VIOLATION OF WOMEN'S PRODUCTIVE RIGHTS: A CASE OF FEMALE GENITAL MUTILATION IN KAPCHORWA DISTRICT (1970-2007)

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DECEMBER, 2009

DECLARATION

I, Chepsikor Muhammed Monges Pripinya, hereby declare that the work contained in this report is my original work and has never been submitted to any other University or college for an award of a degree or its equivalent.

Signed ………………………………………………..

CHEPSIKOR MUHAMMED MONGES PRIPINYA

Date …………………………………………………

APPROVAL

I certify that Chepsikor Muhammed Monges Pripinya, carried out research and wrote this dissertation entitled “Violation of Women’s Reproductive Rights: A case of Female Genital Mutilation in Kapchorwa District (1970-2007)” under my supervision. The report is hereby submitted for examination with my approval as a University supervisor

Signed …………………………………………..

Dr. A.B. RUKOOKO

Date …………………………………………….

DEDICATION

To all my friends and the entire Pripinya family for their patience love, encouragement and sacrifice for making me what I am top day.

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ACRONYMS

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

ABSTRACT

The study aimed at investigating the violation of women's reproductive rights: A case of Female Genital Mutilation in Kapchorwa District (1970-2007).

This was motivated by the fact that although there have been deliberate attempts and formulation of international and national instruments to encourage the Sabiny community to discard the FGM practice, there seems to be persistent resistance to abandoning it, as evidenced by the number of females who undergo the practice. The study was guided by three objectives: (i) To identify and analyze the relevant human rights instruments to women's reproductive rights, (ii) identify the reasons for carrying out FGM in Kapchorwa District and (iii) to find out the challenges faced in the implementation of human rights instruments to women's reproductive rights. An evaluation of a rights-based approach to FGM was also done.

The study used a case study research design in which both qualitative and quantitative techniques of data collection were employed. The study population included females aged 14-25 (90) and opinion leaders from the elders (12), health workers, and Local Council I Leaders (6), whose gender was not predetermined. In all, 144 respondents were involved in the study. A research administered questionnaire, an interview guide and a focus group discussion guide were used to solicit data. The collected data was presented in frequency counts and score tables with varying percentages calculated. Interpretations and conclusions depended on the number of occurrences on each item. For qualitative data, a scheme of analysis was worked out following the coding. categories, using content analysis, quotations and the most occurring ideas on every question.

The study findings also revealed that though there were some levels of support for the eradication of FGM practice, it is unlikely to end. This is because society has cast a state of sacredness on FGM, especially by institutionalizing its norms and linking contravention of such norms to social disaster and loss of benefits to society. Regarding the use of national and international instruments on women's reproductive rights, there were low levels of awareness, lack of social support, and lack of a practical law that would not complicate relationship elements with other tribes. There was also lack of structures and institutions to popularize the evils associated with FGM by according the victims some degree of special attention.

It was observed and concluded from the study that some respondents did not know anything about human rights. Apart from the health workers and local council I leaders, there was little known about FGM as a form of human rights violation. Most of the respondents took the FGM practice as sacred and part of the Sabiny social values. Apart from the local council leaders and health workers who were aware of some of the Uganda constitutional stipulations, knowledge concerning the international instruments was lacking, and thus, a rights-based approach to women's reproductive rights was not known. Although some females were voluntarily taking part in the FGM operation, some were merely forced and compelled to take part. Coupled with the effects associated with the practice, such as pain, excessive bleeding, painful sexual intercourse and difficulty in child birth, the practice was observed to be violating women's rights. However, respondents attached both material and immaterial benefits to the practice.

It was recommended from the study findings that: The government should increase community awareness about the need for eradicating the practice of FGM, develop tools that can facilitate gender-sensitive FGM policy formulation, planning, implementation, monitoring and evaluation. It was also recommended that there is need to enhance advocacy and lobbying for the recognition of women's Reproductive Health Rights

CHAPTER ONE

GENERAL INTRODUCTION

1.1 Introduction

The term Female Genital Mutilation (FGM), refers to the partial or total removal of the female external genitalia (WHO, 1995). Some people call this practice Female Genital Cutting while others use the term Female Circumcision. The practice explains all the procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons.

As the http://en.wikipedia.orglwiki/Female_genital_cutting (August, 2, 2008) highlights, the term is almost exclusively used to describe traditional, cultural, and religious procedures where parents must give consent, due to the minor age of the subject, rather than to procedures generally done with self-consent (such as labiaplasty and vaginoplasty) . It also generally does not refer to procedures used in gender reassignment surgery, and the genital modification of intersexuals.

Irrespective of the term used, the practice seriously endangers the health of women, as it causes them considerable pain and suffering besides threatening their lives. It is a form of human rights violation as mutilated women lose a sense of sexual desires; a fundamental right that all human beings ought to enjoy by the virtue of their humanness.

1.2 Background to the study

Globally, women are being deprived of reproductive autonomy (Centre for Reproductive Law and Policy, 1997). Exploitation, inequality, violence, coercion, and neglect of basic health services, have prevented women from having both the freedom and the empowerment to control their own reproductive lives. Many of the abuses violate women's rights without necessarily inflicting a direct health pain on their beings. However, FGM the concern of this study, was a name given

during the 3rd Conference of the Inter-African Committee on Traditional Practices involving the removal and/or alteration of part of a woman's external genitals.

The practice is sometimes referred to as infibulation. In modern usage, infibulation is the practice of surgical closure of the labia majora (outer lips of the vulva) by sewing them together to partially seal the vagina, leaving only a small hole for the passage of menstrual blood. The legs are bound together for approximately two weeks to allow the labia to heal into a barrier. The procedure is usually done on young girls before onset of puberty, to ensure chastity. It is usually performed at the same time as removal of the clitoris. The labia minora (inner lips of the vulva) are often also removed.

The practice of FGM is widespread in Somalia, Ethiopia, Sudan and the Middle East. It involves the cutting off the clitoris and other parts of the female genitalia. Between 85 and I IS million women and girls have undergone Female Genital Mutilation; approximately 2 million are subjected to it annually (Toubia, 1993). In most cases, the operation takes place in primitive conditions where by un-sterilized cutting tools are used, no anesthesia, no antiseptic and no antibiotics are provided to reduce on the pain and enhance faster healing (Light Foot-Klein 1991; Sarkis, 1995). The fact that the countries that practice Female Genital Mutilation continue to have a thriving population is a testimony to the fact that most women survive (Salonen, 1991). However it should be noted that others die. But the actual number of women and girls who die as a result of Female Genital Mutilation is not known. However, in areas in the Sub Saharan Africa where antibiotics are not available, it is estimated that one third of the girls undergoing FGM die. Others are permanently crippled and / or face pain and a variety of other problems throughout their lives.

In 1996, the Uganda-based initiative; Reproductive, Educative, And Community Health (REACH) began using the term "FGC", observing that FGM may imply excessive judgment by outsiders as well as insensitivity toward individuals who

have undergone some form of genital excision. As Amal (2003) notes, the FGM practice in Uganda affects approximately 5% of the women population among the Sabiny of Kapchorwa District. The other Districts are Moroto and Nakapiripirit whereby the Pokots and Tepeth tribes are affected, and the Somalis and Sabiny immigrants and pockets of Kalenjin people in Masindi and Fort Portal. Amal (2003) also highlights that the practice of FGM exists in Soroti and Moroto districts, though in secrecy.

FGM is one of the practices whose physical and psychological effects are often traumatic because of the irreversible nature of the procedures that affects women's health and well-being, particularly sexual and reproductive health of those who undergo the procedure (UNFP A, 1997). As a result, some girls drop out of school, marry early and face many problems after the circumcision ritual. The girls and women who undergo the practice are predisposed to a number of health risks ranging from severe bleeding, HIV/AIDS infection, hemorrhage, and painful intercourse, obstructed labour, low sexual desire, life-long frigidity, menstrual problems, fistulae, incontinence, and a number of other permanent disabilities as well as psychological trauma and stigma (Met Calf, 1996, Kakuba, 1995). To Hasken (1998), 26% of women who undergo FGM develop physical and psychological complications resulting into death.

International Human Rights Conventions generally see FGM as a traditional practice, which violates women and children's rights. Amnesty International, USAID, and WHO are among the organizations that have condemned FGM practice. It is considered a practice that brutally abuses Human Rights and this has opted reactions from the human rights perspective on universally recognized Human Rights. For example, Article 1 of the Universal Declaration of Human Rights (UDHR) states that "All human beings are born tree and equal in dignity and rights. They are endowed with a spirit of reason and conscience and should act towards one another in a spirit of brotherhood." And article 5 adds, "No one shall be subject to torture or to cruel, In human or degrading treatment or punishment."

A human rights perspective on the issue of FGM affirms that girls and women have the right to physical and mental security, the right to freedom from discrimination on the basis of gender, the right to the highest standards of physical and mental health and other related rights. The African Charter on the Rights and Welfare of the Child, adopted by the Organization of African Unity (OAU) in 1990, requires governments to take appropriate measures to eliminate social and cultural practices, "harmful to the welfare, normal growth and development of the child, in particular those prejudicial to the health or life of the child and those customs and practices discriminatory to the child on grounds of sex or related status (Hosfall, 2000).

The programme of Action of the United Nations International Conference on Population and Development in Cairo, September 1994, stipulates that governments are urged to prohibit FGM wherever it exists and to give vigorous support to efforts among Non-governmental and Community Organizations and Religious Institutions to eliminate such practices (Centre for Reproductive Law and Policy, 1997). Further more, it revealed that, from a Human Rights stance, governments have clear obligations to take appropriate and effective action to eradicate FGM including legislations on eradication of the practice and sensitization programmes citing the negative aspects of FGM. A National Initiative on FGM requires a coalition of government, Non-Governmental Organizations, the Media and the Private Sector.

Uganda is a signatory to most of the International Human, Rights Conventions and Instruments. By ratifying these Conventions, the Government agreed to ensure that everyone within the country enjoys the Human Rights covered by these conventions. These included among others, the rights of life, liberty, to human dignity, fulfillment of basic needs such as the right to food, shelter, clothing and health, freedom of association and the like.

These rights have been incorporated in the Constitution of Uganda (1995), for example, Article 24 of the constitution states that "No person shall be subjected to

any form of torture or cruel, in-human or degrading treatment or punishment" Article 32 (2) further states that "laws, cultures, customs which are against the dignity, welfare or interest of women.. ..are prohibited by this constitution " and Article 33 (1,2 and 3) state that "women shall be accorded full and equal dignity of the person with men (2) the state shall provide the facilities and opportunities necessary to evidence the welfare of women to enable them to realize their full potential and advancement and (3) their rights, taking in to account their unique status and natural maternal functions in society……." More so, in 1996, a court intervened to prevent the performance of FGM under Section 8 of the Children Statute, enacted that year, that makes it unlawful to subject a child to social or customary practices that are harmful to the child's health.

At the local level, the Reproductive Education and Community Health programme (REACH), an advocacy organization was established in Kapchorwa in 1995 to eliminate female circumcision. It has been working hand in hand with UNFP A and the Government of Uganda (Kirya and Kibombo, 1999). However, their efforts have tackled FGM from a medical perspective focusing on the harmful effects of the practices to maternal, social and physical health of the victims.

Important to note is that no laws have been drafted and enacted to support their implementational strategy of eradicating the FGM practice. With financial constraints, lack of massive sensitization about the dangers of the practice and limited personnel, the implementation of the International Human Rights Instruments has not been effective and thus, the practice has survived a test of time and continues to be manifested, especially in Kapchorwa District.

It is out of the above concerns that the researcher picked interests to address the FGM practice on Human Rights Perspective such that human rights-focused alternatives can be adopted for the benefit of women as far as enjoying their natural entitlements is concerned. This was done focusing on Kapchorwa District as a case study.

1.3 Statement of the problem

Although there have been deliberate attempts and formulation of international and national instruments to encourage the Sabiny community to discard the FGM practice, there seems to be persistent resistance to abandoning it. This is evidenced by the number of females who undergo the practice.

Studies conducted on FGM have concentrated on knowledge, attitudes, beliefs and awareness levels about the dangers of the practice on human health (For example, Kakuba, 1995; Kirya and Kibombo, 1999). Such studies have indicated that the level of knowledge on the potential health risks of FGM is low. Women's reproductive rights continue to be violated as they undergo pain and experience long-life physical, health and psychological effects as a result of the FGM practice. No single study has come up to address the practice of FGM on a human rights perspective. This study, therefore, was intended to tackle the FGM practice on a human rights basis such that alternatives can be sought to protect, promote and enhance the enjoyment of reproductive health rights by women. This was done focusing on the Sabiny community in Kapchorwa District as a case study.

1.4 Definition of key terms

In this study, the researcher used different terms that were given operational definitions. It was within the interests of this study that the words were defined the way they are to avoid double meaning. They include:

(i) **Female Genital Mutilation:** The practice that involves partial or total removal of the female external genitalia.

(ii) **Human Rights Instruments:** Conventional and law provisions that provide standards of common pursuit to safeguard and promote human entitlements.

(iii) **Women's reproductive rights:** Entitlements that pertain the gender relations of women in society.

(iv) **Challenges**: Factors that constrain effective implementation and use of instruments and laws pertaining the promotion, safeguard and enjoyment of women's reproductive rights.

(v) **Health**: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, with due regard of recognizing health as one of fundamental rights of every human being.

(vi) **Reproductive health**: A condition in which the reproductive process is accomplished ;n a state of complete physical, mental and social-well being and is not merely the absence of disease or disorders of the reproductive process.

1.5 Objectives of the study

1.5.1 General objective

The general objective of this study was to assess the violation of women's reproductive rights through Female Genital Mutilation in Kapchorwa District.

1.5.2 Specific objectives

(i) To identify and analyse the relevant human rights instruments to women's reproductive rights.

(ii) To identify the reasons for carrying out FGM in Kapchorwa District.

(iii) To find out the challenges faced in the implementation of human rights instruments to women's reproductive rights in Kapchorwa District.

(iv) To propose how the challenges faced in the implementation of human rights instruments to women's reproductive rights can be overcome in Kapchorwa District.

1.6 Research hypotheses

This study was guided by the following null hypotheses (Ho):

(i) There are no practical relevant instruments stipulating the protection and promotion of women's reproductive rights in Kapchorwa District.

(ii) There are no clear reasons for carrying out Female Genital Mutilation in Kapchorwa District.

(iii) The implementation of human rights instruments has had no significant challenges in safeguarding and promoting women's reproductive rights in Kapchorwa District.

1.7 Scope of the study

Geographically, the study was carried out from Kapchorwa District, found on the slopes of Mt. Elgon, one of the Africa's highest Mountains in Eastern Uganda. The study covered all the three counties of Kong as is, Kween and Tingey.

