An Assessment of the Alternative Rites Approach for Encouraging Abandonment of Female Genital Mutilation in Kenya

Population Council

Frontiers IN REPRODUCTIVE HEALTH

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DEDICATION

The late Leah Muuya (died December 2000) has left an invaluable imprint in the struggle to free young girls from the practice of Female Genital Mutilation. As Maendeleo Ya Wanawake Organisation's (MYWO) Programme Officer for Harmful Traditional Practices, Leah spearheaded activities related to the alternative rites of passage. Her enthusiasm and willingness to work with various communities in seeking to influence change of attitudes and behaviour made a great impact in the success of the programme.

As a tribute to her, we dedicate the work contained in this report to her to commemorate her contribution to the eradication of this practice, on behalf of all the young girls she enabled to find hope despite the clutch of culture.

SUMMARY

Maendeleo Ya Wanawake (MYWO), with technical assistance from the Program for Appropriate Technology in Health (PATH), has been implementing an Alternative Rite of passage programme as part of its efforts to eradicate the practice of Female Genital Mutilation (FGM) in five districts in Kenya. Although the approach has been implemented since 1996, and is a continuation of anti-FGM efforts that started a few years earlier, the approach itself has not yet been systematically documented or assessed. This study addressed the factors that influence some families and individuals to adopt the alternative rite while others, exposed to the same messages discouraging FGM, decide not to. It also evaluated the effect of the training component of the Alternative Rite on the girls who participated.

The study was undertaken in three districts (Tharaka, Narok, and Gucha), where MYWO/PATH have been implementing the approach and which cover four ethnic groups. A comparison was made of knowledge, attitudes, and practices concerning FGM and reproductive health among households and individuals who had participated in the alternative rite and those who had not. Data were collected through 37 focus group discussions, 53 key informant in-depth interviews, a household survey of 634 parents, 1,068 girls and 364 boys, and nine case studies of families who have participated in the Alternative Rite.

FGM practices vary among the four sites. Type 1 (clitoridectomy) and Type 2 (excision) are practised in all four sites. There are indications of changes in the way FGM is practised in all sites, and particularly a move towards reducing the harm caused through medicalisation, particularly in the predominantly Abagusii and Maasai ethnic group sites, and the use of individual instruments.

Those families choosing for their daughters to participate in the Alternative Rite are somewhat different than those not choosing to do so, in that they are slightly more likely to have ever attended school, more likely not to be members of the Catholic or Pentecostal churches, slightly less likely to be labourers or farm workers, more likely to be of higher socio-economic status, slightly more likely to have females with more positive gender attitudes, and more likely to already not be cutting their daughters and to express regret for those already cut.

The Family Life Education (FLE) training that girls who adopt the Alternative Rite are exposed to does have an effect on the girls' awareness and knowledge about reproductive health issues, but it also appears to engender somewhat less positive attitudes towards the practice of family planning among unmarried partners and adolescents, including condom use.

The MYWO sensitisation activities that preceded and accompanied the Alternative Rite have played a role in the behaviour change process among those who have decided to discontinue the practice and who have adapted the alternative rite. It is also clear, however, that these sensitisation activities have not functioned in isolation from other influences operating in the communities, notably the stance taken by certain churches as well as individuals' existing beliefs that the practice should be discontinued. The contribution that an Alternative Rite intervention can make to efforts to abandon the practice depends on the socio-cultural context in which FGM is practised. For the approach to be replicated successfully in other situations will require a good understanding of the role of public (as opposed to familial) ceremonies in that culture, and a judgement as to what format for the ritual is the most appropriate means of helping those that have decided to abandon the practice to actually do so.

CONTENTS

TABLES AND FIGURES

ACKNOWLEDGEMENTS

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AR	Alternative Rite
FGC	Female Genital Cutting
FGDs	Focus Group Discussions
FGM	Female Genital Mutilation
GTZ	German Technical Corporation *(Deutsche Gesellschaft für Technische Zusammenarbeit)*
HIV	Human immunodeficiency Virus
IEC	Information Education and Communication
KDHS	Kenya Demographic and Health Survey
MYWO	Maendeleo Ya Wanawake Organization
MOH	Ministry of Health
NFP	National Focal Point on FGM
NGOs	Non-Governmental Organizations
Non-AR	Non-Alternative Rite
PATH	Program for Appropriate Technology in Health
RH	Reproductive Health
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
UNICEF	United Nations Children Fund
WHO	World Health Organization

BACKGROUND

Female Genital Mutilation (FGM), also referred to as female circumcision, Female Genital Cutting (FGC) and genital surgeries[1], refers to several different traditional practices that involve the removal or cutting of part, or all, of the female genitalia. The World Health Organisation (WHO, 1995) recommends a three-type classification of FGM[2], which includes varying degrees of severity depending on the amount of tissue excised:

Type 1 or Clitoridectomy: removal of the clitoral hood with or without removal of part or the entire clitoris.

Type 2 or Excision: Removal of the clitoris together with part or all of the *labia minora*.

Type 3 or Infibulation: Removal of part or all of the external genitalia (clitoris, *labia minora,* and *labia majora*) and stitching and/or narrowing of the vaginal opening leaving a small hole for urine and menstrual flow.

All types of FGM can be associated with immediate and long-term complications, although Type 3 seems to be associated with more serious problems (Jones et. al., 1999). The immediate complications can include severe pain, trauma, tetanus, urine retention, urethral or anal damage, excessive bleeding, and shock from haemorrhage. The long-term health and physical complications may include urinary and bladder incontinence, recurrent urinary track infections, lack of sexual stimulation and painful sexual intercourse, infertility, vaginal cysts and abscesses, blockage of menstrual flow and elevated risks of obstructed labour (PATH, 1997). The socialisation process that accompanies the practice may also entrench gender ideologies and practices that contribute to the disempowerment of women (Chege 1993).

At least two million girls a year worldwide are at risk of experiencing genital mutilation (Rainb♀, 1995). The practice has been documented in many countries but is most prevalent in Africa, being reported in at least 28 countries (Carr, 1997), with some countries reporting over 90 percent prevalence. During the past decade, the United Nations, many governments, international development agencies, and international and national women's organisations and professional associations have developed policies condemning the practice, and have proposed guidelines and plans of action towards accelerating the elimination of FGM. In countries where the practice is prevalent, many governments and national leaders have publicly denounced the practice. However, few governments have translated their concern into laws prohibiting FGM or programmes to eradicate the practice.

FGM in Kenya

FGM is prevalent in Kenya, with 38 percent of women aged 15-49 years reporting being circumcised (KDHS, 1998), and the practice is found in over half of the districts in the country. There are differences among ethnic groups, however. FGM is nearly universal among the Kisii (97%) and Maasai (89%), and is also highly prevalent among the Kalenjin (62%), Taita Taveta (59%) and Meru / Embu (54%) groups, and to lesser extent among the Kikuyu (43%), Kamba (33%) and Mijikenda/Swahili (12%). Although the Kenya

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[1] The term FGM is used in Kenya when the practice is discussed by organisations and those working at the national level, and female circumcision is the term most frequently used by communities and individuals. Consequently, these terms will be used inter-changeably in this report.

[2] There is also a fourth category which is used to include all other practices that "mutilate" the genital organs, such as pricking, piercing, stretching, cauterising, scraping, or introducing corrosive substances, but this category is not relevant to this study.

Demographic and Health Survey (KDHS) does not include data from the North Eastern province, it is believed that infibulation is nearly universal among the population. Clitoridectomy and excision are the predominant types practised in the rest of the country.

However recent studies have indicated changes in attitudes, beliefs and practices in communities that traditionally have upheld the practice. For example, qualitative research by UNICEF/PATH among the Kikuyu and Kalenjin ethnic groups indicate that families with higher levels of formal education, higher economic status and that are Christian, are more likely to have more positive attitudes and practice towards abandoning the practice than other groups (UNICEF/PATH, 1998).

These qualitative findings are confirmed by quantitative data from the 1998 KDHS, which indicate that:

- The higher the level of mother's education the lower the prevalence of FGM;
- Women residing in rural areas are more likely (42%) to have been circumcised than those residing in urban areas (23%);
- Older women (35 – 49 years) were more likely to have been circumcised (47%) than those aged 15-24 years (33%).

Recent declines in the practice, measured by differences in these two age groups (35-49 years versus 15-24 years) as reported in the KDHS, is particularly pronounced among the Kalenjin (62% to 33%), Kikuyu (43% to 18%) and Kamba (33% to 12%), with the least decline amongst the Kisii (97% to 93%) and Maasai (89% to 77%).

Efforts To Eradicate FGM In Kenya

Efforts to eradicate FGM in Kenya go back to pre-independence days when the Protestant Christian missionaries in Central Kenya campaigned against the practice. Consequently, between 1926 and 1956, the colonial government enacted legislation that sought to ameliorate the practice by reducing the severity of the cut, defining age at circumcision, and enhancing parental consent before a girl could undergo the procedure. However, due to the ensuing opposition and related political outcomes, the colonial government was forced to revoke all the resolutions related to FGM in 1958 (Chege, 1993; Kenyatta, 1938; Thomas, 1992).

In independent Kenya, some key government officials, including the current President, have spoken against FGM. To date, however, the Government has not legislated against the practice, although Kenya is a signatory to many international conventions calling for its eradication. In 1999, the Ministry of Health launched a twenty-year National Plan of Action (Ministry of Health, 1999), which was developed with support from the World Health Organisation. With an overall goal of accelerating the elimination of FGM, the National Plan has four objectives: to reduce the proportion of girls and women undergoing FGM; to increase the proportion of communities supporting the elimination of FGM; to increase the proportion of health care facilities that provide care for girls and women with physical and psychological problems associated with FGM; and to increase the technical and advocacy capacity of organizations and communities involved in FGM elimination programmes. Programme development and management, provision of basic health services, advocacy, and action oriented research and documentation are the four main programme components for implementing the National Plan of Action.

In addition to these efforts, a large number of non-government organisations (NGOs) have also been actively encouraging communities to discontinue the practice. Following a consultative conference in March 1997, at which were represented 67 local NGOs, Governmental, bilateral and international organisations, a National Focal Point (NFP) was initiated, with the NGO *Northern Aid* being nominated to host the NFP. A second conference held a year later attracted 96 organisations, which consolidated and endorsed the role of the NFP as the co-ordinating body to maximise collaboration between all organisations concerned with FGM in Kenya.

Clearly, there is much interest and activity at both the grass roots and national levels in seeking ways to eradicate this practice. Two of the most active of the local NGOs, that work at both levels, have been Maendeleo Ya Wanawake (MYWO), a nation-wide community-based women's organisation, and the Program for Appropriate Technology in Health (PATH), an international NGO with a national office that focuses on improving the health of women and children. Over the past decade, these two organisations have worked closely together using a wide variety of funding support to learn about the practice and to then use this information to develop strategies for encouraging its abandonment.

Three broad phases in their activities can be identified. Over the period 1991 – 1993, PATH coordinated a series of qualitative and quantitative research studies with MYWO to learn about the nature and extent of the practice in four districts (Kisii[3], Meru[4], Narok and Samburu). Based on these findings, MYWO and PATH developed and started implementing numerous community mobilisation, behaviour change communication (BCC) and educational activities with leaders, religious groups, schools and parents in these districts, and educational and advocacy activities with opinion leaders and the media at the national level. These sensitisation activities, which began in 1993 and are still continuing, were implemented under the auspices of MYWO's broader 'Traditional Harmful Practices' programme and provided the basis for the most recent phase, which was the development of the 'Alternative Rite of Passage' and its introduction in 1996.

Development of the Alternative Rite of Passage

In 1995, MYWO and PATH organised a national seminar to bring together MYWO national and grass root level elected leaders and staff from the districts implementing anti-FGM activities. Among many (but not all) of the ethnic groups, female circumcision features as the central component of a traditional rite of passage ceremony that girls are expected to pass through in their transition from puberty to adulthood. In these situations, therefore, having made the decision to not cut their daughters, parents are then faced with the dilemma of what to do about the traditional ritual, which allows them and their daughters to publicly announce the transition to womanhood. To address this problem, PATH introduced the idea of an 'alternative ritual', which excluded the genital cutting but maintained the other essential components such as education for the girls on family life and women's roles, exchange of gifts, eating good food, and a public declaration for community recognition.

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[3] The former Kisii district has now been subdivided into three districts namely, Kisii, Gucha, and Nyamira. Project activities are implemented in what is now Gucha district.

[4] The former Meru district has now been subdivided into four districts namely, Meru North, Meru Central, Meru South, and Tharaka. Project activities are implemented in all the four districts.

Attending this seminar were MYWO leaders from many districts, and those from one district in particular (Tharaka) were immediately inspired to begin discussing the idea of starting an alternative rite of passage with members of their community. Through consultations with families that had decided to stop circumcising their daughters, these women leaders worked with MYWO and PATH to develop and introduce the first 'alternative' ritual in 1996. The first alternative rite took place in August 1996 at Tharaka, with 29 girls participating. Although this strategy was first tried in a district where the MYWO/PATH programme of sensitisation on FGM had been undertaken for a short period (1995-1996), several of the districts where sensitisation had already been implemented rapidly adapted it. Since that time, approximately 30 alternative rite of passage ceremonies have taken place in Gucha, Meru North, Meru South, Narok and, most recently, Samburu districts. By December 1999, about 1,600 girls from these districts had gone through the ritual and by April 2001, approximately 3,000 girls from these districts had participated as initiates.

An alternative rite of passage ritual refers to a structured programme of activities with community-level sensitisation to first gain support and to recruit the girls who will participate, which is followed by a public ritual that includes training for the girls in family life education (FLE), and a public ceremony similar to that in traditional rites of passage. The intention is to simulate the traditional ritual as closely as possible without actually circumcising the girls. A full description of the alternative rite of passage (as implemented in three districts) is given later, but in brief the approach has three inter-related components.

Community sensitisation: In those areas where MYWO has already been implementing its FGM sensitisation activities, the idea of an alternative ritual has subsequently been promoted to provide a tangible mechanism to support those who have already made the decision to stop the practice in their own families, or who are considering doing so and need social support to enable them to carry through with the decision. Messages to raise awareness of the health risks of FGM and that the practice violates human rights are therefore supported by generating interest within the communities for an alternative ritual for those wishing to publicly declare that their girls are women but are not circumcised.

These activities can be described in terms of the model of behavioural change for FGM posited by Izett and Toubia (1999). This model proposes that for a change in a long-running behaviour to occur, individuals, families and communities need to pass through several stages before there is a sustained behavioural change. Exposure to new information about the behaviour (in this case about its health risks, socio-psychological effects, violation of human rights, among others.) can motivate individuals and families to begin to *contemplate* a behaviour change. Although this stage may lead to an intention to change the behaviour, there is normally a need to ensure that the decision can be fully supported so that the necessary action can be fulfilled. Consequently, the behaviour change strategy needs also to *prepare* individuals prior to them being able to *act* on the decision.

The community sensitisation activities need, therefore, to provide both sufficient and appropriate new information to stimulate contemplation about a change, and to create sufficient familial and social support to prepare individuals and families to actually act by making the change.

MYWO uses its nationwide network of community-level women's groups as the entry point in sensitising communities. Community sensitisation is undertaken through organised public meetings, small group meetings and workshops targeting various groups in the community

such as students and teachers in schools, women's groups, and church groups. Group meetings and workshops include demonstrations (using anatomical models), talks by respected leaders, and if possible the videos that MYWO has produced. An important part of the sensitisation strategy has been the identification of persons who show active support for eradicating the practice, who are consequently recruited and trained as peer educators (see later).

