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Effectiveness of the Policy Interventions in Eradicating FGC Practices in Marani Sub-County, Kisii County, Kenya

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Abstract: *Female Genital Mutilation/Cutting (FGM/C) is a harmful practice that violates the human rights of women and girls. Despite global efforts to restrict the practice, there have been few reports on major positive changes to the problem. This study sought to evaluate the effectiveness of the policy interventions in eradicating FGC practices in Marani Sub-County, Kisii County, Kenya. The study was guided by the theory of Reasoned Action. This study used a quasi-experiment design. The researcher used cluster sampling to identify 200 households and purposive sampling procedures, to identify 13 key informants for the study. The study used questionnaires, key informant interview and focus group discussion to collect both qualitative and quantitative data. In this context, quantitative data was analyzed quantitatively. Qualitative data (words/propositions) was analyzed descriptively. The study revealed that stress, stigma, isolation, and marital problems were main psychological effects. Findings from this study concludes that in spite of various interventions, FGC is still an ongoing practice within the Gusii community with women and health professionals being the main perpetrators. The study recommends an adoption of alternative rites of passage to eliminate the practice. This can be possible through the re-socialisation of community members to change their negative tradition for the psychosocial wellbeing of the girl child.*

Keyword: *Female genital cutting, psychosocial, women, girl child, Gusii, re-socialisation*

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1. Introduction

Female Genital Mutilation/Cutting (FGM/C) is a harmful practice that violates the human rights of women and girls. Despite global efforts to restrict the practice, there have been few reports on major positive changes to the problem. FGC has proved remarkably persistent despite nearly a century of attempts to eliminate it (UNICEF, 2013). The underlying reasons for the practice vary across cultures, between and within communities. However, under the cultural, religious and social surface, it becomes clear that such reasons are all rooted in gender-based discrimination and harmful gender stereotypes about the role of women and girls in society. Kimani et al. (2020) and Bavel et al. (2017) posit that justification for this practice include tradition and, prevention of immorality, better marriage prospects, rite of passage and preservation of virginity.

In Kenya and Tanzania, a higher percentage of Christian than Muslim women undergo FGC (38% vs. 28%, and 19% vs. 14%, respectively) (Oino & Towett, 2016). In colonial Kenya, communities in the Meru District believed that FGC "remade girls into women" (Njuguna, 2020). According to (KDHS, 2014), the Gusii community was ranked third in Kenya with a prevalence of 84%. This means that despite the general decrease of the incidences of FGC in Kenya, the prevalence among the Abagusii community is still high, invoking the need for strong policy in eradicating FGC practices in Marani Sub-County, Kisii County. The strategies that have been most used to address the issue of female circumcision have been community-level campaigns that have served to educate the people about the physical health risks portraying it as an assault on their fundamental right to bodily integrity (Abusharaaf, 2006).

Clare Robertson (2010) after spending time in Kenya researching the socio-economic practices of women confirmed that the information available about FGC in the west had been collected using sloppy methods and was not a true representation of what was happening with African women. The impression was that FGC was something that all African women practiced. One of the controversial issues, is the use of the term "mutilation." Attention to language is vital in understanding the political and ideological debates that surround female circumcision (Abusharaaf, 2006). In 1985, during the UN conference in Kenya, African women reacted angrily when the term "mutilation" was used. The use of the term "mutilation" created hostility and was the colonial tones of Western feminism. The use of the emotive term "mutilation" in the presence of women survivors, and the revulsion expressed by international activists, who considered women victims of FGC to be 'incomplete' or 'disabled,' appeared to be another form of abuse (Pickup et al., 2001). Recognizing the hostility generated by the term, many scholars and field workers instead prefer to use the terms "Female Circumcision" or "Female Genital Cutting". However, these have also been criticized for appearing to trivialize the severity of the practice. Female circumcision, only, refers to the mildest form of operation, which affects a small percentage of the millions of women that undergo the cut (Baden, 2001).

