THE PERSISTENCE OF FEMALE GENITAL MUTILATION (FGM) AND ITS IMPACT ON WOMEN'S RIGHTS OF KAJIADO SOUTH CONSTITUENCY, RIFT VALLEY PROVINCE, KENYA

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DECLARATION A

"This dissertation is my original work and has not been presented for a Degree or any other academic award in any University or Institution of Learning".

Mutale Magdalena

Name and Signature of Candidate

3/10/2012

Date

DECLARATION B

"I/We confirm that the work reported in this dissertation was carried out by the candidate under my/our supervision".

Name and Signature of Supervisor

Name and Signature of Supervisor

3/10/2012

Date

Date

DEDICATION

For Duncun Makori

"The constant force that prods me ahead"

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ABSTRACT

This study was undertaken to find out the factors that have contributed to the persistence of FGM in Kajiado South Constituency were female genital mutilation is still prevalent despite numerous efforts by various entities like the government, non governmental organizations as well as community based organizations, towards abolishment of this harmful cultural practice. The study was based on a qualitative methodology that employed the use of questionnaires and interviews in data gathering. The research design was a descriptive survey that set out to establish a relationship between the persistence of FGM and the abuse of women's rights in Kajiado south constituency. The study pinpointed a number of women's rights violated by this practice and concluded that culture was the main reason for the persistence of this practice. Other factors like illiteracy, patriarchy and male dominance as well as lack of a popular alternative rite of passage for young girls also contributed heavily. Recommendations made included: use of the media for an active anti FGM campaign and forming and popularizing an alternative right of passage for the girls, churches and schools should also take an active role in campaigning against this practice and systems set for the rescuing girls and reporting to the police and concerned forces.

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ACRONYMS

CEDAW Conventions on the Elimination of All Forms of Discrimination Against Women

KDHs Kenya Demographic and Health Survey

KHRC Kenya Human Rights Commission

FC Female Circumcision/Female cutting

FGM\C Female Genital Mutilation \Cutting

FLE Family Life Education

FPAK Family Planning Association of Kenya

GBV Gender Based Violence

GOK Government of Kenya

GTZ Gesellschaft fuer Technische Zusammenarbeit

ICPD International Conference on Population & Development

INGO International Non Governmental Organizations

MDGs Millennium Development Goals

MOH Ministry of Health

MYWO Maendeleo Ya Wanawake Organization

NGO Non-Governmental Organization

PATH Programme for Appropriate Technology in Health

REACH Reproductive Educative and Community Health Programme

TBA Traditional Birth Attendant

UN United Nations

UNICEF United Nations International Children Educational Fund

UNESC United Nations Education, Scientific and Cultural Organization

UNFPA United Nations Population Fund

WHO World Health Organization

CHAPTER ONE: INTRODUCTION TO THE STUDY

BACKGROUND OF THE STUDY

Female Genital Mutilation/Cutting (FGM/C)

Definition and terminology

According to World Health Organization (WHO) Female Genital Mutilation/Cutting has been defined and classified as *all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reason* (WHO 2000a).

It is classified according to WHO (2000b) as:

Type I - Excision of the prepuce with or without excision of part or the entire clitoris;

Type II - Excision of the prepuce and clitoris together with partial or total excision of the labia minora;

Type III - Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation)

Type IV includes any other procedures that fall under the definition of FGM/C.

However, it is not always possible to distinguish clearly between the different types, and other classifications do exist.

The following types are used in Kenya: Type I excision is called *Sunna* circumcision, (sunna means the "tradition of the Prophet"). Type III excision is the so-called *Pharaonic Circumcision*, means purification, cleanliness. *Defibulation* is the cutting open of the infibulated labia before or during delivery to allow passage of the fetal head. *Reinfibulation* is the restoring of the defibulated labia after delivery, and it often involves additional tightening of the introitus to the size before marriage.

The terminology of FGM/C is still under debate, and an international consensus has not been reached. WHO, United Nations and Non-governmental Organizations mostly use the term Female Genital Mutilation (FGM), to point at the mutilating nature of the procedure and violation of human rights. This term was also adopted at the third conference of the Inter African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) in Addis Ababa in 1991 (Shell-Duncan 2000). It is also most widely used in a scientific

context. However, the term "FGM" could be offensive for those who practice FGM/C and do not intend to harm or mutilate. Many women who are circumcised do not consider themselves mutilated. Other terms commonly used include Female Genital Cutting (FGC) and Female Circumcision. Some argue that, strictly speaking, the term "circumcision" refers to the removal of the prepuce of the clitoris, and this is difficult to achieve in young females. It also equals FGM/C with male circumcision (Toubia and Izett 1998, pp.2-3). Some United Nations organizations have started using "Female Genital Mutilation/Cutting" in order "to capture the significance of the term mutilation at the policy level and, at the same time, in recognition of employing non-judgmental terminology with practicing communities" (UNICEF 2005a, p.2).
In this study, the term FGM/C will be mostly applied but other terminology may appear in the quotations.

Generally FGM is a global phenomenon which has claimed its casualties mostly in Africa and countries of the Middle East. It has been estimated that about 135 million of the world's girls and women have undergone genital mutilation while about two million girls a year are at risk of mutilation. It is extensively being practiced in Africa and among Muslim populations in Indonesia, SriLanka and Malaysia. Countries of the Middle East concerned include: Egypt, Oman, Yemen, Jordan, and the Occupied Palestine Territories, in some Kurdish communities in Iraq and India (UNICEF 2005c,), and in Central and South America. It is also practiced in migrant communities throughout the world (WHO 2000d).
More specifically FGM/C is practiced in 28 countries in Africa, and predominantly in those countries that extend from Senegal in the west to Somalia in the east. However, considerable variations may exist within these countries.

Practices of FGM/C have been found throughout history in many cultures, but there is no definitive evidence documenting when or why this ritual began. The origin is thought to predate the rise of Christianity and Islam. Egyptian mummies have been described displaying characteristics of FGM/FGC, and it is thought that FGM/C may have been a sign of distinction amongst the ruling class (Worsley 1938a, pp. 686-691). Herodotus, the Greek historian who traveled around the Mediterranean in the 5th century B. C., reported that the Phoenicians,

the Hittites, and the Ethiopians practiced circumcision (Taba 1979, p.43). A Greek papyrus from 163 B.C., exhibited in the British Museum in London, refers to the circumcision of a girl in Memphis in Egypt. It seems that circumcision was practiced both by early Romans and by Arabs (Lightfoot-Klein 1989).

Strabo, a Greek geographer, described circumcised women along the East Coast of the Red Sea at about 25 B.C. (Hosken 1993a, p.73). Infibulation has been practiced along the Nile on slave girls, as observed by travelers during the 18th century (Widstrand 1965). It seems that FGM/C was "spread by dominant tribes and civilizations, often as a result of tribal, ethnic, and cultural allegiances" (Toubia 1995a, p.21). FGM/C in the form of clitoridectomy was also practiced in Europe and America in the 19th century as a cure for mental/nervous disease (Sheehan 1981, pp.9-15).

Female circumcision is also said to have existed for over 4,000-5,000 years originating in a period predating God's covenant with Abraham to circumcise his people. It began in Egypt and was frequently performed by the ancient cultures of the Phoenicians, Hittites, and the ancient Egyptians. Those people had the idea that was based on the belief that, the foreskin was the feminine part of the male and the clitoris the masculine part of a woman. (Tanui 2006, 20)

Female Genital Mutilation in Kenyan communities is a practice that is widely believed to increase a girl's chances of marriage, prevent promiscuity and promote easy childbirth. Women who did not circumcise their daughters ran the risk of being seen as irresponsible, immoral and imitators of Western culture. Single men of marrying age from all over the community accompanied by their parents and relatives freely visited a family known to have circumcised their daughter to try their luck in getting a future wife to their son. (www.maendeleo-ya-wanawake.org[referred 27. 4.2009]).

Circumcision afforded the initiate to officially belong to a community. They were and still are taught, expected and even demanded that the lessons learned be firmly cemented in the initiates mind for lifetime and to be passed onto the coming generations as the only way to preserve and ensure the survival of a community. The practicing communities looked at circumcision as a commandment passed down from ancestors and gods to be practiced

without any question or alteration whatsoever and so the tradition is ultimately kept and fulfilled. (UNICEF, 2004)

Female Genital Mutilation is predominant in Kenya, with 38 percent of women aged 15-49 years reporting being circumcised (KDHS, 1998). The practice is found in more than a half of the districts in Kenya though There are differences among ethnic groups, FGM is nearly universal among the Kisii (97%), Maasai (89%). It is also of a wide extent amongst the Kalenjin (62%), Taita Taveta (59%) and Meru / Embu ethnic groups (54%) and to lesser extent among the Kikuyu (43%). The Kamba ethnic group is recorded to be 33% and Mijikenda/Swahili (12%). Although the Kenyan Demographic and Health Survey do not include data from the North Eastern province, it is believed that infibulation is nearly universal among the population. Clitoridectomy and excision are the most common types of female genital mutilation practiced in the rest of the country. (KDHS, 1998.)

Every elder (circumcised woman) had the responsibility bestowed upon graduating from circumcision rite to correct, advise, guide and even punish children if need be anytime, anywhere in the community. It was as well a great mistake and a betrayal of the society if an elder failed to carry on this important duty assigned to by the community. (Tanui 2006, 45-46.)

The reasons for the practice and the underlying beliefs are multi-faceted and vary from community to community and throughout history. Reasons for FGM/C will be described under the headings as suggested by WHO(2000d):

Psychosexual reasons

In many societies, it is believed that uncircumcised women will not be able to control their sexuality, and "that a girl who is not excised will run wild and disgrace her family" (Hosken 1993b, p.40). Therefore, reduction or elimination of the sensitive tissue will reduce sexual desire in the female. A woman without sexual desire will not seek sexual relations outside marriage, and FGM/C will therefore ensure faithfulness. Circumcision, and especially infibulation, is also seen as proof of chastity and virginity before marriage and will increase a daughter's marriage prospect (WHO 2000e). FGM/C is also thought to increase men's sexual pleasure (Toubia 1995b).

Sociological reasons

Custom and tradition are commonly given as reasons for FGM/C. It provides identification with the cultural heritage, and it defines who belongs to the group. Toubia suggests that "the fear of losing the psychological, moral, and material benefits of 'belonging' is one of the greatest motivators of conformity" (1995c, p. 37). Therefore, it may serve social integration and ensure the maintenance of social cohesion (WHO 2000f).

For some groups, FGM/C is considered as a rite of passage into womanhood. For example, in some societies in West Africa, the clitoris is considered a male part, while the prepuce of the penis is viewed as female, and "both have to be removed to before a person can be accepted as an adult in his/her sex" (Hosken 1993c, p. 40).

Hygiene and aesthetic reasons

Hygiene and cleanliness are common reasons for FGM/C. In Arabic, the terms used for the procedure are synonymous with those for cleanliness or purification (Hosken 1993d,p 41). Uncircumcised women are regarded as unclean and sometimes not allowed to handle food and water. There is a commonly held view that female external genitalia are ugly (El Dareer 1982, p. 73).

Myths

Many myths are associated with FGM/C. A common belief, e.g. in Ethiopia and Nigeria, is that the clitoris may grow to such a size and length that it may dangle between a women's legs (Hosken 1993e, p 41; and Lightfoot-Klein 1991a). FGM/C is believed to improve fertility (Toubia 1995c), and to facilitate childbirth (Lightfoot-Klein 1991b). In some communities, it is thought that the clitoris may damage the penis, or that a baby may die when the head comes in contact with the clitoris (Hosken 1993f, p. 40).

Religious Reasons

FGM/C is practiced across religions including Christians, Jews, Animists, and Muslims.

Within Muslim communities, religion is a commonly cited reason for FGM/C. Female circumcision is not mentioned in the Koran. However, a much-disputed reference to it may exist in the Sunna, which is a collection of the words and actions of the Prophet Mohammed.

