Contribution of state-community partnership structure in implementation of female genital mutilation (FGM) policy: A case of Chepalungu Sub-County, Kenya

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ABSTRACT

In its effort to end female genital mutilation (FGM), the state in Kenya has operationalised key legislation: the Prohibition of Female Genital Mutilation Act 2019. Notwithstanding the statutory recognition of community participation in the implementation of the policy, there remains a structural void that weakens the partnership between the state and the community. This is more pronounced in Chepalungu Sub-County of Bomet County, where incidences of FGM are on the increase. This paper assessed the effectiveness of state-community partnership structures in the implementation of FGM policy in Chepalungu Sub-County. It was informed by both the partnership and structural functional theories and used a descriptive survey research design to determine the target population at 340, from which a sample size of 169 was selected using Slovin's formula. The sample size was arrived at using a purposive sampling technique among key influencers and policy implementers, while the household heads were simply randomly sampled. Data were collected using a questionnaire, interview schedule and focus group discussions. The analysis of data was done using descriptive statistics and the thematic analysis method and presented in tabular form, pie charts, narratives and graphs. The findings indicated that 20 (63%) agreed that there is weak and often ad hoc coordination between the state and the community which negatively affected the implementation of the FGM policy. Further, 12 (37%) agreed to inadequate monitoring and evaluation of the implementation process. Notwithstanding the foregoing findings, 20 (63%) of the respondents indicated that there is some form of state-community collaboration, especially in the apprehension and arrest of offenders (7 (22%)), the rescue of cut girls (3 (9%)) and the taking of risk mitigation measures (2 (6%)). The involvement of the state, however, in alternative rites of passage as a strategy for controlling FGM was minimal. This is largely left to the civil society organisations (20 (62.5%)) in their efforts to promote girl child rights. About 10 (31.25%) agreed that civil society also engages in sexuality and reproductive health awareness as a strategy to de-campaign the FGM practice. This paper concludes that there is weak structural collaboration between the state and the community in the implementation of the FGM policy. The state remains a dominant actor in the implementation process in a community whose cultural practices are criminalised. It recommends the creation and maintenance of definitive partnership structures to reify the collaboration between the state and the community.

Keywords: Community, Female Genital Mutilation, Policy Implementation, Partnership, State

I. INTRODUCTION

Female Genital Mutilation is recognized internationally as a violation of the human rights of girls and women just as it remains an inherent cultural and religious practice in large population groups across the globe. It nevertheless reflects deep-rooted inequality between the sexes and constitutes an extreme form of discrimination against girls and women. It is often carried out, according to the United Nations Children's Fund (UNICEF), on minors and emerges as a major violation of the rights of children, right to health, security and physical integrity; freedom from torture, cruelty and inhuman or degrading treatment and the right to life. It is estimated that 230 million women and girls have undergone the practice globally (Hendel, 2022), Middelburg & Desiderio 2014). As a result, a growing number of states have designed policies aimed at eradicating or at least managing the proliferation of FGM either as a cultural or religious practice.

The implementation of the anti-FGM policies varies from state to state. Whereas it is largely not practised in the Global North, the onset of immigration from the Global South has seen its rise in countries in Europe and North America as well as Australia and New Zealand (Mathews 2011, The FGM Education Programme n.d). In Muslim countries, despite the controversy on the acceptability of FGM in Islam, the practice is rampant and legal in almost all Islamic countries (Al-Awa, 2019). Barrett, et al. (2021) has noted, however, that some Muslim countries in the Global South especially Iraqi Kurdistan, Djibouti, Egypt, Somalia, Yemen and North Sudan have criminalized FGM and

recognized it as gender-based violence (GBV). Nevertheless, the existing laws are seldom enforced since the practice remains deeply rooted in culture and tradition (Macfarlane & Dorkenoo, 2014). It has thus been recommended to pursue a multi-sectoral and multi-level strategy to address the challenges of implementation (Varol et al., 2015).

Other than the African Muslim states that permit the practice, many non-Muslim states on the African continent similarly practice it as an inherent social and cultural requirement. This is more pronounced in the Horn of Africa, Eastern Africa and some states in Central and West Africa (UN Women, 2026). However, the cultural, social, political and economic contexts of the FGM practice make it very complex to address. On one hand, pro-FGM advocates argue against Western hegemony and liberal feminism that interferes with others' cultural beliefs (Nnaemeka, 2005). On the other hand, anti-female genital mutilation (FGM) campaigners have been accused of being ethnocentric and imposing 'Western' values onto non-Western communities, most notably by postcolonial feminists and anthropologists (Van Bavel, 2023, Atkinson et al. 2019). Nonetheless, some African states have outlawed FGM through the promulgation of specific laws, for instance, in Tanzania, Burkina Faso, the Gambia, Guinea, Guinea-Bissau, Mali, Mauritania, Nigeria, Senegal, Rwanda, Botswana, and Namibia (UNFPA 2026, 2026b).

In Kenya, the anti-FGM crusade has been conspicuous. Through the Prohibition of FGM Act of 2011, the state has established a legal framework against the practice of FGM hence effectively criminalizing it (Kimani, & Obianwu, 2020). The framework establishes several interventions including awareness raising, designing and coordinating anti-FGM practices, mobilizing resources for anti-FGM initiatives, monitoring and evaluating FGM, and strengthening institutions for the successful implementation of the plans as some of the strategic anti-FGM themes to focus on the fight against FGM (Republic of Kenya 2019, Berer, 2015). The impact has been felt on the drop in reported national incidences. However, county level evidence indicates rising rates especially in Somali-dominant counties (94%), Samburu (86%), Kisii (84%), and Masaai dominant counties (78%) (Matanda et al., 2023). This occurs despite spirited campaigns from the state and non-state actors.

