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The Role of Religious and Traditional Leaders in Female Genital Mutilation/Cutting Prevention

An Analysis of two Kenyan NGOs

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ABSTRACT

Female genital mutilation/cutting (FGM/C) is common in many countries worldwide. This harmful practice violates women's and girls' rights and perpetuates discriminatory social norms. Interventions aimed at its abandonment are numerous, ranging from criminalisation, and other legal measures to education, awareness-raising, and other initiatives aimed at changing the social norms and traditions that sustain the practice.

Kenya is one of the most advanced African countries in terms of prevention activities and the country has witnessed a decrease in the practice in the last few years. Yet, despite the complete criminalisation of the practice and the prohibition of medicalisation, FGM/C is still ongoing in numerous communities, pointing to the need for other approaches to ensure long-term abandonment of the practice.

This study focuses on the role of religious and traditional leaders in FGM/C prevention, arguing that they can play an important role in NGO interventions aimed at changing social norms and traditions around FGM/C. Chapters 2 and 3 introduce the practice of FGM/C and present an overview of FGM/C prevention efforts. Chapter 4 zooms in on the role of religious and traditional leaders in FGM/C prevention efforts, outlining common rationales for cooperation and types of engagement. Building on this analysis, the last chapter presents an empirical analysis of two Kenyan NGOs (Amref and Men End FGM) and their cooperation with religious and traditional leaders. The conclusion sums up the analysis and raises new perspectives on the topic.

Keywords: female genital mutilation/cutting, prevention, religious leader, traditional leader, Kenya, NGOs, health risks approach, gender equality approach, theological approach

LIST OF ABBREVIATIONS

ARP	Alternative Rites of Passage
AU	African Union
AUC	African Union Commission
CEDAW	Committee on the Elimination of all forms of violence Against Women
CRC	Convention on the Rights of the Child
DHS	Demographic and Health Survey
EAC	East African Community
EU	European Union
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation/Cutting
GBV	Gender-based Violence
IAC	Inter-African Committee
IO	International Organisation
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
KNBS	Kenyan National Bureau of Statistics
MYWO	Maendeleo Ya Wanawake
NGO	Non-Governmental Organisation
RECs	Regional Economic Communities
SDGs	Sustainable Development Goals
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
VAW	Violence Against Women
WHO	World Health Organisation

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1. INTRODUCTION

“Culture [is] a coherent self-contained system of values and symbols that a specific cultural group reproduces over time, which provides individuals with the required signposts and meanings for behaviour and social relationships in their everyday life” (Wadesango et al., 2010: 121).

As reflected by the above-mentioned statement, culture is an important source of identity and belonging (Wadesango et al., 2010: 121). Unfortunately, some of the practices resulting from culture are harmful to the people involved. Practices such as breast ironing, child marriage, marriage by abduction, virginity testing or female genital mutilation/cutting (in the following FGM/C) are some examples of what is commonly referred to as “harmful practices”. These practices often discriminate against women, placing them in a “submissive role” with an inferior status (Wadesango et al., 2010: 128) and controlling their sexuality (Wadesango et al., 2010: 126), making it difficult to reach full gender equality in the practising communities. In addition, harmful practices often have serious physical and mental complications (Klein et al., 2018: 4), making them a form of violence against women (VAW). In the case of FGM/C, some girls die from infections; others suffer their whole life from long-term complications (Klein et al., 2018:4). As such, FGM/C and other harmful practices can be said to constitute a violation of women’s and girls’ rights in various ways.

Today, FGM/C is practised in different parts of the world. An estimated 4.32 million girls are at risk of being subjected to FGM/C in 2023 alone (United Nations, 2023). International organisations, governments, NGOs, activists, and others engage in a wide variety of activities aimed at preventing and eventually eradicating the practice. As a human rights violation, there is broad consensus on the need for legal measures banning FGM/C. However, as the practice is deeply rooted in social norms and traditions, criminalisation is rarely enough, and there is a need for long-term efforts addressing the norms and traditions that contribute to sustaining, legitimising, and encouraging the practice.

In this, cooperation with religious and traditional leaders can play an important role. Reflecting broader interest in religion and religious actors in the fields of development and human rights more generally, recent years have witnessed increasing attention to religious and traditional leaders in FGM/C prevention efforts. In Africa, religious and traditional leaders are often important figures in the local community; and they enjoy a high degree of trust, respect,

and legitimacy. As normative authorities, they are considered the custodians of their community's traditions and culture (Mkuwa et al., 2023: 6; Oloo et al., 2011). As such, they can contribute to *sustaining* the practice of FGM/C – but they can also contribute to *abandoning* it, pointing to alternative interpretations of culture and tradition. Therefore, working with religious and traditional leaders is essential to the long-term abandonment of FGM/C.

1.1. RESEARCH QUESTION

The overall objective of this thesis is to explore NGO engagement with religious and traditional leaders in their efforts to prevent FGM/C as a human rights violation. Based on desk studies as well as case studies of two Kenyan NGOs, this thesis seeks to answer the following research questions:

- *What are common rationales for engagement with religious and traditional leaders among FGM/C prevention actors?*
- *What are their approaches?*
- *What kinds of activities do they engage in?*

1.2. STATE OF RESEARCH

The thesis draws on academic research as well as so-called “grey literature” in the form of reports and analyses from NGOs, international organisations, and other practitioners in the field. While the literature will be discussed in more detail in the different chapters of the thesis, the following provides a brief overview.

FGM/C is widely discussed in the literature, with different disciplines focusing on different aspects of the practice. Medical scholars discuss the issue in terms of the health complications and mental consequences of the practice but also focus on the health risks approach and training of healthcare providers such as nurses and midwives (Kimani et al., 2018, 2020; Klein et al., 2018). Anthropologists explore the cultural traditions and origins of the practice, as well as its causes and justifications (e.g. Gerry Mackie, 2000; and Bettina Shell-Duncan, 2000). Debates on terminology are also common, as shall be discussed in Chapter 2. Within the field of human rights research, there is also increasing attention to the topic, especially after the Vienna Conference on Human Rights in 1993 where FGM/C was recognised

as a form of violence against women (Al-Nagar et al., 2017: 5; Shell-Duncan & Hernlund, 2000: 227). There is also a plethora of grey literature on FGM/C, produced by actors working on the matter, including international organisations such as UNFPA, UNICEF, and the World Bank; international NGOs like Care, PATH, Tearfund, or MYWO; as well as government and national offices such as the Kenyan Anti-FGM Board or the Kenyan Demographic Health Survey.

Literature on cooperation with religious and traditional leaders has been growing in recent decades, reflecting broader attention to religion in the fields of development and human rights. Much of this research focuses on the role of religious and traditional leaders in the context of HIV and AIDS interventions (Orubuloye et al., 1993; Murungi et al., 2022; Rafiq et al., 2022). Research focusing specifically on the role of these actors in FGM/C prevention efforts is (still) scarce, with the work of e.g. Mkuwa et al. (2023), Shell-Duncan et al. (2018), and Tolo Østebø & Østebø (2014) as important exceptions. The latter is one of the rare pieces of academic literature that explores the challenges of working with religious and traditional leaders. Within the field of grey literature, the topic is more common, and various international organisations and NGOs discuss the role of religious and traditional leaders in reports, project evaluations, or other studies. Worth mentioning here are Le Roux and Bartelink (2017), Matanda et al. (2021), and the World Health Organisation (WHO) (1999).

In general, however, the role of religious and traditional leaders remains relatively understudied in research on FGM/C prevention efforts, whether academic or grey literature, and there is a need for empirical studies that provide more detailed descriptions and analysis of this type of intervention. The present thesis seeks to contribute, albeit in a small way, to filling this gap.

1.3. METHODOLOGY

This study's analysis of the role of religious and traditional leaders in FGM/C prevention efforts in Kenya is based on a combination of desk studies and qualitative interviews. Chapters 2, 3, and 4 are based on desk studies. Existing literature on the topic, including academic articles and books (primarily from social sciences and anthropology, but also medical research) as well as reports, evaluations, and other forms of grey literature have been collected and analysed. In addition, the desk study includes collection and analysis of relevant resolutions, policies, and statements on FGM/C prevention. All this forms the basis for this study's overall analysis of FGM/C prevention efforts and the role of religious and traditional leaders in this.

Chapter 5 presents a case study of two Kenyan NGOs, providing illustrative examples of how engagement with religious and traditional leaders can look like in practice. The study is based on qualitative online interviews with representatives from the two NGOs, namely Denge Lugayo, programme manager for gender-based violence and child protection at Amref, and Tony Mwebia, founder and executive director of Men End FGM. Denge Lugayo was interviewed once, while Tony Mwebia was interviewed twice.¹ Each interview lasted approximately one hour. All interviews were conducted via Teams.² The interviews were semi-structured, loosely following an interview guide with 12 questions. The second interview with Tony Mwebia was also following an interview guide but with 7 more specific questions (both interview guides are attached as an appendix to the thesis). The interviews were transcribed, but as requested by the interviewees, the transcripts remain for personal use only. Information from the interviews was supplemented by information from the two organisations' respective websites (<https://amref.org/kenya/> and <https://menendfgm.org/>), and Tony Mwebia's website (<https://tonymwebia.co.ke/>).

Importantly, the case study does not provide a comprehensive analysis of NGO engagement with religious and traditional leaders in Kenya as such; this would have required an extensive mapping of all actors in the field of FGM/C prevention. Furthermore, with this thesis, I do not pretend to provide an in-depth ethnographic analysis of the two NGOs' engagement with religious and traditional leaders; something which would have required long-term fieldwork and on-site observations. Instead, and more modestly, I present how these two organisations understand the role of religious and traditional leaders and how they engage and implement their activities with them. I describe and analyse this engagement based on the two NGOs' own narratives, as presented in my interviews and on their websites. I do not evaluate if their cooperation with those leaders works because I did not have access to any materials allowing me to do so, such as evaluations or reports.

The choice to focus on Kenya in this study has been made for two reasons. First, Kenya criminalised the practice and implemented numerous legal measures and policies to ban FGM/C, but the practice is still very present despite a strong decrease in the recent years. This allows to support our hypothesis that the criminalisation of the practice is not enough to eradicate FGM/C and implementing other approaches in combination is needed. Secondly, there

¹ The interview with Denge Lugayo is referred to as (Lugayo, 2023). The interviews with Tony Mwebia are referred to as (Mwebia, 2023a), and the second one as (Mwebia, 2023b).

² The interview with Denge Lugayo was conducted on the 3rd of May 2023. The interviews with Tony Mwebia were conducted respectively on the 4th of May and the 28th of June 2023.

is a large availability of resources discussing FGM/C in Kenya and numerous anti-FGM/C actors working there.

Regarding the choice of the organisations, an analysis of the organisations working in Kenya and cooperating with religious and traditional leaders has been made. I contacted some of them, and both Amref and Men End FGM replied and agreed to do interviews.

1.4. TERMINOLOGY

Before starting this analysis, a few words on the use of the term female genital mutilation/cutting and other key terms of this thesis.

The term *female genital mutilation/cutting* is used to refer to “all procedures involving the removal of the external female genitalia or other injuries to the female genital organs for non-medical reasons” (EndFGM European Network, n. d.), without distinction between the various types of cut.

Historically, the ritual practice of cutting or removing external female genitalia was commonly referred to as “female circumcision”. However, critics of the term argued that the term was inappropriate and should be abolished insofar as it implied a similarity with male circumcision even though the two practices are very different, with female “circumcision” having far more serious effects on girls’ and women’s physical and psychological health than male circumcision (UNFPA, 2022).³ Since the 1980s, then, the term “female genital mutilation” (FGM) gained ground, with proponents of this term arguing that it more adequately reflects the gravity of the practice. As noted in the 2008 UN Interagency Statement on Eliminating FGM: “[The] use of the word “mutilation” reinforces the fact that the practice is a violation of girls’ and women’s rights, and thereby helps to promote national and international advocacy for its abandonment” (WHO, 2008: 22).

The term “mutilation” has, however, also been criticised by various actors. Some argue that it unnecessarily stigmatises women that have undergone the practice (Shell-Duncan, 2017: 6), and that it is very judgmental towards the families that cut their daughters, not because they intend to mutilate them, but to ensure their well-being (Tostan, n. d.). Related to this, the term is also accused of reflecting an overly Western perspective, not taking sufficiently into account the cultural aspects of the practice (Van Bavel, 2023: 380). Indeed, it seems that using the term

³ There are also important differences between the two practices with regard to HIV transmission; while male circumcision supposedly reduces the risk of HIV transmission, FGM/C increases the risk (UNFPA, 2022).

female genital cutting prompts less opposition from communities, and allows intervening actors to engage with them (Tostan, s.d.; le Roux & Bartelink, 2017: 12). Against this background, the present master's thesis employs the term female genital mutilation/cutting (FGM/C), seeking to simultaneously acknowledge the serious harm that this practice undoubtedly causes as well as the good intentions that may sometimes lie behind the practice. This term is also commonly used among a wide range of actors engaged in prevention efforts.

The term *religious leader* is understood to include imams, pastors, priests, sheikhs, and other religious authorities. Religious leaders are individuals who are “recognised by their faith community [...] playing authoritative and influential leadership roles within faith institutions to guide, inspire or lead others (of faith)” (Le Roux & Bartelink, 2017: 2). While this can obviously also include women, in practice most local religious leaders are male.

The term *traditional leader* is used in this paper to denote a wide range of different actors, including cultural leaders/rulers, ethnic leaders, a council of elders, traditional chiefs, and community elders who possess a certain form of leadership, understood as someone commanding authority or influence within a group (Masango 2003: 313). These individuals occupy “communal political leadership positions sanctified by cultural mores and values, and [enjoy] the legitimacy of particular communities to direct their affairs” (Adewumi and Egwurube (1985) quoted in Keulder, 2010: 152).

The term *FGM/C prevention actor* is used to denote the various actors that engage in FGM/C prevention efforts, including international organisations, governmental bodies, international NGOs, national NGOs, and other civil society actors.

1.5. OUTLINE OF THE RESEARCH

This study is divided into four main chapters.

Chapter 2 introduces the practice of FGM/C. The purpose of this chapter is to present the multiplicity of ways FGM/C is practised and the complexities surrounding the practice, allowing us to understand the difficulty of prevention work against it.

Chapter 3 provides an overview of FGM/C prevention efforts, outlining their historical trajectories and identifying different conceptualisations and approaches in the field of contemporary FGM/C prevention. A key argument here is that criminalisation efforts are rarely

sufficient and that prevention efforts need to focus on changing underlying norms and traditions.

Chapter 4 then zooms in on cooperation with religious and traditional leaders as a key element in interventions aimed at changing norms and traditions. The chapter identifies common rationales for engaging with religious and traditional leaders and presents a basic typology of approaches to this engagement.

Against this background, Chapter 5 presents a case study of NGO cooperation with religious and traditional leaders on FGM/C prevention in Kenya. After a brief description of the Kenyan context with regard to FGM/C, the chapter analyses the ways in which two Kenyan NGOs engage with religious and traditional leaders, discussing their rationales, approaches and activities.

Finally, Chapter 6 summarises and concludes on the foregoing analysis, ending with a discussion of some of the possible challenges that cooperation with religious and traditional leaders may raise, in relation to FGM/C prevention as well as human rights interventions more broadly.

2. FGM/C: A BRIEF INTRODUCTION

Today, FGM/C is practised in various parts of the world, including Africa, Asia and the Middle East as well as among diaspora groups in Europe and North America. The specific procedures involved vary across different religious, cultural and ethnic communities.

This chapter gives a brief introduction to FGM/C. It first gives an overview of the occurrence and prevalence of FGM/C practices, with a particular focus on Africa. Then, the practice is explained with a presentation of the four types of cuts. Finally, the chapter discusses some of the harmful consequences and the underlying rationales for the practice. As this practice is complex and varies widely according to numerous criteria, this overview of the situation is essential to better understand the difficulty in abandoning the practice despite a growing criminalisation, and the complexity and variety of anti-FGM/C interventions, presented in the following chapters.

2.1. FGM/C OCCURRENCE AND PREVALENCE

According to estimates, about 200 million girls and women worldwide have been subjected to FGM/C (WHO, n. d.).⁴ It is mainly practised in Africa, but also in Asia (especially Indonesia), Latin America and the Middle East (WHO, n. d.). The United Nations Population Fund (UNFPA) states that “it is also practised among migrant population throughout Europe, North America, Australia and New Zealand” (2022). In Africa, the practice is more common in the Western, Eastern and North Eastern regions of the continent, with reported cases in 33 countries (UNFPA, 2022). The map below shows the prevalence of the practice in those countries (cf. Figure 1).

FGM/C is mainly practised on young girls, before and during adolescence, than on adult women (WHO, n. d.). According to USAID’s Demographic and Health Survey Programme (DHS), “girls are being circumcised at younger ages [than before]” (Yoder et al., 2004: 53). One reason for this development may be that parents want to make sure that their daughters are cut before they become sexually active (Oloo et al., 2011: 17). Others note that younger girls

⁴ Studies mostly measure the evolution of cases of FGM/C by looking at the percentage of girls between 15 and 19 years old that have undergone the practice (UNFPA, 2015: 27). This is because younger girls may not have been cut yet; thus, including them would result in a seemingly decreasing trend in FGM/C while, in reality, it may not be the case (UNFPA, 2015: 27).

are believed to heal faster from the cut (Shell-Duncan et al., 2017: 20). And some speculate that the age decline may have something to do with the criminalisation of FGM/C and the need to hide the practice from authorities: younger girls may be easier to control, meaning that the cutting can be performed more discretely (Njue & Askew, 2004; Shell-Duncan et al., 2017: 20).

According to the NGO Population Reference Bureau, “FGM/C is practised at all educational levels and in all social classes and occurs among many religious groups (Muslims, Christians, and animists), although no religion mandates it” (Population Reference Bureau, 2010: 2). It is also more commonly practised in rural areas than in urban areas (UNFPA, 2015: 20) possibly due to easier access to education while living in an urban area. Thus, with an education, women are more likely to become economically independent and depend less on marriage and their partner (El-Dirani et al., 2022: 175). However, ethnicity remains the main factor in the distribution of the practice (UNFPA, 2022).

Since the 1980s, the prevalence of FGM/C has been slowly decreasing globally, reflecting increasing international, regional and national efforts to eradicate the practice. In Africa, 16 out of 23 countries analysed have witnessed a decline in the practice (UNFPA, 2015). Nonetheless, not all countries showed a decline, and the “pace of decline has been uneven” (UNICEF, 2016). For example, Guinea and Mali showed an increase in the prevalence of FGM/C (UNFPA, 2015: 30). Furthermore, the practice of FGM/C also grows due to global population growth. In 2019, the number of girls cut has been estimated to grow by 0.5 million in less than 15 years and to reach 4.6 million girls cut by 2030 (UNFPA, 2022). Additionally, the pandemic of COVID-19 exacerbated girls’ and women’s vulnerability by deepening the existing gender gap and strengthening economic disparities (UNFPA, 2022). Prevention programmes were interrupted which reduced by 33% the number of girls and women protected from having to undergo the procedure (UNFPA, 2022).

