion why do you think FGM/C practices are persistent in your community?
13. Do people in your community perceive any benefits to FGM/C?
14. Do people in your community perceive any negative effects to FGM/C?"
15. What do women in your community who do not undergo FGM/C stand to gain or lose?
16. Do you think it is possible to end/eliminate FGM/C in your community and beyond?
  - a) If no, explain why not?
  - a) If yes, explain how while clarifying who you think should take what specific action?
17. What, in your opinion, are the factors that (would) make it difficult to stop the practice of FGM/C in your community and beyond?
18. What would you suggest as ways to overcome these difficulties?
19. Are there any community strategies or actions to end FGM/C in your community that you are aware of?
  - a) If yes, please explain what strategies or actions there are
  - b) If not, why do you think there are no strategies or actions to end FGM/C in your community?
20. What individuals or groups are important supporters or guarantors of the continuation of FGM/C in your community? What do you think are the reasons why each of these individuals or groups support FGM/C?
21. Are you aware of any laws (including by-laws), policies, guidelines, regulations, or alternative rites that prohibit FGM/C in your country?
  - a) If no, skip to Question 28
  - b) If yes, Continue to Question 22
22. can you please tell what you know about these (some of the practices, actions, laws, policies, guidelines, regulations, or alternative rites that relate to the practice of FGMC in your community)
23. Do people in your community know about these laws (including by-laws), policies, guidelines, regulations, or alternative rites for the elimination of FGM/C?

24. what do people in your community think about them?
25. Do people in your community generally follow the existing laws (including by-laws), policies, guidelines, regulations, or alternative rites?
26. What punishments are there for people who fail to observe these laws and policies?
27. What changes, if any, would you like to see effected in the current ~~practices, actions,~~ laws, policies, guidelines, regulations, or alternative rites to make communities members accept and implement them?
28. How is FGM/C reflected or included in your government policies, plans, programs, and budgets at national and district/county levels?
29. Are there any coalitions/networks/movements or groups that are currently working on FGM/C in your country or district/county that you are aware of? If yes,
  - a. What coalitions are there?
  - b. Please describe what they do?
  - c. What do you like most and what do you not like about what they do?
30. What international treaties or commitments related to FGM/C has your country committed to?
  - a. To what extent is this commitment being implemented
31. As a country we have been unsuccessfully trying to eradicate FGM for so many years now –
  - b. what do you think are the main challenges, obstacles or barriers that made us fail to succeed?
  - c. What do you suggest as ways to eliminate these deterrents for the success of eliminating FGM/C?

#### **Stakeholder Identification and Assessment**

32. Who, in your opinion are the key actors in for the making and implementation of policies on FGM/C at the continental and regional levels that Plan International and its partners must involve to ensure the right policies, programs and legislative frameworks are in place to support their work in Guinea and Kenya?
33. What other groups, networks, or alliances do you believe can play important roles at the continental or regional levels to advance the agenda of eliminating the practice of FGM/C
  - a. What can they do to contribute to the stoppage of FGM/C in their respective areas of operations?
  - b. What authority, influence, or power do they have to contribute to the stoppage of practice of FGM/C -

#### **Capacity Assessment and Gap Assessment**

34. Plan International and its partners intend to support communities in Guinea and Kenya to engage in initiatives that promote the formulation and implementation of laws, regulations, policies, and programs to eliminate FGM/C in selected districts or counties in their respective countries.
  - c. What opportunities do you see for Plan International to contribute to making this happen?
  - d. What kinds of policies and programs would you recommend they focus their advocacy efforts on? Why?
  - e. At what level of engagement (district, county, national, regional, or continental) will the interventions of Plan International and its partners make the greatest impact in contributing to the stoppage of the practice of FGM/C?
35. What challenges do you foresee that Plan International and her partners may face in trying to support the governments of Guinea and Kenya, as well as other international organizations to make the abolition of FGM/C a reality real?
36. Do you have any other comment, observation or recommendation regarding FGM/C in your community or country?

Thank you

INSTITUTE FOR PEACE AND DEVELOPMENT

**Plan International, Germany**

**Plan Guinea**

**Plan Kenya**

Feasibility Study On Interventions To Stop Female Genital Mutilation/Cutting In Guinea And Kenya

Key Informant Interview 02 (KII\_02) Interview Guide: District, Provincial/County and National Level

**Target Participants:** Elected/appointed Political officeholders (Mayors, Governors); Senior civil and public servants in Ministries, departments, and agencies responsible for Health, Social Welfare, Women’s Affairs, etc.; Senior government officials at Municipal, District, National, and regional/provincial levels of government; Leaders of faith-based organizations (Pastors, Imams, Traditional priests) and Civil society organizations at these levels.

**Focus:** Legal and regulatory frameworks; Stakeholder analysis; Capacity and Gap Analysis. Factor Analysis; Actor Analysis; Capacity and Gap Analysis

**Interview Number:**      **Date of Interview:** \_\_\_\_\_ **Time Started:** \_\_\_\_\_ **Time Ended:** \_\_\_\_\_

**Introduction**

My name is \_\_\_\_\_. I am here on behalf of the Institute for Peace and Development (IPD) and Plan International and its partners. I am part of a team that is conducting feasibility studies for interventions that would contribute to stopping the practice of female genital mutilation or cutting (FGM/C) in Plan International’s project districts in Guinea and Kenya. The findings of this study will enable Plan International and its affiliate offices in Guinea and Kenya to design interventions on the practice of FGM/C in the participating communities, and the country at large.

We do not promise that you will personally benefit from the research. However, your participation in the study will help Plan International and its country level partners design interventions that may benefit your community and others.

We will treat the answers that you provide in this research as confidential. We will keep a list of the people we interviewed in case we need to come back and clarify some information from you. However, the list will not be shared with anyone. It will be kept under lock at IPD offices in Tamale and will be destroyed after the analysis is done. We will not mention your name in the report. If we need to quote something that you have said word for word during the interview, we will use a different name so that no one knows who made the statement. You may choose not to have your name written. Do we have your permission to write your name on the list of participants? **Yes [ ] No [ ]**

Your participation in the research is voluntary. You may choose to withdraw any point during the interview. If you decide not to participate or choose to stop your participation, you will not suffer any loss as a result. Do you accept to participate in this study? **Yes [ ] No [ ]**

Do you have any questions about the study? **Yes [ ] No [ ]**

Name of Interviewee \_\_\_\_\_ Phone #1 \_\_\_\_\_ 2. \_\_\_\_\_

Name of Interviewer \_\_\_\_\_ Supervisor \_\_\_\_\_

If you have any concerns about this study, you may contact directly of the following persons:

Hippolyt Pul Executive Leader, Institute for Peace, and Development. Lead Study Researcher	A55 Gumani Rice City, P O Box TL1799 Tamale, NR, Ghana Tel: +233 (0) 244 311 098 Email: Hippolyt. <a href="mailto:pul@ipdafrica.org">pul@ipdafrica.org</a>
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### **Geolocation of Data Collection Sites - GPS Location of Interview (automatic)**

1. In which country data is the data being collected?
  1. Guinea
  2. Kenya
  3. Ethiopia (AU office, AU Liaison Office)
  4. Tanzania ECA Office, Arusha
  5. Nigeria ECOWAS Office, Abuja
  6. Other (Specify)
2. In which of the targeted districts for Plan's FGM/C activities is the data being collected
  1. Macenta, Guinea
  2. Nzérékoré, Guinea
  3. Yomou, Guinea
  4. Kajiado County, Kenya
  5. Tharaka Nithi County, Kenya
  6. None of the above

### **Personal and Institutional Profiles**

3. How would you characterize your position at the district, county/regional, and national governance system?
  1. Elected/appointed Political officeholders (Mayors, Governors).
  2. Senior civil and public servants in Ministries, departments, and agencies responsible for Health, Social Welfare, Women's Affairs, etc.
  3. Senior government officials at Municipal, District, National, and regional/provincial levels of government.
  4. Leaders of faith-based organizations (Pastors, Imams, Traditional priests)
  5. Leader of Civil society organizations at these levels.
  6. Other (Specify)
4. Is the organization that you work in now also working on issues related to ending the practice of FGM/C in your district, county, country, or international level?
  - a) If yes, what specifically does your organization do in respect of making and implementing laws, rules, regulations, policies, programs, and other decisions that affect the practice of FGMC/C in your district or country?
  - b) For how long has your organization been working on FGM/C?
5. What is your personal role in your organization in respect of the practice of FGM/C?
  - a) How long have you been in that role?

### **Knowledge, attitude, and practices towards FGM/C**

6. How widespread is this practice of Female genital mutilation and cutting FGM/C in your district/region/country?
7. How important is the practice of FGM/C to the customs and traditions of the people in this district/region?
8. What, in your opinion, are the meanings, values, and importance attached to the practice of FGM/C by
  - a) men,
  - b) women
  - c) both
9. Who are the gatekeepers of change who ensure the continuation of FGM/C?
  - a) who would we need to work with in order to stop the practice of FGM/C in your district, county, or country?
10. What actors and coalitions do you have at your district, county, or national levels that are advocating for policies and budgets for ending FGM/C in your country?
  - a) How effective are they in contributing to ending FGM/C in your district, region, or country
  - b) What challenges do these coalitions and movements encounter?
11. What national policies or laws are in place to regulate the practice of FGM/C?
  - a) To what extent are these laws enforced in your district/county/region?

- b) What makes people respect and enforce these laws and policies?
  - c) Why do people choose not to respect and follow these laws and policies?
12. What do you see as actual or potential enablers or obstacles to adherence to these regulatory frameworks?
  13. Are prevention of FGM/C initiatives reflected in the national policies and plans of the government in your County, District, or country such as:
    - a) National Development Plans County/District development plans?
    - b) Annual budgets of the country, county, or district?
    - c) Other: \_\_\_\_\_
  14. Do your national or county/district governments have specialized funds that support policies and programs to end FGM/C at their respective levels?
    - a) If yes, how impactful have these funds been in contributing to ending FGM/C.
    - b) What do you suggest as opportunities for improvement?
  15. To what extent do you think that Kenya and Guinea are compliant with the international treaties and commitments?
  16. What is your assessment of the extent to which political leaders at the National and Sub National government levels are willing to end FGM/C?
  17. To what extent do you believe that the government can stop the practice of FGM/C in your community through the laws and policies it implements?
  18. What do you see as the main challenge with political will of your district, county, or national governments in ensuring that they put in place laws, policies, and programs that effectively contribute to ending FGM/C?
  19. In your opinion, what other categories of persons or institutions have the power and influence to stop or make contributions to the stoppage of the practice of FMGC in your community or district?

#### **Stakeholder Identification and Assessment**

20. Who, in your opinion are the key actors in for the making and implementation of policies on FGM/C at the continental and regional levels that Plan International and its partners must involve to ensure the right policies, programs and legislative frameworks are in place to support their work in Guinea and Kenya?
21. What other groups, networks, or alliances do you believe can play important roles at the continental or regional levels to advance the agenda of eliminating the practice of FGM/C
  - a. What can they do to contribute to the stoppage of FGM/C in their respective areas of operations?
  - b. What authority, influence, or power do they have to contribute to the stoppage of practice of FGM/C -

#### **Capacity Assessment and Gap Assessment**

22. Plan International and its partners intend to support communities in Guinea and Kenya to engage in initiatives that promote the formulation and implementation of laws, regulations, policies, and programs to eliminate FGM/C in selected districts or counties in their respective countries.
  - a. What opportunities do you see for Plan International to contribute to making this happen?
  - b. What kinds of policies and programs would you recommend they focus their advocacy efforts on? Why?
  - c. At what level of engagement (district, county, national, regional, or continental) will the interventions of Plan International and its partners make the greatest impact in contributing to the stoppage of the practice of FGM/C?
23. What challenges do you foresee that Plan International and her partners may face in trying to support the governments of Guinea and Kenya, as well as other international organizations to make the abolition of FGM/C a reality real?
24. What suggestions would you make to Plan International, its partners, and other organizations working to stop the practice of FGM/C, to ensure they can support the implementation of policies and programmes to stop FGM/C in your district, county, or country?"

Thank you.

*Appendix 3.3: Interview Guide for KII-03 – AU and Regional Level Participants*

INSTITUTE FOR PEACE AND DEVELOPMENT

**Plan International , Germany**

**Plan Guinea      Plan Kenya**

Feasibility Study On Interventions To Stop Female Genital Mutilation/Cutting In Guinea And Kenya  
Interview Guide for KII-03 – AU and Regional Level Participants

**Target Participants:** Regional and Continental officeholders at AU, ECA, and ECOWAS Levels; Regional and Continental Civil Society Actors on FGM/C; Plan International Liaison Office to the African Union (Plan AULO)

**Focus:** Legal and regulatory frameworks; Stakeholder Analysis; Capacity and Gap Analysis

**Interview Number:**      **Date of Interview:** \_\_\_\_\_ **Time Started:** \_\_\_\_\_ **Time Ended:** \_\_\_\_\_

**Introduction**

My name is \_\_\_\_\_. I am here on behalf of the Institute for Peace and Development (IPD) and its partners. I am part of a team that is conducting feasibility studies for interventions that would contribute to stopping the practice of female genital mutilation or cutting (FGM/C) in Plan International’s project districts in Guinea and Kenya. The findings of this study will enable Plan International and its affiliate offices in Guinea and Kenya to design interventions on the practice of FGM/C in the participating communities, and the country at large.

