THE STATE OF KENYA POPULATION 2020

"Zero Harmful Practices – Accelerating the Promise of ICPD25"

JUNE 2020

GOVERMENT OF KENYA

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FOREWORD

Kenya, through the National Council for Population and Development (NCPD) publishes the State of Kenya Population Report each year to domesticate the global theme of the State of World Population Report. The report affords readers an overview of the Kenyan situation within the context of the annual global theme.

The State of Kenya Population Report, 2020focused on getting to zero harmful practices with a special focus on marriage and motherhood in childhood; Female Genital Mutilation (FGM) and son preference. During the Nairobi Summit on ICPD25, Kenya made commitments towards accelerating the promise on zero harmful practices and committed to eliminating, by 2030, all forms of Gender Based Violence (GBV), including child and forced marriages, by addressing social and cultural norms that propagate the practice while providing support to women and girls who have been affected.

Child marriage has negative outcomes for both boys and girls, but girls are more adversely affected by this practice because in most cases they have to leave school and begin motherhood when they are not mentally and physically ready for motherhood experience. Their lives may be threatened with disease and death resulting from pregnancy and child birth. This harmful practice is therefore a threat to the development prospects because it prevents many girls from achieving their full potential and participating in social and economic activities that can improve their wellbeing.

Son preference is a product of gender-biased systems that assign and reinforce higher social status to men and boys and that favor male over female children. From a human rights perspective, gender-biased sex selection is a harmful practice because it translates a preference for boys over girls into a deliberate prevention of female births.

Ending discrimination against women and girls is not only an inalienable human right but the key to the social progress and economic development of Kenya. GBV and harmful practices such as FGM and child marriage are hindrances to achieving gender equality. The Sustainable Development Goals (SDGs), especially Goal 5 on Gender Equality, cannot be realized if progress is not made in this area.

Clearly, the propagation of harmful practices stands to prevent Kenya from achieving a demographic dividend and the noble goals set in the Kenya Vision 2030, Big 4 Agenda, Population Policy for National Development, and the ICPD25 Kenya country commitments among others. It is therefore imperative that harmful practices be publicized and addressed with a view of ending them.

Finally, the National Council for Population and Development hopes that this report will prove to be a useful resource to all the actors in the population sector involved in efforts to end all harmful practices thereby putting the country on track towards to achievement of her development goals and improve the quality of life for all citizenry.

Hon. (Amb). Ukur Yatani, EGH.
Cabinet Secretary,
The National Treasury and Planning

June, 2020

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The technical team, under the leadership and coordination of the NCPD Director Technical Services (DTS), Mr. Peter A. Nyakwara played a critical role in the compilation of this document and coordination of the entire process. Special thanks go to Ms. Lucy Kimondo; Mr. Nzomo Mulatya, Mr. Francis Kundu, Ms. Fidelis Ndung'u, Mr. Ken Lwaki, Ms. Irene Muhunzu, Mr. Morris Gitonga, Mr. Ezekiel Ngure, and Ms. Loise Alix for their efforts in ensuring the production of this timely and good quality report.

The Council renders special recognition to the internal and external reviewers of the report for the valuable professional support provided during the process. To all who contributed in one way or another to the development of the SKPR, 2020, we say thank you. This report will serve as a key reference document for policy makers and programmes across the country.

Dr. Mohamed A. Sheikh
Director General
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June, 2020

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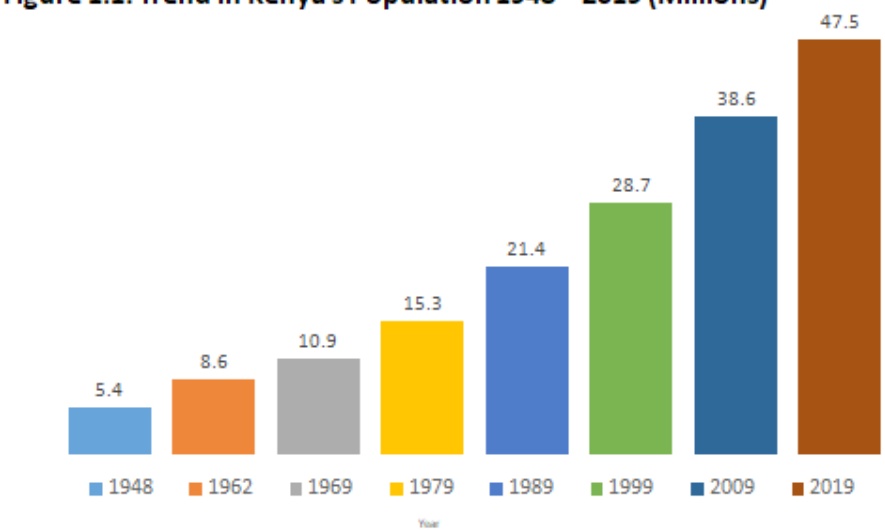
CHAPTER ONE

Demographic Situation of Kenya

1.1 Population Size and Structure

Kenya's population was enumerated at 47.6 million in 2019 with an inter-censual population growth rate of 2.3 percent. This was an increase of about nine million over the 38.6 million enumerated in 2009. From independence in 1963 up to 2019, the country's population increased five (5) fold as shown in Figure 1.1. The population is dominated by young people with those below age 15 making up for 39 percent of the population. Compared to 2009, the proportion of this population decreased from 43 to 39 percent. From the 2019 census, Kenya's labor force (15 – 64 years) accounts for 57 percent and youth constitute 29 percent of the total population. The elderly (age 60 and above) are 6 percent of the total population.

Figure 1.1: Trend in Kenya's Population 1948 – 2019 (Millions)

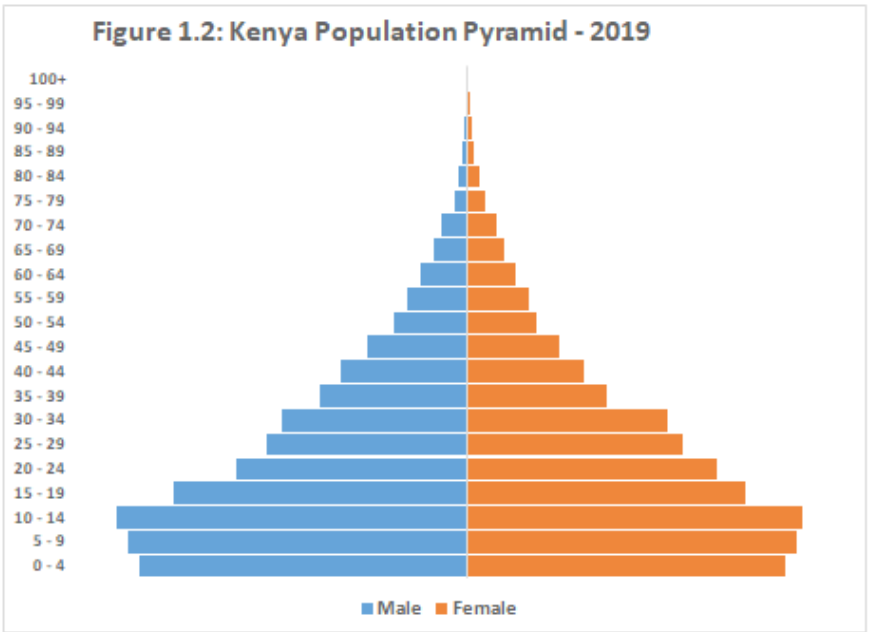


Source: *Kenya Population and Housing Censuses (1948 – 2019)*

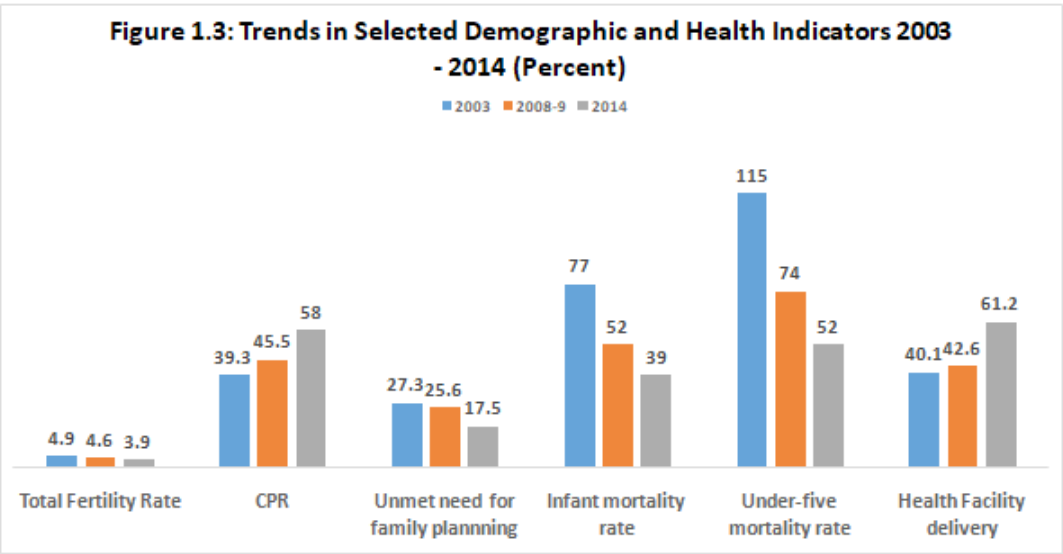
According to the census, Kenya had 918,270 people aged 5 years and above living with a disability. More females than males had disabilities. The common types of disability found in the country during the census were mobility (385,417) and visual impairment (333,520). A total of 9,729 persons had some form of albinism.

Kenya's 2019 population pyramid shown in Figure 1.2 is typical of a population that is dominated by young persons. This pyramid shows that the population of those in the age cohort 0-4 and 5-9 years is less than that of those in the 10-14 years cohort. This is a clear signal of the country's declining fertility over the years and hence a reduction in the proportion of the population below 15 years when compared to previous censuses. In 2019 it was estimated that 75

persons in the dependent ages (0-14 and those above 64 years) are supported by 100 persons in the working ages.



Source: *Kenya Population and Housing Census 2019)*



Source: *Kenya Demographic and Health Survey, 2003, 2008/9, and 2014*

1.2 Population Dynamics

Figure 1.3 indicates that Kenya experienced a decline in fertility from 5 children per woman in 2003 to 4 children in 2014. This can be attributed to the increase in contraceptive use whose prevalence rose from 39.3 percent of married women in 2003 to 58 percent in 2014. The effect of increased contraceptive use and decline in fertility is the decline in population growth rate from 2.9 percent to 2.2 percent between 2009 and 2019.

Positive trends have also been witnessed with other population dynamics indicators such as infant and under five mortality rates which have declined substantially over the last two decades. This can partly be attributed to the increase in health service deliveries which improved from 40 to 61 percent over the same period.

Overall, the positive performance of the above population dynamics indicators shows that the implementation of Kenya's Population Policy for National Development is on course and the country is moving towards the goal of matching the population growth rate to the available resources for sustainable development.

1.3 Population Distribution and Density

There is a substantial variation in the size and spatial distribution of populations in the counties. The five Counties with the highest population are Nairobi City (4,396,828), Kiambu (2,417,600), Nakuru (2,162,107), Kakamega (1,867,539) and Bungoma (1,670535) while the five Counties with the least population Lamu (143,916), Isiolo (267,993), Samburu (310,320), Tana River (315,941) and Taita Taveta (340,664). Some of the rural counties with high population densities (number of persons per square kilometre) are Vihiga with 1,047, Kisii with 958, Nyamira with 675, and Kakamega with 618 respectively. Marsabit County has the lowest density in the country of 6 persons per square kilometer followed by Tana River and Isiolo with 8 and 11 persons respectively. The patterns of the spatial distribution with regard to population density show that they remained unchanged between 1999 and 2019.

1.4 Effect of COVID-19 on Kenya's Population

Since the outbreak of COVID-19 on the world scene in December 2019, the first case in Kenya was reported in March 2020. By that time, thousands of people had fallen sick from the disease and some had died especially in China, Italy and Spain. Between December 2019 and March 2020, Kenya took several measures in preparation to combat the disease. These measures included training health workers, creation of COVID-19 treatment and quarantine centers, and educating the public on the disease. When the disease hit the country in March 2020 and the number of infections continued to rise alarmingly in Europe and America, further measures were implemented including closing down of learning institutions and certain types of businesses, restriction of movement across the country's international borders and across the borders of certain counties, and introduction of daily curfew hours.

The above measures were taken to minimize the impact of COVID-19 on Kenya's population in terms of number of infections and deaths. As of 1st July 2020, the total number of reported infections and deaths stood at 6,673 and 149 respectively representing a 2.2 percent death rate of positively diagnosed cases. More infections and deaths had been reported among men compared to women. At the beginning of July 2020, the global death rate from COVID-19 was about 4.6 percent while in some of the worst hit countries it was about 15.5, 14.4, 4.3, and 4.0 percent in United Kingdom, Italy, United States of America, and Brazil respectively. Though still at risk, Kenya's population has remained relatively safe for now from COVID-19 deaths.

On the flip side, measures to contain the spread of COVID-19 appear to have had a negative effect women and children, especially girls. From anecdotal sources, incidents of gender based violence are on the increase because many people have been forced to stay home longer thereby creating a situation where perpetrators and victims of gender based violence spend more time together. In addition to this, the closure of schools had led to an increase in pregnancies among school girls as a result of defilement or engagement in sexual activities since some spend quite some time

alone without parental or guardian supervision.

