

FEMALE GENITAL MUTILATION AND WOMEN HEALTH;
A CASE STUDY OF KAPCHORWA DISTRICT

BY

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DECLARATION

I, Araptai Baba Louis, do hereby declare that the work in this report was my own piece of work and has never been submitted for any award of publication in any university or institution of higher learning.

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Sign.

.....

Date

APPROVAL

This is to certify that, this report entitled, “Female Genital Mutilation and women health in Kapchorwa district” was done by Araptai Baba Louis under my supervision and has been submitted for examination with my approval as the institute supervisor.

.....

Sign.

Dr. Arinaitwe Julius

.....

Date

DEDICATION

This Research report is dedicated to my beloved father Mr Chemusto Milton, my mother Eva Chemusto, my sisters; Nabuduwa Juliet, Yamusobo Joan and Yariwo Araminta, not forgetting my only blood brother Chemonges Vincent and my uncle dad Fundi Fred Fahad for their assistance both morally and financially.

I also in a special way dedicate my work to my supervisor; Dr Arinaitwe Julius and my dear friends; Asio Esther, Ilukut David Patrick, Amisi Morris, Abiara Emmanuel, Otau Steven Victor, Baluku Sharif and Amumpaire Ronald for their continuous advice, encouragement and financial assistance.

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I thank you all very much.

LIST OF ACRONYMS

FGM - Female genital mutilation

FGC - Female genital cutting

WHO - World Health organization

HIV - Human immune Virus

AIDS - Acquired immune defficiency syndrome

NHS - National health service

PTSD - Post- traumatic stress disorder

TWWP - Tharaka women's welfare program

UK - United kingdom

UNICEF - United Nations Children's Fund

ABSTRACT

The study assessed the impacts of FGM on women psychological and social health in Kapchorwa district Uganda. The study was guided by four objectives namely; to assess the drivers of FGM in kapchorwa district, to find out the unsafe practice of FGM on women in kapchorwa district, to find out the ways to substitute FGM in kapchorwa district and to determine the relationship between FGM and women psychological and social health in Kapchorwa district. The study used descriptive survey research design which applied both qualitative and quantitative approaches. The questionnaires and interviews were also used to support data collection.

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CHAPTER ONE:

GENERAL INTRODUCTION

1.0 Introduction

This chapter covered the background of the study on Female Genital Mutilation and women health, the statement of the problem, the objectives of the study, definitions of key terms and the conceptual frame work.

1.1 Background of the study

Though the exact reason for the origin of Female Genital Mutilation (FGM) or Female Genital Cutting (FGC) is unknown due to the dearth of conclusive evidences, multiple theories revolve around how the practice began. FGM precedes both the start of Islam and Christianity and is practiced predominantly because of cultural traditions. FGM is not limited to a single community, religion or ethnicity (Debangana, 2018).

Female circumcision has existed for over 4,000-5,000 years originating in a period predating God's covenant with Abraham to circumcise his people. It began in Egypt and was frequently performed by the ancient cultures of the Phoenicians, Hittites, and the ancient Egyptians. Those people had the idea that was based on the belief that, the foreskin was the feminine part of the males and the clitoris was the masculine part of a woman. (Tanui 2006, 20.) According to Inungu and Tou (2013), the practice is believed to have originated in Egypt where circumcised and infibulated mummies were found. Gradually, it spread around the contiguous areas of the Red Sea coast among the tribes through the Arabian traders.

FGM is believed to first have spread in the form of infibulation, clitoridectomy increasingly became the more acceptable form of FGC. During the Pharaonic era, the Egyptians believed in gods having bisexual features. (Lightfoot Klein 2010)

Boyle (2002), recounts that these bisexual features were believed to reflect upon the mortals, with women's clitoris representing the masculine soul and men's prepuce that of the feminine soul. Thus, circumcision was considered to be a marker of womanhood and a way to detach from her masculine soul. As it became a socio-cultural norm, FGM became the utmost criteria for women's marriage, inheritance of property and social acceptance in ancient Egypt.

Population control was also one of the driving forces behind the practice as by controlling a woman's sexuality, it kept the woman's desires in check and made her sexually modest. Due to the narrowing of the vaginal orifice through infibulation, women would experience excruciating pain during sexual intercourse and thus, it becomes an effective measure to hinder premarital sex among women and ensure their fidelity. In fact, in places like Darfur, sudden desertification of arable lands made infibulation one of the population control measures were in high demand due to the lessening possibilities that they would become impregnated. But after the arrival of Islam in the region, a strict prohibition towards enslaving other Muslims allowed the practice to get extended to other parts of Africa when the slave traders introduced infibulation among the non-Muslims to raise women's value as slaves. This not only explains the introduction of FGC among North-African communities, but also explicates the coincidence of its spread in Africa simultaneous. In some cases, the practice has also sought its validation through Islamic scriptures. Doraine Coleman (2013), suggests that one of the hadiths in Islam is thought to permit a limited form of cutting, though the hadith is also contested for being deficient of its genealogical authenticity. Despite the Prophet being explicit about sunna (tradition) on male genitals, FGM's existence within Islam remains debatable. The practice was believed to be introduced in the South East Asian countries at around approximately 13th century, supposedly due to the reasons of Islamic conversion process after the change in regime. The predominant Shafi school of Sunni Islam in Indonesia and Malaysia justifies FGM as an Islamic practice and is culturally influenced by the Eastern part of the Arabian Peninsula, the region where presently Yemen and Oman are situated. The justification for the practice in these countries comes as they prescribe 'nicking' of the outer clitoral skin without really injuring the female genitals. In fact, this explains the burgeoning medicalization of the practice in these two countries. In Singapore, the practice prevails due to the regional influence of Shafi Islam on the one hand and a few practicing ethnic Malay population on the other. The practice is rife among the Kuria, Kikuyu, Masai and Pokot people in Kenya, Zaramos in Tanzania, Dogon and Bambara people in Mali to name a few. Scholars have also indicated the income-generating facet of the practice in the face of unavailability of alternative livelihoods for the individual circumcisers.(Lightfoot-Klein,2010)

Though immigration due to slave exportation and other reasons is considered to be one of the predominant forces behind the spread of FGM in the West, Amede Obiora (2013),claims that it

was also performed on western women, especially in the United States, even in the 1950s as a cure to ‘unnatural female sexual behavior’ that ranges from homosexuality, female masturbation to depression. References to ‘genital altercations’ in the Western countries are also unfamiliar.

Boyle (2002), suggests that the Egyptian practice of FGM and slavery can be correlated for providing an explanation of its origin. Before the advent of Islam, Egyptian rulers expanded their kingdom towards the southern region in search for slaves. As a result, Sudanic slaves were taken to Egypt and the areas nearby. Incidentally, slavery became commonplace with its aim to deliver servants and concubines to the Arabic world. As a result, women with stitched vaginas.

Although religion, aesthetics and social culture have been identified as features which contribute to the practice, FGM remains primarily a cultural rather than a religious practice, occurring across different religious groups. FGM is not sanctioned by any religious texts. Although in some communities, religious interpretations have been used to justify the practice. Hygiene and aesthetics are frequently quoted as factors supporting FGM, often underpinned by beliefs that female genitalia are ugly, have a bad odour and can be made more beautiful by FGM.

As a whole, the practice has transformed and evolved dynamically since its origin. FGM through the course of its evolution came up with multiple facets and spread across cultures and geographic regions with various manifestations, meanings and narratives being attached to it. Tracing its origins, thus, not only helps in understanding its nuances but also minimizes the tendency towards its homogenization.

In Countries like Somalia, Kenya, Tanzania and Uganda, FGM operates as a social norm stemming from gender inequality. The cultural anxiety over the loss of virginity or pregnancy before marriage for girls encourages the practice of FGM by communities as an effective sexual control measure. It is linked with the assurance of girls’ or women’s social status, chastity or marriageability. In practicing communities, there is a collective negative image of girls and women who have not undergone FGM. They are considered “not marriable” and suffer from stigma, with exclusion from social functions and mockeries from both men and women. This compels some of them to endure the pain of the “knife”.

The myth of how female genital mutilation (FGM) began among the Igembi people of Kenya is that many years ago, the Igembi went to war over their stolen cattle and goats, and all the men, except for the young boys, were gone from the village. When they came back, they found all the women pregnant. Men decided to punish the women for their mistake and prevent them from having further sexual desires, the practice of FGM then started. When the girls undergo FGM in the Igembi society, they make a vow with their blood that they will continue this tradition or bring down a curse upon their families and land. (Tanui 2006, 17.) FGM appears as a cultural practice perpetuated by ancestors and linked with girls' passage to womanhood. Hence, it is often practiced through ceremony of rite of passage. (Armelle et al, 2018).

During the whole process of the rite, one got to know the deeper culture of the society and the society's rituals and secrets. Without circumcision, an individual was seen as a child no matter how old she could be. The female passage of rite (circumcision) was the only way the youth could be fully accepted, but the uncircumcised were seen innocent as children who were not supposed to know the deeper secrets of the society until they were circumcised. They could not even enter into a business deal with any party, as elders or parents could render this null and void on the spot. Where could uncircumcised lodge a case against a circumcised member of the society pertaining to the common disciplinary issues usually punishable by good flocking? It could not matter even if the master administering the disciplinary action was relatively younger than the complainant.

FGM is deeply embedded in society, and its elimination requires a clear understanding of the cultural perceptions and beliefs it feeds on. The practice takes place without the administration of anesthetics and under very unhygienic conditions. Mixtures of local herbs, earth, cow dung, ash or butter are used to treat the wound. The reported immediate complications were excessive bleeding at the time of the procedure, difficulty with urination, and shock during the procedure ulceration of the genital region and injury to adjacent tissue. Fibrosis, keloids, synechia, and clitoral neuroma are consequences of FGM.

Despite the banning of the practice within countries, its eradication is still a problem as the practice merely gets hidden from the eyes of the public and continues quietly.

1.2 STATEMENT OF THE PROBLEM

The problem seeks to find out the impact of FGM on women psychological and social health in Kapchorwa district.

1.3 OBJECTIVES OF THE STUDY

1.3.1 Major objective

To investigate the impacts of FGM on women psychological and social health in Kapchorwa district.

