

The “Uncut” Stigma: Debunking the Myths and Misconceptions that Promote Female Genital Mutilation in Kenya

Fredrick Mukabi, Viola Chepngeno, Dorine Onchagwa

Kenya School of Government Learning and Development Division P.O. Box 402-60100, Embu

Email: Fredrick.mukabi@ksg.ac.ke (Corresponding Author), viola.chemgeno@ksg.ac.ke,
doreen.onchagwa@ksg.ac.ke

To Link this Article: <http://dx.doi.org/10.6007/IJARBSS/v12-i7/14441>

DOI:10.6007/IJARBSS/v12-i7/14441

Published Date: 25 July 2022

Abstract

Female Genital Mutilation is widespread in Kenya and globally. With it come myths and misconceptions creating misinformation on the practice to stigmatize against ‘the uncut’. Reports by global agencies and scholars have delved into the topic and findings suggests a lacuna in this cultural practice. Deeper understanding of misconceptions promoting the practice through stereotyping and stigmatization concerns this research. The United Nations put in place efforts to create global awareness through a dedicated day, ‘The International Day of Zero Tolerance for Female Genital Mutilation’, first marked in 2003. The Kenya Demographic and Health Survey (2020) reports the national its prevalence at 21%, despite stakeholder efforts. Nevertheless, communities practicing FGM argue of more than just ‘the cut’ hence their stigma justification. The paper aims at unravelling misinformation about FGM through investigating how knowledge levels contribute to its prevalence in Kenya; demystifying myths and misconceptions around the practice; evaluating the efforts by agencies in the campaign against FGM; and also establishing alternative knowledge sharing mechanisms on the FGM practices. Using mixed approaches in data collection and reports collating, the researchers established that the practice in communities is highly stigmatized and those not initiated were deemed social misfits. Much ground had been covered in demystification of the practice while much remains shrouded in cultural mystery. Significance is attached to the practice across generations and the initiation process is also considered an opportunity to pass over cultural values. Alternative approaches towards understanding FGM could grant further research into communities maintaining valuable cultural aspects while shunning ‘the cut’ for being retrogressive.

Keywords: Stigma, Knowledge, Uncut, Myths, Misconceptions, Female Genital Mutilation

Introduction and Background

According to the World Health Organization, Female Genital Mutilation (FGM) comprises 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. The practice is mostly carried out by traditional practitioners even though in several settings, there is evidence suggesting greater involvement of health care providers in performing FGM due to the belief that the procedure is safer when medicalized. WHO strongly urges health care providers not to perform FGM.

FGM is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against girls and women. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security and physical integrity; the right to be free from torture and cruel, inhuman or degrading treatment; and the right to life, in instances when the procedure results in death. In 2008, the World Health Assembly passed resolution WHA61.16 on the elimination of FGM, emphasizing the need for concerted action in all sectors - health, education, finance, justice and women's affairs.

FGM is primarily practiced among various ethnic groups in more than 28 countries in Africa on girls aged 15 years and below and also in some countries in the Middle East and Asia and the Bedouin tribes of Saudi Arabia. The prevalence of FGM in Africa shows that the practice is more than 70% in Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Guinea, Mali, Mauritania, Northern Sudan, Sierra Leone, and Somalia (WHO, 2020). Globally, it has been proposed that Type II FGM is the most frequently practiced form, representing an estimated 80% of all procedures. FGM Type III is thought to represent about 10% in Africa, it is preferred and most frequently used type in some countries like Djibouti, Somalia, and northern Sudan (Berg et al., 2010)

While the exact number of girls and women worldwide who have undergone FGM remains unknown, at least 200 million girls and women have been cut in 30 countries with representative data on prevalence. However, the majority of girls and women in most countries with available data think FGM should end and there has been an overall decline in the prevalence of the practice over the last three decades, but not all countries have made progress and the pace of decline has been uneven (UNICEF, 2021)

According to The United Nations (UN) efforts to curb and create awareness to every individual both nationally and internationally, came up with The International Day of Zero Tolerance for Female Genital Mutilation in 2003. The day is commemorated annually and whose significance is to create awareness on the effects of FGM. There are other international days and events marked for the fight against FGM such as *The International Women's Day*; *The day of the African Child*; *The International Day of the Girl Child*; and *Sixteen Days of Activism against Gender Based Violence*. It is reported that the UN is currently seeking to ensure that before 2030 it will have resolved FGM practice even though the economic impact of the pandemic and resultant lockdowns is expected to lead to a resurgence of the practice (O'Neill et al., 2020).

Prohibition of FGM Act 2011, was part of the efforts of the government since it provided a legal framework. Among the strategic themes to focus on reference to 2014 Anti FGM Board were Policy formulation, Awareness creation, Design and coordinate Anti-FGM practices, Mobilization of resources for FGM, Monitoring and evaluation of FGM, and strengthening institutions towards implementation of the plans effectively (Benardatte & Loloju, 2018).

In 2012, the UN General Assembly designated February 6th as the International Day of Zero Tolerance for Female Genital Mutilation, with the aim to amplify and direct the efforts on the elimination of this practice. In 2022, the UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation: Delivering the Global Promise launched the 2022 theme; "Accelerating Investment to End Female Genital Mutilation." It reports that many countries are experiencing a "crisis within a crisis" due to the pandemic including an increase in female genital mutilation. That is why the United Nations calls on the global community to reimagine a world that enables girls and women to have voice, choice, and control over their own lives. The UN General Assembly further reports that in 2021, the COVID-19 pandemic negatively and disproportionately affected girls and women, resulting in a shadow pandemic disrupting SDG target 5.3 on the elimination of all harmful practices including, female genital mutilation. Hence, UNFPA estimated that an additional 2 million girls were projected to be at risk of undergoing female genital mutilation by 2030.