In the sites where MYWO and PATH had been working up to 1995, sensitisation has been undertaken with the intention of preparing individuals and families to decide not to cut their future daughters. However, many ethnic groups traditionally believe female circumcision to be a critical component of a girl's passage to womanhood, and some form of public declaration that a girl has completed this passage remains an important part of some cultures in Kenya. Consequently, it was felt that making the final step of actually acting on the decision not to cut a daughter could be inhibited if such a decision prevented her from being publicly recognised as having completed this passage.

Thus providing an alternative rite, which does not feature genital cutting but which is equally acceptable to the community because it includes seclusion, training and a public ceremony, offers the opportunity to declare the girl to have made the transition in a socially acceptable way. This opportunity can both reduce the barrier of perceived social disapproval for those not yet confident to make the final step from decision to action, and also allows those who have already taken action to declare this step and reinforce public acceptance of their daughter's status as an uncircumcised woman.

Seclusion and training: To mimic the traditional practice whereby girls are put in seclusion immediately after being circumcised and are taught by an aunt or other relative or friend (who is slightly younger than the girl's mother) about women's roles, cultural values and sexuality, the girls going through the alternative ritual also undergo three to five days of 'seclusion' with teaching. MYWO accommodates them together in a hotel or school or community hall, and provides them with formal instruction on family life skills, community values and reproductive health. In addition to the formal sessions that follow a curriculum developed by PATH and MYWO and that are normally led by MYWO staff, informal discussions are held in the evenings during which the girls are taught about the positive aspects of their culture from selected mothers.

Public ceremony: The timing and nature of the public ceremony are dictated by the specific socio-cultural context in which the alternative ritual takes place. These ceremonies normally take place immediately after completion of the seclusion training and require the participation of both of the girl's parents (if possible), as well as other invited members of the community and local leaders. The ceremonies include several activities such as communal feasting, traditional singing and dancing, gift giving to the girls passing through the ritual, declarations by the girls that they have not been and will not be cut, and declarations by fathers, mothers and community leaders of their commitment to support abandonment of the practice.

METHODOLOGY

The fact that a large number of girls have participated in the alternative rite, that many such events have taken place, and that the ceremonies can be implemented with relatively little or no opposition, indicates clearly that the approach is programmatically feasible, is culturally acceptable, and that there is a demand for it. Whether this cumulative process of sensitisation

and alternative ritual has had an impact on the practice itself is not known, and cannot be evaluated through this or other studies because systematic baseline data were not collected and adequate control groups cannot be created *post hoc*. It should be noted that this is not through a lack of planning by MYWO or PATH, but is because the approach has evolved gradually over time. An evaluation study was recently undertaken by MYWO and PATH (Olenja, 2000), in which a cross-sectional survey was completed in the four districts where the baseline data were collected in 1991-1993. For several reasons, however, it is not possible to make direct comparisons with the baseline data and so a conclusive assessment of the impact of these activities over time cannot be made. Bearing in mind these limitations, this study had the following objectives.

Objectives

The ultimate objective of this study was to provide policy makers, donors and project managers with information to strengthen and guide interventions aimed at eradicating FGM. More specifically, the study sought to[5]:

- Describe the coverage, operating structure and procedures of the alternative rite of passage in Tharaka, Narok, and Gucha districts.
- Determine the factors that account for some families and individuals adopting the alternative rite while others, exposed to the same sensitisation and IEC intervention, opt to undertake the traditional rite.
- Assess the contribution of the alternative rite of passage intervention in increasing knowledge of harmful effects of FGM, awareness of women and children's rights, and fostering positive attitudes towards eradication of FGM in the intervention sites.
- Assess the impact of the alternative rite in increasing positive reproductive health behaviour, knowledge, and attitudes among girls undertaking the alternative rite.
- Assess the impact of the alternative rite in fostering positive gender attitudes among girls undertaking the alternative rite and their parents.

Study Design

The purpose of this study was to gain a better understanding of how the programme is currently functioning. The study used a design that allowed a comparison to be made between:

- Families that are exposed to the MYWO community sensitisation activities, and whose eligible daughter(s) participate in the alternative ritual (hereafter referred to as AR families);
- Families that are exposed to the MYWO community sensitisation activities, and whose eligible daughter(s) do not participate in the alternative ritual (hereafter referred to as non-AR families).

Data were collected from families living in the same communities but who could be differentiated in terms of whether or not any of their eligible daughters had been through the alternative ritual. Families with at least one daughter aged between 8 and 20 years were

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[5] The study also intended to measure the costs of implementing the alternative rite and to assess the sustainability of the intervention. However, it was impossible to collect the necessary data on programme costs from PATH or MYWO.

eligible for the study because the extreme younger and oldest ages at which girls are circumcised are four and 17 years, and the first alternative rituals were held four years prior to the study[6].

Study Sites

The alternative rite approach has been implemented in several districts[7], but only those districts where the approach has been used for at least two years were considered eligible for the study. Three districts were selected on this criterion, which between them represent four ethnic groups (see below). Tharaka district was chosen as one of the three districts because it was the first district where this approach was undertaken. Although it is not formally part of MYWO's Harmful Traditional Practices programme and so had not received the sensitisation activities, funding and technical assistance for the alternative rituals was received from PATH and the woman instigating the alternative ritual was a MYWO grass root elected leader.

District	Divisions	Ethnic group
Tharaka	Tharaka North Tharaka Central Tharaka South	Meru
Gucha	Ogembo Nyamache	Abagusii (Kisii)
Narok	Mau Mulot	Maasai Kalenjin

Data Collection

Data were collected from all study sites through a combination of qualitative and quantitative methods. Altogether, 37 focus group discussions were held with representatives of community leaders, adolescent girls and boys, male and female parents, and with some of the community trainers who provide the family life education. In-depth interviews were held with 53 key informants, including MYWO programme staff, male and female community leaders, and two traditional practitioners.

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[6] This may have led to the inclusion of some non-AR families who had "eligible" girls but who had not necessarily been considered for either ritual at some time during the previous four years. However, it would have been very difficult to identify such girls practically, and the number is likely to be small anyway.

[7] With effect from November 2000, GTZ in collaboration with the Ministry of Health has been implementing an alternative rite intervention in Trans Mara district.

Case studies were conducted of nine families who had undertaken the alternative rite. In each site, three of these were purposively selected based on the family's willingness to participate in the in-depth interviews. In the selected case study families, male and female parents were interviewed, as well as girls, and grandparents (where applicable) regarding the socio-economic status of the family, factors influencing the family's and individual's choice and participation in the AR and experiences with community members due to the family's or individual's choice not to cut daughters or be cut.

In each study site, a questionnaire survey was carried out among AR and non-AR families. The AR families were identified from the lists kept by MYWO of girls who had been through the alternative rite. In total, 601 families were identified, with approximately 200 per district. The non-AR families were identified by first creating eight clusters in each district, and then listing all households using the listings from the 1998 census (provided by the Central Bureau of Statistics). Within these clusters, all known AR families were removed from the listing and a random sample of 200 families with girls aged between eight and 20 years was drawn from the remainder.

For each AR family and non-AR family selected, individual confidential interviews were held with: all girls aged 8 – 20 years; one female or male parent[8]; and for families where the female parent was interviewed, one male sibling aged 8 – 20 years. This sampling plan resulted in a total of 1,201 families being included and 2,066 individual interviews undertaken as follows:

	Tharaka	Gucha	Mulot (Narok)	Mau (Narok)	Total
AR families	200	223	130	70	**601**
Non-AR families	200	200	130	70	**600**
Female parents	115	219	60	42	**436**
Male parents	56	57	56	29	**198**
Girls	281	494	170	123	**1068**
Boys	111	181	41	31	**364**

Given the close association between ethnicity and FGM in Kenya, the ethnic affiliation of respondents in each study site was analysed. As seen below, each of the study sites was found to be remarkably homogeneous for one major ethnic group – the Meru[9] in Tharaka, the Abagusii[10] in Gucha, the Kalenjin[11] in Mulot, and the Maasai in Mau. Some diversity can be

[8] Ideally, if a female parent was selected in one household, a male parent was selected in the next household. However, due to the widespread unavailability of male parents due to work and temporary migration, more female than male parents were interviewed.

[9] The Meru ethnic group comprises of nine sub-groups, one of which is Tharaka.

[10] In the KDHS and elsewhere, the ethnic group known as the *Abagusii* are usually named the *Kisii*. As this name refers to the area where they live it is not strictly correct and so the term Abagusii is used in this report.

noted in Mau, where 12 of the 13 non-Maasai parents and all of the 14 non-Maasai youth respondents were Kikuyu[12]. Because of this close association between ethnicity and study site, and because FGM is itself related to ethnicity, the remainder of the analysis will be described by ethnic group rather than study site.

% of sample in each ethnic group	Tharaka (Meru)	Gucha (Abagusii)	Mulot (Kalenjin)	Mau (Maasai)
Parents: main ethnic group	98.8%	99.6%	99.1%	81.7%
Parents: other ethnic groups	1.2%	0.4%	0.9%	18.3%
Youth: main ethnic group	99.5%	99.3%	99.0%	90.9%
Youth: other ethnic groups	0.5%	0.7%	1.0%	9.1%

[11] The *Kalenjin* ethnic group comprises of six sub-groups, and in Mulot the majority of respondents calling themselves Kalenjin are from the *Kipsigis* sub-group. However, to allow for the possibility of non-Kipsigis being included in the sample, the term Kalenjin will be used here.

[12] From pre-colonial times, there has been intermarriage between the Maasai and the Kikuyu. Although both communities have traditionally practiced FGM, because of the strong missionary and colonial government intervention against FGM in areas where the Kikuyu traditionally live, support for and practice of FGM has declined considerably among the Kikuyu. Because of this, the Kikuyu who have intermarried with the Maasai are likely to be influenced to take on the practice.

MEANING AND PRACTICE OF FGM

Reasons For Practising FGM

There are striking similarities and some differences in the meaning and importance attached to FGM among the four ethnic groups represented in this study (see Table 1). Among all four ethnic groups, focus group and survey respondents gave a multiplicity of reasons why FGM is practised in their community and their personal views regarding the practice. Analysis of survey responses indicates a difference between parents and youth, and some differences between ethnic groups.

The highest proportions of both parents and youth mentioned preservation of custom and tradition (80% parents and 50% youth) followed by improvement of marriage prospects (27% parents and 19% youth) as the main reasons for practising FGM in their community. Limiting a woman's sexual desire, preventing immorality and a rite into adulthood were also mentioned, but by only small proportions of respondents, suggesting that these reasons are not predominant in these cultures.

There were significant differences between the four ethnic groups. Preservation of custom and tradition is particularly important among the Abagusii and Maasai, although the Abagusii do not place much emphasis on FGM as being necessary for marriage or as a rite of passage. The Kalenjin, Meru and Maasai groups appear to be more concerned with circumcising a girl to make her eligible for marriage.

Table 1: Perceived reasons for the community practising FGM (%)

	Parents				Youth			
	Abagusii	**Meru**	**Kalenjin**	**Maasai**	**Abagusii**	**Meru**	**Kalenjin**	**Maasai**
Custom & tradition	92	73	63	81	57	42	38	57
Good tradition	5	7	28	20	4	4	15	17
Better marriage prospects	7	40	48	34	5	28	39	37
Limit sexual desire	10	5	6	1	4	4	1	3
Prevent immorality	8	20	6	3	8	8	1	0
Rite into adulthood	0	8	4	10	2	8	4	14
Cleanliness	1	7	3	7	0	6	1	2
Don't know	2	4	4	3	29	34	28	22
Other Reasons[1]	3	17	9	9	6	10	7	6

1 = includes responses such as to preserve virginity, remove dirty genitalia, confer respect, and make delivery easier.

A much higher proportion of youth (30%) than parents (3%) said that they did not know why FGM is practised in their community, suggesting that the cultural meaning for the practice may be less strongly promoted now than before. A weaker understanding of the cultural values associated with the practice may partly explain the secular decline noted earlier.

Analysis of in-depth interviews and focus group discussions provide more detail about the cultural meaning and significance attached to these reasons.

Cultural and Tribal Identity: Circumcision was a requirement for one to be identified as a full member of the ethnic group. This view is particularly strong among the Abagusii who hold circumcision as a mark that distinguishes them from their uncircumcised neighbours such as the Luo. Therefore to be uncircumcised among the Abagusii is a shame.

Confer Social and Spiritual Authority to Marry and Procreate: The adult status gained through having been circumcised allowed the young woman to participate in adult privileges, duties, and responsibilities such as marriage and procreation. Some ethnic groups traditionally follow the cutting with a period of seclusion during which a girl recovered and was provided with the tribal knowledge on sexuality, procreation, and how to relate with and treat a husband and in-laws. In addition, the shedding of the blood had spiritual implications that made it right for a girl to conceive and procreate. Traditionally, the Maasai have a belief that an uncircumcised girl has unclean blood, which needs to be removed through the cutting of part of the genitalia. Among the Meru of Tharaka, the Kalenjin and the Maasai, a child born of or conceived by an uncircumcised girl was considered ritually unclean and she/he could not participate in some cultural events and activities. Among the Maasai, such a child was stigmatised through out his/her life and treated as an outcast even in his/her family.

The Meru of Tharaka believe that if a man takes bride price for a girl who is not circumcised, the ancestors would curse the family. The Abagusii believe it was traditionally required that girls must be cut so that a "proper man" marry them. If they were not, they would not be accepted and would be ridiculed as '*egesagane'*, which means an "adult child." Their peers and the community would despise them. Among the Kalenjin, circumcision allowed the girl to perform socially prestigious tasks such as cooking for her father.

Control Women's Sexuality: Among all the four ethnic groups, there exists a belief that the clitoris makes a woman easily sexually excited. Since she cannot control her sexual desires, she becomes sexually immoral and cannot stick to one man. Control of sexual desire is a definition of true womanhood in these ethnic groups. As one Maasai respondent put it: *"A man can seduce a Maasai girl for 10 years and she will never give in but for some one who is not circumcised she gives in easily"*. Culturally, "not giving in" to sexual advances is considered honourable for a woman.

Rite Of Passage to Adulthood: In all the groups, FGM is considered a rite of passage from childhood to adulthood/womanhood. Traditionally, an uncircumcised girl was considered a child irrespective of age, and as such could not receive any respect in the community and was ridiculed and scoffed at by peers and the general community. The transition to adulthood was commonly celebrated through a rite of passage, usually at the time of puberty, involving a ceremony and a period of seclusion. In some communities, the cutting itself was the indication that the transition through puberty had been made. In communities where girls are circumcised at a young, usually pre-pubertal, age, the timing of the cutting is not directly associated with the timing of the transition to adulthood, although the procedure must have been undertaken for the later recognition of womanhood.

Confers Physical Cleanliness: In addition to receiving spiritual cleanliness, circumcision made a girl physically clean. During focus group discussions in all the sites, particularly with groups that support FGM, it was reported that uncircumcised girls are unclean and their genitals produce a bad odour.

Make Birth Easy: In all the ethnic groups, circumcision was believed to make child delivery easier. Among the Maasai, for example, it was believed that if the clitoris was not cut then it could grow long and obstruct the birth of a baby during delivery.

