The More Things Change, The More They Remain the Same: FGM Emerging Trends among the Kisii

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Harmful traditional practices continue to define the lives of many women and girls across the world. In particular Female Genital Mutilation (FGM) and Early marriages has affected the social and economic well being of numerous generations of women and girls. Globally, many campaigns have been mooted to help end these harmful traditions. In Africa, numerous campaigns have been put in motion to counter these cultural practices such as FGM and early marriages. A number of governments, NGOs, CBOs, CSOs, and other institutions have also adopted various intervention methods to tackle FGM. One of the strategies that have been employed in Kenya, for instance, is the strengthening of policy and legal frameworks. This has taken the form of legislation and institutionalization through an anti FGM board with a mandate to coordinate and support the abandonment of these harmful practice. There has been a steady decline in the prevalence of FGM in Kenya over the last few decades[1]. However, even as the country is making progress towards the abandonment of FGM not all actors share in this vision. In some FGM practicing regions, disparate voices continue to champion continuation of harmful practices. One such region is in the south west of Kenya, home to various communities including the FGM practicing Maasai, Kisii and Kuria ethnicities. In this context new and not so new trends continue to facilitate the continuance of FGM.

A recent examination of the phenomenon was undertaken among the Kisii community region that commonly reside within the boundaries of Kisii County. An in-depth investigation shows that the continued practice of FGM goes against established trends. The Kenya Demographic Health Statistics[1] show that there has been a decline in some ethnic groups in Kenya. The data also indicates that there is low prevalence of FGM among those that are more educated and those with a high wealth quintile. However, the rapid urbanization of the region comprising Kisii is surprisingly not influencing the decline seen among other urbanizing communities elsewhere. According to the demographic survey mentioned, majority of the Kisii people live in urban areas and are well educated, but despite such high developmental indices, evidence suggests very low

declining FGM prevalence among the Kisii community[1]. In addition, FGM practices have increasingly been medicalized FGM among this community[2].

An interview with a doctor working in a health facility within Kisii county revealed that the health system within the county has been strengthened in various ways such as improved service delivery, infrastructure as well as empowered human resource personel providing support within the various levels of the health systems. She retorted that "*the quality of primary health care has really improved and this means that they are able to manage FGM complications adequately more especially when dealing with botched circumcisions" (Key informant interviewer, medical doctor)*. Regarding the emerging trends of medicalization of FGM, she said "…..*the practice has moved to private clinics within housing estates. In this community, the people that are cutting girls are retired nurses, other hospital subordinate staff*" revealed a female respondent from Bobaracho). Some interviews with other anti-FGM actors and campaigners indicated the availability of mostly private health facilities and health personnel that have facilitated the continuance of FGM practice.

The Prohibition of FGM Act was enacted in Kenya 2011. This has resulted in members of some communities that practice FGM become more innovative to hide or have clandestine cutting of girls and women. This has resulted in some girls being cut at a younger age, during the night and even in very unlikely places such as in private clinics, across the border among others. One of the interviewers said the following; "*nowadays younger girls around the age of 4 to 6 years are being cut in order to avoid attracting too much attention*….. and as a remedy she added that the Anti-FGM law should be reviewed to allow for any survivor to seek legal redress at whatever time they became aware of the injustice" (Female respondent 1).

Another reason advanced for the continued practice of FGM has to do with community attitudes. One of the key informants interviewed for the study also mentioned that "*…the Kisii as a community continue to accept FGM as a necessary social norm. This means that many mothers are subjected is a lot of pressure to have their girls cut. In fact if a mother chooses not to cut their girls, the only way they can survive is if the move outside of the county to avoid the mental abuse from insults, stigma and discrimination that follows*" (Female respondent II). The community in general reinforces the idea that a woman requires to be cut in order to be a respected member of the community. One of the women respondents reiterated that county leaders should

[1] KDHS. (2014). Kenya National Bureau of Statistics. KNBS.or.Ke.
[2] Shell-Duncan, B., Naik, R., & Feldman-Jacobs, C. (2016). A State of-Art-Synthesis of Female Genital Mutilation/Cutting: What Do We Know Now? Evidence to End FGM/C: Research to Help Women Thrive. Retrieved from https://www.popcouncil.org/uploads/pdfs/SOTA_Synthesis_2016_FINAL.pdfShell

also take more responsibility and speak openly about the practice. She said that "*… the leadership too chooses to remain silent*" (Female respondent I1).

The above preliminary outputs of a much bigger study provide us some ideas on how intervention programs and policy could be tailored. The foregoing emerging trends point to the need for continuous research to understand the trends in order to adapt FGM interventions. For instance, the emerging new trends calls for the need to have more surveillance of private health facilities to identify those that might be conducting FGM. Similarly, stricter guidelines on the use of publicly supplied medical kits such as local anesthesia, tetanus toxoid vaccines etc., should be put in place. Strong sanctions should be instituted for health personnel found to be facilitating the cutting of girls so as to discourage FGM perpetuation. Most importantly there has to be a strategy targeting retired nurses and subordinate staff in health facilities. Similarly, the close monitoring of girls from birth to age of maturity ought to take place to prevent the likelihood of them undergoing the practice. Regarding the cutting of younger girls, it might be prudent to have policies within the county that allow children to attend clinic until the age of 5 or 6 years to increase possibilities of monitoring the cutting status of these young girls. This is the period when the girls are transitioning from kindergarten to primary school level which conceals the whereabouts of the child. More sensitization on FGM of the community is also required alongside anti-bullying measures put in place in schools to protect girls learning in these institutions.