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Female Genital Mutilation: A Religio-Cultural Sensitive Issue Determining Maternal Health Care Choices among Somali Women in Dadaab Refugee Camp, Kenya

Josephine Gitome Ph.D.
Newton Kahumbi Ph.D.
Muthoni Mainah Ph.D.
Jacqueline M.Kituku MSC
Teresa Mwoma Ph.D.
Priscilla Ndegwa Ph.D.
Kenyatta University, Kenya
Jennifer Bagelman Ph.D.
Newcastle University

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Abstract

The paper addresses Kenya's development challenges in maternal health care with a specific focus on the impact of traditional birth attendants (TBAs) and female genital mutilation (FGM) among the refugees. It purposes to achieve four objectives: to discuss the persistence of FGM among Somali women in Ifo Refugee Camp, to establish the hospital process of providing maternal health care to mothers who have gone through FGM; find out the level of preparedness of the midwives to handle mothers with religio- cultural concerns such as prayer, non-involvement of male nurses and how the practice of FGM contributes to the preference of TBA by mothers. The study assumes that midwives' training may not have effectively addressed FGM, a social-cultural sensitive issue affecting childbirth and care. Secondly, the specific support of midwives in refugee camps contexts remains limited. A qualitative research approach was used in

the study, involving Snowballing sampling method, in-depth interviews, and focus group discussions (FGDs). These methods brought out pertinent issues that make TBAs the preferential option for some mothers in spite of the presence of level 4 category hospitals in the refugee camps. In case of birth complications, the mother's choice for TBA delays the family's decision to take her to the hospital and for health care workers to save mother and child. The shortage of midwives and the presence of male midwives in hospitals make some Somali mothers seek assistance from TBAs. There is a need to contextualize midwifery training by enhancing the curriculum with evidence-based /mother-centered skills.

Keywords: Infibulation, de-infibulation, Traditional Birth Attendants; (TBA), female circumcision, Refugees, episiotomy.

Introduction

Kenya hosts refugees mainly from Somalia, DRC, Rwanda, and Burundi. These refugees are hosted in different refugee camps in the country, including the Dadaab refugee complex. As of August 2021, the Dadaab refugee camp had approximately 52.7 percent of its population being Somalis. According to World data information (2021), Somalis constitute the 11th largest group of refugees worldwide.

It is noted that the Somalis have social and cultural practices that are also practiced in the refugee camps. One of these practices is FGM, and it has an impact on the deliveries by Somali mothers. Munala, J; (2003 UNHCR report), noted that female circumcision is a major contributor to deaths during delivery for women in Dadaab. This is in tandem with NCAPD Policy Briefs (2010), which states that 98 percent of the Somali women in Kenya undergo female circumcision out of whom eighty percent experience infibulation. However, religious and cultural reasons make it difficult for such women to be adequately helped on maternal healthcare choices, especially because they are locked in a cultural background offering few or no choices to make.

The 2014 Kenya Demographic and Health Survey data describes the factors that determine where women deliver in Kenya and explore the reasons given for home delivery (KDHS, 2014-2015). Also, the percentage of births attended by a skilled provider and the percentage occurring in health facilities each increased by a magnitude of 20% from 2003 to 2014.

The persistence of some Somali mothers in the camp to seek birthing care from traditional birth attendants is of significant concern because the government of Kenya made maternal health care free in public hospitals in

2013 with an aim of reducing the mortality rate, which was 488 maternal deaths per 100,000 live births according to the Ministry of Health data. Somali refugees have come from a country that experiences a disproportionately higher maternal mortality ratio of 732 per 100,000 live births and a neonatal mortality rate estimated at 38.8 per 1000 live births. (UNHCR Health Information System Dadaab annual report 2015, unpublished).

UNHCR supports the refugee mothers by providing maternity facilities in each of the refugee camps in Dadaab free of charge. The question as to why some of these mothers do not appreciate the hospital maternity is of great concern.

Methods

The in-depth qualitative study selected respondents who included; four TBAs, four pregnant women using TBA services, 5 women who delivered in hospital, two men whose wives have delivered children in the hands of a TBA, two save mothers (Form 4 female Somali refugee school leavers with basic maternal health care skills sent to the community by hospital administration), ten hospital midwives. Three separate FGDs of 7 community leaders, 6 mothers, and 6 midwives brought out pertinent issues demonstrating the presence of FGM practices in Dadaab. In-depth Questionnaires were used to interview individuals and an Interview guide questionnaire was used in the Focus group discussions. The data has been analyzed using qualitative and quantitative mixed methods to demonstrate the findings.

Results

Prevalence of FGM among Somali women

The question of how deep the practice of FGM is in the Somali community and particularly among Somali women in the Dadaab Refugee camp formed an objective for this study. The researcher sought to establish the degree to which the practice was entrenched among Somali women and possibly establish the reasons for the practice. To achieve this, the researcher interviewed respondents in different categories, including pregnant women, TBAs, and community leaders. Besides, the researcher sought the perspectives of nurses in Red Cross Hospital in Ifo refugee camp health facilities, which is a well-structured medical facility. Notably, female circumcision is viewed as the norm among and by the Somalis, including the women themselves. The respondents that the researcher interviewed noted that it is a mandatory practice for every young girl to go through. Figure 1

below shows the responses of the respondents when asked if they had undergone FGM.