The study aimed at investigating the violation of women's Reproductive Rights through Female Genital Mutilation. Special focus was put on identifying and analyzing the relevant human rights instruments to women's Reproductive Rights, identifying the reasons for carrying out FGM and finding out the challenges faced in the implementation of human rights instruments to women's reproductive rights.

The study covered a period from 1970-2007, reasons being that this time helped the researcher to evaluate the trend of FGM, for example, whether there has been a decline or an increase in FGM incidence and the reasons attributed to the practice.

More so, there has been an enhanced recognition of women's rights and the women rights movements and empowerment, especially for the last ten years. This has taken cognizance of the FGM practice. Its is in this regard that the time scope was spread for a good number of years to effectively trace and track all the three variables of the study (instruments stipulating women's reproductive rights concerns, reasons for practicing FGM and challenges in the bid to promote women's reproductive rights).

1.8 Justification for the study

Kapchorwa District was selected due to the fact that the community still cherishes the practice of FGM despite its reproductive dangers, the existing human rights instruments and several attempts made to eradicate the practice. This would, therefore, provide a clear ground for finding out the possible reasons for carrying out the practice of FGM.

The women emancipation movement, enjoyment of women and human rights, capabilities and functionings have become a great concern for most of the governments, Non-Governmental Organizations, Civil Societies and Community Based Organizations. It was, therefore, to this concerted effort that the researcher found it necessary to empirically find out the ridding factor to the maintenance of the FGM practice irrespective of all the policy instruments and all the efforts directed towards ending the practice.

1.9 Significance of the study

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

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

The study concentrated on a human rights-based approach to addressing FGM. Most of the studies done on FGM have tended to concentrate on the health concerns and evaluating the legal instruments in the bid to eradicate the practice. The major component of this study (reproductive rights), therefore, is hoped to

provide the government, policy makers, traditionalists and the citizenry at large to address the practice as a violation of human rights. This kind of awareness is hoped to pave a grounded way of completely doing away with the practice.

The study focused on issues and challenges that are encountered by women and the girl child as a result of FGM within the community. It is hoped that knowledge of such nature can enable government, the community and individuals to come up with realistic legal redress to the customs and harmful traditional practices that cause intimidation, psychological problems and above all reproductive problems to women.

The study findings are also expected to provide up-to-date literature that can be used by academicians who may wish to carry out more studies on the subject matter of women reproductive rights or a related field. It is thus hoped that the study finding will stimulate further research.

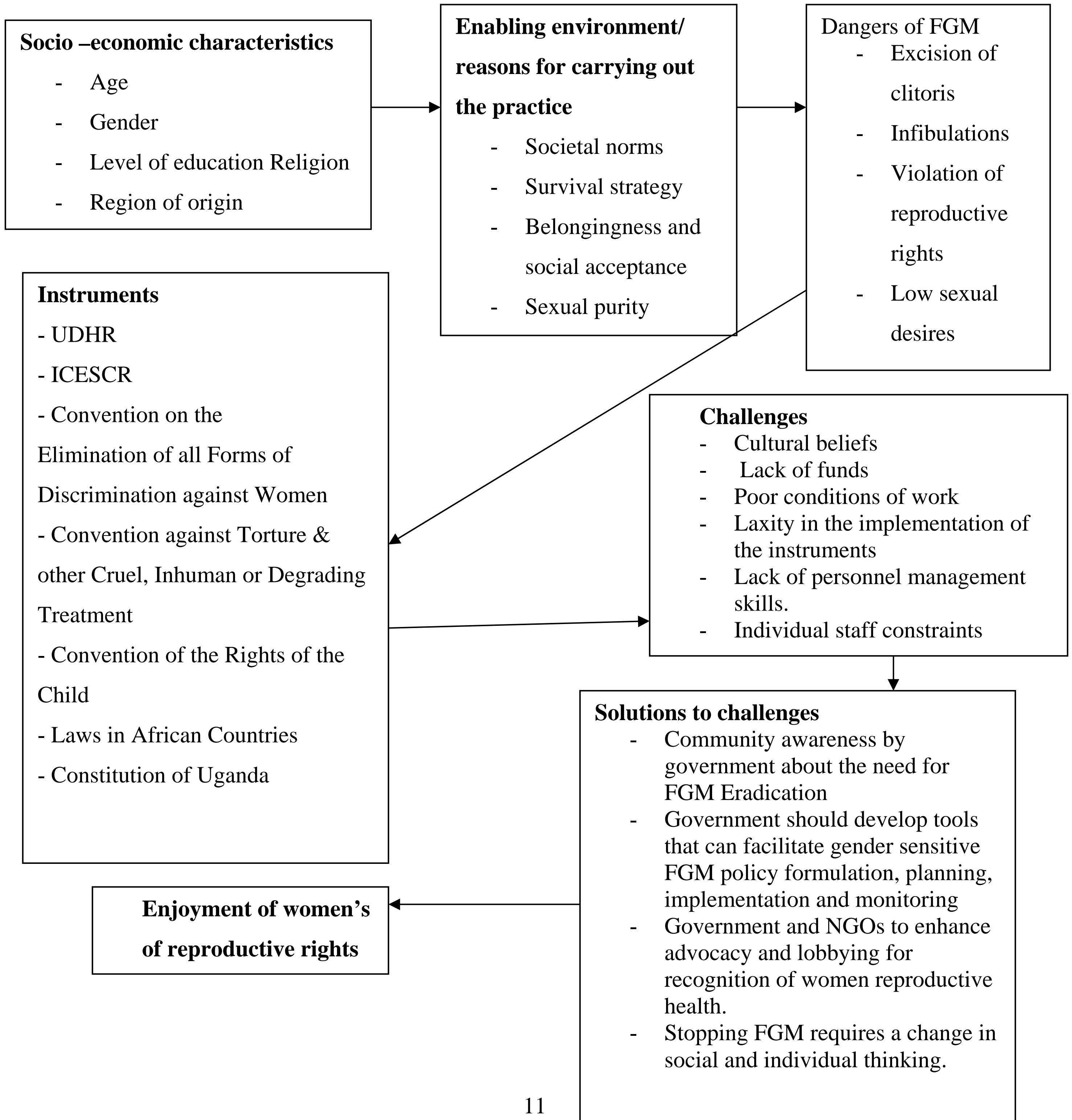
1.10 Conceptual framework

The study was conceived on the assumption that the socio-economic characteristics of an individual will greatly determine the extent to which she will fall a victim of FGM. For example, girls are mutilated at a given age and this is greatly determined by where the person is naturally born from. The practice of FGM mutilation is facilitated by the cultural norms and beliefs as well as the social survival strategies such as the social feeling of belongingness. It is due to such factors that the practice of FGM has survived for a test of time irrespective of the several attempts to end the practice.

Due to the resultant effect of FGM on women's reproductive rights, including ultimate deaths in some cases, a number of legal and policy instruments have been designed to formally end the practice. However, this has not always been easy due to a number of challenges. The study was also conceived on the fact that with effective use of the instruments and legal support, especially coupled with devoted

personnel and stakeholder support, the practice can subsequently be eradicated, thereby attaining high levels of women's reproductive rights enjoyment. This is explained in figure 1.

Figure I: Conceptual framework for the topic: Violation of Women's Reproductive Rights: A Case of Female Genital Mutilation in Kapchorwa District (1970-2007).



CHAPTER TWO

REVIEW OF LITERATURE

2.1 Introduction

This chapter presents a review of relevant literature on the subject matter of the study. It was presented in accordance with the major themes of the study: the relevant human rights instruments to women's reproductive rights, reasons for carrying out FGM and the challenges faced in the implementation of human rights instruments to women's reproductive rights in Kapchorwa District.

In reviewing the literature, materials were drawn from different sources for the researcher believed that any relevant literature irrespective of the place or time could still provide the study with a substantial basis upon which the study inferences could be based. An attempt was made to fill the research gap, between the past writers and the present situation, especially in the Kapchorwa District context.

A comprehensive assessment was also done at the end of the chapter, thereby reflecting on the stringent reproductive rights, pointed out by the instruments as well as the extent to which various governments, especially Uganda have gone to safeguard women's reproductive rights with due cognizance of FGM as a form of violation.

2.2 The relevant human rights instruments to women's reproductive rights

2.2.1 International Instruments

(i) The Universal Declaration of Human Rights (UDHR)

The UDHR consists of a preamble and 30 articles, setting out the human rights and fundamental freedoms to which all men and women are entitled, without distinction of any kind (United Nations, 2000)

The Universal Declaration recognizes that the inherent dignity of all members of the human family is the foundation of freedom, justice and peace in the world. It recognizes fundamental rights which are the inherent rights of every human being including, inter alia, the right to life, liberty and security of person; the right to an adequate standard of living; the right to seek and enjoy asylum from prosecution in other countries; the right to freedom of opinion and expression; the right to education, freedom of thought, conscience and religion; and the right to freedom from torture and degrading treatment. These inherent rights are to be enjoyed by every man, woman and child throughout the world, as well as by all groups in society, as some of the stipulations so point out.

For example, Article 1 of the UDHR states that "All human beings are born free and equal in dignity and rights. They are endowed with a spirit of reason and conscience and should act towards one another in a spirit of brotherhood." And article 5 adds, "No one shall be subject or to torture or to cruel, inhuman or degrading treatment or punishment." With regard to FGM, it ought to be noted that the practice totally subjects the victims to torture, pain, physical, psychological and health implications if not death. The issue at stake is that the practice is manifested in some of the countries that fully ratified the UDHR. In view of this, this study intended to find out whether the women victims are aware of their rights as regards objecting the practice. This was done with a focus on the Sabiny community of Kapchorwa District.

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

Economic, social and cultural rights are fully recognized by the i9-ternational community and in international law and are progressively gaining attention. These rights are designed to ensure the protection of people, based on the expectation that people can enjoy rights, freedoms and social justice simultaneously (Centre for Reproductive Law and Policy, 1997).

The Convention embodies some of the most significant international legal provisions establishing economic, social and cultural rights including, inter alia, rights relating to work in just and favourable conditions; to social protection; to an adequate standard of living including clothing, food and housing; to the highest attainable standards of physical and mental health; to education and to the enjoyment of the benefits of cultural freedom and scientific progress. By the fact that FGM violates women's full enjoyment of their physical being, as their bodies are subjected to malformations, reflects the fact that the convention is not fully recognized. It was, therefore, to the interest of this study to find out why the convention has not been put to full use, especially for countries like Uganda that ratified the convention.

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

As the United Nations (2000) puts, the convention on the Elimination of All Forms of Discrimination against Women was adopted by the General Assembly in 1979 and entered into force in 1981. Despite the existence of international instruments which affirm the rights of women within the framework of all human rights, a separate treaty was considered necessary to combat the continuing evident discrimination against women in all parts of the world. In addition to addressing the major issues, the Convention also identifies a number of specific areas where discrimination against women has been flagrant, specifically with regard to participation in public life, marriage, family life and sexual exploitation.

The objective of the Convention is to advance the status of women by utilizing a dual approach. It requires state parties to grant freedoms and rights to women on the same basis as men, no longer imposing on women the traditional restrictive roles. It calls upon state parties to remove social and cultural patterns, primarily through education, which perpetuate gender-role stereo-types in homes, schools and places of work. It is based on the premise that states must take active steps to promote the advancement of women as a means of ensuring the full enjoyment of human rights. It encourages state parties to make use of positive measures,

including preferential treatment, to advance the status of women and their ability to participate in decision-making in all spheres of national life- economic, social, cultural, civil and political. Article 17 of the Convention establishes the Committee on the Elimination of Discrimination against Women to oversee the implementation of its provisions.

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

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

Over years, the United Nations has developed universally applicable standards against torture which were ultimately embodied in international declarations and conventions. The adoption, on 10 December 1984 by the General Assembly, of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, was the culmination of the codification process to combat the practice of torture. The Convention entered into force on 26th June 1987 (United Nations, 2000). It should however be noted that despite the convention, torture, cruel and inhuman treatment is still being inflicted on women who are mutilated. This points to the fact that much as there could be laws, committing crime may still be explained by the social structure, norms, beliefs and values upheld by a given society. It is to this extent that the study opted to focus on Kapchorwa District where the practice of FGM has shrived for a test of time.

(v) Convention on the Rights of the Child

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

Among other provisions of the Convention, state parties agree that children's rights include: free and compulsory primary education; protection from economic exploitation, sexual abuse and protection from physical and mental harm and neglect; the right of disabled child to special treatment and education; protection of children affected by armed conflict; child prostitution; and child pornography. Under Article 43 of the Convention, the Committee on the Rights of the Child was established to monitor the implementation of the Convention by state parties (Centre for Reproductive Law and Policy, 1997). Despite this monitoring structure in place, children have continued to fall victims of physical and psychological torture as a result of FGM practice.

In implementing the instruments, as Rukooko (2001: 138) puts, states ought to set verifiable benchmarks for subsequent national and international monitoring. In this connection, states should consider the adoption of a framework law as a major instrument in the implementation of the strategies. Considering Uganda, one would say that the country has complied to the international instruments by putting human rights aspects in her constitution. The issue that remains unresolved is whether the necessary stakeholders were consulted during the structuring and compilation of the constitution. This would point and bring to light why there have been some resistance to do away with FGM even when the constitution so puts forward grounds as to why the practice should be stopped. This fact appears a great concern

that this study laboured to resolve with a focus put on human rights perceptive and particularly women's reproductive rights.

2.2.2 Laws in other countries (Outside Africa)

(i) United States

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

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

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

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

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

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

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

(iii) United Kingdom

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

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

(iv) Spain

Genital mutilation is considered a crime punishable with prison sentences ranging from 6 to 12 years. The Penal Code allows for a reduced sentence if the victim has consented free and spontaneously, but the consent of a minor is not considered valid (Coello, 1999).

Reflecting on the laws regarding FGM in the afore-listed countries, it can be observed that there is clarity over the nature of reprimand and due punishment in case one so circumcises or mutilates a female. What remains urgent to note here is that much as laws restrain one's acts, especially as regards what is legal and illegal, criminology cannot wholly be explained by the failure to observe the laws. There is, therefore, need to explicitly reflect on other factors such as culture, awareness levels and purported benefits in committing an act like FGM. It is this legally lacking element in the explaining the practice of FGM that this study was set to

find out. On top of recognizing the illegal component of FGM, the study equally approached the practice from a human rights perspective, with focus put on women's reproductive health.

