

# Shifts In Social Norms Around FGM/C in Garissa County





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## LIST OF ACRONYMS

<b>CBS</b>	<b>Central Bureau of Statistics</b>
<b>COVID-19</b>	<b>Coronavirus Disease 2019</b>
<b>DHS</b>	<b>Demographic and Health Survey</b>
<b>EDC</b>	<b>Electronic Data Collection</b>
<b>FGM/C</b>	<b>Female Genital Mutilation/Cutting</b>
<b>KNBS</b>	<b>Kenya National Bureau of Statistics</b>
<b>MICS</b>	<b>Multiple Indicator Cluster Survey</b>
<b>MOH</b>	<b>Ministry of Health</b>
<b>ODK</b>	<b>Open Data Kit</b>
<b>SDGs</b>	<b>Sustainable Development Goals</b>
<b>UN</b>	<b>United Nations</b>
<b>UNFPA</b>	<b>United Nations Population Fund</b>
<b>UNICEF</b>	<b>United Nations Children Fund</b>
<b>UNJP</b>	<b>United Nations Joint Programme</b>
<b>WHO</b>	<b>World Health Organization</b>

## FOREWORD

I am delighted to present the findings on the ‘Shifts in Social Norms and Practices Associated with Female Genital Mutilation/Cutting (FGM/C) in Garissa County, Kenya’. This study falls under EACHRights’ broad implementation strategy on research and knowledge management, which seeks to generate and share data, information, and evidence to inform organisational practice and policy influencing. To this end, EACHRights has been undertaking various forms of research, including applied research, baseline studies, perception surveys, position papers, and policy briefs. EACHRights recognises that research is critical in understanding the challenges faced by vulnerable and marginalized communities, thus designing and implementing research-driven, evidence-based programmes to address the aforementioned challenges.

The main sources of data on Female Genital Mutilation (FGM) in Kenya are the Demographic and Health Surveys and Multiple Indicator Cluster Surveys. These surveys collect data on various health aspects. Even though the surveys provide high quality data on FGM at a national and urban/rural level, the surveys are not powered to conduct detailed analyses at local levels. The surveys are also not conducted on a frequent basis to provide the much-needed up-to-date data on FGM. In addition, the questions in the FGM module are not comprehensive and are limited in measuring changes in social norms. There is therefore paucity in FGM data that cannot allow for detailed within-country analysis, especially at the county level.

The study will therefore provide a valuable foundation for enhancing evidence-based programming and decision-making among state and non-state actors in Garissa County in their ongoing efforts to end FGM/C and will also position EACHRights as a credible institution that leverages field experiences and knowledge to shape opinions, promote learning, and drive innovation.

**Otieno Okero**

**Chairperson, Board of Directors**

## Acknowledgements

On behalf of EACHRights, it is a great pleasure to share this research titled 'Study Report on Assessing Shifts in Social Norms and Practices Associated with Female Genital Mutilation/Cutting (FGM/C) in Garissa County, Kenya'.

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Finally, special appreciation goes to ERIKS Development Partners for their generous financial support, which made this research possible, and to EACHRights Board for their unwavering support in advancing the vision and mission of EACHRights.

**Gilbert Onyango**  
**Executive Director**

## Executive Summary

The main sources of data on Female Genital Mutilation/Cutting (FGM/C) in Kenya are the Demographic and Health Surveys and Multiple Indicator Cluster Surveys. These surveys collect data on various health aspects. Even though the surveys provide high quality data on FGM/C at a national and urban/rural level, the surveys are not powered to conduct detailed analyses at local levels. The surveys are also not conducted on a frequent basis to provide the much-needed up-to-date data on FGM/C. In addition, the questions in the FGM/C module are not comprehensive and are limited in measuring changes in practices and social norms associated with FGM/C. There is therefore paucity in FGM/C data that can allow for detailed within country analysis, especially at the county level.

The objectives of this study were: 1) examine community members' knowledge, beliefs, attitudes and practices associated with FGM/C in Garissa County, Kenya; 2) assess changes in social norms associated with FGM/C with a focus on shifts across generations in Garissa County; and 3) provide recommendations for targeted interventions geared towards ending FGM/C in Garissa County. A total of 16 focus group discussions were conducted using a semi-structured interview guide.

Study findings showed that FGM/C remains widespread in Garissa County, driven by deep-rooted beliefs around sexual purity, marriageability, and social acceptance. Type I (Sunna) is increasingly preferred over the more severe Type III (Pharaonic), often perceived as outdated and dangerous. While older generations uphold FGM/C as essential for female virtue and community honour, younger participants, especially girls and urban youth are beginning to question these norms. Social pressure, religious beliefs, and fear of stigma continue to sustain the practice, despite widespread awareness of its serious health risks and emotional harm. The medicalization of FGM/C, particularly Type I, is gaining ground as a harm reduction measure. Attitudes are gradually shifting, with urbanization, education, and youth advocacy driving growing resistance to the practice. Effective intervention requires culturally sensitive, community-led strategies that engage both older and younger generations, especially in rural areas.

Key recommendations from this study include investing in community-led dialogue forums that offer safe and inclusive forums spaces for community members to engage in FGM/C matters; expanding health and human rights education; supporting youth-led advocacy; addressing the role of religion and its relationship with FGM/C; providing psychosocial and medical support to those affected by FGM/C; integrating FGM/C abandonment interventions into broader development policies; and monitoring and regulating medicalization.

# Chapter 1: Introduction

This chapter provides an in-depth background on Female Genital Mutilation/Cutting (FGM/C), outlining its definition, global and national prevalence, drivers, and consequences, while situating the discussion within broader efforts to achieve Sustainable Development Goal (SDG) 5 on gender equality. It highlights that despite global and national progress such as the decline of FGM/C prevalence in Kenya from 38% in 1998 to 15% in 2022, the practice remains entrenched in certain communities due to deep-rooted social norms. The chapter reviews the evolving nature of FGM/C, including its medicalisation, and details the severe short- and long-term health, psychological, and social consequences faced by survivors. It further underscores the range of interventions employed to combat the practice while emphasizing persistent gaps in locally specific data.

## Background

Female genital mutilation (FGM/C) is defined as “all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons” (1). There are numerous types of FGM/C practised across the globe and the World Health Organization (WHO) has made an attempt to classify the various types into four major groups: Type I, also called clitoridectomy involves partial or total removal of the clitoris and sometimes only the prepuce; Type II, also known as excision entails partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora; Type III, also called infibulation includes the narrowing of the vaginal opening by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris; and Type IV which includes all other harmful procedures to the female genitalia for non-medical purposes such as pricking, piercing, incising, scraping, and/or cauterizing the genital area (1).

At a global level, estimates by the United Nations Children’s Fund (UNICEF) show that over 230 million women and girls had undergone FGM/C (2). Additional statistics show that approximately 70 million girls aged below 14 years have been cut or may be at risk of being cut (3). Every year, UNICEF estimates that approximately 3.6 million girls are at risk of FGM/C and the number could rise to 4.1 million by 2050 if appropriate measures are not taken to combat the practice (4). The number of women and girls either cut or at risk of being cut is alarming and that is why one of the Sustainable Development Goals (SDG)—SDG 5, recognizes FGM/C as a form of gender-based violence that threatens efforts to achieve gender equality and empowerment of girls and women. Target 5.3 of SDG 5 seeks to eliminate all harmful practices, such as child marriage and FGM/C, by the year 2030 (5).

Statistics by UNFPA and UNICEF show that if no concerted efforts and accelerated actions are taken in countries where FGM/C is prevalent, more than 68 million additional girls are more likely to undergo FGM/C by 2030 (UNFPA, 2019; UNICEF, 2020). The UNFPA report further brings to the fore the significance of the emergence of COVID-19 in 2020 which has negatively impacted efforts towards achieving zero new cases of FGM/C by 2030. As a consequence, it is estimated



**Analysis on how countries have progressed towards reduction and eventual eradication of FGM/C shows a mixed picture and the need for more effort to achieve such a feat. For example, from 29 countries that have national data on FGM/C, 15 out of the 29 countries showed no clear evidence of progress while 14 countries showed a declining trend (Shell-Duncan et al., 2016)**



that approximately 2 million additional FGM/C cases that would otherwise have been averted could occur over the next decade due to negative effects of COVID-19 (8).

A look at trends in FGM/C abandonment in Kenya shows that there has been a noticeable national decline in FGM/C prevalence for women aged 15-49 years—from 38% in 1998, 32% in 2003, 27% in 2008-9, 21% in 2014 to 15% in 2022 (9,10). A detailed descriptive analysis of the Kenya Demographic and Health Surveys (KDHS) showed evidence of variation in the prevalence of the practice over the years across social-economic and demographic characteristics. Specifically, the analysis showed that FGM/C prevalence has remained high throughout the years among the Kisii and Somali women, but has substantially declined among younger women aged 15-19 years of Kalenjin, Kamba, Kikuyu and Taita/Taveta ethnic communities (11). An advanced

Bayesian geo-additive modelling analysis conducted by Kandala and colleagues in 2017 for young girls aged 0-14 years observed that national trends for FGM/C rates from 1998 to 2014 had stagnated. Importantly, the analysis showed that Garissa, Kisii, Mandera, Nyamira, and Wajir Counties had persistently high levels of FGM/C among girls aged 0-14 years as compared to the national average (12).

Analysis on how countries have progressed towards reduction and eventual eradication of FGM/C shows a mixed picture and the need for more effort to achieve such a feat. For example, from 29 countries that have national data on FGM/C, 15 out of the 29 countries showed no clear evidence of progress while 14 countries showed a declining trend (Shell-Duncan et al., 2016). For countries that are showing progress, caution needs to be exercised while interpreting statistics at a national level as the averages tend to conceal important within- and between-country variations. Analysis has also shown emerging trends in how FGM/C is practiced such as medicalisation of the practice, where FGM/C is performed by medical professionals, with the belief that medicalisation reduces potential health risks (3) and guarantees safety (13,14).

Research on reasons why FGM/C persists has pointed to various factors including preservation of cultural values for acceptance in the community, acting as a rite of passage from childhood to womanhood, safeguarding purity and virginity before marriage and fidelity in marriage, and observing perceived religious commitments (15-18). The social norms theory positions FGM/C as a marital strategy where girls and women who undergo the practice increase their marital prospects while those who choose not to be cut risk being ostracised by members in their reference group and consequently rendered unmarriageable (19). Notably, further empirical investigations on FGM/C as a social norm have shown that the practice may be locked in place not only by norms associated with marriageability, but also other norms and meanings associated with ethnic identity, rites of passage to womanhood, religious affiliations, honour

and modesty codes, sexual restraint, aesthetics and hygiene (19).

Extensive research has been conducted to document immediate and long-term consequences of FGM/C. Some of the immediate repercussions of conducting FGM/C include experience of severe pain and excessive bleeding, urine retention, and genital tissue swelling (20–22). Documented long-term consequences of undergoing FGM/C include obstetric complications (perineal tearing, obstructed or prolonged labour, caesarean section, episiotomy, and postpartum haemorrhage) and a myriad of reproductive health issues such as urinary tract infections, bacterial vaginosis, genital herpes and dyspareunia (22–27). Other long-term consequences include associations of the practice with women's poor sexual functioning (lack of sexual desire, pain during sexual intercourse, and diminished sexual satisfaction) (28,29), and poor mental health and well-being (22,30–33).

