

**Managing and preventing
Female Genital Cutting (FGM/C)
among the Somali Community
in Kenya**

Maryam Sheikh Abdi

Guyo Jaldesa

Ian Askew

April 2008

This study was possible through the generous support of the people of the United States through the United States Agency for International Development (USAID), under the terms of Cooperative Agreement No. HRNA-00-98-00012-00 and In-house project 8016 53093. The contents are the responsibility of the FRONTIERS Program and do not necessarily reflect the points of view of USAID or the United States Government.



Background

Female genital mutilation / cutting (FGM/C), also known as female circumcision, is practiced in 28 countries of sub-Saharan Africa, a few countries in the Middle East and Asia, and among immigrant populations from these countries in Europe, North America and Australasia. As many as 100-140 million girls and women worldwide have undergone the practice, and at least two million girls are at risk of being cut each year, about 6,000 girls a day. FGM/C refers to the intentional removal of part or all of the external genitalia, or other damage to the female genitalia, for cultural or other non-medical purposes.¹ WHO recognizes four types of FGM/C², the most severe of which is type III (sometimes known as Pharaonic circumcision³ or infibulation). Approximately 15 percent of all genital cutting is of this type.⁴ Type III consists of narrowing of the vaginal orifice with creation of a covering seal by cutting and sealing the labia minora and or labia majora with or without excision of the clitoris (infibulation)⁵. Thorns or stitches may be used to hold the two sides of the labia majora together, and the legs may be bound together for up to 40 days. A small opening is left to allow urine and menstrual blood to escape.

The Somali ethnic community, both in the country of Somalia and those living in Kenya, has practiced genital cutting for centuries and the practice appears to have remained largely unchanged. The 2003 Kenya Demographic and Health Survey (KDHS)⁶ found a prevalence of 96.8 percent among Somali respondents and 98.9 percent for the North Eastern Province where the majority live. Type III predominates, although type II is also prevalent.

This report is a summary of a project that developed and tested two FGM/C-related interventions among the Somali community in Kenya and that was funded by the United States Agency for International Development (USAID) mission in Kenya. The interventions were informed by data gathered through a diagnostic study undertaken in North Eastern Province (Wajir and Mandera districts) and the Eastleigh area of Nairobi in 2004⁷ and a baseline study in Wajir district in 2005⁸. Both studies collected data through in-depth interviews and focus group discussions with community and religious leaders, and with recently married and unmarried men and women. The

¹ WHO. 2007. Eliminating Female Genital Mutilation: An Interagency Statement, WHO: Geneva, Switzerland.

² Ibid

³ This term is used as this form of genital cutting is thought to have been introduced by the Pharaohs of Egypt.

⁴ WHO, 2007, op cit

⁵ WHO, 2007, op cit

⁶ Central Bureau of Statistics (CBS) [Kenya], Ministry of Health (MOH) [Kenya], and ORC Macro. 2004. Kenya Demographic and Health Survey 2003. Calverton, Maryland: CBS, MOH, and ORC Macro.

⁷ Jaldesa GW, Askew I, Njue C, Wanjiru M. Female genital cutting among the Somali of Kenya and management of its complications. FRONTIERS final report, Population Council: Nairobi, Kenya

⁸ FRONTIERS 2005. “FGM/C Baseline Study, Wajir District, FRONTIERS, Population Council: Nairobi, Kenya.

diagnostic study also interviewed health providers, undertook an assessment of their clinics' readiness to offer safe motherhood and FGM/C-related services, and interviewed antenatal clients who had been cut.

These studies confirmed that FGM/C is a deeply rooted and widely supported cultural practice that is supported by many cultural reinforcements for its continuation. Several closely related reasons are used to sustain the practice: being a Somali tradition and the belief that it is an Islamic requirement formed the two main reasons given. The practice is also perceived to prevent immorality as it is seen as a way to reduce women's sexual desires through using infibulation to enforce the cultural value of sexual purity in females by ensuring virginity before marriage and fidelity throughout a woman's life. It was evident from the studies that there is a fear of women becoming promiscuous if not circumcised and so FGM/C was erroneously believed to as be in compliance with Islamic requirements of chastity and morality. The practice is also believed to enhance women's cleanliness and beautifying the genitalia. Marriageability is another reason for the practice, since the community believes an uncut woman or girl cannot be married, or if married, will be divorced once the husband discovers she is not. FGM/C plays no role as a rite of passage in the community, however, as it is generally performed on girls aged 6-7 years, and on girls as young as four years.

