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Mothers' Perceptions of the Medicalisation of Female Genital Cutting among the Kisii Population in Kenya

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Abstract

While within the Kisii community in Kenya the prevalence of female genital cutting (FGC) is decreasing, the practice is increasingly being performed by health professionals. This study aims to examine these changes by identifying mothers' motives to opt for medicalised FGC, and how this choice possibly relates to other changes in the practice. We conducted face-to-face semi-structured in-depth interviews with mothers who had daughters around the age of cutting (8-14 years old) in Kisii county, Kenya. Transcripts of these interviews were coded and analysed thematically, applying researcher triangulation. According to mothers' accounts, the main driver behind the choice to medicalise was the belief that medicalising FGC reduces the practice's health risks. There were suggestions that medicalised FGC may be becoming the new community norm or the only option. The shift to medicalisation was examined in relation to other changes in the practice of FGC signalling how medicalisation may provide a way to increase the practice's secrecy and decrease its visibility.

Keywords: female genital cutting, female genital cutting/mutilation, medicalisation, social norms, decision-making

Introduction

Female genital cutting (FGC), a term which refers to all procedures involving the partial or total removal of the external genitalia or other injury to the female genital organs for non-medical reasons, remains a global problem (WHO 2010). Numerous national and international initiatives have attempted to discourage the practice. Kenya is often cited as an example of anti-FGC initiatives' success, with FGC prevalence decreasing steadily (Grose et al. 2019). The year 2014 Kenyan Demographic Health Survey (KDHS) reveals that an FGC prevalence of approximately 30% in the oldest age cohort (45-49 years old) decreases to approximately 10% in the youngest age cohort (15-19 years old) (Shell-Duncan, Njue, and Moore 2017). Kenya is also remarkable because the decrease in FGC prevalence co-exists with an increase in FGC medicalisation (Shell-Duncan, Njue, and Moore 2017), which refers to any situation in which a health-care provider practises FGC, whether in a public or private clinic, at home or elsewhere (WHO 2010).

In Kenya, strong variation in FGC prevalence and medicalisation by ethnicity has been reported (Hayford 2005; Shell-Duncan, Gathara, and Moore 2017). Based on our calculations using three waves of the KDHS (1998, 2008-2009, 2014), we estimated both prevalence[1] and medicalisation percentages,[2] and their change across several birth cohorts for the 11 most prevalent ethnic communities in Kenya (Figures 1 and 2). These trends reveal an interesting situation within the Kisii community: (1) decreasing prevalence percentages appear alongside increasing medicalisation percentages; (2) while only 2% of cuts within the 1960-1969 birth cohort were medicalised, this increased to over 60% for the 1990-1999 birth cohort; and (3) comparing the different ethnic groups, the youngest Kisii birth cohort had the second highest FGC prevalence, at 40%. Despite this last trend, FGC prevalence in the youngest Kisii birth cohort has fallen considerably in comparison to the oldest cohort of Kisii women, born between 1960 and 1969, for which it was almost 100%.

[FIGURE 1 & 2 NEAR HERE]

The trend towards medicalisation raises concern in the fight against FGC. On the one hand, it may reduce the adverse immediate health consequences of FGC and is associated with less severe forms of FGC (Shell-Duncan, Njue, and Moore 2017; Shell-Duncan 2001). On the other hand, medicalisation may serve to legitimise the practice, especially when it is performed by medical professionals (2001, 1). Policymakers, both national and international, have taken a clear stand against the medicalisation of FGC, stating that it impedes the fight for FGC abandonment (WHO 2010). A recent study in Egypt, however, has shown that the medicalisation of FGC can co-exist alongside declining trends in the prevalence of FGC (Van Eekert et al. 2020).

The current paper offers an in-depth analysis of the medicalisation of FGC within the Kisii community, aiming to fill a number of gaps in the literature. Firstly, while the trend towards medicalisation is widely recognised in Kenya and among members of the Kisii community (Shell-Duncan, Gathara, and Moore 2017; Shell-Duncan, Njue, and Moore 2017;

[1] The prevalence percentages were calculated by dividing the number of girls and women cut in a certain birth cohort by the total number of girls and woman belonging to this birth cohort.

[2] The medicalisation percentages were calculated by dividing the number of medicalised cuts that occurred in girls and women from a certain birth cohort by the total number of girls and woman cut belonging to this birth cohort.

