

IMPACT EVALUATION OF COMMUNITY LED ALTERNATIVE
RITE OF PASSAGE MODEL TO ERADICATE FEMALE GENITAL
MUTILATION/CUTTING IN KAJIADO COUNTY, KENYA

Anthony Mveyange, Samuel Oji Oti, Martha Bande, & Hellen Kayiaa
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Approval

Reviewed by:

Title: Programme Director, RMNCAH & Nutrition

Name: Anne Gitimu

Signature: _____

Date: _____

Reviewed by:

Title: Monitoring, Evaluation and Research Manager

Name: Samuel Muhula

Signature: _____

Date: _____

Approved by:

Title: Country Director

Name: Dr Meshack Ndirangu

Signature: _____

Date: _____



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LIST OF ABBREVIATIONS

ARP	Alternative Rite of Passage
CLARP	Community Led Alternative Rite of Passage
CBO	Community-Based Organisation
CoG	Council of Governors
CPO	Children Protection Officer
CSO	Civil Society Organisation
DiD	Difference in Difference
DEQ	Detailed Evaluation Question
CEFM	Child Early and Forced Marriages
ESRC	Ethics and Scientific Review Committee
TP	Teenage Pregnancy
FGD	Focused Group Discussion
FMG/C	Female Genital Mutilation/Cutting
HEQ	High-level Evaluation Question
ICF	Informed Consent Form
IDI	In-Depth Interview
KDHS	Kenya Demographic Health Survey
KII	Key Informant Interview
MCA	Member of County Assembly
NCPD	National Council for Population and Development
SRHR	Sexual Reproductive Health and Rights
TBA	Traditional Birth Attendants
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

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EXECUTIVE SUMMARY

Founded in 1957, Amref Health Africa is an international health development organisation whose core mission is to increase sustainable health access to communities in Africa through solutions in human resources for health, innovative health services and solutions and investments in health, all geared towards a Universal Health Coverage (UHC). With a presence in seven African countries and one hub in Western Africa, Amref prides itself as the leading champion of a people-centred UHC that ensures individuals and communities - who are at the centre of our programmatic work – in Africa access the essential and quality health services they need without suffering financial hardship.

Amref Health Africa in Kenya commissioned an independent impact study of one of its interventions – the community led alternative rite of passage (CLARP), rolled out for the first time in 2009 in Kajiado county. The objectives of the study were: i) To determine the impact of the CLARP model on the following outcomes; Female Genital Mutilation/Cutting (FGM/C), child early and forced marriages (CEFM), teenage pregnancies (TP), and educational outcomes; ii) Explore and document experiences and stories of CLARP and non-CLARP beneficiaries, as they relate to child early and forced marriages, educational attainment and teenage pregnancy; iii) Explore the attitude, perception and practices of community stakeholders towards FGM/C practices.

This report comprises of two interlinked sections. The first section uses quantitative analysis which builds on quasi-experimental approaches to quantify the impacts of the CLARP model on FGM/C and other range of health and education metrics in Kajiado county. The second section deploys a qualitative approach to complement the quantitative analysis further. While the evaluation emphasised the CLARP model implemented in Kajiado county, the impact analysis also provides broad insights on three core areas: the **lessons** of what works and does not work for the CLARP model, **accountability** of CLARP results and overall value independently and impartially consistent with generally accepted principles and standards for evaluation, and **advocacy and fundraising** efforts in line with Amref's mission and vision.

Methodology

In response to the need to change societal norms that undermine girls and women, especially in Maasai societies where FGM/C practices are rampant, Amref designed and rolled-out the CLARP intervention in Kajiado county which is predominantly Maasai. The main objective of the CLARP intervention was to reverse the then alarming FGM/C prevalence rates.

The analysis used difference-in-difference (DiD) approach to quantify the average impact of the CLARP model, focusing on Kajiado as the intervention county, with Mandera, Marsabit and Wajir as control counties. The quantitative analysis exploited the Kenya Demographic and Health Survey (KDHS) data 2003, 2008-2009 and 2014. Also, the study collected qualitative data from various stakeholders to document individual stories and determine their attitude and practices towards FGM/C.

Main findings

- i) FGM/C prevalence declined by 24.2 per cent in Kajiado compared to control counties (Marsabit, Mandera and Wajir).
- ii) Schooling years for girls and women increased by 2.5 years in Kajiado compared to control counties (Marsabit, Mandera and Wajir).
- iii) Child early and forced marriages rates declined by 4.9 per cent in Kajiado compared to control counties (Marsabit, Mandera and Wajir); and
- iv) Teenage pregnancy rates declined by 6.3 per cent in Kajiado compared to control counties (Marsabit, Mandera and Wajir).

Qualitative analysis indicated that key perceived benefits demonstrated by the girls who went through CLARP are:

- i) CLARP delays marriages and childbirth.
- ii) CLARP leads to better school retention and completion.
- iii) CLARP reduces teenage pregnancies.
- iv) CLARP contributes to the declining FGM/C prevalence in Kajiado county.

Analysis of the perceptions, attitudes and practices of community stakeholders about FGM/C practices, shows a strong consensus that the communities in Kajiado County have positively embraced CLARP, which has also shown demonstrable impacts in the lives of its beneficiaries and their families. However, there remain some barriers to the intervention's total effectiveness. These are:

- i) Some resistance to cultural change, especially by elders;
- ii) Persistent stigma among uncut girls and women;
- iii) Persistent peer pressure among girls to undergo the cut; and
- iv) An increase in secret cross-border FGM/C.

Limitations

The study has three main limitations:

- i) The quantitative analysis used 2003, 2008-2009, and 2014 KDHS data, which are dated. Collection of KDHS is after every four years. The 2018 data has not been released for public use yet and thus was not included in the analysis. The interpretation of the results must, therefore, consider one important caveat: the documented impacts of CLARP interventions may have worked during the period 2003-2014 only. It is essential to treat the estimated results as upper-bound effects that can be revised down in magnitude once more recent data is available to complement the present analysis.
- ii) Using aggregated KDHS data to isolate and attribute the specific impacts of CLARP interventions on the Maasai community is difficult because sampled respondents came from different ethnic groups (also living in Kajiado and practice FGM/C). A back of the envelope calculation indicates that roughly 19.4 (out of 67) per cent of non-Maasai KDHS respondents underwent FGM/C and lived in Kajiado during 2003, 2008-2009 2014 surveys. Therefore, the generated analysis and reported results had relied on one fundamental assumption: KDHS respondents living in Kajiado are directly or indirectly related to Maasai culture and that the results should be interpreted more broadly across Kajiado and not necessarily to Maasai respondents and communities.
- iii) A comparison of the quantitative and qualitative findings is indirect (and not direct): analyses from both approaches follow different underlying data generating processes. For-example, while quantitative analysis captures Kajiado county, the qualitative data was only captured from Oloitoktok and Magadi, which are segments of Kajiado. Similarly, the presence of time lags in data collection and availability: quantitative analysis used secondary data for the period between 2003 and 2014, whereas qualitative analysis used the most recent primary data collected in 2019.

Recommendations

The study proposes three main recommendations:

- i) Sustainable CLARP models that place responsibility for continued community discussion, a continuation of knowledge diffusion and public declarations should be adopted. The existing CLARP models run on-and-off projects to specific hotspot locations as opposed to a full-fledged programme that can be scaled-up to a large community. Social norms like FGM/C take time to change, and change is made possible through extended engagements with communities to a level where "tipping points" are realised to result in the sustained change.

- ii) Integration of communities' leaders, local stakeholders and law enforcement agencies (including border authorities) in the CLARP model should be encouraged and trained to work with communities in changing social norms, rather than rigidly apply the law. Failure to appreciate the deep-rooted cultural drivers of FGM/C that take more than legal action to change has resulted in changed forms of FGM/C (e.g., medicalisation, cutting of girls at a younger age, and secretive practices) which fail to eliminate the practice but makes prevalence undetected.
- iii) Investing in high-quality, and state-of-the-art automated data collection and management infrastructure and human resources needed to manage, collate and analyse data is critical. Creating a state-of-the-art database that can help keep track of CLARP beneficiaries and their families useful for following up on their progress post-CLARP training -- to provide the necessary support (e.g., psychological support) or re-engage girls for various CLARP-related community activities such as school visits, and intergenerational dialogues.

Conclusion

Quantitative analysis of the study revealed that CLARP intervention played a decisive role in attenuating FGM/C, CEFM and TP in Kajiado. The results also indicate that the interventions increased schooling years for girls in the County. The qualitative analysis further confirms the quantitative results. Specifically, the findings show that the CLARP model is slowly being embraced by the Maasai communities (in the two hotspots of Magadi and Oloitokitok) and its implementation has left positive experiences on the ground. Additionally, the intervention empowered girls and women to claim and protect their social and human rights, aside from further improving their lives. Overall, the results show significant contributions of the CLARP interventions in reducing the adverse impacts of FGM/C and its related manifestations in Kajiado County.

1. INTRODUCTION

1.1 An Overview of Amref Health Africa

Founded in 1957, Amref Health Africa is an international health development organisation whose core mission is to increase sustainable health access to communities in Africa through solutions in human resources for health, innovative health services and solutions and investments in health, all geared towards a Universal Health Coverage (UHC). With a presence¹ in seven African countries and one hub in Western Africa, Amref prides itself as the leading champion of a people-centred UHC that ensures individuals and communities - who are at the centre of our programmatic work – in Africa access the essential and quality health services they need without suffering financial hardship.

In Kenya, Amref works closely with both the central and county governments and other stakeholders to effectively support Kenya's Big Four-goal on affordable healthcare for all, especially women, children and youth. Aligned with Kenya development vision 2030, three key pillars characterise Amref's work in Kenya: human resources for health, innovative health services and solutions, investments in health. With an average annual budget of US\$ 35 million, Amref Health Africa in Kenya works with a diverse range of communities from urban slums in Nairobi, remote rural areas in the north-east and south, to lake regions in the west and coastal regions in the east.

Amref's theory of change hinges on improving the lives of disadvantaged people through better health, bridging gaps between communities, health systems and governments, and by being a leading force for advocacy for health system reforms. Amref's strategic implementation of programmes and project in Kenya primarily feed to and from the ever-changing Kenyan health landscape. For-example, the country is categorised as a lower middle income triggering the commencement of a shift among development agencies to move away from a traditional donor-recipient relationship with Kenya to an equal bilateral partnership of doing business. Also, Kenya's under-investment in health despite being a signatory to the Abuja 2001 declaration. Similarly, the burden caused by communicable, non-communicable diseases and maternal and neonatal mortality. As a leader in the NGO community operating on health and development issues, Amref also endeavours to address supply-side constraints. For example, Amref addresses the gap in human resources in the health sector by developing relevant training programmes, under-investment in the health sector by strategically investing in health through social accountability, financial protection, and budget advocacy. Considering Kenya's vibrant, youthful population, Amref Kenya's theory of change seeks, at the impact level, to support and spur Kenya's 2030 vision and movement towards the attainment of the Sustainable Development Goals.

1.2 An overview of the CLARP model

Towards supporting the lives of marginalised Kenyans through better health and advocacy for health reforms, in 2009 Amref Health Africa in Kenya, designed and implemented a novel intervention – dubbed community led alternative rite of passage (CLARP) -- aimed at curbing the devastating FGM/C prevalence rates in the country. Successfully piloted and rolled out in Kajiado county, this community-led intervention sought to change social norms and reverse the alarming trends in FGM/C rates in Kajiado by involving and engaging community stakeholders including cultural leaders, Morans, traditional birth attendants, County Governments, religious and cultural leaders.

¹ In Ethiopia, Kenya, Malawi, South Africa, Tanzania, Uganda, and Zambia.

The whole CLARP process takes 6-48 months to complete, and it entails several steps as summarised in [Box 1](#).

Box 1: Community Led ARP model process

Step 1: Context analysis, identifying entry points.

- Engaging stakeholders – cultural leaders, Morans, female circumcisers/TBA's, County government department and religious leaders

Step 2: Community Led ARPs Triggering –structured community dialogues facilitated

Step 3: Sensitization and training of Cultural Elders, Morans, women groups and circumcisers – Communities define their own ARP process

Step 4: Community mobilization and sensitization & training – collaboration and strengthening of CSO's (e.g. local women groups, youth-led organisations, etc...)

Step 5: CLARP 3-days training of boys and girls on sexual and reproductive health rights, positive norms & values, self-esteem, life skills.

Step 6: CLARP ceremony with girls' graduation through CLARP, blessing by Cultural elders and leaders'

- Public denouncement of FGM/C.

Step 7: Sustaining FGM/C free communities

The key outcomes of the CLARP interventions include the establishment of a community movement that takes action to transform social and gender norms that perpetuate FGM/C, early and forced child marriages and early teenage pregnancies. At the core of the CLARP, are boys and girls who are engaged and supported to know and claim their sexual reproductive health rights and take informed action when deprived of their rights. The CLARP model fosters community-led discussions and empowers not only girls and women, but also policymakers and community leaders to develop and implement local laws and policies on FGM/C and its adverse manifestations. In the end, the intervention aims to protect girls and women from FGM/C, measured by reduction in FGM/C cases, reduced cases of both child early and forced marriage and teenage pregnancy, and improvement in secondary school completion rates.

1.3 Female Genital Mutilation/Cutting (FGM/C): Context, evidence and policy issues

FGM/C is a global concern, particularly in Africa and the Middle East (UNICEF 2005; 2013). Although the prevalence rates have started to wane, especially in Africa, recent data reveal that FGM/C is still practised as a social norm and thus remains persistent and ubiquitous across countries. However, concerted international efforts and commitment to address FGM/C continue to grow. Countries have made strides in designing strategies, plans, policies and in passing laws against the practice in addition to resource mobilisation to support the efforts to eradicate FGM/C.

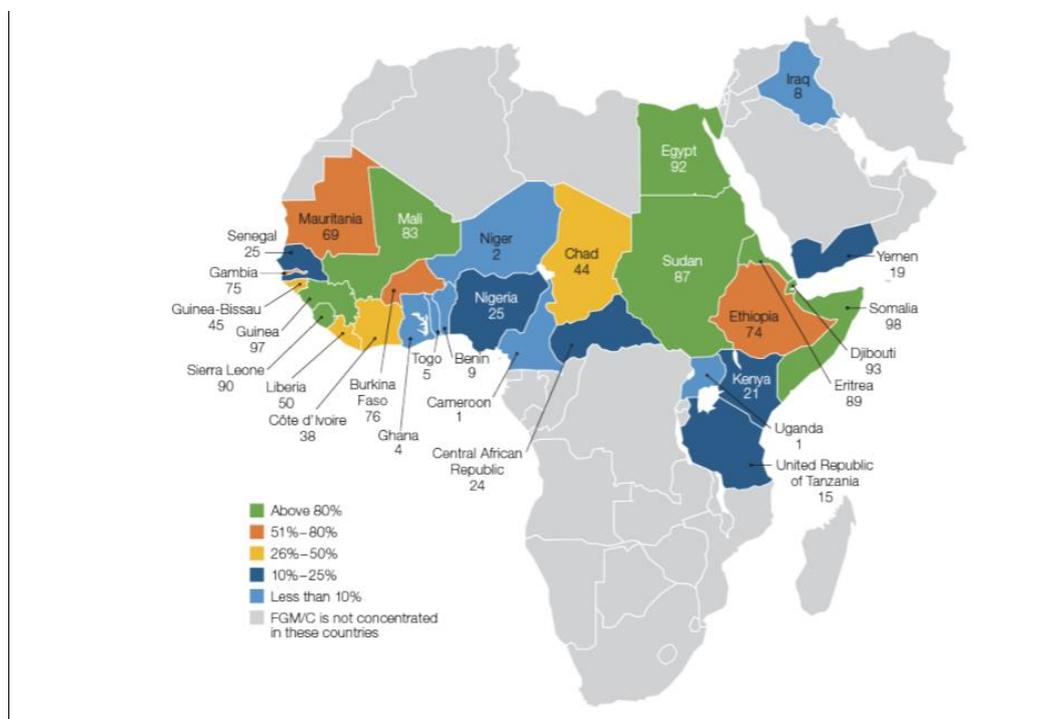
The United Nations and its various agencies (e.g., UNICEF, UNFPA, and WHO), through the Sustainable Development Goals, has established quantifiable targets and indicators of development support the end of FGM/C practices – that is, promotion of good health and well-being (goal 3) and gender equality (goal 5) that empowers women. With its core mission to increase sustainable health access to communities in Africa, Amref is also an active agent of change and has contributed significantly in the global fight against FGM/C. Amref has played a crucial role in the fight against FGM/C by providing solutions in human resources for health, health services delivery and investments in health, all geared towards a Universal Health Coverage (UHC). In Kenya alone, with an annual budget of US\$ 35 million, Amref works with a diverse range of communities all over the country to address not only the change in social norms

for complete eradication of FGM/C practices but also for containing other FGM/C-related risks such as childbirth and maternal deaths.

1.3.1 Why addressing Global FGM/C matters?

According to WHO (2008), FGM/C is a cultural practice involving partial or complete removal and alteration/injury to the external female genitalia for non-medical reasons.² Statistics show global estimates of roughly 200 million women and girls who have undergone the FGM/C practise (WHO, 2018). In Africa, especially in Sub-Sahara, Egypt and Ethiopia, data also indicate that approximately **three million girls** undergo FGM/C practise every year (UNICEF, 2008). UNICEF (2013) report shows that in half of the countries that practise FGM/C girls were cut before the age of 5 while in other countries cutting occurs for girls between 5 and 14 years of age.

Figure 1a: Global FGM/C prevalence rates



Source: https://www.popcouncil.org/uploads/pdfs/SOTA_Synthesis_2016_FINAL.pdf page 6

Across most countries, girls and women victims have undergone either clitoridectomy or excision or both as part of cultural gender and social status identity, with traditional practitioners being the main perpetrators of the practice. **Figure 1a:** provides a spatial outlook of FGM/C prevalence and paints a gloomy picture that the practice is mainly concentrated across 29 countries from the Atlantic coast to the horn of Africa with a wide variation in the percentage of women and girls cut, both within and across countries.³ The figure shows that most of the girls and women who have undergone the practice live in north-eastern, eastern and western parts of Africa where the practice is rife.

² FGM/C may take four key forms: partial or total removal of the clitoris (Clitoridectomy or Type I); partial or complete removal of the clitoris and labia (Excision, or Type II); narrowing of the vaginal opening (Infibulation or Type III); and other harmful practices such as incising, piercing or scraping of the genital area (Type IV).

³ UNICEF (2008) also report that global patterns of FGM/C are driven by migrations patterns (e.g. resulting from internal and external displacement due to civil unrest and conflicts) from one part of the world to the other.

Globally, FGM/C has gained increasing recognition as a health and human rights issue in recent years. According to UNFPA⁴ FGM/C undermines, physiologically and psychologically, the health of women and girls in several ways. First, it can cause severe and deadly injuries that can result in such complications as haemorrhage and infections. Second, complications during pregnancy and childbirth, mainly due to FGM/C, continue to be the leading cause of death among 15- to 19-year-old girls in most parts of the developing world (UNICEF, 2003). Third, FGM/C can cause serious health problems and pains. For-example, scarring, cysts, abscesses and tissue damage, infertility and pain during menstruation, urination and sexual intercourse (more common to women and girls who have gone through Type III FGM/C). Finally, going through the FGM/C ordeal and the resultant psychological effects can have devastating effects on girls' and women's mental health.

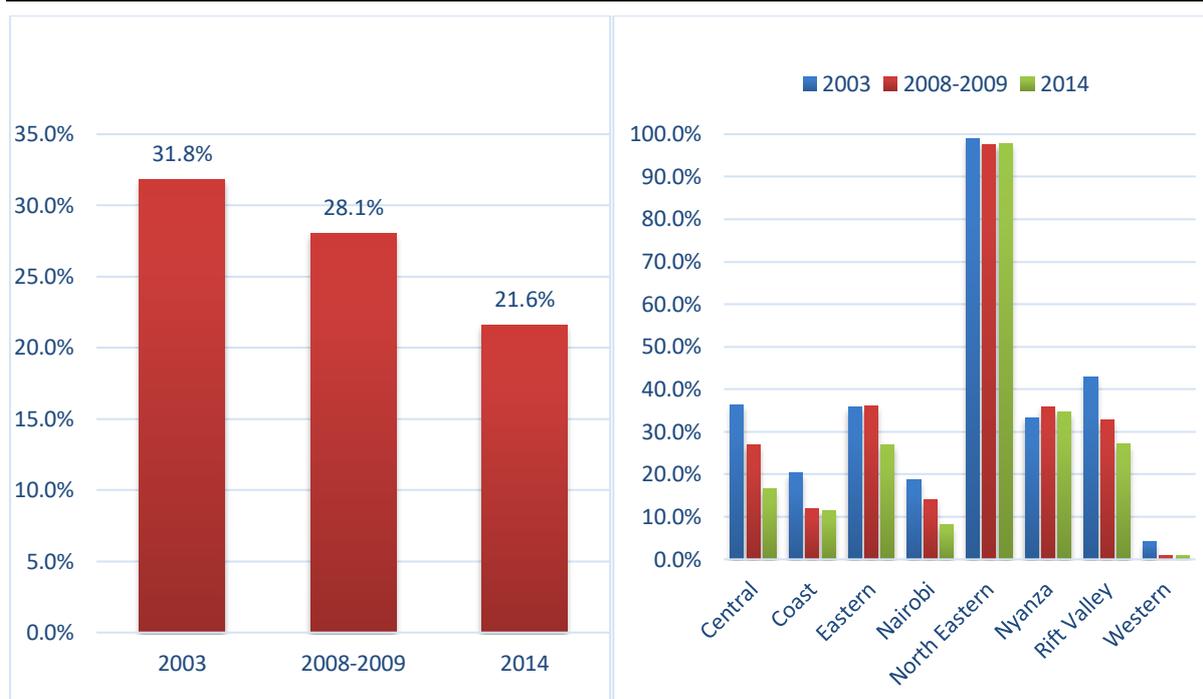
As a human right issue, FGM/C denies girls and women not only their physical and mental integrity but also their right to freedom and from violence, discrimination and protection of their lives (UNICEF, 2008). Deeply entrenched as a social norm, FGM/C practices perpetuate mental enslavement of girls and women who most often fall victims of societal norms of shame and exclusion that exacerbate and, in turn, adversely affect their wellbeing and violates their rights to enjoy life. Addressing FGM/C is not only a matter of policy but of survival for most girls and women who face the risks of falling victims. Indisputable evidence has shown that FGM/C causes permanent lifetime physiological and psychological damages to girls and women in addition to depriving them of their human rights. The fight against FGM/C undoubtedly requires concerted efforts by parties involved at all levels – from family level to higher levels of public and private sector stakeholders. As a private-sector agent dedicated at thwarting the devastating effects of FGM/C, Amref's long pedigree dedication and stewardship in the protection of girl's and women's dignity is commendable.