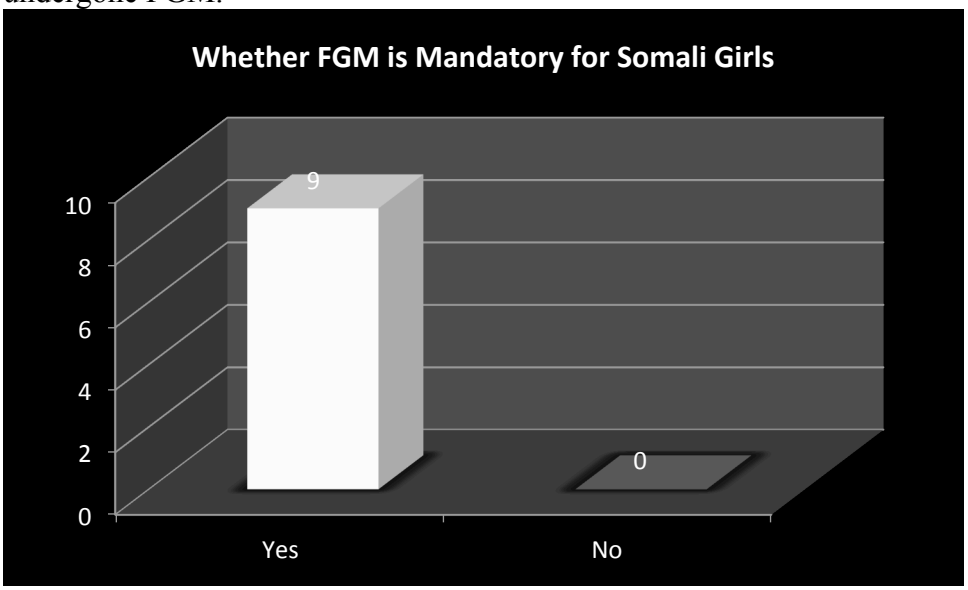

Fig. 1. The prevalence of FGM among Somali women in Dadaab Refugee Camp

From figure 1 above, it is noted that FGM is a deeply rooted practice. The mothers who were interviewed during the study all indicated that every Somali girl has to undergo female circumcision. According to the responses, anyone who does not go through the practice is considered unclean and she may even fail to find a husband. According to respondent 9, "No girl is allowed to refuse FGM" (September 2021).

It is important for this paper to note that FGM among Somali women is viewed as a rite of passage and, therefore, a cultural and traditional expectation. It is expected that young girls would undergo the cut and that there would not be any question about it. Young girls undergo different types of FGM as indicated in figure 2 below by mothers interviewed who had experienced FGM at the age 6-14 Years old noted.

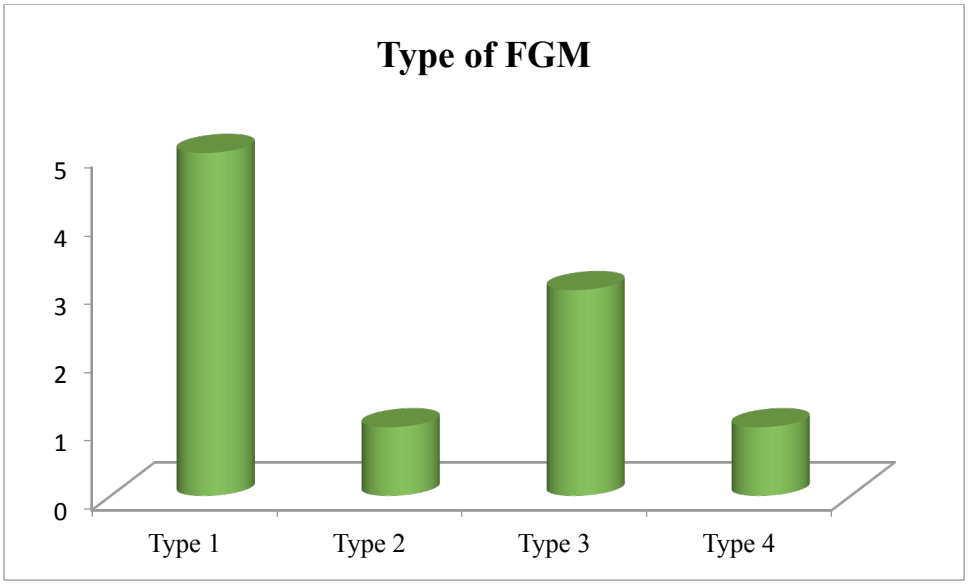

Figure 2. Types of FGM practiced

Out of the 10 respondents who were interviewed, (5) indicated that they underwent type 1 FGM when they were between 6 years and 12 years. It means that type 1 FGM was the most practiced among the Somalis, followed by type 3. Type 3 is indicated as the worst kind that leaves the women with infibulations and ends up creating challenges during delivery. However, this paper notes that the rest of the types could also result in challenges at delivery in some cases as one respondent noted, thus: "…experienced obstructed labor, had to go through episiotomy before (giving) birth to hasten delivery."

