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Research Paper

Socio-Cultural Factors That Perpetuate ThePractice Of Female Genital Mutilation In Samburu County, Kenya.

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ABSTRACT : *Female genital mutilation which is the collective name given to several different traditional practices that involve the cutting of female genitals for cultural or any other non-therapeutic reasons is a direct violation of girls and woman rights. Although the practice has being outlawed, it is being practiced by some communities in Kenya, albeit under strict secrecy. The main objective of this study conducted among men inLedero village Samburu County, Kenya was to describe the social cultural reasons to the practice of Female Genital Mutilation (FGM). Majority of the participants were aged between 18-29 years (29.02%), 30- 39 years (23.32%) and 7.8% were above 60 years. According to the study, the various reasons for practicing FGM include; tradition, (91.7%), for admission into women groups (97.4%), to decrease high sexual drive in the women (90.2%), to be accepted as a bride (Increases chance of Marriage) (98.5%), to maintain cleanliness (98.5%), to ensure female purity (96.9%), to improve fertility (71%),virginity protection76.7% and 13% believed that religion plays a role in female mutilation in the community. In the Samburu community men are decision makers, therefore it is important that more education and campaigns on abandonment of FGM.is carried out.*

Keywords: *Female genital cutting, Female genital mutilation, cultural believes*

I. Introduction

Female genital cutting/ mutilation is the partial or complete removal of the clitoris, prepuce, or labia of a girl or young woman, as practiced among certain cultures, especially in parts of Africa and western Asia. FGM/C is a widespread practice in some parts of the world. It is performed on female infants, children or pubescent girls under non-sterile conditions without anesthesia [1].

The extent of cutting varies from a small superficial skin cut to removal of the entire external female genitalia. Female genital cutting exposes a female to risks of serious infections and may cause sexual dysfunction, reproductive dysfunction or death from hemorrhage or sepsis. Female genital cutting should be condemned in the strongest possible terms and should not be tolerated by any health care practitioner, any agency responsible for public health or any government.

According to WHO [1], FGM/C occurs throughout the world. It estimates that between 100 million and 140 million girls and women alive today have experienced some form of FGM/C practice. It is further estimated that up to 3 million girls in sub-Saharan Africa, Egypt and Sudan are at risk of genital mutilation annually. In North eastern Africa, the prevalence varies from 97% in Egypt to 80% in Ethiopia. In Western Africa, 99% of the women in Guinea, 71% in Mauritania, 17% in Benin Africa and in the united Republic of Tanzania the prevalence are slightly lower at 18%.

UNICEF estimated in 2016 that 200 million women in 30 countries, 27 African countries, Indonesia, Iraqi Kurdistan and Yemen, had undergone the procedures [2]. In Africa countries; 15 are from West Africa. These are Benin (13%), Burkina Faso (76%), Côte d'Ivoire (38%), Gambia (76%), Ghana (4%), Guinea (96%), Guinea-Bissau (50%), Liberia (66%), Mali (89%), Mauritania (69%); Niger (2%), Nigeria (27%), Senegal (26%) , Sierra Leone (88%). The other countries in Africa are Cameroon (1%), Central African Republic (24%), Chad (44%), Democratic republic of Congo (5%), Djibouti (93%), Egypt (91%), Eritrea (89%), Ethiopia (74%), Kenya (27%), Somalia (98%), Sudan (88 % of women from Northern Sudan), Tanzania (15%) and Uganda (1%).

According to Finke [3], FGM/C is recognized as a harmful practice which abrogates human rights. It is prohibited by law in several African and Western countries. Women who have been subjected to FGM/C are

also more likely to experience increased pain during intercourse, reduction in sexual satisfaction and reduction in sexual desire compared to women who have not been subjected to FGM/C

FGM/C is practiced in over half of the districts in Kenya, with 34% of all women aged 15-49 years reporting being circumcised. According to the results from Kenya Dermographic and Health Survery[4], FGC is nearly universal among certain ethnic groups such as the Somali, Kisii, and Maasai, and is highly prevalent among the TaitaTaveta, Kalenjin, Embu and Meru groups, and is practiced to a lesser extent among the Kikuyu and Kamba. The Clitoridectomy (type 1) and excision (type 2) are the predominant types of cutting practiced, the Somali, Borana, Rendille, and Samburu practice the (type 3) form of infibulation, which is practiced on girls at pre-puberty and younger ages [1].

Samburu County where this study was conducted is largely occupied by the Samburu people and is located just at the tip of Lake Turkana. Ledero village has high incidences of FGM despite the many efforts that have been put across to stop this backward cultural practice. The mortality of girls and women undergoing these practices is high in Ledero village as the activity is done in secrecy and few records are kept and deaths as a result of FGM cases are rarely reported. It is largely a patriarchal community and the men have the final say on all issues related to health and development. This one setting provided a rich source of information on social cultural reasons for female genital mutilation.