His quote "Do not cut deep; this is enjoyable to the woman and preferable to the man" has stirred up opinions and served as an argument both for and against
FGM/C (Abu Sahlieh 1994).

Illiteracy

This is the main reason as to why FGM is still persistent In various developing countries of Africa, Asia, Caribbean and Middle East, illiteracy is deemed responsible because. People who are unable to read and write, and do not have the opportunity to go to school, may grow up in their traditional societies, glued to their customs, never mixing with people from other societies and, therefore, not ready to forsake their culture and patterns of existence

Economic gains

FGM is a source of income for practitioners who are paid a certain amount of money for performing the operation and material incentives to the girls, which include new clothes, shoes, money and other related gifts. The fees charged for the "operation" range from 300-5000 Kenyan shillings among the traditional circumcisers. The 5000 is charged when a girl is circumcised while pregnant to enhance the circumciser to "cleanse" herself since being pregnant while uncircumcised is considered unclean and a bad omen (FPAK 1996)

Cultural reasons

Studies (MYWO, 1991 and FPAK 1991) have revealed the cultural and social significance attached to the traditional Family Life Education (FLE) imparted to girls during circumcision to be a factor responsible for its entrenchment. While some community members who practice female circumcision in Kenya acknowledge its dangers and seem to favour the less severe type of the practice or its total eradication, the majority indicated that teaching accompanying the female circumcision ceremony should continue. The same studies have revealed that, there is a strong belief that the teaching or socialization of specific cultural norms and values given to girls during seclusion plays a significant role in preparing them into responsible women or wives. The young girls are neither considered eligible for marriage nor respected unless they have been circumcised.

A woman's status in the society where female circumcision is practiced and her eligibility for marriage therefore is dependent on this initiation process (FPAK 1994:35; Sokoni 1995:42, MYWO 1991:84) Another factor responsible for the perpetuation of female circumcision in Kenya is that the ceremonies provide the initiate's parents and relatives the opportunity to display their wealth, generosity and social status to the rest of the community.

Political reasons

The practice of female circumcision has also been used as a rallying tool politically and culturally when communities are threatened. For example during the Mau Mau war of independence, the Agikuyu used girl's circumcision as a rallying point and as a symbol of cultural unity against the colonialists and the Christians (Kenyatta 1938: 67). In addition, in the 1990's female circumcision has come to be used as a political tool to threaten and compromise the security of women. In May 1992, the late Member of Parliament for Kerio Central, Mr. Chepkor declared in parliament that he would circumcise the co-coordinator of the green belt movement the late Professor Wangari Mathai if she dared to step in the ethnic clashes zones. In the early 1990's the tribal tensions between the Saboat Maasai and the Bukusu's in Western Kenya led to mass forced female and male circumcision in the Mt. Elgon district.

Female circumcision has also been used rampantly as a political weapon to demean and threaten women politicians. For example, Mrs. Martha Karua the MP for Gichugu and former Minister for Constitutional affairs was insulted by her political opponents by being told she was unfit to address the parliament because she was not circumcised. In addition, female circumcision is grossly used to intimidate female politicians on the basis that they are children and unfit to lead anybody. Male politicians have also been politically intimidated on the basis that their wives are not circumcised. It was on this basis that a politician in Nyambene district had his wife, mother of two, circumcised so that he could win elections, in which he was miserably defeated (Daily Nation 1995, FPAK, 1997).

FGM/C is associated with a vast number of health complications. In their systematic review of the complications of FGM/C, Lovel et al (2000) included 422 published and unpublished papers and reports. As early as 1938, Worsley documented some consequences of FGM/C III (infibulation) observed during seven years as Gynecologist in Sudan (Worley 1938b). In 1967, Shandall did a cross-sectional clinical study of FGM/C complications of 4024 females in Khartoum (Shandall 1967a). Aziz (1980a) looked at FGM/C complications of 7505 Sudanese women. El Dareer (1983) interviewed 400 women in Khartoum including outcome measures such as "health problems consequent upon FGM/C". Short-term complications reported include severe pain, bleeding, damage to adjacent tissues, and urinary retention due to the changes of the anatomical structure. Lack of hygiene during the procedure may result in wound infections, including tetanus (Hosken1993g, p253), and it has been postulated that FGM/C may increase the transmission of HIV (Monjok et al 2007). Long-term adverse effects include abscesses, inclusion cysts, keloid scars, and difficulties with menstruation, vaginal and pelvic infections, complications in pregnancy and childbirth, and a wide range of psychological and psychosomatic disorders. FGM/C may have an impact on a woman's sexuality resulting in painful and difficult intercourse (Dareer 1981), and loss of enjoyment and satisfaction (Hosken 1993h, p 253).

Recently, a huge landmark study by WHO, including 28,393 women, demonstrated that women with FGM/C are significantly more likely than those without FGM/C to have adverse obstetric outcomes such as caesarean section, postpartum hemorrhage, episiotomy, extended maternal hospital stay, resuscitation of the infant, and inpatient perinatal death. The risk of adverse outcomes increases with more extensive FGM/C
(Banks et al 2006b).

Human Rights Perspective

The practice of FGM/C contravenes fundamental human rights, including the right to non-discrimination, to integrity of the person and to the highest attainable standard of physical and mental health. A number of international declarations related to international human right laws have condemned FGM/C, or provide a basis to support elimination, e.g. The Universal Declaration of Human Rights, The International

Convention on the Elimination of All Forms of Discrimination against Women, or the Convention of the Rights of the Child. These have been complemented by regional treaties such as the African Charter on Human and People's Rights, the so-called Banjul Charter (Kwateng-Kluvitse 2005, pp. 61-71).

It has been debated whether human rights can be applied universally, or whether they are culturally relative. A certain behavior or culture that seems without sense to one person may have a meaning for those who practice it. Some argue that people have the right to their own culture. The right of people to develop and enjoy their own culture has also been stated in a number of human rights document. However, it has been acknowledged that these have limitations, and that any cultural practices should not infringe upon other human rights (Rahman and Toubia, 2001, p.15-39).

Statement of the problem

Female genital mutilation is a cultural procedure that has been perpetuated over history by various cultures across the world. It's a procedure that involves the total or partial removal of female genitalia for cultural and non therapeutic reasons and its justified as a right of passage from childhood to adulthood, it is said to be a procedure that protects a woman's honor and at the same time making her a respectable member of society.

However this is not the case as FGM is a procedure that is a gross violation of women's rights, the practice itself is equivalent to torture and it has serious heath implications that can lead to death. Despite attempts by government and non governmental organizations as well as local community based organizations at eradicating this harmful practice, some communities like the Maasai of Kenya are insistent on perpetuating this practice at the expense of the females within that community. Others have medicalized the practice making it harder to eradicate it.

This study aims at seeking community perceptions in regard to persistence of FGM despite knowledge of adverse effects of this practice.

Purpose of the study

This study aims at analyzing reasons as to why FGM is still being practiced among the Maasai community. I also aim to reveal efforts at abolishment and main reasons as to why the practice is still rampant in this community. The effects of female genital mutilation on women and young female children as well as establish the gross abuse of human rights that are perpetrated by this practice.

Objectives of the study

The persistence of FGM poses a real threat to human rights of the Maasai women and girl child development. Therefore the objectives of this study are:

Overall Objective:

The overall aim of this study is to use the findings to develop effective strategies to empower the community to completely abandon the practice of Female Genital Mutilation/Cutting.

Specific objectives

The specific aims of this study are to:

- To investigate the level of persistence of FGM despite awareness on dangers
- To investigate the impact of fgm on women's rights
- Establish how the government, NGOs& CSOs, schools and the church played a role in the campaigns against FGM practice in Maasai community.
- Find out what is a possible alternative to FGM as a rite of passage among the Maasai people.
- Establish why this cruel practice has persisted despite the existing awareness of its dangers on the girl child and the many concerted efforts to eradicate it.

Research questions

The research questions that this study aims to answer are:

- What are some of the factors enhancing the persistence of FGM practice among the Maasai people?
    - What is the impact of FGM on women's rights
- How does the culture of the Maasai people play a role in the persistence of FGM practice among the community?
- How does the community's attitude play a role in the perpetuation of FGM?
- How does the school or education play a role in the eradication or promotion of the practice of FGM?
- What is an alternative rite of passage to FGM among the Maasai people?
- Why has this cruel practice persisted despite the existing awareness of its dangers on the girl child and the many concerted efforts to eradicate it?

These research questions serve as guidelines in the search for answers to the problem statement. They also serve as tentative hypotheses in this qualitative study. In accordance with the research questions the study sets out to address the objectives below.

Significance of the study

The study is significant and sociologically relevant because it will provide insights into the causes and persistence of FGM practice and its effects on women as well as the girl child, particularly her human rights and rights to social development. It will therefore unearth certain crucial issues that need to be strongly addressed by policy makers and implementers, organizations, advocacy groups, and the wider society in their endeavor to eradicate completely this harmful practice. It therefore includes the sociological significance and

relevance, societal input, policy implications and the solution to the problem. The study aims at shedding light on the problems of rampant and persistent FGM practice in the Maasai context and its continued effects on the advancement of girls' education. This information is significant and contributes to those who might wish to fight the persistence of FGM and to promote the girl child education and professional growth among the Maasai community. It also aims at highlighting misconceptions and some negative cultural practices and beliefs that impede upon girl child education. It is necessary and of value that a sociological investigation be undertaken since it is vital and relevant in assisting the Kenyan society, and specifically the Maasai to either modify such cultural practices or drop them all together.

The Maasai community on the other hand was chosen as it is still among those communities in Kenya who value and uphold FGM. Despite all the efforts by both the GOK and other organizations to stamp out FGM, the practice continues in this part of the country. The education of the girl child is adversely affected, hence the low number of women graduating and become professionals in this community. An observation of the district reveals that this community is still deeply rooted in their traditions, irrespective of the adverse effects it has on its members. There is therefore a need to carry out a study in this area so as to reach the girl child and promote as well as protect women and the girl child in this part of the country, hence the importance of this study.

Finally the study findings, conclusion and recommendations will contribute to the existing body of knowledge about FGM, its causes, persistence of practice and its effects on the girl-child, particularly on her human rights study aims at providing useful insights and groundwork for future researchers hence it is an academic study intended to enrich the existing body of knowledge.

Hypothesis

There exists a significant relationship between the persistence of fgm and the abuse of women's rights among the maasai community of kajiado south constituency.

Scope of the study

Scope

The **geographical scope**: This research carried out in Kenya's kajiado south constituency.

The **content scope**: The study examined the persistence of female genital mutilation and its effect on women's rights in Kajiado South constituency.

The **Time Scope**: this research considered the period from January 1990 to December 2011

The ***Theoretical Scope***: The study was based on social theory, the intention to perform a particular act is seen as a consequence of the relative weight of attitudes and normative considerations. Packer (2005:224) argues that attitudes are determined by beliefs about the consequences of a particular behaviour. Normative considerations consist of social pressure to perform or not to perform a particular behaviour. The norms on which these considerations are based are communicated by important „others" through socialisation and social interaction and the individual"s motivation or desire to comply with these.

Operational definition of key terms

Circumcision: This is a collective name used to a variety of practices involving the female genitalia. It often refers to operations that fall under type I FGM.

Incision: Refers to making cuts in the clitoris, cutting free the clitoral prepuce but also related to incision made in the vaginal wall and to incision of the premium and the symptis.

Clitoridectomy: Refers to partial or total removal of clitoris.

Infibulation: Refers to removal of the clitoris, partial or total removal of the labia minora, together with labia majora.

Unclassified circumcision: All others, including pricking, piercing or incision of the clitoris or and Labia stretching of the clitoris and surrounding tissues; incision to the vaginal wall, scrap, introduction of corrosive substances or herbs into the vagina to cause bleeding with an aim of tightening or narrowing the vagina respectively.

Access to Education: It is used to refer to the opportunity or right by pupils to get formal education through the school setting.