The sentiments above indicate that though considered a rite of passage and a mandatory practice among Somalis, FGM has impacted greatly on the maternal and even sexual lives of the women who undergo the cut. In spite of the type, female circumcision has the potential to affect delivery. Besides, while all the respondents acknowledged that the practice has a cultural background, there were those that felt that it had no importance in modern-day society, and they did not find any reason as to why it was being practiced. In fact, one of the respondents indicated that some girls today were rebelling against it, only undergoing "sunna" as a way of fulfilling the requirement of their culture. Other than that, there were respondents who had the opinion that it should be eradicated completely (Respondent 3, Sept. 2021). The feelings of these respondents are indications that there are long-term and short-term effects of FGM on both the mother

and the fetus. The following are some of the long terms impacts of the practice:

i. The mother

Some of the respondents noted long-term effects of FGM on the mother to include pelvic infections; Prolonged, obstructed labor; Need for Cesarean section (CS); Some endure deep incision/ De- infibulation; Obstetric Fistula; Excessive bleeding; Keloid formation; and Vaginal Cyst Formation

ii. The Fetus

One of the midwives from Ifo Red Cross Hospital noted that FGM increases the risk of stillbirth three to four times; lack of oxygen during the second phase of labor can result in stillbirths, and children with cerebral palsy or epilepsy are a possibility.

The major impact of FGM on Somali women's maternity

The researcher noted that there were impacts on the maternal health care of the mothers who underwent FGM. In an interview with one of the hospital midwives, it was noted that FGM causes trauma to the mothers during delivery and this has a bearing on the maternal health of such mothers. The respondent indicated thus:

"They have difficult delivery and the mother experiences a lot of trauma arising from the cut to remove the stitches" (Respondent 7, midwife)

Somali Mothers' FGM and TBA Birthing Care

Giving birth is a medical affair, but among the Somali refugee migrants in the Dadaab Refugee camp, it is both a medical and community affair with phobia and partial resistance to Hospital deliveries. A few mothers in the Dadaab refugee camp still prefer to deliver at home under the care and support of a TBA. The TBA among the Somalis is an important person when it comes to the mothers' birth care. She is the person who is responsible for the safe delivery of the mother and the disposing of the umbilical cord. Notable is the fact that the new mothers have to be kept away from the eyes of the public to avoid a bad omen, according to the beliefs of the Somalis. Therefore, it is the TBA who keeps away the people and determines who and how many people would see the new mother and baby. Some of the TBAs have learned their practice since they were children, looking at what their mothers were doing. This has enhanced their expertise in child delivery among the Somali women and they understand the traditions and customs of their people.

The provision of skilled health care attendance at delivery, postnatal, antenatal care, and family planning as important interventions does

not guarantee a reduction in mortality and morbidity because of the shortage of medical staff, especially in remote regions. The journey to the hospital is at times complicated by poor road infrastructure and the TBAs come in handy (especially at night) in support of expectant mothers who have undergone FGM. This is because TBAs understand the community culture and religious practice and can mitigate by helping the mother release tension during labor. In the event of complications, the TBA escorts the mother to the hospital.

During the survey, one respondent, TBA 2 referred to this type of circumcision as the Sunni type. She said they find ease while helping deliver with those mothers who have undergone Sunna type of circumcision which is confirmed by WHO (2010) to be a milder form involving the pricking or slight cutting off the tip of the clitoris. The TBA 2; narrated how she experienced 2 types of challenges and is against the Sunni type of girl circumcision and recommends the Sunna type. In TBA 2 words the problem included:

Over bleeding due to FGM complications, having to cut the mother at times deeply

leading to need for urgent hospital help and bad presentation of the baby

This implies that even though the Sunna type of female circumcision is becoming more common than the Sunni type, those mothers who came from Somalia having undergone the Sunni type in childhood (6-14years old) and are still giving birth encounter a difficult birth process. According to the World Health Organization, the FGM practice is a determining factor in the increased complication in childbirth and maternal deaths. Mothers suffer severe pain, heavy bleeding, infections, infertility, psychological trauma, and difficult coitus. UNICEF (2008) also recorded that babies are put in substantive danger during childbirth resulting in high mortality rates among babies born by mothers who have undergone FGM. The patriarchal nature of the Somali culture complicates maternal health care when the health care providers in the hospitals find cesarean section as the only option to help mothers with obstructed labor complications.

According to the data collected, it was noted that the majority of the Somali women preferred and had used the services of a TBA. Out of the 9 women who were interviewed at different stages of the study, the researcher notes that 6 of them responded in the affirmative when asked if they delivered with the help of a TBA. The figure below shows the responses of the percentage of the women who sought the help of a TBA during pregnancy and/at delivery.

