FEMALE GENITAL MUTILATION PRACTICE AND ITS EFFECTS ON WOMEN’S REPRODUCTIVE HEALTH IN BARWAQO WARD, WARTA NABADA DISTRICT, MOGADISHU SOMALIA

AYAN SAID TUKALE
REG. NO: Q57F/CTY/PT/20599/2012

A RESEARCH THESIS SUBMITTED FOR THE DEGREE OF MASTER OF PUBLIC HEALTH (MONITORING AND EVALUATION) IN THE SCHOOL OF PUBLIC HEALTH OF KENYATTA UNIVERSITY

MARCH, 2017
DECLARATION

This thesis is my original work and has not been presented for a degree in any other University

Signature........................................ Date..............................................

Ayan Said Tukale
Department of Community Health

Supervisors:

This thesis has been submitted with our approval as University Supervisors.

Dr. Isaac Mwanzo
Department of Community Health
Kenyatta University

Signature. ...................................... Date................................................

Dr. Pacificah Okemwa
Department of Gender Studies
Kenyatta University

Signature. ...................................... Date................................................
DEDICATION

This thesis is dedicated to my beloved mother Halima Iman Mohamed who has given me the opportunity of an education with all kinds of support and motivation throughout my life.

God Bless You Mum
ACKNOWLEDGEMENT

First of all, I want to thank Allah who made it possible to work on my thesis.

I express my warm thanks to my supervisors Dr. Isaac Mwanzo and Dr. Pacificah Okemwa for their support and guidance. I wish to express unreserved thanks to Dr. Peterson Warutere for his invaluable support and unending encouragement. Special gratitude also goes to the School of Public Health, Department of Community Health for all support accorded in pursuit of my Masters in Public Health. Special appreciation goes to Somali Federal Government- Ministry of Culture and Higher Education, and Ministry of Health and Human Services, Warta Nabada District Authority, SOS Mother and Children Hospital, Banadir Hospital, Somali Women Development Centre (SWDC), Center for Education and Development (CED) and Horseed International University. I also acknowledge Exactitude Research for guidance given in data management and analysis. I also express my gratitude to my family for their support throughout the Master of Public Health (MPH) course.
## TABLE OF CONTENTS

DECLARATION ......................................................................................................................... i  
DEDICATION .......................................................................................................................... ii  
ACKNOWLEDGEMENT ........................................................................................................ iii  
TABLE OF CONTENTS ......................................................................................................... iv  
LIST OF FIGURES ................................................................................................................ vi  
LIST OF TABLES ..................................................................................................................... vii  
OPERATIONAL DEFINITION OF TERMS ............................................................................. viii  
LIST OF ABBREVIATIONS AND ACRONYMS ..................................................................... x  
ABSTRACT .............................................................................................................................. xi  

### CHAPTER ONE: INTRODUCTION ..................................................................................... 1  
1.1 Background ...................................................................................................................... 1  
1.2 Problem of the statement ............................................................................................... 4  
1.3 Justification ..................................................................................................................... 5  
1.4 Research questions ......................................................................................................... 6  
1.5 Hypothesis ....................................................................................................................... 7  
1.6 Objectives of the research ............................................................................................. 7  
1.7 Significance of the study ................................................................................................ 8  
1.8 Limitations of the research ............................................................................................ 8  
1.9 Conceptual framework .................................................................................................. 9  

### CHAPTER TWO: LITERATURE REVIEW ..................................................................... 10  
2.1 Introduction ...................................................................................................................... 10  
2.2 FGM in Somalia ............................................................................................................... 12  
2.3 Socio demographic characteristics that influence FGM ............................................... 13  
2.4 Women’s knowledge and attitudes towards FGM ......................................................... 15  
2.5 Effects of socio cultural and religious beliefs on FGM ................................................ 16  
2.6 Health complications experienced by women who have undergone FGM ............... 22  

### CHAPTER THREE: MATERIALS AND METHODS ....................................................... 24  
3.1 Introduction ...................................................................................................................... 24  
3.2 Research design .............................................................................................................. 24  
3.3 Variables ......................................................................................................................... 24  
3.4 Location of the study ..................................................................................................... 25  
3.5 Study population ............................................................................................................ 25  
3.6 Sampling techniques and Sample size ......................................................................... 26  
3.7 Construction of research instruments ......................................................................... 28  
3.8 Validity and reliability of the research instruments ..................................................... 28  
3.9 Data collection techniques ........................................................................................... 29  
3.10 Data analysis and presentation ..................................................................................... 29  
3.11 Logistical and ethical considerations ......................................................................... 29  

### CHAPTER FOUR: FINDINGS ....................................................................................... 31  
4.1 Introduction ...................................................................................................................... 31  
4.2 Preliminary information ................................................................................................. 31  
4.3 Socio demographic characteristics and influence on FGM practice ....................... 31  
4.4 Knowledge and attitude on FGM risks and eradication programs ............................ 34
4.5 Influence of socio cultural and religious beliefs on FGM eradication programs ..........39
4.6 Health complications associated with FGM ..................................................43

CHAPTER FIVE : DISCUSSION, CONCLUSION AND RECOMMENDATION ........47
5.1 Introduction ......................................................................................................47
5.2 Discussion ......................................................................................................47
5.3 Conclusions ....................................................................................................56
5.4 Recommendations .........................................................................................57

REFERENCES ....................................................................................................58

APPENDICES ......................................................................................................62
Appendix I: Questionnaire ..................................................................................62
Appendix II: Informed Consent ............................................................................70
Appendix III: Consent Form for Focus Group Discussion .................................72
Appendix IV: Focus Group Discussion Guide ......................................................75
Appendix V: Key Informant Interview Discussion Guide ....................................76
Appendix VII: Map of Warta Nabada District .....................................................78
Appendix VIII: Map of Somalia ..........................................................................79
Appendix X: Birth Complications: SOS Children Hospital Data .......................79
Appendix IX: Kenyatta University Research Authorization ...............................80
Appendix X: Kenyatta University Research Proposal Approval ..........................80
Appendix XI: Research Authorization Ministry of Health & Human Services .......81
Appendix XII: Research Clearance Permit Ministry of Culture and Higher Education ..83
LIST OF FIGURES

Figure 4.1: Knowledge on what FGM involves .................................................................35
Figure 4.2: Type of FGM known ....................................................................................36
Figure 4.3: Common type of FGM practiced in community ............................................36
Figure 4.4: Presence of health complications .................................................................44
LIST OF TABLES

Table 3.1: District Wards of Warta Nabada District .................................................. 26
Table 4.1: Socio-demographic characteristics of the women ........................................ 33
Table 4.2: Socio-demographic characteristics of the woman’s cont: ............................. 34
Table 4.3: Women’s definition of FGM ........................................................................ 35
Table 4.4: Awareness of interventions to eradicate FGM .............................................. 37
Table 4.5: Interventions to eradicate FGM proposed by women ..................................... 39
Table 4.6: Social-cultural and religious reasons for FGM practice .................................. 40
Table 4.7: Perceptions on FGM .................................................................................. 41
Table 4.8: Woman’s perception on FGM continuity ....................................................... 42
Table 4.9: Sunna perceptions by women ....................................................................... 43
Table 4.10: Health complications associated with FGM .............................................. 45
Table 4.11: Actions taken by women to reduce the effects of FGM .............................. 45
Table 4.12: Source on information on how to handle FGM complications ..................... 46
OPERATIONAL DEFINITION OF TERMS

**Attitude:** is an expression of favor or disfavor toward a person, place, thing, or event.

**Clitoris:** A small mass of erectile tissue in the female that is situated at the anterior apex of the vulva, near the meeting of the labia majora (vulva lips). The clitoris is the human female's most sensitive erogenous zone.

**Culture:** Culture is the sum of the learned behavior of a group of people that are generally considered to be the tradition of that people and are transmitted from generation to generation.

**Fatwa:** a legal opinion or decree handed down by an Islamic religious leader.

**FGM:** Female Genital Mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

**Knowledge:** is a familiarity, awareness or understanding of someone or something, such as facts, information, descriptions, skills, which is acquired through experience or education by perceiving, discovering, or learning.

** Tradition:** is a belief or practice passed down within a group or society with symbolic meaning or special significance with origins in the past

**Type 1 (Sunna):** is the removal of the clitoral prepuce, with or without excision of part or the entire clitoris.
Type 2 (Sunna kabir): is where the prepuce, clitoris and all or part of the labia minora is removed.

Type 3 (Infibulation or Pharaonic): involves the excision of part or all the external genitalia and then, through infibulations, stitching the vulva closed, leaving only a small opening for urination and menstruation. The most severe form and often repeated after each childbirth

Type 4: includes unclassified procedures such as cauterization of the clitoris, cutting of the vagina and the introduction of corrosive substances or herbs into the vagina for the purpose of tightening or narrowing it.
LIST OF ABBREVIATIONS AND ACRONYMS

CED- Center for Education and Development
EU - European Union
FC- Female Cut
FGC- Female Genital Cutting
FGM- Female Genital Mutilation
HIV- Human Immunodeficiency Virus
MPH- Master of Public Health
NEDARC- National EMSC Data Analysis Resources Center
NETFA- National Education Toolkit for Female Genital Mutilation Awareness
NGO - Non Governmental Organization
SPSS - Statistical Package for Social Science
SWDC- Somali Women Development Centre
UN - United Nations
UNFPA- United Nations Fund for Population Activities
UNHCR - United Nations High Commissioner for Refugees
USA - United States of America
WHO - World Health Organization
ABSTRACT

Female Genital Mutilation (FGM) is total or partial removal of external female genitalia for non-medical rationale. The practice is mostly common in sub Saharan Africa. An approximated number of between 100-140 million women have undergone FGM and 3 million girls yearly are perceived to be at risk globally. Somalia has the highest global prevalence (98%) of FGM. A number of studies demonstrate significant association between FGM and various gynecological and pregnancy complications. The main objective of the study was to assess FGM practice and its effects on women’s reproductive health. The study adopted a descriptive cross-sectional design to establish the socio demographic characteristics, knowledge and attitudes of FGM, socio cultural and religious beliefs and health complications experienced by women who had undergone FGM. The study was conducted in Warta Nabada District in Banadir region of Somalia. Sample size of 344 women aged 15 to 49 years was determined using the Fisher formula and finite correction for proportions. Systematic sampling was used to select households from which respondents were purposively selected if one and randomly selected if many to complete questionnaires. Key informants and focus group discussion participants including professional midwives, head nurses and traditional birth attendants, women organizations, religious leaders, local authority of the district and youth organizations were purposively selected. Validity of research tools was ensured through pretest and reliability through Cronbach alpha of 0.86. Data was entered, coded and analyzed using Statistical Package for Social Sciences (SPSS) version 20. Descriptive statistics were used to generate frequencies and proportions. Chi square test were used to test the association of the variables. The qualitative data was coded and analyzed using content analysis approach and presented in verbatim. Ethical approval was sought from University, permission from various authorities and consent from all respondents. Study findings indicated that age and marital status (p-value<.001) were the socio-demographic characteristics that influenced FGM practice. Majority (67%) women were not aware of FGM risks and eradication programs. FGM was negatively perceived as it violated women religious and human rights. Socio cultural and religious beliefs that FGM was cultural, keeping virginity and consideration in getting a husband negatively affected the FGM eradication programs. Pain (74.5%), bleeding (71.9%), difficulties with menstruation (69.9%) and infections (60.9%) were the main reproductive health complications associated with FGM. These problems were mainly addressed through seeking medication. The study recommends that the government of Somalia should sensitize the public on the illegality of FGM together with associated health risks; and strengthen systems that prohibit the practice.
CHAPTER ONE: INTRODUCTION

1.1 Background

The term Female Genital Mutilation (FGM) describes procedures of total or partial removal of external female genitalia or other intentional injury to the female genital organs for non-medical reasons (Fried *et al.*, 2013). FGM is a practice which is thought to have existed for thousands of years. It is most commonly practiced in countries in sub Saharan Africa, in the Sahel region, in the horn of Africa and Egypt, but it is also found amongst women and families migrating to European countries and the United States of America (USA) from these locations. Globally it is estimated that between 100-140 million women are thought to have undergone FGM and 3 million girls annually are thought to be at risk (Karmaker *et al.*, 2011).

In 2010, the European Parliament estimated that up to half a million women living in Europe had been subjected to FGM, with a further 180,000 at risk. According to United Nations High Commission for Refugees (UNHCR), nearly 20,000 women from FGM/C practicing countries applied for asylum to the European Union (EU) including, France, Italy, Sweden, United Kingdom of Great Britain, Belgium, Germany, Netherlands, Finland, Greece, Ireland, Spain and Malta in 2011 with an estimated 8,809 female applicants aged 14-64 years likely to be affected by FGM. In addition to those coming to the European countries who have already been subjected to FGM, there is anecdotal evidence supported by criminal prosecutions, particularly in France and Sweden, that suggests that FGM is conducted in the European countries. This has led to the implementation of FGM elimination campaigns in the European countries (Brown, Beecham, & Barrett, 2013).
FGM is also common in countries like Iraq, Kurdistan, Malaysia, Indonesia, Europe, USA and Australia among many other countries where migrants carry along their culture (Kaplan, 2013).

In Africa, FGM is most prevalent in 27 countries whereby 67.7 million girls and women aged 15-49 years are affected. This number rises to 85.9 million in women aged 50 and older who have undergone FGM in 27 African countries (Bjalkander et al., 2013).

Somalia has the highest prevalence of 97% of FGM in the world. Somalia is characterized by decades of civil war that propelled approximately 25% of its people to migrate to Western countries such as Norway, (Gele, Bo, & Sundby, 2013a). Data on prevalence of FGM in Somalia is scarce but WHO estimated it to be approximately 98% in 2006. About 90% of these cases had undergone infibulation (Fried et al., 2013). Somalia has the highest global prevalence (98%) of FGM and despite a long history of abandonment efforts, it is not clear whether or not these programs have changed people’s attitudes toward the practice (Gele, Bo, & Sundby, 2013b).