Both immediate and long-term negative effects of FGM/C on the health and well-being of women and girls have led to implementation of a raft of interventions with the aim of encouraging abandonment among communities that have traditionally performed FGM/C. Some of the common interventions implemented to curb FGM/C include interventions using the rights-based approaches, education on the health complications that result from undergoing FGM/C, performing alternative rites of passage where girls go through the ceremony without being cut, the use of laws and policy measures to mitigate the practice, engaging religious leaders as agents of change, promotion of girls' education, engaging in intergenerational dialogue, and the use of safehouses/rescue centres to support girls running away from FGM/C and or early/forced marriages (34).

While numerous studies have contributed to the evidence on FGM/C prevalence and some of the drivers of the practice, the issue of contextual application of evidence still lingers. This study contributes to the importance of generation of local data that is contextually sensitive. The study also expands the FGM/C module popularly implemented during national surveys by exploring the use of more comprehensive questions to aid measurement of changes in social norms associated with FGM/C at a local level—Garissa County.

“

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# Study Objectives, Rationale and Hypothesis

## Study Objectives

The specific objectives of the study are:

- 1) Examine community members' knowledge, beliefs, attitudes and practices associated with FGM/C in Garissa County, Kenya;
- 2) Assess changes in social norms associated with FGM/C with a focus on shifts across generations in Garissa County; and
- 3) Provide recommendations for targeted interventions geared towards ending FGM/C in Garissa County.

## Study Rationale

There is need to accelerate the pace of change to end FGM/C. To this end, governments and programme implementers spearheading interventions to end FGM/C must be provided with data and evidence that is sensitive to the local context. Nevertheless, available data and evidence has been hampered by limited specificity at the local level which is key in targeting interventions for maximum effect in bringing change and facilitating FGM/C abandonment. Therefore, this study will provide the much-needed up-to-date data on FGM/C in Garissa County by implementing comprehensive questions that will assist in measuring community members' knowledge, beliefs, attitudes and practices associated with FGM/C, and changes in social norms at the county level.

## Study Hypothesis

This study hypothesises that using a comprehensive set of questions meant to measure changes in practices and social norms associated with FGM/C at a local level will lead to better estimates of such changes compared to the use of simple questions commonly asked during national surveys.

## Chapter 2: Conceptual Framework

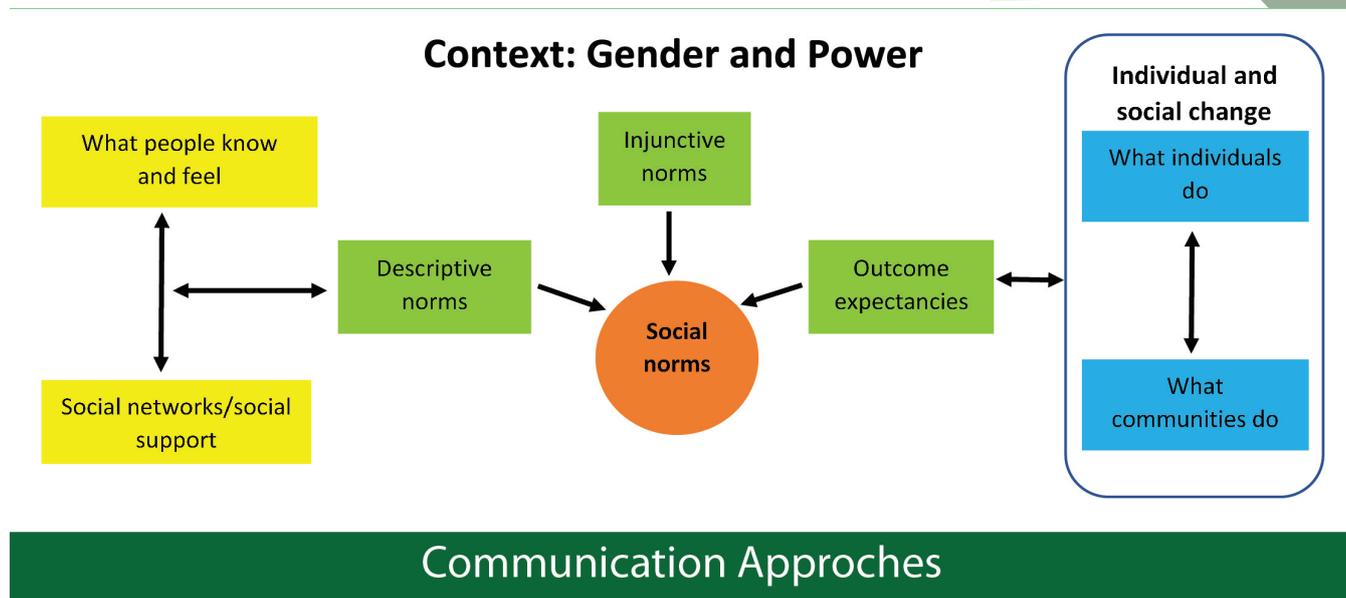
This chapter outlines the theoretical foundations of the study, drawing primarily on social norms theory to explain the persistence of FGM/C and guide strategies for its abandonment. According to the theory, FGM/C endures in practicing communities because it functions as a social convention tied to marriageability and communal acceptance, creating an equilibrium where no single family can easily abandon the practice without social repercussions. Sustainable change, therefore, requires collective action; mobilizing communities through dialogue, reflection, and the formation of a critical mass to reach a tipping point where non-cutting becomes the new social norm. The chapter presents the ACT conceptual framework which integrates social norms theory with a social-ecological perspective to examine the interaction between knowledge, affective and behavioural factors; context, gender, and power dynamics; and processes for monitoring and evaluating change.

### Theoretical Foundations

The theoretical underpinnings of strategies for the abandonment of FGM/C relate to social norms theory, which suggests that in communities where FGM/C is widely practiced, no single family would choose to abandon the practice on its own because it would affect the marriageability of its daughters (35). The social norms theory describes the state where no family has the incentive to move away from the expectation of cutting as an equilibrium state. The equilibrium state of having no family willing to abandon FGM/C can, nonetheless, shift if all families in a community choose not to cut their daughters and hence cutting will no longer be the social norm. The strategy of an intervention is therefore to convince all families within the community to abandon FGM/C and move them at the same time from the equilibrium state of practicing FGM/C to not practicing FGM/C (35,36). To make this possible, FGM/C interventions are encouraged to use intensive community dialogues that enable community members to reflect and deliberate on harmful practices and reverse the social convention. The process starts with a core group that must mobilize a sufficient number of people, as a critical mass, to become self-sustaining. Once the critical mass has grown and represents a large proportion of the community and a tipping point to abandon FGM/C has been established, a recognition of this shift to a new equilibrium state of not cutting is celebrated as a public declaration to mark the ending of the practice of cutting (36). All this is done with careful consideration of community values through deliberations. It is anticipated that deliberations about what one should do and what others should do to abandon FGM/C can begin in a small core group, and diffuse in an organized fashion through the remainder of the reference group, until enough members of the community are ready to change (37,38).

**Figure 1** illustrates the conceptual framework guiding this study as adapted from the ACT framework and informed by the social norms theory (39). The acronym ACT stands for the different constructs of the framework and steps necessary to measure social norms change relative to FGM/C. The “A” represents i) knowledge, affective, and behavioral factors; and ii)

Figure 1. Conceptual framework guiding the study



the normative factors, including descriptive and injunctive norms and outcome expectancies. The “C” represents i) the context, especially gender and power; and ii) collecting data on social networks and social support. The “T” refers to the monitoring and evaluation process which includes: i) information on how to track change over time; and ii) how to triangulate the data using a mixed-methods approach to improve validity, enrich data, allow for holistic interpretation, and foster feedback.

At the heart of the conceptual framework are social norms comprising of: descriptive norms (beliefs about what others do), injunctive norms (beliefs about what others think), and outcome expectancies (rewards and sanctions) (37). The central placement of social norms signifies that social norms are an intermediary step between what people know and feel; their social networks and levels of social support; and individual and social change you are likely to see. It is important to note that the conceptual framework incorporates a social-ecological perspective that situates individuals within their broader environment and the different levels of influence at play. Specifically, it acknowledges how what people know and feel shapes, and is shaped, by who they talk to, and the social support received. Likewise, what individuals do is influenced by what happens within a community, and vice versa.

The issue of context – gender and power is equally significant because the model is mitigated by these contextual factors. Social norms cannot change if contextual factors such as power and gender are not adequately addressed (37). Likewise, what people know and feel, social networks and support, and the level of individual and social change achieved are all affected by, but also can affect, the contextual factors of gender and power. Communication approaches at the bottom of the framework depict its direct influence on individual and social change, and the indirect ways it affects change by impacting knowledge, affective factors, social networks, social support, social norms, and contextual factors.

There are clear ethnic patterns demonstrating FGM/C is more strongly associated with ethnicity than any other personal characteristics (40). If the practice is viewed as the rite of passage to



marriage ability and social standing in certain ethnic groups, there is a high chance that the practice will continue to be protected and hence an individual or family will find it problematic to change the social norms on their own (35,40). However, it is important to note that ethnicity and sometimes locality are proxies for more local relations of interdependent expectations. For example, actual local relations take place in geographic proximity, or because of historical reasons, local groups of a particular ethnicity expect the practice. In a number of places, the complexity of ethnicity comes to the fore. For example, within an ethnic group some members are cut, and others are not; and in a village, some ethnic groups cut, and others do not. The primary unit of interest is the local reference group, which is often conveniently proxied by geographic or ethnic variables.

# Chapter 3: Methodology

This chapter describes the study design, area, sampling, ethical considerations, and analytical approach adopted for the research. The study employed a cross-sectional qualitative design using focus group discussions (FGDs) to explore social norms related to FGM/C among women aged 15–49 years and men aged 15–54 years in Garissa County, Kenya. A total of 16 FGDs were conducted, stratified by gender and generation (younger: 15–24 years; older: 25 years and above), with each group comprising 6–8 participants. Strict ethical protocols were followed to ensure participant confidentiality, informed consent, and emotional safety, including the use of unique identifiers and secure data handling. Data analysis followed an inductive thematic approach, beginning with iterative open and analytical coding of transcripts, team-based reconciliation of codes, and development of thematic matrices to capture consensus, divergence, and generational or gendered differences in perspectives.

## Study Design and Area

This research adopted a cross-sectional study design whereby focus group discussions (FGD) were conducted among women aged 15–49 years and men aged 15–54 years in Garissa County, Kenya. Garissa County is located in the North-Eastern region of Kenya. Garissa town is the headquarters of the county and the largest urban area in the county. It has six constituencies comprising of Garissa Township, Fafi, Dadaab, Lagdera, Balambala and Ijara. The county is expansive covering a land area of about 45,720 km<sup>2</sup> with the current population estimated to be about 841,353 (41). Majority of the population are ethnic Somali, are pastoralists and practice Islam. Just like the other counties located in the North-Eastern region of Kenya, the Somali communities residing in Garissa County have traditionally practiced FGM/C—almost universally. Data from the 2014 KDHS showed that 93.6% of women and girls aged 15–49 years in Garissa County have undergone the practice (9,11). The study location was chosen because it is one of the counties in Kenya where FGM/C prevalence is considerably high with limited changes across the years (12,42).

## Sample Size Determination

A total of 16 FGDs were conducted using a semi-structured interview guide to measure shifts in social norms among younger and older generations. Eight FGDs were conducted among the younger generation of respondents aged 15–24 years (4 for women and 4 for men) and the older generation of respondents aged 25 years and above (4 for women and 4 for men). The total sample size for respondents participating in FGDs was based on the recommended number of participants per group of between 6 and 8 (43).