Gender: It refers to cultural definition of men, women, boys or girls used to categorize them into different areas of responsibilities, opportunities and roles within society. Gender refers to femininity and masculinity which are socio-cultural constructions.

Impact: Used in the study to indicate that actions or state of affairs are influenced by another action or state of affairs. (Cause and effect analysis). The term has also been used to refer to positive and negative effects of FGM practice.

Stigmatization: The process by which people are viewed negatively and are often discriminated against by others.

Stigma: A mark on someone. A group of people may also internalize stigma and believe that they deserve to be discriminated against or treated badly, if they are not circumcised.

Development: This is a process by which men and women with degrees of external support increase their options for improving their quality of life.

Empowerment: It is a process by which all people, communities and countries in disadvantaged positions increase their access to knowledge, resources, decision making, and power and raises their awareness of participation in their communities in order to reach a level of control over their own environment and lives.

Culture: It is a whole complex ideas and things produced by a group of people in their historical experiences at a given time. It entails those patterns of thinking and doing that permeates their activities and distinguishes them from other people. Culture is thus the shared products of human groupings, including values, language and material objects. The intangible objects of culture (belief systems) are seen as the nonmaterial culture, while physical objects within a culture are the material culture.

Socialization: It is a process by which the individual develop into a more or less adequate member of a social group they are born into. It is learning to perform social roles according to norms and values of a certain society. According to the oxford student's Dictionary, socialization is defined as a process by which somebody especially

a child, learns to behave in a way that is acceptable in their society.

CHAPTER TWO: LITERATURE REVIEW

Introduction

This chapter focuses on material and documentations as well as previous work of other authors and scholars in relation to the practice of female genital mutilation and cutting. It also includes literature on women rights and works that relates FGM to human rights abuse.

Concepts, Ideas, Opinions from Authors/Experts

Female genital mutilation 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 1995:9; WHO 1997a; WHO 1997b:1; WHO 2008a; WHO 2008b:1; Shell-Duncan et al 2000; FORWARD 2002:2; UNFPA 2007:1). From the studies that have been conducted, four different types of female genital mutilation have been identified, (WHO 1997b:1; WHO 1998:6-8; WHO 2008a; WHO 2008b:4; FORWARD 2002:2; UNFPA 2007:3; Shell-Duncan et al 2000:4-5). 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.

About 28 countries in Africa are said to be practicing FGM. According to *The Hosken Report* published in 1979, which showed a global review and country by country estimates of the prevalence of the practice, some countries like Somalia have an estimated prevalence of about 98% while countries like Uganda have an estimated prevalence of about 5% (Skaine 2005:36-37). The presence of increasing numbers of refugees and immigrants from countries where female genital mutilation is practised it is spreading in non practicing countries among

the immigrant communities. Some of these countries include Norway, Denmark, Netherlands, Sweden, United Kingdom and France (WHO 1997b:3; WHO 1998:18-19).

While there is no religion that requires this practice, it is widely practiced in Morocco, Sierra Leone among the Muslims and among the orthodox Christians in Ethiopia. However this procedure is not practiced in Iran, Libya or Saudi Arabia which are Muslim countries, (Toubia 1995:21). In Kenya female genital cutting is practiced among various communities like maasai, kissii, ameru, kalenjin, taita, akamba among others though its for purely traditional reasons.

Female Genital Mutilation (FGM)

FGM is illegal in Kenya but permitted under customary law causing the government to be reluctant to enforce current legislation. FGM has been classified by the World Health Organization (WHO) into four types.

Type1: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy)

Type 2: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision)

Type 3: 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 4: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and Cauterization

Maasai practice has been classified as Type II i.e. removal of the clitoris and excision of the labia majora.

The operation is as excruciating as it sounds and usually carried out by certain old Maasai women who are considered as traditional practitioners. Although the practice is illegal, some private clinics are reported to be conducting the operations illegally.

Where private clinics are not accessible, the old Maasai traditional practitioners use 'innovative' objects such as "knives, scissors, razor blades, broken glass" (Blyth, 2008, p.213).

The practice is widespread. The unveiling of the problem has produced a strong effect on International forums as a gross violation on human rights for women and girls all over the world.

Kenya has committed itself to some international agreements developed to eliminate FGM. The commonly mentioned ones are the Convention on the Elimination of All forms of Discrimination against Women (CEDAW), United Nation Convention on the Rights of the Child (UNCRC) and the African Union Protocol on the Rights of women in Africa (CEDAW country report; 2009; Mildred, & Plummer; 2008; African Union Protocol on the Rights of women in Africa; n.d).

Statistics estimate:

That 91.5 million girls and women older than nine years in Africa are currently living with the negative irreversible consequences of female genital mutilation (Lindner, 2008).

In Kenya, the former Gender Minister, Esther Murugi ("Fight against FGM continues in Kenya",
2009) gives an account of 37 tribes in the country out of a possible 53 tribes who continue to practice FGM; particularly in the rural areas, despite the illegalization of the practice over ten years ago. Although 38 percent of Kenyan women from these 37 tribes have been circumcised (Whiting, 2002), a baseline survey conducted in Kajiado district by the Ministry of Health and GTZ (Evelia, Sheikh, &Askew, 2008) indicated that 93.9 percent of Maasai women and girls in the area had undergone FGM and that in some parts of the district, a prevalence rate of 100 percent was recorded.

The Government has adopted a plan of action to stop FGM through program activities that sensitize the communities on the dangers relating to FGM and has established services to provide healthcare and counselling for physically and psychologically traumatized girls and women (Evelia, Sheikh, & Askew, 2008).

FGM has been found to result in traumatic physical consequences, often lasting throughout the women's life time. Use of the same instrument during multiple surgeries increases chances of infections. Similarly, when wounds do not heal well this creates a high chance of HIV transmission through vaginal or penile fluids during sex. Further studies of the Population Council (2007) linking FGM with HIV as an indirect cause of increasing women's vulnerability to infection through several pathways found:

Cut women are 1.72 times more likely than uncut women to have older partners, and women with older partners are 2.65 times more likely than women with younger partners to test positive for HIV. Cut women have 1.94 times higher odds than uncut women of initiating sexual intercourse before they are 20, and women who experience their sexual debut before age 20 have 1.73 times higher odds than those whose sexual debut comes later of testing positive for HIV (Yount, & Abraham, 2007, p. 73).

The procedure of FGM also contributes to both psychological and physical consequences such as: anxiety, terror, betrayal, depression, humiliation, sexual dysfunction, impaired sexual fulfillment and physical consequences such as severe pain, hemorrhage, damage to tissue or organs surrounding the clitoris and labia, urinary and reproductive tract infections, fertility difficulties, painful or dangerous sexual intercourse and death (Blyth, 2008, p. 213).

When seeking to understand the reason as to why Maasai performs FGM on girls and women a UNICEF (2005) survey indicates that women cite custom and tradition or that it is a 'good tradition' as the main reason for carrying on with the practice.

Some Maasai will continue to carry out FGM as propaganda continues to perpetuate the practice (IRIN news, 2010): A senior FGM 'surgeon' is convinced that FGM is the only way to stop a girl or woman from sleeping around with any man she meets, be faithful and not bring the disease to the community. Maasai believe that the practice marks the entry of a girl (child) into womanhood and this is when a woman can begin to engage in sexual relations including marriage (IRIN news, 2010).

Nnaemeka and Ngozi (2005) advises that it is worth considering the notion of custom and tradition (UNICEF, 2005) that applies to FGM and to establish the particular socio cultural context within which it is perceived and practiced (p. 221). The concept of how to maintain the identity of Maasai develops over psychosocially a long period of time.

The Maasai community, particularly the girls and women practicing FGM, are highly patriotic to their culture for genuine reasons of maintaining their identity as Maasai to fit in the cultural paradigm. The initiation process of a Maasai girl into womanhood is socially and psychologically significant and related to the hope of being accepted into marriage and family life. It also means a hope of not being rejected as a sexual partner:

Although individual influences on circumcision are possible, decline in the prevalence of the practice is likely to take place simultaneously across social groups, rather than as a result of isolated individual decisions (Guttmacher, 2005).

It is simply human nature for Maasai girls and women to depend on the wider social group because that is where their human needs for survival are met.

The majority of Maasai girls and women will almost fiercely defend this survival tactic against any rallying cry intending to change or abandon the practice.

Rationalizations for the fgm

Momoh (2005:9-10) says that in societies that practice female genital mutilation 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 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 (1991:38), 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 FGM include family honour, 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 FGM. 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 2004:10-12; WHO 2008b:5). FGM 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 marriagabilty of the girl child. The roots of the practice run deep into the individual's psychology, sense of loyalty to family and belief in a value system (WHO 1998:2). The above justifications are similar to what Gollaher (2000:198) 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 provide an environment in which circumcision becomes a requirement for social acceptance hence the continuous practice (Centre for Reproductive Rights 2003:8). Toubia (1995:37) summarizes the reasons as follows: beauty/cleanliness, male protection/approval, health, religion and morality. Tamar Wilson as cited in Ni Mhordha, (2007:7), summaries the reasons for practicing FGM 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 overwhelmingly important reproductive role." FORWARD (2002:3) argues that, "The reasons for FGM 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." Horsfall and Salonen of godparents Association argue that although there are some consistencies they should not be seen as sufficient for allowing the practice to continue.

Medical implications of fgm

FGM is a procedure which causes a number of health problems for women and girls. Despite the fact that there is little documentation on the social, psychological and psycho-sexual effects of the practice, anecdotal evidence of women's experiences shows that FGM affects women adversely in these areas of their lives (FORWARD 2002:5). (WHO 1997b:2; WHO 1998:28-30; WHO 2008a; WHO 2008b:11), documents some of the implications of female genital mutilation on the health of girls and women. Although no study has been undertaken, t is assumed that death can occur as a result of over bleeding, pain, trauma or severe

infection. Other consequences include: severe bleeding, shock, injury to neighbouring organs, urine retention, infection, painful sexual intercourse, painful menstruation and complications in labour and delivery (ibid).

The Population Reference Bureau (2001:16) notes that FGC can cause harmful health effects for women, including haemorrhage, infection, pain, fever, difficulty urinating, and shock. FGM is a man-made problem that causes grave damage to women (Toubia 1995:13-14).

Efforts at abolishment

Over the years a number of initiatives have been formulated to deal with the issue of female genital mutilation in the different countries where it is practiced. Missionaries, colonial administrators as well as governments of certain countries like Sudan and Egypt have tried to deal with the problem of female genital mutilation (Lightfoot-Klein 1991:43-44; Centre for Reproductive Rights 2003:10). There has been a change in approach to dealing with female genital mutilation to information, education and communication campaigns. Innovative methods such as the use of music, theatre and films are being used (Walker and Parmar 1993).

International involvement

According to Newman and Weissbrodt (eds) (1996:3) a number of treaties have been signed to establish the universal standards by recognising fundamental rights and require governments to take action to ensure these rights are observed. Strong legal basis to abandon FGM is found in treaties such as the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC) (WHO 1998:51). CEDAW strongly promotes the rights of women and specifically addresses discriminatory traditional customs and practices (WHO 1998:51). Article 2f calls on States Parties to take immediate steps towards eliminating discriminatory acts or practices as well as, "to modify or abolish existing regulation, customs and practices which constitute discrimination against women." In Article 5, State Parties are obliged to, "modify the social and cultural patterns of conduct of men and women, with a view to achieve the elimination of prejudices and other practices which are based on the idea of the inferiority or superiority

of either of the sexes or on stereotyped roles for men and women". States Parties are obligated in Article 10 to ensure that women have, "access to specific educational information to help to ensure the health and well-being of families". Article 12 of CEDAW says that States Parties are obligated to, "take all appropriate measures to eliminate discrimination against women in the field of health care..." In the CRC, Article 19 protects children from, "all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation," and this applies to FGM. In Article 24:3, CRC makes mention of harmful traditional practices by saying that, "States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children."