There are a growing number of studies which demonstrate a significant association between FGM and various gynecological and pregnancy complications. World Health Organization (WHO) reports (2000) concluded that FGM has negative implications for women's health, with women who have undergone FGM more likely than others to have adverse obstetric outcomes. FGM has no health benefits and harms girls and women both physically and mentally. These impacts occur at the time of the procedure as well as adulthood, particularly motherhood. All forms of FGM have psychological effects, particularly related to female sexuality and sexual relationships. The UN regards FGM as a violation of female reproductive rights (United Nations
Population Fund [UNFPA], 2007), and thus the ending of FGM is of relevance to all health professionals. Understanding the issues associated with preventing FGM is particularly relevant to health professionals who work with FGM affected and at risk women and girls. This is because they are in a position to communicate directly with affected community members and may also be linked with organizations which engage in prevention as well as obstetric and gynecological treatment of FGM complications. Some of the popular interventions that have been employed are; health risk information, conversion of exercisers, training of health professionals as change agents, alternative rites programs, and community led approaches, public statements and legal measures (Ahmadu, 2007).

FGM is associated with a series of health risks and consequences. According to Yasin et al. (2013) immediate consequences are pain and bleeding; difficulty in passing urine; infections including the Human Immunodeficiency Virus (HIV); death caused by hemorrhage or infections; unintended labia fusion; and psychological consequences. Long term health risks include chronic pain, keloid formation, reproductive tract and sexually transmitted infections, poor quality of sexual life, birth complications and psychological consequences. Type three FGM bears additional complications like need for later surgery, urinary and menstrual problems, painful sexual intercourse and infertility (Yasin et al., 2013).

Several studies have demonstrated a significant association between FGM and various gynecological and pregnancy complications. Yet, women, who bear these consequences, continue with the FGM practice. According to WHO reports, there is evidence that FGM has negative implications for women’s health, with women who have undergone FGM more likely than others to have adverse obstetric outcomes
The impacts of FGM occur at the time of the procedure and at adulthood, particularly motherhood (Brown, Beecham, & Barrett, 2013). All forms of FGM have psychological effects, particularly related to female sexuality and sexual relationships.

In a study by Gele, Bo, & Sundby (2013a) which involved 215 randomly selected persons, both men and women carried out from July to September 2011, in Somalia, revealed that 97% of the study’s participants were circumcised with no age differences and that of this 81% were subjected to Type 3, while 16% were subjected to Type 1 and 2 and only 3% were left uncircumcised. Approximately 85% of the women had intention to circumcise their daughters, with 13% planning the most radical form of FGM. In conclusion the researchers showed that the persistence of the practice was profoundly high in Somalia.

1.2 Problem of the statement

The Somalia’s Provisional Constitution defines FGM as “torture” in Article 15 (4) - “Circumcision of girls is a cruel and degrading customary practice, and is tantamount to torture. The circumcision of girls is prohibited.” However, there is no specific law against female circumcision, and the practice remains widespread in both rural and urban areas in this Horn of Africa nation (Abdirahman, 2015). Moreover, after nearly four decades of campaigning against FGM, there is still a rather slow decline in prevalence of FGM which raises questions about the effectiveness of interventions to eliminate the practice. Some of the popular interventions that have been employed include; health risk information; conversion of exercisers; training of health professionals as change agents; alternative rites programs; community led approaches; public statements; and legal measures. Evidence on the effectiveness of these
interventions is insufficient, particularly whether they have led to an actual decline in the incidence or prevalence of FGM. This study sought to find out the prevailing women’s knowledge and attitude towards FGM in Warta Nabada District.

Despite the fact that people are aware of the health risks and human rights violations associated with FGM, they still support the continuation of the practice. This shows that the over 30 years of campaigns have limited progress in eradication of the practice. This study aimed at assessing FGM practice and its effects on women’s’ reproductive health in Warta Nabada District, Mogadishu -Somalia.

1.3 Justification

Internationally FGM is recognized as a violation of human rights of girls and women, reflecting deep rooted inequality between the sexes. FGM is almost always also carried out on minors hence is also a violation of the rights of children (WHO, 2012). Parliamentarians from all over Africa met in Dakar on 3-4th May, 2010 to push for a continent wide ban on FGM and calling on the UN to pass a General Assembly resolution appealing for a global FGM ban, as it violates human rights (Karmaker et al., 2011).

In a study by Gele, Bo, & Sundby (2013a) which was conducted in Galkayo and Hargesia from July to October 2011 and May of 2012, the results showed that the most prevalent type of FGM is the Sunna cut which involves either the partial or total removal of the clitoris, followed by two stitches. When the operation involves stitching WHO classifies it as Type III regardless of the number of stitches. Both the opinion leaders and the ordinary people in Somalia in this study were found to be
against the total abandonment of FGM but supporting the continuation of the Sunna form (Gele, Bo, & Sundby, 2013b).

According to Gele, Bo, & Sundby (2013b), in Somalia, no single individual has control over their behavior concerning FGM since the practice is a deeply rooted in the social norms and at the same time it is performed on very young girls. In such a social environment, knowledge creation and awareness campaigns alone may not be enough to change the status quo as FGM has been practiced for decades.

Little research had been done on how socio-demographic factors contribute to FGM in Warta Nabada District. Most of the studies have been conducted in Hargesia and Galkayo unlike in the southern part of Somalia (Mogadishu). Mogadishu has been facing war from Al-Shabaab forces and is currently experiencing peace as a result of African Union Mission to Somalia (AMISON) peace keeping forces taking up residence as a way to maintain peace. This study sought to determine the socio-demographic determinants of FGM in Warta Nabada District.

1.4 Research questions

i. What are the socio demographic characteristics that influence FGM in Warta Nabada District, Mogadishu, Somalia?

ii. What is the knowledge and attitude of the women’s reproductive health in Warta Nabada District, Mogadishu, Somalia on the risks associated with FGM?

iii. What are the effects of socio cultural and religious beliefs on the health programs targeting the elimination of FGM in Warta Nabada District, Mogadishu, Somalia?
iv. What are the health complications that women experienced when they have undergone FGM in Warta Nabada District, Mogadishu, Somalia?

1.5 Hypothesis

i. FGM practice has no effect on the women’s reproductive health.

ii. Women’s knowledge and attitude towards FGM has no association with the practice of FGM.

iii. Socio demographic characteristics among women have no influence on FGM.

iv. Socio cultural and religious beliefs have no effect on the health programs targeting the elimination of FGM.

1.6 Objectives of the research

1.6.1 General objective

The main objective of the study was to assess FGM practice and its effects on women’s reproductive health in Warta Nabada District, Mogadishu, Somalia.

1.6.2 Specific Objectives

i. To determine the socio-demographic characteristics that influence FGM practice in Warta Nabada District, Mogadishu, Somalia

ii. To establish women’s knowledge and attitudes on FGM risks and eradication programs in Warta Nabada District, Mogadishu, Somalia.

iii. To determine the effects of socio cultural and religious beliefs on FGM eradication programs in Warta Nabada District, Mogadishu, Somalia.

iv. To determine the reproductive health complications associated with FGM and how they are managed in Warta Nabada District, Mogadishu, Somalia.
1.7 **Significance of the Study**

This study contributed to the existing information/literature about the effects of FGM on women in Warta Nabada District, Mogadishu. This study was significant for it provided more information on FGM hence, contributing to knowledge on attitudes and effects of FGM.

Furthermore, this assisted the stakeholders including internal partners (Local NGOs), donors, Somalia Government, UN agencies, humanitarian aid workers and Somali community to know the existing socio cultural and religious beliefs and their effects on the health programs targeting the eradication of FGM.

This study was significant to a number of sectors. The findings of the study helped policy makers and legislators to develop a comprehensive health policy targeting elimination of FGM due to its health consequences which the victims undergo.

The findings of the study was also be beneficial to the Somalia Government in promoting anti-FGM campaigns among the Somalia community based on the health matters associated with FGM which reduces productivity of the women as well as the community. The findings of the study also helped other scholars understand the dynamics of FGM in Somalia and possibly they may be interested to carry out other studies in other regions of Somalia or any other country or community.

1.8 **Limitations of the Study**

The security situation was of a concern during data collection however there were insecurity incidences witnessed.

The scope of the study was limited by finances and time and also detailed data collection was limited by sensitivity of some research questions.
1.9 Conceptual Framework

![Conceptual Framework Diagram]

**Figure 1.1 Conceptual framework;** Source (Adopted and modified from Yusuf, 2006)
CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of related literature on various aspects of FGM. It lays out a description of the types of FGM practiced globally and in the study area, Somalia. It also reviews women’s knowledge and attitudes towards FGM as well as other socio-cultural and religious determinants of FGM. Health complications experienced during and after FGM are also highlighted herein.

2.1.1 Types of FGM

The World Health Organization (WHO) classifies FGM into four types depending on the extent of tissue removed (Berg & Underland, 2013). 1.) Type I (Sunna Type), the mildest of the types, involves partial or total removal of the clitoris and or the prepuce, 2.) Type II (Sunna Kabir) involves partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora. 3.) Type III, (infibulation), is the most extensive involves narrowing of the vaginal orifice with creation of a covering seal by cutting and a positioning the labia minora and or the labia majora, with or without excision of the clitoris (Yasin et al., 2013). WHO (1996) also suggests a fourth form Type 4, which includes unclassified procedures such as cauterization of the clitoris, cutting of the vagina and the introduction of corrosive substances or herbs into the vagina for the purpose of tightening or narrowing it (Pereda, Arch, & Perez-Gonzalez, 2012)

2.1.2 Reasons for the practice of FGM

Traditionally, the arguments that support FGM have been based on cultural, religious and social beliefs within families and communities, although religion actually offers
little support and justification for the practice. The reason why the practice of FGM is performed and perpetuated has more to do with social convention, tradition and cultural ideals of communities (Pereda, Arch, & Perez-Gonzalez, 2012).

Research has shown that in cultures which defend the practice, majority of the most highly educated classes such as university students, continue to believe that it is a religious dictate (77.4% of males and 50% of females), this being especially the case among Muslim students (Pereda, Arch, & Perez-Gonzalez, 2012). Communities have several reasons as to why they practice FGM. FGM is often described as a means to safeguard against premarital sexual activity and as such prevent promiscuity and preserve virginity. In Kenya, 30% of women supporting continuation of the practice agreed that FGM helped to preserve virginity and avoid immorality, in Nigeria, similar rates of 36% were reported by women, while 45% of men supporting continuation of the practice agreed with this statement (Yirga et al., 2012).

FGM was believed to be proof of a girl’s virginity, thereby improving the marriage prospects of unmarried girls who have undergone the procedure. In Côte d’Ivoire, “improved marriage prospects” was cited by 36% of women favoring continuation of the practice once married. FGM is also believed by some communities to ensure that a woman is faithful and loyal to her husband (Yirga et al., 2012). There are a number of reasons why this practice continues today, including chastity, religion, culture, aesthetics and hygiene and socio-economic factors. Almost all of these are linked to girl’s social status and marriage ability. This all comes down to power over women (Molleman & Franse, 2009).
2.2 FGM in Somalia

The Inter-African Committee on Traditional Practices affecting the health of women and children and WHO have adopted the term FGM because not only is it used as an effective policy and advocacy tool but is also a more apt description of the physical act and extent of injury on the genitalia when the procedure is performed (Berg & Denison, 2013). Although current trends indicate that the practice is becoming less prevalent, as many as 30 million girls under the age of 15 may still be at risk of FGM. In countries where more than 70% of women aged 15-49 years live with FGM for example Eritrea, Ethiopia, Mali and Somalia, fewer daughters than mothers have been subjected to FGM. Women who underwent FGM are also noted to support continuation of FGM. An example is in Ethiopia where 31% of women believe that the practice should continue (Berg & Denison, 2013). The entire Africa FGM prevalence is illustrated in annex VI, table 1.1. WHO notes that most girls undergo this practice between birth and age 15, but FGM occurs at all ages (Human Rights Watch, 2010). FGM is performed on girls at different ages, but most commonly around the ages of 7 - 10 (The National Education Toolkit for FGM in Australia (NETFA, 2014). Sometimes it is performed on babies and sometimes on women when they are much older. Some sources say that in Somalia, FGM is carried out on girls between 3 and 8 years of age while other sources set the age range between 4-12 years (Matsuuke, 2011). In some cultures, FGM is used to initiate girls into adulthood and to ensure their marriage ability (Human Rights Watch, 2010; NETFA, 2014).

Normally FGM is carried out by a traditional practitioner and mostly the operations are carried in the villages and not in a health institution (Matsuuke, 2011). In a study done by the World Bank in 2004 it was noted that in most parts of Somalia, traditional
circumcisers (Guddaay) conduct most operations. The number of professional health providers who carry out milder forms of circumcision to girls for a fee was also found to be increasing but at the same time these professional health providers were found to be also discouraging the work of traditional circumcisers and the Pharaonic FGM. Complications arising from FGM were found to be turning more families towards health providers, trained TBAs and nurses who perform whatever type of FGM parents’ desire (World Bank, 2004).

2.3 Socio demographic characteristics that influence FGM

In a study by Karmaker et al. (2011) which involved 12,049 women, results showed that age and religion were the most significant demographic variables associated with the risk of FGM in Burkina Faso. As age increased, the proportion of women and their daughters who had undergone FGM increased.

Success of these community-led interventions varies between communities. A long-term evaluation of an intervention in Senegal showed a reduction of prevalence in the youngest generation (0-9 years of age) of almost 70% and in another area in the same country, the reduction was about 24%. However when run in neighboring Burkina Faso only 3% reduction was identified compared to the control group. When the same programme was run in Somalia, the public declaration achieved was only to change the type of cutting from the pharaonic cut to the sunna cut rather than the abandonment of FGM. These variations are suggestive of the differences in social and religious factors in this communities (Johansen, et al., 2013).