2.2.3 Laws in African countries on FGM

(i) Djibouti

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

(ii) Ghana

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

(iii) Burkina Faso

Law outlawing FGM passed in October 1996. The Penal code articles enacted include Article 380: Whoever attempts or harms the physical integrity of the genital organ of a female, either by total ablation, excision, anesthetization or by other means, will be imprisoned for a period of three to six years and fined 150,000 to 900,000 francs or be ' subject to one of these penalties. If death ensues, the penalty will be imprisonment for a period of five to ten years. Article 381 states that penalties will be applied to the fullest extent of the law if the culprit belongs to the medical or paramedical field. The jurisdiction of judgment may forbid him to practice for a period of no longer than five years. Article 382 states that a person having knowledge of the acts aforementioned in article 380, and failing to advise the proper authorities, will be fined 50,000 to 100,000 franc.

(iv) Guinea

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

(v) Senegal

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

(vi) Egypt

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

(vii) Ivory Cost

Ivory Cost implemented the Law Concerning Crimes against Women in December in 1998, which is a local law that civilly and criminally punishes those who practice FGM (Wllerstein, 1999).

In view of the FGM provisions in African countries, there is a common observation that irrespective of the differences in the individual country's provisions, the practice of FGM is highly considered criminal as it constitutes to the violation of human rights. What remains an issue of great concern is the reason as to why the cases of FGM keep on being committed irrespective of the existing provisions. It is not clear whether the provisions are inherently weak or lack implementational strategies/law enforcement. It is this unclear scenario that this study intends to address, focusing on FGM and women's reproductive rights in Kapchorwa District as a case study.

2.2.4 Ugandan Constitutional provisions on FGM

Art 20 (1): Fundamental rights and freedoms of the individual are inherent and not granted by the state.

Art 20 (20): The rights and freedoms of the individual... enshrined in this chapter shall be respected, upheld and protected by all organs and agencies of government and by all persons. These two articles imply that if human rights are to be respected, upheld and protected, then women should not be mutilated since FGM violates their natural entitlements and is totally against the afore-listed clauses.

Equality and freedom from discrimination

Art 21 (1): All persons are equal before... the law in all spheres of... social and cultural life ... same rights as men, if men are not mutilated so shall not women be.

Art 21 (2): ... A person shall not be discriminated against on the ground of sex. Discrimination comes from the fact that only women are mutilated, and not men. This reflects a form of human rights violation that ought to be stopped if females are to fully enjoy their reproductive rights.

Protection of the right to life

Art 22(1): No person shall be deprived of life.

You are deprived of life if you do not live a full healthy life. FGM' leaves the victims with physical harm that deprives them from fully enjoying their

reproductive rights. Such a scenario reflects the fact that FGM violates this article as generated women may not live a full healthy life, especially as a result of post mutilation effects.

Protection of personal liberty

Art 23(1): No person shall be deprived of personal liberty. However, it should be noted that one is deprived of liberty, if he/she does not have a right to say no to the FGM practice. This is the common case in Kapchorwa District where women are forced to take part in the female circumcision ceremony as a cultural practice of initiating the youth into adulthood/motherhood.

Respect for human dignity and protection from inhuman treatment

Art 24: No person shall be subject to any form of torture, cruel, inhuman or degrading treatment. FGM is torture and cruel, inhuman and actually a degrading treatment.

Right to privacy of person, home and other property

Art 27(2): No person shall be subjected to interference with other property. Thus, to this effect, it can be argued that there should be no interference with the property of your own body. FGM does not recognize this, and thus, becomes a form of human rights violation.

Rights of women

Art 33(1): Women shall be accorded full and equal dignity of the person with men. Clearly women are not equal to men if FGM is performed on them.

Art 33(3): The state shall protect women and their rights...

The state should protect the woman's right to privacy of her own body and against torture.

Art 33(4): Women shall have the right to equal treatment with men...inc;lude equal opportunities in social activities, such as dating or enjoying sex.

Art 33(6): Laws, cultures, customs or traditions which are against the dignity, welfare or interest or women or which undermine their status are prohibited by this constitution. To put it clearly, FGM does all the aforementioned, regardless of being prohibited by the constitution.

Rights of children

Art 34 (3): No child shall be deprived by any person of... other social... benefit by reason of religious or other beliefs. If the girl is under 16 years, and FGM is performed, then she is deprived of her social benefits.

General limitation on fundamental and other human rights and freedoms

Art 43(1): No person shall prejudice the fundamental or other human rights and freedoms of others. No person has a right to perform FGM because a woman has a right not to be mutilated.

Art 43(2) (c): Public interest... .shall not permit any limitation of the enjoyment of the rights and freedoms prescribed by this chapter. Specifically, this chapter (especially the clause against torture) clearly supports the ban of FGM. Thus, even though the public interest is to continue the practice, it still should be banned.

In view of the stipulations within the Ugandan Constitutions, there would be no reason to practice FGM, even for the sake of observing the contents of the law of Uganda as a country. What insinuates controversy that ought to be resolved is the fact that the Sabiny females brave for the practice. Is it absolutely the cultural element that drives the Sabiny women into FGM exercises? Do they know that their rights are being violated by having their female organs mutilated? Much as culture has been pointed out by some studies, for example Kiirya and Kibombo (1999), it is apparently true that most of the human rights violations go without knowing that they constitute to human rights abuse. To this extent, therefore, a study on human rights concern, reflecting on FGM practice, proves a clear way on

empowering the Sabiny women to not only agitate for, but also protect and promote their natural entitlements.

2.3 Reasons for carrying out FGM practice

According to Pasquinelli (2003), it is not easy to reconstruct the origin of FGM given the variety of forms and the fact that the practice is spread widely throughout the African continent. There is no lack of hypotheses however. According to some excision dates back to ancient Egypt but also ancient Rome, where it was practiced on slaves and seems related to considerations of the female body as property. This was already a form of violation of human rights. Infibulations was also found in Rome, though performed originally only on males. A sort of pain, fibula, was applied to young men to keep them from having sexual relations. But the center of female Infibulation seems to have been the Egypt of the Pharaohs, as the name Pharaonic circumcision seems to suggest.

In Uganda, folktales indicate that FGM among the Sabiny in Kapchorwa is as old as the Kalenjin ancestry, a tribe from whom the Sabiny descended. Although the real origin of FGM is not well known by the present generation, Sabiny legends indicate that like their descendants (the Kalenjin), men used to move long distances to graze cattle and hunt (Kiirya and Kibombo, 1999). As a result, a number of them kept away from their homes, wives and children for a long period of time. Infidelity among married women and promiscuity among girls was high whenever men kept a way from home grazing cattle and hunting.

From the above, therefore, FGM was introduced as a measure against infidelity for married women and to initiate girls into womanhood. Girls were, therefore, not allowed to engage in coitus before circumcision. FGM gradually grew and later became an accepted way of life (norms) and associated with a range of cherished values. Presently, the Sabiny regard FGM as a sacred ritual sanctioned by ancestors, protected by cultural beliefs and used to initiate girls into adulthood.

Therefore, a number of adults and young people often associate with it irrespective of the associated health risks for purposes of identity and dignity (Kiirya, 1997). Values, norms, taboos and beliefs held among the Sabiny have been advanced as the major causes and enhancement of FGM. Values refer to the intangible benefits or satisfaction community derives from a practice while norms refer to the set of rules produced and reproduced and held by members of a community. Values are of a universal nature, immutable and represent ideas and high ethics societies follow or honor and comply with to ensure the overall good of the community. Norms are learned by both direct instruction (do as I say) and imitation (do as I do) and followed by society for purposes of dignity and identity (Farah, 1996).

In a study conducted by Kiirya and Kibombo (1999), it was observed that values and norms of the Sabiny culture are closely linked to FGM taboos. In promoting the cultural norms, society has therefore cast a sort of sacredness and developed taboos on FGM to maintain a stable power structure in the community, legitimize production of the values and limit opportunities for questioning the practice even as more knowledge is acquired.

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

2.4 The challenges faced in the implementation of human rights instruments to women's reproductive rights

2.4.1 Women's low social status

As Rahman (2003) puts, women's low status has greatly constrained the implementation of instruments and laws regarding women's reproductive health. Legislation targeting FC/FGM is likely to have little positive effect in a legal context in which women's rights are not recognized or are explicitly undermined. It ought to be noted that for effective implementation of the human rights instruments, governments must ensure that they have ratified the major human rights treaties guaranteeing women's rights, including the Convention on the Elimination of All Forms of Discrimination against women. This will help bring an national-level laws into conformity with the rights guaranteed in the treaties. Also, there is need for constant monitoring to ensure that governments are conforming to the required standards of effecting the stipulations that they ratified

Women's weak social standing reinforces their inability to reject FGM. In matters affecting individual rights, and customary practices, there has always been a tendency to uphold the customary practices. Because customary laws frequently govern such matters as marriage, and inheritance in Mrica, a government's refusal to enforce women's equality when customary law is at issue may result in a perpetuation of conditions that lead to women's insubordination.

2.4.2 Resistance at the community level

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

In Kapchorwa District where custom plays a vital role towards the FGM practice, it would be very critical to ensure that a broader government strategy which includes outreach and awareness-raising programmes aimed at individual behavior and social norms, is in place prior to any national level criminalization of the practice. Legislation that targets FGM may itself calls for such measures prior to enforcement of criminal sanctions. Government should be devoted to reach out to communities that practice FGM, especially by forming alliances with NGOs, local leaders and the health care professionals.

2.4.3 Influence of strong cultures and traditions

As the http://en.wikipedia.org/wikilFemale-Eenital_cutting (August, 2, 2008) highlights, the traditional cultural practice of FGC predates both Islam and Christianity. A Greek papyrus from 163 B.c. mentions girls in Egypt undergoing circumcision and it is widely accepted to have originated in Egypt and the Nile valley at the time of the Pharaohs. Evidence from mummies have shown both Type I and Type III FGC present. While the spread of the practice of FGC is unknown, the procedure is now practiced among Muslims, Christians, and Animists.

Although FGC is practiced within particular religious sub-cultures, it transcends religion as it is primarily a cultural practice. UNICEF stated that when "looking at religion independently, it is not possible to establish a general association with FGM status. The arguments used to justify FGC vary; they range ITom health-related to social benefits, reinforced by the cultural and traditional implications such as maintenance of cleanliness, good health, preservation of virginity, enhancement of fertility, prevention of promiscuity, increase of matrimonial opportunities, pursuance of aesthetics, improvement of male sexual performance and pleasure and promotion of social and political cohesion.

2.4.4 Vulnerability of minority groups

When FGM is common among one ethnic group or community and not the majority, enacting and applying a criminal law could fuel ethnic tensions (Rahman, 2003). In countries in which FGM is practiced primarily by a minority ethnic

group, criminal laws prohibiting FGM may be perceived as a pretext for harassing or persecuting members of that group. This may particularly be the case when criminal legislation is enacted in the absence of concerted governmental efforts to reach women and girls through outreach and empowerment programmes. Whereas the case of FGM in Kapchorwa is subsequently a concern of the minority, relative to the ethnic groups in Uganda that do not practice FGM, it would have been better for the government to take steps showing that the actions of eradicating the practice are not motivated by an interest in disrupting the lives of members of a minority group. This not been effectively done for the case of Uganda. There has been no recognized effort to take steps aimed at increasing consultations with minority organizations and enhancing appropriate outreach programmes, as well as allocating resources to community groups, particularly women's groups.

2.4.5 Weak enforcement mechanism

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

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

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

2.4.6 General denial of reproductive health care

Studies carried out on FGM show that the government has not put in place the recognition of a link between the practice of FGM and the need for reproductive health services for all women (Katzive, 2003; Kiirya and Kibombo, 1999; Centre for Reproductive Law and Policy, 1997). First, where such services are lacking, women have less information about their own reproductive health. Women who understand the harmful health consequences of FGM may be less likely to undergo the procedure or encourage their daughters to do so. Second, women who have already undergone FGM have the greatest need for medical attention, particularly during pregnancy, childbirth and the post-partum period. In countries like Togo, legislation prohibiting FGM has taken special note of the health needs and directs public and private health facilities to ensure that the most appropriate medical care to the victims of FGM arriving in their centers or establishment. Whereas this appears a noble approach, there is no legislation in Uganda that focuses on measures that ensure women's access to reproductive health care. In most of the rural health centers, there are insufficient trained personnel on top of lack of the necessary drugs.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

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

3.2 Research design

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

3.3 Population of the study

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

3.4 Sample selection methods and size

3.4.1 Selection of communities

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

3.4.2 Selection of respondents

From the six villages selected, fifteen females were selected for the study using systematic random sampling. The Local Council One Chairpersons for the selected six villages were purposively selected for the study. Six health workers from community health centers and private clinics were also purposively selected for the study. Two elders from each village were also purposively selected for the study. In all, 114 respondents were involved in the study. All the targeted number of respondents participated in the study.

3.5 Research instruments

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

3.5.1 Research-administered questionnaires

These were administered to the females aged over 14 years. Questionnaires were made up of both structured and un-structured questions. The structured questions aimed at generating quantitative data from multiple choices for each question, while the unstructured questions aimed at generating peoples' ideas and perceptions

about the practice of FGM. The study used a questionnaire because they help generate reliable data and helped generate quantitative data.

3.5.2 Interview guides

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

3.5.3 Focus group discussion guide

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

3.5.4 Written documents

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

3.6 Procedure

The researcher first got a letter of introduction from the Department of Philosophy, Makerere University, which he presented to the Local Council III chairpersons requesting for permission to carry out a study in their sub counties. With the assistance of the leaders, a sample frame was obtained. Appointments were made with the selected respondents to select their own convenient time to participate in the study exercise. The researcher administered the questionnaires himself The

interviews lasted for at least thirty minutes and during this time, the researcher kept on jotting down the major points.

3.7 Data analysis

3.7.1 Quantitative data analysis

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

3.7.2 Qualitative data analysis

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

3.8 Limitation to the study

The researcher encountered poor response rates from the respondents. Respondents complained of their tight schedules. To overcome this, the researcher made appointments suiting the respondents' ideal activities regarding when to be interviewed.

Respondents, especially the FGM victims were not willing to provide data. This was because they either considered such issues sacred or thought the researcher had other intentions. This was overcome by explaining the intention of the study as purely academic. The researcher also had to clearly identify himself using the Students' Identity Card and the Letter of Introduction.