1.3.2 What is the status of FGM/C in Kenya?

Out of approximately 125 million girls and women who underwent FGM/C by 2013, Kenya accounted for more than 9.3 million (about 7.4 per cent) of FGM/C victims (UNICEF, 2013). Despite these alarming country statistics, FGM/C prevalence rates had been on the decline.

Figure 1a: FGM/C Prevalence in Kenya

⁴ Information available at: <https://www.unfpa.org/news/5-ways-female-genital-mutilation-undermines-health-women-and-girls> accessed on 31st Jan 2020 at 22:49.



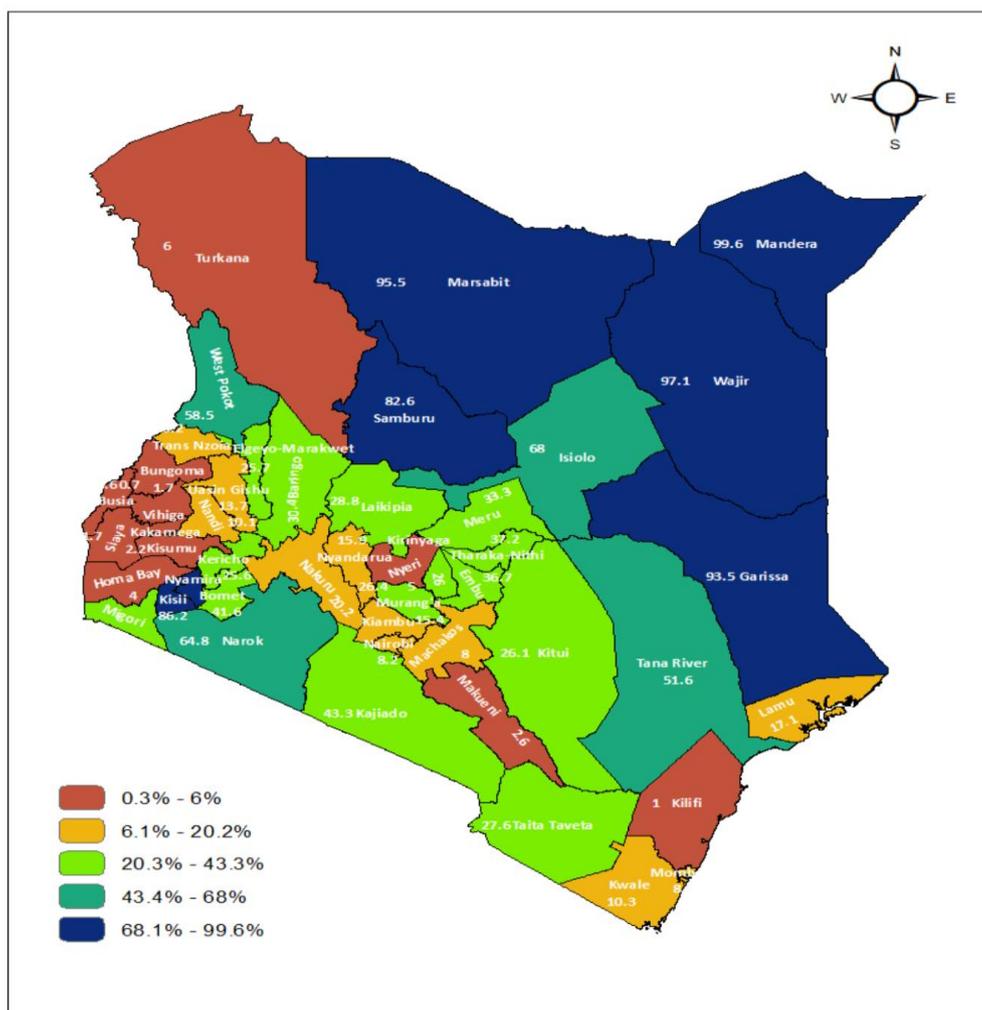
Source: Authors' construction using 2003, 2008-2009, 2014 KDHS data

Figure 1a shows FGM/C prevalence rates in Kenya computed using slightly dated and available 2003, 2008-2009 and 2014 demographic health surveys. The left panel indicates that the overall prevalence rates declined from 31.8 per cent in 2003 to 21.6 per cent in 2014. The right panel shows the distribution across major Kenyan regions⁵ and indicates alarming FGM/C prevalence in Northern Eastern Kenya (with an average above 90 per cent across the three survey waves) with Western Kenya recording the lowest prevalence rates below 5 per cent.

Unpacking statistics presented in the right panel of Figure 1a; Figure 1b shows the spatial distribution of FGM/C prevalence rates across Kenyan counties in 2014. Twenty-five counties (out of 47) in Kenya had higher than average prevalence rates. These counties include Mandera, Wajir, Marsabit and Garissa counties where prevalence rates were more than 90 per cent. At the other end of the spectrum are counties with low prevalence rates (less than 5 per cent). These include Kilifi, Uasin Gishu, Bungoma and Vihiga counties.

Figure 1b: 2014 FGM/C prevalence rates in Kenya

⁵ Note that for declaring the survey data in STATA software computations used on 2003 and 2008-2009 surveys and used regions as strata for assigning appropriate sample weights while for 2014 survey the computations used counties as strata.



Source: Author's construction using 2014 KDHS data.⁶

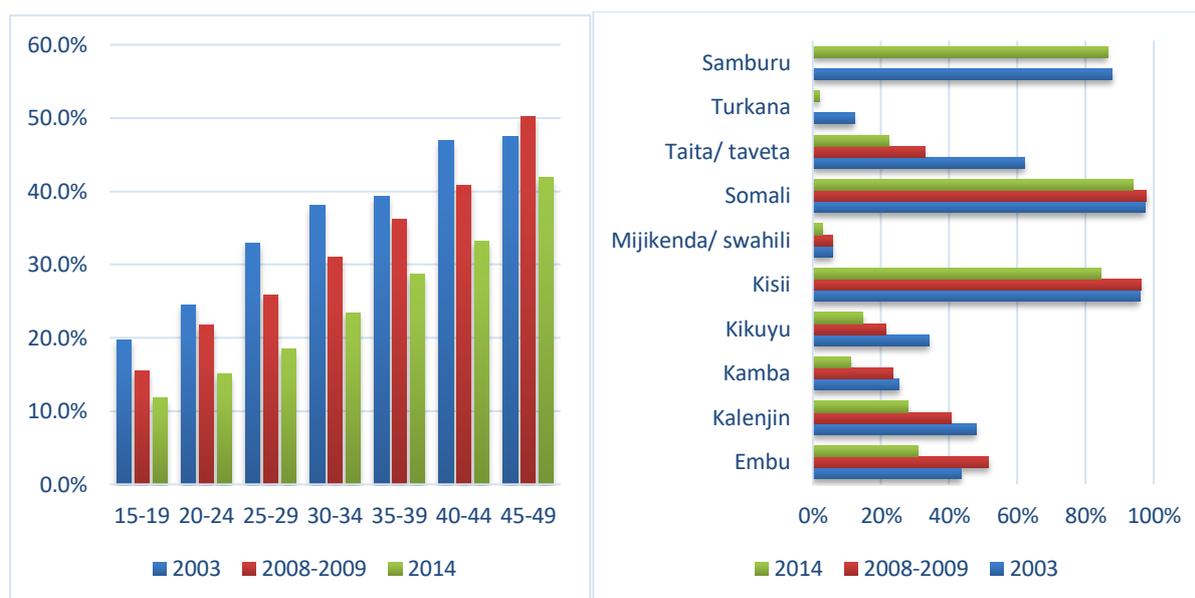
Within Kenya, there are also wide ethnic and cultural variations in the distribution of FGM/C prevalence rates. Ethnic differences appear to highly correlate with high prevalence rates in sub-regions and counties that are predominated by the Somali, Samburu, Kisii and Maasai communities at 94, 86, 84 and 78 per cent, respectively (UNFPA-UNICEF, 2016). Even the specific form of FGM/C practised varies across communities. For example, 75 per cent of the FGM/C exercised by Somalis are of the most severe Type III infibulation (Andrew Wasike, 2016). The Kisii and Maasai communities practice Type I clitoridectomy and Type II excision, respectively (Wilson Ann-Marie, 2013). Traditional beliefs⁷ and practices are also associated with high rates of child, early and forced marriages and teenage pregnancies in Kenya. Statistics show that up to 2.3 million girls in Kenya have had their first pregnancy at adolescent years, while 535,441 women aged between 20 and 24 had their first pregnancies by the age of 18 (Loaiza and Liang, 2013). Additionally, child marriages remain high, at 23 per cent (UNICEF, 2017).

FGM/C practise also varied significantly across different age cohorts and ethnicities over time. Figure 1c shows average prevalence rates by age cohorts across 2003, 2008-2009, and 2014 KDHS survey waves. A cursory look at Figure 1c shows that not only has FGM/C been declining but it has been doing across different age cohorts and ethnicities.

⁶ Maps layers we extracted from <https://gadm.org/maps/KEN.html> (downloaded on 17th Feb 2019 at 10am EAT time)

⁷ Associated with marriage prospects for girls, chastity in marriage and womanhood status.

Figure 1c: FGM/C prevalence across age cohorts and ethnicity



Source: Authors' construction using 2003, 2008-2009, 2014 KDHS data

The first panel reveals two key contradicting patterns. First, a steady decline in prevalence rates across years for all the age cohorts, which is consistent across the three survey rounds suggesting somewhat persistent but declining FGM/C practices. Second, disproportionate increases⁸ in prevalence rates across the different age cohorts in each survey year with older cohorts registering increases in the FGM/C practices. KDHS (2014) reports that, concerning the type of circumcision, 2 per cent of circumcised women age 15-49 experience FGM/C Type I, 87 per cent had Type II, and 9 per cent Type III. The reports further show high mother-daughter correlations -- girls age 0-14 are more likely to go through the practice if their mother had undergone FGM/C -- with 8 per cent of Kenyan girls age 0-14 having gone through FGM/C Type III. The second panel also shows a declining FGM/C trends in some ethnic groups -- Embu, Kalenjin, Kamba, Kikuyu, Mijikenda or Swahili on the coast, and Turkana -- but reveal a gloomy picture (as noted in Figure 1b above) in other ethnic groups -- Kisii, Samburu and Somali -- with not only high FGM/C rates (above 90 per cent) but also the rate of reduction over the years was minuscule signalling persistence of the practices.

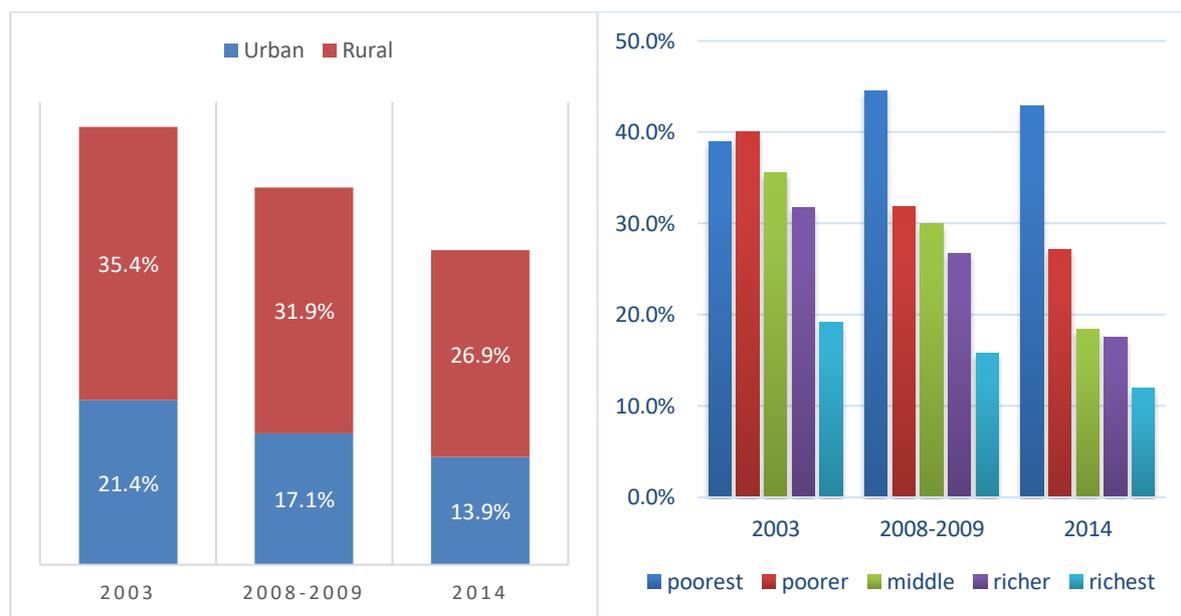
KDHS (2014) reports that there are still a few (11 per cent or less) Kenyan women and men who believe that their community or their religion requires FGM/C practice or that the practise should continue. The decline in the number of Kenyans who prefer to see the practice continue correlates with the recent intensive and extensive End-FGM/C efforts by the national and county governments, local communities and international organisations. Because of these concerted efforts, FGM/C prevalence rates declined -- also see Figure 1a -- steadily over the past decade: circa 22 per cent among women aged 15 -- 49 years in 2014 compared to 27 per cent in 2008-2009 and 32 per cent in 2003 (KDHS, 2014; Gramaans et al. 2017; UNFPA-UNICEF, 2016).

Aside from interplay between geography and culture, socioeconomic factors are also critical drivers of FGM/C practices in Kenya (UNFPA-UNICEF, 2016). To contextualise the extent to which socioeconomic factors drive the FGM/C practise Figure 1d shows the decomposition of FGM/C prevalence rates by wealth and residence status. The Figure indicates that prevalence

⁸ One possible explanation to this pattern, as argued by UNICEF (2008) is the fact that demographic health survey data do not necessarily reflect most recent prevalence rates in the surveyed societies because of the time difference between the experience of the cut and the data collection (e.g. data on girls cut at 5 would be recorded ten years later because of the targeted respondents are between 15-49 years of age).

rates were predominantly high for poor and rural girls and women. The left panel shows high FGM/C prevalence rates for women residing in rural relative to urban areas. The estimates are consistent in all three survey waves across the decade reinforcing the notion that traditional beliefs and practices, especially in rural areas, exacerbated FGM/C practices in Kenya. The right panel also shows persistently high prevalence among poor women in all survey waves suggesting that poverty could also somewhat explain the high prevalence rates, especially in rural areas.

Figure 1d: FGM/C prevalence by residence and wealth status



Source: Authors' construction using 2003, 2008-2009, 2014 KDHS data

Efforts to end FGM/C in Kenya date back to the early 1920s when the colonial government and missionaries made attempts to persuade communities to abandon the practice. Missionary/church-led approaches, with the sanctions⁹ they attracted, did little to reduce prevalence rates as they equalled to colonial oppression (Matanda et al., 2018). The immediate post-independence government did little to eliminate the practice either, but increased advocacy and international pressure in the 1980s and 1990s saw a commitment from the government to address the practice.

To date, the country has adopted several legal and legislative texts to eliminate FGM/C. Article 44 (3) of the Kenyan Constitution bars any person from compelling another person to perform, observe or undergo any harmful cultural practice or rite. Moreover, Article 53 (d) categorically states that children should be free from harmful cultural practices, inhuman and degrading treatment. Other pieces of legislation include; Prohibition of Female Genital Mutilation Act, 2011, which prohibits any form of genital mutilation of all females. The law prescribes penalties to offenders who are liable to either imprisonment for not less than three years or a fine of US\$ 2000 (Government of the Republic of Kenya, 2011).

The Children's Act, 2001 criminalises genital cutting of any female below the age of 18 years, with penalties of twelve months imprisonment or a fine of up to US\$ 600 imposed on anyone violating the law (Oloo et al., 2001). The Penal Code, Cap 63, also provides chargeable offences for FGM/C offenders. The Protection against Domestic Violence Act, 2015 classifies FGM/C as violence. The Act provides for protective measures for survivors and victims of domestic violence, including FGM/C. More recently, the government has stepped up efforts to

⁹ Denial of children's enrolment to missionary schools and denied participation in religious functions.

enforce the law, with the anti-FGM/C unit operating under the office of the Director of Public Prosecution, and more than 20 prosecutors deployed across the country, and over fifty cases prosecuted (Migiro, 2014).

Kajiado County passed an FGM/C act in December 2019 to signal serious County government's commitment to eradicate FGM/C -- a social norm that adversely affects girls and women in the County. Aside from proposing the CLARP model that, amongst others, promotes community dialogues, the policy also outlines several levers needed to eradicate FGM/C in Kajiado. These levers include: (i) sensitising the community that FGM/C is illegal and a violation of human rights; (ii) empowering and supporting cutters performing FGM/C to embrace alternative sources of livelihood; (iii) strengthening multi-sector interventions, coordination, networking, partnership, and community participation in accelerating the eradication of FGM/C; and (iv) developing research, data collection, information, and knowledge management functions related to FGM/C.

Table 1a: Government of Kenya Laws and Policies on FGM/C

Year	Laws/Policies	Mandates
1999 - 2019	National Plan of Action for the Elimination of Female Circumcision in Kenya	Launched by the Ministry of Health, provided governments commitment to ending the practice
2001	Policy directive by the Ministry of Health	Banned FGM and prohibited government hospitals from performing FGM
2001	Children's Act	Criminalised FGM on any female under 18 years. prohibits female circumcision as a cultural rite, custom or traditional practice that negatively affects the life, health, social welfare, dignity or physical or psychological development of a child
2008-12	National Action Plan for Accelerating the Abandonment of FGM/C in Kenya	Sets goals, objectives, strategies and indicators for accelerating the abandonment of FGM/C
2010	The Kenya Constitution	Chapters 44 and 53
2011	Prohibition of Female Genital Mutilation Act (Reviewed in 2016)	Criminalised all forms of FGM performed on any female, regardless of age or status.
	Penal Code - Chapter XXIV, Articles 250-251	Categories FGM/C under acts of "grievous harm."
2019	Kajiado County FGM/C policy	<ul style="list-style-type: none"> - Sensitising community on the illegality of FGM/C; - Proposes the use of CLARP approach in the fight against FGM/C; - Support cutters to embrace other sources of livelihood; and - Coordinating and strengthening multi-sectoral interventions. -

Source: Compiled by authors from different literature reviews

The highlighted legal texts in

Table 1a collectively provide a framework for engagement with all stakeholders and provide protective measures for girls and women. More importantly, conscious of the critical role girls and women play in economic development, Kenya's economic development blueprint – the Vision 2030 – also targets the creation of public awareness in the fight against FGM/C. End-FGM/C efforts by the national and county governments, local communities and international

organisations have significantly contributed to accelerating the abandonment of the practice. The effectiveness of these laws to end FGM/C is however hampered by ineffective implementation due to capacity limitations on the part of enforcers, lack of witnesses to have identified cases prosecuted, as well as low fines that fail to act as an adequate deterrence especially for affluent families (Muthumbi et al., 2015).

However, legal actions alone are inadequate to change attitudes and behaviours as it fails to address underlying socio-cultural drivers of FGM/C. Rigid enforcement of the law may result in the unintended effect of encouraging difficult to detect approaches in effecting the cut, making reporting of prevalence difficult (Muthumbi et al., 2015). The ARP model in Kenya is one of the classic models of community-led initiatives aiming at changing perceptions, attitudes and behaviours towards FGM/C practices.

1.4 Purpose of the impact study

Until recently when FGM/C prevalence rates started to decline, the practice had become a widespread social and health predicament in many parts of Africa, Asia and the Middle East (UNICEF 2008, 2013; WHO 2018). Several factors are behind the recent turnaround of the FGM/C prevalence rates: the increased and improved levels of educational outcomes, changing social-cultural norms bolstered by enforced legal reforms and growing dissent voices against FGM/C practices and socio-economic development (Mpinga et al., 2016; Kandala et al., 2018; UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting, 2017). All these factors contributed to the steady reverse in the FGM/C practices and thus declining prevalence rates.

Like many other countries fighting the practice in Africa, Kenya has also witnessed a downward trend in FGM/C prevalence. An analysis of the Kenya Demographic Health Surveys (KDHS) indicates a decline from 31.8 per cent in 2003 to 21.6 per cent in 2014. Shell-Duncan et al., (2017) propose that the decline in FGM/C prevalence is partly because of community programmes such as the ARP. The ARP model compliments efforts geared at ending FGM/C practices by creating awareness of their devastating physiological, psychological and social effects on girls and women who undergo such traumatising experience. The model, which is implemented primarily in settings where FGM/C practices are rites of passage, provides alternate means through which communities can acknowledge the rite of passage with positive benefits on the wellbeing of the girls and women.

In Kenya, the CLARP model was first rolled out in Kajiado County in 2009 in line with Amref's vision to eradicate widespread FGM/C practices across the African continent by 2030. Kajiado county features prominently among counties with high prevalence rates for both teenage pregnancies and child marriages. Child marriage rates remain high, at 28 per cent (UNICEF, 2017). Kajiado's school enrolment rates are marginally low and stand at 75 per cent and 26.3 per cent for primary and secondary school, respectively (National Council for Population and Development, 2017). These statistics point to a lower school enrolment rate for secondary schools, influenced by, amongst other, harmful practices such as FGM/C and forced child marriages. High prevalence rates of FGM/C cases and child marriage with its resultant effect on high teenage pregnancies in Kajiado mainly inform various interventions by national, county governments and development partners, such as Amref Health Africa. Given these gloomy statistics in Kajiado, the CLARP model stands out as one of the essential community-led initiatives that have the potential to address FGM/C practices and the associated consequences. Therefore, the CLARP model provides training targeted at reducing and eventually eliminating not only FGM/C but also child early and forced marriage (CEFM) and teenage pregnancies (TP) and improve girls' or women's levels of educational outcomes.

