

# **NO JUSTIFICATION**

## **Medicalization of Female Genital Mutilation in Maasai Communities**

**A Case of Narok County, Kenya**



With support from  
The Girl Generation-Africa Led  
Movement to End FGM/C



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## Abbreviations & Acronyms

<b>ALM</b>	Africa Led Movement to end FGM/C
<b>CHWs</b>	Community Health Workers
<b>CHVs</b>	Community Health Volunteers
<b>CHEWs</b>	Community Health Extension Workers
<b>COVAW</b>	Coalition on Violence Against Women
<b>FGM/C</b>	Female Genital Mutilation/Cutting
<b>FGD</b>	Focus Group Discussions
<b>HCWs</b>	Healthcare Workers
<b>IDIs</b>	In-Depth Interviews
<b>KDHS</b>	Kenya Demographic and Health Survey
<b>KIIs</b>	Key Informant Interviews
<b>NGOs</b>	Non-Governmental Organizations
<b>MoH</b>	Ministry of Health
<b>TBA</b>	Traditional Birth Attendant
<b>TGG</b>	The Girl Generation
<b>TOR</b>	Terms of Reference
<b>UN</b>	United Nations
<b>WHO</b>	World Health Organization

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This work was generously supported by The Girl Generation Africa Led Movement to End FGM/C.

## Operational definitions

**Female genital mutilation/cutting (FGM/C):** We used the WHO definition and classification. These are procedures that involve partial or total removal of the female external genitalia or other injuries thereof for cultural or non-medical reasons. The WHO classification of four types of FGM/C namely clitoridectomy (type I), excision (type II), infibulations (type III) and other modifications of external genitalia for non-medical reasons such as piercing, pulling and pricking (type IV).

***Kisasa* or *Kiswahili* type FGM/C:** This term is used to refer to a type of FGM/C gaining traction among the Maasai of Narok County. It refers to the modern type of FGM/C that is a less severe form compared to what used to be performed previously (type II FGM/C). The *kisasa* FGM/C is performed by either a healthcare worker or a traditional cutter. It is regarded as a less severe form of FGM/C. '*Kisasa*' is a kiswahili word for 'modern'

**Medicalization of FGM/C:** This is female genital cutting performed on girls or women by any cadre of health worker (medical doctor, clinical officer, Nurse/Midwife) in a clinic, health facility or neutral place like a home among others places.

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## Executive Summary

**Background:** Female genital mutilation/cutting (FGM/C) has persisted despite its impact on human rights, gender equality and health of women and girls in the world. Interventions for addressing FGM/C in Kenya have continued to bear fruit with the national prevalence as of 2022 reported at 15%. However, despite the decline associated with robust interventions, there are notable geographical and ethnic variations in FGM/C prevalence. For example, Narok County had an exceptionally high (78%) FGM/C prevalence in 2014 characterized by slow decline that currently stands at 51% (2022) as well as emerging reports of medicalization (FGM/C performed by health workers using health supplies). The Coalition on Violence Against Women (COVAW) has been implementing end FGM/C programs in Narok County. COVAW has identified the emerging trend of medicalization and *Kisasa* type of FGM/C in the Maasai community. However, evidence of the magnitude and scale of medicalization and *Kisasa* types of FGM/C among the wider Maasai community remains scanty. Therefore, for robust evidence base programming and decision-making around these types of FGM/C, data and evidence are necessary.

**Objective:** To conduct an evidence-based-research on medicalization of FGM/C in Narok county to support targeted approaches for addressing medicalized FGM/C as an emerging trend.

**Methods:** The study was conducted in Suswa Ward in Narok East sub county of Narok County using mixed methods design involving desk review, qualitative and quantitative data collection methods. (1) Desk review was conducted to glean information from COVAW documents and other relevant sources on FGM/C prevalence, policies and interventions; (2) key informant interviews (KIIs) were conducted with policy makers from national/county governments, non-state actors in gender and youth ministries, duty bearers (including children services, teachers, chiefs), religious/community leaders, circumcisers, traditional birth attendants, healthcare providers, youth leaders, and representatives from CSOs to elicit information on medicalized and *kisasa* FGM/C; (3) focus group discussions (FGDs) were conducted with program beneficiaries including girls, women, young men, and older men to obtain information regarding their experiences about FGM/C and any changes observed; (4) In depth interviews (IDIs) were conducted with practitioners and survivors of medicalization and *kisasa* FGM/C to unravel what it entails; and (5) household surveys involving 356 respondents and their 879 confidants were conducted with women respondents, their confidants to obtain information on their FGM/C status and that of their daughters. Data were analyzed and triangulated for the narrative herein.

51%

FGM/C Prevalence in 2022

## Key Findings

We conducted reviews on relevant documents and reports, KIIs with 22 stakeholders, IDIs with 10 practitioners and survivors of *kisasa* and medicalized FGM/C, 11 FGDs with beneficiaries, and house-hold survey involving 356 respondents and 879 confidants involving six villages in Suswa Ward in Narok County. The summary of the key findings follows below.

### **The documented prevalence of FGM/C in the Maasai community is still high:**

The proportion of women aged 15-49 years who had undergone FGM/C as of 2014 was 78% (KDHS 2014) and 78.9% in 2021 (Orchid project midterm review) and as at 2022 was 51%. 71% of the women were subjected to FGM/C by traditional cutters and 28% underwent the *kisasa* type of cut.

**The estimated prevalence of FGM/C is high in Suswa ward:** We established the overall proportion of women (15-49 years) with FGM to be 87.8% with respondents (88.1%) and their confidants (87.4%) having similar rates — an indication that the social desirability (underreporting) bias was addressed through appropriate questions in the survey.

**There exist pockets of FGM/C activities among women (15-49 years) in Suswa ward:** At least 1.3% female respondents and 1.2% of their confidants underwent FGM/C twelve months prior to this study. This is possibly adult women cutting - an emerging trend of FGM/C linked to end FGM/C interventions and girls' education but does not also rule out girls being cut as a rite of passage.

**There exists substantial medicalization and *kisasa* type FGM/C in the Maasai community:** The performer of FGM/C on women respondents and confidants were healthcare workers (21.5%), traditional cutters (73.4%) and traditional birth attendants (5.1%). The practitioners performed medicalization/*kisasa* (38.9%) or traditional type (60.1%) of FGM/C. The *kisasa* type FGM/C is gaining momentum and there is intersection of the performer of either medicalization and *kisasa* type. The emerging role of traditional cutters who use health supplies could be leading to more severe cut because data showed that flesh removed (type 2 or 1) was the predominant (88.7%) type compared to no flesh removed (8.04%) cutting. This appears to negate the emerging reports that FGM/C is shifting from more severe (type III, II) to less severe (I or IV).

**A trend of FGM/C considered “safer” exist in Maasai community:** This is basically medicalization, that has acquired a new naming of *kisasa*, or *Kiswahili*. This represent similar trend of less severe type of FGM/C performed in a modern way using health supplies by diverse practitioners (HCWs and traditional cutters) to avert or minimize health complications, perpetuate the harmful practice and for evading the law.

**In Suswa medicalization of FGM/C is meted on girls or women during birthing:** FGM/C was reportedly performed by HCWs in private health facilities disguised as

treatment for other disease conditions. The practice was also reportedly done on expectant girls or women who visited the health facilities for delivery under the instructions of their mothers.

**Medicalization of FGM/C in the Maasai community in general is stimulated and sustained by health, social and legal factors:** These factors triggered the shift of FGM/C practice to medicalization or *kisasa*. Specifically, the factors promoted faster healing, culture, evading the law, economic reasons, healthcare workers shared cultural beliefs with the community, threat and intimidation among girls and teenage pregnancy. The teenage pregnancy is a double edged problem given that it is triggered by FGM/C as well as noted to trigger FGM/C because it is a taboo for a girl to deliver when uncut.

**There is decrease of FGM/C among the young generation (0-14 years):** We established a prevalence of 4.4% among daughters (0-14 years) of the respondents (4.9%) and confidants (3.9%). Indeed, only 2 girls had been reportedly cut 12 months prior to this study. The decrease is attributed to FGM/C interventions and awareness creation implemented in the county of Narok.

**Similar to their mothers, the daughters are increasingly being subjected to *kisasa* type FGM/C:** Approximately 75% of respondents' daughters underwent *kisasa* FGM/C performed by both traditional cutters (56.3%) and HCWs (22%), an indication of the increasing role of medicalization, health supplies and equipment in FGM/C for girls.

**The medicalization or *kisasa* type of FGM/C were attributed to health related complications:** The complications were identified as immediate physical, birthing, long term and psychosexual complications.

## Recommendations

The findings of this medicalization of FGM/C study highlight several possible avenues for leveraging positive change. The end FGM/C interventions including awareness creation has successfully improved the knowledge on the health impacts and legal sanctions of the practice in the Maasai community. However, this has un-intentionally stimulated '*kisasa*', '*Kiswahili*' and '*medicalization*' type of FGM/C as a way to address the health and legal effects by both traditional cutters and HCWs. The following recommendations are aimed at addressing this emerging issue.

- Programmers should develop targeted interventions for healthcare workers. The interventions should aim at training and sensitization of HCWs on FGM/C-related complications, legal and human rights issues, and their role in the prevention of the practice and its medicalization.
- Advocacy around addressing FGM/C and its medicalization with health professionals regulatory and associations. A deliberate and structured

advocacy mechanism should be initiated to sensitize the HCWs on human rights and health impacts of FGM/C including recommitment to “do no harm”, and the ethical principles and fidelity to the oath they took to protect clients and patients.

- Interventions and special focus should shift to chemists and pharmacists through training and advocacy, regarding their role in selling health products, equipment and supplies key in sustaining medicalization and *kisasa* type FGM/C.
- Strengthen the health monitoring and surveillance system to facilitate identification of medicalized FGM/C cases through multi-sectoral approach at all levels especially with the private health facilities, practitioners, community level health promoters and *nyumbakumi* initiative to facilitate action.
- Community dialogues and awareness creation on the dangers of medicalized FGM/C and the fact that medicalization is a form of FGM/C. This will stimulate similar attention and interventions to the wider FGM problem among community, programmers, policy makers and implementers.
- Support the implementation of family level end FGM/C interventions to mitigate *kisasa* and medicalization because these forms of FGM are increasingly been done as private family affair where key decisions are made with less community fanfare.
- Support the implementation of girl empowerment and promotion of agency because FGM/C is meted on girls and women through coercion and perpetuation of power imbalances and powerlessness. Through awareness creation, training and education for girls on human rights and FGM/C complications would provide the much needed tools for the girls to question and say no to the practice.
- Sustained investment and evaluation of the End FGM/C programs being implemented among the Maasai community as they have been shown to work going by the prevalence of FGM among girls 0-14 years. *This should include adult education for the young mothers who were noted to have very low educational attainment.*
- Health sector should provide leadership in addressing FGM/C and its medicalization through health curriculum enrichment with FGM/C content, training of the professionals and structured integration End FGM/C interventions.
- Need for further research on best approach for accurate FGM/C estimates including how to develop more innovative ways and questioning on FGM/C to establish accurate estimates and impact of social desirability bias in FGM/C among girls of 0-14 years.