II. Materials And Methods

2.1 Study design

Cross sectional descriptive and analytical study designs were used to determine the factors that perpetuate the practice of FGM/C in Ledero village.

2.2 Study population

Ledero village has a population of 8230 people; 4129 being male.

2.3 Inclusion criteria

All willing men aged 18 years and above, inhabitants of Ledero village for the past one year were included in the study.

2.4 Sample size determination

A sample size of 193 calculated using Fischer's et al 1998 formula was involved in the study.

2.5 Sampling procedure

Census sampling method was used. This is because the community engages in nomadism and most of them had gone in search of pasture and water for their livestock.

2.6 Data collection technique

Both quantitative and qualitative methods were utilized to gather data for the study. Focused group discussion, key informant interview and semi structured questionnaires were used on the target group.

2.7 Data collection instruments

A semi structured questionnaire was developed and used to collect information. Video tapes for recording information were also used. Two weeks before data collection, a pre-test was carried out in the neighboring village of Kisima to validate the instruments used. Based on the results of pre-test, appropriate changes were made on the structure of the questionnaires before actual data collection began.

2.8 Data analysis and presentation

The data was coded, entered and cleaned before analysis. SPSS version 20.0 was used to analyze quantitative data while qualitative data was analyzed according to emerging themes. The results were presented in tables and graphs.

2.9 Ethical considerations

Ethical authority was granted by ethics committee of Great Lakes University of Kisumu and further authority granted by the local provincial administrators. Prior informed and written consent was sought from the subjects to ensure confidentiality. The information from the subjects was kept confidential.

III. STUDY FINDINGS

3.1 Socio-Demographic Characteristics of the Study Participants

Majority of the participants were between 18-29 years of age (29.02%). Other participants (23.32%) were in age category of 30-39 years of age while the least (7.8%) were above 60 years of age. Concerning marital status,most of the respondents were married (57%) while only about 4.7% were either divorced or separated. On religion, Christianity was the predominant religion of the participants in this study and this comprised of Protestants (50.7%) and Catholics (44.0%). Muslims constituted 3.6 % of the study sample.Analysis of the highest level of education attained by the respondents showed that the majority, 45.1% had primary school education while 24.4% had secondary education and only 1% had the University level of education. Concerning the occupations of the study participants, a sizeable proportion of the participants were

farmers (45.6%) while others were either students (34.7%), unemployed (12.4%) or employed (7.2%).With regards torespondents' monthly income, more thanhalf reported earning less than Kshs 15,000.

Table 1. Distribution of respondents by Socio-Demographic Characteristics

Characteristics		Total	
		n=193	%
Age group	18-29	56	29.02
	30-39	45	23.32
	40-49	41	21.24
	50-59	36	18.65
	>60	15	7.77
Marital status	Single	74	38.34
	Married	110	56.99
	Divorced/separated/widowed	9	4.66
Education level	None	36	18.65
	Primary	87	45.08
	Secondary	47	24.35
	College	21	10.88
	University	2	1.04
Religion	Catholic	85	44.04
	Protestant	98	50.78
	Muslim	7	3.63
	Others	3	1.55
Occupation of respondent	Student	67	34.72
	Employed	14	7.25
	Unemployed	24	12.44
	Farmer	88	45.60
Number of Children	0-2	77	39.90
	3-4	65	33.68
	>4	51	26.42
Respondents monthly income	Ksh 0-5000	19	9.84
	Ksh 5001-10000	18	9.33
	Ksh 10001-15 000	68	35.23
	Above Ksh 15 000	88	45.60

FGM Definition Given By the Respondents

Of all the recruited respondents in this study defined genital mutilation as "cutting (removing) part of female (56.7%), organ and/or removal of clitoris (58.7%), removing extra skin from female organ (47.9%), cleaning (78.4%), removal of dirty part from female organ (67.9%).