There is an apparent missing link that influences the prevalence of the practices in the Kenyan Counties. This is partly attributed to absence of effective structures that develop and sustain partnership among the actors. This is in concurrence with Mathews (2011) who stated that "governments usually only enact laws to combat this phenomenon, but they cannot apply them. This is because these laws require that society be prepared for them. Society cannot be prepared automatically, as these are the responsibilities of governments and civil organizations. Governments must work harder to change the attitudes, customs and the inequality of women." This implies a lack of effective cooperation amongst civil society actors and the state.

1.1 Statement of the Problem

The implementation of Kenya's Prohibition of Female Genital Mutilation Act 2011 in Chepalungu Sub-County has largely been lackluster partly due to the dominance of state actors and absence of effective structures to reify the partnership with the community. Expectedly, the state actors in the sub-county have criminalized the age-old cultural practice leading not only to driving the FGM practice underground. This has estranged the community and created mistrust between the state and the community. Paradoxically, the state expects support from the affected community to ensure the eradication of the FGM practice. Evidence from the crimes offices in the sub-county indicates that, in 2019, 15 women were charged for undergoing an aided FGM practice at Chebunyo. In 2018, in Kapkesosio and Kyogong locations, 9 women were charged for undergoing the practice (Ombogo, 2018). The prevalence of the crime is further attributed to the connivance of local cultural leaders notwithstanding their responsibility in helping to control the crime as per the statute. This study, therefore, assessed the contribution of the partnership structure in the relationship between the state and the community for implementing the anti FGM policy in Chepalungu Sub County. It advances the argument that effective partnership structures between the state and the community are indispensable in t implementing the FGM policy in the sub-county.

1.2 Research Objective

This paper assessed the effectiveness of state-community partnership structures in implementing the anti-FGM policy in Chepalungu, Bomet County.

II. LITERATURE REVIEW

2.1 Theoretical Review

This paper is informed by two theories: partnership theory and structural functionalism theory. The partnership theory stands out prominently in business operations and deals with how commercial partners cooperate in the implementation of business ventures (McQuaid, 2000). Since it entails working or acting together it denotes a cooperative effort between partners in pursuit of mutually beneficial outcomes. It is characterized by various dimensions including partnership's goals, the actors involved in the interactions, the time factor in the development of the relationship, spatial dimension and mode of implementation, the potential benefits and likely drawbacks of the

partnership. This theory is valid to the argument raised in this paper to extent that it informs the relationship between the state and the community especially within a context of disparate practices but similar goals.

The partnership theory feeds into the structural functionalism theory which evolved from the writings of Emile Durkheim, Talcott Parsons and Robert Merton (Fontes & Guardalabene, 2006). Structural functionalism holds that social structures and societal organization have an impact on how people behave and how society functions. The theory views society as a complex system with different parts that are interdependent, hence working together to promote stability and solidarity. It advances that societies change with time, with formalized, large-scale institutions evolving to fulfill the functions that smaller, more intimate communities originally filled. Individuals start to depend on one another more. It informs the implementation of public policy especially when the local community and the state ought to develop and sustain structures that promote a partnership in putting FGM policies into action.

2.2 Empirical Review

Public policy facilitates the resolution of existing emerging societal challenges by establishing structures and defining processes which the different actors must experience. Female Genital Mutilations (FGM) falls in this space of challenges in which interventions vary from state to state. According to Rouzi (2013), it is prevalent in many Muslim countries and emerges in many non-Muslims countries as an inherent cultural trait. It is understood that many Islamic countries do not mandate the practice though its realization through public policy is not felt (Al-Awa, 2019). Macfarlane and Dorkenoo (2014) stated that: "western countries, and some countries in the Global South have criminalized the practice of FGM as the campaigns recognize it as gender-based violence (GBV), but this does not mean that laws are enforced. The practice remains deeply rooted in culture and tradition" (Macfarlane & Dorkenoo, 2014).

Due to socio-cultural conventions and belief systems unique to each group, female genital mutilation is widespread in many communities in Africa and the Middle East. However, it takes many different forms and can be more severe than in other cases (Ali, 2022). Several states have undertaken interventions with a view to eradicating it. This has happened in some states in Somalia and in Uganda where public policy interventions exist amidst widespread practice within communities. Due to the legal sanctions involved, its practice tends to be driven underground. In these countries, there is tacit recognition that public policy implementation is not effective because of lack of structures to support collaboration of the various actors. The disjointed approaches in policy implementation and the apparent state inertia have seen an increase in civil society organizations that advocate for the eradication of the FGM practice. This has seen the introduction of community-based rescue centers that engage girls in alternative (World Vision, 2019).

States are apparently the prime actors in policy interventions against FGM. This is also recognized in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC). Article 5 of CEDAW which require state parties to "... take all appropriate measures: (a) To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women." Article 24 of the CRC says in sub-paragraph 3 that "States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children." At the regional level, the Maputo Protocol addresses the elimination of harmful practices, including FGM (African Union, 2003). Article 5 says that "States Parties shall prohibit and condemn all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognized international standards. State Parties shall take all necessary legislative and other measures to eliminate such practices." These measures include awareness-raising through information campaigns, formal and informal education, and outreach; Prohibition, through legislative measures backed by sanctions, of all forms of FGM, including medicalized procedure; Support for victims of FGM in the form of health care, legal counsel, psychological care and support, education and training; and protection of women who are potential victims of FGM or other forms of violence, abuse or intolerance.

While there are regional frameworks that address violence against women and girls, the Istanbul Convention on Eradication of Violence against Women there is no legally binding international treaty specifically dealing with violence against women and girls or more specifically FGM. Nevertheless, the General Comments of CEDAW and CRC87 can be viewed as authoritative interpretative instruments, which give rise to a normative consensus on harmful practices and the application of treaties (Ghanem, 2023).

