

“DO NO HARM”: Female Genital Mutilation And Its Effects On Women And Young Girls.

*Intensifying Local Efforts, Sharing Global-Good Practices
To Effectively Eliminate FGM/C In Kenya.*



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Figure 1: A Young Masaai Girl Undergoing an Alternative Rite of Passage
Photo Credit: Eric Lemayian - The 'Talking Trees Project' -2016 -2017.

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The Enduring Voices Foundation For Anthropological Research - is a coalition of indigenous pastoralists' communities collaborating with researchers, scientists and academic organizations to facilitate cultural, linguistic, social anthropological and community-oriented-health-research projects in Kenya and across the sub-Saharan Africa.



The **Wellcome Trust** is a biomedical research charity based in London, United Kingdom. It was established in 1936 with legacies from the pharmaceutical magnate Sir Henry Wellcome to fund research to improve human and animal health. The aim of the Trust is to "achieve extraordinary improvements in health by supporting the brightest minds", and in addition to funding biomedical research it supports the public understanding of science.

ABSTRACT

Female Genital Mutilation (FGM/C) is described as various traditional practices that involve all procedures for partial or total removal of the external female genitalia for cultural, religious, traditional and or non- therapeutic reasons in many societies of the world (WHO, 1997, 2010). Statistics by the WHO indicates that FGM/ affects more than 130 million women globally. FGM/C has no known health benefits but severe effects on the physical, social consequences, mental and psychosocial well being of those who have undergone it and once which occurred before and after the FGM/C procedure was carried out.

Female Genital Mutilation (FGM/C) is no longer a practice experienced African women only, research indicates that FGM/C has spread out beyond borders and become a global menace, brought about by the increased immigration rates towards the west. According to legislations in many countries, Female Genital Mutilation (FGM/C) is considered a criminal offence because it violates human rights, compromises the health of women and puts girls at risk of life-long complications and infections. Empowering people and communities where FGM/C is practiced with knowledge on the subject and providing them with necessary resources can hasten the fight against FGM/C and also help in eliminating the practices.

This study also looks at the legislations on FGM/C and legal policies and frameworks formulated for the eradication campaigns and on the abandonment of FGM/C in Kenya. It discusses the best practices, the lessons learnt, the opportunities for the abandonment of FGM/C as well as the challenges facing the elimination of FGM/C practices in Kenya and especially among the pastoralists' communities of Kenya. It reviews the Kenya National Policy on FGM/C, the National Plan of Action for the eradication of FGM/C and looks at the mandate of the Kenya National Anti FGM/C Board and other FGM/C Stakeholders, providing services for women and girls who are at risk of undergoing FGM/C in Kenya.

This study addresses the concept of FGM/C practice as well as the different myths and beliefs that support its continuation. The study focuses on the experiences of pastoralists' women and girls of Narok and Kajiado Counties of Kenya, who have undergone FGM/C and the ones who haven't. Ones who have suffered the consequences of FGM/C and ones who have been rescued from the risk of FGM/C. These are women who understand their cultures best and can tell more on the practices, by looking at their flashbacks, the FGM/C procedure, consequences involved before and after FGM/C, cultural beliefs, religious views on FGM/C practices, and the human rights that violation against girls and women through forced or coercive Female Genital Mutilation.

This study also investigates the Female Genital Mutilation (FGM/C) and its effects on maternal deaths prevalent among the pastoralists' communities of Kenya. Female Genital Mutilation (FGM/C) is recognized both locally and internationally as an outdated traditional practice, which violates the rights of women/girls and one that is difficult to eradicate. Lack of education, unemployment and poverty are mentioned as some of the variables that enabled the FGM/C practices to thrive in these communities.

While research indicates that there are many types of Female Genital Mutilation (FGM/C), with other unclassified types, some practicing communities in the locations where this study was conducted neither know of the either harmful nature or the consequences of any one type of FGM/C. Among these communities, Female Genital Mutilation (FGM/C) still remains a sensitive and a taboo topic to be discussed in the public. However, we all agree that the time has come for

FGM/C and other harmful practices to be addressed, albeit with great concern and care on people's feelings and culture.

For this study, the Principal Investigator and the 'Talking Trees Project' team interviewed women from 22 small towns and villages spread across Narok and Kajiado Counties namely: *Magadi, Namanga, Ngong, Kiserian, Kajiado, Kule, Narok, Jerusalem, Olkeri, Oljororok, Ntilal, Naijile Oltina, Naadadapo, Sarara 1, Sere Olipi, Lauragi 2, Lengarde/ Leshunyai, Lenchekut, Lorian and Sionta 2*, where the FGM/C was still practiced.

The 'Talking Trees Project' which was implemented between 2016 - 2017, was organized around: Maternal healthcare, FGM/C, alternative rites of passage, women's health, human rights, child development and early child-marriage. The ultimate goal of the programme was to mobilize indigenous pastoralists' communities to participate in open public health debates and forums, which led to voluntary open public declarations on the abandonment of harmful traditional practices like: FGM/C and child marriage.

The 'Talking Trees Project' brought a multidisciplinary team of experts and pastoralists communities together, to discuss and develop an understanding of the discrepancies between modern science and traditional practices that would help the researchers to understand the causes and ways through which maternal deaths prevalent among these communities could be prevented or reduced.

The 'Talking Trees Project' also helped the project team and the researchers/scientific experts involved in compiling an inventory of existing indigenous health care training and capacity building activities relevant to the management and sharing of public health research data to the target groups, to improve research collaborations among like-minded researchers and share findings in research institutions in ways that have the potential to accelerate progress in public and or maternal health.

In this regard, this publication aims to galvanize the efforts of local and international movements and campaigns to end Female Genital Mutilation (FGM/C). The publication covers the 'Talking Trees Project's own activities, and can be shared freely and promoted among the pastoralists communities, donors, partners and researchers, who might find it useful or thought-provoking in the context of their own work.

Key words: *Female Genital Mutilation, Pastoralists' communities, Religion, Infibulation, Clitoridectomy, Excision, FGM, Consequences, Flashbacks, Effects, Forums, Maternal Health, Mortality Rate, Debates, Interviews, Talking, Trees, Project, Implementation, Evaluation, Kenya, Acacia, Masaai, Moran, County, Narok, Kajiado, Somalia, Sudan, Ethiopia, Africa.*

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INTRODUCTION

Key facts

- Female Genital Mutilation (FGM/C) includes procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons.
- The procedure has no health benefits for girls and women.
- Procedures can cause severe bleeding and problems urinating, and later cysts, infections, infertility as well as complications in childbirth and increased risk of newborn deaths.
- More than 125 million girls and women alive today have been cut in 29 countries in Africa and Middle East where FGM/C is active.
- FGM/C is mostly carried out on young girls sometime between infancy and age 15.
- FGM/C is a severe violation of the human rights of girls and women.

While Kenya is grappling with enormous challenges in tackling Female Genital Mutilation (FGM/C) - considered as a major contributing factor for high maternal deaths among its Pastoralist communities, the World Health Organization (WHO) estimates that 10,000 pastoralists' women die from FGM/C related complications annually. FGM/C involves all procedures for partial or total removal of the external female genitalia (WHO, 1997). Among the pastoralists' communities of Kenya, the causes of FGM/C include cultural, religious and social factors. Although a global campaign against FGM/C was launched in October 2014, abandoning FGM/C in its totality remains a challenge for these communities.

The Pastoralists' communities are indigenous tribes of Kenya, comprising mainly of the (*Masaai, Samburu, Rendile, Kalenjin, Turkana, Pokot and Somali* people). They have distinct traditional values, cultural practices and religious beliefs systems. However, some of these traditions and cultures are beneficial to all members, while others are extremely harmful to specific groups, especially women. Female Genital Mutilation (FGM/C) is one such harmful traditional practice affecting the health of women that has been held by these communities for generations. Despite its harmful nature, FGM/C persists due to lack of coordinated actions deemed necessary to bring about change within the pastoralists communities.

Female Genital Mutilation (FGM/C) is a century old cultural practice that continues to be a serious social and health problem in Kenya, directly affecting girls and women. The practice has led to physical injuries, death, emotional stress and psychological suffering, with complications arising during child birth for women and infections caused by lack of sterilized equipment including transmission of various infections such as HIV/Aids. FGM/C causes discrimination of women and girls in communities where it is practiced and violets their human rights through gender based violence, early marriage of young girls and termination of their formal education.

FGM/C involves all procedures for partial or total removal of the external female genitalia (WHO, 1997). Statistics by the WHO indicates that FGM/C is a socio-cultural, religious and traditional ritual affecting 130 million women globally.

FGM/C has no known health benefits but severe effects on the physical, mental and psychosocial well being of those who have undergone it. Immediate complications include: severe pain, shock, haemorrhage, tetanus or sepsis, acute urine retention, open sores in the genitalia and injury to

nearby genital tissue. The Long-term consequences include: Keloid formation, perineal tears, fistula, loss of libido, genital malformation, delayed menarche, chronic pelvic complications, recurrent urinary retention, obstructed labour, psychological trauma and infertility.

Among the Pastoralists' communities of Kenya, where FGM/C prevalence stands at 95%, it is believed that, if the clitoris of an uncircumcised woman touches the head of a baby during birth, the child must die. The clitoris is seen as the male characteristic of the woman; in order to enhance her femininity, this male part of her has to be removed. If a child dies from FGM/C complications, the circumciser is not held responsible; rather, the death is attributed to evil spirits.

The practice is primarily performed on girls aged 4-16 by elderly female circumcisers, who also double as untrained village midwives. They use unsterilized instruments such as knives, razors, sharp sticks, scissors or even broken glass, to perform the FGM/C ritual without the use of anesthesia and in very unsanitary conditions. Some of these instruments are used repeatedly on numerous girls, thus increasing the risk of HIV/AIDS transmission. The operation involves the total removal of the clitoris, labia minora and severing the inner side of the labia majora. The sides of the labia majora are then sutured together, leaving a small hole to allow urine and menstrual discharge to pass.

Obstetric complications are the most frequent health problems, resulting from vicious scars in the clitoral zone after excision. These scars open during childbirth and cause the anterior perineum to tear, leading to haemorrhaging that is often difficult to stop. Infibulated women have to be opened, or deinfibulated, during childbirth and be stitched back together (reinfibulated) after each delivery. Infant mortality and maternal deaths in traditional pastoralists' villages where untrained traditional birth attendants and circumcisers perform the operations rank among the highest.

The "Talking Trees Project" has been raising awareness on FGM/C practices and stimulating dialogue about the increasing maternal deaths among the pastoralists' communities, by bringing together a multidisciplinary team of gynaecologists, urologists, anthropologists, traditional FGM/C practitioners, researchers, pastoralists' elders and the general public, to discuss and develop an understanding of the discrepancies between modern science and outdated traditional and cultural practices. It fostered, built and strengthened collaborative health research, planning, implementation, and outcomes between scientists, anthropologists, researchers and indigenous communities in Kenya and beyond.

The "Talking Trees Project" engaged the pastoralists' communities, indigenous women, village elders and morans, perceived to be the custodians of their own cultures through an all inclusive participatory health forum and dialogue designed to enlighten and change the attitude of the pastoralists' people against FGM/C in order to embrace alternative rites of passage.

To archive these, the "Talking Trees Project" in partnership with a coalition of indigenous pastoralists communities is brought together a multidisciplinary team of experts to discuss and to understand the discrepancies between modern science and traditional practices that would help the research team to understand the causes and ways through which Maternal deaths prevalent among the pastoralists communities of Kenya could be reduced.

This project also aimed at developing appropriate information materials in indigenous languages that actively contributed to community outreach work and in raising awareness on FGM/C, thus contributing to building of trust and understanding between scientists, researchers and the pastoralists, by communicating modern medicine and science using indigenous languages to solve severe health concerns facing Kenya's pastoralists' communities.

For this project, Narok and Kajiado Counties were selected as the pilot and the first study area, where the FGM/C is affecting 80% of women thus; eliciting "The Talking Trees Project's open public health research forum's interest.

BACKGROUND OF THE STUDY

In 2016-2017, the “Talking Trees Project” - a public health research and forum addressing maternal deaths prevalent among pastoralists’ communities of Kenya’ was launched and implemented in Narok, and Kajiado Counties of Kenya, by the Enduring Voices Foundation.

In 2016, the ‘Talking Trees Project’ was organized around maternal healthcare, FGM/C, alternative rites of passage, women’s health (sexuality, pregnancy management, HIV/Aids and death), human rights, child development and early child-marriage. The ultimate goal of the project was to mobilize indigenous pastoralists’ communities to participate in open public health debates and forums, which led to voluntary open public declarations on the abandonment of harmful traditional practices like: FGM/C and early child-marriage.

The Aims and Objectives of this project were:

- Awaken the interest of pastoralists’ communities and intensifying their participation in future community health research and project implementation.
- Raise awareness on the dangers of FGM/C and to advocate for behavioral/ attitude change towards the practice of FGM/C.
- Develop community health research infrastructure and improve pastoralists’ communities’ livelihoods- through project workshops and seminars.
- Forge stronger project collaborations among the researchers, gynecologists, pastoralist communities and the public.
- Strengthen capacity for future collaborations in quality public engagement work locally, regionally and globally
- Involve pastoral communities in participatory health forums to deepen their understanding, to impact their behavioral change around FGM/C.
- Develop strategies for galvanizing positive social change, in order to influence policies that support the development and promotion of alternative rites of passage through scientific research, tested and proven approaches for programs that promote best practices in abandoning FGM/C practices.

The purpose of this project was to:

- Engage the pastoralists’ communities through an all inclusive participatory health forum and dialogue designed to enlighten and change their attitude towards FGM/C in order to embrace alternative rites of passage.
- To obtain baseline data on:
 - i. the current FGM/C prevalence among women of childbearing age in the pastoralist communities in the study locations;
 - ii. the FGM/C prevalence types performed among pastoralist communities in the study locations;
 - iii. the age when the procedure was FGM/C performed, who performed it and where;
 - iv. why the women think the FGM/C practice is done; whether women are pleased it was done on them; whether they will do it to their daughters and why;
- To record data by observing women participants in the ‘Talking Trees Project’ forums, debates and interviews on issues concerning FGM/C as raised in the questionnaires;

- To determine whether any progress has been made towards attitudinal changes after 1 year of project implementation and unparalleled campaigning through forums, debates and interviews;
- To use the information obtained for future planning of actions to eradicate FGM/C practices and to develop appropriate information materials in indigenous languages that would actively contribute to community outreach work and in raising awareness on FGM/C and by communicating modern medicine and science using indigenous languages to solve severe health concerns facing Kenya's pastoralists' communities.

To achieve success, the 'Talking Trees Project' team designed and adopted a '*Do No Harm*' ethical principle to underpin the 'Talking Trees Project' research, health and social programming, shielding researchers and the multidisciplinary project team from causing intentional harm to the pastoralists' communities.

This 'Do No Harm' approach was invented and produced in partnership with the Girl Generation, through a communications programme aimed at galvanising a global movement to end Female Genital Mutilation (FGM/C). The 'Talking Trees Project' team applied the 'Do No Harm' principles, to mitigate the risk of advocating for social change interventions inadvertently creating societal divisions, particularly in contexts of conflict and fragility or unforeseen and unintended negative effects.

This study contributed to our understanding the identification of challenges and support gaps in FGM/C research and dissemination to the general public. It also helped us in developing appropriate information materials in indigenous languages that actively engaged and contributed to community outreach work and in raising awareness on FGM/C.

Research Questions?

Female genital mutilation is one of the most outdated and dangerous cultural practices that cause torture and death among those who undergo the procedure. While communities which do not practice FGM/C tend to identify it as violating the human rights of women and young girls, those who do practice FGM/C do not see it as violating the rights of women and girls, but rather as a rite of passage from childhood into adulthood, and as a part of their inter-generational tradition that was passed down to them by their forefathers and as one that must be followed. Without much knowledge, FGM/C practicing communities, FGM/C practitioners and FGM/C victims do not know much about the violation of human rights.

Through the implementation of the 'Talking Trees Project', the Principal Investigator and her project team traversed 15 constituencies, bringing anti-FGM messages to over 200,000 people in Narok and Kajiado Counties and interviewed members of the pastoralists' community (i.e. women, girls, men, morans, the clergy, many resourceful persons and health professionals) in 22 villages and reviewing previous literature on FGM/C. In so doing, the PI aimed at finding answers to the following questions:

1. What is Female Genital Mutilation?
2. What kinds of reasons are there for practicing Female Genital Mutilation?
3. What kinds of experiences do women have of the Female Genital Mutilation?
4. How does Female Genital Mutilation violate the rights of women and children?
5. What are the consequences of Female Genital Mutilation?
6. How can we stop the practice of Female Genital Mutilation?

WHAT IS FEMALE GENITAL MUTILATION (FGM/C)?

Female Genital Mutilation (FGM), also known as Female Circumcision (FC) or Female Genital Cutting (FGC) is a universal practice that results in many health-related and life threatening complications. It also has other physical and psychological effects that do great harm to the wellbeing of women and children who have had it performed on them.

According World Health Organization (WHO), Female Genital Mutilation (FGM/C) is defined as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs, whether for cultural, religious or other non-therapeutic reasons.

The FGM/C practice is mostly carried out by traditional circumcisers, who often double as untrained Traditional Birth Attendants (TBAs). However, more than 18% of all FGM/C is performed by healthcare providers, and the trend towards medicalization is increasing worldwide.

FGM/C is practiced in more than 20 countries of Africa, the Middle East and Asia, and within immigrant populations throughout the world, with prevalence rates ranging from 5-99%. Its practice can be found among all religious, ethnic and cultural groups and across all socio-economic classes. It is estimated that up to 130 million women and girls have already been subjected to some form of FGM/C and 2 million more are expected to undergo it each year.

In the countries where most or a large number of women have been genitally mutilated, the medical complications that result from these practices place a heavy burden on the healthcare services of these countries.



Figure 2: Normal Female Genitalia. Photo Credit: Bob Onyango - Freehand Artist - Bob Graphics

FGM/C is recognized internationally as a violation of the human rights of women, girls and young children, who are forced to undergo it at a tender age. It promotes violence against women, reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women who have not undergone it.

FGM/C practice also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, in-human or degrading treatment, and the right to life when the procedure results in death.

Who is at Risk of FGM/C?

Procedures are mostly carried out on young girls sometime between infancy and age 15, and occasionally on adult women. In Africa, more than three million girls have been estimated to be at risk for FGM/C annually.

More than 125 million girls and women alive today have gone through FGM/C in the 29 countries in Africa and Middle East where FGM/C is active.

The practice is most common in the western, eastern, and north-eastern regions of Africa, in some countries in Asia and the Middle East, and among migrants from these areas.

Causes of FGM/C

The causes of Female Genital Mutilation (FGM/C) are said to include a mix of cultural, religious and social factors within families and communities.

- Where FGM/C is a social convention, the social pressure to conform to what others do and have been doing is a strong motivation to perpetuate the practice.
- FGM/C is often considered a necessary component in raising a proper girl-child, and a way to prepare her for adulthood and marriage.
- FGM/C is often motivated by beliefs about what is considered proper sexual behaviour, linking procedures to premarital virginity and marital fidelity. FGM/C is in many communities believed to reduce a woman's libido and therefore believed to help her resist "illicit" sexual acts. When a vaginal opening is covered or narrowed (type 3 above), the fear of the pain of opening it, and the fear that this will be found out, is expected to further discourage "illicit" sexual intercourse among women with this type of FGM/C.
- FGM/C is associated with cultural ideals of femininity and modesty, which include the notion that girls are "clean" and "beautiful" after the removal of body parts that are considered "male" or "unclean".
- Though no religious scripts prescribe the practice, practitioners often believe the practice has religious support.
- Religious leaders take varying positions with regard to FGM/C: some promote it, some consider it irrelevant to religion, and others contribute to its elimination.
- Local structures of power and authority, such as community leaders, religious leaders, circumcisers, and even some medical personnel can contribute to upholding the practice.
- In most societies, FGM/C is considered a cultural tradition, which is often used as an argument for its continuation.
- In some societies, recent adoption of the practice is linked to copying the traditions of neighbouring groups. Sometimes it has started as part of a wider religious or traditional revival movement.
- In some societies, FGM/C is practiced by new groups when they move into areas where the local population practices FGM/C.

CLASSIFICATIONS OF FGM/C



Figure 3: Circumcised Female Genitalia. Photo Credit: Bob Onyango - Freehand Artist - Bob Graphics

Female Genital Mutilation (FGM/C) procedures vary throughout the world. However, the WHO classifies FGM/C into four types as follows:

Type I: Clitoridectomy: Involving the partial or total removal of the clitoris (a small, sensitive and erectile part of the female

genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).

Type II: Excision: Involving the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).

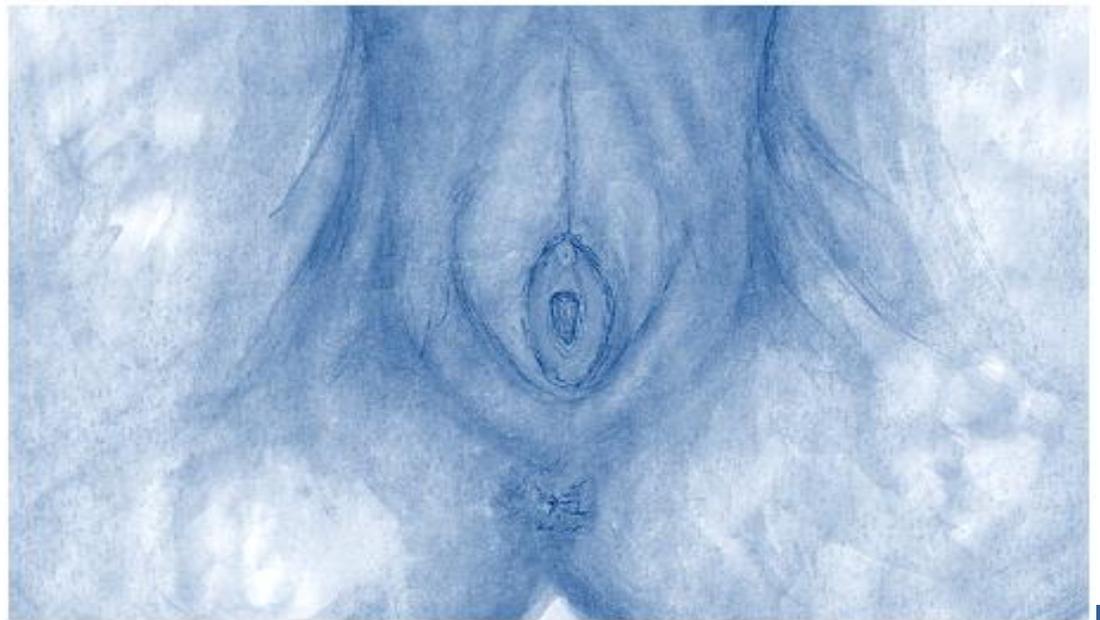


Figure 4: Circumcised and Sewn Genitalia. Photo Credit: Bob Onyango - Freehand Artist - Bob Graphics

Type III: Infibulation: This is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.

The small hole (typically less than 5cm) is left to permit the passage of urine and vaginal secretions. This hole may need extending before first sexual intercourse.



Figure 5: Circumcised and Completely Sewn Genitalia. Photo Credit: Bob Onyango - Freehand Artist - Bob Graphics

The most commonly practiced genital mutilation types are: **Type I:** Clitoridectomy and **Type II:** Excision, both comprising of about 85% FGM/C cases in Africa. Although

genital mutilation is practiced in mostly Islamic countries it is not an exclusively Islamic practice.

Type IV: Unclassified FGM/C

This involves all other harmful procedures, including any other damage to the female genitalia including pricking, piercing, burning, and cutting, introduction of corrosive substances, incising, scraping and cauterizing the genital area.

Besides being a pre-Islamic cultural practice, Female Genital Mutilation (FGM/C) is not found in much of the Middle East Islamic countries.

Female Genital Mutilation (FGM/C) is cross-cultural and inter-tribal practice, practiced in Africa and some parts of the Middle East.

It is practiced by Muslims, while members of the various Christian

religions including: Protestants, Catholics (Sierra Leone), (Kenya), Jews (Ethiopia) and among indigenous communities like the indigenous pastoralists' communities of Kenya, comprising mainly of the (*Masaai, Samburu, Rendile, Kalenjin, Turkana, Pokot and Somali* people).

Unclassified FGM/C

This involves scarification of the hood of the clitoris, labia minora and vagina and removal of the hymen in some societies. It also includes pricking, piercing, or stretching of the clitoris /or labia.

There are no pictures for this particular type of FGM/C because it contains various operations that are difficult to sketch into a picture. Each community has its own way of performing unclassified FGM/C practices.

The most common types of Female Genital Mutilation (FGM/C) are Type **II** and Type **I** with variation among countries. Type **III**, infibulations, constitutes about 20 per cent of all affected women; and is most likely found in Somalia, Northern Sudan and Djibouti. Both immediate and long-term complications are reported following the genital mutilation process.

Multiple problems occur after Type **III**, as it's considered as one of the extreme form of FGM/C in countries where it is practiced. The immediate complications include but are not limited to: sudden death, extreme pain, tetanus, urine retention, and excessive bleeding. The long-term complications may include: menstrual cramps, lack of sexual desire, painful sexual intercourse and bladder infections (Afro-Arab 2003).

The Female Genital Mutilation (FGM/C) procedure is extremely painful, since it is often done traditionally without any type of medication or anesthesia. The traditional circumcisers and FGM practitioners, who also double as midwives, improvise the tools they use from pieces of glasses, broken bottles and sharp thorns from trees, blunt knives made locally using corroding tins, and some from curved from stones. The age at which FGM/C is performed on women and girl children varies from one country to another, from one community or tribe to another; and other different circumstances. Mostly, the age ranges from a few days after birth, to adolescent and just before marriage or after first pregnancy. In Somalia girls, undergo the practice aged four to nine years, in Ethiopia when the baby is a few days old up to just before onset of puberty, in Kenya before puberty and in Sudan from a few days old, to adolescent and just before marriage.

