FEMALE GENITAL MUTILATION AND WOMENS PARTICIPATION IN DEVELOPMENT IN KITOWOI SUB-COUNTY, KWEEN DISTRICT- UGANDA

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MAY, 2018

DECLARATION

I hereby declare that this Research Report has not been presented to any institution either partially or in total for any academic award, publication, or other use. The works here are original. Where the works of others are quoted, appropriate references has been given.

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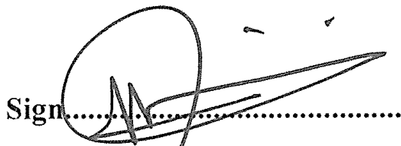
APPROVAL

This research report has been approved in fulfillment of partial requirements for the award of the Bachelor of Development Studies of Kampala international University by the university examination supervisor.



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LIST OF ACRONYMS

AIDS:	Acquired Immune Deficiency Syndrome
CBOs:	Community Based Organizations
FC:	Female Circumcision
FGM:	Female Genital Mutilation
HIV:	Human Immunodeficiency Virus
NGO:	Non-Governmental Organization
REACH:	Reproductive Educative and Community Health
UDHR:	Universal Declaration of Human Rights
UN:	United Nations
UNFPA:	United Nations Fund for Population Activities
USAID:	United States Agency for International Development
WHO:	World Health Organization

ABSTRACT

The study focused on Female genital mutilation/circumcision in Kween district, eastern Uganda, the study objectives sought to establish; (i) the relationship between Female genital mutilation and women participation in development (ii) the reasons for carrying out FGM (iii) To establish the relevant human rights instruments to fight FGM (iv) To establish the possible challenges faced in the implementation of the instruments to fight Female Genital Mutilation are terms used to incorporate a wide range of traditional practices that involve the partial or total removal of the external female genital organs based on traditional and cultural reasons, The study was motivated by the fact that although there have been deliberate attempts and formulation of both international and national instruments to discourage the Sabiny community to discard FGM practice, there seems to be persistent resistance to abandoning it, as evidenced by the number of females who undergo the practice, The study used a case study research design in which both qualitative and quantitative techniques of data collection were employed. The study population included females aged 14-25 and also opinion leaders from the elders, health workers and local council leaders, in all 144 respondents were involved in the study. A research administered questions; interview guide and focus group discussion were also used to solicit data. The data was presented in frequency counts and score tables with varying percentages calculated, interpretations and conclusions depended on the number of occurrences on each item. For qualitative data, a scheme of analysis was worked out following the coding, categories, using content analysis, quotations and the most occurring ideas on every question. The study findings also revealed that there were some levels of support for the eradication of FGM practice is unlikely to end. This is because society has a state of sacredness on FGM, especially by institutionalizing its norms and linking contravention of such norms to social disaster and loss of benefits to society, regarding the use of national and international instruments on FGM, there were low levels of awareness, lack of social support, and lack of practical law that would not complicate relationships elements with other tribes, It was recommended from the study finding that the government should increase community awareness about the need for eradicating the practice of FGM, formulation of policies, planning, monitoring and evaluation It was also recommended that there is need to enhance advocacy and lobbying for the recognition of women's reproductive rights

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CHAPTER ONE

INTRODUCTION

This chapter comprises of the statement of the problem, objective of the study, scope of the study and justification of the study. It also includes Background of the study, significance of the study and conceptual framework.

1.1 Background of the Study

1.1.1 Historical perspective

The term female genital mutilation has undergone a number of changes. Boyle (2005:41) writes that WHO adopted to use the term female circumcision because this practice was referred to as a social and cultural issue as opposed to a medical issue.

Universally, FGM is widely performed with unsanitary and unsterile materials and used for multiple girls which affects the health and wellbeing of the girl and women as well as there are possibilities for the transmission of HIV/AIDS. FGM does not provide psychological and biological benefit for girls and women who have mutilated but effects for the immediate and long health problems (journal of political science and public affairs). The program of Action of the United Nations International Conference on Population and Development in Cairo, September 1994, stipulates that governments are urged to prohibit FGM wherever it exists and to give vigorous support to efforts among Non-governmental and Community Organizations and Religious Institutions to eliminate such practices (Centre for Reproductive Law and Policy, 1997). Furthermore, it revealed that, from a Human Rights stance, governments have clear obligations to take appropriate and effective action to eradicate FGM including legislations on eradication of the practice and sensitization programs citing the negative aspects of FGM. A National Initiative on FGM requires a coalition of government, Non-Governmental Organizations, the Media and the Private Sector.

Uganda is a signatory to most of the International Human, Rights Conventions and Instruments. By ratifying these Conventions, the Government agreed to ensure that everyone within the country enjoys the Human Rights covered by these conventions. These included among others,

the right to life, liberty, to human dignity, fulfillment of basic needs such as the right to food, shelter, clothing and health, freedom of association and the like. These rights have been incorporated in the Constitution of Uganda (1995), for example, Article 24 of the constitution states that "No person shall be subjected to any form of torture or cruel, in-human or degrading treatment or punishment" Article 32 (2) further states that "laws, cultures, customs which are against the dignity, welfare or interest of women are prohibited by this constitution " and Article 33 (1, 2 and 3) state that "women shall be accorded full and equal dignity of the person with men (2) the state shall provide the facilities and opportunities necessary to evidence the welfare of women to enable them to realize their full potential and advancement and (3) their rights, taking into account their unique status and natural maternal functions in society......." More so, in 1996, a court intervened to prevent the performance of FGM under Section 8 of the Children Statute, enacted that year that makes it unlawful to subject a child to social or customary practices that are harmful to the child's health.

1.1.2 Theoretical Perspective

According to Shell-Duncan et al (2000:6), the term female genital mutilation (FGM) was adopted at the Third Conference of the Inter African Committee on Traditional Practices Affecting the Health of Women and Children in 1990 and is now used in the World Health Organization and other United Nations documents to emphasis the violation of human rights involved. Therefore, though FGM was mean to apply to all women in the community, not all of them like the practice.

Ethically, Immanuel Kant (arguably considered one of the greatest philosophers of the modern era) used the idea of having a moral 'duty' to help us workout what do in an ethical situation. In making the distinction between the two kinds of imperatives, hypothetical in studying FGM through an entire objective ethical perspective. Kant comments that formulations of moral commands that apply to everyone are not dependent on personal desires.

1.1.3 Contextual Perspective

On the international context, International Human Rights Conventions generally see FGM as a traditional practice, which violates women and children's rights. Amnesty International, USAID,

and WHO are among the organizations that have condemned FGM practice. It is considered a practice that brutally abuses Humans. This has opted reactions from the human rights perspective on universally recognized Human Rights. For example, Article 1 of the Universal Declaration of Human Rights (UDHR) states that "All human beings are born free and equal in dignity and rights. They are endowed with a spirit of reason and conscience and should act towards one another in a spirit of brotherhood." And article 5 ads, "No one shall be subject to torture or to cruel, Inhuman or degrading treatment or punishment." A human rights perspective on the issue of FGM affirms that girls and women have the right to physical and mental security, the right to freedom from discrimination on the basis of gender, the right to the highest standards of physical and mental health and other related rights. The African Charter on the Rights and Welfare of the Child, adopted by the Organization of African Unity (OAU) in 1990, requires governments to take appropriate measures to eliminate social and cultural practices, "harmful to the welfare, normal growth and development of the child, in particular those prejudicial to the health or life of the child and those customs and practices discriminatory to the child on grounds of sex or related status (Hosfall, 2015).

At the regional level/Uganda, FGM has existed for a very long time for example, Beatrice cheptoyek underwent female genital mutilation (FGM) at the age of 16. That was three decades ago. At that time, it was common practice for girls from sabiny as well as such cases are also recorded among the Karamojongs in the north east of the country. A girl who was uncircumcised was considered impure. (Mary karooro Okurut 2016).

1.1.4 Conceptual perspective

The Reproductive Education and Community Health program (REACH), an advocacy organization was established in Sebei sub-region in 1995 to eliminate female circumcision. It has been working hand in hand with UNFPA and the Government of Uganda (Kirya and Kibombo, 1999). However, their efforts have tackled FGM from a medical perspective focusing on the harmful effects of the practices to mental, social and physical health of the victims. Important to note is that no laws have been drafted and enacted to support their implementation strategy of eradicating the FGM practice. With financial constraints, lack of massive sensitization about the dangers of the practice and limited personnel, the implementation of the International Human

Rights Instruments has not been effective and thus, the practice has survived a test of time and continues to be manifested, especially in Kween District. It is out of the above concerns that the researcher picked interests to address the FGM practice on Human Rights Perspective such that human rights-focused alternatives can be adopted for the benefit of women as far as enjoying their natural entitlements is concerned. This will be done focusing on kween District as a case study. At the community level, using the term mutilation can be viewed as being judgmental and scondemnatory. Female Circumcision is used by practicing communities because it is direct translation from their own languages (Population Reference Bureau2001:3). In 1996, the Reproductive-Educative and Community Health Program (REACH), a United Nations Population Fund programmers, opted to use female genital cutting (FGC) instead of female genital mutilation which was thought to imply excessive judgment by outsiders as well as insensitivity towards individuals who have undergone the practice, (Ni Mhordha 2007:5; Shell-Duncan et al2000:6). For purposes of this study, the terms female genital mutilation (FGM) and female genital circumcision/cutting (FGC) will be used alternately. The global picture estimates that between 85-115 million girls and women have undergone FGM, and at least 2-3 million girls a year are at risk of undergoing or subject to it annually worldwide (Toubia, 1993), (WHO 1997b:3; WHO 2008b:1; Momoh 2005:5).

As a result of immigration this practice is also common in the African immigrant communities in North America, Europe, Australia and New Zealand (WHO 1997b:3; WHO1998:18) and also practice of FGM is widespread in Somalia, Ethiopia, Sudan and the Middle East. It involves the cutting off the clitoris and other parts of the female genitalia. In most cases, the operation takes place in primitive conditions where by un-sterilized cutting tools are used, no anesthesia, no antiseptic and no antibiotics are provided to reduce on the pain and enhance faster healing (Light Foot-Klein 1991; Sarkis, 1995). The fact that the countries that practice Female Genital Mutilation continue to have a thriving population is a testimony to the fact that most women survive (Salonen, 1991). However, it should be noted that others die. But the actual number of women and girls who die as a result of Female Genital Mutilation is not known. However, in areas in the Sub-communities (2003 health report) notes, the FGM practice in Uganda affects approximately 5% of the women population among the Sabiny of kween District. Saharan Africa where antibiotics are not available, it is estimated that one third of the girls undergoing FGM die. Others are permanently crippled and / or face pain and a variety of other problems throughout

their lives. According to (Amal 2015), the other Districts are Kapchowra, Bukwo, Moroto and Nakapiripirit, Amudat whereby the Pokots, Tepeth among other tribes are affected, the Somalis and Sabiny immigrants. FGM exists in Soroti and Moroto districts, though at rear cases due to immigrants from practicing cultures.

FGM is one of the practices whose physical and psychological effects are often traumatic because of the irreversible nature of the procedures that affects women's health and well-being, particularly sexual and reproductive health of those who undergo the procedure (UNFPA, 2014). As a result, some girls drop out of school, marry early and face many problems after the circumcision ritual. The girls and women who undergo the practice are exposed to a number of health risks ranging from severe bleeding, HIV/AIDS infection, and painful intercourse, obstructed labour, low sexual desire, life-long frigidity, menstrual problems, fistulae, incontinence, and a number of other permanent disabilities as well as psychological trauma and stigma (Met Calf, 2011, Kakuba, 2016). (Hasken 2017), 26% of women who undergo FGM develop physical and psychological complications resulting into disability and sometimes death due to over bleeding.