We do not promise that you will personally benefit from the research. However, your participation in the study will help Plan International and its country level partners design interventions that may benefit your community and others.

We will treat the answers that you provide in this research as confidential. We will keep a list of the people we interviewed in case we need to come back and clarify some information from you. However, the list will not be shared with anyone. It will be kept under lock at IPD offices in Tamale and will be destroyed after the analysis is done. We will not mention your name in the report. If we need to quote something that you have said word for word during the interview, we will use a different name so that no one knows who made the statement. You may choose not to have your name written. Do we have your permission to write your name on the list of participants?  
**Yes [ ]    No [ ]**

Your participation in the research is voluntary. You may choose to withdraw any point during the interview. If you decide not to participate or choose to stop your participation, you will not suffer any loss as a result. Do you accept to participate in this study? **Yes [ ]    No [ ]**

Do you have any questions about the study? **Yes [ ]    No [ ]**

Name of Interviewee \_\_\_\_\_ Phone #1 \_\_\_\_\_ 2. \_\_\_\_\_

Name of Interviewer \_\_\_\_\_ Supervisor \_\_\_\_\_

If you have any concerns about this study, you may contact directly of the following persons:

Hippolyt Pul Executive Leader, Institute for Peace, and Development. Lead Study Researcher	A55 Gumani Rice City, P O Box TL1799 Tamale, NR, Ghana Tel: +233 (0) 244 311 098 Email: Hippolyt. <a href="mailto:pul@ipdafrica.org">pul@ipdafrica.org</a>
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**Geolocation of Data Collection Sites - GPS Location of Interview (automatic)**

In which country data is the data being collected?

1. Ethiopia (AU office, AU Liaison Office)

2. Tanzania ECA Office, Arusha
3. Nigeria ECOWAS Office, Abuja
4. Other (Specify)

## **Section 1: Profile of Respondents**

2. Gender of Respondent

1) Male [ ]      2) Female [ ] 3) Other (specify) \_\_\_\_\_ [ ]

3. What position do you hold in your organization?

4. How is the work you do related to the practice of FGM/C on the continent?

### **Assessment of Level and Quality of Awareness on FGM/C issues**

5. How widespread, in your view, is the practice of FGM/C on the African continent?

6. What in your opinion are the factors that drive and sustain the practice of FGM/C on the continent?

7. How important is the eradication of FGM/C in the African Communities?

8. How high a priority is the eradication of FGM/C in your country?

Regional blocs and Member States of the African Union subscribe to global conventions for the elimination of FGM/C such as the Sustainable Development Goals (SDG 5.3), the Convention on the Elimination of all forms of Discrimination against Women (CEDAW), and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol).

9. What laws, regulations, policies, and programs has the African Union put in place to support the elimination of FGM/C?

10. What mechanisms does the AU have to support member states to adopt legislative frameworks and implement actions that would stop the practice of FGM/C in their jurisdiction?

11. What mechanisms are in place to ensure that the AU's conventions, policies, programs, and guidelines on the practice of FGM/C are consistent with those of member states and regions?

12. Are you aware of any regulatory frameworks that the East African Community (EAC) or the Economic Community of West Africa formulated that aim to end the practice of FMG/C on the continent?

a. If yes, please share examples with us.

b. How effective do you think these regulatory frameworks are in contributing to the stoppage of FGM/C in Guinea and Kenya in particular, and in Africa as a whole?

13. What makes it difficult for member states to translate these commitments into actionable polices, programs, and legal frameworks that facilitate compliance with these commitments?

14. What changes would you like to see in these laws and policies to make them more effective for the elimination of FGM/C?

### **Stakeholder Identification and Assessment**

15. What Opportunities do you see for Plan International and other NGOs and CSOs working on FGM/C to support policy and advocacy initiatives for ending FGM/C in Africa?

16. Who, in your opinion are the key actors in for the making and implementation of policies on FGM/C at the continental and regional levels that Plan International and its partners must involve to ensure the right policies, programs and legislative frameworks are in place to support their work in Guinea and Kenya?

17. What other groups, networks, or alliances do you believe can play important roles at the continental or regional levels to advance the agenda of eliminating the practice of FGM/C
  - a. What can they do to contribute to the stoppage of FGM/C in their respective areas of operations?
  - b. What authority, influence, or power do they have to contribute to the stoppage of practice of FGM/C -
18. In your opinion, which categories of individual and institutional actors in Guinea, Kenya, ECA, ECOWAS, and African Union levels have the power to make decisions that can end FGM/C in their respective zones of operations? (Probe to disaggregate by different actors, institutions, gender, location, etc.)
  - a. What are the sources of their power (formal and informal)
  - b. How has the power been/can be used to support or hinder the elimination of FGM/C

### **Capacity Assessment and Gap Assessment**

19. Plan International and its partners intend to support communities in Guinea and Kenya to engage in initiatives that promote the formulation and implementation of laws, regulations, policies, and programs to eliminate FGM/C in selected districts or counties in their respective countries.
  - a. What areas of policies and programs would you recommend they focus their advocacy efforts on? Why?
  - b. At what level of engagement (district, county, national, regional, or continental) will the interventions of Plan International and its partners make the greatest impact in contributing to the stoppage of the practice of FGM/C?
20. What do nonstate actors such as Plan and other NGOs and CSOs need to do to better support the AU and its member states to advance the agenda of stopping FGM/C on the continent?
21. What capacities do International organizations, the governments and politicians in Guinea or Kenya need to have to effectively disseminate and resource existing laws for the abolition of FGM/C (in line with AU and other international protocols/engagements)?
  - a. What opportunities do you see for Plan International to contribute to making this happen?
  - b. What challenges do you foresee that Plan International and her partners may face in trying to support the governments of Guinea and Kenya, as well as other international organizations to make the abolition of FGM/C a reality ~~real~~?
22. NGO/CSOs led interventions tend to fizzle out with the end of donor funding. What, in your opinion, should Plan International and its partners do to ensure that the processes and outcomes of their interventions outlive their presence and operations at all levels?
23. Do you have any other suggestions for Plan International and its partners to ensure that their interventions in Guinea and Kenya truly lead to the elimination of FGM/C in the communities where they work?

Thank you.

Appendix 3.4.: Community-level Focus Group Discussion Guide

INSTITUTE FOR PEACE AND DEVELOPMENT

FEASIBILITY STUDY ON INTERVENTIONS TO STOP FEMALE GENITAL MUTILATION/CUTTING

**Plan International , Germany**

Feasibility Study on Global  
Guinea and Kenya

**Plan Guinea**

**Plan Kenya**

Programme to Stop FGM/C in

Community Focus Group Discussion Guide

Target Participants: Community-level custodians of the institution and practices FGM/C (i.e., traditional leaders - chiefs, elders, queens) religious leaders (Pastors, Imams, Traditional priests, leaders of sacred or initiated societies), FGM/C service providers, women who are 18 years or older, women leaders; youth leaders (male and female).

**FGD Number:** \_\_\_\_\_ **GPS Location of Interview (automatic)**\_\_\_\_\_

**Facilitator:**\_\_\_\_\_ **Notetakers**\_\_\_\_\_

**Name of Group:**\_\_\_\_\_

**Name of Community (village, or town/section of town):**\_\_\_\_\_

**Participants:**

Gender	Adults	Youth
Male		
Female		
Total		

Date of FGD	:___/___/___ DD/MM/Yr.
Time Started	
Time Ended	

**Introduction**

[**Note To Data Collectors:** Greet participants and take your seat according to local traditions. Make sure everyone is conformably seated and socially distanced in observance of COVID-19 Protocols. Ensure everyone has a mask on. Pass around hand sanitizers and ensure everyone sanitizes their hands].

**Introduction For Facilitator:** Hello. My name is [YOUR NAME]. I will be the main facilitator for our discussions today.

**Introduction For Notetaker:** Hello. My name is [YOUR NAME] and I am also part of the research team. I will be taking notes during the discussion. I am part of a team that is conducting feasibility studies for interventions that would contribute to stopping the practice of female genital mutilation and cutting (FGM/C) in Plan’s project districts in Guinea and Kenya.

**Purpose of Research:** The findings of this study will enable Plan International and its affiliate offices in Guinea and Kenya to design interventions that support the stopping of FGMG in the participating communities, and the country at large.

**Compensation:** We are unable to compensate you for your time in this discussion and we do not promise that you or your community will directly benefit from the research. However, your participation in the study will help Plan International, its national operations in Guinea and Kenya, and other stakeholders to understand how to design interventions that would contribute to the end of FGM/C practice in project communities in Guinea and Kenya, and Africa at large.

**Data Protection:** We would like to have a list of the people we interviewed in case we need to come back and clarify some information from you. However, the list will not be shared with anyone. It will be kept under lock at IPD offices in Tamale and will be destroyed after the analysis is done.

Do we have your permission to write your name on the list of participants? Yes [ ] No [ ]

**Duration and Participation:** This discussion will last approximately 90 minutes. It is important to give everyone an opportunity to speak about his or her experience, so I will do my best to be sure everyone has a chance to participate. Your participation is voluntary. You may choose not to take part or withdraw at any point during the discussion. If you decide not to participate or choose to stop your participation at any time during the discussion, you will not suffer any negative consequences as a result.

Do you accept to participate in this study? (*Get a vocalized answer*): Yes [ ] No [ ]

**Confidentiality:** We will ask you a number of questions about your knowledge of policies, programs, laws, and regulations related to FGM/C. We will listen to your views and take notes of the discussions in writing. With your permission, we would also like to do audio recording only of the discussions to ensure we correctly note your contribution to the discussions. We, however, assure you that whatever is discussed here will remain confidential. The answers that each of you provide to the questions we ask will be treated as confidential. The recordings will also be stored securely and destroyed at the end of the research project. We will not mention any person's name in connection with anything that is said in this discussion. If someone says something very important that we want to quote word for word, we will not use that person's name in our report. Instead, we will use a different name that will not reveal the identity of the person making the statement. If you do not want your name written, we will respect that, and we will not hold it against you in any way.

Are you clear on why we are asking you to participate in this interview? Yes [ ] No [ ]

Do you understand the informed consent requested? Yes [ ] No [ ]

Do you agree that we do an audio recording only of the discussion? Yes [ ] No [ ]

Do you have any questions about the study? Yes [ ] No [ ]

If you have any concerns about this study, you may contact directly of the following persons:

Hippolyt Pul Executive Leader, Institute for Peace, and Development. Lead Study Researcher	A55 Gumani Rice City, P O Box TL1799 Tamale, NR, Ghana Tel: +233 (0) 244 311 098 Email: Hippolyt. <a href="mailto:pul@ipdafrica.org">pul@ipdafrica.org</a>
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### Discussion Guide

1. How long has this group been working together?
2. What activities do you normally undertake together?
3. What do you all think about the practice of FGM/C in your community?
4. Are there different ways in which FGM/C is practiced?
  - a) If yes, could you please share with me some examples?
5. How important is the practice of FGM/C to the customs and traditions of your community?
6. What, in your opinion, are the consequences of FGM/C for women who undergo it?
7. What do women in your community who do not undergo FGM/C stand to gain or lose?
8. What do you think of the idea that the practice of FGM/C in your country (Guinea or Kenya) needs to be abolished ?
9. What, in your opinion, are the factors that make it difficult to stop the practice of FGM/C in your community?
10. What individuals or groups do you think are important supporters of the continuation of FGM/C in your community?
  - a) Why do you think they support the continuation of the practice?

11. Are you aware of any national policies/guidelines or regulations that prohibit the practice of FGM/C in your country?
  - a) If yes, can you please tell me what you know about these some of the policies and laws that relate to the practice of FGMC in your community.
  - b) What do you like about these laws and policies that regulate the practice of FGMC in your community?
  - c) What do you not like support about the current set of laws, regulations, and programs that pertain to the institution of FGM/C in their respective communities and districts?
12. How effectively can these policies and laws contribute to the elimination of FGMC in your community?
13. What is the state of compliance with these regulatory frameworks? Do people obey them?
14. What punishments are there for people who fail to observe these laws and policies?
15. What changes, if any, would you like to see effected in the current laws and policies to make communities members accept and implement them?
16. If the practice of FGM/C is to stop in your community, what are some of the important things that must be done first at the following levels to make that happen
  - a) At the Community-level
  - b) At the District level
  - c) At the National Level
17. What other groups, networks, or alliances in your community or district do you believe can play important roles to advance the agenda of eliminating the practice of FGM/C
  - a) What concrete actions can they undertake to contribute to the stoppage of FGM/C in your community or district?
  - b) What is the source of their authority, influence, or power to make the contribution you believe can lead to the stoppage of practice of FGM/C?
18. What other suggestions do you have to ensure the practice of FGM/C is stopped permanently in your community?

Thank you.

