



A baseline study on  
child marriage, teenage pregnancy and  
female genital mutilation/ cutting  
in Kenya

Baseline Report  
December 2016

by

Tabitha Gitau  
Lincie Kusters  
Maryse Kok  
Anke van der Kwaak

Royal Tropical Institute  
Amsterdam, the Netherlands

# Preface

**YES I DO.** is a strategic alliance of five Dutch organizations which main aim is to enhance the decision making space of young people about if, when and whom to marry as well as if, when and with whom to have children. Funded by the sexual and reproductive health and rights policy framework of the Ministry of Foreign Affairs of the Netherlands, the alliance is a partnership between Plan Nederland, Rutgers, Amref Flying Doctors, Choice for Youth and Sexuality, and KIT | Royal Tropical Institute. Led by Plan, the alliance members have committed to a five year programme to be implemented between 2016 and 2020 in seven countries: Ethiopia, Indonesia, Kenya, Malawi, Mozambique, Pakistan and Zambia.

The YES I DO Alliance partners and the Ministry of Foreign Affairs of the Netherlands acknowledge that child marriage, teenage pregnancy and female genital mutilation/cutting are interrelated issues that involve high health risks and human rights violations of young women and impede socioeconomic development. Therefore, the YES I DO programme applies a mix of intervention strategies adapted to the specific context of the target countries. The theory of change consists of five main pathways: 1) behavioural change of community and "gatekeepers", 2) meaningful engagement of young people in claiming for their sexual and reproductive health and rights, 3) informed actions of young people on their sexual health, 4) alternatives to the practice of child marriage, female genital mutilation/cutting and teenage pregnancy through education and economic empowerment, and 5) responsibility and political will of policy makers and duty bearers to develop and implement laws towards the eradication of these practices.

The programme includes a research component to investigate the interlinkages between child marriage, female genital mutilation/cutting and teenage pregnancy and look at what works, how and why in the specific country contexts. The research focuses on testing the pathways of the theory of change, underlying assumptions and interventions as well as on looking for mechanisms triggering change and enhancing programme effectiveness. To that end, the research component of YES I DO started with a baseline study in each of the seven countries where the programme is implemented.

The aim of the baseline studies is to provide a contextualized picture of the prevalence, causes and consequences of child marriage, teenage pregnancy and female genital mutilation/cutting (where applicable) in the intervention areas of the YES I DO programme. Also, the studies aim to act as a reference point for the monitoring and evaluation of the YES I DO programme throughout its implementation. In four of the seven countries, the baseline studies included control areas. Each baseline study was conducted by KIT | Royal Tropical Institute, in close collaboration with local research partners.

The present report details the baseline study conducted in Kenya. The report draws on literature about child marriage, female genital mutilation/cutting and teenage pregnancy in Kenya, details the methodology used, presents the main results and provides general recommendations for policy and practice on child marriage, female genital mutilation/cutting and teenage pregnancy in Kenya. The findings and recommendations can be used by different stakeholders working in the YES I DO programme as well as in other programmes on sexual and reproductive health and rights of young people.

## ACKNOWLEDGEMENTS

The authors wish to thank the YES I DO alliance team in Kenya for their cooperation and supporting role in the research project and for their constructive contribution during the validation workshop and update meetings. Special thanks go to our study participants for agreeing to participate in this research; we also extend our sincere gratitude to the community leaders in Kajiado for their unwavering support. Finally, we would like to acknowledge the data collection team for going out in the field and ensuring that data were efficiently collected.

# Table of contents

<b>LIST OF TABLES AND FIGURES</b>	5
<b>LIST OF ACRONYMS AND KEY TERMS</b>	6
<b>EXECUTIVE SUMMARY</b>	7
<b>1. INTRODUCTION</b>	10
1.1 BACKGROUND ON CHILD MARRIAGE, TEENAGE PREGNANCY AND FEMALE GENITAL MUTILATION/CUTTING	10
1.1.1 CHILD MARRIAGE	10
1.1.2 TEENAGE PREGNANCY	11
1.1.3 FEMALE GENITAL MUTILATION/ CUTTING	11
1.1.4 INTER-RELATIONSHIPS BETWEEN CHILD MARRIAGE, TEENAGE PREGNANCY AND FEMALE GENITAL MUTILATION/ CUTTING	12
1.2 THE PROGRAMME’S THEORY OF CHANGE IN KENYA	13
1.3 THE YES I DO RESEARCH COMPONENT IN KENYA	15
1.3.1 RELEVANCE OF THE RESEARCH: JUSTIFICATION	15
1.3.2 OBJECTIVES OF THE STUDY	15
<b>2. METHODOLOGY</b>	16
2.1 OVERVIEW OF METHODS AND STUDY SITES	16
2.2 DATA COLLECTION METHODS	16
2.3 SELECTION AND RECRUITMENT OF STUDY PARTICIPANTS	18
2.4 DATA ANALYSIS	18
2.5 ETHICAL CONSIDERATIONS	19
<b>3. RESULTS</b>	20
3.1 CHARACTERISTICS OF THE STUDY POPULATION	20
3.2 CHILD MARRIAGE	21
3.2.1 REASONS FOR CHILD MARRIAGE	21
3.2.2 CONSEQUENCES OF CHILD MARRIAGE	24
3.2.3 REFUSING MARRIAGE	24
3.2.4 COMMON WAYS OF MARRIAGE	25
3.2.5 MARRIAGE REGISTRATION	25
3.2.6 OPINIONS ON CHILD MARRIAGE	26
3.3 TEENAGE PREGNANCY	27
3.3.1 CIRCUMSTANCES OF GETTING PREGNANT	28
3.3.2 CONSEQUENCES OF TEENAGE PREGNANCY	29
3.4 FEMALE GENITAL MUTILATION/CUTTING	30
3.4.1 CULTURAL CONTEXT, CUSTOMS AND BELIEFS	30
3.4.2 CIRCUMSTANCES OF FEMALE GENITAL MUTILATION/CUTTING	31
3.4.3 YOUNG WOMEN’S FEELINGS AND PERCEPTIONS TOWARDS FEMALE GENITAL MUTILATION/CUTTING	32
3.4.4 CONSEQUENCES OF FEMALE GENITAL MUTILATION/CUTTING	33
3.5 COMMUNITY CONTEXT	34
3.5.1 SOCIAL NORMS REGARDING YOUNG WOMEN EN MEN	34
3.5.2 PHYSICAL AND SEXUAL VIOLENCE AMONG MARRIED PERSONS	34
3.5.3 THE ROLE OF DIFFERENT STAKEHOLDERS	36
3.6. YOUTH ENGAGEMENT	38
3.6.1 TALKING ABOUT SEXUALITY AND RELATIONSHIPS	38
3.6.2 WORRIES ABOUT SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS	39
3.7 SEXUAL AND REPRODUCTIVE HEALTH SERVICE UTILIZATION AND INFORMATION	39
3.8 GIRLS EMPOWERMENT	40
3.9 POLICY AND LEGAL ISSUES: KNOWLEDGE ABOUT MARRIAGE LAW	40

<b>4. DISCUSSION</b>	42
<b>5. CONCLUSIONS AND RECOMMENDATIONS</b>	45
<b>6. REFERENCES</b>	46

# List of tables and figures

## LIST OF TABLES

TABLE 1.	Overview of methods and number of participants	17
TABLE 2.	Socio-demographic characteristics between respondents in the intervention and control areas	20
TABLE 3.	Child marriage	22
TABLE 4.	Marriage certification	24
TABLE 5.	Teenage pregnancy	27
TABLE 6.	FGM/C	30
TABLE 7.	Young women's feelings and perceptions towards FGM/C	33
TABLE 8.	Experience of physical violence	34
TABLE 9.	Frequency of sexual harassment	35
TABLE 10.	SRHR service utilization and knowledge	39
TABLE 11.	Knowledge about marriage law	41

## LIST OF FIGURES

FIGURE 1.	Yes I Do programme's theory of change in the Kenyan context	13
FIGURE 2.	Pressure to get married among married respondents	22
FIGURE 3.	Choice in marriage among married respondents	22
FIGURE 4.	Common ways of marriage	25
FIGURE 5.	Opinions on child marriage	26
FIGURE 6.	Opinions on the benefits of child marriage	27
FIGURE 7.	Consequences of FGM/C	33
FIGURE 8.	Opinions on physical violence in case of family dishonour	35
FIGURE 9.	SRHR topics discussed by young people with family and/or friends	38
FIGURE 10.	Young people's main worries around SRHR	39
FIGURE 11.	Ways of preventing pregnancy	40

# LIST OF ACRONYMS AND KEY TERMS

## ACRONYMS

AMREF	African Medical and Research Foundation
ANC	Antenatal Care
CBO	Community Based Organization
DHS	Demographic Health Survey
FBO	Faith Based Organization
FGD	Focus Group Discussion
FGM/C	Female Genital Mutilation/Cutting
FP	Family Planning
IDI	In-depth Interview
KDHS	Kenya Demographic and Health Survey
KII	Key Informant Interview
KIT	Royal Tropical Institute
NGO	Non-Governmental Organization
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexual Transmitted Infection
UNICEF	United Nations International Children Educational Fund
UNFPA	United Nations Population Fund
UN	United Nations

## LIST OF TERMS

Young women and men: all girls and boys within the age range 15 to 24.

Child marriage: any legal or customary union involving a girls or boy below the age of 18.

Teenage pregnancy: all pregnancies before the age of 20.

Female genital mutilation/cutting: all procedures involving partial or total removal of the external female genitalia or another injury to the female genital organs for non-medical reasons.

# Executive summary

## INTRODUCTION

Child marriage, teenage pregnancy and female genital mutilation/cutting (FGM/C) are manifestations of deeply rooted gender inequalities, social norms and poverty. In addition, limited economic perspectives and inadequate access to (comprehensive sexuality) education and adolescent sexual and reproductive health services are contributing factors. Since 2016, the “Yes I Do” Alliance, consisting of Plan Netherlands, Amref Netherlands, Choice for Youth and Sexuality, Rutgers and the Royal Tropical Institute (KIT), has started a programme that aims to address these three problems by applying a mix of context-specific intervention strategies in Kenya.

## OBJECTIVES

The overall aim of this study was to collect baseline data on the causes and effects of child marriage, teenage pregnancy and FGM/C, to inform context specific interventions in Kajiado County, Kenya.

The specific objectives for the study included:

1. To describe the socio-demographic and behavioural characteristics of the sample
2. To explore attitudes of community members and gatekeepers around child marriage, teenage pregnancy and FGM/C, whether and to what extent they take action to prevent child marriage, teenage pregnancy, and FGM/C and which factors influence this and how
3. To explore and analyse whether and to what extent adolescents take informed action on their sexual and reproductive health and which factors influence this and how
4. To explore and analyse whether and to what extent education and economic empowerment of young women provide them with alternatives beyond child marriage, teenage pregnancy and FGM/C
5. To provide insight into developed and implemented laws and policies on child marriage, teenage pregnancy and FGM/C
6. To contribute to the evidence on effective and context-specific intervention strategies to eliminate child marriage and FGM/C and reduce teenage pregnancy

## METHODOLOGY

The study was conducted in Kajiado County; Kajiado West was the intervention area (Ilodokilani and Ewaso Oo Nkidong’i) and Kajiado Central was the control area (Matapato and Purko). The study used a mixed methods approach. A standard survey tool was used to collect quantitative data from a total of 1,368 youth aged 15-24 years. Twenty-five percent of the sample was male and 75% was female. Qualitative data were collected to provide a more in-depth understanding of the causes and consequences of child marriage, teenage pregnancy and FGM/C. Thirteen focus group discussions (FGDs) were conducted with females and males between the ages 15-19 and 20-24 as well as guardians. Seventeen in-depth interviews were conducted: two with females and two with males between the ages 15-19 and 20-24 years, five with caregivers, two with health workers and two with teachers. Lastly, a total of five key informant interviews was conducted with health workers, administrative leaders, and non-governmental organization staff.

## RESULTS

### GENERAL CHARACTERISTICS OF THE SURVEY RESPONDENTS

A total of 1,368 respondents were interviewed; the majority (74%) was female and over 60% of the respondents (64.3%) were in the 15-19 years age group. Among all respondents, 22.7% had ever married and 21.3% were married at the time of the survey. The intervention area had twice the proportion (29.6%) of married young people than the control area (15.6%). Most of the respondents had received mainstream education across both areas, with only 10% having received education up to the university/tertiary level.

Most (86.5%) of the respondents were unemployed. Respondents with a form of employment were either self-employed, casual/part time labourers or in informal trading. When stratified by age group, significantly more 15-19 years olds (74.7%) were unemployed and still in school compared to 20-24 years olds (25.3%). Almost all respondents reported to belong to a religion, with quite some variety including Christians, Muslims and others. With respect to household size, on average respondents reported to be living with six persons across both intervention and control areas.

### **CHILD MARRIAGE**

A total of 310 (22.7%) respondents reported to have ever been married. Of these, close to half (49.1%) were married when they were below age of 18. Of the married respondents, 19.4% were married when they were below 14 years, 43.9% were married between 15 to 18 years and 36.7% between 19 to 24 years. Of the 310 respondents who had ever been married, 96% were female. The child marriage rate among female respondents aged 18-24 years was 22%. Significantly more females than males had experienced child marriage.

Respondents who dropped out of school due to marriage were 37 in total, all female, and nearly all (88%) were from the intervention area. In total, 3.6% of all female respondents dropped out of school because of marriage, and 1.6 % of the female respondents aged 15-17 dropped out of school because of child marriage. It should be noted that this figures have a high probability to be underreported. The average age gap between married young women and their partner was nine years. This is in line with the qualitative finding that young women are married off to older men in exchange of financial benefits for the parents of the young women. The qualitative data indicate that traditional marriage involves consent from families and payment of dowry (bride price) prior to marriage. The decision to marry was reported to be often a result of coercion or as a means of addressing other issues, such as pregnancy, extreme poverty, peer pressure or preserving family honour. The findings indicate that, among the Massai community, marriage is a common response to teenage pregnancy, as a means to avoid shame.

### **TEENAGE PREGNANCY**

The overall teenage pregnancy rate among young women aged 20-24 was 42%. Twelve percent of all female respondents aged 15-24 had dropped out of school because of a pregnancy, 9.8% of the female respondents aged 15-19 dropped out of school because of a teenage pregnancy (also here, this might be underreported). None of the young men reported to have left school as a result of a pregnancy. About half of the female respondents who had had a teenage pregnancy and child marriage (47.7 %) married before the teenage pregnancy occurred, 17.4% had first the teenage pregnancy and then a marriage, and 33.3% had experienced both teenage pregnancy and child marriage in the same year.

### **FEMALE GENITAL MUTILATION/ CUTTING**

Approximately half the female respondents (51.8%) reported to have undergone FGM/C, with a higher proportion being observed in the intervention area (56%) compared to the control area of the study (45%). About 60% of the respondents reported that FGM/C was a social norm, with the majority (76%) of the respondents reporting that FGM/C is carried out at ceremonies. At the same time, the majority (88%) reported that they had no desire to circumcise their daughters.



## **DISCUSSION**

Child marriage, teenage pregnancy and FGM/C is common among young women in Kajiado County. Most study participants indicated that FGM/C has an effect on child marriage and that child marriage is mainly beneficial to the young women's parents or family with negative effects on young women's health and education. Availability, access and utilization of family planning services was found to be minimal in Kajiado County. There is need for improving accessibility and increasing utilisation of these services to reduce the rate of teenage pregnancy and child marriage. Although FGM/C is common among the Massai community, data indicate a declining trend. However, more efforts are needed to comprehensively address the problem and consequently eliminate the practice. Further, males who were seen as the household heads by the majority of the study participants, and who are key decision makers in communities, need to be better engaged in seeking alternatives on the issues of FGM/C and child marriage.

## **RECOMMENDATIONS FOR YES I DO**

1. Develop and adopt commitments to ending child marriage and FGM/C by community leaders, health workers and parents.
2. Engage (young) men in developing and adopting commitments to ending child marriage and FGM/C and sensitize community members to report cases of FGM/C and child marriage.
3. A religious-oriented approach can be an effective strategy to try to demonstrate that FGM/C is not compatible with the religion of a community and thereby can lead to a change of attitude and behaviour.
4. Peer education can be crucial for transmitting messages related to FGM/C, child marriage, access to sexual and reproductive health and rights services and prevention of teenage pregnancy.
5. Promote young women and men's education to know and exercise their rights, develop skills to support their own life plans and to have opportunities to connect with their peers and support each other.
6. Schools to offer comprehensive sexuality education as part of the school curriculum, to expand learners' knowledge and understanding on their sexual and reproductive health and rights, and how they can access services.
7. Involve local leaders and other stakeholders in promoting (young) women's and girl's rights through education-in-culture and culture-in-education.
8. Promote easy and confidential access to family planning services through health centres, school-linked health centres and condom availability programmes to reduce teenage pregnancy.
9. Provide adequate health, education, justice and other services, to remove structural barriers that push young women into child marriage, teenage pregnancy and FGM/C. These services include providing adolescent-friendly health services, ensuring that schools are accessible and child friendly, and providing safe spaces where adolescents can meet and discuss their issues freely.
10. Promote agency and empowerment of young women so that they can better influence decision making processes around harmful practices.
11. Provide financial assistance in the form of bursaries to enable young women from poor backgrounds to access quality education and/or allow school re-entry programmes for teenage mothers.
12. Review existing laws and ensure that legal and policy frameworks are in line with registration of marriages, the minimum age for marriage, and with the African Charter on the Rights and Welfare of the Child. In addition, remove legal loopholes related to parental consent or customary laws.
13. Support enforcement programmes focused on the implementation of laws against FGM/C and child marriage.
14. Strengthen civil registration systems, which record births and marriages.