28 Too Many 2016; Njue and Askew 2004; Okemwa, HMK, and Ayuku 2014; Matanda et al. 2018; Christoffersen-Deb 2005), little is known about the motives of mothers who opt to have their daughters undergo medicalised FGC. Secondly, little is known about how the shift towards medicalisation interacts with other possible trends, especially with normative practices concerning FGC as a whole. In this study, we report on mothers' perceptions of their own decision-making process concerning their daughter's cut to develop a response to both these research gaps.

Current FGC practice among the Kisii population

The Kisii (also known as Abagusii) traditionally inhabit Nyamira County and Kisii Counties in Western Kenya). The type of cutting typically practised in the Kisii community is clitoridectomy (Humphres et al. 2007). Among the Kisii population, FGC is believed to be a traditional cultural obligation (Njue and Askew 2004; Mose 2008). FGC is usually described as a rite of passage from childhood to womanhood. Once a girl has undergone FGC, she is ready for marriage. The dominant perception is that uncut girls are a disgrace to the community and are not suitable marriage candidates (Okemwa, HMK and Ayuku 2014; Momanyi 2001). The initiatory ritual of FGC involves more than the cut, as during a period of seclusion, girls learn about sexuality and role as a wife and mother to their future husband and children (Momanyi 2001). Traditionally, when a girl completes her period of seclusion, she graduates to adulthood, which is celebrated in dance and song, as well as eating and drinking (Okemwa, HMK and Ayuku 2014). Previous research has shown that FGC is performed in order to conform to community expectations and to avoid social exclusion (Okemwa, HMK, and Ayuku 2014; Gwako 1995).

More recent studies, however, have shown that, within the Kisii community, the practice of FGC has changed significantly. While some authors argue the practice is declining, others state that the practice has gone underground and is now performed in secret to avoid government prosecution (Okemwa, HMK and Ayuku 2014; Njue and Askew 2004). In addition, FGC has shifted from being a community event with public celebration to an event organised by individual families and conducted in secret (Matanda et al. 2018; Oloo, Wanjiru and Newell-Jones 2011; Christoffersen-Deb 2005). Moreover, it has been argued that the age at which girls are being cut is also decreasing in the belief that younger girls are better able to survive the experience and more easily convinced about the need to undergo FGC (Njue and Askew 2004; Matanda et al. 2018; Oloo, Wanjiru, and Newell-Jones 2011). Some studies suggest the procedure itself has also changed, with less tissue being cut, and the use of anaesthesia to make it less painful (Njue and Askew 2004; Matanda et al. 2018). While the dominant type of cutting is clitoridectomy (Humphres et al. 2007), pricking or nicking of the tip of the clitoris has become increasingly popular, and is usually carried out by trained health professionals (Njue and Askew 2004).

A shift towards medicalisation is also recognised within the Kisii population (Kimani and Kabiru 2018; Njue and Askew 2004; Matanda et al. 2018; Christoffersen-Deb 2005): health professionals are increasingly performing FGC (Okemwa, HMK and Ayuku 2014; Matanda et al. 2018; Oloo, Wanjiru and Newell-Jones 2011). In Kenya, health professionals typically perform FGC in homes, hospitals or temporary 'clinics' during school holidays (28 Too Many 2016). Medicalisation in Kenya has increased following the implementation of the Children's Act in 2001, which criminalised the conduct of FGC on girls under the age of 18. In 2011, the Prohibition of Female Genital Mutilation Act (2011) criminalised FGC regardless of the age or

status of girls or women, but also addressed the stigmatisation of uncut women, placing the onus on the Kenyan government to protect women and girls from FGC (28 Too Many 2016, 2018). The Act specifically states that anyone performing FGC, including health professionals, is committing a criminal offence (28 Too Many 2018). Previous research has shown that the primary motivation of mothers to medicalise their daughter's cut is to reduce the risk of adverse health outcomes (Matanda et al. 2018; Njue and Askew 2004). Moreover, if the procedure is medicalised, it can be more easily hidden from outsiders (Njue and Askew 2004), while it is also perceived as being more modern (Kimani and Kabiru 2018). The health professionals involved are often members of the practising communities and share their norms and values, thus they may also support the customary values of FGC, which may motivate them to perform the practice (Christoffersen-Deb 2005; Njue and Askew 2004). Moreover, some may be driven by economic gain (Christoffersen-Deb 2005; Njue and Askew 2004), as the medicalisation of FGC is increasingly seen as a commercial practice (Njue and Askew 2004).

