JRIIE Journal of Research Innovation and Implications in Education
Center for Research Implications & Practice

Website:www.jriiejournal.com ISSN 2520-7504 (Online) Vol.7, Iss.2, 2023 (pp. 300 - 308)

The Place of Women in the Implementation of FGC Interventions on the Psychosocial Wellbeing of the Girl Child in Marani Sub-County, Kisii County, Kenya

[1]Magdaline Gesare Magangi, [2]Peter Gutwa Oino & [3]George Ezekiel Aberi
[1&2] Department of Sociology, Gender and Development Studies, Kisii University Kenya
[3]Department of Languages, Linguistics and Literature, Kisii University , Kisii, Kenya

Email: mgesare13@gmail.com

Abstract: *In Kenya, Female Genital Mutilation/Cutting (FGC) is a cultural practice that is widely practiced. Despite interventional efforts to end FGC, progress has been limited both in preventing it and caring for girls and women who have already undergone the cut. The practice has persisted, albeit with some changes. This study sought to examine the place of women in the implementation of FGC interventions on the psychosocial wellbeing of the girl child in Marani Sub-County, Kenya. The study was anchored on the step change theory. The study used interviews and questionnaires to collect qualitative and quantitative data. In this context, quantitative data was collected using questionnaires, analyzed quantitatively. Qualitative data (words/propositions) was collected through key informant interviews, focus group discussions, and analyzed descriptively. The study revealed that stress, stigma, isolation, and marital problems were main psychological effects. Findings from this study conclude that FGC is an ongoing practice within the Gusii community with women and health professionals being the main perpetrators though its practice has reduced drastically compared to previous years. The study recommends an adoption of alternative rites of passage to eliminate the practice. This can be possible through re-socialisation of community members on the need to change this negative tradition for the psychosocial wellbeing of the girl child.*

Keyword: *Female genital cutting, Psychosocial, Women, Girl child, Gusii*

How to cite this work (APA)

Magangi, M. G., Oino, P. G. & Aberi, G. E. (2023). The place of women in the implementation of FGC interventions on the psychosocial wellbeing of the girl child in Marani Sub-County, Kisii County, Kenya. *Journal of Research Innovation and Implications in Education, 7*(2), 300 – 308**. https://doi.org/10.59765/rai3mti7**

1. Introduction

Female Genital Mutilation/Cutting (FGC) is a cultural practice that is widely practiced. It is a form of violence against women and girls that has been around for more than a thousand years. While its origins are unclear, eradicating it will bring the world one step closer to achieving gender equality. However, despite interventional efforts to end FGC, progress has been limited both in preventing it and caring for girls and women who have already undergone the cut. Female genital mutilation/Cutting is widely practiced by many Kenyan communities. This is a cultural practice that is widely considered an extreme form of violence, abuse, and violation of human rights against girls and women (Oloo et al., 2011; Bavel et al., 2017).

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). Furthermore, 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 girls and women victims of FGC. 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, school dropout, early marriage and less sexual satisfaction to affecting the psychological health of girls and women and the violation of their rights (Berg et al., 2010; Elsayed et al., 2011; WHO & PAHO, 2012). In this context, the majority of studies have focused on the social, economic, and political effects of FGC but with little focus on the place of women in the implementation 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 researchers propose this study to fill the aforesaid existing knowledge gap.

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. Another reason why parents might expose their daughters to such a painful and dangerous procedure is the belief that it will protect her virginity and chastity, thus ensuring her marriageability and the family's honour. Additionally, FGC is used to control women's sexuality and enhancement of men's sexual pleasure, although aesthetics, cleanliness and hygiene are also reasons regularly given to justify this practice (Robertson & Szaraz, 2016).

2. Literature Review

FGC has been, and is, used to control women's sexuality by limiting their sexual desire and satisfaction (Berg & Denison, 2014), and promoting premarital virginity as a guarantee of moral standards and an assurance of marriageability (Berg and Denison, 2014). Further, the practice predates all major religions and no religion, condones FGC. FGC is practiced by Muslims, Christians, Jews, and people of other religions alike (Berg & Denison, 2013).