In a study by Yirga et al. (2012) which was conducted among 858 females of reproductive age (15-49 years) in the year 2008, it was concluded that the likelihood
of girls and women undergoing FGM might be related to socioeconomic factors. The results showed that 80% of the women were illiterate and unemployed. The researchers also concluded that the practice of FGM was therefore, considered to be a societal norm and a source of income for the perpetrators. Girls terminate their education to meet their family responsibilities at an earlier age and the options would be marriage or becoming engaged. In Ethiopia, there is a tendency for families with no or little education to keep their sons and daughters at home to serve the family and help with agricultural work. Therefore poverty, lack of education, insufficient information and inadequate knowledge might put this women at a risk of becoming victims of FGM (Yirga et al., 2012).

The health consequences for women are very serious and can include recurrent urinary tract infections, severe pain during sexual intercourse, infertility, difficulties in bearing children and increased risk of neonatal death (Molleman and Franse, 2009). Women who have undergone any form of FGM are traumatized and likely to develop physical, psychological and social problems. The physical and psychological trauma results in poor quality of life and low self-esteem during adulthood. Psychological problems can also be seen in women in the form of diagnoses like anxiety, phobia and low self-esteem (Peltzer & Pengpid, 2014). Women with type 2 and type 3 FGM are more likely to require cesarean section and have postpartum hemorrhage than women who had not had FGM (Yirga et al., 2012). Scar tissue that develops after the practice of FGM leads to problems during child delivery like obstruction, tears and or need for an episiotomy.

FGM also contributes to high health care demands and medical costs. Spontaneous deliveries do not need as many healthcare resources as cesarean sections or other
assisted deliveries. The procedure is also done mostly in unhygienic conditions hence it can be predicted that contagious and blood borne diseases including Human Immunodeficiency virus due to use of the same instruments in multiple operations can be spread from one person to another. New born from mothers who have undergone FGM might have a complication during birth and birth injury; this may be costly to treat afterwards. A WHO study in six African countries revealed that the annual cost of FGM related obstetric complications amounted to $3.7 million and even more so when performed on young girls who are put through enormous suffering. The annual cost ranged from 0.1%-1 of government spending on health care for women aged 15-45 years (Yirga et al., 2012). Social systems are key to families not being isolated. Therefore some families are forced to practice FGM due to fear of discrimination for deviating from community norms (Yirga et al., 2012).

### 2.4 Women’s knowledge and attitudes towards FGM

When people lack awareness of how their behavior affects their health and wellbeing, they have little reason to put themselves through the misery of changing the risk behaviors they have engaged in for many years. Although increased knowledge creates a precondition for change, additional communal or self-influences are needed to overcome the impediments to adapting and maintaining new behaviors. As much as there are many behavior change theories, changing the behavior of FGM requires a unique approach as the Female Cut (FC) is a communal rather than an individual behavior (Gele, Bo, & Sundby, 2013b).

In a study by Yasin et al. (2013) conducted in Erbil city, involving 1,987 women aged 15-49 years, it was generally agreed that the women’s education may have contributed to a reduction of the practice of FGM. This was a contradiction to several studies that
have reported a negative association between FGM and the education level of mothers. The findings of these other studies suggested that education alone is not sufficient to lead to the abandonment of FGM and may show the superiority of traditions, cultural beliefs and religious dictate over education. In the study by Yasin et al. (2013), the results also showed a significant association between FGM and the education status of the father. This may have reflected the decision making process on FGM in the family and the society and the potential power of the father which agreed with a study in Egypt. Research from other settings like Gambia has shown that the decision making for undergoing FGM is in a large part made by mothers. However there are instances where it is a joint decision by both mother and father with the latter only informed to obtain his agreement (Yasin et al., 2013).

In a study by Karmaker et al. (2011) which involved 12,049 women, the results showed that there was higher prevalence among women with no education and their daughters. The study also found that education was associated with a reduced likelihood of undergoing FGM for both Protestant and Catholic women but not for Muslim women(Karmaker et al., 2011). In a study conducted in Kenya by Livermore, Monteiro, & Rymer (2007) showed that awareness of complications of FGM is greater than awareness of both the law against FGM and educational programs.

2.5 Effects of socio cultural and religious beliefs on FGM

2.5.1 Socio cultural aspects of FGM

Globally as the campaign against FGM continues to gather momentum, researchers have focused mainly on the socio cultural, legal and clinical aspects of FGM. There has also been an increasing awareness among clinicians and human rights
campaigners that understanding the motives behind the socio cultural elements may be an avenue towards abandonment of the practice (Ezenyeaku et al., 2011). FGM is a very delicate topic that is deeply entrenched in the tradition and culture of many communities in Africa and in many religions FGM is regarded as interference in tradition and a dictation from the communities in the western world. Religion, particularly Islam, is used very often as an argument for FGM, although some scholars have found out that in the Holy Qur’an and in Islam there is no single justification for FGM (Molleman & Franse, 2009).

FGM is a practice which is multifaceted and deeply rooted in a strong cultural and social framework. It is endorsed by the community and supported by the loving parents with what is believed to be the best interests of a young girl at heart. FGM can only be understood within its cultural context, for in the societies where it is practiced, despite its harmful physical effects, FGM provides women with many social and cultural benefits. As much as beliefs about FGM vary from one ethnic community to another, there are several themes that are common (FGM New Zealand, 2016). These common themes in beliefs are as follows: Many societies believe that FGM prevents the women and girls from being promiscuous. This they believe is to tame the girl so that she is not oversexed. FGM is held high in societies where virginity is a prerequisite for marriage. In these societies any form of extramarital relationship is punishable by extreme penalties. FGM is therefore believed to preserve their virginity, prevent them from being oversexed, and save them from temptation and disgrace. In times of war FGM is also thought to protect women from rape. In other societies FGM is associated with family honor, which is of vital importance in the Horn of Africa. The most dishonorable experience for a man is the sexual impropriety
of a female member of the family, and once lost it cannot be restored. In some communities they also believe that FGM promotes fertility and increases the man’s sexual pleasure, both of which enhance a woman’s attractiveness in marriage.

Many groups that practice FGM come from patriarchal societies whereby resources and power are passed down and held solely under male control, with a woman’s access to land and to economic resources being exclusively through her husband (or the male members of her family). In order for a woman to be eligible for marriage it is essential that she is a virgin, the association between virginity and FGM is so strong that a girl who has not undergone infibulated or excision has virtually no chance of marriage, regardless of her virginity and worse of all has no access to land and future resources (FGM New Zealand, 2016). Other societies practicing FGM are patrilineal, whereby a woman represents and retains her father’s lineage and her marriage is not only a union of two people, but an alliance of two lineages. This alliance strengthens clans and clan relationships with other groups and a woman who has not undergone FGM brings great shame and dishonor to her father’s lineage.

Most women who are affected by FGM come from rural areas and have limited access to reproductive health education. Many myths especially those on hygiene have been passed from generation to generation. In areas where there is high infant mortality and fertility is important, FGM is promoted as a prerequisite for the cleanliness of a woman and the good health of her baby. In Somalia, the external female genitalia are considered as dirty, ugly and disfiguring. Infibulation is believed to produce a clean smooth skin surface that is desirable to touch (FGM New Zealand, 2016).

FGM is considered to play a significant role in men’s sexuality in the Horn of Africa. The narrowed vaginal opening is believed to enhance a husband’s sexual pleasure and
the challenge of penetrating a tight opening is considered to be linked to a man’s virility. In societies where polygamy is the norm, it is thought to be physically impossible for men to satisfy the many wives they have hence the practice of FGM comes in handy as it makes the wives less sexually demanding (FGM New Zealand, 2016).

Traditionally in the Somali culture FGM was performed in adolescence as an initiation into womanhood. The procedure is no longer considered to be a rite of passage anymore and is today mainly performed on girls aged five to eight years. Traditionally circumcisers conduct most operations but the numbers of FGM performed by professional health providers is now on the increase (Fried et al., 2013). Media, religious debates and anti-FGM campaigns by local nongovernmental organizations (NGOs) seem to have activated discussions on FGM among the Somali people hence breaking many traditional taboos leading to growing questioning of the practice. Somalis from Somaliland who return home from the Diaspora with Western views towards FGM constitute another important influence besides the media, religious reports and anti-FGM campaigns (Fried et al., 2013).

For Christian women it was found that education appeared to have a protective effect while for Muslim women or for women who followed a traditional or animist religious belief this was not the case. The researchers also concluded that deep cultural issues and strongly personally held beliefs are likely to be involved in the perpetuation of FGM (Karmaker et al., 2011).

In a study by Fried et al. (2013) which was conducted in a maternity clinic in Hargeisa, the results of the findings showed that there was a shift in FGM practice from the Pharaonic type to the Sunna type. This shift in practice was said to be
influenced by both religious leaders and information through media. It has been shown that traditional and religious beliefs are the reason as to why most females accept the practice of FGM in most societies.

Evidence suggests that the negative health effects of FGM presented by a health authority such as a medical professional are a key motivational factor for religious leaders to take a clear and strong stance against the practice, and which might lead to the issue religious edicts (Fatwa) against FGM. Such Fatwas were issued for example in Egypt in 2006, in Mauritania in 2010. Fatwa’s are believed to contribute to change in communities where people link the practice of FGM to Islam (Johansen et al., 2013). There are many surveys that find women who express a negative attitude to the continuation of FGM, while they still intend to let their daughters undergo the practice. A major reason for this contradiction between attitude and behavior is a social and cultural pressure to uphold the tradition. This has led to widely recognition of the importance of community-wide change as opposed to individual change to enable individual families to abandon FGM. Experience shows that large-scale abandonment can only be expected when FGM is no longer an all-dominant social norm and families can abandon the practice without the risk of stigmatization and exclusion (Johansen et al., 2013).

In communities where FGM is common, it is upheld as a social norm and enforced through social sanctions of individuals or families that do not conform. The risk of being socially ostracized, excluded from community activities, denied financial and practical support, as well as marriage possibilities can outweigh the health risks associated with the practice (Johansen et al., 2013). Community-led programmes have been identified as a necessary factor to tackle the social convention of FGM. These
programmes aim at promoting the empowerment of women and girls and the community at large to enable them to critically examine their own tradition and to gain control over the factors and decisions that shape their lives. The interventions usually integrate the issue into a wider learning package, including aspects such as gender and development, as well as the social, political, legal, health and economic development of a community (Johansen et al., 2013)

2.5.2 Religion aspect of FGM

Many studies have shown that FGM is practiced by followers of many different religions such as; Muslims, Catholics, Jews, Animists, and Christian Coptic. In the religious texts of these religions there is no any basis for FGM. The association between FGM and religious obligation is assumed to be the result of historic concurrence and incorrect interpretation and teaching of religious texts (FGM New Zealand, 2016). There is no mention of FGM in the Bible or Quran. Although its origins are pre-Islamic, it became associated with Islam because of that religion's focus on female modesty and chastity, and is found only within or near Muslim communities. It is praised in several hadith (sayings attributed to Muhammad) as noble but not required, along with advice that the milder forms are kinder to women. In 2006 several leading Islamic scholars called for an end to the practice, and in 2007 the Al-Azhar Supreme Council of Islamic Research in Cairo ruled that it has no basis in Islamic law (Kaplan, 2013). According to Mackie & LeJeune, (2008), it is not practiced in Mecca and Medina in Saudi Arabia, Islam's holiest cities, although there have been reports of it in that country, perhaps among immigrant communities. Surveys have shown that there is a widespread belief in several countries, particularly Eritrea, Egypt, Guinea, Mali and Mauritania, that FGM is a religious requirement.
Practitioners may not distinguish between religion, tradition and chastity, which make it difficult to interpret the data.

2.6 Heath complications experienced by women who have undergone FGM

The severe effects of FGM on the health of girls and women have been widely documented (World Bank, 2004). FGM is associated with a series of health risks and consequences including pain, bleeding, difficult in passing urine, infection, death and hemorrhage (Yasin et al., 2013). According to the World Bank (2004) long-term consequences of FGM/FGC include infibulation cysts, keloid scar formation, damage to the urethra resulting in urinary incontinence, pain during sexual intercourse, sexual dysfunction and difficult in childbirth, difficult menstrual periods among others. Similar complications were made in a study by Dike et al. (2012) in which they noted that among the complications that result from FGM as listed by the women included bleeding, infection and painful coitus. FGM has both immediate consequences including severe pain, shock, hemorrhage, tetanus or infection, urine retention, ulceration of the genital region and injury to adjacent tissue, wound infection, urinary infection, fever and septicemia. Hemorrhage and infection can be of such magnitude as to cause death and long-term consequences include anemia, the formation of cysts and abscesses, keloid scar formation, damage to the urethra resulting in urinary incontinence, dyspareunia (painful sexual intercourse) and sexual dysfunction, hypersensitivity of the genital area (UNFPA, 2010).

According to Ahmadu (2007) some of the popular interventions to reduce the effects of FGM complications that have been employed included; health risk information, conversion of exercisers, training of health professionals as change agents, alternative rites programs, and community led approaches, public statements and legal measures.
Trained staff can recognize and manage the physical, sexual and psychological complications of FGM/FGC (World Bank, 2004).
CHAPTER THREE: MATERIALS AND METHODS

3.1 Introduction

This chapter explained the research methodology. The sections included were the research design, target population, sample design, data collection instruments and procedures and data analysis.

