SOCIO-ECONOMIC DRIVERS OF FEMALE GENITAL CUTTING AMONG THE ABAKURIA OF MIGORI COUNTY, KENYA

RHODA ROBI NCHAGWA

A RESEARCH PAPER SUBMITTED TO THE INSTITUTE OF ANTHROPOLOGY, GENDER AND AFRICAN STUDIES IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF THE DEGREE OF MASTER OF ARTS IN GENDER AND DEVELOPMENT STUDIES.

NOVEMBER, 2018

DECLARATION

This research paper is my original work and has not been presented for examination in any other university.

Signature: _____ Date_____

Rhoda Robi Nchagwa

This research paper has been submitted for examination with my approval as the university supervisor.

Signature: _____ Date _____

Dr. Dalmas Omia

DEDICATION

I dedicate this work to the Almighty God; the far I have come is because of His love, mercy and grace.

To my parents, Richard Nchagwa and Sarah Nchagwa, you are and always will be my source of support and inspiration. Thank you for their prayers and ceaseless support and encouragement through the entire period of the study.

To my siblings, Miriam, Evans, Julius and my Daughter, Mitchelle, you believed in me and constantly reassured me. I dedicate this paper to you.

ACKNOWLEDGEMENTS

First, I would like to thank the Lord Almighty, for the far that He has brought me. I am grateful for His guidance and protection. He is forever wonderful and faithful.

My special gratitude goes to my supervisor Dr. Dalmas Omia for his support and professional guidance throughout the project. Your inputs were intellectually rich and inspirational.

I wish to extend my gratitude to the faculty members at the Institute of Anthropology, Gender and African Studies for their support especially at the time of proposal development and defense. The knowledge I acquired was instrumental to the production of this work.

My incomparable gratitude goes to the DCC Kehancha Mr Maracha for the towering support during data collection. My sincere appreciation goes to my study informants for their cooperation throughout the study period. I valued your openness and outstanding assistance during data collection.

I wish to convey special cognizance to my college mates Mary Bosuben and Becky Oketch for inspiring my work with knowledge, you greatly influenced my passion to carry out the study. Lastly I cannot forget to acknowledge Mr Chacha my best friend for his encouragement and inputs in to the study. I wish you well in your ventures.

TABLE OF CONTENTS

LIST OF ABBREVIATIONS AND ACRONYMS

CBOs	Community Based Organizations
FBOs	Faith Based Organizations
FGM/C	Female Genital Mutilation/Cutting
FHI	Family Health International
HIV	Human Immunodeficiency Virus
INGOs	International Non-Governmental Organizations
KDHS	Kenya Demographic and Health Survey
KNH/UoN	Kenyatta National Hospital/University of Nairobi
NACOSTI	National Commission for science, Technology and Innovation
NGOs	Non-Governmental Organizations
UN	United Nations
UNICEF	United Nations Children's Education Fund
UoN	University of Nairobi
WHO	World Health Organization

ABSTRACT

This is a cross-sectional descriptive study on drivers of female genital cutting among the Abakuria of Migori County, Kenya. The specific objectives of the study include; document the social and economic factors that influence persistence of female genital cutting and establishing the extent to which social and economic factors. The study is premised on structural functionalism theory. The study was conducted with 30 women aged between 18 and 55 years who are purposively sampled and snow-balled. Data was collected through case narrative, focus group discussion and key informant interviews and analyzed thematically in line with the study objectives.

Findings show that the persistence of FGM/C is under the influence of embedded social and economic factors. The social factors include need to conform to social 'order' of FGM/C, stigma for nonconformity, social pressures, FGM/C as a precondition for marriage and the perceptions on a women's sexuality. The economic factors include the financial gain that comes with value of circumcised women especially during marriage and the gain for practitioners.

Although many societies have criminalized the practice of FGM/C, there are socio-economic barriers that frustrate the fight against the practice. It is recommended that stakeholders, through participatory way, hold consultative meeting to increase community buy-in on the need to abandon the practice.

CHAPTER ONE: BACKGROUND TO THE STUDY

1.1 Introduction

Female Genital Mutilation/Cutting (FGM/C) is defined by World Health Organization (WHO) as "the practice that comprises all the procedures that involve partial or total removal of the external genitalia, or other injury to the female genital organs for non-medical reasons" (WHO, 2000:2). UNFPA also defines it as the practice that involves altering or injuring the female genitalia for non-medical reasons (UNFPA, 2016). It's thus a socio-cultural practice that involves alterations on parts of the female genitalia that do not in any way have a medical connection. WHO classified FGM into four broad categories namely: Type I: Partial or total removal of the clitoris and/or the prepuce; Type II: Partial or total removal of the clitoris and labia minora, with or without excision of the labia majora; Type III: Narrowing of the vaginal orifice by cutting and bringing together the labia minora and/or the labia majora to create a type of seal, with or without excision of the clitoris. In most instances, the cut edges of the labia are stitched together, which is referred to as 'infibulation'; and, Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization (WHO, 2008).

Slack (1988) observed that FGM/C has been in existence for more than 2000 years. Although its emergence is not clear, research accounts for how the practice emerged. Mostly, communities and traditional groups with patriarchal cultural setups have been found to have this practice. On one perspective, FGM/C is considered to have religious origin, significance and backing. However, research has revealed that the practice was in existence before Islam and Christianity. Researchers suggest that the practice dates back to 5th century BC in Egypt, where 'Pharaonic circumcision' was used to insinuate some forms of infibulations (Slack, 1988). It is believed by another section of anthropologists that female circumcision was practiced by Equatorial African herders as a measure to cushion young female herders against rape; as a tradition among stone-age people in Equatorial Africa; or as 'an outgrowth of human sacrificial practices; or as a measure to control population (Lightfoot-Klein, 1989: 46). The practice was also reported in Somalia in the early 1600s where it attracted higher prices for female slaves, and in the late 1700s in Egypt where it was believed to prevent pregnancy among women and slaves (Mackie, 1996). However, the fact that FGM is practiced across a broad-spectrum of cultures inclines some

scholars to argue that it is possible that it occurred independently among different populations (Lightfoot-Klein, 1989), with diffusion occasioned by cultural contacts as in the raids and trade.

The severest form, otherwise known as infibulation, is practiced in Sudan, Somalia, parts of Ethiopia, Southern Egypt and by some groups in Northern and Coastal Kenya as well as some parts of West Africa such as Mali. In Kenya, the types frequently performed are I and II (Population Council, 2007). The Population Council (2007) report further notes that even within Kenya, the type of cut also differ by ethnic group. For example, clitoridectomy is practiced by the Abagusii, excision by the Ameru, Agikuyu and Abakuria and infibulation by the Somali, Borana, Rendille and Samburu. Olungah (2007) also observes that the Munyoyaya of Tana River District are also among those communities practicing infibulation.

It is estimated by United Nations Children's Educational Fund (UNICEF) that at least 200 million girls and women alive today living in 30 countries have undergone FGM/C and that millions girls in Africa are at risk each year (UNICEF, 2017). FGM is not just an African problem; in the US, an estimated 507,000 women and girls are either at risk or have undergone FGM/C. In Europe, it affects around 680,000 women and girls (Rora, & Jacobs, 2016). In Sub-Saharan Africa, it is estimated that about 3 million girls are at risk of undergoing FGM/C every year (UNICEF, 2017). In Kenya, FGM/C is widely practiced by ethnic groups mostly found in the Northern part of the country like the Rendille, Somali, Oromo, Gabra; some Bantu communities like the Abakuria and the Abagusii. Some Nilotic communities like the Samburu and subtribes of the Kalenjin also engage in the practice of FGM/C. Several studies (Nyamongo et al., 2008, Khasakala, 2005, Slake, 2008) have shown that FGM/C is motivated by beliefs about what is considered proper sexual behaviour for women and what is necessary to prepare girls for marriage.

The Kenya Demographic and Health Survey (KDHS 2014) revealed that approximately twenty-one percent of women age 15-49 years have been circumcised compared to 27% in 2008-2009, and 32% in 2003. In spite of the steady decline nationally, there are huge differences among regions and ethnicities within the country. The prevalence still remains very high amongst some communities such as the Somali at 94%, Samburu 86%, Kuria 84%, Kisii 84%, and Maasai at 78%. This suggests that the presence or absence of the practice is influenced by factors that are shared among specific population groups within various areas of a country.

Where FGM/C takes place, the meaning attributed to it determines its practice and the age varies by ethnic group. For those that practice it as a transition from childhood to adulthood such as Ameru and Aembu, cutting is normally undertaken around the age of puberty. Among the Abakuria and Samburu, who practice it as a means of denoting that the girl is ready for marriage, the cutting is usually undertaken post-puberty, and can often be when the girl is in her early teens; indeed, FGM/C can sometimes form part of the marriage ritual. Although a few circumcise during infancy (e.g. Taita), several ethnic groups practice FGM/C pre-puberty, between the ages of 6 and 10 years (e.g. Abagusii, Somali, Borana) because they believe that bleeding is minimal, the tissues are soft to cut, the wound will heal faster and the young girls are easier to handle during the process as they are keen to be socially accepted and do not always understand the implications (Jaldesa, 2002, Population Council, 2007).

Some scholars (Isman& Berggren, 2013; Mackie & Le Jeune, 2009) have argued that economic gains associated with FGM play a role in the continuation of FGM/Cutting. The cutting is done by traditional practitioners (circumcisers), commonly elderly women in the community (Isman& Berggren, 2013). The circumcisers get paid for each girl cut and some of them have pursued this as their professions and only source of income. Secondly, during FGM in Kuria, the community and families plan elaborate ceremonies which become lucrative business opportunities. The newly cut girls receive gifts from family friends and relatives, songs are sang in their praise to make it look admirable to those yet to undergo the practice. Moreover, FGM marks transition into adulthood which means the girl is deemed ready for marriage and the dowry that is paid is source of wealth to the family (Mackie & Le Jeune, 2009). Whereas some of the motivation for this practice could be economic, it is a combination of social, economic as well as cultural drivers that ensure the persistence of this practice. Of interest to the current study is how these social and economic divers have sustained the practice of FGM/C among the Abakuria.