The UNICEF report further shows that in 8 countries the rate of women who think that men want FGC to end is significantly lower than the reality. In Guinea Conakry, for example, 12% of women think that men want to stop whereas 42% of men want the practice to end (UNICEF, 2013:72). This seems to point to a lack of communication between men and women, which the report confirms. The actions and decision for performing the cut are highly meaningful and are aimed at preserving the culture of the community. Women undergo FGC to gain cultural conformity, social significance, and a sense of identity and respectability as an ideal member of the community (Berg and Denison, 2013).

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 (O'Neill, 2013). The UNICEF report (2013), however, showed that in 16 African countries the percentage of men who want to stop FGC is higher than the rate of women who want to stop FGC, apart from in Sudan and Nigeria (UNICEF, 2013). However, the study does not show the place of women in the implementation effectiveness of FGC interventions on psychosocial wellbeing of girls. Hence, the knowledge gap.

In many societies, especially among the Abagusii, FGC is a deeply rooted traditional custom considered to be part of the cultural heritage of the community. Ordinarily, a girl is never considered an adult, ready for marriage without undergoing FGC, which also serves to define her gender and/or ethnic identity. That is, by being cut, the girl becomes a woman and demonstrates her transition into adulthood along with her readiness to take on the roles of a wife and mother. Other reasons why parents might expose their daughters to such a painful and dangerous procedure is the belief that it helps to protect their virginity and chastity, thus ensuring her marriageability and the family's honour, it is also used to control women's sexuality and enhance men's sexual pleasure, although aesthetics, cleanliness and hygiene are also reasons regularly given to justify the practice (Robertson & Szaraz, 2016). According to Hicks (2011), FGC was seen as a way of purifying women of their masculinity, because the clitoris is viewed as undeveloped penis. A woman who still has her clitoris intact is seen as somehow bisexual. If these claims are true that women's genitals are offensive, ugly to look at and obstruct sexual intercourse, the uncircumcised women would find it difficult to have sexual and marriage partners, which has never been the case. However, if women themselves feel they are unclean and are denied their sexual pleasure because of the obstruction from their genitals, then they would be the ones to want to be circumcised.

The consequences and complications of FGC vary according to the extent of the operation, the instruments used, the skills of the circumciser, as well as other circumstances during and after the operation. According to the WHO (2011), the most common short-term consequences of FGC include severe pain, shock caused by pain and/or excessive bleeding (hemorrhage), difficulty in passing urine and faeces, because of swelling, oedema, and pain; as well as infections. Death can be caused by hemorrhage or infections, including tetanus and shock. A study by the WHO (2011) showed that FGC is associated

with increased risk of complications for both the mother and child during childbirth. Rates of caesarean section (29% increase for Type II and 31% increase for Type III FGC) including postpartum hemorrhage (21% for Type II and 69% for Type III) were both more frequent among women with FGC compared to those without FGC. In addition, there was an increased probability of tearing and recourse due to episiotomies while the risk of birth complication increased with the severity of FGC.

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 at childbirth, as women (Elnashar & Abdelhady, 2007; 28 Too many, 2013). 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 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.

Step Change Theory

This study was anchored on the Step Change Theory developed by Kurt Lewin In 1951. Kurt Lewin introduced the Three-Step Change Theory. In his view, behavior is a dynamic balance of forces working in opposite directions while driving forces facilitate change as they push entities in the preferred track. 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 in changing behavior which is movement. 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. The purpose of refreezing, therefore, is to create stability to the new equilibrium resulting from the change.

This theory is considered appropriate in this study because to eradicate the practice of FGC, there is need to create the right movements through persuasion to help channel the views of various stakeholders. Therefore, through this theory, the study elaborated and integrated the subsequent steps of elimination of FGC.

