CONTEXT AND IMPACT OF FEMALE GENITAL MUTILATION IN KENYA
NGINYANG DIVISION ,EAST POKOT DISTRICT , KENYA

By

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APRIL ,2011

DECLARATION

I LOCHOMOLUK K MARK , declare that this research project report is from my own findings and has never been submitted to this or any other institution of learning .

Sign .....

Date ..4th may 2011.....

APPROVAL

This project work has been done under my supervision .

PROF.DR.B.MAKANGA

Sign:.....

Date : 4th May 2011

DEDICATION

This work is dedicated to my father Laurent lokituk my mother Cheptui Lochomoluk , all my brothers and sisters especially Kakuko Mike and Josephine Kakuko and to those who love and care for me , they have consistently given me more than I ever wanted through the tough academic stages of schooling .

ACKNOWLEDGEMENT

I would like to take this opportunity to thank the almighty God for his strength , grace and protection through to the completion of this project .I also extend my thanks to all my colleagues course mates at the campus for their encouragement and support they gave me during all this time .I would also want to thank my supervisor who worked with me all through in giving me guidelines .

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS:	Acquired Immune-Deficiency Syndrome
CBS:	Central Bureau of Statistics
FGD:	Focus Group Discussion
FGM:	Female genital Mutilation
GOK:	Government of Kenya
GTZ:	German Technical Cooperation
HIV:	Human Immune Virus
KDHS:	Kenya Demographic Health Survey
MYWO:	Maendeleo Ya Wanawake Organization
NGO:	Non Governmental Organization
WHO:	World Health Organization

EXECUTIVE SUMMARY

This study was conducted in Nginyang divisions in East Pokot district, Rift Valley province of Kenya. The overall objective was to establish the contextual factors influencing the practice of female circumcision - FGM and its consequences on women and girls in Ninyang. The study adopted a cross-sectional survey research design. It targeted fathers, mothers, young adult males and females aged between 12 and 20 years, and a number of key informants. To elicit the relevant data, quantitative data collection methods were used. Quantitative data were collected using a structured questionnaire from a sample 120 of respondents. The collected data were analyzed within the context of each specific objective.

The study established that the prevalence rate of FGM was 71.7 percent. However, the prevalence among mothers was higher 90% than the girls 53.3% The median age at circumcision was 15.0 years with a range of between 12 and 16 years. Circumcised girls and mothers were aware of the part of the body removed and all underwent infibulations type of circumcision (**Type III**). In traditional context, circumcision was conducted using a shared traditionally-made knife, while one razor blade per initiate is used currently. Circumcision was predominantly performed in a secluded place at the home of one of the initiates. The family and the community played a prominent role in the decision to circumcise a girl. However, the immediate family members, especially the girl, mother and father, play a first hand role in the decision with the fathers making the final ruling.

There is a lot of significance attached to FGM incorporating both social and economic connotations at the individual, household and community levels. FGM is practiced because it is a good tradition, customs and tradition demand, for social acceptance and better marriage prospects. It was this social and economic significance that perpetuated the practice in the community. However, FGM had both immediate and long-term socioeconomic, health and psychological consequences on the girl child. FGM at times causes irreversible, life-long risks at the time of the actual operation, and during urination, menstruation, consummation of marriage (sex) and childbirth. Socially, it affects girls' education and leads to loss of opportunity for self development and achievement of self ideals. The health consequences include excessive bleeding, severe pain, urinary retention and infections, prolonged and obstructed labour, and

blood infection. The psychological effects include the dilemma between identity, sense of belonging and pain which cause internal conflict within a young girl resulting to psychological trauma and loss of self esteem. This cause psychosexual and psychological health as the removed part of the body may leave a lasting mark on the life and mind of the woman.

There were several efforts in the community and the country at large to eliminate FGM. The efforts were spearheaded by local community awareness and involvement in activities against FGM, government previous and existing policy and program interventions, and private organizations. However, there was lack of relevant government sectoral policies and legislation that support elimination of the practice. There was also lack of proper coordination and understanding of how to effectively address FGM. This was therefore rendering all the available but disjointed legislative tools ineffective to facilitate elimination of FGM in the communities. The government efforts to eliminate FGM through enactment of policies and programs had bore little success due to lack of proper structures to coordinate and operationalize them. Most of the activities had therefore been shouldered by the civil society organizations, religious bodies and the private sector. These organizations work through partnerships with the local communities. The main challenges facing them include their limited scope defined by scarce resources, lack of cooperation by the local communities, lack of adequate collaboration and sharing of resources among stakeholders. The most appropriate people to be targeted in the campaign against FGM are parents, community leaders, girls and religious leaders and to a lesser extent teachers, boys and politicians; while the most appropriate channels for reaching the community and the target groups were Baraza, religious leaders and community leaders in cultural ceremonies. A majority of the respondents welcome the participation of NGOs in the campaign against FGM.

The community was aware of several activities and messages against FGM. The common sources were religious leaders, NGOs, radio, government and schools. The activities target the entire community, especially parents, girls and community leaders. However, there were remarkable difference in the support and satisfaction with activities and messages against FGM. A Majority of the community leaders, uneducated parents and traditional practitioners were not satisfied; while young people, religious leaders and health workers were satisfied and in support.

Based on the findings, the study recommends that there: need to create an enabling environment that supports change with the government spearheading the process in partnership with civil society organizations; need to increase advocacy and awareness campaigns about the consequences of FGM; need to empowering traditional practitioners so as to abandon performing the practice; introduce alternative rites of passage that preserve the positive socio-cultural aspects of FGM and uphold the community values, aspirations and the societal fabrics; improve access and equity of girls to educational opportunities; training and working with health care providers and workers; training and working with teachers in schools; and institute research and monitoring and evaluation programs.

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CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Communities embrace various cultural practices which influence the quality of life and general well-being of its members. Some of the practices are deeply entrenched despite being retrogressive with associated dire consequences on health, education and wellbeing of women and the girl child. One of such cultural practice with strong traditional attachment is circumcision, especially female circumcision (FC), also known as female genital mutilation (FGM). Despite efforts to curtail its practice, FGM - defined by World Health Organization (WHO), the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) as "the partial or total removal of the female external genitalia or other injury to the female genital organs for cultural or other non-therapeutic reasons" - is still a deeply rooted tradition in more than 28 African countries, in some countries in Asia and the Middle East, and among immigrants in Europe, Australia, Canada and the USA (Shaaban & Harbison, 2005; WHO, 2007).

According to WHO, there are different types of FGM known to be practised today. However, the four common ones include:

(i) **Type I:** Clitoridectomy which involves the removal or splitting of the clitoral hood (female prepuce or "clitorodotomy"), with or without excision of the clitoris.

(ii) **Type II:** Excision which involves the removal of the prepuce and the clitoris plus the partial or total removal of the labia minora, the inner lips of the vulva. **Type II** circumcision is a more extensive form of FGM than **Type I.** The sewing together of the leftover labia minora epidermis, which contains sweat glands, a buildup of sweat and urine in the closed off space beneath this closure can lead to local or urinary infection, septicemia, hemorrhaging and cyst formation

(iii) **Type III:** Infibulation which involves extensive tissue removal of the external genitalia, including all of the labia minora and the inside of the labia majora, leaving a raw open wound. The labia majora are then held together using thorns or stitching and the girl's legs are tied together for two to six weeks, to prevent movement and allow the healing of the

two sides of the vulva. Only a small opening is left at the inferior portion of the vulva to allow urine and menstrual blood to pass. Infibulation is often carried out by an elderly matron or midwife of the village without anaesthetic and under unhygienic conditions (Pieters & Lowenfels, 1977).

(iv) **Type IV** – Other unclassified types of FGM. They usually do not involve any tissue removal at all, but rather the "cutting" is simulated with a knife as part of a ceremony. This includes a diverse range of practices

- Pricking, piercing or excision of the clitoris and/or labia.
- Stretching of the clitoris and/or labia.
- Cauterization by burning of the clitoris and surrounding tissues.
- Scraping (angura cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina.
- Introduction of corrosive substances into the vagina to cause bleeding or her into the vagina with the aim of tightening or narrowing the vagina.
- Any other procedure that falls under the definition of FGM given above.

The most commonly practised type is **Type II** (excisions) accounting for up to 80 % of all cases; while the most extreme is **Type III** (infibulation), which constitutes about 15 % of all cases. In the world today, an estimated 100 million to 140 million girls and women have undergone FGM. Currently, about 3 million girls, the majority under 15 years of age, undergo the procedure every year (WHO, 2007, 2002).

There is no clear understanding of the origin of FGM, but it has been perpetuating from one generation to the next. Within the socio-cultural context, initiation of girls through circumcision marks the rite of passage from childhood to adulthood, enhances social acceptance, it is an induction on societal expectations and accords marriage-ability status. There are many myths and misconceptions associated with FGM. Traditionally, the practice was marked with ceremonies which enhanced social networks. The ceremonies were also used to provoke the uncircumcised girls using derogatory labeling to mock and lure them. The initiates were also given sacred traditional teachings which enhanced their social acceptability. As a result, the uncircumcised felt incomplete, despised and ostracized (Olenja & Kamau, 2001; Althaus, 1994).

As a result of cultural dynamism, FGM has been evolving with time to cope with challenges of modernity. Traditionally, it was performed by a traditional practitioner with crude instruments and without anesthetic. However, due to the threat posed by HIV/AIDS, the modes of operation are slowly changing. For example, a baseline survey carried out in Trans Mara district in 2000 by a MOH/GTZ FGM Project revealed that although traditionally one instrument was used in multiple operations, the emergence of HIV/AIDS had necessitated medicalization and the use of one instrument per initiate. However, WHO is opposed to all the types of FGM, even with medicalization.

Although FGM has been going on for a long time, it has recently attracted a lot of attention as a public health issue within the context of Reproductive Health. WHO (2006, 2000); Morison, et al. (2001); Toubia (1993) observed that FGM is a social problem that causes grave damage to women. The complications of FGM are both immediate and long term and vary according to the type and severity of the procedure used. The immediate complications include hemorrhage, infection, pain, fistulae, urine retention, stress and shock, and damage to urethra or anus. The long term problems include: sexual dysfunctions, increased risk of hemorrhage, difficulty in menstruation and delivery, infertility secondary due to infection, and often psychological and psychiatric morbidity.

At the international level, FGM is viewed as a violation of human rights against women and the girl child. There are various international and regional conventions aimed at eliminating the practice. Many western countries have even enacted laws prohibiting FGM. However, the laws have been limited by inability to prohibit children being taken out of the countries for circumcision (UNICEF, 2005; Olenja & Kamau, 2001). In Kenya, there is no specific law criminalizing FGM. But recently, piecemeal legislations such as the Children Act (2001) and Sexual Offences Act (2006) seek to address FGM as a human right violation. Advocates against FGM have expressed concern that criminalization might make the practice go underground and greatly inhibit elimination process. According to them, the answer to FGM eradication lies not in condemnation but appreciation, not in activism but advocacy, not in legislation but understanding, not in public pronouncement but education and not in emotion but pragmatism (National Focal Point Newsletter, 2001). FGM has proven to be an enduring tradition that is

difficult to overcome given the deeply held cultural and sometimes political significance. A significant difficulty lies in the fact that FGM, as an identifying feature of indigenous culture, is intimately associated with the endogamous potential of young women. As a result of this, anti-"circumcision" activists increasingly recognize that to end FGM, it is necessary to work closely with concerned local communities.

Given the difficulties in eradication of FGM, the government of Kenya through the Ministry of Health in 1999 developed a National Plan of Action for the "Elimination of Female Genital Mutilation in Kenya". The essence was to accelerate the elimination of FGM in order to improve the health, quality of life and well being of women and the girl child. MOH/GTZ developed a pilot project in two districts – Transmara (2000) and Koibatek (2001). The Plan of Action indicates that FGM was practiced in 49 out of then 64 districts, and there were three common types including clitoridectomy, excision and infibulation. Excision was the most common while infibulation was the least. The KDHS (2003) estimated that 32 % of women aged 15–49 years had undergone FGM compared to 38 % in 1998, with differences across ethnic groups ranging between 12 % (among the Miji Kenda) and 97 % (among the Kisiis). The practice was almost non-existent among the Luhyas and Luos where it had declined from 4 % to less than 1 %.

In support of the efforts by the government, civil society organizations have been in the forefront in advocating for elimination of FGM through creating partnerships and working relationships with the local communities. One such organization is Actionaid International Kenya (AAIK) which endeavours to systematically effect changes by understanding the process of FGM, factors influencing it, its consequences and the best alternative intervention strategies. Due to the entrenchment of FGM among the pastoral communities, AAIK sought to establish the formative and stimulus variables around the practice of FGM in Nginyang division, East-Pokot District, Kenya. The study was designed to provide information to characterize the practice of FGM in the area and help come up with effective intervention strategies.

1.2 The study Objectives

The overall objective was to establish the contextual factors influencing the practice of FGM and its consequences on women and girls in Nginyang division of East Pokot as a basis for designing and implementing appropriate policy and program intervention strategies.

Specific Objectives:

This study was guided by the following specific objectives:

(i) To establish the types of FGM practised by the Pokot community in Nginyang division of East Pokot,

(ii) To identify the individual, household and community level factors influencing the practice of FGM,

(iii) To identify the main consequences of FGM on women and girls,

(iv) To assess the effectiveness of the previous and/or existing policy and program interventions,

(v) To propose innovative strategies to curb the practice of FGM

1.3 The Study Area

This study was conducted in Nginyang division of East Pokot district, Kenya. East Pokot district, which was recently curved out of Baringo district, is located within the Rift Valley Province of Kenya. The district borders West Pokot, Turkana, Baringo, Marakwet, Laikipia and Koibatek districts (**see Map 1**) .A Parts from Nginyang division, the other four administrative divisions forming the district are Tangulbei, churo and Kolowa Politically, the district has one parliamentary constituency, Baringo East, and several civic wards.

Nginyang division cover an estimated area of about 1345km$^{2.}$ Nginyang division has four locations, namely Kositei ,Ribko, Akoret and kapau . According to the 1999 National Population and Housing Census, the former larger Nginyang division had a total population of 19505 persons. With a growth rate of 3.5 percent per annum, the population is hiked up to 32887 persons in the year - 2009(CBS, 2001). The population density is estimated to be 20 persons per

square kilometer of land with wider variations within the area. The low population density is attributed to socio-cultural and environmental factors.

The average household size is between 7 and 8 persons. There are high levels of illiteracy characterized by 25 % enrollment rate and high drop out rates. This is attributed to the entrenched cultural practices, especially male and female circumcision, early marriages and general negative attitudes towards education. It is estimated that in every household of about eight children, only two attend school. However, even the two who manage to attend school, join at older ages and are more likely to drop out at some point. A majority of the children stay away from school looking after their family livestock and helping with domestic chores. A girl child under the age of 15 years is disproportionately affected as she is supposed to be married off immediately after circumcision.

A large proportion of East Pokot district is arid and semi-arid with temperatures averaging 34° C and rainfall ranging from 450mm to about 650mm per annum (G.o.K., 1996). It is predominantly occupied by the Pokot community which religiously practices male and female circumcision, with about 90 % of its members practicing FGM. The community is essentially pastoralist with livestock being their economic mainstay and source of food. As a result of the harsh climatic condition and the nomadic lifestyles, the district has high poverty level incidences of between 54 and 64 % (CBS, 2005). The local community therefore relies on relief food to supplement their staple food, mainly meat and milk. However, with increasing population and settlement in the neighbouring districts, the community is slowly shifting from nomadism and adopting sedentary farming. Currently, the main economic activities are livestock rearing, bee keeping, fishing along Lake Baringo and seasonal subsistence crop farming, especially in areas where there is enough rainfall. Nginyany division is driest receiving the least amount of rainfall and most of the people practice pastoralism

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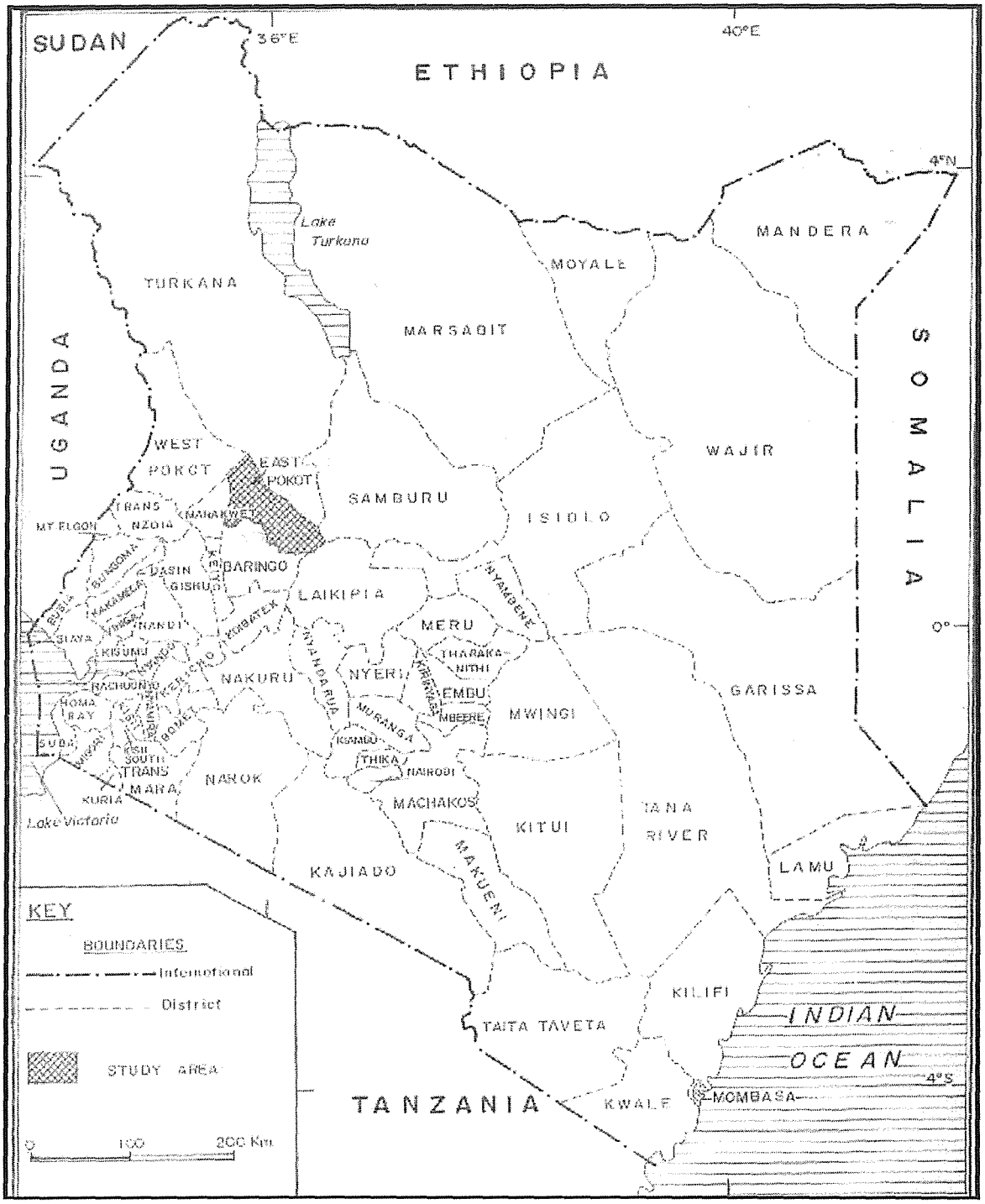
The study was conducted in Kositei and Ribko locations of Nganyang division . The study area was chosen because of the available evidence of high illiteracy levels and majority of the members of the local community (Pokot) practise female genital mutilation.



