AN ASSESSMENT OF THE IMPACT OF HEALTH CAMPAIGNS AGAINST FEMALE GENITAL MUTILATION IN WEST POKOT DISTRICT, KENYA

BY

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Reg No. 157/7381/2002

“A thesis submitted in partial fulfillment for the award of the degree of Master of Public Health and Epidemiology of Kenyatta University”

DECEMBER, 2006
DECLARATION

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

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Signature

Date 22/1/07

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We as the University supervisors confirm that the candidate carried out the work reported in this thesis under our supervision.

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DEDICATION

This thesis is dedicated to students of St. Eliza’s Girls’ Kabichbich Secondary School, and my entire family members whose encouragement and patience made me go through the study successfully.
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<td>Area Development Programme</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ARP</td>
<td>Alternative Rite of Passage</td>
</tr>
<tr>
<td>BC</td>
<td>Before Christ</td>
</tr>
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<td>Demographic and Health Survey</td>
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<td>EDIHS</td>
<td>Eritrea Demographic and Health Survey</td>
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<td>Female Genital Mutilation</td>
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<tr>
<td>FPAK</td>
<td>Family Planning Association of Kenya</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>KDHS</td>
<td>Kenya Demographic and Health Survey</td>
</tr>
<tr>
<td>KSH</td>
<td>Kenya Shillings</td>
</tr>
<tr>
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<td>Maendeleo Ya Wanawake Organization</td>
</tr>
<tr>
<td>PATH</td>
<td>Programme for Appropriate Technology in Health</td>
</tr>
<tr>
<td>ROK</td>
<td>Republic of Kenya</td>
</tr>
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<td>UNICEF</td>
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ABSTRACT

An estimated two million girls worldwide are at risk of experiencing genital mutilation every year of which the majority are young girls in 28 African countries. In Kenya, the practice is prevalent with 38% of women aged 15-49 years reporting being circumcised. The practice is nearly universal among the Kisii (97%) and Maasai (89%) and very common among Kalenjin (62%), Taita/Taveta (59%), Embu/Meru (54%), and to lesser extent among the Kikuyu (43%), Kamba (33%), and Mijikenda/Swahili (12%). Female Genital Mutilation causes irreversible, life-long health risks for girls and women, at the time of operation, during menstruation, consummation of marriage and during childbirth. The purpose of the study is to evaluate the impact of health campaigns on the community’s practice of female circumcision through education, awareness campaigns and advocacy for alternative rites of passage. Simple random sampling technique was used to identify study subjects in the two purposively selected divisions namely, Chepareria (intervention site) and Sigor (control site). A total of 750 participants was randomly sampled comprising 375 household heads from each study site. Structured questionnaires, focus group discussions and interview guides were used to collect data on knowledge, attitudes and perceptions of the community on FGM and anti-FGM advocacy activities. The data collected were processed and analyzed using the computer Statistical Package for Social Sciences (SPSS). Chi-square test for independence was used to establish associations in health knowledge, attitude and perception of anti-Female Genital Mutilation advocacy activities. The student t-test was also used to determine the differences between mean ages in the two study sites. The results of the study indicate differences in the knowledge of health risks, attitudes and practices of Female Genital Mutilation between the study sites. For instance, it was found out that the prevalence of female circumcision was significantly higher in the control site than in the intervention site ($\chi^2 = 222.279; df = 2; p<0.001$). The result also showed that awareness of the health and social implication of the procedure on women was significantly higher among the respondents in the intervention site ($\chi^2 = 99.8192; df = 3; p<0.001$). This could be attributed to their participation in the anti-FGM campaigns. The results also revealed that awareness of anti-FGM advocacy activities ($\chi^2 = 32.1963; df = 1; p<0.001$) and participation ($\chi^2 = 49.230; df = 1; p<0.05$) were statistically significant between the study sites. Similarly, awareness of the alternative rite of passage ($\chi^2 = 188.140; df = 1; p<0.001$), involvement ($\chi^2 = 21.890; df = 4; p<0.001$) and adoption ($\chi^2 = 13.040; df = 1, p<0.001$) showed significant difference. This reveals that more households in intervention site participate in anti-FGM activities than those in control site. Future plans to circumcise daughters ($\chi^2 = 26.580; df = 1; p = <0.001$) and willingness to stop the practice ($\chi^2 = 26.860; df = 2; p<0.001$) also showed a significant difference indicating that families in the intervention site were abandoning the practice. The study concludes that exposure to and dissemination of information on the social, psychological and health risks of the practice on girls and women has impacted on the community’s beliefs and practices about FGM. The study recommends that campaigns against female circumcision should be integrated in the social and economic development initiatives that particularly focus on women’s empowerment.
CHAPTER ONE

INTRODUCTION

1.1 Background

Female Genital Mutilation (FGM) also referred to as female circumcision, female genital cutting and genital surgeries, refers to several traditional practices that involve the removal of part, or all, of female genitalia (WHO, 1995). It also comprises 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. The female external genital organs consists of the vulva, which comprises the labia minora (inner vaginal lip), labia majora (outer vaginal lip), and the clitoris covered by its hood in front of the urinary and vaginal opening (WHO, 1997).

Female circumcision is practiced in many parts of Kenya. In communities where it is practiced, the custom marks the transition between childhood and adulthood. It is also believed to bestow respect and honour on the initiates. Thus the uncircumcised girls are often ridiculed and thought of as “unclean” and childlike (FPAK, 1996).

A wide body of literature shows that Female Genital Mutilation causes irreversible, lifelong health risks for the girls and women at the time of operation, during menstruation, consummation of marriage and during childbirth (Toubia, 1994). The after-effects include: urinary tract infections, hardened scars, cysts, abscesses, menstrual and sexual problems, infertility, pelvic inflammatory diseases, increased risk of obstructed
labour (Rushwan, 2000). The practice is neither medically necessary nor mandated on religious grounds (Carr, 1997).

Thus Female Genital Mutilation remains a contentious issue. Officials of public health agencies, governments and women groups have persistently advocated for its eradication. But the targeted communities consider this an affront on their tradition and as a threat to their values. In essence, the campaigners are often depicted as outsiders or foreigners who do not understand local values (Kenyatta, 1938).

Generally, efforts to eradicate FGM in Kenya date back to pre-independence days when the Protestant Christian Missionaries in Central Kenya campaigned against the practice. Consequently, between 1926 and 1956, the colonial government enacted legislation that sought to ameliorate the practice by reducing the severity of the cut, defining age at circumcision, and enhancing parental consent before a girl could undergo the operation. However, due to the ensuing opposition and related political outcomes, the colonial government was forced to revoke all the resolutions related to FGM in 1958 (Kenyatta, 1938; Chege, 1993).

In independent Kenya for instance, key government officials and religious leaders have spoken against FGM. In 1999, the Ministry of Health launched a twenty-year National Plan of Action (MOH, 1999) supported by World Health Organization with an overall goal of accelerating the elimination of FGM. The national plan had four objectives:

1) To reduce the proportion of girls and women undergoing FGM.
2) To increase the proportion of health care facilities that provide care for girls and women with physical and psychological problems associated with FGM.

3) To increase the proportion of communities supporting the elimination of the practice.

4) To increase the technical and advocacy capacity of organizations and communities involved in FGM elimination programmes.

In addition to these efforts, large numbers of Non-Governmental Organizations have also been actively encouraging communities to discontinue the practice. Some of the active NGOs are Maendeleo Ya Wanawake Organization (MYWO), Programme for Appropriate Technology in Health (PATH) and World Vision. These NGOs have proposed and in some cases introduced alternative rites of passage, which excludes the cutting of the genitalia and maintains the other essential components such as education for the girls on family life and women’s roles, exchange of gifts, eating of good food and a public declaration for community recognition. This has been done in Tharaka, Gucha, Meru North, Narok and Samburu (ROK, 2001). In 1998, the World Vision Kenya initiated the West Pokot District Marich Pass anti-Female Genital Mutilation /Early marriage project. The aim of the project was to sensitise the community on the need to adopt harmless alternative rites for initiation in order to increase girl child enrolment in schools and retention at both primary and secondary levels.

The Child Act of 2001 made FGM illegal and 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 affect the child’s life, health, social welfare, dignity, or physical or psychological development” (ROK, 2001). This was passed by parliament in 2003 as a law to protect the girl child.

1.2 Statement of the Problem

In recent years, the merit of female circumcision has been questioned, and in some cases publicly condemned. The Non-Governmental Organizations in particular have been advocating the abandonment of FGM in various districts in the country. Despite all these efforts, little change in the prevalence of FGM in the target communities has been noted. It may well be that, those campaigning for the eradication of the practice are not informed of the local conditions and experiences of the community. This study, therefore, aims at assessing the community responses to the World Vision anti-FGM advocacy activities in West Pokot District.

1.3 Research Questions

(a) What is the community’s health knowledge, attitudes and practices of FGM?

(b) What factors have led to its continuity in the contemporary Pokot community?

(c) What is the community’s perception of anti-FGM campaigns?

(d) What is the difference in the prevalence of FGM between intervention and control sites?
1.4 Null Hypotheses

(a) There is no difference in the health knowledge, attitudes and practices of FGM between Chepareria Division (intervention site) and Sigor Division (control site).

(b) Factors perpetuating FGM in intervention and control sites are not similar.

(c) There is no difference in the community’s perception of anti-FGM campaigns.

(d) There is no difference in the prevalence of FGM between intervention and control sites.

1.5 Objectives of the Study

1.5.1 General Objective
To establish the impact of health campaigns against FGM on knowledge, attitudes and practices of the Pokot community.

1.5.2 Specific Objectives

(a) To evaluate the impact of anti-FGM campaigns on the women’s knowledge of the health risks associated with the practice of FGM.

(b) To investigate the community’s attitude and reactions to anti-FGM campaigns.

(c) To document current practice of FGM and assess the appropriateness of the alternative rite of passage of young girls to adulthood in the Pokot community.

(d) To establish the most suitable strategies to be employed to eradicate FGM in the community.
1.6 Justification of the Study

In Kenya, Type I - Clitoridectomy, Type II - Excision and Type III - Infibulation are the forms of Female Genital Mutilation practised to varying degrees. A survey conducted by MYWO in 1992, found that nearly 90% percent of women over 14 years of age in Kisii, Meru, Narok and Samburu Districts have been subjected to one of these procedures. In its survey of these four districts, MYWO, found that Type I is practised in Kisii, Type II in Meru and Narok and Type III in Samburu. Female circumcision is a violation of girls' and Women's rights (Toubia, 1994). The Government of Kenya in 2003 made FGM illegal practice by passing through parliament the Child Act of 2001 (ROK, 2001). The World Vision anti-FGM intervention in conjunction with the government of Kenya have been actively trying to eliminate this practice in West Pokot District through education, awareness campaigns and advocacy for alternative rite of passage for young girls to adulthood. Despite the progressive efforts and the fact that FGM has been identified as a health risk and a harmful traditional practice, the Pokot community still upholds the practice, and the type that is most severe, infibulation still persists. The findings of this study, therefore, will be applied to strengthen the anti-FGM intervention and generate ideas for new approaches and strategies to address the practice, and to invoke policies and legal efforts.
2.1 Historical background of Female Genital Mutilation

It is historically reported that female circumcision evolved from early times in primitive communities desirous of establishing control over sexual behaviour of women (Olayinka, 1987). Genital surgery took place in some Western Countries, in the United States and in England, but this involved only clitoridectomy, and was performed to cure nymphomania, masturbation, hysteria, depression, epilepsy and insanity (Sanderson, 1981; Toubia, 1995). Research from historian, Herodotus explains that in the fifth Century BC the Phoenicians, Hittites, Egyptians and Ethiopians practised female circumcision. Again, in 1967, the German traveller Niebuhr, the sole survivor of the first Europeans Scientific Expedition to Arabia, Egypt and Syria, reported that this operation was fairly prevalent in some countries of the middle and near East (WHO, 1979).

In African communities, it is reckoned that these surgical methods were known to have existed in the middle belt of Africa region before records were kept (MYWO, 1992). The practice dates back as early as 5\textsuperscript{th} century BC (Toubia, 1995). For instance, traces of infibulations were found in Egyptian Mummies dated 200 BC, as an operation done at the time when women received their own bride wealth (Dorkenoo, 1994).

In Kenya the origin of female circumcision cannot be traced but it is linked to the early civilization in the Nile and MYWO contend that the tradition was borrowed from
Egyptians (MYWO, 1992). The custom is said to have originated in Egypt and Ethiopia (Toubia, 1995). It is therefore difficult to date the first operation or determine the country in which it took place.

2.2 Types of Female Genital Mutilation

The World Health Organization (WHO, 1995) classified FGM into four types on the basis of the amount of tissue excised. These four broad categories of FGM operations include:

2.2.1 Type I – Clitoridectomy

This entails the removal of the clitoral hood with or without removal of part or the entire clitoris. This is what is commonly referred to as “Sunna circumcision”.

2.2.2 Type II – Excision

This involves the removal of the clitoris together with part or all of the labia minora. This is the most common form of Female Genital Mutilation, comprising up to 80% of all cases in the world.

2.2.3 Type III – Infibulation

The procedure involves the removal of part or all of the external genitalia (clitoris, labia minora, and labia majora) and stitching and/or narrowing of the vaginal opening, leaving a small hole for urine and menstrual flow. This type is the most severe form of FGM.
2.2.4 Type IV – Unclassified

This involves all other operations on the female genitalia including prinking, piercing, stretching or incising of the clitoris and/or labia.

In Somalia for instance, there are four types of female circumcision (Toubia, 1994). There is Sunna I - synonymous with the least intrusive form of Type I involving the excision of the prepuce and the pricking or piercing of the clitoris. Second type - Sunna II - synonymous with a more intrusive form of Type I where part of the clitoris is excised with one stitch to reduce bleeding. The third one is Sunna III - synonymous with Type II and the last type is Pharaonic which is synonymous with Type III. After the operation and stitching up of the wound, the girls' legs are tied together until the wound is healed leaving a small opening to allow for the passage of urine and menstrual blood. During marriage and childbirth the opening is widened (de-infibulation), but usually re-stitched again (re-infibulation) after childbirth (Lightfoot-Klein, 1989). This clearly illustrates the three feminine sorrows experienced by infibulated women; the sorrows on the day of mutilation, the wedding night when the opening must be cut and birth of a baby when the opening must be enlarged and often stitched, accompanied by pain at each point (Fourcroy, 1998).

