PSYCHOLOGICAL AND EMOTIONAL IMPACT OF FEMALE GENITAL MUTILATION AS EXPERIENCED BY KIKUYU WOMEN: A CASE STUDY AT KIAMBU COUNTY IN KENYA

by

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DECLARATION

This thesis is my original work and has not been presented for a degree or any other award in any other University.

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TABLE OF CONTENTS

DEDICATION

To my ever-loving dear mother, Dorcas Mumbi wa Mambo encouraging me to “read always and to always read” and that “education has no end”. Thank you for being there for me and for sharing the happy and sad moments in my life. I will always love you Mami; may your kind generous loving soul rest in eternal heavenly peace. Amen. To a prayer worrier, I was strengthened, God bless you. I love you dota. To my special angel blessed of God to bless and has lovingly walked with me on this journey of success. May God bless you abundantly, I love you mama. To my sincere loving encourager and motivator, thank you is not enough, I love you son..

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ABSTRACT
Female genital mutilation or female circumcision is the term given to traditional practices involving the intentional cutting or partial or total removal of the external female genitalia. Female genital mutilation is often associated with physical experiences suffered by 100-130 million girls and women but there is less awareness about the psychological and emotional impact that can haunt a woman throughout her lifetime. The objectives of the research explored the experiences of the women who had gone through female genital mutilation in Kiambu County, Kenya; explored women's perceptions about female genital mutilation; and explored women's psychological and emotional impact of female genital mutilation; and how the women managed the psychological and emotional impact of female genital mutilation. A qualitative methodology was undertaken in the research using phenomenology technique. In the study twelve participants were interviewed using a semi-structured interview. The data was analysed using interpretative phenomenological analysis. In data collection, semi-structured interviews guided by open-ended questions, face-to-face in-depth interviews were used. The research focused on effects narrated by the participants, including physical, psychological, social, and sexual effects. Findings indicated that, despite the many reasons given for the practice, none of them justified the continuation of the practice. Findings of the study suggested that participants felt that clinical practitioners needed to understand how female genital mutilation is accounted for, for example, reasons, many consequences of the procedure for instance, on physical health, psychological health and relationships. The findings revealed that the participant's knowledge about the effects of female genital mutilation was limited. Implications and recommendations for further research are suggested including, training opportunities specifically regarding female genital mutilation. The study indicated that more education and support of the women to manage the effects of female genital mutilation is required. Further research is required to explore the connections between the physical and psychological effects of female genital mutilation. The research has shown that female genital mutilation has been eradicated in most parts of Kiambu County, Kenya.
Key words: *effects, female genital mutilation, Kikuyu, phenomenology, psychological, traditional.*

LIST OF TABLES

LIST OF FIGURES

ABBREVIATIONS AND ACRONYMS

ARP	Alternative Rite of Passage
FC	Female Circumcision
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
KNBS	Kenya National Bureau of Statistics
KDHS	Kenya Demographic and Health Survey
MYWO	Maendeleo ya Wanawake Organisation
PATH	Programme for Appropriate Technology in Health
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations International Children Education Fund
UNPF	United Nations Population Fund
WHO	World Health Organisation

DEFINITION OF TERMS

According to World Health Organisation (2000), the female genital mutilation definition of terms is listed as follows:

Clitoridectomy: This involves the removing of clitoral hood with or without removing, part or entire of the clitoris.

Excision: This involves the removing of clitoris together with part of all labia minora. This is the common form of female genital mutilation.

Female Genital Mutilation (FGM), Female Cutting (FC), and Female Circumcision (FC): This involves removal of some or all the external female genitalia.

Gender: This refers to cultural definition of men, women, boys or girls used to categorize them into different areas of responsibilities, opportunities and roles within society. Gender refers to femininity and masculinity which are socio-cultural constructions.

Health Risks: This refers to dangers caused to the life of an initiate after circumcision.

Infibulations: Involves the removing of part or all external genitalia, labia minora and stitching or narrowing the vaginal opening, leaving a small hole for urine and menstruation. This is the most severe form of female genital mutilation.

Labia majora: Outer lips of a woman's genitals covering the vagina.

Labia minora: Inner lips of a woman's genitals covering the clitoris.

Operation:	This refers to actual procedure of female genital mutilation.
Religion:	This is an organized collection of beliefs, cultural systems, and world views that relate humanity to an order of existence.
Traditional values:	This refers to cultural beliefs that are valued highly.
Vulva:	The external visible part of female genitals.

(Lockhat, 2004)

Phenomenology:	This is a research method tries to understand human experience through analyzing a person's description of that experience. It attempts to understand people's perceptions, perspectives and understandings of a situation or phenomenon (Manen, 1990).

CHAPTER ONE

INTRODUCTION AND BACKGROUND TO THE STUDY

Introduction

The study explored the experiences of women who had gone through female genital mutilation in Kiambu County, Kenya; explored women's perceptions about female genital mutilation; and explored women's psychological and emotional impact of female genital mutilation. Chapter one gives the definition of the main problem, and introduces the topic for research, provides a background to the study, statement of the research problem, purpose of the study, objectives of the study, research questions, justification of the study, significance of the study, assumptions, scope of the study, definition of terms, a summary of chapter one, and overview of remaining chapters.

According to the WHO (2000), female genital mutilation (FGM) is defined as "procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons". The specific female genital mutilation procedures vary according to ethnicity or geographical region, and grouped into four main types of female genital mutilation depending on the severity and extent of mutilation that has occurred as follows:

Type I:	Clitoridectomy. Excision of the prepuce, with or without excision of part or the entire clitoris.
Type II:	Excision of the clitoris with partial or total excision of the labia minora.
Types III:	Infibulation. Excision of part or all the external genitalia and stitching/narrowing of the vaginal opening.

Type IV: Unclassified and includes pricking, piercing, or incision of the clitoris, stretching of the clitoris and/or labia; and the introduction of corrosive substances or herbs into the vagina to cause bleeding or for tightening or narrowing it.

In the research carried out by WHO (2000), female genital mutilation types I and II are the most commonly practices forms of female genital mutilation. The estimate that excision of the clitoris and labia minora (Type II) is the most prevalent form of female genital mutilation accounts for 80% of all cases. However, infibulation (Type III) is understood to be the most severe and most harmful to women's bodily and psychological integrity. The procedure is carried out by the girl child's or woman's female relatives or by a traditional birth attendant member of the community. The practice is normally performed without the use of anaesthetic or hygienic surgical tools. Where families can afford to, the procedure is sometimes carried out in a hygienic setting. Instruments known to be used in performing the mutilation, or cutting vary from the use of sharp rocks, razor blades, or kitchen knives (WHO, 2000). Shell-Duncan who has been studying the practice in many countries for years, suggests using the term "cutting" rather than "mutilation," which sounds derogatory and can complicate conversations with those who practice Female Genital Cutting (Shell-Duncan, 2001).

According to Thierfelder, C., Bodiang, C.M.K., & Tanner, M. (2005), female genital mutilation is now considered an act of violence against women because of the physical damage that it causes, and which, if complications are not treated, can cause irreparable harm to female genitalia and reproductive organs. The removal of, or damage to healthy, normal genital tissue interferes with the natural functioning of the

body and causes immediate and long-term health consequences (World Health Organization, 2001; 2008). The short-term complications are, for example, shock, haemorrhage, pain, urinary retention, injury to adjacent tissue i.e. injury to the urethra, vagina, infection, fracture or dislocation the hip joint can occur, and failure to heal, amongst many more complications (WHO, 2008). According to Thierfelder, et al. (2005), the following long-term complications cause sexual complications, pregnancy and childbirth complications. The recurrent urinary tract infections (UTI's) damage to the lower urinary tract during FGM can also result in urinary tract infections and can lead to chronic incontinence or difficulty in passing urine. Infertility can occur due to chronic pelvic infections causing irreparable damage to the reproductive organs.

Background to the Study

Female Genital Mutilation (FGM) also known as female circumcision (FC), female genital excision (FGE), or female genital cutting (FGC), comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (World Health Organisation, 2008). The first historical reference to female genital cutting is in the writing of Herodotus in ancient Egypt in the 5th century B.C. He reported the custom had originated from Ethiopia or Egypt as it was being performed by Ethiopians and Phoenicians and Hittites (Rahman & Toubia, 2000). A Greek papyrus in the British Museum dated 163 B.C., mentioned that circumcisions were performed on girls at the age when their parents received their dowries. Female circumcision was practiced by early Romans and Arabs (Lightfoot-Klein, 1989). In the 1950s, physicians in the United Kingdom and the United States also performed FGC to treat hysteria, lesbianism, masturbation, and other female deviations (Rahman & Toubia, 2000).

Prevalence of FGM in Africa

The World Health Organisation estimates that 100 million to 140 million girls and women worldwide have undergone female genital mutilation and more than 3 million girls are "at risk" for cutting each year on the Africa continent alone (WHO, 2000). Abbas calculates that 100,000 women and girls die from complications related to female genital mutilation in childbirth per annum (Abbas, 2006). The prevalence of FGM varies widely from country to country. female genital mutilation ranges from "nearly 90% or higher in Egypt, Eritrea, Mali, Sudan, and Somalia, to less than 50% in the Central African Republic, and Cote d'Ivoire, and 5% in the Democratic Republic of Congo, and Uganda (Rahman &Toubia, 2000). The practice persists in 28 African countries. Estimates based on the most recent prevalence data indicate that 91.5 million girls and women over nine years old in Africa are currently living with the consequences of female genital mutilation (Yoder & Khan, 2007). For example, traditional and religious beliefs of women having a history of female genital mutilation play a key role in the occurrence of FGM on their daughters. They circumcise children at a younger age because it is easier to reduce public scrutiny, while taking advantage of their children's inability to resist.

