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Abstract

Purpose: The study sought to establish the determinants of traditional birth attendants' compliances to existing legal frameworks against female genital mutilation/ cutting in Garissa County, Kenya. The study intended to answer complex interplay of cultural, religious, and social factors influencing traditional birth attendants' compliance with legal frameworks against FGM/C.

Methodology: Study adopted cross sectional study design. Mixed methods approach (Survey and KIIs) was used to collect data. Targeted TBAs, law enforcers and opinion leaders residing in Dadaab Sub- County. Semi-structured questionnaires were used to collect quantitative data while key informant interview guide was used to collect qualitative data. Quantitative data collected was entered into Epidata (version 3.1) database then exported to R (version 3.6.4) for analysis while qualitative data were thematically analysed. 261 participants were recruited, with 86.21% being compliant to existing law against FGM/C.

Findings: The independent predictors for compliance to existing legal frameworks against FGM/C in this study were marital status of the active TBAs: married (AOR=7.78, 95% CI=2.4544-24.6443, p<0.001) and widowed (AOR=4.76, 95% CI=1.2063-18.8181, p=0.0259); Education level of the active TBAs: primary education (AOR=5.80, 95% CI=1.3887-24.2616, p=0.016); Required ages for girls/women before circumcision being 5-11 years (AOR=7.91, 95%, CI=2.73-22.95, p<0.001); Mothers accompanying girls/women to circumcision (AOR=7.02, 95% CI=2.0899-23.6125, p=0.0016); Religious background of girls/women to be circumcised (AOR=2.94, 95% CI=1.1688-7.4096, p=0.022); active TBAs who asserted that FGM/C was still deemed necessary in their community (AOR=0.11, 95% CI=0.0146-0.8844, p=0.0378); active TBAs who identified FGM/C Type I as the most predominant in their community (AOR=0.10, 95% CI=0.0261-0.3673, p<0.001); FGM/C being practiced for traditional purposes traditional (AOR=9.86, 95% CI=1.8419-52.7653, p=0.0075); Advocacy through religious approaches on the abandonment of FGM/C (AOR=5.90, 95% CI=2.173-16.0309, p<0.001); active TBAs cognizant of the punishments imposed on perpetrators and accomplices of FGM/C (AOR=3.11, 95% CI=1.279-7.5576, p=0.0123); active TBAs aware of the laws/legislations prohibiting FGM/C in Kenya (AOR=3.06, 95% CI=1.3759-6.7912, p=0.0061); Active TBAs supporting for the education of TBAs on existing anti-FGM/C laws (AOR=4.64, 95% CI=1.7885-12.0514, p=0.0016); active TBAs aware of someone in the community who had reported FGM/C as a crime (AOR=2.71, 95% CI=1.2296-5.9762, p=0.0134).

Unique Contribution to Theory, Practice and Policy: Information from the study will influence policy formulation and complement existing literature.

Keywords: *Compliance, Determinants, Female Genital Mutilation, Traditional Birth Attendants, Legal Frameworks*

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INTRODUCTION

The fundamental rights of girls and women to be free from female genital cutting (FGC) or female genital mutilation (FGM) have received global and regional protection through robust legal frameworks and policies. In 1994, an Intercontinental Forum on Population and Development in Egypt, attended by over 20,000 delegates from various countries, reached a consensus to enhance the reproductive health of girls and women by abolishing harmful cultural practices. A similar resolution was made during the fourth international women's forum in Beijing, emphasizing the need to prevent physical, sexual, and psychological abuse against women and girls, including practices like FGM (Elise et al., 2012). Despite Africa hosting the first anti-FGM campaign in Egypt in 1920, over 29 countries on the continent still practice FGM (Abdi et al., 2013). Progress in abandoning the practice has been limited, with cultural significance varying across countries and communities (UNICEF, 2016), and the age at which it occurs differing from infancy to adolescence (UN Women, 2017). In Kenya, FGM is practiced by certain ethnic groups driven by cultural beliefs about appropriate sexual behavior and marriage preparation (WHO, 2014). Recognized as a violation of rights with potential severe medical complications, Kenya's progressive constitution has led to legislative and policy frameworks addressing circumcision issues. The Health Ministry launched the National Action Plan for eliminating FGM in 1999, reinforced by the Children Act in 2001, marking Kenya's first anti-FGM law. In 2008, a six-year UNFPA-UNICEF joint partnership for fast-tracking FGM abandonment in Kenya was launched, followed by the National Policy for Abandonment of FGM Practices in 2010. The Prohibition of Female Genital Mutilation Act 2011, Kenya's second anti-FGM law, nationwide banned the practice. The Population Policy for National Development in 2012 identified FGM as perpetuating gender disparities, and in 2019, during the 25th anniversary of the International Conference on Population and Development (ICPD), participants committed to ending FGM by 2022 and all gender-based violence and discrimination by 2030 (NCPD, 2020).Despite successful campaigns leading to a significant drop in FGM prevalence in Kenya, certain areas, like Garissa County, still cling to the practice due to deeply ingrained cultural norms. Traditional birth attendants (TBAs), responsible for nearly all reported cases (Amina *et al*., 2013), view circumcision as a measure of purity, maintaining chastity, marital faithfulness, easing childbirth, and upholding family and community honor (Kandala *et al*., 2019; Kayombo, 2013). Efforts to eliminate FGM persist, recognizing the importance of challenging cultural norms and community engagement for sustained progress.