On February 6th 2022 which is the International Day of Zero Tolerance for Female Genital Mutilation, the UN Secretary-General António Guterres asked the international community to join in calling to accelerate investment to end female genital mutilation and uphold the human rights of all women and girls.

FGM Practice in Kenya

Female Genital Mutilation is still prevalent in several communities in Kenya. It is a cultural practice in over 50% of Kenyan ethnic groups. According to the Kenya Demographic Health Survey in 1998 for Kenya Tribal Affiliation on FGM, communities had the following percentages of FGM practices; Somali 97.7, Kisii 97, Maasai 89, Kalenjin 62, Taita Taveta 59, Meru/Embu/Mbeere groups 54, Kikuyu 47, Kamba 33, Mijikenda/Swahili 12, Luo 0.8-1, Luhya 0.8-1 (Matanda & Kabiru, 2019). The Kenya Demographic and Survey Data 2003 (KDSD-2003) shows that FGM is nearly universal among the Somalis (97%), Kisii (96%), and Maasai (93%). It is also common among the Taita (62%), Kalenjin (48%), Embu (44%) and Meru (42%). The levels are lower among the Kikuyu (34%) and Kamba (27%) (Kandala et al., 2017).

According to the last Kenya Demographic and Health Survey (KDHS-2014), the national prevalence of FGM stands at 21%, compared to 27% in 2008/2009 and 32% in 2003. This decline can be attributed to multifaceted approaches mounted by the Government of Kenya, UN agencies, NGOs, and CBOs. Despite the steady decline nationally, the prevalence of FGM remains relatively high in communities, such as the Somali (94%), Samburu (86%), Kisii (84%), and Masaai populations (78%)(Matanda & Kabiru, 2019).

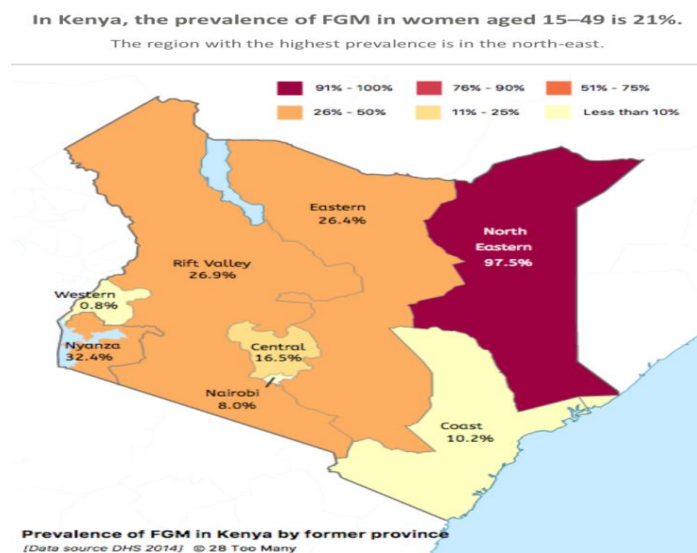


Fig. 1: Prevalence of FGM in Kenya (Adapted from KDHS, 2014)

The practice is rooted in gender inequality, attempts to control women's sexuality, purity, and modesty. Normally, it is carried out by women who term it and refer to it as a source of honor. Some fear that failing to have their daughters and granddaughters chopped off their genitalia will expose them to social exclusion and be regarded as not able to control their sexuality which therefore puts their reputation in question.

Problem Statement

Female Genital Mutilation is a practice shrouded in myths and misconceptions which lead to social stigma around those affected by the practice, particularly the initiates and misunderstandings by communities that practice it, a fact that could be attributed to the various government, non-governmental and other global agencies that depend on limited information that promotes the practice. Global and local statistics go as far as confirming this incidence with evidence of information gaps around the practice in its entirety.

It is therefore imperative that for effective management of this practice, perceived mostly as retrogressive, there is need to debunk some of the myths and misconceptions so as to allow all players for and against the practice adequate information to enhance appropriate interventions. It is also important to remove the social stigma associated with this practice for appropriate and adequate information sharing by all stakeholders in the ant-FGM campaigns.

The purpose of this study is therefore to help demystify this practice and to unravel how the social stigma surrounding the practice of FGM contributes to its prevalence in Kenya through an understanding of some of the myths and misconceptions.

Objectives of the Study

The main objective of this study is to unravel the social stigma associated with myths and misconceptions hence contributing to FGM practice in Kenya.

Specifically, the study will aim at:

- i. To Demystify myths around FGM
- ii. To investigate efforts by other agencies in the campaign against FGM
- iii. To establish Alternative knowledge sharing mechanisms around FGM

Methodology

This meta-analysis design which according to Creswell, J.W, 2005 is an analytical methodology designed to systematically evaluate and summarize the results from a number of individual studies, thereby increasing the overall sample size and the ability of the researcher to study effects of interest. Through this design the major contributors to stigmatization of the FGM in Kenya are discussed and analyzed.

Primary data was collected from the Child Protection Practitioners from different parts of the country. Questionnaires were issued to randomly sampled respondents who are child protection practitioners across the different Counties in Kenya. These were 124 and with samples drawn from all the 47 Counties. This data was used to get general facts in an attempt to debunk the stigmatization of FGM across Kenya.

Secondary data collection was done using statistical data from Kenya Demographic and Health Surveys, Kenya National Bureau of Statistics, Economic Surveys, World Bank Reports, Reports from UNICEF.

Contextual Literature Review

The procedure of FGM is most often done to girls between birth and age of 15. In general, it is conducted from days after birth to puberty and even beyond. In countries from which national figures of FGM are available, it is usually done before girls turn 15 years. Its procedures differ according to the country or ethnic group thus bringing in the types of FGM practiced across the globe.

