CHANGING TRENDS THAT LEAD TO THE PERSISTENCE OF FEMALE GENITAL MUTILATION IN KISII COUNTY, KENYA

Phoebe Kemunto Maosa.
Master Student, Department of Sociology, Gender and Development Studies, Kenyatta University, Kenya.
Dr. Grace Mose Okongo.
Senior Lecturer, Department of Sociology, Gender and Development Studies, Kenyatta University, Kenya.
Dr. Muthoni Mainah.
Senior Lecturer, Department of Sociology, Gender and Development Studies, Kenyatta University, Kenya.

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ABSTRACT

This study examined the current trends of Female Genital Mutilation (FGM) that contribute to its persistence in Kisii County, Kenya, where prevalence remains alarmingly high despite ongoing eradication efforts. Recognized as a violation of women's and girls' human rights, FGM hinders gender equality and limits the full realization of women's potential. The study sought to identify emerging forms of FGM that sustain the practice in the region. Its specific objectives were to review the traditional process of FGM in Kisii County and to identify the changing trends influencing its continuity. Anchored in Social Convention Theory (Mackie, 1996), the research adopted an exploratory design. The target population included members of a self-help group, the area chief, traditional birth attendants, social workers, a head nurse, female teachers, and female students from one secondary school. A multi-stage sampling approach was used, purposive sampling identified key informants such as the chief, teachers, and nurse; simple random sampling selected members of the self-help group and social workers; while snowball sampling was used for traditional birth attendants due to the sensitivity of the topic. In total, 112 participants took part in the study. Data were collected through key informant interviews, focus group discussions, and questionnaires for female learners to ensure anonymity. A desk literature review was also conducted to establish the historical context of FGM in Kisii. Both quantitative and qualitative data were analysed, quantitative data using SPSS and qualitative data thematically. Findings revealed that the age of circumcision has dropped from 15 years to 6 years, and the prevalence has risen from 84% in 2014 and 77.3% in 2022 (KDHS) to 86% in 2024 according to this study. The research recommends continuous monitoring of emerging FGM trends, promotion of positive parenting, and collaborative efforts among government, NGOs, schools, and families to ensure sustainable eradication of FGM.

INTRODUCTION

Female Genital Mutilation is recognized internationally, regionally and locally as a violation of the humanrights of girls and women. It reflects deep rooted inequality which violates their rights to health, life, human dignity and is an extreme form of discrimination against women. In Kenya, FGM is prohibited and the government has put in place laws to protect women and girls. Europe Institute for Gender Equality (2013) report shows that 66,000 women in UK have undergone the cut, 61000 in France and 35000 in Italy. WHO (2008) offers several FGM classifications which include Type I 'clitoridectomy' in which the prepuce and/or clitoris are removed entirely or in part. Type II 'excision' entails either the excision of the labia majora or the excision of the clitoris and labia minora. Type III 'infibulation' in which the labia are positioned to form a seal and the external

genitalia are removed, leaving a pinhole-sized aperture through which blood and urine can travel. Type IV, the last category, includes all unclassified forms such as pricking, nicking, and piercing the skin covering or in close proximity to the clitoris without causing tissue removal.

An estimated 200 million women and girls have undergone Female Genital Mutilation in African countries where prevalence data is available (Miller, 2016). Nonetheless, the prevalence of FGM varies across nations. For instance, it is more than 90 percent in Djibouti and less than 10 percent in Niger, Togo and Uganda while it is moderately low in Kenya at 21 percent (Yoder, 2008). According to Ahmadu (2007), various strategies have been used to eradicate FGM such as conversion of exicors, sensitizing the community on the health consequences, training of doctors and nurses as change agents, using community based organizations, introduction of alternative rites of passage and the implementation of the law (World Bank, 2004). These efforts notwithstanding, the prevalence rate of FGM across most countries is still high. According to UNICEF (2005), three million African girls are at danger of having FGM each year. Conversely, WHO (2008) states that progress has been made in reducing the magnitude of the problem though its prevalence is still high. Therefore, it is necessary to identify how various communities sustain the practice despite the campaigns against it.

In Kenya, Njue and Askew (2004) argue that despite medicalization being illegal, the procedure has grown and takes place in hospitals or clinics where it is performed by doctors and nurses using anaesthetics among the Abagusii community. The Population Council (2017), reports that 15% of Kenyan girls undergo FGM via medicalization. This means that although most of the girls are cut by traditional circumcisers, medicalization has increased over the years. Further research findings from various researchers show a trend towards girls undergoing FGM at younger ages.

KDHS (2014) further states that communities such as the Maasai, Pokot and Kuria that live along the border with Tanzania and Uganda practice cross-border cutting of girls and women so as to escape law enforcers. Legal and Human Rights Centre report (2008) in Tanzania states that even elderly women are undergoing FGM so as to sell their body parts for purposes of witchcraft. That the flesh is dried and sold as charms for witchcraft to traders in Tanzania. Therefore, there was a need to determine whether similar trends are taking place among the Kisii community and what other new emerging trends are being practiced since FGM prevalence is still high.

The Demographic and Health Survey (2017) indicates that if communities are educated on the dangers of FGM in a culturally sensitive way, then it can start a conversation that gives space for the practice to be questioned. DHS (ibid) further states that where the strategy has been used effectively, support for the practice of FGM reduces significantly. However, FGM is practiced as a social norm in most communities and the rewards associated with it may encourage its continuation even among persons who may tend to be against the practice. In addition, the desire to attain social status among families and the girls may influence adherence to the practice. This

may force parents to create ways of carrying out FGM undetected; therefore, it is important to shed light on the changing trends that are taking place.

In a study by Chege, Askew and Liku (2001), they state that FGM among the Kalenjin has declined from 90% to 43% while among the Meru and Embu it has declined from 74% to 46%. However, among the Abagusii community, it is still universally practiced at 77.3% (KDHS, 2022). Moreover, the prevalence is still high despite similar anti-FGM activities that have been carried out in other communities being implemented among the Abagusii. Therefore, the practice still goes undetected raising concerns on how it is carried out to ensure its sustenance. In his research among the Abagusii, Gwako (1992) claims that while social change has had an impact on FGM, this does not mean that the practice is eradicated. Therefore, this study attempted to unearth the new patterns emerging in FGM.