3.9 Ethical considerations

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

CHAPTER FOUR

LEVELS OF AWARENESS AND ACHIEVEMENTS ON WOMEN'S REPRODUCTIVE RIGHTS

4.1 Introduction

This chapter presents the study findings related to the peoples' awareness and achievements with regard to the practical use of the relevant instruments to women's reproductive rights in Kapchorwa District. The socio-economic background of the respondents was incorporated in the presentation of findings to give the study a basis for interpreting the findings (section 4.2). Subsequently, presentation on the levels of awareness and practical application of the relevant human rights instruments begins with section 4.3

4.2 Respondents' socio-economic background

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

4.2.1 Age of respondents

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

Table I: Respondents' age distribution

Item	Frequency	Percentage
Females from the Sabiny Community (n=90)		
- Below 20 years	06	6.7
- 21 – 25 years	23	25.6
- 26-30 years	39	43.3
- 31 and above	22	24.4
Total	**90**	**100**
Local Council I Chairpersons (n=6)		
- Below 20 years	00	00
- 21 – 25 years	00	00
- 26-30 years	02	33.3
- 31 and above	04	66.7
Total	**6**	**100**
Health workers (n=6)		
. – Below 20 years	00	00
- 21 – 25 years	01	16.7
- 26-30 years	02	33.3
- 31 and above	03	50
Total	**6**	**100**

It can be seen from table I that the majority of the respondents among the targeted female respondents (43.3%) were within the age bracket of 26-30 years, while the least (6.7%) were below 20 years. For the case of Local Council I Chairpersons, 66.7% were within the age bracket of 31 and above years while 33.3% were within 2630 age bracket. Concerning the health workers, 50% were within the age bracket of30 and above years, 33.3% fell under the age bracket of 26-30 years while 16.7%

were between 21-25 years. For the case of the elders, all of them were above 30 years.

Thus, with respect to the respondents' age, the respondents' composition was reliable as all of them had either taken part (for the case of females), had witnessed or seen some one who had underwent the FGM practice, as well as handling case related to FGM practice. As the http://dusteye.wordpress.com/tag/education(Aug, 4, 2008) highlights, this, generally agrees with the observation made by Kulany, that it is mere luck for someone to escape the uncircumcised as all Sabiny girls, upon attaining puberty, are initiated into womanhood through circumcision. Those who refuse are tormented as their in-laws despise them because they are not circumcised.

4.2.2 Sex of respondents

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

On the other hand, it should be noted that the pre-dominance of females in view of the total sample composition, especially with regard to females for the survey questionnaire, was somewhat predetermined to target the female victims of FGM. Otherwise, the proportionately selection of elders on a gender-balanced component was aimed at attracting views from both sexes on the traditions explaining the long time held belief and the benefits attached thereof that has survived a test of time among the Sabiny communities.

4.2.3 Respondents' level of education

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

Table II: Respondents' level of education

Item	**Frequency**	**Percentage**
Female respondents (n=90)		
- Post-graduate	00	00
- Graduate level	04	4.4
- Diploma level	10	11.1
- Secondary level	12	13.3
- Primary level	28	31.1
- No formal education	36	40
Total	**90**	**100**
Local council 1 Chairpersons (n=6)		
- Post-graduate	00	00
- Graduate level	00	00
- Diploma level	03	50
- Secondary level	03	50
- Primary level	00	00
- No formal education	00	00
Total	**06**	**100**
Health workers (n=6)		
- Post-graduate	00	00
- Graduate level	00	00
- Diploma level	06	100
- Secondary level	00	00
- Primary level	00	00
- No formal education	00	00
Total	**06**	**100**
Elders (n=12)		
- Graduate level	00	00
- Diploma level	12	16.7
- Secondary level	01	8.33
- Primary level	05	41.7
- No formal education	04	33.3
Total	12	100

It can be observed from table II that although the majority (40%) of the selective female respondents had not attained any level of formal education, there were some levels of education attained thereof For instance, 31.1% had attained primary level,

13.3% secondary level, 11.1% diploma level while 4.4% were graduates. For the case of the Local Council I Chairpersons, 50% had attained formal education to the diploma level and another 50% had attained secondary school level.

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

4.2.4 Respondents' religion

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

Figure II: Respondents' religious faith (n=114)

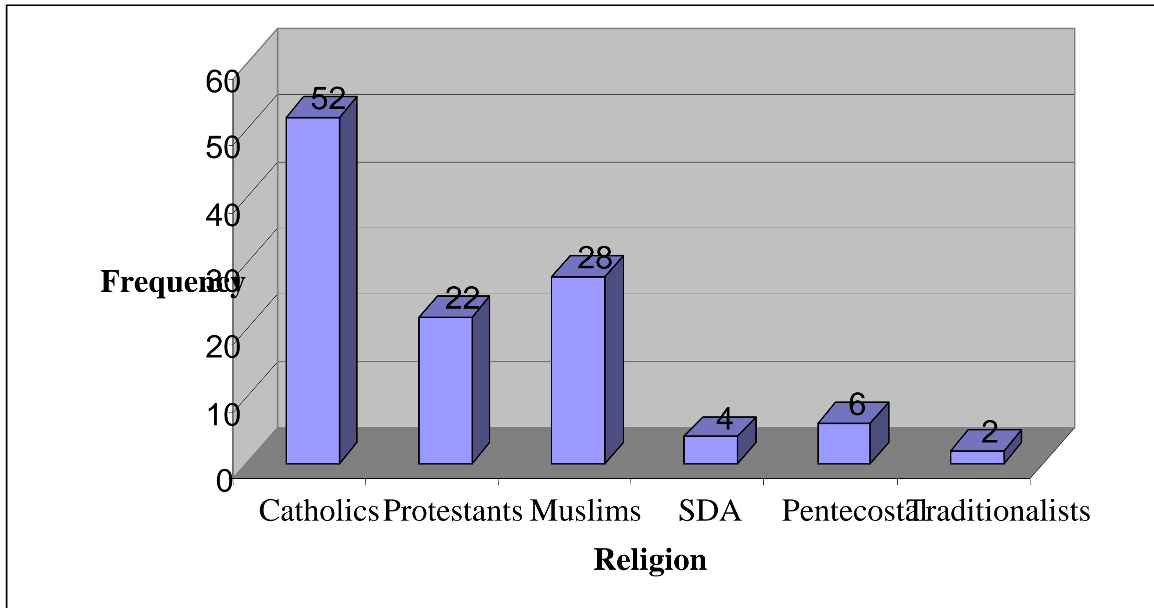


Figure II shows that the majority of the respondents (52/45.6%) were Catholics, followed by the Muslims (28/24.6%), Protestants (22/19.3%), Pentecostal (6/5.3%), Seventh Day Adventists (4/3.5%). The least were the traditionalists (2/1. 7%). It can be observed from figure II that there was a fair representation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

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

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

4.3 The relevant human rights instruments to women's reproductive rights

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

4.3.1 Awareness about women's rights

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

Table III: Responses to knowledge about human rights

Item	Frequency	Percentage
Female respondents (n=90)		
- Yes	51	56.7
- No	39	43.3
Total	**90**	**100**
Local Council I Chairpersons (n=6)		
- Yes	6	100
- No	00	00
Total	06	100
Health workers (n=6)		
- Yes	6	100
- No	00	00
Total	**06**	**100**
Elders (n=12)		
- Yes	5	41.7
- No	7	58.3
Total	**12**	**100**

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

For those who were aware, still had different levels that varied from one form of human rights to another. This can be seen from table IV below.

Table IV: Commonly known rights that women are entitled to

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

It is evident from table IV that among the 56.7% of the females who were aware of human rights, the majority 86.3% pointed out the right to enjoy freedom of thought, conscience and religion, while 70.6% mentioned the right to education. For the case of the local leaders and health workers, all of them were certain of the right to education and health living. A look at the elders, majority (60%) were certain of the right to education. None of the elders considered freedom from torture and degrading treatment as a form of human rights violation. Issues mentioned under the category of others included the right to marry, own property and live a recognized life.

4.3.2 Awareness of international and national instruments safeguards and promote human rights

There was a general linkage between the levels of awareness about human entitlements and the instruments stipulating the need to safeguard and promote the

fundamental human rights. Apart from the Local Council Leaders and health workers who were aware of some of the Ugandan Constitutional stipulations, knowledge concerning the international instruments was lacking. This pointed to the need for enhanced campaigns to improve the communities' awareness, especially through information communication and providing the community members with materials that can popularize access and utilization of national and international instruments and laws that relate to human rights.

Although there were linkages between the occupied social positions and level of awareness (as all the local council leaders and health workers were aware of the fundamental human rights), there was no linkage between one' s level of education and knowledge concerning human rights and latter women's reproductive rights. This was manifested by the fact that some of the females, who had attained some education above the primary level, did not know anything while some of those who had not attained any formal education were certain of some human rights. This coincides with Gruenbaum's (2001) observation that issues regarding cultural practices seem to be persisting even in instances when there are higher levels of education. As a matter of fact, one of the respondents had this to say;

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

The above led the study to a realization that though the social positioning my favour the realization of human rights, acquiring formal education per-se, may not have a significant impact on the cultural practices. Education needs to be enhanced by power and authority, a position that can be reinforced by the support of those in positions of authority and the law.

4.3.3 FGM and women's reproductive rights

Respondents were also requested to state whether they were aware that FGM was a form of women's reproductive rights violation. This greatly related to the levels of awareness about the general concept of human rights and levels of education. 56.7% of the females were certain that FGM was a form of women's reproductive rights violation. All the local leaders and health workers were certain that FGM was a form of women's reproductive rights violation.

However, a look at the results in table IV shows that though some respondents were certain of issues like right to a health living and freedom from torture and degrading treatment as some of the human rights, they did not consider FGM as a form of women's reproductive rights violation. This reflected how the practice has gone so native into the lives of the Sabiny that its performance is in no way considered a form of human rights violation. There was a great disposition of culture over human rights. As responses from the elders so emphasized, FGM was a practice that reinforces kinship relations, and females' social transformation from childhood to adulthood.

The above point agrees with the Centre for Reproductive Law and Policy (1997) irrespective of the existing laws and instruments on reproductive health rights, the practice of FGM has persisted for a long time due to low levels of awareness within the targeted communities. The communities resist adopting and implementing the reproductive laws due to the held belief that the practice is part of their lives.

The low levels of awareness also pose a somewhat question to the http://dusteye.wordpress.com/tag/educationJ (August, 4, 2008) report that, interests curtailing the practice of FGM has increased in the past 10 years. This argument was largely based on the example, of awareness that on 30 April 2007, women's rights activists in Uganda petitioned the Constitutional Court demanding that FGM, practiced by several communities in the east of the country be declared illegal. This, therefore, points to the fact that irrespective of the activists' campaigns

against FGM, the rural communities have not yet got the message regarding FGM as a form of human rights violation. However, this points out something to appreciate about the work done by civil society organizations in addressing the issue of FGM. The mass media, especially the print media, has also taken greater steps in trying to depict the dangerous aspect of FGM through publications. For example, the news paper articles, (refer to the list of news papers cited in the Bibliography) clearly stress significant aspects pertaining FGM, especially in Kapchorwa District.

In view of the findings on this hypothesis, it can be put that much as there are international and national laws that stipulate safeguarding and promotion of human rights, there is a substantial number of people in Kapchorwa District that do not know anything about human rights and latter women's reproductive rights. A good number of respondents do not know that FGM is a form of human rights violation. It is substantially out of such a scenario that FGM has survived a test of time and attracts majority support from the community members.

The afore-listed, therefore, agrees with the stated hypothesis (There are no practical relevant instruments stipulating the protection and promotion of women's reproductive rights in Kapchorwa District). The vital issue to consider here is much as there could be international and national laws; they have not been put into effective implementation to eradicate the practice of FGM in Kapchorwa District.

CHAPTER FIVE

THE STATUS AND REASONS FOR CARRYING OUT FGM

5.1 Introduction

This study variable was guided by the hypothesis which stated that **"There are no clear reasons for carrying out Female Genital Mutilation in Kapchorwa District"** The generated responses were presented under the following sub themes: Circumcision status for the female respondents, age at which women were circumcised, type of circumcision commonly used, voluntarism in taking part, state on the instruments used, reasons for carrying out FGM, social status of the uncircumcised women, benefits accruing from the FGM practice and the dangers associated with the practice of FGM.

5.2 Circumcision status for the female respondents

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

There were variations about the age at which the respondents were circumcised. The generated responses were presented in table V.

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

Item	Frequency	Percentage
Below 14 years	2	2.2
14-24 years	87	96.7
Any other	1	1.1
Total	**90**	**100**

The table shows that though majority (96.7%) revealed that they had been circumcised between 14-24 years, some were circumcised as early as below fourteen (2.2%) while (1.1 %) pointed out that they were circumcised after their first birth. This coincides with the observation made by Kirya and Kibombo (1999) that women were circumcised at different ages, some as early as 14 years to avoid the prevalence of women who, after joining high schools and in most cases boarding schools refuse to be circumcised. For those who may escape early circumcision, may be still targeted to the age of even 20 years and above.

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

5.3 Type of circumcision commonly used

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

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

Table VI: Responses to the type of circumcision used

Item	**Frequency**	**Percentage**
Type I	59	65.6
Type II	31	34.4
Type III		00
Type IV		00
Total		**100**

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

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

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

Table VII: Type prevalence of FGM per country

Country	Prevalence (100%)	Type
Burkina Faso	71.6%,	II
Central African Republic	43.4%	I and II
Cote d'Ivoire	44.5%	II
Djibouti	90-98%	II
Egypt	78-97%	1, II and III
Eritrea	90-95%	I, II and III
Ghana	9-15%	I, ll and III
Guinea	98.6%	I, II and III
Indonesia	No figures	I and IV
Nigeria	25.1%	I, II and III
Senegal	5-20%	II and III
Sudan	91%	I,ll and III
Tanzania	]7.6%	II and III
Togo	12%	II
Uganda	5%	I and II

Adopted from: http://en.wikipedia.orglwiki/FemaleJ5enita'-cutting (August 2,2008),

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

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

5.4 State of the instruments used

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

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

5.5 Voluntarism in taking part

Regarding the element of voluntarism, the study tried to find out whether the Sabiny women were voluntarily taking part in the FGM operations. The results were presented in Figure III.