Practice of FGM

Prevalence

When asked whether they felt the practice was still prevalent in their communities, participants in the focus group discussions and key informant interviews gave different responses depending on their ethnic group. Among the Abagusii, it was clear that female circumcision was still highly regarded and universally practised, and respondents felt there were no signs of it declining. A similar situation was reported among the Maasai interviewed in Mau. Among the Meru in Tharaka, however, the feeling was that although FGM was still practised in some areas, overall it was declining in the district. In Mulot, respondents felt that there had been a drastic decline in recent years among the predominantly Kalenjin group, and that it was not practised very much these days.

These perceptions reflect fairly accurately the results of the 1998 KDHS among the same ethnic groups. The proportions of women reporting that they had been cut[13] have dropped substantially between the oldest (40 – 49 years) and youngest (20 – 24 years[14]) age groups among the Kalenjin (90% to 43%) and the Meru/Embu (74% to 46%). However, no decline was found among the Abagusii (97% to 96%); for the Maasai, the sample sizes in the KDHS are very small although a comparison of the proportions cut in each age group seem to indicate a slight decline (12/13 in the older age group and 22/30 in the younger age group).

Among the non-AR families interviewed in this study, substantial differences were found between the four ethnic groups in terms of the proportions of girls aged over 15 years who were cut. Among the Abagusii (n=200), 85 percent of these girls were cut, whereas the equivalent proportions for the other groups were much lower: Maasai: 5 out of 45 girls; Meru: 4 out of 54 girls; Kalenjin: 0 out of 37 girls. This is further evidence that the practice is still highly prevalent among the Abagusii, whereas among the other groups the practice is definitely declining.

Age at Circumcision

As can be seen on Figure 1, the average (median) age at which circumcision is undertaken has not changed much over time[15]. This age is similar in three of the sites, although much younger among the Abagusii in Gucha. This is because, for the Abagusii, the timing of the cut need not be directly linked with the biological transition through puberty and so is not normally an integral part of this group's traditional rite of passage. As genital cutting is a strongly held cultural definition of womanhood for the Abagusii, however, it is necessary that it be undertaken some time preceding the public declaration of a girl's transition to becoming a woman.

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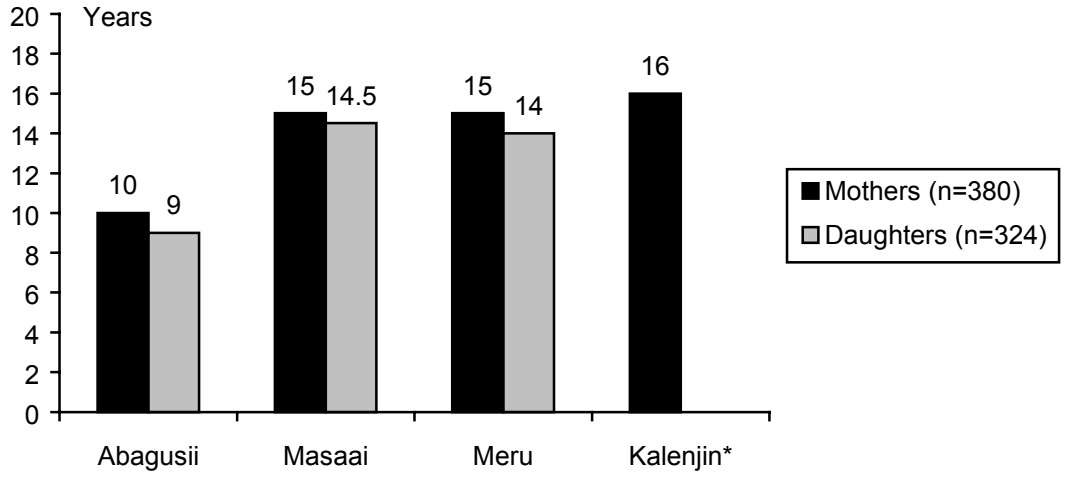
[13] The results presented here are drawn from analyses undertaken of the KDHS datasets and do not appear in the KDHS report.

[14] The youngest age group in the KDHS (15-19 years) are not included because there is a possibility that some of the younger women in this age group reporting themselves as uncut may still be at risk of being cut.

[15] Only two circumcised Kalenjin girls were interviewed and so are not included in these analyses.

Figure 1: Median age at circumcision for mothers and daughters



* only two circumcised Kalenjin girls were interviewed

Decision to Circumcise

There are some important differences in decision-making between the sites. Among the Abagusii and the Maasai, it is clearly a decision made by the parents, as was apparent from the focus group discussions as well as the household surveys (see Table 2). Conversely, among the Meru, and to a lesser extent the Kalenjin, the majority of girls and women who had already been cut indicated that they were the ones who made the decision.

Table 2: Person reported to make the decision for circumcision by ethnic group (%)

Category		Abagusii	Maasai	Kalenjin	Meru
Mothers					
	Father	96	95	44	13
	Mother	91	68	37	15
	Self	30	8	77	94
	Other	6	13	4	8
Girls					
	Father	78	67	N/a[1]	6
	Mother	93	54	N/a	11
	Self	1	13	N/a	83
	Other	9	4	N/a	6

1 = only two circumcised Kalenjin girls were interviewed

Type of Circumcision

Type 1 and type 2 cuts are found in all study sites, although with some differences in their proportions between the ethnic groups. No type 3 cuts were reported. Among both the

Abagusii mothers and daughters, type 1 is the predominant type, whereas type 2 is more widely practised among the other three groups, particularly among the Meru. There are difficulties in interpreting the situation for the Abagusii daughters, however, because half of them reported not knowing which type of cutting had been done. Information from the qualitative data suggests there may be a move among the Abagusii towards a mild form of type 1 where only the tip of the clitoris is cut, and not necessarily removed, which may explain the difficulty in classifying the type of cut.

Who Performed the Procedure?

Across all four groups, virtually all mothers (94%) who had been cut reported that a traditional circumciser had cut them. Among the daughters who had been cut, the Meru (15 out of 19 girls) and the Maasai (19 out of 24 girls) still tend to use the traditional circumciser, but there has clearly been a change in practice among the Abagusii. Of the 279 Abagusii girls who were cut, only 29 percent reported being cut by a traditional circumciser, with 70 percent reporting that a nurse or doctor had performed the procedure, suggesting a clear trend towards medicalisation of the practice.

Traditional circumciser from Kenya

Where was the Procedure Performed?

The place for circumcision varied by site for both mothers and daughters. The vast majority of the Meru (91%) and Maasai (82%) mothers were cut at their own home, and this tradition has continued for the daughters in both ethnic groups. Conversely, most of the Kalenjin mothers (81%) were cut at another person's home.

For the Abagusii, the majority of mothers (68%) were cut at the home of the traditional practitioner, with a further 13 percent being cut "in the bush" and the remainder at their own or someone else's home; only two percent reported being cut at a health facility. Among the Abagusii daughters, however, the location has changed considerably over time – only 14 percent were cut at the home of a traditional practitioner and seven percent in the bush, while 37 percent were cut at a health facility and 40 percent at their own or another home. Further analysis shows that of the 70 percent of Abagusii girls who were circumcised by a medical practitioner, about half (53%) were cut at a health facility and about half (47%) at their own or another home. This clearly demonstrates that the procedure is not only being practised at health facilities contrary to Ministry of Health policy, but also that health staff are privately providing this service at families' homes.

Mothers and daughters were also asked whether they were cut alone or in a group. Among all groups, the proportions of girls (79%) and mothers (81%) who report being cut in a group is about the same.

Instrument Used for the Procedure

Among the mothers, for whom three-quarters were cut in a group and by a traditional circumciser, most were cut with either a shared razor (43%) or knife (31%). Indeed, among the Meru a special knife is used for circumcision called a *Kirunya*, which is easily sharpened and has a small handle so that it can fit in the pocket. The Maasai in Narok use a similar

knife known as an "O*rmurunya*". Among the daughters who knew what instrument was used (11 percent did not know), 77 percent were cut using their own razor blade. Only 13 percent used a shared razor or knife. This gives further evidence of a trend towards looking for safer ways of performing the procedure.

Experience of Problems

When asked if they had experienced any problems related to being cut, 15 percent of mothers and five percent of daughters reported any such problems[16]. In both groups, bleeding was the problem most frequently mentioned. These figures should be interpreted with caution, however, as they represent women's and girls' subjective judgements that a particular health problem they have suffered can be attributed to the genital cutting. The lower level of reporting among the daughters may be because they have been cut for a shorter period of time and most have not given birth – stillbirths were the second largest category of problems cited by the mothers. Even traditional circumcisers are aware of the fact that the practice can lead to adverse health effects although this is attributed to practitioner's skills.

> *"During child birth, you may experience problems with the operated part of the genitals if the operation is not done well. This used to happen long ago when people had not been trained to circumcise. It used to cause the inside of the vagina to swell. During birth, the swelling was removed using a ring-like leather strap. Today, women experience no problems related to female circumcision"* (Tharaka – active Traditional Circumciser).

Recently circumcised Maasai girl, coming out of seclusion. The decorative headband will stay in place until she gets married.

[16] These figures correspond with similar findings from research undertaken in Mali and Burkina Faso, where five percent and 14 percent of women respectively reported experiencing problems associated with being cut (Jones *et al*, 1999).

IMPLEMENTATION OF THE ALTERNATIVE RITE APPROACH

Description of the Approach

The idea of the alternative rite of passage, as conceptualised by PATH and MYWO, is to work with communities to develop and support a rite of passage that excludes genital cutting, but which is still relevant to the cultural beliefs and behaviours of each ethnic group. The approach used is to work with communities where MYWO has already undertaken FGM sensitisation activities over the preceding years through its 'Harmful Traditional Practices' programme. In these communities a group of girls are identified who do not want, or whose parents do not want them, to be cut and a culturally appropriate alternative rite of passage is developed and supported by MYWO and PATH.

Because of the different ways in which the community sensitisation activities were undertaken in each site, and because of the differences between the three districts in the traditional rite of passage itself, the alternative rite approach has been implemented with considerable variation in the three sites. However, the same peer education approach for community sensitisation and other IEC activities, the same three-day and five-day curricula (developed by PATH) for training peer educators and the girls, and a public ceremony are used in all sites.

Community Sensitisation through Peer Educators

A key sensitisation activity is the training of MYWO field staff so that they in turn can train selected community members as 'peer educators'. During their interactions with community members, MYWO staff identify community members who show support for FGM eradication and are suitable to receive training as voluntary peer educators. In some cases, community leaders assist in their identification. In all the three sites, the peer educators are from all age groups: youth (25 – 30 years), middle aged (35 – 40 years) and older (50 years and above). Both men and women are recruited, although most peer educators are women. The youth are girls who have decided not to be circumcised and are used as role models. The peer educators are expected to undertake one-to-one and group meetings, to identify parents and girls willing to participate in the alternative rite, and to assist MYWO staff in group sensitisation workshops.

The role of the peer educators is to educate other community members on FGM, the intention being to encourage them to contemplate abandoning the practice. With participation from MYWO and community groups, PATH developed a three-day curriculum for training peer educators which includes topics such as: the meaning and importance of peer education; perception and value clarification; interpersonal communication; harmful traditional practices; types of FGM and related physiology; basic facts on FGM; rumours and misconceptions about FGM; male and female empowerment, and developing a plan of action.

A review of the current peer educator's curriculum reveals that it places more emphasis on the health complications of the practice and its societal meaning than on its violation of a girl's basic rights. In 1998, however, PATH produced a manual for the training of trainers (Crane *et al.*, 1998), which firmly places the eradication of FGM in a human rights framework, although the health implications are still covered in depth. The extent to which this greater emphasis on human rights has percolated the practice of MYWO staff and volunteers at the community level is not clear.

Training Girls in Family Life Education

PATH and MYWO felt that the seclusion component of the traditional rite was still very relevant because of the teaching about adult life that takes place at that time. To emulate this traditional practice, the Alternative Rite includes a "seclusion" of three to five days during which the girls are given information on reproductive health through a formal curriculum, and receive "words of wisdom" from selected parents regarding their culture. The sessions are fully participatory and interactive and avoid too much lecturing. Initially, PATH conducted the training, but afterwards trained staff and volunteers from MYWO and *Ntanira na Mugambo* (see a description of this group in the next section) were used as trainers of trainers (ToTs) to continue with the exercise.

The topics covered in the curriculum include: interpersonal communication, understanding harmful traditions, Female Genital Mutilation, human anatomy, decision making, pregnancy and conception, STIs & HIV/AIDS, courtship, dating and marriage, and empowerment of men and women. The training curriculum does not provide guidance to the parents on the types of messages they give, and so it is difficult to assess whether girls receive messages that entrench existing gender roles and stereotypes or whether they receive female empowerment messages from these "mothers". However, gender empowerment is covered in the formal training curriculum and there is some discussion of girl's and women's right to equal education opportunities and sexual enjoyment and how FGM limits these rights. MYWO staff and trained volunteers cover the formal FLE sessions.

Public Ceremony

At the end of their seclusion and training a public ceremony is held during which the girls have a "graduation" to mark their coming of age. Public celebrations take place and the initiates receive gifts from the project and/or their families and members of the community. Through their songs, dances and drama, the girls make a public pronouncement that they have abandoned FGM. Influential political, religious and government administrative leaders are invited to give speeches on this day. In some cases, donor agency and other NGO staff as well as media personnel are invited to witness the occasion.

Implementation of the Alternative Rite in Tharaka

Although Tharaka is not one of the districts included in MYWO's 'Harmful Traditional Practices' Programme (through which the FGM sensitisation activities were undertaken), this district was the first (in 1996) to initiate an alternative rite (AR). Indeed, the AR ceremonies held in Meru South, Meru North, Gucha and Narok districts started later and sought to replicate the one developed in Tharaka.

The idea to start an FGM intervention strategy in Tharaka was first raised after the MYWO leaders from Tharaka attended the seminar organised by the MYWO national headquarters in 1995 to discuss FGM intervention strategies. The Tharaka MYWO leader came away from the seminar convinced that something could be done. Although Tharaka had not been selected as a project site for the alternative rite approach by MYWO because it was not part of the 'Harmful Traditional Practices' programme, the Tharaka leader and the then MYWO Meru District Coordinator went back to their community to try and develop a strategy to sensitise people about FGM, and to work towards the idea of holding an alternative ritual. The MYWO leader shared the information gathered on FGM and the idea of an alternative rite with people in her area and more specifically in her local church.

This information was received with much suspicion and she faced many obstacles. Nevertheless, using the MYWO network, she sensitised other women and particularly those

with girls who were old enough to be circumcised. Together they started sensitising the wider community on the harmful effects of female circumcision, and discussing the possibility of an alternative ritual. By August 1996, 29 girls and their families had accepted to undertake the alternative rite.

Although the MYWO volunteers spearheaded these activities, Tharaka was not eligible to receive funds from MYWO's 'Harmful Traditional Practices' Programme. To respond to this enthusiasm, PATH provided some direct funding to the group of volunteer individuals developing the alternative rite and encouraged and supported them to register as a welfare organisation so that they could solicit for additional funding. Consequently, they formed the *Ntanira na Mugambo* (NNM) organisation. Those who support the objectives and activities of this organisation register as members and to date there are over 200 families who have participated in this organisation and these are not restricted to families that have girls who undertake the alternative rite.

