FEMALE GENITAL CUTTING: PERCEPTIONS AND EFFECTS ON MATERNAL HEALTH IN SAMBURU COUNTY.

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REG. NO: N69/69208/2011

A RESEARCH PROJECT PRESENTED TO THE INSTITUTE OF ANTHROPOLOGY, GENDER AND AFRICAN STUDIES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS IN GENDER AND DEVELOPMENT STUDIES OF THE UNIVERSITY OF NAIROBI.
DECLARATION

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

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

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DEDICATION

I dedicate this work to my parents, Mr. Emmanuel Kisombe Mwatibo and the late Joyce Wakio Mwatibo, for their undying support always, my sisters Winnie, Lucy and Phidiliah and finally my fiancé, Mr. Samuel Kioko, who have always had it at heart that the value of education is priceless.

I wish to express my sincere gratitude to my supervisor, Dr. Wilfred Sublo, for his selfless dedication and encouragement in making this project a reality. I would also wish to acknowledge my lecturers Dr. Osebio Chagwa, Dr. Olayango Ouma, Dr. Odolicho and Dr. Shinnhiko. I also wish to acknowledge the contribution of the rest of University of Nairobi fraternity especially the library staff, the administration office which coordinates the MA programme and moderators to the success of this project.

Sincere appreciation goes to my entire family for their moral support and encouragement and understanding when I was not there for them during the project period; I could not have made it this far without you.

I would also like to extend heartfelt appreciation to the respondents in Samburu County for their assistance and cooperation throughout the research period and more so during data collection. Most important of all I extend my gratitude to the Almighty God for strength, good health, knowledge and wisdom that helped make this project a reality.
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I wish to express my sincere gratitude to my supervisor Dr. Wilfred Subbo for his selfless dedication and encouragement in making this project a reality. I would also wish to acknowledge my lecturers Dr. Owour Olungah, Dr. Onyango Ouma, Dr. Ondicho and Dr. Shilabhuka. I also wish to acknowledge the contribution of the rest of University of Nairobi fraternity especially the library staff, the administration office which coordinates the MA programme and moderators to the success of this project.

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ABSTRACT

This study focused on the impact of female genital cutting. It investigated the perceptions and effects on maternal health in Samburu County. The main objective was to determine the factors affecting women’s reproductive health in Samburu County. It focused on the perceptions and effects of FGM on Maternal Health in Samburu County. The specific objectives were; to determine the types of FGM practiced in Samburu County and also to assess the knowledge level of the negative implications of FGM on reproductive health among women of reproductive age in Samburu community; identify socio-cultural factors that contributes to the practice of FGM specific to Samburu County and establish key challenges in curbing the practice despite the Anti-FGM policies, interventions and programs in Samburu County. The study used a descriptive cross sectional research design. The target population of the study included women of reproductive age and selected key informants. Primary data was collected through interviews and focus group discussions. Secondary data was obtained from literature review, public policy documents, health centers, hospitals, non-governmental organization (NGO) files and other useful sources identified in the course of the study. Data was coded and analyzed by aid of Statistical Package for Social Scientists (SPSS) software. The findings were presented through charts, histograms and narratives. The findings indicate that there is still widespread practice of female genital cutting among the Samburu. The key findings indicate FGM is still being widely practiced in the study area and although there are laws to deal with it, many people practice it secretly. The key challenges were identified as ignorance of the law on FGM and lack of knowledge that the people have power to deal with it in their community.
CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

The World Health Organization (WHO) defines Female Genital Mutilation (FGM) as comprising of ‘all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons’. An estimated 100-140 million girls and women currently live with the negative consequences of FGM, majority of whom live in African countries (WHO:2000).

The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as the role of Traditional Birth Attendants (TBAs). However, more than 18% of all FGM is performed by health care providers, and this trend is increasing. Procedures are mostly carried out on young girls sometime between infancy and age 15, and occasionally on adult women.

Evidence from the Kenya Demographic Health Survey (KNBS: 2009), shows that the overall prevalence of FGM has been decreasing over the last decade. In 2008/9, 27% of women had undergone FGM, a decline from 32% in 2003 and 38% in 1998. Older women are more likely to have undergone FGM than younger women, further indicating the prevalence is decreasing. However, the prevalence has remained highest among the Somali (97%), Gusii (96%), Kuria (96%) and the Maasai (93%). Relatively low among the Kikuyu, Kamba and Turkana and rarely practiced among the Luo and Luhya (less than 1%) (KNBS: 2009)
FGM has no proven medical health benefits, and it harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissues, and interferes with the natural functions of girls' and women's bodies. FGM of any type is also associated with a series of long-term health risks. The main reasons for the continuation of the practice of FGM are firstly as a rite of passage from girlhood to womanhood; a circumcised woman is considered mature obedient and aware of her role in the family and society. Secondly, FGM perpetuated as a means of reducing the sexual desire of girls and women, thereby curbing sexual activity before and ensuring fidelity within marriage.

FGM is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979, and the Convention on the Rights of the Child (CRC), 1989, focus on the rights of women and girls and also provide a basis for the elimination of FGM as a human rights violation. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979 defines discrimination against women as:

“any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.”

(Article 1)
Although not explicitly mentioned, the practice of FGM fits within the definition of discrimination against women as set forth in CEDAW. It is a practice exclusively directed towards women and girls with the effect of “nullifying their enjoyment of fundamental rights.” Whatever the common justifications for the practice of FGM, cultural or religious, FGM causes great short-term and long-term physical and mental harm to its victims and perpetuates the fundamental discriminatory belief of the subordinate role of women and girls. The practice also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death.

According to the World Health Organization (WHO 1996), the different justifications reflect the ideological and historical situation of the societies. A variety of motives which range from myths to economic need help to maintain FGM. The myths can vary from region to region and from ethnic group to ethnic group. The most frequently cited justifications or explanations include:

- **Control over women’s sexuality**: Virginity is a pre-requisite for marriage and is equated to female honour in many communities. FGM, in particular is defended in this context as it is assumed to reduce a woman’s sexual desire and lessen temptations to have extramarital sex thereby preserving a girl’s virginity. FGM has the assumed ability to diminish women’s desire for sex. This implies that women cannot control their sexual desires. Uncircumcised women are therefore assumed to be overly sexually active than circumcised women. “Excision is believed to protect a woman against her over sexed nature, saving her from temptation, suspicion and disgrace while preserving her chastity” (MRG1992/3). This appears to be one of the core reasons for the existence of FGM. It is
believed that FGM serves as a means to discourage premarital sex and reducing sexual desire of a girl thereby preserving her virginity. The reduced desire even during the marriage is expected to ensure faithfulness of a woman to her husband. This is why it is believed that uncircumcised girls are assumed to run wild, or are considered of loose morals bringing shame and disgrace to their families.

- **Hygiene**: 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). It is believed that the removal of the clitoris and labia contribute to the cleanliness and beauty of women because an uncircumcised woman is considered dirty and polluted. This is one reason why uncircumcised women are ostracized within their own families and communities. 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 have foul smells and are unhygienic and so makes the female body unclean. In reality FGM can be considered unhygienic because of the closing of the vulva and preventing the natural flow of urine and menstrual flow and consequently leading to the retention of urine and menstrual blood causing foul smell. In some FGM-practicing societies, women who have not gone through the practice are regarded as unclean and are not allowed to handle food and water or serve elders. The absence of the clitoris keeps the vagina clean.