1.2 Statement of the Problem

Whereas findings from the most recent Kenya Demographic and Health Survey (KDHS, 2014) on the prevalence of Female Genital Mutilation/Cutting (FGM/C) show a decline in the national prevalence rates from 27% in 2008 to 21% in 2014, evidence suggests the persistence of the practice among certain ethnic communities like the Somali (94%), Samburu (86%), Kuria (84%), Kisii (84%), and Maasai at (78%). Although activists have been championing the abandonment

of FGM/C among the Kuria, grounding their interventions and initiatives on rights-based approach, backed up by the Anti-FGM Prohibition Act of 2011, and other international instruments like the Maputo Protocol, the practice still continues to persist in the community. Several initiatives led by Civil Society Organizations (CSOs) including Community Based Organizations (CBOs), Faith Based Organizations (FBOs) and the administration have failed in their efforts to rid the community of the practice.

There is need to then understand the underlying factors working against the interventionist models championed by various anti-FGM/C actors to understand the persistence of FGM/C. There are isolated social and economic factors deeply rooted within the community's attitudes and perceptions that ensure that the practice continues to thrive in its original form despite the on-going abandonment initiatives. Informed by this background, this study seeks to understand the social and economic drivers that influence the persistence of FGM/C among the Abakuria.

This study therefore seeks to explore the social and economic environments in which FGM/C takes place among the Abakuria. The study was be guided by the following research questions:

i. What social factors influence the persistence of the practice of FGM/C among the Abakuria?
ii. What economic factors influence the persistence of the practice of FGM/C among the Abakuria?

1.3 Study objectives

1.3.1 Overall objective

To investigate the socio-economic drivers of female genital mutilation/cutting among the Kuria in Migori County, Kenya

1.3.2 Specific objectives

i. To document the social factors influencing the persistence of the practice of FGM/C among the Kuria in Migori County, Kenya.
ii. To establish how economic factors like bride wealth, circumcision fee, value of a circumcised girl, poverty etc. influence the persistence of the practice of FGM/C among the Kuria in Migori County, Kenya.

1.4 Assumptions of the Study

1. Marriageability is a major social driver of FGM/C among the Abakuria.
2. High bride price/gifting during the season is a major economic driver of FGM/C among the Abakuria.

1.5 Justification of the Study

This study on the social and economic factors that influence the persistence of FGM/C among the Kuria living in Migori County could show the people's understanding of FGM/C, while exposing the factors that are influential in the persistence. An understanding of the underlying drivers that perpetuate FGM/C could help in the development of evidence-based interventions. The study findings could be used by anti-FGM/C activists like FBOs, CBOs, NGOs, I NGOs and the State to come up with evidence based policies and action plans that are culturally-responsive. This study identified the economic constraints in the elimination of this practice hence the findings were used to come up with relevant initiatives that are acceptable to the people themselves based on their socio-economic perceptions. The study findings contributed to the existing body of knowledge on FGM/C, its sustaining socio-economic factors, and reliable efforts in its abandonment.

1.6 Scope and Limitations of the study

The study addressed the social and economic drivers of FGM/C specifically among the Kuria living in Migori County. The study focused on exploring the social as well as economic factors that contribute to the persistence of the practice of FGM/C among the Kuria.

The study employed qualitative techniques. 30 case narratives were conducted to ascertain the nature of how the social and economic factors play out in the practice of FGM/C among the Kuria. Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) was used to obtain qualitative information on the nature of the study topic. Community leaders, individuals leading initiatives against FGM/C, circumcisers and community elders formed part of the study as key informants. The selection was on a voluntary basis using appropriate sampling methodology as is detailed in chapter three.

The main limitation of this study was its sensitive nature as it involves obtaining information on a cultural practice that affects the lives of women and girls on a practice that the law considers illegal hence the participants would find it difficult to share information. In order to overcome this challenge, issues of confidentiality and anonymity were emphasized as consent was sought from participants in the study. The study instruments were administered in a private manner in their houses so as to ensure the participants feel confident enough to share information openly.

1.7 Definition of terms

FGM/C – The UN accepted term used to refer to the practice of female circumcision; it takes care of the human rights approach and also the cultural rights of practicing communities.

Adolescent: individuals aged 13-18 years.

Economic determinants: Factors associated with income, wealth or commodities such as socioeconomic status, unemployment, poverty, etc.

Sexual activity: The cognitive, emotional, behavioral and biological aspects that include personal bonding, sharing of emotions and the physiology of the reproductive system, sex drive, sexual intercourse among all forms of sexual behavior

Social determinants: Factors related to society or its organization such as culture, age, race, peer pressure, religion, dating behavior, family characteristics, parental support and control among others.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter reviews the existing literature relevant to the research problem. The literature is reviewed using the following headings: The social drivers of female genital mutilation or cutting among the practicing communities; and, economic drivers that motivate the persistence of the practice of FGM/C. This chapter further discusses the theoretical framework and its relevance to the study.

2.2 Social Factors Influencing the Practice of FGM/C

In spite of the unknown origin of the practice and the efforts put towards its eradication, FGM/C prevails among many African communities often preserved by the very women it harms most. Certainly, there are latent factors of social nature responsible for enabling continuity of the practice in the current context. Strengthened by myths and beliefs, these social drivers of FGM include a community's traditions and culture, their perception towards female sexuality, their understanding of gender identity, their religion and their norms and customs (Khasakhala, 2008).

Foremost in the maintenance of FGM/C in many current societies is the very culture that codes this practice into the communities' cannon of necessary ritual. Among the Odi community of the Izon ethnic group of Bayelsa state Nigeria, the belief is that female circumcision is a mark of a genuine Izon woman (Atibinye, Loveth, & Uzere, 2014). An uncircumcised Female is an outcast and unworthy of being part of the community. The view is that since it is a tradition handed down from their ancestors, it is a defining hallmark of being Icon (Atibinye, Loveth, & Uzere, 2014).

A cultural justification among the Beja of Eastern Sudan is a myth that the uncut female is easy prey for 'evil spirits and thus circumcision in the first week of life acts to remedy this (Ismail, 2011). With culture and tradition in mind the foundation for the continuation if FGM/C is comprehensible.

Closely in line with culture in driving FGM/C, are the concepts of sexuality and marriageability within the practicing community. As a rite of passage in most practicing communities, FGM/C heralds womanhood for the girl and signals her availability for marriage. Moreover, there is the belief by some societies that the practice ensures virginity for marriage, and that it curtails female sexual desire. Among the Somali and Borana (Olungah, 2008), the view is that an uncut woman

has a high potential for promiscuity due to the myth that the intact clitoris grows with time and hence becomes vulnerable to stimulation thus causing the uncut woman to engage in premarital sex. Further, these communities believe that the narrowing of the vaginal opening (infibulation) enhances male sexual pleasure thus reducing instances of divorce and infidelity. In this light FGM/C serves the purpose of pleasing the males in the society, a hallmark of patriarchy. Failure to conform to the social norms lead to forceful circumcision that often involves a lot of violence toward the victims. Many of the times FGM/C was to pave the way for a marriage that comes years before it is due. The men make partners that are more suitable for girls who have undergone FGM/C.

Another social factor driving the prevalence of FGM/C is the practicing community's religion. It is important to note that no religion supports this practice though many societies cite religion as a basis for the act. Many Muslim communities especially carry out the practice under the misguided notion that their holy teachings proscribe it. FGM/C has acquired a religious dimension because it is in practice extensively among Muslims in FGM/C practicing countries. Furthermore, some religious terms are used to describe it, as the popular term to describe FGM/C is *tohara*, which means in Islam (ritual cleanliness). There is a deep-rooted belief that uncut women cannot reach this state of cleanliness because the clitoris grew forming skin folds, which stashes hard to remove dirt that prevents absolute cleanliness that is a prerequisite for engaging in prayer (Abdi, 2007).

Ahmadu (2000) observed that socially valued images of physical beauty and sexuality have enabled the perpetuation of FGM/C. While these images differ among social groups and different ages, there are concrete or symbolic aspects of female genital cutting that reinforce cultural conceptions of beauty in any given setting. Consequently, the fear of being ugly or masculine interferes with proposals for modification or elimination of the practice. Aesthetic and cosmetic preferences are not trivial matters, as opinions about body hair, tissue flaps and smoothness, may be as salient to a sense of bodily beauty as tattooing one's lips, using lipstick, blacking eye lashes, and other such practices. Although this area of the body normally is not visible, even to one's husband, it is considered sensual to be smooth, free of hair, and well scented hence the pressure on most women to conform with the stereotypes.

For some communities that practice FGM/C, whether it is shrouded in rituals and celebrations, or whether it involves a visit to the local midwife, FGM/C is an integral part of a girl's social development. The practice is deeply embedded in the social norms of the community and there is immense social pressure on all young girls to conform. A girl who does not undergo FGM/C is likely to be severely socially penalized, and is often despised, taunted, ostracized and made the target of ridicule. No one in her community may want to marry her, and what is clearly understood to be her life's work - marriage and childbearing - will be denied to her (Shell-Duncan and Hernlund, 2000; Abdulcadir, 2017). These social pressures imposed on individuals through family and community members makes girls outcasts, forced to leave their community or are forced sometimes physically to undergo the operation (Khasakhala, 2008). Thus the fear of stigmatization within the host society's cultural norms in regards to the integrity and rights of girls and women's bodies as well as the overt perceptions that FGM/C is a deviant practice that requires criminalization has been documented to inadvertently limit women and men from discouraging FGM/C.

2.3 Economic Drivers of Female Genital Mutilation/Cutting

The prevalence of FGM/C tends to be linked to the household economic level. The parental socio-economic level is a significant factor determining FGM/C practice in Sudan (Almorth, 2005). A study among adolescents (13-19 years) in Khartoum found a strong association between the economic status of the parents and the state of FGM/C of the daughters. Most of the girls with parents of high socio-economic status were not cut while the majorities (91%) of those with parents of lower socio-economic status were cut (Abdel Magied *et al.* 2003). Similarly, in Burkina Faso, the probability a daughter will be cut is lower among richer families than among poor families (Ouedraogo, 2009).

