THE IMPACT OF CUSTOMS AND SEXUAL PRACTICES
ON YOUNG MAASAI WOMEN’S
ABILITY TO NEGOTIATE THEIR SEXUAL AND
REPRODUCTIVE HEALTH
IN RELATION TO HIV AND AIDS
IN LOITOKITOK, KENYA

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A thesis submitted in partial fulfilment of the requirements
for the Degree of Master of Social Practice
UNITEC New Zealand, 2010
DECLARATION

Name of Candidate: Matogo Joyce Njeri

This Thesis entitled: The Impact of Customs and Sexual Practices on Young Maasai Women’s Ability to Negotiate Their Sexual and Reproductive Health in Relation to HIV/AIDS in Loitokitok, Kenya,

Is submitted in partial fulfillment for the requirements for the Unitec degree of:

Master of Social Practice

Candidate’s declaration

I confirm that:

• This Thesis Project represents my own work;
• The contribution of supervisors and others to this work was consistent with the Unitec Regulations and Policies.
• Research for this work has been conducted in accordance with the Unitec Research Ethics Committee Policy and Procedures, and has fulfilled any requirements set for this project by the Unitec Research Ethics Committee.
• Research Ethics Committee Approval Number: 2007.954

Candidate Signature: Date: 23 April 2010

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ABSTRACT

This research study sought to ascertain the perceptions of young girls and women between the ages of 16-25 years about how one becomes infected with HIV/AIDS and whether prevailing customs and sexual practices contribute to their vulnerability to HIV infection.

It also investigated strategies the women considered appropriate, practical and effective to cope with these risks. The field study was conducted in the Loitokitok district of Kenya. Qualitative data was generated using focus group discussions, semi-structured interviews and informal observation methods.

An extensive review of the literature was also conducted. The influence of gender based customs and practices are highlighted in a number of scholarly works, governmental and non-governmental documents with regard to women’s vulnerability to Sexually Transmitted Infections (STIs).

The researcher maintained an ‘insider-outsider’ position and a participatory role in order to try to identify the current state of Maasai women’s reproductive health at the grass roots level.
ACKNOWLEDGEMENTS

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<table>
<thead>
<tr>
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<th>Full Form</th>
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<tbody>
<tr>
<td>AID</td>
<td>Africa Infectious Diseases</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>AMREF</td>
<td>Africa Medical Research Foundation</td>
</tr>
<tr>
<td>CBS</td>
<td>Central Bureau of Statistics</td>
</tr>
<tr>
<td>EFA</td>
<td>Education for All</td>
</tr>
<tr>
<td>FEMNET</td>
<td>African Women Development Communication Network</td>
</tr>
<tr>
<td>FGC</td>
<td>Female Genital Cut</td>
</tr>
<tr>
<td>FGM</td>
<td>Female Genital Mutilation</td>
</tr>
<tr>
<td>FIDA</td>
<td>Federation of Women Lawyers- Kenya</td>
</tr>
<tr>
<td>G.O.K</td>
<td>Government of Kenya</td>
</tr>
<tr>
<td>Gov.</td>
<td>Government</td>
</tr>
<tr>
<td>GTZ</td>
<td>Deutsche Gesellschaft für Technische Zusammenarbeit</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immune Virus</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Organisation</td>
</tr>
<tr>
<td>IRIN</td>
<td>Integrated Regional Information Networks</td>
</tr>
<tr>
<td>K.A.G</td>
<td>Kenya Assemblies of God</td>
</tr>
<tr>
<td>KBS</td>
<td>Kenya Bureau of Standards</td>
</tr>
<tr>
<td>K.C.P.E</td>
<td>Kenya Certificate of Primary Education</td>
</tr>
<tr>
<td>K.C.S.E</td>
<td>Kenya Certificate of Secondary Education</td>
</tr>
<tr>
<td>KDHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>KOHA</td>
<td>Kaihono hei Oranga Hapori o te Ao</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MPIDO</td>
<td>Maasai Pastoralist Indigenous Organization</td>
</tr>
<tr>
<td>NASCOP</td>
<td>National AIDS/STD Control Program</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Governmental Organization</td>
</tr>
<tr>
<td>NZAID</td>
<td>New Zealand’s International Aid &amp; Development Agency</td>
</tr>
<tr>
<td>OVC</td>
<td>Orphans and vulnerable children</td>
</tr>
<tr>
<td>PICD</td>
<td>Partnerships for International Community Development</td>
</tr>
<tr>
<td>PLA</td>
<td>Participatory Learning and Action</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>U.R.E.C</td>
<td>Unitec Research Ethics Committee</td>
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<tr>
<td>UNAIDS</td>
<td>United Nations Program on HIV and AIDS</td>
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PROLOGUE

My interest in working with pastoralist women arose from my undergraduate internship in 2003 when I first visited Bogoria in the Rift valley of Kenya. The internship provided me with an opportunity to experience the pastoralist way of life by interacting and staying in the Nilotic community.

After the completion of my undergraduate study in the Catholic University of Eastern Africa and successful completion of a field report handed in to the Child Fund Kenya, I was offered a role as a community mobilizer and program officer of the ‘Emali Dedicated Project’ an affiliate organization of ‘Child Fund Nairobi’, who assigned me to work in Kajiado and Makueni district-Kenya in a HIV/AIDS family help project.

My role involved working with deprived, excluded, vulnerable children and their families for one year and in the second year the community organization was successfully funded by Kaihono hei Oranga Hapori o te Ao (KOHA). Partnerships for International Community Development (PICD) NZAID funding scheme, in which my role as a program officer in partnership with Child Fund, was to implement youth, orphans and vulnerable children (OVC) program activities. During this time I was part of the successful initiation and formation of three young women’s youth groups with micro-enterprise initiatives, the formation of five children’s rights clubs in five schools in Kajiado and Makueni and five youth peer campaigns in Emali Kenya. Working with the youth was a rewarding experience for both myself and the youth involved in the groups.

My initial work experience with young women’s groups and child rights clubs developed my interest in the study of pastoralist women’s health. Most of these girls had dropped out of school or had never been to school. The majority of the girls who came from Kajiado district were not privileged with an education and exposure to information and communication as much as the young girls in Makueni district in Kenya. This I noted was attributed to distinct cultural practices among the pastoralist community and it kindled an interest to study the community and to try and understand the current socio-economic and political status particularly regarding reproductive health.

I come from a minority group of the Abagusii of Kenya; minority in this context meaning population size and having the disadvantage of low access to equitable distribution of country’s resources. I am therefore able to relate to the experiences of
these women who not only go through challenging economic times brought about by post colonial capitalism and globalization, but who are also located in society in ways which serve to subjugate woman’s socio-economic and political position. The marginalized position of women in this society affects their ability to control and make equal decisions about their reproductive health and sexuality.

Figure 1. Joyce Matogo at Olchoro Sub Location, Loitokitok District, Kenya. Private Collection of Joyce Matogo

Figure 2. Group of Maasai women at a village during visit to Loitokitok District, Kenya. Private Collection of Joyce Matogo
CHAPTER ONE

Introduction

Chapter One begins by providing an overview of the Maasai people in order to provide a context for the project. There is a brief description of the geographical location of the group involved in the research, information about Maasai rural livelihoods and how this influences women’s reproductive health. It also provides a description of the age set system identified as the most important social organization in Maasai culture and how this assists in understanding the cultural construct of gender.

A highly significant period of colonialism in Kenyan history is discussed to highlight its impact on Maasai women’s reproductive health. Another important aspect of Maasai society which is discussed is the culture of religion and its influence on women’s reproductive health status.

This Chapter provides aims and objectives of the research study and highlights reproductive health challenges facing young Maasai women 16-25 years in Loitokitok district.

Overview of Maasai background

The Maasai of Kenya are found in Narok, Transmara, Olkejuado, Laikipia, Central Baringo, and parts of the Nakuru districts along the Great Rift Valley plains and at the border of Kenya and Tanzania around the Mt. Kilimanjaro area where the study area of Loitokitok district is situated (Tarayia, 2004, p. 185). About one million Maasai live in Kenya and Tanzania of which 145,000 people live in Loitokitok district (Phillips, Jacqueline, & Peshotan, 2002; Gachimbi, 2002). “Loitokitok District has an area of 6,356.3km²” (“Overview of the District”, n.d.).

The Maasai of Kenya have been independent citizens from the time of colonisation to the present. However, they like most ethnic groups in Kenya have gone through the historical experience of colonisation under British rule for seventy five years. In these years, they had to give up most of their traditional structures to pave way for British rule. This research considers the impact of colonisation and how it has influenced the present Maasai women’s sexuality and reproductive health.

1 Loitokitok was formerly a division of Kajiado district but recently (2009) became a new division of Kajiado district.
The area the study focused on is mainly the Southern part of Kenyan state called Loitokitok which also borders neighbouring Tanzania (Refer to Figure. 3, Map of Southern Kenya). Loitokitok District occupies 21,105km2 on the southern slopes of the Kenyan Highlands and the Rift Valley. “The climate is typical of other semi-arid districts in Kenya; the average temperature is 10C due to the presence of the Mount Kilimanjaro” (Woodhouse, Bernstein & Hulme, 2000).

Loitokitok is predominantly occupied by the Maasai, followed by Kikuyu and a few Chaga; a Bantu speaking indigenous Africans and the third largest ethnic group in Tanzania. The noun Loitokitok is derived from a spring with a Maasai name Enkoitokitoki that means a bubbling spring (Ntiati, 2002).

I stayed within 15km of the border Kenya and Tanzania at an area called Rombo where I commuted each day to and from Olchoro. Rombo is one of the six districts of the Kilimanjaro region of Tanzania. It is bordered to the north and east by Kenya. The Rombo districts contain a large portion of Mount Kilimanjaro.

Maasai Rural livelihoods

Economically, Maasai largely depend on land, livestock (mainly cows) and traditional occupations such as bead work, dairy (making ghee, selling milk) and traditional herbal medicines (Flintan, 2008). The land occupied by Maasai is divided into ranches and usually owned by the community to provide a wide area for livestock grazing. However, this has changed over time following environmental degradation, and altered socio-economic and political conditions. These constraints have made the Maasai adapt to crop farming as an activity that will provide household income (Okello, 2005, p.19).

Another coping strategy Maasai have had to adapt to is capitalism; an individualistic economic ideology initiated during the era of colonialism, to cope with the demands of modern lifestyles hence increasing the need for other livelihood options (Okello, 2005). In the present economic situation, Kenya as a developing country has had to develop its trade and industry strategies. This has meant selling their land, migrating to other areas in search of jobs and reverting to practices such as giving up premature girls for marriage for economic gain.

Hughes (2006) not only confirms Maasai loss of land as being a consequence of socio-economic poverty but also takes us back to the land alienation process which was begun in 1904 by the British.

The land alienation process commenced when the early British settlers were received as guests by the indigenous Maasai people. The British settlers had undeclared interests that translated into formulating unsupported treaties that were signed by the Maasai people (Lonsdale, 2006, p. 89). The outcome was that they lost all their land to their then colonial masters and had no means of obtaining justice in the newly established legal systems which favoured the colonists (Ndaskoi, 2006).

However, in 1963, Kenya gained its independence which meant that British colonists had to give back most of the land to the first Kenyan government. Part of what the Kenyan government took up were the initial colonial land laws that had been enacted to continue serving the interests of the British. This gave the new President’s office the authority, which was previously vested in the British Monarch, to alienate and allocate land in Kenya (Ndungu, n.d.).
Coupled with vested interests resulting in corruption, some politicians, government officials and some members of civil societies continue to control the general economic status of the Maasai. As a result of the land controversies, low household incomes cannot adequately cover education, health related needs and household expenses (Radeny, Nkedianye, Kristjanson & Herrero, 2007 p. 32).

In remote areas like Olchoro Sub Location in Loitokitok district, the constant competition for resources has led people to temporarily migrate to other areas; particularly men, to find pastures for their livestock or alternatively get paying jobs (May, & McCabe, 2004, p.3).

The need to migrate relates to the concern of this study as to how migration brings an increase in sexually transmitted infections particularly HIV/AIDS. May & McCabe (2004) ethnographic research uncovered Maasai’s lack of accurate knowledge concerning the realities of STIs including HIV/AIDS that relates to some of the cultural and sexual practices that are widespread in the culture:

Theorists speculate that migration can affect transmission in sub-Saharan Africa through movement from areas of low endemicity to more congregated populations (May & McCabe, 2004, p. 3).

The problems associated with migration combined with certain cultural practices may have catalysed the spread of sexually transmitted infections in heterosexual relationships. These cultural and sexual practices are discussed in Chapter Two.

**Influence of Feminist Scholarship on the Research**

Chilsa and Preece (2005) define feminism as “the exposure of gender inequalities and gender oppressive behavior” and negate negative associations of the term ‘feminism’ frequently categorized as; “being anti-male or that feminist writers are only writing for other feminists or women” (pp 211-212). Feminist research exposes dominant practices that create gender dissimilarities. It also assumes that “the powerful dominate social life and ideology and that men and women differ in their perceptions of life due to their social status” (“Improve data collection on women, says UN”, 2006).

One of the most important aspects of Maasai society is the social organization which is patriarchal and managed through a male age-set system. This study proposes that the male dominated social organization influences women’s socio-economic and political status. Lack of female representation in the social organization under prioritizes women’s socio-economic needs. Male representatives at the organization structure
may not always be in touch with women’s perceived needs as these needs may not affect them directly. On the other hand, male authorities may not challenge harmful male dominated customs and sexual practices which they defend as being culturally appropriate. This ultimately impacts on Maasai women’s equal participation in matters concerning their reproductive and sexual health:

Feminists from developed and developing countries critique the patriarchal power structures in many societies that restrict women’s autonomy and calls for inclusion of men's involvement in roles supportive of women’s sexual and reproductive decisions, especially contraception and the encouragement of men’s responsible sexual and reproductive practices to prevent and control STIs (Dudgeon & Inhorn, 2004, p.1380)

The discussion of gender is an important feministic approach for this study that privileges Maasai women’s voice. A feminist approach reveals the gender dissimilarities between Maasai men and women. It describes how Maasai gender relations and power imbalances influence the aspects of sexuality that deal with contraception in Chapter Two (literature review) and Chapter Four (presentation of data analysis). Discussions on gender, customs and sexual practices that limit Maasai women’s autonomy in reproductive health matters are also considered.

**Description of Maasai Social Organization**

The Maasai are highly organized in their day to day social activities and the major structural principles in the culture are patrilineal. They organize themselves in age-sets or age groups to form part of political structures where important decisions are made on behalf of the community (Talle, 2007, p. 608). “Of primary importance in the community, is the subset of warriors (Moran) who have been most recently initiated” (“Maasai social political organization”, n.d.). The warrior period is described as Moranism in Chapter Two, which also discusses the impact this period, has on young Maasai women’s reproductive health.

The social age-set system is normally appointed by men and delegated by men (Talle, 2007) and “women do not have their own age-set but are recognized by that of their husband’s age set group” (Ikonya, 2008). The study considers that the cultural construct of gender presented in the context of Maasai social organization is a crucial determinant of women’s reproductive health and sexual autonomy. The research project furthers the discussion on gender relations and its influence on Maasai women’s reproductive health in Chapter Two.
Colonization and African Women’s Sexuality

Literature concerning women’s sexuality during the colonial period concerns itself with a struggle against repression, injustice and how this impacts on their reproductive health. Undie and Benaya (2006) notes that the era negatively taints the image of African women’s sexuality in the developing world. Their reproductive ability was seen as an economic asset that contributed cheap human labour to industry (Kuumba, 1999, p. 447). The author expresses the view that the more children were born, the more likely households supposed that they would survive on a combined income. Giving birth to many children became a norm and a way of life. This could perhaps explain one of the economic reasons why the average Kenyan woman as well as Maasai woman has at least five children (Yin & Kent, 2008).

The extent of African women’s coercive experience with colonialism was heightened by the silencing of their sexuality (Ampofo, Beoku-Betts, Njambi, & Osirim, 2004, p. 692) through Western forms of feminism that portrayed Euro-centric prejudices in the 1980s (“The Imperial Archive”, 2006):

At this time feminist critics began to question this bias and unveiled such realities with a purpose of intervening in the neglected situation of the so-called “Third World woman” (“The Imperial Archive”, 2006)

Understanding colonialism assists in the understanding of how the present health status of Maasai women came to be, rather than singling out its negative impact. In fact, (Kanogo, 2005, cited in Clough 2007) points out the positive impact of colonialism, stating that:

It saw a widening of opportunities for African women that can be attributed to both forces like urbanization and changes in African attitudes and practices caused in part by direct European influence despite values and policies of officials and missionaries being highly influenced by Victorian sexism (Clough, 2007, p. 347).

It is through the influences of colonialism that the consciousness of the average African woman was raised against certain injustices that were perpetuated within customs and practices. Some colonialists; especially Christian missionaries, raised concerns about extreme practices that women and girls were going through such as FGM/ clitoridectomy or circumcision, early marriage and female discrimination (Kanogo, 2005). The challenge facing the missionaries was the lack of an effective cultural approach that would influence change to detrimental practices women and girls were going through. For this reason, early missionary work strained to intervene for the
wellbeing of young girls and women afflicted by certain customs and sexual practices. Equally, the study observes that early missionary work was not effective in challenging the oppressive colonial and local traditional structures that subjugated indigenous people including the young girls and women.

The main objective of colonialism remained as the furtherance of vested interests and used all possible strategies to realize its objective. The colonialists also used gender as a tactic by introducing men to supremacist ideology in everyday relations with their wives hence providing a platform to divide and rule households on the basis of gender inequities ("The effect of colonialism," 2007):

This unfounded feeling of male superiority is said to have generally been absent in non-Islamized African states ("The effect of colonialism," 2007).

The author considers that this colonialist exploitation could be a possible explanation of the present gender relations among Maasai men and women which determines the ability of Maasai women to negotiate reproductive health options in the context of gender. Hunnicutt, (2009) presents that:

The theory of patriarchy contends with the potential divergence of structure and ideology and that variety of patriarchal ideology may exist apart from structural conditions (p. 555).

The author identifies that gender relations lacked spontaneity due to the infiltration of patriarchal, male supremacist ideologies and other external structural conditions that created a discourse of female subordination which served to limit women’s self determination in matters that concern their reproductive wellbeing. Colonial socio-economic and political structures were put in place where “political leaders, missionaries and state officials attempted to control Kenyan women’s status through legislation and social control” (Kanogo, 2005, pp. 785-786).

Colonial structures particularly those relating to justice, were not concerned with the indigenous people’s welfare other than whom the structures were to benefit. A number of injustices were openly perpetuated on women’s health:

Custom law, conflicts over female education, and struggles over female genital mutilation (FGM) among other practices that point out the degradation of women’s growth, were ignored (Clough, 2007).

These and other examples demonstrate women’s lack of empowerment and their suppression which ultimately impacted upon the reproductive health status of the
average Maasai women in remote areas like Olchoro Sub Location in Loitokitok district, Kenya.

The gender hierarchies and dominations of these Maasai women are reflected in existing cultural and sexual practices identified as themes in the data analysis in Chapter Three. The present reproductive health status of the pastoralist Kenyan woman, as of most African women, is not led by personal choice but rather is explicity linked to the historical and social context of Africa.

**Religion as a Culture Influencing Women’s Reproductive health**

According to the International Religious Freedom Report (2008), approximately 80% of the country practices Christianity, 10% practice Islam and 10% practice other diverse religions; both Christianity and Islam have been inculturated within indigenous African culture. This research sought to identify the correlation between the culture of religion and women’s reproductive health.

**Negotiating Reproductive health**

Cultural determinants such as gender, age sets, religious and spiritual beliefs, Maasai ethnicity sexual practices, socio-economic class, sex and education influence women’s negotiating ability in matters concerning reproductive health.

Negotiation applies in situations where Maasai women are not able to fully express themselves within the areas of gender and cultural affiliations. Consequently, reproductive health rights and the freedom to make decisions on how to manage their own sexuality are withdrawn (Parisimei, 2009, p.2).