Female genital mutilation is mostly carried out on girls from birth to 15 years (Yoder & Khan, 2007). The difference between the percentage of women aged 15 years to 49 years, who have undergone female genital mutilation and the percentage of women aged 15years to 49 years with at least one daughter who has undergone female genital mutilation indicates a change in prevalence, signifying a generational trend towards ending the practice. In Egypt and Guinea, for example, where almost all women aged 15–49 years have gone through FGM, half of the women indicated

that their daughters have undergone female genital mutilation (UNICEF, 2005).According to UNICEF (2005a), the age at which female genital mutilation is performed varies with the cultural group, but it is decreasing in some countries. Africa signified its commitment to the eradication of all forms of violence and inequality against women at legislative level, on 11th July 2003, when 28 governments signed the Maputo protocol at the second ordinary summit of the African Union. (Njoroge, 2005).

Prevalence of FGM in Kenya

The 2016 Kenya National Bureau of Statistics (KNBS) indicates that the total population in Kenya was estimated at 44.4 million people in 2015.The Kenya Demographic and Health Survey (KDHS, 2008-2009) estimates show that there are 42 different ethnic groups of Kenya. These groups can be classified into three different linguistic groups: Bantu, Nilotic, and Cushitic. The largest are the Kikuyu, with about 7 million people, making up 20% of the nation's citizens. Together, the five largest groups, namely, the Kikuyu, Luhya, Luo, Kamba, and Kalenjin make up 70% of Kenya's population. The KDHS survey further estimates that female genital mutilation is practiced in more than three-quarters of the country, with prevalence of the practice varying widely from one ethnic group to another (KDHS, 2008-2009). Prevalence rates differ by regions with rates of 26.5%, 33.8% and 32.1% recorded in Central, Nyanza and Rift Valley regions respectively. Recent data suggest a decline from highs of 38% in 1998, to 32% and 27% in 2003 and 2008–2009 respectively (KDHS, 2008-2009). According to UNICEF (2013), 9.3 million women and girls, or 27 per cent of all women and girls in Kenya, have undergone genital mutilation, placing Kenya 17th among the 29 countries in Africa that carry out the practice.

In Kenya, the practice was nearly universal among some communities, for example, the Kisii and Maasai, and very common among Kalenjin, Taita/Taveta, Embu/Mbeere, and to a lesser extent among the Kikuyu, Kamba, and Mjikenda/Swahili (Lokurosia, 2011). Of the two ethnic groups with the highest percentage of women circumcised is the Somali which is predominantly Muslim, and the other, is the Kisii which is predominantly Christian. The proportion of Somali women in the North-Eastern region who practice virtually universal female genital mutilation and believe cutting is required by Islam is extremely high at 86.5% (KDHS, 2008-09).

In Kenya, female genital mutilation is performed on girls aged between 12 years and 18 years. However, some studies have shown that girls are now being cut earlier, between the ages of 7 years and 12 years. It is thought that the decrease is to avoid detection as a response to legislation banning the practice (Population Council, 2007). The most prevalent type of female genital mutilation practised within Kenya is 'flesh removed' Types I and II. The Kisii and Kikuyu ethnic groups practise Type I clitoridectomy, the Maasai and Meru practice Type II excision, and the Somali, Borana, Rendille, and Samburu Type III infibulations. There is a trend to cut less flesh; for example, among Somali women there was a reported decline in the severity of the cut among younger girls (Population Council, 2007). A similar trend was also observed among the Abagusii, where there has been an increasing trend to carry out a symbolic pricking or nicking of the clitoris, mostly carried out by medical professionals (Population Council, 2007).

Kikuyu Female Genital Mutilation/Circumcision

Mwaipopo (2004) explains that female circumcision among the Kikuyu marks

a girl's transition from childhood to womanhood. Cultural identity or belonging to a lineage group is considered very important to Kikuyu families. Given that parents want their children to become a part of the society and pass on the culture, the practice of female genital mutilation centres the full social acceptability and integration upon females and assigns status and value to the girl or woman, as well as to her family (Mwaipopo, 2004). The circumcision marks a woman's assumption of her female identity, allowing her both to procreate, and to take part in traditional rituals. It is also the time when initiates are instructed in an age-grade marker in the rules and regulations of their society and their responsibilities (Finke, 2000-2003). This rite of passage delineates right from wrong, purity from impurity, insiders from outsiders, and it constitutes the deep structure of the Kikuyu society. During the circumcision ceremonies, the girls receive gifts from their parents and friends, and in return parents receive a much higher bride-price for their daughters being circumcised than those who have not (Mwaipopo, 2004).A Program for Appropriate Technology and Health (PATH) report, explains that for fathers, it is a time to show off their circumcised daughters and their wealth, and to negotiate with prospective in-laws for bride price; for grand-parents, it is a time to reflect on the family's progress and status, to hand-down ancestral teachings, and to feel proud that the new generation is following in their footsteps (Muteshi& Sass, 2005). The study by Finke (2000-2003), established that there was little political will to outlaw female genital mutilation with Kenya's first President, the late Mzee Jomo Kenyatta, who was a strong proponent of the practice, which he used as mobilising agent around cultural rights. The practice of female genital mutilation is becoming less common as traditional social structures break down and women gain increasing access to modern modern western education,

and indeed the cash economy (Finke (2000-2003). However, it is still practiced among those with traditional beliefs.

The Main Concepts and Research Gap in the Study

This section interacts with different concepts for and against the practice of female genital mutilation as an important cultural and social practice, the Kenya-anti FGM Law, Christian campaign against FGM, and the alternate rites of passage.as well as addressing research gaps in the area of study.

FGM is often practiced out of respect for and in conformity to society's culture and traditions. Female genital mutilation has many health risks to women. Utz-Billing (2008), asserts that FGM is a very delicate topic that is deeply rooted in the tradition and culture of a society. Pain affects mood, incontinence can result in social isolation, and women with vaginal fistulae often experience tremendous stigma and are treated as outcasts (Gruenbaum, 2005).A difficult birth may be traumatising for the mother, and if the baby is harmed this may cause severe grief to the mother (Epstein, 2007). The different physical complications are listed as a reminder that they will result in consequent psychological burden to some degree (Gruenbaum, 2005).

Osinowo and Taiwo have shown that the traditional meaning of female genital mutilation sets out how women should behave, and circumcision is expected to make women submissive to men. They report that circumcised women have significantly lower self-esteem (Osinowo & Taiwo, 2003).The ceremonial aspect of female genital mutilation creates a tie between young girls and their community and they may feel achievement at reaching adulthood. Girls go through FGM with their peer group, which may be a protective influence on their mental health. Social support is an important resource for coping with stress (Lesthaeghe & Vanderhoeft, 2001).

For those who support its continuation it is a culture that defines a woman's social standing and ultimately a community's identity. Past experience has demonstrated that to motivate a community to consider abandoning a deeply ingrained and socially sanctioned practice such as FGM, abandonment programs must address the social norms, the beliefs, and the attitudes of communities as a whole, as well as of those individuals who reinforce the continuation of the practice. They must begin with a respect for culture and traditions and an understanding that female genital mutilation occurs because parents love their daughters and want the best possible future for them (Muteshi & Sass, 2005).For most women, the psychological and emotional effects are likely to be subtle and buried beneath layers of denial.

Christian Campaign against FGM in Kikuyu land

The Christian missionaries, raised concern about extreme practices that Kikuyu women and girls were going through such as clitoridectomy circumcision (Kanogo, 2005). It is through the influence of colonialism that the consciousness of the average Kikuyu woman was raised against certain injustices that were perpetuated within customs and practices (Kanogo, 2005). The controversy involved debate between local groupings and between different versions of tradition and modernity (Bodil-Folke, 2008). The missionaries successfully banned the ceremonies, the public dances and songs which they considered to be extremely obscene (Ahlberg, 1991). Therefore, the physical operation and related public celebrations which gave meaning to circumcision being no longer publicly visible has made preventing female genital mutilation difficult.

Kenya-anti FGM Law

FGM is illegal and the government has made efforts to end the practice,

including running various anti-FGM programmes in partnership with international agencies. Since 2011, when the FGM law was introduced, Kenya's anti-FGM prosecution unit has deployed teams across the country in an attempt to prosecute cases. Some girls and/or their families may be at risk of FGM/C and/or face discrimination amounting to persecution or serious harm because of their resistance to the procedure. Each case depends on its specific facts (The Prohibition of Female Genital Mutilation Act, 2011).

Alternate Rites of Passage

In Kenya, girls were traditionally secluded after they had been cut, to give them time to heal as well as to receive instruction. Offering alternative rites of passage, without cutting, is an acknowledgement of the original purpose of the tradition of FGM, namely to celebrate the rites of passage of girls into womanhood. Traditionally, these rites met a few individual and community needs, including introducing girls to their responsibilities as community members, educating them on their future roles as wives and mothers, and teaching them about sexuality and motherhood. Moreover, they were an occasion for family and community cohesion and celebration. Results suggest that this approach is clearly an option when female genital mutilation is practiced as part of an (Muteshi & Sass, 2005).