1.2 Statement of the Problem

Although there have been deliberate attempts and creation of international and national instruments to encourage the Sebiny community to disregard the FGM practice, there seems to be persistent resistance to putting it to an end. This is evidenced by the number of females who undergo the practice. Studies conducted on FGM have concentrated on knowledge, attitudes, beliefs and awareness levels about the dangers of the practice on human health (For example, Kakuba, 1995; Kirya and Kibombo, 1999). Such studies have indicated that the level of knowledge on the potential health risks of FGM is low. Women's reproductive rights continue to be undermined as they undergo pain and experience long-life physical, health and psychological effects as a result of the FGM practice(Ban ki-moon 2014).

No single study has come up to address the practice of FGM on a human rights perspective. This study, therefore, is intended to tackle the FGM practice on a human rights basis such that alternatives can be sought to protect, promote and enhance the enjoyment of reproductive health rights by women and girls. There is also need to understand the interaction between FGM and

women participation in development. This will be done focusing on the Sabiny community in kween District as a case study.

1.3. General objective

Examine the significance of FGM and women participation in development.

1.3.1 Specific objectives of the study

i Examine the impact of FGM in Kitowoi sub-county

ii. Examine the structures put to end FGM in Kitowoi sub-county.

ii. Examine the origin of FGM.

1.4 Scope of the study

Geographically, the study was carried out from kween District, found on the slopes of Mt. Elgon, one of the Africa's highest Mountains in Eastern Uganda. The study covered Kitowoi sub-county.

The study covered a period from 1970-2018, reasons being that this time helped the researcher to evaluate the trend of FGM, for example, whether there has been a decline or an increase in FGM incidence and the reasons attributed to the practice. More so, there has been an enhanced recognition of women's rights and the women rights movements and empowerment, especially for the last ten years. This has taken cognizance of the FGM practice. It is in this regard that the time scope was spread for a good number of years to effectively trace and track all the three variables of the study (instruments stipulating women's reproductive rights concerns, reasons for practicing FGM and challenges in the bid to promote women's reproductive rights).

1.5. Research questions

(i). what is the origin of FGM?

(ii)What is the relationship between FGM and women participation in development?

(iii). Why it has taken long to end FGM?

1.6 Justification for the Study

Kween District was selected due to the fact that the community still cherishes the practice of FGM despite its reproductive dangers, the existing human rights instruments and several attempts made to eradicate the practice. This would, therefore, provide a clear ground for finding out the possible reasons for carrying out the practice of FGM. The women emancipation movements, enjoyment of women and human rights, capabilities and functioning have become a great concern for most of the governments, Non-Governmental Organizations, Civil Societies and Community Based Organizations. It was, therefore, to this concerted effort that the researcher found it necessary to empirically find out the ridding factor to the maintenance of the FGM practice irrespective of all the policy instruments and all the efforts directed towards ending the practice.

1.7 Significance of the study

The study findings are expected to be useful to different categories of people in different ways:

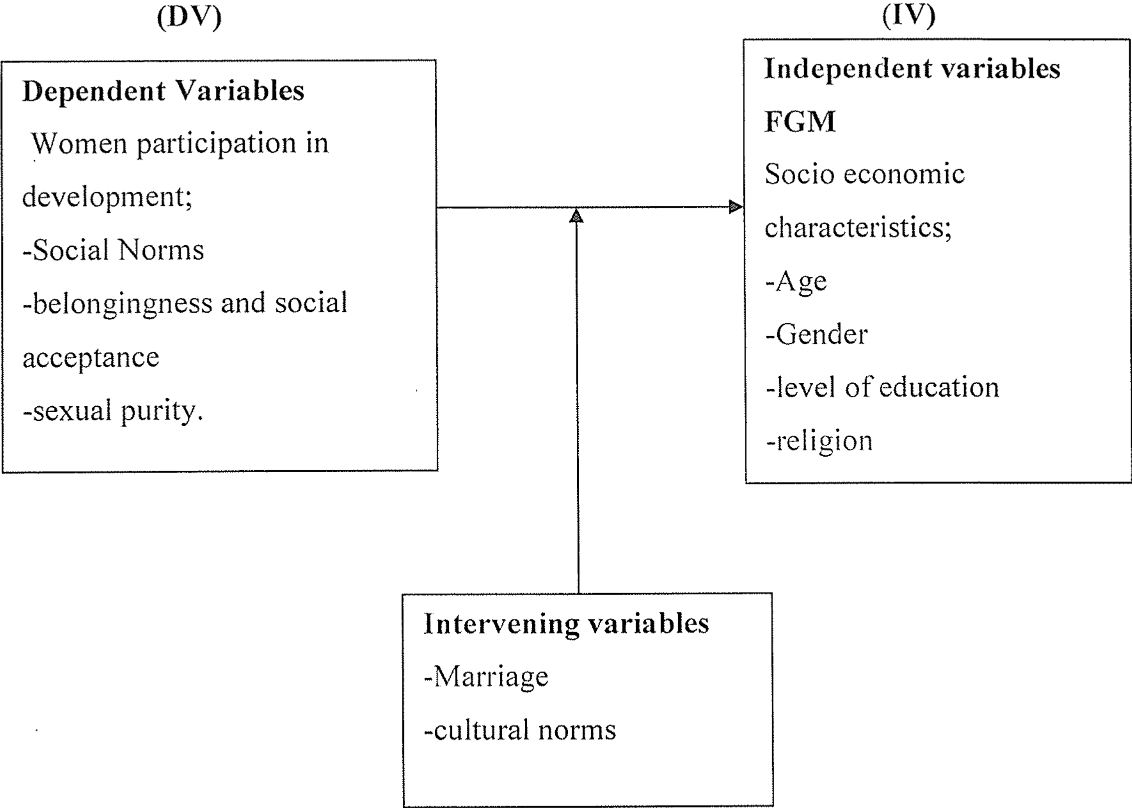
The study findings are expected to form baseline information for policy analysts to effectively evaluate the progress made by the existing women's rights instruments and all the stakeholders (especially women activists) involved in the protection and promotion of women's reproductive rights. It is thus hoped that the study findings will be useful in providing an insight into the explanation for the persistent FGM practice, thereby leading into a scenario of ascertaining the best possible policy alternatives that can be adopted to completely eradicate the practice.

The study concentrates on a human rights-based approach to addressing FGM. Most of the studies done on FGM have tended to concentrate on the health concerns and evaluating the legal instruments in the bid to eradicate the practice. The major component of this study (reproductive rights), therefore, is hoped to provide the government, policy makers, traditionalists and the citizens at large to address the practice as a violation of human rights. This kind of awareness is hoped to create a grounded way of completely doing away with the practice.

The study is focused on issues and challenges that are encountered by women and the girl child as a result of FGM within the community. And compare the interaction between FGM and development. It is hoped that knowledge of such nature can enable government, the community and individuals to come up with realistic solutions to confront the customs and harmful traditional practices that cause intimidation, psychological problems and above all reproductive problems to women. The study findings are also expected to provide up-to-date literature that can be used by academicians who may wish to carry out more studies on the subject matter of women reproductive rights or a related field. It is thus hoped that the study finding will stimulate further research.

1.8 Conceptual framework

Figure 1: Conceptual framework showing: Female Genital Mutilation in Kween District.



Source; Ah Elduma 2018

1.9. The relationship between FGM and women participation in development.

There is a close relationship between the two variables. In 2015, the SDGs recognized the close connection between FGM, gender, inequality and development, arguing global action to end FGM by 2030(UN-DESA 2015)

FGM ranks as one of the worst manifestation of gender inequality as it directly affect women participation in development. Last year, African development report estimated that gender inequality is costing sub-Saharan Africa 6% of its GDP. Leading to around US$95 billion in lost revenue. (Ruth Kiagia and Siharth Chatterjee 2017).

While education is arguable the best solution for ensuring women and girls gain equal access to political and socio-economic power in society, FGM makes this impossible because very often in Kitowoi sub-county, for girls, post-mutilation, is the end of schooling, early marriage and denial of sexual and reproductive health rights. This has been a sure recipe for perpetuation of poverty, misery and inequality specifically in Kitowoi sub-county. We therefore must seek alternative rites of passage to broaden opportunities for girls while recognizing this important milestone for many girls to whom every school holiday comes as a choice but running from home and facing a gruesome, dream-crushing ritual, the country must accelerate the search for lasting solutions, to make real progress, this battle must not be seen as just a confrontation against a harmful cultural practice, but as all-encompassing effort to address the political social and economic drivers that hamper African women advancement and participation in development.

The programs must include addressing the gaps between legal provisions and practice in gender laws; transforming discriminatory institutional settings and securing women economic, social and political participation.

Gains in reducing gender inequality will be defined by more women finishing secondary school, more of them in the formal places of workplace, more women entrepreneurs accessing credit and more of them contributing in the political as well as social decision making process.

During the 25/2015/July visit of former US president Barrack Obama to Kenya, observed, just because something is part of our past doesn't mean it defines our future; the progress towards

Kenya's vision 2030 which also apply to Uganda must include dealing with harmful traditional practices and other scourges that have held back women from progressing.

While examining FGM in Kitowoi sub-county, it's important to note that women not mutilated are not free in the society. They are denied rights to participation. For example, they shouldn't talk or address the congregation. Besides that, activities like milking, entering into the corral, not allowed to climb into the granary, traditional dance for example dancing round the house after circumcision of a male child is forbidden of them. Such cultural "persecutions" undermine the personal freedom of a women and participation in development in the community.

Just as FGM makes girls marriage materials even at an early age and leads to school dropout, such girls after marriage will be full dependants on their husbands hence leading to under development more especially in Kitowoi sub-county where the researcher picked interests in.

CHAPTER TWO

LITERECTURE REVIEW

2.0 Introduction

This chapter comprises of theoretical framework, list of constructs and variables relevant to the study, statistical analysis and social science theories that can be used to explain FGM. It also comprises of reasons for carrying out FGM, related literature, the relevant human rights instruments to fight FGM laws in other countries and the challenges faced in the implementation of human rights tight FGM in Kween district.

2.1. Theoretical framework

The key variables are FGM and women participation in development.

The factors that contribute to the presumed/unauthorized effects of genital mutilation ranges from health, psychology economic and social effects. The practice causes lasting effects on women's body and distorts the productive Oder, besides that, makes young girls who were to continue with education run away from school for marriage.

2.2. List of constructs and variables relevant to the study

(i). Dependent variables.

Attitudes towards FGM constitute the dependent outcome variable and asserted by asking respondents their opinion on discontinuation of FGM. The response alternatives are "continue" "discontinue" or "don't know" for the current analysis, only responses in the two categories are included.

(ii). Independent variables

Data on access to information about FGM was collected by asking respondents whether over a period of a year, they had read about FGM in the printed media, heard of FGM on television/ radio, community meetings, gathering in the church/mosque or even had discussed FGM, with family or friends.

Beliefs about FGM were assessed by asking the respondent's whether they agree or disagree that FGM is part of religion, preferred by husbands that could lead to girl's death, causes problems in delivery, whether can prevent adultery or lessen sexual satisfaction. The demographic variables include where age, marital status, literacy level and occupation status.

2.3. Statistical analysis

Difference in values of the dependent variable (altitude towards the discontinuation of FGM) between participants in different categories of the explanatory variable (i.e. access to information, beliefs about FGM and demographics) were assessed to estimate the independent association between the dependent and independent variables, logistic rogation was performed. The magnitude and direction of associations are expressed in statistical ratios.

2.4. Social science theories that can be used to explain FGM

Three major theories have emerged to attempt to explain the persistence of FGM as well as other similar traditions.

(i). Feminist theory; the feminist theory predicts that abandonment of FGM will be correlated with increased rights of women including improved education for women, protection from domestic violence, property rights and other factors related to the improvement of women's rights more broadly (SAGE journals 2016).

(ii). Modernization theory; modernization theory posits that FGM abandonment is correlated with social modernization including improved education in society, increased access to modern media and other indicators linked to modernization(Alcott parsons 1902-1979).

