

**FACTORS INFLUENCING THE PRACTICE OF FEMALE
GENITAL MUTILATION IN KENYA: A CASE STUDY OF
GACHUBA DIVISION, NYAMIRA COUNTY**

**BY
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MAY 2014

DECLARATION

DECLARATION BY STUDENT

I declare that this Research Project Paper is my original work and has not been submitted for any other degree.

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DECLARATION BY SUPERVISOR

This Research Project Paper has been submitted for examination with my approval as the University Supervisor.

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DEDICATION

I dedicate this research work to the Almighty God, whose grace is sufficient and has brought me this far.

To my immediate family, my dear husband, **Joshua Orangi**, and our children **Lamech**, **Austin** and **Lenny** for their love, patience, encouragement and understanding that made this possible.

To my mother, Rosebella Mokeira, and my father, Alfred Moranga who believed in the education of girls, my brothers and sisters for their encouragement and support.

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My friends Carren, Marygorret and Salim for the encouragement when the going got tough.

ABSTRACT

The study sought to examine the persistence of FGM among the Kisii. The study was guided by four specific objectives: To find out the justification for the persistence of FGM among the Kisii community; to establish the efforts towards eliminating the practice of FGM among the Kisii; to investigate the issues and challenges facing the practice of FGM among the Kisii and To find out peoples knowledge of the law concerning FGM. The study was also premised on the social exchange theory, structural-functional approach and the feminist theory. The study adopted the descriptive research design. The study adopted the cluster and purposive sampling techniques to identify the respondents for the study. The researcher adopted both qualitative and quantitative approaches to data collection which included questionnaires, key informant interviews and the focus Group Discussions. The study revealed that all the female respondents involved in the data collection process through the survey had undergone FGM. In the sample 74.2 percent had circumcised their daughters whereas 25.8 percent had not. The study found that most of the respondents had indeed had undertaken their daughters through FGM. The persistence of FGM was attributed to traditional / cultural beliefs. The study found that 76.2 percent of respondents had undergone FGM willingly compared to 23.8 percent who were forced. This was enhanced through socialization within the community that reinforces the stereotypes against uncircumcised girls or women and thus a girl will choose to undergo the process so as to avoid mocking from the community and their peers. In regard to the effect of FGM the study found that 51.5 percent indicated excessive bleeding, 2.0 percent were obstructed labour, and 7.9 percent were sexual complications and 38.6 percent. Anti – FGM campaigns were the major source of information on FGM as indicated by 48.5 percent, health centers were 5.0 percent, radio announcements were 1.0 percent and personal experience was 45.5 percent. The study found that government agencies were the most popular facilitators of FGM as cited among 38.6 percent of the sample, non – governmental organizations were 6.9 percent, religious organizations were 46.5 percent, women groups were 4.0 percent, radio broadcasts were 2.0 percent and community based organizations (CBOs) were 1.0 percent. Findings indicate there is a high level of awareness on the law concerning the practice of FGM as espoused by Figure 13 which depicts that 91.1 percent of respondents

answered yes, 5.0 percent said no, 2.0 indicated don't know. Among the respondents 61.4 percent indicated they knew of the Anti – FGM law, 29.7 percent were Children's Act of 2001, 2.0 percent were the Kenya Constitution 2010. The study recommends for emphasis on awareness on the dangers associated with FGM which should be integrated into the education of the girl child; a multi-sectoral approach to eradication of FGM through coordinated efforts from the government agencies, non-governmental organisations, community based organisations on the fight against FGM; empowerment of community groups in the fight against FGM and emphasis on sensitization among medical practitioners who are involved in FGM practice.

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LIST OF ACRONYMS / ABBREVIATIONS

DHS	Demographic Health Survey
FGC	Female Genital Cutting
FGD	Focus Group Discussions
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation and Cutting
GECPD	Galckayo Education Center for Peace and Development
KDHS	Kenya Demographic Health Survey
KIHBS	Kenya Integrated Household Budget Survey
MoH	Ministry of Health
MYWO	Maendeleo ya Wanawake Organisation
PTSD	Post Traumatic Stress Disorder
SPSS	Statistical Package for Social Scientists
UNICEF	United Nations
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Female Genital Mutilation (FGM) or female circumcision is one of traditional practices whose origin can be traced to ancient times. Even though it was first discovered in Egyptian mummies about 200 BC, it is practiced on all the continents of the world (Aziz, 1980). According to the World Health Organization (2008) the term “Female Genital Mutilation” (FGM) denotes any procedure involving partial or total removal of the external female genitalia, as well as injury to the female genital organs for non-medical reasons. FGM is a fundamental violation of human rights. It is not only a severe form of discrimination against women, but also a violation of the rights of girls, on whom it is most commonly performed. FGM violates the right to health and to freedom from torture or cruel, inhuman or degrading treatment and, in some cases, even the right to life. WHO (2008) estimates that more than 130 million girls and women alive today have undergone FGM/C, primarily in Africa and, to a lesser extent, in some countries in the Middle East. Oloo et al., (2011) also give an estimation of 100 – 140 million girls and women whom currently live with the consequences of FGM, most of whom live in 28 African countries (Snow et al., 2002; Grisaru et al., 1997) with several others in the developed world including small communities in the Middle East and Asia (Asali et al., 1995), Indonesia, Australia, Canada, New Zealand, United Kingdom, Ireland and the United States

Developing countries over the last decades have experienced unprecedented growth in social, economic and cultural aspects. The development and the use of technologies to the increased access to education have changed the way individuals and groups inter relate with each other. On the other side traditional patterns of culture, social and economic life persists and contributes to maintaining cultural malpractices, including FGM. These cultural malpractices stand in the way in the achievement of the Millennium Development Goals Number 4 and 5 while disregarding progress that has already been achieved so far. Onuh et al., (2006) note various reasons have been given for the practice of FGM in these different geographical and cultural settings ranging from culture, religion to superstition. This is also supported by Oloo et al., (2011) whom identifies that

the main reasons for the continuation of FGM are firstly, as a rite of passage from girlhood to womanhood; a circumcised woman is considered mature, obedient and aware of her role in the family and society. Secondly, FGM is perpetuated as a means of reducing the sexual desire of girls and women, thereby curbing sexual activity before, and ensuring fidelity within, marriage.

Evidence from the recently launched Kenya Demographic and Health Survey (KDHS) 2008-2009 indicates that the overall prevalence of FGM has been decreasing over the last decade. In 2008/9, 27% of women had undergone FGM, a decline from 32% in 2003 and 38% in 1998. Older women are more likely to have undergone FGM than younger women, further indicating the prevalence is decreasing. However, the prevalence has remained highest among the Somali (97%), Kisii (96%), Kuria (96%) and the Maasai (93%), relatively low among the Kikuyu, Kamba and Turkana, and rarely practiced among the Luo and Luhya (less than 1%). The practice of FGM occurs mainly at the teenage and adolescent years; however it is also practiced at later ages. Kenya Demographic and Health Survey (2009) results show a broad range of age at circumcision. One-third of circumcised women say they were 14-18 years old at the time of the operation, 19 percent were 12-13 years old, and 15 percent were 10-11 years old. Twelve percent of women were circumcised at 8-9 years of age, and an equal proportion was circumcised at 3-7 years of age. Only 2 percent of women were circumcised before 3 years of age.

Shell-Duncan and Hernlund (2000) note efforts to abandon the practice in Africa can be traced back to the beginning of the twentieth century when missionaries and colonial authorities emphasized the alleged adverse health effects and framed the practice as “uncivilized, barbaric, and unacceptable in the eyes of Christianity. In response, FGM became an instrument of war to the ethnic independence movement among the Kikuyu reacting against what they perceived as cultural imperialistic attacks by Europeans. Other ethnic groups (Meru, Kisii, Kuria & Kalenjin etc) affected by the British prohibition of the procedure drummed help to strengthen Mau Mau movement against British colonial rule in the 1950s (FIDA Kenya, 2009)

Several international treaties and conventions identify FGM as a human rights violation, Among these are the Convention on the Rights of the Child (CRC), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the African Charter on the Rights and Welfare of the Child, the African Charter on Human and People's Rights and the Additional Protocol on Women's Rights (Maputo protocol), and the European Convention on Human Rights (UNICEF, 2005). Governments then have a responsibility to respect and promote human rights and can be held accountable for failing to fulfill these obligations.

Over the years political and non-political leaders have translated this concern into laws prohibiting FGM or supporting intervention programs aimed at persuading practicing communities to abandon the practice; for example retired president Daniel Arap Moi banned the practice of FGM when already 14 girls had died for the complications due to this procedures. Nevertheless, approximately 50% of girls continued to be circumcised indicating that legislation against FGM in Africa have not been successful (Kiarie & Wahlberg, 2007). WHO (2006) identifies FGM into four classifications and their practice vary according to ethnic groups in Kenya. Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy) being more pronounced among the Kisii; Type II involves partial or total removal of the clitoris and the *labia minora*, with or without excision of the *labia majora* (excision) and is more prevalent among the Maasai, Kalenjin, Meru, Kuria; Type III which is narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the *labia minora* and/or the *labia majora*, with or without excision of the clitoris (infibulation) is more common among Somali women. Type IV includes all other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

Inorder to fully comprehend the persistence of FGM among the Kisii; the study recognizes that collective intentionality in the form of "shared attitudes" is crucial for the proper understanding of social practices and social institutions. The practice of FGM should therefore be understood on the basis of social norms and how these rationalize and normalize behaviour. Norms are learnt and reinforced through everyday social interaction

while shaping and influencing behaviour where control of female bodies and sexuality is normalized (Berger & Luckman, 1967).

FGM is undoubtedly a cultural issue that holds society together Anton (1995) in the work of Wright (1996) said that when criticizing the act of FGM you are affecting on peoples' sense of values, identity, wellbeing and their inner self's. When suggesting an eradication of FGM it practically means the eradication of their whole culture in those peoples' eyes (Kiarie & Wahlberg, 2007).

The different forces who have been active in the activities aimed at persuading communities to abandon FGM have not taken time to understand the tenets that undergird the practice; in response the study espouses Merton (1957) who discusses the latent and manifest functions of seemingly irrational ancestral practices. Latent functions are the unintended, unrecognized and subtle ramifications functions of a social phenomenon (FGM) in a social system which was not foreseen as part of the primary, intended manifest functions of FGM.

1.2 Problem Statement

Female genital cutting or circumcision is widely practiced in many Kenyan communities. It involves partial or total removal of the external female genitalia or other injury to the female organs for cultural or other non-therapeutic reasons. Prevalence of the practice varies widely among ethnic groups. KDHS (2009), it is nearly universal among Somali (97%), Kisii (96%), Kuria (96%) and Maasai (93%) women. It is also common among Taita/Taveta (62%), Kalenjin (48%), Embu (44%) and Meru (42%). Levels are lower among Kikuyu (34%), Kamba (27%), Turkana (12%) and Mijikenda/Swahili (6%). Kisii County largest share of the population in regard to gender are women at 601,818 compared to men at 550,644 according to the 2009 National Housing and Population Census. This shows that FGM is widely practiced in Kenya.

Since 1979, WHO has identified FGM as a serious threat to the health of women, especially in the Sub-Saharan African region. In 1982, WHO issued a statement on FGM stating its commitment to support national governments' efforts aimed at eradicating the

practice. The Kenyan government has ratified various international conventions on child and women rights; these include Convention on the Rights of the Child (1990), the African Charter on the Rights and Welfare of the Child (1990) and of the Protocol on the Rights of Women in Africa, “Maputo Protocol” (2003). International and domestic legislation attempts have been unsuccessful in eradicating the practice of female circumcision. The Constitution of Kenya 2010, in section, 44 (1) ,44(3)53(1) and 55(d)has provided for the protection of rights of the girls and women and affirmative action. The Sexual Offences Act 2006 elaborates the kind of punishment to be meted on such offences. The children’s act of 2001 identifies children who are likely to be forced into circumcision as those in need of care and protection.

The Nyamira District Strategic Plan 2005-2010 links the spread of HIV/AIDs and STDs as mainly due to poverty, outdated cultural practices like FGM which is also a major issue affecting children and youth in the district. Intervention measures to reduce the practice of FGM involves sensitization and education of the public and parents on reducing incidences of the practice co-ordinated by the Ministry of Education, Office of The President and churches.

Countrywide, the Ministry of Health launched the National Plan of Action for the Elimination of FGM in order to reduce the proportion of girls, women and families that will be affected over the next twenty years in 1999. This included a government-led commission to coordinate activities for the elimination of the practice, bringing together partners involved in the fight against FGM on national and regional levels to share expertise, raising resources and collaborating on initiatives. The commission has had mixed success in establishing networks at regional level, for example, Kuria has a thriving network which coordinates anti-FGM action, whereas in Kisii attempts to establish a strong network have been largely unsuccessful to date.

Local and international NGOs such as Maendeleo ya Wanawake Organization (MYWO) along with the Programme for Appropriate Technology in Health (PATH), developed a comprehensive programme to end FGM. For instance, Alternative Rites Passage (ARP) which has usually been part of a programme involving raising community awareness,

working with schools, health providers, religious and community leaders. Despite both the government and non-governmental organizations' efforts and interventions to reduce the practice, the community still seems to hold on to it. The study therefore seeks to undertake an in-depth investigation into the socio-cultural contexts within which the Kisii undertake FGM, how it is rationalized, the practitioners, the patterns, trends, effects and efforts to eradicate it and why it goes on undetected.

1.3 Research Questions

- 1 What is the relevance of FGM among the Kisii?
- 2 What are the health implications of FGM among the Kisii?
- 3 Why has the practice of FGM persisted despite of government interventions?

1.4 Objectives of the Study

The overall objective of the study was to identify factors influencing the practice of Female Genital Mutilation in Kenya.

1.4.1 Specific Objectives

1. To find out the justification for the practice of FGM among the Kisii community.
2. To establish the efforts towards eliminating the practice of FGM among the Kisii.
3. To investigate the issues facing the practice of FGM among the Kisii.
4. To find out community's awareness of the law concerning FGM

1.5 Justification of the Study

According to the Kenya Demographic Health Services (2003) with regard to ethnicity, female genital cutting is far more prevalent among the Somali at 98% and the Kisii at 96%. Also emerging factors and features from previous studies on FGM reflect the high level of ignorance of child rights as described in the Children's Act of 2001 among the community and the negative impact that it has on the girl child's development and advancement. There has been a marked trend towards girls undergoing FGM much younger, with many girls under 10 years of age. This appears to be in order to circumcise

them before they might refuse and also in response to the illegality of FGM under The Children Act, since 2001.

The practice of FGM has also been associated with girls' and health risks such as physical and psychological trauma, sterility, damage to the urethra and anus, tetanus, child and maternal mortality and more recently HIV infection. For example in both Samburu and Garissa districts, FGM has become a significant cause of maternal mortalities due to inability to access health facilities in time (FIDA Kenya, 2009).

Although studies have been carried out indicating the highlighted negative impact and consequences of FGM; they have not addressed reasons for the persistence of the practice. Therefore a proper understanding of the persistence of the practice is needed for the achievement and participation of women in the development goals and the realization of women health. In spite of the efforts directed towards FGM the numbers remain high, the efforts are increasing and the ways of hiding the practice are becoming more discrete. Therefore it is an issue that requires an in-depth investigation into persistence of FGM

1.6 Scope of the Study

The scope of the study includes factors for its persistence, its rationale, existing anti-FGM efforts, their effect, the history of anti-FGM efforts, leader perception of FGM, local people perceptions of FGM, challenges faced in the war against the fight against FGM eradication and people knowledge of the law concerning FGM.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter comprises of past studies done on the phenomena of FGM in order to conceptualize the study problem with other previous work. The essence of undertaking a literature review is for the researcher to acquaint with what kind of data and material is available and identifies methodologies that have been used to undertake similar studies. The researcher also introduces the conceptual framework that will guide in the study along with the theoretical framework that contextualizes FGM practice in society.

