

Original Research Article

Impact of introduction of the anti-female genital mutilation law on the practice of female genital mutilation in Garissa County, Kenya

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ABSTRACT

Background: Female genital mutilation (FGM), is a social traditional practice performed by cutting parts of the external female genitalia. Garissa county in north eastern Kenya has the highest prevalence of FGM in Kenya at 94%. This practise was illegalised in Kenya in 2011. The aim of the study was to assess the successes of anti-FGM programs in Garissa County.

Methods: This was a cross sectional study involving 108 participants of both genders and different age groups. Questionnaires were used in data collection. Obtained data was analyzed using SPSS version 25. Chi square was used to compare characteristics between female participants who had undergone FGM and participants not circumcised.

Results: Of the 108 participants, 53.7% were females. The median age of participants was 23 years [Interquartile range (IQR)]15-40]. The prevalence of FGM was 62% with the mean age at circumcision being 8.34 years (SD=2.69 years). Being of Muslim faith was associated with practice of FGM ($p < 0.001$). There was high level of awareness of the anti-FGM law among youths at 84%. Two thirds of participants did not support FGM. Excision was the main type of FGM practiced. Among those circumcised, 14.7% were circumcised by trained nurses.

Conclusions: Introduction of the anti-FGM law, and its advocacy by NGOs has led to a reduction in the practice of FGM in Garissa county. There is an increase in the medicalization of FGM in Garissa with evidence of the practice going underground. This study recommends NGOs to have a clearer focus on the method chosen for use in advocating for the abandonment of FGM.

Keywords: Female genital mutilation/cut, Kenya, Anti-FGM, Somali

INTRODUCTION

Female genital mutilation (FGM), a traditional social practice involving the cutting of parts of the external female genitalia in various forms is largely practised in some Asian communities and in more than 25 African countries as a way of controlling female sexuality and to uphold a cultural practice of rite of passage to womanhood.¹ Over the past 20 years, there has been an increase in agitation aimed at preventing the practice of

FGM, however, due to heightened hostilities from the political and legal world over the issue, this awareness is yet to translate to measurable changes in the prevalence of FGM.² Even so, the precise statistics of girls and women who have gone through FGM worldwide remains unknown, however, it is estimated that globally, not less than 200 million girls and women have been circumcised.³ Current estimates indicate in excess of three million women, the majority under 15 years of age, undertake the cut each year.³ In Kenya, FGM is practiced by some ethnic groups as part of beliefs about what is considered proper

sexual behavior for women and what is necessary to prepare them for marriage.⁴ The practice of FGM is widely recognized as a violation of children and women's rights due to its potential to cause serious medical complications such as increased risk of child birth complications, excessive bleeding, pain during intercourse, trauma to those on whom it is inflicted and death.⁵ These complications increase depending on the severity of FGM the woman has received. In the year 2011, Kenya passed a law 'The Prohibition of FGM Act 2011', which prohibited the practice of FGM within its territory. Pursuant to this, a board was established to protect against defilement of female mental or physical integrity through the practice of FGM.⁶

According to the Kenya Demographic and Health Survey (KDHS) 2014 report, among the communities that practice FGM in Kenya, Somalis are leading with a prevalence of 94%. The level of FGM acceptance among persons from this community was highest compare to other communities at 92% with women being the main perpetrators with an acceptance level of 81% compared to male at 79%.⁶ Though the Kenyan government has banned FGM, the practice still persists and has even become medicalized⁴ as indicated by the reported increase in FGM medicalization of 15%.³ Garissa County in Kenya records high neonatal death and adverse obstetric outcomes compared to other counties. Teenage marriages are also rampant in the area which mainly occur following the circumcision of the girls. In light of this, this study aimed to assess the success of anti-female genital mutilation programs in Garissa County by looking at the gains made between 2011 when the anti-FGM law was enacted in Kenya and 2018 when this study was done.

METHODS

Study design

This study adopted mixed method approach entailing descriptive cross-sectional design and desk review to assess the impact which the introduction of anti-FGM law has had on the practice of FGM among residents of Garissa county.