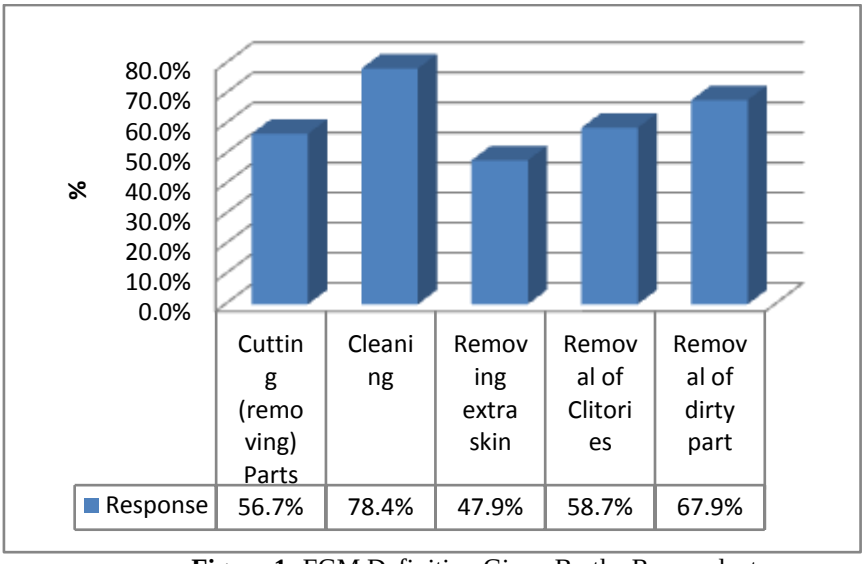

Figure 1: FGM Definition Given By the Respondents

4.4.2 Common reasons given why FGM practiced

There are various reasons for their being practicing FGM, due to tradition, (91.7%), to be admitted in to women group (97.4%), to decrease high sexual drive of in the women (90.2%), to be accepted bride (Increases chance of Marriage) (98.5%), to prevent pre-marital sex (83.4%), to maintain cleanliness (98.5%), to ensure

female purity (96.9%), to improve fertility (71%) and 76.7% for virginity protection. 13% of interviewed men believe that religion plays role in female mutilation in the community

Table 2: Common reasons given for the practice of female genital mutilation

	Agree		Disagree	
	n	%	n	%
Presence of FGM in the village	177	91.71	16	8.29
Religious requirement	25	13.0	168	87.05
To protect virginity	148	76.68	45	23.32
FGM improves fertility	137	70.98	56	29.02
To be accepted bride(Increases chance of Marriage)	190	98.45	3	1.55
To make child birth easier and prevent infant death	97	50.26	96	49.74
To decrease high sexual drive	174	90.16	19	9.84
To be admitted in women group	188	97.41	5	2.59
FGM prevents pre-marital sex	161	83.42	32	16.58
FGM maintains cleanliness	190	98.45	3	1.55
FGM ensures female purity	187	96.89	6	3.11

Bivariate Analysis OfSelected Socio-Demographic With Mutilating Sister/Daughter

Religion, age, marital status, Knowledge of FGM complications and education level were assessed as in relation to Mutilate daughter as shown in Table 7. Respondents who were above 50 years of age were more likely to mutilate their daughters (OR=2.145; 95%CI: 0.751-1.984; p<0.025), compared to those less than 50 years of age. Marital status also had significant level of carrying out the practice (OR=3.227; 95%CI: 0.357-4.222; p<0.045). Level of education, religion among the respondent did not have any significant association with mutilating the daughter**.**

Table 3.Association between selected demographic factors and their level of acceptance to having their own daughters/sisters mutilated

Characteristics		**Mutilating Daughter /Sister**				**OR**	**95% CI**	**p-value**
		S. Agree (%)	Agree (%)	Disagree (%)	Strongly Disagree (%)			
Age group	18-39	25.81	57.29	5.21	11.69	1		
	>40	54.33	41.75	1.25	2.67	2.522	0.751-1.984	0.025
Marital status	Others	41.63	31.86	14.86	11.65	1		
	Married	47.91	48.45	1.09	2.55	3.227	0.357-4.222	0.045
Education level	None/Primary	58.27	39.29	0.98	1.46	1		
	Secondary /Tertiary	21.45	45.69	4.26	7.66	1.070	0.444-2.581	0.847
Religion	Christian	31.58	51.32	21.58	15.56	1.091		
	Muslim	54.9	45.1	0	0		0.494 2.408	0.954
	No	36.54	53.07	7.61	2.78			

IV. Discussions

Currently the continuing practice of Female Genital Mutilation throughout the world is a cause of great concern. From the study majority of the respondents 29.2% were between the age of 18-29 years and the least 7.7% were above 60 years of age.The prevalence of FGM in the study area was found to be high with 86.5% of men saying that they would mutilate their daughter. A significant proportion of men, (46.6%) believed that the decision to have their daughter/sister mutilated is solely on the father signifying how men still control important decisions on a woman's life. In this study, infibulations (pharonic) and sunni types were the commonest types of FGM practiced at 50.4% and33.5%respectively.Majority of study participants reported that FGM was mainly conducted between the ages of 6-14 years (55.4%), while a further 32.1% were circumcised at above 14 years. This report was in agreement with that of Ethiopian Demographic and Health survey (EDHS) and the report from 22 African countries including Ghana and Somalia on their induction of age to FGM [5].With regards to awareness of the dangers of FGM, respondents with primary or below primary education were three times likely to have low or no awareness (p<.001) as compared to secondary and post-secondary levelrespondents.There is strong association (p<.001) between awareness level and age of the respondents. The older age group (>50 years) were four times likely to have low awareness than the younger counterparts to have low or no awareness about dangers of FGM. Socio demographic characteristics were assessed in relation to 'mutilate daughter' as shown in Table 3. Respondents who were above 50 years of age were more likely to mutilate their daughters (OR=2.145; 95%CI: 0.751-1.984; p<0.025), compared to those less than 50 years of age. Marital status also had significant level of carrying out the practice (OR=3.227; 95%CI: 0.357-4.222; p<0.045). Level of education and religion among the respondents did not have any significant association with mutilating the daughter. Knowledge of FGM complications was also not statistically significant (p=0.658) in mutilating the daughter.