Different elements of culture are seen in societies where Female Genital Mutilation (FGM/C) is practiced. These include different kinds of beliefs, religious, social hierarchies, norms and customs. When it comes to Female Genital Mutilation (FGM/C), some communities tend to share same cultural thinking and ways of life. However, culture is verbally transmitted from adults to children, and for this reason, FGM/C is spreading faster from one generation to another (Millos f. and Denniston c. 2000).

Social pressure is also seen as one of the factors among many communities where most girls and women are circumcised. Through this, family and friends have created an environment in which the FGM/C practice becomes a requirement for social acceptance among the peer groups, or to avoid name calling for one to fit in the group (Boyle 2002).

Exploring the issues of gender, women and children's right, the practice of Female Genital Mutilation (FGM/C) is a big threat to the women's health and violation of their human rights. Although the FGM/C practice is perceived as illegal in countries that have imposed FGM/C laws on it, better understanding of the FGM/C practicing communities needs to be considered in finding ways of encouraging these communities to stop the FGM/C practices, since it's deeply rooted in their cultures and believes (Hernlund and Shell-Duncan 2007).

Majority of FGM/C cases are found among the 28 African countries. In countries like Egypt, Ethiopia, Somalia and Sudan, FGM/C prevalence rates are as high as 98%. (*See Table 1. below*). While in other countries like Nigeria, Kenya, Togo and Senegal prevalence rate is between 20 and 50 % (Amnesty international 1997).

However big or small the FGM/C case percentages in different countries are; specific ethnic groups do practice FGM/C and not the entire country. FGM/C has spread to other parts of the world; and is now taking place in the Arabian Peninsula among the Yemen and Oman people. It is also practiced in Pakistan, Indonesia and Philippines in Muslim populated areas. Immigration and refugee movement have also contributed to the spread of the FGM/C to USA, Canada, Europe, Australia and New Zealand. Research by Forward (2002) indicated that 6,500 girls were at risk of FGM/C within the United Kingdom every year.

Country	FGM/C Prevalence	FGM/C Type Practiced
Benin	5-50%	Excision
Burkina Faso	Up to 70%	Excision
Cameroon	-	Clitoridectomy and Excision
Central Africa Republic	45-50%	Clitoridectomy and Excision
Chad	60%	Excision and Infibulations
Comoros	-	Excision
Cote d' Ivoire	Up to 60%	Excision
Congo	-	Excision
Djibouti	98%	Excision and Infibulations
Egypt	85-95%	Clitoridectomy, Excision and Infibulations
Eritrea	95%	Clitoridectomy, Excision and Infibulations
Ethiopia	70-90%	Clitoridectomy, Excision and Infibulations
Gambia	60%-90%	Excision and Infibulations
Ghana	15%-30%	Excision
Guinea	65%-90%	Clitoridectomy, Excision and Infibulations
Guinea	-	Clitoridectomy and Excision
Kenya	50%	Clitoridectomy, Excision and Infibulations
Liberia	50%	Excision
Mali	94%	Clitoridectomy, Excision and Infibulations
Mauritania	25%	Clitoridectomy and Excision
Nigeria	60%-90%	Clitoridectomy, Excision and Infibulations
Senegal	20%	Excision
Uganda	-	Clitoridectomy
Sierra Leone	90%	Excision
Somali	98%	Infibulations
Sudan	90%	Infibulations and Excision
Tanzania	18%	Excision and Infibulations

Table 1. FGM practices by country and Type practiced. Source: (Afrol News)

Global Prevalence of FGM/C

Female Genital Mutilation (FGM/C) is a widespread practice that is carried out on young girls between the ages of 5 and 15 years, and in some countries on grown women as well. It is reported to exist in 28 African countries and parts of the Middle East. It is also found in immigrant communities worldwide. An estimated 100 to 140 million girls and women have undergone FGM/C. In Africa, around 3 million girls are thought to undergo FGM/C every year.

In many communities, FGM/C is seen as a rite of passage and a prerequisite for marriage. However, it can cause life-long health complications, physical and psychological trauma. Unlike male circumcision, Female Genital Mutilation (FGM/C) is not a Religious obligation required by Islam, Christianity, Judaism or any other known religions. The practice is nevertheless a cultural tradition practiced many African and in some Asian countries. At one time, it is said to have even existed in Europe before it was abolished some centuries ago. In recent years, immigration and population movements have exported the practice to Western countries, where the medical and obstetrical complications that mutilated women and girls are seeking treatment for is causing a lot of concern among healthcare providers. This concern is expressed through the constant attention FGM/C receives from international health and human rights organizations, as well as from the global media.

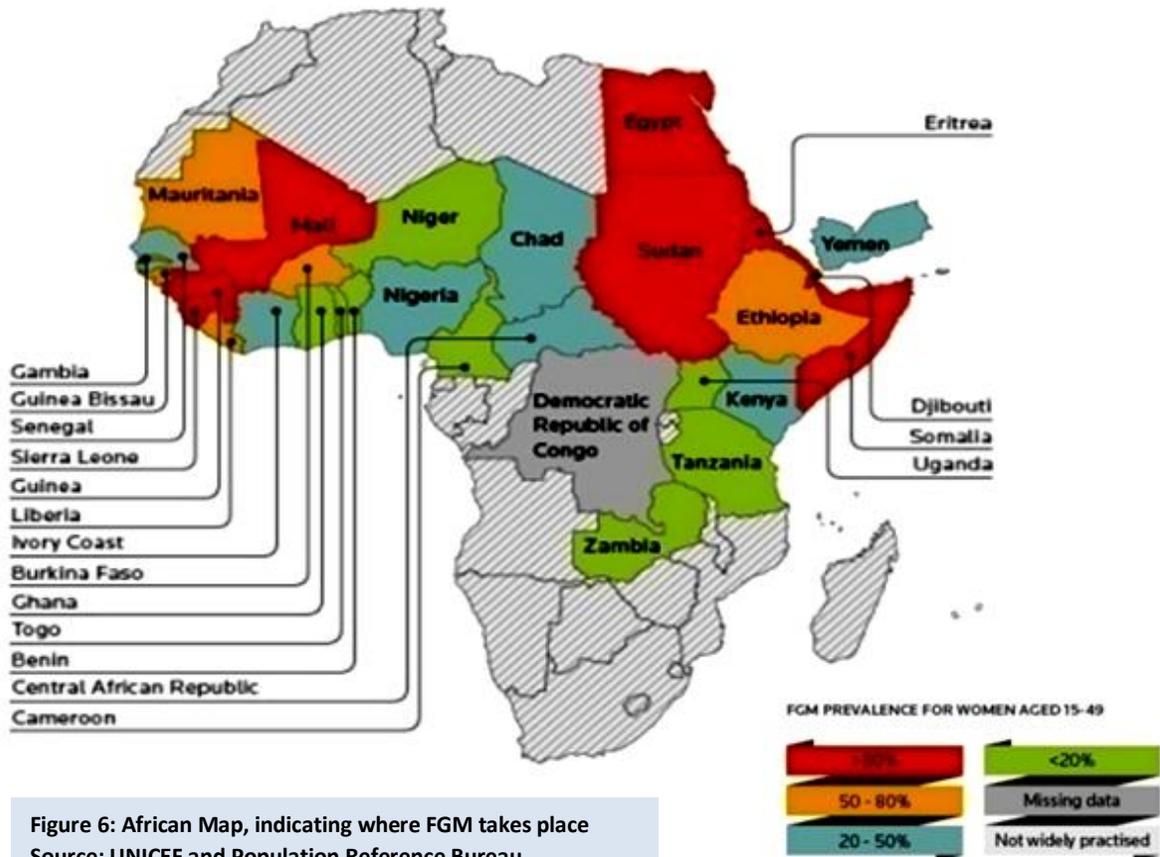


Figure 6: African Map, indicating where FGM takes place
 Source: UNICEF and Population Reference Bureau
 Image Credit: Thomson Reuters Foundation

Global Opinions on Female Genital Mutilation (FGM/C)

The United Nations and other humanitarian organizations consider Female Genital Mutilation (FGM/C) a violation of human rights. As early as 1979, the WHO recommended the eradication of FGM/C practices and in 1993 the World Health Assembly called for the abolition of FGM/C. Consequently, most countries created and enacted strict laws forbidding the FGM/C practice.

Female Genital Mutilation (FGM/C) In Asia

Female Genital Mutilation (FGM/C) is occasionally reported to be practiced by a limited few in Oman; Saudi Arabia; United Arab Emirates; Yemen; and by even fewer in certain communities in Indonesia; Malaysia; India and Pakistan.

Female Genital Mutilation (FGM/C) In Africa

Female Genital Mutilation (FGM/C) is reported to exist in 28 African countries. In some countries, FGM/C is performed on all or most women, while in others it may be performed only on some women belonging to certain ethnic groups.

The countries where FGM/C is reported to be practiced with varying applications of Types and at different prevalence rates are: Benin; Burkina Faso; Cameroon; Central African Republic; Chad, Democratic Republic of the Congo, Djibouti, Egypt, Eritrea, Gambia, Ghana, Guinea, Guinea-Bissau, Ivory Coast, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Somaliland, Sudan, Tanzania, Togo, Uganda. (See Figure 6 above).

Female Genital Mutilation (FGM/C) In Kenya

It has long been accepted that FGM/C is ubiquitous among the pastoralists' communities in Kenya, albeit accurate data lacking thereof. Anecdotal evidence suggests that the procedure was commonly performed on girls between the ages of 4 and 15 and that 95–100% of pastoralists' women had undergone the procedure, the majority of whom having been subjected to the most severe form of mutilation. The study included in this publication shows that 37 % of the pastoralists' women receiving antenatal care at public hospitals across the country have undergone FGM/C. In Kenya, the women have undergone Type I or II forms of Female Genital Mutilation (FGM/C) that also involves stitching of the interior part of the genitalia to varying extent. Many successful awareness campaigns have been run in Kenya since 2009 and as a result, more pastoralists' are now willing to openly discuss the topic of FGM/C and even becoming increasingly concerned about the health risks associated with the procedure.

THE PROCEDURE OF FGM/C

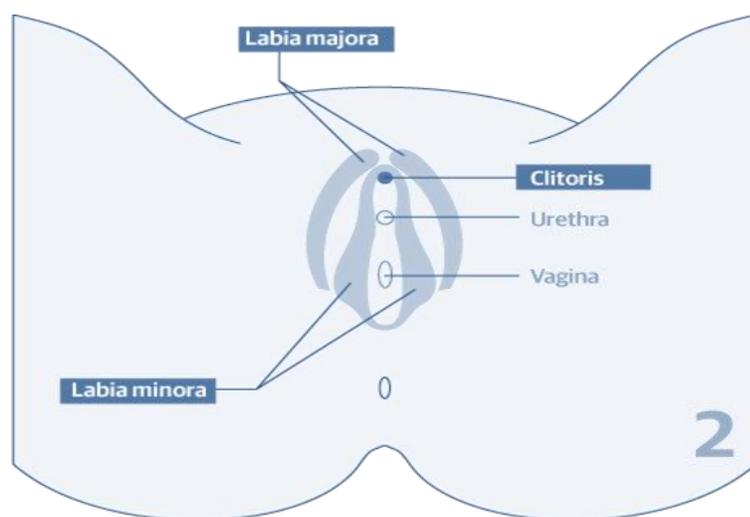


Figure 7: The normal parts of the vagina before FGM
Source: ACCM (UK) - Agency for Culture and Change Management - Sheffield.

A joint research between the United Nations (UN) and the World Health Organization (WHO) found that there were many different forms of FGM/C and the WHO decided to simplify the different forms by classifying it into the following four types: (See Figures 3-5 above).

Among the pastoralists communities of Kenya, the day of the FGM/C is considered a D-day and a very important event that is a kept secret from the pre-menarche child, and then sprung upon her once the necessary

preparations have been made. Senior female members of the community, relatives, Traditional Birth Attendants (TBAs) or occasionally healthcare

workers may be called upon to carry out the FGM/C procedure.

No anesthesia is used, while this very sensitive part of the female body is cut, except where the operation is being performed by a health professional, who has access to anesthetics.

The age at which Female Genital Mutilation (FGM/C) is performed varies from country to country and according to the type of genital mutilation being done. **Type I:** Clitoridectomy is generally performed at a very young age and may be carried out soon after birth, during the first week of life or at any time before the Menarche. **Type II:** Excision and **Type II:** Infibulations are performed at an older age, in order to allow more tissues are given a chance to grow, before they are removed. This is said, to give the operator a better pinch or grip. According to the findings of this study, it was discovered that, the usual age when Excision and Infibulations are performed when a girl is between 7 and 9 years of age.

How is FGM/C carried out?

The way the FGM/C practice is carried out varies from community, tribe and families to the other. Among the pastoralists' communities of Kenya, it is often the mother, grandmother or other elderly female relatives who decide when a girl should undergo circumcision and what type of FGM/C a girl-child should undergo. This may depend on the circumciser or traditional practitioner performing the mutilation.

FGM/C Practitioners

FGM/C is usually performed by Traditional Birth Attendants, midwives, and of late healthcare providers. In rural settings, older women without any medical training usually carry out the FGM/C. In countries like Egypt and the Northern part of Nigeria, male village barbers sometimes perform the operation.

However, of late and in the urban areas, trained doctors, nurses and midwives perform FGM/C much more frequently with anaesthetics in hospitals (Naheed, Comfort). This medicalization of FGM/C has been condemned as it is seen to ingrain FGM/C and make it acceptable to communities that practice it.

Traditional FGM/C is mostly performed without anesthesia and under highly unsterile conditions by using knives, razor blades, glass pieces, and scissors as instruments. After performing genital mutilation, the victim's legs are usually tied together for a long time with a rope until the wound heals. A newly circumcised girl is considered a '*little bride*' and is marriageable thereafter.

Anaesthetics

Anaesthetics and antiseptics are never used. However, pastes containing traditional herbs, local concoctions, or ashes are frequently rubbed on the wound to stop bleeding. The girl or woman may also be made to sit in a bath or river of cold water, to numb the genital area or to anaesthetize the area before an FGM/C procedure is done.

The girl may be held down by female relatives to prevent her from resisting or struggling. Unintended damage may occur due to crude tools used, poor light rooms and septic conditions. Sometimes herbs are put on the tongue, so that the girl will does not bite her tongue off due to the excruciating pain.

Instruments and Methods

A variety of instruments are used to perform FGM/C, depending on the country and the communities involved. Special knives, scissors and razor blades may be used.

For example, special saw - toothed knives are used in Mali. Razors, scissors, pieces of glass and sharp stones are commonly used among the pastoralists' communities of Kenya, while fingernails are sometimes used in Gambia to pluck out the clitoris of babies (Comfort, WHO).

In other remote villages across Africa, unsterile instruments used to perform FGM/C. Often many girls are operated on during a single mass-ritual ceremony. In these cases, the same razor or knife could be used on a number of girls thus, increasing the risk of transmission of STIs and HIV / AIDS infections.

The following instruments are used among the pastoralists' communities of Kenya.

- Any sharp cutting instrument such as a knife, broken glass and razor blade will do, or the operator may have somehow acquired medical instruments like a scalpel, forceps or scissors.
- The instruments may be new or may have already been used for other purposes and/or on other persons before.
- Sterilization is seldom known nor performed by these traditional operators.



Figure 8: Instruments used to carry out an FGM/C - ©Photo Credit: Eric Lemaiyan - Enduring Voices Foundation.

The Sutures

- Regular surgical Catgut, Silk or Cotton thread.
- Domestic sewing thread.
- Vegetable or nylon fiber pre-selected by the operator.

The Needles

- Regular surgical suturing needles (round bodied or sharp and any size)
- Domestic sewing needle.

Approximating the wound

In some cases, instead of suturing together the raw edges of the wound, these are held together with thorns that are inserted on opposite sides of the wound and then laced together with thread and left in place for seven days or until the tissues of the wound have had time to fuse together. This type of Infibulation is often practiced by nomads and agro-pastoralists.

Condition of Hands

- No gloves are worn during the operation.
- Hands may or may not be washed and in any case wet fingers are slippery and should the operator have difficulty in pinching the skin being removed,
- It is not unlikely for the operator to wipe his/her hands on the thighs of the child or even on the sand on the ground in order to dry them and thus improve dexterity!
- The operator allows his/her nails to grow as they are used as pincers during operations. Rings, amulets and other hand ornaments are rarely removed, as these items are not recognized by the traditional healer as likely sources of contamination.

Clothes and bedding

Since bleeding will occur and there will be some secretions for some days, the family usually utilizes an old mat or floor covering, which can later be discarded. Sometimes sand is placed on the mat under the buttocks of the girl, in order to absorb blood and other secretions. However, affluent or educated families may be aware of the risks of infection and may have clean sheets or gauze pads to absorb any blood or secretions from the wound.

The FGM/C Operation Itself

The girl is made to squat on a stool or a mat facing the operator at a convenient height that offers the operator a good view of the parts to be cut. The child is also held as still as possible in order to avoid inflicting cuts, other than those intentionally meant to be cut. For this, two adult helpers may grab and pull apart the legs of the little girl and hold down her hip on both sides; a third person may hold back her head and torso. To prevent kicks from the child, her legs are held back by tying a rope to each of her ankles which is then tied to her thighs thus keeping each leg in a tightly fixed position.

If available, this is the stage at which a local anesthetic would be used, before the clitoris by pinching it between her nails aiming and to amputate it with a slash. The organ is then shown to the senior female relatives of the child, who will decide whether the amount that has been removed is satisfactory or whether more is to be cut off.

After the Clitoris has been '*satisfactorily*' amputated, and the female relatives have '*ululated*' that the business at hand is progressing well, the operator can then proceed with the total removal of the *labia minora* and the paring of the inner walls of the *labia majora*. Since the entire skin on the inner walls of the Labia Majora has to be removed down to the perineum, the child could be writhing in pain, screaming, struggling and also bleeding profusely, making it difficult for the operator to hold with bare fingers and nails, the slippery skin and the parts that are to be cut or sutured together.

It should be noted that, for the wound to heal by first intention may not only be important for the protection of the child from a repeat operation, but also mainly to preserve the popularity of the operator who would otherwise acquire a bad reputation and also would lose potential clients if the wounds did not heal well. Having made sure that sufficient tissue has been removed to permit the desired fusion of the skin, the operator may pull together the opposite sides of the labia majora, ensuring that the raw edges where the skin has been removed are well approximated.

The wound may now ready to be stitched or for thorns to be applied. If a needle and thread are being used, close tight sutures would be placed to ensure that a flap of skin covers the vulva and extends from the Mons Veneris to the Perineum and which, after the wound heals, would form a bridge of scar tissue that would totally occlude the vaginal entroitus.

A small hole (typically less than 5cm), may be left un-stitched in order to permit the flow of urine and other vaginal secretions. If thorns are being used, an equal number would have been inserted into each side of the *labia majora*, and a string would then be used to pull the thorns together thus, bringing the raw edges of the *labia majora* together. The string would be wound in the manner that sports shoes with hooks are laced.

If the GFM/C is being done by a healthcare professional, regular medical disinfectants would be applied. Otherwise, after the stitching, a raw egg would be broken over the wound, then sprinkled, with whatever herbs, sugar or concoctions that was prepared according to local customs. This concoction, consisting of egg, herbs, sugar, and the blood of the child, would all clog together and form a crust over the sutures or the strips of cloth holding the thorns together. In order to prevent leg movement, the child's legs are bound together from the hips down to her toes and the child is then made to lie on her side.

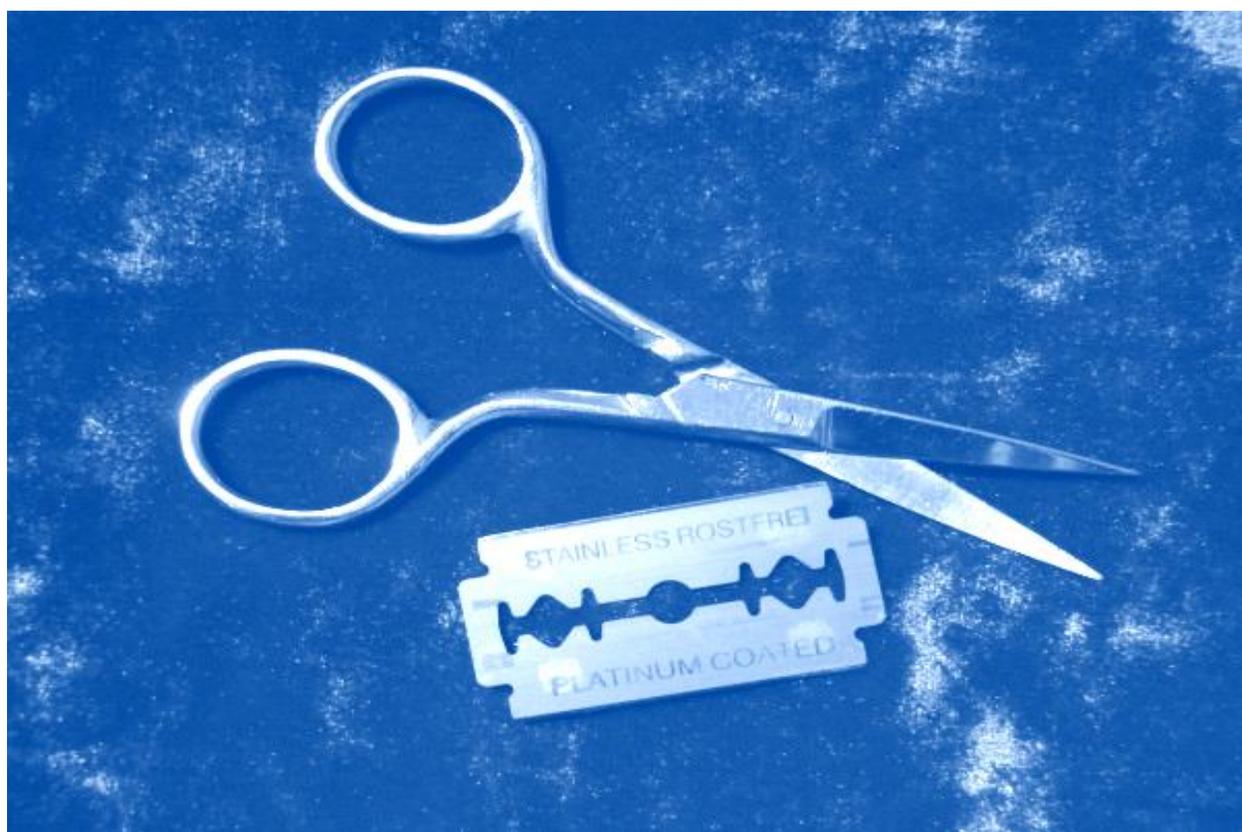


Figure 9: Some of the Instruments used to carry out FGM/C. Source: Google Search Engine

No dressing is used and the legs are kept together for a week, after which the leg bindings are slightly loosened and the child is allowed to take small steps. The leg bindings would only be removed after a further week.

To ascertain that the urethra has not been accidentally closed, either by a blood clot or suture, the child is encouraged to urinate a few hours after the operation. Whether sutures or thorns were inserted, these would be removed on the seventh day but only after the operator is satisfied that

the two sides of the labia majora have fused together and that the remaining hole left for urinating is not wider than three to five millimeters in diameter.

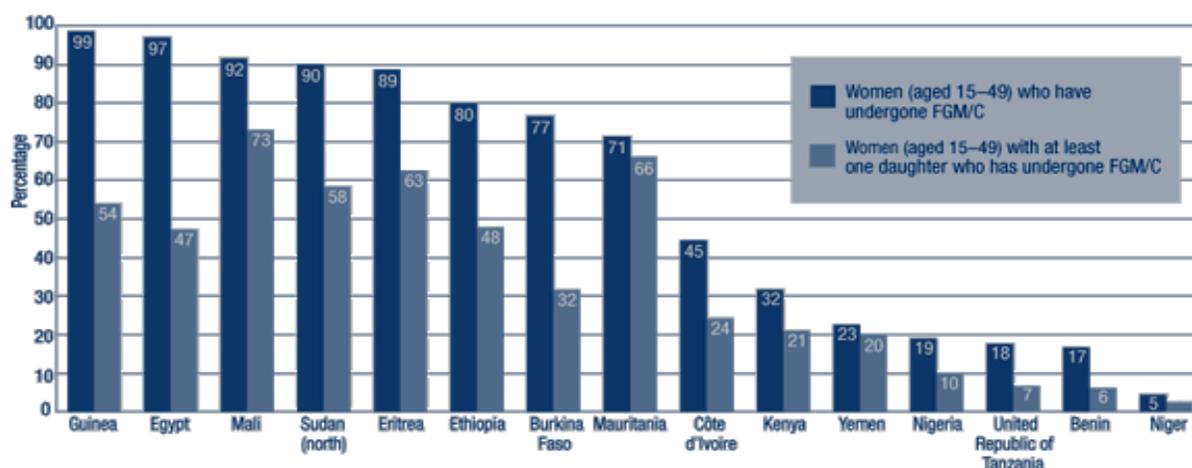
De-Infibulation at the time of Marriage

The closure of the *introitus* must be reopened at the time of marriage, so that the woman is able to have sexual intercourse. The opening up of the Infibulation occurs as part of a ceremony and in the presence of female members from the bride and groom’s families, to verify that the bride is a virgin at the time of marriage. The opening of the Infibulation could be performed by a senior female member of the community, a TBA, or in a hospital by medical staff. Occasionally, the husband forcibly performs penetration and bursts through the scar of the Infibulation.

Age of Girls and Women Undergoing FGM/C

FGM/C can take place at a different age in a girl’s or woman’s life depending on the country, community, ethnic group, clan and family. It may vary among different groups in the same area of a country. For example, in Ethiopia, the Falashas community performs the operation when the baby is a few days old. In Egypt the girl is genitally mutilated between seven and ten years old. In Kenya, the ceremony may not occur until the girl is of marriageable age, which according to indigenous pastoralists’ communities could mean approximately 10 to 16 years of age.