Map 1: Location of East Pokot District in Kenya

CHAPTER TWO

RESEARCH METHODOLOGY

2.1 Introduction

This chapter discusses the methodological procedures that were used in data collection and analyses. The discussion includes the research design; sampling procedure and sample size; data collection instruments and procedure; and data analysis.

2.2 Research Design

This study adopted a cross-sectional survey research design targeting male parents (fathers), female parents (mothers), young males and young females aged between 12 and 20 years as the units of enumeration. A cross-sectional survey is a research design which entails the collection of data on a number of variables concerning more than one case, simultaneously and at a single point in time in order to detect patterns of associations/relationships (Bryman, 2001; Mugenda & Mugenda, 1999). The design was adopted because the study simultaneously assessed female circumcision and its formative and stimulus variables at one point in time from different target groups in the community.

2.3 Sampling Procedure and Sampling Size

A sample size of 120 respondents for the study area was determined using Fisher's formula. After determining the sample size to be drawn from the study area, a two-stage cluster sampling approach was used to adequately select the study sites (clusters) and the study units (the 120 respondents). In the first stage, study sites (clusters) were selected and in the second stage, sampling of the study units (respondents) was performed. The two stage cluster sampling is explained below.

In the first stage, all the two locations (defined as clusters) in the division were purposively included in the study. The clusters included Kositei and Ribko locations from Nginyang division. The selection of all the two clusters was used to provide sufficient variability in the distribution of the sample and increase the amount of diversity in the information to be collected. This also

permitted a comparative appraisal of the variables influencing FGM among the clusters so as to inform in the development of specific intervention strategies.

In the second stage, the study units (120 respondents) were distributed and selected from the two clusters. The sample size was equally allocated to the selected two clusters with each getting 60 respondents. All clusters were also dominated by the Pokot community in which an estimated 90 % of its members practising FGM. The selection of the respondents was based on a systematic random sampling technique with every second household with subjects eligible for the study being visited. A central starting point was determined on the ground for each of the clusters. From this starting point, households with subjects eligible for the survey were systematically selected by moving to the next household. Two respondents were targeted from each household visited. In each household, a youth aged 12-20 years and a parent, either male or female or both, were interviewed based on availability of each category. This was partly to spread out the sample as well as minimizing bias of the information. Therefore, with 60 respondents allocated to each cluster, a total of 30 households were targeted and visited. This meant that in each cluster, 16 respondents from each cohort (young males, young females, female parents and male parents) were selected and interviewed.

2.4 Data Collection Instruments and Procedure

The study was mainly exploratory supported by descriptive statistics. Therefore, it utilized only quantitative data collection methods to exhaustively capture the necessary data. Despite the fact that FGM is a complex socio-cultural phenomenon that could not be adequately addressed by one method only, there was no option due to inadequate funds and limited time .

Quantitative data were collected using a standardized/structured questionnaire based on the sample size (120) and means of randomization . The study used four sets of standardized questionnaires targeting specific groups: male parents, female parents, young females and young males. Some of the information elicited using the questionnaires include FGM prevalence, average age of circumcision, percentage of parents supporting or opposing continuation of FGM, percentage of circumcisions performed by health workers, etc.

To ensure validity, the research instruments were piloted and pre-tested in Chemsik village in Kositei location sub-location of East Pokot district. A pre-test sample of 10 % of the sample size (38 respondents). The data was collected with the help of 4 local enumerators under the supervision of the researcher. The research enumerators were recruited on the basis of their literacy level, understanding of the area and its traditions, proficiency in local dialect and residence of the area. The enumerators underwent a one day training on the use of the research instruments. The research assistants were also used to evaluate the items and instructions in the instruments to identify ambiguities, gender biases and cultural biases of the items. The actual data collection took a period of 10 days ,five days in each cluster..

2.5 Field Challenges

In the execution of the survey, some challenges were encountered and which are worth noting since they affected the exercise. These included:

(i) The terrain was rugged with homesteads widely spread out and as a result the enumerators had to cover long distances. In connection with this, the nomadic lifestyle of the community made it impossible to trace some of the identified respondents in the homestead. This affected more young people as majority were looking after livestock by the time of the study. Therefore, the systematic random sampling procedure proposed could not always be strictly adhered to, as some of the selected homesteads were vacant during the survey time. Subsequently, neighbouring homesteads were selected as "replacements" and the eligible respondents interviewed instead.

(ii) At the initial stages, some respondents, especially women and girls, were reluctant to talk about female circumcision because of the oath taken during circumcision prohibits them from discussing anything concerning the practice with persons who have not gone through the rite. This also includes men in the community. Attempts to overcome this were made by assuring them of confidentiality of all information elicited. Thus, although they disclosed to us some information, it could be that there is more to the practice that we might not have covered. These problems notwithstanding, efforts were made to assure all respondents their confidentiality and help them feel comfortable to open up and give correct information.

(iii) Tribal hostility and conflicts between the Pokots and their neighbouring pastoral communities frequently affected data collection. For example, during the first day of data collection the Pokots stole their tugen neighbours goats and this interrupted the process as the targeted respondents all ran away for safety and/or combat.

2.6 Data Analysis

Since this study was mainly exploratory supported by descriptive statistics. Qualitative methods was only used. Quantitative data from the completed standardized questionnaires were edited, coded, and entered into SPSS version 11.5 and cleaned for analysis. This was done using mainly descriptive statistics. Descriptive statistics including frequencies, percentages and means presented in tables, charts and cross-tabulations were used to summarize, organize and analyze data, and describe the characteristics of the sample.

CHAPTER THREE

STUDY FINDINGS

3.1 Introduction

This section present a discussion of the research results from the collected data based on the research objective of the study. The section begins with a brief overview of the background characteristics of the 120 respondents included in quantitative data collection.

3.1.2 Characteristics of the Respondents in Quantitative Survey

As earlier stated,the survey targeted young males aged 12-20 years, young females aged 12-20 years, female parents and male parents from two selected clusters (locations) in Nginyang divisions within East Pokot district. These groups exhibited varied demographic and socio-economic background as explained in the following subsections.

3.1.2.1 Age Distribution

Age is a very important physical, social, economic and cultural factor in the growth and development of a person in a society. In socio-cultural terms, age determines social order, defines the various roles played by different people in the society and influences decision-making power at the household and community levels. In this study, the age of the young females and young males ranged between 12 and 20 years with a mean age of 17.20 years and 17.94 years, respectively. The age of female parents ranged between 25 and 77 years with a mean age of 44.46 years. The male parents were aged between 27 and 87 years with a mean age of 52.38 years.

3.1.2.2 Marital status

Majority of the young persons (86.57% of girls and 83.3 % of boys) were still single while all the parents (male and female) were married (Table 1). This was expected to influence the status and roles of the respondents at their household level.

Table 1: Marital status of the respondents

Marital status	Girls	Boys	Mothers	Fathers
Single	26(86.7%)	25(83.3 %)	0	0
Married	4(13.3 %)	5 (16.7 %)	30 (100.0 %)	30 (100.0 %)
Total	**30**	**30**	**30**	**30**

3.1.2.3 Level of Education of the Respondents

The level of education of a person indicates his or her level of awareness and ability to make informed decisions in life. In the study area, the level of illiteracy was very high with 55 percent (66) of the respondents having never been to school (Table 2). Comparisons across the cohorts of respondents revealed that majority of the parents

(66.7 % of mothers and 76.7% of fathers) had never been to school compared to the young people (40% for girls and 46.7 % for boys). Across the board, majority of the respondents had not gone beyond primary school level of education.

Table 2: **Highest level of education of the respondents**

Level of education	Girls	Boys	Mothers	Fathers	Total
Never been to school	13 (43.83)*	10(33.3)	20 (66.7)	23 (76.7)	66(55.0)
Informal education	0 (0.0)	0 (0.0)	0(0.0)	0(0.0)	0(0.0)
Pre-primary school	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)
Primary incomplete	6(20)	8(26.7)	6(20.0)	3(10)	23(19.2)
Primary continuing	6 (20)	6(20.0)	2 (6.7)	0(0.0)	12(10.0)
Primary complete	1(3.3)	2(6.7)	0(0.0)	2 (6.7)	7(23.3)
Secondary incomplete	2 (6.7)	2 (6.7)	0 (0.0)	0 (0.0)	4 (3.3)
Secondary continuing	0 (0.0)	1(3.3)	0 (0.0)	0 (0.0)	1(0.8)
Secondary complete	2 (6.7)	1(3.3)	2(6.7)	1 (3.3)	6(5.0)
Middle level college	0 (0.0)	0 (0.0)	0 (0.0)	1(3.3)	1 (0.8)
Total	**30**	**30**	**30**	**30**	**120**

Note: * Figures in parenthesis (brackets) are percentages

3.1.2.4 Religion of the Respondents

Religion and the extent to which its followers adhere to its core tenets have a strong influence on their behaviors and general ways of lives. This determines their social, economic and cultural attributes of the followers. Table 3 depicts the distribution of the respondents and their type of religion.

Table 3: Religion of the respondents

Religion	Girls	Boys	Mothers	Fathers
Christian	16(53.3)	12(40.0)	15 (50.0)	10(33.3)
Traditional African religion	9 (30)	14 (46.7)	11 (36.7)	20(66.7)
Muslim	0	0 (0.0)	0(0.0)	0
No religion	5 (16.7)	6(20.0)	4(13.1)	0
Total	**30**	**30**	**30**	**30**

Note: * Figures in parenthesis (brackets) are percentages

Table 3 indicates that a majority of the young people and their mothers were Christians (53.3 % of girls, 40.0 % of boys and 50.0 % of mothers), while a majority of the fathers (66.7 %) were followers of traditional African religion. Traditional African religion was reported to be the African traditional way of worshipping where people believe in ancestral powers in addition to claiming the word of God. It was this traditional religion that had entrenched the traditions and customs in the community.

3.1.2.5 Occupation of the Respondents

The main occupation of a person influences his social and economic status and that of his/her households. It determines their source of living, source and access to food, and ability to adapt to changing situations of living. Table 4 highlights the main occupation across the four cohorts of respondents. The study reveals that majority of the respondents were predominantly involved in herding. However, there were variations in the kind of occupation of the respondents from each cohort. A Majority of the young people (30% of girls and 33.3 %boys) were engaged in herding with another substantial number (20.0% and 26.7 %, respectively) still in school. Majority of the fathers were herders (50 %), while a majority of the mothers (53.3 %) were housewives.

Table 4: Current occupation of the respondents

Occupation	Girls	Boys	Mothers	Fathers	Total
Pupil	6 (20.0)	8 (26.7)	0 (0.0)	0 (0.0)	14 (11.7)
Student	1(3.3)	1(3.3)	0 (0.0)	0 (0.0)	2 (1.7)
Herding	9 (30.0)	10 (33.3)	0 (0.0)	15 (50)	34(28.3)
Self-employment	1 (3.3)	2(6.7)	5 (16.7)	4 (13.3)	12 (10)
Nothing	1 (3.3)	2 (6.7)	0 (0.0)	0 (0.0)	3 (2.5)
Volunteer/casual worker	2 (6.7)	3(10)	0 (0.0)	0 (0.0)	5(4.2)
Housewife	6 (20.0)	0 (0.0)	16 (53.3)	0 (0.0)	22(18.3)
Handling domestic chores	4(13.3)	0 (0.0)	0 (0.0)	0 (0.0)	4 (3.3)
Formal employment	0 (0.0)	0 (0.0)	2 (6.7)	5(16.7)	7(5.8)
Crop farming	0 (0.0)	4 (13.3)	7 (23.3)	6 (20)	17 (14.2)
Total	**30**	**30**	**30**	**30**	**120**

Note: * Figures in parenthesis (brackets) are percentages

3.1.3 Prevalence of FGM

To determine the prevalence rate of female circumcision in the study area, female respondents (girls and mothers) were particularly targeted and asked about their circumcision status. Boys and fathers were also asked about the circumcision status of their sister(s) and daughter(s), respectively. Therefore, a number of variables were examined as follows:

a) Of all the 30 female parents who were interviewed, **90% (27)** of them were circumcised with **83.53% (25)** reporting that they had circumcised daughters.

b) For the 30 young females interviewed, **53.3 % (16)** were circumcised, while **46.7 % (14)** were not. For the 44 uncircumcised, only **28.6 % (4)** had intentions to be circumcised in future, while **10 (71.4 %)** had no such intentions for circumcision.

c) From the percentages of female parents **(90 %)** and young females **(53.3 %)** who were circumcised, the overall female circumcision prevalence rate for the study area is therefore **71.7 percent**. Table 5 illustrates the breakdown of the prevalence rate young females who were circumcised by some selected background characteristics.

d) To confirm the high prevalence rate, 70 % (21) of the young males reported that they had circumcised sisters, while 63.3 percent (19) of the male parents had circumcised daughters.

e) The median age at circumcision was 15.0 years (with the mean age of circumcised girls being 15.33 years while that of female parents was 14.81 years).

f) All the young females and female parents who were circumcised knew which part of the body of their genitalia were removed and reported that they underwent **infibulation** type of circumcision (**Type III**).

Table 5 shows the prevalence of FGM among girls by their background demographic and social characteristics. For example, 25.0 percent of the girls aged between 12 and 16 years were circumcised and this represents 2 out of the 9 girls in that age category. The table shows that the percentage of girls who were circumcised was strongly influenced by the level of education, religion and the location of residence of the girls

Table 5: Prevalence of FGM among the girls by background characteristics

Background characteristics	% circumcised	n out of N
Age		
12-15	250%	6 out of 16
16-20	75%	12 out of 16
Level of education		
No education	61.5%	8 out of 13
Pre-primary complete	0.0%	0 out of 3
Primary incomplete	66.7%	4 out of 6
Primary continuing	16.7%	1 out of 6
Primary complete	100%	1 out of 1
Secondary incomplete	50%	1 out of 2
Secondary complete	50%	1 out of 2
Religion		
Christian	47.8%	7 out of 16
Traditional African religion	66.7%	6out of 9
No religion	100%	5 out of 5
Location of Residence		
Tangulbei	46.7%	7 out of 15
Korossi	73.3%	11 out of 15

3.1.4 Antecedents of FGM

3.1.4.1 Why FGM is Practiced (Perception of the Community)

To assess the reasons behind the practice of FGM in the study area, several variables were identified and examined from the views of circumcised girls, boys with circumcised sisters and

parents with circumcised daughters. The study sought to understand the reasons for female circumcision from the 16 young females who were circumcised; 21 young males with circumcised sisters; and 19 male parents and 25 female parents who had circumcised daughters **(see section 3.2.3)**. The results indicate that the main reasons for practicing FGM included: to keep with the traditions and customs, social acceptance and good marriage prospects. However, there were marked variations in the way the girls, boys, mothers and fathers perceived the reasons for practicing FGM. Parents highly valued female circumcision as a good tradition and custom and as a guarantee for better marriage prospects of their daughter(s). More girls viewed it just as a way of keeping with traditions and social acceptance, while boys considered it as a good tradition and better marriage prospects. The differences are attributed to their difference in perceptions about the importance of female circumcision in their community and level of awareness. Other reasons were also mentioned as indicated in Table 6.