From the above, COVID-19 poses a threat to the gains made in improving the demographic indicators and quality of life of the population. More action is required to arrest the spread of this pandemic.

1.5 Demographic Dividend

Kenya has made several strides in an effort to achieve a demographic dividend from the large population of young persons in the country. The decline in fertility levels over the years is a good indication that Kenya is on the right path in creating conducive environment for a demographic dividend. To actualize this, a demographic dividend roadmap was developed in 2017 to guide the country in making strategic investments in the health, education and training, economic, and governance sectors with the aim of harnessing the potential of young people and accelerate socio-economic development that would ultimately lead to a better quality of life for the citizenry. In this regard, access to reproductive health information and services as well as to education and training opportunities for young persons is being improved countrywide. More employment opportunities are also being created and youth are continually being empowered to participate in governance at all levels.

With the above measures in place, Kenya is projected to achieve a demographic dividend for a period of 40 years starting from 2038. However, the advent of COVID-19 threatens to reverse the gains that have been made to harness the youth potential. Further, some harmful practices also threaten to impede the progress being made to enhance the role of women and girls in actualizing and benefiting from the anticipated demographic dividend. The State of Kenya Population 2020 report therefore gives attention to three harmful practices that affect women and girls mostly; child marriage, female genital mutilation/cutting, and son preference. These practices are highlighted with the aim of encouraging discussions and action to end these practices in harmony with Kenya's commitment made at the Nairobi Summit on ICPD25 to ensure "Zero Harmful Practices by 2030".

CHAPTER TWO

Harm and Human Rights

The criteria for determining whether or not a practice is harmful was laid down in a Joint General Recommendation issued by the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) Committees in 2014. The Committees described harmful practices as: persistent practices and behaviors that are grounded in discrimination on the basis of, among other things, sex, gender, age, in addition to multiple and/or intersecting forms of discrimination that often involve violence and cause physical and/or psychological harm or suffering. The harm that these practices cause to the victims surpass the immediate physical and mental consequences and often has the purpose or effect of impairing the recognition, enjoyment and exercise of the human rights and fundamental freedoms of women and children. There is also a negative impact on their dignity, physical, psychosocial and moral integrity and development, participation, health, educational, economic and social status.

Child/forced marriage and teenage pregnancy, Female Genital Mutilation (FGM), and Sexual gender-based violence (SGBV) and Son Preference are harmful practices determined by the CEDAW and CRC Committees that meet these criteria and recognized as human rights violations. There are provisions under international, regional and national law that prohibit harmful practices and oblige states to take measures to eliminate both harmful practices and their root causes. However, these practices remain common in Kenya with prevalence rates of 23 percent for child marriage, 18 percent for teenage pregnancy, and 21 percent for FGM (KNBS, 2015).

2.1 International Legal Framework

a. Convention on the Rights of the Child (CRC)

Right to protection from abuse: Article 19 of the CRC imposes the obligation to protect children from: All forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent (s), legal guardian(s) or any other person who has the care of the child. Forced marriage or child marriage is regarded as a form of violence against the child while subjecting a child to the rigors of motherhood before her body is ready for sexual activity and pregnancy.

Right to health: This is provided for in Article 24. State parties have the obligation to 'diminish infant and child mortality'. Article 24(3) obliges state parties to take 'all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children'. FGM, pregnancy, birth complications and medical conditions such as fistula reinforce child marriages as a 'traditional practice' harmful to the health of children. Son preference is a harmful practice that may lead to selective abortion or female infanticide. This practice denies the girl child good health, education, recreation, economic opportunity and the right to choose her partner.

Right to education: The primary duty of state parties embodied in Article 28 of the CRC is to ensure provision of equal education to children. Article 24(2)(a) of the CRC requires measures be taken to encourage regular attendance at schools and the reduction of drop-out rates. Both elements above cannot be achieved where communities practice child marriage because it is not feasible for a child to take care of family responsibilities and attend school at the same time.

Freedom from all forms of exploitation: Article 36 of the CRC requires states to protect the child from all forms of exploitation prejudicial to any aspects of the welfare of the child. This provision strengthens the argument that child marriage is a form of exploitation and in this case, it is sexual exploitation.

Right to state support after exploitation: Article 39 provides as follows: States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment. State parties

are required to put in place recovery interventions in order to realign children's lives. State parties must rescue children from harmful practices and then put them through a recovery process.

b. The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)

CEDAW entered into force in 1981 and is the premier binding instrument for the protection of women's rights under the UN human rights system. FGM is a violation of the principle of 'equality between men and women' administered on women based on sex and gendered discrimination. Article 1, CEDAW defines discrimination as any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women.

FGM is also a violation of the right to health as enshrined in article 12 of CEDAW. The extreme physical and psychological pain which FGM victims endure violates their freedom from 'degrading treatment' in violation of article 7 of the International Covenant on Civil and Political Rights. Child marriages violate article 16(2) of CEDAW, which states that 'the betrothal and the marriage of a child shall have no legal effect ...' and that necessary action should be taken to specify a minimum marriage age and to make the registration of marriages in an official registry compulsory.

CEDAW requires states parties to take all appropriate measures: to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women.

c. ICPD25 - Accelerating the Promise

The ICPD PoA on Gender Equality, Equity and Empowerment of Women focused on elimination all forms of discrimination against the girl child and the root causes of son preference, which results in harmful and unethical practices regarding female infanticide and prenatal sex selection. Governments were urged to prohibit female genital mutilation wherever it exists and to give vigorous support to efforts among non-governmental and community organizations and religious institutions to eliminate such practices. The PoA explicitly recognizes female genital mutilation as a violation of basic rights that must be prohibited. In commemoration of 25 years of ICPD in 2019, Countries re-affirmed commitment to deliver on the ICPD PoA and Sustainable Development Goals (SDGs). This includes striving to achieve zero sexual and gender-based violence and harmful practices.

d. 2030 Agenda for Sustainable Development (SDGs)

Gender equality (SDG 5) is an agreed goal under the 2030 Agenda for Sustainable Development, which also explicitly calls for ending all forms of discrimination, violence and harmful practices against all women and girls. Governments are required to put in place various interventions to address child marriage through collaborative efforts to support coordinated approaches to gender equality and the empowerment of all women and girls, including through the UNFPA/UNICEF Global Programme to Accelerate Action to End Child Marriage.

e. Maputo Protocol

The Maputo Protocol starts off by defining harmful practices as 'all behavior, attitudes and/or practices which negatively affect the fundamental rights of women and girls, such as their right to life, health, dignity, education and physical integrity'. Article 2(2) of the Protocol requires states to 'modify the social and cultural patterns of conduct of women

and men ... with a view to achieving the elimination of harmful cultural and traditional practices and all other practices ...' This must be achieved through education and other strategies of disseminating information at the initiative of states.

Under both international and regional law, children are regarded as incapable of giving their full and free consent to marriage and the marriage of children is therefore widely prohibited. Article 6(b) of the Maputo Protocol specifies that the minimum age of marriage shall be 18 years of age. Universal Declaration of Human Rights stated that "men and women of full age... have the right to marry and to found a family" and that "marriage shall be entered into only with the free and full consent of the intending spouses". Eighteen years later, that language was echoed in the International Covenant on Civil and Political Rights. The right to marry free from coercion and force is also embodied in the Women's Convention. Similarly, Article 5 of the Maputo Protocol, which mandates the elimination of harmful practices, contains an explicit reference to FGM in article 5(b).

State parties to the Maputo Protocol are required by article 25 to provide 'appropriate remedies' to women whose rights have been violated. In providing appropriate remedies, states are required to establish institutions to ensure that such 'remedies are determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by law.

f. The African Charter on the Rights and Welfare of the Child (ACRWC)

FGM and child marriage have also been recognized as harmful practices under the African regional human rights system. The African Charter on the Rights and Welfare of the Child (ACRWC) is the regional initiative for the protection of the rights of children in Africa. It came into force on 29 November 1999.Article 21 of the ACRWC provides States Parties to take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child. Article 21 contains a specific reference to child marriage in article 21(2). Articles 16 and 27 of the ACRWC prohibit child abuse and sexual exploitation.

2.2 National Legislation and Policy Framework in Kenya

A number of national legislation and policy frameworks have been put in place in Kenya to address child/forced marriage and teenage pregnancy, Female Genital Mutilation (FGM), and Sexual Gender-Based Violence (SGBV) and son preference. These legislations and policies are:

a. **Constitution of Kenya (2010)** prevents any person from compelling another person to 'perform, observe, or undergo any cultural practice or rite.' Children are also protected from 'abuse' and 'harmful cultural practices' under Article 53(1)(d) of the Constitution. This has seen enactment of legislations such as the Prohibition of Female Genital Mutilation Act (2011) and revision of the Children Act (2016).

   The constitution sets the minimum age of marriage and prohibits early marriage under the age of 18. The Marriage act of 2014 consolidates existing marriage laws into a single Act that provides guidelines on types of marriages in Kenya and minimum age for marriage. This helps to dissuade families and communities from marrying off their daughters as children.

b. **The Children Act (2016)** Article 14focuses on protection of the child against FGM, early marriage and other cultural rites. It Stipulates that "no person shall subject a child to female circumcision, early marriage or other cultural rites, customs or traditional practices that are likely to negatively affect the child's life, health, social welfare, dignity or psychological development". The Act aims at protection of children from retrospective cultural practices. It criminalizes child marriage and FGM. The Act safeguards the rights and welfare of the child against child abuse and sexual exploitation

c. **The Sexual Offences Act (2006)** is a comprehensive legal instrument that focuses on defilement and indecent acts that are specific to persons below the age of 18. The Act similarly proposes harsh penalties for offenders which range from 3 years imprisonment for sexual harassment to life imprisonment for defilement rape, attempted rape and gang rape.

d. **The Prohibition of Female Genital Mutilation Act (2011)** criminalizes all forms of FGM, regardless of the age or status of the girl or woman. It bans stigmatization of women who have not undergone FGM. It also makes it illegal to aid someone in performing FGM, fail to report a case to the authorities or carry out FGM on a Kenyan woman abroad.

e. **The Marriage Act(2014)**calls for registration of all marriages effectively granting women a legal basis for land ownership claims.

f. **The Matrimonial Property Act (2013)** protects women's rights to property acquired during marriage, and the Land Registration Act defers to it. The Land Act provides spouses some protections from having their home or land leased or sold without their knowledge.

g. **The Law of Succession Act (2012)** gives both male and female children the same inheritance rights.

h. **The National Gender and Equality Commission Act (2011**) seeks to promote gender equality and freedom from discrimination in accordance with Article 27 of the Constitution. It also provides a framework to co-ordinate and facilitate mainstreaming of issues of gender, persons with disability and other marginalized groups in national development.

i. **Persons with Disability Act (2003)** Has very progressive and responsive provisions to promote and protect the rights and freedoms of persons with disabilities both adults and children.

j. **The Population Policy for National Development (2012)** calls for tackling of harmful socio-cultural practices such as early marriages, FGM and nutritionally biased taboos that still exist in some communities by proposing a raft of measures such as Implementation of the Sexual Offences Act of 2006 and the Children Act, establishment of the Gender Based Violence (GBV) centers in public health facilities and development of guidelines on the management of rape and sexual violence.

k. **The National Policy for the Eradication of Female Genital Mutilation (2019)** focuses on strategies for the complete eradication of FGM in Kenya. These strategies include; strengthening multi-sectoral interventions, coordination, networking, partnership and community participation; addressing emerging trends and practices largely aimed at avoiding the enforcement of the law; addressing gender inequality by promoting the empowerment of girls and women; strengthening research, data collection, information and knowledge management on FGM.

l. **The National Policy towards Prevention and Response to SGBV (2014):** This policy puts in place a framework to accelerate implementation of laws, policies and programmes for prevention and response to GBV by state and non – state actors for the realization of a society where men, women, boys and girls are free from all forms violence.

m. T**he National Guidelines on the Management of Sexual Violence (2014):** provides a framework for the provision of services to SGBV survivors.

n. **County Government Policy on Sexual and Gender Based Violence (2017)** The policy provided the framework to be adapted by the counties in dealing with SGBV.

2.3 Recommendations

Human rights obligations are understood to require governments to respect, protect and fulfill the human rights of their populations. Because harmful practices often involve violence against girls and women, governments have an obligation to prevent, investigate and punish such acts, including when non-state actors, such as family members, perpetrate the violence (UN CEDAW, 2017, 1992). In this regard the following recommendations are made;

- Though the policy and legal environment in Kenya has improved and is progressive, the existing policy and legal framework ought to be embraced and implemented adequately by supporting enforcement programmes focused on the implementation of policies and laws against FGM/C, Early Marriage and Son preference
- There is need to make some amendments to some of the legal and policy provisions to respond to emerging challenges and gaps, and expand scope of acts to address some of the life-threatening conditions faced by women and girls e.g. "medicalization" and cross-border nature of FGM.
- The implementation of the policies and laws calls for multi-sectoral and inter-linkages across the sectors of health, education, social services, community leadership, law enforcement, private sector, civil society, legal and forensic. It is imperative to have an implementation framework that brings all these sectors together.

It is rarely due to the absence of laws that women and girls have their genitals cut, get forced into marriage, are fed far too much or too little, or are less desired as progeny. Effective measures to prevent and eliminate harmful practices must be part of a "well defined, rights-based and locally relevant holistic strategy", according to the treaty bodies that monitor adherence to the Women's Convention and the Child Rights Convention. The strategy should comprise laws, policies and social interventions "combined with commensurate political commitment and accountability at all levels".