Materials and Methods

In collaboration with the Technical University of Kenya (TE as local supervisor), we undertook qualitative research in Kisii county, Kenya. We conducted 29 in-depth interviews with mothers in the Kisii population, sufficient to reach data saturation. Purposeful sampling was applied using different criteria (Silverman 2014, 2017; Mortelmans 2013; Bryman 2012). The social network of the local researchers and one additional local contact were used to identify and recruit potential respondents. The targeted respondents were mothers with at least one co-habiting daughter[3] between the age of 8 and 14. The daughter's age range was chosen because FGC usually occurs around this time, and therefore the decision-making on daughter's cut would either be a relatively recent or an ongoing event for these mothers, which increased confidence in the credibility of the interpretation of the data. Respondents were selected at locations varying in rurality within Kisii county. Reaching respondents in the urban area of Kisii county proved challenging, as women living in this area tend to be less at home during the daytime when interviews were performed.

In interviews, we asked mothers about all their daughters to explore how decision-making possibly evolved between older and younger daughters. We interviewed mothers with daughters who were traditionally cut, medically cut, or not cut. However, daughters' FGC status was not a selection criterion, as we expected that asking this sensitive information beforehand would put off potential respondents and create a barrier for respondents to participate in the research. All respondents lived in Kisii county and identified themselves as members of the Kisii population. Ethical approval for this research were provided by the Ethics Committee of the Faculty of Social Sciences at the University of Antwerp and by AMREF Kenya and NACOSTI in Nairobi. In addition, the local Kisii county commissioner[4] gave permission to conduct the research in the area under his jurisdiction.

All interviews were conducted by the first author (NVE) and four researchers who lived in Kisii county. The local researchers interviewed people in their local language (Kiswahili and Ekegusii). When the first author performed an interview in English, she was accompanied by

[3] For one respondent the daughter within this age range was actually a granddaughter that lived with her and for whom she was the primary care giver

[4] Represents national administration at county level.

a local researcher for immediate translation. We reviewed the transcripts for systematic differences by interviewer and interview language – by no bias was detected.

The interviews took the form of semi-structured face-to-face interviews (Silverman 2014, 2017; Mortelmans 2013; Bryman 2012). The topic list was based on a literature review and earlier analyses of the KDHS data. Respondents were first asked about their socio-demographic status, household composition, daily life and social situation. The interviews were conducted in the respondents' homes.[5] At the beginning of each interview, written informed consent was obtained, anonymity assured, and the freedom not to answer a question if it was too sensitive or personal, was stressed.

Information from the interviews was audio-recorded and transcribed verbatim if conducted in English or transcribed in English after translation by the local researchers. During data collection, interview transcripts and field notes were reviewed and thematically analysed. This interim analysis helped us monitor the quality of the data collected and adapt the topic list when and where necessary. It also assisted in identifying data saturation. All transcripts were read, coded and analysed by the first author (NVE), supported by NVivo 12. Independent analysis of a sample of interview transcripts was undertaken by several co-authors (SVdV, SA, EL), and initial findings were discussed in the team to enhance the trustworthiness of the data. Coding schemes were compared in order to prepare a final code list. Researcher triangulation and reflexivity increased the credibility of the study. The final code list was analysed and sorted to identify overarching themes, and codes were examined in relation to each other to identify any associations.

Results

Within respondents' narratives concerning their decision about their daughters' cut, we identified five major perceptions concerning the practice of FGC. First, FGC is increasingly performed by trained health professionals. Second, due to anti-FGC legislation, the practice is performed more secretly. Third, FGC has become a more individualised practice. Fourth, social control over the practice of FGC has shifted. Fifth, the practice itself seems to be vanishing.

Increasing medicalisation and its drivers

Almost all respondents mentioned how today, in most cases, FGC is practised by trained health professionals.[6]

> You know, of late it's doctors who do it, unlike in the past [when] it was just an ordinary person. (R35)

Some of the reasons given for medicalised FGC were related to girls' health, such as the use of medication, hygiene, clean equipment used for each girl, less bleeding, less flesh cut, the possibility of follow-up by a trained health professional in the case of any health

[5] Except for one, which was conducted in a house where the interviewee was working as domestic help.

