Chapter 5
Transformation and Continuation: FGC Among the Gusii People in Western Kenya

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Kenya has a long history of attempts to stop this practice. The challenge started at the beginning of the twentieth century with the activities of the Scottish missionaries and the colonial government among the local people, e.g., the Meru and the Kikuyu people (Hetherington 1998; Thomas 1996, 1998, 2003). The controversy regarding FC has persisted for more than one century. Recently, legal frameworks such as the Children Act (2001) and the Prohibition of Female Genital Mutilation Act in 2011 (Republic of Kenya 2012) provided for public engagement and advocacy to accelerate the eradication of this practice (Kimani and Obianwu 2020). However, even after illegalisation, the prevalence is still high among some ethnic groups such as the Gusii (Kisii)[1] people of western Kenya.

In this study, the main purpose is to focus on changes regarding FGC among the Gusii. Throughout the research (conducted by the author in 1998 and 1999–2000)[2] it was observed that there has been a growing trend to medicalize FC, reduce the involvement of cutting and bleeding, and diminish the rituals. Yet in spite of the efforts to abolish it for decades, it maintains a high prevalence. I would like to examine the reasons for its continuation with reference to current research about the Gusii.

[1] "Gusii" is used as the ethnic group name in this paper. In their local language (in *Ekegusii*), the name of the group is *Abagusii* (Singular form: *Omogusii).* Geographically, the area name is Kisii i.e., Kisii County (previously Kisii District).

[2] The author carried out the anthropological research in 1998 and then 1999–2000 for several months in some of the rural communities of Kisii Town, Kisii County. Research involved in-depth interviews with 5 nurses, 6 traditional circumcisers, 9 pairs of girls with their mothers as participant observers. There were 22 cases in December 1999. Interviews were also conducted with officers working actively for the eradication of FGM in Kisii Town, and members of a self-help group working to change the situation of gender inequality (including FC) in rural areas (more detailed information in Miyachi 2004, 2014, 2021).

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5.1 Introduction

In the typology of FGM, there are three main types: Type I (clitoridectomy), Type II (excision), Type III (infibulation or pharaonic circumcision), and Type IV which is used to describe all other harmful procedures to the female genitalia in the absence of medical necessity (WHO 2010). In Kenya, several types exist. Kenya's FC eradication movement has a long history of more than one hundred years. It began at the beginning of the twentieth century with the Scottish missionaries and the colonial government (Thomas 1996, 1998, 2003; Natsoulas 1998; Robertson 1996; Adima 2020). In the 1950s, the issue became controversial under the colonial situation. The practice was considered as strongly connected with the ethnic identity of the Kikuyu people (Kenyatta 1962). In the 1970s, global attention increased and anti-FGM campaigns became widespread. Influenced by the wave of anti-FGM activity, President Daniel Arap Moi announced the presidential ban prohibiting the practice on girls. (*Nairobi Times*, "Moi Condemns Girls 'Circumcision"' July 27, 1982). The global wave promoted eradication programmes in Kenya in the 1990s and finally, it was totally criminalized in 2011 by the Prohibition of Female Genital Mutilation Act (Republic of Kenya 2012).

Kenya is recognized as a success story for eradication. However, as UNICEF has recently shown, the practice is not abolished yet (UNICEF 2021). To comprehend the continuity of the practice in this study, we will consider it from a long-term and anthropological perspective. Reference will be made to previous ethnographies of the 1940s and 1970s (Mayer 1953; Matsuzono 1991, and others) and research done during the 1990s (Gwako 1993, 1995; Miyachi 2004, 2014) as well as more recent research into the Gusii (Van et al. 2021; Matanda et al. 2021). This historical view, covering several decades of one ethnic group, will help to comprehend local people's perspectives in more depth.