Study area

This study was conducted in Garissa Sub-county of Garissa County. Garissa County is an administrative county in the former North Eastern province of Kenya; it covers an area of 44,174.1 km.^{2,7} It has seven sub-counties namely: Fafi, Garissa, Ijara, Lagdera Balambala, Hulugho and Dadaab. Of the seven sub-counties, Garissa sub-county is the most densely populated and seat of the county government of Garissa County. This study targeted persons from three population groups: women of childbearing age, adolescent between the ages of 12 and 18 years and the elderly above 60 years. The three groups contributed to a total sample size of 108 respondents. Systematic random sampling was used in selecting study

participants. Six residential areas (Bulas) within Garissa Sub-county Township were randomly selected. 18 participants from each Bula were systematically selected. Every 10th person reached and falling within the target population in each Bula was recruited in the study, those who agree to participate were enrolled.

Data collection

Interviewer administered questionnaires were used in data collection. A Likert scale was incorporated in the questionnaire to assess the attitude of area residents towards FGM. Secondary data from UNICEF was reviewed to give baseline data on FGM in the county.⁸

RESULTS

Between October and November 2018, a total of 150 residents of Garissa county were invited to participate in this study. In total 108 eligible residents of different age groups and both gender consented to participate in this study. From these, 108 questionnaires were filled. Informed consent/assent was required from participants prior to participation in the study.

Socio-demographic characteristics of study population

As summarized in Table 1, this study's participants had a median age of 23 years (IQR, 15-40). Approximately half (N=49, 46.2%) were aged below 18 years, about one in five (N=23, 21.7%) were aged between 19 and 35 years while one in three (N=34, 32.1%) were aged above 36 years. Female participants were slightly more (N=58, 53.7%) than male (N=50, 46.3%) participants. Islam was the main practiced religion (N=95, 88.0%) by area residents. Approximately two in three (N=75, 69.4%) of participants had primary education as the highest level of education, on the other hand, less than one percent (N=1, 0.9%) had tertiary education. When students were excluded, nearly half of residents were married (N=53, 49.1%) while 2.8% (N=3) were single. One in five of respondents (N=25, 23.1%) were either traders or businessmen, one in twenty (N=5, 5.6%) were in formal employment while one in four (N=28, 25.9%) were unemployed.

Prevalence of FGM and sociodemographic characteristics of female participants who had undergone FGM

Out of the 58 female participants in this study, 56 responded to the question on their circumcision status (Table 2). Of this, 62.5% (n=35/56) had undergone female circumcision. The mean age of participants at the time of circumcision was 8.34 years (SD 2.69 years). The prevalence of FGM was highest among participants aged below 18 years (n=15, 26.8%) with approximately one in four in this age bracket having been circumcised. Approximately, one in five participants aged above 36 years was circumcised. Approximately two in three of

those circumcised (n=34, 60.7%) were Muslims while less than 2% (n=1, 1.8%) were Christians. Majority of those circumcised had primary education (n=20, 35.7%) with one in ten (n=6, 10.7%) having secondary education, another one in ten (n=7, 12.5%) lacked formal education. On the other hand, most of the circumcised women were married (n=17, 30.9%). Majority of those circumcised were primary school students (n=14, 20.5%) followed by the unemployed (n=9, 16.1%) and traders (n=7, 12.5%). There was no statistical significance between circumcised and uncircumcised participants based on age group, highest level of education, marital status or occupation. However, a statistically significant difference was observed based on religious practice (p=0.001).

Influence of individual youth and adolescents' characteristics on knowledge of the anti-FGM law in Garissa county

Out of the 73 adolescents and youth (participants aged below 35 years) who participated in this study, 84% (N=61) knew of the anti-FGM law (Table 3). Knowledge of the anti-FGM law was highest among female participants at 89.2% (N=33/37). More Christians 100% (N=12/12) knew of the law compared to 80.3% (N=49/61) of Muslims. All participants with tertiary/college and high school education knew of the law compared to 81.8% (N=45/55) with primary education and only 50% (N=1/2) with madrasa education. 81.0% of respondents who were married and all singles knew of the law.

