ASSESSMENT OF ANTI-FEMALE GENITAL MUTILATION STRATEGIES ON SOCIAL INCLUSION: A SURVEY OF WOMEN IN MIGORI COUNTY, KENYA

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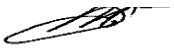
DECLARATION AND APPROVAL

Student

This thesis is my original work and has not been presented for a degree in any other University or for any other award

Signature:  Date: 10/07/2025

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I honor through this work, Teresa Adhiambo Akuno posthumously for all the positive influence she had in my life. My late mother saw and nurtured my potential and pushed me to seek knowledge to advance society.

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ABSTRACT

The practice of Female Genital Mutilation/cutting (FGM/C) is widespread globally with aan estimated two hundred (200) million girls in just 30 countries having undergone FGM with 44% of them aged at least 15 years, and 3 million at risk every year. FGM/C has posed deleterious health consequences to girls and women, including death, and but it also increases their risk of contracting sexually transmitted infections. The Kenyan prevalence is at 21% with policies seen as out of tune to the deeper FGM/C contexts, including alternative rites of passage which still hasn't deterred FGM perpetrators from clinging to the practice. The objectives of this study were; to examine the extent to which policy factors affect social inclusion among women in Migori County, to evaluate the effect of personal factors on social inclusion among women in Migori County, to examine the effect of community factors on social inclusion of women in Migori County and to explore alternative anti-FGM strategies that respond to social inclusion among the women of Migori County. The study population was women 15-64 years old in Migori county who have undergone FGM or alternative rites of passage. The study used mixed approach methodology with a descriptive design, in Migori County, primarily targeting 324 women who have undergone FGM/C or alternative rites of passage, and 15 men, opinion leaders, policy makers and other interest groups. Key findings were, that prevalence of FGM/C stands at 44% among the respondents, with parents, especially mothers influencing the daughters to undergo the cut at 64.8%. The study proposes increase in public awareness campaigns to educate the public and key stakeholders on FGM/C and the effects on women, advocacy for non-discrimination and social inclusion of affected women to enjoy full rights and dignity, a review and harmonization of existing legislation and enforcement mechanisms to enhance the protection of girls and women against FGM/C and strengthening multi-sectoral collaboration and holistic approaches to facilitate alternative rites of passage. In conclusion, the study calls for to all stakeholders to work together and ensure protection of rights and dignity of women who choose not to undergo the harmful practice.

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LIST OF ACRONYMS

AGYW	Adolescent Girls and Young women
AIDS	Acquired Immune Deficiency Syndrome
ARP	Alternative Rites of Passage
CSO	Civil Society Organizations
DHS	Demographic and Health Surveys
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation/Cutting
GCC	Global Consultation Committee
HIV	Human Immunodeficiency Virus
KDHS	Kenya Demographic and Health Survey
KNBS	Kenya National Bureau of Statistics
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
NACOSTI	National Council for Science & Technology
STI	Sexually Transmitted Infections
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

As the introductory chapter to the thesis, it comprises the broad overview of the study, presenting the context and situation that informed the work, the issues that have been identified for determination or problems that require were to be addressed, the main reason why the study was necessary to be undertaken and where it was undertaken, what were some limitations and assumptions during the same. It contains general explanations of what this thesis discusses in this study. In context, the introduction equally has been organized systematically for ease of following and as consistent with presentation of thesis document. Below is the summary of the sections of Chapter One and its content: -

1.0 Background to the Study

There are a number of definitions that have been used to describe Female Genital Mutilation or Cutting, which is shortened as FGM/C. The commonest definition that has been adopted at global and policy levels have described it as the cutting or removal of some or all of the vulva depending on the practicing communities reasoning or justification for such a cut or removal. While FGM is practiced in many almost globally, the magnitude and severity of the problem depends on geographies, with certain areas of the global map having higher prevalence that others. Observably, most of the cases are in Africa, some parts of the Asian continent and also spread across the Middle East. There are also those in diasporas who carry on the practice based on their countries of origin where the practice is normalized. The act of removing the external female genitalia whole or partially for non-medical purposes is known as female genital mutilation, or FGM (WHO, 2021). It is believed to have been in place for centuries and is associated with a number of countries globally, especially in culturally and religiously conservative communities and in developing countries.

Girls and women's fundamental human rights to life, physical wellbeing and general health are violated by Female Genital Mutilation, especially when such procedures go wrong, causing

physical damages or worse still, where the victims end up bleeding to death, or undergo mental trauma over the same. Thirty countries are approximated to be responsible for over two hundred million girls who had been subjected to the cut according to a 2022 report by NICEF. This is significant; it outstrips the equally worrying large numbers of reported HIV cases among the same population worldwide. Further analysis shows that 44% of these girls are aged 14 years and below, worsening the risk for reproductive health complications and death. According to these global authorities an estimated three million girls are likely to face the practice each year.

FGM/C has been a topic of concern at the global level, with numerous efforts being initiated to eliminate the practice. Over the years, there have been initiatives under led by the global agencies like the United Nations (UN) in raising global concerns and advocacy for the abolition of FGM. These efforts have targeted member states and governments who are the duty bearers, with a joint press statement in 2009 to support countries in the elimination of FGM after it became a global health concern. These efforts at the global level have stimulated a host of member countries to domesticate instruments aimed at criminalizing this religious and culturally sensitive practice.

Commemorative days have been marked worldwide against FGM and have been used by victims and survivors of FGM/C to share personal stories and what kind of the pain they went through and the consequences of this ancient practice against any attempts at a civilized response, in an effort to highlight human-interest stories. Not only may FGM cause physical harm, but it can also lead to STIs like HIV, which exacerbates the already severe health and reproductive issues that affect adolescent girls and women worldwide.

For this reason, the Global Consultation Committee on FGM officially launched an advocacy to rally the support and cooperation of all medical practitioners worldwide to support the abolishment of FGM, by refusing to practice it in their health facilities or elsewhere, as a clarion

call in 2007 that has been sustained to date. UNICEF in 2021 observes that the Africa continent bears the highest proportion of countries practicing FGM, with 27 out of the 28 high prevalence countries being found in the continent. It has been observed that FGM tends to run from one generation to next, where daughters of mothers who undergo the practice being highly predisposed to the same practice down the line.

Further, the report explores the distribution of young girls aged below 15 who have undergone the cut in the same countries, comparative to the larger female populations. Niger is the world's leading Under-15 FGM prevalent country at 50%, with Uganda, Chad, Mali and Somalia at 47.7%, 47.6%, 47% and 46.2% respectively, all the top-5 countries with >45% <15 FGM prevalence being in Sub-Saharan Africa (UNICEF Global Report, 2021).

It is worth noting that there has been a coordinated global campaign to end FGM due to its harmful effect on women's health and wellbeing. According to WHO, apart from immediate effects such as physical trauma and pain, infections such as HIV and STIs resulting from unsterilized equipment use, anaphylactic shock resulting from tissue trauma, excessive bleeding due to blood vessel puncture and physiological consequences, it also has long-term effects such as urine retention, impaired wound healing, painful urination and reproductive health complications such as obstetric and perinatal deformities. A correlation has been established between FGM and other reproductive health consequences resulting from compounded demographic determinants such as AGYW fertility, maternal mortality rates (MMR) and infant mortality (MMR) in African countries (UNFPA, 2022). FGM is considered is a critical stage of transitioning into adulthood and a form of controlling women's sensuality and sexuality. FGM is performed in Kenya, primarily among pastoralist groups. In Kenya, 21% of women have had FGM, with a trend of younger girls being cut. Whereas 28% of girls currently aged 20-24 having been cut at 5-8 years old, only 17% were cut between 45-49 years of age (KDHS, 2019). There are very wide ethnic and religious variations, with Muslims being the highest circumcising

religion at 20% followed by Roman Catholics at a distant 21% and Somalis being the highest circumcising ethnic group at 98%, followed by Samburu at 86%.

According to data from the national survey through the KNBS 2019, of the women aged 15-49, there were approximately 21% who had undergone or been subjected to FGM in some way. The report further provides an important pointer that level of education affects the practice. Education is observed to be a major factor influencing the practice of FGM, with those who have not achieved any level of proper education and those with some education registering 26% and 15% FGM prevalence respectively. The report also notes that poverty remains a major determinant in the practice of FGM/C. It shows that, 29% of women in the upper quintile of poverty as compared to 13% in the upper quintile of economic means, had undergone the cut. This summarizes that both poverty and education bear great significance in the overall prevalence of FGM in Migori County (KNBS, 2019).

Kenya's journey towards elimination of FGM is riddled with successes and missteps along the way. At policy level, Kenya has existence of anti-Female Genital Mutilation policies which includes a comprehensive law, referred to as 'The Prohibition of Female Genital Mutilation Act of 2011.' Through this legislation, it is a criminal offence to practice of FGM in Kenya while also providing mechanisms for cross-border collaborations, noting that our neighboring countries also practice FGM. It is instructive to note that the Anti-FGM Act has provided a number of key provisions and definitions that underpin this law. Among them is the clear definition of **Criminalization**: The performance, procurement and or abetting FGM is therefore cited as criminal according to the Act. On cross-border FGM, the act has offered clarity that **Cross-border FGM** also addresses cross-border FGM, preventing individuals from being taken out of Kenya where the practice of FGM will be conducted. Where a commission of the offense relating to FGM, that act cites that using premises for FGM is prohibited, while also spelling out that possession of tools for FGM is also an offense. To further strengthen the enforcement

and collaboration and accountability by community members, the law states that it is the responsibility of everyone to report suspected or actual incidences of FGM and where one fails to willfully report such cases, they are committing an offence as everyone has a duty to report instances of FGM. On the penalties, the law provides that violations of the Act can result in imprisonment or a penalty as prescribed by Kenyan Law.

In fact, the country has noted with concern that some parents collude with practitioners across the border to have the girls cross the border to have the cut, away from the watchful eyes of the Kenyan authorities. This act is part of Kenya's broader efforts to eradicate FGM, which includes the establishment of the Anti-FGM Board and the National Policy on the Eradication of FGM. These agencies have been bestowed with responsibility for awareness creation, advocacy and working closely with the other organs of the state in preventing the practice or responding appropriately where individuals face the forceful community pressure to conform, including the provision of rescue or safe houses for vulnerable girls.

While the policy initiatives are a positive step in the right direction, it appears that there is a higher-level engagement with policy makers and leaders with very little effect on the ground. Similarly, it is being observed that some of the commitments by the leaders to eliminate the practice are only pronouncements made in political settings but different messages are delivered to the masses on the ground. In fact, it remains unclear how much awareness of the same is understood by the community. Similarly, the policy enforcement of the same will require interrogation. Of interest too will be the understanding of how consultative the policy formulation and implementation has been. Campaigns against FGM as a harmful practice started with the early church in Kenya, and has been proscribed as an illegal social practice in Kenya since 2001 under laws prohibiting customs harmful to children. In the year 2011, a specific legislation was passed, the Prohibition of FGM Act 2011, a substantive legislation to criminalize FGM with and attendant corporate body, the National Anti-FGM Board formed in

2013 to oversee its implementation. The provisions under the Act provides a breakdown of the offences under it including; conduct of FGM, paying someone to perform FGM either in Kenya or outside, providing space or premises to carry it out, possession of instruments used in FGM, or failing to report the act (KNBS, 2019).

1.1 Statement of the Problem

Alongside legislation, at the continental level, African countries resorted to address the traditional practices that affect the wellbeing of women and children, aimed at influencing policies regarding the elimination of harmful traditional practices that promote the abuse of women's and children's human rights. This is just one of many global efforts made to stop FGM/C in many countries.

Recognizing that laws and interventions aimed at ending FGM have been implemented in many countries, it appears that these efforts may not be contextually appropriate. It is important to understand the socioecology at play within the communities and the determinants that are either barriers or facilitators to doing the practice to these communities. Different counties in Kenya have different causes for the persistence of FGM/C, and these reasons change with time.

Despite vigorous and concerted efforts, campaigns, massive sensitization and the implementation of law including arrest of FGM perpetrators, the women of Kuria in Migori County for example still cling to the practice and do not show any intentions of responding to changes happening in the anti-FGM landscape. A recent sentencing of 3 women in Kuria West in Migori County brought to light the eternal conundrum of implementing legislation vis-a-vis the social inclusion of uncircumcised women. The Kenyan media has reported numerous cases where women who underwent alternative rites of passage instead of the “cut” are later resorting to still undergo the cut due to social exclusion. Most of them are married women who face stigma by their fellow married women who still regard them as girls or children and are denied

opportunities to interact and participate in community or social activities (KNBS, 2013). Social inclusion in these communities is so weak that it has created a need to examine the current disconnect between policies and/or legislation and a community's way of life, including how policy influences a society's process of change.

According to Ahanonu and Victor (2014), a large proportion of mothers hold middle-ground views about FGM, with 55% saying FGM had no benefit, while 4% thought girls who haven't undergone FGM will become promiscuous. In addition, they gathered that 30% of respondents think FGM promotes a woman's faithfulness while 22% believe there are no major gynecological risks attached. This study will assess the extent to which personality factors in Kenya are barriers or facilitators to the practice and the inherent social exclusion of those who do not practice FGM.

According to a report dubbed '28 Too Many 2018' there are major deficiencies in the implementation of laws, policies and guidelines on FGM. As such, the authors recommend that the implementation of the same should consider the following: a) to institute systems for monitoring and reporting of FGM cases. This recommendation acknowledges that there are weaknesses in the systems to document technical and policy briefs that can inform the key actors and coordinate their efforts in addressing FGM issues comprehensively. It also notes that the non-state actors may not be working closely with the relevant law enforcement and judiciary to monitor and report progress being made across the cascade, b] There is need for robust awareness creation. This recommendation responds to the observation that the community affected by the law are not adequately informed over the same. There is not enough evidence to suggest that they were involved in the policy formulation and subsequent implementation, c] strengthen collaboration and partnership within the region. The cited cases of cross border migrations to have the cut done in one country to avoid the watchful eyes of administration in one jurisdiction remains a major barriers. Such steps would therefore ensure that there is

harmonization and coordination across jurisdictions to tame such illegalities, d] stronger engagement of influential community leaders at local level and faith leaders. This assertion is reinforced by the fact that opinion leaders at the community level have immense influence over cultures and traditions. Similarly, religion is seen as a powerful transformative force, especially in constructive engagement on harmful cultural practices. Harnessing their potential is seen a critical pillar in the fight against FGM as key stakeholders, e] Capacity building and continuous learning and development among the judicial officials and other parties like prosecutors and police. This recommendation can be strengthened through the Court Users Forums that have been found to be instrumental in monitoring the progress of court cases and offering timely support as required. The training of judicial officials and law enforcers becomes a necessary step in strengthening the investigation, presentation of watertight cases and application of the law as required, f] intensify awareness creation around successful prosecutions and ongoing cases. Awareness creation at the community is important, but it is even greater when the community are made aware of the consequences of violating the law. Case laws should be summarized in a manner that makes sense to the local communities, especially those that practice FGM. Local media, especially radio stations that broadcast in local dialect and have wide reach and coverage should become allies in the campaign, not just commercial partners. When such media houses own the agenda, they are more likely to stay engaged for longer and have sustained conversations not just reportage of cases. g] Enhance witness and survivor protection measures to inspire confidence. Cultural practices tend to attract a lot of community led sanctions against those who are seen to go against community norms, practices and traditions. Therefore, it is risky for individuals and families to report cases for fear of reprisals from the community. Communities are known to become hostile against those who report cases or become witnesses in such cases. They are often ostracized or excommunicated, some undergo public punishments including whipping or physical violence. To encourage community

members to report, deterrence measures need to be put in place to eliminate such occurrences. Where there are fears expressed by those who report cases or witness, they ought to be given protection through safe houses or witness protection measures as per the provisions of the Witness Protection Act, h] Institute early warning signs and map out areas for potential higher risks. This recommendation acknowledges that cultural practices are perpetuated across disciplines and ignorance of the law fuels continued silence or abuse. Bringing on board multidisciplinary teams for training or sensitization therefore broadens the reach and awareness in the community. Teachers for example become great agents of change due to the ready audience they have in school, i] Consider messaging options for low literacy groups. This recommendation can be implemented in tandem with the earlier one on awareness creation, as radio stations that broadcast in local dialects remain the best vehicle for reaching and disseminating information. In addition, the National Government Administrative Officers, who are mandated to hold regular public barazas can mainstream FGM messaging in all their outreaches for wider reach among low literacy residents, j] Enhance and strengthen the capacity of health providers to report FGM routinely. Since the government is harmonizing the medical records and reporting, indicators around FGM should be embedded to ensure that the medical reports capture theses in timely manners, k] Explore safeguarding of girls and women at risk through safe spaces or rescue centers or educational institutions that offer boarding services. This is consistent with the requirement under witness protection. This recommendation therefore becomes a cog in the efforts to prevent the forceful cutting of school girls that is very prevalent during school holidays. Best practices around these have been recorded in parts of the country where civil society organization and the Ministry of Education have partnered to have some schools operate as safe houses where girls are admitted full time and not released to go home until the unsafe environment has been addressed for reintegration into the community.