(iii). Conventional theory. Conventional theory contents that practices like FGM will only be abandoned by communities or sub-groups, rather than by individuals or households because of the challenges in being the first to abandon traditional practices and face ostracism or rejection from the community. Among the three theories, feminist theory seems a strong model for support of FGM for both outcomes; higher education is significantly correlated with decreased support of FGM particularly secondary education, which has a larger coefficient that middle

school education. Also higher tolerance for domestic violence which treats a woman as a property of her husband is correlated with higher support of FGM with both outcome variables.

2.5 Reasons for carrying out FGM practice.

In Uganda, FGM among the Sabiny in Kween is as old as the Kalenjin ancestry, a tribe from whom the Sabiny descended. Although the real origin of FGM is not well known by the present generation, Sabiny legends indicate that like their descendants (the Kalenjin), men used to move long distances to graze cattle and hunt (Kiirya and Kibombo, 1999). As a result, a number of them kept away from their homes, wives and children for a long period of time. Infidelity among married women and promiscuity among girls was high whenever men kept away from home grazing cattle and hunting. From the above, therefore, FGM was introduced as a measure against infidelity for married women and to initiate girls into womanhood. Girls were, therefore, not allowed to engage in coitus before circumcision. FGM gradually grew and later became an accepted way of life (norms) and associated with a range of cherished values. Presently, the Sabiny regard FGM as a sacred ritual sanctioned by ancestors, protected by cultural beliefs and used to initiate girls into adulthood. Therefore, a number of adults and young people often associate with it irrespective of the associated health risks for purposes of identity and dignity (Kiirya, 1997).

Momoh (2005) says that in societies that practice female genital practice like Sebei are cultural beliefs of the tribe, behavioral norms, and custom rituals of the society force most of the individuals to the act because its expected of everyone and failure to adhere to the practice can lead to serious penalty which in most cases curses and finally death.

According to(lightfoot-klein 1989), other reasons for carrying out female genital mutilation seem to be the same practice in most of the African societies and theses practices are based on myth and ignorance of biological and medical facts while others belief that the clitoris is seen as unclean and hazardous to the health of men and new born babies.

Sarkis (2000) writes that some of the reasons for carrying out FGM include family honor, cleanness, protection against spells, insurance of virginity and faithfulness to the husband which

is trying to deny women sex when their husbands are not around or it reduces the desire for sex within the women.

Values, norms, taboos and beliefs held among the Sabiny have been advanced as the major causes and enhancement of FGM. Values refer to the intangible benefits or satisfaction community derives from a practice while norms refer to the set of rules produced and reproduced and held by members of a community. Values are of a universal nature, immutable and represent ideas and high ethics societies follow or honor and comply with to ensure the overall good of the community. Norms are learned by both direct instruction (do as I say) and imitation (do as I do) and followed by society for purposes of dignity and identity (Farah, 1996). In a study conducted by Kiirya and Kibombo (1999), it was observed that values and norms of the Sebei culture are closely linked to FGM taboos. In promoting the cultural norms, society has therefore cast a sort of sacredness and developed taboos on FGM to maintain a stable power structure in the community, legitimize production of the values and limit opportunities for questioning the practice even as more knowledge is acquired.

Although the original value for undergoing FGM was regulation of sexual desire and fidelity (faithfulness) in marriage, other values have been evolved and added to the practice. Notable among these are respect in society, hygiene, maintenance of virginity until circumcision or marriage, keeping secrets and being firm during delivery. For a female to be respected and recognized as a woman in the Sebei culture, she must undergo circumcision. Such values are reproduced by discriminating against uncircumcised women/girls. This is done by putting body marks on all circumcised women/girls and denying certain dignified roles and privileges to uncircumcised women.

2.6. Related literature.

Female genital mutilation a violation of human rights; this literature argues that FGM is a violation of human rights. When looking at the universal declaration of human rights, FGM violates article three and five specifically article three states "everyone has the right to life, liberty and security of a person" (Yesha 2017)

FGM and gender; this literature argues that FGM sustains gender norms and stereotypes that contravene human rights and it's harmful to the health and wellbeing of girls and women. (Mach Barcia, jillia Nkowalchuck, Jessie chiliza and Bettina shell-Duncan 2017)

2.8. Literature gab

Though research about FGM has been done, there is gab in this work for example; most of the work done has been centered on FGM as a violation of human rights. This creates questions like, "what if the person is willing to go in for FGM without force or influence from the community members?" One can rightfully argue that it's her right to be circumcised.

Such literature does not explain the relationship between FGM and development that is why the researcher was also focus on how FGM affects development and women participation in development.

2.8 The Relevant Human Rights instruments to fight FGM

The Universal Declaration of Human Rights (UDHR) The UDHR consists of a preamble and 30 articles, setting out the human rights and fundamental freedoms to which all men and women are entitled, without discrimination of any kind (United Nations, 2000). The Universal Declaration recognizes that the inherent dignity of all members of the human family is the foundation of freedom, justice and peace in the world. It recognizes fundamental rights which are the inherent rights of every human being including, the right to life, liberty and security of person; the right to an adequate standard of living; the right to seek and enjoy asylum from persecution in other countries; the right to freedom of opinion and expression; the right to education, freedom of thought, conscience and religion; and the right to freedom from torture and degrading treatment. These inherent rights are to be enjoyed by every man, woman and child throughout the world, as well as by all groups in society, as some of the stipulations so point out. For example, Article 1 of the UDHR states that "All human beings are born free and equal in dignity and rights. They are endowed with a spirit of reason and conscience and should act towards one another in a spirit of brotherhood." And article 5 ads, "No one shall be subject to torture or to cruel, inhuman or degrading treatment or punishment." With regard to FGM, it ought to be noted that the practice totally subjects the victims to torture, pain, physical, psychological and health implications if not

death. The issue at stake is that the practice is manifested in some of the countries that fully ratified the UDHR. In view of this, this study intended to find out whether the women victims are aware of their rights as regards objecting the practice. This was done with a focus on the Sebei community of Kween District Kitowoi sub-county.

(ii) The International Convention on Economic, Social and Cultural Rights

Economic, social and cultural rights are fully recognized by the international community and in international law and are progressively gaining attention. These rights are designed to ensure the protection of people, based on the expectation that people can enjoy rights, freedoms and social justice simultaneously (Centre for Reproductive Law and Policy, 1997). The Convention embodies some of the most significant international legal provisions establishing economic, social and cultural rights including, international rights relating to work in just and favorable conditions; to social protection; to an adequate standard of living including clothing, food and housing; to the highest attainable standards of physical and mental health; to education and to the enjoyment of the benefits of cultural freedom and scientific progress. By the fact that FGM violates women's full enjoyment of their physical being, as their bodies are subjected to deformations, reflects the fact that the convention is not fully recognized. It was therefore, to the interest of this study to find out why the convention has not been put to full use, especially for countries like Uganda that ratified the convention.

(iii) Convention on the Elimination of all Forms of Discrimination against Women

As the United Nations (2000) puts, the convention on the Elimination of All Forms of Discrimination against Women was adopted by the General Assembly in 1979 and entered into force in 1981. Despite the existence of international instruments which affirm the rights of women within the framework of all human rights, a separate treaty was considered necessary to combat the continuing evident discrimination against women in all parts of the world. In addition to addressing the major issues, the Convention also identifies a number of specific areas where discrimination against women has been flagrant, specifically with regard to participation in public life, marriage, family life and sexual exploitation. The objective of the Convention is to advance the status of women by utilizing a dual approach. It requires state parties to grant freedoms and rights to women on the same basis as men, no longer imposing on women the

traditional restrictive roles. It calls upon state parties to remove social and cultural patterns, primarily through education, which perpetuate gender-role stereo-types in homes, schools and places of work. It is based on the premise that states must take active steps to promote the advancement of women as a means of ensuring the full enjoyment of human rights. It encourages state parties to make use of positive measures, including preferential treatment, to advance the status of women and their ability to participate in decision-making in all spheres of national life-economic, social, cultural, civil and political. Article 17 of the Convention establishes the Committee on the Elimination of Discrimination against Women to oversee the implementation of its provisions.

What remains a concern of this study is that irrespective of the stipulated intentions and framework of action, the convention has been accorded minimal recognition as regards women discrimination relative to FGM. It would be prudently put that the cultural attributes especially among the Sabiny have survived a test of time and greatly influenced the community perception about the practice of FGM. The issue of human rights, with regard to culture seems not to have been greatly considered. It is this major aspect that necessitated redressing the practice of FGM from a human rights perspective with a belief that recognizing that FGM is a violation of the fundamental human rights would stimulate enhanced advocacy and lobbying strategies to completely eradicate the practice.

(iv). Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment

Over years, the United Nations has developed universally applicable standards against torture which were ultimately embodied in international declarations and conventions. The adoption, on 10th December 1984 by the General Assembly, of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, was the culmination of the codification process to combat the practice of torture. The Convention entered into force on 26th June 1987 (United Nations, 2000). It should however be noted that despite the convention, torture, cruel and inhuman treatment is still being inflicted on women who are mutilated. These points to the fact that much as there could be laws, committing crime may still be explained by the social

structure, norms, beliefs and values upheld by a given society. It is to this extent that the study was opted to focus on Kween District where the practice of FGM has survived for a test of time.

(v) Convention on the Rights of the Child

The convention embodies some of the general principles for guiding implementation of the rights of the child: non-discrimination ensuring equality of opportunity. Here, when the authorities of state take decision which affect children, they must give prime consideration to the best interests of the child; the right to life, survival and development which includes physical, mental, emotional, cognitive, social and cultural development. Children should be free to express their opinions, and such views should be given due weight taking the age and maturity of the child into consideration.

Among other provisions of the Convention, state parties agree that children's rights include: free and compulsory primary education; protection from economic exploitation, sexual abuse and protection from physical and mental harm and neglect; the right of disabled child to special treatment and education; protection of children affected by armed conflict; child prostitution; and child pornography.

Under Article 43 of the Convention, the Committee on the Rights of the Child was established to monitor the implementation of the Convention by state parties (Centre for Reproductive Law and Policy, 1997). Despite this monitoring structure in place, children have continued to fall victims of physical and psychological torture as a result of FGM practice. In implementing the instruments, as (Rukooko 2001: 138) puts, states ought to set verifiable benchmarks for subsequent national and international monitoring. In this connection, states should consider the adoption of a framework law as a major instrument in the implementation of the strategies. Considering Uganda, one would say that the country has complied with the international instruments by putting human rights aspects in her constitution. The issue that remains unresolved is whether the necessary stakeholders were consulted during the structuring and compilation of the constitution. This would point and bring to light why there have been some resistance to do away with FGM even when the constitution so puts forward grounds as to why the practice should be stopped.

2.10. Laws in other countries

(i) United States

FGM was added in 1996 to the Assault Chapter of Title 18, US Code 116 FGM:

a) Except as provided in subsection (b), whoever knowingly circumcises, excises, or infibulates the whole or any part of the labia majora or labia minora or clitoris of another person who has not attained the age of 18 years shall be fined under this title or imprisoned not more than five years, or both,

b) A surgical operation is not a violation of this section if the operation is:

(i) Necessary for the health of the person on whom it is performed, and is performed by a person licensed in the place of its performance as a medical practitioner; or

(ii) Performed on a person in labor or who has just given birth and is performed for a medical purpose connected with that labor or birth by a person licensed in the place it is performed as a medical practitioner, midwife, or person in training to become such a practitioner or midwife;

c) In applying subsection (b) (1), no account shall be taken of the effect on the person on whom the operation is to be performed of any belief on the part of that person, or any other person, that the operation is required as a matter of custom or ritual (Maguigan, 1999).

It can be deduced from the US stipulations that despite the allowance of health related concerns in the provision, mutilating an adult may not constitute to violation of women's Reproductive Rights, as the provision only condemns the practice on a person that is less than 18 years. This forms a basis of divergence and disagreement between FGM provisions between different countries. If Uganda was to adopt the US's FGM provision, the practice would still thrive as the target would be 18 years and above to cross over the bracket being labeled a human rights violator.