Attitude of residents of Garissa county towards the anti-female genital mutilation law

Of the 108 participants, 104 responded on their attitude towards FGM. Of these 34.6% (N=36) supported FGM while 1.9% (N=2) were not sure of their stand on the subject. Two in three participants (63.5%, N=66) did not support the practice. Pairwise comparison between knowledge of FGM and advocating for FGM found that most people who had knowledge of anti-FGM law (N=50, 46.7%) did not support the practice compared to those who had knowledge of the law and supported the practice (N=19, 17.8%). This difference was statistically significant (p=0.001) (Table 3).

Reason for supporting or not supporting FGM

Reasons for advocating for or not advocating for FGM were grouped into four: religious, cultural, social and sexual. 39% of respondents supported FGM due to religious reasons, 29.3% due to social reasons, 22% due to sexual reasons and 41.5% due to cultural reasons. Those opposed to the practice due to the same reasons were 11.0%, 58.9%, 26.0% and 17.8% respectively. By gender,

male respondents supported FGM due to religious, cultural, social and sexual reasons while female responders did so due to religious and sexual reasons.

Perception on the negative effects of FGM

The main negative effects of FGM given by male respondents was problems during labor (15.2%), followed by difficulties during menstruation (4.3%), impaired intercourse (3.3%) and fertility problems (1.1%). Female respondents viewed problems during labor (26.3%) as the main negative effect of FGM followed by difficulties during menstruation (13.0%) and sexual problems (2.2%). Overall, difficulties during labor (44.6%) was viewed as the main negative effect of FGM followed by difficulties during menstruation (17.4%), sexual problem (5.4%) and fertility problem (1.1%). Even so, 19.6% of male and 12.0% of female respondents were of the view that FGM had no negative effects.

Factors influencing the implementation of the anti-FGM law in Garissa county

For approximately two thirds of participants, the decision to get circumcised was made by their mothers (68.8%) while for approximately one in ten of participants (12.5%) the decision was made by fathers. On the other hand, 6.3% of participants of their own volition decided to be circumcised.

Type of circumcision performed

Two thirds of the participants- 66.7% (20/31) had a portion of their flesh removed while for 16.1% (5/31) of participants, the genital was nicked without flesh removal. Traditional circumcisers were the main circumcisers (61.8%) followed by traditional birth attendants (17.6%). Trained nurses/midwives circumcised 14.7% of respondents (Figure 1).

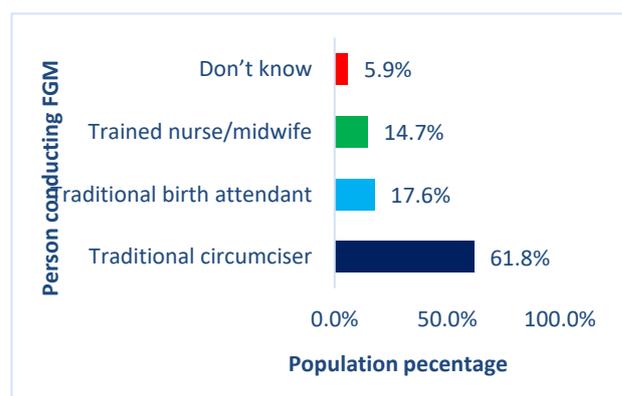


Figure 1: Person performing the circumcision.

Table 1: Sociodemographic characteristics of study participants.

Participant characteristics		N (%)
Age (median)	23 years [Interquartile range (IQR) 15-40]	
Age group (years)	≤18	49 (46.2)
	19-35	23 (21.7)
	≥36	34 (32.1)
Gender	Male	50 (46.3)
	Female	58 (53.7)
Religion	Muslim	95 (88.0)
	Christian	13 (12.0)
Education	Primary	75 (69.4)
	Secondary	13 (12.0)
	Tertiary/college	1 (0.9)
	Madrassa	5 (4.6)
	No formal education	14 (13.0)
Marital status	Single	3 (2.8)
	Married	53 (49.1)
	Divorced	1 (0.9)
	Widowed	2 (1.9)
Occupation	Formal employment (salaried)	5 (5.6)
	Informal employment (casual)	1 (0.9)
	Trader/business	25 (23.1)
	Agriculture unemployed	2 (1.9)
	Student	47 (43.5)
	Unemployed	28 (25.9)

Table 2: Influence of individual characteristics of female participants on female circumcision.

