FEMALE GENITAL MUTILATION: HEALTH RELATED PROBLEMS AMONG THE SOMALI COMMUNITY IN GARISSA TOWN, KENYA.

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156/1981/2000

A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE MASTERS DEGREE IN PUBLIC HEALTH AND EPIDEMIOLOGY OF KENYATTA UNIVERSITY

MARCH, 2003
DECLARATION

This thesis is my original work and has not been presented for a degree in any other university or any other award.

Sign ___________________________ Date ____________

We confirm, that the work in this thesis was carried out by the candidate under our supervision as university supervisors

Prof. Alloys S. S. Orago
Kenyatta University

Sign ___________________________ Date ____________

Dr. James Kisaka Waswa
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Sign ___________________________ Date ____________
DEDICATION

To my family, wife Hindia, children; Nasri, Fatuma, Warsame, Nuria, Asha and Mahat, and my parents father Yusuf and mother Nuria.
ACKNOWLEDGEMENTS

I would like to record my sincere and profound gratitude to the administration of Kenyatta University for providing a conducive environment for my studies and the Vice chancellor Professor George Eshiwani for his exemplary leadership in the University and my supervisors Professor Alloys S. S. Orago and Dr. James K. Waswa for providing efficient and effective supervision for the completion of this thesis.

I appreciate the academic and support staff of the Department of Zoology, Kenyatta University especially Professor Alloys S.S. Orago, Professor R. Okelo, Dr. James K. Waswa, Mr. Moses Njau, Dr. John M. Mbithi and all other course lecturers for their timely criticism, comments and guidance.

I am indebted to my research assistants Mr. Abdullahi Dahir and Mr. Abdi Hussein Bulle. I also wish to give special thanks to the District Commissioner Garissa District, the District Education Officer and Medical Officer of health Garissa District Hospital, the Headmistress of Northeastern Province Girls High School and Umma Salama Girls school for their support.

Last but not least, I would like to thank Ebony Computer Services for typing this thesis and all study subjects who participated in the research work for this thesis and my wife Hindia and the children for their continued support.

There are many people who helped in many different ways and because of inadequacy of space, their names are not mentioned here but all the same, I thank them most sincerely for their help and cooperation.
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# Glossary of Abbreviation

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>FGM</td>
<td>Female Genital Mutilation</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immuno deficiency virus</td>
</tr>
<tr>
<td>PATH</td>
<td>Programme for Appropriate Technology in Health</td>
</tr>
<tr>
<td>NGO</td>
<td>Non governmental Organisation</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nation Children’s Fund</td>
</tr>
<tr>
<td>PBUH</td>
<td>Peace be upon him</td>
</tr>
<tr>
<td>MYWO</td>
<td>Maendeleo ya wanawake organisation</td>
</tr>
<tr>
<td>FIDA</td>
<td>Federation of Women lawyers</td>
</tr>
<tr>
<td>KDHS</td>
<td>Kenya Demographic Health Survey</td>
</tr>
<tr>
<td>FPAK</td>
<td>Family Planning Association of Kenya</td>
</tr>
<tr>
<td>ARP</td>
<td>Alternative right of passage</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
</tr>
<tr>
<td>SD</td>
<td>Standard Deviation</td>
</tr>
<tr>
<td>SPSS</td>
<td>Statistical Package for Social Sciences</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nation Developmental Programme</td>
</tr>
<tr>
<td>UNEP</td>
<td>United Nation Environmental Programme</td>
</tr>
<tr>
<td>FC</td>
<td>Female Circumcision</td>
</tr>
<tr>
<td>GOK</td>
<td>Government of Kenya</td>
</tr>
</tbody>
</table>
Female circumcision or Female Genital Mutilation (FGM) is a tradition since antiquity and its exact origin is unknown. The spectrum of these genital procedures has been termed as female circumcision and more frequently FGM as a collective name describing several types of traditional female circumcision. According to the World Health Organisation (WHO), FGM is a form of violence against girls and women with serious physical and psychological consequences on health and must be abolished entirely. FGM is a deeply rooted cultural practice and most of the adherent communities consider WHO version as Eurocentric and cultural imperialism. Circumcision of girls and women among the Somali community in Garissa is almost universal

Despite the widespread practice of FGM among the Somali community in Garissa District, no previous study had investigated health-related effects that should be associated with this practice.

A descriptive cross-sectional survey was conducted in Garissa town Kenya between January and March 2002 to evaluate the health related effects of female genital mutilation among the Somali community in Garissa town. A total of 250 respondents were interviewed and nine focus group discussions (FGD) were held comprising of 90 participants in total.

Some 99.6% of the respondents in this study were circumcised and the majority (94%) were circumcised at the tender age of 0 – 10 years. FGM appeared hazardous to health, as the majority of the study population (63.5%) had developed health problems after circumcision and there was a significant relationship between number
of health problems and type of circumcision ($X^2 = 12, P \leq 0.05$). However, there was a dramatic shift from the traditionally preferred type of circumcision, namely infubilation, to a milder type of FGM, the clitoridectomy adopted by most of the respondents (42.2%) compared to only (24.1%) who had undergone infubilation. Education had played an important role in this change of attitude from infubilation to clitoridectomy and there was a significant association between education level of respondent and the type of FGM preferred ($X^2 = 9, P < 0.05$).

Despite education and health problems associated with FGM some 67.6% of the respondents wanted FGM to be continued and believed it had some benefits. Eradication of FGM did not appear easy and achievable in the near future but there was a change from harmful type of FGM to the relatively harmless type, clitoridectomy. Most of the respondents (52%) preferred the Islamic Sunna type, which involved the removal of the prepuce of the clitoris and was as harmless as the male circumcision. The study has contributed to a deeper understanding of health related effects of FGM. Modification and or elimination of FGM is an all around effort that involves legal, social, political and economic measures. The immediate efforts should focus on information, education, and communication in order to facilitate change in the society’s attitude towards the practice.
CHAPTER 1 – INTRODUCTION AND LITERATURE REVIEW

1.1 GENERAL INTRODUCTION

The historical customary rites of female circumcision which is a complex psychological and physical process that entail ritual cutting and alteration of the female genitalia of infants, girls and adolescents has been referred to as Female Genital Mutilation (FGM) by Eurocentric cultural imperialists and this term in many African countries is considered as derogatory (WHO, 1995). However, FGM has been adapted by World Health Organisation (WHO) as an official term, which refers to female circumcision (FC). FGM has been considered as one of the harmful traditional practices and a form of violence against girls and women with an adverse and serious physical and psychological consequence leading to discrimination against women and the girl child. From a number of global conservancy like the United Nations Declaration on violence against women 1993, the fourth world women conference held in Beijing China in 1995, the convention on the rights of the child (CRC) in 1990, there has been a global focus on the elimination of FGM and enormous amount of money and time have been spent, several strategies were suggested by international and national organisations including World Health Organisation. As a result, several international and local non-government organisation (NGO) have cropped up to spearhead the elimination of FGM.

However, FGM is a deeply rooted traditional practice, which has transgressed all barriers including religion, education, race, tribe and language (Raqiya, 1982).
Despite aggressive campaign on the elimination of FGM by western culture and Christianity and in the absence of religious backing from the Koran and the Bible, the elimination of FGM has become a difficult task especially among the Somali community where FGM is highly prevalent and almost universal. (Northern Aid, 1995)

There is no doubt that the type of FGM largely practised by the Somali Community namely infibulation and Excision (Type II and III) are hazardous to health. However, efforts to stop them must concentrate, on the individual social identity and changing of the women consciousness (FIDA, 2000). Even though the human right context is crucial at the international level for passing resolution and pressing governments to take action, it is not appropriate for negotiating changes at the family level (FIDA, 2000). This research is intended to objectively examine harmful or beneficial health effects of FGM and recommend total elimination of FGM or put in place specific and acceptable interventions, that will respect the communities roles and status of women without violating the rights of women and the girl child.

1.1.1 RELIGIOUS PERSPECTIVE OF FGM

a) Christianity and FGM

When Christian missionaries came to Africa, they encountered FGM. The two major denominations were Roman Catholic and Protestant Evangelists. The bible doesn’t mention FGM. The book of Genesis 17 gives
of account how God made covenant with Abraham to circumcise every male in his household but the Bible doesn’t mention or say anything about the female circumcision. The Catholics ignored and at times condoned the practice as a way of maintaining women’s sexual purity, which is an issue of great importance to the church (Toubia, 1995).

The Protestant church took more active position in the fight against FGM, which they saw as unchristian and barbaric act that had to be eliminated at all costs. The other Christian denominations such as Orthodox and Coptic Church, which existed in Egypt, Sudan, and Ethiopia, accepted FGM. In Ethiopia, the Orthodox Church considered women unclean and many priests refused to let such women in their churches (Toubia, 1995).

b) Judaism and FGM

The Torah has no specific mention of FGM. The only few Jews know to practice FGM are the Ethiopian Falashas, who now live in Israel (Toubia, 1995).

c) Islamic Religious Perspective

FGM started in the Islamic society during what the Muslims call “Al-ghahiliyah” (The era of ignorance). It is believed to have started in Egypt during the Pharaoh’s Empire (Raqiya, 1982).

The Quran is silent on the subject of FGM but the Sunna (The words and action of the prophet Mohammed PBUH) contains a number of references to female circumcision. A discussion was recorded between Prophet Mohammed (PBUH) and um Habibah (or um Atiyyah), a woman who performed infibulation on
slaves. She said she would continue the procedure “unless it is a forbidden act and you order me to stop doing it”. He replied according to the translation “Yes, it is allowed come closer so that I can teach you. If you cut do not over do it, because it brings more radiance to the face and it is more pleasant for the husband”. This passage states that the least invasive form of circumcision was allowed but did not encourage it or made it compulsory (Hick, 1993).

Prophet Mohammed (PBUH) is also recorded as speaking of the Sunna circumcision to the Ansar’s wives saying, “cut slightly without exaggeration because it is more pleasant for your husbands” (WHO, 1997). Nonetheless, it clearly forbid severity in circumcision on the bases of elimination on both potentials to harm the woman’s and to make her less desirable to her husband. Islamic laws protect women rights to sexual enjoyment as demonstrated by the fact that a woman has the right to divorce on the grounds that her husband doesn’t provide sexual satisfaction. Therefore Islamic laws do not mandate FGM but tolerates only most mild form of female circumcision, the removal of the prepuce or hood that covers the glans of the clitoris, the sunna circumcision. (Imad – ad dean Ahmed PHD, 2000).

1.1.2 The African Perspective of FGM

In most Africa communities, FGM is a rite of passage and they have ceremonies to make this initiation. The initiation of the young is one day in the rhythm of the individual life and by extension, the co-operate group society. What happens to a single youth happens to the parent’s, relatives, the neighbours, the living and the
dead. The significant aspect of the rites is the introduction of the candidates to adult life and the art communal living (Mbithi, 1969). They are now allowed to share the responsibilities, privileges, and the duties of the society. They inherit new rights and obligations. The rite prepares the young people in matters of sexual life, marriage procreation and family responsibilities (Gachiri, 2000). The cutting of the sexual organ symbolises and dramatises the separation from the childhood to adulthood. Once that link is severed, the young person is freed from ignorance and inactivity into another stage of knowledge and reproduction. The physical pain, which the initiates are encouraged to endure, is the beginning of training for difficulties and suffering of later life (Mbithi, 1969).

The endurance of the physical and emotional pain is a great virtue among the African people. The real anthropological study therefore equated female circumcision (clitoridectomy) to the Jewish male circumcision which is not merely body mutilation and is regarded as the condition *sine qua non* of the whole teaching of the tribal laws, religion and morality. This is the phenomenon, which has made female circumcision among African tribes persists despite European cultural influence, Education, and Christianity (Kenyatta, 1938). In 1931, a conference on the African child was held in Geneva under the auspices of Save the Children Fund. In this conference, several European delegates argued that time was ripe when an Act of Law should abolish this "barbarous custom". However most of the delegates did not accept this approach (Kenyatta, 1938)

During pre-independence days in Kenya, anthropologists like Jomo Kenyatta glorified the practice arguing that it had a deeper significance beyond the physical operation (Gachiri, 2000)
1.2 LITERATURE REVIEW

1.2.1 Definition of female genital mutilation

World Health Organisation (WHO) has defined female circumcision as comprising of "All procedures involving partial or total removal of the female external genitalia or injury to the female genital organs for cultural or other non-therapeutic reasons (WHO, 1997).

1.2.2 Definition of Health

World Health Organisation has defined health as a state of complete physical, mental and social well being of an individual and not merely absence of disease and infirmity (WHO, 1946).

1.2.3 Situation Analysis And Prevalence Of FGM

1.2.3.1 Global Situation

An estimated 135 million of the world’s girls and women have undergone genital mutilation and at least 2 million girls are at risk of FGM every year at the rate of approximately 6,000 per day (Toubia, 1995). It is practised extensively in Africa and is common in some countries in the Middle East. It also occurs, mainly among immigrant communities in parts of Asia, and the pacific, North and Latin American and Europe. There are no figures to indicate how common it is in Asia. But it has been reported in Muslim populations in Indonesia, Sri Lanka and Malaysia. In India, a small sect, the Dandi Bohra practices clitoridectomy. In the
Middle East, FGM is practised in Oman, Yemen and the United Emirates (WHO/UNICEF/UNFPA, 1997).

Industrialised western countries, FGM occur predominantly among immigrants from countries where FGM is practised. It has been reported in USA, UK, Sweden, Netherlands, Italy, France, Denmark, Canada and Australia (WHO, 1997).