# 1. INTRODUCTION

## 1.1 Background on Female Genital Mutilation/Cutting (FGM/C)

Female genital mutilation/Cutting (FGM/C) is a longstanding cultural practice associated with negative socio-economic impacts notably human rights violations, health complications and perpetuation of the poverty cycle among women and girls<sup>1</sup>. These impacts are associated with gender inequality, power imbalance and are barriers to realization of full potential for women and girls. The impacts motivated the global and national stakeholders including UN agencies, donors, governments, civil societies, non-governmental organizations, community based organizations, activists and professionals to take action against FGM/C. The actions include anchoring FGM/C into the global agenda notably the sustainable development goal 5.3 on ending all forms of harmful practices including FGM/C<sup>2</sup>. Other measures include FGM/C prevention, protection and care anchored in the international standards and norms (mechanisms/treaties) that require accountability since FGM/C is defined and identified as a violation of human rights<sup>3</sup>.

The magnitude of FGM/C as analyzed from representative data obtained from 31 countries, estimates that at least 200 million women are living with some form of FGM/C globally, while approximately 4.2 million girls are at risk of the cut annually<sup>4</sup>. Although the practice is highly prevalent in some 30 African countries, it is now a global problem with nations in Asia, Middle East, Latin America, Europe, America, Australia and New Zealand due to asylum seeking following conflicts/ other drivers supporting FGM/C<sup>5</sup>. The practice is mostly performed on girls of the ages 0 to 14 years too young to make decisions or give consent and commonly under coercion associated with peer pressure, stigma and discrimination. The practice is predominantly performed by traditional cutters but because of the associated health complications, the narrative thereof and the need to mitigate the immediate health complications, families are increasingly subjecting their daughters to FGM/C performed by the healthcare professionals (medicalization)<sup>6</sup>. This has

# 4.2M

Girls at risk of the cut annually globally

- 1 UNICEF, 'Female Genital Mutilation/Cutting: A Global Concern UNICEF's Data Work on FGM/C Support for Data Collection Data Analysis and Dissemination,' 2016. <https://data.unicef.org/resources/female-genital-mutilationcutting-global-concern/> (Accessed on 1<sup>st</sup> March 2023).
- 2 United Nations Statistical Division. '5.3.2 Proportion of Girls Who Have Undergone Female Genital Mutilation or Cutting'. Global SDG Indicator platform. <https://sdg.tracking-progress.org/indicator/5-3-2-proportion-of-girls-who-have-undergone-fgmc/> (Accessed on 1st March 2023)
- 3 R. Khosla, J. Banerjee, D. Chou, L. Say, and S.T. Fried, "Gender equality and human rights approaches to female genital mutilation: a review of international human rights norms and standards," 2017 14 (59) Reproductive health, 322-325.
- 4 UNICEF. Female genital mutilation (FGM) [Internet]. UNICEF global databases, 2022, based on DHS, MICS and other national surveys, 2004-2021. 2022. Available from: <https://data.unicef.org/topic/child-protection/female-genital-mutilation/>
- 5 UNICEF. Female Genital Mutilation/Cutting: a Global Concern. 2016; Available from: [https://www.unicef.org/media/files/FGMC\\_2016\\_brochure\\_final\\_UNICEF\\_SPREAD.pdf](https://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf)
- 6 WHO, Global Strategy to Stop Health-Care Providers from Performing Female Genital Mutilation. 2010, World Health Organization: Geneva (Accessed on 1st March 2023)

increasingly put the health professionals at the center of FGM/C as perpetrators of the medicalized option. Therefore, combined strategies by all actors should be harnessed, implemented, and scaled up not only to eliminate FGM/C but equally its medicalization. Over the last four decades, interventions aimed at ending FGM/C have included legal-policy and community interventions for prevention, protection, and care service of girls and women against FGM/C<sup>7</sup>.

The World Health Organization (WHO) categorizes FGM/C into four, namely: clitoridectomy (type I), excision (type II), infibulation (type III) and other harmful procedures on female external genitalia (type IV) for non-medical reasons<sup>8</sup>. Clitoridectomy is partial or total removal of the clitoris and/or the prepuce of the clitoris; excision is the partial or total removal of the clitoris and/or the prepuce as well as the labia minora with or without excision of the labia majora; infibulation is the narrowing of the vaginal orifice and creation of a covering seal by cutting and apposition or sewing together the labia minora and/or the labia majora, with or without excision of the clitoris; and type IV entails all other harmful procedures to the female external genitalia for non-medical reasons which may include pricking, piercing, incising, scraping and cauterization. Furthermore, FGM/C has undergone considerable changes from the traditional types (infibulation or excision) to less severe forms (type I or IV), cutting of girls at younger age and medicalization of FGM/C.<sup>9; 10</sup> The so-called medicalization is not that straight forward as it depends on the context but generally there appear to be consensus around it being a less severe type of FGM/C. For example, in communities who practiced infibulation, they are now practicing type II or I or IV facilitated by the health professionals. In the community that practice Islam *sunna* is the most predominant type of FGM/C with indications that it could be type II, I or IV with a common underlying element or theme being the less severe type of FGM/C.

## 1.2 Overview of Medicalization of FGM/C

The WHO defines medicalization as situations in which FGM/C is practiced by any cadre of health-care workers (doctors, nurses, midwives, clinical officers) in a public or private clinic, at home, or elsewhere at any point in a woman's life (including re-infibulation (reclosing of external genitalia once the woman with type III FGM has been opened up for birth, consummation of marriage or other gynecological procedures) for non-medical reasons.<sup>11</sup> The highest prevalence of medicalization of FGM/C accounting for over 90% of all medicalized FGM/C globally has been

7 Williams-Breault, Beth D. 2018. "Eradicating Female Genital Mutilation/Cutting: Human Rights-Based Approaches of Legislation, Education, and Community Empowerment." *Health and human rights* 20(2).

8 World Health Organization. Guidelines on the Management of Health Complications from Female Genital Mutilation, 2016. <http://www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm/en/> (Accessed on 1st March 2023).

9 S. Kimani, C. W. Kabiru, J. Muteshi, and J. Guyo "Female Genital Mutilation/Cutting: Emerging Factors Sustaining Medicalization Related Changes in Selected Kenyan Communities," (2020) 15 (3) *PLoS ONE*, e0228410.

10 S. Kimani, Samuel and B. Shell-Duncan "Medicalized Female Genital Mutilation/Cutting: Contentious Practices and Persistent Debates," (2018) 10 (1) *Current Sexual Health Reports*, 25-34.

11 WHO, UNFPA, UNHCR, UNICEF, UNIFEM, FIGO, ICN, MWIA, WCPA, WMA, "Global Strategy to Stop Health-Care Providers from Performing Female Genital Mutilation," 2010. <https://www.who.int/publications/i/item/WHO-RHR-10.9> (Accessed on 1st March 2023).

documented in Egypt, Sudan, Guinea, Kenya, Nigeria and Djibouti<sup>12</sup>. Furthermore, nuanced analyses of data show that the risk of medicalized FGM/C is higher among daughters (0-14 years) compared to their mothers (15-49 years) with 82% in Egypt, 78% in Sudan, 20% in Kenya and 12% in Nigeria, girls having FGM/C performed by health professionals<sup>13</sup>. This is an indication that medicalization is gaining momentum, a trend more likely to normalize FGM/C, encouraging its continuation rather than abandonment.<sup>14</sup> Although there is no clear evidence of what entails medicalization due to lack of objective clinical data on status of external genitalia, interview reports show it is a less severe form implying it could be excision, clitoridectomy or type IV FGM/C associated with rubbing, scraping, stretching, pricking and piercing, incision, and excision<sup>15</sup>.

Evidence show that the decision to adopt medicalization in FGM/C is dependent on community, family as well as healthcare professional related factors. These factors include conforming to communities' social norm systems, sustained through rewards on one hand and punishment on the other aimed at enforcing adherence across generations. Medicalization has also been perpetuated through the narrative that it minimized risk of immediate complications such as pain and bleeding associated with FGM/C. The narrative is based on the notion that in medicalization, there is less severe cutting, FGM/C is done by a health professional and the use of supplies from health facility could help address the anticipated immediate complications<sup>16</sup>. The performers of medicalized FGM/C are known to benefit financially from payments done for the girl as well as elevated social recognition status for offering 'special services' to the community. This status and considerations help to build confidence and trust with community members, promoting the uptake of other health services offered by the professional guaranteeing income for the longest<sup>17;18; 19</sup> Of importance is the notion that community members and health professionals from FGM/C prevalent cultures believe medicalization is acceptable, promotes quick recovery and could help evade law enforcement because of quick turnaround time for healing.<sup>20</sup> Additionally, the health professionals perform FGM/C to reduce harm as they consider performing it would prevent expected danger as opposed to the procedure being carried out by the traditional cutter.<sup>21</sup>

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12 Shell-Duncan, B., Z. Moore, and C. Njue, Trends in medicalization of female genital mutilation/cutting: what do the data reveal? 2017, Population Council: Nairobi. [http://www.popcouncil.org/uploads/pdfs/2017RH\\_MedicalizationFGMC.pdf](http://www.popcouncil.org/uploads/pdfs/2017RH_MedicalizationFGMC.pdf).

13 As Above 12

14 H. M. Doucet, C. Pallitto, and D. Groleau, "Understanding the Motivations of Health-Care Providers in Performing Female Genital Mutilation: An Integrative Review of the Literature," (2017) 14 (1) *Reproductive health* 46.

15 World Health Organization. Guidelines on the Management of Health Complications from Female Genital Mutilation, 2016. <http://www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm/en/> (Accessed on 1st March 2023).

16 As above 11

17 C. Njue and I. Askew, "Medicalization of Female Genital Cutting Among the Abagusii in Nyanza Province," 2004, Population Council [https://knowledgecommons.popcouncil.org/departments\\_sbsr-rh/32/](https://knowledgecommons.popcouncil.org/departments_sbsr-rh/32/) (Accessed 1<sup>st</sup> March 2023).

18 A. J. Pearce and S. Bewley, "Medicalization of Female Genital Mutilation. Harm Reduction or Unethical," 2014 24 (1) *Obstetrics, Gynaecology and Reproductive Medicine*, 29-30.

19 B. Shell-Duncan, "The Medicalization of Female 'Circumcision': Harm Reduction or Promotion of a Dangerous Practice?" 2001 52(7) *Social Science and Medicine*, 1013-28.

20 Samuel Kimani, Bettina Shell-Duncan. Medicalized Female Genital Mutilation/Cutting: Contentious Practices and Persistent Debates. *Current Sexual Health Reports*. March 2018, Volume 10, Issue 1, pp 25-34.

21 As above 11

### 1.3 The practice of FGM/C and its Medicalization in Maasai Communities

In Kenya, as of 2022 fifteen percent (15%)<sup>22</sup> of women aged 15-49 years had undergone FGM/C being a substantial decline from 37.6% in 1998 and 21% in 2014<sup>23</sup>. However, the 2022 FGM/C data has not been analyzed along the geographical and ethnic lines for substantial conclusions to be drawn. While the decline is remarkable, there are geographical and ethnic variations in the prevalence with communities such as the Maasai having far higher (78%) rates than the national prevalence while the pace of decline has been slower currently is 51%<sup>24</sup>. Furthermore, while there has been decline in FGM/C among the Maasai community, increasing medicalization of FGM/C has been reported including the *kisasa* type that is presumed to be “safer” compared to the traditionally performed FGM/C. The national prevalence of medicalization as of KDHS 2014 data was 19.7% among girls aged 0-14 years against 15% in 15-49 years old women in Kenya<sup>25</sup>. Geographically, among the hot spots areas reported to have medicalization of FGM/C include Kisii, Nyamira, Garissa and Nairobi counties<sup>7</sup>, with anecdotal evidence of the practice gaining traction in Narok and Kajiado counties.