Participant characteristics	Circumcision status		P value
	Circumcised (n=35) (%)	Not circumcised (n=21) (%)	
Age group (years)	≤18	15 (65.2)	X ² =0.804, df=2, p=0.669
	19-35	9 (69.2)	
	≥36	11 (55.0)	
Religious	Muslim	34 (72.3)	0.001*
	Christian	1 (11.1)	
Level of education	Primary	20 (54.1)	0.112*
	Secondary	6 (66.7)	
	Tertiary/college	1 (100)	
	Madrassa	1 (50)	
	No formal education	7 (100)	
Marital status	Single	17 (63.0)	X ² =0.029, df=1, p=0.864
	Married	17 (60.7)	
Occupation	Employed	4 (80.0)	0.428*
	Trader/business	7 (63.6)	
	Unemployed	24 (60.0)	

Note: df- degrees of freedom, X²- Chi square, *Fischer's exact (one sided).

Table 3: Knowledge of the anti-FGM law among youth and adolescents in Garissa county.

Participant characteristics	Have knowledge of anti-FGM knowledge		P value
	Yes (n=61) (%)	No (n=12) (%)	
Gender	Male	28 (77.8)	X ² = 1.730, df=1, p=0.188
	Female	33 (89.2)	
Religious	Muslim	49 (80.3)	0.196**
	Christian	12 (100)	
	Primary	45 (81.8)	0.402**

Continued.

Participant characteristics		Have knowledge of anti-FGM knowledge		P value
		Yes (n=61) (%)	No (n=12) (%)	
Level of education	Secondary	9 (100.0)	0 (0)	
	Tertiary/college	1 (100.0)	0 (0)	
	Madrassa	1 (50.0)	1 (50.0)	
	No formal education	5 (83.3)	1 (16.7)	
Marital status	Single	42 (84.0)	8 (16.0)	0.5*
	Married	17 (81.0)	4 (19.0)	
Occupation	Employed	4 (100.0)	0 (0)	0.836**
	Trader/business	6 (85.7)	1 (14.3)	
	Unemployed	50 (82.0)	11 (18.0)	
Advocate for FGM	Yes	19 (17.8)	8 (7.5)	0.001
	No	50 (46.7)	2 (1.9)	
	Not sure	18 (16.8)	10 (9.3)	

Note: df- degrees of freedom, X²- Chi square, *Fischer's exact (one sided), **Fischer's exact (two sided).

DISCUSSION

At 62.5%, the prevalence of FGM/C in Garissa county area was lower than what has been reported in previous studies, even so, it is still higher than the reported average Kenya national prevalence of 15%.^{4,6} Previous studies conducted in Garissa country and among persons of Somali origin have reported an FGM prevalence of 98%.³ Nonetheless, the reported prevalence of 62.5% falls within the range reported by Johansen et al in their review of FGM among 28 countries who reported an FGM prevalence ranging from 0.6% to 98%.⁹ However, it is noteworthy to mention that the 62.5% FGM prevalence reported in this study is significantly lower than the 98% which had been reported by KDHS, and the 95% prevalence reported by UNICEF in the same area.^{4,6} The reduced prevalence in this study could be explained by the introduction of the anti-FGM law, sensitization of residents on the negative effects of the act and the punitive measures proposed on those who practice or perpetrate the act.