Maasai culture is predominantly patriarchal in its operations. The author notes the issue of male control in customs and practices and considers a feminist perspective when looking at women’s ability to negotiate their reproductive health (Dudgeon & Inhorn, 2004, p. 1380). Further, the existence of certain customary laws accepts the conduct of such practices which in turn influences the ability to negotiate. Unlike men, women do not belong to any democratic groupings where they can take part in decisions passed through customary laws. As noted above, men belong to an age set system where they have more influence in the wider community’s political concerns.
Impact of Customs and Sexual Practices on Women

The average Maasai women who live in the rural areas like Olchoro Sub Location in the Loitokitok district of Kenya, experience the adverse effects of customs and sexual practices that place high demands on their womanhood. Their basic human rights are violated. Socio-economic and political marginalization by the patriarchal system is the reason why women face the following challenges;

- Early sexual experiences and the demands of having to marry at very young ages
- Cultural expectations to bear an accepted and desired number of children
- Unprotected sex with multiple partners through the demands of polygamy, Esoto, and gender based sexual violence
- Inconsistent use of safe sex methods that would reduce susceptibility to sexually transmitted infections (STI) particularly HIV/AIDS which is incurable
- Limited access to education denying women the ability to increase their capacity to safeguard their health and wellbeing.

These issues are discussed in the literature review section of the thesis. The data analysis section also discusses themes relating to the above issues.

Rationalization for the Study

Loitokitok is faced with health related challenges particularly among women and young girls of the reproductive age 16 – 25 years. The scope and magnitude of the problem is considerable. While focusing on HIV, it is “estimated that there are around 122 women living with HIV in Kenya for every 100 men” (Mahmud, 2004, p.155).

This study highlights the complicated consequences customs and sexual practices have on the reproductive and sexual health of young Maasai women between 16-25 years in relation to HIV and AIDS. It not only looks at sexual behaviour of individuals as the only important or salient aspect of sexuality but also the cultural aspects influencing these sexual behaviours.

According to the Kenyan Ministry of Health reports, culture beliefs and poverty in the community are cited as the major factors that have contributed to the rise of HIV infection rate in Kajiado District; including the present Loitokitok district ("District strategic plan", 2005):
In the year 2002 HIV prevalence rate was reported to be 13% having increased from 10.5% in 1997 (p. 17).

The young women this study focuses on are reported to be particularly vulnerable to HIV infection compared to young men. Further empirical evidence suggests that:

HIV prevalence in girls 15 - 19 years old is six times higher than that in boys of the same age (3% of young women in this age range are infected, but less than 0.5% of young men). HIV prevalence among women 20 - 24 is over four times that of men in the same age group (9% versus 2%) (“An overview of HIV/AIDS in Kenya”, 2002, p. 2).

The Joint United Nations Program refers to this intense period of HIV and AIDS infection as:

Feminisation of the epidemic where 57% of adults infected in sub-Saharan Africa is women, and 75% of those infected are young women and girls (Wright, 2005, p.55).

The research has identified the areas where young women are most susceptible to sexually transmitted infections (STI) particularly HIV. These areas include; gender relations, socio-economic impact on access to health care, practices that influence women’s reproductive health choices, contraception use, female socialization and education.

**Kenya Millennium Development Goals**

The Kenyan Government committed to the Millennium Declaration and agreed to work towards achieving its development goals; by 2015, from the year 2000 (“Millennium Development Goals in Kenya”, 2005). Women’s health issues (focused on in this study) that are addressed in the Millennium Declaration include: reproductive health issues, gender parity, socio-economic status and STIs particularly HIV/AIDS and education.

In relation to women’s health, developmental efforts have been channelled towards: contraception including family planning and STIs, promotion of health care and emphasis on reducing incidents of gender based sexualized violence².

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² Reported cases of rape and attempted rape rose steadily from 1,050 in 1997 to 2308 in 2003. During the same period, cases of assault and battery increased from 10,288 in 1997 to 13,401 cases in 2003 (“Millennium Development Goals in Kenya”, 2005, p. 84).
MDG relating to gender parity and realizing socio-economic equity has assisted the Government to come up with a policy framework that acknowledges:

The greatest obstacle in achieving gender Equality and Women Empowerment is that most of Kenya’s development policies and strategies are grounded and rationalized by the paradigm of gender and regional inequalities (“Millennium Development Goals in Kenya”, 2005, p. 87).

Traditional customary laws and patriarchal organization influence action plans and decisions where Maasai women’s right to inheriting property and acquiring economic stability is seriously impinged upon. Property and inheritance and its relationship with women’s economic ability to address their reproductive health are discussed in Chapter Two.

In relation to education, the Government introduced free primary education for all in the year 2002 (Education International, 2005). The study highlights the significance of education for Maasai girls and women towards realizing the goal of reproductive health. Similarly, the study identified gaps within the education system that effect the enrolment and retention of girls in school. One of the most significant factors discussed is the lack of a cultural endorsement which results in the Maasai community seeing little relevance for schooling, particularly for girls. “Boys outnumber girls in schools; while girl dropout rates are caused by pregnancy and cultural practices such as early marriage” (p. 86). This study considers that education and reproductive health are integral for Maasai women and that lack of education impacts significantly upon their ability to make informed health choices. Chapter Two discusses the developmental attributes of education.

This study has discussed factors that challenge the motivation of Kenya to meet the MDG recommendations for health, including: Maasai customs and sexual practices, lack of female representation in socio-economic organization, customary law, lack of Kenyan law being explicit in addressing women health issues and inadequate resources to implement reproductive health programs. Consequently, Maasai women experience deficiencies in reproductive health areas such as: contraception, safe sex options, physical, psychological wellbeing and sexual response systems (biological function of the female genitalia).
Aims and Objectives of the Research Project

Purpose

The purpose of this study is to identify how cultural and sexual practices impact upon pastoralist women's (16-25 years) ability to negotiate their sexual and reproductive health; particularly in relation to HIV and AIDS.

Objectives

1. To ascertain the perceptions of young girls and women about how one becomes infected with HIV/AIDS and whether the cultural sexual practices contribute to their vulnerabilities to HIV infection

2. To investigate the strategies considered by young girls and women as appropriate, practical and effective to cope with these risks

The research focused on the implication of gender related cultural and sexual practices and the impact these had on women's reproductive health. Central questions of the research included:

1. How do young women and girls negotiate their sexual relationships and reproductive health in their everyday lives?

2. What are the cultural and sexual practices that are common among male-female relationships of the pastoralists in Loitokitok area?

3. What is the level of knowledge, attitudes and practices of women and girls in regards to sexually transmitted infections and reproductive health (with a focus on HIV and AIDS)

Summary

This Chapter provided an over-view of the research topic; how customs and sexual practices impact on young Maasai women’s ability to negotiate their sexual and reproductive health in relation to HIV. It provided background information and sought to contextualize the topic within contemporary Kenya. Topics discussed include: the geographical locality of Maasai women, rural livelihoods, a description of Maasai social organization, the experiences of colonialism and its impact on African women’s reproductive health, the culture of religion and its Influence on reproductive health and finally, ways in which women negotiate their reproductive health needs.
CHAPTER TWO

LITERATURE REVIEW

Introduction

Chapter Two considers a wide range of international sources of secondary data and local primary data that relate to how customs and sexual practices impact on young Maasai women’s ability to negotiate their sexual and reproductive health in relation to HIV. A number of secondary sources have been reviewed, including: books, research studies, organization documents, journal articles and online resources. Primary documents reviewed, particularly those affiliated to local development organizations e.g. government ministries, UNESCO, Kenya AIDS consortium and sources from other relevant UN bodies in Kenya, gave a closer perspective of the research topic.

The literature review incorporates topics introduced in Chapter One and it also looks at how the culture of religion influences reproductive health. It also identifies existing Maasai practices such as FGM, early marriage, polygamy and how they impact on women’s ability to negotiate reproductive health. When establishing Maasai sexual practices such as Esoto and multiple sexual relationships through polygamy, the discussion on contraception use and its appropriateness is highlighted. Contraception use is also discussed in the context of family planning.

The previous chapter introduced the theme of women’s negotiating ability in the context of gender. This chapter further explores the topic by looking at how gender relations determine the status of women’s reproductive health. It also presents an understanding of the root causes of gender differences by presenting how Maasai culture socializes young women from childhood. Factors such as education and its role in reproductive health rights are also discussed.

Gender Relations and Reproductive health

To understand the extent to which dominant patriarchal and the age-set organization influences Maasai women’s reproductive health, an analysis of Bem’s theory of gender polarization has been utilized (Kornblum, 2008, p.343). The theory identifies three lenses through which gender is viewed:

the lens of androcentrism or male centeredness (historically crude perception that men are inherently
superior to women) and the lens of gender polarization (whereby the male-female differences are forged on every human experience) and the biological essentialism which rationalizes and legitimizes other lenses as natural and inevitable consequences of the intrinsic biological natures of men and women (Kornblum, 2008, p. 343).

Androcentrism or male centeredness is evident in sexual practices such as Esoto where young Maasai warriors lend themselves the right to act on sexual desires on unwilling young women (Talle, 2007). Esoto is one of the practices that defies reproductive health within a turbulent era of STIs particularly HIV. Further discussion on Esoto can be found in Chapter Two. Such practices limit young women’s ability to make self-directed choices regarding their health. They also perpetuate reproductive health rights that stipulate the right of women to enjoy sexual health free from intimidation and violence (ICPD, 1994; Sumbeywo, 1999).

Gender polarization is seen where Maasai women take up responsibility to conform to socio-cultural norms that define how they should behave or act as women. Significantly, Maasai female socialization is one of the processes where customs and practices are transferred from mothers and aunts to girls. Despite the fact that some of these customs (which are considered as natural) cause physical and psychological harm, contesting them is considered abnormal and opposition brings the risk of being cast out of the community.

Some customary practices are detrimental to women’s health. For example, the practice of mutilating women and girl’s genitalia and Esoto which are practiced widely, ultimately injurious to women. Rural Maasai girls and women, who are not exposed to other options of self determined living, seldom express their thoughts powerfully on male dominated customs to avoid isolation from the same socio-economic and political institutions that are male dominated.

Gender relations and power are identified as the most influential social determinants of health in this study. Burnett, Anderson, & Heppner (2001) present a feminist perspective that identifies that “socially constructed masculine characteristics are more valued than feminine characteristics” (p. 323). This has been recognized within Maasai socio-economic organization that has male representatives and excludes female representatives. The theory also explains the observable fact where development opportunities such as education are widely preserved for boys and men than for girls and women. Further, the theory partly elaborates why female rights to economic property and inheritance are withdrawn by traditions and customary law.
In the context of human rights, this determines women’s ability to negotiate and control their own reproductive health. Burnett, Anderson, & Heppner (2001) acknowledge women’s vulnerability as a gender issue that requires social justice and human rights interventions. The Human rights Act; Kenya National Commission on Human Rights (KNCHR, 2002) considers women are equal to men and are free to choose what they consider fit for their general wellbeing. This means the right to accept or decline adherence to any practice they consider will compromise their health. However, existing male dominated customs consider human rights for women as a privilege rather than entitlements.

To illustrate further, the model of reproductive health rights is spelt out in the International Cairo program of Action and Development (ICPD, 1994) as:

The right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and have the information and means to do so and the right to attain the highest standard of reproductive and sexual health free of discrimination, coercion and violence as expressed in human rights documents (ICPD, 1994).

In terms of the implementation of the ICPD program in Kenya, the Cairo Programme helped Kenya strategize reproductive health needs for its population in 1999 (Sumbeywo, 1999):

Feminist scholars believe that women are positioned as socially, politically and economically subordinate to men in the structure of society and this mainstreaming requires a feminist approach (Burnett, Anderson, & Heppner, 2001 p. 30).

Ampofo, Beoku, Njambi, Osirim (2004) imply that by intervening in social injustices through strategizing gender needs, equality is promoted to give women and girls the choice to make decisions regarding their own health.

In the situation of Maasai girls and women, socio-political organisations through the age set system discussed in Chapter One, are entirely appointed by men and delegated by men which has a significant effect on women’s right to equity.

**Historical Struggle for Gender Parity in Kenya**

There have been important attempts to close the gender parity gap in Kenya. This study highlights some of the challenges Kenya faces when attempting to ratify
agreements, enact bills, and make commitments after participating in international conferences that concern women’s reproductive health rights.

Efforts have been frustrated on several accounts by a lack of political will, the magnitude of the patriarchal and religious cultures.

One example is Kenya’s participation in the 1999 ‘Beijing World Conference on Women’ where lack of political will and resources lessened its impact. Although the conference created awareness to the wider society in regards to women’s rights, Kenya missed out on opportunities to address gender disparity (Wainaina, 2003, p.3). The Beijing Conference was geared towards looking into matters such as reproductive rights, gender, inheritance rights, land ownership and violence against women (Timothy, 2004, p. 56).

Political leadership and decision making is largely blamed for the marginal inclusion of women’s concerns in nearly all sectors of development (Achieng, 2000).

In regard to political leadership, this study notes that there has always been an unequal representation of men and women in previous and current (2007-2012) Kenyan parliament. Patriarchy has made women to shy away from influential positions in parliament even though the current constitution allows women to vie for political seats. Systematically, men have thought their role as the sole custodians of socio-economic and political institutions was the norm, whereas women have gotten used to being the recipients of decisions made by men even when these decisions were not shared or inclusive of their needs. This scenario bears out earlier feminist theory that, “socially constructed masculine characteristics are more valued than feminine characteristics” (Burnet, Anderson, Heppner, 2001).

A former female parliamentarian, Beth Mugo, attempted to push the enactment of a Gender Equity Bill in 2000 with the recognition that “Kenyan laws are not explicit on cultural issues affecting the rights of women, like ownership of land, rape, and violence” (Achieng, 2000). The Bill did not pass through due to religious factors that stated:

The bill is based on Western values and would thus entangle Muslim values (Afro News, 2001).

Religion and its influence on efforts to realize gender parity also shows how the Kenyan government struggles to recognize religions (not only Islam) within a secular society. However, when culturally sensitive considerations were made to meet the interest of all groups:
On including Muslim representation to respond to the Beijing and New York Gender Conference in 1999, former president Daniel Arap Moi withdrew his support in June 2000 claiming that the Kenyan constitution already ‘provides’ for equal right for each citizen (Afro News, 2001).

The withdrawal of former President’s support was conscience and knowledgeable that the current Kenyan Constitution; that dates back from the time of colonisation, excludes contentious gender issue as ownership of land, rape, and violence. Nonetheless, it is proposed that the ongoing Draft Bill of the Constitution of Kenya; when amended and passed would lessen the gender parity gap and insufficiency (Nzomo & Mbote, 2003).

Commendable steps taken by the Kenyan government towards realizing gender parity include:

Approval of Session Paper No. 2 of 2006 which provides responsive programming and strengthening national institutions that are geared towards the advancement of women (Chelaite, 2007).

**Socio-economic Impact on Access to Health Care**

Maasai’s economic and social conditions have changed considerably. Rural Maasai women face socio-economic inequalities in health and health care access. As a result they are not able to access some of the most basic needs such as adequate nutrition, sanitation and shelter.

Mulama (2009) points out that expensive private health services that are not only inaccessible to the majority’s low earnings, but also to middle income earners. Kenya has no welfare systems to subsidize the health needs of its citizen except when donor funding comes through non-governmental organizations that intervene for health needs of the people are established.

At the national level, Government lacks adequate funds to implement sustainable programs in the health sector. As a result, activities set out to realize health goals become stagnated (Thumbi, n.d.). Such activities would include setting up a welfare system that will lessen the burden of currently inaccessible health services on low income earners, family planning initiatives and capacity building for young women to enable them become self efficient and reliant.

In relation to building young women’s (16-25 years) capacities to manage their own reproductive health, the study relates inadequate funding and resources to limited
ability to implement programs necessary to increase knowledge and prevention methods relating to HIV/AIDS.

In relation to family planning initiatives, Kenya’s last Demographic Health Survey (KDHS) in 2003 indicated unavailability of contraception in government facilities and women’s inability to afford this through private service providers (Mulama, 2009):

This result showed that 24% of women, who do not want another child within the next two years not using contraception, are forced to conceive without intention (Mulama, 2009).

Most young women do not use any method of contraception either due to unavailability in health facilities, affordability or inadequate awareness of contraception use. Specifically concerning condom use, “less than 2% of young women between age 15-24 years use male condoms as the only method that reduces the chance of HIV infection’ (“Kenya demographic and health survey-youth in Kenya and HIV”, 2003, p. 8)

Another important cultural factor to consider while relating Maasai women’s reproductive health and socio-economic situation is socio-economic gender roles. According to Maasai culture, men make decisions and manage main sources of household incomes e.g. livestock production while women make decisions regarding household care giving (Coast, 2002):

One of the main ways in which it is (traditionally) acceptable for a Maasai woman to earn cash income is to sell milk that is surplus to household requirements although the ability to sell milk varies seasonally (p. 17).

According to Hulme & Fukudu (2009), poverty and disempowerment are inextricably inseparable. Women’s inability to meet primary needs results in dependency on powerful others to meet these needs hence limiting their capacities for making autonomous reproductive health choices:

The absence of choice is likely to affect women and men differently because gender-related inequalities often intensify the effects of poverty (“Gender equality and women’s empowerment”, n.d.)

Distinct gender roles potentially keep women from opportunities to access proper health care. Maasai women who have to seek funding from partners for some reproductive health needs may face disapproval if the partner assesses these needs as unnecessary or culturally inappropriate e.g. family planning (Sen, Östlin, & George, 2007, p. 30).
The impact of illiteracy increases health challenges where women make up 70% of the country’s illiterate population therefore affecting their economic ability (Swart, 2009, p.19). Educated women have a higher chance of exploiting opportunities that would maximize their economic capacities and meet their health needs compared to women that are not educated at all.

**The Culture of Religion and Its Influence on Reproductive Health**

Religion has been seen to influence the nature of women’s reproductive health and choices:

Belief systems are reflected in people’s reproductive behavior such as beliefs concerning family planning, abortions, domestic violence, sexual behavior, widowhood status and HIV/AIDS (Ambasa, 2002, p. 11).

For example, African traditional religion affects reproductive health of women through views on family planning. The religions emphasize the bearing of many children as a sign of God's blessings and for personal immortality. This affects the choice of partners who might want to control family size and at the same time meet the requirements of religion (Ambasa, 2002).

Some African traditional religions accept cultural practices such as polygamy and FGM that are highly contested within reproductive health and human rights fields. Equally, the Islamic culture accepts practices such as polygamy where a man is allowed to marry up to four wives, can divorce any wife on a fourth warning (‘talak’) and take up another wife.

The Roman Catholic Church and African instituted churches influence reproductive health through teachings concerning the use of contraception. The religions prohibit use of certain methods of contraception without necessarily offering sustainable options (Ambasa, 2002):

The Roman Catholic Church believes that artificial contraceptives only serve to promote sexual promiscuity and immorality (Rodis, 2008).

Religious leaders fervidly deny that these restrictions have frustrated the struggle to reduce the spread of sexually transmitted infections particularly HIV/AIDS. Some religious teachings regarding HIV and AIDS have made a controversial interpretation of ‘punishment of sin’. This results in further stigmatization and secrecy of the condition. Bruning (2009) defines this as “internalization of stigma where the stigma is accepted
and turned inwards by the stigmatised person” consequently contributing to high spread of HIV and other STIs (Ambasa; 2002; Bruning; 2009: 26).

It is possible to analyse how some of these cultural requirements of religion have over time been established to deny women’s autonomous reproductive health rights particularly in patriarchal societies. Codou, (2005) notes that:

Some of the religious cultures blame international human rights by claiming them to be “Western” with the intention of continuing male domination over women (p. 31).

On the other hand, Afkhami (2001) has found out that in religious cultures as Islam:

Neither Islam nor the culture of Muslim people is an obstacle to women’s rights; rather the patriarchal structures misrepresent religion as a culture so that it is permissible to carry out human rights violations against women (Afkhami, 2001).

FGM; a custom fervently practiced amongst Maasai and the wider Islamic community, is not an Islamic requirement. Kenyan communities practicing FGM began carrying out the practice long before the introduction of Islam into their own cultures and took up the custom as a social symbol of purity incorporating it as part of a religious requirement ("IRIN interview with Daniela Colombo, an advocacy expert on FGM", 2010).

Religion is used as a means to perpetuate injustices against women thereby causing negative impacts on their reproductive health.

**Practices that Impact on Women’s Control of Reproductive health and Sexuality**

**Female Genital Mutilation (FGM)**

FGM is illegal in Kenya but permitted under customary law causing the government to be reluctant to enforce current legislation. FGM has been classified by the World Health Organization (WHO) into four types. Maasai practice has been classified as Type II i.e. removal of the clitoris and excision of the labia majora. Refer to the following table:
WHO Classification

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
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<tbody>
<tr>
<td>I</td>
<td>Partial or total removal of the clitoris and/or the prepuce (clitoridectomy)</td>
</tr>
<tr>
<td>II</td>
<td>Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision)</td>
</tr>
<tr>
<td>III</td>
<td>Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulations)</td>
</tr>
<tr>
<td>IV</td>
<td>All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization</td>
</tr>
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</table>

*Table 1. Classification of FGM (2008).*

http://www.who.int/reproductivehealth/topics/fgm/overview/en/index.html

The operation is as excruciating as it sounds and usually carried out by certain old Maasai women who are considered as traditional practitioners. Although the practice is illegal, some private clinics are reported to be conducting the operations illegally. Where private clinics are not accessible, the old Maasai traditional practitioners use ‘innovative’ objects such as “knives, scissors, razor blades, broken glass” (Blyth, 2008, p.213).