Coverage of the alternative rite in Tharaka is not defined in terms of administrative boundaries (the NNM team has even visited neighbouring Mwingi District). Whenever or wherever a parent expresses an interest, the NNM mobilises its trained members to sensitise the parents on the harmful effects of FGM, after which they invite them to seminars where they are given more information on the alternative rite approach. Once the parents and their daughters are sensitised and declare that they want their daughters to go through the alternative ritual, the girls are registered to participate in the next ritual.

When the project began in Tharaka it targeted only girls and mothers. Since only a few people explicitly wanted to stop the cutting, it was difficult to get the necessary level of support, and so a decision was made to use lobbying and advocacy strategies targeting community leaders (local administration, political leaders, and teachers) to gain wider social acceptance. To increase the participation of men, the team used their wives to gain their support for stopping the cutting and for participation in the alternative rite. This deliberate effort to involve men in the rite helped to improve the project's image. In addition, the project targets provincial administration officers such as chiefs, District Officers, and District Commissioners as well as elected political leaders to encourage them to talk about the harmful effects of FGM and discourage the practice in their area of jurisdiction. The NNM also uses schools, churches, and women's groups as avenues for passing on their messages and identifying parents willing to have their girls to participate in the alternative rite.

The training and ceremonies are organised during the months of August and December when the schools are on holidays and when traditionally the rite of passage with cutting takes place. According to the traditional practice, girls are cut at the age of puberty after which they undergo a period of seclusion. During the period of seclusion the initiate remains indoors and is visited only by other girls who have gone through the ritual, female relatives, and parents. A woman who is either an aunt or friend of the initiate is assigned the role of a "supporter" who takes care of the initiate. She ensures that the initiate receives the traditional family life education that prepares her for her role as an adult member of the community, as a wife, and as a mother. Both the cutting and the education received are what transform the girl from a child to an adult.

To publicly announce this transition, to mark the change, and to get community recognition, a public celebration is held on the first day she comes out of her hut to mark the end of her seclusion period. In addition, the initiate receives a new name. This important event brings honour to the initiate and her parents. Male and female, young and old members of the community, friends and relatives participate in this public celebration that is marked by feasting, drinking traditional brew, dancing, shouting and ululations. The initiate receives

gifts from her parents, relatives, and friends. In keeping with this tradition, community members in Tharaka and parents of Alternative Rite initiates actively participate in the 'alternative' ceremony through dancing, providing and cooking food for the celebration and giving gifts to the initiate.

A mother presents a gift to her daughter at the public AR graduation ceremony.

Implementation of the Alternative Rite in Gucha

Gucha was identified as one of the districts for MYWO's 'Harmful Traditional Practices' programme right from the beginning because of the almost universal practice of female circumcision among the Abagusii. Activities began with exploratory and baseline research in 1991-3, which was followed by sensitisation activities that began in 1994, and in April 1997 the first alternative rite took place. Because of financial constraints, the project in Gucha cannot possibly cover all of the administrative divisions, and even in divisions where the project is implemented not all locations and sub-locations have been covered. MYWO staff and leaders utilise the network of existing women's grass root groups and recruit and train peer educators to sensitise the community on FGM. In addition, the project uses schools to reach teachers and youth. In addition, the project targets provincial administration staff and other community leaders to influence them to talk about FGM in their public meetings so as to encourage community members to abandon the practice.

Although some families have been influenced to abandon FGM and adopt the AR, implementation of anti-FGM activities has met strong, although gradually weakening, opposition in Gucha. Apart from the district provincial administrative officials, most community leaders have not been forthright in their support, girls undertaking AR are subject to ridicule by their age-mates, and MYWO elected leaders themselves have been the subject of public verbal attack by some leaders in the district.

Before launching the first formal AR in April 1997, some parents who had decided not to cut their girls organised public ceremonies with the encouragement and support of MYWO staff, although the girls did not go through the seclusion and FLE training. The girls' parents, relatives, and friends met the cost for the food and gifts given to the girls. MYWO staff and peer educators present at these village-based celebrations also gave gifts to the "initiate girls". The parents who had decided not to cut their daughters did this because they felt that since they had participated and contributed food and gifts at the ceremonies of daughters of their

friends and relatives who had been cut, the 'Alternative Rite' public ceremony would give them an opportunity to receive the gifts and support from their friends and community in return. Even after the launching of the official MYWO-supported AR ceremonies, families wishing to have public ceremonies based in their villages continue to receive moral support from MYWO staff and peer educators.

By April 2000, only five formal AR ceremonies targeting 350 girls had taken place in Gucha over the three-year period. The FLE training component presents a challenge in Gucha. Traditionally among the Abagusii, the end of girl's seclusion is marked with a public celebration whereby groups of girls receive gifts from friends and relatives. However, Abagusii girls are cut at an early age (between 6 and 12 years) and for such young girls the type of education given through the PATH/MYWO curriculum to prepare them for adult life is more suitable for older girls. The MYWO staff in Gucha have used this curriculum, but have introduced some changes to suit the younger girls.

In Gucha, the girls themselves are reached primarily through the schools where MYWO carries out sensitisation activities. Their parents are fully involved, however, in making decisions regarding their girls being not cut, and their participation in the alternative rite ceremony. In the four case studies of AR families carried out in Gucha, all respondents reported that either the mother or father of the girl had initiated the idea of the girl not being cut and participating in the AR. Moreover, these parents themselves had usually been sensitised by MYWO staff or peer educators.

> *"I took my daughter for the alternative rite in 1999. You know this was the right age for her circumcision and we had not decided to take her for circumcision. When we told her that she will go for the alternative rite, she was not very hard because she had seen and heard from her friends about the alternative rite… The first time she hesitated to accept because of the obvious fact that her friends will ridicule her, but when we explained it to her she easily agreed and she was happy especially when she went for the training and found many other girls. She was encouraged… You know in our home we do not have cases where the mother figure is the only person to tell a child certain things. No. We have set a free atmosphere where the father can tell the girls anything and I can tell the boys anything.*
>
> *On this very occasion, we discussed the issue with the father and later informed the child. Both of us have been involved in the MYWO teachings so there was no big problem… I introduced the idea because I went for the MYWO training earlier. When I told him first he squarely asked me what it was that I was telling him. He did not like the idea but later the MYWO people visited him and he agreed to the issue. But initially, he was opposed and he was wondering whether I wanted to make my girl to be like a Luo [laughter]. But when he realised, he became a big supporter."* (A 41 year-old mother of a 14 year-old AR initiate - Gucha).

Implementation of the Alternative Rite in Narok

The project in Narok started with a baseline study, the findings of which indicated that FGM was perceived to contribute to teenage pregnancy and early marriage. MYWO decided to start an anti-FGM campaign using the importance of girls' education as an entry point. Although there are cultural differences between the Maasai and the Kalenjin who live in Narok in relation to FGM, MYWO used similar sensitisation strategies when reaching both groups. To sensitise community members and provide information on the harmful effects of

FGM, MYWO staff and volunteers in Narok used the existing network of women's groups, schools, and churches. Since 1994 when the sensitisation and IEC activities started, the project has not been able to cover all the administrative divisions due to financial constraints and in divisions where the project is implemented not all locations and sub-locations have been covered.

Among the Maasai of Narok, the end of a girl's seclusion period after undergoing genital cutting is not a public ceremony but instead the parents organise a feast at home. The Kalenjin have also abandoned their traditional public ceremony, by making the cutting an individual family affair. In view of this cultural practice, the project in Narok began by holding the seclusion training for the girls who were not being circumcised, but without the public ceremony. The FLE training in Narok does not, however, always conform to the basic requirements of the PATH curriculum in terms of duration, organisation, or content. Training does not necessarily go on for five days and the curriculum used is more relevant for peer educators. It is not clear whether this is due to financial constraints or to a deliberate choice by the Narok MYWO staff to do things differently.

Since the public ceremonies were reported to be successful in the other districts where MYWO was implementing the Alternative Rite approach, the MYWO staff in Narok were influenced to include the public ceremony component in their alternative rituals. Before implementing the first Alternative Rite incorporating the public ceremony component, the project had already implemented two AR activities (comprising of 49 girls) without the public ceremony component. The first AR incorporating the public ceremony component took place in December 1998, and up to April 2001 the project had implemented eleven such ceremonies targeting 750 girls from Mau, Mulot and Trans Mara[17] Divisions. MYWO has held AR ceremonies in Mau and Mulot with both Maasai and Kalenjin participants, as well as separate ceremonies with only one group participating. Unlike Tharaka and Gucha, however, where parents and community members actively participate in the public ceremony through providing gifts, cooking food and dancing, parents in Narok do not make any contributions at all. Indeed, MYWO also provides transport to the parents to come and witness the graduation ceremony. Whether this public ceremony component should continue in Narok with such a notable lack of enthusiasm from the girls' parents is clearly debatable.

To identify girls who will participate in the alternative rite, MYWO relies on schools and community leaders to propose girls who are thought to be eligible, i.e. who are thought to not be circumcised. Information from focus groups and in-depth interviews indicate that, in some cases, the parents of girls going through the alternative rite are not always fully informed; indeed, some thought that their daughters were attending a training seminar whose objective they did not understand. This lack of full involvement by some parents was further confirmed by the three case studies of families in which girls had been through the alternative rite. One father commented that:

> *"My daughter was selected from school. She was given an invitation letter. She informed me and explained what they were going to do. That is to be given family life education training by MYWO. I did not like the way they were selected at school because I believe I should have full responsibility for my children and when they are just selected and whoever is going to be with them during the seminar does not come to me as a parent it's not a good show. ...*

[17] Trans Mara was originally an administrative Division in Narok district, but since 1999 the Division was given the status of a district.

In fact I did not personally see any MYWO member coming to me to ask for the girl and I do not think they even explained fully to my daughter what they were going to do" (Father of a 13 year old initiate from Narok).

A mother of another initiate echoed the same sentiments:

"*My daughter's invitation was done when in school. She informed me that she had to attend a seminar in Narok town. I did not object although I did not like the approach. A responsible person should have approached me first. It's not fair for anyone to approach teachers to get my daughters away from home over the holidays because I have duties I have assigned my daughter to do during the holiday which teachers do not know anything about."* (A mother of a 14-year-old initiate – Narok).

One of the girls stated that:

"I was selected from school and was given an invitation letter. I informed my parents who did not object although I had to explain what we were going to do there. It was a tough job because I did not know what it meant to go through the alternative rite. I thought we were just to be taken for a seminar to be taught about life. But when we went for the seminar we were told that when one goes through the alternative rite she will not be circumcised" (Narok AR initiate, 13 years old).

As these statements indicate, even though most parents of girls attending the alternative rite support the idea of eradicating the practice and, indeed, have not and will not cut their girls, the methods used by MYWO to recruit the girls for the alternative rite should have involved the parents more fully to avoid these situations. Unfortunately, during the study[18] it was found that, for a small number of parents who were not consulted and sensitised about discontinuing the practice and having their girls participate in the alternative rite, the discovery that their girls were about to go through the alternative rite, or had already participated, provoked them into circumcising their girls anyway.

New AR graduands accompanied by MYWO officials at a street demonstration, which is part of the AR graduation ceremony.

[18] This situation was also noted for isolated instances during the study by Olenja (2000).

EFFECT OF THE ALTERNATIVE RITE PROGRAMME ON GIRLS' REPRODUCTIVE HEALTH KNOWLEDGE AND GENDER ATTITUDES

The MYWO/PATH Alternative Rite programme includes a component that seeks to replicate and strengthen the traditional period of seclusion during which girls are educated in a group about the transition from girlhood to womanhood. Within the Alternative Ritual programme, this component has been formalized into a training activity to educate girls about a variety of reproductive health and other issues. This section reviews the results of interviews with the 442 'initiates' who went through the alternative ritual and attended the 'seclusion' training, and compares them with those of the 626 girls sampled (from both AR and non-AR families) who did not attend the training (the 'non-initiates').

Description of Initiates

As described in the sampling plan earlier, all girls known to have gone through the alternative ritual were identified by MYWO, and as many as possible were interviewed during the fieldwork – 132 in Narok, 152 in Gucha, and 158 in Tharaka. Table 3 describes the background characteristics of the initiates in each district, and also provides a comparison of these girls with those who were interviewed from the AR and non-AR families that had not gone through the alternative ritual.

Table 3 Characteristics of AR initiates and other girls sampled

	Narok (n=132)	Gucha (n=152)	Tharaka (n=158)	All initiates (n=442)	All non-initiates (n=626)
Median age	16	14	16	16	13
Read English (%)	96	94	95	95	75
Attended School	99	100	99	99	97
Primary	50	76	63	64	85
Secondary	47	24	33	34	14
Tertiary	3	0	4	2	1
Father can read	82	93	90	89	87
Father attended school	82	92	90	88	86
Mother can read	65	83	80	77	68
Mother attended school	64	86	79	77	73

There were some differences in age between the groups – all the Abagusii girls going through the alternative ritual in Gucha were less than 20 years and were younger on average than the Maasai and Kalenjin in Narok and the Meru in Tharaka. In all three sites, and in Narok and Tharaka in particular, it is notable that almost half of all the initiates (49% in Narok and 50% in Tharaka) were aged over 17 years and above, and so were beyond the age at which they would have gone through the traditional rite and at which they would have been expected to be cut.

There were also a small number of AR initiates (eight in Narok and three in Gucha) who were actually cut. Interviews with some of these girls indicate that, for the most part, they

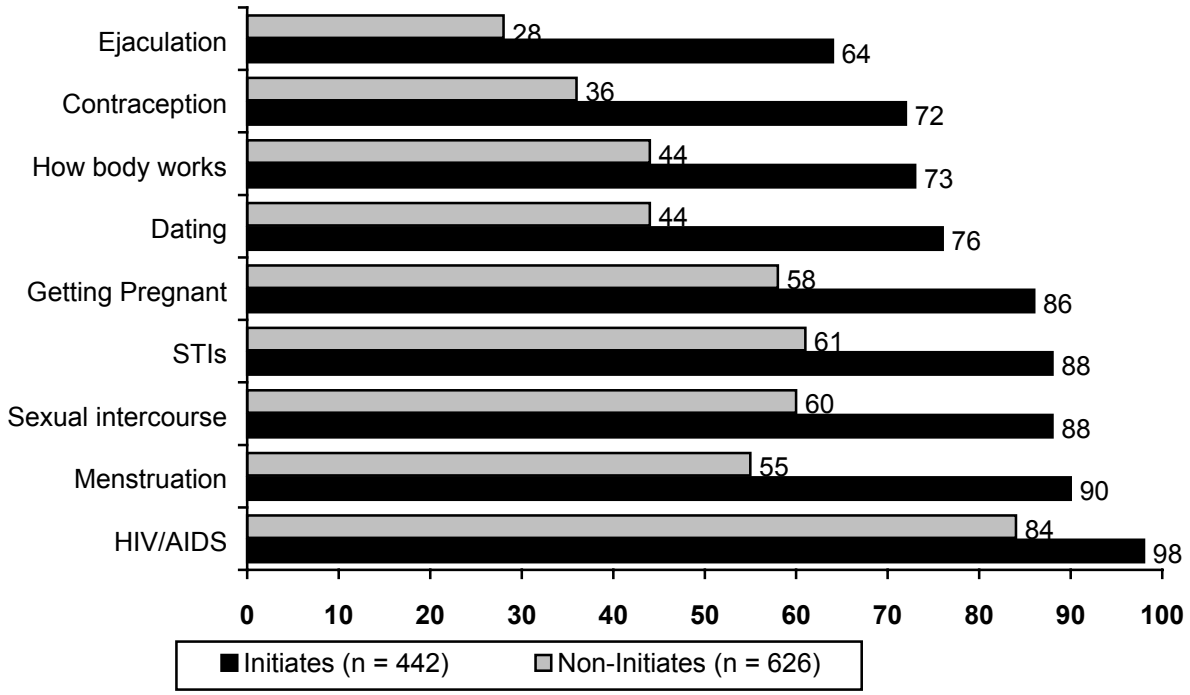
concealed their status from the MYWO staff because they wanted to participate in the training given during the seclusion period and in the public ceremony. Some of the girls in Narok also said that as a result of their conversion to "born again" Christianity, they had become convinced that FGM was "sinful" and wanted to demonstrate publicly their change of heart by participating in the alternative ritual**.** However, two of the girls from Gucha were in support of having been cut, did not regret the fact that they were cut, wished to cut their future daughters, and expressed the view that FGM should continue, and so it is not clear why they participated in the alternative rite.