# 1. Introduction

Child marriage, teenage pregnancy and female genital mutilation/cutting (FGM/C) are manifestations of deeply rooted gender inequality and social norms, poverty and limited economic perspectives, inadequate access to (comprehensive sexuality) education and adolescent sexual and reproductive health (SRH) services, and voiceless youth. Child marriage, teenage pregnancy and FGM/C are interrelated issues that involve high health risks and human rights violations of young women, and impede socio-economic development in a large number of developing countries. Following lessons learnt from current programmes, as well as evaluations and recommendations of international organizations like UNICEF, UNFPA (Loaiza Sr and Wong 2012, Duncan, Sommarin et al. 2013) and “Girls not Brides”, the “Yes I Do” Alliance, consisting of five partners, will address child marriage, teenage pregnancy and FGM/C with a five-year programme, applying a mix of intervention strategies adapted to the specific contexts of the target countries, including Kenya.

## 1.1 BACKGROUND ON CHILD MARRIAGE, TEENAGE PREGNANCY AND FEMALE GENITAL MUTILATION/CUTTING

### 1.1.1 CHILD MARRIAGE

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. In practice, young women are most likely to experience child marriage. Although child marriage is considered a human rights violation, more than 30% of today’s women in developing countries were married before their 18th birthday and a total of 70 million girls worldwide are affected, mostly in South Asia and Sub-Saharan Africa (UNICEF 2014). In Kenya, the age at first marriage has increased over time; from 19 to 20 as the mean age of first marriage among women aged 25-49 (KDHS 2014, 2003, 1998). However, child marriage is common, even though it is illegal (KNBS and ICF Macro 2010). At a national level, the prevalence of child marriage has declined but remains high. Data indicate that the percentage of women first married by the age of 18 was 32.6% in 2003 and 28.7% in 2014 (KDHS 2014, 2003).

In many settings, child marriage marks the beginning of frequent and unprotected sexual intercourse, leading to a greater risk of sexual transmitted infections (STIs), HIV early pregnancy, and a high number of children with limited spacing. Research indicates that worldwide, 90% of the teenage pregnancies take place within marriage and the complications related to these pregnancies and childbirth are among the leading causes of death among young women aged 15 to 19 in low- and middle-income countries (Williamson 2012). Studies from Kenya and Zambia show that married young women had 50% higher rates of HIV prevalence compared to unmarried sexually active girls. This was due to more frequent sexual intercourse, lower condom use and older partners who were more likely to be HIV-positive (Clark 2004). Besides these SRH related consequences, young brides and their children experience poor overall health and nutrition. Compared to women who marry later, young brides often have less access to information, education and health services (such as immunization), which is directly linked to decreased investments in education and health for their children (Williamson 2012).

Literature on child marriage highlights that when young women marry early, their formal education often terminates, which prevents them from acquiring knowledge and skills that determine their prospects for employment opportunities (Williamson 2012). Schools do not only provide education but also allow young women to develop social skills and networks; and provide them with support systems enabling them to be mobile and participate in community activities (Williamson 2012). Various consequences of child marriage and school drop-out have been pointed out: less chances of participation in decision making (within households and in the broader society), greater risks of being subjected to violence, isolation from school, friends and work places and therefore lack social support which is critical for their emotional-wellbeing and economic opportunities, and also less ability to negotiate safe sex, birth spacing, contraceptive use and to protect themselves from gender-based violence (Parsons et al. 2015; Muthengi et al., 2015; Williamson 2012).

### 1.1.2 TEENAGE PREGNANCY

Teenage pregnancy, defined as pregnancy before the age of 20, is a reality for 7.3 million young women in developing countries every year (UNFPA 2016). As stated above, complications from pregnancy and childbirth are among the leading causes of death among young women aged 15-19 (Williamson 2012). A recent study has indicated that teenage pregnancy is highly prevalent in Sub-Saharan Africa and that the proportion of teenage pregnancy that ends in (unsafe) abortions vary highly (4%-55%) between countries. In Kenya, in 2012, the pregnancy rate was 174 among 1,000 females aged between 15 -19 years (Sedgh et al. 2015). At the national level, the percentage of women (25-49 years) who had their child by the age of 18 was 29.9% in 2008/9 (KNBS 2010). Child marriage has been indicated as a major cause of teenage pregnancy (KDHS, 2014).

The causes and consequences of teenage pregnancy have been the topic of many studies and debates (Onsomu et al., 2014). Generally, all studies acknowledge that teenage pregnancy is associated with poor social and economic circumstances. Poverty, low level of education, being from an ethnic minority, lack of access to SRH information and services: all increase the likelihood for young women to become pregnant (Williamson 2012). Studies have shown that young people from families with a low socio-economic status have a higher chance of teenage pregnancy (Miller, Benson et al. 2001). In addition, social and cultural norms and values at the family and society level play a role. For example, parent/child connectedness, parental supervision or regulation of children's activities, and parents' values against teen intercourse influence young people's risk for teenage pregnancy. Experience with violence also increases the risk for teenage pregnancy (Miller, Benson et al. 2001). When a teenage pregnancy occurs within marriage, it is mostly intended by the couple. However, at the same time, (unintended) teenage pregnancy is one of the most common reasons for child marriage in many countries, showing the interrelatedness of these two problems.

As with child marriage, teenage pregnancy can have immediate and lasting consequences for young women's health, education and income-earning potential, which are often passed on to her child(ren). As such, it alters the course of young women's entire life. The health-related consequences of teenage pregnancy include risks of maternal death. The risk of death associated with pregnancy is about a third higher among 15 to 19 years olds than among 20 to 24 years olds (Williamson 2012). Besides higher mortality, teenage pregnancy also contributes to illness and disability, fistula, complications from unsafe abortion, STIs and HIV (Williamson 2012). Other consequences of teenage pregnancy are the interruption or termination of education and the accompanying lost opportunities with regard to labour participation and status in the household as well as at the community level.

### 1.1.3 FEMALE GENITAL MUTILATION/ CUTTING

Female genital mutilation or cutting comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. Between 100 and 140 million girls and women in the world are estimated to have undergone FGM/C and more than three million girls are at risk every year (WHO 2010; 28 Too many 2013). FGM/C is a fundamental violation of girls' and women's rights and confronts girls with immediate, life- long physical and psychological distress (OHCHR and UNDP 2008).

There are different types of FGM/C, which are classified into four categories. Type I involves partial or total removal of the clitoris and/or the prepuce (clitoridectomy). Type II involves partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). Type III involves narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation). Type IV involves all other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization. Types I, II and III female genital mutilation have been documented in 28 countries in Africa and in a few countries in Asia and the Middle East (OHCHR, UNDP 2008 and Berg et al. 2014).

Female genital mutilation or cutting is mostly carried out on girls between the ages of 0 and 15 years. The age at which FGM/C is executed varies with local traditions and circumstances (UNICEF 2005, KHDS 2014). In every society in which it is practiced, FGM/C is a manifestation of gender inequality that is deeply entrenched in social, economic and political structures (OHCHR and UNDP 2008, UNFPA and UNICEF 2014). There is a strong link between FGM/C, marriageability and the construction of gender identities (Jones, Ehiri et al. 2004). Analysis of international health data shows a close link between women's ability to exercise control over their lives and their belief that FGM/C should be ended (Miller, Moneti et al. 2005). Where FGM/C is widely practiced, both men and women, usually without question, support it and anyone departing from the norm may face condemnation, harassment and ostracism. As such, FGM/C is a social convention governed by rewards and punishments, which are powerful forces for continuing the practice. In view of this conventional nature of FGM/C, it is difficult for families to abandon the practice without support from the wider community. In fact, it is often practiced even when it is known to inflict harm upon girls, because the perceived social benefits of the practice are deemed higher than its disadvantages (UNICEF 2005). In societies where FGM/C takes place, it is believed to contribute (and be essential) in raising the girl properly and preparing her for adulthood and marriage. In some societies, it is embedded in coming-of-age rituals and girls' entry into women's secret societies (Ahmadu 2000). Often, girls are awarded after the FGM/C, and as such, it has become an important part of the cultural identity of girls and women and may also impart a sense of pride, a coming of age and a feeling of community membership (Behrendt and Moritz 2014).

Female genital mutilation or cutting has many harmful consequences, both physically and psychologically. Women who have undergone genital mutilation have significantly increased risks for adverse events during childbirth, such as post-partum haemorrhage and other obstetric complications (Berg, Odgaard-Jensen et al. 2014; Oloo et al 2011).

In Kenya, the national prevalence of FGM/C is about 21%, but there are large regional differences, with pockets of FGM/C prevalence as high as 98% in the North East (KNBS 2010). According to the Kenya Demographic and Health Survey (KDHS) 2014, 21% of women reported being circumcised compared to 27% in 2008-2009 (KDHS, 2014). In 2011, Kenya passed a law 'the prohibition of the FGM act 2011', that banned FGM nationwide. This law could have contributed to the slight reduction of FGM. The proportion of women that have been circumcised varies per ethnic group, with the majority of women from the Somali (94%), Samburu (86%), Kisii (84%) and Masaai (78%) being circumcised. The age of circumcision is declining, with 43% of young women aged 15-19 having undergone through circumcision between the age of 5 and 9, in comparison with 17% of women aged 45-49 having undergone circumcision between the age of 5 and 9.

#### **1.1.4 INTER-RELATIONSHIPS BETWEEN CHILD MARRIAGE, TEENAGE PREGNANCY AND FEMALE GENITAL MUTILATION/ CUTTING**

Child marriage, teenage pregnancy and FGM/C are interrelated. They have common root causes and social drivers such as gender inequality, social and cultural norms, poverty, and inadequate access to education and sexual and reproductive health and rights (SRHR) information and services. Child marriage and teenage pregnancy have comparable impacts on the health and education of young women and girls, and therefore on economic opportunities, decision-making and agency of young women and girls. Female genital mutilation or cutting also has a negative influence on agency and empowerment of young women and girls. Besides sharing common causes and consequences, these three issues can be mutually reinforcing: child marriage increases the likelihood of teenage pregnancy and the other way around (Williamson 2012). Female genital mutilation or cutting and child marriage seem to be directly linked to each other: in many areas where FGM/C is practiced, undergoing the cut is a prerequisite for marriage (World Vision 2014).

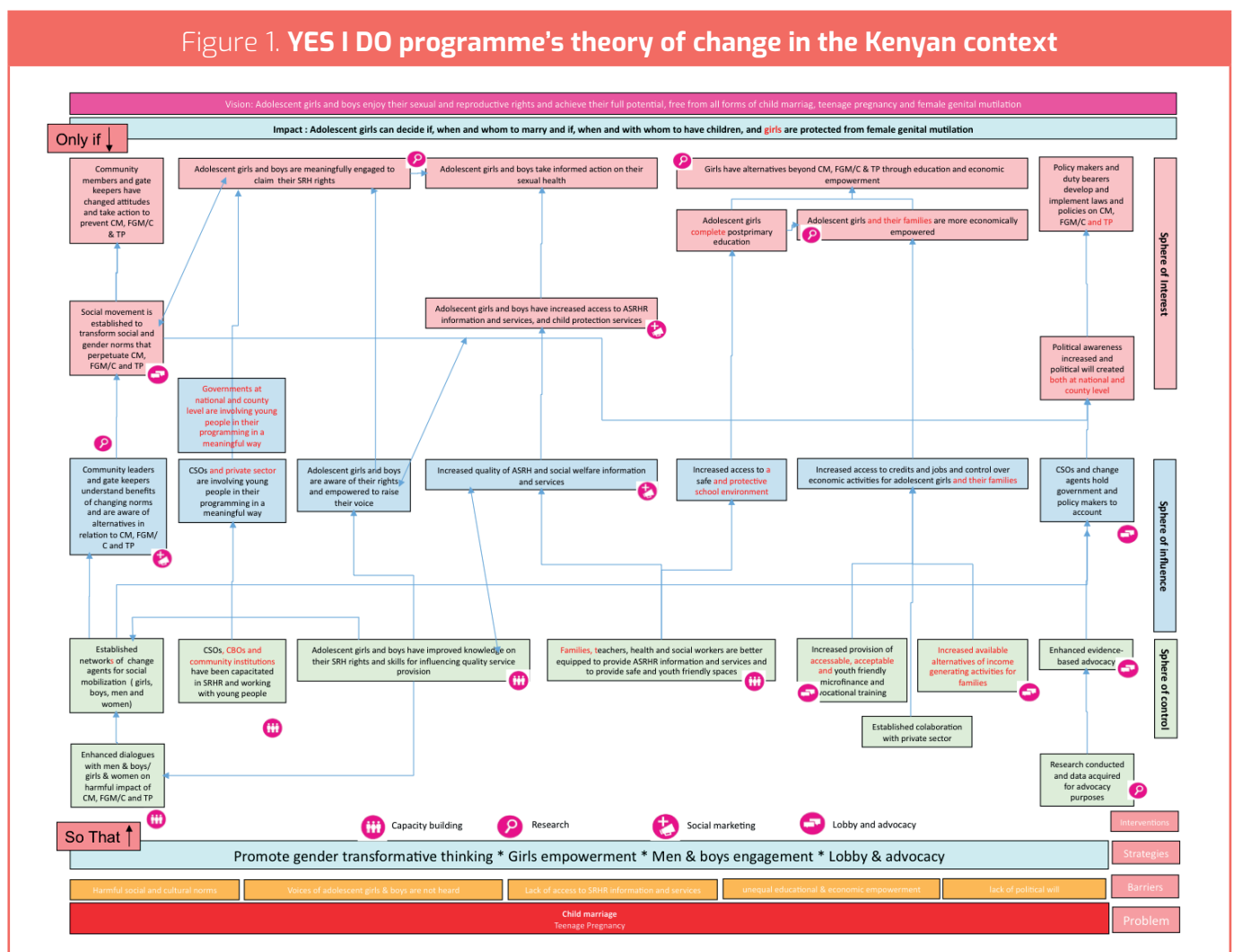
Following the above, it is clear that programmes and interventions that aim to reduce child marriage, teenage pregnancy and FGM/C often share the same focus. They try to address social and cultural norms and values, enhance girl and women's empowerment, increase access to SRH and education services and try to influence laws and regulations related to SRHR. They also involve the same actors, such as girls, boys, young women and men, community members and other duty bearers that have an important role in society. Child marriage, teenage pregnancy and FGM/C are intertwined with respect to the causes, consequences and therefore also the possible intervention strategies to address them.

## 1.2 THE PROGRAMME'S THEORY OF CHANGE IN KENYA

The Yes I Do programme aims to contribute to a world in which adolescent girls can decide if, when and with whom to marry and have children, and are protected from FGM/C. This desires innovative intervention strategies that address child marriage, teenage pregnancy and FGM/C in a combined and holistic manner. The programme's theory of change in the Kenyan context is presented in Figure 1. The programme has five strategic goals:

1. Community members and gate keepers have changed attitudes and take action to prevent child marriage, teenage pregnancy and FGM/C
2. Young women and men are meaningfully engaged to claim their SRH rights
3. Young women and men take informed action on their sexual health
4. Young women have alternatives beyond child marriage, teenage pregnancy and FGM/C through education and economic empowerment
5. Policy makers and duty bearers develop and implement laws and policies on child marriage, teenage pregnancy and FGM/C

The five goals are related to five intervention strategies, illustrated in Figure 1. The intervention strategies focus on forming a social movement, empowering and meaningfully engage young people, improving access to information and services, stimulating education and economic empowerment for young women and enhancing evidence-based lobbying and advocacy for improved legal and policy frameworks. These intervention strategies follow experiences of Yes I Do Alliance partners and global evidence on what works in trying to reduce child marriage, teenage pregnancy and FGM/C (OHCHR and UNDP 2008; Malhotra et al. 2011; Williamson 2012, Loaiza and Liang 2013).



With regard to strategy 1, several interventions will build broad social movements, which can influence social norms in communities on child marriage, teenage pregnancy and FGM/C. They will engage in advocacy towards policy makers and meaningfully engage young women and men to claim their SRH rights. Strategy 2 involves empowering and meaningfully engaging young people. In relation to this, multiple interventions will focus on the role of local government institutions, non-governmental organizations (NGOs) and community-based organizations (CBOs) in meaningfully engaging young women and men in their policy making and programming. As a result, it is hoped that young women and men increasingly and effectively raise their voice; and that mechanisms will be in place to sustain training and meaningful engagement of young people. In addition, government institutions', NGOs' and CBOs' policies and programmes would increasingly reflect the needs of young people in the field of SRHR. Strategy 3, on improving access to information and services, focuses on increased access to quality and affordable youth friendly SRHR and child protection information and services. Strategy 4, on education and economic empowerment for young women, aims to increase the number of years that young women spend in primary and secondary education, and that young women have increased access to productive assets and economic opportunities. Finally, strategy 5 involves enhancing evidence-based lobbying and advocacy for improved legal and policy frameworks. The aim here is that policy makers and duty bearers develop and implement legislation and policies that are directed to eliminating child marriage and FGM/C and preventing teenage pregnancy.