Statement of the Problem

Females' genital mutilation is one of the harmful traditional practices affecting the health of women. It has physiological, sexual, psychological and emotional impact on women. It is a cultural practice based on custom and tradition. FGM as experienced by women is associated with a series of health risks and consequences. The women who have undergone female genital mutilation experience pain and bleeding as a

consequence of the procedure (Obermeyer, 1999). The health consequences are not only physical but can cause deep emotional scarring including impaired cognition, nightmares, panic attacks and post-traumatic stress syndrome. (Masho & Matthews, 2009). Cultural practices may appear senseless or destructive. However, culture is not static; it is in constant flux, adapting and reforming. People will change their behaviours on understanding the hazards and indignity of harmful practices when they realize that it is possible to give up harmful practices without giving up meaningful aspects of the culture (Population Council, 2007). There is much scientific literature on the adverse physical health complications that can result from undergoing female genital mutilation (Mulongo & Martin, 2014). However, despite its danger, it is still being practiced (Saeverås, 1999-2003). Psychological issues occur which relate to FGM. Therefore, the researcher explored psychological and emotional impact of female genital mutilation as experienced by Kikuyu women.

Objectives of the Study

The study explored the following objectives:

- Women's experiences regarding female genital mutilation.
- Women's perceptions about female genital mutilation.
- Psychological and emotional impact of female genital mutilation.

Research Questions

The study addressed the following research questions:

- What are women's experiences regarding female genital mutilation?

- What are women's perceptions about female genital mutilation?
- What is the psychological and emotional impact of female genital mutilation?

Assumptions of the Study

The study assumed that the participants were honest and truthful when answering the questions, and that they were objective and competent when they answered the questions. The next assumption the study confirmed was that the participants, irrespective of the marital status were residents at Kiambu County.

Justification of the Study

This study was justified because of its focus on a historical analysis of Kikuyu female genital mutilation or circumcision. Justification is embedded in the culture of the people practicing it, and individuals seeking to comply with the belief they perceive their families and the significant elders of their community hold notably that girls should be circumcised (Packer, 2005). In socio-cultural norms where a person's life affects their behaviour and decision making, the social and cultural norms remain strongly in favour of female circumcision. The family and community are the most significant transmitters and guardians of norms. It is through the family that the practice of female circumcision is maintained and upheld as a tradition (Packer 2005).

Significance of the Study

The study was relevant because it provided insights into the female genital mutilation as experienced by Kikuyu women. The study also explored the psychological and emotional impact of female genital mutilation by women. The research contribution helped the women who have gone through the practice to

understand female genital mutilation and its psychological and emotional impact. The outcome of this study will become a point of reference for other scholars who would want to carry out similar research.

Scope of Study

The Kikuyu are found throughout Kenya, but the heaviest concentration is in Central region, known as the traditional Kikuyu homeland. The study was carried out in Kiambu County, in Kenya. The county has cosmopolitan tendencies with a high presence of residents from across the country. The choice of the area is because the County is predominantly occupied by the Kikuyu speaking people. Among other counties, Kiambu came into existence after the promulgation of the New Constitution on the 27th August 2010. Kiambu County borders Murang'a to the North and North East, Machakos to the East, Nairobi and Kajiado to the South, Nakuru to the West, and Nyandarua County to the North West (Appendix IV). The major economic activity is agriculture. The County is strategically positioned especially due to its proximity to Nairobi County. Kiambu is the home to the first president of Kenya, the late, His Excellency Mzee Jomo Kenyatta, and the current fourth president of Kenya, His Excellency Uhuru Muigai Kenyatta.

Limitations and Delimitations of the Study

The study entailed physical travelling with public means of transport, and, therefore, time limitation was a challenge. There was a little constraint on the finance since the researcher was funding the study. The researcher's opinion was that there was reluctance by some members of the community, and were cautious from having a conversation about female genital mutilation. Some of interviewees withdrew from participation openly with distorted views that the county officials who have

authorised this research will intimidate them. What was apparent to the researcher was that the unfavourable situation needed to be salvaged to afford any possibility to elicit the quality of data required for the study. This awkward situation could not continue and was resolved over a cup of tea; this agreed with the participants. This brought about a sense of curiosity and the researcher was asked personal questions which paved the way for dialogue to continue, though unrelated to the aims of the research. However, this departure from the topic on relationship building was necessary because the researcher realized that it was crucial to be able to bond further with the women, in the hope that eventually a level of rapport would develop that could be more conducive to the achievement of the research objectives. The researcher bonded with the participants, secured the situation, and the participants reconciled with the study. Therefore, the researcher, established empathy and trust and had the opportunity to re-state the research objectives and further explain to the participants the purpose of the research. Other participants were not happy with voice recording, and they preferred that the researcher write notes during interviewing, which was agreed. However, the participants broke the secrecy around female genital mutilation and spoke about their experiences freely.

Chapter Summary

Female genital mutilation is mostly carried out on girls from birth to 15years (Yoder & Khan, 2007). According to Thierfelder, et al. (2005), female genital mutilation is now considered an act of violence against women because of the physical damage that it causes, and which, if complications are not treated, can cause irreparable harm to female genitalia and reproductive organs. 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 female genital mutilation. In the long term, post-traumatic stress disorder (PTSD), anxiety, depression and memory loss may occur (Behrendt & Moritz, 2005).Female genital mutilation has had many health consequences and the psychological and emotional impact of the practice. Despite this, it is believed that many clinical psychologists have little knowledge about the procedure and the possible psychological consequences (Lockhat, 2004).

CHAPTER TWO

LITERATURE REVIEW

Introduction

Chapter two presents and discusses what has been written relating to topics relevant to the research study. By examining what others have researched and written, the study has demonstrated the existence of an aspect of the field to be explored, a gap which has been investigated in the study. The chapter contains literature review and theoretical framework. The study sought to explore the female genital mutilation as experienced by women, psychological and emotional impact FGM has on women. The researcher used phenomenology to study the experiences of the women participants. Behrendt & Moritz observe that physical health consequences of female genital mutilation are well documented, however, psychological effects remain limited (Behrendt & Moritz, 2005). Therefore, the researcher explored psychological and emotional impact on women who have experienced female genital mutilation.

Literature Review

Experiences Regarding FGM

Female circumcision is traditionally perceived to be an important rite of passage and is celebrated accordingly. Women experience anxiety about their ethnic or national identity. The social event that the family holds following the daughter's circumcision is central to local culture. Families use the circumcision of their daughters as an occasion to which they invite people to celebrate.

There are a range of childbirth complications that can be associated with female genital mutilation, for example, obstructed labour due to partial or total occlusion of the vaginal opening (Thierfelder, et al. 2005). Because the pain of FGM

recurs throughout a female's life as the traumatized area is directly affected during female biological processes such as menstruation, urination, and childbirth, the anxiety and depressive episodes may have a similar persistent effect(Thierfelder, et al. 2005). Many women who have undergone female genital mutilation experience various forms and degrees of sexual aberrations. These may include fear associated with initial sexual intercourse, pain associated with sexual intercourse, difficulty or inability to have sexual intercourse. It was also found that women suffer from feelings of incompleteness, anxiety, depression, chronic irritability and frigidity because of undergoing FGM. Most of these factors are associated with FGM, and thus have the capacity to manifest as psychosexual dysfunction in a circumcised woman (Elnashar, et al. 2007).

Behrendt, et al. (2005) results from research in practising African communities are that women who have had FGM have the same levels of Post-traumatic stress disorder (PTSD) as adults who have been subjected to early childhood abuse, and that most of the women (80 per cent) suffer from affective (mood) or anxiety disorders. Because female genital mutilation causes young girls such intense pain in a very sensitive area of the body, it carries the potential to cause substantial psychological problems. The depressed and anxious mood caused by painful memories of undergoing circumcision may continuously lead women to feel worthless, guilty, and incapable, sometimes leading to suicidal ideation. Long-lasting and excruciating pain is a key contributor to the development of anxiety and depression (Whitehorn, et al. 2002). Mutilation of the genitalia, the intense pain felt during intercourse, and the inability to achieve sexual gratification are all elements of female genital mutilation that predictably lead to feelings of inadequacy and incompleteness that ultimately

force a woman into a state of depression (Nnodum, 2007). Therefore, this study highlights the important connection between the physical effects, psychological and emotional impact of female genital mutilation.

Perceptions about Female Genital Mutilation

FGM can only be understood within its cultural context in the societies where it is practiced, but despite its harmful physical effect female genital mutilation provides women with many social and cultural benefits (Population Council, 2007). The beliefs sustaining the practice of FGM vary greatly from one ethnic group to another (DHS, 2008; 2009). Circumcision becomes a social status marker, communicating a woman's place within the structure of society. It is also considered to make girls 'clean' and aesthetically beautiful (UNICEF, 2005). There are arguments that female genital mutilation provides cultural identity, cultural cohesion, role clarification and a sense of pride. For many societies, female genital mutilation is clearly about curtailing a woman's sexuality and preventing her from engaging in promiscuity. The most frequently offered reason why female genital mutilation is performed relates to the decreasing of a woman's sexual desire. In societies where virginity is an absolute pre-requisite for marriage and where any type of promiscuity or extramarital relationship may lead to the most severe penalties (World Health Organisation, 2008).

Social Integration

Female Genital Mutilation is a socio-cultural tradition, enforced by community pressure and the threat of stigma. In many societies, the practice of female genital mutilation is considered a vital part of a young girl's social development. For a woman living in a patriarchal society with no access to land or education and no

effective power base, marriage is her main means of survival and access to resources, and female genital mutilation is her pre-requisite for marriage. Custom and tradition are commonly given as reasons for female genital mutilation (WHO, 2000). The social intent of female genital mutilation is thought to be the prevention of sexual promiscuity among women, and to avoid pregnancy outside of wedlock (UNICEF, 2005). Therefore, FGM is a deeply entrenched social convention among some ethnic groups and as such carries consequences both when it is practiced or not practiced. Girls and women will often be under strong social pressure, including pressure from their peers and risk victimization and stigma if they refuse to be circumcised. It is associated with broader issues, for instance, gender, class, and the desire to improve access to socio-economic resources (Berg & Denison, 2010). With the beliefs surrounding female genital mutilation deeply embedded from childhood, the social approval, and the sanctions women face if they do not undergo female genital mutilation, the benefits of female genital mutilation would seem to outweigh the physical difficulties women experience (Population Council, 2007).

