FACTORS INFLUENCING GROWTH OF FEMALE GENITAL MUTILATION AMONG ORMA AND WARDEI COMMUNITIES IN TANA RIVER COUNTY, KENYA

BY

ADHAN NURI BERHE

A RESEARCH PROJECT REPORT SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF DEGREE IN MASTER OF ARTS IN PROJECT PLANNING AND MANAGEMENT OF THE UNIVERSITY OF NAIROBI.

2014

DECLARATION

This Research project report is my original work and has not been presented for any academic award at any other university.

……………………........ ……………………………….

Adhan Nuri Berhe Date

REG, NO L50/74363/2012

This research project report has been submitted for examination with my approval as the University Supervisor.

………………………………. ……………………………….

Dr Angeline Mulwa Date

Lecturer

Department of extra mural studies

University of Nairobi.

DEDICATION

I dedicate this work to my family for their encouragement and continued prayers towards successful completion of this course.

ACKNOWLEDGEMENTS

A successful project report is a combination of efforts from various parties. I would like to express my sincere gratitude to them all without exception. First and foremost, I would wish to express my sincere thanks to Almighty Allah for guidance and protection and strength to enable me handle the study programme.

My heartfelt acknowledgements are expressed to my entire study group whose efforts and advices contributed immensely in one way or another to the completion of the research project special thanks are extended to my Supervisor, Dr Angeline Mulwa for her positive criticism, guidance and support throughout the study period. Her positive sentiments greatly enhanced and enriched this study.

Finally, I sincerely wish to thank my family for their support and understanding and all those who gave me support in one way or the other towards the completion of this study; these include the school administration, friends and workmates for their spiritual, emotional, constant support and encouragement in pursuance of this course and the entire project report.

TABLE OF CONTENTS

DECLARATION .... **ii**

DEDICATION .... **iii**

LIST OF TABLES .... **vii**

LIST OF FIGURES .... **viii**

ABBREVIATIONS AND ACRONYMS .... **ix**

ABSTRACT .... **x**

CHAPTER ONE:INTRODUCTION **1**

1.1 Background of the study 1

1.2 Statement of the problem 5

1.3 Purpose of the study 6

1.4 Objectives of the study 6

1.5 Research Questions 7

1.6 Research Hypotheses 7

1.7 Significance of the study 8

1.8 Definition of Significant Terms 9

1.9 Organization of the study 10

CHAPTER TWO:LITERATURE REVIEW **11**

2.1 Introduction 11

2.2 Theoretical Literature Review 11

2.3 Marriageability and Female genital mutilation 12

2.4 Family honour and female genital mutilation 17

2.5 Control of sexual desire and female genital mutilation 18

2.6 Religious requirement and female genital mutilation 21

2.8 Literature gaps 27

2.9 Conceptual Framework 29

2.10 Summary of literature 30

CHAPTER THREE:RESEARCH METHODOLODY **31**

3.1 Introduction 31

3.2 Research Design 31

3. 3 Target Population 31

3.4 Sample size 32

3.5 Sampling procedure 33

3.6 Data collection instruments 33
3.7 Validity of Research Instruments 33
3.8 Data Collection Procedure 34
3.9 Data Analysis 35
3.10 Ethical Considerations 35
3.11 Operational Definition of variables 35
CHAPTER FOUR:DATA ANALYSIS, PRESENTATION AND INTERPRETATION 37
4.1 Introduction 37
4.2 Response Rate 37
4.3 Demographic Information 37
4.4 Knowledge on Female Genital Mutilation 39
4.5 Marriageability and female genital mutilation 43
4.6 Culture and Social Identity factors influencing Female genital mutilation 46
4.7 Influence of Family honor on Female genital mutilation 49
4.8 Control of sexual desire and Female genital mutilation 50
4.9 Religious requirement and Female genital mutilation 51
CHAPTER FIVE : SUMMARY OF FINDINGS, DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS 54
5.1 Introduction 54
5.2 Summary of the Findings 54
5.3 Discussions of the Findings 56
5.4 Conclusions of the Study 58
5.5 Recommendations of the study 59
5.6 Recommendation for further studies 59
REFERENCES **60**
APPENDICES **63**
Appendix I: Letter of transmittal 63
Appendix II: Research Tool for Women and Girls 64

LIST OF TABLES

Table 3.1: Operational Definition of variables 36
Table 4.1: Age status....................38
Table 4.2: Marital status 38
Table 4.3: Education status....................38
Table 4.4: Employment status....................39
Table 4.6: Chi-square Results on the Knowledge on FGM among the respondents 41
Table 4.7: Correlation between knowledge on FGM and practice of FGM 42
Table 4.8: Responses on marriageability....................43
Table 4.9: Testing of research hypothesis....................45
Table 4.10: Culture and social factors 46
Table 4.11: Chi-Square testing on Culture and social identity factors on FGM practice..48
Table 4.12: Family Honor....................49
Table 4.13: Control of sexual desire....................50
Table 4.14: Religious requirement....................52

LIST OF FIGURES

Figure 1.1: Conceptual Framework 29

ABBREVIATIONS AND ACRONYMS

CBO	Community Based Organizations
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CIDA	Canadian International Development Agency
COVAW	Coalition on Violence against Women
DHS	Demographic and Health Survey
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation /Cutting
FIDA	Federation of Women Lawyers
FPAK	Family Planning Association of Kenya
GCN	Girl Child Network
GoK	Government of Kenya
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IAC	Inter African Committee
ICT	Information Communication Technology
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
IT	Information Technology
KDHS	Kenya demographic health survey
MCC	Muslim Consultative Council
MCH	Maternal and Child Health
MoE	Ministry of Education
MoH	Ministry of Health
MDGs	Millennium Development Goals
MYWO	Maendeleo Ya Wanawake
NGO	Non-Governmental Organization
RWPL	Rural Women's PEACE Link
STD	Sexually Transmitted Disease
UNIFEM	United Nations Development Fund for Women

ABSTRACT

The purpose of this study was to determine the factors influencing the growth of female genital mutilation among Orma and Wardei communities in TRC. The study limitation is the financial constraint and high level of literacy among the sampling population. The objective of the study is to establish the contribution of family honour, marriagibilty, control of sexual desire, religious requirement and social identity contribution to female genital mutilation. This research was conducted through a descriptive research design. The research investigated the target population of 18,545 through selection of sample to analyze and discover occurrences. The study targets females including girls and women, the researcher also organized Focus group discussion (FGD) and also talked to key informants. Data was analyzed nominal scales into mutually exclusive categories and frequencies by employing descriptive statistics using (SPSS V.2O.O). The focus group discussion and key informants contribution were included in the report as a narrative description of what was said by the participants. The major findings of the research is that the studied community largely undergo type three method of FGM also known as infibulation and FGM continue unabated with almost 95% of the Orma and Wardei girls still undergo FGM. The study concludes that culture and social identity and control of sexual desire are major factors behind the unabated FGM practice within the Orma and the Wardei communities. The study will immensely contribute to the understanding of FGM practice in the communities. The research recommends that the communities should be given enough information on the problems of FGM and disassociating FGM from religious and this awareness should largely target the local woman who carry out circumcision and target the whole community because FGM is not an individual problem but a societal problem. From this research, many anti-FGM campaigners, CBOs, policy makers and key influencers will contribute immensely. The research findings would help facilitate local networking to enable information sharing, education and increased awareness of key issues, enabling local NGOs to be part of a greater voice to end FGM locally.

CHAPTER ONE
INTRODUCTION

1.1 Background of the study

Female genital mutilation is a practise that has a wide outlook and perspective as well. This research critically looks at FGM in a global perspective, regional and local outlook to determine the diverse practise on the same. A variation of authors is cross-referenced to give a dimension well understood by the reader and to give the researcher a wide opportunity of opinions. Rahman & Toubia, 2000 defined Female Genital Mutilation (FGM), simply, as “the collective name given to several different traditional practices that involve the cutting of female external genitalia”. However, way back in 1997, the WHO, UNICEF and the UNFPA issued a joint policy statement on FGM which gave the following definition: “Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons” (WHO, 1997).

According to the World Health Organisation (WHO), FGM comprises all procedures which involve partial or total removal of the external female genitalia or injury to the female genital organs whether for cultural or any other non-therapeutic reasons. The age at which girls undergo FGM varies enormously according to the ethnic group practising it. The procedure may be carried out when the girl is a newborn, during childhood, adolescence, at the time of marriage or during the first labour. In some FGM practising cultures, women are re-infibulated (re-stitched) following childbirth as a matter of routine. (WHO, 2003)

Various authors refer FGM in difference terminologies. Female Genital Mutilation/Cutting (FGM/C), sometimes known as female circumcision (FC), is a traditional practice performed primarily on girl child, adolescents and sometimes on adult women. The World Health Organization (WHO) estimates that about 130 million women throughout the world have undergone some form of FGM/C, and a further 2 million girls are at risk annually. There are 28 Countries in the Sub Saharan Africa practicing FGM/C, where national

prevalence rates range from 5 percent in Kenya to 98 percent in Somalia. The practice is also found in small groups in Asia and the Middle East and among migrant communities in Europe, Australia, Canada and USA. (WHO, 1997).

FGM is also linked to tradition and culture to reflect the localization of the practice. Even though cultural practices may appear senseless or destructive from the standpoint of others, they have meaning and fulfill a function for those who practice them. However, culture is not static; it is in constant flux, adapting and reforming. People will change their behavior when they understand the hazards and indignity of harmful practices and when they realize that it is possible to give up harmful practices without giving up meaningful aspects of their culture (WHO, 1997).

Female genital mutilation (sometimes called female genital cutting and female genital mutilation/cutting) is defined by the WHO as referring to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. FGM is a form of gender-based violence and has been recognized as a harmful practice and a violation of the human rights of girls and women. Between 100 and 140 million girls and women in the world are estimated to have undergone such procedures, and 2 million girls are estimated to be at risk of undergoing the procedures every year. (WHO, 1997)

In Africa, FGM has been reported in 28 countries and occurs mainly in countries along a belt stretching from Senegal in West Africa, to Egypt in North Africa, to Somalia in East Africa and the Democratic Republic of Congo (DRC) in Central Africa. It also occurs in countries in Asia and the Middle East and among certain Diaspora communities in North America, Australasia and Europe. As it is with many ancient practices, FGM is carried out by communities as a heritage of the past and is often associated with ethnic identity. Communities may not even question the practice or may have long forgotten the reasons for it. (WHO, 2003)

FGM is often motivated by beliefs about what is considered appropriate sexual behavior, with some communities considering that it ensures and preserves virginity, marital faithfulness and prevents promiscuity/prostitution. There is a strong link between FGM and marriageability with FGM often being a prerequisite to marriage. FGM is sometimes a rite of passage into womanhood, and necessary for a girl to go through in order to become a responsible adult member of society. FGM is also considered to make girls 'clean' and aesthetically beautiful. Although no religious scripts require the practice, practitioners often believe the practice has religious support. Girls and women will often be under strong social pressure, including pressure from their peers and risk victimization and stigma if they refuse to be cut. (WHO, 1997)

FGM is always traumatic (UNICEF, 2005). Immediate complications can include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue. Long-term consequences can include recurrent bladder and urinary tract infections; cysts; infertility; an increased risk of childbirth complications and newborn deaths; the need for later surgeries (WHO, 2003)

The local population refers to FGM by a variety of localised dialects which, according to feminists Rahman and Toubia, "are often synonymous with purification or cleansing, such as the terms *tahara* in Egypt, *tahur* in Sudan and *bolokoli* in Mali" (Rahman & Toubia, 2000). The terminology itself also varies between and within countries; for example, in the Sudan FGM may be referred to as *Sunna* or infibulation; otherwise known as *pharaonic*. A common misconception is that FGM is analogous to male circumcision as both practices remove healthy tissue and are carried out on children without their consent. However, there are key differences between them. For example, whereas male circumcision is a requirement of certain religions, FGM is not (WHO, 1998). Moreover, FGM is far more severe than male circumcision since it removes critical parts of the sexual organ.

Another feminist Zenie-Ziegler confirms, “there is no similarity between male circumcision, a prophylactic measure recommended for boys in almost every society and female circumcision, the motive of which is to diminish, if not suppress sexual desire in women” The eradication of FGM is pertinent to the achievement of four millennium development goals (MDGs): MDG 3; promote gender equality and empower women; MDG 4; reduce child mortality, MDG 5; reduce maternal mortality and MDG 6; combat HIV/AIDS, malaria and other diseases. (Ziegler cited in Abu-Sahlieh, 1994).

In Kenya, an estimated 27.1% of girls and women aged 15- 49 years have undergone FGM (KDHS 2008-09), a figure that has decreased from 37.6% % in 1998, and 32.2% in 2003. There are significant regional variations, with prevalence ranges from 0.8% in the west to over 97% in the north-east (KDHS 2008-09). The practice is particularly among the Somalis in the North Eastern province practice (97.7%). The prevalence is also highest among the Kisii (96.1%) and the Maasai (73.2%). FGM is a deeply rooted cultural practice, although the reasons vary between ethnic groups. For some, it is an important rite of passage, for others it is closely tied to marriageability or the concepts of family honor and the need to preserve sexual purity.

