PRACTICE OF FEMALE GENITAL MUTILATION AMONG WOMEN OF REPRODUCTIVE AGE IN KAJIADO COUNTY, KENYA

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DECLARATION

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

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DEDICATION

To my family for their motivational words, prayers, humble time and support.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABBREVIATIONS AND ACRONYMS

CSAK Centre for the Study of Adolescence Kenya

EDHS Ethiopia Demographic and House Survey

FGM	Female Genital Mutilation
FIDA	The Federation of Women Lawyers Kenya
HHs	Households
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immuno-Deficiency Syndrome
KDHS	Kenya Demographic and Household Survey
KII	Key Informant Interview
KNBS	Kenya National Bureau of Statistics
MDGs	Millennium Developments Goals
MMR	Maternal Mortality Rate
NCPD	National Council for Population and Development
NACOSTI	National Commission Of Science, Technology and Innovation
SDGs	Sustainable Development Goals
SPSS	Statistical Package for Social Sciences
UK	United Kingdom
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children Education Funds
WHO	World Health Organization

DEFINITION OF OPERATIONAL TERMS

Cultural factors: Refers to established values, beliefs, traditions and laws of a community.

FGM Practice: For purposes of this study, FGM practice mean whether the women of reproductive age have undergone partial or complete genital mutilation.

Illiteracy level: It refers to lack of ability (especially knowledge or education) to do something.

Legal factors: The term means edicts and policies set aside to protect the rights of the women from cultural exploitation, to assess the awareness level of the community on these rights, and to determine the level of compliance with these acts among the community members and the local authority and leadership

Religion: It refers to a structured collection of cultural systems, beliefs and world views relating humanity to an order of existence.

Excision: Removing totally or partially the labia minora and clitoris, with or without labia majora excision.

Infibulation: This is vaginal opening narrowing by the creating a covering seal. The seal is as a result of cutting and repositioning the labia majora or labia minora, sometimes by stitching, with or without clitoris removal.

ABSTRACT

Although female genital mutilation in Kenya is outlawed and there are strict legislations that prohibit the practice, some communities still practice it. This is attributed to ethnic

and cultural diversity across the ethnic groups as it is used as a rite of passage. This research's aim was to investigate the female genital mutilation practice among women of reproductive age in Mashuuru Sub- County, Kajiado County. The study specific objectives were; to determine the proportion of women who have undergone female genital mutilation, identify socio-cultural factors and the legal factors associated with FGM practice. The study adopted a descriptive cross-sectional study design. Both probability and no-probability sampling methods were employed. Two hundred and forty-six (246) women of reproductive age were systematically sampled from Kenyawa-Poka ward of Mashuuru sub-county at a predetermined interval of 4. Interview schedules and questionnaires were used for data collection. All required approvals from relevant authorities and informed consent from research participants was obtained. Descriptive data was analyzed using Statistical Package for Social Sciences version 22.0 with the aid of Microsoft Excel program to generate frequency tables, graphs and pie-charts. Qualitative results from key informants were triangulated with quantitative data as verbatim quotes. In Calculating inferential statistics,Chi-square tests were done at confidence interval of 95% with ≤ 0.05 p-values deemed significant to test variables' connection . The results of this study revealed that 68.6% of women of reproductive age in Kajiado County had undergone FGM. The study concludes that majority of demographic, socio-cultural and legal factors were significantly associated with practice of female genital mutilation. Approximately seven out of ten women of reproductive age in the county had undergone female genital mutilation which is above the national average. The study recommends that the county government of Kajiado together with other stakeholders should advocate for an alternative rite of passage, scale up sensitization campaigns and involve men in demystifying the cultural beliefs attached to FGM practice. The law enforcement officers at the community level should create anonymous channels for reporting female circumcision exercises.

CHAPTER ONE: INTRODUCTION

1.1 Background of the Study

World Health Organization (WHO) defines female genital mutilation (FGM) as all procedures involving total or partial removal of the external female genitalia or any other injury to the female genital organs for non-medical reasons (WHO, 2016). There are four types of FGM according to WHO: "Type I - clitoridectomy, involves partial or total removal of the clitoris and/or the prepuce; Type II - excision, involves partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora; Type III - infibulation, involves narrowing of the vaginal orifice with creation of a covering seal by cutting and positioning the labia minora and/or the labia majora, with or without excision of the clitoris; and Type IV - other, involves all other harmful procedures to the female genitalia for non-medical purposes, such as pricking, piercing, incising, scraping, and cauterization" (WHO, 2016; Berg, Denison & Fretheim, 2010).

It is a form of cultural practice that is harmful as well as violating women and girls' human rights. In Africa, Middle East and Asia, approximately, over 200 million females living today have been through some kind of FGM (UNICEF, 2016). Infibulation is the most common type of FGM done to an estimated 20% of affected women in Africa (Seketian, 2015). In Ethiopia and Nigeria, 65% and 50% women of women of reproductive age have undergone FGM respectively (WHO, 2016). Notwithstanding efforts to eradicating it, more than 3 million females are likely to undergo the practice annually. After failure to attain Millennium Development Goal (MDG) on eradication of FGM, the matter was still incorporated in the sustainable development goals (SDG). A sustainable development goal 5 (SDG 5), target number three on elimination of forced

marriages and genital mutilation geared towards the achievement of gender equality and empowering all girls and women by Vision 2030 (UN Women, 2017).

In the past decades, worldwide attention concerning physical harm related to FGM has been drawn by medical organizations and several national, regional and international humanitarian organizations (Bosch, 2011). They are against FGM as an unnecessary medical practice with potentially life-threatening complications. For example, United Nations and European Union Spotlight Initiative is a non-governmental organization focusing on harmful practices like gender-based, sexual and domestic violence. FGM is internationally recognized as women's human rights violation (WHO, 2018). In 2016, UNICEF, WHO and UNFPA jointly initiated FGM health complications management guidelines (WHO, 2018). Several nations such as United Kingdom and Sweden banned even consented FGM. In Sweden, external female genital organs operation meant to give any permanent changes of mutilate them regardless of with or without permission by the concerned parties is forbidden (Seketian, 2015).

According to the Government of Kenya Report 2013, Kenya has been classified in Group 2, where only certain ethnic groups practice FGM and FGM prevalence is intermediate, at rates that vary (UNICEF, 2014). The rates are highest in North-Eastern at more than 97%, 35.8% in Rift Valley and 0.8% in Western Kenya. The diverse ethnic communities reflect the regional difference in individual communities; highest among Somali (97%), Kisii (96.1%), Maasai (73.2%) and lowest among Turkana, Kamba and Kikuyu while rarely practiced in Luo and Luhya (less than 1%). Therefore, it is evident that despite the efforts put to curb FGM, such as enactment and enforcement of

legislations against this practice, some of the regions are still ignorant to the new measures put to curb it.

1.2 Problem Statement

A considerable amount of efforts have been put across to reduce FGM prevalence in both developing and developed nations that include but not limited to: ant-FGM legal factors and policies, awareness campaigns, creating shelter/safe houses, educational programs to address the issue among others (Gathara *et al.,* 2017). However, nearly 50 percent of women of reproductive age in Africa have undergone FGM. In Kenya, some communities still record high FGM prevalence rate of almost 90 percent (Centre for the Study of Adolescence Kenya [CSAK], 2017). Majority of inhabitants of Kajiado County are the Maasai whose prevalence of FGM stood at 73.2% (Seketian, 2015).

Female genital mutilation (FGM) has significant high-risk public health repercussions varying from immediate to long-term problems. The procedure can cause injury to nearby genital tissue, open sores in the genital region, inability to urinate, tetanus or sepsis, bleeding, shock, severe pain among other problems (Seketian, 2015). Long-term consequences include need for later surgeries, complications at child birth and death of newborns, cysts, urinary tract infections and intermittent bladder. These effects may force women to continue suffering thus leading to increased maternal mortality rates (MMR) if the practice is not tamed. There is higher MMR in regions where the practice is still prevalent (KDHS, 2014). The practice has also led to significant school dropouts and adolescent pregnancies due to preparation for early marriages (NCPD, 2016).

1.3 Justification

The practice of FGM in Kajiado County is still significantly high. Mashuuru sub-county where the study was conducted is made up of Kaputiei sub-tribe of the Maasai, who are known to practice FGM (Kajiado County Report, 2017). Despite increased efforts in creating community awareness on the practice's effects, it is still practiced adamantly through adoption of different approaches to keep the public unaware. Although there have been a few studies previously conducted in Kajiado on FGM practice, they have attributed FGM persistence to the culture of the Maasai community. There is a need for further exploration of the reasons for persistent practice in order to promote women's empowerment in the Maasai community as anticipated in the sustainable goal 5 (empower all girls and women and achieve gender equality). This would reduce deaths related to the practice and enhance enforcement of the laws aiming at eradicating the practice of FGM. Therefore, this is an issue that requires a thorough scholarly investigation on the factors driving FGM practice in the sub-county of Mashuuru.

1.4 Study Research Questions

i. What are the socio-demographic factors associated with practice of FGM among women of reproductive age in Mashuuru sub-county?
ii. What is the proportion of reproductive age women who have undergone FGM in Mashuuru sub-county?
iii. What are the socio-cultural factors that influence FGM practice among reproductive age women in Mashuuru sub-county?
iv. What is the role of legal factors on practice of FGM among reproductive age women in Mashuuru sub-county?

1.5 Study Hypotheses

H_{01}: There is no significant statistical relationship between demographic, socio-cultural and legal factorsand practice of FGM among women of reproductive age in Mashuuru sub-county.

1.6 Study Objectives

1.6.1 Main Objective

To explore the driving forces associated with practice of female genital mutilation among females of reproductive age in Mashuuru Sub-county, Kajiado County.

1.6.2 Study Specific Objectives

i. To identify socio-demographic factors associated with FGM practice among women of reproductive age in Mashuuru sub-county.
ii. To determine the proportion of reproductive age women who have undergone FGM in Mashuuru sub-county.
iii. To identify the socio-cultural factors that influence FGM practice among reproductive age women in Mashuuru sub-county.
iv. To assess the influence of legal factors on FGM practice among reproductive age women in Mashuuru sub-county.

1.7 Study Delimitation and Limitation

Delimitation in research mainly refers to choices made for the study by the researcher under his or her control (Mugenda & Mugenda, 2012). The conceptual delimitation in this research was the problem choice itself and it was important to note that there existed other related and similar problems that could have been chosen to study on, but the

researcher only concentrated on drivers of FGM practices among women in the sub-county of Mashuuru. The geographic delimitation was the study excluded sub-counties such as Kajiado West, Kajiado South, Kajiado Central and Kajiado North where FGM is practiced due to time constraints. The social and demographic delimitation included the study was restricted to residents of Mashuuru sub-county.

According to Wanjohi (2014), a limitation refers to "anything beyond the researcher's ability to control that may affect the study's internal validity". The study encountered some limitations. They included; lack of corporation among the study respondents because of sensitivity of the topic of the study. Thus, for this reason, the respondents might have feared taking part in the study, more especially parents who may think analysis of the information they provided would be used against them. To overcome this, the study purpose was explained by the researcher, which was academic to all the respondents and consent was obtained from the respondents by creating an understanding with them. Geographic limitation was encountered due to the vastness of the study area which was a challenge for the researcher in collecting data in all anticipated parts (villages/blocks). In overcoming this, he purposively selected an area with the community where FGM is highly practiced (Kaptiei subtribe of the Maasai community).

1.8 Conceptual Framework

This is a product that is written or visual, indicating the concepts, key variables or factors and the presumed relation among them (Miles & Huberman, 2012). There are three key factors that influence practices of FGM among reproductive age women in Kenya. Figure

1.1 represents the conceptual framework of the association between factors and FGM practice.

