

Female Genital Mutilation in Kenya: Impacts of Women's Health Intervention Programs on FGM Prevalence

Corinne Sabetti¹, Megan Traversy¹, Elina Gentilhomme¹, Maximiliano Dean¹

Key intervention elements that had a positive impact on FGM prevalence



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Affiliations

¹McGill University

Correspondence

megan.traversy-drolet@mail.mcgill.ca

corinne.sabetti@mail.mcgill.ca

Abstract

Female genital mutilation (FGM) is practiced in 30 countries, mainly concentrated in the Western, Eastern, and North-Eastern regions of Africa, in some countries the Middle East and Asia, as well as among migrants from these areas (1). FGM is therefore a global health and human rights concern. Although the prevalence of FGM has decreased in the past years, some communities still resist abandoning the practice. Kenya is a distinctive example of a country where the practice of FGM has decreased significantly but interventions have failed to eliminate the practice at a local and national level. The purpose of this case study is to provide an overview of interventions that have been carried out in different communities of Kenya and assess what is necessary for an intervention to be successfully implemented and have a positive impact in communities.

Disclaimer: Before going on, the authors of the article want to explain why they decided to use the term female genital mutilation (FGM) throughout the article. Many different words and expressions are used to describe the intervention. Some refer to it as cutting, female circumcision, female genital mutilation/cutting (FGM/C), sexual mutilation and/or pharaonic circumcision. While all these terms refer to the same procedure, the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children refers to it as female genital mutilation (FGM) since 1990 and the World Health Organization since 1991. Considering these two organizations are at the forefront of this debate we decided to use the same nomenclature. Similarly, our stance on the issue is similar theirs. Therefore, we are opposed to any practice that is harmful to the physical and psychological health of women without their educated consent. This entails complete opposition to performance of FGM on children.

Background

Female genital mutilation (FGM) has been forcibly performed on over 200 million girls and women world-wide, and it is currently practiced in 30 countries (2). According to the World Health Organization (WHO), FGM “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” (1).

FGM is classified into four categories by the WHO as follows:

- Type 1 (clitoridectomy) involves the partial or complete removal of the clitoris.
- Type 2 (excision) involves the partial or complete removal of the clitoris and labia minora, with or without the removal of the labia majora.

- Type 3 (infibulation) involves the narrowing of the vaginal opening by cutting and repositioning the labia, through stitching, with or without the removal of the clitoris. This is the most invasive procedure.
- Type 4 FGM involves all other medically unnecessary procedures done to the female genitalia, such as pricking or incising (1).

In Kenya, FGM has been declining in recent decades. Its prevalence has decreased from 38% in 1998 to 21% in 2014 among women aged 15-49 (6). However, it is still pervasive in certain regions, with a rate as high as 97.5% in the North Eastern region as of 2014 (7). Aside from geographical region, FGM rates also vary due to factors such as religion, education, and ethnicity (7). Additionally, the reasons for performing FGM vary widely between cultural and ethnic groups. Reasons include celebrating a rite of passage, becoming eligible for marriage, and preserving/controlling family honor and sexual purity (7).

Despite the current legislation of complete criminalization in Kenya, FGM persists. The Kenyan Prohibition of Female Genital Mutilation Act was introduced in 2011 and revised in 2012. The law criminalizes FGM, individuals who aid or abet it, individuals who take someone out of the country to perform FGM and imposes consequences for practitioners if the procedure causes death (6).

Aside from the government, there are many constituents working towards the eradication of FGM in Kenya. These include local NGOs, community-based organizations, faith-based organizations, international organizations, and multilateral agencies (7).

What impacts did localized women’s health intervention programs have on the prevalence of FGM in various communities of Kenya?

