"I will never let her go through what I did …. never, not me"

MOTHERS` PERSPECTIVES OF FEMALE GENITAL MUTILATION

AMONG THE MAASAI COMMUNITY IN KENYA

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Abstract

The purpose of this study was to find out mothers perspectives on female genital mutilation (FGM) among the Maasai community in Kenya. The aim of the study can be used in utilizing the research result when planning education programs in preventing female genital mutilation. The research was carried out in co-operation with a local village which is situated in South-West Kenya, and West from Nairobi, the Kenyan capital city.

Qualitative method was used to implement this study. Data was collected by interviewing four mother´s aged between 20-35 years of age, who had young daughters. The interviews were conducted between December 2010 to February 2011. The data collected was analysed by using content analysis.

The results of this study revealed that the mothers interviewed have good knowledge about the effects of female genital mutilation in general and the risks involved with its practice, although afraid of losing their culture. They were also aware of the long term and short term effects to their daughters and the unborn child, which could be as serious as leading to permanent disabilities and death. The mothers interviewed had knowledge on the signs to look for after FGM infection and to determine if medical treatment was required instead of depending on natural treatment only. Most mothers admitted use of natural treatment as well as modern medicine and other treatment methods.

They acknowledged other recommended alternatives to stop female genital mutilation, such as girl child education since their daughters had more knowledge and facts to prove why female genital mutilation was harmful to them. Additionally the study results indicated the willingness of the participants to work closely with health professionals who have better knowledge about FGM and its effects. They are also aware that FGM is illegal in Kenya and if they are caught, they are liable to prosecution.

Further research is recommended to focus on father's opinion. The study could also provide more knowledge to the government and policy makers in raising awareness especially to mothers who have different opinions about female genital mutilation.

Keywords
Female genital mutilation, circumcision, cut, initiation, perspectives, knowledge, prevention, culture, beliefs, experiences, treatment.

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Tiivistelmä

Työn tarkoitus oli selvittää äitien suhtautuminen nuorten naisten sukupuolielinten silpomiseen Maasia -yhteisössä Keniassa. Työn tavoitetta voidaan käyttää tutkimustuloksena suunniteltaessa valistusta silpomisen ehkäisemiseksi. Tutkimus tehtiin yhteistyössä paikallisen kylän kanssa, joka sijaitsee Lounais-Keniassa, Kenian pääkaupungista Nairobista länteen.

Tutkimuksen tekemisessä käytettiin laadullista tutkimusta. Tietoa kerättiin haastattelemalla neljää 20–35 -vuotiasta äitiä, joilla kaikilla oli nuoret tyttäret. Haastattelut tehtiin joulukuun 2010 ja helmikuun 2011 välisenä aikana. Kerätty tieto analysoitiin käyttämällä sisältöanalyysiä. Tutkimuksen tulos paljasti, että haastatelluilla äideillä oli hyvin tietoa siitä, mitkä ovat sukupulielinten silpomisen vaikutukset yleisesti ja sen harjoittamiseen liittyvät riskit. Äidit pelkäsivät kuitenkin menettävänsä perinteensä.

Äidit olivat myös tietoisia pitkä- ja lyhytaikaisista vaikutuksista tyttöihin ja sikiöihin. Seurauksena voi olla jopa pysyviä vammoja ja sikiön kuolema. He hyväksyivät muita suositeltuja vaihtoehtoja, jotta naisten sukupuolielinten silpominen saataisiin loppumaan. Suurin osa äideistä myönsi luonnollisen hoidon ja myös nykyaikaisten keinojen käytön.

Heidän tyttärillään oli enemmän tietoa ja todisteita siitä, miksi silpominen oli haitallista heille. Haastatellut äidit tiesivät mitkä ovat tulehduksen merkit ja osasivat päättää tarvittaisiinko sairaalahoitoa luonnollisten keinojen lisäksi. Jatkotutkimuksen suositellaan keskittyvän isien mielipiteeseen. Tutkimus voisi myös tuottaa lisää tietoa hallitukselle ja lainsäätäjille tietoisuutta lisäämään ja erityisesti äideille, joilla on erilaiset mielipiteet asian suhteen.

Avainsanat (asiasanat) Naisten sukupuolielinten silpominen, ympärileikkaus, leikkaaminen, alullepano, näkökulmat, tieto, ennaltaehkäisy, kulttuuri, uskomukset, kokemus, hoito.

Muut tiedot

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1 INTRODUCTION

Female Genital Mutilation (FGM) is defined as the practice that involves partial or total removal of the external female genitalia for cultural or religious beliefs, rather than medical reasons according to Journal of Human Rights, (2007).Types of geographical location, socioeconomic status and the ethnic background. It is not always easy to distinguish who will practice which type of female genital mutilation (Journal of Human Rights 2007, 6:392-413).
Female genital mutilation has been traced back three centuries however, it has undergone cultural transformations.

It is practiced in most African, Asian and Middle East countries with an estimated three million girls at a risk of undergoing FGM yearly, which is equivalent to 8,000 girls daily (Momoh, 2010).The various reasons proposing continuation of female genital mutilations may be categorized in to socio-cultural, psychosexual, religious and hygiene purposes and the ritual is observed to mark the coming of age where-by it is accompanied by celebrations and gifts exchange (Nursing Standard 2008, 43-47).

Most of the time, victims of FGM have no knowledge about the exact day when the procedure will be carried out and sometimes they guess as the villagers may plan ceremonies the previous night. Preparations involve gifts to the girl, nourishment with food, singing songs of praise to the girls and treating her with royalty while others may have no clue. Instead they are suddenly drugged from the bed before dawn and led to a deserted area, hut, sacred tree or river (Baron & Denmark 2006, 339-355).

The interest for the above topic was drawn from observing that nursing has become an international profession, and all nurses have a responsibility to familiarize with different cultural and religious beliefs, so as to offer holistic care without discrimination or stereotyping the clients. Due to immigration, cultural diversity has increased and it can never be ignored in the nursing profession especially when health may appear to be getting compromised.

The purpose of the study is to find out the mothers` perspectives of female genital mutilation among the Maasai community in Kenya. The aim of the study can be utelised in the research results in future when planning education programs in preventing FGM.

2 FEMALE GENITAL MUTILATION.

Female genital mutilation was originally known as *female circumcision.* It is now worldwide accepted as female genital mutilation (FGM). FGM is defined as a partial or total removal of the external genitalia or other injury to the female genital organs for cultural and other non-therapeutic reasons (Batal 2008, 43-47). Female genital mutilation is a common practice among most African communities and it still happens secretly in Kenya although it is illegal and forbidden by the law.

2.1 **Classifications of Female Genital Mutilation**

The World Health Organisation (2008) has classified female genital mutilation in to four major types, and each method depends on its severity. The first one is method is clitoridectomy or sunna in Arabic, meaning tradition. It involves partial or total removal of the clitoris and or prepuce. The second is excision meaning partial or total removal of the clitories and labia minora with or without excision of the labia majora.

Both practices are the most common types among the Maasai community. Third type is called infibulation or Pharaonic and the most extreme form comprising of 15% of all cases. It involves narrowing of the vagina orifice with creation of a covering seal by cutting and a positioning of the labia minora and or labia majora with or without excision of the clitoris see appendix 5. The fourth type includes some or all the three and pulling of the labia minora (Batal2008, 43-47). The procedure is done, once the candidate arrives at the designated location by midwives, traditional birth attendants or elderly women.

Some of the commonly used instruments include razor blade, knives, sharp rock, broken glass or scalpels. There is normally no use of analgesics, anesthesia or antiseptics and girls endure critical pain. In case of the 3rd type,

(infibulation), the raw ages of labia majora are stitched together using thorns and a straw is inserted in the vagina to leave an opening for urine and menstrual passage (Whitethorn 2002,).

