University of Applied Sciences

Faculty of Life Sciences

Public Health Degree

INVESTIGATION OF SUCCESSFUL INTERVENTIONS IN MITIGATION OF FEMALE GENITAL MUTILATION/CUTTING (FGM/C) AMONG SELECTED KENYAN COMMUNITIES: Maasai, Kisii and Kuria

Master Thesis

Date of submission: **30.04.2015**

Submitted by: **Chepkoech Buttia**

Matriculation number: 2140353

Examination supervisor: Prof. Dr. Christine Färber

Secondary supervisor: Ms. Charity Mugure Tongoi

PREFACE

This thesis marks the completion of my Master's Degree in Public health at the University of Applied Sciences Hamburg, Germany. It is based on literature review that was done from August 2014 to April 2015.

Having been born and brought up in Kenya, I became aware of various health issues affecting the country. This sparked off my interest in working in the health sector. I completed my undergraduate studies in biological sciences in Bonn, Germany and later decided to master in public health which would earn me more experience that I would eventually apply in helping out with health issues in Kenya.

I became interested in the topic Female Genital Mutilation after watching the film *"Desert Flower"* directed by Sherry Hormann based on the book by Waris Dirie and Cathleen Miller. The film depicts the remarkable life of Waris Dirie who escaped an impoverished childhood in Somali to avoid a forced early marriage. In an interview she talked of being forced to undergo female circumcision as a young girl. I then decided to carry out more research on the topic and found out that FGM is still highly prevalent among some Kenyan communities. My goal in researching the effectiveness of approaches to mitigate FGM is to help various anti-FGM campaign teams and organizations in their efforts to eradicate the practice.

I would like to express my sincere gratitude to my supervisor Prof. Dr. Christine Färber for the continuous support of my master`s research, for her motivation, enthusiasm, insightful comments and inner knowledge. Her guidance throughout my research enabled me to develop a greater understanding of the subject and writing of this thesis. I could not have imagined having a better advisor and a mentor. I also owe my deepest gratitude to my second supervisor, Miss. Charity Tongoi, M.Sc. Health Sciences, for her encouragement and for providing helpful material for this thesis. Besides my supervisors, it is a pleasure to thank all the professors and staff members of Hamburg Universtiy of Applied Sciences for support and knowledge throughout my master studies. I further thank Dr. Eric Macharia for the motivation and useful ideas and lastly, special thanks go to my family for their moral support throughout my life.

To my daughter Misha, I love you.

ABSTRACT

Female Genital Mutilation (FGM) is defined by World Health Organization (WHO) as “the practice that comprises all the procedures that involve partial or total removal of the external genitalia, or other injury to the female genital organs for non-medical reasons”. It is estimated by WHO that approximately 100-140 million women worldwide are affected by FGM and about 3 million women in Africa are assumed to be at the danger of undergoing the practice every year.

FGM is widely practiced in many Kenyan communities. The Kenya Demographic and Health Survey (KDHS 2008-09) revealed that approximately 27% percent of Kenyan women had undergone female genital mutilation by the year 2008/2009. However, there are variations in prevalence between different ethnic groups. The practice is a deeply rooted cultural practice, with tradition being a powerful driver in many societies. It is often motivated by beliefs such as preservation of family´s honour, fidelity in marriage, maintaining chastity, rite of passage into womanhood and reducing female sexual desires. The practice poses serious physical, social, sexual and mental health risks for women and young girls, especially for those who have undergone extreme forms of the procedure.

Many local NGOs, CBOs, faith-based organizations, international organizations and multilateral agencies are working in Kenya to eradicate FGM. There are still many challenges though to overcome the practice due to lack of clear interventions that are effective. The author of this thesis aimed to present a systematic review summary of the literature about successful interventions designed to reduce the prevalence of FGM among the selected Kenyan communities: Maasai, Kisii and Kuria. The primary method of study identification was electronic searches: PubMed, Medline, Google, The lancet, African Index Medicus, Global Health, Science Direct and MSN Search. Electronic database searches were supplemented by studies of organizations engaged in the FGM projects such as WHO, UNICEF, UNPFA, UNWOMEN, Population Reference Bureau (PRB), the Population Council and Kenya Demographic Health Surveys (KDHS). Kenyan newspaper articles, books, journals and brochures were also used in this research.

It is concluded that through a combination of effective comprehensive campaigns with involvement of powerful people in the society, FGM can be eradicated.

TABLE OF CONTENTS

PREFACE i

ABSTRACT ii

TABLE OF CONTENTS iii

FIGURES AND TABLES v

LIST OF ABBREVIATIONS vi

1 BACKGROUND ON FEMALE GENITAL MUTILATION 1

1.1 Classification of FGM 4

1.1.1 Type I: Clitoridectomy 4

1.1.2 Type II: Excision 5

1.1.3 Type III: Infibulation 5

1.1.4 Type IV: Other 6

1.2 Prevalence and geographic spread of FGM 6

1.3 Consequences of FGM 8

1.3.1 Physical complications of FGM 9

1.3.2 Psychological consequences 11

1.3.3 Social consequences 12

1.3.4 Sexual consequences 12

1.3.5 Obstetric and Gynaecological complications 13

1.3.6 Complications associated with FGM which affect men 14

1.4 The practice of FGM in Kenya 14

1.4.1 General statistics of FGM in Kenya 15

1.4.2 Region and ethnic variation 15

1.4.3 Age at circumcision 16

1.4.4 Reasons for practicing FGM in Kenya 16

1.4.5 FGM implications for the education and economic perspectives of girls/women 18

1.5 Efforts to mitigate FGM 19

1.5.1 International and regional (African) Human rights instruments 19

1.5.2 Government policies 21

1.5.3 The role of NGOs, CBOs and faith-based organizations 21

1.5.4 The role of the health care providers 23

1.6 Study objective 23
1.7 Significance of the Study 23
2 RESEARCH METHODOLOGY 24
2.1 The process of search and selection of sources 24
2.2 Inclusion and exclusion criteria 25
3 RESULTS 26
3.1 FGM prevalence by age, region, ethnic group and place of residence 27
3.1.1 FGM prevalence by age 27
3.1.2 FGM regional prevalence 28
3.1.3 Prevalence of FGM in Kenya by ethnic group 28
3.1.4 Prevalence of FGM in Kenya by place of residence 29
3.2 Summary of the approaches to the abandonment of FGM in Kenya 30
3.3 The Maasai community of Kenya 31
3.3.1 Tradition and lifestyle 31
3.3.2 FGM information among the Maasai 31
3.4 Findings 32
3.4.1 1st CASE STUDY: Maasai community in Narok, Kenya 33
3.4.2 2nd CASE STUDY: Maasai of Kilimanjaro region of Tanzania 36
3.4.3 3rd CASE STUDY: Maasai of the southern Rift region of Kenya 39
3.4.4 4th CASE STUDY: FGM among the Kisii community 41
3.4.5 5th CASE STUDY: FGM among the Kuria community 46
3.5 Summary of the key findings 49
3.6 Limitations, reliability and validity 50
4 DISCUSSION 51
5 RECOMMENDATIONS 54
5.1 Summary of the benefits and shortcomings of anti-FGM approaches 56
6 CONCLUSION 58
REFERENCES 59

FIGURES AND TABLES

Figure 1: Clitoridectomy..4

Figure 2: Excision 5

Figure 3: Infibulation...6

Figure 4: Prevalence of FGM among the young and the old 7

Figure 5: Regional distribution of Kenyan tribes and FGM prevalence (%)......................28

Figure 6: Prevalence of FGM in Kenya by ethnic group..29

Figure 7: Prevalence of FGM in Kenya by Place of Residence in 2009 30

Table 1: Summary of consequences of Female Genital Mutilation.....................................8

Table 2: Prevalence of FGM in women and girls by age (%) in Kenya 27

Table 3: Effective interventions and approaches...49

Table 4: Summary of benefits and shortcomings of the anti-FGM approaches..................56

LIST OF ABBREVIATIONS

ACHPR	African Commission on Human and Peoples' Rights
ADRA	Adventist Relief Agency
ARP	Alternative Rites of Passage
BNM	Bogoria Network Ministries
CAT	Committee against Torture
CBO	Community based Organisation
CEDAW	Committee on the Elimination of Discrimination against Women
COVAW	Coalition on Violence Against Women
CRC	Committee on the Rights of the Child
DHS	Demographic & Health Surveys
DSMIV	Diagnostic and Statistical Manual of Mental Disorders
EFA	Education for All
FC	Female Circumcision
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
FIGO	Federation of Gynecologist and Obstetrician
FPFK	Free Pentecostal Fellowship of Kenya
GAMCOTRAP	Gambia Committee on Traditional Practices Affecting the Health of Women and Children
GBV	Gender based Violence
HIV	Human Immunodeficiency Virus
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICM	International Confederation of Midwives
KDHS	Kenya Demographic and Health Survey

MED	Maasai Education Discovery
MICS	Multiple Indictors Cluster Surveys
MYWO	Maendeleo Ya Wanawake Organization
NCA	Norwegian Church Aid
NGO	Non-Governmental Organization
OHCHR	Office of the High Commissioner for Human Rights
PRB	Population Reference Bureau
RWAYDO	Reach Women And Youths Development Organization
SDA	Seventh Day Adventist
TNI	Tasaru Ntomonok Initiative
UN	United Nations
UNDP	United Nations Development Programme
UNECA	United Nations Economic Commission for Africa
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations Human Rights Council
UNICEF	United Nations Children's Emergency Fund
UNIFEM	United Nations Development Fund for Women
UNWOMEN	United Nations Women
USAID	United States Agency for International Development
WHO	World Health Organization
YMCA	Young Men Christian Association

1 BACKGROUND ON FEMALE GENITAL MUTILATION

Female Genital Mutilation (FGM) is defined by World Health Organization (WHO) as "the practice that comprises all the procedures that involve partial or total removal of the external genitalia, or other injury to the female genital organs for non-medical reasons" (WHO factsheet N°241, 2014). The terminology Female Genital Mutilation (FGM) is often used interchangeably with Female Genital Cutting (FGC) or Female Circumcision (FC).

In recent times, organizations engaging with local, regional and inter-regional levels have come up with, and given a lot of support to anti-FGM initiatives that use behaviour change approaches. Some key global players include the World Health Organization (WHO), the United Nations Children's Emergency Fund (UNICEF), United Nations Women (UNWOMEN) and the United Nations Population Fund (UNFPA).

Anti-FGM initiatives, have mostly been developed with little attempt to document how they work, or to illustrate their effect on intelligence, beliefs, attitudes and behaviour. This is due to the fact that many agencies responsible for the implementation of the anti-FGM initiatives are small scale and working with limited budgets. Philanthropic foundations and most of the bigger international development assistance organizations are now supporting such initiatives with huge financing levels, giving the chance to document and evaluate the initiatives more systematically. With greater financing also comes greater hopes that literal evidence be collected to illustrate whether or not anti-FGM initiatives work, how and why they work, and what effect they have in ultimately influencing support and achieving changes in practice. Recently, serious commitments have been made to adapt and develop research and evaluation methods to generate quality information concerning FGM.

State and Non-Governmental Organizations (NGOs) anti-FGM initiatives in FGM-high prevalence countries have focused on educational anti-FGM programs, campaigns using media and research dissemination. Government and civil society organizations mostly get financing for anti-FGM campaigns from international funding organizations such as the United States Agency for International Development (USAID) and United Nations (UN). Many small-scale programs are also organized by Community-Based Organizations (CBOs) that often have only tenuous associations with national and global institutions. In African societies this tends to present them as agents of the 'Whiteman'. Despite some evidence of tensions between local and international approaches in fighting FGM,

traditional communities are likely to take inspiration from international declarations (Skaine, 2005: 13, 14).

Whereas anti-FGM education and sensitization based on information of the harmful effects of the practice have gone on for decades, there is failure by NGO activists to domesticate the information materials used in the process of eliminating FGM. This failure to reflect on local level reality has often led to contestation, the hardening of identities and ambivalence among people who shun FGM but still practice it on new-born babies so as to stifle resistance at maturity.

FGM is always a traumatic thing to experience (UNICEF, 2005). Immediate side effects include pain, shock, haemorrhage and injury to nearby genital tissue. In addition, the need for later surgeries, urinary tract infections, recurrent bladder infections, cysts, infertility, complicated child births and infant deaths are some of the long-term consequences. An example is the Type III infibulation which requires the vagina to be reopened later in life during sexual intercourse and childbirth (WHO factsheet N°241, 2014).

From about the 1990s, female genital mutilation has gained recognition as a human rights issue among parliaments, the global nation, women's organizations, and professional associations. International and national efforts to end FGM have given aid to legislation targeting people who practice the act (UN, 2006).

Over the past 70 years, anti-FGM campaigns with a number of interventions have been undertaken to motivate individuals, families and communities to abandon the harmful practice. Anti-FGM campaigns have come up to persuade individuals to do away with the practice. They have come up with educational campaigns by colonial governments and Christian missionaries in East Africa that provide awareness of the health complications that come along with the act. Creating awareness that rests mainly on the adverse health outcomes of genital cutting has subsequently been the predominant method put in place. There is evidence of such practices, and highlighting adverse health outcomes may even have contributed to medicalization of the practice as communities seek ways to maintain the tradition while reducing the likelihood of doing harm. There have also been efforts to stop traditional practitioners and health care providers who perform mutilation but has little much effect on motivation to continue the practice (WHO, 2008).

In 1997, the WHO, the UNICEF and the UNFPA jointly issued a statement on FGM which shade light on the consequences of the practice for public health and human rights and at

the same time supported its abolishment (WHO, UNICEF, UNFPA, 1997). This statement was later revised in 2008, with nine other United Nations partners (OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM) joining the WHO to issue a new statement on the elimination of FGM and to support increased advocacy for the abandonment of FGM (WHO, 2008).

According to the evidence provided on the practice, FGM poses serious physical, psychological, sexual and mental health risks for women and young girls, especially for those who have undergone extreme forms of the procedure. WHO study on FGM and obstetric outcome, claimed that female genital mutilation can be associated with increased complications in childbirth and even maternal mortality (WHO, 2006).

The practice of FGM exposes victims to serious infections and other health hazards which include HIV/AIDS, tetanus, hepatitis B and haemorrhage (Insel & Roth, 2006).

Female Genital Mutilation (FGM) has continued to be a vital global health development and human rights threat. It is an irreversible and irreparable abuse that is internationally recognized as a violation to human and gender rights of women and girls and reflects the deep-rooted gender inequality in the society between the two sexes. It is also a feature of Gender- Based Violence (GBV) that transcends the bounds of race, culture, class and religion, touching a large community across the globe.

In most cases, it is normally carried out among minorities in a society resulting to violation of rights to good health, education, dignity, security and freedom. FGM is often overlooked by customs and reinforced by institutions or organizations thriving on impunity for the harmful practice.

Article 25 of the Universal Declaration of Human Rights states that “everyone has the right to a standard of living adequate for health and well-being” and has been used to argue that FGM violates the right to health and bodily integrity (United Nations, n.d.).

In December 2012, the United Nations General Assembly adopted a Resolution to Ban FGM worldwide. The Resolution [A/RES/67/146] was co-sponsored by two thirds of the General Assembly, including the entire African Group, and was adopted by consensus by all UN members. Its adoption reflects universal agreement that female genital mutilation constitutes a violation of human rights, which all countries of the world should address through “all necessary measures, including enacting and enforcing legislation to prohibit

FGM and to protect women and girls from this form of violence, and to end impunity" ("General Assembly of the United Nations," n.d.)