Without intensive and sustained actions from all societies, millions of girls will suffer unnecessary harm. It is estimated that with the impact of population growth observed in the last three decades, 63 million more girls could be cut by 2050 (UNICEF, 2016). Therefore, it is critical to comprehend the dynamics of change and the context of FGM in order to handle it effectively. Those developing advocacy campaigns and policies can benefit by being aware of how, where and when the practice occurs (Population Council, 2016). According to Mose (2008), the views of women from practicing communities are lacking in the analysis of the phenomenon of FGM as most studies document western views. The Population Council (2007) further notes that important evidence gaps remain in the understanding of why FGM practice is still being perpetuated. This study therefore sought to establish the changing trends of FGM that have occurred over time among the Gusii community. This will help to unveil what has sustained the practice and so that the concerned stakeholders will design practical interventions.

Statement of the Problem

In recent decades, FGM has gained more worldwide attention. In both inside and outside of Africa new laws against the practice have been passed. The African Charter on the Rights of Women in Africa and the Convention on the Rights of the Child (1990) are two international conventions on women's and children's rights that Kenya has ratified. Besides, the enactment of Prohibition of FGM (2011) Act has been put in place; however, its enforcement still remains a hurdle. There have been various interventions since the 1990s where MYWO in conjunction with PATH introduced Alternative Rites of Passage (ARP) so as to replace the actual cutting. In addition, USAID in Kenya has been funding research programs and initiatives geared towards eradication of the practice. Despite these efforts and financial aid, FGM prevalence still remains very high in the Kisii region at 77.3 percent. Worse still, there are concerns that FGM is still carried out secretly. Changing trends have been reported by scholars showing that the age of cutting girls has reduced and open ceremonies have been modified or hidden. One wonders if such trends are being carried out in Kisii County to conceal the practice. This study sought to identify the various changes that have

been effected to replace how FGM was traditionally done. Further, this study sought to unveil if these changing trends have contributed to the persistence of FGM with the goal of offering practical approaches that would lead to complete eradication of FGM.

Objectives of the Study

The research objectives include:

i. To conduct a desk literature review of the traditional process of FGM in Kisii County.
ii. To identify the changing trends of FGM in the county.

LITERATURE REVIEW

Review of the Traditional Practice of Female Genital Mutilation

Female Genital Mutilation (FGM) is an ancient cultural practice with a history stretching back over 2000 years (Slack, 1988). Although its exact origins remain unclear, anthropological evidence links it to Egypt in the 5th century BC, where it was possibly introduced by Equatorial African herders to protect young female herders from sexual assault or as a form of population control (Lightfoot-Klein, 1983). Mackie (1996) suggests that FGM likely emerged independently among different societies and was reinforced by slave raids from Sudan, which involved capturing women for trade. Over time, FGM spread beyond Africa, appearing in parts of Asia, the Middle East, and even Australia. Historically, communities justified the practice as a way to ensure virginity, marriageability, and family honor, or to promote fertility based on the belief that the female orgasm could harm sperm (Socialstyrelsen, 2002; Sala & Manara, 2001).

Different communities practiced FGM for diverse cultural and symbolic reasons. In Ethiopia, for example, EGLDAM (2007) found that among the Afar, girls were circumcised within eight days of birth in private family ceremonies, while among the Sidama, it was a celebratory pre-marriage event overseen by the mother-in-law to confirm virginity. Similarly, in Liberia, FGM was part of the *Sande* initiation, a traditional ritual that prepared women for adulthood and symbolized fertility, spirituality, and womanhood (Koso-Thomas, 1987). However, most studies focused primarily on rural practices and ignored the evolving attitudes in urban settings, raising questions about whether modernization has weakened traditional beliefs about FGM. This gap inspired further research into changing perspectives among communities like the Kisii in Kenya.

Across West and East Africa, FGM continued as a rite of passage deeply tied to social identity. Among the Mali, it was practiced on girls up to age 12 during elaborate initiation ceremonies involving symbolic cleansing rituals (28 Too Many, 2014; Jemphrey, 1997). In Uganda, the Sabiny community's practice of FGM diminished after marriage because parental control over women ended (Namulondo, 2009), yet men often refused to marry uncircumcised women, showing persistent patriarchal influence. Among the Pokot, the practice was economically motivated, as parents received higher bride prices for circumcised daughters (Kuka, 2004; Godparents, 2011).

These examples reveal that while cultural motives differ, FGM remains a deeply embedded social expectation, with limited research exploring its changing patterns or modern deterrents. The current study thus seeks to fill this gap by identifying emerging trends and proposing effective mitigation strategies.

In Kenya, the Population Council (2014) reported that FGM among the Kuria was once a public celebration conducted alongside male circumcision after harvest seasons. Yet, recent research shows a shift toward more private family-based ceremonies. Among the Abagusii, FGM was traditionally preceded by years of moral and social preparation starting from early childhood, transforming it into an educational process about womanhood rather than a mere physical procedure (Mose, 2008; Okemwa et al., 2014). However, studies vary while Mose and Okemwa highlight structured training, others like the Population Council (2014) and Nyansera (1994) indicate that circumcision was performed privately within families, suggesting evolving cultural adaptations. Contemporary Kisii families increasingly combine traditional rituals with modern values (Mose, 2008), reflecting a society in transition. Despite modernization, FGM persists due to deep-seated cultural beliefs and social pressures. As Abdi (2009) notes, although many rituals have been abandoned, the core practice continues, warranting ongoing research to explain why FGM endures despite widespread awareness and legal prohibitions.

Current Trends on Female Genital Mutilation

The practice of Female Genital Mutilation (FGM) has been evolving over time due to social changes, yet it remains persistent in many communities. Gwako (1992) notes that while FGM is changing, its continuation indicates deep-rooted cultural persistence. Shell-Duncan et al. (2017) highlight that examining these changes can reveal which communities are adopting new practices. The UN (2005) observes that over the past generation, circumcision increasingly separates from traditional rituals, signifying a shift in societal perceptions.

In Eritrea, the 2010 Population and Health Survey (EPHS) reports that most girls undergo circumcision before age five, mainly because mothers believe younger girls heal faster. The survey found that 80.3% of women aged 15-49 were initiated by traditional practitioners, with minimal involvement of health professionals, indicating limited medicalization. However, this focus on prevalence overlooks other covert changes.