Table 6: Reasons why FGM is practiced by groups

The main benefits	**Girls**	**Boys**	**Fathers**	**Mothers**
Keeping with traditions and customs	12(75.0)	11 (52.4)	11 (57.9)	21 (84.0)
Social acceptance	7 (43.8)	8 (38.1)	7 (36.8)	9 (36.0)
Better marriage prospects	6 (37.5)	14 (66.7)	15 (78.9)	22 (88.2)
Easy delivery	0 (0.0)	1 (4.8)	2 (10.5)	4 (16.0)
Religious demand	0 (0.0)	0 (0.0)	0 (0.0)	4 (16.0)
Remove dirty genitalia	2 (12.5)	2 (9.5)	3 (15.8)	4 (16.0)
Enhance husband pleasure	1 (6.3)	1 (4.8)	4 (21.1)	3(12.0)
Control sexual desires	1 (6.3)	0 (0.0)	0 (0.0)	5 (20)
Improve fertility	0 (0.0)	0 (0.0)	0 (0.0)	8(32)
Preserve virginity	0 (0.0)	1 (4.8)	0 (0.0)	4 (16.0)
Total	**n = 16**	**n = 21**	**n = 19**	**n = 25**

Note: The n only refers to the girls who had been circumcised, boys who had circumcised sisters and parents who had circumcised daughters. The percentage (indicated in parenthesis/brackets) refers to the independent proportions supporting that particular reason out of the total. They therefore do not add to 100 % at the end.

3.1.4.2 Decision to Circumcise

The study revealed that both the family and the community in general had a prominent role to play in the decision to circumcise a girl. However, the immediate family members, especially the girl, mother and father, played a first hand role in the decision. The circumcised girls were

therefore asked about the person who made the final decision for them to be circumcised (Figure 1).

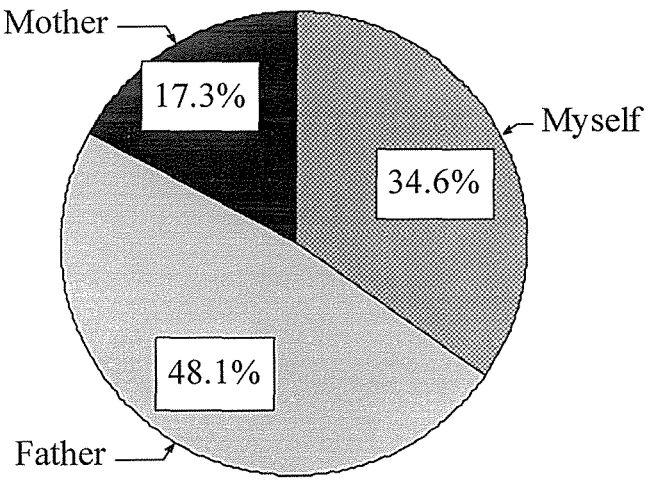


Figure 1: The final decision maker for circumcision

Figure 1 indicates that both parents (mother and father) and the girl to be circumcised played roles in the decision-making process. However, even though the mothers and daughters had a role to play in the decision making, it was the father who made the final ruling about circumcision of his daughter.

3.1.4.3 Conducting FGM

All the 16 circumcised young females and 27 circumcised mothers reported that they were circumcised by a traditional circumciser *(kokomelkong)*. Out of the 16circumcised girls, 14 (87.5%) of them and all the 27 mothers were circumcised in a secluded place either in their own home or in the home of one of the other initiates. The secluded place in own home or another home was reported to have been either a cowshed or in a specific hut. The remaining 12.5% percent of the girls were circumcised at the home of the *kokomelkong*. There was a marked

difference in the instruments used for circumcision between the circumcised girls and female parents. Majority of the girls (86.7 %) were circumcised using one razor blade per initiate while 73.3 percent of the mothers were circumcised using a shared knife/scapel *(rotwa).* The variation in the instruments used was attributed to the difference in the time when the girls and mothers were circumcised. Traditionally, the initiates were circumcised using a shared *rotwa,* which was meant to create a bond among the group of initiates. However, due to the recent level of awareness of the potential health risks of sharing the instruments during circumcision, there was the use of one razor blade per initiate. Therefore, most the mothers who shared *rotwa* were circumcised long time ago, while the girls were circumcised recently. Table 7 shows the place of circumcision and instruments used by circumcised girls and mothers.

Table 7: Place of circumcision and instruments used

Place of circumcision	**Girls**	**Mothers**
A secluded place in own home or in another initiates home	14 (87.5)	27 (100.0)
Home of the practitioner/circumciser	2 (12.5)	0 (0.0)
Total	**16**	**27**
Instruments used	**Girls**	**Mothers**
One razor blade per initiate	14 (87.5)	4 (14.8)
Shared razor blade	2 (912.53)	3 (11.1)
Shared knife/scapel	0 (1.9)	18 (66.7)
One knife per initiate	10(1.9)	2 (7.4)
Total	**16**	**27**

Note: * Figures in parenthesis (brackets) are percentages

All the circumcised girls and mothers also indicated that they were briefed about the expectations of circumcision on the night prior to the day of circumcision and went through the seclusion period after circumcision. Majority of them (87.5 % of the girls) were circumcised in a group of between 5 and 10 initiates. All the sampled respondents (girls, boys, mothers and fathers) indicated that uncircumcised women in their community are mocked and alienated from important community functions. Such a woman is treated as if she is still a child (*sorin/chepto*), dirty and smelling.

3.1.5 Awareness of Consequences of FGM

The study established that FGM has various associated consequences on the initiates. Out of the 16 girls who had been circumcised, 43.8 percent (7) of them had personally experienced problems after undergoing the exercise. In addition, 48.1percent (13) of the 27 mothers with circumcised daughters reported that their daughters experienced problems from circumcision. The young males and male parents also indicated that their circumcised sisters and daughters, respectively, also encountered these problems. However, being a gender and personal experience, the 7 circumcised girls and 13 mothers were assumed to be in a better position of highlighting the actual problems that they experienced and/or witnessed as a result of circumcision. Table 8 captures the consequences as highlighted by the 7 circumcised girls and 13 mothers.

Table 8: Consequences of FGM

Consequences	Girls (n = 7)	Mothers (n = 13)
Excess bleeding	5 (71.4)*	10 (76.9)
Urine retention	4 (57.1)	7 (53.8)
Disease infections	3(42.8)	8(61.5)
Scarring	3 (42.8)	10 (76.9)
Tetanus	2 (28.6)	7(53.8)
Painful menstruation	2 (28.6)	8 (61.5)
Prolonged/obstructed labour	2 (28.6)	8 (61.5)
Severe pain	1 (14.3)	11 (84.6)
Recurrent bladder and urinary infections	1(14.3)	9 (69.2)
Still birth	3(42.8)	25 (61.0)
Trauma and depression	2 (28.6)	25 (61.0)

Note: * Figures in parenthesis (brackets) are percentages

Table 8 indicates the consequences of FGM from personal experience by circumcised girls and personal witness by mothers of circumcised girls. For the circumcised girls, the most apparent and prominent consequences were excess bleeding, urine retention, disease infections and scarring. It is important to note that the six cases of still birth and eleven cases of prolonged/obstructed labour among the girls were all reported by the eleven girls who had earlier indicated that they were married. However, there were differences in the frequencies of the consequences witnessed by the mothers of circumcised daughters and those personally reported by the sample circumcised girls. This was attributed to the fact that the girls were giving

individual problems encountered, while the mothers were reporting problems witnessed among all their circumcised daughters.

3.1.5.1 Future Intentions

Given the significance of FGM and the level of awareness of associated consequences, the study sought to determine whether the respondents would circumcise any other daughter(s), if any, in future. The future intention was therefore cross-tabulated with the cohorts of the respondents. The results demonstrate a sharp variation between young people and parents as demonstrated in Table 9.

Table 9: Future intentions to circumcise daughter

Future intentions to circumcise daughter(s)		Respondents				Total
		Fathers	Boys	Girls	Mothers	
Yes	Count	25	6	3	21	**55**
	%	82.3%	20%	10.0%	70%	**45.8%**
No	Count	3	20	25	6	**54**
	%	10.0%	66.7%	83.3%	20%	**45%**
Depend on the girl	Count	2	4	2	3	**11**
	%	6.7%	13.3%	6.7%	10%	**9.2%**
Total		**30**	**30**	**30**	**30**	**120**

Table 9 indicates that on the overall, 45.8 percent(55) of the 120 respondents had intentions to circumcise their daughter(s), if any, in future. Comparing across the different cohorts of respondents, a large proportion of parents (83.3 % of fathers and 70% % of mothers) indicated that they would circumcise any other daughter(s), if any, in future. This was in contrast with young people where 66.7 percent of boys and 83.3 percent of the girls indicated that they would not circumcise their daughters in future. Minority in each of the four categories of respondents indicated that their decision will depend on the willingness of their daughter(s). The parents reported that they based their future intentions of circumcising their daughter(s) on the significance role of female circumcision in their society, while the young people considered their level of awareness of the associated consequences of the practice. Fathers and mothers would want to better the marriage prospects of their daughters, get dowry, and social acceptance, recognition and honour in the community. In connection with future circumcision of their

daughter(s), male parents and young males were asked if they would contemplate marrying uncircumcised woman in future. Figure 2 depict their responses.

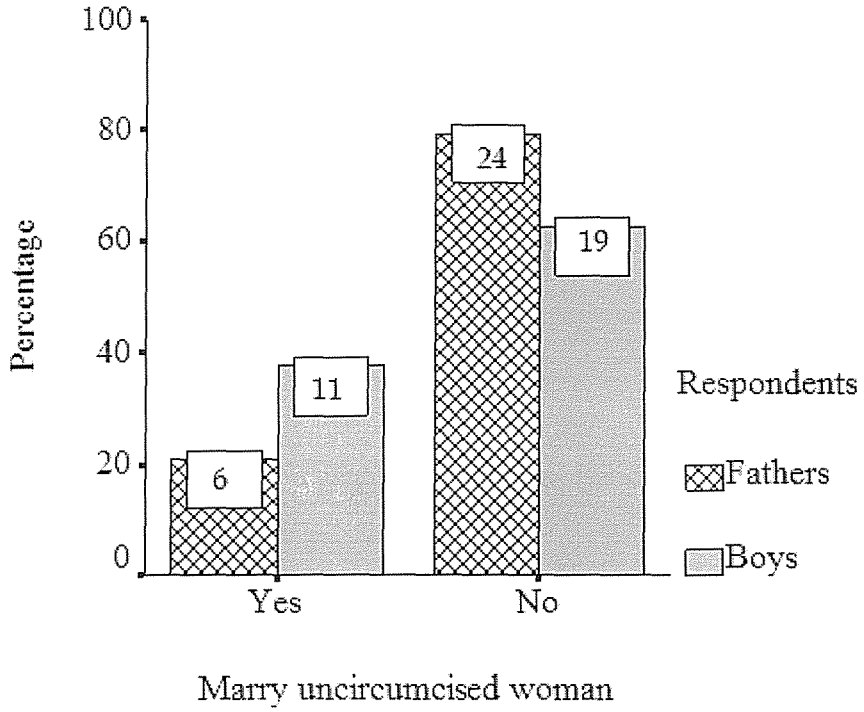


Figure 2: Future intentions to marry uncircumcised woman

Figure 2 indicates that only 36.7 percent (11) of the 30 young males and 20 percent (6) of the 96 fathers would, if given an opportunity, consider marrying uncircumcised wife in future. Majority of the young males and fathers could not contemplate marrying uncircumcised woman in future. This demonstrates how strong men value female circumcision and its influences on the prospects of marriage in the community.

3.1.6 Sources and Type of Information against FGM

In order to find out the appropriate strategies and messages that could be used in the fight against FGM, the respondents were asked whether they had heard of any messages against the practice. They were also asked to state the source of this information, the kind of messages and the appropriate channels that can be used in disseminating information against the practice of FGM in the community.

The study established that majority of the respondents were aware of activities and had heard of messages against FGM as indicated in Figure 3 and Tables 10 and 11.

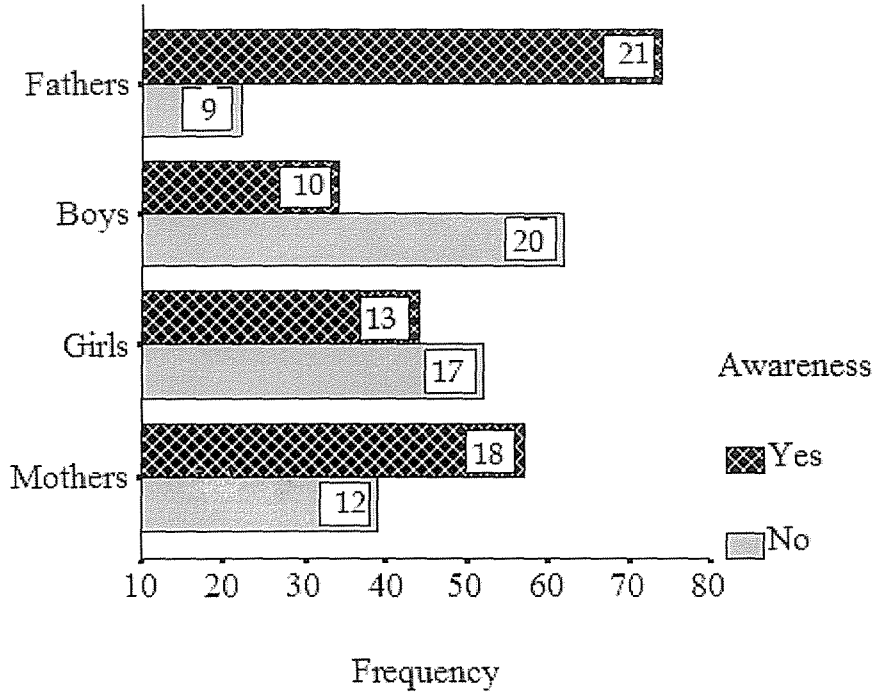


Figure 3: Awareness of activities and messages against FGM

Figure 3 indicates that on the overall, majority of the respondents were aware of activities and messages against FGM in their community. However, there were difference among the cohorts of the respondents with more parents (21 fathers – 70 % and 18 mothers – 60 %) aware of activities and had heard of messages against FGM than young people (10 boys – 33.3 % and 13 girls – 43.3 %). This was attributed to the fact that parents had witnessed these activities for quite along time compared to young people. Most activities had also targeted parents first as persons who had more influence on the decision of circumcising their daughters. They were therefore the most appropriate persons targeted first by the campaigns. The study also established that there were also variations among the young people with more girls than boys being aware. This was linked to the fact that in addition to the parents, girls were the next prime targets of these activities.

The respondents who were aware of activities against FGM **(see Figure 3)** were asked about the messages that they had heard against FGM. Table 10 shows that the types of messages varied ranging from access to educational opportunities to violation of human rights. The most

prominent messages across board were FGM limits education of girls; can lead to sexually transmitted diseases/infection like HIV infection; and can lead to birth complications and excess bleeding. The least prominent messages were that FGM is against religious teachings and a violation of human rights of women.

Table 10: Type of messages heard against FGM

Message	*Girls (n=13)*	*Boys (n=10)*	*Mothers (n=18)*	*Fathers (n=21)*
FGM limits girls education	10 (76.9)	8 (80)	15 (83.3)	14 (66.7)
Can lead to STI/STDs	9 (69.2)	4 (40)	12 (66.7)	9 (42.9)
Can lead excess bleeding and birth complications	6 (46.2)	2 (20)	8 (44.4)	10 (47.6)
It is against religious teachings	3 (23.0)	1 (10)	6 (33.3)	4 (19)
It is a violation of human rights	2 (15.4)	1 (10)	3 (16.7)	1 (4.8)

The respondents who had heard of messages **(see Figure 3)** were also asked about the sources. Table 11 shows that the leading sources of messages against FGM across the board were religious leaders followed by organized pressure groups and community leaders. Church leaders were reported to have been preaching against the practice of FGM and emphasize its irrelevance according to the Biblical teachings. This was done during public meetings (crusades) and sermons especially when they are conducting marriage ceremonies of uncircumcised girls. They have also set the example of not taking their girls for circumcision. Organized pressure groups, especially NGOs, were vigorously in creating awareness of the adverse consequences of FGM. A few of the community leaders who were ready to embrace change were involved in sensitizing the community on the values of formal education and also talked about the changing times. However, a close examination of the table reveals that a good majority of the fathers (57.1 %) mentioned community leaders a source, while mothers (42.9 %) had organized pressure groups like NGO. This was attributed to the fact that some of the fathers also happened to be community leaders in their own right, while organized pressure targeted more mothers in the community.

Table 11: Sources of the messages against FGM

Source	*Girls (n=13)*	*Boys (n=10)*	*Mothers (n=18)*	*Fathers (n=21)*
Religious leaders	10 (76.9)	7 (70)	13 (72.2)	18 (85.7)
Organized pressure groups eg NGOs	3 (23.0)	1 (10)	9 (42.9)	2 (9.5)
Community leaders	2 (15.4)	3 (30)	2 (11.1)	12 (57.1)
Radio	2 (15.4)	2 (20)	2 (11.1)	3 (14.3)
Social meetings and gatherings	1 (7.7)	1 (10)	1 (5.6)	2 (9.5)
Schools and the government	2 (15.4)	2 (20)	6(11.1)	4 (19.0)

For the activities and messages against female circumcision to have a positive impact, the recipients are supposed to have a positive attitude towards them. A Majority of those who had heard the messages against FGM were comfortable and satisfied with them as illustrated in Table 12.