Although theories on the origin of FGM abound, no one really knows when, how and why FGM started historically. FGM is documented back to more than 2000 years ago. It is still believed by some societies that the practice originated from ancient Egypt in sub-Saharan Africa, where it was viewed as a sign of distinction among the aristocracy. Some believe that it started during slave trade when the black slave women were taken to the ancient Arab societies, while others believe that it was started during the introduction of Islam to the Sub-Saharan countries (FGM National Clinical group, 2007).

Overall, it was believed that FGM was introduced to ensure women´s virginity and to reduce female sexual desires.

1.1 Classification of FGM

WHO, UNICEF & UNFPA classify FGM into four different types; type I: Clitoridectomy, type II: Excision, type III: Infibulation and type IV: Others. The classification is according to the procedures employed in each type. Type I – Type III are the main ones and are mostly performed traditionally without anaesthetics (Howard, 2014).

1.1.1 Type I: Clitoridectomy

Clitoridectomy involves partial or total removal of the clitoris; the most sensitive part of the female genitals. This is the most common form of FGM which requires the practitioner to be skilled and precise (WHO, 2008). In this process, bleeding is normally stopped by inserting stitches around the clitoral artery or by packing the wound with gauzes and application of a pressure band. It is widely practiced in many parts of the world (Howard, 2014).

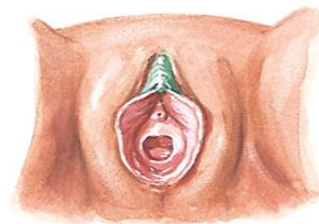

***Figure 1*: Clitoridectomy**

Source: Daughters of Eve, n.d.

1.1.2 Type II: Excision

Excision is a procedure that involves cutting off of the clitoris, the inner lips (the labia minora) and in some cases the outer lips (labia majora) as well. It is an extremely painful procedure which damages the sexual sensitive skin and poses a high risk of infections (Howard, 2014).

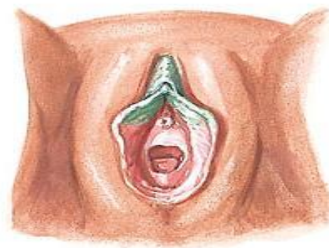

***Figure 2*: Excision**
Source: Daughters of Eve, n.d.

1.1.3 Type III: Infibulation

Infibulation involves narrowing of some or all of the external parts of the genitals by cutting off or repositioning through sewing or stapling the two sides of the vulva. Only a very small opening is left open for the passage of urine and menstrual fluid. The procedure is painful and damages the sexual skin. It is also distressing since the opening can be too small that it requires cutting to be able to have sexual intercourse and give birth (Daughters of Eve, n.d.).

Infibulation is also referred to as Pharaonic circumcision. It is the most harsh and most degrading form of genital mutilation in practice. It is said to have been done in Upper Egypt during the reign of Pharaoh (Ayenigbara et al., 2013 pp. 07-10). During Pharaonic circumcision, the clitoris and labia minora are removed and then the labia majora is sewn closed while leaving a small opening at the vulva for urination and release of menstrual blood (J. Boddy, 1982 pp. 682-698).

***Figure 3*: Infibulation**

Source: Daughters of Eve, n.d.

1.1.4 Type IV: Other

This type of FGM is unclassified since it is still under research and for now termed as type IV. It involves several harmful forms of mutilation such as; piercing, pricking, incising, stretching and cauterising of the female genitals. Pricking and nicking involves cutting to draw blood, but not the removal of the tissue and no permanent hampering of the female external genitalia. According to the 2013 UNICEFs´ report on `*A statistical overview and exploration of the dynamics of change*´, this type of FGM is sometimes referred to as `*symbolic circumcision*´ and despite its controversies, it has been proposed as an alternative to the severe form of cutting in Africa and other countries that perform FGM (UNICEF, 2013).

1.2 Prevalence and geographic spread of FGM

Over the last two decades, reliable data on FGM have been generated through two major household surveys: Demographic and Health Surveys (DHS), supported by the United States Agency for International Development (USAID), and Multiple Indicator Cluster Surveys (MICS), supported by the United Nations Children's Fund (UNICEF). Data from these two sources provide an accurate estimation. This data can be used in the strategic allocation of the resources and setting of the interventions to monitor the progress towards the elimination of FGM (UNICEF, 2013).

According to WHO, approximately 100-140 million women worldwide are affected by FGM. About 3 million women in Africa are assumed to be at the danger of undergoing the practice every year (WHO factsheet N°241, 2014). FGM is practiced in at least 28 countries in Africa and a few others in Asia and the Middle East and is more prevalent among girls aged 15-19 as well as among women of 35-39 years in most of the countries (UNICEF, 2013). A study by UNICEF (*Female Genital Mutilation/Cutting: a statistical exploration*) provides figures on how the practice of FGM has spread within 7 countries in

East and West Africa (see figure 4 below). In these countries, female genital mutilation is done at all educational levels and in all social classes and occurs among many religious groups (Muslims, Christians, and animists), although no religion demands it (UNICEF, 2005).

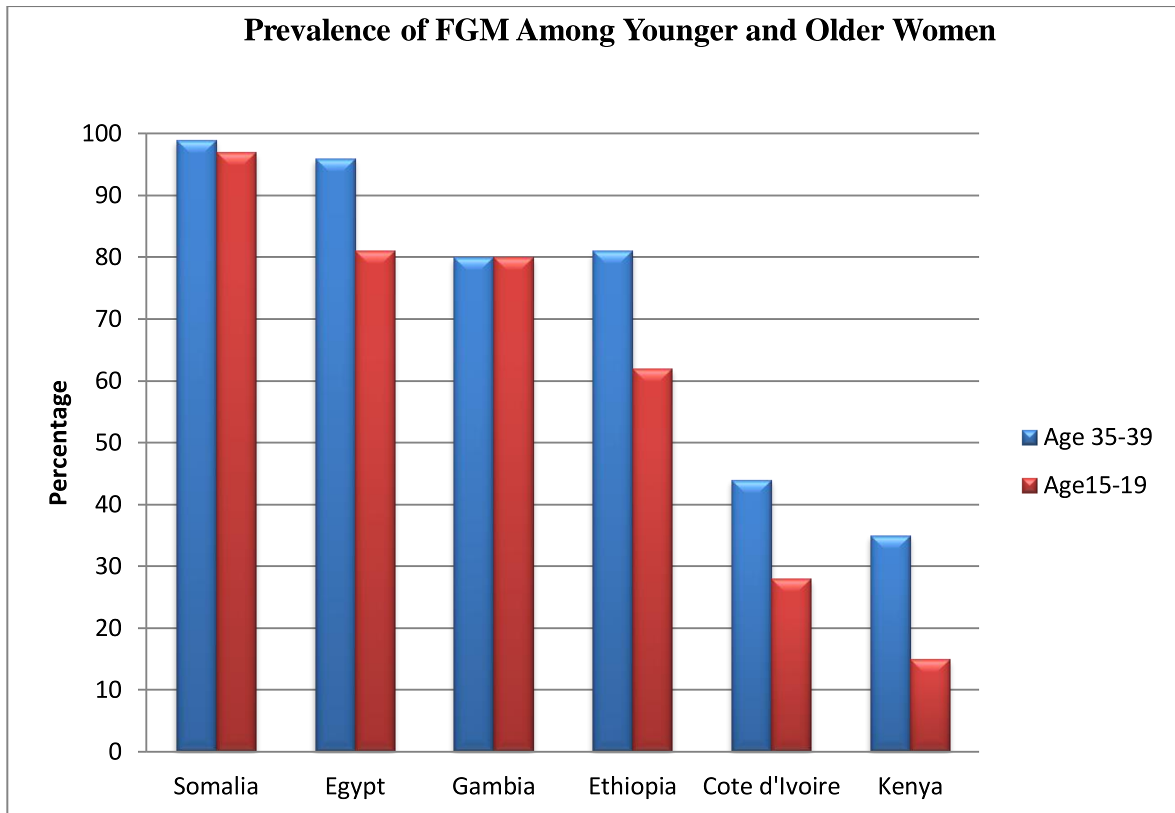

***Figure 4*: Prevalence of FGM among the young and the old**

Source: (Population Reference Bureau, 2010)

Prevalence rates vary from country to country (from nearly 98 percent in Somalia to less than 1 percent in Uganda). While in some countries there is little difference in prevalence between older women (ages 35-39) and younger women (ages 15-19), in others such as Ethiopia, Côte d'Ivoire and Kenya there is a significant difference. This could be a sign of the abandonment of the practice (Population Reference Bureau, 2010).

Although prevalence data obtained over the last decade have shown little change in the recurrence of FGM, they do show several trends, possibly due to the emphasis on the negative health implications of the practice. Today, 94% of women in Egypt arrange for their daughters to undergo the "medicalized" form of FGM, 76% in Yemen, 65% in Mauritania, 48% in Côte d'Ivoire, and 46% in Kenya. This approach may reduce some of

the immediate consequences of the procedure such as pain and bleeding (Yoder et. al., 2004).

1.3 Consequences of FGM

FGM poses serious physical, social, sexual and mental health risks for women and young girls, especially for those who have undergone extreme forms of the procedure. The World Health Organization has listed some of the effects of FGM on the well-being of the girl child (WHO, 2008).

***Table 1*: Summary of consequences of Female Genital Mutilation**

Immediate physical health risks	**Long-term physical health risks**
• Extreme pain • Haemorrhage • Acute painful urination and infections • Human Immunodeficiency Virus (HIV), Hepatitis B and other infections • Haemorrhagic shock • Death	• Difficulty in passing urine • Recurrent urinary tract infections • Pelvic infections • Infertility • Quality of sexual life • Birth complications • Keloid scar
Psychological consequences	**Social consequences**
• Traumatic experience • Psychological instability • Chronic anxiety • Depression • Fright, helplessness and fear • Pain and trauma	• Harassment • Exclusion from important communal events and support networks • Discrimination by peers • Incompleteness and loss of self-esteem • Stigmatization

Sexual consequences	Obstetric and Gynaecological complications
• Painful sexual intercourse (dyspareunia) • Trauma • Loss of self-esteem • Sexual dysfunction • Unstable marital relationship	• Caesarean section • Postpartum haemorrhage • Extended maternal hospital stay • Infant resuscitation • Stillbirth or early neonatal death • Perineal tears • Obstructed labour and obstetric fistula (abnormal opening)
Complications associated with FGM which affect men	
• Pain and complications • Risk of contracting HIV, Hepatitis B and other infections during sexual intercourse	

1.3.1 Physical complications of FGM

The **Immediate physical complications** include:

Extreme pain occurs due to the procedure which is normally performed with crude instruments or without anaesthesia. The clitoris is a vascular organ with many nerves, leading to difficulty in administering the local anaesthesia. The type III, infibulation requires a longer process and so is likely to take a long healing period (Momoh, 2005 p. 7, WHO, 2008).

Excision is a procedure that involves cutting off the clitoris, the inner lips (the labia minora) and in some cases the outer lips (labia majora). The clitoral artery has a strong flow and a high pressure. Stitching or tying to stop the bleeding may lead to excessive bleeding (haemorrhage). Secondary haemorrhage may occur few days later due to infection (Yoder et al., 2004). The procedure can be fatal out of excessive bleeding causing haemorrhagic anaemia (Momoh, 2005 p. 7).

Difficulty in passing urine or faeces can occur due to pain or swelling (Yoder, 2004). Abusharaf, 2006 in his study argues that women who have been infibulated are likely to experience urine retention, as the urethra may be obstructed and urine cannot come out freely. They are exposed to infections that damage the urinary bladder. They also experience painful periods and may contract infection out of the withheld blood. FGM can also lead to internal infection which may result in fatalities and due to the stagnation of menstrual blood and other vaginal secretions, pelvic inflammation can occur. Infections may prevent the wound from healing and may result in an abscess, fever, ascending urinary tract infection, pelvic infection, tetanus, gangrene or septicaemia (Abusharaf, 2006 pp. 73-104).

Sometimes the procedure is administered with unsterilized tools and it is more likely that the participants are never aware of how the infection happens in order to avoid it. The surgical tool is used to cut many girls without being sterilized, making girls vulnerable to HIV, Hepatitis B and other infections (Parekh, 2005).

Due to sudden loss of blood, the girl may go into shock (haemorrhagic shock) and experience severe pain and trauma (neurogenic shock) and this can be fatal (Almroth et al., 2005). Death can be caused by haemorrhage or infections including tetanus (WHO, 2008).

Long-term physical complications may include:

Chronic pain may occur as a result of damage on the urethral opening which may lead to difficulties in urination (WHO, 2008).

Recurrent urinary tract infections occur mostly after infibulation, when the normal flow of the urine is deflected causing the perineum to remain constantly wet. This may also lead to bladder infections. Later, these infections can spread to the ureter and the kidneys potentially resulting in the renal failure if not treated (Almroth et al., 2005).

Pelvic infections are also common among the women who have undergone the type III form of FGM. These infections are painful and may spread to the fallopian tubes and the ovaries.

Chronic infection of the reproductive organs may result to infertility (Almroth et al., 2005).

Following clitoridectomy, a girl/woman experiences reduced sexual sensitivity and pleasure during sexual intercourse. Pain can be felt too during the penetration leading to depression to both partners (R.E.B Johansen, 2007).

Birth complications occur following severe forms of mutilation, because the tough scar tissue that forms causes partial or total occlusion of the vaginal opening. Furthermore, increased tearing and episiotomies increases the risk of obstructed labour. This prolonged and obstructed labour can lead to tearing of the perineum, haemorrhage, fistula formation, and uterine inertia, rupture or prolapse. These complications can cause harm to the neonate (including stillbirth) and maternal death. In the event of miscarriage, the foetus may be retained in the uterus or birth canal (Rushwan, 2000).

Excess scar tissue (keloid scar) may occur due to slow and incomplete healing. This may obstruct the vaginal orifices, resulting to dysmenorrhea (painful menstruation). Women who have undergone infibulation may have difficulties during sexual intercourse due to difficulties in penile penetration, leading to sexual and psychological problems (WHO, 2001a).

1.3.2 Psychological consequences

Women, who have undergone the cut, term it as a traumatic experience that has left them psychologically tortured and mentally instable.

UNICEF, (2005) stated that the cut causes psychological instability and Toubia argued that, many infibulated women suffer chronic anxiety and depression as a result of stigmatization over their status (Toubia, 2000). A study of the psychosocial impact of FGM/C among the Somali in Kenya found that women who have undergone the cut are seen to have emotional difficulties and psychosocial problems, including loss of trust within the mother-daughter relationship. According to WHO, the trauma and memory of being cut as well as the pain a cut woman may experience in her lifetime, mainly during sex and delivery of a child, also result in more stress (WHO, 2008).

A study by UNICEF about the experiences of cut girls in Kenya found that all circumcised participants remembered the day of their circumcision as extremely frightening and traumatizing. Over 78% of the girls described feelings of great fright, helplessness and fear. The study reveals that girls who undergo FGM go on to experience self-discredit, fear and mental disorders than uncut girls (UNICEF, 2013).