The most typical age for **Type III:** Infibulations seems to be between 4 and 8, although the age is generally falling – indicating that FGM/C is having less and less to do with initiation into adulthood.



Chat 1: Chart indicating ages women undergo FGM/C - Source: Image Credit: WHO/Reproductive Health

In the UK, NGO’s and professionals campaigning against the FGM/C practice argue that the age when female children are circumcised is falling, because parents and families are becoming aware that schools are monitoring children and they are doing it before children start school to invade the law (ACCM, Comfort etc).

Marwa Ahmed in (Comfort 2005), states that the majority of the women have had FGM/C done in their country of their parent’s origin regardless of them being born in Britain, with highest number circumcised while aged 6 years old.

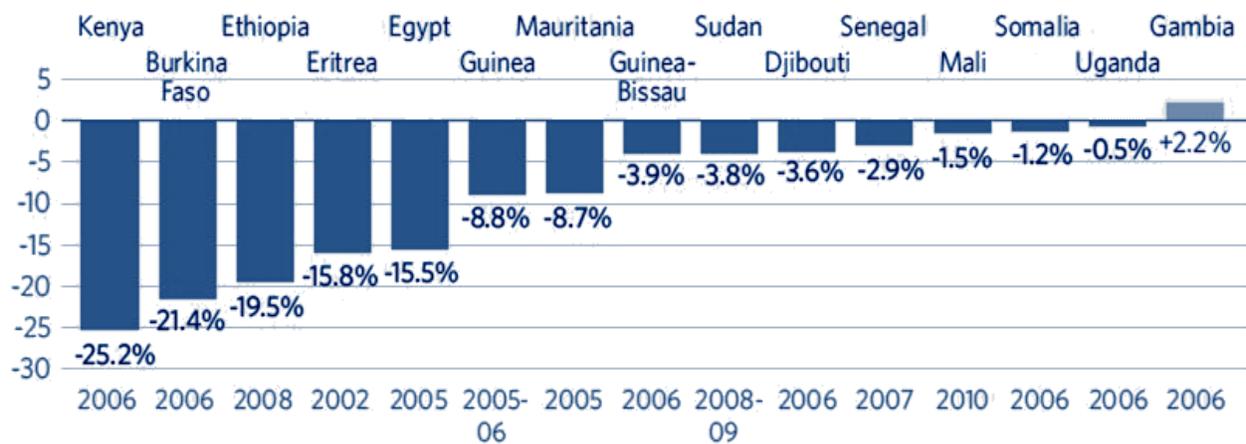
The lowering of the age at which the FGM/C operation is performed could also be attributable to the increased awareness of the condemnation of FGM/C practices and the laws prohibiting it, both in African countries and in countries where refugees and other immigrants have settled.

Professional bodies, NGOs and campaigners are now very much aware of the implications of FGM/C as girls and young women are now being monitored especially in schools, forcing parents to perform FGM/C to girls before they start of school.

However, many girls are no longer being subjected to Type **III** or **II** FGM/C, but are now going through **Type I**: Clitoridectomy, which is considered to be very mild and does not leave severe health or social implications that can be noticed (ACCM, Comfort, LBWHA).

Younger women have lower rates than older women

Percentage point difference in prevalence rates in women aged 15-19 compared to women aged 40-44



Chat 2: Chart indicating the different ages of FGM/C prevalence in women.
Source: UNFP/UNICEF Joint Programme-Monitoring

THE DANGERS OF FGM/C

FGM/C puts female children at risk of life threatening complications, as well as health problems that remain with them for life. They may suffer bleeding at the time of the FGM/C procedure or develop severe infections, both of which can lead to death if not treated promptly. Those who do not develop life-threatening complications will still suffer from severe pain and permanent trauma.

The FGM/C procedure also permits the transmission of viral infections such as hepatitis which can lead to chronic liver diseases and even HIV/Aids. The women may suffer complications such as: recurrent infections, pain and obstruction associated with urination and they are at higher risk of painful menstruation and intercourse, pelvic infection and difficulties in becoming pregnant. Retention of urine and recurrent infections often require repeated hospital admissions and some women carry a risk of developing nephritis. The development of cysts and keloids at the site of the scar are very common, often causing embarrassment and marital problems, and usually require surgery for removal.

During pregnancy, many further complications that may occur as a direct result of the FGM/C. Labour may become obstructed and if early medical intervention is not sought or provided, this may lead to the death of both baby and mother. WHO estimates that many women giving birth die in the process, simply as a result of FGM/C. If the mother and baby survive, there is the risk of damage to the vagina leading to the formation of fistulas into the bladder or bowel, which causes constant incontinence as a result of a *vessico-vaginal fistula* or *recto-vaginal fistula*.

Women in this condition are often rejected by their families and become social out-casts. During the years that the Kenyatta National Hospitals (Kenya's main national referral hospital) have been in operation, the fistulae of over 3,000 women have been surgically repaired. Besides numerous physical complications, the girls and women experience considerable psychological problems including depression, anxiety and post-traumatic stress disorder (PTSD).

These psychological problems are exacerbated at the time of marriage and often lead to increased distress and fear of sexual intercourse. If de-Infibulation is performed, the woman is again exposed to the life threatening complications of sepsis and bleeding, and the transmission of chronic infections such as HIV, Hepatitis and damage to the urethra, if a traditional operator makes an error when performing a de-Infibulation cut.

Complications of FGM/C

Considering the clumsy and un-hygienic conditions under which Female Genital Mutilation (FGM/C) is usually performed, complications are frequent and numerous and can be classified in the order in which they are likely to occur.

Immediate

- Shock
- Fear
- Pain
- Hemorrhaging
- Other lacerations: in addition to the intentional cuts on the clitoris, *labia minora* and *labia majora*, there may be accidental lacerations inflicted on the child as a result of her struggles.

These cuts may involve the vagina, urethra, anus and thighs. As a result, quite a few children are taken to hospitals for the control of hemorrhage, or for the repair of severe lacerations.

Within the first days of the procedure

- Infection: infection to the wound and septicaemia are often encountered and tetanus is not uncommon.
- Retention of Urine: (5 possible causes)
- Post-Traumatic Oedema of the vulva resulting from the damages inflicted on the clitoris and labia impedes or obstructs the passage of urine through the swollen urethra
- Obstruction of the urethra by a blood clot or by the thorns that were inserted to hold the sides of the *labia majora* together.
- Accidental suturing of the Urethra itself
- Over-tight application of the binds that were used to keep the thighs and legs together
- Psychosomatic urine retention out of fear and pain

- **Failure to Infibulate:** when the two sides of the labia majora fail to fuse, it necessitates that the child undergoes a repeat operation at a later date.

At the onset of menstruation

- **Dysmenorrheal:** when the post-Infibulation vaginal whole is too small there is a constant stagnation of menstrual blood and other vaginal secretions, causing bacteria to spread into the vaginal and uterine cavities. This is likely to increase the risk of chronic pelvic inflammation that might cause the severe abdominal cramps experienced by infibulated females during menstruation
- **Recurrent Urinary Tract Infection:** because of the flap of skin obstructing the urethra after Infibulation, urine does not jet out during maturation.

Instead, it hits the flap of skin obstructing the vulva and is then sprayed back into the vagina and then trickles out in drops. This obstruction also prevents proper vaginal hygiene and drainage and causes urinary stasis which is likely to cause recurrent urinary tract infection.

- **Possible Second FGM/C:** because the small artificial opening that had previously permitted the passage of urine becomes insufficient to permit the drainage of the more viscous consistency of menstrual bleeding, doctors often have to convince the parents of these girls that the small vaginal opening be enlarged to permit the flow of menstrual blood. This, the families resist because they fear that if the opening is too wide it may not be sufficient proof that their daughter is a virgin when her time comes for her to get married.

At the time of Marriage

- **De-Infibulation:** The Infibulation opening that had until then permitted the passage of urine and vaginal secretions are no longer able to permit intercourse. This will require that the husband make a forcible penetration, to burst the skin obstructing the entrance to the vagina, or the opening to be cut open with scissors or a knife to allow the consummation of marriage.
- **Dyspareunia:** the scar tissue that surrounds the vaginal orifices may be rigid and inelastic and can cause pain during sexual intercourse.
- **Infertility:** because of the constant stagnation of menstrual blood and other vaginal secretions that have accumulated in the vaginal cavity, the resulting pelvic inflammation may obstruct the fallopian tubes and block the normal travel of the ovum along the tubes, preventing it from becoming fertilized by the male spermatozoa.
- **Vulval keloids and dermal cysts:** apart from their unaesthetic appearance, these may interfere with consummation of marriage or with childbirth during delivery

During Pregnancy

- It is not uncommon for an infibulated and pregnant woman to attend the antenatal clinic for follow up of the pregnancy or for a pregnancy related complaint and find that the opening of the Infibulation will not admit the introduction of even one finger into the vagina for diagnostic and exploratory purposes. Such women will require a de-Infibulation during pregnancy if complications are to be avoided at the time of delivery.

During Labour and Delivery

- **Caesarian:**

Some women arrive at the maternity hospital in labour with a very small Infibulation opening. If the vagina is seen to be too rigid and scarred, and thought to be a possible cause of severe vaginal lacerations or third degree tears, it is likely that an elective caesarian section will be decided upon. If keloids have formed and are too large, a Caesarian section might be the best option to deliver this woman.

- **Prolonged second stage of labour:**

Because the vagina, perineum and the labia have all undergone mutilation that has left extensive scar formation, the vaginal canal becomes inelastic and the pelvic floor muscles rigid. Thus preventing the normal and gradual dilation of the vagina as well as the descent of the presenting part of the child during the second stage of labour.

- **Foetal Complications:**

- a. Large caput formation
- b. Excessive molding of the head
- c. Intra-cranial hemorrhage
- d. Hypoxia
- e. Foetal distress
- f. Intrauterine death

- **Maternal Complications:**

- a. Obstructed labour
- b. Extensive vaginal and perineal lacerations
- c. Third degree tears
- d. Uterine inertia
- e. Uterine rupture
- f. Impacted foetus
- g. Maternal distress
- h. Maternal death

- **Post-natal Complications**

- a. Infection of the lacerations
- b. Delayed healing of the repaired perineum and vaginal tissues
- c. Sloughing of the vaginal wall, resulting in Vessico-vaginal fistula and/or
- d. recto-vaginal fistula
- e. Anemia
- f. Puerperal infection
- g. Cystocele and Rectocele: because of the prolonged labour during each delivery, there is added stretching of the vaginal wall muscles.

h. This causes a prolapse of either the bladder or rectum to bulge into the vagina.

▪ **Other Complications**

In recent years and since the HIV/AIDS pandemic, likelihood of transmission of the AIDS virus has become added to the long list of complications associated with female genital mutilation. The risk is made real because the traditional healers who perform circumcisions do not know the dangers of using unsterilized instruments that have previously been used on different individuals who might have been carriers of the AIDS virus.

Reasons Given for Female Genital Mutilation (FGM/C)

Some of the reasons that drive FGM/C practices lie deep within tradition and cultural heritage; and are complex and difficult to determine. Although there are variations between societies, there are common themes that promote the practice. FGM/C is believed to have religious and cultural origins. Among societies that practice it, FGM/C is believed to preserve the woman's virginity before marriage and to ensure fidelity during marriage. Others believe it is hygienic, aesthetically pleasing and or that it increases fertility.

For many women, it is part of social integration and the mutilating process is accepted in return for promises of acceptance in society and improved prospects of marriage. Older women believe they have benefited from FGM/C and that it has shaped to their identity. By the same reasoning they allow FGM/C to be performed on their daughters, fearing that failure to do so may bring them suffering, social isolation and ridicule from the society.

Understanding these complex, multifaceted thought processes within societies is very important in carrying out successful eradication campaigns against FGM/C.

CAMPAIGN TO ERADICATE FGM/C

a) The International Campaign against FGM/C

The International Campaign against FGM/C was started through advocacy and resistance from individual health professionals from African countries working in FGM/C practicing communities. Their efforts were commended as they worked in unreceptive environments with little support. However, the extent of the impact of their resistance is not known since there are no records of these efforts.

b) UN's involvement in the eradication of FGM/C

Although the UN's support for the eradication of FGM/C is actively strong, lack of knowledge on the subject, first prevented UN agencies from addressing FGM/C. When awareness finally came to the UN about the extent of the practice and the serious health and psychological effects that result from it, they recognized it as a major Human rights issue. Conferences were held, studies were commissioned and discussions were finally opened on the FGM/C topic. However, the mainly European representatives chairing these discussions did not understand the deep cultural ties that propagated the FGM/C practice and they were unprepared for the resistance they faced by recently decolonized African nations who saw the attention accorded to the FGM/C issue as another intrusion.



Figure 10: The Anti-FGM/C Campaign Caravan, drumming the message on the Abandonment of FGM/C across Narok and Kajiado Counties.
Photo Credit: Erick Lemaian- and National Anti FGM/C Board.

However, there were exceptions throughout East African countries, including Kenya where the most severe forms of FGM/C are practiced and who had more active campaigns were more appreciative of UN's involvement. After these first rounds of conferences around the 1980s, talking about FGM/C became sensitive, thus derailing the immediate abolition of FGM/C. While mandates condemning FGM/C were taken, the UN took the approach of funding local efforts, mainly targeting education and advocacy.

Training was needed for the health professionals dealing directly with the victims. Governments were lobbied to create policies against FGM/C and if such policies already existed, they were encouraged to implement them proactively. The general public was educated on the subject, thus permitting steps towards achievable change. Today, the struggle continues albeit with varying degrees of success. Although complete eradication of FGM/C has not been achieved, the topic is more openly discussed now than it was thirty years ago.

c) The Campaign against FGM/C in Kenya

In March 1979, during the formation of the *Maendeleo Ya Wanawake* (National Women's Group of Kenya), Mrs. Zipporah Kittonyi was the first woman to publicly denounce FGM/C and pioneered the campaign for its eradication in Kenya.

From that time, she has campaigned against FGM/C at many important occasions, including during the WHO Seminar on the Mental and Physical Complications of FGM/C; in the

Conference for women in Lusaka. In Dakar in 1984 when she was elected a member of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children; In 1986 in EMRO Egypt; 1987 in Addis Ababa and the lobbying of the Organization of African Unity. During the Beijing Women's Conference in 1995 and between 1988 and 1997 when she tirelessly along with international colleagues, lobbied WHO/UNICEF and other Human Rights Organization.

It was during the first annual meeting of the *Maendeleo Ya Wanawake*, that Zipporah got a golden opportunity to address women leaders in their respective provinces across Kenya. It was the first time the problem of FGM/C was spoken publicly in public in Kenya.

In the early 1980's research into the physical, psychological and sociological aspects of FGM/C was carried out by the Kenyan academy of Sciences. In 1988 the government campaigned to eradicate the practice on health and religious grounds. *Maendeleo Ya Wanawake* continued their struggle and over the following years founded a campaign based on health complications and human rights. Both campaigns collapsed in 1991 with the introduction of Multi-party political systems in Kenya. Any organizations agitating for change of any kind were seen as anti-government or anti-establishment and were abolished and their leaders severely punished.

In 1997, at the time when Zipporah Kittonyi was a women's Representative in Kenya, UNICEF requested her to assist in obtaining the government's approval of for a seminar to be held in Nairobi, to launch the first seminar to revive the campaign to eradicate FGM/C. The seminar was approved and held and a national committee and a regional task force were established to develop formal policies. This work is being continued to date, through the Kenya National Anti-FGM/C Board. Additionally, numerous individuals, community based organizations and women's groups run their own FGM/C eradication campaigns.

Encouraging signs that the FGM/C awareness campaigns are having the desired effects have been reported. A recent Save the Children publication on child rights in Kenya, found that most girls and boys, care givers, community leaders and government officials, pointed to the harmful traditional practices of FGM/C as the most negative aspect of the pastoralists' communities' traditions and culture.

Education and the empowerment of women brought about by FGM/C eradication campaigns are changing the views of pastoralists' communities of Kenya on FGM/C. However, it is only by the implementation of projects like the 'Talking Trees Project' conducted in Narok and Kajiado Counties by the Enduring Voices Foundation, that the rate of change and abandonment of FGM/C can be approximated or accurately recorded and evaluated. In a society like the pastoralists' communities' of Kenya, where the FGM/C practice is almost unanimously accepted, change will occur slowly for as long as people fear discrimination for choosing to break with century old traditions and cultures.

LITERATURE REVIEW

Prior to this study, there had been very few studies conducted on FGM/C. The most accurate data on FGM/C comes from Fran Hosken, who in 1982 compiled statistics from her many years of studying FGM/C in Africa. The Demographics and Health Surveys data published between 1995 and 2002 by compiling questionnaire from 16 countries excluded data from Kenya. Countries that have had their data and statistics on FGM/C repeatedly collected have shown relative decline in FGM/C prevalence or adherence to less severe forms of FGM/C. Published studies from African countries, in particular Nigeria, have estimated FGM/C prevalence carried out over short periods.

In 1997 a national survey by the Kenya Ministry of Health, stated a 96% prevalence rate among the pastoralists' communities of Kenya. In 1999, Care International studied the pastoralists' communities of Kenya and stated that it stood at 91%, with most girls and women undergoing Type II forms of circumcision. In 1991 a Swedish study published, questioned 290 Somali women living in Sweden and found that 100% had undergone FGM/C, with 88% being Type III despite a relatively high socio-economic level, and the majority was willing to perform FGM/C on their daughters due to religious and cultural reasons. A recent study by the WHO and UNICEF looking for the first time, into HIV prevalence also asked women about their FGM/C status. The study included 769 women and found that 98% had undergone Type II and Type III FGM/C.

Female Genital Mutilation (FGM/C) is one of the oldest practices found among the Hittites, Ethiopians and Egyptians, Momoh (2005, 5). She further argues that in the 19th century FGM/C was practiced by gynecologists in the UK and USA, to cure women from insanity and masturbation. Momoh (2005, 1) continues to say that in societies that practice Female Genital Mutilation (FGM/C), different factors of culture are present that support the continuation of these practices. According to her research, she mentions certain beliefs, custom rituals, behavioral norms, social hierarchies and religions as some of the factors that encourage the continuation of the FGM/C practice. She adds that culture is learnt and children learn it from adults. Haralambos and Holborn (2000, 790) defines culture as a way of life for its members, a gathering of routines and ideas that are shared and conveyed to further generations.

Boyle (2002, 26) states clearly that the dilemma of Female Genital Mutilation (FGM/C) is not anymore a matter for Africa only. Due to immigration, FGM/C has taken a turn and is spreading greatly in other parts of the world. FGM/C is undoubtedly a cultural issue and something that seems to hold the societies that are practicing it together.

The first research tackling issues on immigrants that came from countries where FGM/C was still practiced was conducted by Mölsä (2004) - a Somali born Finnish doctor, who stated that, immigrants that came from countries where FGM/C was still practiced supported the FGM/C practice. However, their point of view about the practice had changed and none of her study interviewees supported the Type I: Clitoridectomy form of mutilation. Nonetheless, they were uncertain on many issues concerning Female Genital Mutilation (FGM/C). Due to the sensitive and sexual issues related to FGM/C, Mölsä encountered difficulties when conducting her research and failed to find enough participants to be interviewed. Deep seated matters were not discussed especially between male and females in other societies like the African (Ihmisoikeusliitto ry 2004,5).

Consequences of FGM/C

In 2008, the World Health organization (WHO) documented some of the implications of Female Genital Mutilation (FGM/C) on the health of women and girls. This included death that occurred due to over bleeding and extreme pain caused by the cutting. Traumatic stress and severe

infection that occurred during the FGM/C procedure and the kinds of tools used were reported. Other effects included urine retention, injury to neighboring organs, painful sexual intercourse, and complications in labor and painful periods.

A study on Female Genital Mutilation (FGM/C) comprising 28,000 participants and victims of FGM/C, indicated that high risks of caesarean sections and post-partum hemorrhage were reported to be higher among women who were mutilated with Type I, II, and III FGM/C, when compared to those who did not undergo FGM/C (WHO 2008). However, studies conducted from Sudan and Somalia indicated negative effects on self-esteem and self-identity among women and girls who are mutilated. (Toubia and Rahman, 2000).

FGM/C and Sex intercourse

One of the main reasons why Female Genital Mutilation (FGM/C) is practiced among many African societies follow the belief that FGM/C controls the sexual urges of women and young girls. Dorkenoo (1995, 36) shares her view on psychosexual reasons towards FGM/C, by giving examples of Mali, Kenya, Sudan and Nigeria, as African countries where it is believed, that if women are mutilated, they are likely to be faithful to their husbands. She also adds that FGM/C practicing communities in these countries believe that if not cut, the clitoris could be dangerous to a baby at birth; and that when it comes in contact with the baby's head, the baby could get killed.

In Ethiopia, according to FGM/C research people believe that if a woman's clitoris is not cut, it may grow and resemble the men's penis and therefore cutting minimizes the growth rate and helps the women to maintain the femininity (Dorkenoo, 1995).

Female Genital Mutilation (FGM/C) causes torture for most mutilated women. Sex can be excessively painful and even put the women's life at risk. Women who have been infibulated may experience painful intercourse throughout their lives if they do not seek medical advice. In cases where there is no pain, then there is no sexual fulfillment (Amnesty International, 1997).

While the clitoris remains an important organ sexual pleasure and orgasm among women, mutilation of the clitoris could negatively influence sexual fulfillment of many women who have undergone through FGM/C (Light foot-Klein 1989, 11). Female Genital Mutilation (FGM/C) affects women's enjoyment during sexual intercourse (Asaah H. and Levin, 2009).

Another study conducted by Amnesty international (1997), among the mutilated women indicates that 90% of the women, who had undergone FGM/C disclosed having experienced an orgasm. Therefore, the element that influences sexual enjoyment and having orgasm are misunderstood. Additional factors like the type of FGM/C, the quantity of tissues taken away, extent of scarring, experience of the initial procedure, cultural and social expectations are reported to have impact on sexual functioning of those who have undergone the FGM/C procedure (Momoh, 2005, 7).

In other research, it is indicated that women who have not undergone FGM/C are more sexually active than men are. Therefore, mutilating them could keep their sexual desires is under control. (Marks 1996). Women and girls are affected socially, psychologically and psychosexually in their lives if they were mutilated (Forward 2002).

Religion and FGM/C

Female Genital Mutilation (FGM/C) is practiced with many religious sects worldwide. Including Islam, Protestants, Catholics, Judaism, Seventh Day Adventist and Animists. (Mustafa 2001) and fellow writers note, that FGM/C is more common in Muslim communities than in other religious institutions. For example, in Sudan and Somalia, where the majority of people are Islamic, 80% of

Muslim women versus 18 % of Christian women are mutilated. Many Muslim practitioners have linked FGM/C by reflecting it to “SUNNA” in the Koran (Parekh 2005).

However, there is no clear information in religious books concerning FGM/C and the practice of FGM/C is neither mentioned in the Koran nor the bible. Therefore, changing such misinterpretations could only be possible if female religious leaders become involved in the interpretation of religion because they are the ones affected by the practice (Waris, 2005, 168).

Human Rights and FGM/C

According to (USAID 2004) Female Genital Mutilation (FGM/C) was first recognized in the agenda of the United Nations in 1948 within the context of the Universal Declaration of Human Rights (UDHR). It was seen as a harmful tradition practice in the 70s and 80s, during the United Nation’s year for women 1975-1989. Efua Dorkenoo (1994) in the work of (forward 2002) states Female Genital Mutilation (FGM/C) is a clear demonstration of gender-based human rights violation, which intends to control women’s sexuality and freedom.

Internationally the Female Genital Mutilation (FGM/C) practice is recognized as a form of torture and violence against women and girls. International agencies like World Health Organization (WHO), United Nation Children Education Fund (UNICEF), World Medical Association and the United Nations Population Fund consider FGM/C as a violation of human rights. In 1993, the UN passed a declaration to support the use of the term “Female Genital Mutilation” to describe clitoridectomy, infibulations, excision and other FGM/C related practices. In 1999, WHO officially opposed the practice on FGM/C by classifying it as a violation of human rights in an effort in the fight against FGM/C.

Sweden, the UK, and Finland have shown interest in the eradication of FGM/C practices by imposing some laws (Mölsä, 2004, p 18). In Finland, Female Genital Mutilation (FGM/C) is a criminal and punishable act by Finnish law. Since 1993, Female Genital Mutilation (FGM/C) has been made illegal in Sweden (WHO 1998). According to the UN’s Article1 on “Discrimination against women” based on sex, FGM/C infringes on women’s rights to enjoyment and the fulfillment of their fundamental rights. The pain caused by FGM/C in not being able to be satisfied sexually, is violating women’s rights to life and physical integrity including freedom from violence.

Female Genital Mutilation (FGM/C) also affects the right to life in situations when death occurs resulting from the FGM/C procedure. FGM/C infringes their rights to physical integrity, the right to liberty and security, when women are subjected to FGM/C unwillingly before they have reached the age at which they can consent to FGM/C.

The Right of the Child

Female genital mutilation is regarded as a violation of children’s rights by many researchers. In those communities where it is practiced, children as young as a few months after birth to 17 years are subjected to the practice. When looking at those affected they meet the definition of ‘child’ when considering factors such as the age.

Right to Health

The International Human Rights law stipulates that every individual has the right to enjoy the highest attainable, standards of physical and mental health. Female Genital Mutilation (FGM/C) is associated complicates and negatively affects women’s and girls’ physical and emotional health. Subjecting FGM/C victims to health risks, in the absence of necessary medical facilities is a violation of that person’s right, in addition to not using medication before and during the

FGM/C procedure and not allowing victims to seek medical assistance after the FGM/C procedure, violates a victim's rights to health.