In communities where nearly all girls are circumcised, it is evident that families feel that their daughters must go through this process before they can get married. This is done to ensure that the girl is ready for adulthood and has a "proper" marriage, which has socioeconomic benefits. In the converse, girls who don't go through this are ostracized and don't easily get married.

According to UNICEF (2021), this turns FGM into a societal norm that all parties must abide by, since it is assumed that everyone else has already undergone the procedure. The complex interplay of social expectations, personal experiences of exclusion, community expression of repulsion or acceptance for those who have not and have undergone FGM respectively, make it difficult to respond to the progressive policies that have been developed to respond to FGM. These factors were interrogated in the context of this study to inform policy recommendations.

1.2 Purpose of the Study

To examine the lived experiences and perspectives of women who have been "socially excluded" as a result of having undergone the alternative rites of passage as a way of conforming to the anti-FGM law, the study was conceptualized. The study expanded these perspectives by drawing a cause-effect relationship and determining both the nature and effects of social inclusion and how they contribute to the fight against FGM in the county. The experiences of these women helped draw the analysis on other socio-demographic impact of social inclusion.

1.3 Study Objectives

1.3.1 Broad Objective

To examine the role of anti-FGM strategies on the social inclusion of women who have undergone alternative rites of passage in Migori County.

1.3.2 Specific Objectives

1. To assess how anti-FGM policy elements impact women's social inclusion in Migori County.
2. To assess how FGM status affect women's social inclusion in Migori County.
3. To investigate how community elements affect women's social inclusion in Migori County, and
4. To investigate how anti FGM responses in Migori County affect women's social inclusion.

1.4 Research Questions

1. To what extent does the existing anti-FGM policy factors affect social inclusion among women in Migori County?
2. What is the effect of FGM status on social inclusion among women in Migori County?
3. What is the effect of community factors on FGM on social inclusion among women in Migori County?
4. How have the anti-FGM strategies adopted afftected social inclusion among women in Migori County?

1.5 Significance of the Study

It is acknowledged that there are health and social harms associated with FGM with a heavy burden and cost to the individuals, families, communities and government. The study findings sought to contribute to the evidence that communities, policy makers and leaders can use to promote the merits of social inclusion regardless of FGM-status and the extent of violations and abuse it brings about when sustained, and suggest better policy frameworks to harness social inclusion.

1.6 Scope of the Study

The research scope was confined to Migori County, in Kuria East and Kuria West sub-counties, with a view of understanding the nature of anti-FGM policy formulation and implementation and how that affects the social inclusion of women who have undergone alternative rites of passage. The study focused on gathering information on personal and communal experiences, views on factors promoting FGM, progress on efforts to eliminate FGM and personal recommendations on how policy formulation and implementation processes should respond to social inclusion. The scope of this study extended to the women of reproductive age within Migori county, religious leaders and gatekeepers in Kuria East and Kuria West.

1.7 Study Limitations

Limitations are circumstances outside the researcher's control that could constrain the study, according to Best and Kahn (1998). The community is very suspicious about individuals who ask questions around Female Genital Mutilation and they suspected that the study results could be used to identify perpetrators or those who have participated in the practice for purposes of prosecution. The researcher used the community leaders for entry process and this helped to calm the curiosities and suspicions among the residents. Equally, the presence of the local research assistants who translated the conversations in local dialect was beneficial. While undertaking the data collection in the field, some of the respondents sought help from the researcher to respond to various health and social issues they were undergoing. While the researcher was not able to respond to these requests, the participants were referred to health and social services to seek assistance.

1.8 Delimitations

The researcher established connection with stakeholders in the community including health service providers, social workers and law enforcement officers. These working relationships

supported the ability to discuss culturally sensitive issues. Additionally, the use of research assistants from the local community who understood the dialects and nuances made it easier to conduct the study.

1.9 Assumptions of the Study

Here are some of basis for design and interpretation:

i. Every respondent would possess fundamental and pertinent knowledge of Female Genital Mutilation whether they have directly participated in the practice or not.

ii. Every respondent would answer inquiries in a sincere, accurate, and truthful manner.

1.10 Operational Definition of Key Terms

Female Genital Mutilation (FGM): WHO defines FGM as partial or total removal of the external female genitalia or harm to the female genital organ for cultural or any other non-medical reasons. In Kenya, three distinct forms of FGM are carried out: The first type or Type I is characterized by minor removal or chipping off the tip of the clitoris. The 2nd type which is equally prevalents or Type II refers to a case where both the clitoris and labia are also excised. The third type, which is considered very dangerous both at the point of cutting and later when the woman is engaged in sexual activity and childbirth is a case where total removal is done for the clitoris, the labia from the inside and outside and skin sewed, with a small aperture left, often said to be used for urination purpose, according to an earlier study by GTZ, 2005).

Social inclusion: is the act of making certain groups of people, who exhibit perceived contrary characteristics within a society, to feel accepted and valued. It also includes removal of social marginalization where a section of people is relegated to the fringes of society. Accordingly, social inclusion has to have the following attributes: 1] Participation where emphasizes is laid on the importance of every member of a group or community having the ability to take part in almost all aspects of society, including economic, social, cultural, and political activities, 2] Equal Opportunities that demands that an environment is created as a level playing field where all members of a group or society regardless of their religion, sex, age, economic status or other backgrounds have the same chance to reach their full potential, notwithstanding the their circumstances, 3] Access to Resources is to ensure that access to necessary and essential resources like social and health services, information and education, ability to engage in gainful employment, decent housing among others accorded to all, 4] Dignity and Respect is a corner stone of individuality. It is premised on fostering a community and a collective society where every individual is accorded dignity and respect, regardless of their status and that their right and autonomy is safeguarded, 5] Addressing Systemic Inequalities, which is anchored on the

fact that some groups and individuals are disproportionately disadvantage by the systems at play. It therefore recognizes and addresses such systemic (at family, community, environment or policy) barriers that limits particular individuals or groups from fully participating in society, such as discrimination based on gender, ethnicity, disability, or other factors.

Alternative rites of passage (APR): This is a set of interventions and strategies designed to simulate an initiation of girls into adulthood as a woman, devoid of the FGM. These APR may vary from one setting or community to another.

CHAPTER 2: LITERATURE REVIEW

2.0 Introduction

The researcher considered "cultural relativism" as the appropriate source which was examined in order to comprehend and appreciate the complexity around FGM/C with associated socio-cultural conflicts. According to the theory of cultural relativism, a person's views and actions can only be comprehended in light of their own culture and society (Schaefer et al., 2017). This then provides the ground for an in-depth analysis of cultural fundamentals of policy making and legislation. A number of existing legislative references and policy documents have been examined in order to understand the maxims under which they were made, concordance with related laws and guidelines, historical backgrounds and sources of such legislation, as well as trends and practices that informed policies. Literature from global authorities included published and unpublished works of UN agencies and continental bodies within the regions where the practice is rampant as well as scholarly papers.

2.1 Empirical Literature

It is imperative to note that Kenya is among a host of countries with an eclectic blend of legal systems. The foundation of the Kenyan law was premised on English common law, but also embedded both religious, particularly Islamic law and customary law. This type of system sometimes creates a conundrum when faced with customary or religious laws in conflict with the constitution, which is the supreme law. Kenya is a signatory to a number of treaties and agreement signed at the international level. The Kenyan constitution provides that such instruments be ratified locally for them to form part of the local laws. So far, most of these agreements have been ratified and are operational. In addition, Kenya has devolved government which creates two separate levels or government which are both distinct and interdependent, referred to as national and county governments. This architecture is a product of the progressive Constitution of Kenya (2010) which has assigned subtle supremacy to national government

even for those offenses committed at the county level, where most religious and customary practices are dominant. In the hierarchy of laws, the constitution is superior, then the National law are designed to supersede any laws made at the county level. The default is to refer to the national legislation in instances where the county has not formulated any substantive legislation or policy framework. It is instructive to note that the Constitution of Kenya 2010 has not made any direct mention on the issue relating to FGM. However, Article 29(c) of the constitution provides the right not to be 'subjected to any form of violence' or (f) 'treated or punished in a cruel, inhuman or degrading manner'. These provisions are cited to alongside Article 44(3) which states that 'a person shall not compel another person to perform, observe or undergo any cultural practice or rite'. Comfort is found on protection of children under Article 53(d) which safeguards them from 'abuse, neglect, harmful cultural practices, all forms of violence, inhuman treatment and punishment . . .' subsequent to provisions cited above, the enactment of The Prohibition of Female Genital Mutilation Act, 2011 (FGM Act 2011), is seen as critical instruments to effect the protection from FGM in Kenya. As pointed out earlier in this section, the existence of this law provides the criminal justice system with the necessary legislation to handle all matters relating to offences and all forms of FGM.

The UNFPA report (2022) has shed more light on the severity and magnitude of FGM in a number worldwide and attendant factors which have exacerbated the practice despite efforts to countermand its growth. In his publication in the Health Education Journal of Nigeria, Ahanonu and Victor (2014) have observed that a large proportion of mothers hold middle-ground views about FGM, with 55% saying FGM had no benefit, while 4% thought girls who haven't undergone FGM will become promiscuous. In addition, they gathered that 30% of respondents think FGM promotes a woman's faithfulness while 22% believe there are no major gynaecological risks attached. The variance in views had a correlation with educational levels, with the desire for more community awareness to change perceptions.

Another troubling development in FGM practice in Kenya is that of the entry of medical practioners as circumcisers. While traditional circumcisers are still the majority, with 74.9% of the girls (0-14) reported as being circumcised by them, and an additional 83.3% of the women aged 15-49% reporting the cut from same traditional circumcisers, the entry of medical practitioners is an alarming trend. Over time, there is data showing that there is an increase in the medicalization of FGM in Kenya as families tried to evade the community rituals associated with the rite of passage. Of greater concern is the observation that 41% of cases of FGM have been reportedly been conducted by health care workers in some parts of the country. These illegalities are reported to have been within the precincts of health facilities, individual residences and some with learning institutions. Although Kenya Demographic and Health Survey (2019) used a much smaller sample of women and girls, it does suggest that 14.8% of women aged 15–49 and 19.7% girls aged 0–14 have been cut by a medical professional. The frontline healthcare workers, that is nurses and midwives were seen as the ones carrying out most of the circumcision cut. Earlier comparative studies from 2016 indicated that Kenya is among the leading countries in this unprofessional conduct, coming at position three in the world for cases of medicalized Female Genital Mutilation/Cutting (FGM/C). This is a blatant commission of an offence in relation to the Act 2011, that outlaws any medical personnel from conducting FGM under any pretext except where such surgical practice is for therapeutic purpose. It is imperative to note that any such surgical procedures must be consistent with what has been defined by the regulatory bodies within the medical profession. Suffice it to emphasize, that any actions contrary to the law is equally corroborated as an offence under the KMPDU Act 2012, which provides for appropriate administrative and disciplinary procedures for any medical practitioner found to have participated or committed such offence as laid under the law. The penalties vary but may include suspension or removal from the membership to the profession through the medical register or worse still, the cancellation of medical practice

license. Other medical practitioners' bodies like the Nurses Council have also weighed in on the same matter. While their Act does not expressly address FGM, any misconduct may result in the same punitive measures as those of KMPDC.

In his review of global secondary data, Muthumbi *et al.* (2015) observes that despite policy legislations in 27 African countries reviewed, only 2 had successfully tamed FGM through stringent regulations with very close legislative monitoring and active community engagement and advocacy. Majority of those who failed to curb FGM mainly faced challenges with poor enforcement and sloppy reprimand systems, whereas those who have instilled more sever punitive measures ended up being counter-productive. This calls for more innovative approaches to anti-FGM responses which combines legal enforcements with measures that address regnant community socio-cultural and environmental determinants.

Another major challenge in prohibition or elimination of FGM remains the Cross-Border FGM menace. In most countries, ethnic groups live a across the borders and tend to even have family lineages spread across one or more countries. Due to disparity in legal restrictions around FGM, where some countries have put in place measures against the practice, with FGM being criminalized, some cartels have formed to try and evade the consequences of continuing with the practice by finding alternative tricks of having the prospective subjects of circumcision sent across the border for the cut to avoid being arrested locally and going through the punishments including sentencing and penalties. Take for instance Kenya whose neighboring countries are among those where cases of FGM are still dominant with weak enforcement of FGM laws, with porous borders that allow for ease of movement. Since there is free movement of people across the borders on a daily basis for varying reasons, it is not unusual for families to move across the borders. Therefore, the crossing by families from one country to the next to undertake FGM becomes an intricate and often complex scenario for efforts by government and other actors to legally or socially address such web of deceit and opportunities to perpetuate the vice. In terms

of risk profile, the communities and by extension, the uncircumcised females living within near border points are disproportionally vulnerable; worth noting are the cases of ethnic Kuria extraction found in Migori County in Kenya to the southern border with Tanzania and those Pokot communities of West Pokot County on the western border with Uganda. There have been multiple reports including media reports that December school holidays is the riskiest period for such migration of girls across the border for 'cutting season' in Kenya. A case in point was in December 2021, there were media reports that individuals and collective groups of residents from the ethnic Kuria extraction devised plans and crossed over with victims into Tanzania to undergo the cut outside of the purview of the authorities in Kenya. This was seen as a way of avoiding the watchful eyes of the community Anti-FGM activists and civil society organizations who often report such incidences following the enactment of the FGM Act which places stringent measures in place to deal with such illegalities. With the coming into force the EAC as a bloc, it has become less cumbersome for movement of people from one country to the next, as no travel documents are required as was the case before. Every new development comes with an equally challenging scenario. There are observations and media reports documenting the sad tale of married women who are being forced by circumstance to cross over the borders to undergo the cut. Particularly, majority of these married women are from Uganda and are sneaked into despite the existence of both Kenyan law and the EAC Act that prohibit such acts. This happens, notwithstanding the provisions of Kenyan Act 2011 criminalizing such criminal enterprise. The Act expressly states that to 'take another person from Kenya to another country, or arrange for another person to be brought into Kenya from another country' for the purposes of Female Genital Mutilation (FGM) is an offense under the law. Additionally, emphasis is laid on the same reciprocity of these provisions among the members states where those convicted of the same offense in one country may not be charged over the same regardless of the outcome in each jurisdiction, as that would be considered double jeopardy. Within the East Africa region,

these Anti-FGM efforts resulted in the East Africa Community (though this bloc has expanded its membership, at the time of the legislation in 2016, the four members comprising Uganda, Kenya, Tanzania, and South Sudan) enacting a law dubbed the EAC Act 2016. The legislation provided a common instrument for state parties to cooperate in the handling of cases touching on FGM by the harmonization of laws, strategies and policies aimed at ending Female Genital Mutilation within the common market. In addition, the law aimed at creating platform for enhancing public access to information regarding the harmful nature of Female Genital Mutilation and provide for strengthened collaboration of the state parties in the sharing of information, research and data. Consistent with Kenyan law, the Act defines Female Genital Mutilation as 'all procedures that involve partial or total removal of the external female genitalia, or other injury to the female organ for non-medical reasons.' Similarly, the Act spells out its four objectives that revolve around FGM as a 'trans-national crime', while prescribing the punishments under the same, providing an environment for collaboration and partnership as well as ensuring uniformity in the implementation of the law.