[6] We do not distinguish between types of trained health professionals, as in the Kisii language (in which most interviews were performed) the term ‘omoyagitari’ is used, which is a broad term referring to any practitioner drawn from a health-care setting, whether a public hospital, private hospital or private clinic. There is no specification of the health professional’s function or gender. Moreover, respondents assume they are trained health professionals.

complications, and a shorter healing period. Moreover, mothers described having trust in health professionals and their skills:

> You know, for the traditional [procedure] one can bleed so much, but for medicalisation, health professionals know what to do. (R36)

This trust in the skills and experience of health professionals, together with the perceived reduction in health risk, sometimes led to the impression that medicalised FGC did not have an effect on a girl's health:

> […] today, [those] who go to health professionals, they are okay, cause they don't bleed a lot and are given medicines... She returns as healthy as she had left. (R47)

Medicalisation was thus perceived by some as a way to reduce harm. In one case, medicalised FGC was even seen as a compromise between no cut – as preferred by parents – and a traditional cut – as preferred and pursued by the mother's mother-in-law:

> Because the mother-in-law insisted that she will come and pick the granddaughters to be circumcised by a traditional practitioner, me and my husband were forced to give in and agreed with the mother-in-law that we will circumcise our daughters using a health-care provider. (R11)

The choice of medicalisation based on health risk implies that mothers are informed about the health risks associated with FGC. It also implies that being informed about health risks creates the opportunity to question the practice of FGC, making it a choice rather than a self-evident practice. Moreover, decisions concerning FGC and its practitioners tend to be more informed. Information about FGC and its health risks is often discussed on media such as radio and television, through *barazas* (community gatherings), in seminars at schools, in church, and by anti-FGC organisations. Interestingly, health professionals were also mentioned among those who informed people about the health risks of FGC.

> Traditionally, if I had power (it is only that things have changed) female circumcision should be performed. But now, the health professionals have done research and told us that we damage our girls. That is why we have stopped. (R15)

In addition to medicalisation being described as a way to reduce harm and as an informed choice, respondents mentioned that they preferred to go, or felt that they should go to where other people had taken their daughters.

> You see what other people do. When a group of people is doing something, you must also follow. I decided to take my daughters where other people were taking theirs. After some time, female circumcision was banned, and I am not thinking of circumcising the younger ones. (R13)

Medicalised FGC was also mentioned as being more expensive than going to a traditional practitioner. This means that the choice might also be influenced by the financial standing of the mothers or family. Additionally, it may be a matter linked to the availability of

practitioners. Some mothers stated that there was no choice but to medicalise, as health professionals were the only remaining FGC practitioners. Medicalisation was thus seen as the only option rather than a conscious choice.

However, in most cases where a woman had opted to have her daughter cut, and the choice concerning the FGC practitioner had been made, finding a traditional practitioner or a trained health professional who was willing to perform FGC was reported to be easy.

> It was not difficult [to find a circumciser, in this case a trained health professional]. […] she was offering that service. Many people were going there [hospital] and she was always present. (R13)

Increasing secrecy following stricter anti-FGC legislation

The FGM Act of 2011 appeared to be well known about, as it was mentioned by all respondents and perceived to be strictly enforced. Respondents described two major reactions to the law. On the one hand, many said that nowadays people have started to disapprove of the practice – especially younger generations – and are choosing FGC less frequently. Respondents stated that people are also more informed about FGC and its possible negative health consequences. This knowledge, combined with the fear of being caught by the authorities, had motivated them to abandon the practice.

> In the past it was good, they used to respect that thing [female circumcision[7]], but now, they don't want it, because a girl may bleed after circumcision and [it] may bring about a problem or [she might] even die. That's the reason I see most people declining and if the government has banned it, it has seen the reason. (R44)

> Today, since the government banned it, and said you will go to jail, everybody refuses to cut their daughters. They don't want to get arrested and go to jail. (R47)

On the other hand, the practice persists as there are still people who believe in its value and continue to perform it. For example, although several respondents claimed not to have cut their younger daughters, in total, almost half of their daughters had been cut. Moreover, almost all of the respondents stated that local people were continuing the practice but were doing so secretly. Thus, fear of the authorities has not only motivated some people to abandon the practice but also led the practice to go underground.