On policy frameworks, FGC is a reproductive health concern for girls and women. At the national level, the Constitution of Kenya 2010, guarantees the rights of an individual to the highest attainable standard of health, including reproductive health. Similarly, the National Reproductive Health Policy (2007) emphasizes that harmful cultural practices, including nutritional taboos, violate the reproductive rights and impeded attainment of healthy and fulfilling reproductive lives, especially among women (MoH, 2007).

The National Reproductive Health Strategy covering the period 2009 to 2015 as a revision of the National Reproductive Health Strategy 1997-2010 seeks to address the three key issues in the spheres of gender equality (NRHS, 2015): sexual and reproductive rights in Kenya blamed on the lack of empowerment for women to exercise decision on their own reproductive health and rights, including decisions regarding seeking health care for themselves and children; gender-specific harmful cultural practices, including early or child marriages and female genital mutilation (FGC); and, sexual and gender based violence (SGBV) as well as rape. In Kenya however, harmful traditional practices of major concern are early or child marriages and FGC.

2. Literature Review

Female genital cutting is widely practiced in many Kenyan communities. It involves partial or total removal of the external female genitalia or other injury to the female organs, for cultural or other non-therapeutic reasons (WHO, 2018). The practice is widely condemned as harmful, because it poses a potentially great risk to the health and well-being of the women and girls who are subjected to it. It is also generally recognized as a violation of children's' rights.

Shell-Duncan et al. (2017) did a survey on the trends of FGC over a period and established that, the estimated prevalence of FGC among women aged 15-49 is 21%. The prevalence varies substantially by province, with the highest prevalence in North Eastern Province (98%) and lowest in Western Province (1%). The findings show that 72% of Kenyan women living with FGC reside in three regions: North Eastern, Rift Valley, and Nyanza. The prevalence in North Eastern remains at 97. 5%, while that of Nyanza was at 32.4%; it should, however, be noted that within Nyanza province only two communities, namely the Gusii and Kuria communities practice FGC, hence the statistics are rather high among the practicing communities.

Research by Shell-Duncan et al. (2017) further showed the prevalence across a 5-year age cohort on a steady decline in rates of FGC that began in the early 1980's. The decline has not occurred evenly among women from all ethnic groups. Rates of FGC remain very high among ethnic Somali women. Evidently, rates of FGC are high among the older cohorts of Maasai and Gisii women but appear to be declining among younger cohorts of women. According to the Kenya Demographic Health Survey (KDHS, 2020) the proportion of women circumcised increases with age, from 15 percent among women aged 15-19 to 49 percent among those aged 45-49. The study also established that a higher proportion of rural women (31 percent) than urban women (17 percent) have been circumcised and that the

practice varies tremendously by province. The proportion of women circumcised ranges from 1 percent in Western province to 98 percent in North Eastern province. Roughly one-third of women in Eastern, Nyanza, and Rift Valley provinces of Kenya have been circumcised compared with over one-quarter of those in Central province, 14% of those in Nairobi, and 10 percent of those in Coast province.

Health education is the main intervention of interest in this review. It involves different learning experiences designed to help individuals and communities improve their health by increasing their knowledge or influencing their attitude (WHO, 2016). This goes beyond sharing or disseminating information about a health issue to address motivation, skills, confidence, and communication of information. Differences in economic, social and environmental conditions; individual risk factors and behaviours; and use of health systems are also considered (WHO 2012).

It is vital for health education interventions to aim at long-term changes to the health behaviour and the norms that are attributed to a health problem. However, evaluations of the effectiveness of interventions depend on documenting the outcomes, effects, formation, process, cost-effectiveness and benefits of the interventions (WHO, 2012). Health education programmes have been effective in addressing various health related issues such as smoking uptake and cessation, healthy pregnancy and improved newborn outcomes (Ghrayeb et al., 2013). Health education has also succeeded in promoting the use of services such as family planning, particularly in communities that are reluctant to access such services (Bomstein et al., 2010).

