#TogetherWeEndFGM – Baseline Study Report

Baseline Study Report: #TogetherWeEndFGM Programme

Female Genital Mutilation, Child Marriage, Gender-Based Violence and Access to Sexual and Reproductive Health Among Communities in Migori, Kajiado, and West Pokot Counties, Kenya

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Conducted by:

360° Access – Nurturing Diversity and Inclusion

&

RESCOMADE – Research - Communication - Development

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Asante Sana!

Acronyms

CSO	Civil society organization
CICR	Centre for Indigenous Child Rights
ESI	Enkakenya Sidai Initiative
FGC	Female genital cutting
FGD	Focus group discussion
FGM	Female genital mutilation
GBV	Gender-based violence
IPV KII	Intimate partner violence
KNBS	Key informant interview
KDHS	Kenya National Bureau of Statistics
KPHC	Kenya National Demographic and Health Survey
SDG	Kenya Population and Housing Survey
SRH	Sustainable Development Goal
SRHR	Sexual and reproductive health
STI	Sexual and reproductive health and rights
	Sexually transmitted infection

Title page: Women's group, co-design workshop Kajiado. ©James Aniyamuzaala

Executive Summary

The#TogetherWeEndFGMprogramme seeks to reduce and ultimately eliminate female genital mutilation (FGM) while addressing interrelated harmful practices, including child marriage, gender-based violence, adolescent pregnancy, and limited access to sexual and reproductive health and rights in Migori, Kajiado, and West Pokot counties, Kenya. The programme is implemented by Zinduka e.V. and THE RAIN WORKERS in collaboration with local civil society organizations and adopts a gender- transformative, community-centred approach; grounded in social norms change and rights-based programming.

To inform programme design and establish baseline values for monitoring and evaluation, a comprehensive baseline study was conducted between April and July 2025 by 360° Access and RESCOMADE. The study employed a cross-sectional mixed-methods design and collected data from 2,051 respondents across 38 villages. Quantitative household surveys were complemented by the application of an innovative UBUNTU Inclusive Co-Design approach to gauge diverse community perspectives and priorities+. This participatory methodology ensured the inclusion of marginalized populations and strengthened contextual relevance, data validity, and community ownership of findings.

Key Findings

High prevalence and evolving patterns of FGM

The study reveals above national and above county prevalence of FGM across the assessed communities, with FGM reported by 92% of women willing to disclose their status in Kajiado, 90% of women in Migori, and 83% of women in West Pokot. Although lower prevalence was observed among girls, the practice remains widespread, indicating continued intergenerational transmission. Concerning emerging trends include early age FGM (notably among girls aged 5–9 in Kajiado), mature age FGM (18+), and medicalization in Migori and Kajiado, where a small proportion of procedures were performed by healthcare professionals. These trends suggest adoption of adaptive strategies by communities in response to legal restrictions and social change.

Persistent child marriage and adolescent pregnancy

Child marriage remains prevalent, particularly in West Pokot, where nearly one-quarter of girls covered in the survey married. Alarmingly, early marriage was reported for girls as young as 8–11 years in Kajiado. Adolescent pregnancy rates were high across all counties, with 46% of women in West Pokot, 39% in Migori, and 33% in Kajiado reporting first childbirth before age 18. These patterns are strongly associated with poor health outcomes for the mother and child, school dropout, economic vulnerability, and constrained life opportunities for girls.

Widespread gender-based violence

The findings indicate substantial levels of intimate partner violence across all counties, with Migori recording the highest prevalence. Physical, psychological, and sexual violence are commonly reported, and normative acceptance of violence against women persists among some community members, particularly men. This underscores the entrenched nature of patriarchal gender norms and power imbalances.

Limited access to SRH services and low contraceptive uptake

Uptake of modern contraception is moderate in Migori but critically low in Kajiado and West Pokot. Pronounced gender disparities persist, with men reporting significantly lower modern contraceptive use than women. Injectables and implants were identified as preferred methods, while the acceptance rate of the male condom as a low-cost alternative was comparatively low.

Constrained agency and leadership of women and girls

Women's decision-making autonomy remains limited, particularly in Kajiado and West Pokot, where only 22% of women report agency over their bodies and health. Community support for women's autonomy is weakest in West Pokot. While knowledge of the harms associated with FGM and child marriage is relatively high among women, data on women's sense of self-efficacy and confidence to challenge GBV and discuss SRH issues provides a mixed picture, reflecting structural and normative constraints.

Conclusions

The baseline study confirm persistently high rates of FGM, child marriage, gender-based violence, and adolescent pregnancy as well as restricted access to sexual and reproductive health information and services for communities surveyed in Migori, Kajiado, and West Pokot counties. These challenges have significant consequences for women and girls, negatively affecting their physical and mental health, psychosocial wellbeing, and social and economic participation, and ultimately preventing them from realizing their full potential and leading healthy, self-determined lives. Despite existing legal frameworks and civil society interventions, harmful social norms, gender inequality, and poverty continue to drive these practices. Variations between ethnic groups and emerging trends (early/mature age FGM, medicalization) highlight the need for evidence-based, adaptive, location-specific programming.

Key Recommendations

- Focus on individualized, inclusive support for women, girls, families, and marginalized groups to prevent FGM, child marriage, and GBV and promote sexual and reproductive health and rights.
- Design and pilot girl-centred and adolescent-focused interventions to strengthen agency and participation in decision making.
- Ensure anti-FGM interventions are innovative and address emerging trends such as medicalization, cross-border FGM, and early/mature age FGM.
- Implement integrated interventions addressing root causes including poverty, education gaps, harmful norms, and weak participation of women in leadership.
- Strengthen integration of interventions into existing government and community systems to enhance sustainability.
- Mainstream safeguarding, ethical standards, and trauma-informed approaches across all interventions.
- Institutionalize evidence-based decision making through innovative, participatory data collection and learning approaches.

Overall, the baseline provides a robust empirical foundation for adaptive programme implementation. It underscores the urgency of coordinated, multisectoral approaches to protect girls, empower women, and foster sustainable social change toward the abandonment of harmful practices.

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Background

The#TogetherWeEndFGM project is a collaborative initiative between Zinduka e.V. (Germany) and THE RAIN WORKERS (Austria), bringing together the organizations' complementary expertise and experience in the fight against female genital mutilation (FGM) and other harmful practices. Zinduka has been working to end FGM among the Kuria community in Migori County, Kenya, since 2016. This extensive grassroots engagement provides valuable insights into community-driven strategies to eliminate FGM. Building on this, #TogetherWeEndFGM integrates THE RAIN WORKERS' best practices and training methodologies for promoting sexual and reproductive health and rights (SRHR) developed from working across 16 African countries, including Kenya. The project's overarching goal is to reduce and ultimately eliminate FGM. Anchored in Sustainable Development Goal (SDG) 5 - Gender Equality[1], its broader vision is to promote the right to a life free from gender-based violence (GBV) and to advance SRHR, while addressing child marriages, adolescent pregnancies, and limited access to education – all having a major impact on the lives of girls both in the short and long term. The project adopts a comprehensive and gender-transformative approach that engages women and girls as well as their families and communities to address the underlying social and gender norms sustaining FGM, GBV, and barriers to access sexual and reproductive health (SRH) information and services. By fostering collective responsibility, #TogetherWeEndFGM contributes to sustainable change through evidence-driven decision-making, adaptive programming, and iterative learning. This integrated approach aims not only to end harmful practices but also to empower women and girls to actively participate in shaping their futures. #TogetherWeEndFGM is implemented within three high FGM-prevalent communities in Kenya: the Kuria community in Migori county, the Maasai community in Kajiado county, and the Pokot community in West Pokot county. To implement the project at community level, Zinduka e.V. and THE RAIN WORKERS partner with three well- established civil society organizations (CSOs): Zinduka Kenya in Migori, the Enkakenya Sidai Initiative (ESI) in Kajiado, and the Centre for Indigenous Child Rights (CICR) in West Pokot. These collaborations ensure that the project is rooted in local realities and responsive to community needs.

To inform the implementation of #TogetherWeEndFGM, ZINDUKA e.V. and THE RAIN WORKERS commissioned a baseline study. The study was conducted jointly by 360° Access (Austria; overall coordination, inclusive co-design) and RESCOMADE (Kenya; primary and secondary data collection and analysis), under the technical leadership of Dr. Samuel Kimani. Primary data was collected and analysed between April and July 2025 in all three counties. The study aimed to generate evidence for the establishment of benchmarks against which the programme's effectiveness and impact is monitored, evaluated, and validated. Specifically, the baseline study focused on determining the starting point values for the project's impact, goal, and outcome- level indicators. It further sought to strengthen the project's evidence base by identifying community needs, challenges, and opportunities. As such, the baseline assessment is a critical source for guiding design and implementation strategies, tracking and evaluating progress and achievement during the midterm and end term of the implementation cycle as well as providing a reference point for the future.