> Female circumcision was still [occurring] in the past, but now they banned the practice [made it illegal]. It has become a challenge to circumcise. There are lots of challenges, there are those who do it secretly and others who don't do it at all, like in my case, I circumcised before it was banned. (R32)

Today, the practice may be carried out in secret. If the procedure is performed by trained health professionals, it is usually done in a private clinic or at a girl's home. On such an occasion, the health professional usually comes to the house at night or in the early morning

[7] We chose the term 'female circumcision' to discuss the practice with the respondents. In Kisii, the practice is called 'Ogosara chinyaroka'. 'Ogosara' means 'circumcision' and 'chinyaroka' means 'girls'. In Kiswahili, the practice is called 'Tohara ya Kike'.

so as not to raise suspicion in the neighbourhood. After the cut, the girl heals at home, or in some cases at the clinic.

> She is well known in doing that for [a] long [time]. So she asked where my home was located and I explained to her. We exchanged contacts. The following morning, she called and came very early in the morning. She covered her head. I sent one of my children to pick her [up]. She performed the practice very quickly and I escorted her using a different route. (R12)

Moreover, the healing period for a medicalised cut was said to be shorter than a traditional cut which reduced the seclusion period and thus the chance of neighbours noticing that FGC had taken place and reporting it to the authorities. As a result, medicalisation appears to function as a way to continue the practice in secret and avoid being arrested:

> I saw the hospital one, [who] will circumcise, and she takes a few days to heal, you will not get caught, because if I bring the traditional one, she can come and circumcise her then she does not heal quickly and by the time, by… by the time she heals [...], you get caught. (R25)

In addition, legal prohibition and the subsequent risk of being arrested and jailed seemed to have had an effect on the age at which girls were being cut, which now took place at various ages between 5 and 15. It was reported that the age of cutting is now younger, as older girls are able to take a stand against FGC.

> I think, because we have been empowering those 10 years and above, and now they can say no or run away, [so] they have gone 7 years and below. (R18)

The shift from FGC as community practice towards an individual affair

Respondents pointed out that the nature of FGC had changed. While it used to be a social event that was publicly discussed, observed and celebrated, today it seems to have become an individual or family affair. While in the past the cut was combined with other rituals that marked the passage of a girl into womanhood, today only the physical practice remains, without the rituals and celebrations and girls are instructed to keep it a secret. With increasing secrecy surrounding the practice of FGC, the practice is becoming more individualised.

> Long ago, it [FGC practice] was open, even us, you know, we were circumcised long ago but it was open and it was with a ceremony, but these days they do it secretly because the government is against it. These days you cannot know if someone has circumcised their child unless you … they tell you that they took their child to be circumcised. (R21)

Moreover, respondents described how the decision about a daughter's FGC became a more contained family decision, in contrast to earlier when it used to be discussed and followed up within the broader community.

> Yes, at least now, you know during that time when we were growing, like that [girls being circumcised] was like, let us say, one way of a girl growing, it was a must […] Like that should happen, but today there is guidance and counselling, then, like, you are left with the choice … you are the one who will decide what to do, so like at least there is that awareness, you are told this … something like this is dangerous … or maybe it can help you this way, there are the negative and the positive sides, so it's up to you to decide. At least you are educated first. It is not like during that time when you were being forced to and you did not have a choice. (R27)

When we asked respondents about the people involved in the decision-making process, answers varied. Some mothers argued that it was a decision they made alone or privately within their household with their husband. Others said that the decision was made with the broader family (especially grandmothers). FGC was also mentioned as a women's affair, discussed with female family members and/or friends. This is in line with the local custom that rights and responsibilities over care for children are held not just by the biological parents but by the extended family.

While the decision to not cut a daughter may be made by the mother alone or with her husband, the social pressure to cut still exists. Girls who are uncut may be called derogatory names, such as *egesagane*, which means 'uncut girl'. One respondent even reported that she cut her daughter because the daughter herself wanted it, as all her peers at school had been cut and she wanted to fit in.