Among some communities, there has been a trend towards the medicalization of FGM with the procedure being carried out by medical professionals. At the end of 2011, the government passed the Prohibition of Female Genital Mutilation Act 2011 to replace the existing law. There are many local NGOs, CBOs, faith-based organizations, international organizations and multilateral agencies working in Kenya to eradicate FGM using a broad range of approaches.

FGM is practiced for a variety of reasons – sometimes at a certain age or alternatively as a rite of passage, often at puberty which is a time of vulnerability and change. Many young women are affected by HIV/ AIDS and many others marry early which leads to early childbirth, with resulting complications for many of obstetric fistula. (KDHS 2008-09).

1.2 Statement of the problem

The exact genesis of female genital mutilation was unknown. There were many theories of the origin and reported documentation of the practice as long as six thousand years ago. The exact prevalence of FGM was difficult to estimate as limited research had been undertaken. The WHO estimates that 130 million women world-wide had undergone some form of FGM, with an annual incidence of 2 million. There are limited epidemiological data to provide a reliable indication of the relative extent of different forms of FGM or of the incidence of complications. This was in part because women may not associate the health problems they experience with FGM or may simply accept them as part of life. Hence they may present with a condition possibly related, either directly or indirectly, to FGM, but not known of, or accept, the connection. In addition, in some communities the practices have been subject to strong taboos such that they are matters of great sensitivity and privacy to many women who may find them difficult to discuss. Furthermore, some of the reported complications of FGM (for example dysmenorrhoea) are common in the general population and the possible part that genital mutilation plays in these has not been defined. (KDHS 2008-09).

There was very little information about the experiences of older women who have had FGM, but it might be expected that cutting and resuture of the vulva, especially if repeated with many pregnancies, would lead to worsening symptoms such as dyspareunia and incontinence accompanying vulval atrophy after menopause.

FGM affects the physical and psychological health of girls and women; decreases their attendance and performance at school; fails to meet their gender equality rights; and risks their lives at the time of FGM, at marriage and during childbirth. FGM affects up to 3 million girls a year, one every 10 seconds. FGM also has a relationship with other issues such as girls not completing their education and having poor literacy; early or arranged marriage; the spread of HIV AIDS and poor access to physical health and psychological health care. (KDHS 2008-09).

There are also problems in pregnancy and childbirth such as obstructed miscarriage, excessive pain associated with scar tissue, restricted examinations resulting in inaccurate assessment and difficult bladder management, prolonged and obstructed labor and lacerations and haemorrhage at delivery. During sexual practices, difficulties experienced by females include non-consummation due to obstruction, vaginismus or painful scar tissue, trauma on deinfibulation by partner or traditional birth attendant, vaginismus with or without introital scarring and impaired sexual response and enjoyment alongside sexual expression may be problematic and/ or a source of relationship conflict if vaginal intercourse is precluded. The aforementioned problems have caused quiet some psycho-social effects to the female and the general community as a whole and thus the need to establish the underpinning issues and possible strategies for interventions. (WHO, 1997)
With the promulgation of the new constitution and subsequent creation of devolved government called county government it is easier to share the findings of the research with the local leaders who equally understand the problem and its magnitude and solicit support geared towards eradication of FGM. This research therefore comes in handy to support the stakeholders and the government at large to understand the factors that lead to the growth of female genital mutilation among the Orma and Wardei communities in Tana River County and recommend possible strategies for mitigation of the same.

1.3 Purpose of the study

The purpose of this study was to determine the factors influencing the growth of female genital mutilation among the Orma and Wardei communities in Tana River County. Despite the many efforts that had been put to manage or eradicate the FGM practice the practice has never decreased and continues unabated.

1.4 Objectives of the study

This study was guided by the following specific objectives;

1) To establish how the marriageability rite of passage influences female genital mutilation among Orma and Wardei women in Tana River County.
2) To establish how family honor influences female genital mutilation among Orma and Wardei women in Tana River county.

3) To find out whether control of sexual desire could be a factor that influences female genital mutilation among Orma and Wardei women in Tana River County.
4) To assess how religious requirements influences female genital mutilation among Orma and Wardei women in Tana River County.
5) To establish whether social identity influences female genital mutilation among Orma and Wardei women in Tana River County.

1.5 Research Questions

The study sought to answer the following questions;

1. How does marriageability rite of passage influences female genital mutilation among Orma and Wardei women in Tana River County?
2. What is the extent to which family honor influences female genital mutilation among Orma and Wardei women in Tana River County?
3. How does control of sexual desire influences female genital mutilation among Orma and Wardei women in Tana River County?
4. To what extent does religious requirement influences female genital mutilation among Orma and Wardei women in Tana River County?
5. How does social identity influence female genital mutilation among Orma and Wardei women in Tana River County?

1.6 Research Hypotheses

This study sought to test the following hypotheses;

1. Marriageability rite of passage has no relationship with female genital mutilation among Orma and Wardei women in Tana River County.
2. Family honor does not influence female genital mutilation among Orma and Wardei women in Tana River County.
3. Control of sexual desire does not influence female genital mutilation among Orma and Wardei women in Tana River County.
4. Religious requirement does not influence female genital mutilation among Orma and Wardei women in Tana River County.

5. Social identity does not influence female genital mutilation among Orma and Wardei women in Tana River County.

1.7 Significance of the study

This research will add value to the existing body of knowledge especially on the plight of young girls who have been affected for a long time by FGM. Despite the numerous efforts made by the government in eradicating FGM, the practice is still rampant and the government effort has not brought any meaningful change. The finding and recommendations of the research will be shared with county government for better understanding of the problem because FGM is one of the social problem and forms part of the immediate challenge of the county government and hence the county government can easily provide resources to combat the problem.

The prime tenacity of this study is to provide improved understanding of the issues relating to FGM in the wider framework of gender equality and social change and Collating the research data for the county, this study acts as a benchmark to profile the current situation in Tana River County. Whilst there are many challenges to overcome before FGM is eradicated in Kenya, many programmes are making positive active change and government legislation offers a useful platform for deterring FGM practice.

The findings of this study will help program managers to formulate effective strategies towards addressing the problem of female genital mutilation and help to develop programs aimed at meeting the demand of family values through the provisions of appropriate method mix. This study explored factors influencing the growth of female genital mutilation among Orma and Wardei communities in Tana River County which would form a basis for implementation by various service providers to help in reduction of the practice.

The findings and recommendations of this study also help to design messages on fighting female genital mutilation targeting the rural community. The findings form a basis for further research in the area in relation to other regions in the country.

Extracts from this publication might be freely reproduced, provide the due acknowledgement was given to the source and the researcher.

1.8 Definition of Significant Terms

Mutilation: The loss of, or removal of parts of the female genitalia, is and has been practiced by many societies with various cultural and religious significances

Genital: A sex organ, or primary sexual characteristic, as narrowly defined, is any of the anatomical parts of the body which are involved in sexual reproduction and constitute the reproductive system in a complex organism

Rite of passage: is a ritual event that marks a person's transition from one status to another.

Family honor: Involves the perceived quality of worthiness and respectability that affects the social standing and the self-evaluation of a group of related people, both corporately and individually

Control of sexual desire: Not having any sex urge or feelings to have an intercourse or sex

Infibulations: Is the removal of all external genitalia. The inner and outer labia are cut away, with or without excision of the clitoris.

1.9 Organization of the study

The research project report was organized in five main chapters excluding the preliminary pages which contain the title, declaration, dedication, abstract, acknowledgements, and table of contents, list of figures, and list of tables, abbreviations and acronyms. It also contains the references, letter of transmittal and the questionnaires at the end of it.

Chapter one contains the background of Female Genital Mutilation highlighting the fragility of the global perspective in the FGM sphere and overview. Within the chapter, various scenarios and case studies at a global, regional and local perspective are looked at.

Chapter two contains the various schools of thoughts in a desktop review of both theoretical and empirical literature on overall determinants in FGM. A conceptual framework outlining all the various independent variables and their indicators in a relation with the dependent variable, the interceding and moderating variables is also included at the end of the chapter.

Chapter three contains the research design, target population, sampling procedures and sample size, methods of data collection, data validity ,data reliability, data analysis techniques, ethical considerations and operational definition of variables.

Chapter four is a highlight and analysis of the data that was collected from the community and other key players within the study geographical area. It also makes presentation of the data through the use of frequency tabulation and test analysis. Discussion of the data is also made at the end of the chapter to give a clear understanding between the variables and how they affect the independent variable.

Chapter five summarizes the entire analysis of data from the different school of thought comparing with the data analyzed and tested in chapter four. It made conclusions on the data analyzed and recommended steps for intervention. Still in the chapter, a recommendation for further study is made following the literature gaps established.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter discusses the literature related to the factors influencing female genital mutilation among Orma and Wardei women. It focuses on assessing the extent to which marriageability, family honor, control of sexual desire, religious requirement, cultural and social identity factors influence female genital mutilation among the Orma and Wardei women in Tana River County.

2.2 Theoretical Literature Review

The 2003 Kenya Demographic and Health survey (KDHS) showed that FGM/C is still practiced by the majority of ethnic communities in Kenya. Overall, 32% of Kenyan women reported being cut in 2003, although this represents a slight reduction compared with 38% in the 1998 KDHS. Prevalence of the practice varies widely among ethnic groups. The practice is nearly universal among three ethnic groups namely the North Eastern and North Coast Somali (where the Wardei and Orma fall in), Abagusii, and Maasai and is highly prevalent among the Taita Taveta, Kalenjin, Embu and Meru, and was still practiced, although to a lesser extent, among the Kikuyu and Kamba. (KDHS, 2003).

Some ethnic groups in Kenya, notably the Luo and Luhya do not practice FGM/C. Type of cutting also varied by ethnic group. For example, clitoridectomy was practiced by the Abagusii, excision by the Meru, Kikuyu and Maasai, and infibulation by the Somali, Borana, Rendille, and Samburu. The country hosts over 240,000 refugees, mainly from Sudan and Somalia but also from Ethiopia and Eritrea, and these ethnic groups practice type II or infibulation. Age of cutting varied also by ethnic group, and is usually determined by the meaning associated with the practice. For those that practice FGM/C as a rite of passage to adulthood (e.g. Meru/Embu), cutting was normally undertaken around the age of puberty. For the Maasai and Samburu, who practice FGM/C as a means of denoting that the girl was ready for marriage, cutting was usually undertaken post-

puberty, and can often be when the girl was in her late teens immediately prior to marriage. (Abdalla, 1998).

Indeed, FGM/C can sometimes form part of the marriage ritual. Although a few circumcise during infancy such as Taita, several ethnic groups practice FGM/C pre-puberty, between ages 6 – 10 years such as Somali, Kisii, Borana because 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. There were indications of changes in the way FGM/C is practiced in several communities. The KDHS (2003) data suggests marked declines in prevalence had occurred nationally between generations, suggesting a decline in the practice in recent years. The proportion of women cut decreases steeply with age, from nearly one-half of women age 35 years and above, to one quarter of those aged 15-19 years. These declines are particularly pronounced among the Kalenjin (62% to 49%), Kikuyu (43% to 33%) and Kamba (33% to 27%). (KDHS, 2003)

According to Slack (1988), FGM was found in traditional group or community cultures that have patriarchal structures. Although FGM is practiced in some communities in the belief that it is a religious requirement, research showed that FGM pre-dates Islam and Christianity. Other anthropologists believed that it existed among Equatorial African herders as a protection against rape for young female herders; as a custom amongst stone-age people in Equatorial Africa; or as 'an outgrowth of human sacrificial practices, or some early attempt at population control' (Lightfoot-Klein, 1983). FGM is practiced across a wide range of cultures and it is likely that the practice arose independently amongst different peoples (Lightfoot-Klein, 1983), aided by Egyptian slave raids from Sudan for concubines and maids, and traded through the Red Sea to the Persian Gulf (Mackie, 1996).

2.3 Marriageability and Female genital mutilation

Insiders referred to the practice as a tradition, one which links FGM/C to the marriageability of the girl and to her family's standing in the community. Thus, we were

likely to find that FGM/C is general within the local intra-marrying group, of ancient origin, and quite persistent, even among individuals who have come to oppose it in principle. FGM/C was not an individual practice, but a community practice, which can only be resolved at the community level, by organizing the greater part of the intra-marrying group to coordinate on abandonment (WHO 1997).

For several Kenyan communities like the Meru, Embu, Maasai, Kalenjin, FGM/C is considered a rite of passage through which important cultural values and adult expectations are transmitted to the youth. Girls who have not undergone FGM/C are often ridiculed, made to feel ashamed, and addressed as children. Female genital mutilation is practiced in communities where, in general, women will have limited access to economic or social resources and must be eligible for marriage to secure a means of future support. FGM was thought to increase marriageability by ensuring virginity, which is almost always considered a prerequisite for marriage. FGM may also be thought to ensure the lineage of any children by limiting pre-marital sex and encouraging fidelity during marriage (as FGM will lessen sexual desire). Others believe that FGM enhances fertility and/or increases a man's sexual pleasure, both of which enhance a woman's attractiveness as a wife (Black & Debelle, 1987).