The practice is widespread. The unveiling of the problem has produced a strong effect on International forums as a gross violation on human rights for women and girls all over the world.

Kenya has committed itself to some international agreements developed to eliminate FGM. The commonly mentioned ones are the Convention on the Elimination of All forms of Discrimination against Women (CEDAW), United Nation Convention on the Rights of the Child (UNCRC) and the African Union Protocol on the Rights of women in Africa (CEDAW country report; 2009; Mildred, & Plummer; 2008; African Union Protocol on the Rights of women in Africa; n.d).

Statistics estimate:

That 91.5 million girls and women older than nine years in Africa are currently living with the negative irreversible consequences of female genital mutilation (Lindner, 2008).

In Kenya, the Gender Minister, Esther Murugi (“Fight against FGM continues in Kenya”, 2009) gives an account of 37 tribes in the country out of a possible 53 tribes who continue to practice FGM; particularly in the rural areas, despite the illegalization of the practice ten years ago (from the time of this study). Although 38 percent of Kenyan
women from these 37 tribes have been circumcised (Whiting, 2002), a baseline survey conducted in Kajiado district by the Ministry of Health and GTZ (Evelia, Sheikh, & Askew, 2008) indicated that 93.9 percent of Maasai women and girls in the area had undergone FGM and that in some parts of the district, a prevalence rate of 100 percent was recorded.

The Government has adopted a plan of action to stop FGM through program activities that sensitize the communities on the dangers relating to FGM and has established services to provide healthcare and counselling for physically and psychologically traumatized girls and women (Evelia, Sheikh, & Askew, 2008).

FGM has been found to result in traumatic physical consequences, often lasting throughout the women’s life time. Use of the same instrument during multiple surgeries increases chances of infections. Similarly, when wounds do not heal well this creates a high chance of HIV transmission through vaginal or penile fluids during sex. Further studies of the Population Council (2007) linking FGM with HIV as an indirect cause of increasing women’s vulnerability to infection through several pathways found:

Cut women are 1.72 times more likely than uncut women to have older partners, and women with older partners are 2.65 times more likely than women with younger partners to test positive for HIV. Cut women have 1.94 times higher odds than uncut women of initiating sexual intercourse before they are 20, and women who experience their sexual debut before age 20 have 1.73 times higher odds than those whose sexual debut comes later of testing positive for HIV (Yount, & Abraham, 2007, p. 73).

The procedure of FGM also contributes to both psychological and physical consequences such as:

- anxiety, terror, betrayal, depression, humiliation, sexual dysfunction, impaired sexual fulfilment and physical consequences such as severe pain, haemorrhage, damage to tissue or organs surrounding the clitoris and labia, urinary and reproductive tract infections, fertility difficulties, painful or dangerous sexual intercourse and death (Blyth, 2008, p. 213).

When seeking to understand the reason as to why Maasai performs FGM on girls and women a UNICEF (2005) survey indicates that women cite custom and tradition or that it is a ‘good tradition’ as the main reason for carrying on with the practice.

Some Maasai will continue to carry out FGM as propaganda continues to perpetuate the practice (IRIN news, 2010):
A senior FGM ‘surgeon’ is convinced that FGM is the only way to stop a girl or woman from sleeping around with any man she meets, be faithful and not bring the disease to the community. Maasai believe that the practice marks the entry of a girl (child) into womanhood and this is when a woman can begin to engage in sexual relations including marriage (IRIN news, 2010).

Nnaemeka and Ngozi (2005) advises that it is worth considering the notion of custom and tradition (UNICEF, 2005) that applies to FGM and to establish the particular socio-cultural context within which it is psychosocially perceived and practiced (p. 221). The concept of how to maintain the identity of Maasai develops over a long period of time. The Maasai community, particularly the girls and women practising FGM, are highly patriotic to their culture for genuine reasons of maintaining their identity as Maasai to fit in the cultural paradigm. The initiation process of a Maasai girl into womanhood is socially and psychologically significant and related to the hope of being accepted into marriage and family life. It also means a hope of not being rejected as a sexual partner:

Although individual influences on circumcision are possible, decline in the prevalence of the practice is likely to take place simultaneously across social groups, rather than as a result of isolated individual decisions (Guttmacher, 2005).

It is simply human nature for Maasai girls and women to depend on the wider social group because that is where their human needs for survival are met.

The majority of Maasai girls and women will almost fiercely defend this survival tactic against any rallying cry intending to change or abandon the practice.

**Warrior Period (Moranism)**

Moranism is a significant period in Maasai social organization. It is a period where young Maasai men known as Morans (warriors) join in fellow age mates in remote isolated forest camps (*Manyatta*), for the purpose of safeguarding the community (Hodgson, 2004).

This study notes that in areas where insecurity is not a serious concern, the Moran’s role of safeguarding the community diminishes. The study does not intend to suggest any irrelevance of Moranism. In fact, it recognizes its significance as a necessary period that sustainably preserves Maasai culture and offers the community surveillance.
The concern for this study regarding this period is the way in which it enhances sexual exploitations through practices such as Esoto. Morans (warriors) who are usually of the same age set are a highly esteemed component of the Maasai social organization. Gender dissimilarities and unequal power identified among Morans, influence women’s ability to; negotiate safer sex and for some, maintain sexual consent. This period has crucial implication on young unmarried Maasai women’s reproductive health.

**Esoto a Sexual Practice Influenced by Moranism**

The Moran period sees young men, particularly those in communities where insecurity is not an issue, underutilized with minimal or no productive activities to engage in. This gives the young men and women the opportunity to practice a category of sexual activity known as *Esoto*.

*Esoto* derives its name from a hut or dwelling place where sexual activity is conducted among Morans with unmarried women or girls. Esoto is similar to a sexual orgy; a type of unrestrained sex or a splurge of sexual activities involving multiple partners. The activity allows swinging of one sexual partner to another. The high risk surrounding this practice is the inconsistency or lack of condom use at the time of spontaneous intercourse. The practice encourages frequent unprotected sex without taking into account the spread of sexually transmitted infections especially HIV (Seleman, 2007).

Seleman (2007) reports that Esoto; also known as Oloipi by another section of Maasai group in Kenya is one of the reasons that have seen younger girls encounter early sexual experience:

> Prepubescent girls; as young as eight or nine years engaging in forced sexual intercourse with the Morans (warriors) who take advantage of the girls caring for young boys who have just been circumcised residing in the hut (Mbugua, 2007).

While considering Mbugua’s (2007) presentation, Esoto encourages the issue of gender based violence through sex without consent which can be defined as rape. The author also notes that the recently circumcised young men are initiated into a culture that disregards women’s dignity. This type of socialization is not only harmful to the young women’s reproductive health, but equally unfair to the young circumcised men who look up to the older Morans as transmitters of knowledge about Maasai culture:

> The youth are given a lot of freedom and they have an open field for practicing sex. You are encouraged to use your youthful energy and
then by the time you are an elder, you settle down” Moono responds to IRIN (IRIN, 2003).

Within the order of age, authority and gender, some warriors (Moran) consider Esoto a conjugal right that lends them the license to acquire sex at anytime with or without women’s consent as a form of ‘play’ or entertainment (Talle, 2007).

This sexual practice becomes a system where young boys and men continue to learn that it is perfectly normal to deny women the right to abstain from sex if they wish. Also, the girls can be exposed to STIs, which can occur if the boys are infected and do not chose to protect the girls. It also socializes young girls and women to accept such injustices as ‘normal’.

**Relating Tourism and Moranism**

To a larger extent, the tourism industry is highly significant in the presentation of Moranism as having some positive attributes. Tourists come to Kenya from all over the world to learn and interact with their distinct way of life. The Maasai are considered the only natives of Kenyan descent who have struggled and managed to preserve most, if not all of their culture. They are thought “to be the best known African ethnic group outside of Africa” (Igoe, 2001, p. 1). In contemporary society, their fame is reflected through “images found in coffee table books, television commercials and tourists brochures” (p. 33).

However, the author also identifies literature (Igoe; 2001, Middleton; 2004) that suggest Moranism, and the roles involved, has been presented in certain discourses that are detrimental to women’s integral development.

On the aspect of sexuality, Middleton (2004) notes that the industry creates an entry point for sex tourists to explore their sexual fantasies:

> Which view warriors as belonging to ‘wilderness’ and of ‘wild’ sexuality. Their sexual fantasies signify the unconquered, who have the power to control the sex tourist who observe and pay the warriors” (p. 71).

The economic situation of the Maasai is said to be the root cause that escalates the social problem:

> Sex tourists are aware of the economic poverty facing local people who are willing to do whatever they can to benefit materially from the tourists, and younger people in particular are attracted by the material
wealth and behavioural freedom of the tourists, of which they have some knowledge through media (p. 71).

Young women and girls who have unsafe sexual relations with the warriors are at risk of contracting common sexual infections that increase their chances of further contracting the incurable HIV infection (Dyk 2005).

Sex tourism does not give an opportunity for some Morans to consider the consequences of unsafe sexual freedom rendered to them through customs such as Esoto, rather it reinforces the practices.

**Early Marriage of Girls**

The term early marriage began during UN declarations that emphasise young girls should be protected from any form of physical and psychological harm (UNICEF, 2001). Early marriage is a cultural practice where Maasai girls as young as thirteen are offered for marriage usually to men older than them.

Concerns around reproductive health seek to identify whether girls younger than eighteen years are psychologically and physically prepared to meet requirements within the union of marriage. These requirements potentially involve meeting her husband's 'conjugal rights', undergoing conception and delivery, raising children, performing domestic tasks and making sound decisions concerning household care giving.

Low socio-economic status and culture are the motivating factors behind the practice of early marriage (Bunting, 2005). From an economic point of view, some households view girls as 'gold mines' that increase family wealth through combined cattle and cash dowries. On the other hand, fathers are relieved of the economic constraints that come along with raising children (“Barriers to girls’ education” 2007).

Socio-cultural motivations include bearing many children with the aim of ensuring clan survival. In some instances, prominent families want to maintain their name to the next generations so that glories associated with achievements are preserved and widely praised.

However, there are other dire consequences of early marriage that raise serious human rights issues. One such issue is domestic violence based on gender, physical and economic power:
In Kenya, girls who marry before the age of twenty (20) are three times more likely to be the victims of physical abuse than girls who marry later (Miller, n.d.).

It is highly likely that such girls may not be physically fit to defend themselves when confronted by their older husbands who naturally may be stronger than them.

Wife battering is accepted in Maasai culture and culturally understood as ‘disciplining’ or punishing a wife perceived to have done wrong (Ampofo et al. 2004):

Cultural understanding of men’s right to control women leads many societies to condone the physical disciplining of women and girls (p. 685).

Another consequence early marriage has on reproductive health is its potential to quickly spread STIs particularly in polygamous unions:

It is common for young girls to be married off to older polygamous men as additional wives, have sex within or outside marriage and become infected more easily in any act of sex with an infected partner than men will (Clark, Bruce, & Dude, 2006, p. 79).

The curiosity of exploring sexuality associated with puberty and adolescence could be a possible reason why young girls seek sexual adventures outside their polygamous marriage. The mere understanding that the decision to marry was made by her family without her consent triggers a lack of interest in the marriage. It is also noted that there is a strong possibility that some young girls would be less attracted to older polygamous men as compared to younger men. Due to age differences and a generation gap, it is also possible that their older husbands may not retain the sexual demands of their youth. This array of possibilities should be considered especially when looking at how the spread of STIs including HIV is catalysed.

Another consequence early marriage has on young girls is that it cuts short educational opportunities that would increase their life skills. This means that their negotiating ability in matters concerning their reproductive health and sexuality are compromised. One example of this compromised decision making ability is how to know when it is safe for her to conceive and deliver children. Alarmingly, pregnancy is the major cause of mortality for young women ages 16 through 20. Reproductive health of pubescent women in low and middle income countries as Kenya depends on biological, socio-economic and cultural factors (Shariff, 2008; Milkowski, 2004, Graczyk, 2007).

The issue of school dropout rates among Maasai girls because of early marriage is disturbing. The culture rules out the significance schooling can have on young girls’
health. The Kenyan education curriculum incorporates sex education in health related subjects such as biology (Wright, 2005). However, if girls are not attending school they miss out on these lessons.

**Polygamy**

Polygamy is a traditional practice within the Maasai culture where a man has more than one wife. The practice is considered legitimate if the man can meet all the basic needs of his wives.

This study differentiated between the practice of polygamy and promiscuity. The latter is used to describe a practice based on moral judgment. Promiscuity is more associated with negative than positive connotations. May (2003) has sought to clarify moral judgments placed on the traditional form of marriage by the Western world. The risk of such misconceptions:

> Allows for bias in scientific investigations, illustrates the racial, ethnic and social stereotypes that can perpetuate inequalities in the international political arena pertinent to issues of disease, care and suffering (p. 6).

Kenya being part of Sub-Saharan Africa is widely affected by reproductive health related issues hence the need to rely on donor funds especially when governmental funding is strained. Decline in donor funding is one of the reasons MDGs relating to health delay implementation of health programs (“Millennium Development Goals in Kenya”, 2005). Biases discourage fundraising opportunities in developed worlds. This in turn means that health issues such as STI (including HIV), family planning and lack of capacity-building continues to persist.

The status of Kenyan law regarding multiple partners in a marriage under the Marriage Bill cap 150 (Laws of Kenya, 2008) states that:

> If either of you (couple) before the death of the other shall contract another marriage while this remains undissolved, you (couple) will be thereby guilty of bigamy, and liable to punishment for that offence (p. 10).

At the same time, Kenyan laws do not restrict customary laws that recognize polygamy. Nevertheless, this type of marriage offers women, particularly those influenced by modern lifestyles and who contribute to marriage assets, little or no protection in law:

> Women in polygamous unions face additional barriers to realizing their rights to equality as they have no say in whether he (husband) may use her (wife) existing matrimonial property to acquire and
support additional wives and their children ("Kenya’s Laws and Harmful Customs curtail women’s equal enjoyment of ICESCR Rights", 2008, p.2). This is as a result of patriarchal structures resulting in a lack of economic rights pertinent to the ability of women to fund their reproductive health needs.

Existing literature (Wright, 2005; FEMNET, 2008; “An overview of HIV/AIDS in Kenya,” 2002; Mahmud, 2004) indicates the magnitude of HIV and AIDS in Sub-Saharan Africa (including Kenya) which widely affects women as a result of cultural practices such as polygamy. The findings suggest that STI’s including HIV and AIDS challenges the practice of polygamy:

Sixty eight percent (14 million) of those infected with HIV are women and adolescent girls. Seventy five percent of all HIV positive women in the world are African owing to polygamy (FEMNET, 2008).

Ways in which STI’s escalate within polygamy include; inconsistent or lack of condom use and difficulty associated with controlling and managing sexually transmitted infections in multiple partner unions.

**Contraception Use among Maasai**

Prevailing gender relations characterized by the cultural construction of femininity and masculinity influence contraceptive choice particularly in rural areas such as Olchoro in Loitokitok district of Kenya (Dodoo & Frost, 2008). Dodoo and Frost (2008) attribute this to “the role of dowry; which undergirds marriage, in transferring decision making power of reproductive matters to husbands” (p. 49). Young Maasai women with few life skills, often rely on their husbands to make decisions on their behalf.

The significance of dowry in exchange for a bride means that the young woman belongs to the husband and the new family that adopt her. The husband and her new family have a great stake on most reproductive choices of the couple. For instance, if parents-in-law indicate a need for children to be born, she has the obligation to conceive and bear children for the collective consideration of the clan. This further illustrates the women’s inability to negotiate condom use on equal terms at “high risk of unwanted pregnancy, illness and death from pregnancy related causes and sexually transmitted infections” (Bellamy, 2004)

Another factor influencing the status of contraception use among Maasai is the unmet need of contraception:
In 2007, one in four married Kenyan women could become pregnant, did not want a child soon or at all were not using any method of contraception ("Facts on abortion in Kenya", 2009)

Factors affecting contraception in Maasai include the geographical location where the environment is considered arid and semi arid lands with low access to health facilities. People in the area have to walk long distances; even during emergencies, before they can access any facilities. In addition, poor transport and road infrastructure discourage medical personnel from reaching the community that requires contraceptive services. Medical extension workers also face the challenge of inadequate storage facilities for medical supplies (Houten, 2005).

Besides difficulties in accessing contraceptives, the majority of those that intend to use contraceptives are not able to afford the different types on the market. Particularly for young people, the use of one method - much less two- can be difficult enough. Many adolescents cannot afford two methods or cannot obtain them both. Also, adding a second method may impair consistent use of the first ("Dual protection avoiding pregnancy and HIV/AIDS", n.d.).

**Factors Affecting Condom Use**

Owing to the focus on STI’s, primarily HIV/AIDS, as an important aspect of young women’s reproductive health, the author discusses condom use identified as the only contraception that can reduce these risks.

Shoveller et al., (2004) consider some of these factors to be driven by the cultural definition of masculinity and femininity.

Booth (2004) notes that because of cultural factors, women will not suggest to their partners that they take measures to practice safer sex even when they are aware their partners have other sexual partners outside their unions. Earlier in the study while discussing early marriage and polygamous unions and how this influences negotiating ability, the study noted that young girls become intimidated by age difference and socio-economic power. Associated with having older sexual partners is the fear of gender based violence referred to as ‘disciplining’ in Maasai culture, and this affects condom negotiation (Bellamy, 2004).

Another cultural factor identified as affecting condom use is the issue of its appropriateness within Maasai culture. Although condoms have been identified as the
only method that reduces rate of STI’s, it also reduces chances of conceiving. As it is in most African cultures, having children in Maasai culture is highly regarded:

Children are not only valued for ensuring immortality, but are also very important in day to day existence. A man’s wealth depends upon the growth of his tribe. (Ambasa, 2002; Dyk, 2005:121)

In the context of Maasai view, Coast (2007) refers to ‘wasting sperm’ where condoms prevent the purpose of intercourse.

Other cultural factors influencing condom use are attitudes and stigma attached to this type of contraception. Houten (2005) has found out that some social workers widely influenced by their culture consider condom distribution as non-essential and discourage the local people from using them. Equally, the general public reflects the same attitudes by claiming that condoms are ineffective to prevent HIV infection. Rumors circulating in some communities have it that the condoms have perforations from low quality manufacturing therefore allowing HIV (Mwarogo, 2007).

**Maasai Female Socialization Process**

Maasai girls are born into an environment that socially and culturally constructs femininity and masculinity. A cultural construct may be defined as ideas embedded in culture and characteristics such as gender, status of men, status of women, are culturally defined by people (Oregon State, 2008). Cultural constructs are unrestrictedly maintained; therefore they are dynamic and can evolve over time (Kottak, 2002).

Cultural practices identified for this study put forward that female passivity is the essential characteristic of the ‘feminine’ woman (Freeman, n.d.). Yamaguchi (2006) further illustrates that this trait develops in her from the earliest years by stating:

> It is during early childhood and adolescence when children are largely influenced by cultural schemas of appropriate behavior and if gender differences are apparent it is during these times that they are most exaggerated and expected (p. 275).

As young girls grow, they internalize cultural schemas prevalent in Maasai cultural discourse about sexuality within customs such as FGM, early and polygamous marriages and Esoto. Older women particularly those close to a girl such as mother and aunts also play a vital role of teaching girls how to become an ideal Maasai woman. Ambasa (2002) states that:
The system has a potential for girls to view themselves in their role as self-sacrificing, aspiring to be good wives and mothers who pass on perceived good values to the next generation. Whereas the social organization and age-set system prepare boys to aspire to greater opportunities in life including making decisions in all spheres, not necessarily including consultations with women (Ambasa, 2002, p. 11).

The social organization of age-sets portrays male preference and renders them all power in socio-economic and political institutions that influence women's reproductive health. Bem’s theory of gender polarization attributes the dissimilar aspirations between men and women to traditional perceptions that men are naturally superior to women (Kornblum, 2008, p.343). One example of this relates to the low enrolment of Maasai girls in schools; compared to boys, and high dropout rates of the same. Girls are ‘schooled’ in domesticity to fulfill their gendered roles and aspirations to be ‘good wives’ while the boys venture into learning institutions to enhance their capacities and opportunities.

