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Married women's negotiation for safer sexual intercourse in Kenya: Does experience of female genital mutilation matter?

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ABSTRACT

Objective: Married women's ability to negotiate for safer sex is important for HIV prevention in sub-Saharan Africa, including Kenya. Yet, its relationship to female genital mutilation is rarely explored, although female genital mutilation has been described as a social norm and marker of womanhood that can control women's sexuality. Drawing on the social normative influence theory, this study addressed this void in the literature.

Methods: We analysed data from the 2014 Kenya Demographic and Health Survey using logistic regression. Our sample included 8,602 married women. Two indicators of safer sex, namely the ability to refuse sex and the ability to ask for condom use, were explored.

Results: We found that women who had undergone genital mutilation were significantly less likely to report that they can refuse sex (OR = 0.87; $p < .05$) and that they can ask for condom use during sexual intercourse (OR = 0.62; $p < .001$) than their counterparts who had not undergone genital mutilation, while controlling for theoretically relevant variables.

Conclusion: Our findings indicate that the experience of female genital mutilation may influence married women's ability to negotiate for safer sex through gendered socialization and expectations. Based on these findings, several policy implications are suggested. For instance, culturally sensitive programmes are needed that target both married women who have undergone genital mutilation and their husbands to understand the importance of safer sexual practices within marriage.

Introduction

As in many other sub-Saharan African societies, a high prevalence of HIV among married women is one of the most urgent public health concerns in Kenya. According to Kenya's National AIDS and STI Control Programme, about 6% of married women were infected with HIV in 2012, while the prevalence among never-married women stood at 3.5% [1]. Another study has similarly shown that married women are about twice as likely to contract HIV as never-married women [2]. It has been argued that having sexual partners outside marriage (i.e., extramarital affairs), especially among men, may partly explain why marriage can increase the risk of HIV transmission [3]. Gupta et al. [4] have revealed that the proportion of extramarital affairs among married males (11%) is about five times higher than among females (2%). Given the possibility that husbands contract HIV from extramarital affairs, Jewkes and Morrell [5] point out that married women may contract the virus through sexual intercourse within marriage.

In this context, the ability of married women to negotiate for safer sexual intercourse—especially being able to refuse sex and to ask for condom use during sexual intercourse—plays an important role in HIV prevention [6]. However, in sub-Saharan Africa, the cultural construction of marriage often gives males dominance over females in sexual and reproductive decision-making [7,8]. Due to these differentiated gender expectations within marriage, husbands may have unlimited sexual access to their wives [9]. Moreover, women may hesitate to ask husbands for condom use during sexual intercourse, as there are often high expectations of childbearing in marriage [10]. Research has also indicated that some married women may feel reluctant to ask for condom use as it may connote either infidelity on their part or mistrust of their husbands [11].

Cultural practices and the ability to negotiate for safer sex in Kenya: The case of female genital mutilation

Previous studies have documented a wide range of social, economic and cultural circumstances that may influence married

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women's ability to negotiate over sexual relations [4,7,12,13]. Although these studies are useful, very little attention has been paid to the relationship between women's ability to negotiate safer sex in marriage and the experience of female genital mutilation (FGM) in a context like Kenya with 6% HIV and 27% FGM prevalence rates [1]. According to the World Health Organization [14], FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. The current study was grounded on the understanding that FGM, which is prevalent in Kenya and some other sub-Saharan African societies, is a means to control female sexuality. This understanding is based on previous studies which have suggested that FGM may limit sexual and reproductive choices, and is intended to enhance husbands' sexual satisfaction and prevent wives' extramarital sexual involvement by reducing their sexual satisfaction and desire [15,16]. Although it has been shown that the ability to negotiate for safer sex, including condom use, is widely practised among women in some African societies [17,18], we argue that this may not be the case for women who have undergone FGM, due to their expectations of submission to their husbands' sexual dominance within such cultural settings, which may include forced acceptance of their husbands' infidelity. This, in turn, may expose these women to health risks, including HIV infection [5].

