KAMPALA INTERNATIONAL UNIVERSITY

PROBLEM OF FEMALE GENITAL MUTILATION IN NAROK DISTRICT - KENYA

CASE STUDY: MAASAI MARA, NAROK DISTRICT

BY

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August, 2008.

DECLARATION

I Kassim Sarah Shamim, I here by declare to the best of my knowledge that this piece of work has never been submitted for the award a Degree in any university or any other institution of higher learning.

Sign _____

KASSIM SARAH SHAMIM,
STUDENT

Date _____

APPROVAL

I certify that Kassim Sarah Shamim carried out research under my supervision. The dissertation has been submitted for examination with my approval as a Kampala International.

SUPERVISOR

Sign_____

Name DR. ANNE MWANIKI

Date _____

DEDICATION

I sincerely dedicate this book to the Almighty God who gave me the capacity to research the work successfully.

I also dedicate this book to my lovely brothers and sisters who made my work easy. I also dedicate this work to my friends who in one way or other contributed to the successful end of this research.

ACKNOWLEDGEMENT

I wish to extend my sincere gratitude and appreciation to a number of people, without their encouragement and contributions, this work would not have seen the light of the day.

My special thanks go to my immediate guardian for his financial assistance, skillful guidance and encouragement. He instilled in me a sense of optimism and confidence to go about various hardships encountered in the course of my research.

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Lastly my thanks go to all informants and those who responded to my questionnaires. I am grateful to you all, may God bless you.

LIST OF ABBREVIATIONS

ADVC ..... Assistant Deputy Vice Chancellor

MOH .....Ministry of Health

NGO .....Non – Governmental Organization

UNICEF .....United Nations International Children Emergency Fund

NFP .....National Focal Point

HIV ..... Human Immuno Deficiency Virus

UN ..... United Nation

WHO ..... World Health Organization

H / W ..... Health Workers

MYWO ..... Maendeleo Ya Wanawake Organization

FGM ..... Female Genital Mutilation

DEFINITION OF THE SELECTED TERMS

Clitoridectomy ..... A type of FGM where only the clitoris is surgically removed partially or wholly.

Infibulations ..... A type of FGM whereby clitoris and some parts of the labia major and the minor are surgically removed.

Traditional Circumcisers ... These are groups of old women who specialize in practicing FGM for the purpose of rituals and financial benefits.

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ABSTRACT

A cross section study carried out on 20th April – 10th May 2007 in Maasai Mara District, Kenya. The study was to find factors that contribute rampant FGM: 90 respondents were interviewed both male and female of 10 and above years of age.

The majority of the respondents 80 [89%] female had undergone FGM and the 10 [11%] had not undergone FGM; the majority of female respondents 40 [80%] support FGM while 8 [17%] were against.

The study found that most male respondents 19 [59%] are against FGM, while less than half 13 [41%] support it, the reasons cited are culture 6 [26%], need for FGM [17%], forces 5 [26%] as said that FGM makes a woman acceptable for marriage.

Eradication of FGM girl child education should be strict in the whole community at least to complete O' Level, also community education so as to enlighten them about the dangers that arise associated with FGM.

Health workers should be warned as not to carry out procedures as many do for money. Tradition women "surgeons" should be helped to get other ways of earning, discourage the practice in the community or else be held responsible.

Men also should be encouraged to play a role by marrying uncircumcised woman to reduce this contributing factor.

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CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND OF THE TUDY

Recently FGM has been prohibited in Kenya, by the president and also by the leader of various districts and those of West African countries, but in Kenya no preventive action has followed, except in few districts, it has been noted that until now that there is lack of data on initiatives undertaken to fight FGM in the country, also there is no deliberate efforts that is being taken to monitor elimination progress on FGM down the village level.

The Maasai who lie in the R.Valley in Kenya and the Eastern Uganda (Sabini) still practice female circumcision on a wide range. It mainly involves excision of clitoris and the procedure is done with crude instruments without sterilization or any anesthesia during the exercise. Women undergo circumcision anytime from the age of 10 years to the age of 20 years.

The number of mutilated women and girls in Africa and the Middle East is increasing steadily due to population growth; that is according to the estimates published by (**WIN NEWS**), but further two millions of girls are thought to suffer FGM every year.