Several studies reviewed by Barsoum et al (2011), tested the effectiveness of using religious or other community leaders as an intervention against FGM. The studies refer to the potential usefulness of religious leaders and their role in issuing edicts or making public their stance on FGM. Islamic religious leaders have in the past issued edicts (Fatwa) against FGM, for example, in Egypt (Barsoum et al., 2011) and Mauritania (Johansen et al., 2013). While the independent effects of such edicts have yet to be quantified, such unequivocal positions are likely to have effect on behavior and practice among communities placing high levels of respect on religious leaders. Conversely, reticence by religious leaders can thwart progress towards elimination of FGM (Mehari et al., 2017).

Buttia (2015) argued that "FGM is also associated with cultural and religious obligations. Change in religion and culture for encouraging the abandonment of FGM is hence a promising approach towards FGM eradication." In many places where FGM is practiced, traditional and religious leaders sometimes wield more power and influence than the government (Al-Nagar et al., 2017). In such instances, religious leaders can play an important role in the elimination of FGM at the community level. Evidence suggests that while the role of traditional practitioners in the elimination of FGM cannot be underestimated, efforts to provide traditional practitioners with an alternative income have been largely ineffective (Varol et al., 2015). These efforts may need to be recalibrated if they are to be optimally used in the prevention of FGM at the community level (Johansen et al., 2013). The fact that community partners such as elders and other local leaders are the guardians of their culture might have hampered the progress of policy implementation.

III. METHODOLOGY

3.1 Research Design

This study used descriptive survey research which entailed the use of interviews, a questionnaire and focused group techniques to generate data. Using this design determined and reported the way things were (Mugenda & Mugenda, 1999). It facilitated the description of possible behavior, attitudes, values and characteristics used to investigate the contribution of state-community partnership structure to the implementation of FGM policy in Chepalungu constituency, Bomet County.

3.2 Study Area

Chepalungu Sub-County is the largest Sub- County in Bomet County, Kenya. It is challenged by lackluster implementation of the anti-FGM policy thereby contributing to high incidences of FGM. According to the Anti-FGM representative in Bomet, the County records the highest number of FGM cases in Kenya having an average of 62% when compared to the country's 21% rate. Chepalungu has been identified as one of the 17 hotspots in Kenya for FGM, where the practice is still prevalence despite national declines. The constituency remains a significant concern, suggesting that up to 60% of women and girls in the area have undergone the practice.

3.3 Target Population

This study was conducted among the Kipsigis community members in Chepalungu Kataret, Chebuluu and Chebunyo villages in Chepalungu, Bomet County. The study targeted 340 respondents comprising of 80 Male and female Village elders, (community members) 200 Household Heads, Director NGOs-4, Director, Ministry of Health-1, chiefs-4, sub-chiefs-11 and Officer Commanding Station (OCS)-3.

Table 1

Sampling Technique

Category	Target Population	Sample Size
Village Elders	80	24
Household Heads (Community members)	200	60
Directors of NGO	4	4
Director Ministry of Health(DMOH)	1	1
Chiefs	4	4
Sub-chiefs	11	11
Officers Commanding Station	3	3
TOTAL	**340**	**169**

The researcher employed Slovin's formula in determining the sample size.

Slovin's formula $n=N/(1+N*e^2)$

Means

n= sample size

N=Total Population (340)

e= margin error (0.061 or 6.1%)

N=340, e=0.061(6.1%)

$n=340/(1+340*(0.061)^2)$

n=340/(1+340*0.003721)

n=340/2.26514)

n= 169

3.4 Sample Size

The sample size was 169 involving 24 Village elders, 60 Household Heads, 4 chiefs, 11 sub chiefs, 3 Officers Commanding Police Divisions(OCPD), 4 Non-Government Organization(NGO) Directors and 1 Ministry of Health(MOH) Director.

3.5 Sampling Procedure

Sampling involved purposive selection of key stakeholders (Directors, Chiefs and OCS) to capture specific insights and random sampling for village elders, Household heads, and sub-chiefs to ensure broad representation. This sampling approach captured key influencers -4 NGO Directors (for FGM advocacy), 1 MOH Director (policy), 4 Chiefs (community leaders), and 3 OCS (law enforcement) who provided policy implementation insights on FGM prevention strategies and enforcement of anti-FGM laws. Community members -24 Village Elders (cultural norms), 60 Household Heads (household decisions) and 11 Sub-chiefs (local governance), they shared grassroots perspectives on cultural norms, awareness and challenges in abandoning FGM. The key influencers and village elders were purposively sampled while the household heads were simple randomly sampled.

3.6 Data Collection Tools and Procedure

This study used an interview schedule, questionnaire and focus group discussions as tools for capturing and generating data. The collected data described the status quo on state community partnership and policy implementation in Chepalungu Sub County.

3.7 Data Analysis

The collected data were thematically analyzed while relying on descriptive statistics that were presented in graphs and pie charts.

3.8 Ethical Consideration

The study sought ethical clearance and a research permit from Kisii University and the National Council for Science, Technology and Innovation (NACOSTI) respectively. In addition, concurrence on confidentiality was sought from the respondents by signing a Letter of Consent.

IV. FINDINGS & DISCUSION

4.1 Institutional Structure for Policy Implementation

The institutional structure and process of policy implementation against FGM at the various levels of the state is stipulated in the *Sessional Paper No. 3 of 2019 on National Policy for the Eradication of Female Genital Mutilation* as guided by the principal legislation: *The Prohibition of Female Genital Mutilation Act 2011* and the Sessional Paper of 2019(Republic of Kenya, 2011, Republic of Kenya, 2019). Both documents create structures and establish measures to prohibit, regulate and penalize FGM practices. Whereas the Act provides the macro guidelines, the Sessional Paper provides the detailed institutional structure, composition, and process of policy implementation at the various levels of the state.