According to (Kimani & Shell-Duncan, 2018) medicalization is spreading in African communities as a replacement for the traditional methods and a safe method for FGC. In another study, Leye et al. (2019) found that medicalization practice was 15%. In other countries the prevalence of medicalization was high; 67% in Sudan 38% in Egypt and 15% in Guinea and 13% in Nigeria. Due to awareness and educational campaigns on the negative consequences of FGC and its harmful effects, there has been a tendency to medicalize of the practice. In such cases, younger girls and women are more likely to have been cut by medical professionals than older women. Similar trends toward medicalization have been found in western Kenya (Njue&Askew, 2004), and Tanzania. However, though medicalization improves the condition under which FGC is practiced it largely contributes to the malpractice of the health sector among its practitioners.

There are some studies which have reported successful health education interventions in preventing FGM/C globally, but there is need for more exploration of the interventions including their effects in different communities (Richard et al., 2017). In 2010, WHO together with seven other UN agencies, and six professional organizations, issued a global strategy to stop health-care providers from performing FGC. This was a response to a concern about the increasing rate at which FGC was becoming medicalized. In this case, an estimated 18% of all women who have undergone FGC, have done so at the hands of health-care providers. To our knowledge, there is no systematic review that has synthesized the evidence and ensured understanding of the effectiveness of health education interventions as discrete interventions for FGM/C. The purpose of this review, therefore, was to explore the effectiveness of health education as an intervention to prevent FGM/C in the affected communities.

The Children's Act 2022, which criminalizes FGC (Republic of Kenya, 2022), defines child abuse as the infliction of physical harm on a child by any person, furthermore it is the infliction or inducement of physical harm by any person on a child by acts intended to cause harm. Article 23(1) clause (b) states that no person shall subject a child to harmful practices such as female genital mutilation Clause (g) further highlights any other cultural or religious rite, custom or practice that is likely to negatively affect the child's life, health, social wellbeing, dignity, physical, emotional, or psychological development. Article 23 of this Act (2) states that a person who contravenes the provisions of subsection (1) commits an offence and shall, on conviction, be liable to imprisonment for a term of not less than three years or to a fine of not less than five hundred thousand shillings, or to both. Whereas criminalization of FGC eradicates the practice from being relatively authorized by law, the actual perpetrators of the cut are driven underground, leading individuals to conduct the practice in concealed and cautious ways such as medicalization (Monahan, 2007; Berer, 2015; Kimani et al., 2020). Notice that conducting FGC in secrecy is hazardous, since victims of the same end up undergoing unsafe surgery.

As part of the Kenyan government policy interventions against FGC, the Children's Act 2022 has limitations in that it protects girls only up to the age of 17 years and does not protect women from being forcefully circumcised. In addition, placing FGC within the Children's Act, it (FGC) is seen as children's issue rather than being of wider significance, and therefore carries little weight. It is on this basis that, FIDA–Kenya (2009) suggests the need to review the Children's Act 2001, which should also take into account greater involvement of people at the community level to create sustainable ownership of the process, while at the same time paying specific attention to sections14, which highlights protection of children from harmful cultural rites such as female circumcision and early marriage and 119 (1)(h) which states that "a child is in need of care and protection when she is subjected to female circumcision". The reviewed Act ought to outlaw FGC not

only to those less than eighteen years of age, but also to women above eighteen as well.

The prohibition of FGC Act of 2011 has several provisions which are intended to eradicate the practice of FGC. It is an act of Parliament to prohibit the practice of female genital mutilation, to safeguard against violation of a person's mental or physical integrity through the practice of female genital mutilation and for connected purposes. The Act establishes a board known as the Anti-Female Genital Mutilation Board. The prohibition of FGC act of 2011 seeks to outlaw societal perceptions and attitudes towards FGC which were not provided before in other legal instruments against FGC; these provisions are further elaborated upon. It has provided legal provisions related to provision of training of midwifes or medical professionals in performing FGC. Section 19 (1) states "a person, including a person undergoing a course of training while under supervision by a medical practitioner or midwife with a view to becoming a medical practitioner or midwife, who performs female genital mutilation on another person commits an offence.

