USE OF DRAMA THERAPY IN UNLOCKING THE VOICES OF SURVIVORS OF FEMALE GENITAL MUTILATION AMONG THE KENYAN MAASAI

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DECLARATION

This thesis is my original work and has not been presented for the award of a degree in any other University.

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DEDICATION

To Almighty God, who am I without you. To my darling daughter Zawadi and angel Zuriel, you are my sunshine. To Adori mama and G.S. Okoth papa, your support is endearing. Your love and pravers have seen me through. I love you.

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OPERATIONALIZATION OF TERMS

Drama Performance of personal experience of the survivors of FGM.

Drama therapy The use of drama techniques like skits, dance, games, poetry, storytelling and songs to provide psychological, emotional or physical comfort or healing to the FGM victims by helping them explore past experiences in a free fun way.

Empowerment Improvement of the FGM Victims' confidence and self esteem, in a way that positively impacts their participation and interaction with their classmates and friends both at school and at home.

Escapees The Maasai girls who have run away from home so as not to get circumcised or so as not to be married off without their own free will.

Survivors The Maasai girls who have undergone Female Genital Mutilation by being forced or out of their own free will.

Theatre A means in which the girls in the experimental group were able to communicate their experience to each other through performance and storytelling by being a performing/active audience.

Therapy The survivors' way of finding psychological or physical comfort.

Unlocking A journey of personal discovery of meaning and understanding of the girls' life and experiences through their sharing in verbal and nonverbal means which in this instance is theatre.

Voices The participants' means of expression of emotions and feelings by sound, gestures or movement.

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CREAW	Centre for Rights Education and Awareness
DHS	Demographic Health Survey
FAWE	Forum for African Women Educationists
FGD	Focus Group Discussions
FGM	Female Genital Mutilation
HIV	Human Immune Virus
IRIN	Integrated Regional Information Networks
IPAL	Institute of Performing Artists Limited
MYWO	Maendeleo ya Wanawake Organisation
NAPT	National Association of Poetry Therapists
NCCATA	National Coalition of Creative Arts Therapies Associations
NCATA	National Council for Creative Arts Therapies Associations
PATH	Programme for Appropriate Technology in Health
PC	Population Council
SBV	Sexual Based Violence
SGBV	Sexual and Gender Based Violence
SOA	Sexual Offences Act
STD's	Sexually Transmitted Diseases
STI's	Sexually Transmitted Infections
OSIEA	Open Society Institute for East Africa
WHO	World Health Organisation
UNICEF	United Nations International Children's Education Fund
UNFPA	United Nations Family Planning Association
USAID	United States Agency For International Development.
UTI	Urinary Tract Infection

ABSTRACT

This study investigates the utilization of drama therapy to unlock voices of survivors of Female Genital Mutilation. The study proceeds from the assumption that drama therapy is a useful tool not only to reach out to the survivors but also as an avenue for enhancing their self expression. In this regard, drama therapy helped in enhancing the survivors' self expression skills in their quest to recollect their lives and pursuit of their life dreams and goals while at the same time living in harmony with the community. While using various drama therapy techniques such as story-telling, poetry, role playing, song and dance, this study examines and shows how drama therapy can be used as an effective tool in unlocking the voices of survivors of Female Genital Mutilation. The study employed Nietzsche's Will to Power theory and Rogerian theory of self in showing how drama therapy can be used to unlock voices of FGM survivors. Nietzsche's Will to Power theory was used to explore underlying motives behind the survivors' rebellion against Female Genital Mutilation whereas Rogerian theory of Self was used in exploring the survivors' freedom, choices and personal responsibilities, particularly after surviving Female Genital Mutilation. The study utilized control-group as its research design while it engaged in-depth interviews, questionnaires, focus group discussions and participatory theatre to obtain data for analysis. The data collected was analysed both qualitatively and quantitatively. Findings from the study show that drama therapy as a tool for unlocking the voices of FGM survivors creates a safe and playful environment where the survivors are able to act out their anxieties, fears and mental conflicts due to FGM trauma. In this way, the survivors' emotions were not only evoked but drama therapy provided a platform on which their anxieties and fears were expressed and at same time, the stigma related to FGM emotions expelled. In an unconditional atmosphere, drama therapy helped the survivors to regain their self-confidence, self-esteem and build trust plus teamwork through the performances. Finally, through the use of drama therapy techniques such as improvisation and role play, the participants gained new and valuable perspectives in their lives and in the process were able to freely forgive those who had wronged them, by coercing, forcing or abusing them, before and after undergoing FGM.

CHAPTER ONE

INTRODUCTION TO THE STUDY

1.1: BACKGROUND OF THE STUDY

In Africa, statistics have shown that about three (3) million girls are at risk of undergoing Female Genital Mutilation annually whereas 100 to 140 million girls and women worldwide are living with the consequences of Female Genital Mutilation (CREAW 1, 2008). About 92 million girls aged 10 years and above are estimated to have undergone Female Genital Mutilation (WHO, 2011). The practice is most common in the western, eastern, and north-eastern regions of Africa, in some countries in Asia and the Middle East, and among certain immigrant communities in North America and Europe (WHO, 2008).

Female Genital Mutilation, sometimes called female genital cutting, is defined by the World Health Organisation as referring to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (WHO, 2011). It is observed in most studies that Female Genital Mutilation has been practised for over 2000 years in all the continents (Slack, 1988).

Female Genital Mutilation has quite a number of effects on a person's health both physically and psychologically, and has been linked to childbirth complications and increased risk of death, both at the time of delivery and after birth. It can also

make labour and delivery difficult for women/girls leading to prolonged obstructed labour, which is one of the leading causes of obstetric fistula (CREAW 1, 2008). Female Genital Mutilation often has psychological consequences, where girls lose trust and confidence in their guardians or parents and they may suffer from feelings of anxiety, depression and incompleteness (CREAW 1, 2008).

In Kenya, FGM was largely practised among the Gusii, Kuria, Turkana, Akamba, Ameru, Agikuyu, Aembu, Maasai, among others, and where the practice was existent, Female Genital Mutilation was highly esteemed (Mugubi, 1996). The Maasai community, in which the study is based, are semi-nomadic people of East Africa who live in southern Kenya and northern Tanzania along the Great Rift Valley on semi-arid and arid lands (Population Council, 2007). The Maasai of Kenya are famously colourful people- they paint themselves and often wear red and other bright colours. They have managed to hold on to their traditional way of life till present time (Beckwith & Fisher, 2002).The Maasai practise Genital Mutilation or Circumcision as an initiation rite on both the male and the female members of their society. FGM is done to ensure women's faithfulness to the men in the community when the men go away for long periods of time either in search of pasture or on cattle raids (Coexist Initiative, 2012).

This study focused on the survivors of Female Genital Mutilation among the Maasai. The Maasai community has been one of the symbols of Kenya's tourism because they have managed to maintain their culture, traditions and practices despite the Western and modern influences (Equality Now, 2011).

Various measures have been put in place to rehabilitate survivors and escapees of Female Genital Mutilation in Kenya. These measures include counselling and seclusion of the survivors. However, drama therapy as a rehabilitation mechanism has not been explored much (Okoth, 2008). This was the subject of this study. In drama therapy, the focus on 'performance' is replaced with a focus on the participant's mind-body experiences and helps the practitioners access their intuition effortlessly, drawing upon the inspiration of each moment, freeing them from the pressures of performing (Wilson, 1998). Interventions on behalf of or with those whose voices are not normally heard in the societies they inhabit, are a vital feature of applied theatre practice since they act as a counterweight to the myriad interventions of the dominant into the lives of all of us (Prenkti, 2009). Through drama therapy, however, the voices were unlocked by use of drama techniques like games, use of skits where the participants acted their own stories, use of songs and dances, and thereafter, storytelling. These formed part of the focus group discussions where participants in a free atmosphere opened up and talked about what they had acted in relation to their life experiences.

Drama therapy gave another perspective to group therapy by giving the Female Genital Mutilation participants a forum where they could share in common understanding that their problems are familiar to others through story-telling, games and plays, that we hope made them understand the situations that happened to them, that made them to be where they are; and even to understand the society better, and hopefully make informed choices in the future. As Wilson (1998)

observes, theatre has a way of bringing out the child in us, free and not withholding any fears, sorrows or disappointments. It makes us act spontaneously to situations around us in a way that makes us simple and easy to understand. It opens doors to the hidden feelings and secrets which we could not have otherwise been able to express in a one to one or open forum discussion.

1.2: STATEMENT OF THE PROBLEM

This study aimed at examining the extent to which the goals of drama therapy as outlined by Emunah (1994) like the expression of self through role play leading to good social interaction and interpersonal skills, can be achieved through the survivors of FGM. It set to investigate how drama therapy can be used to empower these survivors to make informed choices and gain more confidence in making use of their experiences to overcome other obstacles in life and in empowering others. Currently, the government has developed policies on the eradication of FGM (Kenya Constitution, 2011). FBOs and NGOs have developed shelters and rehabilitation centres for the escapees and survivors of FGM within the country, that offer counselling services and a temporary safety for the young girls until they complete their education (Equality Now, 2011). However, to our knowledge, FGM survivors are not given a chance to voice their own experiences and opinions regarding the practice through drama therapy.

1.3: AIM AND OBJECTIVES OF THE STUDY

This study aimed at exploring the use of drama therapy in unlocking the silent voices of the survivors of Female Genital Mutilation among the Kenyan Maasai.

The specific objectives were to:

a.) Examine how drama techniques such as story-telling, skits, poetry, dances and games can be used as tools of therapy among Female Genital Mutilation survivors among the Kenyan Maasai.

b.) Investigate how effective drama therapy can be in unlocking the voices of the Female Genital Mutilation survivors among the Kenyan Maasai.

c.) Critically examine the ways in which drama therapy can be used as a form of empowerment to the Female Genital Mutilation survivors among the Kenyan Maasai.

1.4: RESEARCH QUESTIONS

a.) How can drama techniques such as story-telling, skits, poetry, dances and games be used as tools of therapy among Female Genital Mutilation survivors among the Kenyan Maasai?

b.) How can drama therapy help in unlocking the voices of the Female Genital Mutilation survivors among the Kenyan Maasai?

c.) In what ways can drama therapy be used as a form of empowerment to the Female Genital Mutilation survivors among the Kenyan Maasai?

1.5 ASSUMPTIONS

The proposed study was founded on the following assumptions:

a.) Drama Techniques like story-telling, skits, poetry, dances and games are suitable as tools of therapy among Female Genital Mutilation survivors among the Kenyan Maasai.

b.) Drama therapy is a suitable means of unlocking the voices of the Female Genital Mutilation survivors among the Kenyan Maasai.

c.) Drama therapy can adequately be used as a means of empowerment for the Female Genital Mutilation survivors among the Kenyan Maasai.

1.6: JUSTIFICATION AND SIGNIFICANCE OF THE STUDY

The idea of doing a study on drama therapy with survivors of Female Genital Mutilation is well justified because its main focus in engaging group therapy targets attitude and behavioural change (Wilson, 1998). It allows the individual within the support group, in this case, the shelter, to examine her own characteristic manifestations that determine attitude reactions, which in effect direct their daily behaviour approaches to situations and towards other people.

The survivors of Female Genital Mutilation need therapy, understanding, care and shelter, these comprise a large part of their healing. Through therapy, for example, it is possible to understand the reasons why they underwent Female Genital Mutilation, the impact that FGM has had on their lives, physically, psychologically and in their relationship with their families and other relations. Drama therapy may also allow them to give their individual opinions and perspectives on Female

Genital Mutilation despite the positive and negative information that they are told about Female Genital Mutilation. Only by unlocking their voices were we able to know about their future aspirations and if they anticipated any hindrances to the achievement of their dreams.

Drama as therapy for survivors of Female Genital Mutilation has not been widely used in Kenya. Therefore, this study set out to explore how it could help rebuild the confidence of the participants into having their own freedom, choice and social responsibility for their actions. It was hoped it would also help them in standing for the values that they believe in like higher education for girls and marriage with a partner of choice at a mature age. It was also hoped that this research would assist in giving educationists and health practitioners an alternative and additional method of therapy that would enable them achieve long term results with minimal time and costs.

1.7: SCOPE AND LIMITATION

The study was carried out only 24 survivors of Female Genital Mutilation only at AIC Kajiado Primary School, and for the control groups we had 14 survivors from Osiligi Shelter in Narok and 10 survivors at Osotua shelter in Narok. It was not easy to find a full quorum-an equivalent number of survivors as the control group (24 participants) in one shelter in Narok. This was because most of the girls at the Narok shelters were escapees. Therefore, we had to use two shelters to be able to

have an equal population for comparative analysis of the active group and the control group.

Since drama therapy is most effective with a limited number of people at a time, for the active study group, we got our sample from class six because of their age bracket of between ages eight (8) years to fifteen (15) years, and their availability during games time for the study according to the school curriculum. The class seven and eight students are busier during the third term in preparations for final examinations. However, for the control groups, the study was done during the holidays when the shelter was full of the girls who go there when the schools are closed.

Length of time taken for discussion was longer with the control group. In this case, in our first meeting, which we had planned to utilize four hours took the whole day notwithstanding that we were not doing any drama therapy with them except for greetings and introduction which were done while everyone was seated. We did not want to have any form of stimulating activity that could influence the participation of the girls in the control group. The responses took longer because the girls felt as though they were being interviewed. The short briefing that was done to them did not make them enthusiastic about answering the questions, filling in the questionnaires and talking about their experiences.

It was noted that the level of participation in the control group was quite limited in that only a handful of the respondents talked while the others listened. Even though

the information gathered in the control group could be paralleled to the experimental group, there was lack of inclusivity in the group.

Another challenge was time. Most of the sessions were meant to last only an hour after the evening classes and before supper time. Sometimes the students would be delayed to leave for games and therefore we had to wait. This meant that we started at 5pm instead of 4.30pm as scheduled. At other times, because of water problem, the girls would first have to get their daily water before coming for the drama therapy sessions. There were instances due to such delays we had to extend the sessions past the agreed time or postpone them until the following session.

The school examinations programme also extended our sessions by at least two weeks because we could not carry out our sessions during the examinations period. We were informed by the school administration that all co-curricular activities were suspended during such periods. We had to respect the school regulations.

CHAPTER TWO

LITERATURE REVIEW & THEORETICAL FRAMEWORK

2.1: INTRODUCTION

The review of related literature sought to establish the history of Female Genital Mutilation the world over, through Africa and in Kenya, and further FGM among the Maasai as a people. It further looked at how previous works in this area of study have focused on drama therapy. In this review process, key themes covered include conceptualizing Female Genital Mutilation, the History of FGM, FGM in Kenya, alternative rites of passage, drama as therapy and theoretical framework.

2.2: CONCEPTUALIZING FEMALE GENITAL MUTILATION

As stated in the previous Chapter, Female Genital Mutilation (FGM) refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (WHO, 2011). Female Genital Mutilation is popularly regarded as a form of gender-based violence since the 21st Century and has been recognised as a harmful practice and a violation of the human rights of girls and women. However, traditionally it had a societal significance among the communities that practised it. FGM, which traditionally was referred to as female circumcision, is performed to mark the transition from childhood to adulthood. In most African communities Female Genital Mutilation is part of initiation or a ceremony in which a girl learns "how to behave as a woman" and is prepared for marriage (UNICEF, 2008).

In an analysis of Rebeka Njau's social vision, John Mugubi (1996) states that no matter how old or big one was, one was looked at contemptuously and viewed as a child if he or she was still uncircumcised. In comparison, Mugubi cites Austin Bukenya's *The Bride* (1986), where Namvua is disregarded by her circumcised peers such as Ntuta simply because she is uncircumcised. As a foreigner, Namvua could not be initiated with her age-mates; something which condemned her to 'eternal childhood'. The operation symbolized separation from childhood and was parallel to the cutting of the umbilical cord when a child was born (Mbiti, 1969:122-123). Before circumcision, boys and girls were given lessons and instructions on what the society demanded of them after the attainment of adulthood, thus being accepted into the society (Mugubi, 1996). Further, only the initiated could hold responsible positions in the society. At the termination of the initiation ritual, one was already introduced to one's ancestral spirits. Whereas men were permitted to hold such positions as key military posts or eldership in the elder's council *inter alia,* women could join the women's council. The initiated woman was also allowed to marry and own her own property among the Agikuyu (Mugubi, 1996:76).

Female Genital Mutilation is often motivated by beliefs about what is considered appropriate sexual behaviour, with some communities considering that it ensures and preserves virginity, marital faithfulness and prevents promiscuity/prostitution (WHO, 2008). Female circumcision is condescending in the sense that by cutting the clitoris it was expected that the woman's sexual instincts would not be provoked easily (Mugubi, 1996). As if by implication, without circumcision, the

woman would be emotionally untrammelled free, controlled by her 'congenital' overriding sexual urges, as is the case of the Turkana where women were circumcised while men were not (Mugubi, 1996).

Hay (1964) argues that man has been suffering from an overwhelming apprehension which compels him to try and curtail the freedom of the woman. Hay attributes man's anxiety as emanating from a recognition rightly or wrongly that a woman's sexual performance was limitless compared to his own. Thus man having been enveloped in disquietude, reels with misgivings because of the belief that the woman may turn the male gender as a lot who exploits the biological nature of women merely to satisfy their lust (Hay, 1964).

There is a strong link between Female Genital Mutilation and marriage-ability in that Female Genital Mutilation is often considered as a prerequisite to marriage. Traditional belief is that FGM make girls 'clean' and aesthetically beautiful (WHO, 2008). Myths have further been created to propagate this belief. For instance, among the Agikuyu, it was believed that an uncircumcised woman was immature, a social anomaly and unable to participate fully in adult relationships and if she managed to get children, they would all be retarded either bodily or psychically (Mugubi, 1996).

Jomo Kenyatta, the first President of Kenya and a strong supporter of the tradition of FGM, gives a better picture of the importance of FGM in tradition in his book *Facing Mount Kenya* (1958) when he states:

> The operation is (still) regarded as the very essence of an institution which has enormous educational, social, moral and religious implications, quite apart from the operation itself. For the present it is impossible for a member of the tribe to imagine an initiation without clitoridectomy (FGM). Therefore, the abolition of the surgical element in this custom means to the Gikuyu the abolition of the whole institution (126).

He goes on to show the close relation between marriage and FGM. He claims that uncircumcised tribe members cannot marry and are ostracized by the community and tribe:

> In the matrimonial relation, the rite of passage is the deciding factor. No proper Gikuyu would dream of marrying a girl who has not been circumcised, and vice versa. It is a taboo for a Gikuyu man or woman to have sexual relations with someone who has not undergone this operation (1958:127).

Further on marriage-ability, the parents of a boy who married an uncircumcised girl would refuse to be reincarnated through their grandchildren, even though the Kikuyu naming ceremony which involved giving the first born children the names of the paternal grandparents (Kenyatta, 1958; Mugubi, 1996).

Murray (1974), on discussing the Kikuyu myths associated with female circumcision, states that girls were socialized to believe in the falsehood that uncircumcised women had a certain mark of unpalatable behaviour. That they remained less than mature, were unable to cope with their female peers, were disrespectful of elders and uncouth. In a nutshell, an uncircumcised woman does not observe the mature woman's duty and "does not observe the mature woman's

code of behaviour in manners, modesty, respect towards seniors and proper respect towards junior" (Murray, 1974:384).

Although no religious scripts require the practice, practitioners often believe the practice has religious support (UNICEF, 2008). Indeed, among the Agikuyu (the Ameru and the Abagusii), female and male circumcision were considered religious-initiating rites that harboured immense educational, social and moral implications diverse from the operation itself (Mugubi, 1996). Girls and women will often be under strong social pressure, including pressure from their peers and risk victimisation and stigma if they refuse to be cut (UNICEF, 2008). In the belief that drama is a reflection of real life, writers like Austin Bukenya and Ngungi Wa Thiong'o cite female characters who accept to go against all else and other people's expectations so as to get circumcised. In Ngugi's *The River Between (1965)*, we see how highly female circumcision is esteemed, when Muthoni rejects her father's way of life and upbringing and runs away from home as a rebel in order to embrace the Agikuyu traditional customs. In Bukenya's *The Bride (1986)*, the girls of the Albino group did not consider themselves women but 'girls' until they were initiated.

The deep rootedness of this custom is further portrayed in Rebecca Njau's *The Scar (1963)*. In *The Scar*, Mariana is committed to seeing girls unchain themselves from traditions that demean them, such as circumcision, which are ingrained in the society. She organises for the escape of young girls who do not desire to participate in the initiation ceremony, and gains a lot of popularity and support from the girls

who esteem her and trust in her every word (Njau, 1963).In an analysis of Njau's social vision in *The Scar***,** Mugubi (1996) elaborates how Mariana's fate ends tragically. When the truth about her past is revealed, of her being raped by her boyfriend Pastor Yohana, and that she conceived a child whom she, in secret, had let her deceased friend Katarina to adopt, she loses her status as a rescuer of the girls. She becomes an iconoclast and loses the respect that the girls had for her. This is because the society associates children born out of wedlock to lose morals and this is believed to be by of girls who are not circumcised. Therefore, for Mariana, to be empowering the girls to escape from female circumcision in the belief that it demeans the woman, yet she (Mariana) got pregnant out of wedlock, makes the society feel that she is of loose morals. So, her mission is of no value to the girls. Mariana has to relinquish her leadership role because the women she leads can no longer have much faith in her as they have done initially (Mugubi, 1996).

According to World Health Organisation (WHO, 2008), Female Genital Mutilation is classified into four types as summarized in Table 2.0:

Table 2.0 Description of Types of FGM

TYPE OF FGM	**DESCRIPTION**
Type I	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). Note also that the term 'excision' is sometimes used as a general term covering all types of FGM.
Type III	Narrowing of the vaginal orifice with creation of a covering seal by cutting and apositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

Source: Table adopted from WHO 2008 report.

Female Genital Mutilation is always traumatic (UNICEF, 2008). Immediate complications can include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue. Long-term consequences can include recurrent bladder and urinary tract infections; cysts; infertility; an increased risk of childbirth

complications and new born deaths; the need for later surgeries. For example, Type III infibulation needs to be cut open later to allow for sexual intercourse and childbirth (WHO, 2008).

Furthermore, FGM reduces a woman's sexual pleasure. Yet to achieve sexual pleasure depends to a large extent on normal external genital organs. Female Genital Mutilation, however, harms the structure and function of the female external genital organs. It has physical and psychological consequences that often complicate the sexual relationship between men and women. The clitoris is a sensitive part of a girl's body and the most sensitive part of the sexual organs. It provides sexual excitement to the woman when being touched. The inner lips and the clitoris are largely responsible for a woman's orgasm during sexual intercourse. When the clitoris and other parts of the genital organs are removed, the woman's sexual excitement and pleasure are greatly reduced (CREAW 1, 2008).

Other harmful effects of Female Genital Mutilation include: failure to heal, abscess formation, cysts, excessive growth of scar tissue, urinary tract infection, painful sexual intercourse, increased susceptibility to HIV/AIDS, hepatitis and other blood-borne diseases, reproductive tract infection, pelvic inflammatory diseases, infertility, painful menstruation, chronic urinary tract obstruction/ bladder stones, urinary incontinence, obstructed labour, increased risk of bleeding and infection during childbirth (UNICEF, 2008). Early marriages often mean that girls and boys stop going to school, thus limiting their potential in life. It is also associated with high poverty. since higher education often delays childbirth and equips people

better for economic gain. Early marital unions expose many girls to the risk of domestic abuse and sexual violence besides the risk of acquiring STDs, STIs and HIV/AIDS (CREAW 1, 2008).

The eradication of Female Genital Mutilation is pertinent to the achievement of four millennium development goals (MDGs): MDG 3 - promote gender equality and empower of women; MDG 4 - reduce child mortality, MDG 5 - reduce maternal mortality and MDG 6 - combat HIV/AIDS, malaria and other diseases. However, little or no effort is being made to hear the story of the survivors from this ordeal once the girls are rescued and taken to the centres. The rescuers assume that the girls have no say about being stopped from undergoing FGM, and that they are grateful. They thus do not give the girls an avenue to vent out their anger, desperation, joys and fears in an open atmosphere. The girls live in the rescue centre with hope for a better tomorrow in terms of education and social well-being. However, their individual emotional and psychological feelings are not taken into consideration. This formed the basis of this study as we sought to use drama therapy to unlock the voices of FGM survivors in the rescue centres. To give them a chance to share their feelings and opinions about what they liked or did not like about the practice of FGM.

2.3: HISTORY OF FEMALE GENITAL MUTILATION

Commonly, when we think of FGM, we think only of African countries. Certainly the highest number of victims are in African countries, but FGM historically

occurs or has occurred in many countries (Estabrooks, 2013). FGM also occurred historically in parts of the Middle East, in Australia, France, England, Rome, the Far East and among the immigrant population in Europe and the Americans (Moges, 2003;Estabrooks, 2013).

There have been various reports on female circumcision throughout the ages. The first historical reference to it can be found in the writings of Herodotus, who reported its existence in ancient Egypt in the 5th century B.C. He was of the opinion that the custom had originated in Ethiopia or Egypt, as it was being performed by Ethiopians as well as Phoenicians and Hittites (Taba, 1980). Although it has obscure origins, there has been anthropological and historical research on how the practice came about with traces of it to the 5th century BC Egypt, with infibulations being referred to as 'Pharaonic circumcision' (Slack, 1988). A Greek papyrus in the British Museum dated 163 B.C. mentions circumcisions performed on girls at the age when they received their dowries (Widstrand, 1965). Various authors like Sir Richard Burton have shown that female circumcision was practised as well by early Romans and Arabs (Widstrand, 1965).

Other anthropologists believe that it existed among Equatorial African herders as a protection against rape for young female herders; as a custom amongst stone-age people in Equatorial Africa; or as 'an outgrowth of human sacrificial practices, or some early attempt at population control' (Lightfoot-Klein, 1983). There were also reports in the early 1600s of the practice in Somalia as a means of extracting higher

prices for female slaves, and in the late 1700s in Egypt to prevent pregnancy in women and slaves. However, it is believed that Female Genital Mutilation is practised across a wide range of cultures and it is likely that the practice arose independently amongst different peoples (Lightfoot-Klein, 1983).

FGM is closely associated with Africa and Africans especially in the Sahara belt extending from Ethiopia and Djibouti in the east to Nigeria and Ghana in the west (Moges, 2003). It is widely practiced in at least 28 African countries like: among the Galla of Ethiopia, among the Somali, Northern Sudan, Egypt, several groups in Tanzania, most of the Bantus and Plain Nilotes in Kenya, and some countries in West Africa (Mugubi, 1996; Estabrooks, 2013).

According to TACOG (*The American College of Obstetricians and Gynecologists Journal*, 2008), the origins of FGM are a mystery. It is thought to have existed in ancient Egypt, Ethiopia, and Greece (Cutner, 1985). As late as the 1960s, American obstetricians performed clitoridectomies to treat erotomania, lesbianism, hysteria, and clitoral enlargement (Cutner, 1985). Female slaves in ancient Rome had rings threaded through their labia to prevent them from becoming pregnant. Crusaders brought the chastity belt to Europe during the twelfth century (Assad, 1979). Until rather recently, clitoridectomy was the surgical "remedy" for masturbation in Victorian England and even more recently in the United States (Assad, 1979; Wallerstein, 1980).

From approximately 1900 - 1939, FGM was practised in Australia kindergartens as a method of 'curing the precocious masturbator'. This practice was not confined to Islamic groups, as some may suspect, but included Australians of European heritage (Estabrooks, 2013). In Britain, the greatest period of clitoridectomies was from 1858 - 1866. Clitoridectomies were continued in the United States through 1925, replaced by circumcision through as late as 1937, and possibly 1948. It was believed that these procedures would stop masturbation, reduce women's mental disorders, cure female complaints and prevent or stop nymphomania – excessive sexual desire in and behaviour by females (Estabrooks, 2013).

From its probable origins in Egypt and the Nile Valley, female circumcision is thought to have diffused to the Red Sea coastal tribes, along with Arab traders, and from there into eastern Sudan (Modawi, 1974), aided by Egyptian slave raids from Sudan for concubines and maids, and traded through the Red Sea to the Persian Gulf (Mackie, 1996). Niebuhr, the sole survivor of the first European scientific expedition to Arabia and Egypt in 1767, reported that the practice of infibulation was performed on slave girls by slave traders along the Nile and this was observed by a number of 18th century travellers (Widstrand, 1965; Cloudsley, 1983). Sir Richard Burton, the noted British 19th century explorer, lectured extensively on the subject of sexuality among what he described as primitive Peoples (Cloudley 1983). Burton (1954) noted that while the intent of the custom was to dampen the female sexual drive, its effect was often quite the opposite. He came to the conclusion that excision of the clitoris and labia rendered women more lascivious but far less easily satisfied:

> The moral effect of female circumcision is peculiar. While it diminishes the heat of passion, it increases licentiousness and breeds a debauchery of mind far worse (sic) than bodily unchastity (1954;108).

This is supported by Lerner who states that the methods used to repress female sexuality throughout history up to the present have been many, and have extended worldwide (Lerner, 1986;139). He further observes that in ancient Mesopotamia, the Code of Hammurabi marks the beginning of the institutionalization of the patriarchal family. From 1250 B.C. on, public veiling and the sexual control of women have been essential features of patriarchy. In some groups FGM appears to have been a mark of distinction, in others a mark of enslavement and subjugation.

The practice of FGM in Africa is highly observed among the Bantu communities and the Plain Nilotes and is a highly secret ritual in most tribes. Often the girls are taught to keep the secret code so as not to scare others (Beckwith & Fisher, 2002). The practice transcends religion, geography, and socioeconomic status. Although Female Genital Cutting predates Islam, a small number of Muslims have adopted the practice as a religious requirement (Cutner, 1985). The practice seems to be very extensive among the Muslim population in the FGM practising countries and as such has acquired a religious dimension. In Ethiopia and Egypt, for example, both the Coptic Christians and the Muslims practise FGM (Mottin-Sylla & Palmieri, 2010). However, not all Muslims practice FGM. For example, it is not practised in Saudi Arabia, Libya, Jordan, Turkey, Syria, the Maghreb countries of northwest Africa, Morocco, Iran and Iraq. Not all the Muslims in FGM practising

countries practise it. For instance, in the case of Senegal where 94% of the population is Muslim, only 20% practise FGM (Mottin-Sylla & Palmieri, 2010).

None of the two major religions, Islam and Christianity, impose the practice of FGM. There is nothing specific in the Bible or the Koran which allows the mutilation of women (Toubia, 1993). The Koran does not refer to FGM but a few sayings of the Prophet (Hadith) quote His dialogue with a circumcisor where He is quoted to have said "reduce but do not destroy" (Toubia, 1989). Religious leaders, except some missionaries, have not until recently recognized it as a harmful practice and/or discouraged its practice. In a 1998 symposium of religious leaders they agreed that FGM has no religious basis and has nothing to do with Islam (Moges, 2003). However, they tend to link the moral benefits attributed to FGM (such as purity, virginity, morality) with religion (Moges, 2003).

Female circumcision continues in practice today in over forty countries (Olayinka, 1987). In spite of wide geographical, racial, and religious distribution, the custom has attracted little attention in social or medical literature, and substantive research on the subject has been limited (Estabrooks, 2013). According to UNDP in the WHO 2008 report, those who support and help perpetuate the practice argue that the decision to engage in such a custom is the prerogative of a society, and that other societies have no right to impose their contrary morals and beliefs (WHO, 2008). The report further states that the opponents of female circumcision underscore its adverse physical and emotional effects on women, young girls, and babies. The heart of the controversy lies in finding a balance between a society's

cultural self-determination, and the protection of individuals from the violation of their human rights (WHO, 2008).

Olayinka Koso-Thomas' (1987) observation on the current status of the practices in most regions of Africa is pertinent here. She declares that the eradication of female circumcision must involve the social, religious and cultural transformation of certain communities, rather than overturning or uprooting this base by rapid decrees, because the legislative attempts of the past, which were aimed at prohibiting it, did not succeed.

Efua Graham of the Women's Action Group in Great Britain views the prospects for rapid change even more bleakly. Given the poor economic situation facing many African states in recent times, she says, many legislators would undoubtedly see female genital mutilation as a non-issue (Ogamien, 1988). She goes on to say:

> Even the African women in the health profession see it as a non-issue. We need to educate people at grass root level. (Ogamien, 1988:28)

Among the Nigerian Igbo a considerable decline in the rate of female circumcision in recent decades has been reported by one researcher. A study by Megafu found that in 1983 among a sampling of 140 women between the ages of 36 and 45, 85% were circumcised. By contrast, this percentage had dwindled to 33% among a sampling of 120 females between the age of 16 and 25 (Megafu, 1983). In Sudan, while many young intellectuals declare their intent to begin abolishing the practice by not circumcising their own daughters, a mere handful has good intentions into

action. There is simply too much family pressure and fear of breaking with tradition. The same scenario has been reported in Somalia (Grassivaro Galli and Viviani, 1988).