Families of girls or women among the Samburu support cutting because it made their daughters not only marriageable but able to attract high bride price. James S. publication of 2001 revealed that among the Maasai community, marriage was an important factor to girls’ life as it assures the girl of a home, it was important for the continuation of the family tree. Maasai men feel honored if they marry a circumcised girl, and this tradition has made it difficult to abandon the practice. According to the elders, those who were campaigning against FGM/C cannot be elected as leaders (chiefs and councilors) among the Maasai and Samburu community. Women also believed that a marriage was not complete unless the mother cuts her daughter and prepares her for marriage. In other communities, such as the Kuria and Kisii, uncut girls are considered as children. Among the Kuria, the girls are referred to as “*Kunene*”, a derogatory term making it difficult for them to be married. Family Law Council (1994) puts it that tradition is one of the more

common reasons given for performing FGM. For many, FGM was a normal part of a woman's life, experienced by all women. It was an expected and anticipated step in a girl's development to adulthood. The practice may be associated with cultural celebrations of the passage of the young girl to womanhood and this can involve present giving and feasting. This tradition is upheld by social pressure to the extent that girls may be stigmatized and ostracized for non-compliance. (Boddy & Womb, 1998).

The first justification of FGM was the sociological aspect which presents the operation as a transition in life stages. FGM was taken to be an initiation rite, coming of age rite of passage**.** It was performed at puberty on girls 12 to 14 years old, or just before the onset of menstruation and just before marriage (The Population Council, 1996).

FGM as an initiation rite emphasized the transition in age status from girlhood to womanhood and to marriageable age. As an uncircumcised girl had no chance of having a suitor, the operation is a signal for her readiness for marriage and availability. Before the initiation through mutilation, the girls are kept in seclusion for a period of time (at least 2 weeks) and given instructions on morality, tribal law, social codes, being a good wife, behaviors around elders and other age groups. Group initiation rites create a sort of club to which uncircumcised ones are not accepted. In some communities, like in Sierra Leone, it is a secret society that one joins only through going the initiation rite (Dorkenoo, 1995).

Recent studies by Abdalla, (1982) indicated that the initiation part of FGM was declining and that the age of operation was also declining. In many parts of Africa this justification does not hold grounds as the operation takes place on infants 7 or 8 days old as in Ethiopia and parts of Nigeria, and girl-children most under 5 years of age. The victims are too young even to understand the word marriage itself. To give a better picture of the importance of FGM in tradition, the late President of Kenya, Jomo Kenyatta, was quoted as a strong supporter of the tradition of FGM, who used the practice as a rallying point in his war of liberation. The operation is still regarded as the very essence of an institution which has enormous educational, social, moral and religious implications, quite apart

from the operation itself. For the present it is impossible for a member of the tribe to imagine an initiation without clitoridectomy (FGM). Therefore, the abolition of the surgical element in this custom means to the Kikuyu the abolition of the whole institution. (Abdalla, 1982)

In an article by James, (1994), Jomo Kenyatta goes on to show the close relation between marriage and FGM. He shows us that uncircumcised tribe members cannot marry and is ostracized by the community and tribe. "In the matrimonial relation, the rite of passage is the deciding factor. No proper Gikuyu would dream of marrying a girl who has not been circumcised, and vice versa. It is a taboo for a Gikuyu man or woman to have sexual relations with someone who has not undergone this operation. If it happens, a man or a woman must go through a ceremonial purification, - namely, ritual vomiting of the evil deeds. (Abdalla, 1982)

A few detribalized Gikuyu, while they are away from home for some years, have thought fit to denounce the custom and to marry uncircumcised girls, especially from coastal tribes, thinking that they could bring them back to their father's home without offending the parents. But to their surprise they found that their fathers, mothers, brothers and sisters, following the tribal custom, are not prepared to welcome as a relative-in-law anyone who has not fulfilled the ritual qualifications for matrimony. Therefore, a problem has faced these semi-detribalized Gikuyu when they wanted to return to their homeland. Their parents have demanded that if their sons wished to settle down and have the blessings of the family and the clan, they must divorce the wife married outside the rigid tribal custom and then marry a girl with the approved tribal qualifications. Failing this, they have been turned out and disinherited." (Abdalla, 1982)

In most of African and Middle Eastern communities practicing FGM, the main justifications concentrate on morality, virginity, honor and marriage, and control of sexual desire, FGM is expected to fulfill and maintain these virtues. For most African women as well as other Third World women marriage is not an option but a must for

survival. Marriage and reproduction are the only guarantee for women to gain economic security and social status. (Lightfoot-Klein H. 1998)

Infertility is one of the worst fates that a woman can face in her life in these communities. Marriage ensures a woman with old age pension or security as well as respect in the society. A woman without children or an unmarried woman will have a very difficult life and a devastated old age, especially ones without any support from their relatives or community. The whole practice of FGM is the base for marriage. Without undergoing FGM, a woman is denied the right of marriage, in most cases also the denial of receiving bride price. An unmarried woman is an outcast in the society (Lightfoot-Klein H. 1998)

According to publication composed by a combination of Walker, Pratibha, Warrior & Jonathan, (1993), African marriage does not come easily without its sacrifices. Virginity must be maintained at the time of marriage and the lack of it has damaging social consequences to the individual as well as to the parents. Virginity is the base for marriageability and it also enforces the prohibitions of sexual relationships outside marriage. Virginity is also considered as a base for a family's honor. A girl is expected to bring honor to her family through the preservation of her virginity. This is where FGM comes as a means of ensuring virginity. It is also believed that virginity of a woman ensures the fatherhood of the husband. (Pratibha, 1993).

Another misconception is that women are presumed to be weak in areas of emotion and, therefore, must be controlled. In other words, women are unable to control their sexuality. That is why it is believed that uncircumcised girls are assumed to run wild, or are considered of loose moral, bringing shame to their parents. FGM is expected to play that role by reducing the girl's sexual desire and prevent sexual experience before marriage. The reduced desire even during the marriage is expected to ensure faithfulness of the woman to her husband. It is believed that FGM controls women's sexual desire effectively. FGM may reduce the feelings but it cannot reduce the desire and, in addition, it does not guarantee chastity. It does not guarantee the morality of women, as shown by the fact that FGM practicing countries have relatively high numbers of prostitutes. In

addition, FGM has nothing to do with moral behavior which comes basically from proper moral education and the individual's intended behavior. (Slack, 1988)

2.4 Family honour and female genital mutilation

The tradition of FGM is also linked to the understanding of family honor, a vital component of community position and of community cohesion. Honour is jealously guarded by a family and can be lost through the actions of its members, in particular the female members. FGM is considered to be a normal precaution to ensure the morality of girls and the preservation of virginity. The practice of FGM is perpetuated within the social system, as deviation from the norm implies immorality and therefore can cause loss of honor ('son of an uncircumcised mother' is reported to be an extreme term of abuse in some communities). This is particularly detrimental for females as marriageability will often be the only opportunity for status and economic support beyond their family (Iris Berger and Frances, 1999).

Nahid Toubia, (1993) argues that Female genital mutilation is also thought to foster social cohesion between groups of girls who are operated on in the same time period, as girls will affiliate with those who have undergone the same experience at the same time. Among the Somali, it is believed that a family that fails to circumcise its daughters' risks losing respect and its members may be ostracized to become outcasts. This is because of the great importance and value that they attach to virginity and marriage. (Nahid Toubia, 1993)

The virginity of a bride, usually ascertained by the narrowness of the vagina after infibulation, attracts a high bride price. This is also similar in other communities and no father would fail to subject his daughter to the practice in order to attract a high bride price. FGM/C is said to confer on girls and women a new identity; Women who do not circumcise their daughters run the risk of being seen as irresponsible, immoral and imitators of Western culture. These sentiments are common among other groups such as the Meru, Kalenjin and Abagusii (Els Leye, Maria de Bruyn, Stan Meuwese, 1998).

The upholders of FGM argue that the removal of the female genitalia contributes to the cleanliness and purity of women. In some communities popular terms for mutilation are synonymous with purification, for example *tahara* in Egypt and *tahur* in Sudan (AI 1998) and the opposite *nejasa* (unclean). It is believed that the removal of the clitoris and labia contribute to the cleanliness and beauty of women. In such societies an un-mutilated woman is considered dirty and polluted. (AI, 1998).

This is one reason why uncircumcised women are ostracized within their own families and communities. They are not part of the social life such as communal feasts. The absence or removal of the clitoris keeps the vagina clean and makes vaginal intercourse more desirable than clitoral stimulation. These misconceptions are based on the fact that secretions produced by the glands in the clitoris, labia minora and majora are bad smelling and unhygienic and so makes the female body unclean. It is believed that the absence of the clitoris keeps the vagina clean. On the other hand, its presence is believed to damage the baby at delivery and affects the husband's genitalia during intercourse. It is also believed to enhance fertility. Other myths include that FGM enhances the husband's sexual desire; prevents maternal and infant mortality. As one can easily deduct this deep-rooted beliefs are incompatible with reality. Under normal conditions secretions are odorless and if the secretions are bad smelling, excessive and colored, then this is an indication of infection or other serious problems, probably requiring medication. In reality FGM can create uncleanliness by closing the vulva and preventing the natural flow of urine and menstrual flow and consequently leading to the retention of urine and menstrual blood causing offensive smell (Leye, 1998).

2.5 Control of sexual desire and female genital mutilation

This component outlines and discusses how the sexuality and gender roles play a big role in the growth of female genital mutilation among some communities in Kenya. Cutting and stitching a girl's genital organ is thought by many ethnic groups to suppress her sexual desires, as a way of keeping her from having sex for pleasure, before, during or outside of marriage. In some groups FGM functions as a way of marking the girl so that she is able to fulfill her role as a woman, a wife and a mother. The practice may be

understood as the determinant of gender identity which may be closely related to the concepts of chastity, the safeguarding of the purity of women and the control of female sexuality, all of which may be pre-conditions for the ability to marry and have children (Catherine Coquery, 1997).

In some cultures it was believed that the clitoris is a masculine feature which must be excised to create true femaleness, some also believing that the clitoris is an infant penis whose growth must be forestalled by surgery. Women who have not undergone FGM are thought to maintain, or have the potential to develop, characteristics thought to be appropriate only for men, such as sexual desire, aggressive behavior and promiscuity. Feminist commentary cited FGM as evidence of the continued oppression of women. The removal of the clitoris is seen as an attempt to control the sexual activities of women; a denial of the freedom of sexual desire and expression. FGM is seen as a misogynistic message about the expectation of the behavior appropriate for the female gender, including the prohibition of sexual pleasure and freedom and the expectation that women should exhibit behavioral characteristics such as compliance and docility. (Minority Rights Group International, 1996).

The Abagusii believe that a circumcised woman will not want to have pre-marital or extra-marital sex because she will not have a strong sexual drive. Uncut women are thought to be easily aroused and possess strong sexual desires which are not culturally acceptable. In some communities such as the Somali, after giving birth or after a divorce and before remarrying, a woman may be re-infibulated to enhance the husband's sexual pleasure. The main reason behind FGM/C, according to elders from Isiolo, was to reduce the libido of the girls, enforce the cultural value of sexual purity /virginity until marriage (Tracey Skeleton and Tim Allen, 1999).

Feminist scholars and anti-FGM activists (such as Hosken; Koso-Thomas; Rahman and Toubia; Walker, Weil-Curiel to name but a few) interpret FGM as an assault on women's sexuality as well as an oppressive and cruel act which has a grave and catastrophic impact upon women and girls' health. They further associate FGM with a patriarchal desire and

need to control women, their bodies, and their sexuality in order to maintain female chastity and fidelity. Women, over time have been successfully persuaded to attach special importance to female circumcision, motherhood, and housekeeping, in order to maintain male domination in patriarchal societies (Koso-Thomas, 1987).

Koso-Thomas' revolutionary stance urges (African) women to free themselves from ignorance, fear and mental servitude and join in the education of their sisters. Others, such as Pickup, regard FGM as an act of material bargaining that women make with patriarchy in order to derive economic support. For example, it may be a rational and even loving decision for a mother to decide to genitally mutilate her daughter in a culture where she will stand little chance of finding a husband otherwise. FGM is thought to reflect and reinforce the social and moral order – in which women are obliged – or, as Walker and Parmar argue, forced and brainwashed - into being pure and faithful. A problem for feminist analysis has been that women themselves are mostly the ones inflicting FGM; however, the above explanations, by inferring that women simply carry out the desires of men, implies that men are in essence the real, hidden perpetuators. (Pickup, 2001).

'Third World' feminists, in turn, have criticised Western attitudes; firstly, for homogenizing and reductively situating them. Secondly, for their tendency to dominate both theoretical and practical aspects of the feminist movement, and thirdly, for their condemnation of FGM which, they argue, carries hidden assumptions of superiority and ethnocentrism. As Ahmadu notes, women are seen as blindly and wholeheartedly accepting mutilation because they are victims of male political, economic, and social domination. Moreover, they accuse Western feminists of interpreting FGM out of its socio-economic, political and historical context. Whilst most feminists would regard the subordination of women as a matter of international concern, many resent the categorisations being predominately centred around European and American personalities and events. (Ahmadu, 2000:284).