1.2.3.2 African Situation

Female Genital Mutilation is known to be prevalent in 28 African countries out of the 46 members of world health organisation Africa region (WHO, 1995).

Historians state that the traditional practice of FGM begun in Egypt during the period of pharaohs which later spread to other African countries in all directions (Badri and Badri, 1990).

In some countries, the practice is widespread while in others it is limited to few ethnic groups. Unfortunately, the data on FGM in Africa is often lacking and unreliable. However, it is estimated that 100 million girls and women in Africa have undergone FGM (WHO, 1995). However, it is important to note that modern physicians in England and United States used FGM in early as 1940’s and 1950’s to “treat” hysteria, lesbianism, masturbation, and other so called female deviance (Toubia, 1995).

There are no definite studies that have been conducted on the prevalence of FGM in Africa and the Middle East. Therefore, it is important to keep in mind that these are only estimates. They are based on Fran “Hosken’s Report”. She
estimated that there are more than 79.97 (about 80 million) mutilated females in the world. Today there are more than 114 million women who have undergone some form of FGM in the world. That’s almost double of what the 1998 estimates showed.

Table of Prevalence of FGM in Africa

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>PREVALENCE</th>
<th>ACTUAL NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>50%</td>
<td>1,200,00</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>70%</td>
<td>3,290,00</td>
</tr>
<tr>
<td>Cameroon</td>
<td>40%</td>
<td>4,485,510</td>
</tr>
<tr>
<td>Central Africa Republic</td>
<td>50%</td>
<td>750,000</td>
</tr>
<tr>
<td>Chad</td>
<td>60%</td>
<td>1,530,000</td>
</tr>
<tr>
<td>Cote d'Ivoire</td>
<td>60%</td>
<td>3,750,000</td>
</tr>
<tr>
<td>Djibouti</td>
<td>98%</td>
<td>196,000</td>
</tr>
<tr>
<td>Egypt</td>
<td>50%</td>
<td>13,625,000</td>
</tr>
<tr>
<td>Ethiopia and Eritrea</td>
<td>90%</td>
<td>23,940,000</td>
</tr>
<tr>
<td>Gambia</td>
<td>60%</td>
<td>270,000</td>
</tr>
<tr>
<td>Ghana</td>
<td>30%</td>
<td>2,325,000</td>
</tr>
<tr>
<td>Guinea</td>
<td>50%</td>
<td>1,875,000</td>
</tr>
<tr>
<td>Guinea Bissau</td>
<td>50%</td>
<td>250,000</td>
</tr>
<tr>
<td>Kenya</td>
<td>50%</td>
<td>6,300,000</td>
</tr>
<tr>
<td>Liberia</td>
<td>60%</td>
<td>810,000</td>
</tr>
<tr>
<td>Mali</td>
<td>75%</td>
<td>3,112,000</td>
</tr>
<tr>
<td>Mauritania</td>
<td>25%</td>
<td>262,500</td>
</tr>
<tr>
<td>Niger</td>
<td>20%</td>
<td>800,000</td>
</tr>
<tr>
<td>Nigeria</td>
<td>50%</td>
<td>30,625,000</td>
</tr>
<tr>
<td>Senegal</td>
<td>20%</td>
<td>750,000</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>90%</td>
<td>1,935,000</td>
</tr>
<tr>
<td>Somalia</td>
<td>98%</td>
<td>3,773,000</td>
</tr>
<tr>
<td>Sudan (North)</td>
<td>89%</td>
<td>9,220,400</td>
</tr>
<tr>
<td>Tanzania</td>
<td>10%</td>
<td>1,345,000</td>
</tr>
<tr>
<td>Togo</td>
<td>50%</td>
<td>950,000</td>
</tr>
<tr>
<td>Uganda</td>
<td>5%</td>
<td>467,500</td>
</tr>
<tr>
<td>Zaire</td>
<td>5%</td>
<td>945,000</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>114,296,900</td>
</tr>
</tbody>
</table>

Source: - Anecdotal Information only; no published studies
1.2.3.3  FGM IN KENYA

FGM prevalence in Kenya is high as more than fifty percent of Districts of Kenya practice FGM (ROK, 1999).

It is estimated that only 15 out of 64 districts do not practice FGM (Kenya Demographic Health Survey, 1998).

Thirty percent of the Kenyan women between the age of fifteen to nineteen years have been circumcised (ROK, 1999). The proportion of the women circumcised increases steeply with the age from twenty-six percent among fifteen to nineteen years old to nearly fifty percent among those aged thirty years and above. However, it is more common in the rural areas and among the less educated (ROK, 1999).

The differences across ethnic groups are striking. Among the women in Luo and Luhya communities, FGM is almost non-existence and very rare. Among the Somalis and Kisii it is nearly universal about (97%). The Kalenjin (62%), the Meru-Embu communities (54%), the Kikuyu (43%); the Kamba (33%) and the Miji Kenda and Swahili communities (12%) (ROK, 1999).
1.2.4 TYPES OF FGM

There are at least four different types of FGM as broadly classified by World Health Organisation (WHO, 1995).

a). Type 1 – Clitoridectomy

Involves the excision of the skin of the surrounding the clitoris with or without excision of a portion or the whole clitoris. The “Sunna circumcision” involves the removal of the prepuce of the clitoris.

b). Type 2 – Excision

This involves the removal of the entire clitoris and parts of or all the labia minora. The person with this type of circumcision does not have typical contour of the anterior perennial structures resulting from the absence of the labia minora and the vaginal opening is not covered.

d) Type 3 – Infubilation

This is the drastic and severe form of FGM, which involves the removal of the entire clitoris. Some or all of the labia minora and an incision is made in the labia majora to create a raw surface. In some cases a portion or whole of the labia majora is removed. The raw surfaces of the incised labia majora are stitched together to cover the urethra and the vaginal introitus leaving a small opening for the urine and menstrual flow.
1.2.5 Health Problems Associated with FGM

The health problems associated with FGM as pointed out by (Koso – Thomas, 1987) depend on the type of FGM and the environment in which the operation was performed. Infubilation is considered to have the most severe and serious medical complications. The other general effects depend on the types of FGM, the expertise of the circumciser, the hygienic condition under which the operation was conducted, the general health and the co-operation of the person circumcised.

However, the medical complications are categorised as immediate, intermediate and late complications, which include obstetric, gynaecological complications and psychological disorders.

1.2.5.1 Immediate Complications

Approximately 25% of the infubilated women suffer from one or more of the immediate complications of FGM (Elchala et al; 1977).

A study among Somali women revealed that 39% of the circumcised women developed acute complications (Dirie et al; 1992)

The immediate complications are agonising pain due to lack of anaesthesia, haemorrhage, infections, septicaemia, shock due to either haemorrhage or pain, trauma to the urethra, bladder or and anal sphincter.
1.2.5.2 Intermediate complications
These include anaemia, due to haemorrhage, dysmenorrhoea, irregular virginal bleeding, vulva dermoid cysts, anal abscesses, and formation of the akeloid scars, dyspareunia and other sequelae and HIV/AIDS infection.

1.2.5.3 Late complications
These include obstetric and gynaecological complications such as haematocoplus, which can be mild or severe, infertility; vesicle – vaginal fistula, recto – vaginal fistula, obstructed labour and other sexual problems including fragility, virginismus, and loss of libido.

1.2.5.4 Psychological disorders
These include post – traumatic stress, behavioural disturbance, psychosomatic disorders, anxiety and depression (Koso – Thomas, 1987)

1.2.6 Health Benefits
1.2.6.1 Prevention of Carcinoma of the Cervix
In 1936 Handley and Walton reported circumcision provided protection against cervical cancer. They reported on the low incidence of cervical carcinoma among the Fuji island compared with Hindu immigrant from India living in the island. They speculated that ritual circumcision practised by the Fijians but not by the Hindus may be providing protection against carcinoma of the cervix. Although population based incidence data are generally lacking, there is evidence that cervical cancer is also less frequent in the Muslim women who are circumcised (Kessler, 1994).
1.2.7 Reasons why FGM is practised

Kopelman (1994) has summarised four reasons proposed to explain why is FGM practised:

a) Cultural and preservation of group identity.

b) Hygiene and aesthetic.

c) Control of the female sexuality and reproductive functions.

d) Marri agebility.

The other reasons include economics, psychosexual and religious factors (Kopelman, 1994).

a) Cultural and tribal identity

In majority of African communities female circumcision is performed as a rite of passage; which is transition from the girls to the status of womanhood. The process involves a holistic and total physical and spiritual education which encompasses sex education, religion, cultural and traditional beliefs, including values that are the guiding principles to proper social behaviour and understanding of the laws that are specific to this community (Gachiri, 2000).

The education is aimed at enhancing the women’s maturity through improved relationships by teaching the law and regulation that govern the relationships with members of her intermediate family, in – laws, and generally the whole community. She is also taught the care of the family property, the property of the members of the community and the moral and ethical standards of her society (Gachiri, 2000).
The initiates are trained to handle their feelings and emotions such as fear, joy, hunger, and pain. They also gain certain rights, privileges and responsibilities as full members of their society in marriage, procreation of legitimate children who will ensure security in old age and advancement in social status. They also became accessible to certain social life's coupled with social responsibilities to other members of the societies.

The rite also creates bonds between age groups that are everlasting and develops social structures with special unity and loyalty that makes the whole tribe a family. The age groups give many supportive facilities and gains automatic life long companion with psychological, moral, emotional and even financial support, which gives great security especially to the less privileged members of the communities in good and bad times. Female circumcision also gives the recipient a symbolism of cultural, personal and group security. This partly explains why educated immigrants in America and Europe practice FGM despite western education and prohibition by law of the host country (Gachiri, 2000).

In communities where girls are circumcised at young age usually pre-puberty, the cutting is not directly associated with transition to adulthood or rite of passage although the procedure leads to later recognition to adulthood. The education process is also gradual and long but complete in all spheres of life just like the other communities who practice FGM as rite of passage. The education and training leaves a memory of joy and nostalgia (Raqiya, 1982).
b) Marriagebility

Traditionally, marriage had been a relative unitary concept consisting of a relationship between two adults one male and one female which is legally recognized through participation in a religious or civil marriage ceremony.

In Britain, the royal commission on marriage and divorce (1956) defined marriage as a voluntary union for life of one man and one woman to the exclusion of all others (Band et al; 1994).

The Somali Marriage is regarded not so much between two individuals but between two kinship group (Raqiya, 1982).

The importance attached to the concept of virginity in Somali society cannot be over emphasised. The preservation of woman sexual purity and honour is thus essential if the patrilineage is to maintain its social status, broaden its kinship ties and enhance its patrimony. The traditional Somali marriage has two aspects, a union of two spouses, and alliance between two lineages. The role of female circumcision for an eligible marriageable woman is a significant mark of womanhood and chastity, which is highly valued in the Somali society. Female circumcision explicitly transforms a girl into a potentially marriageable woman and it’s perceived as the preliminary stage for marriage.

In fact, the main reasons for female circumcision among the Somali Society is to preserve virginity and chastity. Social disapproval of pre and extramarital sex is demonstrated by the attitude towards prostitution and the children who are born out of the wedlock.
The shame and the stigma affects not only the girl or the woman but her entire family and clan. This can jeopardize the Marriagebility of other girls of the family and clan at large. Marriagebility is universal desire among the African society particularly the Somali society (Raqiya, 1982).

c) Control of female sexuality and reproductive functions

Historically, the control of women sexual life has been practised world-wide. The early Roman technique of shipping rings in which a ring was put through the labia majora of the female slaves to prevent them from becoming pregnant as child bearing will impede their work.

The chastity belt or belt of honour introduced in Europe was yet another mode of controlling women sexuality by acting as barrier against unsanctioned sex. The women pelvis was locked and key kept by the husband especially when he was away from home. In Africa FGM has been largely associated with rite of passage but is also a measure of controlling of female sexuality. (Fida, 2001).

However, until a few decades ago it was believed that the clitoris was a very dangerous part of the anatomy. Sigmoid Freud stated in one of his books entitled sexuality and the Psychologies of Love “The elimination of the clitoral sexuality is necessary precondition for development of femininity” (Imad – ad – Dean Ahmed, 2000). As recently as 1979 Dr. James Burt performed “the love surgery” of women in United States Ohio, the so-called “love surgeon” who introduced “clitoral relocation to the medical establishment. He believed and acted upon the
idea that the excision of the clitoris doesn’t prevent sexual pleasure but enhanced it (Imad – Ad – Dean Ahmed 2000).

Nawal El Saadawi a victim of infubilation stated “The importance given to virginity and intact hymen on these societies is the reason why female circumcision still remains a very widespread practice despite a growing urbanization in Egypt. Behind circumcision lies the belief that by removing parts of the girls’ external genital organs sexual desire is minimised. This permits a female who has reached a dangerous age of puberty and adolescence to protect her virginity and therefore her honour with great ease. Chastity was imposed into male attendants in the male harem by castration, which turned them into inoffensive eunuchs. Similarly, female circumcision is meant to preserve the chastity of young girls by reducing their sexual desire (Nawal El Saadawi 1980). Female circumcision is another example of efforts common by societies around the world in manipulating women’s sexuality to ensure their subjugation and control of their reproductive functions. Although nearly all societies subjugate women in some way, FGM is the most drastic measure taken by any society to control female sexuality and reproduction (Toubia, 1995).