The post-operative treatment of FGM involves use of homemade remedies and drugs such as milk, eggs, mixture of herbs, ash and cow dung which is applied on the wound to enhance the healing process and at times the girl's legs are bound together for forty days (Baron & Denmark 2006, 350).Previous studies show that female genital mutilation is still ongoing in most African countries (Dorkenoo, 1994; Wasuna, 2002; WHO 1996; Journal of Human Rights, 2007 and Nursing Standards, 2008).

Female genital mutilation continues to practice secretly in Kenya despite its barn in 2001. According to a Kenyan local newspaper (Daily Nation Newspaper, 2004), there was a public outcry, when twenty girls who got complications after circumcision and they needed reconstructive surgery. This is a delicate issue that must be handled with care by the local citizens, the law and religious leaders. FGM is an unending debate due to its sensitivity and despite heated campaigns against its practice from scholars, government officials and health professionals, the decision lies in the communities of those who practice it (Journal of Human Rights, 2007).

According to the Journal on Human Rights (2007), there was a report of a girl who died after having undergone FGM because the parents never took her for medical care, due to the fear of being arrested. It is not clear why this was so, although it is believed to be a rite of passage and for one to have a sense of identity in the community (Momoh, 2010).FGM is performed on young girls aged between 9 to 15 years.

The girls have no autonomy to express their feelings about FGM and they are ignored by their mothers. Their mothers assume that since they underwent the same procedure, their daughters too must experience it. Therefore most girls lack the confidence to bring up the subject because discussing female genital

mutilation is a taboo, never to be discussed publicly (Journal of Human Rights 2007, Obiora, Hernlund &Shell-Duncan 1997, 67-69).

This research study mainly focused on the mothers in the local village, and their opinions on FGM were considered. Narok District Hospital is the main local hospital where girls who have complications with FGM are referred to; especially if they might require surgery or medical intervention. The nurses in this Hospital work closely with the local community to promote women health especially on the above mentioned subject.

Narok is situated in South-West Kenya, and West from Nairobi which is Kenya's capital city, along the Great Rift Valley. It is 267 kilometers from Nairobi. Narok has a population of approximately 40,000 inhabitants. Most of the Maasai people are pastoralist. They keep livestock and immigrate from place to place searching for green pastures and water for their animals (Wikipedia.org/wiki/narok). Maasai community has a rich culture and they are a source of tourist attraction. They mostly live in temporary homes called "manyata", which are made of mud, grass and cow dung and their staple food is meat (appendix 4).

FGM raises ethical questions on nurse's responsibilities of ensuring that they safeguard the lives of the vulnerable. The health risks involved are tremendous because It doubles the risk of mother`s mortality rate during child birth and increases still births by 3-4 times. 10% of girls and mothers die from short term complications of FGM while 25% of deaths results from FGM type 3 due to long term effects (Momoh, 2010).

2.2 **Beliefs of FGM.**

There are several reasons that have allowed female genital mutilation to thrive despite its criticism of causing more harm than good. This beliefs range from culture, health purposes and religion. It is believed that a girl must pass through FGM before getting into woman-hood and into the society. (Barrie,

2008, 56). Majority of women believe that the procedure will give them the ability to overcome childbirth. In addition, it is a bravery act and offers women status in the community (Omar-Hashi & Entwistle 1995, cited in Baron & Denmark, 2006).

Girls who have not had FGM are stigmatized because they are considered unmarriageable and face harsh economic consequences. Communities who practice it believe women`s status depend on marriage for income, protection and security (Barrie, 2008, 55-56). Due to low educational level most women in the community may not be aware of the future effect of FGM involved. However, the participants involved in this research study had some awareness, although not as much as their daughters, who had been resisting FGM. Women who have not been genital mutilated are stereotyped to be masculine (Boyle, 2002, 28).

The mothers feel proud of their daughters being accepted in the community after FGM is done. It is an important ceremony that implies rite of passage which mothers, aunts and grandmothers have undergone before with dignity moreover, the environment which they live in give girls social status which allows them to participate in the community (Barrie, 2008, 56).

Female genital mutilation has not been justified by any religion yet and (Barrie, 2008, 57) argue that neither the Bible nor the Koran support FGM. However, there are other interpretations of female anatomy such as “clitoris” will grow to the size of the penis”. Furthermore, it is believed that women who have had FGM prevent men from acquiring HIV & AIDS. Some mothers still believed that FGM increases fertility (Barrie, 2008, 57).

Despite the many beliefs why female genital mutilation continues to thrive, there is none that can be proved to be correct however, tradition and culture have been cited to be the causes (Bibbings, 1995, 55; Carr, 1997, 27). Some beliefs state that clitoris can produce poison that causes infant death during birth and makes a man impotent if it gets in contact with the penis (Burstyn (1995, 28-35).

Others illustrate that each individual possess both male and female souls. The feminine soul of a man is believed to be located in the penis prepuce while the male soul of a woman is located in the clitoris. Therefore circumcision is done for healthy gender development (Boyle, 2002, 27).

Some communities believe that girls are clean and appear beautiful once the body parts considered male and unclean are removed (Momoh, 1999). Due to all the beliefs and reasons stated as to why FGM has continued to thrive, it is difficult to state exactly when this practice will eventually be eliminated. However, it might take a long time and health promotion to raise awareness to those communities who still practice it.

3 EFFECTS OF FEMALE GENITAL MUTILATION

The health risks associated with female genital mutilation are great where by the girls experience emotional pain, psychological pain and physical pain (Baron &Denmark, 2006). The risks associated with female genital mutilation shall be categorized further and then be discussed in depth. This is emphasized more by a survey carried out in Egypt which stated that husbands' preferred circumcised women (Carr, 1997) and similar findings in Tanzania concluded the same (Bisimba, Lee & Wallace, 1999).

3.1 **Physical Effects**

FGM involves the removal and damaging of the normal female genital tissue thus interfering with the natural functions of the female body. It causes hemorrhage due to rapture of clitoris blood vessels, acute pain, shock, loss of blood and infections for examples tetanus, HIV, hepatitis B and C may occur. Other serious effects may lead to death due to excessive bleeding (Shell & Hernlund 2000, 1). Furthermore, it can cause pelvic infections resulting to sterility, prolonged labor and fetus brain damage. The pain might cause one to suffer silently, if they do not seek medical help. Potter& Perry (2007) states that pain can have many negative effects such as lack of sleep, appetite and sometimes depression (Potter & Perry 2007, 48).

The infibulated women often encounter a re-opening of the vagina for penetration to occur during intercourse leading to pain and other long term complications include urinary tract infections, infertility and decrease in birth rate (shell-Duncan 2008, 225-236). Denmark (2006) also comments that persons who have undergone female genital mutilation may likely require surgery later as a result of the sealed or narrowing of the vagina to allow sexual intercourse and childbirth (Denmark, 2006).

FGM has other consequences to pregnant mothers and the unborn child due to upper genital tract infection; making it difficult for the fetus to exit the uterus,

forcing those mothers to get episiotomy. Moreover; when re-infibulation has not taken place, there is a likelihood of the expectant woman to suffer from prolonged labor, perineal tear, excessive loss of blood or having brain damaged infant (Barrie, 2008,56). Other findings reflect that if the scar has not been opened properly during child birth, it becomes an obstacle in delivery (Nursing Standard 2008, 44).