[1] SDG 5 - Gender Equality, Department of Economic and Social Affairs

Methodology

The current baseline report is based on primary data collected in Migori, Kajiado, and West Pokot counties, triangulated and contrasted with available data from secondary sources, notably the Kenya National Demographic and Health Survey (KDHS)[2]. Primary data collection was led by RESCOMADE and covered 23 villages in Migori, 12 in Kajiado, and three in West Pokot, where #TogetherWeEndFGM is implemented.[3] A cross-sectional mixed-methods approach was applied, with a household survey serving as the main data collection tool. Sampling was conducted in collaboration with CSO-partners responsible for implementation in the respective county. It followed a two-stage process: villages were first selected as clusters, and households were then randomly sampled within them.

Sampling further focused on social roles, rather than strict sex-age-categories. It centred around women of reproductive age (15-49), who had given birth to at least one girl, and their family members – partners, daughters, and sons. Through this approach, 1,314 women and 282 men of reproductive age (age 15-49) as well as 228 girls and 227 boys (age 10-17) were identified and interviewed.[4] In total, 2,051 respondents (583 in Migori, 831 in West Pokot, and 637 in Kajiado) participated, achieving a 99% response rate against the target of 2,070.

A unique feature of the baseline study was the application of the UBUNTU Inclusive Co-Design approach, developed by the 360° Access team under the technical leadership of Dr. James Aniyamuzaala. The approach aimed to ensure that the research process was grounded in the lived experiences, perspectives, and needs of marginalized and underrepresented community members. To support this, ahead of primary data collection, the 360° Access team conducted inclusive co-design workshops with service providers, teachers, duty bearers, civil society representatives, and government officials, complemented by focus group discussions (FGDs) with diverse community members, including young, adult, and older women and men with and without disabilities in all three counties. This process helped to identify the participation needs of different social groups, generate recommendations for adapting data collection tools and procedures to the local context, tailor training content for data collectors, and strengthen community and stakeholder buy-in.

Primary data was collected using a structured household questionnaire. The tool was developed collaboratively by the RESCOMADE and 360° Access teams, based on the impact, goal, and outcome-level indicators included in the project's log-frame. The questionnaire was piloted prior to the main data collection, and insights from the piloting as well as the inclusive co-design process (see above) were used to refine and adapt the questions to the local contexts in the three counties. The finalized tool

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[2] Kenya National Bureau of Statistics (KNBS): Kenya Demographic and Health Survey (KDHS) 2022. Volume 1, June 2023, p. 637.

[3] Due to the extensive area covered by the project in Migori, only half of the target locations were included. For Kajiado and West Pokot, all project locations were covered by the survey.

[4] This resulted in an age overlap between the categories of women/men "adults" (15–49) and girls/boys "children" (10–17). While the research team recognizes the challenges of classifying minors—particularly girls—as "adults" (e.g., potentially overlooking their enhanced legal protections and psychosocial development needs), it was decided that structuring the analysis according to gender identities/social roles was relevant and in alignment with globally recognized indicator definitions (e.g. SGD 5 indicators). Practically, the number of under-age survey participants in the "adults" group was insignificant (one girl age 15-17 in Kajiado and West Pokot, respectively).

was then uploaded to KoboCollect, an Android-based data collection platform. Data collection devices were GPS-enabled to allow tracking of household locations and to monitor the timing of interviews.

To support data collection in the communities, the RESCOMADE team, with support from partner CSOs, recruited 30 data collectors (ten per county). Enumerators were selected from local communities to leverage their knowledge of local dialects, geography, and socio-cultural practices related to harmful traditional practices. To ensure high-quality data, enumerators were required to hold a degree in social sciences or equivalent, have prior experience in primary data collection and management, and be familiar with the practices of FGM and child marriage. A three-day training workshop was conducted for all enumerators, covering the objectives of the baseline survey, and data collection tool and approaches including concepts on research ethics, safeguarding, and inclusion, reflecting on location-specific findings from the inclusive co-design workshops.

Data analysis and disaggregation followed the project's intervention logic and indicators. To strengthen validity, primary data were triangulated and complemented with secondary data obtained through a literature review of existing studies, reports, and policy documents. In addition, preliminary results were presented to and discussed with project partners and implementing teams during a workshop held in Nairobi from 21 to 25 July, 2025. Workshop reflections enhanced the depth and reliability of the analysis and contributed to shaping recommendations.

Group discussion with men in West Pokot to gather their perspectives during the inclusive co-design process. ©*James Aniyamuzaala*

Context

FGM,child marriage, GBV, and limited access to SRH services and information are persistent challenges affecting the lives and wellbeing of women and girls in Kenya.

FGM prevalence, drivers, and trends

Kenya's strong anti-FGM legal and policy framework, active engagement of progressive CSOs, and interventions implemented by national and county governments across multiple geographies have contributed to successful reduction but have not been able to eliminate FGM. The national FGM prevalence has consistently declined from 38% in 1998 to 21% in 2014 and 15% in 2022.[5]

In terms of FGM prevalence, considerable geographical variations exist, with Migori, Kajiado, and West Pokot counties showing FGM rates above national average. In addition, data indicates considerable variation of FGM prevalence between different ethnic communities. As a result, FGM data from a county with a diverse, multi-ethnic population could result in gross underestimation because of dilution from non-practicing communities, while data from an ethnically homogeneous population group may show considerably higher prevalence of FGM, as will be illustrated.

In Migori county, FGM prevalence was 20% in 2022.[6] However, very high rates of the practice have been recorded for specific communities living in the county such as the Kuria (86%), Kisii (84%) and Somali (94%), according to data from the 2014 KDHS,[7] while other communities in the county do not practice FGM. Relevant dynamics for FGM in Migori include cross border and emerging medicalisation of FGM and widespread, publicly celebrated cutting of girls in complete defiance of the law and law enforcement efforts among the Kuria community.[8] Positive developments observed in Migori include existence of strong child protection and gender technical working groups, a conducive environment characterized by existence of administrative and political support towards addressing FGM, and the presence of many CSOs working to end the practice in the county.

Kajiado county had an FGM county prevalence of 24%[9] in 2022, with FGM driven by culture, rite of passage, marriageability as well as existence of medicalisation and cross-border FGM activity involving the Maasai of Kenya and Tanzania. Considerable variation among ethnic communities exists. For instance, prevalence among the Maasai community could be as high as 78%.[10] Kajiado has a conducive legal-policy and administrative environment evidenced by the existence of a county-level anti-FGM policy and numerous FGM interventions such as the promotion of alternative rites of passage and community dialogues around FGM.

For West Pokot, data indicates FGM prevalence of 44% as of 2022[11] - the highest amongst the three counties - driven by rite of passage, respect and cultural conformity

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5 KNBS: KDHS 2022.
6 Ibid.
7 KNBS: KDHS 2014.
8 In December 2024, several Kuria clans returned to openly performing FGM after having previously refrained from the practice. See: „FGM's bold return: A decade of silence, now proudly public, and why old messages aren't working", Daily Nation, February 06, 2025.
9 KNBS: KDHS 2022.
10 KNBS: KDHS 2014.
11 Ibid.

as well as existence of cross-border FGM activities with communities in Uganda. In West Pokot, the legal-policy environment is also conducive and there are many CSOs implementing robust FGM interventions.

In Kenya, key trends include medicalization as well as FGM performed at an early age. While FGM continues to be performed mainly by traditional practitioners, nationally, 14% of girls (age 0–14) and 17% of women (age 15–49) underwent FGM by a healthcare professional.[12] Medicalization is a key concern because it legitimizes and sustains FGM rather than eliminating it. Another worrying trend is FGM performed on very young girls when they have little to no agency. In the 2022 KDHS, 45% of women and girls (age 15-49) reported that they had experienced FGM at age 10-14. However, a concerning 30% had undergone FGM when they were only 5-9 years old, with an even higher prevalence of early age FGM among urban populations (41%).