## Ethical Considerations

The interviews were conducted in private. Interviewers were instructed to inform participants that the interview should be conducted in private and identify a private space in consultation with the participant that is safe and private for conducting the interview. At all times, research assistants were on the lookout to ensure that girls and women participating in the study were protected from further harm or trauma. The research teams were trained on the need for confidentiality. All collected data was treated confidentially. No names of participants appeared on the tool used to capture information. Rather, unique identification codes were used to identify participants; no personal identifiers were recorded on the data collection tools. All data was kept separately from any identifying information that might be captured in the consent forms. Access to the research data was limited to research staff only.

The study protocol was submitted for review by the Amref Ethics and Scientific Review Committee. Following ethical review and approval (AMREF-ESRC P1371/2023), the investigators applied for and obtained a research permit (NACOSTI/P/23/27269) from the National Commission for Science, Technology and Innovation (NACOSTI).

## Data Analysis

We used an inductive approach to analyze transcripts of focus group discussions. Beginning with the premise that “coding is analysis” (44), we used an iterative process that involved successively more focused rounds of coding text to identify themes or categories. This was followed by writing memos to explore themes and identify relations among themes or categories, and linking themes to building analytical models (45,46). The analysis team began with a close reading of the transcripts and open coding or inductive coding, and double coding the first three transcripts in relation to an initial coding scheme of the PI (who will serve as the “gold standard”). Members of the analysis team met regularly to discuss codes, reconcile coding strategies, and work together to build a list of codes and sub-codes. The first round of coding involved topic coding that labeled key topics followed by a round of analytical coding that groups topics along the line of themes (47).

A summary document was created for each FGD, identifying the major themes raised, grouped along the lines of advantages or disadvantages of FGM/C. Notations were recorded with emphasis placed on each theme (ranging from being a passing remark to a topic that participants deeply explored), as well as the degree of consensus, debate or disagreement that came about during the discussion. This process served as an analytic approach to discerning the degree to which normative statements and positive or negative associations were shared among participants, debated, or possibly actively contested during the discussion. As recommended by Knodel (48), we used a team approach to both creating data summaries and identification of themes in an effort to improve reliability of our analysis. The summaries for each focus group was used to create an “overview grid” (following methods of Knodel 1993, and elaborated by Shell-Duncan et al., 2017) (48,49), allowing comparisons along the lines of break characteristics (younger vs. older and men vs. women). Basic themes were grouped into overarching themes, and a summary matrix was created for each overarching theme. The matrix recorded variation in themes and direction and degree of consensus along break characteristics.

## Chapter 4: Findings

This chapter presents the key findings on the persistence, evolving dynamics, and shifting perceptions surrounding FGM/C in Garissa County. It highlights how the practice continues to be sustained by deeply rooted beliefs around sexual purity, control of female sexuality, marriageability, and social acceptance, all closely intertwined with cultural and religious identity. Despite widespread awareness of the health, sexual, and psychological harms associated with FGM/C, many community members still justify the practice, particularly the less severe Type I (Sunna) as a religiously sanctioned and socially necessary practice. The findings reveal generational and gendered differences, with older men and women remaining staunch defenders of the practice, while younger, educated, and urban participants increasingly question or reject it. Emerging shifts include preference for medicalized FGM/C and gradual rejection of Type III (Pharaonic) cutting, signalling an ongoing but uneven transition. Interventions led by government agencies, NGOs, schools, and religious leaders have fostered awareness and dialogue, yet their reach remains limited, especially in rural and pastoralist areas where traditional norms prevail.

### RESULTS

#### Reasons for Continuation of FGM/C

**Table 1. Summary matrix of perceived advantages of FGM/C**

Advantages of performing FGM/C	Younger Men (15-24)	Older Men (25-54)	Younger Women (15-24)	Older Women (25-54)	Interpretation
Sexual purity and controlling female sexuality	+	+	+/-	+	Strong consensus across male and some female participants that FGM/C reduces sexual desire, preserves purity, prevents immorality, and disciplines girls. However, there was contestation, particularly among young women, with some rejecting these views as myths and misconceptions.

Advantages of Performing FGM/C	Younger Men (15-24)	Older Men (25-54)	Younger Women (15-24)	Older Women (25-54)	Interpretation
Marriage-ability (FGM/C as a requirement for marriage)	+/-	+	+/-	+/-	Majority of participants, especially in rural settings, believe that FGM/C is a pre-requisite for marriage. Nonetheless, some of the young men and women across the ages, especially in urban areas, acknowledged that some men might still marry or prefer uncut women. They also viewed cultural justifications for marrying cut women as myths that are being challenged by the changing attitudes towards uncut women.
Social acceptance	+/-	+	+/-	+	FGM/C is widely regarded as a core aspect of both Islamic identity and Somali culture. Participants across gender and age stated that being cut defines one as a "true Muslim" and part of the Somali community. Uncut girls are viewed as outsiders or even as non-Muslims leading to pressure to conform. There were a few differing opinions among the younger generation of participants who were of the view that the Islamic faith does not support FGM/C and that uncut women shouldn't be stigmatized but rather supported and accepted in the community

**+**, positive consensus

**-**, negative consensus

**+/-**, divergent views

**Blank**, theme not raised

## Sexual Purity and Controlling Female Sexuality

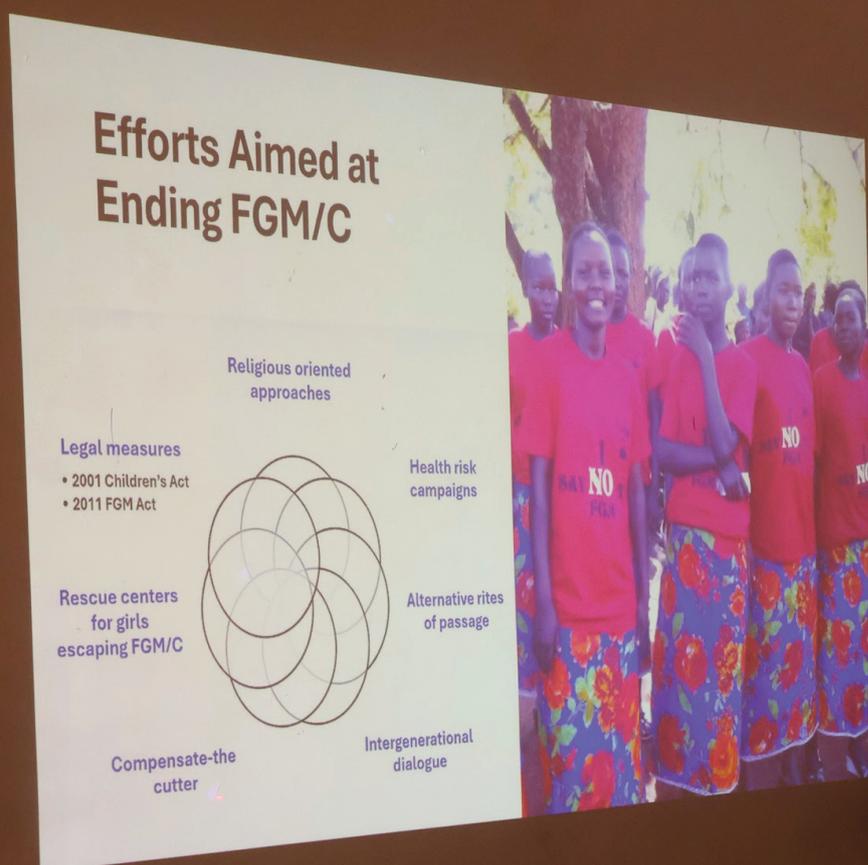
Many participants across age and gender (Table 1) believed that FGM/C controls female sexual desires and prevents immorality by maintaining sexual purity. They noted that FGM/C controls women's sexual behaviours by restricting them from having pre-marital or extra marital affairs. Some of the participants felt that controlling female sexuality is advantageous to a man since one man cannot easily satisfy an uncontrolled woman with high sexual drive.

*"The good thing about that is the girl becomes pure, and it kills her sexual desires, so the girl doesn't play around with boys (all laugh). The reason why girls nowadays are having sexual desires is because they aren't circumcised in this manner." 48-year-old female, no education*

*"FGM is good for the young girls or daughters because it controls their sexuality and prevent them from forming premarital relationships with men. On the other hand, the wife who is cut becomes easily satisfied sexually and doesn't engage in extramarital affairs." 16-year-old female, primary education*

*"A non-circumcised woman has a high sex drive just like the non-Muslims. They end up having sexual intercourse before marriage." 33-year-old male, no education*

*"We only practice the type 1 female circumcision, and its advantages are, it lowers their [women] excess sexual desires, it prevents them from fornicating and having children without parents. If a woman is not circumcised, she will have a strong desire to fornicate whereby it will result*



to giving birth to unwanted child who will not be taken care of. So, I see there is benefit for them to be circumcised as our religion suggests and circumcised women have good manners compared to uncircumcised one.” 22-year-old male, secondary education

“It [FGM/C] protects your daughter’s excessive sexual desires. When she is out there studying, you will not be worried about her since a circumcised woman is different from uncircumcised one in terms of sexual feelings. We know that women who are not circumcised have more sexual desires and when she is amid her male classmates she might be tempted to fornicate. After all we are all human and we cannot easily control our feelings. So, when your daughter is circumcised, she will have less sexual feelings, and you will be not worried about her. And if I speak the truth, we men know that we cannot satisfy uncircumcised woman so having a woman who has a lesser sexual desire is for our own benefit. Men and women have different sexual urge, uncircumcised one has lots of sexual urge and one man cannot satisfy her, that is my opinion.” 21-year-old male, secondary education

“**First of all, the type 3 circumcision is a cultural thing that has been going on for ages. It involves cutting and then sealing the woman. This was done in order to discipline a woman and ensure she maintain hers purity till marriage. Type 2 circumcision is now being done by most people, and I feel like it is not as effective as the type 3 circumcision.**”

Some participants opined that the practice ensures that girls are well disciplined by instilling good behaviour, preventing unwanted pregnancy, and maintaining virginity and hence purity until marriage. A participant further associated the increase in unwanted pregnancy with shifts in FGM/C practice from Type III to Type I which is less severe and considered a religious prescription though not effective in controlling female sexual desires.

“Female circumcision disciplines the girls and prevents them from misbehaving. However, we cannot let the girls be uncircumcised because the girls misbehave and lose their purity.” 43-year-old male, incomplete primary education.

“Type 3 circumcision is a cultural thing that has been going on for ages. It involves cutting and then sealing the woman. This was done in order to discipline a woman and ensure she maintain her purity till marriage. Type 2 circumcision is now being done by most people, and I feel like it is not as effective as the type 3 circumcision.” 22-year-old male, no education

“FGM is used to know if a woman is a virgin or not. Back in the days, men used to prefer the type 3 circumcision because the woman was sealed, and they would know instantly about her purity. However, the type 1 circumcision where the lady is slightly cut can be disadvantageous to a man because he would not know if the woman had sexual relations with other men.” 23-year-old male, secondary education

*“Our community believes that if a girl is not circumcised, she becomes a prostitute. They say there are chances that she will bring illegitimate kids, unwanted pregnancies. They believe if you circumcise a girl, you will reduce immorality. That’s why you will find a man circumcising his daughter so that she does not bring unwanted pregnancies. To purify her.” 24-year-old female, tertiary education*

*“I believe FGM is good for girls because it keeps in check the chastity of the girls. As a community, we believe it reduces their sexual urges.” 35-year-old female, tertiary education*

*“The most advantageous thing is for women to have sexual pleasures. But if FGM is meant to take that away, then even getting married has really no point...it is going to be one sided. I have a lot of traumas because of FGM and then the one thing that you are probably looking forward to for your 28 years of life and then you are married, and it is more painful. So, it is very sad.” 27-year-old female, tertiary education*

## **Marriageability**

The role of FGM/C in marriage emerged as a dominant theme with perspectives indicating both generational and gender nuances. Across the board, participants especially women and older men consistently linked FGM/C to increased prospects of marriage for girls, often viewing it as a religious, social, and cultural prerequisite.