Types of Female Genital Mutilation

There are four types of FGM namely;

Type I: *Clitori dectomy*. Whereby there is the total or partial removal of the sensitive clitoris and its surrounding skin. (the external and visible part of the clitoris, which is a sensitive part of the female genitals)

Type II: *Excision*. This is the complete or partial removal of the inner labia, with or without removal of the clitoral glans and outer labia. This type then branches into three parts which are;

- a. Type IIa is the removal of the inner labia
- b. Type IIb, removal of the clitoral glans and inner labia;
- c. Type IIc, removal of the clitoral glans, inner and outer labia.

Type III: *Infibulation*. The cutting and repositioning of the labia minora and the labia majora - the outer skin folds that surround the vagina. This often includes stitching to leave only a small gap. In other words, it is the removal of the external genitalia and fusion of the wound. The inner and/or outer labia are cut away, with or without removal of the clitoral glans. This type is mainly applied in the Northern Africa parts like Djibouti, Ethiopia, Eritrea, etc.

Type IV: includes all other harmful procedures to the female genitalia for non-medical purposes, including pricking, piercing, incising, scraping, and cauterization. This is common in southern and eastern Africa which sought to enhance sexual pleasures for the man.

Type I and Type II are the most common. Type III is found in the far eastern areas bordering Somalia. Studies indicate it is practiced mostly in rural areas where the majority are not informed on the effects of such practices and how dangerous they can be to women and girls. They also do it because they have been subscribed to their cultural practices and some of their religion-based faith and beliefs.

Reasons for FGM Practice

FGM is deeply rooted in many cultural practices, for socio-cultural reasons, economic reasons, religious reasons, and myths and misconceptions. The most cited reasons for carrying out FGM in many communities and countries in the world are; seek for social acceptance, religious beliefs, and misconceptions about hygiene, a means of preserving a girl or woman's virginity, making the woman "marriageable" and enhancing male sexual pleasure and also maintaining a woman's sexuality. In some communities, FGM is a rite of passage for every woman to graduate to womanhood congruously to how boys graduate to being men after initiation.

Many communities believed that FGM was a necessary practice to ensure that a girl is accepted socially and hence eligible for marriage. Those who practiced FGM on women and girls usually viewed it as a way of preserving their future. There was also perceived misconceptions on the health benefits associated with removing the genitalia whereby one was not recognized or accepted if she has not undertaken what it requires to be part and parcel of the society. By undergoing the practice, one produced cognitive dissonance which heightened group interaction among initiates after the 'cut', and hence avoids social stigma.

The practice was also believed to act as a form of preservation of the girls' virginity whereby it attempted to control women's sexuality before marriage (Lodewijx *et al*, 2005), or so it was believed. It was also perceived to be a rite of passage into womanhood as it helped to preserve and maintain girls' status in the community since virgins were the source of pride to families and communities as it was viewed as a way of protecting their honor. Some communities were rooted with perceived religious justifications of FGM even though there are no documented records of religions that advocate for FGM. This is according to (Berg and Denison, 2013).

Sereya (2015) breaks down these reasons into psychosexual reasons that are majorly attributed to maintaining women's sexuality; sociological and cultural reasons such as those associated myths and misconceptions about FGM and seeking for social pressure; hygiene, and aesthetic reasons whereby the external female genitalia are considered dirty or ugly and are removed to promote hygiene and aesthetic appeal; rreligious reasons, though it is not regarded to have been endorsed by Islam or Christianity, religious doctrine is often used to justify the practice and social-economic factors.

Effects of FGM

FGM is associated with many health effects on the body and lives of women and girls who undergo such initiation including pain, bleeding, difficulty in passing urine, infection, death, and hemorrhage (Yasin *et al.*, 2011).

World Health Organization (2004) says that the long-term consequences of FGM are infibulation cysts, keloid scar formation, damage to the urethra resulting in urinary incontinence, pain during sexual intercourse, sexual dysfunction, and difficulty in childbirth, difficult menstrual periods, etc.

FGM has both short-term effects including severe pain, shock, hemorrhage, tetanus or infection, urine retention, ulceration of the genital region and injury to adjacent tissue, wound infection, urinary infection, fever and septicemia. The formation of cysts and abscesses, keloid scar formation, damage to the urethra resulting in urinary incontinence, dyspareunia (painful sexual intercourse) and sexual dysfunction, hypersensitivity of the genital area also is attributed from the practice. FGM is also associated with psychological effects on the lives of women such as negative self-esteem and self-identity. The psychological stress of the procedure may trigger behavioral disturbances in children and loss of trust. In the longer term, women may suffer feelings of anxiety and depression. Sexual dysfunction also can lead to marital conflicts and, in some marriages women are divorced (WHO, 1996).

From the anthropological and historical research to help people understand how FGM practice came about, although it is practiced in some communities in the belief that it is a religious requirement and research shows that FGM predates Islam and Christianity. Researchers have traced the practice to Egypt in the Fifth Century Before Christ. BC. It argues that the geographical distribution of FGM originated on the west coast of the Red Sea. Some anthropologists believe that FGM was practiced among Equatorial African herders. This was to protect young female herders from being raped (Lightfoot-Klein, 1983). Moreover, they used it as population control to ensure they lived in their preferred population. It is then presumed that FGM mainly originated in Africa thus answering the question as to why we have a high number of countries practicing it, 28 plus countries practicing it.

Initially, the practice was known as Female Circumcision (FC) until the 1980s when Missionary Council began to refer to it as 'Sexual Mutilation of Women' in 1929 after Marion Scott Stevenson (1871-1930), a Missionary from Scotland. In the 1970s the name Female Genital Mutilation was coined by Australian-American feminists from Hosken, Genital and Sexual Mutilation of females (Fee, 1980).

In 1990, the name started being used by the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children. Thereafter, World Health Organization (WHO) recommended it to the United Nations one year later in 1991. The terminology became a dominant terminology to differentiate the severity of the procedure from that of the male circumcision which involves the removal of the foreskin.