Even though FGM is ingrained in communities, numerous multifaceted initiatives have been launched to stop the practice's spread, some of which involve training and empowering local advocates against the practice. For instance, joint program implemented by UNFPA-UNICEF regarding FGM has published information about a recent campaign it implemented through local champions that is stimulating the development of a new societal norm to protect girls against FGM. Some of them later reported that they married girls from other tribes who are uncut.

Government agencies and technical figureheads spearheading anti-FGM policy formulation can only provide strategic thrusts to the whole effort of FGM eradication and social inclusion of women who have undergone ARP. The strategic themes of these policies can only be realized

if effectively implemented, with the "responsibility for the execution resting with all stakeholders" (Kenya Anti-FGM Board, 2018).

2.2 Theoretical Literature

A number of theories explain the whole sociological thinking behind the persistence of FGM in traditionally practicing societies. The study will rely on the *social convention theory.* This theory explains how social conventions or norms impact behavior. Making decisions is a process of interdependence; for example, a family's decision may influence or be influenced by the decision made by other family members or by families in general. This theory aims to elucidate the reasons behind mothers allowing their daughters to undergo this traumatic operation (UNICEF, 2010). When parents make decisions regarding how circumstances affect their girls, they desire to act in their daughters' best interests. Concerns have been raised through stakeholder engagements documented in the Anti-FGM Board Report 2020 over the Anti-Female Genital Mutilation Act 2011 for failing to address those women in Kenya who involuntarily participate in FGM due to immense threats and intimidations by members of community. For instance, when women who had escaped the practice either through alternative rite of passage or a decision by parents not to subject their daughter to the cut, there seems to be a danger ahead waiting for such women. Cases abound of uncut women who get ostracized from their community and then get cornered by tradition, begrudgingly participate in the cut in despair or out of options as they must appear compliant to gain acceptability within the community. Unsurprisingly, these women remain at risk of being accused and prosecuted for the offence under the current law as it were. There is precedence to this; there was the incident reported in the media involving some three women aged 21, 29 and 30 who were presented in court having been arrested for undergoing Female Genital Mutilation in Nakuru County, Kenya in December 2017. During their defense in court, these women pleaded that had been forced by circumstances to undergo the practice of FGM to fit into their society. The accused made the

court aware that they had been subjected to high levels of ridicule and isolation from the community and particularly their peers or other women in the community and were considered or referred to as ‘unclean’ by the same women. In courts with these three women was one man who was a husband to one of these women who was considered to have aided and abetted the commission of a crime. This case clearly presented the dilemma in this legislation. It presents the need for a review and need for handling of victims of such exploitation and forced participation in the rituals for conformity.

The case scenario above is not the only dilemma facing this legislation. There is an equally controversial position that has been taken by a Kenyan who has petitioned the court over the constitutionality of the FGM Act 2011. This follows the filing of a petition in Machakos Court by one Tatu Kamau (Dr.). During her presentation, the petitioner asserted that it is her considered view that the FGM Act 2011 was inconsistent with the Constitution of Kenya 2010 and should be declared unconstitutional. She argued that the determination of whether or not to undergo the cut should be left to the individual to make a choice, which the providers should respect. This position appears to support the medicalization of FGM which has also been provided for as being an offence under the FGM Act. There has been great public interest in this matter with individual champions and civil society organizations and activists who support the Anti-FGM joining in the case as interested parties while others are dedicating efforts and campaigns that are arguing that the case is an abuse of the court process and should not be tolerated by the courts. However, the matter is still under court and has not been determined yet.

Families in places where almost all girls are in circumstances that need them to go through this process before they may marry feel that doing so will prepare their daughters for adulthood and help them have a "proper" marriage that bears socioeconomic benefits. Girls who don't experience this, on the other hand, face rejection and difficulty finding marriage. Because

everyone assumes that everyone else has already undergone FGM, this turns FGM into a social norm that everyone must abide by (UNICEF, 2010).

Considering the FGM conundrum in the context of this idea, we can appreciate how difficult it would be to stop the practice on its own because it will have an impact on the daughter's future. However, female circumcision would not be a requirement for marriage if every family in a community decided not to embrace the practice (UNICEF, 2010).

Theory of feminism, as explained by Yount (2002) opines that abandonment of FGM will expand the human rights space of women such as education. In his studies conducted in Egypt, these rights expansions only end at the level of the women since they still worry about the societal options for their daughters. Easton and Finke (2006) on the other hand posit that the persistence of FGM is simply a perpetuation of patriarchal control over women in society and can only end when such cultural conceptions are ended. This, according to Mitike (2008) would still require the facilitation by the same women as they are seen as a strong factor in FGM perpetuation, hence the same strength still needs to be tapped in ending FGM.

2.3 Conceptual Framework

The study drew a conceptualization of the above theorems and their relationship with the study objectives, examining how the researcher-controlled independent variables influenced the respondent-driven dependent variables, with the presence of intervening variables. In Migori, reference is made of superstitions held in high esteem especially by the Kuria tribe, which either promote or can be relied upon to curb FGM and push for social inclusion of women who have undergone ARPs, including those women in community service (Batha, 2017).

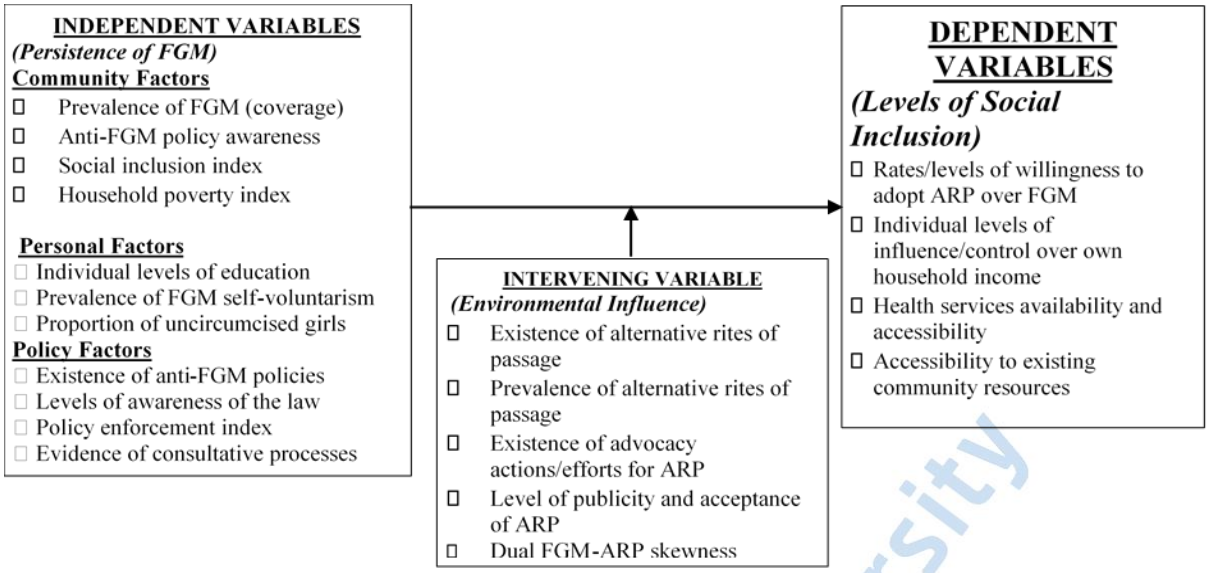

Figure 1 Conceptual Framework

2.4 Research Gap

Previous researches have delved into the discourse focused on FGM in a variety of settings. Certain researches have provided insights on the harm associated with FGM and its aftermath along the way for people who participate in the practice, while other studies have addressed the proper contextualization and theoretical framework for the topic around FGM and its aftermath.

Using different methods such as mixed methods as well as pure qualitative methods, these studies have highlighted various shortcomings at policy and implementation level of the interventions that have been specifically structured to addressed and reduce incidences of FGM/C practice among affected ethnic and religious groups that hold onto the culture in Kenya. However, very few studies have specifically given focus on the experiences and perspective of women have been socially excluded as a result of undergoing alternative rites of passage. Specifically, these studies have not delved deeper in understanding the impact FGM/C has on social inclusion how this plays back on encouraging the FGM/C practice based on policy, personal and community-based factors. Some of the studies that have informed both policy and practice on the subject are summarized below in terms of what methodology they adopted, the focus of the research and what study gaps exist in relation to this this particular study.

Table 1 Literature review and gaps

Author	Methods	Research focus	Gap
Grose et. al. (2019)	This was a cluster randomized prospective study in which over 31,000 women aged 15-49 years were interviewed. Sampling was carried out basing on the KDHS (2014) data	The study focused on the community influences on FGM in Kenya while exploring the norms, opportunities and ethnic diversity	Results indicated that girls whose mothers had not had FGM/C, who lived in a community free of FGM/C, and who belonged to a more ethnically diverse group were at a lower risk of participating in the practice. The study did not however incorporate the views of other important players in the community such as men as well as show the impact of FGM/C on social inclusion
Mwendwa et. al. (2020)	A qualitative exploratory study with activists against FGM/C from two rural Meru sub-counties. Four focus groups with thirty anti-FGM/C supporters were used to collect data.	Four key topics were addressed by the study: Broadly, it looked at whether there have been changes in the cultural interpretation of FGM and whether the interventions put in place are working in Meru County.	Some of the recommendations of this study were encouraging as it took a family centric approach. One of the study's shortcomings, though, is that it did not have the participation of the victims and survivors. The study did not take into account how social inclusion is affected by factors connected to FGM/C.
Muhula et. al. (2021)	This study employed a mixed methods approach to capture experiences, attitudes, and practices about FGM/C. Secondary data from KDHS (2003, 2008, 2009, and 2014) were used, and FGDs, IDIs, and KIIs were conducted with a variety of respondents and community stakeholders.	The study assessed how the community-led alternative rite of passage model affected teenage pregnancies, early and forced marriages, FGM/C, years of schooling for girls, and the attitudes, perceptions, and behaviors of community stakeholders regarding FGM/C in Kenya's Kajiado County.	The study largely provided evidence that communities have explored other rituals to compensate for transition into adulthood by girls. Although the study showed the benefits of adopting culturally acceptable pathways, it did not specifically address how FGM/C affects social inclusion.
Kimani et. al. (2020)	The purpose of this cross-sectional qualitative study was	Using mixed method, this study also	This study indicated that the dissemination of the FGM/C practice went beyond the

	to ascertain why families asked medical professionals for FGM/C for their daughters providers accepted to cut the girls	included Migori County.	community and involved even members of the community who were thought to be fully educated of the dangers of FGM/C and comply to social standards. This study recommended focused interventions aimed at health care providers, families, and communities. Significant findings suggested that girls and women who had not undergone FGM/C would face social isolation. However, the study did not address the specific social inclusion difficulties and how they were especially affected by the FGM/C practice.

2.5 Recap of Literature Review

Based on empirical and theoretical literature referred to above, there is enough evidence and background information and justification of the persistence of FGM and the efforts that continue to be made to respond. This literature also outlines proposals and recommendations on how FGM can be eliminated and theoretical considerations. The conceptual framework for this study concretized the inferences of both literatures, and crystallized the relationship between all that historical information with the focus of the study objectives on social inclusion.

CHAPTER 3: RESEARCH METHODOLOGY

3.0 Introduction

The third chapter includes the research methodology, research design, study location, target population, sampling procedure and techniques, sample population, research instruments, testing for validity and reliability, methods of data collection, data analysis, and ethical considerations.

3.1 Research Methodology

To undertake the study, the researcher adopted mixed methos where qualitative and quantitative approaches were used. There was a combination of primary and secondary data collection methods, while adhering to scientific rigor and relevance. Statistical approaches were used to analyze data and create inferences to provide insight into grey areas around the topic of FGM and social inclusion.

3.2 Research Design

The research was conducted using a descriptive study design, with the participants or respondents chosen based on their previous experience to the practice, either directly or indirectly. Descriptive studies aim to determine, characterize, or identify what is, whereas analytical research attempts to establish why it is that way or how it came to be (Fox and Bayat, 2007). The study observed participants to establish their backgrounds with the context, norms and realities of FGM. This design was preferred because it explored both the exposure and outcome simultaneously. The study was conducted retrospectively focusing on the lifetime of the respondents.

3.3 Location of the Study

Migori County is situated in what was previously referred to as South Nyanza. On its northern side lies Homa Bay County While Kisii County is found on the North Eastern side. On the Eastern side facing Rift Valley, lies Narok County while the South Eastern border faces Tanzania and fresh water, Lake Victoria covers the western side. As at the latest census of 2019, there are approximately 917,170 residents of the county with a population density of 353/km².

The county has high poverty rates with 43% of its residents living below the poverty line. The age breakdown was 49% for those aged 0 to 14, 48% for those aged 15 to 64, and 3% for those aged 65 and over. The population of the county is made up of Somalis, Suba-Luos, Luos, Kuria, Abagusii, Luhya, and a tiny area of Indians, Arabs, and Nubians. The county is divided into Awendo, Nyatike, Rongo, Uriri, Suna East, Suna West, Kuria East, and Kuria West Sub-counties. Thus, the entire county was covered by this study, with a suitable sample flowing from the county through the sub-counties to the wards and villages.

3.4 Target Population

Women between the ages of 15 and 64 drawn from Kuria East and Kuria West sub-counties of Migori County and have undergone FGM/C or other alternative rites of passage, as well as women who have had their bodies circumcised, were the study's target demographic. The two identified sub-counties, which mainly practice FGM/C. According to the latest Kenya population census, Migori County has approximately 580,214 females (KNBS, 2019). The female population in Kuria West and Kuria East sub-counties was 107,417 and 49,894 respectively in 2019 (KNBS, 2019). Forty-eight percent (48%) of the population of Migori County is aged 15 to 64 years. This implied that the female population of Kuria West sub-county is approximately 0.48*107,417, that is, 51,561 and 0.48*49,894, that is, 23,950 in Kuria East sub-county assuming equal proportion of 48% of female population in the two sub-counties accounted for by those aged 15-64 years.

