KNOWLEDGE AND PERCEPTIONS OF COMPLICATIONS ASSOCIATED WITH FEMALE GENITAL MUTILATION/CUTTING AMONG SOMALI COMMUNITY IN WAJIR COUNTY, KENYA

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DECLARATION

This dissertation is my original work and to the best of my knowledge, has not been presented to any university for any purpose.

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DEDICATION

I dedicate this dissertation to my dear husband, Ali Adan Mohamed whose unconditional love, support and generosity inspired me to complete this work.

My brother Adan Isaack Hussein for his encouragement and support which strengthened me to continue working. To my mum for her love and prayers.

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LIST OF ABBREVIATIONS AND ACRONYMS

ACCAF	Africa Coordinating Centre for the Abandonment of FGM/C
AIDS	Acquired Immune Deficiency Virus
ARP	Alternative Rite of Passage
CARE	Cooperative for Assistance and Relief Everywhere
CBOs	Community Based Organizations
FBOs	Faith-Based Organizations
FGC	Female Genital Cutting
FGDs	Focus Group Discussions
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation /Cutting
GoK	Government of Kenya
GTZ	German Federal Enterprise for International Cooperation
HIV	Human Immune Deficiency Virus
IBM	International Business Machine
KDHS	Kenya Demographic and Health Survey
KII	Key Informant Interview
KNBS	Kenya National Bureau of Statistics
KNH	Kenyatta National Hospital
MOH	Ministry of Health
MYWO	Maendeleo Ya Wanawake Organization
NGOs	Non-Governmental Organizations
PATH	Program for Appropriate Technology in Health

PPH	Post-Partum Hemorrhage
RAs	Research Assistants
RTIs	Reproductive Tract Infections
RVF	Recto-Vaginal Fistula
SPSS	Statistical Package for Social Scientist
UNFPA	United Nation Population Fund
UNICEF	United Nation Children Fund
UON	University of Nairobi
USA	United State of America
USAID	United States Agency for International Development
VVF	Vesico- Vaginal Fistula
WHO	World Health Organization

ABSTRACT

Introduction: Female Genital Mutilation/cutting (FGM/C), defined by the World Health Organization (WHO) as "all procedures that involve intentional partial or total removal of the external female genitalia or others injuries to female genital organs for non-medical reason". The practice is usually done at birth, adolescent and even on adult women. FGM/C causes a wide range of immediate and long term obstetric, gynecological, psychological and sexual complications. The practice of FGM is common in Wajir County with prevalence of over 80 percent with infibulation and excision being the commonest forms practiced. Despite the concerted efforts that have been made by various stakeholders such as the government, NGOs, CBOs and other organizations to discourage the practice, it persists among the Somali community thus making it necessary to consider knowledge and attitudes of the community members towards FGM.

Methodology: The study adopted cross sectional descriptive design. Mixed methods approach (Survey, FGDs and KIIs) was used to collect data for the study. In the quantitative survey the number of participant selected were 240, while there were 14 KII and 9 FGDs conducted in the qualitative study. Quantitative data collected was entered and cleaned using MS Excel spreadsheet package then imported into SPSS version 22 for analysis. Univariate analysis with basic frequencies, proportions and means was first conducted before bivariate analysis by cross tabulations was conducted. Chi square distribution was used to test for statistical significance which was calculated at $p< 0.05$.

Result: Age, sex, education level, occupation or the nature of the settlement area are important socio demographic parameters that affect the knowledge and perceptions towards FGM. Women (mothers and grandmothers) – who have undergone FGM/C are still at the fore front in advocating for it. Men as decision makers at the household level support FGM/C. Both men and women have sufficient knowledge regarding the FGM/C related complications (85.4 %). This knowledge is however more among women than it is in men. Women are also more aware of the complications during and after FGM/C compared to males. More married women compared to single, divorced or widowed just like women from rural areas compared to those from urban and peri-urban areas. Young people are ready and willing to have their daughters undergo the practice though type 2 most preferably. Culture and religion contributes more towards shaping the community's perception regarding FGM/C though the contribution of religion is still contestable. Religion (Islam) is quoted widely as advocating for the practice something that has no basis in the Quran, the prophetic saying, scholarly opinion and the analogical deduction. The practice persists partly because it is believed to maintain the sexual purity of a girl by containing her sexual desires until marriage. About 72.1% of the members of the community not aware of any interventions or campaigns against FGM/C in the area.

Recommendations: Targeted awareness creation campaigns on the dangers of FGM/C on the young Somali girls by the local and International NGOs, CBOs and Human Rights groups in the County. This should target mainly older women, mothers, fathers, young girls and young boys who are future parents. Local radio stations, sermons in the mosques, school programs and during Maternal and Neonatal and Child health clinics (MNCH) in local health facilities; male involvement in campaigns against FGM/C are critical avenues for this. Finally, involvement of religious leaders such as sheikhs and Imams to help as knowledge, attitude and practice change agents within the community should be prioritized.

DEFINITION OF OPERATIONAL TERMS

Female Genital Mutilation/Cutting (FGM/C) – "Refers to all procedures that involve intentional partial or total removal of the external female genitalia or others injuries to female genital organs for nonmedical reasons" (WHO, 2014).

Clitoridectomy: "involves partial or total removal of the clitoris (sensitive, small and erectile part of female genitalia)".

Excision – "a type of FGM/C (type II), done by removing part or total clitoris and labia minora"

Infibulation– "is a type of FGM/C (type III) in which the entire clitoris (a sensitive, small and erectile part of female genitalia) and labia minora (small lips surrounding the female vagina) are cut away and labia majora are thinly sliced or scraped and the raw surfaces either stitched together or sealed".

Type IV:- "includes pricking, piercing or incising of the clitoris and/or labia, stretching of the clitoris and/or labia, cauterization by burning of the clitoris and surrounding tissue, scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts), introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it and any other non-therapeutic operations or procedure intended to cause harm to the female genitalia with a view to prohibit sexual intercourse and/or maintaining virginity (WHO, 2000)".

Post-Partum Hemorrhage (PPH) – "loss of more than 500mls of blood within 24 hours following childbirth. (COBUILD Advanced English Dictionary)".

Apgar score – "a test designed to quickly evaluate a newborn's physical condition and to see if there's an immediate need for extra medical or emergency care. (Cambridge advanced learner's dictionary thesaurus)".

Knowledge: "is information and understanding about a subject which a person has, or which all people have (COBUILD Advanced English Dictionary)".

Perception: "is a belief or opinion often held by many people and based on how thing seem. (Cambridge advanced learner's dictionary thesaurus)

CHAPTER ONE: INTRODUCTION

1.1 Background of the study

1.1.1 The practice of FGM/C

Female Genital Mutilation/cutting (FGM/C) is a practice usually done at birth, adolescent and even on adult women. (UNFPA, 2014). Per World Health Organization (WHO), Female Genital Mutilation/Cutting (FGM/C) refers to "all procedures that involve intentional partial or total removal of the external female genitalia or others injuries to female genital organs for nonmedical reasons". Those who perform the practice are generally the circumcisers but these days it is also done by health personnel. (WHO, 2014).

Female Genital Mutilation (FGM/C) has been classified into four types by the World Health Organization (WHO).

Type I - includes partial or total removal of the clitoris (sensitive, small and erectile part of female genitalia).

- Type II: - entails removing part or total clitoris and labia minora (small lips surrounding the female).
- Type III: - (also identified as infibulation or Pharaonic circumcision), includes removal of all the clitoris, labia minora and then Labia majora are thinly sliced or scraped and the raw surfaces either stitched together or sealed. Thorns or stitches may be used to hold the two sides of the labia majora together and the legs are put together for about forty days. To enable the outflow of urine and menstrual blood a small opening is usually left. A gum believed to be antiseptic is applied to aid in healing.
- Type IV :- includes pricking, piercing or incising of the clitoris and/or labia, stretching of the clitoris and/or labia, cauterization by burning of the clitoris and

surrounding tissue, scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts), introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it and any other non-therapeutic operations or procedure intended to cause harm to the female genitalia with a view to prohibit sexual intercourse and/or maintaining virginity (WHO, 2014).

Female Genital Mutilation/Cutting (FGM/C) is mostly practiced in 28 African countries. Certain countries in the Middle East, part of Asia also practice FGM/C. Between 100 and 140 million of the world's girls and women are estimated to have undergone the procedures, and every year 3 million girls are at risk of going through the practice every year. To add to this, 15% of all FGM/C in the African continent have been established to be infibulations (28 too many, 2013).

21% of all girls and women who are of age 15-49 years have gone through FGM/C in Kenya alone. (KDHS, 2014). There has been a decline in the proportion of women in the reproductive age who have undergone FGM/C from 38% in 1998 to 32% in 2003 to 27% in 2008-09 to the current 21% per the KDHS.

According to the KDHS 2014, North Eastern province is estimated to have 97.5% of its women in the reproductive age circumcised. Followed by 32.4% of those in Nyanza, 26.9% rift valley and Eastern 26.4%.

Among the practicing communities, Female Genital Mutilation/Cutting (FGM/C) is deep-seated traditional practice and different communities in Kenya practice it for different reasons. For example the Meru, Embu and Maasai, practice it because it is a significant alternative rite of passage (ARP). Among the Maasai it is done for marriageability. For Somalis it is for family honour and preservation of sexual cleanness. For Kisii it is a symbol

to control their sexual desires and differentiating them from their neighboring Luo ethnic group (28 too many, 2013).

Clitoridectomy (type I) and excision (type II) are the predominant types of cutting, however Somali, Borana, Rendile and Samburu practice the more severe (type III) form of FGM/C (KDHS, 2014). Female Genital Mutilation/Cutting among the Somali community living in Wajir is a universal practice. Over 80 per cent of girls and women living in this region have undergone the most severe types of cutting (infibulation and excision). Several reasons are used by this community to justify the continuation of the practice which includes: a means to control female sexuality, perceived as religious requirement, marriageability and beauty/cleanliness of the genitalia (Jaldesa *et al*, 2005).

1.1.2 Effects of FGM/C

Female Genital Mutilation/Cutting (FGM/C) is very painful experience and can lead to very serious harmful health consequences (UNICEF, 2005). The immediate complications associated with this practice include: shock, infections, hemorrhage (bleeding), open sores in the genital area, severe pain, urine retention and injuries to the nearby genital tissues. The long-term complications are: increased risk of childbirth, recurrent bladder and urinary tract infection, foetal complications, infertility, psychological, menstrual disorders, sexual complications. (Adriana, 201 1).

Great efforts both international and local have been put in place to counteract FGM/C. In Kenya, the practice is widely condemned because of the great health risk it poses to the affected persons. Several anti FGM/C efforts to encourage abandonment of FGM/C in Kenya have been put in place. These include several policy guidelines e.g. National Plan of Action for the Elimination of Female Genital Mutilation/Cutting (FGM/C) in Kenya, in 2001, the current national constitution 2010, and the children act of 2001. Several approaches have also

been used for the past 20 years, this include: offering alternative income, religious oriented approaches, human rights approaches, legal approaches, dialogue and promoting girl's education. The perceptions held on the complication associated with Female Genital Mutilation/Cutting (FGM/C) per members of this community however still generally remains that if a girl gets any complications it will be because of God's will but not because of the procedure or the person doing the cut (Jaldesa et al, 2005).

FGM/C and Religion

Though there are those who believe that Islam, the predominant religion in this area advocates for FGM/C especially type II, the religious teachings do not make any mention to its related complications being promoted by Islam. There is actually no any Islamic evidence that support the practice. *Ahadith (prophetic sayings)* quoted are either weak or unconnected to FGC. Weak *ahadith* cannot be used by a Muslims to govern their conduct, especially if it is harmful to people, for example as in FGM/C.

1.2 Problem statement

Despite all the efforts that have been put in place to eradicate FGM/C through the years, the practice persists with negative health consequences among the Somali community. This is despite the many complications that women face because of the practice. The practice remains a deep-seated and broadly supported cultural practice among the Somali community (Abdi, 2005) with 75% of the females from this community having undergone the type 3 of Female Genital Mutilation/Cutting.

While studies on FGM/C have been conducted in Wajir County, none has exclusively provided in-depth information on the knowledge and perception of complications associated with Female Genital Mutilation/Cutting (FGM/C) and the reasons for its continuation despite the associated complications. This study therefore undertook a comprehensive and detailed

understanding of the community's perception and level of knowledge on complications associated with FGM/C and the underlying reasons for its perpetuation despite the complications.

1.3 Study Objectives

1.3.1 General Objective

The overall objective of the study was to assess the knowledge and perceptions of complications associated with FGM/C among Somali community in Wajir County in Kenya.

1.3.2 Specific Objectives

The study sought:

i. To establish the association of socio-demographic factors of members of the Somali Community in Wajir County with knowledge and perception of complications associated with FGM and factors that determine persistence of FGM/C.
ii. To determine the level of knowledge and perceptions of FGM/C complications among members of the Somali Community in Wajir County.
iii. To establish the reasons for persistence of FGM/C practices despite the related complications among members of the Somali Community in Wajir County
iv. To establish the levels of intervention by various stakeholders aimed at alleviating FGM/C complications in Wagberi, Wajir County.

1.4 Research Questions

The study sought to answer the following questions:

i. What is the association of socio-demographic factors of members of the Somali Community in Wajir County with knowledge and perception of complications associated with FGM and factors that determine persistence of FGM/C?

ii. What is the knowledge levels and perceptions of members of the Somali Community in Wajir County on complications associated with FGM/C?

iii. What are the reasons for persistence of FGM/C practices despite the related complications among members of the Somali Community in Wajir County?

iv. To what extent have various stakeholders been involved in addressing FGM/C implementing the interventions aimed at alleviating FGM/C complications in Wajir County?

1.5 Justification of the study

Despite associated health complications and efforts put in place to encourage the abandonment of the practice, the practice of FGM/C is still rampant in North Eastern Province where Wajir County is found – 97.5% (KDHS, 2014). The study sought to understand the community's perceptions and level of knowledge with respect to complications associated with FGM/C and the underlying reasons for the persistence. The findings would provide useful information for the strategized interventions to end FGM/C in the region and specifically Wajir County. The findings will also be useful to FGM/C interventionists and policy makers targeting evidence based and advocacy interventions to speed up the abandonment of the practice. These processes will eventually contribute to safeguarding the heath and dignity of women in the region.

1.6 Scope of the study

In content, space and time, this study was restricted to assessing the knowledge and perceptions of complications experienced because of FGM/C among the Somali women. The investigator interviewed the community men, women and youths through structured questionnaires, FGDs and KIIs. The investigator also interviewed the NGOs and the CBOs that also work towards FGM/C abandonment.

1.7 Limitations and Delimitations of the Study

Being a sensitive topic, discussing issues related to the FGM/C among all members of the society especially men was challenging due to religious and cultural issues associated with the practice. The principal investigator took time to clarify some of the concerns raised by the participants with the focus of making the participants as comfortable as possible. Female participants were separated from their male counterparts to address the cultural and gender issues that would otherwise affect the objectivity of the discussions. Confidentiality of the discussions was also assured at the consenting stages of the different interviews.

The other limitation was the high regard of the practice among members of the community especially the proponents of the practice and the existing laws against the practice which could have hampered honesty for fear of victimization.

1.8 Conceptual Framework

1.8.1 Independent, Intervening and Dependent Variables

Socio Demographic Differentials namely: - Age: FGM/C in Wajir is usually carried out on girls up to fifteen years. The community targets the children while they are too young to protest or even understand what is going on. Depending on the kind of person her guardian is, her knowledge and perception on complications associated with FGM/C will be affected. Education: if a mother has more education especially secondary and university, it is more likely that she will have knowledge on complications associated with FGM/C and can protect her daughter from undergoing the procedure or pass the knowledge to her daughter. The second will be religion. Members who practice FGM/C believe that it is mandated by religion (i.e. Islam) and that it facilitates living up to religious expectations of sexual constraint. This can affect their knowledge and perception of complication associated with FGM/C. Then gender will follow. Women tend to have a better perception of the complications since they

experience them as opposed to the men who are passive actors. The other will be socio economic status. Members from low socio-economic status might be forced to accept their community's harmful traditional practices e.g. FGM/C despite the associated complications, because it attracts high bride price. Low income and lack of formal education puts them at risk of having inadequate knowledge on complications associated with FGM/C.

There will also be consideration for the perception on FGM/C at community level. FGM/C is perceived as an important cultural and traditional practice and a girl who is not circumcised brings shame to the family and community and may be treated as an outcast. Due to the above factors the negative medical and social effect of the practice are not perceived as critical. Government policies and FGM/C abandonment interventions will be considered intervening variables. This is because the government together with other FGM/C abandonment interventionists has put in efforts to disseminate messages on the negative health effects associated with the practice. This has to some extent affected on the communities' perception and knowledge on the female mutilation complications. Perceived benefits will be considered dependent variables. Improved Knowledge and changed perceptions based on the understanding of the FGM/C complications. The interaction of all the three types of variables as conceptualized are presented in figure 1 below.