However, despite the declining trends in FGM/C prevalence, it remains unclear the extent to which the CLARP model had a role to play in such declines in Kenya, and particularly in

Kajiado county. Consequently, to shed light on the contribution of CLARP in the fight against FGM/C, the present study sought to evaluate (quantitatively and qualitatively) the impact of the CLARP intervention/model in Kajiado.

1.5 Evaluation objectives

The main objectives of the evaluation were to:

- i) Determine the impact of the CLARP model on social and educational outcomes: Female Genital Mutilation/Cutting (FGMC), child early and forced marriages (CEFM), teenage pregnancy (TP) and girls' educational outcomes;
- ii) Explore and document the experiences, stories and determine the educational and marital/parental status of girls who have gone through CLARP; and
- iii) Explore the perspectives, attitudes and practices of community stakeholders towards FGM/C.

The present study thus underpins the vital role of research in providing evidence-based knowledge useful in supporting such community-led initiatives as the ARP model. Accordingly, the analysis and findings of the study can be of use in three broad areas:

- i) **Learning:** Findings can help in identifying and feeding lessons learnt on potential impacts and what works and does not work for the CLARP programming in Kajiado. The lessons are crucial for evidence-based decision making by Amref's management for the current and future CLARP programming and more broadly across other related programmes and projects.
- ii) **Accountability:** Assessing CLARP model results and overall value independently and impartially consistent with generally accepted principles and standards for professional evaluation; and
- iii) **Advocacy and fundraising:** The findings of the study can be useful for Amref's advocacy and fundraising efforts – to scale-up the CLARP model to other counties in Kenya and other Amref operational countries in Africa.

Therefore, in line with the terms of reference (TOR), the present study has, to the extent possible, estimated the quantitative impacts of CLARP interventions on various social and educational metrics. The evaluation also collected and analysed qualitative data to provide a detailed qualitative analysis of the outcomes associated with the CLARP intervention.

1.6 Evaluation Questions

The Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD/DAC)¹⁰ developed a set of evaluation criteria widely used in development evaluations. These criteria comprise relevance, efficiency, effectiveness, coherence, impact and sustainability. This evaluation examines whether CLARP programming outcomes have led to social and educational impacts through quantitative and qualitative analyses. This report, thus, addresses the following evaluation questions in [Table 1b](#).

Table 1b: HEQ and DEQs to answer in the evaluation study

HEQ: What were the impacts of Community Led Alternative Rite of Passage on Female Genital Mutilation/Cutting and Sexual Reproductive Health Risks outcomes in Kajiado County in Kenya?

DEQ 1: Has the CLARP programme led to any impacts on social (i.e., FGM/C, child early and forced marriages, and teenage pregnancy) and education outcomes (i.e., educational attainment and years of schooling) of its beneficiaries?

DEQ 2: What are the experiences, stories and the status of the girls who have gone through the CLARP model?

¹⁰ Available at <http://www.oecd.org/dac/> accessed on 28th Jan 2020 at 13.33



HEQ: What were the impacts of Community Led Alternative Rite of Passage on Female Genital Mutilation/Cutting and Sexual Reproductive Health Risks outcomes in Kajiado County in Kenya?

DEQ 3: What are the perceptions, attitudes and practices of community stakeholders about FGM/C practices?

2. METHODOLOGY

2.1 Background

The study measured the impacts of the CLARP model by testing the assumptions and hypotheses underpinning the implementation of the model, particularly on the targeted girls and women population in Kajiado County. Therefore, to quantify and document the impacts of the CLARP model the study used a two-tier approach: a quasi-experimental approach which is quantitative, and a qualitative approach involving structured in-depth interviews (IDIs) focus group discussions (FGDs) and key informant interviews (KIIs) in addition to a detailed desk review of relevant documents.

2.2 Evaluation Framework

Table 2a summarises the evaluation questions;

Table 2a: Issues addressed by the present evaluation study

Issue/ Question	Approach
DEQ 1: Has the CLARP programme led to any impacts on social (i.e., FGM/C, child early and forced marriages, and teenage pregnancy) and education outcomes (i.e., educational attainment and years of schooling) of its beneficiaries?	Quantitative approach: <ul style="list-style-type: none"> Quasi-experimental approach (Difference-in-Difference)
DEQ 2: What are the experiences, stories and the status of the girls who have gone through the CLARP model?	Qualitative approach: <ul style="list-style-type: none"> In-Depth Interviews (IDIs); Focus Group Discussions (FGDs)
DEQ 3: What are the perceptions, attitudes and practices of community stakeholders about FGM/C practices?	Qualitative approach: <ul style="list-style-type: none"> Key Informant Interviews (KIIs)

2.3 Quantitative Analysis Methodology

2.3.1 Econometric Model

The study employed a robust quantitative quasi-experimental method to quantify the impacts of the CLARP programme. Specifically, the study used a difference-in-difference (DiD) approach to quantify the impacts of the CLARP model credibly. Pegged upon the relevant assumptions to hold, theoretically, the DiD approach calculates the average treatment effects by differencing the average outcomes before and after programme implementation across control (i.e., without intervention) and treated (i.e., with interventions) groups. In the context of the CLARP programme, the DiD approach measures the average impacts of the CLARP roll-out on social and educational outcomes (DEQ 1) in Kajiado county (where the Amref introduced the CLARP model). The results are then compared with select counties with no CLARP model (i.e., control groups) before and after the model was rolled-out in 2009.

Figure 2a summarises the setting of the quantitative approach and illustrates DiD framework used to assess the impacts of the CLARP intervention. The DiD approach estimates¹¹ the

¹¹ Mathematically, the DiD model can take the following specification:

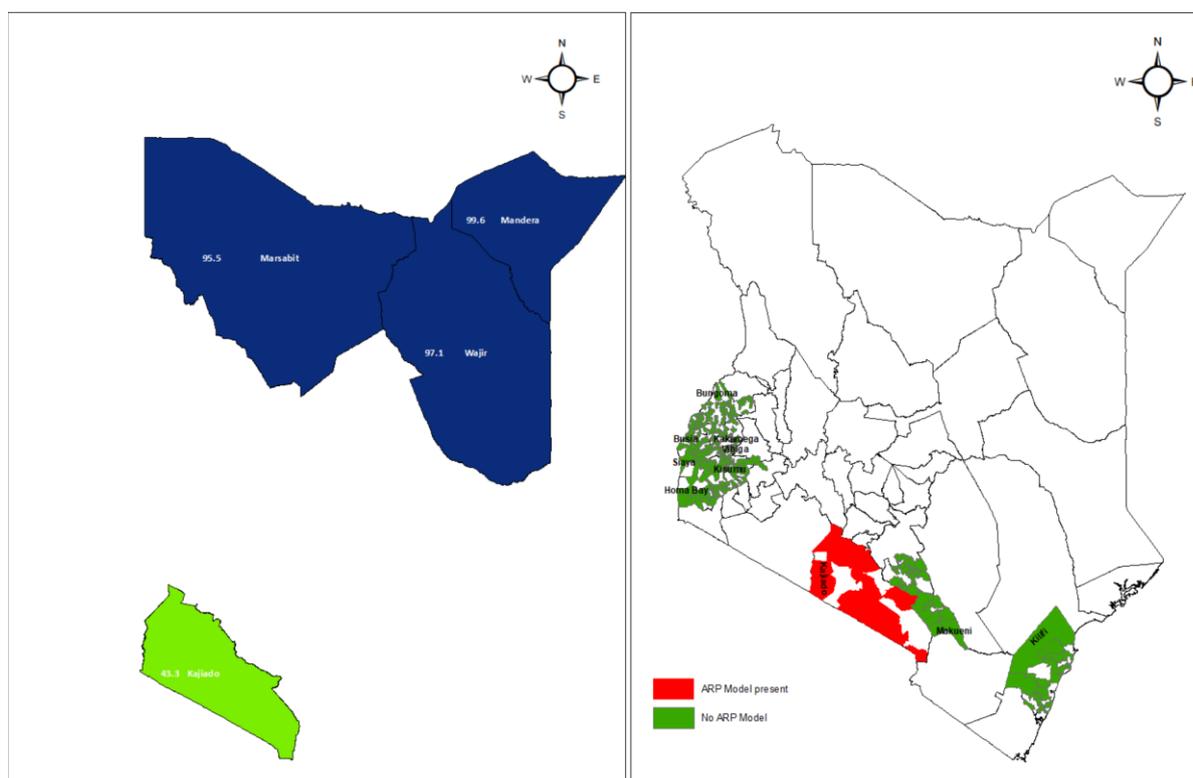
$$Y_{c,t} = \alpha_0 Post_t + \alpha_1 ARP_{c,t} + \alpha_2 Post_t \times ARP_{c,t} + X'_{c,t} \alpha_3 + District_d + Year_t + District_d \times Year_t + \epsilon_{c,t}$$

Where c and t stand for counties and years, respectively. $Y_{c,t}$ measures the various health and educational outcomes of interest (i.e., female genital mutilation/cutting, child early and forced marriages and teenage pregnancy as well as girls' years of schooling). The study exploited the rich KDHS individual records data (which captures information on women aged 15-49) and extracted and analysed the following key survey variables: (i) whether the respondent is circumcised or not, (ii) whether the respondent was married below 18 years, (iii) whether the respondent gave birth below 20 years, and (iv) education in single years. Notice that (i) to (iii) capture latent binary variables while (iv) captures continuous variable. $Post_t$ is a binary indicator taking the value of 1 for years post 2009, and 0 otherwise. $ARP_{c,t}$ is also a binary indicator taking the value 1 if the CLARP was rolled out in a county

average effects of CLARP programme on FGM/C prevalence rates and other social and educational outcomes before and after its rollout in 2009 across Kajiado versus two sets of control counties with high and low prevalence rates of FGM/C:

- i) Cluster 1 (*left panel*): The counties included are **Mandera, Marsabit and Wajir** which have the highest FGM/C prevalence rates as per 2003, 2008-2009 and 2014 KDHS data. The existing Amref records indicate that CLARP intervention or a similar one, as late as 2015, was non-existent in these counties; and
- ii) Cluster 2 (*right panel*): The counties¹² included are Bungoma, Busia, Kakamega, Vihiga, Siaya, Homa Bay, Kisumu, Kilifi and Makueni which have both the lowest FGM/C prevalence rates and where the CLARP model was non-existent. These counties were test cases to explore any potential alternative explanations and run sensitivity checks to the baseline DiD estimates.

Figure 2a: The DID approach – Kajiado vs control counties



in 2009, and 0 otherwise. α_0 captures the separate average effects of time before and after the CLARP rollout. α_1 captures the average effect of being in a county with the CLARP versus the county with none. α_2 captures the average effect of the CLARP rollout. Variable $District_d$ stands for district/sub-county fixed effects which include unobserved district/sub-county characteristics (e.g., cultural beliefs and practices, the difference in districts/sub-counties responses' on FGM/C issues including the level of effort and resources deployed by sub-county authorities, and unobserved geographical factors). $Year_t$ stands for year fixed effects which include unobserved year effects specific to the different counties. $District_d \times Year_t$ captures year specific district/sub-county unobserved effects. $\epsilon_{c,t}$ is an error term that captures all the other residual factors not captured in the specified model. To address potential intra-cluster correlations the standard errors of all coefficient estimates will be clustered at the county level. The vector $X_{c,t}$ captures time-varying observables that would otherwise confound the coefficient estimates of the CLARP roll-out effects. Since the study estimated the impacts of CLARP on social and educational outcomes, that analysis, informed by the relevant literatures (cf. Annexe 1), included the following control variables: age at first cohabitation, age and sex of the household head, ethnicity, wealth index, age cohorts, residence (rural or urban) and religion. The inclusion of these variables attenuated the potential underlying bias that they could have on the average CLARP rollout effects.

¹² To address potential concerns on the self-selection bias on the control counties, the analysis also explored three more potential control groups: (i) all counties with FGM/C prevalence rates less than 5 per cent, mostly counties in Western Kenya; and (ii) the baseline control counties plus Narok. As we show later in the key findings, the results are also robust to (i) and (ii).

Source: Constructed using maps layers from <https://gadm.org/maps/KEN.html>

2.3.2 Data sources and descriptive analysis

To empirically investigate and respond to DEQ 1, the study employed Kenya Health Demographic Surveys (KDHS)¹³ collected in 2003, 2008-2009, and 2014. KDHS data are not only detailed and statistically representative but also the only available dataset to respond to the objectives of the present study. The analysis used STATA 14 software.

It is essential to understand the definition and characteristics of key variables of interest to contextualise the quantitative findings. Calculations of FGM/C rates use KDHS binary indicator (0=No, 1=Yes) on responses of girls and women circumcision status. Education relies on school years in single digits while the construction of child early and forced marriages rates (CEFM) exploited the binary indicator (0=Not Married, 1 Married at the time of being surveyed) and the age variable, allowing filtering of the sample to include the proportion of girls married below 18 years. Likewise, teenage pregnancy (TP) rates exploited binary indicator on current pregnancy status and age, thus generating proportions of young girls below 20 years who reported to be pregnant at the time of the survey.

Table 2b: Summary statistics, KDHS 2003, 2008-2009, and 2014

Variables	Control group			Treated group			Overall		
	Obs.	Mean	Std	Obs.	Mean	Std	Obs.	Mean	Std
Age	2458	27.774	8.938	788	28.121	8.634	3246	27.858	8.865
Age at first cohabitation	1905	17.720	3.663	577	19.492	4.499	2482	18.132	3.944
Age h/head	2455	42.019	13.921	788	39.443	12.166	3243	41.393	13.559
Sex h/head [1=Female]	2121	1.289	3.552	529	7.726	6.255	2650	2.574	4.952
Circumcised [1=Yes]	1619	0.983	0.128	439	0.412	0.493	2058	0.862	0.345
Education [years in school]	2458	0.011	0.106	788	0.008	0.087	3246	0.010	0.102
Married < 18 years [1=Yes]	2458	0.003	0.057	788	0.003	0.050	3246	0.003	0.055
Pregnant < 20 years [1=Yes]	2458	0.012	0.108	788	0.010	0.100	3246	0.011	0.106
Residence [1=Rural]	2458	0.424	0.494	788	0.320	0.467	3246	0.399	0.490
<u>Wealth Index</u>									
Poorest	2458	0.649	0.477	788	0.245	0.430	3246	0.551	0.497
Poor	2458	0.072	0.258	788	0.066	0.248	3246	0.070	0.256
Middle	2458	0.074	0.261	788	0.076	0.265	3246	0.074	0.262
Rich	2458	0.111	0.315	788	0.165	0.371	3246	0.124	0.330
Richest	2458	0.094	0.292	788	0.448	0.498	3246	0.180	0.384

Source: Authors' construction using 2003, 2008-2009, 2014 KDHS data

Table 2b reports the summary statistics for girls and women aged 15-49 years across KDHS waves in 2003, 2008-2009, and 2014. The sample is divided into control (Wajir, Marsabit and Mandera counties) and treated (Kajiado county) groups, and the analysis compares the key summary statistics across the two groups. Except for FGM/C rates which are higher on control than in the treated groups, on average, the statistics indicate a close balance in both control and treated groups of the key outcome variables (schooling years, EFCM and ETP) and their potential confounders.

¹³ Demographic Health Surveys available at: <https://dhsprogram.com/Data/>

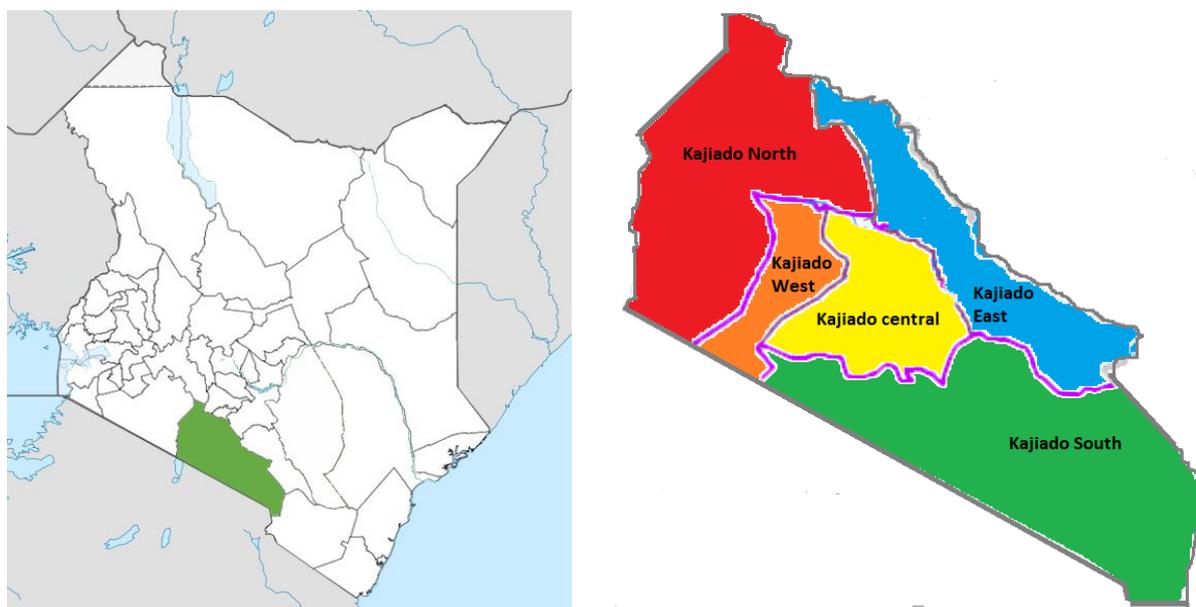
2.4 Qualitative Analysis Methodology

The study used qualitative analysis to gain a deeper understanding of the quantitative results and on the status of CLARP interventions in Kajiado County. Therefore, to answer DEQ 2 and 3, the study employed qualitative approaches (cf. [Table 2a](#)) to examine the socio-economic benefits that have accrued to CLARP beneficiaries and capture perceptions and attitudes of stakeholders in Kajiado county. As previously noted, the analysis and findings of the qualitative survey provide a better contextual understanding of the underlying facilitators and barriers to the success of the CLARP programme in Kajiado. Carefully triangulated with the results from quantitative estimations, the generated qualitative insights and lessons can guide the scaling up of the CLARP programme to other counties in Kenya and other Amref operational countries in Africa. The findings can also inform advocacy and fundraising activities in the future.

2.5 Study area

Kajiado County is one of 47 counties in Kenya established after the country's most recent constitution adopted in 2010. The county covers an approximated area of 21,000 sq.km and is adjacent to Nairobi, the capital city of Kenya. Kajiado county consists of several administrative districts including Kajiado Central, Isinya, Oloitoktok, Magadi, Mashuru, Namanga and Ngong (see [Figure 2b](#)). Magadi and Oloitokitok, where Amref rolled out the CLARP model for the first time in 2009, were identified areas used for qualitative surveys.

Figure 2b: Map of Kenya showing Kajiado county (left); Map of sub-counties within Kajiado (right)



Source: Maps extracted from wikimedia.org and Softkenya.com

The county has an estimated population of about 800,000 people as per 2012 census and a population growth rate of 5.5 per cent. The economy thrives mainly on agriculture and related activities including food crop farming, livestock production, dairy and beef production, hides and skins, poultry and horticulture. Kajiado County is also a tourist attraction as it hosts the famous Amboseli National Park, also known as the 'Home of the African Elephant' (Kajiado County, 2019).

2.6 Recruitment and training of field staff

The study recruited and trained nine field interviewers, all native Maasai speakers, university graduates with prior experience in qualitative data collection. The training took five days from 19th to 23rd August 2019. The training content included the study objectives, importance of data quality, qualitative data collection techniques, research best practices and ethics, and understanding the interview guides. The field interviewers were also involved in the piloting and refining of the interview guides in the field. Debriefing sessions preceded training and pilot interviews. The research team accompanied the field team (Amref field staff and research assistants) in piloting interviews and led the debriefing sessions.

2.7 Sampling procedure, sample size determination and recruitment of study participants

The study used a three-pronged approach to draw the sample of both CLARP and non-CLARP beneficiaries. For In-depths Interviews (IDIs), a random sample of CLARP beneficiaries (<5 years post-graduation) drawn within a school from a randomly drawn list of schools in both Magadi and Oloitoktok. The underlying assumption was that most CLARP beneficiaries in this category are students and still residents of both Magadi and Oloitoktok. CLARP beneficiaries with over five years post-graduation were randomly drawn from CLARP beneficiary's database and traced for interviews during the fieldwork. The stratification of respondents into recent (<5 years post-graduation) and long-time (>5 years post-graduation) graduates ensured that the interviews capture a broader range of experiences, especially from the latter category. Using the Amref's database, the sampling filtered CLARP beneficiaries who joined and graduated from the programme between 2011 and 2016.

Sampling for Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) participants was purposive. KIIs participants included county government officials, local chiefs, religious and cultural leaders, children protection officers, community-based officers, members of county assembly, grandparents, traditional birth attendants, and teachers. FGDs participants included adolescent boys and girls, young men and women, Morans, and male and female parents.

Besides being included in the sample, eligibility to the study required potential respondents to be residents of the study areas and be willing to participate in the study voluntarily.

2.8 Data collection¹⁴ tools

The study used a theoretically grounded qualitative methodology to provide analysis of in-depth, existential accounts and perspectives of the sampled respondents using the standard qualitative data collection techniques: in-depth interviews (IDIs), key informant interviews (KIIs) and focus group discussions (FGDs). IDIs applied to CLARP beneficiaries (women and girls aged 15 years and above who have graduated from the CLARP programme) and aimed at capturing the experiences and views of CLARP beneficiaries. IDIs also applied to non-CLARP beneficiaries (women and girls aged 15 years and above who did not participate in the CLARP training) as comparison group. As shown later in the results section, IDIs captured and documented individual stories, case narratives and respondents' status on outcome variables: FGM/C, child early and forced marriages, teenage pregnancies and educational outcomes.

KIIs and FGDs¹⁵ were employed to conduct detailed qualitative inquiries with various stakeholders to evaluate their experiences, perceptions, attitude and practices towards

¹⁴ Data collection started between 2nd and 13th September 2019 in Oloitoktok (2nd -- 6th September) and Magadi (9th -- 13th September).

¹⁵ They were conducted across individual sub-groups to ensure that the interactions within the sub-groups lead to a free and open expression of perspectives (Krueger and Casey, 2015).