CHAPTER THREE

Marriage and Motherhood in Childhood Undermines Girls

When a GIRL is married, her rights are violated. Her schooling ends. Childbearing in childhood begins. Opportunities evaporate. Doors to the future slam shut. Sometimes she is given away. Sometimes she is traded for something of value. Sometimes she is a burden off loaded onto someone else. Sometimes she is handed over to someone deemed to be capable of ensuring her security. But rarely, if ever, is she the one who makes the decision

3.1 Overview

Child marriage exist in all parts of the world and affects both boys and girls. However, this harmful practice adversely affects girls much more than boys because it robs girls of their education, health and long-term prospects. Child marriages undermine the lives and future of about 12 million girls worldwide every year. Most of the time, the children involved in these marriages do not have a say on the matter. It happens because girls are usually less valued than boys, and because poverty, insecurity and limited access to quality education and work opportunities mean that child marriage is often seen as the best option for girls (Girls Not Brides, 2019) or as a way for parents to mitigate the household's difficult economic circumstances. This practice is a violation of the human rights of girls and most times its consequences are costly and impossible to mitigate, correct or reverse. On the other hand, the elimination of child marriages will bring about great benefits to girls, families, communities and their countries. These benefits include empowerment of girls, better health and well-being, improved education attainment, increased labor force participation and incomes. It is because of this that the Sustainable Development Goals, under the United Nations 2030 Agenda for Sustainable Development, has prioritized the elimination of child marriages, and consequently motherhood in childhood, by the year 2030.

Kenya's Population Policy for National Development recognizes child marriage as a harmful practice perpetuated by diverse cultural and religious beliefs. High levels of adolescent fertility in the country are partly attributed to child marriage. Despite Government efforts and initiatives to curb this practice, it still exists in many communities in the country. During the Nairobi Summit on ICPD25 held in November 2020, the Government of Kenya recommitted itself to end child marriages and motherhood in childhood by 2030 using various strategies.

3.2 Global and Regional Prevalence of Child Marriage

In many countries worldwide, child marriage is still practiced though prohibited by law. About 33,000 children are affected by this practice every day throughout the year. It is estimated that over half a billion women living today were married when they were still children. Child marriage is closely tied to low levels of education, poverty and rural residence. Girls with only a primary education are twice as likely to be married or in a union than those with a secondary or higher education. Girls with no education are three times more likely to be married or in a union before age 18 than those with a secondary or higher education (UNFPA, 2012a). Child marriage has been shown to increase during humanitarian crises caused by natural disaster and conflict.

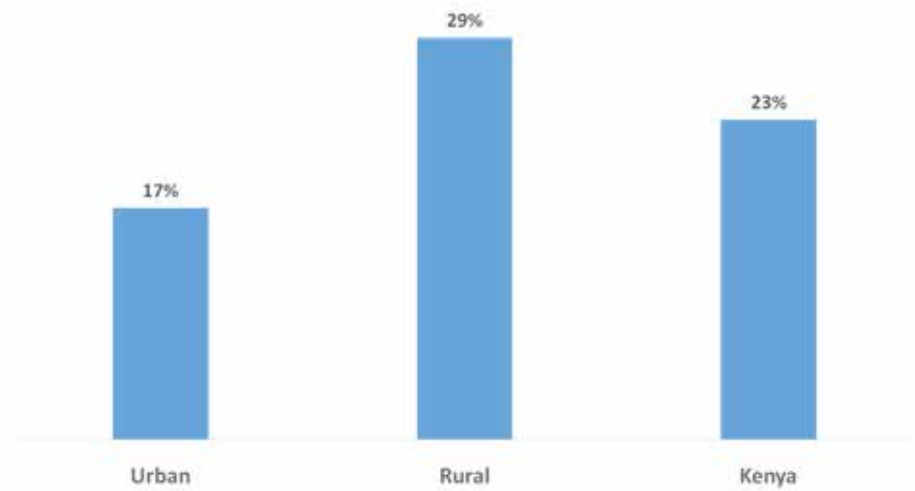
Prevalence of child marriage is measured by computing the percentage of women aged 20 to 24 who were married or in an informal union before they attained the age of 18 years. In 2006, the global prevalence of child marriage was about 25 percent. This prevalence declined to 21 percent in 2019. Regionally, the highest prevalence is in West and Central Africa at 40 percent, followed by East and Southern Africa at 34 percent (UNICEF, 2019a). In Latin America and the Caribbean, the prevalence of child marriage is about 25 per, while in the Middle East and North Africa it is 18

percent and in East Asia and the Pacific it is 7 percent. For the world to eliminate child marriages, more effort will have to be made to combat this harmful practice in South Asia, sub-Saharan Africa and Latin America and the Caribbean.

3.3 Prevalence of Marriage and Motherhood in Childhood in Kenya

The prevalence of child marriage in Kenya is 23 percent according to the 2014 KDHS. This practice is more prevalent in rural areas than in urban areas. The prevalence of child marriage in rural areas of Kenya is 29 percent while in urban areas it is 17 percent as shown in Figure 3.1.

Figure 3.1: Prevalence of Child Marriage in Kenya



Source: *Kenya Demographic and Health Survey, 2014*

Table 3.1 shows the prevalence of child marriage in Kenya by county as established by the 2014 KDHS. The counties with the highest prevalence of child marriage are Tana River, Turkana, Samburu, Wajir, Isiolo, Samburu, and Migori where the prevalence is over 50 percent. Tana River county has the highest prevalence at 60 percent followed by Turkana and Wajir counties at 57 and 53 percent respectively. Nineteen counties have prevalence rates of less than 20 percent. These include Nairobi and Mombasa cities whose prevalence rates are 15 and 14 percent respectively. Makueni and Elgeyo Marakwet counties have the lowest prevalence rates in the country at 10 and 7 percent each.

Table 3.1: Prevalence of Child Marriage in Kenya by County

	County	Prevalence			County	Prevalence
1	Tana River	59.5%		25	Vihiga	24.0%
2	Turkana	57.4%		26	Bungoma	23.3%
3	Wajir	53.1%		27	Kericho	22.2%
4	Isiolo	52.9%		28	Murang'a	20.7%
5	Samburu	50.0%		29	Nyandarua	20.3%
6	Migori	50.0%		30	Baringo	20.0%
7	Narok	42.4%		31	Kisii	19.5%
8	Homa Bay	40.7%		32	Nyeri	19.1%
9	Mandera	40.0%		33	Kajiado	18.8%
10	Garissa	33.3%		34	Kitui	16.7%
11	Busia	33.0%		35	Embu	16.4%
12	Trans-Nzoia	32.3%		36	Tharaka-Nithi	16.2%
13	Marsabit	31.8%		37	Nandi	16.1%
14	Laikipia	31.4%		38	Uasin Gishu	16.0%
15	Kakamega	30.9%		39	Nakuru	15.3%
16	West Pokot	30.4%		40	Nairobi	15.0%
17	Kisumu	28.8%		41	Mombasa	13.8%
18	Siaya	28.7%		42	Machakos	12.6%
19	Lamu	28.6%		43	Kiambu	11.8%
20	Bomet	28.6%		44	Taita Taveta	11.1%
21	Nyamira	27.5%		45	Kirinyaga	10.7%
22	Kilifi	27.3%		46	Makueni	10.3%
23	Kwale	27.2%		47	Elgeyo Marakwet	7.1%
24	Meru	24.6%				

Source: Kenya Demographic and Health Survey, 2014

Normally, marriage precedes motherhood but the converse is not uncommon. An analysis of women aged 20 – 49 years in Kenya who got married when they were children shows that about two-thirds commenced motherhood when they were still children (KNBS, 2015). The proportion is the same for these women irrespective of their residence and wealth status. Table 3.2 shows the proportion of women aged 20 – 49 years who got married and began childbearing when they were still children by county.

Table 3.2: Percentage of Women 20 - 49 Years Who Married and Commenced Motherhood in Childhood by County

	County	Child Mothers		County	Child Mothers
1	Homa Bay	75.8%	25	Kisii	63.9%
2	Migori	72.1%	26	Tharaka-Nithi	63.8%
3	Meru	71.6%	27	Narok	63.8%
4	Tana River	71.4%	28	Kilifi	63.7%
5	Kwale	70.9%	29	Uasin Gishu	63.5%
6	Siaya	70.3%	30	Baringo	63.5%
7	Mombasa	70.1%	31	Kirinyaga	62.3%
8	Nandi	68.4%	32	Mandera	62.3%
9	Nyamira	68.2%	33	Murang'a	62.0%
10	Laikipia	68.0%	34	Taita Taveta	61.1%
11	Busia	67.8%	35	Kajiado	60.6%
12	Nyandarua	67.1%	36	Marsabit	60.0%
13	Kericho	66.7%	37	Bungoma	59.1%
14	Kiambu	65.6%	38	Lamu	58.3%
15	Garissa	65.4%	39	Embu	57.9%
16	Nairobi	65.4%	40	Isiolo	57.5%
17	Nyeri	65.3%	41	Nakuru	57.2%
18	Samburu	65.2%	42	Turkana	56.5%
19	Bomet	65.0%	43	Vihiga	55.4%
20	Kakamega	65.0%	44	Elgeyo Marakwet	55.0%
21	Kisumu	64.8%	45	Wajir	54.1%
22	Kitui	64.6%	46	Makueni	54.1%
23	Machakos	64.3%	47	West Pokot	53.8%
24	Trans-Nzoia	64.1%			

Source: Kenya Demographic and Health Survey, 2014

The results in Table 3.2 show that over 70 percent of women aged 20 – 49 years who were married when they were below the age of 18 years in Homa Bay, Migori, Meru, Tana River, Kwale, Siaya and Mombasa commenced motherhood when they were still children. Homa Bay has the highest proportion of women (76%) who began motherhood in childhood. Wajir, Makueni, and West Pokot have the lowest proportion of women 20 – 49 years who were children when they began motherhood.

3.4 Consequences of Marriage and Motherhood in Childhood

The main consequence of child marriages is early pregnancies and child birth. Due to their tender age, girls are usually not ready physically, emotionally, intellectually or financially for this motherhood experience which is closely linked to the risk of death and injury of child mothers as well as low birth weight, and infant and child disease and death for their newborns. Another consequence of child marriage is the fact that these girls are more likely to have more children in

their lifetime compared to their age mates who get married later (UNICEF, 2019b, 2019c; Yaya and others, 2019). Girls who get married early are also not likely to continue with their education thus leading to higher rates of illiteracy and worse educational outcomes that undermine girls' prospects for entering the paid labor force and gaining economic self-sufficiency. Studies have shown that girls who get married before the age of 18 years are more likely to experience gender based violence which in turn contributes to a poorer quality of life. The combination of violence and early pregnancy can have an adverse and lasting effect on a girl's mental health status (Yaya and others, 2019). Prevalence of child marriage therefore undermines the potential from reaping demographic dividend.

Table 3.3 shows the distribution of women aged 20-24 years in Kenya by education attainment and age at first marriage. The Table indicates that among the women who got married when they were still children, 14 percent had no education and 68 percent had primary education as the highest education attainment. This implies that 82 percent of these women never went beyond primary school and it compares poorly with the proportion of women who did not go beyond primary school among those who got married when they were adults and those who have never married. About 47 percent of the former and 25 percent of the latter never went beyond primary school in their education. The proportion of women who have attained higher education is highest among women who have never married (26%) followed by those who got married when they were already adults (10%) and those who got married when they were still children (less than 1%). From these results it is evident that child marriage and motherhood in childhood deprives women in Kenya from fully accessing their right to education and the benefits that come with secondary and higher education attainment.

Table 3.3: Distribution of Women Aged 20-24 By Education Attainment and Age At First Marriage

County	Age at first marriage/union		
	Child (Below 18 years)	Adult (18 years and above)	Never Married
No education	14.2%	3.7%	1.5%
Primary	67.7%	43.3%	23.7%
Secondary	17.5%	43.2%	48.5%
Higher	0.5%	9.8%	26.3%
Total	100.0%	100.0%	100.0%

Source: Kenya Demographic and Health Survey, 2014

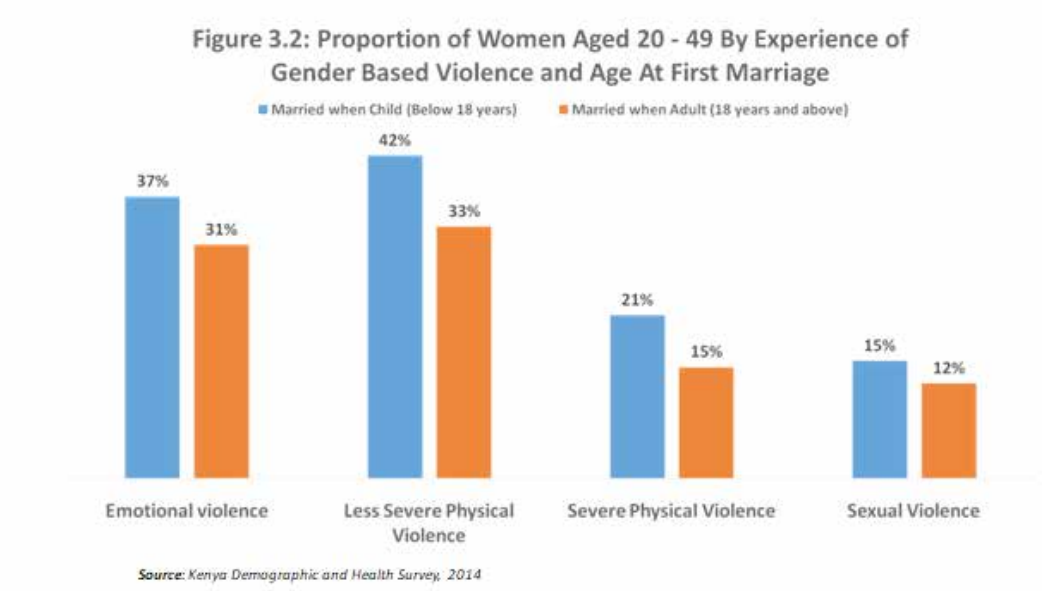
Table 3.4 shows the distribution of women aged 20-24 years in Kenya by their wealth status and age at first marriage. This Table shows that among women who got married while they were still children, over half (54%) are poor. As for the women who got married for the first time when they were already adults and those who have never married, about 30 and 20 percent are poor respectively. At the same time, over half of the women who have never married (62%) and those who got married when they were adults (54%) are rich wealth quintiles. Less than one-third (29%) of women who got married when they were still children are in the rich wealth quintiles. These figures demonstrate the economic disadvantage that women who get married when they are children face later in life.