The organizational structure responsible for the FGM policy implementation at the Sub county level is the Subcounty anti-FGM Committee. The Committee "acts as the community watchdog for prevention and response to FGM" (Republic of Kenya, 2019:25). It consists of an array of stakeholders and is chaired by the Deputy County Commissioner and co-chaired by Sub-County Administrator. The membership of the committee comprises of the Chairperson of Community Policing, Sub-County Health Officer, Sub-County Education Officer, Sub-County Gender Officer, Sub-County Children Officer, Sub-County Public Prosecutor, KEPSHA, Representative of People with Disabilities, Youth Representative, CSOs, Sub-County Chair of FBOs, Officer Commanding Police Division, representatives of Maendeleo Ya Wanawake, Supreme Council of Kenyan Muslims and the National Council of Churches of Kenya. The committee is expected to liaise with the state apparatchiks comprising of the County Government department in charge of gender issues, County Administrators, County National Government Administrators and Community elders and *Nyumba Kumi*. The role of the Committee tasks it to liaise further with faith Based Organizations, Community Based Organizations and the private Sector. The committee's membership and responsibilities portray a multi-sectoral approach to the implementation of the FGM policy which requires concerted coordination and facilitation. The concept of community as envisaged in the policy is therefore very broad. However, what emerges in the policy documents is the absence of recognition and engagement with households – the micro-unit at which FGM is conceptualized, planned and executed.

In its Policy Objective 2, the state is required to strengthen the capacity of institutions and communities to prevent and respond to FGM, promote the establishment of temporary rescue centers for women and girls at risk of FGM and support several initiatives including developing mechanisms to reach communities with information on

prevention and response to FGM, developing a clear structure of communication channels in order to respond to distress, disseminating FGM materials in institutions and communities, establishing and strengthening of the Anti-FGM multi-sectoral working groups at the National, County and sub-County levels, strengthening of the capacity of religious leaders to champion eradication of FGM, facilitating counseling and rehabilitation of the girls and women who have undergone FGM, and establishing a system for anonymous reporting (Republic of Kenya, 2019:20). The status of implementation at the Sub county level, however, tends to provide a different picture of stakeholder coordination and action as demonstrated in the following sections.

4.2 Areas of Partnership in FGM Policy Implementation

The key influencers, including location chiefs, sub location assistant -chiefs, religious/cultural leaders and village heads were asked to ascertain the actual areas of partnership in FGM policy implementation. The total count of participants was 35. Three questionnaires were not returned. The findings are summarized in Figure 1 below.

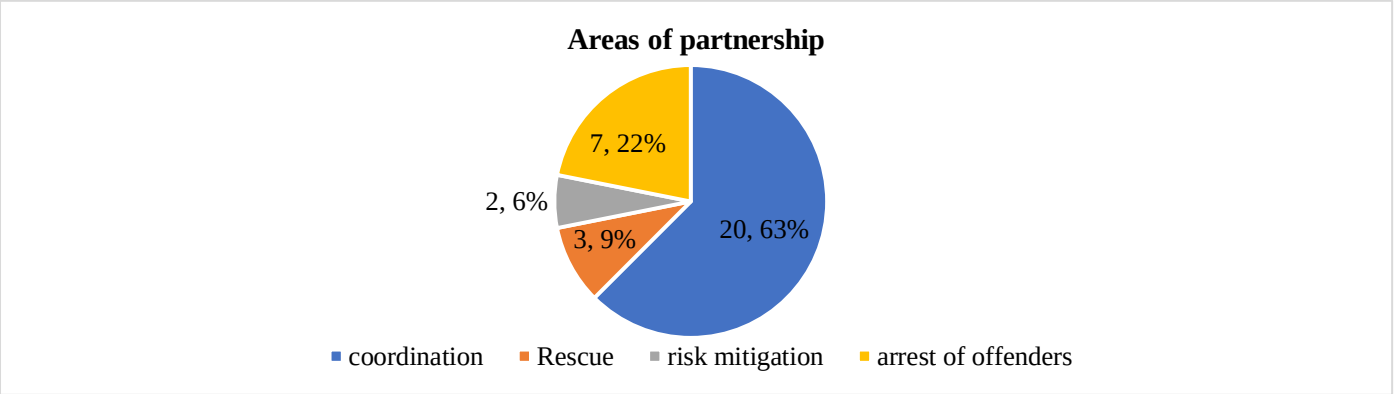

Figure 1
Areas of Partnership

Figure 1 indicates that 20(63%) of the respondents indicated that the state and the community collaborate in coordinating the implementation of the FGM policy at the sub county level. However, 7(22%) agreed to collaborating in the arrest of offenders, 3(9%) in the rescue of cut girls and 2(6%) in taking risk mitigation. The coordination between state and community in implementation of FGM policy was nevertheless not clearly spelt out since issues to do with arrest of offenders scores are low let mitigating risks of FGM. Information on household-level interventions by the state and non-state actors aimed at protecting girls and women at risk of FGM, preventing FGM, and providing care to women and girls who have undergone FGM was nevertheless not easily forthcoming. In an interview with a Director of an NGO it was found that the most visible household intervention was the establishment of rescue centers. He stated that:

> *"Rescue centers or safe houses aim to provide protection and refuge for girls who are at risk of FGM during the cutting period. Notably, most of the studies included rescue centers among other interventions, with limited information on the assessment of rescue centers as an independent intervention. Apart from providing shelter to girls running away from FGM, rescue centers also educate girls on the health risks and illegality of FGM, and its violation of human rights".* (NGO Director, 31st, December 2024).