FGM Abandonment Approaches

The 2005 study by PATH in Muteshi & Sass (2005) outlined some of the female genital mutilation abandonment approaches. A Program for Appropriate Technology and Health (PATH) report describes the importance of the rite for the entire family of the girls being circumcised in the Kenyan context. However, local agencies organize rescue camps for girls running away from female genital mutilation rather than offering an alternative rite of passage (ARP). These camps seek to protect girls by providing refuge through the circumcision period. In these camps, the attendees are educated on the health risks of FGM its illegality and violation of girls

and women's rights. There is a graduation ceremony at the end of the circumcision period and all the attendees are given certificates, however it is neither recognized by parents nor the local community as an alternative rite of passage (Muteshi& Sass, 2005). Alternative "healthy initiation celebrations," "circumcision without cutting" and "circumcision with words" are strategies that have been pioneered in Kenya by PATH in collaboration with the community-based women's group, Maendeleo ya Wanawake Organization (MYWO). A law prohibiting female genital mutilation, the Children's Act, was passed in Kenya in 2001. At the end of 2011, the existing Kenyan anti-FGM law was replaced by Prohibition of Female Genital Mutilation Act 2011, that banned female genital mutilation nationwide (Maendeleo ya Wanawake, 2000).

Theoretical Framework

The study was guided by a theoretical framework which states that humans know the world through their experiences, where the focus is on the experience of the participants (Orbe, 2009). By using different theories, for example narrative, and cognitive behavioural theories, the practice of female genital mutilation can lead to different interpretations to compose a broader understanding of the phenomenon. A theory is defined as a set of interrelated concepts, assumptions and generalizations that systematically describes and explains behaviour (Ndurumo, 2007). With regard to theoretical framework, the norms on which these considerations are based are communicated through socialisation and social interaction and the individual's motivation or desire to comply with the norms (Packer, 2005). The use of a theoretical framework for the study helps to support connections, shape ideas, and draw conclusions related to human behaviour. It is the belief of theorists of cognitive

draw conclusions related to human behaviour. It is the belief of theorists of cognitive

behavioural and narrative techniques that negative thought patterns lead to negative behaviours and a self-defeating attitude toward life (Kreuger, 2006). The study will apply narrative and cognitive theories, both hold that positive thoughts and positive self-narratives tend to have positive or advantageous impact on people's behaviours and emotions.

Narrative Theory

The proponents of Narrative theory, White and Epston argue that people's problems are produced in social, cultural and political contexts that serve as the basis for life stories that people attribute to events. Meaning is produced through language and its context, and the way that language is used to convey thoughts, emotions and histories (White & Epston, 1990). This is connected to the principles of phenomenology through paying respectful attention to a person's direct experience, and by encouraging research participants to tell their own story (Smith, Flowers & Larkin, 2009). This requires an establishment to a link between individual constructions and the environment of social institutions and culture, as well as examine how a theory of practice is also a symbolic construction or story (Saleeby, 1994). This assists in understanding that people position themselves in the world by creating meaning which is viewed through their culture lens. This is effective when dealing with female genital mutilation women because they rarely get the opportunity to tell their stories from their perspective assigning their meaning (Saleeby, 1994).

Narrative theory investigated how the participants made sense of their world, and how they make sense of stories to capture the rich data within their stories. The researcher used narrative analysis to record different viewpoints and interpreted collected data to identify similarities and differences in experiences.

Cognitive Behavioural Theory

Cognitive-behavioural research is based on observed changes in behaviour and cognition with methodological rigor. It is the basis for scientific investigation that there is an objective, measurable and consistent reality. The cognitive-behavioural force of theories is commonly divided into those with behavioural foundations and those with cognitive foundations (Roth & Fonagy, 2005). Within the cognitive domain, several different approaches exist, for instance, Albert Ellis' Rational Emotive Behavioural theory (REBT), and Beck's cognitive-behavioural theory are problem-oriented, directive, and educational (Cormier & Cormier, 1998). Thus, irrational beliefs are learnt from significant others during childhood and people reinforce self-defeating beliefs, keeping themselves emotionally disturbed by internalizing such beliefs (Corey, 2005).

Roth & Fonagy define cognitive behavioural theory as a research based approach based on formulation, and operates on the premise that thoughts, behaviours and feelings are three points on a triangle, and changing either one of these points changes the other two. (Roth & Fonagy, 2005). Therefore, providing clearer evidence about interventions for effectively treating psychological trauma, and emotional post-female genital mutilation issues is a clear requirement to meet the changing needs of the female genital mutilation population of women.

Conceptual Framework

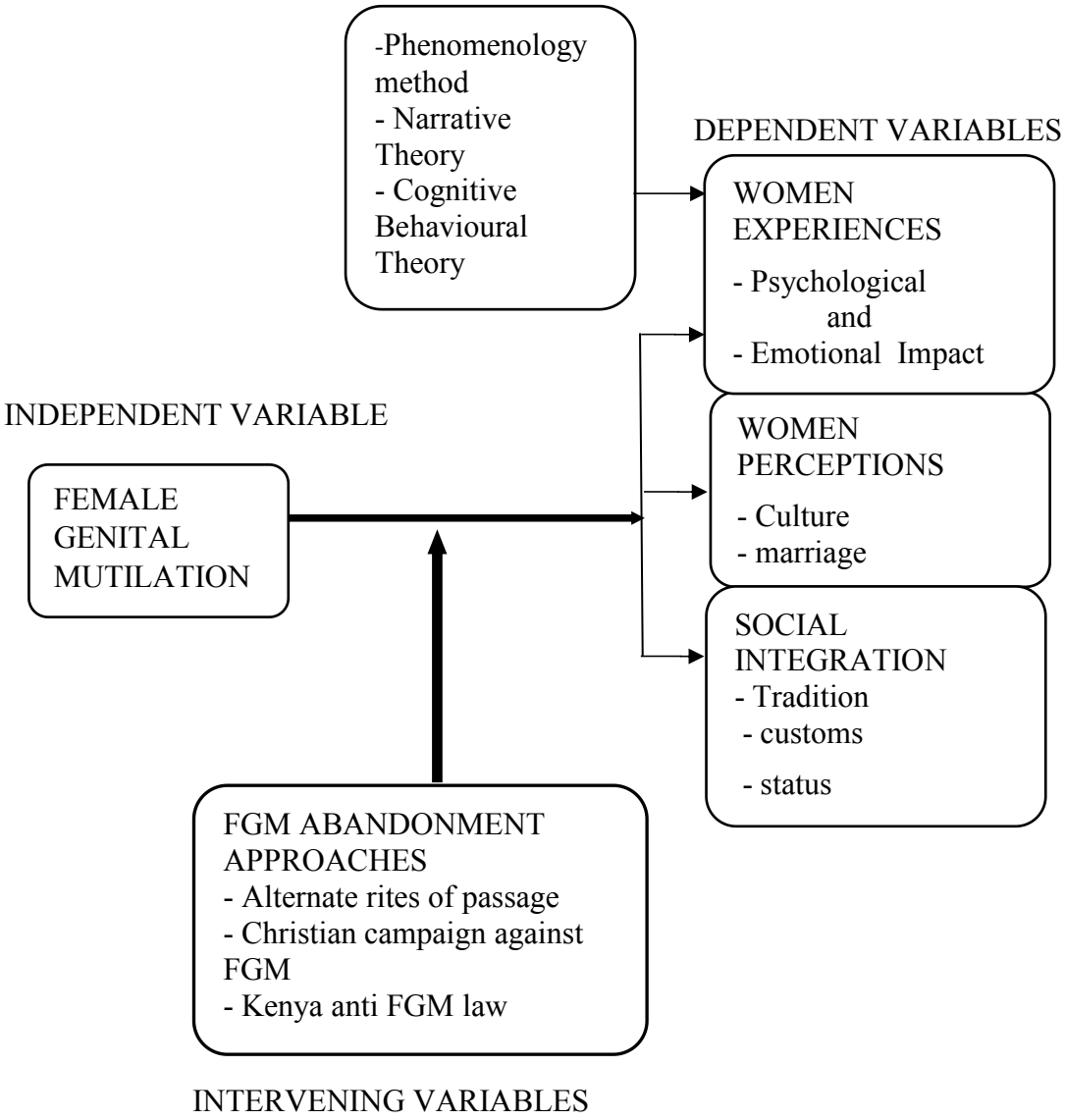

Figure 1. *Conceptual Framework*. Source: Research, 2017

Independent variable is FGM which refers to female circumcision or the cutting of a woman's or girl's genitalia, and it is controlled by an investigator. Dependent variables are controlled by independent variable. Phenomenology method and theories were used to describe the women experiences of FGM and focussing on the meaning of the experience, narrative, behaviour, psychological and emotional impact.

A Synthesis of Research Gap

Despite efforts to end female genital mutilation, progress has been limited caring for women who have gone through female genital mutilation, (WHO, 2017). Lack of research about beneficial psychological and emotional interventions has prohibited conclusions about what may assist the recovery of the women. Therefore, the gap the researcher is addressing in the study is the less well-documented and less understood, psychological and emotional impact of female genital mutilation.

Chapter Summary

In relation to psychological issues surrounding FGM data suggests that following FGM, women experience psychological and emotional disturbances, suffer from anxiety, phobia, and low self-esteem (Berg & Denison, 2010).

