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DOI:
10.1177/10497323211015967

Research Article

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Qualitative Health Research
1–14

DOI: 10.1177/10497323211015967
journals.sagepub.com/home/qhr

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Abstract

Female genital mutilation/cutting (FGM/C) remains a global problem. We aimed to explore Kenyan health care professionals' (HCPs) perceptions of FGM/C abandonment and, in particular, those focused on those serving Maasai communities who continue to practice FGM/C. Using a grounded theory Straussian approach, 18 interviews were conducted with HCPs in Kajiado County, Kenya, to understand perceptions of FGM/C as a cultural practice, identify barriers and facilitators to abandonment, and explore attitudes to medicalization (FGM/C conducted by HCPs) and alternatives of FGM/C. Within a substantive theory, one core category ("FGM/C persists but can be abandoned") comprised two subcategories: "exploring the influencers of persistence" and the "roadmap to abandonment." HCPs believed collaborative multilateral efforts were necessary to support successful abandonment and that "enlightening" the community needed to focus on changing the perception of FGM/C as a social norm alongside a health risk educational approach. Future effective intervention is needed to support the abandonment of FGM/C in Kenya.

Keywords

female circumcision; female genital cutting; abandonment; health care professionals; Kenya; grounded theory; qualitative

Background

Female genital mutilation/cutting (FGM/C) is a procedure involving the partial or total removal of female external genitalia, or other injury to the female genital organs, for nonmedical reasons (WHO, 2020). The classification of FGM/C (type I to type IV) reflects the severity of injury to the external genitalia, with type III being the most severe form (WHO, 2020). It is a practice carrying cultural significance and is a deep-rooted social norm (Muteshi et al., 2016). FGM/C is prevalent in 31 countries and rates are highest in sub-Saharan Africa, as well as in other countries in the Middle East and Asia (END FGM EU, n.d.; UNICEF, 2020b). However, a recent report suggests FGM/C could be present in over 50 countries and that at least 200 million women and girls are affected globally, though these data must be interpreted cautiously (UNICEF, 2020b, 2020c). Only 30 countries in this data set have nationally representative survey data which limits the accuracy of prevalence estimates (Cappa et al., 2019).

Widespread condemnation of the practice has seen its prevalence fall in many countries within the last three decades, but this decline has been unequal and not all countries have made impactful progress (Kandala et al., 2018; Koski & Heymann, 2017; UNICEF, 2020b).

Kenya has seen an overall decline in FGM/C prevalence (among adolescent girls aged 15–19 years) from 41% in 1984 to 11% in 2014, although there are reports of medicalized FGM/C increasing in the country (Kenya National Bureau of Statistics, 2014; Njue & Askew, 2004; Shell-Duncan et al., 2018; UNICEF, 2020a). Medicalized FGM/C is where women and girls are cut by a health care professional (HCP) rather than a traditional cutter who is typically a respected female elder

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within the FGM/C-affected community (Doucet et al., 2017; UNFPA et al., 2010a). The reduction of FGM/C prevalence has also been found to be unequal across Kenya, with some regions experiencing a higher prevalence than others (28TooMany, 2013). FGM/C prevalence varies from 0.8% in western regions to 97% in north-eastern regions, owing to the diversity of ethnic communities (Kenya National Bureau of Statistics, 2014). The Maasai, traditionally nomadic pastoralists, have one of the highest prevalence rates of FGM/C in Kenya, at 78% (among women aged 15–49 years), and traditionally practice Type II FGM/C (Kenya National Bureau of Statistics, 2014; UNICEF, 2020a). However, prevalence data, particularly from nomadic communities, must be interpreted with caution, given that challenges in data collection may affect its representativeness (Randall, 2015).

Several intervention strategies have been employed in different settings globally to promote abandonment of FGM/C, including education about health risks, training HCPs as change agents, community empowerment, legal measures, and alternative rites of passage (ARP), with varying success (Johansen et al., 2013). Health risk approaches have been found to inadvertently contribute to the demand of medicalization and the potential transition toward less severe forms of FGM/C, while the introduction of legal measures has prompted the practice to be driven "underground" (Johansen et al., 2013; Kimani & Shell-Duncan, 2018).

The medicalization of FGM/C is a contentious debate (Kimani & Shell-Duncan, 2018; UNFPA et al., 2010). Medicalization has become increasingly common with estimates suggesting that 52 million FGM/C affected girls and women (1 in 4 of all FGM/C survivors) have been cut by HCPs (UNICEF, 2020b). In high-prevalence settings, it has been argued that medicalized FGM/C reduces the risk of immediate health consequences, although critics claim it undermines efforts to abandon the practice (Awolola & Ilupeju, 2019; Doucet et al., 2017; Njue & Askew, 2004). A study determining the trends of medicalization, based on self-reported data, found rates were highest in Sudan (67%), Egypt (42%), Guinea (15%), Kenya (15%), and Nigeria (15%) (Shell-Duncan et al., 2018). In Kenya, there is also anecdotal evidence to suggest that some HCPs hold pro-FGM/C views, despite the FGM/C Act 2011 prohibiting the practice (The Guardian, 2018; 28TooMany, 2018).

The World Health Organization (WHO) has developed guidance on FGM/C management which also emphasizes the role of HCPs as "caregivers," not "perpetrators" (WHO, 2016). In parallel, there is a need for HCPs to lobby for abandonment as they have an important role in intensifying efforts to reach FGM/C elimination by 2030, as per the Sustainable Development Goals (SDG 5.3) (The Lancet, 2016; WHO, 2016). However, there is a paucity of literature concerning HCPs' involvement in, and their perceptions of, FGM/C abandonment efforts (Berg & Denison, 2012). A systematic review considering the effectiveness of HCP-level interventions found two studies which implemented educational interventions aimed at increasing caregivers' knowledge of FGM/C, although failed to evaluate FGM/C prevention capacities (Balfour et al., 2016). Furthermore, in a systematic review evaluating the effectiveness of interventions designed to prevent the practice, the authors identified one study which trained HCPs on FGM/C and its consequences, reporting there was little sense of advocacy for abandonment following training (Berg & Denison, 2012). However, HCPs are often seen as authority figures and, in high-prevalence FGM/C settings, often have a wealth of experience in caring for FGM/C affected girls and women (Berg & Denison, 2012). Therefore, they could play a key role in efforts to abandon FGM/C through education and outreach (Berg & Denison, 2012; OHCHR et al., 2008).

