EFFECTIVENESS OF ANTI-FEMALE GENITAL CUTTING INTERVENTIONS ON THE PSYCHOSOCIAL WELLBEING OF THE GIRL CHILD IN MARANI SUB-COUNTY, KISII COUNTY, KENYA.

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2023

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DEDICATION

This thesis is dedicated to my lovely daughters Faith and Oprah. You are so dear to me.

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ABSTRACT

Female Genital Cutting (FGC) is a cultural practice that is extensively practiced in 20 out of the 47 counties in Kenya. Despite interventional efforts to end FGC, there has been limited progress in regard to abandonment of this practice among practicing communities. This practice persists with the changing trends notwithstanding. This study sought to examine the effectiveness of anti- FGC interventions on the psychosocial wellbeing of the girl child in Marani Sub-County, Kisii County, Kenya. The study was guided by the following specific objectives: To assess the effects of local construals on the implementation of FGC interventions on the psychosocial wellbeing of the girl child; to examine the place of women in the implementation of FGC interventions on the psychosocial wellbeing of the girl child; to evaluate the effectiveness of the policy interventions in eradicating FGC practices; and to interrogate the challenges affecting eradication of FGC in the Gusii community in Marani Sub-County, Kisii County. The study was anchored on the step change theory, social convention theory and the theory of reasoned action. Moreover, the study adopted a mixed methods research design. The researcher employed cluster, purposive and simple random sampling techniques to recruit the respondents and participants to the study. The study targeted 26,186 households (KNBS, 2019) and sampled 207 respondents of which 200 participated in the household survey, 13 were purposively selected for key informant interview and a further 18 participated in focus group discussions. The study used interviews and questionnaires to collect qualitative and quantitative data for the study. In this context, quantitative data was collected using questionnaires, analyzed quantitatively, and presented in the form of tables, frequencies, percentages, pie charts and bar charts. Qualitative data (words/propositions) was collected through key informant interviews and focus group discussions, and analyzed thematically and presented in form of narratives and quotes. Secondary data was also collected through government publications, journals and articles. The study revealed that stress, stigma, isolation, and marital problems were main psychosocial effects. Also FGC caused strain in marriages where husbands abandoned their wives for younger and uncut women as well as some resorted to sleeping with their daughters. On interventions employed, results show that punishment of perpetrators (92%), advocating for change (85%), engagement of stakeholders (79%) and Establishment of rescue centers (61%) were common FGC intervention in Marani Sub-County. The study noted a reduced trend in FGC in the community implying that anti-FGC interventions were moderately effective while some interventions such as arrest of perpetrators was inefficient and contributed to underground and medicalization of FGC. It was found that men had low level of knowledge on FGC but still believed it was a traditional practice that should be continued. More findings revealed that health professionals such as doctors and nurses were involved in FGC in very secretive ways. Findings from this study concludes that FGC is an ongoing cultural practice within the Gusii community with women and health professionals being the main perpetrators though its practice has reduced significantly compared to previous years. This study recommends a review of the Prohibition of FGM Act among other interventions, establishment of awareness campaigns by various state and non- state actors as well as an adoption of alternative rites of passage as a means to eliminate the practice. This can be possible through resocialization of community members on the need to change this negative tradition for the psychosocial wellbeing of the girl child.

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LIST OF ACRONYMS AND ABBREVIATIONS

AI	:	Amnesty International
ARP	:	Alternative Rites of Passage
BC	:	Before Christ
CBO	:	Community Based Organization
CECOME	:	Centre for Community Mobilization and Empowerment
CEDAW	:	Convention on the Elimination of Discrimination against Women
CRO	:	Committee on the Rights of the Child
DHS	:	Demographic Health Survey
DRC	:	Democratic Republic of Congo
FGM/C	:	Female Genital Mutilation/Cutting
FC	:	Female Circumcision
FGM	:	Female Genital Mutilation
FGC	:	Female Genital Cutting
FGD	:	Focus Group Discussion
FIDA		Federation of Women Lawyers
GBV	:	Gender Based Violence
ISF	:	International Solidarity Fund
KDHS	:	Kenya Demographic Health Survey

KII	:	Key Informant Interview
KNBS	:	Kenya National Bureau of Statistics
MOH	:	Ministry of Health
NGO	:	Non-Governmental Organization
NHS	:	National Health Services
NRHS	:	National Reproductive Health Strategy
PRB	:	Population Reference Bureau
SDG	:	Sustainable Development Goal
SGBV	:	Sexual and Gender Based Violence
UK	:	United Kingdom
UN	:	United Nations
UNFPA	:	United Nations Fund for Population Activities
UNICEF	:	United Nations Children's fund
WHO	:	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

The cultural practice known as female genital mutilation/cutting, or FGM/C, involves modifying or damaging the female external genitalia over purposes other than medical care. It is widely regarded as an extreme form of abuse and violence that puts girls' and women's health and wellbeing at serious risk and is acknowledged as a violation of their human rights. (UNICEF, 2021).

FGC is defined by the World Health Organisation (2016) as a practice that has been ingrained in society for more than a millennium and encompasses any procedures that involve the partial or full elimination of the external female genitalia along with damage to the female genital organs, if for non-therapeutic or cultural purposes. Although its history is unknown, removing FGC will help the world reach its goal of gender equality and FGM eradication, which is a crucial component of the UN's Sustainable Development Goals 5, which calls for gender equality by 2030. Indeed, during the COVID 19 pandemic, a report by UNICEF (2021) indicated that the increasing concerns related to hidden aspects of FGC had led to a number of questions about the accuracy of reported prevalence rates and the fear that individuals and families would not seek medical help or other services in the event that these services were required.

In thirty African and Middle Eastern nations, over 200 million young female and women have undergone FGC in one way or another (UNICEF, 2016). In addition, during the next ten years, thirty million more people are in danger. Experts from all throughout the world, including the WHO, concur that FGC could have detrimental effects on the physical and emotional health of women and girls. That is to say, even if the global FGC drop

continues at its current pace, population increase will result in the amputation of almost 196 million females by the year 2050.

FGC was employed in England and the United States in the 1940s and 1950s for treating hysteria, lesbianism, masturbation, and other feminine deviances. Historical antecedents and social studies revealed that FGC was used by the Phoenicians, Hittites, and ancient Egyptians. Furthermore, studies show that men and women of every age can contribute to the eradication of female genital mutilation, despite the fact that it is illegal due to peer acceptance, social pressure on women and girls to adhere to social norms, and fear of criticism. These interventions target border towns and pastors of religion and their followers.

The underlying reasons for the practice vary across cultures, between and within communities. However, under the cultural, religious and social surface, it becomes clear that such reasons are all rooted in gender-based discrimination and harmful gender stereotypes about the role of women and girls in society. (Kimani et al., 2020; Bavel et al., 2017) posit that justification for this practice include tradition and, prevention of immorality, better marriage prospects, rite of passage and preservation of virginity.

It seems sensible that communities in practice create their own reality regarding the diverse preventive tactics that different players support (Masese, 2012). These facts might or might not accurately represent the beliefs of the particular strategy, but they do direct their activities. This essentially means that the social, economic, and political context of the time as well as particular cultural elements influence the individual knowledge that directs action in the avoidance of FGC.

In this situation, forced and child marriage, marital rape, violence against intimate partners, and other abuses of patriarchal and gendered norms are associated with FGC,

which seems to be used as a tool to control women's sexuality. FGC is seen in many cultures as a significant rite of transition into womanhood that signifies a girl's preparedness for marriage. The practice is frequently seen as a source of both individual and group identification among female immigrants, refugees, and migrants, as well as among women with immigrant backgrounds. It can also function as a sign of cultural identity.

As dads, spouses, and leaders in the society and religion, males may contribute significantly to the continuation of FGC, even though women seem to be leading the charge in this regard. From the findings of one study (Eldirani et, al., 2022) a higher paternal education and residing of parents in an urban region showed a reduced likelihood of FGM/C, in this respect, any other involvement of fathers is scarcely documented in existing FGC research in regard to their influence on the decision-making process on FGC issues. Furthermore, there is limited data on the success of involving men in the abandonment process. Men in their roles as fathers, husbands, community and religious leaders may play a pivotal part in the continuation of female genital mutilation (FGC). Indeed, community dialogues have provided opportunities to discuss societal expectations and norms, health concerns related to FGM, relevant legislation, as well as the roles and responsibilities of different community members. In most instances, community elders and religious leaders have been central to these discussions most of whom are men (UNICEF, 2021). However, the direct involvement and voicing out of men on their views of FGC and their potential role in its abandonment are not well described. Men also hold differing opinions and convictions about FGC. Many of them covertly endorse the practice, while others want it to stop but are unwilling to speak out against it because of social pressure and a sense of duty in the society.

Managing the symptoms of FGC comes at a hefty financial cost. FGC is becoming more common among immigrants from FGC-affected nations in the UK; 137,000 women and girls are said to be living with the aftereffects of the cut at this time. FGC was recognised as a pertinent ailment and treated for a total of 15,390 women and girls who were brought to the national health system (NHS) during April 2015 and December 2017. The annual cost of the NHS care for FGC survivors was estimated at £100 million (WHO, 2016). Similarly, Tordrup, Bishop, Green et.al (2022) sought to quantify the global FGM-related burden in ensuring supporting programmes and policies for prevention and mitigation. Their findings revealed that the economic burden of FGM was approximately US$1.4 billion per year. Without action, this cost would increase to US$2.1 billion per year by 2047 due to the increase in prevalent cases with population growth. In contrast, full abandonment of FGM would lead to a gradual reduction in economic burden, down to approximately US$800 million per year by 2047. In the Kenyan context, the financial statement of 2021/2022 of the Anti FGM board of Kenya had a total expenditure of kshs. 167,631,916 all these funds were used towards ensuring the abandonment of the cut in the hotspots.

According to a gap analysis of the literature on female genital mutilation, there is a pressing need for well-designed studies to support evidence-based policies and enhance the care provided to women and girls who have the procedure (Abdulcadir, Rodriguez & Say, 2015). In the USA, based on 2015 estimates, there are about 137,000 women and girls who have undergone FGC and 507,000 who are at risk of the same (Goldberg et al., 2016). Therefore, FGC presents a challenge to the health system in higher income countries (Dawson et al., 2015).

FGC was mostly performed in Europe by members of the diaspora community on their way back home (during visits or vacations) (Berg & Denison, 2013; Elgaali et al., 2005).

Furthermore, certain cutting is carried out by travelling practitioners who smuggle themselves into Australia, Europe, and North America (Elgaali et al., 2005; Litorp et al., 2008; Moeed & Grover, 2012; Johnson et al., 2014). Against this background, scholars have indicated that the currently available evidence on the number of cases of FGC experienced by girls aged under the age of 18 and living in the UK could be lower that has been previously reported. While a good number of cases are likely to be missing from these figures, the evidence suggests that the risk to children living in the UK is well below the numbers that have been reported by the Government and media. Therefore, current policy and practice relating to FGC/M in the UK may therefore be based on inaccurate evidence (Karlsen, Howard, Carver, Mogilnicka & Pantazis, 2022).

FGC is arguably most common in Africa and Asia, however it is also practiced in isolated areas on other continents. FGC is carried out among migrant populations in several Western countries, the Middle East, Asia, Latin America, and over thirty African countries (East, North East, and West Africa) (WHO, 2008; Yoder et al., 2013; PRB, 2013; UNICEF, 2014). According to estimates, 38,000 women and girls in Sweden have undergone FGC (Forslind, 2015). There are unquestionably numerous, significant, and significant health benefits connected to ending FGC. Unfortunately, 200 million girls and women are projected to have previously been cut, and 3.6 million are at risk of being cut annually (UNICEF et al., 2013; UNICEF, 2016).

FGC has proved remarkably persistent despite nearly a century of attempts to eliminate it (UNICEF, 2013). In West Africa, higher occurrences of FGC have been attributed to the mixture of the people and culture of Burkina Faso, Togo and Mali, where the practice is more common. Some studies reported that traditions and social norms pressure girls to undergo circumcision: women who are not circumcised often experience ridicule from peers and rivals (Akweongo et al., 2001). For instance, in Guinea, Sierra Leone, more

men than women want FGC to end (Leina, 2014). Regarding health consequences, a study in the Gambia showed that 72% of respondents did not know that FGC had a negative impact on the health and well-being of girls (Kaplan et al., 2013).

According to a study conducted in Egypt, men in North Africa thought that uncut women were promiscuous and that arranged marriages (FGM) were necessary to guarantee faithfulness in a marriage (WHO, 2016). Similar beliefs were held by Somali males on FGC's ability to stop premarital sex, protect girls' dignity, and stop marital infidelity. Contrary to popular belief, women who had experienced female genital mutilation (FGM) were shown to be more likely to have several sexual partners in a study done in Sierra Leone (Ahinkorah, et. al., 2022). Men's groups on the job, in sports clubs and at social and religious gatherings discuss FGC as a bad practice and how it may be outlawed due to its health risks. Men who are empowered by education have a better understanding of and attitude towards female genital mutilation (FGM). This helps men make better decisions about FGC because they are the ones who ultimately decide whether or not to perform FGC on their daughters, wives, or sisters.

A man's job in traditional patriarchal countries is to support the family financially. He is also in charge of women's and children's safety and protection. Men are involved in politics, business, education, and religion in the public sphere. Women's role has never been limited to sexuality and childrearing. Since patriarchy touches on themes of identity and culturalism, discussing it elicits powerful feelings. The gender roles that society has allocated to men and women are extremely important to them. Every element of life, including language, attire, and sexual expression, is defined by these gender roles. All ethnic groups in Kenya save the Luo, Luhya, Pokomo, Teso, and Turkana practice female genital mutilation (FGM), but to differing degrees. From 37.6% in 1998 to 21% in 2014 (KNBS & ICF Macro, 2014), the prevalence of FGC among Kenyans aged 15 to 49

dropped, and it is currently at 15% (KDHS, 2022). Nonetheless, there are significant regional and ethnic differences in the shift in prevalence (Shell-Duncan, Njue et al., 2018). In order to stop future FGC instances and lessen the suffering of already-cut girls and women in communities where FGC is widely practiced, integrated solutions must be developed and implemented (Varol et al., 2014).

By restricting women's sexual desire and fulfilment and encouraging virginity before marriage as a guarantee on moral standards as well as an assurance of marryability, FGC has been and continues to be used to regulate women's sexuality (Berg & Denison, 2013). Furthermore, no major religion supports FGC, and the practice predates all of them. Muslims, Christians, Jews, and adherents of other religions all participate in FGC (Berg & Denison, 2013).

The UNICEF study also reveals that, in eight countries, the percentage of women who believe that males wish to stop FGM is substantially lower than the actual rate. For instance, in Guinea Conakry, 12% of women believe that men wish to cease, but 42% of men actually desire to quit the practice (2013:72). This appears to indicate a communication gap between genders, which the study validates. The community's culture is intended to be preserved, which is why the actions or decision to make the cut are so important. According to Berg and Denison (2013), women who undergo FGC do so in order to achieve social significance, cultural conformity, a sense of identity, and respectability as ideal community members. Clift and Jensen (2005) posit that, a common feature is the social conditioning of women to accept female genital mutilation within social definitions of womanhood and identity. This leads them to perpetuate and defend the practice. Although many of these societies acknowledge the dampening effect of genital mutilation on women's sexual pleasure, preservation of chastity is not always the goal. In Egypt, Somalia and Sudan, for example, extramarital sex is completely

unacceptable and female genital mutilation is used to ensure that it does not occur. In Kenya, Uganda and West African countries such as Sierra Leone, a girl may have a child out of wedlock to prove her fertility, then undergo genital mutilation and be married afterwards.

However, despite increasing commitment to combat FGC, there are still significant gaps in the approach to tackle the practice (EIGE, 2013). Since FGC was brought up as an important health issue by the WHO in 1975, it has often been taken for granted that men's domination and control of women has an important role to play in the perpetuation of the practice (Almroth et al., 2001; O'Neill, 2013).

Research has been conducted on interventions that have so far been used in ending the cut among practicing communities. In one such study, at the community level, interventions that have been known to work in abandonment of FGC include addressing gender inequalities and social norms, health education, community engagement approaches, social marketing and media efforts, use of religious/cultural leaders, public declarations/statements as well as conversion of traditional practitioners whereas at individual level, empowering girls and women, formal education for girls and alternative rites of passage seem to bear more fruit (Matanda, et al., 2023). Notably, most studies have not shown the effectiveness of FGC interventions on psychosocial wellbeing of girls. Hence, the knowledge gap in this study.

On policy frameworks, FGC is a reproductive health concern for girls and women. At the national level, the Constitution of Kenya 2010 guarantees the rights of an individual to the highest attainable standard of health, including reproductive health. Similarly, the National Reproductive Health Policy (2007) emphasizes that harmful cultural practices, including nutritional taboos, violate the reproductive rights and impeded attainment of healthy and fulfilling reproductive lives, especially among women (MoH, 2007).

The three main issues in the area of gender equality that the National Reproductive Health Strategy encasing the years 2009 to 2015 attempted to address were: gender-specific harmful cultural practices, such as child or early marriages or female genital mutilation (FGM); and sexual and gender-based violence (SGBV). The former was blamed for Kenya's low level of empowerment for women in making decisions regarding their own sexually active health and rights, which includes options regarding seeking health care themselves and their children. FGC and early or child marriages, however, are two detrimental cultural practices that are of great concern in Kenya.

The Children's Act 2001, now revised 2022, seeks to criminalize FGC on children below 18 years (Republic of Kenya, 2001; 2022). Section 14 of the Act provides that "no person shall subject a child to female circumcision, early marriage or other cultural rites, customs or traditional practices that are likely to negatively affect the child's life, health, social welfare, dignity or physical or psychological development." On its part, Section 18 of the Act stipulates that any conviction for FGC-related offences carries a penalty of 12 months' imprisonment and/or a fine not exceeding Kshs. 50,000. Whereas criminalization of FGC eradicates the practice from being relatively authorized by law, the actual perpetrators of the cut are driven underground, leading individuals to conduct the practice in concealed and cautious ways such as medicalization (FGC in secrecy is hazardous, since victims of the same end up undergoing unsafe surgery.

As part of the Kenyan government policy interventions against FGC, the Children's Act 2001 has limitations in that it protects girls only up to the age of 18 years and does not protect women from being forcefully circumcised. In addition, placing FGC within the Children's Act, it (FGC) is seen as a children's issue rather than being of wider significance, and therefore carries little weight. Indeed, as Dr. Kamau argued in her petition filed against the Anti FGM Board, the main argument against the FGM Act of

Kenya was that this legislation, encroached on the rights of Kenyan women to practice and enjoy their culture, breached key provisions within the Kenyan Constitution of 2010. In her view, a cultural practice such as FGC should not be prohibited or abolished since adult women and adult men have the right to equal opportunities in cultural and social spheres (Ahmadu & Kamau, 2022) FIDA–Kenya (2009) suggests the need to review the Children's Act 2001, which would also take into account greater involvement of people at the community level to create sustainable ownership of the process, while at the same time paying specific attention to sections14 which highlights protection of children from harmful cultural rites such as female circumcision and early marriage and 119 (1)(h) which states that "a child is in need of care and protection when she is subjected to female circumcision". Additionally, a research suggested that FIDA Kenya lead the implementation of the Children's Act 2001 guidelines with important stakeholders such government ministries, CSOs, NGOs, and FBOs in light of the issues that had been found. The review of the Children's Act would specifically focus on sections 14 and 119(I)(h), with an emphasis on incorporating more community members to foster long-term ownership of the process. The revised Act should forbid FGM in all circumstances, including for women over the age of eighteen. It should also establish explicit guidelines for how the Act's FGM provisions are to be implemented, forbid any kind of community dispute settlement in FGM cases, and create a special protocol for training and supervising provincial administrations' application of the Children's Act. Additionally, the Act would be written in plain English and be understandable to even the least educated person. The revised Act should make FGC illegal for women over the age of eighteen as well as for those under the age of eighteen. It is important to note that the reviewed Children's Act 2022 has factored in most of these concerns.

The prohibition of FGC Act of 2011 has several provisions which are intended to eradicate the practice of FGC. It is an act of Parliament to prohibit the practice of female genital mutilation, to safeguard against violation of a person's mental or physical integrity through the practice of female genital mutilation and for connected purposes. The Anti-Female Genital Mutilation Board is established by the Act. The 2011 Prohibition of FGC Act aims to criminalize attitudes and opinions of society towards FGC that were not previously covered by earlier anti-FGC laws; these sections are expanded upon. It has included regulatory requirements for training midwives and other medical personnel to perform FGC. According to Section 19 (1), "anyone who executes female genital mutilation on somebody else commits an offence. This includes someone who is receiving training under the supervision of a medical professional or midwife with the intention of becoming a medical professional or midwife.

Collective intentionality in the form of "shared attitudes" is acknowledged as being essential for the correct understanding of social practices and social institutions in order to fully understand the persistence of FGC among the Gusii people of Western Kenya and the efficacy of interventions. Therefore, it is important to consider how social and cultural standards justify and normalize behavior in order to understand the practice of FGC. Through regular social interaction, norms are learned and reinforced, which shapes and influences behavior that normalizes control over female bodies as well as sexuality (Berger & Luckman, 2017). As a social construction, FGC is influenced by socio-economic and cultural factors such as transition from childhood to adulthood; marriageability and tradition which affect the way girls and young women define, perceive, feel and act/perform their sexuality in various' contexts.

1.2 Statement of the Problem

Female genital cutting (FGC) is a form of violence against women and girls that has been around for more than a thousand years; it is purported to have started during the slave trade when black women entered ancient Arab societies (Ahinkorah, 2022). Whereas the practice of FGC has been termed cultural by those who partake of it, it has been stated to have adverse negative effects ranging from death, bleeding, damaging female genital tissue thus interfering with the natural function of girls and women's bodies, pain during sexual intercourse, posttraumatic stress, school dropout, early marriage and less sexual satisfaction to affecting the psychological health of girls and women and the violation of their rights (Elsayed et al., 2011; WHO & PAHO, 2012; 28 Too many, 2013;UNICEF, 2021) It is worrying that the practice is now conducted on girls as young as 2 years old (Bavel et al., 2017). Eradicating FGC will bring the world one step closer to achieving gender equality; moreover, ending FGM is a key part of the United Nations' Global Goal 5 for achieving gender equality by 2030. The prevalence of the practice varies widely among different ethnic groups in Kenya. Evidently, however, FGC is not only pervasive in the Gusii community (KNBS, 2015), but also accounts for over 84% of FGC cases every year (KDHS, 2018). Among the interventions that have so far been employed to champion the abandonment of FGC are health education, community dialogues with parents and religious leaders, the use of media and social marketing efforts, legislative approach and formal education for women and girls are examples of interventions (Matanda et. al, 2023). Despite international and national efforts to end FGC, progress towards achieving this goal has been limited both in terms of preventing it and caring for the psychosocial wellbeing of girls and women victims of FGC.

In this context, the majority of studies have focused on the social, economic, and political effects of FGC but with little focus on the effectiveness of FGC interventions on the

psychosocial wellbeing of the girl child in Marani Sub-County, Kisii County, Kenya. It is on this basis that the researcher proposed this study to fill the aforesaid existing knowledge gap.

1.3. Objectives of the Study

This study was guided by a broad objective as well as specific objectives of the study.

1.3.1 Broad Objective

To critically examine the effectiveness of anti- FGC interventions on the psychosocial wellbeing of the girl child in Marani Sub-County, Kisii County, Kenya.

1.3.2 Specific Objectives

This study was guided by the following specific objectives:

i. To critically assess the effects of local construal's on the implementation of anti-FGC interventions on the psychosocial wellbeing of the girl child in Marani sub-County, Kisii County, Kenya

ii. To critically examine the place of women in the implementation of anti- FGC interventions on the psychosocial wellbeing of the girl child in Marani Sub-County, Kisii County, Kenya

iii. To evaluate the effectiveness of the policy interventions in eradicating FGC practices in Marani Sub-County, Kisii County, Kenya

iv. To interrogate challenges affecting eradication of FGC in Gusii community in Marani sub county, Kisii County Kenya.

1.4 Research Questions

This study was guided by the following research questions:

i. What are the effects of local construals on the implementation of anti- FGC interventions on the psychosocial wellbeing of the girl child in Marani Sub-County, Kisii County, Kenya?

ii. What is the place of women in the implementation of anti- FGC interventions on the psychosocial wellbeing of the girl child in Marani Sub-County, Kisii County, Kenya?

iii. To what extent are the existing policy interventions effective in eradicating FGC practices in Marani Sub-County, Kisii County, Kenya?

iv. What are the challenges being faced in curbing FGC practices in Marani Sub-County, Kisii County, Kenya?

1.5 Justification for the Study

UNICEF (2018) reports Kisii County to have an FGC prevalence of 84% although the latest KDHS (2022) has given a prevalence of 77%. The high degree of misunderstanding of child rights as outlined in the Children's Act of 2022 in the Kisii community, as well as the detrimental effects this has on the growth and advancement of girl children, are emerging elements and features from earlier studies on FGC. There seems to be a noticeable trend of girls having FGC at significantly younger ages—many of them are as young as ten. This seems to be an attempt to circumcise kids before they might object, as well as a reaction to the fact that FGC has been prohibited by The Children Act as of 2022.

The practice of FGC has also been linked to health hazards for women and girls, including tetanus, anus and urethra injury, sterility, HIV infection, and more recently, physical and psychological stress. As reported in one study by Riang'a & Mutiso (2022) in Kisii County, a majority of the respondents reported bleeding, psychological trauma,

pain, problems giving birth and infections as some of the effects they encountered when they underwent the cut.

Despite the fact that research has been done on the demonstrated detrimental effects and outcomes of FGC, little has been done on the effectiveness of the interventions in regard to psychosocial wellbeing of girls and women. Therefore, a proper understanding of the persistence of the practice as well as the effectiveness of various interventions is needed for the achievement of the primary goal of abandonment of FGC as stipulated in SDG 5.3 by 2030 as well as Agenda 2063 which targets to end FGC by 2025 and participation of women in the development of goals and the realization of women's psychosocial wellbeing. Moreover, in spite of the efforts directed towards eliminating FGC, the number of cases of the same remain relatively high in spite the interventions with the ways of hiding the practice becoming more discrete by the day.

1.6. Significance of the Study

This study will benefit researchers through access to firsthand information on the outcome of the research hence increasing their knowledge in research work, thereby improving their knowledge on the effectiveness of interventions enhancing the lives of the girl child in the study area. These findings will also propose formulation of relevant policies to address the problem. The study will fill the existing knowledge gaps not only through sharing the findings but also development of a resocialization model which once adopted can be a tool used to enhance the abandonment of FGC not just in the Gusii community but all other practicing communities worldwide. It is hoped that the findings from this study will be significant in recommending actionable policy interventions to curb Female Genital Cutting in the practicing communities. Findings from this study will

add to the existing literature on the effectiveness of FGC interventions on the psychosocial wellbeing of the girl child in Marani sub-county, Kisii County, Kenya.

1.7 Scope of the Study

The study examined the effectiveness of anti- FGC interventions on the psychosocial wellbeing of the girl child in Marani Sub-County, Kisii County, Kenya**.** The scope of the study was households in Marani Sub-County.

1.8 Limitation of the Study

The researcher experienced a challenge of getting all respondents as some were out on their own businesses for their livelihood. This was managed through ensuring the equivalent of the participants were thus used as a suitable replacement. Further the data collection rate was above 90% in the case where respondents were unavailable. Subsequently, the researcher employed the use of triangulation as a way ensuring the data collected was representative enough. The study is sensitive and most studies have focused on early marriage and girl's participation in education, but the researcher took a different perspective that is on effectiveness of anti-FGC interventions on the psychosocial wellbeing of the girl child in Marani Sub-County. Respondents' skepticism in divulging vital information due to suspicion was expected to be an obstacle but the researcher reassured the respondents that the research was purely academic and confidential thereby mitigating the problem.

1.9. Theoretical Framework of the Study

This study was guided by three theories namely: step change theory, social convention theory and theory of reasoned action.

1.9.1 Step Change Theory

The foundation of this study was Kurt Lewin's Step Change Theory. Kurt Lewin presented the Three-Step Change Theory in 1951. According to him, driving forces enable change by pushing entities in the desired direction, and behaviour is the result of a dynamic balance of forces acting in opposition to each other. Restrictive factors hinder progress since they push people in opposing directions. In this study, this group stands for those who are against the outlawing of female genital mutilation in the Gusii community in Western Kenya. Lewin's three-step theory can assist in modifying the equilibrium in the direction of the intended change in this instance, which is the eradication of FGC inside the Gusii Community, provided that these forces are understood.

According to Lewin, the initial phase of altering behaviour involves releasing the current condition, which is commonly perceived as the equilibrium state. In order to overcome the instances of individual resistance and collective conformity, unfreezing is crucial. Unfreezing can be accomplished by reducing the restraining factors that adversely impact movement from the current equilibrium, increasing the driving forces that steer behaviour away from the current state, or combining the two approaches.

Activities that can assist in the unfreezing step include: building trust, motivating participants by preparing them for change and their recognition for the need to change, as well as actively participating in recognizing problems and formulating resolutions within the group (Robbins, 2003). This argument will form the premise for analysis of the existing methods and strategies being used in the eradication of FGC amongst the Gusii as a community.

The second step in changing behavior is movement. In this step, Lewin asserts that it is necessary to move the target system to a new level of equilibrium. Three actions that can assist in the movement step include: persuasion of those involved to agree to the terms

that the status quo is not in any way favorable to them but rather harmful and encouraging them to view the issue from a different viewpoint, working together in the pursuit of change through collection of relevant information, shared views, and involvement of various stakeholders that support the change.

The final step of Lewin's three-step change model is refreezing. For this step to be sustainable, the implementation process of the change ought to be complete. This is the process of incorporation of the new values into the community principles and cultures. There's a high likelihood that the change sort may be short-lived, and the participants could easily revert to their old ways, i.e. if this step is ignored. The purpose of refreezing, therefore, is to create stability to the new equilibrium resulting from the change, by ensuring a balance of both the driving and restraining forces. In order to implement Lewin's third step, there is need to strengthen new arrangements and institutionalize them through recognized mechanisms, such as policies and procedures (Robbins, 2003 p: 564-65). In this way, this model, demonstrates the effects of forces that either uphold or impede change. According to Robbins (2003), change will occur when the combined strength of one force is greater than the combined strength of the opposing set of forces.

This theory is considered appropriate in this study, because in order to eradicate the practice of FGC there is need first, to assess the existing situation among the Gusii Community, creating the right movements through persuasion to help channel the views of various stakeholders; and finally to effect the change, thereby stabilizing the new equilibrium through the involvement of opinion leaders in the Gusii community. Therefore, through this theory, the study will elaborate and integrate the subsequent steps of elimination of FGC.

While this theory may seem ideal for the study, one of the biggest critiques comes from McAleese et al. (2013) who question its applicability to organizational change processes

in this age of globalization and digitalization. In their argument, a balance of stability and movement of discrete and emergent change is the reality for today's organizations and this forms the basis for formulation of the theory. The Step Change theory therefore needs well organized structures to effect the required change. These structures may be in form of establishing a legal framework, government organizations, engagement of various stakeholders such as churches, community-based organizations, and institutions of learning among others.

Further to this argument, Hussain et al. (2018) posit that this model is categorized into loops of leadership, management and organization. It involves various stakeholders ranging from parents of the girls at risk of FGC to opinion leaders. The anticipated change may either involve group behaviors for change or increase the leaders pressure for change at even higher levels, which according to the proponent of this theory will create minimal tension and resistance in regard to forces involving status quo. Therefore, according to Hussain et al. (2018) sharing of knowledge, performance outcomes, decision making as well as information flow from multilevel, embracing new technology, sharing skills and expertise are ways of solving problems by all stakeholders in the community particularly parents and their daughters as a way to ending FGC. It is on this basis that the researcher felt the need to introduce the second theory.

