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Mobilize Health Care Providers to Advocate Against FGM/C

FGM/C has become increasingly medicalized in Kenya's Abagusii community. However, providers express willingness to advocate against the practice. Interventions to mobilize providers must address not only their financial motivation for providing the service, but also their understanding of the human rights and health consequences of the practice.

Background

Female genital mutilation/cutting (FGM/C) is illegal in Kenya. The practice has declined slightly (from 38% to 34% according to DHS surveys from 1998 and 2003, respectively).Yet it is nearly universal (96%) among the Abagusii, a relatively affluent, mainly Christian ethnic group residing mainly in the Nyanza province in western Kenya. Half of cut women reported that they had been cut by a health worker.

Little is known about the medicalization of FGM/C or about ways of countering this trend. This study, launched in 2004 by the Population Council's FRONTIERS Program, examined the role of health providers in FGM/C in Kenya's Abagusii community. The study's objectives were to understand the motivations behind this medicalization, and determine the feasibility of using health personnel to communicate messages encouraging the abandonment of FGM/C.

The study included in-depth interviews of 48 key informants and 100 health personnel, 10 focus group discussions (including parents, adolescent girls, young married women with girl children, and young married and unmarried men), 727 interviews with providers from government, private, and faith-based facilities, and 659 antenatal (ANC) clients with girls under age 10. In addition, 23 simulated clients obtained data through sessions with a total of 139 providers at public and private clinics.

Findings

• Providers and clients cited tradition, cultural identity, symbolic maturity, control of women's sexuality and fidelity, and marriageability as rationales for cutting. Girls are reportedly being cut at younger ages—some as young as age six, rather than at puberty as was the tradition.

• Nearly 90 percent of Abagusii interviewees cited nurses and midwives as providers of FGM/C. Only 4 percent cited traditional circumcisers. Respondents said that medicalization of FGM/C had been underway in this community over the past 10 years—mainly due to fear of infection and preference for professional providers.

• Among providers, the main rationale for performing FGM/C was financial (64%) or hygiene and safety (10%); other reasons included community pressure and cultural demands. Circumcision by a medical provider is expensive: 150-500Ksh (US$1.90-6.25) per girl, compared with a traditional circumciser, which can cost as little as 50Ksh ($0.60). This high price suggests a significant motive for providers to continue cutting.

• Awareness of the medical consequences of FGM/C has also affected the type of cut performed (see Table). Cutting is less severe than formerly, though the most common procedure is still a partial clitoridectomy. A more recent, popular practice is pricking or nicking the clitoris

to draw blood, which nurses call "psychological circumcision."

• The criminalization of FGM/C has driven the practice into secrecy. Cutting is mostly performed at the girl's home; or it may be performed at a health facility under another pretext. Informants reported that some providers take a month's leave during the August or December school holidays to open temporary clinics where they cut as many as 50 girls daily.

• Between 6 percent of providers (self-reported) and 19 percent (reported by simulated clients) said that they would perform, or had performed, circumcision. Encouragingly, over two-thirds of providers seen by simulated clients (68%) advised the clients to bring their daughters in for counseling against FGM/C, saying that this is a personal decision; others pointed out that there were ways of initiating girls without cutting them.

• Less than half of providers and ANC clients knew about laws banning FGM/C or protecting children. However, 61 percent of providers and about half of ANC clients agreed that FGM/C violates girls' rights. Remarks made during in-depth interviews showed understanding of a range of human rights and quality of life issues—including education, health, sexual enjoyment, and the right to self-determination.

• Over half (52%) of ANC clients said that they did not intend to cut their daughters. Interviewees cited the media and religious leaders as major influences in changing attitudes and practices, but also as possible factors in medicalization and the move to less harmful cuts.

Reported type of cut (%)		
	Providers n=727	Clients n=659
Part of clitoris removed	76	78
Pricking or nicking the clitoris	11	9
Whole clitoris removed	3	4
Excision of clitoris and part of labia minora	-	2
Don't know or no response	14	11

• Most providers (86%) said that they were willing to speak against FGM/C; and about 40 percent said that they had discussed the issue; but of those, about half said that they had had difficulties. Just over a third of providers (39%) had ever attended training on FGM/C.

Policy Implications

• Efforts to encourage abandonment of FGM/C require clarification and enforcement of existing laws, training for health providers to increase their understanding of the human rights and health consequences of the practice, and addressing the financial motivation for medicalized cutting.

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