Therefore, about 75,511 females living in Kuria East and Kuria West sub-counties between the ages of 15 and 64 were the study's target group. According to UNICEF (2017), FGM/C prevalence in Migori County is approximately 30% which is above the national average of 21%. This implied that, applying the prevalence of 30% equally to Kuria West and Kuria East sub-counties, the approximate number of females aged 15-64 years who have undergone FGM/C is 0.30*75,511, that is, 22,654 females. This study also sought to collect information from opinion leaders (men, elders, and religious leaders) and local actors from the community, policy makers and interest groups working on anti-FGM campaigns.

3.5 Sampling Procedures and Techniques

The process of selecting an appropriate sample to ascertain the parameters or provide an explanation of the tactics that the researcher will employ to choose representative respondents from the target population is known as the sampling procedure (Adams et al., 2007). The sample for this study was selected using a three-step selection approach. The eight sub-counties that make up Migori are Awendo, Rongo, Suna East and West, Uriri, Nyatike, and Kuria East and West.

First, among the eight sub-counties in Migori County, the Kuria East and Kuria West sub-counties are where the majority of FGM/C practices occur. As a result, the two sampling strata for this study—Kuria East and Kuria West in Migori County were the primary focus of this investigation. The frequency of FGM/C is almost 96% in the sub-counties of Kuria East and Kuria West (KNBS, 2014). FGM/C is primarily performed as a rite of passage among the people living in the Kuria East and Kuria West sub-counties, especially for females ten years of age or older. To choose participants for the study's sample size from the two sub-counties, a straightforward random selection technique was applied.

3.5.1 Sample Size

In Kenya the proportion of females who have undergone FGM/C is approximately 21% (KDHS 2014). However, this proportion is higher in Migori County at 30% (UNICEF 2017), when compared to the national average. The sample size of females from Kuria East and Kuria West in Migori County who have undergone FGM/C or other rites of passage was determined by using the Cochran formula (Cochran, 1977). The study's participants were diverse, including men, women, opinion leaders, policymakers, people who have suffered female genital mutilation or circumcision, and members of various interest groups. This called for a slightly larger sample size to gain an acceptable level of precision while maintaining safe confidence levels and higher variability while minimizing sampling error. This study used the Cochran formula (Cochran 1977) shown below to calculate the sample size of females aged 15-64 years who have undergone FGM/C or alternative rites of passage.

$$n_0 = \frac{z^2 \cdot P \cdot (1, -p)}{e^2}$$

- n_0 = initial sample size
- Z = z-value (e.g., 1.96 for 95 % confidence)
- p = estimated population proportion
- e = margin of error

Thus, 30% of females who have had FGM/C and 70% of females who have undergone alternate rites of passage were the proportions of FGM/C in this study, meaning that p=0.3 implies q=1-p=0.7.

Z has a 95% confidence interval of 1.96. Using the Cochran sampling formula, this indicates that the sample size were:

$$n_0 = \frac{1.96^2 \cdot 0.3 \cdot (1 - 0.3)}{0.05^2}$$

n0=Z2pqe2=1.962*0.3*0.70.052=0.810.0025=322

Therefore, the total sample size was 322 females who have undergone FGM/C or alternative rites of passage.

3.5.2 Stratification and distribution of the sample

The sample size of females aged 15 to 64 years was further stratified by 2 sub-counties, Kuria East and Kuria West. In Kuria East sub-county, there are 23,950 females aged 15 to 64, and in Kuria West sub-county, there are 51,561 females aged 15 to 64, of whom 7,185 and 15,469, respectively, have undergone FGM/C.

These formed the target population sizes in each respective sub-county. The sample size of 322 was further stratified by sub-county according to their proportion or contribution. This study used Neyman allocation formula (Neyman 1934) that allowed allocation by the proportionate contribution to the target population.

The formula for Neyman allocation is:

nh=NhN*n

Where N_h is the target population size for stratum h, N is the total target population size, and n_h is the sample size for stratum h.

Therefore, for Kuria East sub-county, the stratified sample was:

A sample of 113 and 242 girls aged 15-64 who have undergone FGM/C in Kuria East and Kuria West sub-counties, respectively, was obtained by applying the Neyman allocation formula.

Table 2: Stratification and distribution of sample by sub-county

Sub-County	**Female population aged 15-64 years**	**Population of females who have undergone FGM/C**	**Neyman allocated stratified sample**	**Stratified sample size of females who have undergone FGM/C**
Kuria East	23,950	7,185	nh=7,18522,654*324=103	101
Kuria West	51,561	15,469	nh=15,46922,654*324=221	221
Total	**75,511**	**22,654**	**100%**	**322**

3.6 Developing Research Tools

Questionnaires and IDI tools were used in this research to gather information from men, opinion leaders, policy makers, interest groups, and women who have experienced FGM/C or other alternative rites of passage, independently. The study questionnaires were administered by locally recruited research assistants, who underwent training before being deployed to conduct data collection. On the other hand, IDIs were conducted by the researcher using in-depth interview guides. The study questionnaires were developed by referring to the areas of inquiry.

3.7 Validity and reliability testing

3.7.1 Validity

O'Leary (2009) posits that validity is predicated on the idea that the subject of the investigation is measurable and capturable. The purpose of this study was to examine construct validity, which measures an idea in light of significant research conjectures by demonstrating the

theoretical degree to which the constructs identify with one another (Zikmund, 2000). The degree to which a research tool is theoretically grounded is known as construct validity (Straub et al., 2004). This suggests that the tools need to have conceptual or theoretical underpinnings that are already established in the literature. The research questionnaire for this study was piloted in the Rongo sub-county of Migori County, which was not involved in under actual research, in order to ensure construct validity. A questionnaire was given to 33 female participants in the area who made up 10% of the targeted sample and have experienced FGM/C or other rites of passage during the pilot study. No discrepancies were noted during the administration of the piloting of tools; hence the tools were later uploaded onto a digital platform which was used for data collection. Mugenda & Mugenda (2003) maintained that a pilot study should use a sample that is one-tenth of the entire sample and has uniform features.

3.7.2 Reliability

According to Lorraine (1987), a test's dependability is determined by how regularly it evaluates the same thing. In order to determine if variations are due to respondent variables or tool design, construct reliability test was examined through subjecting the same tool to a range of respondents. Ensuring that the items being measured are correlated with the desired construct and not with alternative constructs is the goal of construct reliability. Cronbach's alpha coefficient and the triangulation of responses proposed by Denzin & Lincoln (2005) were used in conjunction to assess the two parameters. In order to assess reliability, Cronbach's alpha coefficient will be employed; a value of 0.7 is deemed sufficient for this type of explanatory research (Hair et al., 2006).

3.8 Data Collection Methods and Procedures

Three distinct instruments, each appropriate for a matching category of respondents, were used to gather study data. Instruments are the tools that were utilized to gather data and the methods by which they were created. Oso and Onen (2005). As part of collecting data during the field visit, questionnaires and in-depth interviews (IDIs) were used. Questionnaires were administered by trained research assistants. Close-ended questions and questions on Likert scale were utilized in the questionnaire. In addition to researcher administered questionnaires, 15

IDIs were conducted. Guest *et al*. (2016) noted that this number of IDIs is sufficient to reach information saturation. The IDI respondents, comprising men (5 IDIs), community gate-keepers including religious leaders (5 IDIs) and local administration and leadership (5 IDIs) were interviewed by the researcher using Interview guides.

3.9 Proposed Data Analysis Techniques and Procedures

During entering, data from interviews conducted by researchers was coded. Quantitative data was analyzed using descriptive methods. Where appropriate, means and standard deviations were calculated, and the findings are displayed in tables, graphs, and charts. The Pearson's Correlation Coefficient was also used to evaluate the correlation between the variables.

Data once collected through IDIs was transcribed by trained research assistants into English language. To delineate for purposes of presenting the results by themes, code list was developed and organized based on context. Additionally, deductive codes and their definitions was developed guided by research objectives and interview guides. A software, NVIVO was used to manage transcripts with the same code list being applied throughout the IDI groups. Following the completion of coding of all transcripts, NVIVO was used to generate coding reports for each code with separate coding reports for each IDI group. In order to find general patterns in the data, thematic content analysis was utilized to find similarities and differences between the groups (Ulin et al., 2005). Extra attention was paid in reading and re-reading the data that was in text form to avoid missing out on any information or error. Data was then presented tabular form first using bullets for key and/or novel messages and illustrative quotes.

3.10 Presentation of results

The profile of the respondents was described by descriptive analysis utilizing central tendencies, frequencies, and percentages of the sample attributes in tabulated form, figures, and graphs with written explanations. measurement of parameters with mean and standard deviation, such as age. Furthermore, in order to examine the association between social inclusion and different factors, Pearson’s correlation coefficient was used and the Pearson’s correlation coefficient examined. Factors that would present a significant association at a 5%

level of significance would further be examined on their effect using multiple linear regression and factors with significant effect identified at 5% level of significance. The purpose of assessing correlation was to check the strength of the association and prevent multicollinearity problem. If the p-value for a Pearson correlation coefficient is less than 0.05, it was deemed significant. The magnitude of the correlation coefficient would determine the strength of the association where Boon and Arumugam (2006) suggest 0.80 and above as a threshold for significant strength of association.

3.11 Ethical Considerations

According to Schulze (2002), when performing research, a researcher should adhere to certain ethical considerations. Research activities involving human subjects, whether experimentally or descriptively, requires observance/application of human subject protection and human rights principles. In this study, Ethical Research Certificate of approval from the Mount Kenya University was given to the researcher, followed by letter from the learning institution to the NACOSTI to facilitate research permit to the researcher. Permission was sought from the NACOSTI to undertake the study which was granted. In addition, the researcher used the letters from both Mount Kenya University and NACOSTI to seek approval to undertake study from the concerned County Executive Committee member who issued an introduction letter that was used to gain entry into the study community. At the community level, the researcher engaged with officials from National Government Administrative Officers to ensure that community entry was smooth. The study team ensured that participants were equally informed as consist with the provisions of the study permits. Participants signed consent form after being given an opportunity to read or being read for the consent form. They were equally made aware that they were participating in the study voluntarily and that they could terminate their participation at any point during the study without any repercussions. Due to the personal nature of issues around FGM, participants were assured of their information being solely collected for study purposes and was not to be shared with any other party at any level, more so the government. They were equally assured that the data was to be anonymous and no personal identifier like names were to be use, instead they were assigned Unique Identify Number (UIN).

CHAPTER 4: RESEARCH FINDINGS, ANALYSIS AND PRESENTATION

4.1. Introduction

The findings from the study are outlines in this section of the report. The study deployed three distinct instruments, each appropriate for a matching category of respondents in gathering the study data. Questionnaires were administered by trained research assistants, with close-ended questions and questions on Likert scale utilized in the questionnaire. To explore the participants perspective, experiences, and feelings about Female Genital Mutilation, the researcher had to conduct In-Depth Interviews going beyond simple, surface-level responses. The In-depth Interviews (IDIs) were developed with both unstructured and semi-structured nature to allow for probing further on questions and answers around the sensitive subject matter. Therefore, in addition to researcher administered questionnaires, fifteen (15) In-depth Interviews (IDIs) were conducted. The In-depth Interviews (IDI) respondents were drawn from both sub-counties and distributed appropriately. They were composed of five (5 IDIs) identified as men drawn from the communities, community gate-keepers including religious leaders and those seen to have influence on matters in the community (5 IDIs) and local administration and leadership (5 IDIs) including village elders, chiefs who were interviewed by the researcher using Interview guides.

4.2. Research Presentation, Interpretation and Discussions.

4.2.1. Respondent distribution.

The study required a slightly larger sample size to gain an acceptable level of precision while maintaining safe confidence levels and higher variability while minimizing sampling error. The study participants were distributed across the two geographies under study. Participants were between the ages of 15 and 64. Kuria East had the majority of respondents at 230 (68%) while Kuria West had 107 (32%) respondents. For the 15 IDIs, Kuria East had a majority of 9 (60%) while 6 (40%) coming from Kuria West. The study was able to reach an acceptable response rate. Below is the distribution.

Table 3: Respondent distribution by sub-county

Respondent distribution by Sub-County	**N =337**	**IDI = 15**	**Questionnaire = 322**
Kuria East	**107 (32%)**	**6 (40%)**	**101 (31%)**
Kuria West	**230 (68%)**	**9 (60%)**	**221 (69%)**

4.2.2. Demographic Characteristics

The study collected demographic information on level of education, marital status, age, religion and economic engagement. For age distribution, slightly less than a quarter (24.8%) of the respondents were between the ages 18-24 years, with 17.4% being under 18 years, 13.7% of respondents belonged to the 25-29 and 10.9% being between 30-35 age bracket, while 8.7% of participants reporting that they were aged between 35-39 years, with 5.3% between ages of 40-44 age category and 5.6% being between 45-50 years old. The remaining 10.6% of participants were above the age of 50 years while 3.1% did not disclose their age. (Figure 4.1).

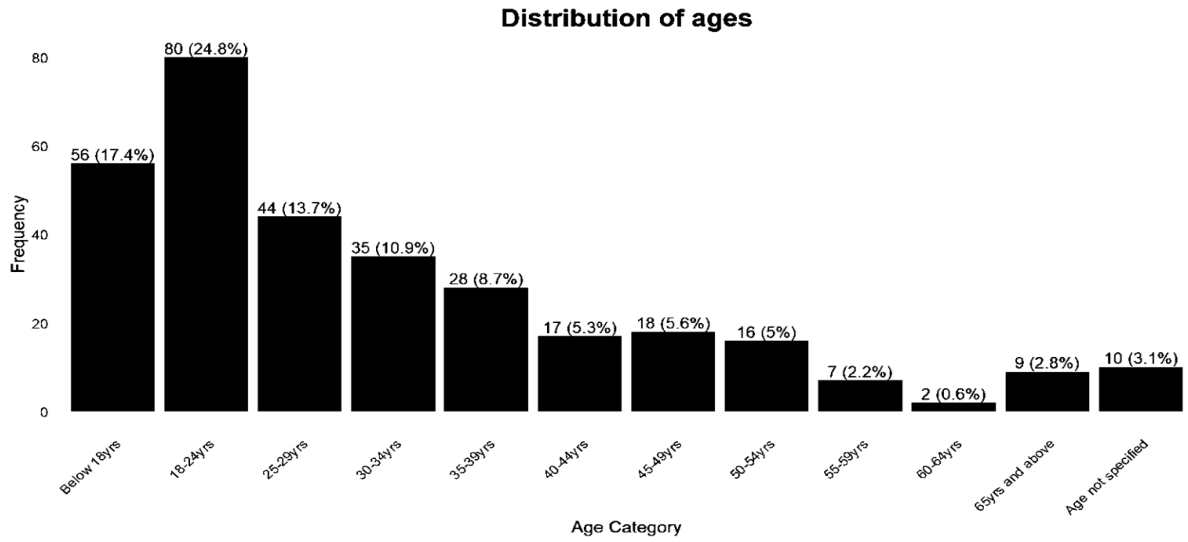

Figure 2: Age distribution

On marital status, a slightly majority at (51.2%) reported that being married with 41.3% being single, with 3.7% being widowed and another 3.7% being either divorced or separated as per the figure 4.2 beneath.