3.2 **Psychological Effects**

Some of the psychological effects resulting from FGM involve change of body image especially if one suffers from recto-vaginal fistula. Fear of discussing the problem openly or seeking medical care due to embarrassment and lack of money may contribute to more stress. (WHO 2006) states that female genital mutilation put babies in danger of resuscitation at 66% in women with FGM type 3. The death rate is higher during and after birth of mothers with genital mutilation 15% with type 1, 32% with type 2 and 55% with type 3 (WHO, Fact sheet 2006, Kenya).

Permanent damages of female reproductive organs such as the urethra, anal sphincter and vaginal wall may occur. When infibulations is performed, sexual organs may be damaged further when re-opening the vulva after marriage, then sewed again and the possibility of re-opening after divorce or death of a spouse (Dorkenoo, 1994, 13-27). As a result of pain and its effects, other psychological problems such as physical and emotional exhaustion, lack of sleep and depression to mention just but a few examples could also occur (Dorkenoo, 1994, 13-27). .

The pain might be acute or chronic depending on how it is treated during and after circumcision therefore enhancing or threatening recovery by slowing activities of living and self-care (Potter &Perry, 2007-48). Culture is a determining factor of how different people perceive pain. Therefore, it causes some people to suffer silently especially if one is expected to show braveness during the procedure without use of any analgesics which can lead to

traumatic disorders. Furthermore, affecting future of the victim and could probably lead to mental health problems (Dorkenoo, 1994, 13-27).

FGM is said to decrease orgasm (Shell et al 2001). Vesico-vaginal and recto-vaginal fistulas (VVF&RVF) are effects leading to unstoppable flow of urine and feces respectively through the vagina. Furthermore, it embarrasses the women and husbands normally end up divorcing their wives leading to further stress (Obiora, 1997). Husbands may also feel the frustrations and shame due to inability to have intercourse with his wife especially on infibulated women because the man is expected to “open her” (Nursing standard 2008, 44).

The incontinence of both urine and feces especially to young females may result to low self-esteem. This results to the person getting victimized, stigmatized, and banished from the community causing emotional feelings. Lack of education or finances to seek medical intervention may cause the family to neglect the victim, thinking it’s a curse laid upon her (Obiora&Amede 2007, 67-90)

After going through FGM, most women suffer emotionally. They feel shy to discuss their feelings such as physical and psychological pain. Sometimes they experience decreased orgasm and urine retention depending on the severity of FGM (Denmark 2006).

It is also common for women to have marital instability due to problems on sexual satisfaction to their husbands and inability to have intimacy. Since this is not a topic discussed by most women, it results to couples disagreement and divorce. Moreover, the women may experience trauma and despair especially when re-infibulations is expected after child birth (Denmark, 2006).

4 FEMALE GENITAL MUTILATION INKENYA

The estimated female genital mutilation of girls and women aged 15-49 years in 2003 was 32.2% and it is practiced in more than three quarters of the country (WHO, Fact Sheet 2006, Kenya). According to the data shown above, 32% of all Kenyan women aged between 15- 49 years are circumcised.

The Kenyan Government is changing policies to make people aware of the health risks involved with female genital mutilation. This was done by replacing the practice with other ceremonies to mark rite of passage such as “Ntanira na mugambo” translated in English as “circumcision through words”. This is done by bringing girls together and educating them about hygiene, women role and reproduction for approximately seven days. At the end of the seven days, the occasion is celebrated with a graduation ceremony together with the community, and the girls don’t necessarily have to be mutilated. Instead they are taught different roles during the seven days (Barrie, 2008, 59).

The government works closely with the local communities to abolish female genital mutilation by adopting new government policies and other recommendations as the one mentioned above. The government policies have cited female genital mutilation as a human rights violation and women productive health threat (WHO 2006b).

The 2001 Children´s Act was enacted which describes “girls who are likely to be forced in to circumcision are children in need of special care and protection”. By so doing, section 14 of the 2001 Act makes FGM a criminal offence also in Kenya (Denmark, 2006).Section 115 of the children`s Act therefore gives right to anyone who comes across a girl under threat of being circumcised to report the offence to the authorities who may therefore take legal action against the offender (WHO, 2006 & Demographic Health Survey, 2003).

The Assistant Minister for Higher and Technical Education criticized the Kenyan legislation for not protecting women over the age of 18 from FGM. In addition, the Minister of State for Home Affairs too commented that the practice is still widespread, despite the legal processes already in place (Ogodo, 2005).A document on FGM in Kenya (2009) illustrated that low education level and violence are common and some husbands take advantage of it and FGM to control their wives. The Kenyan government therefore has a responsibility to protect women from violence and sexual abuse (Domestic violence & FGM in Kenya, 2009,248, 250).

There is clear evidence that medical practitioners are participating in FGM since some ethnic groups are requesting medical practitioners to undertake it. In 1998 Kenya Demographic Health Survey showed one third of all women had reported being circumcised by a health worker. This was 71% of girls aged between 4-17years, who had been circumcised by doctor or nurse while 37% reported being cut at a health facility. However, in 1999, the Ministry of Health (MOH) in Kenya launched a National Plan of Action (NPA) and in 2001 a policy directive was circulated making FGM illegal in all health facilities.

The objectives of the National Plan of Action were to reduce the proportions of women and girls who undergo FGM. To Increase the proportions of communities that support eradication of FGM. Increase the proportions of health care facilities that provide care, counseling and support to girls and women affected by FGM, (Ministry of Health Health1999, 23-24 Kenya National Plan of Action and Elimination).

The Kenyan government is also working hand in hand with the Ministry of Health to achieve the objectives set by the national plan of action. The proposed strategies were establishment of national and district female genital mutilation program co-ordination committees, establishment of multi-sector collaboration to ensure integration of anti-FGM interventions in key development programs, establishment of proactive mechanisms for resource mobilization and allocation to the FGM elimination program and lastly co-ordination of new and on-going FGM interventions (MOH 1999, 23-24).

Female circumcision can be addressed to the welfare of those who practice it. However, despite the harsh judgment and criticism FGM practicing communities face, it is fair to acknowledge that culture contributes to its continuation (Boyle, 2002, 28). Furthermore (Boyle 2002) continues to say that men may have an indirect role to play in enforcing FGM, while mothers take the responsibility for having their daughters circumcised (Boyle 2002, 29).

There is also pride of being socially accepted which motivates parents to circumcise their daughters so that they (girls) can suit in that social class (Barrie, 2008, 56).However critics claim that rights and rules about morality are encoded in and depend on socio-cultural context; the notions of rights, wrong and morality differ throughout the world since the cultures in which they are found differ too (Steiner & Alston 1996:192).

4.1 **The Role of Nurses in Connection to FGM**

The Kenyan National Plan of Action (KNPA) has set some recommendations which can be made to accelerate abandonment of female genital mutilation. In addition, to strengthen the role of the Ministry of Health to manage complications of those already mutilated by doing the following:

Building the capacity of health workers to advocate against FGM during routine consultation for primary health care and during community outreach, dissemination of the ministry of health policy against health workers practicing FGM by ensuring that all health care staff understand that FGM is illegal in Kenya,

inclusion of FGM in pre-service training to educate nurses and other staff in identifying different types of FGM, recognize complications, management and understanding socio-cultural factors that encourage the practice, training and equipping clinical staff workings among populations that practice infibulations to safely provide de-infibulations and assist them to offer services at the time

of marriage, antenatal visits and second stage of labor (Ministry of Health, Kenya 1999, 23-34).

A study carried out in the United Kingdom illustrated that female genital mutilation is a professional responsibility which must be addressed at every available opportunity. The legislation to ban female genital mutilation has been passed in many countries where female circumcision is commonly practiced however, laws are different to enforce perhaps due to the geographical and sensitive nature of this subject (Nursing Standard 2008, 43-47).