Sass, (2005) argues that the psychological effects of FGM on both women and men are significant. When undergoing the procedures, girls are often told something good is about to happen and are told that they are becoming pure by the removal of 'unclean' or impure body parts. The pain and trauma of the procedure, which almost none are prepared for, can

have lifelong effects. Furthermore, the de-infibulation process can have serious and long-term psychological consequences (Sass & Muteshi, 2005).

1.3.3 Social consequences

FGM is a well-recognized social activity among some ethnic groups and as such carries consequences both when it is and when it is not practiced.

The practice is performed in response to strong social conventions and supported by key social norms; thus failure to conform often results in harassment and, exclusion from important communal events and support networks, as well as discrimination by peers.

Denison, (2009) in his study *´Effectiveness of interventions designed to reduce the prevalence of FGM/C´*, concluded that some women from African countries reported that the cut negatively affected their relations with spouse, children and relatives in their country of origin (Denison et al., 2009).

Female genital mutilation is linked to a range of outcomes that negatively impact upon a girl's socio-economic opportunities. Studies show that FGM is linked to girls dropping out of school at a young age. They suffer from health complications including painful menstruation and trauma. This leads to frequent absence from school and hence leading to poor performance and later develop feelings of incompleteness and loss of self-esteem. It is argued that women who drop out of school earlier go on to get less income and have little decision making to do in terms of economic activities. FGM is also believed to have an impact on marriage decisions in those communities that practice it (Yoder, 2008).

Girls and women who have undergone the practice are mostly socially stigmatized, become outcasts in their communities and are unable to get married locally (Muma, 2012).

1.3.4 Sexual consequences

Sexual intercourse can be a painful (dyspareunia) and traumatic experience for women who have been cut. Women who have experienced infibulation, have a hard tissue where the soft opening of the vagina once was, leading to a painful experience of raw flesh being exposed during her first sexual intercourse experience. Vaginal penetration for women with a tight introitus may be difficult or even impossible without tearing or re-cutting the scar. This may lead to loss of self-esteem and sexual dysfunction (Muma, 2012).

Inhibition of coitus because of fear of pain may damage the marital relationship and even lead to divorce (Muma, 2012).

One of the main reasons why FGM is practiced among many African societies is following the belief that it controls the sexual urges of women and young girls (Applebaum et al., 2008.

Applebaum, (2008) shares his view on psychosexual reasons towards FGM. He gave examples of some African countries such as Mali, Kenya, Sudan and Nigeria, where FGM is done so as to avoid unfaithfulness in marriage especially on the woman's′ side. He adds that in Ethiopia, according to FGM research, people believe that if a woman's clitoris is not cut it may come to look like a man's penis and therefore cutting minimizes the growth rate and helps the women to maintain her femininity.

FGM causes torture for most mutilated women. Sex can be excessively painful and even put the women's life at risk. Females who have undergone FGM may experience painful intercourse through their life if they do not seek medical advice (WHO, 2008).

1.3.5 Obstetric and Gynaecological complications

In 2006, WHO determined the relationship between different types of FGM and obstetric complications. The study, *Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries,* involved 28,393 women at 28 obstetric centres across 6 countries which were Burkina Faso, Ghana, Kenya, Nigeria, Senegal and Sudan. Their data showed .that women from these nations who had undergone Type III FGM (infibulation) were 30% more likely to require a caesarean section and 70% more likely to experience post-partum haemorrhage or other adverse obstetric outcomes as compared to those who had not undergone FGM (WHO, 2006).

According to the WHO, 2006 study, 1-2 infant deaths per 100 births were likely to occur among women who had undergone female genital mutilation of all types compared to those who had not been cut. Since the birth weights of the babies involved in the study (WHO, 2006) were alike, these deaths were caused by mechanical problems during birth due to the lack of elasticity in the vaginal tissues.

According to (Leye et al., 2007)it should be noted that the WHO study only dealt with women who had access to hospitals during childbirth. Since in sub-Saharan Africa only 46% of women are attended by any sort of skilled assistant during childbirth, it should be

considered that the number of women who suffer complications and are at risk of death particularly from an inability to deal effectively with post-partum haemorrhage are likely to be much higher.

In 2013 a study review by the Norwegian Knowledge Centre for the Health Services collated findings from a large number of studies and conducted meta-analysis on the soundest results to give a much broader picture. They argued that, women who had undergone FGM were twice more likely to experience difficult labour and 3.3 times likely to experience post-partum haemorrhage compared to their non-cut counterparts. This would lead to 5 more incidents of difficult childbirth and 5 more incidents of post-partum haemorrhaging per 100 women compared to women without FGM ("The impacts of FGC | Orchid Project," n.d.).

Perineal tears, obstructed labour and fistula could result from FGM. The repeated cutting and re-stitching of a woman's genitals with each birth can result in tough scar tissue.

1.3.6 Complications associated with FGM which affect men

There is a possibility that a woman who has undergone FGM is exposed to biological vulnerability to HIV and hence also transmission of the virus to the man.

Sexual intercourse is frequently painful during the first weeks after sexual initiation and the male partner can also experience pain and complications.

In one case study, a husband is taunted by his family for being unable to have sex with his circumcised wife. He responds by forcing violent intercourse and her obvious pain and screaming traumatized him to the extent that they cease to have a sexual intercourse. They get divorced and their psychological health deteriorates steadily. In yet another case, the husband is unable to de-infibulate his wife and eventually commits suicide (Sass & Muteshi, 2005).

1.4 The practice of FGM in Kenya

Female genital mutilation or circumcision is widely practiced in many Kenyan communities. The Kenya Demographic and Health Survey (KDHS 2008-09) revealed that approximately 27% percent of Kenyan women had undergone FGM by the year 2008/2009. The Government of Kenya, through several ministries (Education, Health, Gender, Culture and Social Services, Home Affairs, Natural Heritage, Information and Broadcasting, Justice, Planning) and through local authorities, has been instrumental in

efforts to encourage abandonment of FGM. Presidential decrees were issued in 1982, 1989, 1998 and 2001 by former president Daniel Moi. In 1999, the Ministry of Health issued a National Plan of Action for the Elimination of FGM (1999-2019), which set out broad goals, strategies, targets and indicators. In 2001, Kenya outlawed FGM among girls under the age of 18 years old, known as the children's act. This regulation states that punishment for FGM related offences carries a penalty of 12 months imprisonment or a fine of KSH 50,000 (equivalent to approximately US$600 or both (28 Too Many, 2013b), (Population council, 2007).

In the same year, the Kenyan ministry of health supported the punishment and circulated the policy directive making FGM illegal in all health facilities. In September 2004, Kenya hosted the International Conference on FGM entitled *´Developing a Political, Legal and Social Environment to Implement the African Union's Maputo Protocol´.* The government ratified the protocol, joining Libya, Comoros, Rwanda, Namibia, Lesotho and Djibouti (Sheikh, Njue, & Askew, 2007).

On 30 September 2011 the Prohibition of Female Genital Mutilation Act 2011 was passed by parliament and was signed into law on 6 October 2011. The Act was drafted by the Kenya Women's Parliamentary Association (KEWOPA) with support from the Parliamentary Council, the National FGM Secretariat and the UNFPA/UNICEF Joint Programme. The Act criminalizes all forms of FGM performed on anyone, regardless of age or status, and banned the stigmatizing of a woman who had not undergone FGM in an attempt to tackle social pressure. The penalties include 3-7 years' imprisonment, or life imprisonment for causing death by performing FGM and fines of nearly US$6,000 (28 Too Many, 2013b).

1.4.1 General statistics of FGM in Kenya

In Kenya, an estimated 27.1% of girls and women aged 15-49 years have undergone FGM according to the most recent Demographic Health Survey (KDHS 2008-09), the figure has decreased from 37.6% % in 1998, and 32.2% in 2003.

1.4.2 Region and ethnic variation

Kenya has great ethnic and cultural variations, as seen in the differing rates of FGM prevalence across different cultures. Somalis that inhabit the North Eastern province practice FGM at a rate of 97.7%, with 75% having undergone the most severe Type III

infibulation. The Abagussi or Kisii and the Kuria practice it at 96.1% and the Maasai at 73.2%. The Kisii and Maasai practice Type I clitoridectomy and Type II excision respectively. KDHS report shows that, FGM among the Kalenjin is (62%), TaitaTaveta (59%) and Meru / Embu ethnic groups (54%) and to lesser extent among the Kikuyu (43%). In the Kamba ethnic group, FGM is recorded to be 33% and among the Mijikenda/Swahili to be 12%. On the other hand, the Luhya and the Luo in western side of Kenya have low prevalence of less than 1%. The most common type of FGM is clitoridectomy which in Kenya accounts for 83% of women who have undergone FGM. The type III (infibulation) accounts for 13% and type II (excision) accounts for 2%. The percentage of women circumcised declines steadily as wealth quintile increases (KDHS, 2008).

1.4.3 Age at circumcision

FGM is mostly performed to girls ranging from shortly after birth to age of 15 years. The variation signals that the practice is often a rite of passage from childhood into adulthood. In Kenya, FGM is performed mostly on girls aged between 12 and 18 years. According to the study that was conducted by KDHS, 45% of circumcised women age 15-19 were circumcised before they were ten years old compared with only 14% percent of circumcised women age 45-49. Circumcision of urban women generally occurs at younger ages than for rural women. Coast province has by far the highest proportion of female circumcision performed during infancy. Almost two-thirds of circumcised women in North Eastern province underwent the procedure when they were 3-7 years old. Almost 6 of 10 circumcised women in Rift Valley and Central provinces were circumcised when they were 14-18 years old (KDHS, 2008-09).

1.4.4 Reasons for practicing FGM in Kenya

FGM is a deeply rooted cultural practice, with tradition being a powerful driver in many societies (Sheikh et al., 2007).

28 Too Many is an anti-FGM charity, created to end FGM in the 28 African countries. According to its 2013 report, FGM is often motivated by beliefs about what is considered appropriate sexual behaviour, with some communities considering that it ensures and keeps chastity. The Somali community sees FGM as preservation of family´s honour through the preservation of virginity. The Kisii believe that FGM ensures fidelity in marriage especially in polygamous marriages. (Yang et al., 2006) argue that FGM particularly the

removal of the clitoris is said to reduce female sexual desires, maintain chastity and virginity before marriage and fidelity during marriage and increase male sexual pleasure.

In some communities, FGM is considered as the rite of passage into womanhood and is accompanied by ceremonies to mark the occasion when the girl becomes a mature woman. In other communities girls are subjected to powerful social pressure from their peers and family members to undergo the procedure. They may be rejected by the group or family if they do not follow tradition. It is seen as a necessity for a girl to go through in order to become a responsible adult member of society (Muma, 2012).

FGM is a deeply rooted cultural ordeal. For some, it is an important rite of passage, for others it is closely tied to marriageability. The young girls are neither considered eligible for marriage nor respected unless they have been circumcised. A woman's status in the society where female circumcision is practiced and her eligibility for marriage therefore is dependent on this initiation process (Muma, 2012).

Another factor responsible for the perpetuation of female circumcision in Kenya is that the ceremonies provide the initiate's parents and relatives the opportunity to display their wealth, generosity and social status to the rest of the community (Berg & Denison, 2013).

FGM is not required by any religion yet it is practiced by Muslims, Christians, animists and non-believers in a range of communities. Among some Muslim communities the practice is carried out guided by the belief that it is demanded by Islam. There is no strong support that it is a religious requirement of Islam. Among the Christians, the Bible only talks about male circumcision and there is no reference to female circumcision.

Another factor enhancing the persistence of FGM is hygienic and aesthetic reasons. It is considered to make girls and women pure. In most communities the female external genitalia are considered dirty and unsightly and their removal is considered to promote hygiene and promote aesthetic appeal (UNFPA & World Bank, 2004).

FGM is a source of income for practitioners who are paid a certain amount of money for performing the operation and mutilated girls get material incentives, which include new clothes, shoes, money and other related gifts. The fees charged for the operation range from 300-5000 Kenyan shillings (Ksh) (approximately 3-50US$) among the traditional circumcisers. The 5000 Ksh is charged when a girl is circumcised while pregnant to enhance the circumciser to "cleanse" herself since being pregnant while uncircumcised is considered unclean and a bad omen (Ondieki, 2010).

Every circumcised woman was and is still seen as knowledgeable in the ways of the community amongst the Kenyan communities practicing FGM. This locally enviable status obviously earns them the responsibility to oversee and inspect the uncircumcised girls and women anytime anywhere (Cheserem, 2010).

1.4.5 FGM implications for the education and economic perspectives of girls/women

The establishment of UNESCO in 1948 was accompanied by a resolution, which declared that education was a human right that should be provided to all children, both male and female. The 1990 UNO declaration on the rights of the child and the Jomtien World Declaration (2000) on Education For All (EFA), assert that education remains the single major factor that can narrow the gender imbalance in all areas of development. The 7thdevelopment plan observes that the overall situation however, reveals that females are disadvantaged at all levels of education in terms of access, participation and completion of performance.

In spite of the arguably noted campaigns against FGM, globally, nationally and regionally, the practice is still prevalent in most African and Muslim societies according to the World Bank Report on FGM (1994). There are considerable indicators that girls have lower educational and occupational aspirations in comparison to their male counterparts (World Bank Report, 1994). Education therefore is a fundamental human right or a means of fully participating in social-economic development activities both locally and nationally. Girl child education is therefore, a pivotal point of sustainable growth in development (UNICEF, 2007).

The objective of education is to sharpen an individual's capacity for bettering herself/himself and the various ability to function effectively in the various roles that the individual is expected to play. Education can either be formal material culture, this equation between formal education and material culture is incorrect or informal non-material culture (UNICEF, 2007).

However, research conducted by (Leye et al., 2007) indicates that girls, who have undergone FGM, often undergo attitudinal changes and reject formal education, perceiving themselves as adults and schools as institutions for children. This is further emphasized in a confidential World Bank report (1994) which asserts that FGM has negative repercussions on girl child education as girls may be kept out of school for several days, weeks or months or even be withdrawn as a direct result of FGM.

1.5 Efforts to mitigate FGM

1.5.1 International and regional (African) Human rights instruments

FGM is a violation of the human rights of women and girls as recognized in numerous international and regional human rights appliances. Among the international human rights treaty bodies that seek to abandon FGM are:

- Committee on the Elimination of Discrimination against Women (CEDAW)
- Committee against Torture (CAT)
- Committee on the Rights of the Child (CRC)
- World Health Organization (WHO)
- International Covenant on Economic, Social and Cultural Rights (ICESCR)
- International Covenant on Civil and Political Rights (ICCPR)
- Universal Declaration of Human rights

The CEDAW and the CRC prohibit traditional practices that discriminate against women and harm children. Under the ICESCR, FGM is a violation of the right to health. FGM thus violates the convention due to the numerous adverse health consequences discussed in consequences of FGM above (28 Too Many, 2013b).

In Africa, the human rights instruments include:

- The African Charter on Human and Peoples' Rights (Banjul Charter)
- African Charter on the Rights and Welfare of the Child (African Charter)
- The African Commission on Human and Peoples' Rights (ACHPR)
- The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (The Maputo Protocol)
- Cairo Declaration for the Elimination of FGM
- Gambia Committee on Traditional Practices Affecting the Health of Women and Children (GAMCOTRAP)

The African Charter on the Rights and Welfare of the Child calls all the members states of the African Union to abolish customs and practices harmful to the 'welfare, dignity, normal growth and development of the child. The Maputo Protocol explicitly refers to FGM, under Article 5, 'state parties shall prohibit and condemn...through legislative measures backed by sanctions, (b) all forms of female genital mutilation, scarification and

para-medicalization of female genital mutilation and all other practices in order to eradicate them' (United Nations, n.d.).