Statement of the Problem

Globally, in 2020 about 200 million women/girls had experienced FGM/C with an approximately 3 million teenage girls at risk of undertaking the practice annually. The vast proportion of these girls are exposed to the cut before they turn the age of 15 years old (WHO, 2020). Kenya is home to approximately 4 million girls and women who have experienced the cut. According to the KDHS report, in Garissa County near the Kenya-Somalia border, the practice of FGM/C was predominant among the Somali, Samburu, Kisii and Maasai ethnic groups with each recording a circumcision rate among women of 94%, 86%, 84% and 78% respectively. Conversely, the 2014 KDHS report reveals that 93% of women and 89% of men aged 15–49 are of the opinion that FGM/C should be stopped. According to the KDHS report, in Garissa County near the Kenya-Somalia border, FGM/C is practiced at a rate of more than 97%. This higher rate has been majorly contributed by medicalization of FGM/C and cross border movement to and from the neighboring countries to perform FGM simply because in

other countries it has not been criminalized. In Kenya the practice has been criminalized. Although the practice is still rampant in certain parts of the country, policies and strategies has been put in place to address the abandonment of FGM/C in Kenya. There's paucity of data on the determinants of the practice among the TBAs despite the existence of legal frameworks. While several interventions to end the practice are in place, the proportion of TBAs who are aware of the existing legal framework against FGM in Dadaab Sub County is not known. This study sought to comprehend determinants of TBAs compliance to the existing legal frameworks against the practice in Dadaab Sub County, Kenya.

LITERATURE REVIEW

This chapter reviewed the existing literature of previous similar studies. FGM/C is the rudimentary method of surgery done to women private part; it can be done partial or entire birth canal (WHO, 2008). FGM/C practice has been categorized into four types (WHO, UNICEF & UNFPA, 1997): Type I: also referred to as the clitoridectomy, it involves partial or complete amputation of the clitoris and/or its prepuce. Type II: also referred to as the excision, it includes partial or complete removal of the clitoris and labia minora with or without expurgation of the labia majora. Type III: also referred to as the infibulation, it encompasses constricting the vaginal opening with the development of a casing cap by cutting and tracing the labia minora and/or labia majora, with or without amputation of the clitoris. Type IV: involves all other procedures to the genitalia of girls and women for non- medical tenacities, viz; scraping, piercing, cauterization, pricking, and incising. There are a number of harmful effects associated with FGM/C (Berg *et al*., 2014) It predispose women to risky outcomes such as difficulty labour, depression, anxiety, and post-traumatic stress disorder (Bedri *et al*., 2018). Berg and Denison (2012) reported that it's more probable of a woman who has been exposed to FGM/C to experience discomfort during sexual intercourse and decline in sexual pleasure and desire compared to a woman whose genital tissues remains uncut, this also affect their male counterpart psychologically as reported in Johansen's (2007) study.