FGM is thought to occur mainly in 24 countries although it has been recognized as a form of violation of girls' child right (UNFP) – United Nations Population fund and have declared February 6th every year as a day of zero tolerance against FGM, also in 1984 at a conference in Dakar to follow upon the WHO seminar, the Inter-African Committee (iac) on traditions and practices affecting the health of a woman and child was organized by women to prevent and eradicate FGM.

Infibulations is meant to protect the virginity of a woman, the Maasai place high premium on this as a condition of marriage, infibulated woman bring high prices to their families when they are chosen as brides these are inform of livestock, goods and money.

1.2 STATEMENT OF THE PROBLEM

An estimated of 135 millions of world's women and girls have had FGM and 2 million girls a year are at risk of FGM and approximate 6 thousand per day "250 per hour". Kenya, Somalia, Sudan, and Nigeria accounts for 85% of all cases. It is practiced in Africa, Asia, Middle East and the Pacific. The risk of FGM included pain, shock, haemorrhage and damage of organs around the clitoris and labia using the same instrument on several girls without sterilization, which may lead to HIV spread. More commonly haemorrhage, small benign tumor of the nerves which and result from excision and clitoridetomy. Infibulations can have serious long term effects, for example chronic urinary tract infection, kidney and urethral damage, reproductive tract infection resulting from obstructed menstrual flow, kiloids excessive scar. "Prof: Emilly Banks of Australia nation University". Genital mutilation can make first intercourse an ordeal for women. It can be extremely painful during childbirth; existing scar tissue on exercised women may tear. The importance of clitoris in experiencing sexual pleasure, suggest that mutilation involving partial or complete clitoridetomy would adversely affect sexual fulfillment. The constant cutting and stitching of women's genital can result in tough scar in genital area (**Head 1996**).

Festivities presents and special attention in the time of mutilation may mitigate some of the trauma, pain, terror, humiliation and betrayal, but the most important psychological effect on a woman who has survived is the feeling that she is acceptable to her society having upheld the tradition of her culture and made her eligible for marriage. It is possible that a woman who

did not undergo FGM could suffer psychological problem as a result of reflection by the society where the FGM practicing community is in a minority (**Barsher 1980**).

There is a 70% increase in the number of women and girls who suffer from post operation haemorrhage, in those with infibulations, there is evidence that deliveries among women who have been subjected to FGM are more likely to put their babies in danger.

1.3 OBJECTIVES OF THE STUDY

1.3.1 GENERAL OBJECTIVE

The general objective is to access the factors that contribute to rampant female genital mutilation.

1.3.2 SPECIFIC OBJECTIVES

a) To determine the level of the awareness of the associated dangers of FGM;

b) To determine the attitude of the community towards FGM;

c) To find out the age at which female circumcision is done;

d) To discover alternatives ways of solving the problem of FGM.

1.4 HYPOTHESIS

1. The Maasais are reluctant to give up the practice of FGM.
2. Illiteracy is widespread in the Maasai region.
3. The Maasai can not abandon their culture despite intervention from the government.

1.5 SCOPE OF THE STUDY

The study was held in Narok District, and to cover the Mara sub location under the Maasai Mara Located, three townships were selected, and that is Melili, Nairegiae enkare, Motonyi. In reference to sample size the study, was intended that the researcher covered only the responded selected the target population, thus arriving at using the random technique methods of sampling. The study intended to investigate more on FGM in the entire region which was to be represented by the case study of the sub location in Narok District.

1.6 LIMITATIONS

The study was limited to cover only one sub location in Narok District, found in the R. valley Province of Kenya.

Within its population the target was limited only to the youth and the adolescent of 10, 18, to 30 years of age and the elderly of 50 years and above. This was indented to give a clear knowledge to the research indents to get.

The study expected the following constrains; -

People's cultural perception and superstition hindered the output.

The project anticipated harsh environment and poor transportation system.

The project met a lot of awareness, illiteracy, lack of knowledge and unorganized data in the topic of research most especially in the sub location.

It was constrained by financial problems in trying to attain its objectives.

1.7 SIGNIFICANCE OF THE STUDY

1. Its importance in that it was showed clearly the statistical data information on FGM was to help the girls' activists in advocating more on its zero tolerance.
2. It was to enable the exposure of FGM thus helped the understanding of it in the region.

3. Data collection was tried to create awareness on the observation of human rights and the elimination of traditions that are harmful.