Surprisingly, in Sudan SHHS results showed that the percentage of women (aged 15-49 years) who had any form of FGM/C among those from the poorest households was 57% while it was 77.6% among those from the richest households (SHHS 2006). This may be due to confounding by ethnicity or regions. A study carried out in Egypt found that the socioeconomic level of the parents has no influence on the incidence of FGM/C (Rasheed *et al.* 2011). This may be due to the high prevalence of FGM/C in Egypt.

Abdi (2007) also observed that the commercialization of the practice among the Somalis where more bride wealth is earned by the girl's family if she has undergone FGM/C sustains the practice. This increases pressure from family members to ensure there is conformity by their daughters. Due to this, parents push their daughters to undergo the cut to ensure maximum benefit from the in-laws. On the same note, Moranga (2014) posits that the preference for girls who have undergone FGM/C has led to the persistence of the practice due to the higher bride wealth offered. The Abagusii believe that FGM/C was to control a girl's sexual desires and ensure marital fidelity, especially within polygamous marriages, hence a factor given priority when choosing a partner. The number of cows for uncircumcised women is less compared to that of circumcised women. The bride wealth payment for uncircumcised women may also be delayed despite the woman being already staying in marriage.

Women and girls are normally less educated than men, and have limited job opportunities, especially outside urban centres, hence they have no or few options and would find it difficult to survive without the approval of their community (Landinfo, 2008). According to Nwakeze, women's sexuality is influenced by their limited decision-making power, and the decision making power is a function of their economic independence (Nwakeze, 2001). Along the same line, uncut daughters are not eligible for marriage where FGM/C is a common practice in the community. They may be seen as an extra burden on their parents and to avoid this, parents prefer to cut their daughters (Moges, 2003). This may explain how the economic status of women influences their decision.

On the other side, the circumcisers also play a considerable role in promoting and maintaining FGM/C practice especially in rural areas. Their business provides them with a social status and a regular income in the community (Moges 2003). For instance, in the cases of reinfibulation, some women in Sudan claimed that the midwives are the major decision maker since they are being paid, and a few women stated that the midwife had automatically reinfibulated them after delivery (Berggren *et al.* 2006). In Egypt, a study among practitioners who perform FGM/C revealed that 30% of them perform it only for profit (Refaat, 2009).

According to Moranga (2014), the preference for girls who have undergone FGM/C has led to the persistence of the practice due to the higher bride wealth offered. The Abagusii believe that FGM/C was to control a girl's sexual desires and ensure marital fidelity, especially within polygamous marriages, hence a factor given priority when choosing a partner. The number of cows for uncircumcised women is less compared to that of circumcised women. The bride wealth payment for uncircumcised women may also be delayed despite the woman being already staying in marriage.

Shell-Duncan and Hernlund (2000) observed that in most communities where FGM/C is deeply-rooted, it is a precondition for marriage. Marriage is the only option for most women for a normal life. An uncircumcised girl is not eligible for marriage and may be a burden on her parents as no one member of the community was to dare to marry her. There is no future for a woman in the community without meeting its set values, in this case the operation. Marriage, being vital to a woman's social and economic survival, ensures the persistence of the practice.

The specialists who cut girls enjoy social and economic benefits in terms of prestige and payment. In Egypt and Sudan for instance, rural midwives have not historically been paid but they receive gifts in kind- soap or scents as a show of appreciation and compensation (Pasquinelli, 2004).
While there have been major attempts to classify these drivers in terms of being social, cultural or economic, literature reviewed indicates that these factors are not mutually exclusive and play out in a combined manner to influence the practice.

2.4 Theoretical Framework

2.4.1 Structural Functionalism theory

Structural functionalism is a framework for building theory that sees society as a complex system whose parts work together to promote solidarity and stability. This theory was developed as a follow up to the preliminary functionalist thoughts Emile Durkheim, Radcliffe-Brown and Herbert Spencer. It offers a perspective that sees society as a complex system whose parts work together to promote solidarity and stability. It asserts that individuals' lives are guided by social structures, which are relatively stable patterns of social behavior. Social structures give shape to people's lives - for example, in families, the community, and through religious organizations. And certain rituals, such as initiation rites or complex religious ceremonies, give structure to our everyday lives. Each social structure has social functions, or consequences for the operation of society as a whole. Education, for example, has several important functions in a society, such as socialization, learning (Macionis, 2012).

Barnard (2000) notes that in the functionalist perspective, societies are thought to function like organisms, with various social institutions working together like organs to maintain and reproduce them. The various parts of society are assumed to work together naturally and automatically to maintain overall social equilibrium. Because social institutions are functionally integrated to form a stable system, a change in one institution wasprecipitating a change in other institutions. Dysfunctional institutions, which do not contribute to the overall maintenance of a society, will cease to exist.

Robert K. Merton (1957) argued that functionalism is about the more static or concrete aspects of society, institutions like government or religions. However, any group large enough to be a social institution is included in Structural Functionalist thinking, from religious denominations to sports clubs and everything in between. Structural Functionalism asserts that the way society is organized is the most natural and efficient way for it to be organized. To Merton, institutions come about and persist because they play a function in society, promoting stability and integration. Therefore, structural-functionalism often focuses on the ways social structures (e.g., social institutions like FGM/C, marriage etc.) meet social needs.

Rahman and Toubia (2000) used this theory to examine FGM/C as a complex and deeply rooted traditional practice that, while infringes the rights of women and children, is a fundamental part of collective cultural experience that relates to the essence of a girl's womanhood, family honor, economic prosperity, and social identity. Human behaviors and cultural values, however senseless or destructive they may appear from the personal and cultural standpoint of others, may have meaning and fulfill a function for those who practice them. However culture is not static but it is constant flux adapting and reforming. People were to change their behavior when they understand that hazards and indignity of harmful practices and when giving up meaningful aspects of their culture. In terms of FGM/C, this theory has been used to explain or understand cultural norms around cutting of female genitalia in terms of what the expected behavior is and how it is shaped depending on different institutions such as the family, education, economy etc.

2.4.2 Relevance the theory to the study

Structural functionalism theory can be used to understand social and economic determinants of the persistence of FGM/C such as culture, peer pressure, family pressure, poverty, education of the parents and girls, various influences of opinion shapers and religious leaders etc. This theory is used to understand choices that are not well informed or individuals who make choices that are easily swayed by different misperceptions around realities around them due to their socialization on the basis of existing structures within the society and the functions that these structures play.This theory was used to understand how the FGM/C as a structure plays out in the aspirations of other key actors within the FGM/C cycle.

2.5 Conceptual framework

The conceptualization of this study is that the interaction between socio and economic factors has affected the persistence of FGM/C among the Kuria of Migori County. In this study, social factors and economic factors form the independent variables of the study while the practice of FGM/C is the dependent variable. In an ideal world, social and economic factors are expected to impact on the practice of FGM/C. This relationship of variables is presented in a conceptual framework as shown in Figure 2.1.

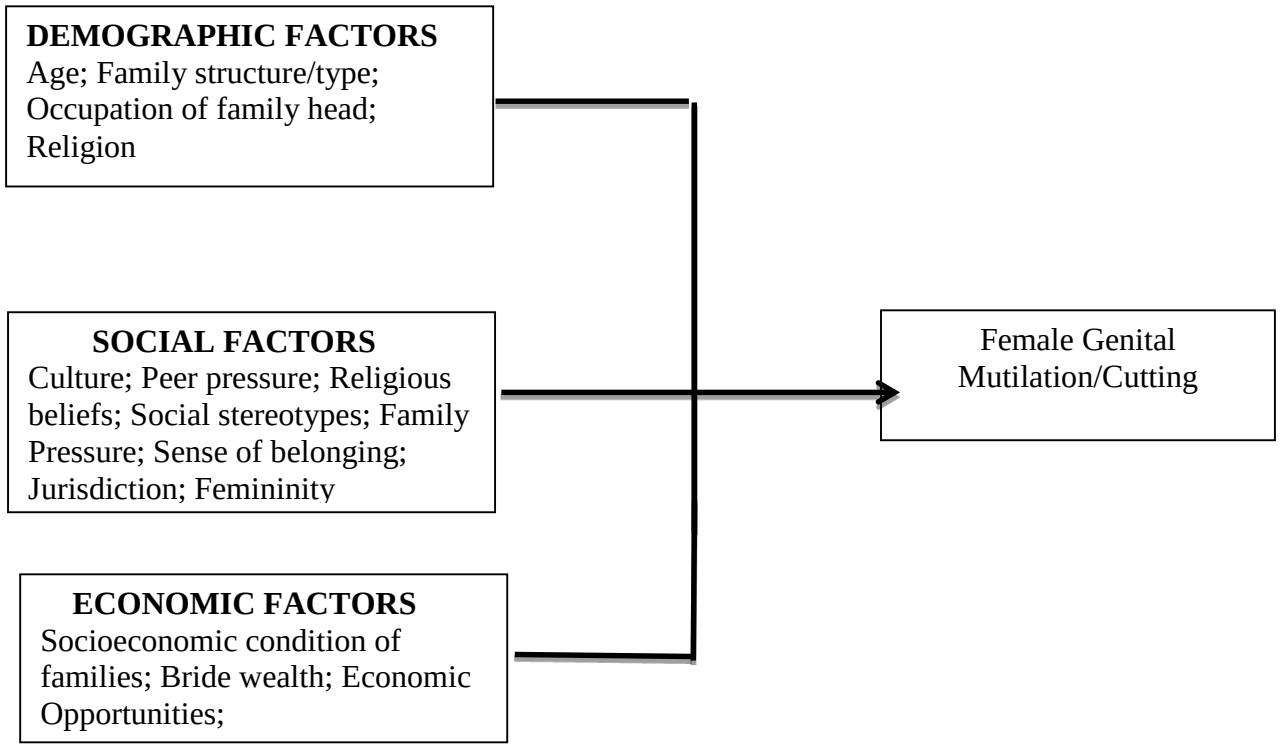

Figure 2.1 Conceptual Framework (Source: Author)

CHAPTER THREE: METHODOLOGY

3.1 Introduction

The site of the study, methodology of the study, the study design and the study population are described in this chapter. The chapter also describes the sampling procedure, sample size, data collection methods and data analysis techniques. Finally, the chapter discusses ethical considerations that were to guide the study.