FGM/C. KIIs probed selected stakeholders to understand their interaction, working, success and suggestions for improving FGM/C interventions. FGDs probed cross-sections of key community members including the CLARP beneficiaries, young boys and girls, Morans and parents.

2.9 Respondents' characteristics

Table 2c presents a summary of the target and an actual number of respondents recruited and interviewed for the qualitative survey in both Magadi and Oloitoktok. Except for an MCA in Magadi and religious leader as well as young women FGD in Oloitoktok, the study surveyed all the targeted respondents totalling 62 interviews.

Table 2c: Qualitative survey respondents by location

Interview type	Respondents	Targeted sample			Surveyed sample		
		Magadi	Oloitoktok	Total	Magadi	Oloitoktok	Total
In-Depths Interviews (IDs)	Recent CLARP graduates	3	3	6	3	4	7
	Long-time CLARP graduates	7	7	14	9	9	18
	Non-CLARP beneficiaries	2	2	4	2	2	4
Key Informant Interviews (KIIs)	Chiefs	1	1	2	1	1	2
	Children protection officers	1	1	2	1	1	2
	MCAs	1	1	2	0	1	1
	Head Teachers	2	2	4	2	3	5
	CBO/CSO officials	2	2	4	2	1	3
	Religious leaders	1	1	2	1	0	1
	TBAs/Cutters	1	1	2	1	1	2
	Cultural elders	1	1	2	1	1	2
Focus Group Discussions (FGDs)	Grand parents	1	1	2	1	1	2
	Adolescent boys and girls (15-18)	2	2	4	2	2	4
	Young Men (19 to 24)	1	1	2	1	1	2
	Young Women (19 to 24)	1	1	2	1	0	1
	Morans	1	1	2	1	1	2
	Parents (males and females)	2	2	4	2	2	4
	Total	30	30	60	31	31	62

Source: Amref CLARP database and survey data

Table 2d presents the characteristics of the interviewed sample. IDIs included 29 respondents whose average age was 16.6 (overall sample), 15.4 (for less than 18 years sample) and 22 (for equal to or above 18 years sample). At the time of the survey, respondents were either enrolled in school (22 in total – 10 in Magadi and 12 in Oloitoktok) or had finished at least primary school education (25 in total). Eighteen respondents lived in male-headed, relative to 9 who lived in female-headed, households. 70.4 per cent of IDI respondents reported that their parents had no education, and they had an average of 5.8 and 4.6 male and female siblings, respectively. Moreover, two respondents were married with a total number of 4 children.

Table 2d: Sociodemographic characteristics

Interview type	Variables (<i>n = individuals</i>)	Male	Female	Total
IDIs	Age (mean years)			
	Overall	n.a.	16.6	16.6
	< 18 years	n.a.	15.4	15.4
	> = 18 years	n.a.	22.0	22.0
	School enrolment			
	Yes	n.a.	22.0	22.0
	No	n.a.	6.0	6.0
	School enrolment – Magadi			
	Yes	n.a.	10	10
	No	n.a.	5	5
	School enrolment – Oloitoktok			
	Yes	n.a.	12.0	12.0
	No	n.a.	1.0	1.0
	Educational status			
	No education	n.a.	2.0	2.0
	Primary	n.a.	18.0	18.0
	Secondary	n.a.	7.0	7.0
	Household heads			
	Overall	18.0	9.0	27.0
	No education	10.0	9.0	19.0
	Primary	6.0	0.0	6.0
	Secondary	1.0	0.0	1.0
	Tertiary	1.0	0.0	1.0
Marital status				
Yes	n.a.	2.0	2.0	
No	n.a.	25.0	25.0	
Number of siblings (mean)	5.8	4.6	5.3	
Have children				
Yes	n.a.	4	4	
No	n.a.	23	23	
KII	Respondents	12	10	22
FGDs	Respondents	91	68	159
	Age (mean years)			
	Overall	25.0	22.6	24.0
	< 18 years	15.2	14.7	14.9
> = 18 years	30.1	26.9	28.7	

Source: Authors' construction using qualitative survey data

Qualitative data collection was not collected to describe sociodemographic of KIIs and FGDs respondents. Nonetheless,

Table 2d shows KIIs included 22 respondents (12 male and ten female) while FGDs (groups of 8-12 participants) included 159 participants (91 males and 68 females) in total. The age profile for FGDs participants indicates that the average age across the groups was 24 years with male and female cohorts having 25 and 22.6 years, respectively. FGDs participant below 18 years, had the mean age of 14.9 (male 15.2 and female 14.7) while the mean age for those above 18 years was 28.7 years (male 30.1 and female 26.9). KII and FGD statistics suggest that not only that the sample had more males than females, but also males included in the sample were, on average, older than their female counterparts.

2.10 Qualitative Data Analysis

The researchers familiarised themselves with the data by reading the transcripts, from which they developed the coding scheme, later loaded in NVIVO 11 software for coding and analysis. The coding scheme built on prior themes from the literature review, research questions and interview guides. Additional nodes/codes that represented emerging themes not covered in the interview guides were added to the original codebook, constituting the grounded codes. A synthesis of the coded data using a framework matrix preceded thematic analysis to identify patterns of meaning or concepts that frequently occurred across interviews/coded data.

3. RESULTS

This section presents the quantitative findings to the high-level evaluation question (HEQ), regarding the impacts of CLARP programmes on FGM/C rates, EFCM, ETP and educational outcomes. **Error! Not a valid bookmark self-reference.** presents a summary (cf. Annexe 3 for all regression results) of the difference-in-difference regression results. Column 1 shows the estimated outcomes of interest. Column 2 provides averages of the outcome variables between the control group counties (i.e., Mandera, Marsabit, and Wajir) and Kajiado (the treated County) before the rollout of the CLARP model. Columns 3 and 4 report the estimated average treatment effects following, consecutively, the magnitude of the average effect and the sign of the effect. Columns 5 report the percentage impact change – calculated as a mean of the estimated average effect divided by the overall mean pre-CLARP model rollout – (reported as a factor change) on all outcome variables. Overall, the reported results indicate the average treatment effects before and after CLARP rollout in Kajiado compared to control counties.

Table 3a: Summary of difference-in-difference regression results

Variables	Pre-CLARP rollout	Estimated Treatment Effects	
	Mean	Mean	Sign
Rates of Female Genital Mutilation/Cutting ¹⁶	0.808	0.242	-ve
Education in single years ¹⁷	3.124	2.469	+ve
Rates of child early and forced marriages ¹⁸	0.012	0.049	-ve
Rates of child early teenage pregnancies ¹⁹	0.015	0.063	-ve

Source: Authors' construction using analysed 2003, 2008-2009 and 2014 KDHS data

The summarised results in [Table 3a](#) were estimated from fully specified models (see footnote 11) controlling for all relevant variables that can, in theory, bias the estimated average treatment effects. Theory and existing literature (see, for-example, KDHS 2014; UNICEF and Gupta, 2013; UNICEF 2008; Shell-Duncan and Herniund, 2006; Hayford 2005; UNICEF 2005; Chege et al., 2001) guided the inclusion of these variables in the analysis. [Table 2b](#) shows that potential variables are the age of respondents, age and gender of household head, age at first cohabitation, residence (rural or urban) status, religion, ethnicity and wealth index included in the analysis. For coherence and clarity, the presentation of the results (for DEQ 1) follows four themes.

3.1 Impacts of CLARP on Female Genital Mutilation/Cutting (FGM/C)

The results suggest that FGM/C prevalence rates declined by 24.2 per cent in Kajiado county compared to Wajir, Mandera, and Marsabit. The analysis of qualitative findings also corroborates the reported quantitative impacts on FGM/C. Qualitative findings indicate

¹⁶ The estimates on FGM/C are on the margin and statistically significant at 10 per cent.

¹⁷ The estimates on Education are significant at 5 per cent significance level

¹⁸ The estimates on Education are significant at 1 per cent significance level

¹⁹ The estimates on Education are significant at 1 per cent significance level

declining FGM/C prevalence in both Magadi and Oloitokitok. Study participants generally regarded the CLARP model as one of the significant contributors to the declining levels of FGM/C in the study communities. The analysis shows that there was a sense that Amref needs to continue with the intervention for FGM/C to continue to decline.

“We would like to tell Amref to continue because we have realized we have moved a step forward. Concerning FGM/C, we have moved a step because it has reduced though hasn’t stopped. It is no longer at the same level as it was previously because it was very high. It was not a secret but the ones currently practicing it are doing it at night as we had previously discussed and taken to other locations for cutting. Therefore, we are requesting Amref to continue with their work because if they do, FGM/C will stop eventually.” ~FGD Morans.

The CLARP programme also appears to have generally contributed to a paradigm shift in the community by normalising the open conversation about the culture of FGM/C, increasing enlightenment about its harms, changing mindsets and empowering families to make better decisions.

“Today, they find it normal. However, it was difficult for leaders to speak against the culture. The community always thought that the person was introducing western civilization and were always up in arms. Things are now working as many people are now ready to hear and even attend the training. After the training, the people can now make better decisions.” KII Member County Assembly

“It has been a good program. Making of decisions to stand up against this culture which has been destroying many lives was something that many people could not make on their own. The training has made it possible. We are now leaving the culture that is not fruitful to us and moving on well. People have realized that the old culture is not of benefit.” ~IDI long-term CLARP beneficiary

3.2 Impacts of CLARP on child early and forced marriage (CEFM) rates

Quantitative analysis shows that CLARP interventions had discernible impacts on child early and forced marriages (CEFM) rates in Kajiado compared to control counties. **The estimates show that CEFM declined by 4.9 per cent.** The estimates are equivalent to a factor of four impact reduction in CEFM.

The analysis of CEFM using the qualitative data shows that CLARP models helped girls and women to make more informed decisions on delaying marriage and childbirth. The analysis shows that all the interviewed CLARP beneficiaries indicated that they would only think about marriage once they have completed their education. Usually, when a girl experiences FGM/C, they are now considered by the community to be mature and ready for marriage. However, the CLARP intervention appears to have empowered its beneficiaries to choose when to get married.

“For me not being circumcised, I will choose on the time to be married. I will continue with my studies up to where I will be able to reach that will make me choose the best person that I have liked to marry me. But for the person that is cut, immediately after cut, your father know that you are now mature to be married. He can give you out without completing your studies and even choosing the person that you don’t liked.” ~IDI long-term CLARP beneficiary.

“Being uncircumcised will help me plan for my future. It will help me finish my schooling on time and get a job before I choose who to marry me at the right time and start having children. But the circumcised she will be married off at the age of 15 or 16 to a man not of her choice and start having children as early as possible.” ~IDI long-term CLARP beneficiary.

3.3 Impacts of CLARP on teenage pregnancy (TP) rates

The CLARP interventions also appear to have had measurable quantitative impacts on teenage pregnancies (TP) rates in Kajiado compared to control counties. **The analysis reveals that TP declined by 6.3 per cent.** Qualitative analysis also backs up this finding. Majority of the respondents indicated that the CLARP intervention had led to a decrease in the number of teenage pregnancies.

“From my observation, it has reduced but still exist. Previously, teenage pregnancy was three or two every term but has dropped to two or three in a year.” ~FGD respondent, male parents.

This apparent reduction in teenage pregnancy was linked to the reduced likelihood of CLARP beneficiaries to be married off early as compared with non-beneficiaries. CLARP beneficiaries were also said to have higher self-worth and consequently, a lower likelihood of engaging in risky sexual behaviours.

“I will say that due to the awareness especially the ARF programs, the trainings, pregnancy has really gone down especially when the trainings that are conducted, they really encourage a lot of girls and make someone among themselves and the issue of self-worth that they take pride among themselves when they don't have those sexual relationships with boys.” ~KII Children Protection Officer.

However, not everyone agreed that CLARP had any differential impact on teenage pregnancy. One participant mentioned that although the CLARP model has led to a reduction in teenage pregnancies, there are still some uncut girls that get teenage pregnancies because of peer pressure.

“We still experience teenage pregnancies. That is something that the nurses and CLARP teachers needs to include now, to say even if you are a woman through CLARP, it doesn't guarantee you to become a woman and give birth. But for now, I can say it is the same.” ~KII Community-based Organisation Officer.

3.4 Impacts of CLARP on educational outcomes

Quantitative analysis also shows that the CLARP interventions had a tangible impact on improving educational outcomes in Kajiado compared to control counties. The estimates suggest that CLARP interventions in Kajiado resulted in an average increase in schooling years for girls and women by roughly 2.5 years.

Improvement in school retention and completion also came out of the analysis of the qualitative data further reinforcing the estimated quantitative impacts. The analysis shows that there was a consensus that CLARP beneficiaries were more likely to complete school as compared to the non-beneficiaries.

“What I can say is, since I joined this school in 2010, school completion has improved because I think that is the same year CLARP started. They complete school and join secondary schools. This type of education has brought a lot of change”. ~FGD respondent, male parents.

The increased likelihood of school completion among CLARP beneficiaries was attributed primarily to the decreased likelihood of early marriage. CLARP beneficiaries appear to have a stronger agency to resist early marriage so that they could complete school.

“My father was suggesting circumcising me and marry me off the same thing he did to my older sisters, but when I attended the training, he tried to marry me off, but I refused. When he realized that I was not changing my mind he started supporting me with my education and he told me, learn until you reach where you want to reach.” ~IDI long-term CLARP beneficiary.

“...There is difference. Because the circumcised will be married between 15 years, 16 years, or, 17 years but am in school, until I complete my school, that's when I will think about marriage.” ~IDI long-term CLARP beneficiary.

Qualitative analysis also included an analysis of the experiences and stories of CLARP (versus non-CLARP) beneficiaries (DEQ 2) and the perceptions, attitudes and practices of community

stakeholders about FGM/C practices (DEQ 3). Section 3.5 and 3.6 report the analysed results in response to DEQ 2 and 3, respectively.

3.5 Experiences and stories of CLARP (versus non-CLARP) beneficiaries (DEQ 2)

This section reports on the experiences and stories of girls exposed to the CLARP intervention and their perceptions of various community stakeholders regarding the CLARP model and how it has impacted the practice of FGM/C in their communities.

Overall, CLARP beneficiaries reported having positive experiences with the program. They pointed out that they had learnt a lot from the program, such as the adverse effects of FGM/C. The uncut beneficiaries also mentioned that because of the CLARP, they had escaped undergoing the cut and felt empowered to make decisions on their lives, including whether to undergo FGM/C or to remain in school.

Even among CLARP non-beneficiaries, there was a general sense that the CLARP intervention had made a positive difference in the lives of its beneficiaries.

“...I told my mother that if I reach 15 years I will be circumcised to be like my sisters. I liked saying that I will be circumcised, but immediately I attended the CLARP seminars, I noticed it’s not good to undergo the cut. I told my parents and friends my stand and they understood me.” ~IDI long-term beneficiary

“At first, I never thought that this education that we were accessing there when we attended the CLARP was of any help. I thought it was a waste of time. But when I attended it continuously and continue getting a lot of knowledge, I saw that it was good, and it was a good decision that Amref made.” ~IDI long-term beneficiary.

“I can say girls have many reasons to celebrate about. One, they haven’t undergone the pain of the cut. Two, they are aware of diseases, so they won’t be infected with any disease. Three, they are sure that they will be educated. What I mean of education is that they won’t be seduced frequently that mean they won’t get pregnant. For that reason, the level of education will improve.” ~IDI CLARP non-beneficiary.

3.6 Perceptions, attitudes and practices of community stakeholders about FGM/C practices

This section reports the analysis on the perceptions, attitudes and practices of community stakeholders about FGM/C practices in Kajiado. The analysis shows a strong consensus that the study communities embraced the CLARP model because of its demonstrable impacts in the lives of its beneficiaries and their families. However, there remain quite a few barriers to the model’s effectiveness. These barriers correlate with the perceptions, attitudes and practices of community stakeholders about FGM/C. This section also highlights some of these barriers. It also identifies opportunities to refresh and reinvigorate the CLARP interventions for better and more sustainable impact.

3.6.1 Barriers

a) Resistance to cultural change

Most of the study participants said they do not see any risk or disadvantage of the CLARP model. However, a few people mentioned that the key barrier to the program is the fact that it is still perceived to go against the Maasai culture.

“According to the community’s belief, they still believe it is important. However, much you try to convince them that it is outdated, they cannot give up the practice. Many, especially the elderly will ignore you”. ~IDI long-term CLARP beneficiary.

The Morans, young men and elderly community members (such as grandparents) were particularly resistant to CLARP because they believed in the sacredness of the FGM/C practise even though they tended to accept that the practice did not provide any tangible benefits.

“This is because of our culture, what I can say is that even the young men are propagating the spread of the FGM/C practice in this community. Most of us do not want to marry uncut girls. For instance, if I got married and during lovemaking, I get to realize that the woman I got married to be not circumcised, I will send her back to her parents”. ~FGD adolescent boys.

b) Persistent stigma

One daunting consequence of the resistance to cultural change is the persistence of stigma. Girls who do not undergo the cut, including those that graduate from the CLARP training remain at high risk of ridicule, discrimination and rejection in the community. Uncircumcised girls/women are looked down upon by the community and endure name-calling using such derogatory terms as ‘*entaapai*’ (uncircumcised). Regardless of their age or educational status, uncircumcised girls are considered by many to be children since they have not undergone the traditional rite of passage into womanhood. In some instances, society looks at them as non-Masai or aliens.

“...Some of us we are big girls but are going to school. We seat with circumcised girls in class. They under look at us only that they consider themselves as women and we are a girl. They will not dare even seat with you”. ~IDI recent CLARP beneficiary.

“Concerning this CLARP, we have some Morans who are against it because they believe if you are not circumcised it won't be good at all; because if you marry uncircumcised woman you will be staying with a girl in the house, and that is not good”. ~FGD adolescent boys.

c) Peer-pressure

CLARP beneficiaries face significant peer-pressure, particularly from young men as well as girls that have undergone the cut. At the core of this peer-pressure are the issues of dating and marriageability. Generally, male suitors prefer girls that have undergone the cut. These girls waste no time in flaunting the attention and gifts they receive.

“...In addition to that, there is no man who would marry anyone who has not undergone FGM/C. When they listen to such advices, they go to class telling their classmates how they feel proud holding each other's hands. Those who have undergone the FGM/C only sit with those who have undergone through FGM/C. If they have boyfriends, they sit and walk together holding hands. Those who have boyfriends have a lot of advantages. This makes those without boyfriends to go for the FGM/C in order to have the advantages.” ~IDI, CLARP recent beneficiary

“When we meet, some girls are circumcised. They will inform you that you can't get a boyfriend unless you are circumcised. They will advise you to get circumcised first. Sometimes you can be convinced by seeing gifts they get from their boyfriends. That might lead you to get circumcised so that you can also get a boyfriend who will give you gifts. That is how it is.” ~IDI, CLARP recent beneficiary

d) A rise in secret circumcisions

One worrying trend that was highlighted by several study participants was the rising practice of FGM/C in secret. The illegality of FGM/C was driving several covert practices including conducting the cut in the dead of the night or sending the girls across the border into Tanzania.

““Some candidates are taken as far as out of this country like in Tanzania, or at the borders there they are circumcised secretly, and they stay there till when they are healed. Apart from that, they may go to reside with some close relatives say grandparents where this act may be conducted. These arrangements are made by the parents who want their children to be circumcised but they are afraid of the authorities.” ~CLARP long-term beneficiary.

“The traditional circumciser will be called to circumcise a girl at home especially at night and the girl is forced to stay indoors until she is fully healed, in case a neighbor visits the homestead he/she is not be aware that there is a girl who has undergone FGM/C.” ~FGD Adolescent boys.

3.6.2 Opportunities to improve/adapt

a) Correcting misperceptions about uncircumcised girls

There remain several misperceptions about uncircumcised girls, especially among young men and Morans. For example, uncircumcised girls were reported to be more sexually active and tend to conceive faster than those who have undergone the cut. Some respondents highlighted that uncircumcised girls were promiscuous, and hence men prefer the circumcised, less promiscuous women. Education and awareness programmes that target the misinformed groups can correct such misconceptions.

“It is the truth because the uncircumcised girl is very loose because her blood is still hot. If you try to seduce them, you will notice the difference between a circumcised and uncircumcised girl. This is because the circumcised girls are very difficult to seduce but for the uncircumcised it is different.” ~FGD Morans.

“You know the circumcised one lost a lot of blood during circumcision therefore the uncircumcised has more heat compared to the other, therefore can conceive quickly.” ~FGD Morans.

b) Highlighting economic empowerment

Some study participants highlighted that circumcision is associated with economic gains because girls are married off soon after the circumcision. Thus, the dowry payment was highlighted as an economic motivation for parents (especially fathers) to have their daughters circumcised in readiness for marriage and in anticipation for dowry payment. It also emerged that the dowry price for circumcised girls is higher than that of uncircumcised girls.

“Yes, girls that are cut and those who are not cut they say their dowry is not the same. A girl who is cut has already passed the rite of passage so her dowry will be high since she has not engaged with other men. They say that the girl maybe a virgin”. ~IDI long-term CLARP beneficiary.

“The parent would want to get money quickly because he will not if the daughter is not circumcised.” ~FGD parents.

However, the narrative appears to be changing. The community is now witnessing a new economic phenomenon involving uncircumcised girls that have completed their studies and gone on to pursue successful careers. These girls then support their parents financially. Given the feedback that the CLARP intervention improved school completion rates among its beneficiaries, therein lies an opportunity for the model to educate the community about the long-term economic empowerment of girls that have passed through the program.

“...CLARP programme also has helped them because they have known the importance of not circumcising their girls. As for now we have girls who go to school, some have jobs and help their parents. Before girls were being circumcised and married off then dowry is paid. Latter those cattle die due to drought. But now they are bringing salary. Whatever small they get they share with their parents. Now parents have seen the importance of not circumcising their girl through the CLARP model.” ~FGD adolescent boys.

c) More visibility to the harms of FGM/C

Another opportunity lies in further educating the community members about visible harms of FGM/C. Young boys appeared quite knowledgeable about these harms, which they mentioned to include high risks of sexually transmissible diseases, complications during childbirth and school drop-out. These young men

“FGM/C negatively impacts the lives of the girls because during FGM/C they destroy part of woman’s body which in turn brings a problem when these girls are giving birth.” ~FDG adolescent boys

“As a Maasai community, we have experienced a lot of challenges in relation to FGM/C because once a girl is circumcised, she drops out of school because she feels she is mature enough to be married.” ~FDG adolescent boys

could be current and future ambassadors of the CLARP interventions to the broader community.