(iii) United Kingdom

The prohibition of FGM is not limited to procedures performed to minors. It is criminal to perform, or to aid, abet or procure the procedure. The act mandates that health care personnel report instances of FGM to law enforcement. The prohibition of Female Circumcision Act provides that the procedure is not criminal if necessary for the physical or mental health of the patient, and that in the application of that subsection, no weight is to be given to the belief that FGM is required by custom (Maguigan, 1999).

To the above effect, of the FGM provision in the United Kingdom, therefore, it would be absolutely criminal to carry out FGM, or aid the procedure of mutilating females. This shows a provision in which cultural purports can never be compatible with issues to do with safeguarding human rights. Whereas this could be the ideal concern for the provision in the United Kingdom, the case seems different in Uganda where the practice of FGM is deeply embedded and supported by the cultural attributes.

(i) Djibouti

Penal Code outlawing FGM was enacted in 1994. The law includes prison term and fine in instances when a female is mutilated.

(ii) Ghana

Law prohibiting FGM was enacted in 1994. Section 69A of Criminal Code makes it a second degree felony with fine and imprisonment. Article 39 of the constitution abolishes injurious and traditional practices. These points to the fact that issues of human rights cannot be compromised over because of cultural and/or traditional bearing as the case is in Uganda.

(iii) Burkina Faso

Law outlaying FGM passed in October 1996. The Penal code articles enacted include Article 380: Whoever attempts or harms the physical integrity of the genital organ of a female, either by total ablation, excision, anesthetization or by other means, will be imprisoned for a period of three to six years and fined 150,000 to 900,000 francs or be ' subject to one of these penalties. If death ensues, the penalty will be imprisonment for a period of five to ten years. Article 381 states

that penalties will be applied to the fullest extent of the law if the culprit belongs to the medical or paramedical field. The jurisdiction of judgment may forbid him to practice for a period of no longer than five years. Article 382 states that a person having knowledge of the acts aforementioned in article 380, and failing to advise the proper authorities, will be fined 50,000 to 100,000 franc.

(iv) Guinea

Article 256 of the Penal Code prohibits FGM. Article 6 of the constitution prohibits cruel and in human treatment. As per WHO (1999), the government initiated a 20 year (1996-2015) collaboration with WHO to work towards elimination of the practice. Government works with non-governmental organizations to eradicate FGM through films, TV, seminars and so forth.

(v) Senegal

In July 1997, the women of Malicounda, a small village in Senegal, set an example for the rest of the world to follow by being the first village to officially stop FGM. In February 1998, President Diduf began drafting the legislation ban on FGM. On January 13, 1999, the Parliament approved the legislation (Jaimmer, 1999).

(vi) Egypt

In 1996, the Ministry of Health and Population issued a decree finally forbidding the practice except for medical indications, and only with the occurrence of a senior obstetrician. The decree (No. 261) states: It is forbidden to perform excision on females either in hospitals or public or private clinics. The procedure can only be performed in cases of diseases and when approved by the head of the obstetrics and gynecology department at the hospital and upon the suggestion of the treating physician. Performance of this operation will be considered a violation of the laws governing the medical practitioners from performing FGM in any governmental facilities or private clinics (since they could face administrative punishment). However, it still did not legally prevent the performance of FGM in a home by nongovernmental medical practitioner (WHO, 1999).

2.11. The challenges faced in the implementation of human rights instruments to fight FGM in Kween district.

(I). Women's low social status

As Rahman (2003) puts, women's low status has greatly constrained the implementation of instruments and laws regarding women's reproductive health. Legislation targeting FC/FGM is likely to have little positive effect in a legal context in which women's rights are not recognized or are explicitly undermined. It ought to be noted that for effective implementation of the human rights instruments, governments must ensure that they have ratified the major human rights treaties guaranteeing women's rights, including the Convention on the Elimination of All Forms of Discrimination against women. This will help bring national-level laws into conformity with the rights guaranteed in the treaties. Also, there is need for constant monitoring to ensure that governments are conforming to the required standards of effecting the stipulations that they ratified Women's weak social standing reinforces their inability to reject FGM. In matters affecting individual rights, and customary practices, there has always been a tendency to uphold the customary practices. Because customary laws frequently govern such matters as marriage, and inheritance. Government's refusal to enforce women's equality when customary law is at issue may result in a perpetuation of condition that leads to women's insubordination.

(ii) Resistance at the community level

A law condemning FGM can only have weight where the practice's harmful effects are understood and recognized at the community level. In Kinship-based societies, behavioral change at the individual level is difficult to achieve without the approval of the community (pasquinelli, 2003). In such a context, using the law to subvert the demands of one's own relatives or community members may cause graver social and economic repercussions for the person resisting FGM than person trying to impose it.

In Kween District where custom plays a vital role towards the FGM practice, it would be very critical to ensure that a broader government strategy which includes outreach and awareness-raising programs aimed at individual behavior and social norms is in place prior to any national level criminalization of the practice. Legislation that targets FGM may itself calls for such

measures prior to enforcement of criminal sanctions. Government should be devoted to reach out to communities that practice FGM, especially by forming alliances with NGOs, local leaders and the health care professionals.

(iii) Vulnerability of Minority Groups

When FGM is common among one ethnic group or community and not the majority, enacting and applying a criminal law could fuel ethnic tensions (Rahman, 2003). In countries in which FGM is practiced primarily by a minority ethnic group, criminal laws prohibiting FGM may be perceived as a pretext for harassing or persecuting members of that group. This may particularly be the case when criminal legislation is enacted in the absence of concerted governmental efforts to reach women and girls through outreach and empowerment programs. Whereas the case of FGM in Kween is subsequently a concern of the minority, relative to the ethnic groups in Uganda that do not practice FGM, it would have been better for the government to take steps showing that the actions of eradicating the practice are not motivated by an interest in disrupting the lives of members of a minority group. This has not been effectively done for the case of Uganda. There has been no recognized effort to take steps aimed at increasing consultations with minority organizations and enhancing appropriate outreach programs, as well as allocating resources to community groups, particularly women's groups.

(iv). Weak enforcement mechanism

In some countries, law enforcement mechanisms resources. Where FGM is widely practiced and approved by most members of society, there are likely to be few cases brought to the attention of the authorities. The burden thus, falls on law enforcement officials to investigate and uncover evidence of the practice (Rahman, 2003). The logistical difficulties of performing such investigations, particularly in rural areas, are obvious.

It should be noted that adopting criminal legislation with no means of enforcing the laws risks disrespect not only for that measure, but also for the rule of law in general. In the context of FGM, some have argued that criminalizing the practice will do more than drive it further underground. Under such circumstances, even occasional enforcement, if highly publicized, may be sufficient to send messages that those who practice FGM incur criminal liability. In all cases,

it is important that enforcement of any kind be accompanied by public education informing people that a law criminalizing FGM has been adopted.

To date, while enforcement of legal measures aimed at stopping the practice of FGM has been uneven, new reports of arrests in several countries with legislation criminalizing FGM, including Senegal and Ghana, have received international attention. There have been scattered prosecutions for FGM in cases where the girl undergoing the procedure died as a result, as in Egypt and Sierra Leone.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter highlights the research design that will used in the study, population of the study, sample selection methods and size, data collection instruments, procedure of data collection, data analysis techniques and encountered limitations to the study.

3.1 Research design

The study used a case study in which both qualitative and quantitative techniques of data collection were employed. The design was used because it is a method of investigation in which self-report data collection from samples of pre-determined interests were done. The quantitative methods established quantifiable data while qualitative methods will be used to establish peoples' perceptions, attitudes and beliefs about the practice of FGM and the attached implications to the enjoyment of human rights.

3.2 The Study Area

The study was conducted in Kween **District located** in Eastern Uganda. The district headquarters is located in Binyiny, one of the town councils in the district. Kween District is bordered by Nakapiripirit District to the north, Amudat District to the north east, Kapchorwa District to the west and Bulambuli District to the northwest. Kween District is generally located in Sebei sub-region located along the slopes of Mt Elgon. The District was created by act of Parliament and started functioning on 1th July 2010. Prior to that, it was part of Kapchowra and Bukwo district.

Kween District together with Kapchorwa District and Bukwo District forms the Sebei sub-region, formerly known as Sebei District.

3.2.1 Population of the study

Both male and female respondents were selected for the study. These were selected among the Sebei females aged between 14-25 years. Other opinion leaders such as the elders, local leaders and health workers also were involved in the study. All these categories of respondents were involved in the study for the researcher believe they are knowledgeable about the practice of FGM and how it affects the health of the victims. For example, the victims are expected to give direct and firsthand information regarding the pain and torture they go through, the health workers also point out the extent to which mutilated women cope with the challenges of FGM while the local leaders helped come up with a reflection of the legal instruments that are in place and used to eliminate the FGM practice.

3.3 Sample selection methods and size

3.3.1 Selection of communities

Two parishes where the FGM is highly practiced were purposively selected for the study. From the sub-county, two villages (Local Council 1 Units) were selected for the study using simple random sampling. The researcher employed purposive sampling to select communities that are predominantly inhabited by the Sabiny that practice FGM.

3.3.2 Selection of respondents

From the sub-county selected, fifteen females were selected for the study using systematic random sampling. The Local Council One Chairpersons for the selected two villages was purposively selected for the study. Six health workers from community health centers and private clinics will also be purposively selected for the study. Two elders from each village will also be purposively selected for the study. In all, 100 respondents were involved in the study. All the targeted respondents participated in the study.

3.4 Research Instruments

The study used three categories of research instruments: a research-administered Questionnaire, interview guides and a focus group discussion guide. A review of the available relevant written documents (documentary review) was also done.

3.4.1 Research-administered Questionnaires

These were administered to the females aged over 14 years. Questionnaires were made up of both structured and un-structured questions. The structured questions aimed at generating quantitative data from multiple choices for each question, while the unstructured questions aimed at generating peoples' ideas and perceptions about the practice of FGM. The study used a questionnaire because it helps in generating reliable data and helps generating quantitative data.

3.4.2 Interview Guides

The researcher administered interviews to the local leaders, elders and health workers using an interview guide. The interview guide contained unstructured questions that reflect the major themes of the study (causes of FGM, instruments and challenges faced to enforce the instruments). The study used an interview guide because it helps guarantee an immediate feedback and generated reliable data especially when adequate probing is done.

3.4.3 Focus group discussion guide

Three focus group discussions (consisting of eight participants), each from the selected villages, were conducted using a focus group discussion guide. The focus group discussion guide consists of women who have undergone the FGM practice.

3.4.4 Written documents

A review of the existing relevant written documents was done. These include textbooks, journals, pamphlets, official records and reports about the FGM practice and its implication on the enjoyment of women's reproductive rights.

3.5 Data analysis

3.5.1 Quantitative data analysis

The responses of the subjects was categorized in frequency counts and score tables and varying percentages calculated. Interpretations and conclusions depended on the number of occurrence of each item. This was done according to the developed themes in the analysis.

3.5.2 Qualitative data analysis

Field notes were written, grouped into themes and sub-themes and work was edited at the end of each working day to ensure accuracy in recording and consistency in information given by respondents. Themes, in respect to the study variables were identified and put in coding categories. A scheme of analysis worked out following the coding categories, using content analysis, quotations and the most occurring ideas on every question.

3.6 Ethical Considerations

The researcher ensured a voluntary participation of every respondent in the study. Consent of the respondents was sought before every data collection session. It was also stipulated before the respondents that their information will be treated with utmost confidentiality, only to be used in compiling an academic report.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND INTERPRETATION OF DATA

4.1 Introduction

This chapter comprises of the respondents socio-economic status, age of the respondents, sex of respondents, respondent level of education and religion. It also comprises of respondent religion, reasons for carrying out FGM in Kween district, status of carrying out FGM and circumcision status of the respondents.

Types of circumcision commonly used, types of prevalence of FGM per country and instruments used.

It also includes the human rights instruments to fight FGM, awareness about women rights, awareness of international instruments of human rights, women social status, social support and eradication of FGM.

4.2 Respondents' socio-economic background

The data pieces elicited on this variable was presented under the following sub themes: age of respondents, sex, and level of education attained and the religion of the respondents.