CHAPTER THREE

RESEARCH METHODOLOGY

Introduction: Preview of the Sections

The study dealt with research design adopted in the study, population studied, samples selected, sampling methods, types of data, and data collection. This chapter describes the research methodology and research methods which are used in this study. The approach and rationale for the methodology has been outlined. Then the researcher explored the research methods for participants' selection, the research setting, data collection, and data analysis. Subsequently, the ethical considerations involved in this study were explored. The researcher was concerned with understanding participants who have gone through female genital mutilation, explored their experiences, and the psychological impact of female genital mutilation in women living at Kiambu County, Kenya.

Research Design Adopted in the Study

The study applied qualitative research. Among the qualitative research method, phenomenology was applied, and the researcher used interpretative phenomenology technique (Smith, 2004).The study allowed the researcher a detailed exploration of psychological and emotional impact of female genital mutilation as experienced by Kikuyu women. The researcher sought to discover the meanings the participants attach to their behaviour, how they interpreted situations and what their perspectives were on female genital mutilation issues (Woods, 2006). The study applied the research questions to explore female genital mutilation experiences of Kikuyu women at Kiambu County, Kenya.

Sample Size

The study was confined to Kikuyu women who offered a rich data. The researcher has significant knowledge of the Kikuyu language, and has previous opinion on FGM and relationship with people who have undergone FGM. According to Pannucci, & Wilkins, (2010), to avoid bias, the researcher applied bracketing method in qualitative research and stepped back from attitudes, explanations, anticipations, assumptions and focussed on recording their experiences from the first five participants and focussed on taking down interview hand-written notes from the rest seven participants.

Samples Selected

The study selected women between the ages of 35 years and 55 years, and the study sought to elicit and contextualize the human trauma and social costs of female genital mutilation. The approximate number was a population of 20 persons who met the criteria for this study. The researcher interviewed 12 participants.

Sampling Methods

The type of sampling the researcher used was snowballing also known as chain referral sampling which is a type of purposive sampling (Mack et. al 2005). The participants with whom contact was made used their social networks to refer the researcher to other people who participated in the study (Mack et. al 2005). A qualitative methodology was undertaken in this study. The study applied bracketing in qualitative research identification of the participants and temporary set aside the researcher's assumptions. Tufford & Newman (2010) found that there may be occasional close relationship between the researcher and the research topic that may both precede and develop during the process of qualitative research; therefore,

bracketing was a method used to protect the researcher from the cumulative effects of examining what was emotionally challenging material. Tufford & Newman (2010) explain that bracketing has the potential to greatly enrich data collection, research findings and interpretation.

Types of Data

The researcher collected data from people gathered specifically for the study. In interviewing, the researcher developed trust and relationship with the participants (Goodwin, 2006). All interviews were conducted by the researcher who understands and speaks Kikuyu. The interviews used for this study were recorded using a digital voice recorder, as well as hand-written notes. Interviews took place in environments selected by the participant's as they felt that the interviews were about personal and confidential issues.

Data Collection Methods

The researcher collected data using semi-structured interviews guided by open-ended questions, face-to-face in-depth interviews based on a series of issues that were relevant to the topic (Moriarty, 2011). The data collection tool was an in-depth interview that lasted for one hour. The researcher drafted the interview guide. Questionnaire assisted interviews with open-ended questions in Appendix II. The researcher collected data and documented the process and the responses of the participants. The interview notes were reviewed after each interview. While the information was still fresh in the evening, the researcher reviewed the notes and the recording and transcription of the data

Instrument Pre-testing

The researcher obtained the Kenya Government approval for the study and proceeded to do a pre-test of the open-ended questions including in-depth interview using phenomenology method which was not used in the actual data collection. After pre-testing feedback, the researcher improved the research tools and proceeded to the field to collect actual data from women participants who have gone through female genital mutilation in Kiambu County, Kenya.

Data Analysis

The researcher introduced each participant with a short explanation of the purpose of the research, aspects of confidentiality and the intended use of data. The main data sources were personal individual interviews, consisting of open-ended questions, which allowed researcher to conduct the interviews. The participants were honest when they answered the questions. Interviews lasted for approximately one hour and followed the procedural guidelines recommended by Smith, et al. (2009). The researcher applied the following phenomenological data analysis method as described by Kleiman (2004). First, the interview transcripts were read in their entirety to get an insight of the transcripts. The interview transcript was then read once more, to divide the data into meaning units. The researcher integrated those sections/units that were identified as having a similar focus or content, and made sense of them. The next stage in the analysis of the raw data occurred with the transformed meaning units being subjected to a free imaginative variation process. The researcher then re-visited the raw data descriptions again to justify the interpretations of both the essential meanings and the general structure, and followed with a critical analysis of the research study.

According to Kleiman, 2004, this critical analysis included verification that:

- Concrete, detailed descriptions were obtained from the participants.
- The phenomenological reduction was maintained throughout the analysis. Essential meanings were discovered.
- A structure was articulated and the raw data verified the results.

Ethical Considerations

An introduction letter from Pan Africa Christian University, Nairobi, Kenya (Appendix V) was obtained by the researcher to allow for completion of writing thesis.

Research authorization from the Kenyan Government was granted to the researcher by the National Commission for Science, Technology and Innovation(NACOSTI), Nairobi, Kenya (Appendix VI).The researcher ensured that participants are aware that they can stop, or not answer questions (Goodwin, 2006). The researcher obtained informed consent from all participants in writing in Appendix I. Disclosed information was treated confidentially, anonymously, and the researcher informed them that their names will not appear in any analysis (Goodwin, 2006). Participants were given a choice of the interview location. The researcher took measures to ensure that the setting for the interview ensured confidentiality, such as, ensuring that the interviews were conducted in a quiet atmosphere.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

Chapter four presents presentation of results and interpretation of findings, and discussion. The chapter answers the research questions. It reports and discusses research findings, as well presenting the results of experiences of women who have gone through FGM. To understand female genital mutilation as a traditional practice, the study looked at consequences, cultural, and social beliefs. The phenomenological study explored female genital mutilation experiences of Kikuyu women, psychological and emotional impact FGM had on women; and their perceptions about cultural traditions.

Presentation of Results

The chapter presents results from the interviews about women's experiences of female genital mutilation. Top reserve the anonymity of individuals, personal details such as exact age or number of children are removed.

Table 1. *Women Participants Biographical Sketch*

Age (years)	Age during FGM	Participants
35 - 40	10 - 12 years	3
41 - 50	10 – 15 years	6
51 - 55	13 – 15 years	3

Each of the participants I interviewed had gone through female genital mutilation. The participants were literate. However, the participants revealed similarities and differences when asked about the practice of female genital

mutilation. The interviews s started with a discussion that enabled me to obtain the demographic data, for example, age, educational level, age at mutilation of participants in Table 1. An observational field note was also used for data collection. The study sought to find out what each participant knew about female genital mutilation. The participants were identified individually using a capital letter 'P' for participant, followed by their numerical position of the interview, for example, '1, 2'.

Interpretation of Findings

Twelve Kikuyu women who had gone through female genital mutilation were recruited through a snowball technique. All participants were women between 35 years and 55 years. Data were collected through semi-structured, in-depth, face-to-face interviews. Individual interviews were conducted according to the language they preferred either Kikuyu or English, taking into consideration the researcher is a Kikuyu. Some of the interviews were conducted in English and the rest were conducted in Kikuyu. The interviews took a semi-structured format because the perception of the participant was important to this research and semi-structured interviews allowed for flexibility (Bryman, 2004). Relevant information was gathered in a short time, a variety of issued were discussed, multiple views were collected, and clarity was sought. Field notes were taken as a reference point for purposes of validity. The interviews revealed the experiences, perceptions, and social integration of Kikuyu women, legislation against female genital mutilation, and alternate rites of passage. The study findings outline the answers of the research questions.

Women Experiences

The information on women experiences was based on interviews generated from the women participants. The following are some of the direct quotes:

P1 revealed that she knew about circumcision at the age of 10 years when her mother told her that it was time for her to undergo the procedure and that there was nothing more to discuss because her mother told her, “there was nothing more to discuss, and mother was very strict as she was supported by my grandmother. I remember after I was circumcised I was notable to walk properly and sleep for three days”.

P2 heard about FGM from older sister who had gone through circumcision. She explains that she questioned the practice as she saw no meaning of it in her life. She continues to say that her sister told her, “you are saying that now but when your time comes there will be no discussion about it, you will do it”.P3 said when she was about 12 years, "that she was given a reason for her to go through circumcision by her mother who told her, “you will become a very good woman and the whole community will like you”.

P4 revealed that she 13 years when her mother told her she was going to be circumcised and she asked why she should do it, her mother said, “because all girls go through it and it is our Kikuyu custom”.

P5 said that she went through circumcision when she was 15 years and her grandmother told her she was of age to go through the ritual. She was told she would feel a little pain but it would be alright. She said she was happy to be circumcised.

The following participants narrated how each one of them did not think about female genital mutilation because it was a normal tradition:

P6 said, “circumcision is a cultural tradition for Kikuyus and there was no way

I was not going to be circumcised. She continued to say, “those old days every girl went through it and it is not like today when children say no to their parents”.

P7 narrated how happy she was when she knew about it from her mother. She said. “I could not wait to be circumcised so that I get to be allocated responsibilities for a grown-up girl”.

P8 explained how she knew she would be among the girls to go through circumcision. She said, “My older cousins came together with my aunties who were called by my mother and my grandmother. My cousins were very excited that the three of us were to become the lucky girls next ritual season, and I was very happy”.