Similar trends are observed elsewhere. Kaplan (2013) in Gambia reports rising medicalization among health workers, with nearly half supporting FGM and some performing it professionally. Koso-Thomas (1987) in Sierra Leone notes delayed initiation and changing timing, though these observations are outdated. Bosire (2012) discusses ritual modifications but neglects specific FGM types, emphasizing the need for insider perspectives. In Tanzania, Too Many (2013) describes secret initiation of infants, with illegal practices underground due to legal restrictions. The LHRC

(2008) reports that flesh from initiated women is used as charms, showing the trade's underground nature.

Kenya exhibits emerging trends such as medicalization and shifts from severe types like infibulation to less invasive forms. The KDHS (2014) notes changes in community practices, with younger girls being circumcised and rituals becoming less elaborate. Studies by Okemwa et al. (2014) and Chege et al. (2001) reveal that FGM often occurs at home and that knowledge about current practices is limited. Mose (2008) discusses the blending of traditional and modern ideas, while Ouko (2014) emphasizes that despite anti-FGM campaigns, the practice persists, possibly taking new forms.

Theoretical Framework

The study is guided by Social Convention Theory, initially proposed by Gerry Mackie in 1996, which explains the persistence and social reinforcement of harmful traditional practices like Female Genital Mutilation (FGM). According to this theory, individual decisions are heavily influenced by the choices and norms of others within the community. FGM exemplifies this, as girls and women are socialized to respect authority figures, with those who have undergone the procedure seen as supportive of cultural norms. The practice is rooted in patriarchal control over women's sexuality, often demanded by men before marriage, with fathers typically paying for the procedure. Despite legal bans and threats of punishment, supporters view legislation as an external imposition and cultural attack, highlighting the deep-rooted nature of the practice.

The theory also explains how communities adopt, maintain, or abandon FGM. Families perform the ritual to confer social status on their daughters, ensuring they are deemed marriageable within their intermarrying group. The actions of one family influence others, creating a social norm that reinforces the practice. In communities like the Abagusii, circumcised women are perceived as better wives and mothers, aligning with societal expectations of femininity and social roles. Women who have undergone FGM are believed to be virgins, making them more attractive for marriage, which drives families to conform to the tradition out of fear of stigmatization and social exclusion.

The theory further posits that FGM is a self-enforcing cultural practice, maintained through fear of seclusion from the community. Historically, girls had to demonstrate domestic competence and submission to men to be deemed suitable wives, and circumcision became a marker of womanhood and fidelity. Uncircumcised women are viewed as rebellious, threatening their prospects of marriage. To eradicate FGM, the theory advocates for community-led change, emphasizing that a critical mass of families and influential community members must collectively denounce and publicly reject the practice. Change is more sustainable when driven internally through organized information sharing and persuasion, rather than external interventions.

RESEARCH METHODOLOGY

Research Design and Target Population

This study was guided by exploratory research design. Exploratory design is used to provide insights and understanding of a phenomenon. According to KDHS (2022), the prevalence of FGM in Kisii County is 77.3% while Nyamira is 74.7%. The study also targeted 80 girls in form four, 1 self help group that had 12 women and 11 men, key informants who included 1 social worker, 1 nurse, 1 area chief, 2 traditional birth attendants and 4 female teachers.

Sampling Techniques and Sample Size

As per Mugenda and Mugenda (2003), 10-30% of the population is representative in a study. Kisii community inhabits two counties which are Nyamira and Kisii County. For this study, the researcher used multi-stage sampling and 10% of the target population was sampled. Thus 10% of the schools, self help groups, social worker and traditional birth attendants was considered adequate for the study. The key informants were purposefully sampled due to their in-depth knowledge on the topic. The study participants were selected using both non-probability and probability sampling techniques. Therefore there was a total of 112 participants in the study.

Table 3.1 Targeted Population and the Sample Size

Categories	Target Population	Sample size
Students	80 girls	80 (purposively selected)
Self-help groups (consisting of men and women)	7	1 (12 women and 11 men) 10% of the total groups
Social workers	7	1 (10% of the total)
Head nurse maternity wing	1	1 (purposively selected)
Administration chief	1	1 (purposively selected)
Traditional birth attendants	15	2 (10% of the total)
Female Teachers	4	4 (purposively selected)
Total	294	112(total number of respondents)

RESEARCH METHODS AND DATA COLLECTION

Different techniques for gathering data were used to probe the subject of the study. Key informant interviews, questionnaires, and focus group discussions were some of the instruments utilized. The researcher administered interviews to one administration officer (chief), 1 head nurse, 1 social worker, 4 female teachers and 2 traditional birth attendants. Self-administered questionnaires were utilized to gather data from the 80 female students in form four from the Secondary School selected. Focus Group Discussions were utilized to gathered data from the 12 women and 11 men randomly selected from the self-help group. The researcher used desk literature review to find information on the traditional practice of Female Genital Mutilation.

Data Analysis and Presentation

Editing the completed questionnaires was done first. It was essential to rectify errors such as gaps found in the questionnaires. The questionnaires were checked to ensure that every question was answered. After this, data was classified into meaningful and relevant categories. It involved assigning a code number to each answer to a question. Coding was developed after the questionnaires had been administered and answered by respondents. Descriptive statistics were used to analyze quantitative data, and tables and graphs were used to display the results.

RESULTS AND DISCUSSION

Desk Literature Review of the Traditional Process of FGM

This section reviews the traditional process of Female Genital Mutilation (FGM) among the Kisii community, highlighting its historical and cultural significance. A desk literature review was conducted to understand how FGM was traditionally performed and to note any changes over time. Silberschmidt (1999) noted that FGM is an ancient practice among the Kisii, integral to their initiation ceremonies, which historically took place annually from October to December following the harvest season. Scholars such as Nyansera (1994) and Mose (2008) documented that prior to FGM, girls had to demonstrate their ability to perform household chores like fetching water, firewood, cooking, and childcare, with informal training beginning as early as age two to instill humility and societal submission.

Traditionally, girls over fifteen underwent FGM, performed by a traditional circumciser using a knife or razor blade. During the procedure, girls' hands were held over their eyes to prevent them from seeing, and they were bathed early in cold water to numb their bodies. Threats of punishment and beliefs that crying would bring bad luck were common. Post-circumcision, girls would be escorted home amid singing and dancing, symbolizing their transition into womanhood. Seclusion for about a month followed, during which they received education on womanhood, sexuality, childbearing, and household responsibilities, preparing them for marriage and adult societal roles. The practice also involved symbolic elements, such as a sacred fire representing continuity and protection against barrenness, and the connection to ancestors, reinforcing its spiritual significance. FGM was viewed as essential for social acceptance, marriage prospects, and community standing, with non-initiated girls considered shameful or unmarriageable. The ritual reinforced gender roles, socialization, and cultural identity, often kept secret to reinforce societal norms.