It continues to state that health professionals should not re-suture a previously infibulated woman after vaginal delivery because it is an illegal act. It is also necessary for members of the community such as schools and media to be knowledgeable about FGM, to review their attitudes, the laws on FGM to be made more strict so as to eradicate the practice (Nursing Standard 2008, 47).

The study above suggested that some immigrants still continue to practice FGM despite the ban and health professionals must be on the lookout (Nursing Standard 2008, 43-47). Since female genital mutilation is an ongoing practice that can easily spread, all nurses should be vigilant by being observant and protective of the welfare of the minors. Nurses as health care professionals have the responsibility to assist patients on health matters especially when women disclose a history of FGM. As a result, patients start to trust nurses if they are treated with respect and dignity (Potter &Perry, 2007, 68-69).

5 AIM AND PURPOSE OF THE STUDY

The purpose of this study is to find out the mothers´ perspectives of female genital mutilation among Maasai girls in Kenya. The aim of the study can be used in utilising the research results when planning education programs in preventing female genital mutilation.

RESEARCH QUESTION

What are mothers' perspectives of female genital mutilation among young Maasai girls in Kenya?

6 STUDY METHODOLOGY

A qualitative research method has been used for this study. Qualitative study reflects on the enquiry based on realities and viewpoints of the informant group (Polit & Beck 2008, 219). Qualitative research develops rich understanding of phenomenon as they exist in the real world and constructed by individuals in the context of that world. Since the purpose of the study was to find out mothers perspectives of female genital mutilation among young Maasai girls, qualitative research method was appropriate as it tends to be holistic and striving for an understanding of the whole.

Moreover, qualitative researchers go in to the field knowing their source of data (Polit &Beck 2008, 220.)Therefore, the researcher in this study did not rule out other possible data sources that might be highlighted as data collection progressed and observation was vital throughout. According to Lobiondo-Wood, Haber& Kranovich-Miller (2006), qualitative research is conducted in natural settings. It uses words or text as data to describe the experiences being studied. The data collected from qualitative research aids in understanding experiences which affects the daily lives of participants. As a result, these data may be used to develop theories, as well as a recommendation for further research (Lobiondo-wood, Haber &Kranovich-Miller 2006, 28-29.)

6.1 **Informant Group**

The informants are individuals co-operating in a study by playing an active role in a research (Polit &Beck 2008, 55). The informants in this study were mothers with young girls among the Maasai community in Narok Kenya. The informant group consisted of four women aged between 20-35years. A letter to seek permission to conduct the research interview was sought through a contact person who was a local leader in the village, and it was accepted.
This research study has included selection criteria which define the population to be studied. Lobiondo et al (2006, 261) states that the inclusion and exclusion criteria should be used to select the sample from all possible units.

An inclusion criterion is viewed as a method of eliminating characteristics that restrict the population to a group of subjects LoBiondo et al (2006, 261).

The selection criteria was met since all the participants were mothers with young girls; and the mothers were over eighteen (18) years of age from the Maasai community and lived permanently in Narok. Three spoke fluent Swahili and one mixed Maasai language and Swahili, all mothers had gone through female genital mutilation, and they had young daughters who were almost the age of having genital mutilation, except one mother who had her first daughter mutilated, and she had other daughters who were still young to undergo mutilation.

As a researcher, it was very vital to demonstrate the exact criteria used to decide whether an individual would be a suitable member of the given population, which has been specifically described by Lobiondo et al (2006, 262). During this research, the informant group selected was found to be congruent.

6.2 **Data Collection**

The data collection process lasted over three months, spreading from December to February 2011. Before conducting the research a pilot interview was done as recommended by Burns & Grove (2005), stressing that a pilot study is conducted to develop and refine a research; it can be used as a data collection tool and a research development plan (Burns &Grove 2005, 42).

However, pilot interview is not used to test an already developed plan. Pilot study is stressed as a way to identify problems with the design as well as to determine whether the sample is representative of the population or whether the sampling technique is effective. Pilot study also gives the researcher experience with subjects, settings and data analysis techniques (Burns & Grove 2005, 42.)Before the actual individual interviews begun, a brief meeting was arranged for briefing the informant group about the study and to ensure that they had sufficient information.

A letter of introduction was issued to the informants to provide them with information about the study. Consent forms were also available for the informants who agreed to sign, while one participant consented verbally. Never the less, the researcher and the informants agreed on the preferable venue and time for the interviews. Interview was suitable for data collection on this study due to the advantages it has, over other methods as it is pointed by (Polit & Beck 2008, 424).

The response rate tends to be higher in face to face interview as people are more reluctant to refuse to talk to an interviewer, who directly seek interviewee co-operation and a well conducted interview normally achieves up to 90% response rate. The interviewer can detect when questions have been misunderstood and therefore clarify otherwise, misinterpreted questions can go undetected by researchers and result to giving misleading responses. In an interview the researcher have control over the order of questioning and can skip from one section to another (Polit & Beck 2008, 424-425).

The researcher of this study considered whether to ask all participants the same questions in the same order or to slightly alter the arrangement, depending on how each interviewee responded. Furthermore, face to face interviews may result to additional information through probing and the interviewee`s level of understanding, social class, co-operation and lifestyle can be judged. However, interviews are expensive and may bear the risk of becoming bias. Never-the less, advantages of interview outweigh its disadvantages (Polit & Beck 2008, 424-425).

During this study, the researcher used a tape recorder which was placed close and comfortably to the participant and each interviewee was allocated equal time for the interview approximately 30-40 minutes. Polit & Beck (2008) recommends that the instruments must be arranged to minimize bias and every instrument should be introduced during the study. The use of tape recorder allows the interviewer more time to concentrate on any additional information that may come forth through observation (Polit & Beck 2008, 425).

Introduction of the tape recorder made the interviewees feel relaxed and ready to talk, knowing that the information they gave was for research purpose only. The fact that confidentiality was provided, made it easier for the interviewees to open up more, since they knew that no one else was listening to the interview conversation. Protecting human beings from physical harm may be straight forward however the psychological results of participating in a study are delicate and require close attention and sensitivity (Polit& Beck 2008, 170).

Since interviews may require participants to express their personal views and weaknesses leading to revelation of personal information, the researcher was therefore aware of the nature of intrusion on participant's psyches. Also if any questions arose during the research, the author was willing to address the subject in question and reassure the interviewees.

Qualitative research requires greater sensitivity since it involves in-depth exploration in to personal areas. The in-depth probing could expose deep fears and anxieties that the study participant had previously repressed (Polit &Beck 2008, 170). Therefore, there was need to provide privacy for all participants in the study. To minimize distractions and interference from those not involved directly with the research (Polit & Beck 2008, 425).

Some interviewees suggested to be interviewed at their homes because it was the FGM festive season and mothers had a duty to care for their daughters. However, this was discouraged to ensure confidentiality throughout the process. Instead, a quiet room was provided for the researcher to carry out the individual interviews as the facility was a walking distance from most interviewees' homes.

The interview room offered was a neutral place for both the interviewer and the interviewees as it reduced noise and distraction from household chores, making recording clear and audible. Three of the interviews were conducted in Swahili language and one was done in a mixture both Maasai and Swahili

language, Since this were the two languages that the participants were more confident in expressing themselves because all of them had only primary education level.

Two interviewees later admitted that they thought they were being trapped to confess their involvement with FGM. It is a common practice to arrest women who are planning to have their girls mutilated in the long December holiday and the participants had the reason to fear. Some had made excuses that they would be travelling and it took a longer time than planned to carry out the research.

