

**UNIVERSITY OF NAIROBI  
FACULTY OF ARTS  
DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK**

**THE RESPONSE OF MAASAI PEOPLE IN REGARD TO INITIATIVES  
TO STOP FEMALE GENITAL CUTTING: A CASE STUDY OF  
IMBIRIKANI GROUP RANCH**

**BY  
SREYA LESENI  
C50/9199/2006**

**A PROJECT PAPER SUBMITTED FOR IN PARTIAL FULFILLMENT OF  
THE REQUIREMENTS FOR THE DEGREE OF MASTERS IN  
SOCIOLOGY (COUNSELING), UNIVERSITY OF NAIROBI**

**DECEMBER, 2015**

**DECLARATION**

This is my original work and has not been presented for any degree in any other university.

**SEREYA LESENI**

**SIGNATURE:**.....

**DATE:**.....

**Declaration by Supervisor**

This project paper has been submitted for examination with my approval as the University Supervisor.

**DR. ROBINSON M. OCHARO**

**SIGNATURE:**.....

**DATE:**.....

## DEDICATION

To my ever loving parents, for always being there and sharing all the happy and sad moments in my life, for always encouraging and putting me on the right path. Especially my mother, I love you mom and could never ask for another mother. *“A mother is the truest friend we have when trials heavy and sudden, fall upon us; when adversity takes the place of prosperity; when friends who rejoice with us in our sunshine desert us; when trouble thickens around us, still will she cling to us, and endeavour by her kind precepts and counsels to dissipate the clouds of darkness, and cause peace to return to our hearts.” Washington Irving.*

To my siblings: for all the support and prayers. *Siblings are the people we practice on, the people who teach us about fairness, cooperation, kindness and caring – quite often the hard way.” Pamela Dugdale.*

To my niece and nephews you are the future leaders of tomorrow and I love you.

## **ACKNOWLEDGEMENTS**

Special thanks to the Lecturers of the Department of Sociology for having contributed to the knowledge base from which this dissertation has been derived. I appreciate the contribution of a number of people who have played a big role in helping me with this dissertation.

First and foremost, appreciation goes to my supervisor, Dr. Ocharo for the guidance, professional supervision and critique during the period of writing this project paper. I thank my classmates for the friendship and words of encouragement and wisdom during the tough times of the program.

Thanks to the staff of Imbirikani Primary School, girls and women and all the other informants who were contacted during the data collection.

Last but not least: special thanks to God for seeing me through by giving me the strength and health to accomplish my second degree.

## TABLE OF CONTENTS

<b>DECLARATION</b> .....	<b>ii</b>
<b>DEDICATION</b> .....	<b>iii</b>
<b>ACKNOWLEDGEMENTS</b> .....	<b>iv</b>
<b>TABLE OF CONTENTS</b> .....	<b>v</b>
<b>LIST OF FIGURES</b> .....	<b>vii</b>
<b>LIST OF TABLES</b> .....	<b>viii</b>
<b>LIST OF ABBREVIATIONS AND ACRONYMS</b> .....	<b>ix</b>
<b>ABSTRACT</b> .....	<b>x</b>
<b>CHAPTER ONE: INTRODUCTION</b> .....	<b>1</b>
1.1 Background.....	1
1.2 Statement of the Problem.....	2
1.3 Research Questions .....	5
1.4 The General and Specific Objectives of the Study .....	5
1.5 Justification of the Research .....	5
1.6 Scope and Limitations of the Study .....	6
1.7 Definition of Key Concepts .....	6
<b>CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK</b> .....	<b>8</b>
2.1 Introduction.....	8
2.2 FGC: An Overview of the Practice, Definitions and Associated Health Issues .....	8
2.2.1 Definitions of FGM.....	8
2.2.2 Types of FGC.....	9
2.2.3 Health Implications of FGC.....	10
2.3 International Response.....	11
2.4 Kenya’s Statistics on FGC .....	12
2.5 Different FGC Perceptions and Human Rights Approach.....	13
2.5.1 Women and Children’s Human Rights .....	15
2.6 Justification for the Practice.....	17
2.7 Theoretical Framework.....	18
2.7.1 Cultural Relativism versus Universalism.....	18
2.7.2 Feminism and Theoretical Debates.....	19

2.8 Conceptual Framework of the Study .....	24
<b>CHAPTER THREE: RESEARCH METHODOLOGY .....</b>	<b>27</b>
3.1 Introduction.....	27
3.2 Research Design.....	27
3.3 Site Selection and Description .....	27
3.4 Source of Data.....	28
3.5 Target Population.....	28
3.6 Sampling Design.....	28
3.8 Data Analysis .....	30
3.9 Data Presentation .....	31
3.10 Challenges and Limitations.....	31
<b>CHAPTER FOUR: DATA, ANALYSIS, PRESENTATION AND INTERPRETATION .....</b>	<b>32</b>
4.1 Introduction.....	32
4.1.1 Demographic Data of the Respondents.....	32
4.1.1.1 Distribution of the Respondents by Age.....	33
4.1.1.2 Distribution of the Respondents by Education .....	34
4.2 Community’s Perceptions on FGC .....	35
4.3 Efforts Put Forth in Abolishing FGC by the Community and Stakeholders .....	38
4.4 The Levels of Acceptance by the Community in bringing FGC to an End.....	43
<b>CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS.....</b>	<b>46</b>
5.1 Introduction.....	46
5.2 Summary .....	46
5.3 Conclusion .....	48
5.4 Recommendations.....	48
5.5 Areas of Further Research.....	48
<b>REFERENCES.....</b>	<b>50</b>
<b>APPENDIX: QUESTIONNAIRES .....</b>	<b>56</b>

## LIST OF FIGURES

Figure 1: Conceptual Framework of the Study.....	25
Graph 1: Distribution of girls in upper classes after the CBO's involvement .....	41

## LIST OF TABLES

Table 1: Distribution of Respondents by Age.....	33
Table 2: Distribution of the Respondents by Education .....	34
Table 3: The Girls Perception on Eradication of the Practice .....	35
Table 4: Distribution Centers for SRH Discussions .....	39
Table 5: Girls in the upper classes before the CBO’s involvement in educating them on FC’s pros and cons.....	39
Table 6: Distribution of the Sample Community on their Take on FGC.....	44



## **LIST OF ABBREVIATIONS AND ACRONYMS**

AMREF: African Medical and Research Foundation

CBO's : Community Based Organizations

CEDAW: Committee on the Elimination of Discrimination against Women

EWAP: Ewangan Women Advocacy Program

FPAK: Family Planning Association of Kenya

KDHS: Kenya Demographic Survey

MYWO: Maendeleo Ya Wanawake Organization

NGOs: Non –Governmental Organizations

UDHR: Universal Declaration of Human Rights

UN: United Nations

UNCRC: United Nations Convention on the Rights of the Child

UNFPA: United Nations Population Fund

UNICEF: United Nations Children's Fund

WHO: World Health Organization

## ABSTRACT

Female genital mutilation / cutting / circumcision (FGM or FGC) are terms used to incorporate a wide range of traditional practices that involve the partial or total removal of the external female genitalia basically for traditional and cultural reasons mostly in African societies. Thus this study addresses the perceptions of this practice and looks at different efforts by the Community Based Organizations (CBO's) and Government to eliminate this traditional practice among the Maasai people of Kajiado County in the Republic of Kenya.

Thus the researcher set out to establish the community's perception of FGC, what efforts have been put in place by both the stakeholders and community in abolishing it and levels of acceptance by the community in bringing it to an end.

This study was conducted among the residence of Imbirikani Group Ranch. In executing this study, snow balling was applied. The application of this technique (snowball) aided the researcher to not only be better placed with the selection of respondents but also in differentiating between the circumcised and uncircumcised girls, as it has been discussed in chapter three. It thus made the data collection exercise easier and time saving. FGC is organized by the village elders bringing together girls of the same age group to be circumcised. This is done majorly to save on costs and also due to the convenience of the period it is engaged.

The research findings revealed that 80% of the girls are not in support of the practice being a must rite of passage. Their perception was found to be in agreement with that of the government and some of the area residence. They were also secure to be introduced to the alternative rite of passage which its teachings would keep to the norms and values of the Maa people without causing any harm to their bodies. The findings also indicated that perceptions held by those who are in favor of the practice are based on a number of motivating factors, tradition topping the list.

The open campaign efforts that are being employed by AMREF and the CBO's in the ranch, with the support of the government to eliminate FGC in Maasai land is slowly being welcomed by the residence. Thus as a result of these efforts, there has been a gradual change in the community; however this does not yet mean that the practice has been eliminated. But through the research findings and recommendations, the practice will slowly be faced off. However through "Cultural Lag Theory," explains the fact that all parts of culture do not change at the same pace. His argument was that the rapid change in material conditions had resulted in numerous examples of what he termed "cultural lag." He used this term to describe what happens when related parts of a culture react to some change to strikingly different degrees, or with different speed.

Hence it aided in understanding why FGC still persists in the Maasai community in spite of the introduction of formal education. The research therefore recommends that the stakeholders through their campaigns of using role models should engage them further to act as mentors and reach out to the young girls. This will hence enable the young girls not to easily be swayed by peer pressure and give into the knife.

## CHAPTER ONE: INTRODUCTION

### 1.1 Background

Female genital mutilation (FGM), also known as female genital cutting (FGC) and female circumcision (FC), is defined by the World Health Organization (WHO) as all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. It is practiced mainly in 28 countries in Africa, in parts of Asia and the Middle East. WHO estimates that 140 million women and girls around the world have experienced female circumcision (WHO 2008).

Anika Rahman and Nahid Toubia (2000), write that attempts in the early 20th century by colonial administrators to halt FGM succeeded only in provoking local anger. In Kenya, Christian missionaries in the 1920s and 1930s forbade their adherents from practicing it. In part because of the medical consequences, but also because the accompanying rituals were seen as highly sexualized and as a result it became a focal point of the independence movement among the Kikuyu, the country's main ethnic group.

FGM is typically carried out between girls of the age of four years old and puberty, although it may be conducted on younger infants and adults. It may take place in a hospital, but is usually performed without anaesthesia by a traditional circumciser using a knife, razor or scissors. The practice is rooted in gender inequality, cultural identity, ideas about purity, modesty, aesthetics, status and honour, and attempts to control women's sexuality by reducing their sexual desire, thereby promoting chastity and fidelity. In communities that practice it, it is typically supported by both women and men, (Momoh 2005).

The health consequences of FGM can include recurrent urinary and vaginal infections, chronic pain, infertility, fatal haemorrhaging, and complications during childbirth. Opposition to it focuses on the health issues, rights violations and lack of informed consent; in 2012 the United Nations General Assembly unanimously passed a resolution banning it. Nnaemeke (2001), writes that there is a large body of research and activism in Africa that strongly opposes FGM, but she cautions that some African feminists object to what she calls the imperialist infantilization of African women, and the idea that FGM is nothing but a barbaric rejection of

modernity. She further suggests that there are cultural and political aspects to the practice's continuation that make opposition to it a complex issue.

The practice continues because of cultural and religious factors that vary from country to country and region to region. It is considered by its practitioners to be an essential part of raising a girl. Women themselves may insist on it for their daughters, or for themselves. The ritual around FGM has been the primary context in some communities in which the women come together. This is because they see it as a way of moving from girlhood to womanhood, and a way of differentiating between each other, (Tamar in Ni Mhordha 2007).

The above is reinforced by Momoh's views of the societies that practice it. According to her a number of cultural elements are present. This includes particular beliefs, behavioural norms, custom rituals and social hierarchies, religious, political and economic systems. She goes on to write that culture is learnt and children learn from adults. Female genital circumcision has been supported by centuries of tradition, culture and false beliefs and it is perpetuated by poverty, illiteracy as well as the low status of women in societies.

In Kenya approximately 32% of the women aged between 15 and 49 are said to be cut, (KDHS 2009). One ethnic group of people called the Maasai practice it. They view it as an expression of cultural identity and a sacred ritual sanctioned by ancestors, (Momoh 2005). In spite of the efforts put by the government and other stakeholders such as international and local organizations to curb the practice. A good number of the young Maasai women are still being put under the knife especially during the August and December school holidays. This therefore, led the researcher to establish the community's perception of female genital cutting and the efforts taken by both the local community and other stakeholders in the fight against it.

## **1.2 Statement of the Problem**

According to Boyle (2005), he writes that WHO, adopted to use the term female circumcision because this practice was referred to as a social and cultural issue as opposed to a medical issue. At the community level, using the term mutilation can be viewed as being judgmental. Thus, female circumcision is used by practicing communities because it is a close literal translation

from their own languages. In 1996, the Reproductive-Educative and Community Health Programme (REACH), a United Nations Population Fund programme, opted to use female genital cutting (FGC) instead of female genital mutilation (FGM) which was thought to imply excessive judgment by outsiders as well as insensitivity towards individuals who have undergone the procedure, (Population Reference Bureau 2001). For purposes of this study, the term female genital circumcision/cutting (FGC) will be used alternately.

In the global picture, estimates show that between 100-140 million girls and women have undergone FGC, and at least 2-3 million girls a year are at risk of undergoing some form of procedure worldwide, ( WHO 2008; Momoh 2005). In Kenya there is one group of people called the Maasai that practices FGC to initiate girls into adulthood.