For those who have trouble in imagining why society would impose circumcision on its women it might be useful to remember Freudian theories of the Western women sexuality by labeling the clitoris orgasm an immature fixation and glorifying vaginal orgasm achieved through intercourse. The Freudian theory in effect imposed psychological clitoridectomy on women. In United States the
majority of women were unaware of their clitoris or its function as recently as 1960 and had difficulty in experiencing orgasm (Toubia 1995).

In general, the sexual life of a Somali woman begins with marriage, given their moral, customary and religious training, approximately 90% of the Somali girls remains virgin until marriage. (Raqiya, 1982)

In this connection, it is relevant to note that the Koran does not cite the manifest function of circumcision is to only ensure virginity. But it is also linked to prevention of independent sexual pleasure and excitability of women. Infubilation is seen as an additional control of women erotic desires not only to maintain virtue in youth but also at time of marriage to ensure the bridegroom is her first and only man (Raqiya, 1982).

An Egyptians physician Amal Ab El Hadi pointed, it is not necessary to exaggerate either what or health sexual damage caused by FGM. She noted that women are not necessarily denied sexual pleasure by FGM for example when asked in various qualitative research studies most women answered that they enjoyed sexual life (E. Kirbirger et al, 1995)

d). Sexual and psychological effects of FGM

The tip of the clitoris like the tip of a penis, which has advanced supply of nerve endings, which are extremely sensitive to touch.

The body of the clitoris is made of spinary erectile tissue with covering layer of sensory nerve ending and rich blood supply from the clitory artery. The erectile tissue spreads deep under the root of the clitoris, is found in the inner lips and
the floor of the vulva, and forms a ring around the entry to the vagina. Although this does not have the same density of nerve endings as the tip of the clitoris, it is more sensitive than the surrounding skin. In comparison the vagina has few nerve endings, most of which are not sensitive to touch (Toubia 1995).

In human beings, the ability to attain sexual pleasure to achieve orgasm is a complex process, which involves the presence of normal external genitals, appropriate hormonal stimulant, and individual psychology.

The clitoris is a specialised sexual organ dedicated only to pleasure. It has no reproductive function but the vagina is an organ of reproduction with minimal sensory capacity for sexual response. The removal of the clitoris takes away the primary specialised female sexual organ. With clitoridectomy some of the sensitive tissues of the base of the clitoris along the inner lips and around the floor of the vulva are still intact and will give sensory sexual messages. In addition, other sexual sensitive parts of the body such as the breast nipples, lips, neck, and ears may become hypersensitive to compensate for lack of the clitoral stimulation and this enhances sexual arousal.

The physical aspect of human arousal is an equally complex phenomenon, which is still not fully understood. It involves emotions, concepts of morality, past experience, acceptance of eroticism, fear of disease or pregnancy, dreams and fantasies. The combination of the physical messages from the sensory organs and emotional images culminate into psychological state during which a person is able to experience orgasm. Women sexuality is a complex issue and it is difficult to separate the purely anatomical and hormonal sexual functions from emotional
and psychological functions. This means that women without clitoris can still reach orgasm because of the present sensitive genital tissues and compensatory substitute sensory area. (Toubia, 1995).

1.2.8 Adolescent sexuality

Approximately one-third of the world’s population between 10-24 years of age and 4 out of 5 young people live in developing countries, a figure which is expected to increase by year 2020 (Friedman, 1993; Ainsworth and Over, 1997). This involves providing them with access to information and resources as well as promoting a climate, which is understanding for the young people in sexual and reproductive health. Rapid urbanization and rural-urban migration has meant that great numbers of young people are living in precarious and impoverished conditions.

The traditional, multigenerational extended families have been increasingly replaced by the nuclear families, lone parents families, and in some cases the complete absence of the parents (Fulgesang, 1997).

There are increasingly many pressures on young people to be sexually active and in case of boys to have several different partners (River and Aggletton, 1998). Evidence from several countries suggested that the age at which young people become sexually active may be falling (Fee and Yonself, 1993). In Uganda for example 50% of young men and 40%, young women recently surveyed reported having sex by the age of 15 years (Konde – Lule et al, 1997). Most importantly legislation and policies which prevent sex education from taking
place or which restrict it's content prevents young people from their sexual and reproductive health (Rivers et al; 1999).

1.2.9 Sex Education

In many societies, the family and the immediate community traditionally provide young people with information and guidance about sex and sexuality.

In some societies including many throughout the continent of Africa, the provision of information about sex used to be formalized as part of initiation into adult role. Elsewhere the provision of information about sex through the family has been more informal, while in some cultures, open discussion of sexual matters between parents and children may actually be very rare.

It is important to recognize these variations in how sex education takes place within families and communities and how they affect the sexual beliefs and behaviours of young people. In many parts of the developing world recent and rapid urbanization and migration have meant that families and community networks have become more widely dispersed. This may have impacted on sexual socialization and education as well as the sexual behaviour and sexuality of the young people.

In parts of East and central Africa traditional rituals of initiation prepared the young people for their adult roles including education on the responsibilities of sex, marriage and child bearing (Fuglesang, 1997).

Sexual behaviours with potential to cause harm through jealousy, emotional discard, and infection were widely recognised and the communities therefore
developed cores of conduct relating to when, where, with whom to have sexual relationship. In order to communicate these principles to the young people initiation ceremonies were held often separately for boys and girls (Fulgesang, 1997).

With increasing urbanisation these rituals have lost their significance and the transition from childhood has been complicated by decline of the traditional source of authority such as the extended family and sexual debut take places earlier than in the past. (Balmer et al; 1997)

1.2.10 Other factors which perpetuate FGM

1.2.10.1 Social Pressure

Parents are under social pressure when they choose to be the pioneers in not having their daughter circumcised. They fear that this act will lead to discord in the society and their children will be disintegrated and this will eventually constitute a betrayal of their ancestors and curse to the tribe (Gachiri, 2000).

Many educated Maasai families still practice female circumcision. They are socialized to believe that an uncircumcised girl is incomplete. Their ties to traditions are very strong despite the fact that they understand the risks of FGM. As far as the Maasai community is concerned, no matter how educated or wealthy one is, or who you are married to or how many children you have as long as you’re uncircumcised, girls are associated with sexual promiscuity. Jennifer and Julius Sardina are Maasai couples from Kajiando, though educated they intend to have their 14 years old daughter circumcised; asked why, Julius
said “If we do not have her circumcised she will be victimized for the rest of her life. She would not even go home and we would not want to take the blame later”

These couple are torn between sticking to tradition that has refused to die and western education which doesn’t offer good alternative (Maendeleo ya Wanawake Organization, 2000).

1.2.10.2 Myths about FGM as reported by FPAK/Plan (1997)

The shedding of the blood has spiritual and religious implications. The Maasai community believes that an uncircumcised girl has unclean blood, which must be removed through the cutting of the part of the genitalia.

The Meru community of Tharaka believes any man who takes bride price of this girl who is not circumcised brings ancestral curse to his family: -

- Uncircumcised girls stink due to fluids from their private parts.
- Circumcision makes childbirth easier.
- Circumcision enhances recognition within their communities.
- Circumcision increases the chances of marriage.
- Circumcision prevents sexual promiscuity and prostitution.
- Uncircumcised girls cannot mature mentally and physically.
- Circumcised girls make better wives.
- The clitoris will grow longer like the male penis.
1.2.10.3 The Economic factors of FGM

Several economic factors contribute to the cultural importance of FGM. Often this ritual involves gifts given to the girls in the ceremony that also honours their families. More importantly, though, it is a fact that circumcision increases the chances of Marriagebility of their daughter, which brings considerable economic gain in terms of bride price to the family. The exciser who performs the operation makes considerable amount of money during the circumcision period. These women gain financial support and place of honour in their communities. (WHO, 1997)

1.2.11 FGM operation performed by the traditional midwife in Somali community.

The circumcision of the girls usually takes place between the ages of 6 to 12. The girl is made to sit on a lower stool in front of the woman “surgeon” who is also seated with her special razor blade or knife. The child’s legs are drawn apart and each one is held by two strong women who are usually friends or family relatives. Two more women hold the girls arms and shoulders pinning her back to the ground. The girl is held tightly to stop her from struggling also to expose her vulva for the operation. She excises the clitoris, the labia minora and part of labia majora.

To sew up the raw edges of the labia majora are fastened together using vegetable thorns and threads are put around the thorn to hold them firmly in position. The raw area is then covered with soaked clothes in special oil and local
herbs called ‘malmal’. The dressing adheres to the wound to adequately control haemorrhage. When the operation is completed, the girl’s legs are tied together from waist to the toe. She is then carried on her special prepared mat to lie on her back supported by several pillows. She remains in that position for 3 to 4 days (Raqiya, 1982).

1.2.11.1 Traditional care after FGM

The girl is given special diet designed to avoid frequent bowel movement and micturation in the initial first two days. This diet consists of hot porridge with pure animal ghee (Somali butter) and few sips of water. When urinating she lies on one side while her thighs are still tied together. Three to four days after operation, the thorns and other dressing on the wound are moistened with oil and carefully removed. The binders are put in the thighs, but loosely so that she can move slowly supported by a stick, at this stage she is allowed to sleep on her side.

No male is normally allowed during the operation and until the child is fully recovered. It is important that the child passes urine to ensure that there is no urinary retention resulting from the damage to the urinary tract during the operation. The girl is taken off her bed and made to sit on her buttocks and encouraged to pass urine. Sometimes water may be poured to stimulate micturation which is usually painful and some girls may refuse to pass urine for 2–3 days with serious consequences of secondary infections.
Modern disinfectants and antiseptic were unknown those days but traditional herbs and dried saps with antiseptic and aromatic properties were burnt and smoke is passed through the wound which helped in the healing process and dissipate bad odours resulting from coagulated blood and stalk urine (Raqiya, 1982).

1.2.11.2 FGM operation in modern urban areas in the Somali community

More recently, in the urban areas elderly-trained midwives have gradually replaced the traditional practitioners. There is also evidence that nowadays even male nurses are in the competition with the midwives and circumcise both girls and boys. These new trained medical personnel of course operate privately in conditions that are more hygienic, use anaesthesia, anti-tetanus toxoid and antibiotics (Raqiya, 1982).

1.2.11.3 Defibulation

Infubilation is usually reversed by "Defibulation" consisting of making a short incision to separate the fused labia majora at the time of marriage. This is done traditionally by midwives or as in recent years by trained midwives or generally by nurses or by the husband incase penile penetration is not possible. (Raqiya, 1982).
SOCIOLOGICAL THEORY

The Organic Evolution

Cooley’s sociological theory which has focused its attention upon the complex relationship between the individuals and the society which contends that in mind, a man doesn’t stand alone as an individual. That is the “Isolated person” and non-individual societies are both equally mystical illusions. The organic view of the society affirms indispensable reciprocity between the individual and the society. They are not empirically separable but a differentiate coincidence of the same phenomenon.

Cooley wrote, “if we say the society is an organism we mean... That it is a complex form of process of which in living and growing by interaction with others, the whole being so unified that takes place in one of the family is reciprocal reality”.

The major social institution for cooley were languages, the family, industry, education and law (Cooley, 1992).

1.2.12.1 Socialisation

Our individual social biographies begin with our birth. At this point and continuously through our lives, we are subject to the process of socialization. Elkin has defined socialization as a process by which someone learns the ways of a given society group so that they can function within it (Elkin, 1960).

The socialization of an individual is either primary at early childhood or adulthood. Culture is often used to include almost every aspect of the entire
pattern of beliefs, attitudes, values, ideas and knowledge that members of
different social group hold about themselves accorded during socialization (Band
et al; 1994)

1.2.12.2 Structural Functionalism

Parson (1951, 1954, 1964) provided the fullest account of the functionalism perspective of the family.

Its analysis identifies two major functions of the conjugal family. First families exist to facilitate the procreation of children and socialize them to adulthood roles of the kind which are accepted by social group in which they live for example in western, the family plays a major role in teaching adult, gender role through primary and secondary socialization to adopt stereo type role of the husband and wife. In traditional family, conjugal families men and women identify adult gender roles as described above and they become role models for their children.

This is the functionalist perspective views that relatively autonomous conjugal with its emphasis or free selection and relatively weak kinship ties the family structure most appropriate for modern industrial societies (Parson, 1964).

1.2.12.3 Feminism

The feminist critique of the family identifies the inherent contradiction of the family. On one hand, the family unit has been established to serve the function of procreation and to provide practical and emotional support to male workers. On the other hand, the family is major source of emotional tension between the
men and women. Whereas the Marxist perspective blame the operation and exploitation of women on the class system of the capitalist. The feminist blames both the class and the family (Abraham, 1984).

1.2.12.4 Patriarchy

This can be as an autonomous system of social relationship between men and women in which men are dominant rather than biologically or naturally determined. Patriarch designates social relationship between men and women. (Garmarnikov, 1978).

1.2.13 Social model of health

The emphasis of the sociological perspective of health and illness are on such aspects of health care as rehabilitation, prevention and social management of illness biological and medical aspect of health care. This approach has become known as social model of health. It contributes to the understanding of illness and disease by pointing out the social rather than the biological context. A useful sociological model would illuminate how social process works in defining illness, understanding the cause of illness and the promotion of health. In England and Wales improvement and health was largely due to social factors e.g. importance of limitation of the family size, increase in food, healthier physical environments and specific preventive and therapeutic measures rather than intervention in the mechanism of disease after it has occurred (Mackeown, 1979).
1.2.13.1 Medical Model

The traditional and generally accepted views of the health is that improvement in health and the quality of health care are attributed to the art and science of medicine. This has been characterized as the medical or biomedical model health.

