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Mental Health Intervention Policy Recommendation for Pokot Girls and Women who have Undergone Female Genital Mutilation / Cutting

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Abstract

Mental Health Intervention Policy Recommendation for Pokot Girls and Women who have Undergone Female Genital Mutilation / Cutting

By Josephine Chenangat Murgor

Female Genital Mutilation or cutting is a global issue that is practiced by various communities around the world for cultural or religious purposes. The practice involves the partial or total removal of the female genitalia. Any damage done to a women's genatalia can cause short or long term health consequences. The trauma and pain of the procedure can cause anxiety, depression and PTSD. In spite of FGM/C being criminalized in Kenya, communities like the Pokot continue to practice FGM/C as a way to transition a girl to womenhood. The high prevalence rate of over 73% in the Pokot community shows that girls and women will continue to be at risk. Few efforts have focused on supporting individuals who may be affected by the mental health impacts as a result of FGM/C. The policy recommended in this thesis will illustrate the importance of examining the mental health aftermath of FGM/C and propose CBT as a mental health intervention that will support Pokot girls and women who have encountered trauma like FGM/C. This intervention includes delivering CBT in the Pokot language and using appropriate terminology that is fit to the Pokot culture.

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I would also like to acknowledge Women of Pokot organization for their dedication in fighting against FGM/C in West Pokot and for continuously providing support to Pokot girls and women. “OKI” RENO TIPIN MUTAT, OP” CHANE KUSOMON” SAY NO TO FGM/C

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Chapter One: Introduction & Background

Introduction and Significance of Problem

Global Context of FGM/C

Female Genital Mutilation (FGM), also referred to as Female Genital Cutting (FGC) and circumcision, is a practice that involves any harm done to the female genitalia for non-medical reasons and is a violation of the human rights of girls and women (WHOa, 2018). As a resolution to end FGM/C internationally, the United Nations (UN) added eliminating the practice to its Sustainable Development Goals (SDG's) which includes a target under the fifth goal. It comprises eradicating any harmful practices such as FGM/C, early and forced childhood marriages by 2030 (UNICEFb, 2016). Globally, 200 million girls and women have undergone the procedure while 3 million are at risk of FGM/C (WHOa, 2018). It's approximated that 44 million of these 200 million individuals are under the age of 15, indicating that young girls continue to be the highest at risk (UNICEFb, 2016).

Overview of FGM/C in Africa

FGM/C is practiced across 28 countries in Africa (Batha, 2018). Twenty-two of these countries have national laws that criminalize the practice and 6 have no laws. Of the 200 million girls who have undergone the practice, 55 million reside in Africa (Batha, 2018). The majority are from Egypt, Ethiopia, and Nigeria where prevalence rates are above 80%. FGM/C continues to be practiced in these countries for various factors including cultural values, lack of education, and gendered cultural forces (Batha, 2018).

FGM/C in Kenya

There has been an overall decline of FGM/C in Kenya but not all communities have made progress. The percentage of girls and women who have experienced FGM/C varies by ethnic groups, but the majority of women are from the Maasai, Kissi and the Pokot communities.

Despite the 2011 Prohibition of Female Genital Mutilation Act, which criminalizes all forms of FGM/C, many communities continue to secretly cut girls. Therefore, Kenyan girls and women from ethnic groups with high FGM/C prevalence rates continue to be at risk of the procedure.

Context of FGM/C in the Pokot Tribe

FGM/C is commonly practiced amongst the Pokot tribe, with a high prevalence rate of over 73% (KDHS, 2014). The primary reason the Pokot practice FGM/C is that it is considered a rite of passage. It is a way to transition a girl from childhood to the status of a woman. After the cut, girls are considered ready to be married. Another important component of FGM/C in the Pokot is the idea that the practice prevents a girl from engaging in sex before marriage. There is also a notion among the Pokot that FGM/C is a preparation for child birth (Kapmor, 2016). Individuals undergoing FGM/C are not supposed to cry or show any signs of fear because the procedure is another way to test if a girl / women can withstand pain, and if so it is assumed that the individual will be able to undergo child birth with no demonstration of pain (Kapmor, 2016).

Association of Mental Health and FGM/C

The removal or damages done to the female genital tissues interferes with the natural functioning of the body and causes psychological and emotional problems such as anxiety and depression (WHOb, 2019). The effects of FGM/C on a girls and women's body can be a long term issue with a stressor like FGM/C. A number of studies have found that pain, trauma, shock, fear, anxiety and depression due to FGM/C hinder a woman's mental health. These affects are due to the trauma of the procedure and the immediate short and long term complications (ICRW, 2018). Evidence reported that girls and women with the FGM III were more likely to remember the day of their circumcision (28 Too Many, 2016). Research published in The American Journal Psychiatry assessed 23 circumcised and 24 uncircumcised Senegalese women, finding that

participants described feelings of intense fear and anxiety (Behrednt & Moritz, 2005). In addition, participants continued to have flashback of the day they were cut. Findings from the Sahiyo organization suggest that those that remember their circumcision day reported feeling helpless, pain and shock (Sahiyo, 2019). Another study analyzed 167 girls and women in the Ethiopian Somali border. Reporting that 88% of the participants were circumcised and reported feelings of intense fear. Vloebergs et al (2012) assessed the mental health consequences of immigrant circumcised women from Somalia, Sudan, Eritrea, Ethiopia and Sierra Leone using in depth interviews and questionnaires approach. Participants were asked about the type of FGM/C they had undergone and how it has affected their current lifestyle. A third of the participants had depression and anxiety however, the transition of moving and adapting to a different culture could have also contributed to these symptoms (Vloebergs et al., 2012).

A study conducted on African communities practicing FGM/C found that women who have undergone FGM/C had the same level of PTSD as adults who have been subjected to early childhood abuse (WHOa, 2018). Girls and women who have undergone the practice may also be affected by chronic pain syndrome, and with other causes of pain there is an increased risk of depression. These psychological effects of the practice are important issues that need to be addressed because girls and women continue to be at risk for FGM/C.

Organizations like the WHO have stated the importance of providing mental health services for individuals who have been cut. They have concluded that 72% of women living with FGM/C in Kenya reside in Northeastern, Rift Valley and Nyanza provinces, and girls and women in rural areas like West Pokot are more likely to undergo FGM/C than those living in urban areas (KDHS, 2014). As a result of living in a community that supports the practice it may be difficult to escape cultural norms that are so prevalent and sheltered from outside influences.

In contrast, urban settings may be diverse and individuals may associate with different people groups that may influence their opinions on FGM/C (POP, 2017). Though there are policies and laws in Kenya that prohibit the practice, none protect individuals who may be affected by the mental health consequences of FGM/C. Therefore, policies and interventions need to be developed to address the mental health conditions that girls and women who have been cut experience.

Framing the Issue

Current research on FGM/C focuses on raising awareness of the harmful effects of the practice but not much has been done to advocate for the mental health consequences of FGM/C (ICRW, 2018). The lack of evidence on the association between the practice and developing a mental illness jeopardizes the health of girls and women, making it difficult for individuals working in this sector to support girls and women who may develop anxiety, depression and PTSD due to FGM/C. While there is some evidence on the mental health consequences of the practice, there is still a significant gap in research to assess the mental health aftermath of FGM/C and support girls and women who have been affected. Therefore, to garner more support and work towards elimination of the practice, researchers, activists and NGO's need to examine the mental health effects of FGM/C.

For the purpose of this thesis, Pokot girls and women are the population of focus. In the Pokot community, girls undergo FGM between the ages of 9 and 14 and are forced to marry soon after being cut. The high prevalence rates of FGM/C, the number of girls and women who are at risk of being cut and the lack of mental health services illustrates the importance of supporting Pokot girls and women who have been subjected to the practice. Worldwide, an estimate of 322 million people live with depression with the majority in developing countries (Nebehay, 2017). Yet a small number of this individuals seek out services (WHOf, 2017). In a county like West

Pokot, mental health services require travelling 296 miles to an urban city like Nairobi. The far distance to this city hinders individuals from pursuing services. The figure below is a map of Kenya, highlighting how far West Pokot is from Nairobi.