### **1.3 THE YES I DO RESEARCH COMPONENT IN KENYA**

The research component of the Yes I Do programme in Kenya investigates the interlinkages between child marriage, teenage pregnancy and FGM/C. Furthermore, it will look at the effectiveness of the above described intervention strategies. In order to find out what works, how and why, and in which circumstances, in the prevention or mitigation of the impact of child marriage, teenage pregnancy and FGM/C, a mixed methods research containing a base-, mid- and end-line will be conducted. This report details the results of the mixed methods baseline study which was focused on the Maasai in Kajiado West, because studies have revealed that FGM/C, child marriage and teenage pregnancy, although reducing gradually, are an issue of concern in many communities amongst the Maasai. The Maasai are an ethnic group mostly in the southern part of Rift Valley in Kenya who are mainly pastoralists with a few practicing farming activities. The Maasai are among the few Kenyan communities that strongly practice their traditional beliefs, which include FGM/C (Karanja 2003). They are reported to be numbering 841,622 in Kenya, according to the 2009 national census (KNBS, 2009). Over time, the Maasai have resisted the urge by the government to adopt a sedentary lifestyle and instead demanded grazing rights to many National Parks in Kenya (Maasai Education Discovery, 2001).

#### **1.3.1 RELEVANCE OF THE RESEARCH: JUSTIFICATION**

This research aims to bridge the knowledge gaps by investigating the interlinkages between child marriage, teenage pregnancy and FGM/C in Kajiado west as the intervention area (Ilodokilani and Ewaso Oo Nkidong'i) and Kajiado central as the control area (Matapata and Purko North). There is limited evidence on the interrelatedness of FGM/C, teenage pregnancy and child marriage (Rotich, 2014; Austrain 2015). This study takes also a different approach by gaining insights not only from women and girls, but also encouraging active participation of community leaders and men and boys to understand their perceptions around FGM/C, teenage pregnancy and child marriage. Furthermore, the study will look at the effectiveness of the Yes I Do intervention strategies, especially during the mid- and end-line stage. The results of this baseline study and the subsequent research projects of Yes I Do will provide evidence for adjustments of interventions and for lobby and advocacy in-country as well as at the global level.



### 1.3.2 OBJECTIVES OF THE STUDY

The overall goal of this study is to provide insight into the (interrelated) causes and effects of child marriage, teenage pregnancy and FGM/C and the extent to which these causes and effects, and the three problems themselves, are present in the intervention areas of the Yes I Do programme, compared to non-intervention areas, over a period of five years, in Kenya. In addition, the study aims to provide insight into different pathways of change, thereby testing the theory of change, and unravel why and how the Yes I Do intervention strategies do or do not contribute towards improved outcomes related to the five strategic goals, and ultimately a decrease in child marriage, teenage pregnancy and FGM/C.

The specific objectives of this baseline study were:

1. To describe the socio-demographic and behavioural characteristics of the sample
2. To explore attitudes of community members and gatekeepers around child marriage, teenage pregnancy and FGM/C, whether and to what extent they take action to prevent child marriage, teenage pregnancy, and FGM/C and which factors influence this and how
3. To explore and analyse whether and to what extent adolescents take informed action on their sexual and reproductive health and which factors influence this and how
4. To explore and analyse whether and to what extent education and economic empowerment of young women provide them with alternatives beyond child marriage, teenage pregnancy and FGM/C
5. To provide insight into developed and implemented laws and policies on child marriage, teenage pregnancy and FGM/C
6. To contribute to the evidence on effective and context-specific intervention strategies to eliminate child marriage and FGM/C and reduce teenage pregnancy

## 2. METHODOLOGY

A mixed methods approach was undertaken at baseline: both qualitative and quantitative methods were used. This section describes in detail the methodology which was used to collect data at baseline.

### 2.1 OVERVIEW OF METHODS AND STUDY SITES

In April and May 2016, a desk review was conducted on the causes, effects, other contextual elements and existing interventions related to child marriage, teenage pregnancy and FGM/C in Kenya. The desk review informed the in-country stakeholder workshop in April 2016, where a country specific theory of change was developed. During this workshop, the intervention and control areas were decided upon. The study was conducted in Kajiado County; Kajiado West was the intervention area (Ilodokilani and Ewaso Oo Nkidong'i) and Kajiado Central was the control area (Matapato and Purko). The workshop also provided input into the country specific research protocol, including research tools.

A survey that addressed the three problems, and their causes and effects, was administered among young women and men in the intervention and control areas. Focus group discussions (FGDs), in-depth Interviews (IDIs) and key informant interviews (KIIs) were held in the intervention areas, covering the same issues more in-depth. The participants of these FGDs and interviews included young women and men, parents and caregivers, grandmothers, traditional and religious leaders, teachers, health and social workers, staff of CBOs and youth organizations and policy makers.

### 2.2 DATA COLLECTION METHODS

#### QUANTITATIVE METHODS

A community-based cluster sample survey was administered, in which young women and men (15-24 years old) were asked questions related to community norms and values around sexuality and reproduction, young people's ability to claim SRH rights, the role of stakeholders and traditional customs, economic empowerment and experiences with on opinions about child marriage, teenage pregnancy and FGM/C. The survey was administered to more females (75%) than males (25%), because FGM/C, teenage pregnancy and child marriage more directly affect young women. Men can be drivers of change, since in the Maasai community, young women are mainly married off to older men. Moreover, young men are also influenced by and part of local cultural norms and beliefs that prevail in the Maasai community, such as nomadic pastoralism, male circumcision, early marriages, and the dependence on livestock. Including young men in the survey therefore gave a more comprehensive insight into the situation on the ground.

#### QUALITATIVE METHODS

The qualitative baseline also provided insight into a variety of issues related to the theory of change. It covered more in-depth the experiences, opinions and feelings of young people, parents and caregivers, community members, religious and traditional leaders, health and social workers, NGO/ CBO/ youth organization staff and policy makers about social and cultural norms and values, community and youth participation in decision making, sexual and reproductive rights, opportunities for schooling and economic empowerment, and SRHR related policies and laws. The qualitative component of the study was only conducted in the intervention areas and used the following methods:

1. Focus group discussions with groups of females aged between 15-19 and 20-24 years, groups of males aged between 15-19 and 20-24 years, as well as with groups of and parents or caregivers. These FGDs provided information about joint or diverging views, community norms and values about SRHR and specifically the issues (influencing) child marriage, teenage pregnancy and FGM/C.
2. Semi-structured IDIs were held with young women aged between 15-19 and 20-24 years; young men aged between 15-19 and 20-24 years; parents or caregivers; grandmothers or elderly women; religious and traditional leaders; teachers; health and social workers; and CBO and youth organization staff. These IDIs allowed us to obtain in-depth information about the causes and consequence of child marriage, teenage pregnancy and FGM/C. They provided an in-depth understanding of why and how interventions are or will be working or not.



3. Key informant interviews with NGO staff and policy makers. These KIIs provided views and experiences of NGO staff and policy makers regarding the pathways in the theory of change, as well as specific information with regard to strategic goal 5.
4. Stakeholder workshops. These workshops were used as a platform of exchange and reflection of preliminary research results, and helped to validate the findings.

An overview of the methods and the number of participants is presented in Table 1.

Table 1. Overview of methods and number of participants				
Method	Participants	Number of participants in the implementation area	Number of participants in the control area	Total number of participants
Survey	Young women and men (15-24 years)	685	683	1,368
FGDs	<ul style="list-style-type: none"> <li>• Young women (15-19 years)</li> <li>• Young women (20-24 years)</li> <li>• Young men (15-19 years)</li> <li>• Young men (20-24 years)</li> <li>• Parents or caregivers</li> <li>• Male parents/caregivers</li> <li>• Chiefs</li> </ul>	21 (3 groups) 7 (1 group) 8 (1 group) 15 (2 groups) 14 (2 groups) 7 (1 group) 4 (1 group)	0	76
IDIs	<ul style="list-style-type: none"> <li>• Young women (15-19 years)</li> <li>• Young women (20-24 years)</li> <li>• Young men (15-19 years)</li> <li>• Young men (20-24 years)</li> <li>• Parents or caregivers</li> <li>• Grandmothers or elderly women</li> <li>• Religious and traditional leaders</li> <li>• Teachers</li> <li>• Health and social workers</li> <li>• CBO and youth organization staff</li> </ul>	2 2 2 2 2 2 2 1 1 1	0	17
KIIs	<ul style="list-style-type: none"> <li>• NGO staff</li> <li>• Policy makers</li> </ul>	1 4	0	5
Stakeholder workshop	NGO, CBO, youth organization staff and community representatives	1 stakeholder workshop	0	20

Research tools were developed based on existing (partly validated) tools. The tools were pre-tested before data collection started. The pre-test was conducted in Kajiado North, an area that was neither the intervention nor the control area. All discussions and interviews were moderated in the local language to ensure maximum participation. Interview and FGDs were digitally recorded. To ensure validity and reliability of research findings, research assistants were trained in quantitative and qualitative sampling, data collection, data capturing and reporting skills. Research assistants were also trained on ethical issues to ensure that guidance on ethical conduct was clearly understood and implemented. During the fieldwork, the research consultant linked with research assistants and other project staff on a daily basis to discuss any difficulties arising during interviews, which may have implications for the quality of the data collected. Strategies were put in place to address identified difficulties.

## **2.3 SELECTION AND RECRUITMENT OF STUDY PARTICIPANTS**

### **QUANTITATIVE COMPONENT**

Respondents of the survey were randomly selected through two-stage cluster sampling. In both the intervention and control area, two wards were selected. In Kajiado West, Ilodokilani and Ewaso Oo Nkidong'I were included as study sites and in Kajiado Central, Matapato and Purko were selected. Selection of wards was based on similarities of characteristics such as health, employment and economic status of the population. To avoid spill-over effects from intervention to control area, the control area chosen was not too close to the intervention area. In each ward, three villages were randomly selected. Within the selected villages, a fixed number of 25 households were randomly selected. The two starting points were at the edge/ border of the village, decided upon by spinning a bottle. For example, if the bottle pointed towards the east after spinning, one team would start at the eastern edge of the village, and the other team would start at the western edge. They walked towards each other. In one out of four households a young man was interviewed. If multiple persons in the right age/sex group were living in the household, one was randomly selected by asking them to write their names on papers and fold it: the one of whom the paper was randomly selected was interviewed.

A variety of respondents was included: different sexes and ages, in- and out of school youth. The criterion of sex was leading during the fieldwork. If after three young women the next selected household did not have a young man, the closest household with a young man available was included. The data collection was conducted at a time that most young people were at home. If young people were out of their homes and not in the neighbourhood, the closest household with a young person available was included.

The sample size calculation was based on being able to detect a 10% reduction over the period of five years in the percentage of women aged 20-24 who have had a live birth by 18 years. The percentage found in the Demographic Health Survey 2010 was 22.9% for Kenya. This provided a sample size of 230 for females ( $p_w=0.8$ ;  $\text{sig}<0.05$ ). Taking into account possible "design effects" because of the clustered sampling, this was multiplied by 1.5 (yielding 345 females). On top of this, 115 males were added, to gather for a 75%-25% selection of females and males. The total sample size was multiplied by two (yielding a minimum sample size of 920), to be able to detect changes in child marriage rate between the intervention area and control area. However, we aimed to include 1,400 respondents for the survey: we selected 25 households in 28 villages, both in the intervention and control area.

### **QUALITATIVE COMPONENT**

The participants of the qualitative component were purposefully selected with help from the Yes I Do Alliance and local partners. The selection of young people focused on including different ages, sexes and those living in more rural areas. Focus group discussions were performed with homogenous groups. Study participants under the age of 18 were included in the research, and therefore consent of parents or caregivers was needed for this group. Regarding health personnel, those working in the field of SRH have been included in the study. Other study participants (religious and traditional leaders, teachers, social workers, representatives of youth associations and CBOs and policy makers at local level) were selected based on their (active) role within the health system and community – they were identified in consultation with local partners and research team members and also through stakeholder meetings. Table 1 provides an overview of the numbers of participants in the FGDs, IDIs and KIIs.

## **2.4 DATA ANALYSIS**

Survey data were analysed using Stata version 13. Demographical and behavioural data for both the intervention and the control area were described. Associations between dependent and independent variables were also analysed, for example with regard to intervention and control areas and sex of the respondents.

Interviews and FGDs were digitally recorded, transcribed (and, where applicable, at the same time translated into English) and independently checked by someone not involved in transcribing. During data collection, daily review meetings helped to identify emerging themes, completeness of work and inconsistencies coming out of the work. Content analysis of the transcripts was carried out using a comprehensive thematic matrix based on the topic guides,

which facilitated identification of common patterns and trends. Emerging themes were added to this matrix. Nvivo software was used to support the analysis of the data. Narratives were written based on main themes.

The analysis from the quantitative and qualitative components was integrated by a multidisciplinary team. This was done to allow for triangulation and to enable the team to draw conclusions on the causes and consequences of child marriage, teenage pregnancy and FGM/C. To enable data triangulation and validation, stakeholder workshops were held, where the initial findings were discussed.

## **2.5 ETHICAL CONSIDERATIONS**

This study was approved by the ethical review committee of KIT, the Netherlands, and the African Medical and Research Foundation (AMREF) Kenya. All participants gave oral informed consent.

# 3. RESULTS

## 3.1 CHARACTERISTICS OF THE STUDY POPULATION

A total of 1,368 respondents were surveyed. About three third (74%) were female and the rest were male. Sixty-four percent of the participants in the study were between 15 and 19 years old. Twenty-three percent of the participants reported to be married at the time of the survey, with twice the number of married participants in the intervention area (30%) as compared to the control area (16%). Almost all respondents (96%) reported to belong to a religion and mainly identified as Christian. The household size was six persons on average (Table 2).

**Table 2. Socio-demographic characteristics between respondents in the intervention and control areas**

Variables	Intervention area n (%)	Control area n (%)	Total n (%)
<b>Sex</b>			
Young female	509 (74.31%)	510 (74.67%)	1,019 (74.49%)
Young male	176 (25.69%)	173 (25.33%)	349 (25.51%)
<b>Marital status</b>			
Unmarried	482 (70.36%)	576 (84.33%)	1,058 (77.34%)
Married	203 (29.64%)	107 (15.67%)	310 (22.66%)
<b>Age group</b>			
15-19 years	423 (61.75%)	423 (61.75%)	887 (64.84%)
20-24 years	262 (38.25%)	262 (38.25%)	481 (35.16%)
<b>Education</b>			
Basic education	12 (1.75%)	55 (8.05%)	67 (4.90%)
Elite education	3 (0.44%)	18 (2.64%)	21 (1.54%)
Mainstream education	566 (82.75%)	546 (79.94%)	1,112 (81.35%)
No education	89 (13.01%)	52 (7.61%)	141 (10.31%)
Vocational training	14 (2.05%)	12 (1.76%)	26 (1.90%)
<b>Current level of education</b>			
Completed	132 (22.64%)	75 (13.02%)	207 (17.86%)
Lower primary	23 (3.95%)	19 (3.30%)	42 (3.62%)
Upper primary	173 (29.67%)	158 (27.43%)	331 (28.56%)
Secondary	194 (33.28%)	257 (44.62%)	451 (38.91%)
University	53 (9.09%)	55 (9.55%)	108 (9.32%)
Vocational training	8 (1.37%)	12 (2.08%)	20 (1.73%)
<b>Employment</b>			
Unemployed	537 (78.51%)	581 (85.07%)	1118 (81.78%)
Unpaid work	18 (2.63%)	18 (2.64%)	36 (2.63%)
Subsistence farming	0 (0%)	2 (0.29%)	2 (0.15%)
Informal trading	13 (1.90%)	9 (1.32%)	22 (1.61%)
Casual/daily labourer	26 (3.80%)	27 (3.95%)	53 (3.88%)
Contract worker	4 (0.58%)	5 (0.73%)	9 (0.66%)
Self employed	57 (8.33%)	21 (3.07%)	78 (5.71%)
Part-time	20 (2.92%)	17 (2.49%)	37 (2.71%)
Full-time	9 (1.32%)	3 (0.44%)	12 (0.88%)
<b>Religion</b>			
Yes	651 (95.04%)	658 (97.48%)	1,309 (96.25%)
No	34 (4.96%)	17 (2.52%)	51 (3.75%)
<b>Household size</b>	6.76±3.3	6.41±2.4	1,367

Most respondents (81%) had received mainstream education, with 10% having received education up to the university/tertiary level at the time of the survey. The majority of respondents (82%) reported to be unemployed. Respondents with a form of employment were either casual/part time labourers, self-employed, or in informal trade. When stratified by age group, more young people between 15 and 19 years (75%) were unemployed but still in school compared to those 20-24 years old (25%). Overall, there was a significant difference in both the educational level and employment status between sexes. More females (11%) than males (7%) had not acquired any form of education, and more females (76%) than males (24%) reported to be unemployed. The results on educational level of males and females was in line with the qualitative data, which indicate that young men had better opportunities to access and continue education as compared to young women.

Participants in FGDs and interviews made the link between educational level and employment clear. Participants shared that females have lower educational levels and mainly engage in beadwork or milk selling, while males are better educated and therefore have better employment opportunities.

*'The boys are getting an upper hand [employment] in most cases. Sometimes you find that the majority of the girls don't have Degree education and this is being used to rule them out.'* FGD with caregivers

*'No employment opportunities. Men access employment more than women, most girls drop out of school due to pregnancy and early marriages hence they don't acquire the qualifications for employment.'*  
FGD with men 18-24 years

## 3.2 CHILD MARRIAGE

A total of 310 (23%) respondents reported to have ever been married. Of those who reported the age of first marriage (289), close to half (49%) were married when they were below age of 18. Forty-four percent were married between 15 and 18 years, followed by 37% between 19 and 24 years; and 19% were married below 14 years. Significantly more respondents in the intervention area (24%) were married when they were below the age of 14 compared to those in the control area (10%). All males (12) who reported to be married lived in the intervention area, with most of them having been married between 18 and 24 years. The majority of the married respondents was female (94%). Significantly more females than males experienced child marriage. The child marriage rate was 20% among females 18-24 years. There was a difference in the rate of child marriage between the intervention and control area. In the intervention area, 30% of females aged 18-24 were married or in union before the age of 18, while in the control area the rate was lower: 11% (Table 3).