To fully comprehend the persistence of FGC among the Gusii people of Western Kenya, the study recognizes that collective intentionality in the form of "shared attitudes" is crucial for the proper understanding of social practices and social institutions. The practice of FGC should therefore be understood based on social norms and how these rationalize and normalize behavior. Norms are learnt and reinforced through everyday social interaction, while shaping and influencing behavior where control of female bodies and sexuality is normalized (Berger & Luckman, 2017).

Theory of Reasoned Action

This study was based on the Theory of Reasoned Action (henceforth TRA) by (Fishbein and Ajzen 1975). The theory argues that human beings are usually quite rational and will always make systematic use of information available to them and that people consider the implications of their actions in a given time before they decide to engage in a given behavior. The theory involves two variables thus below: Attitudes + Subjective norms = Intention (leads to behavior). This theory also reveals that, in practice, two methods of impacting behavior influence attitudes and exert social pressure. Normative beliefs play an important role according to the theory which generally focuses on what an individual believes other people, especially influential people would expect them to do. This theory is relevant to this study because considering its concepts, the Gusii situation may fit; thus, Behaviour- the specific behavior which in this case is abandoning the act of FGC on girls and women, behavioral intention-the perceived likelihood the Gusii community members will abandon or not the practice of FGC basing on the information provided to them by the government and civil society organizations. Attitude- the community members' positive or negative feelings about abandoning the practice of FGC.

In such situation, for the Gusii community members to choose to abandon FGC, their attitudes have to change; that their daughters remaining uncircumcised is more advantageous than undergoing female genital cutting. Evaluation- which in this case is the value attached to the outcome of a Gusii girl/woman remaining uncircumcised. Additionally, the subjective norms could be that people of this generation are also abandoning the practice of FGC; hence they expect them to do so as well. Normative beliefs, which are about whether key individuals such as parents, peers, teachers, and groups such as youth groups and women groups approve or disapprove the issue of girls/women remaining uncircumcised. Finally, motivation to comply is whether the girl's/woman's intention to remain uncircumcised will be affected by what others will think about them remaining uncircumcised.

3. Methodology

This study used a quasi-experimental approach. Like a true experiment, a quasi-experimental design aims to establish a cause-and-effect relationship between an independent and dependent variable. However, unlike a true experiment, a quasi-experiment does not rely on random assignment. Instead, subjects are assigned to groups based on non-random criteria. Quasi-experimental design is a useful tool in situations where true experiments cannot be used for ethical or practical reasons (Thomas, 2020). This design was in line with the purpose of the study as it sought to examine the effectiveness of the policy interventions in eradicating FGC practices in Marani Sub-County, Kisii County. Quasi-experimental designs identify a comparison group that is as similar as possible to the treatment group in terms of baseline (pre-intervention) characteristics. The comparison group captures what would have been the outcomes if the programme/policy had not been implemented. This approach gave a more general understanding of the issue effectiveness of the policy interventions in eradicating FGC practices while providing a detailed comparison and in-depth understanding of the same. The target population was the household heads of Marani Sub-County. According to Kenya Bureau of statistics, population Census 2019, the Sub-County had a total population of 26,186 households spread across locations.

The researchers used cluster sampling to identify households to be included in the study. This involved identifying households covering a particular geographical area of administrative boundaries within Marani Sub-County, Kisii County, Kenya. In addition, the study used

purposive sampling procedures, which are non-probability sampling technique where the researchers employed their own judgment to identify respondents for their study. Purposive sampling was used by the researchers to identify the key informants for the study. The sample population is presented in table 1

Table 1: Sampling Matrix

Serial number	Target Group	Population	Instruments	Sampling Design	Proposed Sampled	Actual Sample
1.	Heads of Households	26,186	Questionnaire FGD Guide	Cluster, Purposive	207 (4(6))	200 (3(6))
2.	Administrative Officers (Chiefs & sub-chiefs)	42	KII	Purposive	10	6
3.	Religious Leaders		KII	Purposive	3	2
4.	Health Professionals		KII	Purposive	4	4
5.	Traditional Practitioner		KII	Purposive	2	1
Total		26,228			226	213