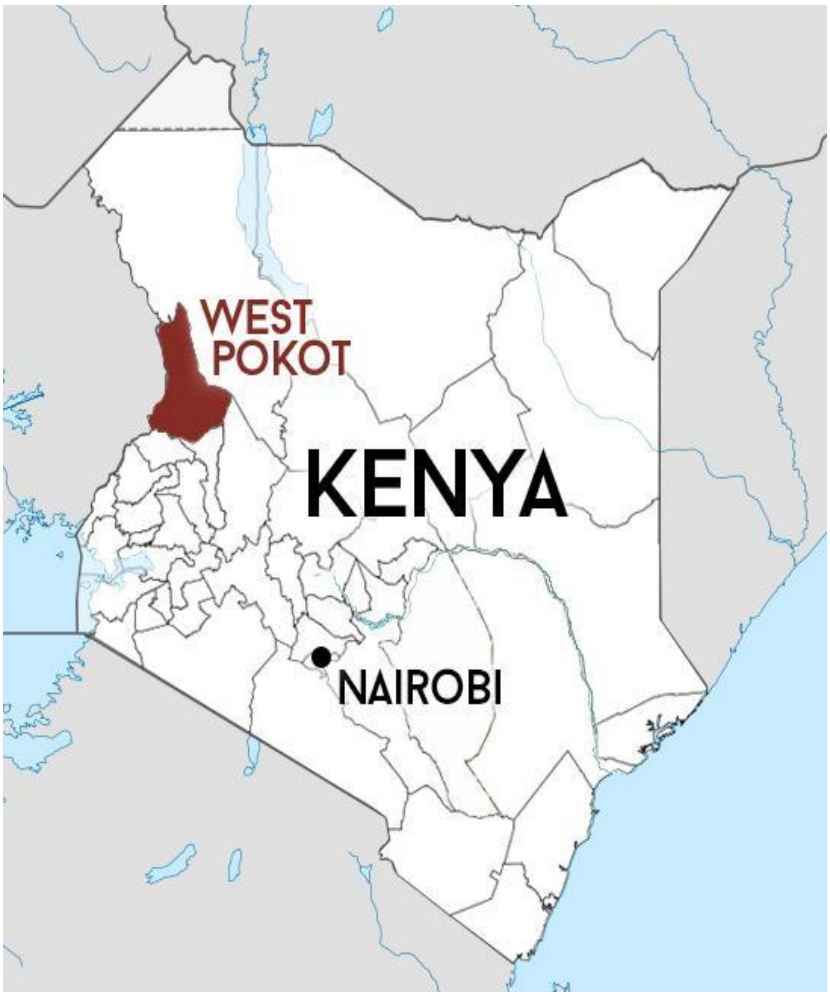

Figure 1 : Map of Kenya (n.d)

Though there are policies and laws in Kenya to eradicate the practice like the 2011 Prohibition of Female Genital Mutilation Act and the Kenya Mental Health Policy that aims to expand mental health services across the country, creating mental health interventions for those who are in need of services is a public health issue that is often neglected. A thorough review of

the literature found that no studies have assessed the mental health aftermath of FGM/C in Pokot girls and women.

The Pokot community has the dual burden of both ongoing FGM/C and reduced access to mental health services. For example, Women of Pokot (WOP) is an organization that is working to eradicate FGM/C in the Pokot community. The organization was launched in 2012 to empower and educate Pokot girls and women on issues like FGM/C. WOP has the capacity to add a mental health educational component to their existing Anti-FGM/C trainings and support girls and women by developing mental health interventions to address the mental health aftermath of the practice. WOP aims to raise more awareness on the consequences of the practice and to empower Pokot girls and women to make the decision to not undergo FGM/C (Women of Pokot, 2019). They also focus on educating women on their rights to decide what happens to their bodies, and on FGM/C laws in Kenya. Moreover, over the last four years, the organization has facilitated Anti-FGM training for more than 30,000 Pokot people, aiming to educate them on how FGM/C hinders a girl's and woman's health (Women of Pokot, 2019). These trainings include materials on the harmful health consequences of the practice, myths surrounding the practice, and FGM/C laws and policies in Kenya (Women of Pokot, 2019). They also disseminate information through methods such as local radio talk shows and an Anti-FGM/C rally during United Nations Zero Tolerance of FGM/C day (Women of Pokot, 2019).

Introduction of Policy Recommendation

To meet the mental health needs of women who have undergone FGM/C, WHO recommends Cognitive Behavior Therapy (CBT) for girls and women who have been subjected to the practice (WHOc, 2016). WHO supports CBT as a form of treatment because it has been successful in reducing depression and anxiety on individuals who have been exposed to torture, war and sexual violence. Given the existing above evidence, WHO believes that this form of

intervention can support girls and women who have experience mental health conditions due to FGM/C. From a human rights perspective, every individual has the right to mental health services (WHOc, 2016). Furthermore, CBT can be modified to fit the socio-contextual framework of a specific population. An example of this is the Friendship Bench in Zimbabwe where CBT was adapted to the local context (Chibanda et al., 2016). This intervention is cost effective and can be facilitated by a trained community health worker.

Objectives:

Evidence from published literature was used to develop the following objectives:

Objective 1: Highlight gaps in mental health services in Kenya for larger policy consideration

Objective 2: Assess existing mental health approaches that have been successful in low income countries

Objective 3: Use evidence from research to develop a proposal for Women of Pokot that addresses why they need to create mental health services for Pokot girls and women who have undergone FGM/C.

Objective 4: Provide a recommendation to Women of Pokot on how they could add mental health to their Anti FGM/C educational materials and educate their Anti-FGM/C trainers on common mental health conditions.

Taken together, FGM/C is a global issue that continues to affect the lives of girls and women. The mental health consequences of the practice are a public health problem that is often overlooked. In order to support the lives of girls and women who have been affected by the mental health consequences of FGM/C it's important to understand the association between FGM/C and mental health, and to create interventions that will help them. This policy recommendation is based on an extensive review of: 1) FGM/C in the Pokot, 2) mental health services in Kenya, and 3) existing mental health interventions that have been used to support survivors of trauma. This proposal aims to recommend a modified CBT intervention that will support girls and women who have encountered trauma like FGM/C.

Definition of Terms

Anxiety	Worry or fear about a variety of events or activities (NIMH, 2019).
Depression	"a serious but common illness characterized by prolonged periods of sadness that interfere with, or at worst, wreck daily life" (NIMH, 2019).
Female Genital Mutilation	This term is used by the UN to describe the practice and "comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons" (WHOa, 2018).
Female Genital Cutting (FGC)	This term is used by UNICEF to describe the same practice (UNICEF, 2019).
Female Circumcision	Is another term used to describe FGM/C but can be misinterpreted to be the same as "male circumcision"
Mhgap	Mhgap is WHO's strategic plan to scale up mental health services in lower income countries.
Post-Traumatic Stress Disorder (PTSD)	A stress that occurs due to a traumatic event that affects the psychological wellbeing of an individual. This includes, sexual violence, gender based violence, childhood physical abuse (WHOb, 2019)
West Pokot	A county in North Western Kenya were the Pokot people inhabit.

Abbreviations:

CBT	Cognitive Behavior Therapy
FGM/C	Female Genital Mutilation/Cutting
ICRW	International Center for Research on Women
KDHS	Kenya Demographic Health Survey
MOHK	Ministry of Health Kenya
SDG's	Sustainable Development Goals

UN	United Nations
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WHO	World Health Organization
WOP	Women of Pokot

Chapter Two: Review of Literature

Introduction

The following literature review provides a summary on FGM/C in Kenya, the Pokot tribe of Kenya and their significance to the current thesis, mental health services in the country, and the mental health consequences of FGM/C. This chapter also goes more in depth on different mental health intervention in low income countries and how they could be used to address anxiety and depression in Pokot girls and women who have undergone FGM/C.

Overview of Kenya

The Republic of Kenya is bordered by Uganda, Tanzania, Ethiopia, Somalia and South Sudan, and is divided into 47 counties. Today, over 51 million people live in Kenya. Of the 51 million, majority practice Christianity while others practice Islam or other traditional beliefs (CIA, 2018). The country is home to more than 42 tribes (CIA, 2018). Many ethnicities including the Kikuyu, Luhya, Kalenjin, Luo, Kamba, Kisii, Meru and the Pokot make up the population. The official languages are Kiswahili and English, and other indigenous dialects spoken by the tribes listed above.

Kenya spends 5.7% of its GDP in the healthcare sector which includes cost of drugs, salaries, supplies, and improvement of healthcare services (CIA, 2019). An average of 63.2% of the population have access to clean water and 30.1% have access to improved sanitation (CIA, 2019). Lack of infrastructure continues to hinder the health care sector of the country. This is concerning given the fact that 46% of the population live below the poverty line (UNICEFa, 2019). Access to basic health care services and education is a luxury to the majority of the population, especially to those from marginalized communities. Those that do not have access to modern healthcare services depend on traditional medicine. Traditional medicine is present in the form of herbalism and administered by a traditional healer (Harrington, 2016).

Overview of the Pokot

Traditionally, the Pokot tribe are pastoral nomads that live in West Pokot and Baringo County, Kenya. They are a subgroup of the Kalenjin ethnic group and are a population of 700,000 (O'Dempsey, 1988). Religion plays an important role in the Pokot people. Some believe in Christianity while others believe in the supreme being, *tororot.* Those that practice Christianity worship God while those that worship *tororot* make prayers and offerings during community gatherings (O'Dempsey, 1988).

Men in the Pokot community are the decision makers, therefore Pokot women have very few rights. Men provide economic support for their household, while women are raised for the sole purpose of getting married so that they can take care of their families (O'Dempsey, 1988). In order to be married, Pokot girls must undergo FGM/C at a young age to prove to the rest of the community that they are ready to transition to womanhood. Polygamy is another factor that plays an important role in the Pokot culture. The number of wives a man has is used to measure his wealth (O'Dempsey, 1988). Though the Pokot people have progressively evolved in changing their ways of living, a majority of them are still traditional and still continue to practice FGM/C and polygamy (O'Dempsey, 1988).

FGM/C Laws and Policies in Kenya

Despite the various laws in Kenya that have been passed to protect girls who are at risk of the practice, many girls remain at risk of undergoing this harmful procedure. FGM activists have been fighting to put an end to the practice since as early as 1906. (POP, 2017). During this time the Scotland Mission, a Scottish faith-based organization that was working in Kenya, prohibited FGM/C on moral grounds. They started raising awareness on the health consequences of the practice, which attracted and influenced the colonial administrators to medicalize the practice. In 1929 a number of missions banned the practice and threatened to penalize those practicing

FGM/C by prohibiting them from partaking in religious activities or enrolling their children in missionary schools. (POP, 2017). This did not settle well with the Kikuyu tribe, and their defense focused on FGM/C as a cultural practice across Kenya. At the time, President Jomo Kenyatta was general secretary and believed that FGM/C was part of the country's cultural traditions. Controversy surrounding the practice led to legal measures. Shortly after, the Njuri Ncheke Council of Meru passed a law that prohibited the practice. However, this outlaw failed under the colonial rule. Girls at risk of FGM/C responded to this ban by choosing to circumcise themselves (POP, 2017).