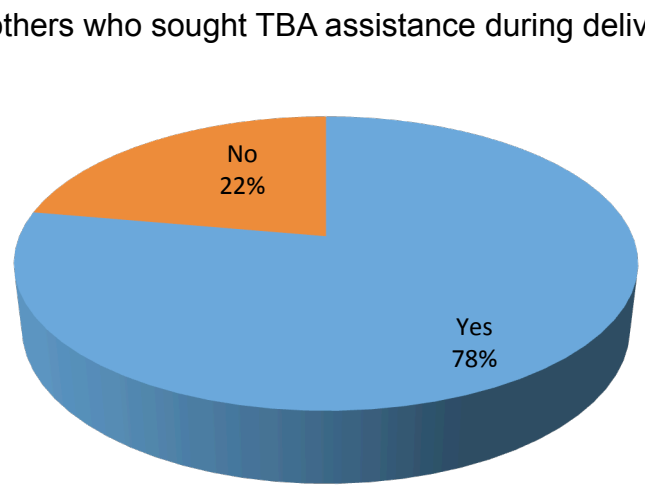

Fig. 3. Rate of TBA Support among Somali women

Figure 1 above indicates that approximately 78% of Somali women seek the help of a TBA during their pregnancy period and/or at the delivery stage. The responses are indicative of the rate of preference for TBA as compared to hospitals and modern health maternal services. The 22% of the women indicated that they did not seek the assistance of TBAs and preferred hospitals and nurses with one of them indicating that she did not have any relationship with TBAs since she goes to the hospital for checkups and delivery. It is noted that the responses from the Dadaab refugee camp were also backed up by data from mothers and TBAs in Eastleigh, a town that is heavily inhabited by Somalis in Nairobi County.

In order to understand further why there was such a high preference, the researcher asked the women how the TBAs helped them, which was a pointer to the reasons for their preferences. Notably, the TBAs were said to be friendly and that they gave full information, to the satisfaction of expectant mothers. This is an important point both in the understanding of why TBAs are preferred and also the advocacy for modern maternal services among Somalis.

Upon further inquiry, it was noted that the FGM tradition is entrenched in the lives of the Somali women to the extent that they consider it as part of their lives. The respondents interviewed indicated that FGM is mandatory and it is a rite of passage. As such, there was the argument that tradition among the Somalis was an important thing to follow, and that created a direct link between the practice of FGM and the high preference for

the TBAs among Somali women. One of the TBAs who was interviewed noted that she has overseen over thirty (30) births since she started the practice and some pregnancies and deliveries can be challenging. A deeper probing indicates that some women experience difficulties in their first pregnancies, especially because of infibulations that are a result of FGM type 3. This shows the impact of FGM on maternal healthcare since, in such cases, the women have to be rushed to a medical facility in order to save their lives. However, in some cases, the TBA handles the situation and stops the bleeding. Thus, among the reasons that TBAs were preferred by expectant mothers included:

i. Mothers are confident when working with a TBA as compared to the nurses, especially the male nurses. The main reason is that TBAs are part of the Somali community and they would easily understand the woman and how she is, even when there are infibulations in her genitals due to FGM.
ii. There is no travel to the hospital since the TBA lives close to the women and can easily be accessed.
iii. In case of complications, TBAs are there to escort the mothers to a health facility
iv. They understand the community's culture and religious practices.
v. They apply massaging and storytelling to relax the mother and increase the chances of giving birth naturally in the place where health care providers are proposing cesarean section

The above reasons are some of the highlighted reasons by the mothers as to why they preferred TBAs and were at ease while working with them. It is noted that the practice of FGM and the general culture and customs of the Somalis make the expectant months unease in the hands of nurses whom they consider strangers and unaware of the ways of the Somalis. Therefore, it would be easier and most preferred to work with a TBA.

Hospitals perceived Unsafe

The Somali IFO refugee migrant community considers the medical health facilities in Dadaab unsafe to their reproductive health interests and their cultural and religious practices. A refugee SAVE mother noted that there are sharp contrasts between the religio- cultural beliefs and how the health system works:

> The Somali refugee migrants in Dadaab IFO camp regard hospitals as unsafe due to fear of undergoing a cesarean section operation

> whenever mothers experience obstructed labor, being served with family planning contraceptives unknowingly, and losing the opportunity to bury the placenta which according to them is part of the human body and should be respectfully buried in the family homestead. The TBAs are more preferred to the trained medical midwife personnel at the hospital.

Qualitative studies have attempted to learn what Somali women want from their western maternal care. Arising from this global effort is a consistent finding: many of the Somali women who have been interviewed hold very negative attitudes about cesarean delivery. However, during the Dadaab survey, a midwife from one of the hospitals informed us that they are still sorted by pregnant mothers stitched all through the birth canal with birth complications and they do de-infibulation procedures so as to save mother and child.