2.2 The History of FGM in the World

FGM is not a new phenomenon of modern times. It is as old as it is widespread. The practice has evolved from early times in establishing control over the sexual behaviour of women. From the many accounts given of FGM, it is not clear of where it originated. Genital scarification and reconstruction are time honoured and worldwide practices. Various traditional practices are known to have existed in many parts of the world to control female sexuality. For example the Romans slipped rings through the labia majora of their female slaves to prevent them from becoming pregnant (El Sadaawi, 1980). Chastity belts were introduced in Europe in the 12th century, intended by the crusaders to acts as a barrier against unlawful or unsanctioned sex. In the western countries, clitoridectomy took place as a pretext to cure masturbation, hysteria, depression, epilepsy and insanity (Foucault, 1976; El Sadaawi, 1980; Toubia, 1993).

It is also believed the practice of FGM was known to have existed in ancient Egypt, among ancient Arabs in the middle belt of Africa before written records were kept. It is therefore difficult to document the first operation or determine the country in which it took place. However, documentalists suggest that FGM dates back to 25 B.C. (El Sadaawi, 1980; Lightfoot – Klein, 1989). The most radical form, infibulation that the Somali community practices, is called pharaonic type. Although this might imply that the practice started in ancient Egypt, there is no certainty that it started in Egypt or some

other African country then spread to Egypt. The pharaonic cut is more popular among the Muslim population in Africa.

Both Muslims and non-Muslims alike practice FGM/C. This practice is not known in many Muslim countries such as Iran, Saudi Arabia and Iraq to name but a few. In Kenya there are many non-Muslim communities practicing it while many other Muslim communities who do not practice FGM/C. Hence this means this practice has no known Islamic origin (Abdi, 2007)

According to Tanui (2006) female circumcision has existed for over 4,000-5,000 years originating in a period predating God's covenant with Abraham to circumcise his people. It began in Egypt and was frequently performed by the ancient cultures of the Phoenicians, Hittites, and the ancient Egyptians. Those people had the idea that was based on the belief that, the foreskin was the feminine part of the male and the clitoris the masculine part of a woman.

Incidences of FGM have been documented in some other countries, including India, Indonesia, Iraq, Israel, Malaysia, Thailand and the United Arab Emirates, but no national estimates have been made (WHO, 2008). In addition, the practice of FGM and its harmful consequences also concerns a growing number of women and girls in Europe, North America, Australia and New Zealand as a result of international migration. The exact number of women and girls living with FGM in Europe is unknown, but is estimated to be around 500 000, and 180 000 girls are estimated to be at risk of being subjected to the practice.

According to Yoder, Abderrahim & Zhuzhuni (2004) FGM/C continues to be practiced for a variety of reasons. Most often, women cite custom and tradition as a main cause for their support of the practice. Other reasons cited by women include religious demands, cleanliness/hygiene, virginity/morality, and better marriage prospects.

In 2010, WHO together with seven other UN agencies and six professional organizations and others issued a global strategy to stop health-care providers from performing FGM. This was a response to a concern about the increasing rate at which FGM is becoming

medicalized. An estimated 18% of all women who have undergone FGM have done so at the hands of health-care providers. There are large variations in this between countries, from less than 1% in several countries, to between 9% and 74% in six countries (WHO, 2010)

2.3 FGM in African Context

Female circumcision, or female genital mutilation, can no longer be seen as a traditional custom. It has come to be recognized as a problem in the modern African societies, countries, and the whole world at large. The section discusses the observed trends in the practice of FGM in Africa through the lens of the residence and region of the practicing community, the age at which FGM is undergone and the influence of education levels among mothers and the likelihood of daughters undergoing the practice.

While FGM prevalence is higher in rural than in urban areas for most countries (Benin, Central African Republic, Côte d'Ivoire, Kenya, Mauritania, Niger, and Tanzania), urban and rural rates are either the same or differ only slightly in Eritrea, Guinea, and Mali. In three countries (Burkina Faso, Nigeria, and Sudan), FGM prevalence was substantially higher in urban than in rural areas. Ethnicity is likely to explain higher FGM rates in urban areas in these countries, as well as regional differences in others. Most of the data on African countries is compiled from country specific Demographic Health Surveys (DHS). In other countries, the extent of the practice varies widely among regions. For example, in Mali, nearly 90% or more of women in five regions (the capital of Bamako, Kayes and Koulikoro, Mopti, Ségou, and Sikasso) have undergone FGM, compared with 10% or fewer of women in Gao and Timbuktu. In Tanzania, a high prevalence of FGM can be found in Arusha (81%), Dodoma (67%) and Mara (43%), while prevalence levels under 2% can be found in ten other regions.

Due to awareness and educational campaigns on the negative consequences of FGM and its harmful effects, there has been a tendency to the medicalisation of the practice. In these cases, younger girls and women are more likely to have been cut by medical professionals than older women. Similar trends toward medicalization have been found in

western Kenya (Njue & Askew, 2004), and Tanzania. Although medicalisation improves the condition under which FGM is practiced it contributes to the malpractice of the health sector among its practitioners.

In most African countries, women with more education are less likely to have undergone FGM. However, in Egypt, Guinea, and Mali, where FGM prevalence is high (97%, 99%, and 92%, respectively) education does not seem to have a noticeable influence (Yoder, Abderrahim & Zuzhuni, 2004). It is more likely that daughters of mothers whom are highly educated are less likely to undergo FGM than daughters of mothers with little or no education.

The difference between the percentage of women aged 15–49 who have undergone FGM/C and the percentage of women aged 15–49 with at least one daughter who has undergone FGM/C indicates a change in prevalence, a generational trend towards ending the practice. This is of particular importance in countries where the prevalence among women is more than 75 per cent. In Egypt and Guinea, for example, where almost all women aged 15–49 have undergone FGM/C, only about half of the women indicated that their daughters have undergone FGM/C (UNICEF, 2005).

In Egypt, Eritrea, and Guinea, FGM prevalence is 75% or more in every region of the country. In other countries, the extent of the practice varies widely among regions. For example, in Mali, nearly 90% or more of women in five regions (the capital of Bamako, Kayes and Koulikoro, Mopti, Ségou, and Sikasso) have undergone FGM, compared with 10% or fewer of women in Gao and Timbuktu. In Tanzania, a high prevalence of FGM can be found in Arusha (81%), Dodoma (67%) and Mara (43%), while prevalence levels under 2% can be found in ten other regions.

Althus (1997) suggests FGM as a cultural and social practice, rather than a religious one. It occurs among all religious groups (Christian, Muslims, a small sect of Jews, and indigenous groups) in Africa, although no religion mandates it. In Burkina Faso, CAR, Côte d'Ivoire, Mali, Niger, and (northern) Sudan, Muslim women are more likely to have undergone FGM than Christian women. However, in Kenya and Tanzania, a higher

percentage of Christian than Muslim women undergo FGM (38% vs. 28%, and 19% vs. 14%, respectively).

In Mali and Tanzania, women who practice traditional religions have the highest prevalence of FGM in the country (95% and 22%, respectively). Notably, ethnicity also confounds efforts to examine the role that religion plays in FGM prevalence (Yoder, Abderrahim & Zhuzhuni, 2004).

Another observed trends in FGM practice has been the widespread trend of a lowering of the average age at which girls are subjected to the procedure, in all centres except one (WHO, 2010) The FGM/FGC qualification age varies from one African country to another. It ranges from infancy in Eritrea, Ethiopia and Mali to seven-month pregnant women in Nigeria. A recent baseline study conducted by Health Unlimited in Awdal, Somalia and Mandera District in Kenya, confirms five to eight years as the circumcision age range. Hawa Aden of Galckayo Education Center for Peace and Development (GECPD) noted that 100 percent of six to eight year-olds who enrolled in the school system had been infibulated.

2.4 FGM in Colonial Era

Kenyatta (1938) notes that although FGM was seen as a harmful practice by the colonial administration that were intent in eradicating the practice; some nationalist politicians glorified FGM/C in the struggle for independence during the 1950s. In the end, the colonial authorities abandoned the idea of using criminal law to prevent FGM/C, turning instead to education and propaganda and whatever administrative action could be undertaken with the assistance of the indigenous authorities.

Missionaries present in the 1920s and 1930s forbade their 'subjects' to practice clitoridectomy. In response, FGM became an instrument of war to the ethnic independence movement among the Kikuyu reacting against what they perceived as cultural imperialistic attacks by Europeans.

Other ethnic groups (Meru, Kisii, Kuria & Kalenjin) affected by the British prohibition of the procedure drummed help to strengthen Mau Mau movement against British colonial rule in the 1950s. Shell-Duncan and Hernlund (2000) note efforts to abandon the practice in Africa can be traced back to the beginning of the twentieth century when missionaries and colonial authorities emphasized the alleged adverse health effects and framed the practice as uncivilized, barbaric and unacceptable in the eyes of Christianity. Attempts to persuade communities to abandon FGM were first recorded by missionary and colonial authorities early in the twentieth century, and were largely seen as colonial imperialism Muteshi and Sass (2005).

In the end, the colonial authorities abandoned the idea of using criminal law to prevent FGM/C, turning instead to education and propaganda and whatever administrative action could be undertaken with the assistance of the indigenous authorities. Meanwhile some nationalist politicians glorified FGM/C in the struggle for independence in the 1950s (Kenyatta, 1938). The efforts of western feminists in the 1960s and 1970s were similarly regarded as being critical of indigenous culture and imposed by outsiders with their own agenda.

The first efforts to eliminate the practice of clitoridectomy and infibulation in Sudan was during the British colonial period (1899–1956) when a British midwife (in 1920) was brought in to organize a training on midwifery and to dissuade the traditional midwives enrolled in the training program to stop the practice, but with very little impact (MYWO, 2009).

Thomas (2001) and Banda (2003) contend these early efforts to ban FGM were seen by many African communities as another attempt at colonial imperialism and led to widespread resistance resulting, in some places, in an increase in the practice and in driving the practice underground. For example, in colonial Kenya, communities in the Meru District believed that FGM “remade girls into women”. Attempts in the 1960s and 1970s by European and American feminists to persuade Africans to abandon the practice also failed to provoke much change, as they were perceived as imposed by foreign countries and alien to the culture and reasoning of the people concerned (GTZ, 2001).

2.5 FGM in Kenyan Communities

Female genital cutting or circumcision is widely practiced in many Kenyan communities. It involves partial or total removal of the external female genitalia or other injury to the female organs for cultural or other non-therapeutic reasons. The practice is widely condemned as harmful, because it poses a potentially great risk to the health and well-being of the women and girls who are subjected to it. It is also generally recognized as a violation of children's' rights.

According to the Kenya Demographic Health Survey (KDHS) 2008/2009 the proportion of women circumcised increases with age, from 15 percent of women age 15-19 to 49 percent of that age 45-49. A higher proportion of rural women (31 percent) than urban women (17 percent) have been circumcised. The practice varies tremendously by province. The proportion of women circumcised ranges from 1 percent in Western province to 98 percent in North Eastern province. Roughly one-third of women in Eastern, Nyanza, and Rift Valley provinces have been circumcised compared with over one-quarter of those in Central province, 14 percent of those in Nairobi, and 10 percent of those in Coast province. The most severe form of circumcision predominates in North Eastern province. 22.8% of 15 to 34 year olds are circumcised. Of these, 80.7% had their flesh removed, 3% were nicked and no flesh was removed while 14.8% were sewn closed; the older the woman the higher the prevalence of circumcision. 92% of 15-34 year olds are circumcised between the ages of 3 to 18. 83% of 15-34 year olds say circumcision needs to be stopped while 9% think it should continue.

Njonjo (2010) reports that North Eastern province has the highest number of circumcised women (98%) with 83% of these being sewn closed. This is followed by Eastern province (36%), Nyanza (34%), Rift Valley (32%), Central (27%), Nairobi (14%), Coast (10%) and Western (0.8%). Coast province has the highest prevalence (29%) of those circumcised at the age of less than 3 years while 67% of women in North Eastern province are circumcised at the age of 3 to 7 years. While an average of 74% of people in

all the provinces say that circumcision should be stopped, only 7.3% in North Eastern say it should be stopped and 87% of them say that their religion requires them to be circumcised (Njonjo, 2010)

In non-Somali Kenya, as in other countries with FGM/C prevalence below 40 per cent, the younger age groups consistently show lower prevalence rates. Pockets of practicing groups live in close contact with non-practicing groups. The trend is associated with specific FGM/C interventions, along with the overall modernization of the country.

The KDHS 2008/2009 reports female circumcision as highest in rural (31%) than in urban areas (17%). The higher the level of education and the higher the level of wealth, the less likely one will be circumcised. Among the 54% of women without education who are circumcised, 40% were sewn closed. Circumcision is also prevalent among the Somali (98%) and the Kisii (96%) ethnic groups as well as among Muslims (51%).

2.6 Causes of Female Genital Mutilation

One of the biggest challenges in curbing FGM is that it is rooted in cultural practices of very many ethnic groups. The cultural practice of cutting female genitalia for non-medical reason is a harmful phenomenon, especially when the society believes that FGM is the entry point for the girls to become a woman. MYWO (2009) notes amongst most cultural groups in Northern Sudan, female virginity at marriage is considered very important and only preserved by clitoridectomy and infibulation. This type of cutting, believed to have originated in Egypt, is controversial due to its long and short term effects on survivors.

Although religion, aesthetics and social culture have been identified as features which contribute to the practice, FGM remains primarily a cultural rather than a religious practice, occurring across different religious groups. Oloo et al., (2011) acknowledge that

FGM is not sanctioned by any religious texts. Although in some communities, religious interpretations have been used to justify the practice.

In the 2008/2009 Kenya Demographic and Health Survey, 24% of women who were circumcised cited 'social acceptance' as the most important reason for circumcision; other reasons cited include 'to preserve virginity until marriage' (16%); and 'to have better marriage prospects' (9%). FGM is a ritual that brings about cultural identity and its (FGM) function is to define a group (ethnicity). Therefore, it is believed that removal of such practice eventually would demise the associated culture (Banks et al., 2006). However where a girl accepts to undergo the practice it is less likely to be from her informed consent rather it is strongly subject to tradition and culture.

Njue and Askew (2004) among the Kisii in Nyanza Province found that FGM is considered an important rite of passage from girl to a respected woman; a circumcised woman is considered mature, obedient and aware of her role in the family and in the society, characteristics that are highly valued in the community.

2.7 Consequences of Female Genital Mutilation

The consequences and complications of FGM vary according to the extent of the operation, the instruments used, the skills of the circumciser, as well as other circumstances during and after the operation. According to the WHO (2011) the most common short-term consequences of FGM include severe pain, shock caused by pain and/or excessive bleeding (hemorrhage), difficulty in passing urine and faeces because of swelling, oedema and pain; as well as infections. Death can be caused by hemorrhage or infections, including tetanus and shock. A study from one country that practices Type I and II FGM, and in which 600 women were questioned about their daughters' complications after FGM Type I and II, reported a death rate of 2.3% (7).

A recent WHO-led study showed that FGM is associated with increased risk for complications for both mother and child during childbirth. Rates of caesarean section (29% increase for Type II and 31% increase for Type III FGM) and postpartum hemorrhage (21% for Type II and 69% for Type III FGM) were both more frequent

among women with FGM compared with those without FGM. In addition, there was an increased probability of tearing and recourse to episiotomies. The risk of birth complication increases with the severity of FGM (WHO, 2011)

Long-term consequences of FGM/FGC include infibulation cysts, keloid scar formation, damage to the urethra resulting in urinary incontinence, pain during sexual intercourse, sexual dysfunction and difficult childbirth, difficult menstrual periods (UNICEF et al. 2001). If the operation is conducted in unhygienic surroundings and/or using shared instruments, the victims are exposed to deadly infections like tetanus and HIV/AIDS.

WHO (2006) FGM of the mother is also a risk factor for the infant. The study found significantly higher death rates (including stillbirths) among infants born from mothers who have undergone FGM than women with no FGM. The increase was 15% increase for Type I FGM, 32% increase for Type II FGM and 55% increase for Type III FGM.