Existing Legal Framework in Kenya to Curb FGM/C

There are various laws that exists to prohibit FGM/C and this includes:

The Prohibition of Female Genital Mutilation Act No. 32 of 2011

The law also provides for advocacy among communities, organizations, and other stakeholders in promoting women's welfare. Outstanding features of the legislation include; not allowing perpetrators claim that FGM is a religious belief or culture requirements.

The Constitution of Kenya, 2010

Chapter four on rights and fundamental freedoms assures women freedoms from all sorts of discrimination.

The Children's Act of 2001

Safeguard the interest of persons below 18 years. It prohibits any individual from carrying out FGM to persons under the age of 18 years; it also permits one-year imprisonment and/or a fine not more than Ksh. 50,000.

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Penal Code

The law states clearly that inflicting grievous bodily such as FGM on a person is prohibited.

The Medical Practitioners and Dentist Act/Nurses Act

It stipulates that practitioners such as doctors and nurses carrying out FGM will have their medical practicing licenses canceled by their respective licensing boards.

National Action Plan for Abandonment of FGM

The policy is being implemented by the government and it co-ordinates mass enlightenment intervention against FGM, advice the state on FGM issues as well as resource mobilization.

Sexual and Gender Based Violence Policy

This policy was established in 2017; and it provides a mechanism to prevention and management of SGBV. The policy classifies FGM/C as violence to women and children rights.

Anti–FGM Board

Do public sensitization among practicing communities, resource mobilization and advocacy. Awareness creation about negative consequences of circumcision and building of rescue homes for girls running away from circumcision.

This conceptual framework is a researcher designed.