The picture below from a researcher in Kisii County shows a keloid formation which poses a huge challenge in a natural delivery.

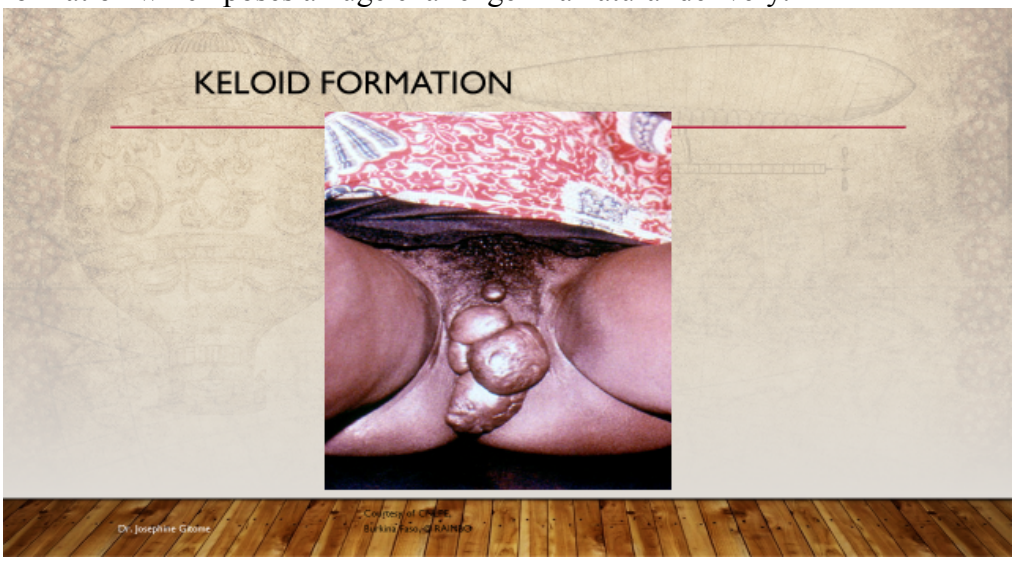

Figure 4. Keloid formation in a circumcised woman

The sentiments in the above excerpt are indicative of how destructive FGM can be to women, especially mothers. There is an obvious need for a CS to be performed in cases where the birth canal has been obstructed so much by the FGM activity that the baby cannot pass through. Besides, there

are mothers who feel so much pain that they cannot give birth normally, necessitating a CS. That affects the mother in different ways, including lowering the number of births that she can have if she has to give birth through Caesarian Section for all the births. The operation has the potential of causing infections that if not correctly and timely handled, could be fatal. The cross-cutting effect that the interviewed midwives posited is the need to perform an episiotomy, which is the cutting of the vulva.

The impact of practices like infibulation is far-reaching. Nurses who have midwifed Somali women with scars of FGM indicated that a majority of them seek the help of nurses and doctors when the situation has gone out of hand and the TBA is unable to handle it. Figure 4 below shows the categories of complications/ care needed by mothers who seek the help of the hospital exhibit, mostly as a last resort.

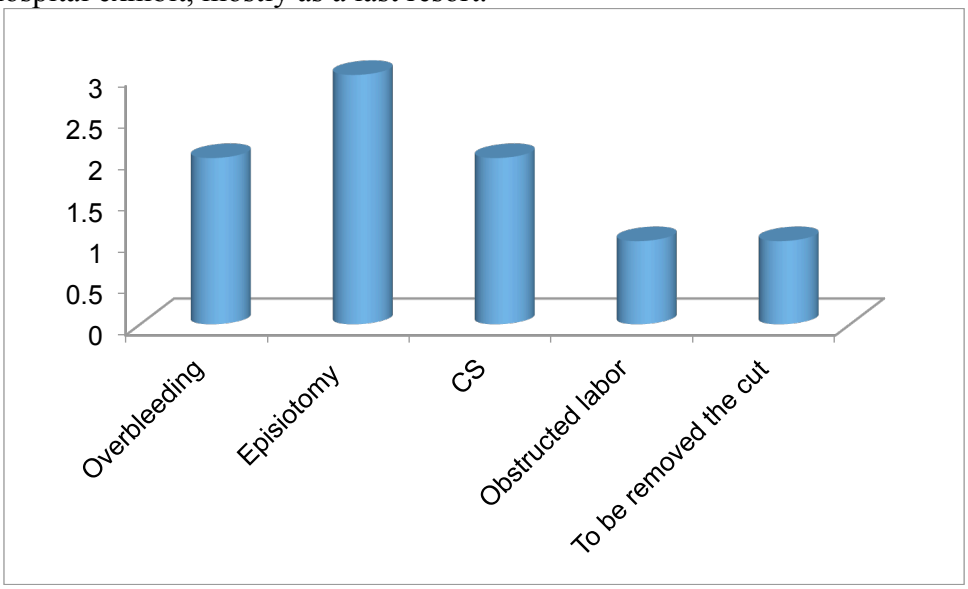

Figure 5. Emergency Needs Rushed to Hospitals by TBAs among Somali women in Dadaab

Figure 5 above indicates that episiotomy is the major attention needed by women who seek the help of nurses as a last resort.