> She was the [one who] wanted to get circumcised, because her friends had been circumcised and she didn't want to be laughed at. Now that she went, they are now like friends. (R47)

Another daughter was reported to have pretended to have been cut because she wanted to fit in at school:

> She [daughter] has to pretend as if she's circumcised, she just says that to fit in. She hides among others, yeah. […]I hope they won't force her in order to check her, but she has finished class 8. (R41)

Generally, the pressure to cut was said to be interfamilial and usually came from women of older generations. For example, two mothers reported that their daughter had been cut without their consent or knowledge. In one case, the respondent's cousin had taken her daughter away to have the procedure done, while in the other case it was the respondent's own mother who had done this.

> My sister-in-law told me that my daughter cried [that she wanted] to join her cousins and she decided to also include her. […] She was circumcising her daughters and included mine because the girls used to be together. (R14)

Shifting social control

The shift of FGC to a merely physical practice, organised in secret and discussed and celebrated privately. R38 told us that she had organised the FGC of her daughter secretly and that she was 'quite sure that people don't know that she was circumcised'. Multiple respondents also told us that today they saw no difference between cut and uncut girls, and that the practice is losing meaning.

> That thing has no benefit. My first two daughters were circumcised and the younger ones are not circumcised but I do not see any difference among them. (R11)

FGC is known to be a strongly socially embedded practice; cutting is seen as the social norm and pressure is high. However, the fact that the practice is less visible makes it less subject to social control within the community.

> For us women, we followed how things were done in the past. You felt that if you don't do it, your daughters will be looked down upon and they will be abused by others. Currently, I don't see whether there is discrimination (against uncircumcised girls). (R13)

As girls' FGC status becomes less visible, some believed that uncut girls are less subject to discrimination, social exclusion and harassment. The majority of mothers who decided not to cut their daughters argued there were few negative comments by others, as many girls were uncircumcised, and there was no difference between cut and uncut girls.

> You see I am not the only one who has not circumcised my girls. There are many people who have not circumcised their girls. The girls will be just the same as others who are circumcised. There is no difference. I have never heard their comments. (R13)

Nevertheless, it seems that social control has not disappeared but shifted – as now the practice is organised secretly to avoid community members reporting it to the police. This may indicate that social control has changed from ensuring girls are cut to ensuring they remain uncut or the practice is hidden.

> In the past, […] the majority of the people used to circumcise. Like, let us say, like this November-December holiday most of them you hear, everywhere children are circumcised. But today, it is not that easy to hear that someone has been circumcised, because it has been banned, if they get you, you are jailed. […] They hide. […] They just say, if you get caught, because the government has banned it, it is on the radio, the gazette and the television, if they get you, you are jailed, now they fear to talk about it. (R25)

For some who oppose FGC, the law gives them the opportunity to speak up against FGC. In addition, for girls at risk of being cut, the FGM Act may provide a legitimate means of refusal. Several respondents told us that they did not cut their granddaughter because their daughters had refused and threatened to report them to the police (R26, R46, R21, R12). Doing this is

encouraged by schools and churches, where girls are taught to report if they are at risk of being cut or have already been cut.

> My daughter refused [to be circumcised]. She even knows that it's bad. She says even [on] the radio [it was] announced not to get circumcised. She is also afraid of it, and if we tell her to get circumcised, she refuses, because she hears [these things]. (R41)

FGC as a vanishing practice

Interestingly, while only few respondents stated that FGC would continue secretly, most were convinced that FGC will cease in the future. Education about FGC was mentioned as the key factor contributing to this change.

> It [FGC] will end totally, there will be no one circumcising at all. It will end, in the next years it will end. The way we are still being … being taught, will come to stop circumcising girls, so school studies will make people stop circumcising girls. (R23)

Moreover, it was suggested that seeing other people abandon FGC would eventually motivate the whole community to end the practice.

> I see that, in future, this practice will end. Those individuals who are still doing it will reach a time when they will stop. Because a large number of people have stopped, those who are doing it secretly will also stop with time. The practice is losing [its] meaning. (R11)

Discussion

This study contributes to the existing research by shedding light on how a shift towards FGC medicalisation interacts with other changes in the practice (Figure 3). Our analysis of these shifts found that decreasing prevalence did not counteract increasing medicalisation. Prevalence and medicalisation data (Figures 1 and 2) reveal that, within the Kisii population, the trend towards medicalisation and decreasing prevalence co-exist, thus challenging the assumption that the medicalisation of FGC counteracts its abandonment (WHO 2010).