Table 12: Satisfaction with messages against FGM by cohorts of respondents

Satisfied with messages against FGM		**Respondents**				
		Fathers (n=21)	**Boys (n=10)**	**Girls (n=13)**	**Mothers (n=18)**	**Total**
Yes	Count	15	6	11	15	**47**
	%	71.4%	60%	84.6%	83.3%	**74.8%**
No	Count	6	4	2	3	**15**
	%	28.6%	40%	15.4%	16.7%	**25.2%**
Total		**21**	**10**	**13**	**18**	**62**

Table 12 shows that a majority of the respondents (71.4 % of fathers, 60 % of the boys, 84.6 % of the girls and 83.3 % of the mothers) were satisfied and comfortable with the activities and messages against FGM. This is a good sign that the more people are aware of the activities and messages against female circumcision, the more are satisfied and comfortable with them.

3.1.7 Involvement in Campaign against FGM

The success of any campaign against FGM in the practising community will depend on the level of involvement of the local members in the activities and messages against the practice. Figure 4 depicts the distribution of the respondents in their cohorts and their willingness to be involved in the fight against FGM.

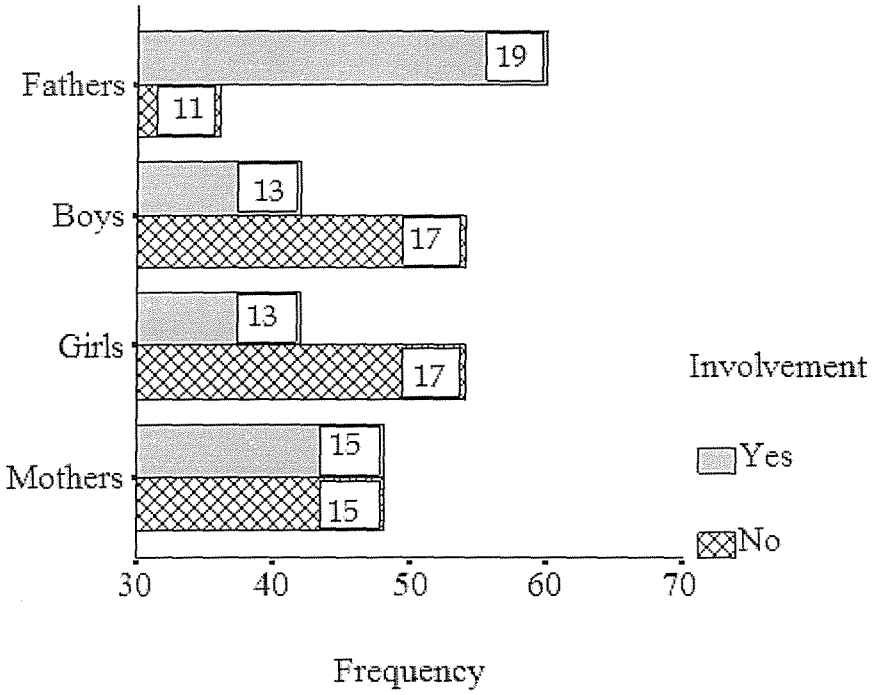


Figure 4: Willingness to be involved in the fight against FGM

Majority of the parents were willing to be involved in the campaign against the practice of FGM than the young people. 19 (63.3 %) of the fathers and 15 (50.0 %) of the mothers were willing to be involved in the campaign compared to 13 (43.3 %) of the boys and 13 (43.3 %) of the girls. Majority of the young people were not willing to be involved in activities against FGM. The young people reported that being a very deeply-rooted community practice, they feared a curse from the community leaders who might view them as opposing the traditions and customs. For the parents who were willing to be involved in the campaign, majority were quick to point out that their involvement should only serve to create awareness of the associated consequences and if possible change a few negative aspects of the practice but not to completely eliminate it.

The respondents highlighted how they would wish to be included in the campaign as captured in Table 13. A Majority of the respondent wanted to be involved in education and creation of awareness; advocating for adequate access and equity of girls to education; appreciating both circumcised and uncircumcised girls; and advocating for alternative rites to FGM.

Table 13: Involvement in the campaign against FGM

Nature of involvement	*Girls (n=13)*	*Boys (n=13)*	*Mothers (n=15)*	*Fathers (n=19)*
Education and creating awareness	10 (76.9)	9 (69.2)	13 (86.7)	13 (68.4)
Advocating for adequate access and equity of girls to education	4 (30.8)	2 (15.4)	5 (33.3)	9 (47.4)
Appreciating both circumcised and uncircumcised girls	3 (23.0)	7 (53.8)	2 (13.3)	3 (15.6)
Advocating for alternative rites to FGM	2 (15.4)	3 (23.0)	4 (26.7)	4(21.1)
Use uncircumcised and successful women role models as inspiration	2 (15.4)	2(15.4)	3(20.0)	2(10.5)
Provision of legal redress for those not willing to undergo FGM	1 (7.7)	0 (0.0)	1 (6.7)	1(5.3)

For the future delivery of messages against FGM, the respondents highlighted the most appropriate channels that could be used in reaching out to their community as depicted in Table 14. Baraza, home visits and other social gathering emerged as the most appropriate and viable channel to be used in delivering messages against FGM followed by religious leaders and community leaders in cultural ceremonies across the cohorts of respondents.

Table 14: Appropriate channels for anti-FGM campaign messages

Channels	*Girls (n=13)*	*Boys (n=13)*	*Mothers (n=15)*	*Fathers (n=19)*
Baraza, home visits and other social gatherings	11 (84.6)	9 (69.2)	15 (100)	16 (84.2)
Religious leaders	5 (38.5)	4 (30.8)	7 (46.7)	4 (21.1)
Community leaders in cultural ceremonies like *sapana* and *lapan*	2 (15.4)	5 (38.5)	4 (26.7)	7 (36.8)
Radio	1 (7.7)	2 (15.4)	2 (13.3)	1 (5.3)
Health workers	2 (15.4)	3 (23.0)	3 (20.0)	2 (10.5)
Pamplets and other literature	3 (23.0)	2 (15.0)	1 (6.7)	0 (0.0)
Politicians	4 (30.8)	2 (15.0)	1 (6.7)	3 (15.8)
Use of uncircumcised and educated role models	6 (46.2)	1 (7.7)	6 (40.0)	7 (36.8)

The most appropriate persons to be targeted in the community in the fight against FGM, across the respondent categories, were parents, community leaders, girls and religious leaders as captured in Table 15. The least person(s) to be targeted were politicians and boys.

Table16: Involvement by Action Aid in the Fight against of FGM

Involvement	*Girls*	*Boys*	*Mothers*	*Fathers*
Increase advocacy, awareness and education on FGM	5 (16.7)	8 (26.7)	9 (30.0)	2 (6.7)
Provide rescue homes for girls not willing to undergo FGM	2 (6.7)	3 (10.0)	4 (13.3)	3 (10.0)
Educate girls forced to undergo FGM	4 (13.3)	5 (16.7)	2 (6.7)	7 (23.3)
Assist in building girls' boarding schools	11 (36.7)	8 (26.7)	12 (40.0)	9 (30.0)
Involve and collaborate with all stakeholders	3 (10.0)	4 (13.3)	3 (10.0)	6 (20.0)
Don't interfere with the cultural practices of the community	2 (6.7)	1 (3.3)	2 (6.7)	3 (10.0)
Total	**30**	**30**	**30**	**30**

Table 16 indicates that the most common suggestions, across the cohorts of respondents were building of girls schools; educate girls forced to undergo FGM; increase advocacy, awareness and education on FGM; involve and collaborate with all other stakeholders; and provide rescue home for girls forced to undergo FGM ands. However, there was a minority group from each cohort of respondents who emphatically stated that Action Aid should not interfere with the cultural practices of the community.

Table 15: Target groups in the fight against FGM

Channels	*Girls (n=13)*	*Boys (n=13)*	*Mothers (n=15)*	*Fathers (n=19)*
Politicians	1 (7.7)	2 (15.4)	2 (13.3)	1 (5.3)
Community leaders	6 (46.2)	5 (38.5)	5 (31.3)	13 (68.4)
Religion leaders	3 (23.1)	4 (30.8)	5 (33.3)	8 (42.1)
Parents	10 (76.9)	7 (53.8)	13 (86.7)	10 (52.6)
Girls	6 (46.2)	6 (46.2)	8 (53.3)	5 (26.3)
Boys	1 (7.7)	3 (15.8)	2 (13.3)	1 (5.3)

After determining the willingness of the sampled girls, boys, mothers and fathers to be involved in the campaign against FGM, the study sought to establish how Non-government organization (NGOs) could be enjoined in the process. All the 120 respondents were asked how they would like the organization to be involved in the fight against the practice of FGM in the community. Table 16 depicts their respondents.

CHAPTER FOUR

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

4.1 Introduction

This chapter presents a summary of the study findings based on the objectives of the study. This was done in order to provide a holistic view of the findings in terms of the rich cultural insights derived numeric data from quantitative survey to develop quantitative indicators for monitoring and evaluation and give meaning and clarity to the study. The chapter also contains conclusions drawn from the summary of the findings based on postulated objectives of the study; and the recommendations based on the conclusions made.

4.2 Summary of the Major Findings

4.2.1 Type and Prevalence of FGM

From collected data, the findings indicate very high prevalence levels of FGM among the Pokot community in Nginyang division of East Pokot community. Female parents had the highest prevalence rate compared to young females aged 12 to 20 years. To confirm the high levels of prevalence of FGM, a majority of the young males and male parents reported that they had circumcised sisters and daughters, respectively. The median age at circumcision was 15.0 years. However, this age at circumcision varied between the female parents and the young females.

All the circumcised young females and female parents knew the parts of their genitalia that were cut and removed. They all underwent infibulations type of circumcision (**Type III**). The young females and female parents observed that the *chaur* (clitoris) is removed, some or all the labia minora are cut off and incisions were made in the labia majora to create raw surfaces/wounds. These raw surfaces are then pressed together by tying the

legs together to prevent the girl from moving and allow the healing of the two sides of the vulva as a "hood of skin", which covers the urethra and most of the vagina. Since a physical barrier to intercourse has been created, a small opening is then reconstructed to allow for the flow of urine

and menstrual blood. Results from the data collected indicated that nowadays, because of the childbirth complications, the size of the opening had been minimally increased to enable easy delivery. However, a part from cases of minimal increase in the size of the opening left, the type of female circumcision in the area has not changed. All the circumcised girls and mothers were circumcised by old women traditional circumcisers, known as *kokomelkong*. Unlike in the traditional context where one traditionally-made knife/scapel (*rotwa)* was used to circumcise all the initiates, currently, there was the use of one razor blade per initiate. A majority of the circumcision cases were conducted in a secluded place at the home of the initiates.

A cross classification of the prevalence rate with selected postulated background factors of the initiates indicate that educational levels of girls, religion and location had a very significant influence on the circumcision status of a girl. Girls who were still continuing with primary school education and those who had completed secondary schools had low level of prevalence compared to those with no education or dropped out of school. Well-educated families exhibited lower levels of FGM prevalence rate compared to the less educated families. The well educated families knew the associated negative consequences of FGM and their educated girls refused to undergo the practice due to their level of awareness. The same was observed for religion. Religion played a significant positive influence on attitude towards FGM with Christian families exhibiting lower levels of FGM prevalence rate compared to those from traditional African religion and no religion. The churches preached against FGM emphasizing that it was unbiblical and against Christian teachings. The liberal or strict practices of any religious group have an important role to play in determining the FGM prevalence in the district. However, this varied among the villages and sub-locations in the area. The prevalence was reported to be low in more urban areas like Chemolingot and Nginyang centres which have been more targeted by NGOs and churches working against FGM (like AIC, ACK and Catholic Church).

4.2.2 Factors Promoting FGM

The justifications offered for the practice of FGM were numerous and, in their specific context, compelling. The Pokot community highly valued FGM as an indispensable and central ritual which was considered as a mechanism of status granting and role assumption and as a way of bringing women's procreative powers under social control. The institution of FGM was deeply

rooted within the community incorporating both social and economic connotations. Socially, FGM brings honour to the family of a circumcised girl and it also brings respect to those who are related to the girl. Such a family is accepted and commands a good sense of belonging and tight bonding with the whole community. Economically, any circumcised girl is considered ready for marriage and marriage of a daughter brings wealth and means of survival through the payment of bride price in the form of cows – a commodity with a lot of value in the community. It is upon these premises that the community put a lot of value on the practice of FGM. However, the importance could also be categorized at the individual, household and community levels

At the community level, FGM is perceived as a legitimate rite of passage for the girls from childhood to womanhood, instilling values, training and grooming to uphold family stability and preparation for the future. The collective ceremonies and rituals performed during female circumcision marked by the family and the community enhanced community social networks. At the individual and household level, female circumcision seeks to protect girls, to guarantee their social acceptance and respect within the community; to ensure marriage ability as it is an essential preparation for a young girl for marriage and she is eligible to get married immediately after circumcision (it is a guarantee that a girl will get married); to ensure cleanliness and enhance male sexuality; to prevent sexual promiscuity by serving as a measure of controlling a girl's sexual sensitivity (to reduce sexual desires); to prevent excess clitoris growth; and to preserve virginity. It was used a source of wealth for the family through the high bride price charged for the circumcised girls getting married. The family gets honor and recognition to be part of the community cohesion and thus guaranteeing equal participating in all community important functions and activities. The data also revealed that there were variations in the benefits of circumcision among girls, boys, mothers and fathers. Parents highly valued female circumcision as a good tradition and custom and as a guarantee for better marriage prospects of their daughter(s). More girls viewed it just as a way of keeping with traditions, while boys considered it as a good tradition and custom and better marriage prospects. The differences are attributed to their difference in perceptions about the importance of female circumcision in the community and level of awareness. It was established that the above justifications prescribed for the practice of FGM were eloquently presented positively to emphasize the advantages of

undergoing FGM. Whether, social or economic, these justifications maintained the social convention of circumcision and contribute to perpetuate the practice.

Given the above individual, household and community level justifications for the practice of FGM in the Pokot community, one of the respondent revealed that there were some myths and misconceptions that served to perpetuated the practice. Families that refused to circumcise their daughter(s) and the girl(s) herself/themselves were despised, considered outcasts and alienated from mainstream community functions and activities. It was therefore a taboo in the community for a girl not to be circumcised and that no girl could easily get married within the community without undergoing the practice. In line with this, the community perpetuated female circumcision through a multitude of myths and misconceptions about a woman who is not circumcised. They included: any man who marries uncircumcised woman was likely to die; a traditional birth attendants risks losing her eyesight when assisting uncircumcised girl to deliver; uncircumcised woman could not get pregnant and married; the clitoris of the uncircumcised woman would grow uncontrollably; uncircumcised woman was immature (nick named *sorin, chepchaurai*) dirty and smells. The uncircumcised woman was therefore viewed as irresponsible, promiscuous and imitators of western and foreign cultures. The study observed that most members of the community strongly believed in these myths and misconceptions and that they were only meant to reinforce and entrench the practice deeper despite the fact that most of them were not actually practical. Therefore, identified cases of uncircumcised women in the community were mocked, not respected and considered to be a coward
who can not withstand pain including child labour, despised and alienated from important community functions such as *sapana.*

The study revealed that both the family and the community in general played a prominent role in the decision to circumcise a girl. However, the immediate family members, especially the girl, mother and father, played a first hand role in the decision with the fathers making the final ruling. From the data, more girls indicated that their fathers made the final decision for their circumcision compared to those who decided on their own or depended on their mothers. The data colloborated these findings by adding that although it was an individual girl's decision to be circumcised, when one is ready, she was expected to inform the mother and seek final decision

from the father. This shows that even though the mothers and daughters had a part to play in the decision making, it was the father who made the final ruling. It was also observed that the family of a girl may only turn down the request of the girl to be circumcised under the following circumstance: when they feel that she is too young to be initiated and may not be able to withstand the pain; that she is too young to get married and they do not wish to lose an important laborer in the household; or simply because they do not have the wealth required to pay for the expenses and ceremonies of the initiation rite.

The study also established that the level of education of the girls influenced their decision on circumcision. There were notable differences in the way girls who had or were attending schools and those who were non-educated in the community participated in decision making about circumcision. Educated girls had more say on their circumcision compared to the uneducated ones. Some of the educated girls had the courage to refuse to be circumcised, others who may wish to undergo the rite, preferred it to be delayed so as to come after they had finished schooling, while others want to be assured that they shall be allowed to continue with education after the ordeal. For the non-educated girls, circumcision and eventual marriage were their main targets in life and therefore some did not even care about their age in order to be circumcised.

4.2.3 Adverse Consequences of FGM

The consequences of FGM on women and girls were wide-ranging, and the practice compromises the enjoyment of human rights including the right to life, the right to physical integrity, the right to health, as well as the right to freedom from physical or mental violence, injury or abuse. The practice is also a violation of the rights of the child to development, protection and participation. Results from the data shows the community was aware of the consequences associated with female circumcision in their community. The data shows that about a half of the circumcised girls had personally experienced problems and complications while or after undergoing circumcision. In addition, about a half of mothers with circumcised daughters also reported that their children had encountered problems while or after undergoing circumcision. The complications from female circumcision were both immediate and long term and varied according to the type and severity of the procedure used, location of the operation

(rural area or urban area), the age and dexterity of the circumciser, instruments used, and the struggle put up by the initiate during the operation.

It was reported that female circumcision irreversibly compromises a girl or woman's physical integrity. The damage caused by this practice can pose serious and life-long risks to her health and well-being, at the time of the actual *rotwa* operation, during urination, during menstruation, during consummation of marriage (sex), and during childbirth. Socially, most girls were married off soon after the circumcision when they were still very young (12-14 years) hence terminating their education. The seclusion period also at times affected the learning of girls with some missing school for a long period of time. Other girls were forced to drop out of school, altogether, while others were even not given that opportunity to join schools but instead preferred to look after livestock as they wait for circumcision.