**Property and Inheritance**

Conventionally, Maasai women do not acquire inheritance of any economic assets or property. Like most ethnic groups in Kenya, culture rationally assumes that once a girl has been born, her basic needs are provided for through her father’s economic ability. Once the time comes for her to be married, it is presumed that her husband and new family will take over the responsibility of providing her needs. Traditionally, the woman should not lack basic needs within the family she has been adopted by. Part of the significance of dowry illustrates the husband and his family’s ability to sustain the wedded woman and the children she will bear. The woman’s family that receives dowry are settled peacefully assuming that their daughter will be well taken care of in her new family (Zachary, 2003; Walsh, 2003).

The dowry narrative assists in understanding the bona fide tradition as to why Maasai women did not inherit any property. On the other hand, Maasai men have been allowed to inherit from their fathers or uncles because socio-economically, they are considered as ‘bread winners’ and the economic pillar of their households.

However, the current socio-economic situation is characterized by low rural livelihoods. Men are equally hard hit in the current Kenyan economy. Women are now just as involved in contributing to household economic assets as men. For example, they provide labour by working in husband’s farms or any other property to boost production.
and alleviate economic pressure placed on partners. The issue of injustices arrives when women are excluded from the right to equitably own combined assets that has been the fruit of labour by both partners. Customarily, all the property and assets will continue to remain under the husband’s name. In the event her husband dies, property and assets will be inherited by a certain male in-law.

Part of the fruits of her labour will unfairly go to her in-law who may be equally battling similar economic hardships and in fact considers the deceased inheritance a relief. With the current customary laws, women are no longer guaranteed economic protection within traditional marriages. The laws retain the traditional norms of practices and do not recognize the right of women to possess or dispose of matrimonial property (Benschop, & Sait, 2006).

A woman who does not have a son to immediately inherit her husband’s property is more at risk. She may not have close kin to take care of her economic needs.

Another cause of injustice is when a man decides to marry more wives and the matrimonial property; equally laboured with the first wife, is partly allocated to co–wives and their households. Women’s labour is not measured as a factor of production that contributes to the overall economic gain of economic assets. For these men, the ends justify the means; economic power. Customary laws do not have any provisions for all these concerns around justice regarding property ownership. Such women are not able to exploit other micro-economic initiatives due to a lack of assets and they cannot obtain credit due to a lack of collateral. This leaves them more vulnerable to infection by having to depend on men or other significant members of community and therefore not able to negotiate for their own reproductive health (FEMNET, 2008).

Education

It is proposed that education is one of the tools that are helpful in realizing development goals related to women’s health (Roy, Giovannini, & Satterthwaite, 2008). Existing literature (Evelia et al., 2008; Mulama, 2009; Panda, & Sehgal, 2009) validate education as a tool that potentially deters certain customs and sexual practices that impede Maasai women’s reproductive health. This study discusses education in the context of institutionalized schooling.

A study conducted in Kajiado district to investigate the prevalence of FGM among Maasai in the area (Evelia et al., 2008) found that:
Among girls whose mothers had secondary school education, less than one-third (29%) had been cut, compared to 72 percent of girls whose mothers had no schooling, girls with secondary school education were less likely to have been cut” (p. 3).

This is because the education curricula in Kenyan schools incorporate human sexuality and reproductive health studies in relevant subjects such as biology. By the time students graduate from primary and secondary school, they are equipped with basic knowledge on sexual and reproductive health. This initiative is the Government’s response to intervene for the plight of HIV and other STI’s facing young people in Kenya. Other initiatives include health clubs such as the Girl Guide movement where peer education on STI’s including HIV and AIDS programs take place (Waweru, Kiplagat, & Mwaniki, 2002). A female Maasai student reports, "we are taught in our school health club that FGM is a harmful practice, and I wish the Maasai would stop forcing girls to do it," (IRIN News, 2010).

Other practices like polygamy have been identified to be more prevalent among women who are not educated than those who have had some education. Mburugu and Adams (2004) state latest statistics from the Kenya Demographic and Health Survey (KDHS) that:

The proportion of married women in polygamous unions in 1998 ranged from 29% among women with no education to 11% among women with at least some secondary education (p. 8).

In the case of young Maasai women in rural areas such as Olchoro Sub Location in the Loitokitok district of Kenya, the author proposes that the young women are more inclined to such practices because they are not exposed to knowledge that informs them on the risks surrounding polygamy. Obeng’, (2005) confirms this by stating that:

Rural residents and less educated women are more likely to be in polygamous marriages and those women with this characteristic, tend to be more traditional in outlook. This also associates women with low status (p.7).

Education provides knowledge that is powerful in assisting women make powerful choices regarding their reproductive health. Their voices are restored to express their views on practices that compromise their sexuality. Their negotiating ability is increased, they are able to identify and make choices on whether or not to carry on with practices with full knowledge of the impact on their health (Grown, Gupta, & Pande, 2005). Further, young women are more likely to understand the cost of risky behaviour (Mulama, 2009).
However, there are challenges that face the aim of education. The author notes critical areas of consideration; the impact of Western forms of education on Maasai culture, disintegration of the community support system as an Impact of educating Maasai women and gaps within the education system of Kenya.

**Impact of Western Form of Education**

The Maasai’s have critiqued the education system in Kenya as borrowing too widely from Western ideologies.

The claim is that the current education system does not promote Maasai ideologies based on a culture of collectivism but rather promotes Western thoughts and ideologies that are individualistic (Phillips, Jacqueline, & Peshotan, 2002). The concern Maasai have is that the skills sought from the current education system in Kenya are not transferable to the next generation.

An individual goes to school, and benefits individually hence not contributing to the community. In the case of educating women, Maasai culture argues that the women like other educated persons, help disintegrate the community. The aspect of social cohesion of Maasai is an important cultural aspect of a collective culture.

**Disintegration of Community Support Systems as an Impact of Educating Maasai Women**

Women are more susceptible to the experience of social stigma brought about by education. Some conform to cultural expectations end up in marriage to avoid the stigma and isolation from the community. “Western forms of education remove a woman from society’s efforts to accommodate or integrate her once she completes her studies” (Kanogo, 2005, p. 198). This works against more girls completing school education.

Maasai girls that pursue their education rights through adulthood seem to be more isolated and displaced than girls who stay on in the community and continued their family life processes as expected by culture. Integrating a Maasai woman back into a patriarchal community is psychologically a daunting experience for her as she faces ridicule and social stigma.

Most of these women hesitate over going back to their original community because of the continuing cultural and sexual practices which they have come to have a different opinion about. These women even if married, will migrate from ancestral homes to find
societies, mostly in urban areas, where they can co-exist with the few others who are similar to them (Mburugu & Adams, 2004).

**Gaps in the Education System**

Women’s education is affected by the regional disparities that widen the gender gap in the country’s education system. Economically advantaged regions have more schools and record higher rates of participation by girls. Mugisha, (2006) connects this to the concept of “urban advantage” which is associated with increased access to facilities such as schools in urban areas than in rural areas.

As the Kenyan Government strives to achieve its Education for All (EFA) goal; set in the Dakar Framework for Action, its quality, relevance and external efficiencies have been checked. There has been a downturn in pupil performance within the last three years (2007-2010). Girl dropout rates are explained by factors such as early marriage or pregnancy as reported by Oketch and Rolleston (2007)

**Girl’s Participation Rates in Education in Loitokitok District**

Loitokitok is one of the rural areas where the number of schools is low and those available are scattered all over the vast district therefore making it particularly difficult to access school facilities. Cultural issues as discussed in this Chapter hinder girls’ participation to school and hence, there is always a disparity between girls and boys enrolment at a particular point. Statistics showing literacy by gender and region show that in the Rift Valley province; of which Loitokitok is one of the districts consolidating the province, “73.2% of women are literate as compared to 83.9% men. In the same province 17.4% have no education as compared to 10.2% of men who have no education” (“Educating the new generations,” 2005).

There are extremely high school dropout rates in the Maasai area. According to Gachukia, (2004), of all the girls who enrol in standard one, only 34 percent accomplish Kenya Certificate of Primary Education (KCPE) as compared to 70 percent for boys. Among reasons associated with low performance are lack of motivation, poor teaching, disenabling learning environments, gender stereotyping and misrepresentation of the roles of women and girls, and burdensome, time consuming domestic responsibilities which leave girls with little energy and little time to study. Field studies have noted that “In a few instances, girls in Kenya are made to sacrifice moving to the next class, some dropping out completely, to enable their brothers to repeat and gain a better chance of enrolling in Secondary school. The reverse is unknown” (Gachukia, 2004, p. 3-4).
Summary

This Chapter reported on the issues identified earlier in Chapter One. Chapter Two looked at a range of literature and studies from different authors who have written topics based on cultural practices that influence women's ability to negotiate their own reproductive health. The chapter bases the research study on principles of feminist ideology which identifies the relationship between gender and patriarchism as important factors to consider when looking at Maasai women’s reproductive health status.

The chapter looked at literature works that provided possible reasons as to why women’s reproductive health status is the way it is in the present Maasai.

Chapter Three discusses the methodology and provides an analysis of how the data was collected for the research project.
CHAPTER THREE
RESEARCH METHODOLOGY

Introduction

Chapter Two reviewed a range of literature and studies from a variety of sources which cover cultural practices that influence women’s ability to negotiate their own reproductive health.

Chapter Three focuses on the research methodology that was utilized in this study. Firstly, the participation approach which provided a foundation to carry out research within a qualitative paradigm is discussed.

The chapter also describes research methods that were employed to elicit qualitative information from young Maasai women from the Loitokitok district in Kenya. The chapter also provides samples and how these samples were arrived at.

Finally, the chapter describes how data analysis was carried out.

Participatory Research Approach

The participatory research approach is a significant aspect of indigenous research methodology which regards the values, beliefs, practices, customs and historical experiences of the group (Smith, 2006). While conducting research with indigenous peoples such as Maasai, Mkabela, (2005) states that “cultural aspirations, understandings, and practices should position researchers to implement and organize the research process” (p. 178). This research notes the importance of taking Maasai women as a single group considering the characteristic of collectivism identity defined in terms of relationships to others (Ma, & Schoeneman, 1997 p. 262).

De Laine (2000) presents a more humanistic approach to participatory research by stating:

The researcher is in the ‘round’; is the thinking, feeling human being who is caring, sharing and genuinely interested in friendship and the needs of others. It puts researchers in more contact with participants in more sensitive ways and is upholds maturity, greater sensitivity, authenticity and integrity (p. 16).
The level and quality of participation affects the type of relationship that will be fostered between researcher and research participants. The researcher recognizes that participation is an entry point that determines if the intention to interact with local people will be attained at all. The study proposes that for the research purpose to be fulfilled, successful relationships between researcher and research participants are a prerequisite. The research acknowledged that young Maasai women are a distinct cultural group that have their own distinct truth-seeking suggestions that are based on knowledge, values, reason, and belief systems.

The participatory approach guided the research with the assumption that young Maasai women prefer to relate interdependently in their day to day lives. Part of their collective culture, is to develop support systems where they look out for each other.

The Africana Womanist Literary theory (Afro-centric theory) fits in the context of research with Maasai women. The Afro centric theory states that “a critical component of Africana Womanism explains the value of the spirit of collective consciousness, mutual reciprocity, and role sharing” (Cooper, 2009, p. 286). Participative approaches in research are viewed as ethical and valid at the community level in developing countries (Smucker et al., 2007, 389).

**Research within a Qualitative Paradigm**

This research is situated within a qualitative paradigm that attempted to discover knowledge, attitudes and practices of Maasai women in relation to reproductive health with a focus on HIV/AIDS.

This paradigm positions the researcher at a point of listening to other people’s stories and piecing together an over-all narrative about their lives. This process assists in expanding knowledge in an area of interest and later translating the findings in a narrative layout (Kouritzin, Piquemal, & Norman, 2009):

> It is argued that a qualitative approach ensures a degree of participation not possible with a quantitative perspective (May, 2002, p. 261).

However, there are diverse complexities in establishing a qualitative study with competing opinions as to what counts as appropriate ways to ensure good research knowledge (Seale, 2003, pp.1:2). There is no best research paradigm to research as the important aspect is whether research objectives have been achieved in a rigorous and valid manner. Mays and Pope (2000) posit that good research depends on the
methods applied and how they contribute to the general rigor of the study. Further, Cohen and Crabtree (2008) state that:

> Appropriate methods are those which ensure clarity and coherence that portray the intention of the research, establish validity and credibility and minimize research bias as much as possible (p 331).

This research utilized qualitative methods that best suited the context in which the participants were involved in. For example, focus groups suited the cultural context where Maasai women like to gather together to talk and ‘hang out’.

However, there are limitations to using this approach to research. Qualitative research is more interested in finding out why certain occurrences appear the way they do. In most cases, when the researcher wanted to pronounce the magnitude or extent of certain occurrences and events, unquantifiable phrases such as majority, most or fewer than, were used. Qualitative research would be a limitation especially when addressing interested parties who have an empirical background. This research would be useful to social policy makers, program implementers but will be statistically insufficient to interested parties such as resource allocators, budgetary organizations and demographic surveyors (Puchta & Potter, 2004; Hennink, 2007).

Researchers adopting a qualitative approach are open to a diverse range of outcomes and data from their research participants, particularly, within dynamic cultural contexts such as this research where the topic dealt with contentious issues relating to sexual practices and culture.

**Applied Local Protocol to Collect Data**

An application to the Kenyan governmental authority to seek endorsement for the research was sought prior to the data collection process. This application was submitted to the Permanent Secretary, Ministry of Education in Nairobi, Kenya. The research was approved through a local ethics committee and a research permit obtained to go into the community and collect data as per the research design (see appendix 1).

Consent forms and information sheets were read and presented to all research participants. Everyone that participated in the research process gave their consent by signing a consent form (See Appendix 2).

The local Tumaini VCT (Voluntary Counseling and Testing Centre) in Loitokitok Town was approached to assist with finding participants. The Tumaini VCT works with youth
groups from the area and this seemed a useful organization to make contact with. The Tumaini VCT recommended contact to be made with a particular youth group that had been established since 2000. This group (which will not be named in order to protect confidentiality) was well known in the local area and the recruitment of participants was relatively uncomplicated as there was a desire to share their experiences.

Another organization; *Mainyoito Pastoralist Integrated Development Organization (MPIDO)*, provided an opportunity through facilitation to accompany them in their work of Girls' education program in the community. This was invaluable in getting to know the local area and its people.

Research assistants, Leah Maiyeso and Christine Kemuma were recruited through a Social Worker in the area. Leah was a young 24 year old woman of Maasai descent. She was a peer educator which means she was trained to educate her peers about HIV and AIDS. She was fluent in Swahili, English and Maa and consequently, made very useful contributions to the research. Prior to the data collection Leah was given training in translation and provided an outline with the aims and objectives of the study. Christine M. Kemuma was a young Kisii woman, (like myself) and her main role to scribe. She took the notes during the interviews and focus groups. The support of the research assistants, the social worker, the *Tumaini* VCT counselor; Laban Leberet Samperu, the Youth Group Chairperson and various others were invaluable to the over-all research process and ensured it was not carried out in isolation. The community connections enabled the research to take place and were partially responsible for facilitating the rich data that emerged.

**Data Collection**

**Focus Group Discussions**

Hennink (2007) defines focus group discussion as, “a unique method of qualitative research that involves discussing a specific set of issues with a pre-determined group of people” (p. 4):

> This method is commonly used to ascertain information on collective views of social issues, such as a community’s perceptions of HIV risk (Desai, & Potter, 2006, p. 154).

It is a “goal of eliciting participants’ feelings, attitude and perceptions about a selected topic” (Puchta, & Potter, 2004 p. 6). The tool for the researcher (moderator) is conversation. It is significant in determining a successful
process of focus group discussion; one which realizes research goal (Puchta, & Potter, 2004).

The researcher utilized this method as a participatory process that fitted within the cultural context of Maasai culture. Holding important discussions in gatherings (Barazas) is a common African social activity also present among Maasai community:

Focus group discussions are similar to group discussions employed where selected members of a community are invited for a discussion by a chief, headperson of a ward, a village leader or a wise person such as a sage (Chilsa, & Preece, 2005, p. 154).

Barazas are held to raise awareness concerning particular social affair affecting the community. Collective wisdom is shared, knowledge is built and relationships forged on (“A baraza for Kenya”, 2009). Further, reciprocity and cooperation through mutual sharing is a strong cultural element among Maasai women. Fletcher (2007) considers the term ‘toiling’ when referring to the process women go about in their daily life in the village and gives an understanding of how women in such a set up are seen to care for each other and accept their lot; the focus group discussions were an extension of that.

The advantage that Participatory Research has over more traditional qualitative approaches such as using questionnaires is its potential to gain an insight into the participant’s self determinism nature. The process creates a bond among members that stimulates discussion in a free unrestricted environment.

The focus groups were conducted outside in open spaces, where privacy could be assured. The women chose this venue because they felt safe and comfortable in this setting and were familiar with it as they often met there in their daily lives. The researcher, the research assistants and the participants gathered together in a circle and carried out the discussions and shared food and drink. The sharing of food and drink was an essential part of the cultural dynamics of the focus groups and the women themselves prepared the food.

Young Maasai women who participated in this research were members of a self initiated youth group that addresses priority issues affecting the wider community through; peer education on HIV/AIDS, human rights issues and
creating awareness on importance of schooling for girls and boys. Their work was motivated by the perceived needs of the community including the needs of women and girls. Their similar experiences and beliefs about reproductive health issues affecting women enabled them to contribute in a focus group set up. Liebenberg (2009) attributes this active role to the focus group discussion method.

It was an advantage for the researcher to stay in the community, be accepted by the group and then become involved with an already existing women youth group to carry out the research. Research with an existing youth group helped manage confidentiality and minimization of harm. It was easier to tackle questions that were related to sexual practices since these matters were part of their group objectives.

The qualitative aspect of focus groups has also been applied in the reproductive health sector for programme evaluation; and so the women were familiar and comfortable with it:

> Focus group discussions have been used in a health and behavioral research, strategic planning, health promotion, policy development and programme evaluation (Hennink, 2007 p. 1)

This is attributed to the descriptive characteristic of the method that brings out lucid information. This research sought to explore information concerning the aspect of reproductive health that deals with contraception use, knowledge on common STI’s, sexual relationships and strategies considered by young girls and women as appropriate, practical and effective to cope with reproductive health risks. The focus group method has been validated through its usefulness in sexuality research. Research that deals with human sexuality is faced with conceptual, methodological and ethical issues. It has been suggested that the focus group method exists within a theoretical structure that integrates sexuality theory in research (Wiederman, & Whitley, 2009). Lederman’s theory (Wiederman, & Whitley, 2009) suggest that focus groups rest on four assumptions:

> People are a valuable source of information
> People can report on and about themselves, and they are articulate enough to verbalize their thoughts, feelings, and behaviours
The facilitator who focuses the group can be used to generate genuine and personal information.

The dynamics in a group can help people retrieve forgotten information (p. 174).

These assumptions guided the research and the focus group method was seen as an appropriate method that would deal with the research topics of cultural and sexual practices.

The focus group process was moderated by a discussion guide (See Appendix 3). Discussions were not limited to topics on the guide as the facilitator was in a position to identify which topics could be further developed to inform the research.

However, focus group discussions are limited and have several challenges.

The duration of time allocated to conduct focus group discussions apply differently across different cultures. Depending on cultural backgrounds; one group may want to undertake the process within forty five minutes, another would consider the process a day’s activity similar to other group activities undertaken in that cultural set up. Discussions with Maasai women took approximately two and a half hours. Challenges can occur when the researcher considers the participants’ important aspects of culture and at the same time has to consider available resources and the research goal.

Dealing with reproductive health issues that look into contentious issues such as customs, sexual practices and STI’s, requires a high level of ethical consideration. Such considerations could potentially limit the focus group process. For instance, it was not culturally appropriate to record voices or take photographs during the discussions. However, voice recording and transcribing are useful tools during data collection that inevitably assist in data analysis. Not being able to record also meant that the research assistants had to take copious notes and occasionally may not have captured all of the dialogue. Completing the research process, including focus groups within a pastoralist community also has another challenge in that participants may not remain in the research area. This is attributed to their pastoralist life style where migration is characteristic and could affect the feedback process if the research participants have migrated to another area.