5.2 Changes of FC/FGC in KDHS

In the reports of the Kenya Demographic and Health Survey (KDHS) published by the Kenyan National Bureau of Statistics (KNBS), the issue of "female circumcision" was first included in the report of 1998 (Chapter 12: Female Circumcision). The topic was covered as "gender violence" in 2003 (Chapter 15: Gender Violence), 2008–2009 (Chapter 16: Gender-based Violence), and then it was described as "female genital cutting" in the report of 2014 (Chapter 18: Female Genital Cutting).[3] The KDHS covers several issues, and interestingly includes data according to ethnic group. Figure 5.1 shows the prevalence of the practice drawn from surveys conducted in 1998, 2003, 2008–2009, and 2014, in the different areas (which correspond to ethnic

[3] The KDHS report of 1993 dealt with "Circumcision" in only two lines regarding HIV/AIDS infection (KNBS 1994, p. 127).

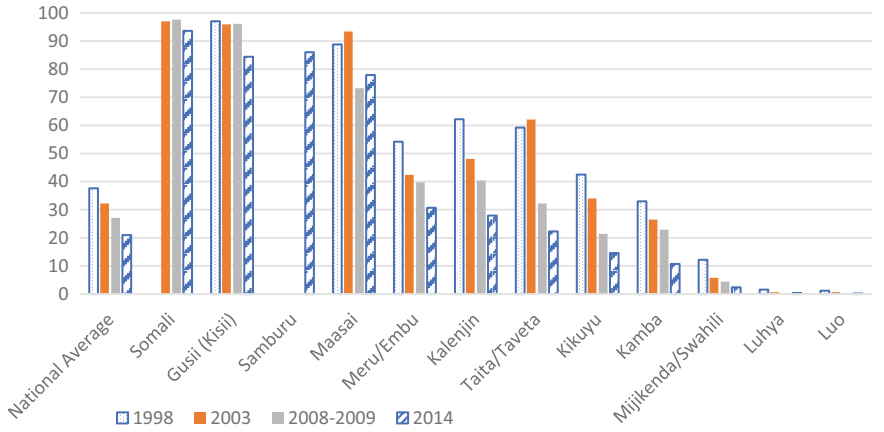

Fig. 5.1 Percentages of FC/FGC prevalence by Ethnic Group. *Source* The original data from the KDHS of 1998, 2003, 2008–2009, and 2014. Because of the limited research in some areas in 1998, 2003, 2008–2009, the data of some ethnic groups were not included (KNBS 1999, 2004, 2010, 2015; Kandala et al. 2017, 2019)

groups). The national average revealed a gradual decline from 37.6% in 1998 to 21% in 2014 (KNBS 1999, 2015).

Figure 5.1 illustrates the diversity of practice among the ethnic groups. In the Luo people, an ethnic group living in the adjacent area of the Gusii, the percentage was quite low because they do not have a tradition of circumcision for girls or boys. The comparison with levels in the Gusii community highlights the importance of circumcision to the Gusii. One must note also the decline among the Kikuyu and the Meru people. Historically, these people have been the ones who have been most vehement in their opposition to the anti-FC movement (Robertson 1996; Thomas 1996, 1998, 2003). The Kikuyu people's practice dropped sharply (1998: 42.5%; 2003: 34.0%; 2008–2009: 21.4%; 2014: 14.6%), and the Meru's also decreased. Ethnic groups showing high prevalence besides the Gusii include the Somali, the Samburu, and the Maasai. The prevalence in the Gusii is the second highest (84%) in the 2014 report (KNBS 2015, p. 333).

The data suggests no correlation between the practice of FGC and the Muslim religion. While most of the Gusii people are Christians, practice is highly prevalent. On the other hand, of the women of the Mijikenda/Swahili people, mainly Muslims, there were 83% who had not heard about FGC (and they comprised only 2.4% of the total prevalence). Yet, there was high prevalence (94%) and performance (often of Type III) in the Somali, who are predominantly Muslim.

Types of operation have been changing too. Among some ethnic groups, there are changes from Type III to Type II. In the case of the Gusii, cutting the genital part has decreased, thus changing from Type II to Type I or even to Type IV by the definition of WHO. Differences also occur in the same family, such as cutting styles differing among sisters in the same home (Nakamura 2021).