1.3.2 Specific objectives

1.3.2.1 To assess the drivers of FGM in Kapchorwa district.

1.3.2.2 To find out the unsafe practice of FGM on women in Kapchorwa district.

1.3.2.3 To find out ways to substitute FGM in Kapchorwa district.

1.3.2.4 To determine the relationship between FGM and women psychological and social health in Kapchorwa district.

1.4 RESEARCH QUESTIONS

1.4.1 What are some of the drivers of FGM in Kapchorwa district?

1.4.2 Why is FGM practice unsafe for women in Kapchorwa district?

1.4.3 Are there any ways of substituting for FGM in Kapchorwa district?

1.4.4 Is there any relationship between FGM and women psychological and social health in Kapchorwa district?

1.5 SCOPE OF THE STUDY

1.5.1 Content scope

The study provided content on the impact of FGM on psychological and social health of women in Kapchorwa district, the drivers of FGM in Kapchorwa district, the unsafe practice of FGM on women in Kapchorwa district, finding ways to substitute FGM in Kapchorwa district and the relationship between FGM and women psychological and social health in Kapchorwa district.

1.5.2 Time scope

The researcher intended to carry out the study within a period of two months between December 2021 and January 2022.

1.5.3 Geographical scope

The research was carried out in Kapchorwa district, in Sebei sub-region. Kapchorwa district which is located in the Eastern part of Uganda. It is bordered by Kween District to the northeast and east, Sironko District to the south, and Bulambuli District to the west and northeast.

1.6 SIGNIFICANCE OF THE STUDY

1.6.1 The study offered practical training experience to the researcher which helped in meeting the academic requirements for the award of Bachelor of Science with education.

1.6.2 The study generated new knowledge and information which was useful to the local leaders, clan leaders and policy makers on the impact of FGM on psychological and social health of women in Kapchorwa district.

1.6.3 The findings of the study enabled the governments of Kapchorwa district, Uganda and the whole world in dealing with FGM in order to improve women health.

1.7 JUSTIFICATION OF THE STUDY

The researcher decided to carry out the study on FGM and women health in Kapchorwa district because Kapchorwa district is part of the world where FGM has been taking place and as of to date FGM is still practiced. Therefore the emphasis on FGM and women health was to ensure that the local leaders, clan leaders and policy makers sensitized the community on the harmful impacts of practicing FGM.

1.8 DEFINITION OF KEY TERMS

1.8.1 Female genital mutilation (FGM):

Female genital mutilation refers to all procedures involving partial or total removal of the female external genitalia or causing other injuries to the female genital organs for non-medical reasons. (World Health Organization, WHO, 1997).

1.8.2 Women health:

Women health refers to the branch of medicine that focuses on the treatment and diagnosis of diseases, disorders and conditions that affect a woman's physical and emotional well-being. Information on Women health includes a wide range of focus areas, such as: Birth control, sexually transmitted infections (STIs), gynecology, Pregnancy, childbirth, Sexual health and other conditions affecting the function of the female reproductive organs.

1.8.3 Psychological health:

Psychological health is "a mental state of well-being" in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. Psychological health includes; an individual's ability to enjoy life and to create a balance between life activities and efforts to achieve psychological resilience.

1.8.4 Social health:

Social health can be defined as a person's ability to interact and form meaningful relationships with others in the community. It also relates to how comfortably we can adapt to social situations. Social relationships have an impact on our mental health, physical health and mortality risk.

1.9 THE CONCEPTUAL FRAME WORK

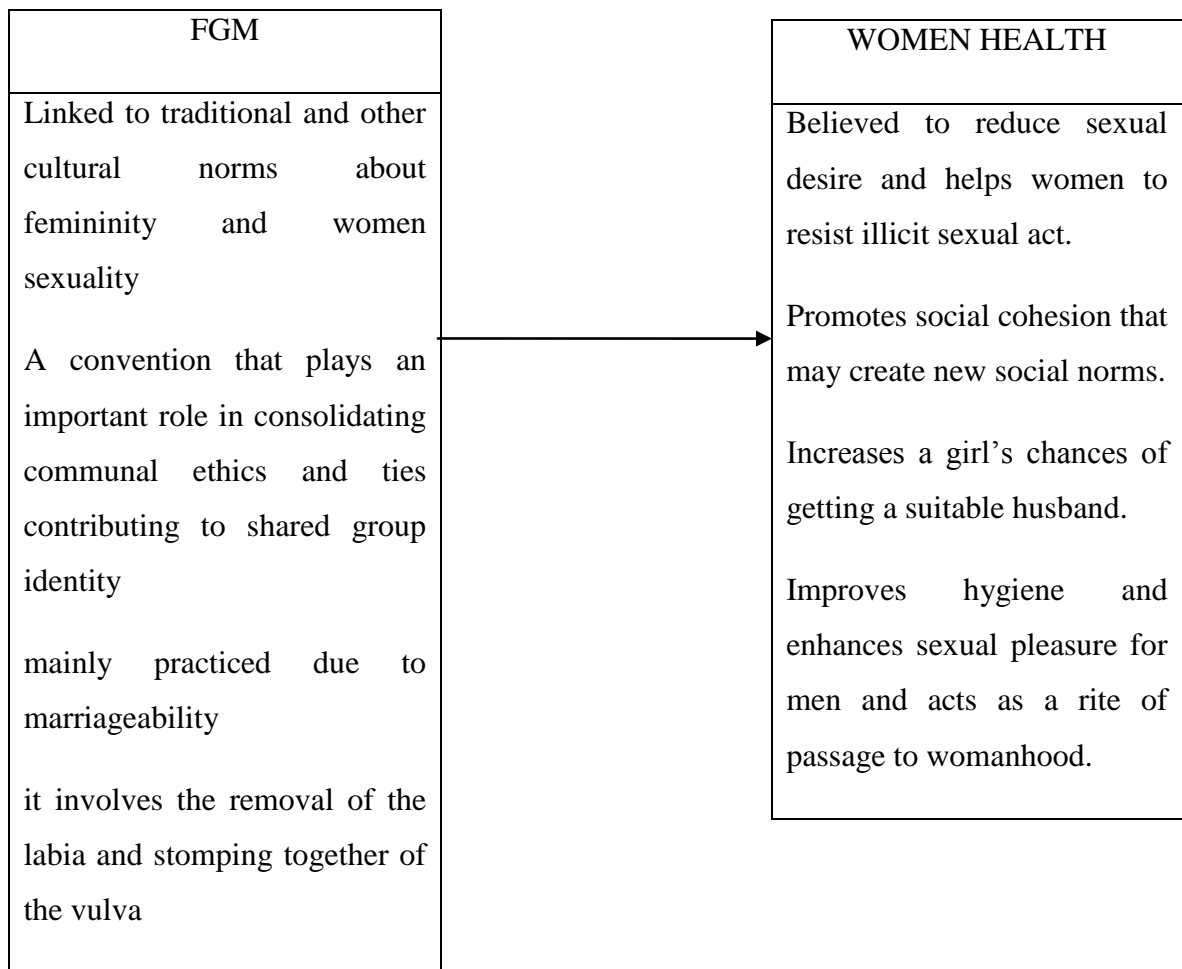


Figure 1: A conceptual framework for the relationship between FGM and women health.

————→ This shows that there is a relationship between FGM and women health.

The relationship in figure 1 was drawn from the definitions of the independent and the dependent variables according to the different scholars as stipulated in the background of the study in the same chapter. The independent variable is FGM and the dependent variable is women health.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter covered the related literature on female genital mutilation and women health in kapchorwa district, the drivers of FGM in Kapchorwa district, the unsafe practice of FGM on women in Kapchorwa district, the ways to substitute FGM in Kapchorwa district, the relationship between FGM and women psychological and social health in Kapchorwa district and the gaps in the study that the researcher intended to fill.

2.1 FEMALE GENITAL MUTILATION

According Yirga W.s, Et Al (2012).Female circumcision (FC) or female genital mutilation (FGM) describes practices that manipulate, alter, or remove the external genital organs in young girls and women. The procedure is performed using a blade or shard of glass by a religious leader, town elder, or a medical professional with limited training. In about 15% of cases, infibulation, the most severe form of FGM, involves the removal of the labia and the suturing together of the vulva; this practice may place the victim's life at risk.

In contrast to male circumcision, the procedure of FGM produces no know health benefits and is not performed for medical reasons. FGM is widely recognized as a procedure that violates a person's human rights, as well as increasing their risk for health complications (Donohoe.M, 2006).

Odemarho B.I \$ Baier. M, (2012), observed that, Parents and religious leaders enforce circumcision throughout their communities in order to ensure the next generations of children maintain tradition. The combination of these aforementioned factors creates a dynamic that renders FGM a public health concern that requires cultural competence to address.

World Health organization (2016). Stressed that, FGM has deep sociological roots that create societal norms in order for families to be accepted by the communities. The social conventions place pressure on parents to perform FGM on their daughters in order to prepare them for marriage and adulthood. Its cultural significance leads to the notion that it maintains girls' chastity, preserves fertility, improves hygiene, and enhances sexual pleasure for men. FGM is

utilized as an initiation rite of passage to womanhood and aims to ensure premarital virginity and marital fidelity by reducing her desire for extramarital sexual acts. When the vaginal opening is altered to create a smaller orifice, the fear of opening it further discourages extramarital sexual intercourse.

FGM is usually performed at the youngest age possible to avoid questions from education authorities and because older girls might defend themselves against the practice (Varol et al., 2014).

The ramifications of FGM affect the girl for the rest of her life and result in many health problems (i.e., extended bleeding, problems with urination, cysts, infections, and complications during childbirth). Aside from health-related, ethical, and moral consequences of FGM, it has been estimated by the World Health Organization (WHO) that the annual cost of obstetric complications is more than \$3.7 million (WHO, 2008). However, rationalization of genitalia mutilation persists; the people conducting the procedure do not believe they are doing harm. The eradication of FGM as a public health initiative is imperative to ensuring that newborn females and youth do not undergo this traumatic ordeal. Moreover, immigrant populations arriving in developed countries, particularly the United States (U.S.), present a particular obstacle in the full-global abolition of female genital mutation as many seek to continue their cultural traditions.