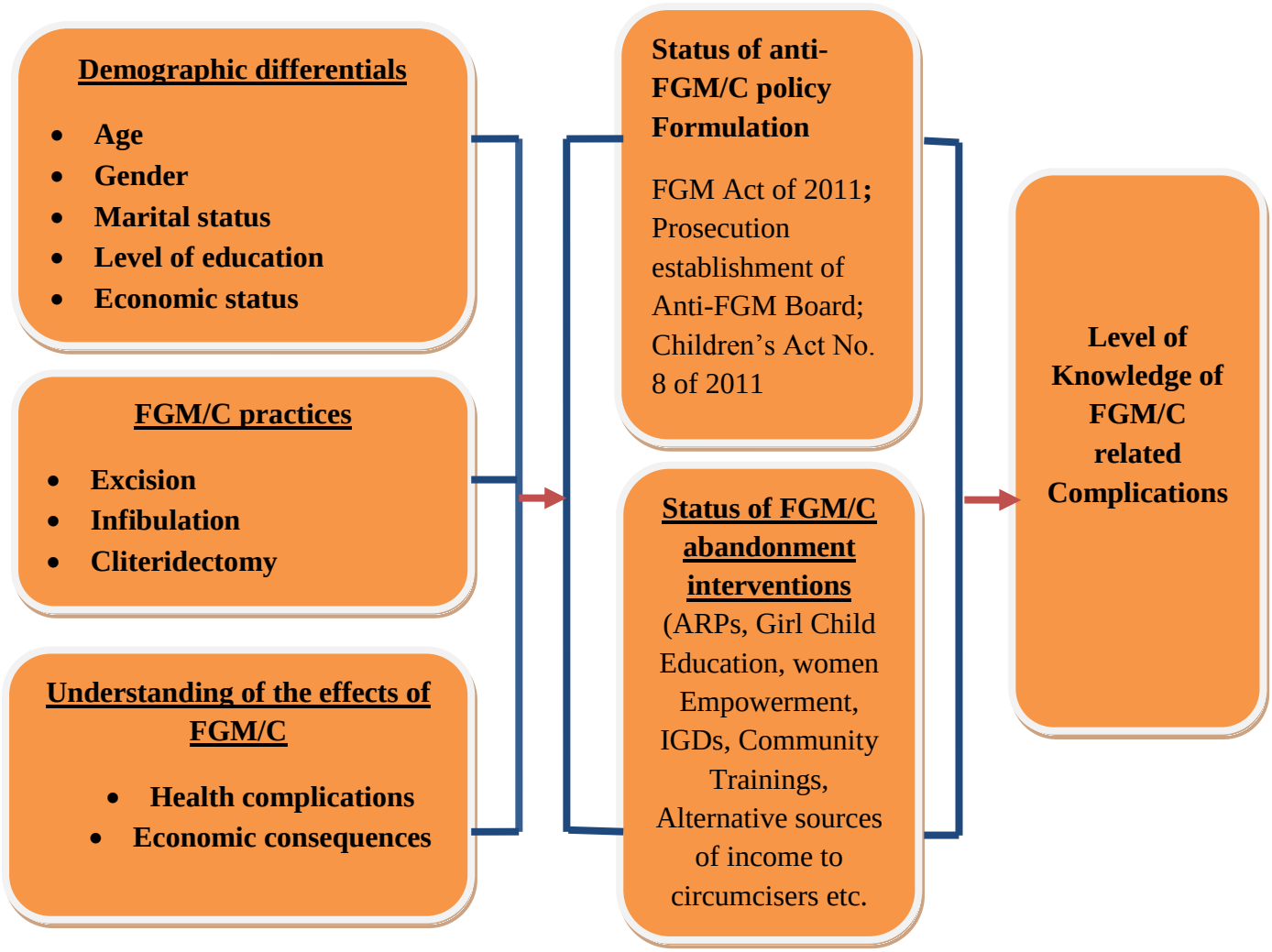

Figure 1: Conceptual Framework

CHAPTER TWO: LITERATURE REVIEW

2.1 Theoretical Review

2.1.1 Perceptions and attitude towards FGM/C

Female Genital Mutilation/Cutting (FGM/C) has been practiced for a long time among the Somalis living in North Eastern part of Kenya. It is considered an entrenched practice among the Somali community. A family is afraid of losing respect and honor within the community if the mother fails to circumcise the daughter. The daughter is considered an outcast if they are not circumcised. FGM/C for Somali women is one way of maintaining the family decency and integrity. FGM/C practitioners believe that it is shameful for the relatives of the girls if she not cut.

The Kuria and the Kisii, believe that it is impossible that a woman would get married or have children before being cut. So, FGM/C is taken as a rite of passage from childhood to adulthood as the cut woman is believed to possess qualities like maturity, obedience and responsible in the family and the society (Oloo *et al*, 2011). Some of the perceptions held on the complication associated with FGM/C put across by the women from different ethnic groups were that if a girl gets any complication it will be because of the will of God but not because of the cutting procedure or the person doing the cut (Jaldesa *et al*, 2005).

Members of communities that practice FGM/C believe that circumcision brings respect to the family and therefore it is linked with the price of the bride wealth the family would get when the daughter gets married. Compensation could be claimed if the husbands finds out that girl has not been cut (Jaldesa *et al*, 2005, Abdi, 2005). In the Somali community virginity is usually sign of wealth because if a girl is virgin she will be given high bride price. FGM/C is said to give the girls and women a new identity. Women who do not cut their daughters are perceived as immoral, imitators irresponsible.. The Meru, Kalenjin and Abagusii share the same perception (Moranga, 2014).

Mothers from the community that practice FGM/C feels that it is their duty to follow the tradition and culture the way it is by having their daughters cut because they too had been cut. The members of the community believe that all mothers should cut their daughters because they also underwent the same procedure. Peer pressure may also contribute to girls agreeing to be cut. If a girl denies to be cut, she will be teased by her friends of the same age. Those girls who are uncut are considered non-believer or the open one. So due to peer pressure they surrender to the cut. (Evalia, *et al* 2007, Abdi, 2005, Jaldesa *et al*, 2005).

2.1.2 Female Genital Mutilation/Cutting and Sexual practices

Most of the ethnic groups that practice FGM/C believe that by cutting and stitching a girl or a woman her sexual desire is suppressed. They consider this as a way of keeping the girl from having premarital or extra marital sex. For example, the Abagusii believe that a cut 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 ((Moranga 2014, Evalia *et al*, 2007).

Among the Kisii and the Kuria, FGM/C restrains sexual urge and desire in women when their husbands stay away for longer periods during grazing and raids of animals. In girls it reduces the chances of pre-marital sex, promiscuity and maintains good morals (Oloo *et al*, 2011).

Among the Somali , cutting the girls is assumed to suppress the girls sexual desire. It is also believed to prevent the girls from being promiscuous and adulterous. They believe that uncut woman cannot control her sexual desire and this is unacceptable because men alone are the ones who are supposed to enjoy matrimonial sex. (Jaldesa *et al*, 2005, Abdi, 2005, Evalia *et al*, 2007).

A woman may be infibulated again after a divorce, before remarrying and after giving birth, to increase the husband's sexual pleasure (Almroth & Elmusharaf, 2009). The main reason

why FGM/C was performed was to reduce the sexual desire of the girls. Women are perceived as people who cannot control their sexual desire; therefore, FGM/C is performed on them to reduce hyper-activity in sexual practice and to prevent early initiation of sexual intercourse before marriage. They are not supposed to be active or enjoy sex. Only men can do so (Yirga *et al*, 2012).

2.1.3 Female Genital Mutilation/Cutting and Religion

Female Genital mutilation is also believed to be a religious requirement. A girl is cut to make her a Muslim and spiritually pure. The Somali, Borana, Orma, Wardey and Boni believe that FGM/C constitutes an Islamic practice of *sunnah* and that uncut girls are regarded as non-Muslim. Prayers (the obligatory prayer on every Muslim, male or female) of uncut persons are considered unacceptable. The parents and family of uncut girls would also be considered non-Muslims because of not cutting their daughters. The clitoris is considered *haram* (dirty or not pure in the sense of religious purity and cleanliness) thus it must be removed. Members from these ethnic groups believe that the women fear that men would consider them nonbelievers; so, they must undergo the cut and be stitched to Islamize them. Most women would not talk of circumcising but only Islamize their daughters (Abdi, 2005, Jaldesa *et al*, 2005)

Religion (Islam) is quoted widely as advocating for the practice something that has no basis in the Quran. The Sunnah or the prophetic sayings that are widely mentioned to be explicit on this subject lacks authenticity and so cannot be relied upon to provide direction on a matter as sensitive as FGM/C. The same applies to the scholarly opinion on the matter. Analogical deduction has been alluded to widely as a justification for the practice. This also lacks credibility since FGM/C in women cannot be compared to male circumcision. (Abdi, 2005)

The practice is not practiced major Islamic countries like Saudi Arabia, Algeria, Libya, Morocco and Tunisia. Infibulation (type 3 or Pharaonic circumcision) is not permitted in Islam, and any woman who had been infibulated could claim for compensation from the operators. Islam does not support infibulation because the Pharaonic circumcision practiced by the Somalis is not in the Quran and the teachings of the Prophet Mohammed. The Somali do it in an unacceptable manner and this result in a lot of serious health complications. It is a culture that is considered very far from the way of Islam, in fact it is like slaughtering someone which can be compensated if the affected person demands for compensation because it is a sin to harm your healthy body (Asmani & Abdi, (2008), Abdi (2007), (2005)).

2.1.4 Female Genital Mutilation/Cutting and hygiene

Women from the community that practice FGM/C, especially among the Somali community perceive FGM/C as a long-term cleanliness to the genital area and that a woman's external genitalia can harbor dirt and germs, thus for them to be cleaned they need to be removed. They believe that uncut women are never clean and that those who are not cut are dirty, and they will always produce a foul smell. The women from this ethnic group also have the perception that the female genitalia in its natural form is ugly and that infibulation makes them smart and good-looking. Moreover, they believe that the clitoris can grow to the length of a penis as the girl grows and this makes the female genitalia look unpleasant. Similar perceptions were held by infibulated women from Sudan (Almroth & Elmusharaf, 2009; Evalia. *et al*, 2007; Abdi, 2005). They also believe that genital organ of uncut women is a danger to an infant's health during childbirth and that the tip of the clitoris is toxic so if it encounters the infant during birth, the baby will die (Oloo, 2011).

2.2 Complications associated with the practice of Female Genital Mutilation/Cutting

Female Genital Mutilation/Cutting (FGM/C) harms girls and women because it involves removal and damage of healthy and normal female genital tissue, and interferes with the

natural functions of their bodies. It carries with it many serious immediate and long term complications and harmful health consequences. These consequences lead to physical complications most of which occur due to unsanitary conditions during the cutting. Mortality from FGM/C are usually poorly documented, however morbidity from the immediate complications like hemorrhage, shock and sepsis are high (WHO, 2014).).

2.2.1 Physical complications

Some of the most immediate physical complications associated with FGM/C include:

2.2.1.1 Severe pain

Severe pain is usually because of cutting the nerve ending and sensitive genital tissue. Pain is associated with all the types of FGM/C but the intensity and duration of pain is more extensive with type 3 (infibulation) because the procedure is of longer period usually 15-20 minutes. The healing period is also more painful, extended and intensified (Njue & Askew, 2004, Jaldesa *et al*, 2005).

2.2.1.2 Bleeding

Bleeding is the most common and dangerous immediate complication of FGM/C. Removal of the clitoris includes cutting the clitoral artery. The blood flows under high pressure through this artery, hence excessive bleeding. Also the removal of the labias leads to excessive bleeding because of damaging the small blood vessels in labias. Secondary bleeding may occur after the first week due to sloughing of a clot over the artery through infection (Jaldesa *et al*, 2005 and Yirga *et al*, 2012).

2.2.1.3 Urine Retention

Injury, pain and fear of passing urine may cause urine retention. Also obstruction of the urethra during infibulation may cause the above condition. In addition to the above urinary

tract Infection may occur due to dirty surroundings and instruments used during the procedure.(Almroth *et al*, 2005).

2.2.1.4 Communicable disease

Communicable diseases such as HIV-AIDS and hepatitis B are other possible consequences because of the use of non-sterile instrument to perform the procedure among large number of girls at the same time, but the direct association is not documented perhaps due to the rarity of mass genital cutting with the same instrument, and the low HIV prevalence among girls of the age at which the procedure is performed (Njue & Askew, 2004; Yirga *et al*, 2012 and Gilbert, 2007). Other immediate complications include anaemia and shock which can also occur due to bleeding or infection/severe bleeding or pain respectively among others. (Jaldesa *et al*, 2005).

2.2.2 Gynecological Complications

2.2.2.1 Reproductive Tract Infection

Reproductive tract infections (RTIs) are mostly seen in women who have experienced FGM/C. This is usually caused by obstruction of urine among those women who are infibulated. Reproductive tract infection also manifest as irritation/itchiness, abnormal vaginal discharge and ulceration (Gilbert, 2007).

2.2.2.2 Acute / Chronic Pelvic Infection

Pelvic infection is usually due to blockage of vaginal discharges due to closing off of the vaginal opening in infibulated women. Also it may be caused due to the presence of vaginal stenosis or vaginal stones. (Jones *et al*, 1999).

2.2.2.3 Infertility

Infertility can be caused by pelvic infection. Primary and secondary infertility can occur due to FGM/C as shown by several studies. (Jackson *et al*, 2005; Almroth *et al*, 2005).

2.2.2.4 Keloid Formation

A keloid is usually scar like tissue and it can block the vaginal opening. This leads difficulty

2.2.2.6 Clitoral Neuroma

Clitoral neuroma is a painful tumor affecting neural tissue. Due to clitoridectomy the clitoral nerve may be imprisoned in the stringy tissue of the scar. This may cause a lot of pain making sexual intercourse very difficult. (Abdulkadir *et al*, 2012).

2.2.2.7 Vulval abscess

A vulval abscess can be due to infection in the unhealed wound after FGM/C (Gilbert, 2007).

2.2.2.8 Fistulae and Incontinence

Vesico-vaginal fistula (VVF) - abnormal passages between the bladder and vagina or recto-vaginal fistula (RVF). Fistulae (abnormal passage between the rectum and vagina), leading to one not being able to hold urine or leaking of urine and this may be due to obstructed labour due to FGM/C, or injury to the urethra after FGM/C. (Jones *et al*, 1999).

2.2.2.9 Vaginal Obstruction

This condition may be due to infibulation. Menstrual blood is usually confined in causing the swelling of abdomen. (Gilbert, (2007),).

2.2.2.10 Menstrual Disorders

Women who have undergone FGM/C experience severe menstrual pain and lack of menstrual flow. This is mostly caused by tight infibulation or scaring which narrow the vaginal opening. (Jaldesa *et al*, 2005).

2.2.3 Obstetric Complications

Infibulated women usually have obstruction to delivery due to tight vaginal opening. Types I, II and IV women also experience obstruction due to vaginal scar and keloids. Contamination leading to infection when cutting can also lead to adhesion of the vulva hence narrowing the vaginal opening. Women with such complications may never conceive and if they do, they experience obstructed and prolonged labor which in turn leads to fistula (Gilbert, 2007 and WHO, 2006).

2.2.3.1 Antenatal complications and early labor complications

Female Genital Mutilation/Cutting (FGM/C) which leads to reduced vaginal opening not only affects delivery but also brings about other obstetric complications. Infibulated women are at high risk of going through caesarean sections as compared to those without FGM/C. Female genital mutilation (FGM/C) also makes vaginal examination antenatal assessment and catheterization very difficult hence putting the mother's and child's life in danger. (Gilbert, 2007 and WHO, 2006).

2.2.3.2 Complications during labor

Women who have undergone FGM/C especially those with type 3 cut usually experience soft tissue obstruction (dystocia) and delayed labor during the second stage, which is usually faster than the first stage of labor (WHO, 2006 and Njue *et al.,* 2004).

2.2.3.3 Episiotomies and perineal tears

This is usually the commonest type of complication experienced by women with FGM/C especially those with type 3 cut. These women undergo more perineal injury and episiotomies during birth compared to those did not undergo the cut. (WHO (2006), Njue & Askew, (2004)).

2.2.3.4 Aching during and after de-infibulation (anterior episiotomy)

Those who are infibulated usually go through additional pain due to the additional cuts that they experience during birth to allow the baby to come out. This pain lasts until after delivery. (Njue & Askew, 2004).

2.2.3.5 Postpartum hemorrhage (PPH)

This refers to loss of more than 500mls of blood within 24 hours following childbirth. There is usually a great increase in the number of women who suffer due to the above complications especially amid those who are infibulated compared to those who are not cut. (WHO, 2006).

2.2.3.6 Maternal death postpartum

Maternal deaths also sometime occur due to negligence on the part of the health care provider like inappropriately handled obstructed labor caused by FGM/C. (WHO, 2006).

2.2.3.7 Maternal Hospital Stay

Cut women were most probably than the uncut ones to have prolonged hospital. Those who have gone through the cut and have delivered normal delivery are more likely to stay in the hospital for a longer period. (WHO, 2006).

2.2.3.8 Foetal Complications

Complications such as low Apgar scores, foetal distress, and pre-labor deaths are more common among the infibulated women than the uncut. women who had been infibulated than

the uncut. Babies of FGM/C mothers usually require to be resuscitated immediately after delivery. Additional babies die because of FGM/C. (Vangen, 2002, (WHO, 2006).

2.2.4 Psychological Consequences

Female Genital Mutilation/Cutting (FGM/C) is a practice that brings with it fear and suppression of feelings. This incident remains forever in the mental development of the affected women and young girls. As they grow older, women may develop feelings of incompleteness, loss of self-esteem, depression, chronic anxiety, phobias, panic or even psychotic disorders. Girls may also have a feeling of betrayal, bitterness and anger because of being subjected to such a painful procedure.

The procedure is often performed on girls when they are young and sometimes even uninformed by those who she so close and trusted. This may lead to a feeling of lack of confidence and trust in their family and friends. This may influence the connection between the girl and her parent and even how she is going to relate with other in future. (Kokonya, 2004). Psychological stress may manifest as sleeplessness, nightmares, loss of appetite, weight loss or excessive weight gain, as well as panic attacks, instability of mood, difficulties in concentration and learning (Njue & Askew, 2005).

2.2.5 Sexual complications

Among the Somali community and other community as well FGM/C is believed to reduce sexual feelings. (Jaldesa *et al*, 2005). Women are seen to complain of pain during sexual intercourse (Morison *et al*., 2001). However the exact relation between FGM/C and sexual desire is still not known. Nevertheless, in type III women sexual intercourse is usually difficult and painful and this can affect their sexual desire. (Njue & Askew, 2004).

Cut women usually go through painful sexual intercourse due to scaring, narrowing of vaginal opening and obstruction of the vagina by infection or elongation of labia minora. In

infibulated women, penetration may be even intolerable without tearing (Jaldesa, *et al.*, 2005). Vaginismus is another form of sexual dysfunction resulting from vulval injury and repeated forceful sexual act. It is characterized by recurrent involuntary spasm of the outer third of the vagina that affects intercourse and is usually caused by psychological trauma during FGM/C or sexual penetration. (Jones *et al.*, 1999).