The link between health care system was created and maintained by the powerful image of the role of medicine in the eradication of infection and the parasitic diseases advances in surgery, the application of the technology and new drugs and lowered infant mortality rate. The result of this orientation is an emphasis on the treatment of illness by medical means rather than on health or normality. For this reason, prevention has always taken a very poor second to treating illness (Band et al; 1994).

1.2.14 Effort in the eradication of FGM

Efforts to eradicate FGM in Kenya can be traced back to 1920. When the British colonizers occupied Kenya in the 19th century, they found the tradition of female circumcision well established (Gachiri, 2000).

The first effort to eliminate the practice was undertaken by the Christian Missionary of the Church of Scotland (CMS) in the early 1920. The missionaries made the campaign against FGM as a part of teaching curriculum. Between 1926 and 1956 the colonial government enacted regulation that sought to ameliorate, the practice reducing the severity of the Act, defining age at circumcision and parental consent before circumcision. The missionaries attack on the practice and
government’s position led to a great controversy that furnished the advocate of independent movement with ammunitions against the colonial government. In central province, it led to establishment of independence African schools and churches that sought to uphold western education and Christianity without interfering with the people’s cultural practices. After much opposition to the legislation, 1958 the colonial government was forced to rescind all resolutions outlawing FGM (Thairu, 2000).

In 1913, Dr. Graford and his group appointed themselves to perform FGM medically using local health facilities at Embu. Circumcision was allowed in hospital as a lesser evil (Gachiri, 2000).

“Ngaitana” (I will circumcise myself) became a symbol of African resistance against the ban of female circumcision by the colonial government in 1956 in Meru district.

Recently circumcised girls in Meru sang this song (Ngaitana) as they performed the punitive, hard labour for defying a ban on female circumcision. The ban was introduced by the African Council of elders “Njuri Ncheke” which issued edict forbidding female circumcision within Meru district and the African district council passed a by law endorsing it. The adolescent girls defiled this by circumcising themselves. (Thomas, 1996).

However, colonial government did not interfere with Somali ethnic community with in North Eastern province and they continued with their traditional practice of female circumcision.
1.2.14.1 The law and FGM in Kenya

FGM is illegal in Kenya as per the child act 2001, which states that “No person shall subject a child to female circumcision, early marriage or other cultural rites, customs or traditional practices that are likely to negatively affect the child’s life health, social welfare, dignity, or physical or psychological development (ROK 2001).

In 1976 Kenya attempted to legislate against FGM through a parliamentary motion, which was rejected (ROK, 1999).

Count down to the ban of FGM in Kenya:

(a) 1982 – President Moi condemns FGM in Baringo District and said anyone found practising or encouraging it will be prosecuted.

(b) 1982 – Director of Medical Services instructed government and mission hospitals not to perform FGM and threatened to prosecute anyone found doing so.

(c) 1989 – President Moi ordered communities which practice FGM to stop forthwith since it was outdated and unacceptable in modern Kenya and this resulted to the practice going underground.

(d) 1989 – President Moi advises the Maasai community to end early marriages of girls and FGM since they were no longer useful.

(e) 2001 – President Moi bans FGM for girls under 18 years of age in line with children’s Act.

(f) 2002 – The children’s Bill becomes a law.
1.2.14.2 Implementation of the Law:- Health worker run girl circumcision racket

Just four-month after Kenya made FGM illegal, FGM has moved from tradition circumcisers to the clean and sterile minor theatres in recognised Kisii hospital performed by trained nurses.

The operation costs KShs. 500 and admission per day ranges from KShs. 350 to KShs 500 and National hospital insurance fund recognises this hospital and gives a rebate of KShs 800 per day. During the school holidays girls flood to the hospitals and stay in the wards for two days to five days.

1.2.14.3 Alternative rite of passage

The idea of the alternative rite of passage as conceptualized by PATH and MYWO is to work with communities to develop and support rite of passage without the genital cutting and is relevant to the cultural belief and behaviours of each ethnic group.

There were three districts in which the alternative rites of passage were conducted, namely Tharaka, Gucha, and Narok Districts; because of the difference in practice by different communities towards FGM, the alternatives rites of passage was implemented with considerable varieties in the three districts.

However, peer education approach for community sensitization and IEC (Information, Education, and Communication) activities were commonly adapted. Three to five days secular training was developed by PATH for the training of peer educators and the initiate girls. Public ceremonies were held in all sites to
symbolize the traditional methods. Community members who showed support for FGM eradication were identified and trained as peer educators. Both men and women were trained as peer educators. Although most of the peer educators were women, the role of the peer educators was to educate community on FGM with intention to encourage the community to abandon the practice. (PATH and MYWO, 2000). To eradicate the traditional practices, the alternative rite of passage included “Seclusion” of the girls for 3 to 5 days. The girls were taught information in reproductive health, interpersonal communication, understanding harmful traditional practices such as FGM, human anatomy, decision making, pregnancy and conceptions, STI and HIV/AIDS, courtship, dating and marriage, an empowerment of men and women.

At the end of their seclusion and training public ceremony is held, during which the girls graduates to mark their coming of age. Public celebration take place and the initiates receive gifts from the project and or their families and members of their community.

Through songs, dances and drama the girls make public pronouncement that they have abandoned FGM. Influential politicians, religious and government officials give speeches at this day (PATH and MYWO, 2000).

However, this alternative rite of passage has created serious social friction and family conflicts, among the community that practice FGM. Below is an extract of what a father had to say whose daughter has undergone alternative rite of passage.
“My daughter was selected from the school, she was given an invitation letter. She informed me and explained what they were going to do. That is to be given family life education training by MYWO. I don’t like the way they were selected at school because I believe I should have full responsibility to my children and when they are just selected and whoever is going to be with them during the seminar doesn’t come to me as a parent, it’s not a good show. In fact, I don’t see MYWO member coming to me to ask for the girl and I don’t think they even explain fully to my daughter what they were going to do (Father of 13 years old initiate from Narok) (PATH/MYWO, 2000).

A mother of another initiate echoed the same sentiments.

“My daughter’s initiation was done when in school. She was informed that she had to attend a seminar in Narok town. I didn’t object although I didn’t like the approach. A responsible person could have approached me first. It is not fair for anyone to approach teachers to get my daughter away from home over holiday, because there’re duties I have assigned to my daughter to do during the holiday which the teacher didn’t know about” (Mother of 14 years old initiate – Narok) (PATH/MYWO 2000).

One of the girls stated

“I was selected from school and I was given an invitation letter. I informed my parents who didn’t object, although I had explained what we were going to do there. It was a tough job because I didn’t know what it meant to go through an alternative rite. I thought I was just to be taken for seminar, we were told that
when one goes through the alternative rite of passage she will not be circumcised" (Narok, Alternative rite initiate, 13 years old) (PATH and MYWO, 2000)

1.3. Rationale for the study

1.3.1 Statement of the Problem

Garissa township is largely inhabited by Somali Ethnic group and FGM is highly prevalent approx. (98 – 100%) especially excision and infibulation which has serious and numerous harmful effects. The practice of FGM is common among the social strata of the Somali Society. Education and westernization has had a little or no impact in the elimination or eradication of FGM despite long and enormous efforts from the international and local organisations.

1.3.2 Research questions

(a) What are the harmful and or beneficial health related effects of FGM?

(b) What are the socio-cultural factors that promote FGM?

(c) What can be done in the prevention of the harmful health effects and enhance health benefits?

(d) What can be done in the elimination or modification of FGM to eliminate harmful health effects?

1.3.3 Justification

A 1991/2 study of the FGM investigated the extent of FGM and factors that perpetuate its continuance in four districts of Meru, Narok, Kisii and Sambu (PATH, 1998).
The quantitative research finding revealed that approximately 90% of interviewed women over the age of 14 years had been circumcised and often in unhygienic conditions. At that time even though most of the circumcised women experience complications attributed to FGM, more than 65% of the women expected to circumcise their daughters and the study revealed 78% of the teenage girls had been circumcised. Qualitative research sheds additional light on the social significance of the practice and the reason for its continuation in Kenya; that FGM is considered the most significant rite of the passage to adulthood enhancing the tribal cohesion and providing girls with important recognition from their peers and increase chances of marriageability (FIDA, 2000). There is therefore a clear indication that the magnitude, extent and the complexity of FGM is not sufficiently known among the Somali community in Garissa town. There is little or no previous research work that has been done to assess and evaluate health effects of FGM among the Somali community in Garissa town and consequently design strategies that could be applied as a community-specific intervention which are both culturally and religiously acceptable.

The study is therefore designed to identify probable health effects of FGM both harmful and beneficial among the Somali Community in Garissa town and design the strategies that can be applied to eradicate harmful health effects and retain beneficial effects without compromising the dignity and human rights status of the girl child and the woman and also creating culturally and religiously friendly environment that does not antagonise the society.
1.4 Hypothesis

a) FGM has no beneficial health related effects in the study population.

b) Socio-cultural factors among the Somali community do not promote FGM.

1.5 OBJECTIVES OF THE STUDY

1.5.1 General Objective

To investigate health related effects of FGM.

1.5.2 Specific Objectives

a) To determine the extent and type of FGM practised by the study population.

b) To identify harmful and/or beneficial health effects of FGM.

c) To determine socio-cultural factors that promotes FGM.

d) To identify appropriate strategies to eliminate harmful health effects of FGM without affecting beneficial health related effects.

e) To determine the relationship between FGM and Various socio-demographic and health related factors.
CHAPTER 2 – MATERIALS AND METHODS

2.1 The study area

This study was carried out in Garissa Township between January and March 2002. The town is located about 350 km from Nairobi and is the provincial headquarters of Northeastern province.

Figure 1 – Map of Kenya showing the position of Garissa District
Figure 2 – Map of Garissa District showing Divisional Administrative Boundaries.
Garissa District is one of the three districts forming northeastern province. It borders Wajir District to the north, Lamu to the south, Tana River, and Isiolo to the west and the republic of Somali to the east (Figure 1).

The district lies approximately between latitude 0° 58° N and 0° 25° and longitudes 38° 34 E and 41° 31 E. It covers an area of 43,931 square kilometers, which is 7% of the total area of the country.

Garissa is low lying with altitude ranging between 70M and 400M above sea level. The River Tana, which runs along the western boundaries of the district is the only permanent river which has a tremendous influence over the climate, settlement patterns and economic activities and it is the single most important source of water; for the fast growing Garissa town (Figure 2).

The climatic conditions are semi arid with low rainfall between 3.6 mm to 34.2 mm annually, with temperatures between 20.5° C to 38° C. The district is divided into fourteen administrative divisions, fifty-one locations, and seventy nine sub location, there are four parliamentary constituencies in the districts. The population size of the district is 124,835, as per the 1999 census, which constitutes (33%) of the total population of the province.

Garissa town, which is the area of study is the administrative headquarters of both districts and the province and has an estimated population of 64,387 as per 1999 census, which represents 21.8% of the total population of the district. 98% of the inhabitants of Garissa district are from the Somali ethnic tribesmen who are Muslims. 1999 population census registered 32,251 primary school age children, 12,381 secondary school age children.
There are 54 primary schools, two youth polytechnics in the district with farmers training, teachers training and nursing training colleges. Most of the educational institutions are found within Garissa municipality in the central division of the district. The total enrolment in primary school was 12,500 pupils in 1995 out of this 4,500 were girls and 8,000 boys. The low enrolment of girls in school is encouraged by among the other socio-economic factors like early marriages and boys preference to girls, which is very common among the Somali communities.

School drop out is high among girls than boys in the district. The major economic activities in the district are nomadic pastoralists with small subsistence farming along Tana River. Health services in the district are provided through 28 institutions comprising of one referral hospital, 4 health centers, 17 dispensaries, five privates, and one mobile clinic.

2.2 The study population

Garissa town, which is the area of the study, has 27,464 of female population out of the total population of 124,835 in Garissa town who are between 15 – 49 years of age which translates to (21.9%). 98 – 100% of these female populations is estimated to be circumcised (Republic of Kenya 1999).

2.2.1 Inclusion criteria

Females between age group of 15 – 49 years who are Somali and willing to participate in this study and have had their first menstrual cycle.
2.2.2 Exclusion criteria

These include:

a) Those females below 15 years of age and those above 49 years of age.

b) Those females who have not had their first menstrual cycle and are in the age bracket 15 – 49 years

c) Those from non-Somali communities

d) Those unwilling to participate in this study

2.2.3 Ethical considerations

a) A written authority was obtained from Department of Zoology and Faculty of science Kenyatta University for data collection. The District commissioner, Garissa district education officer, and the district medical officer of health who also granted permission to collect data from schools, villages and the district hospital.

b) Informed consent was obtained from all participants

c) Participation was voluntary and the participants could withdraw at any time without penalty and loss of privileges

d) Anonymity, confidentiality and privacy were strictly safeguarded.

e) All information was obtained and kept in strict confidence.

2.2.4 Sample size determination

The minimum sample size was calculated from the formula previously used by (Fisher et al 1998).

\[
N = \frac{Z^2 pq D}{d^2}
\]

\(N = \text{Sample size}\)
P = Target population which is women between ages 15 to 49 and is estimated to be 22% of the total population which is (0.2)

Z = Standard normal deviate (1.96 which correspondence to 95% confidence level)

d = Degree of accuracy desire (0.05)

q = (1 - P) = 1 - 0.2 = 0.8

D = Design effect (= 1)

\[ N = \frac{1.96^2 \times 0.2 \times 0.8 \times 1}{0.05^2} = 245.86 = 246 \]

The sample size increased to 300 participants because of the nomadic nature of the study population.