5.3 FGC as a Tradition Among the Gusii People

The Gusii people are Bantu-speaking and live in an area of western Kenya with a high-altitude and moderate rainfall all year round. With fertile soil and a moderate tropical climate, it is one of the most agriculturally active regions in the country. Most people are farmers, and in Kisii, they produce maize, a staple food, and many varieties of vegetables and fruits, as well as tea, coffee, and pyrethrum (Republic of Kenya 1996). In addition to these agricultural products, soapstone-carving, the folk-art industry, is also prevalent. With regard to religion, most people are Christians, belonging to Seventh Day Adventists (SDA), the Lutherans, and the Catholics. Muslim people are few in this area.

FGC has been conducted as a tradition for a long time among the Gusii people. It has been described as a rite of passage, an important ritual for girls and boys (Mayer 1953; LeVine 1979; LeVine et al. 1994; Matsuzono 1981, 1984, 1991; Silberschmidt 1992, 1999; Raikes 1994; Wangila 2007). Because of the high prevalence of the practice among them, the Gusii have received a lot of attention from researchers (Njue and Askew 2004; Kandala et al. 2017, 2019; Ouko 2014; Kimani et al. 2020).

5.3.1 As a Rite of Passage

Circumcision is called *okwaroka* in the Gusii language (*Ekegusii*), meaning "leaving the nest." As an important rite of passage for girls and boys (Mayer 1953; LeVine 1979; Matsuzono 1982; Matsuzono 1984, 1991). This sequence of events involves mainly three processes: preparation, operation, and seclusion.

Preparation starts a few years before the operation. Children must be ready mentally and convince their parents that they are brave enough to endure the pain during cutting. (The circumcision site is considered defiled by crying; a purification ritual then has to be performed to clean the place and the stones for sitting on.) Children are circumcised at their own request with their parent's permission. Parents also need to prepare for the cost of payment to the operator and the cost of the celebration.

According to an ethnography of the Gusii, circumcision activities in the 1970s were performed near the river early in the morning (Matsuzono 1991; Gwako 1993, 1995). The girls were escorted by elder women to the place, where the girls' bodies were dipped in the cold river to make them cold enough not to feel pain in the pubic area. The operations were done by the traditional circumcisers, *omosari*. Usually, these were female farmers who performed the operation only during the circumcision season. The circumciser sprinkled ashes on the girl, grabbed the clitoris, and cut it off with a knife in a deft move that took only a few seconds. In those days, circumcisers cut the labia minor and tip of the clitoris with a blade (Matsuzono 1991).

After the operation, the girls spent a few hours there until the bleeding stopped before returning to their homes. The grandmothers and elder relatives escorted them while singing songs and performing dances. At home, the girls entered a specific

place, such as the grandmother's kitchen hut, to spend a seclusion period. That time was an important part of the rite of passage, as the girls were taught by the elders how to behave well as Gusii women. It also provided healing time for the scars. They were not allowed to go out, not even with their parents; only with caregivers, such as their grandmothers and sisters. The children in the same seclusion hut were, nevertheless, quite happy because they were relieved of various tasks. After the seclusion, about one month in "old days," the celebration ceremony was held. It gave great honour to both the children and other family members, especially mothers and grandmothers.

5.3.2 Reasons for the Practice

There are several reasons given for performing these practices. In the case of the Gusii, many were mentioned,[4] but here, I would like to focus on two, namely, life stages and gender.

5.3.2.1 Life Stages

There are several life stages in Gusii culture, each based on a life event such as circumcision, marriage, and childbirth. In their language, an infant girl is called *ekengwerere* or *omwana*. An uncircumcised girl is called *egesagaane*. After circumcision, a girl is called *omoiseke* and a married woman is called *omosubaati*. Grandmothers are called *omongina* (Table 5.1). These stages, circumcision, marriage, and childbirth, are considered a necessary part of progression into adulthood, and once achieved it is taken for granted that one would then have children and grandchildren. In the Gusii language, there is the word *amasikani*, which means "respect." The community considers it important in daily life to show respect to older persons (Matsuzono 1991, p. 100). The term *omongina* is the most respectful term for women.