2.2 WOMEN HEALTH

2.2.1 Drivers of FGM

The most cited reason for FGM is “cultural tradition” functioning both as a form of social control and identity for women (Berg and Denison 2013). In looking at underlying norms and beliefs that perpetuate adherence to this tradition, some general themes emerge. However, it is important to remember that the causes of FGM vary across contexts and sometimes even between ethnic and religious groups within the same country. Therefore, there is no universal recipe in terms of changing what are considering to be “sticky” social norms. Instead interventions should be carefully designed to accommodate local drivers of FGM.

In particular, three interrelated normative themes underpin the practice of FGM: (a) the linkage of the practice to ideals about femininity and women's sexuality, (b) the role of the practice to a shared group identity, and (c) a belief that the practice is required by religion.

The practice of FGM is linked to traditions and other cultural norms about femininity and women's sexuality. For example, the relationship between FGM and sexual morality is the most recurring theme in studies identifying causes and drivers of FGM (the systematic review of Berg and Denison 2013, the literature review of Alcaraz, Siles González, and C. Solano Ruiz 2013, and the Systematic Review and Meta-Ethnography by Elamin and Mason-Jones 2020). FGM, and especially infibulation, is believed to reduce sexual desire and help women resist "illicit" sexual acts, that is, to ensure a young woman's virginity and a wife's fidelity (Johnsdotter et al. 2009; Philips 2016; Ahlberg et al. 2004).

This view is particularly prominent in cultures where premarital virginity is seen as a proof of morality and where women are seen as promiscuous and hypersexual if they are left uncontrolled (Fahmy, El-Mouelhy, and Ragab 2010; Johansen 2017). In a study from Kersa District, East Hararge, Oromia region, Ethiopia, preventing premarital sex and reducing female hyper sexuality were stated as reasons to continue the practice of FGM (Yirga et al. 2012)

Additional factors related to constructs about femininity include the importance of maintaining good health and permitting male sexual enjoyment. FGM is associated with "cleanliness" and "purity," while the clitoris is seen as dirty, male organ. Cultural norms suggest that women must remove or trim it to become beautiful and truly feminine (Izette and Toubia 2000). Cultural beliefs also suggest that keeping the clitoris may cause negative health consequences (Dotimi 2016). Among the Maasai in Kenya there is a belief that if a baby's head touches a woman's clitoris during birth, the baby will suffer (Van Bavel, Coene, and Leye 2017). The perception that men prefer cut women for sexual enjoyment is also mentioned, specifically the belief that men gain sexual pleasure from the tight vagina of an infibulated woman, although this view seems to be more widespread among women than men, at least among immigrant communities in the West (Johansen 2017; looking at views of Somali and Sudanese immigrants in Norway). These notions of ideal femininity ultimately perpetuate gender roles and stereotypes that view a

woman as a vessel for reproduction and deny her a role as a sexual being (Izette and Toubia 2000).

According to Tostan's (1990), FGM is seen as a social convention that plays an important role in consolidating communal, ethnic, and kinship ties, contributing to a shared group identity. On a societal level, FGM promotes social cohesion. Community-based interventions, including public declarations, often address this social aspect of the practice by suggesting that individuals in a community can achieve social cohesion through other means or that they can create new social norms around the importance of protecting girls and women from the negative outcomes of the practice.

According to Gerry Mackie, FGM is a self-enforcing social convention that is perpetuated first and foremost by concerns about marriageability (Mackie 1996; 2000; 2009). Although the practice of FGM is enforced through a variety of social, moral or religious norms marriageability is considered the “main engine of continuation,” which means that any change to the practice requires coordination among intermarrying groups (Mackie 2000, 265). Mackie predicts that if a critical mass of people in a community were to agree to stop the practice and publicly declared this, it could spread to other communities and lead to a shift in social conventions that would “help bring female genital mutilation to an end” (Mackie 1996, 999).

FGM is thought to increase a girl's chance of finding a suitable husband and having a family (Elamin and Mason-Jones 2020). Marriageability has been identified as the major reason for practicing FGM, for example, in the Somali region of Ethiopia (Abathun, Sundby, and Gele 2016). Being uncut may cause severe social sanctions from the ethnic group; women who are uncut may be seen as not eligible for marriage, which may bring shame to the family and damage the social standing of any future husband (Elamin and Mason-Jones, 2020).

Shell-Duncan et al. (2011) found out that expectations regarding whether other girls in the community will be cut or whether potential marriage partners will prefer cut wives were not listed among the major considerations in the decision-making process regarding FGM. Rather, gaining entry to a women's peer network is a driving factor. First, FGM is considered part of a family's obligation to its daughters. Second, uncut girls and women face substantial harassment

from cut women. Finally, uncut women are excluded from participating in, or even being present for, some activities (most commonly listed were FGM ceremonies and wedding ceremonies) and from collective (family or community) decision making. Therefore, undergoing FGM allows young women to expand their social capital, and, as they age, to benefit from the deference and obedience of younger women, thus gaining personal power in the community. To gain entry to a network, young women use circumcision to signal a willingness to participate in the hierarchy of power.

There are both Christian and Muslim communities that believe FGM is required by religion. Although it is often said that the Quran or the Bible do not mention FGM, it is still widely viewed as a religious obligation among practitioners. Nonetheless, women who live in the diaspora are beginning to refute the association between and religion (Ogunsiji, Wilkes, and Chok 2018; Ahlberg et al. 2004).

2.2.2 The unsafe practice of FGM

Many communities in rural areas where knives, razors or whatever equipment used in the operation is shared by all the girls, the risk of infections due to the contaminated equipment, is very high especially now that HIV/AIDS is one of the serious infectious diseases. (Tinker & Epp 2000, 23-24.)Toubia (1994) stated that because the specialized sensory tissue of the clitoris is concentrated in a rich neurovascular area of a few centimeters, the removal of a small amount of tissue is dangerous and has serious and irreversible effects. Common early complications of all types of circumcision are hemorrhage and severe pain, which can lead to shock and death. Also prolonged bleeding may lead to severe anemia and can affect the growth of a poorly nourished child. Local and systemic infections are also common. Infection of the wound, abscesses, ulcers, delayed healing, septicemia, tetanus, and gangrene have all been reported. (Althaus 1997, 130-133.)Long-term complications are associated more often with infibulation than with clitoridectomy alone, because of interference with the drainage of urine and menstrual blood. Chronic pelvic infection causes pelvic and back pain, dysmenorrhea, and possibly infertility, (Toubia 1994, 720). Chronic urinary tract infections can lead to urinary stones and kidney damage. The other long-term consequences include; increased risk of maternal morbidity,

recurrent bladder and urinary tract infection, cysts, adverse psychological and sexual consequence, infertility and increased risk of neonatal death for babies born to mothers having undergone female genital mutilation. (Maligaye 2007, 43-49.) The most common long-term complication is the formation of dermoid cysts in the line of the scar. These result from the embedding of keratinized epithelial cells and sebaceous glands in the stitched area. They can be as small as a pea or as large as a grapefruit. The formation of keloids is another disfiguring complication that, like dermoid cysts, causes anxiety, shame, and fear in women who think that their genitals are regrowing in monstrous shapes or who fear they have cancer, (Boyle 2002, 14). When painful stitch neuromas develop as a result of the entrapment of nerve endings in the scar, the result is severe dyspareunia and interference with sexual intercourse. (WHO, 1997). Recurrent stitch abscesses and the splitting of poorly healed scars, particularly when they occur over the clitoral artery, can plague women for many years. Childbirth adds other risks for infibulated women, particularly where health services are limited. If infibulation is not performed, exit of the fetal head may be obstructed and strong contractions can lead to perineal tears. If contractions are weak and delivery of the head is delayed, fetal death can occur and necrosis of the septum between the vagina and bladder can cause vesicovaginal fistula, a distressing condition of urinary incontinence for which women are often ostracized by their communities. (Toubia 1994, 712-716.) Another problem related to labor and delivery is emerging among immigrants in Europe and North America more cases have been reported in sub-Saharan countries where physicians are not trained to deal with infibulated women. Unnecessary caesarean section can be avoided with a simple deinfibulation performed with the woman under local anesthesia. (Crowe & Melching 2005, 70-78.) In other local communities, the whole genital was digged and everything was removed, and women remained only with holes thus difficult to give birth, and after giving birth, the womb just comes out. (Hernlund & Shell 2007, 50). Bleeding during this rite leads to death (Creel & Ashford 2001, 543). In September 1991, a 13-year-old girl bled to death after being mutilated by a traditional circumciser in Kitui District, Eastern Kenya. In Kericho District, - western Kenya, 18 years old bled to death after being circumcised by a traditional circumciser at a farmhouse. She bled profusely and died before she could be taken to the nearest health Centre. Her three co-initiates were treated at a local clinic. In August 1991 another girl also died after being circumcised by two women in Meru District. Many young girls have died due to

bleeding but the majority of these cases are never reported since these actions are taking place in rural areas. (Karanja 2003, 66.)FGM was also linked with many divorces as a result of sexual dissatisfaction. Many women have divorced their husbands, because the husbands claim that they are not satisfied sexually. Women blame their plight on FGM, saying it damages them permanently. (Chege 1993, 550.)

2.2.3 The ways to substitute FGM.

The two weeks seclusion acts as the rites (circumcisions) simulation. It brings willing young girls together for a two week in seclusion (camp) where they get traditional lessons about their future roles as women, parents and adults in the community. The girls could also be taught about their personal health, reproduction, hygiene, communication skills, self-esteem and dealing with peer pressure. This practice is like the traditional ritual, except that there is no cutting of genitals. (Chege 2001, 120-129.)During the Seclusion, the girls remain indoors and can only be visited by previous initiates who may have undergone the very original or the simulated one. These include female relatives' parents, neighbors and friends. A woman who is either an aunt or a friend is assigned the role of a supporter or "godmother." She ensures that the girl gets and understands family life education. The two week's ceremony ends with a "graduation" at a chosen day of "coming of age," where religious, political and government leaders are invited to give speeches. (Chege 2001, 90.)