Despite efforts since the early 20th century to eliminate FGM due to health concerns, resistance and clandestine practices have persisted, with the community adopting new, covert forms. The practice remains a vital cultural rite of passage that confers social benefits, including respect, bride price, and perceived moral superiority. Understanding these deep-rooted cultural values is crucial

for developing effective strategies to eradicate FGM, which is viewed as both a cultural obligation and a means of social cohesion.

Current Trends of FGM

Age of Circumcision

The study aimed to explore the age at which the participants underwent FGM. As indicated in Figure 4.1, 63 (86 %) of the participants said that they had undergone FGM while 10 (14 %) said they did not undergo FGM. The study further observed that 44 (60 %) of the girls underwent FGM between the ages of 6-10, 18 (25 %) underwent FGM at the age of 11-15, 7 (9.6 %) underwent the cut at the age of 5 and below, while 4 (5.4 %) underwent at the age of 16 and above.

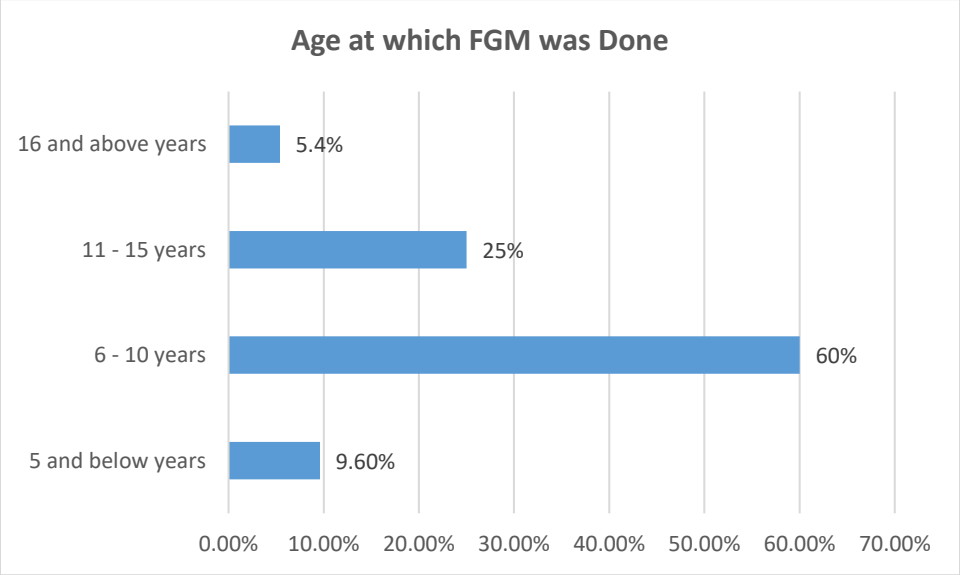

Figure 4.1 Distribution of respondents by age of circumcision

Majority of FGD participants and key informants were in agreement that girls underwent circumcision at the age of 8 years at 8 (66.7%) for female participants, 7 (62%) for male participants and 6 (65.3 %) for key informants. However, 4 (33.3 %) of the female participants stated that girls were circumcised between the ages of 6 and 12, 3 (25 %) of the male participants stated between ages 4 and 9 while 1 (13 %) of the men stated that the age was a secret. In addition, 3 (34.7 %) of the key informants stated between the age of 5 and 12. This is an indication that the age for circumcision is decreasing gradually. A female participant said:

> Girls are circumcised at a lower age than in the past where it was 15 years. Today they are circumcised between 6-10 years because parents are afraid of girls getting pregnant before marriage. It also ensures that girls will not report to the authority or tell neighbours since they are young and scared of their parents.

Place of Circumcision

This study revealed a changing trend from the past in that girls are no longer circumcised at the river as shown by 28 (39 %) of the participants who stated that they were circumcised at home, 26

(35 %) were circumcised in the hospital, 17 (23 %) were circumcised at the village and 2 (3 %) outside the country.

In the focus group discussions, majority of the female participants at 6 (50 %) stated that the circumcision took place in a secret which is not known, 3 (25 %) stated that circumcision took place at the hospital and 2 (17 %) at home, and 1 (8 %) stated in the village. Majority of male participants at 5 (45.5 %) stated that circumcision was carried out in a secret place, 3 (27.3 %) at home, 2 (18.1 %) at the hospital and 1 (9 %) at the village as presented in Table 4.1. However, majority of the key informants at 5 (55.5 %) stated that girls are circumcised at home, 3 (33.3 %) stated that circumcision takes place in the hospital, 1 (11.1 %) stated in the village or unknown.

Table 4.1 Place of Circumcision by FGD Participants

Where FGM was done	Number of women	%	Number of men	%
Home	2	17	3	27.3
Hospital	3	25	2	18.1
Village	1	8	1	9
Outside the country	0	0	0	0
Unknown	6	50	5	45.5
Total number	**12**	**100.0**	**11**	**100**

Person Performing Circumcision

The study revealed that, 41 (56 %) of the respondents stated that a nurse performed the circumcision, 17 (23 %) stated that the doctor performed it and 15 (21 %) stated that they were circumcised by a traditional circumciser, see Figure 4.2.

