Article

The Psychological Perspective of Female Genital Mutilation/Cutting (FGM/C) Among Women in Kenya

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Abstract

Despite two decades of legal prohibition, female genital mutilation/cutting (FGM/C) remains entrenched in several Kenyan highland counties and is increasingly recognised as a public mental health issue, not merely a surgical event. Lived experience interviews with 39 adult women in Tharaka-Nithi County (2020) documented the practice's psychological sequelae. Inductive coding isolated four intersecting impact areas: (1) traumatic recall, reported by 33 participants as flashbacks, nightmares, or sensory intrusions tied to the cutting event; (2) depressive withdrawal, described by 31 as chronic sadness, reduced self-worth, and social disengagement; (3) persistent anxiety, with 29 expressing anticipatory fear around childbirth, medical examinations, or community scrutiny; and (4) stigma-driven social limitation, where 28 cited diminished mobility, economic loss, or reluctance to seek care following disclosure. Only five women regarded the ritual as culturally affirming; most narrated ongoing tension between public belonging and private distress. Three service priorities emerged: (a) embed a brief trauma screen and referral protocol into all reproductive health visits; (b) equip sub-county facilities with trained female psychological counsellors able to coordinate counselling across departments; and (c) centre prevention messaging in survivor-led chama [a Swahili word, meaning society or organisation] forums and elder declarations, rather than relying on abstract clinical warnings. Women's testimonies advance psychological understanding of FGM/C and offer practical, rights-based entry points for service design in Kenya and comparable high-prevalence settings.

Keywords: FGM/C; trauma; depression; anxiety; stigma; Kenya

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Introduction

FGM/C is a non-medical cultural practice that involves altering or removing parts of the external female genitalia. It is categorized into four types: Type I (Clitoridectomy) removes part or all of the clitoris; Type II (Excision) removes the clitoris and labia; Type III (Infibulation) narrows the vaginal opening; and Type IV includes other harmful procedures like piercing or scraping (Muhula, Mveyange, Oti, Bande, Kayiaa, Leshore, Kawai, Opanga, Marita, Karanja, and Smet 2021). Kenya's latest Demographic and Health Survey confirms a national FGM/C prevalence of 15 percent, yet district-level surveillance records rates exceeding 40 percent, including Tharaka-Nithi (Austrian, Soler-Hampejsek, Kangwana, Wado, Abuya, and Maluccio 2020). In this county three constituencies frame the practice in sharply different terms. Elders defend cutting as a prerequisite for sexual discipline and bride wealth, a position reiterated in 74 percent of council minutes reviewed in 2021. Human-rights agencies add an economic lens: 62 percent of girls who undergo the procedure leave school before Form Two, and adult earnings fall by roughly one-third, a trajectory UNICEF links to gendered poverty across the life course (UNICEF 2020). All three discourses acknowledge "psychological harm", yet published evidence has been limited to brief screening scales showing elevated depression, post-traumatic stress and social withdrawal (Tammary and Manasi 2023).

Kenya's latest Demographic and Health Survey confirms a national FGM/C prevalence of 15 percent, however, district-level surveillance shows prevalence exceeding 40 percent in the eastern highlands, including Tharaka-Nithi (KDHS 2022). In this county three constituencies frame the practice in sharply different terms. Elders defend cutting as a prerequisite for sexual discipline and bride wealth, a position reiterated in 74 percent of council minutes reviewed in 2021. County clinicians, by contrast, reported 47 obstetric referrals for infibulated women and 33 chronic-pain consultations in 2021; clinical patterns which match the perineal trauma profile outlined by Berg and Underland (2013). Human rights agencies add an economic lens: 62 percent of girls who undergo the procedure leave school before Form Two, and adult earnings fall by roughly one-third, a trajectory UNICEF links to gendered poverty across the life course (UNICEF 2020). All three discourses acknowledge "psychological harm", but, published evidence has been limited to brief screening scales showing elevated depression, post-traumatic stress and social withdrawal (Akinsulure-Smith and Chu 2017).

What remains undocumented is how those screened symptoms play out in routine social and economic activity. This study addresses that gap through lived experience interviews with 39 women who experienced FGM/C before reaching15 and now live in Tharaka-Nithi. Putting individual narratives within communal expectations of fertility, dowry and moral respectability helps to clarify why statutory bans and biomedical risk messages alone failed dismantling a ritual so closely tied to local definitions of adulthood as FGM/C. The current study findings provide actionable evidence to support

the implementation of Kenya's Mental Health (Amendment) Act 2022, emphasising the need for culturally responsive trauma care, also offer valuable insights for county development plans that integrate women's mental health with labour productivity and civic engagement. The guiding question is: How do women in Tharaka-Nithi County experience and interpret the psychological consequences of female genital mutilation/cutting in everyday life?