National Legislations

The practice is forbidden under many national Constitutions. For example, in Ethiopia, the 1994 Constitution explicitly prohibits harmful traditional practices, including those that oppress women and cause them physical or mental harm. The Constitutions of Ghana, Guinea and Uganda contain similar prohibitions in the provisions therein. In a number of other countries, including Chad, Mali and Niger, FGM is addressed as an injury, in the context of criminal law (UNICEF 2005:29). It should be noted that female genital mutilation is illegal under any criminal code that punishes bodily injury (WHO 1998:56). Lack of will to apply such interpretation to the criminal code and make it applicable to female genital mutilation drives many to call for specific national laws to prohibit the practice (WHO 1998:56). In 1946 under British colonial rule, Sudan introduced such specific legislation to address the issue of female genital mutilation but only for infibulations, while other milder forms were not mentioned. The first independent African state to come up with a law against female genital mutilation was Ghana in 1994 (WHO 1998:56). According to Bentzen and Talle (2007:11) the bottleneck in spite of present legislation is the implementation of the laws as well as lack of political will as seen in the research carried out in some African countries. Domestic legislation prohibiting female circumcision as a strategy in eradicating this practice is often insufficient, according to Packer (2005: 234). According to her, in Egypt the practice still continues despite legislation prescribing those doctors defying the law will be imprisoned and stripped of their license. In non-practicing countries where there are communities of

immigrants coming from practicing countries, a number of initiatives have been put in place to eliminate the practice. In Sweden efforts are under way to eliminate female genital mutilation among the Somali immigrant community. Female genital mutilation has been illegal in Sweden since 1983 (WHO 1998:56). Guidelines have been developed for health workers and the media is being used to raise awareness about female genital mutilation (World Population Monitoring 2002). United Kingdom, Australia and Norway followed suit in 1985, 1994 and 1995 respectively. In United Kingdom alone, despite the adoption of the prohibition of Female Circumcision Act, the British Medical Association estimates that 3000-4000 young girls are circumcised in Britain every year according to Packer.

Local Community Involvement

If female genital mutilation is to be abolished, community-based initiatives need to be implemented. In Senegal, for example Tostan, an international NGO specializing in non-formal education, has developed and refined an approach that is based on the promotion of human rights (Skaine 2005:209-214). It embodies key elements necessary to change a social convention at the community level, including collective action, public declaration and organized diffusion. With the support of UNICEF and in collaboration with the government, it has been implemented in over 1,500 communities in 11 regions of the country. In Burkina Faso, the NGO Mwangaza Action has adapted and applied the Tostan Community Empowerment Programme in 23 villages (The Tostan Programme 2007:2; FRONTIERS Final Report Washington, DC; Population Council 2007:25).

In Uganda, the UNFPA continues to carry out a programme known as REACH to combat the practice through education. The programme has received strong support from the Government as well as support from local leaders from Kapchorwa. It emphasizes close cooperation with traditional authority figures and peers.

Theoretical framework

Social theory and female genital mutilation

Female genital mutilation is a deeply rooted historical, cultural and religious tradition that has been the subject of considerable debate. Baron and Denmark (2006:339), argue that from a human rights point of view it is an unsafe and unjustifiable practice that violates bodily integrity; and feminists argue that it is an inhumane form of gender-based discrimination that capitalises on the subjugation of women, yet nations that endorse the practice define it as an integral feature of the culture. In social theory, the intention to perform a particular act is seen as a consequence of the relative weight of attitudes and normative considerations. Packer (2005:224) argues that attitudes are determined by beliefs about the consequences of a particular behaviour. Normative considerations consist of social pressure to perform or not to perform a particular behaviour. The norms on which these considerations are based are communicated by important „others" through socialisation and social interaction and the individual"s motivation or desire to comply with these (ibid). Similarly Barth (1982:14) argues that human behaviour is shaped by consciousness and purpose. It is explained by the utility of its consequences in terms of values held by the actor and the awareness on the part of the actor of the connection between an act and its specific results. The perception of other people in the community shapes one"s behaviour and way of life. Jenkins says that, "Individuals are unique and variable, but selfhood is thoroughly socially constructed: in the processes of primary and subsequent socialisation, and in the ongoing processes of social interaction within which individuals define and redefine themselves and others throughout their lives" (Jenkins 1996:20-21).

Socialisation therefore plays an important role in the development of values and this affects the way people behave later in life.

Change and mutability are endemic in all social identities but they are more likely for some identities than others. In cases where locally perceived embodiments is a criterion of any social identity, fluidity maybe the exception rather than the rule (Jenkins 1996:21). For the case of female genital mutilation, change is bound to be slow because of the fact that its

justification is embedded in the culture of the people practicing it. Individuals seek to comply with the belief they perceive the significant leaders of their community hold, notably that girls should be circumcised. The theories referred to above explicitly incorporate the influence of the immediate social context on individual behaviour, (Packer 2005:224). A web of socio-cultural norms where a person lives affects their behaviour and decision making, (ibid: 224-225). In Africa social and cultural norms remain strongly in favour of female circumcision. The family and community are the most significant transmitters and guardians of norms. It is through the family that the practice of female circumcision is maintained and upheld as a tradition. In looking at FGC the idea of universality and cultural relativism of human rights needs to be addressed. According to Kwateng-Kluvitse (2005:61), if human rights are not made universal, states could place their traditions and cultural practices above international standards. Cultural relativists however argue that efforts of international organisations like the UN to end the practice are dangerous examples of ethnocentric meddling.

CHAPTER THREE: RESEARCH METHODOLOGY

Introduction

This chapter provides insight into the research design of the study, target population, sample selection and research instruments. The study will mainly use qualitative analyses but elements of quantitative analyses will also be employed to prove and substantiate some findings. These research techniques will be based on the theoretical perspective of the study in order to find answers to the research questions stemming from the research problem of the study.

Research design

Research methodology is the choice one makes how to study a certain topic by gathering data and the methods she/he uses to analyze data in research (Silverman 2005).

Qualitative methodology of data collection will be used in collecting the materials for the research. As defined by Miller and Crabtree (1992) the methods are more than one. It involves exploring attitudes, behavior, and experiences of the group studied. This research will focus on the experiences of Female Genital Mutilation among African women with experiences of FGM and knows more about it. The qualitative approach will be valuable in obtaining more details that can not be achieved in numerical data or by using, for example, a questionnaire. By using interviews, the data will be based on true personal feelings of the participants who took part in the study. The interviews will be made simple and clear to avoid misunderstandings, between the researcher and the research participants.

The research design to be used in this study is a descriptive co relational survey, this study was chosen to find out the relationship between persistence of FGM and women rights abuse

Research population

Kajiado South Constituency, also known as **Loitoktok Constituency** is an electoral constituency in Kenya. It is one of three constituencies in Kajiado District. The constituency was established for the 1963 elections. The entire area of the constituency is located in Olkejuado county council. Loitoktok has a population of 95,430 with an urban population of 7,495 according to the 1999 population census. Loitokitok District has an area of 6, 356.3km^2.

Sample size

According to Morgan and Krejcie table with a population size of over 90,000 people which is N my sample size S would then be 384. The table is contained in the appendix 4. Using the table is much simpler than employing a formula.

Sampling procedures

Sampling procedures will include use of research assistants who will assist in carrying out the interviews as well as distribution of questionnaires to the informants.

The questionnaires will be distributed to local hospitals for nurses and doctors who are suspected of medicalization of the practice. The will also be distributed to local heads of schools to distribute to teachers and pupils as well as giving dates for interviews.

Local NGOs and INGOs operating in the areas will either be contacted for interviews or sent the questionnaires. And also local village elders, local women groups and community based organizations as well as local churches and church elders will be contacted either for interviews or requested to fill in the questionnaire.

Research instruments

The researcher intends to employ different corresponding, related techniques to collect data from the sampled respondents. These will include the use of the following instruments:

* Documentary study of FGM background,

* Questionnaires completed by respondents,

* Interview schedule with specific guiding questions to key informants

Validity of the research instruments

Like Golafshani (2003), he defines reliability as the degree of consistence with which results of a study can be reproduced again using the same methodology. To produce reliable results, qualitative research methods, such as interviews, and literature reviews were used in this research to gather all the information mentioned in this thesis about female genital mutilation.

Data gathering procedures

This research employs the use of survey and therefore combinations of methods are used to collect appropriate data as follows:

a) Documentary study of FGM background

These include recorded information obtained from existing literature, Secondary data obtained from publication and official documents from various relevant sources. The researcher intends to gather relevant and important information from the above sources which are crucial for this study.

b) Questionnaires

The questionnaires will be completed by head teachers, class teachers, local hospital nurses and doctors if possible, and staff of NGOs dealing with FGM. This tool is preferred since it ensures secrecy and anonymity on the part of respondents. It is also appropriate for this group since they are literate hence will read the questions and provide their responses. This method enables the researcher reach the required sampled population easily.

c) Interview schedules

The researcher will also use an interview schedule in this study with predetermined topics or questions to be discussed. This qualitative in-depth technique is used on selected individuals for important information. This group includes the targeted girls and women, the area chief, the council of elders, circumcisers and church elders. The technique is ideal for this group of respondents since it provides exhaustive and appropriate information about their own viewpoints. Furthermore, the interview schedule enables the researcher to verify and guide the kind of information necessary for the study from the respondents.

Data analysis

Analysis will be based on the data provided by participants through open- ended interview questions. The transcripts of interviews will be read several times, according to what the participants were saying they had undergone through during female genital mutilation process. The important points that related to answering the research questions will be grouped together and those that carried the similar information grouped separately. The information obtained from the ten interview questions will then be used to formulate the themes that are used in the data analysis chapter. The data will be presented under set themes and in tables and percentages.

Similarly questionnaires will also be used and analysis made to come up with themes as explained above

Ethical considerations

Ethical considerations will be addressed at the beginning before starting the interviews.
Any sensitive issues that could be distressing to the participants will be considered. It will be made clear to the participants that they can terminate the interview at any stage should they feel uncomfortable with certain questions.
To ensure confidentiality of the participant's welfare, their identities will be protected and any names used will be changed. According to Polit and Hungler (1997), the participation of human subjects in research, especially if one is researching experiences, must be taken care

to ensure the participants are protected. During the interview process, the permission will be sought for recording or writing down the responses granted from the participants. At the end of all the interviews, the time will be taken to transcribe the data and reflects on it. Data will then be coded according to the questions and themes developed from the interview questions. The themes will then be used to analyze all the interviews

Limitation of the study

The expected limitations in the course of this study are expected to be access to informants, considering the nature of the study and the fact that the practice has been made illegal I doubt informant will be forthcoming without persuasion.

Illiteracy levels among this community are very high so communication might be limited to their local language.

The limitations would be overcome through use of research assistants who speak local languages and would then double up as translators when need be.

Secondly through use of local community based organizations and local hospital nurses the researcher is assured of reaching the sample size. The researchers can employ snowballing methods where one informant leads her to another.

Also the researcher will live within this community for the duration of the research and hopefully gain the confidence and trust of local leaders and community at large.

CHAPTER 4: PRESENTATION, ANALYSIS AND INTERPRETATION OF DATA

Introduction

This chapter presents the empirical findings of this research study. A survey using an interview guide with relevant questions regarding the FGM practice was handed to different respondents to be self-administered. The questionnaires were filled out by the District education officer DEO, two circumcisers, the area chief, three church elders, six head teachers, twenty two class teachers and ninety-five pupils from classes 3 to 8, 4 local hospital nurses, 6 staff of local non governmental organizations, 18 local community women and girls i.e. church goers, community women organization members and random local women Interviews were also conducted with some of the respondents holding important positions in the Maasai community. Based on this data-gathering technique, the research questions of this study and tentative hypothesis held are addressed in an attempt to provide answers to:

- What are some of the factors enhancing the persistence of FGM practice among the Maasai people?
- How does the culture of the Maasai people play a role in the persistence of FGM practice among the community?
- How does the community's attitude play a role in the perpetuation of FGM?
- How does the school or education play a role in the eradication or promotion of the practice of FGM?
- What is an alternative rite of passage to FGM among the Maasai people?
- What role does the church play in enhancing or discouraging FGM practice among the Maasai community?
- Why has this cruel practice persisted despite the existing awareness of its dangers on the girl child and the many concerted efforts to eradicate it?