The study used both secondary and primary data to achieve its objectives. Secondary data were achieved by rigorous review of relevant literature. Primary data were achieved through administering of questionnaire to the sampled respondents drawn from household heads. Key informant interviews were used to collect information from administrative officials, religious people, traditional practitioners and health professionals. Interviews allowed the researcher to collect general information on the trends and context in which FGC is practiced in the community and this enabled the researcher to identify approaches reach respondents at the community level. The researcher developed an interview guide with questions regarding the relevance and the continued practice of FGC in the community. This study used the focus group discussion (FGD) as an instrument to collect data from the women and men of the households in Marani. The FGD consisted of 4 groups of 6 participants each. That made a total of 24 participants. Two of the groups consisted of male while the other two consisted of female participants. The researcher categorized the questions as probe questions, follow-up questions and finally exit questions.

Data was analyzed by documentation of data collected, coding, sorting, categorizing, editing, corroborating the findings with research questions and developing themes and connecting to make meaning based on what the researcher was required to investigate and record this in the findings (Creswell, 2003). The data from the completed questionnaires was cleaned, coded and then entered into the computer using the latest Statistical Package for Social Sciences (SPSS).

4. Results and Discussion

This study sought to evaluate the effectiveness of the policy interventions in eradicating FGC practices in Marani Sub-County, Kisii County, Kenya. Respondents were asked to rate the effectiveness of the FGC intervention used in the community. The study used a 4-point scale to establish how effective an intervention was. The scale comprised of 1=Not effective, 2=Lowly effective 3= Somewhat effective, 4 =Very Effective. The summary of the analysis is shown in table 1.

Table 1: Rating for effectiveness of FGC interventions

Female genital interventions	Not Effective	Lowly effective	Somewhat Effective	Very Effective	Mean	Std. Deviation
Advocate for change	4(2%)	15(7.5)	35(17.5%)	146(73.0%)	**3.6**	**.714**
Continuation of practice through other methods such as medicalization	84(42%)	26(13.0%)	55(27.5%)	35(17.5%)	**2.2**	**1.166**
Punishment of perpetrators	7(3.5)	5(2.5%)	27(13.5%)	161(80.5%)	**3.7**	**.685**
Establishment of rescue centers	15(7.5%)	41(20.5%)	51(25.5%)	93(56.0%)	**3.1**	**.981**
Engagement of various stakeholders	11(5.5%)	26(13.0%)	51(25.5%)	112(56.0%)	**3.3**	**.874**
Alternative rites of Passage	106(53.0)	53(26.5%	29(14.5%)	12(6.0%)	**1.7**	**.921**
Media campaigns	2(1.0%)	8(4.0%)	33(16.5%)	157(78.5%)	**3.7**	**.584**
Legislation	2(1.0%)	7(1.0%)	76(38.0%)	112(61.0%)	**3.6**	**.511**
Educational awareness	5(2.5%)	3(1.5%)	64(32.0%)	128(64.0%)	**3.6**	**.653**
Victims' empowerment	19(9.5%)	62(31.0%)	61(30.5%)	58(29.0%)	**2.8**	**.970**

Analysis demonstrates that media campaigns, legislation, punishment of perpetrators, education, and advocating for change were very effective with a mean range of 3.6-3.7. Engagement of stakeholders, establishment of rescue centers, and empowerment of victims were somewhat effective with a mean range of 3.0-3.3.mn=3.7, legislation 3.6, Education mn=3.6. During interviews it was noted that close monitoring of FGC activities by local leaders and arrests of community members reported of practicing FGC was the most effective intervention. As stated by one of the respondents:

> Keenly monitoring of FGC activities in the community has been the most effective. Like I told you in 2020 I arrested a parent who had taken the daughter to Tanzania for FGC. These created fear among community members and since then I have not heard another case" (**K002 Female participant, 43 years**).

