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2023

Factors Associated with the Perception of Ease and Intention to Practise Female Genital Mutilation on Daughters

A Cross-Sectional Study of Cross-Border
Communities in Ethiopia, Kenya, Somalia
and Uganda



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Executive Summary

Cross-border female genital mutilation (FGM) takes place when communities cross national borders to perform FGM, circumvent laws and avoid prosecution. Using data from a recent cross-border study, this report aims to identify factors associated with the perception of the ease of cross-border FGM and the intention to perform FGM on daughters and female relatives in the border communities of Ethiopia, Kenya, Somalia and Uganda. A mixed-methods approach collected data from 1,483 respondents and 63 focus group discussions and used a logistic regression model for quantitative analysis and thematic analysis of qualitative data. Along borders such as those between Kenya and Somalia, and between Kenya and the United Republic of Tanzania, the majority of respondents stated that FGM laws and penalties are not adequately enforced. Along all borders, respondents who viewed cross-border FGM as easy to carry out had 2.6 times higher odds of intending to practise it. Significant factors influencing FGM intention included the perception that it was easier in border areas, the weak implementation of laws, having a female relative with FGM and the lack of a penalty for practising FGM. These factors differed across borders, however. Interventions targeting families with a history of FGM, the enactment and enforcement of laws specific to border areas in ways that reflect diverse contexts and collaborative efforts by governments across borders could help address the practice.

Keywords: Cross-border, female genital mutilation, East Africa, harmful practice.

LIST OF ABBREVIATIONS

DHS	Demographic Health Survey
FGM	Female Genital Mutilation
MICS	Multiple Indicator Cluster Surveys
UNFPA	United Nations Population Fund
UNICEF	United Nations Child Fund

1 Background

Globally, female genital mutilation (FGM) has declined over the last three decades. But the change has not been uniform across and within countries (UNICEF, 2022). A number of challenges and emerging trends continue to hinder progress. In cross-border FGM, communities travel across national borders to procure FGM services, circumvent laws and avoid prosecution, among many other reasons (28 Too Many, 2013; Community of Practice on Female Genital Mutilation, 2019). Cross-border FGM movement is most common in countries in East and West Africa among persons who wish to continue the practice (28 Too Many, 2013).

Of the 200 million women and girls globally estimated to have undergone FGM, about a quarter or 48.5 million are from and live in the neighbouring East African countries of Ethiopia, Kenya, Somalia, Uganda and the United Republic of Tanzania.

(Community of Practice on Female Genital Mutilation, 2019).

If current trends in the FGM rate remain unchanged, estimates suggest that at least 9.41 million girls in Ethiopia, Kenya, Somalia and the United Republic of Tanzania will be at risk of undergoing FGM between 2015 and 2030 (UNFPA, 2022).

While some countries have had consistently declining FGM prevalence over the years, select subregions within them have not seen much change. Areas with high FGM prevalence tend to share common borders and in most cases the same community and ethnic groups (ibid.). For instance, in Kenya as a whole, the prevalence of FGM among girls and women aged 15 to 49 years fell from 37.6 per cent in 1998 to 21 per cent in 2014 (Kenya National Bureau of Statistics and others, 2015). This shift is not consistently apparent at the subnational level, however, particularly in the North Eastern Region, where no meaningful change has been observed (Kandala and others, 2017). FGM in this region remains nearly universal at 97.5 per cent (Kenya National Bureau of Statistics and others, 2015). Similar patterns are evident in Mandera County, the furthestmost part of the region bordering both Somalia and Ethiopia's Somali Region. In Somalia, FGM prevalence is 99 per cent (Federal Government of Somalia, 2020). The rate in the Somali region in Ethiopia is 98.2 per cent, the highest level in the country and above the national prevalence rate of 65 per cent (Ethiopia, Central Statistical Agency, 2017).

Uganda has the lowest national prevalence rate in the region, at 0.3 per cent (Uganda Bureau of Statistics, 2018). But rates in some districts in the Sebei and Karamoja regions remain at over 50 per cent. In the Sebei region, FGM is prevalent among the Sabiny who live on the slopes of Mt. Elgon and share a common border with the Sabao of Kenya. They speak the same language and share common cultural practices. A 2020 case study by the United Nations Children's Fund (UNICEF) noted that many Ugandan girls and young women reportedly crossed into Kenya to procure FGM services (UNICEF, 2021).

Previous thinking around cross-border FGM has centred on borders and States. The key to understanding cross-border FGM, however, lies in the common ties and cultures shared by border communities (Community of Practice on Female Genital Mutilation, 2019). Due to the complex nature of the subject and difficulties associated with data collection, very few studies have examined cross-border FGM. Among existing studies that have attempted to study the practice, most have taken a very narrow focus (Wouango, Ostermann and Mwanga, 2020). Others have only analysed existing situations in border areas using data from Demographic and Health Surveys and Multiple Indicator Cluster Surveys (UNFPA, 2022). These gaps prompted the UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation to conduct a study on cross-border practice in East Africa, with a follow-up study in West and Central Africa.

To the best of our knowledge, the current study is one of the first to provide an in-depth analysis of factors associated with the perception of ease in practising FGM across borders and the intention to mutilate daughters or female relatives in cross-border communities in Ethiopia, Kenya, Somalia and Uganda. Specifically, the study intends to estimate the odds related to the ease and intention to practise FGM and identify factors associated with both.



A group of girls rescued from female genital mutilation and early marriage play hand-clapping games in their dormitories at Morpus primary school in Ortum, West Pokot, Kenya.

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2 Methods

2.1 Study design

The study employed a mixed methods approach entailing a cross-sectional design for data collection and reporting as well as focus group discussions. It took place in four East African countries, Ethiopia, Kenya, Somalia and Uganda, in 2020. Border areas included in the analysis are in Ethiopia, Somalia and Uganda along a common border with Kenya. Data are part of a broader cross-border study to identify the social dynamics of FGM practices in border communities in East Africa.