- **Gender based factors**: FGM is often deemed necessary in order for a girl to be considered a complete woman, and the practice marks the divergence of the sexes in
terms of their future roles in life and marriage. The removal of the clitoris and labia — viewed by some as the “male parts” of a woman’s body — is thought to enhance the girl’s femininity, often synonymous with docility and obedience. It is possible that the trauma of FGM may have this effect on a girl’s personality. In some societies the clitoris is seen as a “dangerous” organ, hence, requiring its removal. Since it represents masculinity in young girls and hence the need to identify their sex clearly becomes of prime importance (Hosken 1993; MRG, 1992/3). This point is better explained by an excerpt from an Egyptian woman: “We are circumcised and insist on circumcising our daughters so that there is no mixing between male and female.... An uncircumcised woman is put to shame by her husband, who calls her ‘you with the clitoris’. People say she is like a man. Her organ would prick the man”. Since FGM is considered part of an initiation rite, then it is accompanied by explicit teaching about the girl’s role in her society.

- **Cultural identity:** In certain communities, where FGM is carried out as part of the initiation into adulthood, it defines who belongs to the community. The procedure is a highly valued ritual, whose purpose is to mark the transition from childhood to womanhood. In traditional societies, FGM represents part of the rites of passage or initiation ceremonies intended to impart the skills and information a woman will need to fulfill her duties as a wife and mother. In such communities, a girl cannot be considered an adult in a FGM-practicing society unless she has undergone FGM.

- **Religion:** None of the two major religions, Islam and Christianity, impose the practice of FGM. There is nothing specific in the Bible or the Koran which allows the mutilation of women (Toubia 1993). FGM is not practiced exclusively by followers of one specific
religion and predates both Christianity and Islam by centuries. There is no possible connection between FGM and religion. In the FGM risk countries it is practiced by followers of all denominations: Christians, Muslims, non-believers and followers of indigenous (traditional) religion. On the other hand, the religious leaders have not until recently recognized it as a harmful practice and/or discouraged its practice. They tend to link the moral benefits attributed to FGM (such as purity, virginity, morality, etc) with religion.

Female genital mutilation is classified into four major types (WHO: 2000):

- **Type I (Clitoridectomy)**: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).

- **Type II (Excision)**: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).

- **Type III (Infibulation)**: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.

- **Type IV**: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

Although it is widely known that FGM can have devastating and harmful consequences for a woman throughout her life, because most communities practicing it are very poor and do not have access to modern health facilities. Medical emergencies arising from FGM are common and often lead to death.
Immediate complications can include severe pain, shock, hemorrhage (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. For example, the FGM procedure that seals or narrows a vaginal opening (type 3 above) needs to be cut open later to allow for sexual intercourse and childbirth. Sometimes it is stitched again several times, including after childbirth, hence the woman goes through repeated opening and closing procedures that further pose immediate and long-term risks.

Female genital mutilation is one of the major reasons for complications during childbirth. The risk of dying during childbirth increases greatly for both the mother and the infant if the mother has been genitally mutilated. Yet, statements on maternal mortality often fail to acknowledge the problem of FGM.

This study focuses on Samburu County of which FGM is still widely practiced among the Samburu people. It is a difficult issue to address because it is so deeply rooted in Samburu culture and the justifications for the continuance of FGM include; the practice being a rite of passage, those who are circumcised are believed to be enlightened, serious consequences are expected for children of uncircumcised parents, including early death, rejection from the
community, and prohibition of their own circumcision and it is feared that ending this long-standing tradition will result in cultural erosion.

It is believed that the Samburu people still practice excision, which has numerous health implications. FGM also poses serious social ramifications for young Samburu girls and women, which may include:

1. Being removed from school prematurely; once circumcised, girls as young as ten years are expected to take on adult roles and responsibilities
2. Suffering psychosocial distress and isolation if their classmates and friends are not circumcised
3. Early marriage, often to much older men, and childbirth
4. Risky sexual behaviour, since circumcision marks one's entry into adulthood. This exacerbates the spread of HIV/AIDS and other sexually transmitted diseases and can result in early pregnancy and childbirth

With these risks and adverse consequences in mind, there is now a large effort to eradicate female circumcision from Samburu culture. FGM is not only increasingly scrutinized in the global arena, but is also widely discussed among the Samburu people. Women's health must be safeguarded, and all members of Samburu communities need to be informed about women's right to refuse circumcision. The irony however is that, even with all these efforts, the practice is still upheld in amongst the Samburu people. Samburu is also the focal area for this study due to the 'beading of culture' practice which involves young girls being subjected to sexual torture by Samburu Morans with the full knowledge of the rest of the community. Once they get pregnant, the Morans are at liberty to immediately dump the pregnant girls leaving them at the mercy of
fate since the community is not willing to accept any girl who becomes a mother before undergoing the horrific Female Genital Mutilation (FGM). Local quacks then find an easy extortion cartel by conducting crude abortions that are not only painful but which also put the lives of the young girl at risk. And in complete disregard of the importance of life, girls who by any chance give birth before undergoing the mandatory FGM are forced to discard their babies into the bush to be feasted on by wild animals.

1.2 Problem Statement

According to WHO, in Kenya, approximately 14,700 women and girls die every year due to pregnancy related complications with an additional 294,000 to 441,000 women and girls suffering debilitating health conditions as a result of pregnancy or childbirth. Conditions arising during the perinatal period are the second leading cause of death and disabilities in Kenya at 9% of total deaths and 10.7% of total disability adjusted life years (DALYs) respectively.

Female Genital Mutilation continues to affect women during childbirth as well as service provision. Women from Samburu, Borana and Somali communities are likely to have repeated episiotomies depending on the number of children or births they have. This is because suturing after an episiotomy still leaves the originally mutilated state of the genital area thereby presenting more physiological challenges and risks during labour, childbirth and the postpartum period. This also increases burden and add unnecessary pressure in already strained health facilities.

Different strategies have been employed in the attempt to eradicate FGM. However they have fallen short of totally bringing the practice to an end. There is need therefore to explore why these strategies have not worked and to come up with more pragmatic ways of eradicating FGM.
through engaging communities that practice FGM beyond communicating what the health effects of the practice are.

1.3 Justification of the study

Female Genital Mutilation is one of the major causes for complications during childbirth. The risk of dying during childbirth increases greatly for both the mother and the infant if the mother has been genitally mutilated. Yet most statements on maternal mortality often fail to acknowledge the problem of FGM. FGM is an important topic that should not be ignored when we talk about maternal health in Africa especially in Kenya. Genitally mutilated women face a much higher risk of serious complications and death during childbirth than women who have not been mutilated.

This study therefore sought to fill the gaps in the implementation process of The Prohibition of FGM Act 2011 and other intervention programs with the aim of bridging the gap that exists due to conflict between law, health and culture. It also aimed to assess the knowledge and attitudes of the Samburu community on the direct linkage between FGM and Maternal health. The information gathered from this study will help in development of a best practice and a holistic approach in eradicating the practice in communities that adhere to strong cultural practices with negative health implications.