P9 said that her grandmother kept the circumcision tradition as it was from past generations and she wanted it to continue and P9 said, “circumcision continued in our family until after the year Mzee Kenyatta died”. She continued to say, “I felt a little pain during the actual process then it was all over and all I saw was the singing and ululations and after three weeks of induction to be a woman I was so happy”.

P10 who was younger than the rest of the participants I interviewed said, “I felt obliged to do it because no one told me what I hear today that it is bad and it is only the chiefs who would come around after a long time to say that it is bad and it is good to stop it.

P11 said, “I was happy that I was to be circumcised but I will not forget the physical force which was used to keep my legs apart and on my hands”. She continued, “The pain I went through soon after circumcision was unbearable especially when visiting the toilet”.

P12 said that she was not happy because she knew from her cousins there would be pain during circumcision because, “My grandmother who was the village’s circumciser used sharp razor blades to cut”.

The study investigated whether the participants would encourage the continuity of female genital mutilation.

P2 said that her two younger daughters did not go through FGM. She continued to say, “I would not encourage FGM because I am now a Christian and God gave us all parts of the body for a good reason. She continued to say, “These days FGM does not exist”.

Regarding the type of female genital mutilation, the study shows that specific female genital mutilation procedures vary according to ethnicity or geographical region according to the WHO (2000). Therefore, regarding the type of female genital mutilation practiced,

P3 answered, “I was not told but like five minutes to the ritual done in the open, the circumcision songs sang and danced to by the neighbours and those invited had vulgar messages describing exactly how the cutting was to be done”.

P3 continued and sang that song in Kikuyu whispering and that tickled her and she laughed loudly. She said, “please do not write what I have just sang because it was a powerful circumcision song those old days and not today, that we have left behind”. The researcher found out that the song by P3 depicted Type I: Clitoridectomy - Excision of the prepuce, with or without excision of part or the entire clitoris (WHO, 2000).

The Christian missionaries, raised concerns about extreme practices

Kikuyu women and girls were going through such as clitoridectomy or circumcision (Kinoo, 2005). The missionaries successfully banned the ceremonies, the public dances and songs which they considered to be extremely obscene (Ahlberg, 1991). Therefore, the physical operation and related public celebrations which gave meaning to the operation being no longer publicly visible, preventing female genital mutilation has become difficult. The women participants explained that female genital mutilation does not help girls or women today and they expressed their contentment that it does not exist in Kiambu County, Kenya. Judging from the participants and in relation to the topic, the researcher found that each participant shared that they would not like to see women suffering because of female genital mutilation. From the interviews about women's experiences of female genital mutilation, the results of this study agree with Packer, (2005) that attitudes are determined by beliefs about consequences of a behaviour, that normative considerations consist of social pressure to perform or not to perform a behaviour, and that the norms on which these considerations are based are communicated through socialisation and social interaction and the individual's motivation or desire to comply with the norms (Packer, 2005).

Psychological and Emotional Impact of Female Genital Mutilation on Women.

The participants noted that they went through female genital mutilation when they were young, and the memories are fresh in their minds and when provoked physically in any way affected them because they did not have anyone to talk to and get the necessary help. They said no one would listen to them because it is past negative history. According to how the procedure is done, despite the different ages,

the women described pain during the cutting process, and each one of them remembered they were not able to sleep and walk. Some of the participants said that they were extremely terrified before the procedure started.

> P10 said, “I remember the pain I felt and the way I was made to sit down and my legs forcefully held wide open and I could not scream because I was told to be strong and not a coward. After circumcision, I could not relieve myself because of pain but on second week I was alright and I forgot about it”.
>
> P12 said, “The problem arose when I got married and there was a lot of pain and it continued to happen. I remember even during my first delivery the baby could not come out normally and the baby was pulled they said they used scissors to pull him out. I was left with so many cuts and stiches and it was horrible”.
>
> P7 said, “I have four grown-up children and during delivery, I would have increased tear on the first two, but the two younger ones, the baby could not come out and as he was already tired and I was tired pushing and pushing”. She continued, I went through two caesarean operations and decided I am through with giving birth”.

From the interviews, the participants revealed that female genital mutilation caused problems during delivery with tearing when pushing the baby out. The researcher found that the participants went through female genital mutilation about 20 years to 30 years ago, but later in life the women suffer feelings of loss trust, frigidity, unworthiness, incompleteness and with no means of expressing themselves. These women expressed some form of embarrassment during clinical gynaecological check-ups. They mentioned that no clinical attendant talked to them about their genitalia

during hospital visits for example, pre-natal, delivery, and post-natal visits. The researcher asked each participant one of the semi-structured questions, for example, "If you were to talk to a psychologist or a counsellor what hopes would you have about the meeting?" Three of the participants said they would expect to talk about family problems they had.

P3 said that because she was not happy in her marriage she would like to know what she has not done right and possibly what to do.

P7 complained, "Problems have been there but I don't know what happened years back and my husband lost interest in me and he kept on complaining about the bedroom affairs and I lost interest and nothing happens about sex. I am just there".

P4 was forthright, she said, "I would prefer to discuss about the behaviour of my husband because everyone knows he has a mistress who is young and like a second wife who is approved by his family. He tells his family that I am a cold woman and he has never settled down with me". She says at her age now she feels she does not have to chase after her husband because she has given him children who are now adults.

P9 had this to say, "I got married and knew that my duty was to take care of my husband and our children but along the way I lost interest and happiness of being married because of my husband being violent. He became so forceful in the bedroom and I lost interest in him. On further probing, she said, "Things are not good in my house but I am not leaving because my husband provides for me and my children".

P11 revealed that "I have emotional problems within myself of being

neglected by my husband and lack of love in our marriage". She continued, "it is like we are a brother and sister in the family". On probing further, she continued, "you know nothing happens in the bedroom".

Most of the women reported being helpless, lack of intimacy, and feeling angry about their conjugal rights.

Psychological and Emotional Impact of Female Genital Mutilation. From this research, women are suffering silently and this has resulted in marital instability. Therefore, most of the participants were experiencing stress due to lack of sexual desire and lack of conjugal rights.

P11 said that, "I do not talk about circumcision and sexuality because I think it is related and the doctors don't ask me about it when they are checking on me. She continued, "I feel it is embarrassing for me, but why should it be embarrassing to the doctors. Perhaps they don't know what to do".

P12 explained that when her husband left her he moved in with another young woman. The husband told her, "I am fed up with your holier than thou attitude every time in the bedroom, and I felt that he has taken away my womanhood from me".

Individual participants except one spoke of the exciting moments preceding the female genital mutilation ritual. The participants had their own unique narratives about the ritual.

P5 who is between 55 – 60 years of age narrated, "In those days, as a girl of about 15 years, there was a two-week celebration before the circumcision day. She continued, "during that period, my aunties, cousins, and sisters stayed in the family homestead preparing for the initiation. There was feasting, singing,

dancing to traditional songs only sang during circumcision season.

She continued to say that she is a Christian and no one practices FGM in their family.

Looking at the second objective of the study, the participants expressed their personal perceptions; they reported that embarrassment was a social consequence when they visit the doctors/gynaecologists because of the way their organs look due to the disfigurement caused by female genital mutilation.

From the interviews conducted, cultural beliefs were the most reasons that supported the continuation of female genital mutilation at the time the participants went through female genital mutilation. The study revealed that there was a connection between female genital mutilation and reduced female sexual function. For instance, some researchers assert that female genital mutilation represents a violation of women's physical intactness and can be classified as a "psychological trauma and a potential cause of post-traumatic stress disorder" (Behrendt & Moritz, 2005).According to Thierfelder, et al. (2005), long term complications cause sexual complications. Many women who have undergone female genital mutilation experience various forms and degrees of sexual aberrations. These may include fear associated with initial sexual intercourse, pain associated with sexual intercourse, difficulty or inability to have sexual intercourse. From the study, clitoris is an important organ in experiencing sexual pleasure and orgasm among women. Mutilation of the clitoris would negatively influence sexual achievement and fulfillment among many women who have undergone the procedure of female genital mutilation (Lightfoot-Klein 1989).

Kenya Anti-FGM Law

A law prohibiting female genital mutilation, the children's act, was passed in Kenya in 2001. At the end of 2011, the existing Kenyan anti-FGM law was replaced by prohibition of female genital Mutilation Act 2011, which banned female genital mutilation nationwide. These include the Children's Act (No.8 of 2001), the Constitution of Kenya 2010, the Sexual Offences Act (No. 3 of 2006), and the Prohibition of Female Genital Mutilation Act, 2011.

Discussion

In this section, the study discusses conceptual framework provided in the literature review in chapter two. The interviews helped to bring out the experiences, perceptions, and social integration of Kikuyu women. The researcher embraced the psychological and emotional impact as revealed by the participants during the interviews as follows:

Women Perceptions

The circumcision marks a woman's assumption of her female identity, allowing her both to procreate, and to take part in traditional rituals. It is also the time when initiates are instructed in an age-grade marker in the rules and regulations of their society and their responsibilities (Finke, 2000-2003).

Marriage and Identity. It was also found that all the participants went through female genital mutilation procedure because of social pressure from peers to avoid name-calling, and from mothers, grandmothers, relatives to find husbands in the future. With further research into the needs of women who have gone through FGM will ensure effective outcomes.

Social Integration

Cultural identity or belonging to a lineage group is considered very important to Kikuyu families. Given that parents want their children to become a part of the society and pass on the culture, the practice of FGM centres the full social acceptability and integration upon females and assigns status and value to the girl or woman, as well as to her family (Mwaipopo, 2004).