Although levels of education reached by the girls appear to be higher for the initiates, this may reflect the fact that their average age is higher and so they are more likely to have completed tertiary education. There is little difference between initiates and non-initiates reporting their fathers' education level and reading ability (although those in Narok are somewhat less educated). A comparison between the girls' mothers reveals no difference in proportions ever going to school, but a significant difference (0.003)[19] in the reported levels of ability to read English.

Reproductive Health Knowledge

As can be seen in Figure 2, those initiates who went through the seclusion training are much more likely than the non-initiates to be aware of important reproductive health issues. As these are the issues that were covered during the MYWO seclusion training the results are unsurprising, but they do serve to illustrate the generally low level of awareness of reproductive health among the non-initiates and the role the MYWO seclusion training can play in increasing basic levels of awareness on these topics.

Figure 2: Proportions of girls aware of reproductive health issues (%)



[19] Fishers' Exact Test.

When asked more detailed questions on specific issues, however, knowledge was found to be poor for all girls, although slightly better among the AR initiates. For example, although overall knowledge was poor about the development of the reproductive system, significantly higher proportions of initiates than non-initiates knew that a girl could get pregnant when she starts her monthly periods (36% compared to 15%) and that a boy can make a girl pregnant when he starts ejaculation (23% compared to 8%). Knowledge about when during the monthly cycle a girl is most likely to get pregnant if she has unprotected sex was also poor overall, but the proportion correctly knowing a girl's fertile period was higher among the AR initiates (20%) than the non initiates (10%). However, a higher proportion of AR initiates (44%) compared to non-AR initiates (17%) thought that they knew the correct timing but actually had incorrect knowledge, indicating that the training needs to make sure that girls fully understand the menstrual cycle and its relationship with fertility.

AR initiates are twice as likely to have heard of contraceptives than non-AR initiates (68% and 33%). Among all of those who say they know of family planning, the pill, condoms, and injectables are the best-known methods. There is no difference in knowledge of specific methods between AR initiates and non-initiates, however, suggesting that the training needs to cover the individual contraceptive methods in more depth.

When asked to name the specific STIs known, the AR initiates had much higher levels of awareness than the non-initiates of HIV/AIDS (97% vs. 86%), syphilis (81% vs. 38%) and gonorrhoea (82% vs. 45%). There was not much difference, however, between the two groups in their awareness of other STIs.

Initiates also had higher levels of knowledge than non-initiates about transmission of STIs and HIV/AIDS – only eight percent of AR initiates compared with 31 percent of non-initiates did not know how a person gets an STI. Interestingly, within the multiple responses given when asked how a person gets an STI, both groups gave a 'partner's other partners' as the main response (44% for AR initiates and 30% for non-initiates), and similar proportions (21-22%) gave 'other sexual partners' as a response. There was a large difference between the groups responding that a person can get an STI from their regular partner – only nine percent of non-initiates compared with 27 percent of AR initiates. This suggests that the seclusion training rightly puts emphasis on the possibility of a woman being infected by her regular partner.

Similarly, AR initiates had higher levels of knowledge about HIV transmission, with only four percent of AR initiates compared with 14 percent of non-initiates not knowing how a person gets infected. On average, AR initiates were able to name more transmission mechanisms than non-initiates, with almost two thirds naming sexual intercourse, non-sterile needles and blood transfusions, although only 12 percent could mention transmission during pregnancy. Whereas only six percent of AR initiates did not know what a person could do to avoid getting an STI or HIV/AIDS, 29 percent of non-initiates didn't know any ways. Again, on average the AR initiates could name more ways of avoiding infection. The majority of both groups cited abstinence as the main means of prevention, but only 14 percent of AR initiates and 12 percent of non-initiates mentioned using condoms. Condom promotion for infection prevention clearly does not feature strongly in the seclusion training.

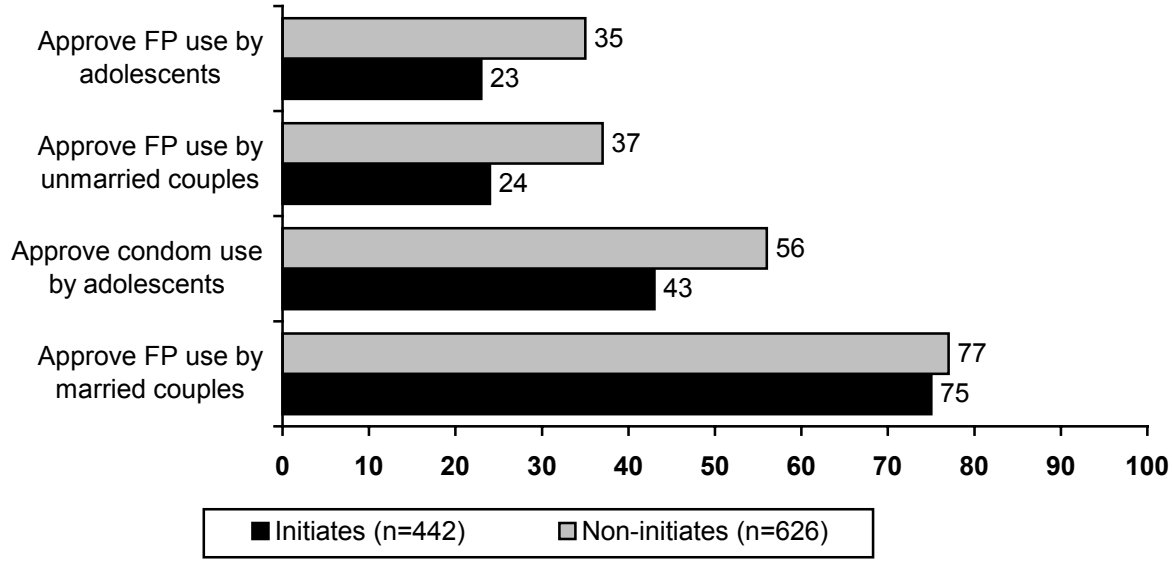
When asked how they first heard about these reproductive health issues and from whom, or where have they heard the most useful information, teachers are the first and the most important source of information for both initiates and non-initiates on all issues except dating and sexual intercourse. For dating, friends and relatives were the first and most important sources mentioned most frequently, and for sexual intercourse friends and relatives were the most frequently mentioned first source, but teachers were slightly more important sources.

Across all reproductive health issues, MYWO was the first source of information for 5 – 10 percent of the AR initiates and the most useful source for 7 – 21 percent of them. After teachers, MYWO was cited as the second most useful source for how the body works, how girls get pregnant, contraception, STIs and HIV/AIDS.

Attitudes and Behaviour Concerning Family Planning and Sexual Activity

Approval of condoms and use of other contraceptives was generally low among all girls, especially by adolescents and by unmarried couples. A slightly higher proportion (45%) approved of condom use of adolescents for STI prevention, pregnancy prevention, or both, and three-quarters approved contraceptive use among married couples. As can be seen in Figure 3, the non-initiates were actually more likely to express approval of contraceptive use in all situations (although the difference is significant only for 'use by unmarried couples'). This suggests that the trainers may encourage a rather negative attitude towards contraceptive use through the way they teach, perhaps through emphasising pre-marital abstinence rather than protected intercourse. This seems to indicate that the training that the initiates receive does not necessarily impart positive attitudes towards contraceptive use or is not capable of changing existing negative attitudes.

Figure 3: Attitudes towards contraceptive use among girls (%)



In relation to their personal sexual activity and contraceptive use, there is no significant difference between the AR initiates and non-initiates. Despite the AR initiates being substantially older on average age than the non-AR initiates, small proportions of both the AR initiates (15%) and non-initiates (16%) have ever had sex. Out of these, about one quarter of the initiates (27%) and one half (41%) of the non-initiates had sex during six months prior to the interview, but this difference is not significant[20]. Of those who have ever had sex, only seven percent of the AR initiates and 12 percent of the non-initiates used a

[20] Used Person Chi-square and Fishers' Exact Tests.

contraceptive method the first time, and only 21 percent of the AR initiates and 28 percent of the non-initiates used a contraceptive method the last time they had sex.

Gender Attitudes

Responses to a series of seven 'agree/disagree' questions concerning different aspects of gender relations indicate that on average both initiates and non-initiates have attitudes suggesting a belief in gender equality. However, AR initiate girls are more likely to express gender egalitarian attitudes than the non-initiate girls. The difference between the initiates and non-initiates was significant for the attitudes that it is not justified for a man to hit partner ($p < .05$); women should have equal opportunities as men ($p<.001$); men and women should have equal rights ($p<.01$); men have a right to sexual enjoyment every time they have sex ($p<.001$); and women have a right to sexual enjoyment every time they have sex ($p<.001$). For the attitude that girls should have equal rights as boys and boys should be sent to school first before girls, the difference between the two groups was not significant. In addition, initiates (59%) were more likely than non-initiates (20%) to express the view that FGM contravenes the rights of women and children.

FAMILIES' BELIEFS AND ATTITUDES ABOUT FGM

Perceptions of Benefits and Disadvantages of FGM

Benefits

When asked their opinion of the benefits or advantages of FGM, those in AR families were much more likely than those in non-AR families to state that there were no benefits or that they did not know of any benefits to the practice (see Table 4). Even within the non-AR families, however, significant proportions were not able to cite any benefits, especially for the girls and boys among whom the majority felt it did not have any importance or benefits. For those giving benefits, the parents were more likely to cite maintenance of tradition or culture, whereas the adolescents, especially the boys, saw benefits for the girl in terms of eligibility for marriage and respect. Across both types of families, there were significant differences between ethnic groups, however, ranging from 35 percent of Maasai to 64 percent of Kalenjin who did not think there were any benefits to the practice.

Table 4: Perceived Benefits of FGM (%)

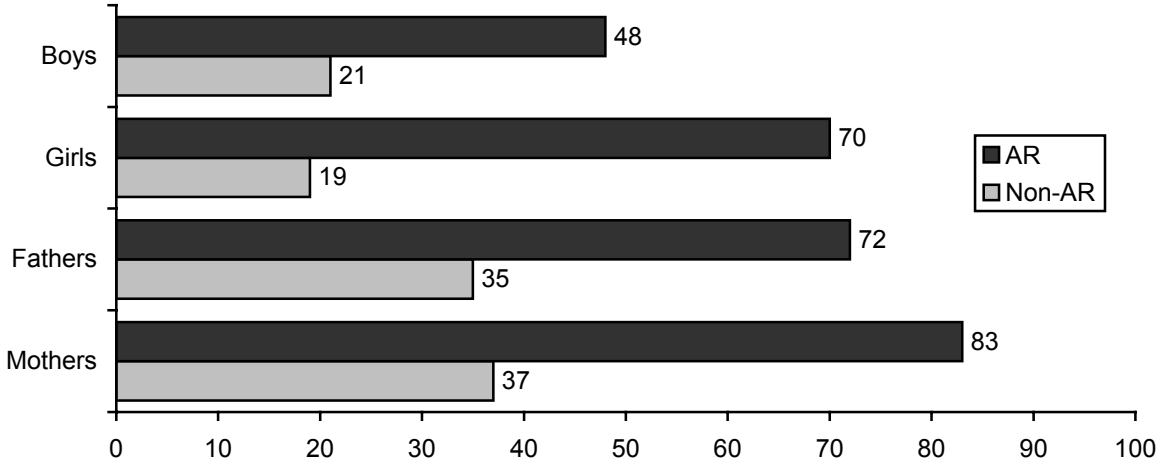
	Girls		Boys		Mothers		Fathers	
	AR	Non-AR	AR	Non-AR	AR	Non-AR	AR	Non-AR
No benefits / don't know	87	67	74	57	79	43	59	32
Maintains tradition/culture	7	7	13	11	16	29	23	42
Eligibility for marriage	4	7	12	23	9	16	14	21
Confers respect for girl	2	13	11	19	9	12	9	14

Disadvantages

One key issue facing all efforts to eradicate FGM is the type of messages and arguments used to convince those practising female circumcision to stop. Two broad approaches are most commonly taken, one that highlights the potential for genital cutting to adversely affect the health (broadly defined) of girls and women, and one that argues that cutting the genitals of girls and women contravenes their human rights to bodily integrity. The MYWO sensitisation activities focused primarily on the health effects approach, although reference to issues of empowerment and equal education were made. To assess the effect of these messages, respondents were asked about their knowledge of any adverse health / psychological / social effects of the practice, as well as their opinion as to whether the practice goes against girls and women's rights.

In all sites, members of AR families are much more likely to know about any health and/or social/psychological problems than their non-AR counterparts (see Figure 4). There were also some differences between ethnic groups, with the Maasai least likely to know and the Meru the most likely to know any of these problems. Among all the groups interviewed, knowledge of health problems was higher than knowledge of any social and psychological problems (see Table 5). Bleeding/anaemia, septicaemia and difficult labour were the most frequently mentioned health problems.

Figure 4: Knowledge of any health and social/psychological problems associated with FGM (%)



Between 15 and 20 percent of all boys, girls and mothers (but only 5% of fathers) mentioned spread of diseases including HIV/AIDS as a potential health problem. This issue arises frequently in public discussions about female circumcision, due to fears of disease transmission through use of a shared instrument (which may have influenced the change in instruments used as noted above), as well as the real possibility that women who have been cut may be at greater risk of contracting a genital infection[21].

Only small proportions (less than 10 percent) of any respondents mentioned social problems such as limiting girls' education and encouraging early marriage, and it was the fathers who were more likely to mention these problems. This suggests that the anti-FGM sensitisation activities tend to emphasise health over social and psychological problems.