Table 3.4: Distribution of Women Aged 20-24 By Age At First Marriage and Household Wealth Index

	Age at first marriage/union		
	Child (Below 18 years)	Adult (18 years and above)	Never Married
Poor	53.5%	29.1%	19.7%
Middle	17.6%	16.7%	17.9%
Rich	28.9%	54.2%	62.3%
Total	100.0%	100.0%	100.0%

Source: Computed from Kenya Demographic and Health Survey, 2014

Figure 3.2 shows the distribution of women aged 20 - 49 years by experience of gender based violence and age of first marriage. The results indicate that women who get married when they are children had a higher chance of experiencing gender based violence compared to their counterparts who get married for the first time when they were already adults. About 37 percent of women who got married when they were children had experienced emotional violence compared to 31 percent who got married later. Experience of less severe violence was more common compared to severe violence in both groups of women. Among those who got married when they were adults, about 13 percent had experienced sexual violence compared to 15 percent among those who were married in childhood.



3.5 Empowering girls to make informed choices

When girls have a choice, they usually decide to marry later. For this reason, many programmes designed to end child marriage choose to empower girls. The Sustainable Development Goals and the creation in 2016 of the UN Global Programme to Accelerate Action to End Child Marriage provides countries and communities with an opportunity to

empower girls and end the practice of child marriage. In this regard, increasing girls' education has proved to be an effective strategy in protecting girls from child marriage. Other strategies for reducing and eliminating this practice are bringing girls together to learn life skills, play sports and in some cases gain literacy and numeracy as well as improving the policy environment through legislation and policies that enhance the empowerment of girls.

Kenya's Population Policy for National Development targets to raise the age at first marriage to 23 by 2030 by enhancing Information Education and Communication on child marriage in communities that still practice early marriages. This will complement efforts that are being made by stakeholders in the country to improve education attainment, female labor force participation and enforce laws against child marriage.

The key actions that Kenya needs to implement are;

- ensure that adolescents and youth attain the highest possible standard of health
- eliminate preventable maternal and newborn morbidity and mortality
- attain universal basic education
- eliminate all forms of gender based violence, including child and forced marriages, by addressing social and cultural norms that propagate the practice while providing support to women and girls who have been affected.

Implementation of the above Kenya country commitments that were made at the Nairobi Summit on ICPD25 will help the country to reduce and eliminate both child marriage and motherhood in childhood.

CHAPTER FOUR

Female Genital Mutilation: Socially Sanctioned Gender-Based Violence

4.1 Introduction

Female Genital Mutilation (FGM), also called female circumcision and Female Genital Cutting (FGC) involves cutting some part of the clitoris or labia for non-therapeutic reasons, usually as part of a rite of passage into adolescence. FGM may entail cutting off a girl's clitoris and labia, suturing together what remains so that only a small aperture is left for urine and menstrual blood to escape. Because this practice involves surgical bodily alteration, a girl's health is of primary concern. Complications from FGM can include haemorrhage, infection, sepsis and death. Depression and long-term loss of sexual pleasure and sometimes function are common. Other long-term consequences include infertility, pain, scarring, urinary issues, and poor obstetric and neonatal outcomes (Nour, 2008). FGM reflects discriminatory and stereotypical beliefs about female sexuality—that women and girls must be protected from it and be put under the control of men. The procedure is mostly carried out on young girls between infancy and age 15 (WHO, 2020). FGM is a harmful practice exclusively directed towards women and girls that violates their fundamental rights to health, to bodily integrity, to be free from discrimination and from cruel or degrading treatment.

A harmful practice like the FGM may start as a one-off event. A girl's legs are forced open and parts of her genitals sliced off. Packed with pain and shock, that one moment, however, then spills into many more.

The "medicalization" of this harmful practice by medical professionals is never justified. Even when the procedure is performed in a sterile environment by a health-care provider, there is the risk of health consequences immediately and later in life. Under any circumstances, FGM violates human rights. It also violates medical ethics (WHO, 2016). Performing FGM in a doctor's office serves to normalize the practice, undermining efforts to eliminate it altogether.

4.2 Global and Regional Situation on FGM

Global human rights instruments unequivocally condemn FGM, yet 4.1 million girls and women are at risk of being subjected to it in 2020 alone. Some 200 million girls and women alive today have undergone some form of genital mutilation. Furthermore, there are an estimated 3 million girls at risk of undergoing FGM every year. The majority of girls are cut before they turn 15 years old. FGM has been documented in 30 countries, mainly in Africa, as well as in the Middle East and Asia. Some forms of FGM have also been reported in other countries, including among certain ethnic groups in South America. Moreover, growing migration has increased the number of girls and women living outside their country of origin who have undergone FGM or who may be at risk of being subjected to the practice in Europe, Australia and North America (WHO, 2020).

FGM qualification age in Africa vary from one state to another and from one community to another. From infancy in Ethiopia, Eritrea and Mali to seven-month pregnant females in Nigeria. In Somali (at the horn of Africa) it was traditionally performed on adolescents as an initiation right to womanhood. Somalia is the country with the highest prevalence of FGM in Africa at about 98 percent of women.

A report by UNICEF, 2020 states that the type of FGM procedure performed varies mainly with ethnicity. Estimates indicate that around 90% of female genital mutilation cases include Type 1, II and IV (See Annex 3). The United Nations strives for the practice's full eradication by 2030, under Sustainable Development Goal 5, which explicitly calls for ending all forms of discrimination, violence and harmful practices against all women and girls everywhere thereby, recognizing the positive effect this would have on the health, dignity, education and economic advancement of girls

and women. FGM is a socially sanctioned gender based violence. Although the act itself is usually performed by older women, it is a patriarchal practice rooted in unequal power relations between women and men, embedded in a system that sustains men's power (UN Women, 2017).

FGM is grounded in beliefs that it improves fertility, enhances sexual pleasure for men, suppresses female sexuality, leads to better hygiene, prevents infidelity, complies with the demands of religious institutions or results in acceptance by the community (Kandala and others, 2019; Alhassan and others, 2016; Ashimi and others, 2015; Bogale and others, 2014). It is believed to uphold a girl's purity, honor and cleanliness and it is used to control women's sexuality as a way to make girls and women more marriageable, conforming to social norms that have sustained the practice for centuries (Mackie, 2009).

Empowering women—and men—to say no for their daughters would be transformational, but they need the agency and information to make a different choice. In almost every context, parents believe that the practice is the right thing to do for their daughters. In many cases, parents are aware of the physical and psychological risks but do it in the interest of social acceptance (Eldin and others, 2018; Tamire and Molla, 2013). Mothers are often the ones who subject daughters to FGM, perpetuating gender-unequal norms that drive the practice from one generation to the next.

FGM can result in severe physical and psychological harm. It can cause painful intercourse, infection, cysts and infertility and can heighten the risk of HIV, obstetric fistula, complications giving birth and newborn mortality. It can also trigger depression, nightmares, panic and trauma. Regardless of why it is done, a girl can be harmed for life. FGM is a procedure with no health benefits, but immediate and long-term health consequences, ranging from infection to disabilities that last a lifetime as shown in Annex 4 and 5.

4.3 Female Genital Mutilation in Kenya

FGM is practiced by some ethnic groups in Kenya as well as in other East African countries and is motivated by beliefs about what is considered proper sexual behavior for women and what is necessary to prepare them for marriage (WHO, 2014b). However, the practice is widely acknowledged as a violation of children and women's rights, and it has the potential to cause serious medical complications. In 2011, Kenya passed a law, the Prohibition of Female Genital Mutilation Act (2011), that banned FGM nationwide. Under this law, it is illegal to practice FGC in Kenya or to take someone abroad for FGC.

The Session Paper No. 3 of 2012 on the Population Policy for National Development notes that FGM is one of the practices that fuels disparities in gender equality, equity and empowerment of women. The Policy proposes the following measures to be undertaken with regard to FGM and other harmful practices; Improve the policy environment for mainstreaming gender and reproductive rights in population and reproductive health programmes; Advocate for availability and access to quality treatment, care and rehabilitative services for victims or those affected by harmful practices and/or violence.

Kenya is home to 4 million girls and women who have experienced FGM. However, according to the 2014 KDHS, 93 percent of women and 89 percent of men aged 15–49 believe that FGM should be stopped. Traditional practitioners usually perform FGM on 7 out of every 10 girls in Kenya. Some medical personnel are also involved in perpetuating the practice especially among the Kisii (UNICEF, 2019).

In 2019, at the Nairobi Summit on ICPD25 that was held to mark the twenty-fifth anniversary of the International Conference on Population and Development (ICPD), participants reiterated their commitment to strive for zero harmful practices. During this Conference, Kenya made the following commitments pertaining to prevalence in gender violence and harmful practices;

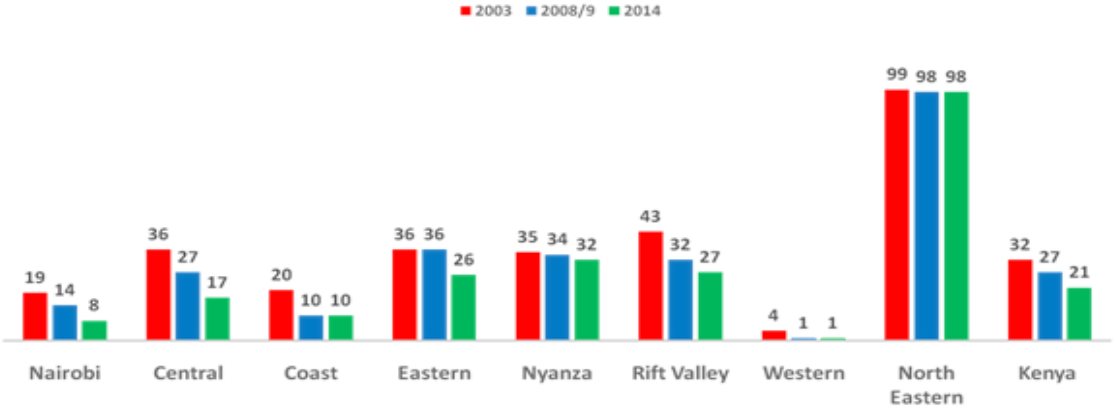
- End Female Genital Mutilation by strengthening coordination in the area of legislation and policy framework, communication and advocacy, evidence generation and support cross border collaboration on elimination of FGM by 2022 (Commitment 13).
- Eliminate, by 2030, all forms of gender based violence, including child and forced marriages, by addressing social and cultural norms that propagate the practice while providing support to women and girls who have been affected (Commitment 14).
- End gender and other forms of discrimination by 2030 through enforcing the anti-discrimination laws and providing adequate budgetary allocations to institutions mandated to promote gender equality, equity and empowerment of women and girls (Commitment 15).

4.4 Trends in FGM Prevalence in Kenya

FGM or female circumcision is widely practiced in some Kenyan communities. It involves partial or total removal of the external female genitalia or other injury to the female organs for cultural or other non-therapeutic reasons. The practice is widely condemned as harmful because it poses a potentially great risk to the health and well-being of the women and girls who are subjected to it. It is also generally recognized as a violation of children's rights (KDHS, 2008/9).

According to the KDHS 2014, 21 percent of girls and women aged 15 to 49 years have undergone the FGM which has had a gradual decline from 32 percent in 2003 as shown in Figure 4.1. Regional variations are notable varying from 98 percent in the North Eastern region to 1 percent in the Western region.