Western feminists appropriate and "colonise" the constitutive complexities which characterize the lives of women in these countries', thus ending up with a crudely reductive 'notion of gender or sexual difference. Mohanty's attempt to subvert

intellectual paradigms is criticised by Chowdhry who considers her work equally neo-colonial. Citing Goetz, Chowdhry argues instead that; Western feminist and Western-trained feminist writing often portray Third World women as victims. These feminists base their analysis and their authority to intervene on their claims to know the shared and gendered oppression of women. In so doing, they misrepresent the varied interests of "different women by homogenizing the experiences and conditions of Western women across time and culture (Goetz cited in Chowdhry, 1995:28).

2.6 Religious requirement and female genital mutilation

Throughout the world, female genital mutilation has been reported to be practiced by Christians (Protestants, Catholics and Copts), Muslims, Jews, Animists, and atheists. Religious requirement may be understood by the individual as the reason that FGM is performed. However, FGM is not included within the formal teachings of any religion. The association of FGM with religious belief and obligation is assumed to be the result of historic concurrence and incorrect teaching and/or understanding of religious texts (Maria and Stan, 1998).

Female genital mutilation pre-dates most modern religions, including Christianity and Islam. One commonly held misconception about FGM is that it is prescribed within the Islamic religion. However, there are many Islamic people around the world who do not practice FGM, notably those of predominantly Islamic Middle Eastern countries, such as Saudi Arabia. For some women the procedure is understood to be Sunna, a religious requirement prescribed within teachings of the Prophet Mohammed. However, there is considerable debate on this issue within the religion (Women's International Network News, 1993).

Some communities practice FGM/C because they believe it is a religious requirement. The Somali, Borana and Boni believe that FGM/C constitutes an Islamic Sunnah practice, that is, the prepuce covering the clitoris should be removed. This is because prayers of uncircumcised persons (males or females) are considered unacceptable. The clitoris is

considered haraam (dirty or not pure in the sense of religious purity and cleanliness) thus it must be removed (Dorkenoo, 1995)

To educate the community on the harms of FGM/C, both religiously and medically, so that they question the rationale for its continuation, there have been heated debates to generate discussion with respect to the correct position of Islam on FGM/C and hopefully build consensus among the religious scholars on this matter. According to Dorkenoo, the religious scholars command much respect, influence opinions in the Somali community, and are therefore instrumental in educating the community. In a narration made during the WHO Research (1996), in Wajir to unearth and correct the misconceptions surrounding FGM/C and Islam, especially in similar communities, it was imperative that the religious leaders are involved. A start up conversation was made through answering the question: Does the practice, in all its types, have any authentic basis in Islam?
The belief that there is a Sunnah type of FGM/C in Islam is held firmly and this can only be questioned using Islamic teachings. (Dorkenoo, 1995)

At present, the religious scholars and the wider community unanimously reject infibulation on the basis that it is haraam (unlawful) in Islam. However they are supportive of some form of cutting, however mild, as they believe it is a religious requirement and refer to it as Sunnah.
“It is part of the religion...Sunnah is a must” and that “one who is not circumcised is not a Muslim, and even her parents are seen as not being in the religion, that is how we see as Somalis (The History of Married men, WHO Wajir Research, 2005)

The belief that FGM is a religious requirement is so strong that women are ready to continue with the practice if there is any solid evidence that it is Islamic, notwithstanding its harmful effects. In her narration of her personal experience of FGM/C during one of the discussion sessions with religious scholars from Wajir, one woman said: “The harms are there. I was in shock for two days. When I started my periods I was in problems. I was done the Sunnah of that time even though the place was infibulated. Is there a Quranic verse on this cut? If it is there, then there is no two ways about it, we have to

continue doing it, but if it is not there, then scholars needed to guide us." (WHO Wajir Research, August, 2006)

There are two problems with this: the Sunnah FGM/C is not defined and nobody can tell for sure how it is to be carried out. Secondly the community has always claimed to practice the *Sunnah* cut when the actual practice has been excision (cutting all the external organs in the female genitalia) and infibulation: "In the old days, once the clitoris and the other flesh around it were cut, the place was stitched using thread and needle and or thorns. During our time we were cut and applied with malma but there was no stitching or thorns. Our legs were bound together for weeks and this healed the wound together thereby causing infibulation. This was considered Sunnah then but it was still Pharaonic. Nowadays, this practice is still on and majority of the people do it. (UNICEF Wajir Report, August 2006).

The first step in the approach is to de-link FGM/C from Islam by critically examining the evidence given for the practice. It is important for the community to understand the Shariah implications of this practice and be made aware of the fact that Islamic Shariah upholds human rights and dignity and that FGM/C violates these rights. As long as this practice is wrongly justified as Islamic, nothing else will make sense to the community, not even the many international instruments, protocols and legislations that prohibit and outlaw the practice, these are man-made laws according to them and hence they cannot bind them. When asked whether the legislation that prohibits the practice in Kenya was able to make the community abandon the practice, respondents in one of the study were quick to point out that, "There is a barrier between us and the government and that is our religion.…we are governed by our religion and we don't care about other laws. We will follow our religion…we will not stop Sunnah but anything more than what is mentioned in the Quran we can stop. We are ready to discuss with sheikhs but we will not stop because the radio or the government has said". But are there any divine laws that actually support this practice? (WHO, 2005).

We can answer this question by weighing the practice against Islamic teachings and proving that there is no Sunnah FGM/C in Islam. Knowledge that the practice is traditional and is in conflict with Islamic principles is a sure convincing way that can help in questioning the practice.

Considering the deep belief that FGM/C is a critical component of Somali culture and a perceived religious requirement, efforts to encourage behavior change cannot focus solely on education about health and rights alone but these arguments can only come in to complement the Islamic stand on FGM/C. (Thomas, 1997).

Health problems that arise from FGM/C alone are not convincing for the community to abandon the practice as these are considered a result of God's will. It is believed that anybody is likely to get such problems regardless of whether or not they have undergone FGM/C. When asked whether they thought there were any complications arising from FGM/C, some respondents in the baseline study asserted that indeed women got tears during childbirth. But others were quick to state that, there is nobody who does not get torn, but it is not because of circumcision, it is God's will and it can happen to anyone, other respondents further claimed that the so-called Sunnah circumcision was actually a right, and hence girls have to undergo it. As a result arguments around its violation of the girls and women's rights will not be convincing enough unless tied to the human rights provisions in Islam. Islamically, it is a right to circumcise girls WHO Wajir Research, (2005), But the religion says it (circumcision) is a must so it is human rights (Women's Group Leader, WHO Wajir Research, (2005) "We agree (that FGM/C is a human rights issue) because we want circumcision to continue" (In summary, this religious oriented approach has been developed because: In the Somali community the practice is not a rite of passage, as it is carried out on girls as young as four years. Strategies such as the Alternative Rites of Passage will not be applicable in this community (Circumcisers, WHO Wajir Research, 2005).

The medical complications, though known to the community, are considered a result of the will of God and not associated with the practice. It is believed that such complications

and problems can happen to anybody, regardless of their FGM/C status. Arguments around the medical complications alone arising from FGM/C would not be convincing enough to help the community question and stop FGM/C. However these medical complications can be blended with Shariah guidelines on the sanctity of the human body and prohibition against cutting healthy organs and causing harm (Aldeeb Abu-Sahlieh S, 2004).

The international, regional and national laws, legislations and protocols enacted to counter the practice are considered to be man-made, and are therefore superseded by beliefs in divine laws. The community was categorical and said that they were ready to listen to religious scholars to tell them what the correct position of Islam was on the practice and that they would be willing to abandon anything un-Islamic. The practice is considered a "right", and hence arguments around it being a violation of the rights of women and girls cannot help in questioning the practice on their own. But if these arguments are tied to Islamic provisions, then it would be easier to question something that violates others rights and amounts to sin in Islam (Family Law Council 2004).

2.7 Cultural and ethnic identity and female genital mutilation:

In the African set up, FGM is often considered a complex issue, with a variety of explanations and motives given by individuals and families who support the practice. FGM is often seen as a natural and beneficial practice by a loving family who believe that it is in the girl's or women best interests. This also limits a girl's incentive to come forward to raise concerns or talk openly about FGM; reinforcing the need for all professionals to be aware of the issues and risks of FGM (Walker, Pratibha, 1993).

It is because of these beliefs that girls and women who have not undergone FGM can be considered by practicing communities to be unsuitable for marriage. People know of it as a tradition. They take it for granted as an operation that must be done to all girls. Despite the harm it causes, many women from FGM-practicing communities consider FGM normal to protect their 'cultural identity'. As a result of the belief systems of the cultural groups who practice FGM, many women who have undergone FGM believe they appear

more attractive than women who have not undergone FGM. Women who have attempted to resist exposing their daughters to FGM report that they and their families were ostracized by their community and told that nobody would want to marry their daughters (Van Der Kwaak, 1992).

Infibulation (type 3) is strongly linked to virginity and chastity, and used to safeguard girls from sex outside marriage and from having sexual feelings. In some cultures, it is considered necessary at marriage for the husband and his family to see her 'closed' and, in some instances, both mothers will take the girl to be cut open enough to be able to have sex, although FGM is practiced by secular communities, it is most often claimed to be carried out in accordance with religious beliefs. However, FGM predates Christianity, Islam and Judaism, and the Bible, Koran, Torah and other religious texts do not advocate or justify FGM. (Abdalla, 2001).

Abdalla adds that despite this, religion is sometimes given as a justification for FGM. For example, some people from Muslim communities argue that the Sunna (traditions or practices undertaken or approved by the prophet Mohammed) recommend that women undergo FGM, and some women have been told that having FGM will make them 'a better Muslim. Most ethnic groups that practice FGM/C in Kenya such as the Swahili/Mijikenda, Kamba, Kikuyu, Meru, Embu, Kalenjin, Taita Taveta, Maasai, Abagusii and the Somali) consider it a deeply rooted cultural practice. Many communities in Middle East, North Eastern and North Coast of Kenya indicated that the reason for mothers to circumcise their daughters was because their grandmother did so, and so their daughters have to undergo the same (Slack, 2003).

Current arguments among anthropologists reveal an old tension between the tolerance of Cultural Relativism and an activist intolerance of repressive or violent conditions. Relativism (as espoused by Franz Boas and his students Ruth Benedict; Margaret Mead and Melville Herskovits) is complex since it raises questions of how much it is possible to understand or comprehend "others'" culturally based realities. As Ingold notes: "Anthropologists stress that there are as many standards of humanity as there are different

ways of being human, and that there are no grounds – apart from sheer prejudice – for investing any one set of standards with universal authority" (Ingold, 1994:29).

Relativists, therefore, are of the opinion that all cultural beliefs and values have underlying meanings which need to be interpreted within their original cultural contexts. In other words, this "hands off" and detached observer approach asserts that no outsiders have the ability nor right to impose change upon "others" and that it should be left to those concerned "to argue it out for themselves, Scheper-Hughes, (1991). Contrasting this is the Universalist approach, which defines FGM as an act of international violence. Intervention is considered a necessary prerequisite on the grounds that "its morality transcends national boundaries and cultural beliefs (Annas, 1996:326).

Geertz dismissed this view arguing that "anti-relativism was really just a symptom of the pre-ethnographic nostalgia, an attempt to put the apple of diversity back into the tree of Enlightenment" (Geertz cited in Barnard, 2002:481). Despite the fact that the majority of anthropologists may consider FGM unethical, they have not adopted a position of moral advocacy against it. This middle ground and value-free approach has thus provoked rejection and accusations of failure (Gordon, 1991).

The fear of being labelled either a racist or cultural imperialist has deterred many people from actively challenging this almost-taboo subject. I would argue, however, that FGM is ritualized violence, is a violation of women's and children's human rights, and is an attack on natural sexuality and bodily integrity. Like all other forms of gender based abuse and discrimination they are, therefore, unacceptable. The reluctance to "interfere with other cultures", voice concern or to take a stand is simply colluding with its perpetuation and putting thousands more innocent women and children around the world at risk (Dorkenoo, 1995).

2.8 Literature gaps

Most of the studies have not in-depthly tackled the issues of female genital mutilation as a research issue most of the studies have studied this as a subsidiary to the large aspect of

FGM/C. This study went deeper in matters of extent to which FGM is mostly preferred among the Orma and Wardei communities in Tana River. The Orma and Wardei community is very slow in adopting the ban of the practice by the government. The previous research focused mostly on the general community, this research will have a focus on all women and girls because of the changing trends in responding to FGM effects and impacts within the society and because they of their eligibility. The study will go deeper to ascertain the FGM/C relationship to knowledge, attitude and practice, which has been a missing factor on the relationships.

Muslims have been indepthly studied unlike the other denominations, this study will look at the religious groups as we know the doctrines are different and some have been critical on FGM prevalence.