Research has shown that sexual problems are also more common among women who have undergone FGM. Women with FGM were found to be 1.5 times more likely to experience pain during sexual intercourse, experience significantly less sexual satisfaction and they were twice as likely to report that they did not experience sexual desire (Berg et al. 2010). Psychological consequences of FGM are anxiety, horror, Post Traumatic Stress Disorders (PTSD) and depression.

2.8 Human Rights context of Female Genital Mutilation

A human rights-based approach recognizes the existence of rights and reinforces the capacities of duty bearers (usually the government) to respect, protect and fulfill human rights. The practice of FGM/C has been condemned internationally, and within Kenya, as a violation of many girls and women's basic rights. These include; The Universal Declaration of Human Rights of the Child (1948), World Conferences on Women, Copenhagen (1980), Nairobi, 1985, Beijing, 1995; World Conference on Human Rights, Vienna, 1993, International Conference on Population and Development, Cairo, 1994, the World Summit for Social Development, 1995, United Nations Declaration on Violence against Women, Convention on the Elimination of all Forms of Discrimination against

Women (CEDAW), Convention on the Rights of the Child (CRC) and the International Day of Zero Tolerance of FGM/C/C, 2005.

In 1979, WHO identified FGM/C as a serious threat to the health of women, especially in the sub-Saharan Africa region. By 1982, WHO had issued a statement on FGM/C stating its commitment to support national governments efforts aimed at eradicating the practice. The 1994 International Conference on Population and Development (ICPD) and the Fourth World Conference on Women in 1995 gave further impetus to international campaigns against FGM/C. In April 1997, WHO, UNICEF and UNFPA issued a joint statement (WHO, 1997) of their commitment to supporting national organizations, governments and communities to promote abandonment of FGM/C.

The other key argument against female genital cutting relates to the issue of informed consent. According to Abusharaf (2000), “Any violation of the physical nature of the human person, for any reasons whatsoever, without the informed consent of the person involved, is a violation of human rights.” Mackie (2003) similarly states that “in general there is an absence of meaningful consent to the irreversible act of FGC,” echoing Nussbaum’s (1999) position that, “female genital mutilation is usually performed on children far too young to consent even were consent solicited.” In a slightly different vein, Rahman and Toubia (2000) take the position that “the act of cutting itself—the cutting of healthy genital organs for non-medical reasons—is at its essence a basic violation of girls’ and women’s right to physical integrity.

Article 5 of the Maputo Protocol also known as the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women on the elimination of harmful practices standardizes the ban on “harmful practices” through-out the signatory states and formulates measures for ending these practices. More specifically, these are: (a) public awareness-raising through information campaigns, formal and informal education and outreach, (b) the prohibition of every form of female genital mutilation, including the medicalized procedure, by means of sanctions and laws (c) support for victims of FGM in

the form of health care, legal counsel, psychological care and support, and education and training, and (d) protection of women who are potential victims of harmful traditional practices or other forms of violence, abuse or intolerance. It is currently working in Ethiopia, Benin, Burkina Faso, Guinea, Kenya, Mali, Mauritania and Senegal. The protocol defines “harmful practices” as all behavior, attitudes and/or practices which negatively affect the fundamental rights of women and girls, such as their right to life, health, dignity, education and physical integrity.

2.9 Policy Framework

FGM is a reproductive health concern for girls and women. At the national level, the Constitution of Kenya 2010 guarantees the rights of an individual to the highest attainable standard of health, including reproductive health. It underscores the importance of prioritizing the needs of vulnerable and marginalized groups in provision of health care. There are also a number of policies and strategies on sexual and reproductive health addressing the practice of FGM including the National Reproductive Health Policy, 2007 and the National Reproductive Health Strategy 2009-2015.

2.9.1 National Reproductive Health Policy (2007)

According to The National Reproductive Health Policy (2007) harmful cultural practices including nutritional taboos violate the reproductive rights and impeded attainment of healthy and fulfilling reproductive lives, especially among women. In Kenya, harmful practices of major concern to reproductive health are early or child marriages, FGC and nutritional taboos. FGC contravenes several basic rights of women and girls, including the right to liberty and security of person, and the rights to be free from inhumane and degrading treatment. In addition, some of these practices contravene the provision of the Children’s Act of 2001 and the Sexual Offences Act of 2006 (MoH, 2007).

2.9.2 National Reproductive Health Strategy 2009-2015

National Reproductive Health Strategy covering the period 2009 to 2015 and is a revision of the National Reproductive Health Strategy 1997-2010. The need for revision was to

address several issues and challenges most of which were not factored in during the time of its development. The policy seeks to address the three key issues in the spheres of gender equality, sexual and reproductive rights in Kenya can be summarized as a lack of empowerment for women to exercise decision on their own reproductive health and rights, including decisions regarding seeking health care for themselves and children; gender-specific harmful cultural practices including early or child marriages and female genital mutilation (FGM); and sexual and gender based violence (SGBV) including rape. In Kenya, harmful traditional practices of major concern are early or child marriages and female genital mutilation (FGM).

Female genital mutilation contravenes several basic rights of women and girls, including right to liberty and security of person, and the right to be free from inhuman and degrading treatment. The 2003 KDHS estimated FGM prevalence at about 32 percent, with one third of all circumcised women reporting having had the operation carried out by health workers. In its quest to eradicate the practice of FGM, one of its strategies includes advocacy and policy dialogue where it seeks to solicit the support of health professionals in the elimination of harmful traditional practices such as FGM.

2.10 Legal Framework on FGM

In Kenya, there are various legal instruments that seek to eradicate the practice of FGM and promote the human rights of girls and women. These include the Children's Act (No. 8 of 2001), the Constitution of Kenya 2010, the Sexual Offences Act (No. 3 of 2006) and The Prohibition of FGM Act 2011.

2.10.1 Constitution of Kenya 2010

The constitution of Kenya 2010 has provisions outlawing the practice of FGM. Section 44 (1) states "Every person has the right to use the language and to participate in the cultural life, of the person's choice". It however does not give individuals the right to compel others to undergo these practices. Section 44 (3) "A person shall not compel another person to perform, observe or undergo any cultural practice or rite. Section 53 (1) states "that every child has a right to be protected from abuse, neglect, harmful cultural

practices, all forms of violence, inhuman treatment and punishment, and hazardous or exploitative labour.” The constitution identifies the right of individuals to practice cultural practices. Section 55, subsection (d) also seeks to engage in affirmative action to protect the youth from harmful cultural practices and exploitation such as FGM and early marriage.

2.10.2 The Sexual Offences Act

The Sexual Offences Act 2006 is an Act of Parliament that makes provisions about sexual offences, their definition, prevention and the protection of all persons from harm from unlawful sexual acts, and for connected purposes. The Act domesticates the provisions of a number of conventions, including the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the United Nations Convention on the Rights of the Child (CRC). The Kenya Sexual Offences Act No. 3 of 2006 also outlaws the practice of FGM on women and girls as stated in Section 29 on cultural and religious sexual offences, states “any person who for cultural or religious reasons forces another person to engage in a sexual act or any act that amounts to an offence under this Act is guilty of an offence and is liable upon conviction to imprisonment for a term of not less than ten years.” The highlight of the Sexual Offences Act (No. 3 of 2006) is it does not leave it to the discretion of the Magistrates, in which it provides for minimum sentences for persons who are found to commit cultural and religious sexual offences.

2.10.3 The Children’s Act

According to the Government of Kenya (1999) the age at which FGM occurs varies widely. In some communities girls are circumcised as early as infancy, while in others, the ceremony may not occur until the girl is of marriageable age – approximately 14 – 16 years old. Most commonly, girls experience FGM between four and 12 years of age, at an age when they can understand the social role expected of them as women. Girls who have not undergone FGM/C are often ridiculed, made to feel ashamed, and addressed as children (Moogi, 1995).

In 2001, the Kenyan Parliament enacted the Children Act (No. 8 of 2001) which seeks to criminalize FGM/C on children below 18 years. Section 14 of the Act provides that “no person shall subject a child to female circumcision, early marriage or other cultural rites, customs or traditional practices that are likely to negatively affect the child’s life, health, social welfare, dignity or physical or psychological development.” Section 18 of the Act stipulates that any conviction for FGM/C-related offences carries a penalty of 12 months imprisonment and/or a fine not exceeding Kshs 50,000. To these, may be added the provisions of Section 234, 250 and 251 of the Penal Code which criminalize grievous bodily harm.

This law has limitations in that it protects girls only up to the age of 17 years and does not protect women from being forcefully circumcised. By placing FGM/C within the Children’s Act, it is seen as children’s issue rather than being of wider significance, and therefore carries little weight. FIDA – Kenya (2009) suggest a review of the Children’s Act, which should take into account greater involvement of people at the community level to create sustainable ownership of the process, while paying specific attention to sections 14 and 119 (I)(h). The reviewed Act should outlaw FGM not only to those less than eighteen years of age, but also to women above eighteen as well.

2.10.4 The Prohibition of FGM Act 2011

The prohibition of FGM act of 2011 has several provisions which are intended to eradicate the practice of FGM. It is an act of Parliament to prohibit the practice of female genital mutilation, to safeguard against violation of a person’s mental or physical integrity through the practice of female genital mutilation and for connected purposes. The Act establishes a board known as the Anti-Female Genital Mutilation Board.

Persistence of FGM is highly attributed by societies’ acceptance and perpetuation. The Kenya National on Human Commission Rights (2012) communities uphold, practice and normalize various forms of abuse on women that include female genital mutilation (FGM), early and/or forced marriage and virginity testing. Government of Kenya (1999) also notes FGM is a deeply rooted traditional practice in most communities where it is

practiced; for these communities, FGM is a rite of passage for girls from childhood to womanhood, instilling values, training and grooming to uphold family stability and preparation for the future within the community. FGM thus continues because society portrays FGM as a good “tradition.” The prohibition of FGM act of 2011 seeks to outlaw societal perceptions and attitudes towards FGM which were not provided before in other legal instruments against FGM; these provisions are further elaborated upon.

It has provided legal provisions related to provision of training of midwives or medical professionals in performing FGM. Section 19 (1) states “a person, including a person undergoing a course of training while under supervision by a medical practitioner or midwife with view to becoming a medical practitioner or midwife, who performs female genital mutilation on another person commits an offence.

The act also addresses the issue of parents and members of society who influence girls and women to undergo FGM by outlawing Aiding and abetting female genital mutilation. Section 20 states, “A person who aids, abets, counsels or procures - a person to commit an offence under section 19; or another person to perform female genital mutilation on that other person, commits an offence. Section 22 of the prohibition of FGM act also outlaws the Use of premises to perform FGM stating, “a person who knowingly allows any premises, for which that person is in control of, or responsible for, to be used for purposes of performing female genital mutilation commits an offence.” Section 23 outlaws the Possession of tools or equipment which may be used for FGM practice; it states, “A person who is found in possession of a tool or equipment for a purpose connected with the performance of female genital mutilation, commits an offence.

Section 24 states, “a person commits an offence if the person, being aware that an offence of female genital mutilation has been, is in the process of being, or intends to be, committed, fails to report accordingly to a law enforcement officer. Section 25 of the act provides for member in society who may ridicule or look down upon girls and women who have not undergone FGM, it thereby states, “any person who uses derogatory or abusive language that is intended to ridicule, embarrass or otherwise harm a woman for

having not undergone female genital mutilation, or a man for marrying or otherwise supporting a woman who has not undergone female genital mutilation, commits an offence and shall be liable, upon conviction, to imprisonment for a term not less than six months, or to a fine of not less than fifty thousand shillings, or both.” The act in section 29 states, “a person who commits an offence under this Act is liable, on conviction, to imprisonment for a term of not less than three years, or to a fine of not less than two hundred thousand shillings, or both.

2.11 Gender and Feminist Focus of the Practice of FGM

Social scientists argue that since it is women who carry out the practice and are its strongest defenders, their inclination to the practice must be analyzed in terms of their weaker social position. In most African countries, FGM is performed by traditional practitioners, usually elderly women in the community who use crude knives and without numbing the survivor. Cruenbaum (1993) FGM forms part of a complex socio-cultural arrangement of female subjugation in a strongly patrilineal, patriarchal society.

2.12 Summary and Gaps in the Literature Review

Literature reviewed includes research on the psychological aspects of FGM/C, including its effect on girl child education and early marriage is needed to increase understanding of the ways in which FGM/C affects girls, and women, psychologically. Such knowledge is important not only to assist in developing appropriate counseling services to address psychological problems, but also to provide information that could be used within anti-FGM/C messages. The knowledge that FGM has been outlawed has culminated in its being undertaken underground and also led to its medicalization. It has therefore become increasingly difficult to monitor FGM trends. For instance, the practice is now not done to any particular age set, but by an individual family at will and without specificity to time. Public celebrations that ordinarily followed such rituals are things of the past. It is imperative therefore for the present study to delve into the present practice of FGM among the Kisi by creating rapport and involving different stakeholders and members of society to shed light on FGM trends among the Kisii.

2.13 Theoretical Framework

The purpose of theory in any academic research literature review is to underpin the context in which the area under study occurs or happens. Through a concise theoretical literature a researcher is able to make a significant contribution to existing literature and allows one to challenge or further the existing literature related to the study.

In this section the researcher will discuss three perspectives related to FGM which include; structural-functionalism, social-exchange and feminist theories from other researchers. Each sociological perspective - functionalist, conflict, feminist, and interactionists - highlights how social problems emerge out of our social structure or social interaction. These sociological imaginations will also help us make a second connection: the one between social problems and social solutions. The most important value of sociology is in its potential to enrich and encourage the lives of all individuals (Lemert, 1997).

2.13.1 Social Exchange Theory

The exchange theory was developed and discussed by among others Blau (1960); Emerson (1962) and Homans (1961) through their view of society as composed of social activity based on social exchange (reciprocity) and integration in small groups. Blau (1977) social structure consisted of the networks of social relations that organize patterns of interaction across different social positions. Thus, the “parts” of social structure are classes of people like men and women, rich and poor.

In Blau’s view, to speak of social structure is to speak of differentiation among people. By a socially relevant distinction, Blau means a social distinction along some distinguishable social characteristic (age, race, sex, religion, ethnicity, etc.) which comes to determine who interacts with whom; this is the macro perspective of the theory. For

instance; if there are distinguishable differences between two communities then there is a less extent level of interaction between the two communities. There are also individual-level (Micro) attributes related to the theory which implies that people calculate the likely costs and benefits of any action before deciding what to do.

This theory focuses on the costs and benefits which people obtain in social interaction, including money, goods, and status. It is based on the principle that people always act to maximize benefit. However, to receive benefits, there must always be an exchange process with others (Marcus & Ducklin, 1998). The social exchange theory emphasizes the idea that, in relatively free societies, social action is the result of personal choice between optimal benefits and costs. The theory is largely associated with the Rational Choice Theory largely applied to economics. This theory assumes that individuals will operate in a rational way and will seek to benefit themselves in the life choices they make (*ibid*).

Social Exchange theorists argue that that all human relationships are formed by the use of a subjective cost-benefit analysis and the comparison of alternatives. For example, when a person perceives the costs of a relationship as outweighing the perceived benefits, then the theory predicts that the person will choose to leave the relationship. The theory has roots in economics, psychology and sociology (Emerson, 1962)

Relating the social exchange perspective to FGM can be observed when individuals opt to undergo the practice. This choice is influenced on the perceived benefits that the practice may have for the individual. According to MYWO (2009) some women opt to be cut despite their education. Some girls who come from communities which do not circumcise embrace the cut in order to avoid losing potential husbands from circumcising communities. For instance, although there is legislation against the practice of FGM, it has been critiqued as having no implication towards women willingly undergoing the practice. The social exchange theory promotes the idea that interaction is guided by what each person stands to gain and lose from others.

The practice of FGM of these women whom regard it as an important element of their being has a negative impact to efforts to eradicate the practice among the Kisii. Also, this scenario gives room to circumcised women to exercise very strong peer pressure on girls who have not been cut.

2.13.2 Structural - Functionalist Perspective

The structural-functional approach is a framework for building theory that sees society as a complex system whose parts work together to promote solidarity and stability. As its name suggests; the approach points to the importance of social structure - any relatively stable pattern of social behavior. Social structure gives our lives shape in families the workplace, or the college classroom. Secondly the approach looks for any structure's social functions, the consequences of any social pattern for the operation of society as a whole.