2.2 Sampling

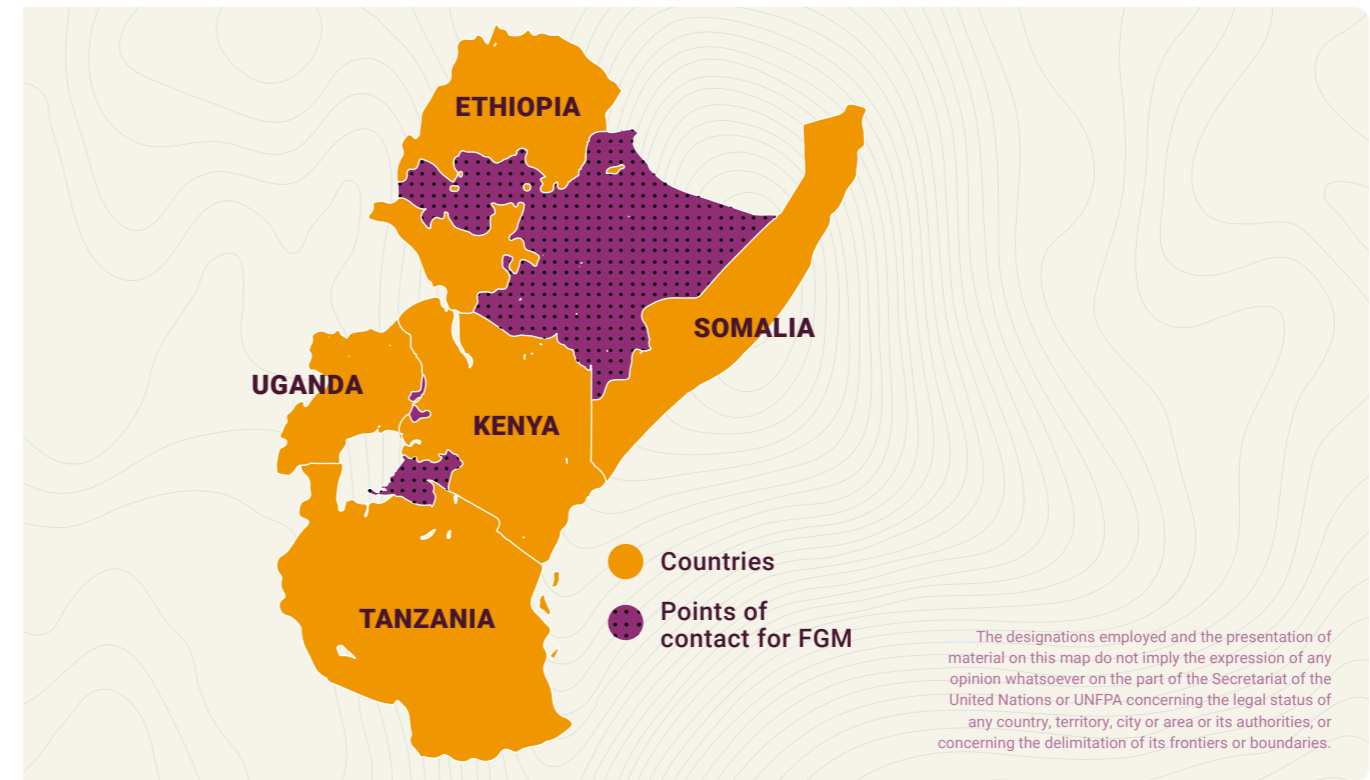
The data collection targeted 12 communities. Due to the difficulty in completing parameters for sample size calculations (e.g., the sample frame), a non-probabilistic sampling technique was used for data collection (Kempf-Leonard, ed., 2005). In recognition of the type of sampling technique used, and in order to reduce bias, respondents were clustered by region and ethnicity, and stratified by gender. Random sampling was then employed to select participants. The study interviewed a total of 1,483 participants in the 12 communities. Qualitative data collection took place in 64 focus group discussions with participants from these communities. Participants were purposely selected using a maximum variation sampling technique that factored in variations in age and gender.

2.3 Study area and context

A key consideration in selecting study sites was the existence of the same ethnic community practising FGM. The sample comprised people from at least six ethnic communities in at least two countries where data were collected, namely, the Somali, Borana (also referred to as Oromo/Oromia), Sabiny/Sabaot, Pokot, Maasai and Kuria. See the following map.



MAP | Geography of Cross Border FGM



- * The Somalis are an East Cushitic ethnic group native to the Horn of Africa. They are primarily concentrated in Somalia (around 8.8 million in the North East Zone), with 5.7 million in Somaliland, about 7.5 million in Ethiopia and about 2.8 million in Kenya (Federal Government of Somalia, Data for a Better Tomorrow and UNFPA, 2014; World Population Review, 2022; Kenya National Bureau of Statistics, ed., 2019). They practise Type III FGM, with prevalence rates between 97.5 per cent in Kenya and 99 per cent in Somalia, according to the latest Kenya Demographic Health Survey and Somali Health and Demographic Survey, respectively. For this study, data were collected among the Somali in Mandera (Kenya) and Bulahawa (Somalia).
- * The Borana is one of the major subgroups of the Oromo-speaking people, the majority of whom live in the Borena Zone of the Oromia Region in Ethiopia. It stretches to the Kenyan border in the south-west. For this study, data were collected in Moyale (Ethiopia), which is an administrative centre for the Moyale Woreda of the Oromia Region, and Moyale (Kenya), which is a former administrative district of Eastern Province. Like the Somali, the Borana practise Type III FGM (28 Too Many, 2013).
- * The Sabaot, also known as the Sebei or Sabiny, is one of the Kalenjin ethnic groups. The group lives around the slopes of Mount Elgon in both Kenya and Uganda. Like other Kalenjin communities, the Sabaot perform and practise FGM as a rite of passage (Evelia and others, 2007; Nalaaki, 2014).