Table 5: Harmful effects mentioned by type (%)

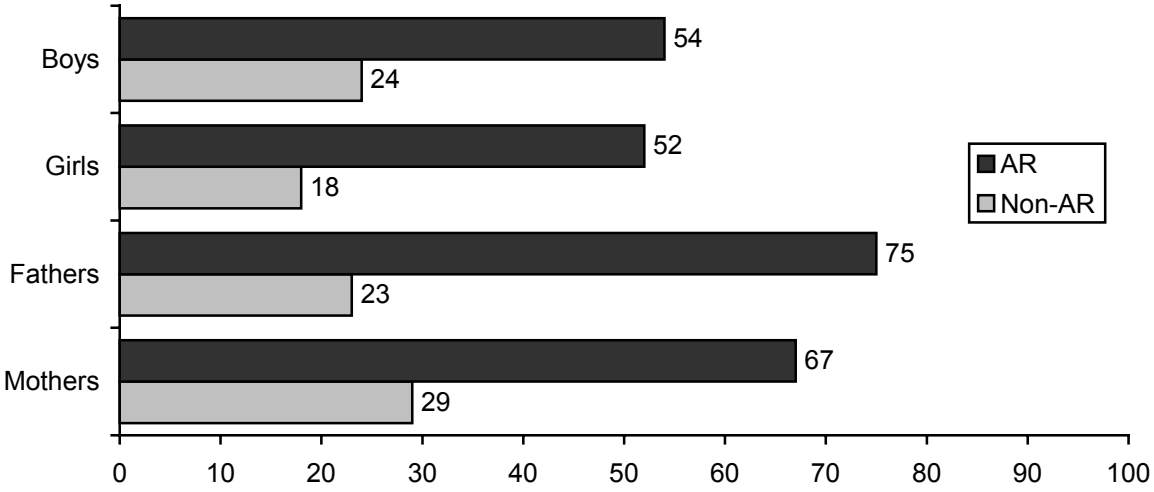
	Children		Parents	
	AR	Non-AR	AR	Non-AR
Bleeding / anaemia	82	71	90	84
Septicaemia	32	18	30	23
Difficult labour	26	13	27	14
Scarring	17	5	25	6
Perineal tears	12	2	17	9
Limits girls' education	8	1	11	8
Encourages early marriage	6	2	9	4
Reduces sexual satisfaction	7	2	6	6
Against women's dignity	1	5	5	2

[21] Studies of gynaecological morbidity associated with genital cutting in The Gambia (Morison *et al*, 2001) and in Burkina Faso and Mali (Jones *et al*, 1999) indicate that women who have been cut are at greater risk of Bacterial Vaginosis and Herpes Simplex Virus-2, and that the more the severe the type of cut the greater the likelihood of a woman having symptoms of a reproductive tract infection.

When asked whether, in their opinion, FGM contravened the rights of girls and women, once again those in AR families were much more likely to feel that it did do so (see Figure 5). It is important to note that those in the Abagusii and Maasai ethnic groups were much less likely to hold this opinion than the Meru or Kalenjin.

Those that did feel this way were then asked, in an open-ended question, which rights in particular they thought FGM contravened. No single right in particular predominated, with the right to protection against physical injury and abuse and the right to fully develop their potential being the most cited by parents and children, with the right to equal educational opportunities also being cited by the boys and girls.

Figure 5: Perception that FGM contravenes the rights of girls and women (%)



Attitudes Towards FGM

Differences between circumcised and uncircumcised girls

Although the majority (56 – 82%) of the respondents in all groups expressed the view that there is no difference between circumcised and uncircumcised girls, a slightly smaller (but statistically significant) proportion of AR household members feel there is a difference. The most frequently given reasons are that circumcised girls are more socially acceptable and are more likely to be respected by their peers.

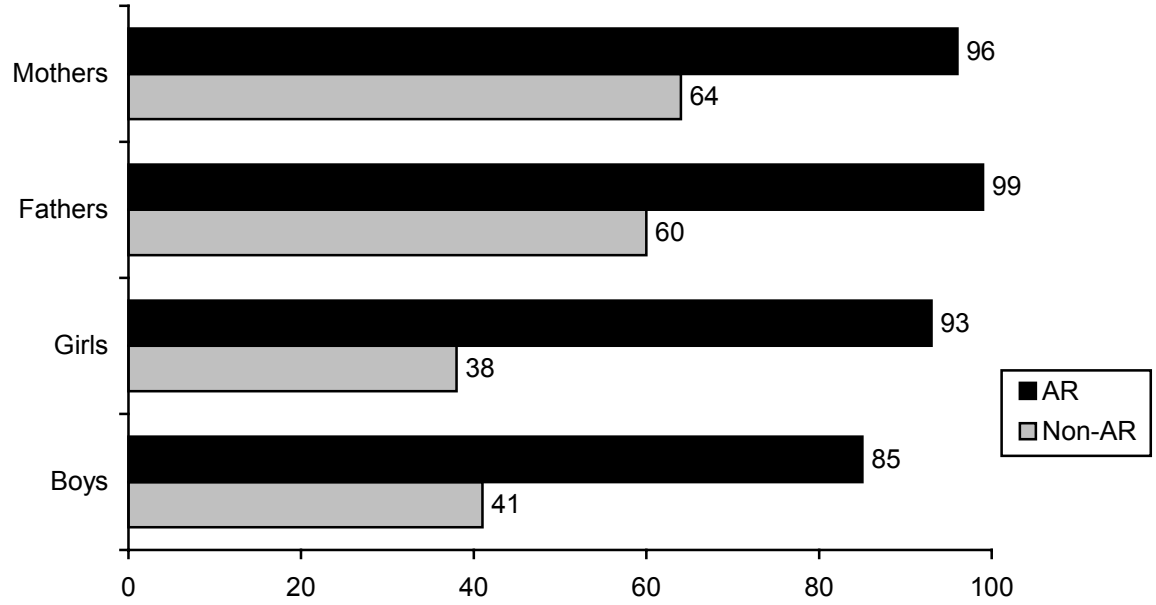
However, 45 percent of AR mothers and 30 percent of the AR fathers who thought there was a difference expressed the view that circumcised girls are more likely to be sexually promiscuous and badly behaved. As noted earlier, this is most likely to be because circumcised girls are perceived to be adults and so there is an expectation that they will behave more like adults, including becoming sexually active. Interestingly, there is some difference in reported sexual activity between circumcised and uncircumcised never married girls aged 15 years and above (except in Tharaka district), in that 34 percent of the circumcised girls compared to 19 percent of the uncircumcised girls reported ever having had penetrative sex. However, among these girls, there is no significant difference between the

circumcised and uncircumcised girls in terms of their being currently sexually active[22], or the mean number of lifetime sexual partners.

Eligibility of Uncircumcised Girls For Marriage

When asked whether they felt that men would marry an uncircumcised girl, the vast majority of those in AR households agreed with this view, whereas significantly smaller proportions agreed from the non-AR households (see Figure 6). Also, respondents from the Kalenjin and Meru ethnic groups are much more likely to hold this view than the Maasai and Abagusii. Moreover, uncircumcised girls (86%) and those girls that have participated in the AR as initiates (96%) are much more likely than those who are already circumcised (30%), and those living in non-AR households (73%), to believe that uncircumcised girls are likely to get a marriage partner.

Figure 6: Proportions of respondents that feel men would marry an uncircumcised woman (%)



Regret concerning Personal Circumcision

Whereas three-quarters of the women from AR households who had been circumcised expressed regret at having been cut, only one quarter of those from non-AR households regretted being circumcised[23]. When asked the reasons for regretting having been cut, the most frequently mentioned are: painful experience (38% mothers and 23% girls); medical complications (21% mothers and 19% girls); against their religion (11% mothers and 21% girls); and the practice has lost its significance (14% mothers and 11% girls).

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[22] Defined as having had sex in the previous six months.

[23] About half of the 33 circumcised girls in the AR families (siblings of those girls who have gone through the alternative rite) also expressed this regret, compared with only 13 percent of the 292 circumcised girls in non-AR families.

All parents were asked whether they now regretted circumcising those of their daughters who had already been cut (up to a maximum of four daughters). There are much higher levels of regret for having had it done among the AR parents than the non-AR parents: of the 124 daughters reported to have been cut by the AR parents, 79 percent of these circumcisions are now regretted, whereas of the 435 daughters reported to have been cut by non-AR parents, only 16 percent of these circumcisions are now regretted.

Intention to circumcise future daughters

The proportions of girls (93%) and boys (81%) in AR households who do not intend to circumcise their daughters are significantly higher than the proportions of girls (36%) and boys (13%) in the non-AR households. Many reasons were cited for this attitude including: medical complications, against religion, lost significance, and having learned about harmful effects through participation in the alternative rite[24]. Those girls and boys intending to circumcise their daughters gave the belief that custom and tradition demand that a girl be circumcised as the main reason, with better marriage prospects also being mentioned, especially by boys.

Abandonment of FGM

When asked whether they felt FGM should or should not continue in their community, almost everyone in AR families felt that the practice should be abandoned, as would be expected (see Table 6). The boys did not feel as strongly as the others, which may be because, of the four sub-groups, they are least directly associated with the practice.

It is important to note that within the non-AR households more parents were in favour of discontinuing than continuing the practice. Moreover, although levels of 'no opinion' are low overall, the proportions are higher among those in non-AR families and among the girls and boys. These results suggest that many of those in the project sites are considering discontinuation of the practice, i.e. are at the 'contemplation' stage of the behaviour change model, and so may be encouraged to move to the action stage if 'preparation' activities (such as the alternative rite) are promoted that would convince them of the social support for changing their behaviour.

Table 6: Attitudes towards the community continuing or discontinuing FGM (%)

	Girls		Boys		Mothers		Fathers	
	AR	Non-AR	AR	Non-AR	AR	Non-AR	AR	Non-AR
FGM should continue	3	53	10	46	3	42	2	43
FGM should not continue	93	32	78	38	96	49	97	49
No opinion	4	15	12	16	1	9	1	8

There are, however, some important differences between the ethnic groups within the non-AR families. Whereas over half of the Abagusii (54%) and Maasai (54%) non-AR parents

[24] It is worth noting that, unlike the other sub-groups of adolescents, a substantial proportion of boys in the non-AR households (37%) were undecided on this issue, although 50 percent of these boys were in favour of circumcising daughters.

stated that FGM should continue, only small proportions of the Meru (16%) and Kalenjin (23%) non-AR parents want the practice to continue. These findings suggest that more sensitisation activities are needed among the Abagusii and Maasai if community-level attitudes in favour of discontinuation are to become the majority view, thereby creating conditions for the alternative rite to become an option.

Among those supporting continuation of the practice in the non-AR families, the majority indicated that this was based on the belief that FGM is a good tradition, with sizeable proportions also stating that it is ensures a girl's marriageability, and that the practice brings honour to the girl and her family.

For those who felt their communities should discontinue the practice, a multiple-response question brought a wide range of reasons why (see Table 7). The most frequently cited reasons overall (for both parents and youth) were that it has lost its meaning, it is against religious beliefs, and has medical complications. There are some slight differences between those from AR and non-AR families, and overall those in AR families are able to give more reasons, suggesting they may be better informed about the problems associated with the practice. For substantial proportions of parents and youth in the AR households, especially among the mothers and daughters, learning about the alternative rite also seems to have been an important factor in their thinking.

Table 7: Reasons given why FGM should be discontinued (%)

	Girls		Boys		Mothers		Fathers	
	AR	Non-AR	AR	Non-AR	AR	Non-AR	AR	Non-AR
Lost significance	37	21	50	46	44	47	51	50
Against religion	31	28	29	24	41	36	48	24
Medical complications	37	25	33	27	38	27	33	34
Limits education	20	14	16	16	21	18	29	10
Painful experience	12	18	6	12	27	31	16	10
Learnt about Alternative Rite	**37**	**12**	**33**	**4**	**45**	**7**	**23**	**2**

FACTORS ASSOCIATED WITH PARTICIPATING IN THE ALTERNATIVE RITE

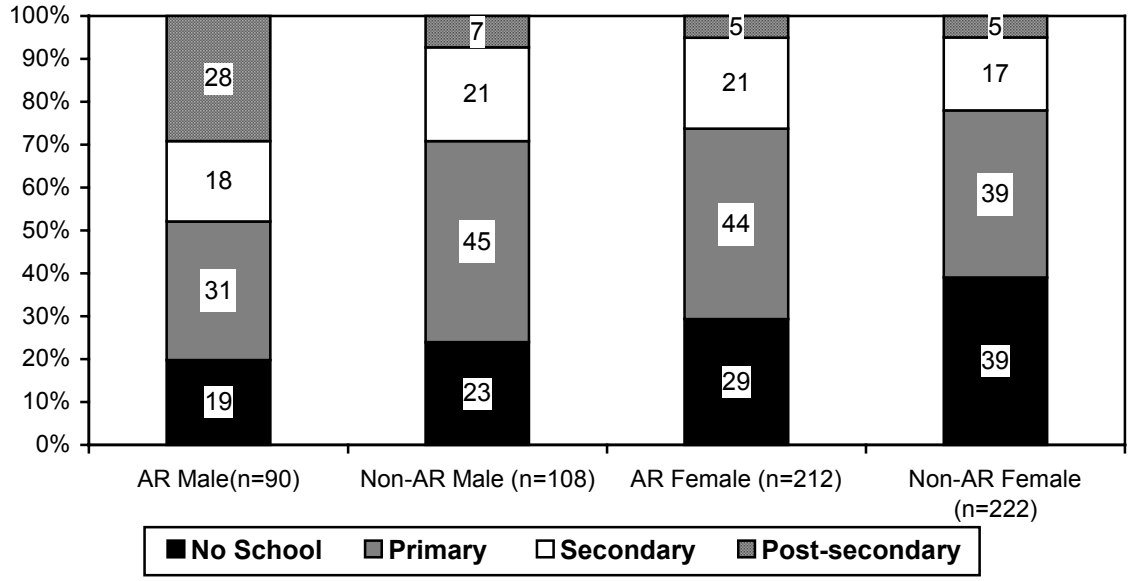
Information gained from focus group discussions and in-depth interviews undertaken prior to the survey suggested that factors such as education, religion, socio-economic status, employment, attitudes towards gender issues, and the mothers' and daughters' circumcision status might pre-dispose an individual or family to abandon the practice of FGM, thereby making them more likely to want their daughters to go through the alternative rite of passage. For example, the rise of Christianity is thought to undermine the fear that people have traditionally had of displeasing the ancestors or drawing a curse upon themselves for failing to undertake some cultural practices. Some discussants felt that circumcision prevents girls' maximising their educational achievement because of the traditional expectation that a circumcised girl becomes a woman who is then free to engage in sex and is expected to marry immediately after being cut. Moreover, urbanisation brings interactions with people from various cultural backgrounds, some of which do not practice FGM.

The following section explores each of these factors, and also explores the role that the sensitisation activities undertaken by MYWO prior to and during the AR programme may have played in encouraging families to abandon FGM.

Education

A higher proportion of parents and youth from the AR households than from the non-AR households have ever attended school, but this difference is not particularly significant overall (although it is significant at the 0.05 level for the female parents). Among those who have ever attended school, however, significantly higher levels were attained by female and male youth aged 15 and above and for male parents in AR households, but there are no significant differences among female parents (see Figure 7).

Figure 7: Parents' levels of education



There is also a difference in school attendance between the four ethnic groups – the Abagusii (83%) and the Meru (70%) have higher proportions of parents of both sexes who have ever been to school than the Kalenjin (58%) and Maasai (41%).

Religion

As seen above, religion was frequently cited as an important factor influencing the decision to stop practising FGM. There are substantial variations in religious affiliation among the parents within and between the ethnic groups:

- Among the Abagusii, the Seventh Day Adventist (SDA) church has by far the highest representation (about 60%), followed by Catholics and Pentecostals.
- Among the Meru, most are Methodists (44%) or Catholics (37%), with a small proportion of Pentecostals.
- Among the Kalenjin, by far the predominant denomination is the African Gospel Church (AGC) (over 50%) followed by Catholics and Pentecostals.
- Among the Maasai, the African Inland Church (AIC) (38%) and Pentecostals (18%) are the predominant formal churches, but 35% of respondents stated that they had no religion or belonged to a non-mainstream church.