1.9.2 Social Convention Theory

This study will also use the Social Convention Theory to understand the role social construction plays to influence the continued practice of FGC among the Gusii community of Western Kenya. The proponent of the Social Convention Theory is Mackie (1996) a political scientist and expert of social norms. In his view, FGC is a social practice determined by group norms, as well as individual decisions. Initially, Mackie sought to establish the commonalities between FGC and Chinese foot binding. In

both cases, young women were physically disabled in an effort to make them less likely to cheat on their spouses (Arnhart, 2009). As such, both are related to suitability for marriage. It is assumed that men will not marry women who, in one scenario, have unbound feet or, in another, have not had their circumcision (Magangi, 2013). Social constructions are deeply rooted social traditions that spell out consequences for one who fails to abide by their dictates. Mackie highlights that change is projected to result from coordinated abandonment in intermarrying groups, so as to preserve a marriage market for uncircumcised girls. Mackie goes on to say that in an environment of great inequality and resource scarcity, (FGC) developed as a way to communicate faithfulness and improve marriages. From there, it spread to become a requirement for marriage for all women. Therefore, the anti-cutting pledge—a public declaration by a group of parents not to have their girls cut—is emphasised by Mackie (1996, 2000) as the primary means of putting a stop to the practice. Subsequently, Mackie (2000) stresses that when such a group pledge to desist from the cut, then the knowledge that they are a critical mass will make it instantaneously their responsibility to honour their pledges, hence persuade the rest of the community to join in and end the practice.

Because FGC expectations are interdependent, change needs to be coordinated among social network members who are related to one another (Shel-Duncan, Obiero, and Muruli, 2001). Arnhart (2009) argues that Mackie's justifications for these practices are instances of self-executing social conventions, meaning that unless a significant number of participants can be persuaded to join within a shared responsibility to discontinue the practice, entities can't change the practice without suffering retaliation. According to Mackie, there is a special aspect of the FGC practice that no one can truly succeed at on their own, even if every member of the group felt the need to give up the practice.

Obermeyer is among the most ardent opponents of the convention hypothesis. Obermeyer (1999) contends that there is insufficient data to establish the "facts" regarding the adverse consequences of FGC. He offers three further theories: First off, since both the better educated and the less educated continue the practice, there may not be much harm from FGC. Second, since the alleged connection between female sexual pleasure and the clitoris is a social construct instead of a psychological truth, FGC might not cause any harm.

Thirdly, FGC may be of minimal harm because it is so widespread and persistent. Nonetheless, Mackie (2003) maintains that FGC is detrimental. According to him, the irreversible loss of human ability in the lack of meaningful consent makes it a reason for concern. In this regard, Shell-Duncan et al. (2011) confirmed that, in contrast to popular belief, FGC is typically only tangentially associated with marriageability through worries about maintaining virginity. Rather, they discovered compelling evidence in favour of a peer convention, which is an alternate convention. Female Genital Cutting makes it easier for older women to gain status and power and for younger men to accumulate social capital. They suggest that this being new evidence and reinterpretation of social convention theory, interventions aimed at eliminating FGC should target women's social networks, which are intergenerational and include both men and women.

This theory proposes a multilateral strategy consisting of advocacy, public education from dependable sources, in which case information is transmitted to extensive audiences and public declarations, where everybody involved declares not to go back on the promise (Magangi, 2013). Anti-circumcision pledges are not the only means of ending FGC. Education on the negative consequences of FGC is necessary for elimination of the practice (Hayford, 2005).

One of the strengths of this theory is that it tries to explain the existence and persistence of the practice of FGC and highlights recommendations on the abandonment. This theory explains why some negative social behaviours become self-enforcing social norms and why people find it difficult to change, as well as how to organise for a swift and widespread breakup of such a convention (Magangi, 2013).

According to the idea, FGC logically serves the needs of the girl as well as her family if, in an intermarrying group, households with daughters assume that families with sons view girls' sex as a requirement for marriage. Being cut guarantees the daughter's capacity for marriage and contributes to her family's increased financial stability. Mackie points out that the social and economic circumstances of practising societies make marriage itself particularly significant. To ensure the long-term financial security for daughters and their families, marriageability is deemed important in the majority of FGC-practicing areas due to patriarchal economic practices and institutions (Mackie & Le Jeune, 2008). Finally, Mackie (2002) highlights that, given a means of communication, it ought to be simpler for people with altered perspectives to wed one other's offspring the more populous and educated the society is.

In the words of Mackie (2003), there is evidence in all the nations analysed that parents want what's best for their children, hence this study is best suited to this idea. The most fundamental principle is what drives a parent to execute FGC, even with the help of medicalization, since a less painful treatment all in readiness for marriage, as girls and their families suffer social isolation and shame when they don't follow societal norms. This provides a foundation for the study's case against the Gusii community's cultural practice of FGC in Western Kenya. This practice not only interferes with the girl’s basic rights, but is also harmful to her physical and psychological wellbeing. The theory also gives a foundation of argument on the eradication of the FGC practice. The theory is

appropriate for this study, since it champions for sensitization of the community, as one of the ways by which the FGC practice can be curbed among the Gusii Community of Western Kenya.

1.9.3 Theory of Reasoned Action

Fishbein and Ajzen's (1975) Theory of Reasoned Action, or TRA, served as the foundation for this investigation. According to the theory, humans are often highly logical and always make methodical use of the knowledge at their disposal. They also weigh the potential consequences of their choices before acting, according to the theory, and they examine these factors before choosing a certain course of action. The two variables in the theory are as follows: Attitudes + Subjective norms = Intention (which drives behaviour). This theory also shows that there are two practical ways to influence behaviour: influencing attitudes and applying social pressure. The theory, which often focuses on the things an individual feels other people, especially prominent individuals, would expect them to do, suggests that normative views have a significant impact. This theory is pertinent to our research since, taking its ideas into account, the Gusii predicament might fit in this way; Behaviour: The specific behaviour in this case is giving up the practice of FGC on girls and women; behavioural intention: Based on information from the government and civil society organisations, the Gusii community members' perception of the likelihood that they will or won't give up the practice of FGC. Attitude- the community members' positive or negative feelings about abandoning the practice of FGC.

In such situation, for the Gusii community members to choose to abandon FGC, their attitudes have to change; that their daughter remaining uncircumcised is more advantageous than undergoing female genital cutting. Evaluation- which in this case is the value attached to the outcome of a Gusii girl/woman remaining uncircumcised.

Additionally, the subjective norms could be that people of this generation are also abandoning the practice of FGC; hence they expect them to do so as well. Normative beliefs, which are about whether key individuals such as parents, peers, teachers and groups such as youth groups and women groups approve or disapprove the issue of girls/women remaining uncircumcised. Finally, motivation to comply is whether or not the girl's/woman's intention to remain uncircumcised will be affected by what others will think about them remaining uncircumcised.

The biggest critique of this theory comes from a scholar by the name Ogden (2003). In her argument, a 'good theory' should consist of constructs which are sufficiently specific so as to generate hypotheses. Such hypotheses should be testable and, in principle at least, a good theory should be able to be rejected. The theory of reasoned action can be considered a pragmatic tool for social scientists, health psychologists and researchers from allied research areas to draw upon.

But in using this theory for a purpose such as this, say in this case, effectiveness of interventions against FGC, Ogden argues, the essential flaws in their conceptual basis ought to be recognized. This model cannot be tested, since it focuses on analytic truths rather than synthetic ones and may create and change both cognitions and behaviour rather than describe them and as such does not pass the criteria set for a 'good theory'. Ogden further posits that if this theory is to be given the status of theories, then she recommends that the critical eye that psychologists place upon other areas of research should also be cast upon this one. In a rejoinder, Trafimow, (2009) disputes the argument presented by Ogden asserting that "A good theory" must be falsifiable. In his argument, when one decides how much to believe or disbelieve a theory, such as the theory of reasoned action, the issue is the weight of the evidence, the plausibility of alternative

explanations, and presumptions about the validity of auxiliary assumptions, rather than conclusive proof or disproof.

Whereas falsification is clearly an inadequate philosophy of science, a more sophisticated version has some desirable characteristics (Trafimow, 2003). As a result, if one theory makes riskier predictions than another, it is assumed to imply that the other theory would have made riskier predictions in the context of more creative auxiliary assumptions. However, the fact that a particular theory has been presented to make risky predictions is a point in its favour: the theory therefore permits researchers to make predictions of something that they would otherwise have been be unlikely to predict without it (Trafimow, 2009).

On their part, Ajzen and Fishbien, (2003) argue that Ogden limited her review of the theory to a 5-year period (1997–2001) hence, they dispel that Ogden's conclusion that the theory's constructs are too general to permit precise tests; therefore, it cannot be disproved. They put to question the rationale of negative results that, Ogden feels, should lead to rejection of the theory are of two types: Firstly, that the findings to the effect that one or another of the theory's antecedent variables fails to predict the outcome measure and secondly, that these findings that the theories' predictors do not explain most of the variance in intention or behavior. They affirm that even with these limitations, meta-analyses show that the reasoned action approach has done exceptionally well (Ajzen & Fishbien, 2003).

In the same argument, Trafimow (2009) further states that behavioral intention, in turn, is determined by the attitude one has in evaluation of perceived behavior and subjective norm which define an individual's evaluation of what's of importance in regard to what others think one should do, either of which might be the most important determinant of any particular behavior.

Under normal circumstances, this is revealed empirically by the beta weights obtained from multiple regression analyses, where behavioral intention is regressed on to attitude and subjective norm. Supposing the result is a larger attitude than subjective norm beta weight, the behavior is presumed to be more under attitudinal than normative control, however if it is the other way, then the behavior is considered to be more under normative than attitudinal control. In either case, therefore, it is desirable to know what determines attitude or subjective norm, in that regard, whether a researcher wishes to influence the behavior.

Attitude is determined by behavioral beliefs about the likelihood of a number of consequences and evaluations of how good or bad it would be if those consequences happened. As a result, subjective norm is determined by beliefs about what specific important others think one should do and how much one is motivated to comply with those important others. Both attitude and subjective norm are assumed to be determined by summative processes.

In view of this, Trafimow (2009) posits that attitudes are presumably determined by beliefs about consequences (and evaluations of those consequences) whereas subjective norms are determined by normative beliefs (and motivations to comply). It is on this basis that this argument justifies that all the arguments presented in regard to this theory of reasoned action are amenable, in principle, and to some degree of falsification, depending on how skillfully one is at choosing auxiliary assumptions. Additionally, several examples that are provided of tests that may have resulted in a reasonable degree of falsification or that actually did result in a reasonable degree of falsification of ideas that had been said by at least some people to not be falsifiable (Trafimow, 2009). In this light, therefore, as a conclusion, Ajzen and Fishbien (2003) argue that the model of reasoned action can be tested, and the measures used to test them are not redundant but possess

discriminant validity. Whether, in a given study, the completion of instruments of data collection, such as, questionnaires, interview guides, and focus group discussions, have biased self-reports of behavior, they have changed cognitions, or have influenced later behavior thus, these are empirical questions that cannot be answered by speculation but rather by scientific research. Through use of questionnaires, KII and focus group discussions, this study was able to test the theory of reasoned action and its applicability to this study.

1.10 Conceptual Framework of the Study

Figure 1.0 shows the relationship existing among the main variables of the study namely:

The independent variable, the dependent variable and the moderating variable.

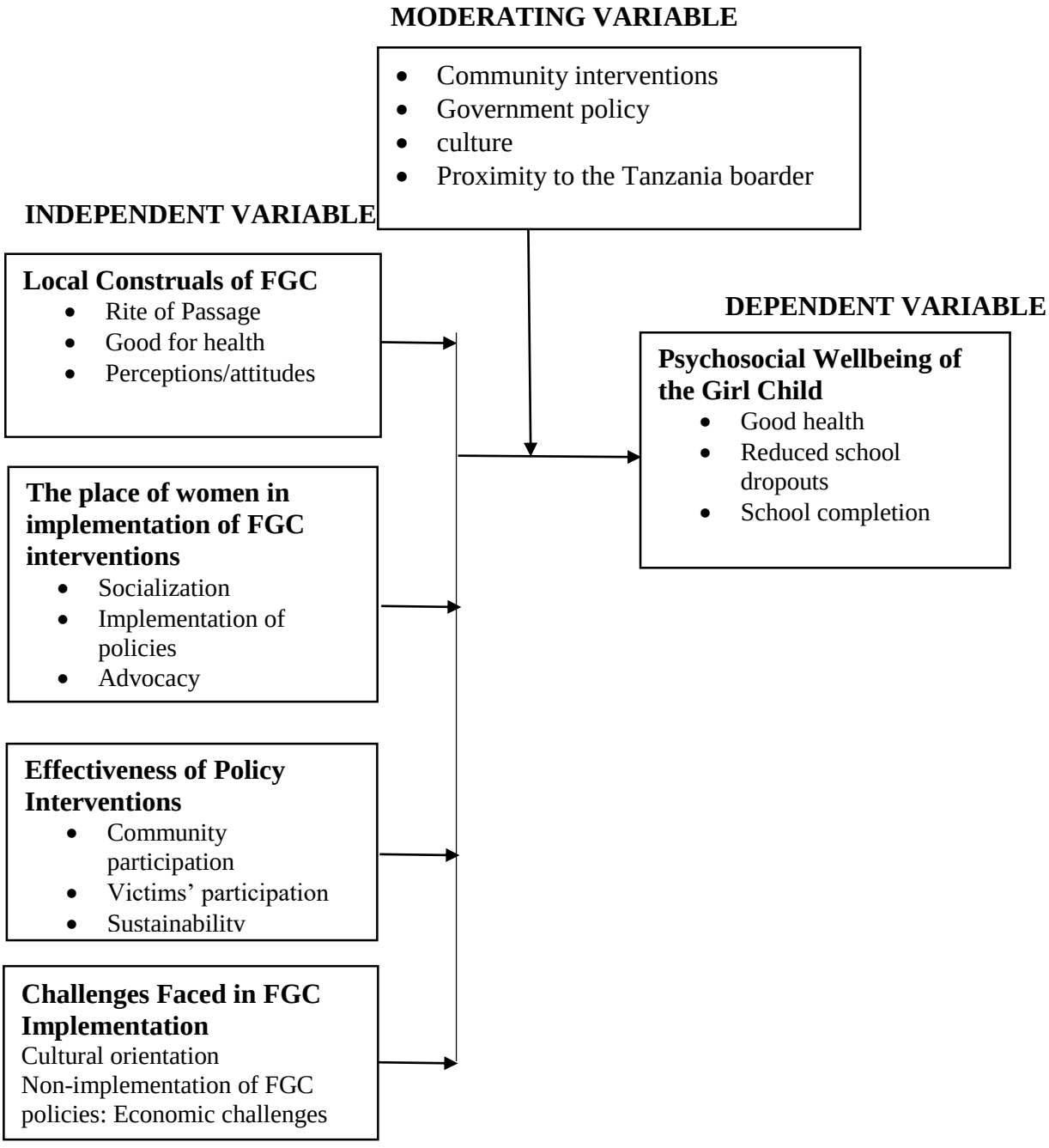

Figure 1.1: Conceptual Framework

Source: Researcher, 2022

The figure above shows the relationship between independent variable and dependent variables. For instance, in the independent the researcher interrogated variables such as local interpretation, cultural norms and practices, effectiveness of interventions and challenges faced in prevention of FGC. Here the researcher focused on attributes such as rite of passage, good for health, socio-cultural norms, perceptions/attitudes, socialization, social norms, community participation, victims' participation, and sustainability approaches. The dependent variable was psychosocial wellbeing of the girl child. Here the research measured wellbeing by focusing on psychosocial stability, good health, reduced gender-based violence and continuity in education. It is evident from the findings that in FGC practicing communities such as the study area, behavior of individuals is a dynamic balance of forces working in opposite directions while driving forces facilitate change as they push entities in the preferred track. Confining forces obstruct change since they drive individuals in the conflicting direction in which case, in this study, this group represents those opposed to the eradication of FGC among the Gusii community in Western Kenya. In Lewin's view, the first step of this process of behavior change is unfreezing the existing state this is the status quo often viewed as the state of equilibrium.

1.11 Operational Definition of Terms

Psychosocial:

Described as the intersection and interaction of social, cultural and environmental influences on the mind and behavior. It is the influence of social factors on an individual's mental health and behavior.

Effectiveness:

A measure of the extent to which a specific intervention, procedure or service when deployed in the field in routine circumstances, does what it is intended to do for a specific population.

Wellbeing:

The feeling of having a clear sense of purpose or meaning in life, as well as excellent mental health, that comes from one's ideas, feelings, deeds, and experiences. It is having a positive, purposeful, wholesome, and socially connected sensation.

Intervention:

An action or series of actions designed to alter a procedure, path of action, or series of occurrences in order to alter one or more of their attributes, such performance or anticipated results.

Place of women:

Primarily recognized as the social, political, economic, cultural and religious spheres of women where they possess efficient skills and abilities, so they are able to render their participation in an effectual manner.

Household:

A social unit of people who live together under one roof related either by blood or non-blood and share resources.

Female Genital Mutilation/Cutting:

The World Health Organization (WHO) and the United Nations (UN) define FGM/C as "any partial or total removal of the external female genitalia or any other injury of the female genital organs for nonmedical reasons." The United

States also uses this definition in its efforts to end the practice. FGM/C is sometimes called "female circumcision." Also referred to as Female genital cutting (FGC) or Female genital mutilation (FGM).

Local Construals

Perceptions, Comprehension and Interpretation of the world around one

Girl child

A biological human female offspring from birth to eighteen years of age.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter comprises of sections reviewing previous studies on FGC in order to conceptualize the problem under study. These include the history of FGC in the world, FGC in the African context, FGC in the colonial era as well as sections on the various objectives of the study. Literature review is essential since it acquaints the researcher with information on previously conducted studies thus highlighting the methodologies that have been used and how successful they may have been. Further, the chapter also critically analyses literature in line with the objectives of the study in regard to interventions and their effectiveness in abandonment of FGC.

2.2 The History of Female Genital Cutting in the World

Geographically speaking, FGC appears to have evolved along the west coast from the Red Sea, however it is thought to have begun in Egypt in the fifth century BC. While existing evidence points to the year 25 B.C. for the origin of FGC, other researchers speculate that the practice may have begun when black women were brought into ancient Arab communities as slaves (Lightfoot-Klein, 1989; Ahinkorah et al., 2022). Egyptian mummies show women infibulated as shown by a Greek papyrus in the British Museum dated 163 BC. Female genital mutilation (FGM), also known as female genital cutting (FGC) and female circumcision (Oino & Towett, 2016; Ahmadu & Kamau, 2022), is the ceremonial cutting or removal of some or all of the external female genitalia (WHO, 2016). The practice is primarily observed amongst immigrant members of communities from places where female genital mutilation (FGM) is endemic in Africa, certain regions of Asia and the Middle East, and even some European countries (Jasmine, 2019). From its inception, FGC has been practiced with the intention of controlling women's sexual

behavior. Reconstruction and genital cutting are age-old, well accepted practices. In this regard, it is known that numerous traditional methods of restricting female sexuality have been used in many different parts of the world. It was rumoured that the Romans would immediately put rings through their female slaves' labia majora to prevent pregnancy (El Sadaawi, 1980). It has been reported that an approximate of 70 million girls aged 0-14 years have been cut or may be at risk of being cut (Shell- Duncan, Naik, and Feldman-Jacobs, 2016) with an annual, approximation of 3.6 million girls being at risk of FGC. Alarmingly, the statistics are feared to rise to 4.1 million by 2050 (UNICEF, 2014).

The practice of FGC has become an issue of concern not only to the modern African societies, but the world at large. It is worth noting that the prevalence still remains significantly high in girls and women between the ages of 15 – 49 years in most countries across the continent with Somalia being at the top (98%), followed by Guinea (95%), Djibouti (94%), Mali (89%), Egypt (87%), Sudan (87%), Sierra Leone (86%), Eritrea (83%), Burkina Faso (76%), and Gambia (76%) all in the top ten worldwide; Kenya ranks 20th with a prevalence of 21% (UNICEF, 2020).

As a result of awareness and educational campaigns on the negative consequences of FGC and its harmful effects, there has been a tendency of medicalization of the practice. Consequently, there has been a trend to cut younger girls between the ages of 0 – 14 years with countries such as Mali (73%), Gambia (51%), Mauritania (51%), Indonesia (49%) and Djibouti (43%) being the leading five countries according to the UNICEF (2020) country profile. Though the national prevalence of medicalization in Kenya is at 3%, it is worth noting that for the practicing communities this prevalence is fairly high. However, though medicalization may have improved the condition under which FGC is practiced it has essentially contributed to the unprofessional conduct of medical practitioners within the health sector.

A discernible shift in prevalence has also been observed between the proportion of women aged 15–49 who have had FGC and the proportion of women aged 15–49 who have at least one daughter who has had FGC, indicating a shift in the generational trend towards discontinuing the practice (UNICEF, 2022). This is especially credible in nations where more than 75% of women have undergone FGC. FGC transcends all social and religious boundaries, which include those of the Christian, Muslim, Jewish, and Indigenous societies, claims Althus (2017). The FGC qualifying age varies per African nation, ranging from a woman who is seven months pregnant in Nigeria to an infant in Eritrea, Ethiopia, and Mali. According to a recent study conducted in the Mandera District of Northern Kenya and Awdal, Somalia, the age range for circumcision is 5-8 years (Gilbertson, 2019).

The widespread practice of female genital cutting in many Kenyan communities has been deemed detrimental because to the potential for undue danger to the health and wellbeing of the women and girls who undergo it (WHO, 2018). Along sociodemographic lines, the prevalence of FGC varies as well, with ethnicity having the most notable correlation. National prevalence data from successive waves of surveys show a steady decrease in the prevalence of FGC among women aged 15-49, declining from 38% in 1998 to 21% in 2014. In this data, only Eastern (from 35.8 % in 2008/9 to 26.4% in 2014), Central (26.5% in 2008/9 to 16.5% in 2014) and Nairobi (13.8% in 2008/9 to 8.0% in 2014) have demonstrated a notable decline in the FGC prevalence. (KDHS, 2014)

Research by Shell-Duncan, Gathara and Moore (2017) further showed the prevalence across a 5-year age cohorts on a steady decline in rates of FGC that began in the early 1980’s. The decline has not occurred evenly among women from all ethnic groups. Rates of FGC remain very high among ethnic Somali women. Rates of FGC are high in older

cohorts of Maasai and Gisii women, but appear to be declining among younger cohorts of women. Other ethnic groups have had long-term steady declines in FGC.

Shell-Duncan, Gathara, and Moore (2017) did a survey on the trends of FGC in Kenya over a period of time and established that, the estimated prevalence of FGC among women aged 15-49 is 21%. The prevalence varied substantially by province, with the highest prevalence in North Eastern Province (98%) and lowest in Western Province (1%). The findings show that 72% of Kenyan women living with FGC reside in three regions: North Eastern, Rift Valley, and Nyanza. The prevalence in North Eastern remains at 97. 5%, while that of Nyanza was at 32.4%; it should, however, be noted that within Nyanza province only two communities, namely the Gusii and Kuria communities practice FGC, hence the statistics are rather high among the practicing communities.

The prevalence of FGC has been known to vary along socio-demographic lines, particularly in relation to ethnicity. National prevalence data from successive waves of surveys show a steady decrease in the prevalence of FGC among women aged 15-49, declining from 38% in 1998 to 21% in 2014. In this case, only Eastern province (from 35.8 % in 2008/9 to 26.4% in 2014), Central province (26.5% in 2008/9 to 16.5% in 2014) and Nairobi province (13.8% in 2008/9 to 8.0% in 2014) have demonstrated a notable decline in the FGC prevalence (KDHS, 2014).

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lower in the youngest cohort of women (aged 15-19) in four ethnic groups: Kalenjin, Kamba, Kikuyu and Taita/Taveta. Other changes over time include a trend toward younger age cutting; with 46% of girls being cut between the ages of 5 -9 years old and 43% between 10 – 14 years old, furthermore, the trend of medicalization is on the rise with 20% of respondents citing medical personnel as the person who cut them/their daughter (UNICEF, 2020). To complement this statistical research there was need to conduct a study on the interventions and their effectiveness in regard to abandonment of FGC among the Gusii community of Western Kenya.

The Kenya Demographic Health Survey (KDHS, 2022) reported a national prevalence of 15% with the proportion of circumcised women increasing by age, from 9% percent among women aged 15-19 to 23% percent among those aged 45-49. It is worth noting that whereas KDHS (2022) reports a new trend of cutting children below the age of 4 years recorded at ≤ 1%, UNICEF (2020) reports the rate at 3%. Similarly, while KDHS reports 5 - 9 years at 1%, UNICEF reports the percentage of the same age at 46% and 10 -14 years old being reported at 4% KDHS with UNICEF reporting 43%. This variation in figures could be attributed to the methodology used to collect data or the difference in duration when the studies were conducted bearing in mind that COVID 19 was a period in which many young girls were exposed to this harmful traditional practice.

The study also established that a higher proportion of rural women (18%) compared to urban women (10%) have been circumcised. The prevalence of women between the age of 15 – 49 who had been circumcised was reported by county with Wajir county (97%), followed closely by Mandera (97%), Garissa (83%), Marsabit (83%), Nyandarua (82%), with Kisii county coming in as the sixth rank with 77%. In this regard, bearing in mind that most women in the urban areas are more educated than those in the rural setup, the findings revealed that 56% of women who had no education were more likely to have

their children undergo the cut in comparison to 18 % who had primary education and only 6% with more that secondary education. This is an indication that level of education does influence the abandonment of FGC.

In regard to the type of cut, particularly among 0 – 14 year olds, the latest trend seems to show a preference of girls not sewn (90%) against sewn (9%) an implication that most communities are now avoiding the Type III cut due to its adverse effects and opting for the lesser harmful one, Type I.

In addition, it is noted that medicalization is in the increase with 17% of women aged between 15 - 49 undergoing the cut in the hands of a medical professional. Children between 0 – 14 had 14% of them taken to a medical professional too. This does not mean then that traditional practitioners are unpopular anymore; on the contrary, 86% of children were still taken to the traditional practitioner as reported by the KDHS (2022).

FGC is seen as a customary practice that incorporates cultural and patriarchal social norms, according to Hellensten (2004). FGC is a deeply ingrained cultural practice that dates back centuries and is connected to a girl's social transition from girl to woman (Kaplan et al., 2013). In the past, initiates were taught about the religious and social wealth of their communities, in addition to the roles and responsibilities of girls, women, and mothers and wives, establishing entrenched gender disparities among the sexes. They would also undergo a public ceremony as a transition from childhood to adulthood. This rite of passage differs from modern times in that it is not carried out in secret. One of the biggest challenges in curbing FGC is that it is rooted in cultural practices of a number of ethnic groups. FIDA (2009) in a study conducted in Samburu & Garissa noted that cultural concerns and religious beliefs were deeply entrenched in thoughts, perceptions and actions of communities in this region. As a cultural practice, cutting of the female

genitalia for non-medical reason is a harmful phenomenon, especially when the society believes that it is the entry point of transition for the girls to womanhood.

In their study on FGM and ethnic issues, Elsayed et al. (2011) confirm that the justification for FGM appears to be grounded in the social desire of terminating or reducing feelings of sexual arousal in women so as to reduce their chances of engaging in pre-marital sexual relationships or adultery. In their findings, the scholars found out that, practicing communities in Sudan refer to FGM/C as “tahara”, meaning purity or chastity. FGM/C, thus, is viewed as a social practice, hence those who practice it are highly valued. They view the practice as right because each individual person in the society would like his / her girl to undergo circumcision for purification. In this context, then, circumcision is morally right. Although religion, aesthetics and social culture have been identified as features that contribute to the practice, FGC remains primarily a cultural rather than a religious practice, occurring across different religious groups.

Oloo et al. (2011) acknowledge that FGC is not sanctioned by any religious texts. Though in some communities, religious interpretations have been used to justify the practice, even with UNICEF (2020) reporting Muslim religion at 51%, Catholic at 22%, other Christians 18%, other and no religion 33%, research has demystified the assumption of FGM being instigated by religion.

Just as Njue and Askew (2004) found out in regard to the Kisii in Nyanza Province, FGC is an important rite of passage from girlhood to a respected woman since a circumcised woman was considered mature, obedient and aware of her role in the family, and in the society, Matanda et. al. (2022) also observe that upholding of the culture and traditions is one characteristic that is highly valued in this community. Furthermore, cultural obligation prescribed FGC as a sense of identity and respect, as well as a means of acceptance by family and peers. A study by Khaja et al. (2009) on FGC among the

Somali indicates that most female participants believed that their parents had them undergo FGC because it was an integral part of the Somali culture; a way of showing that a daughter was honorable and chaste. In this study, the respondents were in agreement that all forms of FGC should be banned; though, they expressed anger at the use of the term “Mutilation”, which they felt was degrading and insulting hence in their view, it implies that the westerners regarded them as flawed and uncivilized. In the aforesaid study, the participants reported that unlike other FGC practicing communities, they had come out openly and talked about it. In their view, FGC was a practice they were not proud of but were trying to fight it albeit the resistance. As a matter of fact, the KDHS (2022) report indicated 94% of women and 92% of men did not support the continuation of FGC, similarly, UNICEF (2020) reported 92% women against 89% men who feel this practice should stop. This show of goodwill from both men and women can be a step in the right direction. It may also be an implication that the various interventions by the stakeholders, led by the state and no state actors are bearing fruit.

Some of the most effective interventions in regard to change of attitude towards FGC have been the community-led interventions that have served to educate the people about both the physical and psychosocial wellbeing of girls and women thus portraying it as an assault on their fundamental right to bodily integrity (Matanda et. al. 2023). This however is not enough as the change is not commensurate to the effort put, therefore there is need for more investigation on the interventions that have so far been used and the influence they have on the psychosocial wellbeing of the girl child.

2.3 Local Construal of Female Genital Cutting and the Girl Child’s Psychosocial Wellbeing

The term self-construal was coined by Markus and Kitayama (2001), in reference to how individuals perceive themselves in relation to others, principally the level of

connectedness with and distinctiveness from others, within their cultural context and assumptions. The explanation given by these two scholars in regard to social relations in terms of differing modalities of sense of self is what they refer to as independent and interdependent construal. The APA dictionary of Psychology (2023) defines construal as a person's perception and interpretation of attributes and behavior of the self or of others. Paluck and Shafir (2016) have also described a construal, as the act of interpreting and attaching subjective meaning to forces such as one's peers, leaders or group identities. The interconnectedness of an individual's perceptions with that of the community from which one associates is therefore the guiding principle of one's thoughts, interpretations and comprehension hence the coinage of the term local construals in this study. In this light, different members of a community and cultures have varied reasons for practicing FGM/C; the reasons are often complex and can change over time (UNICEF, 2013). Social acceptability is the most common reason. Among the communities that practice FGC in Kenya, for example, this procedure is a highly valued and traditional ritual, whose purpose marks the transition from childhood to womanhood.

According to Khaja, Barkdull, Augustine and Cunningham (2009) this practice illustrates that a daughter is honorable and chaste among the Somali culture. Whereas Jaldesa, Askew, Njue and Wanjiru (2005) and Elsayed, Elamin and Sulaiman (2011) highlight the justification for this practice as including tradition, prevention of immorality, better marriage prospects and preservation virginity. In another study where the researchers conducted a systematic review and synthesis of national, regional as well as community based studies of different articles in regard to the factors associated with FGM (El-Dirani, 2022), out of the 2230 studies that were identified, 54 published articles were included. In this study, a majority of respondents were from the African Region (n=29) followed by the Eastern Mediterranean Region (n=18). The findings revealed that lower level of

maternal education, family history of FGC, or belonging to the Muslim religion were some of the reasons for participating in the cut.

The pressure from family and peers is considered a significant enabler of the practice. Extended families and parents particularly mothers, aunties, grandmother and mother-in-law who remain traditional in their views around the importance of FGC more often than not are most likely to still engage in the practice. Furthermore, if some of the children in the family have been circumcised, parents may feel all children should be treated equally and therefore undergo circumcision. If a girl chooses to get circumcised, not her dad either will ever know. This is true for the Samburu communities, Kajiado County, and the Maasai communities near Loitokitok and Magadi (Kiage et al., 2014). According to reports from the Kenya National Bureau of Statistics [KNBS] (2015), the percentage of Maasai and Samburu women in Kenya whom have undergone female genital mutilation as well as cutting (FGC) is approximately 78% and 86%, respectively.

Oloo, Wanjiru and Jones (2009) carried out a study on FGC practices in Kenya. The study employed the use of a qualitative approach, exploring attitudes and social practices. The purpose of the study was to understand the factors which influence decision-making in relation to FGC. Focus group discussions (FGDs) and key informant interviews (KIIs) using semi-structured questions were conducted with selected respondents. The study found out that the main reasons for FGC among the Abagusii community are; upholding the culture, preserving sexual morality and social pressure: an uncircumcised girl is mocked by her peers and often referred to as “egesagane” (a derogatory term used to refer to an uncircumcised girl). Similarly, Omigbodun et. al. (2022) conducted a study to understand the psychological experience of girls in the urban and rural communities of Izzi in Southeast Nigeria, the findings revealed that during the period of adolescence, Izzi young women who had not undergone FGM reported being subjected to extreme social

stigma, humiliation as well as rejection by their peers out of this humiliation, unbelievably, young girls who opted to undergo the cut were not shy to admit that they looked forward to trolling and stigmatizing the uncircumcised girls, thereby engaging in a complex habitus that underscores their severe trauma as well as their newly acquired social status.