- * The Pokot people live in West Pokot County and Baringo County in Kenya and in the Pokot Karamoja Region in Uganda. They are a section of the Kalenjin ethnic group and speak the Pokot language. For this study, data were collected in Amudat District in Uganda, which borders Kenya to the east, and in West Pokot in Kenya.
- * In the common border area shared between Kenya and the United Republic of Tanzania, data were collected in Kenya from the Maasai in Transmara and the Kuria in Isebania. The Maasai are a Nilotic ethnic community that inhabits the Great Rift Valley in Kenya and northern Tanzania. FGM among the Kuria is considered a rite of passage from childhood to adulthood; girls who have not gone through the process are considered “children” (Evelia and others, 2007; Oloo, Wanjiru and Newell-Jones, 2011). Data were also collected among the Daasanach, a Cushitic-speaking community found in the Omo Valley in Debub/South Omo, Ethiopia. They share a common border with the Turkana of Kenya. The Turkana do not traditionally practise FGM.

2.4 Data entry and analysis

Quantitative data were first encoded into an Excel database for cleaning and exported into Stata version 16.0 for data analysis. Descriptive statistics of participants’ sociodemographic characteristics were presented using percentages, medians and interquartile ranges. Univariate and multivariable logistic regression models investigated relationships between the outcome and explanatory variables at p -value <0.05 . Qualitative data from the focus group discussions were recorded, followed by transcription and translation. Transcribed data were coded in NVIVO version 12 followed by thematic analysis as recommended by Creswell and others (2003).



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3 Results

3.1 Characteristics of study participants

● QUANTITATIVE

Data were collected from 12 border communities in Ethiopia, Kenya, Somalia and Uganda. The majority of the respondents were from border communities in Kenya, at $n=757$ (51 per cent). Respondents in Uganda, Ethiopia and Somalia represented 28 per cent, 13.5 percent and 7 per cent of the total, respectively. BGM–Sabaot, West Pokot, Mandera, Turkana, Moyale, Transmara and Isebania–Tarime are border communities in Kenya. Sabiny and Pokot Amudat are border communities in Uganda. Debub/South Omo and Moyale are border communities in Ethiopia. Bulahawa is a border community in Somalia.

Respondents shared similar demographic profiles, with the majority being female (52.6 per cent), married (8 out of 10) and between the ages of 25 and 39 (42 per cent). Over 50 per cent of respondents had religious (church/Quranic) education in Debub/South Omo (Ethiopia), Mandera (Kenya), Moyale (Kenya), Transmara (Kenya), Turkana (Kenya), West Pokot (Kenya) and Pokot Amudat (Uganda). In Sabiny (Uganda) and BGM–Sabaot (Kenya), more than half of respondents had high school or higher levels of education. The Islamic religion was practised by a majority of respondents in Mandera (Kenya), Bulahawa (Somalia) and Moyale (Kenya), while the majority of those in BGM–Sabaot (Kenya), Sabiny (Uganda), West Pokot (Kenya), Pokot Amudat (Uganda), Transmara (Kenya), Isebania–Tarime (Kenya) and Turkana (Kenya) practised mostly Christianity (Table 1).

● QUALITATIVE

Focus group discussions involved men and women, both younger (aged 18 to 34) and older (aged 35 and older), in each of the border areas. For the qualitative study, 40 focus group discussions took place in Kenya, 8 in Uganda, 7 in Ethiopia and 8 in Somalia. In all countries, the groups involved equal participation by age and gender, except in Ethiopia, where only one (instead of two) sessions took place involving older men.