These research questions served as guidelines in the search for answers to the problem statement. They also served as tentative hypotheses in this qualitative study. In order to substantiate the Diffusion of innovations theory, the research questions were used to guide the qualitative sociological research by answering the research questions to correlate with the theory.

In addressing the above research questions, different related aspects from the data have been categorized and put into tables to allow easy access to data to find answers to the research questions. Both qualitative and quantitative methods of data analyses were utilized in this study.

The findings from this study revealed the complex factors set out to investigate causes and factors for persistence of FGM practice and its effects on the rights of women of kajiado south constituency.

Data analysis

The purpose of this study was to describe situations and events regarding FGM practices in the kajiado south constituency. The study aimed primarily at mainly qualitative analyses and elements of quantitative analyses of the particular cultural practice where most of the population is still illiterate. An investigation was conducted to describe why observed patterns of cultural behavior still existed and clarify the implications thereof.

The questionnaires were filled out by the District education officer DEO, two circumcisers, the area chief, three church elders, six head teachers, twenty two class teachers and ninety-five pupils from classes 3 to 8, 4 local hospital nurses, ten staff of local non governmental organizations, 18 local community women and girls i.e. church goers, community women organization members and random local women Interviews were also conducted with some of the respondents holding important positions in the Maasai community. The interviews were conducted by the researcher with the help of five research assistants who also doubled up as interpreters.

The research findings were presented by using qualitative descriptive analysis. Descriptive techniques like tables were used to describe and explain the events regarding FGM. Also used for analysis was categorization into related themes, which were presented alongside qualitative data. There was also an element of quantitative analysis.

Social theory

In social theory, the intention to perform a particular act is seen as a consequence of the relative weight of attitudes and normative considerations. Packer (2005:224) argues that attitudes are determined by beliefs about the consequences of a particular behaviour. Normative considerations consist of social pressure to perform or not to perform a particular behaviour. The norms on which these considerations are based are communicated by important „others" through socialisation and social interaction and the individual"s motivation or desire to comply with these (ibid). Similarly Barth (1982:14) argues that human behaviour is shaped by consciousness and purpose. It is explained by the utility of its consequences in terms of values held by the actor and the awareness on the part of the actor of the connection between an act and its specific results. The perception of other people in the community shapes one's behaviour and way of life. Jenkins says that, "Individuals are unique and variable, but selfhood is thoroughly socially constructed: in the processes of primary and subsequent socialisation, and in the ongoing processes of social interaction within which individuals define and redefine themselves and others throughout their lives" (Jenkins 1996:20-21).

Socialization therefore plays an important role in the development of values and this affects the way people behave later in life. , it was established that the Maasai girl child is caught up in this web of non-adaptability to ending female genital mutilation, the community is so resistant to change. They embrace and stick to their cultural belief systems and continue with the practice of FGM. Neither the formal education nor the church is able to change the peoples' attitude towards this cultural practice. This notion corresponds with the theoretical premise of this study that normative considerations consist of social pressure to perform or not to perform a particular behaviour. The norms on which these considerations are based

are communicated by important „others" through socialisation and social interaction and the individual's motivation or desire to comply with these. This rigidity had contributed heavily to the persistence of practice of FGM, despite the growing awareness of its dangers. The study revealed that among the Maasai people, cultural socialization process, in relation to women and girls, was associated with the practice of FGM. It involved the transfer of cultural knowledge, which the initiates had to internalize unquestionably. Therefore, cultural beliefs did not change. For the case of female genital mutilation, change is bound to be slow because of the fact that its justification is embedded in the culture of the people practicing it. Individuals seek to comply with the belief they perceive the significant leaders of their community hold, notably that girls should be circumcised. A web of socio-cultural norms where a person lives affects their behaviour and decision making, (ibid: 224-225). In Africa social and cultural norms remain strongly in favour of female circumcision. The family and community are the most significant transmitters and guardians of norms. It is through the family that the practice of female circumcision is maintained and upheld as a tradition, (ibid).

Research findings

These research findings are discussed according to the different research questions stemming from the research problem of this study. This method of analyses proves that all research questions have been answered out of the data collected.

Factors enhancing the persistence of FGM

The researcher sought to determine the reasons for the persistence of FGM in this area. From the data gathered, asked for the reasons why FGM persists in spite of the evident awareness on its dangers, four of the six head teachers said that the reason for persistence of FGM was culture and fear of stigmatization. One attributed it to lack of sensitization or awareness, while another one felt that it was due to laxity in laws or punitive measures against those who practice it as shown in the table below. Similarly some of the local women interviewed also attributed the persistence of the fgm to culture and reiterated the facts that they had no knowledge of existence of anti fgm laws. As already stated, tables are only used

in this study to allow easy access to data to find answers to the research questions and to substantiate qualitative data and not to quantify any data.

Reasons for persistence of FGM	Frequency
Culture or Stigmatization	22
Lack of sensitization or awareness	01
Absence of laws and punitive measures	01
TOTAL	24

Most of the respondents interviewed felt that the major reason for the persistence of FGM was culture. Apart from the head teachers and the interviewed women, other respondents including the circumciser, the area chief, council of elders and the three church elders all concurred that culture was the main contributor to the persistence of FGM in kajiado south constituency

Role of culture in the persistence of FGM

The researcher found that culture played a major role in the persistence of FGM. It was clear that culture influenced some members of the society as far as issues of FGM were concerned, irrespective of either religion or social status. This was further confirmed by interviewing three church elders on whether their own children (girls) had undergone FGM. It was surprising that all three church elders said that their own girls had undergone FGM due to cultural reasons.

This finding shows that the church elders too support this practice, but some of them said that they would not have their daughters circumcised given a second chance.

This was further supported by the cultural belief by some of the respondents, i.e. the circumciser and village elder that an uncircumcised woman would not be able to undergo normal delivery. She had to be circumcised even as an adult to avoid stigmatization. The researcher also established that all the girls who had not undergone FGM between classes 3-8 in the sampled schools were all from other surrounding communities, but attending schools in kajiado south constituency. The main reason given by these uncircumcised girls was that it was against their culture and that it was painful.

The researcher further found that the traditional village elders, who were culturally looked upon by the community as being wise and earned a lot of respect and admiration, also played a role in encouraging this practice. It was confirmed that one of their major roles was to determine the FGM calendar and the whole community looked forward to this major cultural event in their calendar.

Role of the community's attitude in the perpetuation of FGM

The researcher sought to establish the level of awareness of the existence of FGM among the respondents. All the six head teachers of the sampled schools admitted that they were aware of the existence of FGM within the Maasai community. During the interview with the head teachers to further establish why FGM persisted in the community, they cited culture as a rite of passage, social demands, prestige, ignorance, requirement for marriage and identity as some of the reasons. This confirmed the fact that all the head teachers interviewed were aware of the existence of FGM irrespective of social status, but admitted that there was very little or nothing they could do about it as it touched on culture and therefore very sensitive proving that this piece of culture is so entrenched in society that it's nearly inescapable.

Some of the interviewees (circumciser, village elder and one pastor) believed that FGM was part and parcel of their culture and was there to stay as of them had a positive attitude towards FGM and saw nothing wrong with it. One actually claimed that to marry an

uncircumcised girl is an abomination, she would be unable to give birth and she would therefore have to be circumcised even as an adult.

Most of the respondents thought that FGM was a source of pride and identity and therefore very necessary. During the interview, the circumciser stated thus "**Circumcision for the woman is a must, otherwise how does she fit into the community**?" It was further established that the uncircumcised girls were subjected to ridicule by both the circumcised girls and their male counterparts.

Data availed by the district education office to the researcher also revealed a drop out of school among the circumcised female pupils. The district office confirmed that they interviewed girls who had dropped out; some reported that they were stigmatized and even threatened that they would lack husbands if they remained uncircumcised. The district education officer stated that due to this, they gave in to circumcision and eventually dropped out of school immediately after circumcision and got married. The researcher established that circumcisers were really respected due to the nature of their work in the society. Their people looked upon them with a lot of adoration and respect. During the research, as we passed through the Market place, women kept on stopping to greet the circumciser in my company. She would in turn nod in appreciation and told me proudly that most of those had been her clients. It was established that the community's attitude played a major role in perpetuating FGM as both the process and the circumciser are looked upon with a lot of respect and admiration.

The researcher also sought views of the six head teachers on how often parents consulted the school about their children's education and whether there was a direct relationship between the parental literacy levels and their concern for education. The head teachers felt that parents had a negative attitude towards education or did not value education at all. Five out of the six head teachers interviewed reported that parents rarely consulted the school about their children's educational progress. Only one of them said that parents occasionally consulted the school regarding educational issues. the head teachers felt that most of the parents had little or no concern over their children's education. According to the head

teachers this could be one of the reasons why many girls dropped out as the parents really did not value education. From interviewing the children, the researcher also found that most of their parents were either illiterate or semi-illiterate and this may have contributed to their ignorance or indifference on the value of education, especially for the girl child. It was concluded that they valued FGM more than formal education. This parental negative attitude may have been a contributory factor to girls dropping out of school after FGM as they got married at a tender age, leading to lack of educational advancement and no real future.

However, there seemed to be a slow change in attitude towards FGM among the community, for example, when asked whether they would circumcise their daughters, given a second chance to decide, all the interviewed church elders said that given a second chance, they would not subject their daughters to FGM. One of them, the catechist from the Catholic Church, just like their other colleagues, was very categorical during the interview as he commented: "Why would I do that to my daughter when now I know very clearly that it is wrong and does more harm than good? My own son has married a well educated Luo girl who is not circumcised and we have accepted her in my family".

Most of the circumcised girls interviewed responded that given a second chance, for one reason or the other, they would not undergo FGM. One of the reasons given was that it interfered with their education as they report witnessing their school mates drop out of school and get married after undergoing FGM. This response showed an increased awareness of the dangers of FGM and a slow change of attitude among the Maasai people. It is hoped that this change of attitude may in future lead to reduction in the number of girls undergoing FGM in the district.

Role of the school/education in eradication of FGM

One of the research questions was to find out whether the school played any role in either eradicating or promoting FGM. When the sampled head teachers were asked whether FGM had any effects on the schooling of the girl child, all those interviewed were unanimous that FGM affected the schooling of the girl child. During the interviews, the head teachers

revealed that from their experience the girls who successfully went through the rite qualified for marriage and therefore dropped out of school. This way, it was agreed that FGM impacted negatively on the education of the girl child. They further said that those who had attained the age of being circumcised but did not undergo the rite were normally stigmatized. They were unable to concentrate on their class work and were most likely to perform poorly in their examinations. This was yet another negative impact for FGM not only on those who underwent it, but also those who had not as they were forced by circumstances to undergo the cut so as to belong just to end up dropping out of school immediately after the cut. These findings were in the agreement with Mwaniki (1986:24) and Namu (1969:56) who consecutively thus observed: "this adversely affects girls' education who immediately after then believe that they are old enough to engage in sexual intercourse quite often", and "girls often drop out of school immediately after the cut and end up in early marriages thus resulting into premature pregnancy, early or forced marriage and finally school dropout".

The researcher further sought the views of the head teachers whether the practice should continue or not. Out of the six head teachers of the sampled schools, two said it should be discouraged, neither said it should be encouraged or modified and four said it should be abolished. One of the four, who wanted it abolished, was very open and clearly stated as follows: "FGM should be past tense, it adds no value at all to the lives of our daughters and is the major contributor to the girls dropping out of school and the poor academic standards experienced in the constituency".

It was therefore evident that most of the head teachers (four out of six) of the sampled schools did not approve of FGM at all and would like an end to it by having it abolished. The rest (two) thought that it should be discouraged and none thought that it should be encouraged. From the above, there are therefore indications that the school played a role in eradicating FGM as the awareness creation helped in changing their attitude and keeping them in school.