The high prevalence of FGM/C in the geographies inhabited by the Maasai community is despite Kenya having favourable social, economic and political environment characterized by: favorable legal-policy environment supported by progressive constitution, anti-FGM law (prohibition of FGM act 2011), vibrant anti-FGM board, implementation of FGM/C-related interventions across geography, vibrant civil society organizations and support from highest policy level- the presidential decree on ending FGM/C by 2022<sup>26</sup>. Although medicalization is noted to be gaining momentum in Narok, the so-called *kisasa* FGM/C has been reported with no clear indications of whether it is similar to medicalization and whether the performers are specifically health workers or the traditional cutters or both performing the *kisasa* FGM/C. This requires credible evidence to unravel this form of FGM/C referred to as *kisasa*.

### 1.4 Rationale for the study on medicalization of FGM/C

To address the challenge of persistent FGM/C and its nascent medicalization in the Narok County, interventions have been implemented and are ongoing. One such end FGM/C program is spearheaded by the Coalition on Violence against Women (COVAW). COVAW with support from The Girl Generation (Africa-led Movement to End FGM/C Programme) has been implementing a one-year project on ending FGM/C

22 <https://www.knbs.or.ke>. (Accessed on 1st March 2023).

23 KDHS. 2014. Kenya National Bureau of Statistics (KNBS) [Kenya], Kenya Demographic and Health Survey Kenya Demographic and Health Survey 2014.

24 KDHS. 2014. Kenya National Bureau of Statistics (KNBS) [Kenya], Kenya Demographic and Health Survey Kenya Demographic and Health Survey 2014.

25 As above 23

26 Anti FGM board, “speech by His Excellency Hon. Uhuru Kenyatta, CGH, President and Commander in Chief of the Defence Forces of the Republic of Kenya during the high level elders forum held on 8th November 2019 in Nairobi, Kenya.” <http://www.antifgmboard.go.ke/download>. (Accessed on 2<sup>nd</sup> March 2023).



in Narok titled Ailepu (Maa for Arise). The project aims at accelerating community-based efforts towards ending FGM/C through triggering an uprising of a diverse and inclusive youth-led anti-FGM movement in Narok who will influence and shape evidence-based anti-FGM/C campaigns that are geared towards sustainable solutions. The project is being implemented in Suswa area in Narok County in the following six villages of Oloshaiki, Inkoiriento, Inkilonkosi, Oletepesi, Kipise and Enariboo<sup>27</sup>. COVAW's efforts in reaching out to the communities in Narok have been ongoing through various anti-FGM/C initiatives. Indeed, through the community awareness forums, the community members mention that medicalization was slowly gaining momentum as it was perceived as "safe" cutting.

Beyond the FGM/C-related community interventions implemented by COVAW among the Maasai communities in Narok County, a study on the magnitude of medicalization of FGM/C amongst Maasai communities and the impact of medicalization was required. The findings of the study were to facilitate development of an advocacy brief on the role of healthcare professionals in eradicating medicalized FGM/C and to provide key recommendations on what can be done to curb the practice. Additionally, the findings and recommendations from the study were to be shared with the communities in Narok, Narok County Health Management Team, Narok County Health Committee, Anti-FGM Board and other relevant stakeholders involved in the decision-making, programming and policy making towards eradication of FGM/C.

## 1.5 Study Purpose and Objectives

The overarching purpose of this study was to conduct research on medicalization of FGM/C amongst the Maasai communities in Narok and to use the findings and recommendations for decision-making, programming and policy and to develop an advocacy brief on the role of healthcare professionals in eradicating medicalized FGM/C.

### 1.5.1 Broad Objective

To conduct an evidence-based research on medicalization of FGM/C in Narok county to support targeted approaches for addressing medicalized FGM/C as an emerging trend.

### 1.5.2 Specific Objectives

Specifically, using mixed method approach involving quantitative and qualitative data

**Beyond the FGM/C-related community interventions implemented by COVAW among the Maasai communities in Narok County, a study on the magnitude of medicalization of FGM/C amongst Maasai communities and the impact of medicalization was required.**

27 COVAW, TOR for a research on medicalization of FGM/C in Maasai communities, 2023, (Accessed on 2nd March 2023).



collection, the research strived to address the following objectives;

1. To understand the magnitude of medicalized FGM/C as a 'safer' form of FGC in Narok County.
2. To understand the health, social and legal factors underpinning medicalization of FGM/C.
3. To understand the type of FGM/C carried out by healthcare professionals. To get a clear understanding and definition of *Kisasa* in Narok County.
4. To understand the health and psychological implications of medicalized FGM/C.
5. To determine the role of health professionals in ending medicalized FGM/C.

## 2. METHODOLOGY

### 2.1 Brief description of COVAW

The Coalition on Violence Against Women (COVAW) is a national women's rights organization in Kenya, founded and registered in 1995. COVAW works to advance women's rights towards a society free from all forms of violence against women and girls. The organization has a track record in engaging with grassroots communities in Kenya. To date, COVAW has project experience in Narok, Samburu and Nairobi implementing 3 key initiatives; access to justice, movement building, advocacy and communications. COVAW adopts a multifaceted approach to ending FGM/C, working with community members, elders and traditional leaders, community activists, religious leaders, and county-level duty bearers to prevent cultural practices that are harmful to women and girls. This includes FGM/C, gender-based violence and child early and forced marriage. The organization continues to implement evidence-based interventions in ending violence against women including FGM/C. The need for evidence-based programs to end medicalization of FGM/C calls for robust research to understand this new trend in the practice.

### 2.2 Study design

This was a cross-sectional study adopting mixed methods approach involving quantitative and qualitative data collection methods as follows.

- (a) **Desk review:** This involved the review and gleaning of information from documents and reports relating to ending FGM/C in Narok County implemented by COVAW, partners, the county and national government among others.
- (b) **Qualitative data involving:** (i) Interviews with stakeholders (Key informant interviews (KIIs): This was a participatory process engaging with stakeholders as key informants through interviews. The KIIs targeted policy makers from national and county governments and non-government actors in gender and youth ministries, duty bearers (including children services, law enforcement, prosecution, teachers, deputy county commissioner, chiefs, sub chiefs), religious leaders, community leaders both male and female, circumcisers, and traditional birth attendants, clan elders, youth leaders, and representatives from CSOs. The interview lasted for 30 to 60 minutes through which notes were taken and audio recording of the interview was done. (ii) Interview with health service providers (KIIs): These were conducted with health service providers to determine the type of FGM/C, any changes in the practice of FGM/C, the complications associated with FGM/C including for medicalization and interventions implemented

to mitigate the complications. In addition, the role of health providers in promoting abandonment of FGM/C was explored including working with legal/justice and protection systems. The interviews helped to identify gaps in capacity and skills among the service providers in responding to girls and women at risk of and those living with FGM. Each of the interviews lasted for 30 to 60 minutes through which notes were taken and audio recording of the interview was done. (iii) Interview with community health service providers (KIs): These were conducted with community health system service providers (CHWs, CHVs, CHEWs) to determine how common FGM/C was in the community, who was performing it, the type of FGM/C (traditional/*kisasa*) and any changes with the practice of FGM/C, the complications associated with FGM/C including for medicalization and interventions implemented to mitigate the complications. How common were the complications of FGM/C and how adequate are the health system response to any complications? The role of community health system in responding to FGM/C was explored. The interviews helped identify gaps in capacity and skills among the community health service providers in responding to girls and women at risk of and those living with FGM/C. The interviews lasted for 30 to 60 minutes each through which notes were taken and audio recording of the interview carried out. (iv) In depth interviews with survivors of *kisasa* or medicalization type FGM/C (IDIs): The interviews involved women or married girls who had undergone *Kisasa* or medicalized FGM/C to explore the type, extent of tissues removed, supplies used and any complications. The potential of the interviewees providing information of who, where and when the *kisasa* type of FGM/C was explored. (v) In-depth interview with practitioners of *kisasa* or medicalization type FGM/C (IDIs): The interview involved healthcare providers or traditional cutters who performed *kisasa* or medicalized FGM/C to help describe the type, extent of tissues removed, supplies used and any complications. This helped to unravel the extent of *kisasa* type FGM/C with potential for coming up with answers on how to address the type of FGM/C. The potential of the interviewee providing information of who, where and when the *kisasa* type of FGM/C was explored. (vi) Focus group discussions (FGDs) with girls and women (14-17 years, 18-30 years; 31-49 years; 50 and above) and men: This was conducted with groups of girls, women and men of similar age set to assess their experiences with FGM/C including stigma, peer pressure and FGC-related health complications. The discussion lasted for 45 to 90 minutes, notes were taken as well as audio recordings of the discussion.

- (c) **Quantitative data collection involving household survey:** The survey interviews were held with community members (women who had daughters at least less than 14 years) to elicit information on prevalence, type and possibly the new types of FGM/C. Data were collected using a modified confidante method that is used to collect data for stigmatized

behaviours such as abortion. This was to help address social desirability effects and challenges of under reporting when a practice is outlawed, for example, FGM/C which is illegal in Kenya. The confidante approach for eliciting FGM/C prevalence and incidence is still in the nascent stage spearheaded by the Population Council FGM/C data hub. Through the partnership and collaboration with the wider TGG-ALM end FGM/C project, Population Council has been testing FGM/C data measurement tools. With their permission to utilize the confidante method as a global good, we modified some questions to include those that generate data on FGM/C among girls 0-14 years as well as incorporated the KDHS questions for relevance. The questions were implemented through Kobo Collect, an open data kit with GPS-enabled gadget for community members (women) as respondents at the household level. The respondents were asked to identify 3 confidants they share confidential information with. The questionnaire had questions regarding the FGM/C status of the confidants, their 0-14 years' old daughters as well as the respondents themselves and their daughters. The GPS helped determine the geographical location of families. The questionnaires were translated into Kiswahili or local languages to address possible misunderstanding and misinterpretation of questions by the enumerators. The sample size was predetermined during the protocol development taking into account the demographics, stratifications, gender and geographical coverage of COVAW interventions site. The sample size was proportionately determined based on population sizes of the targeted geographical areas ensuring the sample size was representative and adequate to compare data in the target areas. The data was disaggregated on the bases of settings and age among other variables.

## 2.3 Sampling Strategy

The target participants were selected through consultation with COVAW who provided the list of intervention target villages in Narok County. The plan was to have as representative sample as possible for both the quantitative and qualitative data. The study project was implemented in Suswa ward in Narok County, covering the following six villages: Oloshaiki, Inkoiriento, Inkilonkosi, Oletepesi, Kipise and Enariboo where COVAW FGM/C abandonment programme was being implemented.

**Qualitative (KIIs, FGDs, IDIs) data collection:** The KIIs, FGDs and IDIs were utilized to collect views on FGM/C including its medicalization and the associated complications from state and non-state actors, the health service providers, the community health service providers, the survivors, the practitioners of medicalization and the women and girls who had undergone or were subjected to any form of the practice. The participants were purposively selected based on their experience and knowledge on FGM/C in the target population. The survivors and practitioners of *kisasa* FGM/C were

selected based on their willingness to voluntarily provide information on what the type of FGM/C was involved and the complications thereof. The KIIs, FGDs, IDIs were conducted in the relevant languages by trained research assistants. The KIIs, FGDs, IDIs were held at a location that provides privacy and were acceptable to the selected participants.