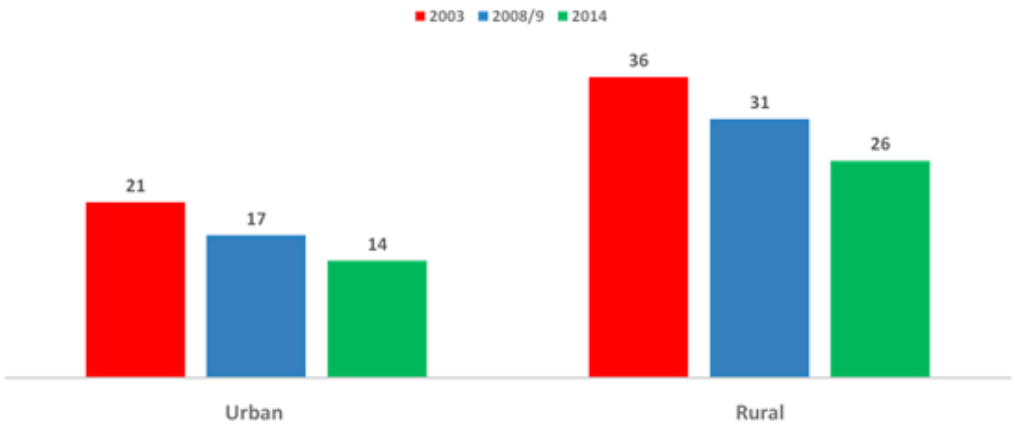
Figure 4.1: Regional Trends in Prevalence of FGM in Kenya 2003 – 2014 (Percent)



Source: Kenya Demographic and Health Survey, 2003, 2008/9, and 2014

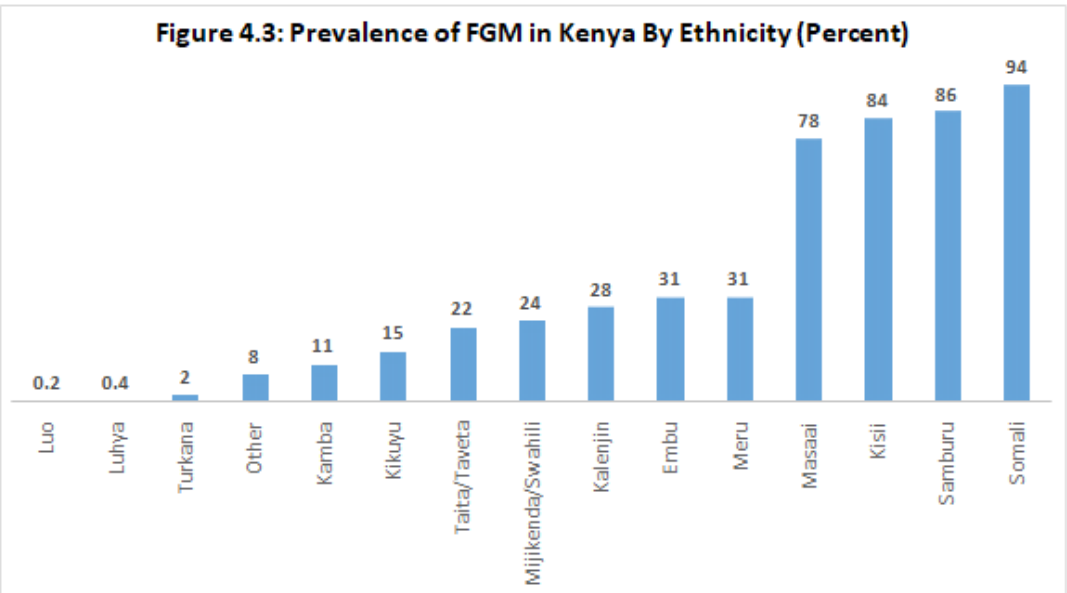
Figure 4.2 shows the trend in FGM by place of residence from 2003 to 2014. There is a remarkable decline in FGM over the years both in urban and rural areas. Rural women are more likely than urban women to be circumcised.

Figure 4.2: Trends in Prevalence of FGM 2003 – 2014 By Residence (Percent)

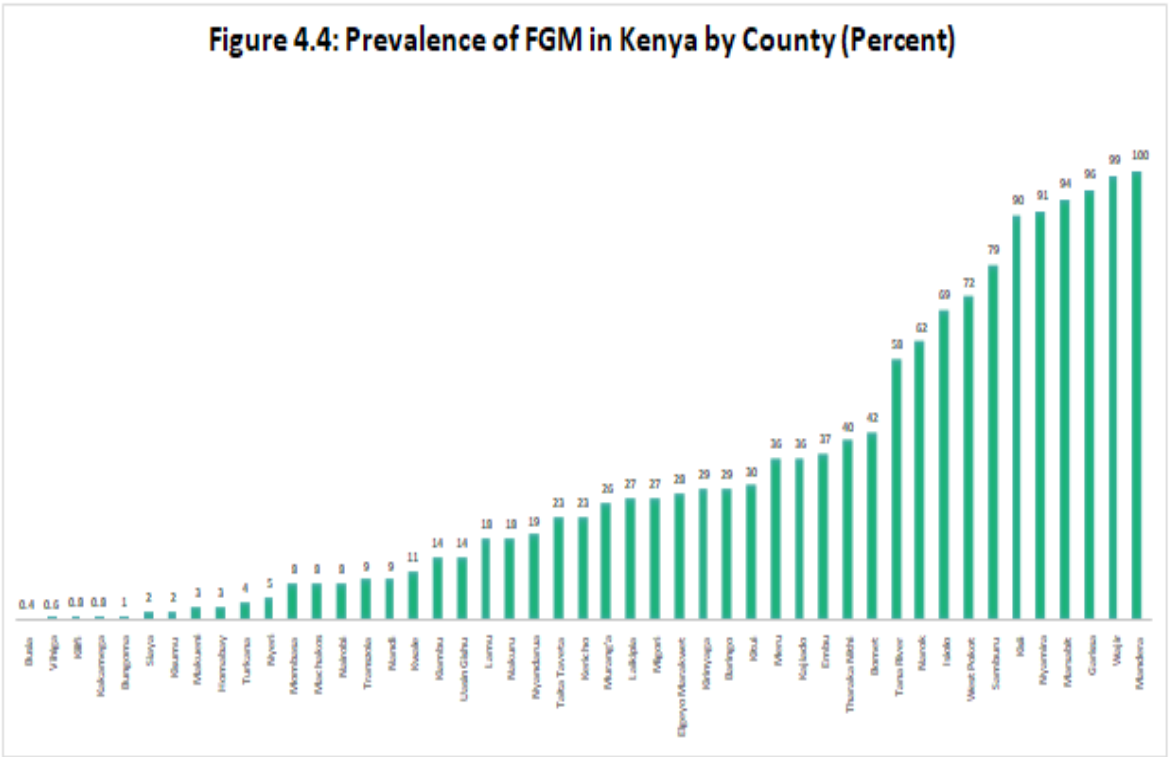


Source: Kenya Demographic and Health Survey, 2003, 2008/9, and 2014

Figure 4.3: Prevalence of FGM in Kenya By Ethnicity (Percent)



Source: Kenya Demographic and Health Survey, 2014



Source: *Kenya Demographic and Health Survey, 2014*

Variation across ethnic groups is dramatic; the practice is a universal phenomenon among some ethnicities and non-existent among others. Majority of Somali (94 percent), Samburu (86 percent), Kisii (84 percent), and Maasai (78 percent) women are circumcised as shown in Figure 4.3. Most FGM occurs during adolescence, with substantial variations in age cutting across ethnic groups: The majority of cases occur before age 10 among the Somali, while in other groups, the practice is mainly performed at age 10 or later.

Figure 4.4 shows the prevalence of FGM in Kenya by County. FGM in Mandera County among women 15-49 is universal (100 percent). In contrast, 1 percent or less of women in the Kilifi, Kakamega, Vihiga and Busia are circumcised. Counties in the North Eastern region have high prevalence of FGM, while Counties largely in Western and Luo Nyanza have low prevalence. To note are Counties in the Central region of Kenya, where FGM is relatively high in Kirinyaga and Murang'a Counties at 29 and 26 percent respectively. To reduce FGM and achieve the SDG target, a huge decline in the practice is required in North Eastern region and parts of Rift Valley and Nyanza regions.

4.5 Recommendations

FGM is a harmful practices held in place by a mix of societal forces. Addressing this retrogressive practice requires holistic multi-sectoral approaches that engage with households, community leaders, institutions and policymakers.

In Kenya, since the communities that practice FGM are known, there is need to design county specific FGM programmes if the fight against FGM is to be won.

The involvement of medical staff in perpetuating FGM must be addressed by the government more strictly. The Ministry of Health and that of Interior have in the past issued prohibitions against the practice, but it appears not to have succeeded in changing behavior. It is important to revisit this issue, and enforce the prohibition more effectively, with stricter sanctions.

Agencies and partners implementing activities in regions where FGM is practiced need to consider more closely the reasons why the practice of FGM persists in these communities, and develop alternative messages and strategies.

More interventions are needed to help girls cope with the tremendous social pressure that forces them to submit to the practice, for example through girl empowerment to help girls resist the social pressure to undergo FGM. These can be as simple as clubs in schools to teach life-skills, and offer information and social skills training to resist family pressure.

There is need to build upon the initiatives that have been identified as encouraging abandonment, such as encouraging girls to stay in school, supporting teachers in discussing FGM with girls and boys, encouraging churches to actively oppose FGM, implementing girl empowerment and Alternative Rite of Passage (ARP) programmes.

Increased community education is needed on the negative health and social effects of FGM and its illegality. Programmes should engage the whole community, including boys, men, local authority staff, teachers, community and church leaders, and traditional circumcisers and health professionals.

Government and the local agencies need to strengthen public awareness around the existing laws in relation to FGM and the process of reporting cases of FGM to the authorities. The government also needs to enforce the laws more diligently at local and national levels. Stronger enforcement of the existing laws prohibiting FGM and promoting children's rights is needed.

Engage men and community leaders in initiatives to abandon FGM. Although the practice is seen as largely a women's affair, men can have a role to play as heads of households providing the resources needed for the ceremony. The community needs to be persuaded that cultures can and do change, and it is not therefore necessary to cling to a practice whose purpose is upholding cultural tradition.

CHAPTER FIVE

Son Preference Violates Many Rights

5.1 Overview

Son preference is a product of gender-biased systems that assign and reinforce higher social status to men and boys and that favor male over female children. Son preference may also be expressed through gender-biased sex selection: the termination of a pregnancy when the fetus is determined to be female, or pre-implantation sex determination and selection, or "sperm-sorting" for in-vitro fertilization. From a human rights perspective, gender-biased sex selection is a harmful practice because it translates a preference for boys over girls into a deliberate prevention of female births. In some low-income countries of Asia and sub-Saharan Africa, for example, son preference is widespread, but postnatal and gender-biased sex selection are uncommon.

When Boys are valued more highly than girls, pressure to have a son is intense. The preference for sons over daughters maybe so pronounced in some societies that couples will go to great lengths to avoid giving birth to a girl or will fail to care for the health and well-being of a daughter they already have in favor of their son.

Unlike son preference in general, the manifestation of it in gender-biased sex selection may be more directly measured through a country's data on "sex ratio at birth" (Guilmoto, 2015). The "natural" or normal, sex ratio at birth in most parts of the world is between 105 and 106 male births for every 100 female births (Chahnazarian, 1988). Any deviation from this natural sex ratio at birth therefore reflects some degree of gender-biased sex selection (Chao and others, 2019; Tafuro and Guilmoto, 2019). Literature indicates that in general, couples do not engage in gender-biased sex selection for their first child. However, they may subsequently opt for sex-selective abortions if their first child was a girl. In 2001, measured census data revealed that the sex ratio at birth among women who already had two girls increased to 223 (UNFPA, 2013).

5.2 Global Situation on Son Preference

The strongest son preferences are observed in countries with sex ratios exceeding 120: Mauritania, Senegal, Guinea, Nepal, Azerrbaijan, Jordan, Mali, Armenia, Niger and Chad (John Bongarts,2013). Two countries—China and India—together account for about 90 percent to 95 percent of the estimated 1.2 million to 1.5 million missing female births annually worldwide due to gender-biased (prenatal) sex selection (Chao and others, 2019; Bongaarts and Guilmoto, 2015). In India, a deeply entrenched preference for male children continues, and some families still seek to abort female fetuses, even though gender-biased sex selection has been banned, or neglect the nutrition and health of daughters in favor of sons. In her review of the empirical evidence on gender preferences, Fuse (2008) concludes that, although North Africa has not been subject to much research compared to East or South Asia, there is evidence of strong gender bias against girls. She further writes that of all sub-regions in the world, it appears that the least is known about Sub-Saharan Africa. Evidence from a comparative analysis by Rossiand Rouanet (2015) shows that predominance of son preference in North Africa (Morocco, Tunisia and Egypt) has increased over time. They concluded that there is weak evidence of son preference in Mali, Senegal and in the Great Lakes region.

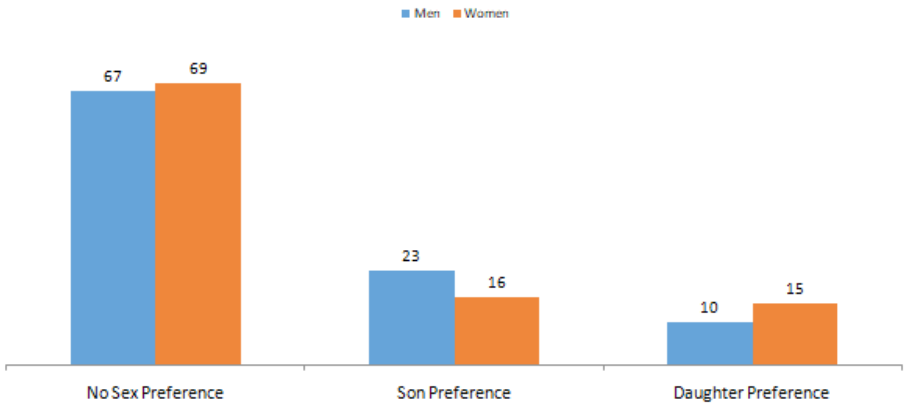
In most of the sub-Sahara African countries, more women have son preference than daughter preference (Kana,2008). Sub-Saharan African countries that had substantial son preference as reported in DHS surveys from the early 1990s (Arnold 1997) continued to have considerable son preference in the 2000s (i.e. Mali and Senegal). Son preference is especially prominent in Burkina Faso and Senegal, where more than 30 percent of women have son preference than daughter preference.