In Kenya, ARP has been lauded as a pioneering intervention to tackle FGM/C and maintain the cultural significance conferred on cutting (Droy et al., 2018). ARP is thought to be a feasible alternative in communities where FGM/C is considered to be central to girls' initiation to womanhood and generally includes components such as community sensitization, seclusion of girls from the community where they can be instructed in topics such as FGM/C, life skills, human rights, health, as well as a public graduation ceremony (Droy et al., 2018). However, to date, there has been little evidence-based research into its effectiveness (Chelala, 1998; Droy et al., 2018; Graamans et al., 2019b). One qualitative study exploring the lessons from ARP implementation in Maasai communities found that suspicion and perceived outsider interference were reasons for nonadherence (Graamans et al., 2019b). Given the importance of alternatives to FGM/C, it is important to understand the role of HCPs in promoting ARP, which may serve as a way to remove barriers from perceived outsider interference.

This grounded theory (GT) study aimed to investigate the perceptions and attitudes of HCPs to the abandonment of FGM/C in Kajiado County, Kenya. The objectives were to (a) understand the perceptions of FGM/C as a cultural practice, (b) identify barriers and facilitators to its abandonment, (c) explore attitudes to the medicalization of FGM/C, and (d) explore attitudes to alternatives of FGM/C such as ARP.

Method

Theoretical Approach and Positioning

A GT approach was used for this study, given that GT has been used in other qualitative studies researching FGM/C

and the sparse literature pertaining to HCPs' views on abandonment of the practice (Glover et al., 2017; Johnson & Waterfield, 2004; Tarr-Attia et al., 2019). GT aims to develop new theory "grounded" in data that are systematically collected and analyzed (Connelly, 2013; Strauss & Corbin, 1990). A Straussian approach was used as this methodological genre of GT aims to develop a substantive theory and provides more structure for data collection and analysis, compared with classic GT (Chun Tie et al., 2019; Evans, 2013). While the classic and Straussian GT approaches have a shared ontology, there are some epistemological differences, namely in how the latter approaches data analysis (Evans, 2013; Heath & Cowley, 2004). The Straussian approach supports familiarization with the literature in the early stages of research, and this developed theoretical sensitivity then informs data analysis (Evans, 2013; Hallberg, 2006). This approach emphasizes a balance of induction, deduction, and verification of discovered concepts and categories and was deemed most appropriate for our study, given that early reading of the literature informed the generation of the study question (Evans, 2013; Heath & Cowley, 2004).

Study Setting

This study explored the insights of HCPs to the abandonment of FGM/C in Kajiado County, Kenya. Kajiado houses a large Maasai population and has a history of anti-FGM/C intervention efforts, including ARP (Coast, 2002; Graamans et al., 2019b). The County Government also enacted an FGM/C policy in 2019 to facilitate abandonment of the practice and the views of HCPs could potentially be of significance to inform this policy (Amref Health Africa, 2019; Berg & Denison, 2012; OHCHR et al., 2008).

Study Design and Recruitment

All interviews were one-to-one and took place at Kajiado County Referral Hospital (KRH). KRH is the only Level 5 government hospital in Kajiado County and was therefore likely to be exposed to a greater patient population and, by extension, more FGM/C affected patients, which potentially speaks to HCPs' experience of the practice, clinically.

Interviews were conducted between January and February 2020 in a one-to-one, semi-structured format which aligned with the Straussian GT approach (Duffy et al., 2004). Interviews followed a topic guide developed based on existing literature and through discussions within the research team (Supplementary Table 1). This topic guide was developed iteratively throughout data collection, as part of the constant comparison method (Corbin & Strauss, 2014). Prior to all interviews, a short questionnaire was conducted to capture additional information about participants (Supplementary Table 2).

We liaised with a hospital contact, and initially used purposive and snowball sampling in recruitment. A local research assistant also assisted with recruitment by approaching and liaising with eligible participants. A transition to theoretical sampling was then achieved, guided by concepts discovered from theoretical memos (Corbin & Strauss, 2014). Where participants gave permission for their contact details to be stored, interviews were scheduled via mobile, or were otherwise face-to-face. Recruitment stopped when theoretical saturation was achieved, which was verified through reflection on theoretical memos and discussion within the research team (Birks et al., 2008).

Participants were eligible for recruitment if they worked as any HCP cadre including, but not limited to, doctors, nurses, midwives, social workers, and community health workers. Participants had to be working at KRH, have experience of caring for FGM/C affected girls or women within the last 5 years, be able to converse fluently in English, and give written informed consent to interview and audio-recording. There were no exclusion criteria.

In total, 18 interviews were conducted, lasting on average 29 minutes (range = 15–40 minutes). Supplementary Table 2 describes the participant characteristics. The majority of participants were: female; over the age of 35 years; a nurse; regularly providing care to FGM/C-affected girls or women; reported that FGM/C prevalence was high; and aware of local abandonment activities and FGM/C illegality. Half of participants identified as Maasai.

Data Management and Analysis

Interviews were audio-recorded, transcribed clean verbatim, and managed using NVivo Version 12. Prior to analysis, all transcripts were read to achieve immersion and familiarization with the data (Corbin & Strauss, 2014). Analysis was conducted through open coding, axial coding, and selective coding with the constant comparative method used alongside this to construct accurate codes (Chun Tie et al., 2019; Corbin & Strauss, 2014). However, a coding paradigm was not utilized during axial coding as this was thought to limit inductive analysis by "forcing" the data to fit into a preconceived paradigm (Hallberg, 2006). Instead, diagrams were used to visually document how concepts and categories related to each other.

Throughout analysis, theoretical memos were used to define codes, document discovered concepts and categories, and interpret a core category (Birks et al., 2008; Corbin & Strauss, 2014). An independent second-coder coded two of the most data-rich transcripts with a list of

codes derived from initial analysis. Any disagreements during analysis and construction of categories were discussed and an agreement reached.