INSTITUTE FOR PEACE AND DEVELOPMENT  
FEASIBILITY STUDY ON INTERVENTIONS TO STOP FEMALE GENITAL  
MUTILATION/CUTTING

Plan International , Germany

Plan Guinea      Plan Kenya

Feasibility Study on

FGM/C in Guinea and Kenya

Global Programme to Stop

## Survey Questions

**Target Participants:** Traditional leaders (chiefs, elders, queens), women leaders; youth leaders (male and female); Elected/appointed Political officeholders (Mayors, Governors); Senior civil and public servants in Ministries, departments, and agencies responsible for Health, Social Welfare, Women’s Affairs, etc.; Senior government officials at Municipal, District, and regional/provincial levels of government; Leaders of faith-based organizations (Pastors, Imams, Traditional priests).

**Interview Number:**      **Date of Interview:** \_\_\_\_\_ **Time Started:** \_\_\_\_\_ **Time Ended:** \_\_\_\_\_

### Introduction

My name is \_\_\_\_\_. I am here on behalf of the Institute for Peace and Development (IPD) and its partners. I am part of a team that is conducting feasibility studies for interventions that would contribute to stopping the practice of female genital mutilation or cutting (FGM/C) in Plan International’s project districts in Guinea and Kenya. The findings of this study will enable Plan International and its affiliate offices in Guinea and Kenya to design interventions on the practice of FGM/C in the participating communities, and the country at large.

We do not promise that you will personally benefit from the research. However, your participation in the study will help Plan International and its country level partners design interventions that may benefit your community and others.

We will treat the answers that you provide in this research as confidential. We will keep a list of the people we interviewed in case we need to come back and clarify some information from you. However, the list will not be shared with anyone. It will be kept under lock at IPD offices in Tamale and will be destroyed after the analysis is done. We will not mention your name in the report. If we need to quote something that you have said word for word during the interview, we will use a different name so that no one knows who made the statement. You may choose not to have your name written. Do we have your permission to write your name on the list of participants? **Yes [ ] No [ ]**

Your participation in the research is voluntary. You may choose to withdraw any point during the interview. If you decide not to participate or choose to stop your participation, you will not suffer any loss as a result. Do you accept to participate in this study? **Yes [ ] No [ ]**

Do you have any questions about the study? **Yes [ ] No [ ]**

Name of Interviewee \_\_\_\_\_ Phone #1 \_\_\_\_\_ 2. \_\_\_\_\_

Name of Interviewer \_\_\_\_\_ Supervisor \_\_\_\_\_

If you have any concerns about this study, you may contact directly of the following persons:

Hippolyt Pul Executive Leader, Institute for Peace and Development. Lead Study Researcher	A55 Gumani Rice City, P O Box TL1799 Tamale, NR, Ghana Tel: +233 (0) 244 311 098 Email: Hippolyt. <a href="mailto:pul@ipdafrica.org">pul@ipdafrica.org</a>
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## **Geolocation of Data Collection Sites - GPS Location of Interview (automatic)**

1. In which country data is the data being collected?
  1. Guinea
  2. Kenya
  3. Ethiopia (AU office, AU Liaison Office)
  4. Tanzania ECA Office, Arusha
  5. Nigeria ECOWAS Office, Abuja
  6. Other (Specify)
  
2. In which of the targeted districts for Plan's FGM/C activities is the data being collected
  1. Macenta, Guinea
  2. Nzérékoré, Guinea
  3. Yomou, Guinea
  4. Kajiado County, Kenya
  5. Tharaka Nithi County, Kenya
  6. None of the above

## **Section 1: Profile of Respondents**

I would now like to begin by getting to know you better. Would you mind if I ask:

3. To which gender category would you say you belong?
  - 1) Male [ ]      2) Female [ ] 3) Other (specify) \_\_\_\_\_ [ ]
  
4. How old were you on your last birthday?
  3. (Write age down in years) \_\_\_\_\_
  4. I do not know my age (please mark) [ ]
  
5. What is the highest level of education you attained? (Check one)
  17. Never been to school [ ]
  18. Less than six years of Primary Education [ ]
  19. Primary Education up to Middle School/Junior Secondary School [ ]
  20. Completed secondary school
  21. Completed Teacher/Nursing/Vocational Training College [ ]
  22. Tertiary Institution up to Diploma/Higher National Diploma [ ]
  23. University Degree up to bachelor's level [ ]
  24. University Degree up to the master's level [ ]
  25. University Degree up to the Doctorate level [ ]
  26. Other (specify) \_\_\_\_\_ [ ]
  
6. What religion do you practice or are you affiliated to?
  1. African Indigenous Religion [ ]
  2. Agnostic (I do not know if there is a God) [ ]
  3. Atheist (I do not believe there is a God) [ ]
  4. Christianity [ ]
  5. Islam [ ]
  6. I do not have a religion
  7. Other (Specify) [ ] \_\_\_\_\_
  
7. How would you describe the place where you normally live?
  6. Village
  7. Town
  8. District Capital
  9. Municipal Capital
  10. Regional Capital
  11. National Capital

8. How would you describe your status of employment?
- 7. Not employed [ ]
  - 8. Self-employed [ ]
  - 9. Employed in the private sector [ ]
  - 10. Employed in the government sector [ ]
  - 11. Still in school or under training
  - 12. Other [ ] (Specify)\_\_\_\_\_
9. If you are employed, how would you describe the kind of work you do?
- 10. Public Servant (Appointed government official at the regional, district or local level)
  - 11. Civil Servant (an employee hired by the government such as doctors, nurses, teachers, etc., on government payrolls)
  - 12. Security Services (Military, Police, Immigration, Customs, Fire Service etc.)
  - 13. Businessperson (storeowner, mechanic, construction, manufacturing, etc.) .
  - 14. Hospitality (owner/manager of hotel, motel, restaurant, drinking bar, etc.)
  - 15. Farmer, Herdsman,
  - 16. Stay-at-home spouse
  - 17. Other (Specify)
10. What role do you play in your community?
- 6. Community leaders (chiefs, youth, and women leaders
  - 7. Religious Leader – Priest, Pastor, Imams, Rev. Sister, Nun, etc., Spiritualist).
  - 8. Elected or appointed Municipal, district, or regional local government representative
  - 9. Other (Specify)

### Knowledge, attitude, and practices towards FGM/C

11. How important is the practice of FGM/C to the customs and traditions of your community?
- 1. Very important
  - 2. Important
  - 3. Neither important nor unimportant
  - 4. Not important
  - 5. Not at all important
  - 6. I do not know
12. What are the things that make the practice of FGM/C important for your community?
- 1. Cultural beliefs
  - 2. Religious reasons
  - 3. Social reasons e.g., status symbol
  - 4. Source of income for circumcisers
  - 5. Inhibiting women sexual feelings
  - 6. Peer pressure e.g., fear of losing membership of family, groups, or friends for noncompliance
  - 7. Others specify.....
13. Which gender categories do you believe support the continuation of the practice of FGMC the most?  
(Multiple answers possible. Please choose all that apply)
- 1. Older Men
  - 2. Older women
  - 3. Young men
  - 4. Young women
  - 5. I cannot tell
14. Are you aware of any national policies or laws that ban the practice of FGMC?
- 1. Very much aware
  - 2. Aware
  - 3. Somewhat aware
  - 4. Neither aware nor unaware
  - 5. Unaware
  - 6. Not at all aware
  - 7. Can't tell

15. To what extent are these laws enforced in your community/district/region?
1. To a very large extent
  2. To a large extent
  3. To some extent
  4. To a Low extent
  5. To a very low extent
  6. I do not know
  7. I am not sure
16. What makes people respect and enforce these laws and policies?
1. They are convinced that they are for their own good
  2. They are afraid of the punishment for noncompliance
  3. Other (Specify)
17. Why do people choose not to respect and follow these laws and policies?
1. They are not convinced that they for their own good
  2. They see no benefits in obeying them
  3. There are no consequences for not obeying them
  4. Other (Specify)
18. To what extent do you believe that the government can stop the practice of FGMC in your community through the laws and policies it implements?
1. Very strongly belief
  2. Strongly belief
  3. Somehow belief
  4. Neither belief nor disbelief
  5. Do not believe
  6. Strongly do not belief
  7. I don't know
19. Are you aware of any policies/ guidelines or regulations that prohibit FGM/C?
1. Yes
  2. No
  3. ~~Can't recall~~
20. If you are aware, how effective do you think are these policies/ guidelines or regulations in stopping the practice of FGM/C in your area?
1. Very effective
  2. Effective
  3. Somewhat effective
  4. Neither effective nor ineffective
  5. Ineffective
  6. Very ineffective
  7. I can't tell

21. To what extent do you believe that the following categories of persons have the power and influence to stop the practice of FMGC in your community or district?

Possible Security Service Providers	To a very large extent	To a large extent	To some extent	To a Low extent	To a very low extent	Don't Know
1. Government officials at the Municipal/District Levels						
2. Government officials in the Health Sector						
3. Government officials in the educational sector						
4. Security agencies such as the Police and Military						
5. Traditional leaders such as chiefs and elders of the community						
6. Religious leaders (Priests, Pastors, Imams, Traditional Religious priests, etc.)						
7. Women leaders						
8. Youth leaders						
9. Community members who provide FGMC Services						
10. Youth of the community						
11. Others (Specify)						

Plan International and its partners intend to advocate with the African Union, regional bodies such as the East Africa Community, ECOWAS, and national governments for the implementation of existing laws, policies, and programs. They also seek to increase accountability and promote realistic resource allocation to programs that help to eradicate FGM/C in Guinea and Kenya. Plan also intends to bring together high-level peers, stakeholders, civil society, and government agencies to exchange views on how to support the effective implementation of high-level laws and policies that lead to the stoppage of FGM/C in the two countries.

22. Relevance: To what extent are the planned interventions the right ones to contribute to the stoppage of FGM/C in Guinea or Kenya?

1. To a very large extent
2. To a large extent
3. To some extent
4. To a Low extent
5. To a very low extent
6. I do not know
7. I am not sure

23. Coherence: how well do you believe these planned continental, regional, and national levels engagements fit with the understanding community-level actors on how the practice of FGM/C can be stopped in Guinea and Kenya.?

1. Very strongly belief
2. Strongly belief
3. Somehow belief

4. Neither belief nor disbelief
  5. Do not believe
  6. Strongly do not believe
  7. I don't know
24. Effectiveness: How effective will the planned interventions be in helping Plan International achieve its objectives of stopping FGM/C in Guinea and Kenya?
1. Very effective
  2. Effective
  3. Somewhat effective
  4. Neither effective nor ineffective
  5. Ineffective
  6. Very ineffective
  7. I can't tell.
25. Efficiency: How are the intended use of resources available to Plan International and its partners for the interventions above the most efficient way to achieve the objectives of stopping FGM/C in Guinea and Kenya?
1. Very efficient
  2. Efficient
  3. Somewhat efficient
  4. Neither efficient nor inefficient
  5. Inefficient
  6. Very inefficient
  7. I can't tell.
26. Impact: what difference will the interventions of Plan International and its partners make on the stoppage of the practice of FGM/C in the targeted communities?
1. Very high impact
  2. High Impact
  3. Limited Impact
  4. Neither impactful nor unimpactful
  5. No impact
  6. No impact at all
  7. I can't tell
27. Sustainability – To what extent will the benefits of the interventions be in ensuring that the stoppage of FGM/C practices in the project communities last beyond the life of the project?
1. To a very high extent
  2. To a high extent
  3. To a limited extent
  4. Neither high nor low extent
  5. To a low extent
  6. To a very low extent
  7. I can't tell

Thank you

#### Appendix 4 Chi-Square Test Values

##### Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.117 <sup>a</sup>	4	.017
Likelihood Ratio	12.822	4	.012
Linear-by-Linear Association	.980	1	.322
N of Valid Cases	264		

a. 0 cells (0.0%) have an expected count of less than 5. The minimum expected count is 11.13.

