UNIVERSITY OF NAIROBI

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FACTORS INFLUENCING THE PERSISTENCE OF FEMALE GENITAL MUTILATION AMONG THE MAASAI COMMUNITY: ACASE STUDY OF MAILI 46 LOCATION, KAJIADO WEST COUNTY

BY:

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DECLARATION

I declare that this research project is my own original work and it has not been presented to any other university or institution for academic credit.

Signed: Date: 21-November-2023

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This research project has been presented for examination with my approval as the university supervisor.

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DEDICATION

This work is dedicated to my beloved children, mother and friends. You all stood by me and were a source of encouragement. Thank you.

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This work was only possible through the support of several individuals. I sincerely thank my supervisor for tirelessly encouraging me and his timely advice through review of several drafts of this report.

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May the almighty God bless all abundantly.

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ABSTRACT

The number of girls and women who have had FGM is estimated at 200 million worldwide, but the prevalence of the procedure is rising as the world's population expands. In Kenya, female genital mutilation occurs among several ethnic groups and in more than half of the country's locations. The study sought to identify the customs that lead to the persistence of FGM, ascertain the methods used to address the issue of FGM, identify the factors to an effective campaign against female genital mutilation and ascertain the influence of social pressure on FGM among the Maasai of Maili 46 location in Kajiado West County.

This research used the Feminist theory and the structural functionalism perspective to help understand the different roles in different systems and ways of defending women's rights in a community concerning female genital mutilation: this was a case study. The research involved a descriptive sample method incorporating both quantitative and qualitative methods. A survey comprising 102 respondents was collected using simple systematic and purposeful sampling strategies was used. Both qualitative and quantitative approaches have been used in the execution of this analysis. Various descriptive statistics, including mean scores and standard deviations for frequency distributions and percentages, were used to examine the data using SPSS. According to the research, women are still held in high regard in their culture after having undergone FGM. It also found out that there are some cultural activities like food and drink handling and marriage rites practices that only women who have undergone FGM are involved in thus influencing the practice greatly. The majority of the respondents confidently confirmed that despite stiff measures implemented by the Government on the practice, underground practices are rampant in the area and propelled by factors like social pressure and cultural obligation. It was noted that FGM is tied to other major cultural practices such as marriage and thus it's deeply rooted in the society hence creating a huge problem in eradicating the menace. The study found that social pressure was in two ways, between the age sets and down to the kin so putting pressure on the girls to fit in society and to be respected one had to be circumcised. The study suggests that there is a need for organizations to work together with different partners to implement women's and young girl's privileges through trainings and education on culture, training on existing arrangements and laws is important, a progressively extreme discipline ought to be taken against those that are for FGM and education to men on FGM should be included since they are the greatest impediment in the fight against FGM.

CHAPTER ONE
INTRODUCTION

1.1 Background of the Study

Female Genital Mutilation is a common sociocultural practice among the Maasai community in Kenya. As such, women and girls in the community are subjected to the practice by default. The prevalence of FGM is not only marked by geographical factors. Still it varies among the ethnic groups present in the 30 countries of Sub-Saharan Africa and some countries in the Middle East and Asia where it is ancestrally performed in the context of rites of passage and as a socializing element for girls (WHO, 2005). The demographic weight of the sub-Saharan migrant population in Spain with high rates of masculinity conducive to family regrouping and the high fertility rate of African women augurs a sharp increase in our clinics and schools of girls at risk of being subjected to FGM. For primary care professionals, this has meant discovering different cultural realities and facing new care challenges in the context of complex processes of acculturation and social integration (Kaplan et al., 2006).

An estimated 200 million girls and women are reportedly reported to have been exposed to FGM worldwide but FGM rates are growing indicating an increase in the global population size. Girls and women who have undergone through FGM reside mainly in the United Kingdom and the Arab States. However, FGM is still practiced in selected countries in Asia, Eastern Europe and Latin America. The procedure of FGM in the UK focuses only on minors ignoring that young adults are a central factor. During the previous decades a few universal and national compassionate and therapeutic associations have attracted overall regard for the physical damages related to FGM (Bosch, 2011). For instance, the WHO and the International Federation of Gynecology and Obstetrics have criticized FGM as an inappropriate medical procedure with severe and even life-threatening risks (WHO, A Common Practice that Threatens Health, 2006). Many nations including Sweden and the UK have narrowed themselves to paying no regard for permission and disciplinary methods would seem to be protected by the enactment. For instance, Sweden has outlawed procedures on the external female genital parts that are intended to damage them or result in other long-lasting modifications regardless of whether or not people have consented to this operation. The key explanation has been the medical rationale of the procedure in the last two decades in Europe and North America.

FGM has been practiced in Africa for reasons other than those that are strictly social traditional or religious. The primary justification is that training is crucial for social and professional development (Yonder, Abdeerrahim & Zhuhai, 2004). Without much stretch, advances in science and drug could object to such medicinal avocation unlike social angles in the African setting. Uncircumcised women are recognized as unclean in FGM-practicing communities in Africa and are not permitted to treat food and drink. It is a cultural phenomenon profoundly ingrained within African and Western cultures and many policymakers worldwide have been concerned about the growing trend. Governments have invested extensively in sensitizing the masses in response to these trends and placed legislative steps to curtail the practice.

FGM and circumcision of girls are still common practices in more than 28 countries in Africa. World Health Organization report (2008) indicates that about 100 million to 140 million women undergo circumcision every year and about two million girls are at risk of genital mutilation every year. The statistics go on to say that in the 30 nations in Africa wherein FGM is the most prevalent, over 200 million women and girls who are alive today have undergone the procedure. The practice is most prevalent in the three regions of Africa the West, East and Northeast as well as among immigrants from these areas. Female genital circumcision is a frequent practice in Africa with approximately 28 countries reportedly involved in female genital mutilation. Over 85% of women in these countries get clitoridectomy in which the entire clitoris is removed or excision in which the entire or a larger part of the labia minora is removed. The most notable structure infibulations which involves the evacuation of all or parts of the external genitalia is followed by stitching and shrinking of the vaginal entrance is still present in 15% of the cases of this practice in Africa. According to estimations made by the WHO, clitoridectomy is the most widely used structure to circumcise women in Nigeria accounting for roughly half of the country's female population (WHO, 2009). In Senegal, the activity is illegal and according to Amnesty International FGM has dropped to 26 percent in that region. In Mali, the rate is high at over 91% and in Guinea it is 96% (The Normal, 2019).

In East Africa for instance Tanzania FGM practice is rampant and deeply entrenched in cultural traditions and social norms with reports indicating that approximately 7.9 million women and girls have undergone FGM despite the government efforts to curb the menace by declaring the practice illegal in 1998 in the Sexual Offenses Special Provisions Act (SOSPA) which altered the Penal Code (WHO/UNICEF, 2013). FGM is a fierce practice that jeopardizes the lives of young girls

and women. It denies them their privileges and capacity to arrive at their maximum capacity and contribution towards the country working in the general public. The reported prevalence of FGM in girls and women (15-49 years) in the Tanzania Demographic Health Survey (DHS, 2010) is 14.6 percent. Since 2004 DHS which reported the same rate, the average rate has not increased. However, the rate declined by 3.3 percent from 17.9 percent in 1996 (DHS, 1996). The phenomenon is rooted in gender discrimination efforts to regulate the sexuality of women and ideas about virginity, modesty and aesthetics. The highest prevalence in the world is in Djibouti and Somalia in Africa.

Kenya according to KDHS (2008), FGM practice is very common in Kenya with reports indicating that 38 percent of women aged 15-49 years undergo it every year. The FGM is spread in over half of the locations and among different ethnic groups in Kenya. Statistics indicate that FGM practice is almost universal among the Kisii community at a rate of (97%), and Maasai (88.8%). It is also widespread among the Kalenjin, Taita Taveta, Meru/Embu ethnic groups and to a lesser frequency among the Kikuyu. Among the Kamba community reports indicate that FGM is 33% and Mijikenda/Swahili (12%). The FGM practice also results in unnecessary health problems, inflicts pain on women, causes excessive bleeding during this rite, causes hospitalization and increases the risk of infections because of sharing of equipment used in operation. In severe cases, it results into loss of life. It poses a health hazard and as a result intense campaigns are made to halt FGM in Kenya. Recently, Kenya has been ranked third among countries with the most cases of the medicalization of FGM.

The Maasai community continues to practice Type II of FGM called excision. The rate stands at 73.2% after Kisii, which practices Type I called clitoridectomy at a high rate of 96.1%(KDHS, National Council for Population and Development,2008). The rate went up from 73.2% in 2008 to 77.9% in 2014 (KDHS, 2014). Out of an average of 128 women admitted monthly at Loitokitok Sub-County Hospital about 50% usually have a complication related to FGM. In April and September 2013 the incidences of FGM complications in Loitokitok Sub-County Hospital rose to 60 from 29 women admitted. After the government offered free maternity services also more women subjected to FGM complications came out clearly (Muchene, Mageto & Cheptum, 2008). However, despite the government efforts to end the FGM practice through various preventive measures like creating various regulatory provisions and institutions to eradicate the vice FGM is still practiced in parts of Kenya especially areas that are far from the cities with devastating long-

term complications on the women who Undergo It (Jimale,2018). These developments coupled with the never-ending need to comprehend the factors that trigger the perpetuation of this practice among Study areas motivated the urge for this study.

1.1 Problem Statement

Since the 1970s, the issue of FGM has also been approached scientifically. While initially the focus was on medical considerations to mitigate or avoid complications or discomfort. FGM has now become the focus of social sciences for example rural sociology (Christakis, 2016; Wade, 2009). While some studies compare trends in FGM rates across several countries over time (Kandala et al., 2018; Cheserem, 2010), others focus on individual socio-demographic factors of women survivors (Nungari, 2007; Wilson, 2017). Some authors combine both dimensions (Engelsma et al., 2020; Feldman-Jacobs & Clifton, 2010). Such literature has often not considered women's life course from sociocultural perspectives (as a counter-example, see: Farina and Ortensi 2014). However, this is necessary as many studies suggest an implicit causality between social and cultural life events at the time of the survey and individual mutilation although this may not be possible in terms of time and especially among indigenous communities in Kenya. For example, the average age of circumcision in Egypt community is under ten years but compulsory schooling is nine years so it is not fulfilled until around 15 years of age (UNICEF, 2015; Wilson, 2017). In order to further address this research gap, emerging maternal social and cultural attitudes that trigger the practice of FGM is necessary for the approximation of future decision.

1.2 Research Questions

i. How do cultural practices contribute to the persistence of FGM?
ii. How does social pressure affect FGM practice among the Maasai?
iii. How effective are the current efforts to stop FGM among the Maasai?
iv. What are the challenges facing the Maasai in combating persistence of FGM?

1.3 Objectives of the study

1.3.1 General Objective

This research aims to assess the factors influencing the persistence of FGM among Maasai of Maili 46 location in Kajiado West County.

1.3.2 Specific Objectives

1. To determine how cultural practices, contribute to the persistence of FGM among the Masaai.

2. To find out how social pressure affects FGM practice among the Maasai.
3. To find out how the existing interventions address the problem of FGM practice among the Maasai.
4. To establish the challenges to the successful fight against FGM among the Maasai.

1.4 Justification of the Study.

Emerging maternal social and cultural attitudes that trigger the practice of FGM are necessary for the approximation of future policymaking and decision which is against the background that the number of FGM in the study area has remained persistent despite efforts by diverse groups such as Non-governmental organizations to end the practice. It affects quite a number of Maasai women hence affecting their well-being. By providing them with knowledge, the research would enable policymakers to explore the factors influencing the continuation of FGM. In the interest of tackling the problem of FGM, policymakers have been establishing methods to prevent FGM practices through the Ministry of Health for as long as anyone can remember. As a result, the findings of this research study will provide valuable data regarding the variables that promote the persistence of FGM across different ethnic groups in Kenya.

It is justifiable for academicians to understand the emerging sociocultural factors triggering FGM in contemporary indigenous communities. However, this can enhance knowledge of new causes of FGM not necessarily the traditionally known sociocultural triggers. It offers academicians the advantage of modeling micro and macro-sociological conditioning factors on the issues of FGM. To this end, the research study was justified to analyze the persistence of FGM. Subsequently, a model of justification is postulated that considers the structures of society as a whole. The physical representation of gender, sex and the contradiction between values and health aspects. Finally considering the sociological aspect, it was justifiable to give an insight into the topic using indigenous communities in Kenya since most of these communities are staunch practitioners of FGM.

1.5 Scope and Limitations of the Study

The study was limited to the research study area. The study was also limited to specific variables including cultural practices that enhance FGM, the influence of social pressure on FGM, existing interventions that address the problem of FGM and the challenges to the fight against FGM. The study also involved only household heads as the main respondents. The key informants were the traditional "surgeons," village elders, and local administrators who were purposively

sampled/judgmental/selective in this sampling. The researcher solely judged the people to interview.

CHAPTER TWO
LITERATURE REVIEW

2.0 Introduction.

This chapter examines the research on factors influencing the persistence of FGM. The review of related literature commences with a review of related literature on how cultural practices, social pressure, interventions and impediments influence the persistence of FGM. A theoretical study of literature where theories such as structural functionalism perspective and Feminist theory were used, conceptual framework, and summary chapter is provided with research gaps.