The research findings aim to:

- Contribute to knowledge in researches conducted in FGM in relation to maternal health hence assist in the development of best practices in curbing FGM in communities that
are deeply enrooted with harmful cultural practices in various parts of Africa where the practice is still upheld.

- To challenge retrogressive cultural practices by empowering the Samburu community on the linkage between FGM (negative implications) and Reproductive health especially maternal health.
- Helping to fill gaps in the implementation of Anti-FGM laws, policies and programs in Kenya.

1.4 Study Objectives

1.4.1 General Objective

To determine factors affecting women’s reproductive health in Samburu County especially through focusing on the perceptions and effects of FGM on Maternal Health in Samburu County.

1.4.2 Specific Objectives

The specific objectives of the study were;

i. To determine the types of FGM practiced in Samburu County and also to assess the knowledge level of the negative implications of FGM on reproductive health among women of reproductive age in Samburu community.

ii. To identify socio-cultural factors that contribute to the practice of FGM specific to Samburu County.

iii. To establish key challenges in curbing the practice despite the Anti-FGM policies, interventions and programs in Samburu County.
1.5 Research Questions:

i. To what extent is FGM practiced in Samburu County and the community’s acknowledgement on the direct linkage between FGM and its’ effect on maternal health focusing on Samburu East?

ii. What is the perception and attitude of the community towards circumcised and uncircumcised girls and the practice of FGM in general?

iii. What are the knowledge levels of the community members on the legal framework surrounding FGM in Kenya and their power to eradicate the practice?

1.6 Limitations of the study

The major limitation was the presence of bias. Various forms of bias arose as shown below:

i. Selection biases including volunteer or referral bias, and non-respondent bias. This was due to the vast terrain and was overcome through liaising with the County administration and leadership.

ii. Recall or memory bias also arose. The respondents recalled positive events more than negative ones. Consequently, certain subjects were questioned more vigorously than others, thereby improving their recollections.

iii. Interviewer bias: the use of many different interviewers could have influenced the data collected through their own understanding and preferences or judgments. The information was collected by research assistants who were trained on the questionnaires and how to avoid bias.
1.7 Scope and Limitation of the study

This study involved an issue that is rarely discussed when discussing maternal health because FGM has not been identified by many as a major cause of maternal mortality thus there is inadequate literature on the relationship between FGM and maternal health especially in Samburu County. The study was limited to Samburu County. Poor infrastructure was also a major hindrance. Other factors like language barrier, high illiteracy level, and biased respondents especially among women due to fear or notion of a potential gain were also identified as hindrances.

1.8 Assumptions of the Study

i. High level of illiteracy among the community members has been one of the major factors contributing to the practice of harmful cultural practices like FGM.

ii. The deemed retrogressive cultural practices of the Samburu community contributes to FGM leading to reproductive health implications especially maternal health.

iii. The accepted socio-cultural norms and behaviours within the Samburu community create a conducive environment for the continuance of the practice.
CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

The most common FGM complications are dermoid cysts and abscesses. A dermoid is an overgrowth of normal, non-cancerous tissue in an abnormal location like the vaginal opening. An abscess is a collection of pus in any part of the body that, in most cases, causes swelling and inflammation around it. Chronic pelvic infections that can cause chronic back and pelvic pain, and repeated urinary tract infections have been documented in both girls and adults. A recent WHO-led study showed that FGM is associated with increased risk for complications for both mother and child during childbirth. Rates of caesarean section (29% increase for Type II and 31% increase for Type III FGM) and postpartum hemorrhage (21% increase for Type II and 69% for Type III FGM) were both more frequent among women with FGM compared with those without FGM. In addition, there was an increased probability of tearing and recourse to episiotomies. The risk of birth complication increases with the severity of FGM.

FGM of the mother is also a risk factor for the infant. The study found significantly higher death rates (including stillbirths) among infants born from mothers who have undergone FGM than women with no FGM. The increase was 15% increase for Type I FGM, 32% increase for Type II FGM and 55% increase for Type III FGM. FGM can also lead to negative psychological consequences. Documented effects include post-traumatic stress disorder, anxiety, depression, and psychosexual problems. A recent study shows that women who have undergone FGM may be more likely than others to experience psychological disturbances (psychiatric diagnosis, suffer from anxiety, somatization, phobia and low self-esteem).
Research has shown that sexual problems are also more common among women who have undergone FGM. Women with FGM were found to be 1.5 times more likely to experience pain during sexual intercourse, experience significantly less sexual satisfaction and they were twice as likely to report that they did not experience sexual desire. Additional risks have been documented for the most extensive form of FGM (Type III). Further surgery is usually necessary later in women’s’ lives when infibulations must be opened to enable sexual intercourse and further again in childbirth. In some countries this is followed by re-closure (re-infibulation), and hence the need for repeated de-infibulation later.

Urinary and menstrual problems are not uncommon, particularly prior to de-infibulation at first marriage. For many women sexual intercourse is painful during the first few weeks after sexual initiation, as the infibulation must be opened up either surgically or through penetrative sex. The male partner can also experience pain and complications. Type III FGM is also associated with infertility. Evidence suggests that the more tissue is removed, the higher the risk for infection.

2.2 Empirical Review

2.2.1 Lack of access to health care

A study done by Coalition on Violence Against Women (COVAW) 2012, “Experiences of Childbirth during by Women and their Health Care providers in Narok and Isiolo Counties”, stated that female genital mutilation (FGM) continues to affect women during childbirth as well as service provision. According to one midwife in Narok “we are yet to see a change in the numbers of FGM”. And in Isiolo a midwife explained that “the majority of Boranas and Somalis even with the third baby they will get an episiotomy even sometimes the fourth. This is because when you suture an episiotomy you suture what you cut, so you leave behind again the very
small hole that you met. Sometimes you give bilateral episiotomies and she will still tear however much you support that perineum, even if they are birthing a child of two kilograms”.

In the home setting “if she [TBA] attends a birth of a woman who hasn’t been circumcised they have to “pay” her a cow as she only deals with women and if a woman hasn’t been circumcised it means that she is still a girl and therefore should not be having a baby. That is an incurred cost to her. So the cow is like a fine”.

Although as mentioned earlier, a midwife was of the opinion that in addition to the possible fine, the TBA will perform the cut once the baby is born. No TBA though reported to have served any women who had not been circumcised yet. However, some women in the community noted that “now FGM has been disallowed, but we have heard that there is a good difference experienced in childbirth for those not cut”.

Apart from the physiological challenge and risks this act presents to a mother during childbirth and the postpartum period, it also adds a lot more pressure on already strained health service providers. “Conflict sometimes arises when some women raised in different parts of Kenya who may not be circumcised but are accompanied to the hospital by their relatives” recounted a midwife in Isiolo. “It is upon me to manoeuvre the situation”. Another midwife was forced to support a woman “who gave birth in the corridor because I had to promise that I wouldn’t cut her. Anything I held she thought were scissors so she told me sister lift up your arms. Only to realize that when she was being circumcised when she was eight or nine years it was done by someone who worked in a hospital using a pair of scissors and she is still very traumatized by scissors. My options were either a dead baby or a third degree tear needing to be repaired in theatre. And she got the latter”. As trying as these situations are they make the midwives feel “so
proud, I felt so encouraged, because at the end of the day we need to help those who want to be helped”.