2.3 Geographical distribution of Female Genital Mutilation

The partial or total removal of a woman's external genitalia has been practised for centuries in a large number of African countries as one of the rites of passage marking young girls' preparation for womanhood and marriage. The World Health Organization
estimates that 130 million girls and women worldwide have undergone this practice (WHO, 1997). Each year an additional two million girls will be subjected to it (Toubia, 1995). The majority of the two million females circumcised annually are young girls in twenty eight African countries where the practice is most prevalent (Carr, 1997). It is estimated that 80 to 115 million African women and girls alive today have undergone some form of FGM (Hosken, 1979; 1993). In Djibouti and Somalia 98 percent of girls are mutilated (Toubia, 1995).

2.4 Prevalence rates and types of FGM by country

Prevalence by country reflects politically defined national boundaries within which the majority or only a few tribes may practice female circumcision. FGM prevails and spreads by ethnic, cultural and religious affiliations of neighbouring tribes who may live in different countries. Prevalence by type can vary dramatically from almost 100% of Type III in Sudan to less than 5% of Type I or II in Uganda. Type I- Clitoridectomy and Type II- Excision are practised in West Coast of Africa from the Democratic Republic of Congo to Mauritania. It is also practised in Chad, Egypt, Kenya and Tanzania. Type III- Infibulation is done in Mali, Sudan and Somalia. (Toubia, 1995; Carr, 1997).
<table>
<thead>
<tr>
<th>Country</th>
<th>Prevalence (%)</th>
<th>Type(s) most commonly practiced</th>
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<tbody>
<tr>
<td>Gambia</td>
<td>80</td>
<td>Type I and II</td>
</tr>
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<td>Guinea Bissau</td>
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<td>Type I and II</td>
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<td>Type I, II and III</td>
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Source: Carr, 1997.

2.5 Situational analysis of FGM in Kenya

Female Genital Mutilation is practised in over fifty-percent of the districts in Kenya. As a whole, 38 percent of women age 15-49 have been circumcised (KDHS, 1998). There are striking differences across ethnic groups (Figure I). Circumcision among women aged 15-49 is nearly universal among the Kisii (97%) and the practice is very common among
the Maasai (89%), Kalenjin (62%), Taita (59%) and Embu/Meru (54%) groups and to lesser extent among the Kikuyu (43%), Kamba (33%), Mjikenda/Swahili (12%) and Luo/Luhya (3%) (KDHS, 1998). The median age at circumcision amongst eldest daughters is 11-12 years of age although there is substantial variation. For instance, the median age at circumcision for Kisii ethnic group is 9-10 years. Type I-Clitoridectomy and Type II-Excision are the predominant types practised by these ethnic groups while in the North Eastern Province, Type III-Infibulation is nearly universal in the Somali community (KDHS, 1998).

![Figure 1: Circumcision among women aged 15-49 in Kenya](source: KDHS, 1998)
2.6 Understanding why the practice of FGM continues

Female Genital Mutilation is a cultural practice. Irrespective of where and who practices, it share similar beliefs as in "Mental Map" model that present compelling reasons why the clitoris and other external genitalia should be removed (Mohamud, 1997).

![Diagram: The Mental Map]

**Figure 2: The Mental Map**

Source: Mohamud, 1997
The mental map shows the psychological and social reasons, and the religious, societal and personal (hygienic and aesthetic) beliefs that contribute to the practice. These beliefs involve continuing longstanding custom and tradition; maintaining cleanliness, chastity, and tradition; upholding family honour and controlling women’s sexuality in order to protect the entire community (WHO/PATH, 1999). These concerns formed a “Mental Map” (Figure 2) that needed to be dismantled through audience specific strategies and intersectoral collaboration in the community.

2.7 Reasons advanced for the practice of FGM

Significantly, female circumcision is usually associated with poverty, illiteracy and low status of women in communities in which people face hunger, ill health, over work and lack clean water. In such settings an uncircumcised woman is stigmatized and not sought in marriage, which helps explain the paradox that the victims of the practice are also its strongest proponents. They can scarcely afford not to be. In the best of circumstances, people are reluctant to question or take an independent line lest they lose social approval. In poverty-stricken communities acceptance and support may mean the difference between life and death (WHO, 1979).

This paradox is clearly captured by Abdalla (1982). He notes, “It seems that everybody is reluctant to break the established institution and tradition connected with the custom and no one dares to be the first to abandon it” (Abdalla, 1982). He proposed theories or reasons to explain why communities practice female circumcision. These are:
1) To control women’s sexuality. In ancient Egypt female circumcision was an attempt to obtain control of women’s magic power that was perceived as being linked to women’s independent sexuality.

2) To guarantee virginity until marriage. The excision of the clitoris would decrease sexual desire and pleasure, and closure of the introitus would ensure that penetration could not take place until the marriage night, when the infibulation was cut open. This has been postulated as a reason for circumcision in nomadic tribes in which women could not be strictly secluded.

3) To ensure an economic future for a girl child. “Men require infibulated wives and since a girl has no other choice in life but to marry, she must undergo the operation”.

4) To subjugate women and reduce them to what was considered their proper roles, that is, provider of male pleasure because of having a tight introitus and vehicle for child bearing.

5) For protection against rape for young girls who took the animals out for pasture in the pastoral communities.

6) For hygienic and aesthetic reasons, because a women’s genitalia were considered unclean and unsightly.

7) As a religious ritual. There is little support for this in Koran, and female circumcision is not practised in Saudi Arabia the “Cradle of Islam”.

All these reasons illustrate how the practice of FGM subjugates women within a patriarchal society. As sanctioned and celebrated event in girls’ lives, FGM reinforces
and symbolizes other limiting oppressive acts against women. Hence there is need for consciousness raising among communities practicing it through education and awareness campaigns on health, social and psychological implications of the practice on women and girls. This also calls for proper dissemination of anti-FGM information to correct misconceptions of the role the practice plays in life of girls and women.

2.8 Health consequences of FGM

All forms of FGM place girls and women at risk of infections and chronic and painful complications of the gynaecological and genital-urinary tract (WHO, 1996). Various writers offer consequences for these surgeries on physical and mental health of women who undergo them (Olayinka, 1987 and Toubia, 1994). These health risks include the medical, gynaecological, social, emotional and psychological problems. It is also noted that the highest maternal and infant mortality rates are in FGM-practising regions (Hosken, 1993). Female Genital Mutilation causes irreversible, life-long health risks for girls and women, at the time of operation, during menstruation, consummation of marriage and during childbirth (WHO, 1997). Immediate and long term physical, sexual and psychological complication may occur. Problems that can occur during or immediately following the procedure are shock from haemorrhage and pain, acute retention of urine, risk of transmission of blood-borne diseases such as hepatitis B and HIV/AIDS due to the use of unsterilized cutting instruments during group circumcision and damage to the urethra (WHO, 1986). If the procedure is done under septic conditions, the girls are at risk of serious infections, or tetanus (Toubia, 1994). Some of these immediate potential side effects could lead to death (Brady, 2000).
The after effects of FGM include: urinary tract infections, hardened scars, cysts, abscesses, menstrual and sexual problems, infertility, pelvic inflammatory diseases, increased risk of obstructed labour which predisposes to socially ostracizing fistula formation (vesico-vaginal fistula and recto-vaginal fistula) (Rushwan, 1990). These conditions cause anxiety and fear among women and interfere with sexual intercourse. Obstructed labour often occurs if a woman has been infibulated and these causes life-threatening complications for both the mother and the child, including perineal lacerations, bleeding and infections and possible brain damage to infants (Olayinka, 1997). Toubia (1994) suggested “the psychological effects are often subtle and are buried in layers of denial and acceptance of social norms”. As a result of these serious health complications, FGM has become a controversial issue in the media, the medical and legal arena and among women’s rights groups. Voices, both for and against the practice are struggling to be heard and to resolve the issue of this painful, yet culturally significant practice.

2.9 Campaigns on eradication of FGM

Global efforts to end FGM have used legislations to provide legitimacy for project activities, to protect women, and to discourage circumcisers and families from circumcising girls. In 1960s, WHO was the first United Nations specialized agency to take a position against female genital cutting. In 1982 the organization issued a formal statement to the United Nations Commission on Human Rights and recommended that:

1) Governments should adopt clear national policies to end FGM, and educate and inform the public about its harmful aspects.
2) Anti-FGM programs must consider the practice’s association with difficult social and economic conditions and respond to women’s needs and problems.

3) Women’s organizations at the local level should be encouraged to take action.

It also expressed unequivocal opposition to the medicalization of the practice, and strongly advised health workers not to perform FGM under any conditions “FGM must not be institutionalized; nor should any form of FGM be performed by any health professionals in any setting, including hospitals or other health establishments” (WHO, 1982). In 1998, WHO began to integrate FGM into the development context of Primary Health Care. In 1990s, FGM gained recognition as a health and human rights issue among African governments, the international community, women’s organizations and professional associations (WHO, 1998).

2.10 International Conventions, Charters and action Platforms on FGM

To ensure that all human beings enjoy a happy and healthy life, free from discrimination and violence regardless of their country, colour, religion, race, gender or age, United Nation member states agreed on the Bill of Rights in 1948. Twenty-eight years later (1976), many governments also adopted the International Convention on Civic and Political Rights. The same member states also agreed in 1981 to follow the rights outlined in the African Charter on Human and People’s Rights. The resolutions of the Convention to Eliminate All Forms of Discrimination Against Women (CEDAW) came into effect in 1981. This was followed by the Convention on the Right of the Child (CRC) in 1989. Because FGM results in a potential loss of the sexual function of women, it violates women’s sexual, physical and mental health. It also violates
reproductive health rights even when medical personnel in hygienic conditions perform it. When performed in infants and children under 18 years old, it can be interpreted as a violation of the rights guaranteed for the child (UN, 1993). The health rights that are guaranteed by the Universal Declaration of Human Rights, the Convention on the Rights of the Child and the African Charter of Human and People’s Rights include the following:

1) The right to gender equality;
2) The right to be free from all forms of mental and physical violence and maltreatment;
3) The right to the highest attainable standard of health;
4) The right to be free from torture or cruel, inhuman, degrading treatment;
5) The requirement to abolish traditional practices prejudicial to the health of children.

The ills of female circumcision were again strongly condemned in 1994 during International Conference on Population Development in Cairo, Egypt. The conference urged governments of the 184 United Nation member states to protect and support every possible effort made by NGOs, religious institutions and community organizations towards the elimination of this practice.

In 1994, the World Health Organization urged all member states “to establish national policies and programmes that will effectively, and with legal instruments abolish FGM and other harmful traditional practices affecting the health of women and children”
Information Kit on FGM was produced by the WHO (Geneva July, 1994). The Kit provides a definition of FGM, outlines the negative health consequences and concludes by suggesting actions for eradication of FGM that include awareness, lobbying, promotion, influence, monitoring and training.

In 1995, the Fourth World Conference of Women held in Beijing, China stressed the importance of education especially to parents so that they might understand the health consequences of this operation. The conference described the practice as a gross violation of women's rights and human dignity. The United Nation member states signatory to the convention once again committed themselves to take all effective and appropriate measures to abolish traditional practices that are prejudicial to the health of women and children (UN, 1996).

These conventions explicitly recognize harmful traditional practices such as FGM as violation of human rights, including the right to non-discrimination, the right to life and physical integrity, the right to health and the right of the child to special protection.

2.11 Evolution and trends of FGM eradication efforts in Kenya

In Kenya, as in many other African countries, FGM is forbidden by law, but the laws are not enforced and the population barely, if at all, aware of their existence. The practice of FGM was outlawed in Kenya in 2003 through the Child Act No. 8 of 2001. It states that "nobody should subject a child to female circumcision, early marriage, or other cultural rites, customs or traditional practices that are likely to affect the child's life, health, social welfare, dignity or physical or psychological development" (ROK, 2001). Kenya is also a

Most FGM eradication activities in Kenya have, to date, been fronted by various NGOs: Programme for Appropriate Technology in Health (PATH), Maendeleo Ya Wanawake Organization (MYWO), Federation of Women Lawyers, Kenya Chapter (FIDA), Northern AID, Family Planning Association of Kenya, World Vision Kenya, amongst others. These efforts have taken place without clear national policy on FGM until 2003 and these have led to constrain on FGM elimination efforts.

2.12 Policy and Legislation

Effort towards elimination of FGM in Kenya dates back as early as 1913 when the Christian Missionaries and the British Colonial Government condemned the practice as immoral. It exposed the genitals, as well as being painful and unhygienically done. Female circumcision was also condemned on medical grounds (Thiong'o, 1965). In 1918, for instance, a missionary conference declared that the unnatural custom of circumcising girls practiced among tribes in the protectorate is in all instances purposeless and useless, and highly dangerous and that the custom ought to have been abolished (Mwaniki, 1985). Consequently in 1921, some mission churches in Githumo, Kijabe and Kiambu in central province stopped their followers from carrying out female circumcision and this forced the government to take a stand against the practice. The Kikuyu Central Association was formed in 1924 and took a firm stand in support of the colonial government to condemn or regulate the nature of the procedure. This led to some areas modifying the operation
from *pharaonic* (infibulation) to clitoridectomy while those in Embu and Meru still preferred the more severe type-infibulation (Mwaniki, 1985).

In 1945, there was a parliamentary inquiry on FGM and this acknowledged that FGM constituted a medical problem. It recommended and adopted a policy of slow and careful education and enlightenment to avert a revolt by natives guarding their customs and organizations. Thus between 1926 and 1956, the colonial government enacted various legislations seeking to ameliorate the practice by reducing the severity of the cut, defining age at circumcision and endorsing parental consent before circumcision amongst other regulations. In 1957, the Local Native Council passed a ban on all forms of female circumcision but Kenyans did not respect nor implement the ban as it was spearheaded by the colonial government. However, due to the ensuing opposition and related political outcomes, the colonial government was forced to revoke all the resolutions related to FGM in 1958 on the grounds that FGM was a deeply rooted and accepted custom in the affected communities (Kenyatta, 1938; Chege, 1993).

In 1977, the Bishop of Mt Kenya East Diocese condemned FGM as medically dangerous and appealed to Christians to refrain from going back to customs that were no longer necessary. In July 1982, Daniel Arap Moi then the president of Republic of Kenya also condemned the practice in Baringo district and stated “If I hear of a person circumcising girls in this district, he will be on fire.” He also indicated that those found committing the act or encouraging it would be prosecuted. In the same year, 1982 September, the director of medical services instructed all hospitals to stop FGM and observed that
Medical Practitioners and Dentists Acts, as well as the Nurses, Midwives and Health Visitors Acts authorize prosecution of medical personnel engaging in FGM.