The diagnostic study also found that the health system is ill equipped to serve women who have been cut, and particularly infibulated women who are pregnant and delivering. This stems from an overall weakness in the availability and quality of maternal and neonatal health services in North Eastern Province. Evidence from the Kenya Demographic and Health survey (2003) showed very low antenatal care (ANC) attendance among this population, with about 70% not attending any ANC care, compared with less than 10% nationally. Community mobilization and education could be used to emphasize the importance of early attendance for ANC, for de-infibulation prior to delivery, and for an attended delivery organized through outreach activities by the health facility staff. ANC consultations are also an opportunity to discourage mothers from cutting their daughters.

In addition, and especially in urban areas, health workers are increasingly being requested to perform infibulations and re-infibulations; many nurses are responding to these requests, with the justification that they can do it more safely than traditional practitioners, and because they can supplement their income, despite the fact that the practice is illegal and punishable. The belief that a lesser cut for women is a requirement in Islam was strongly held by community members, including health care providers, and so they carry out these procedures thinking that they are abiding by their religion and are hygienically carrying out the practice.

With financial support from USAID/Kenya, FRONTIERS developed interventions to address FGM/C among the Somali in North Eastern Province from two perspectives; a) first, to develop, implement and evaluate a community-based behavior change intervention to encourage the Somali community to abandon a harmful practice; and b) secondly, to strengthen existing antenatal and delivery services in health facilities used by Somali women so that they are better able to manage pregnancy and delivery of infibulated women and the associated complications.

Objective

To reduce the suffering caused by FGM/C among the Somali community in Kenya through improving the health system's capacity to manage women who have undergone genital cutting, and through encouraging the community's abandonment of the practice.

COMPONENT 1: Intervention to improve management of health and other complications associated with FGM/C

Improved management of complications associated with FGM/C was addressed within the framework of improving safe motherhood services generally. This intervention also sought to contribute to the Ministry of Health's efforts to encourage communities to abandon the practice through ensuring that staff adhere to the MOH policy of not undertaking the procedure and to motivate staff to advocate against the practice with their clients and. This component had the following specific objectives:

1. To develop a training curriculum and materials for managing pregnancy, delivery and postpartum care for women with genital cutting, for managing gynecological and sexual complications among women who have been cut, and for advocating against the practice, that can be used for pre- and in-service training by health workers providing antenatal and basic obstetric care.
2. To strengthen the capacity of Provincial and District Health Management Teams in Wajir and Mandera districts of North Eastern Province to supervise and support the provision of antenatal and basic obstetric care services for women who have undergone FGM/C.
3. To improve the quality of care received by women attending for antenatal, obstetric and gynecological services in Wajir and Mandera districts through strengthening the capacity of clinics and clinic staff to provide such services among a population that practices FGM/C.

Identification of weaknesses in providing antenatal, delivery, newborn and gynecological services for women with FGM/C

Collaboration was sought with UNICEF's on-going 'Emergency Obstetric Care' Project in North Eastern Province, with GTZ's anti-FGM Project to support the MOH, and with DANIDA's health systems strengthening project. This activity was initially focused on two districts of North Eastern Province, Wajir and Mandera, but was expanded to include more districts after consultations with UNICEF and DANIDA, which were undertaking similar activities in Garissa and Ijara districts in North Eastern Province, as well as Moyale district in Eastern Province⁹.

The first step was to undertake a participatory assessment of the capacity of the health care system to manage FGM/C complications in the context of the existing antenatal, delivery,