On the health consequences, there were cases of excessive bleeding, prolonged and obstructed labour, sepsis, and blood infection (septicaemia). Prolonged and obstructed labour caused repeated cutting and suturing (stitching), which in turn led to numerous long-lasting physical, sexual and psychological effects. The type of circumcision practiced by the Pokot community was reported to further complicate the consequences and had multiplied the associated health risks. Infibulations type of FGM is the most severe form because of its health implications. Some of the immediate health complications caused by infibulations include:

(i) Associated and extensive initial and the repeated cutting and suturing (stitching) involved
(ii) Bleeding and risk of haemorrhage are greater
(iii) Severe pain which is usually less likely to be dulled by the local anesthesia like *pipi* and woman breast milk
(iv) Because of the large raw wound left, the risk of infections and stitch abscess (blisters or sore) is higher
(v) Urine retention is more common since the skin is stretched over the urethra, obstructing the normal flow.

The long-term complications of infibulations are:

(i) Repeated urinary retention

(ii) Excess growth of the scar tissue at the site may become disfiguring

(iii) Pain during sexual intercourse due to physical discomfort or the woman finds it psychologically traumatizing due to small opening that is supposed to be forcefully penetrated

(iv) Obstructed labour. During child labour, a tightly infibulated woman must be de-infibulated to allow the fatal to crown. This makes the mother and infant susceptible to morbidity and mortality risks.

The findings indicate that although FGM had important gender implications in all its aspects, it deprived girls and women an essential part of their bodies, which impacted negatively on their sexuality. This may cause psychosexual and psychological challenges as the removed part of their bodies leave a lasting mark in the life and mind of the woman who has undergone it. Other psychological effects include the dilemma between identity, sense of belonging and pain which cause internal conflict within a young girl resulting to psychological trauma and loss of self esteem.

However, regardless of the awareness of the associated consequences of female circumcision in the Pokot community, the community highly valued the practice and there was a general feeling among the majority of the people that the practice should continue. The data indicate that the community believes that there were still very many aspects of female circumcision that were vital to the social fabric of the community through inculcation of common ideals and values. The continuation of female circumcision in the community was therefore facilitated by community leaders, parents (male and female) and young girls for various reasons mentioned earlier. The results also indicates that there were some people in the community who were advocating for the practice to be stopped or otherwise some changes needed to be introduced to reduce its negative impacts on the girl child. The most prominent people who are either seeking for discontinuation of the practice or change in some of its harmful aspects include religious leaders, Christians, well educated (both parents and daughters), school teachers and health workers.

4.2.4 Efforts to Eradicate FGM

The data indicates that there have been several efforts in the community and the country at large to eradicate FGM. These efforts were spearheaded by local community awareness and involvement in activities against FGM, government efforts in terms of previous and existing policy and program and the role of private organizations (churches and civil society).

4.2.4.1 Community Awareness and Perception of Activities against FGM

The results indicate that there were various activities and messages against FGM in the community. On the overall, majority of the people targeted in the survey were aware of these activities against FGM in their community. However, there were differences among the cohorts of the respondents with more parents being aware of activities and messages against FGM than young people. This was attributed to the fact that parents had witnessed these activities for quite along time compared to young people. Most activities had also targeted parents first as persons who had more influence on the decision of circumcising their daughters. They were therefore the most appropriate persons targeted first by the campaigns. The study also established that there were also variations among the young people with more girls than boys being aware. This was linked to the fact that in addition to the parents, girls were the next prime targets of these activities.

These activities against FGM carried the messages against the practice and the need to stop it. The common messages were: FGM limits the education of a girl child; it is against religious teachings; it has health complications resulting from infections, excess bleeding and obstructed delivery/labour; and it is a violation of the human rights and dignity of the woman and the girl child. The common sources of these activities and messages were religious leaders and the church (Kositei Catholic Mission, Anglican Church of Kenya, African Inland Church – Chemolingot and Nginyang), non-governmental organization (World Vision) radio, government and schools. All these sources were vigorous in creating adequate awareness about the associated consequences of female circumcision and the need for the community to stop practicing it. Most of these activities targeted the entire community, especially parents, girls and community leaders.

However, there were remarkable differences in level of satisfaction with the activities against FGM. From the data, majority of the community leaders, uneducated parents (female and male) and traditional practitioners were not satisfied with the activities. They argued that the importance of FGM in the community outweighed any
associated perceived or real consequences. However, the activities were supported by young females and males, religious leaders and health workers. They based their support on their awareness of the negative implications of the practice including: health consequences, religious tenets and limitation of girls' education. From the data results, majority of the respondents aware of the activities were also satisfied and comfortable with their and messages against FGM.

From the survey, a number of respondents, especially young persons, a few parents, religious leaders and health workers reported had participated in the campaign against FGM in their community. However, they varied in the roles that they played in these activities which included rescuing girls who were not willing to undergo the practice, creating awareness of the consequences of the practice, being a good role models to the uncircumcised girls, and general mobilization of the community to attend awareness meetings. However, they rated the activities as having been less effective in addressing FGM in the community. They argued that the community in most cases attended awareness meetings but did not implement what they learn due to the level of entrenchment of the practice in the community.

4.2.4.2 Government Policies and Programs for Eradicating FGM

Content analysis through document reviews and personal communications with relevant government officials revealed that the government of Kenya had for a long period of time shown efforts towards elimination of FGM, albeit with minimal success. The government had been a signatory to various international and regional conventions aimed at upholding rights of women and children. It had also domesticated these conventions through enactment of legislations such as Children Act (2001) and Sexual Offences Act (2006). This was in addition to various presidential and even ministerial pronouncements and decrees aimed at eliminating the practice of FGM by the three government regimes.

However, despite the fact that efforts towards elimination of FGM in the country dated as far back to the pre-colonial days, there had been little (if any) tangible results. The government had failed to adequately consolidate all its efforts under a specific sectoral policy and program that could tackle female circumcision head on. Little had been done in terms of creation of structures that could operationalize some of the legislations that seem to take care of the rights of the women and children. For example, despite the enactment of the Children Act in 2001, its operationalization was still shrouded in mystery as there was no coordination among the various responsible arms of government. This was in addition to the section of the Judiciary Act where customary laws are required to ensure that customs and traditions conform to the principles of morality and justice to everybody; and the recent Sexual Offences Act (2006). A discussion with some of the local government officials expected to operationalize these legislative efforts revealed lack of clarity on what was expected of them. Therefore, little had been done in terms of coordination and creation of adequate structures and manpower to enforce them.

In realization of the disjointed and uncoordinated efforts to fight against FGM, the government in 1999 initiated a process of consolidating all efforts towards fighting FGM through the establishment of a National Plan of Action for the "Elimination of Female Genital Mutilation in Kenya" (1999-2019). The essence of the plan of action was to accelerate the elimination of FGM in order to improve the health, quality of life and well being of women, girls, families and communities in the country. It also aimed at increasing the number of "communities supporting the elimination of FGM," as well as the number of health facilities providing support services to victims. But up to now, there is no specific law criminalizing FGM. An attempt to legislate such a law against FGM in the country through a parliamentary motion was defeated in November, 1996.

Literature indicates that the presence of legislative efforts such as Children Act (2001) had not adequately helped in eradication of FGM in communities. Various policy pronouncements by the government had only served to make the practice go underground and this could greatly inhibit elimination process. While the law was seen as useful in ensuring greater leverage in persuading communities to abandon the practice, it could also drive the practice underground. Therefore as we push for legislation, the more appropriate approach would be where

communities, out of their own volition see the need of ending FGM. Strategies, policies and programs are to rely more on persuasion rather than force or coercion. The more urgent task is to educate and address FGM issues with the aim of encouraging abandonment rather than using the law to punish the offenders. Government is required to work with other agencies to create an environment where women could freely abandon the practices.

4.2.4.3 Private Sector Participation in the Fight against FGM

In realization of the inabilities by the government to address FGM, the civil society organizations, religious bodies and private organizations had been in the forefront in advocating for elimination of the practice through partnerships and creating of working relationships with the local communities. These bodies had adopted various approaches of working with the affected communities after realizing the difficulties involved in legislation. The most prominent organizations that were involved in the fight against FGM were: Catholic Mission, AIC and World Vision. These organizations were involved in creating awareness about the consequences of FGM, the need to stop it, rescuing of girls forced to undergo the practice, and even advocating for alternative rites of passage. In some cases, the traditional practitioners, especially the circumcisers, were trained on alternative income generating activities to depending on female circumcision.

The activities of these organizations had basically targeted the entire community especially community leaders, parents and girls. The organizations had realized some successes including: increased level of awareness and openness to talk about FGM; increased number of girls attending schools; and increased participation of the local community in the campaign against the practice. However, the main challenges facing these organizations included their limited scope defined by scarce resources, resistant and lack of cooperation by the local communities, and lack of adequate collaboration and sharing of resources among stakeholders involved, especially the government.

4.2.5 Local Community Efforts and Involvement in the Fight against FGM

FGM being a deeply rooted tradition in the Pokot community requires that any efforts to eradicate it should begin with strengthening of the already existing local/home-grown initiatives and strategies. This will encourage local ownership and involvement in activities and efforts against the practice of FGM. From the survey, majority of the respondents who were opposed to any activities against FGM in their community did not want to be involved in the campaign. They included majority of the community leaders, uneducated parents (female and male) and traditional practitioners. These groups argued that FGM and all other cultural practices had been the pillars of their social cohesion, integration and transfer of knowledge from one generation to another. The respondents feared repercussions and the wrath of other discussants in openly stating their willingness to fight such a sacred practice. This proves the extent to which the community collectively embraced the practice and how deep it had been entrenched. The study revealed that although a good number of parents were willing to be involved in the campaign, majority of them were quick to point out that their participation should only serve to create awareness of the associated consequences and if possible change a few negative aspects of the practice but not to completely eliminate it.

For the young people, majority attributed their unwillingness to the fear of a curse from the community leaders who might view them as opposing the traditions and customs. All religious leaders and health workers in the interviews also expressed their willingness to be involved in the campaign against FGM based on religious tenets and their level of awareness of the associated adverse consequences.

However, the respondents who were willing to participate in the campaign against FGM varied in the ways that wished to be involved. The results indicate that the common ways of involvement proposed included:

(i) Mobilizing and educating the community on the consequences of FGM and its impacts on the girl child and the society in general. They suggested that this should be strategically done just immediately before the FGM ceremonies using locally-made posters, radios among other media.

(ii) Organizing seminars and workshops targeting parents and girls

(iii) Advocating for alternative rites to FGM

(iv) Appreciating both circumcised and uncircumcised girls
(v) Advocating for adequate access and equity of the girl child to education
(vi) Using uncircumcised and successful women role models as inspiration.

The most suitable members of the community that were proposed to be targeted for appropriate action against FGM were parents (both mother and fathers), community leaders, girls and religious leaders and to a lesser extent teachers, boys and politicians. Parents and girls emerge to be the most suitable targets as they were the key players in the practice of FGM in this community

Several strategies and appropriate channels for reaching the community and the target groups with messages against FGM were proposed. These channels included Baraza, radio, religious leaders, community leaders in cultural ceremonies like *sapana, adong'o* and *lapan*, health workers, pamphlets and other literature, politicians, schools and use of uncircumcised and educated role models. Out of these, the most appropriate channels that emerged were Baraza combined with home visits and other social gatherings, religious leaders and community leaders in cultural ceremonies across the cohorts of respondents. This indicates the major role these three organized groups could play in the community in dissemination of information and decision making.

After determining the willingness of the respondents to be involved in the campaign against FGM, the study sought to establish how NGOs could be enjoined in the process. The most common suggestions across the respondent categories were building of girls schools; educate girls forced to undergo FGM; increase advocacy, awareness and education on FGM; involve and collaborate with all other stakeholders; and provide rescue home for girls forced to undergo FGM. However, there was a minority group from the cohort of respondents in the surveys who vehemently opposed the involvement of NGOs in the cultural practices of the community. This group observed that though they welcomed NGOs and the programs it had initiated in the community so far, the organization should keep away from interfering with their cultural practices which are so dear to them like FGM.

4.3 Conclusions

The study examined relevant formative and stimulus variables influencing the practice of FGM in the Pokot community in Nginyang divisions of East Pokot district. It established that female circumcision is a cultural practice that is deeply rooted within the culture and customs of the people of this district so much so that it has been institutionalized and is considered a sacred practice. The prevalence rate of the practice of FGM is high at 71.7 percent. However, there are variations in the prevalence rate between female parents (90 %) and young females aged 12 to 20 years (53.3 %). The median age at circumcision was 15.0 years (with the mean age of circumcised girls being 15.33 years while that of female parents was 14.81 years) with a range of between 12 and 16 years. All the circumcised young females and female parents were aware of the part of their genitalia that were removed during circumcision. They all underwent infibulations type of circumcision (**Type III**). All the circumcised girls and mothers were circumcised by old women traditional circumcisers, known as *kokomelkong*. Unlike in the traditional context where one traditionally-made knife/scapel (*rotwa)* was used to circumcise all the initiates, currently, there was the use of one razor blade per initiate. Majority of the circumcision cases were conducted in a secluded place at the home of the initiates. It was also established that the family and the community played a prominent role in the decision to circumcise a girl. However, the immediate family members, especially the girl, mother and father, played a first hand role in the decision with the fathers making the final ruling.

The study established that the justifications offered for the practice of FGM were numerous and, in their specific context, compelling. There was a lot of significance attached to the practice incorporating both social and economic connotations at the individual, household and community levels. At the community level, it was perceived as a legitimate rite of passage for the girls from childhood to womanhood, instilling values, training and grooming to uphold family stability and preparation of girls for the future. At the individual level, FGM sought to: protect girls, to guarantee their social acceptance and respect within the community; ensure marriage ability as it is an essential preparation for a young girl for marriage and she is eligible to get married immediately after circumcision (it is a guarantee that a girl will get married); ensure cleanliness and enhance male sexuality; prevent sexual promiscuity by serving as a measure of controlling a girl's sexual sensitivity (to reduce sexual desires); prevent excess

clitoris growth; and preserve virginity. At the household level, FGM was used as a source of wealth through the high bride price, social acceptance, and sign of honor and recognition. It was this social and economic significance at individual, household and community levels that perpetuated the practice of FGM in the Pokot community. It was established that the above justifications prescribed for the practice of FGM were eloquently presented positively to emphasize the advantages of undergoing FGM. Whether, social or economic, these justifications maintained the social convention of circumcision and contribute to perpetuate the practice.

The study also established that the practice had socioeconomic, health and psychological consequences on the girl child in the study area. The consequences were both immediate and long term and varied according to the type and severity of the procedure used, location of the operation (rural area or urban area), the age and dexterity of the circumciser, instruments used, and the struggle put up by the initiate during the operation. Circumcision at times caused irreversible, life-long risks for the girls and women, at the time of the actual *rotwa* operation, during urination, during menstruation, during consummation of marriage (sex), and during childbirth.

The socio-economic consequences included the effects on the girls' education (since many girls are married off immediately after circumcision and drop out of school), loss of opportunity for self development and achievement of self ideals. The health consequences included excessive bleeding, severe pain, urinary retention and infections, prolonged and obstructed labour, and blood infection (septicaemia). Prolonged and obstructed labour caused repeated cutting and suturing (stitching), which in turn led to numerous physical, sexual and psychological effects which were long-lasting. The health consequences were further complicated and multiplied by the severe type of circumcision practiced by the Pokot community, that is, infibulations. The psychological effects included the dilemma between identity, sense of belonging and pain which caused internal conflict within a young girl resulting to psychological trauma and loss of self esteem. Other impacts included serious health problems associated with the practice together with the trauma associated with the irreversible loss of an essential part of the body parts, which impacts negatively on the girl sexuality. This caused psychosexual and psychological health as

the removed part of their bodies leave a lasting mark on the life and mind of the woman who has undergone it.

There were several efforts in the community and the country at large to eradicate female circumcision. These efforts were spearheaded by local community awareness and involvement in activities against FGM, government efforts in terms of previous and existing policy and program and the role of private organizations (churches and civil society). The community was aware of several activities and messages aimed at fighting female circumcision. The common sources of these activities and messages against FGM were religious leaders and the church, non-governmental organization, radio, government and schools. Most of these activities targeted the entire community, especially parents, girls and community leaders. However, there were remarkable difference in the support and satisfaction with activities and messages against FGM. Majority of the community leaders, uneducated parents (female and male) and traditional practitioners were not satisfied with the activities and messages against FGM; while young females and males, religious leaders and health workers were satisfied and in support.

The government had for a long time attempted to eliminate FGM in the country. In this regard, there are various efforts that had been made through enactment of policies and programs to fight the practice. However, these efforts had bore little success as the practice was still being perpetuated. There was lack of proper structures to coordinate and operationalize the available policies, programs and various legislations aimed at fighting female circumcision in the country. Most of the efforts were therefore disjointed, uncoordinated and lack a specific and relevant sectoral policy framework. In realization of this impasse, the government in 1999 initiated a process of consolidating all efforts towards fighting FGM through the establishment of a National Plan of Action for the "Elimination of Female Genital Mutilation in Kenya" (1999-2019). This was in addition to numerous presidential decrees and pronouncements on the need to stop FGM by the three government regimes. But up to now, there is no specific law criminalizing FGM and all efforts by the government have not been successful.