2.3 Study Design

This was descriptive cross-sectional study.

2.4 Data collection methods and research instruments

Multistage sampling which is an extension of cluster sampling methods was applied and equal number of girls were selected from the two girl schools. Equal numbers of women participants were selected from the two Bullas (village) in Garissa Township using random selection from those willing to participate and fulfilling the inclusion criteria.

The study used both quantitative and qualitative methods of data collection.

The research instruments included structured questionnaires, focus group discussion, interviews and observations by the principal investigator.
2.4.1 Questionnaires

Questionnaires were administered to girls and women between the ages 15 to 49 years to provide information about their health, culture, religion, and sex life in relation to FGM.

2.4.2 Focus Group Discussions

This was held in Garissa town in the schools, bullas (Villages) and various other places. The focus group was consisting of various groups, the religious leaders, political leaders, women leaders (Maendeleo Ya Wanawake), women and girls who were circumcised, the traditional circumcisers and the health workers. The participants were selected as a panel. Most of the discussion were based on preset questions and the participants were not less than 8 and not more than 12 (twelve) per session.

The method used for selection of the participants was by positive/convenient sampling (Dawson et al 1993) and the respondents gave informed consent. The principal investigator facilitated focus group and notes were taken by trained assistants. In addition to the notes, the FGD were recorded into magnetic and videotapes. A total of nine FGD were held.

2.4.3 Interviews and observations

Interviews were conducted in Garissa town with individual girls and women, health professionals and traditional circumcisers based on their personal experience. Observations on the factors of the socio-cultural, religious and economic nature that promoted FGM were also any checklist made. The FGM operations and delivery of women in hospital maternity were also witnessed by the principal investigator.
2.5 Data Management and analysis

2.5.1 Quantitative data

The data was coded and entered into the computer. The SPSS (Statistical Package for Social Sciences) was used to analyze the data. Chi-square was used to test for association between variables.

2.5.2 Qualitative data

Data from FGD, interviews, and observations, were analyzed manually according to the study and summary written which provided for the necessary explanation of the quantitative data.
CHAPTER 3: — RESULTS

3.1 Introduction

In this chapter presentation of the findings in this study are made. The quantitative data were based on responses from 250 study subjects while the qualitative results were from 9 FGDs. The results are presented in qualitative relation to the specific study objectives including the socio-demographic characteristics of the study population.

3.2 Socio-demographic characteristics of the study population

As shown in the Table 1 below the majority of the respondents (70.8%) were aged 15 – 20 years; (16%) were aged between 21 – 30 and the remaining (13.2%) were aged between 31 – 49 years.

The majority of the respondents (78.4%) were educated at various levels with primary education accounting for 13.22%, secondary school 56.8%; college education 8.4% while 21.6% had no formal education.

A large proportion of the respondents was unmarried (68%) with only 31.6% being married.

Table 1: Socio-demographic characteristics of the study subjects

<table>
<thead>
<tr>
<th>Age of the respondents</th>
<th>No. of Respondents (n)</th>
<th>Proportion of respondents (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 – 20 years</td>
<td>177</td>
<td>70.8</td>
</tr>
<tr>
<td>21 – 33 years</td>
<td>40</td>
<td>16.0</td>
</tr>
<tr>
<td>31 – 49 years</td>
<td>33</td>
<td>13.2</td>
</tr>
<tr>
<td>Total</td>
<td>250</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level of education</th>
<th>No. of Respondents (n)</th>
<th>Proportion of respondents (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>33</td>
<td>13.2</td>
</tr>
<tr>
<td>Secondary</td>
<td>142</td>
<td>56.8</td>
</tr>
<tr>
<td>College</td>
<td>21</td>
<td>8.4</td>
</tr>
<tr>
<td>No education</td>
<td>54</td>
<td>21.6</td>
</tr>
<tr>
<td>Total</td>
<td>250</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>No. of Respondents (n)</th>
<th>Proportion of respondents (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>79</td>
<td>31.6</td>
</tr>
<tr>
<td>Not married</td>
<td>171</td>
<td>68.4</td>
</tr>
<tr>
<td>Total</td>
<td>250</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table 2: Circumcision status, age at circumcision and type of circumcision performed.

<table>
<thead>
<tr>
<th>Circumcised</th>
<th>Frequency</th>
<th>Proportion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>249</td>
<td>99.6</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Total</td>
<td>250</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Age at circumcision

<table>
<thead>
<tr>
<th>Age at circumcision</th>
<th>Frequency</th>
<th>Proportion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 10 years</td>
<td>234</td>
<td>94.0</td>
</tr>
<tr>
<td>11 – 20 years</td>
<td>14</td>
<td>5.6</td>
</tr>
<tr>
<td>Above 20 years</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Total</td>
<td>249</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Type of circumcision performed

<table>
<thead>
<tr>
<th>Type of circumcision performed</th>
<th>Frequency</th>
<th>Proportion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clitoridectomy</td>
<td>105</td>
<td>42.2</td>
</tr>
<tr>
<td>Excision</td>
<td>79</td>
<td>31.7</td>
</tr>
<tr>
<td>Infubilation</td>
<td>60</td>
<td>24.1</td>
</tr>
<tr>
<td>Others</td>
<td>5</td>
<td>2.0</td>
</tr>
<tr>
<td>Total</td>
<td>249</td>
<td>100.0</td>
</tr>
</tbody>
</table>

3.3 Circumcision status of study population

As shown in Table 2, circumcision among the female respondents was almost universal (99.6%) and the majority of them (94%) were circumcised at the ages between 0 –10 years and (5.6%) between 11 – 20 years with only 0.4% above 20 years of age. Most of the respondents had undergone clitoridectomy (42.2%) followed by excision (31.7%) and infubilation (24.1%) while other types of female circumcision were less frequent accounting for approximately 2% of all cases.

3.4 Harmful and beneficial effects of FGM

The majority of the respondents (63.5%) had experienced some health problems after circumcision while 36.5% did not encounter any health problems.
3.4.1. Harmful health effects of FGM

The commonest harmful health problem (66.5%) was painful menstruation followed by difficulty in passing urine (37.3%) with painful sex (16.5%) and delivery problems (3.2%) respectively (Figure 3).

Figure 3: The frequency of type of harmful health problems reported by the respondents

![Bar chart showing the frequency of different health problems.]

Table 3 - The number of different problems reported by respondents after circumcision

<table>
<thead>
<tr>
<th>Number of health problems</th>
<th>Number of respondents</th>
<th>Proportion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ONE</td>
<td>120</td>
<td>75.9</td>
</tr>
<tr>
<td>TWO</td>
<td>26</td>
<td>16.5</td>
</tr>
<tr>
<td>THREE</td>
<td>5</td>
<td>3.2</td>
</tr>
<tr>
<td>FOUR</td>
<td>6</td>
<td>3.8</td>
</tr>
<tr>
<td>FIVE</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Total</td>
<td>158</td>
<td>100.0</td>
</tr>
</tbody>
</table>
As shown in Table 3, the majority of respondents approximately (76%) who experienced health problems after circumcision reported only one type of health problem (16.5%) reporting at least 2 types of health problems while 3.2% and 3.8% reported three and four problems respectively.

3.4.2 Beneficial health effects of FGM

The beneficial health-related effects of FGM as reported by the respondents is summarized in Figure 4

The most commonly associated health benefits of FGM as indicated in Figure 4 are maintenance and preservation of virginity (67.2%) marriagebility (16%) helps in general hygiene (15.2%) and (4%) prevention of STDS (4.0%).
3.5 Socio – Cultural factor that promote FGM

As shown in Table 4 and illustrated in Figure 5 most of the respondents (56.1%) believed cultural beliefs and practices were the largest factors that encouraged FGM followed by religion (39.6%), aesthetic (2.3%) and economic (1.9%)

As indicated in Table 5 the majority of the respondents (67.6%) felt FGM should be continued. Those who disagreed constituted 24.8% with 4.0% remaining uncertain. This clearly indicated FGM was a deeply rooted traditional belief where education and western influence had little or no influence because the majority of the respondents (78.4%) were educated at least up to primary education. Most of these respondents felt FGM had benefits while (62.8%) strongly agreed, 19.2% strongly disagreed, while 8.4% disagreed.

Table 4: Socio-cultural determinants that promoted FGM.

<table>
<thead>
<tr>
<th>Determinants</th>
<th>Frequency (n)</th>
<th>Proportion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religion</td>
<td>103</td>
<td>39.6</td>
</tr>
<tr>
<td>Cultural belief and practices</td>
<td>146</td>
<td>56.2</td>
</tr>
<tr>
<td>Economic</td>
<td>5</td>
<td>1.9</td>
</tr>
<tr>
<td>Psychosexual/aesthetic</td>
<td>6</td>
<td>2.3</td>
</tr>
<tr>
<td>Total</td>
<td>260</td>
<td>100</td>
</tr>
</tbody>
</table>
3.5.1 Feelings about the practice of FGM

The most commonly associated health benefits of FGM as indicated in Figure 4 were maintenance and preservation of virginity (67.2%), marriageability (16%), helps in general hygiene (15.2%) and only (4%) associated it with prevention of STD.
### Table 5: Feelings about FGM

<table>
<thead>
<tr>
<th>Feeling about FGM</th>
<th>Frequency</th>
<th>Proportion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>107</td>
<td>42.8</td>
</tr>
<tr>
<td>Agree</td>
<td>62</td>
<td>9.2</td>
</tr>
<tr>
<td>Not certain</td>
<td>10</td>
<td>4.0</td>
</tr>
<tr>
<td>Disagree</td>
<td>23</td>
<td>24.8</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>48</td>
<td>19.2</td>
</tr>
<tr>
<td>Total</td>
<td>250</td>
<td>100</td>
</tr>
</tbody>
</table>

#### 3.5.2. Feeling of Sexual deficiency after circumcision

As indicated in Table 6 majority of the respondents (64.4%) did not feel sexually deficient and 18% felt sexually deficient while (17.6%) did not have sexual experience.

### Table 6: Feeling of sexual deficiency after circumcision

<table>
<thead>
<tr>
<th>Feels sex deficient since circumcised</th>
<th>Frequency</th>
<th>Proportion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>45</td>
<td>18.0</td>
</tr>
<tr>
<td>No</td>
<td>161</td>
<td>64.4</td>
</tr>
<tr>
<td>No sexual experience yet</td>
<td>44</td>
<td>17.6</td>
</tr>
<tr>
<td>Total</td>
<td>250</td>
<td>100.0</td>
</tr>
</tbody>
</table>

#### 3.6 Substitution and/or preferred modification of FGM

##### 3.6.1 Substitution of FGM

Table 7 shows that most of the respondents (49.6%) wanted the values of female circumcision taught in schools and madrasa (Islamic Schools) while 33.2% believed FGM had no substitute and only 17.2% believed in the continuation of FGM education without the surgical procedure. If surgical procedures had to be continued the preferred forms of FGM would be clitoridectomy as shown in Table 8.
Table 7: FGM Substitution

<table>
<thead>
<tr>
<th>FGM Substitute if was to be stopped</th>
<th>Number of respondents (n)</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>No substitute</td>
<td>83</td>
<td>33.2</td>
</tr>
<tr>
<td>Continue educate without surgery</td>
<td>43</td>
<td>17.2</td>
</tr>
<tr>
<td>Teach its culture values in school and Madrasas</td>
<td>124</td>
<td>49.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>250</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

3.6.2 Type of FGM preferred

In Table 8 most of the respondents (52.0%) preferred clitoridectomy, (the Islamic Sunna type). 22.4% prefer excision type, and 15.2% prefer other types and infubilation was most unwanted with only (10.4%).

Table 8: Type of FGM preferred.

<table>
<thead>
<tr>
<th>Type of FGM prefer if it was to be done</th>
<th>Number of respondents (n)</th>
<th>Proportion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clitoridectomy</td>
<td>130</td>
<td>52.0</td>
</tr>
<tr>
<td>Excision</td>
<td>56</td>
<td>22.4</td>
</tr>
<tr>
<td>Infubilation</td>
<td>6</td>
<td>10.4</td>
</tr>
<tr>
<td>Others</td>
<td>38</td>
<td>15.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>250</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

3.7 The relationship between FGM and Various socio – demographic and health related factors

In order to determine the factors that had some relationship with female genital mutilation, cross tabulation were done on each of these variables: age, education, type of circumcision, type of health problems after circumcision, type of FGM preferred, feeling about benefit of FGM and the number of health problems.
3.7.1 Age of the respondent and the type of circumcision performed.

Table 9: Age of the respondents and the types of circumcision performed.

<table>
<thead>
<tr>
<th>Age</th>
<th>Clit.</th>
<th>Excision</th>
<th>Inf.</th>
<th>Others</th>
<th>n</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 – 20 years</td>
<td>n</td>
<td>79</td>
<td>46</td>
<td>49</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>75.2</td>
<td>58.2</td>
<td>81.7</td>
<td>40.0</td>
<td></td>
</tr>
<tr>
<td>21 – 30 years</td>
<td>n</td>
<td>20</td>
<td>16</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>19.1</td>
<td>20.3</td>
<td>5.0</td>
<td>20.0</td>
<td></td>
</tr>
<tr>
<td>31 – 49 years</td>
<td>n</td>
<td>6</td>
<td>17</td>
<td>8</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>5.7</td>
<td>21.5</td>
<td>13.3</td>
<td>40.0</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>105(42.2%)</td>
<td>79 (31.7%)</td>
<td>60(24.1%)</td>
<td>5(2.0%)</td>
<td>2</td>
<td>0.002</td>
</tr>
</tbody>
</table>

Most of the respondents (42.2%) had undergone clitoridectomy, which is least severe type of FGM especially among the youth between the ages 15 – 20 (75.2%). There was a marked shift from the most severe type of FGM infibulation by (24.1%) (60/249) which had been practiced traditionally to this less severe type of FGM. Therefore, there was a significant relationship between age and type of circumcision performed ($X^2 = 6$, $P <0.05$).
3.7.2 Type of circumcision and low libido as a health problem.