They view it as an expression of cultural identity and a sacred ritual sanctioned by ancestors and protected by cultural beliefs. Thus, they practice FGC because it is to them a rite of passage from childhood to adulthood. The cultural significance of the practice is seen to be the preservation of chastity and to ensure ‘marriagability’ of the girl child. The roots of the practice run deep into the individual’s sense of loyalty to family and belief in a value system (WHO 2009).

The above justifications are similar to what Gollaher (2000), writes about the reasons advanced for circumcision. These closely relate to perceived benefits circumcision comes with. Social pressures in Kajiado where most women are circumcised, provides an environment in which circumcision becomes a requirement for social acceptance hence the continuous practice, (Centre for Reproductive Rights 2003). Toubia (1995), summarizes the reasons as follows: beauty/cleanliness, male protection/approval, health, religion and morality.

Tamar Wilson as cited in Ni Mhordha, (2007), summaries the reasons for practicing FGC as: “the enhancement of women’s femininity by excising masculine traits; the marking of ethnic boundaries; the limitation of women’s excessive sexual desire; and to purify women, “readying” them for their overwhelming important reproductive role.” FORWARD (2002) argues that, “The reasons for FGC are diverse, often bewildering to outsiders and certainly conflicting with

modern western medical practices and knowledge. The justifications for the practice are deeply inscribed in the belief systems of those cultural groups that practice it.”

Therefore, in spite of it being viewed as a rite of passage by its practitioners it has health implications that calls for the stakeholders to be alarmed and call for its end because, circumcisions are predominately performed by un-trained older women, or village barbers on “earthen floors of huts, under lighting conditions that are inadequate to any surgical procedure” (Lightfoot-Klein, 1991). Since antibiotics and anesthetics are seldom administered, children are kept restrained and immobilised by several women. Cutting is carried out using an assortment of rudimentary and often un-sterile instruments ranging from knives, razors, glass or scissors. To ease the wounds and prevent bleeding a variety of mixed herbs, earth, or ashes may be applied. It is important to note that even though risks can be substantially reduced when FGC is performed by a qualified health practitioner within a health care facility they are by no means eliminated (WHO, 1998; McLean & Graham, 1983).

Although predominately associated with Africa, FGC is not just an African phenomenon and, according to WHO (1994), it has existed in all countries at one time or another. This study will thus argue for the eradication of the harmful practice of FGC which in Kajiado district is undertaken during the school holidays.

There is a considerable variance among the stakeholders and the community on the understanding of the benefits and persistence in carrying out the practice. Whereas the community (Maasai people) views it as a rite of passage and way of life that has been psychologically internalized and protected over the years, their counterparts have taken to the ‘western ideologies’ as – carrying hidden assumptions of superiority and ethnocentrism. This has lead to conflict as the stakeholders claiming to fight for the children and human rights, impose on the continuity of the practice on a community that has been socialized into it from one generation to the next.

This therefore, has resulted into a debate on cultural relativism versus universalism, that has resulted to fear of many people being labeled racists or cultural imperialists thus deterring an

active challenge of this almost- taboo subject. Despite the fact that the majority of sociologists may consider FGC unethical, they have not yet adopted a moral position against it creating a middle ground that has a value- free approach that has provoked rejection and accusations of failure (Gordon, 1991).

### **1.3 Research Questions**

1. What is the attitude of the Maasai on FGC?
2. What are the efforts from both the community and other stakeholders in putting an end to the practice?
3. What is the response of the Maasai in regard to bring the practice to an end?

### **1.4 The General and Specific Objectives of the Study**

The general objective of this study is:-

To explore initiatives taken by the local community and other stakeholders in the fight against female genital circumcision.

#### **Specific Objectives**

This study aims to:-

1. To establish the community's perception of female genital cutting.
2. Find out what efforts have been put in place by both the community and other stakeholders in abolishing FGC.
3. To find out what are the levels of acceptance by the community in bringing it to an end.

### **1.5 Justification of the Research**

Female genital circumcision is a harmful practice and it is against the human right of girls and women. Its health, social and psycho-sexual implications for girls outweighs its cultural and the misconceived religious purpose. In recognition of the violations that underpin FGC, the government has legislated against the practice. However, legislation alone is not sufficient and is just but part of the solution. A lot more needs to be done such as, a concerted effort to create awareness on the dangers of the practice and sensitize the communities that practice FGC such as Imbirikani group ranch to abandon it and seek alternative ways. It is imperative to adopt holistic

measures that are multifaceted to bolster the legal provision. This can only be achieved through creating awareness and putting policy measures that articulate the various approaches of tackling the FGC problem.

### **1.6 Scope and Limitations of the Study**

The research was carried out in Kajiado district in Imbirikani Group Ranch. Isolated by geography, poverty and/or low levels of development the Maasai community in Kajiado live in widely dispersed areas in this district. They are well known for circumcising their women. They are fiercely protective of their culture and this is most probably the heart of the reasons as to why this practice continues. The hilly terrain in the district makes transport and communication very difficult. The primary occupation is raising cattle. The respondents mainly involve women even though men also play a role in it.

The research was involved and not limited to find out; the community's perception on the practise as perceived widely by the women who are of the age of thirty years and above and girls who are eleven to sixteen years of age, who suffer stigmatization and isolation on the hands of their peers. Secondly; the study tried to fill the gap on whether the community was ready and willing to buy into the stakeholder's ideologies and alternative practices, or they will still continue with their tradition.

This thus led to the study examining on the issue of Cultural Relativism versus Universalism and feminist theory. Lastly the research wanted to investigate whether the community has embraced the efforts of the stakeholders in introducing an alternative rite of passage and the various campaigns in sensitizing them on the various health impacts caused by FGC on the girls. Also, what part they played and will continue with in attaining the intended aim.

### **1.7 Definition of Key Concepts**

**Female genital mutilation (FGM)**, also known as **female genital cutting** and **female circumcision**, is defined by the World Health Organization (WHO) as "all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons."



FGM is typically carried out on girls from a few days old to puberty. It may take place in a hospital, but is usually performed, without anesthesia, by a traditional circumciser using a knife, razor, or scissors. According to the WHO, it is practiced in 28 countries in western, eastern, and north-eastern Africa, in parts of the Middle East, and within some immigrant communities in Europe, North America, and Australasia.

The WHO estimates that 100–140 million women and girls around the world have experienced the procedure, including 92 million in Africa. The practice is carried out by some communities who believe it reduces a woman's libido.

**Clitoridectomy** - surgical removal of the clitoris: a form of female circumcision especially practiced as a religious or ethnic rite.

**Excision** – is the removal of the clitoris and the partial or total excision of the labia minora.

**Infibulation** - Is the removal of the clitoris and the partial or total removal of the labia minora. In addition, incisions are made on the labia majora to create raw surface that are then stitched together or kept in contact by tying the legs together until healing occurs.

**Perception** –the way the community understands the meaning of female genital cutting; their own belief or option of it.

**Abolish** –to put an end to the custom and adopt to the alternative practice or ritual as a passage of rite, such as educating the young women on the proper ways of taking care of themselves when handling a man (husband), a child when their ready for child bearing and mostly on their own personal hygiene.

## **CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK**

### **2.1 Introduction**

Female genital cutting is the collective name given to several different traditional practices that involve the cutting of female genitals for cultural or any other non-therapeutic reasons, (Toubia 1995; WHO 1997a; WHO 1997b; WHO 2008a; WHO 2008b; Shell-Duncan et al 2000; FORWARD 2002; UNFPA 2007).

From the studies that have been conducted, four different types of female genital cutting have been identified, (WHO 1997b; WHO 1998; WHO 2008a; WHO 2008b; FORWARD 2002; UNFPA 2007; Shell-Duncan et al 2000).

These include;

- ❖ 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).
- ❖ Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulations).
- ❖ Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

### **2.2 FGC: An Overview of the Practice, Definitions and Associated Health Issues**

#### **2.2.1 Definitions of FGM**

In a joint statement by WHO, UNICEF and the UNFPA on FGC is as follows;

*“Female genital cutting comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons”* (WHO, 1997).

Indigenous populations refer to FGC by a variety of localised dialects which, according to feminists Rahman and Toubia, “are often synonymous with purification or cleansing, such as the

terms *tahara* in Egypt, *tahur* in Sudan and *bolokoli* in Mali” (Rahman & Toubia, 2000). The terminology itself also varies between and within countries; for example, in the Sudan FGC may be referred to as *sunna* or infibulation – otherwise known as *pharaonic*. A common misconception is that FGC is analogous to male circumcision as both practices remove healthy tissue and are carried out on children without them fully understanding it’s impacts on their health. However, there are key differences between them. For example, whereas male circumcision is a requirement of certain religions, FGC is not (WHO, 1998). Moreover, FGC is far more severe than male circumcision since it removes critical parts of the sexual organ. As feminist Zenie-Ziegler confirms, “there is no similarity between male circumcision, a prophylactic measure recommended for boys in almost every society and female circumcision, the goal of which is to diminish, if not suppress sexual desire in women” (Zenie-Ziegler cited in Abu-Sahlieh, 1994).

### **2.2.2 Types of FGC**

The type of mutilation performed depends upon the geographic location and ethnic population as well as the degree or severity of cutting. Recognizing the need for a standardized definition the WHO produced a classification which delineated FGC into four types (WHO, 1995).

The most prevalent forms are Type I and II, which account for approximately 80 to 85 per cent of all mutilations (Morison, 2001; Toubia, 1995). Type III represents the most severe form of mutilation, constituting approximately 15 to 20 per cent of all FGC practiced (WHO, 1998; WHO, 2001).

In this instance, the entire clitoris is removed together with the labia minora and the inner surface of the labia majora. The raw edges of the vulva are then stitched together using either silk, thorns, poultices or catgut sutures leaving a small posterior usually 2 to 3 cm in diameter but sometimes as small as the head of a matchstick, which allows for the flow of menstrual blood and urine. During the healing process, which lasts approximately 2 to 6 weeks, the girl’s legs are bound together from hip to ankle and a foreign object such as a piece of wood or reed is inserted into the opening to prevent closure (WHO, 1998, 2001).

A common theory is that FGC is evolving and perhaps becoming even “more widespread or extreme” (Mackie, 2000). Toubia discusses a disturbing modification to FGC, one which she claims is “more severe than clitoridectomy and only a little less damaging than infibulation” (Toubia, 1995). Known as ‘intermediate circumcision’, she argues that it has “developed in countries where infibulation has been outlawed (such as Sudan) or where the impact of infibulation on women’s health has been criticised” (Ibid). Lightfoot-Klein also notes a variation taking place in Sudanese FGC but relates it to the repair procedure which occurs after the birth of a child. In order for women to give birth a temporary incision is made in the infibulation scar, which is re-stitched after birth. However, she argues that “instead of the vaginal opening being restored to the size it was before women are now being re-sewn to a pinhole-sized opening” (Lightfoot-Klein, 1989).

Such repair or reconstruction, she suggests “is a bastardization of the Western vaginal tuck, first practiced by educated upper-class women with exposure to the West and which has gradually filtered down” (Ibid). The purpose of which is “thought to ensure the wife’s position by providing her husband with a “virginal” vagina once more” (Ibid).

### **2.2.3 Health Implications of FGC**

FGC is regarded as public health concern because of its potential to cause serious complications (WHO, 1997, 1998, 2001). Short-term complications can include severe pain, shock, haemorrhage, urine retention, and ulceration of the genital region, injury to adjacent tissue and organs and infection - not to mention death. Longer term complications can include retention of menstrual blood, chronic infections, cysts, damage to the urethra, sexual dysfunction and difficulties with child birth and HIV/AIDS (WHO, 1998, 2001; Toubia, 1995; BMA, 2001).

Hosken (1979) and Koso-Thomas (1987) argue that FGC can also inhibit fertility and lead to sterility, but the extent of this still remains unclear. The BMA conclude that “risks are intensified when operators work in un-sterile conditions without anaesthesia” (BMA, 2001).

Risks and complications depend upon the type and severity of the procedure performed the hygiene conditions, the co-operation and physical condition of the child or woman and the precision and eyesight of the operator. Mutilations are predominately performed by un-trained older women,

TBAs or village barbers on “earthen floors of huts, under lighting conditions that are inadequate to any surgical procedure” (Lightfoot-Klein, 1991).

Since antibiotics and anesthetics are seldom administered children are kept restrained and immobilised by several women. Cutting is carried out using an assortment of rudimentary and often un-sterile instruments ranging from knives, razors, glass or scissors. To ease the wounds and prevent bleeding a variety of mixed herbs, earth, or ashes may be applied. It is important to note that even though risks can be substantially reduced when FGC is performed by a qualified health practitioner within a health care facility they are by no means eliminated (WHO, 1998; Mclean & Graham, 1983).

### **2.3 International Response**

In 1997, the World Health Organization (WHO) issued a joint statement with the United Nations Children’s Fund (UNICEF) and the United Nations Population Fund (UNFPA) against the practice of FGM. A new statement, with wider United Nations support, was then issued in February 2008 to support increased advocacy for the abandonment of FGM.

The 2008 statement documents new evidence collected over the past decade about the practice. It highlights the increased recognition of the human rights and legal dimensions of the problem and provides current data on the frequency and scope of FGC. It also summarizes research about why FGC continues, how to stop it, and its damaging effects on the health of women, girls and newborn babies.