The rescue centers, however, faced challenges with operations of which state intervention was pertinent. In an FGD interview, a member observed:

> *"Rescue centres face challenges such as limited resources and lack of recognition and buy-in of the intervention by the community and there is therefore limited evidence on their effectiveness"* (FGD Member, 31st, December 2024).

It is apparent that rescue centers are risk mitigation measures against FGM. With under resourced rescue spaces then the fight against FGM would not be effective. The findings indicated that there seemed to be coordination between the state and specific members of the community in terms of implementing anti-FGM policy, however, the terms of engagement are not well defined. The community participation structure is a loose one or looks odd instead of a well-structured engagement. This concurs with experiences identified with the establishment of rescue centers in Narok County where household engagement is quite low (UNFPA, 2026). Furthermore, incidents of arrest of offenders are frequent though not consistent with the high levels of FGM prevalence (Barret et al., 2021). The number of offenders, however, includes the victims of the practice, a phenomenon that requires further scrutiny and policy reform.

4.3 State-Community Partners

To identify the non-state stakeholders in the implementation of certain aspects of FGM policy the researcher asked the key influencers to identify the state partners and the challenges that they face. The total count of participants was 35. The return of three questionnaires was absent. The findings are summarized in Figure 2.

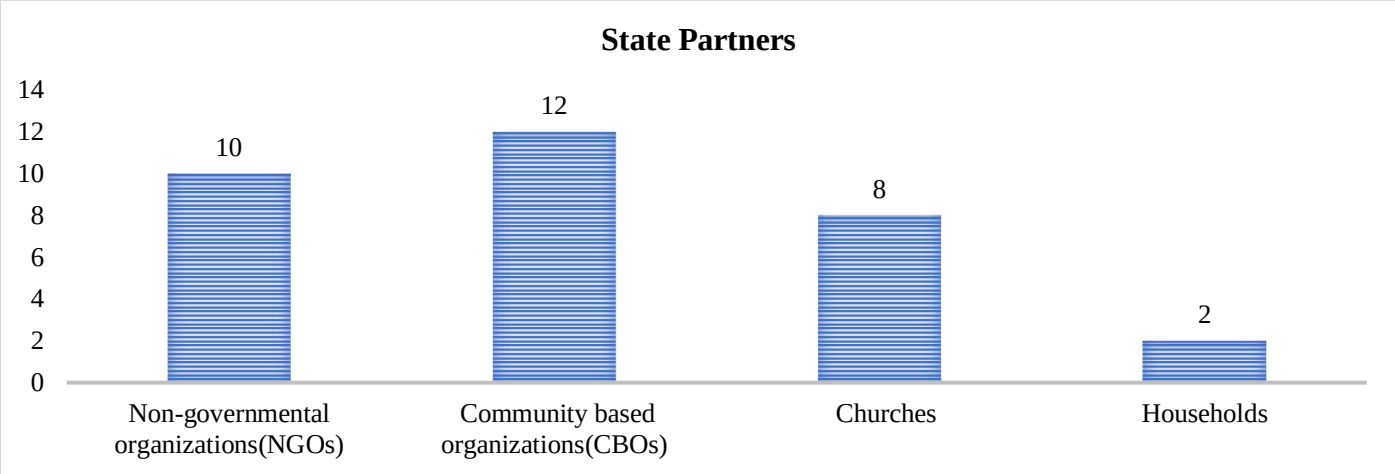

Figure 2

State-Community Partners in FGM Policy Implementation

For effective implementation of FGM policy, the state ought to partner with non-state actors as envisaged in the national legislative and policy framework. In particular, community engagement is crucial as evidenced in Eritrea where the fight against FGM has institutionalized the adoption of a working multi-sectoral approach pivoting on the role of the National Union of Eritrean Women (United Nations Children Fund [UNICEF], 2020). In its Communication for development Action (C4D) for example, UNICEF states that "intensive and sustained community dialogue and sensitization have been conducted as part of this holistic approach to behavior change, with key interventions on FGM. The aim of the ongoing community level discussions, debates, theatre, poems and house-to-house campaigns is to trigger a social movement for the abandonment of FGM. Once a critical mass declaration of people has become engaged, communities can decide to make a public commitment and declaration to abandon FGM and replace it with positive norms that would promote children's and women's rights and increase gender equality" (UNICEF, 2020).

As shown in Figure 2, twelve (12) respondents indicated that CBOs mostly partner with the state in the implementation of FGM policy while 10 agreed to the NGOs. It is true that these entities work in communities and take the front in anti-FGM campaign. However, with a paltry 2 respondents for households, it is indicative that household involvement is minimal and thus calls for restructuring of the composition of community engagement in anti-FGM campaign. The composition of community should adhere to the conceptualization advanced by Oyaro *et al.* (2022) in which they state that a community comprises of "a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings, thus influencing their way of life and offering a sense of identity to its members. With regards to FGM/C, four key stakeholders should be addressed in the community: (1) the victims (young girls and women); (2) the perpetrators; (3) the custodians of the community's tradition/culture; the local and religious leaders); (4) policy makers (health-care providers; civil leaders at local and national level)".

FGM remains a challenge to the community in Chepalungu Sub County. Though it is recognized as social and cultural rights, several influencers are of the view that it should be eradicated notably with government support. In an interview session one local leader stated that:

> *''In our community, FGM is seen as a rite of passage. We need to challenge these norms and promote alternative rites'' community leader. Community-led initiatives are crucial, but they need government support and resources to succeed''* (a member of the NGO 24th November 2024).