This statement clearly indicates that arrests and close monitoring of FGC activity were the most effective methods. This could be attributed to the changed nature of FGC which is practiced as a secret activity than an open community traditional exercise. Championing for continuation of practice through other methods such as medicalization and Alternative rites of Passage with a mean of 1.7 and 2.2 respectively had low effect in reduction of female genital cutting in the community.

Studies have established a growing trend in medicalization of FGM/C in practicing communities. This study concurs with another study (Kimani & Shell-Duncan, 2018) that reported the spread of medicalization in African communities as a replacement for the traditional methods and a safe method for FGC. There however remains a debate on ethics of the practice and dual loyalty of medicalization of FGC. To ascertain the community perception of the same this study asked household heads to indicate if they support or do not support the practice. The responses were summarized and shown in figure 1.

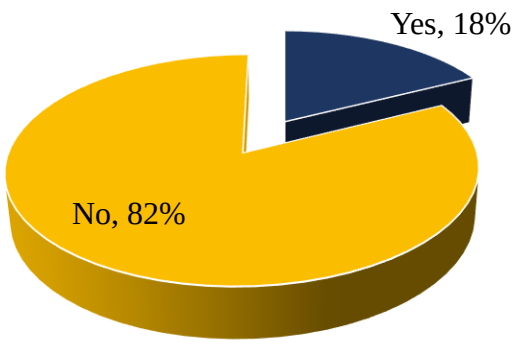

Figure 1: Support for medicalization of female genital cutting in Gusii community

Out of 200 respondents 165(82%) did not support medicalization of FGC in Gusii community while 35(18%) supported the medicalization of FGC. These results show that medicalization of FGC was not supported by the community thus not an effective intervention for FGC and protection of girls' wellbeing. Qualitative results reveal that doctors might be involved in the FGC practice. A respondent explained that:

> "Nowadays it's like doctors do it because the old mamas who used to do it are no longer there or they fear being arrested. Once the parents are arrested the child reveals the one who did it." (KI003 Male, 45 years).

From this statement, it's noted that medical staff might be involved but it is not very clear. Another respondent from FGD shared similar sentiments. Thus, it can be concluded that medical staff are involved in conducting FGC in secrecy. These results could also imply that FGC is reducing within the Gusii community.

These results agree with findings by Leye et al. (2019) who found that medicalization practice was 15%. In other countries the prevalence of medicalization was high; 67% in Sudan 38% in Egypt and 15% in Guinea and 13% in Nigeria. The trend is rising as many people opt to use health professionals to carry out the act. This trend has been explained to be attributed to the high health approach used in anti-FGM/C interventions in most countries.

A report by WHO (2020), explained that the campaigns against FGM/C stressed the adverse health consequences of the practice if this would help raise awareness. Contrary to the expectation the approach has contributed to unintentional medicalization of FGC thus the continuation of the practice using modern approach. Despite the change in the approach the practice remains detrimental to the wellbeing of a girl who can face stigmatization and other health complications.

5. Conclusion and Recommendations

5.1 Conclusion

From the findings it is clear there is no biblical explanation of FGC among Gusii community but rather socio-economic activity of warfare among the community explained why it was traditionally adopted. Some participants shared that FGC was practiced reducing sexual urge among women while others have argued that despite this being the belief, it was not practically possible. Further, it was revealed that reduction of sexual urge was not a true factor for continued practice of FGC since women who have been cut do not attest to the perception of reduced sexual urge. Both quantitative and qualitative findings indicate that FGC is conducted for traditional reasons. The traditional reasons, however, do not hold a lot of strength since because of modernization thus the practice has reduced significantly. The role of various stakeholders in ending the practice is the most effective intervention so far adopted.

5.2 Recommendations

The study recommends the integration of anti FGC in schools' guidance and counseling and training of church leaders and members on alternative programs for FGC so that girls can still benefit from teaching received during the initiation process without actually taking the cut. Finally, this study recommends the concept of re-socialization as a

way of ensuring that effective interventions are adopted to bring FGC to an end.

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