Rights of Minorities

International human rights law recognizes that members of the minority groups, racial, ethnic, religious, linguistic and indigenous peoples' are entitled to special protection to enable them to maintain their own culture free of interference and discrimination.

However, FGM/C is practiced by minority groups and not by everyone in those particular societies the world over. It is also practiced among the immigrants who are still considered to be minority groups in the countries where they have settled. Under such circumstances, the majorities who are against the FGM/C practices over power the minorities, although the minority needs protection by the law.

Rights to Religious Freedom

The right to religious freedom is deemed a fundamental human right to everyone. The UN's Universal Declaration of Human Rights protects the right to freedom of conscience and religion. The issue of religious freedom arises when religious institutions support FGM/C under religion. African communities, where Islam is practiced believe that FGM/C is a part of religion, although there is no support of FGM/C in the Koran, Therefore, advocating for the abandonment of FGM/C practices in such places, is regarded as a violation of their religious right.

FEMALE GENITAL MUTILATION LAWS IN AFRICA

Many governments of the world have taken steps to eliminate the practice of FGM/C in their countries. These steps include laws criminalizing FGM/C and penalizing practitioners, the use of civil remedies, administration of policies and regulations that prevent the practice from of FGM/C. A growing number of African countries have enacted national laws outlawing Female Genital Mutilation (FGM/C).

Sixteen out of the 28 African countries (namely: *Togo, Tanzania, Senegal, Kenya, Guinea Ghana, Egypt Djibouti, central Africa republic, cote deivoir, Benin and Burkinafaso*), where Female Genital Mutilation (FGM/C) is practiced have introduced specific policies and legislations to ban FGM/C, either by statute, decree or even in their constitution (Afrol News 2006).

Ethiopia

Ethiopia outlawed Female Genital Mutilation (FGM/C) in 2004. However, FGM/C practices are still deeply rooted in the country. In 2005, Ethiopian government health survey found out that 74 percent of women and girls had undergone the ritual cutting. The penalties for the FGM/C practitioners ranged from a minimum of three months to a maximum of life in prison or monetary fines (Population Media Centre 2009).

Social pressure dictates the continuation of FGM/C practices, even though some girls and women would not prefer to undergo the procedure. When properly enacted, laws act as legal avenues,

parameters and tools necessary for the eradication of FGM/C practices. In some countries where Female Genital Mutilation (FGM/C) laws have been implemented, the percentages of mutilation and even FGM/C prevalence have decreased. While in other countries like Sudan and Somalia, where FGM/C laws have not been enacted, the prevalence remains high, due to lack of a willing power from the central government (Afrol news 2006).

“In some cases, people are well informed and educated about the FGM/C practices; however, they cannot stand the belief that women can live with their clitoris uncut”. The law is not meant to break up families and generations but *“it sets the standards and informs what is morally right or wrong”* (Nahid Toubia 2000).

Kenya

Section 18 of the Kenya (Children’s Act, 2011), stipulates, that: *“Any conviction for FGM/C related offences carries penalty of 12 months imprisonment or a fine of KES. 50, 000 or both”.*

The Kenya demographic and Health survey (KDHS 1998), revealed that approximately 32 percent of Kenyan women had undergone Female Genital Mutilation (FGM/C). Kenya, considers FGM/C to be a dangerous and outdated cultural practice, and has thus enacted national laws meant to prevent the practice of FGM/C from continuation. In 2001, Kenya enacted the Children’s Act, outlawing Female Genital Mutilation

(FGM/C) among girls under the age of 18 years old.

Section 18 of the Kenya Children’s Act 2011, stipulates, that *“Any conviction for FGM/C related offences carries penalty of 12 months imprisonment or a fine of KSH 50, 000 or both”.* The same year the Kenya Ministry of Health (MoH), supported the punishment enacted by the Kenya Children’s Act 2011 and circulated the policy directive making FGM/C illegal in all government health facilities. In 2003, the Kenya signed the Maputo protocol, which in Article 5 stipulates that, FGM/C should be prohibited and condemned (MoH 1999).

Somalia

There are no permitted legislations presently that prohibit FGM/C in Somalia. However, the administration introduced legislation against Female Genital Mutilation (FGM/C) in 1999. The awareness campaign against Female Genital Mutilation (FGM/C) initiated in 1980s, ended as the regime collapsed in 1991. In a few years following the civil war, international and local organizations, including the National committee against Female Genital Mutilation (FGM/C) and Save Somalia Women and children (SSWC) resumed activities in other parts of the country. However, since there was no parliament in Somalia, there were no laws against Female Genital Mutilation (FGM/C) passed in Somalia. (World Bank & UNFPA 2004).

Sudan

Sudan was the first African country to introduce legislation against Female Genital Mutilation (FGM/C) in 1946, when FGM/C practice was banned through supplement to the penal code. The first law was passed in 1957 when Sudan gained its independence. The sentence passed was a fine or imprisonment for seven years. However, in 1974, the maximum sentence was reduced to five years (SOAT 1999). According to a report from the U.S Department of State (2001), the current penal code in Sudan does not cover Female Genital Mutilation (FGM/C), although its provisions on ‘Physical Injury’ might potentially cover FGM/C.

DO NO HARM

‘Do No Harm’ was a concept founded by the Girl Generation, a communications programme which aims to galvanize a global movement to end Female Genital Mutilation (FGM) with partners that share in their values and find it useful or thought-provoking to apply the concept in the context of their own work.

The ‘Talking Trees Project’ undertook the Girl Generation ‘Do No Harm’ approach, in order to mitigate the risk of advocating for social change interventions that could inadvertently create societal divisions, particularly in contexts of conflict, fragility and unforeseen or unintended negative effects.

The adoption of a ‘Do No Harm’ ethical principle to underpin the ‘Talking Trees Project’, health research and social programming, shielded the Principal Investigator and the multidisciplinary project team from causing intentional harm to the pastoralists’ communities in Narok and Kajiado Counties.

‘Do No Harm’ and FGM

“The Girl Generation defines Female Genital Mutilation (FGM/C) as a very sensitive, religious and sometimes highly politicized issue that goes to the heart of gender identity and gender relations. Insensitive approaches and implementation could risk driving the practice underground, thus, undermining existing efforts to end the FGM/C practice, contributing to a backlash or adding to other political/conflict tensions” (Girl Generation, 2014).

‘Do No Harm’ is an ethical principle underpinning much research and health and social programming. It means that those undertaking research and/or intervention should not, intentionally or otherwise, cause harm. There is a risk of social change interventions inadvertently creating societal divisions, particularly in contexts of conflict and fragility. Negative effects are often unforeseen and unintended (Girl Generation, 2014).

FGM/C is at the core of the control of girls and women’s sexuality in FGM/C -practicing communities. In the case of FGM/C, harm can arise as a result the actions of well-meaning individuals and organisations, who want to do something to address FGM/C but have limited understanding of the complexity and the sensitivities around FGM/C. The types of harm that Girl Generation says should be avoided include:

- Reinforcing support for the practice of FGM/C;
- Cultural insensitivity evoking backlash and denial which could back efforts to end FGM/C;
- Undermining local efforts and leadership to end FGM/C by reinventing the wheel rather than building on existing work;
- Fragmenting efforts or causing divisions among actors working to end FGM/C;
- Rigid donor-led approaches which may be out of sync with local realities;
- Putting activists, survivors, young people or other potentially vulnerable people at risk;
- Stigmatizing or causing emotional distress to those who have undergone FGM/C;

- Replacing the most severe forms of FGM/C with so-called minor forms;
- Increasing corruption.

The Girl Generation disputes that in the context of efforts to end FGM/C, and the nature of the global movement in particular, the realization of the principle of ‘Do No Harm’ is complex. They recognize that some form of backlash, particularly from social and religious conservatives, is unavoidable when social change results in shifting power dynamics. For any social change to happen, some people will lose out in terms of power, influence or economic resources. The Girl Generation identifies backlash as a sign that positive change is occurring, and backlash or protests against change can pose a positive opportunity to discuss the issue more openly, engage in dialogue, and move towards conflict resolution.

An example is a recent protest by Masaai women to have Kenya’s anti- FGM/C laws repealed following an arrest of a local chief who had organized the cutting of a little girl. The backlash helped to bring various issues into the open and enabled them to be addressed to a certain degree. After dialogue and consultations, the women changed their position. They now agree that promoting education for girls is better than FGM/C ¹.



Figure 11: Masaai Women in Endaadapo Village, Kajiado County, looking on as the project team passes by their community.
Photo Credit: Erick Lemaiyan - The Talking Trees Project 2016-2017.

In some situations, some types of harm will be unavoidable to some people (e.g. the abandonment of FGM/C will lead to loss of income and status for those who perform the practice or those who preside over FGM/C; some women who have undergone FGM/C and men from FGM/C practicing communities may be angered by calls for change (particularly if they are perceived to be from external actors or from outside agitators). Putting this in a historical context of western colonization of the south, the people affected may perceive any criticism of FGM/C as cultural imperialism. In rebutting such claims supporting FGM/C as culture, the issue of credibility of those responding is crucial.

It is important to avoid unnecessary (non-productive) backlash that actively sets the movement for change back, e.g. that which alienates or discourages those who would otherwise have supported an end to FGM/C (e.g. conservative parents, men), or that which politicizes FGM/C even further. Examples of the types of intervention that can lead to non-productive backlash include:

- Simplistic media exposé of FGM/C, which is sensational and demeaning to girls and women who have undergone FGM/C (e.g. focus on graphic images on mutilation and screaming of girls)
- Criticism of the culture as a whole instead of the practice
- Use of terms like ‘barbaric’ and ‘savage’ in relation to the ‘other’ (those practicing FGM/C)
- Lack of authenticity of messengers becoming the public face of campaigns
- Poor messaging on health consequences of FGM/C whereby Type **III** FGM/C complications are assigned to Type **I**, Type **II** and some aspects of Type **IV**
- Inability to translate international human rights law on FGM into convincing local messages that make sense to the grassroots
- Blaming one religion or ethnic group for FGM/C
- Strident or aggressive messaging focusing on women’s rights and sexual freedoms which may alienate some social conservatives who otherwise might support an end to FGM/C
- Blaming all men as responsible for FGM/C
- Inflexibility on the use of terminology of FGM
- Using FGM to attract political votes, drive organizational membership and funding for other issues not necessarily connected to FGM/C
- Lack of transparency and accountability in the use of FGM/C funds

It is important to note that the role of The Girl Generation is catalytic, and once the programme has been launched, it will be virtually impossible to control all of the activities that take place under its banner. We cannot control the communications approaches of all supporters, but programme platforms will promote responsible and ethical use of imagery and language.

Do No Harm Approach

Analysis, risk assessment (sensitive to political and cultural context), identification, monitoring and mitigation strategies will be applied at all stages of the programme cycle. We will draw up questions for work in focal countries. These include:

1. How might key actors potentially perceive **x**?
2. Who might be harmed by **x**? (Including emotional harm)
3. What political impact might **x** have? (Political economic analysis)
4. Does **x** meet our key guiding principles?
5. If any potential harm has been identified:
6. Do we need to revise the approach?
7. What risk mitigation strategies do we need to put in place? What needs to be prepared in advance?
8. Does the balance of benefits outweigh the risks? How/why?

All brand and message development will be aligned to our Do No Harm approach. The approach will be incorporated into a quality assurance process for all programme outputs (e.g. field testing and peer review where appropriate, ensuring outputs are evidence-based, accurate, appropriate and sensitive).

We will operate a robust monitoring mechanism across focal countries and in relation to the programme activities, to rapidly identify and respond to negative unintended consequences, and revise our strategic approach where necessary. This will be supported by the Strategic Advisory Group.

Central to our Do No Harm strategy is reframing the discourse around FGM/C to maximize positive impact and minimize opposition (e.g. celebrating positive change, valuing and empowering women and girls, focusing on solution-based and practical action where everyone can play their part). This is in contrast to former approaches which focused narrowly on the negative health consequences of FGM/C or the suffering of the girl child.

This guidance has been developed to ensure that the principle of Do No Harm is systematically applied, in order to control and mitigate potential harm. It outlines guiding principles, recognizing that in different situations, a degree of judgment will be required, and expert, local or external advice may need to be sought.

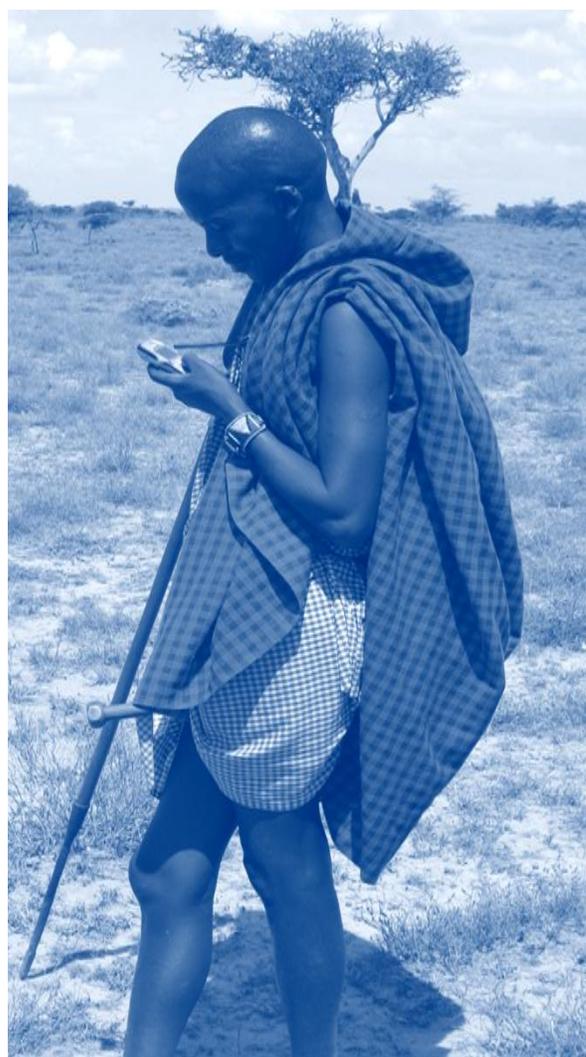


Figure 12: A Masai man tending to his cattle and chatting on his phone in Endaadapo Village, Kajiado County, looking on as the project team passes by their community.

Photo Credit: Erick Lemaiyan - The Talking Trees Project 2016-2017.

‘Do No Harm’ Strategies

The politicization of FGM/C has been reported by a number of stakeholders. Right-wing Islamic fundamentalist politicians, largely from the north of Sudan, are increasingly using FGM/C as a flagship issue for their movement. When the Muslim Brotherhood came to power in Egypt, one of the first things they did (unsuccessfully) was try to alter the legislation on FGM/C to make it legal to choose to have it done from the age of 10.

Following Arabic Islamic scholars being invited to Mali to debate the issue of FGM/C on air, Malian religious leaders rallied to promote and protect FGM/C. Islamic Fundamentalist and conservative religious leaders in focal countries such as Mali, The Gambia, and Somalia may respond to FGM/C campaigns by advising or issuing a fatwa that followers carry out FGM/C, quoting hadiths to support this.

There is a growing anti-western sentiment amongst some Africa intellectuals, e.g. Dr. Fuumbai Ahmadu, who sees western discourses round FGM/C as part of cultural imperialism and racism, comparing FGM/C to western cosmetic surgery, which the West is silent about.

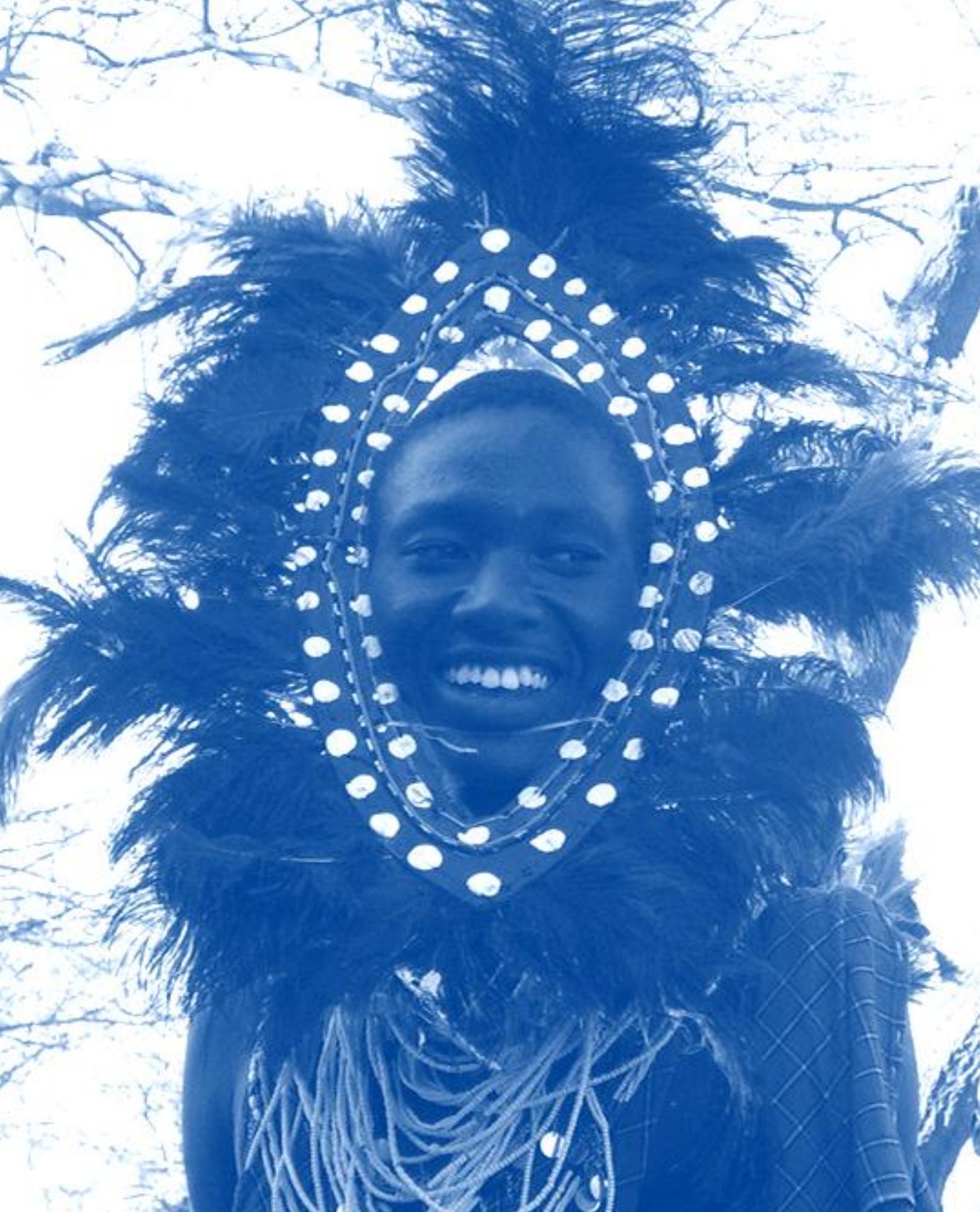


Figure 13: A Masai man wearing his wearing his Traditional Headgear in Sarara 1 Village, Kajiado County.
Photo Credit: Erick Lemaian - The Talking Trees Project 2016-2017.

Do No Harm Approach

Of great and significant importance were the following guidelines developed by the Girl Generation to help the ‘Talking Trees Project’ team to ensure that the principle of ‘Do No Harm’ is systematically applied, in order to control and mitigate potential harm.

Area of Potential Harm

Reinforcing the practice: communications and messages designed by external actors, which communicate judgmental or inappropriately framed arguments, can result in a negative backlash that reinforces the practice of FGM/C as a symbol of cultural identity and resistance to outside forces of change. Although the life-long health implications are very important, communications emphasizing only the health consequences or ‘barbaric’ way in which it is carried out risk promoting medicalization rather than abandonment.

Do No Harm Guidance

- Change must be led from within (Africa/Community-led), and should be informed by knowledge.
- Avoid approaches that could be interpreted as western imperialism, underhand tactics, scaremongering or insulting to local sensitivities.
- On the other extreme, over-simplification of the issue and patronizing approaches do not have impact but reinforce stereotypes and perceptions of Africans as children who are mutilating girls out of ignorance and can be cajoled out of it with superficial programmes.
- Westerners involved in the campaign must adjust their profile according to the context (e.g. should not have a high profile at national events, or in local media, and should not be seen as fronting the campaign but working in partnership and supporting local action).
- Careful selection of ambassadors/public figures to represent the programme.
- To understand the local political context and make sure that public figures used in the campaign are accepted by community members.
- Careful explanation of why the international communities are supporting this work (coming behind and supporting the Africa/Indigenous community leadership on matters FGM/C).

Area of Potential Harm

Do No Harm Guidance

Compromising the dignity of human subjects /human rights (visuals): However well intended, showing video-footage and photo-images of child abuse can be seen as a form of re-abusing that child. Children cannot consent to such footage being shown. This also isolates FGM from other forms of gender-based violence (which do not tend to use such tactics). Watching child abuse and torture can be shocking, disturbing and potentially traumatize audiences. Viewing torture is classified as a form of torture. It can create flashbacks for survivors and is ineffective for audience engagement (people turn away in horror or denial). When communities themselves see such footage, they feel their dignity is stripped as they feel implicated. Such footage gives only one view of how FGM is practiced - when in fact, it also takes place in clinical conditions with anaesthetic.

*For these reasons, our project team avoided using such approaches, when carrying out the 'Talking Trees Project'.

- Not to use FGM/C imagery in the public domain, which could compromise the dignity or privacy of human subjects, e.g. graphic photos and videos of girls undergoing the FGM/C procedure, or photos that directly suggest the procedure (pools of blood on the floor, bloodied razors).
- Exceptions: closed spaces with no minors, e.g. for the purposes of training professionals or key decision and policy makers, where the graphic nature/content is disclosed in advance, to allow people to leave if they do not wish to see the content.

Compromising the dignity of human subjects/human rights: In cases of FGM/C in the Diaspora, negative terms could reinforce racism and discrimination among immigrant minorities who come from FGM/C practicing countries. People do not feel the terms apply to them if they are practicing a medicalized form of FGM/C.

- Not to use language that could compromise the dignity or privacy of human subjects and culture, e.g. barbaric, uncivilized. A language and messaging guide will be developed which will provide more details.
- Not to use language or images in public, that suggests that girls and women who have undergone FGM/C are 'spoiled' or otherwise stigmatized.

Inaccurate or incomplete information and evidence:

Factual errors or facts which could not be backed up with evidence could open up the campaign to criticisms from opponents e.g. 'oh no, this does not happen in Kenya, they are peddling lies about us'. In addition, it weakens the credibility of the campaign (lack of professionalism).

- All materials for external publication should be checked and fully referenced by coordinators, against agreed data sources (e.g. UN publications or peer reviewed journals).
- While all the factual outputs of members/partners could not be controlled, country fact-sheets could be created to encourage use of accurate evidence.
- All communication approaches ought to be informed by the best available evidence about effectiveness (e.g. Not to promote alternative income generation for cutters, which has been shown to be ineffective and to potentially cause harm).

Vulnerable people: Some of the particular risks and vulnerabilities relating to working with women and girls at risk of, or affected by FGM/C (including awareness raising communications):

Women who have had FGM/C may:

- Not correctly understand the type of FGM/C that they have experienced, and be shocked and traumatized when they realize this (especially if they have more severe forms).
 - Not link or understand other symptoms that they are experiencing with FGM/C (e.g. recurrent urinary tract infections, or mental health issues).
 - Have very little access to services that may help them, or know what those may be (for example, clinical services (such as de-Infibulation), or mental health support services).
 - Have few sources of social support where their experiences of FGM/C can be discussed in a safe
- Where appropriate and possible, mobilizing appropriate protection mechanisms.
 - Risk assessments included in all national and local strategizing (e.g. when developing the national campaign strategy), including locally appropriate child protection guidelines and referral links.
 - Outline child protection obligations of core team, consultants and consortium members in different contexts.
 - Guidance will be provided for staff working with survivors of FGM/C and other potentially vulnerable people, e.g. Individual minors or other vulnerable people will not be identifiable in mass media contexts, unless in exceptional circumstances where appropriate safeguarding and support mechanisms have been put in place.
 - Provide guidelines/due diligence for recruiting/working with survivors and other potentially vulnerable people, e.g. not putting vulnerable people, minors, people at immediate risk, etc. in the spotlight; developing different appropriate levels of engagement for survivors; developing a checklist of systems that need to be in place before launching a survivor-led campaign (e.g. group/counselling support, information sheet with link to support services, links to police). This will be context-specific, as this may not be available in many contexts.
 - Concrete ways of ensuring survivor empowerment as a key consideration at every stage of the process.

way.

- May be experiencing other forms of abuse (e.g. domestic violence).
- May be coming under pressure to have FGM/C committed on their own child.
- May be in contact with girl children who are at risk^{2a} of FGM/C (their own child, or others within their household).

Cultural imperialism: Anti- FGM/C initiatives seen as a threat to cultural traditions/sovereignty. Human rights approaches seen as neo-colonial. As a document from the UNFPA notes: “People with no education do not respond to the idea of human rights. They think it is a reflection of Western values, not African values.” Externally imposed messaging, priorities, or pace of change can set the campaign back.

- Focus on strengthening the civil society foundation for the campaign – bringing together unified local voices. A broad-based civil society foundation will own and drive the national campaign, and will be able to respond to its critics.
- Consultation, participation, and a bottom-up approach will guide our work at all levels. Participatory, broad-based development of national campaign strategies, such that the agenda is set by local priorities and according to local expertise.
- Aligning all work with national plans and priorities, and working through national coordinating/stewardship structures (e.g. National Task Force, UNJP in country focal points) - we will work with countries, building on the work that has already been done, as opposed to telling countries what to do.
- Recruit traditional or religious leaders as advocates: as in this example in Kenya by UNFPA.^{3a}
- African leadership for the Global Movement (Strategic Advisory Group, national stakeholders and campaign panels).
- Diaspora contributions will support national and community efforts to end
- FGM/C, rather than enforcing ‘Diaspora’ solutions or messages.
- Promoting the importance of African/local leadership for social change among international partners.