During such a ceremony, the girls appeal to their elders to cease circumcision and let them complete their education after which they would decide whether to be circumcised or not. They protest through the market centers, where they dance and sing traditional songs that urge their mothers not give them out for marriage. The first Cutting through Words ceremony occurred in 1996, when 30 families from Gatunga village in Tharaka, about 200 miles east of Nairobi, initiated their daughters through words. Since then, the alternative rite has been progressively performed in three other communities- the Maasai and Kalenjins of the Rift Valley Province and the Abagusii of Western Kenya.(WHO, 1997)The months that traditionally rites are likely to occur are chosen to stage the alternative rite. For instance Tharaka Women's Welfare Program (TWWP) has saved more than 2,400 girls from undergoing FGM in Kenya, and since it was partnering with Women's Global in 2007, it has saved an additional 260 girls through the

Circumcision with Words ceremony. (Herlund & Shell 2001, 6-8, 23, 26-30.) Formal education has tremendously helped change the perception of female circumcision. Many women are now educated, employed and parenting. (Hernlund & Shell 2006, 69-71). The elite groups have spearheaded campaigns against female circumcision. They too have not only taught about how to combat poverty by educating girls and female empowerment but, have also served as best examples in the communities as they have made a difference between their own families and those whose women (wives) are serving as housewives who yielded to tradition in their youthful past. (Adams, Kelly & Paula 2005, 490.).

2.2.4 The relationship between FGM and women psychological and social health

Female Genital Mutilation (FGM) “comprises of 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” (WHO, 2016, p. 1). An estimated 200 million girls and women globally have undergone FGM (UNICEF, 2016). Although practiced worldwide, it is most prevalent in 30 African, Middle Eastern and South-East Asian countries. It is estimated that as a result of international migration, 60,000 girls born to mothers with FGM are now living in the UK (Macfarlane & Dorkenoo, 2015) with 20,000 girls at risk of being ‘cut’ (Yoder et al., 2004). Research has suggested that the physical health complications that can arise from FGM also lead to psychological effects (Lockhat, 2004), however despite being treated within the National Health Service (NHS) system, there are few services for psychological support and little recognition of the links between the psychological and physical impact of FGM. This has particular implications for health care professionals dealing with survivors of FGM (Girls Summit, 2014; Global Summit to End Sexual Violence in Conflict, 2014).

The World Health Organization (2008, Annex 5) reported that immediate psychological trauma may stem from the pain, shock and the use of physical force by those performing FGM. In the long term, post-traumatic stress disorder (PTSD), anxiety, depression and memory loss may occur (Behrendt and Moritz, 2005).

study in practicing African communities found that women who have undergone FGM have the same levels of Post-Traumatic Stress Disorder (PTSD) as adults who have been subjected to

early childhood abuse, and that the majority of the women (80 per cent) suffer from affective (mood) or anxiety disorders (Keel, 2014, p.6).

Women who have undergone FGM may also be affected by chronic pain syndrome, and with other causes of chronic pain there is an increased risk of depressed mood, with reduced social functioning, worthlessness, guilt, and even suicidal ideation. Limited mobility also increases social isolation and role loss in society (Whitehorn, Ayonrinde and Maingay, 2002, p.166).

Burrage (2015, p.99) writes that women who have experienced FGM tend to develop psychological conditions which make them withdrawn and uncommunicative or distrustful. There are anecdotal reports of teenage girls 'returning to the UK from "holidays" abroad who were well adjusted to school before they went, but who fail to thrive in the learning environment after they return' (p.99). Other psychological effects include emotional distance, flashbacks, sleep disorders, social isolation, and somatization.

It has also been found that the psychological trauma that women experience through FGM 'often stays with them for the rest of their lives' (Equality Now and City University London, 2014, p.8). A study of a sample of newly married women in Benha city found that the psychological complications resulting from FGM 'may be submerged deep in the child's subconscious and may trigger behavioral disturbances' (Elnashar, Abdelhady, 2007, p.243). Dr Brenda Kelly, Consultant Obstetrician from Oxford Rose Clinic, mentions a case of one of her patients who had undergone FGM about 30 years ago, but still recalls the trauma of the procedure (Chung, 2015).

It is necessary to take into account other circumstances that affect the development of psychological disorders in women who have undergone FGM. In 2012, Vloeberghs et al (2012) examined the consequences of FGM in the Netherlands. The sample was 66 women who had migrated from Somalia, Sudan, Eritrea, Ethiopia and Sierra Leone. One-sixth suffered from PTSD and a third had symptoms related to depression and anxiety (p.677). Women who were infibulated and who clearly remembered the event, and women who had received education concerning FGM reported more PTSD symptoms as well as greater anxiety and depression. Women who were older at the time and with whom FGM was discussed also reported more PTSD symptoms. Memon (2014, pp.5-6) points out that both the severity of the procedure and

the age at which it occurred appear to be related to the psychological effects; nevertheless, all the women in the study reported some negative effects of stress, such as recurrent bad memories and nightmares.

Women and girls may experience cognitive dissonance where the norms of FGM are not shared (Burrage, 2015, p.99). According to Festinger's (1957) theory, cognitive dissonance arises when one holds conflicting beliefs, causing one to feel uncomfortable. Festinger suggests that people strive to maintain consistency in their beliefs. For women who have undergone FGM, the 'desire to gain social status, please parents, and comply with peer pressure is in conflict with the fear, trauma, and after-effects of the operation' (Toubia, 1994, p.714). As Sarajane Rodgers, author of the FGM and Initiation Rituals article for 28 Too Many (2015), argues, women who have undergone FGM may have experienced pain and other negative consequences, and may not have wished to go through FGM. However, many were forced to undergo this procedure, and here cognitive dissonance arises because of their conflicting beliefs and actions. In an attempt to resolve the inconsistency, it may be easier for women to say that 'it wasn't so bad' rather than, 'It was terrible and I can't change the fact that it was done to me' (Rodgers, 2015).

As to whether the psychological effects are the same in the UK as in Africa, Dr Brenda Kelly (Chung, 2015) noted that psychological distress is something Westerners do talk about and is acceptable to talk about in the UK. In Africa, there is a stigma associated with talking about anything outside the marriage. Hence, the psychological consequences of FGM are not necessarily more prevalent in Western society, but it can be easier to talk about them.

Women who have undergone FGM are more likely than women without FGM to experience painful intercourse, reduced sexual satisfaction and reduced sexual desire (Berg, Denison, 2012, pp.41-56). FGM may lead to sexual phobia (El-Defrawi et al, 2001, p.472). Women may also experience more difficulty reaching orgasm, and shame or embarrassment about intimacy (Burrage, 2015, p.115). Narrowing of the vaginal opening may make intercourse painful for both partners (British Medical Association, 2011, p.6). A study (Elnashar, Abdelhady, 2007, p.241) carried out on a sample of newly married women in Benha city found that 40.5% of women who had undergone FGM experienced dyspareunia (difficult or painful sexual

intercourse), while only 18.8% of uncut women experienced it. 17.5% of the women who had undergone FGM felt their husband's dissatisfaction, while only 4.7% of those uncut felt that way.

Lack of sexual pleasure for both parties can lead to husbands having extramarital affairs with women who have not undergone FGM (FORWARD, 2002, p.6). Emotional or physical pain during sexual intercourse reduces enjoyment for both the woman and her partner, thus affecting the intimacy in the relationship (Whitehorn, Ayonrinde, Maingay, 2002, p.167). An interview with Dr Brenda Kelly (Chung, 2015) revealed that when intercourse is painful, the vaginal muscles contract, making intercourse even more difficult, thus perpetuating a vicious cycle. As a result, these women avoid sex, which could lead to marital dissatisfaction.

In addition, immigrant females may have 'altered expectations' of sexuality due to the 'new sexual culture, media or new peers' (Whitehorn, Ayonrinde, Maingay, 2002, p.166). A woman who has undergone FGM may become aware of differences in the appearance of her genitalia and may feel embarrassed during clinical examination or sexual intercourse. Furthermore, women who are aware of a lack of sexual enjoyment may feel anger, guilt, shame or inadequacy.

Traditionally, a female member of the community performs the FGM procedure. She may be closely related or a total stranger. Some survivors experience a sense of betrayal by someone emotionally close to them (Whitehorn, Ayonrinde, Maingay, 2002, p.165). In many cases, girls are held down by their female relatives while FGM is carried out (British Medical Association, 2011).

As Dr Brenda Kelly states (Chung, 2015), if the survivor is younger than two years old, she is unlikely to remember it and is unlikely to experience PTSD. Those most at risk of PTSD are children older than the age of five who recall being forcibly held down and who experienced great pain and/or complications afterwards.

2.3 Gaps

These are the gaps in the studies that the researcher intended to fill;

Internationally, there have been a few studies conducted and Uganda particular on FGM and women health, so the researcher intended to add clue on the sphere of knowledge already posed about FGM and women health especially in Kapchorwa district.

Also most of the studies in the literature were cross country, for instance Florendo (2007) in Nigeria. The researcher therefore intended to do the research in Uganda and particularly Kapchorwa district.

Also cross sectional research design was more employed in studies however in this research, the researcher employed a descriptive Case study design because it allowed proper analysis of the phenomena under study and also the design allowed an in-depth exploration of a given phenomenon (Zainal, 2007).

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter presents the methodologies used in the study and these include; Research design, area of study, study population, sampling procedures, sample size, sampling techniques, data collection and instruments, data quality control methods, data management and processing, data analysis, ethical considerations and limitations of the study.

3.1 Research design.

The study employed a descriptive case study design because the design enables an in-depth exploration of a given phenomenon (Zainal, 2007) and thus it was suitable in assessing the impact of FGM on Women psychological and social health in kapchorwa district.

A descriptive case study was used for the inquiry because it allowed an in-depth investigation of a phenomenon (Mugenda & Mugenda, 2003) such as the drivers of FGM in Kapchorwa district, the unsafe practice of FGM on women in Kapchorwa district, the ways to substitute FGM in Kapchorwa district, the relationship between FGM and women psychological and social health in Kapchorwa district.

The use of quantitative and qualitative study approaches was meant to increase in depth experiential knowledge being explored and was supplemented through triangulation. Quantitative data was thus collected to understand the magnitude of the assumptions underpinning the impact of FGM on women psychological and social health.

3.2 Area of study.

The research study was carried out in kapchorwa district.

3.3 Study population.

The target population for the study was kapchorwa district. The researcher purposively choose 40 women and 10 cultural leaders. This target population was thought to provide reliable in-depth information to the researcher.