Myths and misconceptions about FGM

Female genital mutilation is widely discussed with a lot of myths and misconceptions. It generally involves the removal of the female genitals. One of the misconceptions is that it is believed to be carried out by medically trained people who are able to conduct it in a medically sound environment. However, it mainly is carried out by elders, traditional medicine men, or relatives. Whereas trained healthcare would involve the use of sterilized scalpels, traditional practitioners use unsterilized razor blades or a piece of glass is used. There

is therefore no use of anesthetic too. To stop the bleeding they end up using dust to top the bleeding causing more infections and complications.

Another misconception is that FGM occurs before adolescence so as to preserve a girl's "purity" and innocence and it is said to deprive them of sexual excitement in puberty. The girls however are not aware of why the procedure is carried out neither have a say in it (Robinson et al., 2022). In the ceremonies, they are provided gifts and celebrations the pain and agony during the cut is unbearable making the act traditional meaning futile, so that even when they get old enough young girls are not told what happens before it begins.

Religion is another misconception as one of the reasons most often raised in defense of FGM. The practice is often seen as a "Muslim practice". This could be explained by the fact that it is practiced by different Muslim communities. Nevertheless, not all Muslim communities carry out FGM and for example, Morocco, Algeria and Tunisia do not, while several non-Muslim communities, Christian do practice it. In Burkina Faso and Sierra Leone, for example where FGM is practiced by both Christian and Muslim communities. Ba (2018) says that FGM is a traditional practice which existed well before the arrival of monotheistic religions such as Islam. After people converted to these religions, certain traditions were integrated into religious practices and in the name of religion. Over time, tradition and religion were fused.

Studies have also revealed that FGM in Africa is broadly connected with social status and how girls and their families would be respected in the community. This is evidenced in Sierra Leone culture where it is strictly required to undergo FGM or else it will lead to social exclusion and being ousted from the society in general. In this regard, parents are left with no practical choice than to subject their daughters to this act in order to safeguard their images and that of their families. Therefore, the consent of these parents earns them the status of honorable members in the community and their families will be well recognized according to (Shakirat et al., 2020). This reflects the social stigma against the 'uncut' and those who do not support the practice.

Another misconception about FGM is that people who practice are 'barbaric' and 'irrational'. This is not necessarily true. To understand the practice, we should remember that it is not carried out as an isolated action. FGM is part of a complex web of ritual and daily practices of constructed gender roles linked to feminine and masculine status. In some communities, circumcision is an obligatory ritual in order for a girl to be considered an adult woman, a full member of her community and a potential candidate for marriage. When FGM is the norm within a community, its members can face heavy social pressure. Some aspects of the practice are diverse and vary from one context to another: respecting tradition, protecting virginity and women's fidelity, religious and obligation.

Some communities are convinced that FGM is hygienic and beneficial to health. These preconceived ideas can be explained by the vast lack of understanding of the clitoris and in general female sexual organs in many parts of the world, including Europe. The clitoris is perceived as a source of "sexual promiscuity", something that might continue to grow if it is not cut and it may be seen as damaging for the baby. The lack of clear understanding and knowledge around the consequences of FGM also further aggravates the misconception. That is why, according to the Mali culture, they are considered inept in many societal roles. To

quote a Malian man, “We call a woman who has not undergone FGM ‘*bilakoro muso*’. This means that even if she is a woman of a certain age, instead of being treated as an adult woman, she will be treated like a little girl”.

Many individuals trust FGM has nonmainstream roots, including people who help and sustain the activity; at the same time, its premise is prevalently social. There aren't any non-common scripts that recommend the training. In greatest social orders wherein FGM is rehearsed, social culture is an outflow of other worldly occupants commonly virginity and constancy. FGM is in many cases finished as a function of section and to make ladies more "eligible." This explains the stigma associated with those that may not have undergone it.

There are also arguments that FGM is just a woman model of male circumcision. However, there are a couple of key varieties While male circumcision is similarly easily proven wrong, it's miles certainly recommended with the guidance of certain religions and cultures, though FGM isn't. Also, male circumcision is the evacuation of skin, and not the intercourse organ itself as is done with the clitoris, and does not regularly cause the equivalent extensive-term wellness inconveniences to the individual.

There are perceptions that FGM diminishes the experience of sexual joy and that it protects ladies by keeping them from partaking in sex and that it frequently succeeds (Kelleher, 2019). The injury of slicing could likewise be thought process women to go without. However, sexual fulfillment after FGM isn't generally unrealistic, and numerous young ladies have said having the option to delight in sexual interest despite having gone through cutting.

These myths and misconceptions are summarized in a model by Mohammed et al (1999) that describes the various perceptions of FGM which culminate into a myth.

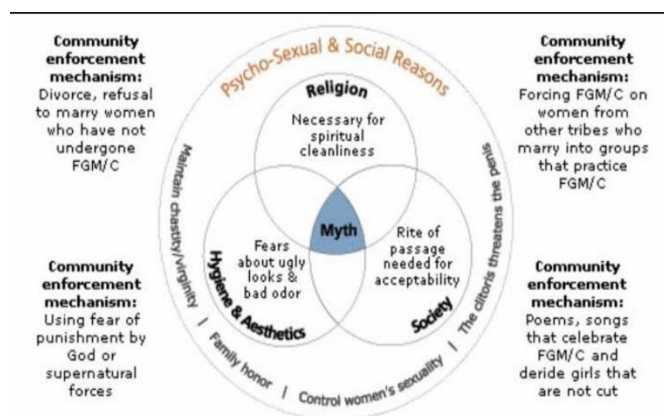


Figure 2: Perceptions about FGM (Adapted from Mohammed et al., 1999)

Global Progress in Elimination of FGM

In the last two decades, FGM prevalence rates have dropped by a quarter and the proportion of girls and women in high-prevalence countries who oppose the practice has doubled.⁷ However, in some countries FGM remains near universal or is as common today as it was even 30 years ago. For the global community to meet SDG target 5.3 by 2030, progress would need to be at least 10 times faster than it has been over the past 15 years.⁸ There are also alarming global trends that not only present significant barriers to the elimination of FGM by 2030 but

may also roll back progress to date. Rapid population growth in some of the world's least-developed countries with the highest FGM prevalence rates may increase the number of girls at risk of undergoing FGM from 4 million in 2020 to 4.6 million in 2030.