Other ambassadors of change could include the Traditional Birth Attendants (TBAs) who were typically the people responsible for executing the cut. The analysis suggested a declining role of TBAs and that some of them are embracing a new way of thinking.

“I refused and instead joined the church. I told the community I will not do that again” ~KII Traditional Birth Attendant.

“It has made them respect me more...They like me because I have stopped what they also don't like.” ~KII Traditional Birth Attendant.

d) Follow-up and reaching excluded groups

According to some study participants, improvements of the CLARP model would require reaching out to specific groups that were not adequately involved in the implementation of the intervention. These include small community-based groups, older men and women, parents and men who are the household heads. They also stressed the need for follow-up with former CLARP participants to ensure they adhere and live by CLARP training expectations consistently to help beneficiaries not to succumb to peer pressure and backslide to

“What I am requesting you is, try and set aside a week to train the old men because that is the only time, they will understand what Amref is talking about. Let us not take them for a joke. If we approach them as young men, they will not take us seriously but if you people approach them and they see us together they will take the issue seriously”. ~FGD Morans.

“This is due to peer pressure because if a girl is not circumcised and she comes back to a community where majority of the girls have been circumcised, she will be ridiculed by her peers hence the pressure to undergo FGM/C.” ~FGD Adolescent girls.

e) Law enforcement and political will

It was evident from the interviews that the study communities were aware of the laws of the land in so far as FGM/C is concerned. Several participants mentioned that the risk of arrest and prosecution had served as a significant deterrent to FGM/C in their communities. However, some participants were unconvinced that the laws were being enforced adequately, especially by some local chiefs. Others were worried about being stigmatised for cooperating with law enforcement officials. Future CLARP interventions should, thus, consider how best to work with government officials to socialise and implement the respective anti-FGM/C laws.

“FGM/C stopped though our wives are circumcised. It is not practiced anymore in this area because of the training that have been conducted and the government is also against it. If any parent now practices FGM/C he or she will be arrested and taken to jail.” ~FGD Morans.

“I know it is unconstitutional and unlawful and you can be charged in the court of law. But in the real sense we have never seen or heard a person who has facilitated the proceeding taken to court of law. I can say they are there but silent.” ~FGD Young men.

3.7 Linking quantitative and qualitative results

This section triangulates the reported findings from both quantitative and qualitative analyses. While the findings converge in supporting the impacts of CLARP interventions on FGM/C, EFCM and ETP reduction as well as improvement in educational outcomes in Kajiado, their analyses compare indirectly (and not directly) for several reasons. Firstly, the different data generating process behind both analyses. Secondly, quantitative analysis captures Kajiado, whereas qualitative analysis only considers segments/hotspots of Kajiado (i.e., Magadi and Oloitokitok). Thirdly, the presence of time lags in data collection and availability. Quantitative

analysis used dated secondary data between 2003 and 2014. The qualitative analysis used the most recent primary data collected in 2019. Therefore, the linkages and triangulation of the two sets of findings should bear these caveats.

Nevertheless, the findings provide correlated insights. On the one hand, quantitative findings provide the magnitude of CLARP interventions. On the other hand, qualitative findings contextualise the quantitative findings by providing a richer understanding of the different potential pathways through the estimated quantitative impacts can happen. For example, the quantitative findings report an impact of 24.2 per cent reduction in FGM/C, the result that correlates with the resounding qualitative finding that CLARP interventions contributed to the declining FGM/C rates in Kajiado. Indirectly, as revealed by qualitative analysis, the declines relate, amongst others, to the visibility of FGM/C practices as illegal and that it deprives girls and women of their social and human rights thus influencing a change in social norms.

The reductions in CEFM and TP by 4.9 and 6.3 per cent, respectively, also mirror qualitative findings reported by CLARP beneficiaries that the intervention helped them make informed decisions and thus delaying marriages and childbirth as well as teenage pregnancies, respectively. For example, the qualitative analysis also revealed that CLARP beneficiaries would only think about marriage once they have completed their education. Equally, the reduction in teenage pregnancy relates to a reduced likelihood of CLARP beneficiaries to be married off early as compared with non-beneficiaries. Notably, CLARP beneficiaries were also said to have higher self-worth and consequently, a lower likelihood of engaging in risky sexual behaviours.

Similarly, improvement in schooling years by 2.5 years shown by quantitative analysis also relates to the claim by qualitative respondents that CLARP model in Kajiado has led to better school retention and completion. Qualitative analysis revealed that CLARP training has the potential to empower girls and women to claim their social and human rights, majority of whom reported to prefer to accumulate their human capital than getting married off early when still young.

In general, note that the results from quantitative and qualitative analysis, although informed by different approaches and data sources, they are related²⁰ to making meaningful inferences and implications of CLARP interventions in Kajiado. The next section builds on these linkages to discuss the findings, draw conclusions and practical recommendations.

²⁰ Evidently, there is a need to re-estimate quantitative results with more recent KDHS data to confirm and build confidence on the evaluation quantitative findings.

4. DISCUSSIONS OF THE FINDINGS

Existing empirical evidence on the interplay between FGM/C and CLARP models indicate that the latter plays a significant role in shifting knowledge, attitudes and perceptions of FGM/C practices in a society (UNICEF and Gupta, 2013; Dagne, 2010; UNICEF 2008; Shell-Duncan and Herniund, 2006; UNICEF, 2005; Chege et al., 2001; Oloo et al., 2001). By catalysing influence on its abandonment, CLARP models have directly and indirectly contributed to the declining FGM/C's prevalence rates, improved educational outcomes for girls, and reduction in child early and forced marriages and teenage pregnancies (UNICEF and Gupta, 2013, UNICEF 2008; UNICEF 2005). Shand ell-Duncan et al., (2017) and Johansen et al., (2013) assert that the effectiveness of the CLARP models hinges on its community-led approach in changing social norms on FGM/C, as well as empowerment of girls and women through education.

Much of the existing literature on the evaluation of CLARP models have centred on their impacts on community knowledge, attitudes and perceptions (UNICEF and Gupta, 2013; Dagne, 2010; UNICEF 2008; Shell-Duncan and Herniund, 2006). Nevertheless, there is growing recognition that CLARP can have farfetched impacts beyond changing the social norms and behaviours on FGM/C (Dagne, 2010; UNICEF 2008; Oloo et al., 2001). Despite these recognitions and widely celebrated impacts of CLARP models in changing societal norms and behaviours towards FGM/C, scant evidence exists on the quantitative and qualitative impacts of CLARP models in not only reducing FGM/C prevalence rates but also in reducing child early and forced marriages, teenage pregnancies and improvement in educational outcomes. The present evaluation study bridges the existing knowledge gap by quantitatively and qualitatively evaluating the impacts of the CLARP model in Kajiado county in Kenya.

Employing quasi-experimental and qualitative methods to sleuth and analyse detailed quantitative and qualitative survey data, the findings of this study lend credence to the claim that the rollout of the CLARP model reduced FGM/C practices, child early and forced marriages, teenage pregnancies and improved girls' schooling years in Kajiado. Quantitatively, the estimated magnitude of impacts indicates that CLARP model reduced FGM/C by 30 per cent, reduced early and forced child marriages and early teenage pregnancies four-folds over, respectively, and increased schooling years by 79 per cent. Further analysis of KDHS data also broadly corroborate these findings: not only have FGM/C rates been on the decline (cf.

Figure 1a), but CEFM and TP have also been on the decline. CEFM declined from an average of 1.22 per cent in 2003 to 0.37 per cent in 2014. TP declined from an average of 1.29 per cent in 2003 to 0.38 per cent in 2014. On the other hand, the average years of schooling increased from 6.87 years in 2003 to 9.3 years in 2014.

Despite the reported barriers, qualitatively CLARP interventions appear to not only have left positive experiences to its beneficiaries but also improved their lives. The analysis also shows that the CLARP model has several perceived benefits to its beneficiaries: empowering girls to make decisions to delay marriage and childbirth and thus pursue the accumulation and development of their human capital. Finally, the findings reveal that Maasai communities in two sub-counties of Kajiado (Oloitokitok and Magadi) have embraced the CLARP model because of its tangible positive effects on young girls' lives in these communities.

The findings reported in this study are also consistent with those of the *Yes I Do Alliance* (YIDA) programme (Egberts, F., and Demenint, M., 2018) which also point to a reduction in child marriages, teenage pregnancies and FGM/C prevalence as a result of community engagement and sensitisation on gender equality and sexual and reproductive health knowledge. YIDA's interventions aim at promoting gender-transformative thinking, girls' empowerment and engagement of men and boys as gatekeepers. The five (5) year

programme (2016-2020) is working with vulnerable communities to end FGM/C, teenage pregnancies and child marriages in Ethiopia, Kenya, Malawi, Mozambique, Zambia, Pakistan and Indonesia. In Kenya, the programme works within the Maasai community to provide an alternative rite of passage to girls, with more than 1,300 girls having been trained and graduated from the programme. A mid-term review of the programme indicates a positive influence on community perspectives on deeply rooted cultural norms such as FGM/C, with community members appreciating the importance of girl child empowerment through education, which consequently is delaying child marriages and teenage pregnancies.

The findings of the present study have important policy implications for policymakers, health development practitioners, and Amref Health Africa and Kenya office. The findings provide persuasive evidence that CLARP not only works but has discernible impacts on its beneficiaries in Kenya providing scope for scaling-up the models to other areas and countries where FGM/C practices are widespread and rampant. By extension and in line with other studies (e.g., UNFPA, 2013; Johansen et al., 2013; Gitagno, 2015; UNICEF, 2005; Oloo et al., 2001) the results suggest that harnessing and mainstreaming CLARP interventions into, for-example education curricular and community-led outreach programmes, can have more tangible and sustainable impacts on both its beneficiaries and the society at large.

Efforts by governments, multi-lateral organisations and community-led initiatives have driven recent declines in FGM/C rates in Africa (Muthumbi, et al., 2015; Kandala et al., 2018). The fact that CLARP interventions have had positive impacts in Kajiado gives hopes, at least on the margin, for yielding substantial results if scaled-up. Presumably, the positive CLARP interventions effects signal the need for, amongst others, more resource mobilisations to entrench the interventions further interior to the rural and grassroots areas to effectively fight the persistent FGM/C practices standard in such places.

Typically, FGM/C, child early and forced marriages, teenage pregnancies and girls' educational outcomes are interlinked (Koski, et al., 2017; Gitau et al., 2016; UNICEF, 2013; UNICEF, 2008; Hayford, 2005). Thus, the documented positive findings suggest that the CLARP models can act as a safe bet for replacing FGM/C rituals as a rite of passage and at the same time be an educational and empowerment conduit for empowering girls and women in Kenya. The findings also signal the potent role CLARP models have in lessening and curtailing the alarming rates of child early and forced marriages (Koski et al., 2017; KDHS, 2014) and thus contain its spillover effect to teenage pregnancies (Gitau et al., 2016) minimising maternal death and childbirth complications associated with teenage pregnancies (Loaiza and Liang, 2013; UNICEF, 2013).

The findings also have implications in answering the question of attribution versus the contribution of CLARP interventions to the outcomes measured and of Amref's contribution to the broader efforts to eradicate FGM/C. Analysing attribution requires the with and without the intervention assessment. The present impact study has attempted to do so, although the interpretation of the results has caveats in the data used for analysis and broader ethnic context of FGM/C practices in Kajiado. While the quantitative analysis resonates with the attribution aspect, the analysis focuses on the entire Kajiado County (assuming the Amref rolled out CLARP model throughout the County, which was not the case). Therefore, the analysis provides upper-bound estimates and encompasses the entire County while interventions rollout was for specific hotspots (e.g. Magadi and Oloitokitok). Moreover, the direct attribution to the Maasai community is hard to make because of the presence of multiple ethnicities that live in Kajiado and practice FGM/C (cf. [Figure 1c](#)).

Therefore, although grounded on and estimated using a robust approach for establishing attribution, the presented quantitative findings, by and large, show contribution, as opposed to



attribution, of CLARP interventions on the metrics of outcomes of interest. Similarly, the interpretation of the qualitative results tilts towards contribution (rather than attribution) because of both sampling limitations and difficulties to identify direct causal and effects because of a myriad of inter-related qualitative factors that can affect measured outcomes of interest in different unknown ways. Spearheading the FGM/C fight in Kajiado, alongside governments, local and international, CLARP model, is evidently, a force to reckon. The contribution of CLARP interventions in the fight against FGM/C practices and their related manifestations not only signal Amref Health Africa's noble work but also suggest more resources and collaborative efforts (from other stakeholders) are needed to scale-up the CLARP interventions to eradicate FGM/C.

5. CONCLUSIONS AND LESSONS LEARNT.

This study evaluated the impacts of the CLARP model rolled out by Amref Health Kenya in Kajiado county in 2009. The main objectives of the evaluation were to: (i) determine the impact of the CLARP intervention on social and educational outcomes: Female Genital Mutilation/Cutting (FGM/C), child early and forced marriages (CEFM), teenage pregnancy (TP) and girls' educational outcomes; (ii) explore and document the experiences, stories and determine the educational and marital/parental status of girls who have gone through CLARP; and (iii) explore the perspectives, attitudes and practices of community stakeholders towards FGM/C.

Exploiting Kenya's demographic health surveys (KDHS) surveys, the study's quantitative analysis revealed that CLARP interventions played a decisive role in attenuating FGM/C, CEFM and TP in Kajiado. The results also indicate that the interventions increased schooling years for girls in the county. Furthermore, the study conducted detailed qualitative surveys to complement quantitative analysis. The findings from qualitative analysis further confirm the quantitative results. Specifically, the findings show that the CLARP model is slowly embraced by the Maasai communities (in the two targeted sub-counties of Magadi and Oloitokitok) and its implementation has left positive experiences on the ground. Additionally, the intervention empowered girls and women to claim and protect their social and human rights and accumulate more human capital, aside from further improving their lives.

While its evidence in favour of the CLARP interventions is compelling, the present study is not without limitations. The quantitative analysis relied on slightly dated data between 2003 and 2014 because current data is unavailable. Therefore, there is no guarantee that the findings will hold if a new analysis takes on board the most recent data. The interpretations of the findings thus need to bear this caveat in mind. That is, the estimated impacts of CLARP interventions seem to have worked during the period 2003-2014 only. Moreover, the multiplicity of ethnic groups that both practice FGM/C and live in Kajiado county (as captured in the KDHS data) makes it difficult to isolate and attribute the aggregated impacts of CLARP models to Maasai communities predominant in Kajiado, although the study collected qualitative data to provide more Maasai community relevant and related insights. The main limitation of our qualitative analysis, however, is small sample bias making it challenging to draw broadly representative inferences.

Finally, it is important to note several lessons that this evaluation study has illuminated:

- i) The overwhelming need for collecting reliable, consistent, credible, and relevant data related to the CLARP model for generating evidence-based reporting and for sound decision making.
- ii) The need to revise the current CLARP model to improve its design and reach for more profound, long-term and sustainable impacts;
- iii) The need to closely work with local stakeholders, border authorities and authorities in neighbouring countries to curb cross-border FGM/C;
- iv) The need to mobilise more resources (financial and human) to scale-up CLARP interventions to a broader community; and
- v) The significance of intensified community-led engagements and open discussions and dialogues to address identified barriers: resistance to cultural change, peer pressure, stigmatisation, and misconceptions about uncircumcised girls and women.

6. LIMITATIONS OF THE STUDY

The study has three main limitations:

- i) The quantitative analysis used 2003, 2008-2009, and 2014 KDHS data, which are dated. Collection of KDHS is after every four years. The 2018 data has not been released for public use yet and thus was not included in the analysis. The interpretation of the results must, therefore, consider one important caveat: the documented impacts of CLARP interventions may have worked during the period 2003-2014 only. It is essential to treat the estimated results as upper-bound effects that can be revised down in magnitude once more recent data is available to complement the present analysis.
- ii) Using aggregated KDHS data to isolate and attribute the specific impacts of CLARP interventions on the Maasai community is difficult because sampled respondents came from different ethnic groups (also living in Kajiado and practice FGM/C) as suggested in [Figure 1c](#). A back of the envelope calculation indicates that roughly 19.4 (out of 67) per cent of non-Maasai KDHS respondents underwent FGM/C and lived in Kajiado during 2003, 2008-2009 2014 surveys. Therefore, the generated analysis and reported results had relied on one fundamental assumption: KDHS respondents living in Kajiado are directly or indirectly related to Maasai culture and that the results should be interpreted more broadly across Kajiado and not necessarily to Maasai respondents and communities.
- iii) A comparison of the quantitative and qualitative findings is indirect (and not direct): analyses from both approaches follow different underlying data generating processes. For-example, while quantitative analysis captures Kajiado county, the qualitative data was only captured from Oloitoktok and Magadi, which are segments of Kajiado. Similarly, the presence of time lags in data collection and availability: quantitative analysis used secondary data for the period between 2003 and 2014, whereas qualitative analysis used the most recent primary data collected in 2019.

7. RECOMMENDATIONS

- i) **New comprehensive, engaging and sustainable CLARP 2.0:** The existing CLARP models run on-and-off projects to specific hotspot locations as opposed to a full-fledged programme that can be scaled-up to a large community. The CLARP models in Kajiado run on a short-term basis limiting an effective change process. Social norms take time to change, and change is made possible through extended engagements with communities to a level where “tipping points” are realised to result in the sustained change. Integrating models of social change that encourage collective discussions on community values, increase awareness on the cost of FGM/C, collective decisions to abandon practice, public declarations of abandonment to create a sense of social change within the community, knowledge diffusion within social networks and sustained advocacy to ensure complete shift in social norms before programmes end. A sustainable model that placed responsibility for continued community discussion, a continuation of knowledge diffusion and sustained public declarations should be adopted.

Ensuring that the new CLARP 2.0 is comprehensive, engaging and sustainable, the study recommends a set of activities:

- a) Amref to conduct community-level engagements and participatory research to gather more new socio-cultural norms and traditions that relate to CLARP interventions. Engaging such influential community leaders as elders, parents, Morans, and youth is critical for the new refurbished CLARP model to have long and community-wide sustained impacts;
 - b) Fieldwork revealed that the exit of CLARP interventions in specific sites reduced sensitisation of community members and may likely have perpetuated new incidences of FGM/C in Kajiado. The new CLARP 2.0 must thus focus on whole communities as opposed to hotspots. The limitation of targeting hotspots lies in the fact that migratory patterns and family ties extend beyond locations. Where localised interventions fail to shift social norms completely, that intent on the continuation of the practice will opt to undergo the practice in a different “untreated” location. Fieldwork evidence in Kajiado indicated families opting to take their daughters as far as Tanzania to undergo the practice, as well as other locations within Kajiado where CLARP is non-existent. Mobilisation and more allocations of resources to CLARP interventions will be necessary to ensure a broader reach to more community members;
 - c) Take advantage of the visibility of FGM/C in the communities to design short but recurrent and specific community-led activities tailored to directly respond to such issues as resistance to culture change, stigmatisation, peer pressure and misconceptions about uncircumcised girls and women;
 - d) Explore ways to mainstream and integrate CLARP training into school curricula, especially in areas where FGM/C is widespread and rampant. Mainstreaming CLARP models into school curricular can help reach out to more girls and make CLARP training continuous, trackable, measurable and sustainable. As part of the curricular development, Amref should consider developing digestible, friendly and an easy-read CLARP manual for teaching in schools; and
 - e) Establish mentorship programmes, especially for in-school girls before, during and after the CLARP graduation.
- ii) **Strategic collaboration with communities, border authorities and authorities in neighbouring countries:** Amref needs to integrate communities leaders, local stakeholders and law enforcement agencies in the CLARP model: law enforcers should be encouraged (and trained) to work with communities in changing social norms, rather than rigidly apply the law. Failure to appreciate the deep-rooted cultural drivers of FGM/C that take more than legal action to change has resulted in changed

forms of FGM/C which fail to eliminate the practice but makes prevalence undetected. These new forms include medicalisation, cutting of girls at a younger age, and secretive practices. Amref also needs to engage with border authorities and authorities in neighbouring countries to stop the reported cross-border FGM/C. Examples of activities that Amref can undertake are:

- a) Regular training on community engagement to law enforcement officers;
- b) Initiate, support and finance cross-border joint task forces to help stop cross-border FGM/C;
- c) Design and rollout intensive media campaigns with other Amref offices in neighbouring countries – useful for fighting covert cross-border FGM/C; and
- d) Work closely with community stakeholders to design and introduce a whistleblowing system for discreet reporting of secretive FGM/C.

iii) **Data collection and management:** Amref Health Africa invest in high-quality, and state-of-the-art automated data collection and management infrastructure and human resources needed to manage, collate and analyse data. Analysis of CLARP interventions requires rich high-frequency data to help Amref teams make sound and informed decisions. Thus, there is an urgent need to revise the existing CLARP database by making sure it is consistently and regularly updated. The existing database is operated manually and prone to measurement errors making it somewhat unreliable for statistical inferences and decision making. Specific activity to complement this recommendation include;

- a) Creating a state-of-the-art database that can keep track of CLARP beneficiaries and their families for at least five years. The data can help with tracking the beneficiaries to follow up on their progress post-CLARP training, e.g., to provide the necessary support (e.g., psychological support) in case there is peer pressure to deviate to FGM/C. The database can help track girls and re-engage them for various CLARP-related community activities and consultations such as school visits, and intergenerational dialogues.

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ANNEXE 2: A LITERATURE REVIEW

Theoretical Perspectives on FGM/C practices

The origins of Female Genital Mutilation/Cutting (FGM/C) practices remains unclear, although there is consensus that the practices have existed for years particularly in several countries in Africa (Kouba and Muasher, 1985). Debates have ensued among researchers, academic scholars, practitioners and policymakers on the forces underlying FGM/C practices. Consequently, a body of theories has evolved to provide clarity on the reasons for FGM/C practices.

The social norms/convention theory views FGM/C as a social practise determined by group norms, and therefore social pressure compels conformity to these social norms/conventions to avoid sanctions by the community (Hayford, 2005). The theory asserts how certain harmful social practices are self-enforcing, why they are universal in a community, and why they are firmly embedded and therefore difficult to change. In communities that practise FGM/C undergoing the cut is considered a means through which women acquire social status and maintain modesty for increased marriageability prospects (Yount, 2002). Similarly, girls who have undergone the cut attract high bride price because of the belief that FGM/C maintains girls' purity, chastity and morality. Parents, therefore, must conform to such social norms by ensuring their daughters undergo the cut to assure their security through marriage (Hayes, 1975).