In realization of the little and unsuccessful efforts that government had made in the fight against FGM, most of the activities in the campaign in the country have, up to date, been shouldered by

the civil society organizations, religious bodies and the private sector. These organizations were working through partnerships and creating of working relationships with the local communities. These bodies had adopted various approaches of working with the affected communities after realizing the difficulties involved in legislation and isolation of the affected community. The most prominent organizations in the fight against FGM in the study area were: Catholic Mission, AIC and World Vision. These organizations were very much involved in creation of awareness about the consequences of female circumcision; the need to stop it; rescuing of girls forced to undergo the practice; and even advocating for alternative rites of passages to FGM. In some cases, the traditional practitioners, especially the circumcisers, were trained on alternative income generating activities to depending on female circumcision. Despite these efforts, the organizations faced numerous challenges in undertaking these
activities. The challenges included their limited scope defined by scarce resources, resistant and lack of cooperation by the local communities, lack of adequate collaboration and sharing of resources among stakeholders involved in the campaign.

The most appropriate people to be targeted in the campaign against FGM were parents (both mother and fathers), community leaders, girls and religious leaders and to a lesser extent teachers, boys and politicians. The most appropriate channels for reaching the community and the target groups were Baraza combined with home visits and other social gatherings, religious leaders and community leaders in cultural ceremonies. This indicates the major role these three organized groups play in the community in dissemination of information and decision making.

Majority of the respondents welcomed the participation of NGOs in the campaign against FGM. They suggested that the organization should be involved in building of girls schools; educating girls forced to undergo FGM; increasing advocacy, awareness and education on FGM; involving and collaborating with all other stakeholders; and providing rescue home for girls forced to undergo FGM ands. However, a minority of them were against the organization's involvement in the fight against FGM.

4.4 Recommendations

In the view of the above conclusions based on the objectives, this study makes the following recommendations relating to approaches and activities for the containment of the practice within Nginyang Division, and the entire East Pokot district.

(i) Creating an enabling environment that supports change: The success in promoting the abandonment of FGM will depend on the commitment of the government, at all levels, to introduce appropriate social measures and legislations, implemented by effective advocacy and awareness efforts. The civil society organizations like World Vision and the private sector should form an integral part of this enabling environment. In particular, the media and opinion leaders in the community should have a key role in facilitating the diffusion process of information against the practice.

In connection with this, there is therefore a need for the government and all other stakeholders to harmonize their activities through establishment of more specific and sectoral policy framework to fight the practice of FGM. The government should take a leading role by providing an enabling environment through coordination and harmonization of all instruments fighting for elimination of female circumcision. The government policies and programs on FGM should be spearheaded by local administration including District Officers, Chiefs and Assistant Chiefs, who are always in close contact with the local community. There is need for a strong commitment and policy action on the part of the government to promote equal rights for boys and girls and for women and men. Local efforts and innovative strategies should be identified and strengthening as a spring board and entry point in the fight against FGM in the community.

(ii) Advocacy and awareness campaigns: There is need for NGOs and other stakeholders to have continuous advocacy and awareness campaigns in the community about the consequences of FGM so as to enable conscious and informed decisions among its members about the practice. This should capitalize on both arranged and other various social gathering and meetings in the community. These advocacy and awareness campaigns should be done through non-judgmental, non-directive public discussions and reflections so as to enable the community to realize the cost of FGM and share experiences. Care should

be taken in picking the people targeted for advocacy campaigns. Some of the people in the community are more facilitators or inciters of FGM than conduits for its eradication.

This should target more parents, girls, community leaders, churches (religious leaders), young males, school teachers and health workers. Female parents, especially those circumcised, should be given the first priority in the campaigns as they are the most notorious in inciting and mocking the uncircumcised women. Fathers should be educated to minimize their desire for the high bride price charged for the circumcised daughters. They should be sensitized on the need to allow their daughters to attend and complete schooling.

The advocacy and awareness campaigns should make great use of local people to foster local ownership and use of more appropriate home-grown strategies like locally-made information education and communication materials. The advocacy and awareness campaigns should make use of community mobilization through barazas in order to reach out to more people with activities and messages against FGM. It is crucial, therefore, to involve the members of the community in designing and conducting any FGM eradication campaign.

In addition to the parents, the advocacy campaigns by NGOs should take advantage of the majority of young males (66.7 %) and young females (83.3 %) who indicated that they would not circumcise their daughters in future. Girls should be sensitized on the importance of education and the need to attend, concentrate and complete their education. Boys should be educated that there is no physical and biological difference between circumcised girls and thus none should be prioritized for marriage. If anything, circumcised girls are more at risk of complications during child delivery compared to the uncircumcised. Concentration on boys and girls will greatly assist in reducing the future prevalence rate of FGM in the area.

There is also need for NGOs and all other stakeholders to tailor their advocacy and awareness campaigns and concentrate and intensify them during the months prior to circumcision period (during the school holidays of months of April, August and

December). This aims at ensuring that the potential girls awaiting circumcision are actually targeted at the right time. In the campaigns, successful and uncircumcised women in the community should be targeted and used in the campaigns as role models to show girls that they can also make it in life without circumcision. The campaigns should also learn from successful interventions and examples that have been applicable in other areas to eradicate FGM. They should be devolved to the interior areas of the community which are still registering high prevalence rates of FGM.

(iii) Empowering traditional practitioners: In addition to advocacy and sensitization campaigns, NGOs should also look into the plight of the traditional practitioners performing FGM. The organization should borrow from the experiences of the Catholic Church and World Vision, and educate those who perform the practice about the risk associated with the practice and if possible explore possibilities of empowering the practitioners (through training) to engage in alternative forms of income generation. Therefore, education on the harmful effects of FGM should be combined with development of new skills and other initiatives to find an alternative source of livelihood. Another vital step could be following the training of the practitioners by a public or private ceremony which may involve the exercisers denouncing the practice and symbolically surrendering their instruments or making an oath to stop it. In connection with economic empowerment of the traditional practitioners, they (practitioners) should also be reminded that FGM in the area is a seasonal event and thus should not be misconstrued to be their only source of livelihood. This aims at informing the practitioner that they should not take advantage of this heinous human violation for economic gains.

(iv) Introduction of alternative rites of passage: Because FGM in the district was associated with initiation rites that mark transition to adulthood, there is need for organizations to develop and introduce effective alternative rites of passage that preserve the positive socio-cultural aspects of FGM, upholds the community values, aspirations and the societal fabrics. Such a program should start with community-level awareness, sensitization and discussions. The educational component of this program should build on the traditional knowledge usually imparted to girls during the seclusion period, and enhanced with

additional information on sexual and reproductive health. This should culminate in a public event modelled on the community's traditional ceremony to mark the passage to adulthood. Such an initiative was more likely to be more acceptable within this community, churches should partner and collaborate with World Vision and Maendeleo Ya Wanawake which have already initiated such efforts.

(v) Improving access and equity of girls to educational opportunities: There is need for churches and NGOs to put more efforts in expanding access and equity of the girl child to available educational opportunities in the area. This could be done through supporting the expansion of the already existing few school to increase their enrolment capacity. Parents should also be sensitized on the importance of education of the girl child and encouraged to take their girl child to the available schools. All this should aim at realizing the important role that education can play in demystifying the negative cultural beliefs and values of communities. In connection with this, schools should be encouraged to be on high alert not to allow circumcised girls who go back to school to incite those who are not circumcised. Circumcised girls should be strongly warned about engaging in any incidences of incitement of those yet to be circumcised. There is need to prioritize schools in the remote areas that have been identified to have high prevalence rate of FGM. Emphasis should be placed on facilitation and building of boarding schools to keep girls away from the lures in the community.

(vi) Training and working with health care providers and workers: As a result of the critical role that health personnel play in the management of FGM related complications as well as for the promotion of its abandonment. Government should therefore prioritize health workers in the area for training in FGM related issues. Such health workers could therefore be vital in advising parents of the health risks of FGM and the need to abandon it.

(vii) Training and working with teachers in schools: NGOs should also partner with primary and secondary school teachers in the area and support them in recognizing girls at risk and discuss FGM related issues. NGOs should collaborate with health workers in facilitating and assisting teachers in these activities. The organization should assist in developing

reference manuals and guides on FGM for teachers and students and also provide training on FGM to trainers and teachers.

(viii) Research and Monitoring and evaluation programs: Research is essential to understanding FGM and designing effective reforms. It is crucial for Government to include formative research and impact evaluation and to conduct operation research to identify what determines programmatic success or failure so that further efforts can be made more effective. The organization should periodically institute such similar studies and monitoring and evaluation programs in order to assess and establish trends and patterns in the attitudes and perceptions towards the practice.

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APPENDICES

Appendix A: Structured Questionnaire

Appendix A: Structured Questionnaire for Young Females (12-20 years)

DATE

I am a student from Kampala international university faculty of Education, department of science. I am conducting research on;**Context and impact of Female genital mutilation in Nginyang division, East pokot district in Kenya**. Please help me by answering all the questions .The information will be treated confidentially and used for academic purposes

Section A: Background Information

Questions and Filters	Coding categories		Skip
1. Your age (in complete years) ***Ask for the year of birth first***			
2. Marital status	Single Married	1 2	
3. Have you ever been to school?	Yes No	1 2	 → 6
4. What is the highest level of education you have achieved?	Informal education Pre-primary complete Primary incomplete Primary continuing Primary complete Secondary incomplete Secondary continuing Secondary complete Middle level college University	1 2 3 4 5 6 7 8 9 10	
5. If primary or secondary incomplete, what made you to drop out of school?	Lack of school fees Marriage Illness Death of parent(s) Circumcision Other (specify)	1 2 3 4 5 6	
6. What is your current occupation?	Pupil Student Herds-girl Other (specify)	1 2 3 4	
7. What is your religion?	Christian Muslim Traditional African religion None Other (specify)	1 2 3 4 5	
8. Name of location	Kositei Ribko	1 2	

Section B: Background on Female Circumcision

Questions and Filters	Coding categories		Skip
1. In your opinion, does the practice of female circumcision affect the standards of education in this area?	Yes No	1 2	
2. What is the local term for female circumcision? ***Verbatim***			
3. Who performs female circumcision? ***Record all the responses given***	Traditional practitioner (circumciser) Grandmother Doctor/Nurse Mother Auntie Other (specify)	1 2 3 4 5 6	
4. Where is female circumcision carried out? ***Record all the responses given***	At the initiate's home Hospital In a secluded place Home of the practitioner Don't know	1 2 3 4 5	
5. What instruments are used to carry out female circumcision? ***Record all the responses given***	One razor blade per initiate Shared razor blade Scapel Shared knife One knife per initiate Don't know Other (specify)	1 2 3 4 5 6 7	
6. Are there any payment charged for female circumcision?	Yes No	1 2	→ **9**
7. What are the forms of payment? ***Record all the responses given***	Cash Animal(s) ***(name of the animals)***..... Other properties ***(write the property)***..... Other (specify)	1 2 3 4	
8. On average, how much is charged?	Cash ..... Animal(s) ***(name of the animals)***..... Other properties ***(write the property)***.....		
9. Who makes the final decision for a girl to be circumcised in the community? ***Record all the responses given***	The girl herself Father Mother Grandparents and other relatives Community Other (specify)	1 2 3 4 5 6	

Section C: Personal Experiences and Process of Circumcision

Questions and Filters	Coding categories		Skip
1. How old were you when you were circumcised?	Age	....	
	Don't know (can not remember)	1	
	Not circumcised	2	→ SF
2. After circumcision did you go through the seclusion period?	Yes	1	
	No	2	→ 6
3. How long was the seclusion period?			
4. Which kind of information were you given during this seclusion period?	How to be a good wife	1	
	Importance of circumcision	2	
	My expected social responsibilities	3	
	Not to be a coward	4	
	Other (specify)	5	
5. Who provided this information?	Mother	1	
	Traditional practitioners (circumcisers)	2	
	Grandmother	3	
	Auntie	4	
	A group of community women	5	
	Other (specify)	6	
6. Who circumcised you?	Traditional practitioner (circumciser)	1	
	Grandmother	2	
	Doctor/Nurse	3	
	Mother	4	
	Auntie	5	
	Other (specify)	6	
7. Where was the circumcision carried out?	Own home	1	
	Hospital	2	
	In a secluded place at home or another home	3	
	Home of the practitioner	4	
	Don't know/can not remember	5	
8. Were you alone or in a group?	Group	1	
	Alone	2	→ 10
9. If in a group, how many were you?			
10. What instruments were used to carry out the circumcision?	One razor blade per initiate	1	
	Shared razor blade	2	
	Scapel	3	
	Shared knife	4	
	One knife per initiate	5	
	Don't know/can not remember	6	
	Other (specify)	7	
11. Do you know which part of your body was removed?	Yes	1	
	No	2	→ SD
12. What part of the body was removed?			

Section D: Factors Promoting Female Circumcision

Questions and Filters	Coding categories		Skip
1. What have been the benefits of you being circumcised? ***Record all the responses given***	Keeping with the traditions and customs Social acceptance Good marriage prospects Easy delivery Religious demand Remove dirty genitalia Enhance husband's pleasure Limit my sexual desires Improve fertility Preserves virginity Other (specify)	1 2 3 4 5 6 7 8 9 10 11	
2. Who made the decision that you should be circumcised?	Myself Mother Father Grandmother Auntie Bother/sister Community	1 2 3 4 5 6 7	
3. Did you personally support the idea that you should be circumcised?	Yes No	1 2	→ 5
4. Why were you opposed to it? ***Record all the responses given***	Bad tradition Lost significance Against religion Would affect my education Associated health consequences Other (specify)	1 2 3 4 5 6	
5. In your opinion, which kinds of people facilitate female circumcision in this community? ***Record all the responses given***	Community elders Women Girls Boys Politicians Religious leader Men Other (specify)	1 2 3 4 5 6 7 8	
6. What do people say about a girl/woman who is not circumcised? ***Record all the responses given***	Can not get pregnant and are unmarriageable She is sexually promiscuous Can not be assisted by traditional birth attendant in delivery Husband likely to die One is still a child Other (specify)	1 2 3 4 5 6	

Section E: Consequences of Female Circumcision

Questions and Filters	Coding categories		Skip
1. Have you experienced any problems as a result of circumcision?	Yes No	1 2	 → 3
2. What kind of problems have you experienced from the circumcision? ***Record all the responses given***	Excess bleeding Severe pain Infection Recurrent bladder and urinary infection Tetanus Painful menstruation Difficulty in urination Still births Scarring Prolonged/obstructed labour Trauma and depression Other (specify)	1 2 3 4 5 6 7 8 9 10 11 12	
3. Do you ever wish that you had not been circumcised?	Yes No	1 2	 → 5
4. Why do you wish that you had not been circumcised? ***Record all the responses given***	Medical complications Painful experience Against dignity of women Prevents sexual satisfactions Limited my education Against religion It has lost significance Ridiculed by peers Other (specify)	1 2 3 4 5 6 7 8 9	
5. If you were to have a daughter in future, would you circumcise her?	Yes No	1 2	 → 7
6. Why would you want to circumcise her? ***Record all the responses given***	Custom and tradition demand Good tradition Religious demand Better marriage prospects Preserves virginity Remove dirty genitalia Enhance husband's pleasure Limit woman's sexual desires Improve fertility Other (specify)	1 2 3 4 5 6 7 8 9 10	
7. Why wouldn't you want to circumcise her? ***Record all the responses given***	Prolonged/obstructed labour Painful personal experience Against human rights and dignity of women Prevents sexual satisfaction Limited education Against religion Might lead to infertility Has lost its significance Have heard messages against it Other (specify)	1 2 3 4 5 6 7 8 9 10	

Section F: Questions for Uncircumcised Girls

Questions and Filters	Coding categories		Skip
1. Are you intending to be circumcised in future?	Yes No	1 2	→ 4
2. If No, why wouldn't you want to be circumcised? ***Record all the responses given***	Prolonged/obstructed labour Painful personal experience Against human rights and dignity of women Prevents sexual satisfaction Limited education Against religion Might lead to infertility Has lost its significance Have heard messages against it Other (specify)	1 2 3 4 5 6 7 8 9 10	
3. Who made the decision that you should not be circumcised?	Myself Father Mother Church leader Sister/Brother School Other (specify)	1 2 3 4 5 6 7	
4. Why do you want to be circumcised? ***Record all the answers given***	Good tradition Important rite Brings honour to the girl and family Gifts are received Improves fertility It is a learning opportunity Uncircumcised girls are shunned Good marriage prospects Other (specify)	1 2 3 4 5 6 7 8 9	
5. Have you faced any problems in the community for being uncircumcised?	Yes No	1 2	→ 7
6. If yes, what kind of problems have you faced? ***Record all the responses given***	Mistreatment Being seen as a child Shunned by boys Disrespect and despised Considered sexually promiscuous Considered unmarriageable Other (specify)	1 2 3 4 5 6 7	
7. Has your family in general faced any problems because you are not circumcised?	Yes No	1 2	→ 9
8. If yes, which problems have they faced? ***Record all the responses given***	Despised and not respected Considered as weak people Alienated from important community functions Considered as outcasts Other (specify)	1 2 3 4 5	
9. What do people say about a girl/woman who is not circumcised?	Can not get pregnant She is sexually promiscuous Can not be assisted by traditional birth attendant in delivery	1 2 3	

	Husband likely to die Other (specify)	4 5	
10. Do you think you will get a husband in future considering that you are not intending to be circumcised?	Yes No	1 2	
11. Please give reasons for response to Q10?			