Even in countries where the practice of FGM has become less common, progress would need to be at least 10 times faster to meet the global target of elimination by 2030.

Opposition is building, propelling momentum to abandon FGM. In the last two decades, the proportion of girls and women in high prevalence countries who want the practice to stop has doubled

Role of UNICEF in anti-FGM

Within 22 countries across Africa and the Middle East, UNICEF is seen to support anti-FGM practice by ensuring girls are educated, empowered, healthy, and free from violence and discrimination. This organization therefore applies a multi-sectoral and holistic approach that supports the elimination of FGM by addressing the intersecting factors that are attributable to the continuance of the practice. Such factors like weak infrastructure, poverty, barriers to meaningful participation, and vulnerability to shocks and fragility in crises are said to be significant agencies for the practice. Away from contributing to meeting SDG target 5.3, through ending FGM advances the UNICEF Strategic Plan, 2018– 2021, in its Key Result Area 3: on “Every child is protected from violence and exploitation” is also able to give this agenda prominence and a platform for attention and support.

Additionally, since 2008, UNICEF, in collaboration with the United Nations Population Fund (UNFPA), has also been implementing the world's largest programme on FGM elimination in 17 countries through what they refer to as the '*Joint Programme on the Elimination of Female Genital Mutilation: Accelerating Change.*' This Programme supports the development of enabling policies and legal frameworks, access to essential services, girls' and women's empowerment, and community-led social and gender norms change.

Similarly, another approach dubbed '*Communication for Development (C4D)*' acknowledges that communication could challenge discriminatory social and gender norms and support the elimination of FGM. The UNICEF C4D approach for ending FGM which includes organized diffusion or peer-to-peer influence, community dialogues and theatre; mass media such as radio and television; and digital tools such as U-Report and use of social media.

UNICEF also uses social norms marketing and 'edutainment' to reach large numbers of people at relatively low cost, which is suitable for modelling and promoting new social norms in ways that resonate with target audiences, promoting the benefits of new norms such as keeping girls intact, changing attitudes towards harmful practices at scale, and amplifying stories of change.

In Kenya, the Anti-Female Genital Mutilation Board is a semi-autonomous government agency that was established in December 2013 following the enactment of the Prohibition of Female Genital Mutilation Act, 2011. It is in the Ministry of Public and Gender Affairs. Through the Agency, a National Anti-FGM policy was launched by the President in 2019.

Theoretical Framework*Social Exchange Theory*

The exchange theory was developed and discussed by among others Blau (1960); Emerson (1962); Homans (1961) through their view of society as composed of social activity based on social exchange (reciprocity) and integration in small groups. Blau (1977) social structure consisted of the networks of social relations that organize patterns of interaction across different social positions. Thus, the “parts” of social structure are classes of people like men and women, rich and poor. In Blau’s view, to speak of social structure is to speak of differentiation among people. By a socially relevant distinction, Blau means a social distinction along some distinguishable social characteristic (age, race, sex, religion, ethnicity, etc.) which comes to determine who interacts with whom; this is the macro perspective of the theory. For instance; if there are distinguishable differences between two communities then there is ales extent level of interaction between the two communities. There are also individual level attributes related to the theory which implies that people calculate the likely costs and benefits of any action before deciding what to do. This theory focuses on the costs and benefits which people obtain in social interaction, including money, goods, and status. It is based on the principle that people always act to maximize benefit. However, to receive benefits, there must always be an exchange process with others (Marcus & Ducklin, 1998).

The social exchange theory emphasizes the idea that, in relatively free societies, social action is the result of personal choice between optimal benefits and costs. The theory is largely associated with the Rational Choice Theory largely applied to economics. This theory assumes that individuals will operate in rational way and will seek to benefit themselves in the life choices they make (ibid). Social Exchange theorists argue that that all human relationships are formed by the use of a subjective cost-benefit analysis and the comparison of alternatives. For example, when a person perceives the costs of a relationship as outweighing the perceived benefits, then the theory predicts that the person will choose to leave the relationship. The theory has roots in economics, psychology and sociology (Emerson, 1962). Relating the social exchange perspective to FGM can be observed when individuals opt to undergo the practice. This choice is influenced on the perceived benefits that the practice may have for the individual. According to MYWO (2009) some women opt to be cut despite their education. Some girls who come from communities which do not circumcise embrace the cut in order to avoid losing potential husbands from circumcising communities. For instance, although there is legislation against the practice of FGM, it has been critiqued as having no implication towards women willingly undergoing the practice. The social exchange theory promotes the idea that interaction is guided by what each person stands to gain and lose from others. 27 The practice of FGM of these women whom regard it as an important element of their being has a negative impact to efforts to eradicate the practice among the Kisii. Also, this scenario gives room to circumcised women to exercise very strong peer pressure on girls who have not been cut.

Structural - Functionalist Perspective

The structural-functional approach is a framework for building theory that sees society as a complex system whose parts work together to promote solidarity and stability. As its name suggests; the approach points to the importance of social structure - any relatively stable pattern of social behavior. Social structure gives our lives shape in families the workplace, or the college classroom. Secondly the approach looks for any structure’s social functions, the

consequences of any social pattern for the operation of society as a whole. The structural-functional approach owes much to Auguste Comte, who pointed out the need for social integration during a time of rapid change. Emile Durkheim, who helped establish sociology in French universities, also based his work on this view. A third structural-functional pioneer was the English sociologist Herbert Spencer (1820–1903).