Mitigating Measures and Interventions

The health facilities in Dadaab, have provided basic Midwifery skills to female secondary school leavers and sent them to the communities as SAVE mothers or community midwives. Their role is to help explain the need to go to the hospital, attend to expectant mothers in need of basic support and introduce them to hospital health care provisions.

They also have a “mama taxi” service for the pickup of mothers to the hospital. The service enables expectant mothers to get medical and maternal services quicker as compared in cases where there are no forms of transport that could be relied on. One of the nurses noted that some locations are deep in the interior and, therefore, having mothers reach the hospitals in time is sometimes very challenging.

Education was cited as one of the ways that the practice could be eradicated. Mitigating the effects of FGM, as respondent 7 noted, could be very difficult for the hospital. The harm is already done. Therefore, whenever the women go to the hospital seeking help, all the hospital can do is cut the stitches to enable her to give birth and then stitch her again to satisfy the cultural status quo.

Another mitigation measure by the nurses and the hospitals, in general, is to offer civic education. The nurses and doctors should continually inform the mothers about the effects of FGM and attempt to have them see the need for the practice to be eradicated (Respondent 5).

Discussion

FGM, also called female circumcision and Female Genital Cutting (FGC) involves cutting some part of the clitoris or labia for non-therapeutic reasons, usually as part of a rite of passage into adolescence. FGM may entail cutting off a girl’s clitoris and labia, stitching together what remains so that only a small aperture is left for urine and menstrual fluids to pass through. World Health Organization (WHO) 2010 definition of FGM as “all procedures that involve partial or total removal of the external female genitalia, or other injuries to the female genital organs for non-medical reasons.” There are classified into 4 broad types

1. **Clitoridectomy;** the partial or total removal of the clitoris (a small sensitive and erectile part of the female genitals)
2. **Excision**; partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).
3. **Infibulation**; narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.
4. **Pricking, piercing or incising** of the clitoris and/or labia stretching of the clitoris and/or labia cauterization by burning of the clitoris and surrounding tissue scraping of tissue surrounding the vaginal orifice or cutting of the vagina introduction of corrosive substances or herbs

> into the vagina to cause bleeding or for the purposes of *tightening* or narrowing it.

Four (4) million girls are at risk of undergoing FGM every year; (WHO: 2020), and the majority of girls are cut before they turn 15 years old. Thus, FGM has been documented in 30 countries, mainly in Africa, as well as in the Middle East and Asia. Some forms of it have also been reported in other countries, including among certain ethnic groups in South America. Moreover, the growing migration has increased the number of girls and women living outside their country of origin who have undergone FGM or who may be at risk of being subjected to the practice in Europe, Australia, and North America (WHO, 2020). Somalia is the country with the highest prevalence of FGM in Africa at about 98 percent of women. A report by UNICEF (2020) states that the type of FGM procedure performed varies mainly with ethnicity. Estimates indicate that around 90% of FGM cases include Type 1, II, and IV

FGM is practiced by some ethnic groups in Kenya as well as in other East African countries and is motivated by beliefs about what is considered proper sexual behavior for women and what is necessary to prepare them for marriage (WHO, 2014b). However, the practice is widely acknowledged as a violation of children's and women's rights, and it has the potential to cause serious medical complications. In 2011, Kenya passed a law, the Prohibition of FGM Act (2011), which banned FGM nationwide. Under this law, it is illegal to practice FGM in Kenya or to take someone abroad for FGM. However, Ndube, 2016), Reports from Human Rights Dialogue 2.10 (2003), affirm that although the Kenyan National law has jurisdiction over all Dadaab refugee camps and banned the practice of FGM under the 2002 children's Act, FGM continues to be practiced. Ndube further notes:

> Ninety-eight percent of all Somali women and girls are estimated to have undergone FGM and most of them (90%) have experienced "Pharaonic" or Type III FGM. To take one example of Somali refugees, UNHCR estimates that 97% of Somali girls under the age of eight in the Dadaab camp in Kenya have had FGM performed on them.

Female circumcision is the epitome of womanhood and the core for entry into marriage and childbearing in several communities in Africa. Female circumcision is a deeply ingrained custom in Somalia, practiced for centuries, with one of the highest rates of circumcision in the world at 98 percent (Munala: UNHCR, 2014). The practice is one of the major cultural practices that Somali mothers have to combat during deliveries. UNHCR (2010) Dadaab Study concluded that female circumcision is a major reason

why women die during delivery. The challenge is aggravated by the fact that health care providers may not be fully prepared to address deliveries complicated by religio-cultural context inhibitions such as FGM type 3 (infibulation).