Child marriage

The three counties also have substantial rates of child marriage, although only data for West Pokot is above national average. The national child marriage prevalence declined from 26% in 2008/09[13] to 23% in 2014[14] and 13% in 2022.[15] In 2022, 2% were married before age 15.[16] In West Pokot, 19% of the girls (<18) had been married in 2019, and 8% had been married off before age 15, according to the 2019 Kenya Population and Housing Survey (KPHS).[17] In Migori and Kajiado counties, 12% of the girls had been married before age 18,; 4-5% had been married before age 15.[18] Poverty has been identified as a key risk factor for child marriage in Kenya, with high correlation between child marriage prevalence and a community's wealth, employment and education levels documented.[19]

Gender-based violence

Substantial levels of GBV are reported both at national level as well as in the three counties. Important to note, women experience violence predominantly within the partnership. At national level, in 2022, 28% of married/partnered women said they had experienced physical, sexual, or psychological/emotional violence by an intimate partner (IPV) during the previous 12 months.[20] In Migori, however, almost half of married/partnered women (47%) reported that they had recently experienced IPV.[21] IPV (past 12 months) rates recorded for Kajiado and West Pokot (both 25%[22]) were closer to the national average. In contrast, across Kenya, only 0.6% of the women surveyed for the 2022 KDHS said they had experienced sexual violence by a person who was not an intimate partner during the previous 12 months.[23] Physical violence

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12 KNBS: KDHS 2022. Volume 1, June 2023, p. 637.
13 KNBS: KDHS 2008-2009.
14 KNBS: KDHS 2014.
15 KNBS: KDHS 2022. Volume 1, June 2023, p. xxxvii. The 2019 KPCH reports lower rate of girls being married before age 18 (10%), and a higher rate for girls below age 15 (4%). See: KPHC: Analytical Report on Fertility and Nuptiality, Volume VI, April 2022, p. 21.
16 Ibid.
17 KNBS: KPHC: Analytical Report on Fertility and Nuptiality, Volume VI, April 2022, p. 21.
18 Ibid.
19 Fraym: Analyzing Girl Child Marriage: Kenya Deep Dive, 22 March 2021, p. 46-51.
20 KNBS: KDHS 2022 Fact sheet - Kajiado.
21 KNBS: KDHS 2022 Fact sheet - Migori.
22 KNBS: KDHS 2022 Fact sheet - Kajiado and KDHS 2022 Fact sheet - West Pokot.
23 KNBS: KDHS 2022. Volume 1, June 2023, p. xxxvii.

during the previous 12 months was reported by 16% of women across Kenya.[24] Again, data indicates particularly high GBV incidence for Migori, where 30% of women said they had recently experienced physical violence.[25] Physical violence reported for Kajiado (17%[26]) and West Pokot (19%[27]) was only slightly above the national average.

Teenage pregnancies

Underlying all the aforementioned challenges of FGM, child marriage, and GBV is predictable early pregnancies associated with a lower age at first birth. At national level in Kenya, according to data from 2022, 15% of the girls age 15-19 had ever been pregnant.[28] Above national average teenage pregnancy rates were reported for all three countries, with West Pokot constituting an outlier with a teenage pregnancy rate of 36%, the second highest rate in the country.[29] For Migori and Kajiado, a teenage pregnancy rate of 22% was reported.[30] Early pregnancies tend to result in poor health outcomes for the mother and the baby. In addition, adolescent pregnancies often are related to other violations of the right of girls, including child marriage and sexual violence, and stimulate a cycle of poverty and lack of agency with long-term consequences for a girls' health and prospect in life.

Access to sexual and reproductive health services and information

Iinadequate access to SRH services and information further exacerbates negative health, psychosocial, and socioeconomic outcomes for women and girls. This is reflected in low adoption rates of modern contraceptives. Across Kenya, only six out of ten married women (58%) used modern contraceptives in 2022,[31] with similar rates reported for Kajiado (57%),[32] and Migori (55%)[33]. In West Pokot, however, only 23% of married women used modern contraceptives, indicating a below national average acceptance rate.[34] Overall, access and uptake of modern contraceptive is suboptimal, suggesting lack of agency and presence of barriers to access services and information.

Conclusion

The ongoing rights violations described have significant consequences for women and girls, negatively affecting their physical and mental health, psychosocial wellbeing, and social and economic participation, ultimately preventing them from realizing their full potential and leading healthy, self-determined lives.

[24] KNBS: KDHS 2022 Fact sheet - Kajiado.
[25] KNBS: KDHS 2022 Fact sheet - Migori.
[26] KNBS: KDHS 2022 Fact sheet - Kajiado.
[27] KDHS 2022 Fact sheet - West Pokot.
[28] KNBS: KDHS 2022 Fact sheet - Kajiado
[29] KNBS: KDHS 2022 Fact sheet - West Pokot and KNBS: KDHS 2022. Volume 1, June 2023, p. 157.
[30] KNBS: KDHS 2022 Fact sheet - Migori and KDHS 2022 Fact sheet - Kajiado.
[31] KNBS: KDHS 2022 Fact sheet - Kajiado.
[32] Ibid.
[33] KNBS: KDHS 2022 Fact sheet - Migori.
[34] KDHS 2022 Fact sheet - West Pokot.

Baseline Findings

Thepresentation ofkey baseline findings is structured into various subsections consistent with the thematic areas covered by the project.

Female Genital Mutilation

FGM[35] is a highly sensitive issue and legally prohibited in Kenya, creating a risk of data collection being influenced by social desirability bias. To address this concern, women were first asked whether they felt comfortable sharing their FGM status. Approximately one in three respondents were hesitant to disclose their individual FGM experiences in Kajiado (28%) and West Pokot (34%). This hesitancy may be linked to greater awareness of the law, strict enforcement, and fear of persecution in these two counties compared to Migori. In Migori, only 15% of the respondents declined to share their FGM status, potentially reflecting comparatively lower concern about the law or its enforcement. This finding aligns with evidence that practicing communities in Migori have conducted FGM publicly, in disregard of legal prohibitions (see “Context”).

FGM Prevalence

Data obtained through the two-stage approach described above shows an extremely high prevalence of FGM among women in the target communities: In Migori, 90% of the women (15-49) willing to share their status had undergone FGM as was the case for 92% in Kajiado and 83% in West Pokot. Among the girls (age 10-17) willing to share their FGM status, 31% had undergone the practice in Migori, 29% in Kajiado, and only 7% in West Pokot.

This means that daughters were three times less likely to be subjected to FGM compared to their mothers in Migori and Kajiado counties. In West Pokot, daughters were 11 times less likely to have undergone FGM compared to their mothers (Figure 1). However, this data is insufficient to conclude a reduction over generations; further research and analysis would be necessary to confirm any such trend.[36]

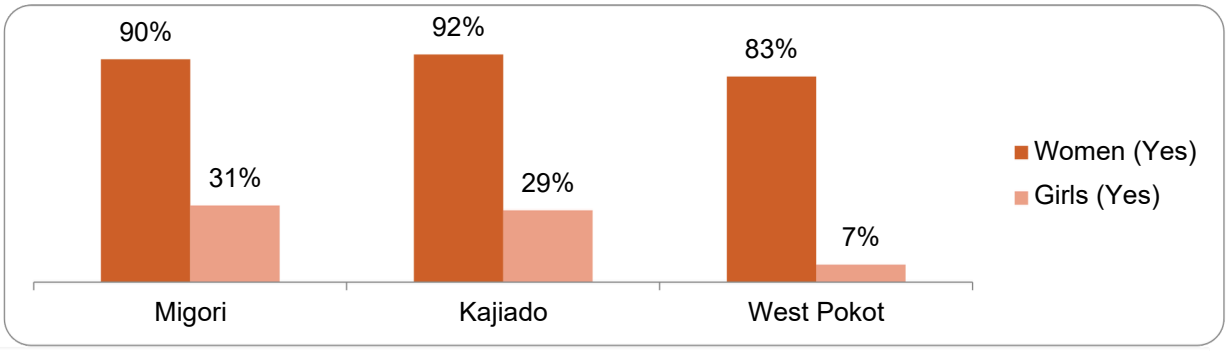

Figure 1: Comparison of FGM Prevalence (%) among mothers and daughters

Age when FGM is performed

[35] In communication with communities, female genital *cutting* (FGC) is sometimes used as a more socially acceptable term. However, this report uses female genital *mutilation* (FGM) throughout to emphasize the harmfulness of the practice, which remains a form of mutilation.

[36] Prevalence data from the 0-14 age group should not be used to reach conclusions about reduction or abandonment of FGM in a community.

Data on age of FGM performance points to both early and mature age FGM. The predominant age of FGM among interviewed mothers and daughters (age 18+) was 10-14 years for Migori (61%/43%) and Kajiado (50/36%), and 15-17 years for West Pokot (47%/46%). Among girls (age 0-17), the vast majority had undergone the practice between 10-14 years: 81% of the girls in Migori, 66% in Kajiado and 86% in West Pokot were subjected to FGM at this age.