2.2.2 Gaps in the implementation of the law

Kenya National Commission on Human Rights (KNCHR) did a report to the Human Rights Committee to inform its Review of Kenya’s Third Periodic Report on implementation of the Provisions of the International Covenant on Civil and Political Rights 2012. This report stated the following:

The State should increase efforts to combat the practice of FGM including through prohibition of FGM for adults, and, in particular, step up the awareness campaign launched by the Ministry of Gender, Sports, Culture and Social Services.

It was noted that:

- Significant progress has been made in this regard, most notably through enactment of The Prohibition of Female Genital Mutilation Act in 2011.
- The Act criminalizes FGM provides sanctions and establishes an anti-FGM Board with the core mandate of designing, supervising and coordinating public awareness programs against the practice of FGM.
- Further, the National Action Plan for the Abandonment of FGM (2008-2012), developed by the Ministry of Gender, Children and Social Services and incorporation with the National Committee on Abandonment of Female Genital Mutilation (NACAF) is currently being implemented.
• However, despite these legal and institutional efforts, FGM is still widespread in some communities in Kenya and justification for the continuity of the practice includes cultural purity, virginity, control of libido and cultural identity.

• In addition, family honour and social expectations play a powerful role in perpetuating the practice, making it extremely difficult for individual families, as well as individual girls and women, to stop the practice on their own account.

To effectively combat FGM:

• The state should carry out awareness creation to sensitize the communities practicing FGM communities about the law.

• The state should also ensure prosecution of perpetrators to deter this harmful cultural practice.

• The state should through the law enforcement officers ensure immediate action of any reported incidences of FGM in accordance with the Anti-FGM law, 2011.

2.2.3 Link between FGM and Culture/ Religion

Each society and each culture has its own standards and values, and the very fact that a particular practice is part of the cultural heritage of a people marks it as integral to the value-system of that people. No one set of these values is more valid than another. In fact--so the reasoning goes--to criticise a culture-bound practice from the outside is to engage in what amounts to cultural and moral imperialism.

The causes of female genital mutilation include a mix of cultural, religious and social factors within families and communities. Where FGM is a social convention, the social pressure to conform to what others do and have been doing is a strong motivation to perpetuate the practice.
FGM is often considered a necessary part of raising a girl properly, and a way to prepare her for adulthood and marriage. FGM is often motivated by beliefs about what is considered proper sexual behaviour, linking procedures to premarital virginity and marital fidelity.

FGM is in many communities believed to reduce a woman's libido and therefore believed to help her resist "illicit" sexual acts. When a vaginal opening is covered or narrowed (type 3 above), the fear of the pain of opening it, and the fear that this will be found out, is expected to further discourage "illicit" sexual intercourse among women with this type of FGM.

FGM is associated with cultural ideals of femininity and modesty, which include the notion that girls are "clean" and "beautiful" after removal of body parts that are considered "male" or "unclean". Though no religious scripts prescribe the practice, practitioners often believe the practice has religious support. Religious leaders take varying positions with regard to FGM: some promote it, some consider it irrelevant to religion, and others contribute to its elimination. Local structures of power and authority, such as community leaders, religious leaders, circumcisers, and even some medical personnel can contribute to upholding the practice.

In most societies, FGM is considered a cultural tradition, which is often used as an argument for its continuation. In some societies, recent adoption of the practice is linked to copying the traditions of neighbouring groups. Sometimes it has started as part of a wider religious or traditional revival movement. In some societies, FGM is practised by new groups when they move into areas where the local population practice FGM. The challenge therefore lies in how to change these beliefs and perceptions.
2.2.4 The economics of FGM

There are several economic factors that contribute to the cultural importance of FGM. One of these factors is the ritual that surrounds the practice. Often this ritual involves gifts given to the girls in a ceremony that also honors their families. More importantly, though, is the fact that it is much easier for the parents of a circumcised daughter to find a mate for their child, than it is for the parents of an uncircumcised daughter. Being able to "marry off" daughters is an important economic consideration in some of the poorer countries that practice FGM. Another important economic consideration is that for the female circumcisers have fewer lucrative options for supporting themselves other than through the practice. These women gain both financial support and a place of honor in their communities for performing this rite especially in a patriarchal society where women are still lagging behind in socio-economic arenas.

2.2.5 Linkage between FGM and Literacy Levels

Recent studies in Uganda have proven a decrease in the prevalence of FGM. Beatrice Chelagat who has been head of the Reproductive Educative and Community Health programme (REACH) in Uganda since 1996 stated that high level of illiteracy among the community members has been one of the major factors contributing to the practice of harmful cultural practices like FGM. She also expressed fears that in rural areas, the practice will go underground if communities do not receive education about the risks of FGM. The decrease in prevalence is however attributed to community health education through adult literacy classes (RNW: 2012).
2.3 Theoretical Framework

2.3.1 Social Change Theory

This theory is about social behavior as people try to meet their needs. The adaptations may show increasing differentiation, as societies become more complex, but the needs they serve remain constant. Thus, despite interferences from external forces, societies constantly seek to preserve or re-establish their social institutions. The rate of change may be positively affected by the presence of a catalyst. Not only is the rate modified, but catalysts may even allow the system to follow a new reaction path. However, catalytic personalities can also produce tremendous impact in existing institutional structures that are not necessarily on the brink of collapse. This catalyst as explained in the social convention theory could be the presence of human rights principles as an attempt to curb the practice of FGM.

However, new insights from social science theory and the analysis of programme experiences indicate that abandonment of female genital mutilation on a large scale results from a process of positive social change. The conventional nature of the practice requires a significant number of families within a community to make a collective, coordinated choice to abandon the practice so that no single girl or family is disadvantaged by the decision (UNICEF, 2005b).

The decision to abandon must be collective and explicit so that each family will have the confidence that others are also abandoning the practice. The decision must be widespread within the practising community in order to be sustained. In effect, it will bring into place a new social norm that ensures the marriageability of daughters and the social status of families that do not cut their girls; a social norm that does not harm girls or violate their rights. Programmes that include "empowering" education, discussion and debate, public pledges and organized diffusion have
been shown to bring about the necessary consensus and coordination for the sustained abandonment of female genital mutilation at community level. The activities encourage communities to raise problems and define solutions themselves regarding a variety of concerns. Emphasis should be placed on emerging social and cultural changes through a multiplier effect, generating interest and demand for new knowledge and encouraging active engagement from different sectors and at different levels. An initial subset of the community was involved and felt encouraged to spread its new knowledge to others, which stimulated discussion and reflection. The individual changes triggered broader social change, as each person influenced his or her own context through individual social networks.

The methodology was designed to include:

- A review of various studies and documentations on FGM and Maternal Health from policy, legal, service delivery and community level.
- Mapping of existing health services offering reproductive health facilities in Satellite County.
- In-depth interviews with key stakeholders to get their views on the linkage between FGM and maternal health.
- Focus Group Discussions with various respondents to explore their attitudes, practices, and preferences with regards to FGM and Maternal Health.
- Community Dialogue Forums to explore community beliefs and practices in relation to FGM.
- Questionnaires were issued to respondents to assess knowledge of negative implications of FGM in Maternal health among women of reproductive age in Satellite County to identify parameters and barriers to Anti-FGM intervention programs. Service provision and
CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This is a descriptive cross-sectional study on factors affecting women’s reproductive health with a special focus on the direct linkage between FGM and maternal health. This involved a detailed investigation of a few carefully identified cases to facilitate analysis of the linkages between FGM and maternal health. However, quantitative data was used to analyze socio-demographic characteristics of the respondents.

