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Tracing change in female genital mutilation/cutting: Shifting norms and practices among communities in Narok and Kisii counties, Kenya

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Evidence to End FGM/C

Research to Help Girls and Women Thrive

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The Evidence to End FGM/C: Research to Help Girls and Women Thrive generates evidence to inform and influence investments, policies, and programmes for ending female genital mutilation/cutting in different contexts. Evidence to End FGM/C is led by the Population Council, Nairobi in partnership with the Africa Coordinating Centre for the Abandonment of Female Genital Mutilation/Cutting (ACCAF), Kenya; the Global Research and Advocacy Group (GRAG), Senegal; Population Council, Nigeria; Population Council, Egypt; Population Council, Ethiopia; MannionDaniels, Ltd. (MD); Population Reference Bureau (PRB); University of California, San Diego (Dr. Gerry Mackie); and University of Washington, Seattle (Prof. Bettina Shell-Duncan).

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List of Acronyms

AMREF	African Medical and Research Foundation
ARP	Alternative Rites of Passage
AIDS	Acquired Immune Deficiency Syndrome
CBO	Community-Based Organisation
CVD	Community Values Deliberation
DFID	Department for International Development
DHS	Demographic and Health Survey
ESRC	Ethics Science and Research Committee
FGD	Focus Group Discussion
FGM/C	Female Genital Mutilation/Cutting
HIV	Human Immunodeficiency Virus
IDI	In-Depth Interview
IRB	Institutional Review Board
KDHS	Kenya Demographic and Health Survey
KNBS	Kenya National Bureau of Statistics
KCA	Kikuyu Central Association
MYWO	Maendeleo Ya Wanawake Organisation
NGO	Non-Governmental Organisation
PATH	Program for Appropriate Technology for Health
PI	Principal Investigator
SDG	Sustainable Development Goals
UN	United Nations
WHO	World Health Organisation

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Executive Summary

Background

Globally, approximately 200 million women and girls in 30 countries have been subjected to female genital mutilation/cutting (FGM/C). In Kenya, the 2014 Kenya Demographic and Health Survey estimates that approximately 21 percent of girls and women aged 15-49 years have been cut. Nationally, there has been a steady and marked decline in the prevalence of FGM/C. There is, however, great variance in the prevalence of FGM/C across the country, with prevalence remaining high among certain ethnic groups such as Somali, Samburu, Kisii, and the Maasai. There have been numerous efforts, at the policy and programme levels, aimed at ending FGM/C in Kenya. The combined effects of such efforts have, however, yielded mixed outcomes, with the near elimination of FGM/C in certain ethnic groups (i.e., Meru, Kikuyu, and Kalenjin), and resistance in other ethnic groups (i.e., Maasai, Kisii, and Somalis), where the practice remains near universal. Given the sustained interest in implementing a myriad of interventions that have varying implementation processes, understanding how they work, the synergism or convergence of combined strategies, and their effectiveness in aiding abandonment of FGM/C is of paramount importance.

Methods

The study design was cross-sectional using qualitative methods. Data gathering activities included in-depth interviews with community gatekeepers, healthcare workers, government officials, programme implementers, parents/guardians, girls living in the community, and girls living in rescue centres. Focus group discussions were conducted with younger and elder community members. The study also mapped ongoing strategies aimed at addressing FGM/C in each county and observed implementation of intervention events by community programmes in the study sites.

Results

In Narok and Kisii counties, programme implementers used a mix of approaches to encourage community members to abandon FGM/C. Changes in norms and practices that promoted continuation of FGM/C included shifts from FGM/C being practised as a community event with public celebrations to events organized by individual families and conducted in secrecy, the use of health professionals to perform FGM/C as opposed to traditional cutters, changes towards performing supposedly less severe forms of FGM/C, and cutting girls at a younger age.

The majority of community members in Narok and Kisii were knowledgeable about the health consequences of FGM/C. There were stark differences in how communities in Narok and Kisii associated FGM/C with “respect" (respect in this context refers to being passive, obedient, unquestioning, and subservient). In Narok, the public perception was that cutting makes girls disrespectful of their seniors while in Kisii, a cut woman was respected and considered respectful of others—pointing to the possibility that FGM/C is apparently more valued in Kisii than in Narok. Some of the challenges that change efforts encounter in their fight against FGM/C included: culture/tradition, beliefs that FGM/C controls a woman’s sexual desire and therefore promotes fidelity in marriage, social sanctions against the uncut, and the practice of supposedly less severe forms of FGM/C on younger girls by health professionals in secret.

Data from Narok and Kisii have shown that the negative effects of FGM/C in relation to sexuality could have prompted a shift in norms where men are now preferring uncut girls or marrying women from ethnic groups that do not practice FGM/C with the hope of sexual satisfaction in marriage. Across the two sites, there was consensus on the possibility that FGM/C heightens a girl’s chances of being married early, but ambivalence towards FGM/C being a prerequisite for marriage,

especially in Narok. Lack of adequate resources to sustain implementation of FGM/C interventions in target populations could be limiting the impact of interventions to bring about the desired behaviour change.

Discussion

A community's shift from approving a harmful social norm to adopting a beneficial, new social norm requires changing expectations at the community level as well as at the individual level. Consequently, abandonment of FGM/C in Narok and Kisii will require genuine community discussions, decisions, and commitment. Given that the practice is being done in secret, there are challenges to promoting open community dialogue. A shift to supposedly less severe cuts and younger age at cutting are likely to be a response to the law that prohibits FGM/C in Kenya. Perpetrators of FGM/C seem to be responding to the health consequences of FGM/C narrative by attempting to minimize health risks by procuring services of health professionals.

The association between FGM/C and sexuality has often been linked to the belief that women are naturally promiscuous unless their genitalia is physically altered. Therefore, FGM/C has been used as a tool to suppress female sexual desire in order to uphold virginity at the time of marriage and fidelity after marriage. However, men are increasingly expressing preference to marry a woman who can enjoy marital sexual relations, prompting a shift toward selecting a marital partner from an ethnic group that does not practice FGM/C. It therefore appears that the cut girl has reduced prospects for marriage in contemporary times. These findings bring into question the social norm theory which posits that concerns over marriageability are central to the origin and maintenance of FGM/C. Similar to findings in Senegambia, concerns over marriageability are eroding, but the practice of FGM/C remains upheld by other normative associations. Indeed, more expanded views of social norms now suggest that there can be multiple norms and associated meanings upholding the practice, and they can shift over time.

Programmes addressing FGM/C in Narok and Kisii have been using the health risks narrative in implementing their interventions and to some extent, have been successful in transferring this knowledge to the public. However, it appears that knowledge on the health consequences of FGM/C alone may not lead to abandonment. Across communities that practise FGM/C, one of the factors that underpin the practice relates to culture/tradition. In communities where FGM/C is prevalent, social pressure and the fear of losing social standing for the uncut girl and her family are important factors that sustain FGM/C. The inference from our study findings is that the transition from childhood to adulthood, which involves initiation and processes of socialisation on gender norms and marked by girls undergoing the cut, is apparently more valued in Kisii than in Narok.

This study has clearly shown that even though the study areas are considered hot spots of FGM/C, norms and practices are not static. While there might not be widespread abandonment yet, people are reassessing norms and traditions in light of the current social climate. These changes may provide a useful starting point for intervention programmes that seek to create dialogue and critical reflection on the practice of FGM/C in an effort to accelerate its abandonment.

Implications for programmes and research

Programmatic implications

- An emphasis on an integrative approach in programme implementation with a clear focus on engaging community members in values deliberation to facilitate community-wide FGM/C abandonment is critical. Intervention efforts need to be coordinated with the aim of ensuring synergy among programmes with overlapping target populations. On value deliberation,

findings show that there is some abandonment accompanied with other changes, such as medicalisation, performing FGM/C at early ages, and in secret. Certainly, there must be a discourse surrounding these changes. The key questions for programmers include what problems are people trying to solve by making these changes and how can interventions build on ongoing changes?

- Programmers must incorporate the human rights approach and address gender norms in programme implementation and not excessively focus on the health risks in efforts to encourage community members to abandon FGM/C. In applying the human rights approach, special attention should be given to the local context, especially on collective rights and the need to work within the frameworks of a cultural context. There is need for anti-FGM/C implementers to engage in addressing the structural gender inequalities related to FGM/C and how it negatively impacts on the entire community, including men.
- Adequate resources need to be allocated to programmes implementing FGM/C interventions, especially local grassroots organisations.
- Programme activities need to be anchored on a theory of change.

Research implications

- There is need to conduct a quantitative survey to measure communities' readiness for change.
- Determining communities' perceptions about the involvement of religious leaders in the fight against FGM/C is imperative, including how best to engage them.

Introduction

Background

Global statistics indicate that at least 200 million women and girls in 30 countries have undergone female genital mutilation/cutting (FGM/C) (UNICEF, 2016). Recent statistics show that approximately 70 million girls aged 0-14 years have been cut or may be at risk of being cut (Shell-Duncan, Naik, and Feldman-Jacobs, 2016). Annually, approximately 3.6 million girls are at risk of FGM/C and the number could rise to 4.1 million by 2050 (UNICEF, 2014). The World Health Organization (WHO) defines FGM/C as "all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons" (WHO, 2016). The practice is classified into four major types:

- Type I (clitoridectomy) involves partial or total removal of the clitoris (a small, sensitive, and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
- Type II (excision) involves partial or total removal of the clitoris and the labia minora (the inner folds of the vulva), with or without excision of the labia majora (the outer folds of skin of the vulva).
- Type III (infibulation) involves the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris (clitoridectomy).
- Type IV includes all other harmful procedures to the female genitalia for non-medical purposes, e.g., pricking, piercing, incising, scraping, and/or cauterizing the genital area (WHO, 2016).

Many studies have documented the immediate and long-term negative consequences of FGM/C to the health and well-being of girls and women (Alsibiani and Rouzi, 2010; Berg and Denison, 2012; Berg and Underland, 2013; Berg et al., 2014; H. Jones et al., 1999; Kaplan et al., 2011; Kaplan et al., 2013; Morison et al., 2001; WHO, 2000; WHO Study Group on Female Genital Mutilation and Obstetric Outcome, 2006). Globally, FGM/C is recognised as a human rights violation that denies girls and women the opportunity to lead healthy and normal lives. The practice is tied to cultural values and sometimes religious beliefs reflecting deep-rooted, gender-based inequalities (Gruenbaum, 2001; Rajadurai and Igras, 2006). In September 2015, the United Nations set new development goals, the Sustainable Development Goals (SDGs). Under SDG 5, FGM/C is recognised as a form of gender-based violence that derails efforts to achieve gender equality and empowerment of girls and women across the world. One of the key targets (i.e., 5.3) under SDG 5 is the elimination of all harmful practices, such as early/child marriage and FGM/C, by the year 2030 (UN, 2015).

Using nationally representative data from 29 countries (27 countries in Africa, plus Yemen and Iraq), Shell-Duncan et al. conducted an analysis on the prevalence of FGM/C. The authors found out that 15 out of the 29 countries showed no clear evidence of progress while 14 countries (Kenya included) showed a declining trend (Shell-Duncan et al., 2016). Nonetheless, national statistics can mask important inter- and intra-country differences. For example, two out of three women that reported to have been cut live in just four countries (i.e., Egypt, Ethiopia, Nigeria, and Sudan), while within countries, the extent to which FGM/C is practised is greatly associated with the ethnic background of the girl/woman. The synthesis also highlighted an important trend in the age of cutting, with most girls cut before the age of five years. The trend towards cutting girls at a younger age has been partly attributed to knowledge that the practice has been targeted for elimination

through intervention activities, including punitive legislation in some countries; earlier age at cutting in the absence of public ritual is often viewed as a strategy for making the practice less public, and hence, less subject to condemnation or prosecution (Shell-Duncan et al., 2011; UNICEF, 2016).

In most countries, FGM/C is performed by traditional practitioners, such as traditional circumcisers and traditional birth attendants with types I and II (i.e., clitoridectomy and excision) being the most common forms of cutting (Shell-Duncan et al., 2016). In some communities there is also an emerging trend towards medicalisation of the practice, where the procedure is performed by medical professionals, such as doctors, nurses, and trained midwives, with the possible intent of reducing potential health risks (Shell-Duncan et al., 2016) on the assumption it will be safer (Njue and Askew, 2004; UNICEF, 2016). In regards to girls at risk of FGM/C, recent statistics show approximately 70 million girls aged 0-14 years have been cut or may be at risk of being cut (Shell-Duncan et al., 2016).

Across countries and diverse cultures, FGM/C persists for a variety of reasons that may include adhering to culture to be accepted in the community, serving as a rite of passage to womanhood, maintaining purity before marriage and fidelity during marriage, and adhering to believed religious obligations (Boyden, Pankhurst, and Tafere, 2012; Boyden et al., 2012; Shell-Duncan and Hernlund, 2000; World Vision UK, 2014). Commonly FGM/C is understood to be a marital strategy, as girls and women who choose not to perform the practice risk being ostracised by their community, and rendered unmarriageable and unable to legitimately bear children (Mackie and LeJeune, 2009). It is important to note that the reasons given for the continuation of FGM/C vary across countries and different cultural contexts and are subject to change over time. Therefore, these reasons represent diverse practices, beliefs, and meanings.

Immediate consequences of FGM/C include severe pain, excessive bleeding, urine retention, and genital tissue swelling (Almroth et al., 2005; Chalmers and Hashi, 2000; Dare et al., 2004; WHO, UNESCO, and others, 2008), while long-term effects can include urinary tract infections, bacterial vaginosis, genital herpes, dyspareunia, and other obstetric complications, such as perineal tearing, obstructed/prolonged labour, Caesarean section, episiotomy, postpartum haemorrhage, extended maternal hospital stay, resuscitation of the infant, and perinatal death (Jones et al., 1999; Kaplan et al., 2013; Larsen and Okonofua, 2002; Morison et al., 2001; WHO Study Group on Female Genital Mutilation and Obstetric Outcome, 2006; WHO et al., 2008). Studies have also linked FGM/C to women's sexual functioning, whereby women who have undergone FGM/C are more likely to report lack of sexual desire, pain/difficulty during sexual intercourse (dyspareunia), and less sexual satisfaction (Alsibiani and Rouzi, 2010; Berg and Denison, 2012). Additionally, women who experience FGM/C can develop long-lasting psychological impairment that adversely affects their mental health (Al-Krenawi and Wiesel-Lev, 1999; Behrendt and Moritz, 2005; El-Defrawi et al., 2001; Toubia, 1994; WHO et al., 2008).

Given its negative effects on the health and well-being of women and the community at large, FGM/C has been recognised as a global problem and the international community, along with national partners, are working together to implement a variety of programmes and policies geared towards abandonment of the practice. Some of the interventions and strategies that have been implemented include: a rights-based approach; addressing the health complications of FGM/C; alternative incomes for traditional cutters; alternative rites of passage (ARPs); legal and policy measures; religious-oriented approaches; promotion of girls' education; intergenerational dialogue; community mobilisation; and, supporting girls' escaping forced marriages and/or FGM/C (28 Too Many, 2013).

In Kenya, ARPs, legal and policy measures, religious-oriented approaches, promotion of girls' education, intergenerational dialogues, and use of rescue centres have been popular strategies. Notably, rescue centres have been used in Narok, Kajiado, and other areas, but not in Kisii. During

the inception phase of the present study, Population Council mapped and compiled existing FGM/C interventions in Kenya. Key questions include: In what detail do we understand the coverage, operating structures, and procedures used in the implementation of the different FGM/C interventions? What is the feasibility and acceptability of such interventions in the community? To what extent are we certain these popular interventions are facilitating FGM/C abandonment? These are empirical questions that we sought to answer by assessing FGM/C programmes implemented in Narok and Kisii counties.