Ethics and Consent

Voluntary written informed consent was sought from all participants by signing a consent form, following explanation of the study, its purpose, their right to withdraw, and how confidentiality would be maintained. However, participants were made aware that admission of illegal activity would lead to confidentiality being broken. Therefore, participants were not asked whether they were aware of "who" engaged in medicalizing FGM/C in Kajiado. Participants were given the opportunity to ask questions and offered 24 hours to consider their participation in the study.

As FGM/C is potentially a sensitive issue, there were measures in place to signpost participants to mental health support services if necessary, as well as offering participants the chance to pause or stop interviews. Female participants were not asked about their own history of FGM/C. To avoid potential social harm, through responses inadvertently being made public, interviews were one-to-one and conducted in a private room (Richards & Schwartz, 2002). In addition, characteristics of participants were not described in the Results of this study to protect anonymity. Instead, participants were given identifiers to distinguish between responses in the reported findings. These actions were taken to minimize the ethical implications of sampling from a small professional cadre where anonymity may be difficult to ensure.

Study data were stored on a password-protected device and then uploaded to a secure encrypted server. Audio-recordings were immediately deleted from the recording device after transcription of interviews. Study data were only accessible to the research team. Participants were given an anonymized identifier which was used on all relevant data sheets. Identifiable data on paper were held securely and destroyed at the earliest opportunity.

Ethical approval was gained from the BMedSc Population Sciences and Humanities Internal Research Ethics Committee (Reference: IREC2019/Student Ayaan Mohamud) and the Kenyatta National Hospital—University of Nairobi (KNH-UoN) Ethics and Research Committee (Reference: KNH-ERC/Mod&SAE/46).

Results

A core category central to the discovered theory was identified: "FGM/C persists but can be abandoned" (Connelly, 2013; Corbin & Strauss, 2014). This was composed of two subcategories, the first of which identified "influencers of FGM/C persistence" and the second identified the "roadmap to FGM/C abandonment." Figure 1 shows the schematic representation of how the core category related to the subcategories and its concepts.

The results of the analysis are presented below. Italics are used with quotation marks to indicate participants' own words being used; the term "FGM" was used in lieu of FGM/C in interviews. The following symbols and what they denote are as follows:

. . . is used when passages have been removed to shorten the quote and ensure its relevancy.
[ ] is used when a word/(s) has been included to ensure the flow of the sentence.

Core category: FGM/C Persists But Can be Abandoned

Subcategory I: Influencers of FGM/C persistence. The persistence of FGM/C in Kajiado was widely reported. Although there was an awareness that the prevalence of the practice had *"gone down a little bit*," Kajiado was still considered to be a high-prevalence setting for FGM/C. This persistence was attributed to numerous causative factors which have been described in more detail below.

Deeply entrenched cultural norms. The cultural practice of FGM/C was reported as being deeply entrenched in Kajiado and perceived as a driving force behind the persistence of the practice. In particular, these cultural beliefs are what participants described as those belonging to the Maasai. FGM/C was believed to be an integral aspect of the rite of passage for girls to become women and without it, girls were thought of as being *"incomplete."* It was perceived by some that the social pressures that came with being uncut further propagated the practice. The *"taboo"* associated with being uncut was reported to lead to isolation, as well as, difficulty in finding a husband or a birth attendant for assistance in childbirth. A few participants also stated that these pressures were so great that young girls themselves may request to undergo FGM/C to avoid being *"an outcast in the community."*

Prevailing cultural beliefs. Participants reported that FGM/C was considered to be such a *"deeply rooted"* social norm that it took precedence over the law. Despite perceived awareness of its illegality in the community, FGM/C was said to have been driven *"underground"* and conducted *"secretly,"* as a result of enacted legislation. Girls undergoing FGM/C would often have their rite of passage hidden from public knowledge by combining it with a boy's circumcision event so only *"one [public] function"* would be undertaken. The secrecy of the practice was attributed to fear *"[of] being arrested"* and why