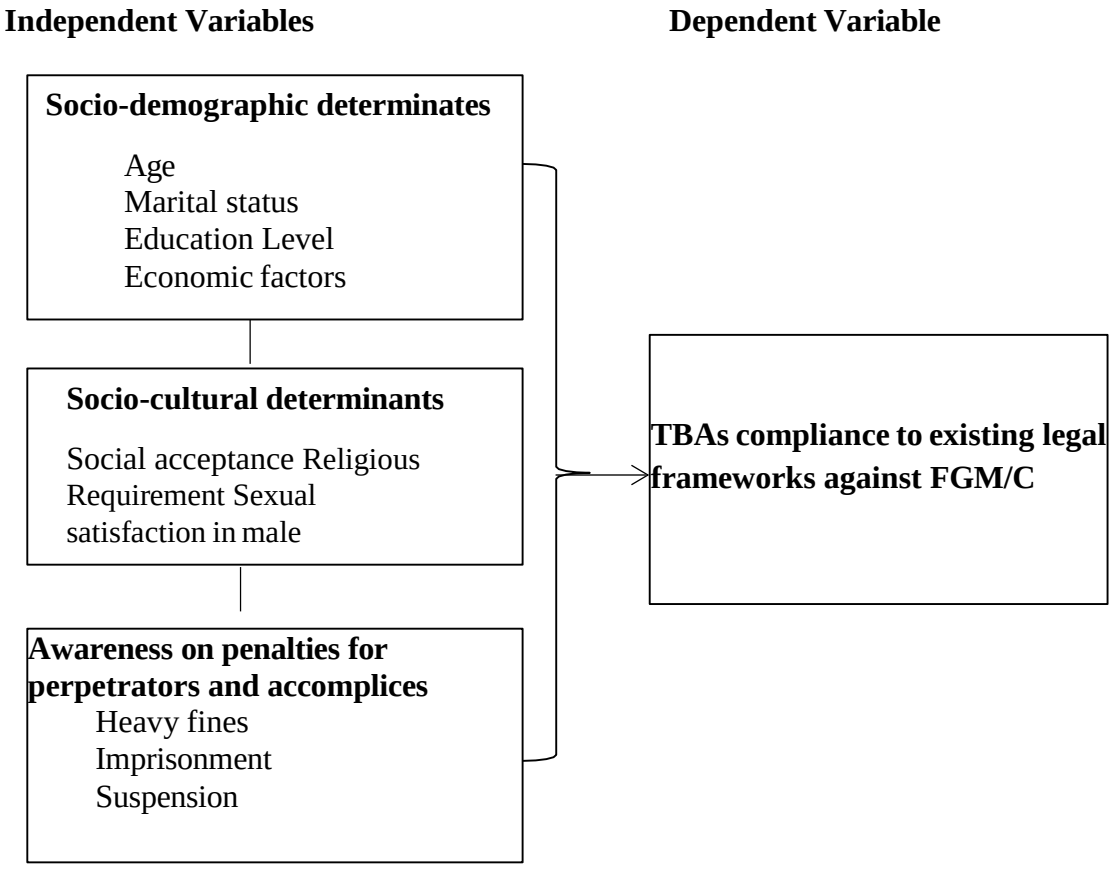

Figure 1: Conceptual Framework

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METHODOLOGY

Study Design

The study embraced a cross-sectional descriptive study approach (Kothari, 2008). This design helped in describing the determinants of traditional birth attendants' compliance to existing legal frameworks against female genital mutilation/ cutting in Garissa County, Kenya.

Location

Dadaab Sub-County in Garissa County (Appendix V) was the place where this study was conducted. Garissa County is situated in the northern of Kenya. It's a semi-arid low-lying region. It has an altitude ranging from 20m to 400m above sea level. It has an area of 5,720 km² and population of 841,353 (KNBS, 2019). Prominent geographical features in the area include laghas and Tana River basin on the western side.it is habited by Somalis ethnic group who are nomadic and their main source of income is camel, cattle and goat rearing. Most cultural practices are based on Islamic tradition. The region also hosts refugees of Somalia origin and so they share same socio economic and socio cultural dynamics with the host community It is projected that above 97% of females in this study site have been subjected to FGM/C.

Study Population

The study targeted all the active Traditional Birth Attendants/circumcisers, who are resident (Kenyan citizen), consenting, residing in the study area and aged 18 years and above.

Sampling Techniques and Sample Size Determination

Sampling Techniques

Snowball sampling method was used to recruit the TBAs for the study to reduce chances of victimization fear which may lead to them providing biased information to avoid being targeted by law enforcement agencies and to build trust in the process of the data collection

Sample Size Determination

This study adopted the formula used by Fisher and colleagues (1998); $n = \frac{z^2pq}{d^2}$

Where; n= is the preferred sample size; z= is the standard deviation (sd) value (1.96) at 95% confidence interval, p= is the projected proportion of female who were cut by a traditional circumciser (based on the report of Kenya Demographic Health Surveillance of more than 80% (0.8) cases nationwide) (KDHS, 2014); q=1-p; d= degree of precision chosen for the study (for this study, it's set at 5%, d = 0.05).

Thus; $n = \frac{(1.96)^2(0.80)(0.20)}{(0.05)^2} = 245.9 \sim 246$

Regulating for a non-response rate of 10%, the expected response proportion was 246+ (246x10%). Thus, minimum sample size expected response frequency=271

Data Collection Techniques

This study collected primary data. Data collection was conducted in a span of two months and it was managed over by the principal investigator with the assistance of two research technical assistants. The questionnaires were written in English; however, the enumerators were able to translate the questions into the local language, when necessary.

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Data Management and Analysis

Quantitative Data Analysis

The collected data from the questionnaires were keyed in into the EpiData (version 3.1) database, where it was verified and cleaned prior to export to R (Version 4.1.1) where analysis was conducted. Descriptive statistics were used to analyze both dependent and independent variables and summary were expressed as frequencies, percentage, mean, standard deviation or range. Bivariate analysis with *chi* square test were applied to analyze the relationship between the dependent variable and independent variables. Multivariate logistic regression model was used to identify independent predictors for knowledge of existing legal frameworks against FGM/C. All the statistical association were considered significant at p-value of < 0.05.

Qualitative Data Analysis

Qualitative data from the key informant interview (KIIs) guide were transcribed and the information translated into English prior coding into word processors. The primary data were then analyzed manually; included coding, summarizing, categorizing, direct quoting and comparisons by theme.

Logistical and Ethical Considerations

Ethical approval was sought from Kenyatta University Ethics Review Committee. Approval letter was also obtained from the Graduate School. Researcher obtained a permit from the National Council for Science, Technology, and Innovation (NACOSTI). A further permit was obtained from the office of the Commissioner of Garissa County. The interviews were conducted in a private setting. Names were not being recorded on the questionnaire. The questionnaire was kept in a locked cabinet for safe keeping of the information. Everything written or recorded were kept private. All interviews were done only after getting written informed consent from the respondents. The identities of the respondents were kept private and confidential. No monetary incentives were given.