The structural-functional approach owes much to Auguste Comte, who pointed out the need for social integration during a time of rapid change. Emile Durkheim, who helped establish sociology in French universities, also based his work on this view. A third structural-functional pioneer was the English sociologist Herbert Spencer (1820–1903).

Spencer (1896) compared society to the human body; just as the structural parts of the human body - the skeleton, muscles, and various internal organs - function together to help the entire organism survive, social structures work together to preserve society. The structural-functional approach, then, leads sociologists to identify various structures of society and investigate their functions. Merton (1957) expands our understanding of social function by pointing out that any social structure probably has many functions, some more obvious than others. He distinguishes between manifest functions, the recognized and intended consequences of any social pattern, and latent functions, the unrecognized and unintended consequences of any social pattern.

Functionalists view social institutions as working in a systematic and coherent manner to sustain and reproduce them. Cultures presents a way of holding society together through sharing of socially accepted customs, values, norms, beliefs and views of the world which in turn influence human behavior. Social structures such as customs and practices have significant contribution to community solidarity but may also contribute negatively to society.

The practice of FGM should therefore be understood from the context of social norms including how these norms shape and normalize behavior. Norms are learnt and reinforced through everyday social interaction, at the same time shape and influence behavior (Berger & Luckmann, 1967) in this way the control of the sexuality of women and their bodies is normalized. FGM among the Kisii is considered an important rite of passage from girl to a respected woman; a circumcised woman is considered mature, obedient and aware of her role in the family and in the society, characteristics that are highly valued in the community. However, FGM causes bodily harm and consequent health complication during child birth which are its negative consequences; which Merton (1957) refers to as dysfunctions.

FGM is generally practiced as a matter of social convention, and is interlinked with social acceptance, peer pressure; the fear of not having access to resources and opportunities as a young woman and to secure prospects of marriage (UNICEF 2007; 2010). This social convention is connected to different concrete socio-cultural perceptions, most of which are linked to local perceptions of gender, sexuality and religion.

Functionalist's view of social problems also contributes positively to the identified social problems. For instance FGM practice calls for more affirmative action towards efforts

towards the abandonment of the practice. FGM concerns have led to a critical focus on the reproductive health of women and girls around the world and in Kenya with FGM taking a lead role as an indicator of health development and improvements in line with the Millennium Development Goals.

As such efforts towards the abandonment of FGM practices require that socio-cultural context of the practicing community be incorporated into these approaches. Dilley (1999) provides a strong basis for the interpretation of the persuasive and the persistence patterns visible in the practicing societies and that social and cultural phenomena must be interpreted within a given context in order to achieve significant results. Governments, development partners and non-governmental organizations should therefore be sensitive to the significance of FGM to practicing communities and involve community stakeholders in educating and raising awareness on the implications of FGM on the overall development of women in society. This social interaction would lead to a more effective acceptance of abandonment approaches among practicing communities.

2.13.3 Feminist theory

Tong (1989) explains that feminist theory is not one, but many, theories or perspectives and that each feminist theory or perspective attempts to describe women's oppression, to explain its causes and consequences, and to prescribe strategies for women's liberation. Feminist theory treats the experiences of women as the starting point in all sociological investigations, seeing the world from the vantage point of women in the social world and seeking to promote a better world for women and for humankind.

Madoo-Lengermann and Niebrugge-Brantley (2004) explain that feminist theory was established as a new sociological perspective in the 1970s, due in large part to the growing presence of women in the discipline and the strength of the women's movement. Although sociologists in this perspective may adopt a conflict, functionalist, or

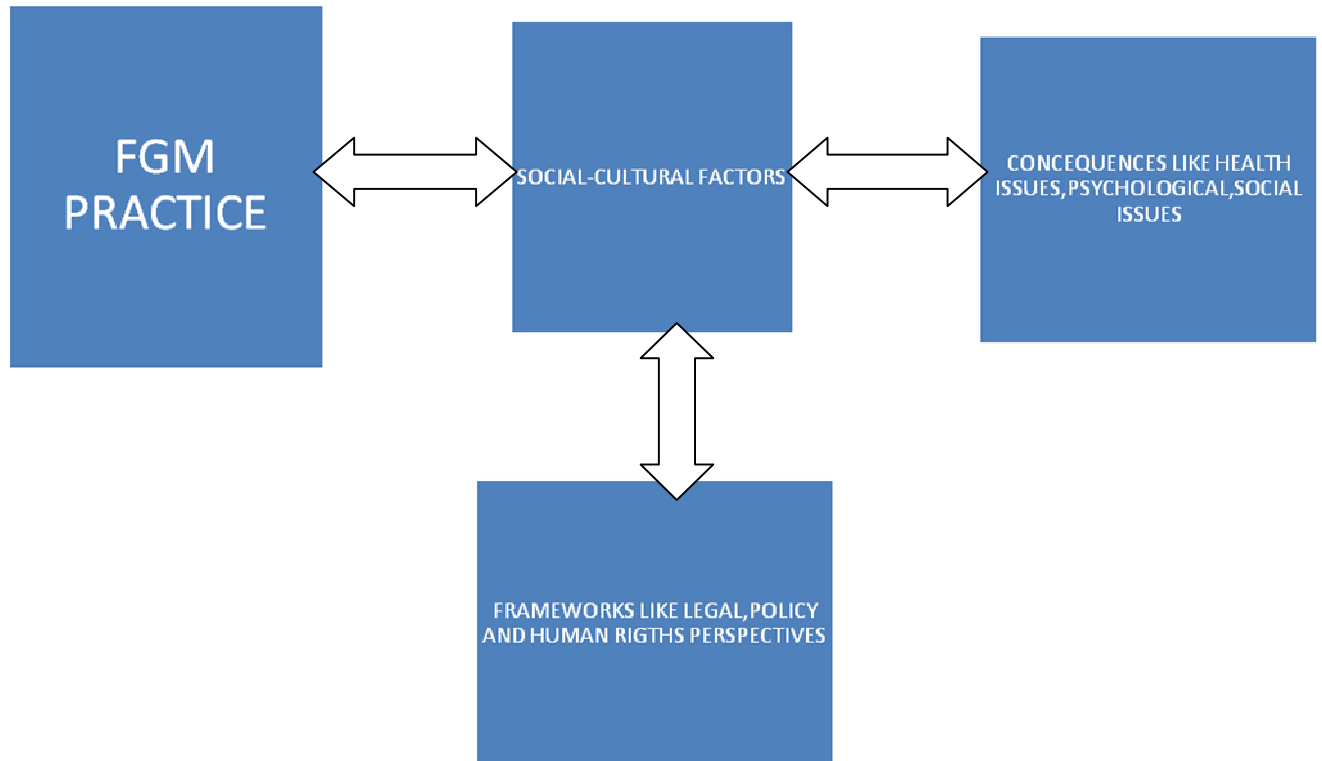
interactionist's perspective, their focus remains on how men and women are situated in society, not just differently but also unequally. As such the feminist approach is centered on making an impact in today's societal problems such as FGM practice. WHO Reproductive Health Research (RHR) indicates the persistence of FGM as associated with the desire to control the sexuality of women as the motivating factor of practicing communities. There was a perception that it was necessary to cut the clitoris of young girls, as this was seen as the site of sexual desire, and removal of the clitoris was therefore expected to reduce women's sexual desire, and thereby improve their ability to comply with local sexual norms that generally emphasize premarital virginity, marital fidelity and sexual modesty.

In the WHO RHR study, an overall focus on the importance of sexual pleasure for the man, rather than the woman, was identified. For example, for those men in Egypt who expressed concern that FGM might reduce women's sexual pleasure, their key concern was on the negative effect that could have on their own sexual pleasure. On the contrary Women with FGM were found to be 1.5 times more likely to experience pain during sexual intercourse, experience significantly less sexual satisfaction and they were twice as likely to report that they did not experience sexual desire. This highlights the concern of feminist theories where patriarchal society is the basis of social problems. Patriarchy refers to a society in which men dominate women and justify their domination through devaluation (Kaplan, 1994)

Feminist perspectives can be linked to FGM abandonment approaches that have been adopted over the years. For instance the involvement of men in intervention strategies has been established as a working mechanism towards the reduction of the practice. Abandonment approaches have also included information education and communication targeted at empowering decision making among women in order to control their destiny and enjoying their rights as espoused by Weiner (1994) feminism involves a commitment to improve life chances for girls and women; and it is concerned with developing equitable professional and personal practices.

The feminist theory also contributes to the present study in reference to the interviewer and interviewee interaction. FGM is a highly gender sensitive practice and although there is no specific research method to feminist research (Burns & Walker, 2005). Oakley (1981) suggests the meeting of the uninvolved interviewer did not stand in the scrutiny of women's lives. Women's voices are heard in research, when 'the relationship of interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her own personal identity in the relationship'. In relation to the present study the researcher is from the Kisii community and female and this would play a significant role in the data gathering process among respondents (Oakley, 1981).

Figure 1: Conceptual Framework



The continued practice of FGM in kisii is seen to be majorly due to social-cultural factors where the initiates undergo the cut to conform to the norms and values regardless whether it is by individual choice or through force. The practice however has social, psychological, health and legal consequences.

Efforts towards abandonment of the practice by Legal instruments, Human Rights frameworks and Policy frameworks have been unfruitful partly due to the weak structures in enforcing the abandonment strategies.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The chapter addresses the various methodological issues in order to achieve the research objectives and consequently answer the research questions. These sections are highlighted from the research design to the methods of data analysis and interpretation.

3.2 Site Description

According to the Kenya County Fact Sheets (2011) Nyamira County has a population of 598,252 covering a Surface area of 899 Km² with a population density of 655 people per Km². The poverty rate of the county based on the Kenya Integrated Household Budget Survey (KIHBS) stands at 48.1 %. The total labour force (15-64 years) for the district is estimated to be 277,027 with 70% involved in agriculture, 6% self-employed in rural areas, and 10% employed in urban centers. Nyamira District has 2 hospitals and 21 health centers. The average distance to a health facility is 7 Km and 78% of the households have access to the health facilities and doctor to patient ratio of 1:65,000.

The major causes of poverty in the district include impassable roads, small land parcels, inadequate health services, inaccessibility to credit, inadequate energy supply, laziness and idleness, insecurity and agriculture decline among others. Poverty in Nyamira is both a cause and effect of population growth and environmental degradation. HIV/AIDS prevalence is high among the productive age group (15-49). It is estimated to be 17% which is well above the national figure of 13.5%. The spread of HIV/AIDs is mainly due to poverty, outdated cultural practices like Female Genital mutilation (FGM) and early marriages. Behavioral change has also been a problem despite government's prevention effort in the district (Nyamira District Strategic Plan 2005 – 2010).

3.3 Site Selection

The researcher seeks to undertake the study in Gachuba Division, Nyamira County. It is an area where the tradition is deep rooted and is among areas with highest prevalence

among the Gusii community; 96% of the women interviewed from this community during the 2008/2009 demographic and health survey had been circumcised. Efforts by NGOs, churches and the government to persuade the community to abandon the practice seem to have limited impact. Having a first-hand experience and knowledge as a resident in the area, I could want to identify the factors that influence the persistence of FGM practices despite abandonment efforts and illegalization of the same.

3.4 Research Design

The study adopted the Descriptive Survey approach to research. Descriptive studies include surveys and fact-finding enquiries of different kinds. The major purpose of descriptive research is description of the state of affairs as it exists at present. The *Ex-post facto* approach of descriptive research a used as *ex-post facto* studies attempt to discover the causes even when the researcher cannot control the variables. Shukla (2008) the descriptive research design is typically concerned with determining the frequency with which an event occurs or the relationship between two variables. Descriptive research design requires a clear specification of who, what, when, where, and why and how of the research and requires clear planning with regard to data collection.

The study used both qualitative and quantitative methods of data collection also known as triangulation. Triangulation is a method used by qualitative researchers to check and establish validity in their studies. According to Guion (2002) there are two types of triangulation that the study seeks to employ; Data triangulation which will involve the use of different sources of data/information by targeting the different categories of respondents for the study as elaborated in the target population section. Methodological triangulation on the other hand involves the use of multiple qualitative and/or quantitative methods or approaches to data collection and analysis. Patton (2001) believes the use of triangulation by triangulation strengthens a study by combining methods. This can mean using several kinds of methods or data, including using both quantitative and qualitative approaches.

According to Creswell (2003) triangulation implies efforts by the researcher to use different data sources of information by examining evidence from the sources and using it to build a coherent justification for themes. By engaging multiple methods, such as, observation and interviews can lead to more valid, reliable and diverse construction of realities of a research. The study incorporated different methodologies which include FGDs, in-depth interviews, and survey questionnaires. Through triangulation, the varying strengths and weaknesses of quantitative and qualitative approaches are well addresses in order to improve the quality of the data as suggested by Salim (2007).

3.5 Sampling Procedures

The study used different sampling techniques. The researcher used cluster sampling technique which is a probability sampling technique which involves subdivision of the population to be sampled into mutually exclusive groups. Cluster sampling is appropriate when the population of interest is scattered, and no list of the population exists (Best & Khan, 1986). The researcher used 4 clusters to identify households to be included in the study. This will involve identifying households covering a particular geographical area of administrative boundaries within Gachuba Division. The researcher adopted a sample size of 120 households which were a representative of either one adult male or female. Therefore each cluster corresponded to 30 households. Since there was no exhaustive list of the population the researcher constructed a listing frame of the households in the identified four clusters from which a random sample was selected.

The researcher used the purposive sampling which is a non-probability sampling technique where the researcher uses their own judgment to identify respondents for their study. Purposive sampling was used by the researcher to identify the key informants for the study whom are girls, administrative officers, health professionals and religious people. The Salim (2007) suggests that there are no rules in determining sample size in qualitative studies. Size depends on what the researcher wants to know, purpose of inquiry, time and resources available.

3.6 Methods of Data Collection

The study used both secondary and primary data to achieve its objectives. Secondary data refers to data that is already in use for other purposes other than that of the researcher. For instance, data in health centers related to FGM cases. Primary data on the other hand, refers to information gathered at first hand by the researcher from respondents in the field.

3.6.1 Quantitative and Qualitative

The researcher used both quantitative and qualitative approaches to data collection. Quantitative research is based on the measurement of quantity or amount. It is applicable to phenomena that can be expressed in terms of quantity. Qualitative research, on the other hand, is concerned with qualitative phenomenon. According to Neuman (2003) qualitative research is especially important in the behavioral sciences where the aim is to discover the underlying motives of human behavior. Qualitative methods allow the researcher to collect rich, in-depth data from respondents which allows for their own construction or view point. This was through key informant interviews and focus group discussions. Quantitative methods on the other hand lend themselves to statistical manipulations of numerical values and this was through questionnaires.

3.6.2 Focus Group Discussions

The researcher used Focus Group Discussions among the girl respondents of the study. The study targeted girl participants under the ages of 18 years and these comprise of students in secondary and primary schools. Namulondo (2009) uses FGD among female informants who had been involved/not involved in the practice of female genital mutilation. Focus group discussions brought out feelings, attitudes, perceptions and experiences that were not revealed in individual interviews.

3.6.3 Key Informant Interviews

These were used as a data collection tool by the study. Interviews were conducted with the key informants of the study, whom included girls, the administrative officials, religious people, circumcisers and health professionals. Interviews allowed the researcher to collect general information on the trends and context in which FGM is practiced in the community and this enabled the researcher to identify approaches reach respondents at the community level. The researcher developed an interview guide with questions regarding the relevance and the continued practice of FGM in the community. The researcher scheduled a meeting with the respective offices given their busy itinerary.

3.6.4 Secondary Sources

Secondary data was sought from various categories of the respondents which are the administrative offices in Nyamira District and also from local health Facilities. Secondary data enabled the researcher to observe trends on FGM in the area of study. Desk research was undertaken to source information from newspapers, published articles and journals and magazines. Secondary data will be obtained from the District Demographic Plan and the Kenya Household Demographic Survey and data from the 2009 population census. Stewart (1984) argues secondary data provides a comparative tool for the research. This assisted to compare existing data with raw data for purposes of examining differences or trends.