These human rights instruments provide a platform for the girl child to be free from all forms of violation. They argue that FGM is an infringement of the right of the girl child which include right to education and physical well-being.

Article 2 of the Universal Declaration of Human Rights states that "e*veryone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex"* (United Nations, n.d.).

The following declarations have been put into place: Article 1 of the UN General assembly Declaration on the Elimination of Violence Against Women, the *GA Resolution 61/143 (2007)* which reminded states that they must not use customs, traditions, or religious beliefs as excuses for avoiding their obligation to eliminate violence against women and girls. The United Nations General Assembly at its 67th Session drafted a revised draft resolution on intensifying global efforts for the elimination of female genital mutilation (United Nations, n.d. (*http://www.un.org/en/documents/udhr/*).

On December 20, 2012, the United Nations General Assembly passed a unanimous resolution urging all the member states to condemn the practice of FGM, to implement and enforce legislation banning FGM, and to establish programs raising awareness about FGM. *(UN Document A/RES/67/146).* It also calls upon States, the United Nations system, civil society and all stakeholders to continue to observe 6 February as the International Day of Zero Tolerance for Female Genital Mutilation and to use the day to enhance awareness-raising campaigns and to take concrete actions against female genital mutilations ("International Day of Zero Tolerance to Female Genital Mutilation," n.d.).

In December 2014, it adopted the *resolution A/RES/69/150.* This resolution call upon intensification of the global efforts to eliminate FGM and support of the integrated strategies like training of the medical personnel, social workers, community and religious leaders in prevention and elimination of FGM (Njue & Askew, 2004).

In 2010, the Commission on the Status of Women adopted a *resolution entitled Ending Female Genital Mutilation (UNWOMEN).* The resolution recognizes FGM as violation of human rights; it urges all the member states to condemn the practice, to enact and implement legislation banning FGM and to enact penalties in regards to FGM (UNWOMEN, n.d.).

1.5.2 Government policies

Efforts to abandon the practice of FGM in Africa have used several methods: a health risk approach, training health workers as change agents, and the use of comprehensive social methods. Some anti-FGM interventions are effective in achieving changes in practices related to FGM, but systematic appraisal of the evidence is lacking (WHO, 2008).

To aid statutory bodies with their duty to safeguard children from FGM, the Kenyan Government has produced Multi-Agency Practice Guidelines. These guidelines set out the role of local authority in mitigating suspected FGM cases. It is intended that the multi-agency guidelines should be used in conjunction with statutory guidance on safeguarding children including Working Together to Safeguard Children. Further work is also underway to increase the number of FGM prosecutions.

Policies established to tackle FGM in Kenya include the 2007 National Reproductive Health Policy, the National Plan of Action for the Elimination of Female Genital Mutilation in Kenya (2008-2012) and the Adolescent and reproductive Health Policy and Plan of Action (2005-2015). In 2011, a new law known as the Prohibition of FGM 2011 was formulated (UNFPA-UNICEF Joint programme on FGM 2012). The ministry of Gender, Children and Social Development, carries out the coordination of all FGM activities from other government, NGOs and donors.

1.5.3 The role of NGOs, CBOs and faith-based organizations

These local organizations work nationally to eradicate FGM. Most of them are dependent on international donors for funding of their programs. They have programs covering several counties and target different ethnic groups (Sheikh et al., 2007).

Some of these organizations include:

Aid Kenya Foundation: The organization's "Stop FGM Now" campaign commenced in 2008 and focuses on the Maasai communities in rural Kisii areas and in Narok. The program offers a platform for the ex-circumcisers to speak out against FGM. It also seeks to offer community dialogue, support and counselling for women and girls who have undergone FGM (28 Too Many, 2013b).

Maasai Education Discovery (MED) is a non-profit organization created and operated by Maasai. It promotes alternatives to female circumcision and works to strengthen Maasai education and rights. They have a handbook program, to train the trainers. These trainers in

turn visit villages and conduct interactive education and dialogue with various groups on adverse effects of FGM. Girls who have completed the educational program continue to work as mentors for other girls. Unlike many non-Maasai anti-FGM activists, MED does not threaten to prosecute the FGM practitioners. Instead, they have open dialogue between community members and discuss possible alternatives. In addition, they encourage girls to speak out their feelings about the practice and in cases where the girl is forced to undergo circumcision, MED ensure that the girl is taken way and later they initiate a reconciliation process to bring the girl back together with her parents and the community. MED also trains midwives and practitioners in presenting knowledge to girls as an alternative rite of passage (survival, 2010).

Bogoria Network Ministries (BNM) is a missionary organization registered in Kenya and Germany and was established in 2006. It offers shelter for girls fleeing away from FGM and pays their school fees (28 Too Many, 2013b).

Maendeleo Ya Wanawake Organization (MYWO) is a non-profitable organization that has been researching on FGM in Kenya for more than 20 years. Some of their programs include scaling up sensitization of community leaders on the need to abandon FGM/C and early marriage, support Alternative Rites of Passage (ARP) for selected districts (Maendeleo Ya Wanawake Organization (MYWO), 2011).

The Norwegian Lutheran Mission: had phased out its West Pokot development program in 2007. The program had worked in many fields: FGM, schools, health, agriculture and education. They built a secondary school with boarding facilities where girls could run away from being circumcised.

Norwegian Church Aid (NCA) has two partners in their projects against FGM, The Coalition on Violence Against Women (COVAW) and Habiba.

COVAW works in Laikipia and Kajiado Districts targeting Maasai people and encouraging community dialogues especially among the youth. They also act on empowerment issues. COVAW uses sensitization in schools and resource mobilization. *HABIBA* works in Mandera, it raises awareness and community sensitization about the adverse effects of FGM. They have also introduced alternative income sources for ex-practitioners, and seek to influence and inspire health providers, leaders, and individuals to become advocates against FGM. They use already established youth- and women's groups and make school visits. They train change agents and organize media campaigns (Tonje and Talle, 2007).

1.5.4 The role of the health care providers

Interventions against FGM started more than 40 years ago. They create awareness of the adverse effects of the practice and this has been one of the successful approaches. Risks to health have been targeted at different focus population groups by providing facts that are evidence-based. This has been done by local health providers, community facilitators and NGO staff. Its´ broadest form is the inclusion of local knowledge and personal reflection coupled with the provision of health services for complications of FGM. Increase of knowledge on the negative health outcomes stimulates reflection and various thinking on FGM (Sass & Muteshi, 2005).

1.6 Study objective

Some of the anti-FGM initiatives have been effective despite the range of ethnic and cultural traditions and beliefs that make it difficult. There are still many challenges though to overcome FGM. Although there are indications of the effectiveness of some anti-FGM initiatives in achieving changes in knowledge, beliefs, attitudes, behaviours and practices related to FGM, systematic appraisal of the evidence is lacking.

The ultimate objective of this research is to present systematic review summary of the literature about interventions designed to reduce the prevalence of FGM by answering the following research question: *What is the effectiveness of interventions designed to reduce the prevalence of female genital mutilation among the selected Kenyan communities (Maasai, Kisii and Kuria)?*

1.7 Significance of the Study

The findings from this study may be useful to the anti-FGM campaign teams in its efforts towards curbing the increased FGM practice in different Kenyan communities through employing strategies that are effective.

The Ministry of Gender in Kenya is one of the ministries that promote women empowerment and sets the laws required in eliminating FGM. The findings may be useful to this Ministry in its efforts towards retooling and repositioning its efforts in fighting FGM practices.

The successful implementation, completion and approval of this study will help anti-FGM campaigners develop positive attitude towards the fight against FGM. It will also offer some analysis of the current situation and will enable all those with a commitment to

ending FGM to shape their own policies and practice to create conditions for positive, enduring change in communities that practice FGM. This research will contribute to the existing body of knowledge in fighting against FGM and can be used as a basis for subsequent researches in similar settings.

2 RESEARCH METHODOLOGY

This thesis is based on literature review. The ultimate objective of this research is to present a systematic review summary of the literature about successful interventions designed to reduce the prevalence of FGM among the selected Kenyan communities (Maasai, Kisii and Kuria). The secondary data comprehends scientific studies, policy papers and literature about FGM. The research employed a qualitative research design with a case study approach. Case study was chosen because this research aims to describe the unique case of FGM, its impacts and mitigation of FGM in Kenya from an ethical perspective.

2.1 The process of search and selection of sources

The stages involved in performing this review were as follows: definition of inclusion criteria for the literature, literature search, screening by title, abstract and full text, review, data selection and evaluation, and data analysis and interpretation.

The primary method of study identification was electronic searches:

- PubMed
- Medline
- Google
- The lancet
- African Index Medicus
- Global Health
- Science Direct
- MSN Search

Electronic database searches were supplemented by searches in the reference lists of the included studies and the international organizations engaged in the FGM projects: WHO, UNICEF, UNPFA, UNWOMEN, Population Reference Bureau (PRB) and the Population Council. The following key words were used to identify the studies: Female genital mutilation, female circumcision, FGM in Kenya, FGM among the Maasai, FGM among the Kisii and FGM among the Kuria.

Most of global, regional (Africa) and local (Kenya, Kenyan districts) information on FGM was collected from reports and publications from various UN sources like, UNICEF, WHO or UNPFA. General facts on FGM in Kenya were based on the "28 too Many Report" (2013); which gives a comprehensive overview of the issue in Kenya among different communities. The report is based on various testimonials, previous research and case-studies that present the diverse experiences of FGM found in different parts of the country. The UN plays an important role in setting the international agenda against FGM. Their electronic resources are up to date with yearly reports and statistics of the practice worldwide.

More specifically local information of FGM based on the three tribes which include Maasai, Kisii and Kuria was collected from 28 too many report (2013), IRINnews (2005) and Kenya Demographic Health Surveys (KDHS). Kenyan newspaper articles, books and brochures were also used.

2.2 Inclusion and exclusion criteria

The articles that are relevant to the topic and those that can answer the research questions were selected for inclusion in the study.

Eligible for inclusion criteria were:

- Studies that provided an integrative literature review of articles published on FGM 2001-2014.
- Articles written in English.
- Articles published in reviewed journals between the years 2000 and 2014.
- Articles containing research method of data collection, data analysis and empirical findings.
- Articles involving FGM intervention and approaches in mitigation of FGM.

Eligible for exclusion criteria were:

- Articles without profound focus on FGM.
- The articles that did not focus on the FGM prevalences, incidences, interventions, policies or public health strategies in Kenya.
- Abstracts with no accessible article.
- Articles that were published before the year 2000.

The first keywords Female Genital mutilation and Female circumcision yielded a total of 368 articles in PUBMED and 360 on MEDLINE. The articles were screened by free full text. A total of 27 articles on FGM/FC in Kenya could be obtained. However, 3 of the articles were able to answer the research question.

3 RESULTS

This research was conducted to better understand FGM as current practice by some Kenyan communities and to identify successful interventions that mitigate the practice. Case studies from three selected Kenyan communities (Maasai, Kisii and Kuria) that were retrieved provided information on *the effectiveness interventions designed to reduce the prevalence of female genital mutilation among the selected Kenyan communities*. The researchers for the case studies of Kisii and Kuria collected information using semi-structured questions. This was done through Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs) (Oloo, Wanjiru, & Newell-Jones, 2010).

Results for the Maasai community were retrieved from the booklet "*Protecting girls from undergoing Female Genital Mutilation"*. This booklet was developed by the organization Equity Now and published in 2011. It contains: *FGM case study from the Maasai community in the Narok district of Kenya* and *FGM case study from the Kilimanjaro region of Tanzania.*

The case study of the Maasai from Tanzania was used here as a comparison to the initiatives that have been applied in the Maasai of Kenya to eradicate FGM. It is sought to find out successful interventions which can be applied to the Maasai of both countries since the community is constantly migrating across the borders of these two countries in search of pasture or to perform practices like circumcision if prohibited in one country.

The literature review indicated that the success of interventions to encourage the abandonment of FGM depends mostly on the cultural context of the communities. By analyzing different interventions that have been used in these communities, it is hoped to identify the successful interventions and approaches.

3.1 FGM prevalence by age, region, ethnic group and place of residence

Despite the fact that FGM is illegal in Kenya, it is still practiced by the majority of the Kenyan communities. A report by the Kenya Demographic and Health Surveys (KDHS, 2008/2009) states that the practice has reduced from 37.6% in 1998 (KDHS 1998) and 32.2% in 2003 (KDHS 2003).

3.1.1 FGM prevalence by age

In Kenya, age at which FGM is performed differs from tribe to tribe with Taita Taveta doing it at birth, while other tribes perform it on girls and women between the ages 4-35 years (*see table 2 below*). The average age is however 12-15 years for most tribes. Among the Meru and the Maasai the age of circumcision is between 12-15 years while that of Kisii has dropped from (12-15) to as low as 4 years (Chege, Askew, & Liku, 2001).

***Table 2*: Prevalence of FGM in women and girls by age (%) in Kenya**

Age in years	1998	2003	2008-09
15-19	26.0	32.3	14.6
20-24	32.2	24.8	21.1
25-29	40.4	22.0	25.3
30-34	40.9	38.1	30.0
35-39	49.3	39.7	35.1
40-44	47.4	47.5	39.8
45-49	47.5	47.7	48.8
Total	37.6	20.3	27.1

Source: (UNICEF 2005; DHS 1998, 2003, 2008-09, 28 too many, 2013)

3.1.2 FGM regional prevalence

Kenya is classified by the UNICEF as a Group 2 Country, where FGM prevalence is intermediate with significant regional variations. These regional differences are reflective of the diverse ethnic communities (28 Too Many, 2013b).

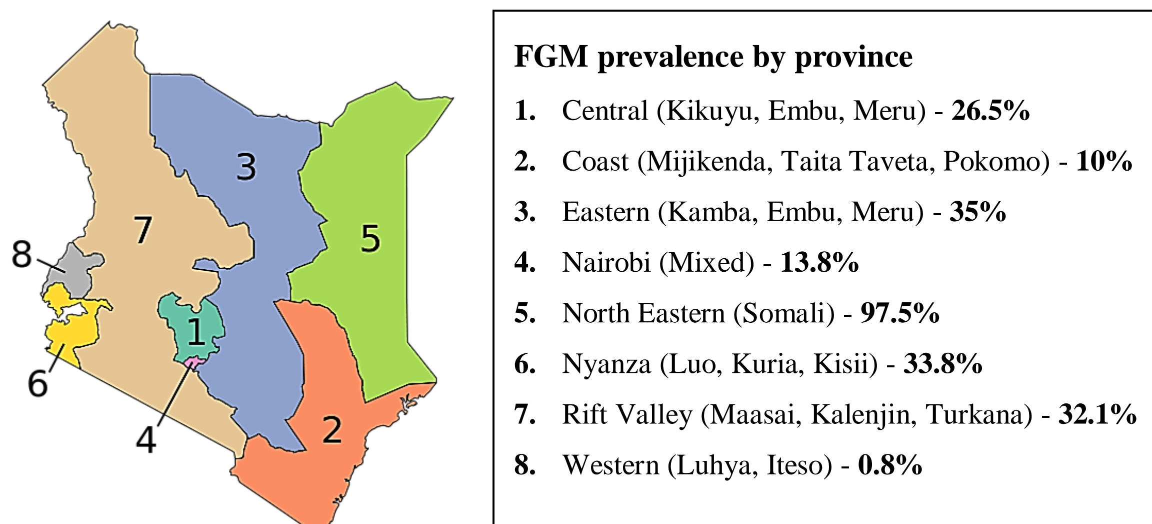

***Figure 5*: Regional distribution of Kenyan tribes and FGM prevalence (%)**

Source: KDHS 2008-09; 28 Too Many, 2013

3.1.3 Prevalence of FGM in Kenya by ethnic group

In Figure 6 below, FGM is shown to be nearly universal among certain ethnic groups such as the Somali, Kisii, and Maasai. FGM was revealed to be more prevalent among the Kisii (96%), Kuria (96%) and Maasai (73%) as compared to other communities.It is highly prevalent among the Taita Taveta, Kalenjin, Embu and Meru groups, and is practiced to a lesser extent among the Kikuyu and Kamba. There are also some ethnic groups, notably the Luo, Luhya and Mijikenda, who almost do not practice FGM (Njue & Askew, 2004).