Approximately 16% of the girls that had undergone FGM in Kajiado were subjected to the practice at an early age between 5 and 9 years. This points to a particularly concerning trend of FGM being performed on very young girls, when they have little to no agency. Given high prevalence of early age FGM at national level and in urban areas (see "Context"), there is a risk of this trend also affecting the three project areas, in particular Kajiado. At the same time, across all three counties, 19-21% of daughters age 18+ said that FGM was performed on them when they were 18+. This points to mature age FGM as a potentially new shift in FGM practice (Table 1).

Respondent	Mothers (15-49)			Daughters 0–17			Daughters 18+		
Age (Years)	Migori	Kajiado	West Pokot	Migori	Kajiado	West Pokot	Migori	Kajiado	West Pokot
0–4	1%	0%	0%	0%	0%	0%	0%	0%	0%
5–9	3%	4%	34%	1%	16%	0%	0%	4%	1%
10–14	61%	50%	47%	81%	66%	86%	43%	36%	32%
15–17	31%	28%		18%	14%	14%	39%	39%	46%
18+	3%	9%	14%	0%	5%	0%	19%	21%	21%

Table 1: Age when FGM was performed on mothers compared to their daughters, by county.

FGM performers

Data indicates that in all three countries, FGM is mainly performed by traditional cutters. However, 7% of women and 2% girls in Kajiado as well as 4% of women in Migori reported that health care professionals had performed FGM on them. This indicates existence of medicalization in the two counties. No medicalization was reported among women or girls from West Pokot.

FGM disclosure by parents

In the baseline survey, disclosure rates of the FGM status for daughters varied considerably between fathers and mothers. Across all three counties, mothers were more likely to report that their daughter had undergone FGM, compared to fathers. 52% (Kajiado) to 66% (Migori) of the mothers reported that their daughters age 18+ had undergone FGM, while only 9% (Migori) to 11% (Kajiado) of the fathers in the same households confirmed that their daughters had undergone the practice. This could be explained by 1) ignorance of the procedure and not wanting to take responsibility among the fathers, 2) awareness of the law prohibiting FGM and not wanting to take responsibility and/or 3) lack of knowledge or interest in FGM matters.

Parents' intention to cut remaining daughters

Parents who had daughters that had not undergone FGM were asked about their intention to have the FGM performed on their remaining daughters. The highest intention rate was recorded among parents in Migori (13%), with a comparatively lower rate in Kajiado and West Pokot, where 5% of the parents reported that they intended to have FGM performed on their daughters. The top five reasons provided by parents for not intending to subject their daughters to FGM included: FGM being outlawed, health complications, awareness created by NGO, education, abandonment of the practice by the family, and FGM being a violation of human rights (Figure 2).

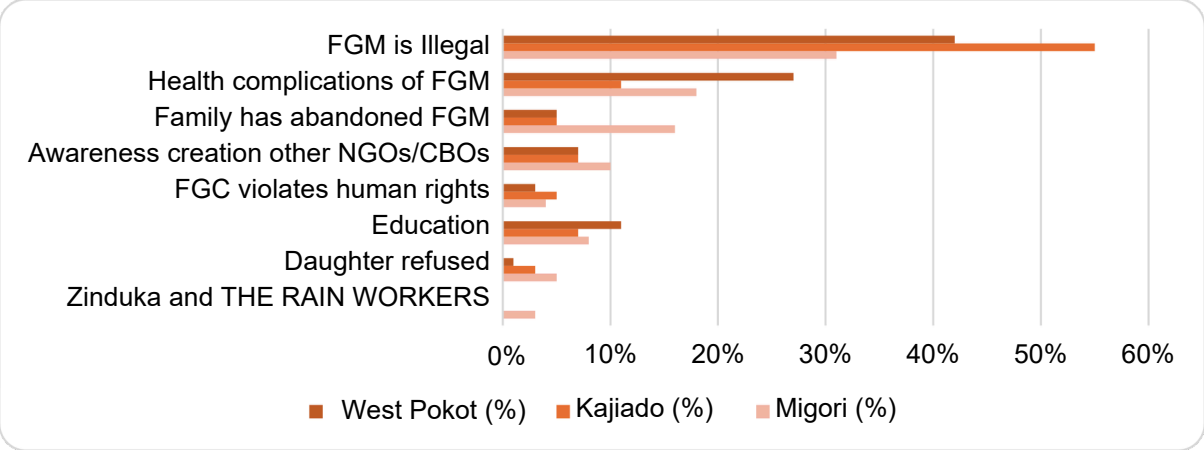

Figure 2: Reasons provided by parents for not intending to subject the remaining daughters (age 0-17) to FGM, by county

Justifications used for FGM

Baseline data indicates that men and boys are slightly more likely to justify FGM than women and girls. 16% of the interviewees in Migori county (20% of men and boys) said it was justifiable to subject a woman or girl to FGM. In West Pokot, 15% of the interviewees (16% of men and boys) were in support, and in Kajiado, 9% of the participants (10% of men and boys) justified the practice. The top three justifications for FGM include culture or tradition, rite of passage and marriageability. Women and girls saw FGM more as a cultural/traditional requirement or rite of passage while men and boys were more likely to refer to marriageability.

Conclusions and Recommendations

Overall, baseline data on FGM indicates above national and above county-level prevalence of FGM among all three communities surveyed. Differences between communities exist, e.g. regarding community attitudes, and trends, including age of FGM performance and medicalization.

For Migori, various baseline values reflect lower concern about the law or its enforcement compared to the two other counties. For instance, a higher share of the women interviewed were open to share both their own FGM status and report that their daughters had undergone the procedure. In addition, parents were considerably more open to confirm their intention to subject their remaining daughters to FGM. Presence of medicalization is a trend to be monitored.

With 92%, Kajiado had the highest FGM prevalence assessed by the baseline survey. Of particular concern is a high share of early age FGM, a trend that could be reinforced through a spill-over effect from FGM practice in adjacent urban areas. Medicalization is also present in Kajiado, according to baseline data.

West Pokot had the lowest FGM rates among both mothers (83%) and daughters (7%). While this data could point to a possible trend towards a reduction of FGM, further research and analysis is required for confirmation. Also of note, 67% of the women and girls underwent FGM when they were age 15+ and 21% when they were age 18+, highlighting the need to continue protecting girls as they reach adulthood. Based on these findings, the following recommendations for programming emerge:

- In Migori, seek close engagement with traditional leaders to obtain a more in-depth understanding of the cultural justifications for FGM and engage them in discussions to transform harmful believes.
- For Kajiado, ensure that FGM prevention measures cover the 5-9 age group. Monitor emerging trends (early age FGM, medicalization) and adapt awareness raising messages and target audiences accordingly, e.g. family-focused interventions and involvement of early childhood educators.
- For West Pokot, design, test, and implement appropriate measures to enhance the protection of women age 18+ from FGM.
- Overall, strengthen male engagement as a strategy is key for promoting the accountability of men, including fathers.
- In Migori and Kajiado, involve health care workers to disrupt the supply side of medicalisation and involve families to address the demand side.

Gender-based Violence

Data on GBV prevalence was collected asking survey participants about their perception of GBV; in addition, women age 15-49 were asked about their own experience.

Community members' awareness of GBV

When asked about their awareness of GBV happening in their community, 67% of survey participants in Migori said they had heard about GBV cases, followed by West Pokot (43%) and Kajiado (20%). Across all three countries, interviewees were mostly aware of physical violence. In West Pokot and Migori, a significant share of interviewees (20% and 17%, respectively) also made reference to verbal violence. In addition, 13% of survey participants in Migori said they were aware of psychological violence happening in their community (Figure 3). Overall, this data indicates that GBV is mainly perceived as physical violence and – to some degree – verbal and psychological violence – while community members are either unaware of or reluctant to speak about sexual violence, social violence and other forms of GBV, which may be sensitive or normalized.