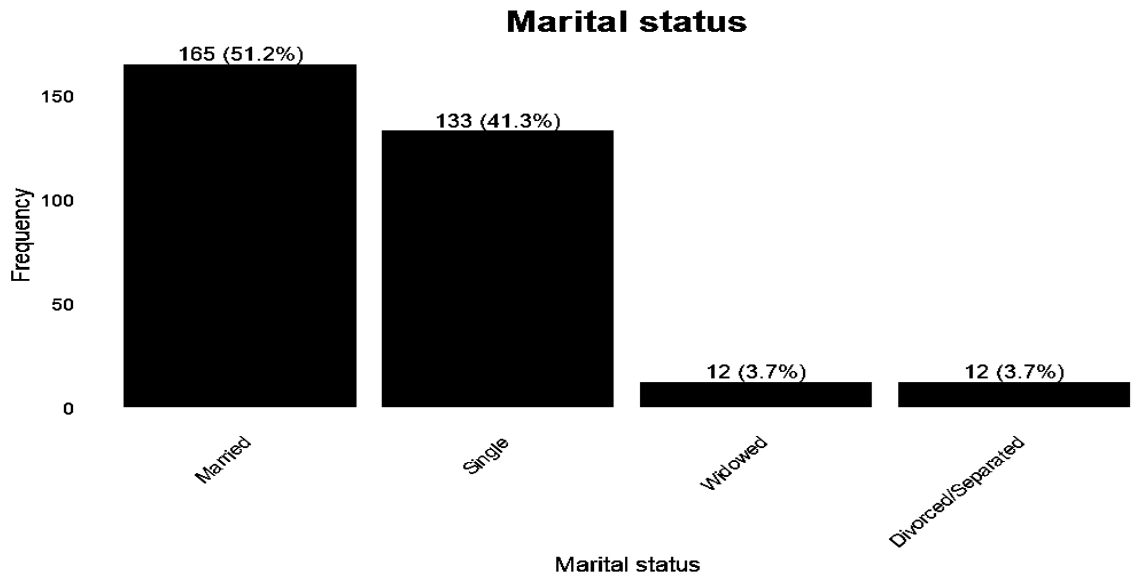

Figure 3: Marital status

Figure 3: Marital status

On education a significant majority at 89.7% reported some level of education, with a majority (39.4%) having completed primary education. There are 10.2% of respondents who indicated they had not had any education.

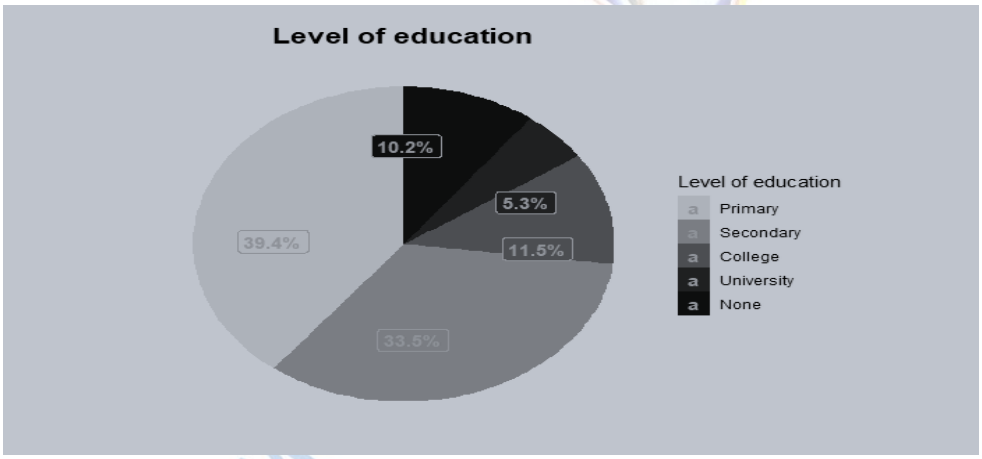

Figure 4: Level of education

Christianity was reported as the dominant religion with (68.3%) of the study participants identifying as protestants, followed by 30.4% who identified as Catholics, hence Christianity dominating at 98.7%, with a small fraction of 0.9% being Muslims and the rest not having a religion to follow.

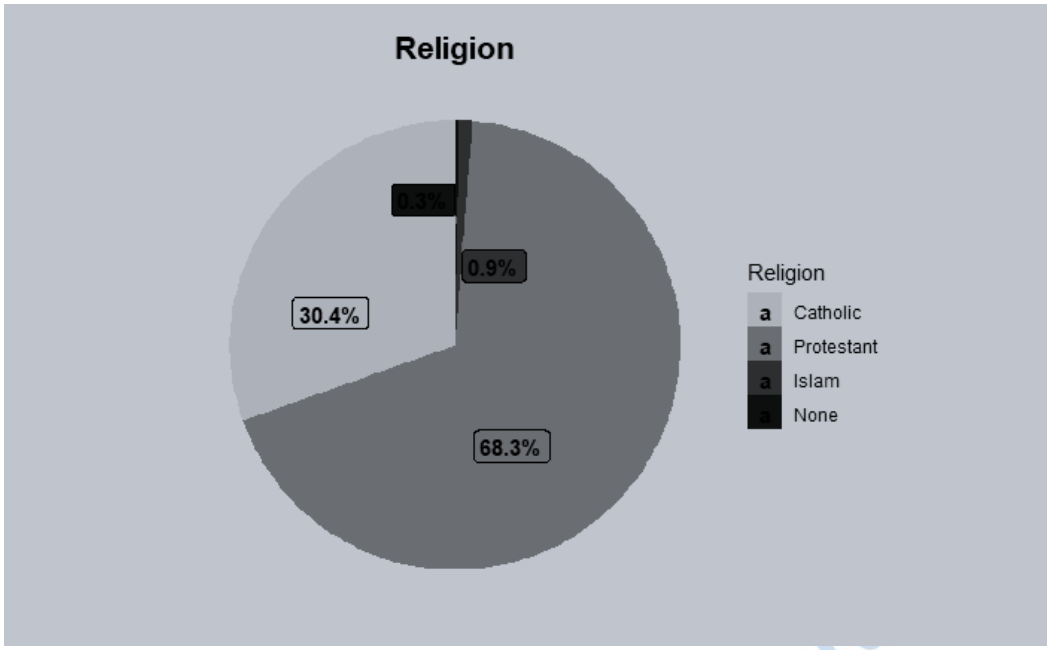

Figure 5: Religion

Figure 4.4: Religion

On economic engagements, 64% of the respondents had a form of economic engagement, with the majority (54.7%) being either in business or farming. Similarly, 51% reported that they had forms of income ranging between Ksh. 1,000 and Ksh. 10,000, while 3.4% had income of between 11,000-20,000, with another 6.2% only having over ksh. 20,000. Over a third of the respondents (36%) reported no income.

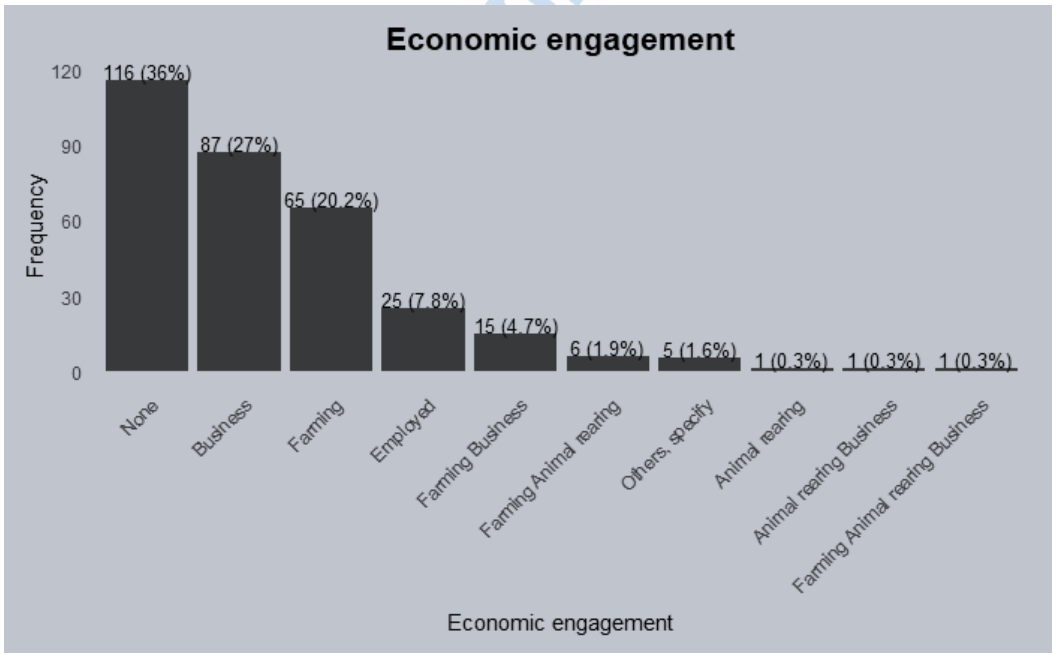

Figure 6: Economic engagement

On FGM awareness, majority (84.8%) of the respondents indicated to have some level of awareness about FGM, with 45% being very aware on matters FGM. Interestingly, there were 15.2% of respondents who indicated that they were not aware of FGM.

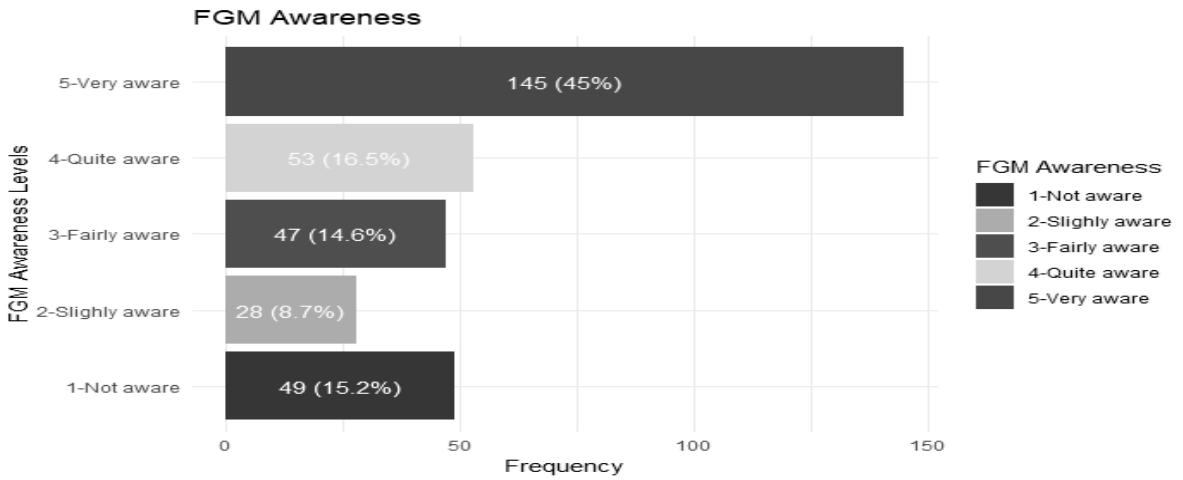

Figure 7: FGM Awareness

4.2.4. Prevalence of FGM

From the responses provided, 44% had undergone Female Genital Mutilation. Although 84% were aware of FGM, not all underwent the practice.

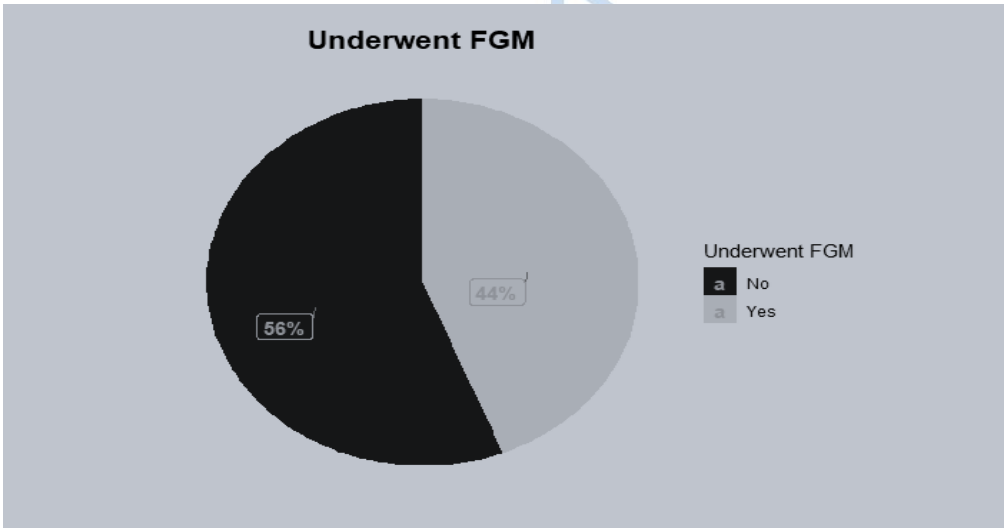

Figure 8: Proportion who have undergone FGM

4.2.5. Who talked to you about FGM?

It was reported that 64.8% of the respondents provided an indication of one's mother being top among those who talked to them about FGM. In comparison, 44% of the respondents indicated that the father talked to them about FGM. Mothers seem to be inclined to ensure their daughters know about FGM and may have influenced their choices on FGM. Family friends also

contributed a significant proportion, 10.4% being the mother's friends and 9.6% being the friends of both mother and father.

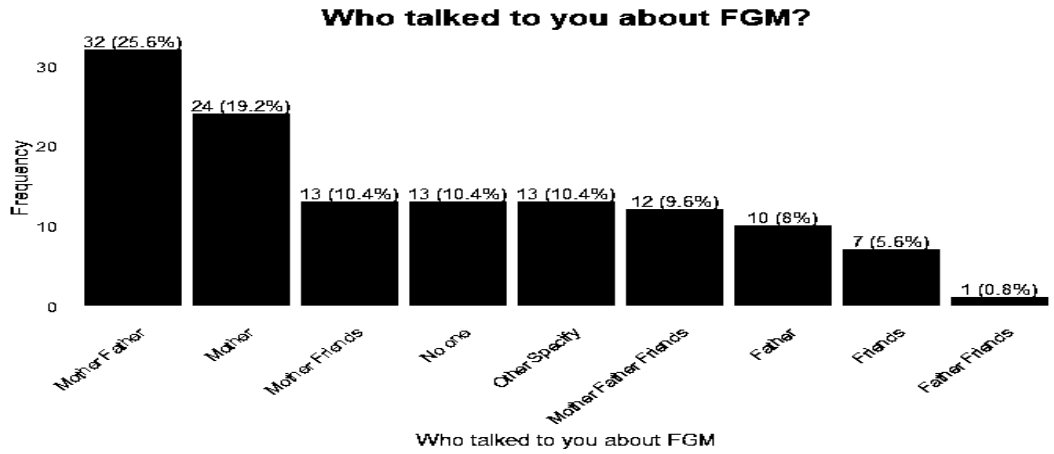

Figure 9: Who talked to you about FGM?

With regards to age when one underwent FGM, 85.8% of the respondents indicated to have undergone FGM at above 5 years of age, while 9.2% of them could not remember the age when they had the cut. Although this is the case, it is worrying that 5% indicate to have undergone FGM while below 5 years of age.

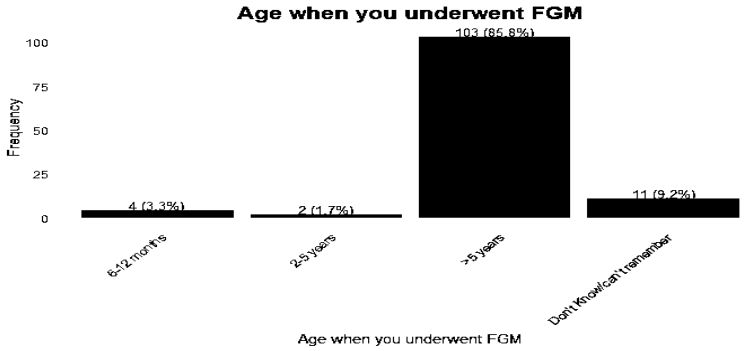

Figure 10: Age when participant underwent FGM

Participants in the qualitative interviews identified drivers of FGM to be cultural influences where women who undergo FGM are considered as full women, encouragement by elders and involuntary circumcision when giving birth.