Interventions

Over the past 30-40 years, interventions to reduce the prevalence of FGM have been implemented in most of the countries where it is practiced. This has resulted in a decreased rate of FGM in most communities (8), but it is estimated that 3.6 million women and girls are at risk of being cut every year (9). In Kenya, a variety of interventions have been carried out in different communities, with the effectiveness and results of these interventions varying greatly. Interventions can be divided in different categories such as health worker training as change agents who feel empowered to refuse practicing medical FGM, formal education provided to young girls, media communication, outreach and advocacy, alternative rites of passage (5, 9). The goal All of these interventions rely on are disseminating

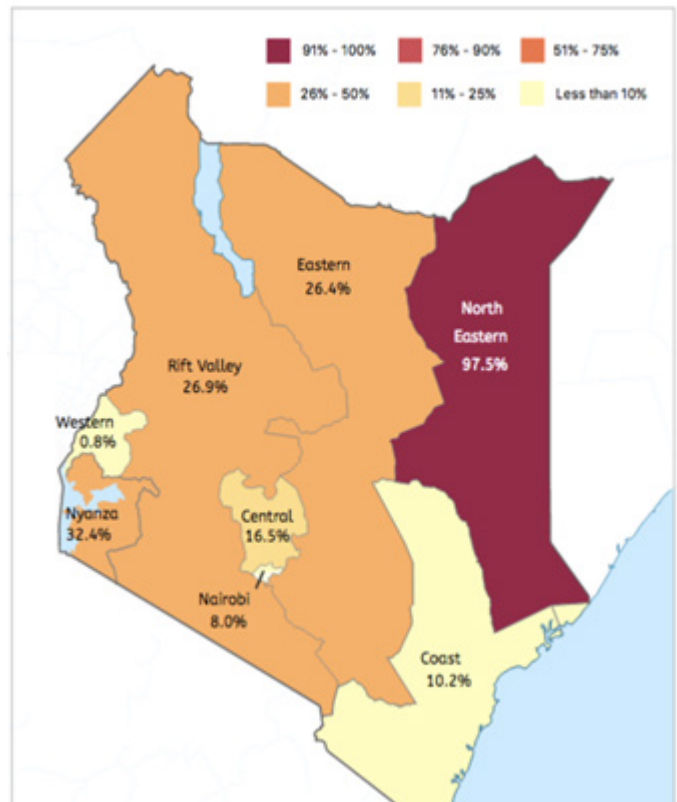


Figure 1. Prevalence of FGM in Kenya by province (source DHS data 2014) (7) information to change behaviours and reducing the prevalence of FGM in young girls and women (5).

Training health workers as change agents

In 2017, researchers from the University of Nairobi conducted a study to evaluate the impact of a training program for nurse-midwives to increase their knowledge on FGM to empower them to better manage and treat complications of FGM and prevent it by refusing to perform the practice when asked (9). Their hypothesis was that providing health professionals with a formal training on FGM and providing anti-FGM strategies could have a significant impact toward its abandonment (9). In Kenya, nurse-midwives form the bulk of the health workforce and are extensively distributed across the country, including in remote areas. Nurse midwives provide primary, as well as reproductive health care, making them the appropriate type of health worker to train in the goal of impacting the prevalence of FGM (9). To assess baseline knowledge on FGM, the nurse midwives completed a 12-question quiz before they begin the 3-day training program. A pre-training questionnaire gave some insight into the knowledge of nurse-midwives on many themes surrounding FGM including the types of FGM, factors for cutting, the role of nurse midwives in managing and preventing the cutting and many others. Overall, the results of the research were encouraging; the baseline

mean score was of 64.8% and was 96.2% post training which shows a significant improvement in knowledge (9). Some of the most notable findings were that their baseline knowledge of which communities of Kenya practice cutting was poor with a pretest score of 61.5% but improved with training (92.3%). Also, most of them believed that FGM was culturally beneficial, even after the training, reminding the strong role that culture has on this practice (9). It was also observed that the fear of social sanctions and banishment was an important contributing factor for the persistence of the practice, as midwives are also part of communities. The study concluded that training offered nurse-midwives the skills to counsel women who underwent FGM, including how to respond when asked to perform infibulation after a delivery and how to counsel husbands by educating them on the health risks (9). Lessons learned from this study indicate interventions should target culture of practices and beliefs as well as education on women's health in order to be effective in decreasing the number of girls being subjected to FGM (9).