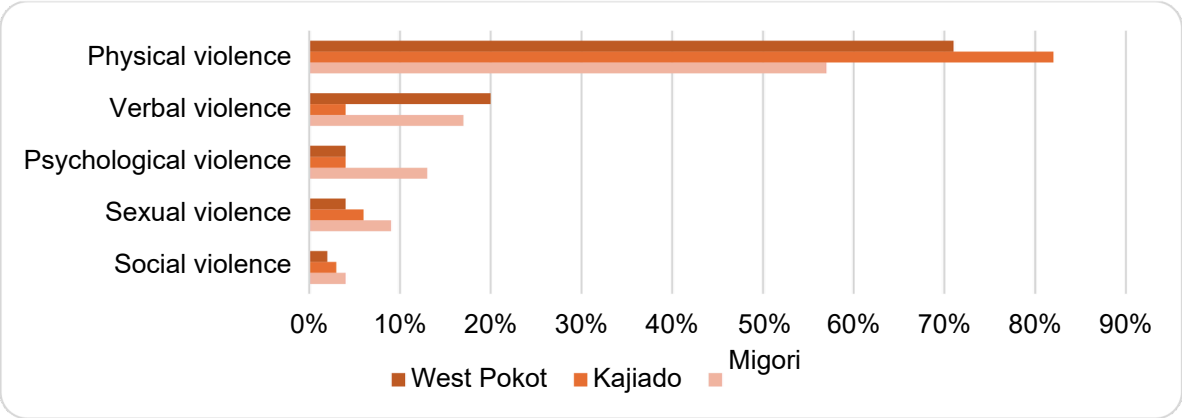

Figure 3: Awareness of different forms of GBV by community members (%)

Acceptance of GBV among community members

In all three counties, a share of the survey population, in particular men and boys, expressed support for the idea that violence towards women was justified for obedience and respect purposes. 13% of interviewees in Kajiado (20% of men and boys) said violence against women was justifiable for these purposes. In West Pokot, 9% of the respondents (14% of men and boys) supported this idea. In Migori, only 6% of participants supported violence against women (13% of men and boys). Overall, this indicates that wife beating and similar forms of GBV are still accepted to some degree among all three communities covered.

Intimate partner violence

The survey also collected data on the individual experience of violence by women and girls. This data should be interpreted taking into account likely underreporting.[37] Data indicates considerable prevalence of IPV across all three counties (Figure 4). Reported physical IPV was highest in Migori, where 33% of ever-partnered women (age 15-49) reported having experienced physical violence from a current or former partner during the previous 12 months. Physical IPV (previous 12 months) was also reported by 26% of women in West Pokot and 14% in Kajiado.

The comparatively low rate of physical IPV reported for Kajiado could result from the fact that acceptance and normalisation of physical violence against women and girls is comparatively high in Kajiado due to cultural factors that condone various forms of physical violence such as wife beating. This is supported by acceptance data reported above and confirmed by verification workshop participants.

Reported psychological IPV was highest in Migori (26%) followed by West Pokot (18%) and Kajiado (17%). Likewise, reported sexual IPV was highest for Migori, where 16% of women said they had experienced sexual violence perpetrated by their partner during the past 12 months. Sexual IPV was also reported by 11% of women in Kajiado and 10% of women in West Pokot.

[37] To ensure women share only what they are comfortable with, interviewers reminded participants during the interview that all answers were treated with confidentiality and that they could choose not to respond or end the interview at any time.

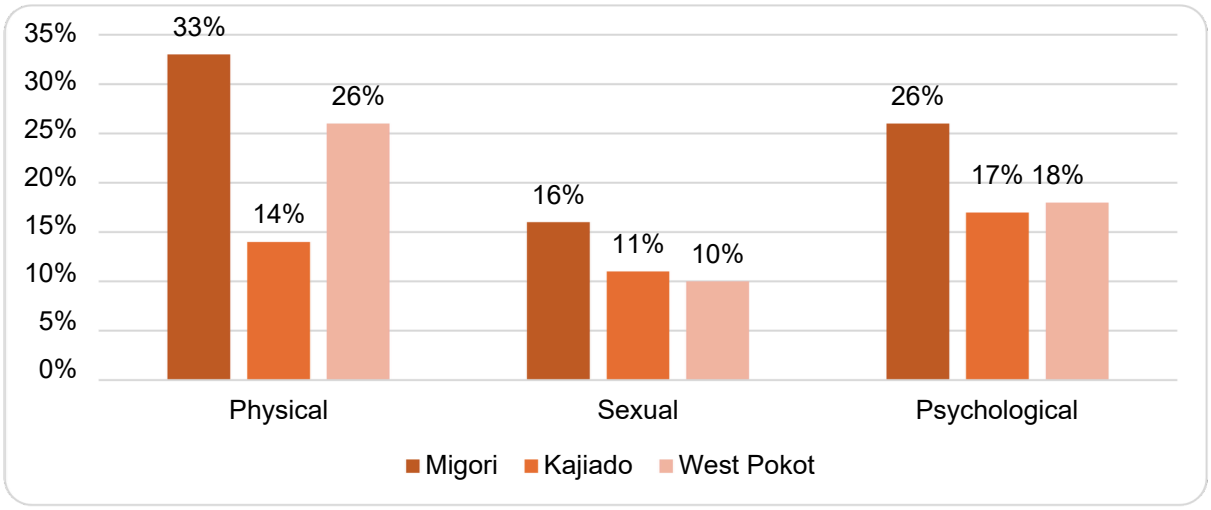

Figure 4: Experience of IPV within the past 12 months as reported by women (age 15-49), by county.

Non-partner sexual violence

Compared to sexual IPV, non-partner sexual violence was less common in all three counties. In Migori, 8% of women aged 15-49 reported having experienced sexual violence by someone who was not an intimate partner over the previous 12 months, followed by 2% in Kajiado and less than 1% in West Pokot. Where reported, the perpetrators of non-partner sexual violence included neighbours, friends, non-partner family members, boda-boda riders[38] and strangers and the violence occurred both in women's homes as well as in the street and while they were using public transport.

Feeling of safety

Overall reported feeling of safety among women age 15-49 was moderate (Migori) to high (Kajiado, West Pokot) (Table 2). Notably, only 19% of women in Migori said they felt safe at night. 38% of the women in the county did not feel free to move and one in four women felt unsafe in public transport. In Kajiado, women's overall safety level was assessed as high, although 41% of the women said they did not feel safe at night and around half of them did not feel free to move. Finally, the overwhelming majority (90%+) of women in West Pokot felt safe in all spaces and during both day and night, but around a quarter of the women interviewed felt they could not move freely (Table 2).

Safety in private and public spheres	Migori		Kajiado		West Pokot	
Day	80%	High	93%	High	100%	High
Night	19%	Low	59%	Moderate	93%	High
Transport	75%	Moderate	90%	High	97%	High
Safe home	82%	High	99%	High	98%	High
Free to move	62%	Moderate	61%	Moderate	76%	Moderate
Safer versus last year	81%	High	92%	High	98%	High
Average	**67%**	**Moderate**	**82%**	**High**	**94%**	**High**

Table2.Safety as perceivedbywomen(15-49),bycounty

[38] Motorcycle taxi conductors.

Conclusions and Recommendations

Overall, baseline data shows that a considerable share of women in all three counties have experienced violence, in particular from intimate partners.

Data further indicates that the assessed communities in Migori might provide a comparatively less safe environment for women. Both for IPV and non-partner sexual violence, the highest rates were reported for Migori. This is consistent with women's reported feeling of safety: the overall feeling of safety as reported by women in Migori was assessed as moderate only, with many women experiencing fear at night, and some reporting safety concerns when using public transport or limitations to their freedom of movement.

In Kajiado, according to baseline data, physical violence against women seems to be still accepted by some community members. Over 80% of survey participants were aware of such violence and 13% thought it was justified to use such violence against a wife to obtain obedience and respect. 14% of the women interviewed in Kajiado had recently experienced physical violence by their current or former partner. While overall feeling of safety was rated high for Kajiado, a considerable share of the women interviewed felt unsafe during the night or that they were not free to move.

In West Pokot, the overall feeling of safety was assessed as high, although around a quarter of women reported feeling not free to move. Also 26% said they had recently experienced physical violence from their current or former partner. Sexual violence by persons other than their partner was not reported as a concern by women in West Pokot, aligning with the assessment that surveyed communities in West Pokot may provide a relatively safe environment for women.

The following recommendations emerge for GBV prevention programming:

- Across all three geographies, actively engage men and boys in GBV prevention in work around positive masculinities, and promoting male role models.
- For Migori, engage with women to identify situations/areas where they feel unsafe. Co-develop and implement community-based mitigation measures. Target boda-boda riders with GBV-related awareness raising messages and engage them as positive role models/change agents.

Interrelated Challenges for Girls

Child marriage

Survey data confirms high prevalence of child marriage across all three counties, with a marked difference by gender: a considerably higher share of women compared to men had been married before age 18 in West Pokot (52% vs. 23%), Migori (46% vs. 7%), and Kajiado (42% vs. 2%). Around 10% of the women were married at age 10- 14, while none of the men were married at this very young age (Figure 5).