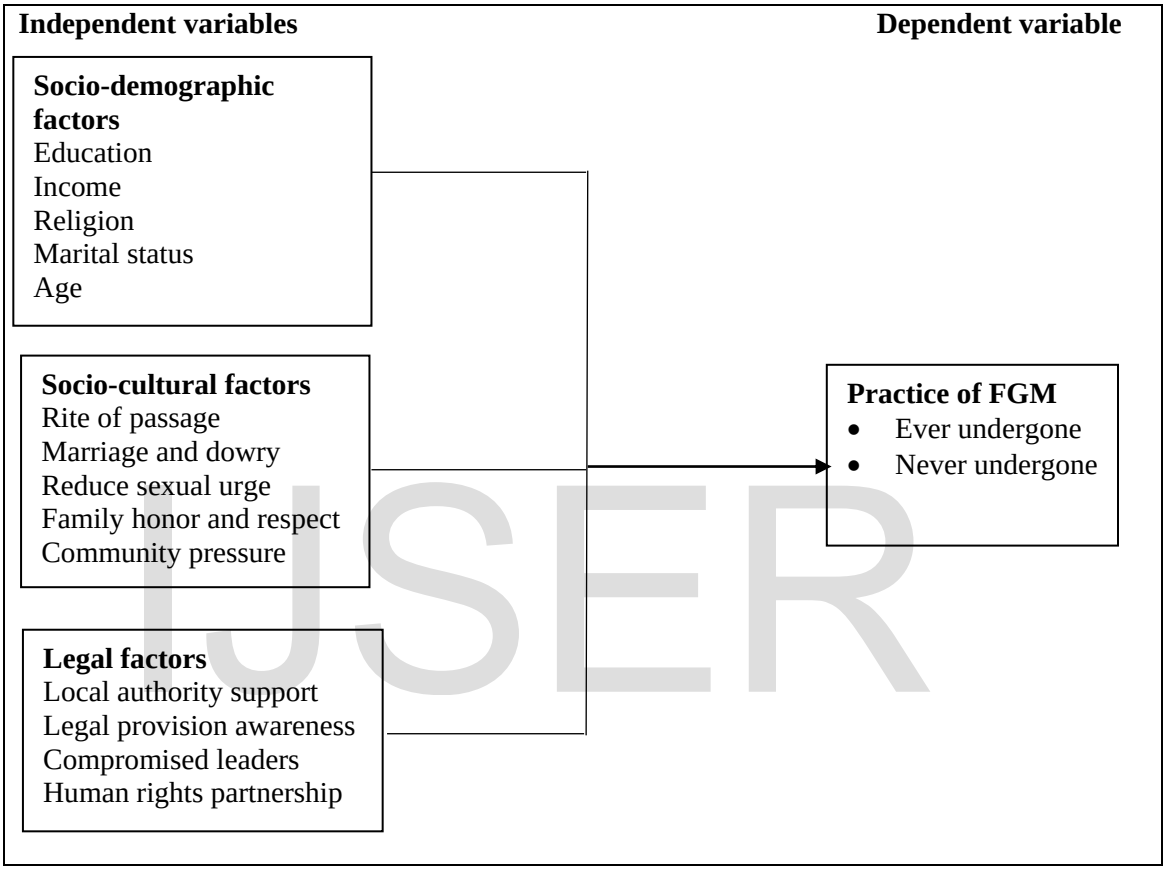

Figure 1.1: Conceptual framework

Source: Adopted and modified from literature review, (2020)

From Figure 1.1, the study dependent variable was FGM practice among women. The indicators of the FGM practices that were of interest to the study was whether the respondent had undergone partial or complete genital mutilation/cut.

Socio-demographic factors, an independent variable was measured through: household income, education level of reproductive women, marital status, religion and age.

Socio-cultural factors, was another independent variable that was examined to show whether it had an influence on FGM practice. Among the key indicators of culture included: In some communities FGM could be a passage rite, it could also be a requirement for one to get married in some communities, it could be a sign of ones respect in his/her community and it could also be a link of an individual in communal activities. Other indicators of socio-cultural factors are payment of bride price and religion.

The other independent variable was influence of legal factors on FGM practices. This was measured using level of compliance of human rights, creation of partnership among all stakeholders so as to train girls and women on dangers associated with FGM practice.

1.9 Significance of the Study

The study provides insights and assessment of the drivers of FGM practice among reproductive age women and girls whose rights could be violated for material gain such as dowry received by their parents. Additionally, the study provides findings on the health issues that are related to female genital mutilation. This reveals the major contributing factors leading to female genital mutilation and associated health problems. This enables the relevant organizations to create interventional measures to reduce the practice of FGM. On the other hand, these findings help policy makers in the area of FGM practices in developing nations. The study findings are crucial to other researchers and scholars since they add to the knowledge base and existing literature for reference.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This section is a presentation of systematic review of literature on the driving forces of female genital mutilation practices among women. Literature sources include published reports, journal articles/periodicals, books, web resources and other grey literature. This chapter covers theoretical review and empirical review organized into themes and sub-themes adapted from key study objectives, summary of literature review with isolated gaps.

2.2 Theoretical Review

The study adopted Feminist theory, Anthropologist's theory and Cultural relativism that discourage female discrimination in a society. Feminist theories are the most noteworthy used theories in analysis of men and women' status in society while trying to convey women's subordination change as a result of gender inequalities in patriarchal societies. In the FGM context, it is argued by feminists from the West that the practice builds inequalities and underpins domination of men over women (Hosken, 1981). Rigmore & Denison (2012), also assert that it is done for sexuality control in female since mutilation of the clitoris weakens the women sexual desires. The Western feminist view claimed that this cultural practice must be proscribed and condemned because it violates the women's rights that must be handled as universal women's rights. Feminists from Africa further condemn the practice but negate to consider. They direct their protesting against Western feminist FGM framing, criticize their neo-colonial and colonial disposition and choose words like torture, brutal, barbaric and many more (Wade, 2006). They argue that there cannot be a separation between African women's bodies and their cultural contexts

thus pointing at the Western feminist perspectives' failure (Thiam, 1995). These cross-cultural clashes make the FGM theoretical frameworks not to be holistic since every view put into consideration lack essential factors to fully understand the FGM phenomenon. Hence, a theoretical framework aimed to bring together the complex FGM puzzle pieces is crucial in allowing a better FGM understanding particularly in the migration context.

2.2.1 Feminist Theories

The feminists' debate over rights of women as human rights presents complex inquiries on economic, social, political and cultural conditions. In developing countries, females face challenges of maintaining their tradition in the era of constantly changing social status as a result of culture change and globalization. When tradition maintenance includes violation of human, the obstacles become a threat to life, and FGM is one of the traditions.

According to Barbara (2008), feminists work tirelessly towards FGM elimination as a practice that is harmful and promote integration and empowerment of women in the societies. The anthropologists and feminist's arguments go hand in hand towards altering other cultures' discriminatory practices.

2.2.2 Anthropologist's Theory

Drawing from ethnological record, individuals not in the culture of FGM, such as anthropologist Gruenbaum (2001), concludes that such harmful practice continuation is against values of humans. Even if all anthropologists are agreement that culture includes the learned ways of being symbolic, adapting, behaving, shared and learned, there exists numerous perspectives regarding FGM. Gordon (1995) believes that tradition and ought

to be interpreted as a lifestyle that are closely intertwined with the cultural and social contexts.

Viewing it from the point of human rights, it is a practice that is not safe and not justified that violates the integrity of the body; they believed that some anthropologists of feminists assert that it is a gender-based discrimination inhumane form capitalizing on the women subjugation (Baron and Denmark, 2006).

In some communities, FGM tend to be an important part of ethnic, religious and cultural identity (Althaus, 1997). Althaus strongly leans towards the interpretation of FGM as human rights violation. Banda (2002) suggests that going away from human rights idea being a "one size fits all" scenario prevents it from being simply a soft law with minimal influence.

2.2.3 Cultural Relativism

The suggestion agrees with pluralism/ relativity cultural issue, human rights equally might be regarded as relative as in various cultural contexts. "Cultural relativism doesn't mean ethical relativism and that an ethics understanding that is universal" (Macklin, 1999). People's upbringing, social encounters, cultural context, religious beliefs and other factors determine the way we understand wrong and right, and good and bad. Therefore, without foresaking the cultural relativity idea, one cannot claim the moral universality.

FGM practice is morally and ethically wrong for being risk to health and individuals from other cultural contexts are not expected to have a similar practice. Some habits, for instance cosmetic plastic surgery in European countries, could be seen as immoral by some other societies. Gruenbaum (1996) suggested that in order to get to a dialogue that

is constructive, its crucial to have a good understanding together with the societies practicing it and the believe in any cultural behavior instead of dismissing FGM automatically as barbaric and backward. Grunebaum (1982) posits that "measures against FGM don't bring seen results as the goodness of preserving the daughter's marriage capability is unnoticed."

WHO (1998) showed that a large number of men in communities practicing FGM don't get any satisfaction in having sex with women who have undergone the cut hence, mostly took on wives or mistresses who are uncircumcised. The main criticism against FGM is that the practice does not have medical necessity/value. As a feminist anthropologist Grunebaum explained further two dilemmas she encountered: Being involved as an activist without ignoring the cultures of others and addressing a tradition where women are the ones inflicting damage on their fellow women.

In reconciling the issues Grunbaum makes use of a "contested culture" approach which emphasizes on inherent contradictions of culture through "gender, age groups, different classes' viewpoints, debates and other social divisions". Grunbaum (1982) also noted that FGM neither destroys nor affects sexuality of females. Grunbaum demonstrates that in Africa, FGM's most significant reasons cited is religion. She succeeded in demonstrating that factors such as sexuality, rituals, region, marriage, and economic development tend to give explanation on FGM prevalence whereby some have a direct relation to gender while others have not.

Gordon (1991) and Gruenbaum (1982) give two anthropological perspectives on FGM practice. Gruenbaum looks at marriage, ritual and patriarchy as reasons for practicing

while Gordon explores the procedures in the context of culture. They tend to provide a deeper understanding for the FGM prevalence and practice duration. There is a correlation between patriarchy and FGM, though an occasional explanation for the enduring FGM prevalence is not adequate (Gruenbaum, 2001). The economic and social subordination that children and women stick to in patriarchal societies are the necessary conditions for this practice's perpetuation.

Gordon (1991) study on FGM looks at it from a cultural context. He says that genitalia mutilation is a passage rite serving as a graduation marker adulthood, where female and male similarity is eliminated, hence confirming a sex ritual differentiation. The ultimate explanation for the practice is that it is serving a symbol of social puberty that signifies powerfully the little girl's future passage into sexuality. Thus, the study attempted to uncover the driving forces of the practice among reproductive age women in the Sub-county of Mashuuru in the view of the foregoing cultural and social debate.

2.3 Empirical Review of Literature

The section reviews the existing research studies focusing on the driving forces FGM practices among women. This part of the study will be based on to the study objectives.

2.3.1 Influence of Socio-demographic Factors on Practice of FGM among Women

In a study conducted by Fikrie (2010) on factors associated with perceived FGM continuation in Ethiopia, secondary data obtained from the Health Survey of 2005 Ethiopian Demographics was used. During the survey, it was revealed that participants with primary level education were 0.65 times less probable of supporting. Compared to with participants with no education, the likelihood of supporting FGM by those with higher education was 0.14 times more (Seketian, 2015). Those who were knowledgeable

on avoidance of HIV/AIDS are 0.60 times more unlikely to support continuation of FGM when comparing to their counterparts.

Women with lower educational attainment have less awareness about harmful nature of FGM. The non-governmental and governmental organizations ought to focus on intensive awareness raising trainings and informal education programs via diverse social groups such as Edir and holidays celebrations. The most common anti–FGM initiatives in the Kisii community are FGM awareness and education (Moranga, 2014). FGM awareness and education in the community targets the girls, parents and the traditional circumcisers themselves. Education is an empowerment tool to young girls targeted by FGM practices to have courage of questioning the practice and oppose it (Ongong'a, 2013).

The FGM practice is in most cases conducted in infancy and early childhood. In most communities, female genital mutilation is done to girls at their early teenage years. A study done among young Somalis in Norway, it was revealed that age was significantly associated with female genital mutilation (Mbanya *et al.*, 2018). In Northern Ghana, majority of the participants interviewed were 15-24 years old (Sakeah *et al*., 2018). In Egypt, women of reproductive age interviewed on FGM had a mean age of 31 years (Mohammed *et al*., 2018) while in Nakuru, Kenya most respondents were aged 30-34 years (Esho et al., 2017).

The FGM practice has been considered as a cultural art that has deep roots in various traditional and religious foundations. For instance, according to studies in the world, Muslims practice FGM more times compared to other denominations such as Christians (Duivenbode & Padela, 2019; Mohammed *et al*., 2018). Most women of reproductive age

practicing FGM in Egypt are Muslims. In Nigeria, religion plays a significant role in influencing female genital mutilation practice (Titilayo *et al.,* 2018). According to a study done in sub-Saharan African countries, regarding effects religion has FGM, it was noted that traditional African religion was the predominant religion (Beller and Kroger, 2018).

In some communities, girls undergo female genital mutilation as a precursor and preparation to get into marriage. This explains the cases of forced marriages among communities practicing the vice. In Ethiopia, girls who have undergone FGM are awaited in marriage (Gabremicheal *et al*., 2018). According to a study done among Somali women in Finland, it was concluded that married women or those in civil unions had a higher probability of undergoing the cut as compared to their unmarried counterparts (Koukkula *et al.,* 2016). In Sudan, it was revealed that ninety five per cent of women who were married had undergone some kind of FGM (Elduma, 2018). In a study done in Ethiopia, majority of women interviewed on female genital mutilation practice were married (Oljira *et al*., 2016). Another research done in Eastern Ethiopia among young adult women on female genital mutilation noted that majority of the participants were not married (Gebremariam *et al*., 2016).

The level of income variedly affects the practice of FGM at significant intervals. According to a study on diagnosis and prevention of FGM in Kenya, it was cited that majority of the participants had no income at all (Kimani & Oknondo, 2020). Income is a significant factor that facilitate practice of female genital mutilation in Northwest Ethiopia (Melese *et al*., 2020). In their study Degefa and others (2017) revealed that most people who practiced female genital mutilation earned an average monthly income ranging 4400 to 17300 Kenyan shillings. In another study done in Saudi Arabia on FGM

among women, it was concluded that the level of income this practice (Rouzi *et al.*, 2020).