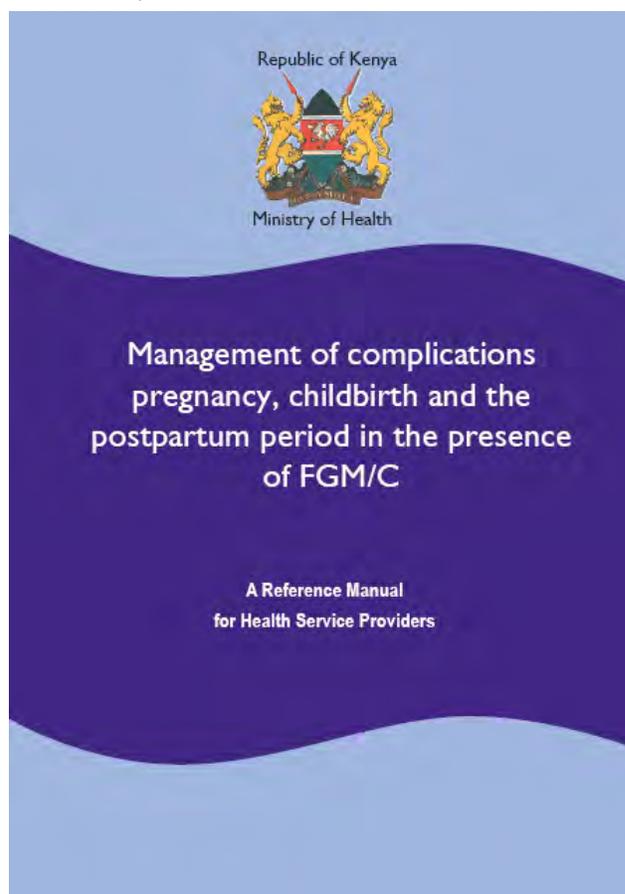
⁹ North Eastern Province consists of four districts: Garissa, Ijara, Wajir and Mandera. Given its proximity and socio-cultural and other similarities, Moyale District in Eastern Province is often included in interventions for North Eastern Province, and UNICEF was implementing its Child Protection program in Garissa, Ijara and Moyale districts.

newborn and gynecological services available in these districts. This was undertaken through convening a five-day workshop in Garissa to which representatives from the Provincial Health Management Team (PHMT) and from all five District Health Management Teams (DHMTs) were invited; representatives from the MOH's Division of Reproductive Health, USAID, UNICEF, DANIDA and GTZ were also invited. Representatives from the each of the DHMTs included: District Medical Officers of Health, District Clinical Officers, District Nursing Officers; District Health Education Officers, and District Public Health Officers. During this workshop participants identified whether there were any particular needs to be addressed among women attending for these services and who have undergone FGM/C, and the weaknesses they perceive in their own facilities' and staff capacities to serve such women, and particularly those coming for antenatal and delivery care. From this assessment, the group came up with practical and affordable strategies for strengthening delivery of these services that could be included in their District Action Plans. In particular, the outline for a staff training and clinic strengthening activity was prepared. This meeting also identified a small number of PHMT and DHMT members who could be trained as resource persons for implementing the staff training and clinic strengthening activities in the region.

During this participatory needs assessment workshop, a plan of action for districts was drawn up with each DHMT. This action plan described the training needs in managing FGM/C and its complications for staff providing ANC and maternity services, as well as in building their capacity to advocate against the practice. It also described the clinic strengthening activities that needed to be undertaken to enable them to provide the minimum acceptable standard (according to national criteria) to offer focused ANC and for maternities, essential obstetric care. Each DHMT was assisted to plan how they could increase awareness among communities served by their facilities of the importance of early attendance for ANC and for organizing deliveries by skilled attendants. The meeting also addressed ways in which the capacity of these health workers could be strengthened so that they can actively advocate against the practice during routine consultations for primary health care and during community outreach activities.

Development of a training curriculum and materials

Based on the findings from this assessment, and drawing from materials developed by WHO and others, a training curriculum and materials for orienting health providers on managing FGM/C among pregnant and delivering women was developed by the FRONTIERS (see box). The curriculum can be used both during pre-service training as well as a stand-alone seven-day in-service training course. The goal is to educate



nurses and other health care providers in identifying the different types of cutting, recognizing complications that may be associated with cutting and their management during pregnancy and delivery, understanding the socio-cultural rationales for continuation of the practice, and basic counseling in sexuality. The curriculum has subsequently been officially adopted as a training manual by the Kenyan Ministry of Health, and the MOH/GTZ project has printed 500 copies of the manual for use by the Division of Reproductive Health.

Training of health care providers

Only 25 percent of women in North Eastern Province receive antenatal care from a health worker, and only seven percent deliver at a health facility. Even though it is not possible to reach the majority of pregnant women through ANC services, those nurses providing antenatal care were trained in advising all pregnant women, and especially those who have been infibulated, to prepare a delivery plan in advance to deliver at a facility, or if this is not possible, to plan for and arrange for an attended delivery, i.e. a delivery at which a medically trained person (not a Traditional Birth Attendant) is present. Health providers were encouraged these women to discuss this plan with their husbands and obtain his agreement to ensure that financial and emotional support will be provided. Staff were trained in counseling infibulated women to be de-infibulated prior to delivery or during second stage of labor and in requesting them not to ask for re-infibulation after delivery.