4.4 Role of Non-State Actors in FGM Policy Implementation

The national policy on FGM eradication identifies an array of non-state actors at the sub county level (Republic of Kenya, 2019). To understand their perception and role in implementing the anti-FGM policy, key influencers were asked to clarify the significance of FGM and their role in the community. The total count of participants was 35. The return of three questionnaires was absent. The findings are summarized in Figure 3 overleaf.

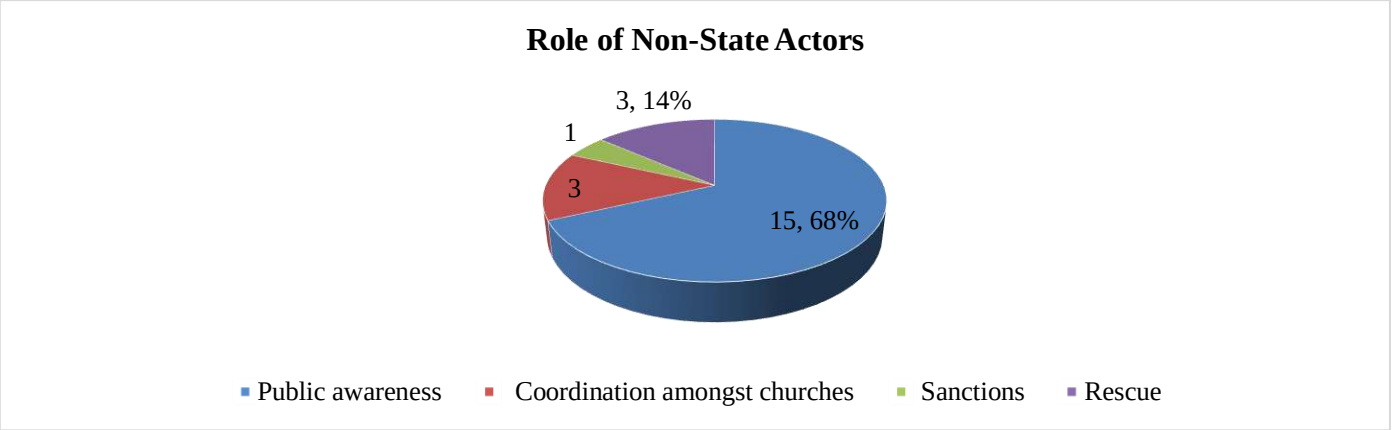

Figure 3
The Role of Non-state Actors

On the significance FGM in the community of Chepalungu sub county, an NGO director, in an interview stated that:

> *"The community believes that it gives the girl/woman a sense of status in her society and lack of it, almost certainly guarantees ineligibility for marriage and poor social standing in these communities. Encouraging the stakeholders in the community to replace this with acceptable alternative rites of passage therefore is one way of building bridges to save the females from FGM/C without disrespecting their culture",* (NGO Director, 15th,July 2022).

Therefore, like other social norms, FGM is transmitted from generation to generation. It is instilled by the family during childhood (primary socialization) and developed through appropriation or rejection in adulthood (secondary socialization) (Naguib, 2012). The prestige of such norms explains why even when the law condemns FGM, it continues to be favored by most of the people who may rather break the law than challenge the norm. In many communities, it is particularly difficult for people to discuss taboo issues such as reproductive and sexual health, including FGM, with members of another generation. Questioning the tradition around FGM is seen as particularly threatening to older generations. Moreover, FGM is traditionally performed by traditional circumcisers to whom the practice has been transmitted from mother to daughter. Rejecting FGM thus implies, for some, rejecting the culture to which one was destined. In an FGD discussion, a member of the community remarked:

> *"It is important to involve the community and particularly certain persons of influence for an effective FGM policy. In the community, there are preconceived notions that older women would not be able to integrate new ideas or learn new practices".* (Community Member, 15th July, 2022)

This statement indicates that FGM policy implementation gets into headwinds when older women are yet to take up the matter since they are critical players. The findings concur with Shell-Duncan *et al*. (2018) who believe that older women are well positioned to change the practice of FGM: who could have more power to change the practice than those who perpetuate it. Her study analyzed focus group data from Senegambian women, exploring what are the constellation of norms associated with FGM/C, when are existing practices and norms being contested, and how does this reflect prevailing structures of power. Their research identifies four overarching themes: Pressure to conform with FGM/C arising from sanctions such as ostracization, and moral norms linked to the embodiment of virtue; upholding tradition as a means of venerating ancestors; upholding social hierarchy by displaying respect for elders; and shifting beliefs about the healthful vs. harmful nature of FGM/C. While strong value is placed on upholding tradition, there is also an appreciation that elements of tradition must be revised to meet fluctuating realities.

The role of NGOs in general is to support anti-FGM campaign and deter FGM in the community. This is similarly captured in Kenya's legislative and policy framework. Since NGOs are well resourced, their support for rescue centers, undertaking anti-FGM campaign etc is important. The presence of a structured government response in Chepalungu is enough evidence in the fight against FGM by giving the mandate to organizations like the Anti-FGM board to lead the fight against FGM and also partners with private companies and NGOs like world vision. However, since FGM is commonly associated with poverty, deprivation and inequalities, there is urgent need for empowering in diverse activities that facilitate the realization of human and women rights.. As shown in Figure 3, 15 (68%) of the respondents agreed to public awareness on FGM policy among the community. On the other hand, 3(14%) of the respondents agree to rescue role. The role of non-state actors such as religious institutions, CBOs/NGOs are thus limited in implementation of FGM policy. A greater mandate needs to be handed to these entities due to proximity to the community.