2.1 Review of related literature.

2.1.1. Cultural Practices and FGM.

Culture is defined as a people's customs or a set of traditions and behaviors learnt and carried on from generation to generation. It is acquired by adults and imitated by adolescents. Traditions are handed on from generation to generation and are essential to those who adopt them. Community expectations perpetuate values and are often a source of evidence that could encourage individuals to reconsider cultural patterns and pose challenges. Over time, practices and beliefs evolve and are rooted in our life history. People who judge cultures and their customs do this purely because they are not used to it (Krivenko, 2015).

In communities practicing FGM, there are different fundamentals of culture found. Customs, a collection of principles, faith and values, are some of the basics. These societies tend to share a shared way of life concerning the practice of FGM an ordinary concept. In certain African cultures for example, it is assumed that if the clitoris is not removed it may expand wildly between the legs to hang down. It is still assumed in some cultures that the clitoris which is not expunged could cause child death and injury (World Bank, 2005). Various cultures claim that eliminating the clitoris diminishes women's sexual impulses and girls are deemed to have passed from childhood to maturity and are eligible to marry and bear children.

On the other hand, men are also expected to visit the girls who have gone through FGM homes with the expectation of marrying their girls. In this regard, girls desire to undergo FGM to avoid their peers' stigmatization, social pressure, and parents' dismissal from society (Ehrenreich & Barr, 2010). However, these allegations are not scientifically supported because babies are born healthy for both communities that are practicing and those not practicing FGM.

There are distinct roots of communities found in societies practicing FGM. The fundamentals include traditions, a list of beliefs, religion and ideals. However, concerning the tradition of FGM a standard definition, these cultures prefer to share a similar way of life. For starters it is believed in some African cultures that if the clitoris is not removed it will spread wildly between the legs to hang down. In certain societies, it is still thought that the clitoris which is not expunged could cause death and injury during child birth (World Bank, 2005). Multiple societies say that clitoral removal eliminates the sexual desires and mutilation of girls and women are assumed to have progressed from childhood to puberty and can marry and bear children.

The eradication of FGM is a method of sabotaging societal capital. It represents an essential social feature so that people who have not undergone FGM are mocked and consequently lack legitimacy in their households. However, this is why most anti-FGM proponents often receive adverse reactions from the groups that practice it. FGM-practicing groups also assume that their community is subjected to foreign attacks and critique whose people are out there to mess with an endeavor they have been engaging in for several years while the outsiders are not prepared to assist them. Exaggerated statements about the topic have become a stumbling block to the practice and eradication attempts as most campaigners typically conflict with local realities causing an integrity void (Shell-Duncan &YlvaHernlund, 2007). Utz-Billing &Kentenich (2008) found that FGM is a holistic matter profoundly embedded in the values and cultures of society. FGM is viewed in some cultures as an initiation rite meant to blend young girls into the group. Inquiring into this custom is also seen as an interference with the customs and values of the culture. It acts as a dictate to the way of life of Western people.

According to Njue and Askew's (2004) research in Kisii Nyanza Province, FGM is an essential rite of passage from a young girl to a respected lady. A circumcised woman is viewed as mature, respectful, aware of her role, responsibilities in the families and with Qualities that are highly regarded in the community. The desire to maintain the deteriorating cultural traditions and distinct tribal principles is the power behind the FGM disruption in most African societies. For example, their cultures, norms and practices are crucial to the Maasai. The local community advocates that any person they associate with should regard their rituals and practices as sacred. Many cultural relativists observe that diverse cultures should respect rituals, values and behaviors.

A survey by, Cheserem (2010) found that when asked about the cultural advantages of FGM, a significant proportion of interviewees assumed that the husband prefers a woman who has undergone FGM and a considerable share agreed with the thesis that FGM prevents licentiousness. If we look at the women's reported knowledge of the medical risks of FGM it is striking that a few women agree with the statement that FGM makes childbirth more difficult while just over half of the interviewees know that FGM can lead to death (Cheserem, 2010). This presentation should better understand the ambivalence in many cultural communities towards FGM because it has a very positive connotation and awareness of the medical dangers increasingly entering the collective consciousness especially in recent years.

Hodgson (2001) maintains that while the ambiguity and inconsistency of the connection between FGM and social aspects it can be concluded that FGM is not anchored in the social orientation of a household unit and the entire community but rather culturally in the practicing communities as expressed by the fact that the same form of circumcision can be dominant within an ethnic group even if its members belong to different religions (Hodgson, 2001). Based on this, it can be postulated that religion and FGM merely enter into a symbiosis since the values transmitted by obedience and subordination are congruently similar.

A survey conducted in Ol Donyo among the Maasai in 2005 observed that all girls above 15 had undergone GM. Despite the determined hold of the Maasais' on their customs, essential FGM characteristics have started to shift. The group for example is aware of the danger raised by the exchange of operational instruments as they will spread HIV / AIDS as the offenders are currently using a single method per patient. To stop the continuation of FGM the perception of core forces that corroborate FGM remains essential throughout the path. In order to obtain a great deal of insight into eradication they also clarify the value of understanding existing views on the activities of FGM and its nonchalance of it. In addition, tolerance and insensitivity towards other cultures and customs are required and the welfare of young people and children should not be undermined.

2.2.1. Influence of Social Pressure on the persistence of FGM

In specific networks, FGM is the transitional experience into womanhood and is joined by functions to stamp the event when the young girl turns into a developed regarded lady. Young girls are exposed to impressive social weight from their companions and relatives to undergo FGM. The gathering or family might dismiss them on the off chance that they conflict with the convention. Humans are social creatures who need to believe they are part of the family and the society they

belong to and is accomplished by complying with the standards and laws of their culture (Fehr & Fischbacher, 2004). FGM is practiced as a social convention and one of the reasons that has made it impossible to face out is the practice of societies. Practice can be seen as a social standard that influences group decision-making rather than individual action (Ibrahim, 2006).

The need to adhere to the laws of society and demands makes some parents and guardians perform the ceremony of FGM rituals because they avoid standing out and prefer to display compliance with the standards of the group (norms). However, this beautifully illustrates how the family's decision will be predisposed and have significant repercussions for the family within their culture. For African cultures, societal approval and respect play a vital role and someone who goes beyond the norms of society is treated as shameful and isolated person who can no longer be part of the society.

In the case of FGM practice, girls who have not undergone circumcision are constantly insulted, humiliated, alienated, sometimes dismissed by their peers and parents of those who have undergone FGM. The impact of FGM on both the child and married men as they are labeled as ashamed married women (Shell-Duncan, Wander, Hernlund, & Moreau, 2013).

Stigmatization also affects the entire family and the community at large and not only the women who have led to the mess. In this view, social pressure is considered integral in promoting FGM for both girls and women. Through this, the families and community have created conducive environment in which the practice is highly allowed accepted and practiced among them as this will lead to conformity and contentment (Boyle, 2005).

In some communities, the practice of FGM give girls and women a sense of belonging, attachment among their peers, they feel more empowered and equal to their peers despite an individual's occupational status. FGM is also being promoted by the migration or displacement of the communities who have been practicing it. Different communities have also been coerced to undertake female circumcision by their neighboring communities, cultural groups or religious groups (Johnsdotter & Carlbom, 2007).

Social norms are of considerable significance in persistence of FGM within the societies that have practiced it. It is seen as the endorsements or disapprovals of society that can be expressed as social pressure and society. In general, social obedience is guided by hopes of a reward for not going against what is deemed valuable by society. Subject to retribution that includes social exclusion, mockery, stigmatization, abuse, insults and one characterized as hypersexual and ridiculed going

against social norms. Girls are protected from sexual harassment, social exclusion and insult by conventional practices such as FGM (Almroth, 2005).

Similarly, the study has shown that girls and women who have experienced FGM practice and their families have been socially accepted, respected and honored by their families. Conversely, those who go against the practice of FGM commonly face a lot of social problems ranging from insults to the girls' mothers, teasing of these girls, social isolation and facing rejection of marriage partners (Khaja, Lay, & Boys, 2010).

According to a study in Sudan by Almroth (2005), it was revealed that the first dimension in which patriarchal structures are considered here are state institutions which in turn can impact those subsequently considered. Although social structures usually have ostensibly objective or impersonal structures, they can be gender discrimination against women (Almroth, 2005). However, the state has an ambivalent role at this point. It can also reduce the gender discrimination it engages in by enacting new public policies that serve the goal of equality.

Similarly, Rahma (2009), in a survey in Darfur revealed that patriarchy could be seen as a social condition in which key positions and other advantages are primarily given to men based on gender. It is thus a graded state in which societies can find themselves in specific social spheres as a whole. Rahma (2009) sums up the central mechanism of patriarchy in the statement "a woman has only the freedom that a man is willing to give her''.

Women are mostly portrayed as passive if not inactive actors. It should not be forgotten that they also (can) take an active role in gender distribution. Furthermore, it is often not considered that not all men have power in patriarchal societies, there is also a hierarchy among them. Furthermore, as already mentioned, it should not be forgotten that although they are the beneficiaries of patriarchy, men did not actively intend this constellation but perpetuated it due to societal inertia (Rahma, 2009).

Research undertaken by Mackie & LeJeune (2009) on the social dynamics around different activities and traditions showed that FGM is treated as a social convention and that the social obligation to adhere to the practice is a great incentive that perpetuates the practice of FGM in different societies that practice it. Therefore, such a tradition has become common within the FGM-practicing communities. The community leaders and elders perpetuate that girls typically encounter FGM to be valued and embraced within their community by their parents, loved ones and elders.

Different people have seen FGM from different points of view. Most African parents generally think it is a significant rite that their daughters should undergo. The practice is critical for their daughters' prosperous prospects and identification. Some parents also believe that if their daughters do not undergo FGM, they can be rejected by the community which has been evident in the Maasai community. In most occasions where local training occurs, men would argue that they cannot marry women who have not undergone FGM as they are viewed as wild. After young women have undergone FGM, they are confined in one place where they are taught and counseled on how to become real women, how to manage their sexuality, marry, be a wife, conduct household chores and rearing of children (Ako & Akweongo, 2009).

Wilson (2017) urged that although many governments have banned FGM practices, they remain socially accepted in practicing communities and maintain their legitimacy in the male-dominated sphere of legality and politics which are supposed to be for everyone. Because men determine the social ideal of virtuous and acceptable women, they can control every aspect of their lives (Wilson, 2017). In the preceding, it was thus shown that the body could represent patterns of social order through which social power can also be instrumental. Female genital mutilation exemplifies how patriarchal social structures can manifest through women's body modification.

Wade (2009) in his study relates FGM as a possible form of body modification that pursues the goal of ensuring that women are provided for as well as possible within their regulations which are restricted by patriarchy. In order to be able to enter into this, women must be prepared for their role as wives and internalize the behavioral patterns associated with this role (Wade, 2009). In order to achieve this, both social and physical control mechanisms are used to achieve and ensure virtue. Moreover, FGM in itself is often a necessary condition for marriage.

According to Kandala et al. (2018), it is about girls gaining the ability to marry in public so that it is evident to other families that the daughter is ready for marriage. At the same time this is the social transition from girl to woman in most societies whereby uncircumcised adult women assume the social position of a girl for instance a child for the rest of their lives which means that their voice only carries their weight. FGM functions at this point as a process of classifying women into the "soil of society". The author observed that after a girl has officially entered the marriage market through her circumcision, it is now her task together with her family to find a husband who is as well-off as possible which in turn gives the entire family a social advantage. To do this, a girl must appear remarkably "socially impeccable" to the outside world. There are countless ways to achieve

this goal; - Beauty, intersubjective health, virginity, and the demonstration of religiosity are among the essential ones (Kandala et al., 2018).

The social theoretical explanation of FGM identifies men as its beneficiaries. However, several empirical studies suggest that women more often attribute men to support the practice than themselves (Engelsma et al., 2020; Feldman-Jacobs & Clifton, 2010; Farina & Ortensi, 2014). Although men are not directly affected by FGM, they are confronted with it in various contexts each assuming specific social roles. Three roles can be identified as central here, the potential husband, the actual husband and the father. The first role in the course of life is as a potential husband. Here, the majority of men need to find a virgin wife. Some do not attach importance to whether this virginity is surgically produced. Due to the high importance attributed to virginity, it is difficult for the most progressive, better-educated men who want to marry a woman who has not been mutilated to convince their own family that their bride is still a virgin if she has not undergone FGM (Engelsma et al., 2020; Feldman-Jacobs & Clifton, 2010).

2.2.2. Existing Interventions in FGM

Different intercession methodologies have been actualized in Kenya to influence networks to desert FGM. A circumstance investigation directed in 2006 recorded the various sorts of intercessions that have been utilized in Kenya, including;

2.2.2.1. Alternative Rites of Passage on Eradication of FGM

As a grassroots movement for the advancement of women, *Maendeleo Ya Wanawake Organization* (MYWO) initially introduced Alternative Rites of Passage as a substitute rite among the tribes who practiced FGM in 1990. It was designed to prevent actual FGM of the female genitalia while maintaining the fundamental elements of female circumcision ceremonies including the public statement for community recognition providing girls with education on family life and the duties and obligations of women partying and gift-giving. Alternative rites of passage (ARP) aimed to convince communities to continue holding public ceremonies to mark girls' transition into respected women while avoiding actual (harmful) FGM (Chege, Askew, &Liku, 2010).