After Kenya gained its independence in 1963, the influence of faith-based missionaries like the Scotland Mission influenced Christians to continue discouraging the practice. This caught the attention of activists, the government, and the international community. This inspired the global campaign to eliminate FGM/C through the United Nations Decade for Women, by focusing on the harmful health consequences of the practice. The hope was to put pressure on Kenyan lawmakers to criminalize FGM in the country. (Pop, 2017). In 1982, President Arap Moi banned FGM in the Baringo and Meru counties advising these communities that anyone performing FGM/C will be prosecuted. Following this ban, the Director of Medical Services passed down a policy to stop healthcare practitioners from performing FGM/C. (POP, 2017). However, this threat did not stop communities from practicing FGM/C.

In 1999 the debate on criminalizing FGM/C was taken to the Kenyan parliament, but laws were not developed. It also led to a controversial debate in between human rights and culture and whether human rights concerns should interfere with a cultural practice (POP, 2017). The Ministry of Health launched a National Campaign to put an end to FGM/C and to raise awareness across the country (POP, 2017). Two years later, the Kenyan government introduced

The Children's Act, which protects minors from early childhood marriages, sexual exploitation, and any other practices that hinder the wellbeing of the female child. Any individual who performed FGM/C on a female child could be charged KSH 50,000, equivalent to $500 USD, for violating the law (POP, 2017). Communities like the Pokot who still practiced FGM/C saw this law as a way lawmakers controlled their cultural practices. This law did not protect adults from undergoing the practice nor did it stop communities from practicing FGM/C. Due to this, FGM/C was practiced secretly to avoid persecution. The Children's Act influenced the Kenyan community to focus on the rights of children including, putting an end to early childhood marriages.

In 2011, the Kenyan parliament passed the Prohibition of FGM/C Act which prohibits the practice in the country. Anyone performing FGM/C or involved in forcing a girl to undergo the practice will face up to seven years of imprisonment and a fine of KSH 500,000, equivalent to $500 USD (POP, 2017). In addition, a person will be subjected to criminal charges if they take a Kenyan citizen to another country to undergo FGM/C, or if they are aware that an individual will undergo the practice. This law permits any law enforcement officer to arrest those involved with performing the practice. (POP, 2017). Despite the history and recent policy advances, FGM/C still continues to be practiced, particularly in the outskirts of Kenya.

The Anti-FGM Board was created in 2013 under the Ministry of Public Service, Youth and Gender Affairs, to empower girls and women through Anti- FGM activities such as advocacy and awareness. In their efforts to eliminate FGM/C, the board initiated a four-year strategic plan (28 Too many, 2016). This strategic plan included the following six objectives: developing and implementing anti-FGM/C programs, lobbying for anti-FGM/C materials to be included in the school curriculum, developing and reviewing anti-FGM/C policies and strategies,

improving mobilization, creating monitoring and evaluation plans for Anti-FGM policies, and strengthening Anti-FGM/C programs (MoDP, 2013).

Summary

Over the years, Kenya has made drastic progress in combating FGM/C. The current status of laws and policies related to FGM/C are The 2001 Children's Act and The Prohibition of Female Genital Mutilation Act that was enforced in 2011. The Children's Act was implemented to protect girls from any harmful practices such as childhood marriages and FGM/C, while the Prohibition of FGM Act criminalizes any form of FGM/C in Kenya. Both these laws aim to protect girls and women who are at risk of undergoing the practice showing that progress is being made in eliminating the practice in Kenya.

Different Types of FGM/C

Female Genital Mutilation (FGM) is also known as Female Genital cutting (FGC) or female circumcision. According to literature, the practice can be performed four different ways depending on culture, traditions, customs and religion. Type I consists of partially or totally removing the clitoris. Type II comprises of partially or completely removing the clitoris and the labia minora. Type III involves sewing the labia minora and or the labia majora with or without the clitoris and is the most severe type. Type IV is any other harmful procedures done to the female genitalia for non-medical reasons such as piercing, pricking and scraping (WHOa, 2018). Figures 1-5 illustrate the four types of FGM/C.

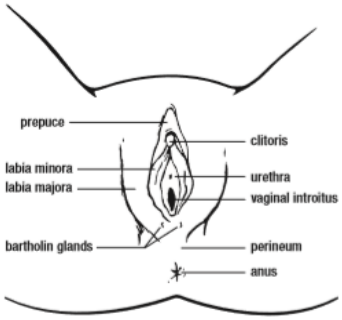

Figure II : Unaltered Female Genitalia (WHOc, 2016).

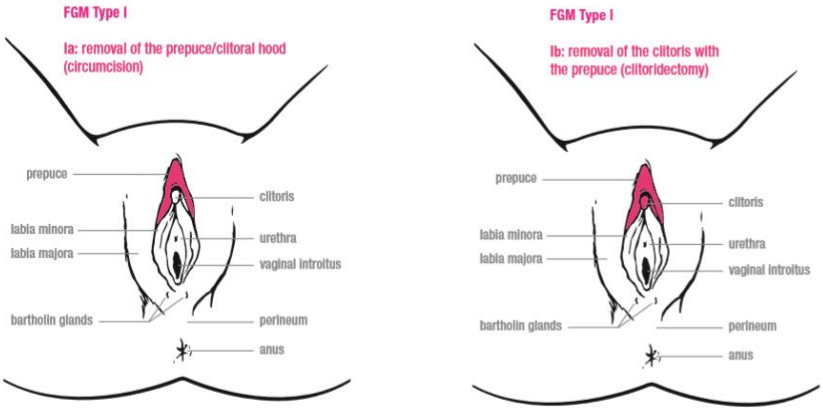

Figure III : Type I FGM/C (Clitoridectomy) (WHOc, 2016).

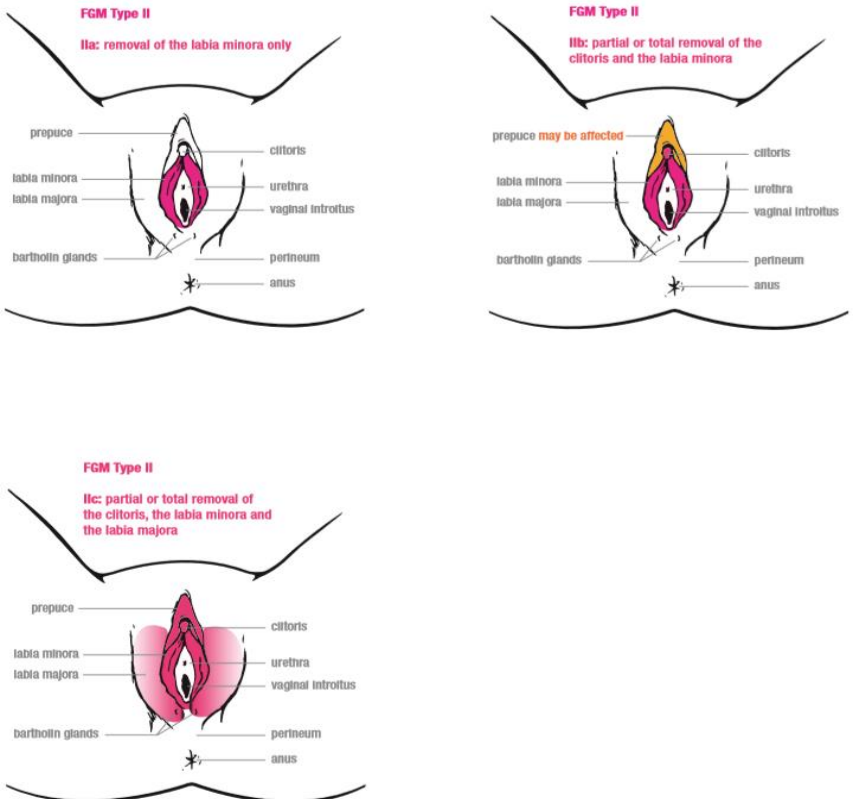

Figure IV: *Type II FGM/C (Excision) (WHOc, 2016).*

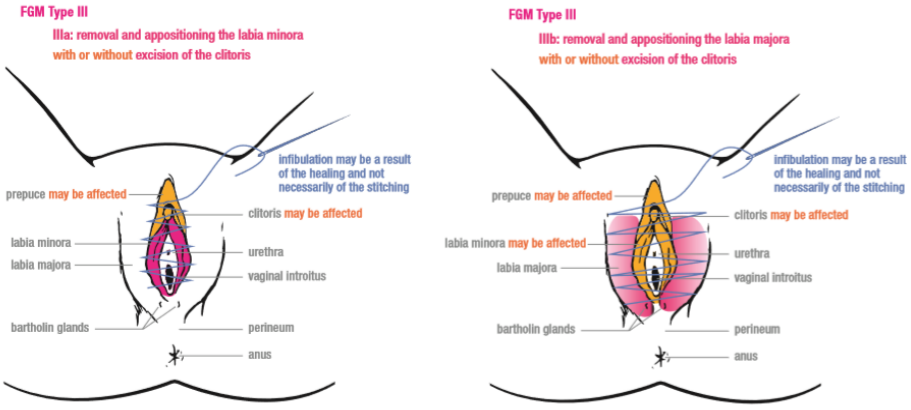

Figure V : Type III (Infibulation) (WHOc, 2016).