In collaboration with UNICEF and DANIDA, FRONTIERS supported the MOH to train 145 health personnel from the five districts, training at least one health worker from every functioning health institutions and including all staff that provide safe motherhood services¹⁰. The training built their capacity to provide the minimum quality of care needed to handle deliveries that may be susceptible to complications associated with infibulation. This included training in deinfibulation¹¹, correct management of obstructed labor, preventing and repairing perineal tears, including episiotomy and caesarean section, and postpartum hemorrhage. It also included handling complications among neonates that may be increasingly likely among infibulated women, such as birth asphyxia (measured by the Apgar score) and being aware of a possibly increased likelihood of perinatal death.

Education materials outlining the legal and human rights status of FGM/C were developed and distributed to all health personnel trained. These materials describe the legislation criminalizing FGM/C through the Children's Act in Kenya, the MOH's policy statement against health workers practicing FGM/C, relevant statements from WHO and other international bodies concerning medical practitioners role in addressing FGM/C, and citations from the numerous human rights declarations to which Kenya is a signatory and which condemn FGM/C.

¹⁰ FRONTIERS. 2006. Reproductive Health Update Trainings for Health Workers in North Eastern Province, Garissa, FRONTIERS, Population Council: Nairobi, Kenya

¹¹ Guidelines for undertaking de-infibulation are available, having been developed primarily to meet the demand for such services among migrant populations in more developed countries, and these were adopted for use in Kenya.

COMPONENT 2: Community-based interventions to encourage abandonment of FGM/C

The community-based intervention had two objectives:

1. To generate a common agreement among Islamic leaders and scholars in Wajir District that FGM/C is not a religious obligation for Somali Muslims through facilitating group discussions among leaders and scholars.
2. To assess the effectiveness of a community-based intervention in Wajir District that leads to a questioning of the need for FGM/C among community groups of Somalis in terms of attitudes and intentions to practice.

Consensus building among religious scholars

Both the diagnostic and the baseline studies found that there was strong adherence to the belief that FGM/C is a religious requirement and that the Somali community was willing to abandon infibulation and to instead practice a lesser type which they perceived as an Islamic requirement. The message that no type of FGM/C is required as an Islamic practice was not well understood or believed unless strong, credible statements were made by religious leaders to this effect. The engagement of credible religious leaders as advocates for total abandonment, and not reduction in severity or medicalization of the practice, was seen, therefore, as a critical and absolutely necessary initial step.

In response to this need, FRONTIERS developed an approach¹² to engage with religious scholars and educate them and the community about FGM/C, with the aim of encouraging a questioning of the rationale for the practice and stimulating a move towards abandoning it. Six symposia were held with religious scholars, during which evidence from essential Islamic documents and texts were used to question whether or not the practice is supported in Islam. Shariah guidelines that are contradicted by the practice were assembled to enable the scholars to understand the correct position of Islam as regards FGM/C¹³. These meetings between scholars were aimed at reaching a consensus that the practice, in all its types, is not Islamic and that it contradicts Islamic teachings on sanctity of the human body and rights of women and girl children. The intention was that the scholars could then to be engaged as community educators to de-link the practice from Islam through their sermons in the mosques and lectures during training sessions.

Following this intervention, a number of scholars have had a mind change and individually will state that they do not support any type of FGM/C; they are not yet willing, however, to speak out publicly against the practice. Two female scholars opposed to the practice have been identified and one of them is now working as a resource person in Wajir. Links have been established with

¹² Sheikh Abdi, M. 2007. A Religious Oriented Approach to Addressing FGM/C among the Somali Community of Wajir, Kenya, FRONTIERS, Population Council: Nairobi, Kenya.

¹³ Ibrahim Lethome Asmani and Maryam Sheikh Abdi. 2008. Female Genital Mutilation: Is it an Islamic practice? FRONTIERS, Population Council: Nairobi, Kenya.

non-Somali Islamic scholars who are opposed to the practice and they have been engaged as resource persons in de-linking the practice from Islam. Since many Somali scholars are still convinced that the practice has a basis in Islam, consensus building among them is vital and continued to realize abandonment of FGM/C.