[FIGURE 3 NEAR HERE]

Furthermore, the circumstances in which decreasing prevalence and increasing medicalisation co-exist appear to be connected and intertwined with several other events and shifts in the practice (see Figure 2). As mentioned above, the *FGM Act of 2011* had a vast effect. On the one hand, it motivated many people to abandon the practice, by informing them of the negative health consequences and through its strict control of FGC, introducing the possibility of fines and imprisonment. This could have contributed to an apparent *decrease in FGC prevalence*, which is clearly shown for the Kisii population in Figure 1. On the other hand, our qualitative data suggest that *secrecy surrounding the practice has increased*, with FGC going underground in order to avoid being reported to authorities. Thus, to a certain extent, FGC has become a secret practice which is no longer openly discussed, performed or celebrated. At the same time, despite FGC becoming a secret practice that apparently nobody

talks about publicly and which mothers or families decide upon alone, it is said to be easy to find practitioners through family or friends. In some instances, the practitioners are still 'known' to the community.

Based on this need for increasing secrecy, FGC is likely to be reduced to a mere physical act and is no longer socially discussed or openly celebrated as a rite of passage. This has turned the practice into a matter of individual and/or intrafamilial choice. Because the practice is discussed and organised secretly and individually, FGC has become less visible. There is no longer common knowledge about which girls are cut and which not. As such, social control seems to have shifted from ensuring girls are cut, to ensuring girls are not cut, which is supported and reinforced by the legal ban. The practice of FGC is a practice in change surrounded by double-edged social norms. Within the Kisii community, there is social pressure to cut, as well as to abandon the practice. On the one hand, anecdotal evidence shows that girls request their parents to have them cut to avoid stigmatisation. Even in the light of changing social norms, girls and women are afraid to be stigmatised if they remain uncut (Oloo, Wanjiru, and Newell-Jones 2011; Kimani and Kabiru 2018). On the other hand, mothers told us they were unable to cut their daughters as they were threatened by their daughters to report them to the police if they would. However, to go against the wishes of older people is seen as rather disrespectful in the Kisii community. Future research on the process resulting in girls standing up against the practice of FGC should be conducted to further understand this new dynamic.

Medicalisation does not have a neutral status in relation to these changes in the practice, as it seems to be related to both the increasing secrecy and invisibility of FGC. As medicalised FGC is perceived to entail a shorter healing period, and thus a shorter period of seclusion after FGC, it contributes to the practice being hidden, as it is less detectable by outsiders. While medicalisation might indirectly contribute to a decline in the prevalence of FGC, the direct effect of medicalisation on FGC prevalence remains unclear. Nevertheless, despite the shift towards medicalisation, almost all respondents believed the practice would end in the future.

Limitations

An important limitation of this research is the possible bias in reported information due to the legal ban. To minimise this bias, we actively attempted to gain the trust of the interviewees by assuring them of anonymity and explaining the neutrality of the research and its independence from the government. Nevertheless, we should assume that respondents' answers display social desirability bias and an element of imply deceit with respect to planned FGC or FGC that took place after the procedure was made illegal. Finally, it is important to recognise that data were collected in (semi-)rural areas and findings cannot be generalised to an urban context in Kisii county.

Conclusion

Medicalisation should be considered in relation to other shifts in the practice of FGC, as an intertwined web of processes. While we did not find a direct effect of medicalisation on decreasing prevalence, it became apparent that medicalisation may be contributing to the organisation of the practice in secret and making it less visible within the community. This invisibility may, in the long-term, lead to reduced social pressure to conform to the social

convention that a girl needs to be cut, as it can no longer be controlled openly within the community. In the longer term, this may contribute to decreasing FGC prevalence as this invisibility may make it easier for some women to refuse to have their daughter cut.

Interventions focusing on medicalisation should bear in mind that the reasons for and consequences of the shift towards medicalisation are not unambiguous and independent of other factors. There are various drivers of medicalisation intertwined in a web of multiple shifts in the practice of FGC. It would be valuable to conduct further research on this complex set of factors, to better understand when medicalisation is facilitated and under what conditions it may lead to decreasing FGC prevalence. Finally, more research is needed on the role of health professionals in promoting the abandonment of FGC.

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Figure 1.