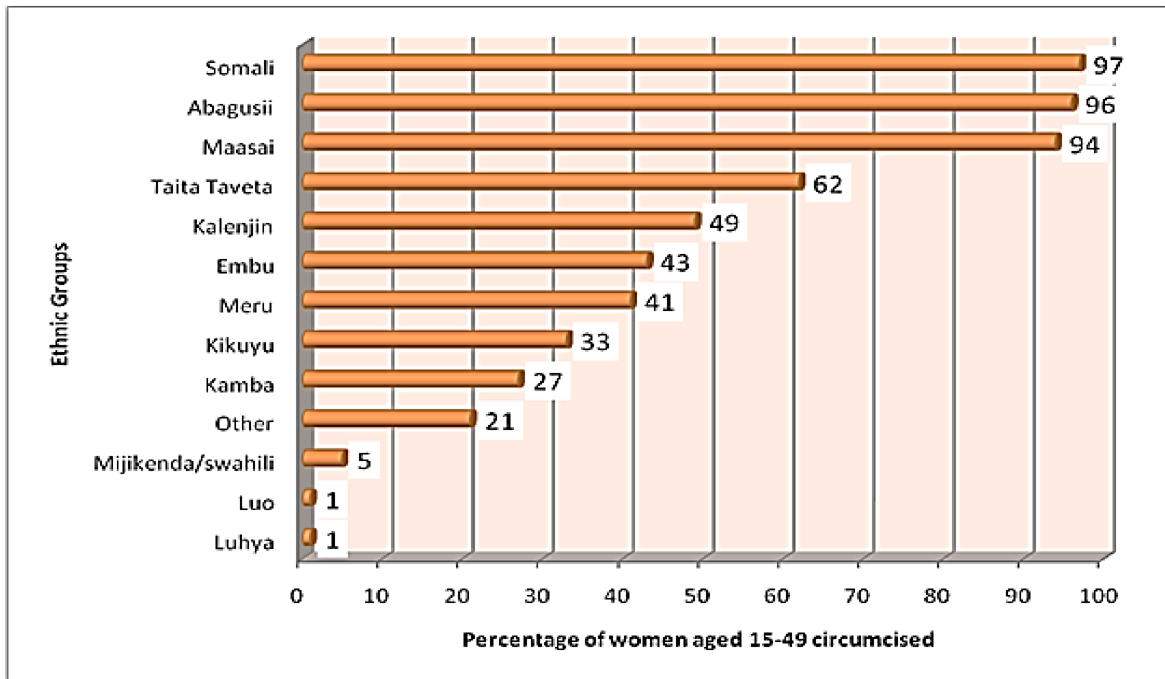

***Figure 6*: Prevalence of FGM in Kenya by ethnic group**

Source: (Njue & Askew, 2004)

Clitoridectomy (type I) and excision (type II) are the predominant types of cutting practiced, although the Somali, Borana, Rendille, and Samburu practice the more severe (type III) form of infibulation, which is virtually universal in those cultures and is practiced on girls at pre-puberty or at younger ages. Type I (Clitoridectomy) accounts for 83%, type III (infibulation) accounts for 13% and type II (excision) accounts for 2%. The percentage of women circumcised declines steadily as wealth quintile increases (KDHS, 2008-09).

3.1.4 Prevalence of FGM in Kenya by place of residence

Findings in Figure 7 (*below)* show that by 2009, 40.6% of girls and women from rural Kenyan areas have to undergo FGM while only 16.5% residents in urban areas fall victim to the practice.

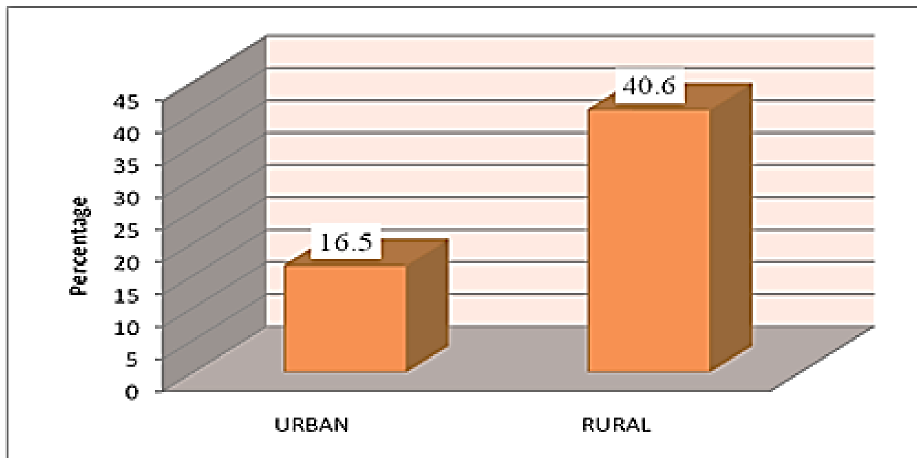

***Figure 7*: Prevalence of FGM in Kenya by Place of Residence in 2009**

Source: (PRB, based on KDHS 2008-09, 28 too many, 2013)

3.2 Summary of the approaches to the abandonment of FGM in Kenya

Through the introduction of range initiatives, different intervention approaches have been used in Kenya to persuade communities to abandon FGM. Early interventions focused mostly on health risks and addressing FGM as a harmful practice. Though not documented, it is suspected that these interventions may have led to harm reduction tendencies in some communities including minimizing the amount of flesh and use of medical staff and implements to perform the circumcision (medicalization) (Oloo et al., 2010).

Some of the interventions that were documented in a Situation Analysis by (Sheikh et al., 2007) include:

- Campaigns addressing FGM as a harmful practice.
- Approaches using the Alternative Rite of Passage (ARP).
- Legal human rights approach and intergenerational approach.
- Interventions addressing health risks and health complications of FGM.
- Offering of alternative income to the practitioners and educating them on the harmful effects of FGM.
- Girls and women empowerment through education to oppose FGM and offering of support to girls who run away from early marriage and FGM.

3.3 The Maasai community of Kenya

3.3.1 Tradition and lifestyle

The Maasai are a semi nomadic community inhabiting several districts of central Kenya and northern Tanzania. Their lifestyle is nomadic; they migrate in search of water and pasture for their animals. They are a proud community with very traditional ways of life (dress, distinctive customs and culture), despite of all colonial and postcolonial pressure to conform modernization. They depend entirely on their traditional food which consists of cow's milk, meat and since colonial times maize meal. All these food are reared and grown by the Maasai making them independent of other communities, which has reduced their exposure to and influence from other cultures (IRIN, 2005).

3.3.2 FGM information among the Maasai

The Maasai have an ingrained sense of culture. They strongly believe in their traditions and continue to uphold their way of life. They do not adapt to change. They have legends about how they originated and how their customs, rituals and traditions came about. FGM is deeply rooted in Maasai mythology.

FGM among the Maasai originated from the story of Naipei, a girl who slept with an enemy of her family. She was punished by being mutilated to prevent her from feeling sexual urge that had made her commit the erroneous act. Since that day, thus the myth, in a bid to protect their honour and the honour of the Maasai society, all Maasai girls who reach adolescence have been circumcised. The aim of FGM is therefore to limit the sexual desire and promiscuity of girls. The perceived socio-cultural importance of FGM among the Maasai is high. Despite criminalization of FGM by the international community and the Kenyan law, the Maasai have held on to this practice as their custom (IRIN, 2005).

The FGM ceremony among the Maasai takes place once a year mostly in December and is seen as a community celebration. It is a huge event, marked by merriment and feasting. FGM is performed by a traditional female circumciser who is usually an experienced elderly woman. The event is a big yearly celebration for all women who have reached adolescence. After circumcision, girls go into seclusion period where they are taught about their rights and duties as women and when they go back to the community they are eligible for marriage and child bearing (IRIN, 2005).

Photo: Justo Casal

Twelve-year old girls from a Maasai community in Kenya. The traditional rite of FGM among the Maasai is performed between the ages of 12 and 14 (IRIN, 2005).

Girls mostly between ages of 12 and 14 are cut in line using one knife (often a sharpened knife known as an "ormurunya"). Cow dung or milk fat is then applied after cutting to prevent the cut from bleeding. Both the use of one unsterilized knife and inadequate wound dressing highly endanger the health of the circumcised girls. The type of FGM practiced is mostly clitoridectomy which involves the removal of all or part of the clitoris. Complications have often been identified. Some of the health complications associated with FGM include severe bleeding, tetanus, urinary tract infections, poor urine retention, ulceration, difficult child birth, and pain during sex (Towett, Oino, & Matere, 2014).

3.4 Findings

The booklet "*Protecting girls from undergoing Female Genital Mutilation: The experience of working with the Maasai communities in Kenya and Tanzania,* (Equality Now, 2011)" emphasizes that the Maasai are showing interest to change despite their deeply rooted cultures. This is due to increased awareness on the adverse effects of FGM.

IRIN, (2005) states that alternative rites of passage ceremonies are being used by several organizations to substitute the practice of FGM. In such ceremonies, girls do not go through FGM but they still get awareness on their roles as women in society, as well as lessons on sexual and reproductive health, and the importance of formal education.

In Tanzania, there is a lack of definition of FGM in the Act and does not explicitly cover

all the persons who may be involved in perpetrating FGM, such as medical practitioners. Some communities like the Maasai of the Kilimanjaro region have passed by-laws against FGM (28 Too Many, 2013a).

In Kenya, Prohibition of Female Genital Mutilation Act 2011 was passed by parliament and was signed into law on 6 October 2011. The Act criminalises all forms of FGM performed on anyone, regardless of age or status, and bans the stigmatizing of a woman who has not undergone FGM in an attempt to tackle social pressure (28 Too Many, 2013b).

Despite that FGM is against the Kenyan law, the practitioners rarely get prosecuted since the practice is mostly done privately. Nevertheless, anti-FGM organizations hope that the Maasai community is ready for change due to an increase in the number of Maasai children going to school. In schools they are taught about the negative effects of FGM and encouraged to say NO to FGM.

Education is a critical component for economic empowerment. It is estimated that more than 75% of the Maasai people are illiterate. Unfortunately, education has become so expensive causing very few Maasai families the ability to afford quality education. Currently only 48% of Maasai girls are enrolled in school and out of that, only 5% of them go to secondary school ("MAASAI EDUCATION," n.d.).

3.4.1 1st CASE STUDY: Maasai community in Narok, Kenya

The case study on the Maasai community in Narok district by Equity Now (2011) identified the interventions and approaches that have been used by the organization Tasaru Ntomonok Initiative (TNI). TNI is a community based organization which was started in 1999 by a Maasai woman, Agnes Pereyio after she underwent FGM. The organization fights for women`s rights and promotes awareness of FGM. Its aim is to fight and eliminate the social and cultural practices that are harmful to girls and women (Equality Now, 2011). Due to Tasaru Ntomonok Initiative (TNI) campaigns in the Rift valley provinces, there is evidence that the prevalence of FGM has reduced to 25% in 2009 as compared to 42% in 2005 (KDHS, 2008-09).

Approaches used by Tasaru Ntomonok Initiative (TNI) to fight against FGM

1. **Community mobilization and education**

   Creating awareness of FGM through education is the key feature of the organization. This is conducted through workshops and seminars targeting the whole community. Discussions within sexes are held separately so that the participants may feel free to contribute and speak out especially women and girls without fearing the men. They are educated on the dangers of FGM, consequences of FGM and on the Kenyan Children's Act of 2011 which prohibits FGM. In addition, they are educated on different topics for example crime, drugs and HIV/AIDs. Women and girls are empowered to say NO to FGM and those affected are encouraged to share their experiences in order to promote understanding of the FGM dangers. Furthermore, TNI has monitors who campaign against FGM, advise affected girls and protect those who are at risk. According to the case study, TNI found out that the strategy of involving the whole community has led to sustainable and fast reduction of the practice (Equality Now, 2011)

2. **Protection of girls fleeing from FGM**

   TNI provides a temporary home, the Tasaru Rescue Center for the girls fleeing away from FGM. They support them morally, educationally and socially and eventually return them to their homes through a reconciliation process with the parents, relatives and the community. An inclusive approach where all the members are involved to participate in the reconciliation process helps to prevent girls from being circumcised by the relatives or other community members. During this process parents and relatives are educated on the dangers of FGM and the anti-FGM law. In case the reconciliation process is unsuccessful, girls remain at the center until they complete secondary school. If reconciliation and return is successful, follow up activities ensure that girls go to school and are not forced to undergo FGM or early marriage.

   The organization also works together with the local administrative authorities, police and teachers in protecting girls from undergoing FGM. Rescued girls are reported to the police (Equality Now, 2011).

3. **Alternative rite of passage**

   The Maasai believe that FGM is a rite of passage from childhood to adulthood. Girls are taught how to behave as women, wives and mothers. TNI organizes the ceremony where girls are trained and graduate to womanhood without being circumcised. During the training girls are taught on several topics like child abuse, human rights and complications of FGM. This approach has reduced instances of early marriage and FGM while promoting girl education (Equality Now, 2011).

4. **Promoting girls´ education**

   TNI puts emphasis on girls' education by ensuring that all the girls at the center pursue education. Access to education and job training enables the girls to contribute economic and social benefits to their families and they also become role models in their communities (Equality Now, 2011).

Successful interventions and approaches used by TNI (Equality Now, 2011)

1. By engaging religious leaders, pastors have taken the initiative of preaching about the negative effects of FGM in churches.

2. Community leaders act as monitors alerting the police and the TNI organization concerning those girls who are at risk of FGM and early marriages. In December 2008, six girls were rescued by pastors from Free Pentecostal Church in Narok South and referred to Tasaru Girls Rescue Centre. In September 2009, another girl was rescued from undergoing FGM by a pastor from her village.

3. Training of the police on the national and international laws against FGM has resulted in the local police in Narok also engaging in the prevention of the practice. During the FGM ceremony season, the police patrol and anyone who is caught performing the cut is arrested.

4. There's successful usage of the legislation by TNI to protect girls by prosecuting those who carry out the practice. Four FGM cases have been referred to court and three 'circumcisers' have been prosecuted and imprisoned for carrying out FGM.

5. By TNI holding workshops on FGM, circumcisers have denounced the practice and are now engaged in the campaigns against FGM.