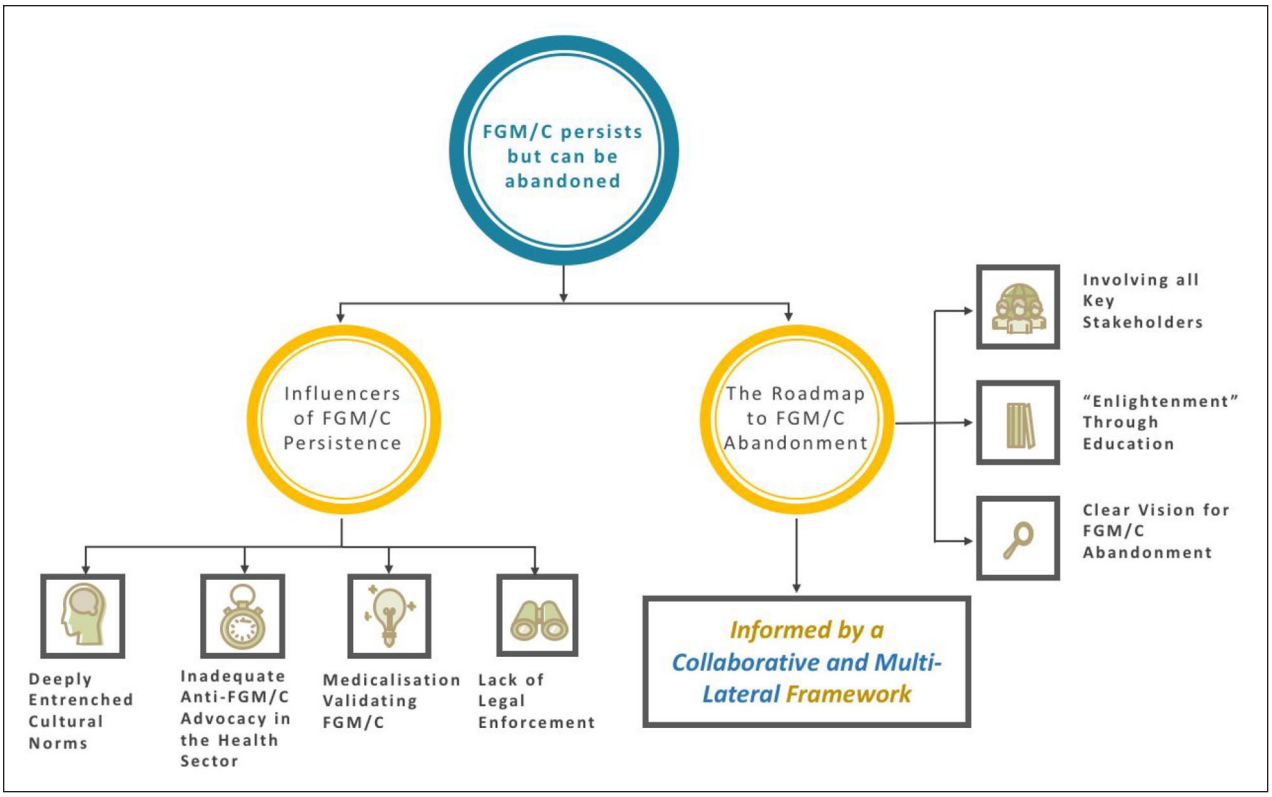

Figure 1. A schematic representation of how the core category relates to the two subcategories and its concepts.

FGM/C was no longer openly practiced and celebrated as it had been in the past. In particular, FGM/C was reported to occur during the school holidays in December, giving girls enough time to heal from the cut. One participant said that the type of FGM/C had *"evolved"* and that girls were now more likely to *"undergo an FGM that is a bit milder so that they heal and go back to school,"* implying an underlying belief that a less harmful form of FGM/C exists.

This secrecy was also reported to extend to ARP, an intervention implemented by some NGOs to reduce FGM/C prevalence (Graamans et al., 2019b). Some participants suggested that ARP may not be wholly effective as *"you'll hear some [girls] have been done the FGM again after they went to training,"* suggesting there might be false acceptance of the program. However, ARP was thought to be generally *"a good programme"* because it gave girls *"knowledge on the effects of FGM"* which *"really slim[med] the chances"* of them going through the practice.

There was also a perception that such deep-rooted beliefs took precedence over any perceived health risks. A number of participants reported that even when health risks were known, FGM/C persisted, and that abandonment could only be achieved by *"removing the notion"* that girls needed to be cut. Conversely, others reported that it was poor community awareness about the consequences of FGM/C that contributed to persistence. There was a general consensus, however, that despite prevailing cultural beliefs, there was evidence of *"change"* and that *"tremendous strides"* had been achieved in changing perceptions of FGM/C as a social norm.

Locality. Locality was thought to be indicative of cultural beliefs and therefore FGM/C prevalence. The practice was described as being more propagated in rural areas, or the *"interior,"* with *"metropolitan"* areas practicing FGM/C less in comparison. This was thought to be because the general *"education status"* of community varied between these two areas, with people in *"town [being more] knowledgeable."* However, some participants believed that anti-FGM/C messages were not being disseminated to rural areas and that despite being most affected, they were the people *"not reached."*

FGM/C as an unimportant issue. The status of FGM/C as a social norm was thought to contribute to the perception of it being an unimportant issue in the community. Participants described FGM/C as being a *"normal"* aspect of their society and that if it had been considered serious, there would be more *"campaigns against it."* One participant explained that FGM/C was not given any

weight because people had not *"come across the dangers involved"* so the community *"take it as a light thing."*

This perception of FGM/C was also reported to extend to HCPs. One participant referred to female HCPs suggesting that some may not consider the practice to be harmful if they had *"gone through FGM themselves."* The high-prevalence setting in which HCPs work was noted to be a reason for this perception, despite their medical background. One participant thought seeing FGM/C affected patients in daily practice led to *"desensitization."* This *"desensitization"* of HCPs was therefore thought to change how they perceived FGM/C as no longer being *"abnormal."*

Inadequate Anti-FGM/C Advocacy in the Health Sector

The lack of HCPs' involvement in anti-FGM/C interventions was widely reported. One participant stated that only activists were involved in current interventions and that HCPs were *"rarely"* involved. One barrier cited was the lack of available forums for HCPs to health educate the community. It was reported most HCPs only had the opportunity to health educate during patient consultations and that the lack of *"interaction with the community"* limited the reach of the information they were disseminating. Likewise, other participants stated that the only opportunities for them to engage in health promotion was when FGM/C-affected women attended hospital for birth or antenatal appointments. However, there was an understanding that this type of health promotion would only be a *"good opportunity for the next generation."* Using health education in this way was thought to be only partially effective because there was no certainty women would *"convey the message"* to the community.

Some participants cited logistical barriers such as the lack of time, high workload, staff shortages, and difficult access to rural areas which made it challenging to engage in FGM/C health promotion. It was reported that HCPs may not *"get a lot of time to go out there [to the community]"* and that *"staffs [were] also few."* Alongside these reported barriers, it was believed that the lack of structured support, namely from Kajiado County Government (KCG), was another challenge as HCPs did not have the *"know-how"* to explain FGM/C health risks to the community. Likewise, another participant stated HCPs' lack of involvement was "*one failure [of] the government."* However, other participants felt that HCPs needed to be *"pro-active as health professionals"* and that they could engage more in advocacy.

The "*desensitization*" of HCPs was believed to contribute to disengagement from anti-FGM/C efforts because HCPs were *"used to [the] problem."* However, another picture indicated an issue with the visibility or co-ordination of HCP-led interventions, as some participants reported that they were involved in outreaches to the community. One participant stated they went to the community and educated on *"the dangers of FGM,"* whereas others explained they were not aware of any outreaches.