Section G: Existing Response Initiatives/Programs

Questions and Filters	Coding categories		Skip
1. Are you aware of any activities against female circumcision in this community?	Yes No	1 2	→ SH
2. What is the message of these activities that are you aware of? ***Record all the responses given***	Female circumcision limits girls education One can still get a husband without being circumcised One can bleed to death Can lead to STI/STDs infection It is a violation of human rights Other (specify)	1 2 3 4 5 6	
3. What are the sources of these activities? ***Record all the responses given***	Community leaders Religious leaders Organized pressure groups Radio and TV Posters and other print media Relatives Other (specify)	1 2 3 4 5 6 7	
4. Who are the main targets of these messages? ***Record all the responses given***	Community leaders Parents Girls Boys Entire community Other (specify)	1 2 3 4 5 6	
5. Are you satisfied and comfortable with the messages of these activities?	Yes No	1 2	
6. Have you ever been involved in these activities?	Yes No	1 2	→ SH
7. What was your role on these activities? ***Record as reported***			
8. Evaluate the effectiveness of these activities in addressing female circumcision in this community?	Effective Less effective Not effective	1 2 3	

Section H: Innovative/home-grown strategies

Questions and Filters	Coding categories		Skip
1. As a young person in this community, would you like to be involved in the campaign against female circumcision?	Yes No	1 2	→ 8
2. How can you be involved in the campaign against female circumcision in this community?	Through education and awareness Advocating for alternative rites to FGM Appreciating both circumcised and uncircumcised girls Advocating for adequate access and equity of girls to education Use uncircumcised and successful women role models as inspiration Provision of legal redress for those not willing to undergo FGM Other (specify)	1 2 3 4 5 6 7	
3. For female circumcision to be eliminated in this community, who else are the most appropriate people to be targeted? ***Record all the responses given***	Politicians Community leaders Religious leaders Parents Girls Boys Other (specify)	1 2 3 4 5 6 7	
4. Which is/are the most appropriate channel(s) of reaching these people? ***Record all the responses given***	Baraza Radio Religious leader Community leaders Health workers Pamphlets and other literature Politicians Other (specify)	1 2 3 4 5 6 7 8	
5. Have there been any changes in attitude regarding female circumcision practice?	Yes No	1 2	→ 8
6. What kind of changes? ***Record all the responses given***	More people are abandoning it Health workers are performing it Uncircumcised girls are being accepted People value education of girls Other (specify)	1 2 3 4 5	
7. What has contributed to these changes? ***Record all the responses given***	Religious leaders Education Health workers Intermarriages Migration Activists and advocates against FGM Other (specify)	1 2 3 4 5 6 7	
8. In your opinion, how can Action Aid be involved in eradication of female circumcision in this community? ***Record as reported***			
9. If you would not want to be involved in the campaign against female circumcision, why? ***Record as reported***			

Thank you very much for sparing some time with me.

Appendix B: Structured Questionnaire for Young Males (12-20 years)

Section A: Background Information

Questions and Filters	Coding categories		Skip
1. Your age (in complete years) ***Ask for the year of birth first***			
2. Marital status	Single Married	1 2	
3. Have you ever been to school?	Yes No	1 2	 → 6
4. What is the highest level of education you have achieved?	Informal education Pre-primary complete Primary incomplete Primary continuing Primary complete Secondary incomplete Secondary continuing Secondary complete Middle level college University	1 2 3 4 5 6 7 8 9 10	
5. If primary or secondary incomplete, what made you to drop out of school?	Lack of school fees Marriage Illness Death of parent(s) Circumcision Other (specify)	1 2 3 4 5 6	
6. What is your current occupation?	Pupil Student Herds-boy Small business person Other (specify)	1 2 3 4 5	
7. What is your religion?	Christian Muslim Traditional African religion Other (specify)	1 2 3 4	
Name of location	Kositei Ribko	1 2	

Section B: Background on Female Circumcision

Questions and Filters	Coding categories		Skip
In your opinion, does the practice of female circumcision affect the standards of education in this area?	Yes No	1 2	
What is the local term for female circumcision? ***Verbatim***			
Who performs female circumcision? ***Record all the responses given***	Traditional practitioner (circumciser) Grandmother Doctor/Nurse Mother Auntie	1 2 3 4 5	

	Other (specify)	6	
Where is female circumcision carried out?	At the initiate's home	1	
	Hospital	2	
	In a secluded home/place	3	
	Home of the practitioner	4	
	Don't know	5	
What instruments are used to carry out female circumcision?	One razor blade per initiate	1	
	Shared razor blade	2	
	Scapel	3	
	Shared knife	4	
	One knife per initiate	5	
	Don't know	6	
	Other (specify)	7	
Are there any payment charged for female circumcision?	Yes	1	
	No	2	→ 9
What are the forms of payment? ***Record all the responses given***	Cash	1	
	Animal(s) ***(name of the animals)***.....	2	
	Other properties ***(write the property)***.....	3	
	Other (specify)	4	
On average, how much is charged?	Cash		
	Animal(s) ***(name of the animals)***.....		
	Other properties ***(write the property)***.....		
Who makes the final decision for a girl to be circumcised in the community?	The girl herself	1	
	Father	2	
	Mother	3	
	Grandparents and other relatives	4	
	Community	5	
	Other (specify)	6	

Section C: Personal Experiences and Process of Circumcision

Questions and Filters	Coding categories		Skip
1. Do you have any sister(s) aged 12-20 years or more?	Yes	1	
	No	2	→ SE
	Don't know	3	
2. How many of these sisters are circumcised?	Circumcised		
	Uncircumcised		
3. After circumcision did she/they go through the seclusion period?	Yes	1	
	No	2	→ 5
4. How long was the seclusion period?			
5. Who circumcised her/them?	Traditional practitioner (circumciser)	1	
	Grandmother	2	
	Doctor/Nurse	3	
	Mother	4	
	Auntie	5	
	Don't know	6	
	Other (specify)	7	
6. Where was the circumcision carried out?	At our home	1	
	Hospital	2	
	In a secluded place	3	
	Home of the practitioner	4	
	Don't know	5	
7. Was/were she/they alone or in a group?	Group	1	
	Alone	2	

8. What instruments were used to carry out the circumcision?	One razor blade per initiate Shared razor blade Scapel Shared knife One knife per initiate Don't know Other (specify)	1 2 3 4 5 6 7	
9. Do you know which part of her/their body that was removed?	Yes No	1 2	→ SD
10. What part of the body was removed?			

Section D: Factors Promoting Female Circumcision

Questions and Filters	Coding categories		Skip
1. What have been the benefits of circumcising your sister(s)? ***Record all the responses given***	Keeping with the traditions and customs Social acceptance Good marriage prospects Easy delivery Religious demand Remove dirty genitalia Enhance husband's pleasure Limit my sexual desires Improve fertility Preserves virginity Other (specify)	1 2 3 4 5 6 7 8 9 10 11	
2. Who made the decision that your sister(s) should be circumcised?	Herself/themselves Mother Father Grandmother Auntie Bother/sister Community	1 2 3 4 5 6 7	
3. Did she/they personally support the idea of being circumcised?	Yes No	1 2	→ 5
4. Why was/were she/they opposed to it? ***Record all the responses given***	Bad tradition Lost significance Against religion Would affect their education Associated health consequences Other (specify)	1 2 3 4 5 6	
5. In your opinion, which kinds of people facilitate female circumcision in this community? ***Record all the responses given***	Community elders Women Girls Boys Politicians Religious leader Men Other (specify)	1 2 3 4 5 6 7 8	
6. What do people say about a girl/woman who is not circumcised?	Can not get pregnant and are unmarriageable She is sexually promiscuous Can not be assisted by traditional birth attendant in delivery Husband likely to die One is still a child	1 2 3 4	

	Other (specify)	5 6	

Section E: Consequences of Female Circumcision

Questions and Filters	Coding categories		Skip
1. Do you know of any problems associated with female circumcision?	Yes No	1 2	 → 3
2. What kind of problems do you know? ***Record all the responses given***	Excess bleeding Severe pain Infection Recurrent bladder and urinary infection Tetanus Painful menstruation Difficulty in urination Still births Scarring Prolonged/obstructed labour Trauma and depression Other (specify)	1 2 3 4 5 6 7 8 9 10 11 12	
3. If you were to have a daughter in future, would you circumcise her?	Yes No	1 2	 → 5
4. Why would you want to circumcise her? ***Record all the responses given***	Custom and tradition demand Good tradition Religious demand Better marriage prospects Preserves virginity Remove dirty genitalia Enhance husband's pleasure Limit woman's sexual desires Improve fertility Other (specify)	1 2 3 4 5 6 7 8 9 10	
5. Why wouldn't you want to circumcise her? ***Record all the responses given***	Prolonged/obstructed labour Against human rights and dignity of women Prevents sexual satisfaction Limited education Against religion Might lead to infertility Has lost its significance Have heard messages against it Other (specify)	1 2 3 4 5 6 7 8 9	

Section F: Questions for Uncircumcised Sisters

Questions and Filters	Coding categories		Skip
1. Is/are your uncircumcised sister(s) intending to be circumcised in future?	Yes No	1 2	→ 4
2. If No, why wouldn't she/they want to be circumcised? ***Record all the responses given***	Prolonged/obstructed labour Painful personal experience Against human rights and dignity of women Prevents sexual satisfaction Limited education Against religion Might lead to infertility Has lost its significance Have heard messages against it Other (specify)	1 2 3 4 5 6 7 8 9 10	
3. Who made the decision that she/they should not be circumcised? ***Record all the responses given***	Herself/themselves Father Mother Church leader Sister/Brother School Other (specify)	1 2 3 4 5 6 7	
4. Why does she/they want to be circumcised? ***Record all the answers given***	Good tradition Important rite Brings honour to the girl and family Gifts are received Improves fertility It is a learning opportunity Uncircumcised girls are shunned Good marriage prospects Other (specify)	1 2 3 4 5 6 7 8 9	
5. Has/have she/they faced any problems in the community for being uncircumcised?	Yes No	1 2	→ 7
6. If yes, what kind of problems has/have she/they faced? ***Record all the responses given***	Mistreatment Being seen as a child Shunned by boys Disrespect and despised Considered sexually promiscuous Considered unmarriageable Other (specify)	1 2 3 4 5 6 7	
7. Has your family in general faced any problems because your circumcised sister(s)?	Yes No	1 2	→ 9
8. If yes, which problems has it faced? ***Record all the responses given***	Despised and not respected Considered as weak people Alienated from important community functions Considered as outcasts Other (specify)	1 2 3 4 5	
9. What do people say about a girl/woman who is not circumcised?	Can not get pregnant She is sexually promiscuous Can not be assisted by traditional birth attendant in delivery Husband likely to die Other (specify)	1 2 3 4 5	
10. Do you think that your uncircumcised	Yes	1	

sister(s) not intending to be circumcised will get a husband in future?	No	2	
11. Please give reasons for response to Q10?			
12. In your opinion, can you marry uncircumcised wife in future?	Yes No	1 2	
13. Please give reasons for you response in Q12			

Section G: Existing Response Initiatives/Programs

Questions and Filters	Coding categories		Skip
1. Are you aware of any activities against female circumcision in this community?	Yes No	1 2	→ SH
2. What is the message of these activities that are you aware of? ***Record all the responses given***	Female circumcision limits girls education One can still get a husband with being circumcised One can bleed to death Can lead to STI/STDs infection It is a violation of human rights Other (specify) …… 	1 2 3 4 5 6	
3. What are the sources of these activities? ***Record all the responses given***	Community leaders Religious leaders Organized pressure groups Radio and TV Posters and other print media Relatives Other (specify) ……	1 2 3 4 5 6 7	
4. Who are the main targets of these messages? ***Record all the responses given***	Community leaders Parents Girls Boys Entire community Other (specify) ……	1 2 3 4 5 6	
5. As a young man, are you satisfied and comfortable with the messages of these activities?	Yes No	1 2	
6. Have you ever been involved in these activities?	Yes No	1 2	→ SH
7. What was your role on these activities? ***Record as reported***			
8. Evaluate the effectiveness of these activities in addressing female circumcision in this community?	Effective Less effective Not effective	1 2 3	

Section H: Innovative/home-grown strategies

Questions and Filters	Coding categories		Skip
1. As a young person in this community, would you like to be involved in the campaign against female circumcision?	Yes No	1 2	→ SH
2. How can you as a young man be involved in the campaign against female circumcision in this community?	Through education and awareness Advocating for alternative rites to FGM Appreciating both circumcised and	1 2	

Record all the responses given	uncircumcised girls 3 Advocating for adequate access and equity of girls to educational opportunities 4 Use uncircumcised and successful women role models as inspiration 5 Other (specify) 6	
3. For female circumcision to be eliminated in this community, who else are the most appropriate people to be targeted? ***Record all the responses given***	Politicians 1 Community leaders 2 Religious leaders 3 Parents 4 Girls 5 Boys 6 Other (specify) 7	
4. Which is/are the most appropriate channel(s) of reaching these people? ***Record all the responses given***	Baraza 1 Radio 2 Religious leader 3 Community leaders 4 Health workers 5 Pamphlets and other literature 6 Politicians 7 Other (specify) 8	
5. Have there been any changes in attitude regarding female circumcision practice?	Yes 1 No 2	→ 8
6. What kind of changes? ***Record all the responses given***	More people are abandoning it 1 Health workers are performing it 2 Uncircumcised girls are being accepted in the community 3 People value education of girls 4 Other (specify) 5	
7. What has contributed to these changes? ***Record all the responses given***	Religious leaders 1 Education 2 Health workers 3 Intermarriages 4 Migration 5 Activists and advocates against FGM 6 Other (specify) 7	
8. In your opinion, how can Action Aid be involved in eradication of female circumcision in this community? ***Record as reported***		
9. If you would not want to be involved in the campaign against female circumcision, why? ***Record as reported***		

Thank you very much for sparing some time with me.

Appendix A: Structured Questionnaire for Female Parents

Section A: Background Information

Questions and Filters	Coding categories		Skip
1. Your age (in complete years) ***Ask for the year of birth first***			
2. Marital status	Single Married Widowed	1 2 3	
3. Have you ever been to school?	Yes No	1 2	 → 5
4. What is the highest level of education you have achieved?	Informal education Pre-primary complete Primary incomplete Primary complete Secondary incomplete Secondary complete Middle level college University	1 2 3 4 5 6 7 8	
5. What is your current occupation?	Housewife Farmer Self-employed Salaried employed Other (specify)	1 2 3 4 5	
6. What is your religion?	Christian Muslim Traditional African religion Other (specify)	1 2 3 4	
7. Name of location	Kositei Ribko	1 2	

Section B: Background on Female Circumcision

Questions and Filters	Coding categories		Skip
In your opinion, does the practice of female circumcision affect the standards of education in this area?	Yes No	1 2	
What is the local term for female circumcision? ***Verbatim***			
Who performs female circumcision? ***Record all the responses given***	Traditional practitioner (circumciser) Grandmother Doctor/Nurse Mother Auntie Other (specify)	1 2 3 4 5 6	
Where is female circumcision carried out? ***Record all the responses given***	At the initiate's home Hospital In a secluded home/place Home of the practitioner Don't know	1 2 3 4 5	

What instruments are used to carry out female circumcision? ***Record all the responses given***	One razor blade per initiate Shared razor blade Scapel Shared knife One knife per initiate Don't know Other (specify)	1 2 3 4 5 6 7	
Are there any payment charged for female circumcision?	Yes No	1 2	→ 9
What are the forms of payment? ***Record all the responses given***	Cash Animal(s) ***(name of the animals)***..... Other properties ***(write the property)***..... Other (specify)	1 2 3 4	
On average, how much is charged?	Cash ..... Animal(s) ***(name of the animals)***..... Other properties ***(write the property)***.....		
Who makes the final decision for a girl to be circumcised in the community? ***Record all the responses given***	The girl herself Father Mother Grandparents and other relatives Community Other (specify)	1 2 3 4 5 6	

Section C: Personal Experiences and Process of Circumcision

Questions and Filters	Coding categories		Skip
1. How old were you when you were circumcised?	Age ..... Don't know (can not remember) Not circumcised	.... 1 2	 → 13
2. After circumcision did you go through the seclusion period?	Yes No	1 2	 → 6
3. How long was the seclusion period?			
4. Which kind of information were you given during this seclusion period?	How to be a good wife Importance of circumcision Expected social responsibilities Not to be scared/coward Other (specify)	1 2 3 4 5	
5. Who provided this information?	Mother Practitioners (circumcisers) Grandmother Auntie A group of community women Other (specify)	1 2 3 4 5 6	
6. Who circumcised you?	Practitioner (circumciser) Grandmother Doctor/Nurse Mother Auntie Other (specify)	1 2 3 4 5 6	
7. Where was the circumcision carried out?	Own home Hospital In a secluded place Home of the practitioner	1 2 3 4	

	Don't know/can not remember	5	
8. Were you alone or in a group?	Group Alone	1 2	→ **10**
9. If in a group, how many were you?			
10. What instruments were used to carry out the circumcision?	One razor blade per initiate Shared razor blade Scapel Shared knife One knife per initiate Don't know/can not remember Other (specify)	1 2 3 4 5 6 7	
11. Do you know which part of your body was removed?	Yes No	1 2	→ **13**
12. What part of the body was removed?			
13. Do you have any daughters aged 12-20 years or more	Yes No	1 2	→ **SF**
14. How many of your daughters are circumcised?	Circumcised ..... Uncircumcised ..... ***If none is circumcised move to SF***		
15. After circumcision did your daughters go through the seclusion period?	Yes No	1 2	→ **17**
16. How long was the seclusion period?			
17. Who circumcised your daughter(s)?	Traditional practitioner (circumciser) Grandmother Doctor/Nurse Mother Auntie Other (specify)	1 2 3 4 5 6	
18. Where was the circumcision carried out?	Own home Hospital In a secluded home/place Home of the practitioner Don't know/can not remember	1 2 3 4 5	
19. Was/were she/they alone or in a group?	Group Alone	1 2	→ **21**
20. If in a group, how many were they?			
21. What instruments were used to carry out the circumcision?	One razor blade per initiate Shared razor blade Scapel Shared knife One knife per initiate Don't know/can not remember Other (specify)	1 2 3 4 5 6 7	
22. Do you know which part of her/their body was removed?	Yes No	1 2	→ **SD**
23. What part of the body was removed?			