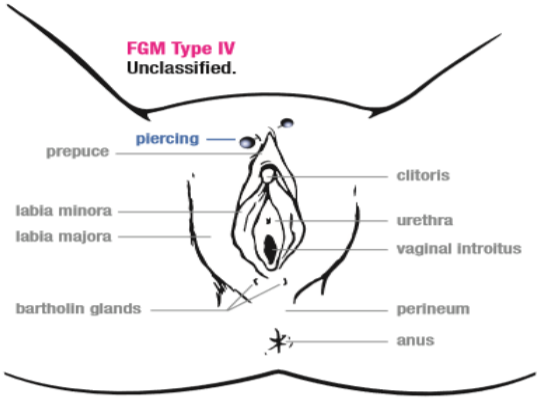

Figure V : Other harmful procedures done to the female genitalia (WHOc, 2016)

Current Prevalence of FGM/C

Globally, girls and women continue to be at risk of undergoing FGM/C (WHOa, 2018). Every second one girl is affected by FGM/C across the globe (WHOa, 2018). The beginning of the practice is still unclear to many researchers (UNFPA, 2019). However, FGM/C has been practiced by various communities across the world for different purposes.

In Africa over 28 countries still continue to practice FGM/C as a way to transition girls to womanhood and to control a women's sexuality, making them less likely to engage in pre-marital sex (POP, 2017). In Kenya, the practice has been cultural and traditional among 38 of the 43 ethnic groups (UNFPA, 2019). In 2014 it was documented that 21% of girls and women in Kenya have undergone FGM/C. Prevalence rates are particularly high among certain communities such as the Somali (97.7%), Kisii (96.1), Maasai (73.2%) and the Pokot (over 73%) (KDHS,2014).

FGM/C in the Pokot

In the Pokot community, FGM/C is a deeply impeded cultural tradition that holds a symbolic meaning. This cultural tradition elevates the status of a child to a woman. The Pokot

also believe that uncut girls are unclean and cannot be married (Kapmor, 2016). Type III FGM/C is the most common type of FGM/C that is practiced by the Pokot.

Girls and women undergo FGM/C at different ages, different communities perform it when a girl is an infant, teenager, or adult. (Kapmor, 2016). In the Pokot community, girls undergo FGM between the ages of 9 and 14 and are forced to marry soon after being cut. As a patriarchal society, girls and women are responsible for house duties. Thus, females living in the rural parts of West Pokot do not prioritize education. (Kapmor, 2016). Girls can be pressured by the community to undergo the practice and often girls are taken out of school to undergo FGM/C, putting them at risk of early childhood marriages (Kapmor, 2016).

In Pokot, FGM/C procedures are ceremonial and often performed by a traditional cutter. This person is often an older woman who plays an important role in society, such as delivering babies (WHOa, 2018). During this ceremony a group of girls undergo FGM/C together. They are then placed in isolation where they are educated on the roles of being a woman, mother, and wife (Kapmor, 2016). In the Pokot, FGM/C is often done under unhygienic conditions which can lead to immediate and long term health problems. In 2016 it was determined that 80.5% of girls and women in Kenya were circumcised by a traditional cutter (28 Too Many, 2016). Moreover, instruments such as razors, knifes, scissors, sharp stones or glass are used (UNFPA, 2019). Because the same instrument is often used on multiple girls, there is an increased risk of infections such as HIV. (UNICEFa, 2019).

Taken together, FGM/C is a painful practice that carries a long both lifelong social and health problems for girls and women. These include infections, severe bleeding, physical and emotional trauma, and in some cases even death from complications (WHOa, 2018). Due to the

severity of the issue, drastic community development measures beyond need to be enacted in order to further reduce and ultimately eradicate the practice of FGM in Kenyan communities.

Mental Health in Kenya

Across Kenya, there is a negative stigma surrounding mental health and those struggling with mental health conditions are often neglected. Individuals consider mental health a western concept and an Un-African problem. (ILA, 2016) There is a notion that those dealing with mental health conditions are cursed, thus influencing individuals to be silent about their mental health conditions (ILA, 2016). Various factors such as lack of education on mental health, lack of knowledge on the risk factors, and poor mental health services continue to impact the provision of care. (ILA,2016).

According to WHO, 10-20% of adolescents across the world suffer from mental health conditions like depression (WHOb, 2019). Some mental health conditions begin at a young age and if left untreated can lead to neuropsychiatric conditions which can cause disabilities in young people (WHOb, 2019). In Kenya, depression, stress, anxiety and substance abuse are the most common mental health conditions (APHRC, 2019). Furthermore, research by the African Population and Health Research Center (APHRC) in Kenya found that 1 in 4 patients in a primary health care facility suffer from a mental health condition (APHR, 2019).

In 2015, the national government implemented the Kenya Mental Health Policy 2015-2030 to strengthen mental health services and systems. (Kenya Mental Health Policy, 2015). The policy states that every individual has the right to health care services and aims to raise awareness, reduce stigma, decrease suicide rates, and increase mental health services in the 47 counties (Kenya Mental Health Policy, 2015). Despite having this policy in place not much has been done to improve services. An estimate of 40% of in-patients and 25% of out-patients live

with mental health conditions (Performance Audit Report, 2017). Various factors, both socio-cultural and structural, contribute to the high rates of mental illness. Socio-cultural factors include the post- election violence in 2007, trauma, accidents and terrorist attacks. Experiencing traumatic events such as these can contribute to the development of anxiety, depression and PTSD.

Structurally, there is a lack of expertise to support the mental health needs of the country; there is a total of 92 psychiatrists serving a population of 51 million (Performance Audit Report, 2017). Most of them practice in Nairobi, demonstrating that people living in rural areas like the Pokot, do not have access to mental health services due to distance and travel constraints. In addition, there is a shortage of healthcare workers in the mental health sector, further limiting services in rural areas (Performance Audit Report, 2017). Due to the inadequate mental health services across the country, patients are often referred to Mathari Hospital in Nairobi, the only mental health facility in the whole country (Performance Audit Report, 2017). In addition to the lack of healthcare infrastructure, poverty limits access to mental health services especially in low-income areas of the country. Most individuals living below the poverty line are unable to afford Mathari Hospital, forcing them not to seek services. The high cost of services at this hospital and poor conditions are other factors that influence patients to be silent about their mental health conditions (Performance Audit Report, 2017).

Due to the challenges in the mental health sector in Kenya, traditional and faith healers are used to bridge the treatment gap of mental health (Kenya Mental Health Policy, 2015). This is partially because they are accessible and affordable to the community. In rural areas of the country, traditional health care practitioners use herbal medication and spirits for the treatment of various illnesses. The National Health Sector Strategic Plan approved the community based

services and recognized the importance of bridging the treatment gap of community-based services and modern health services (Performance Audit Report, 2017). Evidence shows that traditional healers can effectively create more culturally appropriate interventions. Although they are making a difference in the mental health sector, there is lack of collaboration with the healthcare system and lack of knowledge on mental health disorders. This is problematic because traditional healers have significant potential to contribute to the mental health wellbeing of many Kenyans.

Summary

Stigma surrounding mental health in Kenya is a problem that continues to affect Kenyan citizens, forcing individuals to silence their voices about mental health illnesses (ILA, 2016). Across the country, mental health services are not equally distributed. People living in urban areas have a higher chance of accessing services than those in remote areas (Kenya Mental Health Policy, 2015). Though a mental health policy was passed down, not much has been done to expand services to rural areas (Kenya Mental Health Policy, 2015). Institutions and organizations working in the mental health sector in Kenya need to implement more strategies and initiates that can impact the lives of Kenyans across the country.

This lack of mental health services hinders the wellbeing of girls and women who are at risk of developing anxiety and depression due to FGM/C. Evidence from this literature review shows that girls and women who have been subjected to FGM/C are more likely to experience mental health problems due to the pain and trauma of the practice (Smith & Stein, 2017) which can then lead to chronic depression and anxiety if left unresolved. Therefore, the high prevalence rates of FGM/C in the Pokot community provides evidence that girls and women in this ethnic group could be at risk of developing anxiety and depression. Going forward, more research needs

to be conducted to identify how the practice has impacted the mental health of Pokot girls and women.

Chapter Three: Methods

Introduction

This chapter provides a review on the process taken to develop this policy recommendation. This process included a comprehensive search on EBSCOhost and Google Scholar in order to select the appropriate interventions to further analyze for this policy recommendation. This section will also describe what a policy recommendation is and the steps of writing one.

Defining a Policy Recommendation

A policy recommendation is a written document for the purpose of advising a specific organization or government that has the capacity to implement the policy (CARDI, 2012). The primary purpose of a policy recommendation is to highlight a current problem for a specific agency and recommend a solution or an alternative response based on review of existing approaches, research, and evidence. Additionally, the document should include challenges and feasibility of implementation (CARDI, 2012).

Steps to Writing a Policy Recommendation:

1. Define the objective

The first question to address is the objective of the policy recommendation. This can range from introducing a new policy, enhancing an existing policy or shedding light on a local issue. In order to develop an objective, research on the issue is essential to provide evidence on why this issue is important (CARDI, 2012).