Nonetheless, the low prevalence reported could also be due to this study being conducted in Garissa subcounty as opposed to Balambala subcounty where the baseline study by UNICEF was conducted. Garissa subcounty which has a more cosmopolitan distribution with residents having higher literacy levels compared to Balambala subcounty which is rural with lower literacy levels and mainly composed of persons of Somali origin. Additionally, previous studies that were reporting prevalence of up to 98% had been done either before or just a year after the establishment of the anti-FGM board tasked with alleviating the vice while our study was conducted more than three years after the start of the anti-FGM program. Our findings however, differed from those of Johansen et al who reported an overall decline in the prevalence of FGM with girls and young women being less likely to have undergone FGM than older women.⁹ In the current study, we had more young girls and women aged below 18 years (26.8%) who had undergone circumcision compared to older women (19.6%). Even so, this study agrees with findings of KDHS, WHO and Johansen et al of the average age of circumcision being 9 years as participants in our

study were circumcised at an average age of 8.34 years.^{3,6,9} In our study, there was a statistically significant association between participation in FGM and practice of Muslim faith (p=0.001), similar results have been reported by Johansen et al, Andro et al and UNICEF who found FGM to be practiced mainly by persons practicing Muslim faith.^{4,9,10}

There was an increase in the levels of knowledge of the anti-FGM law among youth and adolescents in the study area. At 84%, the level of knowledge of the anti-FGM law was higher than had been reported by the study that noted a lower awareness on the ban on FGM among all population of girls, boys, men and women in Garissa county compared to other study areas in Kenya. This high awareness of the anti-FGM law could be one of the factors that have contributed to lowering of the FGM prevalence among Somalis in Garissa from 98% to the current 62.5% reported in this study. The reported decrease could also be explained by the difference in the study areas where the two studies were conducted; Garissa subcounty versus Balambala subcounty.

Our study found the level of knowledge of the anti-FGM law increased with increase in the level of education. Persons in a marriage relation had lower knowledge of the law compared to single (unmarried) persons. On the other hand, there were more females who knew of the law compared to male participants. These findings partly agree with those of UNICEF who reported awareness of the anti-FGM law to increase with increase in the level of education.

There were mixed attitudes among study participants towards the anti-FGM law with two thirds of participants (both male and female) not in support of the practice of FGM. The percentage of those opposing FGM as reported in this study is higher compared to previous studies that reported higher acceptance of the practice by area residents (both male and female).⁶ According to the KDHS findings, 90% of women in Garissa county were in support of continuation of FGM in comparison to 76% of men.⁶ Having knowledge of the anti-FGM law also led to a reduction in support of the practice. Hence the lack of

support of the practice could be due to fear of the consequences of breaking the law rather than abandonment of the practice. Several studies have noted that in order to evade facing the law, most persons have resorted to underground practice of the act by transporting their daughters to neighboring communities or other countries so as to participate in the cut.^{4,6,9} Such people have been found to feign support of the anti-FGM law while practicing it in secret. A majority of those who supported FGM (41.5%) did so due to cultural reasons while a majority of those who did not support FGM did so due to social reasons (58.9%). The move that led to pronouncing FGM as an abuse against women right was born out of the negative health effects FGM conferred on those who had gone through the acts.¹¹ To this date, the negative health and social effects FGM has on women who have participated in it still constitute the major push for the abandonment of the act.^{9,12,13} The finding of this study of cultural reasons being the main reason for practice of FGM contravene opinions of UNICEF who reported religious reasons to be the main reason for Muslim persons of Somali origin to participate in the act.⁴

Even so, grouping of the reasons by gender of respondent had religious reason as the main reason for supporting the act. Hosken et al has reported FGM as not being part of the Somali culture and that though members of the Somali decent who practice FGM do so in the name of religious reasons, no one of the three monotheistic religions of Judaism, Christianity and Islam has a commandment in their religious books that requires female circumcision, rather practice of the act has been noted as a cultural norm that predates both the Bible and Koran.^{14,15} Sharing information about the health risks associated with FGM has been the most common and effective way used to educate the public on the negative effects of FGM. Participants in the current study reported fertility problems to be the main negative effect of FGM.