A girl is only considered a full-fledged member of her family and society once she has gone through marriage, childbirth, and the birth of grandchildren. In this patrilineal society, a woman moves into the husband's residence from a different area, after which childbirth and her children's circumcision confirm her new position in the society.

[4] In the research in 1999–2000, several different reasons were mentioned. Girls at primary school mentioned peer pressure; they did not want to be called *egesagaane* (an uncircumcised girl). Adolescent girls believed it as necessary for marriage. Mothers mentioned it was also necessary to control girls' sexuality (Miyachi 2014).

Table 5.1 Gusii life stages

Female	Male
Infant (*ekengwerere*)	Infant (*ekengwerere*)
Uncircumcised girl (*egesagaane*)	Uncircumcised boy (*omoisia*)
Circumcised girl (*omoiseke*)	Circumcised boy (*omomura*)
Married woman (*omosubaati*)	Male elder (*omogaaka*)
Female elder (*omongina*)	

LeVine et al. (1994: 81)

5.3.2.2 Gender Perspectives

Gender perspective is an important factor. Before the rituals of circumcision, children of both genders are considered asexual beings. They are not subjected to much regulation regarding the gendered division of labour and behavioural norms. However, after circumcision, girls undergo a status transformation to "females" (Matsuzono 1984: 29) and gain "femininity" (Silberschmidt 1999: 64). Circumcision also provides women with a kind of "power" that allows them to sublimate their feelings of subordination, frustration, and hostility toward men (Silberschmidt 1999: 72). For example, older women's obscene songs and lewd and suggestive dances are considered unacceptable in Gusii communities with their strict gender norms. However, during the circumcision ceremony, unusual acts, teasing attitudes, and songs are allowed. The ceremony is a special occasion for women. In this way, traditional circumcision elevates the life stage from childhood to adulthood and brings with it the consolidation of gender identity.

5.4 Medicalization and Changes of FGC from 1980s Until 2000

As Fig. 5.1 shows, FGC has continued as a custom. However, the style of operation has been changing since the 1980s (Matsuzono 1991; Gwako 1995). This section focuses on the growing medicalization of FGC since the 1980s, and other changes noted in my research in 1999–2000.

5.4.1 Medicalization Since the 1980s

Until the early 1980s, the operation was almost always performed by a traditional circumciser, *omosari*. (Matsuzono 1991, pp. 136–137). Then, because of concern

about infectious diseases, such as HIV/AIDS, medicalization became widespread among the Gusii. Usually, a medicalized operation refers to hygienic surgery performed by doctors or nurses trained in Western medicine and has been considered less harmful to the female body (Shell-Duncan 2001: 1021). Parents, mainly mothers, became concerned about health risks, thus they preferred nurses with a modern method who operated with less cutting and less bleeding. These nurses had studied western medicine in nursing schools (Gwako 1993, 1995; Njue and Askew 2004; Miyachi 2004, 2014).

Interviews during my research with the primary school students in 2000 showed that among 70 girls, 68 of them had been circumcised (Miyachi 2004, 2014). 54.4% (37 girls) were operated on at home, 35.3% (24 girls) at the local private clinics, and 10.3% (7 girls) at hospitals. Among the 68 circumcised girls, 7 were operated on by traditional circumcisers, and the rest by female nurses.

Interviews with *omosari* confirmed the medicalization of the practice. According to them, mothers preferred the nurses with their modern method, thus many *omosari* went out of business. *Omosari* were originally farmers and earned only pocket money from the operation. In the interviews, they showed understanding of this "medicalization wave".

The nurses in the interviews mentioned that they became aware of the presidential ban from the radio and newspapers. Some of them attended the anti-FGM seminars. Nevertheless, they still performed it because they thought if they rejected the request, mothers would take girls to *omosari* which may cause health problems. The nurses also mentioned that if someone was arrested, they would cease practicing it.