6.3 **Data Analysis**

Content analysis was used in this research study. This means that the narrative data collected will be used to identify prominent themes and patterns among the themes (Polit & Beck 2010, 464-469). All tape recorded interviews have been transformed in to a written format. The interview tapes were transcribed word for word, although some information was intentionally omitted such as informants' names, which could easily reveal their identity.

The transcribed interview notes produced an average of 3.5A4 pages per interviewee. All that information has been translated in to formal English by the researcher and completion of the short-hand information scribbled during the interview, since some informants had used Swahili or Maasai which is the local language. The version from the four interviewees totaled to13.5 pages.

According to Burns & Grove (2005, 554-555), content analysis is designed to classify the words and word combinations or themes in a text in to the categories chosen for their theoretical importance. The construction of idea categories along with selection words is a crucial phase of content analysis. (Burns & Grove 2005, 555).

Analysis of qualitative data is an active and interactive process which involves scrutinizing of data, by reading it severally searching for meaning and deeper

understanding (Polit & Beck 2010, 463-465). Since qualitative analysis involves a lot of work to organize and make sense of the information gathered from the several pages of narrative materials, the researcher must be able to reduce the data for reporting purposes (Polit & Beck 2010, 463-465).

The step that followed was assigning different colors to the transcribed notes. Color highlighting marks were used to distinguish every piece of the transcript allocated to a theme and arising sub-heading within the theme. After the coding process, a summary of all informants' responses was made then each response was grouped under a particular theme see (Appendix 3).

The researcher in this study had to familiarise with the data collected and break it in to themes. By doing so, the researcher is then required to fit together that same data and link all attributing factors. Further-more, it was vital to link similarities and differences to result with different themes (Lobiondo-Wood et al2006, 180).

The themes conducted in the interviews were the base of data analysis. The researcher is required to make sense of several narrative materials and weave the pieces of information as a unified whole which is insightful (Polli t& Beck 2010, 463). Since the field notes and audio tapes were transcribed for easy analysis, the transcription was an important step in preparation of data analysis.

7 RESULTS

7.1 **Mothers` experiences of FGM**

Most mothers had different experiences of female genital mutilation, since they were of different ages. One mother stated that since she was the youngest in the group, who were supposed to have FGM on that day, she was not told in advance about it, until she was woken up in the middle of the night. She was advised by her aunt not to cry but to be brave like other girls and despite being scared, she was happy about the surprise.

> *...Bigger girls are told about it a few days before the big day since they are already over-due but I was too small and mum did not know how to tell me…my cousins already knew it before-hand.*

Another mother stated that she had heard girls in her school discussing about the effects of having FGM. When she asked her mother about it, the mother was furious and transported her to her aunt`s house in a different city for FGM without a warning and she only knew about it on the same night from the other girls. She stated that her aunt had also been very cruel stating that if she dared cry, she would call boys in the village to watch the coward and humiliate her.

> *…I was really scared and cried all night long and when my turn came I had no more tears left. Being watched by boys would have been a disgrace…*

Most mothers had similar experiences of the night they had genital mutilation since they had been initiated in to woman-hood, and FGM was a common practice. All mothers stated that there was nothing to complain about since everyone in their time was doing it, and they looked forward to it. However that

evening was special to them since it was festive and they were asked to sleep earlier than other days and aunties from maternal side brought gifts to the girl. Most of mothers agreed that it was a time to be recognised as fully grown ladies who were desirable for marriage and they enjoyed the attention and admiration they gained from the opposite sex. Two of the mothers stated how brave they had been, though out the FGM process because they knew how important it was to remain calm and brave, not showing signs of pain or struggling with the FGM practitioner.

> *…Boys admire brave girls because it is a practice of how to handle child birth pain…*

All mothers had similar experiences on pain during the FGM process. They all stated that despite the pain, no analgesics were administered before FGM was performed. Sitting in cold water was a common practice to numb the nerves and soon afterwards, the pain was unbearable.

> *...It was still dark and the water was very cold… I sat on it naked and shacking since it was freezing cold outside….*

It was many hours later that mild pain killer was sometimes offered. When asked about pre-operative mediation, majority of mothers agreed that natural remedies such as herbs, oil, milk and ash were commonly used.

> *…Burned leaves, dried or chewed herbs are applied on the wound…sometimes milk is used if the wound is raw and painful… ..I was given panadol two days later because I had fever and could not eat...*

Most mothers agreed that the girls who had gone through FGM are allowed to shower, shave their heads clean and dress up in their best ornaments and beads, ready to celebrate the rite of passage in to womanhood (Appendix 5). They described it as an experience that every girl longed for and each mother narrated about it with pride as though it had just happened the previous day.

The mothers stated that the ornaments and beads they received during the festival would be won again on their wedding day or other festivals

> *….We would wear our beautiful shanga (beaded ornaments) on our necks, arms, ankles and clean shaved shinning heads then sing with pride because we are no longer girls but ladies…*

Diet was vital to observe and all mothers stated that they were well fed for the four weeks after FGM. They agreed that food high in proteins such as meat and milk were commonly eaten. They also drank warm fat from goats at least once or twice a week because it is believed to be a remedy for wound healing and smooth skin.

….Goat fat is the best medicine for quick recovery. Either plain or mixed with herbs and our grandparents have used it for generations…

Most interviewees agreed that hygiene was vital especially the use of new clean razor blade. They were aware that they could acquire infectious diseases such as HIV and tetanus if they shared the blade. However only three stated to have used a new blade, which was later disposed in to pit latrine. Sometimes shortage of such equipment's was common due to distance since some lived in remote places and if anyone lost her blade, she had to share or skip to be mutilated another time.

…I was proud opening my new blade and handing it to the birth attendant…

While another commented

…She is my friend so I used her blade but I was scared doing so…..I had no choice since the local shop had none left…..

7.2 **Knowledge mothers have about Female Genital Mutilation**

The results reflected that the mothers interviewed have some good knowledge about female genital mutilation. They have basic knowledge that FGM has negative effects such as excess bleeding, infections and death of the fetus. However there was mixed feelings between the interviewees since some did not understand the link between FGM and still birth. The duration between when one had gone through female genital mutilation and the time they gave birth was a long period enough to have had complete healing.

> *…If one has FGM, it will take some weeks to heal then another nine months to give birth why does the baby die then…*

Most of the interviewed mothers understood short term effects of female genital mutilation since all had had it. They gave some of their own previous experiences and from friends such as urine retention, urinary tract infection, pain during intercourse, and bad odour and majority were willing to seek medical intervention.

> *…After FGM I smelled really bad and I thought I was rotten which scared me but I could not tell anyone….*

Another one commented

> *…every now and again I experience urine retention and pain during intercourse but I can't discuss it with my husband, I just bear with it….*

When asked if they knew any long term effects of FGM, most of them agreed that still birth was common, back pain and infertility. They agreed that sometimes excessive bleeding could occur during FGM and they all agreed that they could seek professional intervention.

> *…How can I just sit and watch her die....I would sacrifice anything for her even my own life….*

All the four interviewees knew the signs to look for in case of infections, and they agreed they could seek medical intervention. It was clear to all that if the wound took over ten days without showing signs of healing they would seek professional help. Wound smelling and change of color in to yellow, greenish and darkening at the edges are signs of infection and a reason to visit a health facility they agreed.

> *…If the wound really smells bad and has not healed after ten days, I would take her to hospital….. even if nurses are harsh and call me names, as long as she is fine, these bad names cannot stick on my face…*

All mothers agreed that they had female genital mutilation, and there was no fuss about it in those days. Everyone looked forward to the big festive day. One mother had a different opinion since she did not want to have FGM done on her and she knew the disadvantages of being mutilated but she was worried of her friends' opinions. Therefore she stated to have felt the pressure from the people around her.