Furthermore, there is change of patterns and general downward trend on levels of FGC according to the findings of recent studies; there is preference of medical staff to perform FGC (medicalization); which in Kenya is more popular in Kisii county than other counties such as Narok (Matanda et al, 2022; KDHS, 2022), lowering the age of the cut from 14 and above to between 0 – 14 years of age and shifting to Alternative Rites of Passage (ARP).

Other changes that have been witnessed in these practicing communities include change from FGC being conducted in public to a highly secretive event, with girls either being taken to their grandmothers where they would then undergo the cut in the wee hours of the morning to avoid being noticed or the girl being fled to the neighbouring country, Tanzania; conducting the cut in secrecy without any public ceremony for fear of being arrested; whereas some of the changing trends include conducting FGC at a hospital or relocating girls due for cutting away from their homes to maintain secrecy (Matanda et.al., 2022).

According to research, this change has been ascribed to established laws, the expanding power of the church, parents learning about the dangers of FGC and its illegality, as well as their exposure to many cultures. People in the community are starting to reassess their values and beliefs as a result of this. Education and being exposed to new information regarding the health dangers and unlawful status of FGC is another aspect that keeps coming up. This has been particularly apparent in cities, and it has caused some Gusii

community members to rethink their position on FGC. Most projects to end FGC have targeted young girls through schools, informing them of the risks to their health and the illegality of the practice while also giving them the power to refuse circumcision (Matanda et al., 2022).

Previous studies on practicing communities, posit FGC as a manifestation of gender inequality that is deeply entrenched in social, economic and political structures. Just like the now- abandoned Chinese foot-binding, as well as the practice of dowry and child marriage, female genital mutilation is a representation of society's control over women. Practices such as these have the effect of propagating normative gender roles which portend inequality and harm towards women. Analysis on international health data showed a close relationship between women's belief that female genital cutting should be terminated and the ability to exercise control over their lives (UNICEF, 2005).

Wherever female genital cutting is common, men and women support it with no question, and anyone who deviates from the norm risks harassment, rejection, and contempt. Therefore, in this sense, FGC is a social norm controlled by incentives and penalties that serve as powerful drivers for the practice's continuation. Given the customary character of FGC, it might be challenging for families to stop the practice without the community's backing. In actuality, the cut is frequently performed even in cases when it is known to cause harm to girls since the societal benefits of forced pregnancy termination are thought to outweigh the risks (UNICEF, 2005). When it comes to female genital cutting, extended family members—especially women—usually participate in the decision-making process the most.

According to Ellenborg (2004), female genital cutting is crucial to raise girls properly so they are ready for adulthood and marriage. According to some practicing societies, the cut is a necessary step for girls to become mature, responsible adults because it is based

in coming-of-age rites that occasionally get them ready to join women's secret societies (Johnson, 2007). Girls may want to have the surgery because they feel pressure from their classmates to follow the custom, or because they fear rejection and stigma from their communities if they don't. Moreover, in certain communities, girls who get the surgery receive prizes including presents, parties, and public acknowledgment (Behrendt, 2005). Female genital cutting has therefore become an essential component of women's and girls' cultural identities in societies where it is commonly practiced; as a result, it may instill a sense of pride, community belonging, and maturation.

It's a common misconception that males will only wed women who have made the cut. The practice may continue because of the desire for a proper marriage, which often aspires to fulfil local notions of gender and femininity as well as social, economic, and stability. Several additional defences of female genital cutting are also strongly tied to girls' suitability for marriage and frequently centre around the qualities that are considered essential for a woman to be considered a "suitable" wife. Occasionally, people hold the misconception that the practice guarantees and maintains a woman's or girl's virginity (Gruenbaum, 2006). It is believed to suppress sexual cravings in some cultures, protecting marital integrity and averting actions deemed immoral or abnormal in terms of sexuality (Hernlund, 2003; Gruenbaum, 2006).

Another belief is female genital cutting makes girls appear "clean" and more appealing. Eliminating "masculine" features like the clitoris is seen to eliminate them (Talle, 1993; Ahmadu, 2000; Johansen, 2007). In cases where indubitation is involved, smoothness that is deemed lovely can be achieved (Talle, 1993; Gruenbaum, 2006). Women have occasionally said that they think males have more enjoyment from sex when they mutilate their female genitalia (Almroth-Berggren et al., 2001). Furthermore, religious beliefs may support the practice in many societies (Budiharsana, 2004; Dellenborg, 2004;

Gruenbaum, 2006; Clarence-Smith, 2007; Abdi, 2007; Johnson, 2007). Despite the fact that FGC is practiced by Christians, Jews, and Muslims, it appears that none of these religions truly support the practice, despite claims made by many of the communities involved (WHO & UNFPA, 2006).

Paradoxically, religious leaders play a variety of responsibilities as well. While some religious authorities genuinely support and take part in efforts to eradicate the practice, those who support the cut typically either see it as a religious act or see attempts to stop FGC as a threat to culture and religion (FIDA, 2009). Religious leaders run the risk of appearing to support female genital cutting if they remain ambiguous or sidestep the subject. Female genital cutting is a practice that is frequently encouraged by local power and authority structures, including elders, religious leaders, traditional leaders, circumcisers, and even certain medical professionals. It appears that more medical professionals are performing female genital mutilation.

In many countries, elder women who have experienced self-mutilation take on the role of cultural guardians, ensuring that the practice is understood as fundamental to the identity of women and girls. Toubia & Sharief, 2003; Draege, 2007; Johnson, 2007). This is probably one of the reasons why women, especially older women, are more likely to embrace FGC and tend to view efforts to oppose the practice as an attack on their cultural identity. It's important to remember that these same actors may be crucial in ending the practice. Sometimes, new groups and places acquire female genital cutting as a result of migration and displacement (Abusharaf, 2005, 2007). As a result, nearby groups have encouraged other communities to embrace the practice; occasionally, this has been prompted by religious or traditional revival activities (Leonard, 2000; Dellenborg, 2004

The preservation of ethnic identity is often marked as a distinction from other, non-practicing groups which might also be important, particularly in periods of intensive

social change. For instance, female genital cutting is practiced by immigrant communities living in countries that have no tradition of the practice (Johnson, 2007). The cut is also occasionally performed on women and their children from non-practicing groups when they marry into groups in which female genital cutting is extensively practiced (Shell-Duncan & Hernlund, 2006).

A wide range of individuals who may have differing opinions and degrees of influence are involved in the crucial decisions for performing female genital cutting on girls (Draege, 2007). The practice of re-infibulation by adult women is comparable (Berggren et al., 2006). Female genital cutting can cause debates and arguments during transitional periods, and in certain instances, certain family members have organized the process while others have not (Draege, 2007). Furthermore, opinions and viewpoints can change through time for both people and societies (Shell-Duncan & Hernlund, 2006). Since decision-making is difficult and usually ensures that families desiring to discontinue the practice make and uphold their decision in order to preserve girls' rights, a sizable number of people must agree to end the practice.

Pastor-Bravo, Almansa-Matinez, and Jimenez-Luize (2022) used a qualitative exploratory research design that uses the method of life stories through an open interview to find out the factors that support the continuation of FGM/C and those that promote the change of attitudes and fight against FGM/C from the perspective of the sub-Saharan women themselves residing in Spain. 24 women, including one participant from Kenya, who lived in the Region of Murcia, Spain, participated in this study. These women were from sub-Saharan nations where female genital mutilation is a regular practice. The results showed that family pressure and ignorance were among the arguments in favour of FGC, while knowledge of the health risks and personal bad experiences were the main drivers of the shift in attitudes that could lead most interviewees to oppose the practice.

Moreover, increasing awareness of one's rights and supportive laws were essential components of any programme designed to counter FGC. Learning about the health hazards and incorporating this kind of practice on women's bodies was a positive first step towards the abolition of the cut. In light of this, knowledge and information regarding the justifications for FGC continued to be one of the main drivers of this development. Accordingly, the study suggested that health education initiatives that aim to stop harmful customs for women's health are essential for influencing public opinion. These programs would not only include information on health risks but also policies focused on the empowerment of women, girls and the community to promote non-violent and gender-sensitive behaviours adapted to the socio-cultural and economic conditions of each case and to meet the particular and community needs of the affected groups (Pastor-Bravo et al., 2022).

2.3.1 Female Genital Cutting Effects on Girl Child Psychosocial Wellbeing

The WHO (2010) categorizes FGC into four kinds:

Type I (Clitoridectomy)	The partial or entire removal of the clitoris and/or the prepuce.
Type II (Excision)	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.
Type III (Infibulation)	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris.
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

Different ethnic groups in Kenya regularly practice all four forms of FGC operations, with each group specialising in a certain style. The Kisii, Kapsigis, and Nandi ethnic groups are reported to practice type 1 (clitoridectomy), the Sebei population of Mount Elgon practices type 2 (excision), and the Pokot, Marakwet, Somalis, and other communities in northern Kenya practice type 3 (infibulation). According to the Setat Women Group Report (2010), infibulation is the most severe type of female genital cutting, although excision is the type of circumcision that is performed most frequently.

Certain religious leaders have publicly criticised the practice of female genital cutting and have worked to put an end to it worldwide. Moreover, the conduct is prohibited by law in practically every country in Europe as well as many other nations where the practice is common. Observe that numerous national and international campaigns and initiatives against female genital mutilation have been carried out in Europe and Africa (UNFPA, 2009).

The size of the operation, the tools used, the circumciser's expertise, and other factors both during and after the procedure all affect the potential problems and consequences of FGC. The World Health Organisation (2011) reports that the most frequent short-term

effects of FGC are excruciating pain, shock brought on by discomfort and/or heavy bleeding (haemorrhage), problems urinating and defecating due to swelling, oedema, and pain, and infections. Haemorrhage or infections, such as tetanus and shock, can result in death. A research from a nation where Type I and II FGC is used, in which 600 women were asked about the issues their daughters had following Type I and II FGC, found a 2.3% fatality rate (7).

FGC is linked to a higher risk of problems during labour for both the mother and the child, according to a 2011 WHO research. Women with FGC had higher rates of caesarean sections (29% increase for Type II and 31% rise for Type III FGC) and postpartum haemorrhage (21% for Type II and 69% for Type III) than women without FGC. Furthermore, there was a higher likelihood of tearing and recurrence as a result of episiotomies, and the risk of a delivery complication rose as the severity of FGC grew. Long-term consequences of FGC include infibulation cysts, keloid scar formation, and damage to the urethra resulting in urinary incontinence, pain during sexual intercourse, sexual dysfunction, difficult childbirth and difficult menstrual periods (UNICEF et al. 2001). If the operation is conducted in unhygienic surroundings and/or using shared instruments, the victims are exposed to deadly infections like tetanus and HIV/AIDS. Moreover, FGC affects the psychological and physical health of girls and women thereby decreasing the attendance and performance of girls at school, including exposing them to risks such as early pregnancy, early marriages, HIV/AIDS and later complications in child birth, as women (Elnashar &Abdelhady, 2007; 28 Too many, 2013).

In a similar way, WHO (2006) notes that the female circumcision of the mother is also a risk factor for the infant. The study found significantly higher death rates (including stillbirths) among infants born from mothers who have undergone FGC than those that did not. There was a 15% increase for Type I FGC, 32% increase for Type II FGC and

55% increase for Type III FGC. Research has shown that sexual problems are also more common among women who have undergone FGC. Women victims of FGC were found to be 1.5 times more likely to experience pain and less satisfaction during sexual intercourse, and that they were twice as likely to report that they did not experience sexual desire (Berg et al., 2010). This is in addition to psychological consequences of FGC such as anxiety, horror, Post Traumatic Stress Disorders (PTSD) and depression.

In their study on university students' perception, knowledge, and beliefs towards FGC in Sudan Sabeeb and Hatamleh (2016) found out that a vast majority of participants were aware of the complications of FGC with 74% of the women having undergone the cut. 85.7% of the male students preferred to marry uncircumcised women over circumcised ones, while 72.7% females and 75% males supported the non-continuation of FGC. Thus, substantial effort should be made to raise awareness within the community and action taken against perpetrators of the practice. Considering the multiple reasons that support and motivate its practice, government and stakeholders were required to state clear guidelines to end the practice. Sabeeb and Hatamleh (2016) concluded that FGC is undeniably a violation of children and women's rights, but laws in most countries were poorly enforced, thus effort needed to be directed towards integrating appropriate information on FGC literacy classes and other public awareness programs, among other actions against FGC, as a deeply rooted cultural practice, with a multiplicity of justifications; awareness campaigns should therefore include topics on human and children rights violations, and be supported by law. The perpetrators should also be punished by imprisonment, payment of fines or loss of work license for professionals.

2.4 Place of Women in Implementation of anti FGC Interventions

Agenda 2063 a framenwork document highlighting the target aimed at being achieved in African states by 2063 states that it is important to recognize that in many African

societies, positive virtues exist side by side with some harmful social practices. This is particularly evident in practices that limit or restrict the rights of women to inheritance, access to land and other productive resources, social practices such as female genital mutilation and early child marriages. In this regard, while African culture, heritage, values and ethics are a source of strength and cause for celebration, certain harmful social practices need to be done away with in the march towards the Africa we want by 2063. In particular, Aspiration 6.1.2 highlights violence and discrimination against women with the target to end all harmful social norms and customary practices against women and girls and those that promote violence and discrimination against women and girls by 2025. Women in the African traditional society have been known to be the custodians of culture, it is no surprise that the very victims of FGC are also the perpetrators. Thus, in order to eliminate the practice of FGC, it only in order that women are placed at the center of its abandonment campaign.

In Kisii, marriageability emerged as a common theme from discussions across all groups in a study by Matanda et. al. (2022) but more so among younger men and women. Both younger men and women were of the view that undergoing the cut was a sign of readiness for marriage, which would result to early marriage, thus the desire to have their daughters married would have a mother subject her daughter to the cut. There were divergent views among younger men as to whether female genital mutilation was considered a prerequisite for marriage, with some observing that a “true” Kisii man cannot accept to marry an uncut woman. In contrast, other younger men observed that the belief that a Kisii man cannot marry an uncut woman has been overtaken by events as currently men are accepting to marry uncut women. Notably, there was consensus across all groups that it was currently acceptable to marry an uncut woman.

A study conducted in Sierra Leone on women's empowerment and FGC intention for daughters sampled a total of 7,706 women between the ages of 15 and 49. Analysis entailed generation of descriptive statistics (frequencies and percentages), and estimation of multi-level logistic regression models to examine the association between women's empowerment, contextual factors and their intentions to cut their daughters. (Ameyaw et al., 2021). Findings indicated that a significantly higher proportion of women who participated in labour force reported that they intended to cut their daughters compared to those who did not (91.2%, and 86.0%, respectively). A significantly higher proportion of women with low decision-making power intended to cut their daughters compared to those with high decision-making power (91.0%, and 85.0% respectively).

Another study by Dirani et al. (2022) conducted a review on factors related to FGM/C. The findings identified lower parental education, religion, rural residence, and family history of FGM/C as some of the factors that are associated with the practice. Disrupting the intergenerational trauma of FGM/C through education, advocacy, and changing social norms may be potential pathways to eliminating FGM/C. Gender equality, improving women's status in society, and education of girls are cross-cutting Sustainable Development Goals that will improve the health and well-being of women globally They established that approaching women's status in society holistically is vital to tackling harmful practices against women.

In a study by Farina et al. (2022) having experienced FGM/C is another significant variable, indicating that familiar normative behavior affects the empowerment process. Hence, choosing to support FGM/C could be a natural consequence of being a woman belonging to this family without discussing possible alternatives, which may be unknown the importance of the link between FGM/C support and empowerment, with major roles played by education, personal experience with FGM/C, and justification of IPV. The

three dimensions describe different levels of empowerment, reflecting existing social and gender norms that act upon resources and agency and are internalized by individual women.

Consequently, these dimensions represent the main policy-making priorities: enforcing educational opportunities, changing family and community norms, and promoting gender equity in family relationships. This study confirmed that the relationship between empowerment and support for the continuation of FGM/C is relevant, complex, and deserving of further investigation. The results indicated that the justification of gender-specific violence by the woman, the women's level of education and the FGM/C personal experience are essential components of empowerment, in other words, women who do not justify gender violence or who justify less, or that are more educated or with no FGM/C are indeed more empowered and tend to not support FGM/C continuation. Autonomy in decision-making is also a dimension correlated with FGM/C support. These variables represent crucial components of the women's empowerment process and indicate to policymakers and social agents where their first actions should take place.

According to Ameyaw et al. (2021) the findings of their study underscore the need to align anti-FGM/C policies and programmes to women who have undergone FGM/C, those with low knowledge, such interventions could highlight the adverse implications of the practice by stressing the psychological, health and social implications of FGM/C on its survivors. In their study, Ameyaw et.al (2021) underscore the need for a review of existing policies and programmes to refocus on women who have undergone the practice, those with low knowledge, those who support wife beating and young women. Such interventions should highlight the adverse implications of the practice by stressing the psychological, health and social implications of FGM/C on its survivors. FGM/C is

prevalent in 30 countries in Africa and several countries in Asia and the Middle East (UNICEF). (2013).

There have also been reports of this practice among some South American and Central American ethnic groups. The number of girls and women who have experienced or may endure the practice has surged in Europe, the US, Australia, and Canada due to the rise in international migration. According to reports, Somalia (98%), Guinea (97%), and Djibouti (93%) have the highest rates of FGM/C among women and girls aged 15 to 49 (Goldberg, & Stupp, 2016). The countries of Gambia (56%), Mauritania (54%), and Indonesia (~50%) have the highest rates of FGM/C among girls under the age of 14 (WHO, 2016). However, the number of impacted women and girls will probably rise by 2030 due to the general drop in FGM/C rates against high rates of population explosion in practising countries (UNICEF, 2013). It is estimated that more than 200 million girls and women worldwide are living with the effects of FGM/C and that every year approximately 3.6 million girls and women are at risk of FGM/C (UNICEF, 2016).

Article 5(A) of the 1979 Convention on the Elimination of Discrimination Against Women (CEDAW), also known as the Maputo Protocol, mandates that all State Parties take all necessary steps to alter men's and women's social and cultural patterns of conduct in order to eradicate prejudices and customs that are based on the idea that one sex is superior to the other or that there are stereotyped roles for men and women. In addition to defining discrimination against women, CEDAW (1979) provides a framework for taking action against it.

A cross-sectional design with a comprehensive pre-tested questionnaire seeking the thoughts and opinions of 105 respondents was utilised in a study by Sabeeb and Hatamleh (2016) on university students' perceptions, knowledge, and beliefs regarding FGC in Sudan. There were 28 male and 77 female students in the sample. The results

showed that 74% of the women had had the cut, and the great majority of those surveyed were aware of the risks associated with FGC. While 72.7% of female students and 75% of male students supported ending FGC, 85.7% of male students said they would rather marry an uncircumcised woman than a circumcised one. As a result, significant efforts should be undertaken to increase community awareness of the practice and to pursue legal action against those who engage in it. Given the various factors that encourage and justify the practice, the government and interested parties have to establish explicit regulations to put an end to FGC. Sabeeb and Hatamleh (2016) concluded that FGC is a violation of children and women's rights but laws in most countries were poorly enforced, thus effort needed to be directed towards integrating appropriate information on FGC literacy classes and other public awareness programs, any action against FGC, due to the deeply rooted cultural practice, should take into account the multiplicity of reasons that support and motivate its practice, awareness campaigns should include topics on human and children rights violations and should be supported by law. The perpetrators should also be punished by imprisonment, payment of fines or loss of work license for professionals.

De Cao (2015) noted that while understanding attitudes about FGC was important for policy, it was difficult due to the sensitive nature of the subject. She conducted her research using a list of experiments to measure attitudes towards FGC. A list experiment was employed in the study to obtain honest responses regarding Ethiopian supporters of FGC. The best approach to end FGC was to prepare efficient policy interventions and create awareness about the origins and effects of the practice. De Cao used a series of tests in this study with the intention of subtly getting respondents' support for FGC. By identifying whether and which respondents misreport their perceptions, the goal was to ascertain the genuine perceptions on FGC. The study concentrated on a novel set of

experiments intended to gauge public opinion about FGC. Finally, the list experiment was used, where the respondents targeted by a Non-Governmental Organisation (NGO) intervention were more or less likely to misreport their attitudes. Regression techniques developed to analyse the list experiment and social desirability bias were also employed, allowing the determination of the existence and magnitude of systematic reporting measurement error of the true outcome.

The findings of the first experiment showed that educated women supported the FGC practice less than the uneducated women. Secondly, the social desirability bias was the greatest among uneducated women who underreported their true beliefs by 16% (p=.013) whereas women targeted by the NGO intervention had stronger incentives to lie about their FGC support 11% (p= .060). Thus the results seemed to confirm the relevance of potential bias in response to direct sensitive questions and were important to keep in mind when evaluating a programme intervention where the outcome of interest was sensitive and the survey error potentially correlated with the program treatment leading to biased conclusions about the effectiveness of the programme. The two random groups used in this study as the sample were the treatment and control. Respondents in the treatment group were given a list of yes/no, non-sensitive questions along with a sensitive question, while respondents in the control group were given a list of non-sensitive questions. The primary premise of the study was treatment randomization, which meant that the sample was split into treatment and control groups at random. The second was the no design effect, which suggested that the aggregate of the affirmative responses to the control items remained unchanged when sensitive items were added. The study found that, although it was challenging because it was a sensitive subject, assessing attitudes about FGC was essential to determining who to target most. According to the findings, 30% of the women were in favour of FGC when asked directly about the practice. However,

39.2% of respondents agreed with the practice when the issue was posed indirectly because of how sensitive it was. It was also observed that the most important factor in elucidating variations in attitudes was the level of education attained by women. Educated women supported FGC at a lower rate (41%) than less educated women. The uneducated women underreported their attitudes by 16% hence, showing that illiterate women seemed to be less willing to share publicly their real attitudes probably due to the incentives such as better marriage prospects. These findings are similar to the KDHS 2022 report that indicated 56% of women with no education had their daughters subjected to the cut in comparison to only 6% of women with education beyond secondary school. De Cao observed that the NGO intervention may not have changed people's attitude but rather how the respondents report it due to social desirability bias. It was noted that women targeted by NGOs underreported their support for the practice.This is because the NGO campaigns aimed at changing the local FGC customs and this may have increased the social pressure around the practice resulting in stronger incentive to reveal a biased answer.

The aim of Shumu, Zeleke, and Simachew's (2023) study was to identify the variables that contribute to female genital mutilation in children under five. An unmatched case control research design centred in the community was employed in this investigation. Utilising a computer-generated basic random sampling procedure, the study participants were selected. 323 volunteers were enlisted, with a 1:4 ratio between cases and controls. A questionnaire given by the interviewer was used to gather data. Binary logistic regression was used to find the relationship between each independent variable and the dependent variable. In a multivariable analysis, variables were considered statistically significant if they had a P-value of less than 0.05 at a 95% confidence interval. Results indicated that the mothers' circumcision status (AOR = 4.6; 95% CI: 2.29–9.25), mothers

who had an unfavorable attitude (AOR = 4.15; 95% CI: 1.96–8.82), households in the poorest wealth quintile (AOR = 3.65; 95% CI: 1.2–11.54), mothers who had inadequate knowledge (AOR = 3.31; 95% CI: 1.51–7.25) and antenatal care visit of mothers (AOR = 2.46; 95% CI: 1.03–5.83) were established as determinant factors of female genital mutilation. This study concluded that mothers' circumcision status, mother's attitude, wealth quintile, knowledge of mothers, and number of antenatal care visits were factors associated with female genital mutilation. Consequently, regular awareness-building on the impacts of the practice and special attention to the mother's attitude are important to eliminate female genital mutilation (Shumu et. al.,2023).

The primary consideration of "the best interest of the child" is one of the tenets of the Committee on the Rights of the Child (CRC), according to a 2008 WHO report. Some parents decide that the advantages of having their daughters undergo FGM/C outweigh the hazards. This view, however, falls short of explaining a persistent and transformative practice that violates girls' fundamental human rights (Ibid). The convention specifically mentions harmful traditional practices such female genital mutilation. The Committee on the Rights of the Child, as well as other United Nations treaty monitoring bodies, has repeatedly stated that FGM/C is a violation of human rights, hence calling on states parties to take all effective and befitting measures to eradicate the practice (UNICEF, 2013).

FGM/C violates a number of well-established norms, standards and human rights principles, including the principles of equality and non-discrimination on the basis of sex, the right to life (when the procedure results in death), the right to freedom from torture and cruel, inhuman, or degrading treatment or punishment, and the rights of the child. Because it interferes with healthy genital tissue in the absence of medical requirement and can lead to severe consequences on a woman's physical and mental health, FGM/C is

also a violation of a person’s right to the highest attainable standard of health. Although many governments worldwide recognize FGM/C as an act of violence against women and girls and as a violation of human rights, the issue is clouded in debate because the practice is deeply entrenched in culture and tradition, making legislation difficult to approve and enforce. FGM has also been reported to increases economic costs to society and women and that these costs will keep increasing over time so long as FGM persists and this is reason enough to accelerate efforts to abandon this harmful practice (Tordrup, et. al., 2022).

In a study published in 2021, Azadia, Tantetb, Syllaa, and Andro examined women who had undergone FGM/C encounters with French physicians. The researchers in this study also talked to them about the benefits of FGM/C screening and prevention at international travel medical clinics. Data collection and analysis were conducted using a qualitative methodology. Twenty-six women participated in semi-structured interviews and focus groups. Thematic analysis and coding were applied to the transcriptions. Every participant was from Africa's sub-Saharan region. They were 32.9 years old on average. Based on the findings, the participants felt that better public education was necessary to encourage communication between women who have had FGC and medical experts. Additionally, some participants highlighted the school's responsibility in alerting families to the potential effects of FGC. It was said that using posters in health centres to promote the practice's elimination was both essential and advantageous. Consultations regarding travel medicine were viewed as one way to prevent FGC and educate the family about its effects. Women in this study reported having a sense of being heard and listened to when the caregiver adopted such a cultural approach, using words carefully, having an appropriate attitude and respecting cultural traditions such as virginity before marriage, while understanding that some women might find it difficult to undergo a gynecological

examination (Azadia et. al., 2021). This study elucidates the role that women, when provided with appropriate forums and sensitization, play in disseminating information about the harmful effects of FGC. Thus, the purpose of this study was to evaluate the impact of treatments on girls' psychosocial wellness. Examining how women contribute to the cut, a variety of evaluated literature can highlight the disparity that exists and support the study.

2.5 Intervention Measures to Prevent Female Genital Cutting Practices

In Africa, efforts have been made to stop the practice of FGC using a variety of strategies. These strategies include training health workers as change agents, educating and converting circumcisers, using comprehensive social development processes, legal frameworks, health risks, alternative rites, positive deviance, and training and converting human rights frameworks. These strategies have been used to address stakeholders at the individual, interpersonal, community, and national levels through interventions (Muteshi & Sass, 2005).

While legal and political measures are necessary to ending FGM/C, community-based educational initiatives are also critical and have become a key component of campaigns worldwide. Government action is necessary to create a political and legal environment that deters people from practicing FGM/C, but it is ultimately the women, their families, and their communities who must be convinced to abandon the practice (Mahamud et al., 2017).

The findings of a comprehensive study conducted in 2007 by the Population Reference Bureau (PRB) on ongoing intervention initiatives in African nations were released (Feldman-Jacobs & Ryniak, 2007). Twenty-seven of the 92 projects that were found through the survey were reviewed, the majority using observational designs. Out of the

27 projects assessed, only four (15%) employed a controlled before-and-after design. This was not a systematic review, and it did not draw any judgements regarding the efficacy of the interventions, but it did provide insightful knowledge about the variety of interventions started to lower the prevalence of FGM/C.

A systematic analysis of the efficacy of therapies aimed at lowering the prevalence of FGC was carried out in 2009. Every study was a controlled before-and-after study carried out in Senegal, Burkina Faso, Egypt, Ethiopia/Kenya, Mali, and Nigeria. At the time of admission, 6,803 participants were involved in all the research. In these investigations, an intervention and no intervention were compared. The locations varied greatly in terms of prevalence, ethnicity, religion, and educational attainment. Four of the interventions focused on the communal level, while two addressed the individual level. In the first study, which was conducted on an individual basis, health professionals in Mali were given training materials and instructed on the history, customs, and health risks associated with female genital mutilation (FGM). In the other individual-based study, which involved female university students in Egypt, information regarding reproductive health—including FGC—was provided.

Six rural communities in Ethiopia got a virtually identical multimodal, community-based intervention that included mass media activities, theatre performances, community meetings, and video sessions. The multifaceted intervention was implemented in a Somali refugee camp in Kenya. Multimedia and gender equity action plan development were among the many community activities offered in Nigeria at three different community levels (Muteshi et al., 2016). All of these initiatives are intended to stop the practice of FGC in the communities where it is currently practiced. In spite these measures, the rate of decline of the practice is not equivalent to the effort put in place.

In a 2013 study, the Population Reference Bureau examined opinions on methods and tactics for effectively addressing FGC, as well as the gaps and suggestions. The study also examined lessons learned over the previous ten years and future directions for immigrant communities in Europe, the United States, Australia, and Canada. The results showed that there is a need for ongoing focus on ending FGC as well as all-encompassing, holistic strategies that combine community-level mobilisation and awareness-raising with lobbying and training initiatives. A study by Matanda et.al.(2023) aimed to synthesize and assess the quality and strength of existing evidence on interventions designed to prevent or respond to FGM between 2008 and 2020.The study drew on a Rapid Evidence Assessment of the available literature on FGM interventions. Of the 7698 records retrieved, 115 studies met the inclusion criteria. Of the 115 studies, 106 were of high and moderate quality and were included in the final analysis. On the other hand, the study suggested that further research be done about the service level (which includes using rescue centres, training healthcare providers, and enhancing the health system's capability). Regarding safe houses or rescue centres as interventions, which aim to protect and provide a haven for girls who are at risk of female genital mutilation during the cutting period, Matanda et al. (2023) note that the majority of studies included these facilities alongside other interventions, with little data available regarding the evaluation of these facilities as stand-alone interventions. Apart from providing shelter to girls running away from FGM, rescue centres were also said to educate girls on the health risks and illegality of FGM, and its violation of human rights. However, these safe houses faced challenges such as limited resources and lack of recognition and there is therefore limited evidence on their effectiveness, furthermore, with the recent trend of cutting girls below the age of 5years and conducting the cut in top secret, there may not be any clear direction in regard to rescue of girls; however, studies

have shown that rescue centres can provide short-term refuge for girls at risk of FGM and can only be successful if integrated with other interventions to eradicate FGM. This is because rescue centres are limited in providing long-term solutions to ending the practice.

An intervention aimed at empowering communities was initially implemented in Senegal and subsequently duplicated in Burkina Faso. It included instructional sessions on women's health, environmental hygiene, problem solving, and human rights. Changes in knowledge/awareness, intentions, and beliefs/attitudes about FGC were the most often reported project outcomes. Results such as self-reported prevalence, practices including discussing FGC with others, perceptions of spouses' disapproval of FGC, and participants' regrets for getting their daughters cut were less often reported. The effect estimates indicate that: there was a significant increase in multifaceted community activities, which required participants to have favourable knowledge and intentions about family planning; community empowerment through education may have positively affected prevalence of family planning; participants' knowledge about the consequences of family planning and their regrets about having their daughters cut; and training health personnel likely produced no effects in knowledge or beliefs/attitudes about family planning (Berg & Denison, 2012). Formal schooling has also been found to be an effective way to lower the prevalence of FGC among females on an individual basis. It is crucial to remember that it can take several years to see the return of formal schooling in ending FGC. At this stage, it is also important to implement interventions aimed at intermediate objectives, such as raising knowledge and altering attitudes and beliefs regarding FGC (Matanda et al., 2023).