4.2.1 Age of respondents

The respondents' age was classified into four major groups and according to the three different categories of the respondents that were involved in the study (females from the Sabiny community members, local council chairpersons, elders, and health workers). The elicited responses were presented in table 1

Table 1: Respondents' age distribution

Item	Frequency	Percentage
Females from the Sabiny Community (n=90)		
Below 20 years	06	67
21-25 years	23	25.6
26-30 years	39	43.3
31 and above	22	24.4
Total	90	100
Local Council 1 Chairpersons (n=6)		
Below 20 years	00	00
21 -25 years	00	00
26-30 years	02	33.3
31 and above	02	66.7
Total	6	100
Health workers (n = 6)		
Below 20 years	00	00
21-25 years	01	16.7
26-20 years	02	33
31 and above	03	50
Total	6	100

It can be seen from table I that the majority of the respondents among the targeted female respondents (43.3%) were within the age bracket of 26-30 years, while the least (6.7%) were

below 20 years. For the case of Local Council I Chairpersons, 66.7% were within the age bracket of 31 and above years while 33.3% were within 26-30 age brackets. Concerning the health workers, 50% were within the age bracket of 30 and above years, 33.3% fell under the age bracket of 26-30 years while 16.7% were between 21-25 years. For the case of the elders, all of them were above 30 years.

Thus, with respect to the respondents' age, the respondents' composition was reliable as all of them had either taken part (for the case of females), had witnessed or seen someone who had underwent the FGM practice, as well as handling case related to FGM practice. As the (http://dusteye.wordpress.com/tag/education) highlights, this, generally agrees with the observation made by Kulany that it is mere luck for someone to escape the uncircumcised as all Sabiny girls, upon attaining puberty, are initiated into womanhood through circumcision. Those who refuse are tormented as their in-laws despise them because they are not circumcised.

4.2.2 Sex of respondents

While administering the questionnaires, conducting interviews and focus group discussions, the researcher took interests to note down the sex of the respondents involved. In all, an overwhelming majority of the respondents (88.6%) were females while only 11.4% were males. Vital to note on the gender issue was that all the Local Council I Chairpersons were males, something that reflected much on the women's ascription to leadership positions among the Sabiny. As a matter of fact, this reflected the fact that more men were in politics and leadership positions than their counterpart females. As a result, such a position reinforces men dominance over women in all social aspects and family decision making process. This is a position held by Hoffman (2002). In a report about the Masai womanhood and circumcision, Hoffman depicts the point that FGM among the Masai can be reduced only when women change their social positioning to ascribe for positions of leadership. Hoffman was critical that unless the Masai women ascribed for leadership positions, they would never advocate or lobby for the eradication of FGM.

On the other hand, it should be noted that the pre-dominance of females in view of the total sample composition, especially with regard to females for the survey questionnaire, was somewhat predetermined to target the female victims of FGM. Otherwise, the proportionately

selection of elders on a gender-balanced component was aimed at attracting views from both sexes on the traditions explaining the long time held belief and the benefits attached thereof that has survived a test of time among the Sabiny communities.

4.2.3 Respondents' level of Education

The respondents were requested to state their highest level of education. The basis of this question was to find out whether one's level of education allowed for or constrained taking part in the FGM practice. Besides, the study wished to find out whether there was any linkage between one's level of education and awareness about women's reproductive rights as well as the instruments and laws that stipulate, safeguard and promote women's reproductive rights. The elicited responses on this issue were presented in table 2.

Table 2: Respondents' level of education

Item	Frequency	Percentage
Female respondents (n=90)	00	00
Post graduate	04	44
Graduate	10	11.1
Diploma	12	13.3
Secondary level	28	4.0
No formal education	39	4.0
Total	**90**	**100**
Local council Chairpersons (n=6)		
Female respondents (n=90)	00	00
Post graduate	00	00
Graduate	03	50
Diploma	03	50

Secondary level	00	00
No formal education	00	00
Total	**06**	**100**
Health workers (n=6)		
Female respondents (n=90)	00	00
Post graduate	0	0
Graduate	03	50
Diploma	03	50
Secondary level	00	00
No formal education	00	00
Total	**06**	**1**
Elders (n=12)		
Post graduate	00	00
Diploma		
Secondary level		
No formal education		
Total		

It can be observed from table 2 that although the majority (40%) of the selective female respondents had not attained any level of formal education, there were some levels of education attained thereof for instance, 31.1% had attained primary level, 13.3% secondary level, 11.1% diploma level while 4.4% were graduates. For the case of the Local Council I Chairpersons, 50% had attained formal education to the diploma level and another 50% had attained secondary school level.

For the case of health workers, all of them (100%) had studied up to a diploma level. To the elders, 41.7% had attained primary level, 33.3% had no formal education, 16.7% had attained a diploma level of education while 8.33% had attained secondary school level of education. It can be observed from table II that irrespective of some respondents who had not attained any level of formal education, there were a substantial number of literate members that would influence community perception over the practice of FGM. However, as the study found out later, education did not have any significant positive influence people's perceptions and beliefs about the FGM practice. This coincides with the observation made by Boyle (2002) that because of its religious and cultural implications, the formal knowledge acquired from schools have not explicitly confronted the practice of FGM to the extent that even the educated women feel much confined by the social meaning attached to the practice.

4.2.4 Respondents' Religion

The respondents were also requested to state their religious faith. This was aimed at finding out whether matters related to FGM and allegiance to the practice had any link with one's religion. The elicited responses on this aspect were presented in Figure II.

Table 3: Respondents' religious faith (n=114)

Religion	Frequency	Percentage
Catholics	52	45.6
Protestants	22	19.2
Muslims	28	24.5
SDA	4	3.5
Pentecostal	6	5.3
Traditionalists	2	1.7
Total	114	100

Table 3 shows that the majority of the respondents (52/45.6%) were Catholics, followed by the Muslims (28/24.6%), Protestants (22/19.3%), Pentecostal (6/5.3%), Seventh Day Adventists (4/3.5%). The least were the traditionalists (2/1. 7%). It can be observed from figure II that there was a fair representation of all the religions in Kween District. The dominance of the Catholics reflects their dominance in the District, and is attributed to the works of the Roman Catholic Church during the early missionary times.

On the whole, however, the representation of all the major religions provided the study with a basis of evaluating whether FGM had any attachment to religion. As the results in hypothesis two reveal, there was no significant linkage between religion and the practice of FGM, for there was an equal proportion of circumcised women irrespective of their religious following (See Section 5.2). The findings here coincide with Johnson's (2000) observation that much as issues related to FGM can be attached to religion, especially within the Muslim world, such a belief ought not to lure any scholar into a thinking the practice is a concern of religion.

To Johnson (2000), much as religion enhances the practice, it does not explain the origin of the practice, especially in African countries where Islam was not an indigenous religion. This brings to light the supremacy of culture as opposed to religion in explaining the phenomenon, origins and social importance of FGM in Kween District. On the whole, this preposition does not reflect any of the human rights concerns, possibly a position that has led to low responses in addressing FGM in a human rights perspective.

4.3 Reasons for carrying out FGM in Kween District

All the respondents involved in the study acknowledged FGM as a socially accepted cultural attribute that the Sabiny communities uphold as sacred practice that distinguishes them from other tribes. Apart from the purity and cleanliness aspects, the practice is upheld for various reasons:

The practice guarantees virginity and promotes morality. There is a common belief that when a woman is circumcised, she loses some of the urge for sex. Ironically, the urge is never revitalized when a circumcised woman finally marries. Instead, she completely loses her sexual desires,

something that results into a form of social incompleteness. The need for morality leads to unhappiness in due turn.

That uncircumcised girl is rude and disrespectful. However, there is no clear proof linking circumcision to being respectful and being well behaved.

(iii) That FGM increases a woman's fertility. It is attributed to the fact that circumcising a woman makes it easier to become pregnant.

(iv) There were responses that FGM increases pleasure for the males during sex as they do not get obstacles constraining their penetration.

(v) That uncircumcised girls smell bad. It is upheld by the Sabiny that an uncircumcised woman may not effectively clean themselves, thereby generating some bad smell. However, it should be noted that the issue of a bad smell relates much to personal hygiene that should not be confused with circumcision issues.

(vi) FGM makes it easier for women to give birth. Whereas this is traditionally upheld, research findings reveal that mutilated women find it hard to give birth; reason being that the vaginal canal is narrowed, hence making it difficult for a child to go through. As pointed out by PATH (2006), there are several myths attached to FGM. PATH reckons with several study findings and reflects that FGM is a ritual-full of myths that violates women's reproductive rights and makes it hard to produce. Circumcised women were observed to take long in labor and would end up being operated than their uncircumcised counterparts.

(vii) That men cannot marry uncircumcised girls. As the findings by PATH (2006) indicate, this is also a myth for testimonies from men indicate that mutilated women are tights and hard for men to penetrate. This makes sex painful for both the man and woman. Men were, therefore, not supportive of the practice, irrespective of its traditional roots. Responses generated pointed out that there were commonly upheld benefits out of FGM practice. There was a general agreement that that:

(i) FGM is a ritual that marks change of a girl into a woman. Having a FGM ceremony, therefore, shows the community that a girl is now prepared for her life as a woman.

Equally so, the family can show that they have educated their daughter in how to be a good wife and mother.

(ii) Some girls give in out of peer pressure. Because girls of their age go in for circumcision, they usually become afraid that their friends and other people will make fun of them. They may also get teased or talked about because they are not circumcised. They also believe that they cannot get a husband if they are not cut. Thus, they are driven by the desire to be like others. The search for this identity and its eventual attainment is ultimately a benefit that the Sabiny women treasure very much.

(iii) The FGM ceremony is perceived as a moment of knowledge transmission from one generation to another. Grandparents like to hand down their wisdom and experience to their granddaughters. They believe this is an important responsibility to the older generation. To parents, the ceremony shows who they are and their tradition, and wants everyone to notice they have raised a good daughter.

(iv) As a social obligation and moment of ceremony, people receive gifts. Parents who have received gifts at the operation of someone's daughter will feel socially obliged to return the favor by organizing a circumcision ceremony for his/her own daughter.

(v) As an inspirational mechanism, the girls themselves get new clothes and other presents. They are also the center of attraction. Besides, they believe that FGM shows their courage and beginning of a new phase in life.

(vi) Everyone enjoys the food, singing, dancing, and the general celebrations that go with FGM. Overall, it should be noted that much as the community members may enjoy a lot of benefits out of a FGM ceremony, such benefits should never override the essence of one's human rights. The individual benefits should never be attained at expense of one's rights for the rights are inherently and naturally attained, and should never be violated.

4.3.1 The Status for Carrying Out FGM

This study variable was guided by the hypothesis which stated that "**There are no clear reasons for carrying out Female Genital Mutilation in Kween** "The generated responses were

presented under the following sub themes: Circumcision status for the female respondents, age at which women were circumcised, type of circumcision commonly used, voluntarism in taking part, state on the instruments used, reasons for carrying out FGM, social status of the uncircumcised women, benefits accruing from the FGM practice and the dangers associated with the practice of FGM.

4.3.2 Circumcision status for the female respondents

The female respondents were requested to state whether they were circumcised. All the respondents (90/100%) acknowledged that they had been circumcised as a practice to initiate them into womanhood. There were no significant difference between one's religion, level of education and FGM practice. This was because respondents from different religious backgrounds and educational levels were all circumcised. The practice remains an obligation for everyone to embrace irrespective of religious attributes and affiliations. There were variations about the age at which the respondents were circumcised. The generated responses were presented in table 4.

Table 4: Responses to the age at which females were circumcised

item	Frequency	Percentage
Below 14 Years	2	22
14-24 Years	87	96.7
Any Other	1	11
Total	90	100

The table shows that though majority (96.7%) revealed that they had been circumcised between 14-24 years, some were circumcised as early as below fourteen (2.2%) while (1.1 %) pointed out that they were circumcised after their first birth. This coincides with the observation made by Kirya and Kibombo (1999) that women were circumcised at different ages, some as early as 14 years to avoid the prevalence of women who, after joining high schools and in most cases

boarding schools refuse to be circumcised. For those who may escape early circumcision, may be still targeted to the age of even 20 years and above.