3.2 Research site

Kuria West is located in Migori County, western Kenya and has a population of 162,857 as per the National Population Census of 2009. While the constituency is harbored by different communities, the Kuria are dominant. It comprises 8 wards (Gokeharaka/Getambwega, Nyamosense/Komsomol, Tagare, Masaba, Mokerero, Isibania, Bukira Central/Ikerege and Bukira East). The inhabitants include Suba-Luos, Luos, Kuria, Abagusii, Luhya, Somalis, small pockets of Indians, Arabs, and Nubians. In Migori County, Kuria West has one of the worst poverty levels (61%) (Soft Kenya, 2017).

The constituency is characterized by low literacy levels with only about 11% having accessed formal education to a secondary level of education or above. The main economic activities include agriculture, fishing, manufacturing and mining. There is some small scale gold mining carried out in the country (Soft Kenya, 2017).

Figure 3.1: Map showing the position of Kuria West Constituency

Source: Soft Kenya 2017

3.2.1 Socio-cultural practices of the Abakuria

Kuria are from the Bantu Language group in Kenya. They are traditionally farmers, mainly planting maize, beans and Cassava as food crops. For cash crops, the Kuria community mainly grows tobacco due to the near location of the BAT tobacco company. They are also cattle herders The Kuria are closely related to the Kisii people of Kenya both in language and physique. They are said to have been one people until a vicious attack by the Maasai in the early 19th century scattered both populations in different directions. This apartness has led to the formation of distinct dialects which are clearly understood by both peoples. The Kuria people are divided into about 16 "subtribes" or clans, namely: Nyabasi, Bakira, Bairege, Bagumbe (who reside in both Kenyan and Tanzanian districts), Batimbaru, Banyamongo, Bakenye, Baikoma, Bamerani, as well as several others. All these subtribes or clans are present in the Abagusii tribe of Kenya (Oloo, 2016).

They share some cultural aspects and various customs. Some of them include circumcision for both sexes. Traditionally circumcision was done at the age around 13 years, just when puberty began. As a rite of passage Circumcision is a central institution in the lives of Kuria people as well as other people which constitutes the transition from childhood to adulthood, marking the changed status of an individual and his or her family, with the concomitant changes in roles, responsibilities, control, and power (Oloo, 2016).

3.2.2 FGM/C prevalence among the Abakuria

The Kuria, living in Migori County at the border of the larger Suba, Migori and Rongo districts is among ethnic communities in Kenya who owe their distinction to rampant Female Genital Mutilation (FGM), practiced quite vastly on girls between the age of 8 and 15 years. According to community elders and non-governmental organisations working in Kuria District, the central purpose of this practice is to initiate a girl into womanhood and adulthood as a vital rite of passage. FGM practice has been propagated by such numerous factors as empowerment of one's social status and reducing a woman's sexual desires among others. But Ms Margaret NkorogoGati, the deputy head teacher at ChachaMoroa Primary School, says the practice has far reaching effects on girls in the community, which range from social, cultural, economic, health and education.

"The rights of Kuria women continue to be abused by the culture of FGM which is a stumbling block to the girl child's pursuit of education and economic advancement. Once the girls undergo the practice at a tender age they are forced into marriage hence they drop out of school and are unable to enjoy opportunities that good education brings people," says Nkorogo. Although there have been efforts from the government and civil society to fight the practice, the community has remained rigid because of the social stigma that is associated with girls who refuse to undergo the rite. The girls known as mosogane – a derogatory word for uncircumcised girl – are barred from attending social functions, getting vegetables from the farm or drawing water from same water points as their colleagues who have undergone the rite. "Young men from the community also shy away from uncircumcised girls and despite its dangers being known to them the fear of losing out on marriage exerts a lot of pressure on them to be circumcised," says Nkorogo.

However, there has been a new impetus in the struggle to save the girls from the harmful cultural practices following a project by Action Aid International Kenya in Kuria. Through the Kuria Local Rights Programme (LRP), Action Aid has been implementing the Safe Schools for Girls (SSG) project aimed at ensuring girls are able to enjoy their rights to education and participate in a violence-free environment for better learning outcomes.

Kuria LRP Manager, Ms. Lina Moraa, says the two-year project was established in 2013 to enlighten girls on their rights and empower them to hold the schools and their communities accountable for safer environment. Moraa says Action Aid wanted to strengthen the capacity of communities and their institutions to advocate for violence- free environment for girls in schools. "We realised that the girl child in Kuria was under risk from FGM and early marriages and the most feasible way of helping them out of the situation was to make the schools safe havens for them. We work with the girls to acknowledge the cultural issues they go through and the impact they have on their health and education," says Moraa.

3.3 Research design

This was a cross-sectional descriptive study using qualitative data collection methods. Cross-sectional are often used to assess the prevalence of acute or chronic conditions they also may

involve special data collection, including questions about the past, but they often rely on data originally collected for other purposes. Qualitative data was collected through case narratives, focus group discussion and key informant interviews which gave the respondents time to open up and explain more on the same. Qualitative data was transcribed, coded and then analyzed thematically in line with the study objectives.

3.4 Study population and unit of analysis

The study targets adult women aged 18 years above residing in Kuria West Sub-County because of their phenomenological experiences around FGM/C in the community. The unit of analysis was the individual Kuria woman in Kuria West. The main logic behind the choice of this group was due to the fact that they have experienced the pros and cons of being circumcised and not being circumcised.

3.5 Sample size and sampling procedure

The study targeted 30 women based on Blalock (1972) sampling model who have undergone FGM/C but are now advocating against FGM/C to be participants in the case narratives. Purposive sampling was used to select study participants. The selection was on the basis of snowball sampling hence one woman, upon completion of the narrative, introduced the researcher to the next participant.

3.6 Data collection methods

3.6.1 Case narratives

A case narrative guide (APPENDIX II) was used to capture the social and economic determinants of the persistence of FGM/C among the Kuria of Migori County. Case narratives were conducted with these women to document their phenomenological experiences of the social and economic factors influencing the persistence of this practice.

3.6.2 Focus group discussions

An FGD guide (Appendix 3) was used to collect data to ascertain group dynamics on the social and economic drivers of FGM/C. Four (4) focus group discussions were conducted. Men were mobilized from *bodaboda* groups while women were from the various table banking and market associations in Kuria West. So as to be in the FGD, a participant must be 18 years and above

from the Kuria with knowledge on the social and economic factors influencing FGM/C. Each FGD consisted of 8-12 participants.

3.6.3 Key informant interviews

A key informant interview guide (Appendix 4) was used to capture key information on the social and cultural norms that perpetuate the practice of FGM/C among the Kuria. Local leaders, religious leaders, abandonment champions and community elders (*Ilchama*) were targeted for the KIIs. The KIIs generated information on the how proceeds from FGM/C in the form of circumcision fee and gifts sustain the practice; how bride wealth is influenced by the practice; the sustaining social factors of the practice; and the influence of family and social networks on girls and women to be circumcised. Such information was recorded with the permission of the key informant to enable the researcher capture all the data. This was guided by the fact that they have interacted with the social and economic factors and perceptions about FGM/C. Their knowledgeable background on the study topic was the basic qualifier for being included as key informants. 5 KIIs were conducted.

3.6.4 Secondary Sources

Relevant sources of secondary information have been used to inform this study proposal such as publications by WHO, UNFPA, UNICEF, among others have and are continuously being used to enrich the findings of this study so as to get a better understanding of the social and economic factors that influence the persistence of FGM/C. This included published books and journals as well as unpublished work on the subject matter.

3.7 Data processing and analysis

Qualitative data was transcribed, coded and analysed by using Nvivo. Audio recordings collected during in case a narrative, KIIs and FGDs was transcribed and where they are not in English, they were translated. This data was then coded and analysed thematically. Themes and content that reveal findings to the question of the study were categorized together.

3.8 Ethical considerations

The researcher obtained ethical clearance from the KNH/UoN Review Board based on the emotive nature of this study to ensure it meets the ethical threshold. A research permit from the National Council for Science Technology and Innovation (NACOSTI) was sought. Before

administering the study tools, the researcher explained to the participants of the study the nature and purpose of the research. An informed consent was sought and a consent form signed before any tool was administered. They were informed that their participation in the study was voluntary and that they were free to withdraw from the study at any time if they wished. Permission was obtained from informants before any recording of interviews as well. The researcher guaranteed the participants to observe the principles of confidentiality and anonymity throughout the study by using codes and pseudonyms to protect their identity. The results of this study were made available at the library services of the University of Nairobi as a project and publications disseminated to the scientific community.

CHAPTER FOUR: SOCIO-ECONOMIC DRIVERS OF FEMALE GENITAL CUTTING

4.1 Introduction

This chapter presents the research findings on the drivers of FGM/C and it is divided into two sections. The first section is a presentation of the participants' socio-demographic characteristics while the second section is a presentation of the study findings based on the research objectives.

4.2. Socio- characteristics of respondents

4.2.1 Age of respondents

Majority of the respondents were aged between 41 and 50 years, accounting for 40% (Table 4.1). Only 10% were aged 51 years and above.

In the study, a woman's age was important in understanding the group dynamics on the social and economic factors influencing FGM/C. Findings show that 50% of women who have undergone FGM/C were aged between 31-40, 30% and 35% aged between 18 and 30.