**Quantitative (household survey) data collection:** The sample was drawn from married women with at least one daughter and married girls living in Narok county. Sampling took into account the demographics, stratifications, and geographical coverage. In selecting the study respondents, the study employed a multi-stage sampling procedure. First, we randomly selected the lowest administrative units and equally divided the total number of expected respondents as per the number of randomly selected lowest administrative units. By creating awareness, with the assistance and guidance of COVAW focal persons and social mobilizers from the target populations, data collectors were deployed to the selected administrative units to conduct the interviews with female participants between the ages of 15-49 years who have given birth to at least one girl until the required size was achieved. Within each household, one eligible woman was randomly selected using a table of random numbers. The survey questionnaires were then administered to the sampled households with eligible members, again following a random selection of eligible women using table of random numbers. The respondents provided information on FGM/C about their confidants. In selecting households to be interviewed, research assistants employed a systematic skip pattern so that households are randomly selected. For example, a skip pattern of 4 households was adopted where research assistants were expected to interview the sixth household that meets the inclusion criteria. The samples were allocated in respect to proportion to population sizes of the targeted geographical areas while ensuring that the sample size was representative.

Interviewers first sought to speak to the household head or any responsible member of the household. They verbally sought the permission of the head / responsible person to ask him/her questions about the composition of the household. The interviewers used the opportunity to identify members who are eligible for individual interview according to the study inclusion criteria. The interviews conducted in the relevant local languages (Maasai, Kiswahili) or English for those participants who are comfortable with the latter option by trained research assistants after obtaining written informed consent from study participants. The interviews were conducted in or outside the household of respondents, in a preferred location that helped ensure interview privacy and the veracity of the responses provided. It was expected that interviews with eligible women would about last 30-60 minutes each. Interviewers were trained to ensure that guidance on ethical conduct was clearly understood and implemented. Such training included focused sessions and exercises regarding the meaning and process of informed consent, as well as the importance of protecting the privacy of subjects, and confidentiality of the information obtained.

## 2.4 Survey Sample Size Calculation

To determine the sample size for the study, we used the Suswa age cohort population based on the age cohort from the Narok County Integrated Development Plan 2018-2022 to calculate the sample size. We used an estimated Suswa ward population of 19,237, a confidence level of 95%, and a 5% margin of error to determine the sample size.

A total of 356 women as shown in Table 1, subdivided across the six villages in Suswa ward, in Narok County, aged 15-49, who have given birth to at least one girl took part in the study, as shown in Table 2.

**Table 1: Sample size for women in Suswa ward based on estimated population**

Narok county CIDP - Population projection per age cohort in 2022					
Age cohort	Male	%	Female	%	Total
0-14	283,799	43.8	274,500	43.3	558,299
15-49	320,117	49.4	316,021	49.8	636,138
50 and above	43,798	6.8	43,862	6.9	87,660
<b>Total</b>	<b>647,714</b>	<b>100.0</b>	<b>634,383</b>	<b>100.0</b>	<b>1,282,097</b>
Total Narok population	Male	%	Female	%	
	647,714	50.5	634,383	49.5	
Estimated Suswa ward population = 19237					
Age cohort	Male	Female	Total		
0-14	4257	4122	8378		
15-49	4801	4740	9541		
50 and above	661	657	1318		
<b>Total</b>	<b>9719</b>	<b>9518</b>	<b>19237</b>		
Sample size using female population aged 15-49 years in Suswa ward					
Age cohort	# of Female		Sample size		
15-49	4740		356		

**Table 2: Proportionate sample size for women aged 15-49 years**

Subcounty	Location	Proportionate sample size of women aged 15-49 years
Narok East	Oloshaiki	60
	Inkoiriento	60
	Inkilonkosi	59
	Oletepesi	59
	Kipise	59
	Enariboo	59
<b>Total</b>		<b>356</b>

## Selection criteria (inclusion/exclusion)

The target population were women aged 15-49 years. The individuals were eligible to take part in the study if they met the following criteria:

### (i) Women

- At least 15 years of age and at most 49 years;
- Unmarried or married, but who have at least one daughter aged 0-14 years;
- Able to at least speak the local language in which the interview will be conducted;
- Able to provide verbal / written informed consent;
- For girls below 18 years, they should be able to give assent and have someone to consent on their behalf.

## Sample size for the qualitative data collection

A summary of sample size for the qualitative data is provided in Table 3 below.

**Table 3: Summary data collection methods with the target groups**

S/No	Method	Targets
1	Key Informant Interviews (KIIs)	24 interviews (1 Gender ministry, 1 children services, 2 teachers, 2 Chiefs, 1 sub chief, 2 Religious leaders, 2 Community leaders, 2 youth leaders, 1 representative from COVAW, 3 healthcare providers, 3 Community health workers, 2 traditional birth attendants, 1 traditional cutters, 1 CBO representative)
2	In-depth interviews	3 Survivors of <i>kisasa</i> 3 survivors of medicalization
3	Focus Groups Discussions	6 FGDs with women (1 in each location) 2 FGDs with Married men 6 FGDs with married girls aged 15-17 years (1 in each location)
4	Survey	356 women aged 15-49 years (population based) with 1058 confidants

## Instrument development

The study instruments (household survey questionnaire, KIIs, FGDs and IDIs guides) had been developed based upon existing knowledge and literature on FGM/C and in line with COVAW medicalization research objectives. Draft versions of the study tools were reviewed by COVAW. Necessary changes were made to enhance clarity and comprehension. Finalized tools were translated from English into the local language



by experienced translators conversant with Maasai language to ensure validity. All language inconsistencies were determined and resolved with the support of bilingual research professionals in English and Maasai or Kiswahili languages.

## 2.5 Pre-testing

The tools were pre-tested for one day with a number of community members and key informants living in the study areas to test validity of instruments and ensure methodological validity and reliability.

## 2.6 Recruitment and training of research assistants

Qualified research assistants with a degree in social sciences who are familiar with the practice of FGM/C, geography of the research area, had previous experience in data collection and were of Maasai ethnicity were recruited. The research assistants were trained for 3 days on the study design and procedures, research ethics as well as on communication skills to avoid judgmental attitudes so that they remain as neutral as possible to create trust and reduce social desirability bias. Male research assistants were to interview male participants while female research assistants were to conduct interviews with women and married girls to ensure they feel comfortable to share their ideas and experiences. The research assistants were expected to adhere to the ethical and professional standards of the study and to deliver high-quality outputs within the agreed timelines.

### Data quality assurance

Data collection was subjected to quality assurance during collection and transmission from various sources. Quality control was integrated in the development of data collection tools, preparation of training materials, training of research assistants, pre-testing and translation of data collections tools, transcription of data and analysis of both quantitative and qualitative including review of study report by COVAW and storage of cleaned datasets for archiving and secondary analysis.

## 2.7 Data management

All data was treated with confidentiality. Quantitative data were downloaded from the tablets into a password-protected laptop. The data were then transmitted for review for consistency and accuracy. Any inconsistent or inaccurate entries by the research teams were followed-up and correction effected. Names of respondents did not appear in the interview guides; instead, each guide was assigned unique identification numbers by the research team at the end of the interview. This was to render it impossible to link a respondent data to any responses given by the participants once data transcription was completed. Also, the study information sheets carry a statement

that everything discussed in the FGD was to be kept confidential and that, during the reporting of the findings, all data were to be anonymized. At the beginning of each FGD, the facilitator reminded the participants of freedom to speak in confidence and asked that nothing discussed was to be shared beyond the study participants after the FGD.

The resultant datasets were anonymized and separated from any identifying personal information. An ID codebook was created in hard-copy form with each participant allocated a unique study ID. The allocated codes were used during transcription of the digital audio files and entry of the demographic data in a password-protected Excel spreadsheet and laptop. Transcription involved removing reference to any other names or locations which may be identifiable. Lastly, transcribers were asked to sign a non-disclosure agreement prior to receipt of the files for transcription. All data were stored in a password-protected computer and then be submitted to COVAW.

**All data was treated with confidentiality. Quantitative data were downloaded from the tablets into a password-protected laptop. The data were then transmitted for review for consistency and accuracy.**

## 2.8 Data analysis

### Desk review

Documents and reports with FGM/C data and related interventions from COVAW, Orchid project partners, Narok County and those from national government specific to the county of Narok were obtained and evaluated. A content analysis on each document was conducted to determine the components and themes relevant to FGM/C in Narok County.

### Quantitative data analysis

Household survey data were exported to a SPSS version 21 for cleaning and analysis. The data were analyzed using descriptive statistics to obtain proportions and percentages and presented in tables, graphs and figures accordingly.

### Qualitative data analysis

Qualitative data from KIIs, FGDs, IDIs were transcribed, typed in Word and translated from local languages and Kiswahili to English. Translated data were then analyzed using template analysis applying NVivo version 11, a qualitative data analysis software. Analysis involved identifying themes based on the guides, looking for patterns and associations between the themes, and comparing within and between the different groups of participants.

## Triangulation

We triangulated the analyzed data from the methodological approaches to create a narrative of the bigger picture around the progress of medicalization of FGM/C in Narok County.

## 2.9 Ethical Considerations

The research was performed with ethical considerations in mind. The administrative approval to carry out the study was granted by the office of county commissioner Narok. Study participants aged 18 years and older signed informed consent, while participants younger than 18 years provided consent to participate, the informed consent provided by a parent and/or legal guardian. During the informed consent process, information about the risks and the fact that participants could decline to respond to any questions that may put them at risk or withdraw from the study, were elaborated. Participants were assured that their responses were not to be shared with other parties.

## 3. RESULTS

### 3.1 Desk Review Findings

During the desk review content analyses, the prevalence, types, the reasons for FGM/C, interventions addressing the practice as well as legal/policy provisions for FGM/C were identified. In particular, the FGM/C prevalence in Narok County was identified at 78% in 15-49 years old as at 2014. The midterm review of Orchid Project end FGM programme estimated the prevalence at 79.8% among women 15-49 years majority of whom had undergone traditional cutting (71%) while 28% had undergone *kisasa* type FGM/C as at 2022<sup>28</sup>. Furthermore, in Narok East in Mosiro 65.8% of women had undergone traditional cutting while 34.2% underwent *kisasa* type FGM/C. However, the review demonstrated limited disclosure of FGM/C to have been performed in the community (38%) and the family (18%) associated with criminalization of FGM/C in Kenya. These under-reporting was reinforced by substantial law enforcement and prosecution of perpetrators of FGM/C in Narok County. This situation could have affected FGM/C disclosure and the gross underreporting of FGM/C in girls 0-14 years as well as recent (less than 12 months) FGM/C. Clearly there is need to develop innovative ways for addressing the challenge of FGM/C underreporting to help obtain accurate data for policy, programming and investments interventions on this practice associated with far reaching ramifications on women and girls.