3.2 Research design

The study adopted a descriptive cross-sectional design. A descriptive cross-sectional study is in which the disease or condition and potentially related factors are measured at a specific point in time for a defined population (National EMSC Data Analysis Resources Center [NEDARC], 2010). A cross-sectional survey collects data to make inferences about a population of interest at one point in time thus a snapshot of the population about which it gathers data (Lavrakas, 2008). The study employed this design to describe socio demographic, knowledge, attitude on women’s reproductive health of FGM in Warta Nabada District, and effects of socio cultural and religious beliefs in Mogadishu Somalia at a specific period and establish the relationship between these determinants of FGM and its practice. At the start of the study, assumption was that there was very few cases of women who had not undergone FGM, however, during the study these cases were sampled thus a description of the determinants and FGM practice among both circumcised and uncircumcised women. Therefore by design the study was not a comparative study.

3.3 Variables

The independent variables were socio demographic characteristics, knowledge and attitudes of FGM, socio cultural and religious beliefs and health complications
experienced by women who undergone FGM. The dependent variable was FGM practice. To assess women’s knowledge on FGM, women were asked whether they knew what FGM was and to describe what it involved. To assess women’s attitude towards FGM women were asked whether FGM should be stopped, whether it prevents promiscuity and whether uncircumcised women were unclean. To assess FGM practice women were asked whether they had undergone FGM. FGM complications were assessed by asking the women whether they thought FGM had associated health complications.

3.4 Location of the study

The study site was Warta Nabada District which lies in the southeastern Banadir region of Somalia. It is one of the larger neighborhoods of the capital Mogadishu. For geographical location refer to Appendix X. Warta Nabada district has five district wards which included, General Da’ud, Horseed, Barwaqo, Hantiwadag and Hamar bile. The selected location has a higher population than any other district around Mogadishu.

3.5 Study population

The district has an estimated population of 61,140 people as at January 2015 according to Banadir regional administration. Women of the reproductive age (15-49 years) compose approximately 23% (14,062) of the population. The target population composed of women of reproductive age who lived within Warta Nabada District especially Barwaqo district-ward which has a total of 3,250 households. The study also targeted professional midwives, head nurses and traditional birth attendant as key informants; and women organizations, religious leaders, local authority of the district and youth organizations for the focus group discussions.
3.6 Sampling techniques and Sample size

3.6.1 Sampling Techniques

Warta Nabada District has five district wards each with four to six villages. Purposive sampling was used to select Barwaqo District Ward (Table 3.1) based on the fact that Barwaqo ward is the most populous. Systematic random sampling was used to select the households from a sampling frame with 3,250 households which had at least one woman aged 15 to 49 years. Having randomly identified the first household, the subsequent 9\textsuperscript{th} household was selected from the sampling frame. If a household had two or more women with the same age, simple random sampling was used to select one. Focus group discussion participants were purposively selected among two women organizations, religious leaders, local authority of the district, and two youth organizations. Key informant interview were conducted among professional midwifes, head nurses and Traditional Birth Attendances (TBAs).

Table 3.1: District Wards of Warta Nabada District

<table>
<thead>
<tr>
<th>District –Wards</th>
<th>Number of HH</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Da’ud</td>
<td>735</td>
</tr>
<tr>
<td>Hantiwadag</td>
<td>1500</td>
</tr>
<tr>
<td>Barwaqo</td>
<td>3250</td>
</tr>
<tr>
<td>Horseed</td>
<td>1250</td>
</tr>
<tr>
<td>Hamarbile</td>
<td>1405</td>
</tr>
</tbody>
</table>

Source (Warta Nabada District Commissioner, 2015)
3.6.2 Sample size determination

The sample size was determined using the Fisher formula (Kasiulevičius, Šapoka, & Filipavičiūtė, 2006) as follows:

\[ n = \frac{z^2pq}{d^2} \]

Where,

- \( n \) = the desired sample size if the target population is more than 10,000
- \( z \) = the standard normal deviate at the required 95% Confidence Interval (C.I.)
- \( p \) = the proportion in the target population estimated to have characteristics being measured.
- \( q = 1 - p \)
- \( d \) = the level of statistical significance set <0.05

To yield maximum sample size a proportion (p) of 0.5 was utilized.

\[ n_p = \frac{1.96^2 \times 0.5 \times 0.5}{0.05^2} = 384.16 \approx 384 \]

Using finite correction for proportions

\[ n = \frac{n_p}{1 + \frac{n_p - 1}{N}} \]

\[ n = \frac{384}{1 + \frac{384 - 1}{3250}} = 343.52 \approx 344 \text{ respondents} \]
The study used a sample of 344 women. The number was increased to 349 women to take care of non-responses.

3.7 Construction of research instruments

Axinn & Pearce (2006) explain that there are four data collection methods; questionnaires, interviews, observation and focus group discussion. Questionnaire is a series of written questions on a topic about which the women’s opinion are sought. Axinn & Pearce (2006) argue that questionnaires provide a high degree of data standardization and adoption of generalized information amongst any population. Connaway & Powell (2010) add that questionnaires are advantageous since they are filled up by the women in their own comfort and facilitate the collection in large amount of data in a relatively short time. The study was us structured questionnaire both open and close ended questions. This was administered to sampled women and girls of reproductive age. FGD was used that targeted key informants including TBAs; professional midwifes; head nurses of Save Our Soils (SOS) of Mothers & Children’s hospital; and professional midwifes, and head nurses of Mother & Child Banadir’s hospital.

3.8 Validity and reliability of the research instruments

The study instruments were validated by reviewing its findings with other similar studies. To establish the reliability of the instruments Cronbach Alpha coefficient was evaluated through the Split-Half Technique and an alpha score greater than 0.7 was considered to ascertain reliability of the research findings and instruments therein. On evaluation an alpha score of 0.82 was obtained indicating the reliability.
3.9 Data collection techniques

Research assistants were involved in data collection after training. Administration of questionnaires was done to collect quantitative data through an interviewer administered approach. Qualitative data was collected through focused group discussions and Key Informant Interview.

3.10 Data analysis and presentation

Data was entered, coded and analyzed using Statistical Package for Social Sciences (SPSS) version 20. Descriptive statistics were used to generate frequencies and proportions. Chi square test were used to test the association of the variables. The qualitative data was coded and analyzed using content analysis approach.

3.11 Logistical and ethical considerations

Ethical approval was sought from Kenyatta University Ethics and Research Committee and research permit was sought from Ministry of Culture & Higher Education. Research authority was obtained from Ministry of Health & Human Services to carry out the study. And Permission was sought from the local authorities in Warta Nabada District. Consent was sought from each woman on voluntary basis. An informed consent form was developed so that only those who consent to participate in the study signed and was given the questionnaire. No names were included on the questionnaires and information was for research purposes only. There were no risks involved in the study. Ethical principles of autonomy, justice, beneficence and confidentiality were applied. The principles of autonomy were applied to let participants make an informed consent on whether to participate. This was included disclosing the nature of the study to participants, the risks, benefits, opportunity to ask questions and to state that the participant was not penalized in case
they withdraw from the study. The principle of beneficence was used to minimize any risks to the participants by explaining to the participants that no risks were involved when they participate in the study. On the principle of justice, there was equitable selection of participants and there was no coercion of the participants. The participants was also assured of confidentiality and anonymity in the use of the study results as the questionnaire was not have names hence there was no victimization of the women.
CHAPTER FOUR: FINDINGS

4.1 Introduction

This chapter contains findings of the study on FGM practice and its effects on women’s reproductive health. Findings are presented under themes based on the objectives including; the socio-demographic characteristics of the women, women’s knowledge and attitudes about the risks associated with FGM on their reproductive health; the effects of socio cultural and religious beliefs on health programs targeting the elimination of FGM and the health complications experienced by women’s reproductive health who have undergone FGM. The study response rate was 100% (349 women).

4.2 Preliminary information

The study established that the FGM prevalence was at 92.3%. Majority 135(42.0%) of the circumcised women had undergone Type 3 (infibulations/ pharaonic) FGM; 123 (38.2%) had undergone Type 1 (Sunna) while 64(20.0%) had undergone Type 2 (Sunna kabir). Majority (58.1%) of the circumcised women were circumcised at age of between 5 and 8 years. Circumcision was commonly done at villages (97.2%). It was also majorly done by unskilled TBAs (78%). Circumcised women mostly (94.1%) received herbal medication after the practice, see Table 4.2.

4.3 Socio demographic characteristics and influence on FGM practice

Majority 125(38.8%) of the circumcised women were aged between 21 and 30 years while most 19(70.4%) of the uncircumcised women were similarly aged between 21 and 30 years. There was a significant association between age and FGM practice (p-
value < .001). This implied that there was age difference between circumcised and uncircumcised women.

Majority 158 (49.1%) of the circumcised women were married while greater part 17 (63%) of the uncircumcised women were single. There was a significant association between marital status and circumcision (p-value < .001). Among the married women, the proportion circumcised was significantly greater than the uncircumcised and vice versa for single women. This implied that marital status varied between circumcised and uncircumcised women.

Among the circumcised women, 46.3% had attained secondary education which is lower compared to 70.4% among uncircumcised women. There was no significant association between education level and circumcision (p-value = 0.142). This implied that education level did not vary between circumcised and uncircumcised women.

A proportion of 40.1% of the circumcised women were housewives while 44.4% of uncircumcised women were self-employed. There was no significant association between occupation and circumcision (p-value = 0.059). This implied that occupation did not vary between circumcised and uncircumcised women.

A portion of 41% circumcised and 44.4% uncircumcised women came from nuclear families. There was no significant association between family type and circumcision (p-value = 0.124). This implied that marital status did not vary between circumcised and uncircumcised women, see Table 4.1.
## Table 4.1: Socio-demographic characteristics of the women

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Categories</th>
<th>Circumcision</th>
<th></th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Circumcised</td>
<td>Uncircumcised</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Count (N = 322)</td>
<td>Count (N = 27)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Percent</td>
<td>Percent</td>
<td></td>
</tr>
<tr>
<td>Age in years</td>
<td>Less than 21</td>
<td>24</td>
<td>7</td>
<td>7.5%</td>
</tr>
<tr>
<td></td>
<td>21 – 30</td>
<td>125</td>
<td>19</td>
<td>19.9%</td>
</tr>
<tr>
<td></td>
<td>31 – 40</td>
<td>129</td>
<td>1</td>
<td>40.1%</td>
</tr>
<tr>
<td></td>
<td>41 – 50</td>
<td>44</td>
<td>0</td>
<td>13.7%</td>
</tr>
<tr>
<td>Marital status</td>
<td>Single</td>
<td>81</td>
<td>17</td>
<td>25.2%</td>
</tr>
<tr>
<td></td>
<td>Married</td>
<td>158</td>
<td>9</td>
<td>49.1%</td>
</tr>
<tr>
<td></td>
<td>Divorced</td>
<td>50</td>
<td>1</td>
<td>15.5%</td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
<td>33</td>
<td>0</td>
<td>10.2%</td>
</tr>
<tr>
<td>Education level</td>
<td>None</td>
<td>26</td>
<td>1</td>
<td>8.1%</td>
</tr>
<tr>
<td></td>
<td>Primary</td>
<td>64</td>
<td>2</td>
<td>19.9%</td>
</tr>
<tr>
<td></td>
<td>University</td>
<td>70</td>
<td>5</td>
<td>21.7%</td>
</tr>
<tr>
<td></td>
<td>College</td>
<td>13</td>
<td>0</td>
<td>4.0%</td>
</tr>
<tr>
<td></td>
<td>Secondary</td>
<td>149</td>
<td>19</td>
<td>46.3%</td>
</tr>
<tr>
<td>Occupation</td>
<td>Housewife</td>
<td>129</td>
<td>5</td>
<td>40.1%</td>
</tr>
<tr>
<td></td>
<td>Self employed</td>
<td>109</td>
<td>12</td>
<td>33.9%</td>
</tr>
<tr>
<td></td>
<td>Government/Private employee</td>
<td>38</td>
<td>3</td>
<td>11.8%</td>
</tr>
<tr>
<td></td>
<td>Unemployed</td>
<td>37</td>
<td>4</td>
<td>11.5%</td>
</tr>
<tr>
<td></td>
<td>Student</td>
<td>9</td>
<td>3</td>
<td>2.8%</td>
</tr>
<tr>
<td>Family type</td>
<td>Nuclear</td>
<td>132</td>
<td>12</td>
<td>41.0%</td>
</tr>
<tr>
<td></td>
<td>Joint</td>
<td>72</td>
<td>2</td>
<td>22.4%</td>
</tr>
<tr>
<td></td>
<td>Polygamous</td>
<td>59</td>
<td>4</td>
<td>18.3%</td>
</tr>
<tr>
<td></td>
<td>Single</td>
<td>59</td>
<td>9</td>
<td>18.3%</td>
</tr>
</tbody>
</table>
Table 4.2: Socio-demographic characteristics of the woman’s cont:

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Dimension</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGM practice</td>
<td>Those Undergone FGM</td>
<td>322</td>
<td>92.30%</td>
</tr>
<tr>
<td></td>
<td>Those Did not Undergo FGM</td>
<td>27</td>
<td>7.70%</td>
</tr>
<tr>
<td>Type of FGM undergone</td>
<td>Type 3 (infibulations/pharaonic)</td>
<td>135</td>
<td>42.00%</td>
</tr>
<tr>
<td></td>
<td>Type 1 (Sunna)</td>
<td>123</td>
<td>38.20%</td>
</tr>
<tr>
<td></td>
<td>Type 2 (Sunna kabir)</td>
<td>64</td>
<td>20.00%</td>
</tr>
<tr>
<td>Age of circumcision</td>
<td>0 – 4</td>
<td>45</td>
<td>14.00%</td>
</tr>
<tr>
<td></td>
<td>5 – 8</td>
<td>187</td>
<td>58.10%</td>
</tr>
<tr>
<td></td>
<td>9 – 12</td>
<td>78</td>
<td>24.20%</td>
</tr>
<tr>
<td></td>
<td>&gt;13</td>
<td>12</td>
<td>3.70%</td>
</tr>
<tr>
<td>Place of circumcision</td>
<td>Hospital</td>
<td>9</td>
<td>2.80%</td>
</tr>
<tr>
<td></td>
<td>Village</td>
<td>313</td>
<td>97.20%</td>
</tr>
<tr>
<td>FGM practitioners</td>
<td>Unskilled TBA</td>
<td>251</td>
<td>78.00%</td>
</tr>
<tr>
<td></td>
<td>Grand mother</td>
<td>50</td>
<td>15.50%</td>
</tr>
<tr>
<td></td>
<td>Health worker</td>
<td>21</td>
<td>6.50%</td>
</tr>
<tr>
<td>Medication received</td>
<td>Anaesthesia</td>
<td>9</td>
<td>2.80%</td>
</tr>
<tr>
<td></td>
<td>Pain killer</td>
<td>10</td>
<td>3.10%</td>
</tr>
<tr>
<td></td>
<td>Herbal medicine</td>
<td>303</td>
<td>94.10%</td>
</tr>
</tbody>
</table>

4.4 Knowledge and attitude on FGM risks and eradication programs

Minority 115(33.0%) of the women knew of what was involved in FGM. A section of 32.6% circumcised women reported to know what was involved in FGM while 37.0% of uncircumcised women reported to know what was involved in FGM, see Figure 4.1. There was no significant difference in reported knowledge of what was involved in FGM between circumcised and uncircumcised women (p-value = .638). This implied that reported knowledge of what was involved in FGM did not vary between circumcised and uncircumcised women. FGM was mostly reported as total/partial removal of clitoris and a traditional practice, see Table 4.3.
All FGD participants believed that FGM violated women religious and human rights by isolating the girl child from the community; social effects; and lack of access of information.