In 1996, MYWO conducted the inaugural conference on alternate rites of passage in which 29 girls participated. Since then several other conferences have been held with a growing number of girls attending each one (Muteshi, 2005). With a focus on raising awareness among the

community, FGM sensitization efforts were implemented to provide an alternate ritual for girls who choose to discontinue the tradition in their communities and families. In this instance, women are informed at grassroots level about information raising public consciousness about the practice's medical risks and the circumstances in which it breaches human rights.

Seclusion and education are used to simulate the conventional practice of immediately secluding girls who have had FGM and teaching them about the roles and responsibilities of women, cultural values and the sexuality of their aunts. The girls participating in the alternative rites must endure between three and five days of isolation and extensive preparation. Girls are housed in comfortable facilities during this time and receive education on reproductive health, community values and life skills. The only difference between this practice and the conventional one is that no girls undergo damaging FGM in this practice (Muteshi, 2005).

In addition to social pressure another argument in favour of the practice is religion which is why religious leaders are a fundamental tool spoken of in the masculine. It is also important to convince traditional leaders to end FGM and sensitize the traditional leaders first to achieve something. They are opinion leaders in their communities. This makes it clear that the opinions of traditional and religious leaders are respected in the communities so in order to eradicate FGM from a community work must be done with men especially those who are opinion leaders so that they can later act as agents of change in their communities (Oloo et al., 2011).

Girls remain indoors throughout the isolation and training period. Only former inductees who had undergone through the preparation session before for example female relatives, parents, neighbours, or acquaintances accepted may pay them a visit. Religious, political and government officials are called to a public ceremony (Graduation) that follows a period of intensive training. During the following speeches they are primarily asked to denounce the practice of GM. The girls were allowed to urge the elders to stop performing female circumcisions and instead support girls' education. It is also imperative to remember that the socio-cultural contexts in which the many alternate rituals occur typically determine the timing and character of public festivities. The rituals take place right away once the training is through. Therefore, the girls and their guardians must participate as much as possible (Prazak, 2007).

2.2.2.2. Establishment of Community-based FGM Rescue Centers

CBRC contributes significantly to the fight against FGM by employing a comprehensive strategy. It educates community members about the subject of GM. Planning seminars and workshops catering for various groups such as community gatekeepers to increase community knowledge about GM. The goal of saving female children from FGM involves religious leaders, chiefs, local leaders, peer educators and FGM practitioners (Wangila, 2007).

An empirical investigation by Diop & Askew (2009) yields notable findings of activity research investigations conducted in Mali, Senegal and Burkina Faso. Their examination develops our comprehension of the significance including network points of view on the training particularly its negative well-being results just as exercises found out about the job of well-being suppliers and the change of conventional experts. Network mediations that utilize an incorporated methodology include open statements and social help for doing without FGM. It is important that the entire community is part of the change and that the social pressure to mutilate girls is eliminated. The alternative to mutilation that ensures that uncut girls are considered respected members of the community is the initiation ceremony without mutilation.

In Spain as in the rest of European countries, health professionals have different strategies and tools to prevent FGM in girls such as providing information and giving health education to families from countries that traditionally perform FGM so that they know the consequences derived from the practice. To reinforce the information provided, professionals can count on intercultural mediators who speak with these families and share their experiences with them (Children's Rights, 2001).

The role played by the "Tsaru Ntomonok" Organization in Kenya had the schoolhouses where girls flee to avoid being mutilated. Providing them with education and sensitizing in the long term both their families and communities so that they are accepted without cutting them off. An important tool for the girls to feel accepted in their community is to celebrate the initiation ceremony in which the girl is considered a woman without performing the mutilation of her genitals. The NGO combines tools aimed at the girls and the rest of the community that mutually empower each other as its coordinator (Messito, 2006).

Additionally, youth who have been edged and fled their homes are screened and assisted by CBRC to avoid GM. They also provide temporary housing for young women who run away from GM. According to Karanja (2004), the main objective is to ensure that young women expelled from

their homes or fled because they refused to have FGM or enter into early relationships are protected, supported ethically, socially and ultimately returned to their residences through a consensual process.

Theatrical performances, film screenings and the talk in Tanzania are tools aimed at the community as a whole so they reach many people. However, they still need to achieve the immediate application of the information and learning. Therefore, this methodology must be complemented with others aimed at a more specific audience to promote a change in attitude towards FGM. By complementing both strategies, it is possible to improve the community's response already sensitized to new interventions against this practice. In this way, social pressure is eliminated as a reason to continue performing FGM or it can even be used to eradicate it as is the case in Senegal and Ethiopia (Peter, 2011).

According to Ghebrezghiabher and Mozaki-Haller (2015), the prevention of FGM must be carried out from a multidisciplinary perspective since it is essential to monitor risk cases from different spheres. Family, health, educational and social. Among the activities proposed by international health agencies such as WHO to eradicate the practice is the creation of promotional measures and instruments that encourage local activities aimed at ending it and orientation to the health system through developing training material and guidelines for the professionals. A good example is the action protocols and tools designed to guide the actions of professionals from different fields in the face of a risk case.

According to Muteshi (2005), the need for these action guides and training campaigns which make it possible for health professionals to offer optimal care for this health problem is justified by their lack of knowledge and inability to address this problem specifically in the Maasai community. Insufficient knowledge of FGM by health professionals has been detected and sub-Saharan women residing in this region report that the professionals who care for them during pregnancy and childbirth do not detect or address the mutilation of their genitalia (Muteshi, 2005).

2.2.2.3. International and local Instruments on Eradication of FGM

Since 1997, the international community has made enormous efforts that have helped fight FGM quite successfully. This has been accomplished by collaborating with regional organizations working closely with the affected populations at the local level researching and creating policies to end FGM. Numerous nations have been successful in enacting strong legislation that criminalizes FGM. On the foundation of the penal code, nations in Europe like Belgium, France

and the United Kingdom (UK) have ratified tough regulations targeting those who committed FGM. FGM was outlawed in Africa in 2007. However, due to anarchy in Somalia, there is still a high frequency of the procedure there. Considering everything the country has approved the guarantee of economic, social, and political rights. The results were evident when the government supported a campaign to abolish FGM in all of its forms in 1988. Regrettably, the 1991 overthrow of the government disrupted and slowed the campaign's continuation (Rahman et al., 2008).

Wilson (2013) maintained that parents or relatives who practice and promote FGM believe it has beneficial effects for the girl child as this has traditionally been the case in their culture of origin. This does not mean that the law and legal mechanisms to protect minors should be inhibited from dealing with the problem. However, it does mean we should approach these cases with special sensitivity and knowledge of the social reality when applying the law. Therefore, if the application of precautionary measures and the use of criminal sanctions should always be the last resort in this case where information and prevention are the only effective solution to the problem. It is even more important not to lose sight of the fact that the application of criminal law and the judicialization of the problem will also be the last option. This means that the need to go to court whether criminal or civil will arise when information and prevention efforts have failed and when there is a risk that a minor has undergone or may undergo genital mutilation.

The Social Council and the Health Assembly agreed in 2008 to pass a comprehensive resolution to support efforts to end FGM. The United Nations issued a fresh declaration in 2008 highlighting the campaign for FGM discontinuation (Wilson, 2013). The Norwegian Church Aid is one of the key worldwide organizations that have played a critical part in fighting against FGM. The Norwegian government initiated this to promote self-respect and dignity among the women who have been part of the groups that engaged in FGM.

Oloo et al. (2011) claimed that to manage FGM especially among indigenous communities in Kenya effectively the application of precautionary measures and the use of criminal sanctions should always be the last resort in this case where information and prevention are the only effective solution to the problem. It is even more important not to lose sight of the fact that the application of criminal law and the prosecution of the problem must also be the last option. This means that the need to go to court whether criminal or civil must come after information and prevention efforts

have failed or in the face of the consequent risk that a child has been or may be subjected to genital mutilation (Oloo et al., (2011).

The Banning of FGM Act of 2011 clarifies that FGM is unacceptable in Kenya. The law's passage represents a significant advancement in protecting and advancing the rights of women and young girls in Kenya. The regulatory system views it as a tool to take on a variety of offenders. The penalties for faulty legal systems are severe. Anybody practicing FGM faces a term of three to seven years in prison or a fine of around $6,000, including customary practitioners, guardians, experts, medical caregivers and even the person who provides the location or the blade. Anyone found guilty of hiring a person to conduct FGM bringing a young lady from overseas to Kenya to undergo FGM, or failing to report an FGM victim will also face similar penalties (Shell-Duncan et al., 2013).

Stark (2009) claimed that FGM intervention often occurs in an environment where the community prevail over the individuals. The individual must submit to the community's designs, needs and decisions. In this framework, the person who migrates is chosen by the extended family as responsible for achieving the objectives of migration. Therefore, the links continue to be maintained materially and emotionally (Stark, 2009). Thus it should be borne in mind concerning the practice of female genital mutilation that the family remaining in the country of origin exerts strong social pressure on the persons who have migrated. This pressure picks when they return home either permanently or on holiday. It is when the migrants return on holiday or permanently to their country of origin that the girl is usually subjected to the rite of passage. There is no specific age although girls are mutilated before adolescence in most cases. At the time of return, the girl is most vulnerable as even if the parents are not in favour of mutilation. The extended family exerts strong pressure to subject the returnees to the community's designs.

2.2.2.4. Girl-Child Education on Eradication of FGM

Since ignorance remains fundamentally abnormal in Kenya and the lack of fundamental education is a major factor in maintaining social stigma surrounding FGM as they relate to the rights and protections of ladies, regenerative well-being and sexuality. Girl child education is crucial in the fight to end FGM. Research by Cloward (2016) found that FGM undermines young women's

opportunities for basic education, keeps them from continuing their education, restricts their access to economic opportunities and directs girls' attention toward early marriages. Contrarily, although there are anti-FGM efforts, they often concentrate on supporting and encouraging girls' education. Men and boys should be equally educated about the FGM practice according to Karanja (2003).

Young women's training has enabled numerous networks to re-examine their values and attributes associated with the training in an accommodative increasingly unique and transparent manner. Different projects are coupled with various forms of training for this situation including cognitive preparation, expository skills, analytical thought, the development of awareness of human rights, morality, general well-being, reproductive and regenerative well-being (Leye et al., 2005).

There has been a need for a movement to encourage girl-child education in Narok County which has led to a decline in the number of girls dropping out of school. This has also gone a long way in deterring FGM in the county. For example, girls who leave rescue centers are given opportunities to access higher education i.e. secondary schools from which they can learn professions and training courses to help them pursue job opportunities and become independent.

Classes and workshops are carried out among the Kuria people community to fuse traditional correspondence tools such as drama, verse narrative, music and action as well as increasingly modern techniques such as PC-based Software and short messages from mobile phones. In comparison, networks-based instructive exercises use broad connectivity such as dramatization video and community radio to crusade against FGM. They use public figures to send evidence and messages about the consequences of FGM. Be it as it might, instructive activities with related data can arrive at all network meetings to preserve a strategic gap from false impressions and to promote intergroup exchange and program support (Wilson, 2013).

Efforts to improve women's social and economic status and education in communities can eradicate this practice. In cultures that represent a validated norm, FGM is practiced by followers of all religious beliefs and non-believers. When considering an intervention in these families it should be approached globally. For instance, Prazak (2007) claimed that the whole family nucleus targets both men and women. Although many men try to disengage and delegate responsibility to women, their role is fundamental as they are the ones who have authority in the family. Therefore, their role is decisive in making progress in eradicating this practice. Community members must

support families with sensitivity and without sensationalists otherwise we risk encountering negative repercussions and mistrust as observed by Prazak (2007). Despite all of these initiatives certain groups like the Maasai still have persistence rates of illiteracy because they place little emphasis on female education and prefer to marry off their young daughters at an early age in order to make money (KDHS, National Council for Population and Development, 2008).

Evaluation of the Alternative Rituals Method in Kenya Promoted the Eradication of FGM. For example, FRONTIERS population Council Valley founded in 2003 provides young Maasai girls escaping FGM and other cultural traditions such as early marriages with residential rescue homes. These rescue centers provide various programs such as preparation, instruction, counseling and promoting the reintegration process of these young girls into their families without the possibility of forced marriages or FGM (Chege, Askew, & Liku, 2010). Among the Maasai in Kajiado County, the YWCA has set up a rescue center that offers preparation to battle the shame on circumcision and bring issues to light about the negative impacts of FGM. In every one of the three zones, the YWCA has joined forces with the neighborhood schools, guardians, religious and network pioneers notwithstanding the ARP and salvage focuses.

Liku (2010) listed various measures to reduce the prevalence of FGM in the African set-up. According to the author condemning FGM from a position of ignorance or with arguments that the targets cannot share, will have no effect or will have the opposite effect as it may activate defense and isolation mechanisms. It may be interpreted as an attempt to destroy their culture. Only by starting from their justifications their concept of hygiene and beauty, their interpretation of health and illness, their scale of values etc. can FGM be avoided. The fact that FGM is a cultural tradition should not prevent us from maintaining that the practice violates universally recognized rights. Also Liku (2010) proposed to develop partnerships with communities and organize information meetings with people from these communities and awareness-raising meetings with the relevant authorities. The author also suggested developing partnerships (information, training and dissemination) with institutions and individuals who may be involved in the FGM detection process (Liku, 2010). Lastly, it is essential to provide psychological support to victims of female genital mutilation as well as establish a follow-up of the protocol through the domestic violence commission (Liku, 2010).