#### Appendix 5 What are the things that make the practice of FGM/C important for your community?

##### Appendix 5a: Crosstabulation of Selection of Culture as a Factor by Country and by Gender

Gender Category of Respondents/Selection		Country		Total
		Guinea	Kenya	
Male	Not Selected	20	8	28
		26.7%	15.4%	22.0%
	Cultural Beliefs	55	44	99
		73.3%	84.6%	78.0%
Total	75	52	127	
	100.0%	100.0%	100.0%	
Female	Not Selected	17	4	21
		22.4%	6.6%	15.3%
	Cultural Beliefs	59	57	116
		77.6%	93.4%	84.7%
Total	76	61	137	
	100.0%	100.0%	100.0%	
Total	Not Selected	37	12	49
		24.5%	10.6%	18.6%
	Cultural Beliefs	114	101	215
		75.5%	89.4%	81.4%
Total	151	113	264	
	100.0%	100.0%	100.0%	

*Appendix 5b: Crosstabulation of Selection of Religious Reasons as a Factor by Country and by Gender*

Gender Category of Respondents/Selection		Country		Total
		Guinea	Kenya	
Male	Not Selected	62	50	112
		82.7%	96.2%	88.2%
	Religious reasons	13	2	15
		17.3%	3.8%	11.8%
	Total	75	52	127
		100.0%	100.0%	100.0%
Female	Not Selected	63	58	121
		82.9%	95.1%	88.3%
	Religious reasons	13	3	16
		17.1%	4.9%	11.7%
	Total	76	61	137
		100.0%	100.0%	100.0%
Total	Not Selected	125	108	233
		82.8%	95.6%	88.3%
	Religious reasons	26	5	31
		17.2%	4.4%	11.7%
	Total	151	113	264
		100.0%	100.0%	100.0%

*Appendix 5c: Crosstabulation of Selection of Social Reasons as a Factor by Country and by Gender*

Gender Category of Respondents/Selection		Country		Total
		Guinea	Kenya	
Male	Not Selected	49	46	95
		65.3%	88.5%	74.8%
	Social Reasons	26	6	32
		34.7%	11.5%	25.2%
	Total	75	52	127
		100.0%	100.0%	100.0%
Female	Not Selected	57	60	117
		75.0%	98.4%	85.4%
	Social Reasons	19	1	20
		25.0%	1.6%	14.6%
	Total	76	61	137
		100.0%	100.0%	100.0%
Total	Not Selected	106	106	212
		70.2%	93.8%	80.3%
	Social Reasons	45	7	52
		29.8%	6.2%	19.7%
	Total	151	113	264
		100.0%	100.0%	100.0%

*Appendix 5d: Crosstabulation of Selection of Source of Income for Circumcisers as a Factor by Country and by Gender*

Gender Category of Respondents/Selection		Country		Total
		Guinea	Kenya	
Male	Not Selected	39	42	81
		52.0%	80.8%	63.8%
	Source of Income for circumcisers	36	10	46
		48.0%	19.2%	36.2%
Total	75	52	127	
		100.0%	100.0%	100.0%
Female	Not Selected	51	53	104
		67.1%	86.9%	75.9%
	Source of Income for circumcisers	25	8	33
		32.9%	13.1%	24.1%
Total	76	61	137	
		100.0%	100.0%	100.0%
Total	Not Selected	90	95	185
		59.6%	84.1%	70.1%
	Source of Income for circumcisers	61	18	79
		40.4%	15.9%	29.9%
Total	151	113	264	
		100.0%	100.0%	100.0%

*Appendix 5e: Crosstabulation of Selection of Inhibiting Women's Sexual Feelings as a Factor by Country and by Gender*

Gender Category of Respondents/Selection		Country		Total
		Guinea	Kenya	
Male	Not Selected	58	34	92
		77.3%	65.4%	72.4%
	Inhibiting women sexual feelings	17	18	35
		22.7%	34.6%	27.6%
Total	75	52	127	
		100.0%	100.0%	100.0%
Female	Not Selected	65	59	124
		85.5%	96.7%	90.5%
	Inhibiting women sexual feelings	11	2	13
		14.5%	3.3%	9.5%
Total	76	61	137	
		100.0%	100.0%	100.0%
Total	Not Selected	123	93	216
		81.5%	82.3%	81.8%
	Inhibiting women sexual feelings	28	20	48
		18.5%	17.7%	18.2%
Total	151	113	264	
		100.0%	100.0%	100.0%

*Appendix 5f: Crosstabulation of Selection of Peer Pressure as a Factor by Country and by Gender*

Gender Category of Respondents/Selection		Country		Total
		Guinea	Kenya	
Male	Not Selected	66	33	99
		88.0%	63.5%	78.0%
	Peer Pressure	9	19	28
		12.0%	36.5%	22.0%
	Total	75	52	127
		100.0%	100.0%	100.0%
Female	Not Selected	69	48	117
		90.8%	78.7%	85.4%
	Peer Pressure	7	13	20
		9.2%	21.3%	14.6%
	Total	76	61	137
		100.0%	100.0%	100.0%
Total	Not Selected	135	81	216
		89.4%	71.7%	81.8%
	Peer Pressure	16	32	48
		10.6%	28.3%	18.2%
	Total	151	113	264
		100.0%	100.0%	100.0%

*Appendix 5f: Crosstabulation of Selection of Other as a Factor by Country and by Gender*

Gender Category of Respondents/Selection		Country		Total
		Guinea	Kenya	
Male	Not Selected	71	51	122
		94.7%	98.1%	96.1%
	Other	4	1	5
		5.3%	1.9%	3.9%
	Total	75	52	127
		100.0%	100.0%	100.0%
Female	Not Selected	73	61	134
		96.1%	100.0%	97.8%
	Other	3	0	3
		3.9%	0.0%	2.2%
	Total	76	61	137
		100.0%	100.0%	100.0%
Total	Not Selected	144	112	256
		95.4%	99.1%	97.0%
	Other	7	1	8
		4.6%	0.9%	3.0%
	Total	151	113	264
		100.0%	100.0%	100.0%

**Appendix 6: Guinea Survey Respondents Questions on FGM/C Feasibility Study**

French	English	Profile of Questioner	
		Gender	Age (in years)
Vous voulez arrêter la MGF?	Do you want to end FMG?	Male	33
L'abandon de MGF?	Abandon FGM?	Male	44
Pourquoi chaque institution vient débiter quelques études mais ne termine pas comme il le faut ?	Why do institutions come and start studies but never end as they should?	Male	38
Pourquoi cette étude?	Why this study?	Male	52
Quel est le but de cette étude?	What is the exact purpose of this study?	Female	38
Pourquoi vous voulez éliminer notre coutume ?	Why do you want to eliminate our custom?	Male	28
Pourquoi vous voulez en finir avec nos traditions ?	Why do you want to stop to our traditions?	Female	45
Pourquoi voulez-vous mettre fin à notre coutume?	Why do you want to put an end to our customs?	Male	76
Pourquoi la fin de notre coutume?	Why end our customs?	Female	46
Quelle est l'intention des activités de MGF au sein de notre communauté?	What is the intention of the activities of FMG in our communities?	Female	38
Quelle est l'intention de Plan par rapport à notre pratique?	What is the intention of Plan in regard to our practice?	Female	28
Pourquoi Plan veut mettre fin à notre coutume?	Why does Plan want to put an end to our customs?	Female	32
Pourquoi les gens persistent toujours pour l'arrêt des MGF étant donné c'est une tradition ?	Why are people always persisting in stopping FGM when it is out tradition?	Female	37
Pourquoi les gens nous demandent de n'est pas envoyer les filles à la forêt	Why are people asking us not to send our girls to the forest [for the rituals]	Female	34
Quelle est l'intention des activités de la MGF?	What is the intention of the FGM activities?	Male	53

## Appendix 7: Stakeholder Identification and Analysis Matrix

### Appendix 7a: Stakeholder Analysis – General

Stakeholder	Location (District/County)	Role	Interests	Nature of Authority, Power, and Influence	Sources of Authority, Power, and influence	Contribution to Project	Impact Level (High, Medium, Low)	Other observations
<b>Community-level Stakeholders</b>								
Traditional leaders (Chiefs, Elders, Heads of Clans, and families)	Villages and	Custodians of customs and traditions of the community	<ul style="list-style-type: none"> <li>Ensure preservation and transmission of community beliefs, values, and practices across generations.</li> <li>Enforcement of rules and regulations</li> </ul>	<ul style="list-style-type: none"> <li>Gatekeepers to communities</li> <li>Community mobilization</li> <li>Porte-parole of communities</li> </ul>	<ul style="list-style-type: none"> <li>Formal – based on position and traditions</li> <li>Informal – based on personal attributes</li> </ul>	<ul style="list-style-type: none"> <li>Can positively or negatively affect project outcomes</li> <li>Can champion anti-FGM/C narrative reconstruction in communities</li> </ul>	High	Subject to manipulation by political leaders;
Religious Leaders (Imams, Pastors/Priests, Leaders of Traditional African Religions such as Seers, Magicians)	Villages, District, and national levels.	Custodians and transmitters of religious values, beliefs, and practices. Provide psycho-religious guidance and support to community practices	<ul style="list-style-type: none"> <li>Uphold religious beliefs and practices.</li> <li>ensure adherence to ritual procedures;</li> </ul>	<ul style="list-style-type: none"> <li>Gatekeepers to religious beliefs, values, and practices</li> <li>Can change FGM/C narratives and engage in actions to stop FGM/C,</li> </ul>	<ul style="list-style-type: none"> <li>Formal – based on position and assigned/recognized roles and responsibilities</li> <li>Informal – based on personal attributes</li> </ul>	<ul style="list-style-type: none"> <li>Can use religious ritual and festive occasions, as well as religious spaces (Churches, Mosques, Shrines) to disseminate information, and shape discourse on FGM/C</li> </ul>	High	Can be difficult to convince to abandon course and preach new world views  Champions of change if they are adequately sensitized and mobilized.
Leaders of Youth groups and associations (male and females)	Members of age, social, or economic groups in the communities. Could have district or even national coverage.	Mobilize and coordinate the engagement of young people in different social, economic, or political activities.	Uncertain direction of interests: some may support the practice of FGM/C; others oppose, and others will be indifferent	<ul style="list-style-type: none"> <li>Enforcers or opposers of FGM/C practices in their communities.</li> <li>Represent forces and sources of change.</li> </ul>	Informal – based on members' allegiance and the ability to champion the collective interests of members	FGM/C is practiced on young and adolescent persons. Can harness new information technologies to expand reach of FGM/C information, education, and communication	Medium	Youth are not homogenous; they live with different experiences. Need to search out and reach them in their appropriate niches.
FGM/C Practitioners	In communities and Health institutions (for medicalized FGM service providers)	Service Providers Can champion supply-side stoppage of service provision	Maintenance of cultural values, traditions, and practices Economic : practice is source of income	Decide on what type of FGM/C practice works best in any given circumstances	<ul style="list-style-type: none"> <li>Expert- recognized ability to perform cutting or excisions</li> <li>Traditional power – if practice is inherited from family lineage</li> </ul>	Can be converted preachers against FGM/C.	High	Can be difficult to convert without assuring them of alternative service provision for income
Persons who have experienced FGM/C	At all levels	Sharing experiences; Change advocates	See practice maintained. Or See practice abolished. happen	Models of lived experiences of FGM/C	Speak to the issues based on personal experience	Advocate for change based on person experiences	High	Some may oppose while others support FGM/C continuation
<b>District/Prefecture/County and National Levels</b>								
Government Ministries, Departments and Agencies with responsibility for FGM/C Education and eradication	District and national levels	Implement government policies and programs. Oversee resource allocation and management	Ensure adherence to State policies, programs, laws, rules, and regulations	<ul style="list-style-type: none"> <li>Make and enforce policies against FGM/C</li> <li>Resource mobilization to support FGM/C fight</li> </ul>	<ul style="list-style-type: none"> <li>Constitutional,</li> <li>Legal – from different laws</li> <li>Administrative – rules enforcement responsibilities</li> <li>Secure and allocate resources</li> </ul>	<ul style="list-style-type: none"> <li>Develop and operationalize structures, systems, and processes to enforce legislation and commitments</li> </ul>	High	Ability to function depends on directives and resource allocation from central government.