Table 4.1: Respondents Age

Age Category (years)	Frequency (n)	Percentage (%)
18-30	7	23.3
31-40	8	26.7
41-50	12	40
51+	3	10
Total	**30**	**100**

4.2.2 Marital Status

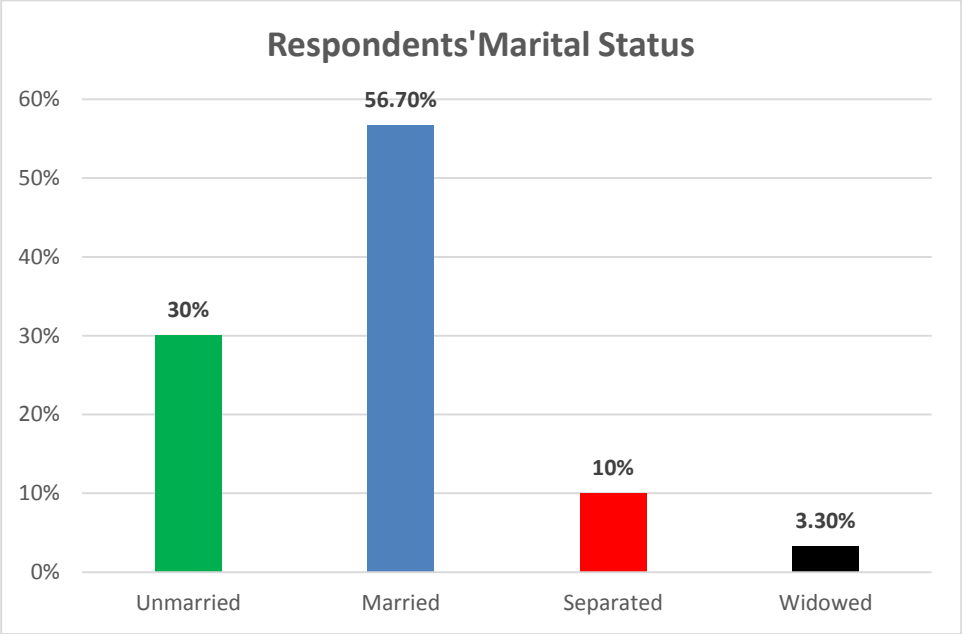

Figure 4.2: Marital Status of Respondents

Most of the respondents (56.7) were married while only 3.3% were widowed. The unmarried group accounted for 30% while respondents who reported separated status accounted for 10% (Figure 4.2).

In the study, marital status was intricately associated with the practice of FGM/C. This is because the practice is a signifier of transition including change in marital status. The findings showed that FGM/C prepares girls for marriage.

4.2.3 Level of Education

In the level of education, most of the participants (36.7%) have Primary level of education while the Secondary level accounted for 33.3% (Figure 4.3). There were respondents who reported not to have formal education and have not attended school. These accounted for 6.7% of the respondents. Only 23.3% reported College/university as the highest level of education (Figure 4.3)

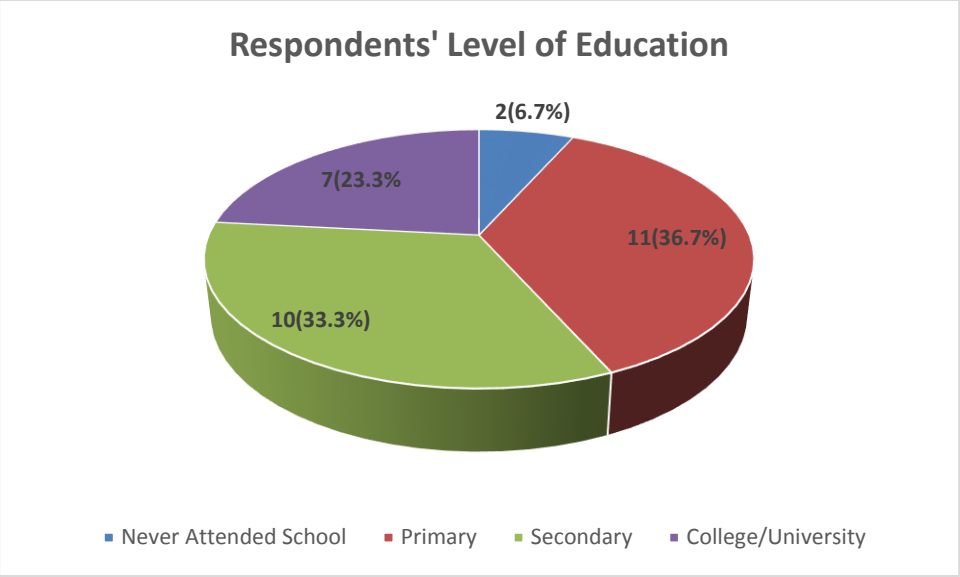

Figure 4.3: Respondents Level of Education

The level of education was found to influence the practice of FGM/C. Essentially, education and school delayed FGM/C and respondents who reported higher levels of education had negative attitude towards FGM. Consider the quote from a focus group discussion.

My children are at school and are not exposed to the environment where they can be cut. At school they are taught about the danger of cutting (FGM). I also learn about it (dangers) in college so I cannot cut her (FGD 1 Discussant 30 years)

The link between education and FGM/C was reinforced by a Key informant.

> Education plays a role in fighting FGM. Well educated parents do not cut girls. Those with low education levels are more likely to do it (FGM/C) (KII 2)

However, not all cases showed this trend as illustrated by the quote below.

> Education is good but you find that it might not help since some educated parents still insist on passing their girls through the ritual (KII 1 Female)

Thus, low level of education might not necessarily be a driver of FGM/C.

4.2.4 Respondents' Occupation

Table 4.2: Respondents' occupation

Occupation	Frequency (n)	Percentage (%)
Formal Employment	4	13.3
Business/Self employed	5	16.7
Informal Employment	15	50
Unemployed	6	20
Total	**30**	**100**

The respondents' occupation was categorized in four classes. Formal employment consisted of respondents who reported to professional work and whose payment is salary. This accounted for only 13.3%. The respondents who reported to earn living through business activities such as operating kiosks and agribusiness were classified as Business/Self-employed and accounted for 16.7% of all the respondents. Informal employment category consisted of respondents who reported to work informally (casual jobs) whose payment is daily or weekly (wage). These accounted for 50%. There were respondents who reported not to engage in any income generating activity and depended on family or community members. These were classified under unemployed and accounted for 20%.

In the findings, occupation is shown to have an economic influence of FGM/C.

4.2.5 Religion

Table 4.3 shows the religious affiliation of the respondents. Majority of the respondents were Protestants (36.7%) while only 10% were Muslims. Catholic respondents accounted for 30% while other African denominations accounted for 23.3% (Table 4.3).

Table 4.3 Religious affiliation of respondents

Religious Affiliation	Frequency (n)	Percentage (%)
Catholic	9	30
Protestant	11	36.7
Muslim	3	10
Other	7	23.3
Total	30	100

Religion was however not shown to be an important driver of FGM/C.

4.3 Social Factors Influencing the Persistence of the Practice of FGM/C

Findings show that FGM/C is influenced by numerous social factors that also act as drivers for the practice's persistence. The social factors identified include consideration of FGM/C as a rite of passage for girls/women, social conformity and stigma, sexuality social perceptions, and marriage precondition.

4.3.1 Perception of Social Status and Rite of Passage

Study findings show that the practice of FGM/C is an important social function within the socialization process. Specifically, the transition from one life stage to another is marked by a ritual which involves initiation of both boys and girls. FGM/C is thus a social symbol for this transition. Consider the quotes below.

> In the community, one is expected to show the shift from childhood to adulthood. This is done through circumcision and it also applies to girls (Case Narrative 18-30 years)
>
> Cutting a girl is a sign that she is no longer a girl. She is a woman and ready for things that women do. It is part of the socialization. Nowadays, they are saying that it is wrong but it is a social thing here (FGD 4 Discussant)

The idea of rite of passage was reinforced by a key informant.

> FGM/C is a rite of passage. It marks the end of childhood and beginning of another stage in life. From birth, girls might be aware that they will be cut since they might have heard other girls go through the same. As they are socialized, circumcision is part of it (KII 2).

Further, FGM/C is considered a marker of a well-defined social status. Consider the quotes below.

> After the practice (FGM/C), the person ceases to be a child. This comes with recognition and respect in the society. There are things that uncircumcised girls cannot do. However, after the cut, they have the status to do it (Case Narrative 31-40 years)

> In the community, even men respect you. Having undergone circumcision comes with some dignity and prestige that elevates your position in the society (FGD 1 Discussant 40 years).

As a pathway to the elevated social status, girls are accustomed to look forward for the transition and acquisition of the new social status. This is revealed by a key informant.

> The danger lies where girls think that it is big qualification and score to be cut. They expect to change social status and earn respect. If girls are otherwise, they would not be willing (KII 3).

Thus, the view that FGM/C is an avenue towards enhanced social status and a rite of passage is a key driver that frustrates efforts to end the practice. Other studies have similar findings on FGM/C being a rite of passage. According to Gachiri (2000), cutting entails a social and physical distinction. In the practicing societies, it is imperative that, just like other rites of passage, FGM/C is part of social progression in an individual life.

4.3.2 Social Conformity/Pressure and Stigma

Findings showed that the need to conform to the social phenomenon and functions associated with the FGM rite of passage. Essentially, the societal expectation is that generations will ascribe to FGM/C and the nonconformists are considered outcasts.

> There is a time I was handling a girl when she was stressed. She feared facing the knife yet she feared being admonished for failing to live up to the social expectation (Case narrative 41-50 years).

The problem is that it (FGM/C) can be contagious. If one girl is cut, it pressures others and their families to follow suit, not to be seen as nonconformist. They do it because of the fear of labeling (KII 1).

> If everyone is doing it in the society, you feel left out and want to be like the rest. Although it is bad (FGD 3 Discussant).

There is also pressure from some of the community leaders, especially those who advocate for FGM/C. As stakeholders, they pressurize parents and mobilize them

> Some female circumcisers are keen on ensuring girls are cut at some season. If they are powerful enough, they can impose sanctions if you do not conform. We feel oppressed since not everyone wants it (FGM/C) (Case Narrative 41-50 years).