Figure Ill: Responses to whether females voluntarily take part in the FGM operations

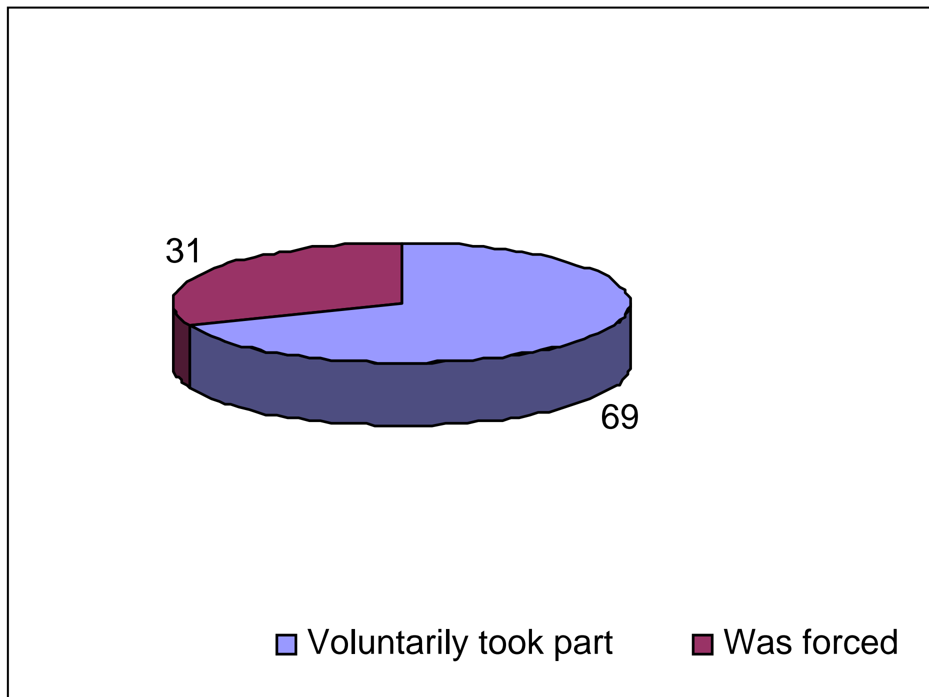


Figure III shows that majority of the female respondents (69%) voluntarily took part in the FGM operation while 31 % never wanted to be circumcised, but were rather forced. Those who voluntarily took part in the operations pointed out that they were motivated by the brevity, social beliefs and practices as a requirement for social transformation and initiation into womanhood. However, for those who were forced, there were gross lamentations over what transpired. This can be manifested in what one respondent from Kaptanya Sub-county forwarded during a focus group discussion guide:

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

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

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

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

5.6 Reasons for carrying out FGM and the benefits thereof

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

(i) The practice guarantees virginity and promotes morality. There is a common belief that when a woman is circumcised, she loses some of the urge for sex. Ironically, the urge is never revitalized when a circumcised women finally marries. Instead, she completely loses her sexual desires, something that results into a form of social incompleteness. The need for morality leads to unhappiness in due turn.

(ii) That uncircumcised girls are rude and disrespectful. However, there is no clear proof linking circumcision to being respectful and being well behaved.

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

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

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

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

(vii) That men cannot marry uncircumcised girls. As the findings by PATH (2006) indicate, this is also a myth for testimonies from men indicate that mutilated women are tights and hard for men to penetrate. This makes sex painful for both the man and woman. Men were, therefore, not supportive of the practice, irrespective of its traditional roots.

Responses generated pointed out that there were commonly upheld benefits out of FGM practice. There was a general agreement that that:

(i) FGM is a ritual that marks change of a girl into a woman. Having a FGM ceremony, therefore, shows the community that a girl is now prepared for her life as a woman. Equally so, the family can show that they have educated their daughter in how to be a good wife and mother.

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

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

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

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

(vi) Everyone enjoys the food, singing, dancing, and the general celebrations that go with FGM.

Overall, it should be noted that much as the community members may enjoy a lot of benefits out of a FGM ceremony, such benefits should never override the essence of one's human rights. The individual benefits should never be attained at expense of one's rights for the rights are inherently and naturally attained, and should never be violated.

5.7 Social status of the uncircumcised women

The social status of uncircumcised women is more of a curse and a misfit in society. The responses from interviews with the elders and focus group discussion revealed that uncircumcised women cannot get married as she is believed to be immoral, dirty and will lack the ultimate preparedness to become a mother in a family. This is a belief that girls are initiated into womanhood through the circumcision ceremonies.

5.8 The dangers associated with the practice of FGM

Respondents were requested to state whether they had witnessed cases of ill-health as a result of the FGM practice. Responses from the 90 females on this aspect were presented in table VIII.

Table VIII: Responses to dangers associated with FGM (n=90)

Item	**Frequency**	**Percentage**
There are dangers associated with FGM	68	75.6
There are no dangers associated with FGM	18	20
Do not know	04	4.4
Total	**90**	**100**

Table VIII shows that majority of the targeted female respondents (75.6%) acknowledged that there were dangers associated with the practice of FGM while only 20% had a negative position over the presence of ill-health as a result of female circumcision. The other 4.4% did not know. They could have never had any problem or had never manifested a case related to ill-health as a result of being operated during the FGM practice.

After establishing that there were health problems associated with FGM, the study embarked on finding out the nature of the dangers thereof This can be seen in table IX.

Table IX: Responses to the dangers associated with FGM (n=68)

Item	Frequency	Percentage
Pain during and after operation	68	100
Excessive bleeding	43	63.2
Difficulty in child birth	34	50
Spread of diseases	18	26.5
Scaring	29	42.6
Death	19	27.9
Painful sexual intercourse	50	73.5
Others	10	14.7

Table IX shows that all the females (100%) who pointed out that there were dangers associated with FGM further pointed out that they experienced pain during and after the operation. Another 73.5% pointed out painful sexual intercourse as a result of loss of frigidity, 63.2% pointed out excessive bleeding, followed by difficulty in child birth due to the narrowing and stitching of the vaginal canal. This agrees with Mugisha's (2006) article that circumcised women get problems during delivery because the scar left after circumcision tears. There were also cases of death (27.9%). These were witnessed cases among the community members as a result of the FGM operation, especially in cases of excessive bleeding that is not urgently attended to.

Other related complications include cases of paralysis as Emasu (2005) observed. Emasu observed that three circumcised women got both of their legs paralysed and developed vesco-vaginal fistula. Looking at the responses in table VI, it can be noted that the FGM practice adversely violates women's reproductive rights.

The responses from the health workers agreed in principle that mutilated women usually face hardships during child birth. One health worker had this to put across:

> The FGM practice has increased the risk of delivery failures in this health center due to narrow vaginal narrowing. It is generally hard for such women to afford a normal delivery.

The above coincides with earlier studies, especially the one done by World Health (I 993). It was observed that the practice of FGM had increased the risk of maternal and child morbidity and mortality due to obstructed labour. It was observed that women who have undergone FGM were twice as likely to give birth to stillborn children than other women. Obstructed labour can also cause brain damage to infants and complications to the mother, especially fistula formation-an abnormal opening between the vagina and the rectum.

More so, the practice of using one instrument over one victims exposes women to contracting HIV/AIDS. A similar observation was made by Etengu (2005) that some of the women are badly cut and left with large holes while others are cut using the same knife, thereby leaving them open to HIV / AIDS infection.

http://en.wikipedia.orglwiki/Female--Eenital_cutting (August, 2, 2008) highlights that prohibition has led to FGC going underground, at times with people who have had no medical training performing the cutting without anesthetic, sterilization or the use of proper medical instruments. However, even without prohibition, it should be noted that the procedure, when performed without any anesthetic, can lead to death through shock from immense pain or excessive bleeding. The failure to use sterile medical instruments may lead to infections. Other serious long term health effects are also common. These include urinary and reproductive tract infections, caused by obstructed flow of urine and menstrual blood, various forms of scarring and infertility. The first time having sexual intercourse will often be extremely painful, and infibulated women will need the labia major a to be opened, to allow their husband access to the vagina. This second cut, sometimes performed by the husband with a knife, can cause other complications to arise.

A June 2006 study by the WHO has cast doubt on the safety of genital cutting of any kind. This study was conducted on a cohort of 28,393 women attending delivery wards at 28 obstetric centers in areas of Burkina Faso, Ghana, Nigeria, Kenya, Senegal and the Sudan. A high proportion of these mothers had undergone

FGC. According to the WHO criteria, all types of FGC were found to pose an increased risk of death to the baby (15% for Type I, 32% for Type II, and 55% for Type III). Mothers with FGC Type III were also found to be 30% more at risk for cesarean section and had a 70% increase in postpartum hemorrhage compared to women without FGC. Estimating from these results, and doing a rough population estimate of mothers in Africa with FGC, an additional 10 to 20 per thousand babies in Africa die during delivery as a result of the mothers having undergone genital cutting.

Conclusively, in view of the findings on this variable, it can be put that there are traditionally held beliefs about FGM practice. These beliefs shape and are in turn reinforced by the benefits associated with the FGM practice. Irrespective of whatever transpires, method or instruments used, the Sabiny community members have their inherent values attached to FGM. To this extent, therefore, to the Sabiny communities, the earlier stated null hypothesis that there are no clear reasons for carrying out Female Genital Mutilation in Kapchorwa District could have been rejected. On the whole however, the whole practice contravenes the stipulations in the national and international instruments regarding the promotion and protection of women's reproductive rights.

CHAPTER SIX

CHALLENGES OF IMPLEMENTATION OF HUMAN RIGHTS INSTRUMENTS TO WOMEN'S REPRODUCTIVE RIGHTS

6.1 Introduction

This chapter presents responses reflecting the challenges that constrain the implementation of human rights instruments to women's reproductive rights. The chapter was guided by the hypothesis which stated that "**The implementation of human rights instruments has had no significant challenges in safeguarding and promoting women's reproductive rights in Kapchorwa District".** The elicited responses were presented under the following sub-themes: women's social status, social support for the eradication of FGM practice, lack of universality of the law, the sacred nature and sacredness of the practice, lack of practical support, specific challenges and possible solutions to the challenges constraining efforts to eliminate FGM practice. A summative remark/conclusion was also made depending on the findings presented.

6.2 Women's social status

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

Figure IV: Responses to women's social status (n=90)

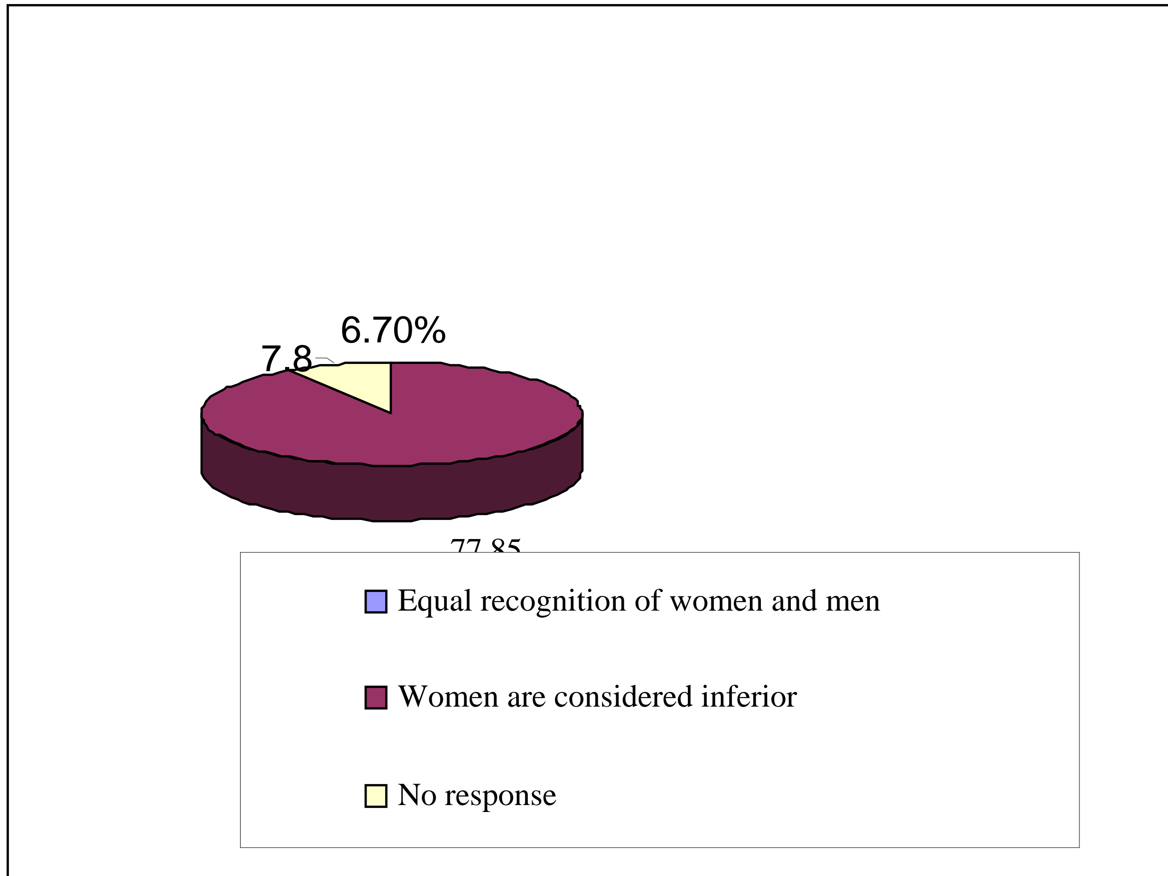


Figure IV shows that an overwhelming majority of the female respondents (85%) revealed that women were not considered equal to men while only 7% revealed that women and men were considered equal in the Sabiny community. This could have been out of the traditional beliefs held that put men in a higher social position than their female counterparts. There was relationship between females' levels of education, the social position and beliefs held thereof It was observed here that in instances of upheld exploitative cultural beliefs, women become native to the social expectations and they seize to consider the practice as exploitative. In such cases, implementing a human rights instrument becomes quite hard for it will not attract support even from women it is protecting. This coincides with Katzive's (2003)

observation that legislation targeting FGM is likely to have little positive effect in a legal context in which women's rights are not wholly recognized or are explicitly undermined due to traditionally upheld practices.

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

http://en. wikipedia.org/wiki/Female_ genital_ cutting (August, 2, 2008) highlights that the Mossi of Burkina Faso and the Ibos of Nigeria believe that babies die if they touch the clitoris during birth. In some areas of Africa, there exists the belief that a newborn child has elements of both sexes. In the male body the foreskin of the penis is considered to be the female element. In the female body the clitoris is considered to be the male element. Hence when the adolescent is reaching puberty, these elements are removed to make the indication of sex clearer.

In years past, doctors advocating or performing these procedures sometimes claimed that girls of all ages would otherwise engage in excessive masturbation and be "polluted" by the activity, which was referred to as "self-abuse". McDonald wrote in a 1958 paper titled "Circumcision of the Female", thus "If the male needs circumcision for cleanliness and hygiene, why not the female? I have operated on perhaps 40 patients who needed this attention." The author describes symptoms as "irritation, scratching, irritability, masturbation, frequency and urgency," and in adults, smegmaliths causing dyspareunia and frigidity. The author then reported that a two year old was no longer masturbating so frequently after the procedure. Of adult women, the author stated that "for the first time in their lives, sex ambitions became normally satisfied. However, justification of the procedure on hygienic grounds, or to reduce masturbation, has since declined. The view that

masturbation is a cause of mental and physical illness has dissipated since the mid-20th century. Thus, if one is to take up this explanation for mutilating women, the practice would be over 100 years gone. The fact that FGM still exists, points to the fact that the gender-based prepositions still hold some value among the communities that practice FGM

6.3 Social support for the eradication of FGM practice

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

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

http://en.wikipedia.org/wiki/Female~enital_cutting (August, 2, 2008) highlights that there are websites promoting the practice like Circlist, BMEzine (Body Modification E-Zine), and the Clitoral Hood Removal Information Page contain

testimonials and citations of medical studies, which support this claim (for example a study done in 1959 Rathmann et al claim that 87.5% of women saw an improvement in sexual pleasure following a hoodectomy. Such elements have justified the need to continue the practice as such revelations so ascertain that the practice is never harmful.