![Knowledge on what FGM involves](image)

**Figure 4.1: Knowledge on what FGM involves**

Different responses on definition FGM were grouped as indicated in table 4.3.

<table>
<thead>
<tr>
<th>Women’s definition of FGM</th>
<th>Frequency</th>
<th>Percent (N= 115)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total/partial removal of clitoris</td>
<td>61</td>
<td>53.0</td>
</tr>
<tr>
<td>Traditional practice</td>
<td>47</td>
<td>40.9</td>
</tr>
<tr>
<td>Harmful practice</td>
<td>5</td>
<td>4.3</td>
</tr>
<tr>
<td>Infertility, psychological problems, physical problems</td>
<td>1</td>
<td>.9</td>
</tr>
<tr>
<td>Effects during delivery time</td>
<td>1</td>
<td>.9</td>
</tr>
</tbody>
</table>

Most 309(88.5%) women were knowledgeable on one or more types of FGM practiced in the community. Type 1 (Sunna) was the most known type of FGM by 81% circumcised and 68.4% uncircumcised women, see Figure 4.2. Knowledge on types of FGM significantly (p-value = .006) varied with whether a woman was
circumcised or not. Type 3 (infibulations/ pharaonic) FGM was significantly more known by circumcised women as compared to the uncircumcised.

![Bar Chart: Type of FGM known](Image)

**Figure 4.2: Type of FGM known**

The most practiced type of FGM according to the women in the community was Type 3 (infibulations/ pharaonic) 174 (56.3%) and Type 1 (Sunna) 107(55.7%). FGM Type 2(Sunna kabir) was also more practiced 6(19.7%) as compared to FGM Type 4 12(3.9%), see Figure 4.3. Similarly according to the FGDs the most common types of FGM practiced in the society were Type 3 (infibulations/ pharaonic) 4(100%) and Type 1 (Sunna) 4(100%) while Type 2(Sunna kabir) was the least practiced 2(50%).

![Bar Chart: Common type of FGM practiced in community](Image)

**Figure 4.3: Common type of FGM practiced in community**
Greater part (77.4%) of the women was not aware of the interventions to eradicate FGM. One sample Binomial test (p-value < .001) indicated that the proportion of women who were unaware of interventions to eradicate FGM was significantly greater than the proportion of those who were aware of these interventions. Among women who were aware of interventions to eradicate FGM; the proportion of those circumcised was significantly greater. This implied that circumcised women were more aware of interventions to eradicate FGM than uncircumcised women, see Table 4.4. Having undergone FGM, this suggested that circumcised women were more aware of interventions to eradicate FGM as compared to uncircumcised women.

<table>
<thead>
<tr>
<th>Awareness on interventions to eradicate FGM</th>
<th>Circumcision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Circumcised (N = 322)</td>
</tr>
<tr>
<td>Aware</td>
<td>78(24.2%)</td>
</tr>
<tr>
<td>Unaware</td>
<td>244(75.8%)</td>
</tr>
</tbody>
</table>

Interventions to eradicate FGM were mainly done through media 51(65.1%) among others as indicated in Table 4.5. Key activities of the interventions included stopping FGM 48(60.8%). Majority of 79 women who were aware of interventions to eradicate FGM thought that the interventions were succeeding 60(75.9%) while 19(24.1%) thought that they were not successful. The main success indicator of the interventions was increased awareness of FGM and its complications 29(36.7%) while the main non-success indicator of the interventions was that the community was still practicing it 11(13.9%). Participants in all the FGDs agreed that community was supportive of interventions towards eradication of FGM since it was a harmful practice. In addition, the FGDs thought that the interventions were succeeding despite the challenges cited, that is, strict adherence to culture 2(50%) and lack of access to information 1(25%).
Similarly most KII thought that the interventions were succeeding because FGM cases were reducing 3(60%), FGM practitioners were also reducing 2(40%) and the cultural belief of keeping girls virgin had vanished 1(20%). The KIIIs cited lack of health awareness 3(60%), cultural beliefs 2(40%) and lack of social media 1(20%) as the challenges facing the interventions. FGDs suggested the way forward in curbing FGM to include increasing health awareness 3(75%) and 1(25%) each: sensitizing TBAs, motivating mothers who do not practice FGM, re-opening those mutilated and religious leaders need to participate in the anti-FGM campaigns. Similarly most KIIIs cited the need to educate mothers 3(60%), FGM practitioners 2(40%) and community at whole 2(40%) against the practice. The KIIIs recommended media talking about effects of FGM 2(40%), launching advocacy programs 2(40%), increasing health education 2(40%) and anti-FGM legislation as the way forward to curb FGM.
Table 4.5: Interventions to eradicate FGM proposed by women

<table>
<thead>
<tr>
<th>Intervention dimensions</th>
<th>Categories</th>
<th>Frequency</th>
<th>Percent (N = 79)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source of interventions</td>
<td>CED</td>
<td>2</td>
<td>2.30%</td>
</tr>
<tr>
<td></td>
<td>Social media</td>
<td>51</td>
<td>65.10%</td>
</tr>
<tr>
<td></td>
<td>NRC</td>
<td>2</td>
<td>2.30%</td>
</tr>
<tr>
<td></td>
<td>SAACID</td>
<td>4</td>
<td>4.70%</td>
</tr>
<tr>
<td></td>
<td>Save the children</td>
<td>2</td>
<td>2.30%</td>
</tr>
<tr>
<td></td>
<td>WHO</td>
<td>13</td>
<td>16.30%</td>
</tr>
<tr>
<td></td>
<td>Women organizations</td>
<td>6</td>
<td>7.00%</td>
</tr>
<tr>
<td>Key interventions activities</td>
<td>Advocacy and health awareness</td>
<td>6</td>
<td>7.80%</td>
</tr>
<tr>
<td></td>
<td>Educating the TBAs</td>
<td>3</td>
<td>3.90%</td>
</tr>
<tr>
<td></td>
<td>Health education</td>
<td>19</td>
<td>23.50%</td>
</tr>
<tr>
<td></td>
<td>Reduce FGM</td>
<td>3</td>
<td>3.90%</td>
</tr>
<tr>
<td></td>
<td>Stop FGM</td>
<td>48</td>
<td>60.80%</td>
</tr>
<tr>
<td>Successful impact indicators</td>
<td>Community awareness on FGM</td>
<td>3</td>
<td>3.80%</td>
</tr>
<tr>
<td></td>
<td>Increased awareness of FGM and its complications</td>
<td>29</td>
<td>36.70%</td>
</tr>
<tr>
<td></td>
<td>Reduced FGM cases</td>
<td>27</td>
<td>34.20%</td>
</tr>
<tr>
<td>Unsuccessful impact indicators</td>
<td>Community still practice</td>
<td>11</td>
<td>13.90%</td>
</tr>
<tr>
<td></td>
<td>People believe it’s their culture</td>
<td>6</td>
<td>8.70%</td>
</tr>
<tr>
<td></td>
<td>Practice is increasing</td>
<td>2</td>
<td>2.50%</td>
</tr>
<tr>
<td></td>
<td>Continued education</td>
<td>71</td>
<td>89.90%</td>
</tr>
<tr>
<td>Inputs for interventions success</td>
<td>Legislation</td>
<td>4</td>
<td>4.70%</td>
</tr>
<tr>
<td></td>
<td>To follow holy QURAN</td>
<td>4</td>
<td>4.70%</td>
</tr>
</tbody>
</table>

4.5 Influence of socio cultural and religious beliefs on FGM eradication programs

Most (84.5%) women had agreed or allowed their daughter or family member and others to be circumcised because circumcision was their culture. Other reasons for circumcision are as indicated in Table 4.6. On the contrary, the FGDs mostly cited the need to keep virginity 3(75%); cultural adherence 3(75%); religion and limiting sexual activities 2(50%); need to be clean, to get a husband and as dictated by parents 1(25%) as the reasons for practicing FGM. Most KII, similar to FGDs, cited the need to keep virginity 4(80%) and cultural adherence 4(80%) as the main reasons for FGM.
practice. Other reasons cited included the need to be clean 2(40%) and to get a husband in future 1(20%).

Table 4.6: Social-cultural and religious reasons for FGM practice

<table>
<thead>
<tr>
<th>Reasons for FGM practice</th>
<th>Frequency</th>
<th>Percent (N = 349)</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is our culture</td>
<td>295</td>
<td>84.5%</td>
</tr>
<tr>
<td>So as to be pure and to reduce my sexual libido</td>
<td>125</td>
<td>35.8%</td>
</tr>
<tr>
<td>Because my mother said so</td>
<td>120</td>
<td>34.4%</td>
</tr>
<tr>
<td>Because my father said so</td>
<td>103</td>
<td>29.5%</td>
</tr>
<tr>
<td>So as not to be ostracized by my family members</td>
<td>96</td>
<td>27.5%</td>
</tr>
<tr>
<td>So as to get a husband in the future</td>
<td>94</td>
<td>26.9%</td>
</tr>
<tr>
<td>To enable me to get land and be economically empowered</td>
<td>80</td>
<td>22.9%</td>
</tr>
<tr>
<td>The Quran stipulates so</td>
<td>39</td>
<td>11.2%</td>
</tr>
</tbody>
</table>

* Percentages do not add up to 100% because of multiple response

Majority 281(80.5%) of the women thought that FGM did not prevent promiscuity. One sample Binomial test (p-value<.001) indicated that the proportion of women who thought that FGM prevents promiscuity is significantly lower than the proportion of women who thought otherwise. However, the perception of FGM preventing promiscuity did not vary with whether a woman was circumcised or not (Pearson Chi-Square test p-value = .166). This implies that the perception of FGM preventing promiscuity did not vary between circumcised and uncircumcised women.

Mainstream 323(92.6%) of the women thought that uncircumcised women were clean. 12(46.2%) women thought uncircumcised women were unclean because long female genitalia (labia) is hard to clean and smelly since urine is retained inside; and they were more susceptible to any infection. One sample Binomial test (p-value<.001) indicated that the proportion of women who thought that uncircumcised women were unclean was significantly lower than the proportion that thought otherwise. However,
the Perception on tidiness of uncircumcised women did not vary with whether a woman was circumcised or not (Pearson Chi-Square test p-value = .993). This implied that the perception of tidiness of uncircumcised women did not vary between circumcised and uncircumcised women, see Table 4.7.

Table 4.7: Perceptions on FGM

<table>
<thead>
<tr>
<th>FGM perceptions</th>
<th>Categories</th>
<th>Circumcision</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Circumcised</td>
<td>Uncircumcised</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Count</td>
<td>Percent (N = 322)</td>
<td>Count</td>
</tr>
<tr>
<td>Promiscuity prevention</td>
<td>Prevents</td>
<td>60</td>
<td>18.6%</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Not prevent</td>
<td>262</td>
<td>81.4%</td>
<td>19</td>
</tr>
<tr>
<td>Tidiness of uncircumcised women</td>
<td>Unclean</td>
<td>24</td>
<td>7.5%</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Clean</td>
<td>298</td>
<td>92.5%</td>
<td>25</td>
</tr>
<tr>
<td>Reasons for untidiness of uncircumcised women (N1 = 24 circumcised, N2 = 2 uncircumcised)</td>
<td>Genitalia is smelly if not cut</td>
<td>11</td>
<td>45.8%</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>It reduces libido</td>
<td>3</td>
<td>12.5%</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Religion requires</td>
<td>2</td>
<td>8.3%</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Susceptible to any infection</td>
<td>7</td>
<td>29.2%</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>They have bad smell</td>
<td>1</td>
<td>4.2%</td>
<td>0</td>
</tr>
</tbody>
</table>

Best part 313(89.7%) of the women thought that FGM should be stopped while 36(10.3%) women thought FGM should continue. Most of circumcised (90.1%) and uncircumcised (85.2%) women thought that FGM should be stopped. One sample Binomial test (p-value<.001) indicated that the proportion of women who thought that FGM should be stopped is significantly greater than the proportion of women who thought that FGM should continue. Pearson Chi-square test (p-value = .424) indicated that the perception on continuity of FGM did not significantly vary with whether a woman was circumcised or not. Cultural belief was cited as the main reason by 83.3% of the 36 women who thought that FGM should continue, see Table 4.8.
Table 4.8: Woman’s perception on FGM continuity

<table>
<thead>
<tr>
<th>FGM perception</th>
<th>Categories</th>
<th>Circumcised</th>
<th>Uncircumcised</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>Percent (N = 322)</td>
<td>Count</td>
</tr>
<tr>
<td>FGM continuity</td>
<td>Stop</td>
<td>290</td>
<td>90.1%</td>
</tr>
<tr>
<td></td>
<td>Continue</td>
<td>32</td>
<td>9.9%</td>
</tr>
<tr>
<td>Reason for FGM continuity (N1 = 32 circumcised, N2 = 4 uncircumcised)</td>
<td>Cultural belief</td>
<td>26</td>
<td>81.3%</td>
</tr>
<tr>
<td></td>
<td>It is good for our girls</td>
<td>4</td>
<td>12.5%</td>
</tr>
<tr>
<td></td>
<td>Religion supports</td>
<td>1</td>
<td>3.1%</td>
</tr>
<tr>
<td></td>
<td>To have pure girls</td>
<td>1</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

Preferred type of FGM

Sunna was thought to be safe by 141(40.4%) women. Most 196(60.9%) of the circumcised women thought that Sunna was unsafe while most 15(55.6%) of the uncircumcised women thought that Sunna was safe. One sample Binomial test (p-value < .001) indicated that the proportion of women who thought that Sunna was safe was significantly lower than the proportion of women who thought that Sunna was unsafe. However, the perception on safety of Sunna circumcision did not vary with whether a woman was circumcised or not (Pearson Chi-Square p-value = .095).