Risks relating to team members' conduct and wellbeing

When working in focal countries, our team and anyone directly contracted to work for the campaign will:

- Observe protocol and consider local sensitivities, including dressing appropriately
- Avoid aligning with any one NGO or political party
- Undertake media engagements/interviews only with prior agreement of the Programme Director and Strategic Communications Specialist
- In any public communications, stick to agreed campaign messaging, as appropriate to country/target audience.

Negative backlash to the campaign: Backlash can result from cultural insensitivity, non-involvement of communities and governments etc in the design of targeted intervention

For this reasons the 'Talking Trees Project' team will:

- Enable people to access materials and messages which arm them with well constructed and locally meaningful arguments against FGM/C, which will be developed from a deep understanding of the issue in context, and which enable the issue to be discussed openly in public forums to raise public and community awareness.
- Tailor all messages and materials to national and local context. There will be no 'one size fits all' approach to our work.
- Respect culture, while protecting universal human rights and understanding culture as dynamic and mutable. Demonstrate that the momentum for change is from within communities themselves and from within the culture.
- Engage a wide cross-sector of society as well as men in community discussions on people's or human rights, not just women's (language is important). Include both those who already hold power and those who have been traditionally marginalized.
- Engage local traditional or religious leaders as advocates against FGM/C.
- Frame implications of FGM/C in a way wider society will be receptive to: not just in women's health and human rights terms – also economic, familial, sexual, etc.

Further politicization of FGM (by Islamists, other radical social campaigners, religious leaders etc.)

For this reasons the ‘Talking Trees Project’ team will:

- Work with a broad variety of groups, and never concentrate on just one sector of society (e.g. religious leaders), so that we do not encourage any particular dominant voice to control the discourse and use FGM/C as a political tool.
- Base all references to religion or ethnicity on facts and the evidence. We will diversify information in the media on ethnic groups practicing FGM/C so that one ethnic group does not feel they are under attack.

Corruption, fragmentation or commercialization of the sector: A flood of money and global attention could do harm to the very sector that we are looking to support.

Throwing money at a problem without necessary measures put into place for accountability will lead to corruption, whether at government level or at civil society level. Without appropriate accountability, a number of FGM/C projects have ended up as individual family businesses. This has had the effect of discrediting the movement.

The long-term future of the movement to end FGM/C will be central to all strategies (e.g. ending FGM/C in a generation prioritized over quick-wins and publicity which might harm the longer term goal).

For this reasons the ‘Talking Trees Project’ team will:

- Influence institutions and donors in the global north in terms of the way they allocate their resources and attention; identifying appropriate channels for resourcing which include a capacity building element particularly on M&E and transparent accounting.
- Emphasize local leadership, and the importance of working through national plans and stewardship.
- Design a global movement identity that is as inclusive and non-divisive as possible, bringing benefits to all parties who share the overall vision.
- Coordinate between NGOs, government bodies and international funders.
- Activities should be coordinated and resources shared freely. This is a key role for the campaign secretariat.
- Provide Guidelines on Engagement (e.g. criterion for who we will and will not partner/engage with).

Containing/managing the Global North: As interest in FGM grows in the global north, there is a risk that enthusiastic people and institutions will flood

For this reasons the ‘Talking Trees Project’ team will:

- Aim to influence and channel these energies so that they can bring something

countries/Diaspora communities with their efforts, which in the absence of in-depth understanding, expertise and insight may do considerable harm.

positive, and get behind the Africa-led movement.

Working with the media: It is important to take into consideration how the Campaign will influence and inform others (including journalists) working towards an end to **FGM/C** such that they Do No Harm (e.g. communications guidelines).

For this reasons the ‘Talking Trees Project’ team will:

- Provide guidance for our work with the media i.e., how can we minimize the harm that they do.
- Provide positive, sensitive messaging, stories and imagery to influence and inform media reporting of the issue.

Sending the practice underground: There is a risk that younger girls are being cut; anti- **FGM/C** law is hard to enforce/results in the practice going underground/becoming medicalised. The World Health Organisation (WHO) mentions the case of Egypt whereby anti- **FGM/C** law has not only failed to decrease significantly numbers of **FGM/C** cases, but has led to the medicalisation of the practice thereby providing false legitimacy to it. It is also very hard to implement and has not resulted in widespread behavioural change.

- Mainstream anti- **FGM/C** initiatives. WHO cite success in Burkina Faso where anti- **FGM/C** initiatives were mainstreamed into government ministerial departments of health and education. Promote a holistic response to ending **FGM/C** (prevention, protection, provision of services, partnerships, prosecution), including prosecution as a last resort/deterrent.
- Community approaches and Behavioural Change Interventions are needed to complement the law.

Medicalisation: Focusing narrowly on the health Implications of **FGM/C** may lead to medicalisation – as has happened in Indonesia and Egypt.

- Use a human-rights approach
- It is especially important to recruit doctors to support anti- **FGM/C** measures and not merely encourage the medicalisation process. In Egypt for example, an initiative of Doctors Against **FGM/C** has started to address the medical sanctioning of the practice in that country.⁴

Ineffective communications: narrow ‘Information, Education and Communications’ Interventions (IEC) can result in desensitization. The WHO cites the case of Ethiopia where posters of a girl and blood on a knife became such a common sight that no one paid any attention. Since IEC interventions do not target the root cause of FGM, they could indirectly contribute to its continuation by making community members less receptive to anti- **FGM/C** messages. Inappropriate messages of IEC interventions can increase support for **FGM/C**. The WHO also provide an example of a poster stating that FGM reduced female sexual enjoyment, which is precisely what supporters of the practice want.

- Instead of focusing on IEC interventions, we should focus on Social and Behavioral Change Interventions which address multiple challenges at the same time. IEC interventions rarely yield successful results on their own.
- Make abandonment initiatives relevant to the local population. Rely on local authorities, not international ones. Approach the issue through concepts already present in communities’ own daily languages and ordinary experiences, e.g. local folklore and other pieces of oral history that portray positive images of women and girls.
- This is also important to make communities more likely to adopt anti- **FGM/C** messages. WHO state that often anti- **FGM/C** are unsuccessful because their messages are too broad, e.g. ‘**FGM/C** is violence against women’. Since **FGM/C** is deeply culturally-embedded, anti-**FGM/C** messages need to relate to the specific community so that they feel invested in the issue.
- Principles for collecting information, feedback and conducting research with target audiences.

Risks with engaging the Diaspora: Although the Diaspora has a degree of political power and influence in their countries of origin, it is difficult to manage, difficult to predict, and could do harm. It is hard to identify and verify who those with power and influence are. Diaspora interventions can be seen locally as top-down and undermining of grass-root efforts as Diaspora members are seen as competing with locals in a narrow job market.

With distance and time, Diaspora members’ links, networks and connections with their country of origin can become distended. Second or third generation Diaspora young people might never have visited their parents’ country of origin, do not necessarily speak local languages or know local cultural codes. Through integration processes, long term immersion in the global

- We will balance the tension between wanting a focus on **FGM/C**, whilst recognizing the holistic approach needed to end it. In practice, this will involve encouraging the integration of **FGM/C** into wider policy and programming on child welfare, health and development linking up with other girls’ rights campaigns e.g. campaigns on child early forced marriages.

North means that Diaspora members have internalized some expectations and aspects of the European/American way of life that can cause tensions when visiting countries of origin.

^{2a} Guidelines for ethical standards on interviewing women affected by FGM/C, Options Consultancy Services/UK FGM Initiative

^{3a} <http://www.unfpa.org/public/news/pid/5410>

⁴ <http://www.unfpa.org/public/home/news/pid/5566>



Figure 14: Narok Masai women attending the 'Talking Trees Project' forum on the Effects of FGM/C on Maternal Healthcare prevalent among the Pastoralists people of Kenya.

Photo Credit: Erick Lemaiyan - The Talking Trees Project 2016-2017.

THE ‘TALKING TREES PROJECT’ AND STUDY

In 2016-2017, the “Talking Trees Project” - 'A public health research and forum addressing maternal deaths prevalent among pastoralists’ communities of Kenya’ was launched and implemented in Narok, and Kajiado Counties of Kenya, by the non-governmental organization ‘The Enduring Voices Foundation’.

This project was organized around the following modules: Maternal healthcare, FGM/C, alternative rites of passage, women’s health (sexuality, pregnancy management, HIV/Aids and death), human rights, child development and early child-marriage. The ultimate goal of the programme was to mobilize indigenous pastoralists’ communities to participate in open public health debates and forums, which led to voluntary open public declarations on the abandonment of harmful traditional practices like: FGM/C and child marriage.



Figure 15: An Anti- FGM/C Workshop organized for Maasai women in Oloitokitok village, Kajiado County. Photo Credit: Erick Lemaiyan - The Talking Trees Project - 2016 -2017.

Research methodology

Research methodology is the choice one makes how to study a certain topic by gathering data and the methods she/he uses to analyze data in research (Silverman 2005).

Qualitative and Quantitative methodology of data collection were used in collecting the materials for this research. As defined by Miller and Crabtree (1992) the methods are more than one. It involved exploring attitudes, behavior, and experiences of the group studied. This research focused on the experiences of women who had undergone Female Genital Mutilation (FGM/C).

The qualitative approach was valuable in obtaining more details that could not be achieved in numerical data or by using, for example, a questionnaire. By using interviews, the data was based on true personal feelings of the participants who took part in the study. The interviews were made simple and clear to avoid misunderstandings, between the project team, the researchers and the research participants.

Sampling and Selection Criteria of the Participants

The selection criterion of the 'Talking Trees Project' participants was based on, choosing girls and women who had been victims of Female Genital Mutilation (FGM/C) and who had ever witnessed it being practiced on other women, either their close friends or their family members. The participants who took part in this research were also chosen from a coalition of indigenous people's organizations and networks that the Principal Investigator (PI) had previously worked with in other collaborative projects. In number, participants were chosen from 22 villages namely: *Magadi, Namanga, Ngong, Kiserian, Kajiado, Kule, Narok, Jerusalem, Olkeri, Oljororok, Ntilal, Naijile Oltinga, Naadadapo, Sarara 1, Sere Olipi, Lauragi 2, Lengarde/ Leshunyai, Lenchekut, Lorian and Sionta 2*, to participate in the 'Talking Trees Project' initiation, implementation and in the research process.

The reason for only having participants from the aforementioned 22 villages for this research was, to ensure that adequate time would be allocated to each of the villages and to the participants to take part in the debated/forums, to tell their stories and for the researchers to be able to do the analysis. All the questionnaires and interviews were conducted in *Swahili* and *Maa* languages because the participants could not communicate in English.

During the project implementation and the research process, the project team did encounter many difficulties and some instances, the participants became very emotional. However, this did not prevent the project team from continuing with the interviews and or implementing the 'Talking Trees Project'. The participants' were given the freedom and liberty to withdraw their consent or participation in the project. (*See: Appendix 3: The Free Prior Informed Consent Form*).

Research Participants

Approximately 200,000 participants took part in the 'Talking Trees Project'. Their ages varied between 05- 70 years old. 90% of the women and girls reported to have undergone Female Genital Mutilation (FGM/C) at one time in their lives, which was reportedly done within their own families, villages and communities. Majority of the participants had no formal educational background, as many had not attended school before, with only a few being students in the few primary and secondary schools within the counties.

Majority of them were married with children and lived with their families, while a few were single and belonged to the age set groups for boys and marriageable groups for girls.

Procedure of Data Collection

Data collection was based on twelve interview questions that were open-ended (*See: Appendix I: Form, Debate and Interview Questions*). Open-ended questions are unstructured questions in which the respondent answers by using his or her own words (Seidman 1998). Two different types of methods were used to gather the information for the ‘Talking Trees Project’ study. This included interviews and materials researched from the different information booklets on Female Genital Mutilation (FGM/C) and internet web pages that other researchers have done.

The interviews took place at mutually agreed time, date, and location chosen by the participants’, indigenous people’s facilitators and community representatives. Ninety minutes is the optimum length for a qualitative research interview (Hermanowicz and Seidman 1998). Therefore, the PI suggested to the participants and the interviewees that the forums, debates and interviews would be approximately one hour but they could take part as long as they wished, so that the project team did not hinder nor limit them with what they wanted to share.

At the end, most of the forums, debates and interviews lasted for one and half hours, and only three ended up being two hours long. All forums, debates and interviews were tape recorded with participant’s permission granted. It was clear and loud to understand what the participants were saying, afterwards when the project team was listening and transcribing the materials from the tape recorders.

All the participants chose to have the interviews with their indigenous people’s facilitators and community representatives present, except for when the girls most affected by FGM/C wanted to confide in the female gynecologist, who was among the project implementation team. The forums, debates and interviews were conducted under acacia tree shades, accustomed to pastoralists’ communities during village gatherings.



Figure 16: Masai youth, taking part in the ‘Talking Trees Project’ Forums and Debates at Namanga village. Photo Credit: Eric Lemaiyan - The Enduring Voices Foundation - 2016-2017.

This is where the participants' felt free to express themselves and easier to concentrate on the forums. While majority of the forums took place in the morning hours, three of the participating villages chose to have the interviews in the afternoon from 12.00 p.m - to 15 p.m. The reason why they chose this time of the day was that, at that at the aforementioned time, they would be free to attend the forums without disturbance after attending to their daily chores i.e. cattle herding, cattle feeding, milking, fetching water and gathering firewood.

However, conducting a forum and or interview with both women and men present was not possible or allowed among the tribes, since it was against their culture for people of the different sexes/gender to sit together in the open or in to be seen side by side in public places. FGM/C practice was a sensitive topic that was usually not discussed among men and women and outsiders, because of the fear of being judged. Therefore, the husbands were not present during the interviews and were only interviewed separately and at separate occasions.

Many of the participating women agreed to open up their stories because they were victims of Female Genital Mutilation (FGM/C) at younger age and they did not have anyone to talk to about what they went through. They therefore felt the need to share their stories with the female members of the 'Talking Trees Project' team and many a times through the indigenous people's facilitators and female community representatives.

It was noted by the participants, their indigenous people's facilitators and community representatives, that those who still practiced FGM/C would know the dangers involved and would be persuaded or convinced to abandon the practice.

Another reason was that, the participating women wanted to let others who did not know about the FGM/C practice to know about it and be able to help the young children who are growing up in those communities across countries that practice FGM/C as part of their culture.

Questionnaire

In order to ensure the uniformity of the data collected, a simple questionnaire was developed and printed to this effect, so that all women who attended the 'Talking Trees Project' forums and debates had the findings recorded on their questionnaire. However, as the 'Talking Trees Project' advanced its forums and debates in other locations across the 22 small towns and villages, the survey questions developed and changed over time.

The number of questions asked of each participant increased with time, so the women involved at the beginning of the study were asked fewer questions than those involved later on in the project. There were no differences to bias the results between the women who participated early in the study, compared to later participants. (*See Appendix 2 and 3: English version of the 'Talking Trees Project' Questionnaires on FGM/C*).

Data Analysis

Analysis was based on the data provided by 300 women participants in 22 study locations, through twelve open-ended forum, debate and interview questions. The transcripts of interviews were read several times, according to what the participants were saying they had undergone during the Female Genital Mutilation FGM/C process. The important points that related to answering the research questions were grouped together and those that carried the similar information grouped differently.

The information obtained from the twelve interview questions were then used to formulate the following project themes that were later used in the data analysis:

- Procedure of FGM/C

- Complications/ consequences
- Flashbacks of the women from the practice
- Culture
- Religious views
- Human rights

Reliability of the Data

Reliability is the degree of consistence with which results of a study can be reproduced again using the same methodology (Golafshani, 2003). To produce reliable results, qualitative research methods, such as interviews, and literature reviews were used in this study, to gather all the information about Female Genital Mutilation FGM/C as mentioned in this publication.

Ethical Consideration

Ethical considerations were addressed at the beginning and before starting the ‘Talking Trees Project’ forums, debates and interviews.

Any sensitive issues that could have been distressing to the participants were also considered and as addressed. It was made clear to the participants that they could terminate their consent in participating in the ‘Talking Trees Project’ forums, debates and interviews at any stage of the project, if they felt uncomfortable with certain questions.

To ensure confidentiality of the participant’s welfare, their identities were protected and any names used had been changed or only used with strict permission. The participation of human subjects in research, especially if one is researching experiences, must be taken care of, to ensure that the participants are protected (Polit and Hungler, 1997). During the forum, debates and interview process, tape-recorder was used to record all the interviews with strict permission granted from the participants.



Figure 17: Masai women, taking part in the ‘Talking Trees Project’ Forums and Debates at Lenchekut village. Photo Credit: Eric Lemaiyan - The Enduring Voices Foundation - 2016-2017.

After all the ‘Talking Trees Project’ forums and debates were implemented in the 22 villages; time was taken to transcribe the collected data and to reflect on it. Data was then coded according to the questions and project themes developed from the twelve interview questions (*See Appendix 1: Interview questions*). The project themes were then used to analyze all the materials.

STUDY LOCATION

This study took place in Narok and Kajiado Counties. The ‘Talking Trees Project’ was introduced in 22 small town and villages namely: *Magadi, Namanga, Ngong, Kiserian, Kajiado, Kule, Narok, Jerusalem, Olkeri, Oljororok, Ntilal, Naijile Oltinga, Sere Olipi, Naadadapo, Sarara 1, Lauragi 2, Lengarde/ Leshunyai, Lenchekut, Lorian and Sionta 2* in several participatory phases, thus dialogue, identification and selection of participants, and implementation of the project itself.

The ‘Talking Trees Project’ set a number of criteria for village selection, having to do primarily with the village leaders’ willingness to feed and accommodate selected indigenous community facilitators and project staff, prepare lists of program participants and beneficiaries, and construct makeshift under-tree program facilities. Abandonment of FGM/C was also set as a marginal condition for a village to be accepted within the ‘Talking Trees Project’. The pastoralists’ communities themselves and their representatives, contributed significantly to the introduction and implementation of ‘Talking Trees Project’ in the above mentioned towns and villages.

The factors that contributed to choosing these particular towns and villages were that, the majority of people inhabiting these places were ninety percent pastoralists’ communities, whose cultures and traditions conformed to the practice of FGM/C. Most of the participants had been living in these places for their entire lives and had built their permanent manyattas and homes there. The regions where the Principal Investigator and her project team planned to involve in this study, were however not easily accessible in terms of transportation and telecommunication infrastructure.

Kajiado County

Kajiado County is located in the southern part of Kenya. It borders Nairobi County to the North East, Narok County to the West, Nakuru and Kiambu Counties to the North, Taita Taveta County to the South East, Machakos and Makueni Counties to the North East and east respectively, and the Republic of Tanzania to the South. It is situated between Longitudes 360 5’ and 370 5’ East and between Latitudes 10 0’ and 30 0’ South. The county covers an area of 21,900.9 square kilometers (Km²).

Administrative Units (Sub-counties, Divisions and Locations)

The county is divided into five administrative sub-counties namely: Kajiado Central, Kajiado North, Loitokitok, Isinya and Mashuuru, with a total of 17 administrative divisions.

Population Size and Composition

The county has an annual population growth rate of 5.5 percent with population in 2012 estimated at 807,069 of which 401,784 were females and 405,285 males.

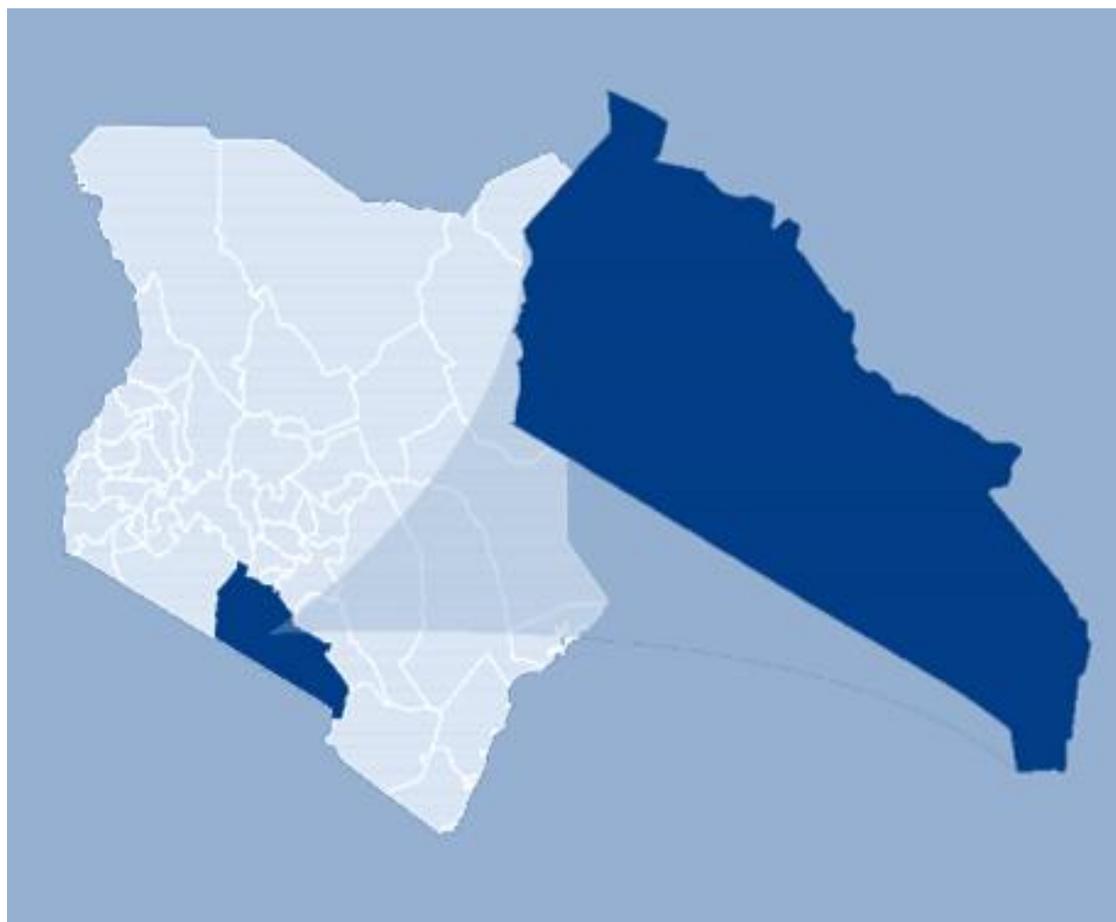
Illiteracy

The county has a high illiteracy rate of 35 percent compared to the national illiteracy rate of 28.6 percent. This can be attributed to a combination of factors which include high drop outs rate, low transition rate and socio-cultural practices among others. The negative cultural practices such as early marriages and Female Genital Mutilation (FGM) are a major impediment to girl-child education and empowerment. In addition, young men embrace moranism while young boys take part in herding at the expense of education.

High Population growth rate

The annual population growth rate in the county is estimated at 5.5 percent which is higher than the national average of 2.9 percent. Challenges posed by high population growth rate include rapid urbanization, pressure on land, human/wildlife conflict, increased crime rate due to unemployment and mushrooming of informal settlements.

Map 1: Location of Kajiado County in Kenya. Source: Survey of Kenya, 2014.



High Poverty levels

There are high levels of poverty in the county with more than 47 percent of the population living below the poverty line. Major causes of poverty include illiteracy, frequent droughts, poor infrastructure and inadequate water resources. A major effect of poverty is high rate of school dropouts as parents are unable to raise school fees. The high dropouts subsequently result to child

labour as the school going children work to supplement family income. In addition, the poor often experience nutrition related conditions that contribute to high morbidity rate among children and women. Poverty has also forced some people into commercial sex work thus exposing them to HIV/AIDS especially in the urban areas. This may result to increased number of orphaned and vulnerable children and high dependency rates.

Inaccessibility of Health Services

There are a few health facilities in the rural areas which are poorly equipped and under staffed. Health of the population is pertinent to social and economic development. Access to quality health care in Kajiado is still a challenge, with majority of available health facilities lacking essential drugs, working tools and equipments. Distribution of health facilities is highly concentrated in the urban areas as compared to rural areas. Existing facilities in the county are yet to be upgraded and requisite facilities.

The average distance to the nearest health centre is 14Km. Majority of the people cannot access basic health care and this affects their productivity. Most people in rural areas rely on traditional methods of treatment as they are cheap and readily available. There are also high occurrences of nutrition related ailments in children due to lack of food variety and adequate quantity as a result of frequent droughts.

HIV/AIDS

HIV prevalence in the county stands at 6.1 percent compared to the national prevalence of 6.3 percent. The contributing factors to the high prevalence rate are alcohol and drug abuse, rapid urbanization and cross border movements. Preventive activities and support for those infected and affected should be focused at the family unit.



Figure 18: Masaai women, taking part in the 'Talking Trees Project' Forums and Debates in Lengarde/ Leshunyai, village. Photo Credit: Eric Lemaiyan - The Enduring Voices Foundation - 2016-2017.

Gender Inequality

Women's ability to make economic decision is constrained by the fact that they are not the owners of productive resources like land and livestock. Wealth in the form of livestock and land are often owned by men.