4.2.6. Willingness to undergo FGM.

At least 69.6% of the respondents informed to have been willing to undergo FGM. This may have been due to the fact that their parents had a greater role in talking to them about FGM. Only a third of the respondents (30.4%) expressed absolute unwillingness to undergo the cut.

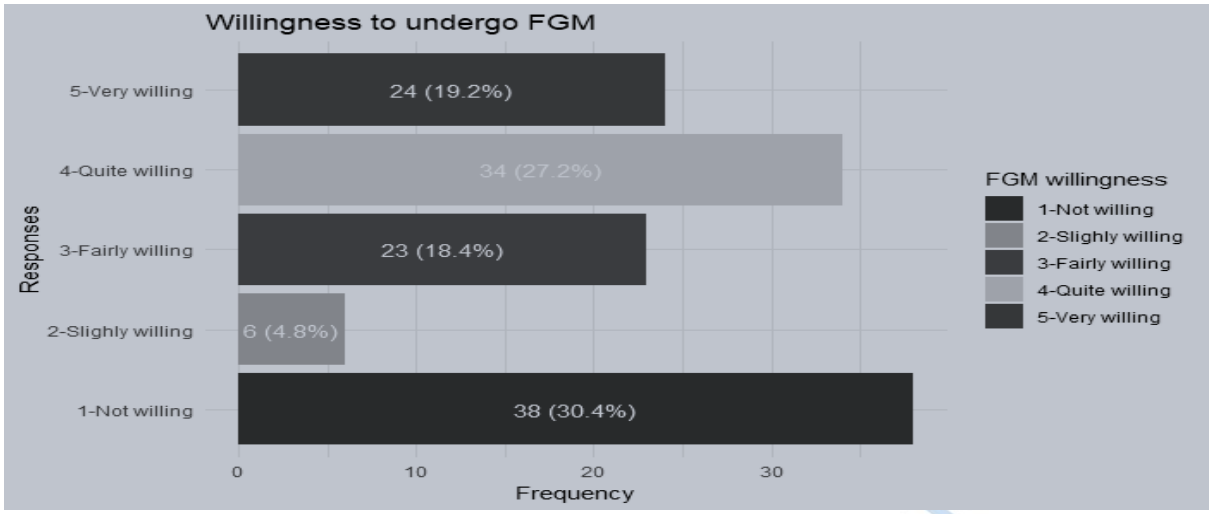

Figure 11: Willingness to undergo FGM

4.2.7. Knowledge of relative or friend who has undergone FGM

The study found that 90.4% of the respondents hinted at knowing a relative or a friend who had undergone FGM. 67.2% indicated being quite or very aware of the same.

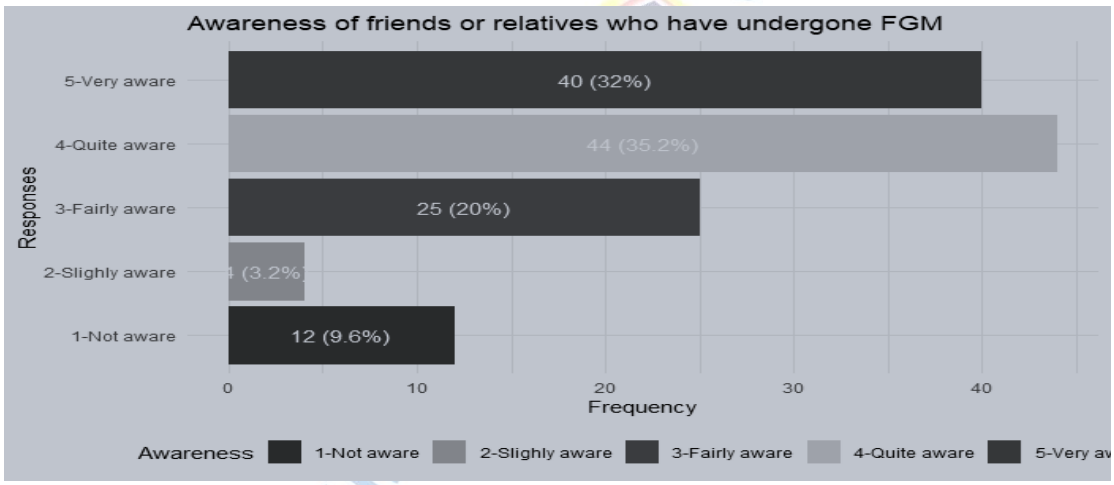

Figure 12: Awareness of relative or friend who has undergone FGM

4.2.8. Homes practicing FGM

On the proportion of homes practicing FGM, it was reported that 59.2% of those interviewed estimated half or more in homes they know are practicing FGM. 18.4% reported they were not aware of any homes that were practicing FGM.

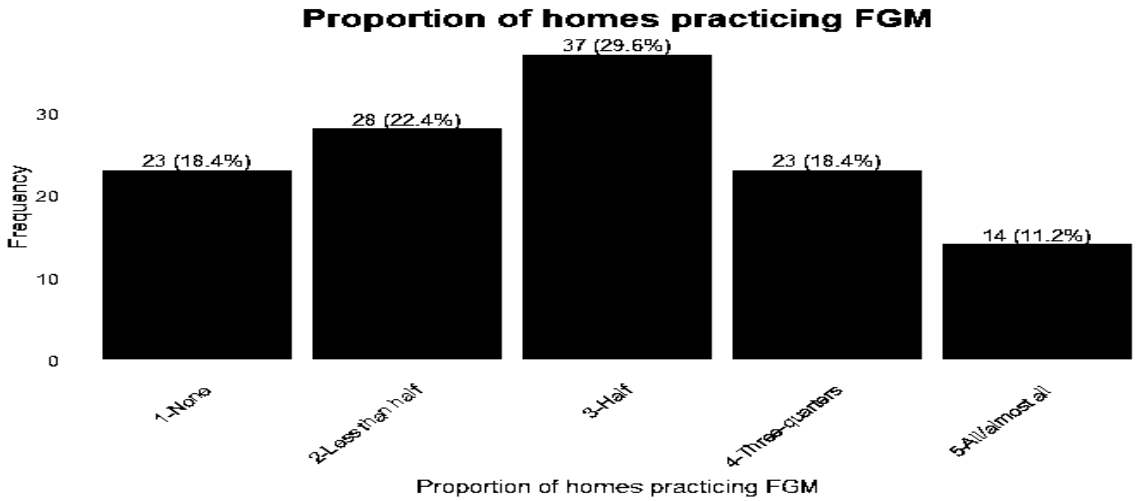

Figure 13: Awareness of households practicing FGM

4.2.9. Perceived benefits of FGM

To corroborate the fact that many homes practice FGM, the interviewees reported that 82% of them considered FGM as something that made them accepted by the community, with 70% noting that undergoing FGM would help them get a sexual partner or husband easily. On the same note, 62% felt that undergoing FGM helps them relate well with their peers.

Table 4: Perceived benefits of FGM

Potential benefits of FGM	1- Strongly Disagree	2- Disagree	3- Not sure	4- Agree	5- Strongly Agree
FGM Makes childbearing easy	10 (8.0%)	60 (48%)	25 (20%)	25 (20%)	5 (4.0%)
FGM Makes me a full woman	9 (7.2%)	51 (41%)	6 (4.8%)	37 (30%)	22 (18%)
FGM Makes me accepted by community	4 (3.2%)	18 (14%)	1 (0.8%)	70 (56%)	32 (26%)
FGM Makes me faithful to sexual partner	11 (8.8%)	55 (44%)	10 (8.0%)	34 (27%)	15 (12%)
FGM Makes me find sexual partner/husband easily	4 (3.2%)	28 (22%)	5 (4.0%)	64 (51%)	24 (19%)
FGM Makes me to relate well with peers socially	4 (3.2%)	35 (28%)	8 (6.4%)	60 (48%)	18 (14%)

Participants in the qualitative interviews were in unanimous agreement that there were no benefits arising out of FGM/C.

4.2.10. Perceived harmful effects of FGM

While many respondents felt the need to practice FGM, 91% indicated that FGM was a painful. Additionally, half of the respondents considered FGM to result in health complications, 85% reported that FGM is illegal and can lead to arrest, 37% perceived FGM to affect sexual intimacy and 38% considered FGM to cause complications during child birth.

Table 5: Perceived harmful effects of FGM

Perceived harmful effects of FGM/C	Strongly Disagree	Disagree	Not sure	Agree	Strongly Agree
FGM affects sexual intimacy	4 (3.2%)	62 (50%)	13 (10%)	31 (25%)	15 (12%)
FGM bring health complications	6 (4.8%)	36 (29%)	21 (17%)	35 (28%)	27 (22%)
FGM created social stigma	3 (2.4%)	72 (58%)	12 (9.6%)	19 (15%)	19 (15%)
FGM is illegal and can lead to arrest	1 (0.8%)	11 (8.8%)	6 (4.8%)	54 (43%)	53 (42%)
FGM is painful	0 (0%)	11 (8.8%)	0 (0%)	56 (45%)	58 (46%)
FGM Results in difficulties during child birth	4 (3.2%)	49 (39%)	20 (16%)	28 (22%)	24 (19%)

Similarly, participants who contributed to the qualitative interviews emphasized that FGM was likely to result in complications as a result of loss of blood, may lead to fatalities, early marriage, early sexual debut and birth complications.

4.2.11. Likelihood of supporting daughter to undergo FGM

Of all the participants, 73.6% reported that they had children who are daughters.

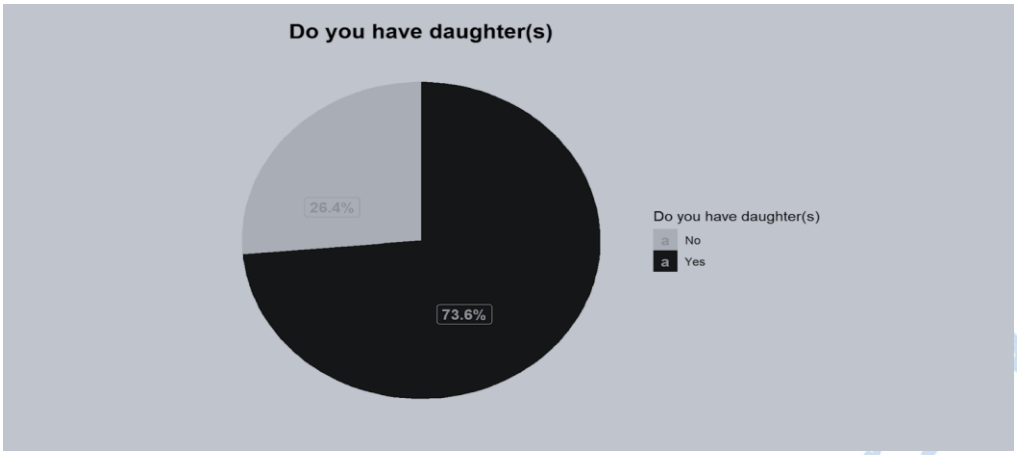

Figure 14: Whether participant has daughter among children

A total of 69.6% of those who had daughters stated that they had many daughters with only 30.4% indicating to have only 1 daughter.

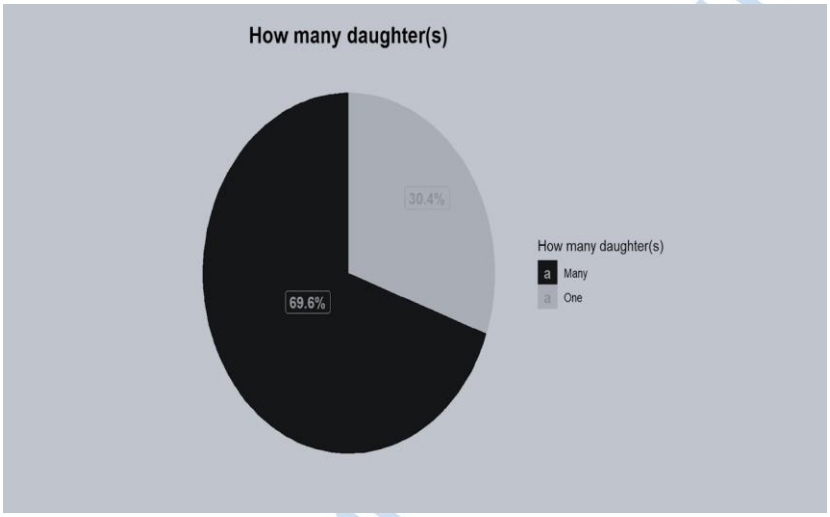

Figure 14 : Number of daughters participant has

4.2.12. Daughters who have undergone FGM

On the question of whether their own daughters had participated in FGM, 64.1% of those with a daughter mentioned that none of their daughters had undergone FGM. This is a contrast since

many of the respondents had earlier indicated that FGM had potential benefits to them.

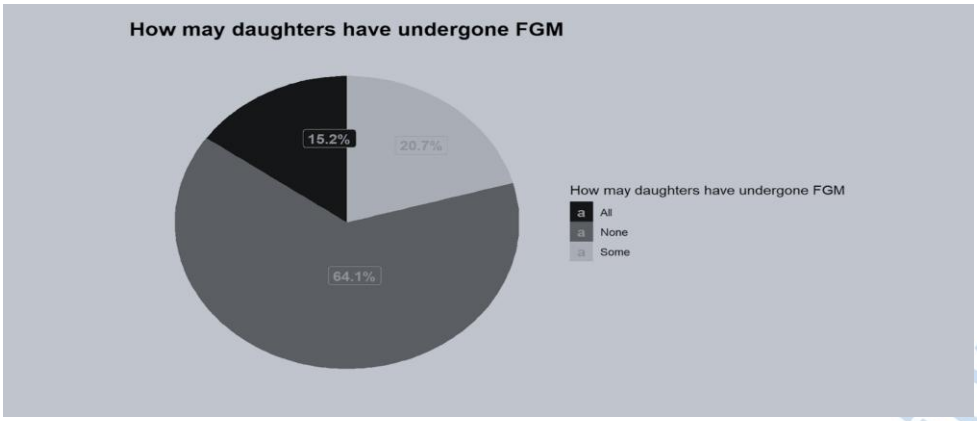

Figure 15: Number of participant daughters who have undergone FGM

Figure 4.15: number of participant daughters who have undergone FGM

4.3. Discussion of Individual Objective Results

Below are the findings per individual objectives of the study.

4.3.1. To investigate how community elements affect women's social inclusion in Migori County

One of the questions under determination was whether community elements affecting women's social inclusion, which has a bearing on whether uncircumcised women have same opportunities in social and economic activities. Below are the findings.

Perceptions towards Social Interaction and FGM Practice

A total of 87% of the respondents said that they were willing to share a social group with a woman who has not undergone FGM. While there are respondents who underwent FGM, 82% of the respondents indicated not to be willing to recommend FGM to other women.