Respondents who dropped out of school due to marriage were 37 in total, all females, with nearly 89% in the intervention area. About 2% of the female respondents aged 15-17 years dropped out of school because of child marriage. The average age gap between married females and their partner was observed to be 9 years. A small difference in age gap was observed between the intervention and control area (Table 3).

### 3.2.1 REASONS FOR CHILD MARRIAGE

Study participants mentioned various reasons for child marriage and stated that the decision to marry was often a result of coercion or a means of addressing other issues such as (extreme) poverty, pregnancy or preserving family honour; or peer pressure.

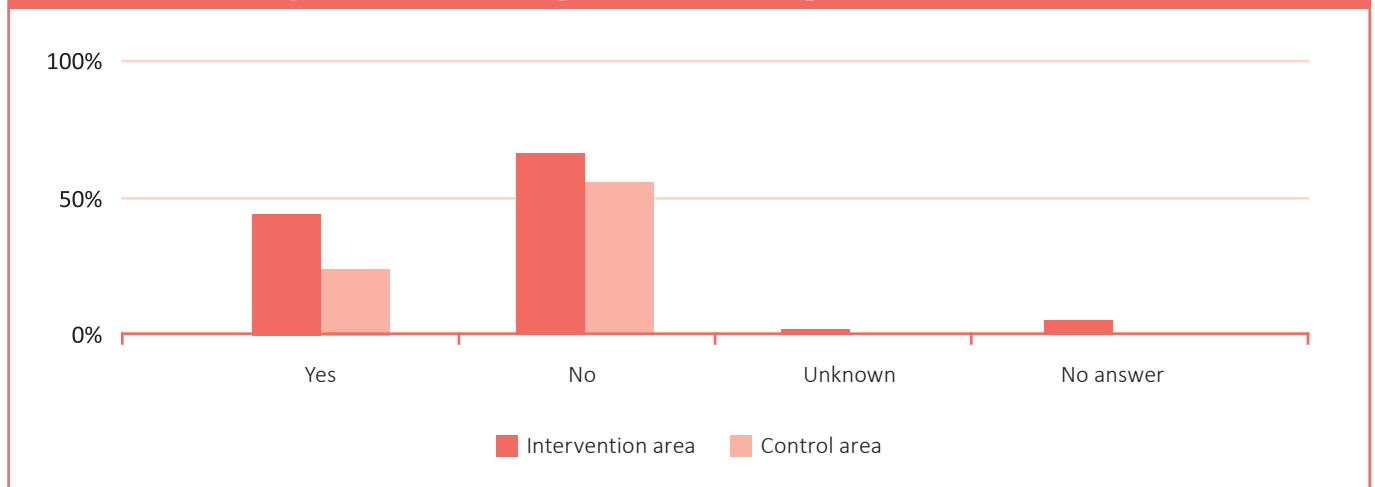
Married respondents were asked about societal pressure into marriage, including family and friends. Thirty-eight percent of the married respondents reported having been pressured to get married. Data indicate that pressure to marry was higher in the intervention area (43%) than in the control area (26%) (Figure 2).

All married survey respondents were also asked whether it was their choice to get married. As Figure 3 shows, about half of the married female respondents responded affirmatively to whether it had been their choice to marry (51%), while the other half did not (48%). Among married male respondents, the percentage of those having made their own choice to marry was higher (71%).

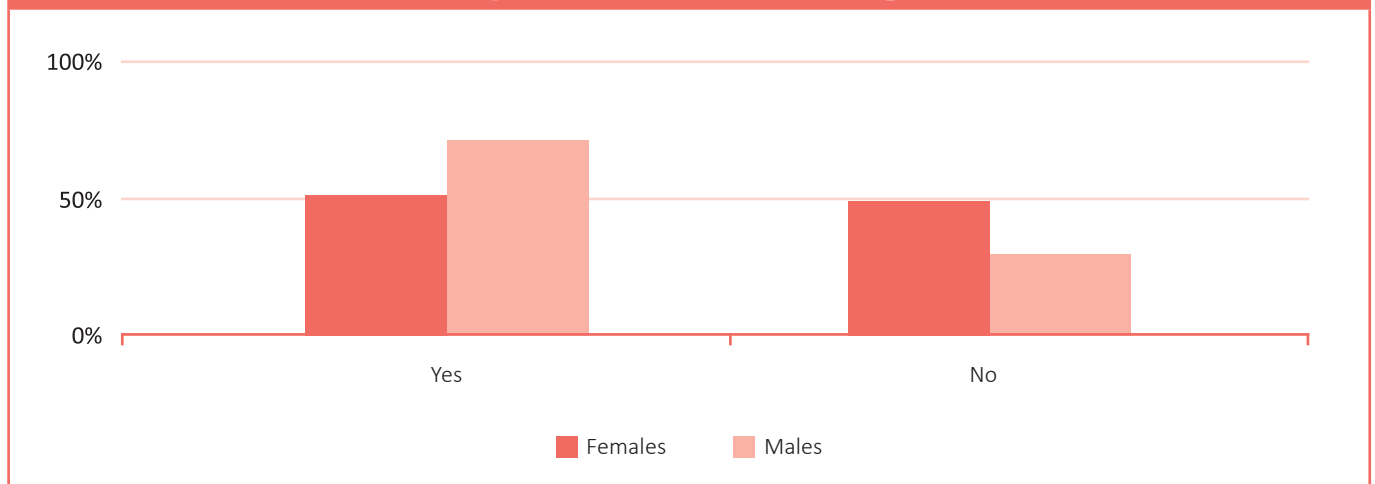
**Table 3. Child marriage**

Child marriage	Intervention area n (%)	Control area n (%)	Total n (%)
Females (18-24 years) who were married or in a union before age 18.	77 (30.3%)	28 (10.7%)	105 (20.3%)
Males (18-24 years) who were married or in a union before age 18.	3 (3.57%)	0 (0%)	3 (1.57%)
Females (15-17 years) old who are (currently) married	33 (13%)	5 (2%)	38 (7.6%)
Males (15-17 years) years old who are (currently) married	1 (1.1%)	2 (3.0%)	3 (1.9%)
Females (15-17 years) who left school due to child marriage	8 (3.2%)	0 (0%)	8 (1.6%)
Females (15-24 years) who left school due to marriage	33 (6.5%)	(0.8%)	37 (3.6%)
Males (15-17 and 15-24 years) who left school due to (child) marriage	0 (0%)	0 (0%)	0 (0%)
Average age gap of married girl and partner	9.8	7.8	9.1

**Figure 2. Pressure to get married among married respondents**



**Figure 3. Own choice to marriage**



The most mentioned reason for child marriage was associated to economic benefits. Both qualitative and quantitative data revealed that among the Maasai community, the most common type of marriage included transactional and pre-arranged marriage. Transactional marriages represented a financial gain for the marrying young women and her family. In some families, transactional marriages were associated to poverty, as they married off their daughters to pay debts or overcome financial burden.

In the case of pre-arranged marriages, agreements relating to marriage could be established before girls were born or later on, when girls were children or reached puberty. In such cases, an older suitor made a proposition to the family indicating his intentions to marry their daughter. These arrangements could include financial support from the man for the girl or her family.

*'[Benefits of marriage] Not really. But the parents will be relieved of the burden of educating her [teenager mother] as well as taking care of her child. The parents will also benefit from the dowry<sup>1</sup> they will receive.'*  
Interview with 23 years old married female

The second most commonly mentioned reason for child marriage by participants was that marriage is a common response to teenage pregnancy. In the FGDs with young females, it was indicated that if a young woman becomes pregnant she should marry the father of the child. If the impregnator denied responsibility, then the young woman was married off to an older man to preserve the reputation and honour of the family and prevent shame. In these cases, young women often married a man that her family selected. These findings also emerged in FGD with young males:

*'They are forced to marry a different man from the one who impregnated her, at times the boyfriend will kidnap her from the man she is married off to. There is enmity between the boy and the girl's family if the father did not marry off the girl to the boy. If a girl refuses to be married off but runs away to be with her boyfriend, the parents will not bother, as they will always marry off her sibling to the man they chose for the other girl.'* FGD with men 19-24 years

During the FGDs, young men also indicated that once a young woman is able to conceive or drops out of school as a result of pregnancy, it means she is ready to marry.

*'When she is able to conceive she is considered ready to be a wife. Once a girl drops out of school due to pregnancy she is considered ready for marriage, as she is now a mother. There is an area where girls do not go to school; they get married off at the age of 9 to grow up in their husband's home.'* FGD with boys 15-17 years

Another common reason for child marriage mentioned by the study participants was the desire to enhance the status in the community of the parents of the marrying young woman. Participants argued that in their Maasai communities, when a young woman is married, her family is more respected.

In an interview with a policy maker, it was highlighted that some young women got married so that they can fit in with their peers, as admiration and perceived freedom is often associated with marriage.

*'In most cases, when a young girl gets married, her friends accompany her and admire her because they think that she has freedom. The next thing you hear is other girls who accompanied the bride also follow to get married at a young age. If they can be barred from accompanying the brides that will save others from getting married too.'* (Interview with policy maker)

<sup>1</sup> Participants refer to 'dowry', which actually means bride price. In the rest of the report, 'dowry' is used, as this was the commonly reported term.

### 3.2.2 CONSEQUENCES OF CHILD MARRIAGE

Young women and men were aware about the potentially harmful consequences of child marriage. Negative consequences of child marriage mentioned by the participants included health risks associated with pregnancy and child birth at a young age, discontinuation from school and psychological problems as a result of lack of experience and knowledge in taking care of a family.

Young women between 19 and 24 years highlighted that child marriage has no benefit but only increased health, psychological, economic and violence related problems:

*'There is no benefit as the girl suffers a lot, these girls are not equipped or aware of the responsibilities of marriage, some girls are too young and not sexually active; they have to run away from their husband for fear of sexual intercourse. In some cases these girls are forced to have sex with the husband, he can invite friends to hold her as he has sex with her and at times his friends also end up having sex with her. This girls bleed, some hurt their limbs, they get infections and even risk contracting sexually transmitted diseases, this girls stay in marriage, as they have nowhere else to go. Should they run away they are beaten and taken back to the husband...The only benefit is to the parents who receive dowry and the man who gets a wife but for the girls it is torture.'* FGD with women 19-24 years

Young men discussed that when a young woman is married she will have little control on the spacing and number of children, which often worsens the economic situation and perpetuates the cycle of poverty.

*'It [early marriage] prolongs the period a woman has babies, leading to a large unmanageable family and poverty, the girls who are married off early do not know how to take care of themselves and the baby, the positive one is that the girls who marry at an early age have a chance of having more children in case she loses her child.'* FGD with boys 15-17 years

### 3.2.3 REFUSING MARRIAGE

FGDs with young women, young men and religious leaders revealed that marriage refusal by young women was not well seen by her family and the community. Participants described that young women refusing marriage were regarded as outcasts and undisciplined.

*'I will use my cousin's example, her parents were illiterate hence they forced her to get married, when she refused she was regarded as an undisciplined girl who did not respect her parents, one is treated as an outcast. The literate people will appreciate the girl for choosing to complete her education. For the uneducated young men they wait for girls to drop out of school so that they get a chance to marry, as they don't believe an educated girl will agree to marry an uneducated man.'* FGD with men 19-24 years

*'In most cases girls do not have a choice in this matter it is the girl's parents who decide, girls who are married off are not happy they lose hope with their lives, when a girl refuses to be married off, the parent will throw a curse at her and this affects her life.'* Interview with religious leader

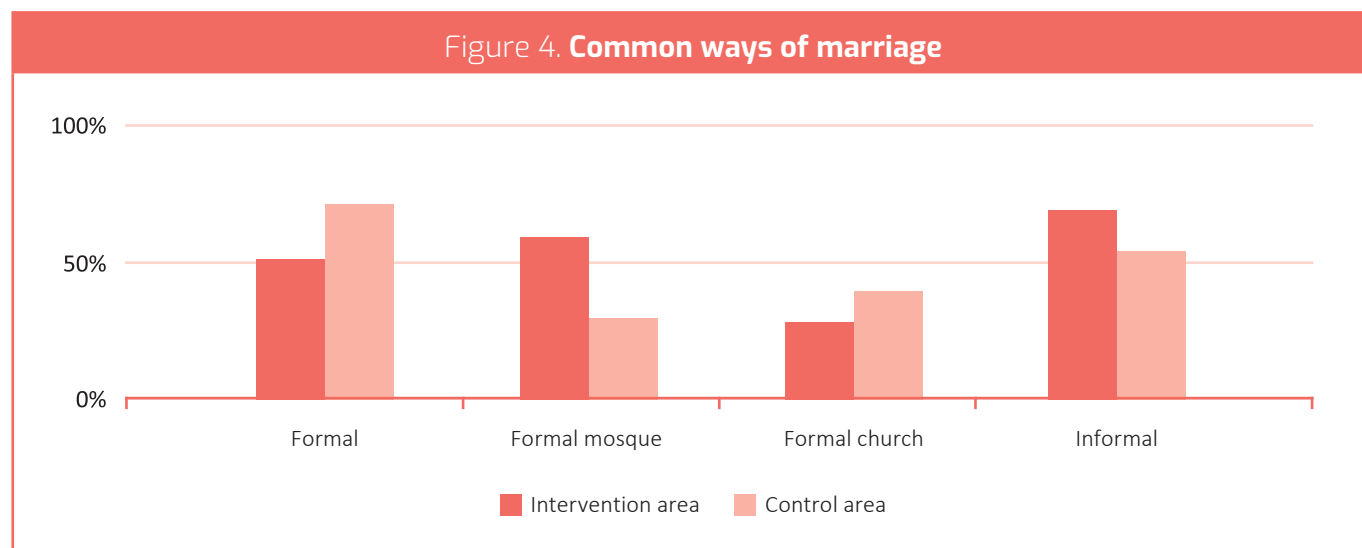
In an FGD with young women as well as in an interview with a religious leader, cases were described where young women run away with the young men they did want to marry or escaped to rescue centres. Some young women shared that they asked for help from rescue centres and/or religious leaders to avoid being married off. In some cases, elders acted as mediators between young women and their parents.

*'The girl and her mother get chased away and they have to seek help from the elders to mediate. Some girls run away to rescue centres, if the father wants to marry a girl off, the mother can make arrangements to take a girl to a rescue centre.'* FGD with girls 15-17 years



### 3.2.4 COMMON WAYS OF MARRIAGE

Data indicate that informal marriage was the most common way of marriage (61%). More respondents in the intervention area (69%) indicated informal marriages to be the main way of marriage compared to the control area (54%). About one third of all respondents reported formal marriages in church as a common way of marriage in Kajiado County. More respondents from the control compared to the intervention area reported formal church and formal ways of marriage (Figure 4).



The payment of a dowry seemed to be more common in informal or traditional marriages, but was also part of formal marriages in church or mosque. In relation to the forms of payment of the dowry, most participants (74%) indicated that it was a combination of cash and in kind payment. Twenty percent of the respondents stated that the payment of the dowry was most commonly in cash, and 5% reported that in kind payments were the most common form.

### 3.2.5 MARRIAGE REGISTRATION

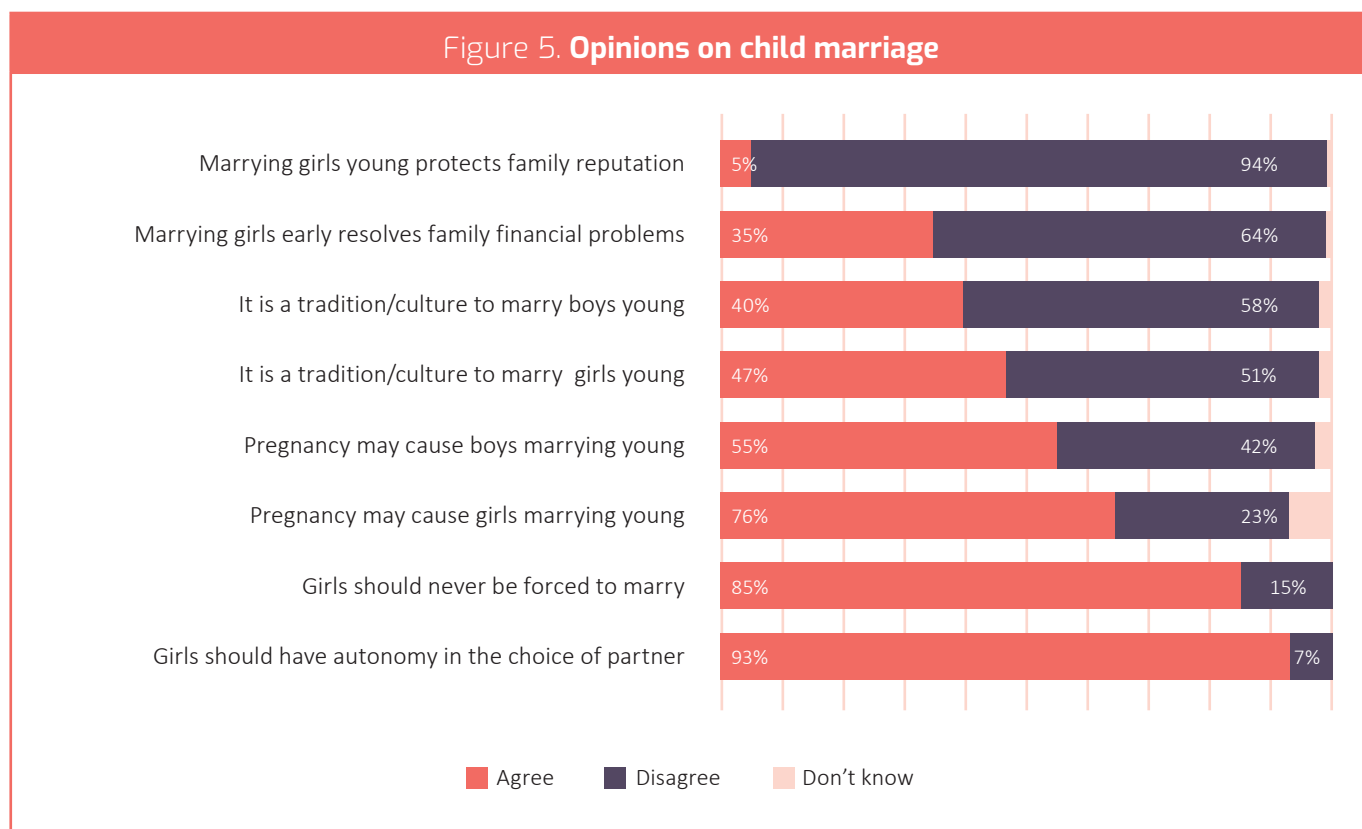
A total of 310 of the respondents were married, however, most of the marriages were not registered (68% in the intervention and 78% in the control area) (Table 4). Of those that had registered marriage, only slightly over a quarter (26%) had copies of their marriage certificates.