There has been concerted effort by many African countries either individually or as continent union to come up with various legislations to eradicate FGC. In 2003, the Protocol to the African Charter on Human and Peoples' Rights adopted the Rights of

Women in Africa, better known as the Maputo Protocol. This is an important regional instrument that pledges comprehensive rights to women and an end to FGC. Article 5 of the Maputo Protocol, 'Elimination of Harmful Practices', stipulates that: "State Parties shall prohibit and condemn all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognized international standards. States Parties shall take all necessary legislative and other measures to eliminate such practices, including prohibition, through legislative measures backed by sanctions, of all forms of female genital mutilation, cutting, scarification, medicalization and paramedicalization of female genital mutilation/cutting and all other practices in order to eradicate them."

The African Union requested in 2011 that the United Nations General Assembly adopt a resolution during its sixty-sixth session to end the practice of female genital mutilation (FGM) globally. It demanded that Member States coordinate their efforts and offer suggestions and directions for the creation and reinforcement of national laws as well as regional and international legal frameworks. On 20 December 2012, the United Nations General Assembly adopted by consensus a ground breaking resolution that called for universal elimination of the practice of FGC. Sponsored by two thirds of the Member States, including the Group of African States, the text condemns the practice, recognizing it as harmful to women and girls and a serious threat to their health. States were also urged to take "all necessary measures, including enacting and enforcing legislation to prohibit FGC and to protect women and girls from this form of violence, and to end impunity." Kenya's Penal Code outlaws the deliberate infliction of "grievous bodily harm" on any individual while the Children's Act of 2001 prohibits FGC and other harmful practices that "negatively affect" children under 18 (UNFPA, 2012).

Despite the existence of many statutory structures, the practice of cutting remains prevalent in certain communities, like Gusii. Therefore, in order to effectively reduce FGC, it is imperative to do thorough research in the following areas: Recognising the patterns, factors, and drivers of FGC in many contexts. Understanding the procedures involved in putting into practice the many FGC abandonment treatments, evaluating their results, their broader implications on the lives of women and girls, and their sustainability. The advancement of women's sexual and reproductive rights must be a priority. Given the diversity of practising communities, single issue approaches will not end FGC. Instead, community-specific, multifaceted programming that acknowledges the various decision-making patterns and the combined influences of education, the economy, politics, law, religion, and social environments will be better positioned to guide efforts towards the abandonment of FGM and C. Mutesh et al. (2016).

Matanda et al. (2021) revealed that media/social marketing initiatives, mother education—as higher a mother's degree of formal education is associated with a lower likelihood of her daughter undergoing FGM—as well as education of girls were found to result in increased knowledge and shifting attitudes. Legislation supported by political will, together with other interventions like sensitization campaigns and regionally relevant enforcement techniques, are examples of supplementary initiatives. The study also found that establishing FGM-free communities with public declarations can result in FGM abandonment, especially when followed by post-declaration follow-up and public opposition to FGM expressed by religious leaders in conjunction with health care providers' involvement in capacity-building and training. Regretfully, researchers have discovered a number of obstacles with the abandonment process. First and foremost, it is taking a long time for legislation to end female genital mutilation (FGM). Additionally, criminalization of the practice has driven it underground, and efforts to convert or offer

alternative sources of income to traditional practitioners have not been as successful in ending FGM because performing the cut is now seen as a source of income, negating the practice's primary cultural justification. Furthermore, because of the shifting trend of circumcision, alternative rites of passage that centre on the public ceremonial passing of females have not been successful in decreasing or eradicating FGM.In this regard, adequately addressing FGM requires a holistic approach bringing together interventions that are sensitive to the complexity of FGM.

In fact, regardless of how the FGC dispute is resolved, it is unlikely that there will be any worldwide movement to end the practice without a careful consideration and comprehension of the cultural, religious, and ethnic justifications for it. (2008) Cassman. FGC still exists despite significant western assistance, despite some cases of effective elimination. According to Cassman, a just solution is required to avoid health problems among populations that practice and to maintain their subjugation through this gruelling process rather than to force Western values on Easterners. According to Cassman, a comprehensive knowledge of FGC, its origins, and its persistence is still lacking. In order to persuade proponents of FGC that the practice is more detrimental than beneficial, one must comprehend the perception of goodness. Thus, the answer should balance the fact that FGC is a practice that is fundamental to valued heritage, value, and respect, while also being cruel, painful, and barbarous.

According to Abdulcadir, Rodriguez, and Say (2014), there are still a number of gaps in the care of women who have had female genital mutilation (FGM), particularly in developing nations, despite efforts to pass legislation and implement community education programmes, support groups, medical guidelines, new surgical techniques, and specialised multidisciplinary centres. First, they contend that prospective evaluations of obstetric outcomes should take into account factors such as age, socioeconomic level,

past reproductive history, health conditions that may have affected the pregnancy, and educational attainment. Second, it's important to assess the efficacy of treatments like perineal re-education as well as long-term postpartum issues including the frequency of postpartum incontinence. Thirdly, they recommend conducting sexuality research on women who have had female genital mutilation, including clitoral repair, in order to precisely identify suitable control groups and select validated questionnaires to assess various aspects of sexuality, such as orgasm. This study aims to identify current gaps through a variety of stakeholders, offering solutions for the long-term elimination of FGC among communities that practice it.

However, studies by Shell-Duncan, Gathara, and Moore (2017) have demonstrated that the prevalence of FGC has been steadily declining since the early 1980s, spanning 5-year age cohorts. It has not been uniformly reported that women from all ethnic groups have seen this reduction. FGC rates are still very high among ethnic Somali women and are notably higher in older Maasai and Gusii cohorts of women, but they seem to be falling in younger cohorts. Long-term, continuous drops in FGC have also been observed in other ethnic groups, including the Kikuyu and Kalenjin.

Over the last ten or more years, efforts made at the national, regional, and worldwide levels have started to pay off. Female genital cutting has become far less common in some locations, and an increasing number of men and women from the practising groups have expressed support for ending the practice. However, the decrease in occurrence is not as significant as anticipated. Consequently, it is critical to step up efforts to stop female genital cutting in order to more successfully address the underlying causes of the practice's persistence. Ending female genital mutilation necessitates a sustained, comprehensive commitment. Studies conducted in the last few decades have shown that this is not a simple task.

In order to successfully eradicate female genital cutting, a strong foundation is needed, one that can handle the underlying beliefs and legal frameworks that encourage the practice (UNICEF, 2005). Reviews that offer some broad lessons exist despite the dearth of systematic evaluations of the numerous activities implemented by governments, nongovernmental organisations, and others (UNFPA, 2007). The most important takeaway from these lessons is the need for multisectoral, long-term, community-led initiatives and interventions. First and foremost, a multisectoral approach guarantees that coordinated efforts from all angles and at all levels are required, ranging from the local to the global. It also involves a variety of sectors, including the health sector, women's affairs, finance, justice, and education. Additionally, it involves numerous categories of actors, ranging from governments and international agencies to community groups and nongovernmental organisations that represent human rights and health professionals. Second, for it to be sustained, behaviour change that is thought to be difficult must be able to guarantee continued action, which is necessary for leaving a lasting impression. Even if things might change quickly, the process of changing them can also be drawn out and tedious. Lastly, it need to be community-led. Programmes run by communities are inherently participative and typically help the community identify the issues and potential solutions.

Programmes that emphasise human rights that gender equality that are neither non-judgmental nor non-coercive have shown success in encouraging the widespread rejection of female genital cutting. They focus on promoting a decision to stop female genital mutilation as a group. Research based on social norm theory and an examination of programme experiences suggest that widespread renunciation of female genital cutting can only come about as a consequence of constructive societal change (Shell-Duncan & Hernlund, 2006).

Due to the customary nature of the procedure, a sizable portion of the community's households must decide to forgo the cut in a coordinated manner, ensuring that no girl or family is negatively impacted by the choice (UNICEF, 2005). In order for each family to feel confident that others are giving up the practice as well, this decision needs to be made clearly and collectively. It should be widely used in communities that practice sustainability. Thus, establishing a new social standard that will ensure daughters' suitability for marriage and the social standing of families who do not subject their daughters to the cut; a social norm intended to protect their daughters from damage or violations of their rights.

Programmes that incorporate "empowering" discourse, education, public commitments, discussions, and organised disseminating have been shown to facilitate the coordination and consensus necessary for the long-term cessation of female genital mutilation at the community level. In relation to a range of issues, including delicate ones like female genital mutilation, the events empower communities to voice issues and determine their own solutions without feeling pressured or condemned.

A range of techniques, such as intercultural dialogue that explores cultural differences both within and between communities as well as elements of cultural adjustment, can be employed to create an environment conducive to candid and reflective discussion. These strategies have been shown to be especially successful when they bring up and encourage conversation about fundamental human rights ideas. It is true that programmes based on these foundations and concepts have shown a notable decline in prevalence even years after the initial programming intervention.

Empowering education facilitates individuals' examination of their personal values and beliefs in relation to the cut in a dynamic and transparent manner that avoids showing inexperience or a menacing viewpoint. In addition to examining conflicting attitudes

towards female genital cutting in the community, educational meetings would be empowering if they not only aim to disclose new knowledge but also to provide a forum for participants to exchange experiences and help them disclose and share intricate innermost feelings. Empowering education may be undertaken through various forms of training, including literacy training, analytical skills as well as problem-solving skills through the provision of information on human rights, general health, religion, and sexual and reproductive health.

Programmes and workshops may incorporate more modern techniques like computer-based applications and text messaging, along with more conventional ones like theatre, poetry, storytelling, music, and dance. Educational activities run the risk of being perceived as morally offensive and causing unfavourable reactions in the communities if they are not attentive to local cultural and religious issues. Information should be supported by evidence and build upon local knowledge and attitudes at the same time. In addition, community-based educational initiatives can expand and enhance their work with social media platforms by utilising local radio stations, videos, and skits. Public figures who oppose female genital mutilation as "champions" can also be utilised to spread awareness about female genital cutting (Population Reference Bureau, 2006).

FGC is an example of gender inequity, hence it's critical to give women's empowerment particular attention. To prevent misconceptions and promote intergroup communication, educational initiatives must provide the same information to every group within the community. The structure needs to be adjusted to fit the needs of each unique group. Young people, both boys and girls, should also be included because they are frequently more receptive to change and can even be significant change agents in their own right. If schools can foster an atmosphere of the highest trust, confidence, and openness, they can provide a venue for learning and discussion regarding female genital cutting. In order to

ensure that teacher training covers topics related to science, biology, and hygiene as well as those in which religious, gender, and other social issues are addressed, artists and other positive role models can be brought into schools. Resources can also be developed and integrated into curricula (UNICEF, 2005).

Nevertheless, since many girls and boys spend the vacations at home, schools might not always be the best place for them to learn about delicate and private subjects. As a result, there is a need for additional youth outreach programmes. While it is advisable to provide the same fundamental information to every group within the community, while creating programmes to address female genital cutting, it is also important to consider all forms and venues of learning, including intergenerational conversation.

Communities need to have the best possible opportunity to discuss and consider new information in public before they can come to the coordinated, collective decision required for the long-term cessation of female genital cutting. Such public discussions offer chances to raise community awareness and comprehension of human rights protections for women and girls as well as national and international legal frameworks pertaining to female genital mutilation. In addition to carrying about recognition of the importance of women in the community, this discourse and debate among women, men, and community leaders frequently focuses on women's and girls' health, their rights regarding FGC, and how to enhance their ability to stop the practice by actively participating in decision-making. Another instance of contact across groups who don't often have open, uncensored discussions on these topics is intergenerational dialogue (GTZ, 2005).

Above all, these public conversations can spark conversations within the private home setting where parents and other family members decide whether to circumcise their daughter (Draege, 2007). According to Bergman and Olausson (2023), men and boys

play a larger role than was previously recognised, indicating a greater degree of their inclusion in all FGM/C therapies. These researchers concur with other scholars who have focused on raising awareness at the individual and community levels. They believe that some of the most effective strategies for abandoning FGC are training sessions involving religious leaders, community leaders, and medical professionals. Notably, key tactics at the individual level include economic empowerment and education; information and visuals like dramas and movies have proven particularly effective in modifying attitudes about FGC. Furthermore, they contend that all initiatives meant to bring about long-lasting change must originate internally, making use of locals rather than outsiders. For this reason, they emphasise the importance of developing community capacity. Finally, sealing the existing communication gap between advocators against FGM/C and practicing communities is key in handling the complexity surrounding FGM/C, especially in relation to cultural sensitivity.

Actions taken to end FGM include community engagement and dialogue, multifaceted and multisectoral approach, collaboration and coordination, access to justice for girls who have experienced or are at risk of FGM, leveraging, linking, and supporting the workforce's capacities to address harmful practices into the national project of strengthening the social service workforce, registering a pool of qualified community resource persons to be called upon in an emergency, and recording lessons learned from COVID-19 to inform future guidelines about how to develop and implement an emergency response for FGM (UNICEF, 2021).

The Anti FGM Board of Kenya, the only government-established board worldwide tasked with ensuring the abolition of FGM, detailed its 2022 financial report. Among its many actions was the creation of active youth networks throughout the 22 FGM hotspot counties, which encouraged youth participation. Embu, Tharaka Nithi, West Pokot, Taita

Taveta, Laikipia, Narok, Kajiado, Kisii, Nyamira, Migori, Marsabit, Elgeyo Marakwet, Samburu, Mandera, Garissa, Baringo, Isiolo, Bomet, Embu, and Tana River were among them. In order to mobilise more resources, the Board further reinforced and built county coordination structures as well as collaborations and connections (Anti FGM board annual report and financial statements, 2022). Unfortunately, the Covid 19 pandemic prevented interventions from being fully implemented, which put many girls at risk. Despite the difficulties mentioned, this is a positive step, as the country's FGC prevalence has now dropped to 15% according to the most recent KDHS (2022).

According to Tammarya and Manasib (2023), there are gaps in the research on the mental and sexual consequences of female genital mutilation/cutting (FGM/C) and the related interventions for these women living in Africa. The study utilised a narrative synthesis approach to compile data on outcomes related to mental and sexual health. The majority of research (n = 13) discussed issues related to sexual health, such as pain during sexual arousal, orgasm and desire issues, and lubrication challenges.

Four studies reported on mental health results, with depression ranking highest, anxiety and somatization coming in second and third, Post Traumatic Stress Disorder (PTSD), and sleep disorders in between. Research did not emphasise interventions that linked mental and sexual health. The results of this narrative synthesis highlight the importance of giving women with FGM/C priority when it comes to the provision of mental and sexual health care services. The report suggests bolstering African health systems by increasing primary care and specialised health workers' knowledge, skills, and capacity to provide mental and sexual health services to women who have had FGM/C.

The results of this scoping investigation showed that while psychosocial and mental health consequences in Africa have been disregarded, there are few studies and interventions that address the effects of living with FGM/C for women's mental and

sexual health. An integrated approach to researching these detrimental effects is also lacking; for instance, combining knowledge of sexual and mental health components or evaluating multilevel therapies that address women's emotional, behavioural, and sexual health. Therefore, the practice has been linked to psychosexual illnesses and post-traumatic stress disorder both in the short and long term after FGM/C. Tammarya and Manasib (2023) suggest a greater emphasis on mental health needs and interventions for women who have experienced FGM/C in light of these detrimental effects.Furthermore, they demand that the core of abandoning campaigns against FGC be the focus of mental health and psychosocial care, which targets the traumatic stress and relational dysfunction that can arise in the lives of such women and young girls.

According to Johansen et al. (2013), there are five ways to stop FGC. First, they suggest learning more about the detrimental consequences of FGC on health. This may encourage introspection and analytical thought, which may ultimately result in a decrease in and eventual cessation of FGC. Research indicates that religious leaders' strong opposition to FGM may have been sparked by information about the harmful health implications of the practice from health authorities like doctors. Second, since traditional practitioners do the great bulk of FGC in Africa, a common strategy has been to target excisers and persuade them to cease FGC. These therapies often consist of teaching people about the physiology of female genitalia, the negative health effects of FGC, how they contribute to its continuation, and how to cease doing FGC. Third, in an effort to stop health professionals from practising FGC, develop their ability to recognise and manage difficulties, and enlist their help as change agents, a number of interventions have been directed towards them. Assessments conducted following health professionals' trainings indicate a greater understanding of FGC and its associated health risks. Fourth, interventions have been developed to replace the rite of passage with FGC, by an alternative rite without FGC.

Such alternative rites are expected to fulfil the cultural tradition of a coming of age ritual, so that girls can be socially accepted without having to go through FGC. These interventions are believed to show positive attitude and respect for cultural traditions and thereby prevent defensive reactions against efforts to abandon FGC and to facilitate abandonment of FGC by maintaining the ritual framework. Community-based organisations in Kenya initially created these kinds of initiatives after consulting with local political, ritual, and religious leaders as well as families. They often include a training phase, frequently in isolation, followed by a public celebration and/or the awarding of a diploma to signify the ritual's completion. The event serves as a public declaration of the young girls' refusal to participate in FGC, and the training itself frequently attempts to give them the confidence to take control of their sexual and reproductive health and rights. According to two assessments conducted in Kenya, following this kind of intervention, a greater number of girls expressed gender egalitarian attitudes and knew about reproductive health issues. Additionally, a greater number of the girls' families said that there were no benefits to female genital mutilation and had more knowledge about the health, social, and psychological issues related to the practice.

Fifth, it has been determined that community-led initiatives are essential to addressing the FGC social convention. Evaluations of FGC abandonment treatments indicate that in order to bring about long-lasting change, community involvement is essential. The goal of community-led interventions to end FGC is to empower women, girls, and the community as a whole so they may question their own culture and decide whether or not to stop it for their own benefit. The process through which women, girls, and their communities take charge of the variables and choices that mould their lives is known as empowerment. Viewed as a tool for empowerment, interventions typically incorporate the topic into a larger educational curriculum that covers topics like gender and

development in addition to the social, political, legal, health, and economic advancement of a community.

Lastly, Studies indicate that legislation and its implementation can have a preventive effect. Most African countries with documented FGC have now passed laws against the practice. This provides an official legal platform for action and offers legal protection for women and can discourage excisers and families for fear of prosecution. It can also offer health professionals a legal framework to oppose requests for performing FGC.

2.5.1 Legal Measures to Prevent Female Genital Cutting

2.5.1.1 Constitution of Kenya

Article 29 (c) of the Kenyan Constitution provides for the rights not to be subjected to any form of violence or treated or punished in a cruel, inhuman or degrading manner" Further, Article 44(3) states that a person shall not compel another person to perform, observe or undergo any cultural practice or rite. Additionally, Article 53(d) protects every child from abuse, neglect, harmful cultural practices, all forms of violence, inhuman treatment and punishment (GOK, 2010). The Constitution is the guiding principle in regard to enactment of law and protection of the Rights of its citizens. In this regard then, the Kenyan Constitution has already highlighted the cultural practice of FGC as a violent act hence punishable by law. The Constitution thus is the main intervention that has been laid down by government in regard to abandonment of FGC. It is from this document that other legislative frameworks are set.

2.5.1.2 Prohibition of Female Genital Mutilation Act of 2011

The Prohibition of FGM Act is an act of parliament that was established in 2011. Through this Act, an Anti-FGM Board is appointed to protect women and girls against FGM/C by offering safe housing; provision of support services as medical services and

psychosocial support; as well as public education and sensitization on the dangers and adverse effects of FGM/C, providing the required information to seek medical services and support. The prohibition of FGM Act 2011 is a comprehensive piece of legislation that established the Anti-Female Genital Mutilation Board and set out the offences and punishments for FGM/C in Kenya.

Part IV (Articles 19–25) of the FGM Act 2011 outlines the criminal offencesrelated to the following aspects of FGM: Article 19–the performance of FGM, including by medical practitioners; Article 20–procuring, aiding and abetting the practice of FGM; Article 21 procuring a person to perform FGM in another country; Article 22–allowing the use of premises for FGM; Article 23–the possession of tools and equipment for the purposes of FGM; Article 24–failure to report awareness of FGM to a law enforcement officer, whether the procedure is in progress, has already occurred oris planned; and Article 25–the use of derogatory or abusive language against a woman for having not undergone FGM (or against a man for marrying or supporting that woman)' This Act however is currently under review.

2.5.1.3 The Children's Act, 2022

The Children's Act, 2022 defines child abuse as the infliction of physical harm on a child by any person, furthermore it is the infliction or inducement of physical harm by any person on a child by acts intended to cause harm. The children's Act 2022 which was assented by the President of Kenya, Uhuru Kenyatta on 6th July' 2022 and commenced on 26th July' 2022, Section 23 cap 1(b) states that no person shall subject a child to female genital mutilation. A person who contravenes the provisions of this subsection (1) commits an offence and shall, on conviction, be liable to imprisonment for a term of not less than three years or to a fine of not less than five hundred thousand shillings, or to

both. section 144 defines a child in need of care and protection as one who (l) who has been or is likely to be subjected to female genital mutilation, intersex genital mutilation, among other customs and practices an authorized officer exercising powers under this section that a child is in need of healthcare, the officer shall forthwith take the child to a registered health institution, and the health institution shall provide the appropriate treatment, care and necessary hospital accommodation for the child. Section 22 subsection 1(a) highlights the protection of children against psychological abuse.

2.5.1.4 Protection against Domestic Violence Act, 2015

According to a report by 28 Too Many, the law defines domestic violence as "female genital mutilation" under Article 3(a)(ii). It also gives rise to protection orders under Article 19(1)(g), which shield potential victims from threats or engagement in "cultural or customary rites or practices that abuse the protected person."(Kenya: FGM and the law, 2018).

2.5.1.5 Policies and Strategies

In a 2020 report, the United Nations Population Fund (UNFPA) stated that: '[Kenya] has a national programme to end female genital cutting that is underpinned by national laws and policies, which further includes an oversight and coordination board, community engagement, girls' empowerment programmes, partnerships with religious leaders, outreach to both traditionalpractitioners and medical personnel, and community services to report and respond to cases.' (UNFPA, 2020). Kimani and Obianwu, in a June 2020 report for the Population Council summarized the various strategies in place:

'In Kenya, FGM/C is addressed in the recent National Policy for the Eradication of Female Genital Mutilation of 2019 (Ministry of Gender Affairs, 2019) as well as health sector–specific National Adolescent Sexual and Reproductive Health Policy of 2015

(Ministry of Health, 2015) and the National School Health Policy of 2018 (Ministry of Education 2018). These regulations put into effect the international treaties that have been ratified, the nation's legislation, and the definition of FGM/C as a harmful practice and a current issue as given by the World Health Organization. These policies, which include measures for tackling FGM/C, have taken into account modifications particular to the sector as well as the devolved governance structure.

‘With regard to the implementation of FGM/C policies in Kenya, there are structures identified and their roles clearly highlighted to include: the national, subnational, hospital level, Sub County, and community levels depending on the policy. The policies include clauses addressing the lead ministry's and partners' obligation to mobilise resources for FGM/C prevention and responses to make the policies a reality. "Finally, the policies that have been reviewed in Kenya have detailed monitoring and evaluation [M&E] strategies for their implementation. These strategies include regular monitoring, updates, and timely reporting to inform programming on any emerging trends related to FGM/C."

Among the documents developed by the [Anti-FGM] Board is the National Policy for the Eradication of FGM (2019) which outlines focus areas for engagement in accelerating FGM/C abandonment (ROK, 2019). These areas include: legal interventions, health, FGM/C data, changes in FGM/C and emerging issues in FGM/C, evidence generation and utilization, as well as continuous multi-stakeholder engagement.’

The Organisation for Economic Co-operation and Development (OECD) (2019) Gender Index report for Kenya states: ‘Under the Prohibition of Female Genital Mutilation Act, the Anti-FGM Boardhas been established (Prohibition of Female Genital Mutilation Act, Sec. 3). Its mandate covers: design, supervision and co-ordination of public awareness programmes against the practice of FGM/C; advice to the Kenyan government; design and formulating a policy on the planning, financing and co-ordinating of all FGM/C-

related activities; the Board also provides technical support to institutions, agencies and other bodies involved in the programmes on elimination of FGM and design programmes aimed at eradication of FGM/C itself (Prohibition of Female Genital Mutilation Act, Sec. 5).'

2.5.2 Implementation of anti- Female Genital Cutting Policies and Frameworks

Matanda et. al. (2018) posits that there have been quite a number of efforts, at the policy and programme levels, aimed at ending FGC in Kenya. The combined consequences of these initiatives, however, have had contradictory outcomes, with FGC all but eliminated among some ethnic groups like the Meru, Kikuyu, and Kalenjin; while, the practice is still practiced widely in other ethnic groups including the Maasai, Kisii, and Somalis. Matanda et al. (2020) go on to say that despite a strong legislative framework that forbids FGC, criminal penalties have not been as successful as anticipated in deterring the practice. The only thing they have done is allow the practice to go underground, with the offenders guaranteeing confidentiality and children being cut at an even younger age than previously, eliminating the associated cultural value of the passage from childhood to adulthood. When there is a contradiction between the formal law and culture or religion, people don't necessarily opt to follow the formal law over their cultural or religious convictions. Lower reporting of FGM/C is a result of fear of punitive consequences. Strict execution of Kenya's FGM/C law has detrimental social effects, such as the incarceration of parents, especially mothers, who are the primary perpetrators, especially in light of the obligatory minimum punishments. Law enforcement personnel must choose between upholding the law and running the danger of having detrimental societal effects or breaking the law and allowing FGM/C to go on.

It is challenging to appropriately execute and enforce Kenya's anti-FGM/C law due to general issues affecting the criminal justice system. Law enforcement personnel travel

great distances between police stations, crime locations, and court stations in rural areas that are hotspots for FGM/C. Witnesses face similar challenges and often lack the resources to attend court sessions. This affects the way investigations are conducted, how evidence is collected, and ultimately how prosecutions are carried out. At the expense of FGM/C, other offences that are deemed more serious are given more prominence. For instance, instead of FGM/C, law enforcement officers frequently focus more on offences like livestock rustling and illicit traditional alcohol making. It is important to note that FGM/C charges are not handled by a separate police bureau. Although the Office of the Director of Public Prosecutions has a specific desk for the prosecution of FGM/C-related offences, police stations do not have this feature. More coordination is required between the several levels and entities responsible for enforcing the legislation, even if FGM/C cases might be handled by the Gender Desk in some stations. UN Women Africa, in an article published in June 2020, described a GenderBased Violence helpline (1195 service) as follows: 'The Nairobi-based helpline is a free-to-call service, setup to give immediate assistance to the public in the event of all forms of sexual and gender-based violence.'(UN Women Africa, report 22 June 2020).

As of September 29, 2020, the national GBV Hotline 1195 has received 810 cases, up 25% from 646 instances in August, according to a report released in October 2020 by the UN Office for the Coordination of Humanitarian Affairs (UN OCHA). Psychosocial first aid (PFA) and referral services were provided to all cases. (OCA, 2020 UN). The public can report cases of FGM in Kisii County by calling 0800222266, the toll-free number for the Centre for Community Mobilisation and Empowerment (CECOME), a community-based organisation whose main goal is to educate the locals about forms of violence and empower girls and women against FGM/C. Unfortunately, there is hardly any data on what proportion of the cases recorded by the hotline relate specifically to FGC. In an

article dated November 2020, the Ministry of Public Service and Gender reported the launch of guidelines for the establishment of Gender Based Violence Recovery Centers (GBVRCs) and commented: 'The GBVRCs are provided for in Vision 2030 as underscored in the social pillar that prioritises prevention and response to gender based violence and eradication of FGM.'(Ministry of Public Service and Gender, 2020). In an article covering the launch of the GBVRC guidelines, dated 3 December 2020, online news site Standard Media reported: 'Recovery centres will operate round the clock and are expected to provide integrated and comprehensive services to survivors of GBV. Both medical and psychosocial assistance will be provided. The establishment of the centres will fall under the purview of the county administrations. A training booklet from the Kenya Police Service will also be available to officers assigned to GBV cases centres. (Media Standard, 2020). Nevertheless, as of right now, neither the number of recovery facilities established by the government nor the locations of any such centres in the nation's FGC hotspot zones are officially recorded.

A Daily Nation article, dated 9 September 2020, reported: 'Gender Chief Administrative Secretary Rachel Shebesh as leading a campaign targeted at female circumcisers in efforts to end Female GenitalMutilation/Cutting (FGM/C) in the country. 'The campaign by the Ministry of Public Service and Gender was aimed at reaching all the 22 counties identified as FGC hotspots. 'Speaking in Tana River County during an anti-FGM awareness tour, Ms Shebesh stated that, to prevent the circumcisers from going back to the outlawed practice, the government will link them to alternative sources of income as well as engage them as anti-FGM/C champions." However, to this date there is no documented data on the number of recovery centres that have been set up by government nor any such centres in the hotspot areas of FGC in the country. Neither is there an

initiative that has been set up to ensure the traditional practitioners get an alternative source of income.

2.5.3 Legislation and Resistance

Since 1965, 24 of the 29 countries with the highest prevalence of FGM/C have used a human rights-based approach to their legislation on FGM/C. Berer (2015) reported penalties can range from three months to life in prison. Several countries also impose monetary fines. Twelve developed countries with substantial FGM/C-practicing populations have also passed laws criminalizing the practice. Some laws ban the provision of FGM/C in government health facilities and by medical practitioners. Some criminalize FGM/C only when performed on minors, while others criminalize it in all cases. Fines may apply only to practitioners or to anyone who knows it is happening and does not report it. The crime may cover only cutting in the country itself or include taking a girl to another country to have it done (UNICEF, 2013).

International law guarantees both the freedom of religion and the right to participate in cultural life. International law, however, provides that restrictions that are required to safeguard the fundamental rights and freedoms of others may apply to the freedom to express one's religion or views. Consequently, FGM/C cannot be justified by citing social or cultural claims, such as those covered by article 4 of the International Covenant on Civil and Political Rights (WHO, 2008).

Legislation is an important tool for eradicating FGM/C, as it can challenge the traditional status quo by providing legitimacy to new behaviors—but unless it is accompanied by measures aimed at influencing cultural traditions and expectations, it tends to be ineffective (UNICEF, 2013).

Individuals, communities, and countries go through transitional stages in terms of their desire to adhere to FGM/C, to contemplate abandoning the practice, and to completely abandon the practice. The readiness to abandon FGM/C varies across countries. For example, in Somalia, there is a high prevalence of FGM/C (98%) and a strong desire to adhere to the practice; in Egypt, two-thirds of women want to adhere to FGM/C, and almost one-quarter want to abandon it; and in Nigeria, almost equal proportions (about 40%) want to adhere to and to abandon the practice, with 14% "reluctantly adhering" and 13% contemplating abandonment (Muteshi et al., 2016). Among these transitional stages of abandoning FGM/C, tensions remain between those who aim to abolish FGM/C and those who desire to perpetuate it. Studies carried out by (Bunei & Ronoh, 2018) shows that since FGM/C is deeply embedded in culture and considered central to the identity of many Africans, the issue must be approached with great respect and effort on the part of Westerners to understand the cultural context and rationale of this tradition. If FGM/C is to be completely eradicated, African communities and international support agencies must work collectively at the grassroots level to evaluate the implications of the practice. Support for a culture of FGM/C is expressed through a reluctance to comply with anti-FGM/C laws and to present evidence against family members, friends, or neighbors, as well as criticism or sarcasm directed toward law enforcers. In a number of cases, local law enforcers and anti-FGM/C crusaders (such as pastors, chiefs, assistant chiefs, and other leaders) may experience a conflict of loyalty by enforcing the law, as it puts them at odds with the local culture, a process sometimes referred to as "social nullification" (Green, 2016) reports that while criminalizing harmful cultural practices such as FGM/C is necessary, it can equally generate rebellion geared toward circumventing or resisting the law (Dajistanli, 2015)

2.5.3 Involvement of Men in Female Genital Cutting Prevention

Both men and women are impacted by FGM/C. Many men wish to see a stop to this practice because they believe that they are also victims of it. According to the KDHS (2022) survey, the proportion of males who oppose the practice's continuation is far larger (92%) than that of those who support it. In a similar vein, according to UNICEF (2020), 89% of boys and men believe that FGC should end. Higher educational attainment is one of the most important indications of men's support for giving up FGM/C, but a sense of societal obligation is a significant obstacle to ending the practice. Numerous studies show that males react well to participating in sexual and reproductive health programmes (Varol et al., 2015).

The Global Alliance against FGC is a French and Swiss-based organisation that continues to emphasise the role that males can play in ending the practice. Leading the charge to expedite the complete eradication of violence against women and girls globally is the alliance. It collaborates closely with voluntary organisations, individuals, the UN General Assembly, UNESCO, WHO, and permanent missions to the UN. The Global Alliance against FGM has arranged conferences and other events since 2009 with the goal of honouring males who have refused to get FGM/C. The alliance prioritises the development of instruments that help maximise efforts at the local, regional, national, and international levels and promotes support for and reinforced grassroots work. Men's participation must supplement the rights-based initiatives that now prioritise education and women's and girls' empowerment. Prominent men in areas where the practice is common should take the lead in advocacy programmes and facilitate communication between women and men, their communities, and governmental organisations (Varol et al., 2015).