During international efforts to eradicate FGM, arguments have been made that females have a choice in the matter. Even if a true choice is allowed, pressure, age-old belief systems, a desire to uphold family honour, fear, and threats of rejection frequently compel young women or parents to submit. Often, for those families who choose otherwise, others who strongly believe in FGM willingly disregard their decision (Estabrooks, 2013). The fight for the abolition of FGM intensifies in many countries in the world, with communities protecting their cultures for various reasons. Female Genital Mutilation is said to be more westernized, unlike what it was before in Africa. The sole purpose was the passing on of cultural values, morals and responsibilities, but today it has since grown from clitoridectomy, to Female Cutting, to Genital Mutilation - a term believed to be more coerced by the western world, as a result of the few exposed communities that practise infubilation (Olayinka, 1987; Moges, 2003).

2.4: FEMALE GENITAL MUTILATION IN KENYA

Various Ethnic communities practised Female Genital Mutilation in Kenya. Kenya is classified by UNICEF as a Group 2 Country, where FGM prevalence is intermediate and only certain ethnic groups practise FGM it at varying rates (UNICEF 2005). Kenya has significant regional variations in FGM, with

prevalence ranges from 0.8% in western Kenya and over 97% in the north-east of Kenya (WHO, 2008). These regional differences are reflective of the diverse ethnic communities. The country has great ethnic and cultural diversity, as reflected in the differing rates of FGM across the ethnic groups, as well as the type of FGM performed and the underlying reasons for practising it (UNICEF, 2005). As this section will show, the most common type of FGM is 'flesh removed' which accounts for 83% of women who have been cut, type III infibulation *(see table 2.0 on page 17)* accounts for 13% and 'nicked-no flesh removed' 2% (DHS, 2008-09). These regional differences are reflective of the diverse ethnic communities. Prevalence of FGM within individual communities is discussed below in Section on FGM in Kenya by region and ethnicity. For purposes of this study, we will divide the groups in terms of their origins and language that is Bantus, Cushites and Nilotes. In this regard, ethnicity appears to be the most determining influence over FGM within a country (UNICEF, 2005). The prevalence of FGM varies hugely within ethnic groups as discussed in the following pages:

2.4.1: BANTU

The Bantu refers to the group of people who speak the Bantu language, and the term was coined from the word 'Umuntu' which is plural for the word 'Abantu' which refers to a person (Nangulu, 2013). The Bantu comprises a lot of communities which practise FGM. These communities are the Meru, Embu, and Agikuyu, the Akamba, the Abagusii, and the Kuria (Nangulu, 2013).

The **Meru** are Bantu people who live in central Kenya around Mount Kenya. Meru groups have strict patriarchal societies that are both age and gender-segregated, and male and female circumcision is related to adulthood and marriage rituals. It is estimated that approximately 39.7% of Meru women have undergone FGM (FGM NETWORK, 2011; DHS, 2008-09). The most common type of cutting among the Meru is Type II excision*(see table 2.0 on page 17)*, (FGM NETWORK, 2011; Population Council, 2007). The **Embu** are Bantu peoples closely related to the Kikuyu and the Mbeere and inhabit the Embu District, Eastern Province. For the Embu, FGM is part of a rite of passage to adulthood, and is usually done around the onset of puberty. It is estimated that 51.4% of Embu women have undergone FGM (DHS, 2008-2009).

The largest ethnic group in Kenya is the **Kikuyu** from the Bantu group, and they comprise approximately one fifth of the total population. It is estimated that approximately 21.4% of Kikuyu women have undergone FGM (DHS, 2008-09). The most common type of cutting by a large majority (over 80%) within the Kikuyu is 'flesh removed' (DHS, 2008-09) or clitoridectomy (Population Council, 2007). Concern exists around the banned Kikuyu sect the Mungiki, a large, violent, political organisation which actively rejects all Western influence. They are known to force women to undergo FGM, in particular, the wives, partners, children and other female family members of those men who have taken the Mungiki oath (UK Border Agency, 2008). The **Kamba** are Central Bantu people who are agriculturalists, and they inhabit areas in south-central Kenya, Machakos and Kitui

Districts. It is estimated that approximately 23% of Kamba women have undergone FGM (DHS, 2008-09).

The second highest prevalence of FGM (at 96.1%) is found among the **Abagusii**, who are also known as the the Gusii (DHS, 2008-09). The Abagusii inhabit Kisii and Nyamira Districts in Nyanza Province, Western Kenya. A significant minority of approximately 20% still practise a monotheistic religion that pre-dates colonialism and the arrival of missionaries. Thus, FGM continues because of tradition and a sense of community, particularly as it distinguishes minority Abagusii from their historically hostile neighbours the Luo, who do not practise it (Wanjiru et al, 2008). FGM is stated as a necessity to be marriageable, to gain the respect, to control sexual desires before marriage and ensure fidelity (especially within polygamous marriages) and that it is fundamental to cleanliness and hygiene (Njue, 2004). Cutting was done with celebration, but has recently become secretive due to prohibition of FGM under law (Wanjiru, et al, 2008; Njue, 2004). Traditionally FGM was performed from 15 years in preparation for marriage but it is now typically performed on girls aged 8-10 years. The most common form of FGM is Type I *(see table 2.0 on page 17)*. (Njue, 2004; Wanjiru, 2008; Population Council, 2007).

The **Kuria** who are closely related to the Abagusii people also perform FGM on girls around the age of puberty (Wanjiru et al, 2008) for the same reasons as the Abagusii. Parents of girls are keen to have their daughters undergo FGM to increase their dowry.

2.4.2: CUSHITES

The Cushites refer to the first group of people that migrated into Kenya and are believed to have an Asian origin. (Nangulu, 2013). Some of the common communities that practice FGM are the Borana, Rendille and Somali.

The **Borana** are a traditionally nomadic people residing in and around Isiolo, Tana River, Garissa, Moyale and Marsabit Districts. The Borana perform FGM for religious reasons. Most Borana are Muslims, although some still practise the traditional religion which worships a supreme being known as Waqa (Equality Now, 2011).

In the Nothern regions we have the Rendille. Originating in Ethiopia, the **Rendille** migrated to the area between the Marsabit hills and Lake Turkana in North Kenya after constant conflict with the Oromo tribe. Social status for men is based on a well-defined system of age sets and initiation ceremonies which symbolize the transition between the ages and which take place every 7 to 14 years. Women's status is much simpler as they are either married women or unmarried girls. FGM is sometimes performed on the morning of the wedding and symbolises the girl's transition into womanhood. The Rendille practise Type III infibulation *(see table 2.0: page 17),* (Population Reference Bureau, 2001) although other commentators report the less severe Type I (Shell-Duncan, 2001). Among the Rendille, men often

'book' girls they wish to marry at a very young age and the marriage often takes place when the girl is around 10-12 years old (Shell-Duncan et al, 2000).

Close to the Rendille in the Northern Kenya are the Somali. The **Somali** are Eastern Cushites originating from Somalia and have inhabited Kenya for around two hundred years. They live in the North Eastern Province, and are mostly Muslim herdsmen. 97.7% of all the women have undergone FGM, with 75% having undergone Type III FGM (infibulation) (DHS, 2008-09). The tradition of FGM among the Somali of Kenya was brought from Somalia. For Kenyan Somalis, tradition is cited as the strongest factor for the perpetuation of FGM, with cultural values around virginity and marriageability a close second, and belief that it is a necessary procedure to be a proper Muslim woman is the third reason, and this counts for the Orma and Boni (Sheikh & Askew, 2009). It is believed that an uncut girl will be sexually promiscuous and unsuitable as a wife, bringing shame to the family (Jaldesa et al, 2005). FGM is enforced via peer pressure amongst young girls at school and by social stigma, and it is usually carried out by traditional practitioners (Population Council, 2007). Girls in the North Eastern region (the Somalis) are typically circumcised at a young age, with two thirds being cut between the ages of 3 and 7 (DHS, 2008-2009).

2.4.3: NILOTES

The Nilotes refer to a group of people who originate from the Nile during their migration. They stretched on both sides of the Nile from Sennar (in Sudan) to Lake

Victoria and their influence penetrated deeper into East Africa (Nangulu, 2013). The Nilotic communities that practise FGM are mainly the Plain Nilotes who are known to have settled along the arid plain lands and most are nomadic pastoralists (Population Council, 2007). These communities are the Samburu, Turkana, Pokot, Kalenjin and Maasai.

The **Samburu** are semi-nomadic pastoralists who live in the Rift Valley Province. They are closely related to the Maasai. Among the Samburu, FGM is considered a passage into womanhood and is usually performed on girls as young as 12 years in preparation for marriage. They practise Type III infibulation (Population Council, 2007). The **Turkana** are a nomadic, pastoral people inhabiting semi Desert Turkana District in the Rift Valley Province of Kenya, where they migrated to from Eastern Uganda (DHS of 2008-09). With a population of around 250,000 people, the Turkana are the second largest pastoral community in Kenya and they practise Type III infibulation (Brockman, 2004). The DHS 2003 states that 12.2% of Turkana women have undergone FGM, although there is no data for the Turkana in the most recent (DHS, 2008-09).

The **Kalenjin** are a group of related Nilotic tribes which came under the single name 'Kalenjin' during the British colonial era. They live in the highlands of the Rift Valley and are famous for their running ability. It is estimated that approximately 40.4% of Kalenjin women have undergone FGM (DHS, 2008-09). Among the Kalenjin, women who have not been cut are seen as promiscuous, immoral and imitators of Western culture (Cheserem, 2010). Another community

is **Pokot** who are split into two groups, around half are semi-nomadic, semi-pastoralists and live in the lowlands west of Baringo District, the other half are agriculturists and live wherever conditions allow farming. Social status in the Pokot tribe is associated with age sets. Progression through the age sets is determined by certain initiation rituals, including FGM around the age of 12 for girls (Shell-Duncan, 2001). Around 85% of Pokots still follow their traditional religion which involves animal sacrifice and they see the sky (Yim) as God, thus the reverence to their God is through rituals of which FGM is one, which they believe connects one to the ancestral spirits and unifies one with God (Cheserem, 2010).

Another Nilotic community that practises FGM in Kenya are the **Maasai** community- they are plain Nilotes who live at the border of Southern Kenya and Northern Tanzania in the arid and semi-arid areas of the southern Rift Valley (Population Council, 2007).

2.4.4: THE MAASAI

The **Maasai** community, from which our study is based, are a semi-nomadic, pastoral Nilotic people. They are cattle herders. However, environmental stresses and the fall-out from intrusive colonial initiatives have meant their traditional ways of life have had to be adjusted. Attempts by governments and NGOs to convince them to abandon their lifestyle and settle in one place have been met with fierce resistance and no success (IRIN, 2005). According to Maasai myth, a girl called

Naipei once had intercourse with an enemy of her family, thus to punish her and suppress her sexual desires, Naipei was subjected to FGM (IRIN 2005, Equality Now, 2011). Since then, every Maasai girl reaching adolescence has undergone FGM, which has been used to curb sexual desire and promiscuity amongst girls. By undergoing FGM, girls bring honour to both themselves and their families (IRIN, 2005). FGM takes place once a year for all girls in the appropriate age group, usually between the ages of 12 and 14 (prior to marriage), and the celebration is an important rite of passage into womanhood (Beckwith and Fisher, 2002, Equality Now, 2011). FGM is performed by the Maasai to mark a girl's transition to womanhood and readiness for marriage, as well as to gain the community's respect, ensure sexual purity and chastity and be taught the ways of the community (Coexist, 2012). A Maasai girl who refuses this rite of passage will be ostracized from her community and alienated from her cultural tradition (Beckwith and Fisher, 2002). The most common type of cutting among the Maasai is Type II excision (Population Council, 2007). Although the Maasai are proud of their culture and are typically deliberately resistant to outside influence, they have shown willingness to adjust their practices, including using a different blade for each girl to minimise infection (IRIN, 2005). There has been a slight but encouraging reduction in FGM prevalence rates, decreasing from 93.4% to 73.2% (DHS, 2003 and 2008-09).

FGM among the Maasai is a ritual that is sacred and communal. At dawn the girl(s) is ritually shaved and washed, then sits in the darkness of a hut before a female circumciser (usually elderly woman), surrounded by her family and held

down by an aunt. Traditionally, a special curved sharp knife known as 'ormurunya' was used to cut away the clitoris and labia minora (Beckwith and Fisher, 2002). Although the Maasai are proud of their culture and are typically deliberately resistant to outside influence, they have shown willingness to adjust their practices, including using a different blade for each girl to minimise infection (IRIN, 2005). After performing the cutting, a paste made of cow dung and milk fat is applied to stop the bleeding. During the weeks of recovery, she is secluded together with other initiates for a period of up to six months, a time that serves as a transition to adulthood (Beckwith and Fisher, 2002), as they are taught about the values and norms of the community (Equality Now Journal, 2011). With a beaded band around her herd, she is not allowed to be seen or spoken to by men, and she receives gifts of livestock to honour her new status and can now look forward to marriage and children (Beckwith and Fisher, 2002, IRIN, 2005).

Despite the fact that there are diverse reasons as to why various ethnic communities in Kenya practise FGM, what is clear from the above analysis is that FGM is performed mostly on girls aged between 12 and 18 (DHS, 2003). There has been a slight but encouraging reduction in FGM prevalence rates, decreasing from 93.4% to 73.2% (DHS, 2003 and 2008-09). It is thought that the decrease is to avoid detection as a response to the legislation that has banned the practice. The proportion of women who have undergone FGM declines with age, indicating a decline in the popularity of the practice among the younger generations (DHS, 2008-09).

2.5: THE FIGHT AGAINST FEMALE GENITAL MUTILATION

The legal fight against FGM began with the United Nations involvement in 1952 when the UN Commission on Human Rights raised the issue for the first time. In 1982, WHO made a formal statement of its position opposing the medicalization of FGM to the UN Human Rights Commission and strongly advised health workers not to perform FGM under any conditions (Estabrooks, 2013). In February 1984, FGM was condemned again as a health hazard and a cause of unnecessary human suffering during a Seminar in Dakar (Senegal) on "Traditional Practices Affecting the Health of Women and Children". In 1985 the World Health Assembly resolution (WHA 38.27) recognized the problem of harmful traditional practices and called for concrete action to eliminate FGM (Estabrooks, 2013).

The terminology from "female circumcision" to "female genital mutilation" was thereby changed by the United Nations upon recommendation by WHO in 1991, after having been proposed in 1990. In 1994, the Sub-Commission on Prevention of Discrimination and Protection of Minorities adopted a Plan of Action for the Elimination of Harmful Traditional Practices affecting the Health of Women and Children: resolution 1994/30 of 26 August 1994 (Estabrooks, 2013). In 1995, the World Health Assembly and The World Conference on Human Rights held in Geneva both formally recognized the problem of harmful traditional practices and called for definite action to eliminate FGM (Estabrooks, 2013, World Conference on Human Rights Journal, 1995).

Growing awareness of the dangers of FGM led UNICEF, the World Health Organization (WHO) and UNFPA to form a joint initiative in April 1997 whose goal was to effect a major decline in FGM within ten years and eliminate the practice within three generations (Estabrooks, 2013). In 2008 WHO together with 9 other United Nations partners, issued a new statement on the elimination of FGM to support increased advocacy for the abandonment of FGM. The new statement builds on the original from 1997 that WHO issued together with UNICEF and UNFPA (WHO, 2008)

In 2010 WHO published a "Global strategy to stop health care providers from performing female genital mutilation" in collaboration with other key UN agencies and international organizations. In December 2012, the UN General Assembly accepted a resolution on the elimination of female genital mutilation. This was adopted in all the United Nations affiliated countries, (which includes Kenya) (Estabrooks, 2013).

In Egypt, Sudan, Kenya, Tanzania and Somalia, many women activists have come up to create awareness on the dangers of FGM. Among them Jawahir Cumar and Fadumo Korn, from Somalia and Burkina Faso respectively (Gehrke, 2013). The two women have been fighting hard to educate girls against the dangers of FGM in their home countries and further to the immigrants in Germany where they started an organization called ‘Stop Mutilation’. They use plays that talk about the negative effects of female genital mutilation to help raise awareness, and re-educate both the men and women on FGM (Gehrke, 2013).

In her book **Sex, Culture and Justice** (2008), Claire Chambers argues that traditional liberalist arguments are insufficient in presenting convincing arguments for the elimination of FGM:

> Political liberalism is peculiarly ill-equipped to deal with injustices resulting from culture and choice because it abandons significant areas of justice to determination by individual choice (2008:160).

Chambers instead proposes an alternative framework for dealing with culturally embedded injustices. She distinguishes two forms of autonomy, calling them first-order and second-order autonomy. In other words, the distinction between the two forms of autonomy is that in the former an individual makes choices based on the rules that she has set. In the latter, an individual makes choices within strong social constraints. She further argues that although an individual's right to make a decision should always be respected, it is a different matter if such a decision is based on social norms: In which case, the state should intervene for the benefit of the girls and women involved. (Chambers, 2008:196).

One of the interventions to FGM that has proven to be successful in facilitating communities to abandon FGM and replace FGM with an alternative rite of passage is the TOSTAN project which has been widely carried out in Senegal, Gambia and Ethiopia and is being rolled out in other African states (Peter and Kristen, 2006). TOSTAN's framework is an 18-month community education programme that addresses hygiene, women's health, human rights, and problem solving, which

include both the women and men in the community, by recognizing their important role in family and community decision-making process (Peter and Kristen, 2006).

According to a USAID-funded evaluation, Tostan is successful because it encourages social change through the community system that is already in place in African villages (Diop et al, 2004). Tostan facilitates group-based decisions rather than encouraging individual women or families to abandon FGM. TOSTAN works with whole villages, and eventually includes hundreds of these in public declarations that validate social change as a communal decision and outcome (Diop et al, 2004). At these declarations, village leaders make a commitment on behalf of their communities, but the event is not solely political. Girls from communities speak about their perceptions on remaining uncircumcised, and people celebrate the continued marriage ties between villages (Peter and Kristen, 2006).

The Tostan Model has been adopted in Kenya by Programme for Appropriate Technology in Health (PATH) and (Maendeleo ya Wanawake Organisation) MYWO in a few of the communities where FGM is rampant like among the Ameru, Abagusii, Kalenjin and the Maasai in Narok. To emulate the traditional practice, the Alternative Rite includes a "seclusion" of three to five days during which the girls are given information on reproductive health through a formal curriculum, and receive "words of wisdom" from selected parents regarding their culture. The sessions are fully participatory and interactive and the girls are taught: interpersonal communication, understanding harmful traditions, Female

Genital Mutilation, human anatomy, decision making, pregnancy and conception, STIs & HIV/AIDS, courtship, dating and marriage, and empowerment of men and women (Chege et al, 2001).

At the end of their seclusion and training, a public ceremony is held during which the girls have a "graduation" to mark their coming of age. Public celebrations take place and the initiates receive gifts from the project and/or their families and members of the community. Through their songs, dances and drama, the girls make a public pronouncement that they have abandoned FGM. Influential political, religious and government administrative leaders are invited to give speeches on this day. In some cases, donor agency and other NGO staff as well as media personnel are invited to witness the occasion (Chege et al, 2001).

A growing number of rural Kenyan families are turning to an alternative to the rite of female circumcision for their daughters so as to uphold its social value of passing community values and norms to its generations without the harmful practice (FGM Network, 2011). For instance in Meru, since 2009, the Njuri Ncheke Supreme Council of Elders (the highest tier in Meru society) publicly condemned FGM, introduced fines on communities found practising it, and vowed to use their power to influence change. A signed declaration of their commitment was given to a Minister from the Ministry of Gender, Children and Social Development (FGM Network, 2011).

In Central Kenya, the new alternative rite of passage is known as 'Ntanira na Mugambo' or 'Circumcision through Words'. It uses a week-long programme of counselling, capped with community celebration and affirmation, in place of the widely criticized practice also known as FGM (FGM Network, 2011).

There are two possibilities for desired outcomes: one, for communities to abandon female cutting altogether, and two, for communities to change to a less destructive form of cutting, and then perhaps continue along that path towards ending the practice. Alternative rites of passage, when created in cooperation with the communities involved, can substitute for the proof of maturity and marital eligibility that the scars of female genital mutilation provide (Chambers, 2008).

One particular challenge of working to reduce female genital mutilation is the need to tailor interventions very specifically to the communities in which FGM is practised since it is an ancient and valued custom. Such practices are often very specific to communities or ethnic groups (Peter and Kristen, 2006).

It is now illegal to practise female circumcision, procure the services of a circumciser, or send somebody out of the country to undergo the illegal ‘cut’. The recent Presidential assent of the “Prohibition of Female Genital Mutilation Bill, 2010” has made the 1999 ban on Female Genital Mutilation (FGM) into law in Kenya. Offenders of this law will serve up to 7 years in prison and fines of up to KSh. 500,000. Also, anyone who causes death in the process of carrying out FGM will be liable to life imprisonment. In addition, providing of premises for purposes

of carrying out FGM, possession of tools associated with FGM or failure to report its incident knowingly are all punishable by law (Chege et al, 2001).

2.6: DRAMA AS THERAPY

Drama therapy is the intentional and systematic use of drama/theatre techniques to achieve psychological growth and change. It uses the potential of drama to reflect and transform life experiences to enable clients to express and work through problems they are encountering or to maintain a client's well being and health (Jones, 2007). Drama therapy is a creative and clinical procedure with its roots in the processes of theatre and drama. Through creative, dramatic structures, it encourages participants to re-examine and explore personal and group issues. Interventions involve a wide variety of styles, from improvisations, movement, voice-work, the use of texts and scripts, story-telling and (story) making, mask and ritual, role exploration and theatre games (Jennings, 1992). Jones explains, in his book *Drama as Therapy*, that the underlying theory of drama therapy is that drama and theatre are more than imitations of life and are essentially ways for people to actively participate in the world (Jones, 1996).

2.6.1: HISTORICAL OVERVIEW OF DRAMA AS THERAPY

Early humans began to make art such as paintings, sculpture, music, dance and drama during the upper paleolithic period about 45,000-35,000 years ago. Experts marvel at the suddenness with which the arts burst onto the human scene. They tie

it to the beginnings of symbolic, metaphoric thought (Pfeiffer, 1982; Mithen, 1996; Lewis-Williams, 2002). Simultaneous with this creative explosion, shamans and priests began utilizing the arts in their healing and religious practices. The origins of the arts and religion seem to be intertwined because the arts naturally provided effective symbolic ways to express abstract religious ideas (Lewis-Williams, 2002). Dance and drama, in particular, were extremely useful in rites to create sympathetic and contagious magic as well as to embody myths and rituals. Details about these ancient origins are sketchy. But many scholars have hypothesized about them, based on surviving cave paintings, artifacts, myths and even on extrapolating from contemporary shamanistic practices (Pfeiffer, 1982; Lewis-Williams, 2002). Jane Ellen Harrison, for instance, theorizes that early art developed directly out of ritual from mimesis or imitation of an experience and became an abstract representation or metaphor which was then available for magical use (Harrison, 1913). In this study, we realize that FGM as a ritual has quite an art in the artifacts used to perform it, the songs and dances done before and after the rituals and even the gifts given to the initiates. The drama that embodies the performance of the ritual is symbolic and presents the beliefs of the people.

Eventually, the art form of theatre developed out of religious rites and rituals. Western theatre history usually begins its formal accounts with ancient Greek theatre. Religious festivals dedicated to Dionysus, god of fertility and revelry, featured theatrical competitions in which plays brought mythology to life for the community. The Great Dionysia, held in Athens in early Spring, featured tragedies,

comedies, and Satirical plays written by citizen-poets and performed by citizen-actors for the entire populace. During a choral presentation at one of these festivals around 560 B.C., Thespis, the first actor, stepped away from the chorus to take on an individual character for the first time and theatre, as we know it, was born (Brockett, 1968).

The first written theoretical account of drama therapy can be found in connection with Greek theatre. In his *Poetics,* Aristotle says the function of tragedy is to induce catharsis which is a release of deep feelings, specifically pity and fear, to purge the senses and the souls of the spectators (Aristotle, trans. 1954). These cathartic feelings are experienced empathically for the characters in the play by the individuals watching the performance and they share that theatrical/cathartic experience with others in the audience magnifying the release and allowing for an adjustment in the community's attitude as a whole. According to Aristotle, drama's purpose is not primarily for education or entertainment, but to release harmful emotions which will lead to harmony and healing in the community (Boal, 1985).

In his analysis of Aristotle's work, Augusto Boal (1985) suggests that this cathartic release helped preserve the status quo in Greek society, for a populace that is content and at peace will not rebel against the rulers in power. Aristotle's ideas about catharsis have influenced many psychotherapy models from Freudian psychoanalysis onward by focusing psychotherapeutic work on the idea that insight into troubling emotional issues and healing occurs only after the patient has achieved catharsis (Boal 1985).

2.6.2 THE MODERN PRACTICE OF DRAMA AS THERAPY

The general aims of Drama therapy sessions include: building trusting relationships, developing communication and social interaction skills, expressing and exploring feelings thus overcoming depressions and loneliness, developing artistic and creative skills by working with the imagination, creating opportunities and skills for self-advocacy and having fun as they gain self confidence and self-esteem (Jones, 2007).

According to Augusto Boal (2000), 'the fore runner of forum theatre which in itself is a form of drama as therapy' forum theatre, instead of taking something away from the spectator, evoke in him a desire to practise in reality the act he has rehearsed in the theatre. The practice of these practical forms creates a sort of uneasy sense of incompleteness that seeks fulfilment through real action. It transfers to the people the means of production in the theatre so that the people themselves may utilize them (Boal, 2000).

Forum theatre focuses on the action itself - the spectator himself assumes the protagonist role, changes the dramatic action, tries out solutions, discusses plans for change – trains himself for real action. Thus, theatre is not revolutionary in itself, but this is surely a rehearsal for revolution. The liberated spectator, as a whole person launches into action. No matter that the action is fictional, what matters is that it is action (Boal, 2000).

Expressive Therapy (Art therapy, dance therapy, drama therapy and music therapy) has proven to be particularly helpful to children and adults experiencing the consequences of a variety of stresses and traumatic experiences. These include: abuse (emotional, physical, sexual), addiction to drugs, sex and bad habits, accidents and life transitions (Gersie, 1995).

According to Gustave Le Bone (Gersie, 1995), a forerunner of social psychology, a collection of people present new characteristics different from those of the individuals composing it. The sentiments and ideas of all the persons in the gathering take one and the same direction and their conscious personality vanishes (Gersie, 1995). Once transformed into a crowd, they develop a collective mind which makes them feel, think, and act in a manner quite different from that in which each individual of them would feel, think, and act were he in a state of isolation. This thinking may thus live with them for a long time and may work well in transforming them to think and behave positively in a way that is beneficial to them and the society (Gersie, 1995).

Drama and theatre involve teamwork and cooperation as a major component in helping achieve one common goal. Therefore, even in therapy purposes, the teamwork helps all the participants to be able to understand and appreciate each other's strengths and efforts in being able to express themselves in the presence of others. As Wilson (1998) states, becoming a part of a group is a crucial element of the theatre experience. For a moment, we are part of a group sharing a common

experience; and our sorrow or joy, which we thought might be ours alone, is found to be part of a broad human response.

Drama can be enjoyable, involving and dynamic. It demands its participants to be active and collectively creative and for this reason can be a useful medium for luring people, even those unused to drama into participation (Preston, 2009). Drama, being a large component of theatre, is a language capable of being utilized by any person with or without artistic talent. Theatre can be placed at the service of the oppressed so that they can express themselves and so that, by using this new language, they can also discover new concepts. Theatre is a weapon, and it is the people who should wield it (Boal, 2000).

Participatory theatre thus offers an interactive forum through which people can dialogue on issues affecting them in a creative and redemptive manner. The process acts as a mirror through which the participants can look at themselves in a relaxed yet introspective style. The process becomes more like a rehearsal of life and serves not only to initiate but also sustain dialogue on key issues affecting the community (Amani, 2011). The participatory approach provides a forum for the public (the participants) to consider, discuss and ask questions about their problems, as well as to propose solutions and practise that change. The (active) audience therefore becomes an agent for social change. It can "live" a different future, which could become tomorrow's reality through their participation in theatre (Mugubi, 2013). For this reason the participatory features of theatre, performance and creativity in general are increasingly called upon to foster

involvement by people in different settings and to meet various developmental, educational and change agendas (Preston, 2009).

2.7: PREVIOUS WORKS ON DRAMA AS THERAPY

The emergence of drama as therapy in modern Western culture began in Europe in the 19th century. At the beginning of the 20th century, the Russian psychiatrist Vladimir Iljine in 1908 adapted Stanislavskian theatre techniques into a form of psychiatric treatment, called therapeutic theatre. This incorporated improvisation training and the production of theatre performances which were then followed by a period of systematic reflection (BADth, 2000). In 1962, Sue Jennings and Gordon Wiseman started the Remedial Drama Group to use educational drama techniques in Clinical settings. In 1970, this became the Drama therapy Centre and by 1972 it had expanded into a private consultancy, promoting training and research, known as Drama Therapy Consultants (Jennings & Minde, 1994).

In August 1973, in the state of Peru in the cities of Lima and Chiclayo, Augusto Boal and Alicia Saco, within the program of the Integral Literacy Operation, did experiments with the People's Theatre with methods derived from Paulo Friere. In which they used theatre as a language where the spectator's thoughts are discussed theatrically on stage with the help of the actors, and all the solutions, suggestions, and opinions are revealed in theatrical form (Boal, 2000).

In 2002 and 2003, Lois Weaver and Peggy Shaw designed and ran workshops in four women's prisons in Brazil and the UK as part of a People's Palace Project entitled 'Staging Human Rights'. This was done with the aim that these methods could be used not only as a means of personal and social transformation but might also be effective in getting women in prison to talk about human rights. This project used Boal-based methodologies, with performance work rooted in individual experience, based on community concerns and invested in the power of the imagination to bring about change, by relying on the imagistic and associate strategies of contemporary performance (Weaver, 2009).

Drama therapy approaches vary from different practitioners in that some are individual focused while others are group focused. Individual dramatherapy sessions are used where the development and emotional needs of the client make group work irrelevant (Brudenell 1987). In a one-to-one drama therapy there is clearly no interaction with the peer group, emphasis is on exploration of the space and its contents, in the presence of and in relation to the therapist (Chesner, 2007).

Ann Chesner and Steve Mitchell from Europe practise drama therapy with different groups of people or individuals. Ann Chesner has worked with adults with learning disabilities successfully in which she helped develop their self esteem. The adults were initially withdrawn, and had no confidence in their abilities to air their views, and in most circumstances did not feel worthy members of the society because of their lack of education. Through the drama therapy process that involved improvisations, different games, and role play, the

participants were able to relive their past and present experiences, evaluate their physical capabilities and find worth in their contributions in the society (Chesner 2007). Steve Mitchell's works on the other hand are more focused on clinical therapies, where he conducts his drama therapy sessions in a hospital or clinic with either day or in-patients for a period of time. Often the works are with groups with a focused problem like schizophrenia, elderly patients, mental illness patients, and long term illness recovering patients like cancer patients (Mitchell, 2007).

Other works on dramatherapy that have been documented and further research papers done on by notable practitioners are like: Roger Grainger's research with thought-disordered adults in 1992; Phil Jones's research with autistic children in 1993 (Meldrum, 2007). Both enabled a synthesis of theatre and therapeutic language with significant changes in the clients was noticed; from withdrawn and aggressive to active and pro-social behaviours and interactions (Meldrum, 2007). Another practitioner is Ann Cattanach, whose works focuses more on children. She has further documented her works in some of her books like: Play Therapy with abused children and, Drama for people with special needs both published in 1992.

In Kenya, recorded works of dramatherapy was first practised at the Langata Women's Prison. It was undertaken with highly positive results in 2005 by the Institute of Performing Artists Limited (IPAL) in Kenya under the directions of the late Bantu Mwaura (Kariuki, 2006). The project was mainly undertaken among prisoners whose term was to end within twelve(12) months so as to assist them to learn how to reconcile with their inner self and those who had wronged them and

to enable them to start a better life with a fresher understanding of the state of things in the society (Kariuki, 2006).

Following its successful first pilot project on drama-therapy at the Lang'ata Women's Prison in 2005 and the recommendations thereof, IPAL saw the need to embark on the project dubbed ‘Ongea Prisons Project’ that sought to enrich the lives of inmates by providing them with a therapeutic theatre festival geared towards reform with ease of future re-integration into society. This project was to provide inmates with recreational, therapeutic, educational and directional occupation while within the prison, that would guide and shape their behaviour inside as well as outside the prison when they would be released. The project focused its activities on prisons within Nairobi, specifically: Langata Women's Prison, Nairobi West Prison, Kamiti Medium and Industrial Area Remand and Allocation Prison (IPAL, 2009).