Medicalization Validating FGM/C

There were differing views on whether medicalization was present in Kajiado. Most participants believed medicalized FGM/C was not present and that the practice was only conducted by *"specific women"* in the community. However, this was in contrast to some instances where participants stated medicalization was currently present or, had been present in recent years. One participant explained that "*unfortunately some health workers. . .[were] still being used by the traditional community for FGM."*

Medicalization was believed to have evolved in recent years and that HCPs who engaged in the practice "*wouldn't go for the major FGM which . . .[could] cause complications"* and instead practice a *"superficial FGM that [would] cause minimal harm."* This suggested that HCPs were aware of the health consequences but continued to engage in the practice regardless, as well a perceived belief that there are forms of FGM/C that are less harmful. While some participants believed their motivations centered around *"financial gain,"* others expressed the view it could be because those HCPs supported FGM/C for *"cultural [reasons]."*

However, despite conflicting views, there was a shared consensus that medicalization validated FGM/C, giving the community a sense that it was acceptable because it was HCPs themselves who engaged in it. This would therefore make it difficult to go *"away from the culture."*

Lack of Legal Enforcement

There were varied beliefs about the level of legal enforcement for FGM/C in Kajiado. Most participants believed that those practicing FGM/C would face *"trials,"* and that there was a *"very serious law process"* alleged perpetrators faced. Enforcement was reported to be the role of the Chiefs in the community, officials of the provincial administration, and that it had *"become mandatory for every Chief in the area to know who [was] being circumcised so that they [could] take action."*

However, in contrast to this, some participants expressed their belief that there was a lack of enforcement due to shortcomings of the legal system, namely through *"corruption."* It was thought that the relationship of the Chief to community members might be a catalyst to such corruption, for example, if the cutter was a

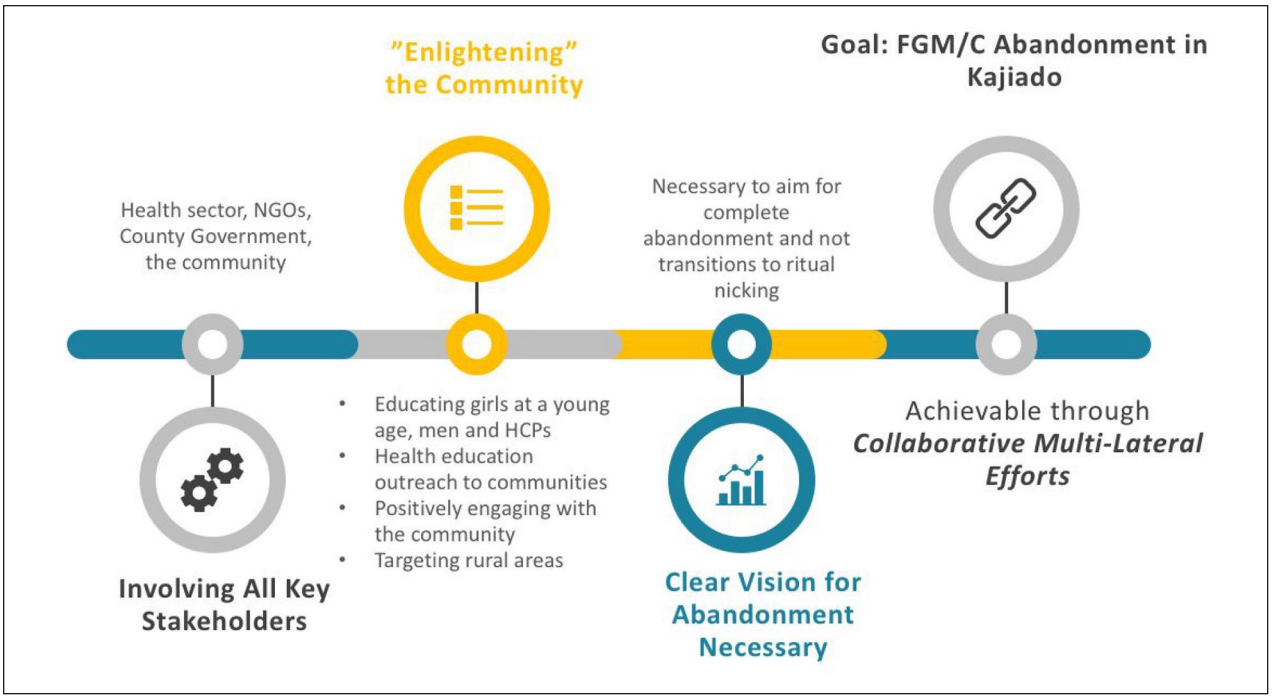

Figure 2. The roadmap to FGM/C abandonment.

"relative" or *"neighbor."* The corruption was reported to potentially contribute further to a lack of enforcement as *"no one tomorrow [would] say someone circumcised a girl."*

Fear of social isolation was also believed to be a contributing factor in lack of legal enforcement as reporting FGM/C could make you an *"outcast"* in the community, so people might be *"scared"* to report cases. This fear was similarly reported to extend to HCPs who may be forced to turn a *"blind-eye,"* because of the *"deep roots of this culture,"* and subsequently also failed to report cases. However, other participants believed failure in reporting was due to a lack of guidance for HCPs, unlike for *"assault"* cases which were taken *"very serious[ly],"* in comparison.

Subcategory II: The Roadmap to FGM/C Abandonment

This second interpreted subcategory focused on the facilitators to the abandonment of FGM/C in Kajiado. Participants reported that while anti-FGM/C efforts have had some success, they have been ineffective to reach the desired outcome of abandonment as so far, the "*war against FGM [was] not going anywhere far."* However, there was a belief that the cultural significance attached to the practice was diminishing in some way and that the perception of FGM/C as a social norm was changing: *"initially when you [were] not circumcised, it was an issue."* Nonetheless, there was an understanding that impactful progress would take time as you could not *"change a culture [in] one day."*

The significance of collaborative multilateral efforts as a framework for FGM/C abandonment in Kajiado was articulated by many participants. Participants reported that efforts should be *"multipronged"* and that those organizing policy and those in the frontline *"should move in one direction."* It was believed that this collaborative effort would lead to greater success in reducing FGM/C prevalence because having more people to champion against the practice would increase the reach of such messages in the community.

> The best way they can do [is], I think involving everyone in the fight so that any forum that we have a group discussing anything, the anti-FGM message is passed on.