FGC prevalence percentages by age 14 per ethnic group over 10-year birth cohorts[8]

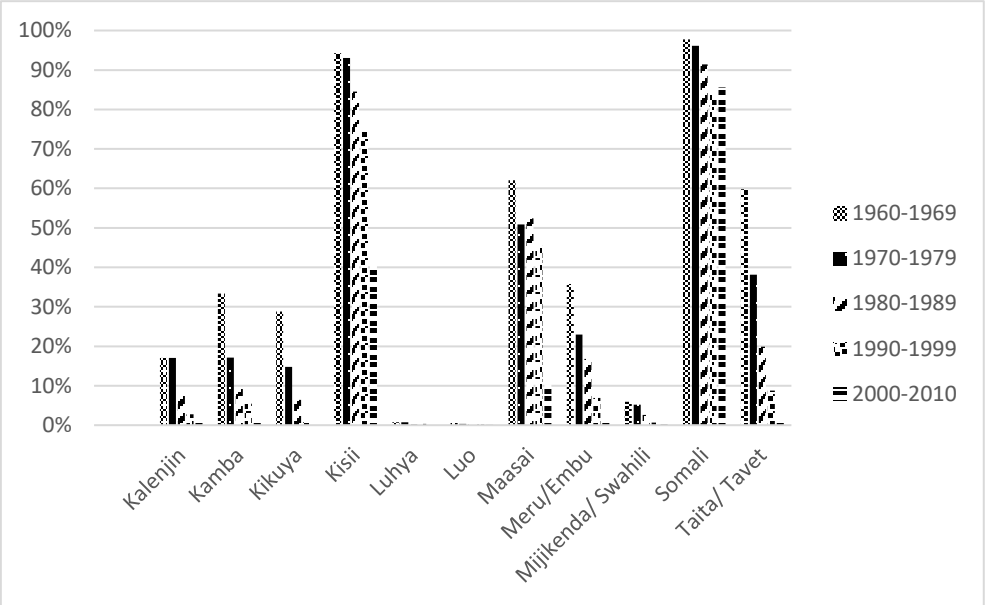
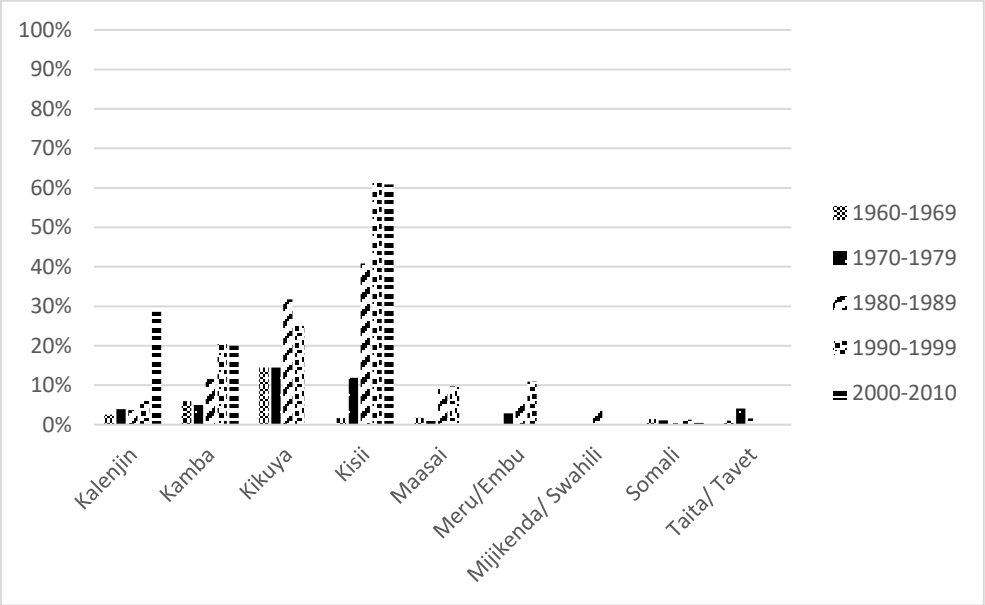


Figure 2.

FGC medicalisation percentages by age 14 per ethnic group over 10-year birth cohorts[9]



[8] We assume that daughters' FGC status at age 14 is definitive since data on most recent birth cohorts suggests that the majority of girls are cut before puberty (28 Too Many 2016; Njue and Askew 2004).

[9] Due to very low FGC prevalence percentages the Luhya and Luo communities are not included in this graph.

Figure 3.

Schematic representation of the intertwined process of shifts within the practice of FGC