2.2.6 FGM/C Complications Affecting Men

Female Genital Mutilation/Cutting (FGM/C) is an experience that not only affects women but also men and the society. Men with women with type III go through complications like bleeding or inflammation of the penis, difficult in penetration among others. It is also expensive for them to take their women for frequent medical care. Their women also do not enjoy sex due to difficult in penetration and this also affects them greatly. (Almroth, 2005).

2.2.7 Social Consequences of FGM/C

While there are few detailed studies on the social impact of FGM/C, however some research has identified the negative consequences for families, girls and women who renounce FGM/C. The practice is performed in response to strong social agreements and supported by key social norms; thus, failure to follow often results in harassment and, exclusion from important communal events and support networks, as well as discrimination by peers. Unless there is a joint agreement within a larger group, individuals and families are likely to consider the social risks to be of greater importance than the physical and mental health risks to girls of FGM/C. Even legal restrictions against FGM/C may be perceived as less important than the restrictions that can be imposed by the community for non-compliance with the practice (Njue & Askew, 2005 and WHO, 2006).

2.2.8 Economic Consequences of FGM/C

Per a study conducted in six African countries Female Genital Mutilation/Cutting (FGM/C) is a potential financial burden to family, society, health systems and the country. (WHO, 2006).

2.3 Abandonment of FGM/C among Practicing Communities

Efforts to persuade the communities to abandon FGM/C started with missionaries and colonial authorities in 20th century, followed by western feminists in 1960s and 1970s. However, these attempts were not taken positively and were largely met with a lot of rebellion and rejection. In 1994 and 1995 international conference on population and development and fourth world conference on women took place in Beijing respectively. Female genital mutilation (FGM/C) was now taken as a health and human right issue and it was agreed that efforts to encourage abandonment of FGM/C needed to incorporate locally led initiatives and full engagement of the communities, health professionals and policy makers. (Abdi, 2005).

A joint international statement against female genital mutilation was issued in 1997 by the World Health Organization, the United Nation Children's fund (UNICEF), and the United Nations Population Fund (UNFPA). The statement emphasized that FGM/C is harmful and violates the right and dignity of women and girls, the right to be free from torture and degrading treatment and the right to life when the procedure leads to death. African Union Protocol to the Africa Charter on Human Rights on the Right of Women of 2003 has also condemned and recognized FGM/C as a harmful practice. Article 5 of elimination of harmful practices states that 'Parties shall prohibit and condemn all harmful practice which negatively affect the human rights of women and which are contrary to recognized international standards (Oloo *et al.,* 2011).

In Kenya, efforts to stop FGM started as early as 1900s, when the colonial authorities and missionaries tried to stop the practice by spreading criminal regulations and using religious propaganda. Nevertheless, these actions did not prosper due to cultural and nationalist resistance. Therefore, the colonial authorities resolved to education to end FGM/C. After independence, from early 1980s, Kenya has attempted to prevent FGM/C and the fight against FGM/C has received support from various levels: internationally through policy dialogue, funding, active commitment and involvement of government ministries, religious groups, international, local non-governmental organizations, United Nations agencies, and at the community level.

The government of Kenya (GoK) has also put in several efforts to encourage abandonment of FGM/C. In 1999, the ministry of health with support from WHO issued National Plan of Action for the Elimination of FGM/C which defined broad targets, objectives and strategies for accelerating elimination of FGM/C. In 2001, the Kenyan Parliament also passed the Children Act that made FGM/C illegal for girls under the age of 18 years. Section 14 of the Act states that "no person shall subject a child to female circumcision, early marriage or other cultural rites, customs or traditional practices that are likely to negatively affect the child's life, health, social welfare, dignity or physical or psychological development". Section 18 of the Act requires that any conviction for FGM/C-related offences carries a penalty of 12 months of imprisonment and/or a fine not exceeding Kshs. 50,000 (approximately US$710). Practitioners and parents forcing the procedure on their daughters can also be prosecuted under child abuse laws, or for dangerous bodily harm or unlawful mutilation of an organ of the body.

In September 2004, Kenya considering promoting international agreements that address gender equity, hosted the International Conference on FGM/C entitled "Developing a Political, Legal and Social Environment to Implement the African Union's Maputo Protocol.

The government approved the protocol, joining Libya, Comoros, Rwanda, Namibia, Lesotho and Djibouti. In addition, the government passed the Prohibition of Female Genital Mutilation Act 2011 and established the Anti-FGM/C board to help speed up abandonment of FGM/C throughout the country. The Ministry of Health has also developed and published a Reference Manual for Health Service Providers on the management of complications of FGM/C.

Government efforts is also evident in Sections 74, 250, and 251 of the current national constitution, the constitution protect every individual from torture and inhuman and degrading treatment, and have been used to argue that FGM/C is an unlawful practice. The government similarly has partnered with development partners (UNFPA, WHO, UNICEF, USAID), International Organizations (GTZ, CARE, PATH), Faith-Based Organizations (FBOs), Community-Based Organizations (CBOs), local Non-Governmental Organizations (NGOs), Educational Institutions (e.g. University of Nairobi via ACCAF), to aid in eradication of FGM/C (Evalia *et al*, 2007, Oloo *et al*, 2011).

Different intervention approaches have been used in Kenya to encourage the communities to abandon FGM/C. A situation analysis conducted in 2007 documented the different types of interventions that have been implemented in Kenya, including:

- Intervention using a health risk approach and addressing health complications whereby messages that emphasizes on the harmful physical and subsequent effects of the practice can have on women were communicated to the practicing communities.
- Educating traditional cutters and offering them alternative income generation. In this approach cutters are identified and are educated on the health risks associated with the practice and providing them with alternative means of income to motivate them not to undertake the practice (Evalia *et al*, 2007).

The alternative rite of passage approach: traditional rites of passage have been an integral part of culture for communities such as Meru, Maasai and Kuria. It was believed that this ceremonial ritual was meant to graduate the girls from childhood to adulthood. During the ceremony girls are taught how to take care of the family and how to become obedient and good wives and mothers. The Alternative Rite of Passage (ARP) which was introduced in 1996 by Maendeleo Ya Wanawake Organization (MYWO) and PATH involves alternative rituals that avoided genital cutting but maintained the essential components of female circumcision such as education for the girls on family life and women's roles (Chege, 2001, Askew, 2001).

CHAPTER THREE: STUDY METHODOLOGY

3.0 Introduction

This section discusses the methodology that was used in the study. It includes the description of study design, study area, study population and sampling procedures, data collection methods, data processing and analysis, possible challenges faced during the study period and ethical consideration.

3.1 Study Design

The study adopted cross sectional descriptive design employing quantitative approach supported by qualitative data. Cross-sectional descriptive study design was suitable because it describes the local community's perception and knowledge of complications associated with FGM/C and the underlying reasons for its continuation despite the negative health consequences. According to the KDHS (2014), the prevalence of FGM/C is still high at 98% in the larger North Eastern region where Wajir is. Knowledge of FGM/C among women of reproductive age is near universal at 99.7%. In this county fewer women visit the health facilities for delivery related care (22%). This increases their risks of complication during delivery because of near universal cases of FGM/C among women in the reproductive age in this County. Cross-sectional descriptive study design using quantitative techniques was therefore suitable in describing the current state of FGM/C practice and the knowledge levels of young girls and older women relating to FGM/C while qualitative techniques were used in understanding the perceptions of Somali Community as relates to the complications associated with FGM/C and the underlying reasons for its continuation despite the negative health consequences.

Mixed methods approach with qualitative and quantitative methods was also used. Qualitative approach was used to get information useful providing a deeper understanding of the community's perception and also in confirming knowledge levels regarding complications associated with FGM/C and the reasons for the perpetuation of the practice despite the associated complications. This approach helped in digging out the feelings, perception and opinion of the participants. This would not have been possible if a purely quantitative approach was used. Quantitative method was useful for triangulating the information obtained by the qualitative approach

3.2 Study Area

The study was conducted in Wagberi Ward, Wajir County among Somali community. Wagberi Ward is in Wajir East Constituency in Wajir County. Wajir County is in the North-Eastern part of Kenya and borders Mandera to the North and North East, The Republic of Somalia to the East, Garissa to the South and South West, Isiolo and Marsabit to the West, and the Republic of Ethiopia to the North West. It has a maximum width (East West) of 260 km and a maximum length (North-South) of 350 km. It lies between latitudes 30 20'N and 00 60' N and between longitudes 390 E and 410 E. Its populations is approximately 661,941 and an area of 55840.6km sq. Wagberi ward, the site of the study, is largely inhabited by the Somali ethnic group. The site was selected because most inhabitants largely practice FGM/C. Another reason for the choice of the sites was due to the high number of maternal deaths related to FGM/C complications (Abdi, 2005). It is estimated that over 80 percent of females in this site have undergone FGM/C. The commonly practiced type of cut here is infibulation (75%) although excision is also practiced (Abdi, 2005).

Kenya map indicating where Wajir is located.

3.3 Study Population

The study targeted all the members of Somali community aged 18 years and above in Wagberi area of Wajir County as well as the individuals working in FGM/C abandonment institution such as NGOs or CBOs. All the classes of participants were targeted in both the quantitative and qualitative arms of the study.

3.4 Inclusion Criteria and Exclusion Criteria

3.4.1 Inclusion criteria

All men and women of Somali origin residing in the study area, above 18 years and willing to participate within the period of study were included. also included are those Consented to participate in the study.

3.4.2 Exclusion criteria

1. Anybody within the accepted age but not be willing to participate in the study.
2. Anyone above 18 years and willing to participate but not of sound mind.

3.5 Sample Determination

For the quantitative survey, the desired sample was arrived at by using the Fischer's formula (Rosner, 2000):

$N = Z^2 * PQ/D^2$ Where:

N = is the minimum desired sample size.

Z = the standard normal deviate usually set at 1.96 with confidence level of 95%.

P = Population proportion of FGM/C in the study population, assumed to be 0.90.

Q = 1.0 – P

D = precision around the estimate P set at 4%

$$N = (1.96)^2(0.9)\ (1.0\text{-}0.9)/0.04^{2\ =}\ \mathbf{216.09}$$

The sample size was then stepped up by 10% mainly due to foreseeable incomplete questionnaire; therefore, the approximate population recruited in the study was 238 participants.

For the qualitative survey, Key informant interviews were conducted by the stakeholders until saturation in terms of information sought was reached. At the end of it, a total of 14 key informant interviews were conducted. The Key informant interviews were conducted as follows: - 2 with circumcisers, 1 with high school teacher, 1 with high school head teacher, 2 with religious leaders (Kadhi and Imam), 2 health care providers (Nurse and facility in-charge Wajir District hospital), 1 with MCA representing the disabled, 1 with FGM prosecutor Wajir law courts, 1 with a male elder, 1 with an elderly woman, 1 with a human rights activist and 1 with FGM/C activist from the study area and at least 6 FGDs (1 with

female high school youths, 2 with male high school youths, 1 with an elderly woman, 1 with a middle aged woman of child bearing age, 1 with old and middle aged men.

3.6 Sampling Procedure

Multi-stage sampling technique was used to select villages to be included in the survey. Wagberi ward was first selected based on the reasons alluded to in the description of the study area. A list of sub locations within the ward was then drawn. In each sub location, a list of villages was drawn based on known settlement areas considering that inhabitants of Wajir County are largely pastoralists. Three villages were then randomly selected (urban, rural and peri – urban) with the largest populations among the villages in the list to form the sampling frame. A courtesy call was made to the assistant chiefs from the sub locations selected and the objective of the study explained to them. The assistant chiefs then introduced the study team to the village elders from the villages sampled as well as the major stakeholders in the fight against FGM/C. To this team, the study team and study objectives were introduced. It is these stakeholders that mobilized the study participants based on the inclusion and exclusion criteria. The trained research assistants then visited all the households in the selected villages to seek consent and interview women found in the households during the 3 days of data collection. For the FGDs in the qualitative survey, participants were purposively selected based on their age, gender, economic status and educational status while the participants for the key informant interviews were conveniently selected based on their position in the society. They mainly involved those involved FGM/C abandonment initiatives among the Somali community in the area to elicit specific information about the perceptions and views as pertains to the practice of FGM/C. This also helped give an insight into the challenges they are facing in their work within the area under study.

3.7 Data Collection

Quantitative data was collected using structured questionnaires seeking to collect basic demoghraphic information of the participants and their knowledge and perception on the complications associated with FGM/C. The questionnaires were administered to all individuals in the study sample including men, women, youth, circumcisers, religious leaders, elders and individuals leading FGM/C abandonment institutions.

Qualitative data was collected using interview guides customized for the FGDs and KIIs were tape recorded. The guides were mainly used to gather information from men, women and high school youth purposively or conveniently selected for their views on knowledge and perceptions on the complications associated with FGM/C, the various mechanisms used by stakeholders in alleviating FGM/C complications and the reasons for the perpetuation of the practice despite the associated complications. Key informant interviews targetted circumcisers, religious leaders, individuals leading initiatives against FGM/C (NGOs/CBOs).

Data collection exercise was presided over by the principal investigator herself with the help of 2 research assistants specifically recruited and trained on data collection in the local Somali dialect. The research assistants obtained the participant's consent before enrolment into the study, administered the study tools and cleaned the data collected from the field.

3.8 Data Processing and Analysis

Files Back-up was done daily throughout the data collection, cleaning and coding period to avoid any loss or tampering. Data cleaning was performed to achieve a clean dataset which was exported into a Statistical Package format (IBM SPSS Version 22) for analysis. Descriptive analysis of the quantitative data was conducted and the findings presented using frequency tables, charts and bar graphs. Bivariate and regression analyses were carried out to

determine the associations between various variables in the study; associations were tested using chi-square tests.

For the qualitative survey, the voices captured in the KIIs and FGDs were transcribed and the information translated into English before coding into word processors. The information was coded and then systematically organized into relevant sub-themes. The coding framework was developed based on the study guide and from reading the interviews and FGD translations from the respondents. The primary data was managed using QSR Nvivo 10 Software © (International Pty 2012, Australia).

3.9 Validity and Reliability

The study started by making necessary arrangements including pre-testing data collection instruments, training of research assistant, and arrangement of appointments to ensure reliability of the responses from the participants. Validity was ensured through triangulation of the results from both qualitative and quantitative surveys. Data collection plan ensured that mobilization for and data collection for both quantitative and qualitative interviews were conducted concurrently to ensure that respondents for the survey and the participants for FGDs and Key informants interviewed were not the same. This was to harness diverse opinions to enrich the study findings.

3.10 Implementation and Ethical Issues

Prior to commencing the study, the study proposal was presented for approval and authority by Kenyatta National Hospital and University of Nairobi Research Ethics Committee.

Before the interviews, each participant was briefed on the nature of the study and provided with the necessary instructions. The researcher and her assistants randomly approached the members of the community in the household in the targeted area of the study, introduced themselves, explained the background and the aim of the study and where a participant

agreed to be involved in the study, and sought consent by issuing the informed consent form.

The informed consent form contained the title of the study, the institution, identity of the researcher and supervisors, the purpose and procedure of the study as well as the assurance of the voluntariness of the study with the option of withdrawing participation at any point in the study without losing any benefits they are entitled to. It was also clarified that the benefits of the study would be to add to the pool of knowledge that would help guide policy making aimed at bolstering efforts towards abandonment of FGM/C practice among the Somali community. Also, no individual benefit would accrue from participating in the study. Participants were assured of the confidentiality of the information collected. This was through an undertaking on the part of the researcher and her team to abide by the local and international laws and protocols governing research. The researcher then requested for individual consent – which were available both in English and Somali - from each subject prior to carrying out the interview. This consent was written. The researcher used coded serial numbers on each questionnaire without names to ensure confidentiality. There was no case encountered that required referral.

CHAPTER FOUR: RESEARCH FINDINGS

4.0 Introduction.

This chapter shows the findings from the study. It is from these findings that discussions and conclusion were made regarding knowledge and perceptions of complications associated with female genital mutilation/cutting and the reasons for the persistence of the practice among Somali community in Wagberi area in Wajir County. In total, 240 men and women meeting the selection criteria were interviewed in the survey while, a total of 45 participants from 6 FGDs and 14 key informant interviews with various stakeholders comprised the qualitative study sample.

4.1 Study Findings

4.1.1 Socio Demographic factors associated with the Somali community in Wajir County, Kenya.

Among the 240 participants interviewed, majority (75%) were female. By age, majority (70.8%) were aged between 18 and 34 years while by marital status, majority (67.1%) were married. Almost all the participants were Muslims (99.6%). Close to 52% of the participants had gone to school though a considerable number (47.9%) of participants had no formal education. Majority (69.9%) of them lived in rural settlements. Home keepers who took care of their families without employment comprised 61 percent. Most of those employed were in formal employment (12.1%) followed by business and livestock raring at 9.6% each as is shown in table 1 below. The participant had on average 3 to 4 children with the highest being 12 children.

Table 1: Socio Demographic characteristics of the participants (n= 240)

Socio Demographic Characteristic:	Participants (n)	Proportion (%)
Sex:		
Male	60	25.0
Female	180	75.0
Age Groups (years):		
18-24	72	30.0
25-34	98	40.8
35-44	67	27.9
45+	3	1.3
Marital status:		
Single	65	27.1
Married	161	67.1
Widowed	10	4.2
Divorced	4	1.7
Religion:		
Islam	239	99.6
Protestant	1	.4
Highest level of education:		
None	115	47.9
Primary (incomplete)	44	18.3
Primary (Complete)	22	9.2
Secondary (incomplete)	8	3.3
Secondary (Complete)	25	10.4
College Diploma	14	5.8
University Degree	1	.4
Informal Education (madrassa)	11	4.6
State of resident:		
Urban	31	12.9
Rural Settlement	167	69.6
Peri – Urban	42	17.5
Occupation		
None	5	2.1
Formal Employment	29	12.1
Take care of family at home	147	61.3
Business Enterprise	23	9.6
Livestock Rearing	23	9.6
Others (specify)	13	5.4

4.1.2 Level of knowledge and perceptions of FGM/C complications among the Somali women in Wajir County, Kenya.

All the women sampled confirmed having undergone FGM/C as young girls with 55% of them having under gone type III and the other 45% type II of FGM/C as shown in figure 2 below. A probe on the description of the nature of cut made was used by the research team (who were already trained on the WHO classification of FGM/C) to classify the type of FGM/C that the respondents had undergone.