At other levels, Kenya attempted to legislate against FGM through a parliamentary motion, which failed in November 1996. A national symposium on the practice was also held in April 1998 at the United Nations headquarters in Nairobi. The recommendations called for a deliberate effort to eradicate the practice of FGM in Kenya. The sessional paper No. 5 of 1999 on the National Population Policy for Sustainable Development under the Article “Gender perspective” recognizes the practice as a harmful cultural practice that girls and women face. In the same year, 1999, National Plan of Action for the Elimination of FGM in Kenya was developed by Ministry of Health with an overall goal of accelerating the elimination of the practice in order to improve the health, quality of life and well being of women, girls, families and communities in Kenya. In 2001 the Child Act was introduced but failed to be passed by parliament. But in 2003, this Act was passed by parliament as a law to protect the girl child (ROK, 2001).

Kenya’s campaign against the practice on other fronts also includes the adoption of various plans of action that view FGM as a violation of human rights against women and girls and the ratification of the various conventions on the rights of women and children. These actions are consistent with the adoption of the programme of action of the International Conference on Population and Development in Cairo, Egypt (1994). The programme of action referred FGM as a basic human right violation and urged governments to prohibit and urgently stop the practice where it exists. Kenya also
adopted the recommendations of the Fourth World Conference on Women held in Beijing, China (1995). This conference also cited the practice as both a threat to women's reproductive health and a violation of their human rights.

2.13 *Maendeleo Ya Wanawake Organization* efforts

This organization has been carrying out FGM research and communication for its eradication in four grass-root communities of Meru, Samburu, Narok and Kisii. The main target audience include school youth (boys and girls), youth out of school and community opinion leaders both men and women. At the national level MYWO has been holding policy meetings with people from key ministries, lawyers, judges and members of parliament. These national level briefings are intended to raise the profile of FGM to people in strategic policy positions.

An evaluation conducted by MYWO on FGM in November 1995 indicated that awareness on the problems and dangers of FGM has accomplished over 80% in the project divisions showing that people openly discuss FGM issues in meetings, family levels and in schools. The mass media also has actively covered anti - FGM activities. The subject of FGM is no longer a taboo and myths which communities held justifying FGM are gradually being debunked from their minds. MYWO in 1991 prepared a curriculum for community initiated rite of passage to maturity for young girls without FGM which was first held in August 1996 with 30 girls as alternative rite of passage graduands.
2.14 Development of an Alternative Rite of Passage (ARP)

The alternative rite of passage was introduced by Maendeleo Ya Wanawake Organization (MYWO) in collaboration with Programme for Appropriate Technology in Health (PATH). This version excludes the genital cutting but maintains other essential parts/components. An alternative rite of passage ritual thus refers to structured programmed activities with community-level sensitisation to first gain support and recruit girls who will participate, followed by a public ritual that involves training for the girls in family life education, and a public ceremony similar to that in traditional rites of passage. The intention is to simulate the traditional ritual as closely as possible without actually circumcising the girls. Hence ARP involves three interrelated components namely community sensitisation, seclusion and training of the girls and public ceremony or declaration for community recognition (MYWO/PATH, 1999).

These activities can be described in terms of the model of behavioural change postulated by Izett and Toubia (1999). This model proposes that for a change in a long running behaviour to occur, individuals, families and communities need to pass through several stages before there is a sustained behavioural change: First exposure to new information about the behaviour; for instance, the health risks, socio-psychological effects associated with the practice and the violation of human rights can motivate individuals and families to begin to contemplate a behaviour change. Although this may lead to an intention to change the behaviour, there is normally a need to ensure that the decision can be fully supported so that the necessary action can be fulfilled. Consequently, the behaviour change strategy needs also to prepare individuals prior to them being able to act on the
decision (Izett and Toubia, 1999). The first alternative rite of passage took place in August 1996 at Tharaka District with 30 girls participating. Between 1995 and 1999 ARPs have been conducted in Gucha, Meru North, Meru South, Narok and Samburu Districts, the MYWO and PATH project areas. By December 1999 about 1600 girls from these districts had gone through the alternative ritual and by April 2001, 3000 girls from these districts had participated as initiates (MYWO/PATH, 1999).

2.15 ARP strategy for FGM eradication in West Pokot District

Changing social norms surrounding cultural practices such as FGM takes time, patience and a long time commitment by donors, implementers, and advocates within communities. The World Vision Kenya anti-FGM project was initiated in Chepareria Division of West Pokot District in 1998 with support from Switzerland. In this area FGM is widely practiced. This community based approach aimed to raise awareness of the human rights and health implications of the procedure through community leaders mobilizing for social changes. The communication for social change interventions included a culturally appropriate ARP. This is built on an existing rite of passage common in the Pokot community where circumcision is part of the process to mark girls coming of age. The framework designed by MYWO and PATH in 1995 promotes the positive aspects of the culture and passing on traditional wisdom while educating girls about harmful effects of FGM, sexuality, family life and HIV/AIDS. It culminates in a celebration of the girls altered social status to offset stigmatization which commonly occurs to those who do not follow conventional norms and a chance to celebrate a new, and healthier social norm in traditional manner.
Impact areas of the strategy include health education to increase knowledge of the dangers of female circumcision and to correct misguided religious doctrines. Targets included parents, operators, children and societal leaders. Another strategy is health care centre at Ortum Mission Hospital aimed at providing early diagnosis, treatment and rehabilitation of the victims of the practice that is all circumcised girls and women suffering from disability as a result of the operation.
CHAPTER THREE

MATERIALS AND METHODS

3.1 The Study Area

West Pokot District, where the study was carried out, is in the Rift Valley Province of Kenya. It is located along Kenya’s western boundary with the Republic of Uganda. The District stretches from 2° 40” North to 34° 37” East and 35° 49” East. The total area coverage is approximately 9100 kilometre square. According to 1999 provincial census results, the district had a population of 309,910 people with a growth rate of 3.4% and population density of 34 persons per kilometre square. The district has six administrative divisions namely Lelan, Kapenguria, Sigor, Kacheliba, Chepareria and Alale Divisions.

The study was conducted in two divisions: Chepareria division (intervention site) and Sigor Division (control site). The intervention area, Chepareria division has six administrative locations, which form the six clusters of the anti-FGM programme: Chepareria, Ywalateke, Senetwo, Chepkopegh, Batei and Parua. The district is one among the eight districts with the lowest literacy rates in Kenya. Fifty percent of men and thirty percent of women are literate, which compares poorly with national averages of 81.4% and 69.7% respectively (KDHS, 1998). Such glaring variation is attributed to cultural practices, which make many school going boys be occupied by tending livestock and girls circumcised at young age leading to early marriages. Ethnically, majority of the people in the district are the Pokots and have a strong regard of social cohesion and cultural values.
Figure 3: Map of the study area
Source: KDHS, 1998
3.2 The Study Population

The sample was acquired through random sampling for the households to participate in the study. To select the respondents, purposive sampling was used to obtain household heads from both study sites. The study considered both male and female who were household heads at the time of the study. A total of 750 participants were sampled consisting of 375 respondents from each site.

3.2.1 Inclusion Criteria

The study respondents were household heads who have been living in the study areas for the past ten years and gave consent to participate in the study.

3.2.2 Exclusion Criteria

Those excluded from the study were household heads who had lived in the study sites for less than ten years. Informants not willing to participate and non-residents in the district were also excluded from the study.

3.3 Ethical Consideration

The permission to carry out the study was sought from the Ethical Review Committee of Kenyatta University, Ministry for Education, Science and Technology. At the district level, permission was sought from the local District Commissioner, the District Education Officer and District Medical Officer of Health. The Divisional Officers, Chiefs and Sub-chiefs were in-turn informed. Further, informed consent was sought from the study subjects who were informed that participation in the study was voluntary and subject to their consent. Finally, confidentiality of the information provided by the study respondents and their anonymity was respected, which helped ensure confidentiality.
3.4 Study Design

The study was an evaluational study. It collected both qualitative and quantitative data that was used to assess impact of anti-FGM advocacy activities on the eradication of the practice in West Pokot District.

3.5 Sampling

Two purposively selected divisions: Chepareria Division (intervention site) and Sigor Division (control site) were the study areas. The control site represented areas with least influence of anti-FGM advocacy activities while the intervention site had specific anti-FGM projects started by World Vision in 1998. Purposive sampling method was used to select 375 respondents from each study divisions. These comprised of household heads. The selected respondents were then interviewed and also participated in the focus group discussions.

3.6 Sample Size Determination

The sample size was determined using the formula as used by Fisher et al. (1998).

\[ n = \frac{Z^2 pqD}{d^2} \]

Where

- \( n \) = the desired sample size (population > 10,000)
- \( Z \) = the standard normal deviate usually 1.96, which corresponds to 95% confidence level.
\[ p = \text{the proportion of the target population estimated to have characteristic being measured. (In this case, the proportion of the study population in the Chepareria Division, the intervention site). The total population for the two study areas was 111,339 and population for intervention area was 68,518, (KDHS, 1998).} \]

Therefore

\[ p = \frac{68,518}{111,339} = 0.6 \]

\[ q = 1 - p \]

\[ = 1 - 0.6 = 0.4 \]

\[ D = \text{design effect} = 2 \text{ since the study had two samples.} \]

\[ d = \text{the degree of accuracy} = 0.05 \]

Thus

\[ n = \frac{1.96^2 \times 0.6 \times 0.4 \times 2}{0.05^2} = 737 \]

Approximately a sample of 750 was taken to cater for attrition and errors.

### 3.7 Data Collection

The assessment involved use of questionnaires administered to a random sample of 750 household heads. Focus group discussions and interview schedules were also held in each site with key informants mostly older men and women and community leaders.
The research questionnaire included a series of questions on FGM and attitudes related to the practice. Questions asked included the history of FGM in the sites, including the age at which it was done, when it was carried out, by whom, the reasons for continuing or discontinuing the practice, the locus of decision making, consequences for young girls' and women's health, regrets having or not having undergone the procedure, future intentions to circumcise, awareness of anti-FGM messages and sources, kind of messages received, targets of the messages and importance of information got to households and appropriateness of ARP as FGM substitute.

Selection of interviewers was random based on household head available at the time of the survey. The results were based on the combined analysis of the individual and group responses. Thus the questionnaire administered to household heads was to explore knowledge, attitudes and perceptions towards FGM and adoption of alternative rite of passage for young girls to adulthood as opposed to female circumcision. The respondents were interviewed using detailed interview guide to establish their perception of the anti-FGM intervention, acceptance of alternative rite of passage for girls, and elimination of the practice in the community. The focus group discussions held with household heads were to establish the community's perceptions on female circumcision and gather information on suitability of alternate rite of passage as FGM substitute.

3.8 Data Management and Analysis

The data collected were coded, edited and entered into the computer. The coded data were analyzed using the computer Statistical Package for the Social Sciences (SPSS). Chi-square was computed to establish the associations between variables such as health
knowledge, attitude and practices of FGM and perception of alternative rite of passage against study sites. The Student t-test was used to establish the differences between means. Thus differences between means were computed using student t-test while differences in proportions were computed by chi-square statistics. The knowledge level on the health risks of FGM was measured on a four point Likert scale where the least represented no knowledge and the highest represented a high level of knowledge. The likert scale consisted no knowledge, low knowledge, moderate and high knowledge. For the respondents who did not state any health risks, it was deemed that they had no knowledge, 1-2 risks which implied low knowledge, 3-4 which indicated moderate knowledge and above 5 risks was deemed to represent high knowledge. The prevalence of FGM in the community was measured in relation to the frequency of the practice. The analysed data were presented in percentages, frequency tables, bar charts and histograms.
CHAPTER FOUR

RESULTS OF THE STUDY

4.1 Demographic Characteristics of Respondents

The study respondents included a total of 750 household heads, with 375 participants from each study site. This constituted 191 (51%) males and 184 (49%) females from the intervention site while those from control site comprised of 162 (43%) males and 213 (57%) females. Most respondents (73%) had gone through formal education. This showed that most of the household heads interviewed were able to read and write (Table 2). The analysis indicated that there was no significant difference in the distribution of respondents by gender ($\chi^2=4.501; \text{df}=1; \text{p}>0.05$) and education attained ($\chi^2=4.643; \text{df}=3; \text{p}>0.05$) between intervention and control sites.

Table 2: Distribution of Respondents by Education level

<table>
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4.1.2 Distribution of Respondents by Marital Status

Out of the 750 household heads interviewed, 689 (91%) were married, 47 (6%) single and another 14 (2%) were separated. The results showed that over 90% of respondents from each site were married (Figure 4) revealing no significant difference ($\chi^2=2.977; \text{df}$
between the two study sites. With regard to religious affiliation the intervention site had 205 (55%) Protestants, 147 (39%) Catholics and those who belong to other religious denominations were 23 (6%). On the other hand, the control site constituted 237 (63%) Protestants, 105 (28%) Catholics and other groups were 33 (9%). Chi-square analysis indicated that there was a significant difference in the distribution of respondent between intervention site and control site with respect to respondent's religious beliefs ($\chi^2=11.020; \text{df}=2; p<0.05$). The intervention site had more Protestants while control site had more Catholics.

Figure 4: Distribution of Study Participants by Marital status
4.1.3 Distribution of Respondents by Age

The age of the household heads ranged from 11 to over 60 years. The mean age in intervention and control site were 35.05 (median 31.57) and 34.51 (median 32.15) respectively. Majority of the study participants were of reproductive age. (Table 3). Some of the household heads were as young as 11 years of age due to the fact that they were married early thus immediately after circumcision. There was no significant difference in distribution of respondents by age in the two study sites ($t_{748} =0.603; p>0.05$). This showed that respondents were equally distributed with respect to age in the study sites.