2.2.4 Impediments to the Fight against FGM

One main obstacle to curbing FGM is that it is profoundly ingrained in the traditional traditions of many FGM-practicing cultures. For non-medical reasons, the cultural practice of FGM female genitalia is generally a negative phenomenon particularly where culture assumes that FGM is the entry point for girls to femininity. MYWO (2008) found that female virginity in marriage is considered very significant by most cultural groups in Northern Sudan and only maintained by clitoridectomy and infibulations. This practice of FGM which is thought to have originated in Egypt is controversial because of its long and short-term adverse impacts on survivors.

Given that faith, style and popular media have been recognized as highlights contributing to the training. FGM as opposed to religious activity remains predominantly a social one operating through multiple religious' communities. Oloo et al. (2011) found that no religious writings affirm FGM.

For government statistics, 24% of ladies who were circumcised referred to different reasons such as social acknowledgement as the most important purpose behind circumcision. Different reasons referred to incorporate 'to save virginity until marriage' (16%) and 'to have improved social mobility (9%). FGM is a custom that achieves social personality and its FGM work is to characterize a gathering (ethnicity). Subsequently, it is accepted that evacuating such social practices would destroy the related culture in the long run (Banks et al., 2006). Be that as it may in circumstances where a young lady acknowledges to experience the training. It is undoubtedly because of a solid subject to convention and culture as opposed to educated assent. Njue and Askew (2004) set up that among the Kisii in Nyanza Province FGM is viewed as a significant soul-changing experience from a young lady to a lady who is regarded by the general public and considered as developed, dutiful and can do her job in the family just as in the general public on the loose.

According to Engelsma et al. (2020), the intervention of the law and fundamentally of criminal law prohibiting the conduct and adopting coercive measures must in all areas including this one be the last resort to be used in the face of the conduct that it is intended to prevent. With FGM communities face profound cultural differences between our basic beliefs and principles recognized in universal human rights, beliefs and traditions of those who practice them. Thus, we must remember that parents or relatives who practice and promote FGM believe it has beneficial

effects for the girl child as this has traditionally been the case in their culture of origin (Engelsma et al., 2020). This does not mean that the law and legal mechanisms to protect girls should be inhibited from dealing with the problem. However, it does mean that cases should be approached with special sensitivity and knowledge of the social reality when applying the law. Therefore, if the application of precautionary measures and the use of criminal sanctions should always be the last resort. In this case where information and prevention are the only effective solution to the problem, it is even more important not to lose sight of the fact that the application of criminal law and the judicialization of the problem must also be the last option.

2.5.Summary of literature review

FGM originated from early times. In Western nations England and the United States of America (USA), clitoridectomy genital surgery has been conducted for numerous uses including masturbation, nymphomania, delirium, sadness, epilepsy, and craziness. FGM has been rehearsed in every one of the world's land masses including Australia. However, the overwhelming majority disposed of it by observing that it filled no requirement and was detrimental to the well-being and violation of the young ladies' rights. For starters, by the fifth century B.C., FGM was rehearsed by Phoenicians, Hittites, Egyptians and Ethiopians (Magoha&Magoha, 2010).

In many African countries and the Middle East, FGM is common varying in degree of severity due to the social, cultural norms and belief systems of each group (WHO, 2005). FGM is performed in many ways including clitoridectomy, excision, and infibulations. Extraction is the removal of the clitoris and some or all of the minor labia; clitoridectomy involves the removal of the clitoral hood regardless of the removal of the entire clitoris and finally infibulations involve the removal of some or all of the external vagina as well as the stitching and reducing of the virginal cavity resulting into a tiny space for menstruation and urination. However, it is important to remember that the definition varies with the victim's age and that the various types of FGM are classified into different categories. There is strong proof of knowledge for regions where FGM remains a common norm.

In Africa, cases of excision are also predominant in countries such as Egypt, Mozambique, Botswana, and Lesotho. Infibulation is a transcendent standard in Somalia, Ethiopia, Sudan, Kenya, Nigeria, Mali, Burkina Faso and sections of the Ivory Coast. Although there is little data

accessible, it has been reported that Muslim populace drill FGM in the Philippines, Malaysia, Pakistan, Indonesia, Brazil, Mexico, and Peru (WHO, 2008).

Several ethnic communities in Kenya perform FGM with religion posing a contentious justification for the practice. Only 7% of the women polled in one Kenya Demographic and Health Survey study believed FGM was needed for their religion. Those who had already had circumcision were more likely to believe this. This information comes from a study conducted in 2008 and it was published in the journal Reproductive Health (DHS, 2008-09). However, while focusing on the Somali and Kisii ethnic groups in Kenya that had the largest percentage of women who had been circumcised, it became clear that two factors stood out. Among the Somali community the practice was widespread because of religion (Islam) whereas among the Kisii the practice was widespread because of culture rather than religion (Christianity).

The real reason why training remains extremely high is that 86.5% of women in the North Eastern region (home to the Somalis who exercise close-to-complete FGM and believe Islam mandates FGM) believe FGM is required by religion. This highlights the protection from eradicating FGM in certain groups (Population Council, 2009). Muslim women are more likely to have had their navels cut (44.4%) than Christian women (17.7%). Pioneers and religious organizations are actively working to eradicate FGM. There is convincing evidence that employing a religion based plan in such networks may be more effective than conventional methods (Population Council, 2009). There are various types of FGM including type I clitoridectomy, type II excision, and type III infibulations (WHO, 2005).

The incidence rate of FGM in Kenya has now been declining annually according to (KDHS). There was a great decrease from 35% in 2003 to an average of 27% among female respondents in 2008–2009. The study also showed that the practice continues to be more prevalent among older women with 15% of women between the ages of 15 and 19 engaging in it compared to 49% of those between the ages of 45 and 49. In other research conducted nationwide by KDHS in 2008–2009, 97.5% of women from the North Eastern part of Kenya had undergone FGM compared to 10% in Western Kenya. Contrary to Nairobi and the coast province 34% of the women in Nyanza province located in Western Kenya were circumcised especially in the Kuria and Kisii districts (DHS, 2008-09).

According to an analysis of every bit of data on FGM by the county, the context of Kenyan culture may be one of the main variables influencing the practice of FGM in the country. The prevalence of the practice is highest in the Somali group (97%), followed by Kisii (96%), Kuria (96%) and Maasai (93%). On the other hand, the Kamba (33%), Mijikenda (12%), Luhya (1%), and Luo groups (1%) have low rates of practice. Moreover, 31% of women in rural areas engage in the practice compared to 17% of women in metropolitan areas (DHS, 2008-09).54% of women without formal training or poor education levels are considered to have undergone FGM. Some research links the high prevalence of FGM to educational levels.

2.1 Theoretical Framework

The structural functionalism perspective and the Feminist theory will be used in this Study.

2.1.1. Structural - Functionalism Perspective

The structural-functional perspective contends that society is a dynamic system whose components interact to advance harmony and peace. Our routines in the workforce or the classroom shape communities as they create the social structure. Second, the methodology looks at the social functions that each system serves and the effects of any social pattern on other aspects of societal life. Auguste Comte, who highlighted the importance of social participation during rapid change is largely responsible for the structural-functional approach. Emile Durkheim, who contributed to the advancement of sociology at French universities also served as a foundation for his work. Another structural-functional dreamer was Herbert Spencer an English sociologist who lived from 1820 to 1903. Spencer (1896) compared society to the human body noting that just as the basic parts of the human body, the muscles, the cranium and the many internal organs work together to promote the existence of the entire organism so the same happens to social institutions in supporting the society.

The structural-functional approach allows sociologists to define and analyze their roles in different systems of culture. Merton (1957) extends our understanding of social roles by discovering that there are undoubtedly multiple functions in any social system, some more apparent than others. He separates the unrecognized and unforeseen effects of any social pattern between manifest functions, the known, the expected repercussions of any social pattern and latent functions.

Functionalists consider social systems as functioning to maintain and replicate them systemically and cohesively. Cultures offer a means of keeping societies together by exchanging the world's socially acceptable traditions, principles, norms, opinions and views that impact human actions. Social constructs such as rituals and traditions make a huge contribution to group cohesion but they may also make a detrimental contribution to culture.

This research's attempt to explain the prevalence of FGM from a position of social norms and how these practices influence behaviour and normalize it, makes this hypothesis crucial. Daily social interactions shape and influence behaviour while teaching and enforcing standards (Berger & Luckmann, 1967). This way, control over women's identities and bodies are normalized. The Maasai refer to FGM as a crucial rite of passage from a young girl to a respected woman. A circumcised woman is regarded as mature, submissive, aware of her place in the family and in society and has qualities that are highly prized in the group. Nonetheless, FGM negatively affects a child's development including physical injury and subsequent health issues which Merton (1957) calls dysfunctions. This social custom is connected to various specific socio-cultural views the majority of which are connected to regional perceptions of gender, sexuality, and religion. The functionalist's understanding of social difficulties positively relates to the social issues discovered. For instance, the culture of FGM demands stronger defenses against efforts to stop the practice. In response to FGM concerns, there is now a critical focus on the reproductive health of women and girls worldwide. In Kenya, FGM has assumed a leading position as a gauge of health development and advancement per the Sustainable Development Goals. Such attempts to abandon FGM activities demand that these techniques be integrated into the socio-cultural sense of the practicing population.

One of the drawbacks of this explanation is that it has been criticized for downplaying the role of individual behaviour and needing to account for social progress. From a functionalist point of view society and its structures are the main units of study. Individuals are essential only in terms of their place within social structures (i.e. Social status and location in social relationship patterns). Some opponents also take issue with functionalism's proclivity to assign needs to culture. They learn that society unlike humans do not have needs rather society is alive in the notion that it is composed of living beings. Functionalism minimizes the position of individuals making it less likely to consider

how individual actions might alter social institutions. Additionally, critics contend that functionalism fails to explain social growth because it emphasizes social balance and stability.

2.1.1 Feminist Theory

In the Netherlands, through the political and women's activist organizations she founded Wilhelmina Drucker (1847-1925) successfully campaigned for the vote and equivalent rights for women. The goal of women's suffrage was met in 1917-19. The historical backdrop of the rights of women is broken into three waves. The emancipation of women in the first wave alludes to an all-encompassing phase of the women's activist movement in the U.K. and the U.S. between the nineteenth century and mid-twentieth century. Initially, it centered on the promotion by their husbands of equivalent contract and property rights for women and the restraint of babble marriage and obligation for ladies (and their young people). The emancipation of women in the second wave refers to the surge of protests in the mid-1960s and lasted into the late 1980s. Researcher Imelda Whelehan argues that the resulting wave was a continuation of the earlier phase of women's emancipation like the U.K. and U.S. suffragettes. The rights of second-wave women have continued to exist since that moment and exist along with what is considered the emancipation of third-wave women. The rights of third-wave women began in the mid1990s arising as a response to the next wave's disappointments and a reaction to the continuous wave of reaction towards events and changes. The emancipation of women from the third wave aims to contradict or remain away from what it calls the basic definitions of the gentility of the second wave which (as they indicated) over-emphasize the encounters of white women of the upper working class. In quite a while for example in a Vindication of the Rights of Women by Mary Wollstonecraft women's activist speculations first formed ahead of time as in 1794 "The Changing Woman", "Aren't I a Woman" and "Discourse after Arrest for Illegal Voting" (Chodorow, 2011).

In the social verifiable and religious customs of numerous ethnic networks FGM is deeply developed. From the point of view of human rights FGM is dangerous and unmerited and just as an infringement of the dignity of the body (Baron & Denmark, 2006). Feminists claim that schooling is an uncaring form of sex that brings together alienation that raise concerning women's inequality. In Feminist theory, the attempt to play out a particular presentation is shown as a result of the overall load of behaviors and regularizing contemplations.

Mentalities are managed by assumptions about the consequences of a given action (Packer, 2005). The contemplations of Norm require social strain to perform or not to undertake a certain action. For example, the main individuals within the network communicate the various values on which these contemplations are based. The religious heads, neighboring supervisors and older town people by socialization and social cooperation feel compelled to pursue this knowledge.

Human action is ultimately created by cognizance and reason. The use of its effects on the characteristics of the screen actor and the development of knowledge in relation to the entertainer of the relationship between the training and its ideal outcome clarifies it. Within the network, the impression of others influences one's actions and method of getting things done. People have exceptional and one-of-a-kind qualities within a network or gathering. However, self-hood is socially established such as in socialization procedures and social participation letting people continue to characterize and reconsider themselves throughout their socialization procedures (Jenkins, 2014). Consequently, socialization plays a vital part in the production and strengthening of traits affecting people's behaviors for the rest of their lives.

The shift is known to be postponed because of FGM as its advocacy is firmly rooted in the way of life of the networks rehearsing it. Individuals try to tolerate and comply with the convictions their important local pioneers and promoters keep for example that young women should undergo FGM to become valued ladies within the network. A lot of ethical and societal norms were their fundamental leadership and behaviour which is affected by an individual’s life. Political and social norms remain closely related to the predominance of FGM in most African nations. The family is the smallest social unit just like the network is the most powerful advertiser and gatekeeper in FGM all over the planet.

The activist theory of women is important to the inquiry as it reduces the gender gap that has existed for quite a while. It promotes the freedom of sexual identity in a location with similar rights, problems and suspense. In this way, the theory promotes the rights of young ladies and women to the point that it involves FGM.