**Table 4. Marriage certification**

Variables	Intervention area n (%)	Control area n (%)	Total n (%)
<b>Certificate of 1<sup>st</sup> marriage</b>			
Registered	63 (31.66%)	21 (21.65%)	84 (28.38%)
Not registered	136 (68.34%)	76 (78.35%)	212 (71.62%)
<b>Copy of marriage certificate</b>			
No	52 (83.87%)	11 (52.38%)	61 (73.49%)
Yes	10 (16.13%)	9 (47.62%)	21 (26.30%)

### 3.2.6 OPINIONS ON CHILD MARRIAGE

As perceived by the participants, the ideal age for young women to get married was lower (23 years) than for young men (25 years). Survey respondents agreed (47%) and disagreed (51%) that it is a tradition/culture to marry young girls. There were slightly more respondents (58%) who disagreed that it was a tradition/culture to marry young boys. The majority of respondents (94%) disagreed to the statement that marrying girls young protects family reputation. Furthermore, a high proportion (75%) agreed to the statement that pregnancy causes early marriages for girls, with 55% of the respondents agreeing to the same statement with regard to early marriage of boys. Forty-three percent of the respondents in the intervention area agreed with the statement that marrying girls early resolves family financial problems, while in the control area less respondents agreed to this (27%). The majority of the respondents (85%) agreed with the statement that girls should never be forced to marry, which was reflected across the two areas of the study. A higher proportion (93%) agreed that girls should have autonomy in the choice of partner (Figure 5). Most respondents (75%) across the study areas agreed that girls below 18 are married to men with more wives.

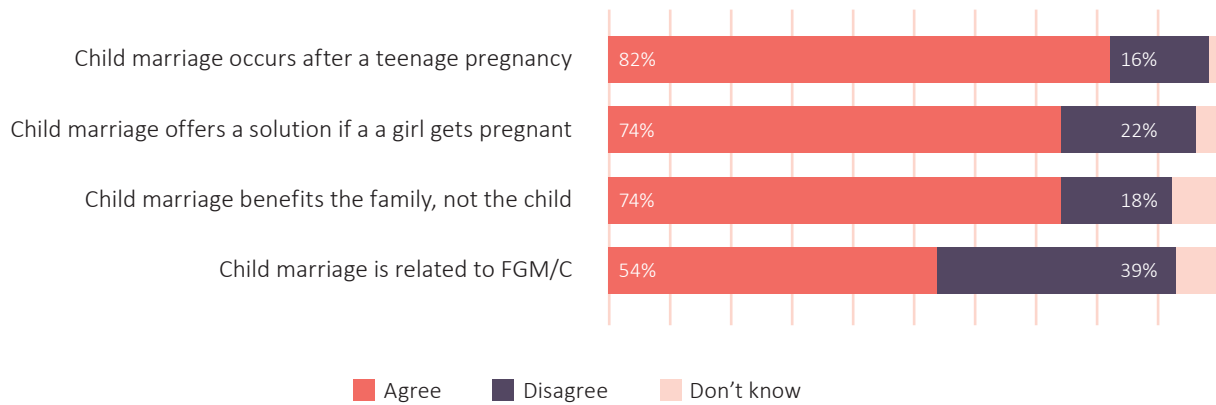


Overall, most respondents (74%) reported that child marriage benefits the family and not the child. As indicated earlier, in the qualitative component, participants also stated that it was clear that the benefits of child marriage were entirely for parents and that the young women got no benefits from being married early.

*‘It is only [benefit of child marriage] to the parent who gets dowry.’* Interview with guardian

A similar proportion (74%) believed that child marriage offers a solution if the girl gets pregnant. The intervention area had a higher proportion (84%) that said that child marriage offers a solution if a girl gets pregnant compared to the control area (64%). Slightly more than half (54%) the respondents across the study areas was of the opinion that child marriage is related to FGM/C, and 80% of all respondents said that child marriage mostly occurs after teenage pregnancy (Figure 6).

Figure 6. Opinions on the benefits of child marriage



### 3.3 TEENAGE PREGNANCY

Data indicate that among all female respondents, 25% had had a teenage pregnancy. More female respondents in the intervention area had had a teenage pregnancy (33%) compared to those in the control area (17%). The study found a teenage pregnancy rate of 42% among female respondents aged 20-24 years (Table 5). Among all male respondents, only 5% had their first child before the age of 20 years.

Twelve percent of female respondents had dropped out of school due to a pregnancy, while among male respondents less than 1% had dropped out of school because of having a child. Data also indicate that one out of four girls (25%) had a teenage pregnancy after being married, a percentage that was higher in the intervention area (26.5%) compared to the control area (21%).

Table 5. Teenage pregnancy

Child marriage	Intervention area n (%)	Control area n (%)	Total n (%)
Females (20-24) who had a teenage pregnancy	96 (48.7%)	55 (34.4%)	151 (42.3%)
Males (20-24) who had their first child under the age of 20	4 (6.3%)	2 (3.3%)	6 (4.8%)
Females (15-24) who left school due to pregnancy	78 (15.4%)	48 (9.4%)	126 (12.4%)
Females (15-19) who left school due to teenage pregnancy	41 (13.2%)	24 (6.8%)	65 (9.8%)
Males (15-24) who left school due to pregnancy	1 (0.6%)	1 (0.6%)	2 (0.6%)
Males (15-19) who left school due to teenage pregnancy	1 (0.9%)	0 (0%)	1 (0.4%)
Females with teenage pregnancy, who first married and then had a teenage pregnancy	45 (26.47%)	17 (20.99%)	62 (24.70%)
Females with teenage pregnancy, who first had a teenage pregnancy and then married	39 (23.4%)	14 (15.7%)	53 (20.7%)
Females with teenage pregnancy who married and had a teenage pregnancy in the same year	44 (26.3%)	21 (23.6%)	65 (25.4%)

### 3.3.1 CIRCUMSTANCES OF GETTING PREGNANT

The high prevalence of teenage pregnancy was driven by early sexual debut. Some participants mentioned sexual debut to be 10 years old. Focus group discussions revealed that distance to school, peer pressure and lack of parents' supervision towards their children contributed to creating an environment where young people engaged in sexual practices.

*'Children have gone to school and to us parents; this is risky because many come back home pregnant. I will also repeat the issue of school distance. Where our children walk together for preps and come back at night. Along the way, many are able to engage with the sexual acts, therefore leading to early pregnancies. We need a boarding school for girls.'* FGD with community leaders

*'As a girl grows, they learn for themselves the changes in their bodies. Most of them do not learn these from anywhere, but through their own experiences. They also learn from their peers mostly to and from school. I am surprised nowadays young girls as young as NINE years are getting pregnant; I have no idea what has changed for that to happen. I wish I can understand. Long distance to and from school is a big challenge.'*

Interview with policy maker

*'I am a pastor and we also have big challenges in the social gatherings like the crusades and other overnight gatherings. Parents release their children and fail to accompany them to the gathering. Afterwards, sometimes they call me to confirm, just to realize that they did not attend. They use the chance to meet their boyfriends and have their pleasure.'* FGD with community leaders

Participants argued that the weekly market day allowed young women and men to engage in sexual activity as they were often left home alone.

*'This is the biggest problem [Saturday market] we have here. Many girls come over to help their parents in these small businesses and end up having sexual affairs. This issue of motorbikes is a big issue. Most of them are left behind and because all the parents are nowhere to be seen, all have gone to the market; young boys take advantage and move to the manyattas to have good time with our girls.'*

FGD with community leaders

Some parents believed that enrolling their daughters in boarding schools would prevent teenage pregnancy and delay marriage. Others emphasized the importance for parents to supervise their daughters, for example to know where young women went at night.

During the interviews it was highlighted that young men often denied responsibility in cases of pregnancy. In addition, participants shared that young men's parents were often not keen on encouraging their sons to marry young women despite having impregnated them. This was mainly because of financial implications, families not being in a position to pay dowry and take care of the pregnant young women. Teenage men were also perceived as too young to lead a family and therefore discouraged to marry. Consequently, young women were married off to an older man as a second or third wife.

*'At first the boy will deny responsibility, when the parents find out a girl is pregnant she is married off.'*

FGD with men 19-24 years

*'If a young boy marries a young girl it becomes awkward, since how can a child control another child? There are also many problems associated to early marriage, since the boy may not even be courageous enough to mingle with men to learn from them and he is not grown enough to head a family.'*

Interview with a 21-year-old woman

### 3.3.2 CONSEQUENCES OF TEENAGE PREGNANCY

Young women and men mentioned various consequences of teenage pregnancy which could be grouped into health, psychological and social consequences, which included school drop-out, child marriage, and stigmatization. Participants shared that for young women teenage pregnancy leads to shock, anxiety and feelings of being emotionally withdrawn and embarrassed. Furthermore, it was highlighted that in the Maasai community, teenage pregnancy was considered as a bad and unexpected event in life and a violation of cultural norms.

*'First the girl becomes stressed, she becomes withdrawn and isolates herself from others, after they deliver some girls are allowed to go back to school, for those not in school they are married off.'*

Interview with 19 years old female

*'First [when a girl gets pregnant] she gets stressed, she is isolated from her friends, some girls are advised by their friends to procure an abortion, sometimes a girl is treated as an outcast by the society.'*

FGD with girls 15-17 years

*'Society views her [pregnant teenager] as a failure, a girl who does not respect her parents or herself, she is treated as an outcast, people will be saying bad things about her, the parents become so harsh to her, her friends shun her as she is not setting a good example.'* FGD with girls 15-17 years

Participants' accounts also reveal that young women who had a teenage pregnancy did often not go back to school after childbirth, and marrying them off was seen as the best immediate solution. However, some parents did take their daughters back to school after giving birth to give them a second chance, while the mother takes care of the grandchild.

*'There are good parents and those who are not good. Some parents take care of the new born for their girl to go back to school, and there are others who just wait for that moment when their daughter drops out and they marry them off.'* Interview with 22 years old female

*'Some parents discuss and allow the girl to stay at school until the time she delivers, after which the mother takes care of the baby as the girl goes back to school. For a girl who gets married they face a lot of challenges as responsibilities are added to them that they cannot handle, some girls run away with the men that impregnated them.'* FGD with women 18-24 years

It was also highlighted by participants that when a young woman got pregnant, some parents married off their daughter as a result of poverty. This was done to ease the financial burden of taking her back to school and taking care of the baby. Marrying the young women off meant receiving a dowry, which could be used to improve the financial position of the young women's family.

During FGDs, it was highlighted that fathers are the main decision makers of the family in the Maasai community. When a young woman got pregnant it was the father who decided if she would go back to school, and if she had to get married or not. In some families, mothers too took part in the decision making process and in some communities, the community leaders intervened to facilitate young women's return to school after childbirth, through the negotiations with young women's parents.

*'The father will decide whether to marry her off or take her back to school.'*

Interview with a 21 years old female

#### 3.3.2.1 ABORTION

Qualitative data indicate that some young women chose for an abortion to end pregnancy. Some sought medical services, whereas others used risky methods to procure abortions, such as drinking cow dung juice, drinking concentrated juice or cleaning detergents.

*'She first tells the boy, then they decide either to run away or to have an abortion. The first thing a girl thinks is to run away, she will look for means to procure an abortion...They go to the doctors and ask for assistance, some drink undiluted juice and cow dung, it is boiled in water then it is drunk when it is cold, and some use detergent.'* FGD with girls 15-17 years

*'Even in those hospitals, they still offer abortion services without any intermediate, as long as they make their money. In fact they are promoting the devils work by doing so.'* Interview with 22 years old female

### 3.4 FEMALE GENITAL MUTILATION/CUTTING

Approximately half of all female respondents had undergone FGM/C, with a higher proportion in the intervention area (58%) than in the control area (46%). About 60% of the respondents reported that FGM/C was a social norm, with a majority of the respondents (76%) reporting that FGM is carried out at ceremonies (Table 6).

Table 6. FGM/C			
Variables	Intervention area n (%)	Control area n (%)	Total n (%)
<b>Females (15-24 years) who underwent FGM/C</b>	292 (57.71%)	233 (45.96%)	525 (51.83%)
<b>FGM/C is a social norm</b>			
No	200 (29.37%)	288 (42.42%)	488 (35.88%)
Yes	469 (68.87%)	342 (50.37%)	811 (59.63%)
Unknown	12 (1.76%)	49 (7.22%)	61 (4.49%)
<b>Circumstances of FGM/C</b>			
Ceremony	242 (82.88%)	158 (67.81%)	400 (76.19%)
Secrecy	49 (16.78%)	67 (28.76%)	116 (22.10%)
Other	1 (0.34%)	8 (3.43%)	9 (1.71%)

#### 3.4.1 CULTURAL CONTEXT, CUSTOMS AND BELIEFS

In the Maasai community, FGM/C is embedded as a traditional custom without religious connotation, i.e. religion does not support the practice. Therefore, the majority of the participants agreed that FGM/C was mainly conducted to fulfil cultural purposes: to allow girls to fit into the community. During the FGDs with young women and men, it was shared that parents' literacy status played a role in FGM/C; those that were literate were less likely to encourage the practice compared to illiterate parents.

*'[Age of FGM/C] At the age of 12, when a family is getting ready to circumcise a boy, the young girl is also taken for FGM/C secretly from as early as nine years. The other issue is no men want to marry a girl who is uncircumcised, should she get pregnant before she is circumcised, the midwives refuse to assist her during childbirth. The community has formed myths to coerce girls into accepting to be circumcised. Another myth is that a girl who is not circumcised is not sexually appealing. The other myth is FGM/C will make women faithful to their husband in marriage.'* FGD with men 19-24 years

The qualitative data reveal that societal myths and beliefs are the key drivers of FGM/C. Some participants highlighted that an uncut young women would experience difficulties getting married and would be seen as dirty, smelly and immature. Therefore some young women opt to be circumcised to fit into society and to find a husband. However, during a key informant interview, a policy maker stated the following:

*'In this area we know several women who have made great families and we all know they were not cut. We know of Christian families who have not taken their girls through FGM/C and none of them is at home*

*[unmarried] as a result. They are all married and happy. So that is just a story to scare the girls to not say “no” to FGM/C. The issue too that girls are asking to be cut is a lie. The girl is mostly given pressure by their mother to tell and demand to be circumcised. Then when the deal is done, they say it was the girl who demanded to be cut. All these issues arise from the parents, especially women. The day women agree not to be doing that, it will completely stop.’ Interview with policy maker*

The quote a=suggests that older women are often pressuring young ones to get circumcised. Also in schools, uncircumcised girls were said to experience pressure from their peers who are circumcised, making it hard for them in school. Some end up asking their parents to get circumcised. Uncircumcised girls experienced stigmatization not only from their peers, but also from the community.

### 3.4.2 CIRCUMSTANCES OF FEMALE GENITAL MUTILATION/CUTTING

During FGDs, participants shared that FGM/C is conducted at a tender age and in secrecy because it is against the law in Kenya. FGM/C is mainly performed between the age of 8 and 10, during school holidays. All the preparations seem to be done without informing girls. After the procedure, girls delay going back to school to allow complete healing.

*‘[FGM decision maker] It starts at the family level, the date is set, then a community meeting is set where the day is set for girls to be cut, all this time a girl is not informed but she gets to know what is being planned, the third meeting is for the community to fetch firewood and water, then on the set day the girl and boy get shaved in preparation for the next morning. Some boys are taken to the hospital in the evening and in the morning the girls are cut at home; the girl is treated with paraffin, sugar, cooking fat to stop the excessive bleeding. At the age of 8-10 in schools almost every girl is cut.’ FGD with women 19-24 years*

*‘[What happens when schools close] Most girls are taken for the cut and for a short holiday i.e. two weeks. The girls don’t report back to school on time, also after a girl is cut society perceives her as a woman and this is when most girls get pregnant. Cases of girls who refuse to be cut are rare, but should we come across one we help her run away to a rescue centre.’ Interview with parent*

During the interviews, almost all participants confirmed that mothers were the ones supporting the practice of FGM/C in the Maasai community. However, at the same time, in some families, it was different and the decision to circumcise the daughters relied on the father or both parents.