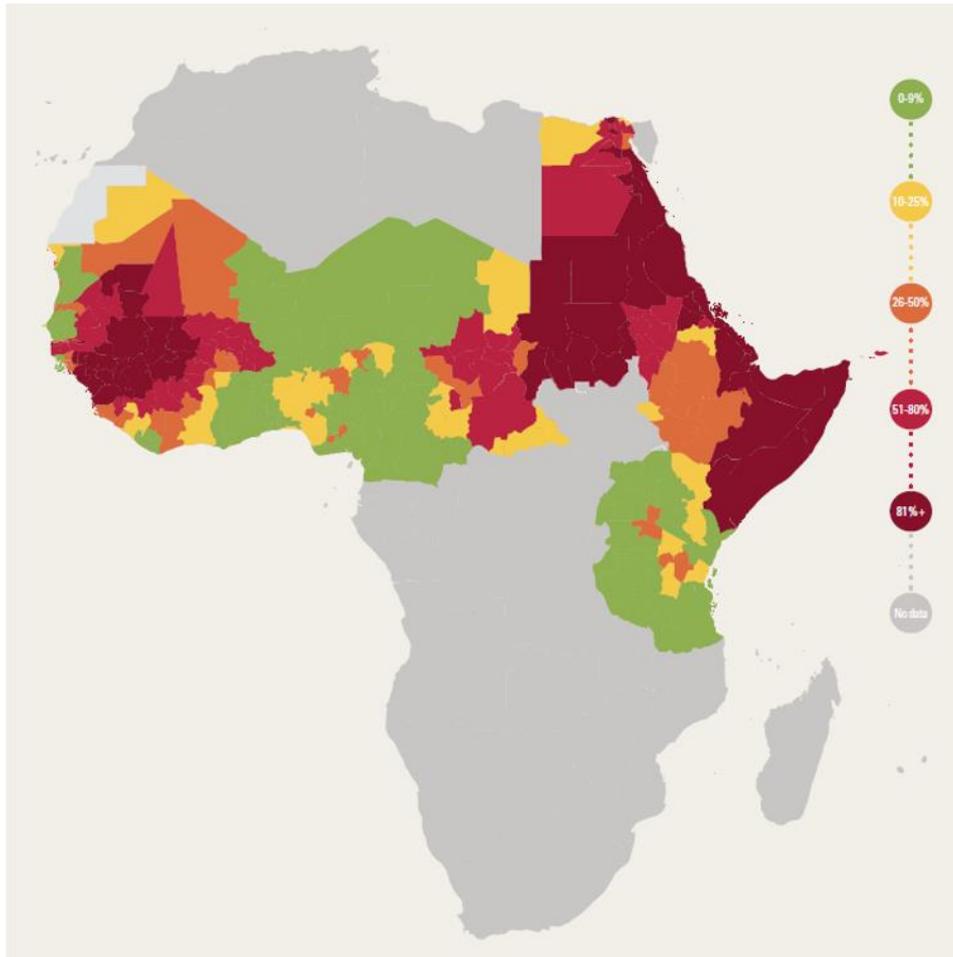


Figure 1. Towards ending Harmful Practices in Africa, A Statistical overview of child marriage and female genital mutilation, UNICEF, 2022, New York: 6

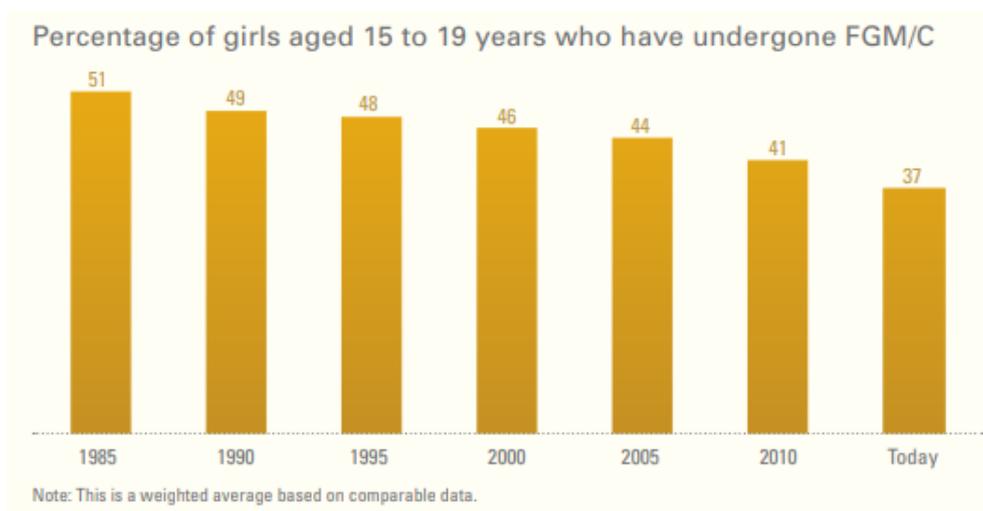


Figure 2. Source: Female Genital Mutilation/Cutting: a global concern, UNICEF, 2016

2.2. THE TYPES OF FGM/C

FGM/C is carried out in different ways in different geographic, ethnic, cultural, and religious communities. The various kinds are commonly classified into four different types, originally developed by the WHO in cooperation with UNICEF and UNFPA in 1997, but have since been further developed and refined (WHO, 1997).

The four overall types of FGM/C are:

- Type 1: “partial or total removal of the clitoral glans, and/or the prepuce/clitoral hood”. It is also known as clitoridectomy (EndFGM European Network, n. d.).
- Type 2: “The external part of the clitoris and labia minora are partially or totally removed, with or without excision of the labia majora” (EndFGM European Network, n. d.). This type is referred to as excision (EndFGM European Network, n. d.).
- Type 3: “The narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoral prepuce/clitoral hood and glans” (WHO, n. d.). It is also called infibulation or pharaonic type (EndFGM European Network, n. d.). Only a small opening remains for urine and menstrual blood to flow out (EndFGM European Network, n. d.).
- Type 4: “includes all other harmful procedures to the female genitalia for non-medical purposes” (WHO, n. d.). Practices such as pricking, scraping, incising, piercing and cauterizing the genital area are mentioned (WHO, n. d.).

According to the UNFPA (2022), types 1 and 2 are the most common, while type 3 is less widespread and mainly practised in three African countries: Djibouti, Northern Sudan and Somalia (UNFPA, 2022). It is sometimes misunderstood that type 4 is considered being FGM/C as it does not necessarily involve a cut (AFRUCA, 2016: 5).

Historically, FGM/C was carried out by elderly people in the community, typically women who were designated to perform this task, or by the community’s birth attendants. This knowledge is usually passed in the family, from mother to daughter or nieces, teaching them how to perform the cut (Fadare, 2022; UNFPA, 2021a). Traditional cutters can also be older men, but in both cases, they have no medical training (Olaniru, 2023: 1). The place where the cut is performed and the tools used (razors, blades, scissors or knives) are unsanitary (Olaniru, 2023: 1). In recent years, however, the practice of FGM/C has been increasingly medicalised, with healthcare professionals replacing traditional practitioners (Shell-Duncan et al., 2017;

UNFPA, 2022; Yoder et al., 2004). It is estimated that almost 35% of adolescent girls have been cut by a medical professional, which is double the number of older women (UNFPA, 2022).

2.3. THE HARMFUL CONSEQUENCES OF FGM/C

FGM/C often has harmful consequences for the person involved, both physically and psychologically. Physically, the procedure can not only cause immediate pain but will often also have long-term consequences, including e.g. “excessive bleeding, severe pain, damage to the surrounding tissue and chronic vaginal and pelvic infections, leading to infertility” (UN General Assembly, 2022). In addition, women having type 3 of FGM/C may suffer from urinary and menstrual problems, painful sexual intercourse (EndFGM European Network, n. d.) and a higher risk of newborn deaths (UN General Assembly, 2022). The most severe case of complications due to the FGM/C procedure may result in the death of the girl due to a haemorrhagic shock or an infection and septicaemia (EndFGM European Network, n. d.). Multiple factors may contribute to complications, including e.g. the severity of the mutilation, the health of the person that undergoes the procedure, the expertise and experience of the person carrying out the practice and finally, the hygiene conditions during the operations (UNFPA, 2022). As noted above, an increasing number of cuts are being carried out by health professionals, since this is believed to be safer. However, while the risks of HIV transmission might be lower than during the traditional rituals where the same razor may be used to cut many girls (UNFPA, 2022), the cut in itself is still dangerous and may generate complications. Moreover, FGM/C complications can also be psychological and may consist of post-traumatic stress, anxiety and depression (UN General Assembly, 2022). Most women who have undergone the practice mention the effect of the procedure on their emotional well-being and report mental health issues including depression or post-traumatic stress disorders (UNFPA, 2021: 87).

Yet, there are also risks for girls not undergoing FGM/C. These risks can also seriously impact a girl’s life. As discussed in the following part of this chapter, FGM/C is required for a proper marriage (Greene & Fahmy, 2023: 8; Mackie, 2000: 263). If a girl is not cut, she will not be able to find a spouse because she is considered unfaithful and unclean (Mackie, 2000: 258). There are also cases of harassment and stigmatisation by the community or by girls who are cut towards uncut girls (Bunei & Rono, 2018: 906; Mukabi et al., 2022: 1982; UNICEF,

2017: xvii). Parents love their daughters, and this is why they rather cut their girls rather than have them rejected and isolated by the community (Mackie, 2000: 280).

2.4. THE ROOT CAUSES AND JUSTIFICATIONS OF FGM/C

The origins of FGM/C are unclear. Some references to the practice have been found from the second century B.C.E. stating that communities on the western coast of the Red Sea were excising women (Mackie, 1996: 1003). A relation between infibulation (one of the four types of FGM/C) and slavery has been studied: in 1609, the missionary Dos Santos reported that Sudanic women were traded as slaves to Egypt and Arabia, and there are indications that infibulation was practised here to prevent them from getting pregnant (Mackie, 1996: 1003). Then, the reasons for FGM/C evolved. Possibly, less fortunate families started cutting their girls to increase their marriageability value (Mackie, 1996: 1004). This theory is only one among many others.

Nowadays, across different cultures and communities, FGM/C plays an important role as a ritual that marks a girl's initiation into womanhood (UNFPA, 2022). Various kinds of justifications are mobilised to explain the necessity of this ritual. While different communities or groups may invoke different justifications, or emphasise some over others, research points to a set of overall justifications that are commonly at play (UNFPA, 2022).

Patriarchal norms around sexuality play a major role in justifying FGM/C. In many communities, women's sexuality is seen as something that needs to be controlled; hence, FGM/C is performed to constrain women's insatiable sexual desire and prevent infidelity (UNFPA, 2022). It is believed that only "unfaithful women or indecent people" do not undergo FGM/C (Mackie, 2000: 254). FGM/C is also seen as a means to guarantee a girl's virginity before marriage, thus protecting her "purity" (UNFPA, 2022). Reflecting this understanding of women's sexuality as something that needs to be controlled and constrained, many cultures consider women's genitalia "dirty" and aesthetically "ugly", and therefore as something that needs to be cut or removed (UN General Assembly, 2022; UNFPA, 2022). The lips of the vagina and the clitoris are believed to be growing, possibly as big as the size of a penis (Kakal et al., 2022; UNFPA, 2022), and to prevent this from happening, the genitalia must be cut.

Socioeconomic factors are also at play. In many communities, FGM/C is required if a woman wants to get married (UN General Assembly, 2018: 6). As women are often dependent on their husband's resources, they have no economic stability, if they are unable to get married.

Therefore, most women undergo the practice due to economic necessity (UNFPA, 2022). As Gerry Mackie highlights, “an individual in an intra-marrying group that practices FGC cannot give it up unless enough other people do too” (2000: 254).

Many individuals and groups believe that FGM/C is a religious requirement. For example, around 80% of men and women in the Somali ethnic group in Kenya believe that “the practice should be maintained as it is required by religion and the community” (UNFPA & UNICEF, 2022: 16). However, there is no reference to FGM/C in the religious texts of neither Islam nor Christianity (UN General Assembly, 2022: 7; UNFPA, 2022). In recent years, numerous religious leaders engaged in the prevention of FGM/C have publicly denounced this harmful practice claiming that it has no foundation in religion (UNFPA, 2022). This is something that we will get back to in Chapter 4.

2.5. SUMMING UP

FGM/C is a harmful practice practised on girls and women all over the world, especially in Africa. It consists in cutting or removing a part or the totality of a female’s genitalia, narrowing the vaginal opening or any other non-medical procedure to a female’s genitalia. Girls can be cut at any stage of their life, but it is usually undergone when they are in their teenage years. FGM/C is often considered a mandatory step in becoming a woman or getting married. Other rationales are cleanliness, fidelity, reduction of sexual desire, beauty, or virginity. FGM/C can lead to health complications such as excessive bleeding, infections, or death, but also mental illnesses. FGM/C is also a serious human rights violation. This aspect is discussed in the following chapter. Nonetheless, the practice is still widely carried out because of social pressures and not undergoing FGM/C is often seen as worse than facing health complications from the cut.

3. PREVENTION OF FGM/C: TRAJECTORIES, ARGUMENTS AND APPROACHES

FGM/C is banned in an increasing number of countries, reflecting a growing consensus on this practice as a human rights violation. This chapter will briefly present a historical overview of global FGM/C prevention efforts, describing key shifts in conceptions of this practice and identifying some of the most important actors and initiatives in this development. Particular attention will be given to current understandings of FGM/C as a human rights violation. Against this background, the chapter then discusses the two main approaches to FGM/C eradication, namely criminalisation and change of socio-cultural norms and practices. As such, the chapter provides the overall framework for the following chapter's analysis of the role and relevance of religious and traditional actors in FGM/C prevention efforts.

3.1. TRAJECTORIES OF FGM/C PREVENTION

Missionary efforts at eradicating FGM/C

While FGM/C practice date back centuries, efforts at eradicating the practice are much more recent. From a historical perspective, criticism of FGM/C practices was first voiced by European missionaries and colonial powers in Africa at the beginning of the 20th century (Gele et al., 2013: 2). They tried to stop the practice by introducing laws and rules in the church criminalising FGM/C (Gele et al., 2013: 2). They considered the practice as being in opposition to the values and goals of the Christian church at that time which was to “save, educate, and civilise the [...] ‘uncivilized natives’” (Joshua, 2009: 5). FGM/C was, in other words, “incompatible with Christianity” and had to be stopped (Joshua, 2009: 5).

In their work to eradicate FGM/C, Christian missionaries typically emphasised the health risks of the practice, as witnessed e.g. in the work of the Anglican Christian Mission Society, the Church of Scotland Mission and the African Inland Mission, who all campaigned against FGM/C in Kenya in the 1920s (Caldwell et al., 2000: 239). The doctors from these missions stated very early on that the practice was “medically harmful” and adopted the term “sexual mutilation” in all their literature to stress the physical harm it causes (Anderson, 2018: 1520-1521). Their approach mainly consisted of exclusion from their services, e.g. refusing

girls who underwent the practice to church services, banning them from school, and excommunicating members allowing the practice on their daughters (Anderson, 2018: 1518-1519; Caldwell et al., 2000: 239).

These actions did not have the expected outcome. As was the case in Kenya for example, the colonial opposition to FGM/C engendered anger from the practising communities (Anderson, 2018: 1512; Gele et al., 2013: 2). In 1929, the Kikuyu communities organised against the Christian missionaries who excommunicated members of the church who practised or allowed FGM/C (Anderson, 2018: 1518-1519). This is famously referred to as the “female circumcision controversy” (Anderson, 2018: 1512). The Kikuyu’s resistance was a response to missionaries’ attempt at changing their culture; a change which was seen to be “forced down [their] throats” and imperialistic (Joshua, 2009: 3). In their fight to defend their culture, FGM/C became a symbol of resistance, contributing to further rooting the practice (Joshua, 2009: 7).

Approaching FGM/C as a health risk

A new wave of interest in the ban of the practice arose in the 1960s and 1970s (Gele et al., 2013: 2). Initially, these efforts to eradicate FGM/C focused primarily on the health risks of this practice for women and girls. African activists and healthcare providers highlighted the health consequences of the practice and “brought it to the attention of international organisations” (Althaus, 1997: 30). In 1964, the United Nations first “voice[d] [their] disapproval of female circumcision” (Hayford, 2005: 121) and denounced FGM/C as a violation of human dignity and the right to health (Boyle & Preves, 2000: 711). In the following years, anti-FGM/C activism started to grow, internationally, regionally and locally, involving not only the UN and other intergovernmental organisations, but also national development agencies, human rights activists, health professionals and others, building “an international movement to create and enforce universal norms defining alterations of the female genitals as fundamentally intolerable” (Shell-Duncan, 2008: 225).

Prompted among other things by African advocacy on the issue, in 1979 the WHO organised its first conference on FGM/C in Khartoum (Gele et al., 2013: 2; Hayford, 2005: 121). This conference highlighted the health and human rights consequences of FGM/C and recommended the abandonment of every form of FGM/C (Gele et al., 2013: 2).⁵ Multiple topics

⁵ The WHO conference was part of a series of conferences “honouring the UN Decade for Women”, from 1975 to 1985 (Shell-Duncan, 2008: 225). Additionally, regional meetings between UN agencies, governments and non-governmental organisations were held “to consider the status of women and to make recommendations for women” (Zinsser, 1990: 21).

surrounding the practice were discussed, including mental health consequences of the practice, and the lack of effectiveness of legislation criminalising the practice (WHO Regional Office for the Eastern Mediterranean, 1979). Some speakers made recommendations such as “general education, health education”, but also “for women’s organisations to take a leading role” in the prevention of FGM/C (WHO. Regional Office for the Eastern Mediterranean, 1979: 20).

In 1984, the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) was established, classifying FGM/C as a “harmful traditional practice” of grave health concern (IAC, n. d.; Shell-Duncan, 2008: 225). Similarly, in 1990, during the Ninth Session of the Committee on the Elimination of Discrimination against Women (CEDAW), General Recommendation No. 14 was adopted, recommending states to take measures against FGM/C to eradicate the practice (28 Too Many, 2019: 1). The recommendation focuses on FGM/C as a health risk, stating that “the practice of female circumcision [is] harmful to the health of women” (CEDAW, 1990: par. 1).