The roadmap to successful abandonment was thought to involve (a) including all key stakeholders, (b) using education to "enlighten" the community, and (c) ensuring a clear vision for abandonment (Figure 2).

Involving All Key Stakeholders

The importance of HCPs' involvement was a widely shared sentiment. Their experience in treating FGM/C affected patients and being important figures in the

community were cited as key reasons. One participant explained that HCPs were even better placed than *"activists"* to deliver FGM/C health education to communities because they had a greater understanding of FGM/C and its effects. Participants also reported that the community *"respect[ed]"* HCPs, so their advice was *"value[d]."* However, some participants maintained that while HCPs might be respected, they could also be seen curiously by the community as *"learned fellows"* who may be *"out of track with the culture."*

Nongovernmental organizations (NGOs) were reported as current actors in anti-FGM/C efforts, and necessary for future initiatives, but that they needed to collaborate with local HCPs before "*going to counter . . . FGM in the communities."* The absence of collaboration was therefore thought to result in many of these local efforts being small in scale because NGO groups were *"few,"* suggesting NGOs involving HCPs could improve the landscape of FGM/C advocacy in Kajiado.

Although the general consensus favored the involvement of HCPs, other participants felt that logistical barriers, such as a high workload, would make this difficult. One participant stated HCPs *"don't get a lot of time to go out there [to the community]."* These constraints subsequently meant health promotion was currently lower down in the hierarchy of priority for some HCPs. But it was acknowledged using the health sector would be effective as there were "*health facilities almost everywhere"* in the county, allowing health education to be disseminated *"very easily."*

Other groups were also identified as being key stakeholders including KCG and the community itself. In particular, it was believed that KCG were *"the ones who should advocate for [FGM/C] much"* but that at the moment there was not *"adequate support from the officials."* It was also believed KCG had a role in allocating *"funds. . .to fight [FGM/C]."* Participants reported that a chronic lack of funding affected potential outreaches to the community as HCPs could not "*go to the community without funds."* It was believed that funding was necessary for training HCPs to gain the *"technical know-how"* in delivering effective FGM/C health education, as well for transportation costs.

Participants also viewed the community as having a role through embracing initiatives and promoting community policing. It was reported that HCPs could not engage in anti-FGM/C advocacy "*without community support"* and this support could also aid legal enforcement through *"community policing."* One participant stated this could be achieved through using the *"Nyumba Kumi initiative. . .[where in every] ten households, there is a leader"* who could be responsible for FGM/C *"surveillance."*

"Enlightenment" Through Education

Participants emphasized the importance of education as a tool to affect behavior change in the community, believing it was *"only education"* that could change cultural practices. In particular, it was reported that "*enlightening the community"* through health education was key. However, it was thought that while education could have an impact, it may not always overcome deep-rooted beliefs in the community because "*you cannot force somebody to get the message if he doesn't want to get [it]."*

Participants reported *"early informing of the community"* was important. Going out directly into the community would allow HCPs to reach those in the community who *"vouch"* for the practice and to reach rural communities who were thought to practice FGM/C more. However, it was also acknowledged that education needed to be delivered in the appropriate way by positively engaging with the community and by teaching, not *"fighting"* them. Some participants thought that anti-FGM/C advocates sharing the same ethnicity as the community would perhaps be seen *"less as outsiders"* and that education would be better understood because the same language would be spoken. But others believed language barriers could be overcome and that *"outsiders"* could still make an impact.

Girls enrolled in school were thought to be more *"enlightened"* and likely to refuse FGM/C because they interacted with uncut girls from other communities and so found it was "*not of any benefit."* Participants reported that girls could also be educated by FGM/C affected women on their experiences. This was thought to be important in dispelling myths about the practice, particularly in relation to FGM/C causing *"low libido."* One participant reported FGM/C was believed by the community to prevent promiscuity, so women don't *"become loose . . . sleeping around with men"* but that this loss of *"sexual satisfaction,"* after FGM/C, in fact encouraged women to go *"looking"* for it. Moreover, educating girls at a young age was reported to be important so girls grew up with the *"confidence that [they didn't] need to be circumcised."* The impact of education was also alluded to when one participant described FGM/C now being practiced at a younger age in the community because *"they realized when [girls] go to school, they get educated, they refuse [FGM]."*

It was reported that it was necessary for education to be extended to all members of the community and particularly men as *"decision maker[s]"* of FGM/C and who fuel the practice as a social norm by being not *"willing to marry"* uncut girls. However, this was contradicted by a few participants who reported that some men are *"getting married to girls who are not circumcised."* This was

thought to be because FGM/C may negatively affect sexual relationships and so FGM/C affected girls may be *"rejected by the men [when] . . . a man experiences someone who has not undergone FGM."*

Participants also reported that in addition to educating the community, HCPs themselves needed to be educated on FGM/C and the relevant legislation so that they *"become more knowledgeable . . . and know what to do when [they] encounter it."* Participants reported that there was little training on FGM/C and that HCPs did not have a good level of medical knowledge about the practice or understanding of the law. It was thought that educating HCPs on FGM/C in high prevalent settings was important and should be through *"regular training"* which could tackle the desensitization of HCPs as "*refreshers [would] bring it back into the forefront."*

Clear Vision for Abandonment of FGM/C Necessary

A few participants expressed the idea that an alternative, potentially less harmful form of FGM/C might be acceptable to the community. This notion of *"symbolic cutting"* was thought to facilitate the community to transition away from the commonly practiced Type II FGM/C among the Maasai. It was thought that *"running away from [FGM/C] completely"* might not be the solution given the ineffectiveness of current initiatives. One participant described that this could be achieved through ritual nicking of the female genitalia where you *"just touch the place, there's blood [and] there's no harm done to . . . the whole tissue."* Within this discourse, participants also referenced Islamic teachings with the mention of *"prophetic hadith[s]"* and *"Sunnah,"* suggesting that ritual nicking could be *"a good approach"* to achieving abandonment from more severe forms of the practice. There was the idea that this milder form of FGM/C would provide both the wider community and girls undergoing the practice with *"psychological"* reassurance, giving the community a sense that their cultural rituals were still upheld and respected by anti-FGM/C advocates.