3. Methodology

This study used a quasi-experimental approach. Like a true experiment, a quasi-experimental design aims to establish a cause-and-effect relationship between an independent and dependent variable. However, unlike a true experiment, a quasi-experiment does not rely on random assignment. Instead, subjects are assigned to groups based on non-random criteria. Quasi-experimental design is a useful tool in situations where true experiments cannot be used for ethical or practical reasons (Thomas, 2020). This design was in line with the purpose of the study as it sought to examine the place of women in the implementation of FGC interventions on the psychosocial wellbeing of the girl child in Marani Sub-County, Kisii County. Quasi-experimental designs identify a comparison group that is as similar as possible to the treatment group in terms of baseline (pre-intervention) characteristics. The comparison group captures what would have been the outcomes if the programme/policy had not been implemented. This approach gave a more general understanding of the issue place of women in the implementation of FGC interventions on the psychosocial wellbeing of the girl child, while providing a detailed comparison and in-depth understanding of the same. The target population was the household heads of Marani Sub-County. According to

Kenya Bureau of statistics, population Census 2019, the Sub-County had a total population of 26,186 households spread across locations.

The researchers used cluster sampling to identify households to be included in the study. This involved identifying households covering a particular geographical area of administrative boundaries within Marani Sub-County, Kisii County, Kenya. In addition, the study used purposive sampling procedures, which are non-probability sampling technique where the researchers employed their own judgment to identify respondents for their study. Purposive sampling was used by the researchers to identify the key informants for the study. The sample population is presented in table 1.

Table 1: Sampling Matrix

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

The study used both secondary and primary data to achieve its objectives. Secondary data were achieved by rigorous review of relevant literature. Primary data were achieved through administering of questionnaire to the sampled respondents drawn from household heads. Key informant interviews were used to collect information from administrative officials, religious people, traditional practitioners and health professionals. Interviews allowed the researcher to collect general information on the trends and context in which FGC is practiced in the community and this enabled the researcher to identify approaches reach respondents at the community level. The researcher developed an interview guide with questions regarding the relevance and the continued practice of FGC in the community. This study used the focus group discussion (FGD) as an instrument to collect data from the women and men of the households in Marani. The FGD consisted of 4 groups of 6 participants each. That made 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.

Data was 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, 2003). The data from the completed questionnaires was cleaned, coded and then entered into the computer using the latest Statistical Package for Social Sciences (SPSS).

4. Results and Discussion

The study examined the place of women in the implementation of FGC interventions on the psychosocial wellbeing of the girl child in Marani Sub-County, Kisii County. As actors, the study revealed women were strategically placed on effectiveness of anti FGC interventions. 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 below.

Table 2 Likelihood of different actors to stop female genital cutting

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

Mothers (86%) were very likely to help in stopping 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 professionals in eradiating FGM/C in communities. A study by (Johasen, 2019) however noted that the medical professionals cannot be effective in intervening on Anti FGC due to the highly privatization of the practice in the communities where it has great cultural identity. This view was further supported by another study that reported that women undergo FGC to gain cultural conformity, social significance, and a sense of identity and respectability as an ideal member of the community (Berg and Denison, 2013) hence, involving professionals in anti FGC might not prove effective in Gusii community.

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 mothers 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 too. However, a study noted men's domination and control of women as having a role in the perpetuation of FGC (O'Neill, 2013). In contrast, the UNICEF report (2013) showed that in 16 African countries the percentage of men who want to stop FGC is higher than the rate of women who want to stop FGC, apart from Sudan and Nigeria. 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 as 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 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.

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 1:

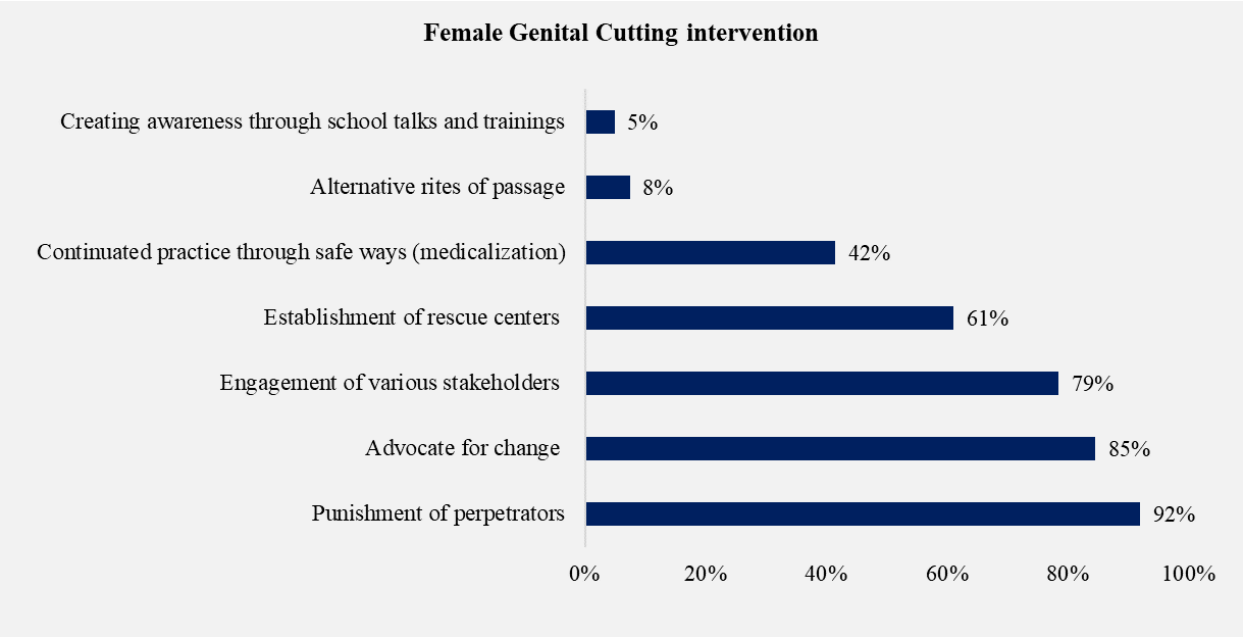

Figure1: Female Genital Cutting Intervention

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 rite 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 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. Mentioned were the Fulda-Mosocho Project, ADRA, Impact Research and CECOME. These organizations used training on the effects of FGC through barazas and seminars. More often, community leaders were trained so that they could in turn train the community members.

Community members such as women, men leaders were trained on the effect of FGC which they reiterated 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.* **(KI003 Male chief, 48 years)**

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

> *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 arrest do not work because you cannot arrest the whole community…let them talk to us we will stop*. **(KI009 old female, 72 years)**.

A chief 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 method for eradicating FGC in Gusii community. In support of this move is a study by Sabeeb and Hatamleh (2016) that stated the need of effort to be directed towards integrating appropriate information on FGC literacy classes and other

public awareness programs. Use of arrests was found not to be very effective in eradicating FGC in the community. Community members resorted into a very secretive approach of practicing FGC and there lacked adequate evidence to prosecute perpetrators who were reported to the authorities.

Rating for Effectiveness of Female Genital Cutting Interventions

Respondents were asked to rate the effectiveness of the FGC intervention used in the community. The study used a 4-point 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 3.

Table 3: Rating for effectiveness of 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**

Analysis demonstrates that media campaigns, legislation, punishment of perpetrators, education, and advocating for change were very effective with a mean range of 3.6-3.7. Engagement of stakeholders, establishment of rescue centers, and empowerment of victims were somewhat effective with a mean range of 3.0-3.3.mn=3.7, legislation 3.6, Education mn=3.6. 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 respondents:

> *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. These 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. 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 lowly effect in reduction of female genital cutting in the community. None of the qualitative results mentioned medicalization as an effective method of practicing FGC.

Regarding respect, the Kisii community, both younger and elder women seemed to agree that a woman who had undergone FGM/C earned respect from both her family and the community at large. The women explained that the process of undergoing FGM/C entailed exclusion of cut girls to a certain location where they were taught how to relate with other members of the community including their fathers, husbands, and elders—a form of structuring hierarchies of power along lines of gender and generation. Another study agreed with this view by reporting that FGC promotes premarital virginity as a guarantee of moral standards and an assurance of marriageability (Berg and Denison, 2014). On the contrary, uncut girls are often disrespected and given derogatory names such as "egesagane" [uncircumcised girl]. With regards to whether cut girls are considered respectful of others, discussants in groups of younger women and elder men supported the view that cut women were respectful of others.