The drawbacks of this theory are that the growth of women feminists has created perplexity about the passable elements between the sexes. People cannot trust their Darwinian senses again rather they are sticking to new inter-sexual direct "women's activist" values since they are extraordinarily

terrified of being accused of being "chauvinist pigs" or "instruments of man controlled culture." The feminist hypothesis is that certain women's activist's ways of thought work on the premise that men and women are absolute. This is correct to the extent the activist theory about women has some utility when one talks of substance. However, as we learn about nature versus help, we learn that in addition to sustaining presently called epigenetics, it is not generally nature versus sustains in any way considerably more than anything like nature which indicates that science might equate to what we believe it is. This study would not use the theory of change because of the shortcomings of the feminist activist hypothesis.

2.1.2 Dynamics of Change

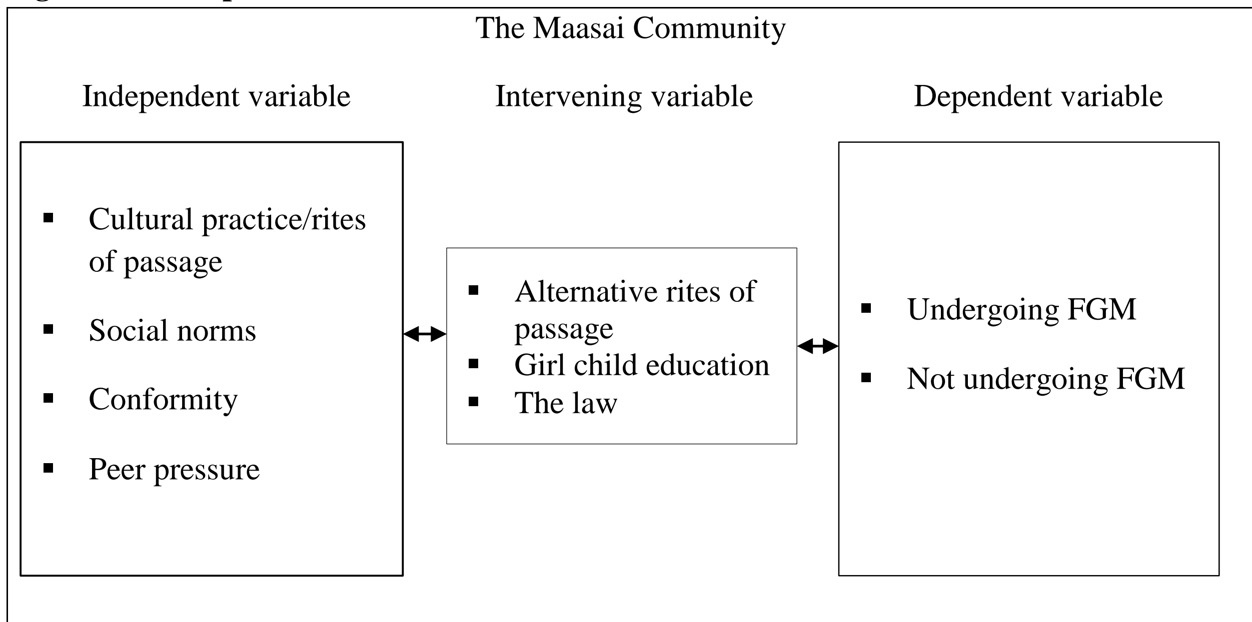
In an empiric analysis, Willig (1998) explained how the discursive construction of sexual behavior has consequences for practical experience by the appointment of the subject (Davies and Harré 1999). Willig even goes to the extent of offering suggestions for how to create new discourse spaces that can steer practice toward safer sex. Driven by their analysis, the writers go a little forward and say that the complexities of transition can be found in the interlacing discourse and counter-discourse spaces. Discourses should not be formulated as isolated meaning bubbles or are ever waterproof (Parker 1992). In other ways including such discourses which establish a separate discursive object by legitimizing or questioning it. For example, FGM / C may be built as a health risk within a medical discourse or as a prevention mechanism against sickness and misfortune within a more conventional discourse. Both discourses concern and build cause-and - effect relationships but in fundamentally different ways. The same people will use multiple and even conflicting speeches to defend excuse or criticize women's genital cutting. In some situations, new definitions are built and alternative practices are introduced in the attempt to harmonize these inconsistencies. In the background of this article we will address interventions to end FGM / C, for example alternate rites. This ritual instills children into the adolescence of women without the girls being cut an intervention to end FGM / C by harmonizing multiple experiences and preventing "ethnic clashes."

2.2 Conceptual Framework

The conceptual framework shows how the independent variables are related to one another. According to Henderson (as cited in Okaya, 2013), the conceptual framework has two major variables: the independent and the dependent variables. The independent form is the causality and

influence of the dependent one. The dependent variables rely on the independent ones (Kothari, 2004). This study intends to assess the factors influencing the persistence of FGM among Maasai of Maili 46 location in Kajiado West County. The conceptual framework shows a succinct explanation of the linkage between various variables that underpin the persistence of FGM among the Maasai community of Maili 46 location Kajiado West County. The independent variables entail cultural practices, existing interventions, impediments and social pressure, while the dependent variable being investigated is the FGM in Maili 46 location Kajiado West County. These variables are related to the study's objectives; these two aspects are the guiding factors in the development of the conceptual framework.

Figure 1. Conceptual Framework



CHAPTER THREE

RESEARCH METHODOLOGY

3.1Introduction

This chapter discusses the research methodology that was employed. This section included the following sub-sections: the study site, the research design, the unit of observation and analysis, the target population, the sampling strategy and sample size, the data collection techniques, the research tools, the data analysis and ethical issues.

3.2Site Description

The study site was Kajiado West County, where the Maasai are the most inhabitants, and the size of the area is 21,901 square kilometers. Kajiado West County borders Nairobi, Narok, Nauru, Machakos, Makueni, and Taita-Taveta counties, extending to the Tanzania border. The estimated population is 687,312. Kajiado North, Central, South, West and East form five constituencies. Maili 46 was found to be the appropriate site for the study simply because its far removed from the influence of urban life and modernity. The Maasai here are still conservative and practice FGM hence could give a true picture for the study.

The area depends on boreholes constructed by the government and AMREF. It is located in Iloodokilani ward Kajiado West Sub-county which is 2010.6 sq. Km has a population of 11,832 and 3090 households (GOK, 2018). Maili 46 is 80 Km from Nairobi. To access the area, one should use Nairobi-Namanga road, approximately 1 hour and 44 minutes' drive to Kajiado town. From Kajiado town, Maili 46 is in the west, which is one-hour drive due to poor roads in the area.

3.3 Research Design

A *research design* is an outline that guides how data should be collected and analyzed in a given research study. The investigation utilized a descriptive survey study design. According to Mugenda & Mugenda (2003), a descriptive design explains the qualities and behavior of a phenomenon as well as how it manifests itself. A research design provides an organization considered critical in the data collection and analyses to give meaning to the studied phenomenon and findings. Through the use of descriptive survey research design, research findings were

prudently done and the researcher got a chance to collect data effectively, summarize and give it meaning using all the study variables which act as a guideline.

3.4 Unit of Analysis and Unit of Observation

3.4.1Unit of Analysis

The entire entity being researched is included in the analysis's unit. The factors that affect the recurrence of FGM were the study's unit of analysis.

3.4.2 Unit of observation

Unit of observation is basically the items measured or studied in a research. It is a subset of the unit of analysis. In this study, the unit of observation was the household heads in the sampled households.

3.5 Target Population/primary respondents

Target population entails a group of people, items or objects under the study upon which the sample size is derived from (Mugenda and Mugenda, 1999). According to GOK Integrated plan (2018), Kajiado West constituency had 25,232 households, Iloodokilani ward had 3090 and Maili 46 had 102 households.

3.6Sample Size and Sampling Techniques

3.6.1Sample Size

Sample size refers to a subset of the whole population and it should not be too small or large for purpose of accuracy (Kothari 2004). The sample size was 102 households' heads who were determined by using a sampling formula based on Yamane (1967) and Israel (2009) as indicated below;

$$n = \frac{N}{1 + N(e)^2}$$

$$n = \frac{138}{1 + 138(0.05)^2}$$

Where n = sample size

N = Target population (138 households)

e = acceptable margin of error of 5%

n= Sample size (102)

n=138/1+138(0.05)2

n=138/1+138(0.0025)

n=138/1+0.345

n=138/1.345

n=102(Sample size)

3.6.2 Sampling Techniques

A Systematic sampling and Purposive sampling were used to select the respondents. In a descriptive research, a sample size of 10-50% is acceptable (Mugenda&Mugenda, 2003). Systematic sampling was used in the study to select primary respondents comprising of 102 household heads. This method is the simplest and most appropriate when the researcher seems to have a specific target population and key informants were chosen through purposive sampling. Here the, the researcher chooses or assesses potential interview subjects.

Two sampling procedures were employed in this study: -

3.6.2.1 Purposive sampling

This was used to select key informants who had in-depth knowledge about FGM practice and the Masaai community.

3.6.2.2 Systematic sampling

Using this technic and in the absence of a list of respondents, I interviewed the 1st and every 3rd Household head in the Masaai Manyatta in Maili 46.I found out that every Masaai Manyatta had At least three (3) and above household heads (the practice of polygyny is widespread) so this process was repeated until the desired sample was achieved.

3.7 Methods of Data Collection and Instruments

The term "methods of data collection" refers to the tools and procedures used to collect data such as paper questionnaires or computer-assisted interviewing techniques. Case studies, checklists, interviews, findings, surveys, and questionnaires are some of the approaches used to collect data

3.7.1 Household survey

A *survey* is a data collection method focusing on a pre-defined group of participants to get insights into the studied variables. A household survey was used to collect quantitative data from primary respondents comprising household heads. A structured questionnaire was used on only selected respondents to collect quantitative data. The questionnaire is very effective because it is cheap and easy to administer especially when the participants are many.

3.7.2 Key Informant Interviews

An interview is a data collection method which collects in-depth information concerning feelings, experiences and opinions. Qualitative data was collected using in-depth interviews. Interviews help a researcher to gather more information from the respondents and get diverse opinions. 10 key informants, including 2 male village elders, 2 female village elders, 4 area authorities (D.O., Chiefs and Sub chiefs), and 2 traditional "surgeons," were interviewed using an interview guide. Through the use of the interview method, expert knowledge was gathered.

3.7.3 Document Review

Document review is a method of gathering secondary data from books, peer-reviewed articles, documentaries, magazines and websites in relation to FGM. This was presented in chapter two under the theme of the empirical literature. Secondary data was also used in the discussion section for the data collected and analyzed. A checklist of relevant sources was developed to guide the review. Some of the documents to be reviewed include Children's Act. (2001) and Kenya Demographic and Health Survey (1998, 2003, 2008 & 2014).

3.8 Instruments of Data Collection

3.8.1 Key Informant Interview Guide

An interview guide was developed to enable guide interviewer in conducting interviews. Organized, semi-structured, and unstructured interviews are the three main types of interviews each with a slight variation from the others.

3.8.2 Questionnaire

The respondents were presented with a set of open questions and answers. Questionnaires were meant to obtain information from a large number of respondents within a short period of time. It gives the respondents a sense of anonymity and has an objective approach and therefore has no prejudice arising from a personal characteristic as an interview(Owens,2002). It’s designed to

captures the demographic characteristics of the respondents and then divided into the main areas of investigation.

3.9 Validity and Reliability of Instruments

3.9.1 Validity

If an instrument tests what it was designed to test, it is said to be valid (Orodho, 2004). The researcher conducted a pilot study with peers to validate the tools used in the research to increase validity. The feedback was used to enhance the tools that were employed.

3.9.2 Reliability

This is the ability of the research method giving consistent stable results using same method. The results are expected to remain constant when conducted several times (Golafshani, 2003). Reliability means the replication of the study findings done consistently using same method and results should be similar. A pilot study of 10 respondents was done and the respondents were not included in the final data collection. Using data from the study's main informants and recipients in addition to secondary sources dependability was guaranteed.

3.10 Ethical Considerations

Ethics in research refers to the moral principles that govern the behavior of a researcher during data collection. The researcher adhered to research ethics for purpose of coming up with valid findings. Permits from various authorities were requested for so that the researcher could be allowed to carry out the study. Secondly, before administering the questionnaires and conducting interviews, informed consent was given to make respondents aware of the purpose of the study. Confidentiality was guaranteed and this was done by ensuring that questionnaires did not provide any place or indicate personal names or any other information that could harm the participants. I therefore declare that no work of other authors has been used without acknowledging them.

3.11 Data Analysis

After data is gathered, there are several steps in data analysis. Using the Statistical Package for Social Sciences (SPSS), the questionnaires are modified, their accuracy verified and they are then coded. Quantitative data was generated using descriptive analysis and displayed using tables and percentages. Key informant qualitative information was used to supplement the quantitative information from the primary respondents.

CHAPTER FOUR

4.1 DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1.1 Introduction

The research, introduction, description and discussion of the data obtained from the study are presented in this chapter. In the Maasai analysis of Maili 46 location in Kajiado West County, the chapter aims to demonstrate factors that influence the persistence of FGM. Tables and percentages were used to assess and illustrate the response frequencies.

4.1.2The respondents' demographic characteristics.

The following factors were taken into account by the study while describing the respondents' backgrounds. Gender, marital status, age, and educational attainment were the items. The demographic data for the research area is formed by background information as well.