Table 3: Distribution of Respondents by Age

<table>
<thead>
<tr>
<th>Age category (years)</th>
<th>Intervention site (Chepareria Division) ($n = 375$)</th>
<th>Control site (Sigor Division) ($n = 375$)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>11-20</td>
<td>19</td>
<td>5</td>
</tr>
<tr>
<td>21-30</td>
<td>153</td>
<td>41</td>
</tr>
<tr>
<td>31-40</td>
<td>99</td>
<td>26</td>
</tr>
<tr>
<td>41-50</td>
<td>53</td>
<td>14</td>
</tr>
<tr>
<td>51-60</td>
<td>33</td>
<td>9</td>
</tr>
<tr>
<td>Over 60</td>
<td>18</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>375</td>
<td>100</td>
</tr>
</tbody>
</table>

4.2 Current Practice of Female Genital Mutilation

4.2.1 Prevalence of FGM

To establish the intensity of the practice in the study areas, respondents were asked to rate the prevalence of female circumcision in their respective communities in terms of the frequency at which the practice was carried out. The results of the study indicated that the practice is more common in control site (96%) than in intervention site (48%).
22 (5%) of the respondents in intervention site and none in control site reported that the practice did not exist in their village. This could suggest that some families in intervention site no longer circumcised daughters (Table 4). Chi-square analysis showed a significant relationship between prevalence of FGM and study site ($\chi^2 = 222.279; \text{df}=2; p<0.001$). This indicates that most families in the control site still uphold the practice.

**Table 4: Prevalence of the Practice**

<table>
<thead>
<tr>
<th>Circumcision prevalence</th>
<th>Intervention site (Chepareria Division) (n = 375)</th>
<th>Control site (Sigor Division) (n = 375)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Commonly practised</td>
<td>178</td>
<td>48</td>
</tr>
<tr>
<td>Rarely practised</td>
<td>175</td>
<td>47</td>
</tr>
<tr>
<td>Never practised</td>
<td>22</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>375</td>
<td>100</td>
</tr>
</tbody>
</table>

**4.2.2 Age at Circumcision**

The results of the study showed that the mean age at circumcision for intervention site was 15.63 (median 15.98) while that of control site was 14.47 (median 14.01) (Table 5).

**Table 5: Age at which girls are Circumcised**

<table>
<thead>
<tr>
<th>Circumcision age (years)</th>
<th>Intervention site (Chepareria Division) (n = 375)</th>
<th>Control site (Sigor Division) (n = 375)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Below 10</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>10- 15</td>
<td>140</td>
<td>37</td>
</tr>
<tr>
<td>16- 20</td>
<td>226</td>
<td>60</td>
</tr>
<tr>
<td>Above 20</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>375</td>
<td>100</td>
</tr>
</tbody>
</table>
From the analysis, it was noted that there was significant difference in age at which girls were circumcised in the study sites ($t_{748}=24.615; p<0.001$). Girls in intervention site were subjected to FGM mostly at an older age (16-20 years) while those in control site were circumcised at an early age (10-15 years).

### 4.2.3 Locus of Decision Making

Figure 5 shows that the girls themselves were involved in decision making more than half of the time (57%). The decision to circumcise girls also involved the girl’s mother (32%), father (26%), grandparents (20%), peers (16%) or other relatives of the family (4%). The involvement of the girls in the decision to be circumcised or not was more in the intervention site (63%) than in the control site (50%). On the other hand, parents tend to be more involved in the decision to circumcise girls in the control site than in intervention site. Statistic chi-square analysis indicated significant difference ($\chi^2=21.661; df=5; p<0.001$) in decision making between the study sites. This revealed that girls themselves were the main decision makers’ in the intervention site. In the control site it was mainly the parents who decided whether girls were to be circumcised or not.
4.2.4 Why FGM is Practised

Respondents in the study gave various reasons for the practice of FGM in the community (Table 6). Circumcision of girls was seen as a rite of passage (86%) from childhood to adulthood, which prepared girls for marriage (92%). It was also reported to be a necessary traditional practice (90%), which purified women making them socially recognized and accepted in the society (23%).

In the focus group discussion, respondents said that circumcised girls tend to make mature and obedient wives that were more respectful. Indeed, an uncircumcised girl was believed to be perpetually a child regardless of her age. Men were quick in responding
that uncircumcised women were over sexy, unclean, rude, bossy and disrespectful. The celebration following the procedure was viewed as an important opportunity for families to display social status and entertain friends. Girls themselves were enticed by the prospects of receiving gifts, dancing and privileges enjoyed at the end of healing. The analysis of these results indicated that there was no significant relationship in the reasons advanced for the practice and study sites ($\chi^2=10.638; \text{df}=7; p>0.05$). Thus factors perpetuating FGM in the study community are similar.

Table 6: Reasons advanced for the circumcision of girls

<table>
<thead>
<tr>
<th>Reasons for circumcising girls</th>
<th>Intervention site (n=375)</th>
<th>Control site (n=375)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Rite of passage</td>
<td>342</td>
<td>91</td>
</tr>
<tr>
<td>Prepare girls for marriage</td>
<td>353</td>
<td>94</td>
</tr>
<tr>
<td>Custom/Good tradition</td>
<td>330</td>
<td>88</td>
</tr>
<tr>
<td>Prevent promiscuity</td>
<td>62</td>
<td>17</td>
</tr>
<tr>
<td>Remove dirty genitalia</td>
<td>29</td>
<td>8</td>
</tr>
<tr>
<td>For social acceptance</td>
<td>78</td>
<td>21</td>
</tr>
<tr>
<td>Sign of courage</td>
<td>71</td>
<td>19</td>
</tr>
<tr>
<td>Economic activity</td>
<td>58</td>
<td>15</td>
</tr>
</tbody>
</table>

4.3 Prevalence of FGM among Adult Female Respondents and their Daughters

4.3.1 FGM Prevalence among Adult Females

Of the 397 female household heads interviewed, 348 (88%) reported having been cut while 49 (12%) were not. The practice was common with a prevalence of 81% (149) in intervention site and 93% (199) in the control site (Table 7). The analysis revealed a significant difference in prevalence of FGM between the study sites ($\chi^2=14.141; \text{df}=1; p<0.001$) indicating that FGM was more prevalent in the control site. The results also
indicated that FGM was equally practiced by Protestants (87%) and Catholics (87%). The procedure was universal (100%) among those belonging to other religious groups. There was no significant relationship in females’ religious faith and circumcision status ($\chi^2=3.927; \text{df}=2; P>0.05$), showing that circumcision was independent of religious background of the respondents.

4.3.2 Age-specific FGM Prevalence among Adult Females

Age-specific FGM rates among female respondents showed that it was less prevalent in younger age group, 11-30 years and increased in the older age groups in both sites. For the females who did not undergo the procedure, majority (89%) in intervention site and all those from control site were aged below 40 years (Table 8). Analysis of the results showed that there was no significant difference in age distribution of circumcised females ($\chi^2=7.659; \text{df}=3; P>0.05$) and uncircumcised ones ($\chi^2=6.833; \text{df}=3; P>0.05$) between intervention and control sites. Thus, the prevalence of FGM was similar in all age groups in both study sites.

Table 7: FGM Prevalence in Adult Females

<table>
<thead>
<tr>
<th>Circumcision Status</th>
<th>Intervention site (Chepareria Division) (n = 184)</th>
<th>Control site (Sigor Division) (n = 213)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Circumcised</td>
<td>149</td>
<td>81</td>
</tr>
<tr>
<td>Not circumcised</td>
<td>35</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>184</td>
<td>100</td>
</tr>
</tbody>
</table>

4.3.2 Age-specific FGM Prevalence among Adult Females

Age-specific FGM rates among female respondents showed that it was less prevalent in younger age group, 11-30 years and increased in the older age groups in both sites. For the females who did not undergo the procedure, majority (89%) in intervention site and all those from control site were aged below 40 years (Table 8). Analysis of the results showed that there was no significant difference in age distribution of circumcised females ($\chi^2=7.659; \text{df}=3; P>0.05$) and uncircumcised ones ($\chi^2=6.833; \text{df}=3; P>0.05$) between intervention and control sites. Thus, the prevalence of FGM was similar in all age groups in both study sites.
Table 8: Females’ Age-specific FGM Rates

<table>
<thead>
<tr>
<th>Age category (Years)</th>
<th>Intervention site (n = 184)</th>
<th>Control site (n = 213)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Circumcised</td>
<td>Uncircumcised</td>
</tr>
<tr>
<td>11-20</td>
<td>5 (3%)</td>
<td>7 (20%)</td>
</tr>
<tr>
<td>21-30</td>
<td>47 (32%)</td>
<td>20 (57%)</td>
</tr>
<tr>
<td>31-40</td>
<td>42 (28%)</td>
<td>4 (11%)</td>
</tr>
<tr>
<td>Over 40</td>
<td>55 (37%)</td>
<td>4 (11%)</td>
</tr>
<tr>
<td>Total</td>
<td>149 (100%)</td>
<td>35 (100%)</td>
</tr>
</tbody>
</table>

4.3.3 Prevalence of FGM among Girls aged over 10 Years

With respect to circumcision status of their daughters, 182 (40%) households in the intervention site reported having circumcised daughters while 264 (60%) had not. In contrast, the control site recorded 317 (53%) out of the total cases. Thus there were more circumcised girls in control site than in intervention site. This indicated significant difference ($\chi^2 = 15.669; df = 1; p<0.001$). The study results also revealed that FGM prevalence among girls aged 10-20 years was lower (43%) in intervention households and higher (76%) in the control counterparts ($\chi^2 = 67.176; df=1; P <0.001$) indicating a significant difference. In the intervention site, the practice was less prevalent among younger girls and more common in the older ones (Figure 6). In comparison, the proportion of circumcised girls in control site was very high in all age groups (Figure 7). Thus from the above prevalence rates, it was noted that FGM among girls had reduced substantially in intervention site and still higher in control site.
Figure 6: Prevalence of FGM among Girls aged 10-20 years in the intervention Site

Figure 7: Prevalence of FGM Among Girls aged 10-20 Years in the Control Site
4.4 Attitude and Perception of the Practice of FGM

4.4.1 Females’ Attitude towards Personal Circumcision Status

To ascertain attitude concerning personal circumcision, female respondents were asked to state whether they had any regret for having or not having been circumcised. Among circumcised females 122 (82%) in intervention and 133 (67%) in control site regretted having undergone the procedure. The analysis revealed a significant relationship in attitude and the study sites ($\chi^2=9.845; \text{df}=1; p<0.01$). More females in the intervention site regretted having been cut compared to those in the control site. This could be due to high level of knowledge among females in intervention site of the social and health implications of the procedure. In contrast, for those who were not circumcised, 31 (89%) in intervention site and all the 14 in control site had no regrets (Table 9).

Table 9: Regrets concerning Personal Circumcision Status

<table>
<thead>
<tr>
<th>Females’ attitude</th>
<th>Intervention site (n = 184)</th>
<th>Control site (n = 213)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Having been circumcised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regrets</td>
<td>122</td>
<td>82</td>
</tr>
<tr>
<td>No regrets</td>
<td>27</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>149</td>
<td>100</td>
</tr>
<tr>
<td>Having not been</td>
<td></td>
<td></td>
</tr>
<tr>
<td>circumcised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regrets</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>No regrets</td>
<td>31</td>
<td>89</td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>100</td>
</tr>
</tbody>
</table>

4.4.2 Reasons for Regrets Concerning Female Circumcision Status

Results indicated that female respondents in the intervention site were more aware of the human rights issues and health risks the procedure predisposes girls and women to (Table
This in turn, could have influenced their attitude. This influence was statistically significant ($\chi^2=77.591; \text{df}=5; p<0.001$). On the other hand, females gave various reasons for having no regrets for being circumcised. The practice was seen as a rite of passage for young girls from childhood to adulthood. It was a tradition (77%), believed to prepare girls for marriage (76%). It also promoted women social acceptance in the community (63%) and improved marriage prospect (81%) (Table 10).

Table 10: Reasons for Regrets for having been Circumcised

<table>
<thead>
<tr>
<th>Reasons for regrets</th>
<th>Intervention site (n=122)</th>
<th>Control site (n=133)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Excessive bleeding</td>
<td>102</td>
<td>84</td>
</tr>
<tr>
<td>Limited education</td>
<td>96</td>
<td>79</td>
</tr>
<tr>
<td>Risk of contracting HIV/AIDS</td>
<td>111</td>
<td>91</td>
</tr>
<tr>
<td>Complication during childbirth</td>
<td>56</td>
<td>41</td>
</tr>
<tr>
<td>Prevents sexual pleasure</td>
<td>32</td>
<td>26</td>
</tr>
<tr>
<td>Against human right and dignity</td>
<td>87</td>
<td>71</td>
</tr>
</tbody>
</table>

Similarly, the uncircumcised female respondents reported regretting having not gone through the procedure because they had limited chances of marriage (89%), skipping an important tradition and rite of passage (92%) and that their families were not honoured in the community (78%) (Table 11). This clearly illustrated how the practice is entrenched in the study community.
Table 11: Reasons for having no Regrets of being Circumcised

<table>
<thead>
<tr>
<th>Reasons for no regrets</th>
<th>Intervention site (n=27)</th>
<th>Control site (n= 66)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Rite of passage</td>
<td>19</td>
<td>70</td>
</tr>
<tr>
<td>Better marriage prospect</td>
<td>18</td>
<td>67</td>
</tr>
<tr>
<td>Women social acceptance</td>
<td>23</td>
<td>85</td>
</tr>
<tr>
<td>Remove dirty genitalia</td>
<td>20</td>
<td>74</td>
</tr>
<tr>
<td>Custom/Good tradition</td>
<td>25</td>
<td>93</td>
</tr>
</tbody>
</table>

4.4.3 Community’s Attitude towards Families with Uncircumcised Daughters.

It was noted that families with uncircumcised daughters had been discriminated against, stigmatised and disregarded by community members. There were 15 (10%) families in the intervention and 59 (31%) in control site who had encountered near social exclusion in the community for not having circumcised their daughters (Table 12). They actually reported that they were not respected and their daughters not sought for marriage as a result of non-conformity to societal tradition and customs. The results showed that stigmatisation was common in the control site than in the intervention site revealing a significant relationship ($\chi^2 = 21.700; \text{df}=1; \text{p}<0.001$). This was in conformity with the fact that more families in control site than their intervention counterparts had plans to subject their daughters to the procedure (Table 13).

Table 12: Attitude towards Families with Uncircumcised Daughters

<table>
<thead>
<tr>
<th>Community’s attitude</th>
<th>Intervention site (n=146)</th>
<th>Control site (n=186)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Have faced problems</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Have not faced problems</td>
<td>131</td>
<td>90</td>
</tr>
<tr>
<td>Total</td>
<td>146</td>
<td>100</td>
</tr>
</tbody>
</table>
4.4.4 Family’s Attitude towards their Daughters’ Circumcision Status

Among the families in the intervention site, 34 (23%) of those who had uncircumcised daughters said they planned to circumcise them as compared to 95 (51%) in control site who had such intentions (Table 13). This revealed significant association ($\chi^2=26.580$; df =1; p<0.001) in attitude of families on future plans to circumcise daughters and study sites. There were more families in control site than in intervention site who had plans to circumcise girls in future.