3.7 Techniques of Data Collection

There are various techniques that the researcher adopted in collecting the data which are elaborated upon below.

3.7.1 Questionnaire

Questionnaires are a quantitative technique for gathering information and were the major tool for the primary data collection process. The questionnaire was semi-structured and contained questions on the relevance of FGM among the Kisii, the health implications of FGM and peoples knowledge of the law regarding the practice of FGM. The

questionnaires were self-administered and this allowed for face-to-face interactions with the respondents for further probing. The essence of having semi structured questions is to allow for a process of interaction between the researcher and the respondent where the latter is given an opportunity to give opinions and ideas on the research questions. The researcher seeks to design two questionnaires which are the women and men questionnaire and practitioners' questionnaire.

3.7.2 Key Informant Guide

The researcher developed a key informant guide which was used in the data collection processes. The guide comprised of questions that the researcher posed to the interview respondents and allowed them to give their views and opinions. A guide is useful in the exercise so as not to lose focus on the study research questions.

3.7.3 Focus Group Discussion Guide

The Focus Group Discussion guide was used by the researcher to conduct discussions with the study respondents. The schedule was developed in relation to the topics relevant to the study. These discussions gave detailed information which was easily placed under each of the sections of the FGD schedule in line with the themes of the research questions.

3.8 Validity and Reliability of the Study

According to McMillan and Schumacher (2006) reliability and validity are conceptualized as trustworthiness, rigor and quality in the qualitative paradigm. This can be achieved by eliminating bias and increasing the researcher's truthfulness of a proposition about some social phenomenon using triangulation. In order to ensure validity for the research instruments the researcher involved the university supervisor and other experts in the design of the data collection instruments. To ensure reliability the researcher conducted a pilot study in order to establish the instruments reliability in acquiring similar responses from the respondents. The researcher then modified the instruments to enhance clarity of the items to the respondents.

3.9 Ethical Considerations of the Study

Shukla (2008) ethics relate to the moral choices affecting decisions, standards and behavior and in research it has become difficult to lay down clear ground rules which can cover all possible moral choices. According to House (1993) ethical principles are abstract and it is not always obvious how they should be applied in given situations. However, there are basic grounds of ethics relating to social research which the study applied during the study as discussed in the subsequent section. The researcher also assured respondents on the privacy of the information they provide by not divulging information to other community members and conducting interviews in a private environment. Confidentiality of the information provided is also an ethical concern which the researcher enhanced by assuring respondents that the information provided is only for academic purposes.

3.8.1 Informed Consent

Given the private and sensitive nature of the issue of FGM the researcher acquired the consent of the study participants. Piper & Simons (2005) informed consent implies that those interviewed or observed should give their permission in full knowledge of the purpose of the research and the consequences for them of taking part. Therefore all categories of the respondents will be provided with the information concerning the study in the most understandable language to enable them to make an informed decision to participate in the study.

3.8.2 Confidentiality and Anonymity

Confidentiality is a principle that allows people not only to talk in confidence, but also to refuse to allow publication of any material that they think might harm them in any way. Anonymization is a procedure which offers some protection of privacy and confidentiality. During the research process participants comprising of the FGDs or community members were assured of confidentiality of the information provided by not attaching their names to their responses and opinions on the study subject matter.

3.10 Data Analysis

Completion of the data collection process calls for the data analysis process. There are several steps which were required to prepare the data ready for analysis; these steps involved data editing and coding, data entry and data cleaning to allow for appropriate entry into the statistical software. The researcher edited the raw data collected through the questionnaire with an effort to detect errors and omissions such that the minimum data quality standards have been achieved. Coding involves assigning numbers so as to be able to group responses into a limited number of classes or categories (Shukla, 2008). The researcher assigned numerical values to the questionnaire item responses and which will be done by developing a codebook for the survey questionnaire. Data entry involved the process of keying the data into the Statistical Package for Social Scientists (SPSS) for statistical analysis.

The study was limited to descriptive statistics because of the nature of the subject matter (Salim, 2007). Descriptive statistics allow social science to organize and summarize data in a meaningful way (Frankfort-Nachmias & Nachmias, 2000). Description is essential to positivist science and a necessary step before any further statistical analyses. Descriptive statistics have an important role to play, enabling data to be explored before any further analysis is undertaken but also as a primary means of describing how things are rather than seeking to explain why phenomena occur. Frequency distributions were used to describe data indicating the frequency of all categories or ranks, either in a tabular form or as a pie chart (Somekh & Lewin, 2005).

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

This chapter of the study comprise of the data presentation and interpretation. The chapter is presented in sub – topics which include the background information of the respondents, the persistence of FGM among the Kisii, the approaches to abandonment of FGM and knowledge of legislation about FGM.

4.2 Description of Respondents

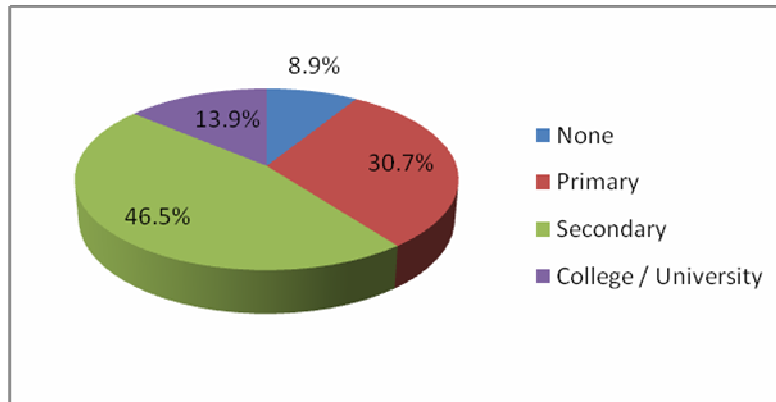
4.2.1 Gender

In the sample there were 56.4 percent male and 43.6 percent female. This is attributed to the fact that male members in the community are more willing to speak about FGM than their female counterparts.

4.2.2 Education

In regard to level of education the study found that 8.9 percent had no formal education, 30.7 percent were primary level of education, 46.5 percent were secondary level of education and 13.9 percent were college / university level of education as shown in Figure 2. This illustrates that most of the community members have a minimum of a primary education and also have secondary education which are the basic levels of education as highlighted in the Millennium Development Goals. This finding is different from that of the Nyamira County Data Fact Sheets (2011) where primary education levels are higher (64.0 percent) than secondary education (17.7 percent). Over the past two decades the Kisii community has focused on schooling their children and are relatively well educated, making the sustained presence of FGM unusual.

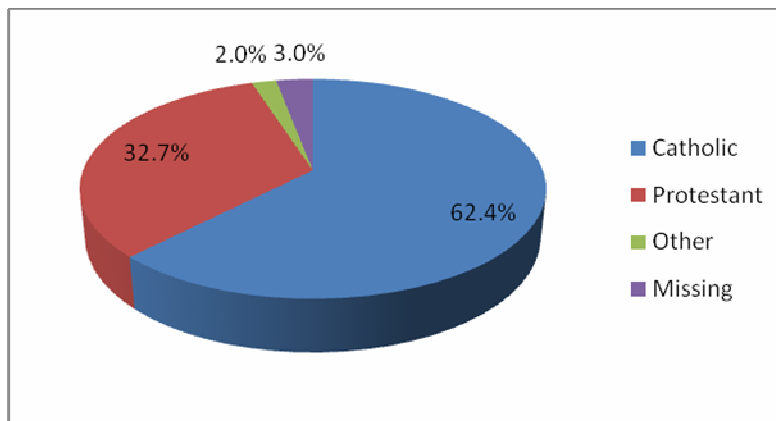
Figure 2: Education Level of Respondents



4.2.3 Religion

In terms of religious affiliation 62.4 percent were Catholics, 32.7 percent Protestants, 2.0 percent were other and 3.0 percent were missing responses as indicated in Figure 3 below. Christianity is the most popular religion.

Figure 3: Religious Affiliation among Respondents

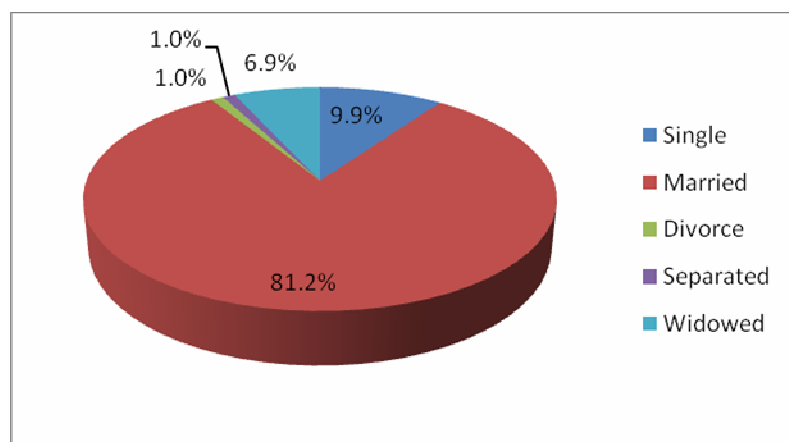


4.2.4 Marital Status

In regard to marital status 81.2 percent were married, 9.9 percent single, 6.9 percent were widowed, 1.0 percent were separated and divorced respectively as reflected in Figure 4 below. This finding is attributed to the cultural importance attached to the institution of

marriage as a union for the reproduction of societal values and cultures. According to the Kenya Demographic and Health Survey 2008 – 2009 there are more married members in the community. Divorce and separation were identified by 1.0 percent and this is attributed to the negative perception associated with separation and divorce by the Kisii culture.

Figure 4: Marital Status of Respondents



4.2.5 Household Composition

A total of 94.1 percent had children and 5.9 percent had not. In regard to the number of girls the study found that 55.4 percent had 1 – 3, 12.9 percent had none, 22.8 percent had 4 – 6, 4.0 percent had 7 – 10 and 5.0 percent had 11 – 15 as shown in Table 4.1 below. In regard to the number of boys, study findings show that 16.8 percent had none, 55.4 percent had 1 – 3, 25.7 percent were 4 – 6 and 2.0 percent had 7 – 10. Nyanza Province has some of the highest total fertility rates in Kenya, at 5.4, compared to 2.8 in Nairobi, and 3.4 in Central Province. According to the KDHS 2008/2009 the Kenyan households consist of an average of 4.2 people. The ideal family size is higher among women in rural areas than urban areas (4.0 versus 3.1). The study found the average household size to be 4 compared to that of the Nyamira District Development Plan 2005-2010 which is 5.

Table 4.1: Number of Children (Boys and Girls)

Responses	Boys		Girls	
	Frequency	Percent	Frequency	Percent
None	17	16.8	13	12.9
1 – 3	56	55.4	56	55.4
4 – 6	26	25.7	23	22.8
7 – 10	2	2.0	4	4.0
11 – 15	–	–	5	5.0
Total	101	100.0	101	100.0

4.3 Persistence of FGM in the Community

4.3.1 Girls Undergoing FGM

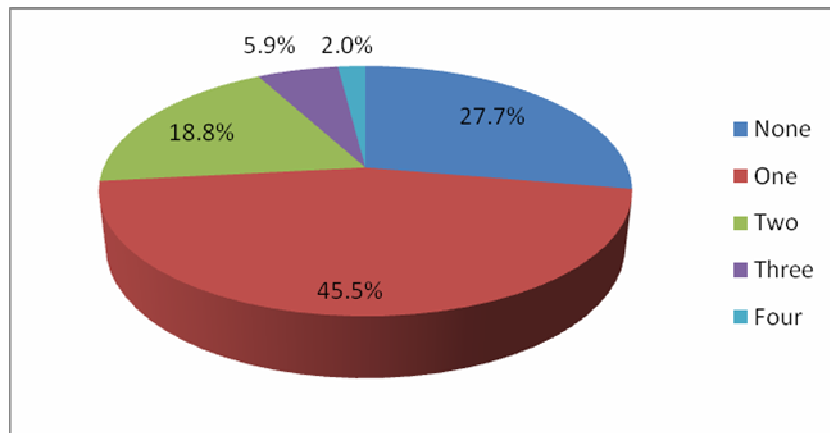
All the female respondents interviewed had undergone FGM. In the sample 74.2 percent had circumcised their daughters whereas 25.8 percent had not. The researcher asked respondents to indicate the number of daughters that had undergone FGM. As shown in Figure 5 below, 45.5 percent were one, 27.7 percent were none, 18.8 percent were two, 5.9 percent three and 2.0 percent were four. Among the Kisii, the practice of FGM has been associated with importance of upholding cultural traditions; preserving sexual morality and social pressure. According to key informants, persistence of FGM was attributed to traditional / cultural beliefs. These include; that circumcised women were less promiscuous compared to uncircumcised women. The income realized through circumcision was also identified as contributing to the persistence of the practice where it's a source of employment for the elderly women in the community. Persistence of FGM was also attributed to the fear of repercussions if one failed to undergo the practice as explained by a nurse at the local health center. She said,

“FGM has persisted because people in the community believe that leaving the traditional culture will lead to a curse from their ancestors”

In one of the FGDs, a youthful female discussant said,

“Yes, I am aware of girls who have been circumcised but I cannot list them here because they are many”

Figure 5: Number of Girls who have Undergone FGM



The continued practice of FGM among the Kisii has also been attributed to the sanctions towards the uncircumcised women. For instance, fear of ridicule and social stigma, as well as stereotyping has stopped many families from abandoning the practice. Among the Kisii, *ebisagane* (uncircumcised women) are also discriminated from participating in cultural ceremonies such as the *ogwasimoria omwana* (celebration of a new born child) or during *chinyangi chie ekegusii* (traditional wedding ceremonies). The study found that uncircumcised women and girls were not allowed to participate in *okwarokia abana* (FGM ceremonies).

The circumcisers, also known as *abasari* or excisors, also play a big role in promoting and prolonging the practice of FGM particularly in the rural areas. Their trade provides them with a regular income and a social status in the community; hence they discourage girls and their parents from abandoning the practice in the name of upholding the tradition in order for them to continue with the trade. Traditional circumcisers charge comparatively less and sometimes are paid with non-monetary items e.g. chicken. Research has shown that trying to provide income generating activities for circumcisers was unsuccessful as it encouraged more women to become circumcisers in order to achieve financial assistance.

4.3.2 Reasons for Performing FGM

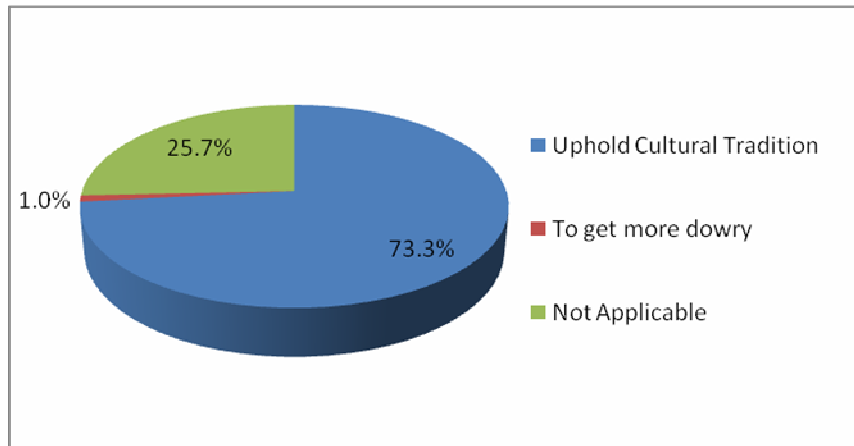
FGM is a socio-cultural tradition, often enforced by community pressure and the threat of stigma. Although every community in which FGM is found in Kenya has different

specifics around the practice, there are several unifying rationales/beliefs. These communities include the Somali, Maasai, Meru, Kalenjin and the Kuria. Among all these communities the reason of FGM is a cultural and ethnic identity, to control sexuality and marriageability. Among the Somali FGM is practiced due to religious reasons, cleanliness and beautification and confers social status and family honour. Among the Maasai the reason is to make birth easier (Abdi, 2009). Among the Kisii, FGM is prevalent due to reasons such as it confers social status family honour, as a rite of passage / transition to adulthood, marriageability, control sexuality, cultural and ethnic identity and the commercialization of the practice.