6.4 Lack of universality of the law

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

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

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

It goes ahead to state that a surgical operation is not a violation of this section if the operation is necessary for the health of the person on whom it is performed. As a matter of fact, the Sabiny argue that they carry out FGM for health reasons such as avoiding bad smell. Thus, upholding the United State's standards may be used to form a firm ground for practicing FGM among the Sanbinys. The New Vision, Friday, March 10th 2006 portrayed that the Sabiny want law on FGM. This would help prosecute the promoters of the practice, thereby substantially reducing on the

levels of the whole practice of FGM. However, this urgently needs significant awareness campaigns such that the interventions are not resisted, especially by the traditionalists who greatly value the practice.

6.5 The sacred nature and sacredness of the practice

Females were requested to state whether how issues regarding FGM operations were handled. All the generated responses revealed that the practice is considered sacred and not open to non-community members. This sacred nature has rendered all efforts regarding the elimination of FGM difficult. This has been out of the fact that community members cannot willingly reveal much about their sacred practice.

Response from the interview with the health workers revealed that their clients usually don't agree that FGM can cause certain illnesses, pointing out that the practice is holly and has been upheld for a test of time. One health worker revealed that majority of the women are diagnosed with painful/blocked menses and recurrent urinary tract infections, but could only link such issues to misfortunes and witchcraft other than FGM practice.

The issue regarding the sacredness of the practice have been widely documented. For example, as Castledine (2008) puts, the U.N. agency and the United Nations Children's Fund (UNICEF) reports that FGM has persisted for a long time because of its sacredness. Normally performed by traditional practitioners, law enforcers may not be tipped on when, where and how the practice has to be operated. This could have been the reason as to why there has been no documented arrests regarding the violation of women's rights by falling victims of mutilation. .

6.6 Lack of practical support

Regarding special attention to mutilated women, majority of the female respondents (70%) revealed that they were not accorded any special treatment in the hospitals and health centers. However, responses elicited from interviews with

the health workers revealed that there are provisions to offer mutilated women special attention in health centers, but the patients do not want to know that they are differently treated. This pointed to the fact that there is need for a formalized structure of concern that should be clearly communicated to all the stakeholders. On the whole, however, the health workers were clear on the fact that access to materials regarding the dangers of FGM is still limited to a few urban and semi-urban places, leaving the rural areas in complete neglect. This idea agrees with Centre for Reproductive Law and Policy (1997) which observed that the government has not put in place the recognition of a link between the practice of FGM and the need for reproductive health services for all women.

Some countries which have prohibited FGC still experience the practice in secrecy. In many cases, the enforcement of this prohibition is a low priority for governments. Other countries have tried to educate practitioners in order to make it easier and safer, instead of outlawing the practice entirely. However, with pressure from the WHO and other groups, laws are being passed in regards to FGC. On June 28, 2007 Egypt banned female genital cutting after the death of 12-year old Badour Shaker during a genital circumcision. The Guardian of Britain reported that her death "sparked widespread condemnation" of the practice. However, Britain has had its own problem confronting cases of FGC, as immigrants from Africa have been known to send their daughters to their home nations to undergo the procedure before returning to Britain.

6.7 Failure to understand the economics of FGM and Women's reproductive rights

As Castledine (2008) observes, there are several economic factors that contribute to the cultural importance of FGM. One of these factors is the ritual that surrounds the practice. Often this ritual involves gifts given to the girls in a ceremony that also honors their families. More importantly, though, is the fact that is much easier for the parents of a circumcised daughter to find a mate for their child, than it is for the parents of an uncircumcised daughter. Being able to "marry off' daughters is an

important economic consideration in some of the poorer countries that practice FGM.

Another important economic consideration is that for those who perform FGM, nearly al1 women, there are few equally lucrative options for supporting themselves. These women gain both financial support and a place of honor in their communities for performing this rite. Thus, there is substantive need to effectively understand the economic benefits, which, as Hoffman (2002) observes, is a significant factor in enhancing and supporting the practice of FGM. It should be noted that a cultural practice that has no ultimate benefit may not survive a test of time. Cultural practices, in most of the times, are a source of survival strategy, either in financial reinforcements or kinship relations.

6.8 Possible solutions to the challenges constraining efforts to eliminate FGM practice

After finding out that there were challenges affecting the implementation of instruments protecting and safeguarding women's reproductive rights, the study embarked on establishing the possible ways of overcoming the challenges. Respondents were requested to state what they thought would help implement the instruments that can help safeguard women's reproductive rights. There was a general agreement that:

(i) The government should aggressively increase the levels of public awareness about the need to eradicate the practice of FGM. This would need beginning from the grass root communities and involving the majority community members into programmes that may help eradicate the FGM practice. However, this should be calculatively done. The attempt should not be an overnight's outcome but should be progressively instituted to compromise the attributes of culture and the prerequisites of safeguarding inherent human rights.

(ii) Train local cadres that can pioneer the cause of eradicating FGM practice. In order to argue against FGM at the local level, there is need to be tactful and use the local and their own life experiences and frames of reference. For example, as

Melron Nicol Wilson (2000), in a FGM study in Sierra Leone, had this to put across;

> I would never approach circumcised women using terminology that referred to them as genitally mutilated. Although "female circumcision" misleadingly equates the practice with male circumcision. it focuses on the intent rather than the consequence and is respectful to the people practicing it.

Thus, with concepts that are familiar and understandable, and grounded in the idea of a precedent set by God, government, law, or man, or that which is just or fair, one can contest the credibility of female circumcision as a practice.

More so, the approach and the continuation of intervention should be technically organized. Reflecting on the possible questions related to FGM, one's position is more forceful when uncircumcised women, are present to prove to people that they have married well, remained faithful, and have husbands who have found pleasure in them and are unashamed of them.

We may not be able to convince our audiences to stop circumcision with our first conversation, but at least they begin to realize certain contradictions, and they start to rethink the "facts" as they understood them. Thus, one should recognize that it is a slow process of change, but arguments supporting FGM can be dismantled with persistent questioning. Human rights declarations, treaties, and languages aside, an appeal informed by an understanding of human rights but which draws upon local cultural and religious notions of common sense, justice, and dignity is often the best way to promote human rights and change the cultural norms that violate them (human rights) .

(iii) Development and formulation of women organizations at the grassroots that can spearhead the cause of implementing policies that promote and safeguard women's reproductive rights. This should however first aim at increasing the levels of awareness to ensure that the organizational members clearly understand why they have to join such organizations. It is the awareness levels that promote a sense of devotedness and being ready to design a framework of addressing the organizational concerns.

(iv) Enhanced collaboration and partnership between the Community Based Organizations, Local and International Non-Governmental Organizations in lobbying and advocating for the necessary resources to aid and facilitate the process of eradicating the practice of FGM.

(iv) Creating a structure in which the women can get disentangled from the traditional beliefs of enslaving women under the violating traditional practices. The structure should facilitate the monitoring process to ensure that women's rights are safeguarded. Otherwise, mere creation of structures without a follow up may not significantly help eradicate the practice of FGM. Local structures of power and authority, such as community leaders, religious leaders, circumcisers, and even some medical personnel can contribute to towards a total eradication of the practice.

Overall, there is need to recognize that one of the biggest barriers to the eradication of FGM is the perception, among those who practice this rite, that Western opposition to the practice is an example of cultural imperialism. This argument is bolstered by the fact that FGM was once performed in the West. In the past, feminists and human rights activists have also created resentment by not respecting the social and religious implications of FGM. One Somali woman states,

> "If Somali women change, it will be a change done by us, among us. When they order us to stop, ten us what we must do, it is offensive to the black person or the Muslim person who believes in circumcision. To advise is good, but not to order."

Thus, a serious problem faced by activists, is how to keep opposition to FGM from being viewed as part of "the current Western onslaught on Islam.

Education programs that are sensitive to the cultural and religious importance of FGM seem to be the best hope of eradicating the practice. Education can, however, be a long process, as evidenced by the UN plan "to bring about a major decline in female genital mutilation in 10 years and completely eliminate this practice within three generations." In Ethiopia, the Ministry of Education has used radio broadcasts

to warn about the dangers of FGM. The broadcasts are sponsored by the National Committee on Traditional Practices in Ethiopia, a committee that includes UN agencies. These actions, along with a government ban on FGM, have had "encouraging" results. The UN has also helped fund programs in Sudan where Dr. Amna Abdel Rahman has been working through the Sudan National Committee on Harmful Traditional Practices (SNCTP) to eradicate FGM. Although the programs in both Ethiopia and Sudan are backed, in part, by UN agencies, they are administered by committees headed by citizens of these countries. This is an important consideration in dealing with the justifiable concerns about Western interference and cultural imperialism.

Not all governments, however, have welcomed efforts to eradicate FGM. The West African nation of Gambia has prohibited any programming that opposes FGM from being broadcast on state-owned radio and television stations, and has even called for the use of radio and television to promote FGM. The reaction of the Gambian government toward educational efforts to end FGM helps to illustrate the difficulty faced by those trying to eradicate the practice. As the Director-General of WHO has stated, we have to realize that female genital mutilation is a deeply-rooted traditional practice. As such, it can only be abolished completely when attitudes have been changed." As this statement suggests, change can only be made by the countries involved, and not by well intentioned Western forces.

In view of the study findings on this variable, it can be observed that the implementation of women's reproductive rights face some significant challenges with regard to the practice of FGM (eliminating the practice). However, with designing clear policy guidelines and interventions, such challenges can be overcome. The outright solution lies in the recognizing that there is need to reflect on the human rights instruments and recognize that women are naturally entitled to their natural entitlements by the virtue of being human beings

CHAPTER SEVEN

TOW ARDS A HUMAN RIGHTS-BASED APPROACH TO REPRODUCTIVE HEALTH

7.1 Introduction

This chapter describes a human rights-based approach to FGM programming and aims to provide guidance to programmers to bring about a large-scale abandonment of FGM in sub-Saharan Mrica, and Kapchorwa District-Uganda in particular. This rights-based strategy analyses the practice of FGM from the perspective of different types of social programming that is intended to bring about lasting social change. The chapter highlights the need for a rights-based approach to reproductive health, human rights in the modern era and the fundamental principles thereof, Cultural Relativism versus Human Rights concerns, Understanding the economics of FGM and Women's reproductive rights and the framework for addressing FGM in a human-rights based perspective.

7.2 The need for a rights-based approach to reproductive health

Human rights and reproductive health advocates are increasingly working together to advance women's and men's well-being. The modern human rights system is based on a series of legally binding international treaties that make use of principles of ethics and social justice, many of which are directly relevant to reproductive health care.

By placing reproductive health in a broader context, a rights-based approach can provide tools to analyse the root causes of health problems and inequities in service delivery. By emphasizing fundamental values, most notably respect for clients and their reproductive decisions, a rights-based approach can shape humane and effective reproductive health programmes and policies. By taking advantage of the international human rights treaty system, a rights-based approach can challenge the

status quo and Pressure governments into working proactively for reproductive health.

7.3 Reproductive rights in the modern era

The concept of reproductive rights is rooted in the modem human rights systems developed under the auspices of the United Nations (UN). Since 1945, the UN has created internationally recognized standards for a range of human rights, including the rights to health and has established mechanisms to promote and protect those rights. In response to atrocities committed during World War II, the UN General Assembly adopted the Universal Declaration on Human Rights in 1948.

It should be noted that transforming the legal obligations into a genuine political commitment to reproductive rights, however, requires concerted and sustained pressure from women's advocates as well as government instruments and support. The women's empowerment movement drew attention to human rights abuse stemming from women's subordinate position in society and pressured governments to change the circumstances of women's lives. It is in this volition that the struggle against FGM has taken root.

The 1993 World Conference on human rights in Vienna affirmed that women's rights are human rights and should not be subordinated to cultural or religious traditions. The conference also made a breakthrough for reproductive rights, acknowledging that human rights can and should be broadly applied to the areas of sexuality and reproduction. In due cognizance of this conference's outcomes, it ought to be observed' that by the fact that FGM interferes with a woman's health and sexuality, is itself condemned. Thus, he who mutilates a woman on the cultural grounds does not only violate the stipulations and outcomes of the conference but also the woman (victim's) natural entitlement.

The 1994 International Conference on Population and Development in Cairo created a comprehensive framework to realize reproductive rights and health. Women's advocates persuaded government to reject population policies focused

solely on reducing fertility and to forge a new approach that focused instead on meeting individual women's needs for a wide array of reproductive health services. The 1995 Fourth World Conference on Women in Beijing confirmed and built on the link established in Cairo between women's reproductive rights and human rights already recognized by international treaties and national laws. The Beijing Platform for Action took a holistic, rights-focused view of health and the social, political and economic factors that affect it. It focused on governments' obligation to fulfill the right to health by creating the conditions that enable women to realize their right to health.

7.4 Fundamental principles and reproductive rights

Many of the human rights defined in international treaties have implications for reproductive health care (Table X). They guide almost every aspect of the delivery of care, defining what services must be offered, to whom and in what fashion. However, three principles are key for reproductive health:

(i) Based on the right to liberty, to marry and found a family, and to decide the number and spacing of one's children, individuals have the right to control their sexual and reproductive lives and make reproductive decisions without interference or coercion.

(ii) The right to non-discrimination and respect for difference requires governments to ensure equal access to health needs of women and men.

(iii) To fulfill the people's rights to life and health, governments must make comprehensive reproductive health services available and remove barriers to care.