Table 13: Family’s Plans Concerning Daughter’s Circumcision

<table>
<thead>
<tr>
<th>Intentions</th>
<th>Intervention site (n=146)</th>
<th>Control site (n=186)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Plans to circumcise</td>
<td>34</td>
<td>23</td>
</tr>
<tr>
<td>Do not plan to circumcise</td>
<td>112</td>
<td>77</td>
</tr>
<tr>
<td>Total</td>
<td>146</td>
<td>100</td>
</tr>
</tbody>
</table>

The families with plans said they needed to conform to societal tradition (90%) and be respected in the community (78%). That circumcising girls also improved their marriage prospects (95%) and prevented promiscuity (56%) (Table 14). The analysis of the results showed that there was no relationship between study site and reasons cited for planning to circumcise daughters ($\chi^2=1.571$; df=3; p>0.05). This revealed that factors promoting FGM in study sites were similar.
Table 14: Reasons Cited for Future Plans to Circumcise Daughters

<table>
<thead>
<tr>
<th>Reasons cited</th>
<th>Intervention site (n=34)</th>
<th>Control site (n=95)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Traditional demand /custom</td>
<td>31</td>
<td>91</td>
</tr>
<tr>
<td>Better marriage prospects</td>
<td>32</td>
<td>94</td>
</tr>
<tr>
<td>Prevented promiscuity</td>
<td>29</td>
<td>85</td>
</tr>
<tr>
<td>Brought family honour</td>
<td>23</td>
<td>68</td>
</tr>
</tbody>
</table>

4.4.5 Reasons for having no Plans to Circumcise Daughters

For those households who had no future plans to circumcise any more daughters, they cited health risks associated with the practice (65%), loss of cultural significance (64%), limited girls education (67%) and violation of human and women rights (43%) (Table 15). Since these were key project messages, it appeared that the anti-FGM crusaders had raised awareness of human rights and health issues. This has positive influence on family’s post-intention to subject their daughters in future to the procedure.

Table 15: Reasons for not having Future Plans to Circumcise Daughters

<table>
<thead>
<tr>
<th>Reasons given</th>
<th>Intervention site (n=112)</th>
<th>Control site (n=91)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Health risks of FGM</td>
<td>102</td>
<td>91</td>
</tr>
<tr>
<td>Limited education</td>
<td>105</td>
<td>94</td>
</tr>
<tr>
<td>Had lost culture significance</td>
<td>98</td>
<td>88</td>
</tr>
<tr>
<td>Against human rights</td>
<td>74</td>
<td>66</td>
</tr>
</tbody>
</table>
4.4.6 Willingness to Continue or Discontinue the Practice of FGM

Of the entire 397 female respondents who were asked whether FGM should be continued or discontinued, 62 (15%) responded that the practice should continue, 329 (83%) said the practice be stopped, and 6 (2%) were uncertain (Table 16). Chi-square analysis indicated significant association between study site and willingness to stop the practice ($\chi^2=25.860; \ df=2; \ p<0.001$). More females in intervention site were for the discontinuation of FGM as opposed to those in the control site.

Table 16: Female Respondents' Attitudes towards the Practice of FGM

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Intervention site (n=184)</th>
<th>Control site (n=213)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Continue</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td>Discontinue</td>
<td>166</td>
<td>90</td>
</tr>
<tr>
<td>Not certain</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>184</td>
<td>100</td>
</tr>
</tbody>
</table>

4.4.7 Reasons for Continuation or Discontinuation of FGM

For those favouring continuity of the practice, they said it was a tradition (58%), which prevented promiscuity (42%). Some cited that FGM removed dirty female genitalia (31%) and felt circumcised girls had better marriage prospects (54%) as men have the notion that circumcised women provided more sexual pleasure to them (19%) (Table 17). There was no association between site and reasons cited for continuation of FGM ($\chi^2=2.874; \ df=4; \ p>0.05$). This showed that traditional beliefs perpetuated the practice in the study community.
Table 17: Reasons Cited for Continuation of FGM

<table>
<thead>
<tr>
<th>Reasons advanced</th>
<th>Intervention site (n=16)</th>
<th>Control site (n=46)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Traditional demands</td>
<td>14</td>
<td>88</td>
<td>38</td>
<td>82</td>
</tr>
<tr>
<td>Cleanliness/Hygiene</td>
<td>9</td>
<td>56</td>
<td>22</td>
<td>48</td>
</tr>
<tr>
<td>Prevent promiscuity</td>
<td>8</td>
<td>50</td>
<td>34</td>
<td>74</td>
</tr>
<tr>
<td>Better marriage prospect</td>
<td>13</td>
<td>81</td>
<td>41</td>
<td>89</td>
</tr>
<tr>
<td>For husband sexual pleasure</td>
<td>5</td>
<td>31</td>
<td>7</td>
<td>15</td>
</tr>
</tbody>
</table>

Women who favoured discontinuation of FGM cited potential health complications (63%) and early marriage (56%) as reasons to stop the practice. Other reasons frequently mentioned were that it infringed on the rights and dignity of women (24%), had lost cultural significance (20%), illegal practice in Kenya (13%), reduces female sexual satisfaction (11%) and sometimes lead to death (5%) (Table 18). The analysis of the study indicate that disapproval of the practice between sites was significant ($\chi^2 = 23.270$; $df = 6$; p<0.001). Females in the intervention site were more informed of the social and health implications of the procedure on their health than those in the control site.

Table 18: Reasons for Favouring Discontinuation

<table>
<thead>
<tr>
<th>Reasons advanced</th>
<th>Intervention site (n=166)</th>
<th>Control site (n=163)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Health risks of FGM</td>
<td>130</td>
<td>78</td>
<td>78</td>
<td>48</td>
</tr>
<tr>
<td>Early marriage</td>
<td>144</td>
<td>87</td>
<td>40</td>
<td>25</td>
</tr>
<tr>
<td>Against human right</td>
<td>68</td>
<td>41</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Lost cultural significance</td>
<td>42</td>
<td>25</td>
<td>23</td>
<td>14</td>
</tr>
<tr>
<td>Reduces sexual pleasure</td>
<td>25</td>
<td>15</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>Illegal practice in Kenya</td>
<td>27</td>
<td>16</td>
<td>16</td>
<td>10</td>
</tr>
<tr>
<td>Can cause death</td>
<td>10</td>
<td>6</td>
<td>5</td>
<td>3</td>
</tr>
</tbody>
</table>
4.5 Awareness of Health Campaigns against FGM in the Community

4.5.1 Awareness and Sources of Anti-FGM Messages

To assess intensity of anti-FGM campaigns in the study areas, respondents were asked whether they had come across messages that are against the practice of female circumcision. Virtually all the respondents had heard of health interventions advocating against the practice. However, results showed that awareness of such activities was higher (88%) among households in intervention site and slightly lower (76%) in the control site (Table 19). The results indicated a significant relationship in awareness and study sites ($\chi^2=32.963$; df =1; p<0.001). This could be attributed to the presence of specific anti-FGM advocacy activities in the intervention site.

Table 19: Households Awareness of the Anti-FGM Campaigns in their Community

<table>
<thead>
<tr>
<th>Awareness</th>
<th>Intervention site (n=375)</th>
<th></th>
<th>Control site (n=375)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Aware</td>
<td>331</td>
<td>88</td>
<td>284</td>
<td>76</td>
</tr>
<tr>
<td>Not aware</td>
<td>44</td>
<td>12</td>
<td>91</td>
<td>24</td>
</tr>
<tr>
<td>Total</td>
<td>375</td>
<td>100</td>
<td>375</td>
<td>100</td>
</tr>
</tbody>
</table>

As shown in Figure 8, NGOs (66%), religious leaders (51%), health workers (31%), political leaders (19%), education officers (13%) and the mass media (6%) were the channels of communication that gave households information. However, there was no relationship between source of information and site ($\chi^2=8.154$; df=5; p>0.05). All community leaders in each site were involved in the dissemination of anti-FGM information.
4.5.2 Attendance of Anti-FGM Seminars

Of the 375 households sampled from each study site, 246 (65%) in intervention site and 147 (39%) in control site had household members attending anti-FGM meetings. This indicated that intervention households were actively involved in FGM eradication project started by World Vision in their community. There is a significant difference between intervention and control site in households’ participation ($\chi^2=49.230; \ df=1; \ p < 0.001$) and individuals attending anti-FGM workshops ($\chi^2=21.890; \ df=4; \ p < 0.001$). In the intervention site, the daughter (69%) mainly attended and to lesser extent the mother (28%), the father (18%), grandparents (8%), or son (7%) also attended. In contrast, in control site, the daughter (46%), the mother (20%), the father (17%), grandparents (16%), or son (11%) attended. In intervention site, the daughters were seen as the main targets of
the anti-FGM messages while in control site any member could attend the anti-FGM workshops and seminars (Figure 9).

Figure 9: Household Members Attending Anti-FGM Seminars

4.5.3 Exposure to FGM Eradication Messages

The anti-FGM messages were built around the practice of female circumcision as a violation of human and women's rights and a threat to the health of women and girls. This was aimed to change harmful norms through exposure to communication for social change strategies that would facilitate reassessment of beliefs and values, ultimately leading to change in attitudes and practices. Majority of the respondents surveyed recalled specific gender, human rights and sexually related messages promoted by the anti-FGM project in the intervention site and other anti-FGM crusaders. As shown in Table 20, respondents in intervention site recalled FGM eradication messages more clearly than those in the control site. This relationship was significant ($\chi^2 = 20.017$; df = 4; p<0.001).
Table 20: The gender and human rights Messages against FGM Recalled

<table>
<thead>
<tr>
<th>Messages recalled</th>
<th>Intervention site (n=331)</th>
<th>Control site (n=287)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Health risks of FGM</td>
<td>241</td>
<td>73</td>
</tr>
<tr>
<td>HIV/AIDS transmission</td>
<td>206</td>
<td>62</td>
</tr>
<tr>
<td>Reduce sexual pleasure</td>
<td>104</td>
<td>31</td>
</tr>
<tr>
<td>Limits education</td>
<td>158</td>
<td>47</td>
</tr>
<tr>
<td>Against human rights</td>
<td>96</td>
<td>29</td>
</tr>
</tbody>
</table>

4.5.4 Importance of Received Information

The study also showed that households in both sites valued the information received (Table 21). The analysis revealed a significant difference in perceived importance of information received in the study sites ($\chi^2 = 13.027; \text{df}=3; p<0.05$). From the above trends of the study, it was noted that households in intervention site were more aware of health risks of the practice than their control site counterparts.

Table 21: Importance of Received Information to Households

<table>
<thead>
<tr>
<th>Rated importance</th>
<th>Intervention site (n=331)</th>
<th>Control site (n=284)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Very much helpful</td>
<td>233</td>
<td>70</td>
</tr>
<tr>
<td>Of little help</td>
<td>60</td>
<td>19</td>
</tr>
<tr>
<td>Not helpful</td>
<td>20</td>
<td>6</td>
</tr>
<tr>
<td>Not certain</td>
<td>18</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>331</td>
<td>100</td>
</tr>
</tbody>
</table>

4.5.5 Awareness and Perception of the Alternative Rite of Passage

Of the entire 750 households, 521 (69%) knew of the existence of alternative rite of passage in the community whereas 229 (31%) had no idea. Despite this high level of
awareness, there were glaring differences between the study sites. In intervention site, 347 (93%) of the respondents were aware and only 174 (46%) in control site knew of the alternative rite of passage. Of these households, 255 (76%) of the intervention households and 152 (87%) in the control site saw it as a substitute of FGM (Table 22). These results indicated that there is diffusion of information from intervention site to other parts of the district not covered by specific project activities. Analysis of the results revealed significant association in awareness ($\chi^2 = 188.140; \text{df}=1; p<0.001$) and perception ($\chi^2 = 13.040; \text{df}=1; p<0.001$) of ARP between intervention and control sites. The results show majority (87%) of households in the control site appreciated ARP as substitute of FGM compared to 73% in the intervention site.

Table 22: Appropriateness of Alternative Rite of Passage as FGM Substitute

<table>
<thead>
<tr>
<th>Appropriateness</th>
<th>Intervention site (n=347)</th>
<th>Control site (n=174)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Appropriate substitute</td>
<td>255</td>
<td>73</td>
</tr>
<tr>
<td>Inappropriate substitute</td>
<td>92</td>
<td>27</td>
</tr>
<tr>
<td>Total</td>
<td>347</td>
<td>100</td>
</tr>
</tbody>
</table>

4.5.6 FGM and its Abolition

The support for the abolition of the practice among respondent varied according to site. Overly, 559 (75%) of the respondents supported its abolition. They felt that education officers (36%), religious leaders (47%) and political leaders (83%) should disseminate information through long term public awareness campaigns explaining the negative impacts of the practice on young girls’ and women’s health. However, 25% (191) of the respondents said they were against the abolition due to the need to respect local tradition
and customs (85%) and because of social pressure from within family and peers (35%). Other responses given included cleanliness (39%), socialization of the young girls and their acceptance in the community (69%), prevent immorality (33%) and increase girl’s chances for marriage (62%). The results also revealed that only 220 (29%) of the entire 750 respondents knew the Child Act which outlawed the practice of FGM in Kenya (Table 23).

Table 23: Awareness of the Child Act

<table>
<thead>
<tr>
<th>Awareness</th>
<th>Intervention site (n=375)</th>
<th>Control site (n=375)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Aware</td>
<td>117</td>
<td>31</td>
</tr>
<tr>
<td>Not aware</td>
<td>258</td>
<td>99</td>
</tr>
<tr>
<td>Total</td>
<td>375</td>
<td>100</td>
</tr>
</tbody>
</table>

4.5.7 Target Groups for FGM Eradication Messages

The respondents in both study sites felt that anti-FGM messages should target primarily the girls themselves (52%), their parents (43%), circumcisers (53%) and teenage boys (40%). Grandparents (32%), religious (21%) and political (17%) leaders needed also to be targeted (Figure 10).
They also reported that the anti-FGM advocacy messages should be disseminated to these groups through political (60%) and religious (18%) leaders, education officers (20%), health service providers (14%) and the mass media (19%) (Figure 11). Thus anti-FGM programs should encourage broad community-based education campaigns for the diverse audience using several channels of communication.
4.6 The Health Risks Associated with FGM

4.6.1 Consequences of FGM

The respondents in both study sites agreed that FGM causes grave damage to girls and women, and which in many cases results in serious health consequences (Table 24). The analysis of the results showed a significant difference in the cited health consequences of the procedure and the study sites ($\chi^2=87.234; \text{df}=8; p<0.001$). The level of knowledge between the study sites was also significant ($\chi^2=66.100; \text{df}=3; p<0.001$) (Table 25).