2.3.3 Socio-cultural beliefs' Influence on practice of FGM among Women

A study by Tou and Inungu (2012) on FGM in Burkina Faso found that culture is a determinant of FGM practice. For instance, the study revealed that as compared to women from the other ethnic groups such as Bobo, Dioula, Dagara and others, women from Gourmatche ethnicity group not likely to undergo FGM. The study recommended that awareness-raising education and programs that empower the girl child should be put into place.

A study carried out by Waritay (2013) found there is great perception that only women who get circumcised are married. The study further revealed that uncircumcised women ought to undergo the cut prior to marriage or at childbirth. The study also found that in some communities, it is believed that uncut women won't get married and attract a dowry. According to a WHO (2012) report which showed that the practice's cultural importance is ensuring the girl-child's marriageability and chastity preservation. The practice's roots go deeper into the belief and psychology of an individual in a value system and sense of loyalty to family.

The study by Moranga (2014) on FGM practice determinants in Nyamira County, Kenya, adopted descriptive survey approach to research. The researcher used 20 households (sample size), a representative of either 1 adult female or male. Questionnaire was used in data gathering. It was found out that respecting cultural beliefs is a key explanation for FGM practice and acquiring more dowry payment. Additionally, circumcision of females

is an integral part of the culture and lifestyle of the Gusii people, with a wide belief that the practice tends to reduce women's sexual urge. With its practice, the Kisii ensure that promiscuity in their women is avoided.

In a survey that was carried out by Ondiek (2010) on the role of parents on FGM practices found that family honour was a key determinant in community promoting its practice. The study further revealed that matters of circumcision decision making, most girls are not involved. Grandmothers, aunts and mothers and other relatives mainly decided whether the girls should or should not undergo through the practice of circumcised with most influential persons being grandmothers and mothers in the decision-making process.

Additionally, culture plays an important role in the persistent practice of FGM amongst community members. Awareness and intensive education initiatives are legal tools that protect girls from FGM as they are the most affected in the communities. Women are found to be enjoyable to their partners and higher hygiene levels can still be maintained without excising them (Davis, 2011). To put an end to FGM practice for religion's sake, religious leaders ought to stand firm against the practice. Otherwise religion would consider it as a requirement with community members fulfilling their religious duty even with its dangers (Macfarlane & Dorkenoo 2015).

The results from a research in Burkina Faso noted that a high FGM proportion was seen more among Muslims and few cases among Christians (Tou & Inungu, 2012). The study further revealed that women proportion with uncircumcised girl children was high among Christians, followed by Animist and then Muslims. Additionally, unlike Catholic women,

Animist were more likely to have undergone FGM, though there was no statistically significant difference. This implies that, religion could be a contribution factor of FGM practices among women and girls.

A conceptual study by Setegn *et al.* (2015) indicated that Muslim women had higher chances of undergoing FGM compared to Orthodox women. On the other hand, in experiencing FGM, the odds were lower among daughters of Protestant women. The study concluded that individual and religious factors played major roles in FGM continuation and its existence. The study recommended that, adopting of integrated and targeted interventions that involve religious leaders in eliminating FGM in spot clusters with high prevalence.

2.3.4 Influence of legal factors on practice of FGM among women

Study findings by Tou and Inungu (2012) showed that "when using the likelihood of having a circumcised daughter as the outcome of interest, the model showed that women who lived in the Center-East region in Burkina Faso, where FGM was highly practiced reported that they received social support from community leaders to circumcise their girls". It was concluded that practice of FGM is high in Burkina Faso, despite the active involvement by the government in fighting against FGM.

Another study carried out by Bosibori (2014) revealed that even though legal provisions existed against the practice, they were not implemented. There are new approaches adopted by those practicing it to avoid penalties in the legal provisions. The study further found that local leaders may be compromised to allow FGM practices to be carried out at night. The study further found out that the circumciser was invited by families to their

homes to be concealed from any investigator of FGM incidences, showing that they knew this was against the law.

The Kenyan Constitution (2010) outlaws the FGM practice. It is stated in Section 44 (1) that each individual person has the right of using the language and participating in the cultural life of their choice. However individuals are not given the right of compelling others to go through these practices. Section 44 (3) "A person shall not compel another person to undergo, observe or perform any cultural practice or rite". Section 53 (1) states "that every child has a right to be protected from hazardous or exploitative labour, punishment and inhuman treatment, all forms of violence, harmful cultural practices, neglect and abuse." Section 55, subsection (d) engages affirmative action in protecting youths from exploitative and harmful cultural practices like FGM and early marriages.

In 2001, the Kenyan Parliament enacted Children Act (No. 8 of 2001) which criminalized practice of FGM on children less than 18 years. The Act's Section 14 gives provision that "no person shall subject a child to early marriage, female circumcision or other traditional practices, customs or cultural rites that are likely to affect negatively the child's life, psychological or physical or dignity, social welfare or health development." Section 18 of the Act states that "any conviction for FGM-related offences carries a 12 months imprisonment and/or a fine not exceeding Kshs 50,000 as penalty." To these, Section 234, 250 and 251 provisions of the Penal Code criminalizing grievous bodily harm may be added.

The law is limited as it protects girls to 17 years, it doesn't protect adult women against forceful circumcision. The Federation of Women Lawyers Kenya, FIDA – Kenya (2009)

suggested the Children's Act to be reviewed by involving persons at the community level creating sustainable ownership throughout the process and pay attention to sections14 and 18.

2.4 Literature summary and gaps

The study has reviewed the existing studies on influence of socio-demographic factors on practice of FGM among women. These included (Fikrie, 2010; Moranga, 2014; Seketian, 2015; Waritay & Wilson, 2013) among others. For instances, Moranga (2014) revealed there are few or no training programmes to educate women on dangers of FGM practice among the Gusii community.

The study also endeavored to examine the socio-cultural factors' influence on practice of FGM among women. Some of the studies that were considered relevant in the study include; (Tou & Inungu, 2012; Abdi, 2014; Waritay, 2013; Ondiek, 2010) among others. According to Waritay (2013), there is great perception in some communities that only women who get circumcised are married. However, the study does not make reference to cross-cultural marriages. Another study conducted by Abdi (2014) established that FGM is a socio-cultural tradition, always influenced by stigma threat and pressure of community. The study further revealed that there is the practice commercialization in which if the girl has gone through FGM, the family receives a higher bride price. This study does elaborate the health impacts that the practice of FGM may have to the women pursuing it.

A handful studies have been considered on the effects the legal factors have on FGM practice. They include: (Bosibori, 2014; The Kenyan Constitution, 2010; Kenya Sexual Offences Act, 2006) among other articles. According to Tou and Inungu (2012), "when

using the likelihood of having a circumcised daughter as the outcome of interest, women who lived in the Center-East region, where FGM was highly practiced reported that they receive social support from community leaders to circumcise their daughters." The study rarely specified the category of community leaders that support women to take their daughters through the practice of FGM in some communities.

According to the reviewed literature, there is no published study on driving forces of FGM practices among reproductive age women in the Sub-county of Mashuuru. Therefore, the current study findings would form a basis data on this social problem. Further, through its findings the researcher would identify other areas of concern which may be of importance and have not been addressed in the study due to time constraint.

CHAPTER THREE: MATERIALS AND METHODS

3.1 Introduction

This chapter presents methodologies applied in this study; “research design, research locale, target group, procedure for sampling and sample size, data collection tools and procedure, validity and reliability of the tools, analysis of data, and ethical and logistical considerations.”

3.2 Research Design

A descriptive cross-sectional study design was deployed as it gave a large population characteristics description, large samples use and this made the findings significant even with multiple variables analysis (Kumar, 2014). This entailed use of quantitative as well as qualitative data collection approaches. This research design is justified as it gave the researcher to capture the phenomenon as it was presented at a particular point in time.

3.3 Research Variables

3.3.1 Dependent

The practice of FGM by reproductive age women was the predicted variable. Those who had undergone partial or complete genital mutilation were considered to have practiced FGM.

3.3.2 Independent

i. Socio-demographic factors such as household income, education level, religion, age and marital status.
ii. Socio-cultural factors such as demand of girls for marriage in form of dowry, adding beauty to girls, community pressure to undergo FGM and threats of

stigma, circumcised are complete for marriage, rite of passage, reducing sexual urge in women and promoting family honor and respect in the community.

iii. The legal factors included: local authority supporting the practice, awareness of the legal provisions against practice, compromising local leaders, community against government agencies that detain female circumcisers and human rights partnership programs for FGM.

3.4 Locale of the Study

Mashuuru sub-county is located in Kajiado County which is divided into three different areas typographically; Central Broken Ground, Athi Kapiti plains and Rift Valley. These encompasses plains, valleys and volcanic hills. It also borders Machakos and Makueni Counties, along the Nairobi – Mombasa /Railway line. Kajiado County is pre-dominantly a semi-arid region. The main economic activities are pastoralism, crop farming and sand harvesting. The research area is in the Eastern part of Kajiado County. Mashuuru is made up of Kaputiei sub-tribe of the Maasai, who are known to highly practice FGM. The sub-county has two wards, namely: Mashuuru and Kenyawa-poka. Therefore, due to high prevalence of FGM practices among the Kaputiei sub-tribe of the Maasai in Mashuuru Sub-county, the researcher found this location to be the most suitable to conduct the study.

3.5 Study population

It targeted all reproductive age women (15-49 years), residents of Mashuuru sub-county because they were believed to possess the information that was critical to the study. According to KNBS (2019) the total number of women of reproductive age for 2019 in Kajiado County was 1117840. The county has 6 sub-counties namely Kajiado North

(306596), Kajiado Central (161862), Isinya (210473), Mashuru (64214), Kajiado West (182849) and Loitokitok (19184). The research was specifically conducted in Mashuuru sub-county. Mashuuru sub-county has a total population of 64214 with 31131 females. The sub-county has 19247 women of reproductive age (KNBS, 2019).

3.5.1 Inclusion criteria

The inclusion criteria refers to a predefined characteristic set which can be used into identifying subjects to be included in a study (Salkind, 2010). The exclusion and inclusion criteria, forms a framework for eligibility criteria which can be used to rule in or out the research study target population. In order to improve the practicability, the internal and external validity of this study, and proper selection of the study participants were observed keenly. This was important in providing uniformity of the sample size and to minimize confounding the study.

To achieve the anticipated findings of this study, all women of reproductive age were included. The study also included only women who are the residents of Mashuuru Sub-county and those who had stayed in the area for more than ten years.

3.5.2 Exclusion Criteria

The study excluded Women of reproductive age who were sick and thus not able to take part.

3.6 Sampling Techniques and Sample Size

3.6.1 Sampling Techniques

In selecting the research area, Kajiado County was purposively chosen since it is among the counties with high FGM prevalence. Mashuuru sub-county was randomly selected

using folded pieces of paper from among the six sub-counties in Kajiado. There are 2 Wards in Mashuuru sub-county namely; Mashuru Ward and Kenyawa-Poka Ward. The study was specifically done in Kenyawa-Poka Ward which was purposively selected based on high prevalence of FGM practice among the Kaputuei sub-tribe of the Maasai community. Then the researcher further sub-divided the stratum (Ward) into sub-locations. There are 11 sub-locations in Kenyawa Poka Ward. Out of these, 4 sub-locations were randomly selected. The selected sub-locations included Eselenkei, Imbuko, Emali and Masimba. There was a total of 37 villages in the selected sub-locations. The villages were distributed as follows; Eselenkei (7), Imbuko (11), Emali (14) and Masimba (5). The selected sub-locations had a total of 941 Households. The number of households were proportionately sampled from each sub-location. To obtain the women of reproductive age for interviewing, the researcher applied systematic sampling procedure where respondents were picked from households at a predetermined interval of 4. Finally, in cases where there was more than one woman of reproductive age, simple random sampling procedure was applied. For instance, if in a household there are five women of reproductive age, the researcher assigned them random numbers (written on small papers) and then select one number to ensure that there was no bias during selection process.

3.6.2 Study Sample Size Estimation

Frankel and Wallen (2006) defines a sample as a group from which a researcher can obtain data or part of a target population selection". The research employed finite population sample size determination formula (Nasiuma, 2000) to estimate the sample size of participants of practice of FGM among women in Mashuuru sub-county.

$$n = \frac{NC^2}{C^2 + (N-1)e^2}$$

Where; n = sample size,

N=Target Population

e= Error Term (2%)

c = Coefficient of variance (30%)

Study sample size selection was from the total population targeted by the study which includes 19247 reproductive age women.

$$n = \frac{(19247)*(0.3^2)}{(0.3^2)+ 19247(0.02^2)}$$

$$=223$$

To cater for attrition and non-reachable participants, 10% of respondents were added. Therefore, 246 women of reproductive age were obtained from the study area. Sampling of key informants included: the chiefs of the study area, local leaders and representatives from various organizations of human rights working in the area and the community elders and some elderly women above 49 years. Thus, the researcher used a sample of 246 subjects in the study. Table 3.1 shows the sampling frame for the women of reproductive age from sub-location of the study area, Kenyawa-Poka Ward of Mashuuru Sub-county.