Literature review

Efforts to accelerate abandonment of FGM/C in Kenya

When developing policies and programmes aimed at abandoning FGM/C, it is important to ensure they are tailored to address the complex social norms and cultural value systems that often shape the meaning and significance of FGM/C in the community. Along with this are the transnational influences and structural factors that may create a supportive, enabling environment for change, or alternatively, pose significant barriers to abandonment (Shell-Duncan et al., 2016). Understanding these factors within a broader historical framework is also essential. Shell-Duncan et al. (2017), have conducted an extensive review of the historical context of FGM/C abandonment programs in Kenya. Their work highlights the long history of activism experienced in Kenya aimed at encouraging abandonment of FGM/C (Shell-Duncan, Gathara, & Moore, 2017). The pre-independence period dating back as early as 1906 is dotted with church-led movements denouncing FGM/C on moral grounds and health concerns that led to colonial administrators restricting the severity of the cutting and mandating medicalisation. These church-led movements were also involved in calling for abandonment of FGM/C among its congregants, with repercussions for those who failed to comply including denying them religious participation or enrolment of their children in mission-run schools. These penalties led to significant backlash from communities that practiced FGM/C in Kenya—the opposition to FGM/C was consequently equated with colonial oppression.

After independence in 1963, the narrative that FGM/C was a symbol of cultural loyalty and defiance against colonialism lacked significance. This led to the revival of Christian, church-led efforts campaigning against FGM/C in the 1970s coupled with government reform efforts. The government reform efforts were majorly precipitated by pressure from local activists and the international community that embraced a renewed global campaign to eliminate FGM/C. The 1980s and 1990s therefore witnessed governmental calls for ending FGM/C, advocacy for prosecution of perpetrators, issuance of presidential decrees, and the implementation of a series of policy directives banning medical professionals from performing FGM/C. Notably, during this period, several attempts to pass formal legislation against FGM/C failed to garner enough support in parliament and were therefore defeated. Efforts to enact legislation against FGM/C were only successful in 2001 when the Children's Act was passed. The Act gave power to the state to protect children from numerous violations including sexual exploitation and specifically banned early marriage and FGM/C in girls under the age of 18. This legislation was later expanded in 2011 with the adoption of the Prohibition of Female Genital Mutilation Act that criminalised conducting FGM/C on women of any age (Shell-Duncan et al., 2017).

The enactment of laws against FGM/C ignited debate especially with the expanded notion of children's rights that emerged in Kenya before the passage of the Children's Act in 2001. As Shell-Duncan and Olungah (2009) argue, the expanded notion of children's rights was fundamental in aiding the passage of the Children's Act but the law was equally considered by some as an assault on culture. There was nonetheless a growing consensus that girls have inherent fundamental entitlements that included the right to not be forced to marry early and undergo FGM/C. There was

also a shift in treating these entitlements as merely of private domestic relevance but rather as concerns of the broader community and more so as entitlements that needed to be guaranteed by the state (Shell-Duncan and Olungah, 2009). This shift led to the opening of formal and informal rescue centres to house and protect girls seeking protection from being forced to undergo early marriage and/or FGM/C.

The phenomenon of “girl rescue” informally began in the late 1990s as neighbours, schools, and churches provided shelter to girls seeking protection, especially during “circumcision season” in early December. At first these efforts were largely informal, as neighbours, schools, and churches provided temporary shelter and protection to girls who were at risk of early/child marriage. Since that time, while informal child rescue has continued, formal safe houses have been built in various regions of the country. One that has received the most press is a safe house in Narok called Tasaru Ntomonok, which in the Maasai language means “rescue the woman.” It was founded by former Maendeleo Ya Wanawake Organisation (MYWO) coordinator Agnes Pareiyo, who was honoured for her work at this centre as the “United Nations Kenya Person of the Year” in 2005 and was recently appointed as the chair of the Anti-FGM board in Kenya. Less attention has been drawn to other safe houses in Narok and other parts of the country, founded and run largely by Christian churches. In Narok, within walking distance of Tasaru is another much more low-profile safe house run by the Full Gospel Church. This safe house is fully funded by church members, and there is anecdotal evidence that some girls prefer the church-run safe house to those run and funded by international organisations, despite the former having poorer physical structures. This preference is attributed to the fact that girls have trust in the religious leaders and believe that they have the power of persuasion needed to facilitate reconciliation between rescued girls and their families. The operation of both permanent and temporary safe houses to rescue girls has not become a mainstay fixture throughout regions of Kenya where the practice of FGM/C persists. In Kisii, safe houses are almost non-existent—because the Abagusii values of community would have girls who have escaped reside with relatives.

Many girls who have sought refuge from FGM/C and early marriage come from communities that have hosted a wide range of programmes aimed at eliminating FGM/C. Many of these programmes feature ARPs as at least one possible element of their intervention strategy. Alternative rites of passage were initiated in the 1990s by the Kenyan Women’s Organisation, MYWO, first with funding from Ford Foundation, and later in conjunction with the Programme for Appropriate Technology for Health (PATH). This programme involved a week long “seclusion” in which girls were taught “traditional wisdom” and “family life skills” on topics ranging from personal hygiene to reproductive health to respectful behaviour. At the end of the week, the girls were “initiated” in a ceremony that featured songs, drama, feasting, gift giving, and “circumcision by words” (ntanira na mugambo). Evaluation of these programmes has yielded mixed results. For example, ARPs did not always involve community sensitisation and mobilisation and did not always seek parental consent (Thomas, 2000). Therefore, families were sometimes surprised by the pledges taken by their daughter, and did not necessarily honour these pledges, choosing instead to proceed with FGM/C. In some communities, ARPs were performed in a fashion that did not at all represent the type of ritual traditionally used in that community. In some cases, girls who participated in the programme were ridiculed by peers for having participated in such a programme only in exchange for a T-shirt that says, “Say No to FGM.” Importantly, even though the ARPs played a role in promoting abandonment of FGM/C, the sensitisation activities that accompanied the ARPs were not the sole influencers of behaviour change; other direct and indirect intervention activities in the communities, notably religious approaches and ongoing changes related to girls’ education and women’s rights, may have influenced the observed changes as well (Chege, Askew, and Liku, 2001). External funding for these initial programmes has ended, but ARPs continue to be included in some form in many ongoing intervention programmes run by local non-governmental

organisations (NGOs) and faith-based organisations. Different organisations have borrowed and adapted different approaches when implementing ARPs making it difficult to generalise findings. In addition, little is known about how this popular approach interacts with other FGM/C intervention strategies such as legal and policy measures, religious-oriented approaches, promotion of girls' education, intergenerational dialogues, and use of rescue centres.

A notable feature of intervention efforts in Kenya is the sheer number of programmes that include elimination of FGM/C as one of their stated goals. The passage of the Children's Act in 2001 and shifting sentiments about the rights of children sparked a cascade of community-based social movements aimed at ending FGM/C. Women in all sectors of society, privileged by their acknowledged authority regarding the care for and well-being of children, became increasingly active participants in social reform efforts aimed at child protection, including protection from FGM/C and early marriage. The number of new community-based organisations (CBOs) skyrocketed, led primarily by Kenyan women, and many included ending FGM/C as at least one of their stated goals. By 2007, organisers of the National Stakeholders Meeting for FGM/C estimated that at least 400 organisations were working to end FGM/C in Kenya; by 2011 this number rose to more than 550. Thus, in communities where FGM/C rates have remained high, a key feature is the large number of organisations working simultaneously to bring about elimination of FGM/C. Earlier, the Ministry of Gender, Children's Affairs, and Social Development was mandated with coordinating FGM/C activities. This mission was taken over by the Anti-FGM Board, formed in accordance with regulations outlined in the 2011 Prohibition of FGM Act. Nonetheless, it is not clear whether having a national coordinating agency has resulted in convergence (activities planned and implemented jointly in a county). Studies of multi-sectoral programme implementation have shown that convergence may include cooperation (sharing or exchange of information or resources), coordination (altering one's activities to achieve a common purpose), collaboration (enhancing one another's capacity), or integration (sharing resources or merging) (Garrett and Natalicchio, 2010). This study aimed not to evaluate programme implementation and coordination, but to assess how multiple and multi-sectoral strategies aimed at reducing FGM/C are experienced in communities identified as "hot spots" for the continuation of FGM/C, having been targeted by numerous programmes aimed to encourage abandonment of the practice.

Theoretical underpinnings

Understanding alterations in norms and practices of FGM/C through the lens of theory of change

Social norms theory, formerly referred to as the social convention theory, has over the years been used to study health-related behaviours and significantly in the design of interventions aimed at changing normative behaviours or practices at the societal level (Shell-Duncan et al., 2018). Some of the examples where norms perspectives have been used to influence behaviour include eating habits (Rah et al., 2004), alcohol consumption (Campo et al., 2004), safer sex, and sexual assault prevention (Scholly et al., 2005). Of significance to this study is its use to address the practice of FGM/C (UNICEF, 2013). Mackie (1996) pioneered the application of the social norms theory to FGM/C. He suggested that FGM/C was a social norm practiced and entrenched in communities with interdependent expectations regarding marriageability. Further empirical investigations on social norms and expanded views on FGM/C have shown that FGM/C may be held in place not only by norms associated with marriageability, but also by a wide range of norms and associated meanings often linked to ethnic identity, adolescent rites of passage, religion, honour and modesty codes, sexual restraint, and aesthetics and/or hygiene (Mackie and LeJeune, 2009). It is therefore important to consider the local context when applying the social norms theory in order to have a deeper understanding of norms and cultural values associated with FGM/C (Gruenbaum, 2001; UNICEF, 2013).

Social norms theory highlights that decision making regarding FGM/C represents a social coordination issue: the choices and actions of individuals are shaped and constrained by shared social norms that can be locked in place by interdependent social expectations. Sanctions arising from non-conformity make it difficult for those opposed to FGM/C to abandon the practice without incurring costs, such as social ostracisation, poor marriage prospects for their daughters, or reduced access to social support. To avert such costs, behaviour change, it is argued, must be coordinated among people interconnected in social networks – a reference group. A salient feature of the model is that once a critical threshold is attained, it is possible to reach a "tipping point" that produces a behavioural cascade among interconnected individuals (Mackie and LeJeune, 2009).

The theoretical underpinnings of strategies for the abandonment of FGM/C relate to social convention theory/social norm theory, which suggests that in communities where FGM/C is widely practiced, no single family would choose to abandon the practice on its own because of the spectre of negative sanctions for non-conformity (Mackie and LeJeune, 2009). Social convention theory describes the state where no family has the incentive to move away from the expectation of cutting as an equilibrium state. The equilibrium state of having no family willing to abandon FGM/C can, nonetheless, shift if all families in a community choose not to cut their daughters and hence cutting will no longer be the social norm. The strategy of an intervention is therefore to convince all families within a reference group to abandon FGM/C and move them at the same time from the equilibrium state of practicing FGM/C to not practicing FGM/C (Mackie and LeJeune, 2009; UNICEF, 2012). To make this possible, FGM/C interventions are encouraged to use intensive community dialogues that enable community members to reflect and deliberate on costs and benefits of FGM/C, question the practice, and potentially reverse the social convention. The process starts with a core group that must mobilise a critical mass of people, to become self-sustaining. Once the critical mass has grown and represents a large proportion of the community, and a tipping point to abandon FGM/C has been established, a recognition of this shift to a new equilibrium state of not cutting is celebrated as a public declaration to mark the ending of the practice of cutting (UNICEF, 2012). All this is done with careful consideration of community values through deliberations. It is anticipated that deliberations about what one should do and what others should do to abandon FGM/C can begin in a small core group, and diffuse in an organised fashion through the remainder of the reference group, until enough members of the community are ready to change (Dagne et al., 2009; Mackie et al., 2012).

We posit that in Kenya, it is likely that dialogue stimulating a critical evaluation of FGM/C arises not from the siloed effects of any single intervention activity, but from synergistic interactions of numerous efforts aimed at encouraging abandonment. This includes legal reform, community-based interventions and programmes such as ARPs, community dialogues, and girls' rescue programmes, and indirect change efforts such as promotion of girls' education. A key question, however, is why the pace of abandonment of FGM/C is proceeding relatively slowly in key "hot spots" of the country?

Objectives

- To explore whether and how unprogrammed factors or programmed FGM/C interventions (ARPs, legal and policy measures, religious-oriented approaches, promotion of girls' education, intergenerational dialogues, use of rescue centres, and other undocumented approaches) influence community values deliberation in Narok and Kisii counties.
- To assess what changes in FGM/C norms and practices have occurred in Narok and Kisii counties, and identify factors motivating these changes.

- To identify barriers to FGM/C abandonment in these key "hot spots", and assess how, in light of empirical findings and theoretical models of behaviour change, intervention efforts might be optimised and coordinated to accelerate abandonment.

Methods

Study design

The study design was cross-sectional using qualitative data collection approaches. Data collection activities included: review of ethnographic research, media reports, historiography, and grey literature; in-depth interviews (IDIs) with a wide array of community members and stakeholders; focus group discussions (FGDs) with community members to elucidate patterns of variation in norms associated with FGM/C; and observation of community events, intervention programmes, and workshops.

Study sites

Kisii County

Kisii County is located in the Western part of Kenya bordering Nyamira County to the Northeast, Narok County to the South, and Homa Bay and Migori Counties to the West. The County's area coverage is about 1,333 square kilometres (km) and is divided into nine constituencies which also form the sub-counties, namely: Kitutu Chache North, Kitutu Chache South, Nyaribari Masaba, Nyaribari Chache, Bomachoge Borabu, Bomachoge Chache, Bobasi, South Mugirango, and Bonchari. The county is densely populated, with a population of about 1,362,779 people in 2017. Most of the land in Kisii County is arable and a majority of the inhabitants engage in agricultural activities (Kisii County Government, 2018).

Kisii County is home to the Abagusii people who predominantly live in both Kisii and the neighbouring Nyamira Counties. The FGM/C prevalence for the Abagusii women aged 15-49 years was estimated to be 84 percent in 2014 (Kenya National Bureau of Statistics [KNBS] and ICF International, 2014). Traditionally, FGM/C was performed around 15 years of age in preparation for marriage, but it is now typically performed on girls aged 5-10 years. The most common form of FGM/C is Type I (Njue and Askew, 2004).

Media reports on FGM/C among the Abagusii highlight strong adherence to culture, the medicalisation of the practice, and the fact that education does not influence whether parents choose to cut their daughters or not. Numerous reports have recorded daughters from elite families being taken to the rural areas where nurses are hired to come and cut their daughters (Standard Digital, 2014b). For example, a media article in November 2014 detailed how one professional Gusii man invited his Nairobi office colleagues to attend the FGM/C celebration of his daughter as this was a sign of great honour and respect, despite the 2011 Anti-FGM Act (Standard Digital, 2014a). One father in particular was quoted as saying "*the pain is worth the respect she will earn from the community as a circumcised woman*" (Relief Web, 2011).

However, there are also reports of abandonment. In the "Rites of Passage in Africa" video, one traditional circumciser notes that families who actively practice Christianity or are involved in the Seventh Day Adventist church are less likely to ask for their daughters to undergo FGM/C. Further, in April 2018, an article by the Kenya News Agency featured a programme by Fulda Mosocho Project where they reported to have saved 300 children from FGM/C when 90 members of the community (half of them male) graduated from a two-year training to end the practice in Kisii County (Kenya News Agency, 2018). Legal measures have also been prominently featured. However, the outcomes seem to have been mixed (Relief Web, 2011). In one instance, a Gusii woman narrates that she hired a nurse to come to her house and cut 11 girls at her home and

immediately after the cutting, the family had a large gathering to avoid suspicion from local authorities. In contrast, some media reports have recounted women serving three or more-year jail terms for obtaining or performing FGM/C. The women reported that they were either unaware of the law, ignored the government's warning not to engage in the practice, or suffered intense stigma from the community as a result of not undergoing FGM/C (Kenya Television Network, 2017). How these diverse events are influencing discourses and practices related to FGM/C have yet to be explored.

Narok County

Narok County is situated along the Kenyan Great Rift Valley. The county is vast, covering approximately 17,944 square km with a population of about 850,920 people. The county's devolved administrative units include six sub-counties, namely: Kilgoris, Narok North, Narok South, Narok East, Narok West, and Emurua Dikirr. The main economic activities in Narok County include tourism and agriculture, especially livestock farming (Narok County Government, 2018).