Table 24: Health Consequences of FGM on Women

<table>
<thead>
<tr>
<th>Health risk cited</th>
<th>Intervention site (n=375)</th>
<th>Control site (n=375)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Shock and pain</td>
<td>342</td>
<td>91</td>
</tr>
<tr>
<td>Excessive bleeding</td>
<td>313</td>
<td>83</td>
</tr>
<tr>
<td>Transmission of HIV/AIDS</td>
<td>233</td>
<td>62</td>
</tr>
<tr>
<td>Obstructed labour</td>
<td>172</td>
<td>45</td>
</tr>
<tr>
<td>Difficult urination</td>
<td>30</td>
<td>8</td>
</tr>
<tr>
<td>Painful menstruation</td>
<td>75</td>
<td>20</td>
</tr>
<tr>
<td>Episiotomies</td>
<td>262</td>
<td>70</td>
</tr>
<tr>
<td>Caesarean sections</td>
<td>105</td>
<td>28</td>
</tr>
<tr>
<td>Death may result</td>
<td>22</td>
<td>6</td>
</tr>
</tbody>
</table>

Table 25: Knowledge of Health Risk of FGM

<table>
<thead>
<tr>
<th>Number of reasons stated</th>
<th>Level of knowledge</th>
<th>Intervention site (n=375)</th>
<th>Control site (n=375)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>0</td>
<td>No knowledge</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>1-2</td>
<td>Low knowledge</td>
<td>95</td>
<td>26</td>
</tr>
<tr>
<td>3-4</td>
<td>Moderate knowledge</td>
<td>230</td>
<td>61</td>
</tr>
<tr>
<td>Over 5</td>
<td>High knowledge</td>
<td>45</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>375</td>
<td>100</td>
</tr>
</tbody>
</table>
4.6.2 Health Problems Experienced by Women

When asked whether circumcised female respondents had any health problem as a result of the procedure, their responses revealed that 125 (84%) in the intervention site and 163 (82%) in the control site reported having had problems (Table 26). The results showed no significant relationship in health problems experienced between sites ($\chi^2 = 2.1487; df = 1; p > 0.05$).

Table 26: Health problems experienced associated with FGM

<table>
<thead>
<tr>
<th>Experience</th>
<th>Interventions site (n=149)</th>
<th>Control site (n=199)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Have had problems</td>
<td>125</td>
<td>84</td>
</tr>
<tr>
<td>Have not had problems</td>
<td>24</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>149</td>
<td>100</td>
</tr>
</tbody>
</table>

4.6.3 Immediate and Long term complications Experienced

The immediate health complications experienced included shock and pain (70%) and excessive bleeding (84%). The long term health problems reported included, obstructed labour (73%), episiotomies (86%), caesarean section (38%), painful menstruation (15%) and difficult urination (5%) (Table 27). The results of the study revealed that although most of the female respondents reported having experienced problems as a result of the procedure, there existed disparities on the reported consequences of FGM. The results showed a significant relationship in the reported health risks and sites ($\chi^2 = 9.460; df=3; p<0.05$). This indicates that large numbers of females in the intervention site could associate the problems with the practice as opposed to those in the control site.
Table 27: Health Problems experienced by Circumcised Women

<table>
<thead>
<tr>
<th>Cited problems</th>
<th>Intervention site (n=125)</th>
<th>Control site (n=163)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Shock and pain</td>
<td>123</td>
<td>98</td>
</tr>
<tr>
<td>Excessive bleeding</td>
<td>118</td>
<td>94</td>
</tr>
<tr>
<td>Obstructed labour</td>
<td>99</td>
<td>79</td>
</tr>
<tr>
<td>Episiotomies</td>
<td>94</td>
<td>75</td>
</tr>
<tr>
<td>Caesarean sections</td>
<td>37</td>
<td>30</td>
</tr>
<tr>
<td>Painful menstruation</td>
<td>31</td>
<td>25</td>
</tr>
<tr>
<td>Difficult urination</td>
<td>8</td>
<td>6</td>
</tr>
</tbody>
</table>

4.6.4 Knowledge of the Experienced Health Problems

The level of awareness of the health risks among the female respondents varied according to the study sites. For those in the intervention site, majority 79 (63%) had moderate level of knowledge. Those with low level of knowledge were 25 (20%) while 21 (17%) had high level of knowledge. On the other hand, in the control site 62 (38%) had low level of knowledge, 98 (60%) had moderate knowledge and a few 3 (21%) had high level of knowledge (Table 28). The result indicated a significant relationship between the level of knowledge of the consequences of FGM and the study sites ($\chi^2 = 26.665; df = 2; p<0.001$). This showed that females in the intervention site were more informed than their counterparts in the control site.

Table 28: Females’ Level of Knowledge of the Problems Experienced

<table>
<thead>
<tr>
<th>Number of health risks cited</th>
<th>Level of awareness</th>
<th>Intervention site (n=125)</th>
<th>Control site (n =163)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>frequency</td>
<td>percentage</td>
</tr>
<tr>
<td>1-2</td>
<td>Low knowledge</td>
<td>25</td>
<td>20</td>
</tr>
<tr>
<td>3-4</td>
<td>Moderate</td>
<td>79</td>
<td>63</td>
</tr>
<tr>
<td>over 5</td>
<td>High knowledge</td>
<td>21</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>125</td>
<td>100</td>
</tr>
</tbody>
</table>
4.6.5 Health and Social Implication of FGM

The effects of the procedure on women are both immediate and long term. They are also social, economic and religious. The respondents cited various implications of the practice on girls and women. The health complications cited included difficulty during child delivery (63%), risk of the transmission of the HIV/AIDS (62%) and excessive bleeding (37%). The social implications were school dropout due to early marriages (31%), against religious faith (11%) and human rights (10%) (Table 29). The analysis of the result showed a significant relationship between the study sites and risks cited ($\chi^2=104.172$; df=5; $p<0.001$) and the level of knowledge of the implications ($\chi^2=99.819$; df=3; $p<0.001$) of FGM and the study sites. More respondent in the intervention site (37%) than in the control site (20%) had moderate to high level of knowledge (Table 30). This could be attributed to their participation in anti-FGM initiatives.

Table 29: Social and Health Consequences of FGM

<table>
<thead>
<tr>
<th>Complications cited</th>
<th>Intervention site (n=375)</th>
<th>Control site (n=375)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Obstructed labour</td>
<td>260</td>
<td>69</td>
</tr>
<tr>
<td>Transmission of HIV/AIDS</td>
<td>244</td>
<td>65</td>
</tr>
<tr>
<td>Excessive bleeding</td>
<td>146</td>
<td>39</td>
</tr>
<tr>
<td>School dropout</td>
<td>195</td>
<td>52</td>
</tr>
<tr>
<td>Against religious faith</td>
<td>33</td>
<td>9</td>
</tr>
<tr>
<td>Against human rights</td>
<td>65</td>
<td>16</td>
</tr>
</tbody>
</table>
Table 30: Knowledge of the Health and social implication of FGM

<table>
<thead>
<tr>
<th>Number of health risks cited</th>
<th>Level of awareness</th>
<th>Intervention site (n=375)</th>
<th>Control site (n=375)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>0</td>
<td>No knowledge</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>1-2</td>
<td>Low knowledge</td>
<td>225</td>
<td>60</td>
</tr>
<tr>
<td>3-4</td>
<td>Moderate knowledge</td>
<td>75</td>
<td>20</td>
</tr>
<tr>
<td>Over 5</td>
<td>High knowledge</td>
<td>63</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>375</td>
<td>100</td>
</tr>
</tbody>
</table>
CHAPTER FIVE
DISCUSSION OF THE STUDY FINDINGS

5.1 Current Practice of FGM

5.1.1 Social Dimension of the Practice

Female Genital Mutilation of girls and women is a complex and deeply rooted traditional practice in some communities. For these communities, the practice signifies a rite of passage for girls from girlhood to womanhood, instilling values, training and grooming to uphold family stability irrespective of the prevailing circumstances. Female Genital Mutilation continues because society views it as a "good tradition". The rationales for FGM were to protect girls, guarantee their acceptance and respect within the community and to ensure marriageability. Other beliefs were to ensure cleanliness, enhance male sexuality, prevent promiscuity and excessive clitoral growth and preserve virginity. Failure of a girl from a practicing community to be circumcised led to social stigmatization and discrimination. The practice has important gender implications in all respects. It deprives girls and women of essential parts of their body. Though seen as a means of preserving virginity in girls, FGM impacts negatively on female sexuality. Ironically, most women who have experienced the procedure are strongly in favour of the practice for their daughters (Olayinka, 1987).

The findings of the study, to a large extent agree with the foregoing analysis. Thus, majority of the respondents (96%) in control site and fewer (48%) in intervention site reported that FGM was still popular. This indicates that households in intervention site were slowly abandoning the practice. Chi-square analysis of the result showed significant
association ($\chi^2=222.279$, df=3, P<0.001) in intensity of the practice between intervention and control sites. This was consistent with FGM prevalence of 76% and 43% among girls in the control site and the intervention site respectively.

### 5.1.2 Prevalence of FGM among Adult Female Respondents

It is estimated that more than 130 million girls and women worldwide have undergone FGM (Toubia, 1995). In Africa alone, more than two million girls are circumcised every year (WHO/PATH, 1999). The prevalence varies from 98% in Somalia to 5% in the Democratic Republic of Congo (Toubia, 1995). In Kenya, a survey conducted in 1992 by MYWO found out that nearly 90% of women over 14 years of age in Kisii, Meru, Narok and Samburu Districts had been subjected to FGM. The study also revealed that 78% teenage girls had been circumcised, compared to 100% of women 50 years and older, suggesting a downward trend. The study showed district specific variation in the prevalence of FGM with Kisii (98%), Narok (96%), Samburu (91%) and Meru (74%) (MYWO, 1992).

The results of the 1998 Kenya Demographic and Health Survey (KDHS) indicated that 38 percent of Kenyan women between the ages of 15 and 49 and over half of women above the age of 50 had been circumcised (KDHS, 1998). Differences across ethnic groups were striking. The prevalence of FGM by tribe was: Kisii (97%), Maasai (89%), Kalenjin (62%), Taita/Taveta (59%), Kamba (33%) and Mijikenda/Swahili (12%) (KDHS, 1998). The 1998 Demographic and Health Survey does suggest a slight downward trend in FGM prevalence attributed to public awareness campaigns to halt the practice and ongoing efforts to promote alternative rites of passage for young girls to...
adulthood. The results of this study indicate that circumcision was very common among women in control site (93%) and less common (81%) among females in intervention site. This indicated significant difference ($\chi^2 = 14.141; \text{df}=1; p<0.001$) although there was no significant relationship between study area and age – specific FGM rates among females ($\chi^2 = 7.657; \text{df}=3; p>0.05$) and distribution of females who escaped the procedure by age ($\chi^2 = 6.833; \text{df}=3; p>0.05$). The results showed that female respondents might have already undergone the procedure before the project started in 1998. The proportion of women circumcised increased steadily from prevalence of 39% in age group 11-30 to 96% among women aged over 40 years. This was consistent with 1998 Demographic and Health Survey which showed that 38% of women aged 15-49 years and over half of women above age of 50 had been circumcised.

5.1.3 Prevalence of FGM among girls Aged over 10 Years

The data on prevalence of FGM among girls of circumcision age (at least 10 years) was collected to provide recent description of the practice than would be provided by looking at women, who may have undergone the procedure 10 or more years earlier. The study indicates that of the daughters aged 10-20 years, 43% in the intervention and 76% in control sites had been circumcised. Female Genital Mutilation was still widely practiced in the control site. There was significant difference in prevalence of FGM between the sites ($\chi^2 = 67.176; \text{df}=1; p<0.001$). For the entire sample, 29% of girls at least 10-15 years old, had been circumcised, a finding consistent with the prevalence of 39% in the youngest age group (11-30 years) of female respondents. In each study site, circumcision was more common in women than girls, but the generational decline in the practice varied. In the control site, circumcision was still widely practiced, with a prevalence of
93% in women and 53% in girls. On the other hand, circumcision had declined substantially in intervention site, 81% women and 47% girls reported having undergone FGM. This suggested that the anti-FGM campaigns in the intervention site might have caused the reduction. The results also indicated that families practising traditional indigenous religion were much more inclined to circumcision as compared to those belonging to other denominations. In a research conducted by MYWO/PATH in 1992 to investigate the extent of FGM and factors that perpetuated it in four districts of Meru, Narok, Kisii and Samburu, it was found out that some communities in North-Eastern Kenya had erroneously quoted that FGM was a requirement supported by Islam and the Quran (MYWO/PATH, 1993; Okumu, 1994). However, in recent times, Islamic leaders attempted to clarify that FGM was not a prescription of Islam and Christian churches have also spoken against FGM. This religious support would help the efforts towards its elimination.

5.1.4 Age of Girls at Circumcision

The age at which FGM occurs varies widely. In some communities girls are circumcised as early as infancy, while in others, the ceremony may not occur until the girl is of marriageable age (approximately 14-16 years old) when they can understand the social role expected of them as women (MYWO, 1992).

For the current study, it is noted that the age at which girls were circumcised in the control site was 10-15 years (61%) as opposed to 16-20 years (60%) in the intervention site. During the focus group discussions the respondents reported that the excision itself
and caring for younger girls following this procedure was thought to be easier than when they were older. In addition, the more rapid healing of the wound in younger girls meant a reduction in the time needed to be devoted to the festive and educational activities that go with FGM. The study results indicated that the average age of girls at circumcision tended to increase from 10-15 years in control site to 16-20 years in intervention site. This difference is significant ($t_{748}=24.615; p<0.001$). Hence interventions against the practice should target girls aged 10-20 years.

5.1.5 Decision Making for Circumcision of Girls

Decision making for or against FGM is a key issue involving the prospective initiates and significant others, especially parents and grandparents. The study attempted to identify who made decision so as to determine the target group of anti-FGM messages.