RESULTS

Objective 1

Socio-demographic Characteristics of the TBAs

Table 4.1 provides an overview of the socio-demographic characteristics of the study participants. The majority of the participants, who were all female and of Islamic faith, were married (72.03%), had 6-10 children (52.87%), and were 45 years of age or older (85.06%). With respect to education, the great majority of participants (91.95%) had no formal education, and this was attributed by the fact that the region was initially marginalized and thus affected their socio economic development in the region with majority of the population especially girls not enrolled in schools for decades. Majority of the TBAs were para 6 and above and this was corresponding with the age factor since most of them were above 45 years of age and above. (66.67%) were homemakers.

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Table 1: Socio-demographic Characteristics of Active Traditional Birth Attendants/Circumcisers in Dadaab Sub-County

Characteristic	Frequency (n=261)	Percentage (%)
Gender		
Female	261	100
Religion		
Muslim	261	100
Age (in years)		
25-34	12	4.60
35-44	27	10.34
45 & above	222	85.06
Marital status		
Single	5	1.92
Married	188	72.03
Separated/Divorced	18	6.90
Widowed	50	19.16
Parity		
None	33	12.64
1-5	23	8.81
6-10	138	52.87
Above 10	67	25.67
Educational level		
No education	240	91.95
Primary	18	6.90
Secondary	3	1.15
Occupation		
Home Maker	174	66.67
Farming	29	11.11
Business	24	9.20
Pastoralist	16	6.13
Formal employment	13	4.98
Home Maker, Pastoralist	4	1.53
Business, Pastoralists	1	0.38

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Table 2: Socio-demographic Characteristics of Active TBAs Associated with their Compliance to Existing Legal Frameworks against FGM/C in Dadaab Sub-County

Characteristic	Compliance to existing legal frameworks against FGM/C		*Chi*-squared, df, p-value
	Yes n (%)	No n (%)	
Age (in years)			
25-34	11(91.7)	1(8.3)	X^2 = 6.4923,
35-44	19(70.4)	8(29.6)	df=2,
45 & above	195(87.5)	27(12.5)	p = **0.0389***
Marital status			
Single	3(60)	2(40)	
Married	169(89.9)	19(10.1)	X^2 = 19.2610,
Separated/Divorced	10(55.6)	8(44.4)	df=3,
Widowed	43(86)	7(14)	p = **0.0020***
Educational level			
No education	157(69.8)	33(30.2)	X^2 = 7.5557,
Primary	65(95.6)	13(4.4)	df=2,
Secondary	3(100)	0	p = **0.0229***
Occupation			
Home Maker	147(84.5)	27(15.5)	X^2 = 2.5841,
Farming	27(93.1)	2(6.9)	df=5,
Business	21(87.5)	3(12.5)	p = 0.7638
Pastoralist	15(93.8)	1(6.2)	
Formal employment	11(84.6)	2(15.4)	
Home Maker, Pastoralist	4(80)	1(20)	
Parity			
None	30(90.9)	3(9.1)	
1-5	19(82.6)	4(17.4)	X^2 = 8.8170,
6-10	125(90.6)	13(9.4)	df=3,
Above 10	51(76.1)	16(23.9)	p = **0.0318***

***Statistically significant (p-value<0.05)

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Table 3: Association between socio-demographic characteristics of girls/women being circumcised by the active TBA and the TBA compliance to existing legal frameworks against FGM/C in Dadaab Sub-County

Characteristic	Compliance to existing legal frameworks against FGM/C		*Chi*-squared, df, p-value
	Yes n (%)	No n (%)	
Required ages of girls/women before being circumcised.			X^2 = 15.0114, df=1, p = **0.0001***
5-11 years	214(88.8)	27(11.2)	
12-18 years	11(55)	9(45)	
Person who accompanied girls/women to circumcision			X^2 = 20.4390, df=2 p <**0.0003***
Mother	191(91)	19(9)	
Both parents	11(68.8)	5(32.2)	
Grandmother	23(65.7)	12(34.3)	
Always enquire on the religious background of girls/women to be circumcised.			X^2 = 4.3049, df=1, p = **0.0380***
Yes	196(88.3)	26(11.7)	
No	29(74.4)	10(25.6)	
Education level of the majority of girls/women that get circumcised.			X^2 = 1.5229, df=1 p = 0.2171
Not yet to start school			
In school	201(87.4)	29(12.6)	
	24(77.4)	7(22.6)	