Stakeholder	Location (District/County)	Role	Interests	Nature of Authority, Power, and Influence	Sources of Authority, Power, and influence	Contribution to Project	Impact Level (High, Medium, Low)	Other observations
Political leaders	Community, District, National, Regional, and Continental	Conveners, mobilizers, opinion leaders because they are listened to.	<ul style="list-style-type: none"> <li>Instrumentalize FGMC for political expedience</li> <li>Political leaders [...] they are after votes, or retention of their political position,</li> </ul>	<ul style="list-style-type: none"> <li>Have position with access to decision-making fora.</li> <li>Have access to money</li> <li>Contributors to legislative processes.</li> </ul>	<ul style="list-style-type: none"> <li>Legal – derived from constitution and different laws</li> <li>Moral legitimacy – based on relationships and degree of support and respect from constituents.</li> </ul>	<ul style="list-style-type: none"> <li>Can leverage or exercise power to mobilize and allocate resources that support project</li> <li>State-community interface.</li> </ul>	High	Tend to follow the winds of votes – i.e., will do what is needed to win and hold on to power and their positions.
Educational Sector Actors: School, Teachers, Students, and children	District and community-levels	<ul style="list-style-type: none"> <li>Educators</li> <li>Childcare and protection</li> <li>Teachers may be respected opinion leaders</li> <li>Students – captive audience for anti-FGM/C education</li> </ul>	<ul style="list-style-type: none"> <li>Openly, want to see end to FGM/C practice</li> <li>Privately, some may want to see practice continued</li> </ul>	Provide information, communication, and education that mold minds, behaviors, attitudes, and practices.	<ul style="list-style-type: none"> <li>Legal– have responsibility to care for and educate children</li> <li>Administrative – use of PTAs and other community outreach to support anti-FGM/C practice</li> </ul>	Can induce change through enhancing knowledge on harm of FGM/C	High	Some youth support the practice and would work against plans to eradicate it.
Women Leaders e.g., County First Ladies in Kenya)	District, Province/County and National levels	<ul style="list-style-type: none"> <li>Targets for FGM/C practice</li> <li>Agents of mobilization and change</li> </ul>	<ul style="list-style-type: none"> <li>May want to see practice abandoned</li> <li>Some may want to see practice continued</li> </ul>	Access to platforms to speak for change to happen	Customary roles as women and mothers Derived from association with male political partners	Ambivalent – could be supportive or oppositional to anti-FGM/C moves	Medium	Relationships and participation in project must be cultivated to ensure support
NGO, L/CBO and CSO <sup>18</sup>	Multiple locations and operating at different levels	Provide advocacy training and action against FGM/C practice	Advancing the objectives of their respective agencies or donors in the fight against FGMC/C	Have penetration, presence, and legitimacy in communities often unreachable by state agencies and actors.	<ul style="list-style-type: none"> <li>Legitimacy through service delivery in target communities</li> <li>Resource power – they bring knowledge, money, technologies, and other resources to communities they work with</li> </ul>	“the non-state actors [can] actively keep the government in check and contribute to the formulation of laws and policies as well as its implementation” (KN_KII_02_3375).	High	<ul style="list-style-type: none"> <li>Engagements depend on donor resources and budget cycles; leads to short durations, lack of continuity or sustainability.</li> <li>May displace governments</li> </ul>
Celebrities: Local “Celebrities like Kipchoge	Local and national levels	Offer spaces of engagement for population, especially the young ones who follow or listen to them	Use engagement in FGM/C activities to advance their social image and popularity, and/or influencers	Seen as role models, voice of the voiceless.	Social influence and modeling behaviors.	Galvanize opinions, support, and spread of mass education to followership; can use their networks to reach others beyond their platforms.	High	Need to cultivate relationships and guide them to understand and support the anti-FGM/C movement
<b>Regional Bodies (Economic Community of West Africa (ECOWAS), East Africa Community (EAC), and African Union (AU) Levels</b>								
Heads of States and Gov'ts of Member States	National levels; collectively at AU General Assembly or Committees	Oversee policy formulation and enactment	Reduce stigmatization of Africa as epicenter of FGM/C practice	<ul style="list-style-type: none"> <li>Make and direct enforcement of laws, rules, and regulations to stop FGM/C</li> </ul>	<ul style="list-style-type: none"> <li>AU Constitution, Conventions, and Protocols</li> <li>National Constitutions and laws</li> </ul>	Review commitments and initiate actions to operationalize or enforce them	Medium	May lack capacity to compel member states to comply with decided commitments

<sup>18</sup> In Kenya the list of such L/CBOs include: Msichana Empowerment, Zamara Foundation, Maendeleo ya Wanawake, Enlighten Generation CBO in Tharaka Nithi, Zamara Foundation, Plan International, Forum for Women Educationists (FAWE), Save the Children, Child Fund International, GOK\_Children services, Youth Anti FGM Network working in 22 counties, Anti FGM Board, Amref, The Girl Generation, Action Aid

Stakeholder	Location (District/County)	Role	Interests	Nature of Authority, Power, and Influence	Sources of Authority, Power, and influence	Contribution to Project	Impact Level (High, Medium, Low)	Other observations
AU Champion on Elimination FGM	AU Level, Member States	Champion of AU's FGM/C eradication agenda Interface between non-state actors and the AU machinery	Serve as the public face and spokesperson of AU for the elimination of FGM/C	Lead AU's engagements with donors and other agencies on FGM/C matters	Derived from constitution and conferred authority from Heads of States and governments of member states.	Can mobilize colleague Heads of States and Governments to support actions at the continental, regional, and national levels for the eradication of FGM/C	High	Ability to influence highly dependent on personal interests and commitment of the position holder to the anti-FGM/C agenda, and quality of engagement from activist groups
Dept of Social Affairs	AU Level	Champion policy and programmatic action to eliminate the continued practice of FGM	Ensure policy and program consistency across all member countries	Policy initiation and implementation oversight	African Union Charter	Assures coherence of social development programs through promoting, monitoring, and evaluating pertinent policies and strategies.	Medium	Lacks authority to compel adherence to agreed principles and policies by member states
African Commission on Human and People's Right (ACHPR) – also known as the Banjul Commission	AU Level	<ul style="list-style-type: none"> <li>Protects, and promotes human and people's right,</li> <li>Resolve disputes concerning and the interpretation provision of the African Charter,</li> <li>Monitor state compliance with charters.</li> </ul>	AU member States enforce laws and support institutions to protect human and people's rights against FGM/C,	<ul style="list-style-type: none"> <li>Lead AU's promotion and protection of human and people's rights.</li> <li>Interprets if Charters of the AU are violated and therefore serves as a forum for NGOs, and other organisations to hold states accountable</li> </ul>	Derived from the African Charter	Promote the elimination of FGM/C on the grounds of human rights protection and settle disputes by interpreting the charters of the AU.	Medium	May lack the capacity to compel and enforce its settlements
Committee of Experts on the Rights and Welfare of the Child (ACERWC)	AU Level	<p>Has mandate to</p> <ul style="list-style-type: none"> <li>promote and protect the rights enshrined in the Charter</li> <li>collect and document information,</li> <li>commission inter disciplinary assessment of situations on the rights and welfare of the child,</li> <li>organize meetings,</li> <li>encourage national and local institutions concerned with the rights and welfare of the child and where necessary.</li> <li>recommendations to Government on FGM/C issues</li> </ul>	<p>Promotion and protection of the African Child against FGM/C/. Interested in adopting legislation to end FGM/C.</p> <ul style="list-style-type: none"> <li>formulate and lay down principles and rules aimed at protecting the rights and welfare of children in Africa.</li> <li>cooperate with other African, International and Regional Institutions and organizations concerned with the promotion and protection of the rights and welfare of the child.</li> <li>monitor's the implementation and ensure protection of the rights enshrined in the Charter.</li> </ul>	The body at the AU in charge of issues concerning the African child of FGM/C is one.	African Charter on the Rights and Welfare of the Child (Article 32-34 of the Charter.)	Can mobilize the various heads of state to take action and support the fight against FGM/C. It's also the committee to liaise in the development of policies at the continental level against FGM/C	High	Validation Workshop on the Draft Joint General Comment on Female Genital Mutilation the from 7 to 8 June 2022

Stakeholder	Location (District/County)	Role	Interests	Nature of Authority, Power, and Influence	Sources of Authority, Power, and influence	Contribution to Project	Impact Level (High, Medium, Low)	Other observations
African Court on Human and People's Rights	AU Level	<ul style="list-style-type: none"> <li>Promotion and protection of Female rights against the practice of FGM/C.</li> <li>Source for resolving disputes on the interpretation African Charter.</li> <li>The forum for settling disputes and hearing cases of FGM/C</li> </ul>	Protection of human and people's rights against FGM/C and ruling on FGM/C-related conflict	Pass ruling on FGM/C that become case laws that enforceable in member states	The Court was established pursuant to Article 1 of the Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights	Serves as an avenue for resolving disputes relating to FGM/C practices.	High	Only acts on cases brought before it. Otherwise, unable to take up cases on its own
African Union Gender Observatory (AUGO)	AU	Knowledge management platform to monitor the implementation and enforcement of regional and international instruments including but not limited to the Maputo Protocol	Serve as a platform for creating awareness, advocating, promoting, and monitoring the fight against FGM/C. Serve as the platform for disseminating evaluations, research, and novel programmatic approaches on eradicating FGM/C. Data hub of information GBV, harmful practices females.	Serves as the foremost body of the AU for monitoring and reporting on GBV, HP and Sexual Reproductive Health.	Collective will of AU member States and non-state parties to support and patronize its services	Repository of reports and other documents for tracking compliance of AU member states' implementation of regional and international instruments, including but not limited to the Maputo Protocol, the Solemn Declaration on Gender Equality in Africa (SDGEA), Agenda 2063,	Medium	Its usefulness depends on what reports/documents it receives and who accesses and uses the documents in its possession

Stakeholder	Location (District/County)	Role	Interests	Influence	Contribution to Project	Potential Risks if		Impact Level (High, Medium, Low)	Other observations
						Involved	Not Involved		
Traditional leaders (Chiefs, Elders, Heads of Clans, and families)	Macenta, N'Zérékoré, Yomou	Holders of traditions (perpetuate it) and rituals, responsible for social ceremonies and rituals, social stability (solve contentious issues, arbitrage disputes, etc)	Keeping traditions and rites Keeping the communities together Keeping their status	Can very much be listened to Can impose "complying" behaviors	Diffuse messages Convince communities Offer alternative rites	If not convinced can diffuse counter messages	Communities might not accept to comply if their traditional leaders are not involved They could feel insulted and sabotage the efforts	High	This group is inevitable in certain areas (deep rural) but can be avoided in others
Religious Leaders (Imams, Pastors/Priests, Leaders of Traditional African Religions such as Seers, Magicians)	Churches, mosque	Religious education, religious offices (preaches and prayers), keepers of morality and values	Transmission of religious values, keeping <b>fidèles</b> in their practice of religious obligations, respecting religious injunctions	Strong	Diffuse messages Convince and reassure the communities about the religious aspects and that it is not against God's will not to engage into the practice	If not convinced can diffuse counter messages	ommunities might not accept to comply if their traditional leaders are not involved They could feel insulted and sabotage the efforts	High	This group is inevitable in certain areas (deep rural) but can be avoided in others
Leaders of Youth groups and associations (male and females)	Macenta, N'Zérékoré, Yomou, Conakry	Spread messages to stop the practice Educate the youth about alternative ways and the dangers of the practice	Being agent of change, Getting access to resources	Can be strong among youth population but mild with the elders and religious leaders, communities because of patriarchal rules	Awareness raising, eventually using new technologies Advocacy Communication campaigns Share and diffuse good practices	Lack of good technical and communication skills can create backlashes and rejection from communities, elders, and other leaders	Might lose an opportunity public to raise awareness of the youth (peer to peer awareness raising) Uninvolved youth leaders might work against the bank	Medium	It is not sure the older generation will accept to change behaviors. There is more hope to change behavior with the new generation, so this group has more potential if well supported.
FGM/C Practitioners	Macenta, N'Zérékoré, Yomou, Conakry	Executing the practice/Allowing for the practice to continue	Keeping the practice alive Continuing the tradition Respecting the customs Preserving women and family honor, Getting access to resources	Strong in communities through their status/position which they often inherited they can convince others of the importance of keeping the practice alive	Difficult to include them, if so through the development of alternative educational rites where they will continue to keep their power and influence	Can secretly sabotage the efforts Can reject the changes	Can sabotage the efforts	Medium	Act as service providers responding to market demands.
FGM/C Survivors or Victims	Macenta, N'Zérékoré, Yomou, Conakry	Share testimonies of the experience, storytelling, touching the hearts	Avoiding for other girls to be victims/ stopping the practice/ Fighting the stigma	Mild because often not publicly vocal for fear of stigma	Can be great contributors if they accept to share their experience	No risk	Lack of legitimacy because lack of true examples	Medium	The do no harm principle for the protection of victims must be respected if they are contributors to the project
<b>District/Prefecture/County and National Levels</b>									
Government Ministries, Departments and Agencies with	Macenta, N'Zérékoré, Yomou, Conakry and other subnational institutions. Includes	Reinforce the legal framework, Enforce laws, protect victims, raise awareness,	Decrease the weight of the practice on health costs, protect the rights of all its	Mild because lack of legitimacy in remote communities, resource poor and	Must be involved and convinced of the durability of the actions (other actors)	Depending on their legitimacy in the areas, it can be more	No political push for enforcement of policies, laws, and rules.	Medium	The state is an important player for stopping the practice, but it is weak – i.e., has limited penetration