4. It was clearly shoed for long FGM has been in place and what possible measures can be put in place to combat it.

CHAPTER TWO

2.0 REVIEW OF THE RELATED LITERATURE

2.1 INTRODUCTION

Many people in FGM-practicing societies, especially traditional rural communities, regard FGM as so normal that hey imagine a woman who has not undergone mutilation. Others are quoted as paying only outsiders or foreigners are not genitally mutilated. A girl cannot be considered an adult in an FGM-practicing society unless she undergoes FGM.

FGM is often deemed necessary in order for a girl to be considered a complete woman, and the practice marks the divergence of the sexes in terms of future roles in life and marriage.

The removal of the clitoris and labia viewed by some as the "male parts" of a woman's body are thought to enhance the girl's felinity', often synonymous with docility and obedience.

It is that the trauma of mutilation may have these effects on a girl's personality. If mutilation is part of an initiation rite, then it is accompanied by explicit teaching about the women's role in her society [Baasher 1990].

Traditions and customs are by far the most frequent cited for FGM. Along with other physical or behavioral characteristics; FGM defines who is in the group. This is most obvious where mutilation is carried out as part of the initiation in adulthood. Women in some countries like Kenya and Egypt vows to have their daughters circumcised "as our parents, sisters, grandparents were circumcised, this is our customs". The women are circumcised and insist on circumcising their daughters so that there is no mixing between male and female..... An uncircumcised woman is put to shame by her husband, who calls her "you with the clitoris" people say she is like a man" [Asaad, 1996].

2.2 FACTORS AFFECTING FGM

In many societies, an important reason given for FGM is the belief that it reduces a woman's desires for sex, therefore reducing the chance of sex outside marriage. The ability of unmutilated woman to be faithful through their own choice is doubted. In many FGM-practicing societies, it is extremely difficult if not impossible, for a woman marry if she has not undergone mutilation. In the case of infibulations, a woman in "sewn up" only for her husband. Societies that practice infibulations are strongly patriarchal. Preventing women from indulging in "illegitimate "sex protecting them in unwilling sexual relations, this is vital because the honor of the whole family is seen to be depended on it. Infibulations does not, provide a guarantee against "illegitimate" sex as a woman can be "opened" and "closed" again. [Basher 1990]

In some cultures, enhance of the mans sexual pleasure is a reason cited for mutilation. Anecdotal accounts, however, suggests that men prefer unmutilated women as sexual partners. Cleanliness and hygiene feature consistently as justification for FGM.

Popular terms mutilation are synonymous with purification [Tamara in Egypt, Tahur in Sudan] or cleansing [sili-ji among the bambarra an ethic grouping Mali.

In some FGM societies, unmutilated women are regarded as unclean are not allowed to handle food and water. The perception of FGM-practicing communities is that women unmutilated genital are ugly and bulky and believed that the genitals will grow and become weighty hanging down between her legs. Some communities where FGM is practiced believe that it enhances fertility, the more the extreme believing that unmutilated women cannot conceive; in some cultures it is believed that clitoridectomy make childbirth safer. [Light foot-Neil 1989].

The late Mzee Jomo Kenyatta; the president of the republic of Kenya argued that FGM was inherent in the initiation which are in itself essential part of

being kikuyu, to such an extent that "abolition " .....will destroy the tribal system . a sturdy in sierra Leone reported a similar feeling about the social and political cohesion promoted by Bundo and Sande secret societies, which carry out initiation mutilation and reaching.[Kenyatta, 1938].

2.3 CONTRIBUTION TOWARDS FGM

FGM was practiced by the minority Ethiopian Jewish community [Beta Israel], formerly known as Falasha, a derogatory term, most of whom now leave in Israel, but it was not known if the practice has persisted following their emigration to Israel. The reminders of the FGM communities follow traditional animist.

International efforts to eradicate FGM date for back to 17th century when Christian missionaries and colonial Administration in Africa hired to prevent that practice. These efforts were perceived as "colonists" attempts to destroy local culture and were strongly resisted. Then FGM first appeared in UN's agenda in 1958. WHO organized a seminar in Khartoum, Sudan in 1979 to set the direction for reviewed international initiatives? Its recommendation calls the African countries to adopt clear nation policies, establish national commission to co-ordinate activities of various official bodies. Also called for enactment of legislating where appropriate and organization of public education and outreach involving health workers and traditional healers. [WHO bulletin, 1990].