Outreach and advocacy

Underlying approaches to prevention and behaviour change are strategies of information dissemination (5). This type of intervention, often referenced to as outreach and advocacy, was provided to members of the Somali community that were situated in a refugee camp in Kenya (4). In this community, the rate of FGM was 100% in 2001 (mainly type III) and the common reasons claimed to justify the cutting are to ensure marriageability, religion, protection of virginity, and tradition (5). The exact educational activities conducted during this intervention were not described in the study. Looking at the results of the questionnaire completed before and after, there was no significant improvement. The intervention was principally unsuccessful: there was no notable impact on the adults' intention to perform FGM on their daughters; there was a minor impact on the belief that FGM compromised human rights of women despite good knowledge of harmful FGM consequences (4). While this intervention failed its objectives, there are still lessons to be learned for future interventions: it is imperative that program planners understand contributing factors to FGM in the specific community it is targeted to, to ensure programs are culturally responsive (4). In the case of the Somali refugee camp, reasons for cutting are strongly linked to Islam (5), and the work that was planned with religious leaders was not carried out. The intervention was also implemented by a Christian group (4), accounting for one probable factor that led this intervention to fail. This highlights the importance of a culturally appropriate approach, which will be discussed later.

Alternative rites of passage

Some studies have shown that FGM can be effectively eliminated when the community is presented with an alternative rite of passage (ARP) that preserves culture and

the health of women (10,11). ARPs are effective in that they incorporate cultural practices or celebrations that traditionally accompany FGM rituals (10). For example, if the girl is usually secluded from the group before and after FGM, then an alternative could be that girl leaves the community to go to an educational program. For this reason, ARPs have been shown to be most effective in communities with public celebrations, as the ARP can replace the cut, while the celebrations can be maintained (11). In communities where FGM is practiced in private or is not associated with a rite of passage, ARPs are less likely to be adopted. According to the WHO, it is also important for the community to play an integral role in planning and implementing the ARP, so that their cultural values respected, and the intervention is not an outside interference (10). The success of an ARP has been attributed to its flexibility to stress different components and celebrations in accordance with a specific community (10).

An ARP project in Meru, Kenya used organized events called "Ntanira na Mugamo" or "Circumcision Through Words." These events involved a weeklong program of counselling, training, and education of young women, ending with a "coming of age" celebration with music, dancing and feasting like they normally would (10). Some topics addressed during the program include teaching of basic anatomy, sexual health, hygiene, development of self-esteem and how to deal with peer pressure. This project reportedly prevented over 1000 FGM procedures over eight years (10). The success of the intervention was linked to the inclusion of the entire community and family members, including males (10).

Another study looked at attitudes towards ARPs in the Kuria and Kisii communities of Kenya. It suggests that the successful implementation of an ARP is strongly linked to local understanding and acceptance, especially by decision makers such as parents and community leaders (11). Therefore, it is suggested that ARPs be embedded in programs with a larger scope involving education, empowerment, and collaboration between different stakeholders like schools, health providers and community leaders (11).

Human-rights & religious approach

In Kenya, the CARE Refugee Assistance Project partnered with the National Council of Churches of Kenya to expand on community level FGM intervention programs. The goal of this intervention was to understand how various community-based programs could affect the understanding of the effect of FGM, and furthermore encourage the abandonment of female genital cutting. The CARE program focused on two camps, the Ifo camp and the Hagadera camp. Before implementation, a pre-intervention baseline survey was done in order to understand the context of the practice (12). The project held community education and public discussion events to understand the way FGM was viewed as a human rights violation (12). Public messages were announced,

emphasizing FGM as a human rights violation to women, as well as how the different forms of cutting were harmful to health. These messages were disclosed over a 21-month period in 2001 and 2002 through community volunteers, religious leaders and mass media activities (12). After the intervention, 62% of the respondents were still unaware that FGM had harmful effects and did not associate FGM with a violation of human rights (12). None of the respondents post-intervention recalled the messages that FGM was a violation of human rights (12). The most prominent message retained was that infibulation (type III FGM) was harmful to health and could have severe medical complications (12).

The most likely reason for this result was that religious leaders were not sufficiently implicated during the intervention and spread mixed messages over what is and is not a violation of human rights (12). This study demonstrated that although public messages on FGM being a human rights violation were prominent in community activities, without the involvement of religious leaders, this increase in knowledge would not translate into increased support of FGM abandonment as it had been hoped.