These concurto an extent with a study [6] done in Ethiopia by Getachew, although in that study religion was significantly associated with mutilating the daughter.

Reasons for Female genital mutilation

In the Samburu community, it is perceived that unless a girl is circumcised she will not become a mature, responsible woman. She will have no right to associate with others of her age group, or her ancestors. Female genital mutilation is believed to ensure a girl's virginity until she is married. From the study, there was a perception that FGM is the rite of passage into womanhood and is accompanied by ceremonies to mark the occasion when the girl becomes a mature woman. The girls are subjected to powerful social pressure from their peers and family members to undergo the procedure. They may be rejected by the group or family if they do not follow tradition.A huge proportion, 83.2% of the respondents believed that circumcised girls are taken to be mature and ready for marriage with a P- value of 0.022. The study revealed that 87.1% of the respondents agreed that circumcised women remained faithful to their husbands at all times, with a P-value of 0.131. In Somalia one study reported that a girl who is not infibulated was subjected to constant ridiculed and often driven out of her community and had a little chance of marriage. The study further revealed that infibulation accorded a girl the right to marriage and protection [6].

In this study 45.35% of the respondents strongly agreed and expressed that they were involved in the decisions to have their daughter mutilated. This was in agreement with another study [7]where menhadtaken part in the decision to have their daughter circumcised.These findings have very significant implications, as it would then be futile to neglect the men folk in the campaign against female circumcision. In general, the study has found out that the involvement of men in any reproductive health programs, in the prevention of female genital mutilation is low. The main reason for this could be fear of social criticism and insufficient health education.A study carried out in Sudan cited tradition as the main reason for FGM practice [8]. Men still seemed to prefer marriage to circumcised women [9]. Similarly, in this study, custom and tradition (91.7%) and requirement for marriage (98.5%) were found the most two common reasons for practicing FGM in the community. Others included to decrease high sexual drive of in the women (90.2%), to prevent pre-marital sex (83.4%), to maintain cleanliness (98.5%), to ensure female purity (96.9%), to improve fertility (71%) and 76.7% for virginity protection. 13% of interviewed men believed that religion played role in female mutilation in the community. In a society where there is no access to education and employment, inadequate financial strength of the family and social support from the government, securing the economic and social future of the daughter were found to be linked to marriageability.

V. CONCLUSION

The study concluded that the main reasons for the practice of the cruel act of female genital mutilation are as cruel as the practice itself and signify the selfishness of men towards women. Education and other strategies aimed at raising the economic status of the girl child and reducing overdependence cannot be over emphasized.

REFEREMCES

[1]. World Health Organization, Female genital mutilation/cutting in African countries: estimates of numbers from national surveys. Submitted to Social Science and Medicine, 2010.
[2]. UNICEF, Female Genital Mutilation/Cutting: A Global Concern", New York: United Nations Children's Fund, February 2016
[3]. B. Finke., Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. Lancet. 2006; 367:1835–1841.
[4]. Kenya Demographic Health Survey, Addressing female genital mutilation. Challenges and perspectives for health programmes2003.
[5]. A .Jasmine, M. Christine, and B. Michel,; Care of women with female genital mutilation/cutting 2011415:123-135.
[6]. S. Wondimu,, Female genital mutilation: prevalence, perceptions and effect on women's health in Kersa district of Ethiopia; International Journal of Women'sHealth,2012
[7]. L.Morison,The long-term reproductive health consequences of female genital cutting in rural Gambia: a community-based survey, Tropical Medicine and International Health, 20016(8), 643-653.
[8]. Satti A, Elmusharaf S, Bedri H, Idris T, Hashim MSK, Suliman GI, Almroth L, ,: Prevalence and determinants of the practice of genitalmutilation of girls in Khartum, Sudan. Ann TropPaediatr201226:303-310.
[9]. Msuya SE, Mbizvo E, Hussain A, Sundby J, Sam NE, Stray-Pedersen B 2012, Female genital cutting in Kilimmanjaro, Tanzania: changing attitudes? Trop Med Int Health 7:159-165.