*‘[FGM practice] Yes in secrecy, it is difficult to know who is doing it as the ceremony is no longer there and it is not announced publically as before. It is the mother as she is the one that advises the girl, the father comes in when the girl refuses.’ Interview with community leader*

*‘[FGM decision maker] It is the family of the girl, but the key decision maker is the father of the girl or the grandfather.’ FGD with boys 15-17 years*

In debrief sessions with the research assistants and stakeholders after the qualitative data collection, it was mentioned that FGM/C amongst girls is secretly conducted during group circumcision amongst boys, because people know that FGM/C is forbidden. In this way FGM/C is covered within the group.

*‘What I can say is that yes FGM/C is practiced but done by women. Men withdrew from forcing their girls and women and the girls themselves now plan the practice. It is also much influenced by peer pressure. In our girls’ schools, those who went through the cut stigmatize uncircumcised girls. When this girl comes home for vacation and shares the same with the mother, the two of them plan without the father’s knowledge. They plan for a meeting they call merry-go-round. This happens so that the girl is taken through FGM/C. The father may therefore know what happens. They just see people celebrating in his home as a women’s group meeting. My request is that you take this education to the boarding schools. Train these girls not to stigmatize the others.’ Meeting with stakeholders*



### 3.4.3 YOUNG WOMEN'S FEELINGS AND PERCEPTIONS TOWARDS FEMALE GENITAL MUTILATION/CUTTING

When both young and older women were asked to give their general perception around the practice of FGM/C during FGDs, different statements were made. Some stated that after FGM/C girls are regarded as real women, and they have the liberty to behave like women, which could lead into early sexual engagement. Other participants emphasized some myths, such as that FGM/C prevents itchiness and pregnancy until girls mature.

*'[Reason for practicing FGM/C] To keep the girl clean I heard that a girl who is not cut feels itchy at her private parts, cutting off the clitoris helps reduce the itching, some girls are cut to avoid them getting pregnant before they become women.'* FGD with women 19-24 years

*'The other downside of FGM/C is that it increases cases of teenage pregnancy as girls assume they are now adults and become sexually active; before girls are cut they don't engage in sexual activity, as they are scared of getting pregnant.'* FGD with women 19-24 years

The quantitative data indicate that more than half of the female respondents (56%) had negative feelings towards FGM/C, with more female respondents in the intervention than in the control area having a positive perception. About 42% of all female respondents reported that FGM/C had no implications and another 33% perceived FGM/C to increase chances of marriage. The majority of all female respondents (88%) had no desire to circumcise their daughters, and more than half reported that they believed FGM/C caused problems with labour, school drop-out and child marriage. Slightly over 40% believed that FGM/C causes sexual and fertility problems (Table 7).

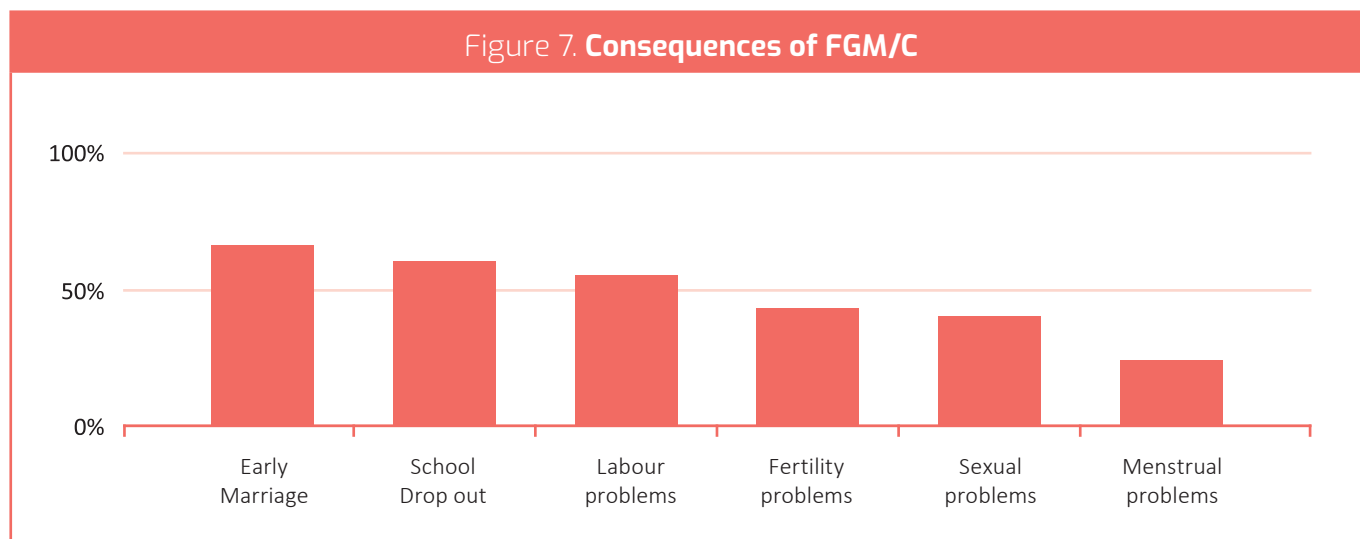
Table 7. Young women's feelings and perceptions towards FGM/C

Variables	Intervention area n (%)	Control area n (%)	Total n (%)
<b>How did you feel about it (FGM/C)</b>			
Good	116 (39.73%)	52 (22.32%)	168 (32%)
Neutral	13 (4.45%)	24 (10.30%)	37 (7.05%)
Bad	161 (55.14%)	131 (56.22%)	292 (55.62%)
No answer	2 (0.68%)	26 (11.16%)	28 (5.33%)
<b>FGM/C will...</b>			
Increase chances of marriage	121 (41.44%)	51 (21.89%)	172 (32.76%)
No implication	106 (36.30%)	113 (48.50%)	219 (41.71%)
Reduce marriage	17 (5.82%)	28 (12.02%)	45 (8.57%)
Don't know	48 (16.44%)	41 (17.60%)	89 (16.95%)
<b>Desire to circumcise their daughter</b>			
No	594 (87.22%)	600 (88.37%)	1,194 (87.79%)
Yes	50 (7.34%)	46 (6.77%)	96 (7.06%)
Unknown	37 (5.43%)	33 (4.86%)	70 (5.15%)

Significantly more respondents in the control than in the intervention area indicated that secret FGM/C was practiced in their area; in the intervention area more girls received open celebration compared to those in the control area. More respondents in the intervention compared to the control area believed that undergoing FGM/C increased one's chances of getting married.



Figure 7. Consequences of FGM/C



### 3.4.4 CONSEQUENCES OF FEMALE GENITAL MUTILATION/CUTTING

As shown in Figure 7, respondents mentioned various consequences of FGM/C, including early marriage, school drop-out, as well as labour, fertility, sexual and menstrual problems.

Qualitative data indicate that the most highlighted consequences were health related problems, including recurrent pain, the retention of urine and menstruation, infection, complications during childbirth and death. Few young women were reported to have died as a result of excessive bleeding. This had brought fear to parents and had influenced their desire to stop the practice.

*'Difficulty during childbirth is one effect. FGM/C leads to early marriages denying girls a chance to grow and mature naturally and also cutting short their education.'* FGD with men 19-24 years

*'In this area, we have witnessed girls who have died after they went through the cut. They bled to death even after they have been taken to the hospital. So families have realized that it is wrong. Both the church and the law is against it. There are others who are generally role models in this community, who said "no" to FGM/C long before others. But that is only a small percentage. The big percentage still practices FGM/C.'*

Interview with policy maker

Despite the death of several girls, which has scared community members to continue the practice, the complications of FGM/C, the national law and work by religious institutes, some parents are still performing FGM/C in a secretive way.

*'After being taken through FGM/C, she bled to death. They are fighting the three [child marriage, teenage pregnancy and FGM/C] and finally some people are leaving them. Yes there is a law that says that a girl should not be circumcised. So people are now doing FGM/C secretly, even when a girl is very young to avoid being reported. The parents of that girl must face the law.'* Interview with a 21 years old female

#### 3.4.4.1 INTERLINKAGES BETWEEN FEMALE GENITAL MUTILATION/CUTTING, CHILD MARRIAGE AND TEENAGE PREGNANCY

Regarding the interlinkage between FGM/C and child marriage, participants mentioned two main interlinkages. First, participants shared that in the Maasai community child marriage could follow immediately after FGM/C. After FGM/C, young women were ushered into adulthood, they immediately dissociated themselves from younger girls, joined the more mature women and started engaging in sexual relationships, exposing them to the risk of teenage pregnancy. Second, participants mentioned that young women's FGM/C status (cut versus uncut) was likely to affect their ability to get into a good marriage. Some of the male participants highlighted that therefore, FGM/C was an essential requirement for marriage.

*'[Effect of FGM] apart from the bleeding and risk of death, it leads to early marriage as girls who are cut are perceived as a woman who is ready to be married off especially for girls who are not in school. Some girls think they are now adults and are free to do whatever they want, i.e. engaging in sexual activity, this leads to early pregnancy.'* FGD with girls 15-17 years

## 3.5 COMMUNITY CONTEXT

### 3.5.1 SOCIAL NORMS REGARDING YOUNG WOMEN EN MEN

Issues concerning child marriage, teenage pregnancy and FGM/C are influenced by the community context. Young people’s definitions of what a good young woman or man is showed the influence of various social norms. These social norms included the importance of respect for elders, gender roles and sexual morality in relation to virginity until marriage, particularly for young women.

As the following quotes show, research participants described a ‘good boy’ as someone who greets elders with respect, someone who is disciplined, not influenced by peer pressure, and a role model.

*‘A good boy is one who is guided by his own principles and not influenced by peer pressure. Someone who is a role model and is able to counsel his peers to avoid peer pressure. [Traits of a good girl] A girl who avoids sexual activity until the right time, respects her body by not engaging in sexual activity.’*

FGD with boys 15-17 years

As for young women, participants emphasised the importance of maintaining virginity until marriage. Some mentioned that young women should not directly communicate with their father, but talk via the mother, and should not refuse decisions made by their father around marriage or FGM/C. Girls are advised by their grandmothers and aunts how to behave as adults. Boys are advised by grandfathers and elders.

*‘Girls are not supposed to talk to their father directly they have to communicate through the mother, boys are free to approach either parents. Girls are not allowed to get into a room where the father sleeps but boys are allowed access to all rooms.’* FGD with boys 15-17 years

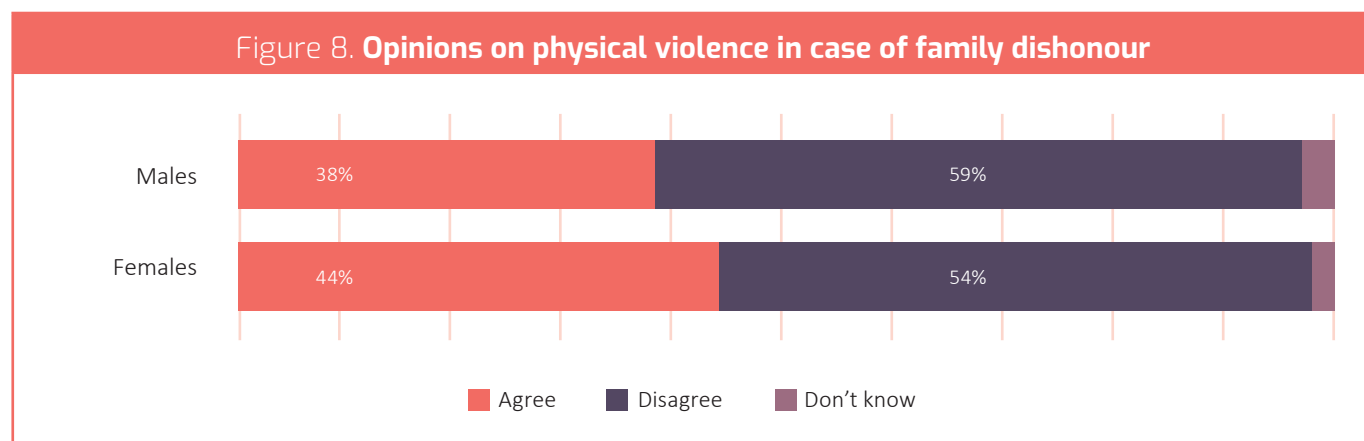
### 3.5.2 PHYSICAL AND SEXUAL VIOLENCE AMONG MARRIED PERSONS

Married respondents were asked if their partners ever physically hurt or hit them and the experience of sexual harassment. Data indicate that seven out of ten married respondents reported to never have experienced physical violence (Table 8). The intervention area had no respondents who reported they were physically violated all the time and 5% in the control area indicated they experienced physical violence all the time. More respondents in the control (13%) than in the intervention area (1%) refused to share their experience with physical violence.

Table 8. Experience of physical violence

Frequency of experiencing physical violence from partner	Control area n (%)			Intervention area n (%)		
	Females	Males	Total	Females	Males	Total
All the time	5 (5.43%)	0 (0.0%)	5 (5.15%)	0 (0.00%)	0 (0.0%)	0 (0.0%)
Frequently	1 (1.09%)	0 (0.0%)	1 (1.03%)	12 (6.42%)	11 (91.67%)	12 (6.03%)
Sometimes	6 (6.52%)	0 (0.0%)	6 (6.19%)	25 (13.37%)	0 (0.0%)	25 (12.56%)
Rarely	4 (4.35%)	0 (0.0%)	4 (4.12%)	17 (9.09%)	0 (0.0%)	17 (8.54%)
Never	64 (69.57%)	4 (80.0%)	68 (70.10%)	132 (70.59%)	1 (8.33%)	143 (71.86%)
Don’t wish to share this	12 (13.04%)	1 (20.0%)	13 (13.40%)	1 (0.53%)	0 (0.0%)	2 (1.01%)

With regard to physical violence, respondents were also asked whether it is sometimes okay to physically beat or punish a girl if she dishonours her family (Figure 8).



A total of 33% of the respondents strongly agreed with the statement that physical violence is okay if a girl dishonours the family. Overall there were more respondents who disagreed (53%) with this statement than those who agreed (46%). However, among male respondents, more than half agreed that it was okay, while among female respondents the majority disagreed with the statement.

Data also indicate a low report of sexual violence. The results suggest that in the control area more sexual violence is taking place and that it is also more difficult to talk about it. More females in the control area (12%) than in the intervention area (8%) reported to be experiencing sexual harassment every day. More respondents in the control (20%) than the intervention area (2%) refused to share their experience on sexual harassment (Table 9). Overall one out of ten respondents experienced sexual violence less than once a month, 6% once or twice a month and 4% once or twice a week. More males (83%) than females (63%) in the intervention and in the control area (males 100% and females 59%) indicated that they had never experienced sexual violence.

**Table 9. Frequency of sexual harassment**

Frequency of sexual harassment	Control area n (%)			Intervention area n (%)		
	Females	Males	Total	Females	Males	Total
Everyday	11 (11.96%)	0 (0%)	11 (11.34%)	15 (8.02%)	1 (8.33%)	16 (8.04%)
Once or twice a week	1 (1.09%)	0 (0%)	1 (1.03%)	13 (6.95%)	0 (0%)	13 (6.53%)
Once or twice a month	3 (3.26%)	0(0%)	3 (3.09%)	21 (11.23%)	0 (0%)	21 (10.55%)
Less than once a month	4 (4.35%)	0 (0%)	4 (4.12%)	18 (9.63%)	0 (0%)	18 (9.05%)
Never	54 (58.70%)	5 100%	59 (60.82%)	118 (63.10%)	15 (83.33%)	128 (64.32%)
I don't wish to share this	19 (20.65%)	0 (0%)	19 (19.59%)	2 (1.07%)	1 (8.33%)	3 (1.51%)

### 3.5.3 THE ROLE OF DIFFERENT STAKEHOLDERS

#### 3.5.3.1 RELIGIOUS AND TRADITIONAL LEADERS

Participants perceived FGM/C as a cultural and not a religious practice. It was highlighted that in their community, most religious leaders were against FGM/C practices. Some participants shared that religious leaders have been at the forefront in the fight against child marriage, teenage pregnancy and FGM/C by offering SRHR education to young people and talking to parents and advise against FGM/C and child marriage.

*'Last years I refused to conduct a wedding where the girl was only 17 years, the couple wanted to be married in church, girls get married as early as 13 years.'* Interview with religious leader

At the same time, as the following quote shows, other participants argued that the positioning of religious leaders towards child marriage and FGM/C was not always clear.

*'For the religious leaders they are against FGM/C, actually some of them are against it but biblically. That's for the pastors and bishops. That's the religious leaders, they say that biblically it was not written whether to practice or not so it's their decision, the community's decision, or the parent's decision or the child's decision to decide whether to be circumcised or not.'* Interview with NGO staff

Similar results were found in relation to traditional leaders. Participants argued that some traditional leaders contribute to the preservation of the practice of FGM/C, or advocate for child marriage in cases of teenage pregnancy. Participants mentioned that when religious and traditional leaders had already circumcised their own daughters, it was difficult for them to condemn FGM/C.

*'Religious leaders do not support early marriages, FGM and early pregnancy, it is however a challenge for leaders who had already cut their girls, they will not openly condemn the practice of FGM/C.'*  
Interview with religious leader

In addition, various participants highlighted that religious and community leaders acted as mediators between parents of the impregnated young woman and the impregnator to find solutions. However, participants also shared that churches could contribute to teenage pregnancy, because when organizing overnight meetings for youth, sexually activity is happening.

#### 3.5.3.2 HEALTH WORKERS

During the qualitative component, participants shared that health workers provide services and information related to SRHR. Participants shared that in the community, most health workers facilitated health talks with young people and parents on issues on SRHR related topics.