The importance of religious support is further demonstrated in a study carried out among the Maasai and Samburu communities in Kenya (13). This study was done to understand which approaches in these communities were most effective for the abandonment of FGM practices. It was found that when religious leaders spoke against the practice using a Christian, religious-based discourse, female genital cutting could be viewed as a sinful or unnatural practice (13). A Christian woman interviewed in this study responded to why she didn't want to be cut with: "Why should I do this? I was born like that. God did very well. He gave me all parts of my body" (13). Maasai and Samburu people were told by their pastors that rather than fear the curse of their ancestors, they should fear the "wrath of God for continuing a practice that is performed against His will" (13).

Indeed, not using the power of religious leaders in their communities would drastically decrease the impacts an anti-FGM intervention could have (13). A country profile of FGM in Kenya by 28TooMany, a registered charity in England and Wales, had similar findings. They analyzed the religious-oriented approach done by the Frontiers in Reproductive Health Project for the Somali community, where religious leaders were encouraged to recount their opinions on FGM. Although the role of religion in FGM practice is complex due to a wide range of religions in Kenya, the highest percentage of women cut in Kenya are predominantly Muslim (51.1% of women) (14). Due to this high number, 28TooMany found that taking a religious-based approach in some communities is successful (7).

These studies demonstrate that although creating a human rights approach is important, without an integrative approach

that includes religious leaders, they are less likely to have a positive impact on the abandonment of FGM. Creating a more holistic approach to anti-FGM interventions allows for a higher retention of messages and therefore lower rates of FGM.

Legal approach

In 2001 the Children's Act was implemented in Kenya, making FGM an illegal practice for girls under 18 years old (7). The law was criticized because it did not include adult women and it did not lead to the expected decrease FGM as it was not accompanied by appropriate awareness-raising. It drove the practice underground and pushed families to conduct FGM in secrecy by fear of retaliation. Moreover, religious beliefs in Muslim areas were viewed as more important than man-made laws which also contributed to the maintained rates of FGM (7). Ten years later, in 2011, the Prohibition of Female Genital Mutilation Act was introduced. This law is more severe as it criminalized a broad list of actions surrounding FGM, including all forms of FGM performed on anyone failing to report the practice to the authorities. To increase capacity-building to better implement the new law, 800 police officers, probation officers, community leaders and others were trained (7). Legal efforts to reduce FGM may be beneficial as it provides a frame to protect girls and encourages health workers to reject the practice. On the other hand, it also has setbacks such as driving the practice underground, encouraging people to cross borders to perform FGM and preventing victims from seeking help when complications occur (7). It was also observed in surveys that the law seems to have pushed FGM to be executed on younger girls, at ages where girls are less aware of the implications of FGM and are less likely to object. Before the law, FGM was mostly performed on girls aged 12 to 18, girls are now being cut mostly between 7 and 12 years of age (7).

Promotion of girls' education to oppose FGM

FGM views and prevalence strongly correlate with education: 53.7% of women with no education are cut and only 19% of women with secondary education are cut (7). Based on this knowledge, some organizations try to promote education for girls with the objective to decrease FGM prevalence in the long-term. The Forum for African Women Educationalists (FAWE) is an African NGO working to empower girls and women through education and has developed the Centre of Excellence (COE) model, which transforms already existing schools into gender-responsive schools that tackle different problems, including FGM. There are two schools in Kenya, AIC Girls' Primary Kajiado and Athwana High School, and both have experienced an increase in the retention rates for girls at over 90% (7). However, this program is presently only implemented in two localized communities and does not reach a great number of girls. Thus, it may only have a small impact on FGM prevalence. The program requires more funding to help the increasing number of girls in the program

that could benefit from the education and awareness (7).

Discussion

First and foremost, more research is needed on the interventions that are created to impact FGM rates in Kenya and other countries (15). We found that very few studies monitored the outcome of their interventions, for example, by comparing the progress to a control group. Measurements of effectiveness should be long-term and preferably include quantitative results in addition to qualitative results (4). Furthermore, data might be compromised as people fear the consequences of admitting having undergone FGM (2). Additional data would help better manage FGM in different cultural contexts. However, we were able to draw some conclusions from the various interventions that were investigated, and the multiple surveys done on the Kenyan population on how FGM prevention should be approached.