2. Identify the Target audience

The second step is to identify the target audience. The audience can be an organization, county or national government, or the community and individuals impacted by the policy. Therefore, the audience can be multiple stakeholders that are affected by the policy. It is also important to make

sure the target audience has the resources and capacity to implement the policy recommendation (CARDI, 2012).

3. Problem Statement

The third step is to state the problem and use literature to support the issue. This demonstrates to the target audience why the problem needs attention (CARDI, 2012).

4. Existing strategies

The fourth step is to review existing approaches that have been used to address the problem and critically analyze current solutions and approaches, including the advantages and disadvantages of each strategy. This stage includes a review of the socio-contextual factors of the target audience and population relevant to the policy recommendation (CARDI, 2012).

5. Present the policy recommendation

The final step is to present the policy recommendation. The objective here is to recommend a feasible option by using existing evidence to argue for the benefits of the proposed solution for the various stakeholders. (CARDI, 2012).

Review the overall issue and purpose, and then refer to the table below. For example, see Table 1 for review of the steps for the current policy recommendation.

Table 1: Steps taken to develop this policy recommendation, 2019

Objective	- Convince the Ministry of Health (MOH) of Kenya why they should collaborate with Women of Pokot to deliver a mental health intervention since the organization is already imbedded in the Pokot community.
Target Audience	- MOH - WOP - The Pokot Community - Pokot Girls and Women who have undergone FGM/C

Problem Statement	- Lack of mental health services for girls and women who have been subjected to FGM/C - Girls and women who have undergone FGM/C are more likely to develop mental health illness than those who have not been cut
Existing Strategies for comparison and review	- Friendship Bench (CBT) - Group Interpersonal Psychotherapy - The TEAM Project
New Recommendation	- Modified CBT: *Kengalala ngala kinanat*

Why a Policy Recommendation?

Policy recommendations have been effective in facilitating change. For example, the Kenya Mental Health Policy influenced Makueni County Government to add mental health in the county's strategic plan (AMHF, 2016). The current policy recommendation was developed to encourage MOH Kenya to support Pokot girls and women who have been subjected to FGM/C by offering more formalized mental health services. It will be recommended that the MOH work with WOP to collaborate on this initiative because of WOP's ongoing community initiatives and investment in the lives of Pokot girls and women.

Selection of Interventions

This policy recommendation utilized a literature review to identify which interventions have previously been used to treat anxiety and depression in low-income countries. In addition, projects that utilized community health workers to deliver mental health interventions were also reviewed. EBSCOhost was chosen as a search engine because it is a large database that contains peer reviewed journals and scholarly articles in behavioral sciences and mental health. A search was conducted on EBSCOhost, using the terms "mental health interventions in low-income countries", "mental health interventions in developing countries", "interventions for anxiety and depression", "cost effective trauma interventions", "prevention for anxiety and depression and

interventions", "anxiety and depression and low resource settings", "mental health and Kenya", and "community and mental health and intervention".

Though EBSCOhost generated a significant number of mental health projects, it did not provide interventions that met the following criteria: feasibility, ability to be modified in a setting like West Pokot, non-pharmacologic intervention, have been implemented in low-income countries, can be administered by a community health worker, and have been successful in treating anxiety and depression. Table two provides a full outcome of the results generated on EBSCOhost using the search terms mentioned above.

The goal was to use academic and non-academic databases to identify all possible interventions that met the criteria of this policy recommendation. Therefore, in addition to EBSCOhost, Google Scholar was used as a search engine to find interventions that have been used to treat anxiety and depression in low-income countries. Google Scholar was chosen because it provides grey literature (literature that has not been formally published by an academic institution) (Haddaway, Collins , Coughlin , & Kirk, 2015). The following terms were searched on Google scholar; "mental health intervention in developing countries for anxiety and depression", "mental health interventions in Kenya", "group interpersonal psychotherapy for depression" and "scale up mental health care in Africa". Programs that did not fit the criteria previously mentioned were excluded. Subsequently, specific terms such as "Kenya" were then excluded in order to generate interventions that have been used in other countries.

Interventions were selected based on: their effectiveness at decreasing anxiety and depression in their respective study populations, their fit in the socio-contextual framework of a low-income country, the use of language appropriate for the community, and if the program can be facilitated by non-mental health professional. Interventions were excluded if they did not

specifically address anxiety or depression. Additionally, interventions that required medication were excluded because Women of Pokot does not have access to clinical staff with the skills to diagnose and prescribe medication. Additionally, if the facilitator required a license, then the intervention was excluded. However, interventions that could be delivered by a community health worker with no professional mental health skills were included. Tables two and three provide a full outcome of the results generated on EBSCOhost and Google Scholar using the search terms mentioned earlier.

Table 2: Methods results using EBSCOhost, 2019

Searching Terms	Refine Results	Number of articles generated	Did any meet criteria?
"Mental health and intervention and in low income countries"		12	No
"Mental health and interventions and developing countries"		19	No
"Interventions and anxiety and depression"		538	No
"Interventions and anxiety and depression"	Female	377	No
"Interventions and anxiety and depression"	Gender: Female Publication Year: 2000-2019	13	No
"Cost affective and trauma and interventions"		0	

"Prevention and anxiety and depression"	Gender : Female Publication Year : 2000-2019	5	No
"Anxiety and depression and low resource setting"	Gender : Female Publication Year: 2000-2019	31	No
"Mental Health and Kenya"	Gender : Female Publication Year : 2000-2019 Subject : Symptom	13	No
"Community and mental health and intervention"	Year of publication : 2000-2019	18	No

Table 3: Methods Results Using Google Scholar, 2019

Searching Terms	Refine Results	Number of articles generated	Did any Meet Criteria
"mental health intervention in developing countries for anxiety and depression"	Publication Year : 2000-2019	35	0
"mental health interventions in Kenya"	Publication Year : 2000-2019	29	1
"group interpersonal psychotherapy for depression"	[redacted]	2	1
"scale up mental health care in Africa"	[redacted]	19	1

Chapter Four: Results

Three low cost programs were identified that met the inclusion criteria for the policy recommendation. These included the following interventions: The Friendship Bench Programme (Zimbabwe), Group Interpersonal Psychotherapy (Uganda), and the TEAM project (Kenya). The following section will review these existing mental health programs that have been administered in developing countries and highlight factors relevant to the current policy recommendation.

Table 4: Existing Approaches, 2019

Name of intervention	**Country**	**Program**	**Type of intervention**	**Facilitator**
The Friendship Bench Programme	Zimbabwe	Depression, Anxiety	Modified CBT	Grandmother
Group Interpersonal Psychotherapy for Depression in rural Uganda	Uganda	Depression	Group Psychotherapy	Local community member
The TEAM Project	Kenya	Educate community health workers on mental health conditions	Mental health education	Community health worker

The Friendship Bench Training Manual

The Friendship Bench was founded in 2006 to address the high prevalence rates of common mental health disorders, lack of mental health professionals, and the nonexistence of a community-rooted mental health intervention in Zimbabwe. The founder, Dr. Chibanda was interested in innovative ways to take mental health services out of institutions and into the community (WHOd, 2018). He began by measuring the prevalence of psychiatric morbidity after

the 2005 slum evacuation that impacted more than 2 million individuals and displaced 700,000 people (WHOd, 2018). Findings from the survey showed high prevalence rates of mental health conditions among individuals who were affected by the slum clearance. Results from this survey influenced Dr. Chibanda to develop The Friendship Bench Programme.

Dr. Chibanda spent the first four years of the intervention working with grandmothers from the Mbare community in Zimbabwe to develop culturally appropriate mental health terms in Shona, the local language and integrating these terms with fundamentals of CBT (WHOd, 2018). This led him to pilot the first "Friendship Bench". This intervention utilizes task shifting as an approach to deliver mental health services (WHOd, 2018). The benches are set up outside a health clinic and are used as a screening tool to measure patients' level of mental health illness, those at risk of suicide are referred the clinic, while those with minor mental health conditions continue using the friendship bench for mental health services (WHOd, 2018).

The objective of the intervention is to reduce anxiety and depression through one on one counselling sessions on a bench by a trained grandmother health worker. The program is made up of three main components: opening the mind, uplifting, and strengthening (Chibanda et al., 2016). Opening the mind allows the patient to open up about their problems. This component includes the grandmother asking questions in order for the patients to open up and share their problems. The uplifting process is working with the grandmother to identify a resolution (Chibanda et al., 2016). This component allows the patient to work with the grandmother to come up with strategies to solve the problem. Finally, the strengthening component focuses on a coping mechanism. This is important because it gives the patient a chance to come up with their own coping strategy. The objective of the program is to use a modified version of CBT to improve patients' ability to deal with stressful experiences. Six months after using the Friendship

Bench, evidence from the program showed that patients who used CBT were three times less likely to have symptoms of depression compared to those who didn't use the service (Chibanda et al., 2016).

Group Interpersonal Psychotherapy for Depression in Rural Uganda

Interpersonal psychotherapy (IPT) was developed by Gerald Klerman and Myran Weissman to treat depression (WHOe, 2016). The foundation of IPT is that there is a correlation between an individual's mood and their interpersonal relationships, suggesting that various life events like change, social isolation, and grief can lead to developing depression (WHOe, 2016). This intervention gives the patient an opportunity to discuss what initiated the depression, factors that have contributed to the depression, and coming up with a solution with a facilitator and the rest of the group (WHOe, 2016)

The group part of the intervention is an important component because individuals learn from other group members on coping mechanisms. Once they come up with a solution, patients are encouraged to try their strategy out and then discuss the results in the upcoming session (WHOe, 2016). This intervention has been adapted to treat other mental health disorders across the globe. This type of intervention can be delivered in an individual or group setting (WHOe, 2016). It can be facilitated by a community health worker, making it possible to be delivered in low and high income countries (WHOe, 2016)

An example of this is a randomized control trial that was used to examine depression in rural Uganda. World Vision International, a non-governmental organization, was interested in assessing depression in Uganda and was motivated by the lack of randomized trials in sub-Saharan Africa (Bolton P, Bass J, Neugebauer R, et al., 2003). The organization was also interested in an intervention that did not require anti-depressants due to the high cost of drugs

and limited access of mental health professionals in Uganda (Bolton P, Bass J, Neugebauer R, et al., 2003).