Since 1997, great efforts have been made to counteract FGC, through research, work within communities, and changes in public policy. Progress at both international and local levels includes:

- wider international involvement to stop FGC;
- the development of international monitoring bodies and resolutions that condemn the practice;
- revised legal frameworks and growing political support to end FGC; and

- in some countries, decreasing practice of FGC, and an increasing number of women and men in practicing communities who declare their support to end it.

Research shows that, if practicing communities themselves decide to abandon FGC, the practice can be eliminated very rapidly.

## **2.4 Kenya's Statistics on FGC**

Female Genital Cutting (FGC) is practiced in more than three quarters of the country, although the prevalence of the practice varies widely from one ethnic group to another. It is nearly universal among Somali (97%), Kisii (96%), Kuria (96%) and Maasai (93%) women. It is also common among Taita/Taveta (62%), Kalenjin (48%), Embu (44%) and Meru (42%). Levels are lower among Kikuyu (34%), Kamba (27%), Turkana (12%) and Mijikenda/ Swahili (6%). FGC is almost non-existent among Luhya and Luo women (each less than 1%). The type of mutilation varies by the ethnic groups (e.g. Type III is most common among Somali women; Type II among the Maasai, Kalenjin, Meru, Kuria; and Type I among the Kisii). There has been a notable reduction since 1998 in the proportion of Kalenjin, Kikuyu, Kamba and Mijikenda/ Swahili women who reported being circumcised.

According to the 2009 Kenyan Demographic Health Survey (KDHS), 32% of Kenyan women aged between 15 and 49 years are said to be circumcised. In 2003 the KDHS recorded a figure of 38%. Among the older age groups, a larger proportion of women have been subjected to FGC, rising from 20% of women aged 15-19 to 48% of those aged between 45 and 49. This implies that there has been a radical decline in the prevalence of the practice (by about half) over the last two decades. A higher proportion of rural women (36%) than urban women (21%) have been circumcised. North Eastern Province, included in the 2009 KDHS, has the largest proportion of women circumcised (99%).

On average, women now aged between 15 and 19 are subjected to FGC at the age of 13, whereas women then aged between 19 and 49 were excused on average at the age of 15. Female infants are also circumcised among the Taita for instance, while other ethnic groups inflict FGC on girls younger than ten years of age that is; Somalis, Kisii and Borana. But in all districts, reports point

to the practice being inflicted on even younger girls. In some cases, poverty is forcing families to marry off their young daughters to obtain dowry, while another factor is the rise in teenage pregnancies. Yet other parents may fear that older daughters might become aware of their rights and refuse to submit to the practice. The type of FGC practiced has also changed, WHO (2000). 62% of circumcised women over the age of 50 have undergone Type II FGC, while only 39% of the 15-19 age groups underwent the same type most of the remainder underwent Type I. There is a strong correlation between education level and FGC. 58% of women with no education report that they are circumcised compared with only 21% of those with at least some secondary education.

Common reasons for the persistence of the practice are the need to observe customs and traditions, the attempt to improve the marriage prospects of women, the wish to curb women's sexual desire and the need to mark the passage from childhood to womanhood.

FGC is predominantly performed by traditional circumcisers. In Kajiado and Kuria trained nurses are increasingly performing FGC. The 1998 KDHS indicates that 27% of cases of FGC are today performed by trained medical staff in hospitals. Although this trend might reduce the immediate pain or risk of infection, it does not prevent long-term complications or psychological trauma. FGC must be seen as representing a danger to women's health as well as a violation of human rights.

## **2.5 Different FGC Perceptions and Human Rights Approach**

FGC, has been practiced for millennia (Shandall, 1967; Rahman & Toubia, 2000), and according to Carr is “nearly universal within the groups where it is found” (Carr cited in Mackie, 2000). However, it was not until the 1960s and 1970s, when Western feminists expressed their empathy through public statements and studies did discussion concerning cutting practices become most prominent. While exposure was helpful in removing the shroud of silence which surrounded the practice up to that time, the subject itself has become a highly contested terrain within sociological, feminist and developmental discourse and practice.

Debate stems not necessarily on whether FGC should end – as most Africans and non-Africans would probably agree that it should - but rather the manner in which it has been approached and the “strategies and methods (particularly their imperialist underpinnings) used to bring about this desired goal” (Nnaemeke, 2001).

Unfortunately, the overall mishandling of the issue has, Toubia argues “created a defensive reaction among people involved with the practice who might otherwise be allies in the fight for eradication” (Toubia, 1995). This was demonstrated by the first president of Kenya – Jomo Kenyatta during the early part of the century. As leader of the anti-colonial movement he considered British attempts to criminalize FGC as a threat to national solidarity and an attack on cultural identity and social order. The scope of the debate has also cast doubt over whether “outsiders” - individuals who have not undergone the operation and who are not from the societies they study - have a right to “interfere” in the customs of other cultures.

According to Dorkenoo (1994); Dorkenoo & Elworthy (1992); Weil-Curiel (2001), FGC is generally performed without consent and can cause considerable harm to sexual, mental and physical health, it is perceived by external observers (mostly Western) as one of the most brutal and flagrant abuses of girls’ and women’s rights. As Walker and Parmar (1993) note, “FGC endangers women and children wherever they live and impacts negatively on people’s lives and health around the world.” All types of FGC are cited as examples of international and gender-based violence comparable to rape, child abuse and domestic violence.

As Vissandjee (2003) argues, FGC is “part of a continuum of terror-inducing acts against women that range from verbal abuse to mutilation and torture, and that can end in death.” However, as Pickup notes, definitions of violence are not universally shared, and “the fact that women in different cultural contexts may not recognise forms of violence makes it essential to bear in mind some kind of objective definition” (Pickup, 2001). A universal sense of objectivity has proved difficult to establish, particularly within the realm of sociology.

Among the Maasai, tradition has played a major role in the extent at which FGC has been continuously been carried down from one generation to the next without failure. Older women in



the Maasai culture believe that the practice is good for their daughters and thus make sure that it is passed down the generation. Many of these women underwent the ordeal when they were at the tender age of 4-7 years, thus they were socialized into it. Lack of education in the past also contributed to the continuity of this practice. However in the recent times things have not changed much and many families are still engaging in it, in spite of having the knowledge and fully understanding the extent FGC can cause to their girls.

A girl's mother is the major decision maker. The father is more involved when decisions are made as to which family her suitor should come from. On the general level, tradition and social importance are mentioned as the main motives for performing FGC. Though FGC can clearly be defined as a patriarchal institution perpetuated to control women, women almost exclusively maintain the practice. Men's roles in its perpetuation cannot be dismissed in totality.

Sexuality is also an aspect that is frequently mentioned. The practice is believed to ensure virginity/ decrease sexual desire or for the benefit of the future husband/ because men prefer it. Thus socializing the community to believing that female genital cutting is socially important. Though this may be so for the majority of the Maasai people, a small fraction of its elite tend to differ and are taking to the western ideology.

### **2.5.1 Women and Children's Human Rights**

Since the UDHR was proclaimed over fifty years ago, governments continue to strive towards the eradication of world poverty, ignorance, hunger, and cruelty. Most governments in countries where FGC is practiced have ratified several UN Conventions and Declarations that make provision for the protection of women and children, including the abolition of FGC.

For example, in 1979 the international community publicly endorsed CEDAW which addresses equal rights for women in all fields, and "calls on governments to modify or abolish customs and practices that constitute discrimination against women or are based on the idea of female inferiority or stereotyped roles" (Toubia, 1995). This was preceded by the World Conference on Human Rights, where 171 governments adopted by consensus a Declaration which stated that the human

rights of women are an inalienable, integral and indivisible part of universal human rights (Dorkenoo & Elworthy, 1992).

Other international standards applicable to FGC include the UN CRC which requires governments to take appropriate measures to protect children from all forms of exploitation whilst abolishing traditional practices prejudicial to their health Article 39 states that “no child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment” (United Nations, 1989: Article 39).

Although the UN Charter affirms the equal rights of women and men, and states that everyone has the right to enjoy human rights without discrimination on grounds of sex, the overall effectiveness of such treaties is questionable. Women’s civil, political, economic and cultural rights continue to be denied in the name of cultural values which are based on unequal power relations. Furthermore, states continue to repudiate accountability for violations against women and children. As Amnesty International notes:

*“The gender-blindness of the international human rights framework has meant in practice that gross violations of women’s rights have often been ignored and structural discrimination against women has not been challenged”* (Amnesty, 1998).

In order for treaties to be meaningful, Dorkenoo and Elworthy suggest that they “should not merely remain a paper provision, to be given lip service to those entrusted to implement it” (Dorkenoo & Elworthy, 1992). Instead they argue that “members of the UN should work at translating its provisions into specific implementation programmes at grassroots level” (Ibid).

Although many Western governments in practice flout the principals of human rights its overall universality remains a challenge. The U.S., for example, remains reluctant to be bound by human rights treaties that embody these principals. It also represents one of the few countries that has not ratified CEDAW or signed up to the CRC. According to Amnesty International “even when it has ratified international human rights conventions, it has often entered extensive reservations, refusing to be bound by many of the provisions within them” (Amnesty, 1998).

Governments such as the U.S. which abstain from or deny the indivisibility of human rights jeopardise the health and well being of millions of girls and women around the world who depend on the reform of FGC and other deeply rooted harmful practices.

## **2.6 Justification for the Practice**

Momoh says that in societies that practice female genital circumcision a number of cultural elements are present (Momoh,2005). According to her these include particular beliefs, behavioral norms, custom rituals, and social hierarchies, religious, political and economic systems. She goes on to write that culture is learnt and children learn from adults. Female genital mutilation has been supported by centuries of tradition, culture and false beliefs and it is perpetuated by poverty, illiteracy as well as the low status of women in societies (ibid).

Lightfoot-Klein (1991), argues that custom, the penalty for not practicing which is total ostracism, make up some of the reasons for female genital mutilation. According to Lightfoot-Klein other reasons for female circumcision seem to be the same in most African societies and are based on myths and ignorance of biological and medical facts. To some practicing communities, the clitoris is seen as repulsive, filthy, foul smelling, dangerous to the life of newborns and hazardous to the health and potency of the men (ibid).

Sarkis (1995), writes that some of the reasons advances for FGC include family honor, cleanliness, protection against spells, insurance of virginity and faithfulness to the husband. Simply terrorizing women out of sex are sometimes used as excuses for the practice of FGC.

Other scholars have associated the justification for this practice with a manifestation of deep rooted gender inequality that assigns the female gender in an inferior position in society and has profound physical and social consequences, (Yoder, P. et al 2004; WHO 2008).

FGC is practiced because it is seen as a rite of passage from childhood to adulthood. The cultural significance of the practice is seen to be the preservation of chastity and to ensure that the girl remains pure until when she is married. The roots of the practice run deep into the individual's psychology, sense of loyalty to family and belief in a value system (WHO 1998).

The above justifications are similar to what Gollaher (2000) writes about the reasons advanced for circumcision. These closely relate to perceived benefits circumcision comes with. Social pressures in communities where most women are circumcised to provide an environment in which circumcision becomes a requirement for social acceptance hence the continuous practice (Centre for Reproductive Rights 2003). Toubia (1995) summarizes the reasons as follows: beauty/cleanliness, male protection/approval, health, religion and morality.

Tamar Wilson as cited in Ni Mhordha (2007), summaries the reasons for practicing FGC as: “the enhancement of women’s femininity by excising masculine traits; the marking of ethnic boundaries; the limitation of women’s excessive sexual desire; and to purify women, “readying” them for their overwhelming important reproductive role.”

FORWARD (2002) argues that, “The reasons for FGC are diverse, often bewildering to outsiders and certainly conflicting with modern western medical practices and knowledge. The justifications for the practice are deeply inscribed in the belief systems of those cultural groups that practice it.”

## **2.7 Theoretical Framework**

### **2.7.1 Cultural Relativism versus Universalism**

Current arguments among sociologists reveal an old tension between the tolerance of Cultural Relativism and an activist intolerance of repressive or violent conditions. Relativism (as espoused by Franz Boas and his students Ruth Benedict; Margaret Mead and Melville Herskovits) is complex since it raises questions of how much it is possible to understand or comprehend “others” culturally based realities. As Ingold notes:

*“Sociologists stress that there are as many standards of humanity as there are different ways of being human, and that there are no grounds – apart from sheer prejudice – for investing any one set of standards with universal authority” (Ingold, 1994).*

Relativists, therefore, are of the opinion that all cultural beliefs and values have underlying meanings which need to be interpreted within their original cultural contexts. In other words, this

“hands off” and detached observer approach asserts that no outsiders have the ability nor right to impose change upon “others” and that it should be left to those concerned “to argue it out for themselves” (Scheper-Hughes, 1991). Contrasting this is the Universalist approach, which defines FGC as an act of international violence.

Intervention is considered a necessary prerequisite on the grounds that “its morality transcends national boundaries and cultural beliefs” (Annas, 1996). Greer dismissed this view arguing that “anti-relativism was really just a symptom of the pre-ethnographic nostalgia, an attempt to put the apple of diversity back into the tree of Enlightenment” (Greer, 2000). Despite the fact that the majority of sociologists may consider FGC unethical, they have not adopted a position of moral advocacy against it. This middle ground and value-free approach has thus provoked rejection and accusations of failure (Gordon, 1991).