6. There’s a significant increase of girls undergoing the Alternative Rite of Passage (ARP) training and attending of school. For example, in 2009, girls who underwent ARP were 204 which was an increase as compared to 137 from the previous year. Between September and December 2009, Tasaru Rescue Centre received 14 new girls who ran away from FGM and early marriage. In 2010, 32 girls were rescued by TNI.

7. Empowering of girls has led to many girls completing their school education. This has made them to be role models in the society leading to many girls going to school and slowly abandonment of the culture like early marriage or polygamy.

Challenges encountered by TNI (Equality Now, 2011)

Despite TNIs efforts to eliminate FGM among the Maasai, there are several challenges which include:

- Deeply ingrained Maasai culture and traditions
- Circumcision of girls at birth to prevent later resistance when they grow up
- Peer pressure
- Illiteracy
- Girl child as an economic asset

3.4.2 2nd CASE STUDY: Maasai of Kilimanjaro region of Tanzania

While the TNI are working with the Maasai of Kenya, the Network Against Female Genital Mutilation (NAFGEM) works with the Maasai of Tanzania in Kilimanjaro region. NAFGEM was founded in 1999 for the purpose of conducting a comprehensive information dissemination and sensitization campaign against the practice of FGM. Its vision is the total elimination of all forms of gender based violence and sexual abuse of women, including FGM in all its forms (Equality Now, 2011).

Strategies used by NAFGEM in campaigns against FGM

In its fight against FGM, NAFGEM uses several strategies including:

- **Community outreach**

  Targeted communities are educated on harmful effects of FGM, anti- FGM laws, and on the relationship between FGM, religion and the rights of women and children. NAFGEM initiates discussion within families and communities on anti-FGM. The organization also recruits monitors who are responsible for community sensitization, and reporting cases of FGM to the police. Monitors also create awareness through public, religious and political meetings. They have managed to engage over 600 community members and about 50 Maasai leaders. Influencing of the Maasai leaders is an important factor since they are the ones who safeguard the traditional values (Equality Now, 2011).

- **Promoting the enforcement of the law to protect girls from FGM**

  NAFGEM is a member of the Tanzania Coalition Against FGM. It participates in joint campaigns launched by the coalition for example creating awareness on FGM issues both in schools and in the community (Equality Now, 2011).

- **Empowering girls and women to say NO to FGM**

  NAFGEM also organizes youth camps for girls and boys between 9-18 years and educate them on their rights and the consequences of FGM. Girls are given information on FGM and are encouraged to publicly voice their concerns and denounce FGM and other forms of sexual abuse (Equality Now, 2011).

- **Creating awareness about the dangers of FGM through media**

  The organization also creates awareness on the dangers of FGM and the laws against the practice through a radio station (Moshi FM radio). They target traditional, religious and government leaders, women, youth, FGM practitioners and health providers. The radio station estimates that about 5 million people have been reached through the radio messages (Equality Now, 2011).

Achievements of NAFGEM (Equality Now, 2011)

1. Maasai leaders have publicly denounced the practice and are now engaged in the campaigns against FGM.

2. Successful use of the media in creating awareness about the dangers of FGM especially in those communities who do not practice it.

3. Successful sensitization campaigns have empowered girls to say NO to the practice, with many running away or threatening to report their parents to court.

4. Successful use of the anti-FGM law by arresting and imprisoning those who are caught doing the practice.

5. Broad-based approach has led to ex-circumcisers laying down their tools, local animators who disseminate information against FGM and church leaders condemning the practice.

Challenges encountered by NAFGEM (Equality Now, 2011)

The Maasai of Kilimanjaro still believe that FGM is a cultural practice and should not be abandoned. They still believe in myths that an uncircumcised girl will always remain a child and that by not undergoing the circumcision, the clitoris will continue to outgrow and at some point it will be similar to the male genitalia. Furthermore, the law in Tanzania is not specific to FGM as it only seeks to protect the rights of children in general.

Some Maasai people from Tanzania migrate to the Kenyan section where FGM is still highly prevalent so as to carry out the practice and vice versa.

In order to overcome these challenges, NAFGEM is planning to carry out a joint campaign with the anti-FGM organizations in Kenya to raise awareness and put a stop to cross-border FGM. It also plans to identify more animators who will continue to sensitize the community and it will continue to shatter the myths and create more awareness on the harmful effects of FGM (Equality Now, 2011 pp. 31-32).

3.4.3 3rd CASE STUDY: Maasai of the southern Rift region of Kenya

This is based on the paper *"Final Mid-Term Evaluation for Anti-FGM Project among the Maasai of the Southern Rift Region of Kenya"* by (Masas & Nairesiae, 2014).

The Free Pentecostal Fellowship of Kenya (FPFK) organization launched an anti-FGM project among the Maasai people of southern Rift of Kenya. The project was launched in 2007 and is expected to end in 2016. The Anti-FGM project focuses strategies for effective elimination of harmful traditional practice of girl's circumcision and subsequent early and forced marriages. The project notes, that whereas the culture of the Maasai people should be respected, there is need to address those aspects that not only violate girls and women rights but have also hindered the community from achieving development goals such as education for the girls and women (Masas & Nairesiae, 2014 p. 1).

To assess the impact of the Anti-FGM project among the Maasai girls and communities in the Southern Rift Region (Kajiado, Narok, Loitokitok and Trans Mara) of Kenya, FPFK conducted a mid-term evaluation in 2014 using the following methods; Desk Review of Secondary data sources, Group discussions/Focus group discussions, Key Informant interviews (KII) and In depth Interviews (IDIs) (Masas & Nairesiae, 2014 pp. 5-6).

The main objective of this mid-term evaluation was to assess achievements and impacts of the Anti-FGM project for the last 8 years and to identify gaps that can be given attention during the project transition period of 2014 to 2016 (Masas & Nairesiae, 2014 p. 4).

Approaches used by Free Pentecostal Fellowship of Kenya (FPFK) organization

The Anti-FGM intervention areas carried out by FPFK included Kajiado, Narok, Loitokitok and Trans-Mara areas of the Southern Rift Region of Kenya. Strategies used during campaign were:

- Community sensitization in public meetings and barazas (deliberation meetings held by a collective group of a people of wisdom).
- Anti-FGM forums in schools among the teachers and pupils, churches.
- Awareness meetings among girls, boys and women.
- Alternative Rites of Passage (ARP).

Achievements of FPFK

1. One goal of the project was elimination of FGM. Its achievement was estimated to be over 70%. Laws against FGM and anti-FGM policy have been enacted and are being enforced. This has created a platform for the advocacy for the rights of Maasai girls and women. It was estimated that 80% had been achieved by creating the platform.

2. Church leaders and NGOs have contributed in facilitating community sensitization. They have built local knowledge and capacity regarding risks that are associated with FGM. It was reported that 90% awareness among the Maasai of the southern rift region of Kenya regarding the negative impacts of FGM had been achieved.

3. Alternative Rite of Passage (ARP) resulted in sensitization of young girls and boys on the dangers of FGM, and due to rescuing and supporting of young girls who have abandoned FGM to continue with schooling, more girls and even boys are enrolling in schools and therefore improving in their academic performances. ARPs have also reduced cases of early marriages.

4. Training of Key Resource Persons (KRPs): KRPs were trained on the risks of FGM, sensitization on advocacy and community mobilization skills. These skills proved to be a useful tool for the effective implementation of the project goals in all the intervention areas.

5. Reduced disease burden among girls and women: The study findings showed that the anti-FGM campaigns that had been undertaken in the projects` targeted areas, have so far resulted in reduced disease burden of girls and women. Diseases like HIV/AIDs, complications associated with child birth and even deaths are on the decline.

6. Building linkages with other stake holders like the government and other NGOs in fighting against FGM has resulted in a successful integrated approach to achieve behavioral changes.

Challenges faced in the implementation of the project by FPFK (Masas & Nairesiae, 2014)

- Clashing in cultural values and beliefs between the Christian and traditional believers in the community regarding whether or not girls circumcision is good.
- Local churches lack resources to accommodate the girls who flee away from FGM
- Increased campaigns against FGM and law enforcement have led to FGM being done secretly to avoid government and church scrutiny.
- Some community and religious leaders do not embrace the change of abandoning FGM; they claim that the anti-FGM activity is an encroachment of their culture.
- Girls fear being outcasts in the community or not getting married within their own community.
- Ignorance regarding the negative effects of FGM among the Maasai is also a great hindrance towards the desired change.
- FGM is seen as an economic value to the girl´s parents since most of the circumcised girls find marriage partners easily and get married at an early age.

3.4.4 4th CASE STUDY: FGM among the Kisii community

Customs, rituals and traditions

The Kisii (also known as Abagusii) are a society that comprises the Bantu community that mainly live in Kisii and Nyamira in Nyanza Province, Western (Njue & Askew, 2004). According to the 2009 Kenyan national census, the ethnic group numbers over 1 million individuals.

Kisii traditions are comprised of many activities connected with historical events, like migrations into the current homeland and the arrival of the British. The prominent folk figures are usually men, but a few are female. The more prominent Kisii ceremonies are transition into adulthood and marriage. Transition into adulthood among women involves clitoridectomy for girls and circumcision for boys. It is meant to prepare children as social beings who know rules of shame and respect (Oloo et al., 2010).

FGM information among the Kisii

FGM is deemed as an important rite of passage for a woman to pass from childhood into adulthood. Without the cut, the female gender is not regarded as a whole woman. The practice is still exercised by the community (Naleie, 2011). The Kisii have by far the biggest number of circumcised women in any Kenyan society, with an estimated 96% of adult women having been cut (KDHS, 2008-09).

According to the case study by (Oloo et al., 2010), the practice is considered today not necessarily as a rite of passage into adulthood but more as a cultural obligation to which families feel compelled to adhere. It is seen as normal Kisii way of life to uphold the cultural tradition of the community. FGM is also believed to preserve sexual morality. In continuing with the practice, the Kisii seek to ensure that their women do not become promiscuous. Uncircumcised women are considered of being incapable to control their sexual desires.

Another reason for the continuation of the practice is social pressure. Girls who are not circumcised are treated with contempt, they are mocked by their peers and they are never respected in the society. They end up not getting married and considered as outcasts in the community (Oloo et al., 2010).

The practice of FGM among the Kisii is largely a private event for most of the families. Every woman to be cut would wake up her mother at dawn and ask for a hen or two Kenyan shillings as payment for the operator. The mother typically pinches the girl and tells her that she was still too young for the cut. The idea is to test her seriousness and courage. If the girl insists on going with her age-mates, she leaves the house naked except for a cloth on her shoulders and is accompanied by her mother. In a chilly dawn they meet the other girls with their mothers at an arranged spot and then proceed, singing, to the home of the operator. The operator is usually a middle-aged woman with a reputation for skills in female circumcision (Oloo et al., 2010).

However, there are regions of the community where the practice is celebrated publicly. At the place of the ceremony a crowd of women surround a stone on which the girl to be operated. For every operation a woman comes behind the girl to support her, firmly holding the girl's hands over her eyes so that she does not see what is going on. The operator applies some white flour to the girl's private part and expertly and swiftly cuts off the head of the clitoris. As soon as this is done the crowd of the gathered women give a

trilling noise, gaily singing and dancing. The girl is then led over to a shed to squat and bleed.

In the dissertation entitled "*Culture and traditions among the Abagusii community influence the practice of genital mutilation: Grounded notions and perspectives about male and female attitudes on how to maintain cultural identity without a cut*", Ondieki (2006) argued that one of the key informant (Onuko Abere) said that practices of female genital mutilation and male genital circumcision among the Kisii are part of the identity of the community. Some elders say that they consider it as part and parcel of their culture and that the practice is as old as the community. Most of the members in the Kisii community are Seventh Day Adventist (SDA) who believe in strict application of biblical text so one theory holds that they read Genesis 17:10-11 which orders Abraham and his descendants to circumcise all their male children. In Hebrew 11:17 and Galatians 3: 29 which by implication say believers of faith are all sons of Abraham if they faithfully keep God's commandments (Ondieki, 2010).

Medicalization of FGM

According to the 1998 KDHS, majority of women have been cut by an expert. Many of them have adopted the use of medical facilities to perform the cut (KDHS, 2008). (Chege et al., 2001), in his study found that 68% of genitally mutilated mothers had been cut at home by a traditional circumciser with a further 13% being cut "in the bush" and the remainder at their own or someone else's home; only 2% reported being cut at a health facility.

Among the Kisii daughters, however, the location has changed considerably over time; only 14% were cut at the home of a traditional practitioner and 7% in the bush, while 37% were cut at a health facility and 40% at their own or another home. Further analysis shows that of the 70% of Kisii girls who were circumcised by a medical practitioner, about half (53%) were cut at a health facility and about half (47%) at their own or another home. This clearly demonstrates that the procedure is not only being practiced at health facilities contrary to Ministry of Health policy, but also that health staff are privately providing this service at families' homes (Chege et al. 2001).

Though cut by a traditional circumciser, a lot of health personnel in Nyamira District, and particularly the female nurses, reported being approached for tetanus toxoid injections to

use after the cutting (Chege et al., 2001). This shows an increasing concern with the safety of the procedure, as families seek various ways to reduce the likelihood of adverse health outcomes while still retaining the practice.

Shell-Duncan, 2001 outlines a hotly contested issue as to whether medicalization is an important intervention to address the dangerous conditions under which FGM is done, or whether it contradicts methods of eliminating the practice.

A lot of people aiming at eradicating FGM have opposed the medicalization of the practice. The World Health Organization (WHO), the International Council of Nurses (ICN), the International Confederation of Midwives (ICM) and the Federation of Gynecologist and Obstetrician (FIGO) have all declared their opposition to the "medicalization" of FGM, and have advised that it should not be performed by health professionals or in health establishments under any circumstances (WHO, 2001b).

Numerous organizations including the International Federation of Gynecology and Obstetrics, the Inter-African Committee, and the U.S. Agency for International Development (USAID) have been against medicalization because it tends to foster the practice of the cut among women which has proven to be dangerous (Njue & Askew, 2004).

Factors that have contributed to change in the practice

Evaluation of the case study "FGM among the Kisii community" was done in order to come up with the most effective approaches to mitigate FGM in the Kisii community. The participants in this case study identified the key agencies that have been active in the community in discouraging FGM. These organizations include: Young Women's Christian Association (YWCA), Maendeleo Ya Wanawake Organization (MYWO), ADRA (Adventist Relief Agency), Action Aid, Fulda Mososcho and Reach Women And Youths Development Organization (RWAYDO). The organizations train the community through workshops, seminars and videos to persuade the Kisii people to re-evaluate their beliefs and to change their attitudes towards FGM (Oloo et al., 2010).

The participants in the case study identified some of the factors that have contributed to change or resistance with regard to FGM. These factors include:

1. **Religious influence**: Churches have continuously rejected FGM by condemning it and by quoting the bible as to support the male circumcision and not the female

circumcision. This has resulted to abandonment of the practice by most of the community members.

2. **Education**: Exposure to new information on health risks and the illegal status of FGM has greatly attributed to the abandonment of the practice especially in the Kisii urban areas. Most of the anti-FGM campaign programs are working through schools to inform pupils and students about the harmful consequences of the practice. They also empower girls to reject circumcision. YWCA works hand in hand with schools by using teachers as facilitators and creation of the anti-FGM school clubs (Oloo et al., 2010).

3. **Exposure to other cultures**: participants felt that intermarriages between people from communities practicing FGM and from those that do not practice have also contributed to the abandonment of the FGM. They pointed out that this has resulted to mothers encouraging their daughters to say NO the FGM (Oloo et al., 2010).