Chilisa and Preece (2005) reinforce the importance of giving feedback of the findings to communities that contributed to the research and to avoid any “violation of the public’s right to know what has been written about them and what knowledge the research advances, that can benefit the community involved” (p. 233).
Semi-structured Interviews

In lay terms, an interview is a conversation between two or more people. The description becomes more detailed when moving from a generalized definition. An interview is guided by a moderator (interviewer) and involves a respondent (interviewee) who responds to the guided questions or topics. This research utilized a type of semi-structured interview because topics or questions had been predicted by previous focus group discussions. The respondents participating in this type of interview had previously participated in focus group discussions with women aged 16-25 years and were already conversant with the aims of research. The issue of rapport had already been created in earlier interactions.

The research sought to access a deeper understanding of topics that were generalized in the focus group discussions. The research was not necessarily looking to elicit information based on personal experiences but rather sought to draw out topics that were generalized in the focus group discussions. For example, trying to understand how female genital mutilation is perceived and how it is carried out requires a non-hypothetical response. The focus groups predicted questions which were generated from responses that the researcher used to pursue other questions of interest relating to the research.

The interviews gave an opportunity for the researcher to ask questions based on observations made during her stay in the research area. For example, why have most twelve year old girls shaved their heads? The response to this question was that the girls’ heads were shaved after their initiation into woman-hood. Shaved heads in this context symbolize a ‘transition into woman-hood and are seen as markers of maturity and also of beauty.

Semi-structured interviews were used to elicit relevant information based on areas where the research sought focused strategies the women considered appropriate to deal with risks surrounding reproductive health.

Although this type of interview gives respondents the opportunity to talk about research areas in detail and depth with minimal direction from the interviewer, there are challenges relating to this technique.

It is not advisable to use semi-structured interviews by themselves, but rather to combine them with other methods so as to increase reliability. This is because the
process is time consuming and samples tend to be small, compared to focus group
discussions where more than one person is interviewed within similar time duration.

Depending on the sensitivity of the topics being discussed, interviews like other
interactive methods may cause some emotional distress. The extent to which the
discussion focused on personal issues means participants may require some
professional therapy referral. Schwartz, (2008) states that, “the potential harm towards
participants must be weighed against the potential benefits to society and is contingent
on informed participant who voluntarily enrol”. In the event that this happens during the
interview process, the interviewer will be required to draw on skills of empathy and tact,
despite the fact that the interview process may call for termination or delay until the
interviewee calms down. If there is a likelihood that the distress may be repeated it is
wise for the interviewer to withdraw from the interview process. Bridgman (2008)
emphasizes that research interviewing is distinct from a counseling-type interview:

There must be a clear distinction between research and therapy
interviews, as almost all therapeutic orientations involve interventions
which are inappropriate for qualitative interviewing. E.g. it would be
wrong to conduct a qualitative interview in cognitive-behavioral style,
as this approach, like most therapies, is ultimately interested in
changing the client’s thoughts and experiences rather than finding out
about them (p.61).

Informal Observation

Observations were made during the field work process to note the following areas that
would inform the research:

- Existing organizations dealing with HIV/AIDS and other reproductive health
  issues
- The Maasai social environment
- Community social events to see how community members relate to each other

Secondary Sources of Data

The researcher reviewed relevant literature from libraries, complementary sources
which included journals, research abstracts and government development plan reports
on education and health as referred to in the literature review.
Sampling Techniques

Focus group discussions

Two focus group discussions were held. Two focus groups gave sufficient information for the research study as opposed to one. Each group; young women 16 -20 years and older women 21-25 years, had twelve participants (Desai, & Potter, 2006).

The available resources determined the number of focus groups the research could manage. They were inexpensive to undertake and time was a factor to consider. The field data collection process was confined to take place within two months of July and August 2009. This method was viewed as the most appropriate choice surrounding these circumstances.

Target Group

The research targeted the following groups:

- Young women 16-20 years
- Older women 21 -25 years
- Women in a youth group
- Maasai women from Loitokitok district in Kenya

The target groups were considered on the basis of their gender and age (16-25 years) and ethnicity (Maasai) of Loitokitok in Kenya. Based on the nature of the study which dealt with sexual practices within a cultural context, the researcher sought to identify Maasai women who were actively participating in a youth group dealing with HIV, cultural practices, human rights and education. The fact that the researcher was both an ‘insider’ and an ‘outsider’ assisted in managing the cultural considerations where issues around sexuality may not be an easy topic to confront for some cultures.

Samples

The researcher considered how women of different age groups related as peers. Categorizing the women into two age groups ensured that power and social status was taken into consideration and encouraged participants to mix freely (Desai, & Potter, 2006).
Social interaction is the main advantage of the focus group method, the researcher must carefully consider the social composition of the group e.g. age, ethnicity or gender (Desai, & Potter, 2006, p. 157).

It was also necessary for the researcher to have the two age categories to assist in comparing information when findings were established at the end of the research. Comparisons of findings based on responses from different age categories could be attributed to age or difference in generation e.g. the word ‘sex’ could be conveyed by different words but have the same meaning among different women of different age groups. When grouping all women 16-25 years, the researcher would not have picked up discrepancies that were important for informing the research.

**Semi-structured Interviews**

Eight semi structured interviews were carried out during the research with Maasai women who had previously participated in focus group discussions of this research study. Four Maasai women 16-20 years were interviewed and another four Maasai women 21-25 years.

Eight Maasai women participating in the research was viewed as a sufficient representation as opposed to considering individual representations for the research (Desai, & Potter, 2006).

**Data Analysis**

**Thematic Analysis**

A qualitative paradigm may involve thematic analysis. Major themes that emerged from the focus group discussions, semi structured interviews and informal observations were identified.

Attride-Stirling (2001) has attempted to establish a type of thematic analyses termed ‘thematic networks’ where “web-like illustrations summarize the main themes constituting a piece of text. The thematic networks technique is a robust and highly sensitive tool for the systematization and presentation of qualitative analyses” (p. 385). Attride-Stirling (2001) suggests the utmost quest for qualitative researchers is to simplify the task of analyzing qualitative data. However, the author proposes that qualitative data could be analyzed in whichever technique a researcher innovates as long as the technique contributes to the rigor of research.
In this research, data analysis occurred throughout the research from taking notes in the beginning to the actual layout of findings.

Note taking involved jotting all information that was of interest to the study during the entire research process.

Secondly, transcriptions were made during agreed interval meetings between the principal researcher and assistant to avoid stock piling of information sought during the research process hence making the process manageable. The next step was to translate any data that was in Maasai or Swahili to English. However, most necessary translations were dealt with during interactions with research participants.

Thirdly, the researcher identified significant issues that emerged. The researcher aimed to understand these themes and developed ideas in which the themes have been interpreted.

Themes were organized and coded and data analyzed categorically.

**Summary**

This research was informed by the participatory research approach which was viewed as being highly appropriate for carrying out research with Maasai women. The chapter has described qualitative methods involved in the data collection process and how the sampling procedures were carried out. Finally the chapter discussed the thematic analyses technique in which qualitative data was analyzed. The next chapter deals with the presentation and analysis of the data.
CHAPTER FOUR

PRESENTATION, ANALYSIS AND DISCUSSION OF DATA

Introduction

The previous chapter described the research methodology that was applied in this study. It presented the methods that were used to collect data on perceptions of whether cultural and sexual practices contribute to Maasai women’s vulnerability to HIV infection and their ability to control their own reproductive and sexual health.

This chapter presents analyses and discusses themes that emerged during the discussions. Further research on the effects of these cultural and sexual practices is warranted.

How Young Women Talk About Sex

Young Maasai women (16-25 years) use slang words in conversations around topics relating to sex. These words change over time. Slang words provided in Tables 2 and 3 below illustrate how discussions about sex are concealed from people in the general public.

<table>
<thead>
<tr>
<th>SLANG WORD</th>
<th>ENGLISH TRANSLATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kujivinjari</td>
<td>Actual meaning in the Swahili slang means to relax or enjoy but in this context, the young people use it to mean sex.</td>
</tr>
<tr>
<td>Kutinywa</td>
<td>Actual meaning in the Swahili dictionary means to be pinched or pressed but in this context it means sex</td>
</tr>
<tr>
<td>Paja</td>
<td>Actual meaning in the Swahili dictionary means ‘thigh’ but in this youth language it means sex</td>
</tr>
<tr>
<td>Kuenda keja</td>
<td>The slang word keja means ‘house’, Kuenda means to go. So full translation is ‘go to the house’ the young people in this area understand it means sex</td>
</tr>
<tr>
<td>Tu shifti</td>
<td>The term draws from the English word, ‘shift’ but in this context means to go have sex</td>
</tr>
<tr>
<td>Upendo</td>
<td>Actual meaning in the Swahili dictionary means ‘love’, in this context it means ‘making love’</td>
</tr>
</tbody>
</table>

Table 2. English translation from local slang language (women 16 – 20 years)
<table>
<thead>
<tr>
<th>SLANG WORD</th>
<th>ENGLISH TRANSLATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Eloloita</em></td>
<td>Sex</td>
</tr>
<tr>
<td><em>Tabia mbaya</em></td>
<td>‘Bad manners’ when talking about sex</td>
</tr>
<tr>
<td><em>Kuhanya</em></td>
<td>‘Promiscuity’ when talking about sex</td>
</tr>
<tr>
<td><em>Kudara</em></td>
<td>Caressing</td>
</tr>
<tr>
<td><em>Kukulana</em></td>
<td>Kissing or sex</td>
</tr>
<tr>
<td><em>Kuekana</em></td>
<td>Meaning sex</td>
</tr>
<tr>
<td><em>Kulala</em></td>
<td>‘Sleeping’ meaning sex</td>
</tr>
</tbody>
</table>

Table 3. English translation from local slang language (women 21-25 years)

Slang words that conceal sex may contribute to the continuing social stigmatization of sex. For instance, terms such as ‘bad manners’ and ‘promiscuity’ are used to base moral judgments on young people who are sexually active.

The research also attributes a cultural reason to young women using slang words. It is considered disrespectful to talk about sex to someone of the opposite sex or someone who is much older or much younger. Slang words are used because it is inevitable for women of the same age to talk about sex. It is also inevitable for young women to talk about sex when they are seeking information or advice about sex.

The impact this has on young women is that the gap between older people and younger women is widened when it comes to talking about sex. This has a direct impact on young women’s reproductive health. Useful advice concerning sexuality is difficult to access from people who are more informed and experienced such as their elders. Consequently, young women are most likely to seek information about their sexuality from members of the same age group.

**Age of First Sexual Experience**

Most young women (16-20 years) believe that girls have their first sexual experience between ages 12-13 years. Whereas the older women (21-25 years) believe the same experience occur among girls between ages 9-13 years.

The difference in response among older and younger women indicates that recently, girls are delaying their first sexual experience. Possible factors that could contribute to
this are enrolment in schooling, discouragement of sexual practices such as Esoto, and awareness of Sexually Transmitted Infections (STI's) including HIV.

All research participants expressed their beliefs as to what they considered the age of the first sexual experience among boys or men. The majority of the young women (16-20 years) believed that the first sexual experiences among men occur at age 14 years. However, all older women (21-25) believed the first experience occurred among young men at age 15 years.

The findings noted that boys had a later first sexual encounter than girls. This further supports previous literature findings that women's early sexual activity causes them to be vulnerable and more susceptible to sexually transmitted infection particularly HIV, than men.

**Cultural Practices that Influence Women’s Choice of Reproductive health**

**Female Circumcision: A Practice that Prepares Women for Maturity?**

All Maasai women (16-25 years) who participated in the research had undergone female circumcision. These findings verified the survey conducted by the Ministry of Health and GTZ in Kajiado district; including Loitokitok, that 93.9 percent of Maasai women in the area, had undergone FGM (Evelia, Sheikh, & Askew, 2008). Circumcision, referred to as female genital mutilation (FGM) in the literature findings (“Classification of FGM”, 2008) was said to be an initiation process of a girl into womanhood.

This initiation process was described by the participants as the entry into womanhood which involved a celebration or feast:

> There is a big feast held after the circumcision to recognize the new mature woman who is no longer a child (Focus group participant, 16-20 years personal communication, 15 August 2009).

Another pointed out:

> I’ve attended circumcision feasts. (Focus group participant, 16-20 years, personal communication, 15 August 2009).

According to the participants, female circumcision is sometimes said to be a voluntary or involuntary process. Young women (16-20 years) said that their peers would voluntarily decide to go through circumcision. The researcher identified that this initiation process is a group event where some girls voluntarily agree to get circumcised.
I remember talking about it with other girls, so when the day reached, we all went together to be cut. I cannot explain to you how painful it was afterwards (Focus group participant, 16-20 years, personal communication, 15 August 2009).

However, the researcher does not rule out the possibility of peer pressure which may influence some girls’ decision to get circumcised.

According to the respondents, the involuntary process meant parents/guardians would pay one older woman said to be the traditional surgeon, to conduct the procedure. The research considered the possibility of female circumcision being a lucrative business in the area of Loitokitok-Kenya:

She is paid around Ksh 400 – 500 (NZ$10) per person (Focus group participant, 16-20 years, personal communication, 15 August 2009).

The cultural significance of female circumcision that emerged strongly was that girls go through the process so that they can be married at a later stage in life. It was identified that most men would not marry an uncircumcised woman:

Maasai men do not marry women that are not circumcised. I have never heard of a Maasai woman who has not been circumcised (Focus group participant, 16-20 years, personal communication, 15 August 2009).

The power of cultural taboos equally determined young girls’ voluntary or involuntary decision to be circumcised:

Most girls fear to be cursed when going against what parents wish (Focus group participant 16-20 years, personal communication, 15 August 2009).

Circumcision was identified as a parental responsibility and viewed as something parents and guardians do for the welfare of their daughters.

My mother died when I was young then later my father left us. My uncle took us in and he is like our father. It is my uncle who said that I should get circumcised….. I couldn’t go against what he says because he said I had to go through the tradition. You ask me about the experience? I can only tell you that it is very painful and glad that I don’t have to go through it a second time (Semi-structured interview, 16-20 years, personal communication, 10 August 2009).

However, despite the fact that female circumcision may or may not be a voluntary process, respondents indicated that the process into womanhood was a painful experience:
You are given your own three razor blades to hold as you wait for your turn. The old woman takes the blades from your hand and asks you to lie down on the hide. At that time you are held firm by other women so that you don’t move. Instant pain comes immediately after it has already been done……the cut part is put under the hide…. It will disappear (possibly decomposes) (Participant, semi-structured interview, 16-20 years, personal communication, 15 August 2009).

The research identified that an existing Maasai traditional healing practice is utilized to assist with initiates healing process:

A mixture of ghee and milk is used to wash the wound to avoid infection (Participant, semi-structured interview, 16-20 years, personal communication, 10 August 2009).

However, questions arise as to how long the healing process takes and whether this would cause further reproductive health issues. This is an issue for further research.

Complications of female circumcision emerged during the discussions with Maasai women. The process involved losing a lot of blood:

I had never seen so much blood come out.... You think you’re going to die. It was all over the hide. One is advised to stay in the house until the wound heals. You cannot move around or urinate easily (Participant, semi-structured interview 16-20 years, personal communication, 10 August 2009).

Surgical accidents during the initiation process also accounted for complications surrounding female circumcision:

Some women are not experienced well enough to carry it out then end up making mistake of cutting the wrong way (Participant, semi-structured interview 21-25 years, personal communication, 10 August 2009).

Such accidents are linked to vaginal fistula a long-term condition said to be deeply rooted in FGM (WHO, 2006).

Besides physical complications that occur during circumcision, psychological trauma also emerged as an issue. A young woman spoke about how she came to develop a phobia for sharp objects after her experience. She further elaborated on this fear by stating she would not comply with getting a head shave and having her lower incisor extracted; both of which are part of the traditions after circumcision.

However despite the risks and consequences to physical and psychological health the research identified that the respondents were members of a self initiated youth group that sought strategies to cope with female circumcision as a reproductive health issue.
The participants pointed out that some women lack knowledge of the possible complications surrounding female circumcision. The strategies that were identified to cope with the risks involved include: reconciling with past experiences and educating the wider community about the risks of female circumcision. The majority of focus group members (21-25 years) agreed that they would not permit their own daughters to be circumcised and would ensure their wellbeing and rights are preserved:

My husband and I have agreed and choose not to take our girls through circumcision. ..... When they are grownups they can decide for themselves. But we do not want to force them (Participant, semi-structured interview 21-25 years, personal communication, 10 August 2009).

The decision most women (16-25 years) made in regard to not having their daughters circumcised in the future, could be attributed to their experiences and anti-FGM initiatives taking place in the area.

A local Church was seen to be part of strategies towards lessening female circumcision incidents:

We (family) attend the Kenya Assemblies of God and our leaders discourage the congregation from practicing FGM (Participant, semi-structured interview 16-20 years, personal communication, 10 August 2009).

Peer campaigns on health education through the dedication of the women youth group was one of these coping strategies that reached out to the community:

Government health workers from the Ministry and AMREF give us trainings on HIV and AIDS peer education. We approach Churches and they assist in mobilizing the congregation so that we go talk to them on what we have been trained on (Participant, semi-structured interview 21-25 years, personal communication, 10 August 2009).

Earlier literature findings identified that:

The likelihood that a mother would decide to have her daughters circumcised decreased as her level of education and exposure to media rose and increased with the proportion of circumcised women in the community (Rosenberg, 2005).

The research observed a high presence of Africa Medical Research Foundation (AMREF) and faith based organizations that reach the community with health education and FGM awareness.
Moranism

Moranism is a set cultural activity that Morans (warriors) engage in. One aspect involves young Maasai men dedicating their youthful years to safeguard the welfare of the community through full time surveillance.

During this time, the young men are not committed to any marriage relationships or other socio-economic activities that will deter them from safeguarding the community:

Part of our group activity is campaigning for communities to send the Morans to school. They spend most of their years serving as Morans and this is not helpful to them since they cannot get jobs to sustain themselves after the period..............other young men in other communities are going to school, the Morans are left behind. Our community is constantly lagging behind because of this. We are aware that school is important but Moranism requires that they do not abandon their role in community (Semi-structured interview, age 21 - 25 years, personal communication, August 10, 2009).

The Morans (warriors) defend the community and have their own designated camp (Manyatta) where they live and provide 24 hours surveillance for the number of years they will serve as Morans (Semi-structured interview, age 21 - 25 years, personal communication, August 10, 2009).

Illmoranis also known as Morans (warriors) are groups of young men who are of the same age set and normally serve for approximately twenty years. The last Moran group had served for twenty seven years after which the Manyatta (camp) was pulled down (Semi-structured interview, age 21 - 25 years, personal communication, August 10, 2009).

During the time a young man is a Moran, he is not supposed to be married until the twenty years (or plus) period elapses. Moran initiation was described as:

After a boy has been circumcised at the age of fourteen he now becomes a Moran, he wears black ‘shuka’ (traditional attire) for a period of two years. After the two years, he begins to wear the red traditional attires and he grows long hair that is braided into locks by his fellow Morans... they smear their bodies and hair with red ochre (Semi-structured interview, age 21-25 years, personal communication, August 10, 2009).

Morans are accorded recognition and high respect in the community because they have been entrusted with the safety of the community. They guard the community from attack of wild animals, neighboring cattle raiders and in the event of external war from
neighboring communities. The Morans carry weapons at all times ready for defense. The weapons range from arrows, machetes to ‘rungus’ (clubs).

However, even though the Moranism period has been allocated for the benefit of the community, some people particularly young unmarried women in the community have come to find the sexual behaviors of some Morans as unhealthy.

Some Morans take advantage of unmarried women:

A Moran can freely walk into any home he knows he’ll find unmarried girls to socialize and even sleep with them.....some will walk into a home even when the girls’ mother is around..... because the mother equally recognizes the powers given to Morans, she will walk out of the house leave her daughters with the Moran in privacy (Semi-structured interview, age 21 - 25 years, personal communication, August 10, 2009).

This is one of the undesired aspects of Moranism that the interviewee has noted. The interviewee goes on and describes the practice:

A Moran plants his spear outside that house so that anyone passing by or intending to get into the house will not because they will know what could be happening (Semi-structured interview, age 21 - 25 years, personal communication, August 10, 2009)

Impact of Moranism on Women’s Reproductive health

Esoto

Esoto is a sexual practice said to take place among young warriors and young unmarried Maasai girls. According to the respondents, the practice takes place frequently though its prevalence is uncertain.