Table 3.1: Sampling frame

Selected Sub Locations	**Reproductive age women**	**Kenyawa-Poka Ward Villages**	**HH**	**Selected HH**
Eselenkei	1,551	7	143	37
Imbuko	1,629	11	298	78
Emali	2,786	14	322	84
Masimba	1,332	5	178	47
Total	**7,298**	**37**	**941**	**246**

Source: Field data, 2020

3.7 Data Collection Instruments

Instrument is the general term that researchers use for a measurement device. There are two broad categories of instruments: the participant administered and researcher administered tools. The study used a questionnaire for the general women population and an interview guide for key informants which falls under subject completed instruments.

3.7.1 Questionnaire

Primary data was obtained using a questionnaire. “The questionnaire is considered as the key of a survey research” (Kothari, 2004). Mashuuru Sub-county residents’ questionnaire were prepared by the researcher for quantitative data collection. The questionnaire items included questions that are clos and open-ended. Some questions dependent on the Likert scale. The tool was organized based on social and demographic data of the respondents with separate sections with questions for each objective.

3.7.2 Interview Schedule

Data from key informants chosen to take part in interview sessions was conducted by use of interview schedule. The tool was unstructured while the key informants were being interviewed, the researcher was taking notes. To enable participants to give responses to the questions using their own words and provide detailed account of their experiences, open-ended questions were used.

3.8 Pilot Study

The researcher selected 10% of the sample and carry out a pilot test to ensure everyone understood the questions in a more uniform way. This was done among participants in

the neighboring Kajiado North sub-county, as people in Kajiado represent the various subgroups with similar characteristics that were targeted by the study.

3.8.1 Instrument Reliability

Ogula (2006) defined reliability of an instrument as "the level of a research instrument of producing consistent measures every time it is given to the same group." Mugenda & Mugenda (2003) states that, reliability of the tool used is deemed high if a test administered twice to a subject yield similar or greater scores when administered the second time as with the first administration. The Cronbach's Alpha method was deployed in the assessment of the questionnaire's reliability. This method entailed running the output of analyzed data by the help of SPSS so as to acquire the Cronbach's Alpha value. The tool was considered reliable if the Cronbach's coefficient value lied between 0.7 and 0.9. The Cronbach's Alpha coefficients were as follows; socio-demographic factors (0.734), socio-cultural factors (0.821), legal factors (0.792) and practice of FGM (0.813).

3.8.2 Instrument Validity

According to Ogula (2006) there is predictive, construct and content types of validity. Content validity was employed in ensuring that the instruments are valid. To verify validity of the instruments, experts in the research field (supervisors) were consulted. A review on the statements was done by the researcher with the experts' help to assess extent to which extent they related to the study topic after the tools had been constructed.

The instrument was considered to have validity where the experts agreed. An independent report between experts on tools' validity was filed and basing on the experts' report, the instruments' content validity was improved. In addition, the recommendations

especially restructuring of research questions as given by the peers and research experts were incorporated in the final instruments. This strategy was used in ensuring the instruments measured the variables intended to be measured.

3.9 Data Collection Techniques

Printed structured questionnaires with all closed-ended items were utilized in quantitative data collection. Due to time constraints, the researcher used three research assistants to help in the data collection process. The assistants went to the households to collect data. They created a good rapport with women in order to explain the intended study purpose. Those who agreed to take part in the study were issued with a questionnaire, a clip board and a sharpened pencil and guided accordingly.

During data collection, language barrier may be a problem and for this reason, the research assistants used a community resource person for translation of the items in the tool. Upon completion of filling up of the questionnaire, the research assistant ensured they filled up information fully provided by the participants who took part in the study.

In the same period, the researcher carried out interview sessions with local women leaders, healthcare providers, church elders and area chiefs so as to gather the additional data. After collecting all required data from the study site, the researcher collected all the completed tools from the research assistants, examined them for completeness of being filled up, and then prepared to code and enter them into a computer for analysis by the use of SPSS and Excel sheet.

3.10 Data Analysis

Data description or summarization using descriptive statistics was first done in quantitative data analysis (Nachmias & Segev, 2003). In summarizing quantitative data into figures and tables descriptive statistics was applied, and to present the results using frequency tables and percentages by the help of SPSS Version 22. Chi-square tests were done at confidence interval of 95% with ≤ 0.05 p-values deemed significant to test variables' connection.

Open ended questions from key informants provided qualitative data. Processing of the data was done first by discussing and categorizing each item' responses based on the study objectives. Editing, coding and reporting of data were done based on narrations of the respondents' opinions, experiences and views. For meaning understanding and enhancement, qualitative data analysis and condensation into theme categories was done by summarizing, paraphrasing and editing. They were later triangulated with quantitative data as verbatim quotes from key informants was used to present data after the coded data has been summarized, synthesized and interpreted.

3.11 Legal and Ethical Considerations

The researcher obtained the research approval and authorization from Kenyatta University Graduate School. Upon KU Ethical Review Committee issuing an ethical clearance letter; the researcher made an application for study permit from NACOSTI. Upon receiving the permit, the researcher asked for authoritative letter from the Kajiado County Commissioner before commencing collection of data. He also used the introduction letter at the contact with the respondents so as to seek their consent to take

part in the study. The respondents were given a written informed consent to enable them make an informed decision.

Other considerations included respondents' confidentiality, anonymity and voluntary participation. Participants were made aware of the study purpose for them to decide if the will take part or not. The questionnaires and key informant guides collected from participants were locked in cabinets and only accessed by the research to avoid unauthorized access.

CHAPTER FOUR: RESULTS

4.1 Introduction

In this study, 246 questionnaires were administered to sampled women of reproductive age in Kajiado County to fill in their responses regarding practice of Female Genital Mutilation. After data collection exercise, 229 questionnaires were duly filled and

considered for analysis. This represented a response rate of 93.1%, surpassing the minimum sample size of 223 required for in this study.

4.2 Respondents' Socio-demographic characteristics

Results for participants' socio-demographic characteristics are summarized in Table 4.1.

Table 4.1: Respondents' Socio-demographic characteristics Distribution (n=229)

Variable	Participant response	Number of respondents (N)	%
Age in years	15-19	36	15.7
	20-24	43	18.8
	25-29	59	25.8
	30-34	31	13.5
	35-39	25	10.9
	40-44	15	6.6
	45-49	20	8.7
Religion	Christians	204	89.1
	Muslims	25	10.9
Marital status	Single	62	27.1
	Married	131	57.2
	Divorced/widowed/separated	36	15.7
Highest level of education attained	Informal	44	19.2
	Primary	89	38.9
	Secondary	60	26.2
	Tertiary	36	15.7
Average family monthly income (Kshs)	≤ 10,000	53	23.1
	10,001-20,000	93	40.6
	20,001-30,000	62	27.1
	≥ 30,001	21	9.2

Findings from the research indicated that 59 (25.8%) of the participants interviewed were aged between 25-29 years followed by 43 (18.8%) who were aged between 20-24 years. 25 (10.9%) of the participants were Muslims while majority 204 (89.1%) were Christians. Regarding the respondents' marital status, more than half 131 (57.2%) of them were married followed by 62 (27.1%) who were single.

Concerning respondents' highest level of education attained results showed that 89 (38.9%) had primary education level, 60 (26.2%) who had secondary education level.

Further results revealed that 93 (40.6%) of the respondents earned between Kshs 10.001-20,000 followed by 62 (27.1%) who earned between Kshs 20,001-30,000.

4.2 Female Genital Mutilation (FGM) Practice

4.2.1 Undergone FGM

The researcher attempted to ascertain the proportion of participants who had gone through partial or complete female genital mutilation. Results revealed that most 157 (68.6%) of the respondents revealed that they had undergone FGM while the rest 72 (31.4%) had not participated in FGM. The findings were displayed in Figure 4.1.

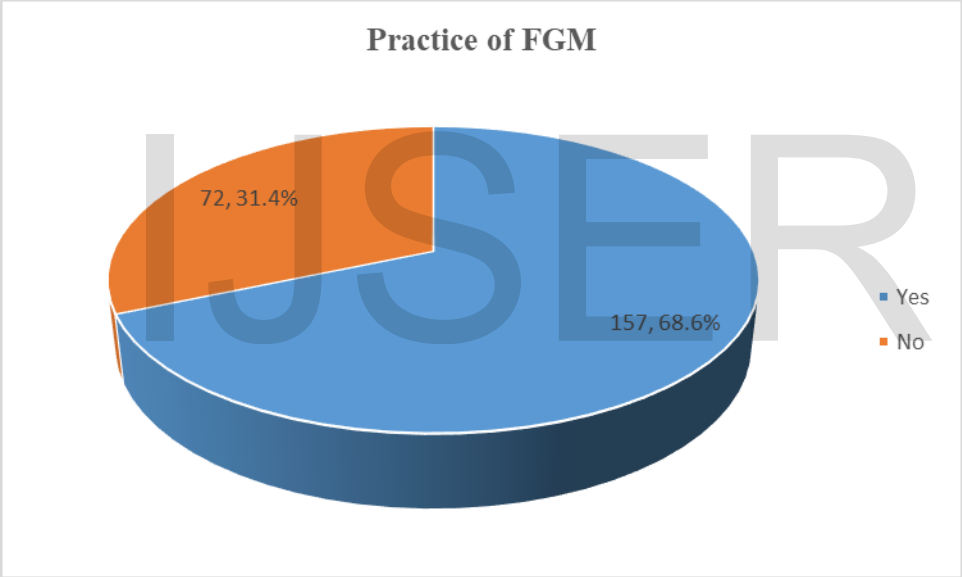

Fig 4.1: Undergone FGM among respondents

4.2.2 Nearly all my age mates underwent FGM

More than half 137 (59.8%) of respondents agreed that nearly all their age mates had undergone FGM followed by 61 (26.6%) who disagreed. The results were shown in Figure 4.2.

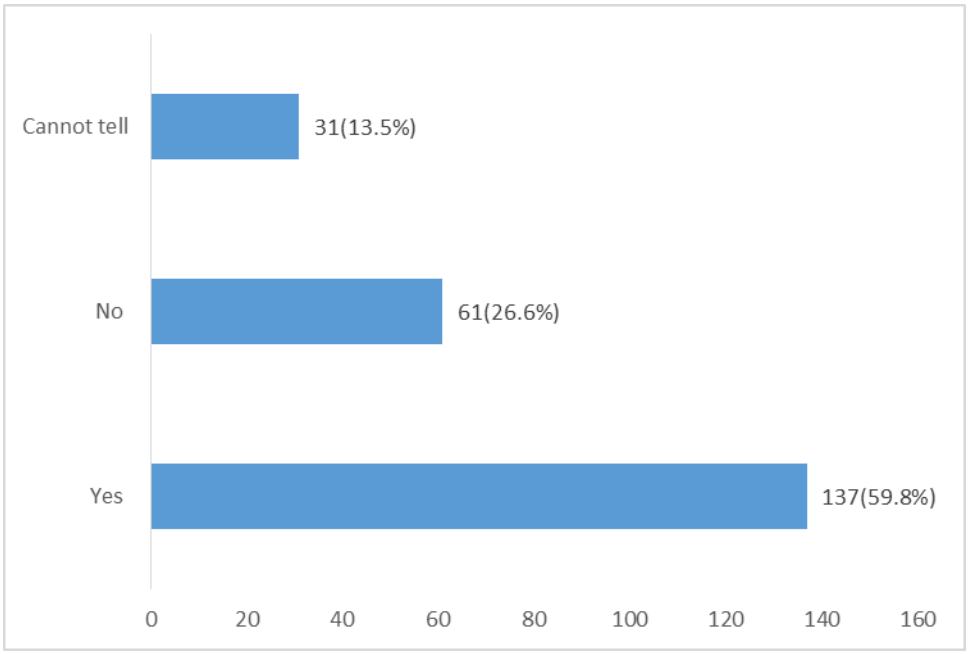

Fig 4.2: Nearly all my age mates have undergone FGM

4.2.3 Recommend your daughters to undergo FGM

The study indicated that slightly more than half 116 (50.7%) of the participants would not recommend their daughters to undergo female genital mutilation followed by 87 (38.0%) who reported that they would recommend. The results were shown in Figure 4.3.