3.4 Sampling procedures

3.4.1 Sample size

According to Borg and Gall (1989) sampling means selecting a given number of subjects from a defined population as representative of that population.

A total sample of 36 women and 10 cultural leaders was selected. The study sample was determined using the recommendations of Krejcie and Morgan (1971) cited in Gay (1996: 124).

3.4.2 Sampling techniques

The researcher employed two sampling techniques; purposive non- probability sampling technique and simple random sampling technique as explained:

3.4.2.1 Purposive sampling

Purposive sampling was used because it allowed the researcher to study cases or subjects that had the required information which was relevant to the study objectives (Mugenda & Mugenda, 2003). The researcher used this technique to purposively select kapchorwa district, women and local leaders for the study because they were the ones who fitted the study concerns in line with the major aim of the study which was to find out the impact of FGM on women psychological and social health in kapchorwa district.

3.4.2.2 Simple random sampling

In simple probability sampling technique, each individual was chosen entirely by chance and each member of the population had an equal chance, or probability of being selected (Goode & Hatt, 2003). The researcher used this technique to randomly select 36 women and 10 local leaders for an interview from a target population of 46 women and local leaders. This was carried out by giving a number to each individual woman and local leader in a target population and then used a table of random numbers to decide which individual was to be included.

3.5 Data collection methods and instruments

Any study requires appropriate study instruments with which to collect the necessary information that can ably answer the study questions (Mugenda & Mugenda, 2003). Lewis (2003) gave a distinction between primary and secondary data and each set of data required an appropriate and relevant collection technique. Since the study objectives required the collection of quantitative and qualitative primary and secondary data, two data collection techniques were used. Quantitative data and Qualitative data were collected through in-depth key informant interviews and questionnaires that consisted of a series of questions and other prompts of the study purpose for gathering information from the respondents were used.

3.5.1 Questionnaire method

Questionnaires are a common tool used in research. The advantage of the questionnaire is its ability to address a specific objective or question of the study (Mugenda & Mugenda 2003) and in this study, a questionnaire was used to generate information from women and local leaders on the impact of FGM on women psychological and social health, the drivers of FGM in Kapchorwa district, the unsafe practice of FGM on women in Kapchorwa district, the ways to substitute FGM in Kapchorwa district, the relationship between FGM and women psychological and social health in Kapchorwa district.

3.5.2 Interview method

An interview guide is an oral questionnaire where the researcher gathers data through direct verbal interactions with the respondent (Kothari, 2004). An interview guide was designed and administered to the key informants (The local leaders and cultural leaders) to capture qualitative information. It was unstructured in nature to meet the specific research objectives of the study

(Amin, 2005). This enabled getting information that cannot be directly observed or difficult to put down in writing and to capture meanings beyond words. The main advantage of face to face interview was that clarity was ensured and that the questions were properly understood by repeating or rephrasing the questions (Sekaran, 2003). A sample of the interview guide is attached to this study (See Appendix 3)

3.6 Data quality control methods

Quality control refers to the different methods and procedures implemented to insure that data is collected, managed, and utilized with accuracy and precision (Creswell & Miller, 2000). The researcher employed the validity and reliability data quality control tools to ensure accuracy of the collected data as explained below:

3.6.1 Validity

Validity refers to the extent to which research instruments are able to measure what they are supposed to measure (Galloway, Lippman, Burke, Diener, & Gates, 2017). It is the criteria appropriateness of the “rigor”: internal validity (isomorphism of findings with reality), external validity (generalizability)” (Guba & Lincoln, 1994, p.114). To ensure internal validity (of the research instruments), experts opinions was sought from the supervisors, and departmental heads in the field of Education. Their inputs were of great help in identifying errors; modifying and improving the instruments. External validity was kept by ensuring high rigor of the sampling techniques and maintaining high ethical standards so that the study findings were reputable as a true representation of the study context.

3.6.2 Reliability

According to Guba and Lincoln (1994), the reliability of a study instruments is measured by its levels of stability and objectivity. To ascertain the reliability of the instruments, the researcher conducted a pre-test survey in any district outside kapchorwa which was selected at random. The reliability of the study instruments were confirmed through re-testing the same instruments in different settings and when the instruments gave similar and consistent results, they were used to conduct the study. In case of variations in the content of the collected data during the testing, such a questionnaire or interview schedule was revised and corrected for correlation and familiarity with the study objectives. Questions that were found to give divergent information

were thoroughly discussed with the supervisor and experts of FGM, corrections were made and refined for the study.

According to Neumann, et-al. (2003), Research data management refers to the process applied throughout the lifecycle of a research project to guide the collection, documentation, storage, sharing and presentation of research data. Research data management and processing involved the active organization and maintenance of data throughout the research process, and suitable archiving of the data at the project's completion, and consisted of planning, creating of data, data processing and analysis, sharing and reusing of data.

The researcher reviewed existing data sources on FGM on women psychological and social health, considered costs and prepared a plan.

The researcher there after then processed, analyzed, shared, and reused the data that was collected from the field.

3.8 Data analysis

Data analysis involves scrutinizing the acquired information and making inferences (Kombo & Tromp, 2006). The questionnaire responses were entered into pre-designed data templates using Epi-Data (version 3.1), which provided for validity checks during data capture. The data was then exported to statistical analysis software –SPSS (version 10) for merging, editing and cleaning, and eventual data analysis. Descriptive statistics were used to calculate frequencies, descriptive and cross-tabulations on the impact of FGM on women psychological and social health in kapchorwa district.

For qualitative data, the researcher identified themes and classified them according to the study objectives as well as keeping an open mind towards emerging themes, concepts, or categories. The data was indexed and then labeled so that parts of the data that referred to more than one theme or category were multi-indexed. The study used the term “indexing” in order to establish how individual sections of data collected related to the study objectives-in this case, to the study themes (Ritchie & Spencer, 2003). The data was then sorted by theme, synthesized and presented in thematic charts so that the key point of each piece of data was summarized for easy analysis. This involved detection, categorization, and classification of data for easy interpretation.

3.9 Ethical considerations.

The research took ethical precautions following Lewis (2003) who contended that any research comes with peculiar ethical reflections and suggestions: obtaining informed consent from participants before the study, ensuring anonymity and confidentiality about the information given and, protecting the participants and the researcher from harm. The researcher sought an informed consent from the local leaders and cultural leaders and also in turn requested to give their assent before participating in the study.

The researcher took time to fully explain the purpose of the study to the participants, the procedures used and how the study was to benefit the study participants.

The study participants were given freedom to exit the study at their own will without any consequences. Moreover, they were given the opportunity to have a copy of the transcribed data to confirm the accuracy of their information. The researcher also ensured that the study participants had an informed consent about how the information they gave was disseminated or published.

3.10 Limitation of the research study.

The first limitation was time constraint since most women were busy with their house work.

There was a limitation of some of the respondents who failed to return the questionnaires, this distorted data analysis.

Also the issue of financial constraint since the researcher was self-supported to carry out the research study.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION.

4.0 Introduction

This chapter presents the drivers of FGM in Kapchorwa district, the unsafe practice of FGM in Kapchorwa district, the ways to substitute FGM in Kapchorwa district and the relationship between FGM and women psychological and social health.

4.1 Characteristics of respondents.

Most of the respondents encountered were from rural areas. And most of them were willing to provide the information they had concerning FGM practice, although others were ignorant, the few who were interviewed had conservative stands since they had not been fully convinced on the importance of the findings.

Table 1: Frequency distribution showing gender of respondents.

Sex	Frequency	Percentage
Male	08	17.4
Female	38	82.6
Total	46	100

Source; primary data, 2021

Out of the 46 respondents, 17.4% were males and 82.6% were females. The female respondents were many because FGM mostly affects them and also they were the target for the study.

Table 2: Age of respondents.

Age	Frequency	Percentage
Below 18	02	4.35
18-25	03	6.52
26-30	10	21.74
31-40	19	41.30
41 above	12	26.09
Total	46	100

Source; primary data, 2021

The table above shows that the respondents of this research who actively participated were; below 18 were 4.35% of the total respondents, 18-25 were 6.52% of the total respondents, 26-30 were 21.74% of the total respondents, 31-40 were 41.30% of the total respondents while 41 and above years were 26.09% of the total respondents. The age group of 31-40 years had a higher percentage of 41.30% because they had experience on FGM and were the target group for the study. At least each age group was able to provide information to assist in guidelines to the study case problem.

Table 3: Education level of respondents

Education level	Frequency	Percentage
Certificate	13	28.2
Diploma	08	17.4
Degree	05	10.9
Masters	01	2.2
PhD	00	0.0
Others	19	41.3
Total	46	100

Source; primary data, 2021.

From the table above, 28.2% of the total number of respondents had a certificate, 17.4% had a diploma, 10.9% had a degree, 2.2% had a masters 0.0% (none) of the respondents had a PhD where as 41.3% of the total number of respondents had others.

4.2 The drivers of FGM.

The first research objective was devised to assess the drivers of FGM in Kapchorwa district. The purpose of this objective was to obtain data about the reasons why FGM is carried out in Kapchorwa district.

Table 4: Summarizes the drivers of FGM in Kapchorwa district as suggested by the various respondents.

Drivers of FGM	Frequency	Percentage
Cultural norm	17	36.95
Linkage to femininity and sexuality	09	19.57
Required by religion	02	4.35
Associated with cleanliness and purity	08	17.39
Promotes social cohesion	06	13.04
Others	04	8.70
Total	46	100

Source; primary data, 2021.

From the table above, 36.95% of the total number of respondents agreed that cultural Norm is the driver of FGM, 19.57% suggested linkage to femininity and sexuality, 4.35% supposed that FGM is required by religion, 17.39% supported that FGM is associated with cleanliness and purity, 13.04% of the respondents said that FGM promotes social cohesion while 8.70% said that there might be some other reasons why FGM is practiced in Kapchorwa district.

4.3 The unsafe practice of FGM on women in kapchorwa district.

In communities where FGM is practiced, knives, razor blades or any other equipment is used during the operation of the practice. However the practice can be unsafe depending on who and how it is carried out. In September 1991, a 13 year old girl bled to death after being mutilated by a traditional circumciser in Kitui district in eastern Kenya. Also another 18 year old girl bled to death after being circumcised by a traditional doctor at a farm house. This information was hardly articulated because the respondents hardly commented about it.