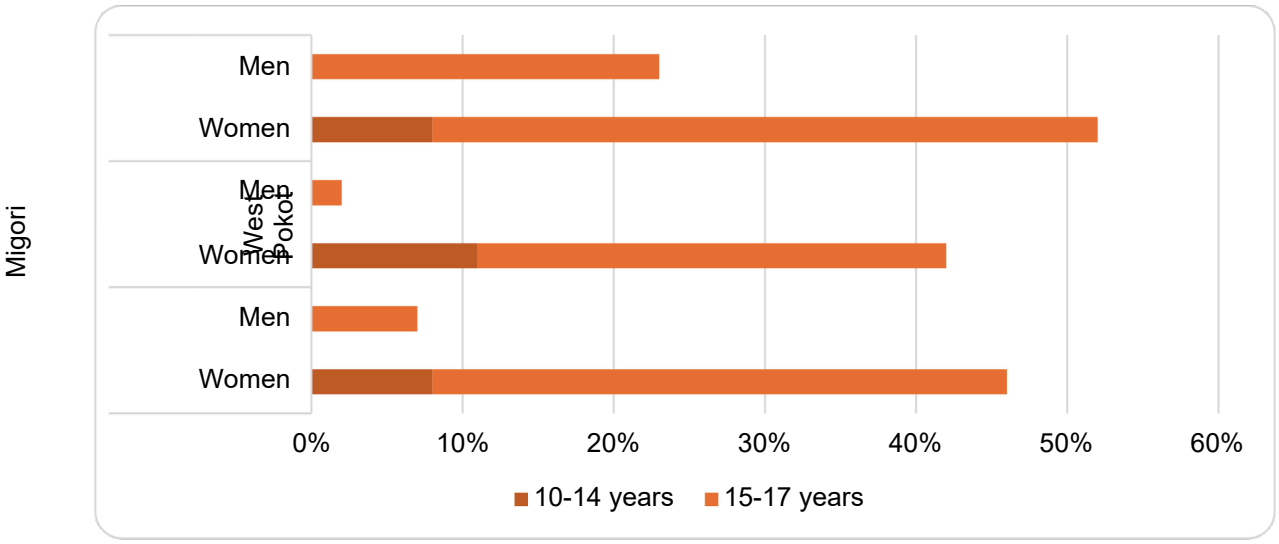

Figure 5: Reported age of marriage among women and men

Child marriage rates among adolescent girls were also assessed to be highest in West Pokot, where 23% of girls were married, compared to 12% in Kajiado and 7% in Migori. Most of these girls (73%-89%) were married off at age 15-17, according to their parents and guardians. However, 21% of the married girls in Kajiado were married at as young as age 12-14. The same was true for 14% of the married girls in West Pokot and 11% of married girls in Migori. Of particular concern, in Kajiado, some girls were subjected to child marriage when they were only 8-11 years old.

The reasons that respondents evoked to justify child marriage included culture, economic benefits, peer pressure, to be like other daughters, family pressure, and religious reasons. Cultural and economic reasons were identified as particularly important drivers for child marriage in Kajiado and West Pokot. In Migori, the most commonly evoked justifications for child marriage were peer pressure, to be like other daughters, and economic reasons. This is an indication that multiple factors drive child marriage, calling for a combination of interventions as well as context-specific measures, adapted to the specific community and primary drivers.

Adolescent pregnancies

Adolescent pregnancy rates were found to be high in all three counties. 46% of women and girls (age 15-49) in West Pokot reported that they gave birth to their first child before age 18, followed by 39% in Migori and 33% in Kajiado. A considerable proportion of women and girls reported getting pregnant and giving birth at an even younger age: 7% of women and girls in Kajiado reported they first gave birth between age 10-14, followed by 5% in West Pokot and 4% in Migori. Pregnancies and childbirth at such young age are of particular concern due to their negative impact on a girl's health and prospect in live, in addition to health and developmental risks for the child (Figure 6).

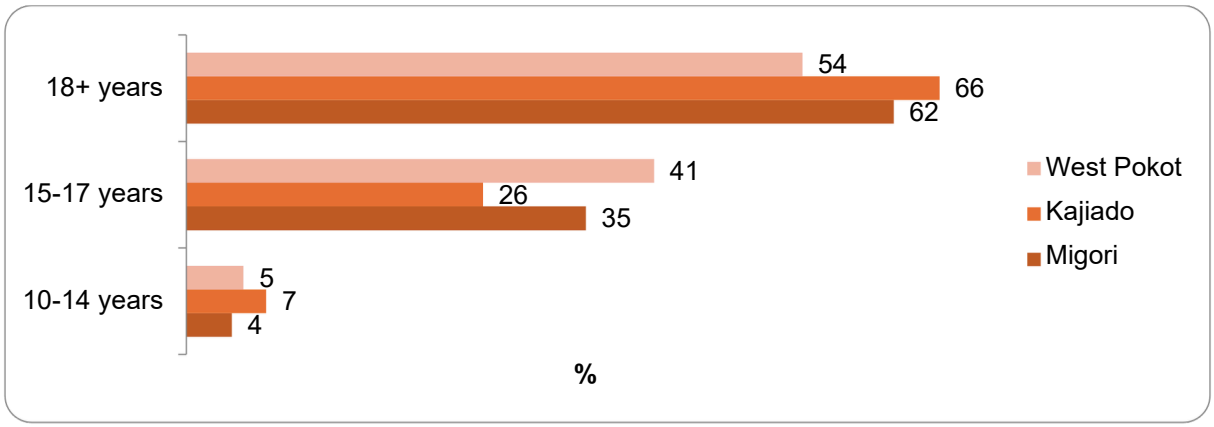

Figure 6: Age when first giving birth (%) by county

School attendance and completion

In Kajiado and Migori, girls' assessed school attendance rate was high, with 95% of girls (10-17) in Kajiado and 89% of girls in Migori attending school or another formal education program full-time or part-time at the time of the survey. In Migori, 43% of the girls had completed primary school[39] and 4% had finished secondary school. In Kajiado, only 11% had obtained a primary school certificate and none of the girls had completed secondary school. In both counties, only 1% of girls, respectively, never went to school. School attendance and completion was identified as a particular concern among communities in West Pokot, where 37% of the surveyed girls never went to school and only 60% were attending school or another education programme. Only 8% had obtained a primary school certificate. In comparison, 91% of the boys in Migori, 88% of boys in Kajiado, and 65% of boys in West Pokot attended school.

Data on the reasons for girls and boys being out of school indicates a strong link of non-attendance with gendered roles and responsibilities. While financial constraint was reported as a key factor across geographies and sex groups, child marriage and/or adolescent pregnancies were identified as important factors that prevented girls from continuing their education. In West Pokot, family responsibilities featured prominently as reasons for both girls and boys to be out of school.

Conclusions and Recommendations

Child marriage, adolescent pregnancy, and school absenteeism or dropout can both cause and result from one another, mutually reinforcing their negative impacts on a girl's health, psychosocial well-being, and overall life prospects.

These interrelated challenges seem to be a particular concern for girls in West Pokot, where almost one in four girls never went to school and around half of the women were married and had their first child before age 18, some even before age 15.

A major concern identified in Kajiado is the young age at which child marriage occurs. More than 10% of the women interviewed were married between the ages of 12 and 14 years. Among the married girls survey, one in five was married at that age, and some as early as 8 to 11. Equally worrying, 7% of the women had their first child

[39] This includes girls currently in secondary school or who already completed secondary school. Children in Kenya are expected to complete primary education by age 12–14, depending on the system they are in.

between the ages of 10 and 14 years. Survey data also shows a correlation between early marriage, early pregnancies, and early FGM (see above). Interestingly, school attendance among girls aged 10–17 was high in Kajiado (95%) despite the fact that 12% of the girls were already married. Further research is necessary to understand the relationship between early marriage and school attendance in Kajiado and how some of the girls seem to manage continue their education even when married.

Finally, in Migori, around half of the women were married before age 18 and one in four also had her first child before reaching adulthood. Notably, similarly to Kajiado, school attendance was high in Migori, where the vast majority girls surveyed were attending school or another formal education program, almost matching school attendance rates of boys of the same age.

Regarding the situation of adolescent girls, the following main recommendations emerge from the baseline findings:

- To address interrelated challenges for adolescent girls holistically and sustainably, support families to gain economic stability and resilience.
- In West Pokot, ensure that programming measures cover out-of-school girls, supporting them to (re-)join schools or other educational programmes and strengthening their agency through engagement at the individual, family, and community level.
- Engage with schools and other education facilities around making available (reusable) menstrual hygiene materials free of charge to mitigate the effect of period poverty on school attendance and participation of women and girls in other spheres of life.