5. Conclusion and Recommendations

5.1 Conclusion

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 study findings it can be concluded that mothers, grandmothers and mother in laws were key players catalyzing continued of FGC practice among the Gusii community. The study 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 psychological effect on girls/women who have been cut than those who have not been cut. Finally, it is evident that cultural beliefs and community resistance were main challenges affecting anti-FGC interventions in Gusii community.

5.2 Recommendations

This study recommends the following:

1. There is 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.
2. 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. The study recommends use of active actors like the girls, doctors and increase of women as key campaigner against the FGC.

References

Ameyaw, E. K., Anjorin, S., Ahinkorah, B. O., Seidu, A. A., Uthman, O. A., Keetile, M., & Yaya, S. (2021). Women's empowerment and female genital mutilation intention for daughters in Sierra Leone: a multilevel analysis. *BMC Women's Health*, *21*(1), 1-10.

Berg R. and Denison E. (2014). "Effectiveness of interventions designed to prevent female genital mutilation/cutting: A systematic review," Varol N., Fraser I., Ng C.. "Female genital mutilation/cutting: Towards abandonment of a harmful cultural practice," *Studies in Family Planning. Australian and New Zealand*

Journal of Obstetrics and Gynaecology. 2012;;4354(2)(5):135–146. 400–405.

Berg, R. C., Denison, E. and Fretheim, A. (2010) Psychological, social and sexual consequences of female genital mutilation/cutting (FGC): a systematic review of quantitative studies. Report from Kunnskapssenteret nr 13-2010.

Creswell, J. W. (2003). Research Design: Qualitative, Quantitative and Mixed Methods Approaches. (2nd Ed.). London, Sage Publications.

Farina, P., Ortensi, L., Pettinato, T., & Ripamonti, E. (2022). The relationship between women's individual empowerment and the support to female genital cutting continuation: a study on 7 African countries. *Genus*, *78*(1), 7.

Goldberg, H., Stupp, P., Okoroh, E., Besera, G., Goodman, D. and Danel, I. (2016). Female genital mutilation/cutting in the United States: Updated estimates of women and girls at risk, 2012. *Public Health Reports,* 131, 1–8.

Johansen, R. E. B. (2019). Blurred transitions of female genital cutting in a Norwegian Somali community. *PloS One*, *14*(8), e0220985.

Kenya National Bureau of Statistics (2015). Kenya Health and Demographic Survey 2013-2014. Nairobi.

Ogunsiji, O., & Ussher, J. (2021). Beyond illegality: Primary healthcare providers' perspectives on elimination of female genital mutilation/cutting. *Journal of Clinical Nursing*, *30*(9-10), 1253-1262

Oloo, H, Wanjiru, M. and NeWell-jones (2011). Female Genital Mutilation Practices in Kenya: The Role of Alternative Rites of Passage: A case study of Kisii and Kuria Districts.Nairobi. Open University press, Buckingham.

Reisel, D., and S. M. Creighton. 2015. "Long Term Health Consequences of Female Genital Mutilation (FGC)." *Maturitas*80 (1): 48–51

Richard F, Ahmed W, Denholm N, Dawson A, Varol N, Essén B, Johnsdotter S, Bukuluki P, Ahmed W, Naeema AGH, et al. (2016) Female Genital Mutilation/Cutting: sharing data and experiences to accelerate eradication and improve care: part 2. *Reprod Health.* 2017;**14**(2):115. doi: 10.1186/s12978-017-0362-x

Singh D, Negin J, Orach CG, Cumming R. (2016). Supportive supervision for volunteers to deliver reproductive health education: a cluster randomized trial. *Reprod Health.* 2016;**13**(1):126. doi: 10.1186/s12978-016-0244-7.

UNICEF (2005). Female Genital Mutilation/Cutting: A Statistical Exploration 2005.

UNICEF (2010). The dynamics of social change. Towards the abandonment of female genital mutilation/cutting in five African countries. Innocenti Digest. Florence

UNICEF (2013). UN Women statement for the International Day of Zero Tolerance for FGM report dated 06/02/2021.