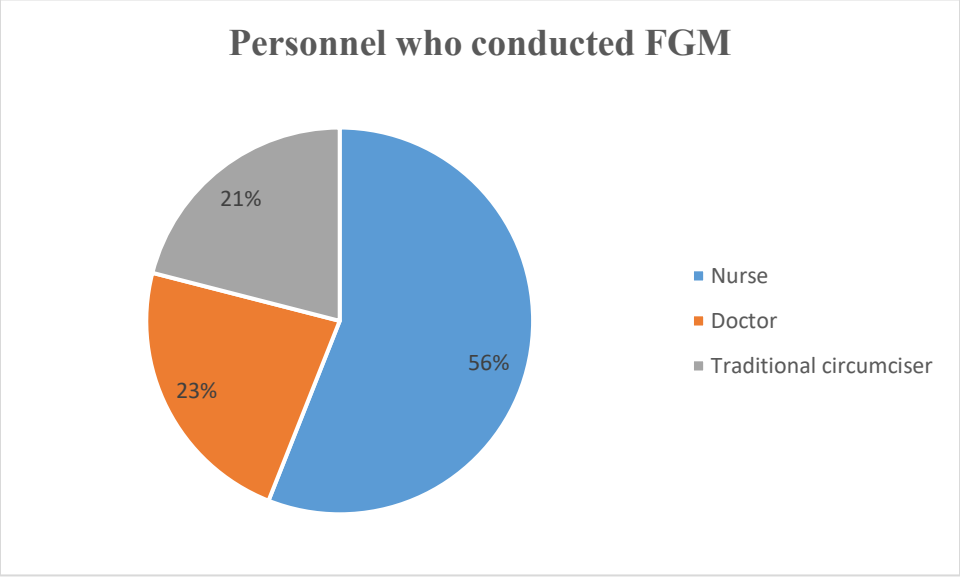

Figure 4.2 Personnel who conducted FGM according to respondents

According to the findings, there has been a shift from *Omosari* to nurses. This was affirmed by 9 (75%) of female participants, who stated that the nurses performed the circumcision while 2 (16.7 %) stated that it was done by a doctor and 1 (8.3 %) traditional birth attendants. According to the male participants, 8 (72.7 %) stated that the nurses carried out FGM, 2 (18.2 %) stated that they are not aware who performs, 1 (9.1 %) stated that it was the doctor and no one mentioned the traditional birth attendants. According to the key informants, 4 (44.4 %) stated that it was the nurse who performed the circumcision, 3 (33.3 %) stated that it was the doctor and 2 (22.2 %) the traditional birth attendants. A female participant said:

> Most of the girls are circumcised by a nurse because the mothers want to avoid any danger like death. The mothers organize with the nurse to carry out the circumcision in the house. In the past, circumcision was painful and some girls would bleed a lot or get infections which will take time to heal. When the nurse is used, the process becomes fast without pain because of anaesthesia.

Medicalization

This study established that, the number of girls circumcised by nurses has increased as indicated by the findings where 41 (56.2 %) of the respondents stated that a nurse performed the circumcision, 17 (23.2 %) stated that the doctor performed it and 15 (20.5 %) stated that they were circumcised by a traditional circumciser.

According to the female participants in the FGDs, 9 (75 %) stated that the nurses performed the circumcision while 2 (16.7 %) stated that it was the doctor and 1 (8.3%) traditional birth attendants. According to the male participants, 8 (72.7 %) stated that the nurses carried out FGM, 2 (18.2 %) stated that they are not aware who performs, 1 (9.1 %) stated that it was the doctor and no one mentioned the traditional birth attendants. According to the key informants, 4(44.4 %) stated that it was the nurse who performed the circumcision, 3 (33.3 %) stated that it was the doctor and 2 (22.2 %) the traditional birth attendants.

In regard to these, a female participant said:

> In our community today, it is the doctors and retired nurses who carry out FGM. Majority of traditional birth attendants are dead and those who are alive are very old to perform circumcision.

Her view was supported by a male participant who said:

> Today nurses are being paid by parents because they believe it will be safe. Old women used to perform circumcision but today things have changed because parents fear infections.

Time of Circumcision

According to the study, 31 (42.4 %) of the respondents were circumcised in the morning, 28 (38.4 %) in the evening, 11 (15.1 %) in the afternoon and 3 (4.1 %) at night see Figure 4.3. The timings

of FGM are either very early in the morning or late in the evening to avoid being tracked by government agencies or raising suspicions.

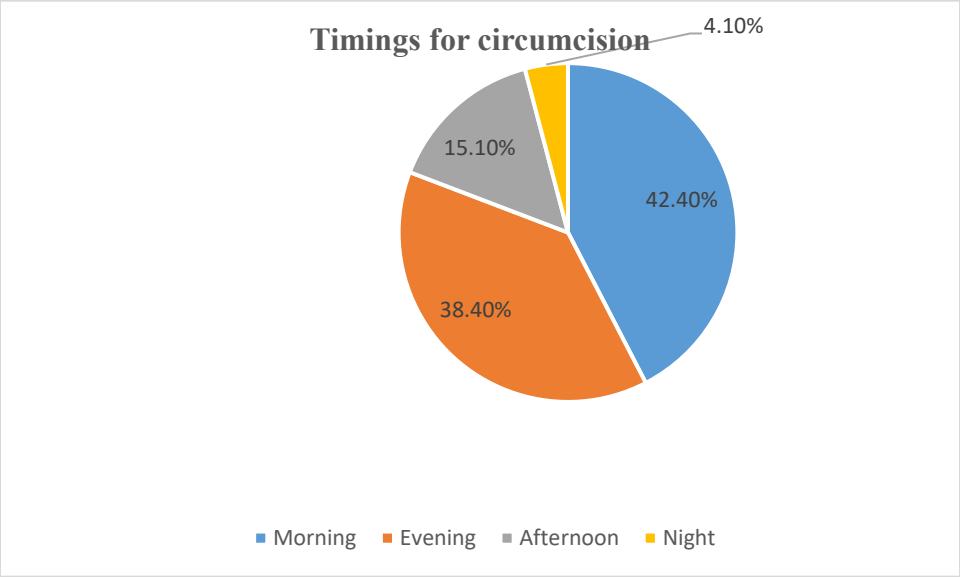

Figure 4.3 Timings for circumcision according to the respondents

From the results of the study, 6 (50 %) of the female participants stated that girls are circumcised in the morning, 5 (41.6 %) stated at any time and 1 (8.3%) stated in the evening while 7 (63.6 %) of the male participants stated in the morning, 3 (27.3 %) at any time and 1 (9.1 %) in the evening. According to the key informants, 6 (66.6 %) stated that girls are circumcised in the morning, 2 (22.2 %) at night and 1 (11.1 %) stated that it is not known. A female participant remarked that circumcision is done very early in the morning when most people are not awake. She said:

> The nurse is invited and since most women are busy with their house chores no one can notice what is going on.

This was also supported by a male participant who stated that:

> Mostly, circumcision is done very early in the morning around 5am or late in the evening around 10pm when people are in their homes and no one can interfere.