Use of modern contraceptives

Overall, uptake of modern contraceptives among women and men of reproductive age (15-49) is moderate in Migori and poor (less than 20%) in Kajiado and West Pokot counties, according to survey data. In addition, a gendered difference in use of modern contraceptives can be observed, with up-take rates being higher among women than men in Migori (42% vs. 3%), Kajiado (20% vs. 7%), and West Pokot (14% vs. 5%) (Figure 7).

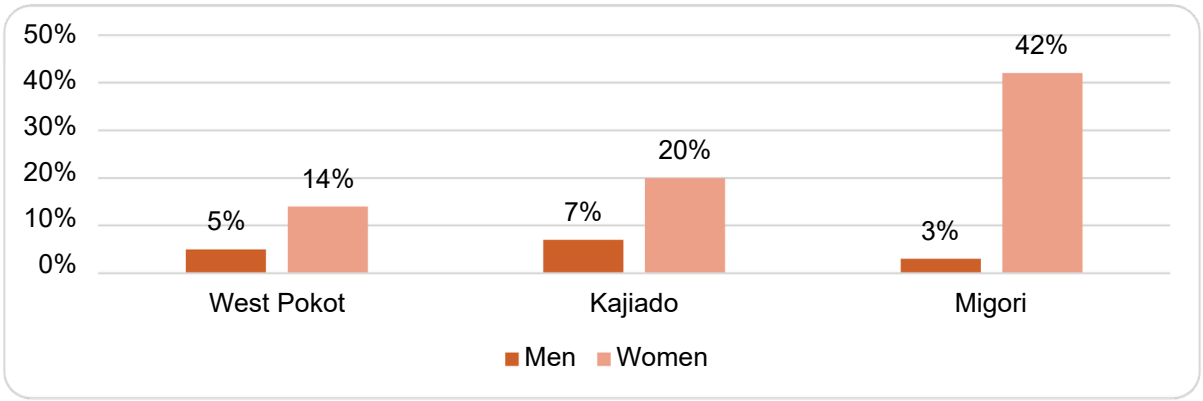

Figure 7: % of people of reproductive age (15-49) using modern contraception, by county.

The preferred methods of contraceptives were injectables (53% acceptance in Migori 34% in Kajiado, 20% in West Pokot,) and implants (59% acceptance in West Pokot, 45% in Migori, 38% in Kajiado) across all regions, followed by male condoms and oral contraceptive pills.

Conclusions and Recommendations

Data from all three counties indicates a marked difference by sex both in terms of overall use of modern contraceptives and in terms of preference for the type.

Women from Migori reported the highest rate of use of modern contraceptives, preferring injectables and implants.

In contrast, West Pokot, only one in seven women reported use of modern contraceptives. Those who did, preferred implants and injectables.

In Kajiado, use of modern contraceptives among women was assessed as relatively low (20%), with equal acceptance rates for implants and injectables.
Recommendations:

- Across all target communities, engage both women/girls and men/boys in SRH awareness raising activities through target-group specific messages, focused on promoting male condoms as a low-cost contraceptive method that also reduces the risk of sexually transmitted infections (STIs);
- Engage with health facilities and pharmacies to ensure availability of free-of-charge/low-cost condoms.[40]

Women‘s and Girls’ Decision-Making and Leadership

Empowering women and girls to have individual agency and take informed decisions regarding their bodies and health, within a supportive family and community environment, is both a goal in itself and a key pathway towards reducing and eventually ending FGM, child marriage, and GBV. As such, women’s and girls’ empowerment is a key focus of the #TogetherWeEndFGM project.

Women and girls’ agency

According to survey data, the share of women (age 15-49) who felt that they had agency was highest in Migori, where 47% of women confirmed that they could take their own informed decisions about their bodies and health. In comparison, only 22% of the surveyed women in Kajiado and West Pokot, respectively, felt they had agency regarding their bodies and health (Figure 8).

[40] In Kenya, as part of HIV/AIDS prevention measures, regional and district health teams can order condoms for distribution free of charge from the national medical store department. However, the actual availability of condoms depends on how actively and timely the relevant authorities are using this system. In addition, the end of USAID funding negatively affected the programme, which is relying heavily on external funding. See: Sandøy IF et al.: Condom availability in high risk places and condom use: a study at district level in Kenya, Tanzania and Zambia. BMC Public Health. 26 November 2012, and “USAID Funding Freeze Risks Shortage Of Condoms”. In: The Kenya Times, 25 February 2025.

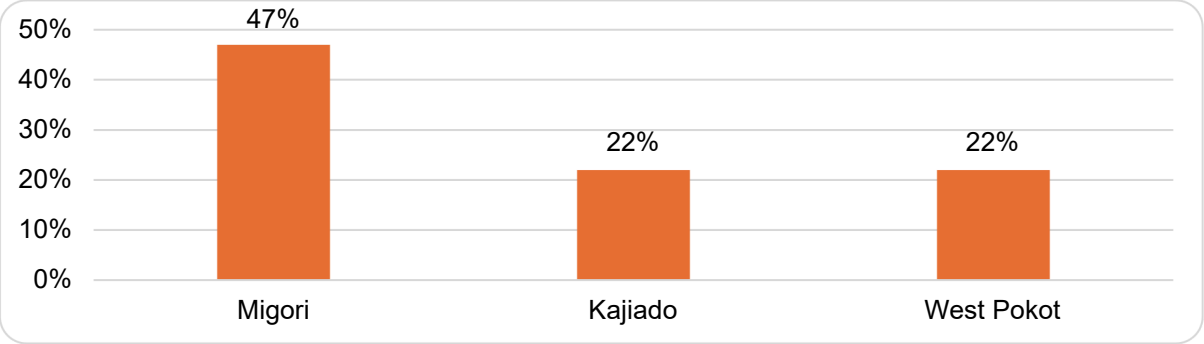

Figure 8: Women (age 15-49) who make their own informed decisions regarding their bodies and health, by county.

Knowledge on FGM and child marriage

Survey respondents demonstrated moderate levels of knowledge on harms associated with FGM and child marriage with women (age 15-49) overall having more knowledge than men. According to assessment data, 92% of women in West Pokot, 80% in Migori, and 74% in Kajiado had adequate knowledge on related subjects.

Sense of self-efficacy

The assessed sense of self-efficacy[41] was highest among women in Kajiado (51%), where 53% said they could stand-up against GBV and 49% reported they could speak confidently about SRH. Sense of self-efficacy was assessed at 44% among women in West Pokot, where 50% said they can oppose GBV and 38% said they could speak with confidence about SRH. Finally, sense of self-efficacy was assessed to be lowest in Migori (40%), where 50% of the surveyed women said they could stand-up against GBV, but only 30% felt they could speak confidently about SRH.

Community attitudes on women's and girls' participation in decision-making

Community members, in particular, men and boys, and community, traditional, and religious leaders play a key role as either enablers of or champions against FGM, child marriage, and GBV. Various measurements were thus conducted to assess the extent to which communities support women's and girls' decision-making.

Data indicates that community support for women and girls' agency is highest in Migori, where support for women and girls making their own decisions related to their bodies and health stood at 71%.[42] In Kajiado (45%) and West Pokot (38%), support rates for women's decision making were considerably lower. Notably, only 26% of respondents in Kajiado and 38% of participant in West Pokot thought that a married women should have the right to say no to sex with her husband, while in Migori, 69% thought that a woman can say no to sex. In West Pokot, only 27% agreed that girls (aged 15-17) should be allowed to decide, choose, and use SRH services and only 28% thought that women should have the right to decide, choose and use family planning methods.

[41] Belief in one's ability to complete a task or achieve a goal.

[42] This includes: family planning, girls' SRH, saying no to sex, own body/health decisions (general), and access to SRH information. The acceptance rate is calculated as a weighted index.

Across all three counties, support for women's and girl's leadership in communities was high and in Migori and Kajiado, where about 60% of the respondents reported that women and girls are assuming leadership roles. In West Pokot, only a third of respondents were aware of women and girls in leadership roles in their community. Such roles included chair of constituency development fund, school board, and leadership roles in religious groups, children's councils, and youth groups.

Conclusions and Recommendations

Overall, baseline data on women's and girls' agency and participation in leadership and decision-making is inconclusive.