This observation agrees with other studies that have reported FGM to be associated with negative health outcomes especially during childbirth.^{4,9,11,15} It is however important to note that approximately one third of area residents did not think FGM had any negative effects on the health and well-being of women with persons of the male gender being the majority those who had this opinion.

The study by UNICEF among communities practicing FGM in Kenya reported similar results with male participants being the majority of those with the opinion that FGM did not cause any negative health complications.⁴ According to our study, mothers of daughters were the main decision makers on whether their daughters would get circumcised or not. These findings differ from previous findings by Johansen et al, UNICEF, WHO and KDHS who have reported the grandmother as the mainly influencer on the decision to circumcise daughters.^{4,6,9,11} However, our findings partly agree with Berg, Underland et al observations that some women

willingly decided to be circumcised as was reported by 6.3% of women.¹³

The percentage of circumcision by excision in our study is slightly lower than the 74% that had been reported in the UNICEF report.⁴ However, our findings are consistent with those of UNICEF and Kimani et al of excision being the main type of FGM practiced among Somalis in Kenya.^{4,12} The reduction in the percentage of excision FGM could be due to an increase in awareness of the harmful type II and III FGM has on women. Though all types of FGM have negative effects on the health of women, excision and infibulation have been associated with worse health outcomes.^{15,16} Johansen et al has reported abandonment of more harmful types of FGM for less harmful ones among communities practicing the act.⁹

Our study found traditional circumcizers to be the main persons offering FGM services to 68.1% of area residents, this was a drop from the 99% that had been reported in the UNICEF study conducted in the same county.⁴ The UNICEF report had noted that traditional circumcizers were the main persons conducting FGM with health care profession performing the act on 1% of the population.⁴

None of the participants in our study reported having sought the service of health care workers to perform FGM, interestingly, 14.7% reported trained midwives and nurses as the ones who performed the act while for 17.1% the cut was done by a traditional birth attendant. Many studies have noted an increase in the number of medicalized FGM allegedly to reduce its negative health effects, and is thus suggested as a harm reduction strategy in response to these perceived health risks.¹⁷ However, this is done in secrecy.

Our findings on the decline in use of traditional circumcizer in performing FGM and the increased preference for medical practitioners agree with Leye et al observation that in many countries/communities where FGM is traditionally practiced, the prevalence rates of medicalization of FGM are increasing.¹⁷ The reported 14.7% of FGM performed by trained midwives in our study is slightly lower than the 15% reported by Shell et al to be the percentage of medicalized FGM in Kenya.⁵ The use of nurses and midwives in performing FGM as noted in our study could be a new way of performing the act so as to bypass the anti-FGM law. Prior to the introduction of the anti-FGM law, the prevalence of FGM in Garissa county and especially among persons of Somali origin was 99%.^{4,6}

Our study found this prevalence to have dropped in the 5 years of the introduction of the anti-FGM law to 62%. Hence the functions of anti-FGM NGOs in the area have helped reduce the vice. On the other hand, introduction of the law could have led to a drop in the age of performing the circumcision. It has been noted that many anti-FGM interventions combine two or more approaches and method while others do not have the total abandonment of all forms

of FGM as the objective, though this is mostly an ultimate goal.¹⁸

Most NGO in Garissa combine information on the negative effects of FGM and the anti-FGM law in advocating for the abandonment of the act. Previously, FGM has been associated with lack of formal education, however, our study recorded high numbers of educated women who were circumcised with others willingly participating in the act.

It has been noted that an increased knowledge of the negative health effects can stimulate reflection and critical thinking, leading to reduce the approval of, and eventually to the abandonment of, FGM.⁹

CONCLUSION

From our study findings, anti-FGM programs in Garissa county have had a measure of success in their activity as indicated by the reduction in the prevalence of FGM in the county from 99% to 62%. Similarly, there has been an increase in level of awareness of the anti-FGM law as well as negative effects of FGM on the health of women. This awareness has resulted in change of attitude of area residents towards practice of FGM by many not supporting it. On the other hand, introduction of the anti-FGM law has resulted in the underground perpetration of the act through medicalization of FGM as well as reduction in the age at which the act is performed.

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