Methodology

An interpretive, multiple case study was selected because the guiding question required a thick, context-bound explanation of how psychological harm unfolds after FGM/C. Analytic generalisation logic, the design permits triangulation of several evidence streams and extended engagement with participants' conditions survey methods cannot satisfy and can be applied in potentially having a better understanding of a complex intervention (Hong and Fàbregues 2024). Using analytic generalisation logic, the study design permits triangulation of several evidence streams and extended engagement with participants' conditions survey methods. Tharaka-Nithi County's situation in Kenya's eastern highlands, offered a critical case: the 2022 Demographic and Health Survey reports a county prevalence of 42.3% against a national mean of 15%. No published qualitative work had examined psychological outcomes in this setting. Three wards including Chiakariga, Marimanti and Igambang'ombe were purposively selected to maximise variation in altitude, road access and ethnic mix. Fieldwork started from May to September 2020, to avoid the April planting and November harvesting peaks and reduce seasonal barriers to participation.

Sampling and Participants

Criterion-based purposive sampling targeted women aged 18 and above who underwent FGM/C before the age of 15 and were currently residing in the three study wards. Village health volunteers compiled an eligibility list of 64 women. Researchers conducted home visits, provided project information and clarified that non-participation carried no penalty. A total of eight women declined to participate in this study, five due to time constraints and three citing their spouse's disapproval. Sequential recruitment was paired with real-time coding and closed when the codebook showed no additions or redefinitions across three consecutive transcripts, denoting substantive saturation. Final enrolment included 39 participants aged between 18 and 54 years (median 38). Most participants (n = 28) were married. Literacy levels varied from primary (n = 25) to college level (n = 7). Occupations included subsistence farming (n = 33), salaried work (n = 10), informal business (n = 1) and unemployment (n = 5), closely reflecting county-level occupational profiles. Most women (n = 26, or 60.5%) reported dual breadwinning roles with spouses or parents, while 14 (32.6%) identified themselves as sole providers.

Data Collection

A semi-structured lived experience guide, was adapted from WHO's *Mental Health after FGM/C* protocol and piloted with two non-study volunteers, explored childhood FGM/C, acute emotional responses, evolving self-concept, reproductive expectations and current coping. Interviews were held in Ki-Meru, Swahili or English determined by the participants' preferences; with the duration of 70 to140 minutes and were audio recorded after signing of written consent. A brief grounding exercise preceded questioning and a locally trained psychosocial aide was on call for debriefing. Field notes captured setting, non-verbal cues and analytic hunches. Recordings were transcribed verbatim and translated into English when required; 20% of transcripts underwent independent back-translation. Discrepancies were resolved jointly by translator and verifier to preserve semantic fidelity. All digital files were stored on password-protected AES-encrypted drives. Raw data will be destroyed five years after publication.

Analysis

Reflexive thematic analysis followed Braun and Clarke's six-phase procedure (2021). NVivo v.14 was used to support open coding and generated 142 initial codes. Two analysts independently double-coded 15% of transcripts; Krippendorff's $\alpha = 0.82$ indicated acceptable reliability. Codes were aggregated into 27 conceptual categories, reviewed against the full data set, and distilled into four integrative themes. An Excel audit trail documented codebook changes, category merges and theme decisions. Credibility was reinforced through fortnightly peer debrief meetings with two external qualitative scholars and through member checking where: six volunteers reviewed provisional theme labels and affirmed thematic resonance, suggesting only minor wording adjustments. Positional reflexivity was maintained via memo writing; the mixed-gender, cross-ethnic analytic team discussed how clinical backgrounds or insider status might influence interpretation and adjusted coding definitions accordingly.

Ethics and Reflexivity

Ethical clearance was granted by the Tharaka-Nithi County Health Research Unit. Written consent detailed voluntary participation, the right to skip questions, and the option to withdraw before transcription. A referral protocol with the county mental health counsellor was in place; three participants accepted routine appointments, and no urgent transfers were required. Reflexive memos after each interview bracketed prior trauma counselling experience and monitored assumptions about symptom expression; these insights shaped later interviews and final coding. Audio files, transcripts and field notes remain accessible only to the research team and will be destroyed in five years post-publication. We also received ethical clearance from the University of South Africa's, College of Human Sciences Research Ethics Committee.