Many 119(84.4%) of women who thought that Sunna was safe thought that it should be allowed to continue. Many of 106(84.1%) circumcised and 13(86.7%) uncircumcised women who thought that Sunna was safe thought that it should be allowed to continue. One sample Binomial test (p-value < .001) indicated that the proportion of women who thought that Sunna was should continue was significantly lower than the proportion of women who thought that Sunna should be stopped. However, the perception on continuity of Sunna circumcision did not vary with whether a woman was circumcised or not (Pearson Chi-Square p-value = .798).

Majority 79(56.0%) of them cited that safety and lack of complications was the major reason for supporting continuation of Sunna, see Table 4.9.
Table 4.9: Sunna perceptions by women

<table>
<thead>
<tr>
<th>Sunna Perspective</th>
<th>Dimension</th>
<th>Circumcision</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Circumcised</td>
<td>Uncircumcised</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Count (N = 322)</td>
<td>Count (N = 27)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Percept</td>
<td>Percept</td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td>Safe</td>
<td>126</td>
<td>15</td>
<td>39.1%</td>
</tr>
<tr>
<td></td>
<td>Unsafe</td>
<td>196</td>
<td>12</td>
<td>60.9%</td>
</tr>
<tr>
<td>Continuity (N₁ = 126 circumcised, N₂ = 15 uncircumcised)</td>
<td>Allow</td>
<td>106</td>
<td>13</td>
<td>84.1%</td>
</tr>
<tr>
<td></td>
<td>Not allow</td>
<td>20</td>
<td>2</td>
<td>15.9%</td>
</tr>
<tr>
<td>Reason for Sunna continuation (N₁ = 106 circumcised, N₂ = 13 uncircumcised)</td>
<td>Safe and has no complications</td>
<td>73</td>
<td>6</td>
<td>68.9%</td>
</tr>
<tr>
<td></td>
<td>Religion supports</td>
<td>30</td>
<td>8</td>
<td>28.3%</td>
</tr>
<tr>
<td></td>
<td>Low menstrual pain</td>
<td>6</td>
<td>1</td>
<td>5.7%</td>
</tr>
<tr>
<td></td>
<td>Sexual purity</td>
<td>5</td>
<td>0</td>
<td>4.7%</td>
</tr>
<tr>
<td></td>
<td>Give health education</td>
<td>2</td>
<td>1</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

* Percentages for reasons for Sunna continuation add up to more than 100% because of multiple response

4.6 Health complications associated with FGM

Greater part 302(86.5%) of the women perceived that FGM was associated with health complications. Majority of 278(86.3%) circumcised and 24(88.9%) uncircumcised women similarly perceived that FGM was associated with health complications, see Figure 4.4. One sample Binomial test (p-value < .001) indicated that the proportion of woman who perceived that FGM was associated with health complications was significantly higher. Likelihood Ratio Chi-square test (p-value = .702) indicated that perception of presence of health complications does not significantly vary with respect to whether one was circumcised or not. This implied that the perception of FGM association with health complication varied between circumcised and uncircumcised women. However, all FGDs were aware of problems associated with FGM.
Figure 4.4: Presence of health complications

Some of the FGM health complications that women had experienced or had seen a family member experience included mostly pain (74.5%), bleeding (71.9%), difficulties with menstruation (69.9%), infections (60.9%), among others as indicated in Table 4.10. Among the most common FGM associated problems according to the FGDs were problems during sexual intercourse 4(100%), menstrual pain 3(75%), birth complications 4(100%) and bleeding 1(25%). These infections can cause infertility, tumor, removal of uterus, urine retention and menstrual pain, mental consequences e.g. trauma, stress, and family conflict. According to the KII, FGM health complications included menstrual pains 5(100%), birth complications 5(100%), sexual intercourse pains 4(80%), urine retention 2(40%) and psychological problems. According to data from SOS Children Hospital abnormal birth rate was at 12.5% (out of 3223 births between May to October 2014), however these complications could not be directly attributed to FGM alone.
Table 4.10: Health complications associated with FGM

<table>
<thead>
<tr>
<th>FGM health complications</th>
<th>Frequency</th>
<th>Percent (N = 302)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>225</td>
<td>74.5%</td>
</tr>
<tr>
<td>Bleeding</td>
<td>217</td>
<td>71.9%</td>
</tr>
<tr>
<td>Difficulties with menstruation</td>
<td>211</td>
<td>69.9%</td>
</tr>
<tr>
<td>Infection</td>
<td>184</td>
<td>60.9%</td>
</tr>
<tr>
<td>Problems with giving birth</td>
<td>174</td>
<td>57.6%</td>
</tr>
<tr>
<td>Urine problems</td>
<td>172</td>
<td>57.0%</td>
</tr>
<tr>
<td>Fistulae</td>
<td>163</td>
<td>54.0%</td>
</tr>
<tr>
<td>Scars</td>
<td>146</td>
<td>48.3%</td>
</tr>
<tr>
<td>Injury to adjacent tissue</td>
<td>141</td>
<td>46.7%</td>
</tr>
<tr>
<td>Death</td>
<td>135</td>
<td>44.7%</td>
</tr>
<tr>
<td>Failure to heal</td>
<td>133</td>
<td>44.0%</td>
</tr>
<tr>
<td>Pain and fear associated with sexual encounter</td>
<td>129</td>
<td>42.7%</td>
</tr>
<tr>
<td>Infertility</td>
<td>110</td>
<td>36.4%</td>
</tr>
<tr>
<td>Death of the infants</td>
<td>110</td>
<td>36.4%</td>
</tr>
<tr>
<td>Vaginismus</td>
<td>35</td>
<td>11.6%</td>
</tr>
</tbody>
</table>

4.6.1 Action taken on health complications associated with FGM

Irrespective of the FGM health complications, 65(18.6%) women took no action while 22 (6.3%) women had no idea on what to do. Actions taken by the women to reduce the effects of FGM complications included mainly seeking medication (21.5%) creating community awareness (19.5%), taking pain killers (10.3%) and stop FGM (5.2%), see Table 4.11.

Table 4.11: Actions taken by women to reduce the effects of FGM

<table>
<thead>
<tr>
<th>Actions taken to reduce FGM effects complications</th>
<th>Frequency</th>
<th>Percent (N = 346)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seeking medication</td>
<td>75</td>
<td>21.5%</td>
</tr>
<tr>
<td>Community awareness</td>
<td>68</td>
<td>19.5%</td>
</tr>
<tr>
<td>Taking pain killers</td>
<td>36</td>
<td>10.3%</td>
</tr>
<tr>
<td>Stop FGM</td>
<td>18</td>
<td>5.2%</td>
</tr>
<tr>
<td>No action</td>
<td>65</td>
<td>18.6%</td>
</tr>
<tr>
<td>No idea</td>
<td>22</td>
<td>6.3%</td>
</tr>
</tbody>
</table>

* Percentages do not add up to 100% because of missing responses (62)
Some 37(10.6%) women were not advised on what to do about the complications related to FGM practice. Sixty nine were missing responses. Apart from self, women were mainly advised on how to handle FGM complications by health workers (22.9%) among others as indicated in Table 4.12.

Table 4.12: Source on information on how to handle FGM complications

<table>
<thead>
<tr>
<th>Source of advice on how to address complications</th>
<th>Frequency</th>
<th>Percent (N = 349)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>85</td>
<td>24.4</td>
</tr>
<tr>
<td>Health worker</td>
<td>80</td>
<td>22.9</td>
</tr>
<tr>
<td>Parents/relatives</td>
<td>54</td>
<td>15.5</td>
</tr>
<tr>
<td>Nobody</td>
<td>37</td>
<td>10.6</td>
</tr>
<tr>
<td>Friends</td>
<td>14</td>
<td>4.0</td>
</tr>
<tr>
<td>Anti-FGM practitioners</td>
<td>5</td>
<td>1.4</td>
</tr>
<tr>
<td>Neighbor</td>
<td>3</td>
<td>.9</td>
</tr>
<tr>
<td>FGM practitioners</td>
<td>2</td>
<td>.6</td>
</tr>
</tbody>
</table>

* Percentages do not add up to 100% because of missing responses (69)
CHAPTER FIVE: DISCUSSION, CONCLUSION AND RECOMMENDATION

5.1 Introduction

This section is organized into three sections, namely; discussion, conclusion and recommendations of the study.

5.2 Discussion

5.2.1 Socio demographic characteristics and influence on FGM practice

This study on FGM and its effects on women’s reproductive health in Barwaqo Ward in Warta Nabada District, Mogadishu Somalia used a sample of 349 female women. The FGM prevalence was at 92.3% of the women who were circumcised while 7.7% were uncircumcised. Majority (58.1%) women were circumcised at age of between 5 and 8 years. WHO notes that most girls undergo this practice between birth and age 15, but FGM occurs at all ages (Human Rights Watch, 2010). FGM is performed on girls at different ages, but most commonly around the ages of 7 - 10 (NETFA, 2014). Different studies indicate that FGM is sometimes performed on babies (less than five years) and on women when they are much older; according to Somali tradition it should be done on girls between 3 and 8 years of age while other sources set the age range between 4-12 years (Matsuuke, 2011). Circumcision was commonly done at home (97.2%) mostly by unskilled TBAs (78%). Circumcised women mostly (94.1%) received herbal medication after the practice. Similarly, Matsuuke (2011) established that FGM is normally carried out by a traditional practitioner and mostly the operations are carried in the villages and not in a health institution. Moreover, in a study done by the World Bank in 2004 it was noted that in most parts of Somalia, traditional circumcisers, (Guddaay), conduct most operations. The number of
professional health providers who carry out milder form of circumcision to girls for a fee was also found to be increasing. These professional health providers discouraged the work of traditional circumcisers and the Pharaonic FGM. Complications arising from FGM were found to be turning more families towards health providers, trained TBAs and nurses who perform whatever type of FGM parents’ desire (World Bank, 2004).

The mean age of the women was 31.78 (±0.82) years within the range of 16 and 50 and majority women were aged 30 and below. This finding were similar to studies conducted in EU countries which includes, France, Italy, Sweden, United Kingdom of Great Britain, Belgium, Germany, Netherlands, Finland, Greece, Ireland, Spain and Malta. and Africa Burkina Faso, Central African Republic, Cameroon, Democratic Republic of the Congo, Djibouti, Egypt, Eritrea, Ethiopia, Ghana, Guinea, Gambia, Bissau, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Sudan, Senegal, Sierra Leone, Somalia, Chad, Togo, United Republic of Tanzania, Uganda, Yemen and Benin where those affected by FGM were aged between 14-64 years (Brown et al., 2013) and 15-49 years respectively (Bjalkander et al., 2013). In this study, the uncircumcised women have a lower age distribution as compared to circumcised. This might be an indication that the FGM practice was slowly fading away in the community as observed in other countries like Kenya and Ethiopia (Mitike & Deressa, 2009).

Majority of the circumcised women were married while majority of the uncircumcised women were single. Most women had attained secondary education and minority had not attended school; with greater proportion of uncircumcised women having attained secondary education. There was no significant relationship
between circumcision and education level. This was contrary to a study by Yasin et al. (2013) among Iraqi Kurdish women which established that the women’s education may have contributed to a reduction of the practice of FGM. Similar views were held in a study by Karmaker et al. (2011) which showed that there was higher prevalence among women with no education and their daughters but education was not associated with a reduced likelihood of undergoing FGM among Muslim women. Although there was insignificant association between occupation and circumcision, most (40.1%) of the circumcised women were housewives while a most (44.4%) of uncircumcised women was self-employed. Similar views were held by Mitike & Deressa (2009) in which they observed that most circumcised women were housewives. A greater part of circumcised (41%) and uncircumcised women (44.4%) similarly came from nuclear families. Mainly (49.1%) of the circumcised women were married and 63% of the uncircumcised women were single. There was a significant association between marital status and circumcision. The proportion of married circumcised woman was significantly greater than that of the uncircumcised. This might be attributed to society preference of circumcised girls for wives. Landinfo (2008) observed that there is massive pressure on mothers (and other female family members) in societies, like Somali, where religion, tradition, ideals of purity, fear of stigmatization and absence of networks beyond the family or clan, plays such a pervasive role. The whole practice of FGM is the base for marriage and without undergoing FGM, a woman is denied the right of marriage, in most cases also the denial of receiving bride price. Moreover, an unmarried woman is an outcast in the society (Moges, 2003).