The methodology was designed to include:

- A review of various studies and documentations on FGM and Maternal Health from policy, laws, service delivery and community level.
- Mapping of existing health service offering reproductive health facilities in Samburu County.
- In-depth interviews with key stakeholders to get their views on the linkage between FGM and maternal health.
- Focus Group Discussions with various respondents to explore their attitudes, practices and preferences with regards to FGM and Maternal Health.
- Community Dialogue Forums to explore community beliefs and practices in relation to FGM.
- Questionnaires were issued to respondents to assess knowledge of negative implications of FGM to Maternal health among women of reproductive age in Samburu County, to identify promoters and barriers to Anti-FGM intervention programs service provision and
utilization of reproductive health services and establish key challenges in service provision.

3.2 Research Site

The study was conducted in Samburu County. With a maternal mortality rate of 1,000/100,000 live births and an under-five child mortality rate approximated at 142/1,000 live births, nearly one third of the population has inadequate access to health, water and education services, as well as livelihood opportunities. FGM is widely practiced among the Samburu people. One of the major consequences of FGM is the complications it has during childbirth especially in this area where there is lack of access to health services due to various reasons such as poor infrastructure.

3.3 Research Design

The study is a descriptive cross sectional study. It is mainly qualitative but utilized questionnaires, focus group discussions and in depth reviews as a source of quantitative and qualitative data in conducting analysis of the socio-demographic characteristics of the respondents. The study also used both primary and secondary data. Primary data was obtained from respondents which include women of reproductive age and selected key informants. On the other hand, secondary data was obtained from literature review, public policy documents, health centers, hospitals, non-governmental organization (NGO) files and other useful sources identified in the course of the study.

3.4 Study Population

Participants in the study were limited to Samburu County, they were identified by purposive selection of 35 women of reproductive age with a special focus on those who have gone through
FGM and childbirth, 10 health providers working, 5 Traditional Birth Attendants (TBA's) and 4 stakeholders.

3.5 Sample Size

In this study, the units of observation were female respondents who are of reproductive age ranging between the age of (15-49) years old who have gone through the FGM practice and gone through childbirth. There were also health providers, TBA's and 4 other key stakeholders. The unit of analysis is the entity around which the variables of interest to the researcher vary (Singleton, 1998: 132). In this study, the unit of analysis was the woman/girl of reproductive age who has undergone FGM.

3.6 Sampling Procedure

A purposive sample is a sample selected in a deliberative and non-random fashion to achieve a certain goal. Purposive sampling is where subjects are selected because of some characteristic. The researcher also preferentially recruited subjects who had the best knowledge and experience in this community related to FGM. These were the circumcisers and elders within the community.

3.7 Data Collection Methods

The researcher sought a research permit from National Commission for Science, Technology and Innovation to assist in data collections. After this, the researcher visited each of the sampled respondents after booking appointments to conduct the interviews and focus group discussions. A research assistant was engaged and inducted to enable them to understand the research problem and research methodology, and how to administer the research instruments. On visiting
the site, data collection commenced with the assistance of the research assistants. Secondary data was collected through literature review, government records, policy documents and non-governmental organizations (NGO) files. Primary data was collected through both unstructured and structured questionnaires based on a topic list, in-depth interviews, focused group discussions and passive observation.

3.8 Data Analysis

The data generated by the study after fieldwork was edited, coded then entered into a computer for processing using the Statistical Package for Social Sciences (SPSS). A master codebook designed to ensure that all the questionnaires are coded uniformly was used. According to Kothari (2004), editing of responses "is intended to identify and eliminate errors made by the interviewer or respondents. Consequently, data was edited for completeness and consistency before analysis.

Descriptive statistics were used to analyze information generated from respondents. Descriptive statistics refers to, "simple statistical methods, which do not support or falsify a relationship but help in the description of the data." Thus, descriptive statistics enable the researcher to organize data in an effective and meaningful way. By use of percentages, frequency distributions, tables, charts, the researcher categorized the variables.

The report will be presented to the University and shared to relevant people including Samburu County government, policy makers, Samburu youth programs, relevant Non-governmental Organizations and posed on various websites and blogs for widespread dissemination. Data from the study may also be used to write a technical paper and abstracts for presentation in local and international conferences.
3.9 Ethical Considerations

Participants were informed of the nature of the study and allowed to choose whether to participate or not. There is wide consensus among social scientists that research involving human participants should be performed with informed consent of the participants (Kothari, 2004). The researcher therefore ensured that participants knew that their involvement was voluntary at all times. Permission to carry out the study was sought from all the relevant authorities i.e. NACOSTI (National Commission for Science, Technology and Innovation), Samburu County government, the Ministry of Health, District Medical Officer in charge of Health Samburu-East and the Reproductive Health Coordinator also in the same region. Participants were also informed that the study is voluntary and that they were at liberty to withdraw from participation if they did not wish to continue. The procedures were only undertaken after they consented by way of signing the consent form. The information obtained from the participants has been kept confidential after being coded to protect identity of participants. This ensures that there are no risks associated with the study.
CHAPTER FOUR

DATA PROCESSING AND ANALYSIS

4.1 Introduction

This chapter presents the results of the analysis on the study on female genital cutting: perceptions and effects on maternal health in Samburu County. Interviews were conducted on the selection of 35 respondents which included: 16 women of reproductive age with a special focus on those who have gone through FGM and childbirth, 10 health providers working in the study area, 5 Traditional Birth Attendants (TBA’s) and 4 stakeholders. All were accessed indicating a 100% response rate as shown on Table 4.1.

Table 4.1 Response Rate

<table>
<thead>
<tr>
<th>Category</th>
<th>Targeted</th>
<th>Received</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>16</td>
<td>16</td>
<td>100%</td>
</tr>
<tr>
<td>Health Providers</td>
<td>10</td>
<td>10</td>
<td>100%</td>
</tr>
<tr>
<td>Traditional Birth Attendants</td>
<td>5</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Community Stakeholders</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>35</strong></td>
<td><strong>35</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Source: Researcher (2015)

4.2 Demographic Information

This section presents the characteristics of personal attributes of individual respondents. These include: gender, age, marital status, religion and level of education. The rationale behind the inclusion of these attributes in the analysis is that they help expose the different perceptions and effects of FGM on maternal health in Samburu County.
4.2.1 Respondents Gender

Most of the respondents were females who had some experience with the female genital cutting. This is because the research involved a sensitive, female genital cutting, issue that affects women/girls directly and other members of the society indirectly. The women were the most appropriate to articulate the issues under the study. This was directly as victims or indirectly by being involved as health providers, traditional birth attendants or as stakeholders at the County level. In the focus group discussions, there were some men who engage as health providers, community activists, religious leaders and as custodians of culture. Their input was very important in establishing the perceptions and effects female genital cutting on maternal health in Samburu County.