FGM predates Islam and is not practiced by the majority of Muslims, but has acquires a religious dimension. Where it is practiced by Muslims, religion is frequently cited as a reason. Many of those who oppose mutilation deny that there is any link between the practice and religion, but Islamic leaders are not unanimous on the subject. The Quran does not contain any call for FGM, but a faith hadith [saying attributed to the prophet Mohammed] refer to it. In one case, in answer to a question put him by ''Um'' Attiyah [a practitioner of FGM, the prophet is quoted saying "reduce but do not destroy".

Mutilation has persisted among Rome converts to Christianity. Christian missionaries have tried to discourage the practice, but found it to be too rooted. In some cases, in order to keep converts, they have ignored and even condoned the practice [Lightfoot-Klein H. 1989].

In April 1997 three UN agencies WHO, UNICEF and UNPF unveiled a joint plan to bring about a major decline in FGM within ten years and completely eradicate the practice within three generation. The plan takes a three prolonged approach; Educating the public and lawmakers, policy makers on the need to eliminate FGM; demadicating FGM taking it as a violation of human rights as well as danger to women's health; and working in UN system to encourage every African countries to develop a national, cultural specific plan to eradicate FGM [Nahid 1999]

CHAPTER THREE

3.0 METHODOLOGY

3.1 INTRODUCTION

This chapter was focused on techniques that the researcher was to employ in attaining the data. The work was used to both qualitative and quantitative method.

The chapter was also showed the study area and the survey population. The study on FGM in Narok was complex which necessitates the use of several different methods. These techniques were to be used to locate populations by referrals: public health data was to be used; this was to be obtained by visiting the different hospitals.

3.2 RESEARCH DESIGN

The researcher used both qualitative and quantitative techniques of data collection.

Qualitative was used for descriptive purposes and quantitative was for tabulation. The reasons for using these techniques was because the research intended to produce tabulated information which was related to the topic of the research and also for descriptive purposes these was included in the historical events that led to rampant FGM, and if the attempts had been successful or not ,and if not why?

3.3 SAMPLING

The research covered about 32 responded who were to be sampled from the three townships in the sub-location. There was random sampling and it was to be represented by ten people (respondent) from each town of the three townships. The total population of the study was 30 (unit) in the entire townships plus two organizations involved in advocating for peace and stopping of FGM, in this case MYWO (Maendeleo Ya Wanawake

Organization) and UNICEF (United Nation International Children Right). The selection was done in stages in the study area: First stage, having identified the township was to be done randomly so as to program them for by the researcher.

Secondly; selecting townships in which the research was carried out.

Thirdly, it was up to the village authorities to randomly pick individual respondents or families to be interviewed with the help of the researcher guiding them all to avoid indiscrimination of respondents.

The other stage was the accidental sampling: this was so because the youths who were the target population were people, who could not sit in one place for long hours so by employing these techniques, a number of them were accessed.

3.4 PROCEDURES

The researcher obtained the introductory letter from the University so as to present to the authorities to be given permission for the research in the study area.

The authorities were then given directives to the authority at the township level to allow researcher start her research. The two organizations were then contacted for some information related to the topic.

3.5 DATA ANALYSIS

The data obtained was analyzed using both qualitative and quantitative technologies of research. This was done due to tabulated data that was expected to be drawn in research and some descriptive information related to the topic.

Secondly, data was included from books and academic works published by various institutions reports like NGO field reports.

Primary data was obtained through public health, in-depth interviews, observation and case studies.

3.6 RESEARCH INSTRUNMENTS

They included the following;-

Questionnaires, interviews, focus group discussion, participant observation and case studies in the research.

The researcher based her research mostly using the questionnaires and participant observation. Other instruments were not widely used.

3.7 QUESTIONNAIRE

The questionnaires were given to each selected village, this was intended to get accurate information and it was also provided to check and balance the prevailing in answering questions when interviewing responded.

3.8 INTERVIEWS

The interviews were conducted in each sampled village. They were directed to the youth when the researcher came into contact and face to face interaction with respondents.

3.9 FOCUSSED GROUP DICUSSION

The FGD was encouraged in the research through its use. This was helped in sharing of more data and information. This was helped in shading more light into the research topic.