TABLE 1 | Characteristics of study participants

Characteristics	Border area											
	Kenya						Uganda			Ethiopia		Somalia
	BGM-SABAOT N=100	WEST POKOT N=116	MANDERA N=113	TURKANA N=108	MOYALE N=118	TRANSMARA N=99	ISEBANIA-TARIME N=100	SABINY N=205	POKOT AMUDAT N=213	DEBUB/ SOUTH OMO N=95	MOYALE N=109	BULAHAWA N=107
SEX, FEMALE	50 (50%)	59 (50.9%)	66 (58.4%)	54 (50%)	91 (77.1%)	50 (50.5%)	50 (50%)	105 (51.2%)	104 (48.8%)	47 (49.4%)	51 (46.8%)	52 (48.6%)
AGE; MEDIAN (INTERQUARTILE RANGE)	42 (28)	35 (24)	32 (17)	30.5 (12)	33 (12)	37 (24)	35 (25)	33 (20)	34 (20)	31 (9)	27 (16)	36 (14%)
EDUCATION												
Church/Quranic	8 (8%)	62 (53%)	69 (61.1%)	58 (59.8%)	71 (60.2%)	68 (68.69)	18 (18%)	21 (10.4%)	164 (77%)	64 (71.1%)	28 (26.7%)	28 (26.2%)
Adult literacy	2 (2%)	1 (0.9%)	3 (2.7%)	4 (4.1%)	3 (2.54%)	0	2 (2%)	3 (1.5%)	25 (11.7%)	1 (1.11%)	11 (10.5%)	29 (27.1%)
Elementary	40 (40%)	3 (2.6%)	12 (10.62%)	11 (11.34%)	2 (1.69%)	0	40 (40%)	8 (3.96%)	13 (6.10%)	17 (18.89%)	18 (17.14%)	14 (13.08%)
High school	40 (40%)	32 (27.35%)	16 (14.16%)	15 (15.46%)	27 (22.88%)	16 (16.16%)	30 (30%)	65 (32.18%)	5 (2.35%)	7 (7.78%)	20 (19.05%)	20 (18.69%)
Diploma	6 (6%)	18 (15.38%)	10 (8.85%)	7 (7.22%)	11 (9.32%)	10 (10.10%)	6 (6%)	95 (47.03%)	6 (2.82%)	1 (1.11%)	18 (17.14%)	13 (12.15%)
University degree	4 (4%)	1 (0.85%)	3 (2.65%)	2 (2.06%)	4 (3.39%)	5 (5.05%)	44%	10 (4.95%)	0	0	10 (9.52%)	3 (2.80%)
RELIGION												
Muslim	0	1 (0.88%)	112 (99.12%)	2 (1.85%)	115 (97.46%)	0	2 (2.06%)	5 (2.48%)	1 (0.50%)	1 (1.09%)	86 (81.13%)	105 (98.13%)
Christian	96 (96.97%)	102 (90.27%)	1 (0.88%)	105 (97.22%)	3 (2.54%)	89 (89.90%)	95 (97.94%)	196 (97.03%)	194 (97.49%)	57 (61.96%)	20 (18.87%)	1 (0.93%)
Traditional religion	3 (3.03%)	10 (8.85%)	0	1 (0.93%)	0	10 (10.10%)	0	1 (0.50%)	4 (2.01%)	34 (36.96%)	0	1 (0.93%)
MARITAL STATUS												
Single	13 (13.13%)	14 (12.07%)	14 (12.50%)	17 (15.74%)	2 (1.74%)	10 (10.10%)	18 (18.18%)	60 (29.27%)	14 (6.86%)	5 (5.26%)	26 (24.53%)	1 (0.93%)
Married	75 (75.76%)	96 (82.76%)	86 (76.79%)	84 (77.78%)	104 (90.43%)	85 (85.86%)	66 (66.67%)	134 (65.37%)	170 (83.33%)	88 (92.63%)	64 (60.38%)	95 (88.79%)
Divorce/widowed	11 (11.11%)	6 (5.17%)	12 (10.71%)	7 (6.48%)	9 (7.83%)	4 (4.04%)	15 (15.15%)	11 (5.37%)	20 (9.80%)	2 (2.11%)	16 (15.09%)	11 (10.28%)

3.1.1 The intention to practise FGM, weak implementation of laws, the existence of penalties and the ease of crossing borders

More than 3 out of 10 respondents in five border communities intended to practise FGM on their daughters or female relatives. These communities included Mandera (Kenya) (55.75 per cent), Moyale (Kenya) (43.22 per cent), BGM–Sabaot (Kenya) (32.65 per cent), Debub/South Omo (Ethiopia) (44.09 per cent) and Moyale (Ethiopia) (44.09 per cent). None of the respondents in Pokot Amudat (Uganda) had an intention to practise FGM, while only 1 out of 10 respondents had such an intention in Bulahawa (Somalia), West Pokot (Kenya) and Turkana (Kenya). The majority of respondents in Transmara (Kenya) (88.54 per cent), Isebania–Tarime (Kenya) (83.84 per cent), Mandera (Kenya) (77.88 per cent), Moyale (Kenya) (53.85 per cent), Bulahawa (Somalia) (88.79 per cent) and Debub/South Omo (Ethiopia) (59.57 per cent) felt that there were no penalties for those who practise FGM. As expected, the proportion of respondents with the perception that there were no penalties for practising FGM was similar to the share with the perception of gaps in the implementation of current laws. Respondents who said it is easy to cross the border and practise FGM were mostly in Kenya's border areas. Those areas included Isebania–Tarime (87.88 per cent), Mandera (74.34 per cent) and Moyale (58.97 per cent). In Uganda, 57.2 per cent of respondents in Sabiny felt that it was easy to cross the border to practise FGM (Table 2).

TABLE 2 | Numbers of respondents intending to practise FGM and perceptions around the ease of practising FGM

Border area		Intention to practise FGM on daughter/female relative	No penalties	Weak implementation of laws	Ease of crossing a border to practise FGM
KENYA	BGM–Sabaot	32 (32.65%)	42 (44.68%)	28 (29.17%)	28 (28.57%)
	West Pokot	12 (10.43%)	42 (36.52%)	34 (30.36%)	35 (30.97%)
	Mandera	63 (55.75%)	88 (77.88%)	88 (77.88%)	84 (74.34%)
	Turkana	9 (9.18%)	50 (47.17%)	26 (27.37%)	7 (7.14%)
	Moyale	51 (43.22%)	63 (53.85%)	57 (49.14%)	69 (58.97%)
	Transmara	24 (26.37%)	85 (88.54%)	63 (64.95%)	37 (39.36%)
	Isebania–Tarime	22 (22.22%)	83 (83.84%)	80 (82.47%)	87 (87.88%)
UGANDA	Sabiny	31 (16.15%)	100 (49.26%)	96 (48.73%)	115 (57.21%)
	Pokot Amudat	0*	92 (46.46%)	61 (32.45%)	35 (17.33%)
ETHIOPIA	Debub/South Omo	41 (44.09%)	56 (59.57%)	55 (59.78%)	28 (31.46%)
	Moyale	51 (43.22%)	46 (43.40%)	57 (49.14%)	69 (58.97%)
SOMALIA	Bulahawa	14 (13.08%)	95 (88.79%)	49 (45.79%)	36 (33.64%)

Note: *Only six respondents replied when asked whether or not they intend to practise FGM on their daughters or female relatives.