Table X: Human rights and reproductive health obligations

Human right	Reproductive health obligation
Right to liberty and security of the person	- Prevent avoidable maternal deaths - End female feticide and infanticide. - Screen for concerns that can be detected early and treated. - Ensure access to dual-protection contraceptive methods.
Right to freedom from inhuman and degrading treatment	- Eliminate FGM - Obtain informed consent for all procedures, including HIV testing, sterilization and abortion. - Encourages clients to make reproductive health decisions.
Right to marry and found a Family	- Prevent early or coerced marriages - Provide access to infertility services to clients. - Prevent and treat reproductive tract infections that cause infertility.
Right to decide the number and spacing of one's children	- Provide access to a range of contraceptive methods. - Help people choose and use a family planning method. . - Provide access to safe abortion services, where legal.
Right to highest attainable standard of health	- Provide access to range affordable, acceptable, and comprehensive reproductive health service. - Provide high-quality care. - Allocate available resources fairly. - Provide access to obstetric care that can prevent maternal deaths.
Right to the benefits of scientific progress	- Fund research on women's as well as men's health needs. - Provide access to emergency contraception. - Provide access to antiretroviral treatment for AIDS. - Provide access to obstetric care that can prevent maternal death.
Right to non-discrimination and respect for difference	- Offer reproductive health services to all groups, including adolescents, unmarried women, and refugees. - Ensure that a husband's or parent's consent is not required for reproductive health services.
Right to receive and impart information	- Make family planning information freely available - Offer sufficient information for people to make good reproductive health decisions
Right to freedom of thought, conscience and religion	- Do not limit reproductive health services, such as emergency contraception, on religious grounds. - Allow providers to refuse to offer contraceptive and abortion services on the grounds of conscience where referrals are Possible and treatment in emergency situations is protected
Right to privacy	- Ensure privacy for all services and information

Source:http://www.path.org/files/EOL_20_4_decoz.pdg (August, 2, 2008)

Vital to note from table X is that although human rights treaties directly place obligations only on state and state officials, they indirectly create responsibilities for other organizations and individuals. For example, each international human rights treaty provides for a committee to monitor the performance of ratifying nations. As part of a country reporting system, each nation periodically submits a report to the committee on their efforts to meet their treaty obligations. The committee discusses the report with country representatives and also hears testimony from UN agencies, nongovernmental organizations and in some cases, individuals.

7.5 Cultural Relativism versus reproductive rights concerns

As Castledine (2008) puts it, there is serious disagreement about whether the practice of FGM is an issue of cultural relativism or an issue of human rights. Some Western anthropologists have equated the practice of FGM with such Western practices as breast augmentation and tattooing. This argument is flawed, however, for at least two important reasons. The first is that in both the examples given, the subjects making these decisions must, by law, be adults. This is not the case with FGM, whose subjects are often as young as three. The second flaw in this argument is that neither breast augmentation nor tattooing impede natural body functions, in the way FGM can. The argument has also been made that FGM is analogous to male circumcision, which is a common practice in the West. While it is true that both procedures are cultural traditions that have no real health benefits, there are major differences between the two. The most important difference between FGM and male circumcision is that, again, FGM impedes the natural functioning of the female body in ways that male circumcision does not. This was the case found in Kapchorwa where some of the circumcised women reported hardships and complications in life after being circumcised.

Many human rights organizations agree with Walker's idea and view FGM as a violation of human rights, calling for its eradication. In a meeting in Geneva, three UN agencies announced efforts to end FGM. These agencies, the World health

Organization (WHO), the United Nations Population Fund (UNFP A), and UNICEF, asked for world support for their goal, calling FGM an "unsafe and unjustifiable traditional practice." Amnesty International has also come out against FGM, saying "the practice is a form of violence and a violation of boldly integrity." Non-Western organizations such as the Egyptian Human Rights Organisation (EOHR) have also joined this campaign. Egypt has been a battleground in the struggle to eradicate FGM, where the practice is currently banned. The goal of EOHR is to teach Egyptians "the harms of the operation to both individuals and society and to clarify that this pagan custom has no connection with Islam." Much as the mass media, NGOs, Civil Society Organisations and the government have laboured to advocate for the elimination of FGM in Kapchorwa, it is important to note here that the practice has persisted over a test of time. This calls for more rigorous and focused law that can completely eliminate the FGM practice.

7.6 Achievement level in addressing FGM in a rights-based perspective

7.6.1 The International response to FGM (Progress)

http://www.who.int/mediacentre/factsheets/fs241/en/. (August, 2, 2008) points out that the international community is identifying FGM more and more as a harmful traditional practice, and a violation of the fundamental human rights of girls and women. Global efforts to bring an end to the custom of female genital cutting are increasing, with many nations putting in place legislation against the practice, and a number of international organizations making the elimination of FGM a priority. The United Nations has designated 8 February as the "International Day of Zero Tolerance of Female Genital Mutilation".

7.6.2 Legislation against FGM

In Africa, thirteen countries have responded to the problem of FGM by implementing legislation against it: According to "Center for Reproductive Rights" there are 16 countries with criminal legislation against FGM: Some of the countries that have criminalized FGM and respective years include : Benin (2003), Burkina Faso (1996), Central African Republic (1966), Chad (2003), Cote d'Ivoire (1998),

Djibouti (1994), Egypt (Ministerial Decree, 1996), Ethiopia (2004), Ghana (1994), Guinea (1965), Kenya (2001), Niger (2003), Senegal (1999), Tanzania (1998), Togo(1998),Nigeria,(1999-2002)
(http://www.who.int/mediacentre/factsheets/fs241/en/. (August, 2, 2008).

As the (http://www.irinnews.rglIn Depth Main.aspx?InDepthId=
15&ReportId=62462, Aug, 2, 2008) puts it, there have been reports of prosecutions or arrests in cases involving FGM in various African countries, including Burkina Faso, Egypt, Ghana, Kenya, Senegal and Sierra Leone. Ten industrialized countries that receive immigrants from countries where FGM is practiced have also passed specific laws criminalizing the practice: Australia, Belgium, Canada, Denmark, New Zealand, Norway, Spain, Sweden, the United Kingdom, and the United States. In Australia, six out of eight states have passed laws against FGM. In the United States, the federal government and 16 states have criminalized it. In France, existing legislation has been used to prosecute FGM practitioners and parents procuring the service for their daughters.

Some countries, such as the US, recognize forced FGM as a basis for asylum. In 1996, Fauziya Kassindja became the first woman to win asylum in the US on the grounds that she would be subjected to FGM if deported to her native Nigeria. However, a heavy burden of proof is placed on women seeking asylum on the basis of FGM or gender-based persecution. Anti-FGM laws have been applied in various countries, as described in the cases below, but a full analysis of the legislation against FGM is explored here below:

7.7 A snapshot of achievements over FGM by country

7.7.1 The United States of America

In 2003 a southern California couple was arraigned in a Los Angeles federal court to answer charges of conspiring to circumcise two female minors. This was the first time the law had been applied in the US and showed the extent to which human

rights instruments had been put to effective use in the bid to safeguard human rights(http://www.irinnews.orglInDepthMain.aspx?InDepthId=15&ReportId=6246, Aug, 2, 2008).

7.7.2 France

In 1993 a medical practitioner was charged with performing female circumcision, with the full knowledge that the practice was illegal. He was found guilty and can no longer practice his profession (http://www.irinnews.orglInDepthMain.aspx?InDepthId15&ReportId=62462. (Aug, 2, 2008).

7.7.3 Kenya

Two teenage girls secured a landmark ruling on 13 December 2000, when a magistrate's court issued a permanent injunction barring their father from having them circumcised.

7.7.4 Uganda

The 1995 constitution, by providing that laws, cultures, customs or traditions which are against the dignity, welfare or interest of women or which undermine their status should be prohibited, government has criminalized FGM. As the http://www.unfpa.org/news/coverage/2007/apriI30-may6-2007.htm (August, 2 2008) highlights, women activists petitioned the constitutional court demanding that FGM, practiced by several communities in the east of the country, be declared illegal. This was after the media reported a case of a woman from Sebei who developed a permanent disability resulting from female genital mutilation. Genital mutilation among the Sabiny is a ritual that marks the transformation of a girl into a woman ready for marriage. However, due to the negative outcomes, the government found it necessary to criminalize the practice.

7.8 World Health Organisation (WHO) progress

In 1997, the issued a joint statement with the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFP A) against the practice of FGM . A new statement, with wider United Nations support, was then issued in February 2008 to support increased advocacy for the abandonment of FGM (http://www.who. inti/mediacentre/factsheets/fs241/len/, August, 2, 2008).

The 2008 statement documents new evidence collected over the past decade about the practice. It highlights the increased recognition of the human rights and legal dimensions of the problem and provides current data on the frequency and scope of FGM. It also summarizes research about why FGM continues, how to stop it, and its damaging effects on the health of women, girls and newborn babies. The http://www.who.int/mediacentre/factsheets/fs2411en/. (August, 2, 2008) also highlights that since 1997, great efforts have been made to counteract FGM, through research, work within communities, and changes in public policy. Progress at both international and local levels includes: wider international involvement to stop FGM; the development of international monitoring bodies and resolutions that condemn the practice; revised legal frameworks and growing political support to end FGM; and in some countries, decreasing practice of FGM, and an increasing number of women and men in practicing communities who declare their support to end it.

It remains a fact to appreciate that, if practicing communities themselves decide to abandon FGM, the practice can be eliminated very rapidly. WHO efforts to eliminate female genital mutilation focus on: advocacy: developing publications and advocacy tools for international, regional and local efforts to end FGM within a generation; research: generating knowledge about the causes and consequences of the practice, how to eliminate it, and how to care for those who have experienced FGM; guidance for health systems: developing training materials and guidelines for health professionals to help them treat and counsel women who have undergone procedures. WHO is particularly concerned about the increasing trend for

medically trained personnel to perform FGM. WHO strongly urges health professionals not to perform such procedures.

7.9 Framework for FGM: A rights-based approach

It should be noted that when performed upon girls and non-consenting women, FGM violates a number of recognized human rights protected in international and regional instruments and reaffirmed in international conference documents. These include the right to non-discrimination, the right to life and physical integrity, the right to health and the right of the child to special protections (Reproductive Rights, 2000).

7.9.1 The right to non-discrimination

FGM/FC violates women's right to be free from all forms of discrimination. Article 1 of the Women's Convention defines discrimination against women as including any distinction based on sex that has the effect or purpose of impairing the equal enjoyment of rights by women. FGM is practiced only on women and girls, and has the effect of nullifying their enjoyment of fundamental rights (Cook, 1993). In addition, the practice carries a strong message about the subordinate role of women and girls in society. It is an attempt to repress the independent sexuality of women by altering their anatomy.

The Women's Convention at Article 2 requires governments to take all appropriate measures, including legislation, to modify or abolish existing laws, customs and practices which constitute discrimination against women. Article 5 further requires governments to take all appropriate measures to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of customary and all practices which are based on stereotyped roles for men and women.

7.9.2 The right to life and physical integrity

FGM threatens women's enjoyment of their rights to life and physical integrity. The right to life is violated 1n the rare cases in which death results from the procedure (Reproductive Rights, 2000). Even when FGM does not result in death, it interferes with a number of protections encompassed in the right to physical integrity. First, it is an act of violence that poses a threat to personal security. In addition, the dignity liberty and privacy interests that are encompassed in the right to physical integrity protect the right to independent decision-making in matters affecting one's own body. An authorised invasion or alteration of a person's body represents a disregard for that fundamental right.

The threat to physical integrity posed by FGM is particularly obvious when girls are forcibly restrained during the procedure. Yet, the subjection of non-protesting girls and women to the practice of FGM without their informed consent is no less compromising of the right to physical integrity. A decision to alter the body of a woman or a girl for the purpose of reinforcing socially defined roles is a clear interference with the right to autonomy in decision-making about one's body.

7.9.3 The right to health

Reproductive Rights (2000) puts it that FGM prevents women from enjoying their right to health. Under international law, women and girls are entitled to enjoy the highest attainable standard of physical and mental health, defined broadly to encompass social well-being. Reproductive health is defined, as including sexual health, the purpose of which is the enhancement of life and personal relations. While the right to health does not guarantee perfect reproductive health for all people, it has been interpreted to require governments to provide health care and to work toward creating conditions conducive to the enjoyment of good health.

It should be noted that because the complications associated with FGM can have devastating effects upon a woman's physical and emotional health, this procedure has been viewed as an infringement upon the right to health. But even in the

absence of such complications, FGM compromises the right to health. Where FGM results in the removal of bodily tissues necessary for the enjoyment of a satisfying and safe sex life, a woman's right to the highest attainable standard of physical and mental health has been compromised. Furthermore, any invasive procedure, no matter how safely performed entails risks to the health of the person who undergoes it.

7.9.4 The right of the child to special protection

Because children in general cannot adequately protect themselves or make informed decisions about matters that may affect them for the rest of their lives, human rights law grants children special protections (Hosken, 1993). The right of the child to these protections has been affirmed in the convention on the Rights of the Child (Children's Rights Convention), one of the most widely ratified international human right instrument. Article 1 of the Children's Rights Convention defines a child as a person below the age of 18 unless majority is attained earlier under the law applicable to the child.

The international community has generally regarded FGM as a violation of children's rights. Because FGM is commonly performed upon girls of younger ages (below 15 years), those most at risk of undergoing the procedure meet the definition of "child" set out in the Children's Rights Convention. Article 24 (3) of the treaty explicit in its call to states to abolish traditional practices is also evident in the African Charter on the Rights and welfare of the Child (African Charter), which was adopted by the Organisation for African Unity (OAU) in 1990 and entered into force in 1999. The African Charter calls upon states to abolish customs and practices harmful to the welfare, normal growth and development of the child and particularly (a) those customs and practices prejudicial to the health or life of the child, and (b) those customs and practices discriminatory to the child on the grounds of sex or other status.

7.10 An alternative Framework for Rights-based Approach

FGM is an act of violence against women and girls and a human rights violation. But it is also a cultural tradition, deeply rooted in religious and social convictions, and ensures marriage prospects for girls. Many who choose to deviate from other patriarchal social norms accept FGM because there is tremendous social pressure to go through with the practice.

In a study on FGM in Sierra Leone, Melron (2000) observed that simply condemning FGM as inhumane, or a human rights abuse, does little to stop it. In his discussions with local women, he reported to have found it more effective to avoid the cultural and religious rationales of the practice and instead concentrate on the associated health risks, creating a more comfortable atmosphere in which to discuss this highly charged issue. Most women accept the fact that FGM causes numerous health-related problems that they would not like their daughters to experience; some have themselves experienced such problems, including chronic infection, damaged organs, intermittent bleeding, and infertility.

Thus, they more readily accept health-based rather than human rights arguments as justifications for resisting long-standing practices. A rights-based approach, on the other hand, which claims that a woman's culture violates her and her daughters' civil rights, is difficult for her to understand and controversial to accept.

7.11 A look at an alternative Rite to FGM

More recently, as the http://www.childinfo.org/fgmcJesources.html (August, 2, 2008) highlights, an 'alternative rites' strategy is being used by NGOs in FGM-practicing communities. This strategy is intended to retain the rites of passage or initiation that the girls would traditionally undergo, with the exception of FGM. The girls are still encouraged to learn what it means to be a woman in their respective communities, but do not have to endure the agony of the cut. This procedure is being tested in several communities around the world and has registered some success in Sierra Leone.

However, alternative rites have also faced serious opposition, and even led to lowering of the age at which FGM is practised in certain communities. For example, the Maasai of Kenya, responded to aggressive anti-FGM campaigns by cutting girls as young as four, rather than teenage girls (http://en.wikipedia.org/wiki/Female~enital_cutting (August, 2, 2008).