Among adult women (25–54 years) from various locations, there was a strong consensus that FGM/C is essential for marriage. It was seen as a means to secure social respect, uphold religious identity, and protect family honour.

*“The advantage at the community level is to get married. Because if you are not circumcised, then marriage will be a problem... you just can’t get married.” 34-year-old female, tertiary education*

*“Men love girls or women who are circumcised because they believe they are hygienic...the ones who are not circumcised cannot be welcomed or married.” 35-year-old female, no education*

*“Men have a perspective that one who is circumcised has good behaviours, a good person, and men want such women...you cannot marry a non-cut woman in our community. We do not allow it.” 25-year-old female, no education*

*“How do you even marry a non-cut woman? It’s not part of our religion and definitely not part of our culture too.” 28-year-old female, tertiary education*

*“As a mother I would not allow my daughter to get married before getting circumcised...the husband of my daughter can chase her out of the house and bring shame to me and the community at large.” 32-year-old female, incomplete primary education*

*“Mostly in the rural areas, they believe that a woman who is not circumcised cannot get married.”  
27-year-old female, tertiary education*

Younger girls (15–24 years) had similar views but also mentioned additional cultural and religious dimensions. They spoke about marriageability in terms of social acceptability and religious conformity. For instance, some equated being uncut with being non-Muslim, while others saw FGM/C as a route to community respect and social acceptance.

*“In Somali culture they always say that they want to marry a circumcised girl because they say that a girl is clean and pure... For the daughter, the man has an advantage because his daughter will get married. In this Somali community they say your daughter will not get married unless she is circumcised. For the wife, circumcision is a sign that she is pure and therefore gets respect from the community.” 24-year-old female, tertiary education*

*“An uncut woman cannot be married because she is not allowed to pray. To simply put it, she is considered a non-Muslim...and hence she is not allowed to marry a Muslim man. Furthermore, the society will judge her for acting like a non-Muslim.” 16-year-old female, incomplete primary education*

*“Men prefer to marry circumcised women. A circumcised woman gains respect from her man. An uncut woman faces a lot of discrimination, and it becomes hard for them to get married as the men in our community love cut women. That is how it is. I do not know why they prefer cut women.” 15-year-old female, incomplete primary education*

Similarly, young men (18–24 years) perceived FGM/C as a critical criterion in choosing a wife indicating their socialization into the norm despite their age.

*“In our community, it will be difficult for uncircumcised women to get married. Men value circumcised women more than uncircumcised women. So, I can say girls should have to be circumcised for them to find a good husband in future.” 19-year-old male, secondary education*  
Among older men (25–54 years), views were often framed around expectations and cultural pride. Some referred to the role of FGM/C in maintaining a girl’s purity and ensuring virginity before marriage. This highlights the entrenched associations between FGM/C, purity, virginity, and fulfilling men’s expectations at marriage.

*“The first thing you are looking for when you’re waiting for your bride is whether she is circumcised...and a virgin...when you get a virgin you become very happy, you become settled and then you will know you have broken a record.” 43-year-old male, tertiary education*

*“It is haram [against our religious beliefs] to marry an uncut woman. Women who are uncircumcised are not even allowed to pray. There is no way that a Muslim man who is circumcised will marry an uncircumcised woman.” 20-year-old male, primary education*

However, there were points of contestation, especially in urban or township-based groups.

Some older women challenged the myth of sexual satisfaction, revealing disillusionment.

*“We have been deceived and told FGM is a good thing for men. The reason women are cut is to be able to get married because no man will marry an uncircumcised woman. However, men cheat and go for non-circumcised women because circumcised women are not good in bed.”*  
25-year-old female, tertiary education

A few younger girls also voiced dissenting opinions, with one noting that it should be acceptable to marry an uncut girl because humans were created in a perfect form, perhaps signaling some pushback from younger women in challenging the norm of having FGM/C as a prerequisite for marriage.

*“Marrying uncut girls should be acceptable in the community because humans were created in perfect form. In fact, an uncircumcised lady will actually feel sexual pleasure during marriage.”*  
24-year-old female, tertiary education

Across age and gender, FGM/C remains deeply tied to marriageability, especially in rural settings. Adult women and men are its staunchest defenders, citing cultural, religious, and reputational motivations. However, among younger participants and urban dwellers, subtle shifts, and disagreements hint at growing contestation, revealing areas where change interventions might find traction.

## Social Acceptance

Across focus group discussions, FGM/C was widely viewed as a deeply entrenched cultural and religious practice that enhances social acceptance, with marked variations in perception across gender and age. Among older women, the practice is framed as a valued cultural and religious tradition that confers respectability and aligns girls with community expectations. Upholding FGM/C is thus seen as a way of expressing pride in identity and parents ensuring that daughters are not ostracized by other community members. Women view FGM/C as a prerequisite for social belonging, with many perceiving it as both an Islamic obligation and a cultural necessity.

*“It’s our culture and we love our girls to be circumcised.”* 39-year-old female, no education

*“The community stereotypes those girls who are not circumcised. There will be a finger pointed, they will be called bad names if you are not circumcised.”* 28-year-old female, tertiary education

*“It is part of our culture hence we are in support of female circumcision.”* 48-year-old female, no education

Among adult men, FGM/C is similarly viewed as integral to both religious practice and communal norms. Male participants justified the practice on Islamic grounds and often associated it with

hygiene and proper upbringing. The perceived consequences of non-compliance were social exclusion and religious invalidation. FGM/C, in this sense, is seen as a marker of conformity and a test of faith, both for the girl and her family.

*“As we are Muslims, circumcision is good for us...both male and female. It is good to circumcise girls while they are young; it is right.” 46-year-old male, no education*

*“For females I think that the advantages are so many when it comes to FGM...one is about hygiene. For hygiene, I think it prevents certain diseases...what we believe in as Somali community is that when she is uncut, she will be unhygienic.” 25-year-old male, tertiary education*

*“First of all, we believe in faith, the Islamic faith. There is a culture that if you do not circumcise your daughters, they will be stigmatized. Even their friends will tell them, why are you not circumcised? are you a Christian?” 25-year-old male, tertiary education*

*“Personally, as a Muslim, I consider this [FGM/C] as an act of worship. It is a ‘sunnah’ that has been performed by the prophet peace be upon him.” 32-year-old male, tertiary education*



Group discussions during the validation of the FGM/C report.

In contrast, younger participants, particularly girls, expressed a strong sense of ambivalence and sometimes dissent. While acknowledging that FGM/C is a basis for social inclusion, they also highlighted the emotional and physical consequences, as well as the discriminatory treatment faced by those who remain uncut. For some younger girls, social acceptance is viewed not as a benefit, but as coercive conformity, enforced through stigma, exclusion from religious rites, and restricted marriage prospects.

*“An uncut woman is treated like a non-Muslim. Uncut women become social rejects; they are not treated similarly like their peers. This is not good.” 20-year-old female, secondary education*

*“Uncut women face a lot of discrimination, and it becomes hard for them to get married as the men in our community love cut women. It causes a lot of unnecessary anxiety and physical and emotional pain.” 16-year-old female, primary education*

Some young men also contested the practice, expressing personal opposition despite acknowledging prevailing community expectations. This reflects a subtle generational shift, where younger men may not support FGM/C at a personally level but feel constrained to act due to communal pressure.

*“In our community, if you are a lady or wife and not circumcised, they will discriminate you... but I personally I prefer women not to be circumcised.” 19-year-old male, secondary education*  
*Within women’s group discussions, even in older age groups, a few voices challenged the value of FGM/C, pointing to its harm. Even though limited, these dissenting opinions suggest cracks in the dominant narrative supporting FGM/C and the potential for change, particularly through increased awareness.*

*“FGM has no advantage. It just has a lot of disadvantages and problems after performing or doing the act. There is a difference in problems between the circumcised and the uncircumcised.” 25-year-old female, no education*

Overall, the role of FGM/C in promoting social acceptance appears uncontested among older generations but increasingly questioned by younger individuals, particularly girls. The discourse is underpinned by religious identity, social conformity, and fear of exclusion. Yet, within this dominant narrative, contesting voices, mainly from the youth are emerging, signaling a potential shift in community perceptions about FGM/C over time.



**Some young men also contested the practice, expressing personal opposition despite acknowledging prevailing community expectations. This reflects a subtle generational shift, where younger men may not support FGM/C at a personally level but feel constrained to act due to communal pressure.**



## Awareness of Health Risks Associated with FGM/C

Across FGDs (Table 2), participants consistently highlighted a range of reproductive health-related, sexual, emotional, and socio-economic disadvantages of FGM/C. The most cited harms included excessive bleeding, infections, pain, complications during childbirth and menstruation, and long-term psychological and marital consequences.

**Table 2. Summary matrix on awareness of health risks associated with FGM/C Reproductive Health Complications**

Participants widely acknowledged that FGM/C results in significant reproductive health complications. One of the most consistently cited issues was difficulty during childbirth, which many attributed to the sealing or narrowing of the vaginal opening. Most participants explained

Awareness of risks associated with performing FGM/C	Younger Men (18-24)	Elder Men (25-54)	Younger Women (15-24)	Older Women (25-54)	Interpretation
Reproductive health complications (excessive bleeding, infections, pain, complications during childbirth and menstruation, and long-term psychological and marital breakdown)	+	+	+	+	Participants widely acknowledged that FGM/C results in significant reproductive health complications e.g., obstetric/childbirth complications including, obstructed labor, high likelihood of birth through caesarean section, extreme pain, and sometimes maternal and neonatal mortality. These obstetric complications were mostly linked to severe forms of FGM/C, especially Type III.

+, positive consensus  
-, negative consensus

+/-, divergent views  
Blank, theme not raised

that this leads to prolonged labour, excessive bleeding, need for surgical interventions, and increased risk of maternal and neonatal death. Multiple male participants in both rural and township settings echoed similar concerns.

*“We know it brings problems to the girl during childbirth and many more problems.” 35-year-old female, no education*

*“A man is disadvantaged because of a circumcised wife... when she is giving birth... she cannot give birth at home. She must go to the hospital.” 20-year-old male, secondary education*

*“Since a circumcised woman is sealed, she experiences a lot of pain during penetration [coitus]. Childbirth also becomes extremely painful for circumcised women. This is why most Somali women have complicated child births.” 25-year-old male, secondary education*

*“My wife experienced difficulties because the opening of the outer genitalia is stitched, making it difficult for the baby to pass through... at times they go through C-section.” 22-year-old male, secondary education*

Many participants linked these childbirth complications to the type of circumcision performed. Less severe forms like Type I—commonly referred to as the ‘Sunna’ cut, were perceived as causing fewer or no problems, while more extreme forms like the ‘Pharaonic’ (Type III) were associated with severe stitching, leading to serious health consequences.

*“I am a father of seven daughters, all of them are circumcised in ‘Sunna’ type...not ‘pharaonic’ type [Type III]. If the Sunna type is performed, then there is nothing like fistula or any complication during birth. What brings complications is the pharaonic type whereby there is stitching.” 50-year-old male, tertiary education*

Interestingly, a male participant while acknowledging the complications of FGM/C during childbirth and menstruation, also opined that the advantages of FGM/C outweigh the health risks. Such views have the potential of perpetuating the practice.