The gist of the social norm theory, therefore, is the belief that FGM/C is a prestigious rite of passage that affirms belonging, with those who have undergone the cut given social status and family honour (Yount, 2002). The implications of the theory, on the contrary, is that ridicule, social shame, ostracise, and even social status denial befall girls and women who are not in line with community values (Brown et al., 2016). With high levels of scrutiny on women's social behaviour and the high expectations of conformity to cultural practices placed on them, there are incentives for women to conform to practises some would consider harmful (McAdam, 1992). Coyne and Coyne (2014) consider this as the cost and benefit of belonging, with parents deriving utility as good parents by conforming to social norms and raising their daughters right. Subsequently, young girls may desire to undergo the cut for the social rewards it brings and a sense of community belonging. Given that others condition an individual's behaviour, the social norm theory suggests that when a critical mass of community members abandon the practice, it minimises social sanctions that place pressure on conformity, making the abandonment of the practice possible.

Modernisation theory considers the progressive transition of rural and agrarian-based societies towards economic development. It postulates that in traditional societies where patrilineal social structures and gender-biased opportunity structures exist, women access to resources and opportunities such as land, education and income is limited, and therefore marriage is considered an economic necessity for access to wealth (Kouba and Muasher, 1985). The theory places high value in conforming to cultural prerequisites for marriage, key among them undergoing the cut (Yount, 2002). In such societies where the gendered roles of men and women are delineated, the woman's economic value correlates with her role of wife and mother, and therefore the cut becomes a critical prerequisite to childbearing (Kouba and Muasher, 1985). However, with increased urbanisation and reduced value of land inheritance, there is a change in attitude towards the position of women in society, resulting to a decline in

the importance attached to FGM/C practices (Yount, 2002). Besides, modernisation also leads to increased levels of education, job prospects for women, and improved incomes, reducing dependency on marriage (Hayford, 2005), and promoting individualised and privatised decisions on the role of family (Andro & Lesclingard, 2016). In her analysis of FGM/C practices in Kenya, Hayford (2005) found that fewer than 30 per cent of women with post-primary education had undergone the cut, while almost half of the uneducated women were circumcised. Further, UNICEF (2005) reports a high correlation between a mothers education level and the likelihood of their daughter undergoing the cut.

Feminist theorists frame the motivations of FGM/C within the context of unequal gender relations and hegemonic masculinity attitudes (Small, Sharma, Nikolova, & Tonui, 2009) that place women as subordinates to men, and subject to the control of their bodies and sexuality (Kouba and Muasher, 1985). These attitudes are learned by both men and women early in life and over time, and therefore reinforce hegemonic patriarchal attitudes as they relate to gender issues, femininity and women's sexuality (Yount, 2002; Hayford, 2005). For-example, men and women view clitoris removal as an act of purifying the woman before marriage and controlling their sexual desires to keep them faithful once married (Andro and Lesclingard, 2016; Omigbodun et al., 2009). In extreme cases, men and women view clitoris as a masculine part on a woman's body, justifying its removal to maintain the femininity of the woman (Gruenbaum, 2005) and maintain the sexual dominance of the man. It is also a means through which the woman obtains some authority in the private sphere of the family due to her status having undergone the cut (Yount, 2002).

Contrary to the belief that hegemonic masculine attitudes about FGM/C cannot change, Brown et al., (2016) find support among men in Kenya to end the practice due to sexual dissatisfaction as a result of mutilation of the female organ. Likewise, Omigbodun et al. (2009) find pockets of support from men in Nigeria as a result of the psychological effects of inflicting pain on their women during sex. Despite changes in men's attitudes, support and demands for the practice relate to men's need to conform to established cultural group norms. UNICEF and Gupta (2013) assert that countries are making concerted efforts to reverse perverse social and cultural norms of conformity that perpetuate FGM/C practices. These efforts can influence not only individual behaviour but also a collective behavioural change in communal perceptions which then can alter social norms and redirect expectations on FGM/C practices.

Declining FGM/C Prevalence Rates: Effect of Social and Legal Changes

In recent years, FGM/C prevalence rates have steadily declined across the globe, especially in countries with high prevalence rates in Africa. Efforts by governments, multi-lateral organisations and community-led initiatives drive these declining trends (Muthumbi, et al., 2015; Kandala et al., 2018). Also, the framing of FGM/C as a human²¹ rights issue has added an impetus in both legal and activists approaches to ending the practice leading to the establishment of legally binding conventions and laws at both international and national levels.

At the international level, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW 1979)²² addresses FGM/C as an unequal gender relations issue,

²¹ Specific rights FGM/C violates includes; right to life - due to excessive bleeding or infections, right to health – reproductive and sexual health, as well as right to physical integrity – physical or mental injury.

²² Ratified by 189 countries.

while recognising that women rights are human rights. The Convention on the Rights of the Child (CRC 1989)²³ also addresses human rights for children. Others include; Convention Against Torture and Other Cruel and Inhuman or Degrading Treatment or Punishment (1984) and International Covenant on Economic, Social and Cultural Rights (1966). Kenya has signed and ratified all these international protocols, treaties, conventions. At the regional level, Kenya is also a signatory to several protocols that mandates governments to make every effort possible to stop harmful social and cultural practices such as FGM/C that affect the welfare and dignity of Kenyan girls and women. These protocols include; the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol, 2003), Article 21 of the African Charter on the Rights and Welfare of the Child (adopted in 1990). Aspiration 6 of Africa's Agenda 2063 which calls for full empowerment of women and girls including eliminating gender-based violence and Africa.

Efforts to end FGM/C in Kenya date back to the early 1920s when the colonial government and missionaries made attempts to persuade communities to abandon the practice. Missionary/church-led approaches, with the sanctions²⁴ they attracted, did little to reduce prevalence rates as they were equal to colonial oppression (Matanda, Okondo, Kabiru, & Shell-Duncan, 2018). The immediate post-independence government did little to eliminate the practice, but increased advocacy and international pressure in the 1980s and 1990s saw a commitment from the government to address the practice.

To date, the country has adopted several legal and legislative texts to eliminate FGM/C. Article 44 (3) of the Kenyan Constitution bars any person from compelling another person to perform, observe or undergo any harmful cultural practice or rite. Article 53(d) on the other hand, explicitly states that children should be free from harmful cultural practices, inhuman and degrading treatment. Other pieces of legislation include; Prohibition of Female Genital Mutilation Act, 2011, which prohibits any form of genital mutilation of all females. The law prescribes penalties to offenders who are liable to either imprisonment for not less than three years or a fine of US\$ 2000 (Government of the Republic of Kenya, 2011). The Children's Act, 2001, on the other hand, criminalises genital cutting of any female below the age of 18 years, with penalties of twelve months imprisonment or a fine of up to US\$ 600 imposed on anyone violating the law (Oloo, Wanjiru, & Newell-Jones, 2001). The Penal Code, Cap 63, also provides chargeable offences for circumcisers. The Protection against Domestic Violence Act, 2015 classifies FGM/C as violence. The Act provides for protective measures for survivors and victims of domestic violence, including FGM/C. More recently, the government has stepped up efforts to enforce the law, with the anti-FGM/C unit operating under the office of the Director of Public Prosecution, and more than 20 prosecutors deployed across the country, and over fifty cases prosecuted (Migiro, 2014).

These legal texts collectively provide a framework for engagement with all stakeholders and provide protective measures for girls and women. More importantly, conscious of the critical role girls and women play in economic development, Kenya's economic development blueprint – the Vision 2030 – also targets the creation of public awareness in the fight against FGM/C. End-FGM/C efforts by the national and county governments, local communities and international organisations have significantly contributed to accelerating the abandonment of

²³ Ratified by 140 countries

²⁴ Denial of children's enrolment to missionary schools and denied participation in religious functions.

the practice. The effectiveness of these laws to end FGM/C is however hampered by ineffective implementation due capacity limitations on the part of enforcers, lack of witnesses to have identified cases prosecuted, as well as low fines that fail to act as an adequate deterrence especially for affluent families (Muthumbi, Svanemyr, Scolaro, Temmerman, & Say, 2015).

However, legal actions alone are inadequate to change attitudes and behaviours as it fails to address underlying socio-cultural drivers of FGM/C. Rigid enforcement of the law may result in the unintended effect of encouraging difficult to detect approaches in effecting the cut, making reporting of prevalence difficult (Muthumbi, Svanemyr, Scolaro, Temmerman, & Say, 2015).

Changing FGM/C Practices

To avoid detection and legal consequences, FGM/C has evolved to include medicalisation, less severe forms of cutting, subjecting girls to the cut at a younger age and more private and secret events to mark a girls transition (Matanda, Okondo, Kabiru, & Shell-Duncan, 2018). WHO (2010) defines FGM/C medicalisation as “a situation where FGM/C is undertaken by a medical professional, whether at a health facility or not.” The practice is gaining traction with families abandoning traditional practitioners for medical professionals as a way of minimising health risks associated with non-medicalised approaches. The rise of medicalisation is also associated with increased advocacy work that focused on the abandonment of FGM/C centred on health risks, therefore motivating individuals to seek lesser harmful practices. Available data on medicalisation from women aged 15-49 indicates that 26 per cent of women who have undergone FGM/C have done so through a medical practitioner, accounting for close to 15 million globally (Shell-Duncan et al., 2017). At 15 per cent, Kenya has one of the highest rates of medicalised FGM/C, although variations exist among communities. Other countries with similarly high rates include Egypt (38 per cent), Sudan (67 per cent), Guinea (15 per cent), and Nigeria (13 per cent). Further, data on the inter-generational prevalence of medicalisation shows increasing medicalisation, with 15 per cent mothers compared to 20 per cent of daughters having been cut by a medical professional (Shell-Duncan et al., 2017).

Additionally, a UNICEF survey on FGM/C in Africa shows a drastic decrease in the average circumcision age, the trend which keeps the practice hidden from authorities (UNICEF, 2005). The survey further shows that about 60 per cent of girls in Ethiopia, Mauritania and Mali undergo the cut before the age of 5. Perpetrators of early age FGM/C to children avoid girls’ resistance, especially with increased rescue centres that provide alternative homes for girls who do not wish to undergo the cut. In Kenya, 46 per cent of circumcised girls age 15-19 were circumcised before the age of 9, compared to 17 per cent of women age 45-49, with a significant proportion of this being women in urban areas compared to those in rural areas (KDHS, 2014). Early age circumcisions are secretive and entail less pompous ceremonies that would traditionally accompany the “successful transition” of the girls. With increased enforcement of laws prohibiting FGM/C, open celebrations have become undesirable. These secret practices also include sending off girls to relatives to undergo the cut in areas or countries where detection by enforcement agencies is low on non-existent.

FGM/C, Early Child and Forced Marriage and Early Teenage Pregnancies

FGM/C, early child and forced marriages and early teenage pregnancies are closely intertwined. They are rooted in unequal gender relations, social norms and deep-rooted cultural beliefs on sexuality and marriage. On the one hand, FGM/C is a bridge of the transition from childhood to adulthood and also a prerequisite for marriage. Therefore, once a girl undergoes the cut, they are ready to be married. UNICEF data, for instance, shows that more than 650 million girls and women alive today have been married as children, with FGM/C being a pivotal contributor to this statistic (United Nations Children's Fund, 2018). A review of the association between FGM/C and child marriage indicates a higher percentage of child marriages among circumcised women compared to uncircumcised women aged between 20 and 24 years (Population Council, 2018). In Kenya, for instance, 23 per cent of girls in this age bracket were married before the age of 18, with 15 per cent of them having undergone FGM/C. On the other hand, child marriages reinforce teenage pregnancies and contribute to school dropout (Gitau et al., 2016). In Kenya, 54 per cent of women with no education report to have undergone FGM/C, the majority of whom are rural areas residents (UNICEF, 2013).

The United Nations defines child marriage as a union of a person(s) before the age of 18. Child marriages disproportionately affect girls who are more likely to get married young compared to boys. Prevalence rates in Sub-Saharan Africa have reduced, although about 33 per cent of girls continue to be married before reaching adulthood (Koski et al., 2017). The decline in child marriages mirrors national legislations that prohibit marriage of persons below the age of 18. KDHS data places prevalence rates before 18 years and 15 years of age at 26 per cent and 16 per cent, respectively. These rates are high despite the enactment of the Children's Act, 2001, which provides legal protection to children against forced and early marriages. Child marriages are human rights violation as children have minimal to no control over the sexual activity and their reproductive decision diminishes. They are at a higher risk of contracting HIV since they are often married to older men who are already sexually exposed and have limited knowledge of preventive measures.

Teenage pregnancy, defined as pregnancy before the age of 20 years, remains high in Kenya. About 40 per cent of girls either have had their first child or are pregnant with their first child at age below 19 years (KDHS, 2014). High rates are standard among marginalised and rural communities, with notable variations also between urban and rural communities. Kajiado county, the focus of this evaluation, has one of the highest rates at 20 per cent. FGM/C is a crucial contributor to teenage pregnancies as once circumcised; girls are married out while still young. In turn, increasing child marriages lead to increasing teenage pregnancy. Teenage pregnancy has adverse effects on the reproductive health of girls, with high maternal deaths recorded among teenage mothers (Loaiza and Liang, 2013).

Alternative Rite of Passage Models: Safe Bet for Replacing FGM/C

Alternative Rite of Passage (ARP) models are structured interventions that aim to preserve the positive socio-cultural aspects of the rite of passage ritual but without the cut (Chege, et al., 2001). ARPs take an integrated and participatory approach aimed at addressing cultural drivers of FGM/C through community-led sensitisation and knowledge awareness engagements. ARP interventions, therefore, are culturally and socially contextualised as socio-cultural motivations may differ among different ethnic groups (UNICEF and Gupta, 2013). Examples of ARP programme implemented in Africa include the Community

Empowerment Programme (CEP). CEP focused on collective community action, public declaration of abandonment of practice and organised diffusion to draw on more change adopters. In Sudan, the Sudanese Programme for Accelerated Social Transformation (PFAST) is working with communities to shift traditional beliefs about FGM/C through encouraging debates on virginity and marriageability, shame and honour. The initiative has set in motion the process of change with community members questioning their deeply held views and exploring alternatives (UNICEF, 2005).

The adoption of ARPs in Kenya date back to the mid-nineties when the Maendeleo Ya Wanawake Organisation (MYWO) working closely with Programme for Appropriate Technology in Health (PATH). Through its “Harmful Traditional Practices Programme”, MYWO engaged several communities in raising awareness on the harmfulness of FGM/C, recruiting mothers and daughters to educative programmes on family, health and education. These efforts have been credited with the near elimination of the practice amongst specific communities, e.g., Meru and Kalenjin, indicating their effectiveness in changing attitudes and behaviours associated with FGM/C (Chege et al., 2001). The approach appreciates that not all individuals will accept change at the same time, and therefore identification of a few change adopters to act as community influencers is key (Askew, 2005). The progressive engagement of a select group of fast movers, who then diffuse knowledge to more groups. Over time a gradual shift in community cultural perspectives towards the rite of passage results in a critical mass that tends to abandon the practice. Also, inclusivity is an essential ingredient of ARP models aimed at recognising the vital role played by men as drivers of demand for FGM/C and therefore key allies in ending the practice (Brown et al., 2016).

ARPs adopt models of systematic behavioural change that educate communities on innovative alternatives to influence decisions on uptake and implementation of these alternatives (Shell-Duncan and Herniund, 2006). ARP models have proved practical and useful in several ways. First, ARPs create safe, non-judgemental and non-coercive spaces where community members share their views on FGM/C, and increase their awareness and understanding of human rights aspects of the practice. The spaces provide an environment for women and girls to voice their opinion, share experiences and bring out the hidden costs of FGM/C (UNICEF, 2005). Second, non-judgemental spaces encourage public discussions to increase awareness among community members, with the cost of FGM/C becoming more evident as men and women share costly experiences by their daughters. Third, increased awareness among community members leads to a collective decision to abandon the practice and adopt alternative approaches that do not violate the rights of women and girls. The success of changing social norms at this stage is dependent on collective action to abandon the practice, rather than individual decisions. Fourth, a public declaration by the community of their decision to change and abandon the practice. Public statements create a sense of social change within the community and stimulate abandonment by community members by affirming group, rather than individual actions (Johansen et al., 2013). They also serve to minimise social stigmatisation of those that opt not to undergo the cut.

ARP models also follow a deliberate process of organised diffusion to ensure the decision to abandon is taken up by the community in a deliberate effort to transmit information and persuade others within one’s existing social networks to abandon the practice to create a critical mass of change adopters (Mackie and LeJeune, 2009). The pressure to conform then translates to pressure to abandon, effectively changing the social dynamics that perpetuated

the practice, and the new social norm of not cutting becomes self-reinforcing. Therefore, ARP models create an environment that supports and sustains this change through sustained advocacy and continued knowledge diffusion, complemented by appropriate legislative measures to minimise reversal to the old practice (UNICEF, 2005). The success of the model has been evident in Ethiopia where the Kembatti Mentti Gezzima (KMG), an NGO working with communities, has adopted this model leading to successful abandonment of deep-rooted harmful practices by the community (Dagne, 2010).

Impact of Community Led Alternative Rite of Passage on Social Outcomes

Existing evidence shows higher rates of school completion among girls who are uncircumcised compared to those that are circumcised, and consequently, girls who remain in school longer are less likely to be married early and have children before adulthood (UNFPA, 2013). Moreover, ARP interventions have positive impacts on community knowledge, attitudes and perceptions on Rite of Passage (Oloo et al., 2001). For-example, an evaluation of the Tostan Community Empowerment Programme in Senegal indicated that 85 per cent of women interviewed had changed their perception on FGM/C as a result of participating in the programme (UNICEF, 2005).

Evaluation of the ARP model among the Keiyo community in Kenya established a strong and positive effect of ARP on girls education (Gitagno, 2015). The evaluation focused on ARP graduates school attendance, performance and retention, with positive outcomes associated with the intervention's encouragement of education and emphasis on its benefits. Ninety-seven per cent of the girls interviewed indicated that their performance in school had improved after participating in the ARP programme. Training that focuses on motivating girls to work hard in school and encouraging focus in school was ARP's key ingredient that contributed to better educational outcomes (Gitagno, 2015). A similar evaluation among the Kisii and Kuria communities also indicated a positive impact on school performance of ARP graduates compared to their counterparts who have undergone the cut (Oloo et al., 2001).

Reviews of the *Yes I Do Alliance* (YIDA) programme do also point to a reduction in child marriages, teenage pregnancies and FGM/C prevalence as a result of community engagement and sensitisation on gender equality and sexual and reproductive health knowledge. YIDA's interventions aim at promoting gender-transformative thinking, girls empowerment and engagement of men and boys as gatekeepers. The five (5) year programme (2016-2020) is working with vulnerable communities to end FGM/C, teenage pregnancies and child marriages in Ethiopia, Kenya, Malawi, Mozambique, Zambia, Pakistan and Indonesia. In Kenya, the programme works within the Maasai community to provide an alternative rite of passage to girls, with more than 1,300 girls having been trained and graduated from the programme. A mid-term review of the programme indicates a positive influence on community perspectives on deeply rooted cultural norms such as FGM/C, with community members appreciating the importance of girl child empowerment through education, which consequently is delaying child marriages and teenage pregnancies. (Egberts, F., and Demenint, M., 2018).

Conclusion

To sum up, the findings of the reviewed studies point to one critical conclusion: the significance of ARP in shifting knowledge, attitudes and perceptions of FGM/C. ARP models also influence the abandonment of FGM/C, resulting in declining prevalence rates, improved educational outcomes, and reduction in early and forced child marriages and early teenage pregnancies. The effectiveness of the ARP model hinges on its community-led approach in changing social norms on FGM/C, as well as empowerment of girls and women through education. The existing literature on the evaluation of the ARP models has majorly centred on their impacts on community knowledge, attitudes and perceptions. However, little knowledge exists on the impacts of ARP models in reducing FGM/C prevalence rates, early and forced child marriages and early teenage pregnancies in Kenya. The present evaluation study bridges the existing knowledge gap by providing both quantitative and qualitative evaluation of the impacts of the ARP model in Kajiado county.