FGM/C is an example of gender inequity, and ending the practice will depend heavily on women's empowerment. To assist communities, families, and individuals to stop FGM/C, a range of documented programmatic, research, and policy interventions are being undertaken under the direction of several national and international nongovernmental organisations and UN agencies (Muteshi et al., 2016). These tactics have included community- and leader-focused advocacy and education initiatives, as well as legislative, capacity-building, health care, media, and community discussion interventions. Empowerment, community actions, and awareness of the health effects of FGC are positively correlated.

In a study published in 2022, Matanda et al. found that men in Kisii and Narok counties were more likely to have extramarital affairs, which could lead to marital conflict, when women's sexual desire was reduced. This finding was based on a factorial analysis of themes that revealed patterns of variation in the strength of beliefs and the extent to which they are upheld, contested, or discarded between the two counties. In Kisii, sexuality was the main topic of discussion in each of the FGDs. A few men, both older and younger, believed that female genital mutilation maintained morals in the community because girls who had their libidos cut displayed sexual restraint.

However, some men contested this view as they believed that even cut girls could be promiscuous. This variation in opinion by men is a clear indication that involvement of men in the abandonment of the practice is one of the interventions that the state and none state actors can employ. CECOME a local CBO based in Marani sub-county, Kisii county, is currently engaged in the involvement of men through an initiative themed ‘Boys to Men’. It is on this basis that this study therefore sought to assess the effectiveness of FGC interventions on the psychosocial wellbeing of the girl child in Marani sub-county, Kisii.

2.6 Challenges faced in implementation of anti- FGC Interventions

Medicalization is the attempt to minimize health risks associated with FGC procedures by having it either performed by health care providers or medically trained traditional cutters, either within or outside a health facility (Berg & Denison, 2011). It is argued that it provides a safer procedure in areas where complete eradication of FGC has not yet been achieved (WHO,2010; KDHS, 2022). It involves, but is not limited to, making sterile medical supplies and equipment more widely available in an effort to perform the cut in a more painless and hygienic manner; training traditional cutters or anyone else performing the procedure; assigning medical professionals, such as physicians, midwives, or nurses, to perform the procedure whether it is performed inside or outside of a clinic facility; and substituting less painful, more symbolic cutting for more severe forms of FGC, such as infibulation, in order to lessen the health risks associated with type III cutting (28 Too Many, 2016). Ironically, the worldwide campaigns against FGC and HIV are largely responsible for the growing tendencies of medicalized FGC practices. Emphasizing the immediate and long term health risks of FGC unintentionally led families and relatives to seek safer procedures, rather than abandoning the practice (UNICEF, 2013).

A study was conducted by Njue and Askew (2014) regarding the FGC trends in the Abagusii community in Kenya. The goal of this study was to provide light on the various ways that healthcare professionals support FGC. Numerous interviews with members of the Abagusii community and healthcare providers confirmed that, depending on the type of FGC performed, families that decide to have their daughter cut typically negotiate directly with a member of the medical staff for the girl to be admitted to the hospital under the pretence of having a disease like malaria. The patient's stay can range from a few hours to several days. The study also revealed instances of nurses carrying out the procedure without the knowledge of other health personnel or management staff.

However, it is more common to have a Healthcare Provider carry out the procedure, often during their annual leave, at a girl's home at night, in order to keep the practice secret due to its illegal status. The study concluded that the community opts for health providers performing FGM as a 'harm-reduction strategy' – a concept that the promotion of safer alternatives can help to reduce health risks associated with risky behaviours. For example, in order to minimize the risk of becoming infected with HIV/AIDS, intravenous drug users can be provided with sterile needles. Although this study assessed the input of medical providers in abetting FGC, it failed to find out the risk mitigation strategies in place to stop this custom and the role of community leaders in exposing the medical personnel who perform FGC. This study will bridge this gap by evaluating the roles of various stakeholders in reduction of FGC.

Proponents of this approach contend that medicalized FGC lowers the risk of problems by utilising anaesthetics to lessen discomfort and the amount of tissue cut resulting from swelling, and by ensuring the process is performed in a more hygienic atmosphere by a skilled cutter. Moreover, it might be argued that the medicalization of FGC raises the possibility that less severe forms of cutting will be used rather than infibulation, which is linked to more serious and permanent obstetric and gynaecological problems.

Seeking a skilled traditional cutter to provide a safer and more hygienic cutting is one alternative available to family members who want to have their female relatives chopped (28 Too many, 2016). It has been reported that some traditional healers and circumcisers in some tribes have received rudimentary medical training. As a result, they are increasingly utilising clean razor blades, scalpels, and scissors to prevent HIV (Njue & Askew, 2014). They also dispose of the instruments after each cutting. When a Gusii family decides to have their daughter cut, they typically work directly with a medical staff member to have the girl admitted to the hospital on the grounds that she is ill.

There has been an increase in the number of cases of doctors, midwives and nurses carrying out the procedure. In spite of the illegality of the procedure, some Healthcare Providers are willing to perform the cutting for economic or material gain (Robertson & Szaraz, 2016).

The Kisii people separate themselves from the nearby Luo ethnic group by this custom, which is said to be essential for restricting women's sexual urges (28 Too many, 2013; Wilson, 2013). (2009) Khaja, Barkdull, Augustine, and Cunningham carried out a qualitative study on Somali women's attitudes on FGC. In-depth interviews were conducted for this study with a convenience sample of seventeen immigrant women from Somalia who had undergone FGC in North America. The study's objective was to gain a deeper understanding of these women's perspectives on and experiences with FGC.

The women were between the ages of 20 and 79. Of the 17 women, 29% had the surgery done in a hospital, and 70% had had the FGC done at home. A smaller proportion of them—53%—had endured infibulations, although a similar amount had undergone excision and 24% had received Sunna (Type 1) circumcisions. Ethnography played a major role in the identification and recruitment of research interview subjects. Results showed that FGC's stimulation and problems aligned with the experiences of circumcised women in previous research. Most participants said that their parents had forced them to get FGC as a sign of honour and chastity, as it was a fundamental aspect of Somali culture. Additionally, respondents thought that their parents saw FGC as a component of traditional Islamic belief systems. Some women who had undergone more severe kinds of excision or infibulation reported issues related to FGC. The difference in risk was linked to the level of skill possessed by the circumciser and if the procedure was carried out in a hospital. It was surprising to learn that most participants thought that FGC should be outlawed in its entirety. In their view, the use of the term ‘female genital mutilation’ or

FGM angered them. Participants labelled the term as ‘degrading’ and ‘insulting’, and believed it implied that Westerners regarded them as ‘flawed’ and ‘uncivilized’. In this study participants were unanimous in their views about wanting FGM/C banned.

The participants further feared that criminalization would lead to practitioners going on with the practice on the underground, hence resulting in more concealment in some communities and consequently inadvertently contributing to its persistence. Various reasoning exists within communities performing FGC and among its defenders, usually reflecting a mix of cultural, religious and social arguments. In many societies, especially among the Abagusii, FGC is a deeply-rooted custom or traditional practice, considered to be a part of the cultural heritage of the community. Ordinarily, a girl is not considered an adult ready for marriage without undergoing FGC, which is performed to define her gender and/or ethnic identity. By being cut, the girl becomes a woman and demonstrates her transition into adulthood along with her readiness to take on the roles of wife and mother. The idea that their daughter's virginity and chastity will be preserved, guaranteeing her marriageability and the honour of the family, is another reason why parents would subject their daughters to such a torturous and risky operation. Furthermore, FGC is employed to enhance men's sexual pleasure and control women's sexuality, albeit it is also frequently justified on the basis of sanitation, cleanliness, and aesthetics (Robertson & Szaraz, 2016). Mali and Sierra Leone (Berg & Denison, 2012), where the frequency reflects ethnicity, culture, and religion in each nation. Among practicing communities, FGC is motivated by beliefs on appropriate sexual behavior, with some communities considering that it safeguards and preserves virginity, fidelity in marriage and prevents promiscuity (Wilson, 2013).

In a study by Kaplan et al. (2013) a significant fraction of Gambian Health Care Practitioners working in rural areas embraced the perpetuation of FGC (42.5%), with as

high as 47. 2% of them intending to subject their own daughters to the cut and 7.6% reported having previously performed it in the course of their medical practice. Respectively, their attitudes, knowledge and practices were shaped greatly by sex and ethnic distinctiveness. But compared to males, women expressed less support for the continuation of FGC and more support for the suggested prevention strategies. The results demonstrated the degree of ignorance among medical professionals on the health effects of FGC, with an overall prevalence of 76.3% for the procedure and 40.9% reporting issues associated to FGC in specific areas. In light of the circumstances, these findings indicated a serious and urgent need to create efficient strategies to increase healthcare professionals' ability to stop the practice, support responsible handling of its aftereffects, and reject medicalization. According to Berg and Denison's (2012) research, there is a significant difference in prevalence both within and within nations that are influenced by ethnicity and custom. The practice of FGC is still carried out among the Gusii, despite the World Health Organization's determination that it violates the rights of women and girls. Research has also shown that the practice continues even in the face of established legal frameworks (WHO, 2012; Wilson, 2013). Given that Kenyan society is largely patriarchal, women's behaviour is constrained by moral and cultural norms. There is a taboo around discussing sex and sexuality in relation to reproduction (Wilson, 2013).

An intervention aimed at empowering communities was initially implemented in Senegal and subsequently duplicated in Burkina Faso. It included instructional sessions on women's health, environmental hygiene, problem solving, and human rights. Changes in knowledge/awareness, intentions, and beliefs/attitudes about FGC were the most often reported project outcomes. Results such as self-reported prevalence, practices including discussing FGC with others, perceptions of spouses' disapproval of FGC, and participants' regrets for getting their daughters cut were less often reported.

The effect estimates indicate that: (1) There was a significant increase in multifaceted community activities, which required participants to have positive knowledge and intentions about family planning; (2) Education of female students may have led to a slight increase in knowledge/awareness about family planning; and (3) Community empowerment through education may have positively affected the prevalence of family planning, participants' knowledge of the consequences of family planning, and regrets about having their daughters cut (Berg & Denison, 2012).

A report on FGC by the Kenya Inspector General of police showed relatively few convictions between 2011- 2014. A total of 71 cases were taken to court, of those only 16 resulted in convictions, 18 being acquittals, 4 withdrawn and 33 were pending (Kaberia, 2014). Among the challenges listed for the low rates of prosecution was the difficulty faced in collecting sufficient proof for conviction, the girls being too young to view the cut as a crime as well as the fear of seeing their parents in trouble, lack of willingness by community leaders to give information as most FGC is done secretly and the threats issued to the FGC victims about pursuing justice against perpetrators. It has further been observed that majority members of the Gisii community are Christian and fairly well educated, thus making the presence of FGC 'unusual' (28 Too Many, 2013).

2.7 Summary of the Literature

According to Kaplan et al. (2013), FGC has been performed for millennia and has taken on an incomprehensible cultural significance. This custom is a rite of passage that involved holding a private ceremony away from prying eyes. The cut served as evidence that a girl had transitioned and was thus deserving of acceptance into the society. During this ritual, initiates received training of the cultural and social wealth of the group in addition to their roles as mothers and wives.

The practice is justified, among other things, by making sure the girl complies with important social norms pertaining to maturity, femininity, respectability, and sexual restraint (WHO, 2008). According to Khaja, Barkdull, Augustine, and Cunningham (2009), this custom shows that a girl in Somali culture is respectable and virginal. Jaldesa, Askew, Njue and Wanjiru (2005) and Elsayed, Elamin and Sulaiman (2011) cite tradition, immorality prevention, improved marriage prospects, and virginity preservation as reasons for this practice.

Upon closely examining critics' descriptions and viewpoints on culture, it becomes evident that the majority of them place a strong emphasis on a few essential characteristics as the essential constituents of culture (Anbaran, 2016). Anbaran believes that it is important to understand one's own culture because culture has shaped people's lives all around the world since the beginning of community development. It is important to acknowledge the impact that culture has on people's lives since it is a universal phenomenon that affects people's ability to live in harmony with one another on a wide range of levels.

With a prevalence of more than 70% in 28 African countries, including Somalia (98%), Guinea (95%), Djibouti (94%), Mali (89%), Egypt (87%), Sudan (87%), Sierre Leone (86%), Eritrea (83%), Burkina Faso (76%), and Gambia (76%), FGC is mostly practiced in these regions (UNICEF, 2020). In Kenya, the prevalence is 21%. It is concerning that the Gusii community, which is located in Kisii and Nyamira counties, would be in the top ten in the world if we were to rank it globally, despite the fact that it was placed 77% and 76%, respectively, in the most recent KDHS (2022). Girls and women who are not circumcised often face shame, exclusion, and mockery (Oloo et al., 2010; Omigbodun et al., 2022).

Though various national and international bodies have established frameworks to eliminate this practice, the rate of reduction amongst practicing communities is barely proportionate to the efforts made (28 Too many, 2013). It is even more worrying that the practice is now conducted on girls as young as 5 years old and below (Oloo, Wanjiru & Jones, 2010; UNICEF, 2020; KDHS, 2022).

While some who participate in the practice refer to it as cultural, it has been shown to have a number of detrimental effects, including death, bleeding, damage to the female genital tract that interferes with the natural function of women's and girls' bodies, pain during sexual activity, school dropout, early marriage, and decreased sexual satisfaction, as well as negative effects on women's and girls' psychological health and rights violations (UNICEF, 2006; Berg, Denison & Fretheim, 2010; Els FGC is still practiced, despite the troubling data regarding its prevalence within the Gusii population.

According to Anderson and Taylor (2013), what is deemed good or terrible, right or wrong, and beautiful or ugly is determined by society. Members of a certain civilization therefore rarely question the culture they are a part of because culture is learned. Therefore, even while culture is necessary for human survival, Macionis, Jansson, and Benoit (2011) contend that culture can also restrict our options and cause us to repeat unsettling behaviours like the practice of FGC.

FGM is being practiced in Kisii County despite the WHO's pronouncement that it violates the rights of girls and women and the creation of Kenya's legal framework (the FGM Act, 2011; WHO, 2012; The Children's Act, 2022). Therefore, it is necessary to determine how well anti-FGC programmes affect the psychological health of young girls in Kisii's Marani sub-county.

Given the diversity of practising communities, single issue approaches will not end FGC. Instead, community-specific, multifaceted programming that acknowledges the various decision-making patterns and the combined influences of education, the economy, politics, law, religion, and social environments will be better positioned to guide efforts towards the abandonment of FGM and C. Muteshi, Miller, and Belizán (2016).

International action towards the abolition of FGC is unlikely, regardless of how the conflict is resolved, unless the cultural, religious, and ethnic justifications for the practice are carefully considered and comprehended (Cassman, 2008). FGC still exists despite significant western assistance, despite some cases of effective elimination. According to Cassman (2008), a just solution is required to prevent health problems among practising communities and to maintain their subjugation during this gruelling process rather than to force Western values on Easterners. According to Cassman, a comprehensive knowledge of FGC, its origins, and its persistence is still lacking. In order to persuade proponents of FGC that the practice is more detrimental than beneficial, one must comprehend the perception of goodness. Thus, the answer should balance the fact that FGC is a practice that is fundamental to valued heritage, value, and respect, while also being cruel, painful, and barbarous.

According to Abdulcadir, Rodriguez, and Say (2014), there are still a number of gaps in the care of women who have had female genital mutilation (FGM), particularly in developing nations, despite efforts to pass legislation and implement community education programmes, support groups, medical guidelines, new surgical techniques, and specialised multidisciplinary centres. First, they contend that prospective evaluations of obstetric outcomes should take into account factors such as age, socioeconomic level, past reproductive history, health conditions that may have affected the pregnancy, and educational attainment. Secondly, there is need to evaluate long-term post-partum

complications such as prevalence of incontinence postpartum or the effectiveness of treatment such as perineal re-education. Thirdly, they suggest sexuality research on women with FGC including clitoral reconstruction, in order to clearly define appropriate control groups and chose validated questionnares to measure to measure sexuality outcomes including orgasm.

As a measure to curb the continued practice of FGC, the government of Kenya through the office of the Director of Public Prosecution has continued to prosecute cases under the prohibition of FGC Act. Though only few cases have been prosecuted, challenges have also been noted since sustaining prosecution dependents on availability of evidence. Other challenges include transportation of witnesses to court, lack of funds to do so as well as intimidation by relatives not to report cases (UNFPA & UNICEF, 2016). Further efforts by the government of Kenya also include the co-ordination at the national, county and community level to enhance program implementation, high level advocacy, and provision of various platforms for partners to jointly plan and execute programmes to end FGC and share success stories and challenges.

Even with all the treatments in place, the cultural practice of female genital mutilation (FGM) continues to have a negative psychosocial impact on women. Girls who have not had FGC frequently face severe shame, stigma, and rejection from their cut peers, as Omigbodun et al. (2022) demonstrated. Many have accepted or requested to be cut in order to put an end to their psychological torment, in part because of the social benefits that FGM/C provides in addition to the continued psychological pain. Almost every woman had signs of extreme anguish prior to, during, and following the procedure. Some voiced their relief at knowing that their psychological torment will come to an end and that they would receive complete capital and social recognition upon being severed. rejected, severely stigmatised, and humiliated by their classmates who have cut. In

addition to the socioeconomic benefits that FGM/C provided, many people accepted or requested to be cut in order to put an end to their psychological torment. Before, during, and after the procedure, almost all of the women reported experiencing extreme distress. Some expressed the emotion of relief from knowing their psychological torture would end and that they would gain social acceptance and total capital from being cut. UNICEF 2021 has also reported fear of stigma and being ostracized by family and the surrounding community as being one of the psychosocial effects that many girls and women who choose not to undergo the cut have to live with. Consequently, there is need to look into the deep rooted impact of culture among practicing communities. There is need to address the entrenched cultural dynamics that seem to cause psychosocial trauma on girls, whether cut or uncut, the desire to eradicate FGC has to be a wholesome affair so that the practice is abandoned in its entirety.

2.8 Knowledge Gap

According to the literature study, female genital mutilation (FGM/C) is a practice that has been practiced for over a millennium, and it is a form of violence against women and girls. Even though those who engage in the practice refer to it as "cultural," it has been shown to have a number of detrimental effects, including bleeding, death, damage to female genital tissue that interferes with the bodies' natural functions, pain during sexual activity, dropping out of school, getting married young, and having less sexual satisfaction. It has also been linked to psychological health issues for girls and women as well as the violation of their rights. While its origins are unclear, eradicating the cut will not only bring the world one step closer to achieving gender equality but also fulfill the obligation of SDG 5.3 by 2030. With the changing trends of cutting girls below the age of 5 and conducting the cut in secrecy, there is fear that the various state and non-state interventions ranging from national and international declarations and legal frameworks;

community sensitization programs; arrest and prosecution of perpetrators to media campaigns may not bear much fruit. Furthermore, the far reaching psychosocial effects of FGC (stigma, humiliation and depression) on women and girls have not been exhaustively been looked into. In this context, the majority of studies have focused on the social, economic, and cultural effects of FGC but with little focus on the effectiveness of FGC interventions on the psychosocial wellbeing of the girl child in Marani Sub-County, Kisii County, Kenya. It is on this basis that the researcher proposes this study to fill the aforesaid existing knowledge gap.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the methodology that was adopted for this study. It entails the research philosophy and the research approach this study will be anchored on. Further, it elucidates the research philosophy, research design, target population, sample size and sampling procedures, instruments of data collection (questionnaires, interview guide and focus group discussion guide), validity and reliability of the research instruments, data collection procedures as well as data analysis techniques and presentation.

3.2 Research Philosophy

This study was anchored on the cultural relativism paradigm which argues that all cultures are valid and thus FGC should be given cultural validity since criminalising the cut denies women their social acceptance without seeking or accepting other comparable means for ensuring social acceptance. This inadvertently leads to defensive cultural adherence (Ipinyomi, 2015). This paradigm asserts that since each culture has its own inherent integrity with unique values and practices, value judgments should be withheld or suspended until cultural context is taken into account (Digan, 2002). Cultural relativism theoretically pursues the thought that both infinite cultural diversity and all cultural practices are valid hence the practice of FGC ought to be assessed devoid of personal bias. In their view, therefore, medicalization is presented as the solution to the assumption of harm since it will solve the health risks. These arguments are an extreme application of cultural relativism which highlights the primacy of culture to the detriment of human rights or physical well-being. Consequently, according to Ipinyomi (2015) the culture relativism narrative contradictorily encourages stubbornness of culture; yet culture is fluid in the manner it serves the people, functioning only for as long as those

who use it need it. Ultimately, the role of societal components changes as society evolves. Cultural relativists argue that culture is more superior to human rights. Culture in this sense is paramount and innate and human rights law is extraneous (Ipinyomi, 2015). Digan (2002) asserts that the understanding of cultural relativism holds that anthropologists should not condemn or defend any cultural practice when utilizing a relativistic perspective. Relativism is a perspective, which allows for a context-specific, systematic understanding of cultural beliefs and traditions. It does not involve any kind of judgment whatsoever. Suspending judgment for the sake of scientific observation and analysis, however, does not mean that such judgments cannot be later made. What is important to consider is that cultural relativism and advocacy for universal human rights need not contradict one another. The anthropologist must have a strong hold on the concept of cultural relativism and understands that violations of human rights are not relative; furthermore, it is vital to remember that cultures are not homogenous. There are individuals in a culture who may not agree with every aspect of their culture (Digan, 2002).

3.2 Study Area

This study was conducted in Marani sub-county, Kisii county, Kenya. Marani has a total of 14 locations and 28 sub- locations. The locations include Kegogi, Metembe, Megogo, Ikuruma, Matongo, Ng'enyi, Mwakibagendi, Mwakibagendi West, Mwagichana, Mwagichana East, Mwamonari, Mwamonari North, Sensi and Kiong'anyo.

3.3 Research Design

This study will use a mixed method research design (MMR). It will be in line with the purpose of the study as it seeks to assess the effectiveness of anti FGC interventions on the psychosocial wellbeing of the girl child in Marani Sub-County, Kisii County. Specifically, a convergent parallel mixed method design will be used. A convergent

parallel mixed-methods design is an approach to inquiry that combines both qualitative and quantitative methods concurrently, prioritising both methods almost equally (Creswell & Clark, 2011, and Creswell, 2014). In this case, the quantitative and qualitative methods complement each other, and provide for the triangulation of findings, hence greater validity of the emerging inferences. Whereas the former approach will give a more general understanding of the issue of the influence of culture on the persistence of FGC, the latter will provide a detailed and in-depth understanding of the same.

The convergent parallel mixed methods design will be preferred because the researcher will prioritize the methods (qualitative and quantitative) equally and keep the strands independent during data collection and then mix them during analysis and at the findings during overall interpretation. It is also preferred because it will enable the researcher to compare and relate data to be collected and analysed easily before interpretations will be made (Teddlie and Tashakkori, 2009). In this study, the researcher will collect data on the effectiveness of FGC interventions on the psychosocial wellbeing of the girl child in Marani Sub-County, Kisii County from the different targeted population. At the same time, the researcher will analyse the data collected using both quantitative and qualitative data analysis techniques and then merge, relate and compare the two data sets. Data will then be presented using a side-by-side method.

3.4 Target Population

The target population was the specific population about which information is desired. Ngechu, (2004), defines a population as a well-defined set of people, services, elements, events, and group of things or households that are under investigatation. It also refers to the population to which a researcher wants to generalize the results of the study (Mugenda & Mugenda, 1999). The target population was the heads of households of Marani Sub-County. Kenya Bureau of statistics, (KNBS) (2019), reports that the Sub-

County had a total population of 107, 464 with 50,598 male against 56,864 female. The number of households is 26,186 spread across 14 locations.

3.5 Sampling Procedures

This study used different sampling techniques. To begin with, cluster sampling technique, which is a probability sampling technique involving the subdivision of the population to be sampled into mutually exclusive groups, was used by the researcher. Cluster sampling is appropriate when the population of interest is scattered, and no particular list of the population exists. In this regard, the researcher used cluster sampling to identify households to be included in the study. This involved identifying heads of households covering a particular geographical area of administrative boundaries within Marani Sub-County, Kisii County, Kenya.

In addition, the researcher used purposive sampling, which is a non-probability sampling technique where the researcher used her own judgment to identify the participants for the study. through this technique, the researcher was able to identify the key informants for the study who are public administrators, mainly chiefs and sub-chiefs, health professionals, traditional practitioners as well as religious leaders. According to Salim (2007) there are no rules in determining sample size in qualitative studies. The size may depend on what the researcher wants to know, purpose of inquiry, time and resources available.

Kothari (2004) emphasizes that a good sampling design should have minimal sample error, be truly representative, viable, generalizable and systematic bias controlled. The study was modeled along this perspective. The study employed both probability (proportionate stratified) and non-probability (purposive) sampling approaches. Such a proportionate stratified sampling approach enables a broader sampling of the population than a single method and therefore greater representativeness of the population in the

sample (Agresti & Finlay, 2009). In this context, Cochran's formula for sample size was used to get an appropriate sample for this population.

3.5.1 Sample Size Determination

A sample refers to the actual item or individual selected for a study whose characteristics exemplify the larger group (targeted population). A sample size is the total number of the participants picked for the study. In this study, various factors influence the determination of sample size. These include margin of error (confidence interval), confidence level and the proportion chosen gave answers for the research question (Aarons et al., 2012). A margin of error of between1% to 5% is considered reasonable in sample size determination. The margin of error serves well for purposes of generalization (Saunders et al., 2014). The sample size for the study was determined at a 95% confidence level; the scientifically acceptable degree of accuracy. To determine the sample size, the Cochran (1963) formula was used. This formula is used when dealing with finite population. A finite population is that which can be counted. Thus:

$$n_0 = \frac{Z^2\,PQ}{d^2}$$

Where:

n_0 = desired sample size

Z = 1.96 (standard normal deviation at 95% confidence level)

p = known proportion of the population with desired characteristics. Prevalence of FGC in the region is 84%, thus 0.84 was used as the value for this study.

q = constant (usually set at 1-p (1-0.84)

d = degree of accuracy was set at 0.05

Thus desired sample (n) = $\{1.96^2 *(0.84*(1-0.84)\}/0.05^2$

Hence; n_0= $\frac{(1.96*1.96) *(0.84*0.16)}{(0.05*0.05)}$

n_0= 206.52 ~207 at 95% confidence level with ±5% precision.

The sample size for this study was therefore, 207.

The total sample size is summarized as shown in the table below:

Table 3.1 Sampling Matrix

Serial number	Target Group	Population	Instruments	Sampling Technique	Proposed Sampled	Actual Sample
1.	Heads of Households	26,186	Questionnaire FGD Guide	Cluster, random	207 (4(6))	200 (3(6))
2.	Administrative Officers (Chiefs & sub-chiefs)	42	KII	Purposive Purposive	10	6
3.	Religious Leaders Health Professionals		KII	Purposive	3	2
4.	Traditional Practitioner		KII	Purposive	4	4
5.			KII	Purposive	2	1
Total		26,228			226	213

3.6 Methods of Data Collection

The study used both secondary and primary data to achieve its objectives. Primary data refers to firsthand information gathered by the researcher from the respondents in the field whereas secondary data is data that is already in use for other purposes other than that of the researcher. For instance, data in health centers related to FGC cases, case files

and other date available at the police desk. The three data collection techniques used by the researcher for this study were used for triangulation and are hereby highlighted.

3.6.1 Questionnaire

Questionnaire, being a quantitative technique for gathering information was the major tool used to collect primary data. The questionnaire was semi-structured and contained questions on the effectiveness of anti- FGC interventions on the psychosocial wellbeing of girls in Marani Sub- County, Kisii County. The questionnaire was self-administered and this allowed for face-to-face interactions with the respondents for further probing. The essence of having semi structured questions is to allow for a process of interaction between the researcher and the respondent where the latter was given an opportunity to give opinions and ideas on the research questions.

3.6.2 Key Informant Interview (KII)

This was used as a data collection tool during the study. KIIs were conducted with the chiefs/sub- chiefs, traditional practitioners, the religious leaders as well as health professionals. KIIs allowed the researcher to collect general information on the FGC interventions on the psychosocial wellbeing of girls in Marani Sub-County, Kisii County. This enabled the researcher to identify the best approach to use on participants at the community level. The researcher developed an interview guide with questions regarding effectiveness of anti FGC interventions on the psychosocial wellbeing of girls in Marani Sub-County, Kisii County. The researcher scheduled a meeting with the respective offices given their busy itinerary. The researcher developed a key informant guide which was used in the data collection processes. The guide comprised of questions that the researcher posed to the interview respondents and allowed them to give their views and opinions while allowing room to probe. A guide is useful in the exercise so as not to lose focus on the study research questions.

3.6.3 Focus Group Discussion (FGD)

The Focus Group Discussion (FGD) guide was used by the researcher to conduct discussions with the study participants. The schedule was developed in relation to major topics centred around the objectives of the study. These discussions gave detailed information which was easily placed under each of the sections of the FGD schedule in line with the themes of the research questions. This study used FGD as an instrument to collect data from purposively selected women and men within households in Marani Sub –County. The FGD consisted of 4 groups of 6 participants each. That gave a total of 24 participants. Two of the groups consisted of male while the other two consisted of female participants. The researcher categorized the questions as probe questions, follow-up questions and finally exit questions.

The researcher considered factors such as age, gender and literacy level of participants while selecting the groups. The researcher had 1 moderator per group thus a total of 4 overall. The moderator was not being a participant but had knowledge on the topic under discussion. The moderator was a neutral member and worked towards eliciting information from all the participants including the dominant and shy. The moderator also ensured the clarity where possible and also that participants discussions were within the topic of discussion and time schedule. Items on the FGD guide were further broken down into a guide with a list of questions among others seeking information on the FGC interventions, the place of men and women in abandonment of FGC, the main stakeholders of FGC interventions, effects of FGC on the psychosocial wellbeing of girls, and challenges faced in the abandonment of FGC in Marani Sub- County, Kisii County.

3.7 Reliability and Validity of the Research Instruments

McMillan and Schumacher (2006) define reliability and validity as trustworthiness, rigor and quality both in the qualitative and quantitative paradigm. This can be accomplished

by disregarding bias and increasing the researcher's truthfulness of a proposition about some social phenomenon through triangulation. Mugenda (2008) recommends that validity should be based upon careful analysis of the individual items by several expert judges. The validity of the instruments used in this research ensured that the researcher takes time to comply with the formalities and procedures adopted in developing research instruments (Onwuegbuzie, 2000). Construct validity is the extent to which the instruments were interpreted as a meaningful measure of some characteristic or quality. It is an assessment of how the theories have been translated to into actual measures. The values of this study were operationalized to reflect the theoretical assumptions that underpin the conceptual framework of the study.

The instruments were analysed by the researcher's supervisors as experts who reviewed them and made comments. The supervisors critically assessed the relevance and appropriateness of the items in each instrument and the sequencing, wording and instructions therein. They were pre-tested and the responses from the participants used to improve on the items in the instruments. The pilot study enabled the researcher to assess the clarity of the items in the instrument so that those items found to be vague were modified to improve the quality of the instrument thus, increasing its validity.

Credibility as an element of validity of qualitative research denotes the extent to which the research approach and findings remain in sync with generally accepted natural laws and phenomenon, standards, and observations (Denscombe, 2005). Since the study involved recording the participants experience and insights on the effectiveness of FGC interventions on the psychosocial wellbeing of the girl child in Marani Sub- County, the participants were asked to confirm that what was recorded reflects their responses on the items in the instrument of data collection. Credibility was assured by peer review, members checking, reflexivity and saturation.

The validity of qualitative research depends on transferability Onwuegbuzie (2000). Content validity of the instrument was determined through review by experts in research, where the responses of the subjects were checked against the evaluation questions. According to Punch (2005) validity ensures that the instrument measures what it is intended to measure effectively.