Christianity which is the widest practiced religion in Loitokitok area is influencing the perceptions of this practice. Some young women termed it as Esongorai meaning immorality. Despite religious practices, the adolescent women 16-20year said that they are aware that Esoto is still in practice:

At night girls meet in a certain house where Morans come to view naked girls expose their entire body. The girls are meant to bend over while stark naked and collect beaded jewelry (Osiririm) from the floor (Focus group participant, aged 16 - 20 years, personal communication, August 15, 2009).
Another participant explains:

Girls that are not able to collect the Osiririm are beaten up. Bending over and collecting the object gives the Moran a view of the girls’ parts. They do this to view if the girl is still a virgin and if she has had sexual experience. If the girl is a virgin, the Moran will scramble to take up the virgins and make sure they have sex with all virgins so that they lose their virginity (Focus group participant, aged 16 - 20 years, personal communication, August 15, 2009).

Virginity is not a value after circumcision; girls can have sex as they so wish:

The other girls that are not virgins are picked up randomly by the Morans (warriors) and go have sex……… The girls too have the freedom of picking the Morans they want to sleep (have sex) with (Focus group participant, aged 16-20 years, personal communication, August 15, 2009).

Esoto is practiced differently in different communities. Chisha (2005) notes that among the Maasai of Tanzania a neighbouring community, Esoto is part of a night celebration held when a baby is born. Women and men (age no limit) dance ceaselessly and end up having unprotected sex with any partner of their choice at the party.

**Early Marriage**

Early marriage emerged as a cultural practice that affects the welfare of young girls in Loitokitok. The preparation for early marriage was said to begin before a girl is born:

They book the child even before she is born (Focus group participant, aged 16 - 20 years, personal communication, August 15, 2009).

The research established that marriage is a highly significant phase among Maasai people. Booking a child before he/she is born in case she turns out female, is considered as minding the welfare of that child as she grows up into an adult.

The significance of marriage is so highly placed that some Maasai families will adhere to the practice of offering their pre-mature daughter for marriage by all means possible:

There are many girls being offered for marriage as young as 13years. Nowadays families are arranging for the daughter and the suitor to run away to Tanzania, stay there until the girl is pregnant then they can return back to Loitokitok area (Semi-structured interview, age 21 - 25 years, personal communication, August 10, 2009).

This illustrates that most community members have awareness that offering pre-mature girls for marriage is illegal. The issue of child rights emerges in this theme where
young girls are illegally passed through the Kenya border to an environment that allows infringement of their rights. The issue of intentionally impregnating young girls so that they can stay in a marriage is a concern in reproductive health and a violation of their human rights and dignity. These are areas for further research particularly by concerned authorities and developing agencies that look into children's rights and reproductive health.

The strategies considered by the research participants; (and) as a youth group, to cope with risks of early marriage are:

- Working with the area provincial administration... one of the administrative police is an associate member of the youth group (Semi-structured interview, age 21-25, personal communication and informal observation, August 10, 2009)

The research identified an administrative police post in the area and confirmed that the police were associated with the youth group by intervening on rights violation issues. Networking with administrative police came up as one of the strongest supports the research participants had in their youth group activities. The research participants indicated that they work with other resourceful persons in the community to alleviate issues of pre-mature girls being offered for marriage. The research proposes that further studies be carried out to identify existing networks in the grassroots of Loitokitok community and their significance in the intervention of young women’s health rights. Youth groups like the one the research participants are involved in could be well equipped with local strategies that look into the issue of young pre-mature girls being offered for marriage.

Another strategy the research participants consider as relevant in coping with the emerging issues of early marriage is through their campaigns that raise awareness on the impact of early marriage on young girls and women.

**Polygamy**

None of the women (21-25 years) interviewed were in polygamous marriages. All four of them were married women and in monogamous marriages. The research observed that there are factors that assist women and their partners to avoid polygamy. These included: low socio-economic status, Christianity and urban influence.

Women who participated in this interview professed the Christian faith in which teachings require that they abandon the cultural practice of polygamy. Innumerable Christian Churches of various denominations in Kenya such as; the Roman Catholic,
Pentecostal Church of East Africa, Baptist, Seventh Day Adventist, African 
Brotherhood Church, Africa Inland Church, Methodist and Anglican Church of Kenya 
do not accept marrying more than one wife or husband.

Contemporary Maasai society is becoming more urban. Urban culture is highly diverse 
and is influenced by; education, globalization and multiple cultures. Kenya’s urban 
cultural influences through its major cities are trickling down into rural areas and small 
towns and several traditions and customs are now perceived as outdated and there is 
less tolerance of practices such as polygamy as the Maasai become more 
sophisticated and educate. Some young Maasai want to identify with contemporary 
society and culture even though the older Maasai generations would prefer that young 
people adhere to most traditions and customs.

Households (Manyatta/boma) with low socio-economic status have fewer wives 
compared to economically stable households. Men take up wives to help with duties 
that are determined by the amount of economic assets they have (Personal 
communication, aged 45 years, July-August 2009).

However, despite being influenced by religion, urban culture or socio-economic status, 
respondents indicated that there are circumstances under which a monogamous 
marriage could end up being polygamous. The following interviewee indicated the 
need for children could sanction a polygamous relationship:

I would not like my husband to find another wife. If he thinks of taking 
up another wife, I would try to find out what I am not doing right and 
do it well. I would talk it through with him..... If its children that I am 
not able to have, then it is okay if he takes up another wife (Semi- 
structured interview, age 21 - 25 years, personal communication, 
August 10, 2009).

This statement illustrates an attitude amongst many Maasai women who accept that 
their marriages may end up polygamous due to the cultural requirement, of needing to 
bear children. This concurs with Cook’s (2007) research findings that identified 
“women showed their concerns that a monogamous relationship may become 
polygamous in the future; that they had little control over their husbands’ taking a 
second wife” (p.232).
Perception of Contraception Use

Condoms

All research participants had come across a male condom and demonstrated general knowledge that condoms are a preferred contraception that is designed to prevent exposure to semen. The research observed that awareness of male condoms was possibly created by existing NGO's and other initiatives in the area e.g. Africa Medical Research Foundation (AMREF), Ministry of Health (MOH), Africa Infectious Diseases (AID village) and the like (Informal observations, July/August 2009).

However, despite the fact that condoms were viewed as being both a contraceptive aid and a STIs including HIV preventative, there appears to be a certain amount of social stigma and prejudice towards using them:

> It is like eating a sweet with its wrapper on (Focus group participant, age 21-25 years, personal communication, August 15, 2009).

Social stigma is a possible factor that influences the consistent use of condoms among young people.

Another factor identified was lack of adequate information concerning correct and consistent use of male condoms. The majority of the young women (16-20 years) said that they were not sure if they could tell when a male condom was used correctly even though they had received some theoretical knowledge of condoms at school. The need for more awareness in this area was identified when they requested the researcher to carry out a condom demonstration. They were referred to their group’s peer educators who were able to address the matter. The researcher identified a gap in the type of training girls received in schools concerning contraceptives and proposed to schools to adopt a more practical way of passing on knowledge relating to contraception use.

The lack of adequate information concerning male condom use also demonstrated that the use of male condoms is considered a male responsibility.

Trust based on faithfulness influenced the decision of young women and their partners to use male condoms. Older women (21-25 years) illustrated that trust among sex partners is a valid means of deciding whether or not to use condom. However, more research is warranted to identify how trust in polygamous unions applies.
The research also sought to identify the level of knowledge regarding the female condom said to be the only female contraception that women have control of. The findings suggest that knowledge of female condoms is low probably because it is not viewed as a popular contraceptive in the area. Indeed, the majority of the women who participated in the research indicated that female condoms were not accessible and familiar to women in the area (including them).

**Other Contraception Use**

Basic knowledge of other suitable contraception methods is among the factors that influence choices of contraceptive use among Maasai women. A respondent in the focus group discussions 21-25 years (August 2009), stated that the pill increases undesired body weight.

> If one uses pills and during that period is engaged in sex, one becomes fat and this is not a good thing (Focus group participant, age 21 - 25 years, personal communication, August 15, 2009).

Her response illustrated that negative side effects of one type of contraceptive discourages a user from attempting any other method of contraception. It also illustrates misguided information regarding the pill; that it is not the combination of sex and use of pills that cause excessive gain of body weights, rather the possibly ‘outdated’ traditional pill by itself. The consequence of this on women’s reproductive health is the lack of control over when they should or should not have children.

The choice to use contraception was also influenced by age. Young women (16-20 years) associate contraception use with the belief that they are suitable for older married women or those in stable relationships. The response of young women indicated that they were less likely to have ever used or to be currently using contraception particularly the condom method. Their response could be attributed to the fact that they were still at school.

The researcher proposes that school attendance affects contraception use (including condoms) because girls spend most of the time in school and are less likely to be engaged in active sex. However, the researcher considers that young women seeking information on contraceptives could be misguided by beliefs that contraceptives are not suitable for them. Such young girls are considered to be at high risk of becoming pregnant and dropping out of school.
Knowledge and Information on Existing Sexually Transmitted Infections

During the data collection, respondents gave their feedback on the sexually transmitted infections that they are aware of.

Two respondents (21-25years) said that they knew of syphilis as a sexually transmitted infection. Four respondents named gonorrhea as a sexually transmitted infection that they were aware of. All twelve respondents (21-25years) said that HIV is a sexually transmitted infection that they are commonly aware of including the mode of transmission.

Equally, young women (16-20years) were aware of HIV as a common sexually transmitted infection and modes of transmission. The young women could name a few STI’s besides the common HIV, such as syphilis and gonorrhea.

There was a high level of HIV knowledge including modes of transmission and prevention, among all research participants but a low level of knowledge of the basic diagnosis of an STI and other existing STI’s besides the few they named.

The researcher proposes more knowledge dissemination on other STI’s to increase knowledge to match the current knowledge of HIV and AIDS has reached the women and wider community. There is a need for awareness creation concerning the relationship between other STI’s and the HIV. Knowledge disseminated exclusively on HIV and AIDS is not enough if HIV is to be controlled and managed.

Control of Sexual Relationships among Partners

The researcher sought to identify whether gender differences influenced control of sexual relationships. Among young women (16-20years) gender did not influence control of sexual relationships and affairs. A majority of the girls (83%) said that it was okay for a girl to decline sex at free will without coercion. However, their response applied only when the girls are not economically dependent on boyfriends:

If a girl is enjoying money and gifts from the boyfriend, then he expects her to have sex with him at any time he wants (Focus group participant, age 16 - 20 years, personal communication, August 15, 2009).
The researcher attributed this response to the fact that the majority of girls were in school, had not been married and had parents or guardians who supplied their basic needs.

Compared to the younger women, only 43% of the older women (21-25 years) responded that it was okay for a woman to decline sex without coercion. The majority who did not believe women can equally decline sex freely based their beliefs on what they considered conjugal rights entailed, fear of gender based violence (wife beating) and accusations of infidelity by husband/partner. The issue of accusation of infidelity came through a response:

> When you refuse to have sex he will think you are getting it from someone else and will accuse you for being unfaithful (Focus group participant, age 21 - 25 years, personal communication, August 15, 2009).

However, the researcher sought to identify whether women can suggest sex as much as they could decline. More than half of all research participants indicated that women could not freely suggest sex to their boyfriends, partners or husbands. Reasons indicated that culturally, it is a man’s role to control sexual matters in a relationship:

> I think it’s normally men who confront or show interest in sex... (Focus group participant, age 21 - 25 years, personal communication, August 15, 2009).

Another stated:

> If a woman suggests that they want sex, the man would take her for a prostitute (Focus group participant, aged 16 - 20 years, personal communication, August 15, 2009).

Another said:

> It is embarrassing (Focus group participant, aged 16 - 20 years, personal communication, August 15, 2009).

Another factor that influenced equal control of sexual relationships is fear of rejection; a psychological factor that indirectly gives men the control to manipulate sexual affairs particularly in relationships among young unmarried people:

> If a girl asks for sex and the man doesn’t want it, the man will think that if he doesn’t give her she will go seek for it elsewhere and he will not trust her anymore (Focus group participant, aged 16 - 20 years, personal communication, August 15, 2009).

The research identified that culturally, women (especially if they were married or emotionally and economically dependent on men) consider it appropriate for men to
control sexual matters. Consequently, this aspect is transferred to all areas of a woman's reproductive life i.e. conception, family planning and contraception.

**Women’s Skills in Negotiating Sex**

The women in the two focus groups 16-20 years and 21-21 years discussed that there are ways in which women can negotiate their way into not having sex without their consent.

A young woman responded:

> Sometimes a boyfriend could be too persistent and wants to take advantage... so would be best to get away from that relationship (Focus group participant, aged 16 - 20 years, personal communication, August 15, 2009).

Another stated:

> You can sweet talk your partner and tell him that you are not ready for sex at that time (Focus group participant, age 21 - 25 years, personal communication, August 15, 2009).

Another tactful skill involved:

> Cheat that you are sick and cannot perform (Focus group participant, age 21 - 25 years, personal communication, August 15, 2009).

Similarly, another pointed out that:

> Tell him you are on your period and cannot do it (Focus group participant, aged 16 - 20 years, personal communication, August 15, 2009).

Some sexual practices such as Esoto; that are regarded as socio-culturally acceptable, could actually promote and lead to sexual misconduct or even sexual violence. Young women devising their own tactful ways are cleverly safeguarding their sexuality and reproductive health. However, the research identified that only a few women will consider an explicit 'no' when sex is proposed to them without having to ‘beat around the bush’. The tactful skills may only last for a short period but when they are confronted with a proposal for sex again, they might run out of skills and give in to sex that is not consensual. Nevertheless, the legal view of sex without consent termed as rape within or outside marriage did not arise in the discussions with Maasai women.
Perceptions or Advice Women have heard from Other Women in the Community Regarding Sex

Women get advice and gain perceptions about sex from other women in the community. The advice women (16-25 years) sought indicated positive and negative sexual experiences of advisors.

The research interpreted information from a respondent as advice possibly based on traumatic sexual experience:

Too much sex is dangerous for example, one can be crippled or have some form of injury in the process (Focus group participant, age 21 - 25 years, personal communication, August 15, 2009).

Some women pointed out that sex has ‘curative’ benefits:

Sex removes stress (Focus group participant, age 21 - 25 years, personal communication, August 15, 2009).

Another respondent said:

Sex cures back pains (Focus group participant, age 21 - 25 years, personal communication, August 15, 2009).

Sex was seen to have a lasting impact on partners’ relationships:

Sex makes relationships last longer and grow stronger, the experience brings the people closer (Focus group participant, age 21 - 25 years, personal communication, August 15, 2009).

A focus group participant brought up the issue of sex in relation to a contraceptive pill; highlights their limited knowledge:

If one uses pills and during that period is engaged in sex, one becomes fat and this is not a good thing (Focus group participant, age 21 - 25 years, personal communication, August 15, 2009).

This quote could indicate that the older generations of the oral contraceptive pill are being prescribed as the more modern pills tend to have lower dosages of estrogen and do not cause significant weight gain and minimize other health problems such as stroke and cancer.

The advice women seek regarding sex may influence the way they approach sexual matters. For instance, some women could be engaging in sex based on advice that indicates its curative benefits. Others may have shied away from engaging in sex because of the advice that indicated the negative experiences of sex. Such advice may affect women’s reproductive health hence the need for accurate information to
make informed reproductive health choices. Based on the researcher’s observation through the stay in Loitokitok area, there were no youth services that assist young people with information concerning their sexuality and reproductive health. Lack of information services is one of the issues that have been considered for the strategizing of the Millennium Development Goals in Kenya (2005). Equally, the MDGs realize that:

Adolescents and youth lack appropriate information and services to respond to their reproductive health needs and engage in unprotected sex, experience the highest levels of STIs, unwanted fertility and risk complications in pregnancy and delivery (p. 82).

Child Rearing Practices

Child rearing practices have been identified as a strong determinant factor in the way women communicate with their sexual partners in adult life. An interviewee identified culture and taboo as methods that inhibit adolescent girls’ effective communication with their parents or guardians. The researcher purposely picked up responses that illustrate how girls relate to other women and men in a domestic set up:

As young girls, there is difficulty when communicating freely with persons older than us particularly parent/guardians and older relatives. One does not want to be considered disrespectful... it is considered rude to forward an opinion over the elder’s (Semi-structured interview, age 16 - 20 years, personal communication, August 10, 2009).

Another asserted:

There is fear of being cursed when you do not take advice. (Semi-structured interview, age 16 - 20 years, personal communication, August 10, 2009).

These responses do not necessarily mean that elders are inconsiderate of young girls rather, culturally, elders are considered to offer the best advice or opinions for the young people’s welfare. This has both strengths and challenges. The strength is that young girls can still look up to elders for advice based on experience whereas the challenge is that the culture does not nurture the girl’s ability to channel opinions or make shared decisions that are not necessarily disrespectful. The impact this has on young women’s reproductive health is the difficulty in making decisions or choices concerning certain customs and traditions that impact on their reproductive health.
The researcher identified that culturally, daughters and their fathers are restricted in the extent to which they can relate. However, this did not mean that most fathers and daughters do not have a caring father-daughter relationship:

There are issues that a girl can share with mother and not the father.....issues of high concern, I'd go talk it with my mother or a female relative... likewise boys are closer to their fathers...... (Focus group participant, aged 16 - 20 years, personal communication, August 15, 2009).

In the Maasai culture, mothers and other significant females are the ones who are closest to daughters. Their responsibility is to bring up daughters to conform to Maasai norms:

...........it is difficult for young girls who do not have mothers and are orphaned. They will end up very lonely with no one to talk to and since they are not able to talk to the father, their needs will be left out. It is also the same for a son who is mostly closer to the father more than the mother (Focus group participant, age 21 - 25 years, personal communication, August 15, 2009).

Another respondent:

It would be good if fathers were part of the development process of their daughters. Nowadays girls are going to school just as boys and both parents are asked to be part of the students' life whether or not it is a girl or boy (Focus group participant, age 21 - 25 years, personal communication, August 15, 2009).

Father-daughter relationships can make a huge difference in how daughters see themselves and even what they expect from their future husbands or boyfriends. Maasai culture conditions fathers and daughters to not be too close to each other which make it uncomfortable when they communicate. This socialization affects the way women communicate their sexual needs and reproductive health choices to men. Women have been socialized to be recipients of what is being communicated to them hence silencing their needs. Men on the other hand, have been brought up seeing women unconsciously taking up a silent role therefore assuming that when they decide on their behalf, it is sufficient.

**Education**

The research identified that some research participants had attained some level of education that is significant to some aspects of reproductive health. The majority (90%) of focus group participants (16-20years) were currently enrolled in a local

Table 4. Level of education among research participants in focus group discussions 16-20 years and 21-25 years respectively.

Referring to Grown, Gupta and Pande (2005); Mulama (2009) argues that education increases women’s negotiating ability and that they are able to make informed choices and are more likely to understand the cost of risky behaviour.

Ninety percent of young women (16-20 years) who had been attending primary schools had been participating in health clubs at school and involved in a youth group that relates to women and health.

Twenty percent of older women (21-25) were peer educators in the youth group because they had enough education to enable them attend HIV/AIDS trainings offered by AMREF and later train their peers (Semi-structured interview, Focus group discussions 21-25 years).

These findings concur with Grown, Gupta and Pande (2005) and Mulama (2009). Moreover, women indicated the significance of education by translating what they learn from the health clubs and training into their current youth group and reach out to more women and the wider community.
Although education was viewed as beneficial to the women, their major concern was whether the girls currently in primary school were going to be able to proceed to a secondary level of education because of the socio-economic factors. One of the girls (16-20 years) interviewed had completed her K.C.P.E. in 2008 but missed the 2009 secondary intake due to lack of fees therefore had to wait until her parents could allocate school fees (Focus group participant, age 16 - 20 years, personal communication, August 15, 2009).

**Summary**

Chapter Four has presented field data that was collected during the research in the Loitokitok area. The Maasai women (16-25 years) discussed cultural and sexual practices they believe affect young women’s reproductive health in Loitokitok. Various themes emerged through the discussions including: aspects of sexuality, female circumcision, early marriage, polygamy, Moran and Esoto. Other emerging themes that influenced the discussions were: schooling and youth group initiatives in which the research participants were members.
CHAPTER FIVE

DISCUSSION OF FINDINGS AND RECOMMENDATIONS

Introduction

The previous Chapter analyzed data that was sought from twenty four Maasai women between ages 16-25 years in Loitokitok district through focus groups and Semi-structured interviews. Chapter Five discusses findings reflecting the previous themes identified in Chapter Four. In this chapter, recommendations are offered based on the findings.