Table 5: Shows how FGM is done.

How FGM is done	Frequency	Percentage
Partial or total removal of the clitoris and labia minora.	16	34.78
Partial or total removal of the clitoris or the prepuce.	23	50.00
Narrowing of the vaginal orifice with creation of a covering seal by cutting and positioning of the labia majora and labia minora.	05	10.87
Pricking, piercing, incising, scraping and cauterization.	02	4.35
None of the above.	00	0.00
Total	46	100

Source; primary data, 2021.

How FGM is done was given by the respondents and were presented by the following percentages; 34.78% agreed that FGM involves the partial or total removal of the clitoris and the labia minora, 50.00% stated that FGM involves the partial or total removal of the clitoris or the prepuce, 10.87% said that FGM involves the narrowing of the vaginal orifice with the creation of a covering seal by cutting and positioning the labia minora and labia majora, 4.35% supported that FGM involves pricking, piercing, incising, scraping and cauterization while 0.00% is the percentage of respondents who said that none of the above ways shows how FGM is done in Kapchorwa district.

Table 6: Shows the persons responsible for carrying out FGM practice.

Persons responsible for carrying out FGM	Frequency	Percentage
Medical practitioners	00	0.00

Local (cultural or traditional) practitioners	44	95.65
Religious practitioners	02	4.35
None of the above	00	0.00
Total	46	100

Source; primary data, 2021.

The above table shows the persons responsible for carrying out the practice of FGM as stated by the respondents. Of the total number of the respondents, none of them(0.00%) pointed out medical practitioners, 95.65% of the respondents pointed out local (or cultural or traditional) practitioners, however 4.35% of the total number of respondents agreed with religious practitioners, and 0.00% of the respondents said none of the above.

Table 7: Table showing the age group at which FGM is mostly carried out.

Age	Frequency	Percentage
At birth	00	0.00
Childhood	09	19.57
Adolescence	13	28.26
Adulthood	22	47.83
Any age	02	4.34
Total	46	100

Source; primary data, 2021.

The table above shows the age group at which FGM is mostly carried out in Kapchorwa district according to the respondents. 0.00% of the respondents said at birth, 19.57% of the respondents suggested at childhood, 28.26% supported during adolescence, 47.83% of the respondents agreed with adulthood, while 4.34% of the respondents pointed out any age.

4.4 Ways to substitute FGM in Kapchorwa district.

In some African societies, FGM involves bringing young girls together for at least two weeks in a camping where they get traditional lessons. While in the camp they remain indoors and can only be visited by previous initiates who may have undergone the very original or stimulated one. This two weeks ceremony ends with a graduation at a chosen day where the local leaders are invited. (Chege, 2001).

Table: 8 Showing the ways to substitute FGM in Kapchorwa district.

State.	Frequency	Percentage
Seclusion or camping women in FGM seasons where they get traditional lessons about their health, and reproduction.	17	36.96
Provision of guidance and counseling programs.	06	13.04
Introduction of formal education.	11	23.91
Putting up laws which help to abolish FGM practice.	12	26.09
Total	46	100

Source; primary data ,2021.

The table above shows the ways to substitute FGM in Kapchorwa district as suggested by the respondents; 23.91% of the respondents agreed with the introduction of formal education, also 36.96% of the respondents agreed with Seclusion or camping women in FGM seasons where they get traditional lessons about their health, and reproduction, 13.04% suggested provision of guidance and counseling programs, while 26.09% of the total respondents supported putting up laws which help to abolish FGM practice.

4.5 The relationship between FGM and women psychological and social health.

Although FGM is practiced worldwide, it is most prevalent in Africa, middle East and south east Asian countries. Research has showed that the physical health complications that can arise from FGM also lead to psychological effects.

Table: 9 Showing the impacts of FGM on women psychological and social health.

State	Frequency	Percentage
Psychological trauma	05	10.87
Post-traumatic stress disorder	07	15.22
Chronic pain syndrome	06	13.04
Emotional distance	03	6.52
Social isolation	05	10.87
Sleep disorders	03	6.52
Depression and anxiety	05	10.87
Cognitive dissonance	04	8.70
Lack of sexual pleasure	08	17.39
Total	46	100

Source ; primary data, 2021.

The results in the table above were obtained from various respondents about the impact of FGM on psychological and social health of women, where by; 10.87% of the respondents pointed out psychological trauma, 15.22% agreed with post traumatic stress disorder, 13.04% of the respondents supported chronic pain syndrome, 6.52% proposed emotional distance, 10.87% agreed with social isolation, also 6.52% of the respondents suggested sleep disorders, then

10.87% supported depression and anxiety, 8.70% pointed out cognitive dissonance where as 17.39% of the respondents agreed with lack of sexual pleasure.

CHAPTER FIVE

FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This research presented the summary of the findings, conclusions and recommendations. The research dealt with the drivers of FGM, The unsafe practice of FGM on women, ways to substitute FGM and the impact of FGM on women psychological and social health. Those questions were answered, a conclusion given and recommendations stated. Female genital mutilation refers to all procedures involving partial or total removal of the female external genitalia or causing other injuries to the female genital organs for non-medical reasons.

5.1 Summary of Findings.

The impacts of FGM are abundant. In the findings, the impacts range from social, psychological, physical and other impacts.

5.2 The drivers of FGM

The most cited reason for FGM is “cultural tradition” functioning both as a form of social control and identity for women (Berg and Denison 2013). In looking at underlying norms and beliefs that perpetuate adherence to this tradition, some general themes emerge. However, the findings showed that the causes of FGM vary across contexts and sometimes even between religious groups within kapchorwa district.

Also, traditions and other cultural norms like femininity and women’s sexuality. For example, the relationship between FGM and sexual morality is the most recurring theme in the study to identify causes and drivers of FGM. This study found that, FGM and especially infibulation reduce sexual desire and help women resist “illicit” sexual acts, that is, to ensure a young woman’s virginity and a wife’s fidelity

This view is particularly prominent in cultures where premarital virginity is seen as a proof of morality and where women are seen as promiscuous and hypersexual. In a study from Kersa District, East Hararge, Oromia region, Ethiopia, preventing premarital sex and reducing female hyper sexuality were stated as reasons to continue the practice of FGM (Yirga et al. 2012)

Additional factors related to constructs about femininity include the importance of maintaining good health and permitting male sexual enjoyment. FGM is associated with “cleanliness” and “purity,” while the clitoris is seen as a dirty, female organ. Cultural norms suggest that women must remove or trim it to become beautiful and truly feminine (Izette and Toubia 2000). Cultural beliefs also suggest that keeping the clitoris may cause negative health consequences (Dotimi 2016). Among the Maasai in Kenya there is a belief that if a baby’s head touches a woman’s clitoris during birth, the baby will suffer (Van Bavel, Coene, and Leye 2017). The perception that men prefer cut women for sexual enjoyment is also mentioned, specifically the belief that men gain sexual pleasure from the tight vagina of an infibulated woman, although this view seems to be more widespread among women than men.

According to the research findings, 13.04% of the respondents suggested that social convention plays an important role in consolidating communal, ethnic, and kinship ties, contributing to a shared group identity. On a societal level, FGM promotes social cohesion. Community-based interventions, including public declarations, often address this social aspect of the practice by suggesting that individuals in a community can achieve social cohesion through other means or that they can create new social norms around the importance of protecting girls and women from the negative outcomes of the practice.

Though some Christian and Muslim communities believe that FGM is required by religion, the Quran or the Bible does not mention FGM, it is still widely viewed as a religious obligation among practitioners. Nonetheless, women who live in kapchorwa are beginning to refute the association between FGM and religion.

5.3 The unsafe practice of FGM

The use of knives, razors or whatever equipment in the operation is shared by all the girls, this increases the risk of infections due to the contaminated equipment, especially now that HIV/AIDS is one of the serious infectious diseases.

The findings found that since the specialized sensory tissue of the clitoris is concentrated in a rich neurovascular area of a few centimeters, the removal of a small amount of tissue is dangerous and has serious and irreversible effects. Common early complications of all types of

circumcision are hemorrhage and severe pain, which can lead to shock and death. Also prolonged bleeding may lead to severe anemia and can affect the growth of a poorly nourished child. Local and systemic infections are also common. Infection of the wound, abscesses, ulcers, delayed healing, septicemia, tetanus, and gangrene have all been reported.

Long-term complications are associated more often with infibulation than with clitoridectomy alone, because of interference with the drainage of urine and menstrual blood. Chronic pelvic infection causes pelvic and back pain, dysmenorrhea, and possibly infertility, (Toubia 1994, 720). Chronic urinary tract infections can lead to urinary stones and kidney damage. The other long-term consequences include; increased risk of maternal morbidity, recurrent bladder and urinary tract infection, cysts, adverse psychological and sexual consequence, infertility and increased risk of neonatal death for babies born to mothers having undergone female genital mutilation.

When painful stitch neuromas develop as a result of the entrapment of nerve endings in the scar, the study found that there is severe dyspareunia and interference with sexual intercourse. Recurrent stitch abscesses and the splitting of poorly healed scars, particularly when they occur over the clitoral artery, can plague women for many years.

Childbirth adds other risks for infibulated women, particularly where health services are limited. If infibulation is not performed, exit of the fetal head may be obstructed and strong contractions can lead to perineal tears. If contractions are weak and delivery of the head is delayed, fetal death can occur and necrosis of the septum between the vagina and bladder can cause vesicovaginal fistula, a distressing condition of urinary incontinence for which women are often ostracized by their communities. (Toubia 1994, 712-716.)

5.4 The ways to substitute FGM

FGM could be substituted with seclusion which acts as the rite's (circumcision's) simulation. It involves bringing willing young girls together for a two week in seclusion (camp) where they get traditional lessons about their future roles as women, parents and adults in the community. The girls are taught about their personal health, reproduction, hygiene, communication skills, self-esteem and dealing with peer pressure. This practice is like the traditional ritual, except that there is no cutting of genitals. (Chege 2001, 120-129.). During such a ceremony, the girls appeal to

their elders to cease circumcision and let them complete their education after which they would decide whether to be circumcised or not.