The FGM prevalence in Barwaqo Ward was at 82.4% which was below the national prevalence of 98% in Somalia (Gele, Bo, & Sundby, 2013b).
5.2.2 Knowledge and attitude on FGM risks and eradication programs

Minority (33.0%) of the women knew of what was involved in FGM. There was insignificant difference in reported knowledge of what was involved in FGM between circumcised and uncircumcised women. Most of those who reported to know what was involved in FGM defined it as partial or total removal of female external genitalia. Knowledge on what FGM involved similar among both the circumcised and uncircumcised women. The increased knowledge on FGM procedures can be attributed to the continuation of FGM practice as it has been noted that increased exposure to potential knowledge and awareness does not necessarily translate into a change in behaviour (UNICEF, 2015). All FGDs believed that FGM violated human rights. These were through the girl child being isolated from the community; violation of access to information and the practice being not stipulated in the Quran.

In this study, FGM Type 3 (infibulations/pharaonic) was the most common and practiced in the community. The other type of FGM commonly known and practiced was Type I (Sunna) followed by Type 2 (Sunna kabir) and finally Type 4. Type 3 FGM was significantly more prominently known among circumcised women as compared to uncircumcised women. Fried et al. (2013) noted in a different study that 90% of women in Somalia had undergone Type 3 infibulations. Sunna is common among the Banadir population in the coastal areas of Somalia (Land info, 2008). Contrary to this findings, Mitike & Deressa (2009) noted that forms of FGM performed on the girls in Somalia included 64% clitoral cutting (Sunna) and 36% vaginal stitching (infibulation).
In this study, majority (77.4%) of the women especially the uncircumcised were not aware of the interventions to eradicate FGM. On a different study, Mitike & Deress (2009) established that women were even less aware of anti-FGM interventions as compared to men. UNICEF (2015) similarly notes that increased exposure to potential knowledge and awareness does not necessarily translate into a change in behaviour. While awareness campaigns and other efforts towards its eradication encourage changes to the practice, these have come about only at a very slow pace (Land info, 2008).

Interventions to eradicate FGM were mainly done through health education and Anti-FGM community awareness campaign by Women associations and social media among others. The community was reported to be supportive of interventions towards eradication of FGM since it was a harmful practice. Women thought that interventions put in place to eradicate FGM were succeeding since FGM cases reduced; there was increased community awareness on FGM and its risks; FGM practitioners were also reducing; and cultural belief of keeping girls virgin was vanishing. The success was despite the strict adherence to culture and lack of access to information. However, lack of health awareness, cultural beliefs and lack of social media pose as the challenges facing the interventions. These findings were similar to a study conducted by Ahmadu (2007) where some of the popular interventions that had been employed were health risk information, training of health professionals, public statement and legal measures. Somalis have a very strong oral tradition. Oral tradition and the scarcity of entertainment forums ensure that news on events that take place in workshops or seminars spread rapidly in remote and nomadic communities (World Bank, 2004).
Various ways suggested to curb FGM included increased community health awareness especially on the health effects caused by FGM; use of religious leaders in the anti-FGM campaigns to fight the FGM culture; launching advocacy programs; and anti-FGM legislation. In a different study Land info (2008) similarly shared the same views in which it was observed that there was slow pace of eradication of FGM in Somalia despite numerous anti-FGM campaigns done. As recommended by World Bank (2004), Anti-FGM initiatives should ideally be initiated with a participatory learning and action (PLA) process in communities. If development agencies address on-going development needs such as water, healthcare, and education first before shifting gear to FGM/FGC, they will easily win the trust between themselves, the community, and leaders.

5.2.3 Influence of socio cultural and religious beliefs on FGM eradication programs

Most (84.5%) women had allowed their daughter or family member and others to be circumcised because circumcision was their culture. Other noted reasons for circumcision included the need to keep virginity, to be clean, to get a husband and as dictate by parents. These findings were similar to studies conducted by Pereda, Arch, & Perez-Gonzalez (2012) in which reasons why the practice of FGM is performed and perpetuated has more to do with social convention, tradition and cultural ideals of femininity.

The perceptions of whether FGM prevents promiscuity were similar among circumcised and uncircumcised women with majority of perceiving FGM did not prevent promiscuity. These perceptions were contrary to findings by Mitike &
Deressa (2009) where the main reason given for genital cutting was to reduce “female hyperactivity” in sexual practice and to prevent early initiation of sexual activity. According to UNFPA (2010) FGM is carried out as a means to control women’s sexuality (which is argued to be insatiable if parts of the genitalia, especially the clitoris, are not removed), to ensure virginity before and fidelity after marriage and/or to increase male sexual pleasure. Study done in Nigeria by Oyefara (2014), established that FGM did not prevent sexual promiscuity but rather promoted it since significant proportion of circumcised women in the study reported extra-marital sexual relationships compared with uncircumcised women.

The perception on tidiness of uncircumcised women was similar among circumcised and uncircumcised women with majority of either group perceived that uncircumcised women were clean. These findings were contrary to the Somali belief that the external female genitalia is considered as dirty, ugly and disfiguring; and that infibulation is believed to produce a clean smooth skin surface that is desirable to touch (UNFPA, 2010). Moreover, a study done by Asmani & Abdi (2008) asserted that there was a strong belief that women who were not circumcised cannot attain state of cleanliness because the clitoris grows long and forms folds of skin, which harbour dirt that cannot be removed. In addition, Jaldesa et al. (2005) established that some women believed that external genitalia can harbour dirt and germs, thus for them to be cleaned they need to be removed. A belief commonly expressed was that uncircumcised women are never clean.

Similar perspective of the need to stop FGM was shared by both circumcised and uncircumcised women. Similar findings were made in a study by Matsuuke (2011) which was found out that continuation of FGM tradition in new generations was not
seen necessary and the overall result of the study was very straight forward: FGM should be abolished from the tradition. These findings were contrary to the views found out by Land info (2008) that 90% of the women in the age group 15-49 were in favour of upholding the custom. This calls for communal behavior change rather than an individual behavior as recommended by Gele, Bo, & Sundby (2013b).

Sunna was perceived by 40.8% circumcised and uncircumcised women as safe and should be allowed to continue since it is a religious practice that is not associated with complications. These findings were similar to those in a study done by Gele, Bo, & Sundby (2013b) in which both the opinion leaders and the ordinary people in Somalia supported abandonment of FGM and continuation of the Sunna. According to Asmani & Abdi (2008) proponents of FGM use certain hadith (sayings) of the Prophet Mohammed (peace be upon him), to give Sunna circumcision an Islamic basis.

5.2.4 Heath complications associated with FGM

Majority of the women perceived that FGM was associated with health complications including pain during sexual intercourse; bleeding; pain and difficulties with menstruation; urine retention; birth complications; and infections that can cause infertility, tumor, removal of uterus, urine retention and menstrual pain. Other associated psychological problems include trauma, stress, and family conflict. According to data from SOS Children Hospital abnormal birth rate was at 12.5% (out of 3223 births between May to October 2014), however these complications could not be directly attributed to FGM alone. The severe effects of FGM on the health of girls and women have been widely documented (World Bank, 2004). Similarly, in a study done by Yasin et al. (2013), FGM was associated with a series of health risks and
consequences including pain, bleeding, difficult in passing urine, infection, death and hemorrhage. According to the World Bank (2004) long-term consequences of FGM include infibulation cysts, keloid scar formation, damage to the urethra resulting in urinary incontinence, pain during sexual intercourse, sexual dysfunction and difficult in childbirth, difficult menstrual periods among others. Similar complications including bleeding, infection and painful coitus were identified in a study by Dike et al. (2012). According to UNFPA, 2010, FGM has both immediate consequences including severe pain, shock, hemorrhage, tetanus or infection, urine retention, ulceration of the genital region and injury to adjacent tissue, wound infection, urinary infection, fever and septicemia. Hemorrhage and infection can be of such magnitude as to cause death and long-term consequences include anemia, the formation of cysts and abscesses, keloid scar formation, damage to the urethra resulting in urinary incontinence, dyspareunia (painful sexual intercourse) and sexual dysfunction, hypersensitivity of the genital area.

5.2.4.1 Action taken on health complications associated with FGM

Actions taken by the women to reduce the effects of FGM complications included mainly seeking medication; taking pain killers and community awareness to stop FGM. This finding was similar to that in a study done by Ahmadu (2007) where some of the popular interventions employed to reduce the effects of FGM complications included; health risk information, conversion of exercisers, training of health professionals as change agents, alternative rites programs, and community led approaches, public statements and legal measures. In this study, some women were not advised on what to do about the complications. Apart from self, women were mainly advised on how to handle FGM complications by health workers. Trained
staff can recognize and manage the physical, sexual and psychological complications of FGM (World Bank, 2004).

5.3 Conclusions

From the study findings and objectives the study concludes as follows:

Uncircumcised women were younger as compared to circumcised women. The education levels among circumcised and uncircumcised women were similar. Most uncircumcised women were single as a result of fewer men being interested in them for marriage. Family type and FGM practice were not associated.

FGM was widely known and practiced in Warta Nabada district. The commonly known and practiced FGM types in this district were Type 3 and Type 1. Anti-FGM interventions carried out by women organizations and media in this district although not very popular were succeeding in reducing FGM incidences, however circumcised women were more aware of these interventions than uncircumcised women.

FGM was practiced mainly in Warta Nabada District because of cultural and religious reasons such as to keep virginity and to get a husband in future. According to women in this District FGM does not prevent promiscuity; women who have not undergone FGM were perceived to be clean. Sunna circumcision was unsafe. There was a wide support of interventions geared towards stopping FGM since most women in this district call for a stop in all forms of FGM.

Women in Warta Nabada District perceive FGM to have associated health complications. The most common health complications associated with FGM experienced by women who have undergone FGM in Warta Nabada District included
pain, bleeding, difficulties with menstruation, infections and among others. Most women seek medical attention to counter the effects of FGM. Health workers were the main source of health information regarding FGM complications in this district.

5.4 Recommendations

From the study objectives and conclusions the study recommends as follows:

i. The government of Somalia should sensitize the public on the illegality of FGM together with associated health risks. Specific law against female circumcision should be put in place and initiatives that prohibit the practice implemented.

ii. There is need to strengthen health institutions to properly deal with FGM associated immediate and long-term illness since its prevalence is still high; and to reduce occurrence of abnormal births.

iii. Since FGM has been shown to be slowly fading away as indicated by its high prevalence among the old as compared to the young women, there is need to continue with community awareness campaigns to ensure that young women do not continue with the practice especially on their girls. Community awareness should be adopted to reduce the rigidity of men to marry uncircumcised women.

iv. There is need to engage religious leaders, TBAs and health professionals in the anti-FGM interventions including campaigns. These persons are more influential and strategic in disseminating information that clearly differentiates religious and cultural practices; and also the short and long term health risks associated with FGM.
REFERENCES


Mackie and LeJeune (2008). "Data on the role of religion are difficult to interpret because in many cases, religion, tradition and chastity are not differentiated.


APPENDICES

Appendix I: Questionnaire

Instructions

Please answer all the following questions in the spaces provided or tick in the boxes provided at the end of each choice.

SECTION A: Socio Demographic Characteristics

1. Age in complete years __________________

2. Gender
   a) Sex: Male [ ]
   b) Female [ ]

3. Marital status
   a) Single [ ]
   b) Married [ ]
   c) Divorced [ ]
   d) Widowed [ ]

4. Education level
   a) Primary [ ]
   b) Secondary [ ]
   c) University [ ]
   d) None [ ]
   e) Others (specify)…………………………….
5. Occupation

a) Housewife [  ]
b) Self-employed [  ]
c) Government employee [  ]
d) None [  ]
e) Others (specify)…………………………..

6. Type of family

a) Nuclear [  ]
b) Joint [  ]
c) Polygamous [  ]
d) Single [  ]

7. Have you been circumcised?

a) Yes [  ]
b) No [  ]

8. If yes, which type circumcision did you undergone?

a) Type 1 (Sunna) [  ]
b) Type 2 Sunna Kabir [  ]
c) Type 3 (Infibulation/ Pharaonic) [  ]
d) Type 4 [  ]

9. If Yes, What age where you circumcised?

a) 0-4 [  ]
b) 5-8 [  ]
c) 9-12 [  ]
d) >13 [  ]
10. Where were you circumcised?
   a) Village [ ]
   b) Hospital [ ]

11. Who circumcised you?
   a) TBA [ ]
   b) Grand Mother [ ]
   c) Health Worker [ ]

12. During the practice of Female Genital Mutilation which of the following did you received?
   A) Anesthesia [ ]
   B) Pain Killer [ ]
   C) Herbal Medicine [ ]

13. If No to the above question 7, do you have any family member who has been circumcised?
   a) Yes [ ]
   b) No [ ]

14. If Yes to the above question 8, who is this family member?
   a) Mother [ ]
   b) Daughter [ ]
   c) Sister [ ]
   d) Aunt [ ]
   e) Grandmother [ ]
15. Which type for this person undergone?
   a) Type 1 (Sunna) [ ]
   b) Type 2 Sunna Kabir [ ]
   c) Type 3 (Infibulation/Pharaonic) [ ]
   d) Type 4 [ ]

16. Residence (Please state) ______________________________

SECTION B: Women’s Knowledge and Attitude about risk associated with FGM

17. Do you know what is involved in Female Genital mutilation or female circumcision?
   a) Yes [ ]
   b) No [ ]

18. ) If Yes Please describe what it involves?