The fear of being labelled either a racist or cultural imperialist has deterred many people from actively challenging this almost-taboo subject. The research would argue, however, that FGC is ritualized violence, is a violation of women’s and children’s human rights, and is an attack on natural sexuality and bodily integrity. Like all other forms of gender based abuse and discrimination they are, therefore, unacceptable.

The reluctance to “interfere with other cultures”, voice concern or to take a stand is simply colluding with its perpetuation and putting thousands more innocent women and children around the world at risk. As such, the research must identify its own position in the debate as a Universalist one.

### **2.7.2 Feminism and Theoretical Debates**

Since the 1970s, FGC has developed into a legitimate topic of scientific inquiry and popular discussion, cutting across disciplines and audiences, and often sparking bitter debate and international controversy. Even the term itself has been attacked and dismissed for being a crude analogy, insinuating intent to harm (Shell-Duncan & Hernlund 2000; Rahman & Toubia 2000). Such controversy became apparent during the 1985 UN Decade for Women conference in Kenya,

where many African women reacted angrily to what they considered were colonial tones of Western feminists. As one Oxfam delegate argued:

*“The use of the emotive term ‘mutilation’ in the presence of women survivors, and the revulsion expressed by international activists who considered women who had undergone FGC to be ‘incomplete’ or ‘disabled’, appeared to be another form of abuse” (Pickup, 2001).*

Recognizing the hostility generated by the term, many scholars and field workers instead prefer to use FC or FGC. However, these have also been criticised for appearing to trivialize its severity. As Baden notes, “female circumcision’, refers to the mildest form of operation which affects a small percentage of the millions of women operated on” (Baden, 1992). Nevertheless, FGC “remains an effective policy and advocacy tool” (Rahman & Toubia, 2000) having been adopted by a wide range of activists and NGOs such as the UN, IAC, and the WHO.

Not only has the term provoked debate but so has the language and the discourse which many consider to be both judgmental and sensationalistic – as something “outside the realm of Western civilization, something “other”, “remote”, “barbaric” (Walker & Parmar, 1993). For example, FGC is “a powerful weapon” (Dorkenoo & Elworthy, 1992), “strange and disturbing” (Lightfoot-Klein, 1997), “a harrowing rite” (Dugger, 1996), a practice which essentially disregards the dignity of women and girls.

Understandably, these descriptions have provoked strong resentment from African and Arab women who oppose the view that only Western leadership can introduce a change to this “barbaric” practice. As Nnaemeka notes, “the images (and photographs) of African and Muslim women in books, magazines and films about circumcision are disturbing at best, and downright insulting at worst” (Nnaemeke, 2001). Western condemnation tends instead to be perceived as either imperial arrogance or hypocrisy, which does not appear too surprising given the fact that the West “allow a surgeon to whittle away female genitalia if the operation is understood to be cosmetic” (Greer, 1999). Although the research agrees with Greer that Western women are in no position to claim a moral high ground since they themselves also engage in so-called-barbaric practices in their pursuit

of possibly-unattainable aesthetic ideals, it is important to emphasise that cosmetic procedures are choices made by consenting adults: not uniformed children.

Feminist scholars and anti-FGC activists (such as Hosken; Koso-Thomas; Rahman and Toubia; Walker, Weil-Curiel to name but a few) interpret FGC as an assault on women's sexuality as well as an oppressive and cruel act which has a grave and catastrophic impact upon women and girls' health. They further associate FGC with a patriarchal desire and need to control women, their bodies, and their sexuality in order to maintain female chastity and fidelity.

As Koso-Thomas argues, "women, over time have been successfully persuaded to attach special importance to female circumcision, motherhood, and housekeeping, in order to maintain male domination in patriarchal societies," (Koso-Thomas, 1987). Koso-Thomas' revolutionary stance urges (African) women to "free themselves from ignorance, fear and mental servitude should join in the education of their sisters" (Ibid).

Others, such as Pickup, regard FGC as an act of material bargaining that women make with patriarchy in order to derive economic support. For example, "it may be a rational – and even loving – decision for a mother to decide to genitally mutilate her daughter in a culture where she will stand little chance of finding a husband otherwise" (Pickup, 2001).

FGC is thought to reflect and reinforce the social and moral order – in which women are obliged – or, as Walker and Parmar argue, "forced and brainwashed" - into being "pure and faithful," (Walker and Parmar, 1993). A problem for feminist analysis has been that women themselves are mostly the ones inflicting FGC; however, the above explanations, by inferring that women simply carry out the desires of men, implies that men are in essence the real, hidden perpetrators.

"Third World" feminists, in turn, have criticised Western attitudes. Firstly; for homogenizing and reductively situating them. Secondly, for their tendency to dominate both theoretical and practical aspects of the feminist movement, and thirdly, for their condemnation of FGC which, they argue, carries hidden assumptions of superiority and ethnocentrism.

As Ahmadu notes, “women are seen as blindly and wholeheartedly accepting “mutilation” because they are victims of male political, economic, and social domination” (Ahmadu, 2000). Moreover, they accuse Western feminists of interpreting FGC out of its socio-economic, political and historical context. Whilst most feminists would regard the subordination of women as a matter of international concern, many resent the categorisations being predominately centred around European and American personalities and events (Ahmadu, 2000; Gruenbaum, 2000; Abusharaf, 1995). With this in mind, feminists such as Minh-ha, Thiam, Spivak and Mohanty have worked towards strengthening the notion of the “Third World woman” and her construction within Western feminist discourse. For example, Mohanty argues that:

*“Western feminists appropriate and “colonise” the constitutive complexities which characterize the lives of women in these countries’, thus ending up with a crudely reductive ‘notion of gender or sexual difference”* (Mohanty cited in Kurian, 2001).

Mohanty’s attempt to subvert intellectual paradigms is criticised by Chowdhry who considers her work equally neo-colonial. Citing Goetz, Chowdhry argues instead that:

*“Western feminist and Western-trained feminist writing often portray Third World women as victims. These feminists base their analysis and their authority to intervene on their “claims to know” the shared and gendered oppression of women. In so doing, they misrepresent the varied interests of “different women by homogenizing the experiences and conditions of Western women across time and culture”* (Goetz cited in Chowdhry, 1995).

It could therefore be argued that by interpreting women as different, or “other”, Western feminists effectively alienate precisely the women whom they claim to support. Nnaemeka argues that, *“feminist activism in the area of female circumcision cannot be separated from the language – verbal, visual - in which the issue is framed and the wider context of Western imperialism”* (Nnaemeka cited in Perry & Schenck, 2001). African women, she says, have in fact become “doubly victimized: first from within (their culture) and second from without (their saviours)” (Nnaemeka, 2001).



French attorney and FGC activist Weil-Curiel, dismisses Nnaemeke's claim that Western feminists use FGC to generate sensationalism. She also criticises Nnaemeke for not mentioning anti-FGC activism among African men and women. According to Weil-Curiel, it is unjust for Western feminists or "the bearers of bad news" to be put on trial and not the perpetrators of the act itself. Instead, she urges African women to "legitimately resist voyeuristic 'saviours' who insult them by exhibiting their body parts in books and films" (Weil-Curiel, 2001).

### **Cultural Lag Theory**

In his cultural lag theory, William F. Ogburn (1964), opinion is that all parts of culture do not change at the same pace. His arguments was that the rapid change in material conditions had resulted in numerous examples of what he termed "cultural lag." He used this term to describe what happens when related parts of a culture react to some change to strikingly different degrees, or with different speed.

According to him cultural lag utilizes the definitions of material culture as "houses, foodstuff and other material objects." Non-material culture includes such phenomena as "custom, folkways, social institutions, beliefs, philosophies, laws and governments."

The idea of cultural lag is that changes and innovations can and do influence different parts of society in different ways, and that these influences can occur at different rates. When differential rates, and impacts, become extreme, those differences most likely create a variety of societal conflicts. Mores, norms and values have changed rapidly around the world in the last several decades as revolutions in technology and society have progressed. Seen in this way cultural lag is more of an explanation for why problems occur than a theory of what causes those differentials, and thus the problems.

Hence it aided in understanding why FGC still persists in the Maasai community in spite of the introduction of formal education. The research therefore recommends that the stakeholders through their campaigns of using role models should engage them further to act as mentors and reach out to the young girls. This will hence enable the young girls not to easily be swayed by peer pressure and give into the knife.

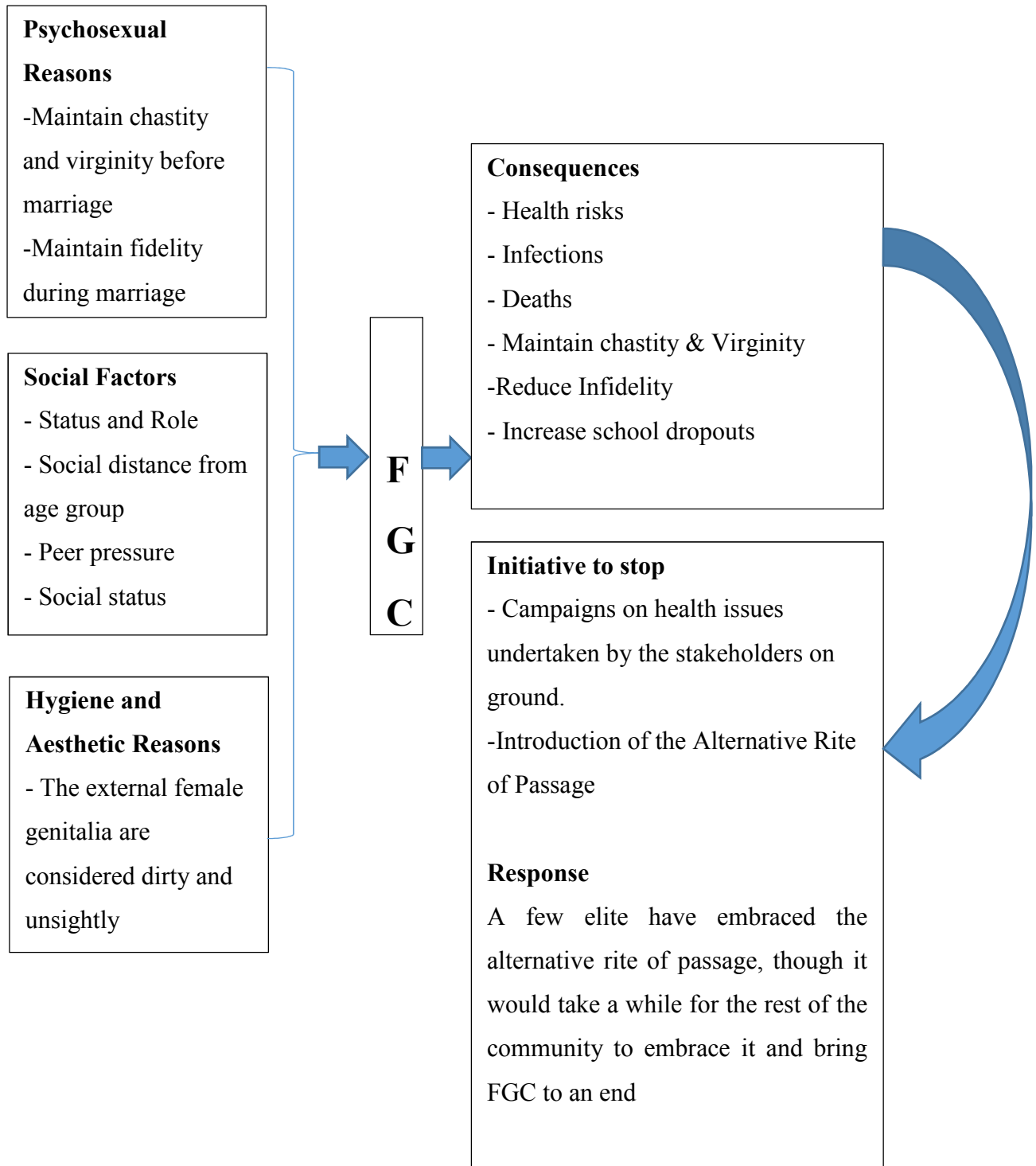
## **2.8 Conceptual Framework of the Study**

In the theories discussed above, the feminists are strongly against the practice. They argue that women are seen as blindly and wholeheartedly accepting “mutilation” because they are victims of male political, social and economic domination (Ahmadu, 2000).

They have gone a step further in ensuring that the girl child rights are recognize and protected by all government through the various stakeholders on the ground. In regards to Cultural Relativism versus Universalism a majority of sociologists may consider FGC unethical; however they have not adopted a position of moral advocacy against it. This middle ground and value-free approach has thus provoked rejection and accusations of failure (Gordon, 1991). This has thus resulted in many loop holes as both parties stand very strongly on their arguments due to the fear of being labelled either a racist or cultural imperialist hence deterring many people from actively challenging this almost-taboo subject.

Momoh (2005), says in societies that practice female genital circumcision a number of cultural elements are present. According to her these include particular beliefs, behavioral norms, custom rituals, and social hierarchies, religious, political and economic systems. She goes on to write that culture is learnt and children learn from adults. Female genital circumcision has been supported by centuries of tradition, culture and false beliefs and it is perpetuated by poverty, illiteracy as well as the low status of women in societies.

**Figure 1: Conceptual Framework Used in the Analysis of Female Circumcision and Its Impact on Sexuality and Reproductive Health Status**



(WHO, 1996; 2000): The perceived benefits for practicing Female Genital Cutting.