2.9 Conceptual Framework

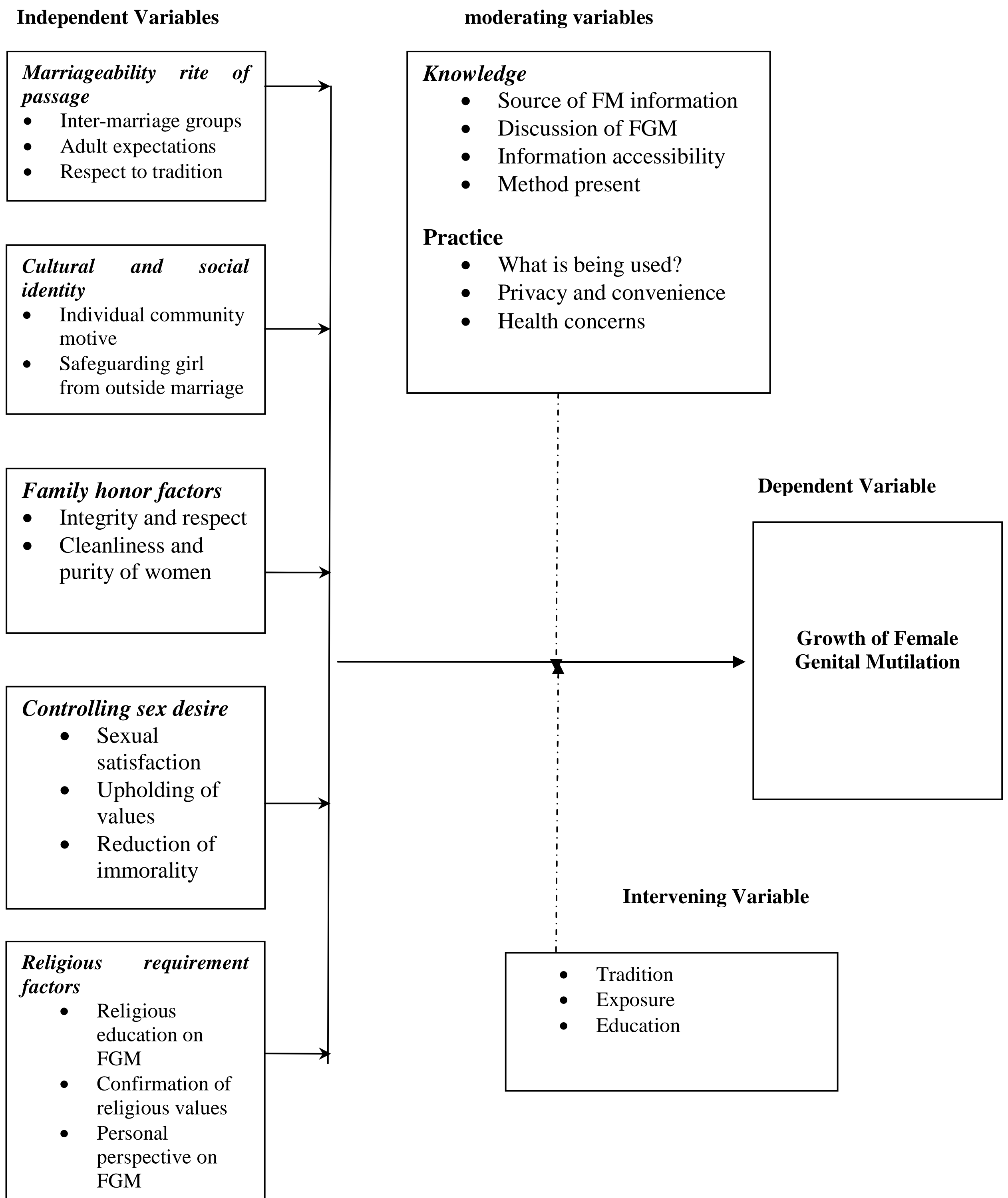

Figure 1.1: Conceptual Framework

2.10 Summary of literature

Literature was reviewed on the factors that influence growth of female genital mutilation among diverse society in the world. This study will deal with demographics, rite of passage, marriageability, culture and ethics, religion, family honor and sexual factors that are thought to have a great influence on the same. The proximate factors are knowledge, attitudes and practice which will lead to method choice and preferences by the FGM practitioners.

Literatures shows that all the other factors save for religion have a greater influence on the extent of female genital mutilation among most communities in the world, Africa and the Country as a whole.

CHAPTER THREE

RESEARCH METHODOLODY

3.1 Introduction

This chapter discusses the methodology that was used to conduct the research. The research design, target population, sample size, sampling procedure, data collection methods and procedure, the validity and reliability of the research instruments, ethical considerations and data analysis and presentation techniques have been discussed in detail. The operational definition of variables was provided in the final section of this chapter.

3.2 Research Design

This study was conducted through the descriptive survey research design. A survey is a research design where the researcher attempts to collect data from members of a population so as to determine the current status of the population with regard to one or more variables (Adeyemi and Adu, 2010). The design was suitable for studies where data was intended to describe the existing conditions. In this study, the independent variables were pre-existing social phenomena and cannot be manipulated. The researcher therefore investigated the target population through the selection of a sample to analyze and discover occurrences. The design enabled the researcher to establish how each of the independent variables either increased or decreased the probability of occurrence of the dependent variable. (Simiyu, 2009).

3. 3 Target Population

The target population consisted of 18,545 females between the ages of 15 - 60 in Tana River county (source: Kenya Demographic Health Surveys, 2009). The researchers' choice of 18,545 clients was guided by the data available for females who were eligible or rather at risk of FGM. This study targeted the females including girls and women visited within their homes at the time of the interview so that primary data and the exact methods chosen or preferred were physically seen. The researcher also surveyed a small population of males to establish their opinion on marrying women who have not undergone FGM

3.4 Sample size.

This study employed only one approach in determining the sample size for the respondents in the quantitative category. The approach used to determine the sample size from the women and girls population was adopted from (Kothari 2004) as illustrated below;

$$n = \frac{z^2.p.q.N}{e^2 N\text{-}1+z^2.p.q}$$

Where;

n - Size of the sample

Z - Value of standard variate at a given confidence level

P - Sample population

q - (1-p) and

e - Acceptable error

In this study, the researcher desires a 95% level of confidence which gives the value of z as ±1.96 and an acceptable error of 0.05.The DMS statistical consulting group –Faraday (2006) stated that the acceptable error was generally set at 0.05 or a 5% probability that a significance difference occurred by chance. Kothari (2004) recommended a value estimate of p at 0.5 as this would give a maximum sample value and yield the desired results. Using these values, the sample size was calculated as follows;

$$n = \frac{1.96^2 \times 0.5 \times 0.5 \times 18{,}545}{0.05^2\ (18{,}545\text{-}1) + 1.96^2 \times 0.5 \times 0.5}$$

$$n = \frac{21{,}249.363}{59.8204}$$

$$n = 255.219$$

$$n = 255$$

Out of the 255 the researcher used 55 individuals for pilot testing so as to improve on the reliability of the research.

3.5 Sampling procedure

Therefore, a sample size of 200 girls and women was drawn using cluster sampling technique. Cluster sampling was a sampling technique used when "natural" but relatively homogeneous groupings are evident in a statistical population. The principle of cluster sampling selection procedure assigned each individual in the sample the same chance of selection. In this technique, the total population was divided into clusters and a simple random sample of the groups was selected (Williams, 1998). The researcher also conducted one focus group discussion comprising of eight males and two women. A sheikh/imam and two health practitioners were also interviewed as key informants.

3.6 Data collection instruments

The study used questionnaire for data collection; the questionnaire was used among the women, girls and men. The selection of the tools was guided by the nature of data to be collected, the size and distribution of the population and the objectives of the study. Questionnaires increased the chances of getting honest responses since they ensure anonymity of the respondent. The questionnaire used both open ended and closed ended questions. The use of open ended questions offered flexibility for the respondent to provide more details. Closed ended questions allowed for quantitative analysis to be done. This balance was useful for a comprehensive analysis. The research also conducted focus group discussion and also talked to some key informants who have key information on particular component of the research, these included Imams and medical practitioners.

3.7 Validity of Research Instruments

Validity is the accuracy and meaningfulness of inferences, which are based on the research results (O. Mugenda & A.Mugenda, 2003). According to Cooper & Schindler (2007), pretesting questionnaires helps the researcher find ways to increase participants' interest; helps in discovering question content, wording and sequencing problems before the actual study and also helps in exploring ways of improving overall quality of study.

Mugenda and Mugenda (1999) contend that the usual procedure in assessing the content validity of a measure is to use a professional or expert in a particular field. To establish the validity of the research instrument the researcher sought opinions of experts in the field of study especially the lecturers in the department. This facilitated the necessary revision and modification of the research instrument thereby enhancing validity. Expert opinions were requested to comment on the representativeness and suitability of questions and gave suggestions of corrections to be made to the structure of the research tools. This helped to improve the content validity of the data that will be collected. Content validity was obtained by asking for the opinion of the supervisor, lecturers and other professional on whether the questionnaire was adequate.

Reliability of Research Instruments

According to Cooper and Schinder (2007), reliability refers to the consistency of measurement and is frequently assessed using the test–retest reliability method. Reliability is increased by including many similar items on a measure, by testing a diverse sample of individuals and by using uniform testing procedures. A number of measures were taken to ensure reliability. Themes on the interview questions will be based on the objectives stated in the study. To achieve reliability of the questionnaire, the instrument was designed with great care matching questions with objectives for the study. The tools were reviewed by my supervisor for suggestions on improvement. The questionnaire was tested in 25 women and 30 girls within the community in a pilot study. The responses generated were examined to check for the common understanding of items in the questionnaire.

3.8 Data Collection Procedure

This study used community resource persons who were used as research assistants; trained on the tools and issued with the questionnaires to administer to the women and girls. The researcher then collected the questionnaires from the research assistants who ensured that all questionnaires were returned. The researcher also organized one focus group discussion of eight men and two women and also talked to key informants a sheikh/imam and two health practitioners.

3.9 Data Analysis

This study sought to establish the extent to which the independent variables influence the dependent variables. It was therefore suitable to analyze data using descriptive analysis. Descriptive analysis is the study of the distribution of one variable and it provides the researcher with profiles of the study population such as their size, composition, efficiency, preferences and so on (Kothari, 2004).

In this case, data quality control and cleaning commenced in the field by the researcher ensuring that all the information on the questionnaires had been properly collected and recorded and checked for completeness of data and internal consistency. Data analysis started once all the data has been captured. Closed-ended questions was analyzed using nominal scales into mutually exclusive categories and frequencies by employing descriptive statistics using the Statistical Package for Social Sciences Version 20.0 (SPSS V 20.0) and MS Excel. Open-ended questions were analyzed using conceptual content analysis. Analysis involved the production and interpretation of frequencies counts, tables and graphs that describe and summarize the data.

3.10 Ethical Considerations

Approval was sought from the District Ethical Committee before undertaking the research. Respondents were informed that the information they give would be purely for research purposes. To achieve anonymity of the data gathered from the respondents, data such as names was left out in the design of the instrument.

3.11 Operational Definition of variables

Variables refer to anything that might impact the outcome of a study. The operational definition of variables described what the variables were and how they would be measured within the context of this study.

The table below shows the operational definition of variables for this study, indicators, measurement, and the data collection methods that will be used.

Table 3.1: Operational Definition of variables

Objective	Independent variable	Indicators	Tools for data collection	Measurement scale	Type of analysis
To determine how marriageability rite of passage factors influence FGM among Wardei and Orma in Tana River county	Marriage ability rite of passage	Inter-marriage groups Adult expectations Respect to tradition	Questionnaire	Nominal	Descriptive Means Frequencies Percentages correlation
To determine how culture and ethical identity factors influence FGM among Wardei and Orma in Tana River county.	Culture and ethical identity	Individual community motive Safeguarding girls from outside marriage	Questionnaire	Nominal	Descriptive Means Percentages correlation
To determine how family honor factors influence FGM among Wardei and Orma in Tana River county.	Family honor factors	Integrity and respect Cleanliness and purity of women	Questionnaire	Nominal	Descriptive
To determine how controlling sexuality factor influences FGM among Wardei and Orma in Tana River county	Controlling sexuality desire	Husbands sexual desire Sexual satisfaction Upholding of values Reduction of immorality	Interview	Nominal	Descriptive Percentages correlation .
To determine how religious requirements factor influences FGM among Wardei and Orma in Tana River county.	Religious requirement factors	Religious education on FGM Confirmation of religious values Personal perspective on FGM	Interview	Nominal	Descriptive Percentages correlation .

CHAPTER FOUR
DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

The study investigated the factors influencing the growth of female genital mutilation among Orma and Wardei communities in Tana River County. This was in the light of the fact that the overall County indicators are above the national indicators. The data is presented using frequency distribution tables and percentages. In all instances, the Chi-square statistic was calculated to test the significance in the relationship between variables. This chapter therefore presents the results of the analyses.

4.2 Response Rate

The variation in the response rate in all targeted clusters realized an overall response rate of 100%. The researcher determined that this response rate would produce reliable results. Although there is no single recommended figure for response rate, most writers indicate that the percentage of responses would probably differ according to the type of study. Generally, 60% is rated as marginal, 70% reasonable, 80% is good while 90% would be excellent (Mundy, 2002).

4.3 Demographic Information

The demographic characteristics are analyzed based on the questionnaire set. A summary of the demographic characteristics for all target respondents is discussed as shown in the Table 4.1 below.

Table 4.1: Age status

Current Age	*Frequency*	*Percent*
21-30 years	34	17.0
31-40 years	72	36.0
Above 40 years	94	47.0
Total	**200**	**100**

The Table 4.1 shows analysis of the findings which revealed that majority of the respondents (83%) are above 31 years, 17% between 21-30 years.