In Migori, almost half of the women interviewed reported that they could make decisions affecting their own bodies and health, and two-thirds of community members supported such decision-making, including the right of women to say no to sex with their husband (69%). In addition, four out of five women demonstrated adequate knowledge of FGM and child marriage. However, only half said they could stand up against GBV, and just one in three felt confident speaking about SRH, suggesting a comparatively low sense of self-efficacy.

In Kajiado, half of the women said they could stand up against GBV and speak about SRH, and three out of four had adequate knowledge of FGM and child marriage. However, only one in five believed they could make decisions regarding their own body and health, and fewer than half of community members supported such decision-making by women and girls. Notably, the majority of respondents in Kajiado (74%) believed that a woman does not have the right to refuse sex with her partner.

In West Pokot, almost all women interviewed had adequate knowledge of FGM and child marriage, but only one in five believed they could make decisions about their own body and health. This may be linked to particularly restrictive community attitudes toward women's and girls' decision-making, with the lowest acceptance levels reported for West Pokot among the three counties, where only 38% thought that a woman can say no to sex with her husband.

Regarding women's and girls' agency and decision making, the following recommendations for programming emerge:

- Continue to invest into providing safe spaces where women and girls can share their experiences and concerns, obtain reliable information, and plan and launch actions to voice their concerns and demand change from communities and leaders.
- Engage community members and community and traditional leaders, in discussions to identify the underlying causes (detrimental gender and social norms, religious beliefs etc.) that limit women's and girls' decision making and co-design and disseminate target-group specific awareness raising messages.
- Engage with public health institutions to provide youth-friendly SRH services and outreach activities to reduce barriers for girls to access SRH-related information and services.

Conclusion

The baseline values provide a firm foundation against which #TogetherWeEndFGM program can be monitored and evaluated in its implementation in Migori, Kajiado and West Pokot counties.

The baseline study confirms that the project's goal framed as

> Reducing/ending FGM, child marriage, GBV, adolescent pregnancies and school dropouts, while promoting the uptake of modern contraceptives and strengthening women and girl's leadership

is valid and justified in the context of target communities in Migori, Kajiado, and West Pokot counties. This is supported by data such as high and above national and county average rates of FGM, child marriage, early pregnancies, and physical, psychological and/or sexual violence among the assessed communities. Additionally, the uptake of SRH services that could mitigate some challenges such as unwanted and teenage pregnancies is suboptimal across the communities, with data exposing prevailing attitudes that further undermine the up-take of SRH services and modern contraceptive use.

To address these challenges, integrated, context-adapted, and adaptive programming is required that is based on evidence that highlights the dynamics at the level of ethnically homogenous communities and addresses the specific access and participation barriers of women, girls, men, and boys *in all their diversity*. It also calls for strong collaboration and partnership with both government and civil society initiatives as well as integration of #TogetherWeEndFGM interventions into ongoing systems such as health, education, and food security to leverage existing resources and promote sustainability. Finally, data highlights the need to address emerging trends (e.g. early/mature age FGM, medicalization) as well as the underlying causes of FGM, child marriage, GBV, and SRH access barriers including poverty and detrimental social and gender norms for effective, sustainable elimination of harmful practices and violence against women and girls and to promote service access and women's and girls' agency.

The baseline values support expedited implementation of #TogetherWeEndFGM interventions to curtail, prevent, and respond to women and girls who are at risk of many challenges, in particular FGM. At the same time, there is a need to build agency of women and girls and promote their leadership in community structures to strengthen their resilience and capacity to stand-up for themselves. In a complementary fashion, intensive engagement with community members, in particular men and boys, as well as religious, community, and traditional leaders is necessary to foster an enabling environment that supports women's and girls' agency and promotes the realization of their rights. Finally, there is need for strengthening the existing child protection systems, through funding, capacity building for the service providers, coordination for the various systems and services relevant to protection, service delivery and referral mechanisms as well as community awareness and involvement. This calls for multistakeholder and multilevel collaboration and partnerships that have the capacity to advance towards FGM abandonment effectively and sustainably.

Overall Recommendations

Thefollowing recommendations for the implementation, adaptation, and expansion of #TogetherWeEndFGM were derived from the baseline findings and discussions with implementing teams and volunteers during the verification workshop, incorporating experiences and best practices from wider anti-FGM programming.

1. To address FGM, child marriage, and GBV effectively and sustainably, shift the intervention focus (further) towards individualized support to women and girls and their families. Ensure interventions adapt to the different needs, participation requirements, and capacities of women, girls, men, and boys *in all their diversity*, with specific attention given to reach persons with disabilities, young adults, older persons, and other marginalized groups and to mobilize and engage community, traditional, and religious leaders as well as boda boda riders. In parallel, continue to invest in community-led awareness to prevent and respond to FGM, child marriage, and GBV, and to promote SRH access.

2. Design and pilot additional interventions that empower girls and promote their agency, and – more broadly – strengthen the participation of adolescent girls and boys in decision making. Specifically:

    a. Develop and pilot girl-centred interventions to assess their applicability and effectiveness, incorporating lessons learned to enhance scalability and adaptability to new villages and geographies.

    b. Strengthen and expand structured awareness creation and training for adolescent girls and boys to enhance their involvement in decision-making processes related to development interventions.

3. Ensure anti-FGM interventions are innovative, state-of-the-art, and grounded in best practices to comprehensively address emerging challenges such as cross-border FGM, medicalization, mature age FGM, and early age FGM.

4. Design and test comprehensive interventions that address the underlying causes of FGM, child marriage, GBV, and SRH access barriers, including poverty, lack of education access, detrimental gender and social norms, and weak representation of women leaders in an integrated way. Specifically,

    a. Protect and promote the livelihood basis of participating families and individuals to reduce the impact of financial constraints on access to health and education and as driving factors for FGM and child marriage,

    b. Support access to education for adolescents and adults, including adult literacy and vocational training for adolescents and young adults,

    c. Strengthen the engagement of community, social, and religious leaders to address detrimental social and gender norms in culturally sensitive ways,

    d. Identify and support existing women leaders, women-led organizations and women's groups in the communities and establish and support women peer support groups, where they do not exist.

5. To promote structured response and sustainability of interventions, strengthen integration of FGM, child marriage, GBV, and SRHR interventions into existing programmes, structures, and services such as health services, schools, peace

and security interventions, and nutritional programs, which have potential for anchorage into government structures and systems. Specifically,

a. build collaboration and partnership with government to revamp youth friendly health services that integrate anti-FGM, child marriage, GBV prevention/response, and SRHR interventions,

b. leverage collaborative efforts to strengthen child protection systems through capacity building, funding, and partnerships.

6. Integrate safeguarding, do no harm; and ethical principles in the implementation of FGM, child marriage, and GBV prevention and SRHR interventions to protect and promote the physical and psychological wellbeing and integrity of everyone involved directly or indirectly. This includes capacity building for staff, volunteers, and stakeholders in psychological first aid, stress- and trauma-informed approaches, and non-specialized psychosocial support provision.

7. Introduce deliberate and intentional evidence and data driven decision making processes for programme design and steering. Develop and test innovative design and data collection methods – such as inclusive co-design and most-significant change tools - that are fit to produce reliable data that bring forward the lived realities of community members, especially women and girls, while promoting their agency and protecting their integrity.

Annex 1: Operational Definitions

Access to sexual and reproductive health: Refers to the ability of individuals to obtain, without discrimination, timely, acceptable, affordable, and high-quality information, services, and commodities that enable them to make informed decisions about their sexual and reproductive lives e.g access to family planning and contraception.

Adolescent pregnancy: Refers to pregnancy occurring in a girl aged 10–19 years.

Child marriage: Refers to any formal or informal union where one or both parties are under the age of 18.

Female genital mutilation: These are procedures that involve partial or total removal of the female external genitalia or other injuries thereof to the organs for cultural or non-medical reasons. The WHO classification of four types of FGM namely clitoridectomy (type I), excision (type II), infibulations (type III) depending on the extent of the genital tissue removed, and others, such as labia pulling (type IV).

Gender-based violence: Any harmful act that is perpetrated against a person's will and is based on socially ascribed differences between males and females. It encompasses physical, psychological, sexual, and economic violence associated with unequal power relations, discrimination, and social norms that reinforce gender inequality.

I**nclusive co-design approach**: Is a collaborative design process that actively involves diverse stakeholders including marginalized, vulnerable, or traditionally excluded groups in shaping solutions, services, or policies that affect them to create more relevant, acceptable, and sustainable outcomes by addressing power imbalances and fostering ownership among all participants.

Medicalization of FGM: This is FGM performed by any cadre of health worker (medical doctor, clinical officer, Nurse/Midwife) in a clinic, health facility or neutral place like a home among others on girls or women.