In 2014, the FGM/C prevalence among Maasai women aged 15-49, who predominantly live in Narok and Kajiado Counties was estimated to be 78 percent (KNBS and ICF International, 2014). The Maasai community are semi-nomadic, pastoral Nilotic people mainly settled in Narok and Kajiado Counties (28 Too Many, 2013). Among the Maasai, FGM/C is practised to mark a girl's transition to womanhood. The practice enables the young girl to gain respect in the community and prepares her for marriage. She is also educated about her role in society (The Coexist Initiative, 2012). Once per year, FGM/C takes place for all girls in the appropriate age group, usually between the ages of 12 and 14 (prior to marriage), and the celebration is seen as an important rite of passage into womanhood. The procedure is often performed during school holidays and also involves having the girl's hair shaved as part of the womanhood ritual (28 Too Many, 2013). Type II (excision) FGM/C is the most common type of cutting in the Maasai community (Evelia et al., 2007). Although the Maasai are proud of their culture and have long been described as resistant to outside influence, they have shown willingness to adjust their practices, including using a different blade for each girl to minimise infection (IRIN, 2005) and embracing ARPs (AMREF Health Africa, 2013).

The Maasai tribe tend to get a lot of media coverage due to their distinct way of life and adherence to culture. Coverage of ARP graduation ceremonies is high with these events attended by key national government figures like cabinet secretaries, high-level dignitaries such as US, UK, or EU ambassadors as well as prominent anti-FGM/C advocates. The Tasaru Ntomonok Initiative, founded by Agnes Pareiyo, has received significant press coverage, especially in popular newspapers and television channels in Kenya. Agnes Pareiyo's sustained efforts to rescue girls from FGM/C, supporting their education even in university, and conducting numerous ARPs has been highlighted. She advocates for cultural education without cutting the girls and intergenerational dialogue that engages elders in the community (The Christian Science Monitor, 2008). Ms. Pareiyo has also been at the centre of tip offs to local authorities aiming to enforce both the 2001 Children's Act and 2011 Anti-FGM Act. She has been instrumental in reporting local chiefs and traditional circumcisers to the police who apprehend and arraign them in court. However, there is limited reporting on the outcome of the cases. In contrast, a few articles have reported backlash from the community where women have taken to the streets and demonstrated against the 2011 Act. They debate the importance of the practice and the stigma that is associated with not being cut as reasons for why they continue to practise FGM/C. Numerous reports have covered the arrests of women who were caught undergoing FGM/C (Standard Digital, 2017). Media reports seem to be lacking parents' perspectives on the value ARPs and if girls who have been rescued from FGM/C have reconciled with their families.

A clear highlight among the Maasai is a wealth of youth-led and "home-grown" anti-FGM/C activism. For example, in Narok, CNN covered the story of Kakenya Ntaiya, an FGM/C survivor who was the first young woman in her village to study in the United States. She founded the

Kakenya Centre of Excellence, a boarding school in Narok that enrols girls from needy families with the condition that their parents or guardians will not cut their daughters, or subject them to early marriage and will allow the girls to be trained to become change agents and anti-FGM/C activists (Teen Vogue, 2017). There is also Seleyian Agnes Partoip, the founder and director of the Murua Girl Child Education Programme Narok who founded the Narok Youth End FGM Network, which reaches 220 young people through monthly forums (The Girl Generation, 2017). Amos Leuka of SAFE Maa spoke at a London event in February 2018, marking the International Day of Zero Tolerance for FGM/C, where he highlighted the organisation's use of traditional songs and storytelling to advocate for ARPs (Thomas Reuters Foundation, 2018). The younger Maasai generation seems more empowered to openly challenge FGM/C and the norms surrounding it and they are willing to speak at the local, national, and global levels. They are using their experiences as insiders to the Maasai culture to demonstrate that FGM/C is no longer a practice they wish to continue or a part of their identity, instead they would rather pursue education and give back to their community. Support for girls' rights to protection from FGM/C is also reflected in the abundance of rescue centres where girls feel more empowered to ask for help when escaping FGM/C. How these new forms of activism are reverberating within the community remains to be explored.

Participants

Table 1 summarises the data collection activities and the number of study participants or events. Mapping of community FGM/C interventions involved conducting site visits to organisations implementing FGM/C interventions in the two counties. We used a list of organisations that had attended a consultative meeting during the inception phase of this study and a snowball sampling approach to identify and document FGM/C interventions. A total of 31 organisations/agencies were documented. Organisations implementing FGM/C interventions and their beneficiaries in Narok and Kisii counties formed the subject population for observation of intervention events. A total of 16 events implemented in the catchment population areas were observed.

Table 1. Number of study participants

Data gathering activities	Narok county	Kisii county	Both sites
Mapping community interventions	18	13	31
Observation of interventions	7	9	16
In-depth interviews			
Village elders	3	2	5
Women's group leaders	2	2	4
Religious leaders	2	2	4
Government officials	2	3	5
Teachers	2	2	4
Healthcare workers	5	5	10
Programme implementers	6	6	12
Mothers of girls aged 5-20	6	8	14
Fathers of girls aged 5-20	7	7	14
Girls in rescue centres (12-17)	7	0	7
Girls in the community (12-17)	7	13	20
Focus group discussions			
Younger women (18-35)	2	2	4
Elder women (36+)	1	1	2
Younger men (18-35)	1	1	2
Elder men (36+)	1	1	2

Ninety-nine IDIs were conducted with community gatekeepers (village elders and women's group leaders), religious leaders, government officials, teachers, healthcare workers, programme implementers, parents/guardians of girls aged 5-20 years, and girls living in rescue centres and in

the community. In-depth interview participants were purposively identified based on their knowledge of, and experiences with, FGM/C in the respective communities. We conducted ten FGDs with men and women aged 18 years and older from families that have traditionally practised FGM/C (Maasai and Kisii ethnicity). Each FGD had six to eight participants of the same sex. Separate FGDS were held for younger (18-35 years) and older (36+ years) participants.

Instruments

Semi-structured interview guides were used in interviews with key informants and during FGDs with community members. The development of IDI and FGD guides was informed by tools used by Shell-Duncan and colleagues (2011) in a study on dynamics of change in the practice of female genital cutting in Senegambia. Observation guides were developed to help research assistants keep track of issues expected to be observed during the implementation of community interventions (Shell-Duncan et al., 2011). All interviews and discussions were recorded using digital voice recorders. Prior to fieldwork, all study tools were pretested and adapted to the local context.

Procedures

Mapping of FGM/C interventions was conducted using the snowball sampling approach. Contacts of programme implementers in Narok and Kisii who had earlier attended the inception meeting for this study were used as the first contacts who then suggested other FGM/C programmes. For IDIs and FGDs, study participants were recruited from the catchment population areas that were reached by various FGM/C programmes in the two study sites. Research assistants, with the help of programme implementers and/or community health volunteers, purposively selected the respondents to participate in the interviews. In-depth interviews and FGDs were conducted in November and early December 2017. Research assistants worked with programme implementers and community members to identify ongoing intervention activities to be observed. Documentation of FGM/C interventions began in September and ended in October 2017. The first phase of observation of FGM/C interventions took place in December 2017 while the second phase was conducted in February and March 2018.

Data analysis

Audio recordings of IDIs and FGDs were transcribed and typed in Microsoft Word and analysed for content using NVivo version 11 software. Interviews conducted in Kiswahili or local languages were directly translated and transcribed into English. In reviewing text data from interviews, inductive analysis was used to identify themes and patterns and construct typologies (Rossman and Marshall, 1995). Codes corresponding to themes and constructs were entered into the database and used to organise data for refined analysis.

An inductive approach was also used to analyse transcripts of FGDs. Beginning with the premise that “coding is analysis” (Miles and Huberman, 1994), we used an iterative process that involved successively more focused rounds of coding text to identify themes or categories. This was followed by writing memos to explore themes and identify relations among themes or categories, and linking themes to building analytical models (Bernard, 2011; Creswell, 2007). A summary document was created for each FGD, identifying the major themes raised, grouped along the lines of advantages or disadvantages of FGM/C. Notations recorded the emphasis placed on each theme (ranging from being a passing remark to a topic that participants deeply explored), as well as the degree of consensus, debate, or disagreement that came about during the discussion. This process served as an analytic approach to discerning the degree to which normative statements and positive or negative associations were shared among participants, debated, or possibly actively contested during the discussion. As recommended by Knodel (1993), we used a team approach to both creating data summaries and identifying themes in an effort to improve reliability

of our analysis. The data analysis team members independently identified topics and patterns, and then met to discuss interpretation of emerging themes and identify “exemplar quotes” – direct quotes from the transcripts that illustrated a concept or theme (Bernard, 2011).

The summaries for each FGD were used to create an “overview grid” following methods of Knodel (1993), and elaborated by Shell-Duncan et al., (2018), allowing comparisons along the lines of break characteristics (younger vs. older, men vs. women, and location of residence: Kisii or Narok county). Basic themes were grouped into overarching themes, and a summary matrix was created for each overarching theme. This matrix recorded variations in themes, direction, and degree of consensus along break characteristics. Analytic memos were created to describe themes that emerged through the analysis, exploring patterns and overarching organizing themes that formed the basis for the interpretation of the results.

Ethical considerations

Ethical approval for the study was obtained from the Population Council’s Institutional Review Board (Protocol 831) and AMREF Ethics and Scientific Review Committee (AMREF-ESRC P380/2017). The Kenya National Commission for Science, Technology, and Innovation granted administrative permission to conduct the research (NACOSTI/P/17/27106/19985). Written informed consent was obtained from participants before conducting the interviews. Potential participants were given an opportunity to decide whether to read, or the research assistant to read for them, the informed consent document and to indicate their willingness to be interviewed by signing the form. Those who could not write were asked to nominate someone to sign on their behalf. For young people aged below 18 years, parent/guardian consent was obtained prior to obtaining individual assent.

Results

This section gives an overview of FGM/C interventions implemented in Narok and Kisii counties and summarises study findings based on the study objectives. It starts by describing the documented FGM/C interventions in Narok and Kisii counties, examines the ability of these interventions to influence community-wide abandonment of FGM/C through community values deliberations, highlights communities’ reactions to the interventions, and documents the experiences of girls living in rescue centres. The section also covers the general knowledge and understanding of FGM/C in the two counties, the decision making process on FGM/C, changes in FGM/C practices resulting from direct and structural change efforts, alterations in norms related to FGM/C, reasons for the observed changes, and barriers for change.

FGM/C interventions in Narok and Kisii counties

The first phase of the study involved mapping out the FGM/C interventions that had been implemented or were being implemented in the two counties. The mapping exercise was followed by interviews with key informants and discussions with community members to understand how the different FGM/C interventions had influenced community values regarding FGM/C. The study also observed the implementation process of a few FGM/C interventions in the two counties.

Mapping and observation of FGM/C interventions

The mapping exercise documented a total of 31 organisations/agencies (18 in Narok and 13 in Kisii) spearheading FGM/C interventions in Narok and Kisii. The geographical coverage of the different FGM/C interventions was mixed with the majority implemented in specific sub-counties rather than the whole county. There was limited coordination between the different programmes with overlapping in target areas. The duration of implementation of FGM/C interventions also varied with the oldest organisation starting its activities in 1997 while the newest organisations had

been carrying out interventions for less than a year. Most of the interventions were still ongoing and only a few organisations had completed implementation of their interventions.

The mapping exercise showed that in both Narok and Kisii counties, most of the implementing organisations/agencies did not have a programme dealing solely with FGM/C. Rather, FGM/C interventions were implemented as a component within their broader programme activities. Programme designers were of the view that FGM/C cannot be treated in isolation from other issues affecting the communities in which they were working. There were also limited funding opportunities to focus exclusively on FGM/C. The type of intervention activities varied across organisations/agencies.

In Narok, various organisations implemented a mix of FGM/C interventions that included: community dialogues on FGM/C through use of traditional songs; running rescue centres that provided shelter and education to girls in danger of FGM/C; advocacy against FGM/C through the church; community sensitisation on children's rights and how FGM/C contravenes these rights; visiting schools and teaching children about their rights and the dangers of FGM/C; conducting dialogue meetings with sub-county teams and engaging the youth; facilitating discussion groups with the help of village elders; reconciliation of runaway girls with their parents/guardians; conducting ARPs; provision of medical care to girls who have undergone FGM/C; and training traditional birth attendants who are later used as FGM/C change agents in the community.

In Kisii, organisations/agencies implemented the following: community outreach and church meetings where issues concerning fistula and FGM/C were discussed; conducting ARPS; addressing gender-based violence (including FGM/C) in schools and in the community; facilitating education of the girl child and promotion of human/child rights; use of radio and social media to transmit anti-FGM/C messages; conducting FGDs on FGM/C with opinion leaders, teachers, and parents; carrying out school visits to offer training on FGM/C; disseminating anti-FGM/C messages using puppets, drama, songs, dances, and acrobatics; organising for public declarations of intent not to engage in FGM/C; organising health talks conducted by health professionals on the adverse effects of FGM/C; and liaising with the police to arrest and prosecute FGM/C perpetrators.

Observing the implementation process of some of the FGM/C interventions provided first-hand information on how these interventions facilitated deliberations among community members on values related to FGM/C. Given that most of the FGM/C interventions were a component within a broader programme, evidence on the implementation of FGM/C activities based on a theory of change was scarce. We observed a total of 16 events (9 in Kisii and 7 in Narok) that involved community/organisation sensitisation meetings/workshops, ARP graduation ceremonies, advisory council meetings to introduce programmes, community dialogues, meetings to review project activities at the community level, meetings with local leaders, public declaration ceremonies, and children's sensitisation workshops. With the exception of four events (two events targeting only children, one event targeting young people and mentors, and one event targeting members of a women's group), all other events were attended by a diverse mix of participants including parents, young people, community leaders, representatives of NGOs, and local administrators (chiefs, county commissioners). Three of the ARP events also had programmes targeting boys.

The topics discussed, and key activities differed by the type of event. The sensitisation events targeting children (two events), organisations (one event), or the wider community (two events) focused on educating participants about FGM/C, its causes and negative effects, anti-FGM/C laws, and the roles of different actors in FGM/C prevention. The sensitisation events targeting children also focused on educating participants on the rights of children. The three review meetings focused on the roles of different actors in FGM/C prevention, the challenges and barriers experienced, and emerging trends in the practice. The advisory council meeting centred on discussions of the roles of different actors in an upcoming programme, which was to focus on promoting children's health,

education, safety, and stability. Similarly, the local leaders meeting focused on the roles of different actors in anti-FGM/C programming and some of the barriers to FGM/C prevention.

During the public declaration event, there were various speeches by different actors on their roles in FGM/C prevention, anti-FGM/C themed entertainment, and an opportunity for all participants to sign a public declaration against FGM/C. During the community dialogues, participants discussed the health effects of FGM/C and changes in the practice. The four ARP ceremonies were preceded by activities held over several days. These activities included training of girls and boys and community sensitisation activities. Training sessions for boys focused on encouraging them to embrace anti-FGM/C campaigns. For girls, the training focused on FGM/C, its harms, the importance of education, building self-esteem, and other life skills. The main event included anti-FGM/C themed entertainment and speeches by different actors on their role in FGM/C prevention. One event also included a march through the local town.

Throughout the observation exercise, we sought to find out how programmes established social networks to spearhead community-wide abandonment of FGM/C, whether there were any sustainability measures put in place to ensure community ownership of the process, and whether there were opportunities for reflections from participants concerning the implementation of the programme. On establishment of social networks, except for one sensitisation event targeting primary school children, all other events brought together different actors involved in FGM/C programming. For most events, the discussions and speeches focused on the roles of different actors in preventing FGM/C. There was limited evidence on the measures put in place to ensure community ownership and sustainability of the intervention activities. However, in at least six of the events, involving community members was viewed as one of the approaches to ensure sustainability. To achieve community ownership, two programmes relied on community volunteers, while another supported the integration of girls rescued from FGM/C in local communities to act as role models—girls who had gone through the rescue centres and were considered successful were used as role models. Several organisations noted that funding was a challenge and limited the reach of the programmes. For two events, participants' reflections on the programme were not highlighted. For the other events, the comments from different actors largely suggested positive views about the programme as reflected by direct positive feedback or by mutually agreed upon activities.