3.1.2 Factors associated with the intention to practise FGM in border areas

Among respondents in all border areas combined, the adjusted logistic regression model revealed that respondents between the ages of 25 and 39 and between 40 and 60 years had 0.39 and 0.35 lower odds, respectively, of intending to perform FGM on their daughters or female relatives, compared to those between 18 and 24 years. The odds of intending to practise FGM were also significant in both univariate and multivariable models for respondents who had a daughter or female relative and viewed FGM as easy across the border (two times higher odds, see Table 2). In both models, respondents with a university degree, diploma and high school education were less likely to report wanting to practise FGM on their daughter or female relatives compared to those with a church or Quranic education. Other significant factors associated with an intention to practise FGM in both univariate and multivariate models included a previous history of FGM practice on a daughter or female relative.

In specific border areas, the univariate analysis showed that respondents living in Mandera (the Kenyan border with Somalia) had 2.5 times higher odds of an intention to practise FGM on their daughters or female relatives compared to respondents in Sabot (Kenya and Uganda border).

Respondents living in Sabiny (Uganda) were significantly less likely to practise FGM on their daughters or female relatives compared to those in the Sabot areas in both crude and adjusted models. In the Ethiopia and Kenya border areas, Moyale respondents were nine times (multivariable model) more likely to intend to practise FGM on their daughters or female relatives compared to those in the Turkana area. Along the Kenyan and Uganda border, respondents in Sabot and West Pokot had four and three times higher odds of practising FGM on their daughters or female relatives, respectively, and those in the Sabiny area had six times higher odds (Table 2).



TABLE 3 | Regression analysis for factors associated with the intention to practise FGM in border areas

	Border areas Univariate (multivariable)											
	Kenya					Uganda			Ethiopia		Somalia	All border areas
	BGM-SABAOT	WEST POKOT	MANDERA	TURKANA	MOYALE	TRANSMARA	ISEBANIA-TARIME	SABINY	DEBUB/SOUTH OMO	MOYALE	BULAHAWA	ALL BORDER AREAS
AGE												
Less than 25												
25–39	1.23 (0.35)	-	0.32 (0.38)	0.70 (0.19)	0.63 (0.02*)	1.13 (0.77)	1.43 (0.68)	0.79 (-)	1.73 (1.39)	0.96 (1.58)	0.78 (0.64)	0.92 (0.39***)
40–60	1.91 (0.56)	0.41 (0.14)	0.57 (0.93)	2.46 (0.79)	0.62 (0.00**)	1.32 (0.62)	1.00 (0.22)	1.17 (-)	4.20 (0.98)	1.75 (2.27)	1.53 (1.26)	1.07(0.35***)
>60	4.36 (0.04)	1.94 (5.47)	0.36 (0.33)	3.83 (5.56)	1.67 (0.01*)	4.33 (4.72)	0.76 (0.15)	1.50 (-)	0.26 (0.05*)	1.50 (5.11)	-	1.42 (0.48*)
Female	0.09*** (0.16)	2.12 (0.69)	2.167* (3.58)	1.28 (2.67)	0.64 (0.31)	0.31* (0.13*)	1.23 (0.62)	1.14 (0.29)	0.95 (0.99)	0.67 (1.22)	0.54 (0.15*)	0.91 (0.72)
EDUCATION												
Church/Quranic												
Adult literacy	-	-	1.45 (2.31)	-	-	-	8.00 (-)	-	-	0.40 (0.23)	0.74 (0.60)	0.69 (0.40*)
Elementary (1–8)	0.72 (1.29)	-	0.52 (0.96)	-	-	-	2.76 (-)	-	0.103** (-)	0.54 (1.13)	0.35 (0.17)	0.56** (0.69)
High school (9–12)	0.59 (-)	0.38 (0.61)	1.21 (1.62)	-	0.46 (0.23)	0.61 (0.82)	2.91 (-)	1.89 (-)	0.31 (-)	0.58 (0.86)	1.15 (0.89)	0.64** (0.62*)
Diploma	-	0.33 (0.99)	0.73 (1.42)	1.09	0.204 (0.207)	2.65 (5.22)	1.60 (-)	0.74 (-)	-	0.59 (0.82)	-	0.35*** (0.34**)
University degree	0.44	-	0.36 (2.66)	-	-	-	-	0.76	-	0.27 (0.32)	-	0.23** (0.14*)
PREVIOUS FGM PRACTICE	2.70* (5.49)	2.36 (0.71)	1.96 (1.49)	7.71* (2.80)	2.60* (5.64*)	2.39 (1.86)	1.75 (9.29*)	10.50* (11.51*)	2.17 (0.80)	-	0.74 (0.14)	2.12*** (1.96**)
PUBLIC DECLARATIONS	1.33 (0.07)	0.34 (0.14)	4.99*** (3.05)	-	0.36 (0.36)	1.31 (0.99)	1.63 (3.05)	0.24* (0.18)	-	0.35	4.52 (10.78*)	1.367 (1.161)
GAP IN LAW IMPLEMENTATION	4.62** (4.59)	2.54 (0.82)	0.99 (0.43)	2.33 (0.36)	1.41 (2.83)	3.78* (2.83)	0.96 (1.08)	0.286** (-)	0.29** (1.69)	1.56 (0.90)	0.87 (0.46)	1.39* (1.49)
EASE OF FGM PRACTICE ACROSS BORDER	4.80** (0.28)	3.78* (11.87)	1.81 (8.91*)	4.80 (1.71)	1.77 (2.43)	1.39 (1.69)	1.52 (4.63)	4.518** (8.10)	0.56 (0.05**)	3.73** (2.89)	1.58 (0.83)	2.41*** (2.62***)
NO PENALTY	1.42 (8.83)	1.91 (2.65)	0.80 (0.46)	8.95* (16.23)	2.20* (4.85)	1.35 (0.23)	2.11 (0.91)	0.58	0.17*** (0.18*)	2.74* (3.41)	0.72 (0.77)	1.21 (0.94)
COMMUNITY LAW ENFORCEMENT	0.09* (0.01*)	0.24* (0.05)	0.28* (0.11**)	0.935 (0.22)	0.43* (0.09**)	0.91 (0.61)	0.89 (0.73)	0.18** (0.27)	-	0.29 (0.25)	-	0.40*** (0.37***)

Notes: *= $p < 0.05$; **= $p < 0.01$; ***= $p < 0.001$; Pokot Amudat excluded due to low response on the intention to practise (only six respondents).

