KNOWLEDGE, ATTITUDE AND PRACTICES ON FEMALE GENITAL MUTILATION AMONG SOMALI COMMUNITY IN NAIROBI COUNTY, KENYA

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ABSTRACT

Background: Female Genital Mutilation (FGM) is associated with many obstetric and gynecological complications. The aim of the study was to assess knowledge, attitude and practice of female genital mutilation among the Somali community in Eastleigh, Nairobi County, Kenya.

Methods: A descriptive cross-sectional study was done among women living in Eastleigh, Nairobi and who have one or more daughters. Systematic random sampling was used to obtain 61 respondents. Questionnaires and interview schedules were used to collect the data.

Results: All the respondents were aware of what FGM entails, and 80.3% were knowledgeable of its complications. Despite the medical complications related to FGM practice, 45.9% of the respondents said FGM should continue, 45.9% said FGM should be stopped while 8.2% were non-committal.

Recommendation: There is a need for campaigns that will target behavioral changes towards the practice, using those who have already abandoned the practice as community role models.

Keywords: Female, Genital, Mutilation, Somali, FGM, Kenya

Introduction

All societies have norms and behaviors based on age, lifestyle, gender and social class. According to World Health Organization (WHO) globally, over 140 million girls and women have undergone Female Genital Mutilation (FGM), with nearly 3 million girls at risk for the practice every year (WHO, 2008). The majority of these girls and women live in 28 African countries, including Kenya. There are also regions in Asia and Western countries that host immigrants from countries with FGM traditions. Female Genital Mutilation (FGM) is a defined traditional practice in some cultures where there is partial or total removal of the external genitalia of girls and
young women for nonmedical reasons (WHO, 2008).

Female Genital Mutilation (FGM) is classified into four types namely: Type I – partial or total removal of the clitoris, with or without excision of part or all of prepuce (clitoridectomy); Type II – partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision); Type III – narrowing the vaginal opening through the creation of a covering seal by cutting and repositioning the labia minora and/or the labia majora, and with or without removal of the clitoris (infibulation); and Type IV – all other harmful procedures to the female genitalia for non-medical reasons, such as pricking, piercing, incising, scraping and cauterizing the genital area (WHO, 2008).

Female Genital Mutilation (FGM) stands in the way in the achievement of the Sustainable Development Goals Number four and five while also disregarding the progress that has already been achieved so far. Various reasons have been given for the practice of FGM in different geographical and cultural settings ranging from culture, religion to superstition. Many communities continue the practice of FGM because it is believed to be a rite of passage from girlhood to womanhood. Thus, a circumcised woman is considered mature, obedient and aware of her roles in the family and society. Secondly, FGM is perpetrated as a means of reducing the sexual desire of girls and women, thereby curbing sexual activity before marriage, and ensuring fidelity within the marriage institution (Oloo et al., 2011).

The prevalence of FGM practice has been reported being overwhelming in various African countries. For instance in Somali the prevalence is 98%, in Egypt 91%, Mali 87%, Nigeria 27%, Kenya 27%, Ethiopia 93% and Uganda 1% (UNICEF, 2013). FGM has been outlawed in Kenya since 2001 and despite this act, a public health survey in 2009 found that 27% of women had been subjected to FGM. While the practice is seemingly decreasing, evidence from the Kenya Demographic and Health Survey (KDHS) 2008-2009, found that the prevalence FGM practice remains high in certain communities in Kenya. Somalis communities have highest FGM practice, as high as 98%, Maasai 73%, Kuria 73%, Embu 51%, Kamba 60%, Kikuyu 21.1% and Borana 56% (Kenya National Bureau of Statistics (KNBS) & ICF Macro, 2010).

Evidence from the 2009 KDHS, as well as other research studies, were recently undertaken in North Eastern Province, indicates that the practice among the Somali community is particularly severe. Not only is it virtually universal in this group, but also the most severe form (infibulation) is practiced on girls as young as four years. A higher level of maternal mortality (17/1000 births) was found among Somali women delivering at the Provincial General Hospital at Garissa in the North Eastern Province compared with women delivering in Machakos (0.45/1000) where women are able to access safe motherhood services and where relatively fewer women are mutilated or are mutilated less severely.

The WHO Fact Sheet (2014), states that FGM has no health benefits and it harms girls and women in many ways. The consequences of FGM practice can be
grouped into long- and short-term effect. The latter manifests itself within a very short period extending from a few hours of the operation to ten days. Long-term complications are life-long, irreversible and require medical attentions to mitigate their effects. Evidence-based study reveals that 83% of women whose genitals have been mutilated required medical attention at some time in their lives for problems associated with the procedure (Oloo et al., 2011).

Immediate complications could include severe pain, shock, hemorrhage (bleeding), urine retention, open sores in the genital region and injury to nearby genital tissue. The cutting of the blood vessels in the vulva (clitoral artery) during the genital mutilation also leads to bleeding (Vloebergh, et al, 2011). Serious bleeding can also cause shock while protracted bleeding can lead to anemia and even death.