The objectives of the study were to assess how effective group interpersonal psychotherapy was at reducing depression over a period of six months, and to measure the cost of such a study in the context of sub-Saharan African. This intervention was conducted once a week over a 90-minute session for six weeks (Bolton P, Bass J, Neugebauer R, et al., 2003). Participants were divided into gendered groups of five or eight. Each group was facilitated by a local Ugandan with no professional mental health experience except for trainings in psychotherapy that was provided by World Vision (Bolton P, Bass J, Neugebauer R, et al., 2003). During the intervention, the facilitator would ask the participants to describe their mood and events that influenced the way they were feeling. Participants were asked to come up with solutions and to provide support to their peers (Bolton P, Bass J, Neugebauer R, et al., 2003). Statements from participants indicated that the problem solving part of the intervention was essential in helping them open up about issues affecting their mental health. Additionally, results from the study demonstrates that there was a reduction in depression among the intervention group (Bolton P, Bass J, Neugebauer R, et al., 2003).

Multi-sectoral Stakeholder TEAM Approach to Scale-Up Community Mental Health in Kenya

The Africa Mental Health Foundation (AMHF) is a non-governmental organization in Kenya that conducts research on mental health, and develops mental health services in the country, especially in rural areas. One of their innovative interventions is the TEAM Project which is known as the Multi-sectoral Stakeholder TEAM Approach to Scale-Up Community Mental Health in Kenya which involves integrating mental health services into a Kenyan community context. The development of this project was inspired by the existing gap of mental

health services and professionals in Kenya, suggesting that community health workers could address this gap (AMHF, 2016). The first scale up project took place in Makueni County, an area with no psychiatrist. Despite the lack of formal mental health professionals in the county, Makueni was the first county out of the 47 counties in Kenya to raise awareness on mental health services at the national level which resulted to a collaboration with AMHF to support a scale up of the TEAM project. This project modified WHO's mental health treatment guidelines to identify which mental health conditions they wanted to prioritize (AMHF, 2016). The project aims to train community health workers to work with other professional health care workers in order to provide mental health interventions, increase mental health education, and partner with local healthcare facilities to strengthen mental health services (AMHF, 2016).

The goals of the projects were to train community health workers to enhance their knowledge on mental health illnesses and to use WHO's-mghap as a reference guide for clinics in Makueni county (AMHF, 2016). In order to train community health workers, AMHF collaborated with Makueni county health team to draft mental health training guidelines for these volunteers. These training materials were adapted in Kikamba, the local language in Makueni county, so that community health workers and volunteers could understand the materials. Training materials focused on basic mental health conditions that were adapted from WHO's mghap specifically for non-mental health professionals. Other stakeholders that participated included traditional healers, faith based groups and the National Traditional Health Practitioners Association (NATHEPA). The clinics and stakeholders were then trained by the AMHF team which comprises experts in the mental health sector. This scale up project is the first in the country to use the available resources to adapt WHO's mhgap to strengthen mental health services. It was cost friendly because it required a collaboration between AMHF and Makueni

county to train community health workers on mental health illnesses. The effectiveness of this model shows that it has the potential to be modified in other counties in Kenya and areas with poor health systems (AMHF, 2016).

Analysis of Chosen Interventions

A major limitation in advocating for mental health services in low income countries is the lack of available resources and lack of prioritization of mental health services. In response to these problems, the Friendship Bench Programme, Group Interpersonal Psychotherapy, and the Team Project were developed. These three interventions were selected to inform the current policy recommendation because they all can be modified to fit the socio-contextual framework of a low-income country, can be administered by a trained community health worker, and do not require the facilitator to prescribe a medication.

The Friendship Bench Programme was selected because it was adapted to fit the local context of Zimbabwe, a country with limited mental health services like Kenya. The intervention has also been adapted in other settings like Malawi, Zanzibar and New York (WHOd, 2018). For example, the program in New York is facilitated by a diverse group of people inclusive of gender and race to meet the needs of the New York population (Nuwer, 2018). Global results from this intervention have found that scaling up this program to address mental health illnesses can make a difference in the world (WHOd, 2018).

Group IPT was also chosen due to the program being administered in a group setting. Group IPT was utilized in Uganda in order to reach a larger population than individual IPT. Similar to The Friendship Bench Programme, Group IPT can be altered to any setting to meet the needs of that population. This intervention also encourages individuals to share their problems with a group of people who may be dealing with the same issues. Giving people an opportunity

to open up and come up with resolutions in a group setting. The TEAM project is different from the other two programs as it's a scale up project that uses existing health systems to strengthen mental health services. As previously stated with a partnership with AMHF, Makueni County was able to train current community health workers on basic mental health conditions. This multi sectoral approach can be implemented if other stakeholders are willing to collaborate.

Mental health programs like the three described have impacted many lives in areas where professional mental health services are scarce. If more interventions are adapted to fit the context of a specific population, more individuals can have access to mental health services. Though, these interventions have been successful there are limitations. The Friendship Bench requires collaboration with local clinics and hospitals in order to fully utilize the intervention. Therefore, in areas where psychiatrists are scarce like West Pokot, modifications to the intervention can be made and partnerships with a local NGO or governmental organization could serve in the role that the clinics have fulfilled up until this point. The team project in Kenya would require a more widespread partnership with a local county government and hospital to reach the target population, however, this is currently not feasible given the scope of this project. Future directions of this work include a potential collaboration with the West Pokot County government and other stakeholders needed to implement this program. Lastly, a limitation of the group IPT is the requirement for more resources and trained personnel to facilitate the intervention. In summary, this chapter provided an overview of three mental health interventions that were chosen as examples of existing strategies that have been used to address mental health in low income countries.

Chapter Five: Policy Recommendation

Policy Statement

As an organization that is working to eradicate FGM/C in the Pokot community, Women of Pokot needs to address the mental health effects of the practice and support girls and women who have been subjected to FGM/C. This policy recommendation will illustrate the importance of addressing the mental health consequences of FGM/C, recommend mental health educational intervention as part of Women of Pokot Anti-FGM/C training materials, and finally propose a mental health intervention program as a strategy that will further aim to provide mental health support for Pokot girls and women who have been cut.

Problem Statement

Harmful practices like FGM/C continue to impair the health, wellbeing, and future of girls and women. If left unresolved many girls and women are at risk of developing mental health conditions. Trauma, pain, and the risks and complications of being cut can lead to short- and long-term psychological problems like depression, anxiety, and fear (Behrednt & Moritz, 2005).

Though there are policies and laws in Kenya that aim to eradicate the practice, such as the 2011 Prohibition of FGM/C Act, and the Kenya Mental Health Policy that aims to expand mental health services across the country, no interventions have been piloted to investigate the degree of mental illness among Pokot girls and women as a result of undergoing FGM/C. Therefore, in order to identify which interventions can support girls and women who are at risk of developing mental illnesses, a review of existing programs was conducted in chapter four to examine which interventions have been used to treat anxiety and depression among individuals who have encountered trauma like FGM/C. The TEAM project and Group IPT were not adopted as programs for WOP to utilize because both programs require more resources which isn't feasible to the organization. Therefore, the Friendship Bench was chosen as an intervention to be

recommended to WOP. As stated in chapter four, the Friendship Bench was piloted in similar setting like West Pokot and utilized CBT as a form of mental health intervention.

Selected Solution

Modified Cognitive Behavioral Therapy

The suggested intervention chosen is a modification of the Friendship Bench based on what has been reviewed in the previous chapter. In the Friendship Bench, community health workers were trained to deliver CBT. In order to understand why CBT was selected as a recommendation the following section provides a review on what CBT is and the modified version to fit the context of the Pokot community.

Cognitive Behavioral Therapy (CBT) is a type of psychotherapy that was developed for those suffering from anxiety, depression, and PTSD. CBT holds the concept that there is a relationship between how we think, feel, and act. CBT aims to help individuals understand the way they think and gives people the tools to adapt their ways of thinking in order to avoid symptoms of anxiety and depression (Adelufosi et al., 2017). It helps people who have encountered traumatic experiences to incorporate healthier behaviors and change their cognition by challenging negative thoughts and behaviors.

CBT training is an ideal approach as community health workers, who are already trusted members of their community, can feasibly implement the training (Adelufosi et al., 2017). This is important in a low-resource area like West Pokot, as there is a shortage of mental health professionals. While there is no available evidence to indicate how effective this method has been on treating anxiety and depression in women who have undergone FGM/C, CBT has been shown to be effective in treating depression and anxiety in victims who have been subjected to torture (Adelufosi et al., 2017). In addition, it has been reported to improve PTSD symptoms, and anxiety and depression in individuals who have experienced other forms of trauma such as

domestic violence by helping them learn how to deal with their thoughts and feelings, resulting in overall improvement on an individual's mental health. Though none of these examples specifically address FGM/C, the existing literature regarding the efficacy of people who have experienced trauma suggests that CBT may still be able to help girls and women who have been cut due to the trauma of undergoing the practice at such a young age. An intervention like CBT would support girls and women who have been subjected to FGM/C. (Adelufosi et al., 2017).