3.1.3 Factors associated with the perception that it is easy to practise FGM across borders

Among all respondents surveyed, compared to respondents with a church or Quranic education, respondents were more likely to perceive that FGM was easy to practise across the border if they had elementary [OR=1.64, $P<0.05$, univariate], high school [OR=2.21 (univariate) and 2.46 (multivariable), $p<0.05$], diploma [OR=2.14 (univariate) and 1.81 (multivariable), $p<0.05$] or university education [OR=2.73 (univariate) and 6.4 (multivariable), $p<0.05$]. Among specific communities, however, significant relationships existed only for respondents with high school and diploma education in Sabiny (Uganda), respondents with diploma education in Pokot Amudat (Uganda) and those with high school education in Isebania–Tarime (Kenya) (Table 4). Other factors with significant differences included having an intention to practise FGM [2.4 times (univariate) and 2.8 times (multivariable)], public declarations [1.30 times, univariate only], gaps in the implementation of laws [4.51 times (univariate) and 3.77 times (multivariable)] and having no penalty enforced if FGM was practised [3.15 (univariate) and 2.81 (multivariable)].

In some communities, significant factors associated with the perception that FGM was easy to practise across the border included: being female in BGM–Saboat (Kenya) [OR=0.18, univariate], West Pokot (Kenya) [OR=0.21, univariate], Mandera (Kenya) [OR=0.21, univariate], Transmara (Kenya) [OR=6.92, multivariable] and Bulahawa (Somalia) [OR=0.22 (univariate) and 0.22 (multivariable)]; having an intention to practise FGM in BGM–Saboat (Kenya) [OR=4.8, univariate], West Pokot (Kenya) [OR=3.84, univariate], Sabiny (Uganda) [OR=4.52, univariate] and Moyale (Ethiopia) [OR=3.58, univariate]; the existence of gaps in the implementation of laws in BGM–Saboat (Kenya) [OR=4.08 (univariate) and 8.36 (multivariable)], Mandera (Kenya) [OR=6.24, univariate], Moyale (Kenya) [OR=5.47, univariate], Transmara (Kenya) [OR=5.58 (univariate) and 8.09 (multivariable)], Isebania–Tarime (Kenya) [OR=5.07, univariate], Sabiny (Uganda) [OR=2.01 (univariate)], Debub/South Omo (Ethiopia) [OR=3.43, univariate], Moyale (Ethiopia) [OR=2.82, univariate] and Bulahawa (Somalia) [OR=5.43 (univariate) and 9.24 (multivariable)]; and no penalty in West Pokot (Kenya) [OR=3.64, univariate], Mandera (Kenya) [OR=3.64, univariate], Moyale (Kenya) [OR=8.50 (univariate) and 9.61 (multivariable)], Sabiny (Uganda) [OR=2.26, univariate] and Pokot Amudat (Uganda) [6.651, univariate]. Factors such as age, education, community law enforcement and public declarations were not significant factors associated with the perception of the easy practice of FGM across borders.



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TABLE 4 | Regression analysis results for factors associated with the perception that it is easy to practise FGM across borders