Before the actual study was done, the researcher conducted a pilot study in one of the Sub-locations in Kitutu Chache Sub – County, Kisii County, on a population sample that did not form part of the final study thus, a part of the study population or sample with similar characteristics with those in the population to be studied. The sample was selected purposively. The purpose of the pilot study was to pre-test the instruments of data collection to enable the researcher improve efficiency as well as ascertain the reliability and validity of the instruments. In addition, this enabled the researcher to adjust strategies and approaches to maximize response rate and to familiarize with their administration (Ogula, 2010). Pilot testing instruments guaranteed success of instruments hence help to capture what the researcher intends to achieve. The result of the pilot study assisted in editing and aligning of the research variables to the respective questions. This helped to eliminate ambiguous words and terminologies in the final questionnaires and FGD guide.

In this study, it was important to ensure that the level of internal consistency with which an instrument measures what it intends to measure (Jarvinen, 2001) was established. This ensured reliability. According to Mugenda (2008), in order for the study results to be reliable, the research instrument must yield consistent results or data after repeated trials. Accordingly, the test-retest method was employed to establish the reliability of the instruments for this study. The technique involved administering the same instrument twice to the same pilot group of participants at different times (Kerlinger & Howard, 2006).

The challenge with this method is to determine the correct delay period between the two administrations of measure (Gall, Gall & Borg, 2002). This is because if the re-test is administered too soon after the initial test, participants may recall their responses to many of the items which tended to produce artificially high reliability coefficient. On the other hand, if the re-testing is delayed too long there is a good possibility that the participant's ability to answer some items changed, and this may lead to lower reliability coefficient (Mugenda, 2008).

To minimize these challenges, a period of two to four weeks is the most appropriate for most social researchers (Kerlinger & Howard, 2006) and in this case a period of two weeks' lapse was adopted. The instruments were administered to the same group in the pilot study twice within an interval of two weeks. Pearson Product Moment Correlation Coefficient was used to compute the correlation coefficient to establish the reliability of the instruments to be used. A reliability of not less than 0.7 is the recommended value of coefficient of consistency Fraenkel and Wallen (2003). In this study, the researcher accepted a level of reliability of .70 which was considered acceptable since instruments with a .70 and above are powerful and stable enough.

3.8 Data Analysis

Completion of the data collection process calls for the data analysis process. The researcher analyzed the data collected using both quantitative and qualitative data analysis techniques and then merged, related and compared the two data sets. Data was then presented using a side-by-side method as opposed to a joint display method. There are several steps which were required to prepare the data ready for analysis; these steps involved data editing and coding, data entry and data cleaning to allow for appropriate entry into the statistical software.

The researcher edited the raw data collected through the questionnaire with an effort to detect errors and omissions such that the minimum data quality standards have been achieved. Coding involves assigning numbers so as to be able to group responses into a limited number of classes or categories (Shukla, 2008). The researcher assigned numerical values to the questionnaire item responses and which was done by developing a codebook for the survey questionnaire. Data entry involved the process of keying the data into the Statistical Package for Social Scientists (SPSS) version 28 for statistical analysis.

Quantitative data was analyzed through the use of descriptive statistics which enabled the researcher to describe the aggregation of raw data in numerical terms that were then computed for presentation and analysis Neuman (2008). The descriptive statistics involved the use of frequencies, means, standard deviation and percentages. The researcher checked for completeness, consistency and errors. Data was then edited, coded and keyed in using SPSS version 28. Data was presented in the form of tables and figures that facilitates description and explanation of the study findings.

Qualitative data on the other hand, analyzed by documentation of data collected, coding, sorting, categorizing, editing, corroborating the findings with research questions and developing themes and connecting to make meaning based on what the researcher was required to investigate and record this in the findings (Creswell et al., 2008). The themes were synthesized through sub-headings and the findings reported in form of narratives and quotes. The researcher begun by transcribing all FGD tapes and insert notes into the transcribed material.

The researcher conducted a clean-up of transcripts by stripping of none essential words, simultaneously assigning each participant comment on a separate line on the page, label each line with the participant and assign a group number. Each line was entered into

Excel spread sheet with each group having a separate sheet. The researcher looked for common themes across the entries and assign numbers/letters to each theme. The themes were synthesized through sub-headings and the findings of each sub-category noting the similarities and differences across the groups. The study was limited to descriptive statistics because of the nature of the subject matter (Salim, 2007).

Descriptive statistics allow social science to organize and summarize data in a meaningful way (Frankfort-Nachmias & Nachmias, 2000). Description is essential to positivist science and a necessary step before any further statistical analyses. Descriptive statistics have an important role to play, enabling data to be explored before any further analysis is undertaken but also as a primary means of describing how things are rather than seeking to explain why phenomena occur.

Frequency distributions were used to describe data indicating the frequency of all categories or ranks, either in a tabular form or as a pie-chart (Somekh & Lewin, 2005). Analysis of data was conducted through descriptive statistics. The quantitative data was obtained from closed ended questionnaires whereas qualitative data was obtained through Key Informant Interviews (KII) and Focus Group Discussions (FGDs). The FGDs comprised verbal and narrative descriptions. The data from the completed questionnaires was cleaned, coded and then entered into the computer using the latest Statistical Package SPSS version 28.

3.9 Ethical Considerations

Ethical issues form an integral component of research as far as the conduct of researchers is concerned. Other issues the ethical research considers are privacy, confidentiality, and sensitivity to cultural differences, gender and anonymity (Kitchin & Kate, 2000). Shukla (2008) states that ethics relate to the moral choices affecting decisions, standards and behavior and in research it has become difficult to lay down clear ground rules which can

cover all possible moral choices. However, there are basic grounds of ethics relating to social research which the study applied during the study. Creswell (2009) asserts that the researcher must obtain informed consent from all the participants before undertaking the study.

The researcher obtained a letter of introduction from Kisii University to serve as evidence of the purpose of the study and further secured a research permit at National commission for Science Technology and Innovations (NACOSTI). The researcher then went ahead and sought authorization from the County Commissioner in Kisii County to conduct her research in Marani Sub – County. Upon being granted permission, the researcher then prepared identification tags for her team of research assistants before heading out to the field. While in the field, the researcher ensured that nobody was coerced to participate in the study. All the participants had the freedom to stop participating any time they felt uncomfortable. Participants in the FGD guide were sought informed consent before engaging in the discussions. The researcher also ensured that confidentiality and anonymity were upheld during the research process by assigning numbers to participants instead of names. These enabled participants to be in control of the disclosure of their identity and their contribution. The researcher also assured respondents on the privacy of the information they provided by not divulging information to other community members and conducting interviews in a private environment.

Confidentiality of the information provided was also an ethical concern which the researcher enhanced by assuring respondents that the information provided was only for academic purposes. All recommended COVID-19 protocol were adhered to by the research team during the conduct of the study.

CHAPTER FOUR

RESULTS AND DISCUSSION OF STUDY FINDINGS

4.1 Introduction

This chapter presents the findings for the effectiveness of anti- FGC intervention on girls' psychosocial wellbeing in Marani sub county, Kisii County in Kenya. The chapter summarizes findings in percentages, frequency, tables, narratives and quotes. The chapter is subdivided into five major sections starting with findings on respondents' demographic information comprising of age, sex, education level and occupation. This section is succeeded by findings for specific objectives and research question for the study. The study used household questionnaire, KIIs and FGD guide to discuss the findings. Out of the 207 households targeted 200 respondents completed the household questionnaires which translated to 97% of the respondents. The 97% response rate was considered appropriate for analysis. Additionally, 18 out of the expected 24 participants responded to the FGD whereas 13 out of the expected 15 responded to the KII.

4.2 Demographic Information

This study considered demographic information for the respondents critical in ensuring representativeness and authentication of information from the respondents. The study sought information on age, gender, education level and occupation of the household heads used for the study. Data obtained was summarized and presented in table 4.1.

Table 4.1: Demographics Characteristics n=200

Variable	Respondents	Frequency	Percentage
Age Category	26-35	60	30.0%
	36-55	85	42.5%
	above 55	55	27.5%
Sex	Male	63	31.5%
	Female	137	68.5%
Education Level	Primary	57	28.5%
	Secondary	106	53.0%
	College	27	13.5%
	University	10	5.0%
Religion	Catholic	59	29.5%
	Protestant	69	34.5%
	Traditionalist	3	1.5%
	SDA	69	34.5%

Analysis in Table 4.1 presents demographic characteristics of respondents. Age category of the respondents was an important aspect of the study. Findings showed a good portion of 42.5 % of the household heads were aged between 36-55 years, 30.0% were aged 26-35 years while 27.5 % were aged above 55 years. These age category shows that majority of the households are headed by middle aged adults. The results also imply that the respondents were of the required aged to provide information sought by the study.

Gender/sex of the respondents is important while discussing concepts and attitude towards FGC in any community. Table 4.1 show majority 137 (68.5%) of the respondents were female while 63(31.5%) were male. The results show more female respondents at household level than male. The results are explained by more reception from women than men who opted for their female household members despite them being the head of the

household. The researcher observed that men were uncomfortable discussing FGC as compared to women.

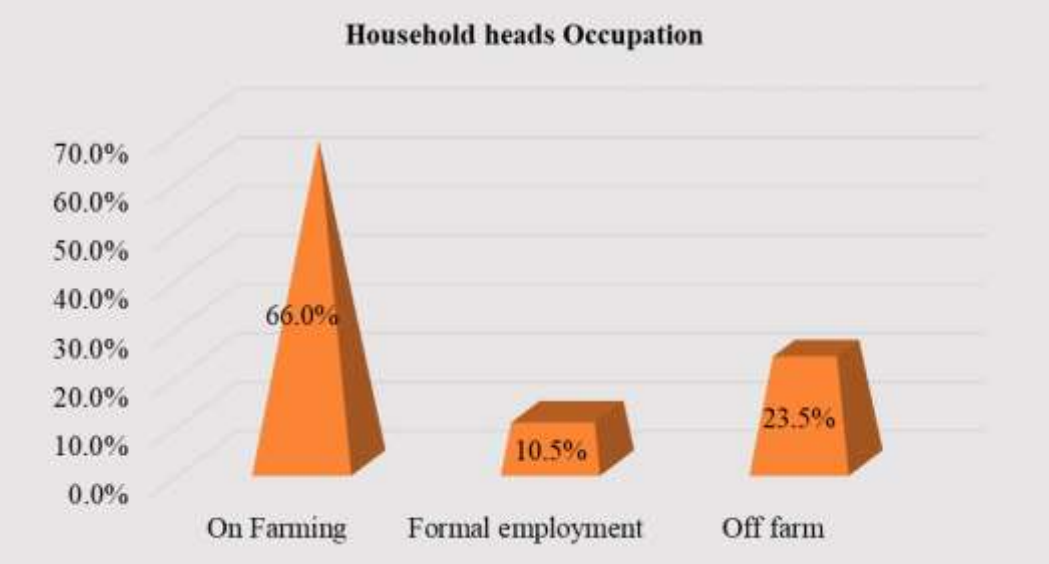
Slightly above half 53.5% of the respondents had attained secondary education level, this was followed by 28.5% who had primary level of education, 13.5% college level and only 5% indicated that they had attained university educational. From the results majority of the household members interviewed were secondary school graduates implying a considerable good literacy level among the respondents to understand concepts and the concerns of the study.

As observed by Beller and Kroger (2018), religion is a key predictor for FGC in various communities across the world. Following their argument, the researcher inquired from the respondents to indicate their religion. An overwhelming 97% were Christians belonging to various religious affiliations. An equal proportion 69(34.5%) were protestants and SDAs, 59 (29.5%) Catholics while were 3(1.5%) traditionalists. These results demonstrate a good representation of religion in the various households. The study however, was not able to find any member from the Islamic religion. A similar study by Kandala et al. (2019), established that FGM/C were considered a religious obligation in some communities. This study also argued that ethnic belonging like being a Gusii, pastoral or Somalia increased the girl's risk to FGM/C.

4.2.1 Occupation of the Respondents

Socio-economic status has been presented as a determinant for FGC. In this line of study therefore, the researcher was interested in understanding the occupation of the respondents. Data obtained were summarized and presented in figure 4.1.

Figure 4.1: Household Heads Occupation



Analysis results presented in figure 4.1 show most (66.0%) of the respondents were carrying out farming. This is followed by 23.5% in off-farm activities and a minority 10.5% were in formal employment. Those in on farm occupation were majorly farmers. The category of respondents in off farm occupation were business people, jua kali workers, casual workers as well as religious workers. Those in formal employment were represented by teachers, medical staff, employees from the financial as well as security institutions. The results show on farm as a main occupation in the Kisii community. A study by Bokaie (2020) found out that there was no significant effect between occupation and intervention for FGC in Iran.

4.2.2 Household Composition

Respondents were requested to give information about the number of members in their household, number of children, gender of the children and number of grandchildren. This data was captured in continuous numerical form. The study summarized this data in mean minimum and maximum number of household members as presented in table 4.2.

Table 4.2: Distribution of Household Mem **n=200**

Household composition	Minimum	Maximum	Mean
Number of Household members	1.	20.00	6
Number of children	0	13.00	5
Number of male children	0	7.00	3
Number of girls children	0	8.00	2
Number of grandchildren	0	27.00	4

Table 4.2 indicates that a household had an average of 6 members with the smallest household having only one member while the largest had 20 members. The average number of children in the household was five with some households having none while others had as many as 13. The results further show that there was no significant difference between the number of male and female children in the studied households. Households had an average of 3 male children with a maximum of 7 while girl children were an average of 2 per households with a maximum of 8.

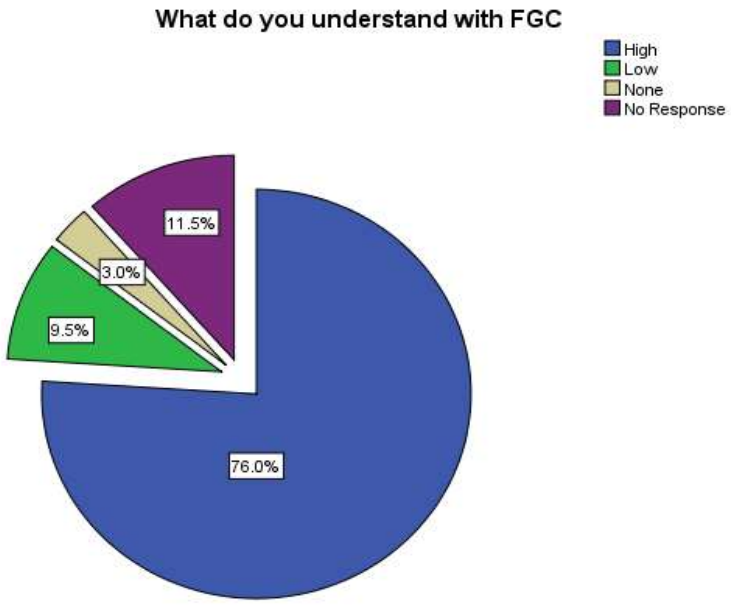
4.3 Effects of Local Construals on Implementation of anti- Female Genital Cut Intervention on Psychosocial Wellbeing of Girls

The first objective of this study sought to examine the effects of local construals on implementation of anti FGC interventions on psychosocial wellbeing of girls. In this section the research presents findings on locals understanding of FGC, reasons for FGC, and the influence of various community actors on the FGC practice.

4.3.1 Locals Understanding of Female Genital Cut in Marani Sub-county

Respondents were asked to explain what they understood by FGC. This was used to evaluate their level of awareness of FGC in the study area. Data was summarized and presented as shown in figure 4.2.

Figure 4.2: The Understanding of FGC



Results in figure 4.2 demonstrate that a majority (76%) of respondents had high knowledge, this was followed by 11.5% who did not respond, 9.5% having low knowledge while 3% who had no knowledge of FGC in the Kisii community. These results show that knowledge on FGC was high among households which are in agreement with the KDHS (2022) which reported that 97% of men and women in Kenya had knowledge of what FGC is. In their description, respondents explained their understanding of FGC as a cultural practice among Abagusii that a girl must undergo, some described the process of FGC as the removal of the clitoris or other genital parts.

Other respondents described their knowledge based on the purpose of the practice noting that it was a practice that reduced sexual urge among girls. Those with low knowledge

indicated FGC to be circumcision. Some clearly stated that they were not aware of the practice and did not know what it entailed. Others however refused to give any answers; a male respondent indicated that he had no knowledge of the practice because it involved girls.

4.3.2 Reason for Practicing Female Genital Cutting

Information about reasons for practicing FGC was sought. Data obtained were summarized and populated in table 4.3.

Table 4.3: Reasons for Practicing Female

Reasons	Frequency	Percent
Fulfill cultural obligation	115	57.5%
For social acceptance in traditional circles	80	40.0%
Reduce sexual urge and protect girls from early pregnancy	68	34.0%
Improve sexual experience in marriage	35	17.5%
Ignorance	45	22.5%

Findings in Table 4.3 reveals that majority (57.5%) of the respondents practiced FGC to fulfill cultural and traditional obligations in Gusii community. Social acceptance was revealed by 40%, reduced sexual urge and protection of girls from early pregnancy 34% were also considered as reasons for continued practice of FGC in Kisii County. Ignorance was mentioned by 22.5% while improvement of sexual experience in marriage was 17.5%. These results clearly indicate that culture and social acceptance continues to explain the instigations behind FGC on girls. This is corroborated with the findings of Omigbodun et. al. (2022) who assert that FGC was profoundly embedded in the local

culture of practicing communities. Qualitative data from key informants unrevealed other reasons for practicing and not practicing FGC. The theory for FGC reducing sexual urge was however contradicted by an informant who posited that it did not. She explained the reason as follows:

> Those who say FGC is supported in the bible are wrong because only Abraham was circumcised but not Sarah. In Gusii communities, men went to war for prolonged periods and they believed that cutting women would help women not go look for men when they were away……I personally went through the cut and there is nothing like lowering sexual urge. (K001 Female chief, 52 years)

Another respondent said:

> …. they say someone who has undergone FGC are not active in sex so they are faithful and those who have not undergone can get diseases easily due to multiple partners…traditional mothers state that people who have undergone FGC are morally upright compared to those uncut whom are considered prostitutes. (KI005 Male Medical officer, 40 years)

From the above findings it is clear there is no biblical explanation of FGC among Gusii community but rather socio economic activity of warfare among the community explained why it was traditionally adopted. Some participants shared that FGC was practiced to reduce sexual urge among women while others argued that despite this being the believe, it was not practically possible. The statement further revealed that reduction of sexual urge was not a true factor for continued practice of FGC since women who have been cut do not attest to the perception of reduced sexual urge thus confirming findings by Ahinkorah et. al (2022) which revealed that in Mali, women who had not undergone

the cut were less likely to have multiple sexual partners compared to those who had been cut thus demystifying the assertion that FGC was meant to reduce sexual urge.

Both quantitative and qualitative findings indicate that FGC is conducted for traditional reasons. The traditional reasons however, do not hold a lot of strength since because of modernization the practice has reduced significantly. The study results also show that the believe that FGC improves faithfulness in marriage is not true but just a perception that is not experienced by girls who have undergone FGC.

4.3.3. Support for FGC in Marani Sub-County

Participants were asked to respond on whether they support FGC in the community. Quantitative results clarified that a majority 172 (86%) did not support the practice, 25(12.5%) supported the idea while 3 (1.5%) were neither supporting nor not supporting the practice. These results demonstrate that FGC practice has low popularity and support by the community members. Qualitative results for the same showed majority of the key informants had negative perception towards FGC and did not support it. A point in case is a female chief participant who explained that:

> …That cannot happen here and if it is happening they are doing it as top secret. In 2020 I arrested a family that had conducted FGC on a girl and took them to Rioma police station. Though the case was thrown out due to lack of evidence people in this area feared practicing FGC because they know they will be arrested." I have also not circumcised my girls (KI001 Female chief, 52 years).

The above findings clearly reveal that FGC is not a welcomed practice even among the local leaders in Marani sub-county. The arrest of perpetrators demonstrates that the practice is illegal and could attract jail term if prove of act is found. The fact that the chief had not circumcised her girls also shows that as an individual and member of the local

community she did not support the practice. During the interview she further asserted that she believed that girls who have not undergone FGC are better than those who have. This additionally shows that FGC practice is not supported in in Marani sub-county.

Another respondent in the FGD commented that she supports the practice but did not give any reason. During interview a participants retorted that she had observed in a meeting that men supported the practice because they believed it was the traditions that must be upheld but they did not know anything and even who and when FGC was done. Another participant was in agreement with the above assertion that:

> Most men are not aware when the cut is done because they are not told the truth but some have negative minds. We had a meeting some few weeks ago with Kenya bureau of statistics of research from Kisii so when they were talking of this practice some men were saying it is wrong to stop it because it is a tradition. I questioned them and I realized they were illiterate and had primitive believe." KI003 Male chief, 60 years)

The above narration indicates that men are not so much in the picture of FGC which could be a female gendered practice. It also shows that some community members upheld the practice to protect a tradition that they did not have much understanding of. These findings are justified by Social convention theory; which states social constructions are deeply rooted social traditions that spell out consequences for one who fails to abide by their dictates. Mackie highlights that change is projected to result from coordinated abandonment in intermarrying groups, so as to preserve a marriage market for uncircumcised girls.

4.3.4 Reasons for not Supporting Continuation of Female Genital Cut

Respondents were asked to explain their reasons for not supporting the continuation of FGC and the findings were summarized as illustrated in figure 4.3.

Figure 4.2: Reasons for not Supporting FGC

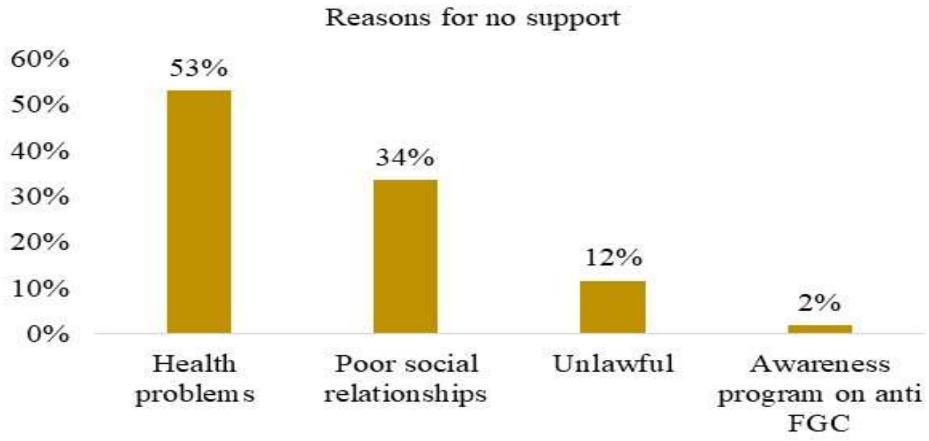


Figure 4.3 revealed that slightly more than half 87(53%) of the respondents did not support the FGC practice because of health reasons. Most of the respondents explained that the FGC caused girls problems while giving birth, others died over excessive bleeding, while others suffered fistula or infected with diseases due to sharing of the razor during the process. A significant proportion 55(34%) of the respondents did not support the practice because it had been declared unlawful and parents or women engaging in the cutting could be apprehended in court of law and charged for violating the rights of the affected girl.

Others 19 (12%) did not support the practice because they had received awareness program that had enlightened them on the effect of FGC among girls and women. A small proportion 3(2%) mentioned that they did not support the practice because it affected the girls' social relationships. They explained that girls who have undergone FGC could not relate with other well in schools or even marriages leading to marriage breakups and dropping out of school.

Qualitative results also show reasons for not practicing FGC. For instance, influence from other non-practicing communities was identified as a major reason for not practicing FGC. One of the respondents stated that "…*most people were not doing the cut so I saw this cutting had no profit." (*K001 Female, 52 years).

From this statement it is clear that FGC can be influenced by staying where people are practicing it. When one stays in a community where the cut is not practiced then they are likely to be influenced otherwise even if it is their culture. This finding supports the theoretical argument from Social learning theory proposed by (Bandura, 1977). According to this theory people change their behavior based on environmental factors. In this case, the respondent having lived in a different environment where FGC is not practiced was able to unlearn FGC which she currently views as a retrogressive practice with no value to the girls despite it being heavily integrated in the culture.

4.3.5 Cultural Beliefs that Enhanced by Practicing Female Genital Cut in the Community

The study observed that despite the various FGC interventions the practice was still being done by some households. To develop effective anti-FGC intervention, it was important for the study to interrogate some of the traditions in the Gusii community that enhance the FGC practices. Respondents were asked to mention some of the things done by the community that enhanced FGC. Data was summarized and presented in table 4.4.

Table 4.4: Cultural Norms and Constructs Enhancing Female Genital Cut

Norms and beliefs	Frequency	Percentage
Upholding traditional ways	196	98%
Transitioning girls to adulthood	177	89%
Preserving girls' virginity	25	13%
Upholding family honor /status	124	62%
Improving girls' marriage status	65	33%
Prevention of early pregnancy	39	20%
Improve chastity in marriage	42	21%

From the analysis in Table 4.4, the study found that majority 98% of the respondents practiced FGC due to their belief of upholding the Gusii cultural traditions, 89% considered it an important norm for transiting girls from childhood to adulthood. Additionally, over 124(62%) of the respondents practice FGC to uphold the family social status. Other beliefs and norms that promoted the FGC practice among the Gusii community included improving girls' marriage status (33%), prevention of early pregnancy (20%), and improving chastity in marriage (21%). These findings reveal that FGC was enhanced by people holding on traditional ways of life and upholding family honor.

Qualitative results indicated that FGC was perceived to reduce sexual urge when men went for war/battle. However, respondents refuted that FGC reduced sexual abuse as stated by a key informant those who are not cut and those who are cut come together those who were cut look more exposed than those who are not cut. This is evidence that it FGC did not support chastity in marriage. Another statement stated that a woman is a woman implying that FGC did not enhance family status nor honor. Practicing FGC as a belief system was commonly identified but majority of locals lacked clear reasons for

practicing FGC. From the perspective of Step Change Theory, it is evident from the findings that in FGC practicing communities such as the study area, behavior of individuals is a dynamic balance of forces working in opposite directions while driving forces facilitate change as they push entities in the preferred track. Confining forces obstruct change since they drive individuals in the conflicting direction in which case, in this study, this group represents those opposed to the eradication of FGC among the Gusii community in Western Kenya. In Lewin's view, the first step of this process of behavior change is unfreezing the existing state this is the status quo often viewed as the state of equilibrium.

4.4 The Place of Women in Implementation of anti- Female Genital Cutting Interventions

The second objective analyzed the place of women in the implementation of FGC interventions on the psychosocial wellbeing of the girl child in Marani Sub- County.

4.4.1 Actors Influencing Female Genital Cutting in Gusii Community

Effective intervention against FGC should have a clear picture on the actors found within and outside the community. In many studies people within the community have been playing a big role in influencing the continued practice of FGC. This study investigated the influence of different actors within the community, particularly women. Respondents were asked to rate the influence of mothers, aunties, fathers, peers, mother in-laws on the FGC practice. Data obtained was summarized and presented in table 4.5.

Table 4.5: Influence of Different Actors on Girls Undertaking FGC

Actors	Mean	Std. Dev
Mothers	3.8	.68
Aunties	3.2	.533
Grandmothers	3.8	1.011
Fathers	2.2	.859
Peers	2.7	.963
Mother in-laws	3.4	.476

Results displayed in table 4.5 demonstrate that majority (*M*=3.8, *SD*=.68) who are mothers and grandmothers are very influential on girls undertaking FGC in the Gusii community. Aunties, mothers-in-law and peers moderately influenced (*M*=3.4, *SD*=.476) the practice of FGC in the Gusii community. While fathers had low influence (*M*=2.2, *SD*= .859) on the cut. These results imply a high influence on FGC practice from mothers and grandmother. Mother in-laws had moderate influence, while the influence of aunties and fathers was very low. Thus it is clear that mothers, grandmothers and mothers-in-law were the actors catalyzing continued of FGC practice among the Gusii community.

Interviews and FGD were conducted to gather more information on actors and strategy they used in perpetrating FGC. Men were found to have low influence on FGC. In an interview with a clinical officer from Eramba, it was noted that midwives were engaged in perpetrating FGC. The respondent stated the following:

> Traditional birth attendants who help other women to give birth in the village do cut women during delivery and there is nothing the victim can say. So we started training these women who help in delivery in the community. Once we have

trained them we give them something small to go and support women in the village deliver and stop the cut. (KI006; Male Clinical officer, 48 years)

From the findings, it evident that there were women with knowledge of delivery who engaged in FGC. Similar sentiments were also revealed by a reformed traditional practitioner/birth attendant who said that, she used to practice FGC on uncut women during delivery. In another interview the informant noted that the old women who were doing the cut have reduced and medical personnel are currently used in doing the cut. This is in agreement with the findings of Matanda et. al. (2022) who revealed that medicalization was more common in Kisii with more people preferring it since it was perceived to be safer than the traditional way. Results from quantitative and qualitative thus illustrate that women, mothers, grandmothers, traditional midwives, and some people with medical expertise engaged in FGC in the community.

4.4.2 Role of Men in Eradicating FGC

Different actors are used in communities to fight against FGC. among these actors are men who either support the practice through their preference for circumcised girls for marriage. To ensure a successful anti FGC intervention a holistic approach involving key people in the community is required. More often communities have argued that men have no role in ending FGC. This study sought information on what role men could play in eradicating the FGC practice within the Gusii community. The data was summarized in table 4.6:

Table 4. 6: Men Role in Eradicating FGC

Men role in Eradicating FGC	Frequency	Percentage
Report to authorities	37	19%
Declare publicly their non-acceptance of the practice	35	17.5%
Protect their wives and daughters from these practice	33	16.5%
be involved in creating awareness	40	20%
Men have nothing to do	55	27.5%

Results in table 4.6 show that 27.5% of the respondents felt that men did not have any role to play in eradication of FGC while a good proportion 20% said that men could be involved in creating awareness on the effects of the practice. Out of 200, 35(17.5%) said that men should declare publicly their non-acceptance of the practice while 37(19%) said that men should report to authorities when they come across such cases. Thirty-three (16.5%) felt that men should be actively be involved in protecting their wives and daughters from being forced into FGC. These results show that men play an important role in eradication of FGC even though some members in the community still feel that men are not involved. Qualitative results on the role of men as actors revealed that men were unaware when the cut was done. Other men blindly supported it as a traditional practice that they felt should be continued without vivid reasons of what value it adds to the community. Interview results show that men were involved in awareness campaigns since most of them had the advantage of attending anti FGC training and represented a good share of leaders in the community. When asked how men were involved in FGC intervention a participant narrated that:

> In this community most leaders are men and they find themselves in many training with NGO anti FGC actors where they are trained on anti FGC intervention. The men thus take advantage of these trainings and they go talk about it in barazas, their homes and in churches (KI002 Female Participant, 43 years).

This statement shows that men were actors in creating awareness and preaching against the practice. However earlier statement that men were not aware when FGC is done might mean that while men spread the anti FGC messages the lack of awareness on when it happens could limit the anti FGC interventions. This finding closes the gap identified by Varol (2015) that men's role in abandonment of FGC was not clear. The study however found minimal interaction between men and women on FGC issues and social obligation limited men active participation in abandonment of FGC in communities.

4.4.3 Actors Involved in Eradication of Female Genital Cut in Gusii Community

Community members were asked to select multiple responses on organization or people they knew were championing the eradication FGC. According to quantitative results majority of the respondents, 70%, indicated NGO/CBOs this was followed by 40 percent indicating Chiefs/police (government) and a minority 12% stating parents. Qualitative results also revealed a similar trend with NGOs such as ADRA, Impact Research, CECOME, and Mwendo Group were mentioned. Key informant also stated that churches, schools, clan elders, government officers such as the chiefs, teachers, and Nyumba Kumi personnel were engaged in eradicating FGC in the community. The following was stated by an area chief in Marani:

> We have worked with some NGOs like ADRA. We involve clan elders, pastors, teachers, and Nyumba Kumi. We taught them on the disadvantages of FGC and

> pastors and teachers were told to speak to pupils and church members about FGC. We also hold barazas with elders. We also involve the children themselves. Children are told to report anybody who force them to be cut. (KI006 Male chief, 52 years)

The health facilities were also mentioned as actors in stopping FGC. In an interview with clinical officer the following was said:

> We have a program attached to the facility which bring pregnant mothers and those others who are educated on results of FGC and home based delivery. After the training they end up saying no to FGC practice. In this training we also have women who help women deliver "wakunga", we also train them on how to help safe delivery at homes and train them on disadvantage of FGC." (KI007: Female clinical officer, 39 years).