The study found that upholding cultural traditions as the most prominent reason for practicing FGM as indicated by 73.3 percent, acquiring more dowry payment with 25.7 percent and 1.0 percent did not apply as shown in Figure 6 below. Female circumcision is considered an integral part of the Kisii peoples' way of life and culture, it is widely believed that circumcision reduces sexual urge in women. In continuing with the practice, the Kisii seek to ensure that their women do not become promiscuous. FGM continues because of tradition and a sense of community, particularly as it distinguishes minority Kisii from their historically hostile neighbours the Luo, who do not practice it.

These findings support those of Abdi (2009) to the commercialization of the practice where more bride price is paid to the girl's family if she has undergone FGM. The preference for girls who have undergone FGM has led to the persistence of the practice due to the higher bride price offered. The Kisii believe that FGM will control a girl's sexual desires and ensure marital fidelity, especially within polygamous marriages. The number of cows for uncircumcised women is less compared to that of circumcised women. For example, the number of cows paid to an uncircumcised woman can be less by 1 the number paid to a circumcised one. The bride wealth payment for uncircumcised women may also be delayed despite the woman being already staying in marriage .

Figure 6: Reasons for Practicing FGM



There are several justifications for the persistence of FGM in the community. As study findings show most communities evoke culture and tradition for persisting with the FGM practice (Bashir, 1997). It is evident that FGM is a deeply rooted cultural tradition among those who practice it as observed by One key informant,

“The continued practice would enhance the existence of the community culture in a society that is rapidly becoming westernized and there is a fear that people might lose their identity. It is also viewed as a way of moving from one stage to another i.e. childhood to adulthood”

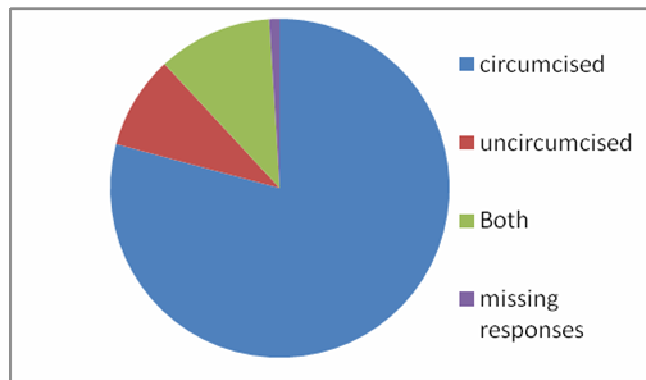
These findings also indicate that there is still perception that a circumcised woman is held in high esteem than uncircumcised women as more bride wealth is paid for those who have undergone the practice. Among the Kisii, it is perceived that girls are circumcised so that they can get married, have children and achieve respectability. There was a widespread belief that uncircumcised girls are promiscuous as it is believed that they are unable to control their sexual desires.

A key informant commented,

“FGM is generally practiced as a matter of social convention, and is interlinked with social acceptance, peer pressure, the fear of not having access to resources and opportunities as a young woman to secure prospects of marriage”

Among the Kisii, there is a preference for women who have been circumcised than those that have not been circumcised. The study found that there was preference for circumcised women by men and parents of the man as indicated by 79.2 percent, 8.9 percent indicated uncircumcised, 10.9 percent were both and 1.0 percent was missing responses as shown in Figure 7 below. As depicted it is evident that the community holds circumcised women in high esteem as a woman or girl who has undergone FGM is seen as upholding tradition. It is culturally perceived that a circumcised woman is sexually moral than an uncircumcised woman. It is also perceived that the clitoris is the source of sexual desire and that its removal improves the prospect of premarital virginity, and marital fidelity, and to ensure “decent behaviour” by the women. This indicates that FGM is a cultural tradition that is also perpetuated by the men in the community. Among the Kisii, older men also reflect the traditional preference for wives who have undergone the procedure. However, Men’s attitudes seem to be changing with there being an increasing trend among young men to publicly announce their preference to marry uncut girls (UNFPA/UNICEF, 2011).

Figure 7: Preference for circumcised women in the community



A nurse at a local dispensary said,

“Men view women who have not undergone FGM as having skipped a very important stage in life thus they are not willing to marry them”

4.3.3 Stereotypes against Uncircumcised Women

The study established that there was discrimination against uncircumcised women in participating in cultural ceremonies. The study also sought to determine whether there were stereotypes and nicknames targeted towards uncircumcised women. Study findings show that 67.3 percent acknowledged this, 20.8 percent were no responses, 10.9 percent didn't know. Further, the study examined what stereotypes were directed towards uncircumcised women. Some of the stereotypes included *Egesagane* (uncircumcised girl/woman), *omogere* (Luo), *omogima* (a whole woman not circumcised) and *Omoisia* (likened to uncircumcised male). Uncircumcised women were also referred to as culture breaker as they were regarded as going against the culture of the community which required girls to be circumcised. Among the Kisii community, circumcision is observed as a cultural tradition which differentiates them from other neighbouring communities. Uncircumcised women are regarded as unmarriageable as they were not preferred as fit for marriage. Circumcised women are more preferred for marriage more than uncircumcised women; dowry paid for uncircumcised women is lower than that of circumcised women.

4.3.4 Age of Undergoing FGM

The literature identified that there are different ages at which FGM is practiced in different ethnic communities. There has been a marked trend towards girls undergoing FGM much younger, with many girls under 10 years of age. This is practiced so as not to have the girls at an age in which they can refuse to undergo the practice. Also this is reinforced as there is no specific law in Kenya against FGM for women over 18 years of age (Oloo *et al.*, 2011). The 2008/2009 KDHS found that the majority of girls in Nyanza Province were undergoing FGM aged 10 – 13 years, at the onset of puberty.

Table 4.2: Age at Which FGM is performed

Age	Frequency	Percent
7 - 9 Years	26	25.7
10 - 12 Years	42	41.6
13 - 15 Years	5	5.0
Not Applicable	28	27.7
Total	101	100.0

In regard to the age at which FGM is performed the study found that 25.7 percent were 7 – 9 years, 41.6 percent were 10 – 12 years, 5.0 percent were 13 – 15 years and 27.7 percent were not applicable as depicted in Table 4.2 above. The median age for girls undergoing FGM was 10 – 12 years. As study findings show, girls above 10 years of age were at higher risk of FGM than younger girls, indicating that the prevalence increases with age. Abdi (2009) showed that the age at cutting is getting younger and the reason is changing –from rite of passage to cultural identifier. Traditionally FGM was performed from 15 years in preparation for marriage but it now typically performed on girls aged 8-10 years. The most common form of FGM is Type I. (Population Council, 2007).

Jaldesa (2002) also found that the Kisii community perceived that by practicing FGM at the pre – puberty stage; bleeding is minimal, the tissue is soft to cut, the wound is thought to 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.

4.4 Issues and Trends of FGM among the Kisii

As the practice of FGM persists in the community there are various issues and challenges that emanate from the continued practice. These included the practice of FGM as were being done forcibly or willingly, effects of FGM and the preference for circumcised women among the Kisii.

4.4.1 Practice of FGM in Community

The study sought to establish the status at which FGM is undertaken in the Kisii community whether it was done willingly or forcibly. As indicated in Figure 8 below those who underwent FGM willingly were 76.2 percent compared to those who were forced at 23.8 percent. Although girls may choose to undergo the practice of FGM, it is not necessarily so but due to the socialization within the community that reinforce the stereotypes against uncircumcised girls or women and thus a girl will choose to undergo the process so as to avoid mocking from the community and their peers. Oloo *et al.*, (2011) argues that there is a lot of pressure on individual girls to submit to circumcision among the Kisii. A girl who is not circumcised is treated with contempt and many participants said that she can never be respected in the community, she will not have any

friends and she will not have a husband because no man will be willing to marry her. One nurse at the local health center commented as follows,

“Girls are at times circumcised willingly because they associate this occasion as earning them respect in the community as they are upholding the culture”

It is evident that there are instances where girls are forced by parents to undergo the practice of FGM as 23.8 percent indicated this. In some cases, the uncircumcised girls envied the gifts like new dresses, delicious food, new shoes and good treatment the circumcised girls received during seclusion, and this often led them to demand circumcision too. Information from the key informants reveals that there are cases where girls are forced to undergo FGM but these cases are not reported as quoted below,

“There are cases where girls are forced into FGM but they never report these cases and therefore no legal action can be taken on the circumciser or the family”

Similar information was also got from a female youth discussant in the FGD as she said,

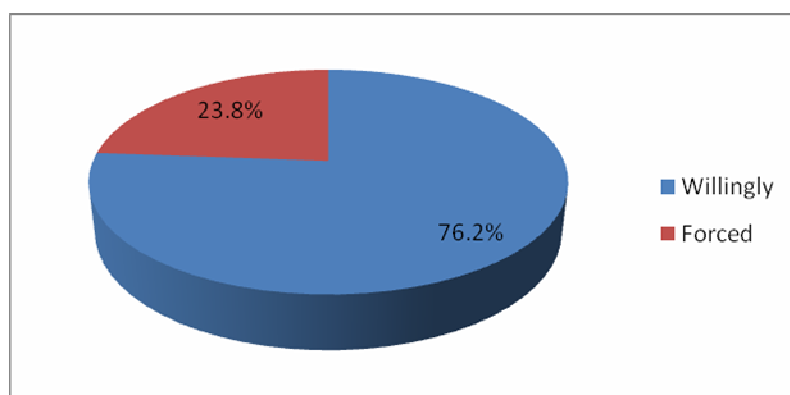
“Girls are forced to undergo FGM by the parents and other village elders in the community with the expectation that parents will get a higher / more rated bride wealth”

A religious leader who was a key informant said,

“Most of the girls are forced to undergo FGM by the parents and other village elders in the community. For example parents expect higher rated bride wealth for their circumcised daughters”

Focus Group Discussions with the girls also revealed that ceremonies associated with FGM were identified as being done in selected places by community elders. This includes the house of the initiate and near the river. Traditionally before circumcision for both boys and girls were undertaken in the rivers and early in the morning so that the initiates could dip into the river and this was perceived to have a numbing effect of the nerves which would act as an anaesthetic to reduce the pain.

Figure 8: Practice of FGM in the Community



4.4.2 Health social effects of FGM

There are several dangers associated with the practice of FGM. Dangers associated with FGM among the community were 51.5 percent indicated excessive bleeding, 2.0 percent were obstructed labour, 7.9 percent were sexual complications and 38.6 percent were not applicable. As depicted in Table 4.3 below most participants in this study were aware of the medical effects of FGM and easily cited problems such as excessive bleeding and obstructed labour. The local dispensary nurse said,

The vaginal canal is affected since they experience a lot of bleeding when giving birth compared to those who are not circumcised”

Table 4.3: Effects of FGM

Effects	Frequency	Percent
Excessive Bleeding	52	51.5
Obstructed Labour	2	2.0
Sexual Problems	8	7.9
Not Applicable	39	38.6
Total	101	100.0

Sexual problems were also identified as common among women who have undergone FGM. This finding supports (Berg, Denison & Fretheim, 2010) that women with FGM were found to be 1.5 times more likely to experience pain during sexual intercourse, experience significantly less sexual satisfaction and they were twice as likely to report

that they did not experience sexual desire. Ondieki (2010) also concurs that the long term effects are more severe. They include scarring, complications at childbirth and even infertility. There is also the psychological trauma, painful intercourse and inability to experience sexual pleasures. As a result of those cited complications, the girls' participation in school activities may be affected negatively

According to the Hosken (1993), the highest maternal and infant mortality rates are in FGM practicing regions. The practice results into irreversible life-long risks for girls and women, at the operation, during menstruation, marriage, consummation and child birth (Ondieki, 2010). Obstructed labour is also an effect of FGM practice and studies (WHO, 2006) have found that women with FGM are significantly more likely than those without FGM to have adverse obstetric outcomes. According to the WHO (2011) the most common short-term consequences of FGM include severe pain, shock caused by pain and/or excessive bleeding (hemorrhage), difficulty in passing urine and faeces because of swelling, oedema and pain; as well as infections. Death can be caused by hemorrhage or infections, including tetanus and shock

Apart from the health effects of FGM on the individual there are also social implications of FGM; for instance, school attendance for the circumcised girl. Ongong'a (1990); Oduyoye (1992) indicate that girls who have undergone circumcision, or whose bride-price have been paid, often undergo attitudinal changes and reject formal education, perceiving themselves as adults and schools as institutions for "children". Psychological consequences of FGM are anxiety, horror, Post Traumatic Stress Disorders (PTSD) and depression.

4.4.3 FGM facilitators

The study examined the practice of FGM and the researcher investigated who are the facilitators / influencers of FGM in the community. Table 4.4 below shows that 22.8 percent indicated parents, 11.9 percent were circumcised women and 41.6 were elderly women.

Table 4.4: FGM Facilitators

Practitioner	Frequency	Percent
Circumcised Women	12	11.9
Elderly Women	42	41.6
Nurse	12	11.9
Parents	23	22.8
Clan Elders	2	2.0
Grandparents	1	1.0
Community members	6	5.9
Missing Responses	3	3.0
Total	101	100.0

Elderly women were more respected in the community and had previously undergone FGM themselves. Culturally it is elderly women who perform the ritual which is passed from one practitioner to another over generations through informal training. Study findings showed that 11.9 percent of FGM practitioners were nurses. This indicates that there is evidence of the medicalization of FGM in the Kisii community.

Medicalisation of FGM in the Kisii community is a continuing trend where most of the families engage the services of nurses to perform FGM to their daughters. This is attributed to the perception that it is safer compared to traditional circumcisers. This finding supports those of the Kenya Demographic Health Survey 2008/2009 that the medicalization of FGM in Kenya has been a trend that has been documented, particularly among the Kisii. In 2003, 46% of Kenyan daughters had FGM performed by a health professional (up from 34.4% in 1998). However, the latest DHS puts the figure at 19.7% overall or 27.8% in urban areas.

4.4.4 Role of Parents in FGM

As a cultural ceremony with the community, the study examined the role of the parents in FGM ceremonies. This was distinguished between the role of father and the mother. FGM is practiced among the Kisii as a means of promoting family honor in the community. Ondiek (2010) reveals that most girls are not involved in decision making concerning circumcision. Mothers, aunts, grandmothers and other relatives were the ones

who decided whether the girls should or should not be circumcised. Mothers and grandmothers are the most influential persons to determine if girls undergo one of these procedures.

Table 4.5 below depicts that the role of the father is to provides finances and resources for the ceremony as indicated by 80.2 percent, 10.9 percent were organize and prepare for the ceremony, 6.9 percent were give permission or authority for the girl to be circumcised and 1.0 percent were to identify the circumciser and missing responses respectively. It is customary for the family to incur costs of circumcision. Again, studies indicate that for a tradition that is more female than male; men in the community play the major role as it comes down to the father of the girl to authorize whether their daughters will undergo FGM. This indicates that FGM is more persistent due to the patriarchal nature of communities that still practice it. The father is also responsible for approving the circumciser which is also influenced by the cost whether in monetary and non – monetary based on the FGM practitioner whether traditional or a medical officer.

Table 4.5: Role of Parents in FGM

Role of fathers	Role of mothers
Provides finances and resources for the ceremony	Guiding and giving rules to the circumcised
Organize and prepare for ceremony	Invite / welcome community members
Give permission / allow girls to be circumcised	Taking care of the circumcised girls
Approving for the traditional circumciser	Search / identify the circumciser
	Prepare food for visitors
	Encourage girls to be circumcised

Taking care of the circumcised girls was the primary role given to the mothers of the initiates as indicated by 26.7 percent, guiding and giving rules to the circumcised was indicated by 13.9 percent as a role of the mother. Unlike in the past where girls were traditionally secluded after they had been cut, to give them time to heal as well as to

receive instruction from grandmothers, aunts and other elderly women, today, girls remain at home and are cared for by their mothers. Inviting and welcoming guests to the FGM ceremony was also identified by 29.7 percent as the role of the mother. Mothers' who have undergone FGM are more likely to encourage their daughters to undergo FGM as indicated by 5.9 percent. However, there is a declining trend given the least number of occurrences (5.9 percent) of women insisting on their daughters to get circumcised.