Formal education has tremendously helped change the perception of female circumcision. Many women are now educated, employed and parenting. (Hernlund & Shell 2006, 69-71). The elite groups have spearheaded campaigns against female circumcision. They too have not only taught about how to combat poverty by educating girls and female empowerment but, have also served as best examples in the communities as they have made a difference between their own families and those whose women (wives) are serving as housewives who yielded to tradition in their youthful past.

5.5 The impacts of FGM on women psychological and social health.

The Research suggested that the physical health complications that arise from FGM lead to psychological effects, however despite being treated, there are few services for psychological support and little recognition of the links between the psychological and physical impact of FGM. This has particular implications for health care professionals dealing with survivors of FGM.

Also, immediate psychological trauma may stem from the pain, shock and the use of physical force by those performing FGM. In the long term, post-traumatic stress disorder (PTSD), anxiety, depression and memory loss may occur (Behrendt and Moritz, 2005).

13.04% of the respondents agreed that, Women who have undergone FGM may also be affected by chronic pain syndrome, and with other causes of chronic pain. There is also an increased risk of depressed mood, with reduced social functioning, worthlessness, guilt, and even suicidal ideation. Limited mobility also increases social isolation and role loss in society.

Burrage (2015, p.99) writes that women who have experienced FGM tend to develop psychological conditions which make them withdrawn and uncommunicative or distrustful. There are anecdotal reports of teenage girls 'returning to the UK from "holidays" abroad who were well adjusted to school before they went, but who fail to thrive in the learning environment after they return' (p.99). Other psychological effects include emotional distance, flashbacks, sleep disorders, social isolation, and somatization.

It has also been found that the psychological trauma that women experience through FGM ‘often stays with them for the rest of their lives’ as suggested by 10.86% of the respondents.

Women and girls may experience cognitive dissonance where the norms of FGM are not shared. According to Festinger’s (1957) theory, cognitive dissonance arises when one holds conflicting beliefs, causing one to feel uncomfortable. Festinger suggests that people strive to maintain consistency in their beliefs. For women who have undergone FGM, the ‘desire to gain social status, please parents, and comply with peer pressure is in conflict with the fear, trauma, and after-effects of the operation.

Women who have undergone FGM are more likely than women without FGM to experience painful intercourse, reduced sexual satisfaction and reduced sexual desire. The study found out that, FGM may lead to sexual phobia. Women may also experience more difficulty reaching orgasm, and shame or embarrassment about intimacy. Narrowing of the vaginal opening may make intercourse painful for both partners.

Traditionally, a female member of the community performs the FGM procedure. She may be closely related or a total stranger. Some survivors experience a sense of betrayal by someone emotionally close to them (Whitehorn, Ayonrinde, Maingay, 2002, p.165). In many cases, girls are held down by their female relatives while FGM is carried out (British Medical Association, 2011).

5.6 Conclusion.

From the findings, the impacts of FGM on women range from physical, social and to psychological impacts.

Psychological health complications that arise from FGM lead to psychological effects, this has particular implications for health care professionals dealing with the survivors of FGM. Therefore the health care professionals should be able to provide services for psychological support and recognition of links between the psychological and physical impacts of FGM.

Also psychological trauma may stem from pain, shock, chronic pain syndrome, depressed moods, and worthlessness. This increases social isolation and role laws in the society.

Women and girls experience cognitive dissonance where by the norms of FGM are not shared. These conflicting beliefs can cause an individual to feel uncomfortable.

Also women who undergo FGM are more likely to experience; painful intercourse, reduced sexual satisfaction and reduced sexual desire. All these may lead to sexual phobias. In addition to that, women may also experience more difficulty in reaching orgasm, it also causes shame or embarrassment about intimacy.

5.7 Recommendations

The researcher came up with the following recommendations:

The government should establish laws against FGM and adequately enforce them so as to eliminate the practice of FGM in Kapchorwa district.

The local leaders, religious leaders, cultural leaders and the entire community should be adequately sensitized and educated about the impacts of FGM.

The government in conjunction with the local leaders should design programs that can substitute for the practice of FGM in Kapchorwa district.

Medical health care professionals should be taught how to deal with victims of FGM in Kapchorwa district.

Also health professionals, religious leaders or any other responsible persons should offer guidance and counseling services to the young girls and other community members in order to reduce on the practice of FGM in Kapchorwa district.

5.8 Suggestions for further study.

A study on; the impacts of male circumcision on male health.

REFERENCES

- A. A. Odukogbe, B. B. Afolabi, O. O. Bello, and A. S. Adeyanju, "Female genital mutilation/cutting in Africa," *Translational Andrology and Urology*, vol. 6, no. 2, pp. 138–148, 2017. View at: [Publisher Site](#) | [Google Scholar](#)
- A. Behrendt and S. Moritz, "Posttraumatic stress disorder and memory problems after female genital mutilation," *American Journal of Psychiatry*, vol. 162, no. 5, pp. 1000–1002, 2005. View at: [Publisher Site](#) | [Google Scholar](#)
- Althaus, A. 1997. Female Circumcision. Rite of Passage or Violation of Rights .*International Family Planning Perspectives*. African journal of women health, Vol 23 No 3 September 1997, 130-133.
- B. I. Odemerho and M. Baier, "Female genital cutting and the need for culturally competent communication," *Journal for Nurse Practitioners*, vol. 8, no. 6, pp. 452–457, 2012. View at: [Publisher Site](#) | [Google Scholar](#)
- Boyle, E. 2002. Female Genital Cutting: Cultural Conflict in the Global Community. 6-16. Chege, J. 2001. An Assessment of the Alternative Rites Approach for Encouraging Abandonment of Female Genital Mutilation in Kenya. Maseno University, 89-129,
- C. Ivazzo, T. A. Sardi, and I. D. Gkegkes, "Female genital mutilation and infections: a systematic review of the clinical evidence," *Archives of Gynecology and Obstetrics*, vol. 287, no. 6, pp. 1137–1149, 2013. View at: [Publisher Site](#) | [Google Scholar](#)
- Creel, L. & Ashford, L. 2001. Abandoning Female Genital Cutting, Prevalence, Attitudes, and Efforts to End the Practice. USA: Washington D.C. Vol 23 No 7 October 2001, 543-620.

Crowe, S. & Melching, M. 2005. Ending Female Genital Mutilation and Cutting in Senegal, 56-78. Female Genital Mutilation 2008 [referred 29.04 2009] available at: [www.socyberity.com/ke/Female Issues/2008/200852](http://www.socyberity.com/ke/Female%20Issues/2008/200852)

H. Lightfoot-Klein, "The sexual experience and marital adjustment of genitally circumcised and infibulated females in the Sudan," *Journal of Sex Research*, vol. 26, no. 3, pp. 357–392, 1989. View at: [Publisher Site](#) | [Google Scholar](#)

H. Rushwan, "Female genital mutilation FGM/management during pregnancy, childbirth and the postpartum period," *International Journal of Gynecology and Obstetrics*, vol. 70, no. 1, pp. 99–104, 2000. View at: [Publisher Site](#) | [Google Scholar](#)

Hernlund, Y. & Shell D-B. 2001. Female circumcision in Africa. Culture controversy and change. 6-8, 23, 26-30.

Hernlund, Y. & Shell D-B. 2006. Stages of change in the practice of female genital cutting in Senegal and Gambia. *African journal of reproductive health*, (2006) 10, 57

J. Abu Dai, "Female circumcision," *Saudi Medical Journal*, vol. 21, pp. 921–923, 2000. View at: [Google Scholar](#)

Karanja, N. 2003. Female Genital Mutilation in Africa. *Gender, Religion and pastoral care journal*, 2003, 51, 40-70.

L. J. Oyefara, "Ritual female genital mutilation: a psychosocial analysis of a flourishing rather than a dying tradition in Oworonshoki community, Lagos, Nigeria," *IFE Psychologia*, vol. 22, pp. 72–83, 2014. View at: [Google Scholar](#)

L. Morison, C. Scherf, G. Ekpo et al., "The long-term reproductive health consequences of female genital cutting in rural Gambia: a community-based survey," *Tropical Medicine and International Health*, vol. 6, no. 8, pp. 643–653, 2001. View at: [Publisher Site](#) | [Google Scholar](#)

M. Donohoe, *Female Genital Cutting: Epidemiology, Consequences, and Female Empowerment*, 2006, <http://www.medscape.com/viewarticle/546497>.

M. M. Islam and M. M. Uddin, “Female circumcision in Sudan: future prospects and strategies for eradication,” *International Family Planning Perspectives*, vol. 27, no. 2, p. 71, 2001. View at: [Publisher Site](#) | [Google Scholar](#)

M. O. Ofor and N. M. Ofole, “Female genital mutilation: the place of culture and the debilitating effects on the dignity of the female gender,” *European Scientific Journal*, vol. 11, pp. 112–121, 2015. View at: [Google Scholar](#)

M. Reyners, “Health consequences of female genital mutilation,” *Reviews in Gynaecological Practice*, vol. 4, no. 4, pp. 242–251, 2004. View at: [Publisher Site](#) | [Google Scholar](#)

Maligaye, B. 2007. Continuing Professional Development. *Women's Health journal*, Vol 22 No 7 September 2007, 43-49.

N. Nour, “Female genital cutting: impact on women’s health,” *Seminars in Reproductive Medicine*, vol. 33, no. 1, pp. 41–46, 2015. View at: [Publisher Site](#) | [Google Scholar](#)

N. Toubia, “Female circumcision as a public health issue,” *New England Journal of Medicine*, vol. 331, no. 11, pp. 712–716, 1994. View at: [Publisher Site](#) | [Google Scholar](#)

news and analysis 2009 [referred 04.05.2009] available at: [Www.irinnews.org/ke/reports/2007/200727](http://www.irinnews.org/ke/reports/2007/200727)

Population Reference Bureau, *Women and Girls at Risk of Female Genital Mutilation/Cutting in the United States*, 2013, <http://www.prb.org/Publications/Articles/2015/us-fgmc.aspx>.