Spencer (1896) compared society to the human body; just as the structural parts of the human body - the skeleton, muscles, and various internal organs - function together to help the entire organism survive, social structures work together to preserve society. The structural-functional approach, then, leads sociologists to identify various structures of society and investigate their functions. Merton (1957) expands our understanding of social function by pointing out that any social structure probably has many functions, some more obvious than others. He distinguishes between manifest functions, the recognized and intended consequences of any social pattern, and latent functions, the unrecognized and unintended consequences of any social pattern.

Functionalists view social institutions as working in a systematic and coherent manner to sustain and reproduce them. Cultures presents a way of holding society together through sharing of socially accepted customs, values, norms, beliefs and views of the world which in turn influence human behavior. Social structures such as customs and practices have significant contribution to community solidarity but may also contribute negatively to society. The practice of FGM should therefore be understood from the context of social norms including how these norms shape and normalize behavior. Norms are learnt and reinforced through everyday social interaction, at the same time shape and influence behavior (Berger & Luckmann, 1967) in this way the control of the sexuality of women and their bodies is normalized. FGM among the Kisii is considered an important rite of passage from girl to a respected woman; a circumcised woman is considered mature, obedient and aware of her role in the family and in the society, characteristics that are highly valued in the community. However, FGM causes bodily harm and consequent health complication during child birth which are its negative consequences; which Merton (1957) refers to as dysfunctions.

FGM is generally practiced as a matter of social convention, and is interlinked with social acceptance, peer pressure; the fear of not having access to resources and opportunities as a young woman and to secure prospects of marriage (UNICEF, 2007; 2010). This social convention is connected to different concrete socio-cultural perceptions, most of which are linked to local perceptions of gender, sexuality and religion.

Functionalist's view of social problems also contributes positively to the identified social problems. For instance FGM practice calls for more affirmative action towards efforts towards the abandonment of the practice. FGM concerns have led to a critical focus on the reproductive health of women and girls around the world and in Kenya with FGM taking a lead role as an indicator of health development and improvements in line with the Millennium Development Goals.

As such efforts towards the abandonment of FGM practices require that socio-cultural context of the practicing community be incorporated into these approaches. Dilley (1999) provides a strong basis for the interpretation of the persuasive and the persistence patterns

visible in the practicing societies and that social and cultural phenomena must be interpreted within a given context in order to achieve significant results. Governments, development partners and non-governmental organizations should therefore be sensitive to the significance of FGM to practicing communities and involve community stakeholders in educating and raising awareness on the implications of FGM on the overall development of women in society. This social interaction would lead to a more effective acceptance of abandonment approaches among practicing communities.

Feminist Theory

Tong (1989) explains that feminist theory is not one, but many, theories or perspectives and that each feminist theory or perspective attempts to describe women's oppression, to explain its causes and consequences, and to prescribe strategies for women's liberation. Feminist theory treats the experiences of women as the starting point in all sociological investigations, seeing the world from the vantage point of women in the social world and seeking to promote a better world for women and for humankind. Madoo-Lengermann and Niebrugge-Brantley (2004) explain that feminist theory was established as a new sociological perspective in the 1970s, due in large part to the growing presence of women in the discipline and the strength of the women's movement. Although sociologists in this perspective may adopt a conflict, functionalist, or interactionist's perspective, their focus remains on how men and women are situated in society, not just differently but also unequally. As such the feminist approach is centered on making an impact in today's societal problems such as FGM practice.

WHO Reproductive Health Research (RHR) indicates the persistence of FGM as associated with the desire to control the sexuality of women as the motivating factor of practicing communities. There was a perception that it was necessary to cut the clitoris of young girls, as this was seen as the site of sexual desire, and removal of the clitoris was therefore expected to reduce women's sexual desire, and thereby improve their ability to comply with local sexual norms that generally emphasize premarital virginity, marital fidelity and sexual modesty.

In the WHO RHR study, an overall focus on the importance of sexual pleasure for the man, rather than the woman, was identified. For example, for those men in Egypt who expressed concern that FGM might reduce women's sexual pleasure, their key concern was on the negative effect that could have on their own sexual pleasure. On the contrary Women with FGM were found to be 1.5 times more likely to experience pain during sexual intercourse, experience significantly less sexual satisfaction and they were twice as likely to report that they did not experience sexual desire. This highlights the concern of feminist theories where patriarchal society is the basis of social problems. Patriarchy refers to a society in which men dominate women and justify their domination through devaluation (Kaplan, 1994).

The feminist theory also contributes to the present study in reference to the interviewer and interviewee interaction. FGM is a highly gender sensitive practice and although there is no specific research method to feminist research (Burns & Walker, 2005). Oakley (1981) suggests the meeting of the uninvolved interviewer did not stand in the scrutiny of women's lives. Women's voices are heard in research, when 'the relationship of interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her own personal identity in the relationship'. In relation to the present study the researcher is from the Kisii community and female and this would play a significant role in the data gathering process among respondents (Oakley, 1981).

Research Findings and Discussions

Findings from Content analysis and Discussions

According to research by Action Aid Kenya 2020, only a handful of girls voluntarily present themselves for the cut. This means that majority of the women/girls are forced to be initiated. Terms used to refer to uncircumcised people such as "kirigu" in the Mt Kenya region are deeply derogatory and stigmatizing. Others condemn the girls as unworthy of people sharing close moments with (Simister, 2018). This demonstrates the level of stigma associated with one not undertaking the 'cut' and goes explain the limited knowledge relating to this practice. As the rite of passage is associated to rituals into womanhood according to Coexist (2012) thus necessary for girls to go through in order to become a responsible adult member of the society. To those communities where FGM is performed as rite of passage into adulthood girls are cut at around the age of puberty (Population Council, 2007). They therefore do not believe that one can become responsible until undergoing the rite yet we are aware that FGM cannot stand as a measure of responsiveness of a person. This is usually personal attribute. Low income and minimal education in most of the communities in Kenya influences the girls towards the engagement in (FGM Survey, 2008). And where poverty is high, the people tend to abide too much in traditions. Due to minimal education, the community also tends not to be aware of the negative effects of the FGM.