Community-led interventions and building trust relationships

Successful elimination of FGM requires that local communities determine their own needs for interventions and that outsiders hand over control to facilitators from the community over time (10). It is essential for the community to be responsible for the change. It is also important to engage all stakeholders over a long period of time to develop trust, thus resulting in effective management of the practice and eventually appropriate policy (16). This can be done through partnership building, communication, establishing multidisciplinary teams, engagement, etc. (16).

To be effective, interventions need to involve community leaders that are trusted and influential. Hence, in the Kenyan context, interventions should include religious leaders as primary change agents and work with them to implement programs and encourage change (4, 12).

Change social norms at the community level

Changing attitudes towards FGM is not sufficient to influence the prevalence rates (10). There needs to be a complete change in social norms. For example, convincing circumcisers to stop cutting girls will not solve the problem as the demand for FGM will be maintained and individuals will find a means to circumvent the obstacles and perform FGM.

Interventions must be tailored to the targeted community by considering different beliefs, as well as ways of performing FGM and reasons to cut. Variation in these elements can result in different responses to the same intervention (5).

Education and women empowerment

Providing girls with proper education will not only give them the power to refuse FGM and resist the pressure from their peers to be cut, but also inform them about their rights and incite them to advocate. Community education and girls' empowerment programs should adopt a more

holistic approach, covering health risks, rights violations, and challenging assumptions about FGM (11). Additionally, long term programs that target a wide range of people/stakeholders are more effective and should be considered during the process of designing the different interventions. Emphasis should be placed on children who do not attend school and their families, as they are less likely to be involved in activities to learn about FGM and girls' rights (11).

FGM will only be eliminated when the socioeconomic factors that perpetuate the practice change. Women need to be given ways to express their social status and respectability other than undergoing FGM (10). Human rights-based programs that foster women's economic empowerment can contribute to progress (17). Moreover, women caregivers, mainly midwives in Kenya, need support to refuse to practice FGM and be provided with clear guidelines for when a girl asks to be cut. They have very little evidence-based guidance to care for women with FGM. For example, there should be protocols for when women ask for re-infibulation after birth (18).

Legislation and capacity building

Furthermore, there is a need for more research and knowledge around how the law banning FGM is currently applied nationally in Kenya and on a local level (4). Researchers should build relationships with policymakers and maintain communication and trust. Meetings and workshops should be held in order to identify knowledge gaps and to ensure that policies are effective in addressing the problem (16).

Future implications and conclusion

Many of these interventions were created with a research-based, western idealistic thought process. However, the way that FGM is centered around many communities is incredibly complex and fundamentally cultural. Entering a community and dictating the rights and wrongs of their cultural practices will in no way create any understanding of how harmful FGM is and how it can be changed. These aforementioned types of interventions use a neo-colonialist approach and attempt to change a practice that has been traditional in the transition of a girl to becoming a woman. To trigger change, relationships with trusted elders should be fostered and open discussions created within the community and by the community, rather than by government and charity organizations. A top-down approach to attempt to change this practice without these relationships will not be sufficient, as discussed by the earlier interventions. Specifically, interventions that do not include fundamental parts of communities such as religious leaders in groups that are centered around religion will have no influence on the social norm in the long run. In addition, these interventions centered around fear, such as legal consequences or accusations of violating girls' and women's rights will only foster further fear and misunderstanding, leading to hidden FGM practices that are more harmful for

the victims. When talking to traditional birth attendants of the Maasai community in Maji Moto, Kenya, it was clear that speaking of FGM as something that is still prevalent was taboo, and more importantly feared (19). The discussion around FGM and its continued use was bypassed completely, leaving no room for change and understanding of how FGM could be abandoned. This leads to the conclusion that although these interventions were created with good intentions, they were focused on a savior complex rather than an understanding of FGM's fundamental use. A bottom-up approach using trusted relationships within communities would create a longer lasting change in social norms, rather than a fear and misunderstanding of FGM and its consequences.

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