In addition to the severe pain during and in the weeks following the mutilation, women who have undergone FGM experience various long-term effects which may be physical, sexual and psychological. They may experience chronic pain, chronic pelvic infections, and development of cysts, abscesses and genital ulcers, excessive scar tissue formation, infection of the reproductive system, decreased sexual enjoyment and psychological consequences, such as posttraumatic stress disorder (PTSD). Additional risks for complications from infibulations include urinary and menstrual problems, infertility, later surgery and painful sexual intercourse (WHO, 2014).

Additional complications of FGM include acquired gynatresia resulting in hematocolpos, vulval adhesions, dysmenorrhea, retention cysts, and sexual difficulties with anorgasmia, injury to the rectum, and purperial sepsis (Okeke et al., 2012).

Infection caused by the use of unsterilized instruments in the unhygienic environment may lead to complications, such as septicemias, tetanus and can even lead to death. Such infections can also cause pelvic inflammation and high risk of HIV transmission through the use of one instrument for multiple operations (Zaidi et al., 2013).

The majority of women who have had FGM done experience difficulty in childbirth which in the case of long and obstructed labor may lead to fetal death and brain damage of the infant and accumulation of blood and blood clots in the uterus and vagina (Zaidi et al., 2013).

In Kenya, an estimated 27.1% of girls and women aged 15-49 years have undergone FGM (DHS 2008-09), a figure that has decreased from 37.6% % in 1998, and 32.2% in 2003. There are significant regional discrepancies, with prevalence ranges from 0.8% in the west to over 97% in the north-east (KNBS & ICF Macro, 2010).

Nonetheless, while FGM has been outlawed in Kenya since 2001, a public health survey in 2009 found that 27% of women had been subject to FGM. Among some ethnic groups where the practice is deep rooted is the Somalis, with the prevalence as high as 97% , the Kisii at 96%, Kuria at 96%.
and the Maasai (93%) and low prevalence among the Kikuyu, Kamba and Turkana, and rarely practiced among the Luo and Luhya (less than 1%).

Female genital mutilation among the Somali community is particularly severe regardless of if it is in the rural or urban setting. Not only is it virtually universal (98%) in this group (KNBS & ICF Macro 2010), but also the most severe form (infibulation) is practiced on girls as young as four years (WHO, 2016). In addition, Momoh’s (2009) study on Knowledge, Attitudes, and Practices of FGM among Somali Community in Kenya at Eastleigh has reported that 90% of the interviewed women in their study knew the FGM and admitted that there was a campaign on awareness of the practice as a harmful cultural practice. Momoh’s (2009) study further reported on attitudes where there was a mixed reaction as 62% of the respondent said the practice should be upheld while 38% of the respondent said the practice should be stopped. In regards to practice, the study showed high prevalence practice of 93% among the respondents (Momoh, 2009).

Despite the existing knowledge on maternal complication the practice of FGM continues to be inherent in the Somali community with high prevalence of the same. Therefore the purpose of this study was to explore changes in the knowledge, attitude, and practices on FGM among women of Somali community at Eastleigh, Nairobi County in Kenya.

Methodology

The study design was a descriptive cross-sectional research. The area of the study was Eastleigh, Nairobi. Eastleigh is located east of the Central Business District (CBD), Nairobi, Kenya. The study area is mainly dominated by people of Somali descent and a few indigenous residents. The main activity in the area is trading and business and also formal employment in the banking and finance sector and also the hospitality sector. In Kenya, the area contains the highest number of registered refugees in urban set up of 33,700 (Country Report, 2012). According to the KNBS (2010), the total population of Eastleigh was 103,098 with the female population estimated at 46,205

The target population was all women of Somali origin who must have lived in the area for more than two months and must have a daughter or daughters whether circumcised or not so as to understand their perception towards FGM. The population was sourced from all the three regions of Eastleigh, which include section I, section II and section III. Systematic random sampling was used to obtain 61 respondents. Ethical approval was gained from Mount Kenya University Research Committee. Permission to conduct the study was obtained from the area chief, and informed consent was obtained from study participants.

Self-administered questionnaires and interview schedules which were guided by research questions were used to collect data. An interview schedule was given to selected participants who did not understand the questionnaire.
Results

Socio-demographic data

The findings on the social demographic were analyzed that included age, marital status, educational level and occupation. The majority of the interviewed respondents were aged between 30-40 years (41%) of the total respondents, followed by 25-30 years (23%), 18-24 years (19.7%), then respondents aged between 41-50 years (9.8%) and above 50 years were represented by 0.1% of the respondents. Marital status revealed that majority were married 72.1%, single 18%, Divorced 0%, and window 9.9%.