Stigmatization and discrimination of girls who are not cut drives them to the practice, according to a UNICEF report of 2013 about Kenyan communities. They do desire to have marriage partners and for bride prices to be paid to their families as undergoing the practice make them eligible and if they do not undergo it, no man would desire to marry them. The girls also do not wish to besmirch the family 'honor' if they fail to undergo the practice. According to UNICEF (2013), factors such as hygiene, social acceptance, marriageability, preservation of virginity and fidelity, reduction of female sexual desires and enhancement of male sexual pleasure may play a major role in influencing the girls to engage in FGM.

The practice is considered to be rooted in male dominated societies that have attempted to subjugate women and repress their sexuality. As the community wish to preserve culture from generation to generation, women become perpetrators of the practice as they push girls to the practice so as to initiate them into the community traditions.

In parts of Kenya where majority of people are educated, they have realized that the practice violates a person's right to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment and the right to life when the procedure results to death (UNIFA, 2005) Since the FGM has no health benefits but rather harms girls

and women by involving the removal and damaging healthy and normal female genital tissues, and interfering with the natural functioning of their bodies. Researches by UNICEF have spelt out how FGM affects the girls' performance in education in one way or another within the communities that practice FGM in Kenya. And although initiation marks the passage from childhood to adulthood (Embu Report, 2008), school authorities continue to treat initiated girls who return to school as children. They expect them to participate in certain activities and punish them in a manner which is considered inappropriate for 'adults'. Some parents are ready and willing to cover the cost of initiation than to cover formal schooling costs and expenses, a situation that also contributes to the girls' poor performance in school (Onsomu et al,2005) Though the circumcision ceremonies are scheduled during school holidays, the process begins earlier, leading to absenteeism from school Participants described the historic meaning of, and reasons for, FGM for families and communities.

While carrying out a study in Meru County, Mwendwa et al (2020) observed that there was widespread agreement among participants and across FGs on how the meaning and purpose of FGM primarily related to a girl's suitability for marriage, and through taking part in this traditional rite of passage, a girl could be prepared and educated about how to take care of her husband and family. There was also a perception that having a child would be more challenging for uncircumcised woman, and that circumcision would make conceiving a child more likely.

Through the provisions of the National Policy for the Eradication of FGM in Kenya identify and summarize from research, the key drivers to the practice as being:

Rites of Passage whereby communities that regard FGM as a rite of passage from childhood to womanhood, perpetuate it for marriageability purposes. In these communities, a girl is viewed as a woman once subjected to FGM. Adulthood is not only determined by biological age but by the rite of passage. The girls are married off soon after.

Religious Beliefs and Culture whereby the practice is deeply rooted in the religious beliefs and culture of the communities. The cutting of girls and women is seen as a religious requirement by the Somali, the Samburu and the Maasai.

Social Norms and Behaviour whereby the reasons for performing FGM vary from community to community. FGM is perpetuated for family pride, prestige, community acceptance, marriageability and inclusion among other factors. Rejecting FGM has social, cultural, economic and political consequences including stigmatization and discrimination. FGM is also considered a cultural identifier among the practicing communities distinguishing their daughters from neighbouring communities who do not circumcise girls and women. The cutting of girls remains a norm in practicing communities to the extent that there is acceptance for continuation and support for the practice. *Economic and Monetary gains* whereby FGM practice brings monetary gains for the circumcisers, elders and bride price for the girls' family.

Survey Findings and Discussions

To further compliment content analysis around the subject in Kenya the researchers a survey tool was administered to practitioners in the field of FGM across Kenya. One hundred and twenty-four (124) respondents of whom seventy-four (74) were male and fifty (50) were female gave feedback on their level of FGM practices in Kenya. They were drawn from

government agencies, community leaders and anti-FGM ambassadors who were mainly drawn from Embu County. They were of mixed religious backgrounds and varied age-groups, most of whom were married.

Most of them attested that they got regular information on FGM practice in Kenya by use of social media since Kenya has a wide internet coverage that is reliable and most people can afford a smartphone through which they can access social media. This therefore means that as a demystification strategy, the use of social media could be appropriate.

Majority of the respondents also confirmed that information on FGM was available on mass media platforms such as TV, Radio and Newspapers. These mass media platforms are also widespread across Kenya with some of them being vernacular radio and TV stations that give attention to community practices and social interventions. In some instances, traditional ceremonies are broadcasted. This was an indicator that such platforms play and could play a significant role in conveying messages around FGM practice. It therefore confirms that the practice is still prevalent and measures to curb it were actively being followed with some positive results and which is in agreement with the UNICEF report of 2020.

The research findings also indicated that information on FGM was passed orally through friends, area administrators, public gatherings, religious and through cultural ceremonies. This therefore suggests that most of this information is not documented and is only passed to those who must know about the practice. This could explain why most of the activities around the practice are shrouded in mystery and equally accounts for the high level of misinformation around this traditional custom. Such a culture significantly contributes to the practice since communities' device a mechanism of 'operating underground' to ensure adherence to their cultural norms while avoiding the anti-FGM agents within the society.

The majority respondents also confirmed that there exists minimal community dialogue that allows for interactive discussions, exchanging and sharing experiences on FGM. It suggests therefore that the practice is limited to only the participants and unless one is playing a key role then information about the practice is not easily accessible. It goes to mean that one needs to appreciate the practice to be in the know of the various activities relating to its practice.

Most of the respondents said that they didn't know the number of girls in the community who had undergone FGM nor were they aware of the people who practice FGM in the community. Most respondents also indicated that they were not aware of the anti-FGM ambassadors. This suggests that the practice was clandestine to a large extent and information on the practice was shared discreetly. It also indicates that the presence of the anti-FGM ambassadors was not being felt probably because of the sensitivity of the subject and the social stigma associated with it.