> *..I knew the dangers….everyone was looking forward to it so what could they think of me and what treatment would I receive after that...*

Most mothers stated that they had gained more knowledge and they are now enlightened more than they were when they got mutilated because a lot of awareness has been raised through health promotion about the subject. Most of them agreed that general cleanliness and hand hygiene is vital. If any of their daughters would undergo FGM like they did, they would advocate for hygiene or pay health professionals to do it they agreed.

> *..I took my son to hospital and he healed very fast… why not my daughter? I would not hesitate since girls are at a greater danger….*

Two mothers commented that use of old fashioned remedies such as dry herbs, ash and cow dung were more dangerous because they have been told so in Hospitals and they would prefer to get professional help rather than risk.

> *…The world is changing fast professionals know better than us so I would always have their opinion…..*

Another one stated that it all depended on how much money one had, the ability to withstand pressure from other women and seeking advice from media books or other sources.

> *…I have better knowledge than my grandparents did, so how much money then should I compromise my child`s life with?....knowledge is power….*

7.3 **Mothers' role in FGM**

Most mothers stated that as a rule, they are supposed to be actively involved especially in caring for their daughters during FGM and the healing process. However, those roles were limited as soon as their daughters were fully healed and celebrated the rite of passage from being girls to ladies. The celebration was marked with the girls showering, shaving their head and wearing their beautiful beads and ornaments.

…soon after shaving their head clean, wearing their beads and showering, we realize that our roles are no longer needed….

Some mothers felt that because they had only attained ordinary level of education, they were intimidated because their daughters had better knowledge about the effects resulting from female genital mutilation, since they had been taught in school while others felt that they were in a dilemma to

choose for their children what was best for them. The results showed different opinions and mixed feelings from all the interviewees.

> *…My daughter can never become a real woman she will always be a girl….why should she be scared? No man will marry her she is a coward…*

One mother replied that she had limited roles to play because the decision of having FGM or not lied on her daughter`s choice. Moreover, it is a crime and fewer mothers were not willing to continue, if it would lead them to prosecution.

> *…They learn a lot from school and she says that she wants healthy children…what does FGM has to do with babies?*

Most mothers agreed that they were ready to assist their daughters if they asked for help but they stated to have limited roles since their daughters could read from books and media. The only role left for mothers was to teach their daughters how to treat their husbands with respect and honor. However, majority agreed facing challenges from their own daughters who stated that both men and women were becoming career oriented and men were not supposed to just sit and wait for their wives, but instead share some roles such and earning an income.

> *…Most young men want educated women and have realized that FGM is bad and my other daughter know a lot about FGM and very much against it….*

Another interviewee felt that FGM has lost its significance since it is taken negatively and she stated that she had no role to play in her own children. She was more worried about her grandchildren who were not likely to have FGM either.

...How can my girl associate with her age sets anymore? She is getting lost in westernisation and no recognition of her own mother`s teachings. I don't expect any better from my grandchildren……

Most mothers agreed that regular confrontation with their daughters about female genital mutilation was drawing them apart. Moreover their daughters had challenging facts about FGM, and they intended to study to the highest levels. Therefore, most of mothers had started to accept the reversed roles, and were willing to learn more through health promotion programs and other sources, as one commented

..I taught her the basics and now she teaches me complicated stuff it's amazing…

7.4 **Culture and FGM**

The results reflected that culture was the most rooted issue affecting most mothers' perspectives on female genital mutilation. Most mothers were willing to adopt any other idea that would not harm their daughters or future generations. They also agreed that girl education was as important as educating boys so they could adopt girl-education and stop FGM. One interviewee narrated how dreadful she felt many years ago when her sister bled to death during FGM. She felt that it was a cultural thing and she had no power to prevent it from happening.

..Its dreadful and terrifying when I imagine my sister`s screams and pleading to be left alone…she bled to death….

Most participants viewed FGM as a cultural thing for girls to comply with do`s and don'ts of the community such as under -going FGM and learning from maternal aunts about becoming good house wives. All were aware that being brave by not showing their emotions or crying during FGM would fetch the

family a bigger bride-price. Since it was a rite of passage, every family was expected to hold a celebration party for girls after they recovered from FGM.

> *…as our custom, the girls are now allowed to shower and dress up for the party…*

One interviewee had a different opinion since she had a dilemma of how she could preserve the culture since her younger daughters had bluntly stated that FGM was the last thing they expected. This act made older women especially grandparents feel like they were losing their culture. However mothers with younger daughters felt that harmful cultural practices could be avoided. Some of the dangers posed to their daughters were infertility, complicated labor, still births and continuous infections.

> *....It was fine with the older daughter because she was looking forward to have the FGM ceremony with the other girls but the younger ones have disappointed me…other women think I can't control my own children…*

Another interviewee had a different point of view and she intended to do everything possible to succeed with ensuring her daughter had FGM. The mother was willing to sneak the daughter to her relatives despite her protest. However, she was scared of the consequences in case her daughter decided to take legal action against the mother.

> *…It has really become hard these days because the younger one has run away several times unless I trick her to visit my sister, and she can have it done there…. If she runs away again, I will stop it because she threatens to report me…very stubborn…*

Most mothers interviewed stated that FGM meant a lot to them and they hated to have their daughters pointed at if they had not done it themselves but the law was getting tight so they had no choice but to comply. All interviewees

agreed that it was a common cultural practice for fathers to have a role in ensuring that they paid for all the FGM expenses.

> *..Fathers must buy food for the ceremony and pay whoever does the "job". As a mother I just ask for money a few days before the FGM is done….*

Two mothers had the dilemma between protecting their daughters from having FGM or complying with the cultural norms and demands of ensuring that the girls underwent circumcision. One concluded by stating that such circumstances are normal but one has to be strong and defends her family.

> *…My mother in-law opposed me and wanted to pay for my daughter`s expenses but I had to stand my ground and she made my life hell…. but she now supports me and can't criticize me any more….*

One religious mother had strongly disagreed with girls being mutilated and did not want to hear anyone talk about FGM because she knew it was harmful to her daughters and the church condemned it

> *…I`m a Maasai and like my culture but am a church leader who can't support FGM what sort of example would I be setting to other women?*

She expressed her grief and the pain of losing children during birth. She could not afford to put her children through the pain she had faced she stated

> *…I have repented and God blessed me with a girl… I will never let her go through what I did and if she wants to, her husband will pay for the price never, not me….*

At one point one of the mothers regretted having gone through female genital mutilation because she had two complicated pregnancies which she blamed on FGM at the age of twelve years.

…If I had known what I now know, I would not have attempted to…all my friends looked forward to it so I felt left out….there was pressure….

7.5 **Treatment and FGM**

Two of the interviewed mothers agreed that they could depend on natural remedies for their daughters such as natural herbs, milk and ash for treatment if the wound was healing well, rather than hospital medication. However, all interviewees stated that they would seek medical intervention if their daughters showed signs of sepsis and infection.

..The distance to health Centre is too far so I would use what is available milk or honey but I would see a doctor for any complications or infection...

When asked about pain management before and after FGM, most mothers agreed that during their time, no analgesics were used except chewing certain leaves which were believed to relief pain. However they all agreed that the pain was almost unbearable after a few hours. One of the mothers who had had her daughter already genital mutilated agreed that she had mild painkillers for her daughter. Another interviewee stated that she would intervene in pain management because it quickens healing process. She regrets not having bought painkillers for herself before- hand and if her daughter ever decided to have FGM, she would take any precautions to protect her daughter from what she experienced.