Stakeholder	Location (District/County)	Role	Interests	Influence	Contribution to Project	Potential Risks if		Impact Level (High, Medium, Low)	Other observations
						Involved	Not Involved		
responsibility for FGM/C Education and eradication	anti-FGM/C Committees at subnational levels	educate, lead advocacy efforts, lead coordination efforts	citizens, respect its international and regional engagement, contribute to the well-being of women, get access to resources	dealing with other priorities in other work weak state	come and go while the state is permanent)	or less risky to involve them. Risks: hijack of Anti-FGM/C campaigns for political purposes.	No institutional framework to graft initiatives on for engagement beyond the project lifespan		to all areas; has limited resources to allocate to FGM/C eradication and bedevilled with inefficiencies, including corruption. Political leaders follow the votes, not the facts that mandate the eradication of FGM/C
Political leaders	Macenta, N'Zérékoré, Yomou, Conakry	No role so far	Little interest	Mild	None	Involvement for the wrong reasons, Distraction	Can champion counter-messaging for political ends	Low	Political leaders can be a risky actor to involve because of their motivation and instability
Educational Sector Actors: School, Teachers, Students, and children	Macenta, N'Zérékoré, Yomou, Conakry	Educate, share information	Acquiring skills and knowledge, protecting girls	Can influence students, parents, communities if they are active in community life	Agent of change, Communication for behavior change	Incorporation of anti-FGM/C education into curricula and other school-based activities	To miss a great vector of change, avenue for sharing messaging	Medium/High	High if they become strong advocate against the practice
Women Leaders <sup>19</sup> e.g., County First Ladies in Kenya)	Macenta, N'Zérékoré, Yomou, Conakry	Women's advocate/ voice/ interest defenders, bridges, witnesses	Stopping the practice for the young girls, avoiding the harmful effects, getting access to resources	They are respected voices, especially on issues affecting women and their development	Can champion community sensitization and advocacy for resource allocation to FGM/C initiatives	Would serve as a role model and voice of reason on Anti-FGM/C initiatives	Could be read as a silent supporter of FGM/C practice	Medium	First Ladies in Africa are becoming increasingly assertive in local and international political and public spaces. They can influence policies through soft and hard diplomacy.
NGO, L/CBO and CSO <sup>20 21</sup>	Macenta, N'Zérékoré, Yomou, Conakry	Advocacy, awareness raising, communication for behavior change, change agents in communities	Defense of community groups interests, Human rights promotion, access to resources, acquiring technical skills and experience	Can be important depending on their relationship and acceptance within the communities	Advocacy and communication campaigns, community relations	Impact negatively the efforts if not properly tooled/trained	Difficulty to access communities/ illegitimacy to lead advocacy campaigns with their agency and voice	High	Have access and legitimacy at community levels but geographical and thematic scopes of action may be limited by institutional mandates, funding amounts and cycles, and limited cross-agency collaboration.
Celebrities: Local "Celebrities like Kiphoqe	Macenta, N'Zérékoré, Yomou, Conakry	Using their arts for messaging and reaching out	Pleasing their audience, sometimes being ambassadors of cause	Strong influence on their audience	Can be ambassadors and vectors of change	Rejection of their legitimacy from the wide public	Can champion counter-messaging	Medium	Just like the political leaders their involvement can be two side of a coin because they are prone to scandals and reputation issues

<sup>19</sup> In Guinea active women organizations on GBV issues are among others: Club des jeunes filles leaders, F2DH, COFFIG, CONAG, REFMAP, REFAMP, Amali, WAFRICA Guinée

<sup>20</sup> In Kenya the list of such L/CBOs include: Msichana Empowerment, Zamara Foundation, Maendeleo ya Wanawake, Enlighten Generation CBO in Tharaka Nithi, Zamara Foundation, Plan International, Forum for Women Educationists (FAWE), Save the Children, Child Fund International, GOK\_Children services, Youth Anti FGM Network working in 22 counties, Anti FGM Board, Amref, The Girl Generation, Action Aid

<sup>21</sup> In Guinea, international NGOs working on health issues including HIV are more or less active on the issue of E/FGM (JHPIEGO, PLAN Guinée, Solthis, AGBEF). Other organisations working on children and human rights issues also treat the issue of E/FGM. A coalition of civil society organization to promote the end of E/FGM practice has also been formed recently. It has great potential for the coordination issue that many respondents have raised.

Appendix 7c: Stakeholder Identification and Analysis - Kenya

Stakeholder	Role	Interests	Influence	Contribution to Project	Potential Risks if		Impact Level (High, Medium, Low)
					Involved	Not Involved	
Forum for Women Educationists (FAWE)	Policy and budget reviews to promote education and deal with barriers to Education such as FGM	Fight for Women Rights and gender-based violence and Education	Support Advocacy against Gender Based Issues	Advocacy Ally at the National Level	No	Loss of existing influential connections	Medium
Lina Jebii Kilimo	Champion for Advocating against FGM	Fight against FGM/C	Mobilisation of women political leaders to review legislation and policies for FGM	Crusader/Ambassador and political mobiliser of parliamentarians to influence policy, planning and budgeting	No	Loss of networking opportunities	Medium
Senator Naisulla Lesuda	Political Leader against FGM	Fight against FGM	Power to influence Parliamentarians	Advocacy Ally at the National Level	Political inclination	Missing powerful representation in parliament	High
Women Political Leaders Caucus	Legislative	Advocates for Gender Equality in Parliament	Power of women against Gender Based Violence and particularly ending FGM/C . They influence Legislation , Policy, Accountability on FGM and budgeting for FGM	Advocacy Ally at the National Level	No risk	Miss out on Women leaders voice	High
Maendeleo ya Wanawake	Policy and advocacy on Gender Issues including FGM	Advocates for Women rights	Amplifying Voices against FGM/C	Good allies to support policy and budget advocacy	No risk	Project may lack one of the most vibrant feminist organizations of all times in Kenya	High
The Girl Generation	Anti FGM Programming	Policy and Advocacy against FGM -Globally	Policy and Advocacy work against FGM	Advocacy Ally at the National Level	No risks	No potential risks	Medium
Youth Anti FGM Network	Voicing on policy and implementation of Anti FGM Policies	Youth against FGM in Kenya	Amplifying youth voices against FGM in Kenya	Advocacy Ally at the National Level	No potential risks	They may speak bout youth exclusion	Medium
Amref	Policy and Advocacy Anti FGM Programming	Anti FGM service delivery and policy and advocacy work	Policy and Advocacy allies to review Anti FGM Laws	Advocacy Ally at the National Level	No risks	Miss out on key medicalization Lessons & perspective of FGM	Medium
Action Aid	Policy and Advocacy on FGM Programmes	Anti FGM Work in Isiolo and National level engagements	Anti FGM Programming	Advocacy Ally at the National Level	No risks	Feminists and all years FGM Organization	Medium
Child Fund International	Child Rights Policy and Advocacy	Child Focused Female Genital Mutilation	Child Rights Protection including protection against Harmful Practices like FGM	Advocacy Ally at the National Level and the AU Level	No risk	Miss on the child focused perspective of FGM/C	Medium
Save the Children Kenya	Child Rights Governance	Focus on child rights governance and report to the AU and engagements at the National Level	Strong Budget and Policy advocacy at the National level and AU .	Advocacy Ally at the National Level and at the AU Level	No risk	Weak coalition Poor understanding of integrated Humanitarian approaches that promote FGM/C	Medium
International Budget Partnerships	Budget Analysis	Key partner in analysis of budgets	Budget analysis and IEC Materials and Advocacy Material development	Budget Study/ Analysis	No risk	Poor budget analysis Good budget analysis training and capacity building	Medium

Stakeholder	Role	Interests	Influence	Contribution to Project	Potential Risks if		Impact Level (High, Medium, Low)
					Involved	Not Involved	
Institute of Certified Accountants Kenya	Budget Study Analysis and Policy Dialogues and Policy paper development	Focus on Budget analysis and policy analysis and	Policy ad Budget Dialogues at the National level	Good ally Budget Study/Analysis -Policy Paper development -Policy Dialogues	No risk	Poor Budget Analysis for FGM Poor Networking and engagements for parliamentarian and Government	Medium
National Gender and Equality Commission (NGEC)	Formed by the government to tackle Gender and Equality like FGM	Focus is to fight gender issues including support to GBV response including FGM	Data and research support on FGM and GBV. Good networking ally in government engagements	Information for policy and budgets engagements	Inclination to government during advocacy moments	Poor understanding of Governments FGM/C in GBV context in Kenya	High
National Gender Affirmative Action Fund(NGAAF)	Formed by the government to address the affirmative issues on Gender	Focus on funding some aspects of gender and FGM forms part of it	They have power to support allocations for the areas where inequality is experienced to address FGM	Good allies to understand affirmative allocations to address FGM/C	Inclination to government during advocacy moments	Poor government agency support Poor understanding of Government funding to address affirmative issues like FGM/C	High
UNICEF	Support Children Programming and tackling child rights issues		Provide strong technical support in design of policy and advocacy strategies in Kenya and AU	Good ally for technical and resource support to advance policy and advocacy agenda	No risks	Weak influencing power Poor guidelines , policy papers and support to address FGM/C advocacy work	Medium
FEMNET Africa	Policy and Budget advocacy for women issues	Policy and Budget advocacy for Kenya and Africa	Strong influence for government in Kenya and Africa	Strong ally to support the advocacy work in Kenya and AU Levels	A feminist approach that may not necessarily consider other factors	Poor feminist approach to FGMC	Medium
Anti FGM Board	Tasked with overseeing the FGM interventions in the country	All interventions regarding response to FGM/C in Kenya	Constitutionally mandated body to deal with FGM/C in Kenya	Strong ally to understand underpinning issues around policy and advocacy work and overall implementation of FGM in Kenya	Political and government influence in their work	Inadequate data and information relevant to advocacy work Poor Understanding of government approach and opportunities to address policy and budget issues for FGM/C in Kenya	High

## Appendix 8 – SWOT Analysis

### Appendix 8a: SWOT analysis for Guinea

Stakeholder	Strengths	Weaknesses	Opportunities	Threats
Community-level Stakeholders				
Traditional leaders (Chiefs, Elders, Heads of Clans, and families)	<ul style="list-style-type: none"> <li>• Custodians of cultural beliefs and ritual practices<sup>22</sup></li> <li>• Convening powers to initiate discussions for change.</li> <li>• Essential part in the community organization of decision-making villages</li> </ul>	<ul style="list-style-type: none"> <li>• Bound by traditions.</li> <li>• No powers to enforce legal sanctions</li> </ul>	<ul style="list-style-type: none"> <li>• Can be co-opted as change agents.</li> <li>• May be deterred or influenced by administrative authorities</li> </ul>	<ul style="list-style-type: none"> <li>• Could harden positions in support of cultural preservation</li> </ul>
Religious Leaders (Imams, Pastors/Priests, Leaders of Traditional African Religions such as Seers, Magicians)	Custodians of religious beliefs, rites, and rituals Religious leaders have the trust from the communities and same convening powers as traditional leaders	Not always able to go against what has been attributed to the holy books or the “words of God” Not enough versed into the science of religion to defend contrary positions to the general grand public beliefs	<ul style="list-style-type: none"> <li>• Can be co-opted as agents of change as they are trusted.</li> <li>• Understand better the purpose of struggle because some are intellectuals. in Guinea where religious leaders tend to have more weight than traditional leaders</li> </ul>	Could harden positions in support of cultural preservation. Could spread urban/rural myths to protect/perpetuate the practice
Leaders of Youth groups and associations (male and females)	Informed and sensitized early about the bad consequences of E/FGM More aware of their human rights More inclined to accept changes and reject bad traditional practices New generation fighting for changes. Easily share information with others More accessible, easy to mobilize	Less power to resist traditions. Less power to decide and influence because of patriarchal environment They move very frequently from their area and therefore cannot sustainably lead to a change in behavior	Can allow for a generational shift to let go of the practice Can be educated about the issues in schools and with the new media Lead advocacy efforts and propose new solutions/ contents	Could reject changes in the name of not letting go of ancestral traditions because of the pressure of their parents and communities. Could be instrumentalized by influent social actors (religious)

<sup>22</sup> In Guinea, we tend to attach rites and rituals to tradition rather than religion and even more since 85%+ of the population is Muslim. So, the argument for E/FGM is more on religion than tradition, even though the ritual aspect is present it is not predominant in the discourse

Stakeholder	Strengths	Weaknesses	Opportunities	Threats
FGM/C Practitioners	Holder of the tradition so if THEY accept the change, can be strong advocates and by not accepting to continue to practice they can contribute to the diminution of the practice Convening powers to initiate discussions for change.	Make a living out of E/FGM Do not recognize the harmful effects of the practice and attribute the consequences to the victim (bad luck, mother was not faithful to their father, etc...) Do not occupy other economic or social functions other than E/FGM and would have difficulties to recycle into/ learn to take on new roles	Can be used to promote new practices or continuity of ritual practices that ensure education but do not use ablation of the organs Existence of partners who can assist in the creation of income generating activities for practitioners	Reject and combat the changes for economic reasons through loss of income from E/FGM Reject and combat changes for social reasons through loss of social status. Existence of traditional practitioners' associations (ZOWO) that would dissuade practitioners from abandoning FGM/C i.e., group and community exclusion
FGM/C Survivors or Victims	Best witnesses of the bad consequences of the practice Strong voices against the practice when they accept to communicate	Prisoners of the communities, stigmatized for their mishappening into the practice, psychological fragile	Use them as first line advocates. Existence of protective laws	Security issues and stigmatization if they communicate publicly Will to be socially accepted and defend the practice
District/Prefecture/County and National Levels				
Government Ministries, Departments and Agencies with responsibility for FGM/C Education and eradication	Very aware and informed of the bad consequences of the practice. Able to enforce the laws. Able to use their status/official position to pledge against the practice into the communities Have access to large citizenry	Lack legitimacy among other kind of power holders (religious, traditional) because at the central level and far away from countryside Lack adequate resources to access large geographical areas (in country) for enforcement of the law/awareness raising campaigns Do not share their real perspectives with the funders who bring financial resources about finding alternative practices that can correspond to the communities' value systems (double language) Moral weaknesses in applying FGM/C laws given that their parents and children are circumcised. Engage into corruption practices. Influence of the community given the scale of the event	Enforce the law. Use international engagements as argument to reinforce the laws. Disseminate information to their peers in government and advocate for their engagement into the fight. Organize synergies of action Mobilize resources from the government (special fund) for stopping E/FGM Organize large advocacy and communication campaigns	Lack of support from other government agencies Lack of resources Lack of technical capacity Lack of coordination capacity Corruption
Political leaders	Capacity to mobilize large numbers. Communication skills	Do not make unanimity (can be greatly liked or disliked)	Use their mobilization capacity to communicate with large number of people.	Refuse to carry sensible issues that are not widely accepted.