4.2.2 Respondents Age

The respondents were asked to indicate their age. Age would help the researcher to discover the different view of respondents with regards to the issue of female genital cutting. Their ages are as presented on Figure 4.1

![Respondents Age Graph](image)

**Figure 4.1 Respondents Age**

Source: Researcher (2015)
The respondents’ age forms a good spectrum for opinion. It includes the older generation and young generation who have divergent views on female genital cutting. There has been recorded a decrease in prevalence mainly attributed to community health education through adult literacy classes (RNW: 2012).

4.2.3 Respondents Marital Status

The research findings show that majority of the respondents are married at 65%. This was followed by those are widowed at 24% as shown on Table 4.2.

Table 4.2 Respondents Marital Status

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>65%</td>
</tr>
<tr>
<td>Separated</td>
<td>6%</td>
</tr>
<tr>
<td>Single</td>
<td>5%</td>
</tr>
<tr>
<td>Widowed</td>
<td>24%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Researcher (2015)

The marital status forms a strong basis for arguments for and against female genital cutting in Samburu County. The fact that majority are married somehow negates the notion that the practice would affect the relationship and in fact supports the argument for female genital cutting. According to the Samburu community, female genital cutting is a rite of passage from childhood to adulthood. It is until a girl has gone through this practice that she is considered fit for marriage. The practice commands a significant number of adherents within the community. Therefore, having to make a collective, coordinated choice to abandon the practice so that no single girl or family is disadvantaged by the decision becomes difficult where parents are engaged in it (UNICEF, 2005b).
4.2.4 Respondents Religion

The religion mainly practiced in the study area is Christianity with 76% of the respondents having indicated this. This was followed by 18% of respondents who are not tied to a specific religion, presumably traditionalists, and then 6% of respondents who practice Islam. This is reflected on Figure 4.2.

![Respondents Religion Graph]

**Figure 4.2 Respondents Religion**

Source: Researcher (2015)

In a community that practices female genital cutting, religion would be credited for helping them change and adopt alternative rites of passage. This seems not to be the case. FGM predates both Islam and Christianity and is cross-religions and practiced by the followers of Islam, Christianity and other traditional religions. FGM is not practiced by all Muslims and has been wrongly associated with Islam. The main teachings of Islam and Christianity, as expressed in the Holy Koran and Holy Bible respectively, do not prescribe or enforce the practice of FGM. There is nothing specific for example in the Bible or the Koran which allows the mutilation of women (Toubia 1993). It is unfortunate that religious leaders have not taken a firm stand to denounce the practice even though they believe that it is not sanctioned by their founders.
4.2.5 Respondents Education

The education levels in the study area are known to be low (41% had no formal education) but due to the special sampling done, over 30% of the respondents had post-secondary education.

Table 4.3 Respondent Education Levels

<table>
<thead>
<tr>
<th>Education</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>41%</td>
</tr>
<tr>
<td>Primary</td>
<td>6%</td>
</tr>
<tr>
<td>Secondary</td>
<td>18%</td>
</tr>
<tr>
<td>Certificate</td>
<td>6%</td>
</tr>
<tr>
<td>Diploma</td>
<td>24%</td>
</tr>
<tr>
<td>Sharia Law</td>
<td>5%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Researcher (2015)

The findings on Table 4.3 show that those with secondary education were 18% while 6% had primary education. The researcher observes that the low education levels would have led to the promotion of female genital cutting as the respondents or community members do not understand the dangers of the practice. Girls end up undergoing the practice as it is seen as part of their culture and has to be followed. The low education levels are in agreement with Ong’onga (1990) who found out that the prevalence of female circumcision to be high among the less educated.

4.3 Female Genital Cutting: Perceptions and Effects on Maternal Health in Samburu County

The main objective of this study was to investigate the perceptions and effects of female genital cutting on maternal health in Samburu County. The findings have been broken down into five categories are discussed in the following sub-sections. The respondents were asked if they had knowledge of a person who had died due to FGM. It was interesting to note that 77% answered
no, adding to the challenge of dealing with the vice. Only 23% reported that they had such knowledge.

Table 4.4 Knowledge of Death due to FGM

<table>
<thead>
<tr>
<th>Knowledge of Death due to FGM</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>23%</td>
</tr>
<tr>
<td>No</td>
<td>77%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Researcher (2015)

The female respondents were also asked if they had been circumcised. The responses when read together with the age brackets indicate that 65% were circumcised while 35% were not as shown on Table 4.5. For those that reported that they were circumcised, they said that it happened when they were young. This is was prevalent within the focus groups where all were circumcised. When asked why they were circumcised, more than half said this was meant to prepare them for marriage as they could not get husbands if they were uncircumcised.

Table 4.5 Are You Circumcised

<table>
<thead>
<tr>
<th>Are You Circumcised</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>65%</td>
</tr>
<tr>
<td>No</td>
<td>35%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Researcher (2015)

4.3.1 Types of FGM practiced in Samburu County

The study found that there are various forms of FGM practiced in Samburu County. However, they all revolved around the removal of the clitoris and the tissue surrounding it as shown on table 4.6
Table 4.6 FGM Types in Samburu County

<table>
<thead>
<tr>
<th>Types of FGM Practiced in Samburu County</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pricking tip of the clitoris only</td>
<td>20%</td>
</tr>
<tr>
<td>Infibulation</td>
<td>7%</td>
</tr>
<tr>
<td>No idea. I know they cut of some tissue but I do not know what exactly.</td>
<td>7%</td>
</tr>
<tr>
<td>Not sure</td>
<td>7%</td>
</tr>
<tr>
<td>Removal of the whole clitoris and tissue surrounding it.</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Source: Researcher (2015)

The type of FGM majorly practiced in Samburu County at 60% is Clitoridectomy whereby the entire clitoris is removed along with healthy tissue surrounding it i.e. parts of the labia minora. The wound is left to heal after application of traditional herbs. Various instruments are used during this process that range from razor blades, traditionally made knives and sharply cut metal.

The practice happens mostly during early morning or late evening.

This practice continues to happen despite the findings of a study done by the Coalition on Violence Against Women (COVAW) 2012, titled “Experiences of Childbirth during by Women and their Health Care providers” that found out female genital mutilation (FGM) continued to affect women and girls during childbirth; a clear indication of the effects of the reported types of FGM in Samburu County.

4.3.2 Knowledge level of the negative implications of FGM on reproductive health among women of reproductive age in Samburu community.

The knowledge of the negative implications of FGM on reproductive health among women of reproductive health in Samburu Community is very crucial in this study. Surprisingly, when asked whether they were in favour of FGM, 66.7% reported that they were against while 33.3% were for it as shown on Figure 4.3.
The respondents had varied views on problems caused by FGM. There were varied problems associated with FGM as per the respondents. There was a linkage established between FGM and maternal health with 52% reporting that there were problems during childbirth. This was followed by 14% who said that there were sexual problems ranging from problems during sexual intercourse. Another 10% reported health problems leading to excessive bleeding and body weakness. This is shown on Table 4.7

Table 4.7 Problems Caused by FGM

<table>
<thead>
<tr>
<th>Problems Cause by FGM</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death</td>
<td>5%</td>
</tr>
<tr>
<td>Fertility problems</td>
<td>5%</td>
</tr>
<tr>
<td>Health problems</td>
<td>10%</td>
</tr>
<tr>
<td>No Problems</td>
<td>10%</td>
</tr>
<tr>
<td>Problems during childbirth</td>
<td>52%</td>
</tr>
<tr>
<td>Psychological problems</td>
<td>5%</td>
</tr>
<tr>
<td>Sexual problems</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Source: Researcher (2015)
4.3.3 Socio-cultural factors that contributes to the practice of FGM specific to Samburu County.