However, responses from the focus group discussions and interviews with the local leaders and health workers revealed that the practice has been greatly changed to target younger girls due to resistance, especially from girls who get exposed to strange cultures as they go to schools. As girls access and acquire higher levels of formal education, they get to know much about their natural entitlements. This helps them agitate for the promotion and protection of their rights. Due to this eventuality, the Sabiny community members target young girls who have not yet acquired much of the formal education or left their traditional homes.

4.3.3 Type of circumcision commonly used

The female respondents were also requested to state the type of circumcision that they had undergone. The majority (65.6%) revealed that they had undergone Type I while 34.4% pointed out that they had used Type II. Type I involves the excision (removal) of the clitoral hood with or without removal of part or the entire clitoris.

Type II involves the removal of the clitoris together with part of or all of the labia minora. The generated responses were presented in table 5.

Table 5: Responses to the type of circumcision used

Item	Frequency	Percentage
Type I	59	66.5
Type II	31	34.4
Type III		00
Type IV		
Total		100

Responses from the focus group discussions and interviews were also in agreement with the responses generated from the questionnaire. There were no responses acknowledging the use of Type III or IV. Type I that was revealed to be commonly used, involves the excision (removal) of the clitoral hood with or without removal of part or the entire clitoris. On the other hand, type II involves the removal of the clitoris together with part of or all the labia minora. The study findings here agree with the observation made by Hosken (1993) that Type I and II operations account for 85% of all FGM. Type III (infibulation) is common in Djibouti, Somalia, Sudan and in parts of Egypt, Ethiopia, Kenya, Mali, Mauritania, Niger and Senegal.

On the whole, however, type III is also referred to as infibulation. This involves the removal of part or all of the external genitalia (clitoris, labia minora, and labia majora) and stitching and/or narrowing of the vaginal opening leaving a small hole for urine and menstrual flow. Type IV is unclassified and involves all other operations on the female genitalia including pricking, piercing, stretching, or incision of the clitoris and/or labia, cauterization by burning the clitoris and surrounding tissues; incision to the vaginal wall; scraping and introduction of corrosive substances or herbs into the vagina.

The http://en.wikipedia.org/wiki/Female_Genital_cutting (August, 2, 2008) highlights also supports the fact that different countries opt for different types of FGM. On the whole, however, it is clearly reflected that type I and II are generally used in most African countries, Uganda inclusive. The type and prevalence of FGM in most African countries is put as can be seen in table VII

Table 6: Type prevalence of FGM per country

Country	prevalence (100%)	type
Burkina Faso	71.6%	II
Central African republic	43.4%	1&11
Cote d'ivoire 44.5% II	44.5%	II
Djibouti	90-98%	II
Egypt 78-97% 1, II and III	78-98%	I, II & III
Eritrea 90-95% l, II and III	90-97%	I, II & III
Ghana 9-15%l, II and III	9-15%	I, II & III
Guinea 98.6%l, II and III	98.6%	I, II & III
Indonesia	no figures	I & IV
Nigeria	25.1%	I, II & III
Senegal	5-20%	II & III
Sudan	91%	I, II & III
Tanzania	7.6%	II & III
Togo	12%	II
Uganda	5%	I & I

Adopted from: http://en.wikipedia.orglwiki/FemaleJ5enita'-cutting

In view of the data in table 6, it can be observed that type I and II are used in almost all the African countries. However, as (Obermeyer 2003) argues, emphasis should not be on the type but the overall impact the practice brings to innocent girls whose health destiny is compromised for the purposes of rituals and cultural values.

It is justifiably right that fulfilling one's cultural practices creates a sense of belonging. But every culture has positive and negative aspects. There are cultural practices that protect human rights and others that violate people's rights. To *this* extent, therefore, we may take it that though respect for culture is important, practices that are detrimental to the physical and mental well-being of its members should not be tolerated. The enjoyment of the right to practice culture should not result in negation of other rights.

4.3.4 State of the instruments used

Regarding the instruments used to carry out the operations, majority of the female respondents (60%) could not recall or tell whether the instruments were sterilized or not. However, 40% were certain that the instruments were not sterilized at all, reason being that a couple of girls were operated at one ceremony, using similar instruments. This agrees with Moussa's (2003) observation that the practice of FGM increases the risk of contracting HIV/AIDS due to the fact that similar unsterilized instruments are used in communal operations.

For the case of the Sabiny, it is usually a practice of organizing more than one girl for the operation. Age mates are operated at the same time in a communal gathering. As regards the safety of the instruments, there is no clear guarantee of not contracting the HIV I AIDS virus as one instrument is usually used over all the candidates. Though there have been efforts to enlighten the community members over the HIV/AIDS scourge, there are still pockets of resistance and the strong belief in the practices still poses a great challenges among the community members. It is to this extent that the issue of FGM ought to take a human rights perspective to safeguard the natural entitlements of females who fall prey to the purports of mere traditional practices.

Those who voluntarily took part in the operations pointed out that they were motivated by the brevity, social beliefs and practices as a requirement for social transformation and initiation into womanhood. However, for those who were forced, there were gross lamentations over what transpired. This can be manifested in what one respondent from Kitowoi Sub-county forwarded during a focus group discussion guide:

I was taken to an open kraal very early in the morning, surrounded by undressed strong men and women who seemed to have drunk the whole night. I was stripped naked leaving my vagina open for everyone around to see. I was later forced to lie flat on my back by strong men who held my legs tight. Some sat on my chest to prevent my body from moving. When it begun, I struggled but all in vain, they cut off my private parts and I faced too much pain and there was severe bleeding which nearly killed me. Surprisingly, all those who were witnessing the tragic exercise were ululating and dancing obscenely.

Responses from the elders and local leaders revealed that it's is a duty and obligation for every female Sabiny to be circumcised as a moment to mark the transformation of females from one stage to another and a precondition for social acceptance and preparation for future family obligation. This idea was earlier put across by Kiirya and Kibombo (1999) who observed that some Sabiny females were forced to be circumcised irrespective of their objective positions. Kiirya and Kibombo (1999) put it that it is rather a compulsory practice that every female has to undergo rather than by choice of age. This compulsory element makes the whole practice of FGM a violation of human rights. Reflecting on Article 20 (2) of the Ugandan Constitution, it is put forth that;

The rights and freedoms of the individual ...enshrined in the chapter, shall be respected, upheld and protected by all organs and agencies of government by all persons.

Thus, someone who is forced to circumcise is denied of the chance to enjoy her natural entitlement, which tantamount to violation of women's reproductive rights.

4.4 The Relevant Human Rights instruments to fight FGM

This study variable was guided by the hypothesis which stated that "**There are no practical relevant instruments stipulating the protection and promotion of Female Genital Mutilation in Kween District** "The generated responses were presented under the following sub-themes: awareness about women's rights, awareness of international instruments, awareness of the instruments that safeguard and promote human rights in Uganda as well as FGM.

4.4.1 Awareness about women's rights

In the bid to find out whether respondents knew something about the relevant human rights instruments, respondents were first requested to state whether they knew something about human rights. The generated responses were presented in table 7.

Table 7: Responses to knowledge about human rights

Item	Frequency	Percentage
Female respondents (n=90)		
No	51	56.7
Yes	39	43.3
Total	90	100
Local council chairpersons (n=6)		
No	06	100
Yes	00	00
Total	06	100
Health workers (n=6)		
No	06	100
Yes	00	00
Total	06	100
Elders (n=12)		
No	5	41.7
Yes	7	58.8
Total	12	100

Table 7 shows that apart from the Local Council I chair persons and health workers, there were some respondents, especially among the females (43.3%) and elders (58.3%) that did not know anything about human rights. It can be observed from table III that there were relatively significant levels of females and elders who were not aware of the existing human rights. The study findings here agree with Pieters and Lowenfels's (1977) report about infibulations in the horn of Africa. It was observed in the report that majority of the populace never associated FGM to a form of human rights violation, but rather an obligation for every female as a precondition 8for becoming an adult and for hygiene purposes. For those who were aware, still had different levels that varied from one form of human rights to another. This can be seen from table IV below.

Table 8: Commonly known rights that women are entitled to

Respondents				
Item	Females (n=51)	Local leaders (n=6)	Health workers (n=6)	Elders (n=5)
Right to education	36 (70.6%)	6 (100%)	6 (100%)	3 (60%)
Right to a health living	31 (61%)	6 (100%)	6 (100%)	2 (40%)
Right to enjoy freedom conscience and religion	44 (86.3%)	4 (66.7%)	5 (83.3%)	1 (20%)
Freedom from torture and degrading treatment	28 (54.9%)	4 (66.7%)	5 (83.3%)	-
Others	26 51%)	1 (16.7%)	2 (33.3%)	2 (40%)

It is evident from table 8 that among the 56.7% of the females who were aware of human rights, the majority 86.3% pointed out the right to enjoy freedom of thought, conscience and religion,

while 70.6% mentioned the right to education. For the case of the local leaders and health workers, all of them were certain of the right to education and health living. A look at the elders, majority (60%) was certain of the right to education. None of the elders considered freedom from torture and degrading treatment as a form of human rights violation. Issues mentioned under the category of others included the right to marry, own property and live a recognized life.

4.4.2 Awareness of international and national instruments human rights

There was a general linkage between the levels of awareness about human entitlements and the instruments stipulating the need to safeguard and promote the fundamental human rights. Apart from the Local Council Leaders and health workers who were aware of some of the Ugandan Constitutional stipulations, knowledge concerning the international instruments was lacking. This pointed to the need for enhanced campaigns to improve the communities' awareness, especially through information communication and providing the community members with materials that can popularize access and utilization of national and international instruments and laws that relate to human rights. Although there were linkages between the occupied social positions and level of awareness (as all the local council leaders and health workers were aware of the fundamental human rights), there was no linkage between one's level of education and knowledge concerning human rights and latter women's reproductive rights.

This was manifested by the fact that some of the females, who had attained some education above the primary level, did not know anything while some of those who had not attained any formal education were certain of some human rights. This coincides with (Gruenbaum's 2001) observation that issues regarding cultural practices seem to be persisting even in instances when there are higher levels of education. As a matter of fact, one of the respondents had this to say;

''I hear the educated girls and members of parliament want the practice eradicated. But how can they stop something that our ancestors have been practicing for ages? Our mothers and grandmothers earned their respect and preserved their honor by undergoing circumcision. One respondent exclaimed.''

The above led the study to a realization that though the social positioning my favor the realization of human rights, acquiring formal education per-se, may not have a significant impact

on the cultural practices. Education needs to be enhanced by power and authority, a position that can be reinforced by the support of those in positions of authority and the law.

4.5 Challenges faced in implementation of human rights instruments in fight against FGM

This sub chapter presents responses reflecting the challenges that constrain the implementation of human rights instruments to fight FGM, the elicited responses were presented under the following sub-themes: women's low social status, social support for the eradication of FGM practice, lack of universality of the law, and Resistance at community level, a summative remark/conclusion was also made depending on the findings presented.

4.5.1 Women's social status

First, the female respondents were requested to state whether they were socially recognized like their male counterparts in Kween District. This aimed at evaluating whether there was a favorable environment that would allow for easy lobbying and advocating for women's reproductive health. The elicited responses were presented in figure IV.

Table 9: Responses to women's social status (n=90)

Respondents	Frequency	Percentage
Equal recognition of women and men		7%
Women are considered inferior		85%
no response		8%

Figure IV shows that an overwhelming majority of the female respondents (85%) revealed that women were not considered equal to men while only 7% revealed that women and men were considered equal in the Sabiny community. This could have been out of the traditional beliefs held that put men in a higher social position than their female counterparts. There was relationship between females' levels of education, the social position and beliefs held thereof It was observed here that in instances of upheld exploitative cultural beliefs, women become native

to the social expectations and they seize to consider the practice as exploitative. In such cases, implementing a human rights instrument becomes quite hard for it will not attract support even from women it is protecting. This coincides with (Katzive's 2003) observation that legislation targeting FGM is likely to have little positive effect in a legal context in which women's rights are not wholly recognized or are explicitly undermined due to traditionally upheld practices.