***Psychosexual reasons:*** perceived beliefs that reduction or elimination of the sensitive tissue of the outer genitalia, particularly the clitoris, can attenuate sexual desire in the female, maintain chastity and virginity before marriage and fidelity during marriage, and increase male sexual pleasure. Male attitudes to sex and sexual pleasure in the communities practicing female circumcision may support this belief. For example, anecdotal reports suggest that in some communities practicing infibulations, achievement of difficult penetration of a tight vagina was a proof of virginity following marriage.

***Sociological reasons:*** identification with the cultural heritage, initiation of girls into womanhood, social integration, and the maintenance of social cohesion.

***Hygiene and aesthetic reasons:*** the external female genitalia are considered dirty and unsightly and are to be removed to promote hygiene and provide aesthetic appeal; ***Myths:*** enhancement of fertility and promotion of child survival.

These cited perceived benefits, affect decision-making within the family about the FC practices. The timing decision-making process is also influenced by the socio-cultural environmental factors, including socio-economic characteristics, region or ethnic, and peer pressure. Type of circumciser, type of cutting instrument, and type of cutting might associate with the extent of FC impact on women's sexuality, reproductive health, and reproductive rights.

## **CHAPTER THREE: RESEARCH METHODOLOGY**

### **3.1 Introduction**

This chapter discusses the research design and methodology used to achieve the objectives of the study. It provides an in-depth understanding of the target population for the study and will apply the use of interview questionnaires for the key informants and guides for the focus group discussions. This will be the techniques used for data collection on the field together with the sampling designs.

### **3.2 Research Design**

Blaikie (2000), states that qualitative research is committed to viewing the social world: social action and events from the view point of the people being studied; that is discovering their socially constructed reality and penetrating the frames of meaning within which they conduct their activities.

This study is therefore descriptive in nature. Descriptive because it has endeavored to describe the community's practice of female genital cutting and efforts taken by the local community and government to abolish this practice. Thus the research aimed at exploring the real life situation of the Maasai from Kajiado district in relation to female genital cutting while in the field.

### **3.3 Site Selection and Description**

The research was carried out in Kajiado district. It is in southern Kenya and shares its borders with the districts of Narok in the West, Nairobi in the North and the Republic of Tanzania in the South. It lies on latitude of 0.023559 North and longitude of 37.906193 East on the map. (Macmillan Secondary School Atlas, 2009).

The Maasai people are known to be nomads but the residence of Imbirikani are mostly agriculturalists and thus the reason it was selected by the researcher. The area is fertile making it easy for its residence to settle down and with the areas proximity to Mt. Kilimajaro with the rainfall ranging between 895mm to 2500mm in high season, providing plenty of water, KDHS (2009). The produce from their farms provides them with substantial amount of monies that

enable them to take their children to school. However, tradition and culture is as deep rooted in the area just as in any other inhabited by Maasai people.

### **3.4 Source of Data**

#### **Primary Data**

The researcher drew a lot of information from the sample group of 179 individuals on their opinion on the topic. This first hand information has been well illustrated in chapter four with the aid of graphs, tables and percentages.

#### **Secondary Data**

Previously researched works on the topic were used in obtaining literature and the required theories to explain this practice, which is not only found to exist in Africa but also in the western countries too.

A substantive amount of information was also collected from newspapers articles and journals. As Stewart (1984), argues, secondary data provides a comparative tool for the research. These helped compare existing data with raw data for purposes of examining differences or trends. However the limitation of using secondary data was that such information was collected for purposes different from the current research.

### **3.5 Target Population**

The Imbirikani residence constituted the entire ranch for the study. One group was of girls and women who have undergone FGC. The other group composed of girls and women who have rejected the practice. A third category constituted the government and employees of organizations (Stakeholders- NGO's and health worker) who work in the struggle to end this practice. The informants were purposively selected because either they were directly involved in the fight against female genital cutting, or they were personally affected by the practice.

### **3.6 Sampling Design**

According to Weil-Curiel, (2001) a sample is a subject of target population to which the research intends to generalize the results.

Hence in this study snow balling was used in selecting respondents by first identifying the community's circumcised and uncircumcised women and girls. This technique was applied in selecting respondents by first identifying an elderly woman who shared on the various age sets or groups that undergo through the practice together. She informed of her own age set and then directed the researcher to the next circumcised woman. The elderly woman also directed the researcher to the girls age set, who after the researcher interviewed one of them and ascertaining through her peers who know her well, would assist in pointing the researcher to the next circumcised girl as they would have gone through the practice together and also due to the announcement of such ceremonies taking place in the village would make them aware of the girls being circumcised at the same period. The rest followed as once the age group was identified the girls would recognize each other and a certain to have undergone through the ritual together.

As for the uncircumcised girls it was not easy to identify them as they hid among the circumcised ones, as they too belonged to the same age set. But with the assistance of the circumcised girls who are locally referred to as siankiki would not want to be associated with ntoye or uncircumcised girls, thus they pointed them out to the researcher who was able to convince one of them to be interviewed and she lead to the identification of the rest. However, it was not easy at first to get them to freely open up and indulge in the topic. Let alone; direct the researcher to their comrades as they saw themselves to be 'less of a girl,' than the circumcised ones, (Nnaemeka, 2001).

However after a long talk and persuasion, they did give in and shared a lot on the stigmatization that they have been exposed to and how they had managed to soldier on. The research did not find any uncircumcised woman of the age of thirty years and above within the ranch. The researcher then selected randomly sixteen women and twelve girls who were representative of the whole community in carrying out separate discussion groups given the nature of the topic.

### **3.7 Methods of Data Collection**

#### **Methods**

The study utilized the following methods in its data collection;

**Interviews** were applied to the Key informants, who helped in bringing out the perceptions, feelings, attitudes, challenges and experiences of the health worker (doctor/ certified nurse), both circumcised and uncircumcised women and girls and an active stakeholder in the area.

**Observation** is another method that the researcher applied on all the issues that complimented and validated data. This method involved observing the discussion informally with the women and girls and probing them for more information. Also finding out how accessible are the stakeholders (NGO's within the area) and government offices. Also what impact they are creating on them as the community.

**Focus Group Discussion** specifically was employed to the female informants who had been involved/not involved in the practice of female genital circumcision. Focus group discussions brought out feelings, attitudes, perceptions and experiences that we're not revealed in individual interviews.

### **Tools**

Questionnaires were carefully formulated to suit collection of information from the sample group. They were all printed in English. However, in the event that there was a respondent not conversant with the language, the researcher interpreted to Kiswahili or Maa. All the questionnaires consisted of closed and open-ended questions. The open-ended questions ensured that respondents were not limited in their responses, while closed ended ensure that respondents gave straightforward answers that were easy to code.

### **3.8 Data Analysis**

The data that was collected was analyzed through the use of quantitative method that took into account the interviewees opinions and perceptions on the research objectives. This was then summarized by use of graphs, and frequency tables for the basic information like number of respondents.



### **3.9 Data Presentation**

Once the data was analyzed the information was presented in the form of simple bar graphs, and frequency tables. This helped in the interpretation and provision of information on the community's demographic data, their perception on the different variables put forth concerning the practice and the data from the stakeholder after their involvement with the residences.

### **3.10 Challenges and Limitations**

Due to the manyattas being sparsely distributed within the ranch, the researcher had to hire a motor bike to transverse the whole area. The other challenge was most of the time the researcher had to get to the manyattas early in the morning so as to get the women in the boma (homestead) before they left for their daily routine; fetching water or fire wood and tending to the animals (both cattle and sheep), among other duties.

Most of the women were at first shy to open up given the sensitivity of the subject but after a short introduction of who I am and where I come from last to my father's age group. Then and only then did they feel comfortable and the discussion would then flow. As for the girls the researcher had to wait until the school went for a tea break or lunch break as learning was not to be interrupted.

## **CHAPTER FOUR: DATA ANALYSIS, PRESENTATION AND INTERPRETATION**

### **4.1 Introduction**

This chapter presents results, interpretation and discussions within the framework of the set study. Female genital circumcision locally known as “emurata” is practiced in Imbirikani group ranch, a remote area of Kajiado district.

The Maasai people perceive female genital cutting as a remedy to reduce if not stop promiscuity among its girls. Therefore, it is an important rite of passage among them. It is practiced in the months of August and December of every year on girls mostly at the age of puberty. It is a well celebrated event that involves the entire community; it is marked by joyful revelry and feasting. A traditional circumciser, usually an elderly woman with great experience, performs the actual procedure. All the girls are circumcised on the same day and, until recent times, with the same instrument, usually a sharp knife known as an “ormurunya”. A paste made from cow dung and milk fat is applied to stop bleeding. The end of the period of seclusion is also marked by celebrations officially welcoming the girls into womanhood.

There are various types of FGC being practiced across Kenya. This has been well illustrated and discussed into details in chapter two. According to Rosemarie Skaine (2005), *Type II* is the most common type of procedure performed on the Maasai girls and women. Where there is a partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). This is similar to what is described by (Shell-Duncan et al 2000) and (WHO, 1998).

#### **4.1.1 Demographic Data of the Respondents**

The respondents targeted in the field comprised of the key informants; a stakeholder-NGO representative, health worker (doctor or certified nurse) and area chief. The others were the girls and women who constituted the main focus of the study.

According to the maasai culture a girl (*entito*) is one who is uncircumcised while a woman is one whose been cut. For the purposes of this study will use the terms circumcised and uncircumcised to differentiate the cut and uncut girl. The religious leaders, elders of the community and the morans’ were also engaged as their input offered a general take on the practice. From the

respondents the following data was collected, the sample size of the interviewed girls both uncircumcised and circumcised was 126 and their age ranged between 11- 16 years. While that of the interviewed women was 50 of whom all are cut and are 30 years of age and above.

#### **4.1.1.1 Distribution by Age**

In the Maasai culture a girl as young as 9 years can sometimes be made to undergo the cut especially in cases where her elder siblings have attained the age of circumcision, (that is 11 to 16 years). A girl who is 16 years and uncut usually faces a lot of stigma and peer pressure as they are viewed as *entito* whilst her cut peers are taken as women ready for marriage.

The researcher, thus choose to interview girls who were of the age of 11years and above as they were more coherent with their culture and know why their parents choose to make them go through the knife. Unlike the 9 year olds who were so young to express themselves well.

Hence the table below show cases the distribution of the girls in the age bracket of between 11 to 16 years. The researcher used data from the 2006 records of Ewangan Women Unity Advocacy Program (EWAP) on page 37, which illustrates the distribution of both circumcised and uncircumcised girls from class five to eight. Where, most of them fall into this age threshold. As for the women the data was purely from the field.

**Table 1: Distribution of Respondents by Age**

<b>Age</b>	<b>Frequency</b>	<b>Percentage</b>
Circumcised girls 11-16 yrs	73	25%
Uncircumcised girls 11-16 yrs	53	15%
Women 30 yrs and above	50	60%
<b>Total</b>	<b>176</b>	<b>100%</b>

The findings presented in this study, was collected from women of the ages of 30 years and above, and girls of the age bracket of 11 to 16 years. The interviewed women represent 60 percent all of whom are cut, while 25 percent represent circumcised girls and 15 percent uncircumcised girls.

#### **4.1.1.2 Distribution of Respondents by Education**

The coming of the Europeans was aimed to colonialize and change the people’s perception on tradition, where the incumbent used religion and education to ‘free’ the Africans. Thus, education has since been used to facilitate the eradication of FGC.

**Table 2: Distribution by Education**

<b>Girls</b>	<b>Class 5</b>	<b>Class 6</b>	<b>Class 7</b>	<b>Class 8</b>
Cut/Circumcised	30	20	13	10
Uncut/ Uncircumcised	22	15	10	6
<b>Total</b>	<b>52</b>	<b>35</b>	<b>23</b>	<b>16</b>

The table above indicates that, of the 52 girls in class five 30 are circumcised and 22 uncircumcised, they represent 70 percent and 30 percent respectively. In class six the cut girls are 20 and uncut 15 representing 75 percent and 25 percent, with class seven having 13 uncircumcised and 10 circumcised. While in class eight the girls who are cut are 10 representing 80 percent and uncut are only 6 representing 20 percent.

According, to WHO (2009), the roots of the practice runs deep into the individuals sense of loyalty to family and belief in value system. Thus the girls are seen to follow in the foot- steps of their elders in keeping to tradition and cultural practices. Momoh agrees with this as she writes that, culture is learnt and children learn from adults through centuries of tradition, culture and false beliefs perpetuated by poverty, illiteracy and the low status of women in society, (Momoh, 2005).

Religion in its modern form causes its leaders to try and conform to it, thus they do not win in the fight to eradicate the practice. This is so as the community has more influence on the girls' life more than the church has. The family which is part of the community socializes them thus they become loyal to tradition.

#### **4.2 Community's Perception on FGC**

This section sought respondent's perception on bringing the practice to a stop. There are different myths about the origin of this practice, not only in Kajiado but also in other communities that practice FGC in Kenya.

Legend has it that, "circumcision was used by jealous men to keep their wives out of adultery."

This over time developed into a practice that is held so dear by the practicing communities. Female genital circumcision is referred to as a traditional practice because it has been maintained from one generation to the next similar to what Skaine, (2005), writes about traditional practices in Africa.