In an effort to implement a mental health program, the first step is for WOP Anti-FGM/C trainers to be educated on common mental health conditions and how to recognize these issues in an individual. With this background knowledge Anti-FGM/C will then be equipped to decide on culturally appropriate mental health terminology in the Pokot language and more effectively provide support for individuals dealing with mental illnesses. Additionally, educating Anti-FGM/C trainers on common mental health conditions will prepare them to better facilitate CBT as a form of mental health intervention for girls and women who have been impacted by the trauma of FGM/C. Education is the key for Pokot girls and women to make sure they have a better understanding about why FGM/C is harmful to their wellbeing. Anti-FGM/C personnel will have the background knowledge needed to educate the Pokot girls and women on the risk and mental harm associated with FGM/C that can impact their lives long after the trauma. When the community is aware of the common mental health conditions that are seen in people who have experienced trauma, stigma will begin to decline and treatment will become acceptable and feasible.

The second recommendation is CBT as a mental health intervention to support girls and women who have been subjected to FGM/C. As previously mentioned, a modified version of CBT was used to treat anxiety and depression in rural Zimbabwe in a setting very similar to

West Pokot. Based on the success of that intervention, a further modification could bring similar results in Kenya. CBT provides a cost-effective framework that can be facilitated by Women of Pokot's Anti-FGM trainers after eight weeks of CBT trainings, which can be done online through the Beck Institute Organization. These trainings will teach Anti-FGM/C trainers how to work with patients who are dealing with anxiety and depression and to teach them skills needed to achieve and sustain mental wellness (Beck Institute, n.d).

Furthermore, this approach will deliver CBT in the Pokot language at WOP offices in West Pokot and will use the appropriate terminology that is most appropriate for the Pokot. An example of verbiage that is not a direct translation but will be understood as anxiety is the Pokot word *Kinanat,* which directly translates to overthinking. Using cultural terms will make it easier for Pokot girls and women to understand and connect with the trainings. This model utilizes the Friendship Bench model because it is appropriate for this setting as routine mental health care in a western clinical setting is stigmatized and would not be acceptable. Instead of grandmothers facilitating CBT as they did in the Friendship Bench model, WOP Anti-FGM/C trainers will administer the trainings because they are trusted in the community and are experts in working with girls and women who have undergone the practice. The Anti-FGM/C facilitator will work one-on-one with an individual and come up with coping strategies. Furthermore, Pokot girls and women who are at risk of developing anxiety and depression due to FGM/C can use CBT to address their wellness and prevent the development of a mental illness. .

In order to monitor care and evaluate the impact of the intervention, Pokot girls and women who choose to participate will complete a pre- and post-intervention survey. The pre-intervention survey will also serve as a measurement tool to assess participants' knowledge of mental health and ascertain if they have experienced any mental health illnesses. This will

inform the care their facilitator will give. Those that indicate any form of mental health issues will be identified by the Anti-FGM/C trainers who will facilitate trainings and administer CBT trainings within the community to address needs as they are identified. With this approach, those seeking mental health services will not have to travel outside the Pokot community to receive these services, reducing a major barrier to care. A post-intervention survey will be conducted three months after starting participation to evaluate the impact of the program and to determine what changes could be made to optimize effectiveness and appropriateness, while minimizing the strain it places on an already burdened public health system. In addition to the pre- and post-surveys, Anti-FGM/C who are facilitating CBT will be trained to deal with crises such as suicidality. If a patient is in crises that cannot be managed by the caregiver, there will be a protocol to ensure the participant receives appropriate medical attention. Further research will need to be done on the exact details of this protocol, including how to partner with local clinics, and where individuals can receive medicine if necessary.

If this recommendation is adopted, there is hope that Pokot girls and women who have been affected by the mental conditions of FGM/C will be able to seek services that could improve their quality of life. This intervention will give Pokot girls and women a platform to open up about mental health conditions they have been experiencing due to the pain and trauma of being cut. Evidence from the Zimbabwe Friendship Bench showed that patients who participated in CBT were three times less likely to have symptoms for depression and anxiety compared to those who did not utilize services (Chibanda et al., 2016). It's crucial to support Pokot girls and women who are at risk of the mental health outcomes associated with trauma after they have been exposed to FGM/C.

Chapter Six: Discussion, Recommendations and Conclusion

Limitations

From the research findings it's quite evident that FGM/C can affect the mental health wellbeing of girls and women. Preventative measures to eradicate FGM/C focus on physical and health consequences of the practice but overlook the mental health side of the practice. There is also a scarcity of peer-reviewed data on FGM/C in the Pokot community, and statistics on number of individuals who have experienced various mental health conditions due to the practice. As previously mentioned in the literature review, most of the studies published used western measurements such as The Hopkins Symptoms, Harvard Trauma Questionnaire and Depression Index as tools to assess depression and anxiety. In low resource settings such as West Pokot, these tools may not take in consideration the socio contextual framework of the population. Therefore, it was difficult to find studies that had participants with similar dynamics like the Pokot. This would have been important in recommending the appropriate mental health intervention.

There is an urgent need to create mental health policies that address depression and anxiety and are appropriate for women from FGM/C practicing communities like the Pokot. This includes developing culturally sensitive tools that meet the needs of women from that particular culture. Given that the practice is a traumatizing experience, individuals who have been cut may not be willing to discuss what their experience of being cut has been like. It was challenging to address how women in high prevalence countries in low resource settings cope with mental health problems.

Due to the poor infrastructure of mental health services in West Pokot County, it was difficult to find a program that could fit this context. For example, the Friendship Bench collaborated with local clinics and hospitals. However in West Pokot, there aren't any

professionals working in the mental health sector. Therefore, it was more reasonable and feasible to collaborate with WOP and MOHK to support Pokot girls and women who have been subjected to the mental health consequences of the practice than to collaborate with local clinics.

Implications of Public Health

The mental health consequences of FGM/C are a public health issue that needs to be addressed. Many Pokot girls and women could be affected by the mental health effects of FGM/C since they have no space to speak about what undergoing FGM/C at a young age is like. International organizations like WHO, have emphasized the importance of providing support for individuals who have mental health conditions caused by FGM/C. Public health researchers and practitioners need to recognize that anxiety and depression are mental health conditions that can be prevented. Therefore, providing services and policies to protect women allows them to live healthier lives.

Future Directions

More research needs to be done to identify how the practice has impacted Pokot girls and women and if girls and women have dealt the mental health aftermath of undergoing FGM/C. Research should also take in consideration the diversity of women who have undergone the practice which includes, types of cutting, cultures and experiences. Therefore, research needs to be done on the appropriate mental health interventions that could work for individuals who have been subjected to FGM/C that experience various mental health conditions due to the practice. The alarming rates of reported mental health conditions by circumcised women is evidence that interventions should be created urgently that address the needs of girls and women who have been circumcised. Future FGM/C interventions need to start raising more awareness on the mental side of the practice so that it can create a platform that can give individuals an opportunity to open about their experience of undergoing FGM/C. It could be helpful if

researchers pilot trials to see which form of intervention is most suitable for treating depression and anxiety in women living with FGM/C. This will require organizations, governmental entities and activists to start raising more awareness on the psychological consequences of undergoing FGM/C. Such research can improve the healthcare of girls and women living with FGM/C. Finally, the association between mental health and FGM/C is an area that needs to be prioritized.

Conclusion

In conclusion, this thesis provides evidence on laws and policies surrounding FGM/C in Kenya and how the mental health side of the practice is a neglected area. It is imperative that individuals working in the FGM/C sector like MOHK, WOP, WHO and UN should provide mental health services for adults who have undergone the practice. If not addressed, women will continue to suffer from flashbacks of the day they were circumcised with the pain and shock of the procedure leading to more severe mental health conditions if left untreated. This recommended policy was selected based on a comprehensive analysis of current interventions that have been used to treat depression and anxiety in low resource settings.

Future studies need to conduct well-designed CBT intervention for women who have been cut to assess if the method is effective in addressing anxiety, depression. Currently, the majority of published literature have focused on analyzing physical health consequences of the practice while the mental health interventions for individuals who have been cut is not prioritized (Adelufosi et al., 2017). In order to make progress in this sector, future public health practitioners should continue to further research agenda on this topic and develop evidence-based policies and interventions that affect women who have undergone FGM/C.

References

28 Too Many (2016). FGM in Kenya Country Profile Update December 2016. https://www.refworld.org/pdfid/58bd4e2a4.pdf

Adelufosi, A., Edet, B., Arikpo, D., Aquaisua, E., & Meremikwu, M. M. (2017). Cognitive behavioral therapy for post-traumatic stress disorder, depression, or anxiety disorders in women and girls living with female genital mutilation: A systematic review. *International Journal of Gynecology & Obstetrics, 136*, 56-59. doi:10.1002/ijgo.12043

Africa Mental Health Foundation (AMHF). (2016). Muti-sectoral Stakeholder TEAM Approach to Scale-Up Community Mental Health in Kenya (TEAM). Retrieved from: https://www.mhinnovation.net/sites/default/files/downloads/innovation/reports/TEAM%20Project%20Report%20to%20County_Final_31_01_17.pdf

African Population and Health Research Center (APHRC). Adolescent Mental Health In Kenya : Where is the Data? https://aphrc.org/?p=10060

Alachkar M. (2016). Female genital mutilation and mental health: how can research help the victims?. *BJPsych bulletin*, *40*(4), 230-1.