### 3.2 Socio-demographic characteristics of the respondents involved in household survey and their confidants

The characteristics of respondents for the household survey and their identified confidants are presented in Table 4. There were 356 respondents and 82.3% (879) of their confidants. This indicates that not all the respondents identified 3 confidants they shared confidential information with. Most (52%) of the respondents and their corresponding confidants (34%) were aged 20-39 years and had similar educational attainment of either no education, primary or secondary level. This shows that confidant selection is somehow determined by similar social and demographic determinants namely age, educational level and possibly the economic status. Additionally, it is an indication of a homogeneous sample of respondents and their confidants where social norms would be applied without major challenges. Noteworthy, the results show high rates (36.2%) of respondents who did not know their age, a fact consistent with the high (44.1%) proportions of women who reported not having any formal education.

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**Table 4: Sociodemographic characteristics of the household survey respondents and their confidants in Suswa Ward**

Characteristic	Frequency (n)	Percent (%)	Frequency (n)	Percent (%)
	Respondent		Confidants	
<b>Age (Years)</b>				
14-19	12	3.4	16	1.8
20-29	131	36.8	185	21.0
30-39	54	15.2	114	13.0
40-49	27	7.6	30	3.4
50-59	3	0.8	10	1.1
Don't know	129	36.2	524	59.6
<b>Total</b>	<b>356</b>	<b>100.0</b>	<b>879</b>	<b>100.0</b>
<b>Marital status</b>				
Never married	3	0.8	40	4.6
Married/living together	350	98.3	828	94.2
Divorced/separated	1	0.3	3	0.3
Widowed	2	0.6	8	0.9
<b>Total</b>	<b>356</b>	<b>100.0</b>	<b>879</b>	<b>100.0</b>
<b>Education</b>				
No education	157	44.1	415	47.2
Primary	97	27.2	197	22.4
Secondary	79	22.2	203	23.1
College/University	23	6.5	56	6.4
Do not know			8	0.9
<b>Total</b>	<b>356</b>	<b>100.0</b>	<b>879</b>	<b>100.0</b>

### 3.3 Socio-demographic characteristics of participants in key informant interviews, in-depth interviews and focus group discussions

A summary of the characteristics for participants involved in qualitative data collection are presented in Table 5. A total of 22 participants were involved in key informants' interviews, and 10 for in-depth interviews. In addition, 11 FGDs were conducted involving 88 participants from Suswa ward of Narok County.

**Table 5: Socio-demographic characteristics of participants involved in the in-depth interviews, key informant interviews and Focus group discussions in Suswa Ward.**

Characteristics	Suswa, Narok County					
	IDIs (N=10)		KIIs (N=22)		FGDs (N=88)	
	(n)	%	(n)	%	(n)	%
<b>Gender</b>						
Male	0	0	11	50	16	18
Female	10	100	11	50	72	82
<b>Total</b>	<b>10</b>	<b>100</b>	<b>22</b>	<b>100</b>	<b>88</b>	<b>100</b>
<b>Age (years)</b>						
15-17	9	90	0	0	24	27
18-27	1	10	2	9	14	16
28-37	0	0	12	54.5	23	26
38-47	0	0	1	4.5	21	24
48 and above	0	0	7	32	6	7
<b>Total</b>	<b>10</b>	<b>100</b>	<b>22</b>	<b>100</b>	<b>88</b>	<b>100</b>
<b>Marital Status</b>						
Single	7	70	1	4.5	27	31
Married	3	30	20	91	61	69
Divorced	0	0	1	4.5	0	0
<b>Total</b>	<b>10</b>	<b>100</b>	<b>22</b>	<b>100</b>	<b>88</b>	<b>100</b>
<b>Educational attainment</b>						
No school	2	20	4	18	33	37
Primary	7	70	0	0	28	32
Secondary	1	10	2	9	22	25
Tertiary	0	0	16	73	5	6
<b>Total</b>	<b>10</b>	<b>100</b>	<b>22</b>	<b>100</b>	<b>88</b>	<b>100</b>
<b>Religion</b>						
Christianity	10	100	22	100	88	100
<b>Total</b>	<b>100</b>	<b>100</b>	<b>22</b>	<b>100</b>	<b>88</b>	<b>100</b>

### 3.4 Relationship between household survey respondents and their confidants

The relationship between the respondents and their identified confidants are presented in Table 6. Most (54.6%) of the confidants were identified as friends, with 15.8% as neighbour, sister-in-law (10.8%) and sister (8.3%) to the respondents, respectively. This shows the weight of the social capital that mainly lies in the friendship and neighbourhood. This is a pointer of the respondents need to expand and maintain their social capital beyond the families. The relationship with friends is preferred because it is devoid of unnecessary familial competitions which sometimes degenerate into unhealthy situations. Moreover, the friend’s relationship is a reciprocal one where a lot of social capital lies. These results are important in understanding the prevalence and magnitude of FGM/C in the target geography because repetitive inclusion of the respondents is minimized. For example, the fact that the majority of confidants were friends ensured the challenge of repetition bias was avoided.

**Table 6: Relationship between the study respondents and their confidants**

Confidant category	Frequency (n)	Percent (%)
Friend	479	54.6
Neighbour	139	15.8
Sister-in-law	95	10.8
Sister	73	8.3
Aunt	22	2.5
Cousin	21	2.4
Mother	14	1.6
Mother-in-law	14	1.6
Daughter	13	1.5
Co-wife	8	0.9
<b>Total</b>	<b>878</b>	<b>100</b>

### 3.5 Prevalence and type of FGM/C among the household survey respondents and their confidants

#### 3.5.1 Prevalence of FGM/C among the respondents

Table 7 shows different aspects of FGM/C among the respondents and their confidants. It was established that FGM/C prevalence in women respondents aged 15-49 years is **88.1%** and **87.4%** among their corresponding confidants in Suswa. These rates

were based on the question “whether the respondents had ever been circumcised as well as whether their confidants had undergone FGM/C”. This prevalence mirrors the rates of 78% obtained in the KDHS 2014 as well as Orchid project mid-term review that showed the prevalence in Mosiro Narok East to be 85.7% (based on the question: “Have you had FGM performed on you?”). The results, provide indications that FGM/C among adult women is happening in Narok County given the 1.3% female respondents and 1.2% of their confidants who reported having been cut in the last 12 months prior to collection of this data. However, this could possibly be explained by new cut performed on women/girls within 15 to 17 years’ period as they were within the FGM/C age for girls in the Maasai community. This was based on the reported age of FGM/C of between 12 to 18 years consistent with the rite of passage in the community. However, this does not rule out adult women who may have escaped the practice because of end FGM/C interventions and education.

### **3.5.2 Practitioner who performed FGM/C on women**

The procedure of FGM/C was reportedly performed by healthcare workers (HCWs) (doctors, nurse/midwives and other HCWs) at 21.5%, traditional cutters (73.4%) or traditional birth attendants (5.1%). The women reportedly underwent either *kisasa* (38.9%) or traditional type (60.1%) of FGM/C. Clearly the results show substantial medicalization and *kisasa* FGM/C in the Maasai community, a practice that needs to be addressed. Of interest is that the rates of *kisasa* and traditional type FGM/C cannot be accounted by data regarding the practitioners who were reported to have cut the women. This could signify that the traditional cutters could be participating in performing the *kisasa* type. This begs the question: what is *kisasa*? Could it be synonymous to medicalization? This is a question addressed through qualitative data. Interestingly, from the quantitative data there appears to be very minor shifts in the severity of FGM/C practice in the Maasai community. The emerging data indicate that FGM/C is shifting from severe (type 3, 2 to 1 or 4), however the study data showed that flesh removed (type 2 or 1) was the predominant (88.7%) type of FGM/C compared to no flesh removed (8.04%) among women respondents. This together with the insights from the intersectionality of data between the *kisasa* and traditional type FGM/C, shows that the practitioners may be cutting more tissues. The qualitative data provide a clearer picture regarding the FGM/C practice in terms of *kisasa* and medicalization or both in Suswa Ward as described in the following paragraphs.



**Table 7: Prevalence and type of FGM among the respondents and their confidants**

FGM status	Frequency (n)	Percent (%)	Frequency (n)	Percent (%)
	Respondent		Confidants	
<b>Have you ever been circumcised; Have your confidants been circumcised?</b>				
No	42	11.9	86	9.8
Yes	311	88.1	768	87.4
Don't know	-	-	25	2.8
<b>Total</b>	<b>353</b>	<b>100</b>	<b>879</b>	<b>100</b>
<b>Did the FGM happen in the last 12 months?</b>				
No	307	98.7	756	98.4
Yes	4	1.3	9	1.2
Don't know	-	-	3	0.4
<b>Total</b>	<b>311</b>	<b>100</b>	<b>768</b>	<b>100</b>
<b>Age when FGM was done</b>				
Less than 11	5	1.6	5	0.7
12-15 years	113	36.3	156	20.3
16-18 Years	75	24.1	104	13.6
19 and above	8	2.6	6	0.8
Do not know	110	35.4	496	64.7
<b>Total</b>	<b>311</b>	<b>100</b>	<b>767</b>	<b>100</b>
<b>Performer of FGM</b>				
Doctor	19	6.1	14	1.8
Nurse/midwife	44	14.1	105	13.7
Other HCWs	4	1.3	6	0.8
Traditional circumciser	229	73.4	557	72.5
Traditional birth attendant	16	5.1	61	7.9
Don't know	0	0	25	3.3
<b>Total</b>	<b>312</b>	<b>100</b>	<b>768</b>	<b>100</b>
<b>Respondent type of FGM</b>				
Traditional cut	189	60.8		
Kisasa	121	38.9		
Don't know	1	0.3		
<b>Total</b>	<b>311</b>	<b>100</b>		
<b>Respondent type of FGM (WHO typology)</b>				
Type IV (no flesh removed)	25	8.04		
Type 1&2 (flesh removed)	276	88.7		
Type III (sewn together)	1	0.3		
Do not know	9	2.9		
<b>Total</b>	<b>311</b>	<b>100</b>		

**This paragraph and the quotes help to understand the magnitude of medicalized FGM/C as a 'safer' form of FGM/C in Narok County.**

The reported changes in FGM/C among the Maasai community was characterized by less severe type of FGM/C (*Kisasa*) performed by both traditional cutters and HCWs (medicalization) using hospital supplies. Both medicalization and *kisasa* types of FGM/C were locally referred to either '*kisasa*' or '*kiswahili*' but represented similar trend of less severe type of FGM/C performed in a modern way using hospital supplies by diverse practitioners to avert or minimize health complications, perpetuate the culture and to evade the law. The FGM/C is performed secretly at night, in the home of the girl or in private health facilities on girls or expectant girls who seek delivery services. These above assertions were supported by the following responses from different stakeholders.