ANNEXE 3: DIFFERENCE-IN-DIFFERENCE REGRESSION RESULTS

Dependent variables	Baseline				Alternative control counties #1				Alternative control counties #2			
	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)
	FGM/C	Education	Marriage	Pregnancy	FGM/C	Education	Marriage	Pregnancy	FGM/C	Education	Marriage	Pregnancy
Post x Treat	-0.242*	2.469**	-0.049***	-0.063***	-0.133*	2.479**	-0.157***	-0.195***	-0.195	4.318***	-0.045***	-0.055***
	[0.133]	[1.218]	[0.015]	[0.021]	[0.078]	[0.964]	[0.022]	[0.016]	[0.152]	[1.122]	[0.016]	[0.019]
Education [years]	-0.011***		-0.001	-0.000	-0.011***		-0.001	-0.002	-0.013*		-0.001	-0.000
	[0.004]		[0.001]	[0.003]	[0.004]		[0.001]	[0.002]	[0.007]		[0.001]	[0.002]
Age	-0.015**	-0.076	-0.039***	-0.038***	-0.026***	-0.188*	-0.039***	-0.036***	-0.016*	-0.037	-0.035***	-0.036***
	[0.006]	[0.075]	[0.010]	[0.008]	[0.009]	[0.108]	[0.011]	[0.008]	[0.009]	[0.080]	[0.009]	[0.007]
Age^2	0.000**	0.001	0.001***	0.001***	0.000***	0.002	0.001***	0.000***	0.000**	-0.000	0.000***	0.001***
	[0.000]	[0.001]	[0.000]	[0.000]	[0.000]	[0.002]	[0.000]	[0.000]	[0.000]	[0.001]	[0.000]	[0.000]
Gender h/head [1=Female]	0.020	-0.362	-0.000	-0.009	0.002	0.019	0.012	-0.002	0.017	-0.158	0.002	-0.011
	[0.013]	[0.251]	[0.007]	[0.009]	[0.015]	[0.209]	[0.008]	[0.007]	[0.021]	[0.251]	[0.006]	[0.008]
Age h/head	0.003	-0.001	0.006**	0.002	0.005	0.006	0.007*	0.003	0.009*	0.001	0.006**	0.002
	[0.002]	[0.052]	[0.003]	[0.003]	[0.004]	[0.042]	[0.004]	[0.002]	[0.005]	[0.058]	[0.003]	[0.002]
[Age h/head]^2	-0.000	0.000	-0.000**	-0.000	-0.000	-0.000	-0.000	-0.000	-0.000*	0.000	-0.000**	-0.000
	[0.000]	[0.000]	[0.000]	[0.000]	[0.000]	[0.000]	[0.000]	[0.000]	[0.000]	[0.001]	[0.000]	[0.000]
Age at marriage	-0.022	0.054	-0.007**	-0.001	-0.032***	0.630***	-0.004	0.001	0.005	0.341**	-0.005*	-0.000
	[0.015]	[0.126]	[0.003]	[0.004]	[0.011]	[0.148]	[0.003]	[0.002]	[0.031]	[0.133]	[0.003]	[0.004]
[Age at marriage]^2	0.001	0.002	0.000**	0.000	0.001***	-0.009**	0.000	-0.000	-0.000	-0.004	0.000*	-0.000
	[0.000]	[0.003]	[0.000]	[0.000]	[0.000]	[0.004]	[0.000]	[0.000]	[0.001]	[0.003]	[0.000]	[0.000]
Residence [1=rural]	0.054	1.568**	0.028***	0.028**	-0.015	1.712**	0.018	-0.006	0.123**	1.490*	0.022**	0.019**
	[0.048]	[0.743]	[0.009]	[0.011]	[0.042]	[0.697]	[0.016]	[0.013]	[0.052]	[0.770]	[0.009]	[0.009]
Constant	0.724***	8.491***	0.695***	0.809***	0.739***	-2.939	0.516***	0.442***	0.492	3.367	0.624***	0.783***
	[0.231]	[2.554]	[0.178]	[0.158]	[0.205]	[2.620]	[0.122]	[0.102]	[0.356]	[2.886]	[0.157]	[0.142]
Religion	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ethnicity	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Wealth Index	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Year FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
District/Sub-county FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
District/Sub-county x Year FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Observations	1120	1749	1749	1749	795	1382	1382	1382	1219	1916	1916	1916
R-squared	0.895	0.850	0.271	0.181	0.739	0.757	0.291	0.214	0.795	0.814	0.265	0.188
Average Dep. Var	0.808	3.124	0.012	0.015	0.166	6.085	0.013	0.013	0.782	3.842	0.011	0.014
S.d. Dep. Var	0.394	5.505	0.110	0.122	0.373	5.671	0.112	0.113	0.413	5.589	0.103	0.119
Percentage impact change (factor)	-0.30	0.79	-4.08	-4.20	-0.80	0.41	-12.08	-15.00	-0.25	1.12	-4.09	-3.93

Standard errors are in brackets and clustered at the regional level.
 ** p<0.10, * p<0.05, *** p<0.01"
 Baseline control counties: Wajir, Mandera and Marsabit
 Alternative control counties #1: Control counties are all counties with low prevalence <5%
 Alternative control counties #2: Control counties include Narok, Wajir, Mandera and Marsabit



ANNEXE 4: QUALITATIVE DATA COLLECTION TOOLS

In-depth interviews – CLARP beneficiaries/ recent CLARP graduates

A.	Do you consent to participate in this study? (Ask after reading the consent form). Yes = 1, No = 2 (stop and thank the interviewee)	[] []
B.	Interviewee number	[] []
C.	Interviewers Signature	
D.	Date of Interview (DD/MM/YY)	[]/[]/[]
E.	Interviewer Code	[] []
Respondent's Background		
Q1	Age	[] []
Q2	Are you currently enrolled in school? Yes = 1 No =2	[] []
Q3	What is the highest level of education that you completed? No Education = 1 Primary = 2 Secondary = 3 Tertiary =4	[] []
Q4	How many siblings do you have?	
	a. Sisters	[] []
	b. Brothers	[] []
Q5	a. What is the gender of the head of the household? Male = 1 Female =2	[] []
	b. What is the highest level of education of the head of the household? No Education = 1 Primary = 2 Secondary = 3 Tertiary =4	[] []
Q6	Which year did you enrol to the ARP programme?	[] [] [] []
Q7	Which year did you graduate from the programme?	[] [] [] []
Q8	Are you married? Yes = 1 No = 2 [skip sequencing]	[] []
	a. If yes, what was your age at marriage?	[] []
	b. Was the decision to get married yours? Yes = 1 No = 2	[] []
	c. If no, who made this decision for you?	
Q9	Do you have children? If yes, Yes = 1 No = 2 [skip sequencing]	[] []
	a. How many children do you have?	[] []
	b. What was your age at first pregnancy?	[] []
	c. What is the age of your first child?	[] []
Open-ended questions		
Q10	a. What is your general opinion of FGM/C practices in this community? [probe further for benefits, disadvantages and attitudes, sexual control]	
	b. What are your views of the effect of FGM/C on the following; i. Schooling [probe for completion, retention and performance] ii. Early/teenage pregnancies iii. Early/child marriage	
Q11	How prevalent/widespread is the practice of FGM/C in your community? How many believe it is a good thing? [probe for age, location, who does it, methods – including the medicalisation of process and other camouflaged continuation of the practice]	
Q12	In your opinion a. Why do some in this community practice (FGM/C) [probe for socio-cultural (transition to womanhood/marriage); and economic benefits (dowry)] b. Why have some abandoned the practice? [probe for socio-cultural (transition to womanhood/marriageability), educational and health reasons]	

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Q13	Have you seen a change regarding FGM/C in your community? [knowledge, attitudes, perceptions, practice] What and who is influencing this change? [probe for both ARP and non-ARP influences]
Q14	In your view, should the practice be continued or be stopped? [probe for reasons; who/what influences your reasoning?]
Q15	How did you experience your transition from childhood to womanhood? [probe for how and why]
Q16	What was your highest level of education? In case you did not complete school, what was the reason for drop-out. Did your (non) FGM status have any influence on your schooling? [probe further for the decision to stay in school, performance]
Q17	How did (not) being circumcised influence your views/decision on when to get married? [probe further to establish before and after perceptions]
Q18	How did (not) being circumcised influence your views/decision on when to have children? [probe further]
Q19	What is the attitude of the community towards girls that are not circumcised?
Q20	a. What role did you have in making decisions about your life course (e.g. education, marriage, having children, et.c)? [probe further for examples of decision making and freedom of choice] b. What factors inform these decisions? [probe for factors not related to ARP, e.g. SRHR]
Q21	In your views, what is the effect of not being circumcised on marriageability compared to one who has undergone FGM/C? [probe further]
Q22	Were you ever in the course of your life thinking of getting circumcised? Why? Is it common to find non-circumcised girls, e.g. ARP graduates revert to FGM/C practices? Why do you think so?
Q23	What is your opinion of the Community Led Alternative Rite of Passage programme? [probe further benefits, disadvantages and attitudes]
Q24	What was your personal experience participating in the programme?
Q25	What is your opinion of the ARP programme as an alternative to FGM/C?
Q26	Would you circumcise your daughter? What would you advise girls from your immediate family about circumcision? Why? Would you say the same to other girls from your community? Why?
Q27	Which interventions on FGM influenced your life and why?
Q28	Do you have suggestions on how these interventions can be improved? Please elaborate [probe for what can be done differently]
Q29	Any other comments or information you would like to share?

Thank you for your time



In-depth interviews questionnaire – Non-ARP beneficiaries

A.	Do you consent to participate in this study? (After reading the consent form). Yes = 1, No = 2 [stop and thank the interviewee]	[]
B.	Interviewee number	[][]
C.	Interviewers Signature	
D.	Date of Interview (DD/MM/YY)	[]/[]/[]
E.	Interviewer Code	[][][]
Respondent's Background		
Q1	Age	[]
Q2	Are you currently enrolled in school? Yes = 1 No =2	[][]
Q3	What is the highest level of education that you completed? No Education = 1 Primary = 2 Secondary = 3 Tertiary =4	[]
Q4	How many siblings do you have?	
	a. Sisters	[][]
	b. Brothers	[][]
Q5	a. What is the gender of the head of the household? Male = 1 Female =2	[]
	b. What is the highest level of education of the head of the household? No Education = 1 Primary = 2 Secondary = 3 Tertiary = 4	[]
Q6	Are you married? Yes = 1 No = 2 [skip sequencing]	[][]
	d. If yes, what was your age at marriage?	[][]
	e. Was the decision to get married yours? Yes = 1 No = 2	[][]
	f. If no, who made this decision for you?	
Q7	Do you have children? If yes Yes = 1 No = 2 [skip sequencing]	[][]
	d. How many children do you have?	[][]
	e. What was your age at first pregnancy?	[][]
	f. What is the age of your first child?	[][]
Q8	c. What is your general opinion of FGM/C practices in this community? [probe further for benefits, disadvantages and attitudes, beliefs e.g. sexual control]	
	d. What are your views of the effect of FGM/C on the following;	
	i. Schooling [probe for completion, retention and performance] ii. Early/teenage pregnancies iii. Early, Child and Forced Marriages	
Q9	How prevalent/widespread is the practice of FGM/C in your community? [probe for age, location, who does it, methods – including the medicalisation of process and other camouflaged continuation of the practice]	
Q10	In your opinion;	
	a. Why do some in this community practice (FGM/C) [probe for socio-cultural -marriage; and economic benefits -dowry] b. Why have others abandoned the practice? [probe for socio-cultural, educational and health reasons]	
Q11	a. In your view, what is the attitude of the community towards girls that have been circumcised compared to those that haven't?	
	b. What is your opinion of girls in your community that are not circumcised? e.g. when you see the girls in the ARP celebrations: what are your thoughts?	
Q12	In your view, should the practice be continued or be stopped? [probe for reasons]	

Q13	What is your opinion of the Alternative Rite of Passage programme compared to FGM/C? [probe further benefits, disadvantages and attitudes]
Q14	What role did you have in deciding on your rite of passage? [probe for factors that influenced this decision]
Q15	How did your rite of passage influence your schooling? [probe further for the decision to stay in school, performance]
Q16	How did your rite of passage influence your views/decision on when to get married? [probe further to establish before and after perceptions]
Q17	How did your rite of passage influence your views/decision on when to have children? [probe further]
Q18	In your view, what is the effect of ARP on marriageability of a graduate compared to one who has undergone FGM/C? [probe further]
Q19	Is it common to find ARP graduates revert to FGM/C practices? Why do you think so?
Q20	What would you tell girls from your immediate family about ARP programme? Why? Would you say the same to other girls from your community? Why?
Q21	Any other comments or information you would like to share?

Thank you for your time

Key informant interview questionnaire – The Chief

A.	Do you consent to participate in this study? [Ask, after reading the consent form]. Yes = 1, No = 2 [stop and thank the interviewee]	[]
B.	Interviewee number	[][]
C.	Position	
D.	Interviewers Signature	
E.	Date of Interview (DD/MM/YY)	[]/[]/[]
F.	Interviewer Code	[][][]
Q1	What is your view of FGM/C practice in this community? How widespread is the practice?	
Q2	How prevalent/widespread is the practice of FGM/C in this community? [probe for age, location, who does it, methods – including the medicalisation of process and other camouflaged continuation of the practice]	
Q3	What, in your assessment, is the level of awareness among community members on laws prohibiting FGM/C practices? (Probe if the community understand why some want FGM/C to be eradicated)	
Q4	How have you been involved in creating awareness or enforcing laws prohibiting the practice?	
Q5	What is your stand towards FGM/C? Do you support or are against the practice? Do you speak up about this? Why (not)? What has been the attitude of the community towards your stand? [probe further to assess opinions on various groups based on age/sex and any other]	
Q6	What are some of the FGM/C related conflicts that you have to deal with in your line of duty? How do you support girls at the centre of these conflicts, both circumcised and uncircumcised?	
Q7	a. What is your opinion of ARP as an alternative to FGM/C? [probe on whether it addresses the community's needs on the rite of passage and its advantages/disadvantages] b. Which ARP interventions are you aware of that have been implemented in this community? (Probe for interventions other than AMREF)	
Q8	a. Do you think the FGM prevalence in your community has changed over the past years? How, why, and what factors do you think have influenced this change? b. What impact, if any, has the change in FGM prevalence had on individual girls, families and the community at large? Can you give examples? [probe on the how and ask for examples]	
Q9	Do you see any difference in the education level among circumcised vs uncircumcised girls: how come? How has not being circumcised/reduction of FGM/C affected the schooling of girls in the community? Why? [probe for completion, retention, performance]	
Q10	Do you see any difference in the teenage pregnancy rate among circumcised vs uncircumcised girls: how come? How has a reduction of FGM/C affected early and teenage pregnancies in the community? Why? [probe further how and why]	
Q11	Do you see any difference in early and forced among circumcised vs uncircumcised girls: how come? How has a reduction of FGM/C affected the early marriage of girls in the community? Why? [probe further for how and why]	
Q12	Current beliefs and attitudes are informing FGM/C practices. What, in your view, has been the role of interventions to end FGM/C in shaping these beliefs and attitudes? [enumerate these beliefs/attitudes]	
Q13	Is it common to find uncircumcised girls revert to FGM/C practices? Why do you think so?	
Q14	Do you have suggestions on how FGM/C can better be eradicated? Please elaborate. How can interventions improve? What is already going well?	
Q15	What would you say are the lessons learnt in efforts to eradicate FGM/C practice in this community?	
Q16	Any other comments or information you would like to share?	

Thank you for your time

Key informant interview questionnaire – Member of County Assembly

A.	Do you consent to participate in this study? [Ask, after reading the consent form]. Yes = 1, No = 2 [stop and thank the interviewee]	[]
B.	Interviewee number	[][]
C.	Position	
D.	Interviewers Signature	
E.	Date of Interview (DD/MM/YY)	[]/[]/[]
F.	Interviewer Code	[][][]
Q1	What is your view of FGM/C practice in this community? How widespread is the practice?	
Q2	What efforts if any, are there in creating awareness among community members on laws prohibiting FGM/C practices? (Probe if the community understand why some want FGM/C to be eradicated)	
Q3	How involved, legislatively or programme-wise is the county government and /or your office in addressing FGM/C practice in the community?	
Q4	What is your stand towards FGM/C? Do you support or are against the practice? Do you speak up about this? Why (not)? What has been the attitude of the community towards your stand? [probe further to assess opinions on various groups based on age/sex and any other]	
Q5	c. What is your opinion of ARP as an alternative to FGM/C? [probe on whether it addresses the community's needs on the rite of passage and its advantages/disadvantages] d. Which ARP interventions are you aware of that have been implemented in this community? (Probe for interventions other than AMREF)	
Q6	What, in your view, is the attitude of the community towards girls who have gone through the ARP programme? How have you been involved in supporting these girls?	
Q7	c. Do you think the FGM prevalence in your community has changed over the past years? How, why, and what factors do you think have influenced this change? d. What impact, if any, has the change in FGM prevalence had on individual girls, families and the community at large? Can you give examples? [probe on the how and ask for examples]	
Q8	Do you see any difference in the education level among circumcised vs uncircumcised girls: how come? How has not being circumcised/reduction of FGM/C affected the schooling of girls in the community? Why? [probe for completion, retention, performance]	
Q9	Do you see any difference in the teenage pregnancy rate among circumcised vs uncircumcised girls: how come? How has a reduction of FGM/ affected early and teenage pregnancies in the community? Why? [probe further how and why]	
Q10	Do you see any difference in early and forced among circumcised vs uncircumcised girls: how come? How has a reduction of FGM/ affected the early marriage of girls in the community? Why? [probe further for how and why]	
Q11	Current beliefs and attitudes are informing FGM/C practices. What, in your view, has been the role of interventions to end FGM/C in shaping these beliefs and attitudes? [enumerate these beliefs/attitudes]	
Q12	Do you have suggestions on how FGM can better be eradicated? Please elaborate. How can interventions improve? What is already going well?	
Q13	What would you say are the lessons learnt in efforts to eradicate FGM/C practice in this community?	
Q14	Any other comments or information you would like to share?	

Thank you for your time



Key Informant Interviews – Child Protection Officers

A.	Do you consent to participate in this study? [Ask, after reading the consent form]. Yes = 1, No = 2 [stop and thank the interviewee]	[]
B.	Interviewee number	[][]
C.	Interviewers Signature	
D.	Date of Interview (DD/MM/YY)	[]/[]/[]
E.	Interviewer Code	[][][]
Q1	What is your opinion of FGM/C practices in this community? [probe for prevalence, benefits/disadvantages (social, economic, cultural – household decisions), usefulness for girls undergoing the practice]	
Q2	How prevalent/widespread is the practice of FGM/C in your community? [probe for age, location, who does it, methods – including the medicalisation of process and other camouflaged continuation of the practice]	
Q3	What are your opinions of programmes/policies/projects to end FGM/C in your community in as far as they seek to protect the rights and well-being of girls in the community? [Note to enumerator: give examples of these programmes/policies/projects]	
Q4	Research in Kajiado suggests that young girls are likely to go through FGM/C if their parents have. What are your thoughts about this? What are the experiences on the ground?	
Q5	Some parents threaten to disown their daughters should they not go through FGM/C. Why do you think this is so, and what do you think can be done about it? What support do you give to such girls?	
Q6	What are some of the FGM/C related conflicts that you have to deal with in your line of duty? How do you support girls at the centre of these conflicts, both circumcised and uncircumcised?	
Q7	What is the attitude of the community towards girls that have participated in FGM/C compared to those that have not?	
Q8	Do you know girls in your community who are uncircumcised? What have you observed about these girls? Can you give examples of positive/negative factors that these girls face in their lives? How is it different from circumcised girls? [probe for what and how]	
Q9	What is your opinion of ARP programme as an alternative to FGM/C? [probe on whether it addresses the community's needs on the rite of passage and its advantages/disadvantages]	
Q10	What has been the attitude of immediate and extended family members on girls that have participated in the ARP programme? [probe for experience on enrolment, during and post-graduation]	
Q11	Do you see any difference in the education level among circumcised vs uncircumcised girls: how come? How has not being circumcised/reduction of FGM/C affected the schooling of girls in the community? Why? [probe for completion, retention, performance]	
Q12	Do you see any difference in the teenage pregnancy rate among circumcised vs uncircumcised girls: how come? How has a reduction of FGM/ affected early and teenage pregnancies in the community? Why? [probe further how and why]	
Q13	Do you see any difference in early and forced among circumcised vs uncircumcised girls: how come? How has a reduction of FGM/ affected the early marriage of girls in the community? Why? [probe further for how and why]	
Q14	Is it common in this community to find ARP graduates revert to FGM/C practices? Why do you think this is so?	
Q15	Current beliefs and attitudes are informing FGM/C practices. What, in your view, has been the role of interventions to end FGM/C in shaping these beliefs and attitudes? [enumerate these beliefs/attitudes]	
Q16	What would you say has worked or not worked well in this programme and why? [probe for reasons and suggestions for improvements]	
Q17	What would you say are the lessons learnt in efforts to eradicate FGM/C practice in this community?	
Q18	Can you give a story about a girl (between 10-25 year) in your community, circumcised or not, that is remarkable to you?	
Q19	Any other comments or information you would like to share?	

Thank you for your time

Key Informant Interviews – Headteachers

A.	Do you consent to participate in this study? [Ask, after reading the consent form]. Yes = 1, No = 2 [stop and thank the interviewee]	[]
B.	Interviewee number	[][]
C.	Interviewers Signature	
D.	Date of Interview (DD/MM/YY)	[]/[]/[]
E.	Interviewer Code	[][][]
Q1	What is your opinion of FGM/C practices in this community? [probe for prevalence, benefits/disadvantages (social, economic, cultural – household decisions), usefulness for girls undergoing the practice]	
Q2	What is your opinion of programmes/policies/projects to end FGM/C in this community? [Note to enumerator: give examples of these programmes/policies/projects]	
Q3	What is your opinion on the ARP programme as an alternative to FGM/C? [probe on whether it addresses the community's needs on the rite of passage and its advantages/disadvantages]	
Q4	Some parents threaten to disown their daughters should they not go through FGM/C. Why do you think this is so, and what do you think can done about it? How do you support such girls?	
Q5	How do community attitudes and perceptions towards circumcised and circumcised girls shape general attitudes towards education in this community?	
Q6	a. How do you/your school support both circumcised and uncircumcised girls in their schooling? b. What has been the attitude of the community towards these efforts?	
Q7	Do you see any difference in the education level among circumcised vs uncircumcised girls: how come? How has not being circumcised/reduction of FGM/C affected the schooling of girls in the community? Why? [probe for completion, retention, performance]	
Q8	Do you see any difference in the teenage pregnancy rate among circumcised vs uncircumcised girls: how come? How has a reduction of FGM/ affected early and teenage pregnancies in the community? Why? [probe further how and why]	
Q9	Do you see any difference in early and forced among circumcised vs uncircumcised girls: how come? How has a reduction of FGM/ affected the early marriage of girls in the community? Why? [probe further for how and why]	
Q10	Can you give a story about a girl (between 10-25 year) in your community, circumcised or not, that is remarkable to you?	
Q11	Is it common in this community to find ARP graduates revert to FGM/C practices? Why do you think this is so?	
Q12	What would you say has worked or not worked well in this programme and why? [probe for reasons and suggestions for improvements]	
Q13	What would you say are the lessons learnt in efforts to eradicate FGM/C practice in this community?	
Q14	Any other comments or information you would like to share?	