The findings in Figure 3 indicate that to successfully implement any long-lasting anti-FGM/C program without wholly involving all stakeholders in the community would be close to the impossible. As this is a deeply rooted cultural practice that defines a female's status in society, anti-FGM/C legislation alone addresses a small

proportion of the problem and indeed on its own, runs the risk of pushing the practice underground. Therefore, community engagement entails raising awareness on health implications of the FGM practice and mobilizing community resources to assist in developing a sustainable and self-reliant intervention. In an interview, a Chief lamented:

> *"Most societies are patriarchal. This indicates the fundamental importance men have in decision making in their households even in matters of women health. Peers have been found to have profound influence on a person's decision. The desire to fit in and the incremental value placed on peer relationships places impetus to take decisions that are socially appealing amongst the peers".* (Chief, 7th May, 2025).

This statement confirms that a mere state anti-FGM policy that imposes sanctions may not work. NGOs undertake public awareness campaigns to undo beliefs such as one would be considered an outcast by family and peers and not being eligible for marriage. The fear of being a social outcast is perhaps the greatest hindrance to effective anti-FGM/C campaigns. In collaboration with state agents like chiefs, NGOs, faith-based institutions encourage mothers in the local health facilities; fathers in local/village meetings on the health hazards of FGM/C to the young girls and encourage them to consider alternative rites of passage.

A Maendeleo Ya Wanawake Organisation (MYWO) survey indicates that scores of girls underwent female genital mutilation (FGM) in Bomet County despite a Government ban. The survey showed that Sigor division led with 2,370 initiates, Ndanai (2,100), Siongiroi (1,735), Longisa (1,617), Mutarakwa (1,687) and Bomet Central (1,012). These numbers are indicative of role by NGOs in taking monitoring and evaluation of true status of FGM in Bomet (Ombogo, 2018).

Furthermore, religious and cultural leaders can be at the forefront of questioning the religious underpinnings of the FGM practices just as they are at the forefront in their campaigns against abortion. In many places where FGM is practiced, traditional and religious leaders sometimes wield more power and influence than the government. Religious and cultural leaders can effectively pass on messages to the community, especially in communities that are ready for change, and play an important role in the elimination of FGM at the community level. Conversely, reluctance by religious leaders can hinder progress towards elimination of FGM.

The norms and values of a community greatly influence an individual's and community's perspective of FGM/C as a whole. That is why the household and community-based organizations are important. The community culture such as the rite of passage to initiate girls into womanhood is a well-known tradition of many communities globally.

4.5 Modes of Public Awareness for FGM Policy Implementation

To understand role of the community, the researcher asked respondents to identify key influencers in the implementation of certain aspects of FGM policy. The village elders, assistant chiefs were asked to identify avenues of Key Influencers in anti-FGM policy implementation. The total count of participants was 35. Three questionnaires were no returned. The findings are summarized in Figure 4 below.

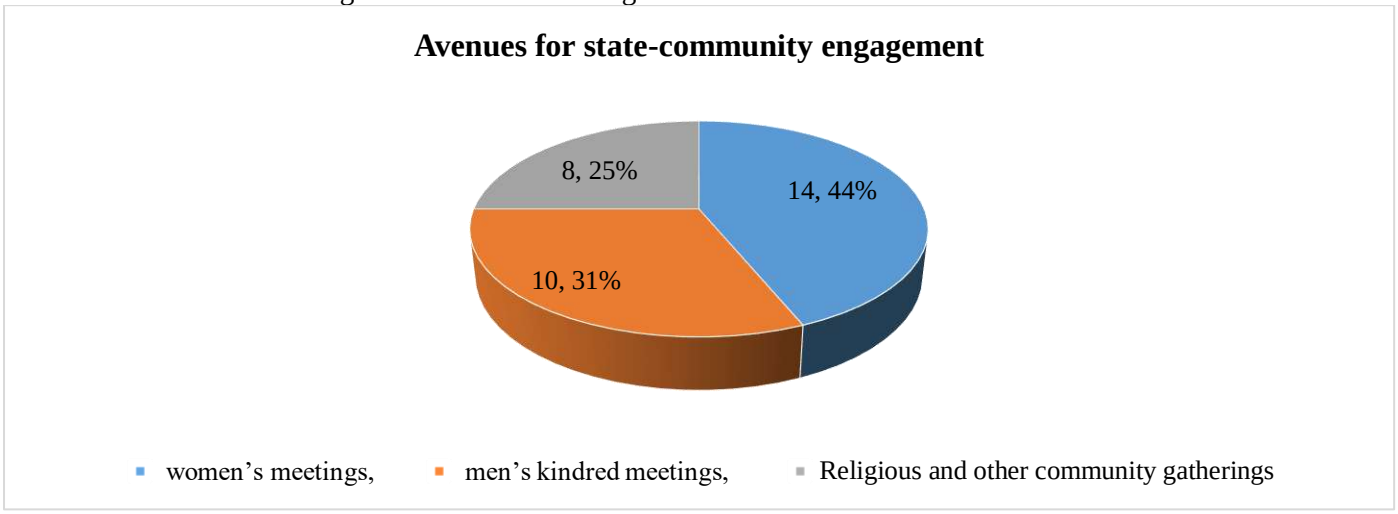

Figure 4

Avenues of State-Community Engagement

As shown in Figure 4, fourteen, 14 (44%) of the respondents agreed that women meetings were the most preferred modes through which anti-FGM campaign took place. This was followed by 10(31%) men's meetings while 8(25%) agree to religious institutions/community gathering. These data imply that FGM is a female issue, but men only come in due to cultural beliefs. The findings in Figure 4 above concur with UNFPA (2017) that in patriarchal cultures, male opposition to FGM/C—coming from traditional and religious leaders; respected elders, rulers and

chiefs; local and national government and law enforcement officials, carries great weight. However, increasingly, the informal, personal power of men and boys raising their voices as friends, brothers, husbands, boyfriends, and sons is also having a huge impact on social norms and family decisions. A study, for instance, by the Touche Pas A Ma Soeur social media campaign from Senegal, men of all ages, classes, styles, professions were pictured proudly holding signs or wearing T-shirts that disavowed FGM/C with a slogan that was at once protective and assertive (UNFPA, 2017).