The peers also add to the social pressure. Findings show that already circumcised girls do not only expect the younger ones to undergo FGM, but also isolate and label them should they postpone or refuse completely. Based on the acquired social status that the ones who have undergone FGM/C have, the uncircumcised girls yearn for the same.

> In their talks, girls encourage each other. They might encourage others either to go for FGM/C or not. In some cases, they encourage each other. If one refuses, they are removed from the group of friends and cannot do things together (FGD 1 Discussant).

In extreme cases, failure to conform to the societal expectation can lead to group ostracism.

> There is a lot of peer pressure from the girls themselves. In fact, the uncircumcised ones can be insulted and labeled as cowards to avoid this labeling, girls might go for it (cut). (KII 2).

The girls are thus doubly pressured: by peers and some community gatekeepers within the genera social world.

Findings also showed that there is stigma and discrimination directed to girls who refuse to undergo FGM/C.

> The circumcised ones can form a group admissible only to girls who have faced the knife. This is an exclusive group and admission is subject to the cut. The girls who refuse the practice are looked down upon. They are also discriminated in group activities (KII 2).

Apart from the stigma and discrimination for nonconforming girls, their parent and families are also stigmatized and discriminated against.

> I went to out *chama* (women's group). At first, I thought people were just tired. They did not talk to me as much and most frowned upon my arrival. I did not ask but a week later I realized that it is because my daughter did not attend the FGM/C function (FGD 3 Discussant 42 years)

> People label those families and described in relation to the FGM/C issue. The family can be called the family of cowards or something like that (Case Narrative 18-30)

The stigma arising from nonconformity is a driver for the persistence of FGM/C. Studies have revealed similar trends even in other communities. In the Maasai community, marriage is an essential part of a girl's life and FGM/C prepares her for a home (Population Council, 2007). Girls who cannot find marriage and have a home are thus ridiculed and primarily so because they have not undergone the cutting.

Gwako (1995) observes that FGM/C is an avenue for socialization and girls who are not cut are subjected to ridicule and shame. They are not considered mature and are equated to children. According to Population Council (2007), girls who are not cut are referred to as *rikunene*, a disparaging term to refer to uncircumcised woman among the Abakuria, invoking the meaning of unclean and therefore unsuitability for marriage and general social fit.

4.3.3 Social perceptions for women sexuality

Findings show that women's sexuality is under immense social construction and definition. Specifically, FGM/C is used to shape and define certain aspects of a woman's sexuality. In the society, a woman is expected to maintain chastity and virginity. In order to preserve this, FGM/C is seen as a way of regulating a woman's sexual activities and make her less sexually promiscuous. The view that FGM/C can control a woman's sexuality and the value of virginity in society perpetuate the practice.

> I would say FGM/C is also done to control a woman sexuality. They say that a circumcised woman cannot cheat on the husband and cannot have many men (Case Narrative 18-30 years)

> There is a perception that FGM/C makes the women sexually inactive. Since people really want to see them (virgins), they prefer FGM/C for girls (FGD 4 Discussant).

It is important that a woman maintains virginity until marriage. Thus, in order to help girls be preserve virginity, FGM/C is preferred for them.

> Virgins are valued here. It is good for social norms. Thus, in order to preserve that, they cut the girl because they believe cutting makes them not to desire sex (KII 2).

Thus, one driver for FGM/C and its persistence is the connection between FGM/C and controlling a woman's sexuality, which is desired. Since a woman's sexual purity is valued, persistence of FGM/C is inevitable.

4.3.4 FGM/C as Precondition for Marriage

Findings showed that the persistence of FGM/C is anchored on the institution of marriage. Apparently, FGM/C precedes marriage and the latter might not happen if the former is not performed. Findings show that families and girls are keen on FGM/C as it prepares the girl for marriage.

> Female genital mutilation is a prelude to marriage in many African communities. In addition, just as in Abakuria, once a girl is circumcised, often forcibly, marriage follows shortly after (FGD 1 Discussant).

In other circumstances, men take their wives to circumcision.

> It is disturbing that some young men are turning back their uncut wives to their parents to undergo FGM," the chief said. They do it in bushes in far places, where local authorities can't reach easily. You only learn about the circumcision ceremonies when it is too late to rescue the girls. However, hailed efforts by the state and NGOs to stem the banned practice, saying 75 per cent of women are resisting the retrogressive culture (KII 1).

Findings also show that in the past, FGM was a precondition for marriage.

> Although not mandatory nowadays, it was a must in previous years that a woman must be circumcised before marriage. This was a must but things have changed though again not completely (Case Narrative 31-40).

> One (woman) might stay at their home (not married) because people know that she is not circumcised. Some elders may not officiate the union if that (FGM/C) is not fulfilled but things are lighter now (KII 3).

Findings also show that men prefer women who have undergone FGM. The idea of controlling sexuality and respect for circumcised women emerged again since uncircumcised woman is considered 'dangerous' and sexually promiscuous

> Men also want respect by marrying a circumcised women. They also do not want to be summoned by elders to be told that the women is loose (cheating). They think she is dangerous. But this is oppressing women anyway since men do not have such standards, controls and measures of purity (FGD 2 Discussant)

Based on the value of marriage in the society, FGM/C persists since it prepares women for marriage. According to Population Council (2007), women in Maasai community believe that marriage is not complete if they do not cut their girls since the cut connects her with marriage. In the same study, the men feel honored marrying a circumcised girl.
Caldwell et al. (2000) posit that in most societies practicing FGM/C, women are concerned about the negative perception society has on the girls and their few chances of being married.

4.4 Economic Factors Influencing the Persistence of the Practice of FGM/C

4.4.1 Bride Wealth

Findings indicate that one of the economic drivers for the persistence of FGM/C is the economic value associated with circumcised girl. Firstly, there are economic interests in terms of bride wealth as illustrated by a key informant.

> This practice is deeply rooted in our society despite interventions by the provincial administration, the churches and NGOs. Some culprits have been dragged into courts of law. However, not all these efforts have deterred the others. Why? Behind each case lies the nagging issue of bride price or bride wealth. So it is, indeed, time we examined the role of bride price in modern society (KII 3).

Another key informant reinforces the value of bride wealth.

> The girl's parents demand the payment in exchange for blessing through the church wedding. Often this is not done amicably. In some situations, we have witnessed brides with swollen eyes from long hours of crying and we have seen grooms gloomy in the church (KII 2).

Secondly, in the community, a circumcised girl fetches a higher bride price than the uncircumcised one. This is another form of pressure where the families that need high bride price must subject their bride to FGM/C.

> When paying dowry, you find that if you girl is not circumcised, you cannot even ask for many cows or money (FGD 1 Discussant)

> It is true that one there is value for circumcision. The groom has to pay more because the girl is made and ready (circumcised) (Case Narrative 41-50 years).

4.4.2 Embedded economic Opportunities

Apart from the economic value of bride wealth and the need to circumcise women for higher bride price, findings show that FGM/C can be a preoccupation and source of income, especially for the practitioners. Circumcision fee and Poverty among the Abakuria fuels the drive for FGM as many *Inchama* (women circumcisers/practitioners) are able to identify when girls are to get circumcised and this is a source of revenue for them. This was well explained in a case narrative.

> The issue is that even the practitioners want something (money). Some do it for a living and it becomes good for them during holidays when circumcision season is on (Case Narrative (51+ years).

> The *inchama* earn from the cutting. When girls are many, the higher the gain (FGD 4 Discussant)

Since there is economic gain from practicing FGM/C, a key informant explains that it is difficult to end it.

> Unless we look for them alternative sources of income, these women make a living from this (FGM/C). With the financial gain, it I hard to convince them to stop (KII 3).

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents a summary of the study findings, discussions, conclusions and recommendations. It also makes suggestions for further research. The findings are summarized in line with the objectives of the study which was to examine the Socio-economic drivers of female genital cutting among the Abakuria of Migori County, Kenya.

5.2 Summary of findings

The study established the influence of socio economic determinants of Female Genital Mutilation among the Abakuria, the study found that Women are given the respect they deserve after undergoing FGM. Also, woman is considered mature, obedient and aware of her role in the family and society if they undergo that practice. This finding was supported by the literature which indicates, that each culture has a distinctive moral code. FGM was traditionally associated with rites of passage ceremonies. Demographic and Health Despite the increased awareness of the dangers of FGM on the girl child, particularly on her educational development and empowerment, FGM has persisted in practice by both the elites and the less educated worldwide, especially in Africa (Jones, 2000).

Rite of passage was other factor which the study found to be the tradition root cause of the practice amongst women of the Abakuria, This finding is in line with the literature of WHO (2008), who states that the cultural significance of the practice is seen to be the preservation of chastity and to ensure marriageability of the girl child. The roots of the practice run deep into the individual's psychology, sense of loyalty to family and belief in a value system.

The study established the influence of illiteracy levels on the practices of FGM amongst the women of the Abakuria in Migori. Lack information in the Abakuria communities living in Migori County is a major problem. Ongong'a (2000) suggest that in most regions of the world, women receive less formal education than men do, and at the same time, women's own knowledge, abilities and coping mechanisms often go unrecognized. Education is one of the most important means of empowering women with the knowledge, skills and self-confidence

necessary to participate fullyin enhancing socioeconomic change. Another issue was the issue of educational influence which motivated them to get married of which they must undergo the "cut" for them to attain that objective. Pracht (2011) who stated that educational ceremonies may last for several weeks or months and girls would leave these as women who are ready for marriage and in this case they must undergo FGM to attain this objective.

The study established the influence of Social Stereo Types on the practice of FGM amongst the women of the Abakuria in Migori. The results indicate that the awareness creation on the negative side of Female Genital Mutilation is important to the community in fighting this practice. This is observed because the decision of FGM is mostly made by the elders who are not much educated, hence forcing the go ahead of this practice. This is supported by Ongong'a, (2000) who indicate that, although local religious leaders managed to generate a considerable awareness among their communities, perception of girls' circumcision as a religious belief is still prevalent among men and women on an equal footing.