19. Do you know the different types of Female Genital mutilations that are practiced in your communities?
   a) Yes [ ]
   b) No [ ]

20. If yes to the above question 13, which types of female genital mutilation do you know?
   a) Type 1 (Sunna) [ ]
   b) Type 2 [ ]
   c) Type 3 (Infibulation/Pharaonic) [ ]
   d) Type 4 [ ]
21. If yes to question 13, which type is commonly practiced in your community?
   a) Type 1 [  ]
   b) Type 2 [  ]
   c) Type 3 [  ]
   d) Type 4 [  ]

22. Are you aware of any intervention(s) being carried out in your community to eradicate FGM?
   a) Yes [  ]
   b) No [  ]

23. If yes to question 20 above, which interventions are you familiar with and by which organizations? (please answer in the space provided)

   …………………………………………………………………………………………
   …………………………………………………………………………………………

   23b) what are the key activities of the interventions?

24. Is the intervention succeeding? Yes/No?
   24bb) Please explain your answer?

   …………………………………………………………………………………………
   …………………………………………………………………………………………

25. What else needs to be done for interventions to succeed?

   …………………………………………………………………………………………
   …………………………………………………………………………………………
SECTION C: Effects of Socio Cultural and Religious Beliefs on the Health Programmes Targeting Eradication of FGM

26. Why did you agree to be circumcised or allow your daughter to be circumcised or did your family member agree to get circumcised?
   a) It is our culture  [  ]
   b) The Quran stipulates so  [  ]
   c) So as not to be ostracized by my family members  [  ]
   d) So as to get a husband in the future  [  ]
   e) To enable me to get land and be economically empowered  [  ]
   f) Because my mother said so  [  ]
   g) Because my father said so  [  ]
   h) So as to be pure and to reduce my sexual libido  [  ]

27. Do you think female genital mutilation prevents the woman from becoming promiscuous?
   a) Yes  [  ]
   b) No  [  ]

28. Do you think women who are not circumcised are unclean?
   a) Yes  [  ]
   b) No  [  ]

29. If Yes to question 26 above, why so? (Please explain)

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

30. Do you think female genital mutilation should be stopped?
   a) Yes  [  ]
   b) No  [  ]
31. If No to question 28 above why? (Please explain)
......................................................................................................................
......................................................................................................................

32. Do you think the Sunna type of circumcision is safe to practice?
   a) Yes [ ]
   b) No [ ]

33. If yes, Should the practice be allowed to continue?
......................................................................................................................
......................................................................................................................

34. Please explain your answer?
......................................................................................................................
......................................................................................................................

35. Is there health complications associated with female genital mutilation??
   a) Yes [ ]
   b) No [ ]

36. If Yes to the above question 16, name some of the health complications have you experienced as a person or have seen a person in your family who has been circumcised experience?
   a) Bleeding [ ]
   b) Death [ ]
   c) Pain [ ]
   d) Urine problems [ ]
   e) Injury to adjacent tissue [ ]
   f) Infection [ ]
g) Failure to heal
h) Problems with giving birth
i) Death of the infants
j) Infertility
k) Scars
l) Fistulae
m) Difficulties with menstruation
n) Pain and fear associated with sexual encounter
o) Vaginismus

37. What action have you taken to reduce the effects of the complications?
38. Who advised you on what to do about the complications?
Appendix II: Informed Consent

TITLE: FEMALE GENITAL MUTILATION AND ITS EFFECTS ON WOMEN AND GIRLS’ REPRODUCTIVE HEALTH IN WARDHIGLEY DISTRICT

a. Introduction Statement that the study involves research

This study in which you want to participate is a research activity.

b. Explanation of the purposes of the research.

The purpose of this research will be to assess female genital mutilation and its effects on women and girls’ reproductive health in Warta Nabada District

d. Expected duration of participation in the research.

This study is expected to last November 2014, But your participation will take only 10 minutes to answer the questionnaire. We will take your number so that we are able to call you at a later date for a discussion on the same research topic.

f. Description of any benefits to the subject or to others which may reasonably be expected from the research.

You and your family may not get any direct benefits if you participate in this study but the information you provide me will help in the better improvement of the current strategies in the eradication of FGM and will enable the policy makers in our country be able to come up with policies which will enable the practice to be abolished completely.

g. Risk involved

There will be no risk involved in the study as you are not required to undergo any invasive procedures.
h. Confidentiality of Records

What you say in this study will be kept private as no one will know who answered the specific questionnaire as the questionnaires will be serialized and you will not be required to write your name on the questionnaire. The information you provide in the FGDs shall remain confidential and no names will be mentioned during the FGDs. The tapes, notes, and transcripts from the FGDs shall be stored in a place where only the researcher will have access to. This will be for a period of 1 year after completing the study, after which they will be destroyed.

i. Questions about research

If you have any questions concerning the study, you may contact Ayan Said Tukale, Tel no: 254-718-031-200 or Chairman of Community Health +254-722-763-186

If you agree to answer these questions and participate in this study, you can tell us that you agree by repeating these words and then signing in the space provided below.

I have read the information above or it has been read to me and I have been given the opportunity to ask questions about it and any the questions asked have been answered to my satisfaction. I consent voluntarily to participate as a subject in this study and understand that I have the right to withdraw from the study at any time.

Individual participant’s signature:__________________________Date__

Interpreter/ Witness signature:__________________________Date__

Person conducting the informed consent: _________________Date__

Individual participant’s cell phone No.__________________________
Appendix III: Consent Form for Focus Group Discussion

a. Statement that the study involves research

This study in which you want you to participate is a research activity.

b. Explanation of the purposes of the research

I would like to understand your perceptions and attitudes about FGM and the different eradication programs that are present in your community. The purpose is to gain more insight on how to improve the current interventions available to end the practice.

c. Description of the procedures to be followed

There will be questions asked about the practice of FGM. With your permission, pictures of the activities of the FGDs may be taken as well as notes to explain my findings. The conversations during the FGDs will be tape recorded, so as I do not miss out on some of the important information that will be said.

d. Expected duration of the participation in the research

We will talk to you for about 30-45 minutes. The questions are general but if you find that some questions are not going well with you, please do not feel compelled to answer any of them for any reason.

e. Disclosure of appropriate alternative to participation

Your participation in this study will be highly appreciated, but however feel free to decline from participating if you are uncomfortable. Taking part in this study will not cost you or your family anything. You may also leave the study at any time, even after agreeing to participate.
f. Description of any benefits to the subject or to others, which may reasonably be expected from the research

You and your family may not get any direct benefits if you participate in this study but the information you provide me will help in the better improvement of the current strategies in the eradication of FGM and will enable the policy makers in our country be able to come up with policies which will enable the practice to be abolished completely.

g. Risk involved

There are no invasive risks involved in this study however in the group discussion the possible risk involved is inconveniences with regards to privacy and confidentiality. This should not disturb you though as in a group discussion like this, the questions asked are general community experiences rather than revealing individuals’ names. You are also requested not to share personal information from this discussion with people in the community.

h. Confidentiality of records

Your name and what you say to us for this study will be kept private as much as the law allows. The information you provide shall remain confidential, and your names or any information that may identify you will not be included in the reports. The tapes, notes, pictures and transcripts shall be stored in a place where only the research team will have access. This will be for a period of one year after completing the study, and then they will be destroyed.
i. Questions about research

1. Do you have any questions about the study and your participation? (Yes/No)

2. Do you agree to participate in this group discussion? (Yes/No)

If you have any later questions about this study you may contact Ayan Said Tukale on Tel no +254-718-031-200 or Chairman of Community Health Trough +254-722-763-186

If you agree to answer our questions and participate in this study, you can tell us that you agree by repeating these words and then putting your name and signature in the space provided below.

I have read (or been read for) the foregoing information, I have had the opportunity to ask questions about it and any I have asked have been answered to my satisfaction. I consent voluntarily to participate as a subject in this study and understand that I have the right to withdraw from the study.

________________________________________
Individual participant's signature Date

________________________________________
Interpreter/ Witness signature / Date

Person conducting the informed consent
Appendix IV: Focus Group Discussion Guide

Questions about Focus Group Discussions

1. What are main types of FGM practiced among your community?
2. What are the main reasons for the practice?
3. Who are the main actors / influencers of the practice?
4. Are you aware of any problems associated with practice (probe menstrual cramps, interference with sexual intercourse etc).................................
5. How does female genital mutilation violate human rights?
   ........................................................................................................................................
   ........................................................................................................................................
6. Are there any interventions in the community against FGM? (probe for activities, organizations, for how long)
7. Is the community supportive/happy with the intervention? (Probe for rejection, resistance or active participation).
8. What are the successes of the intervention and challenges?
9. Do you support the interventions (ask for reasons for the answers)
10. What needs to be done to curb the practice?
Appendix V: Key Informant Interview Discussion Guide

Questions for Key Informant Group

1. What are common health problems associated with FGM?

2. What are the causes?

3. What are the measures put in place to curb or eliminate the practice?

4. What are some of the successes associated with intervention programmes?

5. What are the challenges?

6. What do you recommend that needs to be done to curb the practice?
Appendix VI: Letter of Introduction

NAIROBI KENYA

Dear Woman

RE: DATA COLLECTION

Kenyatta University, pursuing master’s in Public Health. I am currently conducting a research on female genital mutilation practice and its effects on women’s reproductive health in Warta Nabada District, Mogadishu Somalia

You have been selected to participate in this study and would highly appreciate if you assist me by responding to the questions completely, correctly and honestly as possible. Your response will be treated with utmost confidentiality and will be used only for research purposes of this study.

Thank you for your cooperation

Yours Faithfully

Signature of the women Thump signature
Appendix VII: Map of Warta Nabada District
Appendix VIII: Map of Somalia
Appendix IX: Kenyatta University Research Authorization

KENYATTA UNIVERSITY
GRADUATE SCHOOL

E-mail: kuhps@yahoo.com
dean-graduate@ku.ac.ke
Website: www.ku.ac.ke

P.O. Box 43844, 00100
NAIROBI, KENYA
Tel. 020-8704150

Our Ref: Q57F/CTY/PT/20599/12
Date: 20th August, 2014

The Principal Secretary,
Higher Education, Science & Technology,
P.O. Box 30040,
NAIROBI

Dear Sir/Madam,

RE: RESEARCH AUTHORIZATION
MS. AYAN SAID TUKALE - REG. NO. Q57F/CTY/PT/20599/12

I write to introduce Ms. Ayan Said Tukale who is a Postgraduate Student of this University. She is registered for a M.Phil. degree programme in the Department of Community Health in the School of Public Health.

Ms. Ayan intends to conduct research for a Thesis entitled, “Determinants of Female Genital Mutilation and its Effects on Women and Girls’ Reproductive Health in Wardhigley District, Mogadishu Somalia.”

Any assistance and support is highly appreciated.

Yours faithfully,

MRS. LADY BONAFIDE NAHARD
FOR: DEAN, GRADUATE SCHOOL
Appendix X: Kenyatta University Research Proposal Approval

KENYATTA UNIVERSITY
GRADUATE SCHOOL

E-mail: dean-graduate@ku.ac.ke
       kubps@yahoo.com
Website: www.ku.ac.ke

P.O. Box 43844, 00100
NAIROBI, KENYA
Tel. 020-8704150

Internal Memo

FROM: Dean, Graduate School
TO: Ms. Ayan Said Tukale
     C/o Community Health Department

DATE: 20th August, 2014
REF: Q57F/CTV/PT/20599/12

SUBJECT: APPROVAL OF RESEARCH PROPOSAL

This is to inform you that Graduate School Board, at its meeting on 18th August, 2014, approved your Research Proposal for the M.P.H. Degree entitled, “Determinants of Female Genital Mutilation and its Effects on Women and Girls’ Reproductive Health in Wardhigley District, Mogadishu Somalia.”

You may now proceed with your data collection, subject to clearance with the Permanent Secretary, Ministry of Higher Education, Science and Technology.

As you embark on your data collection, please note that you will be required to submit to Graduate School completed Supervision Tracking Forms per semester. The form has been developed to replace the Progress Report Forms. The Supervision Tracking Forms are available at the Graduate School Website under Graduate School webpage downloads.

Thank you.

JOSEPHINE O. NIAGI
FOR: DEAN, GRADUATE SCHOOL

CC: Chairman, Community Health Department

Supervisors:

1. Dr. Isaac Mwanzo
   C/o Department of Community Health
   Kenyatta University

2. Dr. Pacificah Okemwa
   C/o Department of Gender & Development Studies
   Kenyatta University
Appendix XI: Research Authorization Ministry of Health & Human Services

TO: WHOM IT MAY CONCERN

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on "Determinants of Female Genital Mutilation and its Effects on Women and Girls' Reproductive Health in Wardhigley District (Currently Warta Nabada) Mogadishu, Somalia" I am pleased to inform you that you have been authorized to undertake research in Wardhigley District for a period ending 31st December, 2014.

You are advised to report to the Ministry of Health before embarking on the research project.

On completion of the research, you are expected to submit one hard copy and one soft copy of the research report/thesis to our office.

Best Regards,

Dr. Mohamed Abdi Farah
Director General, Ministry of Health
Federal Government of Somalia

Tel: +252-1-8930524 / E-mail: drfarah2011@gmail.com / skype drfarah21 Mogadishu-Somalia
Appendix XII: Research Clearance Permit Ministry of Culture and Higher Education

TO WHOM IT MAY CONCERN

RE: RESEARCH CLEARANCE PERMIT

This is to certify that Miss Ayan Said Tukale of (Address) Kenyatta University P O BOX 43884, Nairobi has been permitted to conduct research for M.P.H. Degree in Wardhigley district (Currently Warta Nabadda District) on the topic "Determinants of Female Genital mutilation and its Effects on Women and Girls’ Reproductive Health in Wardhigley District, Mogadishu, Somalia " for a period ending 31st December, 2014.

Best Regards

Ismail Yisuf Osman
Director General