The successes and achievements of the project are noticeable and measurable. Inmates confessed that they were now more accepted and had reconciled themselves to their actions and prevailing circumstances. Inmates indicated that prior to the project, they were all too inward looking and negative in dealing with their own reality and circumstances. A sense of group cohesion was now more noticeable and inmates had cordial relationships not just amongst themselves but also with other inmates and officials within the prison. The inmates could now relate to their actions without denial and without feeling rejected by the society (IPAL, 2011).

In October 2005, Jijazie Hybrid Thespians (a PATH-supported theatre troupe) began to perform at Shikusa Juvenile Centre in Western Kenya. After seeing how actively the inmates performed and how the performances ignited conversations among inmates, wardens and troupe members, the Prison Officer asked the theatre group to come back once a month, which they have been doing ever since. Nelson, a counsellor at Shikusa Juvenile Centre, said that a group of counsellors who had recently come to talk with the boys wasted several days – they could not get the boys to open up the way Jijazie Theatre Troupe did after just an hour or two of 'Magnet Theatre' (Madiang, 2006).

Magnet Theatre is type of community theatre that typically takes place in outdoor, public spaces. The performances explore community issues and encourage discussion and problem- solving with community members. The actors perform a drama that presents a dilemma based on community problems. The audience participates by offering suggestions to the characters as well as acting out solutions to the dilemma. Magnet Theatre encourages dialogue and allows the audience to discuss and test solutions to problems, in order to bring about individual and community-wide change. The Theatre session is followed by a post-performance discussion where the audience can ask troupe members more personal, in-depth questions (Madiang, 2006).

In the article "Voice of Pride: Drama Therapy with Incarcerated Women" by Leeder and Wimmer (2006), examples were given where dramatherapy assisted

women who had suffered from past experiences of domestic violence, sexual abuse and had been diagnosed with symptoms of depression, anxiety, post-traumatic disorders, eating disorders, psychosis and learning disabilities. In an unconditional atmosphere, dramatherapy helped these victims of domestic violence to regain their self-confidence through performances. They were able to build trust and teamwork, things that were missing in these women's lives which played an important part in their healing process. They were given the chance to participate in a playful and spontaneous environment through games and exercises where they confronted their abusers in a role play and role reversal technique, which stimulated the stepping forth of their otherwise dormant innate creativity (Leeder and Wimmer, 2006). Participating in dramatherapy allowed these women to see themselves in a different light, independent of the stigma associated with being in prison.

Currently, there are few literary recorded works of drama as therapy among survivors of Female Genital Mutilation and the little that is available are records of activities in videos and pictures. Although works of theatre with the persons in the shelters have been in existence, techniques of drama for education, drama for information and drama for entertainment have been the main focus. Such approaches do not give the participants room to be actively involved as performers or as an active audience.

2.8: THEORETICAL FRAMEWORK

In order to explore how drama therapy can be utilized to unlock the voices of FGM survivors, the study employed two theories. The first was Friedrich Nietzsche psychoanalytic theory of "Will to Power", and the humanistic theory according to Carl Rogers Self theory/person-centered theory. The study utilized Friedrich Nietzsche theory of "Will to Power" in which he held the view that all human actions are motivated by the desire "to increase the feeling of power" (Diethe, 2003). In quoting Nietzsche (1968):

> What is good?—All that heightens the feeling of power, the will to power, power itself in man. What is bad?—All that proceeds from weakness. What is happiness?—The feeling that power increases—that a resistance is overcome (Nietzsche, 1968:406).

Nietzsche's (1968) philosophical work has to do with the creation of self, or to put it in Nietzschean terms, "becoming what one is". He contemplates the meaning of values and their significance to human existence. To maintain allegiance to such values, even when they no longer seem practicable, turns what once served the advantage to individuals to a disadvantage and what was once the prudent deployment of values into a life denying abuse of power. When this happens, the human being must reactivate its creative, value-positing capacities and construct new values (Diethe, 2003).

According to Hannay (1992), the major tenets of Nietzsche's 'Will to Power' which were cognate to this study were: the authenticity of action, freedom and

choice and purpose of life. “Authenticity” here meant that one should act as oneself. This involves letting one’s actual values come into play when one makes a choice so that one also takes responsibility for the act instead of choosing without allowing the options to have different values, thus freedom and choice (Hannay, 1992).

According to Richard Schacht (1995), the weakness of Nietzsche’s theory is that instead of building a system, Nietzsche is concerned only with the exploration of problems, and that his kind of philosophy is limited to the interpretation and evaluation of cultural inheritances. However, the researcher found this as strength for the study in that drama as therapy is not supposed to help the participants get a unified solution to their problems. It is to give each of them the insight to explore their problems and individually find a suitable strength to identify with, in building back their self esteem; thus, the power to achieve their dreams both as individuals and as a group.

This study also employed the Humanistic Theory in view of Carl Rogers Person-Centred/Self theory (1961). This is the theory of Personality Development in which Rogers created what is known as client-centred therapy, a non-directive approach that places the client in control of the therapeutic process. As one of the leaders of the humanist movement in psychology, Rogers believed that people were essentially good and healthy. He developed his view through clinical settings and argued that the most overwhelming human drive is the drive to become fully functional; which involves openness to oneself (Rogers 1961).

In a study by Haggbloom et al. (2002) using six criteria such as citations and recognition, Carl Rogers was found to be the sixth most eminent psychologist of the 20th century and second, among clinicians, only to Sigmund Freud. Carl Rogers is respected by many: among them the late American Psychologist Dr. Clark E. Moustakas and Canadian psychologist Sidney Jourard. All these considered Carl Rogers to be the most influential psychologist of the 20th Century because of his emphasis on human potential. He was born in 1902 and grew up in a very religious family with close family ties. He felt drawn to child guidance work and was granted a fellowship at the Institute for Child Guidance where he learned a psychodynamic, Freudian orientation to therapy. He later worked as a psychologist for twelve years in the Society for the Prevention of Cruelty to Children in Rochester, New York. It is here that his profound experiences with children and their parents began to test his assumptions and eventually led Rogers to the original ideas that would evolve into his person-centered approach (Rogers, 1980).

In his book, On Becoming A Person, Carl Rogers argues:

> It is the client who knows what hurts, what directions to go, what problems are crucial, what experiences have been deeply buried... Experience is, for me, the highest authority. The touchstone of validity is my own experience. No other person's ideas, and none of my own ideas, are as authoritative as my experience. It is to experience that I must return again and again, to discover a closer approximation to truth as it is in the process of becoming in me (Rogers, 1961:47).

Humanistic psychology on person-centred therapy has its basic tenets as freedom, values, personal responsibility, autonomy, human potential and self actualization (Farber, Brink & Raskin, 1996). Rogers, in his book A way of Being, says:

> People are essentially trustworthy, that they have a vast potential for understanding themselves and resolving their own problems without direct intervention on the therapist's part, and that they are capable of self-directed growth if they are involved in a specific kind of therapeutic relationship. (Rogers, 1980:138)

He was reactive against the traditional psychoanalytic techniques such as advice, suggestion, direction, persuasion, teaching, diagnosis and interpretation (Farber, Brink & Raskin,1996). This formed the basis for the drama therapy in that drama therapy allows for the client, in this case the participant, room for self directed role play in the re enactment of oneself thus the ability to find one's own solutions and one's own voice.

The weakness of this theory is the systematic approach it may have for a varied audience. However, the strength of this theory lies in the fact that it gives room to develop practices and exercises that would work best for each group as in gestalt therapy and expressive therapy. Another strength lies in the fact that it does not provide answers but focuses on introducing people to the attitudes they will need to make change possible.

By combining the two theories of Nietzsche and Rogers, this study looked at both the psychological and practical aspects of drama as therapy. Nietzsche's theory of 'Will to Power' focused on the psychological progress of the participants

throughout the therapy sessions, while Rogers' theory of person-centred therapy helped in the assessment of the methods and practices that were used in the drama therapy sessions. Drama as therapy is in itself a client-centred therapy in that the participants are the ones who are in control. They are allowed to contribute in the creative process which in turn helps them open up to share and tell their own stories.

These theories were suited for this study in that it was due to the struggle for survival and the struggle for power that the participants came to the rescue centre: to shelter from the oppressive values of their community and families, to fight for the values they believed in. They were seeking empowerment in the form of freedom of choice by refusing to submit. This study thus believed that drama as therapy could give the survivors and escapees of Female Genital Mutilation a voice, a source of freedom to do their exploits and reach greater heights, to find power in their voice by gaining confidence and to build their self esteem so that they could be the best that they could possibly be.

Drama as therapy in this study sought out to give the participants a chance to explore their fears and to bring the emotional upheaval through performance and sharing of experiences in telling their own stories using the survivors own perspectives. Subsequently, drama therapy was employed with a view to finding workable solutions for the survivors problems through integrating real-life conflicts in the games and dramas that they were involved in as a group.

2.9: CONCLUSION

This section focused on the previous studies on both FGM and drama therapy and how they were relevant to this study. It also looked at the alternative rites of passage and the measures that have been taken to eradicate the practice. The next section on methodology discusses the research methods that were employed in this study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1: INTRODUCTION

This Chapter discusses the various research strategies that were used in the study. It is divided into: research design, study site, a description of the sample population, sampling techniques that were applied as well as research instruments. The chapter further explores data management procedures and ethical considerations that ensured the respondents' confidentiality was well taken care of.

3.2: STUDY DESIGN

It utilized control group strategy which involved two parallel experiments being set up. They were identical in all respects except that only one included the treatment being explored by the experiment, which in this case were the drama activities. The control group was the group that nothing happened to whereas the experimental group was the group that was subjected to the variables that were being tried out. The experimentation process was divided into two categories: pre-test and post-test. In the pre-test, the initial conditions of the subjects to be experimented were recorded before subjecting them to therapy. In the post-test, the subjects to whom the drama therapy treatment was applied was examined and their results recorded. That was done by subjecting the experiment group to drama followed by examining their general physiological and psychological behaviour in comparison to a control group who were not subjected to drama therapy with designate notations as follows:

V	X	O
V		O

V=Subjects, X=Experiment, O=Test

However, it was important for both the Pre-test and Post-test experiments to be conducted so that changes in the physiological and psychological dispositions of the survivors could be ascertained. But as well, the control group was still useful as additional factors may have had an effect, since the treatment occurred over a long time and in a unique context as this:

V	O	X	O
V	O		O

V=Subjects, X=Experiment, O=Test

The selection of the survivors and the treatment assigned to them was done randomly, though in practice some groups came as one or were selected on a pseudo-random basis. At the end of the experiment, we examined the differences between the control group, for whom nothing happened, and the experimental group, which received the drama therapy variable. The difference (or similarities) between the two groups was the outcome of the experiment. We did our best to ensure the control groups were as similar as possible to treatment groups.

3.3: DURATION

The length of therapy varies with each person, depending on many factors such as the difficulties experienced, the degree of personal resilience and the amount of support available in the present living situation. The period of project research was four (4) months in September to December 2011. There were two (2) months of participatory theatre research at the AIC Kajiado Girls Primary School, with two drama therapy session per week, each lasting one to two hours depending on the active participation of the respondents. Thereafter, a control group of survivors of Female Genital Mutilation was also administered with the data collection instruments. Interviews with other four (4) respondents who were adult survivors of Female Genital Mutilation were done for the remaining months of the data collection period.

3.4: STUDY SITE

The study site for the drama therapy sessions was at A.I.C Kajiado Girls Primary School; a rescue centre started in the year 2000 by support from FAWE in a bid to rescue young girls who escape from circumcision. The centre offers the girls a home and shelter until they complete their studies and perhaps get a job. It specifically gives priority to survivors and escapees of Female Genital Mutilation. Thus, it was a reliable place to get the persons on whom the research focused. A.I.C. Kajiado Girls Primary School also has a high turnover of pupils and is recognized by the community as a Rescue Centre. Kajiado County is located in the Rift Valley Province of Kenya $1^0$51' 0' South and 36^0 47' 0' East. It is approximately 50km South of Nairobi City. *(See Map in Appendixes).*

The venue for the control group was in Narok County. Narok County is located in the Rift Valley Province of Kenya $01^{0}05'$ South and $35^{0}52'$ East. The control group study was done in two shelters so as to have the same population as the experimental group. These were the Osotua and Osiligi shelters. A rescue centre in Narok was more suitable in identifying a control group with similar characteristics in terms of socio-cultural, economic and circumstantial factors. *(See Map in Appendixes).*

3.5: POPULATION AND SAMPLING

A.I.C. Kajiado Girls Primary School Shelter was selected through purposive sampling method. This seemed to possess the required characteristics that would be able to provide the most relevant information, in line with the objectives of the study.

The population of the school is mixed with both survivors and escapees of Female Genital Mutilation. However, the study focused only on the survivors. The selection of participants was done by purposive sampling through answering of Personal Information and evaluation forms. Thereafter, through snowball sampling, the researcher identified those who wished to participate in the drama therapy sessions but would not otherwise be bold to write in questionnaires.

The participants who were involved in the control group from Osotua and Osiligi in Narok County were also purposively selected in that they had undergone Female Genital Mutilation. The adult survivors of FGM who were interviewed as key informants were however randomly selected - two (2) were literate women and two (2) were illiterate women. This was done to help in comparing the level of knowledge and social beliefs on FGM between the young survivors and the older survivors. Such comparison was necessary in ensuring validity of the information gathered from the focus group discussions.

The Maasai as a community were also selected because they are a symbol of Kenya's heritage and have remained a proud people who have famously retained many of their distinctive customs, culture and dress in spite of the pressure to conform to modernisation and Western Culture (Equality Now, 2011).

3.6: DATA COLLECTION INSTRUMENTS

There were different rese h tools as follows:

a.) Staff Interview Guide

This consisted of semi structured questions to help give an account of the shelter, on the therapies and the rehabilitation strategies used and their effectiveness. It was also used to find out the effects of the drama therapy sessions on the participants. It was administered to the senior staff at AIC Kajiado.

b.) Focus Group Discussions

These were semi structured questions to guide the sessions for focus group discussions. These questions were also used with the control group and the adult survivors of FGM so as to help in comparing their responses to the ones that the drama therapy participants gave. The tool entailed questions for those who have undergone FGM and who participated in the research. These were to tell us of their personal experiences, their opinions and their perspectives on FGM.

c.) Informants Interview Guide

This was a set of questions tailored to find out more about the personal, and socio-cultural factors that made the participants accept to undergo FGM, the effects and the measures they take to ensure their interests are achieved relating to FGM.

d.) Personal information and evaluation form

This was filled by all the participants for both the drama therapy and the control group. This was done before they engaged in the study. This enabled the researcher to get information on background of the participants, their interests and their goals in life. This questionnaire also helped in the purposive sampling of the participants to know which of them had undergone FGM, and thereafter, those participants were used to invite their fellow survivors to attend the drama therapy sessions.

e.) Participants' Attitude Survey Form

This was filled by survivors of FGM after the drama therapy sessions. This was an attitude survey on drama therapy.

f.) Adapted Rosenberg Self Esteem Scale

The Rosenberg Self Esteem scale is a ten item Likert scale with items answered on a four point scale from strongly agree to strongly disagree (Rosenberg, 1965). To score the items, a value is assigned to each of the items from: Strongly Agree=3, Agree=2, Disagree=1, and Strongly Disagree=0. For items which are reversed in valence: Strongly Agree=0, Agree=1, Disagree=2, and Strongly Disagree=3.Other scoring options are possible for example, you can assign values 1-4 rather than 0-3. Some researchers also use 5" or 7" point Likert scales, thus the scale ranges vary based on the addition of "middle" categories of agreement (Rosenberg, 1965).

This adopted the Rosenberg's self-esteem scale so as to help evaluate the perception of the participants about themselves, about their self esteem, confidence and self worth. The Rosenberg self esteem scale was administered twice, before the onset of the drama therapy sessions, and on completion of all the drama therapy sessions. This was to help evaluate any changes in the participants' self esteem.

Self-esteem is a positive or negative orientation toward oneself: an overall evaluation of one's worth or value. People are motivated to have high self-esteem, and having it indicates positive self-regard, not egotism (Rosenberg, 1986). The Rosenberg Self-Esteem Scale is perhaps the most widely-used self-esteem measure in social science research (Owens, 1994). The Rosenberg Self-Esteem Scale was founded by Morris Rosenberg who was a Professor of Sociology at the University

of Maryland until his death in 1992, and his work on the self-concept, particularly the dimension of self-esteem, is world-renowned (Owens, 1994).

The Rosenberg Self Esteem scale was administered to the experimental and the control group too so as to evaluate their self esteem and thereafter compare their change in perception, if any. Even though the control group did not undertake the drama therapy sessions, they had a brief discussion on Female Genital Mutilation. The scores are from 0-3 per question and totals of between 1-60. The Rosenberg Self Esteem Scale was divided into three sections that evaluated: Attitudes towards one self, Attitudes towards relationships and interactions with friends and, Attitudes towards future and other relations. The higher the scores, the higher the self esteem.

3.7: DATA COLLECTION TECHNIQUES

Data was collected using the following techniques:

a.) Interviews

There were in-depth interviews with four (4) adults who had undergone FGM and who accepted to participate in the research. The key informants' interview guide was used and these were recorded on an MP3 Player and thereafter saved on CDs for future reference. There was also open interviews with the staff of AIC Girls Kajiado.

b.) Administering of Questionnaires

Questionnaires were administered to the twenty four (24) participants so as to get their personal information and to evaluate their attitudes before and after the study. The questionnaires also set out to get their views about drama therapy and to evaluate their progress in terms of developing their self esteem, confidence, respect and self worth.

c.) Focus Group Discussions

There were ten (10) focus group discussions where the survivors were encouraged to talk about different issues affecting their lives, their experiences as survivors of FGM and their opinions and perceptions on FGM. This helped them to open up and to share their attitudes and problems and come up with workable solutions. The openness of the participants was possible with time after the theatre exercises and games that helped in breaking the ice between them and the therapist. This was also prior to the performances of skits and dances initiated by the participants. The theatre games further helped build trust among the participants, and allowed them openness during the focus group discussions. Focus group discussions was also held with the control group as the main instrument for data collection, without involving them (the control group) in any drama activities.

d.) **Participatory approach - Participatory Learning and Action**

For the purposes of this research, a participatory approach to data collection was used. In this case, the researcher was a participant observer and was fully involved

in the drama therapy sessions, sharing with the persons as a participant and making observations as a researcher. The participatory approach that was used in this project was theatre/drama as therapy, which incorporated some aspects of focused group discussions/activity/practice. The major therapy activities that were undertaken were: storytelling, use of skits (role - play and role – reversal), theatre games and dances. The therapist acted as a guide and a participant at the same time so as to enable the patients to interact freely without a feeling of being watched or observed.

In storytelling, the participants were encouraged to talk about their lives and their feelings about various issues. This also formed part of the focus group discussions. There was also the use of skits (Role-playing and role reversal) where the participants acted out the issues directly affecting them as survivors of FGM. There was also the use of theatre games and dances to help them get lively and more interactive and be able to work as a team. This promoted their understanding of their inner selves. Use of various songs and dances also helped bring out the participants' inner feelings and thereby release tensions.

3.8: VALIDITY AND RELIABILITY

The validity of these instruments has been tested and verified to be reliable in other studies that the researcher has been involved in. For example, the researcher undertook drama therapy sessions at Bustani (a rehabilitation home for depressed teenagers) in 2007 and with survivors of drug abuse at Mathare Drug

Rehabilitation Unit in 2008, under the supervision of Dr. Frank Njenga (a renowned psychiatrist in Nairobi Kenya) and Dr. Kisivuli Azenga (the medical superintendent at Mathari District Hospital then) respectively. The project study at Mathare Drug Rehabilitation Unit was part of the researcher's Masters project and, with the assistance of the nurses, the drama therapy sessions were carried out with the recovering drug addicts once a week for 2 months in the period February-March 2008. The results of the project were highly positive.

Of the twenty nine (29) people who participated in the drama therapy sessions, at least 86% of the participants promised to reconstruct their lives once they left rehabilitation by trying to live an alcohol free life and getting back to being responsible members of the family and society, going back to school and getting jobs that they would strive to keep. However, 14% of the participants said they did not yet have resolutions because they were still living in denial as they had not yet accepted that they were addicts and they didn't understand why they were in the rehabilitation. It was however hoped that they would be able to accept their situation and work towards change (Okoth, 2008).

The most notable improvement in the patients was their ability to interact with other people more freely and to talk and laugh their hearts out without feeling insecure. There was a strong developed trust among the participants and even towards the nurses and counsellors, something the nurses said was not evident before the drama therapy sessions took place (Okoth, 2008). At Bustani Home, Dr. Frank Njenga was much pleased with the recovery of the patients who after some

time were able to freely talk about their deep feelings and even to move their limbs in dance.

Drama therapy was also conducted at Langata Women's Prison by Bantu Mwaura and Catherine Kariuki of IPAL in 2005, and it had positive results. It helped the prisoners reconcile within themselves and to reconstruct their beliefs from being those of bitterness to acceptance. This project became known as the Ongea Prisons Project which was also adopted by Kamiti Prison, and Industrial Area Remand and Allocation Prison and has since been going on at the adult and even the juvenile section of the prisons (IPAL, 2009).

Steve Mitchell, a drama therapy practitioner states that his works on drama therapy have significant results in the groups he has worked with. He has practised drama therapy widely for instance; with elderly groups at the Lancaster and Morecamber Day Hospitals and at the Ridge Lea Hospital with patients who have been admitted for long so as to prepare them for discharge or extended stay at the hospital. His works are also with communities on schizophrenic patients, rebellious youths, and in conflict resolutions situations (Mitchelle, 2007). Steve Mitchell's practises using different drama therapy techniques depending on the group he is working with. This may range from storytelling, role play or use of games and have been reported to be of positive results in the groups he has worked with (Jennings, 2007).

Quite a number of works have been done on drama therapy with various groups in different circumstances. However, no recorded works have been done with survivors and escapees of FGM, especially with an aim to help them open up and speak about their feelings about the practise. This study, therefore, focuses on the FGM survivors while founded on the belief that drama therapy is a powerful tool. It can help develop confidence, and build trusting relationships which help one to open up and talk about deep-seated feelings.

3.9: DATA ANALYSIS

The data collected from this research was analysed both qualitatively and quantitatively. Qualitatively this was done by coding the responses alongside the themes generated from the objectives. The voices and quotations of some of the respondents and the issues discussed were put into context according to the topics that were addressed in relation to the objectives of the research. Quantitatively, the data collected was analysed using questionaires like: Attitude and Survey Form, the Rosenburg Self Esteem Scale and the personal information and evaluation form, which are quantitative methods of data collection.

The information collected has been put down into a report in both qualitative and quantitative form, and a thematic order with quotations of some of the respondents and the issues put into context according to the topics that were addressed in relation to the objectives of the research.

The units of analysis were the individuals involved in the study, each being evaluated as a separate entity. This was because the various variables that were being analysed were influenced by each individual's background, their opinions and perceptions about FGM, their reasons for accepting to participate in the drama therapy sessions and the impact of the drama therapy on their lives.

The assessment was also based on the interviews taken with the adult survivors of FGM from two perspectives: by interviewing both the literate women and the illiterate women who have undergone FGM. This helped in comparing the level of knowledge and social beliefs on FGM between the young survivors and the older survivors.

3.10 ETHICAL CONSIDERATIONS

The participants were requested to fill a client consent and explanation form *(See Appendix 6).* Permission for participation in the various institutions was obtained from the Principals. The focus group discussions were only recorded on audio and since some of the issues discussed were very sensitive, the video could not be taken as it would reveal the identity of the participants. It was also agreed by the Principal AIC Kajiado, that photos of the girls would not be taken so as to preserve the confidentiality of the girls. The copies of the audio recordings were not given to the participants so as to ensure that the available copies are only used for educational purposes. However some of the dramas done by the experimental

group were recorded on video and each of the participants given a copy of the DVD thereafter.

3.11 CONCLUSION

This section looked at the methods and techniques that the study undertook so as to attain a valid research. The next Chapter seeks to look at the drama therapy techniques that were used and how they were carried out during the sessions.

CHAPTER FOUR

APPLICATION OF DRAMA TECHNIQUES AS TOOLS OF THERAPY AMONG SURVIVORS OF FEMALE GENITALMUTILATION

4.1: INTRODUCTION

This chapter presents a detailed analysis and interpretation of the findings regarding using drama techniques as tools of therapy to unlock the voices of FGM survivors. This has been done using thematic analysis because it goes beyond counting explicit words or phrases and focuses on identifying and describing both implicit and explicit ideas within the data, that is, themes (Bernard and Ryan, 2010). Therefore, the findings are organized according to the themes and subthemes derived from the first objective of this study. The results are discussed in the following order: first, demographic information of the respondents, mainly focusing on age and educational level of the respondents and the general feelings of the respondents; second, dramatic techniques as tools for drama therapy, that is the use of storytelling, dances, role play, improvisation and oral poetry.

4.2: DEMOGRAPHIC INFORMATION

In any research, the background information of the respondents is considered very crucial not only for subsequent discussions of the findings but also for the authenticity and generalization of the results (Bernard and Ryan, 2010). This section, therefore, presents respondents' background information considered

crucial for discussions in this study such as age, educational level and attitudes of the respondents.

4.2.1: Age of Respondents

This study considered the age of the respondents as a crucial component as it reveals the categories of people participating in this research process. The Table below gives the age distribution of the respondents who participated in this study:

Table 4.0:*Age Profile of all Respondents*

Age (Years)	**Frequency**	**Percentage**
9	3	6.2
10	4	8.3
11	4	8.3
12	7	14.6
13	20	41.7
14	6	12.5
15	4	8.3
TOTAL	**48**	**100%**

Table 4.1: Age of respondents in the experimental group

Age	**Frequency**	**Percentage**
9	2	8.3
10	1	4.2
11	3	12.5
12	5	20.8
13	10	41.7
14	2	8.3
15	1	4.2
TOTAL	**24**	**100%**

Table 4.2: Age of Respondents in the control group

Age	**Frequency**	**Percentage**
9	1	4.2
10	3	12.5
11	1	4.2
12	2	8.3
13	10	41.7
14	4	16.7
15	3	12.5
TOTAL	**24**	**100%**

From the Table above, majority of the respondents (41.7%) are aged 13 years followed by those aged 12 years (14.6%). Scholars have pointed out that age determines the extent of involvement of a person in any activity (Sproll, 2004). Collectively, findings from the Table show that young girls aged between 10-15 years find themselves vulnerable to the practice of Female Genital Mutilation. This is attributed to the fact that this is the prime age category that the girls are forcibly married off after undergoing the rite. The findings correspond with a study titled: "Protecting girls from undergoing Female Genital Mutilation: The experience of working with the Maasai communities in Kenya and Tanzania" (World Vision, 2011) which asserts that girls as young as nine (9) years old are taken out of school to undergo the practice in order to facilitate marrying them off quickly in exchange for cattle. The study further notes that girls who undergo FGM are also provided with rewards including public recognition and celebrations, gifts, the potential for marriage, respect and the ability to participate in social functions as adult women. The rewards may motivate some girls to look forward to undergoing FGM. The more reason as to why girls at their tender ages will want to partake the rite.

4.2.2: Level of Education of Respondents

This study considered the level of education of the respondents as a key factor in their future socio-economic well-being. The findings of this variable are presented in table 4.3 below.

Table 4.3: *Level of Education*

CLASS (std)	FREQUENCY	PERCENTAGE
6	46	95.8%
7	2	4.2%
TOTAL	**48**	**100%**

The findings show that a simple majority of the respondents (95.8%) are in Class Six while, 4.2% are in Class Seven. This further indicates that all the respondents have not even attained primary education qualification and therefore should be schooling. However, various studies such as Habil Oloo et al (2011) have shown that the practice of FGM compromises the girls' education. The world vision findings on "Protecting the Girl Child from Female Genital Mutilation"(2011) affirms further this observation when they point out that many Maasai families cannot afford to give their children formal schooling. Hence, to protect their daughters from lives of poverty, they choose to marry them off at a young age since Maasai girls are traditionally considered children until they are circumcised. According to Oloo et al (2011), it is at the rescue centres that most often the girls get the opportunity to continue with their education after the circumcision rite. Or if the parents are educated and live in the major urban centres is when the girls may in some of the circumstances get to continue with their education. For

instance, there is one participant who stated that her parents pick her from school during school holidays and they live in the town centre. But, she underwent FGM, due to peer pressure, despite her parents refusal.

4.3: DRAMA THERAPY TECHNIQUES

The word technique, according to Oxford English dictionary, refers to a method/practice, skill or strategy of doing something. In this context, drama techniques refer to the tools of drama used for therapeutic purposes: that is, dramatherapy. Lahad in an interview with Sue Jennings in Jennings et al (2007) states:

> Dramatherapy is the ability to invite a variety of people with very little declared talent in any of the arts to enter into the creative arts therapy process and, by that, heal themselves. I personally think that creativity is the source of life: the ability to play, the ability to use humour, colours, stories – that is the flame of life. Once you get in touch with that, I think you help the person to heal. (180)

In this regard, we engaged a number of dramatic therapy techniques in order to enable our respondents talk about their FGM ordeal. As Kedem-Tahar and Kellermann (1996) put it, dramatherapy can be done in a group setting or individually and is always under the guidance of a facilitator or dramatherapist. Story telling, story making, role-playing, role reversal, improvisation, narrative, imagery, props and masks are used as stimulation for dramatization (Kedem-Tahar and Kellermann, 1996). In order for us to establish the effectiveness of drama therapy in unlocking the survivors' voices, we had to use a number of drama therapy techniques like games, poetry, role-play, music and dance. These were used to help with the

bonding and, thereafter, less physical or passive tools like storytelling were used during focus group discussion to enable the respondents be at ease so that they could talk freely. It was in this way that we were able to ensure that the survivors had healed from the tribulations of FGM.

It is, however, important to note the difference between Pyschodrama and Dramatherapy so as to understand how to evaluate the different techniques that were used without the assumption that Psychodrama and Dramatherapy are similar in terms of process and technique. As Kedem-Tahar and Kellermann (1996) suggests, there is more cognitive integration in the former. For example, psychodrama focuses on the meaning of an expressed enactment, connecting experiences and awareness. It is often direct and confrontational in dealing with the protagonist's issues. Whereas dramatherapy, on the other hand, allows for expressions to have value in themselves, while the particular experiences are not always dealt with. Participants in dramatherapy are able to manage their own issues in a much more subtle and indirect fashion. Psychodrama, as a therapy, is more theoretically based and the sessions are much more structured. In dramatherapy, however, spontaneity is encouraged and each session has a degree of flexibility incorporated. An interesting point is that psychodrama focuses on the protagonist's emotional involvement in dealing with problematic areas of their lives while dramatherapy allows for dramatic distancing of emotions (Kedem-Tahar and Kellermann, 1996).

We began our typical drama therapy sessions with a “check-in”, in which the respondents shared their current feelings in the rescue centres. This was more like a greet and meet session and it provided important information to the researcher about how to lead the group, what issues were ready to be worked on, and what resistances will need to be worked past to get the group to function openly and smoothly.

After conducting a check in, the next thing we did was a “warm-up” in order to get everyone to focus on each other and on being in the “here and now.” According to Ann Cattanach (2007), the importance of a warm up at the beginning of every drama therapy session cannot be ignored. She posits that a warm-up helps loosen muscles and joints so as to minimize injuries especially during the performance of more physical activities. It also increases one’s creativity and imagination and prepares everyone to work together creatively and safely. During our sessions the researcher noticed that the warm up session enabled the participants to be more alert and concentrate on the activities, further warm-up helped in breaking the boundaries between the participants, which led to more openness during the games and role-play sessions.

4.3.1: WARM UP

A warm up is an engaging, captivating activity that is done at the beginning of the drama therapy session as a prelude to the activities that the group is going to undertake during the session, and that involves the mind, body and voice (Chesner

2007[a]). Since it should involve all the participants at an equal level, and because it serves as a prelude to the activities of session, the warm up cannot be standardised in terms of intensity. In my view, a warm up can be light or intense in terms of the aerobic activities involved, it can be more vocal or more of mime, and it can involve more imaginative exercises and games or more of creative exercises and games. For our sessions, the warm up chosen depended on the activities that the researcher had planned for the day, and thus it guided the direction that the session would take despite the fact that with drama therapy there was free flow of activities from games to role-play to music and dance.