CHARPTER FOUR

4.0 PRESENTATION, ANALYSIS AND INTERPRETATION OF DATA

4.1 DATA PRESENTATION.

In this chapter, the results of the study are presented and analyzed. The interpretation of the results was in line with the research questions which the study was intended to test in attempt to find out the Factors that affect girls and women during FGM in Narok District, Kenya.

4.2 ANALYSIS

Sample size was calculated using;

NF = n / N

Where NF = Sample size

n = number of respondents expected

N = Total number of respondents available.

The researcher expected to sample 200 respondents but only 90 were interviewed.

N = 200

n = 90

NF = 907 1 = 200 / 2

= 90/ 1.5

The required sampling size was 100 respondents but was not possible to cover them but only 90 respondents were interviewed.

4.3 DATA INTERPRETATION

The following were the findings of the 90 respondents out of 100 targeted.

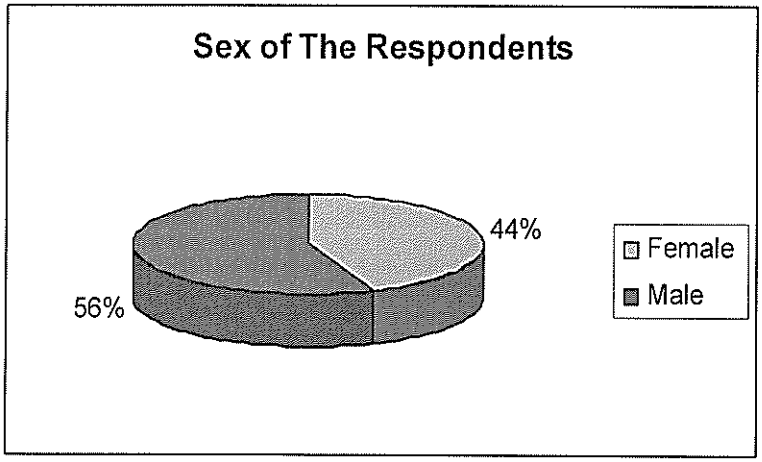
Table 1: Age of the respondents

n=90

Age	Frequency	Percentage
10 – 14	31.3	25
15 – 19	10	12.5
20 – 24	10	12.5
25 – 29	12	15
30 – 34	20	20
Over 35	13	10
Total	**90**	**100**

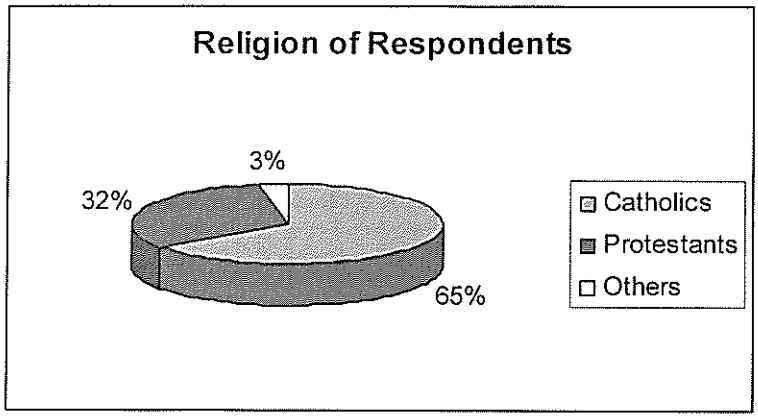
The highest number of the respondents 25 (31.3%) was in 10 – 14 years bracket; while the lowest number of respondents were 10 (12.5%) were 15 – 19 & 20 – 24 years brackets.

Figure 1: Sex of respondents



Most respondents 50 (56%) were females and the rest 40 (44%) were male.

Figure 2: Religion of respondents



The majority of the respondents 52 (65%) were Protestants, 26 (32%) were Catholics and the rest 2 (3%) were in other religions e.g. Muslims.