For both parents and youth, there are significant differences in religious affiliation between the AR and Non-AR households. The Methodists and AGC members were found to be more likely to participate in the AR programme, whereas the Catholics and Pentecostals are less likely to participate. Among the SDA and AIC members, no difference was found in whether or not they participate in the AR programme. This relationship was found consistently for three of the four study sites, the exception being the Mau site, which is primarily Maasai and for which the numbers of practitioners of formal religions are too small to draw conclusions.

Information gathered from focus group discussions and in-depth interviews suggest that the Methodist church in Tharaka (Meru), the AGC in Mulot (Kalenjin), the AIC in Narok (Maasai) and the SDA church in Gucha (Abagusii) do take a stand against FGM. However, in all four sites, it was reported that the Catholic and Pentecostal churches do not actively preach against the practice. Many of those wanting their communities to discontinue the practice (see previous section) felt that FGM is against their religion, and so clearly the organised churches can be an important actor in sensitising their congregations about FGM. For all the study populations, the church plays a major role in their lives (almost 80% of all parents attend church at least once a week), and so messages from their church can be quite influential.

Employment

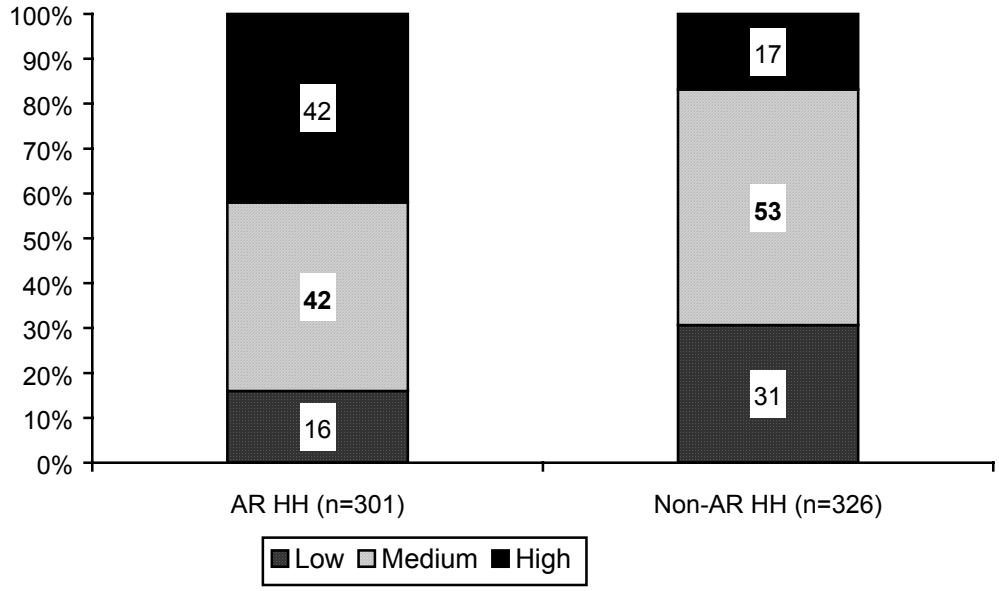
The most common occupation (for 57% of the parents) across the four sites is working as a rural labourer or farm worker (except among the Maasai for which the most common work is herding livestock). There is a weak but significant relationship ($p = 0.02$) between being a labourer and not participating in the AR programme; however, the occupation with the most significant difference between AR and non-AR parents is a regular salaried job. Although the overall proportion of parents in a regular salaried job is low (14%), those in AR households (18%) are much more likely to be in regular employment than those in non-AR household (9%).

Socio-Economic Status

The standard DHS indicators were used to assess the socio-economic status of a household: ownership of land, livestock, radio, T.V., electricity, cash crops, bicycle, and fridge; the type of water source and toilet; roof, wall, and floor materials of the main house. Each household was given a score of one point per item if it had a flush toilet or pit latrine; a roof made of

tiles or iron sheets; the floor made of cement or wood; and the walls made of bricks, stone, or timber. For each of the other items, a household scored one point per item available. Households were then categorised by scoring them as low status (1-4 points), medium status (5-6 points) and high status (7+ points). This categorisation was reached through dividing the overall distribution of points into three approximately equal groups.

Figure 8: Socio-economic status by type of household



As can be seen in Figure 8, a significant relationship exists between a household's socio-economic status and the participation of its daughters in the Alternative Rite, with AR households significantly more likely to have higher socio-economic status than non-AR households.

Gender Attitudes

A series of seven 'agree/disagree' questions concerning different aspects of gender relations were asked of parents and youth to measure their gender attitudes (see Table 8), and these were compared by whether they were in an AR or non-AR household. A significant difference exists between the AR and Non-AR households in two of these questions for the parents and in four of the questions for the youth.

Overall, most respondents indicate attitudes that suggest a belief in gender equality. For the first five questions, the majority of respondents feel that men should not hit women and that females should have equal rights and opportunities to males. Despite this apparently high level of consistency across all groups, there is a general pattern of higher levels of agreement with positive gender attitudes among AR household members than non-AR household members, some of which are statistically significant differences.

When the sex of the respondent is controlled, however, the analysis indicates that there is no significant difference in gender attitudes between AR and Non-AR male parents, and that for the youth there is only a significant difference between adolescent males for the question of whether it is justified for a man to hit a partner. In other words, most of the significant differences observed are due to differences in gender attitudes between the women and girls in the AR and non-AR households.

The questions on right to sexual enjoyment reveal considerable ambiguity on the part of the youth, as expressed in having no opinion (which is not surprising given that only a small proportion have ever had sex), and for about one-fifth of the parents[25]. While there are no differences between AR and non-AR parents, there are significant differences for the youth, with slightly higher proportions of AR youth feeling that both men and women have a right to sexual enjoyment.

Table 8: Gender attitudes by type of household and respondent (%)

Question		Youth		Parents	
	Household	AR	Non-AR	AR	Non-AR
Justified for man to hit partner	No Yes	95 5	90*** 10	N/A	N/A
Women should have equal opportunities as men	Yes No No opinion	65 30 5	54*** 36 10	70 30 0	62* 36 2
Girls child should have equal rights as a boy	Yes No No opinion	77 18 6	74 18 8	83 14 3	77** 23 1
Boys should be sent to school first before girls	Yes No No opinion	18 75 7	22 71 7	16 80 4	20 77 2
Men and women should have equal rights	Yes No No opinion	59 32 9	55 34 12	63 36 1	57 40 3
Men have a right to sexual enjoyment every time they have sex	Yes No No opinion	27 19 54	20*** 17 63	51 30 20	51 30 19
Women have a right to sexual enjoyment every time they have sex	Yes No No opinion	27 21 52	21*** 19 61	56 28 16	50 31 19

Note: * Significant at .05, ** at .01 and *** at .001 levels

Circumcision Status of Mothers and Daughters

A slightly smaller proportion of mothers in the AR households (93%) are circumcised than in the non-AR households (98%), but the difference is not statistically significant. This suggests that whether or not a mother was circumcised is not a major factor influencing the decision whether or not to circumcise her daughter, given that virtually all female parents were themselves cut.

Parents were also questioned about the circumcision status of all their daughters (up to a maximum of four) to try to gain some understanding of what has happened to daughters in the family. AR and non-AR parents were first compared in terms of the proportion of daughters aged 15 years and above that had been circumcised (in line with the KDHS recommendation to control for age). The results indicate that only one quarter of the 493

[25] Controlling for sex of parents reveals that higher proportions of males support the view that men have a right to sexual enjoyment every time than support the view that women have a right to sexual enjoyment every time. Conversely, higher proportions of females express the view that women have a right to sexual enjoyment every time than support the view that men have a right to sexual enjoyment every time.

daughters aged 15 years and above in the AR households had been cut, compared with 81 percent of the 354 daughters in the non-AR households.

Although this suggests that there is a highly significant difference in the likelihood of families having cut their older daughters, this analysis is somewhat compromised by the fact that at least one of the daughters aged 15 and above of the AR parents is expected to be uncircumcised anyway, because all AR parents (by definition) have at least one daughter who has participated in the Alternative Rite (approximately two-thirds of the AR initiates were aged 15 and above).

To address this issue, a sub-sample of the first daughters aged 25 and above was analysed so as to control for age, and for their possible exposure to the MYWO sensitisation activities (which began when these daughters would have been 19 or 20 years old). Although these criteria produce a relatively small sample (103 daughters) across both groups, the behavioural difference observed between the AR and non-AR families remains. Among the 58 daughters of AR parents, half were cut and half were not, whereas among the 45 daughters of non-AR parents, all except two were cut. This suggests that many of the parents in families of which a daughter went through the alternative rite had probably decided not to cut their daughters prior to the beginning of the sensitisation activities. MYWO's sensitisation activities have clearly reinforced this belief, and the alternative rites programme has subsequently provided the opportunity for them to publicly acknowledge this action for their younger daughters.

Role of MYWO's Sensitisation Activities

For those parents in both the AR (n=293) and non-AR families (n=161) who said that they felt FGM should be discontinued, a number of questions were asked to try to assess the role of MYWO's sensitisation activities in reaching this decision. Because of the differences in the way in which sensitisation about FGM was undertaken in each district (see earlier), the results are also analysed by district.

When asked (in a multiple-response question) why they felt their community should not continue the practice, both groups were equally likely to cite that they have always believed it to be unnecessary (64%), but the AR parents were significantly more likely than the non-AR parents to cite MYWO (81% vs. 35%) and their church (84% vs. 62%) as influences.

Some differences are noticeable between the three project districts. In Gucha, only one-third of all parents (and only one quarter of AR parents) said that they had always been against the practice, whereas in Tharaka this reason was given by 93 percent of parents (and 96% of AR parents), and in Narok by two-thirds of all parents. The church appears to be less influential in Gucha than in the other two districts (although it is still cited by two-thirds of all parents as a reason). The MYWO programme seems to have been particularly influential for the AR families in Gucha and Tharaka, where 91 percent and 85 percent respectively of these parents cited the MYWO as a reason for changing their attitudes.

Although very high proportions of both groups of parents reported having ever heard messages against female circumcision, there is a statistically significant difference between the AR parents (98%) and non-AR parents (89%). Across all respondents, MYWO is given as the main source (71%) for these messages, although there are large differences between the AR (83%) and non-AR (46%) parents, with the radio, church and community leaders also being given as sources for the non-AR parents. MYWO is by far the predominant source for AR parents in Gucha (93%).

The importance of interpersonal communications by influential persons is emphasised by the fact that 82 percent of AR parents compared with only 28 percent of non-AR parents said that

someone from MYWO had directly provided them with information regarding female circumcision. This type of communication was particularly important for AR parents in Gucha, where 97 percent said that they had had such direct contact.

As would be expected, the proportions of parents having heard about the alternative ritual are much higher (96%) among those living in AR households than among those in non-AR households (47%). There are similar and high levels of support for such interventions against FGM among both types of parents, with a particularly strong endorsement for anti-FGM activities by parents in Gucha.

For those parents who have explicitly indicated that they feel the practice should be abandoned (whether or not their daughters have participated in the Alternative Rite), a comparison was made between the AR and non-AR parents to assess if they are different in their socio-demographic characteristics and the extent to which the MYWO/PATH sensitisation activities may have influenced them. There is no significant difference between these AR parents (n=293) and non-AR parents (n=161) in terms of their school attendance[26], level of education, employment status, and type of occupation. There is, however, a significant difference in their religious affiliation, particularly among the Meru and Kalenjin, where the AR parents are more likely to belong to the Methodist and African Gospel Churches whereas non-AR parents are more likely to be Catholic and Pentecostals. AR parents are also more likely than the non-AR parents to have higher socio-economic status. While the attitudes of both groups indicate that they have passed through the 'transition' phase in considering a behaviour change, as would be expected because of the sampling strategy, the AR parents are more likely than the non-AR parents to not have cut their daughters aged 15 years and above.

Almost two-thirds of both groups of parents who are against the practice stated that they had always believed the practice to be unnecessary. Those in the AR families were much more likely to have heard of anti-FGM messages and cite the MYWO activities and, to a lesser extent, their church to have influenced them. However, there are differences between the sites, with higher proportions of AR parents in Gucha and Tharaka than in Narok citing influence by the MYWO programme. Almost three times as many AR parents as non-AR parents have had direct contact with a person from MYWO; again, this seems to be particularly important in Gucha (97% versus 22%) and Meru (76% versus 28%).

A comparison was also made between those parents from non-AR families who support continuation of FGM (n=139) and those who support abandonment of the practice (n=161). There is a significant difference in their attitudes and knowledge concerning FGM, with those in support of FGM eradication being more likely to have the woman express regret for being cut, to hold the view that an uncircumcised woman would get a husband, to express the view that FGM contravenes the rights of women and children, and to have knowledge of negative consequences of FGM.

The analysis also shows that, among the Abagusii and Maasai, those in support of FGM eradication are more likely to have been exposed to anti-FGM messages. Moreover, among the Abagusii, those favouring discontinuation are more likely to have been talked to directly by a MYWO project person than those who support continuation of the practice. However, there are no significant differences between non-AR parents in support of and opposed to

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[26] Apart from the Maasai parents, for whom those participating in the AR are more likely (91%) to have ever attended school than the non-AR parents (20%).

FGM eradication in terms of socio-demographic and economic indicators[27] such as school attendance, level of education, and employment, occupation and socio-economic status.

When these two groups are compared in terms of the proportions of their daughters aged 15 years and over who have been cut, the proportions are much lower among those in favour of discontinuing the practice (72% of 160 girls) than those who want FGM to continue (93% of 147 girls); this large difference is not statistically significant, however. This ambiguous finding suggests that there may be some difference between the two groups, in that those who have made an attitudinal change may already have started to discontinue the practice, but the evidence is inconclusive.

Overall, these findings suggest that there has been an attitudinal change in support of FGM eradication among about half of the non-AR households (although with variations by district), and that this change is associated with exposure to anti-FGM messages from MYWO, as well as to messages from the church and to existing attitudes against the practice. However, this attitude change does not seem to have been fully translated into a behaviour change (as is evidenced by those holding similar attitudes and who have participated in the Alternative Rite) because this group is only slightly less likely to have cut their daughters as those who are in favour of FGM continuing.

[27] However, the Abagusii and Kalenjin non-AR parents in support of FGM eradication are more likely to belong to the SDA and African Gospel churches respectively.

SUMMARY OF KEY FINDINGS

In the absence of a prospective study to test the effect and impact of the MYWO/PATH FGM alternative rite approach, this assessment addressed a number of objectives that sought to gain a better understanding of the role that the approach has played in three districts of Kenya. With reference to these objectives, the key findings from the data collected are as follows.

Factors Accounting for Discontinuation of Genital Cutting and Participation in the Alternative Rite

Both AR and non-AR families live in communities in which FGM sensitisation activities have been taking place. The difference between them is that at least one daughter in the AR family has participated in the Alternative Rite, thereby implying that the family has definitely discontinued the practice. The data indicate that about half of the parents in the non-AR families are in favour of discontinuing the practice, but whether they have yet done so is not possible to judge. The comparison of members of AR and non-AR families indicated that AR families are:

- Slightly more likely to have ever attended school, although the female parents in AR families are no more likely to have reached a higher level of education.
- More likely not to be members of the Catholic or Pentecostal churches;
- Slightly less likely to be labourers or farm workers;
- More likely to be of higher socio-economic status;
- Slightly more likely to have females with more positive gender attitudes;
- More likely to already not be cutting their daughters and to express regret for those already cut.