5.4.2 The Places of the Operation

From the research, it was obvious that the medicalized style was common among the Gusii even in rural areas. There were mainly three places to have an operation: at the home, at the clinic, or at the hospital.

5.4.2.1 Operation at the Home

In December 1999, there were nurses visiting girls' houses for operations. At that time, the presidential ban was also widely recognized in rural communities, but operations continued. These home visits occurred at night, because during the day the nurses worked at clinics, but also to hide the operation from neighbours.

I would like to describe one case here. The nurse arrived at the house and was welcomed by family members. They were devoted Christians and the nurse and the girl's mother belonged to the same church. After prayer, the nurse warned the

grandmother and other family members not to make any sounds of joy or celebration.[5] The nurses were very cautious for fear of being arrested. After the prayer, the family members and the nurse went outside and then started preparation. The family members took small chairs from the kitchen for the nurse and the girl to sit on. She put a sheet on the ground and took out her instruments, such as forceps, a clean and new surgical knife, and cotton dressing to stop the bleeding. She also put on surgical rubber gloves to protect both the girl and herself against blood infections. The girl sat on the chair after taking off her underwear and the grandmother held the girl from behind to prevent her from closing her legs. The nurse did not use anaesthesia, because the cutting part was very small, she explained, and the girl was more afraid of the injection than the operation. After cutting the tip of the foreskin (no cutting of labia minor), the nurse put the cotton dressing on the girl's genital parts. Two sisters, around six and ten years old, were operated on. The surgery itself took a few minutes and neither of them cried. After the operation, the girls were able to stand and walk to the seclusion place, in this case, the grandmother's kitchen hut in the compound. They spent one week together in the same hut. The other cases of operations at home were the same. Sometimes cousins were also included so that the girls could spend their seclusion time together.

5.4.2.2 Operation at the Clinic

The operation at the clinic was similar to the one at the home. The small medical facilities in the rural areas are called "clinic," which are private and run by nurses. "Clinic" offers basic medical services, medicines, and family planning methods like injections and pills.

The girl visited a clinic nearby escorted by the mother (though mothers do not attend the operation, as a matter of tradition). On arrival, the girl followed the nurse's instructions. She lay on a bed and her operation was quickly performed using anaesthesia. The nurse asked the girl to open her legs and made a small cut. There was almost no bleeding. A few minutes later, she put the underwear back on with the gauze. After the operation, the girl was able to walk home escorted by the mother. The mother was not at the operation scene but waited at the clinic, and then paid the nurse before they left. I visited the girl one week later, after her seclusion period. She said she had no pain at all at that time and felt happy.

[5] Traditionally, when their grandchildren were circumcised, the grandmothers would congratulate them and make a loud, high-pitched celebratory noise, '*Alili–li–li*!' They would also start singing vulgar songs (Miyachi 2004, 2014). In most cases, the celebration was small, except in the case of the twins, when it was customary to have a large feast.

5.4.2.3 Operation at the Hospital

In my research in 1999–2000, there were a few hospitals in Kisii providing for male circumcision only. Female circumcisions at the hospital were not common there because of the Presidential Ban, and in the case of FGC, the operator is required to be a female, as was the case here. In the interviews with one father, a widower, he explained that there was no female family member to take care of his girl in the compound, so he chose the hospital where he could also ask for one week of post-operative care for the child. Traditionally the father is not allowed to be at the operation or to see his daughter during the seclusion period. According to him, it cost a lot of money for one week of hospitalization.

5.4.3 People's Reactions

There are several issues to clarify here, about girls' behaviours, changing cutting styles, and changing rituals.

5.4.3.1 Girls Behaviour

In December 1999, according to participant observers in the research, the girls after the seclusion period were happy. They were proud of themselves for completing the process, withstanding the pain, and had no more worries about being teased for being "uncircumcised girls." In addition, they could look forward to Christmas presents and a special meal to celebrate Christmas day. And of course, parents and other family members were all honoured. Peer pressure was strong in rural areas, as almost all members practice FGC. Furthermore, at that time, anti-FGM activities were few and only visible in Kisii town. In rural areas in 2000, with no internet, no available radio for girls and mothers, information around FGM was limited.