Table 10: Type of circumcision and low libido as a health problem

<table>
<thead>
<tr>
<th>Type of Circumcision</th>
<th>Low Libido</th>
<th>X²</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clitoridectomy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>6</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>28.6</td>
<td>45.3</td>
<td></td>
</tr>
<tr>
<td>Excision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>10</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>47.6</td>
<td>27.7</td>
<td></td>
</tr>
<tr>
<td>Infubilation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>4</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>19.0</td>
<td>25.5</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>4.8</td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>158</td>
<td>21(13.3%)</td>
<td>137(86.7%)</td>
</tr>
</tbody>
</table>

Low libido was not a major health problem associated with female circumcision as the majority of the respondents did not suffer from this type of health problems (84.7%) with only a mere (13.3%) having reported to have suffered from low libido. Excision was the leading cause of low libido among the others types of female circumcision accounting for (47.6%). Moreover, there was no significant relationship between type of circumcision and low libido as a health problem. ($X^2 = 3$, $P > 0.05$).
3.7.3 Type of circumcision and painful sexual intercourse

Table 11: Type of circumcision and painful sexual intercourse

<table>
<thead>
<tr>
<th>Type of circumcision</th>
<th>Painful sexual intercourse</th>
<th>$X^2$</th>
<th>P-Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clitoridectomy</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>9</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>36.0</td>
<td>62.8</td>
</tr>
<tr>
<td>Excision</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>15</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>60</td>
<td>35.1</td>
</tr>
<tr>
<td>Others</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>4.0</td>
<td>2.1</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>119</td>
<td>94(79.0%) 3</td>
</tr>
</tbody>
</table>

Painful sexual intercourse was not a major health problem as (79.0%) of the respondents didn't have this health problem only (21.0%) of the respondents had painful sexual intercourse as a result of circumcision and excision was the largest cause of this health problem (60.0%). However, there was a significant relationship between the type of circumcision and the experience of painful sex ($X^2 = 3, P<0.05$)
3.7.4 Type of circumcision and painful menstruation.

Table 12: Type of circumcision and painful menstruation.

<table>
<thead>
<tr>
<th>Types of circumcision</th>
<th>Yes</th>
<th>No</th>
<th>$X^2$</th>
<th>P-Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clitoridectomy</td>
<td>n</td>
<td>50</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>40.1</td>
<td>33.3</td>
<td></td>
</tr>
<tr>
<td>Excision</td>
<td>n</td>
<td>24</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>23.1</td>
<td>44.4</td>
<td></td>
</tr>
<tr>
<td>Infubilation</td>
<td>n</td>
<td>28</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>26.9</td>
<td>20.4</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>n</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>1.9</td>
<td>1.9</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>158</td>
<td>104 (65.8%)</td>
<td>54(34.2%)</td>
</tr>
</tbody>
</table>

Most of the respondents (65.8%) had suffered from painful menstruation and a big proportion of these respondents who had undergone clitoridectomy (40.1%) had mostly suffered from this type of health problem followed by infubilation (26.9%) and excision (23.1%) and others (1.9%). This was the leading health problem among circumcised women. There was significant relationship between painful menstruation and type of circumcision ($X^2 = 3, P = 0.05$).
3.7.5 Type of circumcision and difficulty in passing urine.

Table 13: Type of circumcision and difficulty in passing urine.

<table>
<thead>
<tr>
<th>Types of circumcision</th>
<th>Yes</th>
<th>No</th>
<th>(X^2)</th>
<th>P-Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clitoridectomy</td>
<td>n</td>
<td>17</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>28.8</td>
<td>51.5</td>
<td></td>
</tr>
<tr>
<td>Excision</td>
<td>n</td>
<td>23</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>39.0</td>
<td>25.3</td>
<td></td>
</tr>
<tr>
<td>Infubilation</td>
<td>n</td>
<td>18</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>30.5</td>
<td>21.2</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>n</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>1.7</td>
<td>2.0</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>158</td>
<td>59 (37.3%)</td>
<td>99 (62.7%)</td>
<td>3</td>
</tr>
</tbody>
</table>

Difficult in passing urine was not a major health problem because the majority of the respondents (62.7%) did not suffer from this type of health problem. However, most of the respondents who suffered from difficulty in passing urine had undergone excision (39.0%), followed by infubilation (30.5%). Most of the respondents who had undergone clitoridectomy did not have this type of problem.

There was a slight significance in relationship between type of circumcision and having difficulty in passing urine \( (X^2 = 3, P = 0.05) \)
3.7.6 Age of the respondents and health problems after circumcision.

Table 14: Age of the respondents and health problems after circumcision.

<table>
<thead>
<tr>
<th>Age</th>
<th>Yes</th>
<th>No</th>
<th>$X^2$</th>
<th>P-Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 – 20 years</td>
<td>113</td>
<td>63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>71.5</td>
<td>69.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21 – 30 years</td>
<td>25</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>15.8</td>
<td>16.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31 – 49 years</td>
<td>20</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>12.7</td>
<td>14.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>249</td>
<td>158(63.5%)</td>
<td>91(36.5%)</td>
<td>2</td>
</tr>
</tbody>
</table>

Most of the respondents (63.5%) had health problems after circumcision and the majority of these respondents with health problems comprised of the youth between the ages of 15 – 20 years (71.5%). Although there was no significant relationship between age and health problem, there was an obvious relationship between circumcision and health problems. ($X^2 = 2, P < 0.05$).
3.7.7 Age at circumcision and type of circumcision performed

Table 15. Age circumcised and type of circumcision.

<table>
<thead>
<tr>
<th>Age Circumcised</th>
<th>Clit.</th>
<th>Exc.</th>
<th>Inf.</th>
<th>Others</th>
<th>X²</th>
<th>P. Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 10 years</td>
<td>n</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>99</td>
<td>92.4</td>
<td>92.4</td>
<td>66.7</td>
<td>3.8</td>
<td></td>
</tr>
<tr>
<td>11 – 20 years</td>
<td>n</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>5.7</td>
<td>7.6</td>
<td>14.3</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Above 20 years</td>
<td>n</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>249</td>
<td>42.4%</td>
<td>(31.7%)</td>
<td>(24.1%)</td>
<td>(2.0%)</td>
<td>6</td>
</tr>
</tbody>
</table>

Majority of the respondents (92.4%) were circumcised between ages 0 – 10 years and most of the youth had undergone clitoridectomy (94.3%). This indicates there is a shift from the traditional methods of infubilation to clitoridectomy. There is a significant relationship between age and type of circumcision with \( X^2 = 6, P<0.05 \)
3.7.8 Level of Education and Type of FGM.

Table 16 Level of Education and Type of Circumcision.

<table>
<thead>
<tr>
<th>Educational Level</th>
<th>Clit.</th>
<th>Exc.</th>
<th>Inf.</th>
<th>Others</th>
<th>X²</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>n</td>
<td>13</td>
<td>8</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>12.4</td>
<td>10.1</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td>n</td>
<td>65</td>
<td>36</td>
<td>39</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>61.9</td>
<td>45.6</td>
<td>65</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>College</td>
<td>n</td>
<td>9</td>
<td>7</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>8.6</td>
<td>8.9</td>
<td>6.7</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>No Education</td>
<td>n</td>
<td>18</td>
<td>28</td>
<td>5</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>17.1</td>
<td>35.4</td>
<td>8.3</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>249</td>
<td>105(42.2%)</td>
<td>79(31.7%)</td>
<td>60(24.1%)</td>
<td>5(2.0%)</td>
</tr>
</tbody>
</table>

Education has significant influence on the type of FGM performed. Most of the educated women have undergone clitoridectomy, which is less severe. Primary level (12.4%), secondary level (69.9%) and college level (8.6%). Therefore the relationship between education and type of circumcision is significant ($X^2 = 9, P<0.05$).
### 3.7.9 Age of respondents and type of FGM preferred.

Table 17: Type of FGM preferred

<table>
<thead>
<tr>
<th>Age of respond</th>
<th>Clit</th>
<th>Exc.</th>
<th>Inf.</th>
<th>Others</th>
<th>X²</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-20yrs.</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>103</td>
<td>37</td>
<td>21</td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>79.2</td>
<td>66</td>
<td>80.6</td>
<td>40.1</td>
<td></td>
</tr>
<tr>
<td>21 – 30yrs.</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>7</td>
<td>1</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>14.6</td>
<td>12.5</td>
<td>3.8</td>
<td>34.2</td>
<td></td>
</tr>
<tr>
<td>31-49yrs.</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>12</td>
<td>4</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>6.1</td>
<td>21.5</td>
<td>15.4</td>
<td>23.7</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>250</td>
<td>130 (52.0%)</td>
<td>56 (22.4%)</td>
<td>26 (10.4%)</td>
<td>38 (15.2%)</td>
<td>6</td>
</tr>
</tbody>
</table>

Most of the respondent (52%) preferred clitoridectomy. The younger generation between the ages 15 – 20 years (79.2%) and 21-30 years (14.6%) preferred clitoridectomy and the older generation between the ages 31-49 years preferred excision.

There is a dramatic shift from the severe types of infibulation as a traditionally preferred method.

Therefore, there is significant relationship between age and preferred type of female circumcision with ($X^2 = 6$, $P<0.05$)
3.7.10. Level of Education and feeling on the continuation of FGM

Table 18: Level of Education and feeling on the continuation of FGM.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Not certain</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>X^2</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>n 12</td>
<td>10</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% 11.2</td>
<td>16.1</td>
<td>30</td>
<td>17.4</td>
<td>8.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td>n 64</td>
<td>27</td>
<td>4</td>
<td>17</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% 59.8</td>
<td>43.5</td>
<td>40</td>
<td>73.9</td>
<td>62.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>College</td>
<td>n 2</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% 1.9</td>
<td>8.1</td>
<td>30</td>
<td>8.7</td>
<td>18.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. education</td>
<td>N 29</td>
<td>20</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% 27.1</td>
<td>32.2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>250 107 (42.8%)</td>
<td>62(24.8%)</td>
<td>10(4.0%)</td>
<td>23(9.2%)</td>
<td>48(19.2%)</td>
<td>12</td>
<td>0.00</td>
</tr>
</tbody>
</table>

Most of the correspondents agree with continuity of FGM (67.6%). The secondary levels of education respondents lead the advocacy for the FGM (59.8%). This indicates FGM is deeply rooted cultural belief despite western education. Therefore, education has a significant relationship with the feeling about FGM ($X^2 = 12$, $P<0.05$).
3.7.11. Level of Education and Feelings on the Benefits of FGM.

Table 19: Level of Education and Feeling about FGM Benefits.

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Strongly Agree</th>
<th>Not Agree</th>
<th>Disagree</th>
<th>Strongly Agree</th>
<th>X²</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>n 11</td>
<td>8</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% 12.6</td>
<td>16</td>
<td>20.8</td>
<td>19</td>
<td>10.4</td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td>n 70</td>
<td>22</td>
<td>9</td>
<td>15</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% 80.6</td>
<td>44</td>
<td>37.5</td>
<td>71.4</td>
<td>54.2</td>
<td></td>
</tr>
<tr>
<td>College</td>
<td>n 3</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% 3.4</td>
<td>6</td>
<td>8</td>
<td>9.5</td>
<td>22.9</td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>n 3</td>
<td>17</td>
<td>8</td>
<td>-</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% 2.8</td>
<td>34</td>
<td>33.3</td>
<td>12.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>250</td>
<td>87(34.8%)</td>
<td>50(20.0%)</td>
<td>24(9.6%)</td>
<td>48(19.2%)</td>
<td>12</td>
</tr>
</tbody>
</table>

Most of the respondents despite their education feel FGM has benefits (54.8%) and the respondents of secondary level of education (80.6%) are leading in this feeling about FGM having beneficial effects.

Therefore, education has significant relationship with feelings about the benefit of FGM. ($X^2 = 1, P<0.05$)

3.7.12 Level of Education and type of FGM preferred.

Table 20: Level of Education and type of FGM preferred.

<table>
<thead>
<tr>
<th>Type of FGM preferred</th>
<th>Clitoridectomy</th>
<th>Excision</th>
<th>Infubilation</th>
<th>Others</th>
<th>X²</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>n 20</td>
<td>8</td>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% 15.4</td>
<td>14.3</td>
<td>7.7</td>
<td>7.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td>n 86</td>
<td>26</td>
<td>19</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% 66.2</td>
<td>46.4</td>
<td>73.1</td>
<td>28.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>College</td>
<td>n 10</td>
<td>4</td>
<td>1</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% 7.7</td>
<td>7.1</td>
<td>3.8</td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Education</td>
<td>n 14</td>
<td>18</td>
<td>4</td>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% 10.7</td>
<td>32.2</td>
<td>15.4</td>
<td>69.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>250</td>
<td>130(52.0%)</td>
<td>56(22.4%)</td>
<td>26(10.4%)</td>
<td>38(15.2%)</td>
<td>9</td>
</tr>
</tbody>
</table>

66
Most of the respondents preferred clitoridectomy (52%) which is mild form of FGM and most of the educated respondent wanted clitoridectomy. Thus primary (15.4%), secondary level (66.2%) and college level (47.6%) while the respondents with no education wanted excision (32%) which is more severe form of FGM. Most of the respondents did not prefer infubilation, which is the traditionally common type of FGM among the Somali community. This indicates a definite shift from the traditionally preferred type of FGM.