Circumcision during the School Holidays

The study revealed a trend whereby circumcision during the school holidays for girls has increased with emphasis being on December holidays. However, in the study majority of the girls at 63 (86.3 %) stated that they were not aware of any girl who was circumcised during the holidays while 10 (13.7 %) said they knew girls who were circumcised during the holidays, see Table 4.2

Table 4.2 Circumcision during the school holidays according to respondents

	Number	%
Yes	10	13.7
No	63	86.3

According to FGD participants, 11 (91.7 %) of the women stated that FGM is carried out during the December holidays while 1 (8.3 %) stated that it did not happen during the holidays. According to the male participants, 7(63.6 %) stated that circumcision took place during the December holidays, 3 (27.3 %) stated it did not while 1 (9.1 %) stated it is unknown. With regards to key informants, 9 (100 %) stated that FGM is carried out during the December holidays. On the contrary, the findings of the key informants and FGD participants differed with those of the respondents showing that FGM practice is secretive. The girls are afraid to speak about what happens during the holidays hence, very few girls are aware if their fellow girls underwent circumcision when they were out of school.

It is reflected by the comments of a female respondent who stated that FGM takes place during the December holidays because there is enough time to heal at home. She said:

> When schools open, the girls would go back like nothing happened.

Her view was consistent with the chief, nurse and social worker who stated that:

> Some girls are circumcised during December holidays especially if they are in boarding school as it does not require an explanation to the head teacher.

Decision Making on Circumcision

The study showed that mothers still hold the power to decide if a girl is ready for circumcision or not. In the study, 43 (58.9 %) of the respondents stated that their mothers decided that they should be circumcised, 15 (20.5 percent stated that it was their grandmother, 7 (9.6 %) stated that they themselves decided, 6 (8.2 %) stated it was their father, 2 (2.7 %) stated that it was both parents, see Figure 4.4.

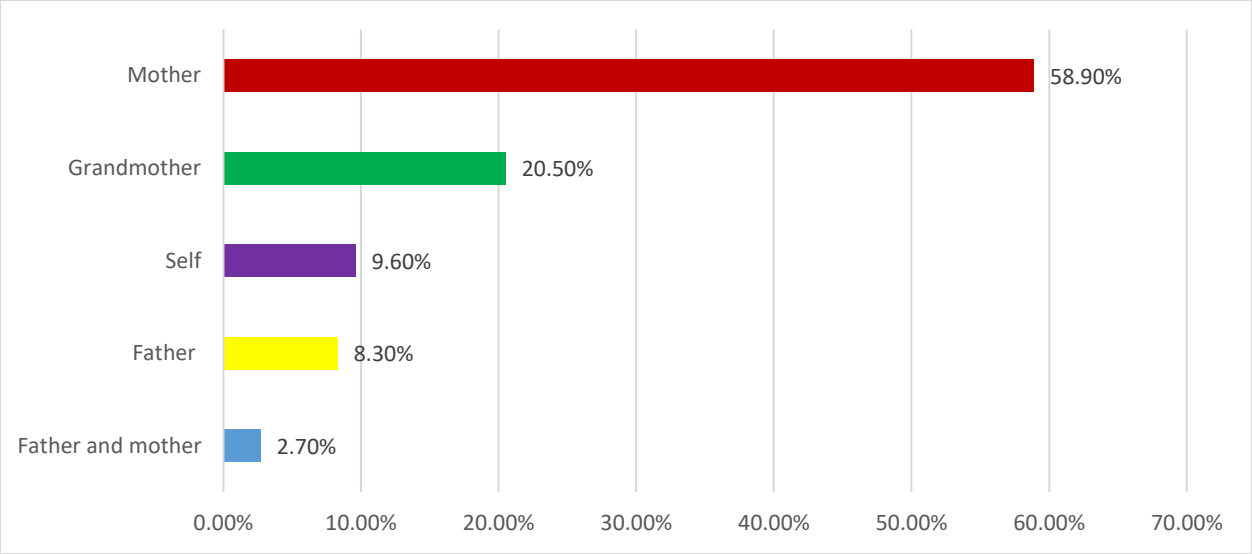

Figure 4.4 Key decision makers for the FGM according to respondents

According to FGD participants, 6 (50 %) of the women stated that mothers made the decision, 2 (16.6 %) father, 2 (16.6 %) the grandmother, 1 (8.3 %) self and 1 (8.3 %) both parents while for the male participants 6 (54.5 %) stated the mother made the decision, 3 (27.3 %) both parents and 2 (18.1 %) the father. They did not mention the grandmothers or the girls themselves as key decision makers, see Table 4.3. According to the key informants, 4 (44.4 %) stated that mothers made the decision, 3 (33.3 %) the father, 1 (11.1 %) the grandmother and 1 (11.1 %) both parents while none mentioned that girls were key decision makers.

Table 4.3 Key decision makers for the FGM according to participants

Decision maker on FGM	**Women**	**% of the Total**	**Men**	**% of the total**
Mother	6	**50**	6	**54.5**
Father	2	**16.6**	2	**18.1**
Grandmother	2	**16.6**	0	**0**
Self	1	**8.3**	0	**0**
Mother and father	1	**8.3**	3	**27.3**

Preparation and ceremony for FGM

Table 4.4 Preparation of FGM according to the respondents

	Number	%
Preparation before circumcision	11	15.1
No preparation	62	84.9

This study revealed a changing trend from the past in that girls are not prepared for circumcision and ceremonies are not held afterwards. According to the study, a few girls at 15.1 percent stated that they were prepared before circumcision took place. However, a majority of the girls at 84.9 percent stated that nothing happened before the circumcision. They were not informed about it and it caught them by surprise.

The respondents who had undergone FGM stated that the celebrations were not elaborate. One of the girls stated that she was promised to be given a dress as a present but was so afraid of what was going to happen to her. Another stated that her mother told her after the circumcision she was going to stay in the house for two months. She added that she was scared of the pain. Still another girl stated her parents told her that they will hold a celebration after the circumcision. When asked if celebrations were done, the respondents gave their views as follows:

Table 4.5 Ceremony performed according to respondents

	Number	%
Ceremony performed	35	47.9
No ceremony performed	38	52.1

In addition, the findings revealed that 35 (47.9 %) stated that a ceremony was carried out while 38 (52.1 %) stated that a ceremony was not carried out. Those who noted that ceremonies were held when probed further indicated that good food was prepared in addition to their parents buying soda and bread for the villagers who were invited.