Stakeholder	Strengths	Weaknesses	Opportunities	Threats
		Not perceived as holder of traditions who can impulse changes	Invite them into meaningful issues that could attract their electoral constituencies	Can go with majority discourse not to lose votes or win votes/ Not fully trustable Can be corrupted
Educational Sector Actors: School, Teachers, Students, and children	Access to community population and children and youth Ability to impact curricula and introduce human rights and reproductive health teachings adapted to the realities of the communities and taking into account social and anthropological particularities of the geographical areas.	Lack technical skills. Lack of appropriate resources to develop new. Far from central authorities to be trained on new issues. Do not use participatory methods/ active pedagogy with children and students to allow for dialogue and understanding. Tend to use violence and not to be open to dialogue with their students. Engage into corruption practices. Ability and opportunities to communicate with girls not yet victims and those victims of FGM	Can have a strong influence on children and youth Can integrate E/FGM issues into their curricula/teachings. Can be great vectors of change because of their proximity with children and youth who are more open to new learnings Can have access to parents to inform them and influence them about E/FGM	If not informed and trained can be strong defenders of the practice and hold the authority of justifying its continuity (“even the teacher said that we should continue the practice”) – can be a strong influencer in a negative way because perceived as the intellectual who knows best Can be corrupted. Potential for community threats to them
Women Leaders <sup>23</sup> e.g., County First Ladies in Kenya)	Survivors and victims of the practice Close to women in communities Advocate for women rights	Lower social position/status in the communities – need to fight harder to impose their views Victims of stigmatization Can be objects and subjects of corruption.	Use them as change agents. Educators to perpetuate the rituals without the ablation	Their leadership can be dismissed by patriarchal schemes (discrimination against women) They can support harmful traditional practices to sustain their leadership, please a majority and maintain the social status and privileges of being leaders
NGO, L/CBO and CSO <sup>24 25</sup>	Access to communities who can accept their messaging because of other work that they are doing with them and benefit them	Not sincere in their interventions (sometimes see opportunities to access resources but not to truly advocate about the issues) Lack of technical capacities Lack of resources	Trust and long-term relationships with the communities instead of punctual interventions Able to stay in the community for long periods of time, necessary for behaviour change	They can pass on the wrong messages and reinforce the resistances because they are not themselves true believers of change and/or well-trained into the issue

<sup>23</sup> In Guinea active women organizations on GBV issues are among others: Club des jeunes filles leaders, F2DH, COFFIG, CONAG, REFMAP, REFAMP, ROAJELF (Réseau Africain des Jeunes Femmes Leaders), Amali, WAFRICA Guinée

<sup>24</sup> In Kenya the list of such L/CBOs include: Msichana Empowerment, Zamara Foundation, Maendeleo ya Wanawake, Enlighten Generation CBO in Tharaka Nithi, Zamara Foundation, Plan International, Forum for Women Educationists (FAWE), Save the Children, Child Fund International, GOK \_Children services, Youth Anti FGM Network working in 22 counties, Anti FGM Board, Amref, The Girl Generation, Action Aid

<sup>25</sup> In Guinea, international NGOs working on health issues including HIV are more or less active on the issue of E/FGM (JHPIEGO, PLAN Guinée, Solthis, AGBEF). Other organisations working on children and human rights issues also treat the issue of E/FGM. A coalition of civil society organization to promote the end of E/FGM practice has also been formed recently. It has great potential for the coordination issue that many respondents have raised. A children protection system at the community/village level put in place by UNICEF called CLEF (Comité local pour l'enfance ou la famille) and SYPEG (Système de protection des enfants en Guinée). Finally, a network of traditional communicators

Stakeholder	Strengths	Weaknesses	Opportunities	Threats
	Understand social and anthropological levers and obstacles. Ability to find the right messaging for the communities			Lack of coordination and synergies which can dilute the impact of their actions Sometimes corruption
Celebrities: Local “Celebrities like Kipchoge	Can be influencers and change agents but more for the youth. Get a lot of attention from the public. Ability to influence and initiate change for their fans or audiences	Their notoriety can be short lived. They can never unanimously be appreciated. They generally do not have the collaboration of local and wise authorities because of their tendency towards cultural modernism.	To have them play a role of ambassadors	For the messages to lose credibility with a certain type of public who will view them as uncredible artists To be used as a way to discredit the issue (by the elders/traditionalists) <sup>26</sup> They are easy targets for scandals
Medias (not sure if they are stakeholders or tools?) and traditional communicators	Can diffuse messages to a large public. Can be opinion leaders		Mass communication campaigns Access to youth through new medias Innovative ways of communicating	

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<sup>26</sup> Artists can be viewed as people who are not serious and cannot be taken seriously on issues that are related to tradition

Most families in Guinea would not appreciate for their children to become artists or celebrities except for sports but even the sports celebrities don't get much credit and legitimacy on these kind of issues

Appendix 8b: SWOT analysis for Kenya

Stakeholder	Strengths	Weaknesses	Opportunities	Threats
<b>Community-level Stakeholders</b>				
Traditional leaders (Chiefs, Elders, Heads of Clans, and families)	<p>Custodians of cultural beliefs and practices.</p> <p>Have the convening powers to initiate discussions for change.</p> <p>Respected and accepted by communities and Government.</p>	<p>Bound by traditions and some support upholding of traditions.</p> <p>Have no powers to enforce legal sanctions.</p> <p>Often do not have funding for convening or actions.</p>	<p>Can be co-opted as change agents.</p> <p>Participate and are respected in Government and community policy and decision-making processes.</p>	<p>Could harden positions in support of cultural preservation.</p> <p>Fear being rejected by communities if they oppose the traditional practices.</p>
Religious Leaders (Imams, Pastors/Priests, Leaders of Traditional African Religions such as Seers, Magicians)	<p>Have a large following of committed congregations.</p> <p>Have the convening powers to initiate discussions for change.</p> <p>Respected and accepted by communities and Government.</p>	<p>Some fear opposing culture, lest they are rejected by community.</p> <p>Some not fully knowledgeable or disinterested about the disadvantages of FGM.</p>	<p>Large gatherings drawn in places of prayer.</p> <p>Involved in Government policy making processes.</p> <p>Have a large following that believes in what they say.</p>	<p>Could fear rejection by community and therefore ignore and not participate in processes to fight harmful culture.</p>
Leaders of Youth groups and associations (male and females)	<p>Have a large population and following.</p> <p>Often have the time to work on FGM and community education.</p> <p>Most directly affected community groups in terms of having a lived experience of FGM and other SRHR violations.</p>	<p>Do not have budget for working on FGM campaigns.</p> <p>Are busy looking for employment and survival.</p> <p>Do not always have the full knowledge and understanding about FGM and its harmful nature.</p> <p>In some areas where FGM does not take place in Kenya, the youth find this topic to be irrelevant.</p>	<p>Donors and politicians are increasingly interested in youth participation.</p> <p>There are many youth groups that have been formed and organized.</p> <p>Many young people in Kenya have a good level of education and can be mobilizers and educators.</p>	<p>Youth fear being rejected and cursed by parents and community leaders who uphold the FGM practice.</p> <p>Some men will refuse to marry a girl who has not undergone FGM. Therefore, the girls simply comply to be marriageable.</p>
FGM/C Practitioners	<p>Are often very respected women in community.</p> <p>Have a great following of women, parents, and leaders who listen to them.</p>	<p>Are keen to continue practice of FGM either for tradition, to earn income or to maintain their status quo of respect in the community.</p>	<p>Can be co-opted by NGOs and Government as leaders to promote alternative rites of passage.</p> <p>Laws and policies now prohibit FGM in Kenya and can discourage the cutters.</p>	<p>Can lose their personal income and respect if they stop practicing FGM cutting.</p>

Stakeholder	Strengths	Weaknesses	Opportunities	Threats
FGM/C Survivors or Victims	They have the full understanding of FGM since they have a lived experience of FGM.	At times can feel ashamed or be traumatized and unable to engage FGM discussions fully.  Have not been involved by NGOs and Government in the FGM fight since many of them do not come out openly to identify as survivors.	In Kenya there are emerging efforts to mobilize survivors into groups and magnify their voices through mass media and social media where they now fight FGM.	There is a risk that disclosing FGM status could cause violation of privacy as well as ridicule among social circles of young survivors.
<b>District/Prefecture/County and National Levels</b>				
Government Ministries, Departments and Agencies with responsibility for FGM/C Education and eradication	Have the authority and mandate to control FGM.  Have developed national laws and policies and structure of the FGM commission that prevent or stop FGM.  Some counties have also developed and adopted their FGM policies.	Do not have enough finances to undertake FGM actions – considering other competing priorities like covid, malaria etc.  Some politicians fear losing votes therefore will not participate in fighting favoured culture like FGM.  Many MDAs in Kenya do not have their sector FGM policies, plans or guidelines. It is not a priority.  Many public sector staff so not understand what and why FGM eradication.	Government processes are streamlined and can be implemented across sectors in one forum, or platform.  Government is respected and listened to because the law and policy support anti FGM actions.  International donors and commitments support and motivate Government to fight and stop FGM.	Government fears being rejected by powerful traditional and cultural leaders in the community.  Some in the Ministry of culture understand that their role is to preserve all forms of culture including FGM itself.
Political leaders	Are listened to and respected by their voters and the Government.	Some do not fully understand and do not prioritize FGM as a problem in their opinion.	Convene forums with large numbers of citizens.  Are mandated to participate in Parliament, monitor and hold accountable those responsible for executing FGM laws and policies.	Fear of being rejected by community leaders and voters if they take a position which is against FGM.
Educational Sector Actors: School, Teachers, Students, and children	Has a large following of students who can report incidences or risks of FGM.  Teachers are respected and could be heard in communities.	Education sector, unlike health or law enforcement sectors, does not have much legal authority or control over what happens in the community.  No officially approved manuals or curriculums for education and actions for FGM in schools.	Have the chance to shape and influence how children today think – in an effort to help transformation of their midframe tomorrow when they become leaders.	Education sector highly regulates and controls what can be said or done with students in schools.

Stakeholder	Strengths	Weaknesses	Opportunities	Threats
Women Leaders e.g., County First Ladies in Kenya)	<p>Women are respected as mothers and listened to in communities.</p> <p>Women have the passion and stamina to fight for their rights as they are directly affected by FGM.</p> <p>Many women in community participate in groups which are well organized and operational.</p>	<p>Women leaders often shy away from controversy. 2 women Reps refused to talk to us when they heard it was about FGM.</p> <p>Women leaders are not all fully knowledgeable about or interested in FGM. Especially in areas where FGM is not practiced.</p>	<p>Donors are interested in funding women groups.</p> <p>Government is interested in appearing to be supporting women who form the larger number of voters in Kenya.</p> <p>Increasingly over time positions are being opened for women in leadership forums like women's reps in Parliament etc.</p>	<p>Women leaders are controlled or restricted by the political agendas or priorities of their spouses or political parties.</p>
NGO, L/CBO and CSO <sup>27</sup>	<p>Have a large following and community groups as well as forums which could address FGM.</p> <p>Have donor funding and structures for FGM.</p> <p>Have good understanding of FGM matter.</p>	<p>Do not always reach the grassroots communities but more concentrated in reachable urban areas.</p> <p>At times force alternatives which are rejected by communities leading to their being at risk of being burnt.</p> <p>At times bring external staff who do not fully understand communities – and force for change and results to take place quickly.</p>	<p>Have donor funding.</p> <p>Participate in Government decision making forums.</p> <p>Are linked to international platforms of action.</p>	<p>Could be rejected by communities as outsiders who are bringing unreasonable foreign driven demands.</p>
Celebrities: Local “Celebrities like Kipchoge	<p>Have a large following that listens to them.</p>	<p>Are at times viewed as too high up there and therefore communities do not feel like they relate to and understand local problems fully.</p>	<p>Celebrities often get access to meetings and mass media where they can convey FGM messages easily.</p>	<p>If the popularity of a celebrity fails or erodes; then even the anti FGM message that he/she sent about FGM will become rejected and the NGO that sponsored it could lose favour or confidence in the eyes of the community.</p>
Media – mass media and social media	<p>Provide a forum for communication and sharing in an open way or in a protected anonymous manner.</p>	<p>Is not personalized therefore limited to informing but less effective on longer-term transformation of mindset.</p>	<p>Attracts and can convene many and varied audiences and informants in the mass and social media platforms.</p>	<p>There are many remote and far out areas of Kenya where FGM s most practised and yet mass and social media is not reaching because of no electricity and no internet coverage.</p>

<sup>27</sup> In Kenya the list of such L/CBOs include: Msichana Empowerment, Zamara Foundation, Maendeleo ya Wanawake, Enlighten Generation CBO in Tharaka Nithi, Zamara Foundation, Plan International, Forum for Women Educationists (FAWE), Save the Children, Child Fund International, GOK \_Children services, Youth Anti FGM Network working in 22 counties, Anti FGM Board, Amref, The Girl Generation, Action Aid