Therefore, education had a significant relationship with preferred type of FGM. ($X^2 = 9, P<0.05$).

### 3.7.13 Number of health problems and type of FGM.

**Table 21. Number of health problems and type of circumcision.**

<table>
<thead>
<tr>
<th>Number of Health Problems</th>
<th>Type of Circumcision</th>
<th>$X^2$</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clitoridectomy</td>
<td>Excision</td>
<td>Infubilation</td>
</tr>
<tr>
<td>1</td>
<td>n 57</td>
<td>34</td>
<td>29</td>
</tr>
<tr>
<td>%</td>
<td>83.8</td>
<td>70.8</td>
<td>74.4</td>
</tr>
<tr>
<td>2</td>
<td>n 9</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>%</td>
<td>13.2</td>
<td>10.4</td>
<td>23</td>
</tr>
<tr>
<td>3</td>
<td>n 1</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>%</td>
<td>1.5</td>
<td>8.3</td>
<td>-</td>
</tr>
<tr>
<td>4</td>
<td>n 1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>%</td>
<td>1.5</td>
<td>8.3</td>
<td>2.6</td>
</tr>
<tr>
<td>5</td>
<td>n -</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>%</td>
<td>-</td>
<td>2.3</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>250</td>
<td>68(27.2%)</td>
<td>48(19.2%)</td>
</tr>
</tbody>
</table>

Most of the respondents who had more than two health problems had undergone infubilation (36%) whereas, most of the respondents who had only one health problem had undergone clitoridectomy (47.1%).

Therefore, there was a significant relationship between number of health problems and the type of circumcision performed ($X^2 = 1, P<0.05$).
CHAPTER 4 – DISCUSSION

4.1 Introduction
This study evaluated the health effects of FGM among the Somali community in Garissa town in Kenya.
The findings from FGD participants and respondent’s demographic characteristics indicated the majority were mature and had formal education. The findings are discussed in this chapter systematically in line with the specific objectives of the study.

4.2 The extent and type of FGM practiced by the study population
Circumcision among the Somali community in Garissa town was almost universal in the study since 99.6% of the respondents were circumcised and the majority of the respondents (94%) had been circumcised at tender age of 0-10 years.

FGM was definitely hazardous to health, as the majority of the respondents have had health problems (63.5%) after circumcision. There was a significant relationship between the number of health problems and type of circumcision ($X^2 = 12$, $P \leq 0.05$). The commonest health problem among the respondent (66.5%) was painful menstruation and there was a significant relationship between the type of circumcision performed on the respondent and painful menstruation ($X^2 = 3$, $P = 0.05$). The majority of the respondents who had undergone clitoridectomy type of FGM (73.5%) had experienced painful menstruation as a health problem. The second most common health problem was difficulty in passing urine with (37.3%) of the respondents having suffered from this type of health problem. The excision type of FGM (47.9%) and infubilation were the leading causes of this type of health
problem among the respondents. There was also a significant association between the type of circumcision undergone and difficulty in passing urine as a health problem ($X^2 = 3, P<0.05$).

Painful sex (16.5%), low libido (13.3%) and delivery problems (3.2%) were the other less common health problems among the respondents, which resulted from female circumcision. The health problems revealed in this study among the respondents were in conformity with the findings from another study done among Somali women which revealed (39%) of the circumcised women developed acute complications (Dirie and Lindma; 1992). Infubilation was the most severe type of FGM, which has numerous health problems. Approximately (25%) of the infubilated women suffered from one or more of the immediate complications of FGM (Echala et al; 1977). Infubilation has been the most preferred type of FGM among the Somali community (Raqiya 1982). However, there was dramatic shift from the traditionally preferred infubilation to milder form of FGM the clitoridectomy. The majority of the respondents (42.2%) had undergone clitoridectomy followed by excision (31.7%) and only (24.1%) had been infubilated.

Most of the respondents (52%) preferred clitoridectomy followed by excision (22.4%). The younger generation between the age 15 – 20 years (58.2%) and 21 – 30yrs (47.2%) preferred clitoridectomy as a type of FGM to be performed. While the older generation, 31-49yrs preferred excision. There was a significant association between age and preferred type of circumcision ($X^2 = 6, P<0.05$). Education has played important role in this dramatic shift from infubilation to clitoridectomy and there was a significant association between education and type of circumcision undergone ($X^2 = 9 P< 0.05$). Most of the respondents who had
undergone clitoridectomy type of FGM were educated. Primary education (39.4%), secondary education (46.1%) and college education (42.9%) whereas the uneducated respondents (51.9%) had undergone excision.

The health problems associated with FGM as pointed out by Koso – Thomas (1987) depends on the type of the FGM and the environment in which the operation was performed. However, all of these complications are preventable if the operation was performed by trained health personnel and in a hospital or other sterile environment particularly if the type of circumcision performed is Islamic sunna type of clitoridectomy. This can make FGM as harmless as the American tattoos and breast argument or even ear piercing.

This has been demonstrated in Kisii town where FGM has been moved from the traditional circumcisers to the clean and sterile minor theatres in Hospital and operation is performed by trained nurses. During the school holidays the girls flood to the hospital and stay in the ward for 2 – 5 days (ROK/MOH, 2002)

4.3. Socio – cultural factors that promoted FGM.

Historically, the control of women sexuality has been practiced worldwide. The early Romans used shipping rings, the chastity belt in Europe and FGM in Africa, which has been largely associated with rite of passage but also a measure of control of female sexuality (FIDA 2001).

In fact, FGM among the Somali community is not a rite of passage but a measure of control of female sexuality. In general the sexual life of a Somali woman begins with marriage given their moral, customary and religious demand, approximately (90%) of the Somali girls remain virgin until marriage (Raqiya, 1982). Infubilation is seen, as not only an additional measure to control woman’s erotic desires to maintain
virtues in youth and also at the time of marriage (Raqiya, 1982). The three main reasons for FGM among the Somali community are to maintain virginity, chastity and marriageability. Female sexuality unlike male sexuality has a far-reaching consequence because in addition to pleasure, sex in female species has procreative role with consequences of pregnancy and other far reaching social consequences. If not controlled properly can bring social crisis like street children, school dropouts as a result of teenage pregnancy etc. The Somali community is a patriarchal society, where the action of an individual affects the entire society. In the absence of the modern scientific family planning and social education, FGM has been the only available tool to control female sexuality.

Female circumcision doesn't largely diminish the sexual feeling of women as demonstrated by this study. (64.4%) of the respondent didn’t feel sexually deficient and low libido is not among the health problems because (86.7%) of the respondent did not state this type of health problem and there was no significant relationship between the type of circumcision and low libido as a health problem $X^2 = 3, P>0.05$.

As pointed out by an Egyptian physician Amal Ab El Haji, it is not necessary to exaggerate other health or sexual damage caused by FGM. She noted that women are not necessarily denied sexual pleasure by FGM as demonstrated in various qualitative research studies whereby most of the women respondents stated that they enjoyed their sexual life (Kirberger et al; 1995)

The expression of sexual fulfillment or enjoyment is demonstrated differently by different societies, in the western world sexual enjoyment as demonstrated in ordinary western films or pornographic films involve a lot of noise and aggression. Most of the educated Somali or other African communities have taken this method.
as a yardstick for sexual enjoyment. In the Somali society, sex has always been an act of procreation largely and to a lesser extent pleasurable, which must be performed with minimal noise and maximum speed because of non-availability of space and privacy. The Somali hut is a small space less than 10 x 10 meters where the entire family sleeps and the western type of sexual expression will not only disturb the entire family but the neighbours. The less noise and less sexual aggression of the Somali people as the way of sexual expression is as a result of primary socialization; which can be changed with education and availability of adequate space and privacy.

4.4 Appropriate strategies to eliminate harmful health effects of FGM

FGM is deeply rooted cultural beliefs which doesn’t have obvious physical health benefit but have social and psychological health benefits and health seeking behaviour.

Most of the respondents (67.6%) wanted FGM continued with (42.8%) strongly agreeing with continuity of FGM. This clearly indicated that inspite of western education influence; complete eradication of FGM is not easy to achieve in the foreseeable future. The main reason for the continuity of FGM is maintenance and preservation of virginity (67.2%), chastity (16%), and Marriagebility and therefore the main reasons are virginity, chastity and marriagebility.

The importance attached to the concept of virginity in the Somali society cannot be over emphasized. The preservation of women sexual purity and honours is thus essential (Raqiya, 1982). Approximately one-third of the world population is between 10 – 24 years (Friedman 1983, Ains Worth and Over, 1997). Rapid urbanization and rural-urban migration has meant that greater numbers of young people are living in
precarious and impoverished conditions. The traditional, multigenerational extended families have been increasingly replaced by nuclear families, lone parents families and in some cases the complete absence of the parents (Fuglesang, 1997).

There are increasing pressures on young people to be sexually active (River and Aglletum, 1998). Evidence from several countries suggest that the age at which young people are sexually active may be falling (Fee and Yourself, 1993).

In Uganda for example (50%) of young men and (40%) women recently surveyed reported having sex by age of 15 years (Konde – Lule et al; 1997).

There is need more than ever before to maintain the good values of virginity and chastity among the youth especially so in advent of the Aids/HIV scourge in our country and with increased evidence of falling age for sexual activity among the youth.

Most of the respondents (52%) preferred clitoridectomy (the Islamic Sunna type) which involves the removal of the prepuce of the clitoris only as the preferred type and modification required which is drastic shift from the harmful traditional type of infubilation. The Islamic Sunna is almost harmless and equivalent to male circumcision and should be done in hospital or sterile environment. The values of the traditional educational method, which was taught to the initiators, should be taught in formal schools and the Islamic schools (madrasas). (49.6%) of the respondents feel these institutions will provide the right substitutes for education to youth, which ingrain the right values of morality, if the relevant educational curriculum is developed.
4.5 Methods to modify FGM without losing health and Social-cultural benefits

The Alternative Rite of Passage (ARP) as conceptualized by PATH and MYWO is a good idea although it has not reached the Somali community in Garissa. The idea requires a lot of homegrown initiatives, which must be added to the operational mechanism of the concept. Unfortunately, (ARP) has not been accepted by the pilot three districts as evidenced by the sentiment expressed by the parent of the graduate ARP in the Maasai communities. The approach is likely to create more problems than solutions and create a group of social misfits in the community. The idea must be taken back to the drawing board to formulate socially acceptable and religiously friendly, approach, which are homegrown and implementable. The social determinants that encourage FGM practice in the Somali community in Garissa are cultural beliefs and practices (56.1%) and religion (39.6%).

These factors of cultural beliefs and practices, and religion can be used positively in the ultimate eradication of FGM. The method recommended by the Islamic religion is the Sunna type, which has no, or minimal health problems. Once there is a shift from the hazardous type, of FGM, namely infubilation and excision type. The cultural beliefs can be modified with aggressive education especially with the involvement and training of religious leaders and opinion leaders. The teaching of the FGM values in the formal schools and Islamic schools (Madrassa) will eventually revolutionize the cultural belief with an aim of ultimate eradication of FGM.

However, the final blow in the eradication of FGM lies in the empowerment of women in terms of education and economics. FGM involves women’s many social roles, the practice relates to superstition, religion, local customs, health practices,
child bearing concept, sexual fulfillment and a range of other important social relationships changing attitudes towards FGM will inevitably involve change overall situation of women.

4.6 The relationship between FGM and various socio-demographic and health related factors.

4.6.1 The law and the FGM

FGM is illegal in Kenya as per the child act 2001. (Children Act 2001, laws of Kenya). The government should not criminalise FGM in the absence of broader strategy to change individual behaviour and social norms, in the existing environment, criminal sanction against once own relatives, clan, or family may have graver economic and social consequences than the penalties meted to put against the perpetrators. The girl who has been circumcised will suffer more because of a criminal sentence meted out against her parents. Sudden enforcement of criminal legislation where the government had by affirmation or by silence permitted the practice to thrive is likely to result in hostile if not outright rebellion and drive the practice underground with more serious health consequences. (FIDA, 2001).

The Egyptian experience tells us that legislation and litigation may not be appropriate at all (Kirberger et al/ 1995). Majority of the participants of FGD felt that legislation against FGM will not work since the attempt to make the practice illegal have not stopped it from the occurring.

The legal frame does provide medium for punishment of the practitioners of FGM. However, the more urgent task is not to punish those who carry out the practice but to inform, educate and communicate to society the facts and issue on FGM and to work towards shifting the social paradigms on the practice (FIDA 2001).
"Regardless" of how we view FGM we must not view it by itself but rather we should think of it as embedded within larger context of shifting discourse moving from identity paradigm to rights paradigm" (Abdullal an-naims PHD – professor of law at Emary University Egypt).

4.6.2 Cultural Relativism vs Human Rights

There is serious disagreement about whether the practice of FGM is an issue of cultural relativism or an issue of human rights. In Kenya, anthropologists like Jomo Kenyatta glorified the practices by arguing it had deeper significance beyond the physical operation (Kenyatta, 1938).

Some western anthropologists have equated the practice of FGM with such western practices as breast augmentation and tattooing (Castle line, 2002).