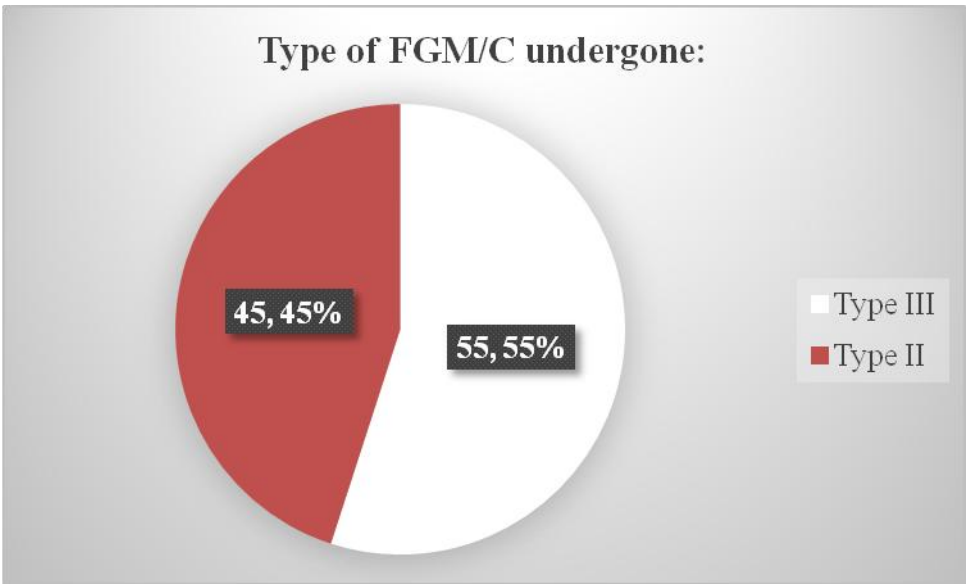

Figure 2: Type of FGM/C reported among women and girls (n=180)

For the 180 respondents who had undergone either type II or Type III FGM/C, 89% had been forced to undergo FGM/C, while for the remaining 11% they had faced it by choice. Among the 160 respondents who did not undergo the practice by choice 98.7% had the decision made for them by their parents while the other 1.3% had that choice made by their guardian as figure 3 below shows.

Table 2: Decision maker over FGM/C Practice (n=160)

Respondents were asked who decided over FGM/C:	**Respondents (n)**	**Proportion (%)**
Parent	158	98.7
Guardian	2	1.3

All the 240 respondents confirmed having knowledge of FGM/C. Based on this knowledge, 84.2% felt that FGM/C was necessary, 6.3% felt that it was not necessary while 9.6% were not sure whether FGM/C was necessary (figure 3).

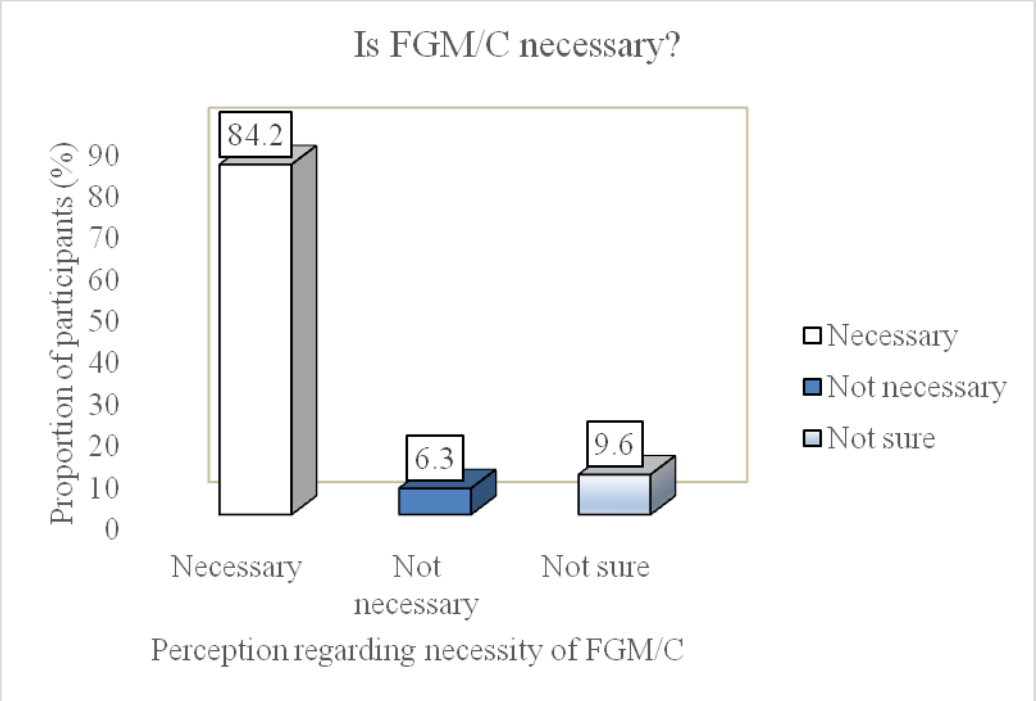

Figure 3: Respondents' opinion on the necessity of FGM/C (n=240)

The findings revealed that perception regarding whether FGM/C was necessary was significantly associated with the level of education (χ^2 (14) = 30.303, P=0.007), the status of the settlement area (χ^2 (4) = 50.827, P=0.000) and occupation (χ^2 (10) = 53.490, P=0.000). Most of the participants with no formal education had the perception that FGM/C in this

community was necessary same with participants from rural areas and home makers as table 3 below shows.

Table 3: Socio demographic determinants of perceptions related to FGM/C necessity

Socio Demographic Characteristics:	Is FGM/C necessary?			
	Yes	No	Not sure	Significance Test:
Highest level of education attained:				
None	50.5% (102)	33.3% (5)	34.8% (8)	χ^2 (14) = 30.303, P=0.007
Primary (incomplete)	19.3% (39)	13.3% (2)	13.0% (3)	
Primary (Complete)	8.4% (17)	6.7% (1)	17.4% (4)	
Secondary (incomplete)	3.05 (6)	6.7% (1)	4.3% (1)	
Secondary (Complete)	9.9% (20)	13.3% (2)	13.0% (3)	
College Diploma	5.0% (10)	20.0% (3)	4.3% (1)	
University Degree	0.0% (0)	6.7% (1)	0.0% (0)	
Informal Education (madrassa)	4.0% (8)	0.0% (0)	13.0% (3)	
State of resident:				
Urban	11.4% (23)	46.7% (7)	4.3% (1)	χ^2 (4) = 50.827, P=0.000
Rural Settlement	76.2% (154)	33.3% (5)	34.8% (8)	
Peri – Urban	12.4% (25)	20.0% (3)	60.9% (14)	
Occupation				
None	2.5% (5)	0.0% (0)	0.0% (0)	χ^2 (10) = 53.490, P=0.000
Formal Employment	9.9% (20)	53.3% (8)	4.3% (1)	
Take care of family at home	65.3% (132)	20.0% (3)	52.2% (12)	
Business Enterprise	10.4% (21)	6.7% (1)	4.3% (1)	
Livestock Raring	9.4% (19)	6.7% (1)	13.0% (3)	
Others (specify)	2.5% (5)	13.3% (2)	26.1% (6)	

From the logistic regression model on socio demographic characteristics and perception of members of the Somali community regarding the necessity of FGM/C, members of the Somali community living in peri – urban areas of Wajir were 9.36 (3.58 – 24.48) times more likely to think of FGM/C as a necessary practice compared to those in urban areas as table 4 shows.

Table 4: Socio demographic determinants of perceptions on the necessity of FGM/C practice among members of the Somali Community

Perception of Necessity of FGM/C:	P-value	OR	OR (95% CI)	
			Lower	Upper
Occupation:				
None	0.52			
Formal Employment	0.65	0.73	0.19	2.82
Business Enterprise	0.28	0.37	0.06	2.28
Agriculture	0.71	1.46	0.2	10.54
Highest Level of Education:				
No formal	0.77			
At Most primary	0.73	0.77	0.17	3.45
At most secondary	0.58	0.64	0.13	3.11
Post – Secondary	0.71	1.31	0.31	5.65
State of resident:				
Urban	0.00			
Rural	0.12	2.58	0.79	8.44
Peri-Urban	0.00	9.36	3.58	24.48

In addition to this, 94.2% of the participants were aware of the reasons why FGM/C was being practiced among the members of the community with the remaining 5.8% not aware of these reasons. Among the 226 who were aware of the reasons for FGM/C, the most common (99.1%) reasons were that FGM/C is a cultural/ traditional practice a religious practice (96.0%,), a rite of passage (81.4%) and a sign of purity on the part of the girl (80.5%) among other reasons as listed in table 5 below.

Table 5: Main reasons for the FGM/C practice among the Somali Community (n=226)

Main reasons why FGM/C is practiced among the Somali Community:	**Participants (n)**	**Proportion (%)**
Cultural/traditional practice:	224	99.1
Religious practice:	217	96.0
Rite of passage:	184	81.4
Ensures purity of the woman:	182	80.5
Ensures Marriage:	170	75.2
Improves fertility:	111	49.1
Father/husband insists:	95	42.0
Maintains honor/ virginity:	54	23.9
Other reasons:	28	12.4
Older women insist:	22	9.7

As for awareness of the reasons why FGM/C is practiced in the community, significant relationship was noted for sex (χ^2 (1) = 4.332, P=0.037) where most of the female compared to males were established to be aware of the reasons why the practice was conducted among the Somali Community. Also, noted to be significantly associated with reasons for the practice of the FGM/C in this community were marital status (χ^2 (3) = 8.055, p=0.045) and level of education (χ^2 (7) = 22.472, p=0.002). Participants who were married and those with no formal education were more aware of the reasons why FGM/C was practiced in the community as table 6 below shows.

Table 6: Socio demographic factors and awareness of the reasons for FGM/C

Socio Demographic Characteristics:	Aware of reasons why FGM/C is practiced in the community?		
	Yes	**No**	**Significance test**
Sex:			
Male	24.8% (56)	50.0% (7)	χ^2 (1) = 4.332, P=0.037
Female	75.2% (170)	50.0% (7)	
Marital status:			
Single	25.7% (58)	50.0% (7)	
Married	69.0% (156)	35.7% (5)	χ^2 (3) = 8.055, P=0.045
Widowed	4.0% (9)	7.1% (1)	
Divorced	1.3% (3)	7.1% (1)	
Highest level of education attained:			
None	47.8% (108)	50.0% (7)	
Primary (incomplete)	18.6% (42)	14.3% (2)	
Primary (Complete)	8.4% (19)	21.4% (3)	
Secondary (incomplete)	3.1% (7)	7.1% (1)	χ^2 (7) = 22.472, P=0.002
Secondary (Complete)	11.1% (25)	0.0% (0)	
College Diploma	6.2% (14)	0.0% (0)	
University Degree	0.0% (0)	7.1% (1)	
Informal Education (madrassa)	4.9% (11)	0.0% (0)	

From the KII and FGDs, the main reasons for the persistence of the practice include- lack of political good will in the fight against the practice: even political leaders secretly taking their girls for the FGM/C. The fact that this practice is considered highly among the members of the community makes enforcing laws against it difficult since engaging in public fight against it has a political consequence and so even those who don't approve of it, don't want to come out in public with pronouncement against it for fear of being political victims. There is also peer pressure among girls - from their peers who have undergone the practice - to undergo FGM/C. Those who have not undergone the practice for fear of being left out and looking socially 'out of place' then pile pressure on their parents – some who may not want to have their girls undergo the practice – to take them through it.

*"There are no campaigns and they even fear approaching us**….** they will not go anywhere and they should leave us alone… if you are to conduct FGM, do the severe way because if you cut only some parts of it, it is like you have done nothing at all".* ***KII Male MCA***

"Even those who have not been cut and their parents feel they won't do it, the girl tells them the other girls look lovely to them and they should undergo the same just like them…So they just do it to please their girls, you know the children come together and lie in the same area so they learn their friends have been circumcised which increases their desire to be circumcised, and they ask each other about the experience they had and if one is not circumcised, she feels ashamed of herself." ***KII with High School teacher***

There was however a widespread misconception among participants in both FGDs and KIIs that FGM/C is a religious practice among the Muslims. This was in fact given as one of the reasons for its persistence. They believe that Islam seeks for girls to undergo the practice to reduce the sexual desires of young girls that may lead them to commit sexual sin before they are married. Type III FGM/C is however a cultural practice among the Somali community and so maintaining it is up holding the community's culture. However majority still held the believe that type III is a religious practice as the following excerpts confirm

"…we practice it because of our religion and tradition as a Somali community obligates us to do so…. we only do what our religion allows us and both our religion and tradition allow circumcision…" ***FGD with Middle aged Child bearing women***

Of the 240 respondents, 97.1% confirmed having knowledge of the types of FGM/C practiced in the area. None of the participants who knew an FGM/C type mentioned type I. Type II FGM/C was however mentioned by 59.7% among those who knew the types of FGM/C practiced in the area, while 54.9% knew type III FGM/C as table 7 below shows.

Table 7: FGM/C types practiced by the Somali Community (n=233)

FGM/C Type practiced among the Somali Community:	**Participants (n)**	**Proportion (%)**
Type I:	0	0.0
Type II:	139	59.7
Type III:	128	54.9
Type IV:	0	0.0

This was further confirmed by the qualitative survey wherein majority of the participants agreed that the Somali community mainly practiced Type II and Type III with the most common being type III. In the context of religion, most of the participants agreed that Type II (sunni type) FGM/C was allowed and practiced. Type II FGM/C involves the total or partial removal of the clitoris and labia minora and is believed not be associated with major complications like type III of FGM/C that involves the cutting away of the entire clitoris (a sensitive, small and erectile part of female genitalia) and labia minora (small lips surrounding the female vagina) and slicing of labia majora with the raw surfaces either stitched together or sealed.

"About 80 percent and beyond did the total removal of the whole organ and of late a small percentage practice sunni type (Type ll). The sunni type heals very fast even in 10 days or a week…" ***KII with High school teacher.***

From the quantitative study, 85.4% of all the respondents were aware of the possible complications that can occur during and after FGM/C. The other 14.6% did not know any complications (figure 4).

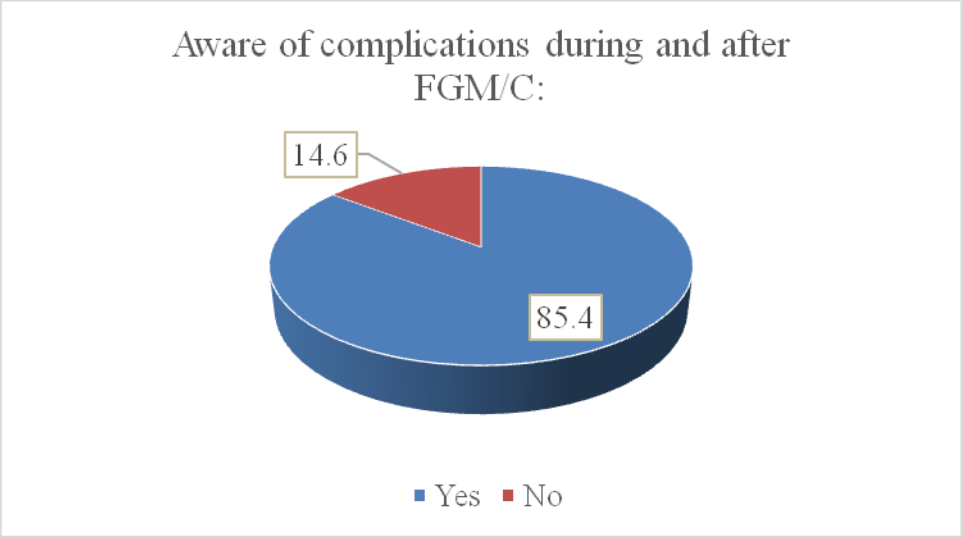

Figure 4: Proportion of participants aware of possible complications during and after FGMC (n=240)

Among the 205 respondents aware of the potential complications during and after FGM/C, the most common complication was related to the genital organ (87.3%) followed by complications during child delivery (80.5%), complications related to sexual activities in marriage (63.9%) and finally, pregnancy related complications (39.0%) (Table 8).

Table 8: FGM/C related complications known by the locals (n=205)

FGM/C related complications Known:	**Participants (n)**	**Proportion (%)**
Complications related to genital organ:	179	87.3
Complications related to sexual activities in marriage:	131	63.9
Complications related to pregnancy:	80	39.0
Complications related to child delivery:	165	80.5

Awareness of the complications during and after FGM/C was significantly related to the sex of the participants (χ^2 (1) = 4.002, P=0.045), their marital status (χ^2 (3) = 8.810, P=0.032) and status of the settlement area where they lived (χ^2 (2) = 9.476, P=0.009). More female participants were aware of the complications during and after FGM/C compared to males in the study. More married women were aware of the complications during and after FGM/C

compared to those who were single, widowed or divorced and finally, most of those who were aware of the complications during and after FGM/C came from the rural areas of the study area (table 9).