Table 2: Occupation of the respondents

Occupation	Frequency	Percentage
Employed	11	12.22
Business	24	26.67
Farmers	20	22.22
Students	35	38.89
Total	**90**	**100**

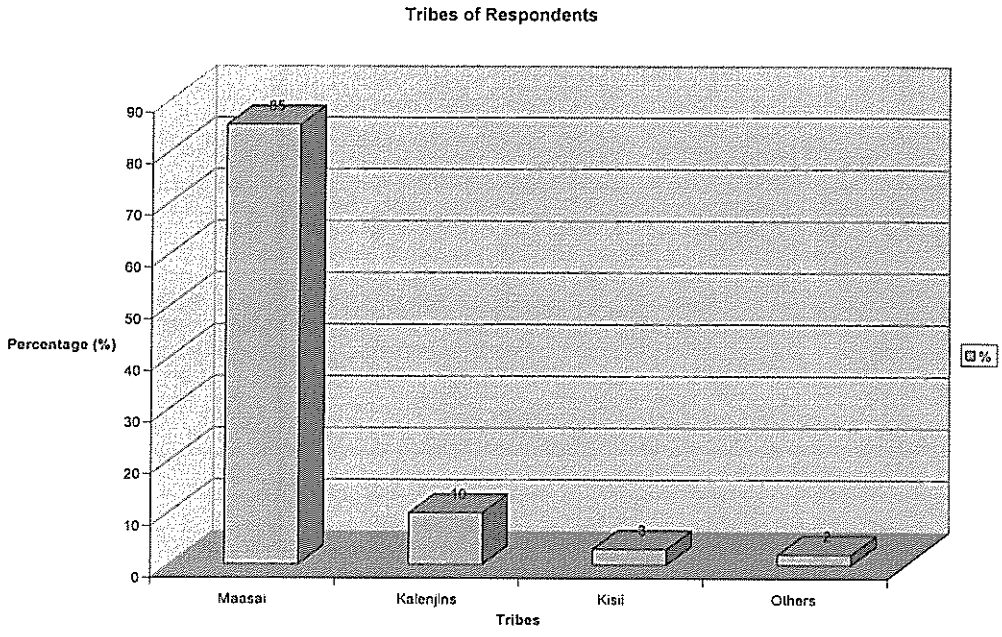
Majority of the respondents 35 (38.89%) students at primary school and 'O' Level and minority are 11 (12.22%) employed the rest 24 (26.67%) are business persons 20 (22.22%) are cattle keepers (farmers).

Table 3: Level of Education of respondents

Level	Frequency	Percentage (%)
Primary	42	46.67
Secondary	26	28.89
Tertiary	22	24.44
Total	**90**	**100**

The highest respondents 42 (42.67%) were primary education (primary eight), while 26 (28.89%) had attained secondary education, and 22 (24.44%) were from tertiary institutions education.

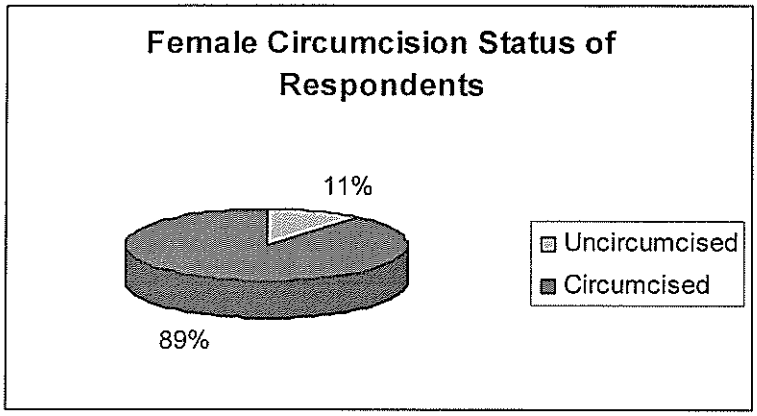
Figure 3: Tribes of Respondents



The majority tribal distributions of the respondents 90 (85%) were the Maasai, while 10 (15%) were other tribes, the Kalenjini, Kisii.

Figure 4: Female circumcision status respondents

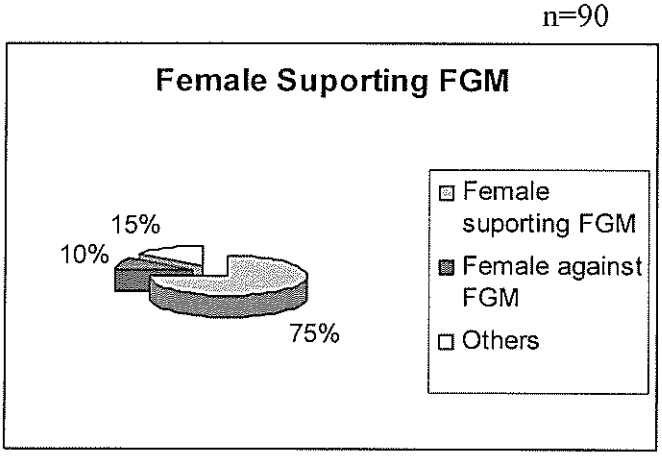
n=90



Female respondents 80 (89%) have undergone FGM, and 10 (11%) have not undergone FGM.