There is a great propensity in the western world to exaggerate general concept of FGM especially its health effects and give monstrous and cruel names like female genital mutilation. The dictionary meaning of mutilate is to injure, damage or disfigure somebody or something by breaking or cutting of necessary part. No parent in his or her right mind will deliberately mutilate his child without obvious gain. Most of the participants of the FGD did not think FGM as a human rights issue and did not agree with term mutilation as a substitute to female circumcision.

The United Nation convention on the rights of the child is ambiguous about FGM. On one hand, article 24 paragraph 3 “state parties shall take all effective and appropriate measures with view to abolishing traditional practice prejudicial to health of the children”. But article 29 paragraph 1c calls for “the development of the respect for the child’s parents, his or her own cultural identity, language and values
for the national of the country in which he or she may originate, and for civilization
different from his her own.

Most organizations working against FGM use health argument to advance their
concerns, stressing physical hazards, which can be easily be eliminated. Upon careful
examination, health is not merely a narrow biological issue and has other dimension
such as political, social psychological and economical dimensions.

Most of the participants in FGD viewed eradication as a part of the current onslaught
on Islam and by extension Eurocentric cultural imperialism. Eradicating FGM is a
major challenge for all and requires a creative and thought approach to multifaceted
human rights problems against women and girls. It requires a rethinking of the
traditional techniques and orientations of its partners in the human rights movement
to devise joint complementary strategies.
CHAPTER 5 – A SUMMARY OF CONCLUSION

a. There is general consensus among the Somali community in Garissa town, that FGM especially the severe types of infibulation and excision is hazardous to health with numerous health problems.

b. The social-cultural factors that enhance value that encourage virginity and chastity, has health beneficial effects in the long run in the prevention of unwanted pregnancies, sexually transmitted disease including the HIV/AIDS and social problems like street children which have overall health bearing.

c. There is need for gradual eradication of FGM and shift from severe types of FGM i.e. infibulation and excision to less harmful type of FGM, the 'Islamic Sunna' clitoridectomy.

d. Eradication/modification of FGM is all around effort that involves legal, social, political and economic measures. The immediate efforts should focus on the information, education, and communication, in order to facilitate change in the society's attitude towards the practice.

e. All the harmful health effects of FGM are preventable and efforts should be put in to place to prevent all these harmful health effects.
6.1 RECOMMENDATION

a) Operation Recommendations

i. A strong collaboration between the government and other stakeholders to maximize on the available resources to expand capacity to intensify campaign of the eradication FGM and avoid duplication of efforts.

ii. Develop strategies that will empower women and girls in educational and economic spheres.

iii. Develop education curriculum in both secular and Islamic School on the harmful and beneficial effects of the FGM.

iv. Disseminate information on FGM through regular health programmes in maternal and child health clinics.

v. FGM should be performed in health facilities. Health personnel should be trained to make FGM as harmless as humanly possible using sterile hospital environment like any other surgical procedures.

vi. The harmless type of FGM the clitoridectomy “Sunna type” should be legalized and law criminalizing FGM should be abolished.
vii. Alternative rite passage is conceptualized from grass root level with strategies that are community specific and culture friendly with help of other opinion leaders, religious and political.

viii. FGM should be de-linked from human rights abuse issues.

b) Research Recommendation

There is need to carry out further, more in-depth research on health effects of FGM.

c) General Recommendation

There's need to develop strategies that will empower women and link FGM with other monstrous health problems, illiteracy and poverty among the women of Garissa in particular, Kenya and the world in general.

6.2 SUGGESTIONS FOR FUTURE RESEARCH WORK.

a. GOK, NGOs and other agencies involved in FGM elimination should focus on long-term plan that will place Somali community especially the women folk at more vantagepoint through political, educational and economical empowerment.

b. FGM a deeply rooted cultural belief which requires strategies and climate that focuses on gradual change and process of modification to the harmless type of FGM. Information, education and communication should be culturally and religiously acceptable.

c. The radical strategies of the eradication of FGM through condemnation of the community beliefs, cultures and religion are counter productive and should be avoided by all means.
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APPENDICES

APPENDIX 1: RESEARCH INSTRUMENTS

A. QUESTIONNAIRES

Introduction

This questionnaire seeks to gather information on health effects of Female circumcision among the Somali women.

Please kindly respond to the questions with honesty and all the information you give will be treated with utmost confidence.

Instructions

1. Answer all questions completely
2. Do not write your name
3. In case of any difficulty, seek clarification from the investigator

1. How old are you?
   (a) 15 – 20 Years
   (b) 21 – 30 Years
   (c) 30 – 49 Years

2. What is your level of Education?
   (a) Primary
   (b) Secondary
   (c) College
   (d) Nil Education
3. Are you married?
   (a) Yes
   (b) No.

4. Are you circumcised?
   (a) Yes
   (b) No

5. At what age were you circumcised?
   (a) 0 – 10 Years
   (b) 11 – 20 Years
   (c) Above 20 Years

6. What type of circumcision did you undergo?
   (a) Type I (Clitoridectomy)
   (b) Type II (Excision)
   (c) Type III (Infubilation)
   (d) Type IV (Others)

7. Have you had any health problems after circumcision?
   (a) Yes
   (b) No
8. If Yes, what type of health problems?
   (a) Difficulty in passing urine
   (b) Painful menstrual periods
   (c) Painful sexual intercourse
   (d) Low libido

9. If non of the above please explain ...........................................
   ...........................................................................................
   ...........................................................................................
   ...........................................................................................

10. Please tick the number that best describes your feelings about female Circumcision.
    1. Strongly agree
    2. Agree
    3. Not certain
    4. Disagree
    5. Strongly disagree

11. Female circumcision has health benefits.
    1. Strongly agree
    2. Agree
    3. Not certain
    4. Disagree
    5. Strongly disagree
12. What are the health benefits of female circumcision that you know?

Please tick your answer (s)

(a) It helps in the general hygiene ( )
(b) Maintenance and preservation of virginity ( )
(c) Prevents sexually transmitted diseases ( )
(d) Helps in getting married ( )

13. If female circumcision was to be done what type would you prefer?

(a) Type I  (Clitoridectomy ) ( )
(b) Type II  (Excision) ( )
(c) Type III (Infubilation) ( )
(d) Type IV (Others ) ( )

14. If female circumcision was to be stopped, what would you suggest as the substitute?

(a) No substitute ( )
(b) Continue with ceremonial education without surgical procedure. ( )
(c) Teach its cultural values in formal schools and Madarasa ( )

15. In your opinion, what are the factors that encourage female circumcision?

(a) Religion ( )
(b) Cultural beliefs and practice ( )
(c) Economics ( )
(d) Psychosexual and aesthetic ( )
16. As a circumcised Somali woman do you feel sexually deficient?

(a) Yes

(b) No

Please explain.................................................................

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17. Do you have any further comments about female circumcision?

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B. GUIDE FOR PARTICIPANT IN GROUP FOCUS DISCUSSION AND INTERVIEWS ON FGM IN GARISSA

1. What is FGM?

2. What are the types of FGM performed among the Somali community?

3. When and how is FGM performed among the Somali community?

4. What role does religion play in FGM?

5. What are cultural factors that encourage FGM?

6. What role does economic status play in FGM among Somali in Garissa?

7. What are the health problems of FGM usually encountered among the Somali in Garissa?

8. What are the health benefits of FGM?

9. How can FGM be eliminated among the Somali Community in Garissa?

10. If FGM cannot be totally eliminated what are other options?

11. What are the social status of uncircumcised women in the society?

12. What are the interventions that are community specific, culture friendly in the elimination of FGM of modification of FGM?

13. What are the factors other than religion and culture that promote FGM?

14. What are the role of poverty in the promotion of FGM?

15. What is the role of education in relation to elimination and promotion of FGM and in the general empowerment of the girl child, or women among the Somali community in Garissa?

16. What is the role of economic empowerment of women in elimination of FGM?

17. How does FGM violated the right of women and girl child?
18. It's claimed by advocates of FGM that it promotes good values such as virginity and reduces sexual promiscuity among girls and women. What are the steps to be put into place to retain these values after FGM is eliminated?

19. What are prevalence rates of School Pregnancies and other extra marital pregnancy among Somali women and what factors affect these?

20. What is the prevalence of STD/HIV/AIDS among the Somali girls and women and what factors affect these?

21. It has been claimed that FGM reduces the sexual urge and performance of women. Explain your views on this?

22. Enormous efforts have been put into elimination of the FGM without success. What have contributed to this and how can the situation be reversed?

23. FGM is now illegal in Kenya, what is the role of this law and the likely implementation and enforcement problems?

24. How will these law help in the elimination or promotion of FGM?

25. What are the possible effects of the implementation of this law?

26. What is the role of the Somali women in promotion of FGM?

27. What is the role of the traditional circumcisers in the elimination and/or modification of FGM?

28. What is the necessary modification required in FGM?

29. How can religion and culture be used in the elimination/modification of FGM?

30. Discuss how FGM enables males to dominate women?

31. Discuss the question of marriageability of uncircumcised Somali women and its social cultural consequences?
C. GUIDE FOR OBSERVATIONS ON FGM IN GARISSA.

a) Observe procedures of Female Circumcision being performed in Garissa town.

b) Observe child deliveries of circumcised women in Garissa District Hospital.

c) Observe the social status of the uncircumcised women among the Somali Community.

d) Observe cultural and religious factors that encourage FGM.
APPENDIX 2: ABSTRACT FOR CONFERENCES/SEMINARS/WORKSHOPS

Female Genital Mutilation: health related effects among Somali community in Garissa town, Kenya.

Investigators
- Major Mohammed Y. E.
- Prof. Orago A. S. S.
- Dr. Waswa J. K.

Conference – Postgraduate Scientific conference
Date - 8th August 2002
Venue - Kenyatta University

ABSTRACT
Female circumcision or Female Genital Mutilation (FGM) is a tradition since antiquity and its exact origin is unknown. The spectrum of these genital procedures has been termed as female circumcision and more frequently FGM as a collective name describing several types of circumcision traditions. According to the world health organisation (WHO) FGM is a form of violence against girls and women with serious physical and psychological consequences on health and must be abolished entirely. FGM is a deeply rooted cultural practice and most of the adherent communities consider WHO version as Eurocentric and cultural
imperialism. Circumcision of girls and women among the Somali community in Garissa is almost universal.

Despite the widespread practice of FGM among the Somali community in Garissa District no previous study had investigated health-related effects that should be associated with this practice.

A descriptive cross-sectional survey was conducted in Garissa town Kenya between January and March 2002 to evaluate the health related effects of female genital mutilation among the Somali community in Garissa town. A total of 250 respondents were interviewed and nine focus group discussion (FGD) were held comprising of 90 participants.

Some 99.6% of the respondents in this study were circumcised and majorities (94%) were circumcised at the tender age of 0 – 10 years. FGM appeared hazardous to health, as the majority of the study population (63.5%) had developed health problems after circumcision and there was significant relationship between number of health problems and type of circumcision ($X^2 = 12, P<0.05$). However, there was a dramatic shift from the traditional preferred type of circumcision, infubilation, to a milder type of FGM, the clitoridectomy adopted by the most of the respondents (42.2%) compared to only 24.1% who had undergone infubilation. Education had played an important role in this change of attitude from infubilation to clitoridectomy and there was a significant association between education level of respondent and the type of FGM preferred ($X^2 = 9, P<0.05$).
Despite education and health problems associated with FGM some (67.6%) of the respondents wanted FGM to be continued and believed it had some benefits. Eradication of FGM did not appear easy and achievable in the near future but there was a change from harmful type of FGM to the relatively harmless type, clitoridectomy. Most of the respondents (52%) preferred the Islamic sunna type which involved the removal of the prepuce of the clitoris and was as harmless as the male circumcision. The study has contributed to a deeper understanding of health related effects of FGM. Modification and or elimination of FGM is and all around effort and involves legal, social, political and economic measures. The immediate efforts should focus on information, education, and communication in order to facilitate change in the society’s attitude towards the practice.
TO WHOM IT MAY CONCERN

Dear Sir/Madam,

REF: MAJOR MOHAMED YUSUF ELMI - IS6/9181/2000

The above named person is a self-sponsored student in our Masters programme in Public Health and Epidemiology. He is in the process of developing a research proposal to enable him write a thesis in partial fulfilment of the requirements for the award of the degree.

I would be most grateful if you could accord him all the necessary assistance with regards to facilitating and funding of his research work including final preparation of the thesis.

Many thanks for your continued support in capacity building for health-related and management of human diseases.

Yours sincerely,
THE DISTRICT COMMISSIONER
GARISSA
P. O. BOX 1
GARISSA

Dear Sir,

The above named is a Master's student in Public Health and Epidemiology of Kenyatta University. He is expected to carry out research work on the investigation of the health effects of female genital mutilation in school girls and women in villages in Garissa as part of his postgraduate training and write a thesis. I would be most grateful if you accorded him all the necessary assistance to facilitate the completion of his research work in good time.

Many thanks for your assistance and support.

Yours sincerely,

Prof. Alloys S. S. Orao
Director, CCMB and University Supervisor.
The Headteachers
Unus Scheme Girls Sec. School
N.E.P. Girls Sec. School.

RE: Introduction Note
Mr. Mahamood M. Abdin-Mading

This is to introduce you to the seer, Major Mohamed, a student from
Kenyatta University. He is out for
a research work, your two schools
inclusive.

This office has authorized him

to conduct the said research and
you are expected to give him the
cooperation he desires.

A.S. Mohamed

for: DES