FGM/C intervention approaches and communities' reactions

In Narok, a majority of those interviewed were aware of the existence of one or more intervention activities being implemented within their surroundings to influence the community to abandon FGM/C. Community outreach was the most common intervention approach where information was disseminated to community members through public meetings, the church, and schools. Respondents mentioned the existence of rescue centres where girls at risk of early marriage and FGM/C sought refuge. Interventions such as ARPs, legal measures, and intergenerational dialogues were also mentioned.

> *"Yes, I have seen one from Siyapei although I don't remember the name clearly, but it was sponsored by the county government. They came here last year when the schools were closing to spread the word. The teachers also participate in this when the schools are closing by reminding everyone not to circumcise the girls. They say that when we close schools, we should not go for girls' ceremonies but rather adhere to what the government is saying."*
>
> Women's group leader, IDI, Narok

> *"Yes, we have seen [Organisation 1, CBO, Narok] usually have alternative rites of passage for girls and also the church [Church 1, Narok] like right now. They teach girls, they*

organise seminars for two weeks, they tell them that they have become mature without circumcision. This has really changed things in this community."

49-year-old mother of girls, IDI, Narok

In Kisii, most of the study participants reported being aware of the FGM/C interventions implemented in the community. The interventions were geared towards encouraging the community to stop practising FGM/C and were typically carried out by different organisations. Some participants mentioned that they were aware of ARP interventions in the community but noted that these interventions were not as vibrant as they were initially. Organisations commonly conducted outreach in schools, religious centres, and in the community to create awareness on FGM/C.

"There are some organisations like [Organisation 2, CBO, Kisii]. They work in schools, in churches, telling people about FGM. So, people have captured a lot of information from them."

16-year-old girl, IDI, Kisii

"They are not so vigorous in our area here now, but a year or two years ago, there was a certain NGO that came and did a campaign for a week, they took some girls…they graduated after one week. It was around December during school holiday the girls were graduating now to adolescents."

Government official, IDI, Kisii

Focus group discussions with elder and younger women and men sought to find out reactions of community members to FGM/C intervention programmes. Table 2 presents a summary of the discussions with community members. Positive consensus as shown in the table means that participants agreed with the statement, while negative consensus means that participants disagreed with the statement.

Table 2. Summary matrix of communities' reactions to intervention programmes

Reaction to Intervention Programmes	**Narok County**				**Kisii County**			
	Elder men	Younger men	Elder women	Younger women	Elder men	Younger men	Elder women	Younger women
FGM/C programmes largely accepted	+	+	+	+	+	+	+	+/–
Most programmes in form of outreaches and alternative rites of passage			+		+	+	+	+
Focus of interventions mainly on negative health effects of FGM/C					+	+	+	+
The anti-FGM/C law largely accepted			+	–	+	+	+	+

+, positive consensus
–, negative consensus
+/–, divergent views
Blank, theme not raised

In Narok, discussants in all of the group categories agreed that most of the FGM/C programmes were largely embraced by community members. Elder women observed that the most common implementation approaches adopted by FGM/C programmes were conducting outreach in the community to create awareness and organising ARPs to initiate girls into womanhood without being cut. However, there were divergent opinions in relation to acceptability of the anti-FGM/C law. While elder women felt that the law was acceptable in the community and had successfully

deterred families from cutting their daughters, younger women felt that the way the law was being implemented created apprehension among community members and subsequently, was not favoured. Interestingly, older women, who are most likely to be targets of legal action, were not critical of the law, while younger women were disapproving. It is worth noting that enforcement of the law has been most aggressive in Narok, compared to other regions of Kenya. There is a possibility that the implementation of the law could have driven the practice underground in Narok.

> *"For [Organisation 3, NGO, Narok], the community has liked them because of education opportunities and their programme on the rights of kids. Now, if a parent decides to circumcise, [Organisation 3, NGO, Narok] comes in to assist the child and once they report, the parents get arrested."*
>
> 19-year-old male, FGD, Narok

> *"There is that fear that people in the community normally have towards the courts. There was a time people known in this community committed the offence [FGM/C] and were arrested. That created great fear in the community."*
>
> 35-year-old female, FGD, Narok

In Kisii, FGM/C programmes were generally accepted by community members with the most liked interventions being those that offered incentives to community members. Nevertheless, a few of the younger girls felt that some of the community members still valued FGM/C and did not support the anti-FGM/C programmes. The majority of FGM/C programmes were outreach activities and ARPs. Messaging during implementation of FGM/C interventions largely focused on the health consequences of carrying out FGM/C. Regarding the anti-FGM/C law, there was consensus that the law was accepted in the community and that people who engaged in FGM/C should be arrested and prosecuted.

> *"They have had road shows and taken girls to seminars and rite of passage…the girls have accepted it and have confidence because of the knowledge gained."*
>
> 37-year-old female, FGD, Kisii

> *"Many are praising the programme though some feel that it has caused their daughters to grow without being tamed just like Luos. But those who have understood do support the programme. We understand that our men have been marrying from other tribes especially Luhyas and Luos because they are not circumcised. So, people are supporting the programmes even though some are against it."*
>
> 26-year-old female, FGD, Kisii

Experiences of girls in rescue centres

Rescue centres have gained popularity as an intervention to help girls escape FGM/C or early/child marriage. We conducted interviews with young girls to find out their knowledge and fears concerning FGM/C, their motivation for joining the centres, how staying at the centres influenced their relationship with their parents/guardians, and their thoughts about the use of rescue centres as an intervention to end FGM/C. Since rescue centres were common in Narok but rare in Kisii, the following findings exclusively refer to girls' experiences in Narok.

The practice of FGM/C was considered a Maasai tradition that the community had performed from generation to generation. Consequently, most of the girls in the rescue centres talked of growing up knowing that they would be cut, just as it had happened to other women before them. Girls in rescue centres were equally concerned that they would be married off after being cut and taken out of school. Their decision to resist FGM/C and eventually run away to the rescue centre seem to have emanated from the information they received about the negative effects of FGM/C.

> *"When I was young…I had that thought that I will get circumcised…I will go through the same path my parents went through. Because my mother was circumcised, and my family*

members got circumcised, so I grew up thinking that I will get married too after I am circumcised."

17-year-old girl, IDI, Narok

Events leading to girls being at the rescue centre varied, but in most cases, schools and churches played a significant role in aiding girls' access to rescue centres. Teachers and religious leaders (pastors) were the main contact persons for girls seeking help to run away from FGM/C or child/early marriage. Teachers and pastors would then connect the girls to rescue centres where they would be accommodated. The involvement of teachers and pastors is an important norm shift and highlights who has the authority to weigh in on the decision as to whether a girl will be cut. In this case, pastors and teachers can not only weigh in, but seek protection backed by the law. This is important because it is not simply that girls are empowered—they need an advocate to help them seek protection.

"My pastor called the people from here [rescue centre 1, Narok] and told them there was a kid he was bringing whose father wants her to get circumcised, but she doesn't want… I slept at the pastor's place, the next morning, we came at a place called Luluma…he took me to a certain office… from there he went and registered me, there was a file he filled, so he talked with the people of this rescue centre and we came."

17-year-old girl, IDI, Narok

"I first went and stayed in school, it was in 2012, so I stayed with the class 8 as they did their exams until they finished. Then there was a project [rescue centre 2, Narok] near the school so that December I stayed there until the holiday was over. When the schools reopened I went back to school. In 2013… I stayed with a teacher in school until after the elections. In April, now the head-teacher knew the director of this centre and he was given a chance to bring me here."

17-year-old girl, IDI, Narok

Interviews with girls also elicited information on how girls' stay at rescue centres affected their families. Initially, most of families were not happy that the girls ran away. Nonetheless, after some time, some families supported the girl's stay at the rescue centre. In some instances, parents whose girls had run away visited the rescue centre, asked for forgiveness, and wanted their girls to return home. In other cases, parents, especially fathers, remained enraged at their daughters for running away and were not ready to allow them to return home. Families that supported girls' stay at the rescue centres were mainly influenced by the educational opportunities being provided by the rescue centres.

"Okay for me, right now my family they are happy about it because they heard that I went to school and now I am about to finish so they are starting to regret about the issue they wanted to do to me. Now they are coming back and saying sorry to me because they have seen that I have done a good job and they are happy about it."

17-year-old girl, IDI, Narok

"My mother has agreed that I can go back home but my father has said I should not…they have never come here apart from my brother who brought me here, he comes here sometimes… My mother did not have a problem with me, my father was the one who did, and he would refuse anything I told him. He said I should not go back home he doesn't want to see me."

17-year-old girl, IDI, Narok

Girls reported having positive experiences while staying at the rescue centres. Most girls recounted that they had been warmly welcomed and given a conducive environment to complete their education. They were provided with basic needs including food, accommodation, and clothing. Girls' positive experiences at the rescue centres seemed to originate from the rescue centres' ability to meet their basic needs—a contrast to what they experienced at home where life was

considered a struggle with limited resources to meet basic needs. Notably, most of the girls at the rescue centres reported missing their families.

> *"I feel good staying at [Rescue centre 1, Narok] rescue centre. Things that I could not get there [home] I now can get…good beddings, good house. At home, the house was not as good, the food was not good… I was not getting good education at home, as in I was not as happy as I am now here…. I was going to school, but here I feel like am concentrating fully on my education because when I was at home I didn't concentrate fully I was stressed that I will be circumcised."*
>
> 14-year-old girl, IDI, Narok

> *"When you are here, you miss your parents a lot… we know that blood is thicker than water, so when you (are) here even if we get everything, you get education and whatever…you still miss your parents and feel like being with your parents and also your sisters…. me as a girl… there is a way I feel like am lacking something… something that could be at home."*
>
> 17-year-old girl, IDI, Narok

Girls' opinions about rescue centres as an intervention to reduce FGM/C was positive. They viewed rescue centres as a safe haven for girls running away from the cut and early marriage. However, while escaping FGM/C or early marriage could be one of the reasons for girls joining rescue centres, girls appreciated other benefits provided at the centres. The ability of rescue centres to provide girls' basic needs, especially paying for their educational needs was frequently mentioned. Girls also spoke to how rescue centres provide some protection from the risk of undergoing FGM/C.

> *"In my opinion, it is good to have centres like this, it will save a lot of girls from being cut, and also from early marriage… advantages of staying in a rescue centre like this one, we get school fees, because in all terms our fees are cleared. We also get shoes, balanced diet meals, everything is catered for. No more stress, you only work hard."*
>
> 14-year-old girl, IDI, Narok

> *"I think they are good because a lot of girls have received help…the advantages are if one of your parents disagreed with you and didn't want to pay your fees and was waiting to give you away for marriage after class 8 so that you don't continue with education. The advantage is that it helps such girls since when they come here they get sponsors and get to continue with their studies."*
>
> 17-year-old girl, IDI, Narok

General knowledge and understanding of FGM/C

The study sought to understand the FGM/C discourse in the two communities. In Narok, the general understanding of FGM/C among study participants was that the practice was part of the Maasai traditional culture. According to community gatekeepers, parents of girls, healthcare providers, and programme implementers, FGM/C was mainly performed as a rite of passage marking a transition from childhood to adulthood in readiness for marriage. Undergoing the cut signified maturity and respect with those failing to undergo FGM/C considered children even though they were of mature age. Younger women (18-35 years) only knew that FGM/C was a practice performed by their community as a traditional event but were less aware about why it was being practiced. They nonetheless believed that it was wrong for them to be subjected to the cut, perhaps because of the information on the harmful effects of FGM/C that had been passed on in schools, rescue centres, and community outreach efforts. Respondents received information about FGM/C being part of the Maasai traditional culture either from family or community members.

"They [Maasai people] have been doing it [FGM/C] because it is a tradition…they found it being done and they continue doing it. It is meant to transform a girl from girlhood to motherhood."

38-year-old father of girls, IDI, Narok

"I have learned [about FGM/C] through my friends who have been circumcised. I have also learned from my mother because it was a tradition for her to circumcise her children…because she has also gone through it."

13-year-old girl, IDI, Narok

Similar to Narok, FGM/C in Kisii was considered a rite of passage from childhood to womanhood. However, among the Abagusii, unlike the Maasai, the cut did not signify readiness for marriage. Rather, the cut signified an initiation that bestowed respect to the girl who was then considered to be mature—more so an element of gender socialisation than marking a transition from childhood to womanhood. The cut was also meant to reduce the sexual urge among the Abagusii women and therefore curb promiscuity. Sexual restraint in this case is considered to be a feminine virtue translating into a gender norm. Information on FGM/C as a traditional requirement among the Abagusii was in most cases passed on from grandmother to granddaughter or from peer to peer. Sources of information on the harmful effects of FGM/C included radios, churches, schools, government meetings (chief's barazas), seminars, and educational programmes implemented by NGOs and self-help groups.

"I heard about female circumcision when I used to stay with my grandmother. She is the one who used to tell us that girls have to be circumcised so that they cannot be promiscuous."

36-year-old mother of girls, IDI, Kisii

"In school, we are visited by programmes people, they teach us about FGM practice and how to protect yourself from FGM perpetrators…We are visited sometimes and taught about circumcision, its effects, and how to evade it."

17-year-old girl, IDI, Kisii

Decision making on FGM/C

The practice of FGM/C is a complex behaviour that may involve various decision making hierarchies. If programme implementers understand who the key decision makers are, they can better target interventions to bring the desired change. This study therefore sought to find out who are the key decision makers in the two communities.

In Narok, decision making on FGM/C involved the girl's parents and members of the extended family. Notably, the mother of the child was considered the most influential because she interacts with the daughter more often. Mothers are tasked with the responsibility of informing the father when the time is right for the girl to be cut. Fathers are equally powerful as they are the heads of households, provide resources for the cutting ceremony, and are direct beneficiaries of FGM/C through bride price payments once cut girls are married. In certain instances, it was reported that the girls themselves would demand FGM/C—a trend that was driven by peer pressure from other cut girls and the need to conform to the norm of cutting and avoid being viewed as an outcast in the community. In other circumstances, grandmothers to the girls reportedly used unorthodox means to get the girl cut even when the parents were against it. A strategy commonly used by grandmothers was talking to extended family members to convince or force the girl to undergo FGM/C. In this cultural context, it seems like grandmothers have the power to make FGM/C decisions. Their decisions are not considered a violation of social norms, as grandmothers are seen as acting within their rights, and have more authority than a young mother.

"The mother is the one that says it's time for the girl to be circumcised but if the girl says no then father steps in and says you must undergo circumcision… because you see usually in most of the villages it was always circumcision and then marriage and so usually most of the girls who have to undergo circumcision are already booked and the bride price has already been eaten up, so they have to circumcise…and you find that in most cases the person that actually pays for the food that is eaten during circumcision is the man who is marrying the girl… that is the biggest challenge because everything has been paid for… even the woman that does the circumcision has been paid by that man so you are in debt and you have to complete and give away the girl to the man."

Religious leader, IDI, Narok

"The grandmother of the girls are the big decision makers, she speaks to his son, excluding the mother. Most mothers are born again Christians, but some grandmothers still want to go ahead with the circumcision especially those who are not born again."

Women's group leader, IDI, Narok

In Kisii, decision making on FGM/C was done by the mother in consultation with the father. There were discussions and consensus reached between the parents on whether their daughter was ready for the cut. Interestingly, even when both parents made the decision, the mother and close relatives, especially the grandmother, had a greater say on decisions pertaining to FGM/C. The majority of the participants mentioned that the most important influencer when it came to FGM/C decision making was the girl's mother. Notably, mothers would in certain instances take the girls secretly for FGM/C if the father had not agreed. Among the Abagusii, it is considered a taboo for the father to discuss sexual matters with his daughter—an aspect of gender identity and separation whereby the Abagusii were socialised at a young age to take pride in playing specific roles in their communities. Consequently, mothers are traditionally tasked with the responsibility of educating their daughters on womanhood issues and preparing them psychologically for the cut. A few participants mentioned that sometimes the girl herself would initiate talks on FGM/C due to peer pressure and a desire to conform to the social norm that girls were expected to undergo FGM/C at a certain age. The grandmothers also play a role in the FGM/C decision making—some participants reported that the girls usually undergo FGM/C when they visit their grandmothers, sometimes without the knowledge and consent of their parents who are against the practice.