Customs and Status. According to the participants, female genital mutilation was a rite of passage delineating right from wrong, purity from impurity, insiders from outsiders, and it constituted the deep structure of the Kikuyu society. (Mwaipopo, 2004). All the women participants said that they did not see themselves as victims because they were fulfilling their Kikuyu tradition.

Psychological and Emotional Impact. With knowledge, many of the identified problems would be at a very low level, and with appropriate knowledge of female genital mutilation, psychological impact would be lessened. Women need support, but also with their spouses for married women, with the help of counsellors, psychologists and therapists using their skills.

Summary

Communities that practice FGM maintain their customs and preserve their cultural identity by continuing the tradition. Society attempts to control women's sexuality by reducing their sexual fulfilment. Therefore, in a community in which most women are circumcised, family and friends create an environment in which the practice of circumcision is a requirement for social acceptance.

All the women participants felt proud to have gone through FGM, for example, they were empowered in their homes and were respected by their relatives.

Female circumcision among the Kikuyu marks a girl's transition from childhood to womanhood (Mwaipopo, 2004).It calls for efforts to involve civil society such as religious leaders who have played a limited role in the fight against the practice but whose input is crucial (National Women's Bureau, 2002). The study by Finke (2000-2003), established that the practice of female circumcision is becoming less common as traditional social structures break down and women gain increasing access to modern western education, and indeed the cash economy. While there is awareness on female genital mutilation, health services focus on the physical effects of female genital mutilation, such as chronic urinary tract infections, painful periods, and acute and chronic pelvic infections that can lead to infertility. However, the medical community do not link the experiences by women of female genital mutilation to the anxiety and panic in their lives. Hence, the researcher investigating psychological and emotional impact in the study.

The study has validated that women who have gone through FGM encountered psychological and emotional impact from having had FGM which relates to physiological complications. However, the extent of the women's suffering related to complications that have arisen from undergoing FGM and the socio-cultural context of their belief system, marital relationship, and support networks. Those working in the health sector as well as social workers are best placed to initiate and facilitate support for women with FGM. The findings of this study provide an indication of psychological and emotional impact on women having FGM.

CHAPTER FIVE

SUMMARY OF FINDINGS, IMPLICATIONS, CONCLUSIONS, RECOMMENDATIONS AND AREAS FOR FURTHER RESEARCH

Introduction

Chapter five presents summary of findings, and policy implications. Conclusions are drawn explaining the extent to which the research questions have been answered. Thereafter, research recommendations are drawn, and possibilities for further research proposed.

Summary of Findings

Female genital mutilation is a traditional practice because it has been maintained from one generation to the next (Skaine, 2005). The norms on which these considerations are based are communicated through socialisation and social interaction and the individual's motivation or desire to comply with the norms (Packer, 2005).Of importance to this study, was the researcher's desire was to hear the voice of women who have gone through female genital mutilation narrating their experiences, and the participants felt safe in the choice of their environment and because they had confidence with the researcher. All participants were debriefed following the interview and were reminded of the full aims of the research. At the end of the interviews, participants were asked about how they found the interview and the expressed their appreciation because they could connect some of their personal challenges with FGM. The researcher made the women aware of the counselling support services that were available within the social services offices in Kiambu County, Kenya, if they felt psychologically or emotionally distressed.

Implications

Many women suffer from a sense of loss. They feel that something has been taken from them that cannot be returned. Many women report feeling physically abnormal. Most women see the emotional and psychological effect as the harshest effect on women.The negative implications extend to the social realm in that women without the procedure risk being outcasts in their communities and cause a woman to be rejected. For example, most women who develop fistulae are abandoned by their husbands because of their inability to have children, and ostracised from their communities because of their foul smell (UNPF, 2008). Fistula formation is sometimes a recognised ground for divorce, and causes a lack of marriageability, and, therefore, female genital mutilation can have the opposite effect of what it sets out to achieve. Raising awareness of the risk of negative psychological consequences is important, with health care professionals requiring training on how to treat and care for women who are suffering with issues that result from having female genital mutilation (Muteshi & Sass, 2005).

Conclusions

The section explains the extent to which the research questions have been answered. The researcher collected information from women who have undergone female genital mutilation and are against it. Based on the interviews, and the review of literature, it can be concluded that female genital mutilation is a traditional practice that is rooted in the culture and tradition. The women participants looked at the custom as protected by cultural beliefs when they went through the circumcision initiation.

Experiences Regarding FGM

Female genital mutilation has psychological and emotional impact on women. On the one hand, women may find the experience so traumatising that it continues to distress them decades later. Circumcised women may find it harder to enjoy sex.The research findings disclosed that due to the removal of the clitoris, which is the sexual stimulant in women, many women did not experience a lot of satisfaction when having sex with their husbands. Participants revealed that they are reluctant to undergo genital examinations, including smear tests. They reported that there have not heard about counselling on women who have FGM. They explained that there are not aware of any services offered in the community's social workers or hospitals dealing with psychological or emotional needs. A few of the participants felt this was unnecessary for them.

Perceptions about FGM

Human behaviours and cultural values, however senseless or destructive they may appear from the personal and cultural standpoint of others, may have meaning and fulfil a function for those who practice them. However, culture is not static, but it is in constant flux adapting and reforming. People will change their behaviours when they understand the hazards and indignity of harmful practices, and when they realise that it is possible to give up harmful practices without giving up meaningful aspects of their culture (Joint Statement by the WHO/UNICEF/UNFPA, 1996 in Gruenbaum, 2011). Making the practice a criminal offence and safeguarding the rights of women and children has also reduced the practice of female genital mutilation in Kiambu County, and Kenya in general.

Abandonment Approaches

Kenya Prohibition of Female Genital Mutilation Act 2011 banned female genital mutilation nationwide. The data collected by the researcher revealed that women participants experienced female mutilation issues and they experienced the effects of female genital mutilation, for example, they had recurrent health issues associated with the FGM. However, the participants were not aware of the female genital mutilation extent.Some of the women found sex painful because of the penetration due to the virginal hole being too small. They reported lack of sexual desire which had led to a few cases of divorce because their spouses were not satisfied sexually and because of the pain women experienced, they withdrew from having sex. They expressed that they required appropriate services from the health facilities. They reported psychological and emotional problems, anxiety, low self-esteem, stress, and for some depression. The researcher appreciated the necessity of, and specific challenges associated with gaining the trust of the participants before they considered speaking out about their experiences. Majority of the people in the Kikuyu community do not like to speak about human sexuality and sexual organs, they feel uncomfortable. However, the participants were very eager to talk about FGM in relation to my study, and the women felt safe and they could present their views and speak for themselves, for example, when their language skills or emotion made it difficult to express themselves.

Recommendations

- The County government should organise capacity building trainings to increase the awareness on the impact of female genital mutilation, for example, to the community leaders, social workers, religious leaders, school teachers, and law enforcement bodies.
- Progress has been limited in caring for women who have gone through female genital mutilation, and to move forward addressing the needs of women in Kiambu County may seem remote, but it can be part of the effort to protect the health of women in the community and to ensure that the community's awareness can support efforts to stop the practice of female genital mutilation in Kenya.
- The psychological effects are less well-documented and less understood. Therefore, additional education through awareness by policy making institutions, and counselling support for women to build both knowledge and confidence is required.
- Positive social change from this study may inform a future seminar on the findings of the study to policy makers.
- The participants expressed how they feel about female genital mutilation which makes them ambassadors for educating women in the community about female genital mutilation through their experiences.
- Continuous enlightenment on the dangers of female genital mutilation will be of great importance in abolishing of female genital mutilation.

- The government should support psychologists/therapists/counsellors to attend to the women who are living with the challenge of sexual satisfaction due to female genital mutilation.
- Women who have gone through female genital mutilation should be identified by the County government and enabled to work as role models and ambassadors in the fight against female genital mutilation in the County and in Kenya.

Areas for Further Research

In this section, the study discusses areas for further research. Women who have undergone FGM need counselling and health-care support to manage the physical, psychosocial, psychological effects that result from female genital mutilation. With suitable knowledge, many of the cultural uncertainties for both women and providers would be absent, and there would be a greater level of understanding and expectations that would be more clearly acknowledged and understood. Women who have gone through female genital mutilation need counselling and health-care support to manage the physical, psychosocial, psychological effects that result from female genital mutilation (World Health Organization, 2017). From the research findings female genital mutilation has direct psychological and emotional impact on women who have experienced circumcision. Therefore, further research about the management of the women's health as well as their psychological and emotional needs with their spouses and partners is required.

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APPENDIX I: WOMEN PARTICIPANT'S CONSENT FORM

I, the undersigned have been informed about the purpose of this research and have been informed that the information I will give will be used only for the study. I am also informed that my identity as well as the information I will be providing will be kept confidential. Based on this, I agree to participate in the research voluntarily.

Name of the participant_____

Signature _____

APPENDIX II: QUESTIONNAIRE FOR WOMEN PARTICIPANTS

Semi-Structured Questionnaire

- Have you ever talked about circumcision with anyone or a professional outside of your community?
- What are your views about female circumcision in your culture?
- If you were going to talk to a psychologist or counsellor, what hopes would you have about the meeting?

Personal Questions Related to FGM

The main question is:

- How do you describe your experience regarding FGM?

The interview questions are:

- Do you have any recollection of your circumcision?
- What was done to you at that time?
- What do you remember of it?
- How do you feel about it now?
- Would you like to add or discuss any other issue on the topic?