Reflecting this emphasis on the health aspects of FGM/C, interventions on the ground consisted mainly of education about the health risks and complications due to the practice at the community level (Shell-Duncan, 2008: 226). They expected that, by doing so, communities would abandon the practice due to the risks. Unfortunately, it did not have the desired effect. Communities continued the practice as, as mentioned in the first chapter, the risks of abandoning it were higher than maintaining it, due to its social and cultural importance (Shell-Duncan, 2008: 226).

Reframing FGM/C as a violation of human rights

Since the early 1990s, approaches to FGM/C started shifting from a narrow emphasis on health risks to a broader understanding of FGM/C as a violation of human rights (Shell-Duncan, 2008: 225). While reflecting the increasing popularity of the human rights discourse around that time, this shift is also, at least in part, the result of unexpected and unwanted consequences from a narrow health risk approach. By only mentioning the health complications resulting from the cut, people turned increasingly to healthcare providers to prevent those risks, picturing FGM/C as an issue that could be solved through medicalisation (Johansen et al., 2013: 3).

A defining moment for the conceptualisation of FGM/C as a human rights violation was the 1993 Vienna World Conference on Human Rights, during which FGM/C was classified as a form of violence against women, and as such was acknowledged as a human rights violation

(Shell-Duncan, 2008: 227). This was further emphasised in 1995, during the Fourth UN World Conference on Women in Beijing, which labelled FGM/C as violence against women, alongside rape, sexual assault, battering and forced prostitution (Hayford, 2005: 121). The Beijing Declaration and Platform of Action, adopted during this World Conference, encouraged governments to adopt and enforce legislation to punish perpetrators of FGM/C and other acts of violence against women (Beijing Declaration and Platform of Action, 1995: 52); largely as a result of pressure from African feminists (Al-Nagar et al., 2017: 5).

African states and NGOs played an important role in promoting an understanding of FGM/C as violence against women. The African Union's Protocol on the Rights of Women (the Maputo Protocol), adopted in 2003, requires State parties to legislate on the prohibition of all forms of FGM/C (28 Too Many, 2019: 2). It also specifically mentions the "prohibition [...] of all forms of female genital mutilation, scarification, medicalisation and para-medicalisation of female genital mutilation and all other practices" (African Union, 2003: 9).

Parallel to the increasing emphasis on gender discrimination and women's rights, FGM/C was also framed as a violation of children's rights, emphasising the fact that FGM/C is often performed on young girls under the age of 15 years. The complications are considered a violation of Article 3 of the Convention on the Rights of the Child (CRC), namely the best interest of the child, a central concept of this convention (UNFPA, 2014: 32-33).⁶ This is strongly emphasised in African human rights frameworks. With the adoption of the African Charter on the Rights and Welfare of the Child back in 1990, the African Union called on Members States to eliminate FGM/C (28 Too Many, 2019: 2), with Article 21 of the Charter stating that "harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child" must be eliminated (African Charter, Article 21).

The reframing of FGM/C as a violation of women's and children's rights did not mean that the health risk perspective disappeared entirely, but these concerns were increasingly framed in a rights language, emphasising various health-related rights. The practice of FGM/C is thus considered to violate the right to life, insofar as there is a risk that a girl dies during or after the procedure due to health complications such as infections (Abdi & Askew, 2009: 18); the right to the highest attainable standard of health due to the short and long-term harms caused to their psychological, physical and sexual and reproductive health (UNFPA, 2014: 30); the

⁶ However, as mentioned in the first chapter, mothers and family members who circumcise their daughters often also consider FGM/C to be in the best interest of the child. They want their daughter to be able to get married and thus access economic security, and not to be marginalised in their community (Mackie, 2000: 271; Shell-Duncan, 2008: 232).

right to physical and mental integrity and many human rights associated to it such as freedom from violence and the right to liberty and security of the person because of the harm done on women's sexual organs and all the lifelong lasting physical and psychological consequences of the practice which also affects their emotional development (UNFPA, 2014: 29).⁷

3.2. THE FIELD OF CONTEMPORARY FGM/C PREVENTION AND ERADICATION

Today, there is broad consensus among intergovernmental organisations, state actors, NGOs and activists on an understanding of FGM/C as a human rights violation. This is reflected in a wide range of international and regional human rights standards as well as “the introduction of laws against FGM/C in several African countries, in the development of national plans of action and national programs, in widespread information campaigns, and numerous community-based programs” (Diop & Askew, 2009: 307). The following presents a brief overview of some of the most important elements in the current global architecture of FGM/C prevention and eradication.

International human rights standards on FGM/C

While FGM/C is today interpreted to violate various international human rights, the practice is not mentioned explicitly in any of the core UN human rights conventions. However, as hinted at above, the issue has been tackled in various soft law instruments, including resolutions, general recommendations and otherwise, contributing to establishing international consensus on the understanding of FGM/C as a human rights violation and as such, as a practice that should be banned.

Key among these soft law instruments is Resolution 67/146, adopted by the UN General Assembly during its 67th session in 2012. The resolution calls for an “intensification of global efforts for the elimination of FGM/C” and urges states to ban and condemn FGM/C and all other forms of harmful practices that negatively impact women and girls (Population Reference

⁷ FGM/C is also considered to violate a range of other rights, including the right not to be subjected to torture or inhuman or degrading treatment or punishment (UNFPA, 2014: 30) and the rights of persons with disabilities, due to the health consequences that can result in disability, and the right of the child.

Bureau, 2013: 2). The resolution has been reaffirmed by similar resolutions in the following years.

In 2018, the Human Rights Council also adopted a resolution about FGM/C. This Resolution on the Elimination of Female Genital Mutilation, which was submitted by Burkina Faso on behalf of the group of African States, “calls upon all governments to take ‘comprehensive, multisectoral and rights-based measures to prevent and eliminate female genital mutilation’” (Equality Now, 2020). Importantly, this Resolution 38/6 calls for more cooperation between States and “relevant stakeholders – including *religious and traditional leaders*, community leaders, [and] health-care providers” (Human Rights Council, 2018: 3, emphasis added); something which we shall look at in much more detail in the following chapters.

Various UN committees have also formulated recommendations on the issue. As noted above, CEDAW presented its General Recommendation No. 14 back in 1990, urging States to eradicate FGM/C. In 2014, the Committees on the Rights of the Child and the Elimination of Discrimination against Women passed a Joint General Recommendation on Harmful Practices, reaffirming the need to “ensure full compliance to eliminate harmful practices” (28 Too Many, 2019: 1).

Regional human rights law on FGM/C

Regionally, the understanding of FGM/C as a form of gender-based violence (GBV) and a violation of human rights has been addressed in multiple legal instruments of the African Union, such as the African Charter and its Maputo Protocol as well as the African Charter on the Rights and Wellbeing of Children, both mentioned above.⁸ Strategic programmes such as the Maputo Plan of Action (2016-2030) for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights, the African Union Strategy for Gender Equality and Women’s Empowerment or the Addis Ababa Declaration on Population and Development (African Union, 2022a: 8).

At the sub-regional level, some States have also pushed further efforts to eradicate FGM/C. For example, to answer to the issue of cross-border FGM/C, the East African Legislative Assembly passed the East African Community Prohibition of Female Genital Mutilation Act (EAC Act) in 2016 (28 Too Many, 2019: 2). This Act ensures cooperation

⁸ These legal instruments have been respectively ratified by 54, 42 and 50 countries according to their status list published by the African Union (African Union, 1963, 2019, 2023a).

between the Member States to better prosecute FGM/C perpetrators by the sharing of information and data, and to harmonise laws, policies and strategies against FGM/C in the region (28 Too Many, 2019: 2).

At the national level, various states have introduced legislation on FGM/C; something which will be discussed in more detail below.

Strategies, policies, and programmes for implementation

In addition to these soft and hard law instruments, a wide range of other initiatives have been launched in recent decades, aimed at the elimination of FGM/C.

In 2008, UNICEF and UNFPA launched the “largest global programme” existing to work towards the elimination of FGM/C as a human rights violation; the Joint Programme on the Elimination of Female Genital Mutilation. The fourth phase of the Joint Programme was launched in 2022 with the objective to accelerate and intensify the efforts towards the elimination of FGM/C by 2030, by “developing, funding and implementing policies and programs” (Population Reference Bureau, 2013: 2).

The Spotlight Initiative, launched in 2017 by a variety of UN actors in cooperation with the European Union (EU), is the “world’s largest targeted effort to end all forms of violence against women and girls” (Spotlight Initiative, n.d.).⁹ Its work towards the end of FGM/C is based on four main strategies: the reinforcement of laws criminalising the practice, the reconversion of ex-circumcisers, the support of survivors and accompanying them in their advocacy and cooperating with religious and community leaders (Spotlight Initiative, 2022).

FGM/C is also included in the 2030 Sustainable Development Agenda launched in 2015. The elimination of harmful practices such as FGM/C is included in Sustainable Development Goal (SDG) number 5.3 (Gender Equality) (United Nations, 2015: 20). This reiterates the importance of the UN and Member States’ interest in ending the practice. However, this goal for 2030 seems ambitious. The SDGs Report of 2022 indicates that progress needs to be “10 times faster” than it is currently to reach this goal (United Nations, 2022: 36).

At a regional level, the African Union has addressed the issue through various strategies and policies, including the Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights (2016-2030) and the Strategy for

⁹ This initiative focuses on violence against women and girls with particular attention to sexual and gender-based violence, human trafficking, domestic and family violence, labour exploitation and harmful practices (Spotlight Initiative, n. d.).

Gender Equality and Women's Empowerment (African Union, n. d.: 8). Finally, Agenda 2063 from 2013 clearly states the organisation's aspiration to eliminate FGM/C and all forms of GBV (African Union, n. d., aspiration number 6: 5).

In 2019, the African Union launched its Initiative on Eliminating Female Genital Mutilation during the 32nd Session of the African Union Heads of State and Government Summit (African Union, 2022a: 5). This initiative, also called the Saleema Initiative, aims at serving as a “platform for the African Union Commission (AUC), Regional Economic Communities (RECs), regional and national civil society organisations, community groups and our committed partners to galvanise continental political action” (African Union, 2022a: 3). Saleema has been operated in Sudan in 2008 and its activities include community dialogue, public statements, and other activities such as girls club or the Saleema Colours Campaign (Evans et al., 2019: 3).¹⁰ Their general goal is to change the social norm surrounding FGM/C to ensure the long-term abandonment of the practice (Evans et al., 2019: 2). They work on increasing the “social acceptance of uncut girls” (Evans et al., 2019: 2). This Initiative will operate in other African Union Member States by 2030 (African Union, 2022a: 11).

In addition to these global and regional efforts, the field of FGM/C prevention and eradication involves a plethora of other actors and initiatives at international, regional, national, and local levels. CARE, Action Aid, World Vision Kenya and Rural Women's Peace Link (RWPL) are some of the NGOs advocating for the abandonment of FGM/C (UNFPA-UNICEF, 2013: 8).

3.3. APPROACHES TO FGM/C PREVENTION AND ERADICATION

Within the field of FGM/C prevention and eradication, although with a risk of simplification, two overall approaches can be identified; namely criminalisation and change of socio-cultural norms and practices. The following presents an overview of these two approaches, discussing some of their strengths and weaknesses.

¹⁰ This consists of wearing Saleema's colours to show support to the campaign (Evans et al., 2019: 3).

3.3.1. Criminalising FGM/C

Following the understanding of FGM/C as a human rights violation, a key aspect of FGM/C eradication efforts is the national-level criminalisation of the practice. By signing and ratifying the legal human rights instruments of the UN and the African Union, State parties have the responsibility to refrain from violating those rights, but also to protect and prevent their violation by other actors. To ensure their effective implementation at the national level, States have to enact national legislation and punish violations (Muthumbi et al., 2015: 33). Therefore, States parties need to domestically criminalise the practice of FGM/C and take all necessary measures to ensure that girls and women's rights are respected and protected (Muthumbi et al., 2015: 33).

African human rights instruments include clear provisions for the criminalisation of FGM/C, as outlined above. The emphasis on criminalisation is also evident in international soft law; Resolution A/RES/71/168, for instance, calls for States to “take all necessary measures, [...] including enacting and enforcing legislation, to prohibit female genital mutilation and to protect women and girls from this form of violence, and to hold perpetrators to account” (United Nations General Assembly, 2017: 4). Likewise, criminalisation of FGM/C is also a key aspect of most policies, strategies and implementation programmes on FGM/C. A central element in the UNICEF-UNFPA Joint Programme, for instance, is to support the development of “legal and policy frameworks banning female genital mutilation” (UNFPA, 2023). Similarly, the criminalisation of FGM/C is also a central part of the global Spotlight Initiative to eliminate violence against women and girls, as well of efforts within the framework of the Sustainable Development Goals.

The first country in Africa to introduce anti-FGM/C laws was Sudan in 1946 to prohibit the most severe form of FGM/C: infibulation (Al-Nagar et al., 2017: 6). Recent years have seen a steep increase in the number of African countries banning FGM/C. Today, 28 countries in Africa have specifically banned FGM/C by law or legal provisions (Equality Now, n. d.). Some researchers argue that the increase in anti-FGM/C legislation in Africa is mainly a result of international pressure (Tolo Østebø & Østebø, 2014: 8), pointing for e.g. to the influence of US legislation in 1996 that “linked foreign aid to anti-FGM policies” (Tolo Østebø & Østebø, 2014: 9). Others direct attention to the important role of the African Union in introducing regional legislation, as well African feminists, and women's rights advocates in pushing for legislative changes at the national level (Gruenbaum, 2005: 107).

Legislation on FGM/C takes different forms. Some countries have a broad ban on harmful practices which can include FGM/C, while others specifically mention FGM/C. FGM/C can be outlawed against children only or fully banned for every woman and girl (Muthumbi et al., 2015: 35). Penalties may also vary across different countries. Perpetrators can be condemned to imprisonment from a few months to years, the fines can be as cheap as 40\$ in Niger to as expensive as 4.000\$ in Benin, Togo and the Central African Republic (Muthumbi et al., 2015: 35). Some countries also have penalties for helping and abetting FGM/C, for death resulting from the practice (Muthumbi et al., 2015: 35). A few countries also prohibit the medicalisation of the practice and have penalties for it (Muthumbi et al., 2015: 35). Finally, Kenya is the only country having provisions for extraterritoriality (Muthumbi et al., 2015: 35).

The legislative approach has multiple benefits. Legislation can prevent future cases of FGM/C as people fear repercussions and punishment, but also by informing the communities that it is a criminal act and should not be perpetuated (Johansen et al., 2013: 6). It can support and encourage people that are ready to abandon this practice (Johansen et al., 2013: 8). In communities where members are questioning the practice or continue to perform it just by peer pressure and for social acceptance, legislation against FGM/C can help them stop (UNICEF, 2021: 32-33).

However, criminalisation can only be effective if the legislation is implemented and enforced, which requires political will (UNICEF, 2021: 32-33) as well as economic and human resources. Governments need to take active measures to ensure the enforcement of the law and make sure everyone is aware of the criminalisation of the practice and respects it (UNICEF, 2021: 33). Unfortunately, the lack of implementation and enforcement of the law is a real issue in many African countries. Even if 28 African countries have criminalised FGM/C, the practice is still widespread in most of those countries, suggesting a lack of will and resources to meet the required standards (Muthumbi et al., 2015: 34). According to Muthumbi and al., the implementation and enforcement of FGM/C laws have been “sporadic and rare” (2015: 36); States often lack resources for implementation and the regulation of the practice vary widely (Muthumbi et al., 2015: 35). According to a report of the organisation 28 Too Many: “Of the 22 countries with anti-FGM laws in place, only two – Kenya and Uganda – directly criminalise and punish FGM and fulfil all criteria considered essential by this study to encourage robust prevention and prosecution of FGM” (2018a: 31).

There are also additional challenges to legislation. For example, resulting from a lack of awareness in more rural communities, women often do not go to tribunals to seek justice

(Packer, 2002: 181). This can also be due to the lack of people speaking their language making their access to justice difficult (Packer, 2002: 181). And States often do not submit their report after ratifying international instruments, resulting in a lack of knowledge about the exact situation of human rights in each country (Packer, 2002: 208). Additionally, some people are also aware of the laws, but do not fear them and continue practising FGM/C (Kimani et al., 2018: 7). This can be a result of the lack of enforcement of the law and thus no punishment for the practice. Or it can also be for other reasons. According to a study on community perceptions of the Kenyan legal system, almost 30% of the men interviewed agreed that it would be acceptable to “break/disobey Kenya’s formal law if one knew that most of the people he/she knew best did not follow the law,” and around 40% of both men and women respondents agreed that it would be acceptable not to respect Kenya’s formal law if “one thinks the law was made without representing the interests of people like him/her” (Meroka-Mutua et al., 2020: 28). These results show that high numbers of people still believe that it is acceptable not to follow the law for various reasons. This can explain the lack of compliance with FGM/C laws, especially with a practice such as FGM/C which is still often considered as good for them.

Finally, the criminalisation of FGM/C has also had unintended consequences in terms of a change in how FGM/C is being carried out. As people fear the consequences of not following the law on the matter, there is evidence that the practice has increasingly gone underground and is done in secret (Johansen et al., 2013: 3; Packer, 2002: 170; UNICEF, 2021: 33). This increases the risks of death for girls with complications as they might now be scared to seek health-care (Johansen et al., 2013: 7; Packer, 2002: 170). But girls are also cut younger or less severely (Matanda et al., 2021: 33). Finally, an increase in cross-border FGM/C has also been observed. People go to another country to perform the cut, where the practice is not illegal or where the laws are not implemented (UN General Assembly, 2022: 14). To prevent this, a few countries legislated on the issue (UN General Assembly, 2022: 14).

3.3.2. Changing the Culture of FGM/C

As can be inferred from the analysis above, a legal approach is insufficient in eradicating the practice of FGM/C, and there is broad consensus among practitioners and academics on the need for a multipronged approach, including also interventions that can address those socio-cultural norms and practices that sustain and legitimise FGM/C to change “attitudes, values and behaviours towards FGM/C” (Mahgoub et al., 2019: 406). As noted in the African Union Commission report (2022), the African Union emphasises the importance to address those

underpinning social norms of FGM/C and other harmful practices at “individual, interpersonal, community, and institutional levels to bring about the needed change for women and girls” (African Union, 2022b: 5).

Initiatives to change socio-cultural norms and practices take a variety of different forms, including education and training, advocacy campaigns, development of alternative rites of passage, programmes to train ex-circumcisers, community dialogues, public statements, and others. For instance, the UNFPA-UNICEF Joint Programme also engages in gender-equality and human rights-based approaches (UNFPA & UNICEF, 2022: 21). They focus on educating and sensitising on FGM/C and mobilise communities to engage against it. Their non-legal activities include clubs for girls and adolescents, life skills programmes, peer education intervention, engagement with men and boys, digital media intervention and community-led dialogues (UNFPA & UNICEF, 2022: 22).