In a report about FGM, (Obermeyer 2003) disagreed with medical justifications offered by cultural tradition and regarded by scientists and doctors as unsubstantiated. He observed that some FGM is gender based and in African societies. The practice is considered part of maintaining cleanliness as it removes secreting parts of the genitalia. Vaginal secretions, in reality, play a critical part in maintaining female health.

Mossi of Burkina Faso and the Ibos of Nigeria believe that babies die if they touch the clitoris during birth. In some areas of Africa, there exists the belief that a newborn child has elements of both sexes. In the male body the foreskin of the penis is considered to be the female element. In the female body the clitoris is considered to be the male element. Hence when the adolescent is reaching puberty, these elements are removed to make the indication of sex clearer.

In years past, doctors advocating or performing these procedures sometimes claimed that girls of all ages would otherwise engage in excessive masturbation and be "polluted" by the activity, which was referred to as "self-abuse". McDonald wrote in a 1958 paper titled "Circumcision of the Female", thus "If the male needs circumcision for cleanliness and hygiene, why not the female? I have operated on perhaps 40 patients who needed this attention." The author describes symptoms as "irritation, scratching, irritability, masturbation, frequency and urgency," and in adults, megaliths causing dyspareunia and frigidity. The author then reported that a two-year-old was no longer masturbating so frequently after the procedure.

Of adult women, the author stated that "for the first time in their lives, sex ambitions became normally satisfied. However, justification of the procedure on hygienic grounds, or to reduce masturbation, has since declined. The view that masturbation is a cause of mental and physical illness has dissipated since the mid- 20th century. Thus, if one is to take up this explanation for mutilating women, the practice would be over 100 years gone. The fact that FGM still exists,

points to the fact that the gender-based prepositions still hold some value among the communities that practice FGM

4.5.2 Social support for the eradication of FGM practice

The study also labored to find out whether eradicating the FGM practice would attract social support. First, the female respondents were requested to state whether they believed the elders would support any program aimed at total eradication of FGM. None of the respondents had a belief that the elders would accept. However, on a personal basis, 30% of the females, majorly consisting of the educated ones accorded their utmost support to do away with the practice while 70% revealed that they would not support any program aimed at stopping the practice.

They would, thus, also encourage their daughters to be initiated into womanhood by undergoing it Responses from the interviews with the Local Council I leaders and the elders revealed that much as the Local Council I leaders would support any program to eliminate FGM, the elders were optimistic to maintain it. This pointed to the element of awareness campaigns that often target the local leaders to gain support for implementation. This agrees with Katzive's (2003) observation that though the governments, international bodies and NGOs have tried to lobby against the FGM, the practice still find its stronghold in the traditional beliefs that most communities, and especially elders strongly support. This strong resistance from elders was observed to be a result of the upheld social and sacred benefits the communities' accord to the FGM practice and ceremonies.

http://en.wikipedia.org/wiki/Female~enital_cutting (August, 2, 2008) highlights that there are websites promoting the practice like Circlist, BMEzine (Body Modification E-Zine), and the Clitoral Hood Removal Information Page contain testimonials and citations of medical studies, which support this claim (for example a study done in 1959 Rathmann et al claim that 87.5% of women saw an improvement in sexual pleasure following a hoodectomy. Such elements have justified the need to continue the practice as such revelations so ascertain that the practice is never harmful.

4.5.3 Weak enforcement Mechanism

There was a strong perception that enacting a law criminalizing FGM would give the communities practicing it a discriminatory perception. There was a general agreement that a law targeting the Sabiny criminalizing their upheld social value, would tantamount to persecuting Sabiny community members alone. This reflected the greatest challenge of culture and perceived women's reproductive rights. Culture, in the case of the Sabiny communities, seems to be stronger than criminalizing FGM, especially due to lack of an amended law criminalizing the practice.

Even a consideration of the international instruments reflects the fact that there are different and contradicting stipulations regarding FGM, for example where as there is a Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, following the Unites State's stipulation may heighten the FGM cases. This is because one of the USA provision states that;

Whoever knowingly circumcises excises, or infibulates the whole or any part of the labia major or labia minora or clitoris of another person who has not attained the age of 18 year!! Shall be fined under this title or imprisoned not more than five years, or both.

It goes ahead to state that a surgical operation is not a violation of this section if the operation is necessary for the health of the person on whom it is performed. As a matter of fact, the Sabiny argue that they carry out FGM for health reasons such as avoiding bad smell. Thus, upholding the United States standards may be used to form a firm ground for practicing FGM among the Sabinys. The New Vision, Friday, March 10th 2006 portrayed that the Sabiny want law on FGM. This would help prosecute the promoters of the practice, thereby substantially reducing on the levels of the whole practice of FGM. However, this urgently needs significant awareness campaigns such that the interventions are not resisted, especially by the traditionalists who greatly value the practice.

4.5.4 Resistance at community level

Females were requested to state whether how issues regarding FGM operations were handled. All the generated responses revealed that the practice is considered sacred and not open to non-

community members. This sacred nature has rendered all efforts regarding the elimination of FGM difficult. This has been out of the fact that community members cannot willingly reveal much about their sacred practice. Response from the interview with the health workers revealed that their clients usually don't agree that FGM can cause certain illnesses, pointing out that the practice is holly and has been upheld for a test of time. One health worker revealed that majority of the women is diagnosed with painful/blocked menses and recurrent urinary tract infections, but could only link such issues to misfortunes and witchcraft other than FGM practice.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

In this chapter, the findings in chapter four-six were summarized, conclusions and recommendations made. This was done in accordance with the major themes of the study; the instruments to women's reproductive rights, the causes of FGM and the challenges faced in the implementation of human rights instruments to women's reproductive rights. Finally, areas for further research were suggested.

5.2 Summary

5.2.1 The status and reasons for carrying out FGM practice among the Sabiny

The study findings revealed that the FGM practice was/is basically carried out in two forms (type I and type II). The type to be used is determined by the operator, guided by the socially upheld norms regarding the used practice. The victim remains subject to the whims of the circumcisers, mentors, parents and elders.

Regarding the instruments used to carry out the operations, majority of the female respondents (60%) could not recall or tell whether the instruments were sterilized or not. However, 40% were certain that the instruments were not sterilized at all, reason being that a couple of girls were operated at one ceremony, using similar instruments. This subjects the victims to the risk of contracting HIV / AIDS due to the fact that similar un-sterilized instruments are used in communal operations.

Although some females (69%) voluntarily take part in the FGM operation, some are merely forced and are compelled to take part (31%) irrespective of whether they like it or not. FGM is seen as a duty and obligation for every female Sabiny to be circumcised as a moment to mark the transformation of females from one stage to another and a precondition for social acceptance and preparation for future family - hood obligations.

FGM is considered a socially accepted cultural attribute that the Sabiny communities uphold as sacred practice that distinguishes them from other tribes.

Apart from the purity and cleanliness aspects, the practice is upheld for various reasons such as promotion of morality as well as the socially attached status that is denied of uncircumcised women. The function also attracts a lot of benefits ranging from money and physical items like chicken and local brew (for circumcisers and aides), gifts and ceremonial attire for candidates, high dowry and respect for parents and family members.

Despite the above benefits, 75.6% of the female respondents acknowledged that there were dangers associated with the practice of FGM. Such include experienced pain during and after the operation, painful sexual intercourse as a result of loss of frigidity and vaginal narrowing, excessive bleeding, difficulty in child birth due to the narrowing and stitching of the vaginal canal. There were also cases of death.

Reflecting on these dangers, it can be put that the FGM practice adversely violates women's reproductive rights.

5.2.2 The relevant human rights instruments to fight FGM in Kween District

The study findings revealed that there were some female respondents that did not know anything about human rights. Equally so, a percentage of the elders did not know anything about human rights. Apart from the health workers and local council I leaders, there was little known about FGM as a form of human rights violation.

There was a general linkage between the levels of awareness about human entitlements and the instruments stipulating the need to safeguard and promote the fundamental human rights. Apart from the Local Council Leaders and health workers who were aware of some of the Ugandan Constitutional stipulations, knowledge concerning the international instruments was lacking.

The practice of FGM has gone so native into the lives of the Sabiny that its performance is in no way considered a form of human rights violation. There was a great disposition of culture over human rights. As responses from the elders so emphasized, FGM was a practice that reinforces kinship relations, and females' social transformation from childhood to adulthood. However,

such issues contravene the stipulations of the Universal Declaration of Human Rights. For example, Article 1 of the UDHR states that "All human beings are born free and equal in dignity and rights. They are endowed with a spirit of reason and conscience and should act towards one another in a spirit of brotherhood." And article 5 adds, "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."

With regard to FGM, it ought to be noted that the practice totally subjects the victims to torture, pain, physical, psychological and health implications if not death. By subjecting one to FGM, one experiences pain and torture which in itself implies a state of human rights violation.

5.2.3 Challenges of implementation

It was reflected by the study findings that though there were some levels of support for the eradication of FGM practice, it is unlikely to end. This is because society has cast a state of sacredness on FGM, especially by attaching to it tangible and intangible benefits, institutionalizing FGM norms and linking contravention of FGM norms to social disaster and loss of benefits to society.

Regarding the use of national and international instruments on stopping FGM, there were low levels of awareness, lack of social support, and lack of a practical law that would not complicate relationship elements with other tribes. There was lack of concerted awareness and concerted efforts to address FGM in a human rights-based approach. There was also lack of structures and institutions to popularize the evils associated with FGM by according the victims some degree of special attention.

5.3 Conclusions

In view of the study findings, the following conclusions, in view of the study objectives were made:

(i) The practice of FGM cherished and jealously guarded cultural practice among the Sabiny. It is seen as the only cultural practice that effects the transformation of a girl into womanhood. One becomes a social misfit without undergoing FGM operation.

(ii) The practice of FGM is seen as a ceremony that signifies the purity and cleanliness of the victim. The practice is also upheld for various reasons such as promotion of morality as well as the socially attached status that is denied of uncircumcised women. Besides, the function attracts a lot of benefits ranging from money and physical items like chicken and local brew (for circumcisers and aides), gifts and ceremonial attire for candidates, high dowry and respect for parents and family members.

5.4 Recommendations

In view of the study findings the following recommendations were made:

(i) There is urgent need for the government to increase community awareness about the need for eradicating the practice of FGM. This can work better by exposing the dangers associated with the practice. Grass root community sensitization campaigns can be a significant input to this effect. Sensitization campaigns can also be through information communication and providing the community members with materials that can popularize access and utilization of national and international instruments and laws that relate to human rights.

(ii) The government should develop tools that can facilitate gender- sensitive FGM policy formulation, planning, implementation and monitoring. These include gender disaggregated-data in all spheres (especially legislation); gender research analysis; guidelines for integration of gender and FGM into the policy formulation process. Such analytical techniques as Gender Proofing, Gender Impact

Assessment, Emancipation Effect Reporting, Gender Indicators and Checklists of Actions for Gender Mainstreaming should be applied in processing gender and FGM disaggregated data at the national level. To close the gender, pay gap, gender pay indicators have to be included in the list of broad economic indicators.

(iii) There is need for the government and NGO's to train national, regional, local officials and community members in order to promote FGM sensitization policies and resource allocation and greater participation women in political decision making process

(iv) There is need for the government and NGO's to enhance advocacy and lobbying for the recognition of women's reproductive health. The government and non-governmental organizations can come up to enhance and facilitate the advocacy and lobbying process.

(v) Stopping FGM requires a change in social and individual thinking. In order to bring about such a change, the government, working hand in hand with NGOs should take multiple approaches as part of a long-term strategy for achieving social justice for women and the enjoyment of their natural entitlements.