Adults have more experience of Masaai culture including FGM so they were the most appropriate

to account for the persistence of FGM.In this study,I deliberately did not seek to interview children as it would be unethical.

4.1.3 Gender

The goal of the study was to categorize the participants by gender because of how the people perceived FGM as a topic and gender was crucial.

Table 4. 1: Gender

Gender	Frequencies	Percentage
Female	78	76.5
Male	24	23.5
Total	**102**	**100.0**

Table 4.1 indicates that female respondents were 76.5% while men were 23.5%. The study show that females were the majority respondents. During interviews more female were found at home than men who were usually found around the markets and or gone grazing.

4.1.4 Age

The age distribution of the respondents was; 18 years and above 18-22, 23-27, 28-32, 33-37, 38-42 and 43 above years.

Table 4. 2: Distribution of the Respondents by Age

Age	Frequencies	Percentage
18-22	23	22.5
23-27	33	32.4
28-32	17	16.7
33-37	16	15.7
38-42	6	5.9
43-47	4	3.9
48 and above years	3	2.9
Total	**102**	**100.0**

Table 4.2 indicates that 22.5% of the respondents aged 18-22 years, 32.4% of the respondents aged between 23-27 years, 16.7% aged between 28-32, 15.7% aged between 33-37 5.9% aged between 38-42, 3.9% aged between 43-47 while 2.9% aged above 48 years.

4.1.5 Level of Education

The study sought to determine the educational level of the respondents. The respondents were asked to select their level of education from the items provided. The items options in this item were; None, Primary education, Secondary education and College/university. Education is important because it influences the perception of respondents on the issue of culture and FGM.

Table 4. 3: Distribution of the respondents by education level

Education Level	Frequencies	Percentage
None	7	6.9
Primary	79	77.5
Secondary	12	11.8
College/university	4	3.9
Total	**102**	**100.0**

Table 4.3 indicates that 6.9% of the respondents had no education, 77.5% had primary school education, and 11.8% had secondary education while 3.9% had college/university education.

4.1.6 Marital Status

The respondents were asked to indicate their marital status. The items provided in this study were; married, single, divorced/separated and widowed. Marital status is impacted by the cultural practice of FGM.

Table 4.4: Distribution of the Respondents by Martial Status

Marital Status	Frequencies	Percentage
Married	63	61.8
Unmarried (women)	21	20.6
Divorced/Separated	6	5.9
Widowed	12	11.8
Total	**102**	**100.0**

The findings as shown in the table 4.4 above indicates that the married respondents were the majority with 61.8%, single with 20.6%, divorced with 5.9% while the widowed with 11.8%.

The majority who are the married were the household heads.

4.1.7 Current Status of FGM Practice in the Area.

The cultural practice of FGM is practiced among the Maasai community despite the heavy measures the government has put in place to stop the practice. To determine the current status of practices associated with FGM, the respondents were asked if FGM has increased or decreased in the recent past (5 years).

Table 4. 5: Current Status of FGM Practice in the Area

FGM Status Quo	Frequencies	Percentage
Decrease	38	37.3
Increase	64	62.7
Total	**102**	**100.0**

Majority of the respondents (62.7%) confirmed that the FGM is still being practiced privately with majority of the circumcisers not known by the government and the minority said it’s not rampant which is (27.3%) as shown in Table 4.5

4.1.8 Current Number of Women who have undergone FGM in the Area

The study inquired from the female respondents those who have undergone FGM. The number of women who have undergone FGM is reported to have increased in recent past due to cultural pressures among the community.

Table 4.6: Current Number of Women who have undergone FGM in the Area

women undergone FGM	Frequencies	Percentage
Undergone FGM	63	80.8
Not undergone FGM	15	19.2
Total	**78**	**100.0**

Majority of the respondents (80.8%) confirmed that they have undergone FGM and (19.2%) not undergone through FM as shown in Table 4.6.

4.1.9 Cultural practices that contribute to the Practices of FGM.

Cultural obligation and expectation that FGM is a rite of passage and community fulfillment is an assumption rooted in the Maasai community. The study was designed to identify the cultural drivers of FGM in the location. Both male and female are involved in the rites of passage which is very important in the Maasai culture. The male Enkippata is the senior boys transition to the next age set then "Emiratta" Circumcision which is done between 12-17years organized by the fathers, 'Enkima" which is marriage is the next stage.

Girls from the age of 9 years go through FGM ready for marriage, doing house chores and raring of children. Only circumcised men marry and marry girls who are circumcised because that is when they are considered mature and ready for marriage. Even small girls of 9-13years get married to men of over 50years as long as they can pay bride price which is considered as a source of wealth. At this point the women are considered clean and can handle foods, drinks and attend marriage ceremonies and other rites of passage in the community.

4.1.10 Preconditions for Marriage.

In many cases, marriage was the excuse either for cutting a young uneducated girl or for fathers to take advantage of the bridal price of their daughters.

The pain endured during circumcision whether of a child is conceived as desirable and a crucial part of the Rite of passage by the community. The same belief calls for the chastity of married women in situations where husbands often mind cattle for weeks on end. This coupled with a

certain lack of belief in the willingness of women to exercise control over their sexual desires and legitimizes a treatment intended to suppress sexual appetite.

4.1.11 Circumcision as a rite of passage.

From girl to womanhood, this is done without anesthesia or surgical equipment. The victims are left with physical scars and psychological and mental trauma. Those who did not willingly undergo the process are ambushed by family and elders at night held down and forced to undergo the process. Some girls die while undergoing this mutilation due to complications caused by lack of hygiene. The process also presents complications during child birth for some women.

Girls who have undergone through FGM are considered mature, clean and can handle food, drinks, attend ceremonies in the community and also have a sense of belonging to the community.

4.1.12 Source of identity.

This is a source of respect from family and community for girls and women who have undergone FGM. As a deeply-rooted and revered tradition, it was a norm for women who had undergone the process to form groups or caucuses with those whom they went through the circumcision. This resulted into alienating the few that may have chosen not to undergo the process and those yet to undergo circumcision.

4.1.13 Social sanctions for uncircumcised women.

They are disrespected and given derogatory names “enoto”. Due to their status, there is an automatic conservativeness by men to marry uncircumcised women. The respondents were asked to indicate if these traditional beliefs were the major influence of FGM.

Cultural conservation is important for the future, but some cultural practices are harmful as such are associated with rites of passage and ceremonies involving organ mutilation. This practice affects the health and social being of the community. Despite the ongoing awareness creation and mobilization, FGM practice has persisted as indicated in the findings where men are still conservative on marrying uncircumcised women. The Rite of passage to womanhood and FGM being a source of identity has led to persistent underground practices.

Jones (2000) states that FGM practice has impacted not only the cultural diminish but also the demography of the girl child through low education levels and exposure to health risks. The findings confirmed by WHO (2008) state that FGM is of cultural significance and is seen to be preserved because of the sanctity of the exercise and matrimony institution of the community.

The combination of the practice with matrimony has deep roots and cannot be abandoned easily.

Table 4. 7: Cultural practices that Encourage persistence of FGM

Cultural Practices on FGM						
	Yes (n)	**%**	**No (n)**	**%**	**Total (n)**	**Total (%)**
Rite of passage from girl to womanhood	89.00	87.3	13.00	12.7	102.00	100.00
Source of identity for women, earns respect from family and community	78.00	76.5	24.00	23.5	102.00	100.00
Social sanctions for women who haven't undergone FGM – disrespected and given derogatory names (emorata)	73.00	71.6	29.00	28.4	102.00	100.00
Conservativeness of men not to marry women who haven't undergone FGM	82.00	80.4	20.00	19.6	102.00	100.00

Table 4.7 shows that most respondents (87.3%) were convinced that the Rite of passage from girl to womanhood influenced FGM practice. In comparison to 12.7% that said no. 76.5% confirmed that undergoing FGM is a source of identity for women and family respects them while 23.5% said no.

71.6% agreed that there is a social sanction for uncircumcised women who are normally disrespected and given derogatory names while 28.4% denied that. Most respondents (80.6%) believed that the conservativeness of men to marrying uncircumcised women is still very common which is a blow to the fight against FGM and 19.4% said no.

4.1.14 Traditional Beliefs Influence on FGM

Some of the traditional practices include; Rites of passage from girl to womanhood, Source of identity for women, earning respect from family and community, Social sanctions for women who haven't undergone FGM that is disrespected and given derogatory names and conservativeness of men not to marry women who haven't undergone FGM. It is clear that traditional beliefs has an influence on FGM.

Table 4. 8: Traditional Beliefs

Factors to Consider	Frequencies	Percentage
Yes	91	89.2
No	11	10.8
Total	**102**	**100.0**

Table 4.8 shows that majority of the respondents (89.2%) agreed that traditions or culture influence FGM practice while 10.8% denied that traditional beliefs influenced FGM practice.

4.1.14.1Traditional Beliefs

4.1.14.2 Patriarchy; In the Maasai community, a council of elders are responsible for dispensing law and maintaining peace between the members of the community; this includes settling disputes and determining fines or compensation during disagreements. The council was predominantly constituted by men who are elderly warriors from within the community. The exclusion of women from the decision-making process further aggravated the fight to end FGM. A society centered around men only viewed women as subordinates with specific roles to play, such as cooking, cleaning, fetching firewood and taking care of the children. Upcoming generations did not question the deeply embedded tradition since the community was attached to value and respect only those who had undergone circumcision.

4.1.14.3Rites of passage; The Maasai believe in rites of passage from childhood to adulthood for both boys and girls. Both genders go through circumcision as a rite of passage. Men who want to join the council of elders go through more initiation rites and training by a selected group of elders. This ceremony is deeply rooted and revered in the Maasai culture; those who go through this process are regarded highly within the community. Those who do not go through the same process are despised and considered outcasts by the community and immediate and close family members. Leadership or other positions within the community were only given to individuals who were circumcised.

4.2. Influence of Social Pressure by the Community

Social pressure is determined by collective movement from one stage to another. Nobody is willing to escape it for fear of being socially isolated.

The second objective was to ascertain how social control affected the persistence of FGM. WHO (2010) asserts that numerous family members, most frequently mothers, dads, grandparents, and aunts, made the decisions and enhanced the procedure of FGM, mostly in Gambia and Senegal. These choices are made in a setting characterized by intense social pressure and high expectations for adherence to the FGM practice. The survey asked if social influence impacted the number of women who had FGM to get the respondents' opinions on the subject. Important resource persons were questioned about the role of social influence on FGM.

It was recorded that girls normally meet to discuss how to undergo FGM. When the interviewees were asked if the girls' parents were aware if such meetings were being held, they said that the affair was communal and almost everybody in the community always knew. It was indicated that women in the community must undergo FGM before marriage and that relatives were key players in the organization of the FGM ceremony.

The collective argument states that men's preference for a wife hinders cubing FGM and greatly influences the FGM practice according to the women elders. Dorkenoo (2004) state that the practice is rooted in the culture and is less affected by religion or external intrusion because of its significance to its community. This has affected the choice of intervention because of the interaction with other major cultural practices like marriage. According to Gruenbaum (2006), some respondents view FGM as social oppression and physical mutilation of women and stopping the practice is an enhancement to the status of the women. The women feel oppressed, but it is a culture they cannot do without. They endure much pain but have to endure because of culture, as stated by the women rep of the area.

4.2.1 The Influence of Social Pressure on FGM practice

4.2.2Traditional elders.

The elders are the directors of cultural practice in the community. They bless or curse cultural practices by leading in the rites of passage across the generations. FGM is a cultural practice that the cultural elders lead. Cultural elders are key to the alternate rites of passage into femininity that requires "orkuaakng'ejuklemurataoontoyie," or, "a modern girls' promotion culture," in which the cut is replaced by pouring fresh milk over the thighs of a child. The gathering of the elders was more than a message about abandoning circumcision; it was an "orkuaakng'ejuk" blessing.

There is pressure on all Maasai youth whether male or female to receive the blessings of the elders.

4.2.3 Peer Pressure:

The Seclusion of two weeks serves as a rehearsal of the rite (circumcision). This brings together eager young girls in Seclusion (camp) for two weeks where they undergo conventional teachings about their potential positions in society as women, parents and adults. Educating girls about their personal well-being, reproduction, grooming, coping skills, self-esteem and peer pressure control was also possible. This procedure is like a traditional rite except the genitals are not removed (120-129, Chege 2001.)

The girls stay inside during the Seclusion and can only be visited by past initiates who may have witnessed the very initial or the replicated one. This involves parents, neighbors and acquaintances or female relatives. The role of a sponsor or "godmother" is given to a woman who is either an aunt or a neighbor. She ensures the girl gets an education in family life and knows it. The two-week ceremony concludes with a "graduation" on a chosen "coming of age" day where figures of faith, politics and government are invited to deliver speeches. (2001 Chege, 90). That girls of the same age move from one stage to the next as a group. Therefore, peer pressure is strong that nobody is likely to escape or not do what their age mates do. There is also peer pressure among parents of the girl of the age to be circumcised. Each parent is under the pressure of other parents and society at large to perform the FGM on their daughters which is done collectively. So there is pressure on each parent to move along with others.