The researcher also found that not all girls sampled had undergone FGM, i.e. out of the 95 girls who responded between classes 3-8, 18 had not undergone FGM. Out of this group,

some (10) had no intention at all of being circumcised and were fully aware of its consequences on their education. This meant that only 67 of girls who responded had undergone FGM. .The six head teachers confirmed the existence of counseling sessions in schools for the girls to create awareness on the existence of FGM.

The following table is used to substantiate the previous discussion.

Table 5: Data gathered on girls' responses regarding FGM Class 3 to 8	**Frequency**
Not circumcised	**18**
Not intending to be circumcised	**10**
Undergone FGM	**67**
Total no. of girls interviewed	**95**

From the information gathered from the 95 girls interviewed from class 3 to 8, the researcher established that 67 had undergone FGM, 18 had not undergone FGM, and 10 were not intending to undergo FGM. The biggest number therefore said they had undergone FGM. This confirmed that a large number of primary school going age girls still undergo FGM.

Role of the church in the eradication of FGM

Although it was expected that the church should act as an agent of change, the researcher established that all the church elders had their own daughters circumcised and saw nothing wrong with it at that time as it was part of their culture although they all had developed a

change of heart. This finding was very discouraging as the churches in most parts of Kenya, are in the forefront in steering the fight against this harmful cultural practice.

On further questioning on whether the practice should continue, it was however established that all three church elders interviewed agreed that the practice should be abolished but contrary to their stand, had not put in place any mechanism to abolish or discourage it. During the research, from all three church elders interviewed, it became clear that only the Roman Catholic Church had set up some form of counseling sessions for girls to try and discourage the practice.

From the churches sampled, especially the African Independent church the elder confirmed that his church had not put in place any viable programs to fight this harmful practice. He further confessed during the interview that indeed they had no plan or program in place to stop FGM. He further stated that the church had realized the importance of such mitigation although they had not thought about it before but would think about it immediately. The researcher concluded that the church, especially the African independent church, had not played any role in discouraging FGM despite the fact that it was fully aware of both its existence and dangers to the girls. They claimed that despite being Christians they also have a duty to promote and protect culture. They therefore had no platform to fight this vice.

Alternative rite of passage in Kajiado South constituency

From the information provided by some of key informants namely, two members of the council of elders and two church elders, on whether they were aware of any alternative rite of passage, three of them said that they were not aware of the existence of any alternative rite of passage. Only one was aware of an alternative rite of passage through the church, but could not explain what it was all about, nor knew of any girl who had undergone it. There was therefore absolutely no knowledge on what it was or what it entailed.

The ignorance towards any alternative rite of passage was clear from one of them who stated that there was no other thing to replace FGM and that they are not even aware that anybody was doing something about it apart from various complaints about it that they had

received. This was a setback since the researcher was able to establish from reliable sources that there were various organizations in the districts offering alternative rites of passage, such as NGOs and CBOs some of which had even established safe houses where girls who ran away to escape from FGM were already sheltered and offered alternative rite of passage, besides continuing with their education. It is therefore evident that alternative rite of passage exists in the area, but despite their existence and operation in the district, their services were neither known to most of the residents nor the leaders. If known, they were simply ignored. This trend pointed to the fact that the practice of FGM was here to stay for a long time before the residents started embracing the existing alternative rite of passage as they are slow in embracing change. It was only in engaging in the alternative rite of passage that the Maasai girl child would be saved from this senseless, harmful practice. The researcher felt that there was therefore great need for the service providers and the administrators to go out of their way and sensitize the entire population first on the existence, and then on the importance of the alternative rite of passage. The institutionalization of an alternative rite of passage in this community would be the only way to fight this negative practice.

Reasons for persistence of FGM despite efforts to eradicate it

The researcher sought to find out why the cruel practice still existed among the Maasai people despite the massive awareness on its dangers on the girl child. From the data gathered through interviewing head teachers and church elders, why FGM still persisted in spite of the evident awareness on its dangers, they stated that the main reason for persistence of FGM was culture and fear of stigmatization. Some of the head teachers attributed it to lack of sensitization or awareness while others felt that it was due to laxity in laws or punitive measures against those who practiced it.

Education was believed to have originated from men since patriarchy reigned in these societies; education was open to social change due to external influences. However, the cultural belief system was reported to be so entrenched that even the family background did not exempt the girl child from undergoing FGM. This was further confirmed by interviewing Church elders on whether their own children (girls) had undergone FGM. It was surprising

that all the church elders confirmed that their own daughters had undergone FGM due to cultural reasons. All of them agreed through their responses that it was not possible to stop a girl from being circumcised as some of them even escape from home, find their way to the circumciser and raise the small fee without the help or knowledge of their parents or guardians. From the church elders responses it means that even the church elders who were believed to champion the crusade against this retrogressive cultural practice were caught up in it in one way or another.

The researcher further established that the traditional village elders who were reputedly looked upon by the community as being wise and earned a lot of respect and admiration, also reportedly played a major role in encouraging this practice. It was confirmed that one of their major roles was to determine the FGM calendar and the whole community looked forward to this major cultural event in their calendar. The occasion was therefore viewed as a cultural symbol and pillar in entrenching their valued cultural practice. One of them confirmed during the interview that the whole community relied on them and waited patiently for them to determine the important dates and for this they earned a lot of respect.

Conclusion

The study revealed that among the Maasai people, cultural socialization process, in relation to women and girls, was associated with the practice of FGM. It involved the transfer of cultural knowledge, which the initiates had to internalize unquestionably. Therefore, cultural beliefs are hard to change as at the time of this practice the girls are taught to be women and in patriarchal societies the treasure the knowledge passed on during this particular time as it is said to be of benefit to the men.

CHAPTER 5: FINDINGS, CONCLUSIONS, RECOMMENDATIONS

Introduction

This chapter presents a summary of findings and draws final conclusions to make recommendations to be included in relevant policies. The overall objective of this study was to understand why FGM as a rite of passage is still practiced in the 21st century. The specific objectives of the study were explored, assessed, investigated and described. The previous chapter dealt with the answering of the relevant research questions according to the data received.

In this study these research questions stemming from the relevant hypotheses in the research problem have been accordingly answered. Because of this, all the tentative hypotheses underlying the different research question were accepted as well in the quest to build new theory on FGM practices. The diffusions of innovations theory had been substantiated and applied to the data analyses.

Findings

The research reviewed existing literature and relevant assumptions which were applied to data gathering and findings in the field. This study on FGM practices as a rite of passage into womanhood was conducted in the Kajiado south constituency. Data was collected through the use of both qualitative and quantitative methods of data analyses Descriptive tables and qualitative analyses were used to describe and explain the events regarding FGM. Related themes were categorized and presented in qualitative analyses.

Effects of genital cutting on the rights of women and girl-children

Although the prohibition of torture has been enshrined in international law since the end of the Second World War, FGM has only recently found a place in the international human rights agenda. Certain factors have worked against FGM being recognized easily as a human rights issue for many years. First, people who are often involved in the practice are private actors rather than state officials. Second, the practice is encouraged by parents and family members who believe it will have beneficial consequences for the child in later life. Third, since genital cutting is rooted in cultural traditions of various societies, outside intervention in the name of universal human rights is often regarded as cultural imperialism. Today, however, the effects of FGM on the human rights of women and girl-children can be viewed under:

The rights to life and dignity of human persons

The rights to life and dignity of human person may be regarded as fundamental since all other species of human rights depend on them. Apart from many international legal documents containing provisions which guarantee the rights to life and dignity, provisions also exist in the domestic laws and constitutions of various nations expressly upholding these rights. For instance, the Constitution of Kenya declares the rights to life and dignity of the human person.

These rights of women and female children have always been adversely affected by FGM. Besides direct loss of life, certain complications also arise in the course of the practice. These include loss of blood resulting in anaemia, urinary tract infections, tetanus, HIV or Hepatitis-B arising from the use of unsterilised instruments, chronic pelvic infections, etc. Such complications have resulted in the death of many women and girl-children in many nations.

The rights to privacy and family life

The rights to privacy and family life are fundamental to the effective realization of the individual's personality and existence. Women and girl-children are seriously in need of these protections because they are often the most vulnerable members of a society. The right to privacy is defined as the right of a person to personal autonomy. It includes the right of a

person to be free from unwarranted public scrutiny or exposure. Privacy, on the other hand is a condition or state of being free from public attention, intrusion or interference with one's body, property, acts or decisions. Various international legal instruments assert the rights of women and female-children to these rights. In Kenya, the Constitution declares the rights to privacy and family life to the end that "the privacy of citizens, their homes, correspondence is guaranteed". It also forbids unlawful infliction of wounds, grievous harms and injuries on any person. The right of women and girl-children to privacy is violated when their genitals are mutilated with or without their consent. Every process of FGM is a violation of the right of women and female children to their personal autonomy. Hence, it is a process which violates their fundamental right to be protected from public exposure, intrusion and interference.
The right to family life of women and girl-children is also at issue since they require their genitals to consummate their marriage and family life. In many instances of FGM, female genitals have been permanently rendered unfit for future reproduction and growth.

The right to peace and common heritage of humankind

The rights to peace and the common heritage of humankind fall into the third generation of human rights. This category of rights entails the right of all persons to live in peace without being subjected to practices like FGM that are capable of inflicting pain. It also includes the right to share in the common heritage of humankind. This species of right involves the ability of women and female-children to have their genitals preserved and enjoy their use in natural sexual intercourse. FGM reduces or completely eliminates the degree of sexual enjoyment.

The right to health and physical integrity

The rights to health and physical integrity are fundamental. The negative effects of FGM on these rights of females have been recognised by the United Nations Organisation. For instance, the Committee on the Elimination of Discrimination Against Women issued several recommendations in 1990 urging States to take appropriate and effective measures to abolish traditional practices prejudicial to the health of women and children. Various health

regulations and laws have also been put in place in many nations prohibiting all forms of traditional practices injurious to the health and well-being of women.

The right to protection and freedom from discrimination

The right of all persons to protection and freedom from discrimination has been given prominence in the UNDHR and CEDAW. At the domestic level, many nations have enacted laws prohibiting all forms of discrimination against members of their societies.

Every injurious cultural practice administered on female members of society in contravention of laws forbidding the practice, such as FGM, violates the right of such individuals to adequate protection against discrimination by the government and other authorities of their nations. FGM is regarded by many as an attempt to confer an inferior status on women and female children by branding them with marks which diminish them and remind them that they are inferior to men. The practice is a signal that women do not have any right to exercise control over the condition and state of their own bodies.

Kenyan Government Efforts to Eradicate FGM

There have been several efforts by the government to eradicate FGM since pre-independence times, when the British colonial government passed legislation to reduce the severity of the cut. In

1958 the colonial government tabled a bill to regulate the age at which girls should be circumcised and to hold parents accountable by forcing those girls who choose to be circumcised to seek parental consent before any operation was performed. This bill was withdrawn after opposition from communities practicing FGM. The only legislation until recently that could be used for protection of girls and women from FGM was the Chief's Act of 1912.

The post independent Kenya government has taken the fight against FGM further through the use of the Presidential decree, the UN Human Rights instruments, and information dissemination on implication FGM on the reproductive health of women. According to the National Aids Control Council (NACC), 1.3 of 32 million Kenyans (5.9%) are currently living

with HIV/Aids. With the advent of HIV/Aids, the government went a step further to include HIV information in the school curriculum.

FGM is taught as one of the cultural practice that encourages the spread of HIV and Aids since traditionally one knife was used for all initiates.

The link between FGM/C and HIV has caused some confusion. The Ministry of Health has recently initiated a campaign of encouraging more men to be circumcised in the Nyanza Province because researchers have found that male circumcision reduces the risk of HIV infection among men. With FGM, however, it has been documented that the HIV-virus has been spread because traditional circumcisers have been using the same knives on many girls. As most people in Kenya are still referring to FGM/C as 'circumcision' although it is a very different procedure than the removal of the foreskin of males' genital organ, this has contributed to some degree of confusion as to the link between HIV and FGM/C.