Table 4.2: Marital status

Marital status	*Frequency*	*Percent*
Widowed	63	31.5
Separated/ Divorced	33	16.5
Married	104	52.0
Total	**200**	**100**

Further analysis of the study findings in Table 4.2 on the marital status, indicate a significant proportion of 52% of the respondents were married. 31.5% represented those who were widowed while 16.5% reported to have been divorced or separated from their spouses.

Table 4.3: Education status

Education status	***NO***	***%***
Never been to school	109	54.5
Primary	77	38.5
Secondary	14	7.0
Total	**200**	**100**
Spouse education status		
Never been to school	181	90.5
Primary	16	8
Secondary	3	1.5
Total	**200**	**100**

The study in Table 4.3, revealed a proportion of 54.5% of the respondents who had never gone to school at all. This proportion increased to 90.5% when the study sought to find out the levels of education for the respondents' spouses. This was indicative of the illiteracy levels within the confinement of the respondents' categories. However, a significant proportion of 38.5% reported that they had gone as far as primary level of education with only 7% who had gone beyond primary level.

Table 4.4: Employment status

Current employment status	*Frequency*	*Percentage*
Self employed	15	7.5
House Wife	72	36.0
Not employed	113	56.5
Total	**200**	**100**

In Table 4.4, the study revealed 56.5% proportion of respondents who had no employment at all. 36% of the respondents reported to be house wives while only 7.5% were self employed.

4.4 Knowledge on Female Genital Mutilation

The study sought to find out the knowledge and opinions of the respondents about FGM and findings tabulated as below.

Table 4.5: Knowledge on Female Genital Mutilation

Indicator	*Response categories*	*Frequency*	*Percent*	*Standard deviation*
Did you undergo FGM	1. Yes	200	100	.000
	2. No	0	0	
If yes, which method	1. Type I Excision of the prepuce, with or without excision of part or all of the clitoris	0	0	.000
	2. Type II Excision of the clitoris with partial or total excision of the labia minora.	0	0	
	3. Type III Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).	200	100	
	4. Type IV Unclassified: includes; pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia;	0	0	
Do you think FGM is of any significance to the society?	1. Yes	200	100	.000
	2. No	0	0	
If yes, what is its significance?	1. Marriageability	120	60	2.456
	2. Rite of passage	0	0	
	3. Culture and ethical identity	40	20	
	4. Family honor	0	0	
	5. Controlling sex desire	40	20	
	6. Religious requirement	0	0	
	7. No idea	0	0	

It was evident from the analysis that in Table 4.5, all (100%) respondents had undergone female genital mutilation.

Further analysis revealed that all the respondents (100%) had undergone Type III of the FGM which involved excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).

Additional comments on this type of FGM implied that most of the respondents regarded or described Type III procedures including infibulation, Pharaonic circumcision and Somalian circumcision most common with the Somali, Orma and Wardei community in Northern part of Kenyan. Type III procedure which involve stitching and narrowing is the

worst form of FGM because its implication is evidenced during the first sexual intercourse as penetration is extremely difficult, Older women are sometimes called to assist young men who are unable to break the virginity of their newlywed wife's. An old women in the Focus group discussion said old women help young men by carefully increasing the vaginal canal using a small knife designed for the purpose, other shy young men who are afraid of asking for help take even months to penetrate their wife's
A close analysis was conducted to establish facts on why the respondents preferred the above method of FGM and 60% of the respondents reported that it was the most preferred method within the region and the husbands' or parents preferred it most. However, a significant proportion of 40% respondents had no idea why the method was mostly used within the region.

The study discovered that FGM was of significance within the region with 100% of the respondents reporting the same. Upon asking the significance within the society, 60% were of the opinion that the ladies become ready for marriage since they were prepared for their men. It was important to note that culture and ethical identity and controlling of sexual desire were also some of the importance of FGM as reported by 20% in each category.

The test results are summarized in the table below.

Table 4.6: Chi-square Results on the Knowledge on FGM among the respondents

	Chi-square value	**Df**	**Asymp. Sig. (2 sided)**	**Monte Carlo Sig. (2 sided)**	**Cramer's V Value**
Method of FGM	55.468	30	0.003	0.024	0.250
Reasons for choosing that method	*48.177*	*20*	*0.383*	*0.378*	*0.209*
FGM is of any significance to the society?	58.100	24	0.000	0.001	0.315
If yes, what is its significance?	25.434	24	0.000	0.005	0.262

In three out of four cases, the results yielded a < 0.05 therefore the null hypothesis is rejected. In all cases the data sets contained cells with an expected count of less than five, therefore it was unclear as to whether the standard asymptotic calculations of the significance level had been met. The researcher therefore computed the Monte Carlo statistic at the 95% confidence interval in place of the exact statistic since the data sets were too large for the exact value to be calculated.

Mehta and Patel (1989) recommend the use of the Monte Carlo method in cases where the exact value cannot be calculated as it provides an unbiased estimate of the exact value without the requirements of the asymptotic method. The Monte Carlo statistic lends support to the Chi-square results. The researcher therefore concluded that of all sub variables computed above, methods of FGM and significance of FGM are the indicators that had a significant influence on knowledge and extent of FGM among Orma and Wardei communities in Tana River County.

Table 4.7: Correlation between knowledge on FGM and practice of FGM

	Knowledge on FGM	Practice of FGM
Knowledge of FGM	1	0.689
Practice of FGM	0.689	1
No. of respondents	200	200

The researcher sought to find out if the respondents had enough information and knowledge about FGM. The study utilized the Pearson correlation co-efficient in establishing the relationship between the two variables. There was a positive correlation of 0.689 between knowledge on FGM among the respondents and the subsequent practice of FGM within the region under study. Similarly, it was evident that respondents had enough knowledge on the same methods they were using hence the 100% of respondents reporting to have used Type III of the methods of FGM.

4.5 Marriageability and female genital mutilation

One of the objectives of this study was to examine the influence of marriageability or rite of passage as a significant factor in FGM among the Orma and Wardei communities in Tana River County. The researcher therefore sought to get a general view of the marriageability factor in determining the extent of FGM practice in Tana River County. The table below gives a summary of the responses.

Marriageability was yet another variable that the researcher sought to find out if it had a correlation with the extent of FGM within the Orma and Wardei communities in Tana River County.

Table 4.8: Responses on marriageability

Indicator	*Response categories*	*Frequency*	*Percent %*
Do men in the society willingly marry women who are not circumcised?	1. Yes 2. No	10 190	5 95
Do girls discuss FGM freely with their peers?	1. Yes 2. No	150 50	75 25
Do these groups discuss about FGM?	1. Yes 1. No	175 25	87.5 12.5
Does FGM have any health effect to individuals?	1. Yes 2. No	80 120	40 60
Is FGM painful	1. Yes 2. No	200 0	100 0
Have you received any education on FGM?	1. Yes 2. No	25 175	12.5 87.5
Are you aware that FGM is illegal in Kenya?	1. Yes 2. No	0 200	0 100
Is FGM a traditional practice?	1. Yes 2. No	200 0	100 0
Do you know of a girl who was married and has not undergone FGM?	1. Yes 2. No	0 200	0 100

The analysis made in Table 4.8 indicates the various responses on the indicators of marriageability factor relationship with FGM in Tana River County. The analysis of the findings is as made below; The study sought to find out if men in the society willingly married women who were not circumcised and findings revealed an overwhelming 95% of respondents who expressed denial with only 5% minority in agreement. The women

interviewed said Men always expect girls to have undergone FGM before getting engaged. If a woman is not circumcised, then her chance of getting married is extremely slim.

It was evident that marriage within Orma and Wardei has great meaning if the married woman was circumcised. Another indicator was the health implication of FGM on individuals. The study findings revealed that FGM had no health implication to individuals as reported by 60% of the respondents. However, 40% confirmed that FGM had health implications to individuals. The practice of FGM within Tana River County, according to the proportion who reported that FGM had a health implication, majority mentioned of excessive bleeding during the procedure and lack of proper medication and poor hygiene leading to infections and other health hazards.

The information obtained from health worker within Hola District Hospital to establish if there had been any health hazards in FGM among women. The health practitioner confirmed that most females from the two communities normally give birth at home but a number of cases have been attended in the hospital with complication resulting from female genital mutilation. Health workers confirmed that women experience birth complications due to the small size of the vaginal canal, incision has to be done to increase the size of the canal to enable the baby to come out, if delivery is not done by health practitioners fatality is very common.

The study still revealed that FGM was very painful as reported by an overwhelming 100% of the respondents. Majority of the women interviewed narrated their ordeal, a lady confirmed that FGM has a serious psychological effect to all women who have undergone the cut, she confirmed that she was in trauma for a long time and always remembered the exercise.

Education to the individuals within Tana River County on FGM seemed to be lacking. This was reported by 87.5% proportion of respondents who confirmed that they had never received any education on FGM. While this was so, a minority of 12.5% seemed to

have been educated on matters of FGM in schools and seminars. Further comments from the respondents confirmed that some organizations within Tana River worked tirelessly educating the community on matters of FGM among other issues of development.

When asked if FGM is illegal, 100% of the individuals reported that FGM was not illegal in Kenya. These comments were symbolic of the fact that FGM had been fully accepted as a traditional practice within Tana River County. Despite the existence of the government Laws banning FGM in the society 100% of the respondent are not aware of this fact; this could be attributed to lack of enforcement of the law.

Upon asking if the respondents knew of any girl within the community who had been married without being circumcised, (100%) of the respondents denied, meaning as for as they know all married women have undergone FGM.

The above analysis indicates that marriageability was greatly connected to the practice of FGM within Orma and Wardei communities In order to justify the relationship between the marriageability factor and FGM practice within Tana River, the researcher conducted the following research hypothesis;

H_0: Marriageability factor does not influence FGM practice in Tana River County.

H_1: Marriageability factor influences FGM practice in Tana River County.

In the test analysis, the study utilized chi-square in establishing the relationship between independent variable (marriageability) and the dependent (practice of FGM) within Tana River County.

Table 4.9: Testing of research hypothesis

	Marriageability	**Practice of FGM**
Chi-Square	117.521	33.662
Df	5	2
Asymp. Sig.	.010	.008

Based on the results in the Table 4.9, the chi-square values on the levels of marriageability were 117.521, at 5 degrees of freedom. The computed value is larger than the table value of the chi-square which is 33.662. The chi-square value on FGM preference and practice is 33.662 at 2 degrees of freedom. The null hypothesis which implies that marriageability is significantly related to the FGM preference and practice is accepted.

4.6 Culture and Social Identity factors influencing Female genital mutilation

To explore the extent to which culture and social identity factors influence practice of FGM among Orma and Wardei community in Tana River County, the researcher used a one - fold approach by use of special questions to individuals who could provide insights on the same.

The table below shows the analysis of results on the indicators that show the relationship between culture and social identity factors and practice of FGM within Orma and Wardei community.

Table 4.10: Culture and social factors

Indicator	*Response categories*	*Frequency*	*Percent*
Who approves the FGM exercise in the society?	1. On-self	0	0%
	2. Parents	40	20%
	3. Society	0	0%
	4. Mother	160	80%
	5. grandmother	0	0%
Are you happy with FGM practice in the society?	1. Yes	180	90%
	2. No	20	10%
Does the culture and tradition recommend FGM?	1. Yes	200	100%
	2. No	0	0%
Would you recommend your friend or relative to be circumcised?	1. Yes	145	72.5%
	2. No	65	27.5%

The analysis of the study findings on the culture and social identity realized were as discussed;

Respondents were asked to give their knowledge and opinions on who approved FGM within the community and responses revealed an overwhelming proportion (80%) reporting that mothers approved the exercise. However, 20% were of the opinion that both parents were mostly involved in giving consent to the exercise. It should be noted that even those who reported that parents were involved, mostly referred parents to mothers since they were so involved with girls' issues within the society.

Mothers and grandmothers are major perpetrators of FGM; they convince the young girls telling them that they will only be accepted culturally if they undergo the cut. They insisted to them the need to conserve the culture as an identity of the community and the place of a circumcised girl in the community. It is equally important to take note that the influence of women in FGM exercise has a great impact on the extent of the practice.

Majority of the respondents (90%) felt very happy with the FGM exercise within Orma and Wardei communities while only 10% expressed their discontent with the exercise. However, culture and tradition seemed to have played a great deal in popularizing the FGM exercise in the two communities as reported by 100% who expressed the fact that culture recommended the act.

The Orma and Wardei culture highly encourage FGM, although both men and women rarely discuss about FGM the practice has a sacred support from the community, the community cannot question the effect of FGM as it is always associated to other normal ailment. The study sought to find out if individual respondents would recommend their friends and relatives to be circumcised. The results findings revealed that 72.5% majority would recommend FGM to other community members. This seemed that majority of the individuals in the two communities still promoted FGM contrary to a few (27.5%) who retorted that they would never recommend anyone to undergone the Cut.

The study sought to test the following research hypothesis:

H_0: Culture and social identity had a significant influence on the FGM practice in Tana River County.

H_1: Culture and social identity did not have any significant influence on the FGM practice in Tana River County.