Conducting warm ups also helps in setting the mood, themes and focus for the rest of the session. Cattanach (2007:37) states that the warm-up is crafted so that it prepares the group not just for the work, or as an introduction to each other but also to introduce the drama tools they will require in that session or in future sessions. Through the warm ups, the therapist can observe the group dynamics and become sensitized to the themes and feelings which create a focus for the drama. The safety of the group is reinforced by the therapist at this stage: ground rules are reinforced, limits and boundaries stated and permission is given for the group to play.

The warm-ups in most instances were stretch exercises, imagination exercises, vocal exercises and aerobic movements. A description of a few of the warm ups are described below;

Warm-up One: Stretch Exercise (Animal poses.)

In this warm up the researcher and the participants lie on the floor and assume to be an animal, say a cat. The researcher then leads the group into making different postures and poses while pretending to be doing it like an animal. For instance, the researcher asks the group to pretend to behave like:

A crawling cat – here the participants get down on their knees and hands and move around.

A swelling cat – here the participants still on their knees and hands stretch their backs upwards and inwards as if breathing deeply in and out.

A stretching cat – here the participants still on their knees and hands, stretch their hands flat on the ground such that their chest is on their knees and their buttocks on their heels. The participants' heads in this pose should be on the floor stretching the back, shoulder and arms.

A cat climbing a wall – here the participants stand up, then they bend their knees and elbows. They then raise their hands and legs alternatively as if climbing a wall but without moving from the same position, this is done in five (5) repetitions after which they jump at a 180^{o}turn and do the same facing that opposite direction.

To do the warm up activities and to play effectively, space is required. To this end, space refers to both the physical space that is enjoyed by all the participants and also the psychological space. Meldrum (2007; 25) defines playspace as an interpersonal and imaginary realm jointly shared by the therapist and client. This playspace is an illusion, an alternative reality brought into the dramatherapy session. The therapist acts as a guide to the client in her inner landscape and effects changes through a variety of techniques and levels of participation within the playspace. For our study, we did imagination exercises as described below;

Warm-up Two: Imagination exercises

Here the researcher asks the participant to sit on the floor with their backs against a wall, then close their eyes and put their hands and legs in the most relaxed position they can possibly thing about. The researcher then asks the participants to breathe in and out deeply and then lightly in silence with their mouths closed, so that they only breathe through the noses, This is done to get the participants to relax and until they can almost feel the still sound of their own breathing. The researcher then asks the participants to imagine themselves:

In the most calm place they have ever been.

In the most beautiful place they ever wish to be.

In the place they would wish to travel to.

Enjoying their favourite meal.

At home with their loved ones.

Sometimes during the imagination exercises the researcher could select a space. For instance the researcher could take them to a distant place by telling them they are in a lake or an ocean-most of them come from Kajiado County thus few had travelled to distant lands and thereby few had seen a large water body like a lake or an ocean. Then imagine they can see the beautiful beaches and sands, the reflection of the skies in the waters and the reflection of the sunset and sunrise. The researcher could sometimes ask the participants to imagine themselves in the forests and in the hills- a place they were familiar with. And to imagine themselves walking, and meeting the different animals, or grazing herds of cattle, collecting fruits, going to the market on market days and chatting with their friends from the river.

During the imagination exercises, caution was taken not to take the participants into painful or sad experiences as this would otherwise make their participation in the subsequent activities very sombre. Taking into note that a warm up session was just the beginning of the drama therapy sessions, high spirits is more encouraged so as to create enthusiasm into the next sessions and thereafter the storytelling and the focus group discussion sessions.

These two warm ups were adapted from Averett Tanner (1995), in his book *Basic Drama Projects*. Tanner talks about the importance of loosening up the mind and body before any physical or dramatic activity. These two basic exercises were very contemporary in that the girls could easily relate to objects, animals or scenes that

we chose to use during the session, thus taking every participant into a world of her own imaginations and freeing her limits.

4.3.2: GAMES

Richard Courtney quoted in Cattanach (2007; 34) posits:

> When the child at play uses imaginative thought and dramatic action to make choices from the evidence, he or she relates the inner world to the environment. Knowledge, in other words, is not an object but a process, a relationship, a dramatic dynamic.

In this context, the drama therapy sessions were the channel through which the participants, made the choice to participate, to turn their imagination into action, and to relate the inner feelings and thoughts into what they can verbalise and share with the other participants and the researcher. These games helped build their relationship with each other, it helped put them in high spirits thus the enthusiasm to freely express themselves without boundaries.

In this study, there were a lot of games that were involved. They were organized as follows:

a.) Assembling

In this game, the girls were divided into two groups of twelve each. One group was given a long roll of cotton wool and matches, while another group was given a roll of tissue paper and ear buds. Each group was told to create anything they wanted, using the two materials.

This game was adapted by the researcher after attending a theatre arts workshop facilitated by one of Augusto Boal's followers and ardent practitioners Ali Campbell in 2011. Ali Campbell who uses it in a lot of his practices in Europe and in his workshops in other continents. Ali Campbell is a Senior Lecturer at Queen Mary University of London, and has practised Applied Performance in many of his projects around Europe for: conflict resolution, awareness creation of critical issues and helping in problem solving among different groups like in adult education groups, rebellious youths, and enhancing self esteem among junior-high school children. Assembling is one of the games from Augusto Boal's image exercises. It is the use of image theatre in breaking silences and opening up discussions by creating abstract images that allows every participant to freely express their thoughts without expectations or inhibitions by the work at hand. (Catannach, 2007).

The aim of this activity is to bring to the realization of the researcher what the participants share in common. This may be in terms of their background or their environment, in the belief that a people from a common place share a common belief and understanding of their circumstances. This game of assembling further enhances communication, cooperation and teamwork among the participants. The participants in every group have to come up with various ideas and then decide on one item to create using the items that they have been provided with. The researcher, had to let the participants decide on the course they wanted to take. Directing them or airing my expectations would in this way have inhibited their

free expressions of their ideas into their work and subsequently into the image they would create.

On the one hand, one group which had been provided with cotton wool and matchsticks, arranged the materials to depict a manyatta homestead - a collection of houses/homes where the Maasai live especially in preparation for a ceremony like circumcision. The families of the men who are to be circumcised all stay within that homestead in preparation for the celebration.

Photo 1: Cotton Wool and Matches used to create a Maasai Manyatta

On the other hand, the other group which had been provided with tissue papers and ear buds arranged them to create a Maasai home, with a cow pen. After this arrangement, we talked about why they had decided to make those specific arrangements and what it meant to them. This resulted in a lengthy discussion about the Maasai gender roles and culture.

Photo 2: Tissue and Earbuds to create a Maasai Home

The girls talked about how in their homes women work more than the men. The women cook, take care of cattle and keep the home clean while the men just sit around drinking and arguing. Sometimes men go herding cattle but only for those who have large herd of cattle. The girls further stated that their brothers just go out to play more often while the girls are left at home. Also the respondents noted that in most homes, the boys are the ones who go to school while the girls do not. It is only in very wealthy families where girls are taken to school. As one of the girls lamented:

> Entito hawasomi, ni kazi tu, hakuna kupumzika na kuzaa.

Translated to:

Girls do not go to school, it is just work and no play and giving birth.

'Entito' in Maasai means a girl, whether circumcised or not. Once a girl is circumcised, she is betrothed and thereafter will no longer be a girl but a woman, a wife.

b.) The circle competition game

Here circles are drawn on the floor using chalk according to the number of the participants less two participants – one who should miss a circle spot and the would be drummer. The drum is played and when it stops everyone has to scramble to get into one circle. The person who does not get into a circle would then be out of the game. After that, one circle is erased from the floor. This routine would be repeated until only one (1) circle is left and subsequently one winner. Habitually, this game would be repeated all over for at least three (3) rounds because, more often, the first persons to be removed out of the game would not find it fair, alleging that they were not ready. A second round would therefore give them a chance to play again.

However, one thing that was evident was that some particular girls were more often among the first three to be out of the game. After the game, there was a discussion on how competition made them feel. How does it feel to be the last one to leave the game? And how does it feel to be the first to leave the game? The pupils had quite a number of reactions.

At one time, after being the first to leave the game three times in a row on the same day, one of the girls cried and lamented saying how she doesn't care whether she is the first or the last to leave the circle because she is used to being pin-pointed as the bad one. She reported that she was harassed both at home and at school. She attributed this to the fact that in her home, she was the one who took the longest time before getting circumcised and therefore her friends and cousins used to scorn and laugh at her. Thereafter, even after she had agreed to be circumcised due to peer pressure, they still went on scorning her because she waited too long to go and get the cut. Thus, the scorning never stopped even after she had been circumcised. Instead, she felt even more humiliated because her age-mates believed they were not of the same set. Those who belonged to her set were way younger than her. She had thought that after all the pain, her friends would accept her fully and the scorn would stop but it did not.

At this point the researcher asked the group to sit in a circle, and we decided that we were all going to say something nice about each other in turns. So we started by saying something nice about the person seated on one's right, in turns until everyone had talked. Then we said something nice about the persons seated on the left of every individual. Further, we went ahead and said something nice about the person who was directly seated opposite us in the circle. To complete the game the researcher asked all the participants to say something nice about the girl who felt harassed – Faith (not real name). The girls said she was kind, humble, and generous, has a good mastery of English language, and a good dancer. She was

very beautiful and had a smooth face without pimples. The group assured her that we all belonged to the same age set as girls of AIC Kajiado, and we assured her that she had a better future than some of her cousins who had been married off already. We made her understand that she was of much worth than she thought and she could scale into greater heights if she believed in herself.

By the time we were through with the drama therapy project, Faith* became bolder and in the subsequent games after this incident, she competed more to stay longer in the game. This was a good sign that she had decided not to give up on but to push herself to her highest limit. It was evident that her confidence was elevated. She later confessed how she was now putting more effort, how she was concentrating more on the games. At the end of the session on the second last meeting to the completion of our drama therapy project at A.I.C. Kajiado, Faith* approached the researcher to express her gratitude.

> Madam Zippy, thanks for coming to play and talk with us. It has really helped me to be able to talk and I understand what my cousins feel. My anger was making me hate everybody even at school for no reason. Now I feel better because I know that my friends like me more and I am happier. I am not afraid of people laughing at me in class, so nowadays I also carry my hands. I will miss the drama. Please come again before we complete Standard 8.

True to the girls' complements, Faith* was one of the girls with the best spoken English, clear and without heavy tribal accent. The researcher was touched by the boldness, and the courage she had gathered to thank the researchers. The honesty in her face and humility was undoubted. Overall, this even showed in her classwork because one of the teachers singled her as one of the most improved

girls in class in terms of participation. The withdrawn girl was now open and bold and free to air her sentiments and answers in class without fear that her classmates would laugh at her, and thus even her performance improved.

Playing with the girls as in the two games above offered important simulations for social interactions to them and offered a variety of transformations in the girls as the researcher tried to understand their emotions. The games also offered a greater possibility for the researcher to create insights into those emotions than their experiences of everyday life. In this way, the girls were able to not only reflect and explore their lives but also express themselves freely without restraint. Gladding (2006) points out that integrating the arts into therapy may speed up self-exploration and allow clients to experience themselves more differently than in traditional therapy. Expressive art modalities assist individuals to move beyond preconceived beliefs with experimentation of new ways of communication and "pretend" experiences (Malchiodi, 2005). Using expressive art like games as described in the preceding pages, and the use of music and dance and role play as described in the subsequent pages, we were able to have the girls talk about their FGM experiences and narrate their own life stories, as explained in the latter pages. It was quite notable that during the first session of drama therapy most of the participants were timid, for they had expectations. They wanted to act in a specific way that they thought the researcher expected. At the end of that first session the researcher noted the timid nature and the feeling of being evaluated. Hence, the keenness on perfection by the participants. Further boundaries were broken by the researcher by explaining the importance of having fun, by not having expectations

and most importantly to play our lives as they were. It was at the end of this first session that rules were set on who were not allowed in our sessions like the teachers and those who had not undergone FGM. The girls felt that if the pupils who had not undergone FGM listened to their stories, they would use the same stories to scorn or humiliate them. Further, they felt that the uncircumcised girls were still children – a sentiment that they had been told before they got circumcised. The girls also felt that the teachers, being a symbol of authority were making them (girls) not participate to their full potential and full freedom.

Wiener's (1994:89) observes: "The stories clients present in therapy about themselves and their lives tend to be problem stories; that is, they are dominated by themes of obstacles, limitations and restraints". Indeed, the girls narrated how difficult it was to escape from FGM. Each time they contemplated escape, a number of limitations and obstacles would crop up like where to go and how life would be if they rebelled against their customs and traditions.

This observation further concurs with the supposition that a theatrical experience utilizes perceptual, cognitive, emotional, and communicative dimensions of humanity, which are four areas commonly explored in therapy (Boerner, Jobst, & Wiemann, 2010). "Expressing feelings and ideas in action is a natural tendency because the physical experience of embodying a role lends a greater degree of fullness, is a stronger expression of will, and more completely affirms the sense of self" (Blatner, 1996;14). This is imperative in that it is impossible to have a positive non-verbal gesture and yet a negative proclamation. In the dramatherapy

sessions we encouraged the acting out of our thoughts and feelings into role play - re-enacting of our lives in a way that we understood best. Words alone in narration may lie. However, when the body is involved, the non-verbal clues and gestures that one portrays in the performance most often go in sync to what is in the person's mind. It is mind over body, and it takes great effort to have the body act against the mind. In this instance, the drama therapist, (the researcher) was able to observe the difficulty in some of the participants, and helped them find a pivot where they freely expressed themselves, by giving them freedoms, removing boundaries and allowing the participant to find their balance in a way that was familiar to them. The outburst was often in the form of words or tears by the participant, or stopping the action altogether.

The researcher, in this case had to allow the participant to complete her reaction and then talk to her about how the performance had made her feel. This would then lead into a discussion that would more often take the remaining time of the drama therapy sessions, with interlude of other related topics coming in as shared contributions from other participants of their own related experiences. As Chestner (2007[b]) states, in dramatherapy the focus may come to rest on one individual for most of a session, but it is more likely that the focus will move freely around the group, unlike in psychodrama where the session is on the psychodramatic journey of one group member.

Andres-Hyman, Strauss, & Davidson, (2007) quotes Anton Chekhov's recommendation to actors:

> Endeavor to penetrate the psychology of persons around you toward whom you feel unsympathetic. Try to find in them some good, positive which you perhaps failed to notice before. Make an attempt to experience what they experience; ask yourself why they feel or act the way they do (2007:84-85).

The truism of this supposition came to the fore as the games we conducted enabled the girls to open up and narrate their experiences. However, as they recounted their experiences of the process of the ritual and, further, the healing process, some of them became emotional and often broke into tears. This was taken as a carthasis moment and the girls were made to feel to belong in that they did not feel discriminated in sharing their experiences, now that all the participants had undergone the same rite. Sometimes the stories would make the other participants to make exclamation sounds, recounting their own experience while empathizing with the narrating participant.

c.) Sharing game

In the sharing game, the girls lined and stretched out their hands. Each one of them was then given a wrapped sweet, asked to unwrap and eat it without folding their elbows. This game was the researcher's own creation. It is one of those ideas that sweep through the mind and boggle one to try it and see how it works. On the specific day, the researcher had promised that she would bring the participants sweets, as an incentive for their active participation. Thus in a bid to create fun in the distribution of the sweets, the researcher introduced the game. The researcher

did it as an attempt to challenge the girls, to see to what lengths they would go just to ensure they ate the sweet.

It took the participants almost five(5) minutes before one could figure out what to do. Some of the antics the girls engaged in were;

i.) opening their mouths wide then throwing the sweets with their fingers, ensuring that the elbow should not fold. In all instances the sweet fell on the floor and the researcher would pick it up, and put it in the girl's hands and then let her stretch her hands and try to get the sweet into the mouth.

ii.) With both hands stretched, some girls unwrapped the sweets with their fingers, put their elbows and arms together and then gently rolled the sweet so that it could get closer to their mouths, hoping they would then stretch their tongue and have the sweet. This too failed for the sweet could be rolled until the elbow, but the tongue could not stretch more than its limit. Sometimes the sweet could touch the tongue and then fall off, which would then elicit an "eeew" cry from the other participants seeing how close one of them was to having the sweet.

iii.) Another participant, sat down with her hands stretched, then threw the sweet into her mouth and it fell on her lap and then she stretched her upper body with her hands straight, as if to touch her toes, so that she

could pick the sweet with her tongue. This too failed for her head could not touch her lap, and the sweet had fallen mid thigh lengthwise.

iv.) Finally, one of the girls took another's sweet, amid protest from the owner of the sweet. She then unwrapped it, and gave it back to which the other girl did likewise. After all the girls saw this, they unwrapped each other's sweet and in essence, each individual fed another.

To eat a sweet, one had to unwrap for a friend and then feed the individual the sweet, each girl had to do this to another girl, and thus the name the sharing game. In this regard, though it was a game, embedded in it was a moral lesson. After the first had done it right, all the other girls did the same. The discussion thereafter was about what they had learnt during the game. Some of the sentiments here were:

> I have learnt that it is good to trust each other, I did not want Clara*(not her real name) to take my sweet, I thought she was going to eat it.
>
> I have learnt that I should help someone so that they can also help me
>
> I loved the sweets. I am happy you brought for us sweets instead of stones, at least we have enjoyed, sweets are sweet.

Asked to elaborate on why she did not trust her friend to take her sweet, one of the girls Mary* (not her real name), recounted how she was misled by her cousins to

believe that FGM was the best thing that could ever happen to her. Mary recalled how her cousins showed off their bracelets and how they had been showered with gifts of new clothes, sweets, rubber shoes and even a goat to crown it all. Her cousins had told her that the pain subsides the moment the knife stops cutting, and the bleeding was just like a simple knife-cut on a finger. According to Mary*, the pain she went through during the circumcision was unbearable. Despite the fact that she was given a lot of gifts by her mother and aunts, she said that for her, trust for her family members ended on that day. In her own words:

> I felt as though my whole body was lifeless. I screamed so loud and even when I was breathless, I could still feel myself screaming in my head. My thighs could not move, I could not even stand, I had to be carried and put on the mat. I felt as though I was dead, I could only hear the voices of my mother crying thinking I was dead, and the circumcisor and my aunt were telling her I was okay. I could not talk, my whole body was numb and I felt a cold chill sweep through my whole body. After some time, I woke up to see blood all over my waist. The circumcisor had put some leaves on my vagina to stop the bleeding. Some crushed leaves mixed into a paste had also been put on my chest. When I woke up, my aunt was next to me and she called my mother. They had prepared some blood to give me when I woke up, but I couldn't eat, my throat was so dry even after I had taken water. The pain was too much for me. The following day, I asked for my cousin and she came. I abused her for lying to me on how there was no pain. For my cousin, it was a matter of revenge; she lied to me because she too had been lied to. She wanted someone else to undergo the pain so as to share the pain and the sentiments.

Another girl Jane* (not her real name), related Mary's story to her own and further narrated how after she had healed, her father insisted that she had to go and visit her aunt in Oloinyakalani, a distance away from her home in Isinya-Kajiado. So her aunt came to pick her and when she went, one of her cousins told her that she (Jane), was going to be married off and that the man would come the following day

to meet her. On hearing this, she kept to herself the whole day, not wanting to provoke her aunt who was very strict and harsh. When early morning came, she took a bucket and told her aunt that she was going to the river. She walked for two days, taking rests on shop fronts. On the second day, mid morning she reached the main tarmac road and started stopping vehicles for a lift. She explained that she was not stopping pick-up vehicles or Nissan vehicles because pick-ups are often owned by Maasai men and she was scared they may take her back to her aunt's home. She also did not stop the Nissan vehicles because they would demand for money and she did not have any. She waived at so many vehicles to stop until one couple at last saw her standing leaning against a tree and waving. They were driving from Namanga to Nairobi and they asked her where she was going and when she said she did not know, they decided to drop her at A.I.C. Kajiado Primary School. The lady in the car had heard of the rescue centre and so as they drove, they asked for directions until they arrived there.

Trust in the group was further elevated after this session because the girls understood the importance of giving people a chance to be good to us. For instance if Jane* had not trusted the couple to give her a lift, then she would have fainted and perhaps died. Jane further told us how she was grateful of the shoes she had gotten as a gift during her circumcision for if she had walked that far barefoot, her legs would have been blistered and would have hurt terribly. For her, the couple was God-sent for they gave her water and biscuits which they had in the car.

Newham (2000:21) points out that theatre has "an essential therapeutic tool, because the psyche may be said to behave according to a dramatic model". We need to understand our personal motivations, drives, and the feelings of the other individuals in our lives in order to improve the relationships, social structures, and interactions with others in our lives (Emanuh, 1994). The same applied to the sharing game. The girls had to understand each other in order to execute their roles. The essence of this understanding was based on how each of them could read and interpret each other's feelings, desires and will power to not only execute what was required of her in the game but also to excel in doing so.

As a closure for this session, the researcher and the girls had discussion on what are the sweet things that we know, to which the girls talked of foods like mandazi, nyama choma, cakes, sodas, sweets and biscuits. Asked on the people they consider 'sweet' in this instance to refer to good, the girls resonated that The Principal at A.I.C. Kajiado was nice to them. The girls said that it was because she protected them from their harsh parents who wanted to marry them off. Out of the 24 girls, at least 18 cited that their parents wanted to marry them off after their circumcision. Further, when they stayed at the rescue centre during the school holidays when the other girls went home, The Principal, bought them snacks and ensured that they were cooked for delicious meals on weekends.

In an interview with The Principal at A.I.C. Kajiado Girls Primary School, she stated that she often gets confronted by fathers in her compound wanting to get their girls out of the rescue centre. She, however has the support of the area chief

and police in Kajiado who are always ready to come to the rescue the moment they are called. The teachers are all aware of the communal conflict, thus when a parent starts to cause a commotion in the school at least one of the teachers alerts the chief or the police who come and put an end to the ordeal. Madam Catherine narrated to us how sometimes some parents storm into the classes directly even without passing through the administration offices and so the security guard has to inform the office immediately. This destabilizes the girls, in that some of them suffer a lot of humiliation and harassment, compounded with the fear they have of their fathers. This continually affects the grades of the girls in school. The school therefore tries to invite volunteers to talk to the girls, especially the girls who have passed through other rescue centres and have excelled, to talk to the girls to have courage and to steer on.

The Principal at A.I.C. Kajiado Girls Primary School, further informed the researcher, how attempts to transfer her from the school has failed because the mothers to the girls usually petition for her return, for the security and confidence they have in her. Having been a survivor of FGM, she has taken it into her stride to protect the girls from the harsh reality of the knife and even for those who have undergone FGM, she protects them from the early marriages. As an example, she underwent FGM when she was thirteen (13) years old. Thereafter, her aunt who lived in Nairobi took her away in pretence that she would be married off, where she stayed until she completed her standard eight (8). When she later came home, she was betrothed to a man twice her age as second wife, to which she protested and went back to live with her aunt. That was how she managed to go to high

school and later to teacher training college, through the help of her aunt. She noted that it was not easy for a girl to protest against parents' will, and it took a lot of courage, which if it was not for the support from her aunt in Nairobi, she would not have managed. Madam Catherine Kipuri, is currently married with children whom she says, she and her husband have agreed not to allow them to undergo FGM.

The girls' sentiments towards Madam Catherine Kipuri was very positive and as researchers we felt her motherly and warm welcome. When we told her of our interest in doing drama therapy with the girls in a bid to help them open up and face their fears by sharing out in a secure environment, she was enthusiastic and allowed us to proceed without a problems. Once we identified ourselves and she proved our background to be correct, she gave us her consent and her support. She later informed us how the girls were still going on with the drama activities during the holidays and the new girls and those from the other classes who had not attended the drama therapy sessions were further benefiting from the knowledge that was being passed on.

Thomas Holt (1992) views all behaviour as necessarily theatrical, because theatre is how we have are invested in reality. Hence, the manner in which the girls interpreted the reality in the sharing game helped them to react in a certain way. The nature of their reaction enabled them to perform the task before hand without necessarily violating the rules of the game. As a result, the game provided the girls with a unique experience of interpreting phenomenon and in the process they came up with unique personal initiatives. The girls' limitation in the game tally with

Wiener's (1994) observation that in drama therapy clients actively engage in a constant process of creating their own personal world with their unique personal experiences.

It is worth noting that in any drama therapy situation, an individual is defining his or her personality through the roles he or she chooses to play at any given time (Lipman, 2003). This indicates that as the girls chose the action to undertake, they were defining their personalities based on the reality upon them. Part of this definition of personality are the choices that one makes and the friends they choose. The people they choose as their friends should be firstly those, as Mary*, one of the girls, observed "the ones they trust" and secondly, they should be willing to help each other.

Renee Emunah (1994) argues that embodying someone else through a dramatic enactment is more effective and powerful than simply imagining that person's situation or problem. He posits that therapy, like theatre, is a rarefied, exotic, and paradoxical world in which the most artificial and unnatural setting and circumstances may bring forth the most authentic and profound aspects of human nature. This was the same situation that the girls found themselves in as they tried to figure out what to do with breaking the rules of the game. In this, they realized that in order for them to effectively perform the task, they needed someone's help.

In the sharing game, the circle competition game and the assembling game, there was the need for emotional significance. All the three games in their own ways,

touched the participants in a bid to make them speak out and share their present and past experiences, freely in a guided way by the therapist. As the girls spoke their minds, the therapist-the researcher, guided the group through the process, by asking open ended questions on an incident, to which the participants at will expressed themselves in words, tears, or actions that embodied what we call drama, which in turn is therapeutic. At the point when the girls laughed out an incident, and listened to each other narrate their experiences, the moment was golden: a rich heavy silence as one narrated, then suddenly followed a chorus where everyone wanted to add a story on what was being told. The rhythm in the room was magical, as the mood of the girls changed from laughter to silence, to sorrow and some to tears, to squirming and resonating sounds of "eeish" and "ouch" as one narrated a painful ordeal. It is in this, that we say, the audience- the participants live in the theatre of everyday life.

Evans (2007) sums up the creative experience:

> Sometimes we create to work something out, sometimes simply to relax. But in any creative endeavor the underlying goal is to solve a problem of coherence between what we know, perceive, or feel, and what we write, paint, sing, or otherwise create. And what we create comes back to us as better understanding of the world and of ourselves. Art is crucial for the healing journey because it touches and also expresses the whole complex human person, including levels of mind, body, and spirit (p.102-103, 107).

In other words, the goal of the creative process is translation from the inner to the outer world and is what is served by developing our creative abilities. The need to create, communicate coherently and symbolize is a basic human need. Therefore, through their experiences in the games the girls realized that they needed to be not

only creative but also use their minds in order to execute the roles. In this way, they learnt that a person does not exist in isolation but needs others in order to carry out their daily activities. They needed each other to share, to listen, to give a helping hand and to trust with their feelings so that they could also be trusted. In the circle competition game they learnt the importance and need to compete in a healthy way, to accept and appreciate their friends when they did not win and to support each other no matter what the circumstances. The games were played in the sessions repeatedly over the drama therapy sessions, with variety in terms of the songs used, the objects/items/props used to create images and even in terms of the direction of discussions that the games took. This helped in reducing monotony and the spontaneity of not knowing what was going to be done in the next session and it elicited a lot of creativity among the participants.

4.3.3: DANCE AND MUSIC

Dance and movement therapy is another form of arts therapy which was pioneered by Marian Chace in the 1940s in Washington. Marian danced waltzes with psychiatric patients in the back wards of a hospital and soon noticed the therapeutic effects that dance had on the patients (Wennerstrand, 2008). Dance and movement therapy focuses on the mind/body connection and allows movement to become a medium through which the mind could be healed (Wennerstrand, 2008). This is because dance is in response to a rhythm which the mind internalises and interprets in terms of movement of various body parts. Hoban (2000) states that in dance/movement therapy, techniques such as mirroring, reflection and

amplification are adopted and the space and objects around the participants are paid specific attention to promote meaningful interactions among participants, increase self-esteem, support self-regulation and alleviate effects of depression. It is with this in mind that we used dance as a major drama therapy tool, for it helped create self-awareness of the participants and allowed for the freedom of self-expression while increasing the interaction and participation level of the girls. Besides, the aerobic nature of dance helps increase blood flow to various muscles of the body and the brain thus increasing alertness and creativity, something that is very useful in the therapy process in understanding oneself and others, thus finding healing. The philosophy of dance and movement therapy is that "if you can dance in your heart, you can dance" (Hoban, 2000).

Space for dance is thus very crucial in dance therapy. This may refer to physical space or psychological space in that the participant needs to feel free and secure to be able to express themselves wholly. As Wethered explains in her book 'Drama and Movement in Therapy':

> In movement therapy, space is used as a **progression towards greater awareness** and objects to emphasize external reality (1973:36).

Dance and movement therapy, like in dramatherapy and psychodrama, requires the participant to be fully engaged with the therapist and form relationships with one another using the movements as a means of communication. Anne Wennerstrand (2008), a dance therapist in the United States, explains that dance/movement

therapy can be used to bring body images closer to reality, to support remembrance and socialization as well as to increase functioning.

Dance and music are some of the tools that were widely used in the study. In fact, dance and music were the most efficient tools in this drama therapy exercise. They were enjoyed by the girls and were most productive right from the warm up sessions. It is the one that could get all the girls enthusiastic and excited and talking in succession about even very sensitive issues.

Music and Dance go hand in hand, in that most people find it easier when they can dance in response to a beat rather than to an imagined melody. Music was thus the melody and rhythm which the therapist found appropriate for the participants. Some music may be noisy or boring, it may be in discord or not sound harmonious to the common listener, but if it works for the therapy then it is considered appropriate. As Webi (2013) states;

> Music is probably the most powerful communication tool available to man. In fact, it is easier to remember a message in a song than in a speech (D'Amico, 2012). This is because music is a universal language and people across the world speak a variety of languages but everyone understands the language of music in its various genres (2013:102).

There was a time we danced for a full hour and no one wanted to stop. We could not do any focus group discussion because we were so immersed into learning a new song and dance style. There were various dances each day. Sometimes we danced to Maasai cultural songs which the girls were very delighted to teach the researcher. Sometimes the researcher also taught the girls some English songs, and

at other times we all danced to music from the music player. This would be after they chose their favourite songs and which the researcher would bring along in the next session.

It was lots of fun seeing the girls, who had once seemed as very reserved and innocent, dancing to moves only seen in music shows, but with few improvisations. At these moments, the one memorable thing was having one person act as a bodyguard to ensure that the other students did not come peeping at the window on hearing the music playing. Some of the songs the survivors danced to included:

a.) Akidosho

'Akidosho' was one of the songs the girls enjoyed. Akidosho is one of the popular folk songs in Kenya, cutting across all cultures. It is mainly sang in urban town schools during Physical Education or games lessons. It has further been used often during theatre workshops in East Africa, more because of the Swahili language that it is sung in and, further, for its participatory nature and its repetitive and engaging rhythm. As part of participation, the researcher taught the girls this song 'Akidosho', here referring to young girl and it became a major warm up exercise and in some cases one of the songs to wrap up our sessions. The song has repetitive words but changes in tone, signifying various emotions like strong desire and mere emptiness. To which every word is said in action with tonal variation and facial expression to signify change of emotions. During the first few sessions the researcher did the solo as the girls sang the chorus, and with time even one of them

could do the solo as we danced and mimed all the gestures and facial expressions as done by the leader, in this regard the soloist. The song is noted below:

Solo: Akidosho
Chorus: Kuja (Come.)
Solo: Akidosho
Chorus: Kuja kuja (come come.)
Solo: Akidosho
Chorus: Kwenda……(go.)
Solo: Akidosho
Chorus: Kwenda kwenda (go go.)

This song included imitating various emotions of happiness, love, anger, tears, pain, jealousy, as the participants mimic the facial expressions and tonal voice to someone calling or chasing away akidosho. It was fun and a favourite of the girls. In this game, the participants came so close to each other, the circle sometimes got so tight that they could smell each other. Sometimes the whisper was so low no one could hear the participants' voices and suddenly the voices could spiral the roof as all the participants ended in laughter. The excitement was intense; no competition and no fears. It was pure concentration and focused on the moment and letting go. At times the researcher found herself on the floor with the girls laughing all over. It was fun and intense, like a mother duck and her ducklings. The researcher forgot herself, the girls forgot themselves and for a while, everyone in the group was lost in nothingness.

When the researcher took to them copies of the DVD of the drama therapy they had done together, they wanted to play one last time and the researcher could not resist it. Akidosho was like a carthasis to the girls. The participants released their motions freely, while letting the laughter heal them. For the participants and the

researcher it was not a moment of release of pity, but a release of fear. Letting go of all fears in laughter and letting excitement overwhelm us. There was no room for self-pity in this game. As another girl recalled, she felt like she was jumping in the air hoping to fall on a mattress without the fear of being hurt. She felt free.