From the findings of the study, girls themselves (63%) were the main decision-makers in the intervention site and involved to a lesser extent (50%) in the control site. This compares with the 1998 Kenya Demographic and Health Survey which reported mothers as the main decision-makers (KDHS, 1998). Other studies have reported considerable involvement of extended family members. For instance among the Malinke community of Faranah District, Guinea decisions are taken by consensus among all the adult members of the family and extended to other members of the social circle (Camara, 1999). The results of the study show that girls have increasingly gained confidence hence their greater involvement in decision-making on matters concerning FGM.
5.1.6 Reasons Advanced for the Practise of FGM

Female Genital Mutilation is a tradition practiced in some communities for various reasons. It has been suggested that FGM may have replaced the practice of human sacrifices in order to please "hostile forces and spirits" (Lightfoot-Klein, 1989). It is believed that infibulation evolved as a means of protecting young girls from rape as they solitarily watch animals graze on lone pastures (Slack, 1998). The practice of infibulation was also intended to ensure woman's virginity before marriage and her chastity to her husband after marriage (Lightfoot-Klein, 1989). FGM marks a rite of passage in which girls were ushered into womanhood (Toubia, 1994).

In West Africa, the clitoris was associated with masculinity, thus the ritual of excision differentiated male and female (Hosken, 1993). In Somalia for instance, it is believed that infibulation determines gender identification by becoming virgins. This was the reason behind reinfibulation done to women after giving birth or after divorce and before remarrying. It was also believed that the practice brings honour to families and husbands and that it enhances husband's sexual pleasure as well (Slack, 1998). Some cultures maintain that women's genitals are ugly and potentially in competition with men's genitalia. Girls who have not undergone FGM are often ridiculed and made to feel dirty and ashamed. Moreover, the practice is often a prerequisite to marriage and payment of dowry. Failure to ascribe to the tradition would deprive girls' family dowry (Shaw, 1995).
In this social milieu, the burden of enduring ridicule and the prospect of never marrying were believed to be too threatening to challenge (Shaw, 1985). The excisors also depended on the economics of FGM and thus eradication programs would be required to persuade them to stop their practice and be assisted to secure other equally lucrative and respected means of support (Hosken, 1993). Others have argued that girls and women accept suffering as part of their sense of womanhood, and that FGM gives them pride and membership in their community of women without any negative psychological effects (Toubia, 1994). These arguments, however, serve to justify the continued practice of FGM while overlooking the physical and psychological trauma that girls and women who have either undergone or face the threat of FGM endure. The psychological effects are often subtle and are buried in layers of denial and acceptance of social norms (Toubia, 1994). Thus FGM in its ritualistic form is done for a variety of reasons in different countries. For instance, it is considered a rite of passage into womanhood, as in Kenya and Siera Leone. Others use it as a means of preserving girls’ virginity until marriage, as in Sudan, Egypt and Somalia (Carr, 1997).

In each community where it is practiced, FGM is considered an important part of the culturally defined gender identity which explains why many mothers and grandmothers identify with and defend the practice. They consider it a fundamental part of their own womanhood and believe that it is essential in ensuring their daughters’ acceptance into their society. In most poor societies, few economic opportunities exist for women outside of marriage and to be circumcised is often a prerequisite for marriage and therefore a critical factor in ensuring social and economic survival for young women (Toubia, 1995).
The results of the research revealed that the study community circumcised girls mainly because of traditional beliefs and practices. The reasons given by respondents whether in intervention or control site were virtually the same. From the findings, it can be shown that FGM has its roots in the regulation of female sexuality; seen as a way to prevent promiscuity, preserve virginity and promote cleanliness. Enforced by the rituals surrounding it, FGM promoted social and tribal cohesion and viewed by the custodians of the culture as essential custom that must be protected from the onslaught of misguided modernizing influences. Those who abandoned the practice were therefore subjected to extreme social pressure and ostracism because of failure to uphold this important social norm. It was also aimed at giving pleasure to husbands and achieving a good social standing. At the heart of all these was rendering a woman marriageable, an important factor in societies where women got social support from husbands because of their low economic and social status. A circumcised woman would also attract a favourable bride prize, thus benefiting her family. Being uncircumcised therefore, meant that a girl or a woman would have low status in the community. There was no significant difference in factors perpetuating the practice in study sites ($\chi^2=10.638; \text{df}=7; p>0.05$) and hence factors perpetuating FGM were similar. From the study, it could be noted that FGM has complex economic, moral, aesthetic and gender identity reasons for its occurrence in the Pokot community. Hence anti-FGM crusaders must attend to the complexity of these reasons and realities of those who favour it.
It became clear during focus group discussions that the ritual of cutting is often an integral part of the ceremonies in which girls are feted and showered with presents and their families honoured. It is seen as a joyous time with feasting, dancing, and atmosphere of freedom for the initiates. The ritual serves to socialize the girls into cultural values and an important connection to family, community, and earlier generations. These ceremonies often involve three interrelated aspects:

a) Educational, where a girl learns her place in society and role as a woman, wife and mother.

b) Physical, in which a girl undergoes physical pain to prove her capability of assuming new role courageously without showing pain experienced all through the actual cutting and punishment received by girls in complete submission throughout the time of initiation and seclusion.

c) Vow of silence, where a girl makes solemn pledge not to speak about her experience during the entire period.

5.2 Attitude and Perception of the Practice of FGM

5.2.1 Females Attitude Regarding Personal Circumcision Status

There were striking contrasts in study sites between high prevalence of FGM and low approval for the practice. For instance, in intervention site, while 81% of female respondents had undergone FGM, only 9% approved of the practice. There were a proportion of women (1%) who were non-committal regarding FGM. Similarly, in control site, 93% of females had been cut, yet only 22% approved of the practice. These findings were consistent with the Demographic and Health Survey results in Burkina
Faso, Eritrea and Kenya, among women aged 15-49 years. In Burkina Faso for example, of the 72% of women who had undergone FGM, only 18% approved of the practice and 12% did not know whether the practice should be continued or stopped. Likewise, in Eritrea, 95% of women had been cut and only 57% supported it (Yoder, 1999). In Kenya, the situation appears not to be different as 38% of women aged 15-49 have undergone female circumcision and only 20% support the continuation of FGM. In contrast, attitude regarding FGM are more consistent with the high prevalence of the practice in Egypt and Sudan. In Egypt, 97% of women have been cut and 82% approve while in Sudan, 89% have undergone the procedure and 79% support FGM.

Demographic and Health Survey on men in Guinea and Eritrea indicated that they were less likely than women to support continuation of FGM. For instance, in Guinea, 68% of women favoured FGM as compared with 52% of men (Yoder, 1999). This was also the case in Eritrea where more women (58%) than men (46%) support continuity of the practice (EDHS, 1995). Qualitative studies conducted in Mali and Burkina Faso by the Population Council Africa (1999) indicated that men recognized that the practice would not be abandoned without their involvement. Thus men involvement is critical in encouraging the abandonment of FGM. However, they have not always been the target of information, education and communication campaigns against the practice.

The results of the research also showed disparities in attitudes regarding personal circumcision status. Among circumcised females, 122 (82%) in intervention and 133
(67%) in control had regrets having undergone the procedure. On the other hand, 31
(89%) in intervention and all (14) in control site had no regrets for being uncircumcised.

There was even wider gap in attitude towards FGM among families in the two sites. For
those families with girls of circumcision age (10-20 years) 112 (77%) in intervention site
and 91 (49%) in control site did not plan to circumcise their daughters. This indicated that
attitude regarding the practice appears to be changing only in the intervention site. This
positive attitudinal change could be attributed to the influence of the campaigns against
the practice. These results were consistent with the findings of the UNICEF / PATH
qualitative research of 1998 among the Kikuyu and Kalenjin ethnic groups which
indicated that families with higher levels of formal education, higher economic status and
that were Christian were more likely to have more positive attitudes and practices
towards abandoning the practice than other groups (UNICEF/PATH, 1998).

Similarly, in Egypt, the 2000 Demographic and Health Survey showed that 81% of
women with daughters reported that they had intentions to circumcise them. This
represents a slight decline from the results of 1995 when 87% had such plans (EDHS,
1995; 2000). Demographic and Health Survey conducted in Eritrea, Central Africa
Republic and Kenya showed that moderate to high disapproval of the practice already
existed among older and younger women. In Sudan, where there is less opposition to
FGM, younger women also expressed greater opposition than their older counterparts.
These suggest that younger generations may have greater access to anti-FGM information
and least influenced by the traditions. Hence general awareness of human rights issues
and loss of cultural significance are instrumental in the decision to rescind FGM. It can be noted from the findings that conservatism, myths and misconceptions still surrounds FGM and the practice remained well entrenched in the study area. During focus group discussion, respondents reported that in areas where social support for the practice had been eroded, it has increasingly gone “underground” as community members clandestinely performed the procedure. Furthermore, awareness of the Child’s Bill banning FGM could intensify this process among families intending to circumcise their daughters.

Various health, social and psychological implications of the procedure were reported for its disapproval. Health risks cited included excessive bleeding, risk of contracting blood borne diseases during group cutting and complications during child delivery. Other reasons were that FGM could lead to early marriage thus limiting girls’ education, against women’s rights and dignity. The results indicated that respondents in intervention site were more informed on these issues and this could be attributed to anti-FGM advocacy activities in their community.

Supporters of the practice argued that the tradition was necessary both to the social fabric and for maturation of girls. Others believed that the cut reduced female promiscuity, ensured virginity at marriage and marital fidelity. Since marriageability had been cited as key factor in maintaining FGM, the abandonment of the practice also had been seen to rest on the abandonment of the belief by both sexes that FGM was a prerequisite to
marriage (Mackie, 2000). The positive attitude of families in intervention site towards uncircumcised girls had great potential to bring about change in the practice of FGM.

5.3 Exposure to FGM Eradication Messages

The anti-FGM project in the study community aimed to change harmful traditional practices through exposure to human rights and health related messages against the practice. This was intended to facilitate reassessment of beliefs and values, ultimately leading to changes in attitude and practice.

The results showed that participation in anti-FGM workshops and seminars in the study sites was significant ($\chi^2 = 21.890; \text{df} = 4; p < 0.001$). This could explain the perception of anti-FGM messages, alternative rite of passage and the subsequent adoption decisions between intervention and control sites. This had possibly influenced the way they perceive FGM and hence significance in influencing behaviour in the adoption of the alternative rite of passage.

In intervention site, 88% (331) of households were aware of anti-FGM advocacy activities and 65% (213) had family member attending anti-FGM workshops and seminars compared to 39% (147) in control site with attendants. Among households in intervention site, 98% (323) of those who had received information reported that the information gained was good and had influenced their attitude towards FGM and the decision to adopt alternative rite of passage.
The implications of these results is that the involvement of majority of households in anti-FGM oriented workshops and training seminars will have positive influence on their perception and adoption of alternative rite of passage. This means that for an accelerated abandonment of FGM and adoption of alternative rite of passage to be achieved, regular and all encompassing workshops and training seminars targeting all households' members and with use of various channels of communication should be organized to enlighten households' members on the health risks to which the girls are exposed. This strategy would lead to abandonment of FGM and adoption of alternative rites of passage in the study community, Kenya and other countries where the practice is prevalent.

These results can be explained in terms of the model of behavioural change for FGM postulated by Izett and Toubia (1999). The model proposes that for change in long running behaviour to occur, individuals, families and communities need to be exposed to new information about the behaviour; for instance, the health risks and socio-psychological effects associated with the practice and the violation of human rights. This will motivate them to contemplate behaviour change. There is need to support this decision and prepare individuals prior to them being able to act on the decision. Such expositions of community members to new information is expected to stimulate behavioural change and adoption of new ones (Izett and Toubia, 1999). The results indicate that anti-FGM messages contain adequate information on health risks of the practice hence the positive influence "abandoning the practice and adoption of alternative rite of passage". Despite the importance of such advocacy activities in raising health knowledge and adoption of the alternative rites of passage, the frequency of participation
in such activities was dismally low, with attendance rate of 65% and 39% in intervention and control site respectively. This showed that either such workshops are rarely organized or if organized on regular basis, participation of households was low.

5.3.1 Suggested Target to Anti-FGM Messages

The respondents in both study sites felt anti-FGM messages should target primarily the girls and their parents. The responses also went further to illustrate the need to target everyone in the community on the demerits of female circumcision. The influence of young men here was notable because they were reported during focus group discussion to be key in humiliating and teasing uncircumcised girls. Awareness creation to all groups using varied channels of communication was therefore necessary to alley fears and misconceptions and to demonstrate the evils of the practice.

5.3.2 Legislation and Abolition of FGM in Kenya

Efforts to eradicate the practice of FGM in Kenya have a long history. For instance, in 1981, a national symposium on FGM led to recommendations calling for deliberate efforts to eradicate the practice in Kenya. Again, parliamentary motion to legislate against the practice was introduced in 1996 but failed to pass in parliament. In 1999, the Ministry of Health issued a “National Plan of Action for the Eradication of FGM, 1999-2019” which set out the goals, broad objectives, strategies, targets and indicators for eradication of FGM. In December 2001, parliament passed the Child’s Bill, which made FGM a criminal offence. In 2003, the Child Bill was passed in parliament as law to protect the girl child. All these indicate the extent to which the discourse has reached a national level. The results of the study revealed that majority of the respondents were not
aware of the Child Act, which outlaws FGM in Kenya, hence the need to raise their awareness.

5.4 Health Risks of FGM

There were varying opinions about the consequences of FGM on the health of girls and women. While many women who underwent FGM do not seem to associate some of their health problems to FGM, for others, the practice can have serious health complications. Some women reported experiencing complications such as haemorrhage, shock and pain, painful menstruation and difficulty in urination. The long-term complications reported included urine retention, obstructed labour, which necessitated episiotomies and caesarean sections. There was significant association with reference to the health risks stated ($\chi^2=9.460; \text{df}=3; p<0.001$) and the level of knowledge ($\chi^2=26.6656; \text{df}=2; p<0.001$) between the study sites. Similarly, there was a significant association in the knowledge of the social and health implication of the procedure on women and the study sites ($\chi^2=99.8192; \text{df}=3; p<0.001$). These differences could be attributed to their previous participation in anti-FGM workshops and seminars by respondents in the intervention sites.