Limitations and Transferability

Twelve percent of non-participants were younger on average (median age 19) and unmarried, potentially underrepresenting emerging adult perspectives. Lived experience narratives are retrospective and may introduce recall variability, however, triangulation with contextual informants; ten key workers including nurses, midwives and religious leaders, helped validate major timeframes and emotional markers. The saturation-based sample, broad age span, and diverse ward representation strengthen confidence that identified themes reflect common psychological trajectories among women who underwent FGM/C in Tharaka-Nithi. Transferability is strongest for semi-arid, Meru-speaking districts with comparable FGM/C prevalence and marriage norms (e.g., Isiolo, northern Embu). In contrast, low-prevalence urban or coastal counties may differ on stigma dynamics and health access. Any future scaling of interventions should therefore reassess context-specific triggers and peer support infrastructure.

Results

Inductive analysis of the 39 participants' narratives yielded four clinically recognisable themes that trace the psychological course of FGM/C from the moment of tissue removal into later adulthood. The sequence reported by most participants is: (1) traumatic recall, (2) depressive withdrawal, (3) persistent anxiety and (4) stigma-driven social limitation. Each theme is grounded in verbatim or near-verbatim language supplied by the women and is reported with the speaker's pseudonym, age and ward of residence to demonstrate breadth across sub-counties. The descriptive tables (1 to 4) which summarise various participants' demographic characteristics including age, ward, education and experience of health complications, are presented below to contextualise the thematic findings.

Table 1: Age Distribution of Participants (n = 39)

Age group	Frequency	Percentage
18 to 24 years	5	11.6
25 to 34 years	13	32.6
35 to 44 years	9	23.3
45 to 54 years	6	14.0
Above 54 years	7	18.6

Table 2: Distribution by Administrative Ward

Ward	Frequency	Percentage
Chiakariga	3	7.0
Marimanti	1	2.3
Nkondi	4	9.3
Igambang'ombe	31	81.4

Table 3: Level of Education

Education level	Frequency	Percentage
Primary	24	55.8
Secondary	7	16.3
College	8	18.6
University	3	7.0
Others	1	2.3

Table 4: Experience of Long-term Health Complications

Response	Frequency	Percentage
Yes	26	67.4
No	13	32.6

Theme 1: Traumatic Recall

Among the 39 women interviewed in Tharaka-Nithi County, 33 participants (85%) described experiencing persistent psychological trauma directly linked to their FGM/C experience. Traumatic recall through flashbacks, nightmares, panic symptoms and intrusive memories was particularly common and often intensified by sensory triggers and life events such as childbirth and menstruation. Respondent 21 shared: "I had nightmares and flashbacks of the anguish I experienced throughout the treatment. I was anxious and terrified because of that," (Olive, June 2020). Similarly, Respondent 12 shared a vivid memory: "When I close my eyes, I still see that day… how they held me down and the sound of metal. That sound comes back anytime I hear a knife or scissors," (Rhoda, June 2020).

A striking 30 out of the 39 women (77%) reported somatic symptoms such as sleep disturbances, heart palpitations and excessive anxiety. These symptoms align with post-traumatic stress disorder (PTSD) criteria, as discussed in the analysis section. Respondent 35 recounted: "When I went to hospital to deliver, a nurse decided to take a photo from my genital part," (Leah, June 2020). Such traumatisation in clinical settings further entrenched anxiety and fear, making it difficult for survivors to trust caregivers or seek medical help. The link between FGM/C trauma and reproductive events was further confirmed by participants like Respondent 8, who described how menstruation and childbirth triggered vivid memories of the cutting. She stated: "The pain and physical discomfort of the process was too much. It made it hard for me to focus on anything else… and thinking about it even now brings fresh memories of the pain back," (Agnes, June 2020).

An additional factor amplifying psychological harm was the complete lack of anticipatory explanation. None of the participants reported having been informed about the nature or purpose of the procedure prior to undergoing it. The shock of realising

what was happening often after the cutting had already begun was cited as a turning point in the emergence of intrusive memories. Respondent 16 reflected on the moment of realisation: “They said it was just tradition, but when I felt the pain, I knew something was being taken away. That memory doesn’t go,” (Mercy, July 2020). The data confirms that traumatic recall is a central, enduring feature of the psychological aftermath of FGM/C. It underscores the urgency of integrating trauma-informed counselling, especially for women approaching reproductive care, and the preventive value of early psychoeducation in FGM/C-practising communities.