APPENDIX III: MAP

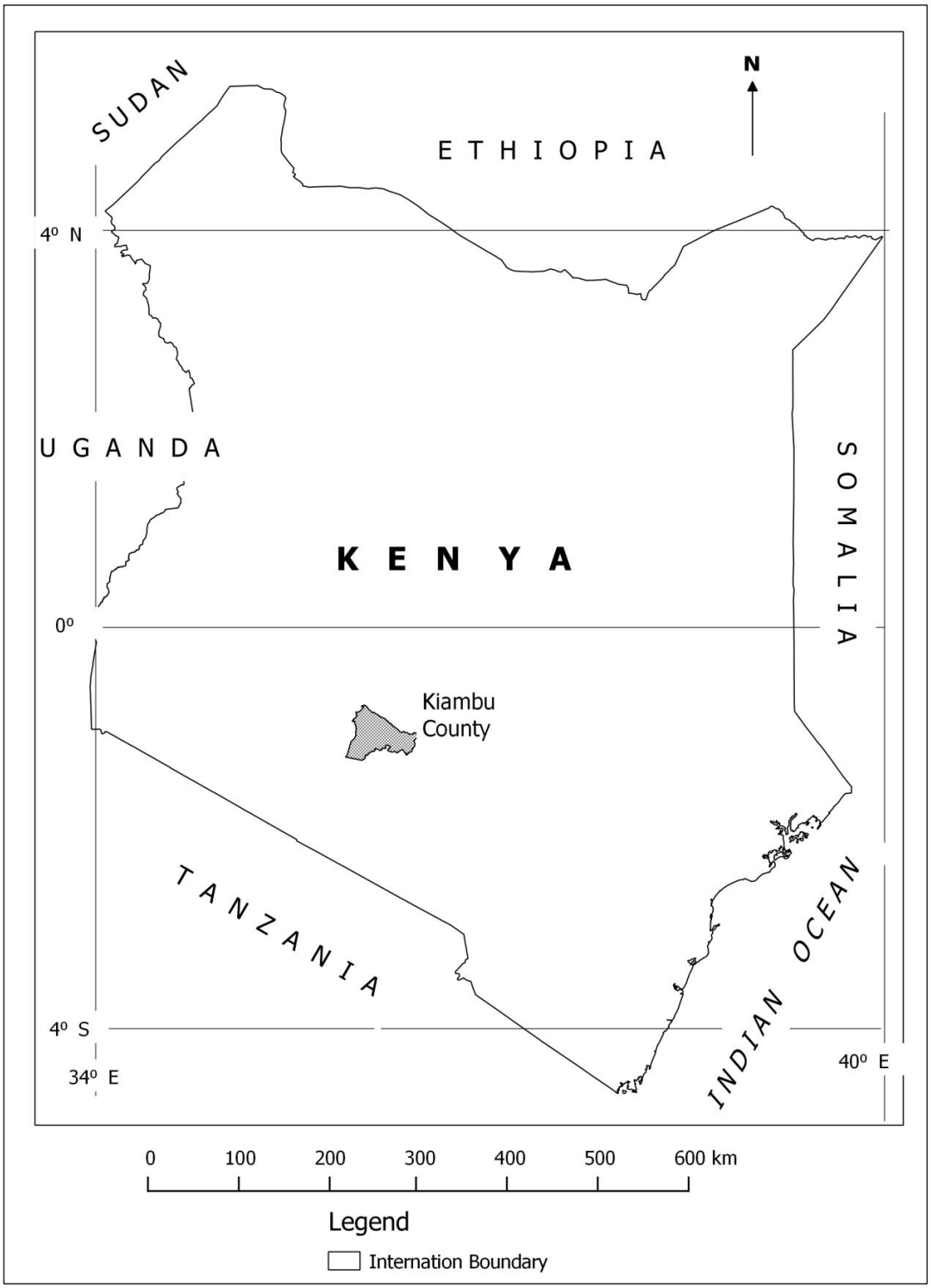

Figure 2. *Location of Kiambu County in Kenya.* Source: IEBC 2013

APPENDIX IV: MAP

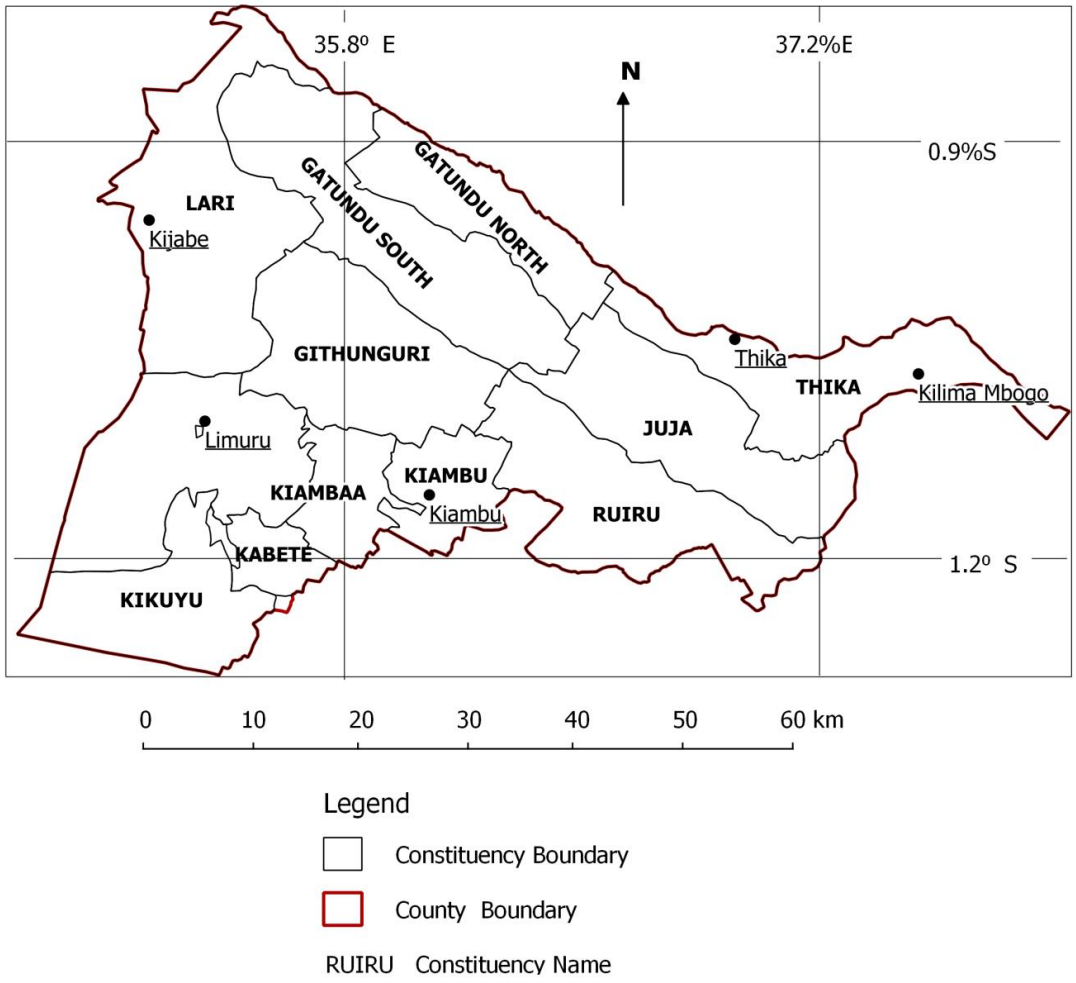

Figure 3. *Map of Kiambu County, Kenya.* Source: IEBC 2013.

APPENDIX V: INTRODUCTION LETTER FROM PAN AFRICA CHRISTIAN UNIVERSITY, NAIROBI, KENYA

27th June, 2017

PAN AFRICA CHRISTIAN UNIVERSITY

P.O. Box 56875, 00200 Nairobi, Kenya
+254 721 932050, +254 734 400694
enquiries@pacuniversity.ac.ke,
admissions@pacuniversity.ac.ke
www.pacuniversity.ac.ke

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

RE: MARGARET NJERI GACHERU REG. NO. MFT/0301/14

Greetings! This is an introduction letter for the above named person a final year student in Pan Africa Christian University (PAC University), pursuing Master of Arts in Marriage and Family Therapy.

She is at the final stage of the programme and she is preparing to collect data to enable her finalise on her thesis. The thesis title is **"Female Genital Mutilation in Kenya – Experiences of Kikuyu Women: Case Study at Kiambu County, Kenya"**

We therefore kindly request that you allow her conduct research.

Warm Regards,

PAN AFRICA CHRISTIAN UNIVERSITY
P. O. Box 56875, NAIROBI - 00200.
TEL: 8561820/8561945/2013146

Dr. Lilian Vikiru
Registrar Academics

27th June, 2017

APPENDIX VI: RESEARCH AUTHORISATION FROM THE KENYA GOVERNMENT BY THE NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION (NACOSTI), NAIROBI, KENYA.

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone:+254-20-2213471,
2241349,3310571,2219420
Fax:+254-20-318245,318249
Email: dg@nacosti.go.ke
Website: www.nacosti.go.ke
When replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No. **NACOSTI/P/17/54990/18074**

Date: **4th July, 2017**

Margaret Njeri Gacheru
Pan Africa Christian University
P.O. Box 56875-00200
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Female genital mutilation in Kenya - Experiences of Kikuyu Women: Case study at Kiambu County, Kenya,"*** I am pleased to inform you that you have been authorized to undertake research in **Kiambu County** for the period ending **4th July, 2018.**

You are advised to report to **the County Commissioner and the County Director of Education, Kiambu County** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

GODFREY P. KALERWA MSc., MBA, MKIM
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Kiambu County.

The County Director of Education
Kiambu County.

National Commission for Science, Technology and Innovation isISO9001: 2008 Certified