Talking to the girls about their favourite song, quite a number cited ‘akidosho’ and they had various reasons for loving the song and the movements involved; For most it was the repetitive simple rhythm that could be enacted in different gestures as each pleased. For another girl, Penina*(not her real name), she loved this song because of the facial expressions that people could make as they imitated various emotions. She thought it was hilarious to see each others’ face turned into a clown-like appearance. For another girl, she loved the way in which the rhythm could rise and shift in tempo or tone, and the imaginary feeling of talking to ‘akidosho’ who was right at the centre of the circle. All the participants in a bid to look at akidosho could see each other in the circle and the imitation of the soloist became an imitation of each other which led to more laughter. In this game, we had no restrain and we became little giggling girls, forgetting the past, not worrying about the future, and just being us.

b.) The Noble Duke of York

Oh the noble duke of York,
He had 10,000 men
He ran them up to the top of the hill
And run them down again
And when they were up, they were up
And when they were down, they were down
And when they were halfway up

They were neither up nor down.

This was a song from the many famous Nursery Rhymes used in preparatory classes. It is a song with a British History. Since Kenya was a British colony, the education system in many ways took up the British System of Education. Even though there have been few changes in the system of education over the years, most of the content, especially at the Preparatory stage has not had significant changes.

'The Noble duke of York' is an action oriented song. All the participants have to be in a circle and marching round as they sing along and do all the actions that the song demands. When singing of "halfway/up/down", they had to stop and bend at the knee to be down, halfway or up. This was quite an energizing song and dance that left all the participants sweating and some falling, especially since the pace would be increased in subsequent rounds of singing.

The researcher used this song often before the role-play/role-reversal parts of the session, and also for the closure. It was very useful in helping lift up spirits of the girls while at the same time it had an aerobic effect thus helping in keeping the girls active and alert. This song was loved by some of the girls, for the reasons that it was a new song thus with newness comes enthusiasm. As one of the girls put it, this song was like a tongue twister to her and so with the activity that it required, she felt so challenged. On the day she was able to sing every word clearly, she felt very happy and wanted us to sing it as a round song- a short song that is repeated over and over again.

Another girl cited that this song made her remember a lot of the games they used to play in nursery school and thus it made her feel like a child again. As a prelude to other activities, sometimes the girls could insist we play and sing other songs that they could remember from their nursery school times. Some of these songs were very popular with most of the girls, though each person had a slightly different version. Some of the songs that had a similar interpretation in terms of activity level like Noble Duke of York was one called ‘Kamares’. The word ‘Kamares’ in this case has no significant meaning. But it involves dancing by shaking and moving of the waist from one side to another:

> "Kamares, Kamares, na Mary* sikuhizi, anaringa ringa ringa, anatoa waist kamares, anatoa waist kamares, anadunda dunda, dunda dunda dunda dunda kadus”

This is translated into:

> “Kamares, kamares and Mary* nowadays, she boast and boasts and boasts, she does waist kamares, she does waist kamares, she shakes and shakes, shakes and shakes and shakes and shakes.”

c.) Maasai cultural songs

> Chorus: Eeeeh, iyage, iyage, iyage manwara x4
> Aganyo regiloliyo, aa iyayo neleleiyo
> Nogoriyo, nigidolwero, aa iyayo neleleiyo.
> Iyaaa, Uhuu, Iyaaa, Uhuu

Translates to:

> Chorus: Eeeh, Memories of my childhood are sweet x4
> I want to keep my traditions, I love my people
> Let us enjoy our life. I love my people.
> Iyaaa, Uhuu, Iyaaa, Uhuu

The girls sang and taught the researcher quite a number of their own indigenous songs. Some were lullabies and play songs and some were circumcision songs for both girls and boys. The researcher and the participants would dance in two lines, moving their necks and chests like Morans and turning side to side, while slightly bending our knees. It was a very graceful dance and the girls were very willing to share the meaning of the songs. Some of the songs could make the girls giggle while some of the songs the girls would blush as they explained in turns what it meant. There were times when the researcher felt they were not giving the right meaning, but they giggled it all away. This the researcher noted was most especially where there were words that would sound obscene when spoken in English.

4.3.4: POETRY

Poetry Therapy refers to the use of the genre for healing and personal growth and may be traced back to primitive man, who used religious rites in which shamans and witchdoctors chanted poetry for the well-being of the tribe or individual, (Pfeiffer, 1982; Lewis-Williams, 2002). Historically, the first Poetry Therapist on record was a Roman physician by the name of Soranus in the first century A.D., who prescribed tragedy for his manic patients and comedy for those who were depressed (Brockett, 1968).

In 1928, Eli Greifer, an inspired poet who was a pharmacist and lawyer by profession, began a campaign to show that a poem's didactic message had healing power. He became a volunteer in order to test his theories and thus in the 1950's he started a "poemtherapy" group at Creedmore State Hospital, (NAPT, 2004). According to National Association of Poetry Therapist, Poem Therapy is part of "Bibliotherapy" - books, or literature, to serve or help medically. The term "poemtherapy" is nowadays substituted by "Poetry Therapy" and is defined as a specific and powerful form of bibliotherapy, unique in its use of metaphor, imagery, rhythm, and other poetic devices (NAPT, 2004). Poetry in our sessions involved use of rhythm, imagery and symbolism in that the words that were spoken represented different meanings to the girls depending on their own life experiences. For instance, in our therapy sessions, the word 'stop' gave a different meaning to different girls. One of the girls stated that the word 'stop' for her meant the end of the mental anguish and the memory of the practise of FGM. To one girl it meant the forgiveness of those who made her undergo the circumcision, and to another it meant the end of the mockery by her peer group who had pressured her to undergo the practice.

As much as we used poetry during some of our drama therapy sessions, we realized that it was not really a point of strength for the girls, in either composition or recitation. We tried to compose together such that every person would write a line and eventually create one poem. However that proved difficult. Hence, the researcher allowed every girl to say just one or two words. Some of the words that the participants cited were; "cry, smile, frown, shake, far away, walk, stop, tears,

joys, shiver, lost, alone, strangers, my land, new place, distance, stare, sleep, think, everything."

After the girls cited these words, the researcher suggested more words, giving hints in form of questions. For example: "I cry then I do what next?" or "I frown and then?" or "I stop what" to which the girls could answer. We then wrote down the simple sentences and created an abstract poem and that was what we worked with. The simple poem that we did with the girls lingered on in their memories for long, as something they could freely express without feeling prejudiced, something they called their own. This poem was created in English and in its simplicity the girls were able to get all the words internalized on the first day. The researcher wrote down the poem and brought each girl a copy of it during the next session. We also used the poem as a prelude to some of our storytelling/storymaking sessions:

I cry,I smile
I frown, I shake
I walk I stop
I cry for tears I do not know
I smile for joys I have never felt
I frown at eyes staring at me
I shake and shiver
I walk distances and distances
To places I have never been
I stop because I fear
I fear getting lost and never be found
I fear being alone in a new land
A land of strangers

A land of my own
I cry, I smile
I frown, I shake
I walk, I stop
I stop and stare
I stop and sleep
I stop and think
I stop, I stop it all.

Despite the fact that the girls had a weakness in poetry, it is worth noting that poetry as a form of therapy and acting share many underlying principles. Belief, desire, and emotion were vital not only on stage, but also to therapy (Oatley, 2004), and expression of these emotions was highly encouraged during the poetry sessions. As Tanner, (1995) posits, acting exercises like poetry were designed to enhance an actor's imagination, reciprocity and openness to talk, therefore as the girls tried to recite the poetry lines they had learnt, they realized that being open and imaginative was key to their creativity.

Getting rid of the fear and shyness in the process of reciting were other key elements that they learnt in reciting poetry. The girls were able to let go of their inhibitions as they acted out various facial expressions and tonal variations, and laughed out the feelings that each line of recitation brought them. For instance the lines;

I cry,I smile
I frown, I shake
I shake and shiver

The above lines were repeated over and over, with the girls trying to act out what each line meant. During each recitation the girls teased each other on who was smiling and who was not smiling, or who was crying or who was not crying. Arguments on the differences between shaking' and 'shivering', or 'crying' and 'frowning' became topics of discussion and practise. During one of the sessions of dramatherapy, we discussed how the words on the poem made them feel. Below is anexcerpt from one of the girls, Felicity*(not her real name), who found it hard to smile:

> Anytime I think of the word 'shivering' I remember the chill that swept through my body the day I was circumcised. I remember my aunt holding me on my shoulders and two other women holding both my legs apart. The next thing was a splash of very cold water on my thing(vagina). This was followed by what I cannot even explain. The circumcisor used a razor on me. I thought it would be fast, but she did it slowly and to me it felt like it was not ending. I felt like, I don't know. It was like a pain I have never felt. My voice first disappeared, my breathing stopped, before I let out a scream so loud. I have never in my life screamed like that. I thought the circumciser would be shaken and stop, but she went on as if nothing was wrong. When she stopped, my aunt lay me on the floor, as they applied some herbal medicine on my vagina to stop the bleeding. I did not bleed so much, however, I was shaking and I felt so much chills as if I was having a fever, even though my body was not hot.

Since most of the poetry was abstract the girls were able to put in various emotions as each of them felt appropriate, and this brought a dynamism and freedom that swept the whole group through the session.

This the other girls echoed by stating how the circumcision in the village by the circumciser felt like a never ending death. The lines of the poem that were resonated by the girls were the last lines of the poem;

I walk, I stop
I stop and stare
I stop and sleep
I stop and think
I stop, I stop it all.

During the recitation of the poem, the girls realised that they had unconsciously arranged the lines of the poem in a way that it ended with hope. The words ‘I stop” were said in authority by the girls in a way that astounded the researchers. One of the girls stated that the last line made her feel free and in control. To her, she was more hurt by her peers at home, who teased her for having taken long before undergoing FGM, even after she had undergone the rite. This last line to her was more like she was stopping all the teasing and all the mockery. She said that the next time they confront her, she would ask them to state how they were better than her because she was ahead of them in class. In that most of those peers who made a mockery of her, were in standard four and some in standard five, while she was in standard six. She stated that after the drama therapy sessions, she felt more proud of her education, and less troubled by what her peers thought. She was proud of herself and she regretted having undergone the knife because of peer pressure.

4.3.5: ROLE-PLAY

According to David Farmer (2011), **Role playing** is the basis of all dramatic activity. The ability to suspend disbelief by stepping into another character's shoes comes quite naturally to most children. By adopting a role, children can step into the past or future and travel to any location, dealing with issues on moral and

intellectual levels (Farmer, 2011). Thus role play can be easily utilized to illuminate themes across the curriculum.

Role play as a model of dramatherapy is a drama model informed by the sociological and social psychological model of sociologist Erving Goffman (1972), which states that the model of development of the person lies in the social interaction and transactions of the individual with others in the environment. Goffman's statement supports the philosophy of symbolic interactionism as expressed by George Herbert Mead (1934) which states how persons construct their personalities through the number and variety of roles they perform with those in the social contexts within which they live, work and play (Goffman, 1972; Mead, 1934). It is in this understanding that the researcher used role-play and role reversal as a way of helping the girls understand themselves by enacting their life roles and those of the people they live with.

The term role-play comes from the words 'role' and the word 'play'. A role is a set of responsibilities on a person, while play is the dramatic piece or performance. Brenda Meldrum (2007) defines role as a social behaviour that the person engages in when taking on a position in relation to others, and these others too have expectations of how the person should behave in that role. Landy (1991) defines role as "the container of all thoughts and feelings we have about ourselves and others in our social and imaginary world". Role playing is therefore the dramatization of a person's behaviours and his/her relationship with others in the society.

Role playing was part of Augusto Boal's approaches of drama therapy in 'Theatre of the Oppressed' and with methods derived from Paulo Friere, and Antonin Artaud's 'Theatre of Cruelty' he did experiments with People's theatre in Peru (Boal, 2000; Weaver 2009). **Role playing** as a technique was first used by the father of dramatherapy Antonin Artaud in his 'Theatre of cruelty' (Artaud, 1970), but was made famous by Augusto Boal, who believed that role-play was the main technique in helping a person understand their predicaments (Weaver, 2009). The drama therapy sessions looked at the process as an avenue for letting out our depressions, unlike Artaud's theatre of cruelty in which Lee (2007) states:

> Artaud sought to remove aesthetic distance, bringing the audience into direct contact with the dangers of life. By turning theatre into a place where the spectator is exposed rather than protected, Artaud was committing an act of cruelty upon them (Lee, 2007:23).

This is the same theory that Augusto Boal used with a little difference in the objective of the process. That is, in role play, we exposed our participants into re-enacting their life experiences. However, the researcher agrees with Boal's technique more, in that role play as part of theatre is not an act of cruelty, but an act of allowing the oppressed to have another chance to review their experiences, to see themselves again and evaluate their actions as appropriate for them:

> **Role playing** is very efficient in group work. By working with particular stories and developing specific characters, rehearsing them and playing them to one another, role rehearsal takes place (Mitchell, 2007:45).

In regard to Mitchell, as the participants re-enact their life experiences, there is role rehearsal in that they get to have another chance to relive the circumstances they

have undergone (Mitchell, 2007). Thereby, a role rehearsal comes about in the belief that when they are faced with the same circumstance again, they will know how to react in a way that will not affect their relationships with others in a negative way. Or rather, they will react in a way that will enhance their associations now and in the future. For instance the participants who talked about being harassed by their peers for undergoing the rite of passage way after their peers had undergone the rite, would have the confidence to understand their peers, and therefore it is hoped that they will not get temperamental when faced with the same circumstances.

Mitchell's sentiments are echoed by Wilson (1998) who states that role playing is a successful approach to drama therapy as role reversal, in which a group of young people for instance, may take the part of their parents while the adults assume the roles of the children. In such role playing, both groups become aware of deep-seated feelings and arrive at a better understanding of one another, thus the forgiveness of their peers who lied to them about FGM. in the circumstance of those who went willingly, and in the forgiveness of parents or relatives; for those who were forced into the rite.

A range of insights and techniques derived from Psychodrama can be employed. Drama therapy is more genuinely dramatic due to the use of metaphor and fictional plots instead of straightforward autobiography. The distinctive characteristic of Drama therapy is the obliqueness of its approach and the creation of fictitious reality which enhances the client's involvement and identification with the drama

(Jennings, 1992). In comparing dramatherapy and professional theatre, Robert Landy states that "In dramatherapy...theatre didn't have to be anything, you didn't have to fit into any role, and you could be in fact any role that you needed to be or wanted to be" (Jennings et al, 2007; 170). In our dramatherapy sessions at AIC Girls Kajiado, we improvised anything and made it be. We could combine roles for example: teacher-student, father-mother, girlfriend-boyfriend, mother-daughter, grandmother -granddaughter… The girls could then choose any combination of roles and act them out. Such role-play did not take much time for preparation and rehearsal. The girls could pick their roles and act them at the spur of the moment. This spontaneity was encouraged by the researcher, because it gave room for more imaginativeness to flow freely, of which the imagination, there are bits and pieces of truth in relation to the participants real life experiences.

Averett Tanner (1995), elaborates;

> To participate in the illusion of reality both actor and audience must **suspend disbelief** and let their imaginations flow freely. However, an active imagination does not imply a lack of control. There must be control in the form of a second awareness that prevents the actor from getting carried away with the part. The importance of imagination is to bring to your mind detailed pictures from which you can create a unique and yet appropriate character. The pictures you visualize spring from your insight and your past life experiences. If your imagination is vivid, the pictures will stimulate you into acting, believing and feeling your part (Tanner 1995:57).

The improvisation in these role-play and skits then formed part of the discussions. It is important to note that not all of the skits were about Female Genital Mutilation. Some were just about ordinary relationships. All the role-play skits between two characters were not lasting more than 2 (two) minutes. However,

there were long skits of 15-20 minutes which the girls could decide on, take 2 (two) days to rehearse and then present to the researcher when we met. This was because the only free time they had was games time and we could not do everything within one hour.

In one of the sessions when we had the short one(1) – two(2) minute skits, two girls picked roles between girlfriend and boyfriend. In this they improvised an act of girlfriend meeting boyfriend. The boy was first seen on the stage and then the girl came and they greeted as the girl shyly held the boys hands. The girl and the boy then danced as they sang imitating the music is from a record player. The two then hugged and the boyfriend left the stage. As the girl was still on the stage and within the scene of the audience, the girl faced away from the audience and put a wrapped sweater in her belly, all the while pretending that the audience could not see her. She then faced the audience again and the boy came to the stage and on greeting her, pushed her away and in hand gestures, pointed to the belly and waved the hands in a manner to imply that he was refusing.

We then discussed what the role play was about, and the girls narrated that boys often lie to girls. That boys buy for girls sweet things like soda and cake and then they make the girls pregnant. Thereafter when girls get pregnant, the boys abandon the girls. Immediately after this role play, other girls wanted to re-enact a role of mother and daughter with her friend, to which we allowed them to proceed. In this skit, the mother was the first one on the stage, then the daughter came in with her belly swollen. The mother looked at the daughter and beckoned to her, and when

she had gotten closer, the mother beat up the girl and the girl ran getting out of the stage.

The discussion that ensued after this was about teenage pregnancy. The girl who had acted as a mother in the latter role play/skit, talked of the way her elder sister had gotten pregnant in High School and when she came home, her mother beat up her elder sister and the sister ran away and lived with the boyfriend and that is how her sister left school in Form Two and got married. She told us that before her sister got pregnant, she was highly pressured to undergo FGM so that she could be as good as her elder sister. Further, she stated that she had been coerced into believing that girls who had not undergone FGM were the ones who got pregnant out of wedlock. When her sister got pregnant, it brought a lot of tension between her parents who blamed each other for not training her well. It was even said that, going to school is what made her sister get pregnant, in that if she had gotten married earlier, she would not have gotten pregnant out of wedlock.

As another 14 year old girl in the group put it:

> I was also told that girls who do not get circumcised are the ones who get pregnant because they have loose morals and they do not respect elders or values of the society. After I got circumcised, I was also told that only boys should go to school, so I should get married, because going to school makes girls meet boys from other tribes who make them pregnant and cannot marry them.

These open role-playing without a focus on specifically FGM, was encouraged because the researcher believed that this would enable the participants to express themselves freely. It is by understanding the participants' other relations and

influences in thoughts and emotions, that we would truly understand their deep seated backgrounds and feelings towards FGM. As Dayton (1994) states, when exploring a role, an individual must explore the reasons, needs, underlying fears, and secondary gains that have led us to play that particular role. By allowing the girls to freely dramatize and talk about anything, the researcher thereby had the opportunity to select what she believed as important for her study, while at the same time, giving the participants the fulfilment of having aired their thoughts without discrimination or prejudice. Further, it is not easy to restrict any individual to talk about what a researcher may want, for it would only make the whole process like a directed and polished dramatic piece.

It was the contention of this study that by engaging the girls in certain dramatic roles or role-play activities, they could achieve a more peripheral view of their problems than merely talking out their issues. Perhaps the most significant aspect of the dramatic paradox concerns the notion that the actor and the role are both separate and merged, and that the nonfiction reality of the actor coexists with the fictional reality of the role (Landy, 1993). Therefore, each time the girls took certain roles, for example, imitating an elder, or parent or friends, we could ask why they chose to do so. One of the girls pointed out that imitating her father made her feel less angry at him (the father). This was because, when she acted as the one being forced to undergo the rite of passage, she felt very bitter because she could remember the pain she had gone through. Then on the day she acted as a father forcing a girl to undergo circumcision, for a moment she forgot her pain. And when she was talking with the others who were acting as the mother and the elders,

she felt a voice of authority and responsibility. After the role play, she felt that it was not really her father's choice to force her to undergo the circumcision, because her father did not understand the pain, and also because if the whole community hated her father and her entire family, the father would be called a coward and a fool for not keeping the social norms. Quite a number of girls both in the experimental and the control group were quick to point out that they were in their present predicament because of the stubbornness of their fathers. The failure of their fathers to recognize that the world was fast changing and their quest to maintain a higher status by keeping the cultural norms, values and traditions made most of them to continue endorsing in Female Genital Mutilation. This is a state that most of the girls; especially those who had been forced, regretted. In the same vein, the respondents were asked to rank who bore the greatest responsibility regarding FGM - that is who in their belief promotes FGM in their family. The findings are as shown in the Figure below:

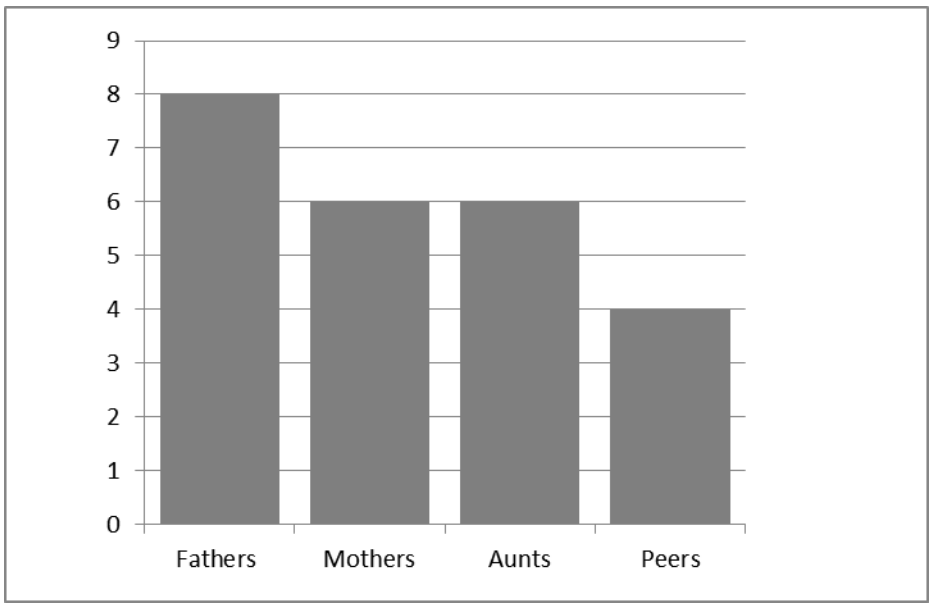

Figure 4.0 Ranking of who bears FGM responsibility

As shown in the graph, 9 girls in the experimental group believed their fathers bore the most of the FGM responsibility. Mothers and aunts took equal responsibility, with peers taking the least of responsibility. This was because, most of the girls believed that it was the respective father who wanted to keep the traditions. The mother was regarded as the next person because the mothers wanted to uphold their family status and, further, they respected their husbands and the elders. The mothers were also in fear that in case anything wrong happened in terms of the girls' upbringing, they would be blamed. For instance if the girl is to get pregnant out of wedlock, or to get married to a man who is not of the tribe, then the mother is the one who is blamed, and sometimes, she is even beaten up by the father, who does not want to bear any responsibility to failure. The aunts also bear almost the same responsibility as the mothers, because they are like mothers to the girls, and more so, according to the Maasai culture, the aunts are the ones to teach the girls about their responsibility in the community. The peers (hereby referring to elder sisters, cousins and friends), bear some responsibility too, though quite a little. This is because, when a girl proves to be stubborn, the elder sisters are put accountable for frightening the girl with stories that make the latter refuse to undergo FGM.

While in role play, the survivors were also asked to identify those who gave them greatest to least pressure for undergoing FGM. The findings were as shown in the Figure below:

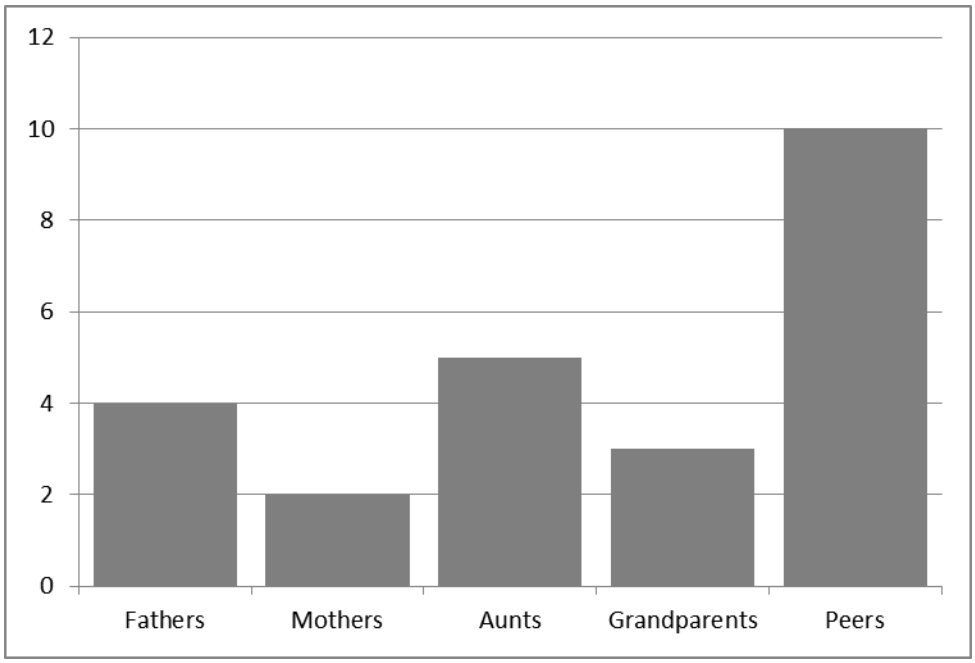

Figure 4.1: Ranking of those bearing the Greatest Pressure for FGM.

It is worth noting that the order has changed from the previous ranking. This indicates that most fathers would want their girls to undergo FGM but they do not pressurize as much. The few fathers who pressurize, do so to uphold their status within the community as to being able to respect the communal norms and values. Peer pressure is one major reason as to why many of the girls decided to undergo FGM. As in the chart, ten (10) out of the twenty four (24) girls in the experimental group stated that most of the pressure come from their peers. Majority of the girls undergo FGM for fear of being isolated, mocked or laughed at by their peers who have undergone the cut. This is simply because as a group of girls, they all want to be honoured and respected in the community, and when one of them doesn't follow the customs, pressure is put on their peers. Thus the peers also incite their uncircumcised friends to undergo FGM. The aunts pressurize the girls with threats of being a bad influence on others and being a shame, whilst the grandparents

pressurize the girls with myths on what will happen or become of them if they did not get circumcised. The myths are discussed in the next section of this chapter. The mothers on the other hand pressurize the girls by luring them with gifts that they (the girls) will receive if they undergo circumcision or by giving their circumcised siblings gifts in order to make the others envious so that they finally undergo the rite of passage.

Within the rescue centres as their setting, the girls would partake of various role play activities. The activities enabled them travel outside the rescue centres, interact with their siblings in role-play. The girls' actions affirmed Wiener's supposition that role-play and theatre improvisation encourages exploration of alternative stories and meanings, particularly those concerning the multitude of relationships in everyday life (Wiener, 1994). Through role playing the girls were therefore able to manifest their real manner of interactions with the people in their lives like peers, parents and elders, while relating this to their past experiences. The spontaneity also required a lot of imagination, and co operation between the participants, especially when the act involved more than two participants in a scene. As McNiff (2007) posits, imagination, far from being a frivolous and egocentric activity, is the intelligence that humans use to understand relationships and others. The participants therefore had to control their egos in selecting what story to act out especially when each of them felt their story was more interesting. For instance, when role playing the part of a grandmother and mother, there was once an argument on what kind of mother should be acted. The two girls were undecided whether to act out a mother who supports FGM or who doesn't support

FGM. As a researcher, I got to know there was a decisions struggle because they took too long to prepare their skit, and when they got onto the stage, they were still whispering to each other. As a researcher, I told them to do both so they can choose which one to start with. They acted out a skit where the grandmother was quarrelling the mother for having taken the daughter to get circumcised in the clinic, citing that it is against the customs. To support this statement Dayton (1994) states that, Drama games make action-oriented role-playing methods available to a wide variety of people in many settings. This implies that with these games, the participants had a variety of choices to make in order to express their thoughts on various issues freely, creating any setting that they wanted.

In role-playing, the girls went beyond mere enactment and improvisation of their experiences. For example they did not only dwell on the experiences of FGM but went further to enact scenes of forgiveness for those who had wronged them. In this way, the girls were able to declare that they had forgiven their fathers, mothers and whoever had forced them to undergo FGM and in the process thanked those who came to their rescue and had given them a place to live.

Through the girls' actions, facial expressions and release of emotions, the girls were able to act, while at the same time, find a comfort in the reaction of those they perform with, thus therapy took place. To be able to see oneself, undergoing through the same situation, and/or being the other whom one held painful sentiments because of past experiences, allowed the release of built up emotions like we have discussed in some of the stories in this section of the chapter. This

reenactment led to some of the girls forgiving those who wronged them and thanking those who gave them shoulders to lean on, thus we see how the art of transformation is central to drama therapy.

4.3.6: STORYTELLING

Storytelling is one major approach to drama therapy. Stories are just not for entertainment. Indeed, as Wiener (1994) points out:

> Individuals develop habitual patterns of self-referential storytelling, leading to the impression of a consistent self-image; put into theatrical terms, we develop one or more characters, operating within a limited range of plot choices (1994:89).

In this regard, storytelling has the power of revealing truths about ourselves, of helping us set directions and choose role models, and of debating the entire question of the nature of right and wrong. Rosenstand (2000) in stressing the importance of storytelling argues that if we in troubled times, can remember stories and hold on to their lessons about humanity, then we have a weapon against giving in to despair.

The Storytelling Technique in drama therapy was developed by Richard Gardner in the 1960s (Bauman, 1986). Storytelling, like play, communicates with children at multiple levels. Stories serve as models. They teach values and skills, and can provide insight on both the conscious and unconscious levels (Bauman, 1986). The Storytelling technique uses the child's language to introduce mature responses and

healthier resolutions to the child's difficulties, as they are communicated in the child's spontaneously produced stories.

Storytelling is drama. In storytelling just like drama we have characters who imitate voices and paralinguistic features. We can imagine a given picture so vividly depending on our past experiences, and thus react as though we were there in the moment. A thrilling story captures the listeners mind and body and takes them to the space where the real action took place. Bauman (1986), emphasises the way that storytelling enacts the poetic function of communication since a storyteller is not valued by an audience simply for the information or message that the performance conveys. On the contrary, it is the storyteller's ability to make a report of events into something remarkable, memorable, and worthy of appreciation and a response that draws the audience's interest. In support of Baumann, we believe that in storytelling, communication is productive; that is, storytelling makes something special, something poetic, out of what might otherwise be a prosaic or mundane message.

As drama therapy, storytelling allows both the participant and the listener to revisit the event and the space, while at the same time feeling safe in this re-visitation, because of the awareness of a shared experience. This removes fears, pity, sadness and any negative feelings associated with the experience. This is when therapy takes place. For instance, when one of the girls narrated her experience of how she escaped from getting married and walked a long distance before being helped by some samaritans on the road who brought her to AIC Kajiado *(story elaborated*

under the subtitle of Games), she relived the experience with more courage because of the trust that she had developed within the group. The more the group talked together and shared without feeling humiliated because of their past, trust developed among them. Stories activate memories and imagination and when the story is captivating, in that if we can relate to it, then we are able see ourselves in the part of the characters.

Storytelling is part of drama as much as drama is part of storytelling. Storytelling like all dramas also have a plot, which is the basis of the story, thus drama and stories are inseparable. Storytelling as a technique of drama therapy, therefore, intrigues the listener, who becomes a participant observer by responding actively in the storytelling session. The active involvement of the listener and the sharing of the performance space by both, reduces the distance between the performer and the listener. For a moment, it feels like both are in the same situation, sharing one and the same roles in the story and in the storytelling and storymaking.

In childhood, stories often provide a shortcut to our understanding of the moral issues involved. Such stories can help us understand ourselves and our world better by providing a cleansing effect, an outlet for our emotions as well as broaden our horizons to include the life experiences of others. Rosenstand (2000) in her book *The Moral of the story*, tells of the benefits of stories, that often real life is too complex, too obscure, too embarrassing or too private for events to serve as examples. No matter how well life can teach us a lesson, the fact remains that most of us like stories. We like to read, watch movies, and sometimes a story stays with

us and becomes a part of our world view. If the story has a moral, then it becomes a tool for learning, teaching and discussion (Rosenstand, 2000).

Our storytelling sessions took different directions during the various sessions. Sometimes they were more of forum group discussions even though at times it was more like a game. Sometimes, we would pick a topic and discuss about our personal experiences and opinions, with each person being given a turn to speak. Sometimes, the topics we talked about were very passionate about home and family. Sometimes, they were about FGM, about the games and the warm up sessions. Every session was different. There were times the researcher prepared a topic for the group discussion and it would take a different turn once the girls started talking, and we could let the topics flow, making the discussion longer and consequently covering even other related topics.