*"the Kisasa kind of circumcision involves the cutting of the upper part of the clitoris unlike the traditional type where a girl used to be cut until the white of the bone is seen. This was referred to as (aar)." (KII, Religious leaders, Inkolonkosi)*

*"the kisasa type is also called the Kiswahili type because the cutting is not performed like before where a girl was cut till the white of the bone was seen. The kisasa is the cut to the clitoris." (IDI, Survivor, Enariboo).*

*"the type of FGM practiced nowadays is called Kisasa. In the past when a girl was cut, all the flesh was removed, but now the Kisasa type it is only the clitoris that is removed. The girl is injected with anesthesia then the clitoris swells, and it is cut off. Only a small piece is cut to just convince the girl that she has been cut. The traditional cutters are the ones doing it using the anesthetics, antibiotics, and gloves." (KII, Traditional birth attendant, Kipise).*

*"the type of FGM performed nowadays is called Kiswahili where only the clitoris is cut. Medicalization is also happening because when I got pregnant while still in high school, I was taken to the health facility to deliver, that's when the cut was performed on me without my knowledge. A nurse helped me deliver my baby and then performed FGM on me. You know during delivery you feel pain, and because I had tears, she told me she is going to mend the tears, and that's when she circumcised me. I asked the nurse why she did that to me, and she told me it's my mother who told her to circumcise me. She performed the Kiswahili type of FGM, she didn't cut everything but she cut half of the clitoris." (IDI, Survivor of Medicalized FGM, Kipise).*

*"medicalization was also reportedly done on expectant girls or women who visited health facilities for delivery and the health worker is asked to circumcise them. "The mother of the girl asks the doctor to circumcise the girl and instructed him not to tell anyone about it, even those who accompanied the expectant lady." (FGD, unmarried girls, Oloshaiki).*

Medicalization was reportedly performed by health workers in private hospitals disguised as treating other disease conditions.

*"mostly it's the nurses who cut the girls, and mostly the girls are taken to hospital, and they can go any time, and it is a private hospital and they have private rooms where a girl can be circumcised, in the name of treating other diseases. I have only heard of private hospitals." (KII with Teacher, Oloshaiki).*

## 3.6 Prevalence and type of FGM/C among daughter (0-14 years) of respondents in household survey and their confidants

### 3.6.1 Prevalence of FGM/C in daughters (0-14 years)

Table 8 shows data of different components of FGM/C among daughters (0-14 years) of the respondents' women and their corresponding confidants. A total of 653 daughters of the respondent women and a further 1496 daughters of the confidants were identified. Of the daughters 4.9% girls belonging to the respondents and 3.9% daughters of the confidants were reported to have undergone FGM/C. In addition, only 2 girls were reported to have been cut in the last 12 months prior to this study. This shows that the practice is increasingly decreasing attributed to the interventions and awareness creation being implemented in the county. Most of the girls who had reportedly been subjected to FGM/C happened from 12 years of age. This is an indication that the FGM/C practice is still performed as a rite of passage a reason that suffices to date in the Maasai community.

### 3.6.2 The type of FGM/C performed on girls aged 0-14 years

The *kisasa* type of FGM is increasingly gaining momentum in the Maasai community especially among the younger generation. The data showed that 75% of daughters belonging to the respondents had undergone *kisasa* type of cut. This data support that *kisasa* FGM/C is performed by both traditional cutters (56.3%) and healthcare professionals (22%). Furthermore, the majority of the respondents believed that their confidants did not support *kisasa* and they were also of the view that all forms of FGM should be abandoned (Table 8).

**Table 8: Prevalence and type of FGM/C among daughters (0-14 years) of respondents in household survey and their confidants**

FGM status	Frequency (n)	Percent (%)	Frequency (n)	Percent (%)
	Respondent daughters		Confidants daughters	
How many daughters 0-14 years do they have?				
0-14	653	100	1496	100
<b>Total</b>	<b>653</b>	<b>100</b>	<b>1496</b>	<b>100</b>
How many of your daughters age 0-14 years have been cut?; How many of your confidant daughters 0-14 years have been cut?				
Yes	32	4.9	59	3.9
No	621	95.1	1437	96.1
<b>Total</b>	<b>653</b>	<b>100</b>	<b>1496</b>	<b>100</b>

FGM status	Frequency (n)	Percent (%)	Frequency (n)	Percent (%)
	Respondent daughters		Confidants daughters	
<b>Did the FGM happen in the last 12 months?</b>				
No	31	96.9	58	98.3
Yes	1	3.1	1	1.7
<b>Total</b>	<b>32</b>	<b>100</b>	<b>59</b>	<b>0.4</b>
<b>At what age was the FGM performed?</b>				
Less than 11	11	34.4		
12-16 years	16	50.0		
Do not know	5	15.6		
<b>Total</b>	<b>32</b>	<b>100</b>		
<b>Type of FGM performed on girls 0-14 years</b>				
Kisasa FGM	24	75		
Traditional type FGM	5	15.6		
Don't know	3	9.4		
<b>Total</b>	<b>32</b>	<b>100</b>		
<b>Performer of FGM in 0-14 years</b>				
Doctor	2	6.3		
Nurse/midwife	3	9.4		
Other HCWs	2	6.3		
Traditional circumciser	18	56.3		
Traditional birth attendant	4	12.5		
Don't know	3	9.4		
<b>Total</b>	<b>32</b>	<b>100</b>		
<b>Does your confidant believe the community should adopt <i>Kisasa</i>?</b>				
Yes			67	7.6
No			794	90.2
Don't know			19	2.2
<b>Total</b>			<b>880</b>	<b>100</b>
<b>Does your confidant believe the community should abandon all form of FGM?</b>				
Yes			827	94.1
No			34	3.4
Don't know			18	2.0
<b>Total</b>			<b>879</b>	<b>100</b>

### 3.7 The types of FGM/C performed by healthcare professionals help understand and define the *Kisasa* form of cutting in Narok County

The trend towards modern FGM/C characterized by less severe cutting was highlighted in the Maasai community in Suswa Ward. This included *kisasa* FGM/C which was performed by the health workers (medicalization) and traditional cutters (*kisasa*) using hospital supplies such as, anesthesia, pain killers, antibiotics and tetanus vaccine as well as scalpels and forceps for curbing bleeding. The cutting was noted to involve the removal of part of the clitoris as opposed to where the clitoris and the labia minora were extensively removed in the past. The claim on the prevalent of less severe types of FGM/C was corroborated by the short recovery period once a girl was subjected to *kisasa* type of cutting. It appears there is intersectionality between *kisasa*, medicalization and Kiswahili types of FGM/C with a clear distinction on the practitioner. The following quotes support what *kisasa* type of FGM/C looks like.

*“when I was talking to that health provider who was cutting girls, she told me, there are 2 types of FGM, the Maasai type and Kiswahili type. In Kiswahili type, the girl is injected and then the clitoris swells up and then it is easy to cut it off, and she can cut it in half, and that is what is called Kiswahili.”* (KII, Community health Volunteer, Inkoiriento).

*“they take the girls to the hospital because when it's done by the health provider, the girl recovers very fast, the following day, you will see the same girl outside fully dressed up. You can't even tell if the same girl was cut or not.”* (IDI, Medicalization survivor, Inkilonkosi)

*“on that day it was me and my mother and some few women. The cutter came at 3pm and ate first. Thereafter, I was taken to the room where the cut was to happen. They placed a plastic bag where I sat so that it could hold the blood. The cutter had gloves, the injection and the anesthetics as well as a scalpel. She injected me, then she cut me, which took about 3 minutes and all the waste was thrown into the latrine. So she left after the cut, and after some hours that's when I started feeling pain. I didn't feel pain when she was cutting me because of the anesthetics. I felt the pain for about a day and a half.”* (IDI, *Kisasa* survivor, Kipise).

*“the cutter doesn't give you painkillers, those ones you may have to buy yourself. I bled, I felt nausea and I could not even eat, I also*

**This included *kisasa* FGM/C which was performed by health workers (medicalization) and traditional cutters (*kisasa*) using hospital supplies such as, anesthesia, pain killers, antibiotics and tetanus vaccine as well as scalpels and forceps for curbing bleeding**

*felt weak and I had a headache. After 3 days I could walk, but it took 2 weeks for the wound to heal completely.” (IDI, Kisasa survivor, Kipise).*

*“the Kisasa type involves the doctors injecting a girl to make the body numb before circumcising the girl. The practitioner of this type of FGM is the doctor that comes home with all the medical tools that should be used during the process. The Kisasa type and medicalization type are the same. This is because in both cases the girl is injected to make the body numb, swells the clitoris to make the cutting easy. The cutting is done by cutting the upper part of the clitoris.” (FGD with 18+ women, Inkoiriento village).*

*“the performer of the Kiswahili type of FGM are the traditional women within the community. This type of FGM is termed as Kiswahili because these traditional circumcisers use gloves, syringes and sterilized knives during the process.” (FGD women 15+ Inkilonkosi).*

*“the doctors are involved in the Kisasa type of FGM because they collaborate with the Kisasa practitioners and teach them how to use the medical tools because you’ll find that most of these practitioners are illiterate. Medical personnel are collaborating with the Kisasa practitioners because they sell these tools to them and teach them how to use them. Because you will find that these women have medicines that they use before and after circumcising the girls.” (Women 15+ Inkilonkosi).*

*“the doctor performs medicalization by either taking the girl to the hospital or performing the cut or also can be brought home to perform the cut. When the family knows that this doctor does perform the cut, they go and see him or her before coming to perform the cut so that they agree where the cut will take place and at what time it is going to be performed. They’re both the same because the injection and the protective materials are used.” (FGD, Women 18+ Enariboo).*

*“nowadays they [girls] just go to the health facility, because the health provider also has to safeguard herself, they don’t like going to homes because they fear being discovered and arrested. So it’s easier to take the girl to the hospital who will just pretend to have come as a patient.” (FGD, Women 18+ Oloshaiki).*

### **3.8 The health, social and legal factors underpinning medicalization of FGM/C**

The participants identified a number of health, social and legal reasons that prompted the shift of FGM/C practice from traditional to medicalization or *kisasa* type. These included faster healing, culture, evading the law, and economic reasons for the cutters among others (**Figure 1**). These reasons are well outlined in the narrative below.

## What drives medicalized/*kisasa* FGM/C in Narok County?

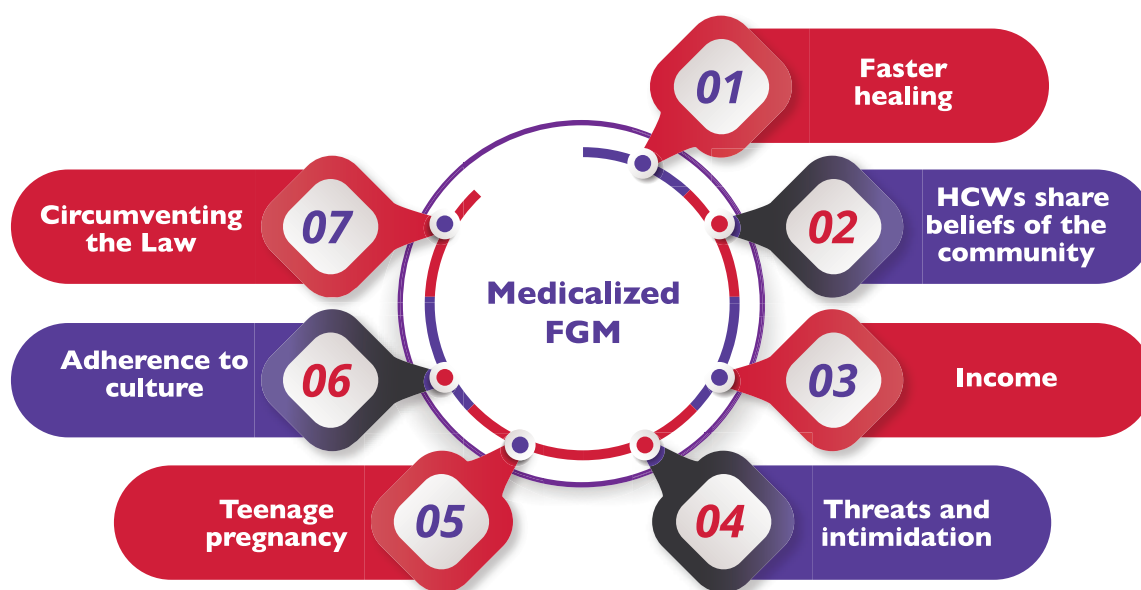


Figure 1: Reasons for medicalization or *kisasa* type FGM/C in Suswa ward

### Teenage and early pregnancy among girls

The participants highlighted that it is a taboo for a girl to become pregnant and to deliver a child without having been cut and therefore, it was suggested to fuel FGM/C in the Maasai community as supported by the quote below.