5.4.3.2 Changing Cutting Styles

Cutting styles and cutting parts were also changing. Previously, the old type involved cutting the labia minor and part of the clitoris (Type II). This changed to cutting a part of the clitoris (Type I), or to pricking and nicking the clitoris (Type IV).

The nurses, operators of the cutting, decided how much to cut the genital part, and tried to minimise it. Operations were performed hygienically. Unlike the old procedure, the nurses simply made an incision and let out a few drops of blood. The important point here was not the kind of operation, but that the fact of cutting itself was considered most important.

How was the reaction of grandmothers to these changes? One of the grandmothers told me that "current cutting is nothing, too small, little blood." The grandmothers

seemed a bit unhappy with the smaller operation, which was different from what they had experienced. But they understood the changes and followed the mother's decision. The mothers, on the other hand, tended to choose a nurse for their daughters through acquaintances in church or some other social network, based on the nurse's reputation. Some common comments were, "I heard that *that* nurse doesn't cut off too much." or "I don't have to worry because she doesn't make girls bleed much."

The fee for the operation was between 100 and 200 Kenyan Shillings (approximately US $1–2). This was not a large amount of money for nurses, and not so expensive for the parents. But in some cases, the parents could not afford to pay in cash, so the nurses received agricultural products as payment. As their main source of income was from hospitals and clinics the nurses did not need the extra cash. In 2000, they mentioned that they would stop operating as soon as the presidential ban led to someone's arrest.

5.4.3.3 Changing Style of Celebration

At the time of the research in 1999–2000, the celebratory feasts were becoming less frequent. There were two main reasons for this: the Presidential Ban and the economic burden for parents. Firstly, the ban impacted nurses who performed the circumcisions; they were afraid of being arrested so they asked families to celebrate quietly. The second reason was that children's education was becoming expensive, so parents did not have enough money to provide food and drinks for as many guests as before. After the seclusion period, most parents had small celebrations. They shared food like *mandazi* (deep-fried buns) and soda, only within the family, that is, without inviting other relatives and neighbours.

The operations took place in December when schools closed for the long year-end vacation so that children could celebrate Christmas with their families after the seclusion period. Circumcision itself was not mentioned explicitly in connection with Christianity, but it was a joyful time for the family as they could celebrate both Christmas and the end of the process of the ritual.

5.4.3.4 Other Changes

Regarding the age of circumcision, earlier ethnographies in the 1940s show it was performed at approximately 15–16 years, in time for the marriage of adolescent girls (Mayer 1953). The age of circumcision tended to decrease every year (Matsuzono 1991; Gwako 1993, 1995), and research in 1999–2000 showed it was performed on girls around 6–10 years old. There were several reasons for this, one of which was based on the parents' request. Some parents mentioned they preferred the girls' operation to occur before the occasion of meeting a boy at school. Parents were worried about girls' sexual behaviour and early pregnancies. Nurses mentioned that younger girls, e.g., under 6 years old, did not have fear. Older girls, on hearing several

stories from other girls at school or from friends, became fearful and nervous, so some nurses felt the operation was easier for little girls who did not yet feel fear.

5.5 How Have People's Attitudes Changed?

There have been many changes in the daily life of people in rural areas. Now there are mobile phones, electricity, internet, TV, and other media which were not in common use in 2000. People's lifestyles have changed. There has been an increase in education, and work in urban areas and even abroad; thus local people are more aware of the global attention to FGM. Intermarriage with different ethnic groups, which do not practice it, is also more common. These social changes affect the perceived importance of the ritual. The situation surrounding the FGM Act and anti-FGM activities and the changing attitudes towards it will be further examined in this section.

5.5.1 Anti-FGM Activities

5.5.1.1 Activities in 2000

In the research of 2000, the Presidential Ban was widely known to nurses and community people. It had led to greater medicalization, a shift of style from Type II to Type I and Type IV, and a decrease in celebratory activities. There was also increased awareness of how other ethnic groups, such as the Somali people practiced FGC, i.e., that they practiced the more severe Type III, called infibulation. Mothers in Kisii disapproved of this, knowing that it causes severe blood loss and long-term physical problems, and believed the operation style in the Gusii was not as harmful and had no negative effects on girls' bodies.