#### **Table 3: The Girls Perception on Eradication of the Practice**

The following 12 variables were used in statements put to them (girls) in levels of agree or disagree; the findings are presented in the table below.

<b>Interviewees</b>	<b>Strongly Agree</b>	<b>Agree</b>	<b>Disagree</b>	<b>Strongly Disagree</b>	<b>Total</b>
<i>Entito</i> , should have the final say on whether to be circumcised or not.	80 (70%)	46 (30%)	0 (0%)	0 (0%)	126 (100%)
Entito should be allowed to willingly participate in circumcision as a rite of passage without being pressured to do so.	70 (70%)	56 (30%)	0 (0%)	0 (0%)	126 (100%)
Parents should always consult their daughters on whether or not to be circumcised.	126 (100%)	0 (0%)	0 (0%)	0 (0%)	126 (100%)
Before a decision is made to circumcise or not to be circumcised <i>entito</i> should be well educated on the pros and cons of the ceremony.	63 (50%)	63 (50%)	0 (0%)	0 (0%)	126 (100%)
FGC is valuable and therefore should be passed onto the next generation.	0 (0%)	0 (0%)	20 (10%)	106 (90%)	126 (100%)
Maasai people should support FGC as a must rite of passage to the community.	0 (0%)	0 (0%)	20 (25%)	106 (75%)	126 (100%)
Efforts to stop FGC should be resisted by all means by the community.	126 (100%)	0 (0%)	0 (0%)	0 (0%)	126 (100%)
The government and key institutions should support FGC.	0 (0%)	0 (0%)	20 (10%)	106 (90%)	126 (100%)

The alternative rite of passage is less harmful both from a psychological, medical and physical point of view and therefore should be supported.	100 (80%)	26 (20%)	0 (0%)	0 (0%)	126 (100%)
The maa community should be properly educated on the alternative rites of passage in order to embrace it.	126 (100%)	0 (0%)	0 (0%)	0 (0%)	126 (100%)
The alternative rite of passage does not in any way infringe on the maa communities values and therefore should be supported.	80 (60%)	30 (25%)	16 (15%)	0 (0%)	126 (100%)
The alternative rite of passage if well managed serves the same purpose of passing on the maasai norms and values to the next generation and therefore should be supported.	106 (90%)	20 (10%)	0 (0%)	0 (0%)	126 (100%)
<b>Total</b>	<b>877</b>	<b>212</b>	<b>76</b>	<b>318</b>	<b>1512</b>
Cell representative	58%	14%	5%	21%	100%

The figure above shows the different cells that are assumed to have same chances and are equally competing. That is each cell has a chance of scoring 100 percent, meaning all the variables have an effect on the girls perception on eradication of the practice. The perception of the respondents is strongly agreed on one end and strongly disagreed on the other end. The measurement of the variables is based on the cell representative which is the actual score over the probable cell times a hundred.

Distribution in the table shows that the variables on the effect the girls' perception and eradicating of the practice are rated differently by the respondents. Strongly agreed cell is rated

high with measurement of 58 percent. On the other hand the cell of strongly disagreed is also rated 21 percent, which means that they object to the practice being supported as a must rite of passage or by the government and the community as a whole. In general, all statements appear strong in measuring the effects of the girls' perception on eradication of the practice.

Evident in the table above is that out of the twelve indicators used to test perception and eradication, the indicator on the alternative rite of passage if well managed serves the same purpose of passing on the norms and values to the next generation is rated the strongest at 80 percent and the indicator on educating the girl on the pros and cons before a decision is made to cut them or not is the least. On the other hand, the weakest indicator on the perception and eradication of the practice is rated strongly disagree at 90 percent.

#### **4.3 Efforts Put Forth in Abolishing FGC by the Community and Stakeholders**

According to the findings from the field, AMREF is the leading NGO on ground undertaking on creating awareness of health issues to the community. They have been on ground in the areas of Loitoktok and Magadi for a period of six years. Through their facilitation for Unite for Body Rights Project the girls have taken part in the mother-girl or safe spaces environment (centers), where they openly address issues around FGC and sexual reproductive health.

There objective being:

1. The use of safe spaces and social networks as a sexual reproductive health (SRH) intervention for nomadic girls and women.
2. The effectiveness of SRH information dissemination and grassroots advocacy in increasing the uptake of information and services.

They used small-group approach to reach Maasai girls and their mothers with information and services. Girls and mothers from close neighbourhoods and in some cases the same churches formed regular meeting fora (space/centers) where they discussed sexual and reproductive health issues. The groups were meant to have a multiplier effect in their villages. The centers were either in schools on Saturdays or in churches after Sunday services. Some girls met in homes of mothers who were their role models. The project regularly brought together 432 girls and 200



mothers. During the sessions, the girls discussed the reproductive health challenges with the help of a facilitator. This is illustrated in the table below.

**Table 4: Distribution Centers for SRH Discussions**

<b>Centers</b>	<b>Participants</b>	<b>Total</b>
Schools	Girls	126
Church	Girls & Mothers	194
Home	Girls & Role Model Mothers	312
<b>Total</b>		<b>632</b>

**Source:** Reproductive health in nomadic communities: Challenges of culture and choice. AMREF, (2006).

The project targets young people of age between 10- 24 years and aims to improve the sexual and reproductive health and rights for the nomadic youth in most parts of Kajiado District, including Imbirikani group ranch. AMREF also empowers the elders to lead community discussions on the need to adapt an alternative rite of passage in place of FGC. There constant persistence on the issue of FGC led them to partner up with two most active CBO's [Ewangan Women Unity Advocacy Program (EWAP) and Ewangan Ee Maa], as they found them to relate on a more personal level with the residence and who were ready to reinforce their objectives.

**Table 5: Girls in the upper classes before the CBO's involvement in educating them on FC's pros and cons**

<b>No. of Girls</b>	<b>Class Five</b>	<b>Class Six</b>	<b>Class Seven</b>	<b>Class Eight</b>	<b>Frequency &amp; Percentage</b>
Circumcised	30	20	13	10	73 (65%)
Uncircumcised	22	15	10	6	53 (35%)
<b>Total</b>	<b>52</b>	<b>35</b>	<b>23</b>	<b>16</b>	<b>126 (100%)</b>

**Sources:** Ewangan Women Unity Advocacy Program (EWAP), recodes of 2006 of Imbirikani Primary school.

Frequency (Circumcised girls) = 73

Frequency (Uncircumcised girls) = 53

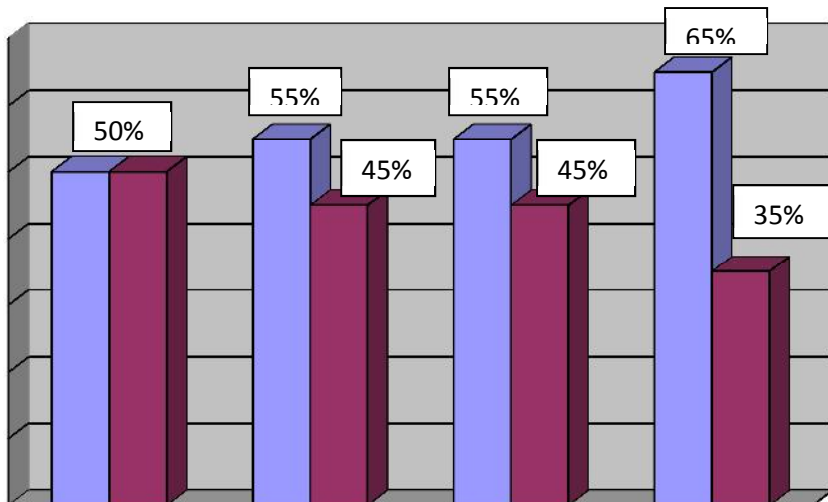
N =126

It is thus noted that a total of 73 girls in the upper classes are circumcised while that of the uncircumcised is 53. This illustrates that majority of the respondents, 65 percent undergo circumcision due to social pressures in communities where most women are cut to provide an environment in which circumcision becomes a requirement for social acceptance which is seen as a way to make FC a continuous practice, (Centre for Reproductive Rights, 2003).

Class 5 has a total of 52 girls; 30 of whom have been cut and 22 are uncut. This indicates that the number of uncut girls is low compared to that of the cut, as shown across the table. The table also indicates that the total number of girls in the class is decreasing, where class 5 has 52 girls and class 8 has 16. This is as a result of early marriages and teenage pregnancies which forces many young girls to abandon their studies. Hence the above is used to explain why the practice will take a long while to be abolished.

The above mentioned community based organizations are recognized to be well vast with aiding most of the girls who run away from home seeking protection from being put under the knife. Though they have tried to rescue many girls, some of them lack the will power to soldier on and succumb to the cut. Thus they have resulted in assisting the girls and using some of them as youth peer educators, who act as role models to the others. These youth peer educators include both circumcised and uncircumcised girls of the same age group. In spite of their (CBO's) active role in creating awareness, teaching the girls on health issues, and involving the whole community into their meetings. They claim that the community elders together with the religious leaders do offer little assistance as many of them still keep to the traditions and beliefs of their ancestors. This leads to the morans or young men to follow suit. Thus making it difficult for a young uncircumcised girl, who is ready for marriage to get a suitor.

**Graph 1: Distribution of girls in upper classes after the CBO's involvement**



**Source:** Ewangan Women Unity Advocacy Program (EWAP), records of Imbirikani Primary school from 2005-2011.

This graph above indicates the impact the NGO and CBO's have had on the girls. The range of circumcised girls in class 5 to 8 steadily rises from 50 percent to 65 percent respectively. This indicates that, the stigma attached to uncircumcised girl 'entito' is so much that most of them cave in. The girls find it easier to be cut than being ridiculed as this traumatizes them so much and the fear of not finding a good suitor when they are ready to settle down.

The CBO's representative narrated how a 16 year old girl who was actively involved in the local church choir was segregated by her peers as she was still 'entito'. This traumatized her so much as no one in the choir wanted to stand next to her, as she was seen to be unclean. She thus demanded her father who was against FGC to get her circumcised. In spite of her father's efforts to involve the CBO and trying to talk his daughter out of it she threatened that she would kill herself if she is not put under a knife. The father without an option decided to get his daughter cut.

The uncircumcised girls' classification ranges between 50 percent in class five and 35 percent in class eight as illustrated on graph above. This is as a result of the campaigns being carried out by the stakeholders. As they use the role models to assist the others who are not yet cut to stand firm with their decision and soldier on with the fight against FC. They have been taught to notice their similarities and realize that they are the same; they have also been taught the pros and cons associated with the practice.

However, despite their efforts to introduce the element of youth peer educators to mediate and act as examples within the community, Imbirikani residence believe that tradition plays a key part of who they are and separates them from the rest of the other communities. This is so as the community can be said to relate with the relativists, who are of the opinion that all cultural values have underlying meanings which should be left to them to interpret it as per their cultural context, (Scheper- Hughes, 1991).

While the CBO's and AMREF take on the universalists side which contrast this approach, which defines FC as an act of international violence. Annas, (1996), says that intervention into the practice should be considered a necessary prerequisite on the grounds that it is morality that transcends national boundaries and cultural beliefs.

The CBO's, complain that the government is not actively engaging in eradicating the practice. They claim that in-spite of their objectives and measures that they have, the government is not giving them the support that they need to reinforce them. For instance the government is not doing enough to ensure the girls security when they run away from home especially from their parents who want to get them cut and married off immediately. They also complained of strained funds owing to their economic status. In most cases they fund the rescue girls' needs from their own pockets which is not usually easy. This then results into the girls returning back home. Once there, they have to abide to the rules set and thus loose them to FGC.

The government on the other hand defends itself by mentioning that the practice is deeply rooted and will not be easily eradicated. The only remedy that they are advocating for currently is

education. They believe that through it the girls will get empowered and be able to choose the path to take.

However, the research findings have revealed that both the government and politicians have taken a non-committal stand given the sensitivity of this topic. In 1982, Kenyan President Daniel Arap Moi condemned FGC and forbade medical officials from performing it after fourteen girls died following excision. The statement and ban were reinforced in 1989. The Kenyan Parliament refused to criminalize FGC in 1996, but in 2001 passed the Children's Act, which made FGC illegal, Andrea Monahan (2007).

Example, in May 2005, Hon. Ole Ntimama a member of parliament representing a section of the Maasai people from Narok district, stated that, "We have more important things to worry about such as the poor and unemployed, the practice of female circumcision will die slowly. There is nothing the government can do. Culturally, I am against the practice but its cultural meaning is hard to replace. I cannot go back as a leader and tell my community to stop practicing it. They will throw me out of parliament," (Daily Nation Newspaper, 2005).

#### **4.4 The Levels of Acceptance by the Community in bringing FGC to an End**

The fear of being labeled as either a racist or cultural imperialist has deterred many people from actively challenging or taking a stand on this almost taboo subject. A 2009 survey of the Maasai community in Imbirikani found that 90 percent of girls above the age of 15 years have undergone FGC, (KDHS, 2009).

In this section a sample size of 179 individuals is used to get their take on abolishing the practice. These included the respondents from the key informants (certified health worker, government representative and a stakeholder representative), women and girls.