***Statistically significant (p-value<0.05)

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Table 4: Association between Sociocultural Dynamics Characteristics of the Active TBAs and their Compliance to Existing Legal Frameworks against FGM/C in Dadaab Sub-County

Characteristic	Compliance to existing legal frameworks against FGM/C		*Chi*-squared, p-value
	Yes n (%)	No n (%)	
FGM/C is still necessary in this community			X^2 = 4.2015, df=1, p-value = **0.0404***
Yes	185(84.1)	35(15.9)	
No	40(97.6)	1(2.4)	
Type of FGM/C practiced in the community			X^2 = 8.0987, df=1, p = **0.0044***
Type I	214(88.1)	29(11.9)	
Type II	11(61.1)	7(38.9)	
Reason for conducting FGM/C			X^2 = 10.9561, df=4, p = **0.0271***
Religious requirement	119(85)	21(15)	
Tradition requirement	75(93.8)	5(6.2)	
Family honor and maintain girls' virginity	9(69.2)	4(31.6)	
To ensure a girl get a husband to marry her	17(85)	3(15)	
Ensure purity of woman	5(62.5)	3(37.5)	
FGM/C will ever come to an end in this community			X^2 = 0.5712, df=1, p = 0.4498
Yes	125(84.5)	23(15.5)	
No	100(88.5)	13(11.5)	
Advocacy through religion approach may/have promoted abandonment of FGM/C in this community			X^2 = 6.0672, df=1, p = **0.0138***
Yes	96(93.2)	7 (6.8)	
No	129(81.6)	29(18.4)	
Presence of alternative rite of passage may/have promoted abandonment of FGM/C in this community			X^2 = 0.0977, df=1, p = 0.7546
Yes	141(87)	21(13)	
No	84(84.8)	15(15.2)	
Experiencing of painful sexual intercourse among the circumcised may/have contributed to the abandonment of FGM/C in this community			X^2 = 0.0072, df=1, p = 0.9324
Yes	149(86.6)	23(13.4)	
No	76(85.4)	13(14.6)	
Practicing of intermarriage may/have contributed to the abandonment of FGM/C in this community			X^2 = 0.0585, df=1, p = 0.8088
Yes	104(85.2)	18(14.8)	
No	121(87.1)	18(12.9)	

*****Statistically significant (p-value<0.05)

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Objective 2

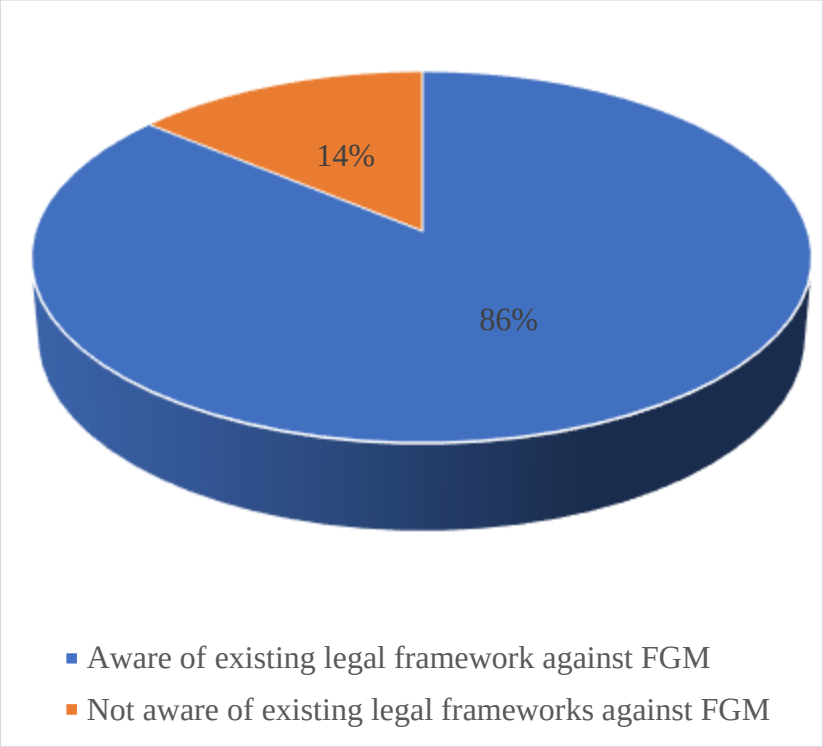

Figure 2: Proportion of TBAs who are Aware of Existing Legal Framework against FGM/C Put in Place in Garissa County