Figure 5: Female Supporting FGM

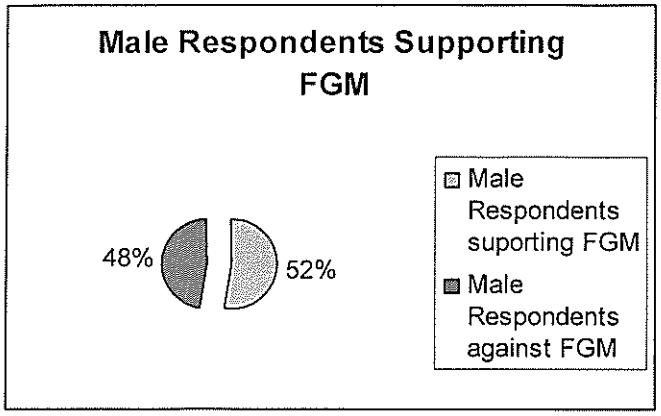
n=90



The majority of female respondents 40 (75%) supported FGM, while 8 (10%) were against FGM. 15% were not in stand.

Figure 6: Male respondents supporting FGM

n=32



Men respondents 19 (57%) oppose FGM and minority 13 (43%) support FGM.

Table 4: Reasons for supporting FGM

Reason	Frequency	Percentage
Parental pressure	5	22
Culture / tradition	6	26
Peer pressure	5	22
Boyfriend / husband	3	13
Other reasons	4	17
Total	**23**	**100**

The female respondents gave culture 6 (26%) peer pressure 5 (22%), force FGM by parents 5 (22%) and others need for FGM 4 (17%) for their reason then boyfriend / husband 3 (13%).

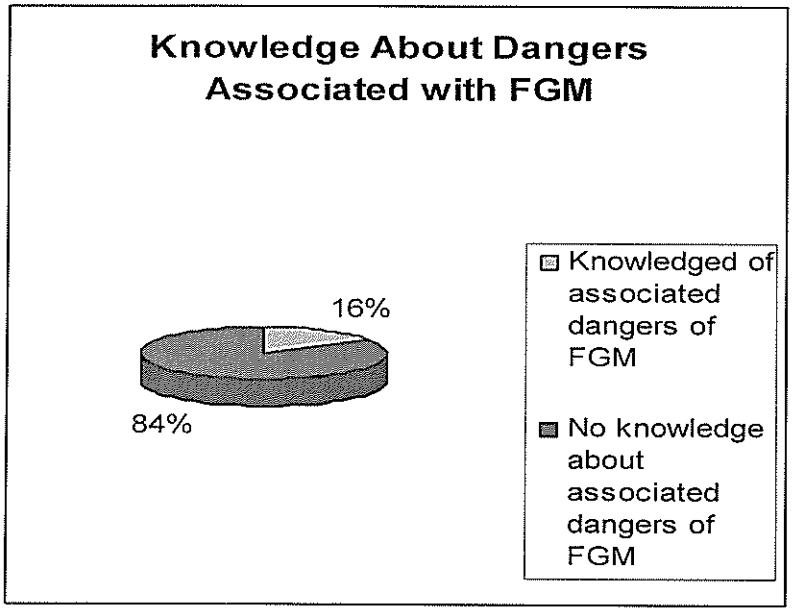
Table 5: Age of circumcisions

Age (years)	Frequency	Percentage
10 – 14	58	64
15 – 19	15	17
Over 20	17	19
Total	**90**	**100**

Most of the respondents 58 (64%) said FGM is done at the age of 10 – 14 years bracket, while 15 (17%) said it is done at 15 – 19 years bracket others 17 (19%) said that it's done at 20 years.

Figure 7: Knowledge about dangers associated with circumcision

n=90



The majority of the respondents 76 (84%) have no knowledge of the associated dangers, only a few minority 14 (16%) know some associated dangers e.g. over bleeding.