Table 6: Perceptions towards social interaction and FGM practice

Other perceptions	1- Strongly Disagree	2- Disagree	3- Not sure	4- Agree	5- Strongly Agree
Willing to recommend FGM to other women	39 (31%)	64 (51%)	0 (0%)	21 (17%)	1 (0.8%)
Willing to share social group with non FGM women	3 (2.4%)	11 (8.8%)	2 (1.6%)	79 (63%)	30 (24%)
Willing to take daughter or other girl for FGM	48 (38%)	53 (42%)	1 (0.8%)	23 (18%)	0 (0%)
Women not undergone FGM experience social stigma	8 (6.4%)	48 (38%)	8 (6.4%)	52 (42%)	9 (7.2%)

Of those who indicated not be willing to share a social group with a woman who has not undergone FGM, 50% stated their reason as being that the community cannot accept that while 33.3% felt that such women are a bad example. Witchcraft and being a bad omen were also mentioned, albeit less as reasons for unwillingness to interact with women who had not undergone FGM.

Table 7: Reasons for unwillingness to share social group with women who have not undergone FGM

Reasons for not being willing to share social group with non FGM women	Frequency	Percentage
Community does not accept	7	38.89%
Community does not accept She is a bad example	1	5.56%
She is a bad example	3	16.67%
She is a bad example Others (Specify)	2	11.11%
She is a witch or bad omen	1	5.56%
She is not a full woman yet, she is a witch or bad omen, Community does not accept	1	5.56%
She is unclean	2	11.11%
She is unclean, she is not a full woman yet, she is a witch or bad omen	1	5.56%

4.3.2. To assess how personal characteristics affect women's social inclusion in Migori County

Below are the findings on how personal characteristics were reported as affecting women's social inclusion in Migori County.

Experiences of Stigma for not undergoing FGM

On women who did not perform or undergo FGM, 53% indicated that they have experienced social stigma from community members as compared to 16.8% who mentioned that the social stigma was from family members. 43.6% had experienced social stigma form friends while 41% from other community women.

Table 8: Experiences of stigma for not undergoing FGM

Because I have not undergone FGM/C..	1- Strongly Disagree	2- Disagree	3- Not sure	4- Agree	5- Strongly Agree
I experienced stigma from other community women	10 (6.4%)	74 (47%)	8 (5.1%)	54 (34%)	11 (7.0%)
I experienced stigma from community members	16 (10%)	50 (32%)	7 (4.5%)	62 (39%)	22 (14%)
I experienced stigma from family members	17 (11%)	107 (68%)	6 (3.8%)	21 (13%)	6 (3.8%)
I experienced stigma from friends	9 (5.7%)	74 (47%)	5 (3.2%)	54 (34%)	15 (9.6%)

4.3.3. To investigate how community elements affect women's social inclusion in Migori County

On whether their perception had changed due to social stigma for not undergoing FGM, 90% felt that their perception about FGM had not changed as a result of experiencing social stigma for having not undergone FGM.

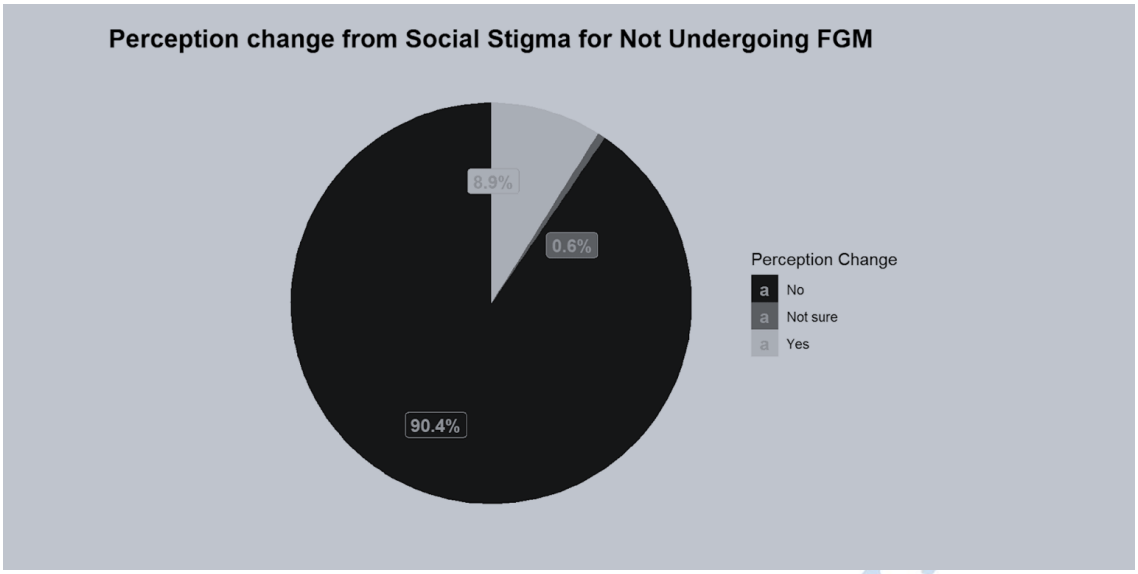

Figure 16: Perception change from social stigma for not undergoing FGM

4.3.4. To assess how personal characteristics affect women's social inclusion in Migori County

Alternative rites of passage

For women who had not undergone FGM, 96.2% had not undergone any alternative rite of passage with only 0.6% indicating to have undergone an alternative rite of passage.

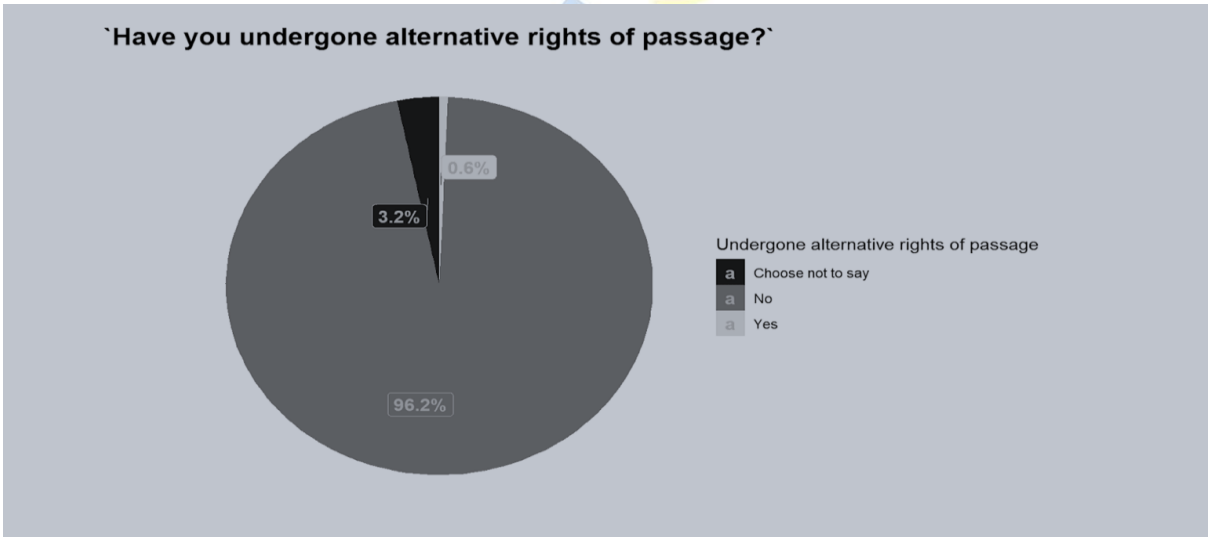

Figure : Proportion undergone alternative rites of passage

Participants in the qualitative interviews mentioned two alternative rites of passage, 'opening the gate' and ear piercing. A couple were unaware of any such procedures, whereas there were some respondents who argued that such practices were unnecessary and outdated and the community was not aware of them.

4.3.5. To assess how anti-FGM policy elements impact women's social inclusion in Migori County

Awareness of existence of anti FGM laws

On policy, 78% of respondents reported that they knew about anti FGM laws, with 85% stating that enforcement of these laws has led to a decline in FGM cases. 62% felt that the community was cooperative with the local authorities in enforcement of the said laws. 43% also felt that there were adequate community structures for enforcement of these laws with 71% saying that they have even witnessed arrest and prosecution of FGM perpetrators. Only 12.8% indicated that they had been involved in one form or another in making of the anti FGM laws. However, 38% of the respondents feel that the anti FGM laws address their concerns.

Table 9: Awareness and perception of utilization of anti FGM policies

Feelings on policy factors	1- Strongly Disagree	2- Disagree	3- Not sure	4- Agree	5- Strongly Agree
Anti-FGM laws address my concerns	2 (1.6%)	42 (34%)	34 (27%)	20 (16%)	27 (22%)
Aware of anti FGM laws	8 (6.4%)	11 (8.8%)	9 (7.2%)	41 (33%)	56 (45%)
Community cooperative with local authorities in enforcing laws	5 (4.0%)	26 (21%)	17 (14%)	17 (14%)	60 (48%)
Enforcement of anti-FGM laws led to decline of cases	2 (1.6%)	4 (3.2%)	13 (10%)	32 (26%)	74 (59%)
Participated in process of making laws	26 (21%)	62 (50%)	21 (17%)	8 (6.4%)	8 (6.4%)
There are adequate community structures for enforcing laws	4 (3.2%)	47 (38%)	21 (17%)	26 (21%)	27 (22%)
Witnessed arrests and prosecution of FGM perpetrators	1 (0.8%)	11 (8.8%)	24 (19%)	33 (26%)	56 (45%)

Perceptions of FGM

On other community factors, 96% felt that FGM should be abandoned, and this may be the case since 73% said that their religion does not permit FGM and another 29% saying that their community does not permit it.

Table 10: Perceptions regarding FGM

Other community factors	1- Strongly Disagree	2- Disagree	3- Not sure	4- Agree	5- Strongly Agree
FGM should be abandoned	2 (1.3%)	2 (1.3%)	2 (1.3%)	30 (19%)	121 (77%)
My community does not permit FGM	39 (25%)	70 (45%)	3 (1.9%)	23 (15%)	22 (14%)
My religion does not permit FGM	25 (16%)	17 (11%)	0 (0%)	38 (24%)	77 (49%)

4.4. Discussion of Individual Objective Results

This section presents the findings as per the outline of the objectives and research questions. The findings have been ordered by objective and research questions as presented below:

Majority of participants in this study pointed to pain as a negative effect of FGM and the illegality of the procedure. Less than half of participants considered FGM to affect sexual intimacy, create social stigma and result in difficulties during child birth. Whereas in other settings medicalized FGM/C has been adopted partly to mitigate the negative effects, and especially hiding from the law and quick healing time, the Kuria community has been documented to consider medicalization as going against their norms (Kimani et al., 2020). Mental and sexual health complications resulting from FGM/C have been documented in various studies. In a systematic narrative synthesis of studies conducted in the African setting, depression, anxiety, post-traumatic stress disorder and sleep disorders were identified as common mental health issues arising from FGM/C, whereas sexual health complications included sexual pain, orgasm, sexual desire problems and difficulties in arousal and lubrication (Tammary & Manasi, 2023). Birth complications arising out of FGM/C have been well documented including obstetric fistula, and are less likely to have skilled birth attendants during childbirth (Mwanri & Gatwiri, 2017; Seidu et al., 2022). The findings may indicate the community has fully understood the illegality of the procedure, but more needs to be done in

providing information on health complications of FGM/C. Despite this information being available and participants reporting awareness of the negative effects of FGM, though a minority, there are those who still practice and encourage it to happen.

Perceptions towards social interaction and FGM practice in this study showed that contrary to held beliefs on community exclusion, the participants themselves expressed willingness to be inclusive of those who had not undergone FGM/C. A majority expressed they were unwilling to recommend FGM/C to other women, and expressed willingness to share social groupings with non FGM women. Most also expressed unwillingness to take a daughter or other girl for FGM. These findings resonate with a study done in Narok county where majority of the women expressed negative attitudes towards FGM and were unwilling to encourage their daughters to practice FGM (Muchene et al., 2018). Similarly, a study done in Samburu county reported that participants were likely to feign the cut or pay off family and community members to pretend that FGM/C had been carried out while it actually had not (Van Bavel, 2022). This points to changing social perceptions towards FGM/C, and adaptive strategies by communities to counter the negative perceptions of not undergoing FGM/C. On the contrary, among those who were unwilling to share spaces with women who had not gone for FGM/C highlighted community unacceptance, uncleanliness, consideration as a bad example, witch or bad omen. Among the participants who had not undergone FGM, over half expressed they had experienced stigma from community members, slightly less than half from other women in the community and some of them from friends and family. The personal experience of stigma from close social circles and community can exacerbate exclusion from the community. These perceptions have been documented elsewhere and contribute to social exclusion among those who have not undergone FGM/C (Brown et al., 2016; Kimani et al., 2020; Sheikh et al., 2023).

In relation to assessing how anti-FGM policy elements impact women's social inclusion in Migori County, participants expressed high awareness of anti FGM laws and considered an

overall positive effect of enforcement of the laws on decline in FGM cases. About two thirds of participants considered the community cooperative in enforcement, though with a low proportion indicating they have been involved in the making of the laws. In a study conducted among six communities practicing FGM in Kenya, findings highlighted those participants considered fear of punishment and imposition of criminal sanctions as motivating to obey the law, including for FGM. However, where participants felt that customs and religion were in support of FGM, there was a willingness to break the law in consideration of keeping with customs or religion, alongside poor enforcement and corruption (Meroka-Mutua et al., 2020). While this study did not explore propensity to break the law in favor of religion or customs, 70% of respondents did not consider FGM to be against community permissiveness and 27% disagreed with the statement that their religion does not permit FGM. The acceptance of community and religion for FGM may be a motivator for social exclusion of those who have not undergone the practice, and may even be a contributor for encouragement to go ahead and practice FGM, since community culture and religion are also considered as laws in themselves by the communities (Meroka-Mutua et al., 2020).

To investigate different anti-FGM tactics in response to Migori County women's social inclusion, only 0.6% of the participants stated they had undergone an alternative rite of passage in lieu of FGM/C. From the qualitative data, there was limited support for alternative rites of passage. In other settings like Kajiado, studies have documented that alternative rites of passage such as training girls on the dangers of FGM, child rights, sexual abuse, substance abuse, self-esteem, good health, culture and harmful traditions have successfully mitigated against FGM/C contributing to decline in prevalence and extended stay in school (Muhula et al., 2021), although concerns are still raised with regard to social inclusion in aspects like marriage (Van Bavel, 2021).

CHAPTER 5: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1. Introduction

In this section of the report, the findings are summarized and conclusions are drawn while also offering recommendations based on the findings. This study sought to assess the anti-female genital mutilation strategies on inclusion of women in Migori county, Kenya. Appropriate methodology was employed using mixed approach with a descriptive design, primarily targeting women who have undergone FGM/C or alternative rites of passage, men, opinion leaders, policy makers and other interest groups.

5.2. Summary of the result findings

Female Genital Mutilation remains a major concern in Migori County in Kenya as reported in the Chapter 4 of this report. Through this study, there is evidence of discordance between policy and practice on the ground. There is still higher prevalence of FGM in Migori compared to the national average, despite concerted legal efforts to stem the vice. There is equally overwhelming evidence that some women who do not practice FGM experience economic and social exclusion on the basis of the practice. It also highlights the challenges and barriers in the implementation of laws that are to safeguard the women and girls in the county and country.

The study illuminates significant discordance in policy formulation, their implementation and the shortcomings in the desired outcomes as appertains to elimination of FGC/M and resultant exclusion, highlighting the need for introspection among policy makers, duty bearers and right holders to offer redress to those gaps and ensure that there is public goodwill and legal instruments to protect those women and girls opting out of the practice safely.