*'They [health worker] conduct training on the effects of FGM/C, at times we have joint sessions with boys to help them understand the effects of FGM/C, these sessions are open to all girls and boys. They intervene by talking to the girls' parents on behalf of the girl. In case of excessive bleeding [after the cutting], health workers try to reach out to the girl for treatment, although most parents hide the girl for fear of being arrested.'*  
FGD with girls 15-17 years

Some participants indicated that health workers did not inform parents sufficiently. In addition, during several FGDs it was mentioned that some health workers were involved in performing FGM/C or training the traditional circumcisers on how to circumcise girls using modern tools. Some health workers were said to be working with the community in circumcising girls who showed up at the hospital for a delivery.

*'No medical practitioners do actively participate in cutting girls, but they train the traditional cutters to use anaesthesia and scalpels and gloves.'* FGD with women 19-24 years

*'[Health worker as female circumciser] Yes they are there. We have witnessed young girls who are uncircumcised taken to hospitals to give birth and when they come back, we get to be informed that they have undergone the cut. So we believe it is performed during that period.'* Interview with a 21 years old female

At the same time, most respondents highlighted that the majority of health workers do not conduct FGM/C, however, some felt that health workers were adamant about reporting cases that were brought to the hospital and to the authority.

*'They [health workers] do not perform the cut, but they do not report the cases either. In my view they are adamant on these issues as they receive the cases of girls bleeding from FGM/C but say nothing to the authorities. They just treat and do not report. They even take them in for admission and do not say a word to the authorities.'* Meeting with stakeholders

### 3.5.3.3 SCHOOLS AND TEACHERS

To some parents, allowing their daughter to attend school prevents the occurrence of FGM/C, teenage pregnancy and child marriage. Hence, early school enrolment was seen as important. On the contrary, other parents felt that when young women went to school they spend too much time with young men and end up engaging in sexual practices. Therefore, policy makers in the Maasai community advocated for availability of boarding schools for young women, which would keep them safe from FGM/C, teenage pregnancy and child marriage by providing a safe space and an opportunity to continue the studies.

*'Both boys and girls walk to and from school for long, thus getting enough time to discuss and indulge into sexual acts. That on its own really contributes to the discussed issues. In the past, our girls used to take some years before going to school. Therefore by the time a girl goes to primary school, they already understand so much about their bodies. They are grown-ups already. So taking girls to school at an early age really prevents all these. Secondly, we take our girls through FGM/C. Once a girl is circumcised, they grow up even mentally and stop to respect their elders. That allows these elders to contribute in impregnating them at an early age. If we can get a boarding school for these girls, that would be very helpful.'* Interview with policy maker

In addition, participants shared that in schools, young women and men receive sexuality education that equips them with information. In schools, teachers offer guidance and counselling, menstrual hygiene and life skills training.

*'There is guidance and counselling and life skills lessons that touch upon sex education.'*  
FGD with men 19-24 years

*'Yes teachers isolate girls and educate them on personal hygiene, reproductive health and menstruation, and teenage pregnancy. We educate girls in class 4-8.'* FGD with women 19-24 years

### 3.5.3.4 COMMUNITY-BASED, FAITH-BASED AND NON-GOVERNMENTAL ORGANIZATIONS

Participants argued that the CBOs, FBOs and NGOs in Kajiado have played a LARGE role in raising community awareness on issues related to FGM/C, child marriage and teenage pregnancy. These organizations highlight the need of taking teenage mothers back to school and offer of rescue centres to prevent child marriage.

Despite the role of NGOs with regard to educating the community, community policy makers aired several concerns about some NGOs that access their community without consulting when choosing role models, resulting in the wrong people being chosen as role models. Participants also highlighted a need for financial transparency around the projects and the need to involve men, since they are the head of the families.

*‘These NGOs have problems more than solutions. The NGO people look for funds then come to ask us to work with them. Then I as a chief go ahead to rescue a girl. The only money the chief has is that to take the person to court. The same NGO does not facilitate for the girls’ education. In that case the burden goes back to the parent. Do you think that this parent will willingly sell any of their cows to educate the same girl that caused them pain? No not at all. Many of these NGOs come with briefcases to make money but no proper action. They therefore bring a gap/misunderstanding between the leaders like us chiefs and the community. The biggest solution they would have brought is building a boarding school for our girls. Another one should be, having some accounts for these disadvantaged girls to avoid coming back to the parents for school fees. They [NGOs] are approaching the issues in a very bad way. You see the guys coming to talk to my wife secretly so I may not know what they are talking about. Why don’t I know as the head of that family? For any project to succeed, both men and women should be included. Otherwise they would end up bringing problems within the families.’*  
 Meeting with stakeholders

**3.6. YOUTH ENGAGEMENT**

**3.6.1 TALKING ABOUT SEXUALITY AND RELATIONSHIPS**

Survey respondents were asked whether they had ever discussed some SRHR and related issues with friends and family members. As can be seen in Figure 9 the least ever discussed topic by young people with friends and or family was dating and relationships (26%). The most discussed topics included rights and entitlements (78%), fears in life (77%) and hopes and fears about the future (77%). Significantly more females (71%) than males (29%) felt comfortable to discuss what circumcision meant with their parents, as well as pregnancy prevention (80% for females versus 20% for males). The rest of the variables did not significantly differ by sex of the respondent. When stratified by area, more respondents in the intervention than in the control area had discussed with friends and/or family about what it meant to be circumcised (57% versus 37%) and to be out of school (78% versus 55%). Less than 50% of all respondents had discussed with family and/or friends on the following topics: sexuality and sexual health, the meaning of being out of school, circumcision and how to prevent pregnancies (Figure 9).

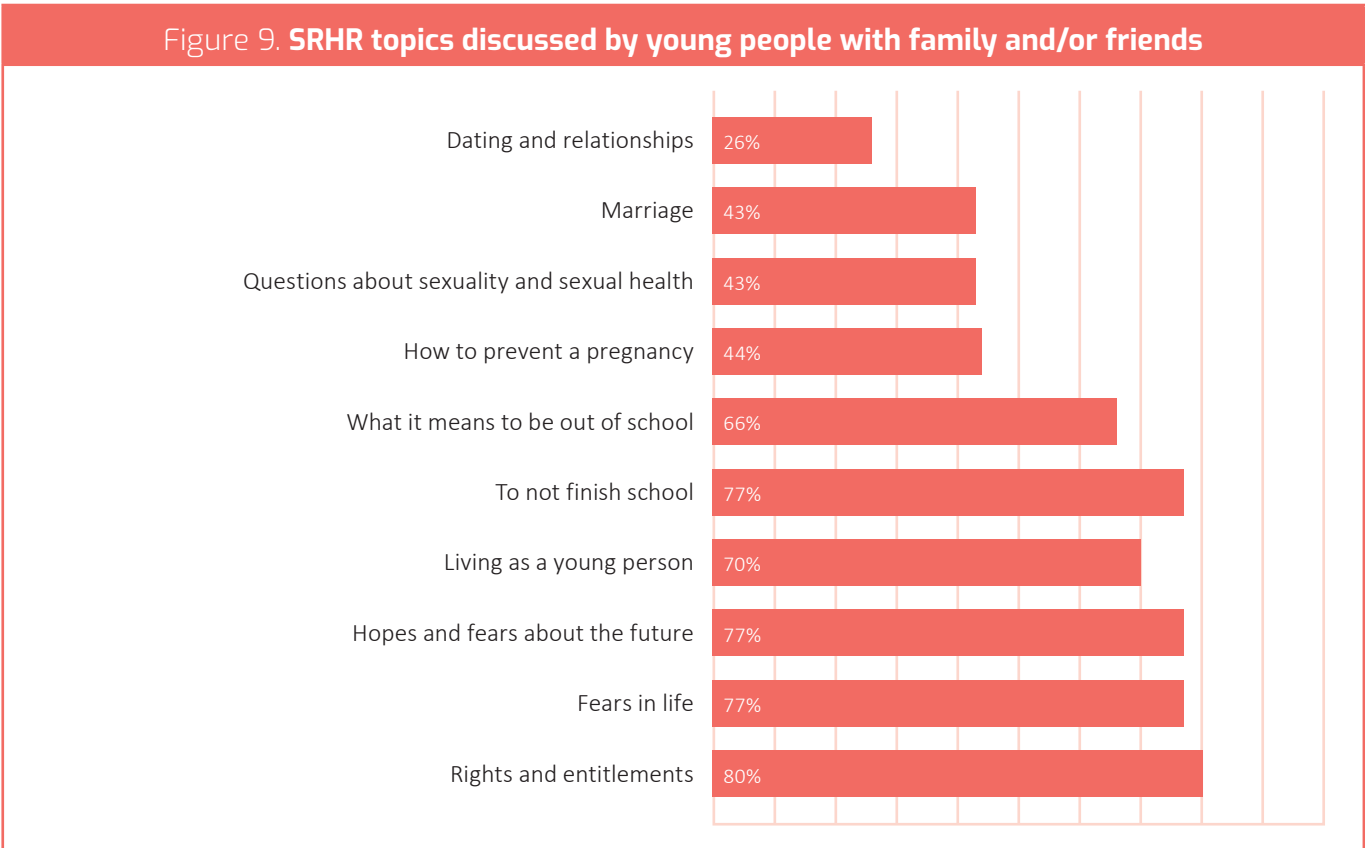
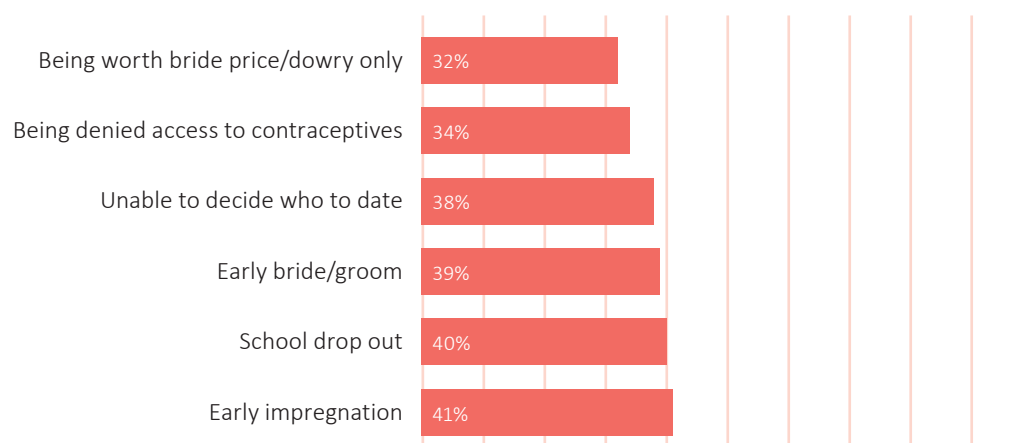


Figure 10. Young people's main worries around SRHR



### 3.6.2 WORRIES ABOUT SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

As Figure 10 shows that the main worries among young people around SRHR were early impregnation (40.5%), being and early bride/groom (39%), and the lack of ability to decide whom to date (38%). Significantly more participants in the control area compared to the intervention area were worried about being an early bride/groom, early impregnated, being worth dowry only, not having a decision on whom to date, dropping out of school and being denied contraceptives. When stratified by sex of the respondent, more females than males were worried about early impregnation and about only being worth a dowry.

### 3.7 SEXUAL AND REPRODUCTIVE HEALTH SERVICE UTILIZATION AND INFORMATION

The study found a low use of SRH services among young people. The most commonly used SRHR services were antenatal care (ANC) and counselling, which had been used by about one quarter of all respondents. The uptake of family planning (FP) and ANC services was twice as high in the intervention area (23% and 31% respectively) compared to the control area (10% and 16%). Significantly more females than males accessed ANC (98% versus 2%) and FP services (70% versus 30%) (Table 10).

In FGDs, it was highlighted that health centres were available, however young people could not always access them because of distance from home, poor roads and infrastructure, or due to service providers. For example, some young women were not comfortable being attended by male health workers.

*'There is free medical care for pregnant women but in this locality people are not aware, most girls are assisted by older women as the health facilities are far away hence they cannot access them. Girls and women are not comfortable with male nurses hence they stay away from clinics when they find a male nurse.'*

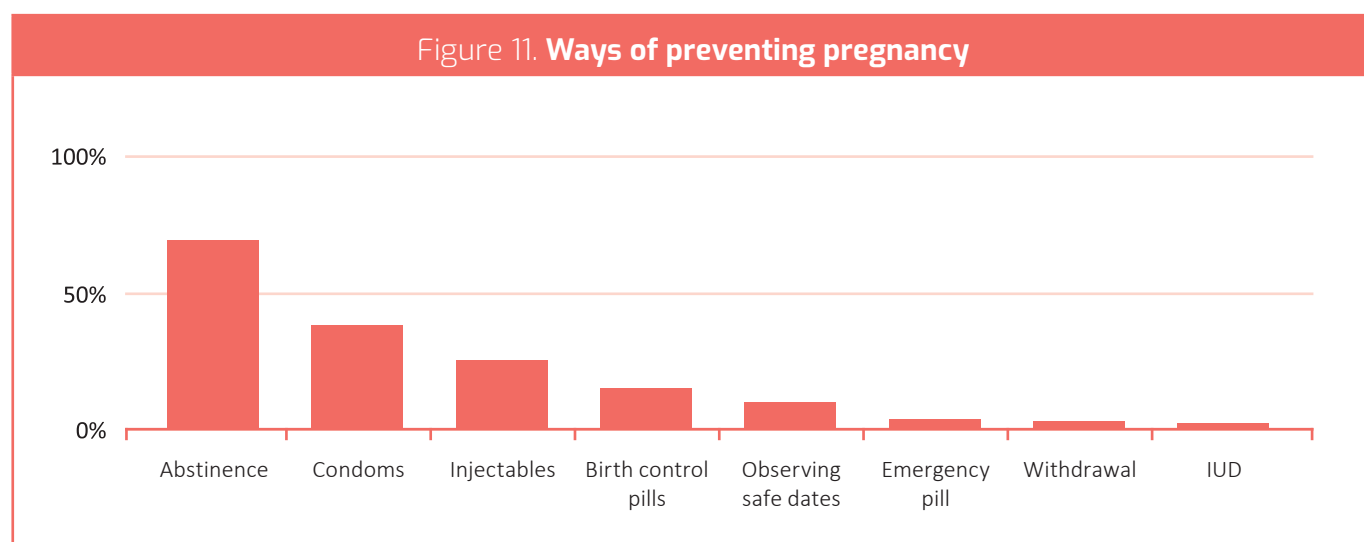
FGD with men 19-24 years

Table 10. SRHR service utilization and knowledge

Variables	Intervention area n (%)	Control area n (%)	Total n (%)
<b>Ever used the following services</b>			
ANC	211 (30.89%)	111 (16.32%)	322 (23.62%)
FP	159 (23.28%)	68 (10%)	227 (16.65%)
Counselling services	178 (26.06%)	181 (26.62%)	359 (26.34%)
<b>Knowledge about modern contraception</b>			
No	209 (30.51%)	233 (34.11%)	442 (32.31%)
Yes	472 (68.91%)	448 (65.59%)	920 (67.25%)
Don't know	3 (0.44%)	1 (0.15%)	4 (0.29%)
Other	1 (0.15%)	1 (0.15%)	2 (0.15%)



Two third of all respondents (67%) were knowledgeable about modern contraception. Thirty-two percent of the respondents indicated that they had no knowledge on modern contraception. The most mentioned way to prevent pregnancy was abstinence (69%), followed by the use of condom (38%) and injectables (26%) (Figure 11). Significantly more females than males reported the use of condoms as a way to prevent pregnancy.



The majority of the community members suggested that access to SRHR information should be a joint venture. Parents, teachers, health providers and churches should all play a part in providing sexual education to adolescents.

*'We have talks once in a term, at home parents talk to the children, most of the sexual education is received in the form of advice by parents. The church organizes seminars and a topic on sexual education is covered.'*  
FGD with boys 15-17 years

*'I suggest that contraceptives should be available for girls who cannot abstain from sex. There is availability of condoms but they are not being used. Also give youth the right information to help them make choices. I would advise the society to stop FGM/C and early marriages as well as include boys in the education of effects of FGM/C and early marriages.'* FGD with me 19-24 years

### 3.8 GIRLS EMPOWERMENT

When asked about how young women could be empowered, the following suggestions were highlighted: avail SRH services, school re-entry programmes, and educate them on livelihood skills and through basic education. Young men suggested the importance of being involved in the fight against FGM/C and the need for education. In addition, they suggested that young women should be empowered with providing them with SRHR information to help them prevent teenage pregnancy. Overall, there was a call for empowering young women through education and providing economic opportunities.

*'Allow girls to complete their education, should a girl drop out due to pregnancy she should go back to school, education is the only key to a better future and the church, this two can lift a community out of poverty.'*  
Interview with community leader



### 3.9 POLICY AND LEGAL ISSUES: KNOWLEDGE ABOUT MARIAGE LAW

Twenty-seven percent of all respondents knew about the existence of the marriage law (Table 11). When asked to indicate the minimum age of marriage for young women and men, the reported average age was 18 years. There was a significant difference between the intervention and control area; respondents in the intervention area were more knowledgeable on the marriage law compared to those in the control area.

Table 11. Knowledge about marriage law			
Variables	Intervention area n (%)	Control area n (%)	Total n (%)
Knowledge of marriage law	253 (37.15%)	112 (16.49%)	365 (26.84%)
Minimum marriage age for girls	18.17±1.61	18.19±2.92	18.18±2.10
Minimum marriage age for boys	18.41±3.13	18.74±3.68	18.51±3.30

Community members in Kajiado seemed to have a high degree of awareness of the existing by-laws around FGM/C and child marriage. However, most indicated a lack of enforcement of these laws.