The absences of expertise in the influence of the community members to eradicate FGM was a major problem, this does not only affect the girl physically but also psychologically. Gruenbaum (2006), argues that FGM is seen by some as both socially oppressive and physically harmful to women and girls, and the discontinuance of the genital surgeries is seen by others as improving the status of women. According to the participants, those who are from Islamic religion had different perception about the practice compared to Christians. Islamic believers were at first supporting FGM because of the information they received from their parents and community elders when they were young that it was part of the Islamic rule.

Some women mentioned that after the practice, one feels incomplete, she meant one of their important parts of their body that makes them feel as women is missing. She also mentioned some of the churches in her own country, which have shown cooperation in campaign against FGM these were: Evangelical Lutheran churches, Seventh Day Adventist church, Catholic Church, Anglican Church.

The FGM belief, religion and bride wealth may be more complicated in the belief revision. In order to stop FGM followers who practice for the sack of religion, religious leaders must take a firm stand of forbidding the practice. Otherwise it will still be considered a requirement by

religion, therefore, individuals and whole communities will continue to fulfill their religious duty despite its severe consequences (Dorkenoo, 2004). Most of the respondent accepted that the issue of bride wealth, circumcision fee, value of a circumcised girl, poverty has an impact in the influence of Female Genital Mutilation practice. Education inadequacy then is the cause of FGM practice.

5.3 Conclusion

The discussion is focused on the results, challenges, and limitations encountered during this research process. The result confirms that the practice of FGM is a social consequence that is affecting a number of women and young girls socially, psychological and physically. To eradicate the practice, there is a need for education campaigns in the communities that practice FGM. Although many African countries have criminalized the practice of FGM, this is not enough because the practice is deeply rooted in cultural and traditional practices. The campaigns needed to include topics on human rights violations and the harmful effects caused by FGM. Issues dealing with culture are so sensitive and therefore those planning to tackle the issue of female genital mutilation that is deeply rooted in culture and traditional beliefs, should have enough knowledge on other people's culture and should not generalize culture.

5.4 Recommendations

The following are recommendations of the study

1. Local leaders should come together with other stakeholders should enforce women and girls' rights through participatory/advocacy for education-in-culture and culture-in-education.
2. The Ministry of Education, Science &Technology needs to strengthen its facility-level supervision mechanisms in both rural and urban area in south west Kenya to stop its staff from performing the practice. The Ministry should develop guidelines for the local government supervisors on the appropriate actions to take to detect and deter the practice.

5.5 Suggestion for Further Research

When studying about people and their culture, also historical, economical social, political and geographical factors need to be taken into consideration, because they are part of the people and their life.

REFERENCES

&id=125:kenya-demographic-health-survey-2014&Itemid=599Accessed on 24th July, 2016 at 12:34pm.

Abdi, S. M. (2007). *A Religious Oriented Approach to Addressing FGM/C among the Somali Community of Wajir*. Population Council/Frontiers. Kenya.

Abdulcadir, J., Catania, L., Hindin, M.J. et al, Female genital mutilation: a visual reference and learning tool for health care professionals. *Obstet Gynecol.* (2017; 128:958–963.

Ahmadu, F. (2000). Rites and Wrongs: Excision and Power among Kono women of Sierra Leone. In: B. Shell-Duncan and Y. Hernlund (Eds.). *Female 'Circumcision' in Africa: Culture, controversy and change*, pp. 283-312. Boulder, CO: Lynne Rienner

Andro, A., Lesclingand, M., Grieve, M., & Reeve, P. (2016). Female genital mutilation. Overview and current knowledge. *Population, English edition*, *71*(2), 215-296.

Arora, K. S., & Jacobs, A. J. (2016). Female genital alteration: a compromise solution. *Journal of medical ethics*, medethics-2014.

Barnard, A. (2000). *History and Theory in Anthropology*. Cambridge: Cambridge University Press.

Boghossian, A. P. (2011). *What is social construction?* Retrieved from https://as.nyu.edu/content/dam/nyuas/philosophy/documents/facultydocuments/boghossian/Boghossian-Paul-socialconstruction1.pdf

Caldwell, C., Orubuloye, C. and Caldwell, P. (2000). Female Genital Mutilation: Conditions of Decline. Population Research and Policy Review 19(3): 233-254

Clayton-Greene, K. (2015). Female Genital Cutting: A New Way Forward. *Waikato L. Rev.*, *23*, 168.

Dorkenoo, E. and Scilla, E. (1992). *Female Genital Mutilation: Proposals for Change*. London Series: MRG report; no. 92/3.

Earp, Brian D. "Female genital mutilation and male circumcision: Toward an autonomy-based ethical framework." *Medicolegal and Bioethics* 5.1 (2015): 89-104.

Gachiri, E. (2000). Female Circumcision: With Reference to the Agikuyu of Kenya. Nairobi. Paulines Publication.

GIZ (2005). *Female Genital Mutilation in Kuria District: Findings of a base line survey.* GTZ / Kenya Ministry of Health

Gruenbaum, E. (2001). *The Female Circumcision Controversy: An AnthropologicalPerspective.* Philadelphia: University of Pennsylvania Press.

Gruenbaum, E. (2002). *FGM in Sudan: Knowledge, Attitudes, and Practices.*

Gruenbaum, E. (2005). Feminist Activism for the Abolition of Female Genital Cutting in Sudan. *Journal of Middle East Women's Studies*, 1: 92–112.

Gruenbaum, E. (2005). Feminist Activism for the Abolition of Female Genital Cutting in Sudan. *Journal of Middle East Women's Studies*, 1: 92–112.

Gruenbaum, E. (2006). Sexuality issues in the movement to abolish female genital cutting in Sudan. *Medical Anthropology Quarterly.* 2006 Mar; 20(1):121-38.

Gwako, E. (1995). Continuity and Change in the Practice of Clitoridectomy in Kenya. A Case Study of the Abagusii. The Journal of Modern African Studies, 33(2):333-337.

Gwako, E. L. M. (1995). Continuity and Change in the Practice of Clitoridectomy in Kenya: A Case Study of the Abagusii. *The Journal of Modern African Studies,* 33 (2): 333-337.

Hayes, R. (1975). Female Genital Mutilation, Fertility Control, Women's Roles, and the Patrilineage in Modern Sudan: A Functional Analysis. *American Ethnologist,* 2: 617-633.

Jaldesa, G. (2002). *Reasons for the practice and health problems associated with femalegenital mutilation: Evidence from four communities in Northern Kenya*.Unpublished report for Action Aid, North East region, Kenya.

Johnson, M. (2000). Becoming a Muslim, Becoming a Person: Female ‘‘Circumcision,’’ Religious Identity, and Personhood in Guinea-Bissau. In B. Shell-Duncan and Y. Hernlund (eds.) *Female‘‘Circumcision’’in Africa.* Boulder, CO: Lynne Rienner, 215–234.

Karumbi, J., Gathara, D., and Muteshi, J. (2017). “Exploring the Association between FGM/C and Child Marriage: A Review of the Evidence,” *Evidence to EndFGMC Programme Consortium Report.* New York: Population Council,http://www.popcouncil.org/uploads/pdfs/2017RH_FGMC-ChildMarriage.pdf.

Kassamali, N. J. (1998). When Modernity Confronts Traditional Practices: Female Genital Cutting in Northeast Africa. In H. L. Bodman and N. Tohidi (eds.) *Women in Muslim Societies: Diversity Within Unity* (Boulder, CO: LynneRienner), 39–61.Kellner, N. I. (1993) 'Under the Knife: Female Genital Mutilation as Child Abuse' *Journal of Juvenile Law*, Vol. 14, pp. 118-132.

Kenya County Fact Sheets Dec 2011 available at https://www.opendata.go.ke/dataset/Kenya-County-Fact-Sheets-Dec-2011/zn6m-25cfAccessed on 23rd August, 2015 at 10:48pm

Kenya Demographic Health Survey (KDHS) 2014 Reporthttp://www.knbs.or.ke/index.php?option=com_phocadownload&view=category

Khasakhala, A. (2008). *A Study on Social Dynamics of Abandonment of harmfulpractices relating to alternative rites of passage (ARP) and Intergenerational Dialogue (IGD) as strategies aimed at eliminating Female Genital Mutilation/Cutting (FGM/C) in Kenya.* Unpublished report Commissioned byUNICEF Kenya Country office- Child protection Section.

Kiarie, M and Wahlberg, J. (2007) *Female Genital Mutilation*. Bachelor's Thesis. Jyvaaskyla University of Applied Sciences.

Kisaakye, E. (2002). *The Human Rights of Women: International Instruments and African Experiences.* London: Zed Books.

KNBS Kenya Demographic and Health Survey 2008http://apps.who.int/medicinedocs/en/m/abstract/Js17116e/

Kothari, Rita C. 2004. *Research Methodology: Methods and Techniques,* 2nded. New Delhi: New Age International Press.

Lightfoot-Klein, H. (1989). The Sexual Experience and Marital Adjustment of Genitally Circumcised and Infibulated Females in the Sudan. *Journal of Sex Research,* 26 (3): 375-393

Mackie, G. (1996). Ending Footbinding and Infibulation: A Convention Account. *American Sociological Review*, 61 (6): 243- 261.

McGee, S. (2005).*Female Circumcision in Africa: Procedures, Rationales, Solutions,and The Road To Recovery*, 11 Wash. & Lee Race & Ethnic Anc. L.J. 133, 142

Merton, R. (1957). *Social Theory and Social Structure: Revised and Enlarged*. London: The Free Press of Glencoe.

Ministry of Health.(1999). *National Plan of Action for the Elimination of Female GenitalCutting in Kenya, 1999 – 2019.*Ministry of Health, Government of Kenya,Nairobi.