4. **Involvement of the local authority, police and a wide range of stakeholders**: participants felt that there is poor coverage of NGOs in the area, hence inadequacy in information on negative consequences of FGM. They felt that the activities to discourage the practice should target the whole community and not only girls and mothers leaving out men and grandmothers who actually contribute most to the continuance of the FGM (Oloo et al., 2010).

5. **Alternative rite of passage**: participants reported that the ARP approach was the most effective method, since most of the girls reject circumcision after the training. They reported that the training of ARP helped the initiates to understand about their body, reproductive health and how their bodies change from childhood to adulthood. At the training, the participants are also taught about the negative effects of FGM, myths and misconception and illegality of FGM (Oloo et al., 2010).

An anti-FGM campaign. Elders in Kisii have asked stakeholders to fight the vice. [Photo: amormagazine.co.uk] (Nyamwamu, 2013)

3.4.5 5th CASE STUDY: FGM among the Kuria community

The Kuria are an ethnic group in Kenya located in Nyanza province southwest Kenya. They have similar cultural traits with the Kisii community including low school completion rates especially among girls. They have several clans and each clan is headed by a council of elders who are respected. The elders dictate the community on ceremonies or cultural beliefs including circumcision. The Kuria believe that the elders have natural superpowers and they are capable of casting spell and curses on individuals who go against their decisions (Prazak, n.d.).

Reasons why the Kuria continue with FGM

Just like the Kisii, the Kuria observe circumcision as a rite of passage from childhood to adulthood. The participants in the case study reported that decision to undergo circumcision is usually made by the parents although in some cases girls decide for themselves due to peer pressure (Prazak, n.d.).

FGM is also seen as a pre-requisite of marriage and child bearing. In cases where the girl is married without going through circumcision, parents organize such that she undergoes the cut while in labour. If a woman became pregnant before circumcision, she would be considered an outcast and nobody from the Kuria community would marry her (Oloo et al., 2010).

From the study other respondents reported that FGM is done to curtail sexual urge in women, thus reducing promiscuity and promoting good morals (Oloo et al., 2010).

Others believe that circumcision is done to uphold the cultural tradition of the Kuria. It is seen as preserving the cultural heritage and eliminating it is like eliminating the Kuria culture (Ondieki, 2010).

Social pressure was reported to be another factor for the continuity of FGM. The community has strong sanctions to discourage woman's refusal to be circumcised. In addition myths and misconceptions were also expressed as another factor (Oloo et al., 2010).

Medicalization of FGM

FGM among the Kuria is still done by traditional circumcisers at large, however there has been involvement of the medical staff and they are sometimes preferred. According to the study by Oloo, 2010, the governments agencies are involved in supply the gloves, surgical blades and disinfectants. This however contradicts with the governments' law in criminalizing the act of FGM (Oloo et al., 2010).

Factors that have contributed to change in the practice

The case study by Oloo, 2010, identifies some of the successful approaches and interventions that have resulted in mitigation of FGM among the Kuria community:

1. **Religious influence**: churches have contributed largely in campaigning against FGM. Some participants reported to have abandoned the practice due to religious reasons. Church leaders are also engaged in denouncing the practice and creating awareness about the harmful effects of FGM (Oloo et al., 2010).

2. **Awareness of the harmful effects of FGM**: Kuria people have realized the negative social effects of the practice such as school dropout and early marriage; this has resulted to most families abandoning the practice. NGOs efforts to discourage FGM have also been successful. These include formation of anti-FGM clubs in school to create awareness on FGM. Some respondents reported that despite the efforts done by NGOs there has been some resistance in some parts of the community (Oloo et al., 2010).

3. **Illegal status of FGM**: the Kuria community lack proper education to address laws against FGM. It was found out that those who knew about the children act did not actually understand it fully. They thought that it was about giving children their right to make their own decisions. Others believed in the powers of the council of elders and failing to adhere to their words would result to individual curses. For those who did not understand the significance of the children act, felt that it was important to sensitize the community about the illegal status of FGM (Oloo et al., 2010).

4. **Education**: report showed that FGM was highly prevalent among those girls who did not pursue education as compared to those in school. Only 19% of Kenya girls who have secondary level education undergo female genital mutilation (FGM) as compared to an alarming 54% of girls who do not get a school education (28 too many Report 2013). Due to FGM some girls dropped-out of school since they felt that they were mature enough to make their own decisions like getting married at a younger age. Some participants argued that education has played a big role in elimination of the practice, since anti-FGM initiatives work with schools as a means of creating awareness on harmful effects of FGM. This means that those attending school are likely to have access to information about abandoning FGM and opportunity to discuss with NGOs, teachers, health workers and their fellow students about FGM (Oloo et al., 2010).

5. **Alternative rite of passage (ARP):** local agencies organize rescue camps for girls running away from FGM rather than offering an alternative rite of passage. These camps seek to protect girls by providing refuge through the circumcision period. In these camps the attendees are educated on the health risks of FGM, its illegality and violation of girls and women's rights. There's is a graduation ceremony at the end of the circumcision period and all the attendees are given certificates, however it is neither recognized by parents nor the local community as an alternative rite of passage. The rescue camps face a lot of challenges including, limited consultation, limited resources, limited follow-up and poor recruitment due to high demand. This has resulted to ARP not being so successful among the Kuria as compared to Kisii community (Oloo et al., 2010).

3.5 Summary of the key findings

***Table 3*: Effective interventions and approaches**

Maasai	Kisii	Kuria
1. Religious influence **2.** Community mobilization and education **3.** Alternative Rite of Passage **4.** Training of the police on the national and international laws against FGM **5.** Successful usage of the legislation **6.** Promoting girls´ education **7.** Creating awareness on FGM through media, seminars and workshops **8.** Successful sensitization campaigns **9.** Broad-based approach **10.** Build linkages with other stake holders **11.** Rescue camps	**1.** Religious influence **2.** Community education on FGM and its harmful effects **3.** Education for girls **4.** Alternative Rite of Passage (ARP) **5.** Exposure to other cultures which do not practice FGM e.g. through intermarriages	**1.** Religious influence **2.** Education for girls **3.** Rescue camps - protecting and providing refuge for the girls who run away from FGM **4.** Health risks approach - creating awareness on the harmful effects of FGM

3.6 Limitations, reliability and validity

Primary data is collected with a concrete idea generally to meet study objectives. As such, secondary data sources provide the study with more and rich amount of information. This is simply because it has been collected to answer a different research question or objectives.

Since the research is based more on secondary sources which are hard to verify their accuracy, the results can be hard to generalize, however this is not always necessary in order to reach an understanding of the problem.

Most of the articles used were from the KDHS, UNICEF, WHO, UNWOMEN and UNFP. These articles were quite reliable since their sources are up to date with yearly reports and statistics of the practice.

It is possible that the relevant studies may not have been included given the limitations of the literature review, the selection of sources and the invisibility of the phenomenon studied. In this case important studies may have been missed out and may affect the reliability of the results.

Kenya consists of 42 ethnic (linguistic) groups, as well as various types of religious affiliations, which makes it harder to reach a deep understanding of the problem. Though it is very difficult to claim wide generalizability of results in a country where cultural and traditional practices vary, it might not be wrong to assume that the women's and men's situation in most areas of the country is not very different, especially not considering the general socio- economic development of Kenya as a whole. The similarity in perceived problems and attitudes from various groups of people, and co-linked with information from other sources indicate the validity of the interviewees responses to the questions.

The research was conducted and analysed by one person (author), making it difficult to rely on the information since it lacks the comparison when analysed by two or many people.

4 DISCUSSION

Since decades, there has been a rather slow decline in the prevalence of FGM in Kenya despite different campaigns against it. This further raises the question about the success of those interventions which aim to eliminate the practice. To assess the issue of intervention outcome, this research analyses documents on interventions and approaches that were implemented in those communities with the highest prevalence rates of FGM in Kenia which are the; Maasai, the Kisii and the Kuria.

From the material reviewed it is not possible to conclude the extent to which the interventions and approaches undertaken by different organizations have influenced decisions to discontinue with FGM.

Only a few interventions and approaches were selected from 5 diverse case studies carried out by local organizations working to eradicate FGM. The case studies were chosen due to availability of FGM information for the three ethnic groups and their ability to answer the research question. The cases selected provided an in-depth analysis of circumstances and sufficient information to answer the research question. However, the data could not be generalised for the whole population.

Religious influence is perceived as an important factor in the mitigation of FGM in all the three communities (Maasai, Kisii and Kuria). Religious leaders in Kenya include pastors, priests, imams and prophets. In this research, pastors, priests and prophets of the three communities, have managed to educate people/followers and convince many parents, including those with strong traditional beliefs, that circumcising girls is not a requirement of the religion. They teach them that the painful and harmful act of circumcising girls is not an obligation of the religion but rather a tradition. They also emphasize that the Bible allows only male circumcision. At Tarasu rescue camp in Narok, girls are engaged in church activities in order to strengthen the anti-FGM messages. The implementation of the anti-FGM project has enabled the FPFK church to gain a foothold among the Maasai people and as a result the church has been able to increase its membership in the region. The biggest challenge is that sensitization of the religious leaders has not yet reached everyone in the community especially those in most remote villages of these communities where prophets still believe that FGM is a religious obligation.

Education is another successful factor that has been used in the three communities to eradicate the practice. Girls are exposed to new information on the health risks and illegal

status of FGM. Among the Maasai community, FGM is an immediate practise prior to marriage. It is an indicator of a girl becoming marriageable and becoming an adult. In this way, girls tend not to resume school after the practice, so promotion of girls' education at an early age to oppose FGM is necessary. The organizations work with schools in order to deliver FGM information and they empower girls to reject FGM. However, teachers feel incapable to address the issue due to social perceptions. TNI emphasizes on the importance of Girls education and ensure that all girls in Tasaru Rescue Camp attend and stay in school. YCWA in the Kisii region works in collaboration with local schools using their facilities and with their teachers being facilitators in the ARP camps. A number of schools are running FGM school clubs. Research also suggests that if a mother has more education, her daughter is less likely to undergo FGM (UNICEF, 2005). Research in Kenya has shown that secondary education is associated with a four-fold increase in disapproval of FGM (PATH, 2011).

Circumcision is seen as an integral component of traditional rite of passage initiating girls and normally boys from childhood to adulthood. This applies to several ethnic groups in Kenya. Most societies attribute great importance to these coming-of-age ceremonies and abandoning FGM is seen as abandoning of the rite of passage which in turn may create conflict in these societies.

As seen in the findings, Alternative Rite of Passage (ARP) is another major intervention that has led to reduction of FGM. Among the Maasai and the Kisii, this intervention has been successful due to vigorous community sensitization outreach and mobilization. ARP allows girls to undergo training and graduate to womanhood without the cut. During this process girls are also educated on different topics like human rights, adverse effects of FGM and are encouraged to say NO to the cut. At the end of the training, girls are awarded certificates.

Involvement of the reconciliation meeting is done by the TNI to reunite girls with their parents. In this process, parents, relatives and the community are educated on the health complications of FGM and are encouraged to send girls to undergo ARP as a coming-of-age tradition. They are also requested to accept their daughters' decisions of not undergoing FGM or early marriage and to allow them to continue with their education. Afterwards, a second meeting is held where the girls return home accompanied by elders and area chiefs. The girls are then monitored by the chiefs and TNI monitors pay regular visits to assess their school and home progress (Equality Now, 2011).

If the reconciliation process is not successful, girls are retained at the centres to avoid being forced to circumcision. This strategy has reduced instances of early marriage and FGM while promoting female education and women's empowerment. ARP has also been replicated in a number of communities throughout the country.

According to this research, rescue camps aim to provide protection and refuge for girls during the whole circumcision period. Girls are educated on the health risks of FGM, its illegality and its violation of rights as girls and women. However, these camps face challenges such as limited resources and lack of its recognition as an alternative rite of passage especially among the Kuria. The case study of the Kuria community does not elaborate what happens to girls after the graduation, it does not state whether there is a reconciliation process or not (R. Elise B. Johansen, Diop, Laverack, & Leye, 2013).

Health risk approach was among the first approaches to be used in eradication of FGM. It builds the idea that, if people are educated or informed about the health risks of FGM, they would stop the practise. It is believed that increase of knowledge on the negative effects of FGM such as haemorrhage, infection, pain and even death, stimulates reflection and critical thinking leading to reduction of FGM cases (R. Elise B. Johansen et al., 2013). According to this research, health risk approach has been widely used either as a stand-alone activity or in combination with other approaches/interventions such as education. However, this approach as stand-alone activity has faced the challenge of medicalization (the situation in which FGM/C is practiced by any category of health-care provider, whether in a public or private clinic, at home or elsewhere ("WHO | Female genital mutilation and other harmful practices," n.d.) of FGM, with non-traditional practitioners such as doctors, nurses and midwives being asked to and actually performing the practice (Njue & Askew, 2004).

Exposure to other cultures is also seen as an important approach which has contributed to abandonment of the practice. Through migration of some of the Kisii people, especially to the urban areas has led to intermarriages with other communities who do not practice FGM. This has reduced the pressure and parents are resisting to circumcise their daughters. The Maasai on the other hand, have ingrained customs and traditions. They rarely rely on other communities making it difficult for them to get exposed to different cultures. Some Maasai girls undergo FGM in order to get married to their own community men.

The author's research showed that legal approach has been successful among the Maasai because it provides a legal platform from which different projects can be organized; it offers legal protection for girls and it is intended to discourage practitioners and families through fear of prosecution (Population Council, 2007). It also offers health professionals a legal framework to oppose request of performing FGM (R. Elise B. Johansen et al., 2013). Laws against FGM are an important policy measure and create an enabling anti-FGM environment. However legal approach has limitations; it is difficult to enforce leading to demotivation of the communities and families to stop the practise. Introducing of laws against such strongly held practices, can lead to FGM being done secretly. In addition, medical complications are not taken care of by the health services due to fear of being prosecuted (Njue & Askew, 2004).

Some other successful approaches among the Maasai community in this study include; successful sensitization campaigns, broad-based approach and building of linkages with other stake holders.

Effective sensitization campaigns have empowered girls to refuse FGM and to report their parents to the court if they are forced to undergo the practice.

Broad-based approach involving the whole community (ex-circumcisers, religious leaders, local animators and law officers) has contributed to decrease in FGM cases by working with the organization to discourage the harmful act.

Interventions based on community engagement, require long-term investment, comprehensive education package and a supportive context. The whole community need to be targeted in order to eradicate the rates practice (R. Elise B. Johansen et al., 2013).

5 RECOMMENDATIONS

Based on the findings of this research:

- ARP is an intervention that has proved to be successful in most of the communities. It is recommended that the whole community including boys, elders, practitioners, traditional leaders, religious leaders and health professional should be targeted in the programme so as to facilitate the abandonment of the practice.
- Schools have provided an excellent avenue to deliver information on the adverse effects of FGM. It is recommended that organizations should work more closely

with schools and should empower teachers to feel free to talk about the practice. There is also need to increase the capacity of teachers so as to facilitate the anti-FGM campaigns. Teachers should be able to discuss with the parents about the harmful effects of FGM and to sensitize them on FGM issues and to be more committed to the law.