Section D: Factors Promoting Female Circumcision

Questions and Filters	Coding categories		Skip
1. What have been the benefits of circumcising your daughter(s)? ***Record all the responses given***	Keeping with the traditions and customs Social acceptance Good marriage prospects Easy delivery Religious demand Remove dirty genitalia Enhance husband's pleasure Limit their sexual desires Improve fertility Preserves virginity Other (specify)	1 2 3 4 5 6 7 8 9 10 11	
2. Who made the decision that she/they should be circumcised? ***Record all the responses given***	Herself/themselves Mother/myself Father Grandmother Auntie Bother/sister Community	1 2 3 4 5 6 7	
3. Did she/they personally support the idea of being circumcised?	Yes No	1 2	→ 5
4. Why was/were she/they opposed to it? ***Record all the responses given***	Bad tradition Lost significance Against religion Would affect their education Associated health consequences Other (specify)	1 2 3 4 5 6	
5. In your opinion, which kinds of people facilitate female circumcision in this community? ***Record all the responses given***	Community elders Women Girls Boys Politicians Religious leader Men Other (specify)	1 2 3 4 5 6 7 8	
6. What do people say about a girl/woman who is not circumcised? ***Record all the responses given***	Can not get pregnant and are unmarriageable She is sexually promiscuous Can not be assisted by traditional birth attendant in delivery Husband likely to die One is still a child Other (specify)	1 2 3 4 5 6	

Section E: Consequences of Female Circumcision

Questions and Filters	Coding categories		Skip
1. Did your circumcised daughter(s) experience any problems as a result of her/their circumcision?	Yes No	1 2	 → 3
2. What kind of problems did they experience? ***Record all the responses given***	Excess bleeding Severe pain Infection Recurrent bladder and urinary infection Tetanus Painful menstruation Difficulty in urination Still births Scarring Prolonged/obstructed labour Trauma and depression Other (specify)	1 2 3 4 5 6 7 8 9 10 11 12	
3. If you were to have another daughter(s) in future, would you circumcise her/them?	Yes No Depend on the willingness of the girl	1 2 3	 → 5 → SF
4. Why would you want to circumcise her/them? ***Record all the responses given***	Custom and tradition demand Good tradition Religious demand Better marriage prospects Preserves virginity Remove dirty genitalia Enhance husband's pleasure Limit woman's sexual desires Improve fertility Other (specify)	1 2 3 4 5 6 7 8 9 10	
5. Why wouldn't you want to circumcise her? ***Record all the responses given***	Prolonged/obstructed labour Painful personal experience Against human rights and dignity of women Prevents sexual satisfaction Limited education Against religion Might lead to infertility Has lost its significance Have heard messages against it Other (specify)	1 2 3 4 5 6 7 8 9 10	

Section F: Questions for Uncircumcised Daughter(s)

Questions and Filters	Coding categories		Skip
1. Is/are your uncircumcised daughter(s) intending to be circumcised in future?	Yes No	1 2	→ 4
2. If No, why wouldn't she/they want to be circumcised? ***Record all the responses given***	Prolonged/obstructed labour Painful personal experience Against human rights and dignity of women Prevents sexual satisfaction Limited education Against religion Might lead to infertility Has lost its significance Have heard messages against it Other (specify)	1 2 3 4 5 6 7 8 9 10	
3. Who made the decision that she/they should not be circumcised? ***Record all the responses given***	Herself/Themselves Father Myself Church leader School Other (specify)	1 2 3 4 5 6	
4. Why does she/they want to be circumcised? ***Record all the answers given***	Good tradition Important rite Brings honour to the girl and family Gifts are received Improves fertility It is a learning opportunity Uncircumcised girls are shunned Good marriage prospects Other (specify)	1 2 3 4 5 6 7 8 9	
5. Has/have she/they faced any problems in the community for being uncircumcised?	Yes No	1 2	→ 7
6. If yes, what kind of problems has/have faced? ***Record all the responses given***	Mistreatment Being seen as a child Shunned by boys Disrespect and despised Considered sexually promiscuous Considered unmarriageable Other (specify)	1 2 3 4 5 6 7	
7. Has your family in general faced any problems because your daughter(s) is/are not circumcised?	Yes No	1 2	→ 9
8. If yes, which problems has it faced? ***Record all the responses given***	Despised and not respected Considered as weak people Not allowed to participate in important community functions Considered as outcasts Other (specify)	1 2 3 4 5	
9. What do people say about a girl/woman who is not circumcised? ***Record all the responses given***	Can not get pregnant She is sexually promiscuous Can not be assisted by traditional birth attendant in delivery Husband likely to die Other (specify)	1 2 3 4 5	
10. Do you think that your uncircumcised	Yes	1	

daughter intending not to be circumcised will get a husband in future? ***If No in q1***	No	2	
11. Please give reasons for response to Q10?			

Section G: Existing Response Initiatives/Programs

Questions and Filters	Coding categories		Skip
1. Are you aware of any activities against female circumcision in this community?	Yes No	1 2	→ SH
2. What is the message of these activities that are you aware of? ***Record all the responses given***	Female circumcision limits girls education One can still get a husband without being circumcised One can bleed to death Can lead to STI/STDs infection It is a violation of human rights Other (specify)	1 2 3 4 5 6	
3. What are the sources of these activities? ***Record all the responses given***	Community leaders Religious leaders Organized pressure groups Radio and TV Posters and other print media Relatives Other (specify)	1 2 3 4 5 6 7	
4. Who are the main targets of these messages? ***Record all the responses given***	Community leaders Parents Girls Entire community Other (specify)	1 2 3 4 5	
5. As a parent, are you comfortable with the messages of these activities?	Yes No	1 2	
6. Have you ever been involved in these activities?	Yes No	1 2	→ SH
7. What was your role in these activities? ***Record as reported***			
8. Evaluate the effectiveness of these activities in addressing female circumcision in this community?	Effective Less effective Not effective	1 2 3	

Section H: Innovative/home-grown strategies

Questions and Filters	Coding categories		Skip
1. As a mother in this community, would you like to be involved in the campaign against female circumcision?	Yes No	1 2	→ 8
2. How can you be involved in the campaign against female circumcision in this community? ***Record all the responses given***	Through education and awareness Advocating for alternative rites to FGM Appreciating both circumcised and uncircumcised girls Advocating for adequate access and equity of girls to educational opportunities Use uncircumcised and successful women role models as inspiration	1 2 3 4 5	

	Provision of legal redress for those not willing to undergo FGM 6 Other (specify) 7	
3. For female circumcision to be eliminated in this community, who else are the most appropriate people to be targeted? ***Record all the responses given***	Politicians 1 Community leaders 2 Religious leaders 3 Parents 4 Girls 5 Boys 6 Other (specify) 7	
4. Which is/are the most appropriate channel(s) of reaching these people? ***Record all the responses given***	Baraza 1 Radio 2 Religious leader 3 Community leaders 4 Health workers 5 Pamphlets and other literature 6 Politicians 7 Other (specify) 8	
5. Have there been any changes in attitude regarding female circumcision practice?	Yes 1 No 2	→ 8
6. What kind of changes? ***Record all the responses given***	More people are abandoning it 1 Health workers are performing it 2 Uncircumcised girls are being accepted in the community 3 People value education of girls 4 Other (specify) 5	
7. What has contributed to these changes? ***Record all the responses given***	Religious leaders 1 Education 2 Health workers 3 Intermarriages 4 Migration 5 Activists and advocates against FGM 6 Other (specify) 7	
8. In your opinion, how can Action Aid be involved in eradication of female circumcision in this community? ***Record as reported***		
9. If you would not want to be involved in the campaign against female circumcision, why? ***Record as reported***		

Thank you very much for sparing some time with me.

Appendix D: Structured Questionnaire for Male Parents

Section A: Background Information

Questions and Filters	Coding categories		Skip
1. Your age (in complete years) ***Ask for the year of birth first***			
2. Marital status	Single Married Widowed	1 2 3	
3. Have you ever been to school?	Yes No	1 2	 → 5
4. What is the highest level of education you have achieved?	Informal education Pre-primary complete Primary incomplete Primary complete Secondary incomplete Secondary complete Middle level college University	1 2 3 4 5 6 7 8	
5. What is your current occupation?	Herdsman Crop farmer Self-employed Salaried employed Other (specify)	1 2 3 4 5	
6. What is your religion?	Christian Muslim Traditional African religion Other (specify)	1 2 3 4	
7. Name of location	Kositei Ribko	1 2	

Section B: Background on Female Circumcision

Questions and Filters	Coding categories		Skip
1. In your opinion, does the practice of female circumcision affect the standards of education in this area?	Yes No	1 2	
2. What is the local term for female circumcision? ***Verbatim***			
3. Who performs female circumcision? ***Record all the responses given***	Traditional practitioner (circumciser) Grandmother Doctor/Nurse Mother Auntie Other (specify)	1 2 3 4 5 6	
4. Where is female circumcision carried out? ***Record all the responses given***	At the initiate's home Hospital In a secluded home/place Home of the practitioner Don't know	1 2 3 4 5	

5. What instruments are used to carry out female circumcision? ***Record all the responses given***	One razor blade per initiate Shared razor blade Scapel Shared knife One knife per initiate Don't know Other (specify)	1 2 3 4 5 6 7	
6. Are there any payment charged for female circumcision?	Yes No	1 2	→ 9
7. What are the forms of payment? ***Record all the responses given***	Cash Animal(s) ***(name of the animals)***..... Other properties ***(write the property)***..... Other (specify)	1 2 3 4	
8. On average, how much is charged?	Cash ..... Animal(s) ***(name of the animals)***..... Other properties ***(write the property)***.....		
9. Who makes the final decision for a girl to be circumcised in the community? ***Record all the responses given***	The girl herself Parents Grandparents and other relatives Community Other (specify)	1 2 3 4 5	

Section C: Personal Experiences and Process of Circumcision

Questions and Filters	Coding categories		Skip
1. Do you have any daughter(s) aged 12-20 years or more?	Yes No Don't know	1 2 3	 → SF → SF
2. How many of these daughters are circumcised?	Circumcised ..... Uncircumcised		
3. After circumcision did she/they go through the seclusion period?	Yes No	1 2	 → 5
4. How long was the seclusion period?			
5. Who circumcised her/them?	Traditional practitioner (circumciser) Grandmother Doctor/Nurse Mother Auntie Don't know Other (specify)	1 2 3 4 5 6 7	
6. Where was the circumcision carried out?	At our home Hospital In a secluded home/place Home of the practitioner Don't know	1 2 3 4 5	
7. Was/were she/they alone or in a group?	Group Alone	1 2	
8. What instruments were used to carry out the circumcision?	One razor blade per initiate Shared razor blade Scapel Shared knife One knife per initiate Don't know	1 2 3 4 5 6	

	Other (specify)	7	
9. Do you know which part of her/their body that was removed?	Yes No	1 2	→ SD
10. What part of the body was removed?			

Section D: Factors Promoting Female Circumcision

Questions and Filters	Coding categories		Skip
1. What have been the benefits of circumcising your daughter(s)? ***Record all the responses given***	Keeping with the traditions and customs Social acceptance Good marriage prospects Easy delivery Religious demand Remove dirty genitalia Enhance husband's pleasure Limit my sexual desires Improve fertility Preserves virginity Other (specify)	1 2 3 4 5 6 7 8 9 10 11	
2. Who made the decision that she/they should be circumcised?	Herself/themselves Mother Father/myself Grandmother Auntie Bother/sister Community	2 3 4 5 6 7 8	
3. Did she/they personally support the idea of being circumcised?	Yes No	1 2	→ 5
4. Why was/were she/they opposed to it? ***Record all the responses given***	Bad tradition Lost significance Against religion Would affect their education Associated health consequences Other (specify)	1 2 3 4 5 6	
5. In your opinion, which kinds of people facilitate female circumcision in this community? ***Record all the responses given***	Community elders Women Girls Boys Politicians Religious leader Men Other (specify)	1 2 3 4 5 6 7 8	
6. What do people say about a girl/woman who is not circumcised?	Can not get pregnant and are unmarriageable She is sexually promiscuous Can not be assisted by traditional birth attendant in delivery Husband likely to die One is still a child Other (specify)	1 2 3 4 5 6	

Section E: Consequences of Female Circumcision

Questions and Filters	Coding categories		Skip
1. Did your circumcised daughter(s) experience any problems as a result of her/their circumcision?	Yes No	1 2	→ 3
2. What kind of problems did they experience? ***Record all the responses given***	Excess bleeding Severe pain Infection Recurrent bladder and urinary infection Tetanus Painful menstruation Difficulty in urination Still births Scarring Prolonged/obstructed labour Trauma and depression Other (specify)	1 2 3 4 5 6 7 8 9 10 11 12	
3. If you were to have another daughter(s) in future, would you circumcise her/them?	Yes No	1 2	→ 5
4. Why would you want to circumcise her/them? ***Record all the responses given***	Custom and tradition demand Good tradition Religious demand Better marriage prospects Preserves virginity Remove dirty genitalia Enhance husband's pleasure Limit woman's sexual desires Improve fertility Other (specify)	1 2 3 4 5 6 7 8 9 10	
5. Why wouldn't you want to circumcise her? ***Record all the responses given***	Prolonged/obstructed labour Painful personal experience Against human rights and dignity of women Prevents sexual satisfaction Limited education Against religion Might lead to infertility Has lost its significance Have heard messages against it Other (specify)	1 2 3 4 5 6 7 8 9 10	

Section F: Questions for Uncircumcised Daughter(s)

Questions and Filters	Coding categories		Skip
1. Is/are your uncircumcised daughter(s) intending to be circumcised in future?	Yes No	1 2	→ 4
2. If No, why wouldn't she/they want to be circumcised? ***Record all the responses given***	Prolonged/obstructed labour Painful personal experience Against human rights and dignity of women Prevents sexual satisfaction Limited education Against religion Might lead to infertility Has lost its significance Have heard messages against it	1 2 3 4 5 6 7 8	

	Other (specify)	9 10	
3. Who made the decision that she/they should not be circumcised?	Herself/Themselves Father/myself Mother Church leader Sister/Brother School Other (specify)	1 2 3 4 5 6 7	
4. Why does she/they want to be circumcised? ***Record all the answers given***	Good tradition Important rite Brings honour to the girl and family Gifts are received Improves fertility It is a learning opportunity Uncircumcised girls are shunned Good marriage prospects Other (specify)	1 2 3 4 5 6 7 8 9	
5. Has/have she/they faced any problems in the community for being uncircumcised?	Yes No	1 2	→ 7
6. If yes, what kind of problems has/have faced? ***Record all the responses given***	Mistreatment Being seen as a child Shunned by boys Disrespect and despised Considered sexually promiscuous Considered unmarriageable Other (specify)	1 2 3 4 5 6 7	
7. Has your family in general faced any problems because your daughter(s) is/are not circumcised?	Yes No	1 2	→ 9
8. If yes, which problems has it faced? ***Record all the responses given***	Despised and not respected Considered as weak people Alienated from important community functions Considered as outcasts Other (specify)	1 2 3 4 5	
9. What do people say about a girl/woman who is not circumcised?	Can not get pregnant She is sexually promiscuous Can not be assisted by traditional birth attendant in delivery Husband likely to die Other (specify)	1 2 3 4 5	
10. Do you think that your uncircumcised daughter intending not to be circumcised will get a husband in future?	Yes No	1 2	
11. Please give reasons for response to Q10?			
12. If given another opportunity, can you marry uncircumcised wife in future?	Yes No	1 2	
13. Please give reasons for you response in Q12			

Section H: Innovative/home-grown strategies

Questions and Filters	Coding categories	Skip
1. As a father in this community, would you like to be involved in the campaign against female circumcision?	Yes 1 No 2	→ 8
2. How can you be involved in the campaign against female circumcision in this community?	Through education and awareness 1 Advocating for alternative rites to FGM 2 Appreciating both circumcised and uncircumcised girls 3 Advocating for adequate access and equity of girls to educational opportunities Use uncircumcised and successful women role models as inspiration 4 Provision of legal redress for those not willing to undergo FGM 5 Other (specify) 6 7	
3. For female circumcision to be eliminated in this community, who else are the most appropriate people to be targeted? ***Record all the responses given***	Politicians 1 Community leaders 2 Religious leaders 3 Parents 4 Girls 5 Boys 6 Other (specify) 7	
4. Which is/are the most appropriate channel(s) of reaching these people? ***Record all the responses given***	Baraza 1 Radio 2 Religious leader 3 Community leaders 4 Health workers 5 Pamphlets and other literature 6 Politicians 7 Other (specify) 8	
5. Have there been any changes in attitude regarding female circumcision practice?	Yes 1 No 2	→ 8
6. What kind of changes? ***Record all the responses given***	More people are abandoning it 1 Health workers are performing it 2 Uncircumcised girls are being accepted in the community 3 People value education of girls 4 Other (specify) 5	
7. What has contributed to these changes? ***Record all the responses given***	Religious leaders 1 Education 2 Health workers 3 Intermarriages 4 Migration 5 Activists and advocates against FGM 6 Other (specify) 7	
8. In your opinion, how can Action Aid be involved in eradication of female circumcision in this community? ***Record as reported***		
9. If you would not want to be involved in the campaign against female circumcision, why? ***Record as reported***		