However, it was also reported that there needed to be a clear vision for the abandonment of FGM/C in the county because "*symbolic cutting*" was *"still FGM."* Using the idea of ritual nicking as an anti-FGM/C message was thought to be counter-productive to abandonment efforts because people would continue to *"do the same"* FGM/C as before but claim to have changed the type they were practicing. Participants believed that efforts should aim to *"stop [FGM/C] completely."*

Discussion

As far as the authors are aware, this is the first GT study exploring the perceptions of FGM/C abandonment among Kenyan HCPs. The core category, based on the interpreted substantive theory, centers around the persistence of FGM/C but that abandonment is achievable through a framework based on collaboration and multilateral partnerships.

The significance of "enlightening" the community through education was a reported facilitator to tackle the influencers of its persistence, namely the deep-rooted FGM/C cultural beliefs and its status as a social norm. In particular, participants reported the importance of health education as a means to achieve this. Utilizing this health risk approach has traditionally been thought to encourage critical thinking about health consequences and ultimately lead to abandonment of the practice (Johansen et al., 2013). However, despite the perceived and documented advantages of this approach, there are a number of disadvantages including a subsequent demand for medicalized FGM/C and defense reactions incited from messages centered on condemnation and shocking imagery (Johansen et al., 2013). The effectiveness of health education is also challenged by various socioeconomic and demographic factors such as age, gender, education, and occupation (Waigwa et al., 2018). Our study also found that while health education can be effective in changing community perceptions, understanding of health risks may not always influence behavior change. Therefore, despite the success of this approach in some settings, it is important for a "whole systems approach" to be implemented in high-prevalence settings to ensure maximum impact of anti-FGM/C efforts (Berg et al., 2010; Johansen et al., 2013; Mwendwa et al., 2020).

To achieve this whole systems approach, "enlightenment" must therefore also focus on understanding and targeting the "mental map" of FGM/C, a map which guides the behaviors of individuals based on their community's cultural values, behaviors, traditions, and preferences (Graamans et al., 2019a; Varnum & Grossmann, 2017). Through understanding this "mental map," interventions can be better designed to facilitate a change in social norm, which is central to successful behavior change strategies (Evelia et al., 2007). Among the Maasai, FGM/C is a rite of passage believed to improve marriageability and reduce sexual enjoyment, thereby preventing wives from being unfaithful to their husbands (Graamans et al., 2019a). However, our study reported some beliefs which contradicted this. Therefore, further research into FGM/C beliefs among the Maasai is necessary given that cultural beliefs are not "static" and can change over time (Varnum & Grossmann, 2017). This would enable a better picture of the FGM/C "mental map" in Kajiado to inform intervention design and development. A study exploring FGM/C in a transnational context similarly concluded that theories of behavior change need to be country-specific with more emphasis placed on meaning-making for individual communities (Johansen & Ahmed, 2021).

The perceptions of some HCPs that educating girls at a younger age can empower them to refuse FGM/C is of particular importance. Some participants noted that FGM/C now occurred among younger girls in the community, in anticipation of the empowerment and understanding of human rights they might gain from schooling. This has similarly been reported among other Kenyan communities, where shifts in FGM/C practice included cutting at a younger age, to avoid resistance associated with intellectual development, among other factors (Graamans et al., 2019b; Kimani & Kabiru, 2018). In our study, FGM/C was also reported to occur predominantly during the school holiday period in December, to allow girls to heal from the cut before attending school again. This phenomenon has similarly been reported in other Maasai communities in Kenya (Graamans et al., 2019a). Interventions to tackle these phenomena could potentially involve establishing clear anti-FGM/C message in both primary and secondary school curricula, as well as developing a protocol to engage with at-risk girls and their families during the holiday period. Such interventions could prove impactful given that internalizing social norms, such as FGM/C, as "absolute truth" has been reported to influence the decision-making power of women in regard to such norms, essentially rendering them powerless (Hamed et al., 2017). Utilizing the already established *Nyumba Kumi* initiative, where there is a designated leader for a cluster of households, could also be another way to address these issues and would not be resource-intensive (Kimani & Kabiru, 2018).

The importance of HCPs' involvement was a significant concept in our study and has been similarly reported in a systematic review which found that HCPs were not only targets of anti-FGM/C interventions, but also had a role as "change agents" themselves (Waigwa et al., 2018). It was reported that if prominent figures of communities, such as HCPs, refrained from advocacy, this could have a negative impact on the success of interventions (Waigwa et al., 2018). However, research has shown that HCPs are typically less involved in anti-FGM/C interventions undertaken in high-prevalence settings (Johansen et al., 2018). This lack of involvement may be as a result of poor knowledge in various dimensions of FGM/C, which therefore could impact their capacity to engage in advocacy (Zurynski et al., 2015). This lack of knowledge was also reflected in the findings from our study, where participants reported the need to re-educate HCPs on FGM/C, which could additionally overcome their "desensitization" leading to FGM/C no longer being perceived as "abnormal." Alongside poor knowledge, the lack of HCPs' involvement was also attributed to inadequate capacity as a result of structural barriers. This could likely be overcome by a cohesive approach involving KCG, thereby providing greater support to HCPs.

The inclusion of HCPs in abandonment efforts may concurrently address the reported medicalization of FGM/C in Kajiado. Evidence also suggests that 9% of Maasai women in Kenya (among women aged 20–24 years) have undergone FGM/C by HCPs (UNICEF, 2020a). The medicalization of FGM/C has long been considered at odds with the oaths of HCPs to "do no harm" but has evolved as a practice based on the principles of harm-reduction (Doucet et al., 2017; UNFPA et al., 2010). However, many HCPs have limited knowledge of the long-term consequences of FGM/C, negating this idea of harm-reduction (Leye et al., 2019). Our study reported that participants largely believed that medicalization validated FGM/C, which has similarly been reported elsewhere (Kimani et al., 2020). However, given the inconsistencies in reports of medicalized FGM/C in our study, likely because of awareness of its illegality and ethical concerns, further research is needed to accurately measure how pervasive this practice is.