*“My wife was circumcised long before we got married. She experiences so much pain during her monthly period, also during childbirth. My wife experienced difficulties because the opening of the outer genitalia is stitched making it difficult for the baby to pass through the birth canal. When comparing the circumcised and the uncircumcised woman during childbirth, we know that the circumcised ones go through more pain and at times they go through c-section for them to give birth. These are some of the disadvantages circumcised women go through, but I stick to my opinion that female circumcision has more benefits than harm.” 22-year-old male, secondary education*

A few participants mentioned that fistula, a debilitating childbirth complication, is common among circumcised women.

*“It [FGM/C] can bring a problem which is called fistula... and it makes them not even to stay near people.” 25-year-old male, tertiary education*

In addition to birth-related complications, many participants both male and female across different age groups expressed concern about the pain and complications cut women endure during menstruation, and sexual intercourse, especially for those who underwent Type III, which involves extensive cutting and stitching.

*“My wife experiences so much pain during her monthly period... she also experienced difficulties during childbirth.” 22-year-old male, secondary education*

*“With our FGM, the labia minora and majora is gone...they take this part and this other part of the skin and then they sew together. What happens is when the wound heals it tends to stick together, and they tend to leave a very small hole for the girl to pee, they think we pee from there, but we pee from something called urethra and it’s up...when the girl is around 14 going through menses, she can’t experience it normally and the clots that is being released from the endometrium can’t pass through the small hole because those clots are big. It is painful and causes infection.” 26-year-old female, tertiary education*

It was also noted that women may experience extreme pain and over bleeding during FGM/C which may lead to death. The cut girls are also prone to infections and the unsterile tools used during the process can also lead to infections and transmission of diseases such as HIV.

*“The first disadvantage of performing female circumcision is that the circumcised girl might over bleed during the process and they may be somewhere with no hospitals around. Some might die, others might contract infections and may not be able to get proper medications. So, my opinion is that girls should be circumcised the type 1 female circumcision, and the community should stop performing the type 3 female circumcision.” 18-year-old male, tertiary education*

*“You see, most of the girls who are circumcised are prone to infections. So, you find them every now and then in every two months, they have to go back to the hospital to get treated for these infections due to due to the circumcision.” 25-year-old female, tertiary education*

*“Women in this village have a lot of problems. In cases where our girls bleed during circumcision, we do not even have hospitals. The roads are terrible, and we struggle when taking patients to hospitals. Also, we do not have water, so this is a big challenge for us.” 45-year-old female, no education*

*“Just a week ago, I met a mother and that mother told me her daughter normally has itching problem when she was five years old. I asked her the reason as to why and she told me at the age of five, she circumcised her daughter. So as a result of that, the girl is having vaginal itching from that age...20 years from now, what will she be facing? So, we probably have infections at the community level...infections start at an early age, and you end up having those infections as many times as possible.” 34-year-old female, tertiary education*

*“Remember we are using the same instruments, same razor blades and using it again on another person not knowing the health status of that child you are mutilating. It can lead to HIV, a lot of infections, sexually transmitted infections and many other diseases.” 24-year-old female, tertiary education*

Indirect consequences such as the economic burden of repeated hospital visits and high treatment costs because of FGM/C complications such as recurrent infections and childbirth complications were also highlighted by a few participants.

*“It is very expensive to keep treating infections as a husband and also taking the wife to hospital every now and then. Today it is an infection, tomorrow it is going to be something else; wife goes to labour, if she dies in that labour room, you have kids to take care of, which is also another disadvantage.” 27-year-old female, tertiary education*

## Impact of FGM/C on Sexual Pleasure and Intimacy

**Table 3: Summary matrix on the impact of FGM/C on sexual pleasure and intimacy**

Impact of FGM/C on sexual pleasure and intimacy	Younger Men (18-24)	Elder Men (25-54)	Younger Women (15-24)	Older Women (25-54)	Interpretation
FGM leads to reduced sexual desire and pleasure in women	+	+	+	+	Strong consensus across gender and age that FGM/C, particularly severe forms (Type III), reduces women’s sexual desire and enjoyment. Many men and women described diminished pleasure, reduced sensitivity, and emotional detachment during intercourse.

Impact of FGM/C on sexual pleasure and intimacy	Younger Men (18-24)	Elder Men (25-54)	Younger Women (15-24)	Older Women (25-54)	Interpretation
FGM/C causes pain during sexual intercourse	+	+	+	+	Universally acknowledged that FGM/C results in pain during penetration, especially among women who underwent Type III. Pain was cited as a major barrier to intimacy and marital satisfaction, often necessitating medical intervention.
Psychological trauma and aversion/ dislike to sex			+	+	Widely reported among women, in relation to those who underwent severe forms of FGM/C.
Male sexual dissatisfaction due to partner's lack of responsiveness	+	+			Many men experience dissatisfaction due to the lack of mutual pleasure during sex. This has led some to seek second wife or alternative practices.
FGM/C contributing to marital strain, separation, or divorce			+	+	Several women cited marital breakdown due to sexual incompatibility and unresolved pain from FGM/C.

+, positive consensus

-, negative consensus

+/-, divergent views

Blank, theme not raised

Across diverse focus group discussions with both men and women from different age groups and locations in Garissa County (Table 3), a recurring and dominant concern about FGM/C was consensus on its detrimental impact on women's sexual pleasure and intimacy. Participants provided vivid, experience-based narratives detailing how the practice leads to physical pain such as painful penetration, emotional, and relational difficulties in sexual life, particularly when more severe forms (like Type III) are performed.

Many male participants expressed dissatisfaction with the diminished sexual response from partners who had undergone FGM/C. They noted that cut women often lack sexual desire or do not enjoy sex due to lack of pleasure, which affects intimacy within marriages.

*"The clitoris veins might be cut when performing circumcision. Thorns are then used to sew; this causes pain to the woman and a lot of blood is lost. It also causes pain during urination and loss of sexual desires. Therefore, we think that we should not practice this circumcision"* 30-year-old male, secondary education

*"Everything that has a good side also has a side effect or disadvantage...from experience, it [FGM/C] hinders them [women] from experiencing sexual arousal...The second thing whereby the woman on the bed is not feeling...the sexual intercourse pleasure. So, the lady is not feeling because the sensitive part of lady is damaged or interfered...it hinders the sexual pleasure of the woman."* 29-year-old male, primary education

Others echoed that women who have undergone FGM/C experience pain during intercourse and are unable to enjoy sex, which in turn diminishes the quality of the marital relationship.

*"Women who are circumcised using the type 2 circumcision are capable of having sexual desires while women circumcised using the type 3 circumcision have no desires. The husband therefore feels stressed because the woman is never in the mood to get intimate."* 36-year-old male, incomplete primary education

*"When performing circumcision, the woman is cut and then stitched using thorns so this would obviously be painful. Also, the woman will feel a lot of pain during intercourse."* 24-year-old male, secondary education

Female participants consistently highlighted the link between FGM/C, especially Type III and trauma, pain, and complications during sexual activity. The extensive removal and stitching of genital parts result in severe pain during penetration, sometimes necessitating medical intervention to reopen the sealed vaginal opening.

*"The girl will experience a lot of pain during penetration, and some have to be taken to hospitals so that they are unsealed."* 25-year-old female, tertiary education

*“I can see we are mixing the type 1 female circumcision with other types of female circumcision. First let us differentiate the types of female circumcision. The type 1 female circumcision will not cause any major harm to the girl because their clitoris is slightly cut, and their outer genitalia will not be stitched, and it will stay natural the way it is supposed to be. But the type 3, women go through lots of problems such as difficulties during menstrual cycle and even when urinating. What I had is that, during the first night, couples experience difficulties when trying to have sexual intercourse since the bride’s opening is so small that they will have to seek the help of a medical professional, whereby she will have to unstitch the bride’s genitalia using a blade or a knife. At the same time, the bride has less sexual arousal making her not enjoy sexual pleasure. So, performing type 3 female circumcision is not okay with me, I really support the practice of type 1 female circumcision whereby girls do not completely lose their sexual desires, but it moderates it. So, the type 3 female circumcision has no benefit for both our daughters and wives.” 21-year-old male, secondary education*

Women shared their perspectives, often noting traumatic first sexual experiences, deep psychological impacts, and long-term relational consequences. One woman described how a girl could not meet with her lover because of the pain and as a result they got divorced because of the pain caused by FGM/C. Another noted that first sexual encounter is such a traumatic and painful experience for women who have undergone severe forms of FGM/C indicating that even if healing occurs physically, the psychological scars remain, affecting future intimacy.

*“When a woman is circumcised...she will bleed a lot...when she is married, and she is taken to her husband for the first night, she will undergo a lot of challenges, and a lot of pain related to circumcision. In our times, women used to be sewn using thorns...that brings a lot of pain to the woman.” 28-year-old female, university education*

*“There is a case scenario where a girl was circumcised, and then she married the love of her life. Thereafter, they were eager to make out, but the girl could not have intercourse with her lover because of the pain she was experiencing whenever they tried to have sex. And then she was taken to the hospital where they had to cut her open...the pain now increased again because of the cut. She could not even go on with the guy. You know, they were in love, but they could not stay together. So, they were separated. They got divorced because of the pain caused by FGM.” 28-year-old female, tertiary education*

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**Women shared their perspectives, often noting traumatic first sexual experiences, deep psychological impacts, and long-term relational consequences. One woman described how a girl could not meet with her lover because of the pain and as a result they got divorced because of the pain caused by FGM/C.**

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*“The woman goes through pain from the period she is married... now this man has to break the sewn skin, break the thread and hymen...how is this woman supposed to enjoy this thing? It’s such a traumatic and painful experience...that’s why most women will lose feelings because they associate the first experience which had all this pain. Even if she heals and she is supposed to be enjoying it, she may not as she relates to the pain she has gone through.” 26-year-old female, tertiary education*

Some narratives also touched on the social repercussions for men, such as marital dissatisfaction when sexual expectations remain unmet emphasizing how the disruption of natural intimacy can lead to harmful sexual behaviors. It is perceived that FGM/C often leads to reduced vaginal sensitivity, leaving women unable to enjoy or respond to sexual activity. As a result, some men turn even to harmful alternatives like anal sex to satisfy their desires, sometimes coercively. It has also led to cases of infidelity, polygamy, and marital rape, highlighting how FGM/C contributes to sexual gender-based violence within marriage by disrupting healthy sexual relations and reinforcing harmful power dynamics.

*“When a man gets married to a woman and she was circumcised and maybe going through sexual challenges...he will keep trying another method of having a second wife, the third and the fourth. So, it is a disadvantage...He will keep looking for something that he will not find because in our culture, every girl is circumcised.” 28-year-old female, tertiary education*

*“I think also a disadvantage. That may be called No, it is now an upcoming thing. Not only is it to the woman but also maybe to the men. It also it has resulted to people to try to try the sodomy, or should we say the anal type of sex, since the woman cannot feel through the vagina. Now they try the anal way which might result to these men, they want their sexual desires to be to be met, but since they cannot they know. You know, we have cases where women are raped by their own husbands. And that is that is that is true so sodomy, you see. So, it has I think it has also brought up that disadvantage.” 25-year-old female, tertiary education*

Overall, the data paints a clear picture that FGM/C, particularly in its more severe forms, erodes women’s ability to experience sexual pleasure and fosters distress and dysfunction within intimate relationships. This shared concern among both men and women across different age groups highlights the need for culturally sensitive interventions that address the long-term sexual and emotional harm caused by the practice.

Ironically, although FGM/C is promoted as a way to enhance marriage prospects, others acknowledged that men may cheat on cut wives in search of sexual satisfaction elsewhere.