During one of the sessions, for instance, the researcher had planned to discuss the advantages of FGM. The girls discussed this topic and then went ahead and talked about the FGM procedure and the myths associated with it. On this occassion, the researcher wanted to know if the girls considered FGM as advantageous or not. The discussion began with laughter for the question was very unexpected. One of the girls thus started talking about the gifts that they receive after the FGM, to which another girl said:

> That pain is so unbearable that you cannot even enjoy the gifts. I was in so much pain that even the sodas *nilikuwa ninaangalia* tu (I was just staring at the sodas). By the time my body had healed, I was so angry at my friends for lying to me...I don't even want to remember.

This then led another girl to tell us about her painful ordeal in undergoing the circumcision. She narrated her story on how she felt weak and almost fainted until her mother started wailing in the belief that she was dead. When she woke up, she was numb and had to be lifted. She didn't even want to eat or laugh because she felt as if her whole body was shivering and swollen and painful even to the touch of a surface. These discussions went on, with some girls chipping in with exclamations and phrases to help the narrator elaborate a point as vividly as possible to the audience.

The researchers realized that the pain was more engrained in the minds of these young girls than anything else. It seemed that the benefits for these young girls was simply the gifts, for in an instant, there was barely any other mentions of other benefits. Different girls stated how, some of them had bled a lot, while others stated how the gifts did not make a difference because they could not urinate well. For those who had undergone circumcision by a health care provider, the procedure was different. One of the girls, 11 years old, stated how she healed in just two days and she could walk from day one:

> Sikuona nyama ikitolewa, alikata tu kidogo na wembe" *blushing.* "I left the hospital the same day jioni and went home with my mother. Sikubleed sana. Niliwekewa tu pad moja yenye nilipewa hospitalini.

This translates to:

> I did not see any flesh removed. They just pricked me with a razor" *blushing.* "I left the hospital same day evening and went home

> with my mother. I did not bleed a lot. I just used one sanitary towel, which I was given at the hospital.

The researcher, who in this case was the drama therapist, also told her stories. Sometimes, when the girls talked about a topic they could ask about the researcher's life too and she was obliged to tell them what they wanted to know, this made them feel secure in the researcher's openness and in knowing that they all shared their deep secrets. Some of the topics they asked about were: how it feels to give birth without undergoing Female Genital Mutilation. The researcher told them her own experience and one of them, having had birth, also narrated her experience.

We began most of our storytelling or story making sessions by telling a joint story. This was like a game: Every participant say one or two word or sentence to connect it to another word until it becomes a long story… most of the stories ended up being about home and school with teacher, grandmother being key persons in the story. An example of such a story of two words goes as follows

> I was-walking on-the river-and then-I fell-on top-of a crocodile –and then-I saw- my mother-screaming loudly-and then- I ran back-to the-river bank-my mother-was crying-she caned me-I ran home-and then-my brother-saw me-crying to-my father-who was-grazing cows-Full stop- I said-how crocodile-almost ate-me at-the river. I saw – my grandmum – cooking food- sweet food- meat and milk-I went – drank milk- my mother – found me – and beat – me up – for drinking –baby's milk – I cried – saw the- thin dog – and ran – to my father –and then – the dog – chased me – and then – my brother – chased it – because of – it ate – the food...

At times the story could get mixed in between and we had to trace where it got broken, or we end up starting another story all together. Further, some of the girls could put three words, when it was supposed to be two words. This was because of instances where some of them thought that the word was too short, some also thought that two word phrases counted as one word. They thus had to be given another chance to re do the sentence.

Storytelling involves both the making of a story and the making of an event of telling. A person becomes a storyteller by making a story or a narrative out of the events of experience. In this regard, the girls as storytellers narrated their stories in turn as we all listened. Different girls spoke during different sessions. Sometimes only one girl could narrate her story, and sometimes we even had more than one narration. Our storytelling sessions usually took place after the warm-up, the games and sometimes after the dance sessions. Storytelling was for us the Focus Group Discussion moment. Thus, storytelling was part of the many drama therapy ways of having the girls to speak out their experiences.

Despite quite a number of the girls getting enthusiastic with time about sharing their stories, there was an incident when the researcher felt challenged. On this instance one of the girls Betty* (not her real name), said she had not been circumcised. This put everyone in silence since most of the girls had openly talked about why and how they had undergone the ritual. When she refused to share, there was a dilemma as to whether she should be told to leave the room or to go on with the drama therapy session. The researcher was left wondering if Betty* was just

being rebellious or not, while on the other hand. We could not tell her to prove it to the group, since it would infringe on her privacy. We just had to trust what she was saying. It was a complicated and an awkward situation for the whole group. The other members of the group believed that she was circumcised since some of them came from the same home area. The researcher allowed her to continue with the participation and told the girls not to pressurize nor humiliate her, insisting that each of us can only share what we feel free to share. At the end of the session, the researcher tried to talk to Betty, if she had anything she wanted to share, but Betty shrugged her shoulders and left the room. Despite allowing her to continue with the participation, she came in for just two (2) more sessions and then stopped coming. Since the whole drama therapy was a voluntary initiative, the researcher did not insist on her to continue.

Storytelling also includes non-verbal language and gestures. And therefore, when Betty* did not want to share with the other girls, when she shrugged her shoulders and left the room, she was allowed to have the freedom to communicate her feelings through silence. Perhaps she was just shy, perhaps she felt her oratory skills were not as good, or perhaps she just had not reached that point of being able to let go. To tell a personal story, one must first free oneself from all fears and inhibitions and find trust in the people with whom one wants to share the story. Richard Bauman underlines the essence of storytelling:

> It resides in the assumption of responsibility to an audience for a display of communicative skill, highlighting the way in which communication is carried out, above and beyond its referential content (1986:3).

In this regard, storytelling involves skill. It needs one to feel obligated to share with an audience, so as to receive some feedback. This display of skill in expression calls on the audience to go beyond appreciating the story to evaluating the ways in which the storyteller enhances experience. As Bauman (1986) suggests:

> Every performance will have a unique and emergent aspect that sets it apart from the conventions and structures that make it possible (1986:6).

The audience and storyteller take up these existing resources to turn back and communicate about them. For instance, the procedures of FGM, may be similar in the Maasai tradition. But every girl's narration of her experience, will definitely sound different because of the details that each highlighted in their story.

Therefore, through stories, the girls narrated to the other participants, events that took place, the process of FGM, the occurrences thereafter and how some of them escaped the FGM ordeal. Some of the stories that the girls recounted seemed new to the other girls as they might have not shared before. The stories and the vividness with which they were told, got better with every succeeding drama therapy session. Since much of the story telling sessions took place after other drama activities (that is, the games, dances and role play sessions), they served as the focus group discussion sessions. This was the determining factor on whether the drama therapy sessions were effective or not. It further enabled the researcher to assess the level of openness of the participants after the drama activities, by assessing how rapid, open and honest the participants were. The validity of what

the participants discussed in the experimental group, was further verified by the information gathered from the key informants.

4.4: CONCLUSION

This chapter analysed the different techniques and the modes in which they were used to achieve the objectives of the study. It has discussed in detail how every drama technique was carried out and the scope in which they were done in terms of variety. The next chapter seeks to analyse how effective each process and technique was to the achievement of the aim of the study, in unlocking the silent voices of the participants.

CHAPTER FIVE

EFFECTIVENESS OF DRAMA THERAPY AMONG SURVIVORS OF FEMALE GENITAL MUTILATION

5.1: INTRODUCTION

This Chapter presents an evaluation of how effective the various drama therapy techniques used were effective in helping the girls open up and express themselves freely without fear. To this end, this Chapter examines whether drama therapy was beneficial to the survivors of FGM and in what ways its usage enabled survivors to talk about their lives. These findings are discussed in the following order: first, unlocking the voices of the survivors of FGM by analysing the range of topics that the girls were able to discuss freely; second, the empowerment of the girls as a result of the drama therapy sessions.

5.2: UNLOCKING THE VOICES OF THE SURVIVORS OF FEMALE GENITAL MUTILATION

It was the contention of this study that drama therapy is a systematic and intentional use of drama/theatre processes, products, and associations to achieve the therapeutic goals of symptom relief, emotional and physical integration, and personal growth. In The Handbook of dramatherapy, they refer to the British National Dramatherapy Association definition of dramatherapy as an active

approach that helps the client tell his or her story to solve a problem, achieve a catharsis, extend the depth and breadth of inner experience, understand the meaning of images and strengthen the ability to observe personal roles while increasing flexibility between roles (Jennings et al, 2007).

Drama therapy created a safe and playful environment where the survivors were able to act out anxieties or conflicts due to FGM trauma or other related issues in their personal lives. Some of the participants had their emotions evoked and their anxieties and fears were expressed and at the same time, the stigma related to FGM emotions expelled.

5.2.1: Effectiveness of Role Play on Forgiveness

In using techniques such as role playing and improvisation, the participants acted out various confrontations with their parents and other people who influenced their lives, on issues regarding FGM or personal events, such as punishment scenes where the girls were chastised for their weaknesses. In one of the instances on role playing the girls acted out **a classroom scene.** In this scene, about five girls sat on a bench and the teacher came in, stood in front of the class and greeted them. The girls then stood up to greet the teacher except for one of them who just sat. (It is customary that in most primary schools in Kenya, the pupils stand up to greet the teacher.) The teacher then reprimanded the girl who had not stood up and told her to kneel down in front of the class. The teacher then taught the class Mathematics and gave them an assignment and left the classroom. The girls also left the

classroom and were seen gossiping that one of them had started her menstruation. The girls then bid each other bye and went home. The following day (in the role playing), only three of the girls came to class. The teacher then came in and asked the whereabouts of the other girls. The girls in class then giggled and whispered, as one of them told the teacher that those absent had gone for circumcision, as another hinted that only one had gone for it while the other was getting married off. The teacher then dismissed the class saying she must do something.

After the enactment of this scene, the girls and the researcher had a discussion on what kind of punishments they were usually given, and further on what the teacher did to assist the girls who had missed school because of FGM and early marriage. On the issue of class punishments, the girls stated that they got punished by kneeling down in front of the class for the duration of the whole lesson. Sometimes, they were commanded punished to go and clean the staffroom or the dormitories. The girls stated that nowadays they were not caned, but the manual punishments were worse than caning. This is in line with the new Kenya Constitution (2010) under Article 191 of the Childrens Act and Article 29 of the Bill of Rights that bans caning and any act of cruelty in schools. One of the girls stated that one day she was ordered to pick all the litter in the whole school compound and it took her the whole day. She therefore, missed all the classes. This was because she had overslept and had got late for parade. Another girl revealed that she had to clean the latrines because of noise making. This made her feel very bad because she hated the smell of latrines and it made her feel disgusted with the class prefect who had written her name down, She felt like beating up the

class prefect after the punishment, but she did not want to get into more problems with the school authority. The researcher then asked her what she would have wished to do for the class prefect now. Her response was that she wished the class prefect could also be punished one day because most prefects do not get punished at all. Coincidentally, the class prefect was in the group, and the situation was one of the first for us, to have a real life confrontation.

The researcher then asked the two girls to stand up and act out **a role play-role reversal** scene. In this case, the prefect became the subordinate pupil, and the punished girl became the prefect. In this **Punishment scene**, the girl as prefect, told the girl as subordinate pupil to kneel down and say the words 'I am sorry for Punishing you' ten (10) times. Hesitantly she said the words. The girl told her to ensure she cleans up the latrines, to which the prefect acting as subordinate pupil refused. She said that the other girl was punishing her too much. That she had already said sorry ten (10) times and yet she was still being told to clean the latrines. She stated that it was not her wish to punish anyone in class but that was the rule. In that if she does not have a list of noise makers then she gets punished instead. The girl then apologised for over-punishing the real prefect, but she was glad the latter now understood what it felt like to be punished, especially when it was repeated over time. The prefect also stated that the other pupil is always a noise maker and that the other classmates always complain. The girl then apologised for making the work of the prefect difficult and promised to be good in class and would reduce her noise in class. It was very astounding to see the other girls see in disbelief how the prefect was being punished, as some of them laughed

at the reversed roles, some of them thought that the punishment was not adequate, while some thought it was too much. Three weeks later, the researcher asked the group if the girl had reduced her noise making and they said that nowadays she was less rude in class. She now even asked the prefect for permission to speak if she needed to whisper anything to anyone.

Through dramatic re-enactments such as improvisation and role playing, the participants gained new and valuable perspectives in their lives. Looking into one of the example we have talked about, in the role play and role reversal of a pupil and the class prefect. The class prefect was able to be in the shoes of the subordinate pupil and thus evaluate the punishment that she made the girl get. The subordinate pupil was also able to re access her behaviour towards the class prefect. This action in drama therapy session as was confirmed later, made their relationship better and more harmonised. This technique of role play as part of dramatic therapy was important here as the girls were able to show that regardless of what had transpired them, they could still afford to forgive each other.

These scenes enabled them to see that they were not alone in their anger and grief, while also helping them tolerate the emotions associated with their sad memories of FGM and other related practices.

5.2.2: Effectiveness of Dance in breaking self boundaries

Other techniques that proved very effective in unlocking the voices of the girls were dance and music. The use of dance, body movement and music as drama therapy devices are predicated on the idea that one's negative, emotion-laden experiences are represented in the body in the form of tension and pain. In the same vein, dance therapy is based on the assumption that body and mind are interrelated and is defined as the psychotherapeutic use of movement as a process that furthers the emotional, cognitive, and physical integration of the individual. In this way, dance and/or movement therapy affects changes in feelings, cognition, physical functioning and behaviour (NCCATA, 2004b). Dance and drama therefore go hand in hand in that both communicate using gestures, facial expression and movement.

Music and dance, can sometimes be even more effective than dialogue drama, because the participants' non-verbal cues and gestures are often relayed as of a stronger message. For instance when someone says they do not want something, and yet they are stretching their hands or moving closer, and smiling, then their message being relayed in action is often regarded as the more powerful message, and in this case, no matter how much one says no, it will be construed that they are accepting. The unconscious is always relayed in the movement of the body, the gestures and facial expressions, even when the words defy.

Dealing with the FGM trauma among the survivors involved physical processing so that unconscious conflicts could be brought into one's awareness. Therefore, in our music and dance therapies, we began with teaching the girls how to breathe, how to relax, then making simple movements and further increasing movement and contact with others. As the girls progressed with music and dance, we conducted focused group discussions in between dance. In the process, we realized that the more the girls danced freely, the freer they were to talk about their traumatic experiences.

Indeed, the truism of this supposition was realized during our music and dance sessions. While enjoying the dance moves, the girls narrated how they underwent FGM, wanted to escape, the obstacles they found on their way and how they finally escaped or were rescued from FGM. The girls talked about the various reasons why they underwent FGM. While some reported that it was their choice to undergo Female Genital Mutilation so that they could be like their cousins or friends who had undergone t, otherssaid they we practice, others confessed that they had been forced into it.The girls at AIC Girls Kajiado had different reasons for undergoing FGM as the following Table suggests:

Reasons for Undergoing FGM	No. of Girls	Percentage of Girls
Personal choice due to Peer Pressure	10	41.67
Personal choice due to Parental Pressure	4	16.67
Personal choice due to Fear of Myths	3	12.50
Personal choice due to Allure of gifts	2	8.33
Forced and threatened	5	20.83
TOTAL	**24**	**100**

Table 4.4 Reasons for Undergoing FGM in the experimental group.

Reasons for Undergoing FGM	No. of Girls	Percentage of Girls
Personal choice due to Peer Pressure	4	16.67
Personal choice due to Parental Pressure	6	25.00
Personal choice due to Fear of Myths	3	12.50
Personal choice due to Allure of gifts	1	4.17
Forced and threatened	10	41.67
TOTAL	**24**	**100**

Table 4.5 Reasons for Undergoing FGM in the control group.

Those who underwent FGM out of their personal choice said that their parents neither coerced them to undergo Female Genital Mutilation nor stopped them when they insisted. Ten (10) girls said they underwent FGM due to peer pressure. Stating that their parents had tried to talk them out of it, but when they (the girls) insisted they wanted to undergo Female Genital Mutilation because of the pressure and discrimination they got from their circumcised cousins and friends during the school holidays, their parents willingly took them to get circumcised.

One of the girls in the experimental group stated that she accepted to undergo FGM because of peer pressure. Since all the friends in the village had already undergone Female Genital Mutilation, they started disrespecting her and she became a point of gossip and a laughing stock. She narrated how she could not go to the market or the river in the company of her circumcised friends. Yet, those who had not been circumcised were younger than her. Thus, she felt she could not join them either. This made her feel very isolated and lonely during school days. She therefore felt the need to belong and that is why she went and got circumcised too.

For two(2) of the girls, undergoing FGM was because they felt that their friends and cousins were given special treatment and gifts during and after the circumcision so they also wanted to get that special treatment. They were more envious of the gifts that one got after being circumcised like new clothes, shoes, cakes and sodas. One of the girls said she received a goat from her grandmother, a new bag from her mother and a pair of shoes from her father. Another girl, though having a different reason for undergoing FGM, stated that her elder brother could now allow her to play games using his phone, and that made her feel really special.

These sentiments were echoed by most of the girls with some saying it is because they believed it was expected of them to get circumcised, after being coerced by their parents and aunties and they did not want to refuse.

In the control group, ten(10) girls against five(5) girls in the experimental group, stated that they underwent FGM because they were forced and threatened by their family members. These were their parents, aunties and uncles and grandparents. Therefore they feared being outcasts from their home and village. Further, in the control group, only four(4) girls against six(6) in the control group stated that they underwent FGM because of parental pressure. Most of these girls in the control group,stated that it was their fathers who insisted that they undergo FGM. The six(6) girls in the experimental group however stated that it was their mothers who kept coercing them to undergo the practice. One of the girls cited how her mother kept crying to her that she (the girl) wants to bring shame to her home and that it is

her mistake that she (the mother) allowed the father to take her to school. She told us how on one incident her mother told her not to touch her necklace because she is unclean. The mother then gave the necklace to her elder sister who had been circumcised and that made her feel very jealous. She was not even allowed to cook for her father because she was a shame. But the father, on his part, never reprimanded her for failing to go through circumcision.

One other girl in the experimental group, however, stated that she heard her father quarrelling and insulting her mother because she(the girl) had not been circumcised. This open confrontation against her mother made her feel very humiliated and she subsequently talked her mother into allowing her to go through the circumcision. Yet, her mother wanted to protect her. But on her insistence, she arranged everything and the girl was circumcised.

Parental pressure is thus quite evident in both the experimental group and the control group. According to adult key informants, it is understood that it is the mother who initiates the FGM process because it is the mother who informs the father that their daughter has now reached the initiation age following the onset of her menstruation cycle. Subsequently, it is the mother who organizes the ceremony with the circumciser. This can happen when a girl is as young as eight (8) years old. The key informants believe that no matter how much the father insists on circumcision, the mother can always get a way of shielding their daughter, even by taking her to a local clinic, then alleging that the operation was done. It is the mother who can decide whether the girl gets a severe version of FGM, that is,

clitoridectomy, or infibulation or excision or a simple pricking on the clitoris. It is the mother who can decide whether to take the girl to have the procedure by a nurse or have it doneat home or at the circumciser's. All the key informants further stated that it was the mother who could influence the girl's choice by telling the daughter about the disadvantages of FGM so as not to undergo it.

One of the key informants stated that due to public demand in the local community, coupled with the Governmental and Non-Governmental Pressure not to practise FGM, the government certified traditional mid-wife attendants, who are regarded as nurses, do the circumcision for parents and girls who demand it. However, they do a mild version of clitoridectomy, which is pricking the clitoris, to satisfy the girl. This is most often in cases where the girl is the one who insists and the parents are not willing. In cases where it is the parents who are willing the procedure is usually done at home, by a a traditional circumcisor.

It is imperative to point out that dance and music as dramatic therapy techniques have proven their value in unlocking the voices of FGM survivors. Although it is difficult to quantify the benefits of these techniques in unlocking the survivors' voices, findings in this study show that music and dance were generally helpful in enabling the girls to relax as they recounted their stories. These genres made them feel energetic, enthusiastic, and they enhanced teamwork and cooperation among the participants. Through music and dance it was noted that the girls were ready and willing to learn from each other and relatively teach each other a new dance move. Therefore it also increased the girls' creativity and imaginativeness during

the role play sessions. As a warm up or as the main drama therapy activity of the day, music and dance proved to be the easiest tool to utilize with the girls. Music and dance as a warm up activity before the storytelling sessions, made the girls at ease with themselves, it broke boundaries for instance of fear of touching another, or looking at another person dancing. Consequently, the removal of such fears and inhibitions translated into the participants feelings about each other. It made them become freer and open about their personal experiences.

5.2.3: Storytelling and games and self exploration

All therapies by their very nature and purpose, encourage individuals to engage in self-exploration. Expressive therapies encourage not only self-exploration, but also use self-expression through one or more modalities as a central part of the therapeutic process. Gladding (1992) notes that using the arts in counselling may actually speed up the process of self-exploration and that expressive modalities allow people to experience themselves differently. He adds that through these forms of self expression, individuals are able to **'exhibit and practise novel and adaptive behaviours'** (1992:6). Therefore, the music, the games, the exercises and dances, together with the role playing gave room for the participants' self-exploration and thereby found a source of comfort in the stories of each other.

Self-expression through a painting, movement, or poem can recapitulate past experiences and even be cathartic for some. However, these are only two aspects of the role of self-expression in therapy. In fact, most therapists using expressive

therapies in their work capitalize on the ability of art, music, play, and other forms to contain self-expression rather than to encourage cathartic communication of raw emotions or mere repetition of troubling memories. In essence, as therapist and client work together, self-expression is used as a container for feelings and perceptions that may deepen into greater self-understanding or may be transformed, resulting in emotional reparation, resolution of conflicts, and a sense of well-being.

The sharing in the games, the dances and the re-enactments in the role playing thereafter gave the participants a chance to experience their pains and fears one more time, to have the confrontations like they had supposedly wanted to in their minds. Which in this aspect, is what we refer to as therapy – to find an answer, to heal, to find comfort, to remove gaps and build bridges and to be able to move on with focus, confidence and greater vision by forgiving and letting go of past hurts and pains.

Drama therapy as a form expressive therapy tries to facilitate discovery of personal meaning and understanding. For this reason, drama therapy sessions involve the use of various dramatic techniques in order to help individuals make sense of their experiences, feelings, and perceptions. While words are generally used to tell personal stories, drama therapy taps the senses as a source of stories and memories since thoughts and feelings are not strictly verbal. Through various techniques such as storytelling, dance and role-play, drama therapy was useful in helping the

survivors to open up and talk about aspects of memories and stories regarding FGM that they would not have been readily willing to talk about.

For instance, all the participants in both the experimental and control groups, together with the key informants indicated that they experienced pain during and after the circumcision. All the participants admitted to having unbearable pain during the process of circumcision, followed by vaginal bleeding and exhaustion. They also talked of pain during urination and admitted to having an itching pain in the vagina to which they were advised not to scratch as it would make the wound take long to heal.

According to one of the key informants, some of the implications were as true as the young girls stated: One of the Key informants states of the process:

> It's a pain of death, to cut someone like a cow or a goat is very painful. Its pure pain, someone wails and cries all day. One cannot walk well, One cannot urinate, it is pure torture.

One of the girls in the experimental group said she bled until she fainted. When she came to her senses, she was given milk and liver. She ate a little then it made her feel like going to the latrine. However, since she could not walk, she relieved herself on the spot. Her mother had to come and clean her up. She was only able to walk after three days with the help of her elder sister and mother. Hence, for three days, she urinated on herself and, the urine itched her wound. The process of urinating was unbearable making her hold the urine, on holding the urine, and endeavour that came with pressure thus more pain. Later she had a 'bladder

infection' medically referred to as Urinary Tract Infection (UTI), as she and her mother were later told by a doctor. This sentiment was further echoed by another key informant in a different site, a 57 year old Maasai woman:

> The truth of the matter is there is no torture like that, you go and cut someone in a bad place, the private part (vagina), then it becomes a wound, she continues to get sick, she continues to feel pain and can't walk…at my age now, I wouldn't accept.

Another girl in the experimental group also said the pain was unbearable that she found herself vomiting repeatedly at the sight of blood. She vomited before and after she was circumcised and anytime she saw blood that day. This made her stitches more painful because whenever she vomited the pressure made the vaginal wall that had been sown to stretch:

> ...unajua venye ukitapika unaskia mpaka huko chini, sasa hiyo sikuni kama times 10 nakwambia, aiaiaiai, nilitamani nisitapike, lakini nikiona damu, ndio hiyo inakuja, nilichoka nikatamani singeenda kwa sababu sikulazimishwa.

In English this translates to:

> ...you know how when you vomit you feel it until down there. So, on that day,it is like ten times, I tell you. Aiaiai(yelling), I wished I didn't vomit, but whenever I saw blood, the vomit came.I was tired. I wished I had not gone(for circumcision) since I had not been forced.

In one of the sessions, one of the girls narrated her long term ordeal in escaping Female Genital Mutilation, with the help of her mother. She explained how she escaped three times in vain. This statement was originally in Swahili. *(See Appendix 7.)*

She had tried to go home severally and the last time, her father wanted to marry her off. However, the Chief helped her not to get married to an old man and this led to her father cursing and disowning her and her mother. She (the girl) now lives at the rescue centre and her mother occasionally comes by to see her without the knowledge of her father.

In an unconditional atmosphere, drama therapy helped the survivors to regain their self-confidence through the performances that we enacted. The girls were able to build trust and teamwork: things that were missing in the girls' lives and which played an important part in their healing process. They were given the chance to participate in a playful and spontaneous environment, which stimulated the stepping forth of their otherwise dormant innate creativity.

Participating in drama therapy allowed the girls to see themselves in a different light independent of the stigma associated with FGM. Through the performances, the girls regained their courage in overcoming their troubled past. In fact, one of the girls stated that the performances "made me feel stronger about myself…not to be afraid of doing what is right even if it is against society and to stand up for myself." This demonstrates the positive therapeutic effects that drama therapy had and how it helped the girls find their voices in the society.

Through drama therapy, the survivors were able to openly talk about myths associated with Female Genital Mutilation. One such myth that the girls in the

experimental group talked about during the storytelling and focus group discussions was that they were told that if they do not get circumcised, they will have difficulty giving birth because the clitoris will cover the vagina thus it will stop the vagina from expanding wide enough to allow for the baby to pass. One participant further stated that she was told that the clitoris would make her stomach and anus tear up (obstetric fistula) during giving birth, of which the reverse is true. To confirm this myth the researcher asked the key informants about the truism of the myth, to which one of them explained that it is not easy to give birth vaginally and that because of circumcision, the vagina does not widen evenly during birth and they only manage to deliver because God loves women.

Another Key informant, an educated and working Maasai woman, explained that fistula tearing and over bleeding are the most common effects associated with FGM. This is especially in cases where the girl is still too young and her hips are not yet enlarged, and also because during circumcision, the incision is done from the front (clitoris) towards the back (anus). This further weakens the pelvic floor muscles, as they are attached to the anal skin and so the elasticity is weakened. This is a common problem which the society looks at as normal. The girls get even third degree tears and they (traditional birth attendants) consider it quite normal and sew it up just like they do sew the vaginal opening during circumcision.

One of the girls who had given birth in the experimental group narrated her ordeal on how FGM made her life unbearable. After circumcision, she was forced to drop out of school in class five (5) and married off to a man older than her father by

over 20years. Her mother tried to protest but it was said that it was the rich old man who had been paying her school fees as part of her dowry. Soon she got pregnant and on giving birth, she split from front to back and had a 3rd degree fistula tear. The traditional birth attendants who helped her to deliver, said it was normal and they stitched her up like they did after the FGM. Almost a month later she started getting fevers and pains in her abdomen, and her bleeding kept coming back and forth. This prompted her mother to rush her to the hospital. She was later treated and her fistula operated on well. The old man was mad at her mother because he had to sell two cows to pay for her hospital bill. After her recovery, she went home to stay with her mother and thereafter when her child was around six (6) months, her aunt took her away and brought her to the rescue centre.

Another girl elaborated how the grandmother told her that the clitoris would grow to be so long that she would not be able to walk as it would be flapping in between the thighs. According to a key informant in Narok, this was confirmed to be one of the myths. She stated:

> It is believed that the clitoris will grow so long that it will interfere with the man's sexual enjoyment...and it (vagina) is further sewn to make it small so that the man can enjoy more. The smaller the size of the vagina, the better for the man. So, the girls are told that the clitoris will grow long and they will not walk. It is not true. It is just that most mothers are not comfortable with talking these things with their little girls.

Some of those in the experimental group stated that they were told that girls who do not get circumcised get pregnant out of wedlock and eventually get no one to marry them. When asked how true they believed in this statement, most of the

girls said it was not true since they have seen quite a number of circumcised girls get pregnant too outside wedlock.

According to the study, among the experimental group, the control group and the key informants, it was clear that the clitoris in the Maasai culture had to be removed to reduce the high libido of the woman. Hopefully, the girl would subsequently be faithful to one man. Thus, anything could be said to convince the girls to have the clitoris totally removed. One of the girls stated that she was told that when she gets married someday and the clitoris is not removed, it will hurt her husband when they have sex, and then her husband would reject her.

Drama therapy, like other forms of therapeutic work, helped the survivors to face the shame, guilt and trauma associated with FGM so that they could move from self-blame towards realistic appraisal. Anxiety, hyper vigilance and fear are understandable responses to trauma. In this regard, we employed drama therapy to explore how the survivors could find their sense of dignity and restore a feeling of personal urgency. Unresolved grief and anger needs to be faced if it is to be accepted, but difficulties may worsen it at the beginning of the trauma healing process. Experiences of drama therapy for participants in the music, dances and poetry energized the survivors and redirected their attention and focus to critical issues in their future lives, thereby alleviating emotional stress as a result of FGM trauma.

Therefore, this study holds that drama therapy among the FGM survivors was very effective. This was so because the goals and benefits for the drama therapy were realized. For instance, drama therapy aims at improving communication skills and other skills and behaviours, appropriate release of emotions, and meaningful relationships (Malchiodi, 2005). Renee Emunah (1994:31-33) outlined five specific goals of drama therapy.

a.) *expression and containment of emotion*, which means learning to control one's emotions, and release them appropriately and acceptably.

b.) *observing self*, or the *director within us*, that finds hope, sees the broader perspective, and considers choices and options.

c.) *role repertoire*, or the experience of experimenting with different identities, and finding and practising new ways of reacting, coping, and behaving.

d.) *modification and expansion of self image*, or the inverse of role repertoire, as it enhances an understanding of the many aspects within ourselves.

e.) *social interaction and interpersonal skills*, which are practised and developed within the group that functions like a microcosmor society.

All these were attained in the drama therapy process that we conducted among FGM survivors as the next section attests.

5.3: EMPOWERMENT TO THE SURVIVORS OF FEMALE GENITAL MUTILATION

According to World Bank 2002 Empowerment Sourcebook, Empowerment is the process of enhancing the capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes. Empowered people have freedom of choice and action. This in turn enables them to better influence the course of their lives and the decisions which affect them, thus improve their quality of life (World Bank, 2002).

5.3.1: Empowerment through Attitude and Behavioural Change

Empowerment being one of the objectives of this study, was to enable the girls find their own voices and to be able to speak out their opinions in an environment that would guarantee them growth and development. The growth of the girls in this case was to be measured using the Rosenberg Self Esteem scale in terms of their individual attitudes towards life and themselves and in their relationship and interaction with others.

FGM survivors more often than not endure certain emotional and psychological problems. Barlow & Durand (2009) point out that emotional problems can trigger a wide array of abnormal psychological conditions including but not limited to performance anxiety and other social phobias, mood and physiological reactions. According to Candace Pert (1997:144), human beings evolved by relying on an

internal emotional response that required us to remember both pleasant and unpleasant experiences in order to survive. This link to memory causes a very deep level of the positive and negative feelings we associate with our past experiences. This study sought to use drama therapy to transform these negative feelings among FGM survivors into more acceptable ones as a form of emotional release. Attaining the cathartic effect of drama therapy implied that the survivors had been able to free themselves from the emotional bondage of the FGM trauma, hence attaining the psychological healing.

The concept of catharsis is widely accepted today within numerous therapeutic fields including drama therapy, psychodrama and group therapy and typically occurs when one has a breakthrough in his/her consciousness in relation to issues affecting him/her. Catharsis can also be synonymous to transformation, which means to change for the better. Drama therapy, therefore, strongly relies on the principle of transformation to facilitate personal healing, personal growth and the movement from psychological or spiritual darkness to light (Hoeller, 2010). In this way, it acts as a form of empowerment since it not only heals the trauma of FGM survivors but also helps them to see their lives afresh. It gives them hope and helps them realize their potentialities regardless of what they have undergone in the past.