*“when a girl gets pregnant, she is first cut then married off. Also early pregnancies are factors driving FGM, because parents do not want their girls to deliver when she has not been cut, because the girl will be termed as Entaapai, which means she is an outcast.”* (KII, Community Health Volunteer, Inkilonkosi)

### Faster healing

The *kisasa* or medicalized FGM were being adopted because girls would recover very quickly.

*“actually what they say is, a girl can undergo the *kisasa* type and the following day she is walking, so no one can tell what has happened. So one of the reasons is the time taken to heal, it can almost be immediate. So they feel that *kisasa* or medicalized FGM is safer.”* (KII, Officer of Local NGO, Narok).

### Need to conform to culture

The participants noted that the community members were choosing medicalization as a way of complying with and perpetuating the Maasai culture involving FGM in a modern way.

*“people still want to stick with the culture, and because they have understood the harmful effects of FGM, they wouldn't want the girl to undergo the traditional type of FGM. So for them it's a way of sustaining culture through kisasa.”* (KII, Officer of Local NGO, Narok).

### **Evading of the law**

Since the practice of FGM is illegal in Kenya, the *kisasa* and medicalized FGM offers a solution to circumventing the law because of faster healing and the secrecy associated with the new trend of FGM practice as shown by the quote below.

*“the girls are cut the kisasa type so that she heals fast before the elders or the chief is aware. After 3 days the girl is healed, she is outside playing. In the past a girl could stay inside for a month before she recovered. Also the kisasa type, the girl does not get infections.”* (KII, Traditional birth attendants, Kipise).

*“with the health provider performing the cut, it will just be between the mother and the health provider. Also the health provider has to protect him/herself because whatever he or she is doing is illegal.”* (Teacher Olshaiki).

### **Economic factors**

The performance of FGM provides income for the HCWs and traditional cutters who charge substantial amount of money. Both the HCWs and traditional cutters charge for the procedure and have influenced the new trends by purportedly making the practice “safer” as supported by quotes below.

*“the cutters want to continue getting income, so they do not want to stop cutting girls. Nowadays they get KES 3,000 shillings per girl and even a goat, yet they just cut a small piece.”* (KII, Traditional birth Attendant, kipsie).

*“the health workers used to charge 2,500 shillings, but the traditional cutter is given 1,000 shillings or even 500 shillings depending on the agreement.”* (KII, CHV inkoiriento).

*“the nurse was then paid 3,000 shillings. When she circumcises a girl who is pregnant, she is paid 3,000 shillings and a sheep.”* (Kisasa survivor, Kipise).

*“the health workers are paid from 2,000 to 5,000 shillings' to perform medicalization of FGM.”* (FGD Women 18+ Oloshaiki).

### **FGM practitioners hold the same culture as the community**

The participants noted that the FGM practitioners are themselves from the Maasai community and therefore subscribe and believe in the Maasai culture.

*“the health providers are Maasai, who want to maintain their culture. The reason for medicalization to maintain that aspect of the culture in a safer way, because the health provider will be able to control bleeding and they also provide antibiotics and the girl recovers quickly.”* (KII, Youth Leader, Inkoiriento).



*“the people who cut are from the Maasai community, so they might want to maintain the culture of FGM, by doing it in a safer way according to them.”* (KII, Traditional Birth Attendants, Kipise).

*“because the health provider is also from this community, that could drive them to perform the cut for cultural reasons so that FGM can continue.”* (KII, Teacher Oloshaiki).

### **Threats and intimidation**

The practice of FGM was noted to be perpetuated by misinformation and fear as a way to threaten and intimidate the girls as supported by the quotes below.

*“it is the kisasa cut that was performed on me and because I was still young, I did not know the negative effects of FGM. So the first reason I was given is that when you’re not cut you will not get married and if you get married without *being cut*, the time you’re going to give birth the cut was going to be performed there. So I had to undergo the cut because I had no other choice.”* (IDI, Survivor of Kisasa, Enariboo).

*“girls are influenced by their fellow age-mates to undergo FGM because they are criticized, pressured and you will find them accepting or demanding that they should be circumcised.”* (FGD, Women 18+, Inkorienito).

## **3.9 FGM-related complications reported among respondents, their confidants and daughters**

There were several FGM-related complications that were highlighted among the respondents, their confidants and daughters (Table 9). The complications were reported to have happened immediately after the cut as well as afterwards. These complications included: immediate physical complications (bleeding, pain, swelling, urination problem, shock, infection); childbirth complications (obstructed labour, fistula, tears, bleeding, and fetal death); and sexual and psychological complications among others. Following the cut, the women were more likely to suffer immediate physical complications with indications that birth complications persisted for a while due to scarring caused by FGM/C. Noteworthy to mention there are psychological and sexual complications attributed to FGM/C regardless of the type of cut whether *kisasa* or medicalization.

**Table 9: Medicalized FGM related complications among study respondents their confidants and daughters in Suswa Ward**

FGM related complications	Frequency (n)	Percent (%)	Frequency (n)	Percent (%)
	Respondent		Confidants	
<b>Medicalized FGM related complications suffered after FGM</b>				
Immediate physical effects	13	76.5	7	50.0
Childbirth	3	17.6	4	28.6
Sexual	0	0	2	14.3
Psychological	1	5.9	1	7.1
<b>Total</b>	<b>17</b>	<b>100</b>	<b>14</b>	<b>100</b>
<b>Medicalized FGM related complications suffered to date</b>				
Immediate physical effects	1	16.7	2	33.3
Childbirth	1	16.7	2	33.3
Sexual	2	33.3	1	16.7
Psychological	2	33.3	1	16.7
<b>Total</b>	<b>6</b>	<b>100</b>	<b>6</b>	<b>100</b>

The quantitative data demonstrating that the medicalized or *kisasa* FGM/C were linked to health complications were corroborated by the responses from interviews and discussions from women, girls and survivors' participants involved in this study. The complications emanating from our study participants spanned from immediate physical, birth, psychological long-term as well as sexual effects as supported in the quotes below in regard to the health and psychological implications of medicalized FGM/C.

### **Bleeding**

Bleeding was noted as the most common immediate complication following the *kisasa* type of FGM as reported by the survivors, young women and the key informants in this study.

*“there was excess bleeding after the cut. I ended up fainting due to the bleeding. Nothing was done at first they only gave me milk, but milk never brought any change and they ended up calling the doctor and I was taken to the hospital for me to be injected for the blood lost during the bleeding.”* (IDI, Survivor of *Kisasa*, Enariboo).

## Long term complications

Although this may have been experienced after sometime following the FGM procedure, the participants noted some women were still living with these complications.

*“for instance, there are people who are prone to getting keloids after an ear piercing, it’s also possible to get keloids after FGM, and it closes the vagina.”* (KII, Youth Leader, Inkoiriento)

## Birth complications

The birth complications were reported among the participants as being common effects of FGM/C because of the scarring on the external genitalia associated with the procedure which tended to affect the elasticity of external genitalia regardless of whether medicalization or traditional cut had been performed.

*“during childbirth a woman who has been cut experiences problems because of the scar which is not able to expand unlike a girl who has not been cut. Even a girl who has been cut by a health provider still experiences the same problem, even if it’s just the clitoris. The girls who have not been cut give birth quickly. Also if a girl is cut when she is young, she might be married off and then she gets pregnant while she is still young, and she will experience lots of challenges, she ends up going through a cesarean section.”* (KII, Youth Leader, Inkoiriento)

## Psychological complications

The respondent women and girls were noted to have exhibited psychological effects linked to medicalization of FGM/C. This was associated flashback and memories as well as the fact that the survivor may have been coerced to undergo the practice.

*“the complications might be reduced as compared to a person who underwent the traditional type of FGM. But I would say the psychological effects are still there. There is emotional or psychological torture. It could be the psychological issue, because you might keep on remembering the process or remembering I did that and maybe I was not supposed to do it. It could be something that could follow someone psychologically.”* (KII, Officer from a local NGO, Narok).

*“the girl has been forced to undergo FGM, even if it has been performed by a health provider and that might depress the girl.”* (Youth Leader Inkoiriento)

## Sexual complications

The women survivors reported that they experienced FGM/C-related sexual complications. These complications were reported despite sexual issues being very sensitive to speak out or discuss. The effects were associated with removal of clitoris which has sexual functions as well as psychologically linked to sexual effects. This is an indication for the need to screen for sexual effects to facilitate identification and response to this neglected aspect of FGM/C as supported through the following responses.

*“she will have psychological problems because if she is a housewife and the husband is educated, the husband will be unfaithful to her because sexually, she will not be able to satisfy her, because FGM reduces the sexual urge. And that will stress him because of the sexual dysfunction, and that’s the main challenge caused by FGM.”* (KII, Non-Maasai participant, Inkilonkosi)

*“also in terms of reproductive health, the part that is removed still has a reproductive function. I think there is an aspect of reduced reproductive function.”* (KII, Officer from a local NGO, Narok).

### **3.10 Role of health professionals in ending medicalized FGM/C**

The participants provided critical insights for addressing the medicalization as well as the *kisasa* type of FGM/C. The suggestions are applicable to the various stakeholders who are critical in handling the issue of medicalized FGM/C. These suggestions included awareness creation, human rights/legal interventions, women/girls empowerment and agency creation among others as supported in the following quotes.

#### **Sensitization of the healthcare workers on the legal framework prohibiting FGM/C**

*“to remind the health providers on the law that prohibits FGM. The law that I know, the perpetrators pay a fine of 200,000 and a jail term of 3 years.”* (KII, Community Health Volunteers, Inkilonkosi).

*“when you discover that the health provider is circumcising girls he or she should be arrested to go and face the law, because there is a law against FGM.”* (KII, Community leader Kipise).

*“it is important to talk to the health providers to stop cutting girls, because it against the law to perform FGM. They should also respect girls, and stop cutting them.”* (IDI, Survivor of Medicalization, Inkilonkosi)

#### **Empowerment and agency of girls to resist and refuse FGM**

*“if girls refuse to be cut, men will still marry them, so the most important thing is to educate the girls about their rights.”* (KII, Community Health Volunteers, Inkilonkosi).