Marriage is a recommended act for all Muslims and many community members have erroneously used FGM/C as a way of ensuring marriageability, in the belief that the practice suppresses the sexual desires of women and girls, thereby making them chaste before marriage, as the norm is that a girl or woman cannot be married unless she is a virgin. Use of infibulation to ensure and prove virginity at marriage was countered with the fact that it inhibits genital hygiene and therefore reduces the girl's or women's ability to perform prayers and other religious acts of worship hence preventing women from worshipping Allah (SWT)¹⁴. Harm caused by infibulation to women's health, the health of future babies, as well as the problems caused to the husband during sex, were also highlighted as arguments against the practice.

Mobilizing attitudinal changes within the community

Several different community groups were sensitized about the practice and discussions held with them to encourage a questioning of the practice. Over 1,200 persons from the community in Wajir district were reached through these community discussion groups:

- i. 458 youth, including 350 girls at Wajir Girls' Secondary School
- ii. 33 men leaders
- iii. 46 women leaders
- iv. 227 women from six women groups
- v. 36 professional women (in collaboration with UNICEF/Kenya Garissa office)
- vi. 43 education officers at the provincial level (in collaboration with UNICEF/Kenya)
- vii. 198 primary school teachers
- viii. 91 TBAs and traditional FGM/C practitioners
- ix. 113 police officers.

The training process for the community also sought to address the reasons given for the practice using logical arguments to counter the held beliefs¹⁵ through the following approaches:

- a) The belief that FGM/C is an Islamic requirement was countered by critical analysis of the evidence used and ascertaining that it has no basis in Islam. A non-Somali Islamic religious scholar would inform the participants that the practice violated a number of Shariah guidelines as regards the sanctity of the human body.
- b) A medical expert was always present at all sessions to give a detailed explanation on the functions of the genital organs and the harm caused by FGM/C. This would then be linked with Islamic teachings on avoidance of anything harmful.

¹⁴ (Quran: 51:56).

¹⁵ Sheikh Abdi, M. 2006. A Religious Oriented Approach to Addressing FGM/C among the Somali Community of Wajir, Kenya, FRONTIERS, Population Council: Nairobi, Kenya.

- c) The belief that FGM/C ensures chastity was countered with Islamic teachings on chastity and morality that do not include any mutilation of organs and no physical means to attain chastity. With help from a medical expert all participants were informed that it is the brain that controls human actions and not the genital organs and so the clitoris has nothing to do with desire. The discussion concluded that it is upbringing, moral teachings and personal choice that are responsible for sexual behavior and so these should be emphasized rather than FGM/C.
- d) The violation of several women's and girls' rights by the practice were discussed at length in each of the trainings, notably the right to life, right to good health, right to bodily integrity, right to enjoy sexual relations and right to make a choice in life. Discussions concluded that anything that violates these divine and human rights was not acceptable, and hence FGM/C was un-Islamic.
- e) The fact that it is a cultural practice for Somalis was cited as a key reason for its continuation, and this was countered with the fact that even though Islam does not prevent various cultural practices by different Muslim communities, it does forbid cultural practice that conflict with its teachings. As FGM/C is against many Islamic teachings, it is not an acceptable cultural practice.

Next steps for continued progress

This project, in conjunction with activities supported by other partners working in North Eastern Province (notably UNICEF and GTZ) has contributed to raising public awareness about the harms associated with FM/C, especially as practiced among the Somali population living in the province. Negotiations are continuing with USAID/Kenya to continue support for these activities and partial support has been obtained from the Wallace Global Fund to sustain the community mobilization interventions. In particular, it will be important to continue working with religious leaders to clarify the position of Islam and to support them to feel confident in speaking out in public about their concerns. Health care providers need further training, especially in the practical skills of managing women during delivery and their infants. Further research is also needed to better understand:

- The relationship between women's decisions to stop or continue FGM/C, and their desire for sexual morality, acceptable sexual behavior and femininity.
- The association between FGM/C and women's sexuality, especially whether and how FGM/C reduces sexual desires and/or alters sexual response.
- Men's knowledge and perceptions of FGM/C and their potential role in efforts to encourage abandonment of the practice.
- Trends in the practice within different age and social groups and what led to changes.