The respondents were asked to state what social-cultural factors that contributed to the practice of FGM specifically in Samburu County. The responses are as shown on Table 4.8

Table 4.8 Socio-cultural factors that contributes to the practice of FGM

<table>
<thead>
<tr>
<th>Samburu Consideration for Circumcised Girls</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suitable for marriage</td>
<td>38%</td>
</tr>
<tr>
<td>Adult women</td>
<td>33%</td>
</tr>
<tr>
<td>Respected/Honoured</td>
<td>25%</td>
</tr>
<tr>
<td>They are blessed</td>
<td>2%</td>
</tr>
<tr>
<td>They can own property</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Source: Researcher (2015)

The responses were collaborated across the respondents with majority stating that FGM makes girls more suitable for marriage at 38% as culturally it is the pre-requisite for marriage. 33% of the respondents also said that FGM ensures that girls are considered as adults as they have transitioned from childhood to womanhood after undergoing the cut. 25% of the respondents emphasized on the fact that girls who undergo FGM are treated with much more respect and are honoured within the community. They mentioned that big traditional ceremonies were held in the past to honour them as they respected their community’s culture and traditions. 2% of the respondents also noted that girls who undergo the practice are also blessed by the ancestors. There were also 2% that indicated that FGM ensures that women are able to own property. Traditionally, women do not own property. According to the respondents, the men own the property and the women take care of it. But in recent times the tradition is slowly allowing for women to own property such as chickens. This can only be done after a girl has gone through FGM and is considered able to own property. The study also sought views on how the
respondents felt about uncircumcised women. There were varied responses as shown on Table 4.9

**Table 4.9 Socio-cultural factors that contributes to the practice of FGM**

<table>
<thead>
<tr>
<th>Samuru Considerations for Uncircumcised Girls</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can be married off to elderly men</td>
<td>2%</td>
</tr>
<tr>
<td>Considered outcasts</td>
<td>48%</td>
</tr>
<tr>
<td>Immature</td>
<td>41%</td>
</tr>
<tr>
<td>Not blessed to be wives or give birth</td>
<td>7%</td>
</tr>
<tr>
<td>Not respected</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Source: Researcher (2015)

According to the data collected, the respondents showed that the community did not value girls who have not undergone the practice. 48% of the respondents said that the girls were considered outcasts. This is because they have chosen to ignore their culture and traditions and therefore do not belong. The uncircumcised girls are also considered immature with 41% of the respondents affirming this. Perhaps the most interesting thing was that the uncircumcised girls are married off to elderly men in the community as punishment for defying the culture and traditions as 2% of the respondents mentioned.

**4.3.4 Key challenges in curbing the practice despite the Anti-FGM policies, interventions and programs in Samburu County.**

There are several key challenges identified by the study. One is the lack of awareness that FGM is a crime under Kenyan law. The respondents were asked whether FGM was against the law and there were varied reasons. Table 4.10 shows that although majority of the respondents at 52% said that they know that FGM is against the law, 40% said that they don’t know and 8% said were not sure.
Is FGM Against the Law

<table>
<thead>
<tr>
<th>Is FGM Against the Law</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I'm not sure</td>
<td>8%</td>
</tr>
<tr>
<td>Yes</td>
<td>52%</td>
</tr>
<tr>
<td>No</td>
<td>40%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Researcher (2015)

Most of respondents that agreed FGM is against the law and confirmed that they heard about the laws from the media such as local radio and from some community leaders such as chiefs, religious leaders and political leaders. For those that reported that FGM is not against the law or that they were not sure further said that FGM is their culture and tradition and is paramount. They emphasized that FGM is a part of their culture and they cannot abandon it because of new laws from the “Western Culture”. They claimed that FGM is a blessing to their community and they will not stop it.

The research also sought to establish if individuals felt like they have power within themselves to help in eradicating FGM. A majority of them at 73% agreed that they have power to help in eradicating FGM in their community as shown in Table 4.11. Among the key informants and focus groups, there were varied responses on what individuals can do to help deal with FGM. Majority pointed at the Prohibition of FGM Act 2011 which they said was very clear on the offences and stiff penalties stipulated in it. However, they lamented that community members still practice the vice secretly arguing it is the work of the law enforcement agents, community leaders and members to vigorously engage in anti-FGM campaign efforts to curb the practice.
## Table 4.11 Power of an Individual to Help in Eradicating FGM

<table>
<thead>
<tr>
<th>Power of an Individual to Help in Eradicating FGM</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>73%</td>
</tr>
<tr>
<td>No</td>
<td>27%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Source: Researcher (2015)

It was encouraging to note 73% of the respondents saw themselves as key players in eradicating FGM in the community. Some noted that by sharing with their neighbors and friends about dangers of FGM then they are getting a step closer in abandoning the practice. Some of respondents, 27%, felt that they are just community members and have no say in matters of culture and tradition. The custodians of culture/elders are the ones who can make such decisions. Some also felt that it is the government’s responsibility to eradicate FGM and not theirs. Others felt it was none of their business what others do.
CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter is divided into four sections. The first section summarizes the findings of the study; the second section shows conclusions that are drawn based on the findings and finally the third section gives the study recommendations for policy and further research.

5.2 Summary of Findings

The study was designed to establish the perceptions and effects of female genital cutting on maternal health in Samburu County. To this end, the study sought to determine the extent of FGM practiced in Samburu County. It also sought to assess the knowledge level of the negative implications of FGM on maternal health among women of reproductive age in Samburu County. The study was also aimed at identifying socio-cultural factors that contribute to the practice of FGM specific to Samburu County by assessing the community attitudes towards circumcised and uncircumcised girls and the FGM practice in general. Finally the study sought to establish key challenges in curbing the practice despite the Anti-FGM policies, interventions and programs in Samburu County.

The first objective was to determine the types of FGM practiced in Samburu County and also to assess the knowledge level of the negative implications of FGM on reproductive health among women of reproductive age in the Samburu community. The findings for the first objective indicate that the most prevalent form of FGM practiced in Samburu County is Clitoridectomy which involves the removal of the clitoris and the tissue surrounding it at 60%. This was
followed by the cutting off the clitoris only at 20% while infibulation was as 7%. There were also 14% of the respondents who were not sure or had no idea what the procedure of FGM entailed i.e. they did not know which part was cut off. There was a linkage established between FGM and maternal health with 52% reporting that there were problems during childbirth. This was followed by 14% who said that there were sexual problems ranging from problems during sexual intercourse. Another 10% reported health problems leading to excessive bleeding and body weakness. The findings also showed that 67% of the respondents reported that they were against FGM while 33% were in support of it.

The second objective of the study was to identify the socio-cultural factors that contribute to the practice of FGM specific to Samburu County. This was done through the assessment of the community’s perceptions and attitudes towards circumcised and uncircumcised girls. There were varied responses but majority stated that FGM makes girls more suitable for marriage at 38% as culturally it is the pre-requisite for marriage. 33% of the respondents also said that FGM ensures that girls are considered as adults as they have transitioned from childhood to womanhood after undergoing the cut. 25% of the respondents emphasized on the fact that girls who undergo FGM are treated with much more respect and are honoured within the community. They mentioned that big traditional ceremonies were held in the past to honour them as they respected their community’s culture and traditions. 2% of the respondents also noted that girls who undergo the practice are also blessed by the ancestors. There were also 2% that indicated that FGM ensures that women are able to own property.