*“We have been deceived and told FGM is a good thing for men. The reason women are cut is to be able to get married because no man will marry an uncircumcised woman. However, men cheat and go for non-circumcised women because circumcised women are not good in bed.” 27-year-old female, tertiary education*

## Impact of FGM/C on Mental Health

**Table 4: Summary matrix on the impact of FGM/C on mental health**

Impact of FGM/C on Mental Health	Younger Men (18-24)	Elder Men (25-54)	Younger Women (15-24)	Older Women (25-54)	Interpretation
Psychological trauma from sexual experiences			+	+	Many women discussed sexual dysfunction, inability to enjoy intimacy, and trauma during penetration.
Long-term relational and marital challenges due to trauma		+		+	Expressed mostly by older women and implied in male narratives. Some participants (both women and men) described the emotional and relational toll, including difficulties in intimacy and affection due to early trauma.

+, positive consensus

-, negative consensus

+/-, divergent views

Blank, theme not raised

The mental health impact of FGM/C emerged strongly from women lived experiences, highlighting deep psychological trauma alongside the physical harm (Table 4). Women who have undergone FGM/C described the profound emotional and psychological consequences, often intertwined with bodily pain and lasting trauma.

*“This is someone who loved you and you want to make her feel good as well, but you have no way of making sure she is feeling good. Because someone took that away from her when she was five years old... and at no point were you consulted as the husband. So, you found her like that, and she has her own trauma. Even with a mere touch, some circumcised women start getting traumas, they do not even want you to talk to them, or to come close to them. Now*

*imagine marrying someone like that...a relationship with someone like that it is going to be very hard." 27-year-old male, tertiary education*

Women and girls predominantly describe FGM/C as a source of ongoing trauma, fear, and psychological distress. The pain experienced during menstruation and sexual intercourse is not only physical but also triggers mental anguish. For example, one woman vividly explained the trauma linked to the most severe form of circumcision (type III), emphasizing the painful menstrual flow and traumatic first sexual experience.

*"When she's around 14 going through menses...those blood clots are big and cannot pass. Already, that is painful... this woman is going through pain from a simple period... then the man has to break through her vagina by breaking the thread...it is trauma!" 26-year-old female, tertiary education*

The psychological trauma extends beyond pain. Women report loss of sexual pleasure, emotional withdrawal, and even depression. A participant highlights how the trauma disrupts intimacy in marriage. Younger girls are seen as particularly vulnerable to psychological trauma due to their immaturity and inability to process the experience, leading to shock and long-term mental health issues.

*"The younger girls are not matured so this is a child. By seeing her blood may get her traumatized and experience other physiological problems and issues." 24-year-old female, tertiary education*  
*"It [FGM/C] causes shock, trauma and depression to the girls." 16-year-old female, primary education*

Men's views, though less frequently voiced in the FGDs, inductively provide insight into relational and emotional consequences from a husband's perspective. Men express sadness and frustration over the inability to provide their wives with sexual pleasure or emotional closeness, recognizing the trauma inflicted on their partners. The emotional distance resulting from FGM/C creates a strain in intimate relationships, affecting not only women but also men who desire a loving and fulfilling marital bond.

*"You as the husband, you like it, it's obviously you're enjoying, but you feel so bad... you want to make her feel good as well, but you have no way of making sure she's feeling good." 27-year-old male, tertiary education*

The lived experiences of women highlight the long-term emotional and physical toll of the practice. As one participant summarized:

*"For me, I think the most disadvantageous thing is for women not to have sexual pleasures. Because if FGM is meant to take that away, then even getting married has really no point. Because it is going to be one sided... I have a lot of traumas because of FGM... and then the one thing that you are probably looking forward to for your 28 years of life and then you are married, and it is more painful. It is very sad." 27-year-old female, tertiary education*

The evidence clearly shows that FGM/C profoundly impacts mental health through trauma, pain, emotional distress, and relational difficulties. Women lived experiences, especially relating to age and sexual life, shape these mental health challenges. Men's perspectives reveal the relational strain and emotional challenges caused by the trauma women endure. This gendered and experiential understanding is critical for designing supportive interventions.

## Changes in FGM/C Practices

**Table 5: Summary matrix on views around age at cutting**

Perceptions about age at cutting	Younger Men (18-24)	Elder Men (25-54)	Younger Women (15-24)	Older Women (25-54)	Interpretation
Performing FGM/C at an early age is preferred	+	+			Strong consensus among men that FGM/C should be performed at a young age for reasons such as easier healing, religious alignment, and controlled sexuality before puberty.

+, positive consensus  
-, negative consensus

+/-, divergent views  
Blank, theme not raised

## Age at Cutting

Several young and older male participants emphasized that FGM/C is best carried out in childhood, primarily due to easier healing, fewer complications, reduced discomfort, and easier acceptance (Table 5). It was also noted that by girls are cut at a younger age due to the practical challenges of cutting older women, such as embarrassment and consequences of uncontrolled sexuality such as pre-marital sex and unwanted pregnancy when girls are not yet cut before puberty.

*"When you circumcise a younger girl it's much easier for her to heal faster compared to when she is old. Also, it's not easy to circumcise a grownup woman because they won't feel comfortable exposing their intimate parts and a grownup woman might have health complications such as diabetics, making hard for them to be circumcised. So, it is easy and better to circumcise a younger girl than to circumcise a grownup woman."* 22-year-old male, secondary education

*"I totally agree with the other participants said about female circumcision and I would like to add a few things. If we compare the body of a young girl to a grownup woman, we can all see that they are totally different when it comes to healing of a wound, younger ones heal faster as compared to grownup women." 24-year-old male, no education*

**Table 6: Summary matrix on views around type of cut**

Perceptions about age at cutting	Younger Men (18-24)	Elder Men (25-54)	Younger Women (15-24)	Older Women (25-54)	Interpretation
Strong preference for Type 1 (Sunna) as religiously acceptable and less harmful	+/-	+/-	+	+	Strong preference for Type 1 (Sunna) as religiously acceptable and less harmful. FGM/C Type III widely rejected as outdated, painful, and "haram." Some men nonetheless believe in the efficacy of Type III (purity control, virginity assurance)
FGM/C Type III widely criticized due to its association with health complications	+	+	+	+	FGM/C Type III widely criticized as painful, leads to complications, and violates human rights. Type 1 or Type 2 (anything other than Type III) are often described as more acceptable.

+, positive consensus  
-, negative consensus

+/-, divergent views  
Blank, theme not raised

## Preferred Type of Cut

Across all groups, FGM/C was widely perceived as a longstanding religious and cultural obligation (Table 6). Most participants drew clear distinctions between different types of FGM/C, with a strong and recurring preference for type I (Sunna) over the more invasive type III (Pharaonic), which is increasingly described as outdated, harmful, and religiously impermissible.

*“Am not in support of the “sewing” [type III] otherwise circumcision is okay.” 38-year-old female, no education*

*“I do not believe at this time of civilization people still practice FGM, in our community people practice type 1 female circumcision. Those who consistently practice type III FGM are those people in Somalia, those still living in bushes and those in West-Africa. But those who live in urban places do not practice FGM. Okay.” 23-year-old male, tertiary education*

Religious identity strongly underpins community support for FGM/C, with Islam frequently cited as endorsing type I FGM/C while rejecting more severe forms. Many participants view FGM/C as a religious requirement, often referencing Islam and the Sunnah form, which they viewed as harmless and both religiously and culturally acceptable. On the other hand, type III circumcision was widely condemned across age and gender groups. Most participants highlighted its severe health impacts including maternal complications, infections, chronic pain, and sexual dysfunction as earlier discussed.

*“There are advantages of performing female circumcision. Female circumcision was in existence for a very long time, and we can say it is for their own benefit and from our religious perspective the type III female circumcision is not allowed, where they cut the outer female genitalia then stitch it. We only practice the type 1 female circumcision... Type III is beneficial to women, since it limits their sexual urge while the type 1, women will have more sexual urge, and our religion says that we should perform type 1 female circumcision.” 22-year-old male, secondary education*

The persistence of type I is deeply rooted in religious justification, and many participants expressed skepticism about abandoning it completely. This suggests that while there is growing rejection of extreme forms, the practice of type I is still strongly embedded in the community's religious identity.

*“You know the older people were using ‘pharaonic’ type [type III] they have been cut and stitched whereby this is haram in Islam...I’m a father of seven, all of them are circumcised in ‘sunnah’ type [type I] not ‘pharaonic’ type.” 50-year-old male, tertiary education*

*“This thing [FGM/C] is religious and sunnah of the prophet. We cannot alienate religion.” 28-year-old male, secondary education*

*“Personally, as a Muslim, I consider this as an act of worship, it is a ‘sunnah’ [habitual practice] that has been performed by the prophet peace be upon him. Performing it I see it’s advantageous and it’s something that’s good from Islamic perspective. Obviously when something is discussed from an Islamic angle and applied...it has advantages because when God says something it is for the betterment of the people.” 32-year-old male, tertiary education*

## Attitudes Towards FGM/C Abandonment and Acceptability of Change

Table 7: Summary matrix on attitudes towards FGM/C abandonment and acceptability of change

FGM/C abandonment and acceptability of change	Younger Men (18-24)	Elder Men (25-54)	Younger Women (15-24)	Older Women (25-54)	Interpretation
Resistance to total abandonment	+/-	+	+/-	+/-	Older men opposed total abandonment, citing religious and cultural justification. Majority of the men emphasized FGM/C to prevent promiscuity, ensure marriageability, and uphold morality. Many endorsed FGM/C Type I as religiously acceptable. Total abandonment was seen as inappropriate; anything other than Type III was perceived as a compromise. Some young men and women as well as older women, especially those educated were supportive of abandonment questioning the morality and logic of the practice, linking it to pain and gendered harm.

**Table 7: Summary matrix on attitudes towards FGM/C abandonment and acceptability of change**

FGM/C abandonment and acceptability of change	Younger Men (18-24)	Elder Men (25-54)	Younger Women (15-24)	Older Women (25-54)	Interpretation
Openness to less severe forms of cutting	+/-	+	+/-	+/-	Strong support for Type 1 FGM/C and rejection of Type III. Type 1 is seen as religiously appropriate, a means to moderate sexual desire, and less harmful. Type III was consistently described as excessive and harmful. A few participants consisting of younger men and both younger and older women expressed disapproval of any form of FGM/C
Openness to medicalization of FGM/C and reduction of harm	+/-	+/-	+	+/-	Strong consensus across groups that health professionals offer safer, cleaner, and less painful procedures. There were a few dissenting voices supporting traditional FGM/C or training of traditional cutters to perform the cut. There was also preference of female health providers over male providers in conducting medicalized FGM/C.

+, positive consensus  
-, negative consensus

+/-, divergent views  
Blank, theme not raised

## Resistance to Total FGM/C Abandonment

There is some openness to abandoning only type III but type I is fiercely protected as a religious prescription (Table 7). This analysis reveals a deep entrenchment of FGM/C practices underpinned by cultural, religious, and gendered ideologies. While there is some emerging dissent among younger men and women, particularly in urban areas, community-wide consensus still leans strongly in favour of continuing the practice especially type I FGM/C. Many participants, especially older men and women, continue to strongly support FGM/C as a cultural and religious obligation. Across nearly all groups, FGM/C type I (commonly referred to as Sunna) is widely accepted with many participants emphasizing its alignment with Islamic teachings. It is also considered medically safer and less harmful compared to Type III, hence a preferable alternative as opposed to total abandonment.