*“also to encourage girls by telling them FGM is illegal, and they could suffer the complication. We shall also discourage the girls from medicalized FGM, by telling her it still has complications.”* (KII, Community Health Volunteer, Lnkorienito)

*“girls should be educated that FGM has no advantage and they are very okay to stay uncircumcised.”* (FGD, Women 18+, Inkoirienito)

## **Health workers should assume the role model role**

*“healthcare workers can champion in ending of FGM by being a role model themselves by not entertaining any of these practices whether in the villages or at the hospitals. They can do this by collaborating with the Ex-officials, area chief and other government officials in ending FGM/C.” (KII, Local administrator, Kipise).*

*“by educating the health providers to stop performing the cut, even at the community level and especially the private hospitals.” (KII, Teacher, Oloshaiki).*

## **Health education on the dangers of FGM**

*“healthcare workers can help in ending FGM/C by educating people of the dangers of FGM/C.” (KII, Local administrator, Kipise).*

*“the health workers can talk to the parents to discourage them because they have experience. For instance, a lot of women nowadays give birth in hospitals, so the health worker can tell the difference of the childbirth experience between the woman who is cut and the woman who is not cut. So they can discourage the community of the disadvantages of FGM.” (KII, Teacher, Oloshaiki).*

## **Sensitization of health workers on human rights around FGM**

*“they just understand from the human right perspective, because when they understand that, they will be able to convince whoever who is advocating to be cut. So they refuse and explain to the clients that come to them to be cut. So they will also be championing.” (Officer from Local NGO, Narok).*

## **Integration of FGM awareness into health-led outreaches**

*“as a medical department they could be holding their own outreaches to create awareness, and they can integrate the health issues whenever they have an outreach. When they have an outreach for family planning, immunization, they can bring in the aspect of medicalized FGM, just to sensitize the community against that from the human right perspective.” (Officer from Local NGO, Narok).*

## **Training of community leaders about harms of medicalization**

*“to build capacity of the community leaders to understand effects of FGM, also from the human right perspective so that they are well able to pass it to the community members against medicalized FGM.” (Officer from Local NGO, Narok).*

## **Multi-sectoral collaboration to address access of medical supplies to traditional cutters that promotes *kisasa* FGM**

*“when the cutters cannot access anesthetics, they cannot cut girls and FGM will stop. For instance, I cannot accept for my daughter to be cut without anesthetics and gloves. Because it's like they take the anesthetics from the public hospitals then they sell it*

*to the cutters at the private hospitals or even in the chemists.” (KII, Traditional Birth Attendants, Kipise).*

### **Partnership between the community and law enforcement in addressing FGM/C**

*“the community should be educated to come out and report those health providers because they are amongst us, who are doing that. If one health provider is arrested, that will be a good example to the rest and they will stop that bad habit.” (IDI, Survivor of Kisasa, Kipise).*

### **Involvement of male in addressing FGM/C**

*“health workers should teach men that there is no effect when you marry a girl who is not cut so that this pressure of being told you cannot get married because you’re not cut to end. (FGD, girls, Enariboo).*

*“in schools, boys should also be involved so that they can be educated that it is fine if they marry uncut girls. Also parents should not refuse their sons to marry uncut girls, and that would end the vice.” (FGD, women 18+, Oletepesi).*

### **Surveillance and monitoring of private practitioners and clinics activities and taking action on those who perform FGM/C**

*“the health providers performing the cut are from the private hospitals, there should be employed a person who can monitor what goes on around the private hospitals.” (FGD, Women 18+, Oloshaiki)*

## 4. LIMITATIONS

The study had some limitations; first, the data on FGM/C was only collected in Suswa Ward in Narok East sub county of Narok County. This could affect how much the findings can be generalized in the rest of Narok county and Kenya in general. However, the study adopted a robust approach that combined quantitative and qualitative data collection that targeted most of the stakeholders, as well as rigorously developed tools that were pre-tested for validity and reliability to counter the limitation. Second, the self-reported data on FGM/C need to be treated with caution because women may have been unwilling to disclose their FGM/C status because of the sensitivity of the topic and the illegal nature of FGM/C in Kenya. This was addressed by using the confidante method for which the results show that the prevalence of FGM/C in respondents mirrors the proportion of the practice in the confidants. Additionally, the prevalence of FGM/C in Suswa Ward is almost identical to the prevalence elicited in Mosiro, a village within Narok East as per the Orchid project evaluation of 2021. This is an indication that our study approach robustly addressed the challenge of non-disclosure among the respondents involved in the household survey. However, the challenge of under-reporting may have persisted in regard to establishing the status of girls 0-14 years because of illegal nature of FGM/C as well as the law enforcement in Narok County. This is because mothers may be reluctant to disclose the actual FGM/C status of their daughters for fear of repercussions, especially where the practice has been the target of campaigns or legal measures to prohibit it. Despite the limitations, the data provide a strong and rich foundation for understanding the issue of medicalized FGM/C and the *kisasa* type of FGM/C in Narok County setting strong foundation for programming, policy and investments to address this emerging trend of FGM/C in Narok County.


## 5. RECOMMENDATIONS

The findings of the study on medicalization of FGM/C highlight several possible avenues for leveraging positive change. The FGM/C interventions implemented in Narok county such as awareness creation, law enforcement and prosecutions have improved knowledge on the health and legal impacts of the practice in the Maasai community. However, the interventions un-intentionally stimulated the problem of '*kisasa*', '*Kiswahili*' and 'medicalization' type of FGM/C in the community. The following recommendations pertain in addressing medicalization of FGM/C as an emerging issue.

- **Programmers should develop targeted interventions for healthcare workers.** The interventions should aim at training and sensitization of HCWs on FGM/C-related complications, legal and human rights issues, and their role in the prevention of the practice and its medicalization. The HCWs should be trained and supported to respond through care and treatment of women and girls who have FGM/C-related complications, including psychosocial support. To effectively train HCWs, FGM/C should be incorporated in the pre-service training while continuous professional development programs should be developed for the working professionals.
- **Advocacy around addressing FGM/C and its medicalization with health professionals regulatory and associations.** Evidence shows that medicalization of FGM/C is perpetuated by doctors, nurses, midwives and clinical officers. A deliberate and structured advocacy mechanism should be established to sensitize these professionals on human rights and health impacts of FGM/C. In addition, the advocacy should aim to facilitate recommitment of the professionals to the principles of "do no harm" and the ethical principles including the professional oath they took not to harm. **Additionally, cultivation of partnership with private hospital associations to revoke licenses of doctors, midwives and nurses found to be performing medicalized FGM as well as signing of a code of conduct for the professionals.** This should be done through professional dialogues as well as leveraging professional conferences and meetings as well as structured training meetings.
- **Interventions and special focus should shift to chemists and pharmacists for their role in selling health products, equipment and supplies that are key in sustaining medicalization and *kisasa* type FGM/C.** This could involve the training and awareness creation about FGM/C, its human rights and health impacts with pharmacists. Additionally, advocacy on FGM/C, its violation of human rights and health impacts with the pharmacy and poisons board and pharmaceutical society of Kenya Narok county branch. The ultimate goal is to improve, control and regulate accessibility of health based supplies and equipment that are used for circumcision of girls and women by non-healthcare professionals.



- **Strengthen the health system monitoring and surveillance system to identify FGM/C cases.** The findings showed that medicalized FGM/C is majorly conducted in private health facilities, sometimes disguised as other illnesses or the HCWs would perform the FGM/C in the girls' homes. This has posed a monitoring and surveillance challenge to the health sector. Improved surveillance and regular supervision to monitor and track the activities of these facilities and practitioners may address medicalization. **This will require multi-sectoral collaboration between MoH, regulatory bodies, Ministry of Interior and law enforcement agencies, and development of requisite tools to capture new and old cases of FGM/C at the healthcare service points.** The monitoring should also be integrated into community dialogues and outreaches in form of anonymous reporting of practitioners and practitioners of medicalization, and follow up surveillance after investigations. Additionally, the MoH should work with health promoters (community health workers, community health extension workers and community health volunteers and *nyumbakumi* (ten houses) initiative to gather information on FGM/C and its medicalization at community and village level.
- **Community dialogues and awareness creation on the dangers of medicalized FGM/C including the fact that medicalization is FGM/C.** Programmers should initiate community dialogue programs and awareness creation involving all stakeholders to highlight the need to stop medicalization and *kisasa* FGM/C as they are similar and same as FGM/C. The key points of the dialogues and awareness should be that medicalized FGM/C and *kisasa* type do not mitigate on long term complications, human rights violation and future risk of girls. The dialogues should also aim at confronting the negative social norms that support and perpetuate FGM/C and disempowerment of girls and women in the community.
- **Support and implementation of family level end FGM/C interventions to mitigate *kisasa* and medicalization.** Evidence shows that the current FGM/C including *kisasa* and medicalization are private family affair where key decisions are made with less community fanfare. Therefore, it makes sense to intervene at family level with deliberate involvement of the father, mother and the daughter. Programmers should develop and pilot innovative end FGM/C family involvement framework to test its effectiveness, transferability and scaling of such a model.
- **Support and implement girl empowerment and promotion of agency.** The practice of FGM/C is meted on girls and women through coercion and other practices that perpetuate powerlessness and power imbalances. Through awareness creation, training and education for the girls, the knowledge level regarding human rights and health complications related to FGM/C are amplified. These would provide the much needed tools for the girls to question and say no to FGM/C. In addition, education has been touted as the most



effective intervention towards ending FGM/C and child marriage as well as the “best contraceptive” protecting girls from teenage pregnancy, cycle of poverty and building girl agency. The girl empowerment and promotion of agency can be effected through FGM/C school clubs and the actualization of the national school health policy of 2019 that comprehensively elaborates interventions for addressing FGM/C in girls.

- **Sustained investment on the end FGM/C programs being implemented in Maasai community.** Going by the prevalence and recent cases of FGM/C in girls 0-14 years within the Maasai community, there is evidence of substantial decline in the practice. This is an indication that the end FGM/C interventions already in place are working and proving to be effective. The investments and adaptation of the existing interventions should be scaled up as the programmers keep watch on the emerging adult FGM/C.
- **Need for further research on best approach for accurate FGM/C estimates.** Further research is needed to better understand and develop more innovative ways and questions on FGM/C to establish the best estimates and impact of social desirability bias in FGM/C among 0-14 years' girls. Furthermore, more research is needed to understand whether covert naming of FGM/C such as *kisasa* and *kiswahili* have impact on FGM/C programming and policy.

## 6. CONCLUSION

The practice of FGM/C in the Maasai community has shifted in terms of the performer, the severity of the cut, and the supplies involved as well as the naming of the practice. In comparison to the FGM/C performed on mothers, the daughters were likely to be cut by a HCW or traditional cutter, less severely using health facility based supplies. The supplies are presumed safer for mitigating immediate complications including bleeding, pain and prolonged healing time. The FGM/C practice is coded with different names such as '*kisasa*' or '*kiswahili*' only understandable by the community members or through in-depth research. Clearly, although the practice is named *kisasa*, it has all the elements of medicalization with the HCWs being central to the practice and potentially best positioned to address this emerging FGM/C practice.

Despite the *kisasa* FGM/C gaining momentum because of health reasons, social and legal factors underpin the practice as well. These include motivation to perpetuate the Maasai culture in a modern way through *kisasa* type because FGM/C is an important rite of passage that promote marriageability of the girl. In addition, the HCW as a practitioner of FGM/C may be from the community still carrying out the practice, identifying with the cultural beliefs of the community as well as gaining economically. Despite the popular belief that medicalization is devoid of health complications, the findings point to the fact that women and girls suffer some form of immediate, birthing, long term and psychosexual complications. These complications present an opportunity for healthcare workers to be champions of FGM/C prevention and response including addressing medicalization. This should take the form of holistic approach that integrate interventions for FGM/C prevention and response at every level of the health system including the community.

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