Furthermore, a key finding of our study was that participants reported harm reduction approaches to FGM/C have involved transitions to "symbolic cutting," with less severe FGM/C being conducted in the community. Some participants also believed this could be the target in Kajiado, as opposed to complete abandonment. This has been similarly reported in a study conducted among the Kisii tribe in Kenya, where most participants reported less tissue being removed and transitions to "nicking" of the clitoris, likened to "psychological circumcision" (Njue & Askew, 2004). To avoid transitions to other forms of FGM/C, a clear vision for abandonment needs to be emphasized in initiatives, alongside educating HCPs that there are harms associated with all forms of FGM/C and their need to champion complete FGM/C abandonment.

Although the involvement of HCPs was thought to be instrumental, abandonment cannot depend on the health sector alone (Catford, 2009). There was a widely reported belief that involvement of HCPs needed to be coupled with co-ordination across multiple sectors in Kajiado including the government, the health sector, NGOs, and the community. The positive implications of collaboration in health promotion have been well documented as it allows knowledge, experience, and resources to be shared (Tzenalis & Sotiriadou, 2010). In our study, it was reported that KCG had a principal role in supporting such multilateral partnerships, although poor government advocacy was noted at present. This is typical of many high-prevalence countries where governments have been found to be "silent" on the issue of FGM/C, leaving interventions to be spearheaded by NGOs (WHO, 2011). However, KCG enacted an FGM/C policy in 2019 which promotes the strengthening of coordinated multisector interventions (Amref Health Africa, 2019). The results of

our study could potentially inform this policy and encourage KCG to involve all key stakeholders in interventions. As well as this, these results could support training of such stakeholders, including HCPs, local government officers, and members of the community such as civil society actors and tribal leaders.

While the Kajiado FGM/C policy aims to overcome the absence of a "whole-systems" approach, there is insufficient evidence to support the effectiveness of proposed interventions such as ARP (Amref Health Africa, 2019; Droy et al., 2018). Our study also reports false acceptance of the program, with participants suggesting some girls may already be "cut" during ARP or undergo the practice afterward. This could be because ARP may ineffectively address the social value attached to FGM/C when engaging communities, thereby failing to remove social pressures for girls to be cut (UNICEF, 2010). Our study also reported that anti-FGM/C advocates may be seen as "outsiders" by the community, which was similarly reported by a study exploring the lessons from ARP implementation in Kajiado (Graamans et al., 2019b). Therefore, further research is important to ensure ARP is accepted locally and adapted suitably for the target population. Research into other interventions to achieve an effective "whole systems approach" is also key moving forward. Aside from health risk approaches, other interventions that could potentially be implemented include community-led empowerment programs, mass media campaigns, and sensitizing men (Johansen et al., 2013; WHO, 2011). It is important that comprehensive research, monitoring, and evaluation are undertaken into the effectiveness of interventions to understand how best to direct limited resources (WHO, 2011).

Strengths and Limitations

This study is strengthened by the robustness of the methodology, which was aligned with a Straussian GT approach. As well as this, a range of HCPs were interviewed, with recruitment also being guided by theoretical sampling, allowing the perspectives of different health care professions to be sampled. However, one limitation was that theoretical sampling was guided by theoretical memos rather than analysis of transcripts. This was due to the time-pressured nature of roles within the health sector, which meant participants were interviewed at times most convenient for them. However, theoretical sampling would have ideally been guided by coding of interview transcripts, as this would have added to the robustness of the methodology (Corbin & Strauss, 2014).

In addition, sampling from a single site (KRH) may have introduced limitations in data collected as the interpreted data reflect only the experiences of one group of HCPs in Kajiado. This therefore affects the transferability of our findings to other Level 5 government hospitals in similar contexts.

To understand how the background of the researcher (British, female, a medical student, from a black and minority ethnic group and from a different FGM/C affected country) may have influenced the study, memos were used to document the research process (Birks et al., 2008). Multiple coders with different backgrounds were also used to facilitate interpretation.

Given the sensitive nature of the topic, a local research assistant supported recruitment to facilitate rapport with participants, which may have removed potential barriers in interview. The nature of the topic also prompted the researchers not to use member validation to verify participant's responses (Birt et al., 2016). Instead, an independent second coder was used to improve the rigor of analysis. Furthermore, as FGM/C is widely believed to be a harmful practice, this awareness may have influenced participants' responses, given that they are HCPs. Therefore, this research could be influenced by social desirability bias (Grimm, 2010). However, participants were assured their responses would remain anonymized to reduce the effect of this bias.

Conclusion

The interpreted core category, FGM/C persists but can be abandoned, highlights what HCPs believe is fueling FGM/C in Kajiado and the existing gaps in anti-FGM/C initiatives. Factors contributing to persistence include the practice being a deeply entrenched cultural norm, inadequate advocacy in the health sector, medicalization validating FGM/C, and a lack of legal enforcement. The roadmap to successful abandonment is achievable and should be informed by a collaborative multilateral approach which includes all key stakeholders, "enlightens" the community through education, and ensures a clear vision for abandonment.

Recommendations

To facilitate behavior change and abandonment, educating the community should not only be through the lens of health but should also focus on targeting the "mental map" of FGM/C among the Maasai to change the perception of the practice as a social norm. However, health education can potentially be transformative and the involvement of HCPs in this type of FGM/C advocacy might be key to achieving successful abandonment in Kajiado. Further research, monitoring, and evaluation are necessary to measure the effectiveness of interventions and ensure resources are being directed for maximal impact.

Acknowledgments

The authors thank Dr. Chege Macharia and Eva Komba for their support in conducting this study on-site. In addition, the authors also thank Jacque Muthonio and Vera Asubila for their support in navigating the ethical approval process in Kenya.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This study was funded by the Wolfson Foundation and the University of Birmingham. Neither funder had any involvement in the planning, execution, or analysis of the study project but study findings have been shared with both parties.

Access to Data

All data requests should be submitted to the corresponding author for consideration. Access to anonymized data may be granted following review.

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Supplemental Material

Supplemental Material for this article is available online at journals.sagepub.com/home/qhr. Please enter the article's DOI, located at the top right hand corner of this article in the search bar, and click on the file folder icon to view.

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