"In many cases, the decisions are made by women. It is the woman who knows that a girl is ready to be circumcised, they even make advance plans with a circumciser. The father will only be informed later that the girl should be circumcised after they have made all the preparations. When the father appears to be against it, he is then cheated that the girl will be sent to pay a visit to the aunt just to realise later that the child has been circumcised."

35-year-old father of girls, IDI, Kisii

"Her grandmother took her without my knowledge. She called the girl and I thought she was sending the girl but later I was informed that my daughter has been circumcised. When I asked the father, he said he did not know. For me, it is like my husband and mother-in-law had discussed about the issue and agreed. I just stopped the discussion about that issue and let it go."

37-year-old mother of girls, IDI, Kisii

Generally, it was evident that mothers rarely make decisions in isolation, and often include grandmothers, who appear to have a great deal of authority. The dynamics of involvement of fathers varies across the two communities. In Kisii, the father may be sidestepped in the decision making process, as FGM/C is considered to be an element of gender socialisation completed by women. In Narok, fathers are powerful as their word is law, they play an influential role in providing resources needed during the FGM/C ceremony and have a vested interest in FGM/C as they stand to benefit through the bride price paid for the initiate. Hence, each community will require tailored approaches to encourage men to be involved in efforts to end FGM/C.

Changes in FGM/C practices resulting from direct and structural change efforts

Individual-level experiences of changes in FGM/C

To find out what changes had occurred in the practise of FGM/C in the two communities, IDIs were conducted with key informants in order to understand their lived experiences amidst the implementation of various FGM/C interventions. These changes were classified as negative (to capture the changes that promoted the continuation of FGM/C) or positive (to refer to changes that promoted FGM/C abandonment).

In Narok, there were changes in the age of cutting with FGM/C performed on girls at a younger age than before. In the past, girls used to be cut when they were between nine and 15 years, but this has changed with girls being cut when they are younger than nine years—a possible indicator that the cut no longer signals that marriage is imminent. The rationale provided for cutting girls at much younger ages included limiting the chances of girls running away or objecting to the cut. Participants noted that most girls older than ten years were likely to have been exposed to anti-FGM/C information and would resist attempts to have them cut.

> *"These days they circumcise when they are still young because they circumcise in secret. They circumcise very small girls when you see them you even pity them. Back in our days…they would let the child to grow a little. Not like now they circumcise when they are still young because when they grow up some of them refuse to be circumcised, so they force them when they are still young."*
>
> 41-year-old mother of girls, IDI, Narok

> *"People are becoming creative. You have heard now they are not circumcising at nine years, they are circumcising the little, the young girls so you come up with a new way to mitigate the practice then they change their tactics."*
>
> Programme implementer, IDI, Narok

Changes from FGM/C being conducted in public to a highly secretive event was also reported. This strategy has been employed to avoid arrests by authorities since the practice has been criminalised in Kenya. In some cases, girls were taken to their grandmothers where they underwent the cut at night to avoid being noticed. Ceremonies to celebrate the cutting of girls that were common in the past are no longer held; the girls do not shave their heads or don beads that used to be worn by the new initiates; and the practice is no longer a communal event unlike the past where people were invited to celebrate the girl's rite of passage. All these measures have been devised by FGM/C perpetrators to circumvent the anti-FGM/C law.

> *"Nowadays…you can't tell who is circumcised and who is not circumcised, because they do it at night and when it is done at night you will not see that girl… Again, they do not put on those beads they used to wear, and they are not shaved the way we used to be shaved, so now it is hard to know."*
>
> 41-year-old mother of girls, IDI, Narok

> *"As you probably know banning [FGM/C] has not been a solution because the overt practice of FGM has disappeared in most areas. Many of these practices have gone underground. It has not been easy because nowadays they don't do it in the public…in this area, they still practise but they go underground, they have decided to do it individually."*
>
> Government official, IDI, Narok

There were changes in the type of cut performed on girls. Respondents in Narok observed that there was a shift to less severe forms of cutting that were less likely to be noticed or result in girls experiencing excessive pain and raise suspicion. Less severe forms of cutting were supposed to enable the cut girl to heal quickly, continue with her normal chores and therefore minimise chances of other community members discovering that she had undergone FGM/C.

"You still cannot miss a few who do it in secret. Those few who do that in secret, do it in hiding and they cut the girls just a little so that it is not even noticeable that it has been done because the girl doesn't become sick."

Village elder, IDI, Narok

"Some people have not stopped but they have lightened the cut… Now, there are some Maasais who have now left the excision, they have moved to Sunna – the small cutting, the nicking of the clitoris. It is because it's like this was a cultural ceremony that was somehow a ritual, they still thought that there should be shedding of blood."

Gynaecologist, IDI, Narok

Apart from the negative changes that have promoted FGM/C continuation in Narok, study participants also noted some positive changes that had encouraged abandonment. There was a general feeling that the FGM/C prevalence had gone down, more girls were in school and cases of child/early marriage had reduced. This contrasted with experiences in the past where almost all girls would be cut, married off and subsequently drop out of school. It is probable that parents in Narok currently see education as a key way of assuring a girl's future well-being, apart from their role as wife and mother. This observation fits with predictions of a form of modernization theory—when there are opportunities for women's security beyond marriage, the motivation to perform FGM/C may decline (Archambault, 2011). The increasing number of uncut girls was also noted as a factor that had led to reduced stigma faced by uncut girls.

"I have seen a very big change because in the past if you hear a girl has not been circumcised like the one of our age it's like a miracle. You can't sit with any person, you can't walk with anyone who is circumcised. They used to say this is a girl who is not circumcised, what is she telling us? … But now, there are many who are not circumcised, and you can't differentiate, we stay together, we dress together, and we are happy together."

41-year-old mother of girls, IDI, Narok

In Kisii, IDIs with key informants revealed changes in FGM/C that almost mirrored the observed changes in Narok. Beginning with negative changes, participants reported that FGM/C was still practised in Kisii County, but the event had transformed into a highly secretive event. Persons practising FGM/C no longer hold cutting ceremonies and have devised ways to avoid being arrested by authorities. Some of the strategies devised by FGM/C perpetrators to evade the law included conducting FGM/C at night and relocating girls due for cutting away from their homes. These measures were meant to enhance confidentiality and ensure that other community members did not get to know that the girl had been cut.

"Some years back celebrations were there even you were called that somebody has been circumcised but nowadays there is none. Only for boys… Also, in the past, it was done by the traditional cutter but nowadays it is done in the hospital or in the house by medical professional…because in Kenya we have corruption, so they accept for more money."

17-year-old girl, IDI, Kisii

Key informants in Kisii observed that currently people prefer medicalised FGM/C which is perceived to be safer. The narrative that FGM/C performed by a healthcare personnel heals faster and is safer was rife in Kisii. FGM/C is reportedly often performed by healthcare professionals as opposed to traditional cutters in a secretive local arrangement either at a health facility or at home. The use of sterilised equipment and separate razor blades for each of the girls was meant to reduce the risk of infection such as the spread of HIV.

"Previously it was done by traditional circumcisers but now it has turned to the professionals. The nurses are the people who are doing it. It is not easy to identify when the girl was mutilated especially this month, a girl can be moved from here to another place, she gets there she gets mutilated and she is brought back, in one week she is ok… Or I

can do it in my own house, I just invite a nurse she comes in my house and do the act, in three days my daughter is in the house in one week she is OK she gets out. Are you able to know?"

Programme implementer, IDI, Kisii

A few respondents reported that there have been changes regarding the age at cutting, venue for the procedure, and the type of cut. It was observed that currently, FGM/C is performed on girls at younger ages mainly to limit resistance from the girl. Some participants reported that FGM/C was done at the hospital or far from girls' homes in order to maintain secrecy. In instances where FGM/C was conducted at home, it was done during the night or the early hours of the morning. Less severe cutting was also reported. Nevertheless, some participants noted that the Kisii have always practiced a lesser form of cutting compared to other communities like the Maasai. These apparently "negative" changes could be cast as community concerns and deliberations about FGM/C that could become part of abandonment strategies.

"Girls are circumcised at a very young age when they are unable to resist unlike the old times when they used to be circumcised at an older age."

36-year-old mother of girls, IDI, Kisii

"Long time ago the cutters used knives but nowadays they use razors and you know long time ago they used to mutilate like the Maasai. Long time ago they used to chop all of it but nowadays they just remove a small part of it."

35-year-old mother of girls, IDI, Kisii

Contrary to expectations, high education levels among Kisii girls did not result in lower prevalence of FGM/C among the Abagusii, while it has among other groups in Kenya with high levels of girls' education or within Christian communities (for example the Kikuyu). As seen in her ethnography, Grace Mose (2008) argues that education is not opening economic opportunities for Kisii women because of the discriminatory gender norms that are inculcated throughout childhood. It is important to note that women are socialised to display feminine virtues, such as practising sexual restraint and showing deference to men. They are also raised to assume gender roles that make women dependent on marriage for access to land and economically dependent on their husbands. So, the predictions of modernisation theory do not come to bear in this community. For that reason, efforts to end FGM/C must be linked to challenging understandings of gender roles.

Community-level experiences of changes in FGM/C

Through FGDs with community members, the study explored what changes in FGM/C were observed at the community level. Table 3 summarises emergent themes as discussed by community members with reference to changes in FGM/C across the two counties.

Across the two counties, most changes in FGM/C discussed by participants were negative and included conducting the procedure secret, medicalisation of the practice, cutting of younger girls, and practising supposedly less severe forms of FGM/C. In Narok, surreptitious practise of FGM/C at night or in the early hours of the morning was reported in discussions with younger men and women while the issue of medicalisation, cutting girls at a younger age, and performing less severe cuts only came up in discussions with younger women.

"Nowadays they circumcise at night…they are doing it in hiding. You just get to hear the girl was long circumcised, yet you have never known."

26-year-old male, FGD, Narok

"Sometimes the nurses are even called to cut the girl at home. All that is totally unacceptable because as was said earlier, cutting is cutting regardless of where it is done. So that practice should be stopped completely."

25-year-old female, FGD, Narok

Table 3. Summary matrix of themes related to the overarching theme of changes in FGM/C practice

Changes in FGM/C Practice	Narok County				Kisii County			
	Elder men	Younger men	Elder women	Younger women	Elder men	Younger men	Elder women	Younger women
FGM/C practised in secrecy – performed at night, no celebrations		+		+	+	+	+	+
Medicalisation – health professionals preferred to traditional cutters				+	+	+	+	+
Change in the age of cutting – girls cut at younger ages				+				+
Less severe form of cutting				+				+

+, positive consensus
–, negative consensus
+/–, divergent views
Blank, theme not raised

Across all groups in Kisii, there was consensus that FGM/C has transformed from being a community event accompanied with celebrations to an event conducted by individual families in prodigious secrecy. Discussants in all of the groups were also in agreement that there has been a shift from using traditional cutters to perform FGM/C to procuring such services from health professionals. Only younger women were of the view that there were changes in the age at which girls are cut with families preferring to cut girls at a much younger age and practising purportedly less severe forms of cutting. Changes in severity of the cut was nonetheless not clear as it was not possible to compare the different forms of FGM/C performed at different periods of time.

> *"Those who are circumcised are circumcised by health professionals by going to hospital or the health provider comes to the house…not the traditional circumciser."*
>
> 36-year-old female, FGD, Kisii

> *"Nowadays we cut girls of younger ages like five years…they do not know what is happening. We therefore give the girl stress and make her emotionally disturbed which affects her schooling."*
>
> 29-year-old female, FGD, Kisii

In summary, negative changes in FGM/C practice were noted, more so among communities living in Kisii county. There is a definite shift from FGM/C being practised as a community event with celebrations to an event organised by individual families and conducted in secrecy. The use of health professionals to perform FGM/C as opposed to traditional cutters seems to be more common in Kisii. There are also changes in the age at cutting with shifts towards cutting younger girls who are likely not to offer resistance and communities performing supposedly less severe forms of FGM/C in both Kisii and Narok. It is conceivable that the changes observed are a response to the anti-FGM law that prohibits FGM/C. Consequently, family members are secretly performing FGM/C to younger girls to avoid being noticed, arrested, and prosecuted. Perpetrators of FGM/C also seem to be responding to the health consequences of FGM/C narrative by procuring services from a health professional to make the practice safer. In other words, the risks they are trying to avert are health complications, detection, and arrest.

Alterations in norms related to FGM/C

To understand how norms and practices related to FGM/C have evolved over time, the study conducted FGDs with community members in Narok and Kisii counties. The discussions explored contestations or consensus on existing norms and practices across gender and by age categories of participants.

FGM/C and sexuality

Table 4 summarises how FGD participants related FGM/C to sexuality across the two counties. Emergent themes discussed under sexuality centred on how FGM/C was associated with sexual restraint, sexual desire, and marital instability.

Table 4. Summary matrix of themes related to the overarching theme of sexuality

Sexuality	Narok County				Kisii County			
	Elder men	Younger men	Elder women	Younger women	Elder men	Younger men	Elder women	Younger women
Sexual restraint – upholding morality and fidelity			+	+	+/–	+/–		
Reduced sexual desire	+	+	+	+	+	+	+	+
Marital instability	+	+	+	+	+	+	+	+

+, positive consensus
–, negative consensus
+/–, divergent views
Blank, theme not raised

In Narok, sexual restraint/fidelity was not raised by older or younger men but was emphasised by older and younger women. Perhaps sexual restraint represents a gender norm on an internalised feminine ideal that is not shared by Masaai men. On the other hand, both men and women in all age groups unanimously agreed that FGM/C leads to reduced sexual desire among women, which was noted to lead to men engaging in extramarital affairs and thus causing conflicts in marriage. These findings suggest that in Narok, FGM/C was practised to uphold morality in the community and safeguard women's fidelity to their husbands. It is worth noting that while women viewed sexual restraint as an advantage, some men regarded it as a disadvantage as it led to reduction in women's sexual desire and therefore denying men the right to enjoy sex in marriage.

> *"They [women] will not go after men. The blood heat [sexual desire] will cool. Men will not be envious because women that are cut will not go for other men."*
>
> 25-year-old female, FGD, Narok

> *"Circumcised women are different from uncircumcised women. For instance, uncircumcised women have high libido and circumcised women have low libido. In fact, they [uncircumcised women] can stay for a long time without having intercourse with their husbands."*
>
> 45-year-old male, FGD, Narok

> *"Nowadays, men say that the uncut girls are better in bed than the cut ones, so you find mostly they marry more than one wife or go to towns to look for those who are not circumcised leaving the circumcised woman at home. So, you see this FGM even breaks families."*
>
> 35-year-old female, FGD, Narok

In Kisii, the overarching theme of sexuality was discussed across the various FGD breaks. In discussions with younger and elder men, participants were of the view that FGM/C had the advantage of upholding morality in the community as cut girls had sexual restraint due to reduced

libido. Some participants from the FGD with younger men mentioned that sexual restraint promoted fidelity in marriage especially when the husband was away from the wife. However, some participants from the male groups contested this view as they believed that even cut girls could be promiscuous. These findings clearly show tension and contestation with regard to FGM/C and sexuality in Kisii. For example, men are showing that they are clearly split on sexual restraint, and some express a preference for uncut partners, even as a marital partner.

> *"I can say due to regulation of the urge [because of FGM/C], the woman does not have higher sexual desires to have extramarital affairs when the husband is away."*
>
> 20-year-old male, FGD, Kisii

> *"What my colleague has said that it lowers libido, I don't see it as true because I circumcised my daughter and she is 'spoilt' [started having sex early]. The cut ones are the most spoilt…she is the most spoilt of all."*
>
> 48-year-old male, FGD, Kisii

> *"The sensitive sexual part [clitoris]…is chopped off, so it is not there, you are flat…men will search for a woman who has it in Luo tribe."*
>
> 39-year-old female, FGD, Kisii

FGM/C and marriageability

The practice of FGM/C has often been linked to marriage whereby cut women are either considered ready to be married off or men consider FGM/C a requirement before marriage. Table 5 summarises how FGD participants related FGM/C to marriageability across the two counties.