Table 4.11: Chi-Square testing on Culture and social identity factors on FGM practice

	Chi-Square Value	***Df***	***Asymp. Sig. (2 sided)***	***Monte Carlo Sig. (2 sided)***
Who approves the FGM exercise in the society?	12.114	4	0.228	0.675
Are you happy with FGM practice in the society?	9. 922	4	0.524	0.312
Does the culture and tradition recommend FGM?	12.972	4	0.944	0.762

In Table 4.11 the analysis indicates Chi-Square statistic results; it shows there was a significant relationship between culture and social identity factors on FGM practice in Tana River County.

In Tana River County, it was evident that women approval of the FGM exercise as well as the recommendation from culture and tradition of the society highly aggravated the practice of FGM to a higher level. This was evidenced from the test where the Chi-Square value exceeded the cutoff point of 10 for the two indicators. This was supported by the Monte Carlo value which after a two sided analysis tested above 0.5 which happened to be the average cutoff point on a parallel analysis. However, it would be induced from the chi-square test that majority of the individuals within the two communities may not be very happy about the exercise. This was evidenced during the test where the value of chi-square went below the cutoff point of ten and thus made the indicator very passive.

In a nut shell, the researcher would simply conclude that the chi-square test ruled out the null hypothesis by simply rejecting it.

4.7 Influence of Family honor on Female genital mutilation

The study sought to find out the relationship between family honor and the practice of FGM within Orma and Wardei communities. In the study, a number of indicators were established in a likert scale to understand the effects of the various indicators in an agreement scale. The analysis was done and represented in the table below;

Table 4.12: Family Honor

Family honor	*Strongly Agree %*	*Slightly Agree%*	*Agree %*	*Disagree %*	*Strongly Disagree %*
Family promotes FGM	65	20	15	0	0
FGM brings family respect	10	17	43	25	5
FGM promotes integrity of the family	6	19	25	50	0
FGM promotes Cleanliness and purity of women	87	8	5	0	0
FGM is a family practice	95	2.5	2.5	0	0

In Table 4.12, the analysis shows the results findings on family honor's impact on FGM practice at family level. The results analysis on a likert scale also represented a test analysis to justify the impact of the tested indicators on the intended variable. This clearly indicates that FGM is not an individual affair but both community and family affair. It was revealed that majority of the individuals strongly supported the indicator that family promoted FGM within Tana River County. This was evident on the agreement scale as the representation was almost above the cutoff point.

However, it was not very certain if FGM contributed to family respect and integrity. Some of the individuals were not of the opinion that FGM brought about family respect/integrity and thus rejected it on the agreement scale. The low levels of support on this indicator denoted that some families have started rejecting the practice of FGM and thus disregard it as a major contributor to family respect as well as family integrity.

It was also tested if FGM was a family practice and the findings strongly support the indicator on the agreement scale. Again, it was proved that some families, based on the education received have started embracing modernization and rejecting FGM. This however was a step to fight the culture and tradition as reported by the respondents during this study. On the agreement scale therefore, it concludes that FGM has backing from the family and hence is more of a family affair than individual choice and its eradication should target the entire community than the individual. In the agreement scale, it was evidenced that majority of the respondents confirmed that FGM promoted cleanliness and purity to women. It was perceived that when a woman was circumcised, she became clean and thus could be allowed to take part in social events without question. This was reported by 95% of the respondents, who strongly agreed that FGM promotes cleanliness and purity thus making the indicator impact on the variable.

4.8 Control of sexual desire and Female genital mutilation

The study sought to find out the relationship between FGM practice and control of sexual desires and findings were shown in the table below.

Table 4.13: Control of sexual desire

Indicator	***Strongly Agree %***	***Slightly Agree%***	***Agree%***	***Disagree %***	***Strongly Disagree %***
FGM Upholds social values	77	6	0	0	17
FGM decreases Sexual desire for women	65	25	0	10	0
Satisfaction of Husbands sexual desire increased	0	0	7	33	60
Both husband and wife become sexually satisfied	0	0	0	27	73
Women who have undergone FGM are not immoral	35	23	25	15	3

The first test on the likert scale sought to establish if FGM upheld social values and the findings revealed a strong support on the agreement scale as reported by 83% of the individuals. This seemed to confirm earlier inferences which also explained on the social impact of FGM within the families. At the family level, it was also important to

understand if FGM decreased the sexual desires for women. Majority of the respondents (90%) strongly expressed support of their opinions on the agreement scale that women sexual urge and satisfaction was at check this is said to translate to reduction in immorality in the community.

The above also supported the ideology that husbands' sexual satisfaction was also lowered since the women sexual urge was low. This was reported by 93% majority who strongly disagreed (33% disagreed and 60% strongly disagreed) on the scale and concluded that husbands were not satisfied either during sexual intercourse.

Majority of the men interviewed said Women do not feel sexually stimulated and hence do not equally motivate their men, and this is attributed to the removal of the clitoris which makes them feel stimulated during intercourse. In other communities this has attributed to men looking for women from other communities who do not practice FGM. An in-depth analysis revealed that the type of circumcision method used frustrated the clitoris and thus lowered the women libido. This therefore reduced the women sexual satisfaction as her strength to stimulate the man also went low.

In a swift connection, individuals inferred that some women who had undergone circumcision had immoral values while on the other hand, it was denied on the agreement scale. Orma and Wardei belief that uncircumcised women are morally loose and can easily be immoral, the presence of clitoris is associated with hyper feeling of sex urge and women cannot control their sexual desire if not circumcised. But to some, it was evident that the extent of the husband and wife not getting satisfied during sexual intercourse simply became the genesis to immorality as each one of them, sought sexual satisfaction elsewhere.

4.9 Religious requirement and Female genital mutilation

All the respondents interviewed in this study were Muslims. This was attributed by the fact that Tana River County was a Muslim dominated region, and more so, the communities targeted (Orma and Wardei) were Muslim follows.

The analysis of the findings also utilized the likert to establish the relationship of the independent variable over the dependent and the findings on the indicators were as shown below.

Table 4.14: Religious requirement

Indicator	*Strongly Agree%*	*Slightly Agree%*	*Agree%*	*Disagree %*	*Strongly Disagree%*
I have knowledge of religious women who were circumcised	97	3	0	0	0
Some Religious scriptures promote FGM	0	0	10	25	65
I am satisfied with my religious stand on FGM	37	63	0	0	0
Sheikhs and Imams encourage FGM in the society	0	0	0	23	77
The religious scholars always talk about FGM	35	23	25	15	3
I know verses in our religious books where FGM originated	0	0	10	25	65

Majority of the respondents (100%) strongly agreed to have known religious women within the society that had been circumcised. This was indicative of the fact that circumcision did not choose the calibre of individual within the society. It was certain that religious leaders had also embraced the exercise not as a religious practise but as a cultural practise.

Majority of the respondents (90%) disagreed on the scale that some religious scriptures promoted FGM and confirmed that they were satisfied with their religion stand about FGM. Similarly, 100% of the respondents strongly disagreed that Sheikhs and Imams encouraged FGM in the society. This inference was indicative of the fact that religion did not play a role in promoting FGM within the region.

During FGD it was clearly said by the members of the group that FGM is not a religious practice but it’s enshrined in the culture of the people and the community has lived with it since the time immemorial and cannot be eliminated overnight.

A good proportion of the respondents (58%) of the individuals strongly agreed that religious scholars always talked about FGM within the society. The discussion had always been distinguishing between social and cultural FGM act and what religion talked about. It was strongly supported by the disagreement by the respondents that there were verses in religious books where FGM originated. Highly varying opinions on whether religious scholars were supporters of FGM could be as a result of participation of Imams and Sheiks in condemning the act.

Most women interviewed had little idea about whether FGM is a Sunna practise as believed in some communities namely Somali women in Wajir and Sudan. A number of women are aware that FGM is not advocated by religion but a deep rooted culture that both men and women in the two communities support. A number of Islamic scholars have issued various Islamic Fatwa on the issue of FGM most of which have disassociated FGM from Islam quoting both Quran as well as Hadith. God created human beings in the best forms and wanted them to keep the nature in which they were created. It is forbidden to make changes in God's creation unless there is a compelling reason for example for medical reasons (WHO, 2001).

CHAPTER FIVE

SUMMARY OF FINDINGS, DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

In this chapter, the researcher summarizes the findings of the study based on the five objectives of the study. In each case, the researcher briefly states the findings and the general implications they have towards FGM practice among Orma and Wardei communities in Tana River County. At the end of the chapter, the researcher states recommendations and highlights areas that need further research.

5.2 Summary of the Findings

The study was designed to assess the factors influencing FGM practice among Orma and Wardei communities in Tana River County. Five factors were identified as possible driving forces to FGM, namely marriageability and rite of passage, cultural and social identity, family honor, controlling of sexual desires, and religious factors.

The indicators of demographic factors focused on age, education and marital status among others. The chi-square statistic revealed a significant relationship between age and FGM practice with a majority (80.2%) of the respondents being in the age bracket 25-49 years. The data analysis on education focused on number of individuals and their spouses' literacy levels, the chi-square statistic revealed a strong association between the variables.

The analysis on the effect of marriageability factor focused on the willingness to marry women who were not circumcised, extent of girls discussing FGM freely, health implication of FGM to individuals, illegality of FGM and tradition relating to FGM practice. The results revealed that FGM as a tradition had the highest positive correlation compared to other indicators. The data also revealed that the individual respondents had the health implication of FGM on individual; the reason for checked FGM practice. The

chi-square statistic results also revealed a significant relationship between marriageability and FGM practice based on the correlation coefficient which had a value of 0.689.

To explore the effect of social and cultural identify, the researcher analyzed the culture and social identity to recommend FGM in the society. Chi-square statistic shows a strong correlation between culture and social identity and the practice of FGM in Tana River County. Culture and social identity had a direct correlation with the attitude the individuals had on FGM practice. Data on the ability to allow parents (especially mothers) to give consent to FGM exercise to be undertaken also reveals a strong correlation between culture and social identity and FGM practice. It was evident that women approval of the FGM exercise as well as the recommendation from culture and tradition of the society highly aggravated the practice of FGM to a higher level. The Chi-Square test value exceeding the cutoff point of 10 for the two indicators justified this inference. This was supported by the Monte Carlo value which after a two sided analysis tested above 0.5 which happened to be the average cutoff point on a parallel analysis. However, it would be induced from the chi-square test that majority of the individuals within the County may not be very happy about the exercise. This was evidenced during the test where the value of chi-square went below the cutoff point of ten and thus made the indicator very passive. In summary, the researcher would simply conclude that the chi-square test ruled out the null hypothesis by simply rejecting it.

Analysis on the effect of family honor factors focused on several years of experience. Data shows there was a significant relationship between family honor and FGM practice in Orma and Wardei communities in Tana River County. This clearly suggests that for decreased in practice of FGM, there is need to continually train the families to keep them updated on FGM issues in general. It was also tested if FGM was a family practice and the findings strongly support the indicator on the agreement scale. Earlier, it was proved that some families, based on the education received have started embracing modernization and rejecting FGM. This however was a step to fight the culture and tradition as reported by the respondents during this study. On the agreement scale therefore, it concludes that family honor and practices had a direct correlation with FGM.

It was perceived that when a woman was circumcised, she became clean and thus could be allowed to take part on social events without question and performed religious rituals more.

5.3 Discussions of the Findings

The first objective was to determine how demographic factors influence FGM practice among Orma and Wardei communities in Tana River County. Three indicators namely age; marital status and education for both spouses were used to test the influence of demographic factors on FGM practice. Data was obtained from questionnaire responses by individual respondents to test the hypothesis that age had a great influence on the FGM practice. The data revealed a significant relationship between age, education and the practice of FGM in the society with a majority being between the ages of 10-49 years. This finding is in agreement with those of Roumi .D (2010) and A. Leyland,(1996) which cited the adoption of FGM being highly acknowledged in the age-group 10 - 35 years as compared to the younger women below 20 years.

Another objective was to establish how marriageability and rite of passage factors influence FGM practice among Orma and Wardei communities in Tana River County-Kenya. The indicators used to test the influence of marriageability factors on FGM practice were counter-tested via Chi-square tests. There seemed to be a greater correlation between the marriageability and the extent of FGM practice in the region since women who were not circumcised have little chances of getting a husband. This relationship was analyzed using questionnaire responses from individual respondents and the findings are in agreement with Raiford et al, (2007) and Wolff et al (2000) which state that the parents (mothers) approval of FGM positively influences adoption of the practice to a greater length.

The study first tested on the likert scale confirmed inferences which also explained on the social impact of FGM within the families. It was also important to understand that FGM decreased the sexual desires for women. The ideology that husbands' sexual satisfaction was also lowered since the women sexual urge was low was investigated. Majority of the

individuals strongly disagreed and concluded that husbands were not satisfied during sexual intercourse. In a swift connection, individuals inferred that some women who had undergone circumcision had immoral values while on the other hand, it was denied on the agreement scale. To some, it was evident that the extent of the husband and wife not getting satisfied during sexual intercourse simply became the driving force to immorality as each one of them, sought sexual satisfaction elsewhere.