Another participant stated; "*I can say of the chiefs, the ministry of health, community resource persons such as the cops, traditional part attendants and the elderly. We also pass anti FGC messages through the media and SDA church camps."* KI004; Male public officer, 54 years). These sentiments were supported by a public health officer who mentioned that some of the sensitization programs were run by ministry of health. This explains that the health facilities and practitioners are involved in interventions against FGC in Gusii community. This is also reported in UNICEF (2021) where several organizations and government bodies are reported to have been involved in training medical professionals.

4.5 Effects of local construals on Implementation of anti- FGC interventions on Psychosocial Wellbeing of Girls.

The study was keen to understand how girls are affected psychosocially by the FGC practice. To unpack the wellbeing, it was imperative to assess the psychosocial effect of FGC according to head of households' perspectives. The study formulated 10 items of psychological effect and measured the household head perception on their effect on a 5-point Likert scale where 1= strongly disagree 2=Disagree, 3=neutral, 4=Agree, 5=strongly agree. Data gathered was summarized in mean and Standard deviation as shown in table 4.7.

Table 4.7: Household perception on Psychosocial Effect of Female Genital Cutting on Girls in Gusii Community

Psychosocial Effects	Mean	Std. Deviation
Circumcised girls get good husbands	2.3	1.400
Kisii men do not marry uncircumcised girls	2.3	1.383
FGC tames a woman's sexual urge	3.9	1.287
Circumcised girls/ women do not have extra-marital affairs.	3.5	1.329
Through circumcision, women learn community values and norms	4.4	1.141
Both learned and unlearned girls undergo FGC	4.2	1.216
FGC signals the transition from childhood to adulthood.	4.6	1.016
The age of circumcision among the Gusii prepares girls for marriage.	2.9	1.659
A circumcised girl is socially accepted among her peers.	4.0	1.224
FGC is a cultural practice passed down from one generation to the next	4.6	.949

Results of table 4.7 confirm that respondents strongly agreed (*M*=4.6, *SD*=1.016) that FGC signals the transition from childhood to adulthood; FGC is a cultural practice passed down from one generation to the next (*M*=4.6, *SD*= .949). These were followed by respondents who agreed (*M*=4.4, *SD*=1.141) that through circumcision, women learn community values and norms; both learned and unlearned girls undergo FGC (*M*=4.2, *SD*=1.216); a circumcised girl is socially accepted among her peers (*M*=4.0, *SD*=1.224). However, some respondents disagreed (*M*=2.3, *SD*=1.400) that circumcised girls get good husbands. There was an agreement among respondents that a circumcised girl is socially accepted among peers.

These results show a high psychosocial effect of FGC on girls in the study community. With the community lot looking at it as a practice that ensures a good marriage then women suffer loss of their body part for no good reasons. The perception that FGC enables girls improve morality by learning the Gusii norms and values still held high acceptance among the households.

A follow up question on psychosocial effects of FGC revealed that girls suffered depression due to isolation from their peers, while some suffer low self-esteem. Marriage problem was also identified as a psychological effect for FGC. This was similar to the findings of Tammarya et. al. (2023) who revealed that women who had undergone FGC suffered depression, anxiety, sleep disorder as well as PTSD. Further, Women who have undergone FGC were said to fail in their marital obligation whereby they were not able to respond to their husbands' sexual needs. These caused conflict in marriage, gender-based violence and infidelity. These findings were enhanced by qualitative finding obtained through key informant interviews and focused group discussion.

Key informants noted isolation and stigmatization of cut girls from those not cut. Some of the informants however noted that FGC was silent and more often girls suffered in silence and it was difficult to know girls who have been cut in the present days. Another respondent averred that the mind set of cut girls' changes into making them seek

marriage as they believed to have transited to adulthood and thus ready to be married. A study by Neiil and Pallitto (2020) identified stress, low self-esteem and lack of confidence as key psychosocial effects of FGC. This study however noted isolation and stigma for girls who have undergone FGC. Most of the psychosocial effects were silent and had not predominantly manifested in the society. This could be due to the reduced number of FGC practice and the manner in which it happens through high level secrecy. This way it was hard for the community to explain psychosocial effects of FGC when its scale of practice is minimal.

Qualitative data revealed other psychosocial effects such as stigma, marriage break up, girls' isolation and cut girls dropping out of school. While explaining psychosocial effects a participant said the following;

> *Like in schools the circumcised and non-circumcised cannot work together since the uncircumcised have not become ladies."*

Another participant said this;

> *"some girls may feel bad during marriage that they cannot satisfy their men like others which makes one feel she is not physically complete." KI002 male chief*

Another participant further said that:

> Girls may avoid general bath place because of the embarrassment that she has undergone FGC. "Before now girls who have been cut were not embarrassed because they were many but now they are few and they fear being laughed at. This prevents these girls from attending church, going to school or any social gathering. (KI006 Male public officer, 43 years).

These sentiments note that there are more psychosocial effects on the girl who has undergone FGC due to embarrassment. While initially those who had not been cut were stigmatized currently it is the ones who have been circumcised who face stigma.

4.5.1 Marriage Problems

The study through qualitative results showed that marriage was affected by FGC. To explain this respondent stated that:

> *"One of the effects of FGC was having low libido which made their men go for other women. This is because they were not satisfied in bed by those women who had undergone FGC. Some men had separated from their wives at their old age because the female have low libido. It has led men to even have sex with their daughters because their wives are not satisfying them in bed."* (KI003 Male assistant chief, 48 years).

These sentiments emerge two themes on the effects of FGC in Gusii community. First there is marriage break up where men opt to look for other women. Secondly there is increased defilement and incest that crop up from men desiring their children. Overly, qualitative and quantitative data has shown the following psychological effects; stress, stigma, embarrassment, incest, marriage breakup, family stress and low self-esteem. A study by (Mulongo & Martins, 2014), identified post-traumatic stress disorder and affective disorder as main psychosocial effects of FGC.

4.6 Effectiveness of Policy Interventions in Eradicating FGC Practices

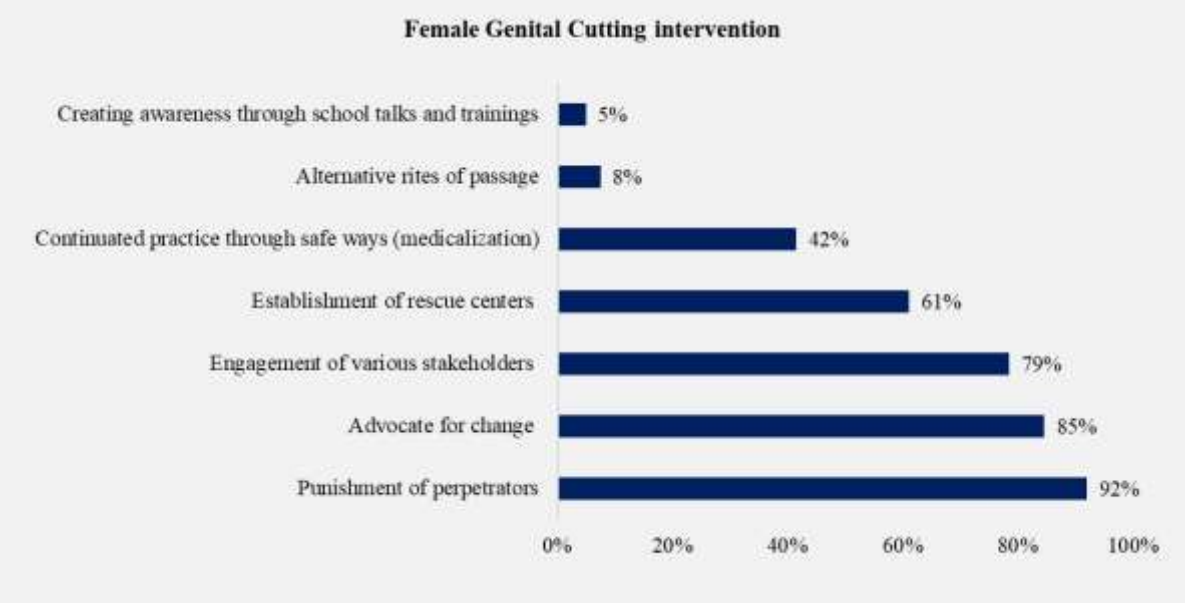
The third objective sought information on how effective the policy interventions were in eradicating FGC in Kisii community. To examine the extent of abandonment of FGC in the community the study examined awareness of the households on existing FGC

interventions and rated the effectiveness of identified policy intervention in eradication of FGC in the community. Data were summarized and discussed as follows.

4.6.1 Female Genital Cutting Interventions Known to Households

The study asked respondents to mention some of the FGC interventions that they were aware of. Data was summarized and displayed in figure 4.4.

Figure 4.4: Female Genital Cutting Intervention



Results in figure 4.4 show that Punishment of perpetrators (92%), advocating for change (85%), engagement of stakeholders (79%) and Establishment of rescue centers (61%) were common FGC intervention in the study community. Other interventions were continued practice through safe methods such as medicalization (42%), alternative rites of passage 8% and creating of awareness through schools and training (5%). The results imply that legal system was more prominent in curbing the FGC practice. Community based interventions such as collaboration on alternative methods and use of safe ways were not commonly used. This was contrary to the findings by Matanda et. al. (2023) who state that community-led interventions were listed as very effective for changing attitudes towards FGC.

This approach could be contributing to the continued practice as the community might continue practicing FGC ensuring that the law does not catch up with them. During key informant interviews various organizations were mentions to be spearheading anti FGC interventions. Those mentioned were Mosocho fulda, ADRA, Impact Research and CECOME. These organizations used training on the effects of FGC through barazas and seminars. More often community leaders were the ones engaged in the training so that they can train the community members.

Community members such as women, men leaders were trained on the effect of FGC which they retaliated through barazas, funerals, and in churches. The leaders also engaged in keen monitoring of households practicing FGC and apprehending them through arrests. Use of teachers and church leaders in talking and creating awareness was found to be effective in discouraging the practicing of FGC in the Gusii community; as explained by an informant. "*Seminars were also mentioned as effective methods for eradication of FGC in the community.* The following statement explained this;

> *"Through seminars they have been taught even they have gone to barazas. Some people come here even the white women come to teach about the effects of FGC."*

Another respondent noted that involvement of medical personnel and local leaders was the most effective method. She explained it this way:

> *Doctors are involved in secret cutting of the girls. I believe they are the key people who should be used in passing the anti FGC message. Chiefs, and clan elders. Involving the girls in the teaching will also make them fear and refuse to be cut* (KI008 women association leader, 68 years).

Another respondent felt that arresting perpetrators was not an effective method; she stated the following,

"*Arrests are done but like me who can arrest me… no one… I feel the arrests do not work because you cannot arrest the whole community… let them talk to us we will stop*." **(**KI009 old female, 72 years).

One chief correspondingly noted that arrest did not work. He said the following:

In 2020, I arrested members of a household for cutting a girl. But the case did not succeed since there was no evidence and the perpetrators were released. Arrest is also failing because this practice is very secretive and families take their girls across to Tanzania for the cut (KI003 Male chief, 48 years).

From these discussions creating awareness using local leaders, chiefs, clan elders, church leaders, teachers and the girls themselves have been identified as effective methods for abandonment of FGC in Gusii community. Use of arrests was found not to be very effective in eradicating FGC in the community. These study findings further reveal that community members resorted to a very secretive approach of practicing FGC and in so doing lacked adequate evidence to prosecute perpetrators who were reported to the authorities similarly, Matanda et. al. (2022) reported in their findings that the Kisii community had resorted to secrecy as a way of hiding from law enforcers or those who are likely to report the perpetrators to law enforcers.

4.6.2 Rating for Effectiveness of Female Genital Cutting Interventions

Respondents were asked to rate the effectiveness of the anti- FGC intervention used in the community. The study used a 4-point likert scale to establish how effective an intervention was. The scale comprised of 1=Not effective, 2=Lowly effective 3= Somewhat effective, 4 =Very Effective. The summary of the analysis is shown in table 4.8.

Table 4.8: Rating for Effectiveness of anti- FGC Interventions

Female Genital Interventions	Not Effective	Lowly Effective	Somewhat Effective	Very Effective	Mean	Std. Deviation
Advocate for change	4(2%)	15(7.5)	35(17.5%)	146(73.0%)	3.6	.714
Continuation of practice through other methods such as medicalization	84(42%)	26(13.0%)	55(27.5%)	35(17.5%)	2.2	1.166
Punishment of perpetrators	7(3.5)	5(2.5%)	27(13.5%)	161(80.5%)	3.7	.685
Establishment of rescue centers	15(7.5%)	41(20.5%)	51(25.5%)	93(56.0%)	3.1	.981
Engagement of various stakeholders	11(5.5%)	26(13.0%)	51(25.5%)	112(56.0%)	3.3	.874
Alternative rites of Passage	106(53.0)	53(26.5%	29(14.5%)	12(6.0%)	1.7	.921
Media campaigns	2(1.0%)	8(4.0%)	33(16.5%)	157(78.5%)	3.7	.584
Legislation	2(1.0%)	7(1.0%)	76(38.0%)	112(61.0%)	3.6	.511
Educational awareness	5(2.5%)	3(1.5%)	64(32.0%)	128(64.0%)	3.6	.653
Victims' empowerment	19(9.5%)	62(31.0%)	61(30.5%)	58(29.0%)	2.8	.970

The results of the analysis demonstrate that media campaigns (*M*=3.7, *SD*=.584); legislation (*M*=3.6, *SD*=.511); punishment of perpetrators (*M*=3.7, *SD*=.685); educational awareness (*M*=3.6, *SD*=.653) and advocating for change (*M*=3.6, *SD*=.714) were very effective. On the contrary, some respondents reported that alternative rites of passage (*M*=1.7, *SD*=.921) and practice through other methods such as medicalization (*M*=2.2, *SD*=1.166) were rated as lowly effective. This implies that media campaign, legislation, punishment of perpetrators, educational awareness and advocating for change were some of the most effective interventions employed. This is similar to findings by Abathun et.

al. (2018) which revealed that awareness campaigns in schools and use of media campaigns were a good source of information that can influence the abandonment of FGC by young people. However, embracing the alternative rite of passage was lowly rated as a result of inadequate information. This could be attributed to a recent study in Awdal, Somalia and Mandera District in Kenya, which revealed that 5-8 years as the circumcision age range (Gilbertson, 2019). This implies that alternative rite of passage is yet to be embraced in the society due to age.

During interviews it was noted that close monitoring of FGC activities by local leaders and arrests of community members reported of practicing FGC was the most effective intervention. As stated by one of the participants:

> *Keenly monitoring of FGC activities in the community has been the most effective. Like I told you in 2020 I arrested a parent who had taken the daughter to Tanzania for FGC. This created fear among community members and since then I have not heard another case.* (K002 Female participant, 43 years).

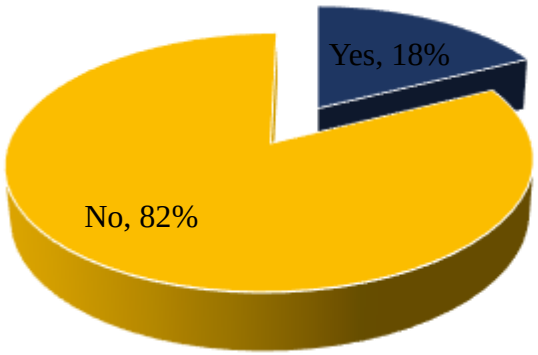
This statement clearly indicates that arrests and close monitoring of FGC activity were the most effective methods. This could be attributed to the changed nature of FGC which is practiced as a secret activity than an open community traditional exercise. This could also be attributed to the harsh penalty in the Children's Act 2022 which states that a person who commits an offence of subjecting a child to FGC shall, on conviction, be liable to imprisonment for a term of not less than three years or to a fine of not less than five hundred thousand shillings, or to both. Championing for continuation of practice through other methods such as medicalization and Alternative rites of Passage with a mean of 1.7 and 2.2 respectively had a low effect in reduction of female genital cutting in the community. None of the qualitative results mentioned medicalization as an effective method of practicing FGC.

4.6.3 Medicalization of Female Genital Cut in Kisii Community

Studies have established a growing trend in medicalization of FGM/C in practicing communities. According to (Kimani & Shell-Duncan, 2018) medicalization is spreading

in African communities as a replacement for the traditional methods and a safe method for FGC. There however remains a debate on ethics of the practice and dual loyalty of medicalization of FGC. To ascertain the community perception of the same this study asked household heads to indicate if they support or do not support the practice. The responses were summarized as shown in figure 4.5.

Figure 4.5: Support for Medicalization of Female Genital Cutting in Gusii Community



Out of 200 respondents 165(82%) did not support medicalization of FGC in Gusii community while 35(18%) supported the medicalization of FGC. These results show that medicalization of FGC was not supported by the community thus not an effective intervention for FGC and protection of girls' wellbeing. Nevertheless, qualitative results reveal that doctors might be involved in the FGC practice. A participant explained that:

> *"Nowadays it's like doctors do it because the old mamas who used to do it are no longer there or they fear being arrested. Once the parents are arrested the child reveals the one who did it.*" (KI003 Male, 45 years).

From this statement, it's noted that medical staff might be involved but it is not very clear. Another respondent from FGD shared similar sentiments. Thus it can be concluded that medical staff are involved in conducting FGC in secrecy. These results could also imply that FGC is reducing within the Gusii community.

These results agree with findings by Leye et al. (2019) who found that medicalization practice was at 15%. In other countries the prevalence of medicalization was high 67% in Sudan 38% in Egypt and 15% in Guinea and 13% in Nigeria. The trend is rising as many people opt to use health professionals to carry out the act. This trend has been explained to be attributed to the high health approach used in anti-FGM/C interventions in most countries.

A report by WHO (2020), explained that the campaigns against FGM/C stressed the adverse health consequences of the practice assuming that this would help raise awareness. Contrary to the expectation the approach has contributed to unintentional medicalization of FGC thus the continuation of the practice using modern approach. Despite the change in the approach the practice remains detrimental to the wellbeing of a girl who can face stigmatization and other health complications.

4.6.4 Actors Likely to Promote Anti-Female Genital Cutting in the Community

To enhance the effectiveness of anti FGC interventions it was important to get actors who are likely to champion change in FGC. Data gathered on this item was summarized and illustrated in the table 4.9.

Table 4.9: Likelihood of Different Actor to Stop Female Genital Cutting

Anti FGC Actors	Very Likely	Moderate Likely	Less Likely	Mean
Mothers	172(86.0%)	17(8.5%)	11(5.5%)	1.2
Aunties	99(49.5%)	85(42.5%)	16(8.0%)	1.6
Peers	76(38.0%)	36(18.0%)	88(44.0%)	2.6
Mother in laws	111(55.0%)	55(27.5%)	35(17.5%)	1.7
Female medics	57(28.5)	58(29.0%)	85(42.5%)	2.8
Grandmothers	112(56.0%)	51(25.5%)	17(18.5%)	1.6

Table 4.9 demonstrates that mothers (86%) were very likely to help in abandonment of FGC in the community. They were followed by grandmothers 112(56.0%) and mother in laws 111(55.0%). Aunties 85(42.5%) were moderately likely to enhance the effectiveness of anti FGC intervention. Female medics 85(42.5%) and 88(44.0%) Peers were less likely to champion anti FGC intervention in the community. The WHO recognizes the role of medical professions in eradiating FGM/C in communities. A study by (Johasen, 2019) however noted that the medical professions cannot be effective in intervening on anti FGC due to the highly privatization of the practice in the communities where it is having great cultural identity.

These results imply that mothers and grandmothers were key in championing anti FGC intervention. Thus, it will be important for the organizations working towards anti FGC intervention to involve more mother and grandmothers to get positive results. Qualitative results show that anyone could be involved in making the FGC intervention effective. According to the interview responses, men can be instrumental in reporting and discouraging FGC in their households. Women were identified as key actors in stopping

since they are the main perpetrators. Other people to engage in anti FGC intervention were church leaders, local leaders and girls who have experienced the cut. Other strategies mentioned included use of law through arrest of culprits, increase anti FGC teaching, including anti FGC message in school guidance and counseling sessions. Alternative rite of passage through counseling classes was suggested a better method of replacing the FGC. Another respondent noted that use of girls' seminars was not an effective method for stopping FGC in Gusii community. A participant explained this stating:

> *According to me these seminars do not work…these programs are done over the holidays but do not work as some girls go to the seminars to have nature walk and when she comes home she cannot say what they were taught* (Male Participant, 46 years).

Incentivizing non cut girls was also mentioned as method for anti FGC. Teaching the young girls on the effect of FGC is an effective way of countering FGC in Gusii community. This was shared by one of the respondents:

> *My daughter who is in grade 5 refused to be cut because she was told it is bad through the holiday seminars. Through the trainings the girls know about FGC and its effects.* (KI004 Male Participant, 47 years).

According to this response it is clear that use of holiday girls training is effective in countering FGC in the community. Some girls have not benefited because they use this time for other activities.

4.7 Challenges Affecting Eradication of Female Genital Cutting

Across communities' eradication of female genital cutting has not achieved hundred percent results. In most cases the interventions face challenges that undermine their

effectiveness. Data was collected on various challenges affecting eradication of FGC in Gusii community. The data was analyzed and summarized as shown in table 4.10:

Table 4.10: Challenges Affecting Eradication of Female Genital Cutting

Challenges	Small Extent	Moderate Extent	Some Extent	Great Extent	Mean
Cultural belief is a challenge faced in the prevention of FGC practices on the girl child	5(2.5%)	7(3.5%)	49(24.5%)	135(67.5%)	3.7
Resistance from the community is a challenge faced in the prevention of FGC practices on the girl child	20(10.0%)	35(17.5%)	44(22.0%)	101(50.5%)	3.1
Voluntary FGC practice is a challenge faced in the prevention of FGC practices on the girl child	40(20.0%)	41(20.5%)	47(23.5%)	72(36.0%)	2.8
Lack of government interventions is a challenge faced in the prevention of FGC practices on the girl child	57(28.5%)	37(18.5%)	47(23.5%)	59(29.5%)	2.5

Based on table 4.10, the study found that culture, lack of effective government interventions and voluntarily FGC were the significant challenges affecting effective intervention for FGC. On whether cultural belief challenged prevention of FGC practices on the girl child 184 (92 %) agreed to a great extent while 16(8%) agreed to a small extent. In the same vain 145(72.5%) agrees to some extent that community resistance was

a challenge for curbing FGC in the community while 55(27.5%) disagreed. These results show that cultural beliefs and community resistance, voluntary FGC practices and lack of government interventions were significant challenges affecting anti FGC interventions in Gusii community.

More than half 119(59.5%) agreed that voluntary FGC practice is a challenge affecting prevention of FGC practices on the girl child while 81(40.5%) disagreed. There is a mixed reaction with almost an equal percentage agreeing and disagreeing with the statement. Similarly, 106(53%) of the respondents agreed that lack of government intervention affected effective intervention on anti FGC in the community while 94(47%) disagreed. These imply that government mechanisms to stop the FGC practice in the study community were not pronounced or active compared to other FGM prone areas. This could be explained by the silent ways used in carrying out FGC. In this regard, therefore, as UNICEF (2021) reports, the contextualization and tailoring of interventions to the specific situations in different communities is vital in abandonment of FGC among practicing communities. This has to involve a series of consultations, observations and open discussions with the practicing communities to inform program design and implementation.

Qualitative data identify challenges such as; lack of clear information on FGC because it is a big secret in the community. In the interviews the study noted the weakness in lack of adequate evidence in prosecuting people arrested while practicing FGC. As explained by an area chief: *"the case did not go anywhere as the lady paid police 200 and was release"*

KI001 Female chief.

Another local leader shared the following:

"*I can say that FGC has not ended but reduced. Those doing it do it very secretively … I have not heard any case for the past two years but the practice is still continued by some households*" KI003 Male chief.

Another participant stated that medicalization of FGC is a major challenge affecting FGC interventions. Other challenges included low participation of women and girls' participation in seminars, barazas and meetings. A local leader stated that:

In this community women are not involved in barazas and meetings. They should be busy at home and sometimes they lack adequate time to attend the seminars. So most of the trainings are attended by men who know very little about FGC in the community.

(KI002 Female leader.)

According to quantitative and qualitative findings the following challenges affect FGC intervention in the Gusii community; lack of information on FGC due to secrecy level it is performed under, existence of strong traditionalist who uphold FGC practice, low participation of women in anti FGC interventions, failure of arrest in eradicating the vice and medicalization of FGC which has made difficult to dictate and address.

Borrowing from the theory of Reasoned Action, the researcher argues that in such situation where FGC is compulsory, for the Gusii community members to choose to abandon FGC, their attitudes have to change; that their daughters remaining uncircumcised is more advantageous than undergoing female genital cutting. Evaluation- which in this case is the value attached to the outcome of a Gusii girl/woman remaining uncircumcised. Additionally, the subjective norms could be that people of this generation are also abandoning the practice of FGC; hence they expect them to do so as well. Normative beliefs, which are about whether key individuals such as parents, peers, teachers and

groups such as youth groups and women groups approve or disapprove the issue of girls/women remaining uncircumcised. Finally, motivation to comply is whether or not the girl's/woman's intention to remain uncircumcised will be affected by what others will think about them remaining uncircumcised.

People's attitude is determined by behavioral beliefs about the likelihood of a number of consequences and evaluations of how good or bad it would be if those consequences happened. As a result, subjective norm is determined by beliefs about what specific important others think one should do and how much one is motivated to comply with those important others. Both attitude and subjective norm are assumed to be determined by summative processes.

CHAPTER FIVE

SUMMARY OF THE FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This section present findings, conclusion and recommendation on the psychosocial effects of anti- FGC intervention in Marani Sub County, Kisii County. The chapter is organized thematically according to the study objective that sought to assess the effect of belief constructs on FGC intervention, examine the psychosocial effect of FGC on interventions, and establish the effectiveness of FGC interventions and challenges affecting FGC in Gusii community.

5.2 Summary of the Findings

The first objective assessed effects of local construals and actors perpetrating FGC in Marani sub-county. Majority (57.5%) of the respondents practiced FGC to fulfill cultural and traditional obligations in Gusii community. Social acceptance was revealed by 40%, reduced sexual urge and protection of girls from early pregnancy 34% were also considered as reasons for continued practice of FGC in Kisii County. Ignorance was mentioned by 22.5% while improvement of sexual experience in marriage was 17.5%. These results clearly indicate that culture and social acceptance continues to explain household pursuit of FGC on girls. Qualitative data from key informants unraveled other reasons for practicing and not practicing FGC. The argument of FGC reducing sexual urge was however contradicted by an informant who posited that it did not. It is clear that there is no biblical explanation of FGC among Gusii community but rather a socio cultural activity of warfare among the community explained why it was traditionally adopted. Some participants shared that FGC was practiced to reduce sexual urge among women while others have argued that despite this being the belief, it was not practically possible. The statement further revealed that reduction of sexual urge was not a true

factor for continued practice of FGC since women who have been cut do not attest to the perception of reduced sexual urge.

Both quantitative and qualitative findings indicate that FGC is conducted for traditional reasons. The traditional reasons however, do not hold a lot of strength since because of modernization this the practice has reduced significantly. The study established that although deteriorating traditional believe that FGC enhanced women faithfulness in marriage, reduced sexual urge enhancing measure against early pregnancy and enhanced chastity in marriage were still held by community members in Marani Sub-County. Findings on actors revealed that mothers, grandmother, aunties and mother inlaws were the major perpetrators of FGC in Marani. It was found that men had minimal knowledge on FGC but still believed it was a traditional practice that should be continued. More findings revealed that health professionals such as doctors and nurses were involved in FGC in very secretive ways. The study also established that traditional old women who were engaged in FGC had reduced.

The second objective assessed the place of women in the implementation of anti- FGC interventions on the psychosocial wellbeing of girls in Marani sub County. Results displayed in table 4.5 demonstrate that majority (M=3.8, SD=.68) who are mothers and grandmothers are very influential on girls undertaking FGC in the Gusii community. Aunties, mothers-in-law and peers moderately influenced (M=3.4, SD=.476) the practice of FGC in the Gusii community. While fathers had low influence (M=2.2, SD= .859) on the cut. These results imply a high influence on FGC practice from mothers and grandmother. Mother in-laws had moderate influence, while the influence of aunties and fathers was very low. Thus it is clear that mothers, grandmothers and mothers-in-law were the actors catalyzing continued of FGC practice among the Gusii community.

Interviews and FGD was conducted to gather more information on actors and the strategy they used in perpetrating FGC. Men were found to have low influence on FGD. Findings further revealed that stress, stigma, isolation, marriage problem and incest were main psychosocial effects of FGC. The main findings revealed that FGC caused strain in marriages where husbands abandoned their wives for younger and uncut women as well as some resorted to sleeping with their daughters. The study further noted that psychosocial effects were silent as FGC was a highly hidden and secretive practice in Marani Sub-County.

The third objective assessed the effectiveness of policy interventions against FGC in Marani sub- county. The findings established that the NGOs/CBOs were main actors in abandonment of FGC in Marani sub-county. On interventions employed, results show that Punishment of perpetrators (92%), advocating for change (85%), engagement of stakeholders (79%) and Establishment of rescue centers (61%) were common FGC intervention in the study community.

Other interventions were continued practice through safe methods such as medicalization (42%), alternative rites of passage 8% and creating of awareness through schools and training (5%). Other actors in anti FGC interventions were local leaders comprising of chiefs, teachers, Nyumba Kumi elders, and church leaders. The health facilities were also instrumental in eradicating FGC through training of traditional midwives on disadvantages of FGC and providing them alternative option through attachment in health facilities to support in midwifery. Intervention for anti-FGC conducted through rewarding girls, conducting training and seminars as well as sensitization in barazas, schools and churches.

The fourth objective sought to establish the challenges affecting eradication of FGC in Marani Sub- County in Kenya. The study found that culture, lack of effective government

interventions and voluntarily FGC were the main challenges affecting effective intervention for FGC abandonment. On whether cultural belief challenged prevention of FGC practices on the girl child 184 (92 %) strong agreed while 16(8%) said to a small extent. In the same vain 145(72.5%) agrees that community resistance was a challenge for curbing FGC in the community while 55(27.5%) disagreed. These results show that cultural beliefs and community resistance were main challenges affecting anti FGC interventions in Gusii community.

More than half 119(59.5%) agreed that voluntary FGC practice is a challenge affecting prevention of FGC practices on the girl child while 81(40.5%) disagreed. There is a mixed reaction with almost an equal percentage agreeing and disagreeing with the statement. Similarly, 106(53%) of the respondents agreed that lack of government intervention affected effective intervention on anti FGC in the community while 94(47%) disagreed. These imply that government mechanisms to stop the FGC practice in the study community, through enactment of laws and policies, arresting and prosecution of perpetrators were not pronounced or active compared to other FGC prone areas.

This could be explained by the silent ways used in carrying out FGC. Qualitative data identify challenges such as; lack of clear information on FGC practice and policies because it is a big secret in the community. In the interviews the study noted the weakness in lack of adequate evidence in prosecuting people arrested while practicing FGC. From the findings, it is evident that culture, medicalization of FGC, failure of arrest for FGC perpetrators, minimal participation of women in anti FGC campaigns, resistance from some community members in abandoning the practice, secrecy level adopted in conducting FGC, and voluntarily participation of girls in FGC were the biggest challenge in abandonment of FGC among the Gusii community.

5.3 Conclusions

Findings from this study provide an indication that FGC is an ongoing practice within the Gusii community with women and health professionals being the main perpetrators. From the findings it is clear there is no biblical explanation of FGC among Gusii community but rather socio-cultural activity of warfare among the community explained why it was traditionally adopted. Some participants shared that FGC was practiced to reduce sexual urge among women while others have argued that despite this being the belief, it was not the possible. Further, it was revealed that reduction of sexual urge was not a true factor for continued practice of FGC since women who have been cut do not attest to the perception of reduced sexual urge. This study has also revealed that FGC has grave psychosocial effects on girls ranging from stigma, to depression.

Both quantitative and qualitative findings indicate that FGC is conducted for traditional reasons. The traditional reasons however, do not hold a lot of strength because of modernization thus the practice has reduced significantly. The results also show that interventions against FGC have enhanced the reduction of the practice however the interventions especially those run by the government have been least effective in eradicating FGC practice within Marani sub County.

It is evident that FGC has immediate and delayed psychosocial effects on girls/women who have been cut than those who have not been cut. The reducing trend of FGC is due to weakening of traditional believes on importance of FGC in maintaining family life, and health implication of the practice. From the study findings it can be concluded that mothers, grandmothers and mother inlaws were key players catalyzing continuation of FGC practice among the Gusii community. It was further noted that men were found to have low influence on FGC. The CBOs were main actors in eradicating FGC in Marani

sub-county. Finally, it is evident that cultural beliefs and community resistance were main challenges affecting anti-FGC interventions in Gusii community.