Table 5. Summary matrix of themes related to the overarching theme of marriageability

	Narok County				Kisii County			
Marriageability	Elder men	Younger men	Elder women	Younger women	Elder men	Younger men	Elder women	Younger women
Cut means readiness for marriage / early marriage		+	+	+		+		+
Cut as a prerequisite for marriage		+	+	+		+/–		
Acceptable to marry uncut women	+		+	+	+	+	+	+

+, positive consensus
–, negative consensus
+/–, divergent views
Blank, theme not raised

The topic on whether FGM/C plays a role in influencing marriage prospects was widely discussed in the various group categories across the two counties. In Narok, younger men, younger women, and elder women were in consensus that FGM/C heightened a girl's chances of being married early. This was partly driven by the bride price prospects for parents of the girl since the girl would normally be married off immediately after the cut. While discussants in the younger men, elder women, and younger women categories mentioned that FGM/C was a prerequisite for marriage (possibly in the past), there was an almost unanimous agreement that it was acceptable to marry an uncut woman. Taken together, these findings suggest that there is a contestation of social norms around the value of FGM/C as a prerequisite for marriage.

> *"According to African [Maasai] tradition, female circumcision shows a woman is mature and has reached the age for marriage."*
>
> 24-year-old male, FGD, Narok

> *"Unlike in the past, currently you don't have to be circumcised to be married. In the past, circumcision used to be important to the mother of the girl, because the girl becomes*

healthy, gains weight, then she is married off. This was an advantage to the girl for she will not be regarded as an outcast if she gets pregnant before circumcision, which was known as 'Entaapai'. Nowadays the girls stay uncircumcised, continue with their education, and when it is time to get married they get husbands even if they are not circumcised."

60-year-old female, FGD, Narok

In Kisii, marriageability came out as a common theme from discussions across all groups but more so among younger men and women. Both younger men and women were of the view that undergoing the cut was a sign of readiness for marriage which would result to early marriages. This is puzzling because cutting in this context takes place so long before marriage. There were divergent views among younger men on whether FGM/C was considered a prerequisite for marriage with some observing that a "true" Kisii man cannot accept to marry an uncut woman. In contrast, other younger men observed that the belief that a Kisii man cannot marry an uncut woman has shifted as men are increasingly accepting or choosing to marry uncut women. There was consensus across all groups that currently, it is acceptable to marry an uncut woman.

"There is no benefit because of decreased libido in an uncircumcised woman. That is the reason Kisii men prefer marrying other tribes because they are not circumcised… Nowadays with the sensitisation, men are happy with uncircumcised girls."

35-year-old female, FGD, Kisii

FGM/C and health complications

Table 6 summarises how FGD participants related FGM/C to observed health complications in Narok and Kisii counties.

Table 6. Summary matrix of themes related to the overarching theme of health

	Narok County				Kisii County			
Health	Elder men	Younger men	Elder women	Younger women	Elder men	Younger men	Elder women	Younger women
Immediate health complications – excessive bleeding, pain	+	+	+	+	+	+	+	+
Long-term health complications – keloids, fistula, pain during sex, obstetric complications, psychological torture, HIV infection	+	+	+	+	+	+	+	+

+, positive consensus
–, negative consensus
+/–, divergent views
Blank, theme not raised

In all discussion categories across the two counties, there was consensus among study participants that there are negative health consequences related to FGM/C. Discussants in all groups were of the view that FGM/C leads to both immediate and long-term health complications. Immediate health problems included excessive bleeding and pain during and after the cut. Long-term health complications included the development of keloids, fistula (involuntary leakage of urine and or faeces from the vagina), injury to genitalia leading to pain during sex (dyspareunia), obstetric complications, and psychological torture. Sharing of unsterilized cutting equipment in performing FGM/C increased the risk of infections especially HIV.

"It can cause death and diseases because the circumcisers are doing it illegally and may use unsterilized tools. Diseases like HIV can be transmitted. When the girl grows there will be complications when giving birth."

32-year-old male, FGD, Kisii

FGM/C and culture/tradition

Table 7 summarises how FGD participants related FGM/C to the Maasai and Abagusii cultural/traditional practices in the two counties. The belief in upholding culture/traditions by performing FGM/C came out as an overarching theme in some of the group discussions in Narok and in all FGDs in Kisii. Discussions on culture/traditions centred on whether FGM/C was a rite of passage from childhood to adulthood, whether FGM/C was a source of identity for women, and existence of social sanctions for women who didn't undergo the cut.

Table 7. Summary matrix of themes related to the overarching theme of culture/traditions

	Narok County				Kisii County			
Culture/Traditions	Elder men	Younger men	Elder women	Younger women	Elder men	Younger men	Elder women	Younger women
FGM/C as a rite of passage from childhood to adulthood		+		+	+	+	+	+
FGM/C as a source of identity for women, earns respect from family and community					+	+	+	+
Social sanctions for uncut women – disrespected and given derogatory names					+	+	+	+

+, positive consensus
–, negative consensus
+/–, divergent views
Blank, theme not raised

In Narok, the only sub-theme under culture/tradition that was discussed was the practise of FGM/C as a rite of passage from childhood to adulthood. This was raised in discussions with younger men and women who observed that for a girl to be considered a grown-up and accepted in the community, it was important that she underwent the cut. Failure to go through this rite of passage was considered an act of disobedience and against the Maasai culture and traditions.

"According to the Maasai culture, it is accepted that you are now an adult if you are circumcised. To be accepted in the community, you must go through the cut. So, in any family, you must be circumcised in order to be accepted that now you are a grown-up person."

35-year-old female, FGD, Narok

"One thing that is derailing the fight against female circumcision is culture. Right now, there are those saying stopping female circumcision is breaking the tradition as a community. So, that discourages one from fighting female circumcision."

19-year-old male, FGD, Narok

In Kisii, the belief in upholding culture/traditions came out as a cross-cutting driver of FGM/C in all FGDs. It was reported that FGM/C was an important gender socialisation and feminine identity process and that the cut promoted morality in the community by reducing promiscuity. Practised as a traditional requirement among the Abagusii people, FGM/C gave Kisii women some form of identity, which earned them respect from their peers, family, as well as the community. On the other hand, the uncut girls attracted social sanctions including not being respected and given

names such as “egesagane”— a derogatory name referring to junior immature girls who are not cut. In Kisii, findings indicate that regardless of age, a woman is never recognised as a mature adult or accepted in the community without having been gender identity inculcated, which for Abagusii women means being cut. Therefore, the practice is critically linked with social recognition of womanhood.

> *“What I can say on the advantage of female circumcision is the respect that one receives having graduated from childhood to adulthood… Sometimes we refer to our young uncut girl as “egesagane” – ekegusii word referring to girls who have not undergone the cut, but when cut, we refer them as “enyaroka” – a young girl who has undergone the cut.”*
>
> 52-year-old male, FGD, Kisii

In summary, findings from the two counties showed that there was a significant influence of culture/tradition on the practise of FGM/C, more so in Kisii than in Narok. It is important to note that “upholding tradition” does not mean never changing a practice. As traditions are taken up by younger generations, they can be modified and tailored to fit current circumstances and social concerns. It would be wrong to interpret "tradition" to mean that a practice is entrenched, static, and immutable. Cultural traditions are more commonly understood to be fluid and malleable, and they can vary within a social group. The belief that FGM/C is a rite of passage from childhood to adulthood and a source of identity for women, and the existence of social sanctions for women who do not undergo the cut were more strongly expressed in Kisii than in Narok. It is likely that FGM/C interventions have had a greater positive impact on influencing traditional beliefs and practices associated with FGM/C in Narok than in Kisii where traditional beliefs and practices are still strongly associated with FGM/C. This is strong evidence of gender norms that are linked to the creation of feminine or masculine identities operating heavily in Kisii.

FGM/C and respect

Table 8 summarises how FGD participants related FGM/C to the respect accorded to the cut girl by family or community members, and whether cut girls were respectful of others. The associations between FGM/C and respect was brought up in some of the group categories and entailed discussions on whether a cut girl earned respect from family and/or the community, and whether a cut girl was considered respectful of others.

In Narok, elder men and younger women were of the view that cut women were likely to be disrespectful of others. They observed that since FGM/C was considered a transition from childhood to adulthood in the Maasai culture, girls who are cut view themselves as mature women and as equals to their elders. The notion that the cut girl is mature even though still a junior by age leads to lack of respect by the cut girl to others.

> *“When a girl is circumcised, she sees herself as a grown-up person… her respect for the elder people is lost because she feels that she is an equal to elder women.”*
>
> 35-year-old female, FGD, Narok

> *“When a girl is circumcised, you are encouraging her to quit school if she was in school. Most of them become arrogant and disrespectful to parents and their peers.”*
>
> 37-year-old male, FGD, Narok

Table 8. Summary matrix of themes related to the overarching theme of respect

Respect	Narok County				Kisii County			
	Elder men	Younger men	Elder women	Younger women	Elder men	Younger men	Elder women	Younger women
Cut girl earns respect from family / community					+		+	+
Cut girl considered respectful of others e.g., elders, fathers and husbands	–			–	+			+

+, positive consensus
–, negative consensus
+/–, divergent views
Blank, theme not raised

In Kisii, both younger and elder women seemed to agree that a woman who had undergone FGM/C earned respect from both her family and the community at large. The women explained that the process of undergoing FGM/C entailed exclusion of cut girls to a certain location where they were taught how to relate with other members of the community including their fathers, husbands, and elders—a form of structuring hierarchies of power along lines of gender and generation. On the contrary, uncut girls are often disrespected and given derogatory names such as “egesagane” [uncircumcised girl]. With regards to whether cut girls are considered respectful of others, discussants in groups of younger women and elder men supported the view that cut women were respectful of others. This was because of the training they received during the exclusion period.

> *“Sincerely nowadays, when one is not cut, she has no respect. There were ceremonies among the Abagusii community that could take 30 days where girls were taught after circumcision how to talk to men after they have been initiated into adulthood, how to have respect to their fathers, and not to sit where their parents are seated.”*
>
> 50-year-old male, FGD, Kisii

> *“In the past, they [women] were taught manners on how to handle her husband, dress, walk, and how to respect parent-in-laws. So, it gave her knowledge on what to do and not do that made her to be respected as a Kisii woman.”*
>
> 37-year-old female, FGD, Kisii

Findings from the two counties show stark differences in how communities relate the practice of FGM/C with respect. While communities in Narok seem to associate FGM/C with a lack of respect, communities in Kisii considered a cut woman to be respectful of others and worthy of respect by family and community members. This can be interpreted to mean that the transition from childhood to adulthood, which is marked by girls undergoing the cut, is apparently more valued in Kisii than in Narok. This point is further underscored by the fact that women who failed to undergo the cut in Kisii faced social sanctions including being given derogatory names.

Reasons for change: the role of direct interventions

The role of direct interventions in bringing change towards FGM/C abandonment was assessed by asking study participants about their views on FGM/C abandonment interventions. Knowing that one's cultural practice is targeted for elimination can drive the practice underground and knowledge of health risks can motivate medicalisation. Therefore, interventions can cause intended and unintended responses. Interventions implemented by churches, NGOs, and CBOs were frequently mentioned as examples of direct interventions that influenced the observed changes in Narok and Kisii.

In Narok, interventions spearheaded by churches, NGOs, and CBOs were cited as the reasons for the observed changes in FGM/C. For example, church-led interventions have included campaigns against the practice, taking in girls who are under threat of undergoing FGM/C, and reporting FGM/C cases to the police. Non-governmental organisations have also played a significant role in the decline of FGM/C through community sensitisation and holding ARP programmes.

> *"We have seen lots of changes. The girls themselves do not want to be circumcised…The girls at risk to undergo FGM run to me as a pastor, then I inform the chief, and the girls are taken to rescue centres that help the girls. So FGM cases are no longer a lot... Also, the health professionals who have brought awareness on the complications circumcised women experience when giving birth."*
>
> Religious leader, IDI, Narok

> *"This practise of female circumcision was cherished by our community, but nowadays it is eroding…because of the introduction of the church. Because you see people in church are really preaching against the practice and they really hate that practice and if one is found cutting their child, they are chased from the church… Like us in church, when we hear that you have cut your girl, we tell the chief and we chase you from the church."*
>
> Village elder, IDI, Narok

Similar to Narok, most of the study participants in Kisii felt that the changes in the practise of FGM/C have been brought about by direct interventions spearheaded by NGOs and the church. These interventions are commonly implemented in the form of outreach and sensitisation activities in the community. The focus of these interventions was largely to create awareness among community members on the negative effects of FGM/C.

> *"In the past years, female circumcision was very common but with the emergence of NGOs providing counselling, people have been educated on the negative effects of FGM. I have seen a big change because many people have stopped circumcising girls and I have seen them educate each other and I believe that if this goes on, there will be a big difference in our communities."*
>
> 35-year-old father of girls, IDI, Kisii

Reasons for change: the role of structural interventions

Formal education and the anti-FGM/C law were often mentioned as structural interventions that influenced the observed changes in FGM/C across the two counties. In Narok, formal education was cited as an existing structural intervention that had played a significant role in the reduction of FGM/C in the county. Unlike the past, many people in the county are currently educated and enlightened about the dangers of FGM/C. Community members have also come to appreciate the benefits of taking their children, especially the girls, to school where they can escape the dangers of being cut and early marriage.

> *"Formal education is one major cause of change… Because those who have been taken to school would not wish to participate in the practice… Many of them [girls] are exposed to formal education and many of their parents know the negative effects of FGM so that is why they abandoned the practice."*
>
> Government official, IDI, Narok

> *"There is a connection between literacy and FGM…as the literacy level rises, the FGM rate will go down. So those two things are interrelated."*
>
> Religious leader, IDI, Narok

The legal framework on FGM/C was cited as another structural intervention that had contributed to the observed changes in Narok. Fear of the anti-FGM/C law was quoted as a factor that had led to the reduction in the number of girls being cut. There have been cases where perpetrators of FGM/C were arrested and charged in court and is consequently acting as a deterrent to other

community members. On the negative side, the law has also led to changes in the way FGM/C is practised such as cutting younger girls in secret, medicalisation, and supposedly conducting less severe forms of FGM/C. This is a clear example of how interventions can cause intended and unintended change.

> *"They do not want to go against the law. So, they are kind of abandoning because in the radio I have heard, and I think it is announced…there are some women who were arrested in Narok… I think they started fearing it."*
>
> 38-year-old father of girls, IDI, Narok

> *"The government is causing these changes because if you try to perform it, you would be thinking that there is someone coming after you. There are now many CIDs [undercover criminal investigative agents] and the CHWs [community health workers], as well as the hospitals, they will eventually hear about it and report it."*
>
> Women's group leader, IDI, Narok

In Kisii, education and legislation on FGM/C featured prominently as examples of structural efforts that have resulted in the observed changes in FGM/C. Key informants observed that girls who are in school access information on the effects of FGM/C through school-based programmes and are therefore likely to develop the agency to resist FGM/C. Such girls also act as change agents by influencing other girls and community members to abandon FGM/C. This is nonetheless puzzling on two fronts: first, high rates of girls' education is not as recent as in Narok, and it is questionable whether girls really have the agency to resist FGM/C—there are no rescue centres in Kisii, so girls resisting FGM/C would need to go through legal routes which can be problematic if it involves their family members. All the same, some participants held the view that educated parents were less likely to cut their daughters compared to uneducated or illiterate parents. Additionally, educated community members were considered more receptive to FGM/C interventions geared towards abandonment.

> *"They are not circumcised because they have got the education and they are enlightened and know the truth about female circumcision. They know the consequences and effects of FGM and now they make their own decisions. They have full control of their lives and their bodies. Just like I said before it is because they are educated. Not like in the old days a girl would want to be circumcised because she will inherit some of the wealth from their parents and get respect which was and is naive."*
>
> Women's group leader, IDI, Kisii

> *"Those who are still practising FGM… are not educated… If he or she knows the effect of FGM, he or she will not allow their child to undergo the same thing… because they are aware of the effects and are educated."*
>
> 25-year-old mother of girls, IDI, Kisii

Participants in Kisii were positive that the anti-FGM/C law had somewhat resulted in the reduction of FGM/C because most people are afraid of being arrested for engaging in outlawed practices. Nonetheless, respondents expressed their concerns that the law had led to the practice being performed in secret to avoid arrest. These finding seem to indicate that while the law has managed to instil fear in the community, it has not achieved its aim of eradicating FGM/C among the Abagusii.