Table 9: Socio demographic determinants of awareness of the complications during and after FGM/C

Socio Demographic Characteristics:	**Aware of complications during and after FGM/C:**		
	Yes	**No**	**Significance Test:**
Sex:			
Male	23.9% (49)	40.0% (14)	χ^2 (1) = 4.002, P=0.045
Female	76.1% (156)	60.0% (21)	
Marital status:			
Single	24.4% (50)	42.9% (15)	χ^2 (3) = 8.810, P=0.032
Married	70.7% (145)	45.7% (16)	
Widowed	3.4% (7)	8.6% (3)	
Divorced	1.5% (3)	2.9% (1)	
State of resident:			
Urban	14.1% (29)	5.7% (2)	χ^2 (2) = 9.476, P=0.009
Rural Settlement	65.9% (135)	91.4% (32)	
Peri – Urban	20.0% (41)	2.9% (1)	

Logistic regression of the socio demographic determinants of awareness of the complications during and after FGM/C revealed that those who had ever married or were married were 2.764 (1.166 – 6.555) times more likely to be aware of the resulting complications from an FGM/C practice compared to those who are single among members of the Somali Community. Those in the peri-urban areas were 14.034 (1.805 - 109.081) times more likely aware of the resulting complications during and after FGM/C compared to those residing in urban areas as table 10 shows.

Table 10: Socio demographic determinants of awareness of the complications during and after FGM/C among members of the Somali Community

Awareness of the complications during and after FGM/C:	P-value	OR	OR (95% CI)	
			Lower	Upper
Sex:				
Male				
Female	0.09	0.48	0.2	1.13
Marital Status:				
Single				
Ever Married	0.02	2.764	1.166	6.555
State of resident:				
Urban	0.00			
Rural	0.51	2.313	.195	27.399
Peri-Urban	0.01	14.034	1.805	109.081

These findings were like what was established from the participants in the qualitative study where majority agreed that the most common complication during FGM/C and immediately after was excessive bleeding that may lead to death followed by difficulties, pain and discomfort during coitus for the man and the woman. Complications during child birth mostly necessitated subsequent episiotomies for all births and prolonged labor. Menstrual problems, infections during and after sexual encounter and urinary retention among the women who had undergone the practice were the associated complications per these participants. FGM/C also has psychological effect which lowers the self – esteem of its victims. These complications per the participants are varied in severity and the type of FGM/C. The physical and more severe ones are mainly associated with type 3 of FGM/C.

"As per the two types [of FGM/C], only one has complications and that is the fir -aun one which leads to many complications even when the girl is being circumcised, she faces a lot of problems while giving birth or even her first night of having sex with her husband, just because if girl will go to hospital since her thing is so small and she will need to be wide a bit, but the one does not have any complication… it also leads to abdominal pain during her

menstruation and also complication occur during the time when the girl is giving birth and this complications…." ***A participant in FGD with Middle Aged Child bearing women***

From the quantitative survey, 59.2% of all the respondents interviewed believed the community did not associate the complications above to FGM/C, instead considering them as results of: bad luck or illness (97.9%), breach of cultural beliefs (78.2%) breach of religious requirements (76.1%), a of negligence on the part of the circumciser but not because of the cut itself (67.6%) and a social taboo (62.7%) among others (table 11).

Table 11: Community perception towards FGM/C related complications among the locals (n=142)

Community perception towards FGM/C related complications:	**Participants (n)**	**Proportion (%)**
Sign of bad luck/illness:	139	97.9
Sign of breach of cultural beliefs:	111	78.2
Sign of breach of religious requirements:	108	76.1
Sign of negligence of the circumciser:	96	67.6
Social taboo:	89	62.7
Normal acts of God:	55	38.7
Sign of cowardice on the part of the girl:	44	31.0
Rite of passage:	24	16.9

The perceptions of whether the community associated the complications experienced with FGM/C were significantly related to marital status (χ^2 (6) = 13.973, P=0.030), highest level of education attained (χ^2 (14) = 32.494, P=0.003), status of the settlement area from where the participant came from (χ^2 (4) = 67.056, P=0.000) and their occupation (χ^2 (10) = 51.140, P=0.000). Most of the participants with the perception that the community associated the complications with the FGM/C itself were those married, with no formal education, those from rural settlements and homemakers (table 12).

Table 12: Socio Demographic Characteristics and perceptions associated with complications of FGM/C

Socio Demographic Characteristics:	Does the community associate complications with FGM/C?			
	Yes	No	Not sure	
Marital status:				
Single	31.6% (31)	20.2% (22)	36.4% (12)	χ^2 (6) = 13.973, P=0.030
Married	58.2% (57)	77.1% (84)	60.6% (20)	
Widowed	8.2% (8)	0.9% (1)	3.0% (1)	
Divorced	2.0% (2)	1.8% (2)	0.0% (0)	
Highest level of education attained:				
None	44.9% (44)	56.0% (61)	30.3% (10)	χ^2 (14) = 32.494, P=0.003
Primary (incomplete)	23.5% (23)	12.8% (14)	21.2% (7)	
Primary (Complete)	9.2% (9)	11.0% (12)	3.0% (1)	
Secondary (incomplete)	3.1% (3)	1.8% (2)	9.1% (3)	
Secondary (Complete)	11.2% (11)	9.2% (10)	4	
College Diploma	0.0% (0)	8.3% (9)	15.2% (5)	
University Degree	1.0% (1)	0.0% (0)	0.0% (0)	
Informal Education (madrassa)	7.1% (7)	0.9% (1)	9.1% (3)	
State of resident:				
Urban	14.3% (14)	14.7% (16)	3.0% (1)	χ^2 (4) = 67.056, P=0.000
Rural Settlement	80.6% (79)	71.6% (78)	30.3% (10)	
Peri – Urban	5.1% (5)	13.8% (15)	66.7% (22)	
Occupation				
None	4.1% (4)	0.9% (1)	0.0% (0)	χ^2 (10) = 51.140, P=0.000
Formal Employment	7.1% (7)	15.6% (17)	15.2% (5)	
Take care of family at home	69.4% (68)	60.6% (66)	39.4% (13)	
Business Enterprise	11.2% (11)	11.0% (12)	0.0% (0)	
Livestock Raring	7.1% (7)	9.2% (10)	18.2% (6)	
Others (specify)	1.0% (1)	2.8% (3)	27.3% (9)	

Logistic regression of the socio economic determinants of perception of community regarding complications associated with FGM/C revealed that only the odds of perception of community regarding complications was significant for settlement area and highest level of education. Those residing in rural and in peri-urban areas were 8.8 times and 6.7 times more likely to perceive complications during and after FGM/C as associated with the actual practice of genital cutting compared to those in urban areas respectively. By highest level of education, those who had reached secondary education irrespective of whether they completed or not were 9.7 times more likely while those who had completed and proceeded

to tertiary colleges were 9.9 times more likely to perceive complications during and after FGM/C as associated with the actual practice of genital cutting compared to those who had not attended school at all as table 13 shows.

Table 13: Socio demographic determinants of perception of complications associated with FGM/C among members of the Somali Community

Perceptions of community of complications associated with FGM/C:	**P-value**	**OR**	**OR (95% CI)**	
			Lower	**Upper**
Marital Status:				
Single				
Ever Married	0.06	2.04	0.98	4.22
State of resident:				
Urban	0.00			
Rural	0.00	8.76	2.24	34.17
Peri-Urban	0.00	6.7	2.29	19.58
Occupation:				
None	0.47			
Formal Employment	0.64	1.28	0.46	3.53
Business Enterprise	0.38	0.49	0.1	2.4
Agriculture	0.78	1.21	0.32	4.63
Highest Level of Education:				
No formal	0.15			
At Most primary	0.10	6.65	0.69	63.87
At most secondary	0.05	9.67	0.99	94.46
Post – Secondary	0.05	9.9	1.05	93.08

The general perception of the community from the qualitative study regarding the complications experienced during and after FGM/C is that they are normal occurrences. For these participants, complications are the will of God implying lack of human hand in the complications experienced during and after FGM/C and so they cannot be dissuaded to abandon the practice.

It's normal thing nothing happened to our girls and as a community it is a practice we found our forefathers doing it and incase of anything we know it is the will of GOD." ***KII with male MCA***

Participants in the key informant interviews, however, differed with the notion that complications experienced during FGM/C were not related to the act itself. According to the health care providers interviewed, complications were caused by improper FGM/C procedures making the wound not to heal and the girl not cooperating during the process of cutting further pointing to the practice and its related complications being looked at subjectively by majority of the members of the community in the area. The resulting complications during or after FGM/C were directly associated with the procedure and handling of the victims than the will of God. More specifically, complications such as Fistula resulted in other conditions such as psychological trauma and spread of HIV in case of shared equipment. Sharing of equipment in such cases is not clinically acceptable.

"Like the growth which develops from the cutting, some people reach on the thing that is used in cutting the girl e.g. the instrument if they have shared there is risk of HIV AIDs infection" ***KII, Nurse, Wajir District Hospital***

When the 240 respondents were asked whether they knew some of the interventions that were applied to prevent or manage complications associated with FGM/C, only 32.1% of the respondents in the survey knew what was done in case of complications during or after FGM/C compared to 67.9% who did not know. Most of 77 respondents who were aware mentioned confinement of the victim to one place with legs tied together to prevent further bleeding and injuries (67.5%), application of malmal to the genitalia to arrest excessive bleeding (24.7%) same as application of tea leaves on the wound to arrest excessive bleeding (11.7%) among others as shown in table 14. In cases of complications the family members especially the grandmothers took charge (75.1%). Also involved were mothers, the circumciser, doctors in health facilities in situations where the victim experienced

complication and required specialized treatment. These people helped the victim get access to appropriate healthcare services.

Table 14: Interventions in case of FGM/C complications (n=77)

Intervention:	**Participants (n)**	**Proportion (%)**
Confined with legs tied together to prevent further bleeding and injuries	52	67.5
Applying malmal to stop bleeding	19	24.7
Application of tea leaves	9	11.7
Sit on burnt charcoal	9	11.7
Egg and white flour applied	5	6.5
Use of sterilized equipment	4	5.2
Opening of newly married	3	3.9
Minimize movement	4	5.2
Application of rabbit feces	4	5.2
Victim taken to hospital	4	5.2
Criminalizing FGM/C	4	5.2
Preaching against FGM/C	4	5.2

Significantly associated with awareness of interventions applied to prevent or manage complications due to FGM/C included the status of the settlement area from where the participants lived (χ^2 (2) = 27.962, P=0.000) as well as the occupation of the participants (χ^2 (5) = 13.498, P=0.019). Participants from rural settlement areas of the study area were more aware of the local interventions in case of complications during FGM/C compared to those from urban and peri-urban areas just like home makers were more aware of these interventions compared to those who were not employed, those in formal employment, those in business and those raring livestock from around the area as table 15 shows.

Table 15: Socio Demographic factors and awareness of FGM/C interventions during complications

Socio Demographic Characteristics:	Aware of interventions applied to prevent or manage complications:		
	Yes	**No**	
State of resident:			
Urban	10.4% (8)	14.1% (23)	χ^2 (2) = 27.962, P=0.000
Rural Settlement	53.2% (41)	77.3% (126)	
Peri – Urban	36.4% (28)	8.6% (14)	
Occupation			
None	1.3% (1)	2.5% (4)	χ^2 (5) = 13.498, P=0.019
Formal Employment	16.6% (13)	9.8% (16)	
Take care of family at home	50.6% (39)	66.3% (108)	
Business Enterprise	6.5% (5)	11.0% (18)	
Livestock Raring	14.3% (11)	7.4% (12)	
Others (specify)	10.4% (8)	3.1% (5)	

The logistic regression analysis of the association between socio demographic characteristics and awareness of the interventions applied to prevent or manage complications related to FGM/C among members of the Somali community established that the odds were significant for marital status and settlement area of the respondents interviewed in the study. Those who had ever married or ever been married were 2.76 (1.166 – 6.555) times more likely aware of the interventions that are applied to manage complications related to FGM/C compared to those who were single. The inhabitants of peri urban areas compared to those in urban areas where 14.034 (1.805 – 109.081) times more likely aware of the interventions that are applied to manage complications related to FGM/C as table 16 below shows.

Table 16: Socio demographic determinants of awareness of the intervention applied to prevent or manage complications related to FGM/C

Awareness of the complications during and after FGM/C:	P-value	OR	OR (95% CI)	
			Lower	Upper
Sex:				
Male				
Female	0.09	0.48	0.2	1.13
Marital Status:				
Single				
Ever Married	0.02	2.764	1.166	6.555
State of resident:				
Urban	0.00			
Rural	0.51	2.313	.195	27.399
Peri-Urban	0.01	14.034	1.805	109.081

From the FGDs with male youth, there was lack of awareness on the proper intervention strategies when complications occurred during FGM/C. Generally, women including mothers, the circumcisers, grandmothers and mothers in law intervened in case of complications. Doctors intervened when they were taken to hospital though there was currently fear among the perpetrators of taking the victims to the doctors for fear of getting arrested; a situation which per participants, made taking the girls to hospital in case of complications a challenging task and which proved even riskier for the girls during FGM/C.

"Nowadays we are afraid of the doctors because if we expose the complications we can be arrested." ***FGD with Old Women***

From the quantitative study, 69.6% of the 240 participants confirmed that men were not aware of the extent to which the complications because of FGM/C affected their wives and daughters while 19.6% were aware of this and 10.8% not sure about the effect of the complications related to FGM/C on their wives and daughters as figure 5 shows.

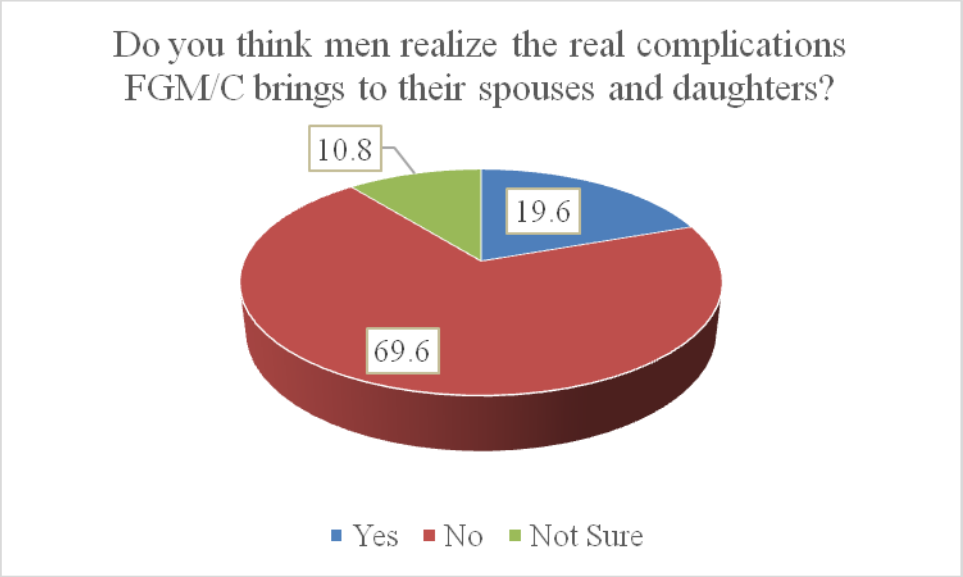

Figure 5: Perception on men's understanding of the real complications FGM/C to spouses and daughters (n=240)

Of all the 240 respondents interviewed, 32% confirmed knowledge of complications that emerge during complications. These include: excessive bleeding and pain (35.1%) among the 77 with knowledge of complications, excessive pain and difficulty during sex (28.6%) and difficulty during the delivery of the spouse (15.6%). The other additional complications included infections after sexual encounter (9.1%), reduced sexual desire (7.8%) and additional costs of seeking healthcare as table 17 below shows.

Table 17: Complications related to FGM/C affecting men (n=77)

Complications affecting men:	**Participants (n)**	**Proportion (%)**
Additional cost of seeking healthcare	2	2.6
Difficult during delivery	12	15.6
Excessive bleeding and pain	27	35.1
Excessive pain and difficulty during sex	22	28.6
Infection	7	9.1
Reduced sexual desire by woman	6	7.8

Complications related to FGM/C attracted additional costs for seeking healthcare which was strenuous for most of them. These costs could be avoided by preventing the practice of FGM/C among girls and their spouses according to 39.7% of the 68 participants who felt that the complications of the FGM/C among girls and women affected men. According to 26.5% of the participants, some of the challenges these women faced was low self-esteem among their (husbands) considering the difficulties they (women) undergo later in their lives. These complications also resulted in pain during sex because of swollen penis (10.3%) and by extension stressful sexual encounter (10.3%), reduced sexual desire, risk of infections after sexual intercourse, psychological challenges such as trauma as well as stigma as table 18 shows.

Table 18: Effects of complications related to FGM/C (n=68)

How the complications affect men:	**Participant (n)**	**Proportion (%)**
Additional cost of seeking healthcare	27	39.7
Pain during sex due to swollen penis	7	10.3
At risk of infection during sexual intercourse	3	4.4
Low self esteem	18	26.5
Psychological torture	1	1.5
Reduced sexual desire	4	5.9
Stigma	1	1.5
Stressful during sexual encounter	7	10.3

4.1.3 Intervention levels by various stakeholders to alleviate FGM/C complications

Of the 240 respondents, 72.1% were not aware of any interventions or campaigns against FGM/C in the area. For 24.6% of the respondents, there were interventions or campaigns targeting FGM/C in the area; some 3.3% of the respondents were not sure about as figure 6 shows.