Appendix 8c: SWOT Analysis For Regional And Continental Bodies

Stakeholder	Strengths	Weaknesses	Opportunities	Threats
<b>Regional Bodies (Economic Community of West Africa (ECOWAS), East Africa Community (EAC), and African Union (AU) Levels</b>				
Heads of States and Gov'ts of Member States	Make collective decisions on laws, protocols, and principles that provide legal backing for actions to end FGM/Cf	No power to compel colleagues to comply with agreed protocols	Identify champions of change and leverage their spheres of influence to promote continental and national level actions to end FGM/C	Unstable contacts due to tenure limitations and other unconstitutional means of removing Heads of States – coup d'états
AU Champion on Elimination FGM	Point person for driving continental agenda for eliminating FGM/C. Focal person representing other Heads of States on the issue	No power to compel colleagues or AU member states to implement agreed protocols	Interface point between nonstate actors with Heads of States and	Unelected, unstable position. President Roch Marc Christian Kabore of Burkina Faso, designated in Feb 2019 was deposed in a coup d'état in 2022. No known replacement yet.
African Union Gender Observatory (AUGO)	Potentially one stop shop for data on state of FGM/C on the continent	Depends on member states and other actors to populate and/or access and use the database	Could provide easy access to shareable data across the continent	Types of technological architecture will determine frequency, timeliness, accuracy, and completeness of data
Dept of Social Affairs	Champions the AU's efforts on ending FGM/C; Central point for coordinating and leading the Saleema project	No executive powers: relies on willingness of AU member states to participate in activities	Serves as a permanent interface point for state and nonstate anti-FGM/C activities to engage with other AU structures working on the topic	Relies on external funding from United Nations, European Union, UNFPA-UNICEF and the World Bank through the Sahel Women Empowerment and Demographic Dividend (SWEDD) Africa Regional Project for funding (African Union, 2021b).
African Commission on Human and People's Right (ACHPR) – also known as the Banjul Commission	Adopted Resolution ACHPR/Res.110(XXXI)07: Resolution on The Health And Reproductive Rights of Women In Africa that congratulates AU member states that have signed the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa and urged others to do same (2007).	No powers to enforce compliance with the protocol on The Health and Reproductive Rights Of Women or associated documents emanating from the AU.	Interface point for dialogue and engagement to facilitate consensus building for actions to eradicate FGMC	AU Member States have different cultural and political traditions, laws, and practices tht conflict with rights that the ACHPR has defined; increasing risks of delayed or denied compliance by member states.
Committee of Experts on the Rights and Welfare of the Child (ACERWC)	<ul style="list-style-type: none"> <li>Capacity to review compliance of AU Member states on implementation of child right protocols, including anti-FGM/C</li> <li>Serves as a reference point for expert guidance for States seeking to implement AU-mandated protocols (GNA, 2016)</li> </ul>	Lacks capacity to compel enforcement of protocols	<ul style="list-style-type: none"> <li>Champion policy, and programmatic action and adopt legislation to eradicate the practice of FGM/C on the continent.</li> <li>With its regional quasi-judicial role engage to settle disputes on FGM/C.</li> </ul>	Relies on Member States to activate its services.

African Court on Human and Peoples' Rights	established to ensure the protection of human and peoples' rights in Africa. complements and reinforces the functions of the African Commission on Human and Peoples' Rights.	Only has jurisdiction over cases from AU member states that have deposited their instruments under Article 34(6) to declare recognition of the authority of the Court on cases emanating from them.	Opportunity to preside over cases filed by a broad range of actors <ul style="list-style-type: none"> <li>the African Commission of Human and Peoples' Rights,</li> <li>State Parties to the Protocol or African Intergovernmental Organizations.</li> <li>Non-Governmental Organizations with observer status with the African Commission and individuals whose State of original has deposited the Article 34(6) declaration recognizing the jurisdiction of the Court to accept cases from individuals and NGOs.</li> </ul>	<ul style="list-style-type: none"> <li>Non-recognition of the Court's jurisdiction of AU member states on cases from them through</li> <li>Failure to deposit Article 34(6) instruments</li> <li>Withdrawal of instruments after deposition as Rwanda did in 2017; Tanzania in 2019; Côte d'Ivoire and Benin in 2020 (ACHRP, 2023).</li> </ul>
East Africa Community (EAC)	<ul style="list-style-type: none"> <li>Enacted the Prohibition of Female Genital Mutilation (FGM) Act in 2016</li> <li>developing an online database to enhance reporting, data collection and access to information concerning FGM.</li> </ul>	<ul style="list-style-type: none"> <li>Dependent on ratification of law by all member states.</li> <li>Not all Member States have assented to the law yet or domesticated appropriate provisions in their national laws. Therefore, operationalization of the law across countries is stalled.</li> </ul>	Could have provided a uniform legal framework to fight cross-border FGM/C service delivery and access.	Differences in priorities and interests of Member States threaten the operationalization of the law
Economic Community of West African States (ECOWAS)	Has adopted AU's commitment to end violence against women, including FGM/C	Domestication and operationalization of commitment dependent on member states	Outcomes of Court Action by CSOs in Mali that have sued the government for not instituting laws to proscribe FGM/C to provide greater guidance responsibilities of state and nonstate actors in enforcing compliance with the joint protocols.	Military coup d'états and/or political destabilization in several countries (Burkina Faso, Guinea, Mali, Niger) divert attention from G=FGM issues and jeopardize state commitment to seeing to implementation of frameworks that stop the practice.

## Appendix 9: Stakeholder Risks Assessment

Stakeholder	Potential Risks if	
	Involved	Not Involved
<b>Community-level Stakeholders</b>		
Traditional leaders (Chiefs, Elders, Heads of Clans, and families)	Hijack and deviate messaging; demands for compensation	Could sabotage project through alternative messaging
Religious Leaders (Imams, Pastors/Priests, Leaders of Traditional African Religions such as Seers, Magicians)	Uphold and defend the religious foundations of the practice.	Reinforce messaging and practice of religious beliefs, values, and practices that support and perpetuate the practice of FGMC/C
Leaders of Youth groups and associations (male and females)	Divided opinions could split youth front and undermine achievement of project objectives	Voices and views of current and potential affected population groups excluded in the policy and decision making and implementation on FGM/C abolition
FGM/C Practitioners	Could find justification to continue with the practice	Could sabotage efforts at eliminating the practice
FGM/C Survivors or Victims	Re-traumatization through experience recalls	Left in Isolation, dejection, unsupported to deal with their trauma
<b>District/Prefecture/County and National Levels</b>		
Government Ministries, Departments and Agencies with responsibility for FGM/C Education and eradication	Abdication of responsibilities Plan and its partners Corruption risk in resource management	Undermine initiatives actively or passively Renege on commitments with excuse of usurpation or interruption by Plan and partners
Political leaders	Could hijack initiatives for their political ends Can be disruptive and diversionary	Undermine with counter messages that galvanize local opposition to anti-FGM/C initiatives, especially it helps them mobilize a political base for electoral gains.
Educational Sector Actors: School, Teachers, Students, and children	<ul style="list-style-type: none"> <li>Potential clash between overzealous administrators and teachers with community members opposing the bans.</li> <li>could put school children under undue pressure to accept or oppose FGM/C against their will</li> </ul>	Opportunity for FGM/C related health and hygiene opportunities lost.
Women Leaders e.g., County First Ladies in Kenya)	Could hijack initiatives for their political ends Can be disruptive and diversionary	Missed opportunity to have role models champion change
NGO, L/CBO and CSO <sup>28</sup>	Aggressive engagement strategies alienate other actors; Usurpation of funding and other obligations of the state	Promote parallel and duplicative interventions that can create confusion.
Local Celebrities	Influence may be limited only to followers or those able to access their spaces e.g., social media. Can be controversial and attract backlash	Could promote alternate messaging that undermines project outcomes.

<sup>28</sup> In Kenya the list of such L/CBOs include: Msichana Empowerment, Zamara Foundation, Maendeleo ya Wanawake, Enlighten Generation CBO in Tharaka Nithi, Zamara Foundation, Plan International, Forum for Women Educationists (FAWE), Save the Children, Child Fund International, GOK \_Children services, Youth Anti FGM Network working in 22 counties, Anti FGM Board, Amref, The Girl Generation, Action Aid  
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Stakeholder	Potential Risks if	
	Involved	Not Involved
<b>Regional Bodies (Economic Community of West Africa (ECOWAS), East Africa Community (EAC), and African Union (AU) Levels</b>		
African Union (AU) Level	<ul style="list-style-type: none"> <li>• Re-igniting interests of member states to domesticate laws and programs that support national and subnational level mobilization of different stakeholders to end FGM/C</li> <li>• Opportunity to apply subtle pressure on Heads of States, through various Commissions and agencies) to domesticate laws and programs that facilitate abandonment of FGM/C may be missed.</li> <li>• Build networks of CSOs and other non-state actors to influence policies that prioritize subnational level engagements to end FGM/C</li> </ul>	<ul style="list-style-type: none"> <li>• Lost opportunities for building consensus on continental commitment, policies, and programs that guide member states to end FGM/C</li> <li>• Make it easier for reluctant member states to dig deeper in their unwillingness to take actions to end FGM/C</li> <li>• Make sharing of lessons and resources across regions and countries harder to achieve</li> </ul>
Regional Bodies (Economic Community of West Africa (ECOWAS), and East Africa Community (EAC)	Leverage opportunities to advocate for greater attention to subnational level engagements that empower communities to champion change for good in FGM/C practices	Missed opportunities to encourage reluctant member states to actively promote the abandonment of FGM/C through mobilization of CSOs and other actors.

## ***Appendix 10: Guiding questions of Feasibility Assessment using OECD Criteria***

### **1. Relevance**

- To what extent are the objectives and anticipated outcomes of the project valid in the light of national development priorities and Plan International priorities?
- To what extent does the proposed project intervention meet the demands and needs of the target population and other concerned stakeholders? Are the orientation, prioritization, and objectives (approach) of the planned project aligned with the target groups and clearly defined?
- Are the underlying assumptions of change likely to hold true in light of the root causes and conditions on all three levels of the proposed intervention?
- Are the measures suggested adequate to address the problems and causes identified?
- Is the approach of working on the proposed three levels of the intervention likely to materialize in the anticipated “leveraging effect”?
- To what extent is institutional support for the project likely and/or necessary, especially when it comes to national law enforcement agencies and key high-level stakeholders?
- To what extent do the intervention goals and design adequately take into account the specific needs of the target groups and stakeholders and structural obstacles in the project region at each level?
- To what extent does the planned intervention address and fill key macro level capacity needs/gaps identified as hampering progress towards eradicating FGM/C?

### **1. Coherence & Coordination**

- To which extent is the project compatible with other interventions in the areas/ countries/ sectors?
- To what extent does the intervention support or undermine other interventions in the areas/ countries/ sectors? To what extent are there synergies and connections between the planned project and other interventions by the same actor (organization) and other actors, specifically regarding advocacy activities on the macro level?
- How coherent are the planned activities with human rights principles (inclusion, participation), conventions and relevant standards/guidelines?

### **1. Effectiveness**

- To what extent are the objectives likely to be achieved given the different country context conditions within the suggested timeline?
- What are the major preconditions influencing the achievement or non-achievement of the objectives (among others level of engagement of different target groups)?
- Are the cause-effect relationships (including assumptions) plausible? Which negative effects could occur?
- Is the chosen methodological approach appropriate to the different contexts, specifically regarding the approach proposed for the regional/national level, and sufficient to achieve the project objective? Are alternatives necessary?
- At which level (multi-level approach) are additional measures needed to increase effectiveness?

### **1. Efficiency**

- Can the project goals be achieved with the available resources?
- Are the investments justified compared to the targeted effects, especially regarding the proposed activities on the regional/national level?
- Which possible alternative and more economic ways are there for achieving the same objectives?

### **1. Impact**

- Which are likely significant positive and negative, intended, or unintended, societal-level (such as social, political, socio-economic) effects?
- Which changes in attitudes and/or behaviours can be expected within the proposed project duration?
- Which are potential personal and/or institutional changes resulting from the capacity development measures?
- How many people are likely to be directly and indirectly affected?
- To what extent is the planned project structure-building, model-like and scalable? On which levels will norms or structures be changed?
- To what extent is the project likely to contribute towards systemic level change? What factors need to be taken into consideration to increase this likelihood?

## 1. Sustainability

- How can technical, financial, and social sustainability be assured after the funding period?
  - Linked to technical sustainability: How can the activities be designed to enable the target groups to continuously capitalize on the project and to continue it after its end? How can established learning and exchange platforms be designed to continue after the end of the project?
  - Linked to financial sustainability: How can the project be designed to be economically self-sustaining after the end of the intervention?
  - Linked to social sustainability: Are the desired social changes in attitude and behaviour likely to uphold after the end of the project? Which additional measures would increase the chance for a lasting change on the societal level?