5.3 Son Preference in Kenya

Although it is well recognized that sons are strongly valued in traditional patrilineal societies in Great Lakes region, no evidence has been found of sex ratios favoring boys at birth in Kenya. There is also no or very few studies that directly link son preference to violation of human rights in the country. According to the census data, Kenya has a natural sex ratio level of 103 which simply means that at birth there are 103 males per 100 females born since 1969.

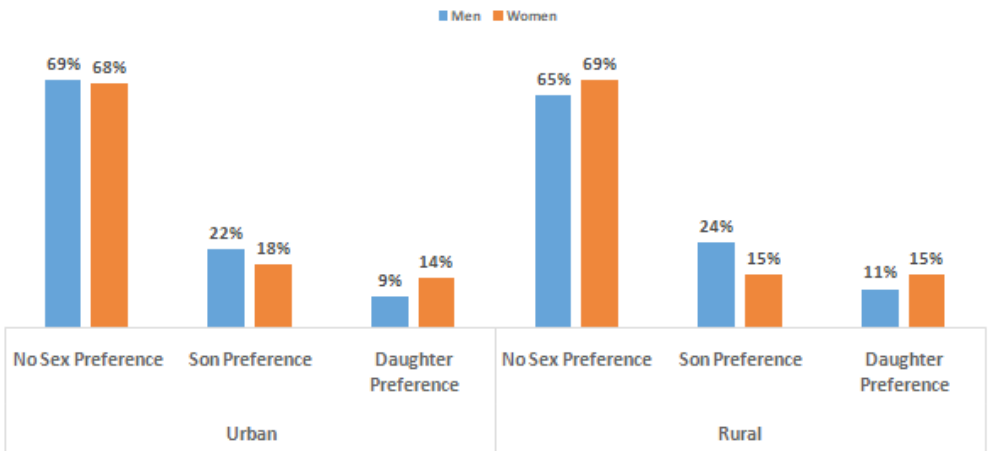
From anlaysis of KDHS 2014 data, a large proportion of women and men (67% and 69% respectively) reported having no sex preference. However, a higher proportion of men than women have preference for sons compared to daughters as shown in Figure 5.1.

Figure 5.1: Son and Daughter Preference Among Men and Women in Kenya (Percent)



As shown in Figure 5.2, men prefer sons to duaghters regardless of whether they are in the urban or rural areas.It is however worthy to note that,despite few cases of the son preference in both rural and urban areas, 7 out of 10 men and women have no sex preference.

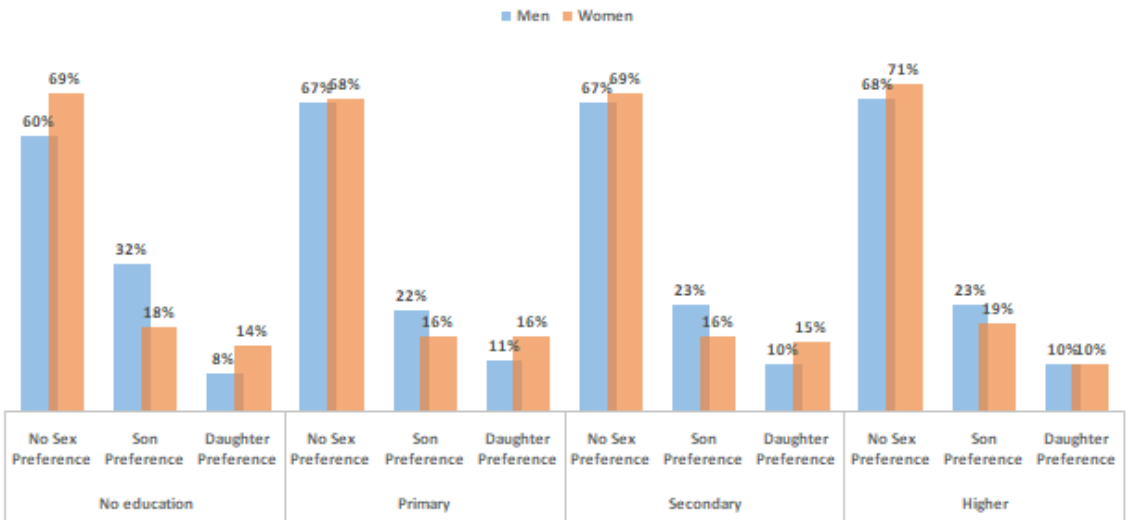
Figure 5.2: Son and Daughter Preference Among Men and Women in Kenya by Residence (Percent)



Source: Kenya Demographic and Health Survey, 2014

As indicated in Figure 5.3, regardless of their education level, a higher proportion of men prefer sons to daughters. On the other hand,women with higher education prefer sons compared to their counterparts with primary and secondary education. The trend is also similar with men form richer backgrounds prefering sons to daughters. There is no varaiation in son preference among women of different wealth levels.

Figure 5.3: Son and Daughter Preference Among Men and Women in Kenya by Education Attainment (Percent)

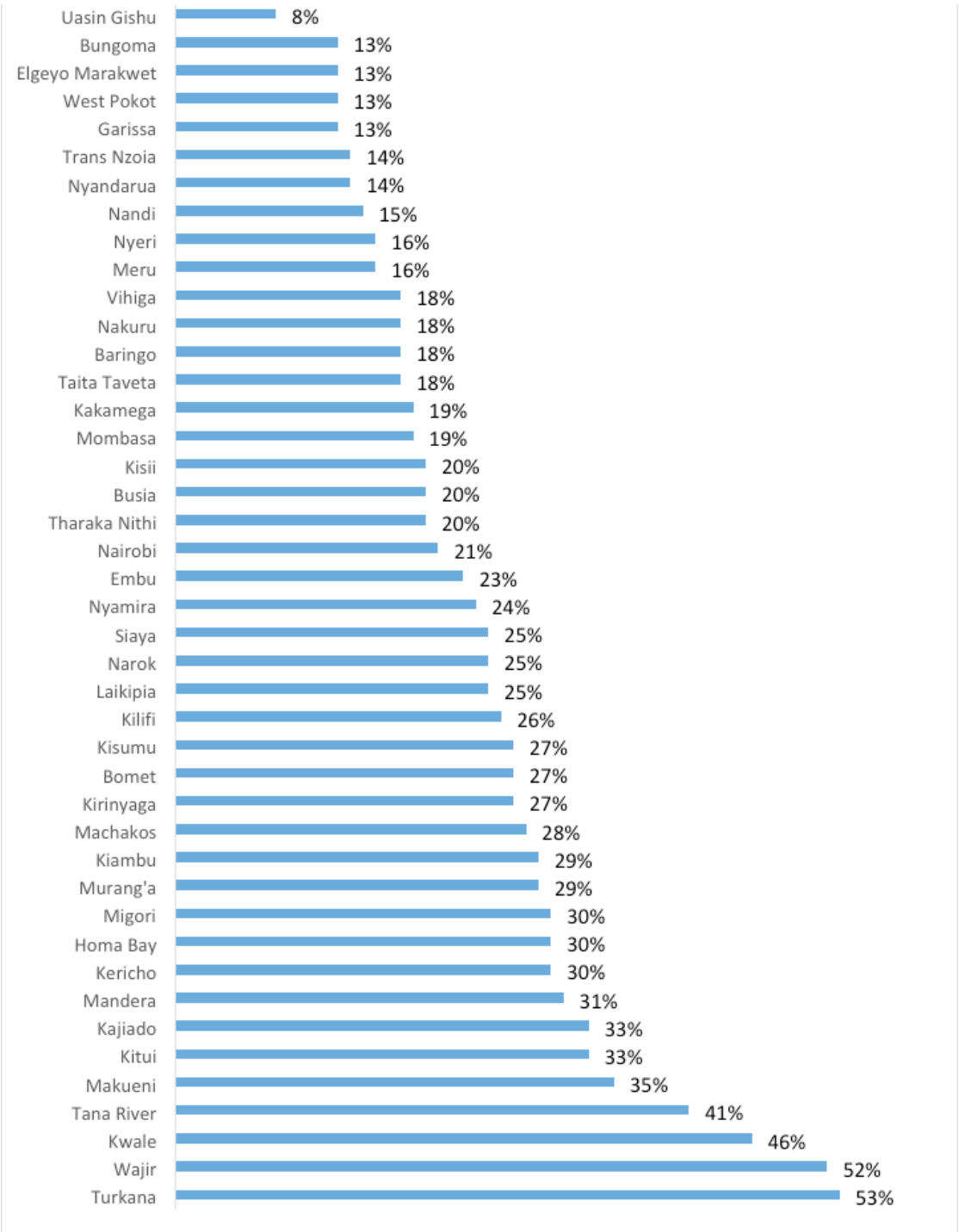


Source: Kenya Demographic and Health Survey, 2014

Analysis of KDHS 2014 also shows that daughter preference is clearly pronounced among men who don't profess to any religion and among the Muslims as compared to other religions. In over half of the Counties in Kenya, a higher proportion of men have a preference for sons than for daughters. Figure 5.4 indicates that the proportion of men who have son preference is highest in Turkana (53%), Wajir (52%), and Kwale (46%) Counties. There was no daughter preference reported among men in Mandera County.

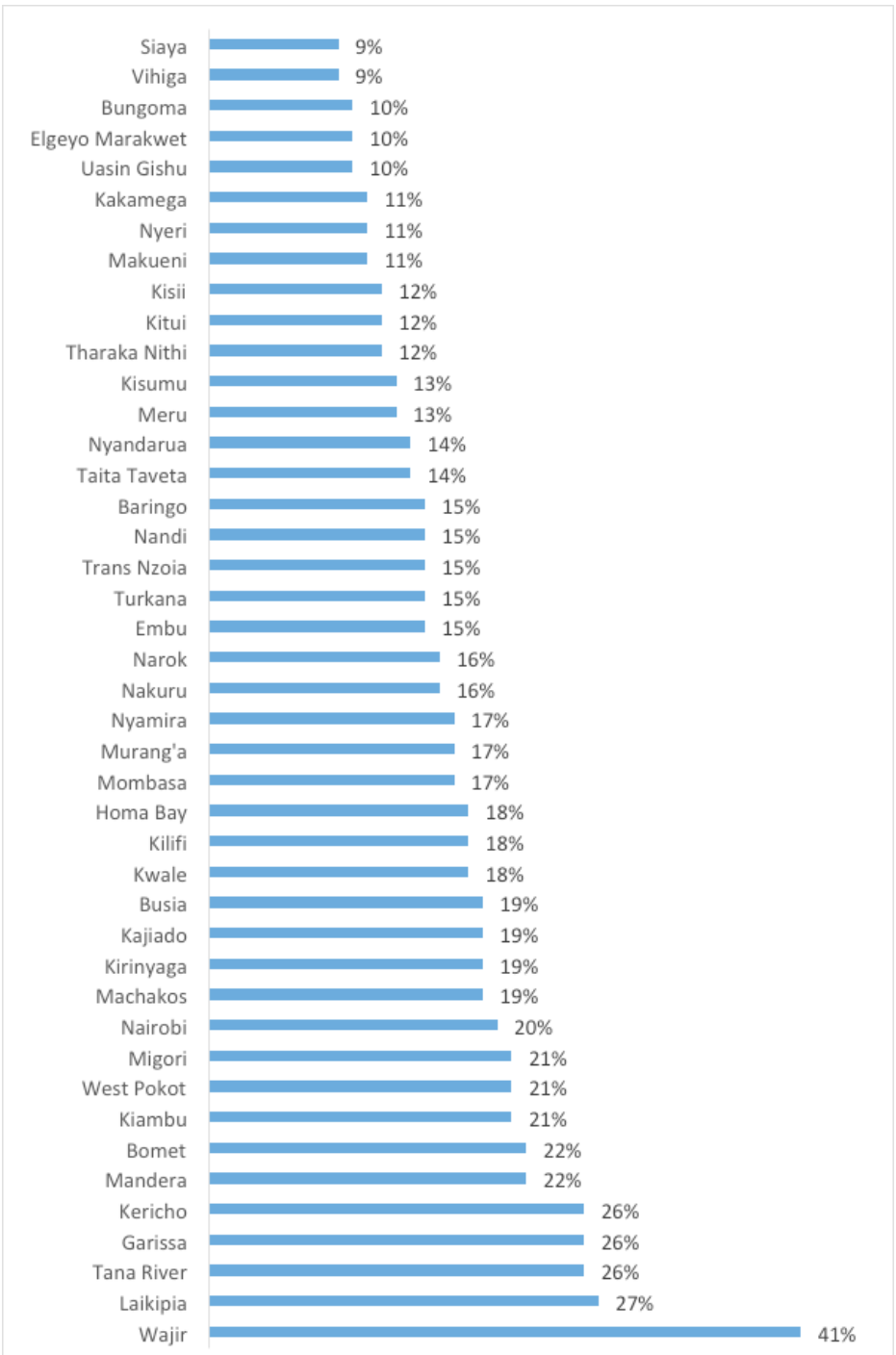
In 26 Counties of Kenya, a higher proportion of women have son preference over daughters. At the same time, a higher proportion of women prefer daughters over sons in the remaining 21 Counties. This is highest in Turkana (29%), Kakamega (27%) and Vihiga (26%) Counties. Figure 5.5 shows that Wajir (41%), Laikipia (27%), Tana River (26%), Garissa (26%) and Kericho (26%) counties have the highest proportion of women who prefer sons over daughters.