As noted by Ndube (2016), the pharaonic type of FGM is the most prevalent among Somalis in the Dadaab refugee camp and it is the most common reason for prolonged or difficult delivery and one of the main causes of maternal mortality in Somalia. (MSF 2012) observed that childbirth requires cutting, and if it is legal in the country where the woman gives birth, partially or completely repairing the infibulation. That causes additional morbidity and increased chances of maternal and child mortality (Deyo, 2012).

Delivery Challenges due to Infibulation

Deyo (2012), in her M.A. thesis, observes that in the case of obstructed or prolonged labor where a life-saving cesarean section is required, these procedures can only be performed with the approval of the woman's father-in-law, and if he is absent, the expectant husband or family elder". This gets very complicated in refugee camps because most often the men are absent. Many women die from this inability to obtain permission, instead of surviving what normally would be a routine procedure. Even in immigrant populations, there is strong resistance to cesarean sections based on the belief that the inherent risks of multiple surgeries will lead to the inability to bear additional children or even death. This fear of infertility is driven by the high value placed on having large families

A report from MSF Story (2012) indicates that to alleviate the risk of complications during pregnancy for women who have undergone infibulations, it is necessary to unstitch the vaginal opening so that the infant can pass through (disinfibulation). However, it is noted that there is one major challenge as stated by Dr. Josiah Oyieke, Maternity Ward Manager, Dagahaley MSF Hospital in the MSF Story (2012):

"Often the women in need of emergency interventions are not in a position to give consent for the required procedure, and need to obtain permission from family members – not just husbands, but other relatives too'

Yet the hospital has all the operation facilities needed to give the mother the best care.

The mothers consider hospitals unsafe due to fear of undergoing a cesarean section operation in the event of experiencing obstructed labor. The Somali family has a big challenge signing for their women to undergo a cesarean section.

A man was asked why he would not approve CS for his wife and he said:

"To us this is like death, the woman becomes disabled she can't do anything thereafter because part of her body is already cut, I fear the possibility of her dying. Even when she recovers, she should not engage in heavy activities until after two years, she will not be able to do much for herself and the children".

More fears arise because a majority of Somali mothers do not believe in practicing artificial family planning and therefore fear being served with family planning contraceptives if they go to the hospital as cited by Kahumbi (2021). Somali mothers in Dadaab believe and seek to adhere to the teachings of the Quran on family planning. Besides, the teaching of the Qur'an (24:31) on the segregation of sexes and prohibition against a woman exposing her body to non-mahram – men who are not close relatives is a barrier to treatment by medical doctors and midwives in hospitals.

Globally, reproductive health affects the broader context of people's lives, including their economic circumstances, education, employment, living conditions, family environment, social and gender relationships, and the traditional and legal structures within which they live. Sexual and reproductive behaviors are governed by complex biological, cultural, and psychosocial factors. Therefore, the attainment of reproductive health is not limited to interventions by the health sector alone. Nonetheless, most reproductive health problems cannot be significantly addressed in the absence of health services and medical knowledge and skills [WHO, 2012; KNBS & ICF Micro, 2010].

Reasons for FGM in the Camps

The situation of FGM among the Somali refugees has improved over the years but the various reasons for FGM remain as explained in UNHCR **Combating FGM in Kenya's Refugee Camps (2003) report;** it is a religious obligation and a tradition; it is believed to ensure virginity until marriage; it gives sexual pleasure to men and enhances their manhood, and it controls the sexual desires of women and girls. Most of the respondents indicated that FGM is part of their cultural and religious beliefs and, therefore, it would be very difficult to eradicate it. The religious inclination to the practice of FGM is what is responsible for the purification mentality that both the perpetrators and the victims of FGM hold, perpetuating the practice. Thus, for purposes of staying pure until marriage, the genitals of the young girls are stitched until marriage. Another important reason to note is the control of immorality. There is a general belief that girls and women who have been circumcised do not "roam" because the FGM makes them docile.

Therefore, they would not be immoral. UNCHR GBV report of 2016 shows a departure from the Sunni type to the Sunna type which is the pricking of the tip of the clitoris is the common current practice by many Somalis in Dadaab.

Somali Religio- Cultural Beliefs and Birthing

The Somali community was introduced to Islam religion in the ninth century. The Islamic religion practiced in Somalia has mainly been influenced by Sufism. However, in recent decades, the Salafi movement has gained more political recognition. It has influenced the country to a more rigid type of Islamism in response to western imperialism. The movement emphasizes the in-depth learning of the Koran, deeply entrenching it in the people's socio-cultural-economic system. As a result of this, the Somali social-economic system cannot stand independent of the Islamic religion.

Currently, there are different hypotheses on how Islamic devotion is believed to shape individuals' sexual and reproductive health and health-related behaviors. The first line of arguments, primarily expressed in epidemiological literature, focuses on risk factors for morbidities caused by Islamic practices (Laird et al, 2007). The second line of arguments particularly focuses on how Islamic attitudes, norms, and value systems implicitly affect the individual's reproductive health. Moreau et al (2013) reported on a complex relationship between individuals' religiosity and sexual and contraceptive behaviors. Similar to other studies, Moreau and colleagues found that regular religious practice was associated with a later sexual debut, but that sexually experienced adolescents, regularly practiced their religion, and were less likely to use contraception. Social control executed by family members and social networks, particularly salient for young women, could possibly act as a barrier to adopting preventive behaviors, thus resulting in greater sexual risks among younger generations of devoted Muslims.