	Border areas Univariate (multivariable)												
	Kenya				Uganda				Ethiopia		Somalia	Total	
	BGM-SABAOT	WEST POKOT	MANDERA	TURKANA	MOYALE	TRANSMARA	ISEBANIA-TARIME	SABINY	POKOT AMUDAT	DEBUB/SOUTH OMO	MOYALE	BULAHAWA	
AGE													
Less than 25	Ref												
25–39	0.63 (0.84)	0.52 (1.24)	0.29 (0.34)	2.00	0.90 (0.26)	2.51 (3.05)	0.33	1.57 (2.64)	7.45	1.27 (0.33)	0.68 (0.59)	1.19	0.93 (1.04)
40–60	1.28 (6.07)	0.36 (1.77)	0.34 (0.34)	1.50	2.40 (1.33)	1.05 (1.48)	0.17	3.02** (11.09*)	6.09	0.17 (0.02)	0.61 (0.20)	2.32	1.05 (1.68)
>60	1.02 (0.53)	0.33 (0.55)	0.12 (0.06)	8.00	0.96 (0.33)	1.87 (1.67)	0.39	1.55 (1.71)	6.22	0.120* (0.02)	1.21 (0.37)	-	0.79 (1.35)
Female	0.18** (0.39)	3.64** (2.64)	0.21** (0.29)	1.36 (0.83)	1.20 (1.13)	1.68 (6.92*)	3.37 (3.45)	1.12 (1.72)	1.26	0.84 (0.34)	0.59 (0.93)	0.22*** (0.22*)	0.99 (1.34)
EDUCATION													
Church/Quranic	Ref							Ref					
Adult literacy	-	-	-	1	-	-	0.38	0.54	-	1.03 (0.99)	1.53 (0.46)	1.12 (1.35)	
Elementary (1–8)	1.03 (1.33)	-	1.60	-	2.38	2.69	0.56	0.54	-	2.21 (0.54)	1.39 (0.40)	1.64** (1.68)	
High school (9–12)	1.33 (1.36)	2.24 (2.20)	8.00	-	2.67	2.37	11.15*	0.19*	5.36	1.55 (0.49)	2.05 (1.63)	2.21*** (2.46***)	
Diploma	0.60 (-)	2.98 (3.11)	4.80	-	3.00	2.96	1.54	0.24*	26.80**	1.99 (1.84)	0.46 (0.08*)	2.14*** (1.81*)	
University degree	-	-	-	-	-	-	0.19	-	-	1.55 (1.02)	1.25 (0.30)	2.74** (6.37**)	
PREVIOUS FGM PRACTICE	1.02 (1.19)	0.93 (0.93)	0.47 (2.45)	4.33 (2.09)	1.51 (0.91)	0.98 (0.73)	0.44 (0.11*)	0.68 (0.43)	0.68	0.24** (0.09)	-	2.65 (6.61)	0.99 (0.8)
INTENTION TO PRACTISE FGM	4.80** (0.56)	3.84* (6.38)	1.81 (6.07*)	4.80 (3.69)	1.77 (0.94)	1.39 (2.05)	1.52 (3.43)	4.52** (10.22)	-	0.56 (0.22)	3.58** (2.74)	1.58 (0.97)	2.41*** (2.81***)
COMMUNITY LAW ENFORCEMENT	0.27 (0.12)	2.33 (4.06)	1.75 (6.14)	5.85*	1.77 (1.04)	0.62 (0.74)	0.99 (1.97)	0.48 (0.04**)	1.77	0.26 (0.16)	0.83 (0.82)	1.05 (0.73)	
PUBLIC DECLARATIONS	1.07 (0.09)	0.90 (1.05)	0.99 (0.81)	10.40**	1.63 (1.31)	0.90 (1.10)	0.27 (0.18)	1.07 (1.64)	1.07	0.29	0.87 (3.12)	1.31* (0.83)	
WEAK LAWS	4.08** (8.36*)	6.24** (5.62**)	6.24*** (4.47)	4.00 (1.84)	5.47*** (1.01)	5.58** (8.09**)	5.07* (2.65)	2.01* (1.76)	1.52	3.43* (1.22)	2.81* (3.89)	5.43*** (9.24**)	4.51*** (3.77***)
NO PENALTY	2.08 (5.38)	3.64** (2.69)	3.64** (33.71***)	2.56	8.50*** (9.61**)	7.20 (5.89)	1.87 (1.23)	2.26** (0.79)	3.65**	0.65 (0.26)	1.98 (0.93)	6.42 (21.81*)	3.15*** (2.81***)

Note: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

3.2 Themes from focus group discussions

3.2.1 Impacts of laws and penalties on practising FGM

The majority of study participants were aware of laws and penalties associated with performing FGM. For some communities and their members, however, this knowledge is not a deterrent. They are willing to challenge the law and law enforcement. Perceptions of the effectiveness of laws and enforcement differ across border communities. For instance, study participants from Transmara, Isebania–Tarime and Moyale (Kenya) were more likely to view implementation of laws on the Ethiopian and Tanzanian sides as weaker compared to those on the Kenyan side. Men and women aged 35 and older were more likely to challenge laws and less likely to understand why laws should prohibit them from practising FGM.



I know that they move from this side to the other side, like this time when we circumcised most of them went into hiding because it was prohibited on this end. Bullets were heard so majority was scared that they would be arrested. I have a neighbor who took her first daughter to Tanzania at night and had her circumcised around 4 am and brought her back home, this child was circumcised and secretly brought back home on a motorbike. Now the second daughter she took her to be circumcised on our side here in Kenya publicly.”

– Women over age 35 in a focus group discussion in Kuria, Kenya

Furthermore, community members seen to favour abandonment are often perceived as traitors for challenging and reporting cases. The fear of being punished discourages those who are against FGM from reporting or pushes them to do so anonymously to protect themselves from the wrath of perpetrators and community gatekeepers such as elders. Reporting may be harder for daughters and women who depend on their fathers and spouses, respectively, for basic needs, including education to challenge the practice.



I have never heard anyone reporting such a case because girls do fear that where will they go, because the parents threaten not to pay school fees for them.”

– Women over age 35 in a focus group discussion in Kuria, Kenya

Those intending to practise FGM who cannot challenge the law and law enforcement find ways to circumvent the law, including by going across borders to procure the services of FGM performers, and in some instances bribing law enforcers to have their way.



The Pokot ladies [practise FGM] both across in Kenya and here in Uganda. It's common for us for people to cross since we have relatives staying in the other side and it's easy to plan as a family on where the party should be put.”

– Men over age 35 in a focus group discussion in Sabiny, Uganda

3.2.2 Shared norms and customs as facilitators of FGM

A common theme in focus group discussions around the continued practice of FGM was how border communities share common norms, customs and languages. This makes it easy for families intending to have their daughter or female relative mutilated; they can easily communicate and share common reasons for performing FGM.



We invite them because they are our relatives, others are our sisters who have been married in Tanzania and we have also married in Tanzania, and so there is no need to leave them, we invite them to come and celebrate.”

– Men aged 18–34 in a focus group discussion in Kuria, Kenya



I was an assistant to a friend's daughter, and I helped her to go get cut at a place called Nyanderema in Tanzania.”

– Women over age 35 in a focus group discussion in Kuria, Kenya

3.2.3 Proximity, cost and quality of FGM performer service

Other elements not captured in quantitative surveys but reflected in focus group discussions were proximity to FGM performers, and the cost and quality of services. In most cases, communities will reach out to an FGM provider who is closer to them. In some instances, their choice is influenced by the quality of services, including how the provider “handles girls”.



Sometimes you find that this circumciser is good at doing her job, she does not cut them painfully, sometimes they see that this one does not cut well so they take their children to the other side of the border.”

— Women aged 18–34 in a focus group discussion in Kuria, Kenya



If used to exist whereby the circumcisers were few in number hence moved from one side to the other from Bulahawa to Mandera and vice versa.”