4.3 Existing Interventions on Reduction of FGM Practice

The third objective was assessing and evaluating existing interventions that addressed the issue of FGM. According to WHO (2010), some of the existing interventions included;

4.3.1. Health education interventions.

Some health initiatives have been seen as potential solutions for improving the health of women and girls living with FGM including screening, detection and treatment of complications of FGM. A number of high-income countries have recognized the need for specialized expertise in treating women with FGM such as defibrillation during pregnancy or in the case of type III FGM. Specialized clinics, treatment guidelines, educational tools and classes have been added. However, considering the learning opportunities available, research on understanding of education and attitudes of caregivers, medical students about FGM revealed a lack of awareness of the prevalence, diagnosis, and management of FGM. There was also evidence of difficulties in properly classifying FGM according to the WHO classification.

4.3.2 Early counseling

The antepartum period, especially for young girls was used before FGM activities to try and voluntarily change the girls' mind about undergoing FGM. In order to promote collaboration, therapy, treatment and prevention FGM is a topic that needs unique cultural skills. Many healthcare providers do not have any prior background in the area and would benefit from further preparation. The research in Mali46 included a four-day instructional program on FGM and its problems linked to health. The curriculum provided IEC exercises, clinic wellness talks and visual

aids for individual client appointments. To simulate counseling, role-playing was used. The entities doing the research oversaw the preparation.

4.3.3 Law enforcement

Government and international security agencies', use of law enforcement to stop FGM practices w has actively reduced the vice due to the prose circumcision of the major players. With the help of social workers from NGOs, people practicing FGM were reported to the area Chiefs. The chief also confirmed that whenever they get any information, they sent the administration police to arrest the culprits who still practice FGM and both the circumcised and the persons to be circumcised are arrested.

The major existing interventions were anti-FGM policies implemented by several arms of government including security, health and culture. Health education (school programs & NGOs) on FGM programs especially at the primary level on anti-FGM were popular though there were no proper monitoring tools to assess the impact. Early counseling in the antepartum period provided by some of the humanitarian organizations in the region to the rescued girls at the centers was preferable to allow the victims to reconsider the consequences of the circumcision. Use of force helped reduce the number of practitioners thus reducing the practice as the results in table 4.9 show.

According to Waritay & Wilson, 2013, girls will not generally be interested in FGM with the development of alternate rites of passage to maintain the cultural element of the ceremony. However, the recommendation is restricted to most cultures where FGM is connected with the rite of passage as in the Maasai culture.

"According to one of the key informants, majority of the anti-FGM NGO's have conducted intensive education on the health risks of FGM and also provide alternative rites for the community to reduce the practice".

Table 4.9: Existing Interventions

Institution/Organizations	**Frequency**	**Percentage**
Health education (school programs &NGOs) on FGM	37	36.3
Early counseling in the antepartum period by NGOs	19	18.6
Force by security agencies to stop FGM	46	45.1
Total	102	**100.0**

4.3.4 Eradication of FGM.

National and international organizations have been actively involved in promotion of eradication on FGM as part of community development and enhancement of socio-economic development. The respondents were required to select from the list provided the type of institution or organization that have been seen, established programs or projects in the community that are associated with eradication of FGM. The options provided in this item were; County government, NGOs and CBOs.

According to the Ministry of Culture and Sports, involvement of security and capacity building of area leaders has yielded positive results in reducing FGM practices in the area. Institutions have been developed and mandated by the government both National and County to deal with eradication of FGM.

Some humanitarian NGOs have established rescue centers in Kajiado like Helga Maasai girls rescue center, AIC girls 'primary to help girls who have undergone the practice but also save those who are being pushed to undergo the circumcision and early marriages. These NGO have helped reduce the impact of the practice while educating the community on the negative effects of the practice on the health and social life of the victims.

The county government through the initiative by the County first lady, have started programs through the ministry of health to educate women on the negative impacts of FGM while also increasing community social workers to monitor and help victims of FGM. These initiatives have yielded positive results with a significant reduction of cases of FGM reported in the last three years as compared to the past.

The challenges identified from the suggestions of the respondents on the interventions by the religious groups on the issue of FGM included; social pressure which included peer and parental. This kind of pressure ensures that girls voluntarily undergo FGM in order to fit in the society despite the risk. The fact that men prefer women who have undergone FGM is also a huge setback to the fight.

The success in combating FGM will be a multi-institutional commitment complemented by a proper creation awareness and advocacy. Community should be effectively informed on the negative impacts of FGM which surpasses cultural conservativeness surrounding the practice.

Institutions like the Ministry of Health (County), Humanitarian Non-Governmental Organization and Local administration have impacted a lot on the fight against FGM in the region. This is attributed by the presence of several organizations in the area working with the community on reducing the practice of FGM. The survey listed several of the organizations engaged in the battle against FGM including the Hope Foundation for African Women (HFAW) whose key goal is to eliminate gender inequality by economic equality, gender activism with FGM as a focus, through the Common Education Model, the UN (WHO) and many others, to support sexual reproductive health and advance human rights in Kenya.

Table 4. 10: Eradication of FGM by institutions/Organizations

Institution/Organizations	Frequency	Percentage
Ministry of Health (County government)	35	31.4
NGOs	44	40.2
CBOs	11	6.9
Total	**102**	**100.0**

Table 4.10 indicates institutions that are involved in the eradication of FGM in Kajiado County. The ministry of health of Kajiado County government had 31.4%, 40.2% were the NGOs while 6.9% were the CBOs. This is well documented by WHO 2010 that shows the majority of programs and trainings that are being initiated by humanitarian organizations both local and international.

4.3.5 Knowledge of Laws on FGM

The constitution and policy changes surrounding FGM have been motivated by a rise in global questions about girls' right to FGM. The major law regulating FGM in Kenya is the Ban of FGM Act, 2011 (FGM Act 2011), which came into force on 4 October 2011. It is a federal act that, regardless of the age or status of a girl or woman, criminalizes all types of FGM. Legislation is in effect to ensure that in the hot areas the operation is managed and minimized. Three women in Meru were arrested in September 2019 and fined kshs.200, 000/= each for performing FGM and this was broadcast by the newspapers. The research aimed to assess the effect of the new constitution and the extent of understanding of the FGM law by evaluating a collection of comments presented during the study by respondents.

Table 4.11 indicates the analysis of statements on the influence of constitution and legislation on FGM and the level of awareness as displayed by the respondents. When the respondents were

asked if they supported prose circumcision of family member caught practicing FGM, 63.7 % said yes while 36.3 said no. The respondents were fully aware of the legislation and consequences of FGM. The fact that majority of the respondents strongly agreed shows that legislation has helped in reduction of FGM practices in the area which is a big concern to the government and NGOs involved. WHO 2010 states that legal ban of FGM led to underground practices of FGM by unqualified circumcisers' because several qualified Circumcisers stopped practicing FGM because of fear of prose circumcision.

The Universal Human Right Declaration protects the right to freedom of the thought, conscience and religion which is violated by the practice of FGM. An argument brought forward by Hughes in the WHO 2010) states that FGM practice is deeply rooted in the cultural practice which has adverse impact on women in case FGM is made as a form of violence against women.

Table 4. 11: Knowledge of Laws on FGM

Knowledge Laws on FGM						
	Yes (n)	**%**	**No (n)**	**%**	**Total (n)**	**Total (%)**
Do you support prose circumcision of family members practicing FGM	65.00	63.7	37.00	36.3	102.00	100.00
Are you aware of the existing legislations against FGM	71.00	69.6	31.00	30.4	102.00	100.00
Are you aware of the consequences of practicing FGM	69.00	67.6	33.00	32.4	102.00	100.00
Have these interventions led to decline in FGM in the area	32.00	31.4	70.00	68.6	102.00	100.00

Table 4.11 indicates the analysis of statements on the influence of constitution and legislation on FGM and the level of awareness as displayed by the respondents. When the respondents were asked if they supported prose circumcised of family member caught practicing FGM, 63.7 % said yes while 36.3 said no. The respondents were fully aware of the legislation and consequences of FGM. The fact that majority of the respondents strongly agreed shows that legislation has helped in reduction of FGM practices in the area which is a big concern to the government and NGOs involved.

4.1 Impediments in the Fight against FGM

The fourth objective aimed at establishing the impediments limiting reduction of FGM. Most of these barriers are global while others are local. According WHO (2009) indicates that cultural practices are the major impediments in the fight against FGM. Some of these impediments included;

4.1.2 Migration

The Maasai are a semi-nomadic and pastoral community. They live by herding their cows and goats. Their tradition of moving from one place to another in search of pasture is a major hindrance in the fight against FGM. Moving from one place to another makes it difficult for government and private organizations charged with the mandate of educating and eradicating the practice to track their progress or to fully enforce the laws against FGM. It also makes it difficult for the agencies to assist the young girls who may be in need of medical assistance after undergoing the procedure.

4.1.3 High level of illiteracy

The Maasai culture is centered on the male child. He is given the first opportunity to access to education and inheritance while the female counterpart is married off to wealthy Moran's at the mere age of 9. Once married off they are expected to be mothers and housewives to their husbands. The high level of illiteracy is a major contributor to the sustained practice of FGM. Lack of knowledge on the dangers and consequences of the practice are also a reason behind the continued practice. The male Maasais' who go to school leave home to the city for white color jobs leaving the uneducated wives at home.

4.1.4 Poor road network

The poor road network has been a major impediment to the fight against FGM for both the security agencies who are supposed to enforce the law and the private government institutions that are mandated to educate and sensitize the public on the negative effects of FGM. Reaching the victims in time before the procedure is done has been greatly affected. Reports may be made to the authorities in time but access to these remote locations is a challenge to law enforcement authorities.

4.1.5 Low access to modern services

Lack of access to modern services such as internet, clinics and hospitals, communication services also decelerates the fight against FGM. Those in remote areas cannot access educational literature and other learning material that educate them on the negative effects of FGM. They cannot also access forums or avenues through which assistance can be obtained for those who do not want to undergo FGM. Access to urgent medical services for those who have complications after undergoing FGM is a key factor to the rise of deaths during the circumcision ceremony.

Table 4. 12: Impediments in the Fight against FGM

Cultural Factors						
	Yes (n)	**%**	**No (n)**	**%**	**Total (n)**	**Total (%)**
Strong cultural practices	93.00	91.2	9.00	8.8	102.00	100.00
High level of illiteracy	78.00	76.5	24.00	23.5	102.00	100.00
Low access to modern services	69	67.6	33	32.4	102.00	100.00
Migration	61.00	59.8	41.00	40.2	102.00	100.00
Poor road network	73.00	71.6	27	28.4	102.00	100.00

The results in Table 4.12 indicate that most respondents strongly agreed that marriage (91.2%) is highly affected by FGM, while 8.8% said no. This is echoed by WHO 2010 report that "According to the Maasai culture, one has to go through the rite of passage to be accepted that you are now ready to be married. Only women who have undergone FGM are regarded with respect so FGM is a source of identity for women. They also believe that only circumcised women earn respect from family and community which is a source of identity. A social sanction for women who have not undergone FGM is disrespected. They were given derogatory names like emorata, meaning "unundergone FGM woman “meaning it was a major hindrance as depicted by the 12.7% of the respondents confirming that in table 4.7 The fact that it is difficult to convince men to marry women who have not undergone FGM was strongly agreed upon by the majority (34%) of the respondents.

Wariaty& Wilson 2013, states that FGM in the Maasai community is a blood offering to the ancestors; thus it is rooted in the core culture of the community hence difficult to get rid of.

The girl child in the Maasai community is discriminated against regarding education. Their role is to give birth and take care of the family. The community at large believe in marrying off their daughters to the rich Morans who can pay many herds of cattle to the family as early as nine years old. A Maasai with many wives, children and herds of cattle was considered prominent in the community because of this even the Moran's with lots of cattle never went to school and this was confirmed by 76.5% yes and 23.5% no.

Due to large numbers of cattle, the Maasais' were forced to move from one place to another in search of pasture and water. They lived in circular temporary homes fenced with thorn bushes and cow dung houses constructed by their wives which were to be abandoned when they lacked water and pasture for their animals. This was confirmed by 48% yes and 54% no.

According to UNESCO 2018, FGM is tied to the cultural practice of Rite of Passage which are the Enkipaata, Eunoto and Olng'esherr. The three interrelated male transient rites of the Maasai community are Enkipaata, Eunoto and Olng'esherr:

- Enkipaata is the induction of young people who lead to initiation.
- Eunoto is the shaving of morans, which leads to the paving of the way for age.
- Olng'esherr is the meat-eating event that marks the end of moranism and the beginning of seniority.

The rites of passage are performed mostly by young people between 15 and 30 in the Maasai culture but women are often active in some activities. Under each rite there is a significant involvement of body piercing, FGM or marriage. Only Eunoto is where women are circumcised and married to their warrior counterparts. This finding is confirmed by WHO (2008), which states that FGM is of cultural significance and is seen to be preserved because of the sanctity of the exercise and matrimony institution of the community. Combining the practice with matrimony which has deep roots and psychology loyalty may be abandoned easily. Since the Maasais' move from one place to another in search of water, they live in inaccessible areas with poor road networks since the government cannot follow up on the development of social amenities where people do not live. This was confirmed by 59.8% yes and 40.2% no. The nature
of the roads being poor was also confirmed by 71.6% yes and 28.4% no.

CHAPTER FIVE

5.1SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1.1 Introduction

The overview of the study results, debate, conclusion and conclusions are provided in this chapter and proposals for future research gaps are also discussed. The description is objective with the aims of the research and the results that affected the persistence of FGM among Maasai of Maili 46, Kajiado West County.