The government has tried to spread the anti-FGM message through public fora like the Chiefs'

barazaa, special UN days like World Population Day, 16 days of Activism, the Women day, the day of the African child, to pass information on the government policy and position on FGM and in Kenya's 10 years development plan often referred to as "Vision 20/30".

The government has also used legislation to make it illegal for anybody to perform FGM. In 2002,

Kenya passed the Children's Act, which protects children from harmful cultural rites and specifically states, "No person shall subject a child to female circumcision, early marriage or other cultural rites, customs or traditional practices that are likely to negatively affect the child's life, health, social welfare, dignity or physical or psychological development." Any person found circumcising a girl under the age of 18 years is liable to be charged and imprisoned for one year or fined 50,000 Kenya shillings (US $710), or both. Under the Penal Code, anybody causing bodily harm to any one is liable for prosecution (Children Legal Action Network, 2008).

The government prohibits FGM/C operations in government-controlled hospitals and clinics. In 1982, the Director of Medical Services instructed all hospitals to stop the practice, stating

that he would prosecute medical professionals performing FGM/C under the Medical Practitioners and Dentists Act and the Nurses, Midwives and Health Visitors Act.

In 1998, the government set out a National Committee under the Ministry of Health. Although the committee has been less active, it has recently been re-activated under the Ministry of Gender and Children Affairs. The committee has now a revised a Plan of Action in close cooperation with INGO, UNICEF, UNFPA, and UNIFEM, bilateral donors and CSOs.

Finally, Kenya is a signatory to the African Union's Maputo protocol, which requires parties to use legislative measures to prohibit and condemn all forms of FGM.

Despite all the legal instruments, the government recognises that changing a deep-rooted culture takes time. The law is rarely enforced against practitioners, or parents forcing their daughters to undergo the procedure. Thus, the government has now decided to engage in a partnership with a broad range of stakeholders as mentioned above to continuously address the obstacles that prevent change in behaviour.

Faith-based and CSOs efforts to eradicate FGM

There are several organizations engaged in the campaign against FGM in Kenya. These ranges from Community-Based organization, faith based institution, to International Non Governmental Organizations. Some of these CSOs are active in the campaign to stop and eradicate FGM are Maendeleo Ya Wanawake (MYWO), GTZ, PATH, World Vision, Seventh day Adventist church (ADRA), FULDA, Plan International, International, Samaritan's Purse, Save the Children (Canada), Methodist Church of East Africa, Anglican Church of Kenya (ACK), Tigania Cultural centre, African Inland Church, The Catholic Church, Action Aid International, Kenya Federation of Women Lawyers (FIDA), Coalition of Women Against Violence, YWCA Kenya and probably even more organizations (Population Council/UNFPA, Situational Analysis, 2007).

The CSOs have used different approaches to discourage FGM practice. Some of the well document ones are: lobbing for policy and legislative change, organizing Alternative Rite of Passage, using HIV and Aids as an entry point to persuade the communities to stop the use of one knife for all initiates. Creating awareness on Reproductive Heath complication which may occur as result of FGM, Providing Alternative livelihoods to circumcisers to encourage

them to abandon FGM as source of income, and building of Rescue Centers for Girls against FGM

Changing trends of female genital mutilation in Kenya

Like all matters regarding human sexuality and reproduction, female circumcision has been regarded at one time in the early 1940s-1950s as a taboo that could not be mentioned in public, let alone discussed. The grandaunts were enjoined in this silence and in some communities it was believed that a curse would be placed on any one who dared to divulge the secrets of the whole process. It is no wonder that up to now there are lots of gaps in research on the subject particularly on the education and socialization imparted to girls during the seclusion period and the mortality rates associated with the practice. Currently, female circumcision has come to the limelight and is being discussed in public both in the urban and rural areas. For example, a number of religious leaders in Nyambene district having been sensitized by FPAK have been incorporating messages on the need to eradicate the practice in their sermons. These religious leaders also caution parents during the baptism of their daughters not to circumcise them. In addition, both the print and the electronic media have been very instrumental in bringing the subject into the limelight. There has been many media coverage on the cases of forced circumcision, other related issues and dissemination of research findings. Based on the newspaper analysis, the debate about female circumcision has led to emergence of two groups. The one group propagates the practice while the other group is against the practice on the grounds of its adverse health effects.

Female circumcision is a traditional, cultural practice, which is so dynamic when it is legislated it goes underground and is extensively practiced. This is evident from the colonial period when the missionaries in Kenya legislated against it, most communities who practiced it continued to circumcise their daughters secretly. For example, in 1982 and 1989, former president Moi issued presidential decrees banning the practice while addressing public rallies. Yet community based studies have revealed that girls were circumcised in mass after each decree (FPAK, 199).

In response to the push to eradicate female circumcision on health grounds, members of certain communities are increasingly turning to health care facilities and qualified heath practitioners to have their daughters circumcised. This is particularly common among affluent individuals. The "medicalization" of the practice is a lesson to advocate its eradication. To diversify their strategies is to sensitize the health workers to the need to eradicate the practice, instead of focusing the attention of the female circumcision on the parents and opinion leaders. While the affluent can afford to take their daughters to the hospital to be circumcised, those who cannot afford take their daughters to private clinics to be given an anti-tetanus injection. The parents also instruct the female circumcisers to use only one razor blade per initiate. The wound is treated using antiseptic detergents. The female circumcisers in turn are using gloves to prevent infections (FPAK 1996:62; PATH 1996:71).Because of the sensitivity of the subject of female circumcision in Kenya; politicians avoid talking about it publicly for fear of losing votes. Both the government and the politicians have taken a non-committal stand. For example, in May 1995, Mr. Ole Ntimama – a member of parliament (MP) and a minister who represented a constituency which is among those with the highest prevalence of female circumcision stated that "we have more important things to worry about such as the poor and the unemployed, the practice of female circumcision will die slowly. There is nothing the government can do. Culturally, 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 the parliament (Daily Nation Newspaper 1995: 13).66
A Study (FPAK 1994:45) established that the proportion of circumcised women in the younger age groups has been decreasing. This means that the tradition is becoming unpopular among the young generation. This is supported by incidences in Nyambene district where in 1995 a number of girls refused to be circumcised after being sensitized on the dangers of the practices. The parents chased them from home but some were later accepted back and they escaped being circumcised. However, one of the girls was never accepted home and the parents stopped paying her school fees. The girl is continuing with her studies with the help of Plan International who pays school fees (FPAK 1996:58).

Conclusions

The study concluded that FGM was still rampant in Kajiado south constituency and the residents viewed FGM as part and parcel of their culture. They were found to be deeply rooted in their culture and even those who had good education or embraced Christianity still held the practice of FGM dear. Culture therefore played a crucial role in the persistence of FGM practice among the community. Apart from culture, the community's attitude also played a big role in the perpetuation of FGM. This was evident in the fact that the community still had a negative attitude towards the uncircumcised girl. This was established to be the reason why girls tried as much as possible to 'belong' and therefore even ran away from home and financed their own circumcision to avoid being stigmatized and isolated both in school and in the society. It was also established that this was further aggravated by the fact that uncircumcised girls were not likely to get husbands within the community.

The school or education however played a major role in the eradication of FGM. It came out clearly that through schooling, the number of girls undergoing FGM had declined since the school/ education empowered the girl and enlightened them on the negative effects of FGM. Through schooling, most girls had learnt to say no to FGM. The educated parents were also not subjecting their daughters to FGM since they knew the dangers. The school therefore was acting as an agent of change. Although the church was expected to play a major role in discouraging FGM practice, it was found that most of the church elders had their daughters' circumcised. The church therefore had no stand against FGM. Apart from the Roman Catholic Church, all the other church elders interviewed had no idea on any strategy on the fight against this vice. To the African independent churches, FGM was part and parcel of their culture and therefore the church could not interfere with this vital practice. Although it was established that there existed an alternative rite of passage to FGM, there seemed to be very little or no awareness on the same among the Maasai community. Most of the respondents seemed to have no idea on the existence thereof. This therefore meant that there was no impact of the interventions being made and much more needed to be done in terms of interventions and awareness creation.

This practice has negatively impacted on the development of this area in that women who were the backbone of this community did not have opportunities to advance and contribute to the economic development due to the slow pace in culture to embrace formal education especially for girls, hence the high poverty levels and slow economic development in the area.

The study also concluded that FGM was the major cause for girls dropping out of school as most girls dropped out and got married immediately after undergoing this rite of passage. The study established that girls were subjected to FGM at ages of 8 – 15 years. This was found to be the critical age when they needed to be in school. It was found that immediately after undergoing FGM, the girls considered themselves as adults. This therefore led to very few girls completing class eight hence the reason for very few girls in the upper classes as opposed to lower ones.

Another conclusion was that apart from FGM, high poverty and illiteracy level were other barriers to children's education in Kajiado south. Most of the children respondents stated that their parents were either peasant farmers with very large families. This led to many not being able to shoulder the expenses associated with secondary education. Most of the respondents cited that the highest level of their children's education was class eight and that they could not afford secondary education expenses.

Most parents/guardians did not value their children's education due to high illiteracy levels. This had led to lack of role models and motivation as most parents had no or very little interest in the education of their children.

Although the researcher found that there existed an alternative rite of passage among the Maasai people, it was not embraced. Most respondents were not aware of the existence of an alternative rite of passage to FGM for the girls in this constituency. This had contributed to the persistence of the practice despite the awareness of its dangers. This could be attributed to lack of information dissemination, hence lack of publicity.

A major finding by this study was that power dynamics, gender and cultural practices had impacted negatively on women's ability to act meaningfully in avoiding FGM practices and that under current circumstances women's social and ethnic context may not bring the desired outcomes to stop this cruel practice.

The persistence of FGM in Kajiado south constituency despite massive awareness on its dangers suggested that there was a laxity by the Kenyan government to enforce the enacted laws to prohibit FGM in this area. Due to this the Kenyan government needs to quickly move in and enforce the law to prohibit FGM.

It is sad that although the majority of teachers in Kajiado south constituency were women during the time of study, there were almost none in the administrative positions where six head teachers sampled, were male. This therefore meant that there was no gender equity in the promotion and appointment of head teachers. The Government should make a deliberate move through affirmative action to promote more female teachers to management levels to act as role models to girls in this community. This policy should also be extended to the appointment of all senior education and provincial administrative officers in the area to improve on gender equity.

The long distances covered by learners to and from school imply that the Government has not constructed enough schools to enable the children access education within the nearest distance possible. There was need for school mapping and building of more primary schools to bridge the distance covered by some learners to school as these impacted negatively on their studies and contribute to the high rates of school dropouts. Alongside this should be the construction of Girls only boarding primary schools in Kajiado district in order to keep girls in school and thus reduce dropout rates, hence increasing retention rate.

Many of the learners did not proceed beyond class eight due to the high cost of secondary education; hence drop out immediately after completing the free primary education cycle. This meant that the Government bursary policy to support the needy children access secondary school education had not been effective especially in the targeting of the neediest.

There was therefore need for the Kenyan government to give priority in terms of provision of bursary to needy children to access education like the rest. This would go a long way in enhancing the government's objective of providing equal education opportunities for all irrespective of their socio-economic backgrounds.

Recommendations

In order to address the plight of the Maasai girl child due to the problems faced as a result of the persistence of FGM and its negative effects, the following should be encouraged so as to contribute to the eradication of this vice and pave way for the empowerment of the girl child in the district;

a) Create more awareness on the dangers of FGM on the education of the girl child by re-evaluating the new challenges confronting FGM and speed up eradication campaign so that a multi-sect oral approach is adopted such as integrating FGM awareness with ante-natal and post-natal programs.

b) Emphasize the importance and strengthen the alternative rite of passage in the area.

c) There should be more intensive campaigns especially through the Media focusing on the dangers and negative effects of FGM on the girl-child and women.

d) It is essential for church leaders to take an active role in the campaigns against FGM.

e) There is need for the parents /guardians in masaai community to be sensitized on the importance and value of education.

d) Anti-FGM crusaders and NGOs need to be more active and set up more safe homes and rescue centers for girls who do not want to undergo FGM.

f) There is need for the education fraternity to set up strong counseling units at both the district and school levels to emphasize on the negative effects of FGM and reduce stigmatization on the uncircumcised girls.