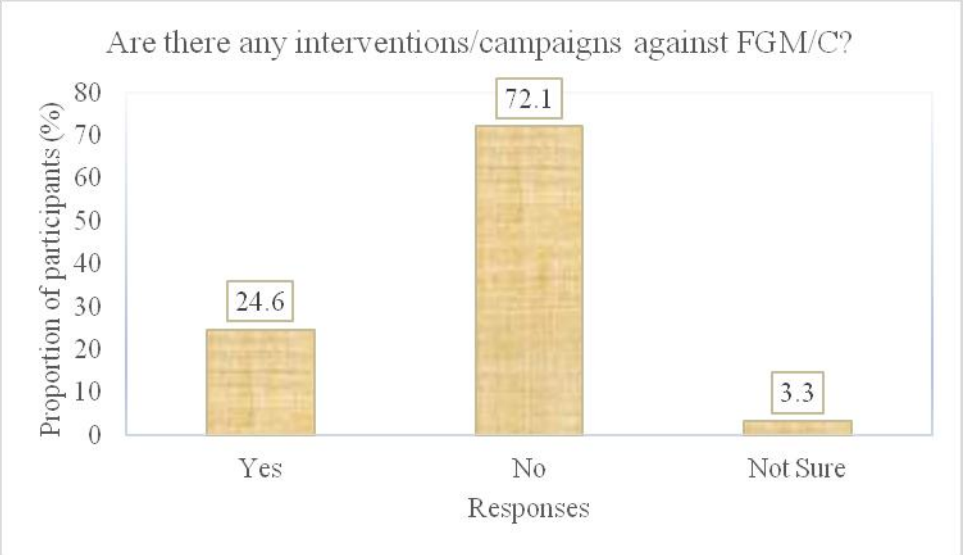

Figure 6: Awareness of the existence of an intervention (n=240)

From the qualitative interviews, the organizations involved in interventions or campaigns against FGM/C NGOs such as World Vision and Save the Children and Human Rights Groups such as Kenya National Commission on Human Rights were the most mentioned organizations involved in interventions and campaigns against FGM/C. This was among other entities such as the area chief, local media – radio, women and gender groups as well as USAID. Each of those involved in these campaigns and interventions focused on a certain area. For human rights organizations, the focus was more in taking up the issue with the law enforcers and taking the victims to the hospital for specialized medical treatment. NGOs mainly focused on awareness creation among the community members on the dangers of FGM/C. This activity was also conducted by local media through local vernacular stations, religious leaders as well as women right groups. Agencies such as USAID focused on supporting other agencies advocating for the abandonment of FGM/C in the area.

For each of these organizations or entities involved in campaigns against the practice, many failures in their efforts had been noted. These included poor follow up which mainly affected the efforts by Human rights groups and NGOs; poor representation in court processes which

mainly affected Human Rights organizations that took up cases for victims to court; lack of accountability on the part of the agencies supported by USAID to campaign against the practice and failure to design proper approaches and strategies to effectively tackle the issue of FGM/C in the area.

The main anti FGM/C campaign mentioned from both KIIs and FGDs was media campaign by use of the local radio stations and sensitization on FGM done by various stakeholders such as NGOs, CBOs, and individuals, political and religious leaders. However, the religious leaders advocate for Type II circumcision over Type III rather than campaigning for eradication of the practice in totality.

"The sheikh says to do it in a Sunnah way but there are no NGOs, who have come." ***FGD with old women***

In addition to this, qualitative study revealed that there was a taskforce on educating the community on FGM Act and complications associated with FGM/C from the office of director of Public prosecution and Anti-FGM board which is in the central government and has not been cascaded down to the counties.

"…. we have gone around Kenya to the various areas to tell people about FGM, we had a taskforce from the office of director of public prosecution. We have been going all around especially last year, we have not started our business here but we have our timetable…" ***KII Wajir Law Prosecutor.***

Among 43 of the participants who had a suggestion on what could be done about the complications experienced by women because of FGM/C, 48.8% of the respondents mentioned engagement of men in the prevention of the practice by refusing to allow their daughter to undergo the practice, participation in campaigns against the practice in the area (44.2%) and reporting the perpetrators to the police (7%) as shown in figure 7.

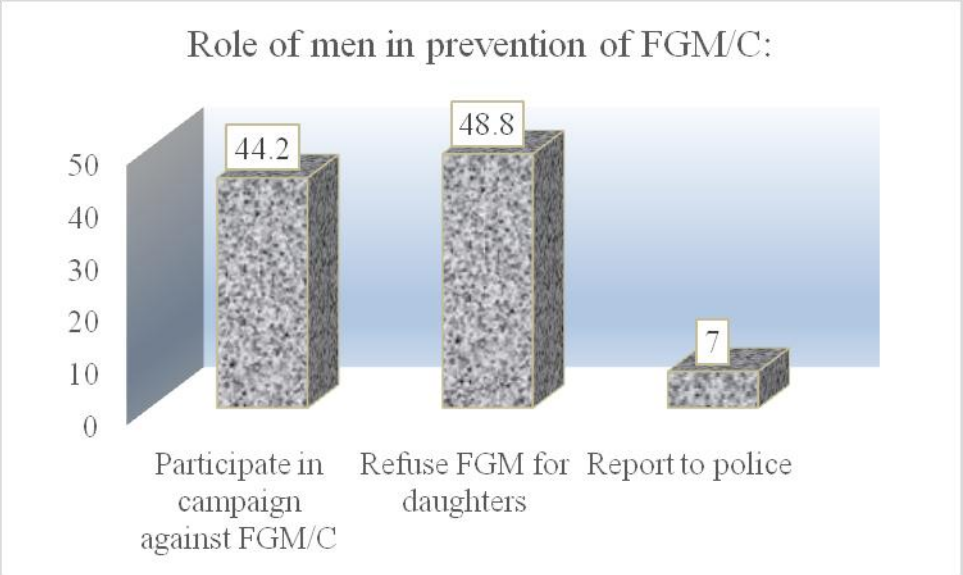

Figure 7: Role of men in FGM/C prevention (n=43)

To most of the participants in the FGDs and KIIs, FGM/C seemed a women's affair and men only stepped in when there was a complication and the girl needed medical attention. However, men as family heads, were involved in the decision of having their daughters undergo FGM/C and hence were critical in this fight against FGM/C. Already some men, including religious leaders, were involved in sensitization of the community on effects of FGM/C:

"Generally, men were not involved in the practice but they did play a role in case of complications like excessive bleeding whereby they put some tea leaves to stop bleeding and they also gave out animals for the victim but of late men referred their daughter to hospital in case of any complications." ***FGD with Male High School Youth***

From the quantitative study, the main reason according to the 235 participants who gave their opinion regarding reasons for persistence of FGM/C among members of the Somali Community was that it was a religious practice (39.6%), a cultural practice (26%) and a rite of passage for 12.3% among other reasons as enumerated in table 19.

Table 19: Reasons for persistence of FGM/C (n=235) among members of the Somali Community

Main reasons for persistence FGM/C:	Participants (n)	Proportion (%)
Cultural/traditional practice:	61	26.0
Religious practice:	93	39.6
Rite of passage:	**5**	**2.1**
Ensures purity of the woman:	25	10.6
Insisted upon by older men and women	9	3.8
Reduces sexual desire	13	5.5
Rite of Passage	**29**	**12.3**

Despite the efforts to eradicate FGM/C there have been some successes and failures in the interventions. Majority of the participants in FGDs and KIIs included reduction of FGM, arrests of some people who subjected their daughters to FGM/C and shifted from the practice of Type III to Type II which was advocated by Islamic religious leaders and was less severe.

"The mother who was doing that FGM was arrested. I took her to police then direct to court. After undergoing a lot of problems and processes in arresting the mother due to our community who were not ready or maybe they were not that much supportive to me arresting the mother… They finished two good years in jail which I believe is a lesson for the rest."

KII Human Rights Activist

These were the same sentiments shared in the KII discussions from where it was revealed that most of the interventions to eradicate FGM in the community have failed mainly because the practice was deeply rooted in the culture of the people hence people feared to address the issue due to hostility in the community and lack of community support. FGM was advocated

by political and religious leaders and the law on FGM was not implemented to the letter and more often there were no arrests for those who circumcised girls. Some NGOs that have funds to address the FGM issue were money oriented and not geared towards fighting FGM and others who wanted to eradicate FGM had the challenge of limited or lack of funding. The Anti-FGM board was also located at the central government and included only women who had undergone FGM locking out other activists who had not undergone the cut.

"There are no campaigns and they even fear approaching us…. in case they [Anti-FGM board activities] are planning to come am telling them that they will not go anywhere and they should stop any campaign in this community and they should leave us alone. We remain with our culture and we are not willing to change even us the leaders. In fact, if you are to conduct FGM, do the severe way because if you cut only some parts of it, it is like you have done nothing at all, I advocate for FGM and people should stay away from us and leave us continue with our practice in peace we don't want our girls to be prostitutes." ***KII Male MCA***

"There are some NGOs who are money minded and use the name FGM to look for funds and I have to also experience the same." ***KII with Male Elder***

4.1.4 Reasons for the continuation of the FGM/C among the Somali community in Wajir County, Kenya.

Finally, when young people aged 18 to 24 years were asked whether they intended to have their daughters undergo FGM/C in the future, it was established that 53.7% of the 54 who answered the question were ready and willing to have their daughters undergo FGM/C in the future. This was higher than the 20.4% and 25.9% who were unwilling to have their daughters undergo the practice in the future and not sure whether they would have their daughters undergo the practice respectively as figure 8 shows.

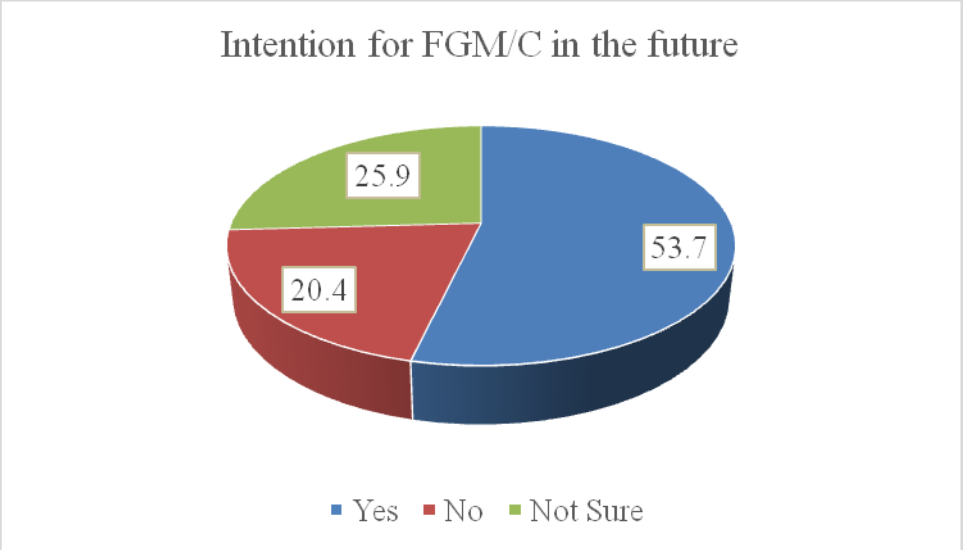

Figure 8: Intention of young people to undergo FGM/C in the future (n=54)

For the 29-young people aged 18 to 24 years old who were willing and ready to have their daughters undergo FGM/C in the future, 96.6% (28) would only have them undergo type 2 as opposed to type 3 FGM/C that only 3.4% (1) of them would allow their daughters to undergo as shown in figure 9 below.

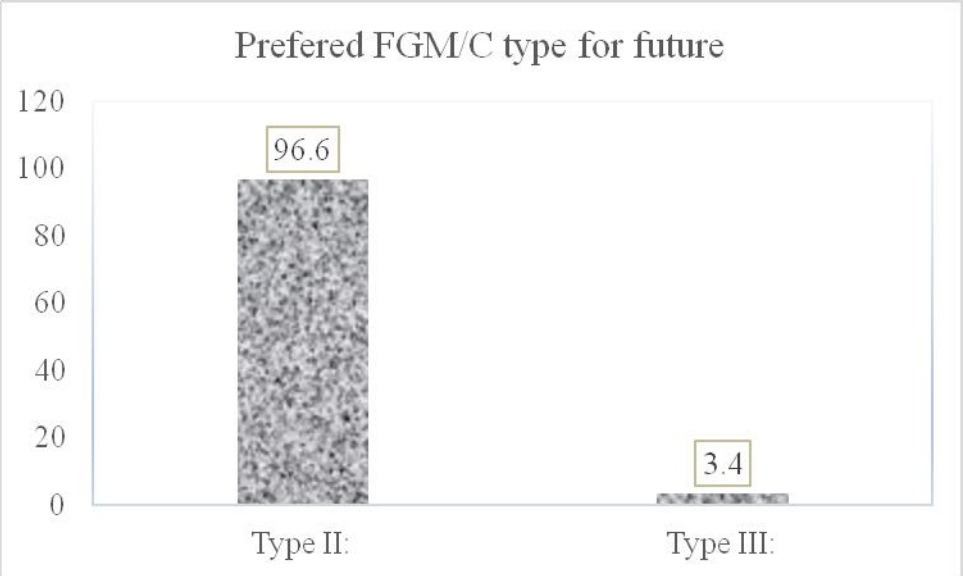

Figure 9: Type of FGM/C preferred for daughters in the future (n=29)

Finally, whether a young person planned to have their daughter undergo FGM/C in the future was significantly related to settlement area, most of the participants from the rural settlement areas were more willing to have their daughters undergo FGM/C in the future compared to those from urban and peri-urban settlement areas. Home makers were more willing compared to those in formal employment, with no employment, in business and in livestock raring to have their daughters undergo FGM/C in the future as table 20 shows.

Table 20: Socio Demographic factors of intention for FGM/C (n=240)

Socio Demographic Characteristics:	**No (n=11)**	**Not Sure (n=14)**	**Significance test:**
Urban	0.0% (0)	28.6% (4)	χ^2 (4) = 20.344, P=0.000
Rural Settlement	36.4% (4)	35.7% (5)	
Peri – Urban	63.6% (7)	35.7% (5)	
None	0.0% (0)	0.0% (0)	χ^2 (10) = 22.216, P=0.014
Formal Employment	18.2% (2)	28.6% (4)	
Take care of family at home	18.2% (2)	42.9% (6)	
Business Enterprise	0.0% (0)	7.1% (1)	
Livestock Raring	18.2% (2)	0.0% (0)	
Others (specify)	45.5% (5)	21.4% (3)	

Logistic regression analysis of the socio demographic determinants of whether one will allow their daughters to undergo FGM/C was established to be associated with settlement area. Those residing in rural areas were 15.41 (1.28 – 185.22) while those in peri – urban areas were about 29 times more likely have their daughters undergo FGM/C in the future respectively as table 21 shows.

Table 21: Socio demographic determinants on whether would allow daughter to undergo FGM/C among members of the Somali Community

Would allow daughter to undergo FGM/C:	P-value	OR	OR (95% CI)	
			Lower	Upper
Occupation:				
None	0.63			
Formal Employment	0.33	2.92	0.34	25.36
Business Enterprise	0.84	1.35	0.07	25.62
Agriculture	0.31	4.63	0.23	91.48
State of resident:				
Urban	0.01			
Rural	0.03	15.41	1.28	185.22
Peri-Urban	0.00	29.04	3.06	275.75

These findings were comparable to the findings in the qualitative study especially the three FGDs conducted among youths, most of them intend to circumcise their daughters as future parents. However, there was a split between the types of FGM that they will let their daughters undergo with most advocating for Type II circumcision which was perceived as having no serious effects compared to Type III circumcision. A few said they will do the Type II for their daughters because it is the culture of their fore fathers while fewer said they will not do it because they have seen the complications associated with it and it has more benefits as was observed from the comments of female high school youth below.

"I will cut her the severe type; I will cut everything because I don't want her to be hyper and follow men. I also believe in what our people used to do and I will follow the footsteps of my great grandparents…Yes but fir-aun method…Yes but fir-aun method" ***FGD with Female High School Youth.***

"*Yes I will cut her but not the severe type (type II) I will do the Sunni type". "No I will not cut her".* ***FGD with Male High School Youth.***

With the consensus being that FGM/C as a practice cannot be abandoned by the members of the Somali community and the preference among most of the participants being that type II of FGM/C should be continued, it was suggested by 58.0% of the participants that awareness creation on the dangers of FGM/C should be continued among the members of the community as well as engagement of the religious leaders in the campaign against FGM/C (46.3%,) among other reasons as enumerated in table 22.

Table 22: Suggestions for FGM/C abandonment (n=240)

Suggestion for abandonment of FGM/C:	**Participants (n)**	**Proportion (%)**
Awareness creation on the dangers of FGM/C should be conducted	139	58.0
Engaging the religious leaders in the campaign against FGM/C	111	46.3
Adopt only type 2 of FGM/C	52	21.7
FGM/C cannot be abandoned because it is a cultural and religious practice	47	19.6
Enforce law against FGM/C	27	11.3
Government should stop interfering with the practice	9	3.7
Support human right groups campaigning against it	8	3.3
In case of complications, one needs to seek health care	1	0.4

More specifically, it was proposed that more effort should be put on awareness creation on the dangers of FGM/C by the CHMT and NGOs in the area as well as talking the religious issues surrounding the practice by the Sheikhs and Imams in the mosques. Finally, human rights groups and healthcare personnel with the help of family members and other NGOs would help the victims to access healthcare in case of complications.

CHAPTER FIVE: DISCUSSION OF STUDY FINDINGS

This study sampled both males and females randomly in Wagberi for quantitative and qualitative surveys on the knowledge and perceptions of FGM/C related complications among the Somali community living in Wajir County. Majority of the people interviewed were females of ages 18 to 35 years, married, Muslims, having gone through at least primary level of education, domiciled in rural settlement and home makers. On average, each of the households from which the respondents came from had between 3 to 4 children reflecting a lower total fertility rate compared to Wajir in the KDHS (2014) which is the highest nationally at 7.8. Knowledge of potential complications during and after FGM/C is more among females compared to males, married compared to single, widowed or divorced and those from the rural areas compared to urban and peri-urban areas. These findings attest to the results related to the prevalence of FGM/C from KDHS 2014 that established that FGM/C prevalence increases with age, is more in North Eastern region, decrease with level of education, more prevalent in rural areas and decreases with wealth quantile.

This study established that knowledge levels regarding complications related to FGM/C is high among the locals reflecting the prevalence of FGM/C in which slightly more than half of all women who have undergone FGM/C having experienced type III FGM/C. Close to half of the women who had undergone FGM/C had experienced the less severe FGM/C type II. These findings reveal that type II of FGM/C which is known as *Sunni/sunna* is slowly gaining popularity in this area suggesting that the community is slowly toning down on the more severe FGM/C practices since the KDHS (2008/09) established that Communities like Somali, Borana, Rendile and Samburu make their women go through infibulation. This could mean that due to the education and religious debates on the dangers of type III in the area, there is some degree of attitude change and a desire to practice type II which is believed to have fewer complications compared to type III. Therefore, education and religious debates

should be strengthened and strategies that argue against the practice in all its types or in totality should be implemented using the correct Islamic teachings since FGM/C has no any authentic basis in Islam.