R. Khosla, J. Banerjee, D. Chou, L. Say, and S. T. Fried, “Gender equality and human rights approaches to female genital mutilation: a review of international human rights norms and standards,” *Reproductive Health*, vol. 14, no. 1, p. 59, 2017. View at: [Publisher Site](#) | [Google Scholar](#)

S. Elmusharaf, I. Elkhidir, S. Hoffmann, and L. Almrotha, “A case–control study on the association between female genital mutilation and sexually transmitted infections in Sudan,” *BJOG: An International Journal of Obstetrics and Gynaecology*, vol. 113, no. 4, pp. 469–474, 2006. View at: [Publisher Site](#) | [Google Scholar](#)

Tanui, K.2006. Dying Voice. Kitale Kenya, 16-46.Tinker, A.; Kathleen, F. & Epp, J. 2000.

UNICEF, Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change, United Nations Children's Fund, New York, NY, USA, 2013, http://data.unicef.org/wp-content/uploads/2015/12/FGMC_Lo_res_Final_26.pdf.

W. S. Yirga, N. A. Kassa, M. A. Gebremichael, and A. R. Aro, "Female genital mutilation: prevalence, perceptions and effect on women's health in Kersa district of Ethiopia," International Journal of Women's Health, vol. 4, pp. 45–54, 2012. View at: Publisher Site | Google Scholar

World Health Organization, Department of Reproductive Health and Research, Eliminating Female Genital Mutilation, WHO, Geneva, Switzerland, 2008, http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf.

World Health Organization, Female Genital Mutilation, 2016, <http://www.who.int/mediacentre/factsheets/fs241/en/>.

APPENDIX 1

QUESTIONNAIRES FOR INDIVIDUAL WOMEN

Dear, Respondent,

I ‘am Araptai Baba Louis, a student at Metropolitan International University undertaking a research study on “FGM and women health in Kapchorwa district”.

You have been chosen as one of the respondents to assist in this study. The rights to participate, discontinue and continuing with the study is reserved free and no penalty is awarded. All information that will be solicited during the study will only be used for the purposes of this study, utmost confidence is assured for all the information provided. Do not write your name elsewhere on this questionnaire. Apply a [√] where appropriate

SECTION A: PERSONAL PROFILE.

1. What is your;

a) Age

Below 18 ☐ 18-25 ☐ 26-30 ☐ 31-40 ☐ 41 and above ☐

b) Academic level

Certificate ☐ Diploma ☐ Degree ☐ Masters ☐ PhD ☐ Others

specify.....

c) Marital status

Single ☐ Married ☐ Others

specify.....

SECTION B: INDEPENDENT VARIABLE (FGM).

2. a) What do you understand by female genital mutilation?

.....

.....

b) Is FGM practiced in your community?

Yes. ☐

No. ☐

c) If the answer to (b) above is no, give a reason why?

.....

.....

3. a) If FGM is practiced in your community, how do you think it is done?

State	Tick
Partial or total removal of the clitoris or prepuce	
Partial or total removal of the clitoris and labia minora.	
Narrowing of the vaginal orifice with creation of a covering seal by cutting and positioning of the labia minora and labia majora.	
Pricking, piercing, incising, scraping and cauterization.	
None of the above	

b) What kind of person(s) carry out FGM practice in your community?

State	Tick
Medical practitioners	

Local/cultural practitioners	
Religious practitioners	
None of the above	

c) At what age was/is FGM carried out?

State	Tick
Birth	
Childhood	
Adolescence	
Adulthood	
Any age	

4. Does FGM pass a girl from childhood to womanhood in your community?

Yes. ☐

No. ☐

SECTION C: WOMEN HEALTH.

5. a) Why is FGM practiced in your community?

State	Tick
Cultural norm	
Linkage to femininity and sexuality	

Required by religion	
Associated with cleanliness and purity	
Promotes social cohesion	
Other reasons	

b) If your answer from (a) above is other reasons, specify.

.....

.....

6 a) Do you think FGM is a safe practice in your community?

Yes. ☐

No. ☐

b) If your answer from (a) above is no, give your view(s).

.....

.....

7. a) Do you think there are alternative ways and approaches to substitute for the practice of FGM in your community?

Yes. ☐

No. ☐

b) If yes from (a) above, suggest any way(s) you know.

.....

.....

c) What are some of the psychological and social health impacts of FGM in your community?

.....

.....

Thanks

APPENDIX II

QUESTIONNAIRES FOR LOCAL LEADERS AND RELIGIOUS LEADERS.

This information is solely for academic purpose and you are assured that the information given shall be treated with at most confidentiality .Please spare some time and respond to the following questions. Tick or give an explanation where necessary.

SECTION A: PERSONAL PROFILE.

What is your;

a) Age

Below 18 ☐ 18-25 ☐ 26-30 ☐ 31-40 ☐ 41 and above ☐

b) Sex

Male ☐

Female ☐

c) Academic level

Certificate ☐ Diploma ☐ Degree ☐ Masters ☐ PhD ☐ Others
specify.....

d) Marital status

Single ☐ Married ☐ Others
specify.....

SECTION B: FGM.

2. a) How can you explain FGM?

.....
.....
b) Is FGM practiced in your community?

Yes. ☐

No. ☐

c) If yes from (b) above, what are some of the reasons for the practice?
.....
.....

3. a) How is FGM carried out in your community?
.....
.....

b) Which kind of persons carry out FGM in your community?

State	Tick
Medical practitioners	
Local/cultural practitioners	
Religious practitioners	
None of the above	

c) At what age would you advise for the practice of FGM to be carried out?

0-11 months. ☐

1-3 years. ☐

4-7 years. ☐

8-10 years. ☐

11-15 years. ☐

16-20 years. ☐

21 years above. ☐

SECTION C: WOMEN HEALTH.

4. a) what are some of the drivers of FGM in your community?

.....
.....
b) Is FGM a safe practice in your community?

Yes. ☐

No. ☐

c) Does FGM pass a girl from childhood to womanhood?

Yes. ☐

No. ☐

d) If yes, why do you think so?

.....
.....
5. a) Do you recommend the practice of FGM to continue in your community?

Yes. ☐

No. ☐

b) If no, which alternative ways and approaches do you think can be put in place to substitute for the practice of FGM in your community?

.....
.....
6. How do you rate women who have undergone FGM with those who have not?

.....
.....
Thanks

APPENDIX III

INTERVIEW SCHEDULE FOR LOCAL (CULTURAL) LEADERS AND RELIGIOUS LEADERS.

Dear, Respondent,

I ‘am Araptai Baba Louis, a student at Metropolitan International University undertaking a research study on “FGM and women health in Kapchorwa district”.

You have been chosen as one of the respondents to assist in this study. The rights to participate discontinue and continuing with the study is reserved free and no penalty is awarded. All information that will be solicited during the study will only be used for the purposes of this study; utmost confidence is assured for all the information provided. Do not write your name elsewhere on this questionnaire. Apply a [✓] where appropriate.

SECTION A: PERSONAL PROFILE.

1. What is your;

a) Age

Below 18 years ☐ 18-25 ☐ 26-30 ☐ 31-40 ☐ 41 and above ☐

b) Gender

Male ☐

Female ☐

c) Education level

Certificate ☐ Diploma ☐ Degree ☐ Masters ☐ PhD ☐ Others
specify.....

d) Marital status

Single ☐ Married ☐ Others
specify.....

SECTION B:

2. a) Do you encourage FGM practice in your community?

Yes. ☐ No. ☐

b) Is FGM done depending on the individual's willingness?

Yes. ☐ No. ☐

c) If the answer from (b) above is no, state how it is done.

.....
.....

d) What equipment(s) is/are used while carrying out FGM?

.....
.....

e) Who is responsible for FGM?

State	Tick
Medical personnel	
Local/cultural leaders	
Religious leaders	

Parents	
Government	

SECTION C: WOMEN HEALTH.

1. a) What are some of the drivers of FGM in your community?

.....

.....

b) Is FGM a safe practice?

Yes. ☐ No. ☐

c) If yes, why do you think so?

.....

.....

2. a) Do you recommend the practice of FGM to continue?

Yes. ☐ No. ☐

b) If your answer to (a) above is no, which alternative ways would you suggest to substitute for the practice of FGM?

.....

.....

c) How do you rate women who have gone through FGM with those who have not?

.....

.....

d) In your own point of view, state the relationship between FGM and women health.

.....

.....

Thanks

APPENDIX IV: TIME FRAME

ACTIVITY	DECEMBER, 2020	DECEMBER, 2020	FEBRUARY- MARCH, 2021	DECEMBER, 2021
Topic submission				
Topic approval				
Proposal writing				
Proposal approval				

APPAENDIX V: BUDGET

ITEMS	UNIT	UNIT COST	COST (Ugandan Shs.)
Papers	1 ream	17,000=	17,000=
Typing & printing			40,000=
Photocopying			20,000=
Binding	3books	2000	6,000=
Research Assistants	2	30,000=	60,000=
Data bundles			20,000=
Miscellaneous			20,000=
Grand total			193,000=

**APPENDIX VI: KREJCIE AND MORGAN TABLE OF SAMPLE SIZE
DETERMINATION**

TABLE FOR DETERMINING SAMPLE SIZE FROM A GIVEN POPULATION

N	S	N	S	N	S	N	S	N	S
10	10	100	80	280	162	800	260	2800	338
15	14	110	86	290	165	850	265	3000	341
20	19	120	92	300	169	900	269	3500	246
25	24	130	97	320	175	950	274	4000	351
30	28	140	103	340	181	1000	278	4500	351
35	32	150	108	360	186	1100	285	5000	357
40	36	160	113	380	181	1200	291	6000	361
45	40	180	118	400	196	1300	297	7000	364
50	44	190	123	420	201	1400	302	8000	367
55	48	200	127	440	205	1500	306	9000	368
60	52	210	132	460	210	1600	310	10000	373
65	56	220	136	480	214	1700	313	15000	375
70	59	230	140	500	217	1800	317	20000	377
75	63	240	144	550	225	1900	320	30000	379
80	66	250	148	600	234	2000	322	40000	380
85	70	260	152	650	242	2200	327	50000	381
90	73	270	155	700	248	2400	331	75000	382
95	76	270	159	750	256	2600	335	100000	384

Note: "N" is population size
 "S" is sample size.

**Krejcie, Robert V., Morgan, Daryle W., "Determining Sample Size for Research Activities",
Educational and Psychological Measurement, 1970.**

Note: "N" is the population size
 "S" is the sample size