4.4.5 Cost of FGM

It is customary for the family of the initiate to pay for the cost of circumcision. The study established that buying food was the most expensive activity of FGM rites as indicated by 81.2 percent of the sample and the average expenses for the food is Kshs.10, 000. Paying the circumciser was also a cost incurred by the initiates' family as showed by 10.9 percent which could either be in cash or in kind. Circumcisers are paid Kshs 3,000-5,000 and could be paid by such a goat or chicken. Cultural occasions predominantly provide that there be drinking of the local beer and was identified as by 5.9 percent which could cost a family Kshs. 4,000-6,000.

Although the public celebration of FGM is still practiced, research participants said that the ceremonies have less pomp than they used to in the past – there is less feasting, fewer gifts for the initiates and less people attending the public ceremonies. This was attributed to current economic challenges and the fear of legal repercussions given that the practice has been declared illegal.

Table 4.6 Cost of FGM

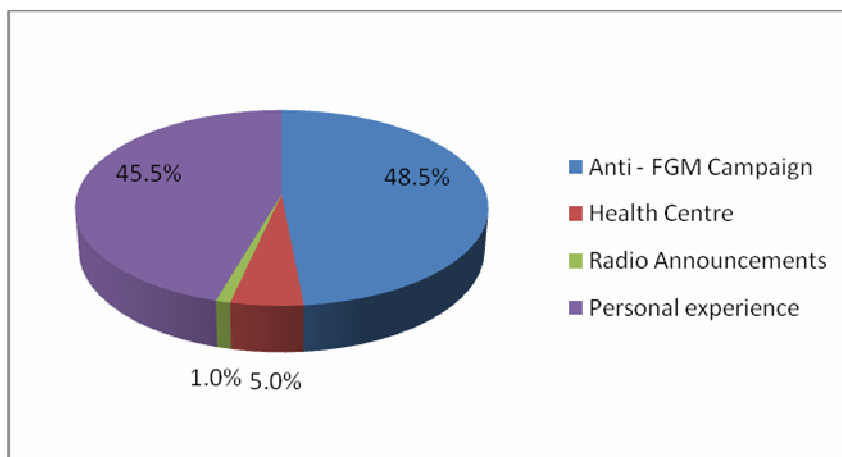
Item	Average cost	Percent
Food	10000	53
Drinks	5000	26
Circumciser	4000	21
Total	19000	100.0

4.5 Efforts towards elimination of FGM

4.5.1 Source of information on FGM

As shown in Figure 9 below, anti – FGM campaigns were the major source of information on FGM as indicated by 48.5 percent, health centers were 5.0 percent, radio announcements were 1.0 percent and personal experience was 45.5 percent. Despite the radio being on one of the most accessible forms of mass communication in the rural areas it was not a major source of information on FGM. Radio has a wide following in the rural areas and especially with the advance of FM stations which broadcast in the local mother tongue and would have a greater impact in the communication of information on FGM.

Figure 9: Respondents Source of Information on FGM Awareness



4.5.2 Anti – FGM Activities in the Community

Education and awareness on the effects of FGM were identified as the most popular anti – FGM activities in the community by 93.1 percent of the respondents. Table 4.7 below depicts alternative rites of passage was identified among 5.0 percent as an anti – FGM activity in the community and 1.0 percent were missing responses and not applicable responses. Alternative rites approach has been widely recognized as the predominant approach to advance the abandonment of FGM in communities. Alternative rituals to mark initiation have been developed to substitute for the traditional cutting ceremonies, comprising traditional education on the role the adolescent girl will be expected to play,

including aspects of sexuality and motherhood. This assists because communities attribute great importance to these coming-of-age ceremonies, thereby abandoning FGM/C may be associated with abandonment of the rites of passage themselves, which may create considerable social conflict and/or a lack of interest in abandoning FGM/C.

Education and awareness of FGM in the community is targeted towards the traditional circumcisers themselves, parents and girls. For community circumcisers the health risks associated with FGM are the predominant theme which also entails providing them with alternatives sources of income. Education is also seen as a tool to empower young girls who are the targets of FGM practices in the community for them to be bold enough to question the practice and not willingly accept to undergo the practice.

Table 4.7: Anti – FGM Activities in the Community

Anti – FGM Activities	Frequency	Percent
Education / Awareness on effects of FGM	94	93.1
Alternative Rites Passage	5	5.0
Not Applicable	1	1.0
Missing Responses	1	1.0
Total	101	100.0

4.5.3 Anti – FGM Activities champions/facilitators

On examining the champions, the study found that government agencies were engaging in anti – FGM activities as depicted in Table 4.8 below by 38.6 percent, non – governmental organizations were 6.9 percent, religious organizations were 46.5 percent, women groups were 4.0 percent, radio broadcasts were 2.0 percent and community based organizations (CBOs) were 1.0 percent. Religious organizations have long been involved in FGM abandonment approaches by demonstrating that FGM is not supported by a community’s religion. It has been an effective approach for changing attitudes and practices. For example, the Kikuyu traditionally practiced FGM/C virtually universally, but when Christian missionaries began to convert them in large numbers, messages

encouraging them to abandon the practice through sermons and other interventions by the missionaries contributed to a reduction in the practice (MoGSC&SS, 2007).

Government agencies have also been actively engaged in the abandonment of FGM in the community through the line ministries such as the Ministry of Health and its departments on reproduction. This education and awareness is rolled out through the government clinics and health center within communities that still practice FGM. Women groups were also identified as facilitators where locally formed groups of like – minded women against the practice of FGM reach out to other women not to undertake their children through FGM and also for girls to not willingly undergo the practice. They are usually trained on the health implication of the practice by other partners such as the Government agencies, NGOs and international organisations.

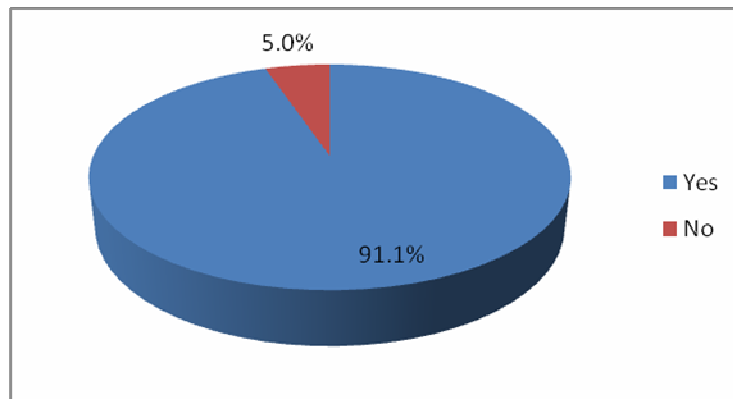
Table 4.8: Anti – FGM Facilitators in the Community

Facilitators	Frequency	Percent
Government agencies	39	38.6
NGOs	7	6.9
CBOs	1	1.0
Religious Organisation	47	46.5
Women Groups	4	4.0
Radio Broadcasts	2	2.0
Missing Responses	1	1.0
Total	101	100.0

4.5.4 Community Participation in Anti – FGM Activities

Figure 10 below shows the community’s participation in anti – FGM activities where 5.0 percent did not participate compared to 91.1 percent who participated. This indicates that there are high numbers of community members who are involved in the abandonment of FGM compared to those who are most likely to support it. This is attributed to the various ranges of activities that are in the community and the efforts of organisation in community sensitization on the negative impact of FGM.

Figure 10: Participation in Anti - FGM Activities



4.5.5 Organizations and Activities

There are several organisations involved in the anti – FGM activities in the community and 40.6 percent indicated religious organisations, 7.9 percent were youth / women groups, 12.9 percent were government agencies who conducted seminars / education and awareness, 5.9 percent were health centers and 4.0 percent were NGOs as shown in Table 4.9 below. NGOs working on FGM activities were less compared to those working in areas of HIV and economic empowerment. Religious organisations were the most active and this is attributed to the disengagement of FGM with religion which has been observed to have a significant impact of the abandonment of FGM in other communities (MoGSC&SS, 2007). These activities were conducted in the church and also in rallies. Community volunteers have formed youth and women groups to sensitize the community on the negative impact of the continued practice of FGM as said by a youthful girl in the FGD,

“There are campaigns against FGM which are conducted by some women volunteers”

Focus group discussions with the girls also revealed that there were information, educational and communication (IEC) materials which were provided for by the government agencies within the community showing the harmful nature of the practice. The use of pictures and illustrations are an effective approach especially if the targets of the campaigns have low literacy levels as suggested by a youthful female in the FGD,

“There are posters which are being put everywhere (shops, restaurants) within the center showing the pictures of the negative impacts of FGM”

Table 4.9: Organisations and Anti – FGM Activities in Community

Organizations’ Activities	Frequency	Percent
Religious organisations educate / create awareness on FGM effects	41	40.6
Youth / women groups assist in community abandonment of FGM	8	7.9
Government agencies conduct seminars / education and awareness	13	12.9
None of the organisations are in the community	21	20.8
health centers provide sensitization on negative effects of FGM	6	5.9
NGO's educate on the impact of FGM on HIV/AIDS	4	4.0
Not Applicable	2	2.0
Missing Reponses	6	5.9
Total	101	100.0

4.6 Community awareness of Anti-FGM legal instruments

4.6.1 Awareness of Anti – FGM legal instruments

Study findings indicate there is a high level of awareness on the law concerning the practice of FGM as espoused by Figure 11 below which depicts that 91.1 percent of respondents answered yes, 5.0 percent said no, 2.0 indicated don’t know and 2.0 percent were missing responses. This finding is attributed to the increased efforts by stakeholders to educate the community on FGM matters. The discussion of the new constitution has also significantly contributed to the knowledge of legal matters among the community which has been attributed to improved community participation in issues.

An elderly woman in the FGD said,

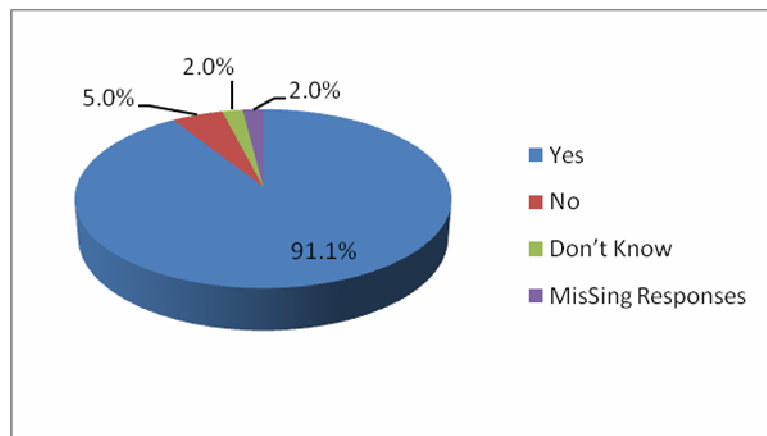
“If you circumcise a baby girl you will be arrested”

“It states that girls should not be circumcised and if anyone goes against it he / she should undergo serious legal punishment”

At the same time, an Assistant Chief who was a key informant acknowledged,

“We were trained on the anti-FGM law but warned by the administration about creating awareness to the community members or saying that we are aware of the law“

Figure 11: Awareness on FGM Legislation



4.6.2 FGM Legal Instruments

There are several legal instruments which seek to address the practice of FGM where 61.4 percent indicated they knew of the Anti – Female Genital Mutilation Law, 29.7 percent were Children’s Act of 2001, 2.0 percent were the Kenya Constitution 2010 as illustrated in Table 4.10 below. The Anti-FGM Act (2011) criminalizes all forms of FGM performed on anyone, regardless of age or status, and banned the stigmatizing of a woman who had not undergone FGM in an attempt to tackle social pressure. It also made it illegal to aid someone in performing FGM, taking them abroad to have the procedure done, failing to report to the authorities if the individual was aware it had taken place or carrying out FGM on a Kenyan abroad. The Children’s Act of 2001, Section 14 of the Act states that:

“No persons shall subject a child to female circumcision, early marriage or other cultural rights, customs or traditional practices that are likely to negatively affect the child’s life, health, social welfare, dignity or physical or psychological development.”

Table 4.10: Awareness of Anti-FGM Legal Instruments

Legal instruments	Frequency	Percent
Anti - FGM Law	62	61.4
Children’s Act 2001	30	29.7
Constitution 2010	2	2.0
Not Applicable	2	2.0
Missing Responses	5	5.0
Total	101	100.0

4.6.3 Understanding of Anti - FGM Law

The study examined the comprehension and understanding of the various FGM instruments where 22.8 percent identified that it was illegal and punishable by law to force FGM on girls, 18.8 percent identified that circumcision was a practice that was prohibited, 20.8 percent that FGM legislation provided for the protection of rights of girls against cultural practices as shown in table 4.11 below. This illustrates that the community have a good understanding of children’s rights (girls) as espoused in the Children’s Act 2001 which seeks to protect children (under 18 years) for being subjected to cultural practices against their will as expressed by a youthful female in the FGD below,

“It discourages the practice of FGM as it leads to the spread of HIV due to the sharing of one razor blade and you will be arrested if you practice FGM in the community”

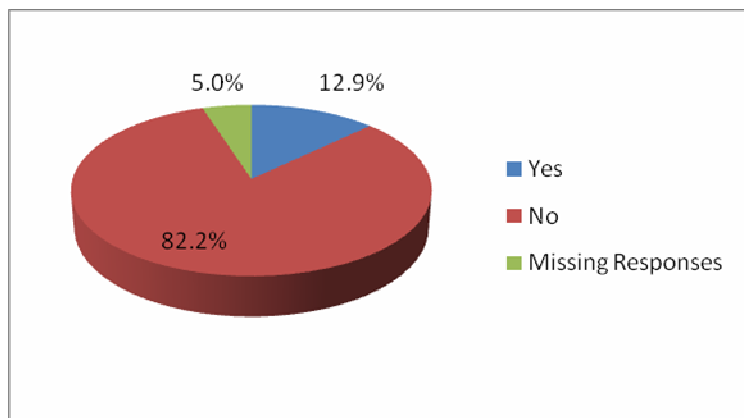
Table 4.11: Understanding of Anti – FGM Law

Content of FGM legislation	Frequency	Percent
Circumcision of girls is prohibited	19	18.8
Provides protection of rights of girls against cultural practices	21	20.8
It is illegal and punishable by law to force FGM upon girls	23	22.8
It advices communities against practicing cultural traditions	9	8.9
Hinders the circumcision of girls	8	7.9
Elaborates penalties and effects of FGM	8	7.9
Not Applicable	2	2.0
Missing Responses	11	10.9
Total	101	100.0

4.6.4 Consequences of Anti – FGM Law

In contravention of the law there is bound to be legal consequences which as indicated in the legal instruments amount to a fine or a jail time. As indicated in Figure 12 below it was evident that only a handful of community members were aware of anyone in the community punished because of practicing FGM as identified by 12.9 percent. However, the majority of the respondents indicated that they were not aware of any person being punished and this were represented at 82.2 percent and 5.0 percent were missing responses.

Figure 12: Punishment for FGM practice



The Children’s Act of 2001, Section 20 notes that any connection of FGM related offences carries penalties of 12 months’ imprisonment or fine of Kshs. 50,000 or both. The connection here includes a person who takes or forces the girl to be circumcised, the circumciser and those involved in the ceremonies. The punishment with this act (Anti – FGM Act 2011) is much more severe than the 2001 Act, and can apply to a wider range of perpetrators. The penalties include three to seven years’ imprisonment, or life imprisonment for causing death by performing FGM and fines of nearly US\$6,000. Key informant interviews revealed that the anti-FGM legislation had significant impact on the practice of FGM as mentioned by a religious leader,

“It has created fear among individuals who are not willing to stop the practice along with reducing the rate at which the practice was previously undertaken before”

4.6.5 Form of Punishment

As depicted in Table 4.12 responses for who had knowledge of punishments where 4.0 percent indicated having knowledge of members of community punished and sentenced and imprisoned for four months, 3.0 percent were parents ostracized from the community, 4.0 percent were verdict has never been passed. This finding is attributed to the slow nature of the legal process which is a feature of the weakness of the judiciary in addressing court cases.