5.1.2 Summary of Findings

The first objective was aimed at finding out which cultural practices and expectations that account for the persistence of FGM practice in the area of study. The results indicated that women were culturally respected in the community after undergoing the circumcision. The results stated that there are some cultural activities that only women who have undergone circumcision are involved in like marriage ceremonies and community celebrations in rites of passages thus influencing a lot on the practice. The second objective was to assess the influence of social pressure by the community on the persistence of FGM.Majority of the respondents agreed that uncircumcised women cannot get suiters for marriage, are ridiculed and given names by the community and also considered as unclean and due to this even with stiff measures implemented by the Government on the practice there are underground practices that are still going on in the area. The third objective was to evaluate the contribution of the existing interventions that address the problem of FGM for the successful fight against FGM. As is indicated by the majority of the respondents FGM is tied to a major cultural practices such as marriage and thus it's deeply rooted in the society hence creating a huge problem in eradicating the menace. The last objective was to establish the impediments to successful fight against FGM. The main impediments were strong cultural practices, lack of social amenities and Migration in search of water and pasture being a nomadic community.

5.1.3 Conclusion

The study confirmed that FGM is still being practiced in Maasai community and there is need to invest more on eradicating the social menace as it is affecting the life of young girls due to rooted culture. The study has identified the need to have a multi-institutional/multi-disciplinary approach in order to overwhelm the practice through education, legislation and poverty alleviation strategies. Issues of culture is extensive and sensitive therefore, there is need to involve community as a whole notably the leaders for advocacy and gentle approach.

5.1.4 Recommendations.

The practice of FGM still remains strong among the Maasai community living in Maili 46. It will require a multi sectoral approach to address the issue of FGM.

1 There is need to invest more on education of the community in order to achieve a mindset change that leads to reduction of FGM practice.

2 Development agencies including civil society organizations need to promote the implementation of alternative rites of passage in the community but retain the educational elements associated with FGM.

3 There should be a special and sustained engagement with Maasai men to change their attitude towards women and FGM.

5.1.5 Suggestion for Further Research

When learning about individuals and their way of life, social, political, cultural and land variables should be contemplated on the grounds that they are a piece of the individuals and their way of life. The second area for further research is why men vehemently insist that FGM should be practiced with the knowledge of how harmful FGM is on women.

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APPENDICES

Appendix 1: Introduction letter

Dear Respondent

RE: REQUEST TO FILL IN THE QUESTIONNAIRE

My name is Emily Grace doing masters at the University of Nairobi. As part of academic requirement, I should do a research on a certain field and go to the field to collect data. I am therefore, doing a study on the factors influencing high rate and persistency of female genital mutilation among Maasai of Maili 46 location in Kajiado West County.

I kindly request you to fill in the questionnaire below. The data you will provide will be well kept and used appropriately for only academic purposes only.

Thanks

Emily A Obingo

4.0 Appendix 2: Questionnaire

Kindly tick inside the box to indicate the best option that is appropriate to you

SECTION A: BACKGROUND INFORMATION

1. Your Gender   Female [ ]   Male [ ]

2. Age bracket

   25 years and below   [ ]

   26-30 years   [ ]

   31-35 years   [ ]

   36-40 years   [ ]

   41-45 years   [ ]

   46 and above years   [ ]

3. Level of education

Primary education [ ]

Secondary education [ ]

College/university [ ]

4. Marital status

Married [ ]

Single [ ]

Divorced/Separated [ ]

Widowed [ ]

5. Religion

Christianity [ ]

Islam [ ]

Hinduism [ ]

Buddhism [ ]

6. How is the rate of FGM today compared to past years?

Increasing [ ]

Decreasing [ ]

SECTION B: CULTURAL PRACTICES AND EXPECTATIONS

7. Do you think culture has influenced the practice of FGM in Maili 46?

Yes [ ] No [ ] Not sure [ ]

8. If yes in (7), which cultural practices influence high rate and persistence of FGM in Maili 46?

   ………………………………………………………………………………………

   ………………………………………………………………………………………..
9. Are women are given the respect they deserve after undergoing FGM?

   Yes [ ]   No [ ]   Not sure [ ]
10. If yes in (9), in which ways are they respected?

    ………………………………………………………………………………………..

    ………………………………………………………………………………………..
11. What is the rate at which marriage influences the practice of female genital mutilation?

    High [ ]

    Moderate [ ]

    Low [ ]
12. Do men marry uncircumcised women in Maili 46?

    Yes [ ]   No [ ]   Not sure [ ]
13. Give the reasons for yes or no in (12 above)

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

    ………………………………………………………………………………………………
14. Woman is considered mature, obedient and aware of her role in family and society after undergoing FGM

    True [ ]

    False [ ]

    Not sure [ ]
15. Girls are forced to undergo circumcision in Maili 46

    True [ ]

    False [ ]

    Not sure [ ]
16. Are there some activities or things the uncircumcised females don't do?

    Yes [ ]   No [ ]
17. If yes in (16 above), which are they?

    Not mix with the circumcised [ ]

    Not eat together with circumcised [ ]

    Don't get married [ ]

    Don't have access to education [ ]

    Not allowed to attend community events [ ]
18. Are you circumcised? (Answer this if you are a female)

    Yes [ ]   No [ ]
19. Do you have daughters? If yes, are they circumcised?

    Yes [ ]   No [ ]
20. Is your wife circumcised? (Answer this if you are a male)

    Yes [ ]   No [ ]
21. Is it a must for a woman to be circumcised before marriage?

    Yes [ ]   No [ ]

22. What ceremonies can't a woman who is not circumcised attend?
....
....
....
23. At which age do most females get circumcised?
10 and below [ ]
11-15 [ ]
16-20 [ ]
21-25 [ ]
26-30 [ ]
31 and above [ ]
24. Do you know a family member who is circumcised?
Yes [ ] No [ ]
25. Do you know somebody who was circumcised this year or last year 2018?
Yes [ ] No [ ]

SECTION C: EXISTING INTERVENTIONS

26. Has your community taken any steps to address issues concerning FGM?
Yes [ ] No [ ] Not sure [ ]
27. If yes, name those steps or interventions
....
....

28. Have you ever attended an anti-FGM training?
    Yes [ ]   No [ ]
    If yes, after how long do you get an opportunity to attend anti-FGM trainings within Maili 46?
    Weekly   [ ]
    Monthly   [ ]
    Yearly   [ ]
    Never   [ ]
29. Who mostly brings such trainings in Maili 46?
    National government [ ]
    County government [ ]
    NGOs   [ ]
    CBOs   [ ]
    Other (specify)………………………………………
30. Do you know somebody within your area who has attended an anti-FGM training?
    Yes [ ]   No [ ]
31. Are there enforcement officers present in Maili 46 to ensure the practice of FGM remains illegal?
    Yes [ ]   No [ ]   Not sure [ ]
32. If yes in (22 above), have you seen them arresting those who practice FGM?
    Yes [ ]   No [ ]   Not sure [ ]
33. Are you aware that the current constitution and the laws on children rights prohibit FGM?
    Yes [ ]   No [ ]

34. Individually, what have you done to eradicate FGM in Maili 46?
    ……………………………………………………………………………………………
    ……………………………………………………………………………………………
    ………………
35. To what extent do you agree with the following statement
    Legislations and prosecircumcised ion of family members affect the children negatively
    Strongly agree (1)   Agree (2)   Neutral (3)   Disagree (4)   Strongly disagree (5)
36. Are the female who undergo circumcision aware of the existing legislations for FGM?
    Yes [ ]   No [ ]   Not sure [ ]
37. Do these interventions reach most people?
    Yes [ ]   No [ ]
38. Do you think the interventions have led to decline in FGM?
    Yes [ ]   No [ ]
39. Are you aware of the consequences of practicing FGM?
    Yes [ ]   No [ ]
40. If yes, name the consequences you know
    ……………………………………………………………………………………………
    ……………………………………………………………………………………………

SECTION D: IMPEDIMENTS IN FIGHT OF FGM

41. What are challenges or barriers that affect the fight of FGM in Maili 46?
    ……………………………………………………………………………………………
    ……………………………………………………………………………………………

42. Is the practice of FGM communal or individual?
    Communal [ ]
    Individual [ ]
43. Do people meet in groups to discuss about FGM?
    Yes [ ]   No [ ]   Not sure [ ]
44. Poverty is the main driver of continued FGM practice in Maili 46?
    True [ ]
    False [ ]
45. Do you get enough information regarding negative impacts of FGM?
    Yes [ ]   No [ ]

46. Does lack of medication influences practice of FGM in Maili 46?
    Yes [ ]   No [ ]
47. To what extent do you agree with the following statement
    It is difficult to convince members of this community to stop FGM practice
    Strongly agree (1)   Agree (2)   Neutral (3)   Disagree (4)   Strongly disagree (5)
48. Do you personally feel comfortable encouraging the practice of FGM?

Yes [ ]   No [ ]

49. Do you know any circumciser in your village?

    Yes [ ]   No [ ]

50. If yes, has she ever been arrested

    Yes [ ]   No [ ]

    If no, why……………………………………………………………………………

    ……………………………………………………………………………………

SECTION E: SOCIAL PRESSURE

51. Do girls who undergo FGM influenced by their friends and family members?

    Yes [ ]   No [ ]   Not sure [ ]

52. Do girls meet to discuss about how to undergo FGM?

    Yes [ ]   No [ ]

53. If yes in (39 above), when do they mostly meet?

    During the day   [ ]

    During the night   [ ]

54. Where do they meet?

55. Are parents aware of the girls meeting?

    Yes [ ]   No [ ]   Not sure [ ]

56. What are the reactions of those who are denied a chance to undergo FGM?

    ……………………………………………………………………………………

    ……………………………………………………………………………………

57. Are uncircumcised females allowed to interact with circumcised ones?

    Yes [ ]   No [ ]

58. Who are at the forefront to organize the circumcision ceremony?

    Fathers   [ ]

    Mothers   [ ]

    Relatives   [ ]

    Outsiders   [ ]

59. For how long does the planning and mobilization of community members take place in order to have a successful FGM ceremony?

    Days   [ ]

    Weeks   [ ]

    Months   [ ]

    Years   [ ]

60. Name ways on how the community members encourage the practice of FGM in Maili 46

    ……………………………………………………………………………………

    ……………………………………………………………………………………

    ……………………………………………………………………………………

61. To what extent do you agree with the following statement

    Women and girls who are circumcised are respected more by the society than those who are not

    Strongly agree (1)   Agree (2)   Neutral (3)   Disagree (4)   Strongly disagree (5)

62. To what extent do you agree with the following statement

There are family and societal conflicts resulting from the criminalization of FGM
Strongly agree (1) Agree (2) Neutral (3) Disagree (4) Strongly disagree (5)

63. To what extent do you agree with the following statement
Parents' decisions to circumcise are never meant to cause harm to the child
Strongly agree (1) Agree (2) Neutral (3) Disagree (4) Strongly disagree (5)
64. If not harm, what do you think are the parents' intentions?
....
....
65. Are you of the opinion that female genital mutilation should be stopped?
Yes [ ] No [ ]
66. If yes or no in (52above), why?..
....
....
67. What does entito mean?..
....
....
68. Do girls like being referred to as entito?
Yes [ ] No [ ]
69. What impact does this name have on the girls and women?
....
....

Appendix 3: Interview guide for village elders

1. What advantages does FGM have on women and society at large?
2. Do you consider this culture helpful?
3. As an elder, which interventions has this community put to curb FGM?
4. Are there any challenges faced in preventing the practice of FGM?
5. Where does the pressure for practicing FGM come from?
6. Are women willing for the act themselves?
7. What is your opinion about practice of FGM in the current society?
8. What recommendations can you give?

Appendix 4: Interview guide for local administrators

1. What is your position/role in this community?
2. For how long have you worked in this position?
3. Are you familiar about government policy with regard to FGM?
4. Tell me more about your programs concerning FGM in this area?
5. Is FGM increasing or decreasing in this area? Why?
6. What are the challenges of controlling FGM in this area?

7. What are some of your achievements you have made so far with regard to ending FGM?
8. What recommendations can you give?

Appendix 5: Interview guide for female surgeons/circumcisers

1. For how long have you been practicing FGM?
2. Like how many women have you circumcised?
3. Who invite you to circumcise in a certain area or home?
4. Have you been caught by government and punished?
5. Why make FGM part of your life activities? Any benefits?
6. How much are you paid per circumcision?
7. In cash or kind? If in kind explain?
8. What challenges do you face while doing FGM?
9. Can you advocate for an end of FGM? Why?

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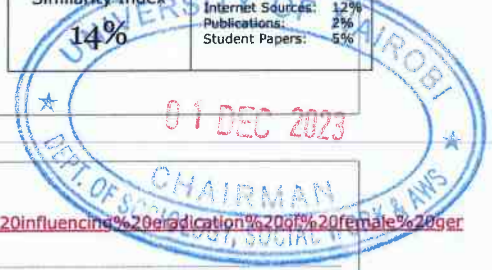

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Supervisor

To: Chairman Department of Sociology, SW & AWS

SUBJECT: CERTIFICATE OF CORRECTION FOR EMILLY AKINYI OBINGO

Emilly Obingo successfully defended her M.A project on **May 10th 2023.** I was mandated by the Panel to oversee and certify that all the corrections were done. I am glad to certify that the candidate has done all the corrections as recommended by the Panel.

Sincerely,

Prof. Beneah Mutsotso
Supervisor

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