Figure 5.4: Proportion of Men (15-54) Who Indicated Son Preference by County



Source: Computed from KDHS, 2014

Figure 5.5: Proportion of Women (15-49) Who Indicated Son Preference by County



Source: Computed from KDHS, 2014

5.4 Implications of Son Preference

Preference for sons over daughters have a number of negative consequences which include the following;

- One notable consequence of the continued disproportionate importance given to boys is the huge pressure put upon women to produce sons. This pressure can have particularly debilitating effects on the mental and physical health of women.
- The pressures to engage in sex selection in a gender discriminatory environment not only directly affect women's reproductive decisions but also put women in a position where they must perpetuate the lower status of girls through son preference.
- Women always bear the consequences of giving birth to an 'unwanted girl' child which include violence, abandonment, divorce (or being forced to live with an additional wife) or even death (Ganatra, Hirve & Rao, 2001; Li, 2007).
- Societal pressures may lead women to terminate pregnancies against their will. In some cases, a woman who refuses to accede to societal expectations may endure physical violence, social exclusion and divorce.
- Societal pressures on couples to have sons may also pressure women to have more pregnancies than they desire, denying their right to freely and responsibly make their own decisions about the timing and spacing of pregnancies.

5.5 Breaking the Cycle: Recommendations for Action

Given the negative consequences of son preference, the following recommendations are made for Kenya:

- **More-reliable data:** To provide a sound basis for policy development and action, more-reliable data are now needed on, the magnitude of gender-biased sex selection-data from a variety of sources including national censuses, registration systems, population surveys and qualitative studies need to be analyzed in order to give a more complete and consistent picture of the situation and its complexities.
- **Use of technology:** Technology is not the root cause of sex selection. Any policies or guidelines on the use of technology in obstetric and fetal medicine should: promote responsible use and avoid reinforcing gender discrimination.
- **Supportive measures for girls and women:** Addressing the root causes of gender discrimination and inequalities requires taking supportive measures for girls and women. Such measures must focus on securing the foundations for the self determination of girls and women by improving: access to information, health care services and nutrition; access to education; and personal security – including protection from coercion.
- **Legislation and policy:** This will involve development and implementation of laws and policies to address the root causes of son preference on inheritance, dowry/bride prize, financing old age and other personal security issues and education
- **Advocacy, communication and community mobilization:** Thus, advocacy to change attitudes and behaviour towards girls and women has to be a central part of work to redress gender inequalities manifested through sex-ratio imbalances. It is therefore very important to give high visibility to leaders and other personalities and influential groups that support fulfilling the human rights of girls and boys equally, and who therefore oppose prenatal sex selection.

CHAPTER SIX

Actions for a Kenya Free from Harm

Solutions to eradicate harmful practices against girls and women will vary across countries. Generally, these strategies must encompass prevention, protection and care and they should aim at achieving gender equality and women's rights at the level of families as well as in institutions and across societies. Countries should endorse these strategies as essential (and investment worthy) steps towards a more peaceful, fair world for everyone with an aim of getting to zero harmful practices while ensuring no community is left behind on this fight. This implies a multi sectoral approach since these practices and the perpetrators are insidious and frequently occur beyond the reach of laws and the data that might track their spread. This will accelerate the promise during the ICPD25 Nairobi Summit as well as the 2030 Agenda for Sustainable Development and its 17 Sustainable Development Goals (SDGs).

Kenya has made substantial gains in ending gender based violence, child gender preferences, elimination of all forms of discrimination against women and harmful practices that negatively impact on girls and women future. During the Nairobi Summit on ICPD25, held last year to mark the twenty-fifth anniversary of the ICPD, Kenya committed to end the Female Genital Mutilation (FGM) by strengthening coordination in the area of legislation and policy framework, communication and advocacy, evidence generation, and support cross border collaboration on elimination of form by 2022; Elimination of all forms of gender based violence, including child and forced marriages as well as Ending gender and other forms of discrimination by 2030. To achieve these goals, our programming should mainly focus on laws and legislations, drivers of FGM, and SGBV, gender equality, teenage pregnancy child and forces marriages among others.

Laws and legislations: Passing laws against harmful practices is not a panacea, but it is a powerful statement of disapproval and is in line with State obligations under international human rights instruments. This speaks to Government's commitments under the 2030 Agenda, the ICPD25 commitments and the Beijing Platform for Action. In recent years, countries in all regions of the world have made progress on legislation to combat violence against women (Commission on the Status of Women, 2020).

As part of this process, and in line with the obligations of international human rights conventions and treaties, Kenya should include explicit prohibitions on harmful practices with laws grounded on human rights and offer a comprehensive framework for prevention, protection and mitigation of harmful practices. These harmful practices which hinders girls and women from achieving their dreams have persisted in Kenya simply due to weak implementation and enforcement and other silent and endemic factors.

Mitigating risks of non-compliance: Since legislating against harmful practices can have the unintended effect of driving them underground, measures may also be needed to mitigate these risks. Laws need to operate in tandem with a clear understanding of the social and economic determinants of harmful practices, and their dynamics over the years. Managing the risks of non-enforcement, community rejection and clandestine practice can build on the meaningful participation of affected individuals and communities in developing and then regularly monitoring and evaluating laws and associated policies and services (Gruskin and others, 2010). International human rights bodies have underscored the need to back legislations, effective enforcement measures as well as monitoring to track impacts in practice with appropriate budgets (OHCHR, n.d.). Also, since gender discrimination and the "permitting" of harmful practices can appear at many points in legal systems for instance when a police officer sides with a perpetrator and refuses to process a complaint or processes it incorrectly. This calls for interventions that involves training and sensitization among police and judicial officials.

According to UNFPA, 2018, health-care providers are increasingly involved in FGM and estimated 52 million women and girls have undergone FGM performed by doctors, nurses or midwives. In view of this light, there is need to differentiate penalties under the law to impose heavier sanctions on people who aid those harmful practices whereas they are supposed to be on the frontline of prevention. These include and not limited to health-care providers participating in the medicalization of female genital mutilation, or "specializing" in sex-selective abortion for which there is no medical justification as well as perpetrators of cross boarder FGM.

Zero FGM in Kenya: Kenya recognizes FGM as a violation of women basic rights that must be prohibited wherever it exists. During the ICPD25 Nairobi Summit, Kenya committed to end Female Genital Mutilation by 2022. A lot of work in areas like strengthening coordination in the area of legislation and policy framework, communication and advocacy, evidence generation and support cross border collaboration on elimination of FGM need to be done in the next two years to achieve this commitment.

All-Inclusive and Innovative Community Engagement: Kenyan communities have heterogeneous beliefs, practices and traditions. The voices, opinions and local knowledge of community members must be sought if efforts to address FGM will bear fruits. Sustaining dialogue sessions with girls, women, boys and men to acknowledge the problem, discuss solutions and recognize the challenges is an important step. This process should conclude with a community action plan that encourages girls to undergo all culturally accepted rites of passage without having to endure FGM.

Resource allocation: There is need for government to upscale funding of the national programme to end FGM that is underpinned by national laws and policy. This programme entails an oversight and coordination board, community engagement, girls' empowerment programmes, partnerships with religious leaders, outreach to both traditional practitioners and medical personnel, and community services to report and respond to cases (UNICEF 2020b).

Regional Collaborations: There is need to collaborate with the neighboring countries where harmful practices cross borders to create and fund regional action plans including a mechanism for regional monitoring and accountability. Ammonized legislations and policies will stress the broad sanction of harmful practices, and limit the chances that people will cross borders to carry out harmful practices in more permissive jurisdictions.

Faith-Based Partnerships: In the North Eastern Region, where practicing communities profess Islamic faith, and in Nyanza, where the Kuria Community has a Seventh Day Adventist following, taking a religious approach to ending FGM is crucial. Partnerships with faith-based agencies and associations foster anti-FGM messages in mosques and churches, and help delink the practice from any religion. When highly respected religious scholars take part in community dialogue sessions and other outreach programmes, they can exert a powerful influence in persuading communities to abandon FGM.

Interventions Targeting Practitioners: Programmes aimed at both traditional excisors and medical professionals aim to break the link between supply and demand. For traditional excisors, interventions focus on education around FGM as a violation of human rights, and on opportunities for developing alternative skills. Among healthcare providers and medical students, the emphasis is on existing codes of conduct and regulations that prohibit medicalized FGM. Also, health-care providers can be enlisted in stopping the medicalization of female genital mutilation, and delivering consistent messages to families and individual patients around the many negative health consequences of harmful practices.

Leadership and Coordination: Progress towards ending FGM by 2022 depends on strong coordination at the national, county and sub-county levels. The Anti-FGM Board, a semi-autonomous government agency under the Ministry of Public Service and Gender, coordinates an extensive network of stakeholders, provides leadership and holds partners accountable. Given the short duration of eradicating FGM, proper coordinated targeted advocacy, public education and community dialogues on FGM should be scaled-up moving forward.

Girls' Empowerment Programmes: These include alternative rites of passage and mentorship programmes imparting life skills. Mentorship involves training girls to reject FGM, and connecting them with local champions for the abandonment of FGM as well as with law enforcement. Both can serve as resources for girls in resisting the practice. This can be facilitated by the media as a tool in the Anti – FGM campaign due to the influential role it plays. Supporting the inclusion of Anti-FGM content in the curriculum of learning institutions and correctional centres should also be prioritized.

Towards Zero Gender Based Violence Including Child and forced Marriages: The state of world population report 2020 recognizes that states pass laws and develop policies to cushion girls and women against all forms of GBV but yet the harm goes on destroying lives and violating rights in every region of the world. Kenya is not immune from GBV and the situation has been exacerbated by Covid-19 pandemic that is currently ravaging the whole world. poverty, level of education, adolescent pregnancy, FGM, natural disaster, partying, escape and traditional practices are the main drivers of GBV and child marriages and efforts should be made to address them. To realize Kenya free of GBV including child marriages and forced marriages in our communities, there is need to lay more emphasis on strategies that empower the girl child and high undertake voltage advocacy at all levels to change behavior and perceptions towards this practice.

Enhanced multi-Sectoral response and support services for GBV boost coordination of provision of legal aid services for GBV survivors. Establishment and operationalization of recovery centers, Safe Houses/Rescue centers for GBV survivors at the county level.

Education is viewed as one of the most successful drivers of transformation in the lives of girls and young women. Cash transfers programmes have had success in keeping girls in school, but need to be accompanied by efforts to counteract the gender discrimination that often derails future opportunities for girls to secure employment. Schools should also be accessible, safe and have adequate facilities for girls and boys (World Bank, 2017).

There is need to intensify trainings and sensitization to prevention service providers and to communities and counties with high prevalence on the effects of these practices.Also, medical practitioners, law enforcement institutions and legal linkages to improve on evidence management and ensure justice is served to the affected accordingly. Lastly, there it is important to facilitate development a national action plan and county policies and laws on GBV to address harmful cultural practices.

Towards gender equality and free from all forms of discrimination: Gender equality is an agreed global goal under the 2030 Agenda for Sustainable Development, which also explicitly calls for ending all forms of discrimination, violence and harmful practices against all women and girls everywhere. In 2020, the world marks the twenty-fifth anniversary of the Fourth World Conference on Women, which built on the 1994 ICPD by elaborating far-reaching commitments to women's rights and gender equality in all areas of life. Disrupting root causes of inequality, including social relations as well as patterns of economic and political power that continue to favour men will go a long way in bridging the gender equality gap (Heymann and others, 2019). Countries as diverse as Bangladesh and the Republic of Korea have shown that when girls and women have better economic options, harmful practices such as child marriage and son preference begin to decline, sometimes dramatically (Naved and others, 2001; UNFPA, n.d.).

In Kenya, implementation of Constitution of Kenya 2010 as well as other policy legislations have borne fruits. The enactment of the two-third gender rule, establishment of Women Enterprise Fund and other women empowerment avenues have mainstreamed women into leadership and business positions, accelerating gains in empowering women to bridge the gender parity in the country.

During the ICPD25 Nairobi Summit held in November last year, Kenya committed to end gender and other forms of discrimination by 2030 through enforcing the anti-discrimination laws and providing adequate budgetary allocations to institutions mandated to promote gender equality, equity and empowerment of women and girls. To realize this commitment among other national and international commitments such as the SDGs, policy legislation, robust programming as well as adequate budgetary allocations are important.

Working with Volunteers: Partners working on this thematic area should be committed to training all volunteers on key concepts of discrimination, inequality, justice and exclusion, and training them on how to identify and report abuse as well as model inclusive, non-discriminatory behaviour. A relational volunteering model can contribute to lasting positive change in communities by merging 'outside' expertise with 'inside' knowledge.

Working with Men, Boys and Community Leaders: Countries that have made progress on this topic have integrated men, boys and male allies in their programming to address GBV and gender equality. Involving men and boys in prevention work is considered a crucial component of best practice. Despising this group of people in various intervention strategies will hinder long term systemic change cannot be achieved without involving men and boys. However, in all this work to address GBV the empowerment and safety of women and girls should be prioritized. They should be supported to clearly exercise their voice and develop the vital spaces and actions they have obtained to address GBV in all its forms.