**Table 6: Distribution of the Sample Community on their Take on FGC**

Respondents	Abolish	Support	Total
Girls	126	0	126
Women	40	10	50
Health Workers	1	0	1
Government Representative	1	0	1
NGO Representative	1	0	1
Total	169 = 75%	10 = 25%	179 =100%

Majority of the community 169 of them are in agreement with the practice being abolished while the rest 10, are in keeping with the tradition. All the key informants and the girls are in agreement while the women are divided on the matter. Where; 40 women want the practice brought to an end and 10 want things to remain as they are.

Though a majority of the women want to do away with the practice, the research found that many of them find themselves being segregated by their fellow women, as tradition requires them to be at the front line pushing for its continuation.

In the women's group discussion one of them, recounted of how her peers would segregate her during occasions such as arrangements of their girls marriage since her daughter is not cut. Thus seen as unclean and could bring a bad omen to the bride's life. Another shared of how she goes to fetch fire wood or water on her own or in the company of her daughters as none of her peers would want to be associated with her as she is seen as an 'outcast.'

This kind of pressure in a small community is what makes most of the women give into FGC. Therefore, due to this middle ground and hands free approach by the Relativists according to Gordon, (1991), has provoked rejection and accusations of failure. Though the Feminists are up in arms about it, they too seem to be adding salt to injuries. They seem to want third world women to borrow from their western sisters who too seem to be no different as they would allow a surgeon to whittle away their genitalia if only for cosmetic purposes, (Greer, 2000).

Results on the table above indicate that, an accumulative majority 75 percent of the respondents sampled want the practice done away with. While 25 percent of the respondents support the practice, they believe that the norm of keeping with tradition should be maintained. Though the research found many residence are still undertaking the practice in secrecy. This fuels the continuous engagement in it by the residence. Where they engage in it at night to avoid the arm of law as the government has put regulations on the practice. The community plays a vital role in determining the life span of the practice of FC.

## **CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS**

### **5.1 Introduction**

This chapter presents a summary of major findings and recommendations. The study sought to find out;

1. The community's perception of female genital cutting.
2. The efforts that had been put by both the community and other stakeholders in abolishing this practice.
3. The levels of acceptance by the community in bringing it to an end.

### **5.2 Summary**

In Imbirikani group ranch, the women who are of the age of thirty years and above are all circumcised. This practice is being carried out by the women as a majority of them believe that it is their duty to carry on with the fabric passed on to them by their ancestors. The school going girls are also circumcised as young as nine or ten years of age. Though, some girls get to teenage without being cut due to education and the involvement of the stakeholders.

Through education the girls' perception has changed over time concerning the practice. They have learnt that there are not different whether cut or uncut. Apart from the harm that some circumcised girls go through during the healing process after the cut and also during child bearing. Thus they are empowered and can decide for themselves on the issue of continuing with tradition once they are of age to have their own families.

The stakeholders who comprise of the government and the local base organizations that are ready to abolish this practice have made strides in their fight against FC. Through the organizations the girls have received support in soldiering on in spite of the constant ridicule and pressure from their peers. The youth peer educators used by the NGO's have significantly contributed to this; hence we see an increase in their (uncut girls) number. The alternative rite of passage has not so much been welcomed by all in the ranch, in spite of it serving the same purpose without causing any harm as the actual practice. Though it has been hard for the NGO's to fully support the girls due to financial constraints and lack of proper facilities to maintain them.



The continued campaigns by both the stakeholders should also see that the whole community is involved in FC eradication to be successful. The practice should not be viewed to affect only the women and girls but the men too. Since they marry them and in case of any complications faced by their wives especially during child birth should be faced by both. Thus the men should be omnipresent during the health talks or campaigns so as to make them aware of FGC's harm.

Religious leaders being key community gatekeepers and opinion leaders should too be required to not only openly speak against but talk on the unnecessary pain inflicted on girls during FC. Eradication of the practice needs more active involvement of religious groups than seen to be happening now. The community should be educated on health implications of the practice so that there is less defiance to law prohibiting FC. The enactment of the Children's Act is a step forward to support FC eradication efforts, which offers government sanctions on the practice.

Although the practice results in multiple health implications; it is not a disease to be cured and has no cure rather than changing the community's attitude and behavior. The strongest influence is the sheer force of tradition and culture without a true sense of understanding the rationale behind it. Thus the major reason as to why the women and girls are hooked to sustaining it is, "marriage-ability" element. Traditional beliefs about cleanliness, chastity, fidelity and spiritual practice also influence the submission of girls into it.

FGC is a practice that has been passed down from one generation to another for centuries now. It has been accepted as the norm and many cultures especially the Maasai do abide with it. Though there are a few elite members in the ranch majority are uneducated and due to the low status of women, the practice is given to continue. The practice has also been used to perpetrate its continuation through viewing of the uncut girl as immature. Thus many have undergone through it as a sign to prove their maturity. Though majority of them came out in support of its eradication, a good percentage of them still keep to tradition and undertake the practice in secrecy. The few who are of the notion that it should be put to an end are in most cases segregated especially during certain functions in the community. Therefore a lot is still needed to be done in the ranch if this practice is to be done away with.

### **5.3 Conclusion**

FGC should be replaced with the alternative rite of passage which is harmless to the girls health. All the stakeholders should be involved in it to ensure that the girl child receives the education that she requires, as education is key.

### **5.4 Recommendations**

1. This practice should be replaced by an alternative rite of passage which is harmless to the girl's health and it adheres to the same norms and values of the Maasai. Thus the community should be well educated on it for them to openly embrace it.
2. The stakeholders through their campaigns of using role models should engage them further to act as mentors and reach out to the young girls. This will hence enable the young girls not to easily be swayed by peer pressure and give into the knife.
3. The government should be more involved in bringing this practice to an end by providing the necessary resources such as; having stringent rules on the practice, facilities that will accommodate the rescued girls and substantial finance kitty, which will aid the community based organizations be better placed in assisting them.

### **5.5 Areas of Further Research**

FGC is an important topic that requires further research. Currently there is no up to date data provided for the morbidity and mortality due to the practice being done in secrecy. Hence keeping the health worker and certified nurse's shut out and only coming in when things have gone out of hand. Though only few cases are taken to hospitals or nearby clinics, leaving all the rest to be attended by the traditional circumcisers or herbalists. Calamities that have befallen the women and girls who practice it ought to be lesson enough to show case the fall of the community. Death cases should be reported from FC and used as data to emphasis the ill effects of the practice. This would make the practice to be deemed as a major risk

Since financial and time constraints did not allow for a nation-wide survey, the research recommends one which will capture the views of a wider spectrum of the communities practicing it. Findings of this study are limited because of its descriptive nature and the fact that it is based only on one group ranch. A more vigorous study on morbidity and mortality related to the practice is highly recommended. This would then be used as evidence to convince the community members on the need to abandon the practice.

## REFERENCES

### Primary Sources

- Abusharaf, R. Mustafa (2006); "Introduction: The custom in question," in Rogaia Mustafa Abusharaf. (Ed) *Female Circumcision: Multicultural Perspectives*. Philadelphia: University of Pennsylvania Press
- A Simple Handbook on the Harmful Traditional Practices (2008).
- Abusharaf, Rogaia (1995); 'Rethinking feminist discourses on female genital mutilation: The case of Sudan' *Canadian Women Studies* 15 (4).
- Amnesty International (1998); *Amnesty International Report* London: Amnesty International Publications.
- Annas, Catherine (1996); 'Irreversible error: The power and prejudice of female genital mutilation' *Journal of Contemporary Health Law and Policy* 12: 325-353.
- Baden, Sally (1992); *The position of women in Islamic countries: possibilities, constraints and strategies for change* Brighton: BRIDGE.
- Baltimore: John Hopkins (2004); *Female Genital Cutting: Cultural Conflict in the Global Community*. University Press.
- Baron, E.M. and Denmark, F.L. (2006); *An exploration of Female Genital Mutilation: Psychology Department, Pace University, New York, NY, USA*.
- Chowdhry, Geeta (1995); 'Engendering Development? Women in Development (WID) in International Development Regimes', in *Feminism, Postmodernism and Development*, Marianne Parchand and Jane Parpart, (eds) London: Routledge.
- Dorkenoo, Efua (1994); *Cutting the Rose: Female Genital Mutilation: The Practice and its Prevention* London: Minority Rights Publications.
- Dorkenoo, Efua and Scilla Elworthy (eds) (1992); *Female Genital Mutilation: proposals for change* London: Minority Rights Group International Report.
- Dugger, C (September 1996); 'A refugee's body is intact but her family is torn', *The New York Times* pp A1-A9.
- Durkheim, Emile (1995); *The Elementary Forms of Religious Life* New York: The Free Press.
- Gollaher, D. (2000). *Circumcision: A History of the world's most controversial issue*. New York: Basic Books.
- Gordon, Daniel (1991); 'Female Circumcision and Genital Operations in Egypt and the Sudan: A Dilemma for Medical Anthropology' *Medical Anthropology Quarterly* 5 (1): 3-14.

- Greer, Germaine (2000); *The Whole Woman* London: Anchor.
- Gruenbaum, E. (2001); *The Female Circumcision Controversy: An Anthropological Perspective*. Philadelphia: University of Pennsylvania Press.
- Holestein, J. A. and Gubrium, J. F. Eds. (2003); *Inside Interviewing: New Lenses, New Concerns*. Sage Publications.
- Hosken, Fran (1979); *The Hosken Report* Lexington MA: Women's International Network News.
- Ingold, Tim (1994); *Companion Encyclopaedia of Anthropology: Humanity, Culture and Social Life* London: Routledge.
- Koso-Thomas, Olayinka (1987); *The Circumcision of Women: A Strategy for Eradication* London: Zed Books Ltd.
- Lightfoot-Klein, Hanny (1991); *Prisoners of Ritual: An Odyssey into Female Genital Mutilation in Africa*, (eds) New York: The Haworth Press.
- Lightfoot-Klein, Hanny (1997); 'Similarities in attitudes and misconceptions about male and female sexual mutilations', in *Sexual Mutilation: A Human Tragedy*, George Denniston and Marilyn Milos, (eds) New York: Plenum.
- Limb, M. and Dwyer, C. (Eds) (2001). *Qualitative Methodologies for Geographers: Issues and debates*. London: Arnold.
- Mackie, Gerry (2000); 'Female Genital Cutting: The Beginning of the End', in *Female "Circumcision" in Africa: Culture, Controversy and Change*, Bettina Shell Duncan and Ylva Hernlund, (eds) pp London: Lynne Rienner Publishers.
- McLean, Scilla and Stella Efua Graham (eds) (1983); *Female Circumcision, Excision and Infibulation: the facts and proposals for change* London: Minority Rights Group Report No. 47.
- Momoh, C. (2005); "Female genital mutilation," in Momoh, C. (Ed) *Female Genital Mutilation*. United Kingdom: Raddiffe Publishing.
- Momoh, C. (2005); "FGM and issues of gender and human rights of women," in Momoh, C. (Ed) *Female Genital Mutilation*. United Kingdom: Raddiffe Publishing.
- Nnaemeke, Obioma (2001); 'If Female Circumcision Did Not Exist, Western Feminism Would Invent It', in *Eye to Eye: Women Practising Development Across Cultures*, Susan Perry and Celeste Schenck, (eds) London: Zed Books Ltd.

- Norad Blaikie, N. (2000); *The Norwegian International Effort Against Female Genital Mutilation*. Oslo.
- Passmore Sanderson, Lilian (1981); *Against the Mutilation of Women: The Struggle to End Unnecessary Suffering* London: Ithaca Press.
- Perry, Susan and Celeste Schenck (eds) (2001); *Eye to Eye: Women Practising Development Across Cultures* London: Zed Books Ltd.
- Pickup, Francine (2001); *Ending Violence Against Women: A Challenge for Development and Humanitarian Work* Oxford: Oxfam.
- Polity Press Boyle, H. (2005). *Designing Social Research: The logic of anticipation*. Cambridge. Prentice Hall.
- Kwateng-Kluytse, A. (2005). *Female genital mutilation and Child protection* London.
- Rahman, Anika and Toubia, Nahid (2000); *Female Genital Mutilation: A Guide to Laws and Policies Worldwide* London: Zed Books Ltd.
- Routledge. Kitchin, R. and Tate, N. J. (2000); *Conducting Research in Human Geography*. London.
- Royce, Anya Peterson (1982); *Ethnic Identity Strategies of Diversity* Bloomington: Indiana University Press.
- Sage Jenkins, R. (2008); *Social Identity*. London Thousand Oaks, California.
- Scheper-Hughes, Nancy (1991); 'Virgin territory: The Male Discovery of the Clitoris' *Medical Anthropology Quarterly* 5 (1).
- Shell-Duncan, Bettina and Ylva Hernlund (eds) (2000); *Female "Circumcision" in Africa: Culture, Controversy and Change* London: Lynne Rienner Publishers.
- Toubia, Nalia (1995); 'Female genital Mutilation', in *Women's Rights: International Feminist Perspectives*, Julie Waters and Andrea Wolper, London: Routledge.
- Vissandjee, Bilkis et al (2003); 'The Cultural Context of Gender Identity: Female Genital Excision and Infibulation' *Health Care for Women International* 24 (2).
- Walker, Alice and Pratibha Parmar (eds) (1993); *Warrior Marks: Female Genital Mutilation and the Sexual Blinding of Women* London: Jonathan Cape.
- Weil-Curiel, Linda (2001); 'Female Genital Mutilation in France: A Crime Punishable by Law', in *Eye to Eye: Women Practising Development Across Cultures*, Susan Perry and Celeste Schenck, (eds) pp 190-197 London: Zed Books Ltd.