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OBJECTIVE 3

Table 5: Association between Punishment for Perpetrators and Accomplices of FGM/C and the Active TBAs Compliance to Existing Legal Frameworks against FGM/C in Dadaab Sub-County

Characteristic	Compliance to existing legal frameworks against FGM/C		*Chi*-squared, p-value
	Yes n (%)	No n (%)	
Aware of any complications that are associated with FGM/C			X^2 = 5.0136, df=1, p = **0.0251***
Yes	210(87.9)	29(12.1)	
No	15(68.2)	7(31.8)	
Types of FGM/C complications			X^2 = 22.0973, df=5, p = **0.0005***
Related to the genital organ	94(78.3)	26(21.7)	
Related to pregnancy	60(100)	0	
Related to sexual activities in marriage	32(100)	1(3)	
Related to menstrual flow/retention	9(90)	1(10)	
Related to urinary flow/retention	8(88.9)	1(11.1)	
Related to the genital organ, Related to pregnancy	7(100)	0	
Aware of any punishment subjected to perpetrators and accomplices of FGM/C			X^2 = 10.1462, df=1, p = **0.0014***
Yes	199(89.2)	24(10.8)	
No	26(68.4)	12(31.6)	
Form of punishment that perpetrators and accomplices of FGM/C are subjected to			X^2 = 0.1567, df=1, p = 0.9246
Imprisonment	93(88.6)	12(11.4)	
Heavy fines	83(90.2)	9(9.8)	
Imprisonment, Heavy fines	23(88.5)	3(11.5)	
Source of information about the punishment that perpetrators and accomplices of FGM/C are subjected to			X^2 = 12.8312, df=1, p = **0.0003***
Chief 'baraza'	145(93.5)	10(6.5)	
Mass media	71(91)	7(9)	
Existing forms of punishment can contribute to the abandonment of FGM/C in this community			X^2 <0.0005, df=1 p = 1
Yes	162(89)	20(11)	
No	37(90.2)	4(9.8)	

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Table 6: Association between Legal Framework Aspect against FGM/C and the Active TBAs Compliance to Existing Legal Frameworks against FGM/C in Dadaab Sub-County

Characteristic	Compliance to existing legal frameworks against FGM/C		*Chi*-squared, p-value
	Yes n (%)	No n (%)	
Aware of any law/legislation that prohibits FGM/C in Kenya			X^2 = 4.0718, df=1, p = **0.0436***
Yes	176(88.9)	22(11.1)	
No	49(77.8)	14(22.2)	
Law/legislation that prohibits FGM/C in Kenya that the participants are aware of			X^2 = 2.3430, df=2, p = 0.3099
The Constitution of Kenya, 2010	114(91.2)	11(8.8)	
The Children Act	39(83)	8(17)	
The Constitution of Kenya, 2010, The Children Act	23(88.5)	3(11.5)	
Source of information about the law			X^2 = 4.8570, df=2, p = 0.0881
Chief 'baraza'	102(91.9)	9(8.1)	
Mass media	44(89.8)	5(10.2)	
Chief 'baraza' and Mass media	30(78.9)	8(21.1)	
Aware of any entity/institution/ persons who disseminate information regarding the existence anti FGM/C laws			X^2 = 2.7169, df=1, p = 0.0993
Yes	193(84.6)	35(15.4)	
No	32(97)	1(3)	
TBAs in this area should be educated on the existing anti FGM/C laws for the abandonment of FGM/C			X^2 = 8.6741, df=1, p-value = **0.0032***
Yes	208(88.5)	27(11.5)	
No	17(65.4)	9(34.6)	
Existing anti-FGM/C laws and policies have been effective in combating FGM/C in this region			X^2 <0.0005, df=1, p = 1
Yes	118(88.7)	15(11.3)	
No	58(89.2)	7(10.8)	
FGM/C has ever been reported as a crime by someone in community that you are aware of			X^2 = 4.6544, df=1, p = **0.0310***
Yes	178(89)	22(11)	
No	47(77)	14(33)	
Easy for the FGM/C case to be reported.			X^2 = 0.5193, df=1, p = 0.4711
Yes	14(77.8)	4(22.2)	
No	211(86.8)	32(13.2)	