The study findings revealed that majority of the respondents, 41%, had been educated to secondary education, while those who had a primary level education were 29.5%, followed by 23% for those who had either college or university level education, while only 6.6% of the respondents had no education. The study findings established that majority of the respondents were self-employed represented by 42.6% of the respondents, 29.5% were employed, while 24.6% were unemployed and only 3.3% were retired.

Level of Knowledge on FGM

All the respondents stated that they have heard of FGM and were able to state what it means correctly. On where they got the information of FGM from, the majority (75.4%) stated that they got the information from community members, others from newspapers (16.4%) while mosque represented 8.2%. 80.3% of the respondents have had of complications related to FGM while 19.7% responded that they had an idea about the complications related to FGM practices.

Attitudes on FGM

On the aspect of attitude, the study found that 45.9% of respondents felt that the act of FGM should continue while 45.9% suggested that FGM practice should come to an end and 8.2% didn’t know whether this act should stop or continue (Table I)

Table 1 Opinion on Need to Discontinue FGM

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Continue</td>
<td>28</td>
<td>45.9%</td>
</tr>
<tr>
<td>Discontinue</td>
<td>28</td>
<td>45.9%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>5</td>
<td>8.2%</td>
</tr>
<tr>
<td>Total</td>
<td>61</td>
<td>100%</td>
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The respondents revealed that the mothers were the most influential in advocating for FGM in the Somali community (60.7%) while 19.7% suggested peers influence, 14.8% said the influence came from fathers, while 4.9% said the influence came from religious leaders. The study revealed that majority of respondents (93.4%) perceived that men accepted the practice and have total approval for FGM, while only 6.6% said the contrary. The study established that the majority of the respondents believed that FGM is part of the religion represented by (67.2%) of the respondents, while 24.6% did not know if it was part of the religion, while only 8.2% disagreed with the statement.
Practices on FGM

When asked about who performs FGM in the community majority of the respondents (47.5%) cited that the elderly women perform the FGM, followed by 27.9% who said it was the traditional birth attendants, 11.5% said it was the health care workers, while 13.1% of the respondents said they did not know who performed the practice.

Majority of the respondents stated that they had undergone FGM (Table 2)

Table 2: Frequency of undergoing FGM

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>53</td>
<td>86.9%</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>13.1%</td>
</tr>
<tr>
<td>Total</td>
<td>61</td>
<td>100%</td>
</tr>
</tbody>
</table>

When asked if they would undergo the FGM if they had a choice again, the majority said they could not (95.1%) while 4.9% said they would undergo the procedure.

Discussion

The study established that 86.9% of the respondents have already undergone the FGM practice and 91.5% of the respondents felt that if they had the choice they will not have undergone practice because such an act is performed on girl child when she is extremely young under the age of 10 years. All the respondents had some knowledge of the FGM practice, and 80.3% of these respondents had information associated with FGM complications while 19.3% had never heard about the complications related to FGM practice.

Despite the medical complications related to FGM practice, it was established that 93.4% of men accepted the act of FGM practice and 60.7% mothers influenced the practice while 67.2% of the respondents assumed that FGM was part of the religious practice. Since the participants had daughters, there was a question of whether they will subject their daughters to circumcision or not. In this question, the majority of the respondents 83.6%, felt they would not subject FGM to their daughters while 16.4% responded that they would subject their daughters to FGM.

However, there were mixed reactions on the subject of whether the practice of FGM will be continued where those who felt that the practice of FGM ought to be continued represented 45.9%, while an equal number of the participants felt the practice should be discontinued. The findings of this study demonstrate that the Somali community is well informed of the complication of FGM yet the prevalence of FGM remains high among the community. This study’s finding is similar to a study done by Oloo et al., 2011 that revealed despite the known complication on FGM especially the long-term complications, FGM remains a highly upheld cultural practice among many communities, including the Somali community.

Conclusion and Recommendations

The majority of the respondents were knowledgeable on FGM and its complications. Though most of the respondents indicated that they would not choose to undergo FGM if given a choice, almost half of them (45.9%) still felt the practice should continue.
Mothers were the majority of the respondents to be the major advocators for FGM. Most women perceived that men accepted the FGM practice.

The fact that significant number of mothers do not intend to circumcise their daughters signaled a good move in the reduction FGM practice. However, the perception of men towards FGM practice is a key challenge that needs to be tackled. Campaigns focusing on men in particular, to support those who currently do not intend to circumcise and eventually use them as role models is highly recommended.

Campaigning and awareness-raising should focus on the misperception of FGM as an Islamic requirement and directly (but acceptable) address the fear of female sexuality. The women's networks could develop messages in this regard.

Campaigning should also focus on highlighting the health consequences of FGM, particularly regarding childbirth, as these are consistently given as the reason for eradicating FGM by those who support its abandonment.

Behaviour change will have to be led by particular groups, and lead groups should be identified and targeted. The study indicates a greater potential for change among more secure, urban populations.

References


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