CHAPTER FIVE

5.0 DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 DISCUSSION

In this cross sectional study 90 respondents were interviewed between 20th April and 10th may 2007 the study reveals that Female respondent 50 (55.5%) had undergone FGM. Those who had undergone FGM cited various reasons like cultural beliefs, forced parental pressure and marriage.

The majority pf the male respondent 10(50%) said they wish the culture demolished through FGM; a third 6(30%) cited on good behavior of women who had undergone FGM; this means with or without a husband they can abstain.

Both male and female respondents cited on Tradition and customs whereby one-fifth of the male respondents supported FGM 4(20%) said girls who undergo FGM will not bring shame to their families and are accepted by their husbands quickly for marriage.

Most male respondents 19(59%) opposed FGM and prefer uncircumcised girls for marriage; these men respondent are less than30 years of age; other respondent (41%) supported FGM and are above 35 years of age. Reasons cited are those girls who had undergone FGM were well behaved and mature and have skills on how to handle the family life like care of husband and children and also considered dean according to custom. They claimed that uncircumsiced girls are clean and can go in to prostitution due to their high sexual urge. (Basher, 1990 in Egypt).

Demographically the study revealed that most circumcision occurs at 10-14 years of age brackets. Most respondents 58(64%)cited to 14 years of brackets,

a fifth of the respondent 15(17%) give 15-19 years of age brackets, few respondents 17(19%) gave 20 years; so many circumcision occur between10-20 years of age. At these girls are in transition to both physical and psychological changes for childhood to adulthood (NFP 2005 May).

A third of the respondent 42(46.6%) were students in secondary school and another third 26(28.5%) were engaged in farming (cattle rearing). The rest 18(22.5%) were in business and 16 (20%) were in salaried employment. Most respondent of higher education levels 42(52.5%) are against FGM, due to awareness of dangers associated with FGM. Most employed 16(20%) see FGM as out dated and should be eradicated, among those with primary education 26(32%) support of FGM is still high due to these tendency to seek solace in FGM in order to gain respect in probably a husband. Those with good education (urbanized) 12 (15%) Could find employment easily and husband so viewed FGM as meaningless (IRIN 2004).

Religion seems to play a part in FGM status in women, most Protestants 52(65%) said FGM was un-biblical, even women who had undergone FGM do not support it. However Catholic respondent 26(32.5%) were liberal and said they did not mind FGM if it makes them happy.

Most respondents 61 (76%) said that circumcision was carried out by traditional women "surgeons" while about 19 (24%) named health workers. Tradition "surgeons" did it mainly as their role in fulfillment of culture and also financial gain workers did it for money (WHO Bulletin of 2000).

5.2 CONCLUSION

From the discussion held with a sample of interviewees; parents, village elders and government leaders should be at front line to sensitize the negative effect of FGM. These matters turned out to be a debate but records from parents,

village elders and government leader showed that most young girls and women are forced for circumcision. Thus, if emphasis is put in place, then with time this act will end.

5.3 RECOMMENDATIONS

Government should improve on the quality of the sensitization in schools and in forums.

The Kenyan Government should and in countries where FGM is practiced, should make rule and regulations if not laws to gap those who are forced into the act.

Parents should encourage their children more so ladies not to go in for female circumcision as it may cause death.

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APPENDICES

Appendix 1: Sample Questionnaires

QUESTIONNAIRE USED TO ASSESS THE FACTORS CONTRIBUTING TO RAMPANT FEMALE GENITAL MUTILATION IN MARA NAROK DISTRICT.

Introduction:

This questionnaire is to help find factors contributing to rampant female genital mutilation

The information obtained will be confidential.

Instruction:

1. Do not write your name ;
2. Feel free to ask any question where you don't understand;
3. Write in space provided for other question and tick at the correct alternative in multiple choice questions.

A. DEMOGRAPHIC DATA (ALL SEXES)

DATE: / / 2006

1. Age:

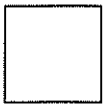
A. 10 – 14 years ☐

B. 15 – 19 years ☐

C. 20 – 24 years ☐

D. 25 – Over 30 years ☐

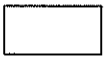
2. Sex:

A. Male 

B. Female 

3. Tribe.

4. Education

A. Primary 

B. Secondary 

C. Tertiary