A key element in many of these approaches is a focus on norms and practices related to gender and sexuality. As a form of violence against women and girls, the practice of FGM/C is seen as closely intertwined with patriarchal and gender-discriminatory norms and practices. The practice “reflects deep-rooted inequality between the sexes” (UNFPA, 2014: 28) and is an “obstacle to gender equality” (Population Reference Bureau, 2013: 2), “nullif[y]ing women’s and girls’] enjoyment of fundamental rights” (UNFPA, 2014: 28). UNFPA also adds that “because it is aimed at controlling women’s sexuality, it incorporates a fundamental discriminatory belief in the subordinate role of women and girls in society” (UNFPA, 2014: 28).

The issue of health is also prominent in many initiatives aimed at changing socio-cultural norms and practices around FGM/C, as manifested e.g. in programmes for health practitioner’s training, health risks dialogues, sexual education, and so on. Through these initiatives, sensitisation on women’s ownership over their bodies can be mentioned as women’s equal rights to have a healthy and fulfilling sexuality. The Fulda-Mosocho project in Kenya had professors in school teaching children about topics related to women’s reproductive health, like menstruation, pregnancy and menopause, but included in a human rights approach to discuss these health-related issues “while examining historical inequities” (Innocenti Insights, 2010: 16). These initiative’s goal is to change attitudes to promote women and girl’s physical and mental well-being (Innocenti Insights, 2010: 38).

Some interventions focus on eradicating the concrete practice of FGM/C but preserving the cultural elements surrounding the practice, e.g. through the development of alternative rites of passage (ARP). ARP allows communities to maintain the ceremony and celebrate girls’

transition to womanhood, but to remove the harmful part of the ritual. This can prevent the practice from going underground by fear of legal sanctions, leaving only the cut and leading to the progressive disappearance of the culture celebrated in such ceremonies (Van Bavel, 2021: 6).

These interventions that challenge the underlying social norms of FGM/C can either empower women or address toxic masculinity. Girls' empowerment can be achieved through sexual education for example. Sexual education that only focuses on the risks associated with sexuality does not necessarily allow women to have a healthy and fulfilled sexuality. Women and girls need to be taught sexual rights and sexual well-being to understand the notion of "sexual self-determination" (Villani, 2023: 6). Regarding men, masculinity needs to be redefined from patriarchal masculinities that recognise the "power of men over women" to transformative masculinities that emphasises "equality, respect and dignity for people of all gender identities" (UN Women, n. d.: 15 & 18).

3.4. CRITICISMS OF FGM/C PREVENTION EFFORTS

While there is consensus among most human rights and development actors on the importance of eradicating the practice of FGM/C, the movement has also encountered criticism. Some claim that anti-FGM/C efforts violate their human rights, arguing that legislation is an "intrusion" (UNFPA, 2014: 33) into the rights of people to participate in their culture, the right of minorities and the right to religious freedom (UNFPA, 2014: 33). However, those rights are not considered absolute and it has been made clear by UN treaty monitoring bodies that "culture and religion cannot be invoked to justify the violation of the rights of women and girls" (UNFPA, 2014: 33).

Another common criticism levelled at FGM/C prevention efforts is that they are patronising and culturally insensitive. Claiming that FGM/C does not respect the best interests of the child is problematic, they argue, insofar as it implies that the parents of girls who undergo the practice do not want the best for them. As mentioned in the previous chapter, in many communities the risks involved in not being cut may outweigh the benefits, and parents may be concerned about their daughters being "different, being treated different, feeling different and being unmarriageable" (Caldwell et al., 2000: 252). In this perspective, the parents are in fact taking into account the best interests of their child by practising the cut (Shell-Duncan, 2008: 227-228). This supports the importance to include religious and traditional leaders in FGM/C

prevention efforts. Indeed, they can contribute to changing the social norms surrounding FGM/C and making it more socially acceptable for girls not to undergo the cut.

Finally, some argue that anti-FGM/C legislation is against religious norms and traditions. Not all African states are parties to legal instruments of the African Union that call for the criminalisation of FGM/C, like Sudan and Somalia for example, and some have given some reservations that exempt them from conforming to its obligation to criminalise FGM/C (28 Too Many, 2019: 3). Those States consider that some provisions of the Maputo Protocol are against the Sharia law (28 Too Many, 2019: 3). This criticism illustrates the need to include religious and traditional leaders in FGM/C prevention efforts. This approach is discussed in detail in the next chapter.

3.5. SUMMING UP

This chapter has presented a brief overview of the trajectory of FGM/C prevention efforts; from the early “civilizing” efforts of Christian missionaries over the 1960s and 1970s’ focus on health risks to today’s broad consensus on FGM/C as a harmful practice that violates women’s and girls’ human rights. The chapter has introduced some of the key international and regional actors and initiatives in the field of FGM/C prevention, identifying different approaches to the topic. Despite the multiplicity of efforts put in place to criminalise the practice, FGM/C is ongoing. A key argument here is that criminalisation efforts are rarely enough to eradicate the practice, or may bring it underground and that there is a need for interventions that address the underlying social norms and practices that sustain and legitimise FGM/C. Here, religious and traditional leaders can play an important role and are uniquely placed to re-interpret and communicate social norms and practices around FGM/C. This approach is analysed in the following chapter.

4. THE ROLE OF RELIGIOUS AND TRADITIONAL LEADERS IN FGM/C PREVENTION

As noted in the previous chapter, change in norms and practices is a key element in global FGM/C prevention efforts. International organisations, donors, and NGOs pay increasing attention to religious and traditional leaders as relevant actors to cooperate with on this matter. Based on a review of existing literature, this chapter explores the role of religious and traditional leaders in FGM/C prevention. The chapter first places the engagement with religious and traditional leaders in a broader context, briefly describing general trends towards increased attention to religion and culture in development and human rights interventions and providing concrete examples of how this trend is reflected in the field of FGM/C prevention. Against this background, the next part of the chapter identifies the key rationales and modes of engagement that characterise cooperation with religious and traditional leaders in this field. The last part of this chapter provides the basic framework for the next chapter, in which are analysed two concrete examples of NGOs' engagement with religious and traditional leaders in Kenya.

4.1. RELIGION AND CULTURE IN DEVELOPMENT AND HUMAN RIGHTS INTERVENTIONS

In the last 20 years, attention to religion and culture in international actions has increased and international organisations and academics' positions on the matter have drastically changed. Historically, religion and culture were “neglected” aspects of development and human rights interventions (Marshall, 2021: 12). The main development and humanitarian agencies, such as the World Bank and USAID, did not engage in any type of work relating to religion (Jones & Petersen, 2011: 1292; Marshall, 2021: 12); the same can be said for major human rights actors such as Amnesty and Human Rights Watch.

Dominated by theories of modernisation and secularisation, many actors in the fields of development and human rights considered religion and traditional cultural beliefs as something that would decrease and eventually disappear from public life as societies developed (Deneulin & Rakodi, 2011: 49; Jones & Petersen, 2011: 1292; Marshall, 2021: 13). Thus, religion was not considered important (Deneulin & Rakodi, 2011: 49; Jones & Petersen, 2011: 1292). Others

paid attention to religion and cultural beliefs, but focused narrowly on the negative aspects, emphasising e.g. the role of religion and traditional cultural beliefs as a source of violence or harmful practices.

In recent years, this position has changed, and growing attention has been brought to the topic. Various factors have contributed to this development. Events like the attacks of 9/11 and the entry into power of religious political parties made it clear that religion had not disappeared from the public sphere (Marshall, 2021: p15) and that “the topic of religion [was] unavoidable” (Deneulin & Rakodi, 2011: 46). The involvement of religious actors in democratisation movements in Eastern Europe, in the Jubilee Campaign for debt relief, and in efforts to prevent and mitigate HIV/AIDS (Rafiq et al., 2022: 1) also contributed in different ways to demonstrating that religion was still, in the words of sociologist Peter Berger, “alive and well” (cited from Marshall, 2021: 155) – and, more importantly, that religious actors could play a positive role in furthering the development and human rights.

A major contribution to this increased attention to religion and religious actors is the World Bank’s 1997 study *Voices of the Poor* which underlined the importance of religion in developing countries. This study made the surprising reveal that many poor people have more trust in religious leaders, institutions and organisations than in government, concluding that: “[f]aith groups can inspire confidence and trust and are often seen as more embedded in, and committed to, local communities. They are often the first groups, which people turn to in times of need and contribute to in times of plenty” (Naraya et al., 2000, cited in Petersen, 2019: 34). Religion is, in other words, a central part of many people’s lives. Worldwide, people mentioned that activities related to their faith and its practice were, according to them, part of their vision of a good life: these activities can be as simple as attending a religious ceremony or service, reading the bible and praying, or undertaking a pilgrimage (Deneulin & Rakodi, 2011: 48). Religious actors also play an important role in very concrete terms: 50 per cent of health and education services in sub-Saharan Africa, for instance, are estimated to be provided by religious organisations and institutions (Jones & Petersen, 2011: 1293; Marshall, 2021: 12).

Today, the importance of religion has been widely recognised, and there is broad acknowledgement that religious actors – including religious and traditional leaders – can present an “added value” to development and human rights work in terms of e.g. their reach, legitimacy and sustainability (Deneulin & Rakodi, 2011: 46; Petersen, 2019: 33). The increased attention to religion and cultural beliefs is witnessed in a wide range of initiatives in the fields of development and human rights. Some examples are the creation of the UN Interagency Task Force on Religion and Development and the Faith Advisory Council (Marshall, 2021: 17-18),

or the Partnership on Religion and Sustainable Development. Other examples include new policies, guidelines and plans of action for partnerships with religious actors, e.g. the UN Plan of Action for Religious Leaders and Actors to Prevent Incitement to Violence (2017), or the UNFPA Guidelines for Engaging Faith-based Organisations (2009). There has also been a surge in research on the role of religion in the fields of development (for an overview see Wilkinson et al., 2022), and – although less so – in human rights interventions (Petersen, 2015).

4.2. ENGAGING WITH RELIGIOUS AND TRADITIONAL LEADERS IN FGM/C PREVENTION

This increasing attention to religion and culture is also reflected in the field of FGM/C prevention in various ways. At the international and regional levels, several resolutions explicitly emphasise the need to cooperate with religious and traditional leaders. In its Resolution 67/146, Intensifying Global Efforts for the Elimination of FGM/C, the UN General Assembly mentions the need to include “community and religious leaders” in the work to eliminate FGM/C and other harmful practices (United Nations General Assembly, 2013: 3). Similarly, the UN interagency statement Eliminating Female genital mutilation (2008) note that including leaders in anti-FGM/C interventions is necessary to “secure a supportive environment for change” (WHO, 2008: 19).

The European Union in its Resolution on an EU Strategy to Put an End to Female Genital Mutilation Around the World also refers to the need to convince community leaders to participate in the efforts against FGM/C “since the practice is transmitted through traditional and culture” (European Union, 2020: 1). The African Union in its Commission Report on Getting to Zero Female Genital Mutilation in Africa: Strengthening Human Rights, Accelerating Efforts and Galvanizing Accountability, recognises the positive relationship between “promising interventions” and the engagement of local community actors which includes faith and traditional leaders (African Union, 2022b: 5). During its 2nd Men’s Conference on Positive Masculinity, the AUC also launched with UN Women and the EU Delegation to the AU, Partnership Guidelines to Support Engagement between the African Union and Traditional and Regional Leaders to tackle gender-based violence in Africa (UN Women Africa, 2022). This initiative illustrates the admitted importance to support religious and cultural leaders, such as the Council of Traditional Leaders of Africa (COTLA), for them to have the capacity to oppose GBV (UN Women Africa, 2022).

At the conference on Interfaith Dialogue, held in June 2023 in Marrakesh, the president of the Pan African parliament, H.E. Hon. Chief Fortune Charumbira, recognises the “incommensurable influence” religious and political leaders hold and urges them to participate in the transformation of our society into a more tolerant one (African Union, 2023b).

Several large-scale programmes also include cooperation with religious and traditional leaders as a key component in their work. The UNFPA-UNICEF Joint Programme supports engagements of religious and traditional leaders. In its third phase, the Programme had 5,406 religious leaders publicly talking about the practice and delinking it from religion (UNFPA & UNICEF, 2022: 32). Using the same approach, the NGOs Tostan and CARE have been working with Islamic religious leaders to remind the body integrity of the human being as mentioned in Islam (Muteshi & Sass, 2005: 14). The EU Spotlight Initiative trains traditional leaders on the topic of GBV and support their engagement against the FGM/C and other forms of VAW (Costa Neves & Lambo, 2021). Finally, the AU Saleema Initiative also partners with religious and traditional leaders who will “drive country-level action through existing interventions and programmes” (African Union, 2022b: 12).

Interestingly, there is not (yet) much academic literature that deals with religious and traditional leaders specifically in the context of FGM/C prevention, but a few researchers do provide important insights on this. Key among them are e.g. Abdi & Askew (2009); Ahmed et al. (2019); Berg & Denison (2013); Mackie & LeJeune (2009); Mkuwa et al. (2023); Shell-Duncan et al. (2018); Tolo Østebø & Østebø (2014). International organisations and NGOs have also published a number of reports and evaluations on the topic, including e.g. Le Roux and Bartelink (2017) on behalf of Tearfund, Matanda et al. (2021) on behalf of UNFPA, UNICEF, WHO and the Population Council, the UNFPA-UNICEF Joint Programme 2018’s annual report, and the UNICEF Baseline study report (2017). Based on this literature, as well as the various initiatives in the field, the remainder of this chapter explores in more detail what engagement with religious and traditional leaders looks like in the field of FGM/C. This study first identifies key rationales for engagement with these actors and then outlines a typology of common approaches. Finally, this study discusses some of the challenges and dilemmas that may emerge from engagement with religious and traditional leaders.

4.2.1. Rationales for Engaging with Religious and Traditional Leaders

Because the criminalisation of the practice has been recognised as not being enough to eradicate FGM/C, efforts to change the social norms and beliefs underpinning the practice are introduced. Today, religious and traditional leaders are widely acknowledged as key actors, and their role in changing social norms is recognised. As noted in a UNICEF report evaluating different approaches to FGM/C prevention, the religious and traditional leaders' approach is "potentially effective in influencing beliefs and attitudes towards FGM as a precursor to change" (2021: 68).

More specifically, four common rationales for cooperation with religious and traditional leaders can be identified: they have normative and/or religious authority and legitimacy, they are locally grounded and know the local context; they have extensive relations and networks; and finally, they serve as gatekeepers and facilitators of access. These rationales are described and discussed below. Importantly, the four rationales should not be seen as mutually exclusive, and IOs, NGOs and other actors usually draw on several of them in their interventions.

Normative authority

Religious and traditional leaders are broadly considered to have strong normative authority and legitimacy. This authority may differ for religious and traditional leaders but is still respected in both cases. Both religious and traditional leaders have informal authority, but in some cases, their authority is also formally recognised by the State. It is the case in South Africa for example, where traditional leaders are acknowledged by the Constitution and in the White Paper of 2003 on traditional leadership (Koenane, 2018: 2).

Local religious and traditional leaders are often very close to their communities and are very respected figures in the community (Mkuwa et al., 2023: 6). For the Maasai, it is said that "respect and obedience to their leaders are among the strongest bonds still maintained" (Mkuwa et al., 2023: 7). People rely on their local leaders to communicate and set the boundaries for social norms and values in the community. Religious and traditional leaders are considered the "custodians of traditions and culture" in the community (Mkuwa et al., 2023: 6), and they have "considerable influence on their communities' beliefs and behaviours" (le Roux et al., 2016: 23), including FGM/C practices. For example, in Kenya, in the Kuria district, the community leaders, which are called the council of elders, are the ones deciding the start of the FGM/C season each year (Oloo et al., 2011: 13). It is the same among the Maasai community, where

the elders are considered responsible for maintaining the culture of the community, and FGM/C is considered being part of this culture (Mkuwa et al., 2023: 4).

Religious and traditional leaders are followed by more people and are often more trusted by them than by the government (Mkuwa et al., 2023: 6; Packer, 2002: 179). When they talk people listen (Mkuwa et al., 2023: 6) – something which is not always the case with the government. Packer argues that the legal authority of African governments is not as strong as the moral and social authority of e.g. local leaders when it comes to private and sensitive issues (Packer, 2002: 179). Other research also shows that many people consider turning to religious or traditional leaders rather than to officials when discussing their problems (Appiah-Nyamekye Sanny & Boateng Asiamah, 2020: 2). Thus, they are in a good position to change social norms and practices around FGM/C and promote gender equality (Mkuwa et al., 2023: 7; UN General Assembly, 2018: 17).

People may also respect their leaders and their commands because they fear them and the repercussions (Oloo et al., 2011: 29). As noted by Oloo et al. (2011) in their analysis of FGM/C in the Kuria and Kisii communities, in some communities the leaders are believed to have supernatural powers and be able to cast spells and curses on individuals who go against their decisions (2011: 15). This social pressure can be a barrier to the prevention of the harmful practice that is FGM/C as people still follow the practice by fear of going against their leaders (Oloo et al., 2011: 29).

Religious authority

While the kinds of normative authority that local religious and traditional leaders possess are in some ways similar, religious leaders also have a particular kind of authority vis-à-vis their religious position. This religious authority is seen as a key argument for cooperation among many practitioners and researchers.

In many parts of the world, FGM/C is still associated with religion, even if there is little theological evidence to back this. In particular, within Muslim communities, there is widespread unclarity concerning the relationship between Islam and FGM/C, and religious leaders' positions on the matter may differ widely, depending on their cultural backgrounds, socioeconomic factors and traditions (Ahmed et al., 2019: 855-856). In some Muslim communities, for instance, infibulation is considered unlawful (haram), but milder forms of cutting are still tolerated and practised as they are believed to be required as part of the Islamic sunnah (Abdi & Askew, 2009: 5).

In communities where FGM/C is strongly associated with religion, awareness of the severe health problems resulting from FGM/C may not be sufficient for them to stop practising it. Their strong belief in the religious requirements of FGM/C results in support for the practice even if they know the risks and have endured the pain of the cut. A woman interviewed by Al Nagar et al. (2017) in their study of the criminalisation of FGM/C in Red Sea explains that even if she is personally against FGM/C, she will not vote to criminalise it as long as the Islamic scholars do not give a clear answer on sunnah (Al-Nagar et al., 2017: 13). Another woman tells about the complications and pains she had after her cut, but still maintains that the practice should be upheld if there is a Quranic verse mentioning it (Abdi & Askew, 2009: 5).