To most of the FGM survivors, catharsis occurred by being themselves in the action rather than characters in the drama therapy processes. In our evaluation on the drama therapy process, at least 92% girls confirmed that the drama therapy was valuable to them. This was evident in their interaction and participation in the

sessions. Of the 92%, it was evident by the end of our last session that at least 71% had completely grown in self-esteem, confidence and their level of interaction. Of the other 21% from the 92% there was significant growth and room for more improvement. Perhaps, with more time, they could have completely found their voices and expressed whatever they were still holding back. This could be seen in their level of shyness in discussing some topics. Sometimes they could start narrating something and shy it off, of which one of the more confident participants could explain further.

There is an instance when we talked about menstruation and how the girls felt during this time. One of the girls started explaining how she gets nauseated and sick, but the teachers do not always understand, the researcher asked why she believed the teacher does not understand, one of the other girls then explained that during her periods she does not carry her hand in class and she is angry all the time- this could be translated that she was having mood swings during her menstruation period. It is because she had not felt confident enough to share her feelings with the group so she shied off explaining. The researcher confirmed with her if what her friend had stated about her behaviour in class during her menstruation period is true and she accepted.

Most of the survivors participated actively in the drama therapy techniques. They danced, sang, role-played, performed exercises and games as instructed and out of their own choice as was appropriate for the sessions. In this way, the girls were relieved of their pain as they freely narrated to us the trauma of FGM. The net

effect was that the girls were psychologically, emotionally and physically transformed. Moreno (1946) expands on the transformative nature of therapy when he points out that by recreating past experiences one can have emotional memory since:

> In playing yourself you see yourself in your own mirror on the stage, exposed as you are to the entire audience. It is this mirror of you which provokes the deepest laughter in others and in yourself, because you see your own world of past sufferings dissolved into imaginary events. To be is suddenly not painful and sharp, but comical and amusing. All your sorrows of the past, outbursts of anger, your desires, your joys, your ecstasies, your victories, your triumphs, have become emptied of sorrow, anger, desire, joy, ecstasy, victory, triumph, that is, emptied of all raison d'etre. You can say to yourself now: Was I ever that fellow (1946:249).

As Moreno discovered like so many before him, letting go of inner conflicts, this time through his technique of psychodrama, led to catharsis and a transformational effect on the personality. In the same vein, the drama therapy that we conducted among the FGM survivors worked the same as Moreno's psychodrama technique. Through drama therapy, the girls mirrored themselves and eventually poured out their sorrows, anger, anguish, disappointments of FGM and told us of their joy, desires and hopes of a better future and life beyond the rescue centres. The girls were able to talk about different aspects of their future like their education, career choices, marital hopes and their relationships with family and friends. Drama therapy, therefore, empowered the girls to talk and live their dreams of a better future. For instance, in career plans the girls had choices as shown in Table 4.6:

Careers	No. Of girls	Percentage
Teacher	8	33.33
Medical Doctor	6	25.00
Journalist/reporter	3	12.50
Actress/Musician	2	8.33
Community Worker	2	8.33
Flower Farmer	1	4.17
Air Hostess	1	4.17
Unsure	1	4.17
TOTAL	**24**	**100**

Table 4.6: Girls career choices in the experimental group.

Most of the girls stated that they wanted to be teachers because of the immediate role models they have in their vicinity. At the rescue centres and even in their towns, teachers are the most common professionals, and are regarded with a very high esteem within the Maasai community. One of the girls stated that she wanted to help little children in her village to learn English when she grows up. She also hoped that when she completes her education, her father would still be proud of her for not accepting to get married early, which would have meant dropping out of school. Another girl wanted to be a lecturer in the university like the researcher so she can buy a big car. 25% of the girls wanted to be doctors, with one of the girls stating that she saw her brother's wife die when giving birth because they could not take her to the hospital which was far and there were no vehicles nearby. There were also barely any doctors in Maasailand and so the traditional birth attendants were the ones who were trying to help her sister-in-law in vain. She narrated how she saw her sister-in-law bleed to death, and thereafter the new born baby fell ill and died about two weeks later. Since that moment, she decided to work hard in order to go to University to be trained as a medical doctor.

The three (3) girls who wanted to be journalists or reporters and the two (2) who wanted to be actresses and the other a musician stated so because of the joy of being seen on Television. They wanted to be popular and they also wanted to travel all over the world seeing things and talking to different people. They therefore believed thought that these kinds of careers would enable them get such opportunities. Another one cited that she wanted to be an actress so that she could get nice clothes like the actresses do. There were two girls who stated that they wanted to be community workers so that they could help girls escape from being circumcised, and from getting married early. One of the participants stated that she wanted to be an air hostess so that she could fly and she thought that they looked great on pictures. Only one girl wanted to be a flower farmer for the love of flowers. Flower farming is also quite popular around Kajiado in green houses and the girl had visited flower farm during class trip and she loved it.

Hence, drama therapy not only enables but also inspires participants' introspection and gives them the ability to overcome memories of traumatic experiences. Through the devices employed, the survivors were let into their own minds, explored the issues affecting them and then finally let them out. By isolating the nature of trauma, drama therapy helped the survivors manage their own conflicts and it empowered the survivors to recognize, control and manage the conflicting issues in their minds. To this end, drama therapy made the survivors to recognize and distinguish their existent and non-existent behaviours, conflicts and emotional trauma leading to their "self-awareness". In this process of self-awareness, the girls' individual tasks are specified and externalized, resulting in their ability to

recognize and correct their behaviours towards others. Hence, the application of drama therapy as a form of empowerment and individual education enabled the survivors search in their souls and recognize what was good for them and that which was not good. At the same time, it helped them make informed choices in their lives.

Drama therapy was proved to be an essential tool towards the social empowerment of the survivors. It is worth noting that drama therapy was a very important tool in helping the FGM survivors to construct their *socialized personhoods*. During the therapy processes, the social abilities of the girls were influenced in one way leading to them constructing correct *optimistic characteristics* and *life philosophy*. The girls felt empowered and saw themselves as the determinants of their future lives. The fears that the girls had had regarding how society viewed them were dispelled. Further, through drama therapy, the survivors felt encouraged to face life and society confidently. Majority of them felt that they had a role to play in society regardless of their being seen as rebellious and betrayers of their own culture.

Kauffman (2001) brought up three major points of having good social abilities, which are: an individual can keep a positive and optimistic relationship with the society, has good acceptance from peers and good adaptation to schools, and is able to adjust oneself to the environment easily. These aspects of the survivors' lives and attitudes were captured in the Rosenberg Self Esteem Scales which was analysed using the chi square as shown in table 4.7:

Chi Square Analysis of the Rosenberg Self Esteem Scale

As indicated in Table 4.7, the degrees of freedom in the Chi Square analysis varied between 2 and 3, being that the Rosenberg Self Esteem Scale that was used was a four point likert scale. The significance values also reflected the positive impact of the drama therapy session on the girls. The significance values that range between 0.000 to 0.050 signify a more positive impact with the lower range indicating more impact. Those questions with significant values of 0.051 and above, signify a lower impact in line with the survivors' responses on the Rosenberg Self Esteem Scale.

The cumulative analysis of pre test and post test of the Rosenberg Self Esteem Scale was divided into three sections: A. Attitudes towards self. B. Attitudes towards relationships and interactions with friends and C. Attitudes towards future and other relations:

Table 4.8: SECTION A. Rosenberg Pre-test on Attitudes towards self.

		0	**1**	**2**	**3**
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
1.	I like most things about myself	17	3	4	0
2.	At times I think I am good, and I feel useful at times.	15	6	3	0
3.	I feel that I have a number of good qualities.	16	8	0	0
4.	I feel I do have much to be proud of.	20	4	0	0
5.	I take positive attitude towards myself	8	10	4	2
6.	I know I can cope with anything that comes my way.	1	19	3	1

Table 4.9: SECTION A. Rosenberg Post-test on Attitudes towards self.

		0	**1**	**2**	**3**
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
1.	I like most things about myself	2	2	0	20
2.	At times I think I am good at all, and I feel uselful at times.	0	1	2	21
3.	I feel that I have a number of good qualities.	0	3	5	16
4.	I feel I do have much to be proud of.	0	1	1	22
5.	I take positive attitude towards myself	0	0	2	22
6.	I know I can cope with anything that comes my way.	1	2	18	3

As shown in Table 4.9, the girls' attitudes towards their lives greatly improved. They started to find pride in their ability to be able to make a choice to be in school and not to be married off early in the community. Through the drama therapy sessions they were able to believe in their strengths for fighting for what they believed was right even if it meant defying their parents. The girls also felt that they were useful members of the community and that was why some of them were now having free education courtesy of FAWE and AIC Girls Kajiado. These two institutions were taking care of their personal and basic needs, and were also providing them with a comfortable home to undertake their studies. The girls also felt proud of the fact that they were able to participate in the drama therapy sessions. One of the girls mentioned that she never believed that she could stand before an audience and perform or even speak in a place where there was a small crowd. Because of the drama therapy sessions, she felt that she could become a reporter, a profession she thought was just for the girls who go to school in Nairobi. During these sessions, the girls were encouraged to be anything they wanted to be and to say anything they wanted to say. In the process all their

dreams came into light and the girls found wings and hopes to one day be able to contribute positively to the society.

The most important aspect of the drama therapy session is that individual education among the survivors helped them to freely talk and teach their fellow participants. In this regard, the girls felt socially empowered. It is worth noting that the teaching plan involves "social adaptation"; thus, the researcher had to also sit back and be taught by the girls. The researcher also had her turn to teach the girls a jig here and there. In this regard, the girls' self-esteem was not only improved but their relationships with friends or peers was also enhanced. This was clearly reflected in the Rosenberg Self-esteem Scale section B:

Table 4.10: SECTION B.: Rosenberg Pre-test on Attitudes towards relationships and interactions with friends.

		0	**1**	**2**	**3**
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
1.	On the whole, I get along well with others.	16	7	1	0
2.	I am able to do things as well as most other girls who have not undergone FGM	13	4	7	0
3.	I feel that I am a person of worth, at least on an equal plane with others.	12	9	3	0
4.	I feel respected by others.	18	2	4	0
5.	I feel like I make a useful contribution wherever I am.	8	10	4	2
6.	I can tell that I am a person my friends can rely on.	20	2	2	0
7.	I am proud of my ability to cope with being able to escape from the practiCe of FGM.	14	6	2	2
8.	I believe I can interact with anyone.	8	12	4	0
9.	I feel that others listen to me when I talk or illustrate something to them.	17	3	3	1

Table 4.11: SECTION B.: Rosenberg Post-test on Attitudes towards relationships and interactions with friends.

		0	**1**	**2**	**3**
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
1.	On the whole, I get along well with others.	0	3	3	18
2.	I am able to do things as well as most other girls who have not undergone FGM	1	1	3	19
3.	I feel that I am a person of worth, at least on an equal plane with others.	0	3	1	20
4.	I feel respected by others.	1	1	12	10
5.	I feel like I make a useful contribution wherever I am.	0	3	19	2
6.	I can tell that I am a person my friends can rely on.	0	1	3	20
7.	I am proud of my ability to cope with being able to escape from the practise of FGM.	0	1	1	22
8.	I believe I can interact with anyone.	0	2	6	16
9.	I feel that others listen to me when I talk or illustrate something to them.	1	2	4	17

The assessment of the questionnaires indicates that the social abilities of the survivors had improved. During the interviews with the staff at AIC Girls Kajiado, the study found out that the survivors' relationships with other peers was getting better after undergoing drama therapy. By the end of our fourth session we realized that the girls had begun to have more confidence in themselves and they felt that their lives in the rescue centres had become happier. Finally, during the interviews with the teachers through to the end of the drama therapy sessions, most of them had noted that after undergoing the therapy sessions, the girls' social skills had improved greatly. This was even noticeable in their participation in class.

The findings show that most of the girls' had low self-esteem, poor attitude towards interacting with friends or anybody, and were not enthusiastic about life after going through the FGM ordeal. This formed this studies' entry point as we aimed at re-correcting their general attitude towards life and raise their self esteem. After ascertaining this, we embarked on drama therapy with a view of empowering them. Drama therapy uses acting activities as the major skill. It regards social interaction as "playing" and those scenes and stages which are constructed for dramas helps individuals eliminate all sorts of interruptions by combining all kinds of conditions and trying to form a new balanced condition for the individual. In this way, the survivors of FGM socialized with each other, acted out roles and shared with one another. The researcher chose to apply drama therapy skills to enhance the social abilities of the FGM survivors in the rescue centres as a form of social empowerment.

Drama Therapy Skills also enabled the FGM survivors to see recognition in society. Not only did the drama therapy processes improve the social abilities of the girls but also their sense of recognition. For instance, most of the girls demonstrated their willingness to participate in drama therapy exercises, in that they attended most if not all of the sessions, and they willingly participated in the sessions by sharing their stories. Although some of the girls were more talkative than others out of their nature, some of the girls who were more quiet in their nature, also contributed the little they could in talking, and in whole in the physical activities. The recognition and confidence of the girls could also be noted in that at times, the girls would lead the researcher in some of the activities such as games,

music and dance. Despite being an obstacle to the willingness for the girls to talk freely, the teachers also wanted to participate in the drama therapy sessions. After consultations with the researchers, the teachers understood that their presence was an inhibition to the performance and the openness of the girls. Not because of fear of the teachers but more because of the larger African traditional value of respect for elders in that children are not allowed to speak around elders.

It was also notable that the self-esteem of the girls improved over time. As we had more sessions it was noted that the girls were willing and more free to talk about sensitive issues in their lives, regarding FGM, sex and relationships, unlike before. *(See Table 4.12 and 4.13 for Section C of the Rosenberg Self Esteem Scale).* The girls overall confidence with other relations outside their peers, and their hopes for a better life, greatly improved.

Table 4.12: SECTION C.: Rosenberg Pre-test on Attitudes towards future and other relations

		0	**1**	**2**	**3**
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
1.	I feel good about my studies at school	0	0	4	20
2.	I am confident that I will be a great person in society in future.	10	9	5	0
3..	When I feel uncomfortable at home, in the presence of my parents or peers, I know how to handle it.	19	5	0	0
4.	I feel that I have a good future and a great career ahead of me.	10	9	5	0
5.	I believe I will get a man to marry me when I complete my education.	0	0	0	24
6.	I believe God loves me.	0	0	0	24

Table 4.13: SECTION C.: Rosenberg Post-test on Attitudes towards future and other relations

		0	**1**	**2**	**3**
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
1.	I feel good about my studies at school	0	0	0	24
2.	I am confident that I will be a great person in society in future.	0	0	0	24
3..	When I feel uncomfortable at home, in the presence of my parents or peers, I know how to handle it.	0	0	6	18
4.	I feel that I have a good future and a great career ahead of me.	0	0	0	24
5.	I believe I will get a man to marry me when I complete my education.	0	0	0	24
6.	I believe God loves me.	0	0	0	24

As indicated in the Table 4.12 and 4.13, most of the girls were very enthusiastic about their education because that was the one thing that was highly instilled in them in the rescue centre. It is also evident in the table that the girls are not worried of the fact that they will get married or not, because according to their traditions, they are already circumcised. What one of the girls cited was that she was just not aware of the fact whether she would be married to a young man or still to an old man. There was also the worry of whether her parents would allow her to get married to a man in the city, because she wants to live in the city. One participant also stated that despite the fact that she is sure she will get married because she is circumcised, she just wasn't sure if her parents would attend her marriage ceremony since she had escaped when they wanted to marry her off to an old man. One of the girls who had been married off and had had problems of birth, indicated that she did not want to get married because she believed her parents would want her to get married to an old man. However, she stated that if she was to get married

to a younger man of her age then she weould accept. All the girls stated that they believed God loved them. AIC Kajiado being a Christian institution and most of the Maasai in Kajiado being Christians it was understood, that all the girls believed in Christianity and therefore the strong reverence in a Deity power.

The most significant issue in this section of the Rosenberg scale was that the girls' belief in their future grew through the drama therapy process. As indicated in the pre-test, at least 79% of the girls were not sure whether they would have a great future or become great people in society. Of the 21% who were sure of their future, were girls who stated that they had gone to have FGM because of peer pressure and yet their parents were against it. These were among the girls who had confessed that their circumcision was done by a certified health care professional in a health care centre. Another factor was that most of the girls falling in the 21% came from homes where the parents were educated and lived in the modern town centres like Kitengela and Oloitokitok centres. They were therefore more exposed because of their family lifestyle. After the drama therapy sessions, it is clear that the girls' self-esteem had improved and they had more confidence in themselves and in their ability to contribute to the society.

Further, most of the girls indicated that they were now more confident that they were in a better position to speak and defend themselves without violence or creating conflicts when confronted about different issues at home or at school, unlike before when they could feel uncomfortable when confronted by their parents or by their peers. This the girls attributed to the fact that they felt that the

other uncircumcised girls and them are no different in terms of their abilities to perform well given equal chances. They stated that education gives them hope and thus they feel they are in a better position than their peers who dropped out of school to get married. They stated that because of the rescue centre, they felt that they had a place to call home and to be able to relive their dreams like all girls who have the same opportunities. One of the girls cited that if she was to be confronted by her peers because of her decision to get circumcised late way after her peers, she would flaunt to them that she is ahead of them in class and that she has a better future, than they (the peers) who some, had already dropped out of school because of early marriages or lack of interest in education resulting to poor grades.

Through drama therapy, most of the girls felt that they could easily adapt into the lives outside the rescue centres once they attain their education. They also pointed out that they not only hoped to live in harmony with their parents, brothers, sisters and other relatives but had also forgiven them and are willing to embrace them. It is evident from this observation that if we can train ourselves to control our behaviours more effectively, we will be content with our expectation to lives more. Goffman (1972) presented a theory called dramaturgical theory which uses drama acting as a metaphor of social interaction. In the process of doing drama acting, every individual has to perform one's own play. The perspective of the dramaturgic theory is that an individual has a good interaction with the society, depends on the image playing ability of the counterpart, adjusts one's performance appropriately and derives recognition and appreciation from others. This observation was at the very core of the drama therapy processes that we conducted

among the survivors of FGM. Our aim was to not only help the girls open up and talk but also give them the feasibility of integrating peacefully and harmoniously with their siblings and immediate society.

5.3.2: Empowerment through Improved Self Esteem

The study emphasized on the social empowerment forms like: enabling the girls to find their own voice, to interact freely and to be able to express their needs and hopes without fear of discrimination or fear of failure. The study also took advantage of the rescue centre to be an important aspect of drama therapy in terms of the physical space that we needed to be able to express ourselves. Every time before conducting the Drama Therapy, rehearsals and stage construction were done. The participants felt that the room was their space to explore themselves, to be free from the world and to talk their minds and dance with each other. It was like a venting room with more joy and calm. The centre offered the girls a safe haven and a shelter in accepting this therapy, thus allowing them to perform the role playing. The role playing made them empathize with themselves to the re-enacted circumstances, therefore helping them depart from the environment that brought them negative appraisements.

We purposed to conduct drama therapy among survivors of FGM in order to raise the survivors' self-esteem, confidence and trust. The survivors' confidence had to be enhanced, which in turn lead to trust among the participants and thereafter, their self-esteem also grew as they found meaning in each other's lives. The three

aspects are intertwined in that without trust, lack of confidence comes up again and thereafter, self-esteem reduces. This is so because the girls offer support to each other. These three are not only crucial for the drama therapy process but also for the interaction of the participants and all persons in social life. Generally, it is not easy to trust people we do not interact with. It takes **confidence** to start a conversation, an interaction and a relationship. This further grows into **trust** as the relationship progresses, and once there is trust, someone's **self esteem** grows. People with more supportive and understanding friends usually have more self esteem because of the support they get from each other. It was for this reason that the study found it important to help develop the girls' confidence, trust and self esteem, so as to be able to help them find their voices. Thus free themselves from whatever inhibitions they may have had in the past. The three aspects are interlinked as shown below:

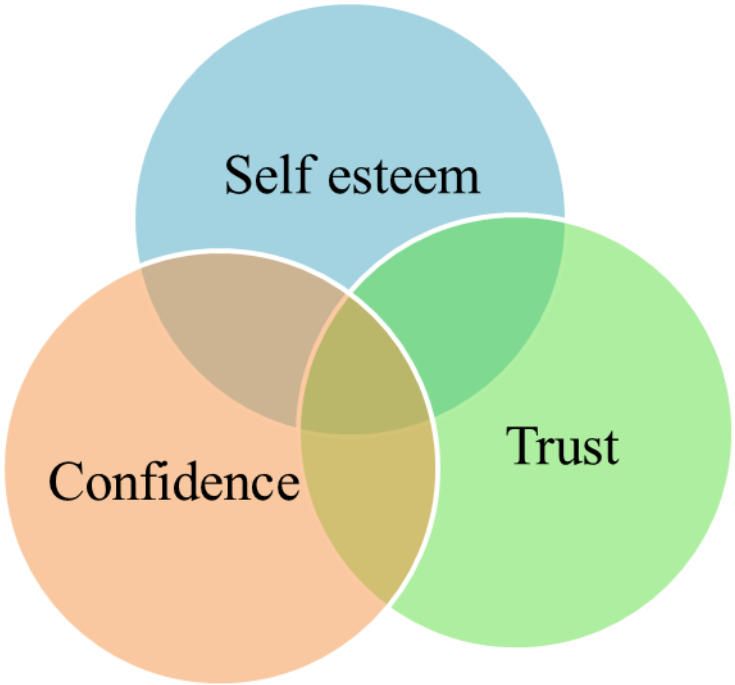

Figure 4.2: Interlink of drama therapy aspects.

It was conceived that realizing the three aspects will form the initial empowerment of the FGM survivors. Drama therapy as a form of social empowerment was used as a means to enhance social interactions between individual survivors rather than concentrating on mental phenomena within the survivors of FGM. Initially, we conceived of the drama therapy activities as an exploration of the individual survivors' intrapsychic life. However, after conducting therapy activities such as the game of sharing, it was clearly evident that the girls realized the need to develop confidence, and trust in others. In this way, the girls realized the need to exist cohesively together as a unit regardless of the challenges that they had faced.

In order to achieve the targeted social empowerment aspects of trust, confidence and a higher self-esteem, the researcher developed the drama therapy activities which were to be conducted as indicated below:

Figure 4.3: Drama therapy activities

In a normal drama therapy setting, the activities do not have to be conducted in any sequence. This is because on some occasions, one activity overtakes another and therefore as a drama therapist, one has to let the participants freely move from one stage of activity to another in a voluntary and enthusiastic way so as to get the most from their open and free discussions. For instance, there were times that the group danced during the whole session and were not able to undertake any role plays. Hence, we ended up just having the storytelling session only. This was an open chat about anything that came up like the way the girls felt about their studies at school and whether they missed home. Most of the girls were enthusiastic about school for that was the biggest sign of hope they had, as the value of education is advocated at the rescue centre. Three of the girls talked about how they miss home since for them during school holidays they stayed at the rescue centre. They were not able to go home because of fear of marriage, and as a result they are not able to see their sisters or brothers. One of the girls cited that she had not gone to her home for three years and her mother visits her at the rescue centre every holiday. She stated that her mother comes alone for the fear of the father who had disowned her from the family. Being an only girl, she was seen as the hope and the redeemer of the family. However, since she refused to get married, her father decided to disown her for the embarrassment she caused him by going to the Chief to rescue her when she heard that arrangements for her marriage were underway. The rescue centre was therefore home to the girls, at the same time it was school. When school was open, they lived in the dormitories, and when the school closed, they stayed in the Hostel constructed for them by FAWE within the school compound. AIC Girls

Kajiado Primary School was, indeed, their home for now until they completed their education.

The sequence of any typical dramatherapy session should however be systematic so as to get the most from the participants. Despite the fact that the participants might be involved in one activity more than the other in any particular session, there has to be a systematic way of conducting every session. If the process is left too open without guidance, then there may be lack of focus and direction and therefore very limited results. The researcher, therefore, recommends the flow of activities for every session to be as indicated in the diagram below:

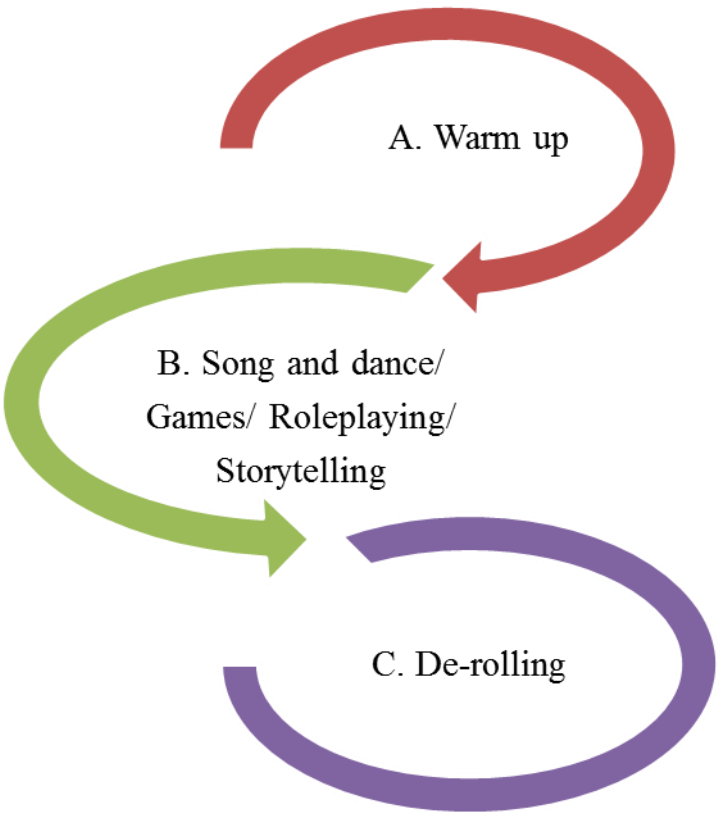

Figure 4.4: Drama Therapy Flow of Activities

As shown above, every session must begin with a warm up activity. This is where we can have the greetings, introduction and getting to know about each other's expectations. In the warm up, we also get to have imagination exercises, creativity and cooperation exercises and sometimes even a few aerobics. We can use games or songs and dances in the warm up. However, every warm-up should provide a prelude to the activities of the session. In section B of Figure 4.4, the therapist can use one or all of the activities shown. This will depend largely on the available time, the enthusiasm of the participants and the general flow of activities. It is important to understand that in this section, there is no typical order in which all those activities must take place. This varies from group to group, circumstances prevailing and the mood of the participants on each particular day of the session, or other related factors like the presence of new therapists, teachers, or new participants to whom the regular participants are not familiar. Take into note that for any sustainable, progressive therapy to take place, there must be trust and, as was stated in the earlier pages, trust takes time, depending on the confidence and the relationships that have been developed over time.

The result of the social assessment skills that this study conducted showed positive statistics. For instance, focused group discussions conducted after the therapy sessions showed the girls willingness to forgive their parents and peers and to embrace their siblings and relatives. Further, the girls showed their ability to make future choices without coercion and intimidation and their willingness to integrate and serve society in various respects.

Drama therapy also involved the art of storytelling. The storytelling activity acted as journey to self-discovery as the girls told their versions of the FGM ordeal. The stories could be described as lying in the fantasy/adventure genre. The duty of the researcher, at its most basic, consisted of retelling the story for affirmation and then asking the listeners some questions about the story. The therapeutic process lay in the relationship between the purpose-built story(ies), the guided questions and the interaction between the participants. Through this, the girls were able to see the commonalities that they shared and the need to forge ahead as a group. In the story telling processes, the researcher did not invite or require much self-disclosure from the girls and did not attempt to clarify the problems a particular person was having. Instead, she only attempted to universalise the idea that everyone has challenges and problems and that this is what everyone's life is all about. The therapeutic effectiveness lay in the storyteller's delivery of the story. As the girls told their stories in turns, the stories drew the attention of the participants as they sought to hear it in an altered state of consciousness; something called "listening to learn" in drama therapy. When the listeners 'enter' the process, they make their own mind pictures and internally 'interact' with those images. This means that while the story is about the journey everyone takes to growing up and forming identity, the process is individualised because the action is mostly internal. So, while the stories offer models for overcoming the problems of life, when the FGM survivors responded and changed their attitudes and behaviour towards each other and society as a whole, it is not because they were told to, but because they simply chose to.

Through the activities administered with the survivors, it emerged that drama therapy is an important social empowerment tool since a number of virtues were realized. These virtues are interrelated to the three aspects of empowerment that were discussed earlier: confidence, trust and self-esteem. The virtues were realized at intervals in every activity as shown in the Figure below:

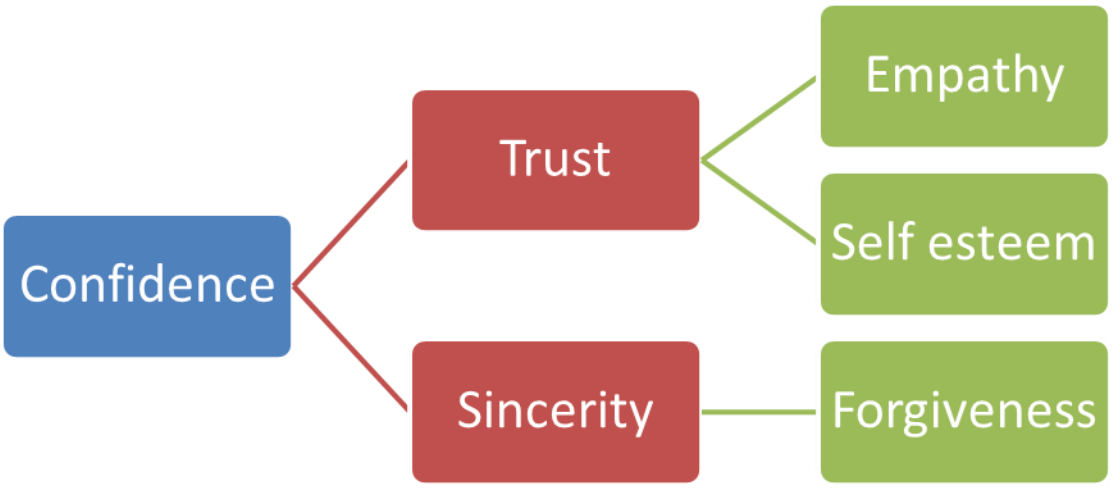

Figure 4.5: Virtues realized from Drama Therapy Activities

It is important to note that each of these virtues were realized after every activity. For instance, during the warm up sessions, the first drama therapy activity administered to the survivors during each session, expressed teamwork and cooperation and creativity which yielded the virtue of **confidence**- the ability to be able to participate, speak and share without fear of humiliation, or harassment. As the sessions went on and as the girls worked together in more sessions, they

developed the virtue of **Trust -** dependency and conviction that someone else believes in you, does not doubt you and hopes for the best in you; and **Sincerity** – genuineness, honesty and openness of oneself to others. The end result of the subsequent drama therapy sessions was **empathy -** to put oneself in the role of another, to share the pains and joys and experiences as though they were your own; and **forgiveness** – to let go of past hurts, pains, conflicts and sorrows that one had undergone in their past. Most important of all, the participants participation in dramatherapy yielded a higher **self esteem** – pride in oneself and belief that one has better future and is an important and respected person in society, and further belief that one has the ability to contribute positively to the society.

Findings from this study indicate that the girls' general dispositions improved greatly after undergoing drama therapy. Even the social abilities of the girls seemed to have improved.

CONCLUSION

This Chapter looked at the ways in which the dramatherapy techniques were useful in enabling the girls to open up and share their experiences and further to empower them. We have been able to come up with illustrations of the drama therapy flow of activities, a summary of the virtues realized from the same and how one virtue builds into another, and then leads to the empowerment of the survivors.

CHAPTER SIX

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

6.1: INTRODUCTION

The Chapter presents a summary of the findings and conclussions of this study. It also focuses on the possible ways of using drama therapy to unlock voices and as a form of healing for Female Genital Mutilation survivors. Finally, it highlights practical action points that can be used to make this a reality and suggests areas for further research.

6.2: SUMMARY OF THE FINDINGS

Drama therapy provides an opportunity to rehearse one's life. For example, most of the FGM survivors have always harboured resentment for different reasons: some of them towards those who made them undergo FGM, and others towards those who wanted them to get married after FGM. For others, it was because of the consequences of having undergone FGM, and the fact that it was their own choice. Most of the participants stated that they could not express their feelings in a real life setting, because there was no opportunity to do that and further because of the fear of discrimination, resentment from others who had undergone FGM, and also because of the understanding that issues to do with FGM, and their sexuality were private and should not be discussed in public. However, these feelings found expression through role play and storytelling in the context of drama therapy sessions. Through the intervention of a drama therapist, the

survivors were able to observe themselves from a different view, recognize their feelings, and have a better understanding of their past experiences. In doing this, they gained new insights by exploring alternative perspectives, attitudes, and responses towards their anger. Through this drama therapy provided alternative avenues where the survivors of FGM could vent their feelings, hidden resentments, fears and pain and in the process let it off their hearts.