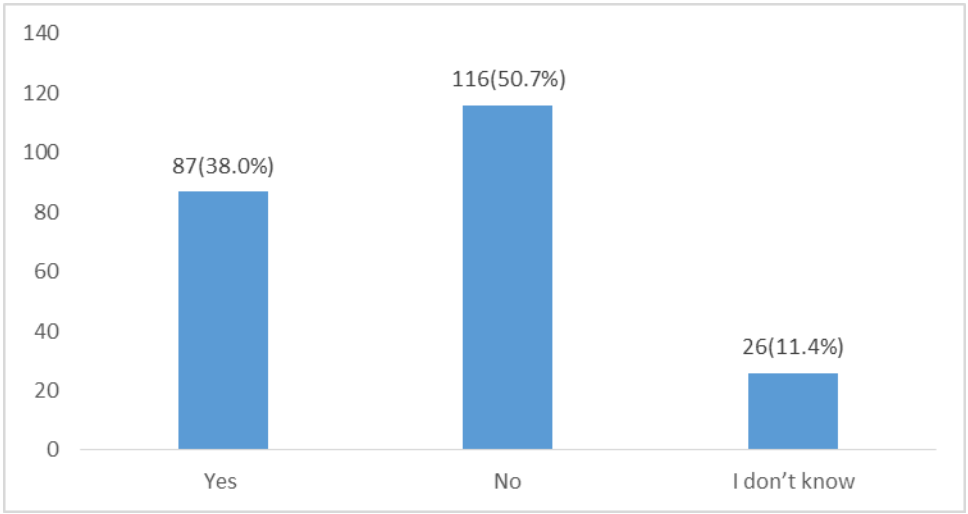

Fig 4.3: Recommending daughters to undergo FGM

4.3 Socio-demographic factors' influence on FGM practice

The researcher sought to explore how social demographic factors influence the practice of FGM among the respondents. Table 4.2. summarizes the results

Table 4.2: Socio-demographic factors associated with practice of Female Genital Mutilation among participants (n=229).

Predictor Variable	Participant response	Undergone FGM		Statistical significance
		Yes (N=157)	No (N=72)	
Age in years	15-19	25(15.9%)	11(15.3%)	χ^2=24.364 df=6 p=0.001***
	20-24	29(18.5%)	14(19.4%)	
	25-29	42(26.7%)	17(23.6%)	
	30-34	21(13.4%)	10(13.9%)	
	35-39	16(10.2%)	9(12.5%)	
	40-44	10(6.4%)	5(6.9%)	
	45-49	14(8.9%)	6(8.3%)	
Religion	Christians	137(87.3%)	67(93.1%)	χ^2=1.704 df=1 p=0.192
	Muslims	20(12.7%)	5(6.9%)	
Marital status	Single	41(26.1%)	21(29.2%)	χ^2=35.808 df=2 p=0.019*
	Married	92(58.6%)	39(54.2%)	
	Divorced/widowed/ separated	24(15.3%)	12(16.7%)	
Highest education level	Informal	36(22.9%)	8(11.1%)	χ^2=23.244 df=3 p=0.023*
	Primary	63(40.1%)	26(36.1%)	
	Secondary	33(21.0%)	27(37.5%)	
	Tertiary	25(15.9%)	11(15.3%)	
Average family	≤ 10,000	28(17.8%)	25(34.7%)	χ^2=14.214 df=3
	10,001-20,000	73(46.5%)	20(27.8%)	

monthly income (Kshs)	20,001-30,000	44(28.0%)	18(25.0%)	p=0.061†
	≥ 30,001	12(7.6%)	9(12.5%)	

***p<0.001; **p<0.01; *p<0.05; †p<0.1

Results reported that 42 (26.7%) of the respondents who were 25-29 years of age had undergone female genital mutilation. Age and undergoing female genital mutilation had a statistically significant relation (*p*=0.001). Majority 137 (87.3%) of the respondents who were Christians reported to have undergone female genital mutilation. Religion and undergoing female genital mutilation did not have any statistical significant connection (*p*=0.192).

On the marital status, more than half 92 (58.6%) of the respondents who were married had undergone female genital mutilation. Marital status and undergoing female genital mutilation had a significant statistical connection (*p*=0.019). A church elder, who was a key informant participant said;

> "*As a church we have indeed tried to sensitize our members on the dangers of FGM. Unfortunately, most of the people here still go ahead and practice it even after the efforts from the government and other non-governmental organizations. I think to my understanding culture and beliefs are the main reasons for persistent practice since parents' belief that when a girl has undergone the vice she is now ripe for marriage and thus can fetch more dowry. We need to continue to educate the parents not to force their girls to undergo FGM and seek for an alternative rite of passage...*"

Less than half of the participants 63 (40.1%) who had attained primary level of education had undergone female genital mutilation. The highest education level achieved and undergoing female genital mutilation related statistically significant (*p*=0.023). Additionally, findings indicated that slightly less than half 73 (46.5%) of the participants who earned between Kshs 10,001-20,000 had undergone female genital mutilation.

However, there was no statistical association between average family monthly income and undergoing female genital mutilation (p=0.061).

4.4 Socio-cultural factors

4.4.1 Socio-cultural characteristics of respondents

The research aspired to assess the socio-cultural characteristics of the participants. Table 4.3. summarizes the results

Table 4.3: Distribution of socio-cultural factors among participants (n=229)

Variable	Participant response	Number of respondents (N)	%
FGM increases the demand of girls for marriage in form of dowry	Strongly Disagree	36	15.7
	Disagree	31	13.5
	Neutral	15	6.6
	Agree	71	31.0
	Strongly Agree	76	33.2
FGM adds beauty to girls	Strongly Disagree	75	32.8
	Disagree	61	26.6
	Neutral	46	20.1
	Agree	21	9.2
	Strongly Agree	26	11.4
There is community pressure to undergo FGM and threats of stigma	Strongly Disagree	46	20.1
	Disagree	55	24.0
	Neutral	51	22.3
	Agree	36	15.7
	Strongly Agree	41	17.9
Marriage is considered for only women who have gone through FGM	Strongly Disagree	26	11.4
	Disagree	20	8.7
	Neutral	26	11.4
	Agree	82	35.8

	Strongly Agree	75	32.8
FGM is an integral part of people's life and culture as a rite of passage	Strongly Disagree	41	17.9
	Disagree	16	7.0
	Neutral	35	15.3
	Agree	72	31.4
	Strongly Agree	65	28.4
FGM reduces the sexual urge in women	Strongly Disagree	31	13.5
	Disagree	81	35.4
	Neutral	10	4.4
	Agree	21	9.2
	Strongly Agree	86	37.6
FGM promotes family honor and respect in the community	Strongly Disagree	56	24.5
	Disagree	71	31.0
	Neutral	31	13.5
	Agree	46	20.1
	Strongly Agree	25	10.9

Results revealed that 76 (33.2%) strongly agreed that FGM increases the demand of girls for marriage in form of dowry followed by 71 (31.0%) who agreed. On whether FGM adds beauty to girls, results showed that 75 (32.8%) strongly disagreed followed by 61(26.6%) disagreed. Regarding the community pressure to undergo FGM and threats of stigma, results showed that 55 (24.0%) disagreed followed by 51 (22.3%) of the respondents were neutral.

The findings from this study revealed that 82 (35.8%) agreed and 75 (32.8%) strongly agreed with the statement that only women who had undergone FGM were considered complete for marriage. On whether FGM is an integral part of people's life and culture as a rite of passage, 72 (31.4%) agreed and 65 (28.4%) strongly agreed. Regarding FGM reducing the sexual urge in women, results revealed that 86 (27.6%) strongly agreed followed by 81 (35.4%) disagreed that it reduced the urge. Further results showed that

71(31.0%) of the respondents disagreed followed by 56 (24.5%) strongly disagreed that FGM promoted family honor and respect in the community.

4.4.2 socio-cultural factors' Influence on FGM practice

The study sought to assess the influence of socio-cultural factors on practice of FGM. The results were summarized and presented in Table 4.4.

Table 4.4: Socio-cultural factors associated with practice of Female Genital Mutilation among respondents (n=229)

Variable	Respondent response	Undergone FGM		Statistical significance
		Yes (N=157)	No (N=72)	
FGM increases the demand of girls for marriage in form of dowry	Strongly Disagree	26(16.6%)	10(13.9%)	χ^2=63.690 df=4 p=0.001***
	Disagree	23(14.6%)	8(11.1%)	
	Neutral	10(6.4%)	5(6.9%)	
	Agree	57(36.3%)	14(19.4%)	
	Strongly Agree	41(26.1%)	35(48.6%)	
FGM adds beauty to girls	Strongly Disagree	55(35.0%)	20(27.8%)	χ^2=11.364 df=4 p=0.071†
	Disagree	40(25.5%)	21(29.2%)	
	Neutral	33(21.0%)	13(18.1%)	
	Agree	14(8.9%)	7(9.7%)	
	Strongly Agree	15(9.6%)	11(15.3%)	
There is community pressure to undergo FGM and threats of stigma	Strongly Disagree	24(15.3%)	22(30.6%)	χ^2=23.824 df=4 p=0.018*
	Disagree	50(31.8%)	5(6.9%)	
	Neutral	36(22.9%)	15(20.8%)	
	Agree	26(16.6%)	10(13.9%)	
	Strongly Agree	21(13.4%)	20(27.8%)	
Only women undergone FGM are considered complete for marriage	Strongly Disagree	21(13.4%)	5(6.9%)	χ^2=19.389 df=4 p=0.038*
	Disagree	11(7.0%)	9(12.5%)	
	Neutral	21(13.4%)	5(6.9%)	
	Agree	61(38.8%)	21(29.2%)	
	Strongly Agree	43(27.4%)	32(44.4%)	

FGM as a rite of passage, is an integral part of people's life and culture	Strongly Disagree	28(17.8%)	13(18.1%)	χ^2=17.138 df=4 p=0.002**
	Disagree	8(5.1%)	8(11.1%)	
	Neutral	20(12.7%)	15(20.8%)	
	Agree	63(40.1%)	9(12.5%)	
	Strongly Agree	38(24.2%)	27(37.5%)	
FGM reduces the sexual urge in women	Strongly Disagree	10(6.4%)	21(29.2%)	χ^2=9.855 df=4 p=0.089†
	Disagree	72(45.9%)	9(12.5%)	
	Neutral	5(3.2%)	5(6.9%)	
	Agree	15(9.6%)	6(8.3%)	
	Strongly Agree	55(35.0%)	31(43.1%)	
FGM promotes family honor and respect in the community	Strongly Disagree	16(10.2%)	40(55.6%)	χ^2=7.282 df=4 p=0.117
	Disagree	60(38.2%)	11(15.3%)	
	Neutral	26(16.6%)	5(6.9%)	
	Agree	40(25.5%)	6(8.3%)	
	Strongly Agree	15(9.6%)	10(13.9%)	

***p<0.001; **p<0.01; *p<0.05; †p<0.1**

Findings revealed that of the participants who strongly agreed that FGM increased the demand of girls for marriage in form of dowry less than half 35 (48.6%) had not had not taken part in FGM. FGM increasing the demand of girls for marriage in form of dowry and having undergone FGM related statistically significant (p=0.001). More than a third 55 (35.0%) of the respondents who strongly disagreed that FGM added beauty to girls had undergone FGM. There was no association between FGM adding beauty to girls and undergoing FGM (p=0.071).

Results showed that 50 (31.8%) of the respondents who disagreed that there is community pressure to undergo FGM and threats of stigma had undergone FGM. Community pressures to undergo FGM and threats of stigma and having undergone FGM relate statistically significant (p=0.018). 61 (38.8%) of the respondents who agreed that women who had undergone FGM are considered complete for marriage had undergone FGM. There was a significant statistical association between only women undergone FGM being considered complete or marriage and undergoing FGM (p=0.038).

Concerning FGM as a rite of passage, being integral part of people's life and culture, 63 (40.1%) of the respondents who agreed had undergone FGM. There exited a statistically significant connection between FGM being an integral part of people's life and culture and undergoing FGM (p=0.02). Qualitative results supported these findings as one of the KII reported;

> "*…these girls themselves sometimes request for the procedure to be conducted because they get abused and discriminated by their peers who had already gone through the cut. In this community it is uncommon to get a girl aged more than 18 years who have not undergone FGM. This is a culture that has been in place for so long and you know it's very difficult to be abandoned just like that. It will require a lot of efforts from both the men and women to end this practice…*"

Less than half 72 (45.9%) of the respondents who disagreed that FGM reduced the sexual urge in women had ever undergone FGM. There existed no significant statistical connection between FGM reducing the sexual urge and undergoing FGM (p=0.089). 40 (55.6%) of the respondents who strongly disagreed that FGM promoted family honor and respect in the community had never undergone FGM. However, FGM promoting family honor and respect and undergoing FGM had no statistically notable connection (p=0.117).

4.5 Legal factors

4.5.1 Distribution of legal factors

The thesis sought to assess the legal factors' distribution among participants. Table 4.5. displays the results

Table 4.5: Responses on legal factors among participants (n=229)

Independent variable	Respondent response	Number of respondents (N)	Percentage (%)
Local authority support practice of female genital mutilation	Yes	62	27.1
	No	142	62.0

	I cannot tell	25	10.9
Aware of the legal provisions against the practice of FGM	Yes	147	64.2
	No	82	35.8
Local leaders are compromised to allow women to undergo FGM	Yes	46	20.1
	No	121	52.8
	I cannot tell	62	27.1
The community is against the government agencies that detain female circumcisers	Yes	56	24.5
	No	137	59.8
	I don't know	36	15.7
The human rights partnership programs for FGM reach Kajiado County	Yes	86	37.6
	No	66	28.8
	I cannot tell	77	33.6

Majority 142 (62.0%) of the respondents revealed that the local authority did not support female genital mutilation followed by 62 (27.1%) who reported they did. Most 147 (64.2%) of the respondents had awareness concerning the legal provisions against the FGM practice whereas the others 82 (25.8%) were not aware. Out of the participants, slightly more than half 121 (52.8%) revealed that the local authority was not compromised to allow women to undergo FGM followed by 62 (27.1%) who could not tell.