Thus, religious leaders can play a key role here: they have the authority to clarify and re-interpret religious norms and practices around FGM/C – and people listen to them. As Abdi & Askew note, people may not stop the practice “because the radio or the government has said so,” but they “are ready to discuss with sheikhs” (Abdi & Askew, 2009: 6). Therefore, it is important to work with religious leaders to teach and inform people on the correct position of religion on the practice. People are often ready to listen when guidance comes from religious leaders instead of the government or other actors (Abdi & Askew, 2009: 22). People will not stop “due to legislation but they are ready to stop anything that is not Islamic” (Abdi & Askew, 2009: 22).

Local grounding and context-knowledge

A second rationale that is often advanced as an argument for cooperation with religious and traditional leaders turns on their local grounding and context knowledge. Religious and traditional leaders are aware of the local context as they live in the community and might have spent their whole life there; their fathers and grandfathers may even have had the same position in the community. Jones and Petersen mention the “historical rootedness” of religious organisations and institutions; this term seems to apply to religious and traditional leaders as well (2011: 1296). By their position, local and specific knowledge has probably been passed on to them by their predecessors. The tradition, rituals, stories and practices they share and perform are proofs of their history (Rafiq et al., 2022: 2).

They also have proximity to people and are connected with their community (Rafiq et al., 2022: 5). They know every citizen in their community, and probably engage regularly with them, discussing their problems and all kinds of information. As a result, they have a good knowledge and understanding of the local dynamics (le Roux et al., 2016: 23; Martinez &

Nozell, 2022). They are the ones who know the community best (Ramsey, n. d.: 2). As such, they can serve as important sources of information and knowledge-building for NGOs engaged in FGM/C prevention efforts, contributing to more context-sensitive interventions that are better suited to the local dynamics of the particular community.

If there is trust in the local leaders, cooperation also contributes to ensuring more reliable information on the situation, something which also contributes to better and more relevant interventions. Sometimes, there are cases where individuals lie when answering surveys or in evaluations after an anti-FGM/C intervention from an organisation. This can be the case when the prevention was not successful, and the practice is ongoing. People might fear reactions if they admit the truth. It is also the case if they do not agree with the position of the intervening actors and lie for them to leave faster their community and go back to their normal practices (Horner, 2016).

The “rootedness” and permanent presence of religious and traditional leaders in the local community also contributes to ensuring stability and continuity of interventions. Unlike many international organisations and NGOs, religious and traditional leaders stay in the community long after FGM/C prevention projects are closed, and the money has run out. This is a real asset as it allows for continuous follow-up from within the community. Religious and traditional leaders could thus contribute to ensuring long-term changes.

Network and relations

Because of their position, religious and traditional leaders often have extensive networks and relations. Vis-à-vis their networks and relations, religious and traditional leaders are in a strong position to communicate messages to a broad audience; and their networks and relations give them a high degree of influence.

Local leaders’ networks and relations can derive from their religious affiliation: religious leaders typically have relations with other authorities and communities from the same religion. In some cases, religious leaders are organised in councils or other institutions, at local, regional, or national levels. This can also include inter-faith councils, facilitating relations across religions. Similarly, traditional leaders are also often organised in councils, e.g. Council of Elders or Traditional Leaders. An example is the Njuri Ncheke Supreme Council of Ameru Elders which brings together traditional leaders from the Meru district in Kenya (Innocenti Insights, 2010: 36).

They can also be close to governmental institutions if their influence has been recognised. In Ghana, for instance, the Asante chieftaincy played “a powerful role in national power structures” (Buur & Kyed, 2007: 2). The government can also recognise their role as a link between them and citizens from remote areas (Buur & Kyed, 2007: 7).

Finally, the community they live in and partially rule is also part of their network and can be extended to members’ relatives. Indeed, when they spread a message in their community, the members potentially discuss it with their entourage and pass on the information. This leads to the next point.

With these expanded networks and their authority, religious and traditional leaders have an asset when it comes to communication and influence. The information they share is trusted by their community, they can reach “remote audiences” (Luetke Lanfer et al., 2023: 1702). Through their connections with other leaders and some national institutions, they can make a liaison between national stakeholders and their communities (Martinez & Nozell, 2022). Through their communication, they can sensitise and educate the communities. It is easy for them to make both big statements to the whole community at once and to discuss them individually with each member. It can be through their preaching at church or the mosque, or when they advise their members during personal conversations with the followers (Orubuloye et al., 1993: 100). Traditional leaders are providing education in some communities (Mkuwa et al., 2023: 6); this is also the case for religious leaders. They can organise seminars and answer questions from their members (Barsoum et al., 2011: 15).

Both categories of leaders are the ones people usually turn to in times of crisis or other complications in their lives (Martinez & Nozell, 2022). This offers a precious connection between the people and the leaders, offering them plenty of opportunities to share any messages and answer their concerns on various topics. Muslim leaders have mentioned using household visits as a means to share their messages (Orubuloye et al., 1993: 7).

Gatekeeping and facilitation of access

Finally, and more concretely, religious and traditional leaders often serve as “gatekeepers” of their community, and as such, they can facilitate – or hinder – access for NGOs and other actors working with FGM/C prevention.

Religious and traditional leaders have a strong influence on the decisions affecting the community (Tieleman & Uitermark, 2019: 716). They can decide what is required in the community such as access to safe water through water pipelines, the creation of a motorway,

and so on. Deriving from this, they also to a large degree control which institutions can connect with and work in the community: as the community representatives, outsiders have to access the population through the chief or local leader (Buur & Kyed, 2007: 12; Tieleman & Uitermark, 2019: 718).

As such, religious and traditional leaders are often considered to be the gatekeepers of their community (le Roux et al., 2016: 23; Tieleman & Uitermark, 2019: 716). This means that they play an important role in facilitating – or hindering – FGM/C prevention actors’ access to a community. As gatekeepers of their community, they can decide whether to allow access to NGOs and other actors. Religious and traditional leaders can sometimes be very sceptical of outside interventions such as anti-FGM/C campaigns because they are seen to threaten their cultural and religious traditions, and its abandonment would be their full responsibility. Those interventions aim to stop, or as they believe “kill”, a practice that is often considered to be a central part of their heritage (Oloo et al., 2011: 16). A traditional leader from a Maasai community said that he “would not allow [his] age group to be the first one to divert from practising a tradition that has always been there” (Tabither et al., 2018: 24). So they often oppose and resist those interventions to protect their traditional systems (Al-Nagar et al., 2017: 11).

If, on the other hand, religious and traditional leaders are positive towards outside FGM/C interventions, they will be able to facilitate access. This means that dialogue with these leaders is considered to be a necessary element in most interventions, aiming to ensure the support of religious and traditional leaders. In the words of Mkuwa et al., “If you win the ethnic leaders, you win the battle against FGM” (Mkuwa et al., 2023: 7).

4.2.2. The Types of Engagement

International organisations, NGOs, and other FGM/C prevention actors engage with religious and traditional leaders in many ways, depending on the actors involved, the community concerned and the objectives of the intervention. Concrete examples of activities include training and education, awareness-raising, information campaigns, development of alternative rituals, public statements against FGM/C and community dialogues.

At a more overall level, this study proposes to describe and categorise this engagement in the form of three different approaches: the health risk approach; the gender equality approach; and the scriptural (or theological) approach. The latter is only applicable to religious

leaders as traditional leaders would not have the same legitimacy over faith communities. But the health risks approach and the gender equality approach can also be related to traditional leaders as it does not require any special religious status.

This basic typology is inspired by and draws on, the work of Le Roux and Bartelink (2017) who distinguish between two main forms of engagement with religious leaders on the issue of harmful practices, including FGM/C: the health risks approach and the theological approach. Building on my analysis of the field of FGM/C prevention efforts in Chapter 3, I argue that it makes good sense to add a third approach to this typology, namely the gender equality approach.

All three approaches are based on an understanding of FGM/C as a human rights violation, and on an understanding of the importance of changing social norms and practices to prevent this violation – but they differ in terms of how they propose to change these norms and practices. The three approaches should, however, not be seen as mutually exclusive; NGOs and other FGM/C prevention actors may use different approaches simultaneously in the same intervention. Each of the different approaches does not relate to a specific rationale. Across these three different approaches, FGM/C prevention actors draw, to varying degrees, on all four rationales. The religious authority rationale is particularly strong in the scriptural or theological approach, but the two other approaches may also draw on religious authority in different ways.

The health risks approach

This approach to engagement with religious and traditional leaders formulates the challenges related to FGM/C in terms of health risks and complications. Despite the weaknesses described in the previous chapter, the health risk approach is still widely used in FGM/C prevention efforts, even if it is now coined in terms of a broader human rights language. As pointed out by Le Roux & Bartelink (2017: 20), this approach presents certain benefits in the engagement with faith and traditional leaders. This is because religious and traditional leaders are not always aware of the implications of the practice. In their report, Le Roux and Bartelink note that “even those [religious leaders] who are theologically trained often lack basic knowledge about sexual and reproductive health and rights” (Le Roux & Bartelink, 2017: 20). However, this could be extended to traditional leaders as well. Patriarchal norms and societal taboos around women’s bodies and sexuality contribute to conceptions of these issues as something that is not relevant or appropriate to discuss in public.

Health risk interventions often consist of teaching and sensitising religious and traditional leaders on the medical complications resulting from FGM/C as a way to start the conversation and reflection on this sensitive topic (Le Roux & Bartelink, 2017: 20). Using a health risk language, NGOs and other FGM/C prevention actors can create a relatively neutral space for dialogue, based on scientific evidence rather than normative judgements of the practice. In concrete terms, activities can consist of the general teaching of the female body and the consequences on the health of the practice, but they can also include videos of the procedure, or testimonials from survivors to explain the health risks more concretely. Through such activities, FGM/C prevention actors seek to encourage religious and traditional leaders to take a new position on the issue and to build their capacities to advise their community on the matter.

Education on the health risks with religious and traditional leaders is also beneficial for delinking the complications from witchcraft or any other type of divine punishment. People are aware of the complications because they see them and live with them; when their wife gives birth, when they have sexual intercourse if their daughter dies after the procedure and so on. But they do not necessarily attribute these complications to the cut in itself. They believe those complications come from a curse on girls who did not respect the rules of the cut, such as the “no sex rule” during the healing period (Oloo et al., 2011: 17). So, when they understand the causality of the procedure and the complications, they might realise that there is an actual concrete solution to those issues, which is to stop the practice. This also makes the issue more their own and not a Western idea that the practice is wrong. They can thus own the issue and its solution, and make the change from within the community (le Roux et al., 2016: 24).

The gender equality approach

The gender equality approach frames the challenges related to FGM/C more broadly in terms of violence against women and girls, gender discrimination and patriarchal norms. It fits in the human rights approach but with a specific focus on gender. Harmful practices such as FGM/C and child marriage, are often rooted in patriarchal norms and stereotypes and sustain them (Khosla et al., 2017: 3). As FGM/C is part of a “social structure that legitimises sexist cultural practices [...] designed to limit women’s self-realisation and enjoyment of life” (Gruenbaum, 2001 quoted in Nyangweso et al., 2022: 3), this approach aims at tackling this social structure to reach gender equality. By extension, this social change would support the abandonment of FGM/C and similar practices (African Union, 2022b: 5).

This approach is also sometimes called the “gender transformative approach” and aims at “create[ing] opportunities for individuals to actively challenge gender norms, promote positions of social and political influence for women in communities, and address power inequities between persons of different genders” (Health Communication Capacity Collaborative, n. d.: 1). By doing so, FGM/C is expected to progressively stop as people would oppose to it due to its underlying causes that they now disapprove. Organisations, when implementing this approach, often work towards the empowerment of women and girls. These interventions focus among others on providing education for girls and ensuring they learn skills to empower them, sexuality education, and ensuring their inclusion and participation in public processes (UNICEF, n. d.: 8). But it can also be implemented through cooperation with religious and traditional leaders.

Religious and traditional leaders are gatekeepers of tradition and culture, participating in the perpetuation of societal norms (Mkuwa et al., 2023: 6). They are thus considered to be the “custodians” of these societal norms (Zambia Center for Communication Programmes, n. d.: 2). By sensitising them on the harmful consequences of the practices, they can change their behaviour towards the relationship between men and women and gender equality, and influence people in their community to do the same and to adapt their attitudes (Voices4Change, 2017: 3). Based on the rationales mentioned previously in this chapter, they can also be a powerful advocate in favour of women’s rights and oppose related gender discriminations such as FGM/C. They can share their new position with their community through dialogues, public declarations or in their preaching. But mostly, by their role as custodians, they can challenge the societal norms in their communities and encourage change from those patriarchal and discriminatory ones for more gender-inclusive norms, leading to the progressive abandonment of discriminatory practices, including FGM/C.

When in cooperation with religious and traditional leaders, interventions based on the gender equality approach aim at sensitising them and have them challenge their perceptions on this issue. For example, the organisation Voices4Change has organised training for Nigerian religious and traditional leaders to discuss their understanding and knowledge of gender (Voices4Change, 2017: 2). In such training, they can be asked to critically reflect on “what it means to be a man” (UNICEF, n. d.: 8), sensitised on the inequalities in such a system and all its impacts on girls and women’s lives. In Voices4Change training, other topics are discussed such as the “social nature of gender roles”, the types of violence and what is a healthy relationship (Voices4Change, 2017: 5).

Thus, this approach contributes to a broader discussion on gender equality and not only FGM/C. This approach can potentially change the gender norms in the community and allow them to reach gender equality. By doing so, other similar practices could be stopped within the same intervention efforts. And there would be fewer risks of return of the practice and commitments would be potentially long-term ones.

The theological/scriptural approach

As noted above, FGM/C is often – although far from always – legitimised with reference to religion. It is, in the words of Le Roux and Bartelink (2017: 17), a cultural norm that has been “couched in religious terminology”. The scriptural approach takes its starting point in religious texts and traditions, aiming to delink FGM/C from religion and to delegitimise the practice religiously. Explicitly drawing on the religious authority and knowledge of local leaders, this approach is only relevant to religious leaders. But a similar approach could be used with traditional leaders. The local socio-cultural norms and practices could be discussed and re-interpreted. Or other practices more sensitive to gender could be identified and implemented. These practices could be historical or contemporary ones. However, no literature mentions this possibility.

The main activity of the scriptural approach is to read and interpret religious texts and traditions, together with religious leaders, to demonstrate that FGM/C is not a religious requirement and that health complications are not expressions of the will of God (Abdi & Askew, 2009: 7). Academic experts and religious scholars often contribute to this process (Le Roux & Bartelink, 2017: 19).

A scriptural approach can contribute valuably to both the health risk approach and the gender equality approach. In relation to the health risk approach, for instance, it may be possible to identify religious arguments against the complications arising from FGM/C. For example, a consequence of infibulation may be that menstruation blood and urine cannot flow properly. According to some Islamic traditions and interpretations, urine and menstrual blood is considered impure and should not stay in the body like that (Abdi & Askew, 2009: 7; Kaundal & Thakur, 2014: 193).¹¹ This is just one example of how religious arguments may support scientific health arguments in the eradication of FGM/C.

¹¹ In Islam, menstruations are usually considered impure only for religious functions like entering a mosque or touching the Quran (Kaundal & Thakur, 2014: 193).

In relation to the gender equality approach, gender-sensitive readings of religious texts and traditions may contribute to identifying religious arguments for gender equality and non-discrimination, thus contributing to challenging gender discriminatory and patriarchal norms that sustain FGM/C practices (Le Roux & Bartelink, 2017: 20) and “translating” norms around women’s rights and gender equality into a religious language. World Vision’s Channel of Hope programme uses this method to tackle gender discrimination which is essential for FGM/C to come to an end. Channels of Hope works in collaboration with religious leaders and teach them to analyse social issues in the light of religious texts to spread this new vision (World Vision, 2019: 1). The programme is based on a methodology that confronts people’s view to encourage them seeing women and men as “created by God as equals” and to implement this positive change of norms in their relations to each other (World Vision, 2019: 2). In light of this training, a pastor in Ethiopia changed his relationship with his wife as he now “realised the potential God has given to women” (World Vision, 2019: 3).

Using sacred scriptures as the basis of the intervention is “a way of engaging faith leaders in terms that they are comfortable with, that they trust, and on which they see themselves as experts” (Le Roux & Bartelink, 2017: 20). And because the opposition to the practice comes from their religion and the sacred texts (the ultimate authority in their views), they – and their constituents – are more likely to trust and accept this new position on FGM/C. It reduces the risks that they oppose the interventions and do not allow to spread the message in their community because they believe it is in opposition to their faith and values (Le Roux & Bartelink, 2017: 18). But, with this approach, the arguments are not coming from Western views and culture, they are not “man-made” (Abdi & Askew, 2009: 7). These arguments based on divine laws and their faith. Then, as they trust this new position, they will spread it to the community and sensitise on the matter.

The theological approach requires a certain degree of religious legitimacy and knowledge on the part of the FGM/C prevention actors carrying out the intervention. Faith-based organisations or NGOs with faith-based partners are arguably much better positioned than secular actors to interpret and engage with the sacred scriptures and to implement this approach (Le Roux & Bartelink, 2017: 21). It is also recommended that they engage in those interventions within communities that have the same faith as they do, or through inter-faith groups (Le Roux & Bartelink, 2017: 21).

4.3. SUMMING UP

The recent increasing importance given to culture and religion in development and human rights interventions has led to growing cooperation with religious and traditional leaders, including in the field of FGM/C prevention. This cooperation is increasingly mentioned and recommended in various legal documents and policies, acknowledging their key position in the field of FGM/C prevention, among others. Some of the most common rationales advanced by researchers and practitioners have been identified and discussed in this chapter. Religious and traditional leaders can be crucial allies in the fight against FGM/C: they benefit from a high authority in their community, have a network and existing means of communication, they have a good knowledge of the local context and are locally grounded, and finally, they are the community's gatekeepers and therefore have the task to protect its best interests. The chapter has also presented an overview of some of the different ways in which FGM/C prevention actors engage with religious and traditional leaders. Cooperation can be based on a health risks approach which emphasises the complications resulting from the cut, or on a gender equality approach challenging the patriarchal and gender discriminatory norms and practices that contribute to sustaining FGM/C. Finally, it can be based on a scriptural/theological approach, emphasising the study of sacred scriptures, and seeking to de-link FGM/C from religion. This basic analytical framework, outlining rationales for and approaches to cooperation with religious and traditional leaders, guides the next chapter's analysis of two Kenyan NGOs' engagement with religious and traditional leaders.