In this study, women reported experiencing complications related to the genital organ, complications during child delivery complications related to sexual activities in marriage as well as pregnancy related complications. These are mainly in the form of excessive bleeding which in some instances have resulted in death; pain and discomfort during coitus for the man and the woman which have in some instances led to psychological effects that lower self - esteem and loss of sexual desire; menstrual problems, infections during and after sexual encounter with a woman who has undergone FGM/C and urinary retention with each of these complications varying in severity and the type of FGM/C as other studies on complications related to type III and type II FGM/C confirmed. To mention but a few, both types II and III FGM/C are mainly associated with severe pain because of cutting of the nerve ending and sensitive genital tissue (Njue & Askew, 2004, Jaldesa *et al*, 2005) and excessive bleeding (Njue & Askew, 2004, Jaldesa *et al*, 2005, Yirga *et al*, 2012, Jones *et al*, 1999). Other complications include urine retention (Jaldesa *et al*, 2005, Gilbert, 2007, Almroth *et al*, 2005); risk of contracting communicable diseases such as HIV-AIDS and hepatitis B because of the use of non-sterile instrument to perform the procedure among large number of girls at the same time (Njue & Askew, 2004, Yirga *et al*, 2012, Gilbert, 2007); reproductive tract infections (RTIs) due to obstruction of urine (Jaldesa *et al*, (2005), Gilbert, (2007), Morison *et al* (2001); Vesico-vaginal fistula (VVF) which are abnormal passages between the bladder and vagina or recto-vaginal fistula (RVF) or obstructed labor (Jones *et al*, 1999) and delivery related complications that range from narrowing the vaginal opening. Women with such complications may never conceive and if they do, they experience obstructed and prolonged labor which in turn leads to fistula (Gilbert, (2007), WHO, (2006), Jones et al, (1999), soft

tissue obstruction (dystocia) and delayed labor during the second stage, which is usually faster than the first stage of labor (Jones *et al*, (1999), WHO (2006), De Silva, (1989), Njue *et al.*, (2004)), perineal injury and episiotomies during delivery than those who are not cut (WHO (2006), Njue & Askew and increased risk of postpartum hemorrhage among infibulated women compared to uncut women (WHO, (2006)). Despite these hazardous complications and the high level of knowledge regarding FGM/C complications the community still strongly upholds to the practice and do not associate this complications to FGM/C. This shows the strong connection of the community to their culture and unwillingness to fight FGM/C. therefore the awareness interventions should include approaches that will position the community to question their own culture.

Awareness of the complications during and after FGM/C is associated with marital status and settlement area. Those who have ever married or been married are 0.48 times less likely to be unaware of the resulting complications from an FGM/C practice compared to those who are single. This was possibly due to the fact that they were the victims of such complications after being married. While those in rural areas are 6.07 times more likely to be aware of the resulting complications during and after FGM/C compared to those residing in urban areas. This could be possibly due to the fact that most of the cut are done in rural areas. FGM/C is viewed as women issue. Most men are not aware of the extent to which the FGM/C related complications affect their wives and daughters. The discussions with male youth who are the future parents revealed that this youth are totally unaware of the total story that surrounds FGM/C and specifically about the FGM/C complications. This could mean that education on the dangers of FGM only target women leaving out men who if involved and educated can bring change to the society due to their decision making role. However men especially those who are married are aware that FGM/C has a cost element for them especially where complications arise, it affects their sexual life in many ways and has a psychological effect on

their spouses and but continue to facilitate the practice. Some are even not willing to have their daughter circumcised but the women perform it on their daughters without their consent, The money spent on treating the complication that arise as a result of FGM/C can be used to develop the society in more beneficial way. Hence male education on FGM/C and its harmful effects should be consistently strengthened so that they can act as agent of change in their own families and community as a whole. These findings are like what Almroth (2005) found out regarding men who were married to infibulated women. These men acquired complications like skin wounds and bleeding or inflammation of the penis, making sexual penetration difficult. They also experienced psychological problems due to social stigma by women and her family because of failure by the man to penetrate. This was in addition to the cost of frequently seeking medical care due to FGM/C complications.

In cases where in the process of FGM/C a complication arises, several interventions are applied by the perpetrators to the girls facing the knife. These include confinement of the victim to one place with legs tied together to prevent further bleeding and injuries, application of malmal in the genitalia to arrest excessive bleeding, application of tea leaves on the wound to arrest excessive bleeding, traditional herbal medicine to stop bleeding and the victims asked to sit above a hole filled with hot charcoal believed to enhance healing. It is the family members of the girls, especially grandmothers and mothers, taking the responsibility over these activities. In cases of complications, the circumcisers and health care workers also get engaged to provide the necessary medical attention. The community still relies on harmful traditional method to prevent FGM/C complications. This method are even riskier to the girls in the sense that it increases the degree of physical pain, psychological torture and also the severity of complications experienced later in life. Introduction of the anti FGM/C law into the law has also brought about its challenges. A few who used to take their daughters to hospital when a complication occurs are now hesitant for fear of arrest. Fear of

arrest has also led to the practice to go underground. The principal investigator herself witnessed four deaths both in the hospital and village and these deaths are reported to be due to delay in seeking health care for fear of arrest. Therefore the community should be educated on the dangers of these traditional methods and encouraged to abandon the practice and rush the affected to the health facility once a complication is suspected in order to get the necessary medical attention. Settlement area is associated with awareness of the interventions applied to prevent or manage complications related to FGM/C. Those residing in peri urban areas are 0.13 times less likely to be aware of the interventions that are applied to manage complications related to FGM/C compared to those in the urban areas. This could be due to the fact that most of the cut are usually done in rural and peri-urban areas.

Despite these reported complications members of the Somali Community interviewed still believe that these are just signs of bad luck or illness, signs of breach of cultural beliefs, signs of breach of religious requirements, a sign of negligence on the part of the circumciser and social taboos and as acts of God that cannot push them to abandon the practice as had been observed by Jaldesa *et al.,* (2005). For most women, it is not their choice to undergo FGM/C but largely the choice of parents or guardians. Perception on the necessity of FGM/C among members of the Somali community decreases with level of education. Anyone with at least primary level of education is 0.12 times less likely to think of FGM/C as a necessary practice compared to anyone who has never gone to school. This could mean that complications are still delinked from FGM/C and parents and guardians play a key role in deciding whether a girl should undergo the practice. Therefore the awareness approaches should be consistently continued and should also include the parents, guardians and the illiterate members of the community.

According to the KDHS (2014), FGM/C is considered a deep-seated traditional practice among the Somali community. Other studies on FGM/C in this area also opine that a family is afraid of losing respect and honor within the community if the mother fails to circumcise the daughter, the daughter is considered an outcast if they are not circumcised. FGM/C for Somali women is one way of maintaining the family decency and integrity. The practitioners claim that if the girl is not circumcised she will bring shame to the mother, relatives and the community i.e. everyone will point a finger at her (28 too many, 2013). Also among the Somali community, other than being a cultural practice, a girl who has undergone FGM/C has increased chances of getting a husband, their family will be honored, their sexual purity preserved and their sexual encounters controlled (Jaldesa *et al*., 2005). This could mean that FGM/C is still a strongly held tradition among this community. This Therefore require sustained education and religious debates that will position the community to question their own culture since most the FGM project in this area are short term.

In addition to the reasons highlighted above, FGM/C persist in the Somali ethnic community due to lack of political good will in the fight against it, social status associated with it also increases pressure on the girls who in the desire to conform end up undergoing the practice as Evalia *et al* 2007, Abdi, 2005 and Jaldesa *et al.,* (2005) also confirmed in their earlier studies. There is also a religious connotation to FGM/C among the Somali community some of who associate the practice with religion as Abdi (2005) and Jaldesa *et al.*, (2005), established in their various studies. This was that among the Somali, Borana, Orma, Wardey and Boni, there is a belief that FGM/C constitutes an Islamic practice of *sunnah* and that uncut girls are regarded as non-Muslim and any one not cut or their daughter not cut is easily considered non-Muslims which is the predominant religion in this region. The community should be made to understand that any matter claimed to be Islamic should have proof from the holy Quran, *Sunna* (the prophetic sayings), the opinions of the scholars, and the analogy. There

exist no any verse in the holy Quran that support FGM/C. As for the *Sunnah* the *hadith* is depended on is weak and cannot be used on FGM/C. As for those who say that the practice is *Sunnah* and that it is recommended by the prophet Muhammad (*Salla llahu Aleihi Wasalam)* they were not able to define amount of the *Sunna* type. Therefore if the practice was truly Islamic then exact measure will be known. All of the Islamic scholars have not obligated the practice. Lastly the *analogy* which means comparing two things. Lets take example of alcohol is prohibited in Islam because it is intoxicant , so any other intoxicant like bhang share the same judgment. FGM/C cannot be equated to male circumcision simply because it harms a woman's body. Also of important to note is the fact that a Muslim woman has the right to possess a healthy body and she also has a right to enjoy conjugal right and no one has the right to deny her that. . The community is guided by religious scholars but these scholars are not ready to abandon the practice and they have different opinion and interpretation regarding the position of FGM/C in Islam. The *hadith* (prophetic saying) that is claimed to support type II cannot be relied on since FGM/C is harmful to the wellbeing of the people. This could mean that some of the religious scholars lack deeper understanding of Islamic teachings regarding FGM/C and are misleading the community. Therefore they should be educated on the correct position of Islam on FGM/C. Once we have the religious leaders who fully understand and accept that FGM/C has no basis in Islam then they can be used as agent of change who will show the community that those who are doing FGM/C are actually straying from and violating the Islamic teachings.

Due to the importance members of the Somali Community, just like any other ethnic community, puts to observance of cultural practices, most of the members of the community believe that this practice is still necessary with this perception more among those with no formal education, those living in rural areas and those unemployed or homemakers. These confirms the socio demographic and socio economic differentials of knowledge regarding

FGM/C practice from the KDHS (2014) that highlights level of education, settlement area and wealth quantiles as critical demographic differentials for knowledge and practice of FGM/C. This could mean that FGM/C is still a strongly held tradition among this community. This Therefore require sustained education and religious debates that will position the community to question their own culture since most the FGM project in this area are short term.

Many development agencies have been at the forefront in coming up with interventions to help stop the practice in this area. The agencies have been engaging the community in different forums to help set the agenda for the abandonment of the practice though lack of political good will works against these efforts. However this interventions are not known by majority of the people in this area and this could mean that the interventions are short term and only reach a small group of people leaving out the majority. This was confirmed in the study by Abdi (2005) who observed that FGM/C became a health and human rights issue and that initiatives towards its abandonment would incorporate locally led initiatives and full engagement of the communities, health professionals and policy makers since the 1994 and 1995 International Conference on Population and Development and Fourth World Conference on Women in Beijing respectively

At local level, some of the agencies established to be involved in interventions or campaigns against FGM/C included World Vision, Save the Children and Kenya National Commission on Human Rights and other local CBOs. The campaigns run by these agencies incorporated

the area chief, local media – radio, women and gender groups with major funding from USAID – one of the major aid agencies that Evalia *et al.*, (2007) and Oloo *et al.*, (2011) highlighted as major partner in the fight against FGM/C.

The efforts of these aid agencies, local organizations and the government towards eradication of FGM/C is however not appreciated by most of the community members who think that the development agencies with their interventions are intent on fighting their cultural practices. These interventions have mainly involved local administrators and other available community entry points but the efforts have not borne immediate fruits though involvement of local chiefs, political class and religious leaders has seen the community slowly starting to abandon the severe type III FGM/C. The interventions have taken a human rights approach with more focus on the legal implications of engaging in the practice in the advent of an act of parliament criminalizing the practice, provision of medical services for victims, awareness creation among the members of the community on the dangers of FGM/C and has also brought on board local media houses. A taskforce on educating the community on FGM Act and complications associated with FGM/C from the office of director of Public prosecution and FGM board which is in the central government has also been set up to accelerate the fight against the practice.

Implementation of the laws on FGM/C by the stakeholders has led to a more serious and undesirable situation where for fear of arrests, the perpetrators don't take their victims for medication in cases where the practice was conducted in secret and a life-threatening complication emerged. This only serves to increase the danger of the complication being fatal to the victim. Other challenges in the implementation of the FGM/C abandonment strategies in the area have been: - poor follow up on cases of FGM/C by human rights groups and NGOs; poor representation in court processes (Human Rights groups) that take up cases for

victims to court; misuse of funds set aside for campaign against the practice and failure to design proper approaches and strategies to effectively tackle the issue of FGM/C in the area.

CHAPTER SIX: CONCLUSION AND RECOMMENDATION

6.1 Conclusions

Majority of the people interviewed were females of ages 18 to 35 years, married, Muslims, having gone through at least primary level of education, domiciled in rural settlement and home makers. On average, each of the households from which the respondents came from had between 3 to 4 children. Knowledge of potential complications during and after FGM/C is more among females compared to males, married compared to single, widowed or divorced and those from the rural areas compared to urban and peri-urban areas

Prevalence of FGM/C among Somali Community is still very high as well as knowledge of FGM/C practice and related complications. In this community, type III FGM/C is more common though due to awareness creation on the risks of the FGM/C, the anti FGM/C laws and involvement of local leaders (chiefs, religious leaders and the political class among other stakeholders and funding for local CBOs to address local enablers to the practice, the more severe form of the practice is slowly becoming unpopular while the type II or sunni type is gaining ground. This means that though the community has not fully abandoned the practice of FGM/C, it is slowly changing attitude and behaviors towards it. Though there are those who believe that Islam, the predominant religion in this area advocates for FGM/C especially type II, the religious teachings do not make any mention to its related complications being promoted by Islam. There is actually no Islamic basis to the practice. *Ahadith (prophetic sayings)* mentioned are either weak and/or unrelated to FGC. A muslim cannot rely on Weak *ahadith* to guide him in his behaviour, especially if it is harmful to the wellbeing of people, for example as in FGM/C. Deeper analyses of Islamic teachings can help counter the practice by showing that it is actually in violation of Islamic law.

Women as the main victims of FGM/C have more knowledge of potential complications during and after FGM/C just like married people and those living in rural areas. FGM/C leads to excessive bleeding that can result in death; pain and discomfort during coitus for the man and the woman lead to psychological effects that lower self - esteem and loss of sexual desire; menstrual problems, infections during and after sexual encounter with a woman who has undergone FGM/C and urinary retention with each of these complications varying in severity and the type of FGM/C. Despite these hazardous complications and the high level of knowledge regarding FGM/C complications the community still strongly upholds to the practice and do not associate this complications to FGM/C. This shows the strong connection of the community to their culture and unwillingness to fight FGM/C. therefore the awareness interventions should include approaches that will position the community to question their own culture. Awareness of the complications during and after FGM/C is associated with marital status and settlement area. Though most men are not aware of the extent to which the FGM/C related complications affect their wives and daughters, they are aware that FGM/C has a cost element for them especially where complications arise, it affects their sexual life in many ways and has a psychological effect on their spouses and by extension them but continue to facilitate the practice. The perpetrators of the FGM/C subject the victims to very unconventional intervention in case of complications which in effect make the experience more painful.

Interventions to fight FGM/C are not known by majority of the people in this area and this could mean that the interventions are short term and only reach a small group of people leaving out the majority. Due to the enforcement of anti-FGM/C laws, most of these perpetrators currently fear taking the victims to the hospital for better medical attention for fear of arrests. This only serves to increase the danger of the complication being fatal to the victim. Other challenges in the implementation of the FGM/C abandonment strategies in the

area have been: - poor follow up on cases of FGM/C by human rights groups and NGOs; poor representation in court processes (Human Rights groups) that take up cases for victims to court; misuse of funds set aside for campaign against the practice and failure to design proper approaches and strategies to effectively tackle the issue of FGM/C in the area.

FGM/C persists in the Somali ethnic community due to perceptions that complications experienced during and after FGM/C are just signs of bad luck or illness, signs of breach of cultural beliefs, signs of breach of religious requirements, a sign of negligence on the part of the circumciser and social taboos and as acts of God which are not grounds enough for the community to stop this cultural practice. In fact, this practice is perceived as a very necessary practice that must be observed by all members of the community most of whom will in the future subject their daughters to the practice. . This means that FGM/C is still a strongly held tradition among this community. This Therefore require sustained education and religious debates that will position the community to question their own culture since most the FGM project in this area are short term. Parents and other elderly people within the community are strong proponents of FGM/C in the interest of cultural preservation and for honor, making their daughters more marriageable, helping preserve their daughter's sexual purity. Perception on the necessity of FGM/C among members of the Somali community decreases with level of education. Anyone with at least primary level of education is less likely to think of FGM/C as a necessary practice compared to anyone who has never gone to school. Settlement area is associated with awareness of the interventions applied to prevent or manage complications related to FGM/C. Those residing in peri urban areas are less likely to be aware of the interventions that are applied to manage complications related to FGM/C compared to those in the urban areas. Settlement area is associated with perception regarding complications associated with FGM/C. People in peri-urban areas are more likely to be perceptive about the practice of FGM/C.