Results also showed that 137 (59.8%) of the respondents reported that the community was not against the government agencies that detained female circumcisers followed by 56 (24.5%) who felt that the community as against. Further results revealed that 86 (37.6%) of the respondents reported that human rights partnership programs for FGM reached Kajiado County followed by 77 (33.6%) who could not tell.

4.5.2 Legal factors' influence on the FGM practice

This research sought to assess how legal factors influence the practice of FGM. The results are presented in Table 4.6.

Table 4.6: Legal factors associated with FGM practice among respondents (n=229)

Independent variable	Respondent response	Undergone FGM		Statistical significance
		Yes (N=157)	No (N=72)	
Local authority support practice of female genital mutilation	Yes	36(22.9%)	26(36.1%)	χ^2=3.750 df=2 p=0.153
	No	102(65.0)	40(55.6%)	
	I cannot tell	19(12.1%)	6(8.3%)	
Aware of the legal provisions against the practice of FGM	Yes	89(56.7%)	58(80.6%)	χ^2=12.015 df=1 p=0.027*
	No	68(43.3%)	14(19.4%)	
Local leaders are compromised to allow women undergo FGM	Yes	35(22.3%)	11(15.3%)	χ^2=4.732 df=2 p=0.094†
	No	86(54.8%)	35(48.6%)	
	I cannot tell	36(22.9%)	26(36.1%)	
The community is against the government agencies that frustrate female circumcisers	Yes	48(30.6%)	8(11.1%)	χ^2=7.866 df=2 p=0.049*
	No	84(53.5%)	53(73.6%)	
	I don't know	25(15.9%)	11(15.3%)	
The human rights partnership programs for FGM reach Kajiado County	Yes	37(23.6%)	49(68.1%)	χ^2=23.422 df=2 p=0.016*
	No	51(32.5%)	15(20.8%)	
	I cannot tell	69(43.9%)	8(11.1%)	

***p<0.001; **p<0.01; *p<0.05; †p<0.1**

Results revealed that most 102 (65.0%) of the respondents who felt that the local authority did not support practice of female genital mutilation had undergone FGM. There was no statistical association between local authority supporting practice of female genital mutilation and undergoing FGM (p=0.153). Majority 58 (80.6%) of the

respondents who were aware of the legal provisions against the practice of FGM had not undergone the practice. There existed a statistical significant connection between awareness on the legal provisions against the practice of FGM and undergoing FGM (p=0.027). During a KII session, one Administrator indicated;

> "…*some of our leaders silently support the practice. Some community members sometimes do report cases of FGM to the authority but it has been noted that those who have been reported do not end up in courts. So, when they realize nothing has been done to those, they have already reported they stop reporting further cases. Some law enforcement officers get bribed and thus allowing the practice to continue illegally. It is ironic that the community members know that the practice is illegal but they continue to allow the practice to continue or do not report the perpetuators*…"

More than half 86 (54.8%) of the respondents who felt that local leaders were not compromised to allow women undergo FGM had undergone the practice. There was no significant association between local leaders being compromised to allow women undergo FGM and undergoing the practice (p=0.094). On whether the community was against the government agencies that frustrate female circumcisers, findings showed that most 53 (73.6%) of the participants who disagreed had not undergone the practice. Community being against the government agencies that frustrate female circumcisers and undergoing female genital mutilation had a statistical significant connection (p=0.049).

Further results revealed that 49 (68.1%) of the respondents who reported that human rights partnership programs for FGM reach Kajiado County had not undergone FGM. There was a significant statistical association between human rights partnership programs for FGM reach Kajiado County and undergoing female genital mutilation (p=0.016).

CHAPTER FIVE: DISCUSSIONS, CONCLUSSIONS AND RECOMMENDATIONS

5.1 Introduction

The discussions, conclusions and recommendations on socio-demographic factors, practice of FGM, socio-cultural and legal factors associated with FGM practice are presented in this section.

5.2 Discussions of Results

5.2.1 Socio-demographic factors

This research attempted to establish the socio-demographic factors associated with practice of FGM among women of reproductive age in Kajiado County, Kenya. The results revealed that less than a third of the participants were 25-29 years old followed by the ones who were between 20-24 years old. This may be due to the fact that youthful form majority of the Kenyan population based on the National Population and Housing Census (KNBS, 2019). These results were the same as those of a research undertaken in Northern Ghana where majority of participants interviewed were between 15-24 years old (Sakeah *et al*., 2018). Based on a study conducted in Egypt among women of reproductive age the respondents had a mean age of 31 years (Mohammed *et al*., 2018)

while in a study conducted in Nakuru, Kenya most of the participants were aged 30-34 years (Esho *et al.*, 2017).

There existed a statistically significant connection between age and undergoing female genital mutilation (χ^2=24.364; df=6; p=0.001; n=229). This is probably because majority of the respondents were teens and others in their 20s when the practice is mostly undertaken. In most communities, female genital mutilation is done to girls at their early teenage years. The results agreed with a study carried out among young Somalis in Norway which indicated that age was significantly associated with female genital mutilation (Mbanya *et al.*, 2018).

Regarding religion, most respondents were Christians. Christianity being the dominant religion in the area could be the best explanation for this. The findings were not consistent with a study done in Egypt among women of reproductive age practicing FGM in which majority were Muslims (Mohammed *et al.*, 2018). According to a study done in sub-Saharan African countries, on religion's effect on FGM where majority of respondents were of traditional African religion (Beller & Kroger, 2018).

Religion and having undergone female genital mutilation did not have a significant statistical association (χ^2=1.704; df=1; p=0.192; n=229). This may be probably be because majority of the participants were Christians hence no significant differences. However, in most communities existence of cultural and religious beliefs that support the practice of FGM has been noted as a factor that plays a significant role. For instance, according to studies in the world, Muslims have a higher likelihood of undergoing FGM as compared to other denominations such as Christians (Duivenbode & Padela, 2019).

The results contrasted those of a study done in Nigeria where religion was found to play a significant task to influence practice of female genital mutilation (Titilayo *et al.,* 2018).

Regarding the respondents' marital status, it was discovered that, of the participants, more than a half were married. Most participants being adults and over 18 years of age and had families could be the reason for this. These findings concur with a study done in Sudan on FGM among reproductive women where most respondents married were 95 per cent of the participants (Elduma, 2018). In a research carried out in Ethiopia, Oljira et al. (2016) reported similar findings where majority of women interviewed on female genital mutilation practice were married. Another investigation in Eastern Ethiopia among young adult women on female genital mutilation noted that majority of the participants were not married (Gebremariam *et al*., 2016).

Marital status and having undergone female genital mutilation related statistically (χ^2=35.808; df=2; p=0.019; n=229). In some communities, girls undergo female genital mutilation as a precursor and preparation to get into marriage. The results concurred with those of a research undertaken in Ethiopia where it was reported girls were supposed to undergo FGM as a fulfillment condition before marriage (Gabremicheal *et al*., 2018). According to study conducted among Somali women in Finland, it was concluded that, compared to those who were not married, married women or those in civil unions were 3.38 times more probable to be circumcised (Koukkula *et al.,* 2016).

Concerning the level of education, it was indicated that less than a half of the participants had attained primary level of education or prior to joining secondary schools. This is because most of this practice occurs during the early teenage years when girls are attending primary schools. Once this is done, they are lured into early and forced

marriages affecting their continuity with further education. The results concur with a study done in Nakuru, Kenya, on FGM practice among women of reproductive age where participants majority had primary education level (Esho *et al*., 2017). According a study done in Sudan on practice of FGM among reproductive age women, it was reported that most of the respondents did not have any formal education (Elduma, 2018).

Highest level of education attained and having undergone female genital mutilation related statistically significant (χ^2=23.244; df=3; p=0.023; n=229). Education empowers women with information regarding the effects of female genital mutilation thus its influence in decision making. Compared to those with primary or informal levels of education, women with higher levels of education attainment are less likely to practice FGM. The results agreed with a research conducted in United Arab Emirates on knowledge, attitude and practice of FGM where education was one of the factors that played a key role in practice of FGM (Al Awar *et al.*, 2020). The likelihood of undergoing FGM by the women who had no education was 3.26 times more as per reports of a study done in Senegal among women of reproductive age (Kandala & Shell-Duncan., 2019).

Further, it was indicated that less than a half of the participants earned between Kshs 10,001-20,000. This could be because majority of the respondents had only attained a primary level of education as well as high unemployment rates in the country reducing their means of income. The results agreed with a research done Kenya on diagnosis and prevention of FGM and noted that majority of the participants had no income at all (Kimani & Oknondo, 2020). According to another study done in Ethiopia, majority of the respondents interviewed on practice of female genital mutilation earned an average

monthly equivalent income ranging 4400 to 17300 Kenyan shillings (Degafa *et al*., 2017).

Despite majority of those who earned between Kshs 10,001-20,000 undergoing female genital mutilation, there was no statistical association between average family monthly income and having undergone female genital mutilation (χ^2=14.214; df=3; p=0.061; n=229). The practice of FGM could have been affected by other factors and not necessarily income. The results contrasted those of a study undertaken in Northwest Ethiopia on predictors of FGM where it was reported that income was a significant factor that facilitated practice of female genital mutilation (Melese *et al*., 2020). In another study conducted in Saudi Arabia on female genital mutilation among women which concluded that the level of income was significantly associated with practice of FGM (Rouzi *et al.,* 2020).

5.2.2 Female Genital Mutilation Practice

The researcher sought to determine the proportion of participants who had practiced female genital mutilation. It was revealed that, of the participants, 68.6% had undergone female genital mutilation in Kajiado County, Kenya. This prevalence was way above the national average which stands at 21% (UNFPA, 2020). This means Kajiado County is one of the greatest contributors to FGM practice with deep rooted cultural and religious beliefs still being existent. The results contrasted those of a study conducted in Sudan where it was reported that 89% of respondents reported to have undergone the cut which is much higher than the prevalence in Kajiado (Elduma, 2018). In another study done in Egypt, the rate of female genital mutilation stands at 76.6% (Mohammed *et al.,* 2018). In Ghana, the practice of FGM among women of reproductive age was reported to have

stood at 61% (Sakeah *et al.*, 2018). In United Arab Emirates, FGM/cutting prevalence among females of reproductive age remains at 41.4% (Al Awar *et al.*, 2020).

The results further showed that most respondents reported that nearly all their age mates had undergone FGM. This would be as a result of peer pressure which may end up convincing themselves to undergo the cut in addition to social stigma which may be attributed to those who have not undergone the cut. The findings had similiarity to a qualitative study done northern Ghana where perception that one's age mates undergoing female genital mutilation led to other girls demanding to have the cut so as not be seen as outcast from the community (Sakeah *et al*., 2019). The results concur with a Focused Group Discussion analysis done in Senegal and Gambia where it emerged that peer pressure has a significant influence on the FGM/cutting practice among peers (Shell-Duncan *et al*., 2019).

Regarding recommending their daughters to get circumcised, the results indicated that majority would not recommend their daughters to undergo female genital mutilation. This is despite majority of the respondents having undergone FGM, they would not like to let their daughters undergo similar experience. This may be due to the numerous campaigns and criminalization of the practice as well as associated consequences. The results had a similarity with a study undertaken in Ghana where 66% of women reported they would recommend their daughters to undergo the cut (Sakeah *et al*., 2018). Mothers always want their daughters to undergo the same practice they underwent has facilitated the persistent FGM practice (Shabila, 2017).

5.2.3 Socio-cultural factors

The study assessed the socio-cultural factors that influence the FGM practice among females of reproductive age. The results displayed that majority of the participants agreed that FGM increases the demand of girls for marriage in form of dowry. The results echoed those of a study done in Kenya and concluded that FGM increases marriageability demand among women (Brown et al., 2016). According to a study done on men's attitude towards FGM, it was reported that Somali's rules demand that you have to marry a girl who has undergone the cut (Axelsson & Strid, 2020). There existed a significant statistical link between circumcised girls having a more demand for marriage in form of dowry and having undergone FGM (χ^2=63.690; df=4; p=0.001; n=229). This may be due to the fact that once a girl has gone through the cut, she is deemed an adult enough who is mature for marriage, hence their parents would lure them into marriage so that they can be given dowry. The results concur with a study conducted on combating FGM in Northeast Africa where it was revealed that dowry for the circumcised bride is more than their counterparts' (Arabahmadi, 2020).

Majority of the participants disagreed that female genital mutilation adds beauty to girls. The proponents of FGM belief that removal of some part of the female genitalia cleanses women hence making them look more beautiful to their proposed husbands (WHO, 2016). This has resulted to the persistent practice of FGM among several communities across the world. The results were inconsistent with a systematic review which women argued that they disliked the new appearance of their genitals after undergoing the cut (Berg *et al.,* 2017). There was no association between FGM adding beauty to girls and having undergone FGM (χ^2=11.364; df=4; p=0.071; n=229). This probably is because

most individuals agree to undergo the cut because it is part of their cultural life and without evening inquiring to know the reason behind the practice. The results were contrary to Obianwu et al. (2018) who undertook a research among women of reproductive age who argued that they only undergo the cut so as to be perceived being beautiful thus lure men to hold their hands in marriage.