Thank you for your time



Key Informant interviews – CBO/CSO Officers

A.	Do you consent to participate in this study? [Ask, after reading the consent form]. Yes = 1, No = 2 [stop and thank the interviewee]	[]
B.	Interviewee number	[][]
C.	Interviewers Signature	
D.	Date of Interview (DD/MM/YY)	[]/[]/[]
E.	Interviewer Code	[][][]
Q1	What is your opinion of FGM/C practices in this community? [probe for prevalence, benefits/disadvantages (social, economic, cultural – household decisions), usefulness for girls undergoing the practice]	
Q2	a. What is your opinion of programmes/policies/projects to end FGM/C in your community? [Note to enumerator: give examples of these programmes/policies/projects] b. Which of these programmes are you involved in implementing?	
Q3	Research in Kajiado suggests that young girls are likely to go through FGM/C if their parents have. What are your thoughts about this? What has been your experiences on this working with community members?	
Q4	Some parents threaten to disown their daughters should they not go through FGM/C. Why do you think this is so, and what do you think can be done about it? What support do you give to such girls?	
Q5	What is the attitude of the community towards girls that have participated in FGM/C compared to those that have not?	
Q6	What is your opinion of ARP programme as an alternative to FGM/C? [probe on whether it addresses the community's needs on the rite of passage and its advantages/disadvantages]	
Q7	Do you know girls in your community who are uncircumcised? What have you observed about these girls? Can you give examples of positive/negative factors that these girls face in their lives? How is it different from circumcised girls? [probe for what and how]	
Q8	Do you see any difference in the education level among circumcised vs uncircumcised girls: how come? How has not being circumcised/reduction of FGM/C affected the schooling of girls in the community? Why? [probe for completion, retention, performance]	
Q9	Do you see any difference in the teenage pregnancy rate among circumcised vs uncircumcised girls: how come? How has a reduction of FGMC/ affected early and teenage pregnancies in the community? Why? [probe further how and why]	
Q10	Do you see any difference in early and forced among circumcised vs uncircumcised girls: how come? How has a reduction of FGM/C affected the early marriage of girls in the community? Why? [probe further for how and why]	
Q11	Is it common in this community to find ARP graduates revert to FGM/C practices? Why do you think this is so?	
Q12	Current beliefs and attitudes are informing FGM/C practices. What, in your view, has been the role of interventions to end FGM/C in shaping these beliefs and attitudes? [enumerate these beliefs/attitudes]	
Q13	What would you say has worked or not worked well in this programme and why? [probe for reasons and suggestions for improvements]	
Q14	What would you say are the lessons learnt in efforts to eradicate FGM/C practice in this community?	
Q15	Can you give a story about a girl (between 10-25 year) in your community, circumcised or not, that is remarkable to you?	
Q16	Any other comments or information you would like to share?	

Thank you for your time



Key Informant Interviews – Cultural Elder

A.	Do you consent to participate in this study? [Ask, after reading the consent form]. Yes = 1, No = 2 [stop and thank the interviewee]	[]
B.	Interviewee number	[][]
C.	Interviewers Signature	
D.	Date of Interview (DD/MM/YY)	[]/[]/[]
E.	Interviewer Code	[][][]
Q1	What is your opinion of FGM/C practice in this community? [probe for prevalence, benefits/disadvantages (social, economic, cultural – household decisions), usefulness for girls undergoing the practice]	
Q2	What is your opinion of programmes/policies/projects to end FGM/C in your community? [Note to enumerator: give examples of these programmes/policies/projects]	
Q3	What is your stand towards FGM/C? Do you support or are against the practice? Do you speak up about this? Why (not)? What has been the attitude of the community towards your stand? [probe further to assess opinions on various groups based on age/sex and any other]	
Q4	<p>a. Why do some in this community practice (FGM/C) [probe for socio-cultural (transition to womanhood/marriage); and economic benefits (dowry).</p> <p>b. Why have some abandoned the practice? [probe for socio-cultural (transition to womanhood/marriageability), educational and health reasons]</p>	
Q5	What is your opinion on the medicalisation of the practice?	
Q6	What is your opinion of ARP programme as a replacement to FGM/C? [probe on whether it addresses the community's needs on the rite of passage and its advantages/disadvantages]	
Q7	<p>a. What has been the effects of ARP programme on the following for girls who have undergone the programme?</p> <p style="margin-left: 40px;">i. Schooling [probe for completion, retention, performance] Why?</p> <p style="margin-left: 40px;">ii. Early teenage pregnancies [probe for prevalence – high/moderate/low] Why?</p> <p style="margin-left: 40px;">iii. Child, early and forced marriage [probe for prevalence – high/moderate/low] Why?</p> <p style="margin-left: 40px;">iv. Marriageability [probe for perceptions and experiences for marriage prospects] Why?</p> <p>b. In your view, what other factors other than ARP programme, (if any), have influenced changes observed in (a) above?</p>	
Q8	Do you think the FGM/C prevalence in your community has changed over the past years? How, why, and what factors do you think have influenced this change?	
Q9	What impact, if any, has the change in FGM/C prevalence had on individual girls, families and the community at large? Can you give examples? [probe on the how and ask for examples]	
Q10	Is it common in this community to find ARP graduates revert to FGM/C practices? Why do you think this is so?)	
Q11	Current beliefs and attitudes are informing FGM/C practices. What, in your view, has been the role of interventions to end FGM/C in shaping these beliefs and attitudes? [enumerate these beliefs/attitudes]	
Q12	What would you say are the lessons learnt in efforts to eradicate FGM/C practice in this community?	
Q13	Any other comments or information you would like to share?	

Thank you for your time

Key Informant Interviews – Religious leaders

A.	Do you consent to participate in this study? [Ask, after reading the consent form]. Yes = 1, No = 2 [stop and thank the interviewee]	[]
B.	Interviewee number	[][]
C.	Interviewers Signature	
D.	Date of Interview (DD/MM/YY)	[]/[]/[]
E.	Interviewer Code	[][][]
Q1	What is your opinion of FGM/C practice in this community? [probe for prevalence, benefits/disadvantages (social, economic, cultural – household decisions), usefulness for girls undergoing the practice]	
Q2	What is your opinion of programmes/policies/projects to end FGM/C in your community? [Note to enumerator: give examples of these programmes/policies/projects]	
Q3	What is your stand towards FGM/C? Do you support or are against the practice? Do you speak up about this? Why (not)? What has been the attitude of the community towards your stand? [probe further to assess opinions on various groups based on age/sex and any other]	
Q4	c. Why do some in this community practice (FGM/C) [probe for socio-cultural (transition to womanhood/marriage); and economic benefits (dowry). d. Why have some abandoned the practice? [probe for socio-cultural (transition to womanhood/marriageability), educational and health reasons]	
Q5	What is your opinion on the medicalisation of the practice?	
Q6	What is your opinion of ARP programme as a replacement to FGM/C? [probe on whether it addresses the community's needs on the rite of passage and its advantages/disadvantages]	
Q7	c. What has been the effects of ARP programme on the following for girls who have undergone the programme? i. Schooling [probe for completion, retention, performance] Why? ii. Early teenage pregnancies [probe for prevalence – high/moderate/low] Why? iii. Child, early and forced marriage [probe for prevalence – high/moderate/low] Why? iv. Marriageability [probe for perceptions and experiences for marriage prospects] Why? d. In your view, what other factors other than ARP programme, (if any), have influenced changes observed in (a) above?	
Q8	Do you think the FGM prevalence in your community has changed over the past years? How, why, and what factors do you think have influenced this change?	
Q9	What impact, if any, has the change in FGM prevalence had on individual girls, families and the community at large? Can you give examples? [probe on the how and ask for examples]	
Q10	Is it common in this community to find ARP graduates revert to FGM/C practices? Why do you think this is so?)	
Q11	Current beliefs and attitudes are informing FGM/C practices. What, in your view, has been the role of interventions to end FGM/C in shaping these beliefs and attitudes? [enumerate these beliefs/attitudes]	
Q12	What would you say are the lessons learnt in efforts to eradicate FGM/C practice in this community?	
Q13	Any other comments or information you would like to share?	

Thank you for your time

Key Informant Interviews – Traditional Birth Attendants

A.	Do you consent to participate in this study? [Ask, after reading the consent form]. Yes = 1, No = 2 [stop and thank the interviewee]	[]
B.	Interviewee number	[][]
C.	Interviewers Signature	
D.	Date of Interview (DD/MM/YY)	[]/[]/[]
E.	Interviewer Code	[][][]
Q1	What is your opinion of FGM/C practices in this community? Do you believe the cut is a good/bad thing? Do you cut yourself? [probe for prevalence, benefits/disadvantages (social, economic, cultural – household decisions), usefulness for girls undergoing the practice]	
Q2	a. What is your opinion of programmes/policies/projects to end FGM/C in your community? [Note to enumerator: give examples of these programmes/policies/projects] b. How have these policies/programmes/projects affected your work? [probe for positive or negative effect]	
Q3	Some parents threaten to disown their daughters should they not go through FGM/C. Why do you think this is so, and what can be done about it?	
Q4	What is the attitude of the community towards girls that have participated in FGM/C?	
Q5	What is your opinion of ARP programme as a replacement to FGM/C? [probe on whether it addresses the community's needs on the rite of passage and its advantages/disadvantages]	
Q6	What is the attitude of the community towards girls that have participated in the ARP programme?	
Q7	What has been the effects of ARP programme on; a. Your work [probe for changes in demand] Why? b. Your standing in the family and community [probe for attitudes/acceptance] Why? Livelihood [probe for effect on income-generating activities] Why?	
Q8	Is it common in this community to find ARP graduates revert to FGM/C practices? Why do you think this is so?	
Q9	What would you say has worked or not worked well in this programme and why? [probe for reasons and suggestions for improvements]	

Thank you for your time



Focus group discussions – Adolescent Girls & Young Women

Instructions:

1. Give a culturally appropriate welcome to group members.
2. Introduce yourself and any other accompanying member of the study group.
3. Allow participants to introduce themselves
4. Make sure participants introduce themselves before they speak
5. Provide context of the study and explain why it is crucial.
6. Read out the consent form to the group and explain confidentiality.
7. Seek participants consent to participate in the study (read the consent form to the group)
8. Control the discussion to allow equal participation and enable participants to speak freely
9. Do not interrupt when participants speak

Research Assistant name:

Supervisor's name:

Start time:

End time:

	Participant Code	Age	Gender
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

Q1	How is FGM/C viewed in this community? [probe for prevalence, benefits/disadvantages (social, economic, cultural – household decisions), usefulness for girls undergoing the practice]
Q2	Some people believe that girls who have not undergone FGM/C are not well prepared for marriage. [probe for marriageability, chastity, risk of infection, readiness for childbearing]
Q3	What opinions/views exist among community members on other approaches/forms/processes of undertaking FGM/C? (probe for medicalisation/clinical approaches)
Q4	What is the opinion of the community about interventions that provide an alternative to FGM/C? [probe on whether it addresses the community's needs on the rite of passage and its advantages/disadvantages]
Q5	What is the attitude of the community towards girls that are not circumcised? Are uncircumcised girls treated differently from circumcised girls?
Q6	What are the attitudes of Morans and young men as immediate and extended family members of girls that are uncircumcised? [probe for experience on enrolment, during and post-graduation]
Q7	a. What has been the effect of not undergoing the cut on the following outcomes for uncircumcised girls? <ol style="list-style-type: none"> i. Schooling [probe for completion, retention, performance] Why? ii. Early teenage pregnancies [probe for prevalence – high/moderate/low] Why? iii. Child marriage [probe for prevalence – high/moderate/low] Why? iv. Marriageability [probe for perceptions and experiences for marriage prospects] Why? b. What other factors other than ARP programme explain the effect observed in (a) above?
Q8	Is it common in this community to find uncircumcised girls revert to FGM/C practices?
Q9	What would you say has worked or not worked well in eradicating FGM/C in the community, and why? [probe for reasons and suggestions for improvements]

Thank you for your time



Focus group discussions questionnaire – Morans and Young Men

Instructions:

1. Give a culturally appropriate welcome to group members.
2. Introduce yourself and any other accompanying member of the study group.
3. Allow participants to introduce themselves
4. Make sure participants introduce themselves before they speak
5. Provide context of the study and explain why it is crucial.
6. Read out the consent form to the group and explain confidentiality.
7. Seek participants consent to participate in the study (read the consent form to the group)
8. Control the discussion to allow equal participation and enable participants to speak freely
9. Do not interrupt when participants speak

Research Assistant name:

Supervisor's name:

Start time:

End time:

	Participant Code	Age	Gender
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
Q1	What is the opinion of FGM/C practices in this community? [probe for prevalence, benefits/disadvantages (social, economic, cultural – household decisions), usefulness for girls undergoing the practice]		
Q2	What is the opinion on programmes/policies/projects to end FGM/C in your community? [Note to enumerator: give examples of these programmes/policies/projects]		
Q3	Some people believe that girls who have not undergone FGM/C are not well prepared for marriage. Do Morans and young men marry uncircumcised girls? why (not)? [probe for marriageability, chastity, risk of infection, readiness for childbearing]		
Q4	What opinions/views exist among community members on other approaches/forms/processes of undertaking FGM/C? (probe for medicalisation/clinical approaches)		
Q5	What are the opinions of the ARP programme as a replacement to FGM/C? [probe on whether it addresses the community's needs on the rite of passage and its advantages/disadvantages]		
Q6	What is the attitude of the community towards girls that have participated in the ARP programme?		
Q7	What are the attitudes of Morans and young men as immediate and extended family members of girls that have participated in the ARP programme? [probe for experience on enrolment, during and post-graduation]		
Q8	Is it common in this community to find ARP graduates revert to FGM/C practices? Why?		
Q9	What has worked or not worked well in this programme and why? [probe for reasons and suggestions for improvements]		

Thank you for your time



Focus group discussions – Parents

Instructions:

1. Give a culturally appropriate welcome to group members.
2. Introduce yourself and any other accompanying member of the study group.
3. Allow participants to introduce themselves
4. Make sure participants introduce themselves before they speak
5. Provide context of the study and explain why it is crucial.
6. Read out the consent form to the group and explain confidentiality.
7. Seek participants consent to participate in the study (read the consent form to the group)
8. Control the discussion to allow equal participation and enable participants to speak freely
9. Do not interrupt when participants speak

Research Assistant name:

Supervisor's name:

Start time:

End time:

	Participant Code	Age	Gender	Child Beneficiary Status (Yes/No)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
Q1	What are the opinions of FGM/C practices in this community? [probe for prevalence, benefits/disadvantages (social, economic, cultural – household decisions) , usefulness for girls undergoing the practice]			
Q2	What opinions/views exist among community members on other approaches/forms/processes of undertaking FGM/C? (probe for medicalisation/clinical approaches)			
Q3	Research in Kajiado suggests that young girls are likely to go through FGM/C if their parents have. Why is this so?			
Q4	How are programmes/policies/projects to end FGM/C viewed in this community? [note to enumerator: give examples of these programmes/policies/projects]			
Q5	Does the community understand why there are efforts including laws that prohibit the continuation of FGM/C practice?			
Q6	Some parents threaten to disown their daughters should they not go through FGM/C. Why is this so and what can be done about it?			
Q7	What is the attitude of the community towards girls that have participated in FGM/C?			
Q8	What opinions exist in the community of the ARP programme as an alternative to FGM/C? [probe on whether it addresses the community's needs on the rite of passage and its advantages/disadvantages]			
Q9	What is the attitude of the community towards girls that have participated in the ARP programme?			
Q10	What has been the attitude of immediate and extended family members on girls that have participated in the ARP programme? [probe for experience on enrollment, during and post-graduation]			
Q11	What has been the effects of ARP programme on the following for girls who have undergone the programme? <ol style="list-style-type: none"> a. Schooling [probe for completion, retention, performance] Why? b. Early teenage pregnancies [probe for prevalence – high/moderate/low] Why? c. Child marriage [probe for prevalence – high/moderate/low] Why? d. Marriageability [probe for perceptions and experiences for marriage prospects] Why? 			

Evaluation of the CLARP Model in eradicating FGM/C in Kajiado County, Kenya



Q12	Is it common in this community to find ARP graduates revert to FGM/C practices? Why do you think this is so?)
Q13	What would you say has worked or not worked well in this programme and why? [probe for reasons and suggestions for improvements]
Q14	Any other comments?

Thank you for your time



Informed Consent form for in-depth interviews

Study Title	Impact Evaluation of Community Led Alternative Rite of Passage (CLARP) Model A case of Kajiado, County in Kenya
Principal Investigator	Samuel Muhula Monitoring, Evaluation, and Research Manager Amref Health Africa in Kenya P.O Box 30125-00100 Nairobi Kenya +254721958734 Samuel.muhula@amref.org
Study Sponsor(s)	Amref Health Africa in Kenya
Co-investigators	Anthony Mveyange Investigator +254700141220 Sarah Karanja Research Officer Amref Health Africa in Kenya David Kawai Project Manager Amref Health Africa in Kenya Samuel Oji Oti Investigator Martha Bande Investigator Hellen Kayiaa Investigator

This Informed Consent Form has two parts:

- Information Sheet (to share information about the study)
- Certificate of Consent (for signatures if you choose to participate)

You will be given a copy of the full Informed Consent Form

Part I: Information Sheet

Hello,

My name is _____. My colleagues and I are conducting this study on behalf of Amref to determine the impact of its FGM/C programme activities since 2009. We are giving you this information because we would like you to participate in the study. Members of our team are here to help you understand more about the study and what Amref has been doing in Kajiado county since 2009. If you do not understand any of the words or ideas asked during the discussion, please ask us to explain the information to you. You can talk to anyone from our team whom you feel comfortable.

Why is this Study Important?

As indicated, we are evaluating the Amref FGM/C programme interventions in Kajiado county since 2009. Based on your responses, we hope to get information that will identify the achievements of the project for many years of implementation.

Who can participate?

You are being asked to take part in this study because you are an ARP graduate/non-ARP beneficiary/parent/guardian to a beneficiary/chief/children protection officer/MCA/Head Teacher/CBO or CSO official/Religious leader/TBA/Cultural leader/Grandparent/Amref staff. Your participation will involve taking part in a face to face



interview with a member of the study where we will ask you questions about Amref's work to eradicate FGM/C, teenage pregnancies and early and forced marriages and ARP. It is expected that the study will take approximately 40 minutes (for IDI)/60 minutes for KII. We will conduct a total of 24 in-depth interviews with ARP graduates and non-ARP beneficiaries and a total of 24 KIIs with various stakeholders, including the chief, children protection officers and MCAs.

Participation is Your Choice

Your participation in this research is completely voluntary. If you choose not to take part, you will continue to receive all of the services that you usually get in your community/health facilities, and nothing will change. Neither will there be any change on how you have always related to Amref or the county government. Should you choose to participate, we will give you a copy of this form to sign to show that you agree to participate.

What are the Risks?

There is a risk that you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the topics in this study. However, we do not wish for this to happen. You do not have to answer any question or take part in the survey if you feel the question(s) are too personal or if talking about them makes you uncomfortable.

What are the Benefits?

There will be no direct benefit to you, but your participation is likely to help Amref and the county government of Kajiado better understand the social and economic impact of the FGM/C programming, including expanding the programme to other affected areas. Your information is valuable to us.

How will we protect your Information and Confidentiality?

All personal information collected will be kept confidential to the fullest extent of the law. Data forms and any other materials for this survey will be identified by coded numbers and not names. All the study materials will be stored in locked cabinets which will only be available to authorised study staff and will not contain any personal information that can be used to identify you. We will not discuss any information about you or what you have shared unless you give written permission. Your name will not be used in any database, or in any reports or scientific papers published, which may result from this study.

Whom Can I Contact?

If you have any questions, you can ask anyone from our team now or later. If you have questions later, you may contact Samuel Muhula at 0721 958 734 or samuel.muhula@amref.org. If you have questions about your rights as a research participant, you may contact:

The Research Officer
Amref Health Africa in Kenya
Wilson Airport, Lang'ata Road
Office Tel: +254 20 6994000
Mobile No: 0795746777
Esrc.kenya@amref.org
Fax: +254 20 606340
P.O Box 30125-00100
Nairobi, Kenya

Do you have any questions at this time?

Part II: Certificate of Consent

You have been given a copy of this consent to sign and keep

Do you have my permission? Yes/No

Interviewer:

If no, thank the respondent and end the questionnaire. Indicate results in the identification table.

If yes, take the respondent through the below statement to obtain a signature and proceed with the interview

I have read the above information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I was asked and have answered the questions to my satisfaction. I consent/assent voluntarily and without coercion or undue influence to participate in this study.



Print Name of Participant _____

Signature of Participant _____

DD/MM/YYYY _____

If visually impaired, physically impaired, mentally impaired or illiterate

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent/assent freely.

Print Name of Participant _____

Thumb/Footprint of Participant _____

Signature of Witness _____

DD/MM/YYYY _____

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the information collected will be kept confidential. I confirm that the participant was allowed to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent.

A copy of this ICF has been provided to the participant.

Print name of the researcher

Signature of researcher

Date (DD/MM/YYYY)



Informed Assent form for in-depth interviews

Study Title	Impact Evaluation of Community Led Alternative Rite of Passage (CLARP) Model A case of Kajiado, County in Kenya
Principal Investigator	Samuel Muhula Monitoring, Evaluation, and Research Manager Amref Health Africa in Kenya P.O Box 30125-00100 Nairobi Kenya +254721958734 Samuel.muhula@amref.org
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Why is this Study Important?

As indicated, we are evaluating the Amref FGM/C programme interventions in Kajiado county since 2009. Based on your responses, we hope to get information that will identify the achievements of the project for many years of implementation.

Who can participate?

You are being asked to take part in this study because you are an ARP graduate/non-ARP beneficiary below 18 years old. Your participation will involve taking part in a face to face interview with a member of the study where we will ask you questions about Amref's work to eradicate FGM/C, teenage pregnancies and early and forced



marriages and ARP. It is expected that the study will take approximately 40 minutes. We will conduct a total of 24 in-depth interviews with ARP graduates and non-ARP beneficiaries and a total of 24 KIIs with various stakeholders including the chief, children protection officers and MCAs.

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Whom Can I Contact?

If you have any questions, you can ask anyone from our team now or later. If you have questions later, you may contact **Samuel Muhula at 0721 958 734** or samuel.muhula@amref.org. If you have questions about your rights as a research participant, you may contact:

The Research Officer
Amref Health Africa in Kenya
Wilson Airport, Lang'ata Road
Office Tel: +254 20 6994000
Mobile No: 0795746777
Esrc.kenya@amref.org
Fax: +254 20 606340
P.O Box 30125-00100
Nairobi, Kenya

Do you have any questions at this time?

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Print Name of Participant	
Signature of Participant	
DD/MM/YYYY	

If visually impaired, physically impaired, mentally impaired or illiterate

I have witnessed the accurate reading of the assent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given assent freely.

Print Name of Participant	
Thumb/Footprint of Participant	
Signature of Witness	
DD/MM/YYYY	

Statement by the researcher/person taking consent

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A copy of this ICF has been provided to the participant.

Print name of the researcher	Signature of researcher
Date (DD/MM/YYYY)	