6.2 Recommendations

The following recommendations are made from the findings of the study:

i. To win the campaign against FGM/C from the members of the Somali Community in Wajir County, more effort should be put on awareness creation on the dangers of FGM/C by the CHMT and NGOs in the area as well as finding ways to address the religious misconceptions and practices around the practice by the religious leaders.

ii. Targeted awareness creation campaigns on the dangers of FGM/C on the young Somali girls and boys should be scaled up among all the members of the Somali Community by local and International NGOs, CBOs and Human Rights groups in the County. The campaigns should target the older women, mothers, fathers, young girls and young boys who are future parents through local radio stations, sermons in the mosques, school programs and during Maternal and Neonatal and Child health clinics (MNCH) in local health facilities.

iii. Male involvement in campaigns against FGM/C should be started through having consistent Focused Group Discussion and selection of Male Anti FGM/C champions among men of the Somali Community who can as well be used to sensitize other men on the need to abandon the practice. This is specifically due to the decision-making role that men play in having the girls undergo FGM/C among the members of Somali Community in Wajir County. Having them on board can be a big step towards abandonment of the practice.

iv. The level of awareness of the position of Islam on FGM/C is not clear among the members of the Somali Community in Wajir County. It is therefore important to have a religious knowledge attitude and practice survey on the matter of FGM/C among members of the Somali Community living in Wajir.

v. All interventions strategies targeting abandonment of FGM/C among the Somali community should integrate parents and guardians since they are critical entry point and are critical enablers of the continuation of FGM/C in this community. This should provide an holistic approach towards dealing with FGM/C in the study area. They should be targeted with behavior and attitude change interventions towards the abandonment of the practice.

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APPENDICES

APPENDIX I: RESEARCH BUDGET

Item	Quantity	Cost Per Item	Total Cost
Printing and Binding			
Draft Research proposal	1	2,000	2,000
Revised Proposal	3	2,000	6,000
Final Proposal	8	2,000	16,000
Study tools (questionnaires, guides, consent forms)			15,000
Draft thesis	1	3,500	3,500
Revised Thesis	3	3,500	10,500
Final Thesis	12	3,500	42,000
Thesis in DVD Copy	3	250	750
Supervision	1	60,000	50,000
Research Permit Ethical clearance)	1	2,000	2,000
Research Equipment			
Stationery (pens, notebooks)	1	5,000	5,000
Field Assistants	4	20,000	80,000
Refreshments for FGDs	60pax	500	30,000
Field Interpreters/Translators	2	10,000	10,000
Pilot Study	1week	10,000	10,000
Accommodation and Subsistence	60days	2000	120,000
Transport			45,000
Field Guide Fee/Mobilizer	45days	500	22,500
TOTAL			**465,250**
Contingency			25,500
GRAND TOTAL			**490,250**

APPENDIX II: WORK PLAN

Activity	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Proposal preparation and literature review												
Piloting												
Data collection												
Data processing and analysis												
Thesis presentation and analysis												
Thesis correction and publication												

APPENDIX III: ETHICAL APPROVAL

APPENDIX IV: CONSENT FORM

KNOWLEDGE AND PERCEPTIONS OF COMPLICATIONS ASSOCIATED WITH INFIBULATION AMONG SOMALI COMMUNITY IN WAJIR COUNTY.

Investigator: Sadia Isaack Hussein.

Introduction

I am **Sadia Isaack Hussein** from School of Public Health, University of Nairobi. I am conducting a study on **KNOWLEDGE AND PERCEPTIONS OF COMPLICATIONS ASSOCIATED WITH FGM/C AMONG SOMALI COMMUNITY IN WAJIR COUNTY.**

Purpose: The study is aims at assessing the knowledge and perception of complications associated with FGM/C among Somali community in Wajir County, Kenya.

Procedure

If you agree to participate in the study you will be asked to fill in a questionnaire. The nature of the questions will be about knowledge and perceptions of complications associated with FGM/C and reasons for persistence of the practice despite the associated complications.

Risks/Discomfort

There is no risk in participating in this study. However, you may experience some discomfort due to the emotive nature of the questions but this will be asked in private and your confidentiality will be maintained at all times.

Benefits

There will be no direct benefit in participating in the study but in case you have any question the investigator will readily assist you. The study will help in determining the level of knowledge and perceptions of complications associated with FGM/C and reasons for persistence of the practice and information obtained will be used in the abandonment of FGM/C.

Confidentiality

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

Compensation

There will be no compensation for your participation in the study.

Voluntariness

Participation in the study is voluntary. If you choose not to participate, you will not be forced. You will also be free to withdraw from the study at any time.

Persons to contact

If you have any questions regarding the study, you can contact Sadia Isaack Hussein. Through telephone number 0722235777.

You may also contact the KNH/UON/ERC Commitee-0735-274288/0721-665077.

Your participation in the study will be highly appreciated.

APPENDIX V: CONSENT CERTIFICATE

I_____ hereby voluntarily consent to participate in the study. I acknowledge that a thorough explanation of the nature of the study has been given to me by Mr./Ms._____. I clearly understand that my participation is completely voluntary.

Signature_____Date_____

Signature of Reseacher/Assistant_____Date_____

APPENDIX VI: STUDY TOOLS

FGDs guides with women and men

I would like to thank each of you for agreeing to be a part of this focus group discussion. My name is Sadia Isaack Hussein, a student from the University of Nairobi, School of public health. My colleague here is called …… will help in taking notes during the discussion. The purpose of conducting this discussion is to assess the community's perceptions and level of knowledge with respect to the complications associated with infibulation in this area. We would wish to inform you that there are no wrong or right answers in this discussion. Please be assured that your personal details or what you say as a person will not be used at any time. What you say is therefore confidential and anonymous. This discussion will also be anonymous – your names will not be recorded in the notes; rather we shall assign codes to the names. You are therefore encouraged to participate actively and to feel free during the discussion. Kindly also respond to the questions with sincerity.

Thank you in advance

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

Probe for:

-Main reasons why girls are circumcised in this community.

Complications associated with FGM/C.

Probe for:

-Types of complications

-Perception of causes of complications.

-Interventions applied

-Who intervenes?

2. Overall perception on complications associated with FGM/C in the cultural context.

3. What are the success or failures of interventions applied to fight FGM/C in this community?

4. Why does FGM/C persist despite the associated complications?

5. What is the role of men in complications and/or interventions?

6. What are the community's explanations for complications associated with FGM/C?

7. What are the ways avoiding or going around complications?

8. Any other suggestions/comments on complications associated with FGM/C.

Focus Group Discussion (FGDs) guide for youth

I would like to thank each of you for agreeing to be a part of this focus group discussion. My name is Sadia Isaack Hussein, a student from the University Of Nairobi School of public health. My colleague here is called …… will help in taking notes during the discussion. The purpose of conducting this discussion is to assess the community's perceptions and level of knowledge with respect to the complications associated with FGM/C in this area. We would wish to inform you that there are no wrong or right answers in this discussion. Please be assured that your personal details or what you say as a person will not be used at any time. What you say is therefore confidential and anonymous. This discussion will also be anonymous – your names will not be recorded in the notes; rather we shall assign codes to the names. You are therefore encouraged to participate actively and to feel free during the discussion. Kindly also respond to the questions with sincerity.

Thank you in advance

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

Probe for:

-Main reasons why girls are circumcised in this community.

Complications associated with FGM/C.

Probe for:

-Types of complications

-Perception of causes of complications.

-Interventions applied

-Who intervenes?

Overall perception on complications associated with FGM/C in the cultural context.

What are the success or failures of interventions applied to fight FGM/C in this community?

Why does FGM/C persist despite the associated complications?

What is the role of men in complications and/or interventions?

What are the community's explanations for complications associated with FGM/C?

What are the ways avoiding or going around complications?

As future parents do you have intention to circumcise your daughters in future?

If yes or no state reasons

What do you suggest could be done so that the community can stop this harmful practice?

Any other suggestions/comments on complications associated with FGM/C.

Key informant interview guide for elders, religious leaders and circumcisers.

I would like to thank you for agreeing to be a part of this discussion. My name is Sadia Isaack Hussein, a student from the University of Nairobi (UoN), School of public health (SPH). My colleague here is called …… will help in taking notes during the discussion. The purpose of conducting this discussion is to assess the community's perceptions and level of knowledge with respect to the complications associated with FGM/C in this area. We would wish to inform you that there are no wrong or right answers in this discussion. Please be assured that your personal details or what you say as a person will not be used at any time. What you say is therefore confidential. You are therefore encouraged to participate actively and to feel free during the discussion. Kindly also respond to the questions with sincerity.

Thank you in advance

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

Probe for:

-Main reasons why girls are FGM/C in this community.

Complications associated with FGM/C.

Probe for:

-Types of complications

-Perception of causes of complications.

-Interventions applied

-Who intervenes?

Overall perception on complications associated with FGM/C in the cultural context.

What are the success or failures of interventions applied to fight FGM/C in this community?

Why do FGM/C persist despite the associated complications?

What is the role of men in complications and/or interventions?

What are the community's explanations for complications associated with FGM/C?

What are the ways avoiding or going around complications?

Any other suggestions/comments on complications associated with FGM/C.

Key informant interview guide for persons heading FGM/C abandonment institutions

I would like to thank you for agreeing to be a part of this discussion. My name is Sadia Isaack Hussein, a student from the University of Nairobi, School of Public Health. My colleague here is called …… will help in taking notes during the discussion. The purpose of conducting this discussion is to assess the community's perceptions and level of knowledge with respect to the complications associated with FGMC in this area. We would wish to inform you that there are no wrong or right answers in this discussion. Please be assured that your personal details or what you say as a person will not be used at any time. What you say is therefore confidential. You are therefore encouraged to participate actively and to feel free during the discussion. Kindly also respond to the questions with sincerity.

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

Probe for:

-Main reasons why girls are FGM/C in this community.

Complications associated with FGM/C.

Probe for:

-Types of complications

-Perception of causes of complications.

-Interventions applied

-Who intervenes?

Overall perception on complications associated with FGM/C in the cultural context.

What are the success or failures of interventions applied to fight FGM/C in this community?

Why do FGM/C persist despite the associated complications?

What is the role of men in complications and/or interventions?

What are the community's explanations for complications associated with FGM/C?

What are the ways avoiding or going around complications?

Any other suggestions/comments on complications associated with FGM/C.

APPENDIX VII: STUDY QUESTIONNAIRE

Knowledge and Perception of Complications Associated with Female Genital Mutilation cutting (FGM/C) in Wajir County

By Sadia Isaack Hussein, School Of Public Health, University of Nairobi.

Respondent's Consent

Good morning/afternoon. My name is Sadia Isaack Hussein, and a student of Public Health, University of Nairobi.

I am carrying out a study as part of fulfillment of the requirements for my Master of Public Health (MPH) degree. The title of my study is ***"Knowledge and Perception of Complications Associated with Female Genital Mutilation cutting (FGM/C) in Wajir County".***

I am talking randomly to men, women and youth in this community to understand more about this practice and the problems that arise because of the practice in this community.

You have been selected to participate in this study and I would like to request you kindly to agree to freely participate in this study and discuss as honestly as you can. Please note that you are not under any obligation to participate and you can quit at any stage, additionally there are neither direct benefits for participating nor any penalty for not participating. I am requesting for your own free will.

Do you agree to participate in the study? Yes …. No …….

Thank you very much.

Now I would like to ask you some questions and I would like to assure you that your answers and opinions will remain confidential and will only be used for purpose of this study. Your name will not appear anywhere in the study report.

I appreciate your lively participation.

Have a good day. Sadia Isaack Hussein

Socio Demographic Characteristics of the participants		
S/No	**Questions**	**Response Codes**
S1	Sex/Gender	Male [1]
		Female [2]
S2	How old are you? (in years)	18-24 [1]
		25-34 [2]
		35-44 [3]
		45+ [4]
S3	Marital status	Single [1]
		Married [2]
		Widowed [3]
S4	What is your Religion	Islamic [1]
		Protestant [2]
		Catholic [3]
		Traditionalist [4]
		Others specify [5] ……
S5	What is your highest level of education attained?	None [1]
		Primary (incomplete) [2]
		Primary (complete) [3]
		Secondary (incomplete) [4]
		Secondary (complete) [5]
		College Diploma [6]
		University degree [7]
		Informal education e.g. (madrasa) [8]
		Other specify [9]
S6	Where do you reside?	Urban [1]
		Rural settlement [2]
		Peri-urban [3]
		Others (specify) [4]
S7	What is your occupation? (Means of earning livelihood)	Formal employment [1]
		Take care of family at home [2]
		Business enterprise [3] (specify).....
		Farmer
		Livestock [4]
		Agriculture [5]
		Others (specify) [6]……
S8	How many children do you have?	indicate here: _____

Section 2: Knowledge and perceptions on FGM/C		
S/No	**Questions**	**Response Codes**
K1	i) **For women only**: Have your undergone FGM/C?	Yes [1]
		No [2]
	ii) If **YES** in K1 (i) above, what type of FGM/C was performed on you?	.....
	iii) If **YES in K1 (i) above**, was undergoing FGM your choice?	Yes [1]
		No [2]
	iv) If **NO in K1 (iii) above,** who's choice was it?	……
K2	Do you know what FGM is?	Yes [1]
		No [2]
K3	In your view is FGM/C necessary in this community?	Yes [1]
		No [2]
		Not Sure [3]
K4	i) Do you know why FGM/C is practiced in this community?	Yes [1]
		No [2]
	ii) If YES in K4 (i) above list five (5) reasons and rate them in the order of importance (NB: interviewer tick as relevant):	Religious requirement: **Tick [__] Rank [__]**
		It is our tradition: **Tick [__] Rank [__]**
		It is a rite of passage: **Tick [__] Rank [__]**
		Ensure purity of woman: **Tick [__] Rank [_]**
		Improve fertility in women: **Tick [_] Rank [_]**
		To ensure girl can find a suitor to marry her: **Tick [__] Rank [__]**
		Family honor/maintain girl's virginity: **Tick [__] Rank [__]**
		Father/Husband insists on FGM/C: **Tick [_] Rank [_]**
		Older women insist on FGM/C: **Tick [__] Rank [_]**
		Others (Specify)……: **Tick [__] Rank [__]**

Section 2: Knowledge and perceptions on FGM/C		
S/No	**Questions**	**Response Codes**
K5	Do you know the main types of FGM/C practiced in this region?	Yes [1]
		No [2]
K6	Which of the following types of FGM/C is mainly practiced in this region: NB:	Type 1: [1]

	(Interviewer must be familiar with 4 types & tick appropriately): **Type 1:** Partial or total removal of the clitoris; **Type 2:** Partial or total removal of clitoris and labia minora; **Type 3:** Total removal of the clitoris and labia minora, involves slicing or scraping raw surfaces or **Type 4:** Pricking, piercing or incising of the clitoris and/or labia, stretching of the clitoris and/or labia.	Type 2: [2]
		Type 3: [3]
		Type 4: [4]
K7	i). Are you aware of any complications that come during and after FGM/C practiced in this community?	Yes [1]
		No [2]
	ii). If **YES in K7 (i) above** list 5 complications you are familiar with in the order of importance: NB: (Interview tick appropriately under the following categories and indicate rating ie.1, 2, 3, 4, and 5etc.)	Related to the genital organ: **tick [_] Rank [_]**
		Related to menstrual flow/retention: **tick [_] Rank [_]**
		Related to poor hygiene: **tick [_] Rank [_]**
		Related urinary flow/retention: **tick [_] Rank [_]**
		Related to sexual activities in marriage: **tick [_] Rank [_]**
		Related to pregnancy: **tick [_] Rank [_]**
		Related to child delivery: **tick [_] Rank [_]**
		Others (Specify).....: **tick [_] Rank [_]**
K8	i. Do you know whether your community associates these complications with FGM/C?	Yes [1]
		No [2]
		Not Sure [3]
	ii. If the answer is no/not sure in K8 (i) what are the perceived causes of these complications? (List 5 perceived causes accordingly and in the order of rating/importance)	Breach of religious requirements: **tick [_] Rank [_]**
		Breach of traditional/cultural beliefs: **tick [_] Rank [_]**
		Social taboo: **tick [_] Rank [_]**
		Bad luck/ or illnesses: **tick [_] Rank [_]**
		God's will/plan/qadar: **tick [_] Rank [_]**
		Others (Specify).....: **tick [_] Rank [_]**

K9. Are you aware of any interventions applied to prevent or manage the complications?

Yes [1] **No [2]**

K10. List 5 preventive interventions and the person who does the intervention:

S/no	Type of preventive Intervention	Person Intervening
1		
2		
3		
4		
5		

K11. List 5 treatment or management interventions and the person who does the intervention

S/no	Type of treatment intervention	Person doing it
1		
2		
3		
4		
5		

K12. In your view, do you think FGM/C causes complications to women and girls?

Yes [1] **No [2]** **Not Sure [3]**

K13. Are you aware of any interventions/campaign against FGM/C in this area?

Yes [1] **No [2]** **Not Sure [3]**

K14. If yes, list 5 of the agencies in this region dealing with FGM/C interventions

1. ……

2.. ……

3. ……

4. ……

5. ……

K15. List observed/real successes and failures against each of the campaigns in the table below:

S/no	Agent/campaign	Successes	Failures
1			
2			
3			
4			
5			

K16. a). Do you know if the men realize the real complications that FGM/C causes to their wives and daughters?

Yes [1] No [2] Not Sure [3]

b) If yes list 5 of the complications that affect the men as husbands/ father. List possible role the men can take in abandonment of FGM/C.

S/no	Complications	How the complications affect men	Role of men against FGM/C
1			
2			
3			
4			
5			

K17. In your own view, why has FGM/C practice persisted despite the complications during and after it?

List any 3 reasons for FGM/C persistence:

1. **…….**
2. **…….**
3. **…….**

Question to be administered to youths only:

K18. a. As a future parent, do you intend to get your daughter undergo FGM/C.

Yes [1] No [2] Not Sure [3]

b) If YES in K18 above, which type (NB: types 1, 2, 3, 4,): …….

K19. List 5 suggestions that you think can help the community abandon FGM/C. And note whatever the comment (whether for or against FGM/C)

1. **……**
2. **……**
3. **……**
4. **……**
5. **……**

K20. List 5 action/efforts that are in place by various stakeholders towards alleviating complications associated with FGM/C.

S/no	List actions or efforts here	Stakeholder
1		
2		
3		
4		
5		

K21. In the space provided below add other comments on complications associated with FGM/C and what actions should be taken in curbing FGM/C in this community.

……

……

……..

APPENDIX Vlll: A map of Kenya showing where Wajir is located.

Kenya map indicating where Wajir is located.