5.5 Areas for further research

In view of the study findings, the following areas for further research were suggested:

(i) A comprehensive follow-up health study can be done to establish the impact of FGM among women. This will help attract support against FGM by ascertaining the dangers associated with the practice.

(ii) A study can also be done to establish the possible policy alternatives that can effectively help eradicate the FGM practice.

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APPENDIX I

QUESTIONNAIRE

FOR THE TOPIC: FEMALE GENITAL MUTILATION: A CASE OF KWEEN DISTRICT

Administered to the female respondents from the Sabiny community

Dear respondent,

- You have been selected to participate in this study without prior knowledge of your existence.

- You are requested to tell the truth.

- The purpose of this study is purely academic.

- Your information will be treated with utmost confidence.

- You may respond by either filling in the blank spaces or indicating with a tick where applicable.

SECTION A: BACKGROUND INFORMATION

1. Name of the Village: .... Sub county........................

2. Age of respondent:

(a) Below 20 years

(b) 21-26 years

(c) 27-32 years

(d) 33 and above years

3. Highest level of education attained:

(a) Post-graduate

(b) Graduate

(c) Secondary Level

(d) Primary Level

(e) No formal education

(f) Any other (Specify)..

4. Religion of respondent:

(a) Catholic

(b) Protestant

(c) Muslim

(d) Seventh Day Adventist

(e) Traditionalist

(f) Any other (Please specify) . . . .

SECTION B: KNOWLDEGE ABOUT REASONS FOR CARRYING OUT FGM PRACTICE

1. Are you circumcised? (a) Yes (b) No

2. At what age were you circumcised?

3. If yes, what type of circumcision did you undertake?

(a) Type I

(b) Type II

(c) Type III

(d) Type IV

(e) Any other (please specify) . . . .

4. Did you voluntarily take part in the circumcision rite or you were forced?

(a) I voluntarily took part

(b) I was forced

(c) Any other (please specify) . . . .

5. If your answer in question 4 is b, who forced you to take part................

6. Could you recall whether the instruments were sterilized?

(a) They were sterilized

(b) They were not sterilized

(d) Do not know/recall

(e) Any other (please specify) . . . .

7. What do you think are the reasons for carrying out FGM?

(i) ....

(ii) ....

(iii) ....

(iv) ....

8. What happens to females who have not circumcised?

(i) ....

(ii) ....

(iii) ....

(iv) ....

9. Would you support your daughter (s) to be circumcised?

(a) Yes (b) No

10 Are there benefits associated with circumcision in the community?

(a) Yes (b) No

11. If yes, what benefits?

(i) ....

(ii) ....

(iii) ………………………………………….

(iv) ………………………………………….

12. Are there dangers associated with the practice of FGM?

(a) Yes (b) No

13. If Yes, what dangers?

(a) Pain during and after the practice

(b) Excessive bleeding

(c) Difficulty in child birth

(d) Spread of diseases like HIV/AIDS

(e) Scarring

(f) Death

(g) Painful sexual intercourse.

(h) Any other (please specify)......................................

SECTION C: KNOWLEDGE ABOUT THE RELEVANT HUMAN RIGHTS INSTRUMENTS TO FIGHT FGM

2. Are you aware of any human rights that females are entitled to?

(a) Yes (b) No

3. If yes, what rights do you know that females are entitled to?

(a) Right to education

(b) Right to a health living

(c) Right to enjoy freedom of thought, conscience and religion

(d) The right to freedom from torture and degrading treatment

(e) Any other (please Specify) . . . .

4. Do you know of any instrument that stipulates the need to safeguard and promote human rights in Uganda?

(a) Yes (b) No

5. If Yes, what Instrument/law (s) do you know?

(i) ....

(ii) ....

(iii)..

(iv)..

6. Are you aware of the fact that FGM is a form of violating women's reproductive rights? (a) Yes (b) No

7. If yes, how did you get to know?

(a) From friends

(b) Read from newspaper and magazine

(c) Read from the constitution

(d) Listened over radio

(e) Watched over the television

(f) Any other (please specify...

8. Do you know of any international or national law/instrument that forbids the practice of FGM?

(a) Yes (b) No

9. If yes, what law/instrument do you know?

(i) ....

(ii) ....

(iii) ....

(iv) ....

SECTION D: KNOWLEDGE ABOUT THE CHALLENGES FACED IN THE IMPLEMENTATION OF HUMAN RIGHTS INSTRUMENTS TO FIGHT FEMALE GENITAL MUTILATION?

1. Are women in this community recognized the way men are?

(a) Yes) No

2. If No, what are the major issues of difference?

(i) ....

(ii) ....

(iii) ....

(iv) ....

3. Do you think the community leaders, especially the elders can allow for complete elimination of the FGM practice?

(a) Yes (b) No

4. If No, why do you think the elders can oppose the ban on FGM?

(i) ....

(ii) ....

(iii) ....

(iv) ....

5. Would you say that enacting criminal laws prohibiting FGM in Uganda may be perceived as a pretext for harassing or persecuting members of that Sabiny group?

(a) Yes (b) No

6. How are issues regarding FGM handled in this community?

(a) As a secret in a sacred manner

(b) The practice is open even to non-community members

(c) Any other (please specify).....................................

7. Are there provisions for giving you special attention in the health centers you visit especially when you are pregnant and during labor?

(a) Yes (b) No

8. There have been government attempts to stop the practice of FGM in Uganda.

However, this has not been successful. What do you think are the challenges the government faces, especially among the Sabiny in Kween District?

(i) ………………………………………….

(ii) ………………………………………….

(iii) ………………………………………….

(iv) ………………………………………….

9. If you were appointed as one of the officials to de-campaign FGM practice, how would

(i) ………………………………………….

(ii) ………………………………………….

(iii) ………………………………………….

(iv) ………………………………………….

10. What do you think the people, government, NGOs and other stakeholders should do minimize the challenges associated with FGM in your community?

People

……………………………………………………………………………………………………

……………………………………………………………………………………………………

Government

……………………………………………………………………………………………………

……………………………………………………………………………………………………

NGOs

……………………………………………………………………………………………………

……………………………………………………………………………………………………

AN INTERVIEW GUIDE FOR THE TOPIC: FEMALE GENITAL MUTILATION: A CASE STUDY OF KWEEN DISTRICT, EASTERN REGION

Administered to the Opinion Leaders (local leaders, elders and health)

Dear respondent, I am Kwemoi Joel, a student of Kampala international University and currently carrying out a research entitled **"Female Genital Mutilation: A Case study of kween District Eastern Region"** as part of the requirements for the award of a Bachelors' degree of Development Studies. You are requested to be part of this academic study by answering the questions in the text. The information you give will be treated with utmost confidence. You are thus requested to tell the truth. Thank you!

SECTION A: BACKGROUND INFORMATION

1. Name of the Village................... Sub county...............

2. Position held in the community:

(a) Local Leader (b) Elder (c) Health worker

3. Age of respondent (State in years) ....

4. Highest level of education attained:

(a) Post-graduate

(b) Graduate

(c) Secondary Level

(d) Primary Level

(e) No formal education

(f) Any other (Specify).......................

5. Religion of respondent:

(a) Catholic

(b) Protestant

(c) Muslim

(d) Seventh Day Adventist

(e) Traditionalist

(f) Any other (please specify) . . . .

SECTION B: KNOWLDEGE ABOUT REASONS FOR CARRYING OUT FGM PRACTICE

1. At what age are girls circumcised?

2. How is it (circumcision) done? (Probe for the various types)

3. Do girls voluntarily take part in the circumcision rite? (Yes/No) Probe to find out if some force is used who uses it

4. Could you recall whether the instruments were sterilized?

(a) They were sterilized

(b) They were not sterilized

(d) Do not know/recall

(e) Any other (Please specify) . . . .

5. What do you think are the reasons for carrying out FGM among the Sabiny?

(i) ....

(ii) ....

(iii) ....

(iv) ....

6. What happens to females who have not circumcised?

(i) ....

(ii) ....

(iii) ....

(iv) ....

7. Are there benefits associated to FGM in this community? (Yes/ No)

8. If yes, request the respondent to mention such benefits

(i) ....

(ii) ....

(iii) ....

(iv) ....

9. Are there dangers associated with the practice of FGM? (Yes/ No)

10. If Yes, what dangers are associated with FGM?

12. Would you say that the practice of FGM violates women's reproductive health?

(a) Yes (b) No

13. If yes, state how:

(i) ....

(ii) ....

(iii) ....

(iv) ....

14. Question 15 and 16 for health workers only: Do you get patients with cases related to FGM?

16. If Yes, of what nature and how often?

SECTION C: KNOWLEDGE ABOUT THE RELEVANT HUMAN RIGHTS INSTRUMENTS TO FIGHT FEMALE GENITAL MUTILATION

6. Are you aware of any human rights that females are entitled to? (Yes/ No)

7. If yes, what rights do you know that women and girls are entitled to? (i)

(i) ....

(ii) ....

(iii) ....

(iv) ....

8. Do you know of any instrument that stipulates the need to safeguard and promote human rights in Uganda? (Yes/ No)

9. If yes, what Instrument/law (s) do you know?

(i) ....

(ii) ....

(iii) ....

(iv) ....

10. Are you aware of the fact that FGM is a form of violating women's reproductive rights? (Yes/ No)

11. If yes, how did you get to know?

12. Do you know of any international or national law/instrument that forbids the practice of FGM? (Yes/ No)

13. If yes, what law/instrument do you know?

(i) ....

(ii) ....

(iii) ....

(iv) ....

SECTION D: KNOWLEDGE ABOUT THE CHALLENGES FACED IN THE IMPLEMENTATION OF HUMAN RIGHTS INSTRUMENTS TO WOMEN'S REPRODUCTIVE RIGHTS

1. Are women in this community recognized the way men are? (Yes/No)

2. If No, what are the major issues of difference?

(i) ....

(ii) ....

(iii) ....

(iv) ....

3. Do you think the community leaders and members can allow for complete elimination of the FGM practice? (Yes/No)/ Do not know)

4. If No, why do you think so?

(i) ....

(ii) ....

(iii) ....

(iv) ....

5. Would you say that enacting criminal laws prohibiting FGM in Uganda may be perceived as a pretext for harassing or persecuting members of that Sabiny group?

(Yes/No/l Do not know)

6. How are issues regarding FGM handled in this community? *Probe to find out whether it is easy to access information related to the practice*)

7. For the health workers only: Are there provisions for giving circumcised women special attention in the health centers especially when they are pregnant and during labor? Yes/ No. If yes, what kind of treatment is accorded?

8. There have been government attempts to stop the practice of FGM in Uganda.

However, this has not been successful. What do you think are the challenges the government faces, especially among the Sabiny in Kween District?

(i) ……………………………………………

(ii) ……………………………………………

(iii) ……………………………………………

(iv) ……………………………………………

9. If you were appointed as one of the officials to decampaign FGM practice, how would you advise the government in her trials to completely ban the FGM practice?

(i) ……………………………………………

(ii) ……………………………………………

(iii) ……………………………………………

(iv) ……………………………………………

END, THANK YOU FOR THE RESPONSE

APPENDIX II

THE MAP SHOWING KITOWOI SUB-COUNTY IN KWEEN DISTRICT

Sumaton P/S

Tapagon trading centre

Tarak P/S

Tabagon

kapkopaliat

Taremboi P/S

Teremboio S/S

healthcentre

kitowoi S/C head quators

Taremboi

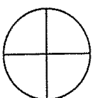
Kitowoi P/S

Mt Elgon national park

KEY

Schools

Trading center


Health Centre

Sub-county head quarters

APPENDIX III: BUDGET

ITEM	COST UGX
Stationary	15000/=
Printing	20000/=
Binding	40000/=
Airtime	20000/=
Meals and drinks	100000/=
Miscellaneous expenses	50000/=
Transport	10000/=

APPENDIX IV: TIME FRAME

November	January	February/March	April	May
Proposal writing	Proposal submission	Data collection and data analysis	Submission of the first draft	Submission of the copy