The influence of religion and culture on sexual and reproductive behavior can partly explain community responses to the choice of maternal health care. Knowledge about Muslims' own experiences of sexual and maternal health care could be helpful. It would help health care providers know how to mitigate high mortality and morbidity rates among the Somali refugees who are from Somalia and are Muslims by faith. Failure to do so means that the health care providers and the community maintain a cold relationship and create unnecessary tension.

Health-seeking behavior and related decisions are largely influenced by the teachings of Prophet Muhammad in the Quran. More to

this is the overbearing influence of religious leaders in the community who reinforce these Qur'anic teachings to the letter. The word of the Imams and other religious leaders has more authority than what the health requirements or the law hold as a right case in point.

Two of the TBAs narrated how they recite some part of the Quran and pray placing the Quran on the womb for the mother and baby's safety and bury the placenta far away from the house so that children cannot urinate on it. They help follow the Somali custom to bring peace and comfort to mother and child.

The Quran states that one of the primary goals of marriage is to produce children and populate the Earth. These children will add honor to a father's lineage and enhance his status and reputation. Children are considered a blessing from Allah, and on average, women in Somalia give birth to 7.3 children during their lifetime. In the refugee camps, women often care for as many as ten children in their families. Even among immigrant populations, where nuclear families and economic challenges are often the norms, couples feel significant peer pressure for the woman to bear many children. As such, contraception and abortions are heavily discouraged in Somali tradition. Women often are ostracized in the community for these practices, and generally do not practice child spacing with the exception of the Quran-blessed breastfeeding of infants for two full years – which does not always avoid future pregnancies. As a result, many women give birth annually which is detrimental to their health, infant mortality is high, and dangerously low neonatal birth weights are all common in the Somali community due to its cultural practices (UNHCR Health Info System Report, 2015).

As noted in the foregoing sections of this paper, Somalia is the leading country in Africa in the practice of FGM, at approximately 98% of its female population. As a result, the practice comes with impacts, including the closure or narrowing of the birth canal. While some women go for the cutting of the vulva because they need to give birth, it is noted that others seek to have the cut or the stitches removed completely because it is painful to have sex and some of them feel pain when passing urine. What this means is that FGM lowers the ability of a woman to experience life in totality, being reduced to a pleasure object for the man. When the vulva is narrowed, as one response indicated, the man feels more pleasure during the intercourse. However, this happens to the detriment of the woman. Further, some cuts are never successful, leading to excess bleeding. That is the period when the hospitals come in, otherwise, they are shunned and viewed as enemies of the custom and, therefore, enemies of their religion.

Conclusion

Worldwide the best way to mitigate the challenges of FGM in communities where the practice is still rampant is through education. The virtual reality tool kit prepared during this study is a showcase carrying the stories from mothers and TBAs needing to be redressed in the community's mindsets. The negative effects of FGM and the need to go for maternal health care in hospitals will need to be emphasized to the communities' stakeholders; Religious groups; Boys and girls in schools; and training midwives in colleges and universities.

Although the stories gathered from the respondents were packaged in the VR tool kit during the study, more data needs to be gathered to match the need for anti-FGM advocacy in affected communities. Community education on the dangers of practicing FGM with a regional contextualization approach is mandatory. That approach could be used to provide boys and girls with skills to make informed decisions against the FGM practice and in its place be introduced to an alternative rite of passage at puberty.

Health care managers in affected regions should bring together the health care providers, SAVE mothers, and the TBAs so as to establish a mediation process. The reason is that each category compliments the other and is significantly useful in eradicating FGM and giving maternal health care. The midwifery training institutions could revisit their curriculum and put more effort in the skill gap on matters related to FGM as a social-cultural challenge.

The problem of FGM may not be going away soon and the campaign against it is not intensified in most affected regions in Kenya. Maternal health care providers and other stakeholders need to look out for durable solutions that work in this century to sensitize affected communities. That way leaders and humanitarian health workers will help Kenya achieve her commitment to ending FGM by strengthening coordination in the area of legislation and policy framework, communication and advocacy, evidence generation, and support cross border collaboration on the elimination of FGM as per Nairobi's Commitment 13 in ICDP25 already getting overtaken by events.

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Human Studies

Before research commenced, the proposal was presented to Kenyatta University's ethical review board whose approval was submitted to the National Commission, Science, Technology & Innovation for further approval. Before starting to collect primary data, the researchers explained the purpose of the research and requested all the respondents individually as well as in a group for their permission to be interviewed using consent forms. In cases where the respondents were illiterate, a translator explained the consent form content, and the respondent consented by signing using a thumbprint in the space of a signature.

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