— Men over age 35 in a focus group discussion in Bulahawa, Somalia

Cost can influence choices around FGM. In some communities, the cost has gone up due to laws penalizing the practice. They cross the border to find an affordable provider and materials to hold celebrations.



I also heard that one and I heard them say they look at the cost. This round many Tanzanians crossed for FGM because the cost of FGM was low compared to theirs. So it is also because of cost.”

— Men aged 18–34 in a focus group discussion in Kuria, Kenya



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3.3 Discussion

The practice of FGM is changing. Cross-border practice is an increasingly problematic phenomenon that needs to be immediately curtailed in view of achieving the global target of ending FGM by 2030. Institutional reforms such as laws banning FGM and advocacy programmes, across and within communities, have proven effective in reducing the practice in high-prevalence areas. (Raymond and others, 2014; Crisman and others, 2016).

Implementation of reforms and interventions across borders, however, has not been uniform. In the current study, factors associated with intentions to practise FGM are similar to those identified in previous studies. For example, weak implementation of laws and low levels of education have always been associated with FGM (ICRW, 2016), so it was not surprising that these were key elements in cross-border practice.

Rates of intention to practise FGM observed in the current study were somewhat lower when compared to estimated prevalence rates in some border communities. These results could reflect recent declines due to laws and penalties meant to deter the practice (Meroka-Mutua, Mwanga and Olungah, 2020; Shell-Duncan, Gathara and Moore, 2017). In focus group discussions, most participants agreed that new laws and policies have had an impact on how and when FGM is practised. Even those who intended to practise FGM affirmed that anti-FGM laws have made the practice more “dangerous” and “difficult” as well as more expensive and inaccessible. Discussions clarified that enforcement of laws, rather than their enactment, may be the principal reason for changes observed. These results further support the existing perspective that the enactment of anti-FGM laws alone or mere declarations without appropriate enforcement may not be enough to effect desired norm change and subsequent FGM elimination (Sakeah and others, 2019; Johansen and others, 2013).

Intentions to practise FGM and perceptions of the weak implementation of laws or no enforcement of penalties are mostly consistent with prevalence rates in cross-border areas. In most cases, border communities with high intentions to practise FGM have higher prevalence rates than those with low intentions (UNFPA, 2022). For instance, in border communities, such as the Somali of Kenya with high FGM prevalence, the intention to practise FGM was considerably higher than in communities with low prevalence, such as the Pokot (Kenya). Most communities with respondents indicating a high intention to practise FGM, such as the Somali, Kuria and Sabaot, were more likely to perceive that laws are inadequate and that there are no penalties for practising FGM. This belief, though unfortunate, is expected, given that FGM is an entrenched harmful social norm and communities sharing similar beliefs are more likely to circumvent new laws (Achia, 2014; Muteshi, Miller and Belizán, 2016). Further, as observed in focus groups and by UNICEF (2010), community members who attempt to adhere to new rules and/or their enforcement are more likely to face sanctions and stigmatization in their respective communities.

Recently, there has been recognition that to sustain gains in eliminating FGM, policies must be consistent across borders, communities and countries. For example, in 2019, five East African countries, including Ethiopia, Kenya, Somalia, Uganda and the United Republic of Tanzania, signed an interministerial declaration to end FGM in the region. This declaration will ensure continued engagement and collaboration among countries as well as the generation of evidence on cross-border FGM (UNFPA and UNICEF, 2022).

3.4 Study limitations

Sampling for the current study was non-probabilistic as drawing conclusions on overall cross-border practices in the region could prove challenging. To reduce selection bias, a clustering sampling approach was employed to ensure appropriate representation, especially by region, gender and ethnicity. Due to the sensitive nature of the subject, certain questions were deliberately omitted during data collection. For example, questions on whether participants have been involved in cross-border practice were omitted. As such, data collection for the current analysis had to rely on “intention to practise FGM” rather than the actual prevalence of the practice.

In some areas, such as Pokot Amudat (Uganda), the intention to practise FGM was rated as low because of the low response rate on the question (3 per cent). In addition, with few exceptions, most variables included in this study were significant in the univariate or multivariate models but not both, suggesting that other predictors in the model may be impacting associations. Therefore, some of these results should be interpreted with caution, with consideration given to the context in which they are used. Lastly, results were obtained from analysing datasets for a cross-border study meant to provide descriptive data from the four countries mentioned above. Only those datasets from the previous study could be used as covariates in the current analysis.

4 Conclusions

Existing social norms and new phenomena continue to slow the decline and subsequent elimination of FGM. In most border communities, community members acknowledge the existence of anti-FGM laws, although some have a general perception that existing laws and penalties are weak and inadequate to deter FGM. Interventions targeting community/religious leaders and families with a history of FGM; leveraging existing goodwill to abandon FGM; and supporting the enactment and enforcement of laws specific to border areas and reflective of their contexts and the collaborative efforts by governments across borders could all help to accelerate the elimination of the practice.



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Ethics approval and consent to participate

The current study received Research Ethics Board approval from AMREF Health Africa and the National Commission for Science Technology and Innovation in Kenya prior to engagement with study participants for recruitment and/or data collection. Prior to data collection, the study obtained informed consent from all participants. Data collection and management followed the strictest ethical standards.

Declaration

The contents of this publication are the sole responsibility of the authors and can in no way be taken to reflect the views of UNFPA, UNICEF and their partners.

Consent for publication

Not applicable

Availability of data and materials

De-identified data used during this study are available on reasonable request. Due to the complex nature of the current topic and potential harm to participants if their identities are disclosed, certain participants' data may not be shared without further institutional ethics board approval.

Competing interests

The authors declare that they have no competing interests.

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