Discussion of Findings

Practices that Influence Women’s Control of Reproductive Health and Sexuality

Female Circumcision

The term ‘female circumcision’ also referred to as ‘female genital mutilation’ by Blyth (2008), was used during discussions with Maasai women. The research did not identify any local Maasai word to mean ‘annihilation’ or ‘mutilation’ of female genitalia when referring to the practice. The research proposes that the minimization of biasness through non-use of value laden language when referring to the traditional practice assists in reducing further psychological effect on women’s health.

The term FGM illustrates one of the Western forms of feminism that portray Euro-centric prejudices on African women’s sexuality (“The Imperial Archive”, 2006). Osman (1998) illustrates how the term FGM came into existence:

The term was intended to lend a linguistic credence to the campaign against FC (female circumcision) by ‘accurately’ describing the practice. The insensitivity of this term has infuriated many who have dismissed it as yet another western imposed ideal (Osman, 1998: 163).

Preconceived cultural notions about female circumcision, pose particular challenges towards intervening and developing health goals that protect girl’s and women’s rights from physical and psychological complications of circumcision. Nevertheless, female circumcision is widely practised and significantly impacts on Maasai women’s reproductive health. All research participants shared their experience of female circumcision. However, during face to face interviews, the younger women were particularly emotionally expressive about their experiences. Interestingly, none of the
women in the study highlighted concerns about experiencing a loss of female sexual pleasure, due to the clitoridectomy. While there is considerable emphasis on the clitoris as a site of sexual pleasure and orgasm for women in the West, (Blyth, 2008; Iweriebor, 1996), in the case of the Maasai women, this was not seen as something that had been irrevocably lost.

Overall, many women indicated sex was for procreation reasons and not predominately for pleasure. The research found that female circumcision is not a leading cause of the spread of HIV at the time of surgery\(^3\), rather the later complications that increase HIV susceptibility among other infections. Findings indicated that surgery is carried out in the least hygienic conditions by untrained women where the risk of infection and cross-infection during or after surgery is likely to occur. Besides the minimal standards of health applied, the practice is life-threatening where girls lose a large amount of blood without any emergency backup. Interviews with young women (16-21 years) spoke about the fear and distress they experienced when they saw how much blood they had lost.

Based on the researcher’s informal observations during the stay in Loitokitok, the nearest health facility was some 30km from the remote Olchoro Sub Location. Female circumcision is illegal in Kenya and hospitals are not allowed to carry out the practice. This would discourage visits to a hospital even in emergency because of the fear of being identified as having carried out an illegal practice. Therefore, the majority of the Maasai in the area rely on the application of traditional medicine as intervention during circumcision despite the fact that there are high chances that such interventions could be ineffective. Furthermore, other than the trust given to the traditional surgeons, no regulations hold them accountable for any irregularities that may cause permanent injury or even fatalities during the surgery.

Findings also indicated that some parents/guardians and also, the wider community have not considered the psychological trauma the procedure has on girls and women. Young Maasai women who participated in the interviews became very emotional as they recalled their experiences of FGM. Some women find it easier to not look at FGM as an experience targeting an individual rather consider the majority of the women who

\(^3\) During circumcision each girl is given three razor blades for the surgery (Focus group discussion 16-20 years, August 2009: Chapter Four). This action under-taken by the traditional surgeons is seemingly to try and avoid any infection particularly, HIV. It also indicates the level of HIV awareness; including its modes of transmission, among the untrained surgeons.
have undergone the same experience. It may not be a justified reason for having one’s rights violated, but it is a coping mechanism to get by in day to day life.

Young girls (16-20), were aware of existing laws that would protect them from involuntarily engaging in the practice but had to give up their rights for fear of being isolated or being disrespectful to significant people in their lives. These findings indicate areas for further research by relevant disciplines to establish the extent of physical and psychological complications that young girls and women suffer in silence.

**Early Marriage**

Early marriage is a practice that sees a significant proportion of women engage in sexual activity at an earlier age than boys. However, findings indicate that recently, girls are delaying their first sexual experience. Possible factors attributing to this is girls’ enrolment in schooling which results in delaying the age of marriage.

However, the age at which girls engage in their first sexual experience is still young as a consequence of marrying early. Since parents/guardians are aware that they are committing an offense, they are now trafficking daughters and suitors into Tanzania. Young girls are made to conceive involuntarily so that they are forced to stay in the marriage. Tanzanian and Kenyan authorities seem to be unaware of crimes that take place around the border. However, further inquiry is warranted.

The marriage act Chapter 150 in the Laws of Kenya (2008) does not accept marriage taking place among young people below the age of 18 years. This still contradicts the recognized traditional customary law which allows girls to be offered for marriage before they are mature.

**Gender Based Violence**

Gender based violence was identified when research participants indicated that beating women is a Maasai cultural norm. Their concern was the beatings women get when they refuse sex. Possibilities of beatings were in relationships with some men (husbands, boyfriends/Morans) who hold the economic power and license to take sex without women’s consent.

Findings indicated that culturally, Maasai men are permitted to beat their wives and so are the Morans who beat their girlfriends during Esoto. This study proposes that young women involuntarily engaging in Esoto be considered as rape victims in violent relationships and in need of rescue. The impact of sexual assault or any form of
violence on women has an impact on both their physical and psychological wellbeing. As mentioned earlier in Chapter Four, discussions based on advice women sought from other women regarding sex, indicated some advice based on traumatic sexual experience. Some women may not know or are in denial that they have been assaulted because they have to go along with cultural conformity. Because gender based violence has entered to the way Maasai construct femininity, women do not feel entitled to talk about their experiences.

Maasai men are important stakeholders in young women's health. Where beatings and emotional manipulation are used to demand sex, young women will ultimately give up their sexual and reproductive health autonomy.

Findings indicate that there are no customary laws that protect women from any forms of gender based violence. However, there are laws in Kenya (FIDA & ICESCR, 2008; Thumbi, n.d.; Bond, 2005) that protect women's reproductive health but fail to translate this in practice due to minimal law enforcement in the area.

A low literacy level is also a contributing factor in women seeming to accept violence that impacts on their integral wellbeing.

**Existence of High Level of Knowledge on HIV/AIDS and Prevention**

Part of the objective of this study was to establish the level of HIV/AIDS knowledge among Maasai women 16-25years in the Olchoro Sub Location of Loitokitok area. The findings showed that there existed high levels of knowledge of HIV/AIDS. The study also sought to identify what women perceived as practices that are most likely to increase the spread STI's including HIV and women were able to identify existing cultural and sexual practices such as; female circumcision, Esoto, gender based violence and Moran’s license to engage in sex that is not consensual.

Cultural practices such as female circumcision, early marriage and sexual practices such as Esoto were identified as the most apparent practices that directly affect Maasai women’s 16-25years reproductive health and sexuality.

**Low Level Knowledge on the Existence of Sexually Transmitted Infections**

Although findings indicate that young women engage in sex at an early age, there is less knowledge of other existing STI's besides HIV. Awareness is an important foundation in reducing STI's which are particularly prone to or accompanies HIV infection.
Condom Use

Research findings indicated that all (24) research participants were aware of the existence of male condoms although most young women (16-20 years) demonstrated low practical knowledge on how a condom is used. Knowledge of the unpopular female condom and its practical use is low in the area.

However, 75% of women (21-25 years) respondents believed that to a greater extent, male condom use protects them from exposure to HIV and other infections.

The social stigma of condom use emerged as being highly influential.

Quality Assurance of Condoms

Findings raise alarming concerns regarding the quality assurance standards of manufactured condoms distributed in Loitokitok area. However, as rumours may not be sound information on which to base knowledge of the standard of condoms, the research study proposes the issue be an area for further research and inquiry. These rumours affect the quality of knowledge on family planning and STI’s including HIV/AIDS and its prevention, and couples willingness to use condoms.

Low Literacy Levels

Low literacy levels affect Maasai women’s access to useful information about reproductive health consequently limiting ability to make informed choices.

Women and girls who have not been to school are not able to access sex education that is incorporated in the Kenyan school curriculum and health clubs. Seemingly, findings showed that advice women sought from other women concerning sexuality indicated lack of adequacy and accuracy.

Customary Laws that Enhance Subjective Cultural Practices

Certain customary laws also recognized by government of state perpetuate forms of injustice. For instance the issue discussed on economic constraints of women is contributed to by certain customary laws that do not allow women to inherit property. The laws are lax on protection of women in both monogamous and polygamous unions in regards to inheritance rights.
Customary law allows polygamy but does not allow equitable distribution of property therefore leaving women economically constrained and having no option but dependence on their powerfully economic partners.

**Role of the State (Ministry of Health Kenya)**

There are monitoring mechanisms for reproductive health and rights in Loitokitok, Kenya. The Ministry of Health through the National AIDS/STD Control Program (NASCOP) is focussing its efforts on HIV/AIDS by having established a Voluntary Counseling and Testing (VCT) center at Loitokitok town. The benefits of VCT centers are; individuals’ awareness of HIV status to minimize the spread of HIV in the community, access to information concerning HIV/AIDS and STI's, minimizes stigma and support human rights (Informal observations- visit to VCT center in Loitokitok, August 2009).

The research proposes that low knowledge of STIs and contraception use (condom) among young women in Olchoro Sub Location could be linked to a number of factors; individual’s low motivation to access VCT services, strategic marketing of VCT services in Loitokitok, accessibility to the VCT center from remote areas, cultural and sexual practices (polygamy, Esoto and FGM), gender imbalances and economic constraints. These factors present areas for further research to establish their correlations.

Cultural practices that allow multiple sexual partnering such as polygamy and Esoto equally challenge the efforts of VCT services. It is difficult to control or manage the spread of HIV by testing individuals without testing their multiple sexual partners. On the other hand, testing is voluntary therefore challenging for all sexual partners to agree on accompanying each other to the VCT center to know their HIV status. It is less difficult for sexual relationships where only two people are involved to manage their HIV status.

Gender imbalances in sexual relationships affect Maasai women’s reproductive health and they have no equal decision making in the relationship. This indicates a possible challenge for women to suggest to their partners to access VCT services.

Equally, women's economic constraint is a barrier to implementing free advice and information sought from the VCT centre when reproductive health needs have been identified.
For instance a VCT centre may refer an individual to access a specialized need e.g. treatment of an STI, but the individual may not have the finances to fund the treatment elsewhere. Economic constraints would cause the women to optimise their reproductive health needs.

**RECOMMENDATIONS AND CONCLUSIONS**

**Improving Education System**

The current education system in Kenya raises concern among Maasai that it does not ensure cultural safety rather, it erodes important cultural values. The author proposes that improving the current education system to meet cultural needs of Maasai is a more holistic approach to the integral development of Maasai society. Referring to Phillips, Jacqueline & Peshotan (2002), this holistic approach to education entails:

> That it maintains a cohesive society, ensures survival of their culture, promote collective ideology and tribal cohesion and that which teaches practical skills for effectively contributing to the group (p.140).

With the technical support of the Ministry of Education a needs assessment research that includes Maasai people’s views on what they feel constitutes a viable education that is beneficial to them as a society, would assist in minimizing fears of rejecting education as a whole noting the importance education has been granted as a tool to alleviating some of the reproductive health issues of young Maasai women.

**Allocating Landless Households**

Land is an important factor of production for indigenous Maasai people. Households with low socio-economic status are largely due to lack of adequate land to sustain their rural livelihoods including health needs.

Another important aspect is for the government to form a welfare system that allocates some land to displaced individuals who have none for their survival. In some situations where land has been allocated for wildlife conservation, it is logical for the respective Ministry to involve the indigenous Maasai in safe gardening natural resources and offering them employment in those industries (“Maasai issues in summary”, n.d.). This not only gives them a source of economic livelihood to meet household basic needs including health, but could also become part of solving historical contentious issues on land.
HIV Prevention through Treatment of STI’s

Though literature reviews indicate high distribution of condoms by the Kenyan Ministry of Health, research findings presented low knowledge on STI’s. Research findings also indicated that most young women did not have practical knowledge or correct and consistent knowledge of male and female condom use. Consequently this indicates; low use of condoms, inability to identify signs and symptoms, prevention and treatment of STI’s.

The most urgent action recommended in this study is for the Ministry of Health to position health extension workers in Loitokitok area to offer affordable if not free treatment for possible STI’s. The health workers could be effective and efficient counsellors who encourage individuals to get treatment. The call for urgency is based on facts that majority of the young people may not be able to identify most STI’s given that symptoms presented may be difficult for a lay person to diagnose. Low socio-economic status will prevent individuals from going to access treatment in health centres. Finally, low literacy levels are obstacles to exploring opportunities where the community can get free STI treatment. If the Kenyan government can manage to offer free condoms, they could prioritize in the health agendas to offer free STI treatment.

Dyk (2005) affirms the importance of treating STI’s as soon as possible as “people with STI’s are most vulnerable to HIV because they are likely to have sex with a number of partners” (p. 53). For a community where cultural practices allow multiple sexual partners and an area with high rape incidence, STI treatment is necessary to reduce the chances of HIV spread.

Condom Use

Increase the Options of Types of Condom

Increasing the option of female condoms as a method that gives women more control of protecting themselves against HIV and other STIs is better than not having an option. This comes with the recognition that gender based inequalities are one of the driving forces of sexually transmitted infections including HIV. Based on the research

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4 “Patients with genital ulcers (sores) from an STI are especially susceptible to HIV infection because the sores create openings in the mucous membranes-openings through which the HIV virus can easily move” (Dyk, 2005, p. 53).
findings, there was evidence that the female condom was not popular and for the minority who said they’d come across the condom, they were not competent in its usage.

Increasing this option is not to rule out the likelihood that female condoms would face as much socio-cultural stigmatization as male condom, but it is suggested that female condoms could be substituted in situations where the male condom is not available.

**Demonstration of Correct and Consistent Usage of Condoms**

There are many media advertisements marketing male condoms hence the need for these advertisements to focus on effective demonstration of proper usage of condoms to meet the objective of use. In situations where media advertisements do not adequately reach rural communities due to lack of electricity and the luxury of televisions or radios, there is a need to invest in other information education and communication materials that are relevant to the rural area and considering the literacy level of the community.

Establishment of information centres in Olchoro Sub Location in Loitokitok district would benefit community members particularly women accessing such useful information at their own pace and suitable to their literacy level. Women who are empowered with this kind of knowledge have a higher chance of translating knowledge into practice and also educating other women and possibly even their daughters. Including men in acquiring this information is important as findings indicate that men need to have a greater stake in women’s reproductive health issues.

**Quality Assurance of Condoms**

There is a need for health organizations in the area e.g. AMREF, VCT centres, faith based organisations and government health extension workers to address the issue of quality assurance of condoms to community members of Loitokitok. The fears of poor quality condoms and that condom have perforations, should be investigated and if found to be accurate, then addressed by the Ministry of Health as emergency task that requires immediate action.

In situations where these fears are genuine and real, sale or distribution of condoms that do not meet required standards need to be withdrawn for further investigation with immediate effect by the Kenya Bureau of Standards (KBS).
However, there is a need for existing laws that safeguard reproductive health rights of people to be reinforced. These laws need to create a mechanism that checks and balances the KBS; a statutory organization of government, to avoid conflict of interests and breaching of law. Equally, there is a need for the Human Rights Commission to seek legal redress on behalf of the common civil society where KBS have breached the law and call for restructuring of corrupt organization systems. Shortly after the completion of field data collection for this research study (August, 2009), the Kenya Television News (KTN) reported:

Experiments showed condoms sprang water after being subjected to an electronic ‘freedom from holes test’ which involved filling them with water” ("Anger and anxiety over ‘leaky’ condoms", 2010).

This news informed the research process by placing the Maasai women’s discussions concerning fears around condoms quality into reality. In the meantime, it is recommended that the KBS inspects condoms from exporters, retailers, manufacturers in the country by carrying out adequate sampling as per their mandate. It is also recommended that the Kenya government; Ministry of Health, positions itself at the community level to restore confidence and ensure its consumers of the safety of the product. Also suggested is the creation of consumer awareness so that they are able to identify defects in condoms such as broken seal, expiry date and how to protect the condom from breakage.

**Make Access to Pleasurable Condoms**

Research findings identified that condoms are unpopular because they are said to detract from sexual pleasure. It could be possible that these types of condoms are linked to the inexpensive condoms and free condoms distributed by some reproductive health agencies.

The affordable commercialized condoms and the extra accessorized i.e. extra pleasure (studded and skinless) condom vary in costs. The later one; which is more expensive

5 “Many Kenyans could unwittingly be exposing themselves to unwanted pregnancies, sexually transmitted infections and HIV through usage of substandard condoms. The shocking revelations emerged as both scientific and rudimentary tests confirmed that several popular brands of condoms in Kenya could have holes big enough for water and other fluids to leak through. Another shocking revelation is that the Kenya bureau of standards does not examine the quality of condoms both imported and manufactured in the country” (KTN, 2010). Retrieved from [http://www.ktnkenya.tv/media1.php?id=7402](http://www.ktnkenya.tv/media1.php?id=7402).
than the previous, is far from the reach of a low income earner. On the other hand there could be a lack of pleasurable condoms available to those who can afford them.

The researcher’s recommendation is for commercial condom companies to find a distribution mechanism to reach rural areas as Olchoro Sub Location with the suggested quality of pleasurable condoms. Wide undiscriminating market and supply of such useful condoms should be encouraged by the Ministry of Health for everyone to rightfully have wide variety of choices.

As to the efforts of the Government and NGOs distributing free condoms, it is worth their while making an extra investment to carry out extensive market research on the top pleasurable standard condoms available and make them free.

It is suggested that this concept of accessible pleasurable standard condoms could be more sustainable and key to consistent use of condoms hence translating to the national goal of curbing the incidence of STIs particularly HIV.

Diaphragm Contraception

There is need for female controlled methods of prevention against STI’s that translate to HIV prevention among Maasai women. This research recommends the diaphragm method of contraception as its use can be controlled by women.

Ramjee et al., (2008) links the use of diaphragms with reduced STI which ultimately reduces HIV infection. The observations suggest that:

Women who use physical barriers that cover the cervix have lower rates of infections with *Chlamydia trachomatis* (CT) and *Neisseria gonorrhea* (GC), which preferentially infects the cervix and upper genital tract, (Ramjee et al., 2008).

It is the view of the research to suggest greater use of the diaphragm as a method by which women can gain full control to protect themselves from STI’s that catalyses HIV infection. Diaphragms are unnoticeable to the Maasai woman’s sexual partner who opposes use of either male or female condoms. This is not to say that diaphragms offer 100 percent protection against HIV and other STI’s, rather are an option where the male or female condom is lacking. However, Steina and Glymoura, (2007) ascertains that “diaphragm plus condoms provides substantially greater protection than either of the two used exclusively” (p. 1823).
Strategic Approach for Testing Multiple Sexual Partners

The researcher suggests that VCT services take into consideration the reality of cultural practices such as polygamy. This could enable the program to come up with a strategy where individuals involved with multiple sexual relationships are encouraged to get tested for HIV. This can be done during counselling of clients who go for testing and identifying their type of union (polygamous or monogamous) and encouraging them to request their partners get tested for HIV. The researcher views this recommendation as a culturally sensitive approach where possible judgmental views on polygamy are discouraged. This would encourage Maasai husbands and wives to go for HIV testing therefore controlling and managing HIV.

Esoto

This study recommends that Esoto be discouraged owing to the fact that it allows the perpetuation of violations of young women’s reproductive health rights. Research findings established that sexual inappropriateness often takes place as violence against women with potential to cause harm. Kenyan law does not recognize Esoto as a cultural practice that needs to be protected.

Although some young women are said to give consent, their sexual patterns are inconsistent. Unlike polygamous relationships, it is more challenging for individuals involved in Esoto to control and manage STIs including HIV.

Research findings indicated high HIV and AIDS knowledge in the study area. The study recommends individual responsibility to change sexual behavior because it is absolutely essential to reproductive health. In addition there needs to be encouragement in the use of contraception, recommending a combination of condoms and diaphragms for protection from STI’s especially HIV.

Human Rights

The research recommends that the Draft Marriage Bill 2007 be enacted (Nzomo, & Mbote, 2003). Women will legally be involved in decisions concerning the prospective husband taking up multiple wives in the future. Referring to earlier discussions on polygamy, the Marriage Bill 2007:

defines marriage as the voluntary union of a man or woman intended to last for their lifetime and states that the marriage could be monogamous or polygamous provided the two parties are in
This is because the union affects women involved directly both physically and psychologically hence determining the state of her reproductive health. The state, during the current era of high HIV/AIDS pandemic largely affecting and infecting women should pass the bill that safeguards the welfare of women’s reproductive rights especially those who are tied up with cultural practices out of no choice of their own.