5.3 Conclusions

Situated in one of the communities in Kenya where FGM/C is still practiced, this study, conducted in Migori county, established a high prevalence of FGM/C at 40% among the study

population based in Kuria East and Kuria West sub-counties. Although participants considered themselves largely accommodative to those who had not undergone FGM/C, they described instances where they faced exclusion from community and friends, and some from family. A majority of participants considered FGM/C to be important in getting a partner and being accepted in the community. Less than a fifth were willing to recommend FGM/C and majority were accepting of those who had not undergone the practice. Participants expressed high awareness of anti-FGM laws and considered them to work for their setting in reducing FGM, with a majority noting they had witnessed an arrest based on breaking anti-FGM laws.

5.4. Recommendations

To the authorities and all relevant government agencies, the recommendation is that robust implementation of public participation be done to create awareness on the risks associated with FGM/C and work towards creating a more equitable and protective socio-economic environment for women, particularly those who opt for alternative rites of passage.

To the FGM/C practicing community, the study recommends that community gatekeepers including elders and influential leaders from faith community conduct advocacy to end the practice. Women leaders and circumcisers should particularly be brought on board to also be change agents, as they are seen to be the silent force behind continued practice.

To the other stakeholders, especially the civil society organizations working to end FGM/C, the study recommends that they should engage more with the community, listen to the nuances and work towards creating a more culturally acceptable alternative rites of passage as well as socio-economic empowerment for girls and women, particularly those who opt for alternative rites of passage. In addition to the above recommendations, consideration should be given by all stakeholders to strengthen inclusion of women who have not undergone FGM/C, those at risk of falling into this category, and every girl child who is at risk of any form of FGM/C. To address

these challenges of social inclusion among the uncircumcised women in Migori, below is summarized recommendations;

1. Increase public awareness campaigns to educate the public and key stakeholders on FGM/C and the effects on women. There is need to engage the public to keep spreading the message of the dangers of FGM on health, overall wellbeing, mental health and even the socio-economic effects.
2. Advocate for non-discrimination and social inclusion of affected women to enjoy full rights and dignity. By breaking the social norms that contribute to women who have not undergone FGM to be excluded, social inclusion can be enhanced so that they are not perceived to be less than those who have undergone FGM.
3. Review and harmonize existing legislation and enforcement mechanisms to enhance the protection of girls and women against FGM/C. By leveraging on the already strong legislative policies, emphasis needs to be placed on enforcement of these laws so that even grassroots leaders can actively contribute to using them to the benefit of the community
4. Strengthen multi-sectoral collaboration and holistic approaches to facilitate alternative rites of passage. Using evidence-based approaches on the rites that have worked in similar contexts, community organizations, law enforcement officers and community gatekeepers need to work together to see how these can be effected in the region.

The report concludes by calling on stakeholders at various levels to collaborate and partner in efforts aimed at ensuring that FGM/C is eliminated, while protecting the rights and dignity of women who choose not to undergo the harmful practice. These endeavors should be harmonized as part of ensuring that no woman continues to suffer the indignity of FGM or the exclusion because of FGM status.

5.5 Recommendations for further research in this field of study.

The study calls for further research in this area. The study recommends studies to address context specific and community-led adoption of alternative rites of passage that will not alienate those who go through the same, and can promote social inclusion of those who take part in them.

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APPENDICES

I) Research tools
II) ERC certificate
III) Introduction letter from MKU
IV) NACOSTI research license
V) Field entry /Research Authorization
VI) Turnitin report (First two (2) pages
VII) Research site map

Appendix 1: Research Tools

Annex 1.2: Consent Form

Dear Participant,

This is to inform you that you have been chosen to voluntarily take part in the research on "Analysis of anti-female genital mutilation strategies on social inclusion among uncircumcised women in Migori County", by providing your views through a/an _____. The purpose of this session is to generate ideas and contribute to new knowledge by gathering information on how to improve FGM response in the community through evidence-informed policy formulations

Privacy: The information you have provided will be kept private at the conclusion of this session, and I will be the only person to know who you are. The opinions you give shall not be used in any way against you as an individual or your institution.

Benefits: We will really appreciate the information you provide as it will help improve health service delivery in your community and you therefore stand accredited for contributing to that. We may not pay you enough for your invaluable information, but you will be compensated for your time, through a small token of KSh. 200 at the end of this session

Informed consent: If you agree to the aforesaid, I kindly request you to confirm that you accept to participate, by way of signing below.

Signature: _____ Date: _____

Annex 1.3: Primary Respondent Questionnaire

Respondent Unique Identifier: _____

Instructions

Please put a tick (√) next to the response applicable to you in this questionnaire.

Section I: Biodata

1.	**Which Sub-County in the county do you live in?** _____
2.	**What is your current age? _____ years**
3.	**What is your marital Status?** *(tick one)* Married ☐ Single ☐ Divorced/Separated ☐ Widowed ☐
4.	**What is your highest level of education?** *(tick one)* None ☐ Primary ☐ Secondary ☐ College ☐ University ☐
5.	**What is your religion?** *(tick one)* Protestant ☐ Catholic ☐ Islam ☐ Others, please specify ☐_____
6.	**What is your main economic engagement?** *(you can tick more than one)* Employed ☐ Farming ☐ Animal rearing ☐ Business ☐ None ☐ Others, specify ☐_____
7.	**How much is you approximate monthly income?** None ☐ Ksh.1,000-5,000 ☐ Ksh.6,000-10,000 ☐ Ksh.11,000-20,000 ☐ Above 20,000 ☐

8.	**On a scale of 1-5, what is your level of awareness about FGM?** 5-Very aware ☐ 4-Quite aware ☐ 3-Fairly aware ☐ 2-Slighly aware☐ 1-Not aware ☐ **NB**: If the respondent answers "1" for "Not aware", the interview ends there.

Section II: Community Factors - *Background Information on FGM*

Kindly state your level of awareness about FGM/C

If the respondent states either level 5,4,3,2 awareness about FGM, proceed to Q9

9.	**Did you undergo FGM?** Yes ☐ No ☐ Don't Know ☐ **If Answer is No, Skip to Question 20.**
10a.	**Who talked to you about the need to undergo FGM?** *(you can tick more than one)* Mother ☐ Father☐ Friends☐ Teachers ☐ No one ☐ Others, please specify ☐ _____

10a.	
10b.	**If Yes in Q9, ask: How old were you when you went through FGM** < 6 months ☐ 6-12 months ☐ 1-2 years ☐ 2-5 years ☐ >5 years ☐ Don't Know/can't remember ☐
11.	**On a scale of 1-5, what would you say was your willingness to go through FGM?** 5-Very willing ☐ 4-Quite willing ☐ 3-Fairly willing ☐ 2-Slighly willing☐ 1-Not willing☐ Others, please specify ☐ _____
12.	**On a scale of 1-5, how much would you say you're aware of friends or relatives who have gone through FGM?** 5-Very aware ☐ 4-Quite aware ☐ 3-Fairly aware ☐ 2-Slighly aware☐ 1-Not aware☐
13.	**On a scale of 1-5, what proportion of homes do you estimate to be practicing FGM in this community?** *(community refers to the answer to Question-1 in Section-1)* 5-All/almost all ☐ 4-Three-quarters ☐ 3-Half ☐ 2-Less than half ☐ 1-None ☐

Section III: Personal Factors - *Attitudes and opinions about FGM.*

14a. Indicate your level of agreement or disagreement with the following statements on the potential benefit(s) of FGM

FGM/C…	Strongly disagree (1)	Disagree (2)	Not sure (3)	Agree (4)	Strongly agree (5)
Makes me a full woman					
Makes me accepted by community					
Makes me find sexual partner/husband easily					
Makes me faithful to sexual partner					
Makes childbearing easy					
Makes me to relate well with peers socially					

14b. Please list other perceived benefit(s) of FGM that you are aware of

15a. Indicate your level of agreement or disagreement with the following statements on the perceived harmful effects of FGM/C

FGM/C…	**Strongly disagree (1)**	**Disagree (2)**	**Not sure (3)**	**Agree (4)**	**Strongly agree (5)**
Is a painful procedure					
Results in difficulties during child birth					
Leads to health complications like fistula					
Affects sexual intimacy					
Is illegal and can lead to arrest					
Creates social stigma by non-FGM practicing communities					

15b. Please list other perceived harmful effects of FGM/C that you are aware of

……

16a. Do you have daughter(s)?

Yes ☐

No ☐

16b. If yes, how many?

One ☐

More than one ☐

16c. If you have daughter(s), how many have undergone FGM/C?

All ☐

Some ☐

None ☐

17a. On a scale of 1-5, kindly state your level of agreement or disagreement with the following statements

Statement	**Strongly disagree (1)**	**Disagree (2)**	**Not sure (3)**	**Agree (4)**	**Strongly agree (5)**
I am willing to take my daughter or other girl relative to undergo FGM/C					
I am willing to recommend FGM/C to other women in my community					
I am willing and ready to share a social/community group or '*chama'* with a woman who has not undergone FGM/C					
Women who have not undergone FGM/C experience social stigma					

17b. If you are not willing and ready to share a social /community group or '*chama*' with a woman who has not undergone FGM/C, what your reasons, select as many as possible from the list provided

She is unclean ☐

She is not a full woman yet ☐

She is a witch or bad omen ☐

Community does not accept ☐

She is a bad example ☐

Others (Specify) ☐_____

18a. Section IV: Personal Factors - *Alternative Rites of Passage*.

ONLY FOR UNCIRCUMCISED WOMEN

Statement: Because I have not undergone FGM/C,…	**Strongly disagree (1)**	**Disagree (2)**	**Not sure (3)**	**Agree (4)**	**Strongly agree (5)**
I have experienced stigma from community members					
I have experienced stigma from my friends/peers					
I have experienced stigma from family members/relatives (mother, father, mother-in-law, father-in-law, husband, siblings, relatives)					

I have experienced stigma from other community women					

18b. If you have experienced social stigma from other members in your community, like church or school, kindly list them below

……

18c. Since you have experienced some form of social stigma because you have not undergone FGM/C, has this changed your perception about FGM/C

Yes ☐

No ☐

Not sure ☐

18d. Since you have not undergone FGM/C, have you undergone alternative rites of passage

Yes ☐

No ☐

Choose not to say ☐

18e. If you have undergone alternative rites of passage, which ones, please specify

……

Section V: Policy Factors

19a. For each of the below statements, tick the box that best describes your feelings

Statement	**Strongly disagree (1)**	**Disagree (2)**	**Not sure (3)**	**Agree (4)**	**Strongly agree (5)**
I am aware about the existence of anti-FGM laws					
I participated in the process of making the said laws					
The anti-FGM laws adequately address my concerns					

There are adequate community structures and human capacity to enforce anti-FGM laws					
I have witnessed a good number of arrests and prosecution of perpetrators of FGM					
The community are very cooperative and assist the local authorities in enforcing the laws					
The enforcement of anti-FGM laws have led to a considerable decline in cases of FGM					

19b. Please list any other thoughts about policies on FGM/C? Please list them in the space provided next

……

Section VI: Community Factors

20a. For each of the below statements, tick the box that best describes your feelings

Statement	**Strongly disagree (1)**	**Disagree (2)**	**Not sure (3)**	**Agree (4)**	**Strongly agree (5)**
My religion does not permit women to undergo FGM/C					
My community does not permit women to undergo FGM/C					
FGM/C should be abandoned					

(These are expected to measure the descriptive norms or the actual behavior of people in the community)

20b. Please list any other thoughts your community has on FGM/C? Please list them in the space provided next

……

Section VII: Recommendations

21. What do you feel are the gaps that should be addressed to tackle stigma?

……

……

……

END

1.4: Sample IDI Schedule

Instructions to the facilitator

1. Total allocated time: 30 minutes

2. Lead a discussion session by allocating maximum 2 minutes per session

Question	Discussion points
1. What is your community role in the county/sub-county/ward/village?	
2. What is your opinion on the prevalence of FGM in this community? What are the drivers?	
3. Do you think FGM has any benefits? Which ones?	
4. Do you think FGM has any dangers? Which ones?	
5. Have you ever participated in any pro-FGM activity? If yes, specify: _____	
6. Have you ever participated in any anti-FGM activity? If yes, specify: _____	
7. Do women in this community feel free to refuse/reject FGM? If YES, what are their options? If NOT, what are the consequences?	
8. What are some of the alternative rites of passage you know of?	
9. How much would you encourage these alternative rites of passage?	
10. What proportion of this community practices alternative rites of passage and how popular do you think it is?	
11. Are you aware of anyone in your community, including friends and relatives, who have been socially excluded as a result of alternative rites of passage?	
12. What do you think should be done to improve social inclusion and stigma facing women who undergo alternative rites of passage?	
13. What do you suggest that should be done to promote alternative rites of passage in your community?	
14. What are some of the anti-FGM laws or legislations you are aware of?	
15. Which ones have you participated in their formulation? Which ones have you participated in their enforcement?	

16. What is your opinion on the process of the enforcement of these laws in your community?	
17. What are some of the challenges to the enforcement of these laws and what solutions do you propose?	
18. What do you think should be done to help better enforce anti-FGM laws in your community?	
19. What other steps do you think need to be taken to tackle ARP-related stigma	
20. Give your general recommendations on elimination of FGM and improving the social environment against stigma	

Appendix 2: ERC certificate

Mount Kenya University

REF: **MKU/ISERC/3740** Date: 29 May 2024

TO: **JOB ODOYANCE AKUNO A**

REG: **MPA (DL) 312/0719**

Dear Sir/Madam,

RE: ASSESSMENT OF ANTI-FEMALE GENITAL MUTILATION STRATEGIES ON SOCIAL INCLUSION: A SURVEY OF WOMEN IN MIGORI COUNTY, KENYA

This is to inform you that **Mount Kenya University** has reviewed and approved your above research proposal. Your application approval number is **2784.** The approval period is **29/05/2024 - 28/05/2025.**

This approval is subject to compliance with the following requirements;

i. Only approved documents including informed consents, study instruments, MTA will be used
ii. All changes including amendments, deviations and violations are submitted for review and approval by **Mount Kenya University**
iii. Death and life-threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to **Mount Kenya University** within 72 hours of notification
iv. Any changes, anticipated or otherwise that may increase the risks or affect the safety or welfare of study participants and others or affect the integrity of the research must be reported to **Mount Kenya University** within 72 hours
v. Clearance for export of biological specimens must be obtained from relevant institutions
vi. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal
vii. Submission of an executive summary report within 90 days upon completion of the study to **Mount Kenya University**

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology and Innovation (NACOSTI) https://research-portal.nacosti.go.ke and also obtain other clearances needed.

Yours sincerely,

The Chairman
Mount Kenya University
Ethics Review Committee

Dr. Alfred Owino, PhD
Chairman, Mount Kenya University ISERC

Appendix 3: Introductory Letter

Dear Participant,

My name is Job.

I'm a student at Mount Kenya University (MKU) pursuing a Master's degree in Public Administration and Policy. I'm currently working on a research project in the Migori County community as a requirement for partially fulfilling a master's degree. In Migori County, I am studying the effects of anti-female genital mutilation strategies on social inclusion among women who are not circumcised. To better serve the community, the results of this study will guide the creation of policies and community-level response tactics for programmers and leaders. I now take the opportunity to request for your participation in the study by providing information through the administration of the following data collection tools.

Thank you for your assistance,

Sincerely,

Job O. Akuno.

Appendix 4: NACOSTI Research Permit

Appendix 5: Field Entry/Research Authorization

Appendix 6: Turnitin report (First two (2) pages

Appendix 7: Research site map