- Chiefs and elders have the highest hierarchy in the traditional communities practising FGM. They are the ones to decide on community ceremonies and are very influential especially among the Maasai. Engaging them in anti-FGM campaigns would lead to affectivity of strategies to reduce the practice.
- It is also recommended that the existing organizations should strengthen advocacy with other partners for effective commitments towards eliminating FGM and other forms of GBV and maintain links with the media through which communities within and beyond the project areas are reached with messages through social media, internet, radio stations and television.
- Community health workers and traditional birth attendants should be encouraged to integrate anti-FGM education during their visits to pregnant mothers.
- Since the Kuria and the Kisii have almost the same traditions, it is recommended that current programmes on girls' empowerment incorporating ARP and extensive community engagement should target both communities and the communities across the region.
- Medicalization of FGM emerges as a major challenge in fighting FGM. Given that dealing with health professionals who perpetuate the practice for commercial gain is beyond the projects; it would be imperative that future strategies towards eradication of the practice of FGM cultivate a close working relationship with the Ministry of Health (MOH) which is better placed to address the issue.

.

5.1 Summary of the benefits and shortcomings of anti-FGM approaches

Effective anti-FGM campaigns like education, ARP, religious approach, health risk approach, legal measures and broad-based approach are possible, but they must be comprehensive.

***Table 4*: Summary of benefits and shortcomings of the anti-FGM approaches**

Approaches and Interventions	Benefits	Shortcomings
Alternative Rite of Passage (ARP)	i. Maintains the key cultural practice of a community. ii. Supports schooling and delayed marriage. iii. Increases knowledge through girls' empowerment.	i. Lack of recognition as a passage into adulthood. ii. Only viable in those communities which FGM is considered as a rite of passage.
Health risk approach	i. Facilitates abandonment of FGM through adverse effects of FGM awareness. ii. Improve health care for complications	i. FGM medicalization ii. Stronger social norms
Legal measures approach	i. Creates an enabling framework. ii. Discourage the society from undertaking FGM	i. Encourages FGM to be done secretly. ii. Discourages seeking of health care for complications.

Broad – based approach	i. Broader support leading to less resistance. ii. The community realises its own problem and therefore easy to come up with solutions.	i. Difficult to target everybody in the community. ii. Failure of some community members to accept change. iii. Practitioners can go on with the practice secretly.
Religious approach	i. Provide information and counselling. ii. Facilitate the abandonment of the practice through quotation of the bible/Quran	i. Misinterpretation of the bible and the Quran. ii. Not an appropriate approach for non-believers.
Education	i. Education can be offered in schools, camps and centres ii. Provide evidence on the health consequences	i. Only available to those who attend schools, camps and rescue centres. ii. Inadequate content of information. iii. Not easily affordable to everyone.

6 CONCLUSION

This study was set out to identify the successful interventions in mitigation of FGM among high prevalence Kenyan communities (Maasai, Kisii and Kuria). To answer the research question, literature review was conducted using 5 diverse case studies.

Findings showed that comprehensive measures against FGM include; religious influence, women and girls empowerment, community education, girl education, health risk approach, exposure to other cultures, alternative rite of passage involving a reconciliation process, rescue camps, successful use of legislation, broad-based approach involving the whole community (ex-circumcisers, religious leaders, local animators and law officers) and community sensitization campaigns.

The value of this thesis is generally important to all the communities practicing FGM. The author hopes that it will be useful to the anti-FGM campaign teams and organizations in their efforts to eradicate the practice. Implementation of effective strategies like religious influence, education, alternative rite of passage, community sensitization and mobilization among others will eventually lead to a decline of FGM.

Despite tremendous approaches that have been put in place by different anti-FGM organizations, the abandonment of the practice, however, is still ahead of us. Anti FGM campaigns should initiate building partnerships and networking with CBOs and other NGOs both at the local and national levels. They should also involve powerful people: teachers, religious leaders, but also community leaders, youth, men and women to facilitate the abandonment of FGM. This is also to avoid duplication of efforts and more importantly to address the issue of sustainability for maximum effect of the successful interventions.

Cultural beliefs slow down the elimination of the practice. However, combination of interventions clearly plays a role in the attitudinal and behavioural changes resulting in a decrease in the practice despite strong social resistance.

REFERENCES

28 Too Many. (2013a). COUNTRY PROFILE: FGM IN TANZANIA. Retrieved from http://28toomany.org/media/uploads/tanzania_final_final_final.pdf

28 Too Many. (2013b). FGM IN KENYA (No. Country´s Profile). Retrieved from http://28toomany.org/media/uploads/final_kenya_country_profile_may_2013.pdf

Abusharaf, R. T. (2006). Female circumcision: Multicultural perspectives, ed. Philadelphia.

Almroth, L., Bedri, H., El Musharaf, S., Satti, A., Idris, T., Hashim, M. S. K., Bergström, S. (2005). Urogenital complications among girls with genital mutilation: a hospital-based study in Khartoum. African Journal of Reproductive Health, 9(2), 118–124.

Applebaum, J., Cohen, H., Matar, M., Abu Rabia, Y., & Kaplan, Z. (2008). Symptoms of Posttraumatic Stress Disorder After Ritual Female Genital Surgery Among Bedouin in Israel: Myth or Reality? Primary Care Companion to The Journal of Clinical Psychiatry, 10(6), 453–456.

Ayenigbara, G. ., Aina, S. ., & Famakin, T. . (2013). Female Genital Mutilation Types, Consequences and Constraints of Its Eradication in Nigeria, 3(5), PP 07–10.

Berg, R. C., & Denison, E. (2013). A Tradition in Transition: Factors Perpetuating and Hindering the Continuance of Female Genital Mutilation/Cutting (FGM/C) Summarized in a Systematic Review. Health Care for Women International, 34(10), 837–895. http://doi.org/10.1080/07399332.2012.721417

Boddy, J. (1982). Womb as Oasis: The symbolic context of Pharaonic circumcision in rural Northern Sudan (Vol. 9).

Chege, J. N., Askew, I., & Liku, J. (2001). An assessment of the alternative rites approach for encouraging abandonment of female genital mutilation in Kenya (FRONTIERS final report). Washington, DC: Population Council.

Cheserem, S. (2010). Female Genital Mutilation in Kenya - A literature review. Retrieved April 28, 2015, from https://publications.theseus.fi/bitstream/handle/10024/26244/CHESEREM.SARAH-PDF.pdf?sequence=1

Daughters of Eve. (n.d.). Types of FGM. Retrieved March 4, 2015, from http://www.dofeve.org/types-of-fgm.html

Denison, E., Berg, R. C., Lewis, S., & Fratheim, A. (2009). Effectiveness of interventions designed to reduce the prevalence of female genital mutilation/cutting (Systematic review No. 25 – 2009) (p. 63). Oslo: Norwegian Centre for Violence and Traumatic Stress Studies. Retrieved from http://apps.who.int/rhl/reviews/FGMSR0925genitalmutilation.pdf

Equality Now. (2011). Protecting Girls from Undergoing Female Genital Mutilation: The Experience of Working With the Maasai Communities in Kenya and Tanzania | Soul Beat Africa. Retrieved March 12, 2015, from www.equalitynow.org

FGM National Clinical group. (2007). How Did Female Genital Mutilation Begin? Retrieved November 3, 2014, from http://www.fgmnationalgroup.org/historical_and_cultural.htm

General Assembly of the United Nations. (n.d.). Retrieved March 3, 2015, from http://www.un.org/en/ga/69/resolutions.shtml

Howard, E. (2014, February 6). The forms of female genital mutilation. The Guardian. Retrieved from http://www.theguardian.com/society/2014/feb/06/the-forms-of-female-genital-mutilation

Insel, P. ., & Roth, W. . (2006). Core concepts in Health (10th ed.). Mc Graw Hill. New York.

International Day of Zero Tolerance to Female Genital Mutilation. (n.d.). Retrieved March 2, 2015, from http://www.un.org/en/events/femalegenitalmutilationday/

IRIN. (2005). Razor’s Edge - The Controversy of Female Genital Mutilation. Retrieved March 13, 2014, from http://www.irinnews.org/IndepthMain.aspx?reportid=62470&indepthid=15

Johansen, R. E. . (2007, pp. -277). Experiencing sex in exile: Can genitals change their gender? On conception and experiences related to female genital cutting (FGC) among Somalis in Norway.

Johansen, R. E. B., Diop, N. J., Laverack, G., & Leye, E. (2013). What Works and What Does Not: A Discussion of Popular Approaches for the Abandonment of Female Genital Mutilation. Obstetrics and Gynecology International, 2013. http://doi.org/10.1155/2013/348248

KDHS. (2008, 2009). Kenya Demographic and Health Survey. Retrieved from http:// www.measuredhs.com/pubs/pdf/FR229/FR229.pdf

Leye, E., Deblonde, J., García-Añón, J., Johnsdotter, S., Kwateng-Kluvitse, A., Weil-Curiel, L., & Temmerman, M. (2007). An analysis of the implementation of laws with regard to female genital mutilation in Europe. Crime, Law and Social Change, 47(1), 1–31. http://doi.org/10.1007/s10611-007-9055-7

MAASAI EDUCATION. (n.d.). Retrieved April 14, 2015, from http://www.mychosenvessels.com/maasai-education.html

Maendeleo Ya Wanawake Organization (MYWO). (2011). Gender Equality-Gender Based Violence/Female Genital Mutilation. Retrieved March 2, 2015, from http://mywokenya.org/index.php/projects/education

Masas, J., & Nairesiae, E. (2014). Final Mid-Term Evaluation for Anti-FGM Project among the Maasai of the Southern Rift Region of Kenya.

Momoh, C. (2005). Female Genital Mutilation. Radcliffe Publishing.

Muma, H. K. (2012, March 29). Impact of female genital mutilation on education of girls with hearing impairement in Gucha County-Kenya (Thesis). Retrieved from http://ir-library.ku.ac.ke/handle/123456789/3588

Njue, C., & Askew, I. (2004). Medicalization of Female Genital Cutting Among the Abagusii in Nyanza Province, Kenya. Frontiers in Reproductive Health Program Population Council.

Oloo, H., Wanjiru, M., & Newell-Jones, K. (2010). Female Genital Mutilation practices in Kenya: The role of alternative rites of passage - A case study of Kisii and Kuria districts. Retrieved March 8, 2015, from

Ondieki, C. A. (2010, June). The impact of Female Genital Mutilation on the educational opportunities of the girl child: A study of Kuria district, Nyanza. University of South Africa, South Africa.

Parekh, B. (2005). Rethinking Multiculturalism: Cultural Diversity and Political Theory (2nd ed.). Basingstoke England ; New York: Macmillan Education.

PATH. (2011). Female Genital Mutilation – The Facts. Retrieved April 19, 2015, from http://www.path.org/files/FGM-The-Facts.htm

Population council. (2007). Contributing efforts to abandon Female Genital Mutilation/Cutting in Kenya - a Situation Analysis.

Population Reference Bureau. (2010). Female Genital Mutilation/ Cutting: Data and Trends.

Prazak, M. (n.d.). Witnessing a Rite of Passage: Circumcision Rites Among the Kuria. Retrieved April 16, 2015, from http://www.gonomad.com/917-witnessing-a-rite-of-passage-circumcision-rites-among-the-kuria

Rushwan, H. (2000). Female genital mutilation (FGM) management during pregnancy, childbirth and the postpartum period. International Journal of Gynecology and Obstetrics, 70(1), 99–104.

Sass, J., & Muteshi, J. (2005). Female Genital Mutilation in Africa: An Analysis of Current Abandonment Approaches. Retrieved from http://www.path.org/publications/detail.php?i=1462

Sheikh, H. E., Njue, C., & Askew. (2007). Population Council, Contributing towards efforts to abandon Female Genital Mutilation/Cutting in Kenya, A Situation Analysis. Population Council and UNFPA.

Shell-Duncan, B. (2001). Are there "stages of change" in the practice of female genital cutting? Qualitative research findings from Senegal and The Gambia. Social Sciences and Medicine, 52, 1013−1028.

Skaine, R. (2005). Female genital mutilation : legal, cultural, and medical issues / Rosemarie Skaine. Jefferson, N.C: McFarland. Retrieved from http://www.loc.gov/catdir/toc/ecip0512/2005013929.html

survival, cultural. (2010, May 7). FGM: Maasai Women Speak Out [Text]. Retrieved March 2, 2015, from http://www.culturalsurvival.org/publications/cultural-survival-quarterly/kenya/fgm-maasai-women-speak-out

The impacts of FGC | Orchid Project. (n.d.). Retrieved February 26, 2015, from http://orchidproject.org/category/about-fgc/impacts/

Tonje and Talle. (2007, July). The Norwegian International Effort Against Female Genital Mutilation. Retrieved March 2, 2015, from http://www.norad.no/en/tools-and-publications/publications/publication?key=109631

Toubia, N. (2000). Female Genital Mutilation: A Practical Guide to Worldwide Laws & Policies. Zed Books.

Towett, G., Oino, P. G., & Matere, A. (2014). The Female Genital Mutilation Act 2011 of Kenya: Challenges Facing its Implementation in Kajiado Central Sub-County, Kenya, Vol. 10 No. 1, 40–49.

Types of FGM. (n.d.). Retrieved January 11, 2015, from http://www.dofeve.org/types-of-fgm.html

UN. (2006). Ending violence against women From words to action. United Nations.

UNFPA & World Bank. (2004). Female Genital Mutilation/ Cutting in Somalia. World Bank and UNFPA. Retrieved from http://siteresources.worldbank.org/INTSOMALIA/Data%20and%20Reference/20316684/FGM_Final_Report.pdf

UNICEF. (2005, November). Female Genital Mutilation/Cutting: A statistical exploration. Retrieved March 3, 2015, from http://www.unicef.org/publications/index_29994.html

UNICEF. (2007). A Human Rights-Based Approach to Education for All. Retrieved April 28, 2015, from http://www.unicef.org

UNICEF. (2013). Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change.

United Nations. (n.d.). The Universal Declaration of Human Rights. Retrieved March 2, 2015, from http://www.un.org/en/documents/udhr/

UNWOMEN. (n.d.). Sources of international human rights law on Female Genital Mutilation. Retrieved March 3, 2015, from http://www.endvawnow.org

WHO. (2001a). Female Genital Mutilation Integrating the Prevention and the Management of the Health Complications into the curricula of nursing and midwifery. Retrieved from http://www.who.int/gender/other_health/Studentsmanua

WHO. (2001b). The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives. Geneva: World Health Organization.

WHO. (2006). WHO | Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. Retrieved March 4, 2015, from http://www.who.int/reproductivehealth/publications/fgm/fgm-obstetric-outcome-study/en/

WHO. (2008). Eliminating female genital mutilation an interagency statement 2008.

WHO | Female genital mutilation and other harmful practices. (n.d.). Retrieved April 19, 2015, from http://www.who.int/reproductivehealth/topics/fgm/medicalization_fgm_kenya/en/

WHO factsheet N°241. (2014, February). WHO | Female genital mutilation. Retrieved March 3, 2015, from http://www.who.int/mediacentre/factsheets/fs241/en/

Yang, C. C., Cold, C. J., Yilmaz, U., & Maravilla, K. R. (2006). Sexually responsive vascular tissue of the vulva. BJU International, 97(4), 766–772. http://doi.org/10.1111/j.1464-410X.2005.05961.x

Yoder. (2004, September). Female genital cutting in the Demographic Health Surveys: a critical and comparative analysis. Retrieved February 24, 2015, from DHS Comparative Reports No. 7