In practices where women’s sexuality continues to be degraded in the name of customs and sexual practices as Esoto, early marriage for girls below the age of 18 years, and culturally acceptable gender based violence in the form of wife ‘disciplining’, law enforcements need to be applied without discrimination.

**Law Enforcement**

In regards to health there is need for Kenyan laws to spell out precisely what is considered as lawful and unlawful, as at present it provides loopholes for some customary laws to openly discriminate against women and their health needs. It is misleading at the community level when the Kenyan law formulates Child Protection Acts and Sexual Offense Bills for minors under 18 years and at the same time turns a blind eye to customary laws that permit such practices as early marriage, Esoto, FGM and the like on a daily basis. The same applies to agreements and laws put in place by the state to eliminate all forms of gender based violence that customarily is termed ‘wife disciplining’.

**Capacity Building for Law Enforcers**

This study recommends that the Ministry of State for Special Programmes sensitizes law enforcers on the effects of certain harmful practices that perpetuate violations against the reproductive rights of women. Some Kenyan law enforcers could be influenced by certain cultural practices and find it challenging to act according to law. This study recognizes the advantage of having a female Minister of State; Hon. Dr. Naomi Shabaan, who could well represent Maasai women’s issues and advocate for reproductive health rights.

The police administration in particular needs to undergo refresher training on human rights before it is fair to judge their capacity. The provision of knowledge should come hand in hand with equipping the administration force with facilities that offer services for its citizens; in this case woman seeks their support. Some of these could include;
• Establish women-friendly protection units at police posts that would encourage reporting of incidents
• Temporary rescue centre for women who go through forms of abuse before they can be referred to the right facilities that network with the police administration
• Free call facility for both police and citizens to reach each other with ease
• Adequate facilities for police to reach remote areas that require their services

**Neighborhood Collaboration between Bordering Countries**

Research findings identified that young Maasai girls below eighteen years and their prospective husbands are sent off by their families to Tanzania to conceive and stay in illegal marriages. This study recommends that the Department of Immigration in Kenya and Tanzania collaborates at the land entry points (Kenya/Tanzania border) to monitor reasons for movement of Maasai girls below eighteen years. Also, the Tanzania authority could assist the Kenya Ministry of State for Provincial Administration and Internal Security by tracking Maasai Kenyan girls who cross into Tanzania to perform early marriage rights and sending them back to Kenya for legal procedures. Investigations leading to tracing these young Maasai girls could begin from the Kenyan families who are based in Loitokitok District.

Tanzanian and Kenyan customs police need to be more restrictive by monitoring the in-out flows of immigrants adequately seeking identification and the age of immigrants and possibly the reason for travel. These are simply the international measures put in place all over the world to safeguard children who are trafficked.

**Keeping Girls in School**

Research findings indicate the benefit of schooling for a majority of young women (16-20 years) who attended school and were not married at a young age or having time to participating in risky sexual activities as Esoto. However, economic constraints challenge schooling as most girls are not able to progress to secondary schools.

This study recommends a bursary program for young Maasai girls as a sustainable way of keeping them safe from experiencing harmful cultural practices.

Free primary education is a commendable government initiative but many young Maasai girls are not guaranteed to enrol in secondary school because of fees. In the
government’s effort to provide education for all, free secondary school education to alleviate the economic transition from primary to secondary school is recommendable.

Equally, the study suggests stakeholders invest in education campaigns that encourage communities to allow girls to attend school. Social and cultural constructs that prefer boys to girls should be discouraged. When Maasai girls attend school with boys, both of them are able to socialize and beat the gender dissimilarities.

Further, the Kenyan Ministry of Education could establish more stimulating learning environments and improve the quality of education through the provision of more teachers, expansion of safe learning facilities and increasing the number of girls’ schools in the area to increase accessibility. Young girls drop out of school from lack of motivation caused by poor or lack of facilities which make learning more difficult.

**Strategic Partnering in Peer Education Programs**

Strategic partnership is recommended to existing women’s groups and other stakeholders operating health initiatives in Loitokitok. The Kenyan Ministry of Health extension services and NGOs such as AMREF, Africa Infectious Diseases (AID village) and faith based organizations (FBO) have a wide presence in Loitokitok/Kilimanjaro area. These stakeholders could partner with existing Maasai women groups who have suggestions on how their health issues could be tackled.

The research outcome noted specific areas where peer education is a viable sustainable tool for intervening in young Maasai women’s reproductive health issues. The outcome of the study noted an inadequacy of information and skills on reproductive health matters dealing with contraception use and STIs. This study recommends refresher training for women’s groups to advance their skills. The women would be able to successfully share reproductive health knowledge and information with their peers.

**Young Women Empowerment**

This study recommends early empowerment of young girls on sex education particularly those girls that have not been privileged to go to school. The young women (16-20 years) said that they learnt a lot from health clubs in schools but young out of school women were left without any empowerment opportunities. This study recommends that there be more training of trainers in reproductive health to reach out to young out of school women and women that have never been to school.
Outreach Activities

Below are suggested outreach activities that could reach the goal of realizing Maasai women’s reproductive health in the community.

Informal Meetings
Informal meetings that hold discussions would encourage young Maasai women to talk about their sexual health with technical support from health workers. This could assist them to be responsible for their sexual life and freely make informed choices concerning their reproductive health. Informal meetings could be an opportunity where young women’s voices are restored and they could speak boldly about reproductive health issues they face. Young women would not have to conceal discussions relating to sex because they would learn to be confident about their sexuality as an entitled right.

Youth-Friendly Information Centre
Stakeholders in the area with the view to promoting health awareness for women and the wider community could jointly assist a community to establish an information centre where education and communication materials relating to reproductive health, human rights and life skills can be resourced. The materials could be accessible to consumers who are both literate and illiterate. The education and communication materials would be those that fit into the cultural context of Maasai. For instance, information published in Maa language and drawn from local concepts would be valuable to reproductive health.

Information centres could be a reflection of what the youth and wider community would like to have in the centres. For instance, a Maasai elder or youth, an art theatre, visual aids, books which they identify would be of practical help for them to gain knowledge. This would enable the youth and wider community to own the information centres and advance the centre according to their needs.

Based on observations, the study highly recommends an information centre because the research area, Olchoro Sub Location, is semi-arid and not fortunate in having facilities that would empower the community to access useful materials for their reproductive development. See figure below, a sample illustration of geographical
situation of remote Olchoro Sub Location in Loitokitok.

Figure 4  Geographical situation of remote Olchoro Sub Location in Loitokitok District, Kenya. Private Collection of Joyce Matogo.

Reproductive Health Awareness for Significant Community Leaders
The study recommends awareness creation on women’s reproductive health issues to important key members of the community e.g. area chief, village elders and influential political and religious figures, who are predominantly men. This follows the fact that most influential figures that would intervene for women’s health issues effectively are predominantly men. As discussed in Chapter One, Maasai social systems are patriarchal and most authorities are predominantly male. These significant male figures are the ‘gatekeepers’ to any community development. Awareness creation of women’s health issues among key figures is also an opportunity to negotiate gender equity. Once gender has been negotiated on equitable terms practices such as ‘wife beating’ (gender violence), sexual violence, female socio-economic and political segregation would gradually reduce. Competition and restrictions would ease and men and women would begin to have compassion for one another.

One of the strengths the Maasai social organisation has is that the system has more credibility from the wider community than any other innovation would. The study proposes that the Maasai social organisation and other key community figures, that could include women as well, would be highly influential in trickling down decisions that are relevant to women’s reproductive needs.

Young Girls Alternative Rite of Passage
This study recommends an identification of an alternative rite of passage that
recognizes and celebrates a healthy and painless entry of girls into womanhood. An alternative rite of passage could be arrived at by the community practising FGM. They would come together and agree on equal terms which healthy alternative passage would make that transitional phase most memorable, astounding, dramatic and effective.

Micro Enterprise Initiatives
This study recommends micro enterprise initiatives for families who under prioritize women’s reproductive needs because of low household income. Micro enterprise initiatives would improve the incidence of families giving away premature daughters for marriage in exchange for dowry, therefore allowing their daughters to enjoy their reproductive health rights.

Culturally Maasai women are not entitled to own economic assets. When some women want to attempt entrepreneurship, they are not able to access capital or credit facilities because they lack collateral to guarantee financial lenders. This denies women the opportunity to advance economically and they continue to live in abject poverty. This study suggests development of credit financers to identify flexible ways for Maasai women to benefit from loans to start micro-enterprises. Equally, increasing women’s capacities would ease economic dependency on their partners. This would particularly benefit young unmarried women, who would not have to forgo their health needs for lack of economic power.
CONCLUSION

This research thesis asked the question, ‘how do customs and sexual practices impact on young Maasai women’s ability to negotiate their sexual and reproductive health in relation to HIV and AIDs in Loitokitok, Kenya. The findings of the research established that women's risk of STIs especially HIV infection is strongly determined by cultural and sexual practices that are gender related.

Are young Maasai women able to negotiate their own reproductive health? Research findings have found that there is a challenge in reproductive health autonomy. The study does not call for cultural change or reformation of traditional culture within the Maasai community; rather it appeals for transformation of customs and practices that cause harm on women’s reproductive health. Valuable cultural practices and intentions that recognize women and celebrate their womanhood should be encouraged in a way that is not physically or psychologically daunting experience on their wellbeing.

To this end, the understanding and knowledge of the Maasai worldview is critical to the intervention of Maasai women’s reproductive health rights. A more cultural approach to Maasai women’s reproductive health is suggested to be more effective. In relation to the adoption of STI prevention measures, Maasai culture plays a key role towards identification of preventive measures and strategies.

Equally, the plea to lessen the gender gap through the involvement of men in women’s reproductive health is essential. A significant contributing factor is the construct of gender identities that lie behind these cultural and sexual practices that bear a mutual relationship to Maasai women’s reproductive health choices. The existing customs and practices tend to be more repressive to the women’s autonomy in sexual health matters as men hold power in all important roles in society.

However, reproductive health issues among Maasai women need a concerted effort of existing stakeholders in the area. Government and NGO health programs need to address the root causes of women’s vulnerability to diseases especially STIs that are determined by the traditional and cultural practices of the Maasai as discussed in the research. This study realizes that there needs to be collaboration between political and religious leaders to be engaged and encouraged to act as behavioral change agents. These key community leaders have influence to advocate for the ending of cultural and traditional practices that encroach on women’s reproductive health.
The Government is the major conduit of development and programs should focus more on greater sensitization and education of all Maasai men and women on the traditions and cultural practices that increase women’s vulnerability to STIs including HIV.

In addition to this, there is need for Government to take measures that ensure all boys and girls of school going-age are in school. Furthermore, the education system should incorporate sex education in the curriculum to provide information on STIs and prevention strategies.

Further, this study realizes that the Government needs to enact laws and adopt policies against Maasai cultural practices that are not only harmful to women but also increase their vulnerability to STIs especially HIV.

The research project is a potential tool to promote a development goal of the youth group involved through advocating for change within the community in regards to reproductive health, education and economic empowerment programs, by highlighting the development issues facing women in Loitokitok.

This research project has identified areas for further research interests particularly through the recommendations that have been provided. The research project could assist in developing proposals to seek funding from the Kenyan government and other local and international development agencies to implement activities that have been assessed as needs in this research project.

In conclusion, education about the spread of HIV and AIDs and its link to cultural practices such as female circumcision, polygamy, Esoto and Moranism is essential. An indigenous and cultural pedagogy which acknowledges and validates Maasai culture is likely to be more successful, particularly when peer educators are involved. Further, the development of human rights-based interventions that address FGM and actively seek to re-inscribe Maasai women’s cultural identity, sexuality and transition to womanhood by affirming alternative rituals to maturity will also reduce the likelihood of HIV infection. As the well known quote on educating men and women states:

"Educate a man, and you educate an individual. Educate a woman, and you educate a nation."

~Author, date unknown~
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http://www.informaworld.com/smpp/section?content=a793367345&fulltext=713240928


APPENDICES

Appendix 1

Research Clearance Permit, Republic of Kenya

CONDITIONS

1. You must report to the District Commissioner and the District Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit.
2. Government Officers will not be interviewed without prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least two (2)/four (4) bound copies of your final report for Kenyans and non-Kenyans respectively.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice.

REPUBLIC OF KENYA

RESEARCH CLEARANCE PERMIT

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PAGE 2

This is to certify that:

Prof/Dr/Mr/Mrs/Miss JOYCE NJERI MATOGO of (Address) DEPT. OF SOCIAL PRACTICE AUCKLAND, NEWZEALAND. has been permitted to conduct research in:

LOITOKITOK Location, KAJIADO District, RIPT VALLEY Province, on the topic How Cultural And Sexual Practices Impact Upon Pastoralist Women(Aged 16-25years)Ability To Negotiate Their Sexual And Reproductive Health Particularly Inrelation To HIV/AIDS for a period ending 30TH SEPT 2009.

Research Permit No. NCST/5/002/R/568
Date of issue 30.07.2009
Fee received SHS 1000

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Applicant's Signature

Secretary National Council for Science and Technology
Appendix 2

Participant information sheet

My name is Matogo Joyce Njeri. I am currently enrolled in the Master of Social Practice degree in the Department of Social Practice at Unitec New Zealand. Part of my program involves a research thesis. My research topic looks at how cultural and sexual practices impact upon pastoralist women’s (aged 16-25 years) ability to negotiate their sexual and reproductive health particularly in relation to HIV and AIDS.

Aim of Research

1. To ascertain the perceptions of young girls and women about how one becomes infected with HIV/AIDS and whether these are attributed to cultural sexual practices
2. To investigate the strategies considered by young girls and women as appropriate, practical and effective to cope with these risks

Values and benefits of the Research

Research involving your empowerment group would benefit you as a group member in the following ways;

- Designing of group activities
- Preparation of plans and budgets for activity implementation
- Potential fundraising tool for group initiatives

Method of Research

I am seeking participants to assist me with my research through focus group discussions and for some participants, a face-to-face in depth interview. You may choose to participate in a focus group discussion or face to face discussion with me or participate in both. I would appreciate it if you could meet with me for about one hour to talk about these topics. I will come to your meeting point whenever agreed upon. I will ask questions and my female research assistant will translate it into Maasai language while the other female assistant will take notes for future reference. I will ensure that no feature identifies you.

If you are unmarried and 18 years old or below and agree to participate, your parent/guardian will be asked to sign a consent form. However, you still reserve the right...
to withdraw from interview even if your parent/guardian gives consent. Throughout our gatherings we will share meals and refreshments provided by the researcher.

**How the data will be analyzed**

Thematic analysis shall be used to analyse data. Before submitting the results from this process the focus groups (including interviewees), will be invited to check (and change if necessary) their own contributions to ensure accuracy of the contributions.

My research and finding will be reported back to the Department of Social Practice. We hope that this will also provide for the institutions academic knowledge.

Please contact us if you need more information about the project. At any time if you have any concerns about the research project:

My supervisor is Helene Connor & Sue Elliot, phone 09 8154321 Ext. 5010 or email hconnor@unitec.ac.nz and sjelliott@xtra.co.nz and Matogo Joyce N. (researcher) on matogj01@studentmail.ac.nz

If you are happy with the above please fill in the attached consent form which I will collect.

**UREC REGISTRATION NUMBER: (2007.954)**

This study has been approved by the UNITEC Research Ethics Committee from (24 June 2009) to (24 June 2010). If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (ph: 09 815-4321 ext 7248). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

Thank you

Matogo Joyce N., and on behalf of Department of Social Practice, Unitec New Zealand
Participant consent forms

How cultural and sexual practices impact upon pastoralist women’s (aged 16-25years) ability to negotiate their sexual and reproductive health particularly in relation to HIV and AIDS: (with a focus on the Kenyan area of Loitokitok)

I have had the research project explained to me and I have read and understand the information sheet given to me.

I understand that I don’t have to be part of this if I don’t want to and I may withdraw at any time.

I understand that everything I say is confidential and none of the information I give will identify me and that the only persons who will know what I have said will be the principal researcher, and research assistants. I also understand that all the information that I give will be stored securely by researcher's supervisors for a period of five years in which after it shall be destroyed.

I understand that notes of my discussion with the researcher will be taken and no photos taken of me.

I understand that I can see the finished research document.

I have had time to consider everything and I give my consent to be a part of this project.

Participant Signature: ………………………….. Date: ………………………

Project Researcher: ………………………….. Date: ………………………
UREC REGISTRATION NUMBER: (2007.954)

This study has been approved by the UNITEC Research Ethics Committee from (24 June 2009) to (24 June 2010). If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (ph:
09 815-4321 ext 7248). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

Consent form for unmarried 16-18 year olds

I have had the research project explained to me and I have read and understood the information sheet given to me.

I understand that I do not have to be part of this if I do not want to and I may withdraw at any time.

I understand that everything I say is confidential and none of the information I give will identify me and that the only persons who will know what I have said will be the researchers. I also understand that all the information that I give will be stored securely by researcher’s supervisors for a period of five years in which after it shall be destroyed.

I understand that my discussion with the researcher will be taped and transcribed.

I understand that I can see the finished research document.

I have had time to consider everything and I give my consent to be a part of this project.

Participant Signature: ………………………….. Date: ……………………………

Parent/Guardian Signature…………………… Date……………………………

Project Researcher: ……………………………. Date: ……………………………

UREC REGISTRATION NUMBER: (2007.954)

This study has been approved by the UNITEC Research Ethics Committee from (24 June 2009) to (24 June 2010). If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (ph: 09 815-4321 ext 7248). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix 3

Discussion guide for focus groups

The questions below shall be translated into the local language understood by the local women.

Entry questions

1. What words do people use here when they talk about or are referring to sex
2. Are there things that are done to prepare girls to become full mature women and have sex?
3. What age are girls/women when they initially encounter their first sexual experience?
4. What age do you think most boys or men are when they have sex for the first time?
5. Who is normally supposed to propose sex – men/boys or women/girls?

Identification of negotiation skills

1. Do you think it is equally right for girls/women to decline sex or suggest sex with their partners/boyfriends
   a. If not why is it not okay for girls/women to decline or ask for sex from their partners/boyfriend
2. What is the reaction of partner(s)/boyfriend(s) when girls/women suggest sex or no sex at all?
   a. When partners/boyfriends wants to have sex and the girls/women do not want to, what do they do?
   b. What happens to girls/women when their partners/boyfriends do not understand their position of not wanting to have unprotected sex or sex at all?

Knowledge attitude and practice

1. Are you aware of any infections/diseases that are transmittable through sexual intercourse?
   a. Can you name any that you are aware of?
2. What kind of advice have other women in the community given you about sex?
3. Do you know about condom use and how it is used?
   a. Which type of condoms have you commonly heard of (male or female
condom)

b. What would be the perceptions of partners/boyfriends towards condom use?

c. What are your thoughts about condom use?

g. What are the common reasons to prefer or not to prefer condom use?

4. Are there other ways (strategies) that girls/women protect themselves from infectious diseases including HIV?
Appendix 4

Unitec Research Ethics Approval

Dear Joyce

Your file number for this application: 2007.954

Your application for ethics approval has been reviewed by the Unitec Research Ethics Committee (UREC) and has been approved for the following period:

Start date: 24 June 2009
Finish date: 24 June 2010

Please note that:

1. the above dates must be referred to on the information AND consent forms given to all participants

2. You must inform UREC, in advance, of any ethically-relevant deviation in the project. This may require additional approval.

You may now commence your research according to the protocols approved by UREC. We wish you every success with your project.

Yours sincerely

Deborah Rolland
Deputy Chair, UREC

CC: Cynthia Almeida
Helene Connor
**GLOSSARY OF MAASAI TERMS AND ENGLISH TRANSLATIONS**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Esoto</td>
<td>A sexual practice where young men and young women engage in sexual intercourse all night long with multiple partners. Sometimes the young women have voluntary sex and sometimes it is forced, i.e. Rape.</td>
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<tr>
<td>Moran</td>
<td>A young Maasai warrior who has been initiated into manhood after his circumcision and delegated the authority, power and responsibility to safeguard the community.</td>
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<tr>
<td>Baraza</td>
<td>A traditional forum or gathering where community meets with chief, elders or any other key figures, to discuss, share and resolve matters affecting the Maasai community.</td>
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<tr>
<td>Osiririm</td>
<td>A beaded ornament which girls wear on their wrists or neck.</td>
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<tr>
<td>Esongorai</td>
<td>Sexual Immorality</td>
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</table>