> *"It is a bit difficult for the community to accept that law and there is also that perception that the laws are for the government and therefore, it is like a struggle between the common person and the law enforcers… Especially for our community, it has been a very dynamic community in terms of FGM...like now they have come up with a very innovative way of managing the law. The law is there, and the practice is there, why? Because they say if the law is there to ban, then I have to hide and perpetrate the practice. So, I can do my FGM practice at night, I will do it any time. It is not now [conducted in] December as it used*

to be, it will be anytime of the year because a kid will be absent from school for a week and the cut could have been done...I will cut my girl and she would also be outside there playing with other children. So, nobody will notice the practice is there."

Programme implementer, IDI, Kisii

"I have seen changes, especially from last year… Even there is a woman who used to do circumcision but when she heard that there is a fine of 300,000 [Kenya shillings] she disappeared. Nowadays, people are afraid especially those who were assisting her with the circumcisions."

37-year-old father of girls, IDI, Kisii

It is important to note that while the anti-FGM/C law may have contributed to the reduction in the number of cut girls by instilling fear among community members in Narok and Kisii, it has also led to covert approaches in conducting FGM/C. It is therefore useful to tease apart the effects of education versus law. Regarding the law, anecdotal evidence shows that there has been much more vigorous implementation of the law in Narok than Kisii. This is because the prosecutor in Narok has developed some unique strategies for building legal cases and accumulating evidence. This may mean that the perceived threat of detection and prosecution may be much higher among people in Narok than Kisii. There are two main theories on the role of law in social regulation: law and economics versus law and society. The law and economics theory focuses on deterrence, arguing that if people come to view the law as enforceable because of at least a few high-profile cases of punishment, this will raise their perception of the costs and motivate abandonment. On the other hand, law and society notes that legal norms (what the law says you should do) can be at odds with social norms, and when that happens, the sanctions for violating social norms may be perceived as a higher cost than those of violating the law. There is widespread awareness of the law in both Kisii and Narok, but there have been real differences in terms of enforcement. It is also the case that girls in Narok have access to adult advocates who help them seek protection from being cut by going to rescue centres. The law strengthens the stance of these advocates to stand up to parents or family of the young girls. There do not seem to be similar protection mechanisms for girls in Kisii. There is a need to think about differences in power and authority—a little girl in Kisii cannot stand up to her mother and grandmother. In Senegal, Shell-Duncan (2011) and others found that the law sparked multiple responses, not just within communities, but even within families. For some it drove the practice underground while for some who were ambivalent about FGM/C, it empowered their position. Some people were angry about the law for "criminalizing culture" and it sparked reactance (Shell-Duncan et al., 2011).

Barriers to change in FGM/C norms and practices

The study sought to find out existing social, cultural, and structural barriers that limit community-wide abandonment of FGM/C in Narok and Kisii counties. In Narok, the Maasai culture/tradition was cited as one of the barriers in changing norms and practices related to FGM/C. Among the Maasai, FGM/C is practised as a rite of passage from childhood to adulthood. For this reason, the new initiates are considered mature and ready for marriage. Another aspect related to culture and FGM/C was the belief that FGM/C lowers a girls' sexual desire and therefore reduces promiscuity. Maasai parents feared that their daughters would get pregnant before they were cut which was a taboo in the Maasai culture. They therefore forced their daughters to undergo FGM/C as soon as they started experiencing their menstrual cycle. There was also the belief that an uncut woman lacked the qualities of being a "good wife" and making a "progressive home"—possibly a home with children and a wife subservient to the husband. This belief made it challenging for uncut women to find husbands. Other myths and beliefs believed to encourage FGM/C included beliefs that uncut women would experience complications during birth, and that giving birth before undergoing the cut could cast a bad spell on men in the family leading to death.

"In our tradition, it [FGM/C] was for marriage. They felt like if you are not circumcised, you have not graduated to be a woman…I think it discourages the ladies from having different partners, it cuts their sexual pleasure so that they are just rooted at home maybe as a housewife."

39-year-old father of girls, IDI, Narok

"They [uncut women] are treated as girls even when they get children. When they get pregnant while at home, they are treated as outcasts and are taken out of the home not through the gate but through a hole that is made on the fence to signify that this is an outcast. They [the Maasai community] believe that when an uncircumcised girl gives birth…all the men of the family will die."

Village elder, IDI, Narok

The social sanctions that uncut women face were also believed to be a hindrance in ensuring community-wide abandonment of FGM/C in Narok. A girl who was not cut was often considered to have gone against the Maasai culture, traditions, and beliefs, and was therefore declared an outcast. Consequently, uncut women are often ostracised and not allowed to participate in community functions and important celebrations. Instead, they are ridiculed and mocked by their peers and other members of the community. There were however divergent views on whether these social sanctions still exist in the present time.

"Where the circumcised are the majority, the uncircumcised one will be ostracised, criticised, and discriminated… They are not even allowed to participate in community affairs."

Government official, IDI, Narok

"Yes, in the past circumcised girls used to be respected but the uncircumcised used to be treated like an outcast. They didn't participate in traditional ceremonies and also it was hard for them to get married."

42-year-old father of girls, IDI, Narok

Although FGM/C was believed to be against Christian teachings, some Christians were torn between adhering to traditional values and beliefs and obeying Christian teachings. This tension between religion and traditional beliefs led some community members to support the practice in secret while at the same time practising their religion.

"Religion tries to end circumcision, but tradition still supports it. Now you find that there are conflicts between the two and you will find that someone is in church but still practises because they respect both tradition and religion… it is hard for them to choose which side to go."

35-year-old mother of girls, IDI, Narok

In Kisii, the major hindrance to FGM/C abandonment was the interlink between FGM/C and the Abagusii tradition/culture. Nearly all participants were of the view that the Abagusii tradition/culture played a significant role in promoting FGM/C. It was observed that FGM/C is a traditional/cultural practice that is performed when a girl attains a certain age as a rite of passage from childhood to adulthood. Community members therefore perform FGM/C as a practice that enhances their tradition/culture and brings a sense of belonging.

"This [FGM/C] was a social cultural practice…it was acceptable without any questions. So, with or without reason, it was acceptable as part of our culture. So, because it was a practice universally acceptable, then one had no reason to object. Whoever went against it, it was a taboo… mature boys were cautioned not to marry an uncircumcised girl…that tradition encouraged the practice, and everybody accepted it because it was a condition. It was considered as a rite of passage; once a girl has been circumcised, now she has matured, she is ready for marriage… it was like a permit, you go through it, you are permitted for marriage."

Government official, IDI, Kisii

The belief that FGM/C controls a woman's sexual urge and therefore promotes fidelity in marriage was considered a barrier towards FGM/C abandonment (note that this is being contested by men who want a marital partner who can have sexual pleasure). In Kisii, cut girls earn respect from peers and other community members which gives cut girls some form of identity. There are social sanctions for the uncut girls who are considered outcasts and are despised by community members. There are also cases where young girls are influenced by their peers to undergo the cut to avoid ridicule. However, participants noted that the stigmatisation of uncut girls had reduced in the recent past with community members starting to accept the uncut girl.

> *"I have witnessed change in stigmatisation. In the past a girl who was not cut would be told get away from here, you have not been circumcised, you do not belong to our group. These days they don't do that, they have seen that it is normal. They cannot also know whether you have been cut or not, they can't sit you down and inspect."*
>
> Religious leader, IDI, Kisii

Barriers towards community-wide abandonment of FGM/C were also highlighted in FGDs with community members. As shown in Table 9, these barriers included culture/tradition, the practise of FGM/C in secrecy, inadequate awareness of the consequences of FGM/C among community members, and limited resources to implement FGM/C interventions.

Table 9. Summary matrix of barriers towards FGM/C abandonment

Barriers Towards Abandonment	Narok County				Kisii County			
	Elder men	Younger men	Elder women	Younger women	Elder men	Younger men	Elder women	Younger women
Culture/traditions		+/–		+	+	+	+	+
Practice of FGM/C in secrecy			+		+	+	+	+
Lack of awareness	+	+				+	+	
Lack of resources	+					+	+	+

+, positive consensus
–, negative consensus
+/–, divergent views
Blank, theme not raised

In Narok, some of the younger men and all younger women were of the view that culture/tradition served as a barrier to ending FGM/C while lack of awareness or ignorance was mentioned as a barrier by the elder and younger men. There was consensus among elder women that programmes working towards FGM/C abandonment are confronted with a more complex scenario because FGM/C is performed secretly. Elder men observed that due to the vastness and poor infrastructure of Narok County, available resources were inadequate which made it difficult for FGM/C interventions to reach all of the targeted populations, especially those living in remote areas.

> *"One thing that is causing female circumcision is culture. Right now, there are those saying stopping female circumcision is breaking tradition as a community. So, that discourages one from fighting female circumcision."*
>
> 19-year-old male, FGD, Narok

> *"There are people who are still conducting female circumcision in secret. This is because it has been a practice that they are used to, and they are not ready to change. There are also girls who still want to be circumcised…they do it secretly with the mother."*
>
> 60-year-old female, FGD, Narok

In Kisii, across all groups, cultural/traditional practices associated with FGM/C, such as gender socialisation and source of identity for women, were considered significant barriers towards FGM/C abandonment. Equally, there was consensus across all groups that the current changes in the practice whereby families performed the cut in secrecy had made it difficult for interventions aimed

at ending FGM/C. Younger men and all women's groups also noted that inadequate resources limited the reach of FGM/C interventions in target population resulting in a lack of awareness of the consequences of FGM/C among certain groups in the community.

> *"Some people are hard-headed, and some believe that they have to follow tradition…even if you tell them the benefits of not circumcising girls, they don't want to understand."*
>
> 35-year-old female, FGD, Kisii

> *"In Kisii they [girls] are cut secretly by health providers…they should stop even be arrested."*
>
> 30-year-old female, FGD, Kisii

Discussion

The first objective of this study was to explore how FGM/C interventions implemented in Narok and Kisii counties have influenced community values deliberations. Study findings showed that programme implementers used a mix of approaches to pass information, mostly on the health consequences of FGM/C, with the aim of encouraging community members to abandon FGM/C. Coordinated group reflections on local values, aspirations, beliefs, and experiences related to FGM/C that are capable of spurring community-wide abandonment of FGM/C were less common. Furthermore, FGM/C is a harmful social practice constructed from expectations and rules that members of a group follow and approve of following. Just like other social beliefs and practices, FGM/C is a complex behaviour that is deeply entrenched and hard to change with simple interventions (Cislaghi, Gillespie, and Mackie, 2016). Research has shown that FGM/C interventions that utilise approaches that emphasise coordinated abandonment and values deliberations are more likely to succeed (Mackie, 2009; UNICEF, 2010). To alter harmful social norms such as FGM/C, it is therefore recommended that deliberate efforts are made for adoption of beneficial new norms beginning with a core group, which engages in values deliberations and diffuses them to the remainder of the community until a tipping point is achieved and enough people are ready to change (Mackie, 1996; Mackie and LeJeune, 2009). A community's shift from approving a harmful social norm to adopting a beneficial new social norm requires changing expectations at the community level rather than at the individual level. Indeed, effective abandonment of FGM/C requires genuine community discussions, decisions, and commitment (Mackie and LeJeune, 2009). Discussions to decide on the course of action and the way forward requires a public sphere open to all that fosters agency among community members to bring the desired change (Cislaghi et al., 2016). Considering that the practice has recently transformed from a public event to an event practiced in secret, interventions that target individual beliefs and attitudes cannot be ignored.

The phenomenon of rescuing girls and keeping them in safe houses as a form of intervention common in Narok requires a critical analysis. At the heart of this type of intervention are adults helping girls claim their rights which seems to come at a price—breaking ties with their family. There were reports that rescue centres reach out to families to try and reconcile the rescued girls with their families. Nonetheless, it was not clear whether values deliberation occurs amongst those who reach out to the families. Archambault's (2011) ethnography on early marriage among the Maasai illustrates how prevailing concepts of "tradition," "culture," "victimhood," and "collective rights" in human rights theory obscure important structural factors that perpetuate such practices. She notes that since the passing of the Children's Act of 2001, a myriad of interventions spearheaded by international, national, governmental, and NGOs have been implemented in Kenya campaigning against and monitoring gender-based infringements on the rights of the child. An example of such interventions includes rescue centres that proceed to "free" girls from the common fate of child marriage and the practice of FGM/C. Archambault argues that such

interventions depict local practices, such as early marriage, as a violation of a girl's right to education by perpetrators who are motivated by tradition, culture, patriarchy, and greed. Contrary to this perspective, she highlights the need to contextualize such practices brought about by cultural change and growing poverty and marginalization. Decisions to marry girls early or perform FGM/C are made with intentions, not necessarily as a symbol of patriarchal oppression but rather of concerned parents. Simplifying the discourse to a violation of girls' rights misses the point as the perpetrators could be victims of economic, ecological, and political forces beyond their control (Archambault, 2011).

While the main purpose of rescue centres is to save girls escaping FGM/C or early marriage, our study findings showed that girls appreciated other benefits provided at the rescue centres, especially sponsorship for their education. The benefit of educational opportunities at the rescue centres raises important questions: Are girls who are not in school at all ever rescued? Do they provide any opportunities to resist cutting when education is not part of their strategy for future security? Maasai parents hold education in high esteem and make great investments in educating their children but are confronted with challenges such as access to school, high dropout rates, poor quality learning, curriculum bias, and low achievement. Consequently, investment in education does not always translate into livelihood security, especially for girls. Such parents therefore continue to turn to the social institution of marriage or engage in practices such as FGM/C as a means of securing their children's future (Archambault, 2011).

The second objective of the study was to investigate changes in norms and practices resulting from combined direct and indirect change efforts in Narok and Kisii counties. Changes in norms and practices that promoted continuation of FGM/C were noted across the two counties. There was a definite shift from FGM/C being practised as a community event with celebrations to an event organised by individual families and conducted in secrecy. Medicalisation was more common in Kisii compared to Narok. In both counties, there were apparent shifts towards performing less severe forms of FGM/C among younger girls who were likely not to offer resistance. These changes mirror the findings of Shell-Duncan and colleagues (2017) who used the four waves of the Kenya Demographic and Health Surveys implemented in 1998, 2003, 2008-09, and 2014 to study when, where, and how FGM/C has been carried out, and trends in changes in the practice (Shell-Duncan et al., 2017). Their findings showed that the reported rates of FGM/C among daughters were highest among daughters of ethnic Somalis (36%) and Kisii (16%). Disaggregation of data by age cohorts showed a trend towards reduction of age of cutting and less severe forms of FGM/C. Comparing data for mothers against daughters showed that girls were being cut at earlier ages and were more likely to experience medicalised FGM/C than were their mothers (Shell-Duncan et al., 2017). Changes to supposedly less severe cuts are likely to be a response to the anti-FGM law that prohibits FGM/C. Additionally, perpetrators of FGM/C seem to be responding to the health consequences of FGM/C narrative by procuring services of a health professional to make the practice safer (Njue and Askew, 2004; Shell-Duncan, 2001). This demonstrates that people are willing to modify the way FGM/C is carried out, more so than abandon it. The question is whether the heightened sense of risk can be used to leverage abandonment.

Across the two counties, community members believed that FGM/C lowers women's sexual desire which was associated with marital instability due to sexual dissatisfaction among men. A woman's diminished sexual desire as a result of undergoing FGM/C reportedly triggers infidelity and conflict in marriage as the man engages in extramarital affairs. Conversely, while women considered sexual restraint as an advantage attributed to FGM/C as it upholds morality and fidelity in marriage, some of the male respondents found it a disadvantage as cut women were considered less satisfying sexual partners. According to Grace Mose's (2008) ethnography on FGM/C in Kenya, women's sexuality is targeted because it is viewed as threatening to the male culture. Marriage plays a key role in ensuring there is no uncontrolled sex outside of marriage that will contaminate

one's lineage, clan, and the community at large with "bad" blood. Therefore, FGM/C is intended to control excessive sexual desire and ensure women remain virgins until they are betrothed (Mose B, 2008). The association between FGM/C and sexuality has often been linked to the belief that women are naturally promiscuous unless their genitalia is physically altered (Mackie and LeJeune, 2009). The practice of FGM/C has therefore been used as a tool to suppress female sexuality (Jones, Ehiri, and Anyanwu, 2004) in communities that practise FGM/C to uphold virginity at the time of marriage and fidelity after marriage (Jones et al., 2004; Muteshi and Sass, 2005).