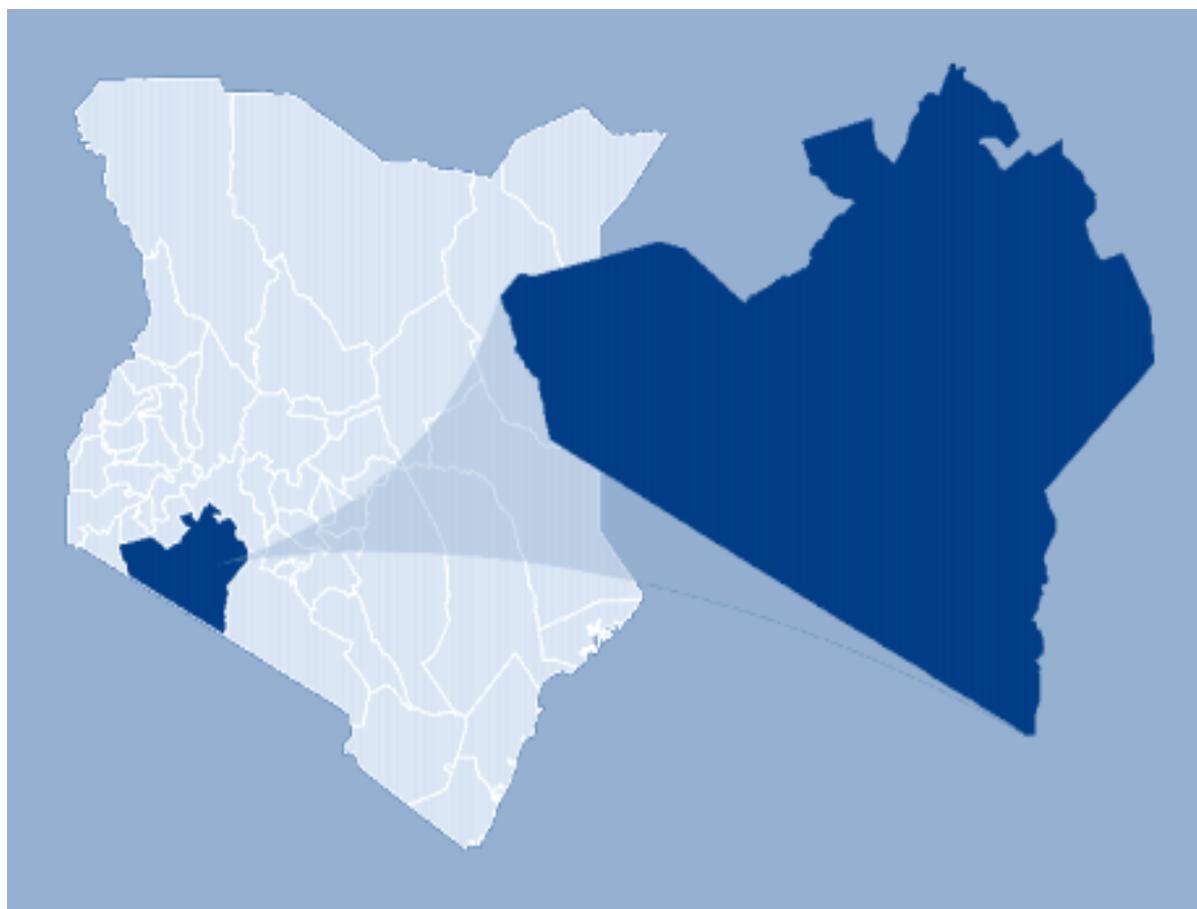
Poor coordination of development activities

There is poor coordination of developmental activities in the county leading to duplication of effort and wastage of resources. This is caused by lack of or poor communication among various development stakeholders in the county.

Narok County:

Narok County is located on the southwestern part of Kenya and constitutes of five sub-counties namely; Narok North, Narok South, Narok East, namely; Narok North, Narok South, Narok East, Transmara West and Transmara East. The county borders the Republic of Tanzania to the South, Migori and Kuria counties to the West, Bomet and Nakuru counties to the North and Kajiado County to the East. It lies between latitudes $0^{\circ} 50'$ and $2^{\circ} 05'$ South and longitudes $35^{\circ} 58'$ and $36^{\circ} 00'$ East.

Map 2: Location of Narok County in Kenya. Source: Survey of Kenya, 2014.



Population Size and Composition

The county has a population of 934,163 of which 470,996 are males and 463,167 females.

It covers approximately 17,988 Sq. km. There are four main livelihoods, namely mixed farming, livestock keeping, agro-pastoral and tourism. (See: *Map 3: Indicating Livelihood Zones in Narok County of Kenya*).

Illiteracy

The county has a high illiteracy rate of 38 percent compared to the national illiteracy rate of 28.6 percent. This can be attributed to a combination of factors which include high drop outs and low transition rates and socio-cultural practices among others. The negative cultural practices like Female Genital Mutilation (FGM) and early child-marriages are a major impediment to girl-child education and empowerment. In addition, young men embrace moranism while young boys take part in herding at the expense of education.

High Poverty levels

Narok County has very high levels of poverty in the county with more than 50 percent of the population living below the poverty line. A major effect of poverty is high rate of school dropouts as parents are unable to raise school fees. Others causes of poverty include illiteracy, frequent droughts, poor infrastructure and inadequate water resources.

The high dropouts subsequently result to child labour as the school going children work to supplement family income. Frequent malnutrition caused by prolonged drought contributes to high morbidity rate among children and women. Poverty has also forced some people into commercial sex work thus exposing them to HIV/AIDS especially in the urban areas. This has resulted to increased number of orphaned and vulnerable children and high dependency rates.

Inaccessibility of Health Services

There are a few poorly equipped and under staffed health facilities in the rural areas. Health of the population is pertinent to social and economic development. Access to quality health care in Narok County remains challenge, with majority of available health facilities lacking essential drugs and equipment. Health facilities are sparsely distributed in rural areas.

The average distance to the nearest health facility is 17Km. Most of the people have no access to basic healthcare. Most people in rural areas rely on traditional methods of treatment as they are cheap and readily available. Frequent droughts cause severe malnutrition cases in children.

HIV/AIDS

HIV prevalence in the Narok County stands at 5.4 percent compared to the national prevalence of 6.3 percent. The contributing factors to the high prevalence rate are rapid urbanization and cross border movements, alcohol and drug abuse. Preventive activities and support for those infected and affected should be focused at the family unit.

Gender Inequality

Women do not own personal land, livestock or property, making them unable to make economic decisions. Wealth in the form of livestock and land are often owned by men.

Poor coordination of development activities

There is poor coordination of developmental activities in the county leading to duplication of effort and wastage of resources. This is caused by lack of or poor communication among various development stakeholders in the county.

HEALTH PROFILE OF THE PASTORALISTS' PEOPLE OF KENYA

While the health of the indigenous people of is among the worst in the world, the pastoralists' people of Kenya rank among the communities with little or no access to basic healthcare.

This statement is supported by the fact that even before the promulgation of the 2010 Constitution of the Republic of Kenya and the devolution of services to the County Governments, Kenya had one of the highest Maternal and Child Mortality rates in the world (Ref. UNICEF, The Progress of Nations, 1997, 130 maternal deaths per 10,000 live births).

While most recent and valid data is not available, what national Maternal and Child Mortality rates have become after the devolution from the national to the county governments since 2013, is a frightening thought. Maternal Mortality rates among the pastoralists' people still rank among the highest in Kenya. Yet, devolution was created to provide equal opportunity to all the populations of the 47 Counties of Kenya. While Kenyan population continues to enjoy their devolved systems, including natural resource governance, revenue allocation/collection and healthcare, the employment of doctors, nurses and midwives remains a challenge in the devolved systems.

The MoH and FGM/C

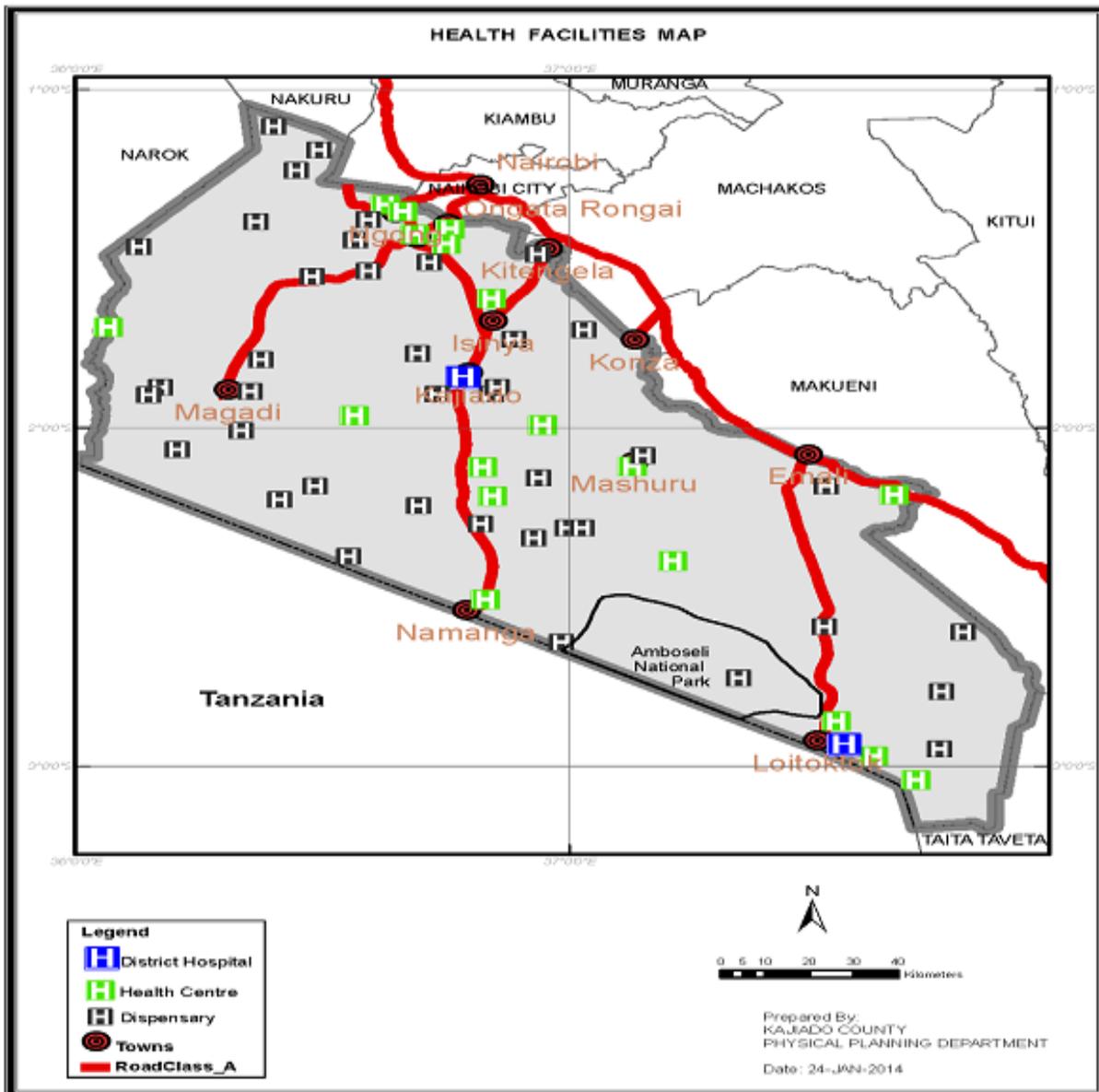
Medical personnel in the government hospitals in Kajiado County are confronting the effects and complications of FGM/C almost on regular basis. Cases including those of children who have been genitally mutilated and sometimes days before being brought to the hospitals and who could still be bleeding heavily or unable to pass urine because of their new stitches are reportedly common.

Other reported cases include newly married girls and women just de-infibulated and suffering from bleeding, infection or just plain pain. Also, women in labour for much longer than they needed to be or cases of women who's scarring from FGM/C prevented their birth canal from dilating properly are reported.

Some of those women are also said to end up with third degree lacerations and other post-natal complications. The government hospitals dealing with cases of this nature have been engaged in a permanent struggle to see an end of FGM/C practices. With the establishment of maternity hospitals across all 47 counties of Kenya, still more services are needed to deal with FGM/C and it is becoming essential for the hospitals to join hands and lead county-level campaigns against FGM/C.

They should also become repositories of all information relating to FGM/C in Kenya. The hospitals need to start auditing processes to have baseline data collection about the prevalence of FGM/C through auditing initiatives in their counties. Hospitals should also hold educational and sensitization seminars for concerned groups. At a patient level, counselling services will be provided to the victims of FGM/C and their families.

Map 3: Distribution of Health Facilities in Kajiado County in Kenya.
 Source: Kajiado County Physical Planning



RESULTS

The six themes generated from the Talking Trees Project' forums debates and interviews were taken into consideration while analyzing the practice of Female Genital Mutilation (FGM/C) prevalent among the pastoralists communities in Narok and Kajiado counties of Kenya. These included:

I. The Female Genital Mutilation (FGM/C) Procedure:

Our research question on FGM/C procedure was: *How is the procedure of Female Genital Mutilation (FGM/C) carried out in your own community?* The information and analysis on the FGM/C procedure was based on the interviews. The participants came up with similarities and differences of the FGM/C procedure in their respective villages and communities.

According to how the FGM/C procedure is done, despite the different villages and communities where the participants came from, some of the words the women used to describe the cutting process included pain, screaming, instruments, haunting, torture, bad, not easy and death.

The following were some of the similarities on how the FGM/C practice was done from the experiences of the participants who took part in this research. Based on the interviews, the age at which FGM/C was performed varied from a few days after birth until before marriage or sometimes before women gave birth.

Countries like Sudan, Somalia and Ethiopia it is usually a few days and goes on until before marriage and for some women it can be before giving birth. However in Kenya, Female Genital Mutilation (FGM/C) takes place before puberty. The process takes 20 minutes per girl or a woman. This is for those who practice Type **II** and **III** which are considered to be more severe. The process is even shorter or roughly five minutes, for those who undergo Type **I** (*See: Figures 2-5*).

The time when the Female Genital Mutilation (FGM/C) takes place varies from one country to another. In Kenya, it is usually done during the end of the year, when the school holidays are longer. In Sudan and Somalia, it is done when the family has money and in Ethiopia, it is during the August holidays, or during the harvesting seasons when they have enough food for the celebration to take place. Midwives and old women, believed to have experience are chosen by the community to carry out the mutilation on the girls and women because. They get cows, goats and money as a form of appreciation, compensation and as part of their income.

The whole process starts by girls arriving together with their parents or close relatives at a chosen location where the mutilation is to take place as early as four o'clock in the morning. They arrive early to get prepared before the FGM/C process kicks off.

The girls are taken into a makeshift bathroom structure to shower with cold water and to make their bodies numb, in order not to feel too much pain where no anaesthesia is used. After that, they are escorted to where the circumciser who also doubles as a village midwife is seated and the mutilation process begins. The following are the kind of tools used that were repeatedly mentioned by the participants:

- White piece of white cloth that symbolizes wholeness is spread on the floor for the girls to sit on.
- Broken pieces of glass or sharp thorns, used as the cutting object. One cutting objects is used on all the girls without changing and not fearing of transmitting diseases such as HIV/Aids or hepatitis.

- Ropes used to tie the legs and hands so that they do not move when they feel pain.
- A candle for lighting the room where the FGM/C process takes place and one that will to be blown off at the end of the cutting process by the girls or women being cut, to drive away the bad spirits from their body.
- A traditional stool is used by the midwife to sit on during the FGM/C process while facing towards the position of sunrise, to give respect to the sun that signifies holiness and good luck.

Additionally, two people assistants may be present to assist the circumciser by holding the girls mouth and pinning down her feet, to avoid loud screaming or too much movement. When all the materials are ready, the “ceremony” starts. The traditional circumciser who often doubles up as a Traditional Birth Attendant (TBA) performs the work, while sitting in front of the girl and starts mutilating the genital parts, they start by cutting the clitoris followed by sewing up the lips together, leaving a small hole for passing urine, menstruation and other virginal secretions only.

The girls are then made to stay indoors with their legs tied together to avoid movement and for quick recovery. The girls are not allowed to drink any kind of fluids for one week to avoid urinating that could make them feel pain and delay the healing of the wound.

If infections occur, they are not allowed to seek medical assistance from a doctor; instead they will be made to sit on a hot charcoal that believed to kills germs. If the FGM/C procedure may be repeated once again if it is not deemed successful, until the parents and the midwife are satisfied with the result. After healing, the girls are showered with presents that include new clothes and some jewelry that symbolizes readiness for marriage.

II. Complications/Consequences of FGM/C:

The tools used to perform the FGM/C procedure are not sterilized, and in many cases, they end up transmitting germs that cause many health complications for the women and girls. The victims of the FGM/C practice suffer from different health consequences that occur due to the wrong instruments used. These consequences can be categorized with four different aspects of “Human life” these include, health, physical, psychological, sexual and social.

Health	Physical	Sexual	Psychological	Social
Short-term Consequences of FGM	Bleeding, Fainting, Fever, HIV/AIDS and Hepatitis Infections, Tetanus		scars, sitting and sleeping difficulties	Embarrassment When visiting Doctors.
Long-term Consequences of FGM	Abnormal growths, Recurring urinary tract infections, Organ damage surrounding the clitoris, Pregnancy complications, Infertility and still baby.	Painful sex, delayed sexual arousal, Lack of sexual desire.	Nightmares, Trauma, Name-calling, Nain and fear.	Respect in the community, Marriage, Isolation, Name-calling, Rejection with peers and Divorce.

Table 3: Health, Physical, Sexual, Psychological and Social Consequences of FGM

The physical health consequences and problems after the FGM/C process show permanent damage to the victims. If they do not die from excessive bleeding and infections such as tetanus, they will have other health risks that may occur during the healing process. Too much removal of the sexual organs from the vaginal area could also cause problems during delivery, by triggering other complications such as tearing and bleeding that could put both the mother and baby at risk.

During delivery, it could also be difficult for the head to pass through a narrow vaginal hole and that could cause death of the infant being delivered. Some of the participants mentioned that scares develop and strange growths grew on their private parts, thus causing embarrassment when they go to hospitals for pre-natal, post-natal care and or gynecological examinations, which is seldom undertaken by women from the pastoralists' communities.

FGM/C also caused psychological problems to the victims. All the participants reported having had nightmares many times about pain and remembering how scared they were the day they were mutilated. The pain they experienced during the cutting is associated with the delivery pain and that has continuously caused women to fear especially when delivering, thereby killing their unborn baby in the process of remembering the first pain they endured during FGM/C procedure.

Loss of sexual interest and desire due to the removal of the clitoris was also reported and featured prominently among women during the interviews conducted for this study. Women also disclosed that they experienced less sexual satisfaction and pain because of vaginal opening. Due to lack of sexual desire, many of the women reported experiencing stress and adulterous behaviour from their husbands who cheat on them with uncircumcised women.

Through cheating, many women became victims of HIV/AIDS, which was transmitted by their husbands. Female Genital Mutilation (FGM/C) causes effects on sexual desires of women and may cause social problems that contribute to divorce, name-calling, isolation, loneliness and depression.

III. Flashbacks and FGM/C victims

In the Oxford Dictionary, flashbacks are defined as sudden recollections of events that are accompanied by strong emotions. In this publication, a flashback assumes the meaning of the memories that took place from the day women and girls underwent Female Genital Mutilation (FGM/C). Majority of participating women in all the 22 small towns and villages aforementioned in this study, were victims of FGM/C and had undergone Female Genital Mutilation (FGM/C) at one time in their childhood, aged between 5-14. While very few women participating in this study had basic education, a whopping majority of them didn't. The interviewers revealed similarities and differences when asked about the Female Genital Mutilation (FGM/C) practices.

The participating women spoke very negatively about undergoing Female Genital Mutilation (FGM/C) at a younger age. Many of them became emotional, while remembering what they had to go through in order to be women. Many cried and sobbed in their '*Khangas*' and '*Lesos*' - the Masaai traditional clothings. Majority of the women confessed that life never became the same again, after undergoing through the Female Genital Mutilation (FGM/C) process.

Almost all of them admitted that they had had health problems and complications associated with their undergoing through FGM/C. Many could not salvage the logic or find the reasons why we were mutilated. However, one thing was evident, in that they were all against the FGM/C practices after they had participated in the 'Talking Trees Project' forums and became aware of the vices of FGM/C practices.

The following are excerpts from the women who participate in the 'Talking Trees Project' and took part during the interviewing process.

Excerpt 1:

Naijile Oltinga

Location: Kajiao **Population Size:** 6,000

Project Timeline: 2nd - 5th August 2016

GPS Coordination: Longitudes 360 5' and 370 5' East - Latitudes 10 0' and 30 0'

‘My Beautiful Dress: Personal Narration of an FGM/C Victim.

At only 16 years old, Jane Saruni is a young mother, whose first baby was premature and stillborn, but her second a healthy boy came to term and survived. She is against Female Genital Mutilation (FGM/C), because the experience for her was horrendous.

Her mother was a seamstress, and usually went off to work in the morning. One evening, when Saruni was aged six, she gave her a new dress, and told her to wear it the following day. I was very happy with my new dress I had no idea what was going to happen. Then my mother told me she would stay home that day and not go to work, and I was happier. Then she said I need not go to school today, and I was even happier.

I remember that an old fat Masaai woman came to our home. She started talking to my mother, and my mother was cooking, laughing, and drinking tea. Everyone was happy, and my mother gave me some nice food. Then after a short time, she told me to go to the bathroom and have a shower. She said she did not want the woman to see or find me dirty, so I should shower and wear my new dress.

My grandmother arrived. She told me I was to be circumcised but I did not understand. She said: *“Now you will be like everybody else, you will not be left behind.”* Then they got ready. They held me at my shoulders and at the knees, and I started crying and trying to close my legs and loosen myself from their tight grip. It was very terrible. I can never forget the brutality I witnessed in the hands of my own mother and grandmother. Saruni faltered as she recalls the trauma. She picks up the story only after the worst was over. *“I was at home for seven days with acute pain in the area they had cut. I was not allowed to drink water, and I couldn't eat any solid food.”*

Saruni and her friends do discuss circumcision. People know it is dangerous and brings difficulty during birth,



they hear this on the radio. There are those who say we should stop. If it was up to me, I would say: “Don't do this to your daughters” but I'm afraid, the society would not accept. My mother knows there are problems, but she believes it is a cultural rule that must be obeyed within the Masaai community. She thinks it is shameful to live with the genital area open. She will always insist that we have to close it.'

Saruni's name has been changed to respect her privacy.

Excerpt 2:

Lengarde/ Leshunyai

Location: Kajiao **Population Size:** 15,000

Project Timeline: 2nd - 5th September 2016

GPS Coordination: Longitudes 360 5' and 370 5' East - Latitudes 10 0' and 30 0' South

“I was given Basic Training”- *Personal Narration of an FGM/C Practitioner.*

Sarah Nkaiseri Nchoko, now in her fifties, has been practicing as a Traditional Birth Attendant (TBA) for 31 years, having learnt the skills from her mother. In 1975, she received a formal training as a TBA. At the time, like others, she was also taught how to do circumcisions with clean instruments, using anaesthetics. There was little effort then by health professionals to discourage the practice.

Sarah lives south of Naijile Oltinga Village, in Kajiado County. A year ago she went to a seminar where she was told that 'Modern clinical-circumcision' was bad, and since that time, she says, people have been less keen. *‘Modern clinical-circumcision is going down because it's not enshrined in the Masaai culture, and people now ask for 'Traditional Masaai-circumcision'. This involves more cutting and includes excision of the clitoris, and is more brutal. It still is the most severe form of mutilation. I myself do not like 'Modern Masaai-circumcision', my father told me long ago that it is against the Masaai culture and I should only perform the 'Traditional Masaai-circumcision'. Though I discourage parents about it, most of them still insist, because they think 'Traditional Masaai-circumcision' is more beautiful and*



adds more acceptance and value into their daughters marriage.”

Naijile Olinga is one small village in the south of Kajiado County, which is divided under separate clan authorities. Sarah knows all the TBAs in her own part, and says they are all dropping Modern clinical-circumcision. 'On the other side where the Naijile Olinga's MoH clinic is, I met seven girls being circumcised through Modern clinical-circumcision.

All the MoH staff were circumcising, and some were insisting on Modern clinical-circumcision and or Medicalization of FGM/C. They are educated and have influence.

They should know better.

Excerpt 3:

Lengarde/ Leshunyai

Location: Kajiao **Population Size:** 15,000

Project Timeline: 2nd - 5th September 2016

GPS Coordination: Longitudes 360 5' and 370 5' East - Latitudes 10 0' and 30 0' South

“I remember the same picture of these two fat women who held me down tightly. The memories are still fresh like it happens yesterday. I remember my friend who was the same as me who died after the process because she lost a lot of blood. I was extremely terrified after hearing my friend screaming and shouting for help because of the pain caused by the cutting. I tried to escape but they brought back. I remember the old try used to carry the broken pieces of glass that were used as the instruments for the procedure another says I remember not being able to sleep, walk and urinate for days”

From all these flashbacks the participants noted that what they underwent through when they were young, the memories keeps on coming back and this has affected them because they did not have anyone to talk to and get the necessary help.

THE IMPACT – SELECTED CASE STUDIES

Case Study 1 - Low awareness/traditional, intransigent attitudes:

Kentai, 55, has lived in Magadi, Kajiado County for the past 20 years. For many years she used to circumcise young girls but stopped when she reflected on the suffering she herself had undergone. However, despite the best efforts of medical field staff and NGOs, she alluded to the deep-rooted traditional beliefs and lack of awareness and knowledge, particularly among those from older generations.

“There are still traditionalists in Kajiado County. When they want me to make a deep cut and I refuse, they get angry”

Case Study 2 - Low awareness/knowledge:

In many parts of Narok, a chronic state of ignorance is compounded by a dangerous set of traditional practices. The following story is a powerful reminder of the need for continued awareness raising and advocacy, particularly in the rural remote areas of the vast Narok County.

“Naisuda - A seven year old girl from Oloolololo village had been circumcised. For three days she suffered from being unable to urinate and showed signs of infection. The parents dug a hole in the yard and put fire in it with ‘cow dung’ -the stools of a cow. They believed this would control the infection. The girl was seriously burnt, and died six

Case Study 3 - Increased awareness/knowledge, but negligible behaviour change due to various factors:

Jacinta Lontomon, who works with Nomadic Communities on behalf of the National Committee on Traditional Practices in Kenya, spoke about the need for continued action.