Theme 2: Depressive Withdrawal

A pronounced psychological impact of FGM/C observed among participants was the emergence of sustained depressive symptoms and withdrawal from social life. Of the 39 women interviewed, 31 (approximately 79%) reported enduring feelings of sadness, diminished self-worth and social detachment following their circumcision. These symptoms often co-occurred with anxiety and manifested in interpersonal difficulties, including distrust, isolation and impaired self-image. Respondent 19 described the lasting effects on her emotional life: “After they cut me, I felt unhappy all the time and worried a lot. Making friends and putting my faith in others were difficult for me,” (Angel, May 2020). Similarly, Respondent 30 explained how internalised shame distorted her self-perception: “The shame surrounding FGM/C-related complications makes me feel like I am dirty and unworthy of love or affection. It is a lonely and painful experience,” (Paulina, July 2020).

Many participants expressed emotions of “emptiness” or “incompleteness”, particularly those who underwent infibulation. These feelings were not simply emotional abstractions but had concrete effects on behaviour including avoidance of social situations, rejection of intimacy and disengagement from community life. Respondent 23 revealed: “After the cut, I felt self-conscious about my appearance... To feel happy about me was difficult,” (Joy, May 2020). The psychological toll also extended into the participants’ professional and educational lives. Feelings of inferiority and social anxiety often disrupted schooling or inhibited women’s ability to participate in economic activities. Respondent 28 reported: “Since that day, I don’t talk much. I sit in my house and feel like I am nothing. I lost the energy to even go sell things,” (Tabitha, June 2020).

These narratives illuminate a pattern of depressive withdrawal, grounded in both trauma and reinforced by environmental stigma. Crucially, participants repeatedly attributed their psychological state not only to the cutting itself, but also to its social repercussions, rejection, discrimination and internalised stigma suggesting that depressive withdrawal is a multidimensional consequence of FGM/C that requires both clinical and socio-cultural interventions.

Theme 3: Persistent Anxiety

Among the 39 women interviewed, 29 (74%) expressed ongoing anxiety following their FGM/C experience. This persistent fear was not limited to the cutting moment but resurfaced in multiple phases of life especially during sexual encounters, menstruation, and childbirth. It manifested in physical tension, social withdrawal, panic symptoms, and dread of medical spaces. Respondent 20 offered a vivid description of menstrual and childbirth-related anxiety: "When I have my period, it hurts a lot, and I bleed too much…I think of my days in hospital getting ready to give birth, now that was extremely difficult, I bled too much. Now I don't have any sexual desire," (Betty, May 2020). Her statement reflects how past trauma from FGM/C resurfaced in reproductive health settings, generating new layers of psychological distress.

For many participants, hospital visits and physical examinations triggered intense anxiety. Respondent 17 described: "When I went to hospital and during delivery a nurse called more nurses to watch at me," (Kaana, May 2020). This perceived public scrutiny left her with heightened feelings of embarrassment and vulnerability, which were echoed in other narratives. Social pressure and internalised fear also contributed to anxiety. Respondent 18 noted the unease of coexisting in mixed-status settings: "When a girl child that has undergone FGM/C goes to a school where girls who have not undergone FGM/C go, she feels challenged," (Charity, May 2020). Anxiety in such social contexts created emotional isolation, reinforcing a cycle of shame and exclusion.

The interviews also revealed that many participants internalised a sense of bodily abnormality. This fear often unspoken surfaced in statements describing self-consciousness and dread around intimacy or exposure. As these fears were repeatedly reactivated, many women described becoming hyper-alert or emotionally detached, hallmarks of chronic anxiety and trauma-related stress. The findings highlight that anxiety, among survivors of FGM/C, is neither momentary nor incidental. It is a recurring and embodied experience that resurfaces during critical reproductive milestones. Addressing this form of psychological harm requires not only mental health support but also reform in how health systems engage with survivors—emphasising dignity, privacy and culturally competent care.

Theme 4: Stigma-driven Social Limitation

Stigmatisation emerged as a pervasive and debilitating consequence of FGM/C among participants in Tharaka-Nithi County. About 75% of respondents reported feeling judged, rejected, or ridiculed in healthcare and community settings because of their circumcision status. This stigma severely affected their willingness to seek medical care and participate in social life, thereby compounding the health and development challenges they already faced. Respondent 7 recalled a deeply dehumanising incident: "I went to the hospital after my circumcision and the doctor made fun of me. He called me a dirty girl and said I deserved to be cut. I never went back," (Joyce, July 2020).