Divergent from the narrative that FGM/C encourages fidelity in women to their husbands and is therefore beneficial to the man, findings from this study provide interesting insights on this matter. Data from Narok and Kisii have shown that the negative effects of FGM/C in relation to sexuality may have prompted a shift in norms where men now prefer uncut girls or marry women from tribes that do not practise FGM/C in order to experience sexual satisfaction in marriage. Across the two counties and in all the FGDs, there was a firm belief that FGM/C had the disadvantage of lowering women's sexual desire which was associated with marital instability due to sexual dissatisfaction among men. A woman's diminished sexual desire resulting from FGM/C triggered infidelity in marriage as the man started engaging in extramarital affairs that led to marital conflicts. Notably, while women reported sexual restraint as an advantage attributed to FGM/C as it encouraged upholding morality and fidelity in marriage, some participants from the male discussion group found it a disadvantage as cut women were considered less sexually satisfying partners—suggesting that men may play a greater role in abandonment efforts. The ambivalence in how women talk about their sexuality suggests the need to further interrogate the meaning of sexual health and pleasure in these communities.

The negative effects of FGM/C in relation to sexuality have prompted a shift in norms where men are now preferring uncut girls or marrying women from other tribes that do not practise FGM/C in order to experience sexual satisfaction in marriage. Therefore, FGM/C as a matrimonial strategy is not an uncontested strategy. For example, in Kisii County some men say uncut girls can still be promiscuous, but the theme of sexual restraint was not raised by women. They all agree that it is a cause of marital instability, but still see it as important for reducing the sexual desire of women. It seems that FGM/C as a marital strategy is questioned, but women seem to firmly adhere to the gender norm of sexual restraint, with FGM/C serving as an embodied form of feminine virtue. It therefore appears that the cut girl has reduced prospects for marriage in contemporary society. If men are beginning to prefer uncut women, and if everyone agrees that FGM/C can cause marital stability, it is critical that programme implementers begin addressing gender norms and more specifically, what is considered appropriate sexual behaviour for each gender. This point is further corroborated by findings on associations between FGM/C and marriageability.

A cross-county analysis examining associations between FGM/C and marriageability showed consensus on the possibility that FGM/C heightens a girl's chances of being married early. From these discussions, it was evident that girls who are cut are likely to be married off after undergoing the cut. There is however ambivalence regarding FGM/C being a prerequisite for marriage especially in Narok. While discussants mentioned that FGM/C was a prerequisite for marriage (mostly in the past), there was consensus that it was currently acceptable to marry an uncut woman. These findings bring into perspective the social norms theory which suggests that the practice of FGM/C is significantly perpetuated by concerns over marriageability (Mackie, 1996; Mackie and LeJeune, 2009). Similar to findings in Senegambia (Shell-Duncan et al., 2011), this study found weak evidence in support of the marriage convention hypothesis. Across the two counties, it appears that FGM/C was linked to marriageability in the recent past but there have been changes. From a norms perspective, this indicates that the reference group may be changing. A balanced view of FGM/C and marriage is therefore needed to avoid stigmatisation of a whole generation of girls who are already cut.

A majority of community members in Narok and Kisii were knowledgeable about the health consequences of FGM/C. The lingering question is why would community members continue cutting their daughters in full knowledge of the health risks involved? Since the advent of interventions against FGM/C, provision of information about the health risks associated with the practice has been the most popular approach (Johansen et al., 2013). This approach builds on the premise that awareness about the negative health effects of FGM/C will lead to abandonment of the practice (Kaplan et al., 2011; Toubia and Sharief, 2003). Evidence shows that the health risks approach has been successful in reducing FGM/C, especially in contexts where religion is a significant driver, and in influencing policy makers to promote laws and regulations against FGM/C (Johansen et al., 2013). Nonetheless, it is equally evident that the health risks approach can lead to changes other than abandonment, most commonly an increase in medicalisation of the practice and changes in the type of FGM/C (Johansen et al., 2013; Shell-Duncan, 2001). Our study findings suggest that FGM/C programmes have been using the health risks narrative in implementing their interventions and to some extent have been successful in transferring this knowledge to the public. However, it looks like knowledge of the health consequences associated with FGM/C alone may not lead to abandonment. Positive stories of what it looks like when a girl is not cut, and FGM/C survivor talks from experience of the practice are likely to bring success.

Across communities that practise FGM/C, culture is one of the key drivers of the practice. In these communities, FGM/C seems to be a cultural practice that is held in place by reciprocal expectations about conforming to shared social norms (Berg and Denison, 2013; Mackie and LeJeune, 2009; Muteshi and Sass, 2005). Findings from this study showed that a constellation of norms play a significant role in facilitating FGM/C. The belief that FGM/C is central to instilling gender norms such as sexual restraint and a source of identity for women, and the existence of social sanctions for the uncut was strongly expressed in Kisii. A look at communities that practise FGM/C in Africa shows that it is often practised out of respect for and in conformity to society's cultures and traditions (Muteshi and Sass, 2005). Among some of these communities, FGM/C confers social acceptance or a sense of belonging (Muteshi and Sass, 2005). Social sanctions for noncompliance with the normative expectations including shame, stigmatisation, a decrease in marriage prospects, rejection, and ostracisation have been reported (Muteshi and Sass, 2005). In Kenya, specifically concerning the Abagusii people, research has shown that FGM/C is associated with beliefs about maturity, obedience, and awareness of a woman's role in the family and society arising from a process of gender socialisation—character traits that are highly valued among the Abagusii (Njue and Askew, 2004). In her ethnography on FGM/C among the Abagusii, Grace Mose (2008) notes that the Abagusii culture has been changing as a result of globalisation and that cultural practices among the Abagusii are not static. Our study findings point to the possibility that FGM/C interventions have been more impactful in influencing traditional beliefs and practices associated with FGM/C in Narok than in Kisii where gender norms, traditional beliefs, and practices are still strongly associated with FGM/C. The fact that young men are increasingly marrying uncut women means that the link to marriageability has weakened. This may open the door for other changes in norms and meanings for FGM/C.

There were stark differences in how communities in Narok and Kisii associated FGM/C with "respect". It is important to contextualise the term respect in this case where it refers to being less aggressive, more obedient, and more subservient. For example, women are "valued" for being weak and agreeable even when the injustices abound. A woman has higher social standing if she is tolerant of norms related to male dominance and condemned for going against the "values" that constrict women (Mose B, 2008). Respondents in Narok associated FGM/C with lack of respect while those in Kisii considered a cut woman to be respectful of others and was treated with respect by family and community members. In communities where FGM/C is prevalent, social pressure and the fear of losing social standing for the uncut girl and her family are important factors that sustain FGM/C (Hernlund and Shell-Duncan, 2007; Mackie and LeJeune, 2009). Women in such communities undergo FGM/C to show bravery and respect for their family, and in some contexts

to transition from girlhood to womanhood (Hernlund and Shell-Duncan, 2007). A study conducted among the Abagusii and the Kuria revealed that in both communities, girls undergoing FGM/C were celebrated and more socially accepted. On the contrary, uncut girls and women frequently experienced stigma, isolation, and ridicule (Oloo, Wanjiru, and Newell-Jones, 2011). Our study findings suggest that social norms associated with FGM/C are more strongly upheld and enforced in Kisii than in Narok. This point is further underscored by the fact that women and girls in Kisii who fail to undergo the cut appear to face more social sanctions than those in Narok. Changing norms regarding marriageability may, however, herald further change.

The third objective of the study was to assess social, cultural, or structural barriers to change in FGM/C norms and practices. Study findings showed that culture/tradition, the belief that FGM/C controls a woman's sexual urge and therefore promotes fidelity in marriage, social sanctions against the uncut, the practise of supposedly less severe forms of FGM/C on younger girls by health professionals and conducting FGM/C in secret posed a challenge to abandonment efforts. The term "tradition/culture" in this case needs to be interpreted in light of gender norms that define culturally upheld ideals of femininity and female gender identity. The fact that gender norms transform a girl into a woman is a crucial social aspect. Women who have been cut embody feminine virtues such as sexual restraint and respect for elders. It defines their "insider" status, feminine identity, group belonging, and access to social acceptance and support. Lack of adequate resources to sustain implementation of FGM/C interventions in target populations may also limit the impact of interventions to bring about the desired behaviour change. These barriers are not unique to this analysis as they have been noted in other studies assessing FGM/C abandonment interventions (Berg and Denison, 2013; Evelia et al., 2007; Johansen et al., 2013; Jones et al., 2004; Muteshi and Sass, 2005).

Limitations

The study was conducted in only two study sites and therefore findings from this study may not be generalisable to other contexts. However, these are "hot spot" communities where many interventions have taken place. An improved understanding of social norms and the dynamics of change can be useful for optimising these interventions.

Qualitative data, particularly the responses of programme implementers, may be overly positive as they might have felt obligated to provide positive responses regarding their attitudes towards FGM/C and their experiences during implementation of project activities. The combination of FGDs, IDIs, and observation of programme activities/community events helped to triangulate more representative insights.

It is important to note that it is not possible to infer a cause and effect narrative from this study. For example, we do not know if interventions have changed norms, or if shifts could be attributed to factors like the indirect effects of girls' education. What is important is the fact that even though the study areas are considered hot spots of FGM/C, norms and practices are not static. While there might not be widespread abandonment yet, individuals are reassessing norms and traditions in light of the current social climate.

Conclusion

Working in two areas known as "hot spots" where rates of abandonment have lagged well behind some other areas of Kenya, this study made an effort to look more closely at the social context and the norms and meanings that uphold the practice of FGM/C. The researchers explored ways in which the circumstances surrounding the practice may be changing, and thus altering the way FGM/C is carried out. Examining what people describe as the positive social meanings, risks, and

reasons for ambivalence provides useful information for thinking through how and where to engage communities in discussions on abandonment. It is clear from this study that even when there is not large-scale abandonment, this does not mean that the practice is unchanging, static, or deeply rooted. There is variation in each of the communities in terms of attitudes and the way in which FGM/C is being carried out. There are also elevated perceptions of risk associated with FGM/C—both the health risks and risks of legal detection. Additionally, results from Kisii indicate the possibility that FGM/C may no longer serve as a useful matrimonial strategy, but actually reduce chances of marriageability. The latter may reduce positive normative associations with FGM/C, but the first two are increasing negative associations of risk. People are adopting changes to try to manage risk: medicalisation, younger age at cutting, carrying out FGM/C in secret, less severe cutting – these are all strategies to reduce risk of adverse health outcomes and criminal punishment.

The main message to be gleaned from this study is that even though the prevalence of FGM/C has remained high, there are substantial changes in the way that FGM/C is practiced. Change is indeed underway. The question then is who are the change leaders and how can the ongoing change be leveraged to promote abandonment? There are local women who are opening organisations that work on children's rights, including protection against FGM/C. Child protection has become increasingly an enterprise for local women that can be leveraged in bringing change. However, such organisations are usually underfunded, implementation of their intervention activities erratic, and sometimes dictated by funders' objectives. Deliberate efforts to fund these local, grassroots organisations is critical. Men's shifting preference for uncut women makes them an important demographic in FGM/C programming. Both men and women should be given roles to work towards FGM/C abandonment. Focusing on the diversity of attitudes and practices is an important contribution.

The other important finding from this study relates to gender norms and their influence on FGM/C. Gender norms are a subset of social norms that are important for socialisation on culturally acceptable notions of femininity and women's roles. Since gender norms arise from a process of gender socialisation, it seems that critical reflection and community dialogue might include strategies for assuring the future well-being of girls. Grace Mose (2008) makes a compelling point that discriminatory gender norms harm both men, women, and the whole family. Reflection upon this point may provide a useful inroad for re-appraising negative outcomes of FGM/C beyond health risks, and garner support for positive changes that are already underway.

Implications for Programmes and Research

Programmatic implications

- **An integrative approach in programme implementation, with a clear focus on engaging community members in values deliberation, will facilitate community-wide FGM/C abandonment.**

  Evidence has shown that successful interventions in facilitating FGM/C abandonment adopt a collective process. The process involves exposure to new information, provision of possible alternatives, intense community deliberation within the social group, organised diffusion, and public declarations or other manifestations of commitment to a new social rule (Mackie and LeJeune, 2009; UNICEF, 2013). Additionally, programmes that adopt a holistic approach that provides support for a wide range of community needs and interests are more likely to be embraced by the community and therefore successful (Mackie and LeJeune, 2009).

As Mackie and LeJeune (2009) note, attaining stable coordinated abandonment of FGM/C requires several steps that begin with ensuring that the greater part of the community practising FGM/C is involved in community discussions to change their attitudes. Community discussions in this case refer to genuine discussions and debates on the merits of continuing or abandoning FGM/C. Importantly, community members must gain awareness of the existence of an alternative to FGM/C and the alternative must become valued more highly than the practice. After community deliberations, a decision to abandon FGM/C is reached and supported by the greater part of the community. This is followed by a commitment from community members through a declaration and a coordinated genuine abandonment plan with monitoring procedures (Mackie and LeJeune, 2009). In communities where peer pressure is rampant, and girls seek FGM/C by themselves, there is a need for concerted efforts to reduce the stigma of being uncut.

- **Programme implementation should integrate a human rights approach and address gender norms while not overly focussing on the health risks approach to encourage community members to abandon FGM/C.**

  It seems that the health risks and criminal punishment risks are not offset by the values associated with gender norms and the formation of female identity. Discriminatory gender norms have adverse consequences not only for girls and women, but for the whole family. Changing discriminatory norms should therefore be a concern of both men and women. For example, since men's marriage preferences in Kisii have begun to shift, there is more room to explore the way that both men and women across generations might be engaged in the change process.

  Programmes that design their interventions in ways that promote human rights and are respectful of the culture and the values of local communities are likely to be successful in addressing harmful practices. Research has shown that before the introduction of participatory human rights education, FGM/C interventions primarily focused on the health risks messaging had limited success (Rogo et al., 2007). The introduction of broad deliberations about human rights in changing social norms within the local context has shown great potential in scaling down FGM/C (Mackie and LeJeune, 2009). There are certainly mixed outcomes of the rescue centre phenomenon. It provides a mechanism for protecting the rights of girls that is preventive in nature, in contrast to criminal punishment that happens after-the-fact. Rupturing relations with family is certainly a negative risk of rescue centres but the positive is child protection. There is need for effective child protection measures in Kisii. The challenge for intervention programme designers is to find ways of promoting child protection by thinking creatively about prevention.

- **Programme activities should be anchored on a theory of change.**

  Closely related to the programmatic implication of community values deliberations is the importance of tailoring intervention activities based on a theory of change. Cislaghi and Heise have recently published a practical framework (the dynamic framework for social change) that can be used by programme implementers in planning and designing health interventions aimed at changing social norms (2018). Using this framework, programme implementers begin by identifying factors hypothesised to generate or sustain the behaviour of interest (in this case FGM/C) through available research, practice-based evidence, and formative research. They then bring together collaborating partners to develop a theory of change to inform intervention development (Cislaghi and Heise, 2018).

- **Sufficient resources must be allocated to programmes implementing FGM/C interventions.**

  Interventions meant to support communities to take collective action to change social norms and harmful traditional practices such as FGM/C require sufficient resources and commitment over the long-term to ensure successful and sustainable change (Muteshi and Sass, 2005). Adequate resources in this case will enable programmes to increase the reach of their interventions in the target population. Programme activities will also be implemented within a timeframe necessary to bring about the desired behaviour change.

Research implications

- **A quantitative survey measuring communities' readiness for change is needed**

  Stages in readiness for change are key to effective programming. Future research should conduct a quantitative survey with a representative sample of the targeted community to effectively measure the community's readiness for change.

- **Research is needed on the use of religious approaches in tackling FGM/C**

  Across the two sites, there was considerable involvement of churches in the implementation of FGM/C interventions. It will be imperative to find out communities' perceptions about the involvement of churches/church leaders in the fight against FGM/C and how best to engage them in FGM/C programming. Additionally, finding out whether the religious organisations create forums for open discussions and critical reflection on values will be key.

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