Table 2
Role of the State in FGM Policy Implementation

State Roles	Frequency	Percent
Policy making	20	62.5
Information sharing	2	6.25
Participatory monitoring and tracking of FGM programs	10	31.25
Total	**32**	**100**

Despite some geographical variation, men seldom directly participate in the decision-making surrounding and the execution of FGM/C (Kaplan et al., 2013). Whilst mothers, grandmothers, or other elderly community women appear to stand at the forefront of perpetuating FGM/C, men also play a significant role in its continuation as fathers, husbands, and community and religious leaders (Kaplan et al., 2013; Varol et al., 2015). Table 2 above indicates that 20(62.5%) of the respondents agreed that the state role was to share information with the public/community on FGM policy and programs to reduces such cases. Also, 10(31.25% agree to states monitoring/tracking implementation of the FGM policy while 2(6.25%) agree to information sharing with other stakeholders.

In recognition that FGM is not only a harmful practice but a violation of human rights, Kenya has ratified several International legal instruments that have become part of the Kenyan law as provided for in Article 2 of the constitution (Republic of Kenya, 2019). These include: The Universal Declaration on Human Rights (UDHR, 1948), International Covenant on Civil and Political Rights (1966), International Covenant on Economic, Social and Cultural Rights (1966), the Convention on the Elimination of All forms of Discrimination Against Women (Shah, P. 2022, CEDAW, 1979), the Convention Against Torture and other Cruel and Inhuman or Degrading Treatment or Punishment (1984) and the United Nations Convention on the Rights of the Child (The FGM Education Programme (n.d). The United Nations General Assembly Resolution 61/143 of 2007 reminds state parties that they should not use customs and traditions or religious beliefs as excuses to avoid obligations to eliminate violence against women while Resolution 67/146 at the 67th – 2012 session seeks to intensify global efforts on the elimination of FGM.

At the regional level, the normative frameworks that became part of the laws of Kenya include: - the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol, 2003), Aspiration 6 of Africa's Agenda 2063 which calls for full empowerment of women and girls including eliminating gender-based violence and Africa Charter on the Rights and Welfare of the Child (adopted 1990). Article 21 of the African Charter on the Rights and Welfare of the Child mandates governments to make every effort possible to stop harmful social and cultural practices such as FGM that affect the welfare and dignity of girls. The Constitution reaffirms the government's commitment to protect and promote human rights and fundamental freedoms. Article 44 (3) of the Constitution bars any person from compelling another person to perform, observe or undergo any cultural practice or rite. Article 53(d) specifically states that children should not be subjected to harmful cultural practices, inhuman and degrading treatment. Article 55(d) requires the State to take measures, including affirmative action programmes, to ensure that the youth are protected from harmful cultural practices and exploitation.

Further to the provisions of the Constitution, the government has enacted the Prohibition of Female Genital Mutilation Act, 2011. The law provides the framework for public engagement and advocacy for accelerating the eradication of FGM. The Children's Act, 2001, Section (14) criminalizes subjecting a child to harmful cultural practices. This provision of statute gives the parents the responsibility of ensuring the safety and security of the child. The Penal Code, Cap 63, also provides offences under which the circumcisers can be charged. The Protection against Domestic Violence Act, 2015 classifies FGM as violence. The Act provides for protective measures for survivors and victims of domestic violence including FGM. In an interview, a health officer pointed out:

> *"The National Policy on Abandonment of FGM, 2010 provided the platform for the enactment of the Prohibition of FGM Act, 2011 which led to the establishment of the Anti- FGM Board. In addition, the National Policy for Prevention and Response to Gender Based Violence, 2014, was approved to accelerate efforts towards the elimination of all forms of gender based violence (GBV) in Kenya. The Policy classifies Harmful Traditional Practices as a form of GBV. It provides for a coordinated approach in addressing GBV, effective programming, enhanced enforcement of laws and policies towards GBV prevention and response, increase in access to quality and comprehensive support services across sectors, and improved sustainability of the GBV prevention and response interventions".* (Health Officer, 8th, October, 2020).

To sum up, the anti-FGM system needs to do more than punish perpetrators where it also seeks to change attitudes and create agents of change. Those found responsible for acts of FGM/C are counseled after their conviction. In this section, it is clear that a state's anti-FGM policy alone cannot deter the practice when communities are not directly involved such that attitudes change towards the practice. As indicated already, there are no elaborate avenues through which the state directly deals with the community.

V. CONCLUSION & RECOMMENDATION

5.1 Conclusion

The objective of the study was to examine state-community partnership structure in implementation of FGM policy in Chepalungu, Subcounty. From the findings, the conclusion is that it is clear that rescue centers are risk mitigation measures against FGM. With under resourced rescue spaces then the fight against FGM would not be effective. The findings indicate that there seem to be coordination between the state and community in terms of implementing anti-FGM policy, however, the terms of engagement are not well defined. The community participation structure is a loose one or looks like an add on instead of a well-structured engagement. The problem is that the state only engages these groups in chiefs' barazas and thus the campaign against FGM does not take a deeper avenue to the household level. This means that in Chepalungu, FGM policy is yet to deeply embraced at household level and thus the need for more direct intervention by the state instead of reliance on NGOs and CBOs. These entities are viewed by the community as foreign supported.

5.2 Recommendation

According to the objective, the study recommends a structured engagement where the community role is specifically spelled out in the FGM policy. The roles of the community seem peripheral which negates the purpose of the FGM policy. This calls for enhanced structures in the policy between the state and community.

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