Another respondent said that:

> It was very nice since her age mates and friends were invited and anything she wanted was made available.

Another stated that, 'There was eating, drinking and dancing' while others pointed out that they were given gifts and offered advice about life. That the celebration was good and enjoyable.

Findings from the FGDs and key informants concurred with the respondents' views that parents no longer prepare girls or hold ceremonies but if they do, it only involves family members so as to avoid attracting unnecessary attention. According to FGD participants, 8 (66.7 %) of the women stated that there was no ceremony while 4 (33.3 %) stated that there was a ceremony. In addition, 9 (81.8 %) of the male participants stated that there was no ceremony while 2 (18.2 %) stated that there was a ceremony. According to key informants, 6 (66.7 %) stated that there was no ceremony while 3 (33.3 %) stated that there was a ceremony carried out. Majority of the women and men stated that there was no ceremony as it will attract attention from the neighbours. The chief and the nurse were also in agreement as they stated that:

> Today, there are no ceremonies since the girls are very young, they do not understand what is happening and parents also are avoiding the authority. The girls are circumcised secretly without anyone knowing to avoid being reported.

The statement was supported by other male participants who stated that:

> There are no ceremonies since it would attract attention and they would be caught. In addition, the practice has gone underground. You cannot tell who has been cut or not since parents do it individually and not collectively as a group. In the past, initiates held a ceremony as a group after seclusion, however today it has been individualized.

Gifts

In the study, 35 (47.9 %) of the respondents stated that they received various rewards while 38 (52.1 %) stated they were not given anything. Some of the rewards included: good food, dresses or shoes.

According to FGD participants,8 (66.7%) of the female participants stated that no rewards were given while 4 (33.3 %) stated that the girls were given rewards. According to the male participants, 7 (63.6 %) stated that rewards were given while 4 (36.4 %) stated that there were no rewards. In addition, 8 (88.9 %) of the key informants stated that the girls were given rewards while 1 (11.1 %) stated that they were not given any rewards. The gifts given to the girls included: clothes, shoes and delicious food. A female participant said:

> Girls are given new clothes, money, delicious food such as chicken and 'maandazi'. The girls are excited when they are celebrated and told that they have become grown-ups.

In contrast, both the teacher and the chief stated that:

> There are no gifts given to girls during circumcision but this attract attention. They are circumcised in secret and after healing life continues as usual. Today, parents do not see the need of giving gifts or having a ceremony because it is against the law and they do not want to be arrested.

Education during Circumcision

According to the study, 25 (34.2 %) of the girls stated that they were taught about the cut while 48 (65.8 %) stated that they were not taught, see Figure 4.5.

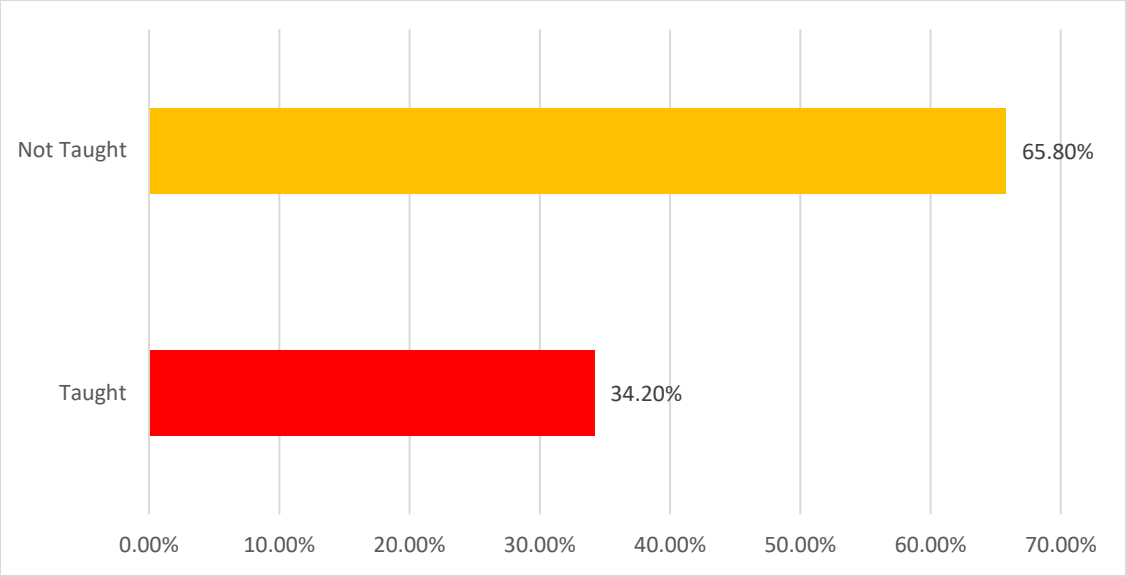

Figure 4.5 Percentage of respondents who were taught about FGM

According to the key informants, 5 (55.6 %) stated that girls are taught about FGM before it is carried out while 4 (44.4 %) stated that they are not taught. This was clear also from the views raised by the FGD participants where 8 (66.7 %) of the female participants stated that girls are not taught about FGM while 4 (33.3 %) stated that girls are taught about circumcision before it is done. According to the male participants, 10 (90.9 %) stated that girls are not taught about FGM while 1 (9.1 %) noted that they are taught. This finding indicates a new trend which was further emphasized by the key informants through interviews. For instance, a female participant stated that:

> Girls are just cut without any prior information. It is done without them being involved in the preparations. In the past, girls would be taught because they were old enough to understand and it was done to prepare them for marriage unlike today whereby girls are too young to be married.

Hence, it is clear that some of the girls are still being taught on how to behave before and after circumcision. Other teachings that were given according to the traditional birth attendant and social worker included:

> Girls are to keep off men and to dress decently. That short dresses are not to be worn since the girls are no longer children but adults.

The study further required the respondents to indicate who had the responsibility of teaching the girls. The results are shown in the figure below.