This experience of public shaming by a medical professional was echoed by others. Respondent 3 similarly described: “I was treated badly since the doctor called others to come and see my nakedness on that because I was circumcised. I felt embarrassed,” (Mary, June 2020).

Beyond hospitals, stigma extended into schools and public gatherings. Respondent 11 expressed how stigma impacted her social worth: “Even if you are not cut, people still treat you like you are less than them. They call you names and say you are not a real woman,” (Noryne, June 2020). Others noted that the fear of public scrutiny or being labelled “not whole” led them to avoid social spaces entirely, reinforcing isolation and diminished self-confidence. The consequences of stigma were not limited to emotional distress; they had tangible developmental repercussions. Women reported skipping antenatal visits and avoiding skilled birth attendance, contributing to preventable maternal and infant health crises. Respondent 1 noted plainly: “Due to discrimination people fear going to the hospital,” (Ruguru, July 2020).

The data further suggest that this stigma is not accidental but structurally reinforced. Respondent 29 stated: “I received bad treatment...calling other nurses to see how I am circumcised,” (Jane, May 2020). The breach of privacy and confidentiality, especially within health institutions contributed to a widespread loss of trust in public services. This theme highlights how stigma acts as a barrier not only to care but also to broader participation in community life. To break this cycle, public health systems must prioritise respectful, confidential care and incorporate stigma-reduction strategies within sexual and reproductive health programmes. Community sensitisation and anti-discrimination training for health workers are equally critical to ensuring survivors of FGM/C are treated with dignity and compassion.

Summary

The findings from this study illuminate the multifaceted psychological toll of FGM/C among women in Tharaka-Nithi County. Four intersecting themes emerged from participants’ narratives: traumatic recall, depressive withdrawal, persistent anxiety, and stigma-driven limitation. These experiences reveal that the impact of FGM/C extends far beyond the initial act of cutting, infiltrating women’s emotional, social and reproductive lives. Intrusive memories and nightmares persist for years, often reactivated during menstruation, childbirth, or sexual activity. Feelings of shame and incompleteness erode self-esteem and lead to social withdrawal, while anxiety compounds the fear of medical settings and intimacy. Most critically, stigma particularly from healthcare workers discourages women from seeking essential services, deepening the cycle of trauma and exclusion. These narratives underscore the need for trauma-informed care, respectful clinical engagement, and community education to mitigate long-term harm. Without such interventions, FGM/C continues to be both a psychological wound and a structural barrier to women’s health, dignity and development.

Discussion

The psychological impact of FGM/C on women in Tharaka-Nithi County reveals four intersecting trajectories: traumatic recall, depressive withdrawal, persistent anxiety and stigma-driven limitation. What distinguishes these findings are the recurring localised phrases, short, emotionally dense expressions, that encode trauma, disempowerment, and social rupture. These idioms not only confirm global literature but expand it by anchoring psychological injury in cultural context.

Traumatic recall was most often conveyed through sharp, sensory-linked phrases like “I see the pain”, “it comes back at night”, or “I remember the blade”, these symptoms and reflections reflect involuntary re-experiencing. Lever, Ottenheimer, Teysir, Singer, Atkinson and (2019) observed these symptoms predominantly in clinical survivors. Tharaka-Nithi County respondents described triggers in everyday settings: the sound of water in a basin, the cry of a baby, or hospital antiseptic. This diverges from Bedri, Sherfi, Rudwan, Elhadi, Kabiru and Amin (2019) viewed the Sudanese cohort, where flashbacks were mainly sexual. Here, trauma circulates in domestic and labour environments, an important shift indicating that trauma-responsive care must move beyond reproductive health units to community-based spaces.

In cases of depressive withdrawal, the women used stripped-down metaphors such as “I lost my joy”, “no strength to sell” and “I sat and watched the farm”. These illustrate functional impairment, confirming Khalifa’s (2023) finding that survivors often struggle with low mood and diminished economic participation. However, the Tharaka-Nithi County narratives link this emotional state explicitly to income loss. Respondents cited unsold produce, idle tailoring jobs, and missed school fee payments. Berg and Underland (2013) suggest that psychological harm erodes development capacity; these findings illustrate how through micro-failures in the agricultural and informal economy. Crucially, women did not present this state as fixed. Those engaged in chama groups described phrases like “the group helped me forget” and “I started laughing again”. This sense of modifiability contrasts with Bedri’s (2020) Sudanese sample, where depression was seen as a form of divine resignation and instead supports a model where community engagement enables recovery.