Regarding community pressure and threats of stigma facilitating FGM practice, the results showed that less than a third of respondents disagreed followed by those who remained neutral. These results are in agreement with Sakeah et al. (2019) whose study in Northern Ghana reported that pressure from peers was the main reason why girls agreed to undergo the cut without necessarily giving out their consent. Also, pressure from parents and family members has been noted as playing a key role in female genital mutilation practice (Klein *et al*., 2018). Community pressures to undergo FGM and threats of stigma and having undergone FGM had an association that was significant statistically (χ^2=23.824; df=4; p=0.018; n=229). This is because going against the community's cultural beliefs may result to one being treated as an outcast resulting to ex-communication from engaging in certain community activities. In a study conducted in rural Egypt, it was concluded that most of the girls felt discriminated against if they did not undergo FGM. However, the results in the study were contrary to the current one as there was no association between community discrimination and practice of FGM (Mohammed *et al*., 2018).

From the results, most participants opined that FGM was an immanent part of their life and culture. This may make girls requesting to undergo the cut so as to be considered as adults by transitioning from childhood to womanhood when they reach a certain age and

when they see their age mates have been circumcised (William-Breault., 2018). This is therefore in conformity with the rite of passage of communities practicing FGM (Kimani *et al.*, 2020). FGM being an integral part of people's life and culture and having undergone FGM related statistically significant (χ^2=17.138; df=4; p=0.002; n=229). The results were in agreement with Shell-Dancun et al. (2018) who reported that in Senegambia, women underwent the cut as a rite of passage and avoid sanctions that come along with not practicing female genital mutilation.

The findings further revealed that majority of the participants disagreed that female genital mutilation reduces the sexual urge in women. However, the proponents of female genital mutilation thought that FGM would reduce promiscuity and tame the sexual desires of woman hence being loyal to one man. The results did not agree with Odukogbe et al. (2017) who studied female genital mutilation in Africa and reported that the main reason for parents to encourage their daughters to undergo the cut is to control female sexuality. FGM reducing the sexual urge and having undergone FGM did not have any statistically significant connection (χ^2=9.855; df=4; p=0.089; n=229). This is because majority of the respondents who disagreed that FGM reduced the sexual urge in women had undergone FGM. Probably other factors necessitated them undergoing the cut rather than controlling their sexual drives. According to a study done on attitude towards FGM, it was noted that FGM makes girls calm and sexually inactive (Abathun *et al.*, 2016). The results contrasted those of Kimani et al. (2018) who reported that among the Abagusii, Kuria and Somalia FGM practice was aimed at suppressing sexual desire thus preventing premarital sex and infidelity.

Further, the findings showed that most of the participants disagreed that FGM promoted family honour and respect in the community. This is because FGM is a cultural practice that binds members of the same society together. When a family is against such an act, they may be seen as defying the social wills that brings people together. The results were in line with those of Shell-Duncan and others (2016), which reported that FGM promotes family honour and respect. Female genital mutilation is a means of preserving family honour among community members Bunei & Rono, 2018). FGM promoting family honor and respect and having undergone FGM did not have any significant statistical connection (χ^2=7.282; df=4; p=0.117; n=229). This is probably because other factors played a key part in facilitating the practice. The results did not agree with Yount et al. (2020) who studied FGM among women of reproductive age in Egypt and revealed that the feeling of family honour prompted parents to pressure their daughters to undergo the cut.

5.2.4 Legal factors

Majority of the respondents revealed that the local authority did not support female genital mutilation. The results echoed those of Arabahmadi (2020) study on combating FGM in Northeastern Africa and reported that one of the challenges in curbing FGM was lack of support from the local leadership especially in the rural areas. The results contrasted Abdulah et al. (2019) who reported that, in Iraq, FGM is regarded as part of the religion thus continued support from religious leaders to practice it. There was no statistical association between local authority supporting practice of female genital mutilation and having undergone FGM (χ^2=3.750; df=2; p=0.153; n=229). However, most of the respondents who felt that the local authority did not support practice of

female genital mutilation had ever undergone FGM. This is probably because FGM has been outlawed in Kenya and it is done secretly due to fear of being victimized and face the consequences of law. The results were inconsistent with another study done on knowledge and perspectives of FGM where it was concluded that local leaders have substantial influence on the persistence of practicing female genital mutilation (Ahmed *et al*., 2018).

Most of the respondents were aware of the legal provisions against the FGM practice. According to a study done in preventing FGM in high income countries, it was concluded that majority were aware of the legal provisions against the practice of FGM (Njue *et al*., 2019). Awareness on the legal provisions against the practice of FGM and having undergone FGM significantly related statistically (χ^2=12.015; df=1; p=0.027; n=229). This is because there have been several campaigns against the practice of FGM including the consequences of those caught undertaking the practice are on the limelight. This has enlightened people throughout several media platforms despite their continued practice of the vice. The results are contrary to a study done on FGM in Africa where it has been noted that people don't have awareness on the legal consequences of the practice (Nabaneh & Muula., 2019).

The findings showed that most participants felt that the local authority was not compromised to allow women to undergo FGM. There was no significant association between local leaders being compromised to allow women undergo female genital mutilation and having undergone the practice (χ^2=4.732; df=2; p=0.094; n=229). However, this being a cultural issue, it has a great concern where those who want their daughters undergo the cut may end up bribing the local authority to avoid being charged

for their wrong doing. The results were inconsistent with Luc and Altare (2018) study, who reported that most of the local leaders are comprised to allow the vice to continue despite knowing the repercussions of the practice.

Further, the results indicated that majority of the participants reported that the community was not against government agencies that frustrate female circumcisers. The results contrasted Mepukori et al. (2016) who reported that, in Kenya, female circumcisers were not reported to the authorities due to fear of being arrested by the enforcement institutions and officers. Community being against the agencies that frustrate female circumcisers and having undergone FGM related statistically significant (χ^2=7.866; df=2; p=0.049; n=229). This means that they were aware of the criminalization of act and the consequences of those at the forefront of perpetuating the practice would face. Arresting those accused of practicing FGM is among the interventions that has been fronted in combating the vice in Nigeria (Yerima, 2016).

Finally, these findings showed that, of the respondents, less than a half reported that human rights partnership programs for FGM reached residents. In southern Sudan, there are several human rights partnerships that are fighting against the combating of FGM in the region (Lugiai *et al.,* 2021). Human rights partnership programs for FGM reaching the residents and having undergone female genital mutilation associated statistically significant (χ^2=23.422; df=2; p=0.016; n=229). Increased partnership programs create channels of disallowing the practice of FGM. This ensures people are reached with information on the effects of the act and thus help in eradicating its persistent practice in communities. The results were consistent with a systematic review on the approaches of

ending FGM which revealed that existence of human rights partnerships are key to eradicating the practice (Khosla *et al.*, 2017).

5.3 Conclusions

This research's results revealed that majority of socio-demographic factors influenced practice of female genital mutilation. They included; Education level (p=0.023), age (p=0.001) and marital status (p=0.019).

The study concludes that the FGM practice in Kajiado County stood at 68.6%. This means that pproximately seven out of ten women of reproductive age in the county have undergone FGM. This is far above the national average which stands at 21%. Nearly all the age mates of the participants had undergone the cut. Majority would not recommend their daughters to go through FGM.

The findings also showed that FGM practice was influenced by most socio-cultural factors. They included FGM increases demand of girls for marriage inform of dowry (*p*=0.001), community pressure and threats of stigma (*p*=0.018), for marriage, only women who have gone through FGM are deemed complete (*p*=0.038), and FGM is an immanent part of peoples' life and culture (*p*=0.002).

Finally, these results concludes that majority of the legal factors played a key role in the FGM practice. In fact, awareness on the legal provisions against FGM practice (p=0.027), community against government agencies that detain female circumcisers (p=0.049) and existence of human rights partnership programs for FGM (p=0.016) were significantly associated with FGM practice. According to the results, it is clear that age, community pressure and cultural beliefs are the key drivers of FGM practice in Kajiado County.

5.4 Recommendations

5.4.1 Recommendations from the study

i. The County Government of Kajiado and other stakeholders in reproductive health scale up sensitization campaigns to boost their knowledge on the dangers and associated consequences thus reduce the cases of FGM practice.

ii. The County Government of Kajiado together with other stakeholders in health ought to advocate for an alternative rite of passage through cultural celebration of girls' transition to womanhood without the cut to suppress the FGM practice

iii. The County Government of Kajiado and other stakeholders in reproductive health should involve men in demystifying the cultural beliefs attached to the FGM practice.

iv. The study finally recommends that the law enforcement officers at the community level should create anonymous channels for reporting female circumcision exercises while other relevant stakeholders should empower reformed traditional female circumcisers to start alternative economic activities.

5.4.2 Recommendations for Future Research

i. This thesis recommends a further research to assess the involvement of men in combating the FGM practice in Kajiado County, Kenya.

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APPENDICES

Appendix I: Introduction Letter

Dear Respondent,

My name is Elias Kathurima, I am currently a student at the Kenyatta University. I am conducting a study to investigate "The Driving Forces of FGM Practice among Women of Reproductive Age in Kajiado County, Kenya." You have been selected to participate in this study. I would be grateful if you assist me in responding to all questions posed to you. Your identity will be kept confidential and this information will be used for academic purposes only. Your co-operation will be highly appreciated. Thank you.

Yours faithfully,

Elias Kathurima

Appendix II: Informed Consent Act as a Research Subject

Investigator Contact Information

Elias Kathurima
Kenyatta University,
Email: kathurima_elias@yahoo.com
Mobile:0720300016

Introduction and Background Information

My name is Elias Kathurima, I am currently a postgraduate student at the Kenyatta University. I am undertaking a research to investigate ***"The Driving Forces of FGM Practice among Women of Reproductive Age in Kajiado County, Kenya."*** You have been selected to participate in this study. I would be grateful if you respond to all questions posed to you. This information will be used solely for academic purposes and your identity will be kept confidential.

Study Location, dates and procedures

The study is anticipated to begin in April 2020 and to be completed by June 2020. The location of the study will be in Mashuuru Sub-county. If you are willing to take part in this study you will be guided how to go about it by the research assistant. The researcher will issue you with data collection tools that you will be required to fill. You may also be selected to take part in the interview session that may be recorded.

Risks and Benefits

There exists benefits and risks to participating in this study. Possible risks include having negative feelings and feeling uncomfortable regarding the subject matter. In minimizing the risks, the respondent have the right of withdrawing from the exercise at any time, ending the sessions and/or declining to respond to any question. To avoid risk to respondent, at his discretion, the researcher may also decide to bring the interview sessions to an end. Possible gains are: having positive feelings about your views in the study and contributing to the research literature about "The Driving Forces of FGM Practice among Women of Reproductive Age in Kajiado County, Kenya.".

Promise of Privacy

The records of this study will be kept private. To protect your identity, your name will only appear on this consent form. The researcher will be the only person with access to the consent forms and the list of subject's names. Subject interviews will be recorded on a recorder. All transcriptions will be numbered and will not include information that could identify participants. All data will be kept in a locked file cabinet in the researcher's home.

Voluntary Nature of the Study

Your decision whether or not to participate will not affect your current or future relations in the community. If you decide that you will participate, you will be free not to answer any question or withdraw at any time without prejudice or negative consequences. If you decide not to participate, there will be no negative consequences to you.

Contact information

If you have any questions contact my supervisors Prof. Margaret Keraka on 0733663606 or Dr. Samuel Mwangi on 0718164726 or the Kenyatta University Ethical Review Committee Secretariat on
chairman.kuerc@ku.ac.ke

Participant's statement

The above information regarding my participants in the study is clear to me and I understand that my decision whether or not to participate will not affect my current or future relations in the community. All my questions have been answered by the researcher. I understand that I have given consent to participate in the study. I have been given a copy of this form to keep for my records.

Participant Number…….

…… …….

Signature Date

Investigator`s statement

I, the undersigned, I have explained to the volunteer in a language she/he understands, the procedures to be followed in the study and the risks and benefits involved.

Name of interviewer……..

……. …….