“Education is the best way to halt mutilation, but posters and workshops are not enough.....the circumcisers may be aware of the harmful effects of FGM/C, but if they do not have something else to do, then they will continue to practice it.”

Women who practice FGM/C earn vast sums by Pastoralists’ standards, whether at home or in nomadic settlements. Nomadic culture is very flexible, and if viable alternative incomes can be found for their circumcisers, one day they may be willing to stop the practice altogether.

Case Study 4 - Increased awareness/knowledge, but negligible behaviour change due to various factors:

It is often the case that men, despite knowing the risks and complications associated with FGM/C, continue to insist on marrying circumcised women. This story was told to ‘The Talking Trees Project’ as another example of how increased awareness and knowledge does not necessarily led to changes in behaviour.

“A learned Masaai man came from the UK to take a wife from Narok, and his family chose a nice girl from a good family. The arrangements for the wedding went smoothly. The man was happy. Just before the wedding, the father decided to inform the man that his daughter was not circumcised. Once the man came to know that his chosen bride was not circumcised, he left the place quietly and without greeting anyone. He went back to the UK the following day. Luckily, the girl married

Case Study 5 -Behaviour change:

Doris Atieno - A Charity health worker described a visit to Kona Baridi village near Namanga Town to see two sick girls:

“We were called to the village to visit two girls who had become very sick after an FGM operation. After inquiring as to who had performed the operation, we discovered that it was an elderly lady, who provided her ‘service’ to villages within a 50km radius. She showed us the place where she performed the operation, which was near to where she kept her animals, and patently unhygienic. Discussions with the old lady revealed that she was aware of the debates surrounding FGM/C, having attended community level discussions on the topic.

However, she believed it to be part of the Masaai culture and tradition, and she pointed out that she had no alternative source of income. We encouraged her to attend more meetings on the topic, particularly with religious leaders, and also offered to provide her with training on how to be a Traditional Birth Attendant (TBA). Six months later, she started work as a Traditional Birth Attendant (TBA) in Kona Baridi, a village near Namanga Town'.

CONSTRAINTS

During 'The Talking Trees Project' forums, the case studies above were chosen to illustrate the three stages that people are at within the pastoralists' communities: (i) complete lack of awareness, (ii) minimal awareness but negligible behaviour change, and (iii) awareness and behaviour change. Yet the stories also reflect some of the constraints faced by those seeking to end FGM/C.

In the first anecdote, Kentai, came under tremendous pressure from traditionalists in Magadi, Kajiado County to perform FGM/C on their daughters and/or female relatives. Deep rooted traditional beliefs and a lack of awareness still exists, notwithstanding the efforts of the international and national communities.

The second case study, where smoke is applied to the genitalia of Naisuda - a seven year old girl from Oloolololo village, is a stark reminder of the ignorance, traditional customs and overall lack of awareness and knowledge that often prevails in rural areas.

The third case, Jacinta Lontomon argues that not only is it important to educate the community about FGM/C, but that alternative sources of employment need to be found for the circumcisers, who will otherwise continue to promote the practice. She said that:

“Education is the best way to halt mutilation, but posters and workshops are not enough.....the circumcisers may be aware of the harmful effects of FGM/C, but if they do not have something else to do, then they will continue to practice it.”

Case four illustrates that an increased exposure to potential knowledge and awareness does not necessarily translate into a change in behaviour. The learned Masaai man from the UK still insists that his wife be circumcised, in spite of, or perhaps because of, being part of a Masaai Diaspora.

Thankfully, in Case Study five, the Charity health worker manages to persuade the FGM/C practitioner to give up the practice, and arranges for her to undertake training to become a Traditional Birth Attendant (TBA).

Case Study 6

Case Study six offers another good example of positive behaviour change. In the story, Mildred Naisula, 55 years old - a practitioner in Oljororok town gives up FGM/C practices after attending a series of workshops targeting circumcisers, Traditional Birth Attendants (TBAs), religious leaders and community elders. The workshops highlighted the many negative consequences of the FGM/C practice.

Another potential constraint can be the attitudes and advocacy strategies adopted by the international community. Rather than judging communities and condemning the entire pastoralists and FGM/C practicing communities, a sensitive long-term approach is needed that

takes into account the local context. In this respect, the voices of the pastoralists' people themselves are vital.

IV. Culture and FGM/C

Culture is defined as a particular people's beliefs in value orientations and value systems, which give meaning, logic and significance to their existence and experience in relation to both the universe and other human beings (Lewis D, 1996). In societies that practice Female Genital Mutilation (FGM/C), cultural elements such as behavioral norms, religious and particular beliefs are present (Momoh, 2005, 1). In this publication, culture is defined as belief systems that support the continuation of the FGM/C practice.

The participating women were asked why Female Genital Mutilation (FGM/C) was practiced in their communities. Based on the interviews, the most cited reason as to why Female Genital Mutilation (FGM/C) was practiced in their communities was: 'Faithfulness' or 'Fidelity' to one future husband. It was a common belief in their communities that, cutting the hood of the clitoris of a woman diminished the sexual needs of the woman. Womanhood, which was vied as only possible once a girl had undergone Female Genital Mutilation (FGM/C), was considered a rite of passage, where a girl moved from childhood into adulthood and was able to bear children and have a husband. Men were allowed to visit the family of the girl who had undergone FGM/C in the hopes of marriage, while in the case of those who were not mutilated, it was vice-versa. Young girls chose to be mutilated to avoid peer pressure, rejection from the community, name-calling and receiving presents from their parents.

"Cleanliness" and "Beautiful" were also mentioned as cultural beliefs that supported the continuation of Female Genital Mutilation (FGM/C) in many of the study locations. Removal of the clitoris was considered feminine by taking away the clitoris that many believed could grow and resemble the penis if it was not cut. Some participating women cited the total removal of the clitoris as beautiful. The PI found out that, the girls believed what they were told with their elders that if a girl was not circumcised, before delivery, the baby's head would touch the clitoris and die, and so they chose to be mutilated out of fear.

V. Religion and FGM/C

Various religions are currently not in favor of the continuation of Female Genital Mutilation (FGM/C) practices. From the interviewees, based on the analysis and information from the interviews, the women were told that FGM/C practice had religious justifications and therefore they had to do it, if they wanted to be religious women.

In some parts of the world where the Islamic believers are, the leaders are arguing that FGM/C should not be practiced because it is altering God's creation, while in some parts they are supporting the FGM/C practice according to the interpretation of Koran by various leaders. Christians have also spoken about the FGM/C practice both in the churches and in seminars organized for both women and young girls to teach them about the negative effects of Female Genital Mutilation (FGM/C). However, with some Christians, the FGM/C practice has remained part of the deep rooted tradition that they feel should be continued and not ignored. (*See. Figure: Alternative rites of passage seminar Banner of the P.C.E.A church below*).

The traditional beliefs have continued to be stronger in most African regions and many have made many religious women to become strict followers of their cultures, which is one of the reasons why the practice is still practiced in many parts of the continent. From most participants' point of view, it was mentioned that, many girls were mutilated in the rural areas compared to those in urban areas. Illiteracy was deemed as the main reason for the FGM/C prevalence rates in the rural areas, where many allowed crucial decisions concerning their bodies to be made for them by the

elderly. Maintaining gender identity and appeasing the ancestors and making them happy was another reason mentioned during the interviews.

Some project participants, who adhere to the Islamic religion, had different perceptions about the Female Genital Mutilation (FGM/C) practice compared to their Christians counterparts. Islamic believers supported opinions on FGM/C practice because of the information they received from their parents and community elders as children.

However, after attending the 'The Talking Trees Project' and getting enlightened with facts on FGM/C, they became angry about the FGM/C practice, considering what they had undergone and the information they had received from their parents and community elders as children.

Christian women participants expressed their opinions by saying that there was no reason why FGM/C was being practiced. They concurred that if it was causing harm, torture and made women feel incomplete, then it ought to be abandoned. A few churches within Kenya that have shown co-operation in the campaign against FGM/C include: Evangelical Lutheran church, Seventh Day Adventist church, Catholic Church, Anglican Church, Presbyterian Church of Eastern Africa.

At the end of every forum in the 22 project locations, many women developed very positive attitude towards the eradication of FGM/C practices and agreed not allow it to be done on their own daughters no matter the circumstances and pressure from their communities. This attitude led to the increase in the number of women who wanted to stop the continuation of FGM/C thus, giving birth to the 'Open Declarations on the Abandonment of FGM/C' in the 22 aforementioned small towns and villages in Narok and Kajiado Counties.

VI. Human Rights and FGM/C

Human Rights refer to the basic rights and freedoms that all people are entitled to regardless of their nationality, ethic, origin, sex, language or other status (Amnesty 2010). Most of the African countries where FGM/C is still practiced do not have strong Human Rights records. These countries consider the FGM/C practice as their century old traditions, which girls must undergo in order to conform and fit in their societies.

Traditional circumcisers who also double as midwives or traditional birth attendants, do this kind of work in order to earn a living. Illiteracy is strongly cited as one of the reasons why the FGM/C practice still thrives. Majority of people in these communities do not know their rights and the consequences FGM/C and its effects on maternal healthcare.

According to the information and analysis based on the interviews given by participants of this study, the 'Talking Trees Project' had awakened them and made them aware on the consequences of FGM/C and enlightened them of their own rights. Nonetheless, in areas where majority of the participants had undergone the FGM/C procedure and therefore had no idea why there were so many hullabalos about the FGM/C practice was all about. Some felt that it was too late to undo the damage done already. However, the correlation between the problems they had experienced after undergoing FGM/C and the kind of education and help they had they had received through the 'Talking Trees Project' had helped them to relate to their experiences and to come up with ways they could recognize whenever they perceived that their rights were being violated by THE Female Genital Mutilation (FGM/C) practice.

The first point that was mentioned by all the participants was that they were mutilated when they were young without themselves being consulted whether they wanted to undergo the FGM/C

procedure or not. By cutting away the clitoris that is used to stimulate the sexual desire of the women and causing other harm to them, they felt robbed off their right to enjoy sex. Some women had also been left unproductive due to complications that arose from the FGM/C procedure.

Using unsterilized instruments/ tools and no medication, and using one instrument for many of girls created avenues for contracting HIV/Aids infections. If an FGM/C victim got an infection, she was not allowed to see a doctor or to seek medical attention at a hospital. Through these, the FGM/C victims felt they were robbed off their right to healthcare.

GOOD PRACTICES

LEGISLATIONS ON FGM/C IN KENYA:

The Prohibition of Female Genital Mutilation (FGM/C) Act No. 32 of 2011:

The Prohibition of Female Genital Mutilation Act No. 32 of 2011 (hereinafter known as the FGM/C law) entered effect on 4th October 2011. This law was a culmination of many years of activism by the civil society raising the alarm over the increase in of FGM/C practices in Kenya. The Prohibition of Female Genital Mutilation Act (PFGM, Act) was a great success towards eradication of the vice and an improvement of the existing laws on Female Genital Mutilation (FGM/C) offences in Kenya which were mainly contained in the Children's Act and the Penal code. The FGM/C Act provides for the protection from/prevention of FGM/C and advocates for the promotion of girl-child and women rights.

Outstanding features of the FGM/C Act include:

- The fact that the law does not allow any person taken to court over any of the offences to claim that culture requirements or religious beliefs or consent of the victim or even ignorance of the law was the reason for the act.
- The law punishes anyone who aids or albeit the practice
- The Act has punished medicalization of FGM/C – act carried out by example, doctors, clinical officers, nurses, midwife or medical students.
- The offence of hiring a person to perform female genital mutilation in another country or inviting the person to Kenya to carrying out the exercise.
- The offence of use of premises to perform female genital mutilation
- The Offence of being in possession of tools and/or equipment connected to FGM/C
- Offence of failure to report commission of the act of FGM/C
- Offence of using abusive language meant to ridicule, embarrass or harm a woman for having not undergone FGM/C, or a man for marrying or supporting woman who has not undergone FGM/C.

Other Supporting legislations include:

- I. **The Constitution of Kenya, 2010** - The foundation of the FGM/C law in the Kenya Constitution guarantees women and children the right to be free from all forms of

discrimination; the right to dignity and physical integrity, including freedom from violence; the right to health and the right not to be compelled to undergo any harmful cultural practices. Article 44 prevents any person from forcing another person to perform, observe, or undergo any cultural practice or rite such as FGM/C. Equally, Article 53 on protects children from harmful cultural practices such as FGM/C and Article 53 requires the government to put into place programmes such as awareness creation in order to protect the youth from harmful cultural practices.

- II. **The Children’s Act, 2001**- does not allow any person to perform FGM/C and other harmful practices that “negatively affect” children (persons under 18 years), providing a penalty of twelve months imprisonment and/or a fine not exceeding fifty thousand shillings.
- III. **Penal Code** - outlaws the deliberate infliction of “grievous bodily harm” (which includes FGM/C) on anyone.
- IV. **The Medical Practitioners and Dentist Act**- practitioners performing FGM/C will have their licenses revoked.
- V. **Nurses Act**- Nurses performing FGM/C will have their licenses revoked.

LEGAL/POLICY FRAMEWORK FOR THE ABANDONMENT OF FGM/C IN KENYA:

The Government of Kenya recognizes that FGM/C is a fundamental violation of the rights of women and girls. Decrees and bans against FGM/C were issued in 1982, 1989, 1998 and 2001. The Children’s Act of 2001 prohibits FGM/C and other harmful practices that “negatively affect” children under 18 years old, imposing a penalty of twelve months of imprisonment and/or a fine. Nevertheless, since the Act only applies to children and was not widely publicized by the government, its impact has been limited.

Policies and action plans were also set up to address FGM/C. They include Sessional Paper No. 5 on the National Population Policy for Sustainable Development (1999); the National Reproductive Health Policy Enhancing Reproductive Health Status for all Kenyans (2007); the National Plan of Action for the Elimination of Female Genital Mutilation (FGM/C) in Kenya (2008-2012); the Adolescent and Reproductive Health Policy and Plan of Action (2005-2015); Vision 2030, and the draft Reproductive Health and Rights Bill (2008).

These strategies and policies reflect an understanding that FGM/C presents serious health dangers to girls and women, and highlight the need to integrate FGM/C activities into the health, legal and social systems in order to accelerate abandonment of the practice. The Ministry of Health prohibits all medical personnel from performing FGM/C.

The National Plan of Action of the Government of Kenya on FGM/C (2008-2012) supports coordination, networking and collaboration among key stakeholders across the public, civil and private sectors. The National Policy for the Abandonment of FGM/C (2009) analyses the prevalence, trends and types of FGM/C in Kenya, and proposes a comprehensive set of activities to encourage abandonment of the practice. The most recent development was the Prohibition of FGM/C Law that was passed in 2011.

THE NATIONAL FGM/C POLICY IN KENYA:

The main purpose of the Policy is to establish a clear vision on FGM/C and make commitments that would guide and accelerate abandonment of FGM/C. The policy is currently being reviewed to be in line with the Constitution of Kenya 2010. The following are the proposals. The Government should;

- Build capacity for law enforcement officers through training and educate the girls and women on the rights of girls and women to be protected against FGM/C.
- Hold public awareness campaigns aimed at educating and encouraging the public to support the legislative efforts to abandon FGM/C.
- Develop and improve services for access to justice, recovery, rehabilitation and integration of girls and women who have suffered from FGM/C. This can be done by identifying a child/woman and help them get access to justice or a rehabilitation centre.
- Promote male involvement in the FGM/C abandonment programme because this is not just a woman's problem.
- Involve community leaders, chiefs, traditional circumcisers, opinion leaders in awareness programmes to foster ownership of the process by the communities and minimize opposition to the FGM/C abandonment.
- Collaborate with the police, opinion leaders, chiefs and community leaders to provide support services in terms of protection.

THE FGM/C STAKEHOLDERS IN KENYA:

Key players engaged in FGM/C activism at the national and/or community levels in Kenya comprise of: government actors, in particular the Ministry of Gender, Children and Social Development, and the Ministry of Public Health and Sanitation; individual Members of Parliament; non-governmental organizations including other organizations like: the Kenya Female Advisory Organization (KEFEADO), CARE, Action Aid, World Vision Kenya, Rural Women's Peace Link (RWPL), and the Socially Organized Education Team (SOET); UN organizations, in particular UNICEF and UNFPA, and other development partners such as the Swedish International Development Agency (SIDA), the Italian Embassy, Norwegian Agency for Development Cooperation (NORAD), German Development Cooperation (GIZ), World Health Organization (WHO), the World Bank, the Netherlands Embassy, and the Austrian Embassy.

THE KENYA NATIONAL FGM/C PLAN OF ACTION:

The plan of action is targeted to enable all partners at all levels to make the best use of their individual and collective support for an effective and efficient national response to FGM/C and avoid duplication and fragmentation of resources. The plan of action is the foundation of Government and civil society unity in fighting FGM/C; national coordinated action. This process is supported by United Nations Population Fund (UNFPA) and UNICEF.

THE KENYA ANTI - FGM/C BOARD:

This is the main government agency responsible for managing programs on FGM/C. It is responsible for protecting women and girls from FGM/C, provide support services to victims of FGM/C and undertaking public education to sensitize communities practicing FGM/C about the law and dangers of FGM/C. The board works in partnership with other agencies and organisations to ensure arrests of offenders whenever reports are made to the board, provide shelter, medical aid, legal aid and other requirements for the victim of FGM/C.

SERVICES FOR WOMEN AND GIRLS WITH OR AT RISK OF FGM/C IN KENYA:

The Talking Trees Project' team compiled an inventory of existing indigenous healthcare facilities that provide services to girls and women affected by FGM/C. They also mapped facilities that offer training and capacity building activities relevant to management and sharing of

data in order to improve research collaborations and to share research findings in ways that accelerate progress in public health.

Kenya Government in collaboration with United Nations Population Fund (UNFPA) and United Nations Children's Fund (UNICEF) implements a joint programme that works toward combating FGM/C in line with United Nations Development Agency Fund (UNDAF) that looks at transformational governance. The agencies collaborate with various NGOs to provide the following services:

- Legal aid,
- Shelter,
- Medical services,
- Legal education,
- Training of service providers
- Psychosocial support,
- Public Awareness
- Resource mobilization – funds to support FGM/C interventions

Whereas the law is targeted at apply in the whole country, these services are intensified in the regions where FGM/C is prevalent. There are several Civil Society lead outreach programmes to educate the communities against FGM/C.

Key successes these services include:

- a. **National Coordination** and management of FGM/C by both Government and Civil Society. There exists a **National Secretariat** that provides the lead in fighting FGM/C in the Country.
- b. **The National coordination** has lead to the engagement of cultural elders (Culture gatekeepers) to engage in discussions of the harm FGM/C cause on girls and women. Certain community elders example '*Njuri Njeke*' – cultural leaders of the *Meru*, Cultural leaders of the *Kuria*, *Pokot* were engaged and upon agreeing to dropping the act they went ahead to form cultural punishments for those found still carrying out the act. These leaders also made declarations in their communities banning FGM/C and instead support girl child empowerment.
- c. **Stakeholder Networks:** Counties like *Baringo*, *Naivasha*, *Samburu*, *Kuria* formed networks of different stakeholders working on FGM/C. These networks are chaired by the respective children's officers who also lead the fight against harmful cultural practices on children. The networks monitor and identify perpetrators from arrest and prosecution. They also provide preventive measures by increasing awareness levels at the community level
- d. **Government and Civil Society:** Working together to support the **Alternative Rite of Passage (ARP)**. ARP has been used to enable the girls still go through life skills education, health and hygiene classes and general maturity talks without undergoing the cut.
- e. **Religious Leaders:** Both Christian and Muslim have publicly denounced FGM/C to have no basis in religion. This greatly helped especially in communities that believed FGM/C was religious.

- f. **Media Support:** Various media houses have taken up FGM/C seriously and have continuously highlighted FGM/C as an issue of national concern-reporting on the occurrence of FGM/C. The media has also reported on positive developments such as;
 - i) Jailing of perpetrators of FGM/C,
 - ii) Girls undergoing Alternative Rites of Passage
 - iii) Opinion leaders' declaration against FGM/C.
- g. **Judicial Engagement:** Prosecution and Improvement of perpetrators. The government established an **Anti FGM/C Unit** under the Director of Public Prosecution (DPP) office that leads the arrest and prosecution of persons practicing FGM/C. Various CSOs have joined efforts in ensuring convictions. Federation of women lawyers recently provided support to the police and DPP office in prosecution of perpetrator of FGM/C who was sentenced for 7 years in prison. The accused appeal was equally denied. This case will be used as a precedent in creating awareness on the seriousness of the law. *Attached is the judgement.*
- h. Demographic Health Survey (DHS) – Kenya has now included data collection on FGM/C in the national statistics to advise development strategy. FGM/C is now nationally acknowledged as detrimental to the country's development.

INFORMATION ON HEALTH PROVIDERS PRACTICING FGM/C IN KENYA:

FGM/C is illegal in Kenya hence finding information on who are the service providers is anchored on high level investigations for purposes of prosecution. The information is not easily available. NGOs working on FGM/C more often than not, while working with communities are able to identify the service providers and where applicable sort for their arrest.

There are however organizations that identify the service providers for purposes of changing their attitudes and where possible show them an alternative sources of income once they down their tools of trade (Trade in FGM/C). The reformers are then targeted for the anti FGM/C campaigns in their communities.

Key challenges and opportunities for the abandonment of FGM/C:

- I. **Challenges:** Most communities practicing FGM/C in Kenya regard the practice as a badge of ethnic identity. FGM/C binds the community together, and those who do not cut are frequently regarded as “traitors” or “impostors”. Among the *Maasai, Meru, Marakwet* and other ethnic groups, the practice is embedded in an elaborate ritual of initiation into womanhood. For the outlawed *Mungiki* sect of the *Kikuyu*, the practice signifies a return to pre-colonial, “authentic” traditions, and is sometimes forced on women as a form of intimidation or retaliation.
- II. **The *Mungiki*** consider the notion of cultural identity as more important than the fact that FGM/C is illegal. Suppressing women's sexual desires is also cited as a reason for the continuation of the practice; it is one way of ensuring that sex for pleasure is discouraged before, during and outside of marriage. Uncircumcised women are thought to be easily aroused and may therefore behave in culturally inappropriate ways.
- III. In most practicing communities, FGM/C is seen as beneficial by girls and parents as a way to improve chances of marriage and encourage a high bride price. Among Kenyan Muslims performing FGM/C (including/in particular the Somali community) the practice is regarded as a religious requirement and obligation. In most communities, the decision to cut is typically made by both parents. As parents become increasingly aware of the health

risks of cutting by traditional means, FGM/C in Kenya has become medicalized, with some doctors setting up temporary FGM/C “clinics” during school holidays.

CHALLENGES FACING THE ELIMINATION OF FGM/C IN KENYA:

- A major challenge to FGM/C in Kenya is the increased medicalization of FGM/C. When the act is done in collaboration with the medics, it becomes almost impossible to realize the act has taken place and more difficult to prosecute parties to the action
- Although policies and strategies have been developed monitoring of the progress made remains a challenge. Example there are cases where even after passing through the alternative rite of passage girls are still sneaked to undergo the cut
- Not all cultural elders in the targeted regions were converted hence FGM/C still continues to enjoy the backing of such elders thus difficult to have attitude change among the communities.
- Inadequate knowledge by community members on the law of FGM/C and National Policy. This inhibits community members participation in ending FGM/C
- FGM/C is entrenched within cultures a major barrier towards abandonment of harmful cultural practices
- Political interference - some politicians continue to support FGM/C on the pretext of promoting their constituents’ culture and giving the people identity.
- Corruption - leading to release of perpetrators and/or no arrests.

OPPORTUNITIES FOR THE ABANDONMENT OF FGM/C IN KENYA:

- A history of efforts to abandon FGM/C at national and community levels; many government and non-government actors have gained considerable practical experience over time;
- The expanding legal and policy structure for empowering girls and women in Kenya promises protection from harmful practices and the persecution of perpetrators. It thereby holds the potential to support advocacy efforts to abandon FGM/C.
- Current reforms by the Kenyan government to its administrative, law enforcement and security agencies. The resulting changes present an opportunity to sensitize key actors in these institutions to play a more proactive role in community sensitization and in enforcing laws relevant to FGM/C abandonment. Heavy investment by the Kenyan government in mobilization and empowerment programmes for women and girls. These programmes offer opportunities for changing public views and, eventually, social conventions/norms and practices that influence gender roles and stereotypes.
- Providing men and boys with relevant information that was previously unknown to them. Given that FGM/C has traditionally been regarded as a women’s issue, men are seldom fully aware of the details of the practice or of its adverse effects on the lives of girls and women. Education holds the potential to engage them as active participants in efforts to abandon the practice.

LESSONS LEARNT:

- The ‘Talking Trees Project’ team learnt that the existing laws and policies without proper monitoring and evaluation would not be effective in combating FGM/C. Although

legislation is a key strategy in preventing the practice, legal instruments by themselves cannot end the FGM/C practices, since traditional and cultural beliefs are deeply rooted in societies. The ‘Talking Trees Project’ team supports any legislation that go hand in hand with education and awareness to have a lasting impact and change.

- Ending FGM/C lies more in change of attitudes and culture than in the implementation of the law. Like many FGM/C communities, the pastoralists’ communities’ device or find ways of circumventing the laws and as already stated, medicalization of FGM/C is one of the current major challenges in the fight against FGM/C.

DISCUSSION

The Talking Trees Project’ team discovered that Type **III** (Infibulation) and Type **I** (Clitoridectomy) are the most common types of FGM performed in most African countries. While Type **III** is mainly practiced by the Ethiopian, Somalian and Sudanese people. Type **I** FGM/C is practiced in Kenya, due to the stringent National policy and law banning FGM/C practices.

In both Narok and Kajiado Counties chosen by the PI as the study area, Type **I** form of FGM/C is preferred, because the pastoralists’ people consider it to be simple, not causing many health problems, can still be practiced and retain their cultural beliefs. Among the pastoralists’ communities found in all the 22 small towns and villages, the research found out that it was grandparents, community elders and other respected community representatives who supported the FGM/C practice. Some of the women and young girls chose to be mutilated for fear of being rejected by the community, family and friends.