… I would not risk at home if she has fever, I would take her to the health Centre…this generation is weaker than we used to be….I would not deny her that opportunity….

All mothers agreed that prevention was better than cure. Correct and early preparations were vital especially during and after FGM. Sitting on one goat skin by all the girls having FGM was not hygienic especially these days when HIV is too common.

…I was lucky to sit on a clean goat skin since the previous one had been very soiled because all those before me had used it…..

Mothers had mixed feeling about having antibiotics before or after FGM, since they believed that herbs were equally good. However, one agreed that it could prevent cross infection from FGM attendant, girls undergoing FGM, the environment which was not sterile and the equipments used.

…Cow dung was used on me…it has been used for generations but nurses oppose stating that it is a health hazard……

When asked if any of the mothers would allow medical professionals to perform FGM, they got excited about it and had this to say

…Most nurses in the local hospital can't do it on girls but you might be lucky in other places …it's not common here…

As another one commented

….won't they be helping us break the law?

All mothers agreed that whenever they asked for help from health professionals, they always got it but felt like they were consuming a lot of the health professional's time. The information they were given was sometimes too much so they forgot most of it. Majority of them could tell signs to look for in case of infections and they always got medical intervention but sometimes it was too expensive so they would turn to use herbs and other natural remedies.

….we can't understand everything nurses say, since we have low level of education and hospital language is sometimes difficult…

8 DISCUSSION

8.1 **Validity and Reliability**

Since most qualitative researchers seek to evaluate the quality of data findings, the four major criteria to establish trustworthiness of qualitative data inquiry has been suggested by Polit& Beck (2010, 259, 492).
The first criterion is credibility of data which refers to confidence in the truth of the data and its interpretation process. The researchers should establish confidence in the truth of the findings in the context of the research, according to Polit& Beck (2010, 492). In this research study, credibility was valid since all the responses were written and recorded according to the way the informants stated them.

The second criteria is dependability, which refers to reliability of data over time and over conditions. Dependability must be able to justify if the study findings would be repeated if the inquiries were replicated in the same participants in the same context (Polit and Beck 2010, 492).

Face to face interview method was used which ensured that the questions the informants were asked were well understood and answered appropriately. Silverman (2010, 290) comments that for reliability to be calculated, the researcher must make clear documentation of procedures so as to demonstrate consistency of the whole process.

The interviews conducted were transcribed and analysed by the researcher, who understood both of the main languages spoken by the informants and translating that information in to English. Transferability refers to the extend in which the data findings can be applied in other settings. Furthermore the researcher has a responsibility to provide descriptive data in

the research for consumers to evaluate its applicability to other contexts (Polit & Beck 2010, 492–493).
The findings in this study can be utilised in future by policy makers, health professionals as well as other non-governmental bodies when planning education programs in preventing FGM and raising awareness about FGM, especially to women and communities who have different views of female genital mutilation.

The last concept is conformability which refers to the potential of agreeing between two or more independent people about the data`s accuracy and meaning. Conformability establishes that the data represent, the information provided by the participants and data interpretations are not guess work from the researcher as it is pointed out by (Polit&Beck 2010, 492). The findings reflected the participants' voice since aim and purpose of the study was congruent. This means that the participants had the opportunity to express their opinions and perspectives on FGM in their own words.

8.2 **Ethical Issues**

The code of ethics demands that all researchers have a duty to care and during this research study, the right to protection was fundamental. (Polit 2008, 171) points out that research participants should not be exposed to situations which they are not prepared to. They must be assured that their participation or the information they provide will not be used against them or disadvantage them in any way.

Polit &Beck (2010) recommends that researchers must adhere to codes and ethics for protecting human rights. When humans are used as study participants, researchers should minimize harm and maximize benefits. The researcher must be ready to terminate a research if there are reasons to suspect that its continuation would result to harm or injury Polit & Beck (2010, 121). There was an expression of fear from the participants when the interview started, and that was resolved and the study continued smoothly.

The code of ethics was also observed by ensuring that the informant group was informed in time before the research begun and they agreed to participate by signing a consent form while one agreed verbally. In the beginning of the study, the researcher experienced resistance from the informants since a few mothers were afraid to be interviewed. They thought that the local authority was involved but word spread fast that the research had nothing to do with "the law", as it had been thought of initially.

Therefore, it was necessary for the researcher to reassure the interviewees by adhering to legal principles. Special attention was given on ethical issues present during and after the study in order to protect the participant´s privacy and confidentiality, when publishing the report by ensuring that no real names have been used.

Since the Kenyan law also forbids FGM and those who carry out the practice or those planning to do it are aware that they were doing it illegally, it was necessary to hear the participant's point of view and allow them to speak freely without feeling as though they were being judged or stereotyped in any way by the researcher. The Kenyan government is also working hand in hand with the Ministry of Health to achieve the objectives set by the National Plan of Action to ensure that health professionals are aware that FGM is illegal and they too must not perform it for parents who may request for it on behalf of their daughters. Mothers are also aware that if their daughters raised the alarm by complaining to their teachers or the local authority, legal action would be taken against such parents.

The data also revealed that most mothers are aware that female genital mutilation is harmful but did not know how, since most participants interviewed had little education and they felt intimidated since their daughters know much more than they personally know therefore privacy and confidentiality was maintained during the individual interviews.

Most importantly, participants have the right to decide voluntarily whether to participate in a study or not, ask questions without risking anything, prejudicial treatment and to withdraw from the study any time they desire to, as well as to be treated with respect and dignity (Polit & Beck 2010, 121-125). This was an important element for the researcher to consider. Fear and lack of trust was common among most participants who thought that if they accepted to be interviewed, the information they gave would be used against them therefore confidentiality was vital.

8.3 **Discussion of the main findings.**

The purpose of the study was to find out mothers´ perspectives of female genital mutilation. The aim of the study can be used in utilising the research results when planning education programs in preventing female genital mutilation. According to the findings of the study, there was a general feeling that most participants had experienced resistance from their daughter, who had learned about the effects of FGM and were not ready to have it done on.

Most participants agreed that times had changed and they were therefore willing to drop the practice, as long as the topic was discussed more openly since they had also learned that FGM had negative effects on their daughters. They also expressed the need of girl child education since they realized that girls can be as good as boys academically, and some girls were even performing better than the boys, instead of marrying the girls off after FGM, since lack of education made mothers feel intimidated when facts about female genital mutilation was given by their daughters.

The study uncovered mothers' good knowledge on signs to look for in case of infection after FGM. They were also aware of the short term and long term effects of FGM, therefore most of them were willing to seek medical intervention. However, some mothers expressed the dilemma they faced on

the distance they had to cover to go to the nearest health center, so they preferred to use the natural remedies they had.

Most mothers were aware of the importance of hygiene and use of sterile equipment but sometimes there were shortages or lack of finances which made them ignore hygiene measures. Therefore since the government is working hand in hand with the Ministry of Health, it would be a good opportunity to implement the national plan of action set by the Kenyan Government.

There was a general feeling among the participants that they were losing their role in FGM as mothers, since their daughters were more enlightened and career oriented hence not interested with their parents old fashioned practices. So the mothers accepted to take roles as they arose and only when their daughters needed it .The mothers appreciated the role played by teachers in schools but still blamed it on turning their daughters in to westernization.

Culture was highlighted as a challenge amongst most participants who expressed their desire to adopt other ideas that would not harm their daughters and future generation. Such methods included educating girl child and “circumcision through words”, which involved teaching girls and celebrating the occasion without necessarily circumcising them. Most mothers accepted integration of such methods with new ideas was the way forward because their daughters would learn a lot even without the real circumcision and learning evidence based knowledge.