## Web Site

- Brisibe, Annie (2001) 'The Pains of Genital Mutilation – The Myths Cast Out'  
[www.ndwj.kabissa.org/ArticlesResearch/AB3/ab3.html](http://www.ndwj.kabissa.org/ArticlesResearch/AB3/ab3.html)
- British Medical Association (2001) 'Caring for Patients and Child Protection Guidance from the British Medical Association' [www.bma.org.uk/ap.nsf/Content/ Female+Genital+ Mutilation?](http://www.bma.org.uk/ap.nsf/Content/Female+Genital+Mutilation?)
- Businge, G. *New Challenge in Female genital mutilation fight* The New Vision 30.07.02.
- Centre for Reproductive Rights (2003), *Female Genital Mutilation: A matter of Human Rights. An Advocates Guide to Action*, Internet WWW page at URL: <http://www.reproductiverights.org> (accessed on 22/02/2011). DOLSA/SCNE Project on FGM and Other Harmful Traditional Practices North Gondar Zone. Addis Ababa:
- Norwegian Agency for Development Cooperation, NORAD 2007 Emasu, A. *Majority giving up circumcision*. The New Vision 11.02.05. 34
- FORWARD (2002) *Female genital mutilation: Information Pack*, Internet WWW page at URL: <http://www.forward.org.uk> (accessed on 23/02/2011).
- Family Education Network (2002) 'The Abolition of Female Genital Mutilation'  
[www.infoplease.com/ipa/A0001524.html](http://www.infoplease.com/ipa/A0001524.html)
- Frontiers Publications of Female Genital Cutting in Sub-Saharan Africa: Analysis of the evolution of the practice of FGM/C in Burkina Faso. Frontiers Final Report, Washington, DC. Internet WWW page at URL: [http://www.norplant.biz/frontiers.projects\\_pubs/topics/fgc\\_afRI.html-38k-](http://www.norplant.biz/frontiers.projects_pubs/topics/fgc_afRI.html-38k-)(accessed on 20/03/2011).
- Girls Adolescence in Burkina Faso: A pivot point for social change. Population Council, (2007); Internet WWW page at URL: [http://www.popcouncil.org/pdfs/Burkinafaso\\_Girls.pdf](http://www.popcouncil.org/pdfs/Burkinafaso_Girls.pdf) (accessed on 20/03/2011).
- Hosken, F. (1979); Hosken Report: Genital and Sexual Mutilation of Women, Internet WWW page at URL: <http://www.middle-east-info.org/league/somalia/hosken.pdf> (accessed on 21/03/09).
- Hosken, Fran (1989) 'Female Genital Mutilation: Strategies for Eradication', [www.nocirc.org/symposia/first/hosken.html](http://www.nocirc.org/symposia/first/hosken.html)

- Lightfoot-Klein, Hanny (1991) 'Prisoners of Ritual: Some Contemporary Developments in the History of Female Genital Mutilation', [www.fgmnetwork.org/Lightfoot-klein/prisoner-sofritual.htm](http://www.fgmnetwork.org/Lightfoot-klein/prisoner-sofritual.htm)
- Ministry of Gender, Labour and Social Development, (2009). Combined 4th, 5th, 6th and 7th Periodic report on the implementation of CEDAW in Uganda, Internet WWW page at URL: <http://www.mglsd.go.ug> (accessed on 21/03/09).
- (Ed) *Female Circumcision: Multicultural Perspectives*. Philadelphia: University of Pennsylvania Press A Simple Handbook on the Harmful Traditional Practices (2008), Internet WWW page at URL: <http://www.mglsd.go.ug/index.php?pagePublications> (accessed on 21/03/2011).
- Population Reference Bureau, (2002); *Abandoning Female Genital Cutting: Prevalence, Attitudes and Efforts to End the Practice*, Internet WWW page at URL: <http://www.measurecommunication.org> (accessed on 30/11/08).
- UNFPA (2007) A Holistic Approach to the Abandonment of Female Genital Mutilation/Cutting, Internet WWW page at URL <http://www.unfpa.org> (accessed on 27/02/08).
- UNICEF Innocent Research Centre. Florence, Internet WWW page at URL <http://www.unicef-irc.org> (accessed on 22/02/08) Walker, A. and Parmar, P. (1993). *Warrior marks: Female genital mutilation and The sexual blinding of women*. Harcourt Brace and Co., NY. 56
- United Nations (1989); 'Convention on the Rights of the Child', [www.unhchr.ch/html/menu3/b/k2crc.htm](http://www.unhchr.ch/html/menu3/b/k2crc.htm)
- World Health Organisation (2000) 'Female Genital Mutilation – Fact Sheet No 241' [www.who.int/inf-fs/en/fact241.html](http://www.who.int/inf-fs/en/fact241.html)
- World Health Organisation, (1999). *Female Genital Mutilation: Programmes to date, what works and what doesn't. A review*. Department of Women's Health, Health Systems and Community Health, WHO&PATH. Washington, D.C, Internet WWW page at URL: [http://www.who.int/reproductive\\_health/publications/fgm/fgmprogrammesreview.pdf](http://www.who.int/reproductive_health/publications/fgm/fgmprogrammesreview.pdf) (accessed on 6/03/08) World Health Organisation, (2008a). *FGM: a joint WHO/UNICEF/UNFPA statement*. Geneva: World Health Organisation .
- World Health Organisation, (2008b). *Eliminating female genital mutilation: an Interagency Statement*. Geneva: World Health Organisation, Internet WWW page at URL: <http://www.who.int/reproductive-health> (accessed on 05/03/08)



## Secondary Sources

Kenyatta, Jomo (1975) *Facing Mount Kenya: The Tribal Life of Kikuyu* New York: Random House

Zenie-Ziegler, Wedad (1998) *In Search of Shadows: Conversations with Egyptian Women* London: Zed Books Ltd

## Articles

AMREF, (2006). Reproductive health in nomadic communities: Challenges of culture and choice.

Andrea Monahan, (2007). From Health Risk To Human Right: The Development of Opposition to Female Genital Cutting in Africa.

Daily Nation 26.5.05. Politics, (2005). Kenya Press Newspaper.

Daily Monitor 4.12.08. 3 May, T. (1997). *Social Research: Issues, Methods and Process*. London Buckingham: Open University Press.

Family Planning Association of Kenya, (1997); Prevalence and practice of female genital circumcision in Kenya. Nairobi: FPAK.

Kenya Demographic Health Survey, (2009): Imbirikani Group Ranch Survey. KDHS

Maendeleo ya Wanawake Organization, (1991); Harmful traditional practices that affect the health of women and children in Kenya. Nairobi: MYWO.

Mafabi, D. *Kapchorwas eternal scars*. Daily Monitor 4.12.08. 3 Mafabi, D. *FGM down in Kapchorwa*.

Tamar W. in Ni Mhordha, M. (2007); Female Genital Cutting, Human Rights and Resistance: A Study of Efforts to End the, "Circumcision," of women in Africa.

UNICEF (2005). *Changing a Harmful Social Convention: Female Genital Mutilation/Cutting*.

World Health Organization, (1998); Female genital mutilation. Geneva: WHO.

## APPENDIX

### QUESTIONNAIRES

**Consent:** The researcher will request for permission from the parents to address or talk to the girls on this sensitive issue. The researcher will thus have to explain in details as to what the exercise will entail and inform them that they have a right to accept or refuse the involvement of their daughter in the discussion.

This will be the same for the women who will be targeted as respondents for the group discussion. They too will be given the chance to decide whether or not they want to be part of it.

### TOOLS

#### **1: Questionnaire for circumcised and uncircumcised girls, (applying snow balling technique).**

##### **Key questions:**

1. Are you circumcised? Yes/ No.
2. If not why?
3. How do you feel about circumcision?
4. Given a choice would you agree to go through FGC or not and why?
5. Do you know of any problems associated with circumcision?
6. Would you advocate it to the other young girls to undergo through FGC? Yes/  
No.
7. If no why?
8. **Entito** should have the final say on whether to be circumcised or not. (Choose one)  
Strongly agree...      Agree...      Disagree...      Strongly disagree...
9. **Entito** should be allowed to willingly participate in circumcision as a rite of passage without being pressured to do so.  
Strongly agree....      Agree....      Disagree...      Strongly disagree....
10. Parents should always consult their daughters on whether or not to be circumcised.  
Strongly agree...      Agree...      Disagree...      Strongly disagree..

11. Before a decision is made to circumcise or not to be circumcised *entito* should be well educated on the pros and cons of the ceremony.  
Strongly agree... Agree... Disagree... Strongly disagree...
12. FGC is valuable and therefore should be passed onto the next generation.  
Strongly agree... Agree... Disagree... Strongly disagree...
13. Maasai people should support FGC as a must rite of passage to the community.  
Strongly agree... Agree... Disagree... Strongly disagree...
14. Efforts to stop FGC should be resisted by all means by the community.  
Strongly agree... Agree... Disagree... Strongly disagree...
15. The government and other key institutions should support FGC.  
Strongly agree... Agree... Disagree... Strongly disagree...
16. The alternative rite of passage is less harmful both from a psychological, medical and physical point of view and therefore should be supported.  
Strongly agree... Agree... Disagree... Strongly disagree...
17. The maa community should be properly educated on the alternative rites of passage in order to embrace it.  
Strongly agree... Agree... Disagree... Strongly disagree...
18. The alternative rite of passage does not in any way infringe on the maa communities values and therefore should be supported.  
Strongly agree... Agree... Disagree... Strongly disagree...
19. The alternative rite of passage if well managed serves the same purpose of passing on the maasai norms and values to the next generation and therefore should be supported.  
Strongly agree... Agree... Disagree... Strongly disagree...
20. Do you know of another girl who is/ isn't circumcised?

**2: Questionnaire for circumcised and uncircumcised women, (applying snow balling technique).**

**Key questions:**

1. Are you circumcised? Yes/ No.
2. If not why?
3. Why did you allow your girls/ daughters to be cut?
4. Do you know of any problems associated with circumcision?
5. If yes, do you think it is good to give consent for your daughters to undergo through FGC?
6. Did you know of the FGC harm before or after undergoing through it?
7. Who do you think are at the front line in ensuring that this practice continuous and Why?

Do you know of any Programs being undertaken by the NGO around you?

8. What are your feelings about the programs that the NGO is running in the community?
9. How do you feel about government involvement, in the elimination of circumcision of women?
10. What do you think can be done differently both by the organizations and government in this fight against FGC?
11. Are there any programs in the community that is aimed at eradicating FGC? If yes are you involved in any?
12. Can you tell me some of the challenges faced in eradication of circumcision?
13. Do you know of another woman who is/ isn't circumcised?

### **3: Focus group discussion interview guide for circumcised and uncircumcised girls and women.**

#### **Key questions:**

1. Give your own definition of FGC.
2. How is FGC carried out according to your traditions?
3. Who undertakes the task of performing it?
4. Who is FGC done to?
5. What is the value of FGC?
6. Has FGC encountered any resistance?
7. Do you know of any efforts to stop it?
8. What are the reasons for the resistance?
9. Do you support the reasons to stop this practice and why?
10. What do you propose to do to put a stop to it as individuals and as a group?
11. What will you propose the government and the NGOs do to bring it to an end?

#### **4: Questionnaire for key informants at national level (Stakeholders- NGO)**

##### **Background information:**

- Gender
- How long have you worked with this institution?

##### **Key questions:**

1. How long has the organization been working with the community?
2. Since the organizations involvement with the community has there been any significant change of attitude from the people?
3. If so, what steps are they taking to ensure that the change is spread to the rest of the community?
4. How effective are they and what measures have they put in place to ensure that they are maintained?
5. Are there any policies that you have put in place to help in aiding this? If yes, which ones?
6. Are you familiar with the government policy in regards to inhibiting female genital circumcision?
7. Are there any measures that have been put in place to fight this practice?
8. How effective are they in reducing the spread of the practice?
9. Is this practice on the increase or decrease since your organizations involvement with the community? (Own opinion).
10. Are there any alternative rites of passage that have been proposed by your organization for this community?
11. Is there anything that is being done to involve elders or religious leaders in these efforts?
12. Are there any achievements to this?
13. What are some of the challenges faced in dealing with this issue of FGC?
14. Any suggestions in relation to future strategies in dealing with FGC?

**5: Questionnaire for a health worker (doctor or certified nurse).**

**Background information:**

- Name of hospital/ dispensary
- Location
- Current Position

**Key questions:**

1. Is the hospital/ dispensary involved with FGC?
2. For how long has it been involved with the practice of FGC?
3. Do you know of any government policy on female genital mutilation?
4. If yes, do you think the government is doing enough in bring this practice to an end?
5. Are there any measures put by the hospital/ dispensary in educating the community on the harm FGC causes to their women? If yes, what has been the response?
6. Is this practice on the decrease/ increase?
7. Yes / No and Why? Explain.

## **6: Questionnaire for the town clerk.**

### **Background Information:**

- Gender
- Period been in office

### **Key questions:**

1. Do you know of any government policies in eradicating this practice in the community?
2. As the government representative, what are the measures put in educating the community in ending FGC?
3. Is the community warming up to it?
4. What are the challenges that your facing from the community in response to the educating them against FGC?
5. What do you think can be done to replace this practice among the people?