5. ENGAGEMENT WITH RELIGIOUS AND TRADITIONAL LEADERS IN FGM/C PREVENTION EFFORTS IN KENYA

The first part of the thesis has provided a general introduction to the practice of FGM/C as well as an overview of contemporary actors and approaches in the field of FGM/C prevention, and it has brought attention to the role of religious and traditional leaders in this, arguing that they can contribute in important ways to changing social norms and practices around FGM/C. Building on these analyses, this chapter presents concrete examples of how this cooperation can look like in practice. Based on interviews with representatives from two Kenyan NGOs engaged in FGM/C prevention efforts, the chapter explores how they engage with religious and traditional leaders, analysing their underlying rationales for cooperation, the approaches they take, and the concrete activities they engage in. The purpose of this is to transpose the findings from the previous chapter to concrete cases of anti-FGM/C interventions from two NGOs in Kenya and confront conclusions related to the cooperation with religious and traditional leaders in anti-FGM/C interventions in the Kenyan context.

To contextualise the case studies, the chapter first gives a brief introduction to the FGM/C situation in Kenya, as well as an introduction to some of the main FGM/C prevention efforts that have been implemented in Kenya, including in terms of legislation as well as education and other efforts to change social norms and practices.

5.1. FGM/C IN KENYA

Kenya is a country in Western Africa and has borders with Somalia, Uganda, Tanzania, Ethiopia and South Sudan. It is a multi-ethnic country with at least 42 ethnic groups (Bunei & Rono, 2018: 904).¹² According to public health scholar Sarah Hayford, Kenyan society did not traditionally practice FGM/C or male circumcision (2005: 136). It is unknown when FGM/C started in Kenya. Today, an estimated 15 per cent of all women and girls have undergone the cut (2022 numbers); a decrease from 38 per cent in 1998 (KNBS & ICF, 2023: 93). This makes

¹² As not all the 42 ethnic groups can be mentioned, only the ones with the biggest disparities are mentioned in this chapter. Both Amref and Men End FGM work within these ethnic groups and counties with higher cases of FGM/C, like the Somali and Meru communities, or in the Kajiado county.

Kenya one of the African countries which have experienced the biggest decrease in FGM/C prevalence (Bunei & Rono, 2018: 904).

The most practised type is the cut with flesh removed, which would be akin to type 1 or 2, with variations according to different ethnic communities (UNICEF, 2020: 10). Infibulation (type 3) is the most common type in Somali communities, representing 9 per cent at the national level (UNICEF, 2020: 10). FGM/C is typically performed by traditional practitioners (UNICEF, 2020: 2), often elderly women (Kakal et al., 2022: 9). The ritual sometimes takes the form of a public initiation ceremony or a rite of passage: this is the case e.g. for Maasai and in the Kajiado County (Kakal et al., 2022: 2 & 9). Among the Kisii, however, FGM/C is typically carried out by health personnel (UNICEF, 2020: 2). For other groups, health personnel primarily come into play when there are complications from a cut performed by a traditional practitioner (UNICEF, 2017: xviii). However, as Kenya does not escape from the issue of the increasing medicalisation of the practice, doctors and health practitioners increasingly practice the cut for other ethnic groups, even in cases where there are no complications, “for a fee at the hospital in secret, or at home” (Kakal et al., 2022: 10).

The cut is performed at different ages across different ethnic and religious groups (UNICEF, 2020: 2). In Somali communities, 36 per cent of girls have been cut before reaching 15 years old, and is even often before 10 years old (UNICEF, 2020: 7). This number can evolve as girls can still be cut after reaching 15, but it shows the early stage of the practice. In comparison, this number reaches 16 per cent for the Kisii and only 3 per cent for the Maasai (UNICEF, 2020: 7). And it is mostly after 15 for the Meru and Kalenjin (UNICEF, 2020: 11). These differences in the ages when the cut is performed reflects partially the reasons it is practised. This is mentioned later in this chapter.

The practice is unevenly widespread across the country and in different ethnic communities. The Somali and the Kisii are among the ethnic groups with the highest number of girls cut. Respectively, the highest are Somali (94 per cent), Samburu (86 per cent), Kisii (84 per cent) and Maasai (78 per cent) (UNICEF, 2020: 6). And, on the opposite, communities with the lowest percentages are the Luhya (0.4 per cent) and the Luo with almost no cases (0.2 per cent) (UNICEF, 2020: 6). The area with the most cases is the North Eastern province of Kenya, alongside Somalia and Ethiopia, with 98 per cent of the girls aged 15 to 49 years being cut (Achia, 2014: 2 & 11; UNICEF, 2020: 4). Other clusters resides near the Lake Victoria and in parts of the Eastern province (Achia, 2014: 11). Some counties have a very low reported number of the practice, such as in the western region of Kenya with only 1 per cent of girls from 15 to 49 years being cut (UNICEF, 2020: 4).

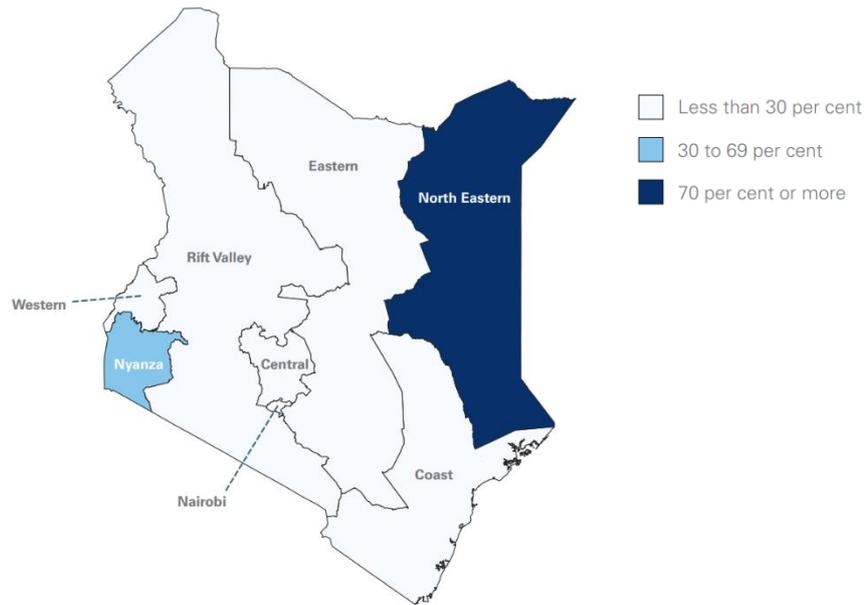


Figure 3. Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by region. Source: UNICEF, 2020: 4.

As in other countries, FGM/C is practised for various reasons in Kenya, but elements such as transition to womanhood, marriageability, personal hygiene and social acceptance often play an important role, regardless of the type of community (UNICEF, 2017: xvii).

In most practising Kenyan communities, undergoing FGM/C is seen to make girls “worthy of respect and marriage”, thus being the ideal wives (Bunei & Rono, 2018: 904-5; Mwendwa et al., 2020: 4). The cut is seen to prevent premarital sex, promiscuity and “marital fidelity due to the reduction of sexual drive” (Achia, 2014: 12; Bunei & Rono, 2018; Mwendwa et al., 2020; UNICEF, 2017). Not undergoing the cut can lead to serious stigmatisation, isolation or harassment, meaning that FGM/C is also often performed for social acceptance (Bunei & Rono, 2018: 906; Mukabi et al., 2022: 1982; UNICEF, 2017: xvii). In the Abagusii, Kuria, and Somali communities in Kenya, uncut girls have reported being insulted, harassed and discriminated against (Kimani et al., 2020: 8). The families of uncut girls are also concerned about this social pressure to cut their girls (Kimani et al., 2020: 8).

In Kenya, FGM/C is also linked with hygiene and aesthetic goal. It is supposed to increase a woman’s attractiveness (Bunei & Rono, 2018: 906; Kakal et al., 2022: 10). This has been reported by Maka Kassim, a community leader advocating against the practice. According to him, this is the case in the Somali culture where uncut girls are considered “unclean” (Mulinya, 2021).

In many communities, the norms and values around gender, marriage, hygiene, etc. are grounded in, and justified with reference to, the cultural traditions of the particular ethnic group or local community. But in some communities, religion also plays an important role in legitimising and encouraging FGM/C. This is primarily the case in Muslim communities. According to UNICEF (2020: 17), approximately 40% of Muslims in Kenya believe that FGM/C is a religious requirement, and in the Somali communities, religion seems to be one of the main justifications for the practice (UNICEF, 2017: xvii).

5.2. FGM/C PREVENTION IN KENYA

As discussed in Chapter 3, FGM/C prevention efforts can be summarised into two overall approaches: criminalisation and legal measures; and change of social norms and practices. This section briefly presents some of the main initiatives in these two realms in a Kenyan context.

5.2.1. Criminalisation of FGM/C

Kenya is signatory to all important international and regional instruments of relevance to FGM/C. The country has ratified the ICCPR, the ICESCR, the CEDAW, the Convention Against Torture & Other Cruel, Inhuman or Degrading Treatment or Punishment and the African Charter on the Rights and Welfare of the Child. It also ratified the CRC in 1990, the Banjul Charter in 1992, and the Maputo Protocol in 2003 (28 Too Many, 2018b: 12). Kenya also has a very advanced domestic law on the matter. The first presidential decrees were issued by the former president Daniel Moi, between 1982 and 2001 (Evelia et al., 2007: 8). The decree of 1982 was an executive order banning the practice (Evelia et al., 2007: 8; Hayashi, 2017: 107). In 1989, FGM/C was officially banned by the government (Evelia et al., 2007: 8). This was followed by directives from the Director of Medical Services to stop medical personnel from carrying out the procedure (Evelia et al., 2007: 8; Shell-Duncan et al., 2017: 8-9).

In 1999, the Kenyan Government launched its National Plan of Action for the Elimination of FGM/C in Kenya from 1999 to 2019 (Government of Kenya, 1999). This Plan of Action aims “to accelerate the elimination of female genital mutilation” leading to an improvement in girls’ and women’s well-being and quality of life (Government of Kenya, 1999:

12). This Plan of Action was followed in 2008 by another one for Accelerating the Abandonment of FGM/C, covering the time frame of 2008-2018 (Hayashi, 2017: 107).

Two years later, in 2001, the Children's Act was passed. Article 14 of this Act criminalised the practice of FGM/C on girls under 18 years and contained a penalty of one year of imprisonment and/or a fine (of 50,000 Kenyan shillings) (UNICEF, 2013: 12). CEDAW addressed, in its concluding observations (CEDAW/C/KEN/CO/7) to Kenya, the gap of the Act consisting in a lack of protection for women and girls over 18 (CEDAW, 2011: 5), as well as for insufficient information about the law across the country (CEDAW, 2011: 5; UNFPA-UNICEF, 2013: 7).

On 4 and 5th December 2005, the African Parliamentary Conference on Violence against Women, Abandoning Female Genital Mutilation: the Role of Parliaments took place in Dakar (African Parliamentary Union, 2005). This conference allowed "parliamentarians from African countries to exchange views, and helped build a better understanding of the role that parliaments should play in fighting FGM/C" and emphasised the need for "societal changes and action at the local level" (African Parliamentary Union, 2005). Following this conference, multiple policies were adopted in Kenya (Hayashi, 2017: 107).

In 2011, the Prohibition of Female Genital Mutilation Act (FGM Act) is finally passed. This Act broadened the ban of the Children's Act of 2001 by outlawing every form of FGM/C on every girl and woman, regardless of their age (28 Too Many, 2018b: 2; Shell-Duncan et al., 2017: 27). It is one of the "most comprehensive laws against FGM in Africa" and is the "principal legislation governing in Kenya" (28 Too Many, 2018b: 2 & 10). Indeed, the anti-FGM Act defines FGM/C, criminalises the performance, procurement, arrangement and/or assistance of any kind of acts of FGM/C, the failure to report cases of FGM/C, the medicalisation and the practice of cross-border FGM/C, and the use of "derogatory language against uncut women" (28 Too Many, 2018b: 10). The FGM/C Act also established the Anti-Female Genital Mutilation Board which aims to "design and coordinate public awareness programs against FGM/C and advice the government on FGM/C-related matters, [and] to implement abandonment programmes" (Muthumbi et al., 2015: 35). The Anti-FGM Board also works on mobilising resources for FGM/C prevention activities and manages the cooperation and coordination of institutions, agencies and anti-FGM/C bodies (28 Too Many, 2018b: 7).

With all those regulations and other initiatives from the government, Kenya is one of the most advanced African countries in terms of criminalisation and punishment of FGM/C (28 Too Many, 2018a: 31). With the implementation of the anti-FGM Act, Kenya has penalties for "aiding and abetting FGM/C", "for death resulting from FGM/C", provisions for

extraterritoriality, prohibits medicalisation and has penalties that include the “revocation of medical professionals’ licenses” (Muthumbi et al., 2015: 35).

5.2.2. Changing Social Norms and Practices around FGM/C

As mentioned in the chapter on FGM/C prevention, there is broad consensus that criminalisation is not enough to ensure the eradication of FGM/C. This is also the case in Kenya. Despite Kenya’s investment in eradicating the practice, the practice is only slowly decreasing. Parallel to the efforts to criminalise FGM/C, the Kenyan government and civil society actors have, together with international organisations, NGOs and others, engaged in a plethora of different initiatives to change the underlying norms and practices sustaining and legitimising FGM/C. The Kenyan Anti-FGM Board supports and coordinates those initiatives to ensure effective efforts.

Education and training are key components in most interventions against the practice. It ranges from the education of girls and/or boys about the health risks and the human rights that FGM/C violates, to the education and training of health practitioners or other important figures such as teachers, and religious and traditional leaders (Berg & Denison, 2013; Innocenti Insights, 2010; Muteshi & Sass, 2005; UNICEF, 2020). Other activities include e.g. awareness-raising and information campaigns, job training for ex-circumcisers, development of alternative rites of passage and community led-dialogues.

The UNFPA-UNICEF Joint Programme, which Kenya was one of the first countries to join in 2008 (28 Too Many, 2018b: 8), is one of the biggest FGM/C prevention programmes in the country. Their activities are multisectoral; they work with men and boys and created more than 52 men’s and boys’ networks across Kenya, they partnered with key stakeholders such as the anti-FGM Board and provide financial support to cooperatives such as the Johari Beads Initiative which engages in community-led interventions and cooperate with community champions to increase awareness in more than 15 ethnic groups (UNFPA & UNICEF, 2022: 22).

Other key actors and initiatives are Maendeleo Ya Wanawake (MYWO), CARE and Forum for African Women Educationalists in Kenya (FAWEK). MYWO implemented the first alternative rite of passage in Kenya in 1996 and is still active today (Van Bavel, 2021: 1). Their approach includes community-level sensitisation, education on sexual and reproductive health and rights and finishes with a public ceremony (Van Bavel, 2021: 2). CARE engages in

education interventions and community-level advocacy activities in refugees camps in northern Kenya (Chege et al., 2004: 4). Finally, FAWEK focuses on communication et education on sexual and reproductive health and rights to girls in schools and the integration of this topic in the school's curriculum to eradicate FGM/C, teenage pregnancies, VAW and other related issues (FAWEK, n. d.).

5.3. ENGAGEMENT WITH RELIGIOUS AND TRADITIONAL LEADERS IN KENYAN FGM/C PREVENTION EFFORTS: A CASE STUDY OF TWO NGOS

Cooperation with religious and traditional leaders is not uncommon in Kenya. As research has documented, many people believe that FGM/C is required by their religion or cultural tradition, and religious and traditional leaders often play an important role in sustaining and legitimising the practice, making this type of engagement relevant in a Kenyan context.

The relevance of cooperating with religious and traditional leaders in Kenya is mentioned in reports by key FGM/C prevention actors; in a recent report, for instance, UNICEF underlines the necessity of cooperating with religious and traditional leaders, also in the Muslim communities of the North Eastern Region and in the Kuria Community which has Seventh Day Adventist followers (UNICEF, 2020: 25). Similarly, UNICEF and other key actors provide anecdotal evidence and examples of success of such interventions; in a 2010 report, UNICEF notes that in the Kisii community, inclusion of religious and traditional leaders in an FGM/C prevention programme led to the formulation of a public statement against FGM/C by 50 former practitioners took a stand against the practice (Innocenti Insights, 2010: 39). Another example is from Nyanza Province, within the Kisii Central District, where the Fulda-Mosocho Project engaged with the entire community, including church leaders and clan elders to sensitise on the topic of sexual and reproductive health and rights (Innocenti Insights, 2010: 37). At the end of their training, teachers included their new knowledge in the school curricula and initiated conversations with the community in public assemblies which led to an increasing engagement of community leaders which included clan elders, churches, administrative authorities and women's leaders' groups based on their own initiative (Innocenti Insights, 2010: 38-39). At the end of the project, results showed the start of a shift in this social norm: plenty of girls at risk of undergoing FGM/C have not been cut and families expressed their commitment to end this practice (Innocenti Insights, 2010: 39).

There is, however, not much research or other documentation that provides more in-depth descriptions and analysis of such interventions, their form, contents or effects. In the following, this study presents a case study of two Kenyan NGOs that cooperate with religious and traditional leaders as part of their FGM/C prevention efforts: Amref Health Africa in Kenya and Men End FGM. Based on interviews as well as website information and official documents from the organisations, the chapter discusses their rationales for working with religious and traditional leaders, the different approaches used and why, and the challenges they face in their work against FGM/C. The purpose of these case studies is to provide new empirical data and provide concrete examples of how NGOs cooperate with religious and traditional leaders in Kenya. Importantly, these case studies cannot say anything general about cooperation with religious and traditional leaders. Only two organisations have been interviewed, making it impossible to draw broader conclusions about cooperation with religious and traditional leaders in anti-FGM/C interventions, whether in Kenya or in general.

5.3.1. Introducing the two Organisations

Amref

Amref Health Africa (Amref in short) is an international non-governmental organisation in Africa, founded in 1957 in Kenya, where its headquarters are (Amref website). Its mission is to increase African communities' access to sustainable health through investments in health, health services delivery and solutions in human resources for health (Amref website). Their goal is to guarantee the respect, protection and fulfilment of sexual and reproductive health and rights to all individuals (Amref website). They intervene in different areas including family planning, water and sanitation, maternal, newborn and child health and other areas related to health (Amref website) and help around 20 million people with their services (Lugayo, 2023). Amref receives funds from multiple donors (foundations, companies, organisations, government) such as the Global Fund US Agency for International Development (USAID), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF) and many other (Amref website).