During our drama therapy sessions, we told and created stories. The tradition of storytelling is ageless and recognized in most cultures as a practice vital to the health of individuals, the community, and the environment (Baumann, 1986). It is believed that stories help people make sense of their world and of their experiences, dilemmas, and hardships (Rosenstand, 2000). This was also true for the participants. Other than their FGM ordeal stories, the stories that the participants told were drawn from their Maasai cultural background. When the survivors told their own stories, they narrated how they found a way of living with their pain, a way of transcending our sorrows and tragedies in the rescue centre. Subsequent to a painful or life-changing traumatic event, the survivors' indicated a strong desire to live better lives in future. Telling their stories enabled them to find meaning in loss and to reassemble the pieces of shattered lives. In the same vein, the sharing of each other's troubles allowed the girls to weave together their life changes into a new more cohesive story shared by all. It was in this way that the drama therapy helped the girls to find new meaning in their lives, thereby leading to deeper understanding which was crucial in the healing process.

Role playing was one of the activities that drama therapy employed. The survivors participated in various role play activities. It is worth noting that role play permits people to extend their repertoire of roles, broadening their perspective as well as creating empathy towards others by taking on their roles. After this, the girls also did role-reversal in which cases they played the roles of those they believed were their oppressors. In this way, the survivors were able to show their forgiveness to their peers, parents and relatives who had either pressurized them to undergo FGM, or were pressurizing them to get married. An example of role play involved two girls who did a 2 minute short skit about a girl who got pregnant and the mother beat her up and chased her away from home because she had brought shame to the community by getting pregnant out of wedlock.

Although role play is work done in imaginary settings, it carries over into life, giving the girls the courage to confront issues traumatizing them and, in the process, provides, imaginary solutions to their problems. It also provided the survivors with an opportunity to discover new ways of co-existing with each other in the rescue centres as they learnt to trust and develop confidence among themselves. It fact we realized that drama therapy played a critical role in enabling the survivors to not only gain but also gradually increase their self-confidence and self-esteem.

Overall, the use of creative-expressive techniques among the survivors, such as poetry, storytelling, music and dance effectively helped in decreasing their trauma. It also enabled them to open up, freely talk about their worries, fears and anxieties

and finally helped them build their own confidence and enhance their self-esteem. Therefore, drama therapy facilitated a more positive sense of self among the survivors as they sought to start their own lives from a healthier perspective and by giving meaning to their hopes again.

6.3: CONCLUSIONS

The study examined the use of drama therapy in unlocking the voices of survivors of Female Genital Mutilation. There were also practical and insightful suggestions on how to facilitate the survivors to open up and talk. Based on the above findings, we can conclude that:

i. Drama therapy is an effective tool in unlocking the voices of FGM survivors. This is evident from how the FGM survivors on whom this study was conducted responded to various activities that were administered to them. They were able to open up and talk freely about their personal and sensitive issues with the researcher. Besides opening up, they improved their interactional and social skills, behavioural, emotional and psychological dispositions. In this way, drama therapy helped the survivors to become well rounded people, active participants and drivers of their own future regardless of the hallowing experiences of FGM.

ii. The research design used in the study was a success as we were able to compare findings from the control groups. The participants were divided

into two groups. One group was subjected to drama therapy while the other was not. The control group findings were compared to the experiment group for validation. We were then able to prove the assumptions of this study. Further the study involved key informants to help establish the valididity of the information from the two groups. To this end, the study established that:

a. Drama therapy techniques such as storytelling, skits, dance and games are suitable tools of therapy among victims of FGM.

b. Drama therapy is a suitable means of unlocking the voices of the FGM survivors.

c. Drama therapy can adequately be used as a means of empowerment for the FGM survivors.

iii. Not only is drama therapy an effective tool for unlocking the voices of survivors of FGM but it also empowered them in many ways. The survivors' self expression, socialization and perspective to view the world improved tremendously through drama therapy. Their confidence, ability to trust others and their self esteem also grew significantly.

6.4: RECOMMENDATIONS FOR FURTHER STUDY

This study was limited to the drama therapy among survivors of FGM in the selected rescue centres at AIC Kajiado, Osiligi and in Osotua Narok. In this regard, we recommend the following:

i. A comparative study can be conducted regarding the use of drama therapy on FGM survivors and other forms of expressive therapy such as fine art, pictures, images and crafts.

ii. We also recommend that further studies be conducted in the use of drama therapy with other groups of people such as street girls, children from conflict areas, refugees, raped victims, within a rehabilitation centres or a community setting to determine its effectiveness.

iii. The study can also be conducted with another cultural group that practises FGM like the Borana, Somali, Kisii, Kuria, Meru, Samburu and Turkana who still practise FGM widely.

iv. Further research can be conducted on drama therapy using other research designs other than the control group to ascertain whether the results can be similar to the findings in this study.

v. Drama therapy as a course should be studied in terms of how it can enhance practices in the medical and anthropological fields. It should therefore be included in our syllabuses more intensely as a therapeutic course, so as to broaden its practice in Kenya.

vi. The findings of this research may also enable the education system in the country to consider including Theatre as therapy into its curriculum in the fields of Medicine, counselling, arts and social studies because of its participatory approach and ability to be used in helping address personal and communal problems in healing, education, reconciliation and interaction.

vii. The government and the NGO's can hold training of trainers on dramatherapy as a medium to help curb a lot of the social ills we see in the society and further to educate communities on behaviour change communications, on issues like agriculture, reproductive health, economic empowerment, and political education.

viii. Finally, the findings from this research should enable the government, Non-Governmental Organisations and authority at various levels to address some of the social issues that have come up in the discussions like the practice of FGM by Certified Health personnels.

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APPENDIXES

A1: STAFF INTERVIEW GUIDE

These are the key questions for the senior staff at AIC Kajiado. These will be semi structured questions.

a.) What is the history of A.I.C. Kajaido Primary School?

b.) Approximately how many people are admitted at the shelter every quarter and how many of them leave the rehabilitation centre after completion of their primary education, secondary education and tertiary education?

c.) Are there instances where some people have been discharged from the shelter after completion of their education and then come back for a second time into the shelter?

d.) Under what circumstances are persons admitted at the shelter?

e.) What are the cultural and social factors that make the participants come to the shelter?

f.) What are the other therapies used in the shelter/rehabilitation and what is their effect on the recovery of the patients, both physically and psychologically?

g.) Do you think the drama sessions were significant in the attitude emotional and psychological development of the participants and why?

h.) What activities are most sustainable in the shelter, for carrying out therapy with more victims of FGM even after the study project is over? (dances, games, theatre exercises, storytelling, role play and role reversal, focus group discussions.)

i.) What is the society's attitude towards those who attend the rehabilitation programmes or those who live in the shelters?

A2: FOCUS GROUP DISCUSSION & INFORMANTS INTERVIEW GUIDE.

These are research questions to guide the focus group discussions sessions. They will be semi structured questions. These questions will also be used with the control group and the adult victims of FGM so as to help in comparing their responses to the ones the drama therapy participants will give.

1. Have you witnessed FGM being carried out and how did it make you feel?
2. Have you undergone FGM? If yes,
    a. how did it make you feel?
    b. were you forced or incited or bullied to do so or did you do it willingly?
    c. If you were forced, what would you do to the person who made you undergo FGM now?
3. What are the socio-cultural beliefs about FGM in your community? Do you believe in these beliefs?
4. Are there any myths that you know, that promote the practise of FGM?
5. Are there any benefits of FGM? If Yes, what are they?
6. Are there any disadvantages of FGM? If Yes, what are they?
7. How has the practise of female genital mutilation affected you in the way you think and behave towards others?
8. What do you think about women who accept to undergo the practise of FGM?
9. What do you think about women who refuse to undergo the practise of FGM?
10. What do you think about men who insist on women undergoing FGM?
11. What does your society think of the escapees of FGM, and those who come to the shelter?
12. What are your resolutions when you leave the shelter? What are your goals and dreams?

A3: PERSONAL INFORMATION AND EVALUATION FORM

NOTE.

1. All information recorded here shall be kept confidential by the therapist/researcher.
2. Please write your comments in the spaces provided or tick as appropriate. You can add an extra sheet of paper if necessary.

PERSONAL BACKGROUND INFORMATION

1. What is your name? .....
2. How old are you? .....
3. What class are you in? .....
4. Where is your home?

   ……
5. With whom do you live?

   .....
6. How many siblings are you? Brothers ..... Sisters

   .....
7. Are you the 1st, 2nd, 3rd, (other specify) born child of your parents.....
8. What are your hobbies/interests? …….....

   .....
9. How many friends do you have?

   .....
10. What do you like about your friends?

    .....
11. What are some of your favourite things in the world and why? .....

    …….....

    .....
12. What are some of the things that you don't like and why? ……

    ……

    .....

13. Have you undergone FGM? (Tick one) **YES** **NO**

    If Yes, When and where? .....

    .....

14. Is this the first rescue centre you have been to (Tick one) **YES** **NO**

    If No, where have you been to before in an attempt to avoid undergoing FGM? .....

15. What do you like most about the shelter/rescue centre? (teachers, friends, class subjects, food, dormitory, homework, games) .....

16. What do you do at your leisure time? .....

    .....

A4: PARTICIPANTS ATTITUDE SURVEY FORM

(Choose any of the following letters and write in capital letters next to your answer.)

H = Happy, NS = Not Sure how you feel, S = Sad

1. How do you feel when you play with others?
2. How do you feel when you hold hands and look into each others eyes?
3. How do you feel when you do the 'sharing games'?
4. How do you feel when you do the 'competition games'?
5. How do you feel when you sing and dance to your cultural play songs?
6. How do you feel when you sing and dance to your cultural FGM songs?
7. How do you feel when you dance together to music played from the system?
8. How do you feel when you learn to sing and dance to new songs?
9. How do you feel when you are the leader of a group?
10. How do you feel when you are a member of a group and not the leader?
11. How do you feel when you hear other people's story about FGM?
12. How do you feel when you see others act a story on FGM?
13. How do you feel when you act in a story on FGM?
14. How do you feel when you tell your story about FGM to others during group discussions?
15. How do you feel when you talk about your family?

    Why do you feel that way? .....
16. How do you feel when you talk about your friends at home?

    Why do you feel that way? .....

17. How do you feel when you talk about your friends at school?

    Why do you feel that way? .....

18. How would you feel about having to stop your education now?

19. How would you feel about having to complete your education and getting a good job?

20. How do you feel about being forced to marry at your age?

21. How do you feel about getting married when you are older, to a person of your choice?

22. How do you feel about being free to express yourself without discrimination?

    .....

23. What have you learnt from the drama sessions? .....

    .....

24. Will you share what we have learnt in drama, with other people you meet in future?

    YES NO

    If Yes, What will you share with others? .....

A5: AN ADAPTED ROSENBERG SELF ESTEEM SCALE

Below is a list of statements dealing with your general feelings about yourself.

Tick where appropriate.

		0	1	2	3
		Strongly Disagree	Disagree	Agree	Strongly Agree
1.	I like most things about myself				
2.	I feel good about my studies at school				
3.	At times I think I am good at all, and I feel useful at times.				
4	On the whole, I get along well with others.				
5.	I feel that I have a number of good qualities.				
6.	I am able to do things as well as most other girls who have not undergone FGM				
7.	I feel I do have much to be proud of.				
8.	I am confident that I will be a great person in society in future.				
9.	I feel that I am a person of worth, at least on an equal plane with others.				
10.	I feel respected by others.				
11.	I feel like I make a useful contribution wherever I am.				
12.	I take positive attitude towards myself				
13.	I can tell that I am a person my friends can rely on.				
14.	I know I can cope with anything that comes my way.				
15.	When I feel uncomfortable at home, in the presence of my parents or peers, I know how to handle it.				
16.	I am proud of my ability to cope with being able to escape from the practise of FGM.				
17.	I believe I can interact with anyone.				
18.	I feel that others listen to me when I talk or illustrate something to them.				
19.	I feel that I have a good future and a great career ahead of me.				
20.	I believe I will get a man to marry me when I complete my education.				
21.	I believe God loves me.				

A6: CLIENT CONSENT AND EXPLANATION FORM

Explanation of the study and the purpose of the theatre therapy programme and study.

Hello, My name is ZIPPORA A. OKOTH, This is a request to confirm your possible participation in a study I am doing to find out the level of effectiveness ofusing drama as therapy in enhancing communication and self expression skills on victims and escapees of Female Genital Mutilation. I am a PhD student of Theatre Arts from Kenyatta University. I also hold an MA in Gender and Development Studies (UoN) and a BA in Drama and Theatre Studies (MU) and certificates on Counselling, with experience in facilitating drama therapy sessions.

The purpose of this study is to explore the use of drama as therapy; its impact, effectiveness and sustainability in a shelter/rehabilitation center, with a focus on female genital mutilation. To find out the other various forms of therapy used in the shelter and assess how drama is used as therapy in the shelter, to explore the personal, cultural and social factors that make the participants come to the shelter, and to find out the impact and outcome of drama as therapy in persons who seek help at the rehabilitation centres/shelters and in the practice of the health practitioners and staff at the shelter.

I hope this information will help to improve the counselling and therapy services provided to people in this shelter/rehabilitation centre and in other places, and that this study will contribute largely in giving health practitioners an alternative and additional method of therapy that will enable them achieve long term results with minimal time and costs.

The success of this study, may also enable the education system in the country to consider including theatre therapy into its curriculum in the fields of Medicine, counselling, arts and social studies. This project may also enable the government, Non-Governmental Organisations and authority at various levels to address some of the social issues that will have come up as core reasons that lead people to become oppressors and continual victims of sexual and domestic abuse.

In order to gather this information I would like to request your permission to participate in the theatre therapy sessions at the _____ shelter/rehabilitation Centre for a period of at least 2 months with at least one or two sessions per week each lasting 1 to 2 hours.

Procedures including confidentiality.

If you agree I will ask you to participate in a theatre therapy session with other men and/or women at the shelter/rehabilitation unit. The sessions will be facilitated by one or two members at any given time. The session may also have in attendance a counsellor/psychologist/teacher from the shelter/rehabilitation centre who will help monitor the therapy activities carried out during the sessions, and thereafter will assist in giving a progressive account of the impact of your participation at the drama therapy sessions.

During the sessions, we will have storytelling, song and dance, role play and role reversal, memory and imagination exercises, and games and thereafter focus group discussions. You will not be forced to talk about your personal life but will be encouraged to talk or act out whatever you feel in an atmosphere of fun.

The discussions in drama therapy sessions, will be recorded with an audio tape recorder/MP3 Player to ensure that I do not miss anything said or record it wrongly. The tapes will not have names of any participants or you and my research team will keep everything confidential. (During the theatre therapy sessions the participants will always take a name that they would like to be referred to and this will thus alter their identification.) Only those present in the sessions will thus be the only ones who will remember your face. After the therapy sessions, all persons present at the theatre therapy sessions will be requested to keep what has been shared confidential though this cannot be controlled by the research team outside the therapy sessions. At the end of the study (the theatre therapy sessions), I will note down what is on the tape/CDs and keep it confidential, and thereafter I will

destroy the tapes/CDs.The researchers will not take any pictures of the girls for the purposes of this study so as to ensure the confidentiality and the privacy of the girls is not infringed on.

Risks, discomforts, and right to withdrawal.

During the discussion you may feel uncomfortable to talk about some topics. However, I do not wish you to feel uncomfortable and you can refuse to participate in the activities or leave the discussion whenever, at your wish. In addition, there is a slight chance that you may share information that is personal and or confidential with the group from the community that you did not want to share. I do not wish this to happen and although my team cannot control the confidentiality of what shall be talked about outside the therapy sessions, my team will encourage all participants in the group to respect the privacy of the other group members.

Benefits.

This study will help you and the rehabilitation centre/shelter directly and I also hope that the information gathered will help to improve the counselling and therapy services provided to other people at the shelter/rehabilitation centre and other places. If you do not want to take part in the therapy sessions or in the interviews, you can refuse. If you do not want to participate you will receive the same service at the shelter/rehabilitation centre as always and nobody will hold this against you.

No payments shall be made to you, to the other participants, to the shelter/rehabilitation centre or to the staff at the shelter/rehabilitation centre. The shelter/rehabilitation centre shall also not be compelled to pay me for the sessions. I (the researcher), will cater for all the costs, props and equipment needed for the purposes of the theatre therapy sessions during the course of the study. Nevertheless, the shelter/rehabilitation centre may be required to avail its facilities and equipment where necessary, if available, to enable the theatre therapy sessions to be carried out.

Sharing of the results.

After the assessment of the theatre therapy is completed, I will be sharing the results with the community and current and future clients who may be in need of the theatre therapy information. In addition, a copy of the data collected will be given to the Kenyatta University for examination purposes, and a copy to the shelter/rehabilitation centre for its records. If you would like to receive a copy of the report, I can be informed and I will make this possible.

Consent and contact.

Do you have any questions that you would like to ask?

Is there anything you would like me to explain again or say more about?

Do you agree to participate in the theatre therapy sessions to be carried out at _____

_____ for purposes of the study?

Contact details:

If you have any other questions about this study later you can contact any of the following persons:

1. **Prof. Wangari Mwai, Department of Literature, Kenyatta University, P. O. Box 43844 Nairobi, Tel: 0722 653745.**
2. **Dr. John Mugubi, Department of Theatre Arts and Film Technology, Kenyatta University, P. O. Box 43844 Nairobi, Tel: 0724 788668, Email: mugubi.john@ku.ac.ke**
3. **Zippora A. Okoth, P.O.Box 52738-00200 Nairobi, Tel: +254 722 446990, Email, agathadani@yahoo.com.**

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study and understand that I have the right to withdraw from the drama

therapy sessions at anytime without it affecting my education/medical care and any other services I receive at the shelter/rehabilitation centre in any way.

Print name of participant _____

Signature of participant _____

Date _____

If illiterate

I have witnessed the accurate reading of the consent form to the potential participant, and the indiviudal has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness_____ Signature of witness _____

Date_____(Day/Month/Year)

A copy of this informed consent form has been provided to the participant _____(initialed by the researcher)

Researcher	***Authority at shelter/rehabilitation centre***
Signature:	**Signature:**
Name:	**Name:**
Date: _____	Date: _____

A.9: TRANSCRIPTS OF SOME OF THE FGDs AND INTERVIEWS

A JOURNEY OF ONE GIRL IN ESCAPING FGM IN VAIN.

"…Baba yangu alikuwa hapo nje, Mimi nikashindwa kutoka, nikaambia mama yangu nimeshindwa kutoka, akaniambie wewe uende uvae blanketi kubwa na usivae viatu. Sasa mimi wacha nichukue blanketi niende. Akaambia brother yangu "Nimeenda, wewe angalia ngombe, mimi nimeenda kuangalia kuni, na nimetuma nani" yeye akaenda, tuakenda kabisa, tukaanza safari, tukaenda kwa auntie, tukakaa one week, tukarudishwa nyumbani. Sijui kwa nini tukarudishwa nyumbani. Tukachukuliwa jioni, tukalala mahali ingine. Asubuhi yake, chief akakuja, tukaenda mbali…kwa mbali tukaona baba yangu, akaambiwa alale… akakuja jioni, amekasirika… akachora msitari kwa mlango akasema, mtu asipite hapo…. Akaweka nyasi kwa nyumba…tukaambiwa tuende boma ingine…tukapata watu wamejaa hata tukachekelewa ati tumerudi… tukaambiwa tukae, tukakakaa kwa hiyo boma, tukakaa siku nyingi, tukafanya exams. Halafu tukaongeleshwa… Halafu, brother yangu, wakapanga vyenye tutatahirishwa, asubuhi yake ya kutahirishwa…mwenye amepanga alikuwa ameoa sista yangu, sista yangu akaambia jirani, jirani akakuja akaambia mama yangu, hiyo jioni, tukapelekwa nyumbani, hatukulala, asubuhi, saa tano, tulitoroka, tukaenda msituni, tukakaa msituni hadi jioni, tulienda tukapotea siku mbili, tukarudi tena nyumbani….(giggles) Tukachekwa, mamangu nikawaambia waniache na

watoto wangu… nikakataa, hawawezi kunifukuza. Kila December tulikuwa tunaenda tunalala nje. Hata mama yangu aliogopa. 2008, tulienda tukatoroka…venye tulitoroka, sasa ilikuwa bahati mbaya, tulishikwa, tulichapwa, baba yangu anapiga tu kisu, nduru ilikuwa watu wakadhani matanga…. mbwa mkali ilikuwa hapo lakini mimi sikuogopa mbwa, watu waliona mbwa wanakimbia. Mimi nikaenda kwa nyumba, kumbe walikuwa kwa nyumba, ukiingia kwa nyumba, unashikwa, unachapwa…tukapelekwa kutahirishwa, mama wa kutahirisha, ilikuwa hajafika haraka… tulikaa tumefungwa, akakuja, nililia, nililia, damu ilitoka nyingi hata wakaogopa, mama yangu akasema nikikufa, anakufa, babayangu akakuwa mkali, baada ya siku nyingi nilipona, halafu nilitoroka nyumbani, walikuwa wanataka, niolewe, nilitoka, nikakimbia, nikakuja mpaka hapa,"

This in English translates to:

"My dad was outside(the hse), so I was defeated on how to leave, so I told my mum, she told me to go wear a blanket. Then she told my brother to go check on the cattle, that she is going to look for firewood and that she is sending me to a neighbour's house. So we left and we went to my aunt's place, we stayed there one week, then we returned back home. I don't know why we returned. We were taken in the evening, we slept somewhere. In the morning, the Chief came and we went far, from afar I saw my dad, he was told to lie down…so we went, he came in the evening, very angry, and drew a line at the door and said no one should cross that line. She then put grass inside the house, and so we were told to go to another homestead. We

found people so many there and they really laughed at us for escaping and returning. They allowed us to stay in that home, we stayed there for long until we did exams. Then we were talked to… Then, my brother organized how I would be circumcised, that morning before circumcision, the person who had organized was my sister's husband, so my sister told the neighbor what they were planning to do, and the neighbor told my mother, that evening, we were taken home, we never slept, in the morning, at 11am we escaped and went to the forest, we stayed in the forest until evening, we were lost for two days, then we came back home again (giggles). We were laughed at, my mother told them that she be left alone with her children, she refused after all they cant chase her from her home forever. Every December, we used to sleep out. Even my mother was scared. In 2008, we tried to escape, but by badluck we were caught, we were really caned, my father was just sharpening his knife, the wailing was so so much until the neighbours thought there was a funeral…There was a dog there, people were scared of the dog, but I ran towards it. When I entered the house, I didn't know there were people inside the house, they caught us, caned us and we were taken to be circumcised. The woman who was to circumcise delayed, so we stayed there tied. Then she came, I cried, I cried, there was a lot of blood until everyone was scared. My mother swore to them that if I die, she dies too. My father became so harsh. After many days, I got well. Then I ran away from home, they wanted to marry me off, I left, I ran away until I got here…"

TYPES OF CIRCUMCISION

According to the key informants at Kajiado, there are three types of circumcision. The maasai circumcision, this is where they cut the whole of the majora and clitoris, this may be referred to as infibulations. The second one is the Pharaoh circumcision which is done like the maasai but it is stitched so that no man will interfere with the girl's virginity until marriage, when the virginity will be tested and verified to be intact. The third one is the Maendeleo circumcision whereby the tip of the clitoris is pricked or cut

The hospitals so as to satisfy the cultural right circumcises the girls, however, they do the 'bottom up approach' in that they just prick the clitoris. The men sometimes complain that they can feel the clitoris but then the women say it was done and so they cannot repeat the ritual.

PARTICIPANTS OPINION ABOUT THE FGM PROCESS

…ni uchungu ya kifo, kukata mtu kama ngombe ama mbuzi ni uchungu sana, uchungu tu, anaendelea na mahangaiko siku yote, huwezi kutembea vizuri, hawezi kukojoa, ni mateso kabisa."

In English this translates to:

"It's a pain of death, to cut someone like a cow or a goat is very painful. Its pure pain, someone wails and cries all day. One cannot walk well, One cannot urinate, it is pure torture."

"Ukweli ya mambo Hakuna mateso kama hiyo, unaenda kukata mtu pahali pabaya, tena inakuwa kidonda,anaendelea kugonjeka, anaendelea kuskia uchungu, anamchukua punda ikawa anagonjeka, hatembei,kwa rika yetu, hakuna kukubali…… Kuamua aje, na wewe ni mtoto mwenyewe, hakuna kuamua, hata ikisema hataki, ukikataa ukikubali, unafanyiwa kwa masharti ya wazazi, anafanyiwa lazima, unalia na unafanyiwa tu.

"

In English this translates to:

"The truth of the matter is there is no torture like that, you go and cut someone in a bad place (private part), then it becomes a wound, she continues to get sick, she continues to feel pain, you take a donkey when it is still sick, cant walk…at my age, I wouldn't accept….How do you decide, and you are a child yourself, there is no choice/deciding, whether you say you don't want, you agree or refuse, you are done for(circumcision) on the choice of the parents, you are forced, whether you cry you are done for (circumcision)."

FGD ON REASONS FOR UNDERGOING FGM

Mimi niliona wenzangu wote wameenda wakatahiriwa, nikaona nitabaki pekee yangu; Utasengenywa na kudharauliwa; Mimi niliona sijatahiriwa; Kwa sababu wengine walitahiriwa na walianza kunidharau; Babangu alikataa lakini nilisema lazima niwe kama wenzangu; Mimi niliona wenzangu wametahiriwa nikataka; Niliamua tu; Niliona cousins wangu wamefanya na walianza madharau; Niliulizwa kama ninataka, nikasema ndio; Wazazi wangu walikataa, lakini niliona venye cousins wangu wanatreatiwa vizuri, hata mimi nikakataa mpaka nitahiriwe; Mamangu, babangu, marafiki wangu wametahiriwa; Niliambiwa mtoto hatapita vizuri nikizaa; Mimi nilipelekwa tu,nikakubali; Niliona madada zangu wakubwa wametahiriwa mimi ndio second last so singebaki; Mimi ni Mteso, wateso hawatahiri wasichana, lakini marafiki zangu wametahiriwa sasa hata mimi nikaenda tu. Waliniambia ati itamea itakuwa refu; .itagrow halafu hautatembea; Itagongana na miguu ‘the clitoris’.

HAVE YOU EVER ATTENDED A CIRCUMCISION RITUAL AND HOW DID IT MAKE YOU FEEL?

Ushawahi hudhuria sherehe ya FGM, na ulisikia aje?

Niliwahi, wakati bila kujua ni mbaya, niliingilia kama sherehe, niliona kama ni kitu kizuri, kabla ya kujua ni mbaya. Nimeingia mambo hiyo sana kwa sababu mimi nilifanyiwa, na wakati nafanyia mimi,iko rika yango tulifanyiwa pamoja, wakati nimekuwa mama mzima, alienda kufanyia msichana kitu kama hiyo, kama hajui chochoto kwa akili yangu ama maarifa yangu, kwa hivyo alijua maneno hiyo sana, tena alifanya, alikaa anakuja kujua siyo kitu ya maana kufanya, ama

kufanyia mtu, ama kufanyia msichana. Na mimi sasa nimekuwa mmoja ya kuzunguka kila mahali kufundisha msichana kuhusu hiyo mambo walifanyia mimi, na mimi aliona kama ni wakati mzuri mimi iliingia hiyo hali, na sasa haitakubalika, hauta kubalika. Na sasa msichana mingi sana alijiunga pande yangu amekataa, kama msichana yangu, na mengine mingi, mingi nimesunguka kanisani, kutengenesa, kutoa huduma ya youth kwa kila kanisa, hata mimi, naitwanga mama ya msichana, kwa sababu nasunguka kila kijiji, hasa mahali najua napendapenda kutahiri msichana, na sisi ni watu wa kungangana, iko iyo mabishano, bwana kama anatoa watu wetu kwa hiyo hali kwa sababu siyo mtu wa maana, naona kama ni mtume tu, ama ni kufinya watu, ama ni kunyanyasa msichana, kwa hivyo ni kuzunguka kila kijiji kutengeneza maisha ya msichana,kueleza vizuri kila kijana…

HOW DO YOU FEEL ABOUT THE PERSON WHO FORCED YOU TO UNDERGO FGM?

Kwa sababu ni mama yangu, na kwa wakati ananifanyia mambo kama hii, hata yeye hajui chochote, kwake ni mila, anaona alifanyia mimi kitu mzuri, kwa sababu hata yeye alifanyiwa. Na sisi, kwa kuokoka, tunaona ni sehemu moja ya shetani… watu anafanya kitendo mbaya sana bila kujua…na sitalipisha…lakini mimi sitafanyia mtoto yangu…

Kabla ya watu kujua maneno ya Mungu, waliabudu sanamu, sasa ni kama hivyo….hiyo sasa ni stori, ni mila, ni sherehe tu..

Sherehe nini: Kwa sherehe, kuna kuunganishwa na spirits za zamani, za watu walikufa, na yenye walisema, sasa inawatia pamoja na hizo spirit.

Mtoto, bila kutahiri, kwa kutahiri inaingia sehemu ya mtu mzima

Hakuna kuolewa msichana bila kutahiri, hakuna kuolewa, hakuna kuzaa. Msichana bila masomo, hakuna kutahiri, na inafunga milango kwa wazee. Msichana pia anajiskia anakuwa mama. Wakati hiyo ya kutahiriwa anaambiwa sasa amekuwa mama.

DO YOU BELIEVE ON THE MYTHS ON FGM?

Key Informant 1: Mimi aliingia mapambano ya msichana yangu asitahiriwe..kutoka nyumbani, kuenda kanisa, Kupitia shule, kuungana na walimu, kuenda kwa DO, nina msichana mmoja, hakuna kutahiri, sasa iko darasa la sita. Mimi huingia mabaraza kuambia wamama, hii ni maneno mbaya, na ni dhambi.

Key Informant 2: Because it is my mother who forced me to undergo FGM, I do not hold any bad feelings towards her because to her it is culture, and according to my mother, she was doing a good thing in circumcising me, because she was also circumcised. But since I started going to church, I received salvation, and in church I have come to realize this is an act of the devil, I have to keep away from cultural things that do not promote my Christian faith. Because during the circumcision ritual, so many things are said, that connects the living and the dead. They call the dead spirits of that home. It is like worshipping idols and dead spirits, besides FGM, do not add any value to a woman's life. It is just a selfish act that undermines women.

Lazima tutoe msichana huko, maasai anatahiri hata usiku. Lazima nipate nguvu ya kusaidia wamama. Mama akikataa, Maasai, anachapa mama, pamoja na msichana, ndio lazima sisi naleta serikali, maasai anaogopa serikali peke yake.

Key Informant 3: The mother has to work together with the government, the school heads, and the rescue men…thereafter the chief warns the homestead, sometimes there is noise sometimes there is a peaceful agreement. I am illiterate but my son helps me write the letters to the girls. I rescue a lot of girls, especially aged 12 years and above so they go to school until secondary….I use some of the old volunteers like Agnes.

We have even rescued girls who have been forced to leave school and get married. There is an instance whereby the girls was rescued but she was already pregnant, so after testing her, we let her give birth, we talked to the mother who took care of the baby as she went back to school, so she just finished her class 8, and is now going to secondary. Then it was said that she was pregnant because she was not circumcised. It is very popular to hear men saying uncircumcised girls are promiscuous.

“Hakuna kutawala maasaini, bado nanyanyasa wewe, hiyo maneno nasaidia aje, bado unaenda kuomba pesa kwa mzee, na mzee anaweza kataa kukupatia wewe, hakuna kitu wewe nafanya. hakuna biashara naweza fanya bila elimu, sasa wewe nakubali tu kitu mzee amesema.

DISADVANTAGES OF FGM

Mambo ya kuzaa ni ngumu sana. Alidanganya sisi ati kutahiriwa inapatia sisi nguvu ya kutawala kitu yake yote. Ni uwongo, kijana nachukua mali ya baba na ya mama yote, wewe hakuna kitu unachukua. Ukitangaza mbele ya wazee, unaweza ambiwa vibaya sana. There are a lot of girls, who we helped rescue, there is one who went to University, there is one in St. Marys and they also refused.

There are those who accepted and in such a case, there is nothing I can do. I try to educate them and I try to stop them, but there are also some very stubborn girls. I try to talk to the mother to stop the girl. They tell the girls that if they accept to go have FGM, they will disown them, and they take them to Joyce (the interviewee). It tries to scare the girls who are defiant, some girls face peer pressure, so they have to be pressurized to stop the idea of undergoing FGM.

I talk to the girls, I tell them if they want to get circumcised, let them complete their education first and after completing their education they can then decide to get circumcised. I tell them that if they get circumcised they will get married immediately and they will have to stop going to school no matter how young they are. So by the time, they complete form four and even college, they will be older and then they will not want to undergo FGM anymore.

The old men, call the uncircumcised ‘jaluo’, so the society do not take it well to be ‘jaluo’.