All in all, FGM remains a practice that violates the basic human rights of women and girls and seriously compromises their health. Nevertheless, among communities that practice FGM it is a highly valued tradition, making eradication difficult. There are also success stories. As individuals become better informed about the negative impacts of FGM, there has been a reduction in the practice and today there are few communities in which 100 percent of girls and women are circumcised. Such a significant stride has been attributed to the change from addressing FGM in a health and cultural perspective to adopting a more and comprehensive rights-based approach.

CHAPTER EIGHT

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

8.1 Introduction

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

8.2 Summary

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

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

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

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

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

Despite the above benefits, 75.6% of the female respondents acknowledged that there were dangers associated with the practice of FGM. Such include experienced pain during and after the operation, painful sexual intercourse as a result of loss of frigidity and vaginal narrowing, excessive bleeding, difficulty in child birth due to the narrowing and stitching of the vaginal canal. There were also cases of death. Reflecting on these dangers, it can be put that the FGM practice adversely violates women's reproductive rights.

8.2.2 The relevant human rights instruments to women's reproductive rights

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

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

The practice of FGM has gone so native into the lives of the Sabiny that its performance is in no way considered a form of human rights violation. There was a great disposition of culture over human rights. As responses from the elders so emphasized, FGM was a practice that reinforces kinship relations, and females' social transformation from childhood to adulthood. However, such issues contravene the stipulations of the Universal Declaration of Human Rights. For example, Article 1 of the UDHR states that "All human beings are born free and equal in dignity and rights. They are endowed with a spirit of reason and conscience and should act towards one another in a spirit of brotherhood." And article 5 adds, "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."

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

8.2.3 Challenges of implementation

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

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

8.3 Conclusions

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

8.3.1 Reasons for carrying out FGM practice among the Sabiny

(i) The practice of FGM cherished and jealously guarded cultural practice among the Sabiny. It is seen as the only cultural practice that effects the transformation of a girl into womanhood. One becomes a social misfit with out undergoing FGM operation.

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

8.3.2 The relevant human rights instruments to women's reproductive rights

(i) There were low levels of awareness regarding the fundamental human rights, reproductive health rights and later instruments stipulating and safeguarding the promotion and enjoyment of women's reproductive rights.

(ii) FGM was somewhat considered a right that all the Sabiny females should enjoy, for the practice was upheld for reinforcing kinship relations, and females' social transformation from childhood to adulthood. Thus, Kapchorwa community members, especially the elders were not comfortable with human rights instruments that disregarded FGM as their natural right.

8.3.3. Challenges of implementation

(i) There were low levels of awareness regarding the concept of human rights a and reproductive rights in Kapchorwa District.

(ii) Regarding the use of national and international instruments on women's reproductive rights, there was lack of social support, and a practical law that would not complicate relationship elements with other tribes. There was also lack of structures and institutions to popularize the evils associated with FGM by according the victims some degree of special attention.

8.4 Recommendations

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

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

(ii) The government should develop tools that can facilitate gender- sensitive FGM policy formulation, planning, implementation and monitoring. These include gender disaggregated-data in all spheres (especially legislation); gender research analysis; guidelines for integration of gender and FGM into the policy formulation process. Such analytical techniques as Gender Proofing, Gender Impact Assessment, Emancipation Effect Reporting, Gender Indicators and Checklists of Actions for Gender Mainstreaming should be applied in processing gender and FGM disaggregated data at the national level. To close the gender pay gap, gender pay indicators have to be included in the list of broad economic indicators.

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

(iv) There is need for the government and NGO's to enhance advocacy and lobbying for the recognition of women's reproductive health. The government and non-

governmental organizations can come up to enhance and facilitate the advocacy and lobbying process.

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

8.5 Areas for further research

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

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

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

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APPENDIX I: LETTER OF INTRODUCTION

APPENDIX II

QUESTIONNAIRE FOR THE TOPIC: VIOLA TION OF WOMEN'S REPRODUCTIVE RIGHTS: A CASE OF FEMALE GENITAL MUTILATION IN KAPCHORW A DISTRICT (1970-2007)

Administered to the female respondents from the Sabiny community

Dear respondent,

- You have been selected to participate in this study without prior knowledge of your existence.
- You are requested to tell the truth.
- The purpose of this study is purely academic.
- Your information will be treated with utmost confidence.
- You may respond by either filling in the blank spaces or indicating with a tick where applicable.

SECTION A: BACKGROUND INFORMATION

1. Name of the Village: .... Sub county……………………
2. Age of respondent:
   (a) Below 20 years ☐
   (b) 21-26 years ☐
   (c) 27-32 years ☐
   (d) 33 and above years ☐
3. Highest level of education attained:
   (a) Post-graduate ☐
   (b) Graduate ☐
   (c) Secondary Level ☐
   (d) Primary Level ☐
   (e) No formal education ☐
   (f) Any other (Specify)... ... ...

4. Religion of respondent:

(a) Catholic ☐

(b) Protestant ☐

(c) Muslim ☐

(d) Seventh Day Adventist ☐

(e) Traditionalist ☐

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

SECTION B: KNOWLEDGE ABOUT THE RELEVANT HUMAN RIGHTS INSTRUMENTS TO WOMEN'S REPRODUCTIVE RIGHTS

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

(a) Yes ☐ (b) No ☐

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

(a) Right to education ☐

(b) Right to a health living ☐

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

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

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

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

(a) Yes ☐ (b) No ☐

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

(i) ………………………………………………….

(ii) ………………………………………………….

(iii)………………………………………………….

(iv)………………………………………………….

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

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

(a) From friends ☐

(b) Read from newspaper and magazine ☐

(c) Read from the constitution ☐

(d) Listened Over radio ☐

(e) Watched over the television ☐

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

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

(a) Yes ☐ (b) No ☐

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

(i) ……………………………………………….

(ii) ……………………………………………….

(iii) ……………………………………………….

(iv) ……………………………………………….

SECTION C: KNOWLDEGE ABOUT REASONS FOR CARRYING OUT FGM PRACTICE

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

2. At what age were you circumcised?

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

(a) Type I ☐

(b) Type II ☐

(c) Type III ☐

(d) Type IV ☐

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

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

(a) I voluntarily took part ☐

(b) I was forced ☐

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

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

6. Could you recall whether the instruments were sterilized?

(a) They were sterilized ☐

(b) They were not sterilized ☐

(d) Do not know/recall ☐

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

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

(i) …………………………………………..

(ii) …………………………………………..

(iii) …………………………………………..

(iv) …………………………………………..

8. What happens to females who have not circumcised?

(i) …………………………………………..

(ii) …………………………………………..

(iii) …………………………………………..

(iv) …………………………………………..

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

(a) Yes ☐ (b) No ☐

10 Are there benefits associated with community?

(a) Yes ☐ (b) No ☐

11. If yes, what benefits?

(i) …………………………………………..

(ii) …………………………………………..

(iii) …………………………………………..

(iv) …………………………………………..

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

(a) Yes ☐ (b) No ☐

13. If Yes, what dangers?

(a) Pain during and after the practice ☐

(b) Excessive bleeding ☐

(c) Difficulty in child birth ☐

(d) Spread of diseases like HIV/AIDS ☐

(e) Scarring ☐

(f) Death ☐

(g) Painful sexual intercourse. ☐

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

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

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

   (a) Yes ☐) No ☐

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

   (i) …………………………………………..

   (ii) …………………………………………..

   (iii) …………………………………………..

   (iv) …………………………………………..

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

   (a) Yes ☐ (b) No ☐

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

   (i) …………………………………………..

   (ii) …………………………………………..

   (iii) …………………………………………..

   (iv) …………………………………………..

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

   (a) Yes ☐ (b) No ☐

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

   (a) As a secret in a sacred manner ☐

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

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

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

   (a) Yes ☐ (b) No ☐

8. There have been government attempts to stop the practice of FGM in Uganda. However, this has not been successful. What do you think are the challenges the government faces, especially among the Sabiny in Kapchorwa District?

   (i) …………………………………………..

   (ii) …………………………………………..

   (iii) …………………………………………..

   (iv) …………………………………………..

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

   (i) …………………………………………..

   (ii) …………………………………………..

   (iii) …………………………………………..

   (iv) …………………………………………..

END, THANK YOU FOR THE RESPONSE

APPENDIX III

AN INTERVIEW GUIDE FOR THE TOPIC: VIOLATION OF WOMEN'S REPRODUCTIVE RIGHTS: A CASE OF FEMALE GENITAL MUTILATION IN KAPCHORW A DISTRICT (1970-2007)

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

Dear respondent,

I am Chepsikor Muhammed Monges Pripinya, a student of Makerere University and currently carrying out a research entitled **"Violation of Women's Reproductive Rights: A Case of Female Genital Mutilation in Kapchorwa District (1970-2007)"** as part of the requirements for the award of a degree of Master of Arts in Human Rights. You are requested to be part of this academic study by answering the questions in the text. The information you give will be treated with utmost confidence. You are thus requested to tell the truth. Thank you!

SECTION A: BACKGROUND INFORMATION

1. Name of the Village:…………………… Sub county...............
2. Position held in the community:

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

3. Age of respondent (State in years):……………………..
4. Highest level of education attained:
   - (a) Post-graduate ☐
   - (b) Graduate ☐
   - (c) Secondary Level ☐
   - (d) Primary Level ☐
   - (e) No formal education ☐
   - (f) Any other (Specify). . . . .
5. Religion of respondent:
   - (a) Catholic ☐
   - (b) Protestant ☐
   - (c) Muslim ☐
   - (d) Seventh Day Adventist ☐

(e) Traditionalist ☐

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

SECTION B: KNOWLEDGE ABOUT THE RELEVANT HUMAN RIGHTS INSTRUMENTS TO WOMEN'S REPRODUCTIVE RIGHTS

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

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

   (i) …………………………………………..

   (ii) …………………………………………..

   (iii) …………………………………………..

   (iv) …………………………………………..

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

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

   (i) …………………………………………..

   (ii) …………………………………………..

   (iii) …………………………………………..

   (iv) …………………………………………..

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

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

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

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

   (i) …………………………………………..

   (ii) …………………………………………..

   (iii) …………………………………………..

   (iv) …………………………………………..

SECTION C: KNOWLDEGE ABOUT REASONS FOR CARRYING OUT FGM PRACTICE

1. At what age are girls circumcised?
2. How is it (circumcision) done? (Probe for the various types)
3. Do girls voluntarily take part in the circumcision rite? (Yes/No) Probe to find out if some force is used who uses it
4. Could you recall whether the instruments were sterilized?
   (a) They were sterilized ☐
   (b) They were not sterilized ☐
   (d) Do not know/recall ☐
   (e) Any other (Please specify). . . . .
5. What do you think are the reasons for carrying out FGM among the Sabiny?
   (i) …………………………………………..
   (ii) …………………………………………..
   (iii) …………………………………………..
   (iv) …………………………………………..
6. What happens to females who have not circumcised?
   (i) …………………………………………..
   (ii) …………………………………………..
   (iii) …………………………………………..
   (iv) …………………………………………..
7. Are there benefits associated to FGM in this community? (Yes/ No)
8. If yes, request the respondent to mention such benefits
   (i) …………………………………………..
   (ii) …………………………………………..
   (iii) …………………………………………..
   (iv) …………………………………………..
9. Are there dangers associated with the practice of FGM? (Yes/ No)
10. If Yes, what dangers are associated with FGM?
12. Would you say that the practice of FGM violates women's reproductive health?
    (a) Yes ☐ (b) No ☐
13. If yes, state how:
    (i) …………………………………………..

(ii) …………………………………………..

(iii) …………………………………………..

(iv) …………………………………………..

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

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

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

1. Are women in this community recognized the way men are? (Yes/No)
2. If No, what are the major issues of difference?

   (i) …………………………………………..

   (ii) …………………………………………..

   (iii) …………………………………………..

   (iv) …………………………………………..
3. Do you think the community leaders and members can allow for complete elimination of the FGM practice? (Yes/No)/ Do not know)
4. If No, why do you think so?

   (i) …………………………………………..

   (ii) …………………………………………..

   (iii) …………………………………………..

   (iv) …………………………………………..
5. Would you say that enacting criminal laws prohibiting FGM in Uganda may be perceived as a pretext for harassing or persecuting members of that Sabiny group? (Yes/No/l Do not know)
6. How are issues regarding FGM handled in this community? *Probe to find out whether it is easy to access information related to the practice*)
7. For the health workers only: Are there provisions for giving circumcised women special attention in the health centers especially when they are pregnant and during labour? Yes/ No. If yes, what kind of treatment is accorded?

8. There have been government attempts to stop the practice of FGM in Uganda. However, this has not been successful. What do you think are the challenges the government faces, especially among the Sabiny in Kapchorwa District?

   (i) …………………………………………..

   (ii) …………………………………………..

   (iii) …………………………………………..

   (iv) …………………………………………..

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

   (i) …………………………………………..

   (ii) …………………………………………..

   (iii) …………………………………………..

   (iv) …………………………………………..

END, THANK YOU FOR THE RESPONSE

APPENDIX IV: FOCUS GROUP DISCUSSION GUIDE

TO BE CONDUCTED WITH WOMEN ABOVE 20 YEARS WHO ARE BELIEVED TO HAVE UNDERGONE THE FGM PRACTICE

I am Chepsikor Muhammed Monges Pripinya; a student from Makerere University and would like to get information about "Violation of Women's Reproductive Rights: A Case of Female Genital Mutilation in Kapchorwa District (1970-2007)" The data
Obtained will be used to improve women's reproductive health and how they can fully enjoy, safeguard and protect their natural entitlements.

You have been identified as the best source of information since you are among the people that undergo the practice of FGM. The information obtained will be kept confidential.

NB. The moderator should introduce the team and ask for permission to jot answers and then set the climate conducive before starting the discussion.

Notes to be jotted

Date …………………………

Time: Start……………… End......................

Duration. . . . .

Number of participants. . . . .

Code	Sex	Designation
1	…………..	…………………….
2	…………	………………………..
3	…………	……………………….
4	…………	…………………………
5	…………….	………………………….
6	…………….	…………………………….

Notes to be taken under successive themes as shown below:

Theme I: An overview of FGM in Kapchorwa District

Theme II: The relevant human rights instruments to women's reproductive rights

Theme III: Reasons for carrying out FGM practice

Theme IV: The challenges faced in the implementation of human rights instruments to women's reproductive rights

Theme V: Suggestions for improving the state of women's reproductive rights through the elimination of FGM.

Any other comments. . . . .

NB: The atmosphere under which focus group discussions are to be held should ensure confidentiality, confidence and should be environment free of noise and interference.

END, THANK YOU FOR THE CO OPERATION