Their office in Kenya partners with local communities across all 47 Kenyan counties (Amref Kenya website) and work with the National government, the County governments and other stakeholders present in the country. They have approximately 40 ongoing projects in Kenya. Their projects concerning FGM/C run in counties with the highest prevalence of FGM/C

such as the Kajiado and Narok county. Their FGM/C initiatives are long-term; because FGM/C is a cultural issue, constant engagement and dialogue are needed to change people's perception of the matter (Lugayo, 2023). Amref implements different approaches to advocate against FGM/C in Kenya, including engagement with religious and traditional leaders.

Men End FGM

Men End FGM is a Kenyan foundation founded in 2019 following an online campaign called #MenEndFGM started by Tony Mwebia in 2013 (Men End FGM website). The goal of this online campaign was to challenge activists, government and organisations to include men in their prevention work against FGM/C (Men End FGM website). Now, this global award-winning movement aims at rallying men and boys on the goal to end FGM/C, child marriage and other forms of SGBV (Men End FGM website).

Men End FGM does a lot of fundraising to fund their activities. Some of their donors are the Wallace Global Fund, Too Young to Wed, or a private donor in memory of the activist Fran Hosken (Men End FGM website). Their current biggest partner is UNICEF with whom they are cooperating. In addition, they cooperate with the Kenyan government and the anti-FGM board, and the UNFPA. Their mission is to educate and sensitise boys, men and elders on the subject while still empowering girls (Men End FGM website). Their work includes community dialogue and sensitisation in local communities, institutions forums such as their Campus Dialogues introduced in 2022, sensitisation through the media and their online campaign (Men End FGM website). Men End FGM work with religious and traditional leaders (mainly community elders) in their interventions against FGM/C in combination with other approaches. They are active in the counties marked as FGM/C hotspots by the government (based on the Kenyan demographic survey) such as in Wajir and Mandera counties, and in the Somali, the Meru communities (Mwebia, 2023a).

Both Amref and Men End FGM interventions are, according to their own accounts, successful. Amref has been able to declare some communities free from FGM/C (Lugayo, 2023). Success stories are published on their website.¹³ Men End FGM also successfully converted religious and traditional leaders and have them actively engaged in anti-FGM/C efforts by talking publicly on local radio or TV stations despite the taboo surrounding the topic.

¹³ Alternative Rites of Passage Project: Voices from the Community (2021): <https://repository.amref.ac.ke/handle/20.500.14173/836>

However, in this study, as I did not have access to any external evaluations or reports, I cannot make any conclusions regarding the actual successes of the organisations' cooperation with religious and traditional leaders. This study will simply present how both organisations understand the role of these leaders and how they engage with them.

5.3.2. Rationales for Engaging with Religious and Traditional Leaders

Amref and Men End FGM engage with religious and traditional leaders for multiple reasons. Based on an analysis of interviews and organisational material, the following section describes the rationales of Amref and Men End FGM, discussing how they relate to the overall rationales identified in Chapter 4, namely: legitimacy and authority; local grounding and context knowledge; network and relations; and finally, their role as gatekeepers.

Authority and legitimacy

Both organisations mention the legitimacy and authority of religious and traditional leaders as an important reason for engagement. Their comments on this aspect are very similar. Denge Lugayo notes that: “if the pastor [and other religious leaders] say it, then it’s taken” (Lugayo, 2023). Tony Mwebia holds a similar discourse, saying that the community listens when community elders speak, making them “true changers” and that religious leaders are more respected than “the government itself” (Mwebia, 2023a). This seems to be a common reality in many communities and countries, as this illustrates a similar position to those mentioned in previous chapters.

Regarding religious leaders specifically, Men End FGM also recognises their authority and legitimacy: because of their knowledge and understanding of religion, what they say is respected, including on the issue of FGM/C (Mwebia, 2023a). He also notes that churches have the power and authority to sanction those members of their constituency who still practice FGM/C, thus putting pressure on the community (Mwebia, 2023a). One could argue that this last element can be risky to enforce as it is like the missionaries' interventions in Kenya which banned members from their churches if they insisted on continuing FGM/C practices. It could thus be important, even if Men End FGM is a local organisation from Kenya, that they are not the ones requesting these punitive measures on the church's members to prevent opposition to their interventions in the future.

Men End FGM also mentioned the leaders' authority as a double-edged sword. They can mobilise and convince the whole society to abandon FGM/C, but they can also oppose it, and external actors can do nothing about it. This can be very damaging to the interventions (Mwebia, 2023b).

Network and relations

Both organisations also mention the central position of religious and traditional leaders and their large networks and constituencies, emphasising how this places them in a good position to communicate messages on FGM/C. The churches and the mosques are great platforms for sharing information about FGM/C; here, religious leaders can talk to people who listen to them, costing them little effort and resources, but reaching a great number of people (Lugayo, 2023; Mwebia, 2023a). Traditional leaders also have great communication means: by their high position in the community, they can make public declarations and spread messages to the whole community. Amref “had to engage with chiefs and community leaders so that these discussions are brought for everybody” in the community and that no one is left out, especially women who are often not included in conversations (Lugayo, 2023).

Men End FGM also provided examples of how traditional leaders' extensive network and relations may benefit FGM/C prevention efforts in other ways, facilitating connections with national-level actors. They engaged with traditional leaders, and more precisely elders, at the national level to make public statements and declarations against FGM/C (Mwebia, 2023a). These public statements are very beneficial for the abandonment of the practice. Tony Mwebia explains that it is impossible to stop the practice if the whole community is not against it (Mwebia, 2023b). These public statements and discussions among leaders allow them to convert more people and rally everyone to the cause. To illustrate this, the National religious leader's Summit of 2018 in Nairobi, Kenya can be mentioned. This summit brought together Muslim leaders and scholars, but also Christian leaders to coordinate and discuss the ongoing efforts to fight FGM/C in Kenya (Mwebia, 2019). The discussion was about what is working and what needs to be improved and to “initiate the process of developing a National Plan of Action on the role of religious leaders in ending FGM/C in Kenya” (Mwebia, 2019).

Local grounding and context knowledge

In the interview, Amref also referred to religious and traditional leaders' context knowledge and their ground presence in the communities. Denge Lugayo mentioned in particular local leaders' knowledge of where harmful cultural practices are happening, and which village or household is still practising them (Lugayo, 2023). This knowledge is useful to intervening actors such as Amref, providing them with information on where they should intervene next or if previous interventions have not had the desired effect and people continue the practice. As such, local leaders can help monitor the situation, when the outside actors leave the community (Lugayo, 2023). They can share follow-up information with the organisation and ensure continuous implementation and improvements.

This is what Amref is doing with religious and traditional leaders: when an FGM/C project ends, local leaders and project coordinators establish a "child protection committee" (Lugayo, 2023). They help report cases of girls at risk of FGM/C, and they can also link victims or potential victims of FGM/C to shelters, or other helpful actors (such as healthcare professionals in case of health complications after the cut) (Lugayo, 2023). Thus, these leaders become an extension of the intervening organisation to ensure long-term protection for these girls and useful allies in the intervention by their continuous engagement, even when the organisations leave. They also sometimes continue to share messages and advocate against the practice to constantly remind people about the negative aspects of the practice and keep the discussion on the issue ongoing.

This rationale has also been mentioned by Men End FGM. When their training is over, Men End FGM leaves the community. Religious and traditional leaders are thus expected to continue the sensitisation and advocacy against the practice in their community as some people might not be convinced after just a few days of training and need constant discussion about the issue to be converted. However, this rationale is not always an argument. Sometimes Men End FGM cooperates with external religious leaders from a community to sensitise them (Mwebia, 2023b). So, when the training is done, they leave the community, leaving the community without a religious leader to monitor the conversion of the community.

As mentioned previously, religious and traditional leaders can sometimes be a hindrance to FGM/C prevention efforts. In some cases, local leaders are sceptical or outright hostile towards external actors, (actively or passively) opposing interventions and encouraging their community to continue the practice. Therefore, trust in the cooperating leaders is essential to guarantee a reliable follow-up and a safe link between the organisation and the community.

Men End FGM sometimes faces similar cases, where the leaders do not agree to stop the practice. Tony Mwebia also mentioned cases of false engagement in some communities, confirming Tolo Østebø and Østebø's (2014) comment in their study on working with religious leaders in Ethiopia, mentioning cases of “pretended acceptance” (Mwebia, 2023b). He describes religious or traditional leaders agreeing to stop the practice in English or Swahili and then switching to their vernacular language to address their community telling them not to listen or worry about the organisation (Mwebia, 2023b). Because these leaders are respected, they cannot do anything about it, even if they are aware of it (Mwebia, 2023b).

Yet, in general, both organisations are successfully welcomed by the communities. Amref and Men End FGM engage with communities to tackle challenges the community raised itself and is “comfortable to talk about” (Lugayo, 2023; Mwebia, 2023b). By doing so, they get to earn the trust of the community and when they discuss later FGM/C the community is willing to listen to them. In some cases, it is even the community itself raising this issue, once their priority issues have been dealt with (such as clean water or education) (Lugayo, 2023).

Gatekeepers

Finally, the last rationale mentioned, although by Men End FGM only, is the role of religious and traditional leaders as gatekeepers of their communities. Tony Mwebia mentions the position held by elders in some African communities: they are custodians of the culture (Mwebia, 2023a). Therefore, Men End FGM identifies them as being “key people” in the decision-making process, and thus essential to cooperate with. Some communities believe that elders have superpowers, being able to curse individuals if they do not respect their will (Oloo et al., 2011). So, Men End FGM encourage them to make public declarations and speak up against the practice so people know they will not be cursed if they abandon FGM/C because this decision is supported by the elders (Mwebia, 2023a).

5.3.3. Their Types of Engagement

The previous chapter identified three overall approaches to engagement with religious and traditional leaders: the health risk approach, the gender-equality approach and the theological/scriptural approach. In the following, the approaches of Amref and Men End FGM are discussed considering these three approaches.

Gender equality or health risks approach?

The discourse used to sensitise FGM/C is an interesting discussion. There are diverging opinions on this topic among FGM/C prevention actors, and Amref and Men End FGM have slightly different practices.

Men End FGM explicitly employs a human rights language in their discourses on FGM/C, avoiding use of the health risk language alone (Mwebia, 2023a). Their rationale for this decision is linked to the increasing medicalisation that has arguably been a result of the health risk discourse, as mentioned above (Mwebia, 2023a). Men End FGM shows men and male champions videos of the actual cutting for them to see how it is done (Mwebia, 2023a). These videos are meant to create a shock and to show men what they are normally not able to witness (Mwebia, 2023b).¹⁴ The videos allow the participants to “digest” the information as they want and not only list the existing health risks: they can see some of them such as excessive bleeding (Mwebia, 2023b). Some challenges for this approach are in relation to religious leaders. In some of their trainings, some religious leaders left the room because it is prohibited for them to see women’s bodies and nakedness (Mwebia, 2023b). However, their training tries to focus on the human rights approach (Mwebia, 2023b). Their trainings not only mention FGM/C, but other forms of gender-based violence and related issues (Mwebia, 2023b). So, they discuss the different human rights violated, the need for girls to stay in school for them to get a job and support their families, child marriages and so on (Mwebia, 2023b).

This choice can be justified by the positive results demonstrated despite the risks of orienting the community to health practitioners to practice the cut. Indeed, as Le Roux and Bartelink state: “the literature on interventions also suggests that public health information is part of successful faith leader engagement” (Le Roux & Bartelink, 2017: 20).

Amref, for their part, is a health-related organisation and as such could be expected to rely on a health risk discourse. In the interview, however, Denge Lugayo did not explicitly use a health risk discourse but explained that they have discussions on the “dangers of FGM/C, what it does, the effects it has on the women, the dangers of marrying a young girl early” (Lugayo, 2023). In their 2021 Annual Report, Amref mentions the implementation of a “comprehensive sexual education” (Amref Health Africa in Kenya, 2021: 46). Thus, it can be interpreted that they use the health risks approach based on these elements. But the organisation also relies on a human rights approach as well. The discussion on the dangers of child marriage

¹⁴ To see men’s reactions after watching the videos: Use of Visuals (films and photos) to Educate Male Champions about FGM #MenEndFGM YouTube channel (<https://youtu.be/Stp26JEkLAE>).

that Amref also has with local leaders and their communities is related to broader human rights topics, including women's and girls' rights, gender discrimination, and sexual and gender-based violence (Lugayo, 2023). They developed a Country Gender Transformative Toolkit and shared it in the Turkana and Samburu counties for them to continue the implementation of gender programmes (Amref Health Africa in Kenya, 2021: 68).

This topic is thus debated, benefits are recognised in both approaches, and challenges are identified in both approaches as well. Some organisations focus narrowly on one approach; Le Roux and Bartelink, for instance, note that all five organisations studied in their report (Tearfund, Christian Aid, Islamic Relief Worldwide, World Vision International, and Joint Learning Initiative/ABAAD) primarily use the health risks approach (Le Roux & Bartelink, 2017: 3). And other organisations, such as Men End FGM (to a certain extent) and Amref, combine the two approaches. Amref implements both the health risks and gender-equality approach. Its interventions sensitise on health complications after undergoing the cut, but also on gender equality and the relation between FGM/C and other harmful practices such as child marriage. Men End FGM uses videos of the procedure but emphasises the human rights approach (as they not only talk about gender discrimination but also other rights at stake like the right to health).

Theological approach

As described above, the theological/scriptural approach can be useful in engaging with religious leaders, insofar as it can contribute to delinking FGM/C from religious norms and traditions, and it can facilitate a “translation” of scientific health concerns and secular human rights norms into a religious language. Le Roux and Bartelink (2017) note that this approach is primarily relevant for faith-based NGOs since it requires a certain degree of religious knowledge and legitimacy (Le Roux & Bartelink, 2017: 21).

Amref and Men End FGM are both secular NGOs. This approach has not been mentioned in the interview with Amref. But it has been mentioned with Men End FGM.

Tony Mwebia mentioned that it is important to have a conversation with religious leaders to teach them that the perceived link between FGM/C and the Quran or the Sunna is a “misconception” (Mwebia, 2023a). They hope to be able to engage in such conversations with religious leaders for them to spread the message because they have the understanding of religion to talk about it and are legitimate to talk on that matter (Mwebia, 2023a). Tony Mwebia

mentioned that when FGM/C is linked with a religion, it is only with Islam, in Christianity, FGM/C is just a cultural thing (Mwebia, 2023b). Therefore, they mainly engage with Sheikhs.

However, Men End FGM do not engage in a theological approach per se. They do not train religious leaders but identify already converted religious leaders. These converted leaders, trained by organisations such as UNICEF or World Vision, are often well-known because they are already engaging in anti-FGM/C efforts: they participate in gathering on the issue and make public declarations (Mwebia, 2023b). So, Men End FGM engages with them and uses them as resource persons to train other future trainers on FGM/C and other related issues (Mwebia, 2023b). Whenever Men End FGM has a conversation in a community with a religious composition, they make sure to bring a religious leader into the conversation to speak about the religious aspects of the practice and “why it is not a religious issue” (Mwebia, 2023b). They also bring them to vernacular radio and TV stations to “speak to the masses” (Mwebia, 2023b).

Tony Mwebia agrees with Le Roux and Bartelink’s position on this approach: it is only applicable to faith-based organisations. Therefore, they only cooperate with trained and converted Sheikhs and work with them to influence other Muslims to join anti-FGM/C efforts. Tony Mwebia says:

“There is no way I can go and pretend to be a sheikh and start telling people about the Islamic religion. They will not listen to me. [...] There is no organisation that will go to speak to the Muslims and just go with a project. It will never work. You have to go with someone they respect, and they respect the sheikh. So, either you find a sheikh and now use them as a resource person to help bring the conversation around religion.” (Mwebia, 2023b).

This supports Le Roux and Bartelink’s argument that non-faith-based organisations do not have the required legitimacy to talk and teach about religion (2017: 21). However, as Men End FGM does, they can engage with external religious leaders and experts to do so. These leaders and experts can share the message and train other leaders or individuals for the conversation to make sense and be listened to. This allows secular organisations to sensitise on the religious aspects of the practice which can be essential in some communities.

5.3.4. Their Activities

The rationales and approaches are reflected in the concrete activities of Amref and Men End FGM in different ways. Both organisations engage in various activities in their actions towards FGM/C abandonment. The following section describes some of these activities in more detail, providing concrete examples of how engagement with religious and traditional leaders can look like in a particular context, relating these activities to the rationales and approaches described above and discussing some of the strengths and weaknesses related to these concrete forms of engagement.

Community-led dialogue

At the most fundamental level, the interventions of both organisations can be described as “community-led”. They do not impose their view on the communities, deciding what should be dealt with in interventions, but engage in a dialogue to design interventions that are relevant to – and accepted by – the community. As noted by Tony Mwebia, it is important to bring the conversation into the community, “under the tree” (2023a).

In this, the role of religious and traditional leaders as gatekeepers and facilitators of context knowledge is important. Amref and Men End FGM engage both religious and traditional leaders from the start of their community-led activities, facilitating the community’s acceptance of external intervention.

Amref, for instance, started working on FGM/C in some communities based on a request from the communities themselves, communicated through their local leaders. Amref was already working with numerous communities in Kenya on other topics such as education and health prevention (Lugayo, 2023). The organisation has been operating in Kenya since its foundation 60 years ago (Lugayo, 2023); it is a trusted organisation on the ground and its interventions are widely known and accepted by local leaders (Lugayo, 2023). The fact that the issue of FGM/C and child marriage was raised by the local leaders and the community themselves opened up for discussion on these issues (Lugayo, 2023). Thus, they did not face any resistance, just a slower process of engagement from rural and less educated communities (Lugayo, 2023).

In addition, for both organisations, FGM/C is not the only issue dealt with. It is part of bigger interventions that also address other challenges in the community. Those interventions are called community vision in the case of Men End FGM. These interventions can include

infrastructures, lack of electricity or water, famine, and so on. This can also prevent fatigue from FGM/C discussions; as noted by Tony Mwebia, for many people, FGM/C is not necessarily a priority and broader interventions that also tackle other issues may thus encourage broader support from communities. Once these issues have been solved or diminished, the communities may be more willing to engage in other issues such as FGM/C and teenage pregnancies or child marriage (Mwebia, 2023a). Interventions are then designed and agreed upon in cooperation with the community (Mwebia, 2023a). This confirms Varol's supposition that "[a]ddressing communities' priorities would be an important gateway to earning their trust and working with men and women towards the abandonment of FGM" (Varol et al., 2015: 12).

Training of leaders

Training is an important component of both organisations' engagement with religious and traditional leaders. Both organisations start their interventions with training for the local leaders. They sensitise them to the consequences of the practice and its underlying causes, so they better understand the practice. Through the training, the organisations encourage the leaders to form their own opinion on FGM/C and to advocate against the practice based on their new knowledge. Their authority and network can be helpful to spread this information on FGM/C to the entire community.