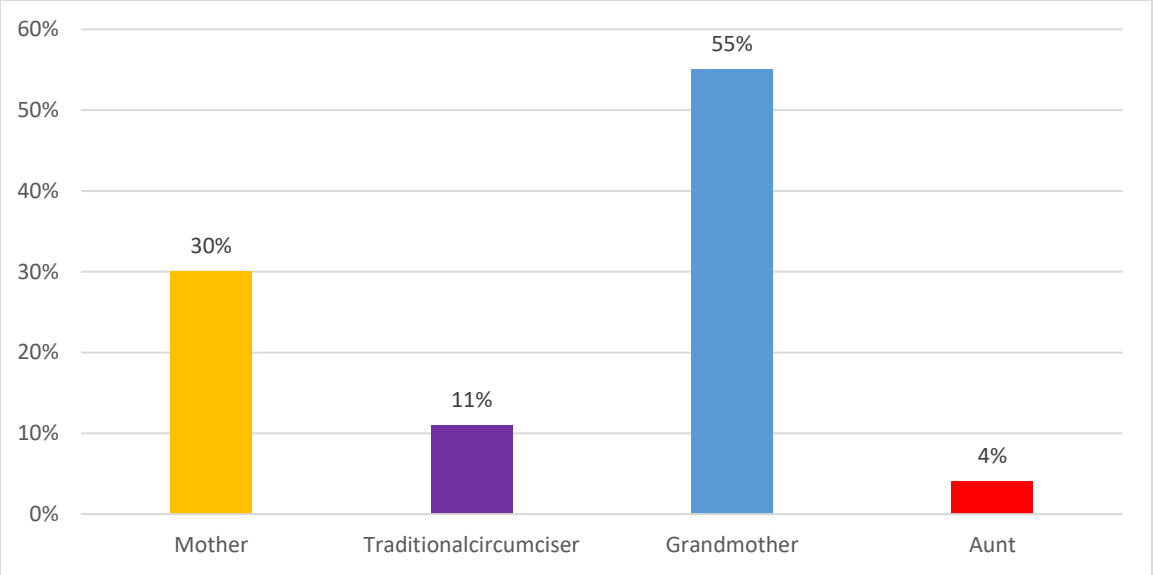

Figure 4.6 The person responsible for teaching the girls according to the respondents

Asked who does the teaching, the respondents revealed that 40 (54.8 %) were taught about circumcision by their grandmother, 22 (30.1 %) mothers, 8 (11 %) the traditional circumciser, and 3 (4 %) aunt. However, the findings differed with the female participants' views where 5 (41.7 %) stated that the aunts taught the girls about FGM, 4 (33.3 %) the grandmother, 3 (25 %) the traditional birth attendant and none indicated the mother.

The opinion was consistent with a female participant who stated that:

> Girls are mostly taught by their grandmothers because they are more experienced. They understand more about the culture and are respected in the community.

Similarly, a nurse stated that:

> The aunts are responsible for teaching the young girls but also in our community grandmothers play a big role in giving information to the girls since they have more experience.

The traditional birth attendant further explained that:

> The girls are told that FGM will help them to control their sexual urges and this will help them to avoid engaging in sexual activity. They will also be seen as capable of being faithful to their husbands and fulfilling their cultural demands and be respected by the community.

Seclusion

According to this study's findings, majority of the female participants at 6 (50 %) stated that, girls are not secluded, while 3 (25 %) stated that girls are secluded between 1-2 weeks and 3 (25 %) one month. However, majority of the male participants and key informants pointed out that girls are still secluded but the period has reduced over the years. This was affirmed by the male participants at 6 (54.5 %) stating that girls are secluded for 1-2 weeks, 4 (36.4 %) one month and 1 (9.1 %) stated that there is no seclusion at all. The key informants held a similar view in that, 6

(66.7 %) claimed that girls are secluded for a period of 1-2 weeks and 3 (33.3 %) stated one month. One female participant stated that:

> The period for seclusion is not known since most parents do not disclose if their girl has been circumcised or not.

In addition, another participant stated that:

> The period depends with the family since some girls are secluded for two or three weeks or a maximum of one month.

These remarks differed with the chief and a male participant who argued that:

> Seclusion is done for only one week and they do not stay for long like in the past because this will raise suspicions and attract the attention of the authorities. Since nurses are the ones who circumcise the girls, healing occurs at a faster rate than in the past. They do not need to stay for one month since they have been given the best care from the nurses.

Their opinion was consistent with the social worker and a teacher who opined that:

> Girls of today are secluded only for one week to two weeks after circumcision. They are not secluded for long since it will attract the attention and questions on whereabouts of the girl. Also, circumcision is done by a nurse so, they heal faster.

From the study it is evident that the period of seclusion is not consistent however, it has reduced from the traditional two months. Despite resistance, the fight against FGM can be successful through well implemented programmes such as Alternative Rites of Passage. Dialogues involving men, women, boys and girls should be organized where issues such as social norms, attitudes, different forms of sexual violence, early marriages and FGM. The girls and boys should also be taken into safe spaces where they will be trained on sexual and reproductive health, negative consequences of FGM, teenage pregancy, early marriages and other important life skills. The Similarly, Oloo et al. (2011) established that today girls are not put in seclusion like it was done in the past so as to receive care and instruction from their grandmothers and aunts for a month. The girls remain at home and are taken care of by their mothers.

Conclusion

The study established that the age of circumcision is gradually decreasing. This might suggest that girls are at risk of FGM from the time they are born. Additionally, most girls are circumcised at home or in a secret place and not in rivers or hospitals as before. However, the trend of medicalization and circumcision during the morning hours has continued with nurses being invited to the homes to carry out FGM. The use of nurses has persisted due to fear of health complications and the use of anaesthesia to prevent pain. This has led to the continuation of FGM in Kisii. Furthermore, girls are still being circumcised during the December holidays to give them time to heal and also they would continue with their studies thus not raising concerns.

Recommendations

i. Since the study findings indicated that the medical personnel are sustaining FGM, the study recommends that government should enforce the law by taking action against health workers and other perpetrators of FGM.
ii. There should be a partnership between NGOs and the government to strengthen the fight against FGM and sensitize the community through large-scale campaigns on the dangers of FGM and men and boys should also be targeted.
iii. The education system should include in the curriculum matters on FGM from the early classes. Schools provide a better avenue to create awareness on FGM.
iv. The church also has significant influence in the community and could be sensitized and educated on FGM and its negative effects thus strengthening their role in the fight on FGM within the church.
v. At the community level, there is need for increased community education on the negative impact of FGM and it should boys, girls, men and women. It will establish strong surveillance mechanisms.

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