The third objective was to establish the key challenges involved in curbing the practice despite the Anti-FGM policies, interventions and programs in Samburu County. There was consensus that there is a general lack of awareness that FGM is a crime under Kenyan law. 52% of the
respondents said they know it is a crime while 40% said that they don’t know and 8% said were not sure. The 52% who know said they have heard in on the media but most were not really sure what the offences and the penalties contained in the Prohibition of FGM Act 2011 are. Some claimed they rely on the local administration to brief them but they are usually dealing with other community issues such as cattle rustling. FGM therefore becomes a lesser priority to be dealt with. Majority of the respondents noted that they have power within themselves to help in eradicating FGM in their community when they join their power with others.

5.3 Conclusions

The results of this study presented evidence of the perceptions and effects of female genital cutting on maternal health in Samburu County. The study concludes that FGM is a major problem in Samburu County. Although respondents reported to know that there are laws against the vice, it continued to be practiced secretly. There were several types of FGM practiced but the most prevalent involves removal of the clitoris and the surrounding tissue of a woman’s reproductive organ. There was also reported knowledge of the negative implications of FGM among the respondents with problems during childbirth being the most noted problem with the Samburu community. There are various socio-cultural factors that contribute to the practice of FGM including making girls suitable for marriage, to be considered adult women and having the ability to own property within the community. The key challenges identified in the study are the lack of or low knowledge levels on the legal framework surrounding FGM in Kenya. The Prohibition of FGM Act 2011 clearly states that FGM is a crime and outlines the penalties if one is found guilty and this awareness should be created to all communities whereby the practice is prevalent.
5.5 Recommendations for Further Research

The following suggestions were made for consideration for future research:

i. There is need for further research to identify how specific types of FGM affect the victims in the long term.

ii. Further studies should be done on best practices from other counties or countries that have adopted Alternative Rites of Passage to be replicated in areas where FGM is still prevalent in Kenya.

iii. Further studies should be carried out in other parts of the country to map the various types of FGM still being practiced and the underlying reasons why with knowledge of the effects of FGM, it is still being practiced.
REFERENCES


Ending Female Genital Mutilation, A strategy for the European Union Institutions, Executive Summary. Brussels, END FGM - European Campaign.


Kenyan Constitution 2010.

Legislative reform to support the abandonment of female genital mutilation/cutting. UNICEF. New York, 2010.

Prohibition of the FGM Act 2011.


The CEDAW General recommendation No. 14 on female circumcision, and General Recommendation No. 19 on Violence Against Women. [CRC addresses FGM under art.24 (3) and made a reference in its General Comment No.7 on early childhood].


Yemen Women’s Union, quantitative study in Aeden, Hadhramout and Al-Hudaidah, including 600 women with at least one daughter cut. Presentation at WHO/UNICEF/UNFPA conference on the medicalization of FGM, Nairobi, Kenya, July 2009.
Radio Netherlands Worldwide 2012: Uganda: Disabled and poverty stricken the sad reality of FGM

Published on: 27 January 2012 - 12:43pm. Available online at


APPENDIX 1: QUESTIONNAIRE

Section A: Demographic Information *(Please tick where appropriate or fill the spaces provided)*

1. Gender... Age......... Marital Status:............... Religion:.................

Level of education:................

2. Are you in favor of female circumcision? Yes No

   a) If yes why? Religious reasons, Cultural reasons, Sexual reasons, Cultural reasons( You can circle more than one)

   b) If no why? Religious reasons, Cultural reasons, Sexual reasons, Cultural reasons(You can circle more than one)

3. Which type of FGM is practiced within the Samburu community?

Section B: Impact of FGM

4. Do you think female circumcision can cause: Menstrual problems, Sexual problems, Fertility problems, Problems during Childbirth, None of the above?

   a) Have you personally experienced any specific problems (especially during childbirth)?

      Yes No

      Comments...

5. Are you aware of any girl who died as a result of FGM? Yes No
6. How does the Samburu community consider circumcised girls and non circumcised girls?

7. (For females only) Are you circumcised?

Section C: FGM and the law

8. Do you think FGM is against the law? Yes No

9. Do you think you have power as an individual to help in eradicating FGM? Yes No

   a) If yes, what are some of the actions/strategies you can be engaged in?

   b) If no, who do you think has the power and what can they do in their capacity to eradicate FGM

-THANK YOU FOR YOUR TIME AND RESPONSE –
APPENDIX 2: MAP OF AREA OF STUDY (MAP OF KENYA/ SAMBURU COUNTY)

11th March, 2015

TO WHOM IT MAY CONCERN

Dear Sir/Madam

MS. JOSEPHINE MWATIBO MARURA – N69/69208/2011

This is to confirm that the above named is a Master of Arts in Gender and Development Studies student in the Institute of Anthropology, Gender and African Studies, University of Nairobi.

She has successfully completed her coursework and is now proceeding to part II of the course which involves project writing.

Any assistance will be highly appreciated.

Yours Sincerely

[Signature]

JUDITH E.O. OBAM
SENIOR ASSISTANT REGISTRAR
INSTITUTE OF ANTHROPOLOGY, GENDER AND AFRICAN STUDIES

JEO/ewk
Following your application for authority to carry out research on "Female Genital Cutting: Perceptions and effects on maternal health in Samburu County" I am pleased to inform you that you have been authorized to undertake research in Samburu County for a period ending 31st August, 2015.

You are advised to report to the County Commissioner, the County Director of Education and the County Coordinator of Health, Samburu County before embarking on the research project.

On completion of the research, you are required to submit two hard copies and one soft copy in pdf of the research report/thesis to our office.

Copy to:

The County Commissioner
Samburu County.

The County Director of Education
Samburu County.
The County Coordinator of Health
Samburu County.
THIS IS TO CERTIFY THAT:
MISS. JOSEPHINE MARURA MWATIBO
OF UNIVERSITY OF NAIROBI, 0-200
NAIROBI, has been permitted to conduct
research in Samburu County
on the topic: FEMALE GENITAL
CUTTING: PERCEPTIONS AND EFFECTS
ON MATERNAL HEALTH IN SAMBURU
COUNTY
for the period ending:
31st August, 2015

CONDITIONS

1. You must report to the County Commissioner and
the County Education Officer of the area before
embarking on your research. Failure to do that
may lead to the cancellation of your permit.

2. Government Officers will not be interviewed
without prior appointment.

3. No questionnaire will be used unless it has been
approved.

4. Excavation, filming and collection of biological
specimens are subject to further permission from
the relevant Government Ministries.

5. You are required to submit at least two(2) hard
copies and one(1) soft copy of your final report.

6. The Government of Kenya reserves the right to
modify the conditions of this permit including
its cancellation without notice.

Applicant's
Signature

[Stamp]
Director General
National Commission for Science,
Technology & Innovation

RESEARCH CLEARANCE
PERMIT

National Commission for Science,
Technology and Innovation

Republic of Kenya

Serial No. A

4968

CONDITIONS: see back page