The third objective was to examine the influence of religious factors on FGM practice among Orma and Wardei in Tana River County. The test to examine the relationship between religion and the FGM practice revealed a significant relationship between religious beliefs and FGM exercise. This result is similar to that of Hagen et al (1999) and Utomo et al (1983) which indicated that religion is not a key factor influencing practice of FGM in Tana River County. In general therefore, the study findings indicated that current actors in FGM were not more religiously educated.

The focus group discussion involved eight persons in different social status; majority of the participants shared the view that FGM is not an individual issue but a community problem. Culture is playing a significant role in enhancing the FGM in the society, it is with this regard that the participants felt that any approach geared towards eradicating FGM should target the community and not individual.

Unlike other communities where FGM is a rite of passage in Orma and Wardei FGM is largely practised as a custom for purification of women and controlling their sexual desire. The community belief that uncircumcised women will be sexually loose and uncontrollable a fact which was not supported by some members of the group. Members who did not support the idea said they have knowledge of circumcised women who are unfaithfully and therefore felt that the issue of sexual desire is not dependent on FGM but moral upbringing of an individual.

When asked if they could willingly marry uncircumcised girl, an old man said during his teenage age men will not dare to marry uncircumcised girl but if he was to do it now he would not mind marrying uncut girl. Majority of the young men are still reserved in marrying uncircumcised girls, those who have gone to school openly expressed their preference for uncimrcusised girl.

The sheikh in attendance said female circumcision in the two communities is largely a secretive affair which elders do not want to discuss or talk about it, most elders and local leaders have not fully accepted the cut as a problem that require immediate attention, because all the medical problem related to FGM has not been fully associated to FGM, the community is well aware of old females who perform the operation but they are not reported, doing this is considered as exposing the community secret to the outside and also for refraining from blame from their families. The sheikh further said the fact that women associate FGM with religion has no basis, uncut woman is clean and can perform religious rituals like any other Muslim, the belief that uncut woman cannot perform daily prayers has no religious backing.

5.4 Conclusions of the Study

This study investigated the factors that impacted on FGM practice within the Orma and Wardei communities in Tana River County. This was in relation to the fact that Tana River County has continued to record a high rate over the years. Various factors were considered, among them demographic factors, marriageability and rite of passage factors, culture and social identity, family honor, control of sexual desire, and religious factors on FGM practice among Orma and Wardei communities in Tana River County.

The study established that demographic factors, marriageability, culture and social identity, and control of sexual desire are factors influencing FGM practices among Orma and Wardei communities in Tana River County. The study further established that culture and social identity and marriageability factors have the greatest impact on FGM practice. Notable views were also provided on the family honor where parents (mothers) approval, knowledge and education on FGM, influence on FGM practice. All explanatory variables

positively influenced the practice of FGM among Orma and Wardei communities in Tana River County.

5.5 Recommendations of the study

In light of the research findings, FGM practice in Kenya in general and among the Orma and Wardei communities in Tana River County in particular is affected by various factors.

- Education to the individuals within Tana River County on FGM seemed to be lacking as a big proportion of individuals confirmed that they had never received any education on FGM. It was therefore a noble idea to increase education to the individuals within Tana River County to ensure that the rate of FGM is lowered. This would also impact on the culture and tradition reduction within the region and embrace positive culture that would not infringe the rights of the individuals.
- It was evident that parents approved FGM within the community and responses revealed an overwhelming proportion reporting that mothers approved the exercise. It was noted that the family had a significant support to the exercise and thus lots of awareness was required at family level to ensure that parents especially mother's understood issues about FGM.
- Husbands' sexual satisfaction was at stake as individuals perceived the sexual satisfaction between husband and wife low. This, according to many has lead to immorality. It was therefore imperative to recommend some drastic measures to be taken to reduce the rate of FGM and increase knowledge of the individuals on dangers of FGM on sexual satisfaction.

5.6 Recommendation for further studies

- An in-depth study on the contribution of Islamic religion on female genital mutilation should be carried out.
- Despite FGM outlawed in Kenya, the practice is till rampant and remains unabatedly practiced. There is therefore a need to carry out research on effectiveness of the Kenyan Law on FGM.

REFERENCES

Abdalla R. (1982). Sisters in affliction. London, Zed Press.

Aldeeb Abu-Sahlieh (1994). To mutilate in the name of Jehovah or Allah: Legitimization of male and female circumcision. Medicine and Law; 13(7-8): 575-622.

Boddy J. Womb, (1982). The symbolic context of Pharaonic circumcision in rural Sudan. American Ethnologist; 9(4): 682-689.

Black J A, Debelle G D (1995). Female genital mutilation in Britain. British Medical Journal; 310: 1590-1594.

WHO/UNICEF/UNFPA, (1997). Female genital mutilation. A joint statement. Geneva, World Health Organization

Hosken F. (1995). Female genital mutilation; Estimate: total number of girls and women mutilated in Africa. Women's International Network News. Lexington MA,

Toubia N. (1995). Female genital mutilation: A call for global action. New York, Women's Ink

Dorkenoo E. (1995). Cutting the rose: Female genital mutilation, the practice and its prevention. London, Minority Rights Publications.

The Population council, (1996). Clinical-based investigation of the typology and self-reporting of FGM in Egypt (Asia and Near East Operations Research and Technical Assistance Project). Final Report. Cairo

World Health Organization, (1996). Female genital mutilation Information kit Women's Health (Family & Reproductive health). Geneva,

Walker A, Pratibha P. Warrior Marks, (1993). History of female genital mutilation. Jonathan Cape London.

Van Der Kwaak A. (1992). Female circumcision and gender identity: a questionable alliance Social Science and Medicine; 35(6): 777-787.

Hosken F. (1993). The Hosken report: Genital and sexual mutilation of females, Fourth revised edition. Lexington, London

Lightfoot-Klein H (1989). Rites of purification and their effects: Some psychological aspects of female genital circumcision and infibulation (Pharaonic Circumcision) in an Afro-Arab Islamic society (Sudan). Journal of Psychology and Human Sexuality; 2(2): 79-91.

Lightfoot-Klein H. (1989). The sexual experience and marital adjustment of genitally circumcised and Infibulated females in the Sudan. The Journal of Sex Research; 26 (3): 375-392.

Slack A.T. (1988). Female circumcision: A critical appraisal. Human Rights Quarterly; 10: 437 486.

James S. (1994). Reconciling international human rights and cultural relativism: The case of female Circumcision. Bioethics; 8(1): 1-26

Koso-Thomas, (1987). The circumcision of women. A strategy for eradication of female genital mutilation. , Zed Books Ltd. London.

Family Law Council. (1994). Female genital mutilation. A report to the Attorney-General prepared by the Family Law Council.

Commonwealth Department of Health and Family Services, (1997). Operating Framework for the National Education Program on Female Genital Mutilation.

London, Foundation for Women's Health Research and Development, (1992). Female genital mutilation: A counseling guide for professionals.

Boddy J. (1991). Continuing the ant circumcision crusade, Medical Anthropology Quarterly; 10(5): 15-17. p16.

Hedley R. (1992). Child protection and female genital mutilation: advice for health education and social work professionals. London, Foundation for Women's Health Research and Development.

Ryan M.M (1994). Female circumcision and related practices survey. Royal Australian College of obstetricians and Gynecologists Bulletin.

Iris Berger and E. Frances. (1999). Women in Sub-Saharan Africa: Restoring Women to History, Indiana University Press,.

Florence Abena Dolphyne. (1991). The Emancipation of Women: An African Perspective Ghana University Press.

Tracey Skeleton and Tim Allen. (1999). Culture and Global Change

Catherine Coquery, African Women: A Modern History, West views Press, 1997.

Mundy, (2002). Minority Rights Group International, Female Genital Mutilation: Proposals for Change.

Fran P. Hosken. (1993). Genital and Sexual Mutilation of Females, Women's International Network News.

Nahid Toubia. (1993). Female Genital Mutilation: A Call for Global Action.

Els Leye, Maria de Bruyn, Stan Meuwese. (1998). Proceedings of the Expert Meeting on Female Genital Mutilation, Ghent-Belgium.

APPENDICES

Appendix I: Letter of transmittal

Adhan Nuri Berhe

P.O. Box 146

Hola

July 13 2013

To Whom It May Concern

<u>**RE: ACADEMIC RESEARCH**</u>

My name is Adhan Nuri Berhe and currently pursuing Master degree programme at University of Nairobi. I am conducting a study in this area on the factors that aggravated the female genital mutilation within the community with specific emphasis on Wardei and Orma communities in Tana River County.

This research will use a questionnaire to collect information in order to understand the situation as it is in the subject under review. It is for this reason that I kindly request for your assistance in offering your consent for the interview as well as giving honestly responses to the interview questions.

Your participation in the study is voluntary, you can choose to participate or not to. The information that you will provide will be treated with confidentiality and will not be used for any other purpose other than the objectives of this study.

Looking forward to your corporation

Thank you.

Adhan Nuri Berhe

REG: NO L50/74363/2012

0722 875917

Appendix II: Research Tool for Women and Girls

Demographic profile

Indicator	**Response categories**
What is Your Current Age?	1. below 20 Years 2. 21-30 Years 3. 31-40 4. Above 40
What is your Current Marital status?	1. Single / never married 2. Married 3. Separated/ Divorced 4. Widowed
Education status	1. Never been to school…………………….. 2. Primary…………………………………… 3. Secondary…………………………………. 4. Tertiary…………………………………….
Spouse education status	1. Never been to school……………………… 2. Primary…………………………………… 3. Secondary………………………………. 4. Tertiary…………………………………….
What is your Current employment status?	1. Employed for a wage 2. Self employed 3. Employed and part time entrepreneur 4. House wife 5. Not employed

Section A: Knowledge on FGM

Indicator	Response categories
Did you undergo FGM	3. Yes 4. No
If yes, which method	**5. Type I Excision of the prepuce, with or without excision of part or all of the clitoris;** Other terms used to describe Type I procedures include circumcision, ritualistic circumcision, Sunna, clitoridectomy **6. Type II Excision of the clitoris with partial or total excision of the labia minora;** Other terms used to describe Type II procedures include clitoridectomy, Sunna, excision and circumcision. **7. Type III Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation);** other terms used to describe Type III procedures include infibulation, Pharaonic circumcision and Somalian circumcision. 8. **Type IV Unclassified: includes;** pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia;
Why did you choose that method?	1. Less painful 2. No health implications 3. Husband's /parent's choice 4. Most preferred 5. No idea
Do you think FGM is of any significance to the society?	3. Yes 4. No
If yes, what is its significance?	8. Marriageability 9. Rite of passage 10. Culture and ethical identity 11. Family honor 12. Controlling sex desire 13. Religious requirement 14. No idea

Section B: Marriageability / rite of passage

Do men in the society willingly marry women who are not circumcised?

3. Yes
4. No

Do girls discuss FGM freely with their peers?

1. Yes
2. No

Do these groups discuss about FGM?

2. Yes
3. No

Does FGM have any health effect to individuals?

1. Yes
2. No

Is FGM pain full?

1. Yes
2. No

Have you received any education on FGM?

1. Yes
2. No

Are you aware that FGM is illegal in Kenya?

1. Yes
2. No

Is FGM a tradition practice?

1. Yes
2. No

Do you know of a girl who was married and has not undergone FGM?

1. Yes
2. No

No.	**Item**	**Agreement scale**					
		Strongly Agree	**Slightly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**N/A**
1	I have knowledge on women who were circumcised After marriage						
2	FGM has security to marriage						
3	I am satisfied with my FGM status						
4	FGM in our area is conducted to girls only						
5	FGM in our area is conducted to older women only						
6	FGM in our area is conducted to both women and girls						

Section C: Culture and social Identity

Who approves the FGM exercise in the society?

6. On-self

7. Parents
8. Society
9. Mother
10. grandmother

Are you happy with FGM practice in the society?

3. Yes
4. No

Does the culture and tradition recommend FGM?

3. Yes
4. No

Would you recommend your friend or relative to be circumcised?

1. Yes
2. No

Section D: Family honour

No.	**Item**	**Agreement scale**					
	Family honor	**Strongly Agree**	**Slightly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**N/A**
2.1	Family promotes FGM						
2.2	FGM brings family respect						
2.3	FGM promotes integrity of the family						
2.4	FGM promotes Cleanliness and purity of women						
2.5	FGM is a family practice						

Section E: Control of sex desire

No.	**Item**	**Agreement scale**					
	Control of sex desire	**Strongly Agree**	**Slightly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**N/A**
2.1	Satisfaction of Husbands sexual desire						
2.2	FGM decreases Sexual desire for women						
2.3	FGM Upholds social values						
2.4	Women who have						

	undergone FGM are not immoral						
2.5	Both husband and wife become sexually satisfied						

Section F: Religious requirement

What is your religion?
1. Muslim
2. Christian
3. Hindu
4. Traditionalist

Do you think FGM is a religious requirement?
1. Yes
2. No

No.	Item	Agreement scale					
	Religious requirement	**Strongly Agree**	**Slightly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**N/A**
	I have knowledge on religious women who were circumcised						
	Some Religious scriptures promote FGM						
	I am satisfied with my religious stand on FGM						
	Sheikhs and Imams encourage FGM in the society						
	The religious scholars always talk about FGM						
	I know verses in our religious books where FGM originated						

THANK YOU