***Statistically significant (p-value<0.05)

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Discussions

Globally, female genital mutilation/cutting (FGM/C) remains a prevalent harmful traditional practice that continues to pose significant risks to the health and well-being of girls and women (WHO, 2023; UNFPA-UNICEF, 2020). Numerous regions and countries have implemented legal frameworks and policies to combat FGM/C, including Kenya (28 Too Many, 2016). The findings of this study, revealing an 86.21% compliance rate among traditional birth attendants (TBAs) in Garissa County to existing legal frameworks against Female Genital Mutilation/Cutting (FGM/C), align with global efforts to eradicate this harmful practice (WHO, 2023). A comparative lens, drawing insights from the broader legal studies context (Dunbar et al., 2023), sheds light on the uniqueness of compliance determinants in Dadaab Sub- County, Garissa County.

The study's findings shed light on significant factors influencing Traditional Birth Attendants' (TBAs) compliance with existing legal frameworks against Female Genital Mutilation/Cutting (FGM/C) in Garissa County. Several demographic factors, including age, marital status, education level, occupation, and parity, demonstrated statistically significant associations with compliance levels among active TBAs.

Education emerged as a significant factor in FGM/C abandonment, with girls/women with higher levels of education being more likely to reject the practice. This finding resonates with existing literature, emphasizing the empowering effect of education in raising awareness of the health risks and legal implications associated with FGM/C. Studies by Ameyaw *et al.* (2020) and Sabahelzain *et al.* (2019) demonstrated a negative correlation between education levels and the intention to practice FGM. Similarly, Rawat (2017) and Berg and Denison (2013) stressed the vital role of education in ending FGM/C, contributing to women's empowerment and economic independence.

Religious considerations also played a crucial role in compliance, The KIIs confirmed the significant role of religion in advocating for the abandonment of FGM/C, as highlighted in the statements below:

"*In our community, we've noticed that one of the significant factors contributing to the abandonment of FGM/C is the role of religion. Many religious leaders, especially within the Islamic faith like me, have been actively discouraging the practice. This has influenced families' decisions to abandon FGM/C, as our community holds religious leaders in high regard….*" **Religious leader.**

The study also highlighted the significance of maternal figures, with the presence of mothers during circumcision being linked to increased compliance among TBAs, indicating the influence of familial support in shaping attitudes towards FGM/C abandonment. The findings of this study align with these recommendations, suggesting that while legal frameworks establish a foundation, addressing social, health, psychological, and economic aspects is imperative for sustained change. The integration of community-driven awareness programs, mental health support for survivors, economic empowerment initiatives, and fostering open dialogues emerged as key recommendations from the Key Informant Interviews, enriching the discourse on comprehensive strategies against FGM/C. Therefore, eliminating FGM requires a multifaceted approach that recognizes the interconnectedness of legal, social, and cultural factors.

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CONCLUSIONS and RECOMMENDATIONS

Conclusions

The study concludes that Socio-demographic, cultural, and legal factors significantly influence TBAs' compliance with anti-FGM/C efforts. A substantial proportion of TBAs are aware of the legal frameworks against FGM/C and lastly the study concludes strong correlations exist between the identified determinants and the levels of legal awareness among TBAs. These insights pave the way for more effective and targeted initiatives aimed at eradicating FGM/C in Garissa County and beyond.

Recommendations

Local Community Leaders, Religious Leaders to promote community-driven dialogues led by local leaders, addressing the cultural and socio-economic aspects influencing FGM/C. This initiative can help dispel myths and foster a collective commitment to abandonment. Support the strengthening and development of Anti–FGM networks using existing community structures (churches and mosques, schools, youth, women and men groups as well as involving stakeholders. Traditional birth attendants and anti FGM crusaders in designing policies to curb the practice.

Conflict of Interest-None Declared

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