Any Anxiety Disorder. (n.d.). Retrieved from https://www.nimh.nih.gov/health/statistics/any-anxiety-disorder.shtml

Batha, E. (2018, September 13). African countries urged to toughen laws on female genital mutilation. Retrieved from https://www.reuters.com/article/us-africa-fgm-lawmaking/african-countries-urged-to-toughen-laws-on-female-genital-mutilation-idUSKCN1LT2OQ

Beck Institute for Cognitive Behavior Therapy. Retrieved from https://beckinstitute.org/

Behrednt A, Moritz S. Posttraumatic stress disorder and memory problems after female genital mutilation. Am J Psy

Bolton P, Bass J, Neugebauer R, et al. Group Interpersonal Psychotherapy for Depression in Rural Uganda: A Randomized Controlled Trial. *JAMA.* 2003;289(23):3117–3124. doi:10.1001/jama.289.23.3117

Carson, Mary. "Kenyan Police Rescue Hundreds of Girls Due to Undergo FGM." *The Guardian*, Guardian News and Media, 18 Dec. 2015, www.theguardian.com/society/2015/dec/18/kenyan-police-rescue-hundreds-of-girls-due-to-undergo-fgm.

Centre for Ageing Research and Development in Ireland (CARDI). (2012). 10 Guidelines for Writing Policy Recommendations. Retrieved from : http://www.cardi.ie/userfiles/Fact%20sheet%20%28web%29.pdf

Chibanda D, Weiss HA, Verhey R, et al. Effect of a Primary Care–Based Psychological Intervention on Symptoms of Common Mental Disorders in Zimbabwe: A Randomized Clinical Trial. *JAMA.* 2016;316(24):2618–2626. doi:10.1001/jama.2016.19102

CIA (2019). Available from Central Intelligence Agency The world Factbook. Retrieved from : Central Intelligence Agency https://www.cia.gov/library/publications/the-world-factbook/geos/ke.html

Figure 1 : T. (n.d.). Map of Kenya [Map of Kenya]. Retrieved from https://yellowmen.org/tag/kenya/

Figure II, III, IV, V. VI. World Health Organization (WHOc). (2016). *New WHO Guidelines to Improve Care for Millions Living with Female Genital Mutilation.* Retrieved from: https://apps.who.int/iris/bitstream/handle/10665/206437/9789241549646_eng.pdf;jsessionid=254BF865FFEC41A0A8B824E29AACE4CB?sequence=

Goldner, E. (n.d.). Simon Fraser UniversityEngaging the World. Retrieved January 27, 2016, from https://www.sfu.ca/sfunews/stories/2016/expanding-mental-health-care-for-adults-children-in-vietnam.html

Haddaway, N. R., Collins, A. M., Coughlin, D., & Kirk, S. (2015). The Role of Google Scholar in Evidence Reviews and Its Applicability to Grey Literature Searching. *PLoS ONE, 10*(9). doi:https://doi.org/10.1371/journal.pone.0138237

Harrington, J. (2016, April 13). Kenya: Traditional Medicine and the Law. Retrieved April, from https://www.africaresearchinstitute.org/newsite/blog/kenya-traditional-medicine-and-the-law/

International Center for Research on Women (ICRW). (2018). Mental Health and Ending Female Genital Mutilation and Cutting : Recommendations for U.S Foreign Policy and Programs. Washington, DC.

https://www.icrw.org/wp-content/uploads/2017/10/FGM-C- Policy-Brief_September_v8_WebReady.pdf

International Institute for Legislative Affairs (ILA). Mental health problems in Kenya and Africa and how their perception negatively impacts the provision of care. https://ilakenya.org/mental-health-problems-in-kenya-and-africa-and-how-their-perception-negatively-impacts-the-provision-of-care/.

Kaprom, Bernedette. Traditional Values Attached to Female Genital Cutting (FGC) amongst the Pokot in West Pokot, Kenya. https://www.iiste.org/Journals/index.php/DCS/article/viewFile/31123/31960

Kenya Demographic and Health Survey(KDHS). (2014). https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf. Kenya

Kenya Ministry of Devolution and Planning (MoDP). (2013) *Strategic Plan 2014-2018*.http://antifgmboard.go.ke/wp-content/uploads/2018/01/ANTI-FGM-STRATEGIC-PLAN-FINAL.pdf. Kenya

Kenya Ministry of Health. Kenya Mental Health Policy 2015-2030. *Towards the Highest Standard of Mental Health.* https://healthservices.uonbi.ac.ke/sites/default/files/centraladmin/healthservices/Kenya%20Mental%20Health%20Policy.pdf. Kenya .

Kobach, A., et al. (2018). "Psychopathological sequelae of female genital mutilation and their neuroendocrinological associations." BMC Psychiatry 18(1): 187.

Marich, J. (n.d.). What are the Signs and Symptoms of Trauma and Stressor-Related Disorders? Retrieved from https://www.gracepointwellness.org/109-post-traumatic-stress-disorder/article/55731-what-are-the-signs-and-symptoms-of-trauma-and-stressor-related-disorders

Nebehay, S. (2017, February 23). Depression top cause of disability, strikes young and old: WHO. Retrieved from https://www.reuters.com/article/us-health-depression/depression-top-cause-of-disability-strikes-young-and-old-who-idUSKBN1621NL

Nuwer, R. (2018, October 16). Future - How a bench and a team of grandmothers can tackle depression.Retrieved from http://www.bbc.com/future/story/20181015-how-one-bench-and-a-team-of-grandmothers-can-beat-depression

O'dempsey, T.j.d. "Traditional Belief and Practice among the Pokot People of Kenya with Particular Reference to Mother and Child Health: 1. The Pokot People and Their Environment." *Annals of Tropical Paediatrics*, vol. 8, no. 2, 1988, pp. 49–60., doi:10.1080/02724936.1988.11748540.

Performance Audit Report on Provision of Mental Healthcare Services in Kenya. https://afrosaie.org.za/uploads/afrosai.intohost.co.za/cms/files/audit_report_on_mental_healthcare_services_in_kenya__29.12.17.pdf

Population Council Female (2017). Genital Mutilation/ Cutting in Kenya : Is Change Taking Place? Descriptive Statistics from Four Waves of Demographic and Health Surveys. https://www.popcouncil.org/uploads/pdfs/2017RH_FGMCKenyaChange.pdf

Sahiyo (2019). Trauma and Female Genital Cutting, Part 1 : What is Trauma?. Retrieved from: https://sahiyo.com/2018/02/26/what-is-trauma-part-1/.

Smith, H., & Stein, K. (2017). Psychological and counselling interventions for female genital

mutilation. *International Journal of Gynecology & Obstetrics, 136,* 60-64. doi:10.1002/ijgo.12051

T. (n.d.). Trauma and Mental Health. Retrieved from https://alamedacountytraumainformedcare.org/trauma-informed-care/trauma-and-mental-health/

United Nations Children's Fund (UNICEFa). (2019). Female Genital Mutilation/Cutting: A statistical Overview and Exploration of the Dynamics of Change. https://unicef.at/fileadmin/media/Infos_und_Medien/Info-Material/Maedchen_und_Frauen/FGM-C_Full_Report_EN_071113.pdf

United Nations Children's Fund (UNICEFb). (2016). *Female Genital Mutilation / Cutting : A Global Concern.* Retrieved from: https://data.unicef.org/wp-content/uploads/2016/04/FGMC-2016-brochure_250.pdf

United Nations Population Fund (UNFPA).(2019). *Female Genital Mutilation Frequently Asked Questions.* Retrieved from :

https://www.unfpa.org/resources/female-genital-mutilation-fgm- frequently-asked-questions

Vloeberghs, E., Kwaak, A. V., Knipscheer, J., & Muijsenbergh, M. V. (2012). Coping and chronic psychosocial consequences of female genital mutilation in the Netherlands. *Ethnicity & Health, 17*(6), 677-695. doi:10.1080/13557858.2013.771148

World Health Organization (WHOa). (2018). *Female Genital Mutilation*. Retrieved from : https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation

World Health Organization (WHOb). (2019). Child and Adolescent Mental Health. https://www.who.int/mental_health/maternal-child/child_adolescent/en/

World Health Organization (WHOc). (2016). New WHO Guidelines to Improve Care for Millions Living with Female Genital Mutilation. https://apps.who.int/iris/bitstream/handle/10665/206437/9789241549646_eng.pdf;jsessionid=254BF865FFEC41A0A8B824E29AACE4CB?sequence=1

World Health Organization (WHOd). (2018). Dixon Chibanda : Grandmothers Help to Scale up Mental Health Care. https://www.who.int/bulletin/volumes/96/6/18-030618/en/

World Health Organization (WHOe). (2016). Group Interpersonal Therapy (IPT) for Depression). https://apps.who.int/iris/bitstream/handle/10665/250219/WHO-MSD-MER-16.4-eng.pdf;jsessionid=4C53CE12215308BB78A6F170758C4042?sequence=1

World Health Orgnization (WHOf). (2017). Treating Depression where there are no mental health professionals. https://www.who.int/bulletin/volumes/95/3/17-030317/en/

Women of Pokot. (2019). Support the Mission to Empower Women and Girls of the Pokot in Kenya. http://www.womenofpokot.com/the-pokot/#new