5.4 Recommendations

The following recommendations for practice, policy, theory as well as areas for future research are made from this study.

5.4.1 Recommendations for Practice

i. The study used descriptive method in assessing psychological effect of FGC on girls who have undergone the cut. This study thus recommends the need for raising awareness of psychological effects of FGC of healthcare professionals in training and treatment of women and girls suffering as a result of FGC.

ii. Findings from the study show various actors within the community and outside the community. Women were found to be minimally involved in employing measures against FGC. Following this findings, the study recommends use of active actors like the girls, doctors and increase of women as key campaigner against the vice.

iii. The study also recommends the integration of anti FGC in schools guidance and counseling and training of church leaders and members on alternative programs for FGC so that girls can still benefit from teaching received during the initiation process without actually taking the cut.

5.4.2 Recommendation for Policy

i. The study recommends an improvement in government intervention. The study found that Prohibition of FGM Act was fraught deterring prosecution of FGC perpetrators and had led to underground practice of FGC.

ii. A review of the Prohibition of FGM Act is needed. The law should improve on areas on how FGC cases are processed, portfolio for evidence and sensitize the community on what the charges of people found practicing FGC entail.

iii. Finally, this study recommends the concept of resocialization as a way of ensuring that effective interventions are adopted to bring FGC to an end.

5.5. Areas for Further Research

This study recommends the following areas of study in the future.

i. Another study on the influence of FGC on mental illness in communities practicing FGC in Kenya.

ii. A study assessing the effects of FGC among women and girls should be conducted to test clinical effects of FGC to reduce assumptions and provide empirical results of physical, psychological and other effects of FGC among girls /women in communities

iii. A longitudinal survey investigating the effectiveness of alternative methods in countering FGC should be done in Kenya. Further, a correlational study on the role of men in ending FGC in practicing communities.

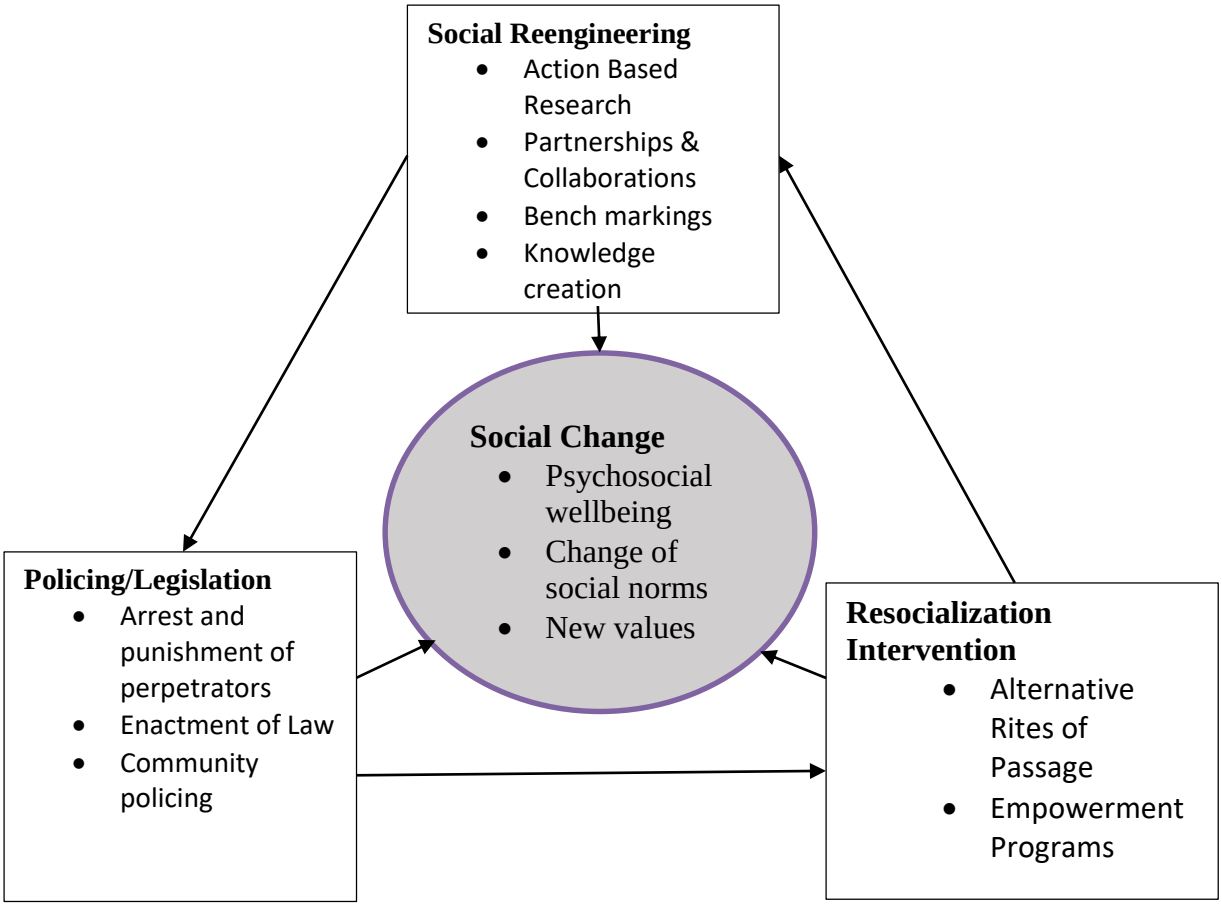
5.6 Contribution to Knowledge

Based on the findings, this study hereby recommends the concept of resocialization as a way of ensuring that effective interventions are adopted to bring FGC to an end. According to Crossman (2019), resocialization is a process in which one's sense of social values, beliefs, and norms are re-engineered, thus, a person is taught new norms, values, and practices that foster their transition from one social role to another. It can involve both minor and major forms of change and can be either voluntary or involuntary. Resocialization differs from the formative, lifelong process of socialization in that the

latter directs a person's development whereas the former redirects their development. It is the process whereby failed social roles are altered or replaced. Subsequently, it implies the pre-existence of some social roles which must be superseded or changed (Melvyn, 1988)

The aim of resocialization in this study therefore, is to bring about social change. As Melvyn (1988) states, it is a concept which bridges the gap between the psychological and the social. In this regard, since resocialization is a deliberate and intense social process and it revolves around the notion that if something can be learned, it can be unlearned (Crossman, 2019), this study considers the practice of FGC as something that has been learned for generations and which, based on a resocialization model, can be unlearned. As a development from the Step Change Theory (Lewin, 1951), which highlights three steps towards realization of social change, that is, Unfreezing; where behavior change especially targeting the status quo as well as the resistant groups seeks to build trust, motivate participants by preparing them for change and active participation in recognizing problems as well as formulating resolutions; Movement to a new equilibrium as the second step ensuring persuasion to view the practice of FGC differently and working with all stakeholders to realize the needed social change; and refreezing as a means that targets sustainability, incorporation of new values, creation of stability for the new equilibrium, strengthening of policies as well as institutions through protection of the girl child, establishments of alternative rites of passage(ARP) and punishment of perpetrators, this study has come up with a model that will ensure the right interventions are adopted to finally bring the practice of FGC to an end.

Figure 5.1: FGC Resocialization Model



In this model, the study identifies a three tier framework through which the practice of FGC can be eradicated within practicing communities. These are social reengineering, policing/ legislation and resocialization interventions. The first tier, Social Reengineering entails development of consciousness among the community through activities aimed at increasing knowledge on the community by empowering them on the negative effects of FGC on the girl child and young women. This will entail action based research, engaging in partnerships and collaborations, benchmarking and knowledge creation. This will be carried out by targeting the experts in the field of academia who through their resourcefulness the right data can be collected and disseminated on the status of FGC in practicing communities, going all the way down to the location and villages. In this tier,

various state and non-state actors can then engage the medical personnel engaged in medicalization and traditional practitioners who have been identified as key players in the practice, in capacity building of women who are the main victims as well as the perpetrators, and finally recruitment of change agents within the community.

The second tier, legislation and policing, involves the utilization of the already set up government structures to eradicate the cut. Through review of the Prohibition of FGM Act and other laws to include punishment of those involved in kangaroo courts, which play a significant role in the persistence of FGC, there is also need to strengthen the community participation by use of community policing, local administration as well as institutions of learning to ensure the safety of girls as well.

Finally, reengineering interventions will entail the bridging of the sociocultural gap created by the eradication of the cut. This will be realized by setting up of an alternative rites of passage (ARP) curriculum that will be included within life skills lessons within schools, rather than have it set up over holiday programs when children are home. This is to ensure that the information shared with the children is all inclusive as well as supervised by the right curriculum implementors. It will also ensure that empowerment programs aimed at training of mainly women, are set up within the community every so often particularly during the peak periods of the exercise. Further, the reengineering interventions also require the involvement of all stakeholders, that is, political leaders, local administration, parents, women and men, young and old, religious institutions, institutions of learning as well as both county and national government bodies. Through this three tier model, the FGC resocialization model will enable the girl child achieve the psychosocial wellbeing of happiness, mental wellness, positive social relations, a supportive environment for learning, play and growth as well as meaningful social roles. They will also maintain good relationships as children and later in life as women realize

emotional stability and finally ensure good values. The model will guarantee all roundedness of girls and young women through improved self-esteem, emotional, cognitive as well as social fitness, and the girls will learn new skills and finally connect with other girls and women across the world.

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APPENDICES

APPENDIX I: INTRODUCTION LETTER

Kisii University

School of Arts and Social Sciences

P. O. Box 480- 40200

KISII.

Dear Respondent,

My name is Magdaline Gesare Magangi, a PhD candidate at Kisii University. I am conducting a research study on the **effectiveness of anti- Female Genital Cutting (FGC) interventions on the psychosocial wellbeing of the girl child in Marani Sub-County, Kisii County, Kenya**. You have been selected to take part in this study. I would be very grateful if you assist me by responding to all items attached in the questionnaire.

Your name does not need to appear on the questionnaire. The information given will be treated as confidential and will only be used for this research. It will not be made available to anyone who is not directly involved in the study. Your cooperation will be highly appreciated.

Thank you.

Yours sincerely,

Magdaline Gesare Magangi

Adm. No: DAS/60016/14

Mobile Number: 0725262244

APPENDIX II: QUESTIONNAIRE FOR HOUSEHOLD HEADS

Do you agree to take part in the study?

Yes

No

If no why?

_____

SECTION A: DEMOGRAPHIC INFORMATION

Please put a tick (√) where appropriate.

1. Age group: Below 25 years ( ) 26 – 35 years ( )

   36 – 45 years ( ) 46 – 55 years ( ) 56 and above ( )

2. Gender

   Male ( ) Female ( )

3. Indicate your highest completed level of education

   Primary incomplete ( ) Primary Complete ( ) Secondary Incomplete ( )

   Secondary Complete ( ) College ( ) University ( )

4. Religion/Denomination

   i. Catholic ( )

   ii. Muslim ( )

   iii. SDA ( )

iv. Pentecostal ( )

v. Other, specify _____

5. What is your occupation? _____

6. What is the number of members in your household? _____

7. As the head of your household;

a) How many children do you have?_____Boys ( ) Girls ( )

b) Do you have any grandchildren? Yes ( ) No ( )

8. If yes, how many are they?

9. What are their ages?

SECTION B: EFFECTS OF LOCAL CONSTRUALS ON IMPLEMENTATION OF ANTI- FGC INTERVENTIONS ON THE PSYCHOSOCIAL WELLBEING OF THE GIRL CHILD.

10. What do you understand about Female Genital Cutting?

11. In your opinion why do people still practice FGC?

12. Do you support the practice of FGC on young girls as a cultural practice?

    Yes ( )

    No ( )

    Prefer not to say ( )

    If yes, why?

    _____

    If no, why not?

    _____

13. At what age are girls being circumcised in your community? Put a tick (√) where appropriate.

    i. Below 5 years ( )

    ii. 5- 10 years ( )

    iii. 11- 15 years ( )

    iv. 16- 18 years ( )

    v. Above 18 years. ( )

14. Who do you think has the greatest influence on the implementation of the practice of FGC in your community? (On a scale of 1- 4 likert scale indicate whether you agree

with the statements below. (**Key:** 4. Very influential 3. Moderately Influential 2. Low Influence 1. Not Influential at all

S/NO	**Who do you think has the greatest influence on the implementation of the practice of FGC in your community?**	**1**	**2**	**3**	**4**
1.	Mothers				
2.	Aunties				
3.	Grandmothers				
4.	Fathers				
5.	Peers				
6.	Mother In law				

15. In your community, how do the anti- FGC interventions affect the psychological wellbeing of the girl child. **Key:** 5. Strongly agree 4. Agree 3.Neutral 2. Disagree 1. Strongly disagree

S/NO	**How do the anti- FGC interventions affect the psychological wellbeing of the girl child?**	**1**	**2**	**3**	**4**	**5**
1.	Circumcised girls get good husbands					
2.	Kisii men do not marry uncircumcised girls					
3.	FGC tames a woman's sexual urge					
4.	Circumcised girls/ women do not have extra-marital affairs.					

5.	Through circumcision, women learn community values and norms					
6.	Both learned and unlearned girls undergo FGC					
7.	FGC signals the transition from childhood to adulthood.					
8.	The age of circumcision among the Gusii prepares girls for marriage.					
9.	A circumcised girl is socially accepted among her peers.					
10.	FGC is a cultural practice passed down from one generation to the next					

16. In your view what are other psychological effects of FGC interventions in the Gusii community?

_____

_____

_____

_____

16. In your community, how do the FGC interventions affect the social wellbeing of the girl child. **Key:** 4. Strongly agree 3. Agree 2. Disagree 1. Strongly disagree

S/NO	How do the FGC interventions affect the social wellbeing of the girl child?	**1**	**2**	**3**	**4**
1.	Circumcised girls get good husbands				

2.	Kisii men do not marry uncircumcised girls				
3.	FGC tames a woman's sexual urge				
4.	Circumcised girls/ women do not have extra-marital affairs				
5.	Through circumcision, women learn community values and norms				
6.	Both learned and unlearned girls undergo FGC				
7.	FGC signals the transition from childhood to adulthood				
8.	The age of circumcision among the Gusii prepares girls for marriage				
9.	A circumcised girl is socially accepted among her peers.				
10.	FGC is a cultural practice passed down from one generation to the next				

18. In your view what are other social wellbeing effects of FGC interventions in the Gusii community?

_____

_____

_____

SECTION C: THE RELATIONSHIP BETWEEN CULTURAL NORMS AND PRACTICE OF THE FGC ON THE PSYCHOSOCIAL WELLBEING OF THE GIRL CHILD

19.What cultural belief does Female genital Cutting enhance? Please select all appropriate

S/NO		√
1.	Tradition	
2.	Transition from childhood to adulthood	
3.	Preservation of a girl's virginity	
4.	Family honour (social status)	
5.	Chastity (reduce extramarital affairs)	
6.	Prevention of early pregnancy among girls	
7.	Improve girls chances for marriage	

20. What other cultural belief does female genital cutting promote FGC?

_____

_____

_____

21. Kindly indicate your agreement or disagreement with the following statements in relation to the anti- FGC interventions in your community. Where Key: 1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree

S/NO		**T**	**F**
1.	Elders in this community promote FGC practice to uphold the		

	community traditions		
2.	FGC enhances a womans' view in the social circles of this community (e.g. family, friends, peers)		
3.	FGC practices teach girls on various norms of the Gusii culture that enhances her value as a woman		
4.	It matters to me how my community views my daughters/ our girls.		
5.	Women who have undergone FGC are allowed to become leaders in the community		
6.	Female genital cutting does not enhance girls' marriage stability		

22. The following are reasons for the practice of FGC. Which one(s) explain the continuation of the practice among the Gusii Community? Put a tick (√) where appropriate.

S/NO	reasons for the practice of FGC	√
1.	FGC is done as a means of sexual restraint	
2.	FGC is done as a mark of transition from childhood to adulthood	
3.	FGC shows that a daughter is honorable and chaste	
4.	FGC prepares a girl for marriage	
5.	FGC is a means of preserving tradition	
6.	FGC preserves virginity	

7.	FGC is done for hygiene purposes	
8.	FGC is a religious obligation	
9.	FGC is done for aesthetics	
10.	FGC is a source of income for the practitioner	

23. What other cultural and traditional reasons explain the continued practice of FGC within the Kisii community?

_____

_____

_____

SECTION D: EFFECTIVENESS OF THE INTERVENTIONS IMPLEMENTED IN ERADICATING FGC PRACTICES ON THE GIRL CHILD

24. The following can be done to end the practice of FGC among the Gusii Community?

Select all appropriate

S/NO	What can be done to end the practice of FGC in the Gusii Community?	√
1.	Advocate for change	
2.	Champion for the continuation of practice through more hygienic methods such as medicalization	
3.	Punishment of perpetrators	
4.	Establishment of rescue centers	
5.	Engagement of various stakeholders	
6.	Introduction of Alternative rites of Passage	
	Other, specify_____	

25. How would you rate the effectiveness of the following intervention in ending FGC practice in Kisii community? **Key:** 4. Very effective 3. Somewhat effective 2. Lowly effective 1. Not effective

S/NO	What can be done to end the practice of FGC in the Gusii Community?	1	2	3	4
1.	Advocate for change				
2.	Champion for the continuation of practice through more hygienic methods such as medicalization				

3.	Punishment of perpetrators				
4.	Establishment of rescue centers				
5.	Engagement of various stakeholders				
6.	Introduction of Alternative rites of Passage				
	Other, specify_____				

26. How would you rate the effectiveness of the following intervention in ending FGC practice in Kisii community? Key: 1. Very effective 2. Somewhat effective 3. Lowly effective 4. Not effective

S/NO	**Which measures the government has taken toward the reduction and eradication of FGC?**	**1**	**2**	**3**	**4**
1.	Advocacy and awareness (e.g. media campaigns)				
2.	Legislation				
3.	Media campaigns				
4.	Education				
5.	Victims empowerment				
6.	Other, specify, _____				

27. How effective are other measures used by the government to reduce and eradicate FGC in Gusii community?

_____

_____

_____

28. Medicalization is the use of a medical practitioner such as a doctor, nurse, or clinical to conduct the cut. Does your community engage in medicalization?

Yes ( ) No ( )

29. Do you support medicalization?

Yes ( ) No ( )

30. Please give reasons for your answer_____

SECTION E: THE PLACE OF WOMEN IN THE IMPLEMENTATION OF ANTI- FGC INTERVENTIONS ON THE PSYCHOSOCIAL WELLBEING OF THE GIRL CHILD

31. In your view which women are likely to champion the interventions of FGC among young girls and women effectively? Key: 1.Very likely 2. Moderate likely 3. Less Likely

S/NO	**Are women likely to champion the interventions of FGC among young girls and women?**	**1**	**2**	**3**	**4**
1.	Mothers				
2.	Aunties				
3.	Grandmothers				
4.	Female medics				
5.	Peer Girls				
6.	Mother inlaws				

32. What is your agreement of the following statements on challenges faced in the prevention of FGC practices on the girl child? Key: 1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree Key: 1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree

S/NO	**The challenges faced in the prevention of FGC practices on the girl child**	**1**	**2**	**3**	**4**
1.	Cultural belief is a challenge faced in the prevention of FGC practices on the girl child				

2.	Resistance from the community is a challenge faced in the prevention of FGC practices on the girl child				
3.	Voluntary FGC practice is a challenge faced in the prevention of FGC practices on the girl child				
4.	Lack of government interventions is a challenge faced in the prevention of FGC practices on the girl child				

33. What role can a woman play in ending the practice of FGC in your community?

i) _____
_____

ii) _____
_____

iii) _____
_____

iv) _____
_____

v) _____
_____

34. What role can men play in ending FGC practice in Kisii community?

i) _____
_____

ii) _____
____

iii) _____

____

iv) _____

____

35. What other comments do you have for the effects of anti- FGC intervention in the Gusii community?

_____

_____

_____

Thank you for your response

APPENDIX III: AUTHORIZATION LETTER

KISII UNIVERSITY

Telephone: +254 20 2352059
Facsimile: +254 020 2491131
Email: research@kisiiuniversity.ac.ke

P O BOX 408 – 40200
KISII
www.kisiiuniversity.ac.ke

OFFICE OF THE REGISTRAR RESEARCH AND EXTENSION

REF: KSU/R&E/ 03/5/ 581 **DATES:** 4th May, 2022

The Head, Research Coordination
National Council for Science, Technology and Innovation
(NACOSTI) Utalii House, 8th Floor, Uhuru Highway
P. O. Box 30623– 00100
NAIROBI - KENYA.

Dear Sir/Madam

RE: MAGDALINE GESARE MAGANGI DAS/60016/14

The above mentioned is a student of Kisii University currently pursuing a Degree of Doctor of Philosophy in Gender and Development Studies. The topic of her research is, "***Effectiveness of female genital cutting interventions on the psychosocial wellbeing of the girl child in Marani Sub-county, Kisii County***".

We are kindly requesting for assistance in acquiring a research permit to enable her carry out the research.

Thank you.

for Prof. Anakalo Shitandi, PhD
Registrar, Research and Extension

KISII UNIVERSITY
05 MAY 2022
REGISTRAR RESEARCH & EXTENSION

Cc: DVC (ASA)
Registrar (ASA)
Director SPGS

APPENDIX IV: RESEARCH PERMIT/LICENCE

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **833025**

Date of Issue: **19/May/2022**

RESEARCH LICENSE

This is to Certify that Ms.. Magdaline Gesare Magangi of Kisii University, has been licensed to conduct research in Kisii on the topic: EFFECTIVENESS OF FEMALE GENITAL CUTTING INTERVENTIONS ON THE PSYCHOSOCIAL WELLBEING OF THE GIRL CHILD IN MARANI SUB-COUNTY, KISII COUNTY, KENYA for the period ending : 19/May/2023.

License No: **NACOSTI/P/22/17512**

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E-mail: dg@nacosti.go.ke / registry@nacosti.go.ke
Website: www.nacosti.go.ke

APPENDIX V: FOCUS GROUP DISCUSSION GUIDE

Dear Participant,

Thank you for agreeing to participate in this discussion. I am interested in collecting your views and opinions on the effectiveness of FGC interventions on the psychosocial wellbeing of the girl child in Marani Sub-County, Kisii County, Kenya. It is my hope that through your contributions I will be able to not only involve various stakeholders in establishing workable solutions to the problem but also make recommendations towards eradicating the practice. The information you give will be treated as absolutely confidential, and it will not be used for any other purpose but for research. I will not associate your identity with anything you say in the focus group and all other participants will be asked to respect each other and keep the information private and confidential. I would like to tape the focus groups so that I can make sure to capture the thoughts, opinions, and ideas I hear from the group. No names will be attached to the focus groups and the tapes will be destroyed as soon as they are transcribed. You may refuse to answer any question or withdraw from the study at any time.

Thank you.

I REBECCA NYAMBEGA Id. No. 41121170 do hereby consent to the terms of this discussion on this date 27/5/022 Sign R.N

NB: This tool is for Identified Heads of Households

1. Are there interventions in place to eradicate FGC?
2. Who are the main stakeholders of anti- FGC interventions implemented in your community?
3. Has the practice of FGC in your community stopped/reduce or it is on?
4. What are the effects of FGC on the psychological wellbeing of the girl child?
5. What are the effects of FGC on the social wellbeing of the girl child?
6. In what ways do cultural norms of the Gusii community influence the practice of FGC?
7. In your view, how can the practice of FGC be eradicated?
8. In your own view, what is your understanding of alternative rites of passage (ARP)?
9. How do you compare ARP with other anti- FGC interventions?
10. What is the sustainability of ARP?

11. What is the place of women in the implementation of anti- FGC interventions on the psychosocial wellbeing of the girl child?
12. What is the place of men in implementation of anti- FGC interventions on the psychosocial wellbeing of the girl child?

APPENDIX VI: KEY INFORMANT INTERVIEW (IMPLEMENTERS)

NB: This tool is meant for government officials, medical personnel, religious persons and other pressure groups)

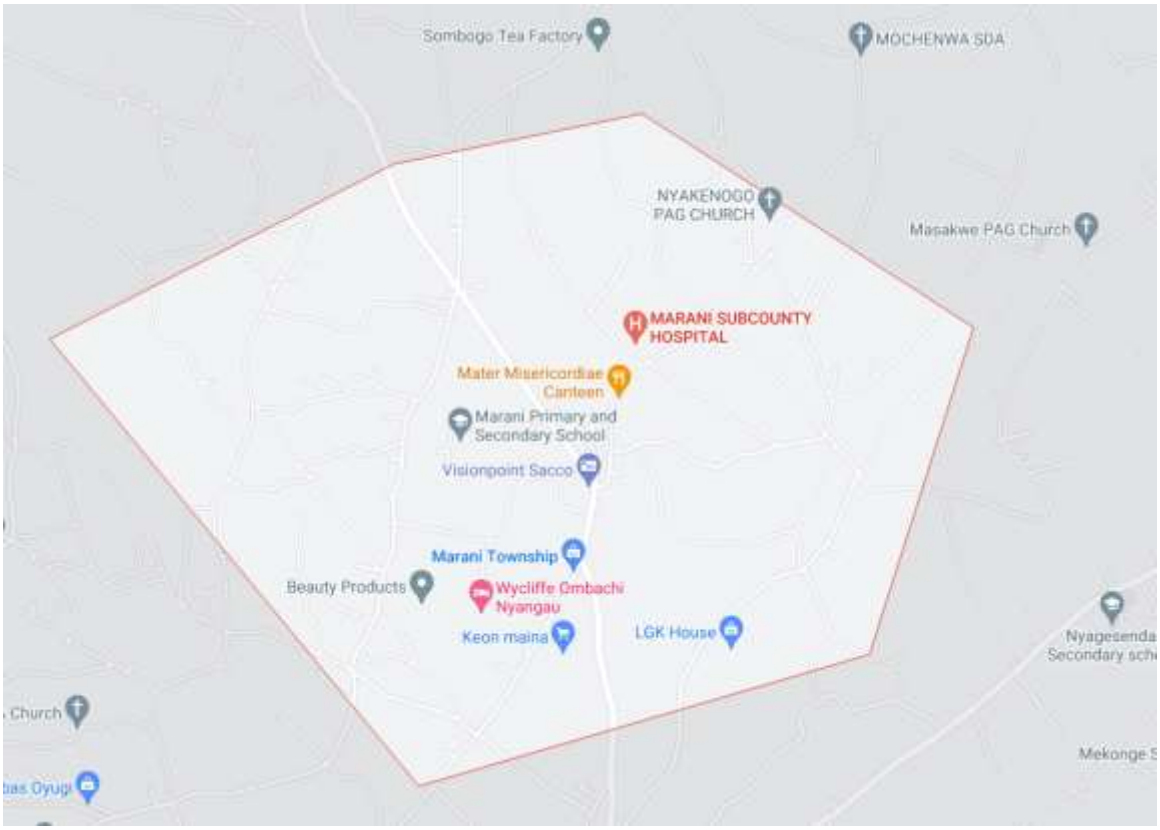
1. In your community, how do the anti- FGC interventions affect the psychological wellbeing of the girl child?
2. In your community, how do the anti- FGC interventions affect the social wellbeing of the girl child?
3. In your opinion, what is the relationship between FGC and sexual morality?
4. In your view, how does the ideal femininity (*being an ideal woman*) ultimately perpetuate gender roles and stereotypes that view a woman as a vessel for reproduction in your community?
5. How are men involved in the implementation of anti- FGC interventions in your community?
6. How are women involved in the implementation of anti- FGC interventions in your community?
7. How are girls involved in the implementation of anti- FGC interventions in your community?
8. How does the contribution of a shared group identity influence implementation of anti- FGC interventions?
9. In your own view, what is your understanding of alternative rites of passage (ARP)?
10. How do you compare ARP with other anti- FGC interventions?

What is the sustainability of ARP?

11. How can women's peer network drive FGC in your community?

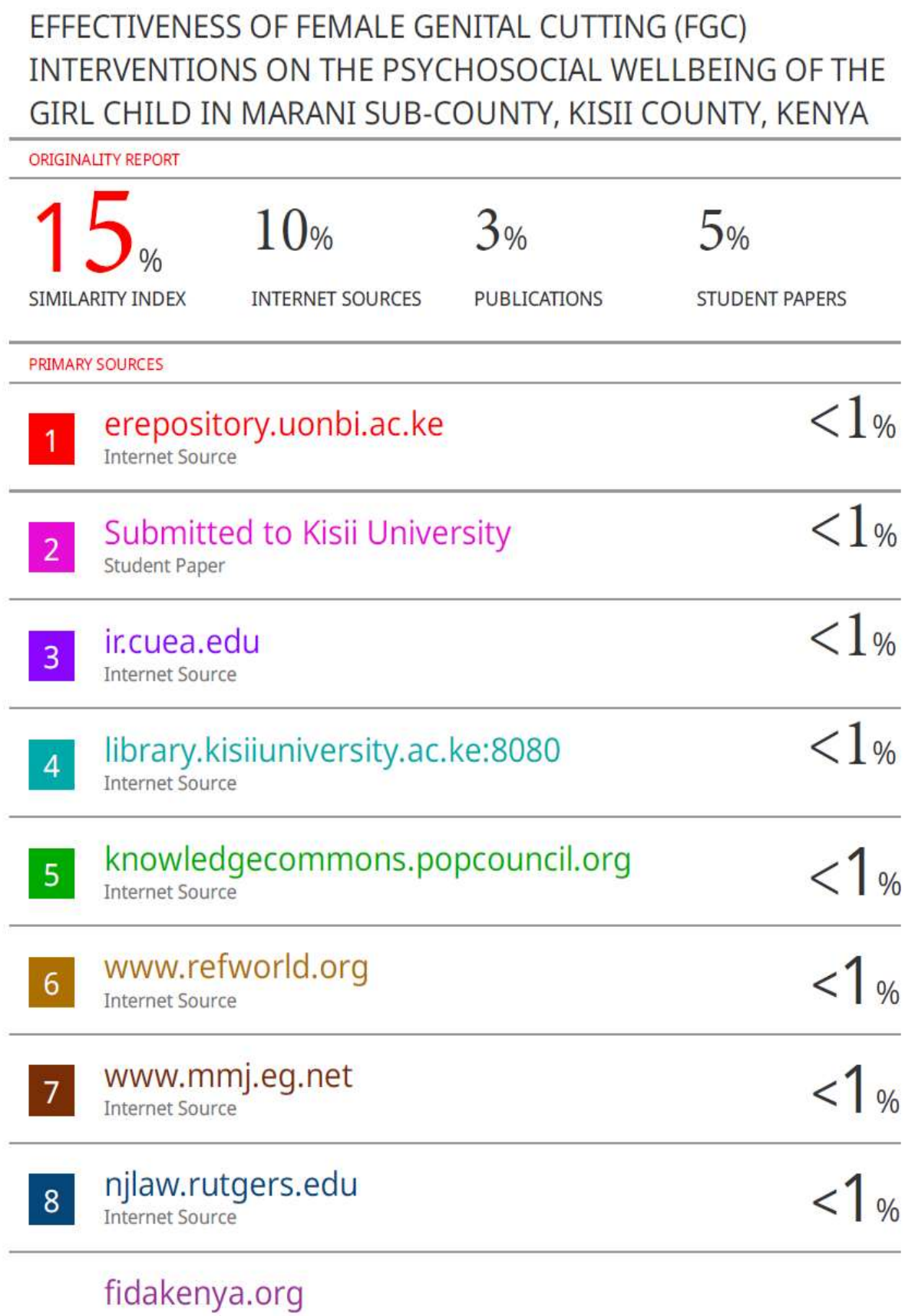
12. How does power relations influence FGC implementation in your community?
13. How well do you understand the legal frameworks in place for the implementation of FGC?
14. As an organization implementing FGC interventions how often do you do documentation of your project reports (**probe: are the reports available? Can they be accessed? Do they inform the current interventions? Do they share the reports with other stakeholders?**)

APPENDIX VII: MAP OF MARANI SUB-COUNTY



Marani Sub-County Map

APPENDIX VIII: PLAGIARISM REPORT



EFFECTIVENESS OF FEMALE GENITAL CUTTING (FGC) INTERVENTIONS ON THE PSYCHOSOCIAL WELLBEING OF THE GIRL CHILD IN MARANI SUB-COUNTY, KISII COUNTY, KENYA

ORIGINALITY REPORT

15%	10%	3%	5%
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