Mohamud, A., Durlauf, S. and Althus, F. (2006). "*Strategies to Abandon FGM: The Roleof Youth and Youth-Serving Organizations*"talk presented at the AfricanAdolescent Forum, Program for Appropriate Technology in Health (PATH), Addis Ababa, Ethiopia.

Moranga, E. B. (2014). *Factors Influencing the Practice of Female Genital Mutilation inKenya: a case study of Gachuba Division, Nyamira County*. Master's Thesis.University of Nairobi, Department of Sociology.

MRG (1992).*Female Genital Mutilation: Proposals for Change.* MRG Report

NCPD/CBS (2009). *Kenya Demographic Health Survey.* Available at http://www.measuredhs.com/pubs/pdf/FR229/FR229.pdf Accessed on 29th June 2014 at 15:34.

NCPD/CBS 2009.*Kenya Demographic and Health Survey 2008.*National Council for Population and Development, Central Bureau of Statistics, and Macro International Inc. Calverton, Maryland, USA.

Njue, C. and Askew, I. (2004). *Medicalization of Female Genital Cutting among theAbagusii in Nyanza Province, Kenya.* FRONTIERS, Population Council.

Norwegian Church Aid (NCA). (2014). *Abandoning the Blade: The Situation of FGM in Mandera and Kajiado County*. Nairobi: NCA

Nour, Nawal, M. (2008). Female Genital Cutting: A Persisting Practice. *Reviews inGynecology and Obstetrics* 1(3):135-139.

Nyamongo, I. K., C. O. Olungah, and S. A. Bukachi. (2008).*Investigating drivers ofFGM in Kenya: Lessons from the Akamba and Maasai Communities.* A reportfor the MOH/GTZ Health Sector Programme.

Obermeyer, C. M. (1999). Female Genital Surgeries: The Known, the Unknown, and the Unknowable. *Medical Anthropology Quarterly*, 13(l): 79-106.

Ogoe, S.E. (2015) *"Why does female genital mutilation persist? Examining the failedcriminalization strategies in Africa and Canada".* University of Manitoba,Faculty of Arts, Master in Sociology thesis, URL: http://hdl.handle.net/1993/30862

Olungah, C. O. (2007). *Report on A Baseline Survey on the Practice of Female GenitalMutilation/Cutting among the Munyoyaya Community of Tana River District*.Nairobi: Ministry of Gender, Sports, Culture and Social Services and UNICEF, Kenya.

Pasquinelli, C. (2004). Anthropology of Female Genital Mutilation. In *Legal Tools forthe Prevention of Female Genital Mutilation*, 76-93, proceedings of the Afro-Arab expert consultation, Cairo, Egypt, 21-23 June, 2003.

Population Council (2007). Report on Contributing towards Efforts to abandon Female Geneital Mutilation/Cutting in Kenya: A Situation Analysis. Nairobi: Ministry of Gender, Sports, Culture and Social Services.

Population Council (2007).*Report on Contributing towards Efforts to abandon FemaleGenital Mutilation/Cutting in Kenya: A Situation Analysis*. Nairobi: Ministry ofGender, Sports, Culture and Social Services.

QualitativeResearch on Female Genital Mutilation/Cutting in West Kordofan and Kassala States. Khartoum: UNICEF Country Office.

Rahman, A. and Toubia, N. (2000).*Female Genital Mutilation: A Practical Guide toWorldwide Laws & Policies.* New York: Zed Books.

Ruddick, Sara, 1983. 'Pacifying the Forces: Drafting Women in the Interests of Peace',*Signs* 8(3): 470-489.

Sargent, C. (1991), Confronting Patriarchy: The Potential for Advocacy in Medical Anthropology. *Medical Anthropology Quarterly*, 5: 24-25.

Schultz, J. H. and Lien, I. L. (2013) 'Meaning making of female genital cutting: children's perception and acquired knowledge of the ritual', *InternationalJournal of Women's Health,* 7: 15-22.

Shaw, J. (2004). Sacred Rites, Sacred Rights: Balancing Respect for Culture and the Health Rights of Women and Girls in Islamic Canadian Communities Seeking to Practice Female Genital Mutilation. *Journal for Law and Equality,* 3(1): 32-65

Shell-Duncan, B. (2001). The medicalization of female "circumcision": harm reduction or promotion of a dangerous practice? *Social Science & Medicine* 52(7):1013-28

Shell-Duncan, B. and Hernlund, Y. (Eds.) (2000).*Female"Circumcision"in Africa:Culture, Controversy, and Change.* London: Lynne Rienner.

Shell-Duncan, B. and Hernlund, Y. (eds.) (2007).*Transcultural Bodies: Female Genital Cutting in Global Context.* Rutgers: The State University.

Shell-Duncan, B., Njue, C. and Muteshi-Strachan, J. (2017). Medicalization of female genital mutilation/cutting: What do the data reveal? *BMC Reproductive Health*

Shweder R. A. (2003). What about female genital mutilation and why understanding culture matters in the first place. In: Shweder R, Minow, M, Markus HR, eds. *Engaging cultural differences: the multicultural challenge in liberal democracies*. New York, Russell Sage Foundation: 216−251.

Slack, A. T. (1988). Female Circumcision: A Critical Appraisal. *In Human RightsQuarterly, Vol. 10,* No. 4 pp. 437-486. Maryland: The Johns Hopkins UniversityPress

Wacquant, L. J. D. (1992). How to read Bourdieu. In *An Invitation to ReflexiveSociology*, 62-68.Pierre Bourdieu and Löic J.D. Wacquant (Eds.). Chicago:University of Chicago Press.

Waris, D. and Miller, C. (1998) *Desert Flower: The Extraordinary Journey of a Desert Nomad*. New York: William Morrow Pub

Wellerstein, J. K. (1999). *In the Name of Tradition: Eradicating the Harmful Practice ofFemale Genital Mutilation*, 22 Loy. L.A. Int'l & Comp. L. Rev. 99. Available at:http://digitalcommons.lmu.edu/ilr/vol22/iss1/3

WHO (2008b).*Eliminating Female Genital Mutilation: An Interagency Statement* byOHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM &WHO. Geneva: WHO

WHO (2016). *Guidelines on the management of health complications from femalegenital mutilation.*

WHO, (2000). *A Systematic Review of the Health Complications of Female GenitalMutilation Including Sequelae in Childbirth*, World Health Organization,Geneva, Switzerland.

WHO, 2013. *Female Genital Mutilation*, Fact Sheet No. 241 http://www.who.int/mediacentre/factsheets/fs241/en/

Yoder, P. S., C. P. Ousmane and B. Soumaoro.(1999). *Female Genital Cutting andComing of Age in Guinea.* Calverton, MD: Macro International.

APPENDICES

APPENDIX I: CONSENT FORM

Introduction

I am Rhoda RobiNchagwa a masters student from the Institute of Anthropology, Gender and African Studies, University of Nairobi. I am conducting a study on the socio-economic drivers of FGM/C among the Kuria of Migori County.

Purpose

The study seeks to establish the socio-cultural factors that influence the persistence of the practice of FGM/C among the Kuria of Migori County.

Risks/Discomfort

There is no risk in participating in this study. Your participation is voluntary.

Benefits

The study will help in determining the socio-cultural factors that influence the persistence of FGM/C and information obtained will be used to assess the role of these factors in the elimination of female genital mutilation.

Confidentiality

Your confidentiality will be maintained at all times. There shall be no mention of names or identifiers in the report or publications which may arise from the study.

Persons to contact

If you have any questions regarding the study, you can contact me through telephone number 0722558211. You may also contact the KNH/UoN/ERB Commitee-0735-274288/0721-665077.

Your participation in the study will be highly appreciated.

Signature_____Date_____

Signature of Reseacher/Assistant_____Date_____

APPENDIX II: NARRATIVE GUIDE

1) Background information:
   i. Age, sex, family background, marital status and socio-economic status;
   ii. Where have you lived and where do you live now;
   iii. Who have you lived with and who do you live with now;
2) Lifestyle and social networks:
   i. Who do you spend time with;
   ii. What sorts of activities do you participate in;
   iii. Describe a typical week in your life; is this reasonably typical of people of your status; if not, how does it vary;
3) Social and ecconomic determinants of FGM/C:
   i. At what age are most girls cut in the community? What was your experience before undergoing the cut and immediatelyb after?
   ii. What factors made you agree to undergo FGM/C.
   iii. What makes FGM/C continue despite efforts to abandon it in the community;
   iv. Did you experience any forms of pressure to undergo FGM/C; if so, from whom, etc.,
   v. Is it generally acceptable for women to not be cut? What do other young people think, what do older people think, etc.;
   vi. What influenced your decision-making on FGM/C;
   vii. What advice did you receive regarding how to do it, or when to do it, by who;
   viii. What are the implications of being either cut or an uncut female in the community?

APPENDIX III: FOCUS GROUP DISCUSSION (FGD)

1. What do you understand by FGM/C in this community?

2. What are the main reasons for cutting girls in the community?

3. Are there families in this community that do not practice FGM/C? Why?

4. What is the place of girls who are not cut? Probe on marriage prospects (ask boys if they can marry uncircumcised girls), self-esteem and family discrimination.

5. What effect does the decision of not cutting the girl have on family in the larger community? (Churches, social circles, extended family and what else)

6. Has there been any change in the way this community view/practices traditional initiation of girls? If yes, what has been the change?

   - Why has there been a change?

   - What factors have encouraged the change?

If no change what factors do you think have contributed to this?

7. Do you have any suggestions or comments regarding the practice FGM/C in the community?

APPENDIX IV: KEY INFORMANT INTERVIEW GUIDE

So as to understand the socio-economic context in which FGM/C takes place, the following themes will be used to collect data:

1. The meaning of FGM/C among the Kuria community
2. Factors influencing the practice of FGM/C in this community
3. Reasons for FGM/C in this community
4. Consequences of not circumcising a woman in this community (At individual level and family level)
5. Conferred advantages of circumcision
6. Major factors for the persistence of FGM/C
7. Community responses towards attempted elimination of FGM/C