Making much more of National Women's Institutions: Women need more positions of power, as a matter of justice and to set new, transformative agenda centered on their equality and rights. Gender equality mechanisms have proven effective in orienting national plans, policies, budgets and institutions around achieving gender equality and the empowerment of women, including spearheading action plans and the removal of discriminatory legislation. They could be well-positioned to lead a drive to eliminate harmful practices, given their explicit commitment to women and women's rights, and their existing work on the multiple and mutually reinforcing dimensions of gender equality. The Government may also consider systematic gender assessments of laws as well as social and economic policies that encourage the undervaluing of girls and women. Among many possibilities, insights gained from such a process can guide reforms to end legal discrimination related to property rights, pension benefits, inheritance, marriage, divorce, child custody, and sexual and reproductive health and rights. Together with other relevant institutions, these mechanisms can mobilize the diverse array of people such as the religious leaders, teachers, youth peers, law enforcement, healthcare providers, parents and policymakers and work towards reducing violations of the principle of equality and freedom from discrimination for the Special Interest Groups.

Mobilizing Women's Movements: National gender equality mechanisms often have close links with women's movements and groups, giving them unique insights into women's concerns and priorities, and allowing a reach from the national to the local level, and into populations facing multiple forms of marginalization and stigma. These groups know many of the solutions to gender discrimination and harmful practices, based on a long record of research, activism and lived experience. There is dire need to scale up investments in both national gender equality commission and women lobby groups to enable them work systematically and drive service and policy changes at the community level (Commission on the Status of Women, 2020).. In a time of pushback against advocacy for gender equality, national gender equality mechanisms could open doors for women's rights organizations to influence and monitor implementation of national affirmative action policies and serve as avenues of promoting public awareness on principles of equality and inclusion in the country.

To sustain the gains made and ensure progress on gender inclusivity, there is need to Review, facilitate and advise on policy, laws, regulations, standards and guides to aid compliance with principles of equality and inclusion. It is also imperative to ensure proper enforcement of laws and policies touching on SIGs as well as develop and operationalize an automated complaints handling system to facilitate legal redress.

Data for Decision Making: As the Government seeks to combat teenage pregnancy, child marriages, and other harmful practices such as FGM, reliable, timely and quality data on key indicators disaggregated by lowest administration possible will be necessary for proper programming. A fully functioning digital harmonized database system that integrates all child protection activities and accessible by stakeholders will enhance data quality, data processing and analysis for quick decision making;

Leveraging on technology: Online violence against women is a growing concern, with younger women at particular risk (Commission on the Status of Women, 2020). Internet technology is used in some cases to perpetrate harmful practices, including the selling of child brides. Platforms with sexist content reinforce broader patterns of gender discrimination that underpin harmful practices. Leveraging on technology such as mobile penetration in Kenya, social media and others can go a long way in accelerating eradication of child marriages and other harmful practices against girls and women.

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Annex 1: ICPD25 Kenya Country Commitments

The ICPD25 Kenya Country Commitments were presented at the Nairobi Summit on ICPD25 by His Excellency Uhuru Kenyatta, President of the Republic of Kenya. Here below is the full text of the seventeen commitments made by Kenya;

On the Essential Reproductive Health Package of Interventions and UHC, Kenya commits to;

1. Employ innovation and technology to ensure adolescents and youth attain the highest possible standard of health. Efforts will be made to eliminate teenage pregnancies, new adolescent and youth HIV infections and harmful practices such as child marriages while at the same time ensuring universal access to friendly quality reproductive health services and information to the youth and adolescents by 2030.
2. Eliminate preventable maternal and newborn mortality, mother to child transmission of HIV and severe morbidity such as obstetric fistula among women by 2030.

In Creating Financing Momentum for the outstanding promises in the PoA, the country commits to;

3. Progressively increase health sector financing to 15 percent of total budget, as per the Abuja declaration by 2030. This will enable the country to cover the cost of implementing Universal Health Coverage and gradually increase financing of family planning commodities from domestic resources.
4. Improve support to older persons, persons with disabilities, orphans, and vulnerable children by increasing the core social protection investment from 0.8 percent of Gross Domestic Product to at least 2 percent over the next 10 years.
5. Enhance integration of population, health and development programmes and projects into Medium Term Plans (MTPs) and the Medium Term Expenditure Framework (MTEF) to ensure budgetary allocations and efficient implementation of programmes and projects by 2030.

Demographic Diversity and Sustainable Development are critical in addressing the country's challenges and therefore Kenya commits to;

6. Enhance the capacity of relevant Government institutions to increase availability and accessibility to high-quality, timely and reliable population and related data at national, county, and sub-county levels, disaggregated by income, gender, age, ethnicity, migratory status, disability and geographic location by 2030.
7. Integrate population issues into the formulation, implementation, monitoring and evaluation of all policies and programmes relating to sustainable development at national, county and sub-county levels by 2030.
8. Harness the demographic dividend through investments in health and citizens wellbeing; education and skills training; employment creation and entrepreneurship; and rights, governance and empowerment of young people by 2022 as outlined in the Kenya's Demographic Dividend Roadmap. This includes the establishment of a National Coordination Mechanism for Demographic Dividend by 2020.
9. Eliminate legal, policy and programmatic barriers that impede youth participation in decision making, planning and implementation of development activities at all levels by 2030.
10. Attain universal basic education by ensuring 100 percent transition of pupils, including those with special needs and disabilities, from early learning to secondary education by 2022. Also raise the completion rate for basic education to 100 percent by 2030.

11. Improve the employability and life-skills of youths by enhancing quality and relevance of Technical Vocational Education and Training (TVET) in partnership with industries and private sector by 2030.

12. Fully implement the Competence Based Curriculum (CBC) so that learners are equipped with relevant competencies and skills from an early stage for sustainable development by 2030.

Prevalence of Gender Based Violence and Harmful Practices is of great concern to Kenya. To address this issue, the country commits to;

13. End Female Genital Mutilation by strengthening coordination in the area of legislation and policy framework, communication and advocacy, evidence generation and support cross border collaboration on elimination of FGM by 2022.

14. Eliminate, by 2030, all forms of gender based violence, including child and forced marriages, by addressing social and cultural norms that propagate the practice while providing support to women and girls who have been affected.

15. End gender and other forms of discrimination by 2030 through enforcing the anti-discrimination laws and providing adequate budgetary allocations to institutions mandated to promote gender equality, equity and empowerment of women and girls.

In the spirit of leaving no one behind, provision of Reproductive Health Services and information in Humanitarian and Fragile Contexts is critical. The country therefore committed to;

16. Ensure universal access to quality reproductive health services, including prevention and management of GBV, in humanitarian and fragile contexts by 2030.

To ensure Kenya accelerates the promise of ICPD Programme of Action the country commits to;

17. Track and monitor the implementation of the ICPD25 Nairobi Summit commitments through the National Council for Population and Development in the State Department of Planning.

Annex 2: Characteristics of Harmful Practices

They constitute a denial of the dignity and/or integrity of the individual and violate human rights and fundamental freedoms of women and children as recognized under international law. Specifically;

- They constitute discrimination against women or children and are harmful because they result in violence, negative physical, psychological, economic or social harm or limit the capacity of a woman or a child to participate fully in society
- They are traditional, emerging or re-emerging practices that are kept in place through social norms that perpetuate male dominance and the inequality of women and children based on their sex, gender, age and other intersecting factors
- They are imposed on women and children by families, community members or society at large, regardless of whether the victim provides or is able to provide full, free and informed consent

Child marriage is defined as any legal or customary union involving a person below the age of 18. This definition draws from various conventions, treaties, and international agreements. The term child marriage is often used inter-changeably with the terms forced marriage and early marriage.

Sexual Gender Based Violence (SGBV) is any act that is likely to or results in physical, sexual or psychological harm or suffering to women (and men) including threats or acts of coercion, arbitrary deprivation of liberty, private or public, in the family or community (UN Women 2012). SGBV is a serious, life-threatening protection issue, primarily affecting women and girls more than men and boys.

Female Genital Mutilation violates a number of human rights protected by the national constitution, regional and international instruments. In particular, it violates: the right to equality and non-discrimination; the right to life; the right to bodily integrity; reproductive health rights; the right to dignity; freedom from torture and cruel, inhuman or degrading treatment and punishment; and the right to health.

Sex Selection in Favor of Boys is a harmful practice of pervasive social, cultural, political and economic injustices against women, and a manifest violation of women's human rights. Sex selection favoring boys is one form of dis-crimination that may occur before birth, or later on which has far-reaching implications for girl child that translate into shorter breastfeeding times for girls, poorer nutrition, inadequate schooling and fewer inoculations. It may mean that a female child is disadvantaged from birth; it may determine the quality and quantity of parental care and the extent of investment in her development; and it may lead to acute discrimination, particularly in settings where resources are scarce.

Discriminatory social and traditions practices perpetuate the notion that sons should inherit land, and that women and girls should negotiate use of land through male relatives such as fathers, uncles, brothers, husbands, and sons.

Annex 3: Types of Female Genital Mutilation

Type I: Partial or total removal of the clitoris and/or the prepuce.

Type II: Partial or total removal of the clitoris and labia minora, with or without excision of the labia majora.

Type III: Narrowing of the vaginal orifice by cutting and bringing together the labia minora and/or the labia majora to create a type of seal, with or without excision of the clitoris. In most instances, the cut edges of the labia are stitched together, which is referred to as 'infibulation'. This is the most severe form of FGM, is mostly practiced in the north-eastern region of Africa: Djibouti, Eritrea, Ethiopia, Somalia, and Sudan. In West-Africa (Guinea, Mali, Burkina Faso, etc.). This type accounts for 10% (8 million women).

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

According to human rights treaty bodies, FGM is a gender-based practice that targets women and girls in ways that directly diminish their ability to enjoy their human rights on an equal basis with men, thereby violating rights to non-discrimination and equality.

Annex 4: Short Term Health Risks of Female Genital Mutilation

Severe pain	Cutting the nerve ends and sensitive genital tissue causes extreme pain. The healing period is also painful
Excessive bleeding (haemorrhage)	Can result if the clitoral artery or other blood vessel is cut
Shock	Can be caused by pain, infection and/or haemorrhage
Genital tissue swelling	Due to an inflammatory response or local infection
Infections	May spread after the use of contaminated instruments (e.g. use of same instruments in multiple genital mutilation operations), and during the healing period
HIV infection	The direct association between FGM and HIV remains unconfirmed, although the cutting of genital tissues with the same surgical instrument without sterilization could increase the risk for transmission of HIV between girls who undergo FGM together
Urination problems	These may include urine retention and pain passing urine. This may be due to tissue swelling, pain or injury to the urethra
Impaired wound healing	Can lead to pain, infections and abnormal scarring
Death	Death can result from infections, including tetanus, as well as haemorrhage that can lead to shock
Mental health problems	The pain, shock and use of physical force during the event, as well as a sense of betrayal when family members condone and/or organize the practice, are reasons why many women describe FGM as a traumatic event

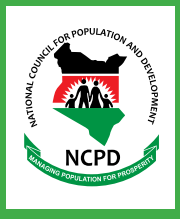
Source: SWOP Report, 2020

Annex 5: Long Term Health Risks of Female Genital Mutilation

Pain	Due to tissue damage and scarring that may result in trapped or unprotected nerve endings
Chronic genital infections	With consequent chronic pain, and vaginal discharge and itching. Cysts, abscesses and genital ulcers may also appear
Chronic reproductive tract infections	May cause chronic back and pelvic pain
Urinary tract infections	If not treated, such infections can ascend to the kidneys, potentially resulting in renal failure, septicaemia and death. An increased risk of repeated urinary tract infections is well documented in both girls and adult women who have undergone FGM
Painful urination	Due to obstruction of the urethra and recurrent urinary tract infections
Vaginal problems	Discharge, itching, bacterial vaginosis and other infections
Menstrual problems	Obstruction of the vaginal opening may lead to painful menstruation (dysmenorrhoea), irregular menses and difficulty in passing menstrual blood, particularly among women with type III FGM
Excessive scar tissue (keloids)	Excessive scar tissue can form at the site of the cutting
HIV infection	Given that the transmission of HIV is facilitated through trauma to the vaginal epithelium, which allows the direct introduction of the virus, it is reasonable to presume that the risk of HIV transmission may be increased as a result of FGM due to the increased risk of bleeding during intercourse
Sexual health problems	FGM damages anatomical structures that are directly involved in female sexual function and can therefore also have an effect on women's sexual health and well-being. Removal of, or damage to, highly sensitive genital tissue, especially the clitoris, may affect sexual sensitivity and lead to sexual problems, such as decreased sexual desire and pleasure, pain during sex, difficulty during penetration, decreased lubrication during intercourse and reduced frequency or absence of orgasm (anorgasmia). Scar formation, pain and traumatic memories associated with the procedure can also lead to such problems
Childbirth complications (obstetric complications)	FGM is associated with an increased risk of caesarean section, post-partum haemorrhage, recourse to episiotomy, difficult and/or prolonged labour, obstetric tears/lacerations, instrumental delivery and extended maternal hospital stay. The risks increase with the severity of FGM
Obstetric fistula	A direct association between FGM and obstetric fistula has not been established. However, given the causal relationship between prolonged and obstructed labour and fistula, and the fact that FGM is also associated with prolonged and obstructed labour, it is reasonable to presume that both conditions could be linked in women living with FGM

Perinatal risks	Obstetric complications can result in a higher incidence of infant resuscitation at delivery and intrapartum stillbirth and neonatal death
Mental health problems	Studies have shown that girls and women who have undergone FGM are more likely to experience post-traumatic stress disorder, anxiety disorders, depression and somatic (physical) complaints, such as aches and pains, with no organic cause

Source: SWOP Report, 2020



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