Therefore what Carr (1997) and Bisimba (1999) had initially found about men preferring genital mutilised women was now changing since both boys and girls were learning its negative effects and most men now prefers women who are not genital mutilised since they too understand its long and short term effects.

Other alternatives such as “circumcision through words”, was a new method which has only been introduced and most mothers who have heard about it are willing to adopt it fully. They also felt that men too were playing a role by paying for FGM expenses. Despite the older generation complying with cultural norms of do`s and don’ts of female genital mutilation, they realized there was a need for change and raising awareness from health professionals, religious and political leaders.

When asked about treatment, most mothers agreed that they had used natural medicines and could still use it on their daughters. They expressed the pain agony they faced was too much to expose their daughters to it. However, they acknowledged they would request professional treatment if need arose and use of antibiotics in case of infection. They agreed that use of analgesics was necessary since it quickened recovery, and majority would intervene with mild painkillers.

A previous study carried by Boyle (2002) which stated that women who have not had FGM are stereotyped to appear masculine appeared to be changing and Barrie (2006, 55-56) which showed that most women who have had FGM do so because it’s a sense of security when they are married appear to be changing according to the research findings since most girls are now more focused in education and are aware that they can also earn an income without necessarily depending on men for their provisions as it was thought before.

9 CONCLUSION AND RECOMMENDATIONS

To conclude, the interviewed mothers had the knowledge about FGM and were willing to change or adopt new methods which would not harm their daughters. They also felt that there was a need for health professionals to step in and raise more awareness about FGM especially in the most remote areas. Although FGM has been abolished by the Kenyan government and the act has been condemned harshly by human rights, this affirms the results of previous studies that FGM is a global problem, which may take many years to fully eliminate.

Most mothers also felt that their husbands were also playing a role by facilitating payment of expenses for female genital mutilation to be carried out. The study recommends future research to also target fathers' opinions and a larger sample in the community, and find out their opinions on female genital mutilation. The girls who are victims of FGM were not interviewed to express their experiences however; their opinions can be researched in the future. Such study would give further insight in the structure of the family as well as provide relevant care towards disease prevention, health promotion and the well-being of the community at large.

In connection to the local government, this study could also provide vital information for policy makers and implementing other organisations in preventing of FGM and raising more awareness especially to mothers who have different opinions on the above subject. By doing so, it can be decided whether to move health facilities to those most in need of them, or provision of mobile clinics, promoting of behavior change or provision of more education knowledge and awareness to females especially in the remote villages.

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Appendix 1

LETTER OF AUTHORISATION

Dear Madam,

I am an international student at JAMK University of Applied Sciences in Finland and I am currently undertaking my Bachelor's Degree in Nursing. The bachelor's subject is about "Mothers perspectives of female genital mutilation among the Maasai community in Kenya". I would kindly like to ask for your permission to conduct a study among the Maasai community and the purpose is to acquire information about the above subject.

The data will be collected by face to face interview and tape-recording will also be done. This will happen in the months of December 2010 to February 2011. Your co-operation will be highly appreciated and I believe it will be of great importance towards acquiring the information I need for my thesis project. Confidentiality and anonymity will be maintained throughout the study. Please feel free to contact me in case of any questions that may arise concerning this study.

Thank you for your participation,

Yours sincerely,

Jane Malaso Oleleparakuo

Contact: pmalasomegan@yahoo.com +254 7221459

Appendix 2

CONSENT FORM

I am signing this consent form to permit the mentioned student to carry a research study about mothers` perspectives of female genital mutilation among the Maasai community. To interview me and using tape recording equipment for research purposes. As a volunteering participant, I understand that I have a right to withdraw from the interview at any time or request the tape recorder to be switched off at any time during the interview.

I understand that confidentiality will be maintained throughout the research, and I cannot be identified from the data analysis in the research.

I am aware that all contents of the tape-recorded information and personal information are strictly for the purpose of the research and it will not compromise my safety in any way.

Date and place

Participant

Signature

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Signature of student nurse

Malaso Jane Oleleparakuo

Appendix 3

Theme Questions

What are mothers` experiences of female genital mutilation?
What role do mothers play in female genital mutilation?

Experiences

- What is your own experiences and knowledge about female genital mutilation? Please explain in your own words.
- Would you explain how pain was managed during FGM in your time?
- What sort of treatment was offered after FGM?
- Tell us about hygiene and type of diet eaten during and after FGM.

Culture and role of mothers

- Is female genital mutilation still a common practice among the Maasai community?
- What are your traditions and cultural roles about FGM?
- What are your religious beliefs about FGM? Explain.
- Do fathers have any role to play in FGM? Please explain
- What is expected of the girl after she has undergone FGM, and are there any celebration during or after?
- Would you prefer your daughter to have FGM in Hospital or at home? Explain why
- What are the preparations done before and after FGM, and are there exchanges of gifts?
- Do all mothers in the village plan FGM for their daughters together? Explain
- Who pays for the expenses of the girl undergoing FGM?
- Is there any special diet for the girl who has undergone FGM?
- If she refuses to get married, what happens next?
- What sort of education do girls receive during the recovery time?
- Who educates the girls during/after FGM, and what education did you gain?
- Is it natural for girls to talk to their mothers about boyfriends after FGM, and are there ways of stopping it in future?

- What are grandparents' roles in teaching cultural beliefs in female genital mutilation?

Knowledge

- What knowledge do mothers have of FGM?
- Have anything changed from when you had FGM and now? Explain more.
- Are there any changes you would like to suggest regarding FGM? Which ones and why please explain in your own words

Treatment

- What type of treatment is commonly used among this community? Explain in your own words
- Are traditional medicines often used during FGM? Which ones are commonly used and why
- What sort of treatment do traditional physicians offer girls after FGM? Please explain in your own words
- Would you seek professional treatment at any time? If yes why and if no why? please explain inn your own words
- How would you compare the treatment you acquired in a hospital to what traditional physicians offer? Please explain in your own words.
- Would you like to add something else about treatment?
- Do you have any more comments?

APPENDIX 4

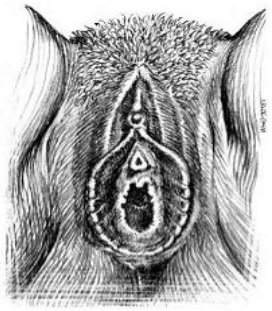
Maasai manyata: A temporary home made of mud, cow dung and grass.

Maasai Manyata. A Maasai woman in her homestead in ordinary clothes

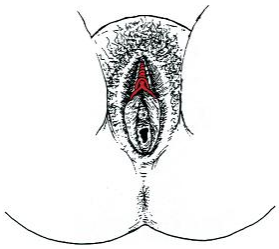
Maasai women. Dressed in their celebration attire and beaded jewelry.

APPENDIX 5

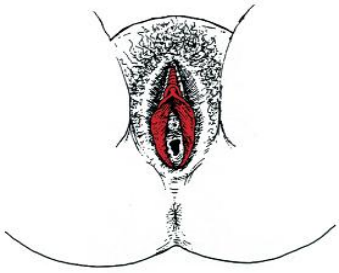
Types of female genital mutilation



Normal genitalia

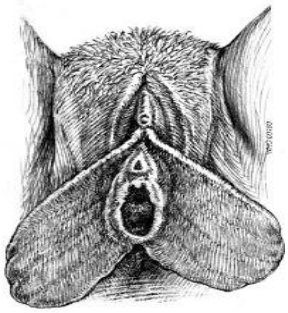


type 1: removal of prepuce
Without damage of clitoris.



Type 2: excision of prepuce ,
clitoris and labia minora

Type 3: infibulated genitalia



Type 4: pulled labia minora.