Areas for further research

The study gives the following suggestions as areas of study for future research in Kajiado South constituency and its environs:

a.) What are the most appropriate alternative rites of passage in Kajiado district?

b.) The mass media as a source of information on the dangers of FGM in Kenya

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APPENDICES

APPENDIX I

TRANSMITTAL LETTER FOR THE RESPONDENTS

KAMPALA INTERNATIONAL UNIVERSITY

Ggaba Road - Kansanga
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Tel: +256- 41- 266813 / +256- 41-267634
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OFFICE OF THE HEAD OF DEPARTMENT, ECONOMICS AND MANAGEMENT SCIENCES
COLLEGE OF HIGHER DEGREES AND RESEARCH (CHDR)

Date: 4th May, 2012

RE: REQUEST OF MUTALE MAGDALENA MWANGO
MHD/14125/111/DF TO CONDUCT RESEARCH IN YOUR ORGANIZATION

The above mentioned is a bonafide student of Kampala International University pursuing Masters in Human Rights and Development.

She is currently conducting a research entitled " **The Persistence of Female Genital Mutilation (FGM) and It's Impact on Women Rights: A Study of Kajiado South Constituency, Rift Valley Province, Kenya".**

Your organization has been identified as a valuable source of information pertaining to her research project. The purpose of this letter is to request you to avail her with the pertinent information she may need.

Any information shared with her from your organization shall be treated with utmost confidentiality.

Any assistance rendered to her will be highly appreciated.

Yours truly,

Mr. Malinga Ramadhan
Head of Department,
Economics and Management Sciences, (CHDR)

NOTED BY:
Dr. Sofia Sol T. Galite
Principal-CHDR

APPENDIX II

INFORMED CONSENT

I am giving my consent to be part of the research study of Ms. MUTALE MAGDALENA that will focus on the persistence of female genital mutilation and its effects on women's rights.

I shall be assured of privacy, anonymity and confidentiality and that I will be given the option to refuse participation and right to withdraw my participation anytime.

I have been informed that the research is voluntary and that the results will be given to me if I ask for it.

Initials:_____

Date_____

Appendix 3: Questionnaire on FGM for women and men among the Maasai Community

Location:_____ Date:_____

Age:_____ Sex:_____

1) What are the reasons for FGM in your community?

Please tick one or several of the following options:

a.)Tradition b.)Religion c.)Husband's preference d.)Hygiene e.)Other

2) Who takes the decision about circumcision in you family?

Please tick one or several of the following options:

a.)Mother b.)Grandmother c.) Father d.)Grandfather e.)Aunt Other

3) What are the women's benefits?

_____

4) Do you think that FGM should be continued?

Please circle your chosen answer.

a.)Yes b.)No

5) If yes - why? If no - why? Please give the reasons for your answer to question 4.

_____

6) Would you have your daughters circumcised in the future?

Please circle your chosen answer.

a.)Yes b.)No

7) Who does circumcision for the children in your community?

Please tick one or several options.

a.)Village Midwives b.)TBAs c.)Other

8) How could FGM be eradicated in the community?

9.) Do you understand what human rights are?

a.) YES b.) NO

10.) Is fGM an abuse of human right?

a.) YES B.) NO

If yes what are some of the human rights that the practice of FGM violates

APPENDIX 4: QUESTIONNAIRE FOR CLASS TEACHERS

You have been chosen to participate in this study. Your responses will be absolutely confidential. You are therefore kindly asked to fill in the questionnaire provided without reservations. Please do not discuss your responses with others.

1. Name of your school .....

2. Date of birth .....

3. Place of birth .....

4. Sex

5. Educational/Professional qualification

   (A)P1 (B) P2 (C) S1 (D) Diploma

   (E) Untrained (F) Degree

6. Are you aware of the existence of FGM (Female Genital Mutilation) in this area?

   (A)Yes (B) No

(b) If so, state the possible reasons for the practice.

(i) .....

(ii) .....

(iii).....

(iv).....

7. (a) Do girls who have undergone the rite of FGM all come back to school?

(A)Yes (B) No (C) Some

(b) If not then state what happens to those who never returns? (Please specify briefly)

.....

.....

.....

8. What is your view should be done with FGM Practice? (Please indicate by (tick) from any of the following:

(A) Encouraged (B) Discouraged

(C) Modified (D) Abolished

13. Why do you think FGM practice has persisted in this area? (Please state briefly)

(i) .....

(ii) .....

(iii).....

(iv).....

14. In your opinion, what are the possible solutions to the persistence of FGM in this area?

(i) .....

(ii) .....

(iii).....

Appendix 5: Interview guides for key informants at national level

Background information

☐ Name of key informant

☐ Position or title

☐ For how long have you worked with the institution?

Key questions

☐ Tell me about your organisation.

☐ Are you familiar with the government policy as regards to female genital mutilation?

☐ Tell me more about your programs concerning female genital mutilation?

☐ how effective is this policy in reducing the practice?

☐ Have you handled any complaints concerning this practice?

☐ What strategies have been put in place by this institution to fight this practice?

☐ What are some of your achievements?

☐ What are some of the challenges faced in dealing with this issue?

☐ Any suggestions in relation to future strategies?

Appendix 6: Interview guides for local organizations

Background information

☐ Name of organization

☐ Location

☐ Name of contact person

Key questions

☐ Tell me about your organisation.

☐ For how long has it been in operation?

☐ Tell me about female genital mutilation (what it is, why is it practiced, how is the practice perceived in the community, are there any changes in attitudes as regards to this practice).

☐ Tell me about the government policy on female genital mutilation.

☐ Tell me more about the programs/projects and/activities are you involved in?

☐ For what reasons are you involved in those programmes?

☐ Is this practice on the decrease/increase? Why?

☐ How effective are these programs/projects/activities in reducing female genital mutilation?

☐ What are some of the alternative rites of passage that have been proposed in communities that practice FGM/C?

☐ What is being done to involve men, religious leaders in these efforts?

☐ Tell me more about some of your achievements.

☐ What are some of the challenges faced in doing your work?

☐ Any suggestions in relation to future activities/programmes and/projects.

Appendix 7: Interview guide for the community (Maasai people) Key questions

☐ Can you tell me about female genital cutting?

☐ Tell me more about your experience?

☐ Do you think it is a good idea to abolish this custom?

☐ What do you think can be done to replace this practice among the people?

Appendix 8: Focus group discussion interview guide for girls/women

☐ How do you feel about circumcision?

☐ Do you know of any problems associated with circumcision?

☐ What are your feelings about the programmes that REACH and SEA are running in the community?

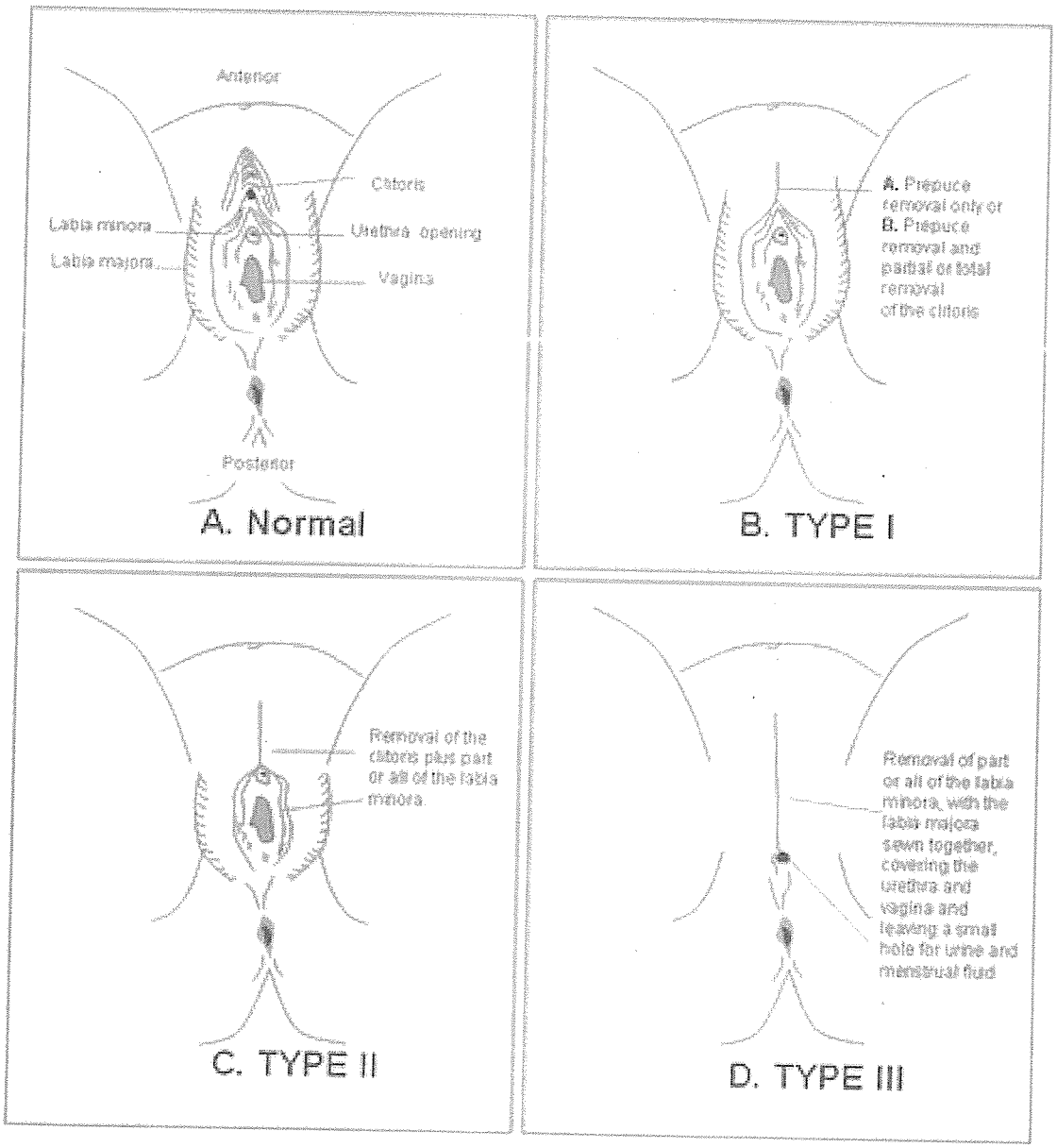
☐ How do you feel about government involvement in the elimination of circumcision of women?

☐ What can be done differently both by the local organisations and governments in this fight against FGC?

☐ Are you involved in any programmes in the community that are aimed at eradication of FGC?

☐ Can you tell me some of the challenges faced in eradication of circumcision

APPENDIX 9: Pictorial representation of different forms of FGM



PERSONAL PROFILE

MAGDALENA MUTALE MWANGO

Tel:(256) 0784375884/ (254) 0717175264

E.mail: dadalyna@yahoo.com

EDUCATIONAL BACKGROUND

2011- Currently: Masters in Human Rights and Development

Kampala international university

2007- 2010: Bachelor in Mass Communication

Kampala international university

2003- 2005: Diploma in Journalism and Public relations

Kenya polytechnic university

1999- 2003: Kenya certificate of secondary education

Sacred heart Girls, Kiganjo

PROFFESIONAL QUALIFICATIONS

2011- Currently: teaching assistant

Kampala international university

2010- Public Relations Assistant

Landmark advertising kampala

2005- People Daily Newspaper, Kenya

Reporting and News writing