Illiteracy in both older and young women played a heavy role in their decisions to practice and or abandonment of FGM/C practices. While many of the women who participated in this study did not know the consequences of Female Genital Mutilation (FGM/C), ignorance, lack of employment, poverty and lack of education seemed to have been the common variables that enabled the FGM/C practices to thrive among the pastoralists’ communities in Kenya today. However and in very rare circumstances, where girls moved out of their villages and communities to get formal education, they were likely to oppose Female Genital Mutilation (FGM/C) and in some situations they would choose to run away from their pressuring families to avoid being subjected to FGM/C practices, with a few ending up seeking refuge in churches and or organizations that support the elimination of the FGM/C practices.

From the ‘Talking Trees Project’ forums, debates and interviews conducted across the 22 villages, traditional customs and cultural beliefs also appeared to be the most apparent reasons that supported the basis and the continuation of Female Genital Mutilation (FGM/C) in these communities today. The FGM/C practice is done on girls and women of all ages, to avoid shame on their families by engaging in sex before marriage and not being able to find husbands in the future.

The criminalization of FGM/C practices and the safeguarding of women’s and children’s rights have also drastically reduced the age of the girls being mutilated in some in Kenya. (KDHS 1998), the government of Kenya outlawed Female Genital Mutilation (FGM/C) on anyone under the age of 18 years.

This study also discovered that, some girls choose to be mutilated to receive presents from parents and be accepted in the community by their age mates. Other reasons for practicing Female Genital Mutilation (FGM/C) according the administered interviews included pleasing the ancestors, to maintain gender identity by not allowing the clitoris to grow and resemble the male organs. Beliefs that if the clitoris of a woman was not cut, it could touch the newborn during delivery and it would die. Hygiene and beauty were some of the reasons why FGM/C is practiced.

While some communities across Africa practices Female Genital Mutilation (FGM/C) for religious reasons, The ‘Talking Trees Project’ research findings revealed that communities with strict religious backgrounds practice mutilation to show their commitment to their deity. However, some of the seventh day Adventist, Pentecostal and Lutheran adherents seem to practice the Female Genital Mutilation (FGM/C) for other reasons not based on the biblical teachings, but some are against the practice now. Nonetheless, Female Genital Mutilation (FGM/C) is more common among the Muslim communities (Mustafa 2001). This was also evident among the minority Muslim communities living in both Narok and Kajiado Counties (i.e. *in Narok, Kajiado, Isinya, Kitengela, Matasia and Magadi*) towns.

Age and Tools

The questions based on the age and tools used indicated that in all the 22 small towns and villages chosen as the research areas, Female Genital Mutilation (FGM/C) was performed on the girls and women. In some villages, the age for mutilation may have been as young as four years old while in some, it was done before puberty or before a woman who had not undergone FGM/C gave birth. The ‘Talking Trees Project’ research findings revealed that, only one instrument was used for all the girls without fear of transmitting diseases such as HIV/Aids and hepatitis. The instruments are traditionally improvised and no medication is used during the FGM/C procedure.

Physical Consequences of FGM/C

The ‘Talking Trees Project’ research findings also revealed that the extent of physical consequences FGM/C depend on the Type of FGM/C performed, as this differ from one family, village or community and from one county to the other. In communities where Type I was widely practiced, the health consequences that resulted thereof were considered minimal. Nonetheless, the health issues resulting from Type I form of FGM/C still presented permanent physical damages to the girls and women. In instances where FGM/C victims survived the excessive bleeding, fever, tetanus and urinary tract infections, other health issues crept up years or decades after the FGM/C procedure was done.

Psychological Consequences of FGM/C

The psychological problems from the interview revealed recurring nightmares about the mutilation day, the pain they went through and fear associated with that particular day. Some women reported that they were psychologically traumatized because the people they trusted would protect them such as their parents and grandparents allow such a painful thing to befall them. Difficulties to sit and lack of sleep resulting from the pain of were also reported.

Sexual Consequences of FGM/C

The ‘Talking Trees Project’ research findings disclosed that due to the removal of the clitoris, which is the sexual stimulant in women, many women from the FGM/C practicing communities in the study area did not experience sexual satisfaction from their husbands. Due to the vaginal hole being too small, many women admitted finding penetration and sexual intercourse to be very painful. Lack of sexual desire was also reported, which participants claimed led to divorce, due to dissatisfaction of the men and due to the pain women felt during sex.

Social Consequences of FGM/C

Many women participants reported embarrassment as a social consequence that kept them away from visiting pre-natal/post-natal care and other allied services from doctors or gynecologists. Many felt that they'd be discriminated against; because of the way their organs looked after the disfiguring caused by FGM/C.

In some communities, it was also found that girls choose to undergo the FGM/C procedure because of social pressure from peers, to avoid name-calling and in favour of finding husbands in the future. Additionally, Female Genital Mutilation (FGM/C) was highly favoured for its association with gifts to be received from loved ones by those who underwent the FGM/C procedure.

Female Genital Mutilation (FGM/C) causes physical, sexual and social health consequences to those who undergo the procedure. The consequences are either short- term or long- term depending on the type of FGM/C procedure performed on an individual. (Toubia and Rahman, 2000), WHO (2008).



**Figure 19: Masaai Women participants, taking part in the 'Talking Trees' Project in Namanga -Kajiado County
Photo Credit: Eric Lemaiyan - The Talking Trees Project 2016-2017.**

CONCLUSION

The discussion above is based on the results, the process of gathering the information, challenges, and limitations encountered during this research process. The result confirms that the practice of FGM/C is a social consequence that is affecting a number of women and young girls socially, psychological and physically. To eradicate the practice, there is a need for education campaigns in the communities that practice FGM/C.

Although many African countries have criminalized the practice of FGM/C, it is not enough because Female Genital Mutilation (FGM/C) is deeply rooted in cultural and traditional practices. The campaigns against FGM/C need to include topics on human rights violations and the harmful effects caused by Female Genital Mutilation (FGM/C).

Issues dealing with culture are so sensitive and therefore those planning to tackle Female Genital Mutilation (FGM/C) should have enough knowledge on other people's culture and should not generalize culture, when discussing about people and their culture, also historical, economical social, political and geographical factors need to be taken into consideration, when dealing with indigenous people and their way of life. In this regard, this study is significant not only for PI and the research team, but also for everyone interested in the protection of women's and children's rights, by advocating against cultures that put children and women at risk.

This study started in June 2016 when the research proposal topic was accepted by the Wellcome Trust- a biomedical research charity based in London, UK. The main objectives of this project were to:

- Awaken the interest of pastoralists' communities and intensifying their participation in future community health research and project implementation.
- Raise awareness on the dangers of FGM/C and to advocate for behavioral/ attitude change towards the practice of FGM/C.
- Develop community health research infrastructure and improve pastoralists' communities' livelihoods- through project workshops and seminars.
- Forge stronger project collaborations among the researchers, gynecologists, pastoralist communities and the public.
- Strengthen capacity for future collaborations in quality public engagement work locally, regionally and globally
- Involve pastoral communities in participatory health forums to deepen their understanding, to impact their behavioral change around FGM/C.
- Develop strategies for galvanizing positive social change, in order to influence policies that support the development and promotion of alternative rites of passage through scientific research, tested and proven approaches for programs that promote best practices in abandoning FGM/C practices.

Additionally, it was equally important to bring out the issues of FGM/C, by providing information on the flashbacks of women who have undergone FGM/C and to, find out how the FGM/C procedure was carried out, the complications involved after the FGM/C practice, cultural factors influencing the continuation of FGM/C, religious views and how the practice violates the rights of children and women.

Since FGM/C is becoming a global threat to the rights of women and girls, this publication contributes to the knowledge already published by other researches concerning the Female Genital Mutilation (FGM/C) practice and also intensifies local efforts, by sharing global-good

practices that will effectively assist in the elimination of Female Genital Mutilation (FGM/C) in Kenya.

The research started by conducting the interviews, which took part within the schedule and agreed upon durations. The interviewers were co operative and everything went as expected. Finding information on books and through the internet was also successful although with limited results. Organizations fighting for the elimination of FGM/C also provided helpful information during this research.

The ‘Talking Trees’ study on the maternal deaths prevalent among pastoralists’ communities of Kenya’ was necessary, due to the little knowledge about the practice of FGM/C in the public domain. Because the Kenyan public does not know much on the practice, it was important to introduce the FGM/C subject, to help foster more campaigns against FGM/C and to bolster the abandonment of the practice in its totality.

Finalizing and winding up the research was very challenging, as this was the first research ever to be conducted within the pastoralists’ communities in the aforementioned study locations. The pastoralists communities had become accustomed to the forums and even look forward to the ‘Talking Trees’ programs. The time the research team spent with the pastoralists’ communities was challenging, but very rewarding at the same time. The skills and experiences gained during the whole process were priceless.

The goals that had been set for the research were accomplished. The research questions were answered according to the information collected from the interviews, library books and the internet. The following themes helped in answering the research questions: Flashbacks and FGM/C, Culture and FGM/C, Human Rights and FGM/C. Personally, and professionally, the project team gained a lot of experience while writing analyzing the research data and preparing the script for this publication.

This project has had positive impact on the project team, in that it has increased their professional development. The entire project team gained knowledge on culturally sensitive practices. This knowledge will remain with them and be put to use their future FGM/C related assignments.

The UN Human Rights law stipulates that every individual has the right to enjoy protection despite their color, ethnic background, nationality or age. However, in the places where FGM/C is practiced, it violets the rights of women and children. Female Genital Mutilation (FGM/C) is cruel, harmful, painful and affects the health of others unnecessarily. Currently the practice is not only seen as a violation of human rights but also a criminal offence among many African countries.

It is therefore crucial for those who already have knowledge on the Female Genital Mutilation (FGM/C) to educate and empower, women and girls by providing information about the dangers and consequences of practice, in order to speed up the momentum against FGM/C and towards complete elimination of the practice. Community health workers should also be encouraged to report any suspected cases of FGM/C practices. Publishing materials in indigenous languages can also help in the elimination of the FGM.

Lastly, Female Genital Mutilation (FGM/C) being a sensitive issue among many cultures of the world, many areas on this topic still needs to be researched. This publication is therefore deemed beneficial not only to the communities where this study took place, but also to community health workers, who work with indigenous groups. Through understanding other people’s cultures, community workers will be able to identify the dangerous cultural practices like FGM/C and be able to save those subjected it unwillingly. It could also act as a future research topic for those who are interested in knowing more about Female Genital Mutilation (FGM/C).

RECOMMENDATIONS

The battle for the abolition of FGM/C is definitely one that is too difficult to be left to individual crusaders and little old women. It has to be fought by all and particularly by government and by professionals such as Obstetricians, Gynecologists, Pediatricians, Nurses and Midwives who are the ones who have to deal with the serious complications caused by female genital mutilation.

Strategies for the eradication of FGM/C

A. Getting FGM/C Laws:

- To date the Kenyan government has made several legal policies, declarations and resolutions against FGM/C. The first priority is to lobby the government to enact more strict laws forbidding FGM/C practices.
- The international community needs to play a more important role in assisting the government to put such a law in place.

B. Involvement of Religious Leaders:

- **Religious leaders:** (i.e. clergy, imams, priests, and deacons) are looked up to for trusted advice and social direction in communities. If they state with a unanimous voice that FGM/C is prohibited in their respective religions, it will go a long way in convincing the general population to abandon the FGM/C practice.
- **Understanding FGM/C:** Which is considered a women's issue. Pastoralists' men don't generally think very much of it, that includes traditional and learned pastoralists' men too.
- **Legality or illegality of FGM/C:** In a religious context, religious leaders can be made aware of existing religious scholarly work available on the FGM/C subject. If possible they can be sent to religious centers and universities for further training and sensitization and to learn from the experiences of communities who have abandoned the FGM/C practice.
- **Support Networks:** Initiatives that have undertaken the sensitization of religious leaders have found that once this group understands the issues and the severity of the problem, they become strong supporters of its abolition.
- **Advocacy:** Once religious leaders are on board their stand must be shown to the public; through the weekly sermons in Mosques, in churches, in Barazas, through television and radio programs, through religious Sunday schools or Madrasas. Information tools such as CDs and DVDs with recorded messages can be developed so their testimony can be taken to remote locations. As agents of change, religious leaders can be put to full use.

C. Sensitizing key Healthcare Professionals:

- **Including more people:** Sensitizing healthcare professionals will increase the number of persons actively involved in the campaign against FGM/C.
- **Coordination/Conformity/Consistency/Uniformity:** FGM/C training must be uniform, to increase/achieve the impact and to avoid mixed messages. Organizations and partners working against FGM/C need to coordinate efforts to ensure a consistent approach.

- **Tools:** training needs to include the tools that healthcare professionals can use to counsel and intervene in FGM/C. These could include booklets, pamphlets, audios and videos made in the local/vernacular languages of the communities being addressed.
- **Data:** Informed and equipped health professional can help collect data about the current state of FGM/C in Kenya as well as keep a record of the progress they make in their individual locations.

D. Sensitization of the Community:

- **Young girls and women:** need to be targeted directly so they become informed about their conditions, options and rights. Establishing early communication with this group at can influence and change their decisions on performing FGM/C on their own daughters later on.
- **FGM/C education:** More efforts should be made to make FGM/C education a part of the school curriculum of all primary, secondary and medical and nursing schools.
- **Parents:** As the primary decision makers in cases FGM/C practices, parents and especially mothers are the most essential group to persuade. Early contact with them needs to be consistent and continuous if progress is to be made in the FGM/C campaign.
- **Men:** FGM/C: although they don't discuss much of it, FGM/C is done primarily to garner their pleasure, and to secure marriage proposals from them. They need to be brought into the FGM/C perspective and be informed of the undesirability/consequences of the FGM/C practices from a cultural, health and sexual contexts. If this group no longer feels that a girl must undergo FGM/C in order to be suitable for marriage, then the stigma of being uncut can be alleviated and more families might abandon it on their own convolution.

E. The Business Community

Members of this group tend to have higher levels of education and appreciation for personal health. Educating them about FGM/C can affect the decisions they make in their own families and the advice they dispense in their circles of influence, especially within their communities.

F. A permanent Media on FGM/C

The campaign against FGM/C cannot be a sporadic or an annual event. This is a serious human rights and health violation issue that effects young children and women across boundaries. A permanent Media presence through billboards, press releases, newspaper articles, pamphlets, videos and CDs, seminars and workshops, websites and blogs, with designs that combine sensitivity with practical evidence against outdated traditions and cultures like FGM/C could help eradicate these practices.

H. Research

More research needs to be done on FGM/C prevalence among the pastoralists' people and communities of Kenya. As of now there is little or no reliable data on FGM/C. Although this study aims to remedy that, there is still room for research and a lot of work that needs to be done.

H. Possible Research Questions to be addressed in Future:

Since more data on the prevalence and Types of FGM/C practices performed among the Pastoralists communities of Kenya is still required, the following research questions mark the second phase of the 'Talking Trees Project' study that will incorporate more pastoralists communities (like the *Somalia, Samburu, Rendile, Kalenjin, Pokot, Borana and Turkana*)

communities. These questions are also deemed suitable for foreign and local researchers looking forward to studying FGM/C as a research topic in Kenya.

- Which type of FGM/C is more frequent?
- Why do those who choose type **III** make that decision?
- Why do those who choose a less invasive type of FGM/C make that decision?
- Can the underlining reasons for choosing one type of FGM/C vs. another be used to influence families to choose a less invasive procedure or to abandon the FGM/C practice altogether?
- What about those that have not undergone FGM/C?
- How did they come to that decision?
- What kind of difficulties have they faced?
- What would have made their choice easier to live with?
- What are the correlations between education and FGM/C?
- What are the correlations between Income and FGM/C?
- Some pastoralists' members have family members living abroad who maintain strong ties and who send remittances from the Diaspora. How do pastoralists' people in the Diaspora feel about FGM/C?
- Do they have any influence over their families in their villages/communities regarding FGM/C?
- Can this connection be used in the FGM/C eradication campaign?
- What ideas about women's sexuality are inherent in the practice of FGM/C?
- Are those reasons openly spoken about or more hidden?
- What about Age, Attitude and FGM/C?
- How do youth, male and female feel about FGM/C?
- Can intensive education campaigns aimed at this group help to stop this practice?
- What about the Medicalization of FGM/C?

- Are health professionals expected to be partners in the performance/elimination of FGM/C?
- What are the personal views of health professionals on the FGM/C Subject?
- Do they practice the custom in their private and non-professional lives?
- How about religion and FGM/C?
- Can a campaign more focused on the religious impermissibility of the practice be more effective than one that stresses health complications or human rights violations?

I. Monitoring and Documentation:

To take full advantage of resources and to measure achievements when necessary, careful monitoring and documenting techniques must be applied in tackling Female Genital Mutation (FGM/C).

The recommendations above indicate the need for wider and an all encompassing approach in the fight against Female Genital Mutation (FGM/C). Because FGM/C practices are so pervasive, it is commendable that all areas of society be targeted, simultaneously and continuously in tackling the menaces posed by FGM/C.

APPENDIXES

Appendix 1: Form, Debate and Interview Questions

- 1 Where did Female Genital Mutilation originate from according to your culture?
- 2 How can you define Female Genital Mutilation?
- 3 What are the different types of Female Genital Mutilation practiced in your community?
- 4 What are some of the effects of Female Genital Mutilation reported in your community?
- 5 What are the reasons why Female Genital Mutilation is practiced in your community?
- 6 What is your understanding of the Basic Human Rights?
- 7 In your own opinion, how would you consider Female Genital Mutilation as a Human Right violation practice?
- 8 When or which time of the year is Female Genital Mutilation practiced in your community?
- 9 Who performs Female Genital Mutilation practiced on girls and women in your community?
- 11 How is culture involved in the practice of Female Genital Mutilation practiced in your community?

- 12 Do you think the practice of Female Genital Mutilation can be abandoned or completely stopped in your community

(See Appendix 2: The English Questionnaire of the ‘Talking Trees Project’)

Questionnaires for the collection of traditional and cultural knowledge and socio-economic data about Female Genital Mutilation (FGM/C) in Narok and Kajiado Counties.

1. Respondent’s details:

Name:

Male/ Female:

Age.....

Occupation:

Location (Name of Village):

Education Level:

Personal Questions:

1. From which village or community do you come?
2. Which language do you speak or understand very well?
3. Which languages are you most likely to use in everyday conversation?
4. In which languages would you like information materials on FGM/C?

Female Genital Mutilation (FGM/C) Questions:

5. Have you undergone FGM/C?
6. What type of FGM/C was performed?

7. At what age was FGM/C performed?
8. Who performed the FGM/C?
9. Where was the FGM/C performed?
10. Why was the FGM/C performed on you?
11. Will you have FGM/C performed on your daughter?
12. Which of the FGM/C Types do you or your community practice? (*They were given choices here)
13. What type of FGM/C would you have performed on your daughter?
14. If yes, why would you have FGM/C performed on your daughter?
15. How well do you understand the dangers and consequences of FGM/C?
16. How well do you understand the rights of women and children?
17. (Presented with a list of statements out of which their attitudes towards both FGM/C and early child marriage practices could be determined)
18. (Presented with a list of questions and statements out of which their feelings of group identity could be derived)

Project Specific Questions

5. When/How did you hear about the Talking Trees Project'?
7. In which ways do you involve in your communities activities?
14. What radio stations do you habitually listen to?
15. (*For those who listened to the NOSIM FM broadcast*) In what ways have you contributed to the broadcast on FGM/C programs?
16. (Presented with a list of statements designed to determine from the respondents if a cultural renaissance was accompanying the continuation of the FGM/C practices)
17. Why was this Talking Trees Project' initiated for this community?

15. Any additional comments/observations with respect to the existence of the FGM/C traditional conservation area within the study locations.

Appendix 3: The Informed Consent

THE FREE, PRIOR AND INFORMED CONSENT FORM (FPIC) FOR THE PASTORALISTS COMMUNITIES OF KENYA

Informed Consent Letter (The Enduring Voices Foundation)

Title of Study: “Talking Trees Project” - 'A public health research and forum addressing maternal deaths prevalent among pastoralists’ communities of Kenya”

Principal Investigator:

Name: Carolyne Adhiambo Ngara

Institutional Affiliation(s):

The Enduring Voices Foundation
P.O Box 38615 – 00100
Nairobi, Kenya
Email: carol.ngara@gmail.com
Phone: +254 -708766322

Background:

You are being invited to take part in the “Talking Trees Project”. Before you decide to participate in this study, it is important that you understand why the project is being done and what it will involve. Please take the time to read the following information carefully. Please ask the Project Manager to explain if there is anything that is not clear if you need more information.

The purpose of this study is:

Study Procedure:

Your expected time commitment for this study is: (1½ Hour)

Project Procedure:

This is meant to help the Project Manager to collect empirical evidence that will help her gain insight into Pastoralists’ communities, historical background, language, culture, religion, traditional practices and ecological knowledge. It is meant to help in documenting “Talking Trees Project” - 'A public health research and forum addressing maternal deaths prevalent among pastoralists’ communities of Kenya”.

The Project Manager aims to collect and create audio, record video, graphic and text documentation material covering a wider knowledge on your historical background, linguistic, cultural, religious and traditional practices like: Female Genital Mutilation (FGM/C), Early child-marriage and Samburu Girl-Beading in a variety of your communities’ social and cultural contexts.

The importance of your participation in the ‘Talking Trees Project’s forums and debates is to help us in collecting, recording, analyzing, and archiving data on FGM/C and to create a range of high quality materials to support description of a variety of your pastoralists’ communities’ phenomena, to enable you to join us in the global campaign against FGM/C, and to help us in the knowledge and literature concerning FGM/C and other cultures of the of the pastoralists’ people and to keep it the information gathered and the project materials safe, in the event that all other sources are lost.

Risks:

The risks of talking part in this study are minimal. These risks are similar to those you experience when disclosing work-related or population censors information to others. The topics in this project may upset you or some respondents. However, you may decline to answer any or all questions and can terminate your involvement in this project at any time if you choose so.

Benefits:

There will be no direct benefits (Monetary or Otherwise) to you for your participation in this study/project.

However, we hope that the information obtained from this project may above all things:

1. Raise awareness on the dangers of FGM/C among your people.
2. Bring changes in you communities’ attitudes against the practice of FGM/C and early child-marriages;
3. Help your people to forge a strong sense of community identity by increasing participation their people in voluntary Public Declarations on the Abandonment of Female Genital Mutilation (FGM/C) and early child-marriage practices;
4. Increase the number of pastoralists’ communities’ declaring and abandoning FGM/C and early child-marriage practices.
5. Act as a green light for continuous community-led initiatives championing the Abandonment of FGM/C and early child-marriage practices - long after this project has ended.
6. Develop standard community oriented project materials to be made available at repository local to your pastoralists’ people and also be archived via the Wellcome Trust’s archives.
7. Decrease the rates of pastoralists’ families wanting to cut their girls by 2%.
8. Awaken your interest intensify your participation in your own community health research and project implementation.
9. Improve your communities’ livelihoods through their regular participation in the ‘Talking Trees Project’ forums, debates, workshops and seminars.
10. Foster continued community-centered research programs and collaboration between researchers, stakeholders, policy makers and the pastoralists’ communities.

Alternative Procedures:

If you do not want to be in the study, you may choose not to participate and leave your answers blank.

Confidentiality:

Please do write any identifying information on your questionnaire. Your responses will be anonymous.

OR

For the purposes of this project, your comments will not be anonymous unless you request that they be. You may request that all or part of your responses be kept anonymous at any time.

Every effort will be made by the Project Manager to preserve your confidentiality including the following:

- Assigning code names/numbers for participants that will be used on all project notes and documents.
- Notes, interview transcriptions, and transcribed notes and any other identifying participant information will be kept in a locked file cabinet in the personal possession of the Project Manager. When no longer necessary for research, all materials will be destroyed,
- The Project Manager and the members of The Enduring Voices Foundation's project committee will review the Project Manager's collected data. Information from this 'Talking Trees Project' will be used solely for the purpose of this project and any publications that may result from this project. Any final publication will contain the names of any public figures that have consented to participate in this project (*unless a public figure participant has requested anonymity*): All other participants involved in this project will not be identified and their anonymity will be maintained if they request so.
- Each participant has the opportunity to obtain a transcribed copy of their interview.
- Participants should tell the Project Manager if a copy of the interview is desired.
- Participant's data will be kept confidential except in cases where the Project Manager is legally obligated to report specific incidents. These incidents include, but may not be limited to, incidents of abuse and suicide risk.

Person to Contact:

Should you have any questions about the project or any related matters, please contact the Project Manager at (carol.ngara@gmail.com or Tel: 0708766322).

Institutional Review Board:

If you have questions regarding your rights as a research/project subject, or if problems arise which you do not feel you can discuss with the Project Manager, please contact the Enduring Voices Foundation's Institutional Review Board Office at 0791266395.

Voluntary Participation:

Your participation in this project is voluntary. It is up to you to decide whether or not to take part in this project. If you do decide to take part in this project, you will be asked to sign a consent form. If you decide to take part in this study, you are still free to withdraw at any time and without giving a reason whatsoever. You are free to not answer any question or questions if you choose to. This will not affect the relationship you have/have developed with the Project Manager.

Unforeseeable Risks:

There may be risks that are not anticipated. However every effort will be made by the Project Manager and her team to minimize any risks.

Costs to Subject:

There are no costs to you for your participation in this study.

Compensation:

There is no monetary compensation to you for your participation in this study.

Consent:

By signing this consent form, I confirm that I have read and understood the information and have had the opportunity to ask questions. I understand that my participation in this project is voluntary and that I am free to withdraw at any time, without giving a reason and without any cost. I understand that I will be given a copy of this consent form. I voluntarily agree to take part in this study.

Signature _____ Date _____

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