These results concur with the findings of Askew, Chege and Liku (2001) in Tharaka District, Kenya where they found out that the reproductive health knowledge of alternative rite of passage participants was significantly higher than their non-alternative rite of passage counterparts. The report also noted that the combination of intensive community sensitization about FGM and offering an alternative rite of passage had clearly played a role in attitudinal and behaviour changes occurring (Askew et al., 2001).
Operational research studies conducted in Burkina Faso and Mali also showed that women who were infibulated were nearly two and a half times more likely to have gynaecological complications than those with Type I-Clitoridectomy or Type II-Excision. Risks during child delivery increased according to the severity of the procedure. For instance, in Burkina Faso women with Type II or III cutting had higher likelihood of experiencing haemorrhage or perineal tearing during child delivery (Nafissatou et al, 1999).

These complications cause anxiety and fear among women (Toubia, 1994). Pregnant infibulated women are at risk of prolonged labour leading to episiotomy to create an opening for passage of the baby, which often causes damage to the urethra, rectum and perineum (WHO, 1986). Thus Toubia calls for education and training in proper clinical management of infibulated women for health care providers (Toubia, 1994).
CHAPTER SIX

CONCLUSION, RECOMMENDATIONS AND SUGGESTIONS

6.1 Conclusion

Female genital mutilation was considered an obligatory rite of passage from girlhood to maturity in the Pokot community. The prevalence was higher among adult female respondents (88%) than in girls (62%).

The decision to circumcise involved girls themselves (57%), parents (29%), grandparents (20%), peers (16%) or other relatives of the family (4%). Hence the need for community based education campaigns against female circumcision for the diverse audience.

Various reasons were given for the circumcision of girls which included rite of passage (86%), improving marriage prospects (92%), prevented promiscuity (33%), for social recognition (23%) and cleanliness (10%). There is need therefore to dispel these beliefs and myths associated with the practice.

The community had low opinion for uncircumcised women. Families who had not circumcised their daughters were discriminated against and stigmatized in the community. This was more in control site (69%) and lower in the intervention site (10%). As a result of the community's pressure, more families (51%) in the control site than in the intervention site (23%) had intentions to circumcise their daughters.
Health and social implications of FGM were reported for its disapproval. The reasons cited were: health risks associating with the procedure (63%), early marriage (56%), infringement on human rights and dignity (24%) and loss of cultural significance (20%). The household heads had some knowledge of the health risks of FGM. However, there is need for awareness raising at all community levels of the risks FGM predisposes women to. This is because majority reported having complications during the procedure (74%) and during child delivery (42%).

Awareness of anti-FGM campaigns was higher in the intervention site (88%) than in the control site (76%). Similarly majority of the respondents in the intervention site (93%) and a few in the control site (46%) knew of the alternative rite of passage. Hence the need to involve all community members in FGM eradication activities.

Finally, the study concludes that exposure to and dissemination of information on the social, psychological and health risks of the practice on girls and women has impacted on the community’s beliefs and practices about FGM. In some cases, this may be associated with reported adoption of alternative rite of passage.

6.2 Recommendations

a) Future programs should focus on and encourage broad community based education campaigns for diverse audience; men and women, opinion leaders, religious leaders, traditional circumcisers, teenage girls and boys. Thus there is need to involve all community members in health campaigns against FGM.
through use of social marketing approach in evaluating the costs and benefits of continuing or abandoning FGM.

b) Campaigns against Female Genital Mutilation abandonment should be integrated in social and economic development initiatives that focus on women’s empowerment. For instance, women should be empowered through literacy training and information related to health, human rights and problem solving to give them information and self-confidence to abandon the practice. To improve their self-image and self-esteem, women must be supported by the entire community in their struggle to improve their lives and to protect themselves and their daughters against deleterious effects of FGM.

c) Alternative rituals to substitute for the traditional cutting ceremonies should be developed. For instance the alternative rite of passage for young girls into womanhood is a promising strategy for reducing FGM. The prevalence of the practice was found to be lower in the intervention site which would be associated to alternative opportunities availed to girls to graduate to adulthood. However the coverage and publicity should be frequent and highly publicized activity.

6.3 Suggestions for Future Work

a) There is need to investigate the barriers to participation in anti-FGM initiatives.

b) There is need for more research to evaluate the effectiveness of anti-FGM interventions in other communities.
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APPENDICES

Appendix I – Questionnaire

QUESTIONNAIRE ON AN ASSESSMENT OF THE IMPACT OF HEALTH CAMPAIGNS AGAINST FEMALE GENITAL MUTILATION IN WEST POKOT DISTRICT, KENYA

SERIAL NO __________________________

DIVISION __________________________

SECTION I: DEMOGRAPHIC INFORMATION

1. Age
   (i) 11-20 years □ (iv) 41-50 years □
   (ii) 21-30 years □ (v) 51-60 years □
   (iii) 31-40 years □ (vi) Over 61 years □

2. Gender
   (i) Male □ (ii) Female □

3. Marital Status
   (i) Single □ (iii) Separated □
   (ii) Married □ (iv) Other (specify) ____________

4. Education Level
   (i) Primary □ (ii) Secondary □
   (iii) College □ (iv) Other (specify) ____________

5. Religion
   (i) Catholic □ (ii) Protestant □
   (iii) Islam □ (iv) Other (specify) ____________
SECTION II: CURRENT PRACTICE OF FEMALE GENITAL MUTILATION

6. How is the practice of female circumcision in your division?
   (i) Commonly practiced □ (ii) Rarely practiced □
   (iii) Never practiced □ (iv) Other (specify)__________

7. At what age are the girls circumcised?
   (i) Below 10 years □ (iii) 10 - 15 years □
   (ii) 16-20 years □ (iv) Above 20 years □
   Give reasons for circumcising girls at this age:
   ____________________________________________________________

8. Who decides that girls should be circumcised?
   (i) Father □ (ii) Mother □ (iii) Grand parents □
   (iv) Girls themselves □ (v) Peers □ (vi) Other__________

9. Why should the girls be circumcised? State reasons
   ____________________________________________________________

SECTION III: HEALTH KNOWLEDGE AND ATTITUDES TOWARDS FEMALE GENITAL MUTILATION

If you are a member of the female gender, kindly answer question 11, 12 and 13

10. Are you circumcised?
   i) Yes □ (ii) No □

11. Did you experience any health problems during time of the operation and after
that could be due to the procedure?

(i) Yes ☐

(ii) No ☐

If yes, which health problems?

--------------------------------------------------

12. a) Do you regret having or not having been circumcised?

(i) Having been circumcised

Yes ☐

No ☐

(ii) Not having been circumcised

Yes ☐

No ☐

b) Give reasons for your answer

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13. a) Do you suggest that female circumcision should be continued or discontinued?

(i) Continued ☐

(ii) Discontinued ☐

(iii) Not certain ☐

(iv) Other

b) Give reasons for your answer.

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If you have daughters aged 9 years and above in your family kindly answer question 14, 15, 16 and 17

14. How many among them are:

Circumcised and aged

(i) Below 10 years

(ii) 10 - 15 years

(iii) 16-20 years

(iv) Above 20 years

(b) Not circumcised and aged

(i) Below 10 years

(ii) 10 - 15 years

(iii) 16-20 years

(iv) Above 20 years
15. (a) Have you faced any problems as a family for having or not having circumcised your daughters?

(i) Having circumcised  Yes ☐ No ☐
(ii) Not having circumcised Yes ☐ No ☐

b) If yes, which problems?

__________________________________________________________________________

16. (a) Do you have plans to have the uncircumcised ones be circumcised?

(i) Yes ☐ (ii) No ☐

b) Give reasons for your answer

__________________________________________________________________________

17.(a) Do you regret for having or not having circumcised your daughters?

(i) Having circumcised Yes ☐ No ☐
(ii) Not having circumcised Yes ☐ No ☐

(b) State reasons for your answer

__________________________________________________________________________

SECTION IV: INTERVENTION AWARENESS

18 (a) Have you come across messages that are against female circumcision?

(i) Yes ☐ (ii) No ☐

b) If yes, from whom? State

__________________________________________________________________________

19. What kind of messages have you heard or received?
20. (a) In your opinion, are they good messages?
   (i) Yes ☐ (ii) No ☐
   
   b) Give reasons for your answer

21. In order to eliminate female circumcision, who should be targeted in anti-female circumcision messages?
   (i) Men ☐ (ii) Women ☐
   (iii) Teenage girls ☐ (iv) Teenage boys ☐
   (v) Grandparents ☐ (vi) Circumcisers ☐
   (vii) Religious leaders ☐ (viii) Political leaders ☐
   (ix) Other (specify) ______

22. a) Has any member of your household been attending the anti-female circumcision meetings?
   (i) Yes ☐ (ii) No ☐
   
   b) If yes, who in your family attends the meeting?
   (i) Husband ☐ (ii) Wife ☐ (iii) Daughter ☐
   (iv) Son ☐ (v) Grandparent(s) ☐ (vi) Other (specify) ______

23. How much has anti-female circumcision messages been of help to your family regarding health knowledge on risks associated with the practice?
   (i) Very much ☐ (ii) Little ☐ (iii) Not helpful ☐
   (iv) Not certain ☐ (v) Other (specify) ______

24. What will be the appropriate channels of communication that can reach your audience?
   (i) Radio ☐ (ii) Barazas ☐
   (iii) Religious leaders ☐ (iv) Community leaders ☐
25. a) Have you heard of alternative rite of passage for young girls to adulthood?
   (i) Yes ☐ (ii) No ☐

   b) If yes, what does it involve?

26. a) Is it a good replacement for female circumcision?
   (i) Yes ☐ (ii) No ☐

   b) Please give reasons for your answer

27. If female circumcision was to be stopped, what would you suggest as a substitute.
   (i) Ceremonial education without surgical operation ☐
   (ii) No substitute ☐
   (iii) Any other (specify)________________________

28. a) Are you aware of any law that prohibits female circumcision in Kenya?
   (i) Yes ☐ (ii) No ☐

   b) If yes, what does it say?

29. What are the benefits of not circumcision girls?


31. Do you agree or disagree that female circumcision could cause or lead to the following health risks?

<table>
<thead>
<tr>
<th>Description</th>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Shock and pain</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(ii) Excessive bleeding</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(iii) Transmission of HIV/AIDS</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(iv) Difficult urination</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>(v) Painful menstruation</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(vi) Obstructed labour</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(vii) Episiotomies</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(viii) Caesarean Sections</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(ix) Death may result</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Appendix II - Focus Group Discussion

A GUIDE FOR FOCUS GROUP DISCUSSION

1) What is female circumcision?
2) What is involved during female circumcision in Pokot community?
3) What roles do female circumcision play in Pokot community that encourages its continuation?
4) In the contemporary Pokot society, does the practice still play the same roles?
5) Have prevalence of female circumcision changed?
6) What might have brought about the changes or hindered these changes?
7) What does religion say about female circumcision?
8) How does female circumcision violate girl child and women’s rights?
9) How then can female circumcision be eliminated in the Pokot community?
10) How best can the community be involved in fighting the vice?
11) What interventions that are community specific and culture friendly can be employed in elimination of this practice in the community?
12) Female circumcision is now illegal in Kenya, how best can this law be implemented to eliminate the practice of female circumcision?
13) Discuss the health problems associated with female circumcision in this community?
14) How can the alternative rite of passage for young girls to adulthood be implemented as an alternative to female circumcision?
15) What aspects of female circumcision should be included or excluded in the alternative rite of passage?
16) Discuss the question of marriageability of an uncircumcised Pokot girls or women and its socio-cultural implications in the community.
17) There have been a lot of efforts to eliminate female circumcision by the Government of Kenya and NGO’s including world vision anti-FGM operating in Chepareria Division without much success. What has hindered change and what should be done to bring more changes?
Appendix III – Interview Schedule

A GUIDE FOR AN INTERVIEW SCHEDULE ON FEMALE CIRCUMCISION

1) At what age are girls circumcised in the Pokot community?
2) When and how is it performed?
3) Who usually does the operation?
4) What gifts are given to the initiates, parents and circumcisers during this period of female circumcision?
5) Do the tokens given to circumcisers depend on the number of girls they operate on? Explain.
6) If the circumcisers are given an alternative source of income, will they relinquish their operations? Explain.
7) What social and cultural factors have perpetuated the practice?
8) What health problems may girls and women may experience during and after the operations?
9) How best can female circumcision be modified or eliminated in the Pokot community.
Appendix IV - Geographical Distribution of FGM

Areas where most women are infibulated

Clitoridectomy and excision widespread in some groups

Some cases reported
Appendix V – Research Authorization

MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY

OFFICE OF THE ASSISTANT MINISTER
JUGOO HOUSE "T"
HARAMBEE AVENUE
P.O. Box 39040
NAIROBI
Date 15th June, 2004

Jackline L. Chepkech
Kenyatta University
P.O. BOX 43844
NAIROBI

Dear Madam

RE: RESEARCH AUTHORISATION

Please refer to your application for authority to conduct research on ‘the Assessment of the impact of Health intervention against Female Genital Mutilation in West Pokot District Kenya, I am pleased to inform you that you have been authorised to conduct research in West Pokot District for a period ending 31st December, 2004.

You are advised to report to the District Commissioner, the District Education Officer and the District Medical Officer of Health, West Pokot District before commencing your study.

Upon completion of your research project, you are expected to deposit two copies of your research findings to this Office.

Yours faithfully

T. MOTURI
FOR: PERMANENT SECRETARY

CC
The District Commissioner
West Pokot

The District Education Officer
West Pokot

The District Medical Officer of Health
West Pokot
Appendix VI – Research Permit

This is to certify that:

Prof./Dr./Mr./Mrs./Miss  JACKLINE L. CHEPKEI

of (Address)  KENYATTA UNIVERSITY

P.O. BOX 30623, NAIROBI

has been permitted to conduct research in

Location, WEST POKOT District,

Province, RIFT VALLEY

on the topic, AN ASSESSMENT OF THE

IMPACT OF HEALTH INTERVENTIONS

AGAINST FEMALE GENITAL MUTILATION IN

WEST POKOT DISTRICT, KENYA

for a period ending 31st December, 2004

Research Permit No.  MOEST 13/001/34C 15

Date of issue  15th June, 2004

Fee received  Shs. 500

APPLICANT'S

PHOTOGRAPH

T. MOTURI

For: Permanent Secretary
Ministry of Education
Science and Technology
FOR: PERMANENT SECRETARY

CONDITIONS

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

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

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

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

5. You are required to submit at least two (2) four (4) bound copies of your final report for Kenyans and non-Kenyans respectively.

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

REPUBLIC OF KENYA

RESEARCH CLEARANCE PERMIT

(CONDITIONS—see back page)