Table 4.12: Punishment to FGM Practitioners

Punishment	Frequency	Percent
Never heard of any punishment in the community	3	3.0
Imprisonment for Four months	4	4.0
Parents were ostracized from community	3	3.0
The verdict has never been passed	4	4.0
Not Applicable	87	86.1
Total	101	100.0

Although there are legal provisions against the practice of FGM, its persistence in the Kisii community is evident from the findings. The study examined the approaches that those who still practice it are able to do so by avoiding penalization as espoused in these provisions. Table 4.13 indicates that FGM is practiced at night as identified by 32.0 percent of respondents, 64.0 percent indicated that families' invited the circumciser to their homes, 23.5 percent were they perform FGM without the rituals such as singing and 2.0 percent were missing responses.

Table 4.13: FGM practice Trends in Community to Avoid Penalization

Avoiding penalization	Frequency	Percent
Perform the FGM rites at night	32	32.0
Invite the circumciser in their home	49	64.0
They perform FGM without the rituals	18	23.5
Missing responses	2	2.0
Total	101	100.0

Study findings indicate that FGM in the Kisii community has taken a new dimension of being performed in the night. Invitation of circumcisers in the homestead is also an

approach adopted by community members where the neighbours and authorities may not have knowledge of what is going on as said by a youthful female in the FGD,

“FGM nowadays is done secretly and mainly at night and there is no way the government can know what is happening”

Key informant interview further revealed that FGM was being undertaken in the hospital where the well –off families would admit their daughters to health centers and clinics as they associate the process as being safer from diseases and other health risks. Study participants acknowledged that a major change in the way the ceremonies are performed over the years has been the increasing preference for using health staff to do the cutting, instead of traditional circumcisers.

This findings support GIZ (2011) findings that the medicalisation of FGM in Kenya has been a trend that has been documented, particularly among the Kisii. In 2003, 46% of Kenyan daughters had FGM performed by a health professional (up from 34.4% in 1998). However, the KDHS 2008/2009 puts the figure at 19.7% overall or 27.8% in urban areas.

CHAPTER SUMMARY

The chapter comprised of the data analysis, presentation and interpretation. The researcher used pie charts and tables to present the data in frequencies and percentages and where possible highlighted both. The interpretation was also complemented by further information which was obtained from the key informant interviews and the Focus Group discussions with the girls where their statements were quoted as per the data collection exercise.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter highlights the major findings of this study and draws conclusions based on the results. It also presents the key areas for further research as informed by the findings of this study.

5.2 Summary

5.2.1 Practice of FGM among the Kisii

The study revealed that all the female respondents involved in the data collection process through the survey had undergone FGM. In the sample 74.2 percent had circumcised their daughters whereas 25.8 percent had not. The study found that most of the respondents had indeed had undertaken their daughters through FGM. The persistence of FGM was attributed to traditional / cultural beliefs. These include; that circumcised women were less promiscuous compared to uncircumcised women. The income attained from circumcision was also identified as contributing to the persistence of the practice where it's a source of employment among the elderly women in the community. The age at which FGM was performed was found to be between the ages of 10-12 years indicating that prevalence of FGM increased with age. The study found that upholding cultural traditions as the most prominent reason for practicing FGM as indicated by 76.2 percent and acquiring more dowry payments with 23.8 percent.

5.2.2 Issues Facing the Practice of FGM among the Kisii

The study found that 76.2 percent of respondents had undergone FGM willingly compared to 23.8 percent who were forced. This was enhanced through socialization within the community that reinforces the stereotypes against uncircumcised girls or women and thus a girl will choose to undergo the process so as to avoid mocking from the community and their peers. In regard to the effect of FGM the study found that 51.5 percent indicated excessive bleeding, 2.0 percent were obstructed labour, and 7.9 percent

were sexual complications and 38.6 percent. The study sought to establish the facilitators of FGM where findings revealed that 22.8 percent indicated parents, 11.9 percent were circumcised women and 41.6 were elderly women.

The role of the father is to provide finances and resources for the ceremony as indicated by 80.2 percent, 10.9 percent were to organize and prepare for the ceremony, 6.9 percent were to give permission or authority for the girl to be circumcised and 1.0 percent were to identify the circumciser. The primary role of the mother was to take care of the circumcised girl as indicated by 26.7 percent of respondents and giving rules to the circumcised as indicated among 13.9 percent of the sample. The study found buying food as the most expensive activity of FGM rites as indicated by 81.2 percent of the sample and the average expenses for the food is Kshs.10, 000. Paying the circumciser was also a cost incurred by the initiates' family as shown by 10.9 percent which could either be in cash or in kind. Circumcisers are paid Kshs 3,000-5,000 and could be paid by such a goat or chicken. Cultural occasions predominantly provide that there be drinking of the local beer and was identified as by 5.9 percent which could cost a family Kshs. 4,000-6,000.

5.2.3 Efforts towards eliminating the practice of FGM among the Kisii

Anti – FGM campaigns were the major source of information on FGM as indicated by 48.5 percent, health centers were 5.0 percent, radio announcements were 1.0 percent and personal experience was 45.5 percent. Despite the radio being one of the most accessible forms of mass communication in the rural areas it was not a major source of information on FGM. Education and awareness on the effects of FGM were identified as the most popular anti –FGM activities in the community by 93.1 percent of the respondents.

The study found that government agencies were the most popular facilitators of FGM as cited among 38.6 percent of the sample, non – governmental organizations were 6.9 percent, religious organizations were 46.5 percent, women groups were 4.0 percent, radio broadcasts were 2.0 percent and community based organizations (CBOs) were 1.0 percent. Majority of the respondents indicated community participation in anti-FGM

activities as cited by 91.1 percent of respondents compared to 5.0 percent who indicated no. in regard to the bodies/organization involved in anti-FGM activities, the study found that 40.6 percent respondents indicated religious organisations, 7.9 percent were youth/women groups, 12.9 percent were government agencies who conducted seminars / education and awareness, 5.9 percent were health centers and 4.0 percent were NGOs.

5.2.4 Awareness of Law Concerning FGM among Kisii Community

Study findings indicate there is a high level of awareness on the law concerning the practice of FGM as espoused by Figure 13 which depicts that 91.1 percent of respondents answered yes, 5.0 percent said no, 2.0 indicated don't know and 2.0 percent were missing responses. There are several legal instruments which seek to address the practice of FGM where 61.4 percent indicated they knew of the Anti – FGM law, 29.7 percent were Children's Act of 2001, 2.0 percent were the Kenya Constitution 2010. Despite the existence and knowledge of anti-FGM legal instruments, majority of the respondents indicated that they were not aware of any person being punished and this were represented at 82.2 percent and 5.0 percent were missing responses. Among those who aware of sanctions against perpetrators of FGM indicated imprisonment. The study sought to identify how community members avoided penalization of practicing FGM where study findings revealed that FGM is practiced at night as identified by 32.0 percent of respondents, 64.0 percent indicated that families' invited the circumciser to their homes, 23.5 percent were they perform FGM without the rituals such as singing

5.3 Conclusion

The study concludes that the persistence of FGM is attributed to the socialization of the community. Its persistence among the Kisii is enhanced by the willingness of women and girls to undergo the practice in order to maintain the cultural integrity of the community. Culture therefore played a crucial role in the persistence of FGM practice among the community. Apart from culture, the community's attitude also played a big role in the perpetuation of FGM. FGM is perceived to be a cultural identification which is highly accepted in the community and entrenched to the following generations. The active

participation of parents in FGM activities continuously enhances the practice. The practice of FGM has persisted due to the socialization of the community which has led to girls willingly accepting to undergo the practice. However, there was evidence to suggest that girls are also undertaken through the practice by force. The dangers and effects of FGM included excessive bleeding, obstructed labour and sexual problems. The effects were associated with the health of the victim which included physical and psychological. Due to this community socialization of FGM women who have not undergone through FGM face continuous discrimination from the community. Uncircumcised women are not invited to participate in FGM activities which are mostly performed by women. Circumcised women are also more preferred in the community as potential wives compared to uncircumcised women. This include the higher bride price (dowry) paid for circumcised women. Anti-FGM activities were the primary source of information for the community in regard to efforts towards eradication of FGM among the Kisii. This included education and awareness activities which were targeted towards the traditional circumcisers. These efforts were coordinated by government agencies and religious organisations where majority of the community members participated.

5.4 Recommendations

1. I recommends for emphasis on awareness on the dangers associated with FGM which should be integrated into the education of the girl child.
2. I also recommend for a multi-sectoral approach to eradication of FGM through coordinated efforts from the government agencies, non-governmental organisations, community based organisations on the fight against FGM.
3. In regard to efforts to eradicate the practice of FGM, i recommend for the empowerment of community groups in the fight against FGM.
4. There is need to emphasize on sensitization among medical practitioners who are involved in FGM practice.

5. In regard to the knowledge of community on the law concerning FGM, the study recommends for intensive education and awareness of the legal instruments protecting girls from FGM as they are the most vulnerable in the community.

5.5 Areas of Further Study

There is need for further research to establish the extent to which efforts against the practice of FGM among the Kisii community have contributed to the abandonment of the practice. This would provide a synopsis of what approaches are more likely to tackle the persistence of FGM in the community.

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APPENDIX 1: QUESTIONNAIRE FOR PARENTS

My names are Evelyn Mariga pursuing a Master of Arts in Community Development at The University of Nairobi. I am undertaking a study on **Factors influencing the practice of Female Genital Mutilation in Kenya**. Your community has been chosen to participate in this research study. All information provided will be kept anonymous and confidential and will only be used for academic purposes only.

Section A: Background Information

1. Gender?

1 = Male []

2 = Female []

2. Highest level of education?

1 = None []

2 = Primary Education []

3 = Secondary Education []

4 = College / University []

3. Religious Definition?

1 = Protestant []

2 = Catholic []

3 = Muslim []

4 = Other (*Specify*)

4. Marital status?

1 = Single []

2 = Married []

3 = Divorced []

4 = Separated []

5 = Widowed []

Section B: The practice of FGM in the Community

5. (a) Do you have children?

1 = Yes []

2 = No []

(b) If yes, How many

Girls

Boys

(c) How many of the girls have undergone FGM?

(d) At what age did they undergo FGM?

(e) If yes, what are the reasons would you subject your girl child to FGM?

1 = Upholding cultural tradition

2 = Preserving sexual morality

3 = Social pressure (stigma)

4 = Other (*Specify*)

6. Do women and girls get circumcised willingly or are forced? If forced, by who or what forces them? If willingly, what are the expected benefits?.....

.....

.....

.....

7. Are there any dangers associated with FGM on girls?

1 = Yes []

2 = No []

3 = Don't Know []

(b) If yes, what are some of these complications?

1 = Excessive bleeding

2 = Obstructed labour

3 = Menstrual disturbance

4 = Sexual problems

5 = Other (*Specify*)

8. In the community, between a circumcised and uncircumcised woman which is preferred?

.....
.....

9. Men who do they prefer?

1 = Circumcised []

2 = Uncircumcised []

10. In terms of bride wealth, who between a circumcised and uncircumcised woman / girl is paid more? Why?

.....
.....
.....

11. Who performs the cultural practices and ceremonies?

.....
.....
.....

12. Do uncircumcised women / girls allowed to participate

1 = Yes []

2 = No []

3 = Don't Know

13. (a) Are there stereotypes / nicknames against the uncircumcised?

1 = Yes []

2 = No []

3 = Don't Know []

(b) If yes, which are these?

.....
.....

14. Is the role of father and mother in the practice of FGM?

Father

.....
.....
.....

Mother

.....
.....
.....

15. What is the cost of FGM on a family? (*Multiple responses allowed*)

1 = Preparations []

2 = Food []

3 = Beer []

4 = Circumciser []

5 = Other (*Specify*)

16. What are the sources of information on the complication of undergoing FGM?

1 = Personal experience []

2 = Health Center []

3 = Anti – FGM Campaigns []

4 = Other (*Specify*)

Section C: FGM Abandonment Approaches in the Community

17. Is there any anti – FGM activity (ies) in your community presently?

1 = Yes []

2 = No []

3 = Don't Know []

(b) If yes, what are some of the activities of these abandonment approaches?

1 = Education and awareness []

2 = Alternative rites of passage []

3 = Other (*Specify*)

18. Who are the facilitators of FGM abandonment activities in your community?

1 = Government Agencies []

2 = Non – Governmental organizations []

- 3 = Community Based Organisations []
- 4 = Religious organisations []
- 4 = Women Group []
- 5 = Youth Group []
- 6 = Other (*Specify*)

19. Do you participate in any of these activities?

- 1 = Yes []
- 2 = No []

20. What bodies / organisations and in what activities do each of these bodies / organisations promote in the community?

.....

.....

.....

.....

Section D: Legislation against FGM in the Community

21. (a) Are you aware of any legislation against the practice of FGM?

- 1 = Yes []
- 2 = No []
- 3 = Don't Know []

(b) If yes, which are these legal instruments?

- 1 = Anti – FGM law []
- 2 = Childrens Act []
- 3 = Constitution 2010 []

(c) If yes, what do you know about it?

.....
.....
.....
.....

22. If yes, what is your opinion on these laws?

.....
.....
.....
.....

23. (a) Are you aware of any family that has been punished for circumcising their girls in the area?

1 = Yes []

2 = No []

3 = Don't Know []

(b) What was the verdict upon conviction?.....

.....
.....
.....

24. What do residents in your community do to avoid penalization for FGM?

.....
.....
.....

APPENDIX 2: FOCUS GROUP DISCUSSION GUIDE (GIRLS)

1. Has anyone here undergone FGM?
2. Do you know of anyone who has undergone FGM in your community? If yes who?
3. At what age did you undergo FGM practiced on girls in your community?
4. Do you support the continued practice of FGM?
5. What do you think are the reasons behind the practice of FGM in your community?
6. Do women and girls get circumcised willingly or are forced? If forced, by who or what forces them? If willingly, what are the expected benefits?
7. Where does the FGM practice take place in your community?
8. Are you aware of law against FGM? (If yes, please explain)
9. Are you aware that FGM is being discouraged? If yes, what are some of these efforts in your community? Who decides?
10. Why do you think it has persisted

**APPENDIX 3: KEY INFORMANT GUIDE FOR ADMINISTRATIVE
OFFICIALS, RELIGIOUS LEADERS, CIRCUMCISORS AND HEALTH
PROFESSIONALS**

1. What do you think are the reasons behind the persistence of FGM in the community?
2. Do you think women / girls are circumcised willingly or forcibly? If willingly what are the expected benefits? If forced who or what forces them to be circumcised?
3. Do you know of any girls who have been forced to undergo FGM? Do they report their cases to law enforcement agencies?
4. What are some of the forms of FGM practiced in this area?
5. What are some of the tools used in undertaking FGM?
6. Is FGM harmful to the well being of the victim of its practice? If Yes, what ways?
7. What is the view of men about women who have not undergone FGM?
8. What are some of the health consequences associated with the practice of FGM?
9. What are some of the reproductive health problems experienced by women who have undergone FGM?
10. Are there FGM abandonment efforts going on in this area? If yes, what are some of these efforts?
11. How are people reacting to these abandonment efforts? Negatively, Why? Positively? What steps have been taken thus far?
12. What is the effect of the anti – FGM law on FGM in Kisii?
13. What do those practicing FGM do to avoid these penalties?
14. Why has FGM persisted in this area? Why is it difficult to abandon it?
15. Can you suggest any alternative strategies to the abandonment of FGM?
16. What assistance do you think would benefit these abandonment approaches of FGM?