There were a few anti-FGM activists in Kisii at that time. There were several nationwide organisations, such as MYWO (Maendeleo Ya Wanawake Organization), and FPAK (Family Planning Association of Kenya, currently named "Family Health Options Kenya"). The international organization PATH (The Program for Appropriate Technology in Health) also offered information about the negative aspects of FGM. When I interviewed the project staff in Kisii Town, the respondent said, "I am a Gusii myself, so I know that this circumcision is important for people. If we try to promote the anti-FGM activities strongly, it will cause people's opposition, and other projects will not be successful. That's why we don't do much against it" (Miyachi 2004: 124).

5.5.1.2 Recent Anti-FGM Activities

Since then, owing to its high prevalence in Kisii, there have been various activist groups against FGM in the area. Religious organisations included the Adventist Relief Agency (ADRA), Action Aid, Julie K, Lutheran Outreach, Christian Children's Fund (CCF), SDA, and WAFNET. Some international medical organisations, such as ATFC, Vivid Communication, CWS, AMREF, World Relief, MARLIN, PATH, Mosocho, and RWAIDO, have also been active (Evelia et al. 2007, p. 10). Since 2008, UNICEF and UNFPA have also contributed to providing programmes for eradication nationwide (UNICEF 2021).

Such activities have included announcements and health talks at churches and community gatherings (*baraza*), outreach to the community and religious leaders, and education for girls focusing on empowerment and reproductive health. "Alternative Rites of Passage" (ARPs) have been promoted by international and national organizations as a substitute for traditional rites of passage. In ARP, instead of cutting genital parts, the girls attend seminars on reproductive health and participate in empowerment programs (UNICEF 2021; Hayashi 2017; Buttia 2016). These activities have been implemented nationwide. UN agencies, such as UNICEF and UNFPA, also sponsor activities. When I visited briefly in 2018, schoolteachers told me that they have also begun to offer education on FGM through DVDs and textbooks. Recently, there have been news reports concerning arrests of parents and those who have performed FGM.

5.5.2 What About the Reaction to Anti-FGM Activities

5.5.2.1 The Community Survey

I would like to refer here to one survey which was conducted in a rural community in Kisii (Okemwa et al. 2014). It included 373 respondents (aged 15 years and above) and employed questionnaires, focus group discussions, and key informant interviews. One of the interesting points of the survey was about men's behaviour. When men were interviewed about the anti-FGM activities, 55% responded, "I would not marry a woman who is not circumcised." Furthermore, women in leadership positions (teachers and nurses) were also seen to support their daughters' operations. The results demonstrated that it was still considered important as a rite of passage in that community. The rate of practice was 99% in the community. While 93% of the population knew about anti-FGM activities, people did not support them. Reasons cited were negative images surrounding such activities, including "loss of respect for parents," "daughters leaving the house," and "girls dressing immodestly" (Okemwa et al. 2014). These results differ from the nationwide research, KDHS of 2014, yet it is possible to comprehend this contradiction. Even if they understood the bad effects of the operation, behaviour change was quite another challenge.

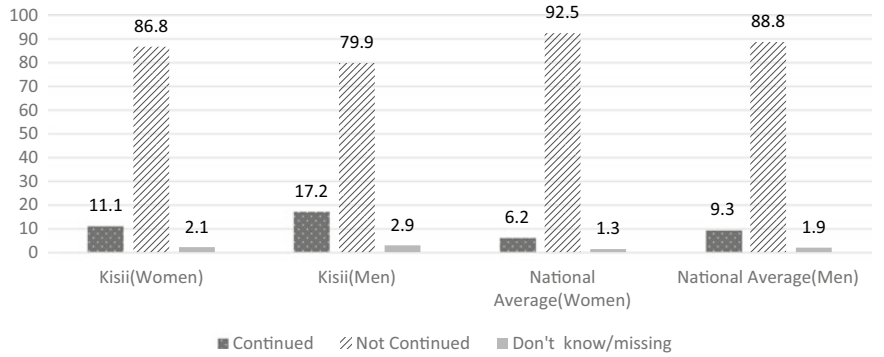

Fig. 5.2 Continue and not continue the practice. *Source* The original data from the KDHS 2014 (KNBS 2015)