These findings suggest that those families choosing for their daughters to participate in the Alternative Rite are somewhat different than those not choosing to do so, but there does not appear to be a particular bias towards or away from a particular group within the population. For those parents who have explicitly indicated that they feel the practice should be abandoned (whether or not their daughters have participated in the Alternative Rite), there is no significant difference between AR parents and non-AR parents who think the practice should discontinue except in terms of their religious affiliation and socio-economic status. While the attitudes of both groups indicate that they have passed through the 'transition' phase in considering a behaviour change, the AR parents, as is expected, are more likely than the non-AR parents to not have cut their daughters aged 15 years and above.

Almost two-thirds of both groups of parents who are against the practice stated that they had always believed the practice to be unnecessary. Those in the AR families were much more likely to have heard of anti-FGM messages and cite the MYWO activities and, to a lesser extent, their church to have influenced them. However, there are differences between the sites, with higher proportions of AR parents in Gucha and Tharaka than in Narok citing influence by the MYWO programme. Almost three times as many AR parents as non-AR parents have had direct contact with a person from MYWO; again, this seems to be particularly important in Gucha and Meru.

Interestingly, there is a significant difference in attitudes and knowledge concerning FGM among those non-AR families that support FGM eradication and those that support its continuation. For the Abagusii and Maasai at least, this difference is associated with having

been exposed to anti-FGM messages and, for the Abagusii, to having been talked to directly by a MYWO project person. However, there are no significant differences between them in terms of socio-demographic and economic indicators. Although those in favour of abandoning FGM are slightly less likely to have cut their daughters aged 15 years and over, the difference is not significant, suggesting that this attitude change does not seem to have been translated fully into a behaviour change.

Beliefs, Attitudes and Knowledge concerning FGM

Those living in AR families are far more likely than those in non-AR families to believe there are no benefits to FGM and that the practice should be abandoned, and to know of adverse health problems that can be associated with FGM. The AR families are also much more likely to believe that FGM contravenes the rights of girls and women. Overall, almost half the parents in non-AR families believe the practice should be abandoned, indicating that even if their daughters have not been through the alternative rite, many families are against the practice in areas where MYWO has had its sensitisation activities. There are important differences by ethnic group, however, with much higher levels of non-AR parents wanting the practice to continue among the Abagusii and Maasai than among the Meru and Kalenjin.

Slightly fewer AR family members than non-AR family members feel that there are differences between circumcised and uncircumcised girls, but overall most respondents in all groups feel that there is no difference. However, whereas virtually all AR parents feel that men would marry uncircumcised women, only two-thirds of non-AR parents have this attitude. Levels of regret for being personally cut or for cutting older daughters were much higher among AR families than non-AR families, as was the intention not to cut future daughters among the youth.

Effect of FLE Training on Reproductive Health Knowledge and Attitudes

Awareness of many reproductive health issues, as well as detailed knowledge of these issues, was significantly higher among girls who have been through the FLE training than those who have not. Awareness that condoms can be used to prevent STI and HIV transmission was poor for both groups. Approval of condoms and of other contraceptive methods by adolescents, by unmarried couples and by married couples was lower among those who have been through the training. There was virtually no difference between the two groups in terms of sexual experience and behaviour.

DISCUSSION

These findings provide an in-depth analysis of the circumstances in which the Alternative Rites programme has been implemented in three quite different situations in Kenya. In discussing these findings it is important to reiterate the fact that it is not possible to draw categorical conclusions about the extent to which the programme of activities undertaken by MYWO and PATH have directly influenced decisions to discontinue the practice of genital cutting. It is also important to emphasise that what is now commonly referred to as the 'Alternative Rites' programme is actually the most recent intervention in an evolving series of activities that have developed over time. The model described earlier for explaining behaviour change in relation to FGM argues that such a change requires a series of stages to be passed through, and so it is unrealistic to expect that one particular stage of the process (e.g. participation in an Alternative Rite) can be assessed without reference to those preceding it. Moreover, as is illustrated in the descriptions of how the programme has been

implemented in the three districts and in the findings from each of the districts, there is no single way in which the programme has been implemented, and indeed the findings clearly demonstrate that this approach needs to be adjusted according to the specific socio-cultural situation.

The data from this study indicate that the MYWO sensitisation activities that preceded and accompanied the Alternative Rite have played a role in the behaviour change process among those who have decided to discontinue the practice and who have adapted the alternative rite. It is also clear, however, that these sensitisation activities have not functioned in isolation from other influences operating in the communities, notably the stance taken by certain churches as well as individuals' existing beliefs that the practice should be discontinued.

Whether the sensitisation activities have sped up a process of attitude and behaviour change that had already started, or whether they have served to trigger a change through encouraging families and individuals to 'contemplate' changing their behaviour when they were not previously considering this possibility, is not possible to disaggregate from this study. Among those living in families that are resident in the areas covered by the MYWO sensitisation programme but who have not gone through the alternative rite, about one-half want the practice to discontinue (albeit with large variations by ethnic group), and so clearly there is a change in attitude occurring in these places. These people are more likely, however, to cite having been already against the practice and/or being influenced by their church than being influenced by MYWO's sensitisation activities.

The role played by offering the Alternative Rite as the logical conclusion in a series of sensitisation activities is not completely clear. It could be proposed that the opportunity to participate in an Alternative Rite also acts as a 'preparation' activity that precedes actually the behaviour change of not cutting a daughter, by providing those who have already contemplated the decision with sufficient social support to act upon it. Or it could be argued that it represents the 'action' stage itself in the change process, by providing an explicit opportunity for those who have already changed their behaviour by not cutting their daughters to demonstrate the fact publicly that this action has been taken.

If the alternative rite is fulfilling the second role, where the decision and action have already been taken, then the Alternative Rite itself will have no direct impact on reducing the practice. Holding it, however, will probably further reinforce the social validity at the community level of the decision not to undertake female circumcision. It could be argued that the Alternative Rite itself may then serve as a 'trigger' (thus fulfilling a similar role to the educational activities during sensitisation) to encourage families currently in favour of continuing the traditional practice to enter the 'contemplation' stage of considering its discontinuation because of the public display of support demonstrated. Whether there has been a further change in attitude or behaviour in a community subsequent to Alternative Rituals is therefore an important issue requiring further research.

If the Alternative Rite is fulfilling the first role, however, then it is clearly an important next step in the behaviour change process because it facilitates the transition from contemplation to action. What is not known, however, is whether it is a *necessary* step for the transition to occur, or whether families and individuals that have already contemplated the decision and want to stop the practice would take that action in the absence of the Alternative Rite. The data show that non-AR families in favour of discontinuing the practice have been cutting their daughters aged 15 and over, which implies that the Alternative Rite may offer the impetus to take the final step of actually stopping the practice. Whether this is actually the case is difficult to know, however, given that it is not possible to know what they are planning to do with their daughters under 15 years of age.

Whether the existing sensitisation activities need to be strengthened by adding an Alternative Rite, and if so, whether the formulation for the Alternative Rite used here is the most appropriate, are not therefore straightforward issues. The findings from the three districts featured in this study shed some further light because of the differences in the cultural meaning and practice of female circumcision in each project site, and in the way the approach was implemented in the three districts.

This study is not able to provide accurate measures of changes in attitude and behaviour over time. Evidence from the KDHS and from some of the qualitative and quantitative data collected in this study, however, clearly support the argument that changes in attitudes and behaviour are happening among some of these ethnic groups generally and in the study sites, and that there are substantial differences in the speed of such changes between the groups. Among the Abagusii and the Maasai the practice remains virtually universal and there is certainly much resistance to change. Consequently, and as demonstrated in this study, the MYWO sensitisation activities in Gucha and Mau (Narok) have played a considerable role in triggering a change in attitudes and in the practice. For the Meru and the Kalenjin ethnic groups, however, there are clear indications that the practice is being seriously reconsidered and is on the decline. In these situations, the MYWO sensitisation activities are probably feeding into and working with other factors that are stimulating a contemplation of the practice, notably messages from the churches. The Alternative Rite has been shown to be more easily introduced in these situations, but there is going to be some point in time when the cultural norm is not to cut, at which point the Alternative Rite may not be relevant.

The level of sensitisation needed before the Alternative Rite can be introduced varies also because of this factor. In Tharaka District for example, where the population is Meru, sensitisation did not begin until the Alternative Rite approach was introduced, and yet this has been probably the most successful of the three districts in being able to introduce the approach with little opposition. Conversely, in Samburu, where MYWO sensitisation activities have been going on since 1993 and where FGM is almost universal, it has been virtually impossible to introduce the Alternative Rite, with the first ceremony involving 72 girls being held in April 2000.

The relevance and nature of a rite of passage that includes female circumcision for a particular ethnic group is also a critical factor. Among the Maasai, there has not traditionally been a public ceremony associated with the cutting or with the rite of passage – the cutting and transition ceremony are normally undertaken within the girl's family and traditionally is followed almost immediately by marriage. Thus introducing a public ceremony where none existed before has proved difficult among this group, as evidenced not only by MYWO's experience in Narok District but also by the experience of the GTZ project to date in the primarily Maasai Trans Mara District. Among the Abagusii also, the cutting itself and the public ceremony after seclusion are not associated directly with celebrations of transition to womanhood because they are undertaken at a young age, and marriage is not expected to take place immediately or in a period of less than five years. Conversely, among the Meru and the Kalenjin, there is a traditional public ceremony associated with the cutting and marking the transition to womanhood, which was traditionally followed by marriage. Changes in attitudes towards the role of genital cutting among these groups, however, have led to the practice gradually becoming less public and more of a family affair. The value of the public ceremony component, therefore, appears to vary depending on the nature of the traditional rite of passage for each ethnic group.

A further factor that may explain why the approach appears to have been most successful in Tharaka District is that the majority of circumcised mothers and daughters among the Meru

indicated that it was them that made the decision to be cut, rather than their parents as is the case in the other groups.

Likewise, the value of the FLE training component for the girls also depends on the degree to which such training is an integral part of the traditional rite, and the relevance of the training to the girls going through the training. In Gucha, for example, the approach began by not having a training component, because the public declaration was the more important aspect for the Abagusii and the content of the training was not directly appropriate for the age of girls participating. Conversely, in Narok the training component is the central feature of the alternative ritual, which perhaps reflects the strategy taken by MYWO of trying to reach the girls themselves first, and then reaching the parents through the girls.

The FLE training does have an effect on the girls' awareness and knowledge about reproductive health issues, but it also appears to engender somewhat less positive attitudes towards the practice of family planning among unmarrieds and adolescents, including condom use. This suggests that there may be a need to review not only the content of the training but the way in which it is being taught. Reviewing the curricula of the peer educators and of the initiates' training sessions indicates that the emphasis is more heavily on the adverse health outcomes than on the contravention of human rights. The most recent curriculum for training of trainers does correct this balance, and the data suggest that those involved with the Alternative Rite, as parents or adolescents, are better informed about the health problems associated with the practice, and are also more aware that FGM contravenes the rights of girls and women.

Relying too much on the health consequences argument could lead to a lack of credibility for the messages, given the relatively low levels of gynaecological morbidity perceived to be associated with the types of genital cutting practised in these populations, as reported here and as found in other populations practising types 1 and 2. It can also lead to medicalisation of the procedure, as seems to have happened among the Abagusii in Gucha. Conversely, relying too heavily on the human rights approach can be difficult to articulate in cultures where rights are not strongly promoted, or where women's rights are heavily subjugated, or where rights are a difficult concept to discuss in concrete terms. Nevertheless, it is essential that future sensitisation activities, including the Alternative Rite itself, make every effort to ensure that the rights argument is a central message.

CONCLUSIONS AND RECOMMENDATIONS

The combination of intensive community sensitisation about FGM and offering an Alternative Rite have clearly played a role in the attitudinal and behavioural changes that are occurring in the project sites. Some differences were noted between those families that have participated in the Alternative Rite and those that have not (notably type of religion and socio-economic status), with exposure to anti-FGM messages being an important factor. Thus the sensitisation activities that have preceded the Alternative Rite are critical for creating the conditions in which the rite itself can be introduced. There is some evidence that participation in the Alternative Rite may enhance the transition from an attitudinal change to a behavioural change, thus supporting the need for this activity to follow the sensitisation activities, but the data are not sufficiently robust to be conclusive.

The role and meaning of traditional rites of passage and of female circumcision varies considerably between ethnic groups. While the Alternative Rites approach has been adapted to local conditions, some of the tensions apparent in its implementation suggest that greater attention needs to be paid to the way the approach is introduced in different communities, or

indeed whether a public ceremony with formalised training is necessarily the best way to conclude the behaviour change process. How girls are invited to participate in an Alternative Rite and whether and how their parents are involved in the decision, are also factors that have varied across the sites, and have determined the feasibility and acceptability of the Alternative Rite itself.

Giving the girls some formal training during the Alternative Rite was demonstrated to be associated with higher levels of awareness of important reproductive health issues, more positive gender attitudes and higher levels of awareness that FGM contravenes human rights of girls and women. These girls were found to have more conservative attitudes towards family planning, however, and so it is important to ensure that factual information is communicated in a progressive manner if traditional attitudes and behaviours that compromise the health and rights of women are not to be perpetuated.

Medicalisation of the practice among some groups indicates that contemplation of the practice triggered by sensitisation can sometimes result in harm reduction rather than complete abandonment. It is essential to ensure, therefore, that not only are the adverse health outcomes discussed but also that the messages communicated during sensitisation are framed in a rights perspective and that they address directly the meaning attached to genital cutting in a particular culture.

The study highlighted a number of issues that would benefit from further research. What is the effect of the public ceremony as a sensitisation activity for triggering or enhancing contemplation of FGM as a harmful traditional practice among those in favour of its continuation? In cultures that are clearly resistant to changing this behaviour (e.g. the Abagusii and Maasai), should resources be allocated primarily to sensitisation, or to organising Alternative Rites, or to a combination? And related to this, what are the reasons why these cultures are so resistant to change when many others are changing around them? If medicalisation of the procedure by health workers is increasing despite government policy against it, what actions can be taken to stop this happening but without driving the procedure back to the traditional practitioners? Conversely, while a prospective controlled study to determine the contribution of this approach to a decline in the practice is attractive, given the uniqueness with which the approach needs to be implemented in each situation it is questionable whether such a study would generate results that could be generalised.

The contribution that an Alternative Rite intervention can make to efforts to abandon the practice depends, therefore, on the socio-cultural context in which FGM is practised. The study has re-confirmed that an Alternative Rite cannot be introduced without a preceding or accompanying process of sensitisation in which an attitudinal change has to have occurred. For the approach to be replicated successfully in other situations will require a good understanding of the role of public (as opposed to familial) ceremonies in that culture, and a judgement as to what format for the ritual is the most appropriate means of helping those that have decided to abandon the practice to actually do so.

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Population Council

The Population Council is an international, nonprofit, nongovernmental institution that seeks to improve the well-being and reproductive health of current and future generations around the world and to help achieve a humane, equitable, and sustainable balance between people and resources. The Council conducts biomedical, social science, and public health research and helps build research capacities in developing countries. Established in 1952, the Council is governed by an international board of trustees. Its New York headquarters supports a global network of regional and country offices.

Frontiers IN REPRODUCTIVE HEALTH

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