Amref has trained 71 chiefs and assistant chiefs for the last four years in Kenya (Lugayo, 2023). The training includes information and discussions on the dangers of FGM/C, what the practice consists of, its effects on women and other information related to the practice in itself, but also broader issues related to FGM/C such as child marriage and the implications (Lugayo, 2023). Men End FGM also meets with what they call male champions, which includes religious and traditional leaders, and trains them on the issues they would like to solve in their community (Mwebia, 2023a).

Once the leaders are trained, they are expected to use their position as authorities who can communicate messages to a large audience with legitimacy and power, e.g. by sharing the information, engaging in discussions with the community, training them, giving advice on the issue and so on. To facilitate this, Men End FGM engages religious and traditional leaders in their "campus dialogues", introduced in 2022. These dialogues bring together different actors with knowledge of FGM/C to answer people's questions on topics related to FGM/C (Mwebia, 2023a). These interventions allow for continuous conversations on the topic, even when the organisation leaves the place. For example, Amref links the trained religious and traditional

leaders to villages to have discussions with the people, monitor the cases of gender-based violence and ensure follow-up conversations with them (Lugayo, 2023). This engagement is continuously done until the communities are declared free from FGM/C because the chiefs and leaders have taken the tasks and successfully addressed the issue with the community (Lugayo, 2023).

Alternative rites of passage

For Amref, the development and implementation of alternative rites of passage (ARP) is also a central part of their FGM/C prevention efforts. Men End FGM is not involved in this type of activity.

As briefly noted in the previous chapters, ARP is a common activity in the field of FGM/C prevention. The purpose of ARP is, as the name implies, to design community rituals that can serve as alternatives to FGM/C, marking the transition from childhood to womanhood in ways that do not cause harm and violate the rights of the girls and women involved. In this, religious and traditional leaders can play an important role; by their recognition of the new ritual and its value, they can contribute to the community's acceptance and use of the ritual.

Denge Lugayo describes ARP as “a process of engagement”, bringing the whole community – including the local leaders – through a discussion on harmful cultural practices (Lugayo, 2023). After the training, girls receive information on helpful resources and where they can find them: where can they find a shelter, who can help them, and what can they do if they face challenges (Lugayo, 2023). Often, they are encouraged to reach out to the religious and traditional leaders they know. Amref specifically links them to chiefs, village elders, and governmental support so they can reach out to them for support (Lugayo, 2023). Then, a celebration is organised which brings the whole community together to celebrate the transformation of the girls and their transition through education, without the cut (Lugayo, 2023). Community leaders, chiefs and other stakeholders are part of this celebration, and the cultural aspects of the ceremony are maintained (Lugayo, 2023).

After the training, Amref follows up the girls with a tracking tool because they can still be subjected to the cut. They track them until they reach university and are old enough to take their own decisions (Lugayo, 2023). It has not been mentioned in the interview, but religious and traditional leaders might be part of this follow-up as they are linked to the girls since their ARP's graduation. Therefore, their local grounding is necessary to implement such activities.

Only having external leaders come into the community would not allow this long-term monitoring.

Media communication

A final activity worth mentioning here centres on communication, drawing on religious and traditional leaders' extensive networks and authority, not only in the community but in broader society. Using radio and other local media, Men End FGM encourages different actors to speak about FGM/C, facilitating the spread of FGM/C prevention messages (Mwebia, 2023a). They bring religious and traditional leaders to talk about religious and cultural aspects of FGM/C, but also other actors to engage on other related topics related to FGM/C, such as legislation, policies, psychological consequences, psychosocial consequences, and so on (Mwebia, 2023a).

Having these religious and traditional leaders actively engaging against the practice and agreeing to go talk on local radio and TV stations is proof of their real engagement and of the success of Men End FGM interventions (Mwebia, 2023b). When they agree to go talk about FGM/C on the radio and TV stations, it shows their involvement and genuine engagement towards the abandonment of FGM/C: "It is very powerful when someone is out there speaking to the whole community, it really shows that they are [...] really convinced, that's why they are out there sharing the message" (Mwebia, 2023b).

This type of activity can also contribute to much broader awareness-raising than the local community. Men End FGM's online campaign #MenEndFGM is partnered by the United Nations in the context of their 2023 campaign on the theme Partnership with Men and Boys to Transform Social and Gender Norms to End FGM (United Nations, 2023). This hashtag is used worldwide and reached more than 6.8 million people (Mwebia, 2023b). Other countries showed interest in their programmes and requested Men End FGM to expand their activities to their country (Mwebia, 2023a).

5.4. SUMMING UP

Historically, FGM/C has been widely practised in Kenya. With the introduction of legislation condemning the practice, the number of cases has greatly decreased in the past decades, but projected numbers still estimate over 475,000 girls at risk of being cut between

2022 and 2030 (UNFPA & UNICEF, 2022: 16). The practice is not consistent throughout Kenya but varies between communities. Thus, the field of FGM/C prevention is vast, including a wide range of international organisations and NGOs as well as governmental and civil society actors. Their interventions are diverse, ranging from advocating for the criminalisation of the practice to changing socio-cultural norms. Many actors work with religious and traditional leaders to prevent FGM/C, reflecting the important role that these leaders play in encouraging, maintaining, and legitimising social norms and traditions in local Kenyan communities.

Amref and Men End FGM, two Kenyan organisations, engage with religious and traditional leaders in their intervention against FGM/C. Both organisations have similar rationales for engaging with them. They recognise their authority, their network and communication channels, their local grounding and knowledge and their role as gatekeepers of the community. Based on these rationales, both Amref and Men End FGM engage in activities such as training and sensitisation of religious and traditional leaders and community-led dialogues. Beyond these common activities, however, their engagement diverges. Amref is very active in implementing ARP in communities in cooperation with religious and traditional leaders. Men End FGM is very active in the media. They bring religious and traditional leaders to talk about FGM/C and other gender discriminatory practices on local radio and TV stations.

Amref and Men End FGM's interventions in Kenya show the diversity of engagement with religious and traditional leaders on FGM/C and confirm the relevance of Le Roux and Bartelink's study (2014) on this topic. Both organisations built their activities on similar rationales but implement it sometimes in a different way. There is no consensus on only one scheme of intervention. This illustrates the complexity of FGM/C and the difficulty of the abandonment of the practice. However, both organisations have positive results. Amref declared some communities free of FGM/C and Men End FGM online campaign #MenEndFGM is used by the United Nations.

6. CONCLUSION AND PERSPECTIVES

Female genital mutilation/cutting is a serious human rights violation that affects millions of girls and women around the world. As discussed in the thesis' first chapters, recent decades have witnessed increasing attention to the practice, and various initiatives have been implemented to push for its eradication. An increasing number of countries have introduced legislation to ban the practice. But while criminalisation is important and necessary, it is rarely enough. FGM/C is a complex issue: the ways in which the practice is carried out, the actors involved and the underlying reasons for the practice vary, not only from one country to another but also between communities. Furthermore, it is a practice that is often deeply engrained in local cultural and religious norms and traditions, requiring sustained efforts to change these. As such, anti-FGM/C interventions have to be tailored in a way that is locally relevant and “sensitive to the local realities” (Mehari et al., 2020: 34). In this, cooperation with religious and traditional leaders can play an important role.

Based on desk studies, Chapter 4 of the thesis analysed the role of religious and traditional leaders in FGM/C prevention efforts, exploring FGM/C prevention actors' rationales for, and approaches, to cooperation with these actors. This study found that religious and traditional leaders are seen - by both researchers and practitioners in the field – to be able to contribute in important ways to FGM/C prevention. Their respected position gives them authority and legitimacy. Their decisions are respected, and they can exert their influence on the community to follow their position. As gatekeepers of their community, they have the power to reject or accept external actors who want to engage with their community and implement their interventions. Through their position, religious and traditional leaders inherently possess a platform allowing them to easily share messages with their community. This can be through their churches or other religious institutions for religious leaders or through everyday conversation with the community for example for traditional leaders, or if they are part of a council. Sometimes, these leaders are often linked to leaders in other communities such as the Council of Traditional Leaders of Africa (COTLA) which is a network spreading to the whole African continent. By cooperating with them, interventions can be more accepted by the communities as the change would not be imposed, but recognised as beneficial for them by the leaders, by their knowledge of the local context, and will thus come from within the community, with the external actors only helping to achieve their goals. Finally, they remain at times the ones maintaining the practice due to it being considered an integral part of their community's

identity and history. Rallying religious and traditional leaders to the cause can help families already questioning the practice to stop as social pressure will decrease by having these leaders opposing the practice. These rationales shape the different approaches and activities used by the organisations working towards the end of FGM/C. Three main approaches have also been discussed in this chapter. The health risks approach emphasises the health complications of the practice, the gender equality approach's goal is to reach gender equality and to change the socio-cultural norms sustaining FGM/C, and finally, the theological/scriptural approach aims at de-linking FGM/C from religion. These approaches are not mutually exclusive and are often used in combination with one another.

Chapter 5 of this thesis presented a case study of two Kenyan NGOs who cooperate with religious and traditional leaders as part of their FGM/C prevention efforts. Based on interviews with representatives from the two Kenyan NGOs, as well as analysis of their websites and other organisational material available online, the thesis analysed their rationales for and approaches to, this cooperation, discussing how they relate to the broader rationales and approaches identified in the previous chapter. The analysis found that their rationales for engaging with religious and traditional leaders correspond to the ones mentioned previously, respectively their authority, their network and communication channels, their knowledge of the local context and their local grounding, and their position as gatekeepers. Their activities are similar, but still remain very different. Both organisations engage in community led-dialogues, training and sensitisation on the topic. Men End FGM uses vernacular radio and TV stations to sensitise and advocate against the practice, while Amref sensitise the communities in the process of the alternative rites of passage they organise. Their discourse is based on the human rights approach (with attention to the gender equality approach but not only). Men End FGM also uses video of the procedures in their trainings but tries to avoid using the health risks approach to prevent medicalisation. Amref, on the other hand, is supposed to engage more with the health risks approach. Men End FGM engages in a similar approach to the theological one: they engage with already trained religious leaders for them to train other leaders using sacred scriptures. However, they consider that they do not have the legitimacy to train these religious leaders themselves as they are a non-faith-based organisation. This is in line with Le Roux and Bartelink's (2017) recommendations. Both organisations consider their cooperation with religious and traditional leaders successful. Some of the communities Amref engages with are now declared FGM/C-free. Men End FGM also successfully convinced religious and traditional leaders to oppose the practice and speak out against it, e.g. on local radio stations, despite FGM/C being widely considered a taboo topic. Again, however, it should be emphasised that I

have not had a chance to observe the organisations' efforts on the ground, nor have I had access to any external evaluations, and as such, the present analysis cannot make any conclusions as to the actual success of the organisations' work.

In my desk studies as well as my interviews, I have not focused systematically or extensively on the identification of challenges that may arise from cooperation with religious and traditional leaders. However, to conclude the analysis, let me point to some of the challenges that this type of engagement may present. It is not within the scope of the present thesis to answer the questions that these challenges present, but with my final reflections, I hope to encourage others to engage in further analysis and discussion around the potential challenges of cooperating with religious and traditional leaders in anti-FGM/C efforts.

One obvious challenge turns on the question of religious and traditional authority. As noted by Tony Mwebia, the fact that leaders enjoy great authority in their communities not only means that they have the authority to encourage and support FGM/C prevention efforts; it also means that they have the authority to stop or nullify these (Mwebia, 2023b). If a leader opposes an intervention, there is nothing Men End FGM can do to convince the community to stop the practice; the leader's authority is greater than that of the NGO, and the community will follow their incentives and continue to practice FGM/C despite the intervention.

Another challenge concerns what Tony Mwebia referred to as the 'pretended commitment' of some religious and traditional leaders. Leaders may pretend to commit to supporting anti-FGM/C interventions when they talk to the NGO but will continue encouraging the practice when they talk to their community. This is in line with Tolo Østebø and Østebø's (2014) findings when they interviewed local NGO representatives about the use of Muslim leaders in anti-FGM/C interventions in Ethiopia who questioned the authenticity of the involvement and public declarations of some religious leaders (Tolo Østebø & Østebø, 2014: 17). This information is a small but interesting addition to our knowledge of the challenges that may arise from working with religious and traditional leaders in FGM/C prevention efforts, and something that deserves further investigation in future research.

A third challenge which is often mentioned in research on religious and traditional leaders – but which did not seem to be an issue for the two NGOs analysed in this thesis – is the risk that this type of cooperation may have an overly “one-sided focus on male religious leaders in [anti-FGM/C] interventions” (Tolo Østebø & Østebø, n. d.: 4). Indeed, religious and traditional leaders are mainly male in most of the African countries (Orubuloye et al., 1993: 97; Rafiq et al., 2022: 3). This means that there is a risk of “silencing and marginalising women's

voices” if interventions focus too much on these leaders (Tolo Østebø & Østebø, n. d.: 4). Indeed, by cooperating with religious and traditional leaders, interventions might inadvertently contribute to strengthening their power, legitimising patriarchal structures and relations. Taking into consideration that FGM/C is typically practised in patriarchal communities with “rigid norms of masculinity” (Greene & Fahmy, 2023: 6), there is a risk that if male leaders are involved, they might take the lead in the conversation, and impose their views, replicating unequal power relations (Mwendwa et al., 2022: 107). This is problematic. FGM/C first and foremost concerns women’s body’s integrity, and as such, women should have the first and last word on the matter. Male religious and traditional leaders could also shape anti-FGM/C interventions in unfortunate ways and take women out of it. Male faith leaders can be hostile to women-led intervention efforts (Le Roux & Bartelink, 2017: 25), or even to the mere inclusion of women in some conversations. Mwendwa et al. (2022) did a study of men’s and women’s positioning on the involvement of men in FGM/C interventions. Here, numerous men mentioned the taboo around FGM/C and their reluctance to discuss the topic with women and girls. One male interviewee said: “In our culture, it is shameful for men to discuss circumcision with women and girls. The best way is to talk to men separately about this issue and women and girls separately because of a joint session? ... no... no... no... this is not good” (Mwendwa et al., 2022: 112). This could lead to women being embarrassed to open up in front of men (Mwendwa et al., 2022: 114) and being left out of the conversation. This enlarges the gap between men’s and women’s equality as well. Religious and traditional leaders’ conservative ways of doing this will affect the interventions as they would only discuss topics that they agree to discuss, and that they feel comfortable discussing. They will thus fail to address the important topics such as the underlying causes of FGM/C: patriarchal norms (le Roux et al., 2016: 25). Topics related to sexuality and gender discrimination will not be discussed, leaving the conversation to only concern medical consequences of FGM/C to appeal to men (Greene & Fahmy, 2023: 6).

Finally, and on a more general level, there is a risk that cooperation with religious and traditional leaders ends up overemphasising the importance of religion and culture in shaping and sustaining FGM/C practices. As discussed at the beginning of this chapter, attention to religion and culture in development and human rights interventions has grown since the 2000s. The importance of religion and culture has been widely acknowledged, and reflected, among other things, in the increasing cooperation with religious and traditional leaders, faith-based organisations, and other religious or culturally related actors. While this trend is a welcome corrective to earlier decades’ strongly secularist approaches, it is not without risks. As

Mwendwa et al (2022: 116) ask, is there a risk that human rights interventions are becoming “too sensitive” to culture and religion? They remind us that even though culture and religion are important to take into consideration, and respect, this should not be at the “expense of continued harm to girls in the community” (Mwendwa et al., 2022: 116). On a slightly different note, others point to the risk that an (over)emphasis on religion and culture may result in other factors being overlooked (Petersen & Le Moigne, 2016: 10). When analysing – or indeed seeking to change – social norms and practices, a range of other important factors need to be taken into account, including e.g. economy, nationality or politics (Petersen & Le Moigne, 2016: 10). Indeed, social norms and practices are shaped by a complex combination of multiple factors, of which religion and culture is only one factor. In her report on religion and gender equality, Marie Juul Petersen quotes a faith-based human rights activist for saying:

“I once talked to this religious leader who had worked tirelessly to combat practices of female genital mutilation (FGM) in his district. He had talked to local religious leaders and people in the communities and had explained again and again that there was no religious justification for this practice. And still, people kept practising FGM. In the end, he went to the women who were responsible for carrying out the ritual and asked them why they continued even when this was clearly not a religious obligation. ‘If we stop,’ they said, ‘how would we earn an income for our families?’” (Petersen, 2020: 23)

The quote illustrates that the economy plays an important role in sustaining the practice of FGM/C – and sometimes perhaps even a bigger role than religious norms and obligations. As such, anti-FGM/C interventions should not only focus on the religious and cultural roots of the practice but pay attention to the wide range of factors that may influence social norms and practices around FGM/C.

Despite these challenges, there is little doubt that cooperation with religious and traditional leaders can be an important element of (multi-dimensional) FGM/C prevention efforts. But much more research is needed to help us understand how, when, where, and why such cooperation will make sense. With this master’s thesis, I hope to have contributed – albeit in a small way – to that work.

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APPENDIX 1 – FIRST INTERVIEW QUESTIONS

1. Please present yourself and the organisation.
2. Are you a secular or faith-based organisation?
3. How are you funded? With whom do you cooperate?
4. How long have you worked with religious and traditional leaders?
5. What is your rationale for working with religious and traditional leaders? What do you hope to achieve? Why did you start working with religious and traditional leaders?
6. What kind of projects and activities do you implement?
7. Do you engage in long-term projects or short-term projects?
8. How do you talk about FGM/C with religious and traditional leaders?
9. What are the strengths of your approach?
10. What are the difficulties – and how do you overcome them?
11. How do you evaluate the project? What methods do you use?
12. Do you know other organisations that work with religious and traditional leaders on FGM/C? Do they use the same approach? Do you cooperate?

APPENDIX 2 – SECOND INTERVIEW QUESTIONS

1. What are the strengths and weaknesses of using the network and communication channels of religious and traditional leaders? Do you have concrete examples?
2. One commonly mentioned rationale for engaging with religious and traditional leaders is their local grounding and context knowledge. Is this also an important rationale for you? Why? What are its strengths?
3. Did you face opposition from some religious or traditional leaders?
4. Do you engage in a health risks approach other than with the use of videos showing the procedure?
5. How do you implement the human rights approach? What do you emphasise, which arguments do you use? What are the strengths and weaknesses of this approach?
6. Do you engage in a theological/scriptural approach? How do you implement it? What are the strengths and weaknesses of this approach? What is your position on Le Roux and Bartelink's statement?¹⁵
7. What are some challenges you face when cooperating with religious and traditional leaders?

¹⁵ Le Roux and Bartelink state that this approach is only relevant for faith-based NGOs since a certain degree of religious knowledge and legitimacy is required (Le Roux & Bartelink, 2017: 21).