5.5.2.2 Men's Attitude

One of the keys to the successful eradication of FGM is male involvement. However, fathers and other males are rather reluctant to be involved in female matters, including circumcision. Fathers say it is a women's issue. The KDHS of 2014 included male participants in the research (KNBS 2015). A question about their attitude towards continuation was included.

As Fig. 5.2 illustrates that most men and women believed that the practice should be discontinued. However, broken down by gender, and ethnic group, a slightly higher percentage of males than females responded that the practice should continue. It was also shown that among the women in Kisii (Gusii people), the preference for continuation (11.1%) was higher than the national average (6.2%).

5.5.3 No More FGC?

During my brief visit in 2018, there were drastic changes. The nurses, key informants of the research in 2000, were no longer performing operations. Some of them had totally retired as nurses. Some said they did not perform it because they were afraid of being arrested. But they mentioned also that others were doing it, instead of them, secretly. In 2000, even though some operations and celebrations were practiced in private, they were happy to talk about it. Now, because of the law, people have become silent. I also visited the mothers and fathers of the girls and the teachers at school. All they mentioned was that "it is not good practice, and we should stop it." It was rather surprising, because the mothers were insisting on its continuation in 2000, but had changed their attitudes by 2018. They said they had learned more about it at seminars, community gatherings, and churches.

Recent research on Gusii mothers shows that FGC has become more individual-based and secret (Van et al. 2021). However, its prevalence has decreased. Van et al. (2021) reveals that 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% (Van et al. 2021: 2). Recent research with mothers (asked about their daughters' situations) revealed that cutting in the younger generation has almost halved (Van et al. 2021, p. 8).

5.6 Conclusion

There have been so many attempts to eradicate FGC in Kisii. The enactment of the anti-FGM law in 2011 has greatly influenced the community. Campaigns by internal and international organisations have been conducted on TV, radio, and in newspapers. People's awareness has increased. Teachers and students have also been educated on the effects. Community members have gained information from attending local meetings, and churches also offer information. However, obtaining information is not enough to achieve abolition. Genital cutting for both girls and boys is a health risk and people are aware of it. Yet it is still recognized as a rite of passage, one that affirms the identity of being a Gusii. The pain caused by circumcision is considered an important part of the process of becoming an adult.

Because of the FGM Act, and under the circumstances of COVID-19, it is difficult to examine the current situation. Under the strict Act, there are concerns about it becoming underground and being performed on even younger girls in Kenya (UNICEF 2021). According to one report, operations seem to have been secretly performed by retired nurses on younger girls in the age group of four to six years old (Komba et al. 2020). Additionally, if there are any health problems after the operation, they cannot go to the hospital, because parents and medical personnel are afraid of getting involved. As such, the zero tolerance approach may drive the practice underground, which puts girls' health at further risk.

Thus far, the global strategy against FGM has been a "zero tolerance" approach, which is simple, powerful, and widely spread. In terms of eradication of FGM, however, alternative strategies should be formulated based on each cultural and social context. There was an innovative activity, run by a self-help women's group in Kisii, which dealt not only with FC but also with other gender issues, like women's inheritance, women's marriage, and domestic violence (Miyachi 2004, 2014). The group found a way to persuade local mothers not to perform FC on their daughters. In addition, they supported income-generation activities for local women. One woman in the group said, "My daughter may be teased for not being circumcised, but one day someone has to break this bad chain of events." They visited houses trying to persuade mothers and grandmothers. This type of local approach was unique and different from those on the national and international levels. This is a grassroots but comprehensive approach, which seemed much more effective among the community people.

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