Interviewer signature Date

Appendix III: Questionnaire for Women (15 – 49 Years)

Section I: Demographic Data

1. What is your age bracket?
15-19 yrs [ ] 20-24 yrs [ ] 24-29 yrs [ ] 30-34 yrs [ ] 35-39 yrs [ ] 40-44 yrs [ ] 45-49 yrs
2. What is your level of household income? …….
3. What is your education level?
Informal [ ] Primary [ ] Secondary [ ] Tertiary [ ]
4. What is your religion?
Christian [ ] Others specify _____
5. What is your marital status?
Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed [ ]

Section III: Influence of Socio-cultural Factors on FGM Practice

6. Please indicate the level of agreement that you have with the following items on socio-cultural factors. *Key: 5-Strongly Agree; 4-Agree; 3-Undecided; 2-Disagree; 1-Strongly Disagree.*

Item	5	4	3	2	1
The cultural beliefs that FGM adds beauty and demand to girls is a determinant of the FGM practice in Mashuuru Sub-county;					
The FGM practice is often enforced by community pressure and the threat of stigma;					
There is great perception that only women who get circumcised are married in Mashuuru Sub-county;					
Female circumcision is considered an integral part of the Maasai peoples' way of life and culture;					
Female circumcision reduces sexual urge in women, that reduce unnecesary sex in Mashuuru Sub-county;					
FGM is practice promote family honour in the community;					

Section IV: Influence of Legal factors on FGM Practice

7. Please indicate the option that best describes your response to the following statements on legal factors. *1-Yes 2-No 3-Cannot tell.*

Item	1	2	3
The local authority leaders e.g. support the FGM practice;			
People are aware of legal provisions against the practice of FGM in Mashuuru Sub-county;			
Local leaders are compromised to allow FGM practices to be carried out at night FGM in Mashuuru Sub-county;			
Ther human right partnershipship programmes for FGM reach in Mashuuru Sub-county;			
The community is against the government agencies that detain the female circumcisors;			

Section IV: FGM Practice

8. Have you undergone FGM practice?

Yes [ ] No [ ]

9. If Yes, when did it happen? 0-5 years ago [ ] 6-10 years ago [ ] 11-15 years ago [ ] more than 15 years ago [ ]

10. Have your sisters undergone FGM?

Yes [ ] No [ ]

If no, please give a reason_____

11. Nearly all my age-mates have undergone FGM

Yes [ ] No [ ]

12. Would you recommend your daughters to undergo FGM

Yes [ ] No [ ] Cannot tell [ ]

THE END

Appendix IV: Interview Schedule for Key Informant

Section I: Demographic Data

1. What is your age? _____
2. What is your occupation? _____

Section II: Influence of Socio-economic Factors on FGM Practice

3. How does family income level influence FGM practice among reproductive age women in the sub-county of Mashuuru?
4. How does family education level influence FGM practice among reproductive age women in the sub-county of Mashuuru?
5. How does family prestige level influence the practice of FGM among women of reproductive age in Mashuuru sub-county?

Section III: Influence of Socio-cultural Factors on FGM Practice

6. How does cultural rite of passage influence FGM practice among reproductive age women in the sub-county of Mashuuru?
7. How does marriage and dowry influence FGM practice among reproductive age women in the sub-county of Mashuuru?
8. How does religion influence FGM practice among reproductive age women in the sub-county of Mashuuru?
9. How does community influence FGM practice among reproductive age women in the sub-county of Mashuuru?

Section IV: Influence of Legal factors on FGM Practice

10. How does human rights policies and law influence FGM practice among reproductive age women in the sub-county of Mashuuru?
11. How does partnership programmes influence FGM practice among reproductive age women in the sub-county of Mashuuru?
12. How does local leadership and legal authority influence FGM practice among reproductive age women in the sub-county of Mashuuru?

END

Appendix V: Research authorization from Kenyatta University Graduate School

KENYATTA UNIVERSITY
GRADUATE SCHOOL

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

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

Our Ref: Q139/CTY/PT/37748/2016 DATE: 24th February, 2020

Director General,
National Commission for Science, Technology
and Innovation
P.O. Box 30623-00100
NAIROBI

Dear Sir/Madam,

RE: RESEARCH AUTHORIZATION FOR MR. ELIAS MUGUNA KATHURIMA
REG. NO. Q139/CTY/PT/37748/16

I write to introduce Mr. Elias Muguna Kathurima who is a Postgraduate Student of this University. He is registered for M.P.H. degree programme in the **Department of Population, Reproductive Health & Community Resource Management.**

Mr. Kathurima intends to conduct research for a M.P.H. thesis Proposal entitled, **"Driving Forces of the Practice of Female Genital Mutilation among Women of Reproductive Age in Kajiado County, Kenya."**

Any assistance given will be highly appreciated.

Yours faithfully,

KENYATTA UNIVERSITY OFFICE OF DEAN 24 FEB 2020 GRADUATE SCHOOL P.O. Box 43844-00100 NAIROBI

PROF. ELISHIBA KIMANI
DEAN, GRADUATE SCHOOL

Appendix VI: Ethical clearance from KU Ethics and Review Committee

Kenyatta University
P.O Box 43844-00100
Nairobi-Kenya

REF: KU/ERC/APPROVAL/VOL1/1 Date: 16th March, 2020

Elias Muguna Kathurima
P.0 Box 43844-00100
NAIROBI

Dear Mr. Kathurima,

RE: APPLICATION NUMBER: PKU/2093/11240 DRIVING FORCES OF THE PRACTICE OF FEMALE GENITAL MUTILATION AMONG WOMEN OF REPRODUCTIVE AGE IN KAJIADO COUNTY, KENYA

This is to inform you that ***KENYATTA UNIVERSITY ETHICS REVIEW COMMITTEE*** has reviewed and approved your above research proposal. Your application approval number is **PKU/2099/11246** . The approval period is ***17th March, 2020 – 17th March, 2021.***

This approval is subject to compliance with the following requirements:

i. Only approved documents including (informed consents, study instruments, MTA) will be used
ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by ***KENYATTA UNIVERSITY ETHICS REVIEW COMMITTEE***.
iii. Death and life threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to ***KENYATTA UNIVERSITY ETHICS REVIEW COMMITTEE*** within 72 hours of notification
iv. Any changes, anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to ***KENYATTA UNIVERSITY ETHICS REVIEW COMMITTEE*** within 72 hours
v. Clearance for export of biological specimens must be obtained from relevant institutions.
vi. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal.
vii. Submission of an executive summary report within 90 days upon completion of the study to ***KENYATTA UNIVERSITY ETHICS REVIEW COMMITTEE***.

Appendix VII: Research Approval from Kenyatta University Graduate School

KENYATTA UNIVERSITY
GRADUATE SCHOOL

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

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

Internal Memo

FROM: Dean, Graduate School

DATE: 24th February, 2020

TO: Mr. Elias Muguna Kathurima
C/o Department of Population,
Reproductive Health & Community
Resource Management

REF: Q139/CTY/PT/37748/16

SUBJECT: APPROVAL OF RESEARCH PROPOSAL

We acknowledge receipt of your Research Proposal after fulfilling recommendations raised by the Graduate School Board of 29th January, 2020.

You may now proceed with your Data collection, subject to clearance with the Director General, National Commission for Science, Technology & Innovation and Ethics Review Committee, Kenyatta University.

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

Thank you.

KENYATTA UNIVERSITY OFFICE OF DEAN 24 FEB 2020 GRADUATE SCHOOL P.O. Box 43844-00100 NAIROBI

EDWIN OBUNGU
FOR: DEAN, GRADUATE SCHOOL

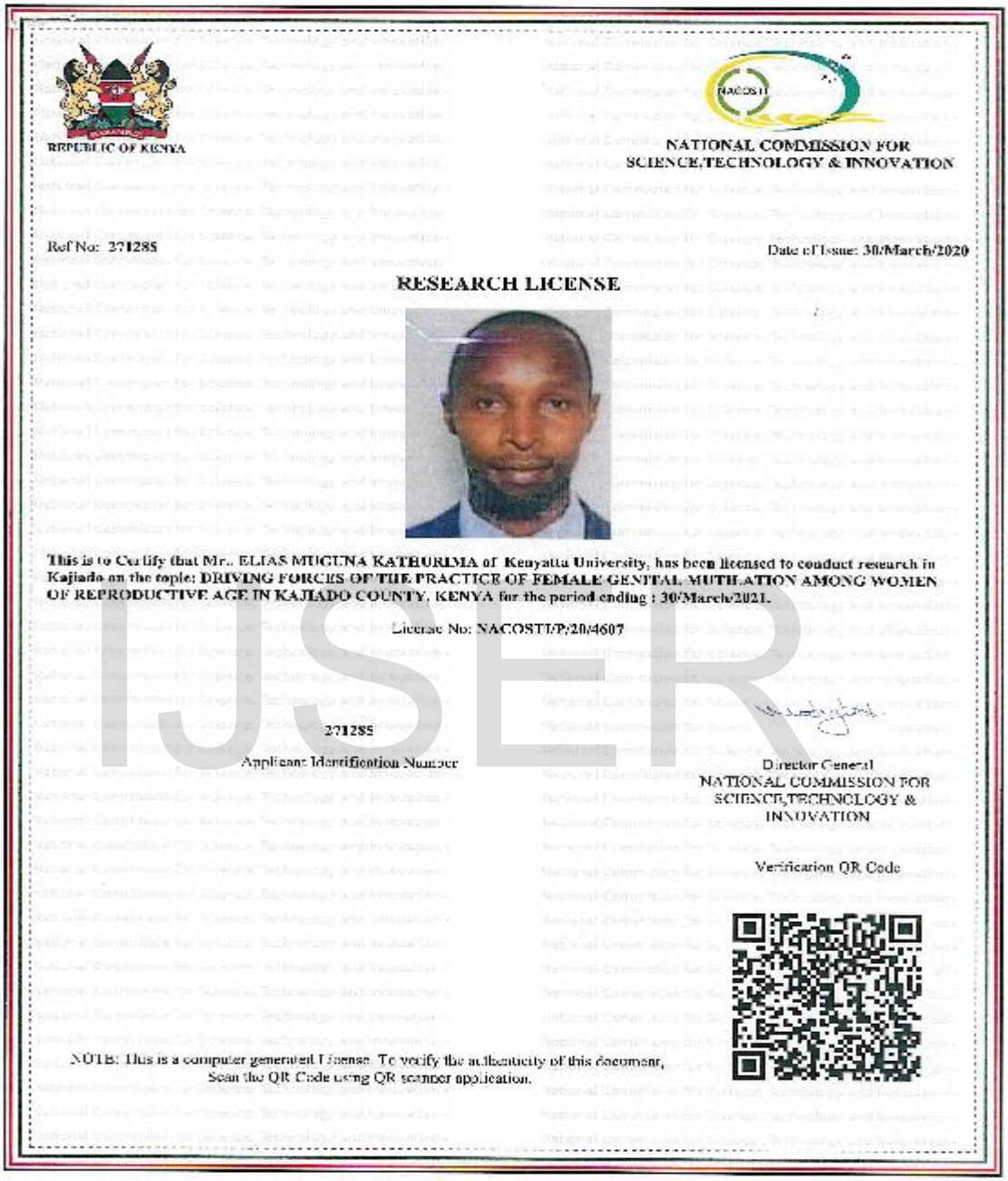
CC. Chairman, Department of Population, Reproductive Health & Community Resource Management

Supervisors:

1. Prof. Margaret Keraka
C/o Population, Reproductive Health & Community
Resource Management Dept.
Kenyatta University

2. Dr. Samuel Mwangi
C/o Department of Sociology, Gender & Development
Studies
Kenyatta University

Appendix VIII: Research permit from National Council for Science, Technology and Innovation



REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: 271285

Date of Issue: 30/March/2020

RESEARCH LICENSE

This is to Certify that Mr.. ELIAS MUGUNA KATHURIMA of Kenyatta University, has been licensed to conduct research in Kajiado on the topic: DRIVING FORCES OF THE PRACTICE OF FEMALE GENITAL MUTILATION AMONG WOMEN OF REPRODUCTIVE AGE IN KAJIADO COUNTY, KENYA for the period ending : 30/March/2021.

License No: NACOSTI/P/20/4607

271285

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

NOTE: This is a computer generated License. To verify the authenticity of this document, Scan the QR Code using QR scanner application.

Appendix IX: Research authorization from Kajiado County

REPUBLIC OF KENYA

The Presidency

MINISTRY OF INTERIOR
AND
COORDINATION OF NATIONAL GOVERNMENT.
DEPUTY COUNTY COMMISSIONER MASHURU

P.O.BOX 1
Kajiado.

24th July 2020.

RE: MSU/DCC/RA/VOL I/ (18)

Elias Muguna Kathurima
P.O.Box 43844-00100
NAIROBI

Dear Mr. Kathurima,

RE: REASERCH AUTHORIZATION – ELIAS MUGUNA KATHURIMA.

Following the request made on your behalf by National Commission for Science and Technology and Innovation vide License **Ref. No. 271285 and License No. NACOSTI/P /20/4607** dated 30th March 2020.

You are herby granted authority to carry out research on **"DRIVING FORCES OF THE PRACTICE OF FEMALE GENITAL MUTILATION AMONG WOMEN OF REPRODUCTIVE AGE IN KAJIADO COUNTY , KENYA for a period ending 30th March 2021.**

It is expected that you adhere to research ethics in doing your study.

DCC MASHURU
P.O. Box 1-01100.
KAJIADO
Date 24/7/20

JACOB KILOKI.
FOR DEPUTY COUNTY COMMISSIONER
MASHURU SUB-COUNTY.

CC:

County Commissioner
Kajiado County.

Appendix X: Area Map