The respondents also confirmed that there was social stigma amongst the girls and women who had not had the 'cut' particularly by their peers who considered them uninitiated and felt not worthy in the social set-up. This in itself promotes the practice quietly among the communities that practice since community conformity is a virtue in many African societies.

Conclusion and Recommendations

From the findings, it can be observed that information on FGM practices is hardly shared by the communities that practice it and hence the myths and misconceptions about it. It is recommended that the anti-FGM intervention strategies could involve approaches that would tap into the details of this practice by way of assessing the actual benefits realized with a view of separating the 'cut' from those constructive traditional rites of passage associated with it.

The findings also attest that the practice is still prevalent and stigmatizing the 'uncut' only goes to intensify the practice amongst the practicing communities. There is therefore need for the anti-FGM strategists to de-stigmatize this practice using community-friendly approaches that positively address the concerns raised by the FGM practitioners against stopping the 'cut'.

From the study, it becomes apparent that information around this cultural practice is still scanty. What is known is mostly the negative attributes of the practice. Very few social scientists have delved into the possible positive reasons for widespread and persistent practice despite the global and local interventions to curb it. The researchers therefore recommend that a study on these possible socially positive activities associated with the practice be carried out to inform an all-inclusive approach towards eradicating 'the cut' that is perceived as negative.

References

- Abusharaf, R. M. (2000) Revisiting Feminist Discourses on Infibulation: Responses from Sudanese feminists, in Shell-Duncan and Hedlund (ed.), *Female 'Circumcision' in Africa* Amnesty International Vlaanderen. (2004). *Vrouwelijke Genitale Verminking*, Factsheet. Available online: https://www.aivl.be/sites/default/files/bijlagen/Vrouwelijke_Genitale_Verminking_versiejul08.pdf
- Barnawi, N. A. (2018). *The Effects of a Digital Educational Intervention On Undergraduate Nursing Students' Attitudes, Knowledge and Self-Efficacy with Female Genital Cutting*. State University of New York at Binghamton.
- Berg, R. C., & Denison, E. (2013). A tradition in transition: factors perpetuating and hindering the continuance of female genital mutilation/cutting (FGM/C) summarized in a systematic review. *Health Care for Women International*, 34(10), 837–859.
- Berg, R. C., Denison, E. M.-L., & Fretheim, A. (2010). *Factors promoting and hindering the practice of female genital mutilation/cutting (FGM/C)*. Norwegian Knowledge Centre for the Health Services.
- Loloju, B. F. M. (n.d.). Understanding the Kenya prohibition of female genital mutilation act, 2011. *Understanding the Kenya Prohibition of Female Genital Mutilation Act, 2011*, 2, 20.
- Fee, E. (1980). *The Hosken report: Genital and sexual mutilation of females*. JSTOR.
- Isman, E., Warsame, M. A., Johansson, A., Fried, S., & Berggren, V. (2013). Midwives' experiences in providing care and counselling to women with female genital mutilation (FGM) related problems. *Obstetrics and Gynecology International*, 2013.
- Kakela, E. (2020). *Rethinking female genital cutting: from culturalist to structuralist framework for challenging violence against women*.

- Kandala, N.-B., Kinyoki, D., Sarki, A., Gathara, D., Komba, P., & Shell-Duncan, B. (2017). *Modeling and mapping of girls' female genital mutilation/cutting (FGM/C) in the context of economic, social, and regional disparities: Kenya Demographic and Health Surveys 1998-2014*.
- Kenya News Agency. (2018). *No Title. FGM*.
- Kenya Bureau of Statistics-Government of Kenya. Demographic and Health Survey 2014. Rockfield, MD USA 2016 <https://dhsprogram.com/publications/publication-fr308-dhs-final-reportscfm> Accessed 11 May 2022.
- KNBS. (2019). *Kenya population and housing census volume 1: population by county and sub-county*.
- Lightfoot-Klein, H. (1983). Pharaonic circumcision of females in the Sudan. *Med. & L.*, 2, 353.
- Matanda, D., & Kabiru, C. W. (2019). *Using Demographic and Health Surveys in the campaign to end FGM/C: A Kenyan example*.
- NeWS, K. (2020). *No Title. FGM and Child Marriages among the Communities*.
- O'Neill, S., Bader, D., Kraus, C., Godin, I., Abdulcadir, J., & Alexander, S. (2020). Rethinking the Anti-FGM Zero-Tolerance Policy: from Intellectual Concerns to Empirical Challenges. *Current Sexual Health Reports*, 1–10.
- Oloo, H., Wanjiru, M., & Newell-Jones, K. (2011). *Female Genital Mutilation Practices in Kenya: the role of alternative rites of passage. A case study of Kisii and Kuria districts*.
- Organization, W. H. (1996). *Female genital mutilation: report of a WHO technical working group, Geneva, 17-19 July 1995*. World Health Organization.
- Pinheiro, Y. A. N., Moore, Z., & Gathara, D. (2019). *Associations between FGM/C and HIV in Ethiopia, the Gambia, Kenya, and Sierra Leone: A limited analysis of Demographic and Health Survey data*.
- Republic of Kenya. (2019): National Policy for The Eradication of Female Genital Mutilation Towards a society free from harmful cultural practices
- Sereya, L. (2015). *The response of Maasai people in regard to initiatives to stop female genital cutting: a case study of Imbirikani group ranch*. University of Nairobi.
- UNICEF. (2020). *No Title. FGM, FGM prevalence. Yasin et al. 2011.pdf*. (n.d.).
- UNICEF. (2013). *Female Genital Mutilation /cutting: a statistical and exploration of the Dynamics of change*.
- Kenya National Bureau of Statistics, (2008). *Embu District Multiple Indicator Cluster Survey*.
- Population Council & Njue, C. (2004). *Medicalization of Female Genital Cutting among*