*“We do not want to abandon female circumcision because the practice is one of the teachings taught to us by our prophet and failure to follow, we will die as non-Muslims. Lesser form of cutting is acceptable.” 47-year-old female, no education*

*“The ‘Sunna’ (type I) does not harm, and it does not destruct anything to do with the virginity... only removing the upper part of the clitoris...No harm.” 50-year-old male, tertiary education*  
*While a few young men expressed opposition to the practice, citing sexual dissatisfaction and outdated beliefs, others supported it as a means to control female sexuality and reduce immorality. This shows internal generational tensions and conflicting views about FGM/C’s role in society.*

*“We should not circumcise girls. If you go to bed with a circumcised woman, she will not feel any pleasure. I like women with strong sexual desire.” 23-year-old male, secondary education*  
*“Since most people in the world have stopped performing female circumcision, it is time for us to abandon it too.” 23-year-old male, secondary education*



Men focused group discussions

*“If the women are uncircumcised...there will be a lot of unwanted pregnancy in the society. So, to avoid this, FGM can be the solution.” 19-year-old male, secondary education*

Among women, especially those exposed to formal education or residing in urban settings, there is increasing resistance even to the “minor” forms of FGM/C. Educated women viewed all forms of cutting as harmful and unnecessary, advocating for total abandonment. However, a generational divide is apparent. Some older or rural women still accept the “Sunna” form as a tolerable compromise, often due to deeply held beliefs about identity, religion, and community belonging.

*“I think we should abandon it because female circumcision is not compulsory according to our religion [Islam].” 23-year-old male, secondary education*

*“I think female circumcision should be abandoned because it is not acceptable for us to interfere with the woman’s sexual desires. Sexual desires are natural, and it is not something that should be removed entirely.” 24-year-old male, secondary education*

*“I said, my daughter will not undergo circumcision... educated mothers like me are not doing that to their daughters... we are supporting eradication of genital mutilation.” 28-year-old female, tertiary education*

*“I think it is possible to abandon. But I genuinely feel very concerned. Because just because it is hard for people to change does not mean we should have a less extensive version of FGM. Because it is all the same, it is very harmful, even when it is cut very small, because you are cutting an organ and some of these kids actually die. So, whether it’s extensive, whether it’s cutting all, whether it’s sewing, it’s very harmful... People are trying to adapt to it, but it should not be encouraged. It is very concerning.” 27-year-old female, tertiary education*

Among adolescent girls, there was clear opposition to the practice. Many challenged the belief that FGM/C prevents immorality, arguing instead, education and proper upbringing shapes a girl’s moral standing. They believe that societal transformation is possible through awareness and intergenerational dialogue.

*“Personally, I do not think it has any advantage. I am very against it. I think if people understand the immorality of a woman has more to do with her upbringing and not cutting part of her genitalia, it might reduce.” 20-year-old female, tertiary education*  
Rejection of Type III FGM/C

“

**Among women, especially those exposed to formal education or residing in urban settings, there is increasing resistance even to the “minor” forms of FGM/C. Educated women viewed all forms of cutting as harmful and unnecessary, advocating for total abandonment.**

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There is some consensus among both men and women across all age groups that the most severe forms of FGM/C particularly Type III are harmful and increasingly untenable. This is evidenced by shifting practices towards less invasive procedures and the use of medical personnel. The practice of having health professionals perform the Sunna type was occasionally seen as a “safer” option. Openness to less extensive forms of cutting reflect adaptation to evolving attitudes but does not signify uniform agreement. While it may serve as a transitional strategy in some communities, it remains a deeply gendered and contested issue, with growing opposition from younger and more educated women or women with lived experiences on FGM/C complications who reject any form of genital cutting as harmful and unjustified.

“Can lead to maternal death... lack of labia minora and majora causes complications during birth.” 26-year-old female, tertiary education

“Female circumcision cannot be abandoned but we can allow the Sunni [type 2] circumcision because it is less harmful to the women.” 48-year-old female, no education

“Type III female circumcision should be banned completely... type 1 is somehow better.” 23-year-old male, tertiary education

## Openness to Medicalization of FGM/C

Across the various groups in both rural and urban settings, there is a shifting perspective towards the involvement of health professionals in performing FGM/C. While some participants oppose medicalization, citing cultural, religious, and gender sensitivity concerns, most favour it as a harm reduction strategy that aligns with evolving norms and increasing health awareness. A few that are in favour of total eradication do not support FGM/C in any form including medicalized FGM/C.

*“We cannot say we can eradicate this from the community... but we can introduce the medical part of it... maybe with time we can sensitize and change the community.” 28-year-old female, tertiary education*

*“That [medicalization] should not be an option; it should be eradicated completely. And the health professionals should not be involved in butchering a child.” 27-year-old female, tertiary education*

*Many participants expressed preference for medical professionals due to their skills, hygienic tools, and ability to manage complications such as excessive bleeding and infections. The hospital setting was viewed as safer, with faster recovery times and less risk of disease transmission.*

*“I believe everything starts somewhere...normally they say better half a loaf than none...I think girls can be taken to the hospital where it’s more safe and less transmission of diseases and so on.” 28-year-old female, tertiary education*

*“Health practitioners will also help the women to teach them that there is a safer method...they know how to do this and also in a way to prevent infection. So, there will be no transmission of diseases; they [girls] will be safer using sterilized items. They will also be treated and looked after in a proper way more than when it is done in the villages.” 25-year-old female, tertiary education*

*“The hospital uses medicines that helps stoppage of excess bleeding... Girls who are not cut by health professionals may die from bleeding.” 25-year-old male, secondary education*

*“It’s acceptable to cut by health professional. In some areas our people use one razor to circumcise ten girls. This may bring transmission of diseases. I personally prefer the health professional.” 42-year-old male, no education*

A few male and female participants frequently emphasized that if FGM/C is to be conducted by health professionals, it must be done by female practitioners. This reflects cultural sensitivities around gender and the protection of female modesty.

*“We prefer women doctors because they are more skilled and can easily perform the Sunna type of circumcision [type I].” 47-year-old female, no education*

*“The male doctors might have other thoughts when circumcising the girls.” 25-year-old male, primary education*

*“The health professional performing the circumcision must be a woman.” 19-year-old male, secondary education*

Some participants rejected the idea of involving health professionals altogether, seeing it as a threat to cultural autonomy and an imposition of foreign (often Western) values.

*“Health professionals are the same people that are against the idea of girls being circumcised... It is better we have our local cutters to perform female circumcision and if the government can pay them monthly, we are okay with that...” 22-year-old male, secondary education*

*“No, allowing health professionals to perform it [FGM/C] will not be acceptable; we just want to do it our way.” 45-year-old female, no education*

*“Instead of professional cutters...how about we train those in the villages who usually do this thing at the village level. We empower them, give them the necessary equipment and then I believe we can do it much better.” 25-year-old male, tertiary education*

## Evolving Social Norms and Intergenerational Perspectives

The study sought to understand the evolving social norms surrounding the practice. There is evidence that community transition is in progress as people are open to less severe forms of cutting and medicalization of FGM/C with a few younger males and educated urban women open to total abandonment of FGM/C (Table 8).

**Table 8: Summary matrix on key shifts in FGM/C practice**

Changes in FGM/C practice	Younger Men (18-24)	Older Men (25-54)	Younger Women (15-24)	Older Women (25-54)	Interpretation
Practice of less severe forms of FGM/C	+	+	+	+	Participants across different groups broadly agree that the community has shifted to only minor cuts (Type I) which are seen as religiously acceptable and less harmful. Clear rejection of Type III as outdated and dangerous.
Community Norm Shift toward Medicalization of FGM/C	+/-	+/-	+	+/-	There is growing acceptance in communities, especially in urban areas, which are already transitioning to medicalized FGM/C, especially due to fear of legal repercussions for traditional cutters and increased awareness of health risks. However, a few participants still preferred traditional methods or were ambivalent.

+, positive consensus  
-, negative consensus

+/-, divergent views  
Blank, theme not raised

Table 8: Summary matrix on key shifts in FGM/C practice

Changes in FGM/C practice	Younger Men (18-24)	Older Men (25-54)	Younger Women (15-24)	Older Women (25-54)	Interpretation
Legality and Hidden Practice of medicalized FGM/C		+		+	While participants acknowledged that medicalized FGM/C is more discreet and “safer,” they also noted that it remains illegal, and therefore unregulated and unspoken, creating a paradoxical situation.

+, positive consensus  
-, negative consensus

+/-, divergent views  
Blank, theme not raised

## Norm Shift Toward Medicalization of FGM/C

Many participants preferred FGM/C to be conducted by trained health professionals in hospital settings rather than by traditional practitioners at home. The motivation includes reduced risk of excessive bleeding, infection, and death and faster recovery that allows girls to return to school or religious classes sooner. Some emphasized the importance of medicalizing FGM/C having it done by trained professionals using anesthesia. A few of the participants were particular that medicalized FGM/C should only be performed by female medics.

*“Nowadays, the women cutters are afraid of performing circumcision because they are afraid of being arrested. It is hard to find someone who cuts our girls. That is why most girls in our area are circumcised at the hospital. It is less painful, and the girls do not even have problems walking.” 27-year-old female, no education*

*“We want our girls to be circumcised at the hospital with the aid of a doctor. The doctor should administer painkillers and anesthesia when performing the circumcision. Also, the doctors should perform the type I and II circumcision because it is the least harmful.” 45-year-old female, no education*

*“People are already abandoning the infibulation type of circumcision and adopting the Type 2 which is medicalized.” 24-year-old female, tertiary education*

*“People prefer hospitals because the tools being used are sterilized and it is safer. However, I do not encourage FGM regardless of who performs it.” 26-year-old female, tertiary education*  
*Some participants differentiated between types of circumcision, rejecting extreme forms while promoting those perceived as moderate and religiously sanctioned:*

*“We should continue practicing the type 1 female circumcision... and stop practicing the type III. We can see the importance of type 1 in our community... our religion supports the type 1 female circumcision.” 22-year-old male, secondary education*

One woman shared her personal decision to abandon the practice for her daughter, linking this to improved awareness and healthcare access:

*“I have faced challenges as a result of circumcision... I am a mother, and when I got my first daughter, I said, “My daughter will not undergo circumcision.”...people have stopped circumcising their daughters, because of this old problem, and even if they do, they do what we normally call the Sunna type, which she gets from the hospital.” 27-year-old female, tertiary education*

## Shifts in Attitude Toward FGM/C

While FGM/C remains present, some participants viewed it as no longer mandatory, suggesting a slow but steady shift in attitudes:

*“Circumcision is not compulsory; one has every right to do it or to leave it.” 24-year-old female, incomplete primary education*

*“I think it [FGM/C abandonment] would be acceptable if they are educated on the disadvantages, causes and the harm it brings to the people than good.” 26-year-old female, tertiary education*  
*Young girls echoed the growing acceptability of rejecting the practice, citing improved education and awareness of harm:*

*“People are now more educated... female circumcision has more harm than good. According to my opinion, I think it might be acceptable [to abandon it] in the future. To my opinion I would happily accept the change” 20-year-old female, tertiary education*

Still, resistance from the older generation persists, especially toward medicalized approaches:

*“The older generation would not accept it to be done by health professionals... they want to make sure the women go through it [traditionally].” 24-year-old female, tertiary education*  
*Changing Notions of Marriageability and Female Worth*

Some participants acknowledged past teachings that linked circumcision with marriageability, but challenged these beliefs based on present realities:

*“I was taught that FGM is a mandatory thing for every Somali girl... it has been practiced by our mothers and grandmothers... and I was told it is a good thing.” 26-year-old female, tertiary education*  
*Other participants shared a shift in how uncut girls are now perceived, even attracting higher dowry:*

*“Our girls should not be cut... when it comes to marriage, people are looking for non-cut girls and they pay double/triple the dowry. We were taught uncut women cannot be married—this is propaganda... Let us not teach this to our kids.” 35-year-old female, tertiary education*

*“Nowadays, the men who are married to cut girls in Garissa are dating non-cut women and are going on vacation with them. If we leave our girls uncut, they will still get married.” 26-year-old female, tertiary education*

The practice of FGM/C remains contested within the community. While many men continue to uphold it as a moral, religious, and cultural responsibility, especially in its less severe forms, increasing awareness particularly among women and the youth is reshaping the discourse. Shifts toward personal choice, medicalized procedures, or complete abandonment are evident, driven by changing marital norms, health education, and generational transitions.