Persistent anxiety was articulated through statements like “I feared the check-up”, “they will laugh at me” and “the doctor called others to see”. These expressions reflect not just trauma, but anticipatory dread amplified by humiliation or moral judgement. Women associated clinical settings with surveillance and exposure. WHO’s (2018) technical briefs emphasise medical trauma in FGM/C survivors but overlook the social gaze as a source of psychological strain. In this study, anxiety was reinforced by communal interpretations of childbirth complications as moral failure and a form of secondary trauma. However, chama sessions again emerged as therapeutic spaces, with phrases like “it stopped the pounding” used to describe cognitive relief. This finding supports Berg et. al (2017) advocacy for integrated reproductive and psychosocial care,

while adding that grassroots dialogue may outperform formal therapy in stigma-heavy environments.

Finally, stigma-driven limitation was consistently voiced in terms such as “I felt dirty”, “they know by looking” and “I hid from the group”. These statements encapsulate internalised stigma and its civic consequences. Wenzen et al. (2021) noted similar withdrawal among Kurdish women, but Tharaka-Nithi County data suggest potential for reversal. After a mixed-faith elders’ forum publicly condemned FGM/C stigma, participation in local baraza [a place where public meetings are held] nearly doubled. This aligns with Mathews and Mathews’ (2019) call for culturally grounded professional empathy, and supports the idea that when moral authority shifts, stigma can be undone. It also shows that phrases like “pain is not virtue” can serve as counter-narratives, dislodging silence and re-opening social space for survivors.

The women’s words such as “I see the pain”, “I lost my joy”, “they laughed at me”, “I hid from the group”, offer not just testimony but theoretical tools. They extend existing scholarship by showing that trauma does not merely “reside in the wound” but is re-lived in context, spoken in idiom, and challenged in community (Diallo 2023). Programmes aimed at mental health recovery, stigma reversal and economic reintegration should begin with these phrases because they are both symptom and solution.

Conclusion

Findings confirm that FGM/C in Tharaka-Nithi County imposes a lifelong psychological burden. Four interlocking trajectories; intrusive recall (85%), depressive withdrawal (79%), persistent anxiety (74%), and stigma-based limitation (72%), combine somatic pain, emotional distress and social devaluation into a single, long-running constraint on agency and productivity. These experiences are not confined to dramatic or clinical moments but emerge during routine activities: grain pounding, livestock tending, school bathing and clinic waiting. Trauma, in this context, is domesticated. It inhabits the rhythms of daily life rather than being restricted to intimate or reproductive settings. Despite overlapping symptoms of flashbacks, panic, low mood and genito-pelvic pain, no respondent had ever received a coordinated psychological assessment. The absence of integrated care underscores a critical service gap, particularly in sub-county hospitals where FGM/C-related obstetric and chronic pain referrals are frequent.

Yet amid this burden, the data highlight viable, culturally grounded sites of resilience. Peer-led savings circles (chama), women-staffed reproductive clinics and public declarations by interfaith elders were consistently identified by respondents as moderating distress. Women described feeling less “dirty”, more “heard”, and more able to “talk freely” when supported by these local institutions. These community-level resources offer actionable entry points for policy. Addressing the psychological

consequences of FGM/C must therefore be viewed not as a secondary concern, but as integral to equitable economic development, gender-balanced governance and improved maternal-child health outcomes in the county.

County health planners should embed a six-item trauma screening tool within antenatal, postnatal, and family planning visits and assign at least one female psychological counselling officer per sub-county facility to support women experience both physical and emotional post-cutting complications. In parallel, peer dialogue initiatives within registered chama groups should be formally recognised and supported with micro-grants to fund monthly survivor-led discussions. Public education units and religious councils should co-develop community declarations that reject the notion that reproductive complications signify moral failure. Progress can be monitored through uptake of clinic-based screening, chama participation metrics and trends in women's engagement with baraza and other civic platforms.

Future research should track symptom progression over the life course from adolescence through marriage, childbirth and menopause using longitudinal qualitative methods that capture shifting self-concepts and coping strategies. Implementation science trials could test low-cost delivery models that attach trauma counselling to microcredit meetings, church guilds and community health visits. In addition, mixed-methods evaluation of faith elder declarations would help determine their reach, durability, and potential for stigma reversal. Such lines of inquiry will refine scalable, community-anchored responses capable of reducing the lifetime psychological burden of FGM/C and informing wider regional strategies to embed trauma-informed services into Kenya's primary healthcare system.

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