*'Yes we know them. But people are using ignorance to practice them. But the fact is, everyone is aware. Why then do they hide when practicing FGM/C? It is because they understand it is illegal.'*

Interview with policy maker

*'Yes there are laws but they are not being followed, the chiefs try to enforce these laws.'*

FGD with boys 15-17 years

*'Local leaders apply this laws with partiality i.e. they will be lenient with their friends but will go ahead and arrest other parents when they marry off their daughters.'* FGD with men 19-24 years

## 4. DISCUSSION

This study explored the prevalence and interrelatedness of child marriage, teenage pregnancy and FGM/C in two areas: Kajiado West as the intervention area and Kajiado Central as the control area.

There were significant differences between the intervention and control area, such as the uptake of SRH services, the child marriage, teenage pregnancy and FGM/C prevalence (all were higher in the intervention area), and perceptions on FGM/C and child marriage. Also, the number of youth who were in secondary and tertiary education was lower in the intervention area compared to the control area, which links with a higher percentage of respondents who had ever dropped out of school in the intervention area (29%) as compared to the control area (18%). Physical and sexual violence seemed to occur more frequently in the control area and it was more difficult for respondents in the control area to respond to questions related to these topics.

The study confirms that child marriage, teenage pregnancy and FGM/C are common in Kajiado. The qualitative component enabled gaining a better understanding of the interrelatedness between the three issues. The study shows that FGM/C symbolizes young women's transition to adulthood, which influences young women's attitudes, behaviours and preferences, including sexual debut. The perception of being adult women seems to influence young women's sexual debut, which often leads to the risk of teenage pregnancy, as sexual intercourse is often without protection. The study shows that some of the respondents dropped out of school due to teenage pregnancy and/or marriage, while others became pregnant after dropping out of school. In the Masai communities, child marriage was generally regarded as a solution to teenage pregnancy. Thus, the interlinkages between child marriage, teenage pregnancy and FGM/C were multiple, and causes and consequences are similar.

These findings are consistent with other studies that indicate that most pregnant young women drop out of school to deliver and after delivery they are married off to older men as either second or third wives, with some going back to school with the support of the administrative leaders (chiefs) who speak to their parents. As stated in the study of Muganda-Onyando and Omondi (2008), pregnancy acts as a catalyst to school drop-out in poor families. O'Connor, M.L. (1999) echoed this by stating that academically oriented females are less likely to give birth while still in high school.

The YES I DO baseline study found a child marriage rate of 20.3% among female respondents aged 18-24 years, despite that the legal age of marriage in Kenya is 18 years. The child marriage rate was significantly higher in the intervention area (30.3%) compared to the control area (10.7%). The study found teenage pregnancy and poverty as the main drivers of child marriage. Young women's marriage had economic benefits for their families. It reduced the financial burdens of the family as a married young woman is not dependent on her family but on her husband. In addition, most marriages required the payment of a dowry which was a direct economic gain (cash or in kind) for the family of the marrying young woman.

Similar to what we found, Andiwo (2002) revealed that poor households in Kajiado view daughters as a source of wealth or a solution to their financial problems. Andiwo argues that girls in Kajiado who are 12 or much younger have their marriage pre-arranged by parents and relatives who force them into such arrangements. According to Andiwo, girls drop out of school to get married, and while a few make a decision to marry after getting pregnant, others succumb to parental and communal pressure to be married off. UNICEF (2011) also described how daughters could be seen as a source of wealth. Among the Maasai community, were traditional and cultural beliefs place a high value on cattle ownership, when young women are married off the fathers are given cattle in exchange. Therefore, daughters are viewed as a source of wealth (UNICEF 2012).

The YES I DO baseline study shows that about half of all female respondents had undergone FGM/C. This is higher compared to recent national data, which puts the national figure at 13% (KNBS, 2014). FGM/C was associated with culture, marriageability and preventing stigmatization (associated with not being circumcised). Various Kenyan studies show similar findings, indicating that the main reasons for the continuation of FGM/C arises from the societal interest in preserving the Maasai culture, increase marriageability, myths around hygiene purposes, social acceptance and the reduction of sexual desires (UNICEF 2013; Oloo et al. 2011; KNBS 2010). The perception and reality on who are driving the practice of FGM/C varies from community to community. In this baseline study general decision making relied on men, while it was found that for FGM/C, adult women and mothers were the ones leading the execution of the FGM/C

practice. Still it is difficult to judge who are the exact drivers behind the practice. In a 2010 study by Shell-Duncan et al., the findings revealed that, while men were very involved in the decision-making around FGM/C, 50 percent fewer fathers in Senegal supported FGM/C than mothers did (Population Reference Bureau, 2013).

The baseline data indicate that two-third of all respondents agreed that FGM/C is a pre-requisite to early marriage. These results are in line with literature arguing that among the Maasai culture, soon after the initiation for girls, marriage could immediately take place, because after circumcision a girl is no longer considered a 'girl' but 'a young unmarried woman' (Ghimire 2006; Ganira 2015). Other studies from Kenya have confirmed this link between FGM/C and marriageability, and found that many men reject women who are uncut. These beliefs exist especially among the Meru, Maasai, Rendille and Samburu communities in Kenya (Oloo et al. 2011; Shell-Duncan et al. 2000; Chege et al. 2001). Hence, when circumcised, the marriage prospects of women increase and can attract a higher dowry (Chege et al. 2001). However, in the 2008-09 KDHS, only 9% of women who underwent FGM/C believed that it increases marriage prospects (Oloo et al. 2011). In addition, our qualitative component revealed that a lack of education played a major role in the practice of FGM/C. We can speculate that in the intervention area, lack of education contributed to the acceptance of and support for FGM/C.

A recent study by Koski et al. (2017) has shown that when girls are circumcised at an increasingly younger age (8 to 10 years), which also seems to be the case in our study area, the age of first marriage and pregnancy also decreases for girls and young women, with all related risks and consequences further worsening. It is also evident from our baseline study that peer influence contributed to young people's involvement in early sex, early marriage and FGM/C. The baseline data indicate that 38% of the respondents agreed that peer pressure is a major cause of child marriage. Mutanana et al. (2015) asserted that teenagers' reliance on their peers for information makes them susceptible to teenage pregnancy or child marriage.

The study found a higher use of FP and ANC services in the intervention area compared to the control area. However, in both areas the use was low. At the same time, the knowledge about how to prevent a pregnancy, including knowledge on modern contraceptives was relatively high and respondents were generally not worried about being denied access to contraceptives. Hence, these results suggest a gap between knowledge and access to SRH services, including modern contraceptives and the use of these services which could be related to whether services are perceived as youth friendly.

The study evidences the need to empower young women and men with basic education, comprehensive sexual and reproductive health education and services, and strengthen their life and social skills in relation to their caretakers and peers. The results also indicate the need to work with parents, teachers, health workers, and community leaders to create a conducive environment to oppose FGM/C, child marriage and teenage pregnancy. The study found that sometimes, health workers and traditional leaders can take a double role preventing and supporting the practice of FGM/C. This double role could be influenced by financial incentives or prevailing Maasai traditions.

Previous research has found a strong relationship between education and FGM/C and child marriage. Therefore, a comprehensive response to FGM/C should have a strong focus on young women's education and empowerment so that they oppose to FGM/C and child marriage and prevent teenage pregnancy (28 Too Many, 2013).

This baseline study has some limitations. The sampling of the survey was conducted randomly, but relied on local data regarding villages in the selected wards, because of a recent change in administration and division of areas. This could have resulted in villages being selected without taking into consideration the exact village size. Despite this, we think that the selection of study villages was appropriate. Young people's SRH is a sensitive issue. Study participants could tend to give socially desirable answers. A variety of approaches were used to ensure that respondents of the survey and participants of the interviews and FGDs felt comfortable and free to express what they genuinely believed. In the qualitative component, the researchers explicitly focused on eliciting in-depth responses to the questions. The research team was trained to listen and observe intently without displaying any judgmental attitude towards information they received from the participants. Due to language-related challenges, despite preparations of materials and training of involved researchers, some data content could have been lost during translation and transcription. The team tried to address this by working with researchers with rich experience in data collection in the

community, ensuring that transcripts were double-checked and compared with the audio records. Also, notes were taken during the interviews to confirm the recorded information.

# 5. CONCLUSIONS AND RECOMMENDATIONS

This baseline study confirms that child marriage, teenage pregnancy and FGM/C are common in Kajiado County, despite a general awareness of the associated negative consequences. Economic burden and the financial benefits linked to the dowry appeared as key drivers of child marriage. Marriage was seen as a solution to teenage pregnancy, and early sexual debut was reinforcing this. The general perception of child marriage was that it could be beneficial for the parents of the marrying young woman, but with negative consequences for young women's health and education. We also conclude that FGM/C could have an influence on child marriage. FGM/C was referred to as a cultural practice with no religious connotation that increased young women's prospects of marriage. Men were less involved and consulted than women in relation to FGM/C. There was a weak enforcement of laws related to the elimination of child marriage and FGM/C. However, most young women indicated that they had no desire to circumcise their daughters, indicating that there is an opportunity for change.

The recommendations for YES I DO are:

1. Develop and adopt commitments to ending child marriage and FGM/C by community leaders, health workers and parents.
2. Engage (young) men in developing and adopting commitments to ending child marriage and FGM/C and sensitize community members to report cases of FGM/C and child marriage.
3. A religious-oriented approach can be an effective strategy to try to demonstrate that FGM/C is not compatible with the religion of a community and thereby can lead to a change of attitude and behaviour.
4. Peer education can be crucial for transmitting messages related to FGM/C, child marriage, access to sexual and reproductive health and rights services and prevention of teenage pregnancy.
5. Promote young women and men's education to know and exercise their rights, develop skills to support their own life plans and to have opportunities to connect with their peers and support each other.
6. Schools to offer comprehensive sexuality education as part of the school curriculum, to expand learners' knowledge and understanding on their sexual and reproductive health and rights, and how they can access services.
7. Involve local leaders and other stakeholders in promoting (young) women's and girl's rights through education-in-culture and culture-in-education.
8. Promote easy and confidential access to family planning services through health centres, school-linked health centres and condom availability programmes to reduce teenage pregnancy.
9. Provide adequate health, education, justice and other services, to remove structural barriers that push young women into child marriage, teenage pregnancy and FGM/C. These services include providing adolescent-friendly health services, ensuring that schools are accessible and child friendly, and providing safe spaces where adolescents can meet and discuss their issues freely.
10. Promote agency and empowerment of young women so that they can better influence decision making processes around harmful practices.
11. Provide financial assistance in the form of bursaries to enable young women from poor backgrounds to access quality education and/or allow school re-entry programmes for teenage mothers.
12. Review existing laws and ensure that legal and policy frameworks are in line with registration of marriages, the minimum age for marriage, and with the African Charter on the Rights and Welfare of the Child. In addition, remove legal loopholes related to parental consent or customary laws.
13. Support enforcement programmes focused on the implementation of laws against FGM/C and child marriage.
14. Strengthen civil registration systems, which record births and marriages.

## 6. REFERENCES

- 28 Too Many (2013). Country profile: FGM in Kenya. Retrieved from [www.28toomany.org/media/uploads/nal\\_kenya\\_country\\_profile\\_may\\_2013.pdf](http://www.28toomany.org/media/uploads/nal_kenya_country_profile_may_2013.pdf).
- Andiwo, D.A. (2002). The girl under siege. Paper presented at the meeting of the women's Congress. Makerere University, Kampala-Uganda.
- Ahmadu, F. (2000). Rites and wrongs: An insider/outsider reflects on power and excision. Female "circumcision" in Africa. Culture, controversy, and change: 283-312.
- Behrendt, A. and S. Moritz (2014). Posttraumatic stress disorder and memory problems after female genital mutilation. American Journal of Psychiatry.
- Berg, R., J. Odgaard-Jensen, A. Fretheim, V. Underland and G. Vist (2014). An Updated Systematic Review and Meta-Analysis of the Obstetric Consequences of Female Genital Mutilation/Cutting. *Obstetrics and gynecology international* 2014.
- Berg, R., J. Odgaard-Jensen, A. Fretheim, V. Underland and G. Vist (2014). Effects of Female Genital Mutilation/Cutting on physical health outcomes: a systematic review and meta-analysis. *BMJ* 2014.
- Clark, S. (2004). Early marriage and HIV risks in sub-Saharan Africa. *Studies in family planning* 35(3): 149-160.
- Chege J, Askew I and Liku J (2001). An assessment of the Alternative Rites Approach for Encouraging Abandonment of Female Genital Mutilation in Kenya. FRONTIERS, Population Council.
- Duncan, B., C. Sommarin, N. Brandt, A. Aden, C. Briones, A. Barragues, S. Martinelli-Heckadon, A. Barume and C. Anicama (2013). Breaking the silence on violence against indigenous girls adolescents and young women. A call to action based on an overview of existing evidence from Africa Asia Pacific and Latin America.
- Ganira, L., N. Inda, P. Odundo and J. Akondo (2015). Early and forced child marriage on Girls' education in Kenya: Constraints, Prospects and Policy. *World Journal of Education*.
- Ghimire D.J., W.G. Axinn, S.T. Yabiku and A. Thornton (2006). Social change, premarital nonfamily experience, and spouse choice in an arranged marriage society. *American Journal of Sociology*.
- Jones, S. D., J. Ehiri and E. Anyanwu (2004). Female genital mutilation in developing countries: an agenda for public health response. *European Journal of Obstetrics & Gynecology and Reproductive Biology* 116(2): 144-151.
- Karanja, N. 2003. Female Genital Mutilation in Africa. *Gender, Religion and pastoral care journal*, 2003, 51, 40-70.
- KNBS (2010). Kenya Demographic and Health Survey 2008 – 2009. Calverton, Maryland, Kenya National Bureau of Statistics (KNBS) and ICF Macro.
- KNBS (2014). Kenya Demographic and Health Survey 2014.
- Koski, A., Clark, S., & Nandi, A. (2017). Has Child Marriage Declined in sub-Saharan Africa? An Analysis of Trends in 31 Countries. *Population and Development Review*, 43(1), 7-29.
- Loaiza, E. and M. Liang (2013). Adolescent pregnancy: a review of the evidence. UNFPA.
- Loaiza Sr, E. and S. Wong (2012). Marrying too young. End child marriage.
- Malhotra, A., A. Warner, A. McGonagle and S. Lee-Rife (2011). Solutions to End Child Marriage. Washington, DC: International Center for Research on Women.

Miller, B. C., B. Benson and K. A. Galbraith (2001). Family relationships and adolescent pregnancy risk: A research synthesis. *Developmental review* 21(1): 1-38.

Miller, M., F. Moneti, C. Landini and A. Lewnes (2005). Changing a harmful social convention: female genital mutilation/cutting.

Muganda-Onyando, R., Omondi, M. (2008). Down the drain: Counting the costs of teenage pregnancy and school dropout in Kenya. Nairobi, Kenya: The Center for the Study of Adolescence (CSA).

Mutanana, N., Mutara, C (2015). Factors contributing to teenage pregnancies in a rural community of Zimbabwe. *Journal of Biology, Agriculture and Healthcare*.

O'Connor, M. L. (1999). Academically oriented teenage women have reduced pregnancy risk. *Perspectives on Sexual and Reproductive Health*, 31(2), 105. A research conducted in the US in 1999.

OHCHR, U. and U. UNDP (2008). Eliminating Female genital mutilation. An interagency statement. Geneva: World Health Organization, Department of Reproductive Health and Research.

Oloo, H., M. Wanjiru and K. Newell-Jones (2011). Female Genital Mutilation Practices in Kenya: The Role of Alternative Rites of Passage: A Case Study of Kisii and Kuria Districts.

Parsons, J., J. Edmeades, A. Kes, S. Petroni, M. Sexton and Q. Wodon (2015). Economic Impacts of Child Marriage: A Review of the Literature. *The Review of Faith & International Affairs* 13(3): 12-22.

Population Reference Bureau (2013). Ending Female Mutilation/Cutting. Lessons from a decade of progress. Population Reference Bureau.

Rotich, K., J. Kipkirui and S. Mutisya (2014). University Education of the Maasai Girls in Kenya at Crossroad: A viewpoint of the role of local leaders and socio-cultural factors. *The International Journal of Social Sciences and Humanities Invention* Volume 1 issue 1 2014 page no.51-61 ISSN: 2349-2031.

Sedgh, G., L. B. Finer, A. Bankole, M. A. Eilers and S. Singh (2015). Adolescent pregnancy, birth, and abortion rates across countries: levels and recent trends. *Journal of Adolescent Health* 56(2): 223-230.

UNFPA and UNICEF (2014). UNFPA-UNICEF joint programme on female genital mutilation/ cutting: accelerating change. Summary report of phase I 2008-2013.

UNICEF (2005). Female genital mutilation/female genital cutting: a statistical report, New York, UNICEF.

UNICEF (2011). *The State of the World's Children 2011, Adolescence: An Age of Opportunity*. New York: UNICEF.

UNICEF (2014). *Ending child marriage: Progress and prospects*. New York: UNICEF.

WHO (2010). *Female genital mutilation and other harmful practices*.

Williamson, N. E. (2012). *Motherhood in Childhood: Facing the Challenge of Adolescent Pregnancy: UNFPA State of World Population 2013*, United Nations Population Fund.

World Vision (2014). *Exploring the links: Female genital mutilation/cutting and early marriage*. London, World Vision.