*“For me it is good to not circumcise girls and people should abstain from female genital mutilation, because they will not feel any pleasure during sexual intercourse. If you go to bed with a circumcised woman, she will not feel any pleasure and men have different preferences. For me I like women with strong sexual desire whom we can have intercourse for a long time. So, we should not circumcise girls.” 23-year-old male, tertiary education*

*“I believe that there are changes that are seen regarding FGM... Most people are not in favour of Type III circumcision. Before it used to happen in rural areas. People used to migrate from urban areas so as to get their girls circumcised but right now it is medicalized. It is still illegal because no one will direct you to a medical facility that performs FGM. In conclusion, we can abandon FGM because we have moved from the severe circumcision to a safer type of circumcision.” 27-year-old female, tertiary education*



**The practice of FGM/C remains contested within the community. While many men continue to uphold it as a moral, religious, and cultural responsibility, especially in its less severe forms, increasing awareness particularly among women and the youth is reshaping the discourse.**



## FGM/C Intervention Efforts and Community Programmes

### Perceptions on Intervention Efforts to End FGM/C in Garissa County

Efforts to address FGM/C were reported across several FGDs, with a mix of governmental, non-governmental, and grassroots interventions. However, the effectiveness, reach, and community involvement in these programmes varied.

In urban and semi-urban areas, especially among youth and township populations, there is relatively high exposure to anti-FGM interventions. Various NGOs and youth-led movements, such as the African-Led Movement (ALM), have been instrumental in sensitizing communities through peer education, social media campaigns, artistic performances, and engagement in calendar events like International Women's Day and Menstrual Health Day. These platforms have helped spread anti-FGM messages among young people and women, emphasizing rights, bodily autonomy, and the health implications of the practice.

*"I use artistic approach... advocating against FGM where we have big events like International Women's Day...I try to use my artistic approach." 25-year-old female, tertiary education*

*"There are many programmes. Most are driven by NGOs and a few by the government. The NGOs have been doing their best to advocate against FGM both in town and in grass-root levels. It has not been successful but there is a small achievement." 26-year-old female, tertiary education*  
*Schools are central to intervention efforts, especially among younger girls. Educators and NGOs use school-based programs to raise awareness about the dangers of FGM, giving girls the knowledge and confidence to oppose the practice.*

*"The school is doing a job in educating the young girls... about the disadvantages and that makes the young girls have an opinion." 20-year-old female, tertiary education*

Religious leaders also play a key role in some areas, as they are trusted figures capable of influencing community norms. Programmes involving religious figures have shown impact, especially when tied to community gatherings or international commemoration days.

*"We also celebrated international days like... women's day with the religious leaders which has a big impact on the community." 28-year-old female, tertiary education*

**Religious leaders also play a key role in some areas, as they are trusted figures capable of influencing community norms. Programmes involving religious figures have shown impact, especially when tied to community gatherings or international commemoration days.**

Despite the presence of these interventions, there are clear gaps in coverage, particularly in rural, pastoralist, and illiterate populations. Participants from these communities report either minimal or no exposure to FGM-related programs. Challenges include limited mobility, security concerns for outsiders, and a lack of tailored messaging for these audiences.

“In our community most people are illiterate...you must go with someone who understands better... we have never seen any person... to tell the awareness of FGM to the people.” 25-year-old male, secondary education

Overall, while anti-FGM/C interventions exist across different regions and target groups, their reach and effectiveness are uneven. To enhance impact, programmes need to prioritize inclusive engagement, involve local leaders, tailor strategies for pastoralist contexts, and sustain dialogue across generations and settings.



## Chapter 5: Discussion

This chapter presents the study's key findings, programmatic implications, and conclusion on FGM/C in Garissa County, revealing that the practice remains deeply entrenched due to long-standing beliefs about sexual purity, marriageability, and social acceptance, particularly among older generations. Despite widespread awareness of its health, sexual, and psychological harms, many continue to defend Type I (Sunna) as a religiously acceptable alternative to the more severe Type III (Pharaonic), reflecting a shift toward harm reduction rather than full abandonment. Marriageability and social conformity emerged as central drivers, while younger and urban participants, especially women, increasingly questioned these norms, framing conformity as coercion rather than choice. The study also noted the rise of medicalized FGM/C, valued for safety but criticized for legitimizing the practice. Encouragingly, gradual normative shifts driven by education, urban exposure, and youth activism suggest growing openness to abandonment, though rural and pastoralist areas remain resistant. The chapter underscores the need for community-led and intergenerational dialogues, religious engagement, youth empowerment, health and rights education, and psychosocial support for survivors, alongside stronger policies to regulate medicalization and integrate FGM/C abandonment into broader gender and development frameworks.

### Summary of Findings

The study revealed that FGM/C is widely practiced in Garissa County due to deeply rooted beliefs surrounding sexual purity, marriageability, and social acceptance. Many participants, especially older men and women, view FGM/C as a necessary means of controlling female sexuality, maintaining virginity, and preventing immoral behavior. Type I (Sunna) is often seen as a religiously sanctioned, less harmful alternative to the more severe Type III (Pharaonic), which is increasingly viewed as outdated and dangerous.

Marriageability emerged as a dominant theme, with FGM/C perceived as a prerequisite for securing a husband, maintaining family honor, and achieving community respect. While these views were more strongly held among older participants, younger girls and urban youth began to question these norms, challenging the idea that being uncut diminishes a girl's value or religious identity. Nevertheless, even among younger men, the expectation that a wife should be cut remains prevalent, showing how socialization into these norms continues across generations.

Social acceptance is another powerful motivator for the continuation of FGM/C. For many, undergoing the procedure is tied to a sense of cultural identity and religious obligation, especially in Islamic contexts. Failing to conform can lead to social exclusion, religious invalidation, and stigma. While these pressures are strongest among older generations and rural communities, younger participants, particularly girls voiced concerns about the emotional and physical toll of FGM/C, framing acceptance as a form of coercion rather than genuine belonging.

Participants across focus group discussions consistently acknowledged the serious health risks associated with FGM/C. These included reproductive complications such as obstructed labor, excessive bleeding, infections, and increased risk of maternal and infant mortality, especially for those who had undergone Type III. Menstrual difficulties, sexual pain, and the spread of disease due to unsterile instruments were also commonly cited. Despite this awareness, some participants, particularly men, still believed the perceived benefits outweighed the risks, revealing the complex interplay between knowledge and belief systems.

Sexual and emotional harm caused by FGM/C was another recurring theme. Many women reported pain during intercourse, loss of sexual pleasure, and deep psychological trauma, especially from Type III cuts. Men also expressed dissatisfaction, emotional distance, and relational strain within marriages. These lived experiences expose the damaging consequences of FGM/C on intimacy and mental well-being, and in some cases, were linked to marital breakdown, infidelity, and gender-based violence.

Attitudes toward abandonment of FGM/C are evolving, with growing openness to rejecting the most severe forms of FGM/C (Type III), while Type I remains largely defended as a religious duty. While urban and educated women were more likely to reject all forms of FGM/C, many rural participants continued to support the practice. Some younger individuals questioned the morality of FGM/C, suggesting that proper education and upbringing, not genital cutting, shape a girl's behavior and values.

The medicalization of FGM/C is gaining traction as a harm reduction strategy, especially for Type I. Many participants preferred the involvement of trained health professionals due to improved hygiene, safer conditions, and faster recovery. However, this shift is contested: some believe it threatens cultural integrity, while others see it as a pragmatic compromise. Notably, many participants insisted that if medicalized FGM/C is done, it must be by female professionals to protect modesty and cultural norms.

Community attitudes are shifting slowly but noticeably. While older generations remain the staunchest supporters of FGM/C, younger people, especially girls, are increasingly questioning its value and legitimacy. Younger girls pointed out that some communities now accept uncut girls, with reports of higher dowries and social respect. This shift, though not yet widespread, suggests that change is possible, especially where health education, formal schooling, and urban exposure are present.

Intervention efforts to end FGM/C are underway, led by NGOs, youth groups, schools, and religious leaders. These efforts are more visible and effective in urban areas, where access to information and education is greater. However, rural and pastoral communities remain under-reached due to logistical, cultural, and security barriers. Effective programming must therefore be localized, inclusive, and sustained over time, involving respected community figures and promoting intergenerational dialogue.

## Programmatic and Policy Implications

### Study findings have both programmatic and policy implications.

- Invest in community-led dialogue forums that offer safe and inclusive forums spaces for community members to engage in FGM/C matters. This should include intergenerational dialogues where community members can openly discuss FGM/C, its impacts, and develop a roadmap towards abandonment. During these dialogues, prioritize the inclusion of key stakeholders in the implementation of FGM/C interventions. Key stakeholders include elders, religious leaders and the youth to foster mutual understanding and shift norms from within.
- Expand health and human rights education. This should involve integrating comprehensive FGM/C awareness into school curricula and adult learning programs, focusing on human rights, bodily autonomy, and long-term health consequences of FGM/C.
- Support youth-led advocacy. There is need to empower young women and men to become change agents by supporting peer-led education, social media campaigns, and storytelling initiatives. Support may include the provision of mentorship and funding opportunities to youth groups and community influencers already engaged in FGM/C prevention.
- Address the role of religion. Programmes implementing FGM/C interventions should collaborate with local religious scholars to disseminate accurate Islamic teachings on FGM/C, emphasizing that it is not a religious obligation.
- Provide psychosocial and medical support to those affected by FGM/C. There is need to expand access to trauma-informed health services, including counseling and reconstructive surgery for FGM/C survivors.
- Integrate FGM/C abandonment into broader development policies. This includes linking FGM/C programming with gender equality, maternal health, education, and poverty reduction strategies. It also involves ensuring that FGM/C interventions are embedded in county-level development plans and budgets.
- Monitor and regulate medicalization. County government should develop guidelines that prohibit the medicalization of FGM/C, supported by health regulatory bodies and professional associations. Health professionals should be trained on ethical guidelines to resist medicalization and support abandonment rather than perpetuation of FGM/C. Health providers who perform FGM/C should be penalized.

## Conclusion

FGM/C remains a deeply entrenched practice in Garissa County, driven by a confluence of cultural, religious, and social beliefs around sexual control, marriageability, and communal identity. While awareness of its adverse health and psychological consequences is increasingly high, social pressures, perceived religious obligations, and fear of exclusion continue to sustain the practice. The preference for Type I over Type III reflects a shifting but incomplete transformation, often framed around harm reduction rather than full abandonment. Encouragingly, emerging attitudes among youth, particularly girls, indicate a readiness for change, though these are counterbalanced by persistent generational and geographic divides. Moving forward, effective intervention strategies must align with local religious and cultural values while leveraging emerging shifts to support safe, respectful, and rights-based efforts to end FGM/C.

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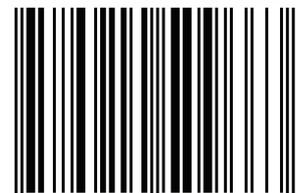
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