In response to these concerns, the Kenyan government passed the Prohibition of Female Genital Mutilation Act, which criminalizes any act of FGM and anything that stigmatizes women who have not undergone FGM. Also, there have been many interventional programmes initiated by governmental and non-governmental organizations to address this problem. For example, the UNFPA-UNICEF Joint Programme on FGM aims to decrease the prevalence of FGM in Kenya [19]. Consequently, the proportion of girls and women in Kenya who have undergone FGM declined from 32% in 2003 to 27% in 2013 [20,21]. Despite this achievement, there are still regional variations, with 98% of women in the North Eastern Province having undergone FGM [22,23]. Given the high prevalence of both FGM and HIV in Kenya, this study contributes to the literature by examining the association between married women's ability to negotiate for safer sex and their experience of FGM.

This study adopted the normative social influence theory, which addresses how behaviours are shaped by social norms. People adapt to social norms in their daily interactions with other members of the same community, including family members, friends and neighbours [24]. According to Cialdini, Reno and Kallgren [25], people behave according to an array of social norms to obtain community acknowledgement and acceptance, and to avoid marginalization and exclusion. Social norms are produced and reinforced through socially accepted standards, expressed in social categories such as gender, religion, place, educational level and socioeconomic status [24–26]. The interplay of these social categories may explain different levels of norm constraints or acceptance over time and space. For example, Kenyan women who live in urban areas may face fewer constraints from traditional gender norms than their rural counterparts [15]. Also, women of higher socioeconomic status tend to have more resources to resist some constraints from social norms [27,28].

Central to the normative social influence theory is how norms are transmitted differently among women and men [29]. Accordingly, people begin to adapt to gender norms in childhood through to adolescence, and thus readily conform to gendered rules governing behaviour in adulthood [30]. As a social norm and marker of womanhood in at least some groups in Kenya, the experience of FGM can be critical to identity construction among women, with its attached social expectations and rewards [31]. Under the social influence of pervasive gender norms, women who have undergone FGM may be less assertive in sexual and reproductive decision-making than women who have not. Given that FGM may create a platform for gendered expectations and socialization, the ability to negotiate for safer sex may differ between married who have undergone FGM and those who have not. Specifically, we aim to examine the following two hypotheses:

H_1: Married women who have undergone FGM are less likely to report that they can refuse sex than their counterparts who have not undergone FGM.

H_2: Married women who have undergone FGM are less likely to report that they can ask their husbands to use a condom during sexual intercourse than their counterparts who have not undergone FGM.

Methods

We drew data from the 2014 Kenya Demographic and Health Survey (KDHS), a nationally representative dataset of women aged 15–49 and men aged 15–54. The KDHS was implemented by the Kenya National Bureau of Statistics (KNBS) with the Ministry of Health, the National AIDS Control Council (NACC), the National Council for Population and Development (NCPD), and the Kenya Medical Research Institute (KEMRI), with technical assistance from ICF International. This dataset provides reliable demographic and health indicators, including FGM status and married women's ability to negotiate for safer sex. The KDHS employed a two-stage sampling design in which a stratified 'probability proportional to size' sampling methodology was applied [32]. Also, the KDHS conducted face-to-face interviews with 14,741 women and 12,819 men, with a response rate of 96% and 90%, respectively. For the purpose of this study, we focused on 8602 currently married women who answered questions on their FGM status and on their ability to refuse sex and to ask for condom use.

Measures

Married women were asked two questions regarding their ability to engage in safer sexual intercourse with their husbands. The first question asked whether they can refuse sex with their husbands (0 = no; 1 = yes), while the second question asked whether they can ask for condom use during sexual intercourse with their husbands (0 = no; 1 = yes). We adopted these questions as our dependent variables. Our focal independent variable was FGM status. Respondents were asked whether or not they had undergone FGM (0 = no; 1 = yes). In line with social normative influence theory, we add control variables for a wide range of social categories, including socioeconomic factors (household wealth quintiles, level of education and employment status) and sociodemographic factors (age of respondents, religious affiliations, region of residence and urban/rural residence). In addition to social factors, research has also suggested that sexual behaviours are influenced by individual psychosocial factors such as knowledge and perceptions of HIV transmission [6,27]. Accordingly, we included three psychosocial control variables, namely adequate HIV transmission knowledge, whether respondents know someone with HIV and whether respondents have been tested for HIV.

Data analysis

In addition to univariate analysis, logistic regression analysis was employed because the dependent variables were dichotomous [33]. First, we estimated the bivariate associations between women's FGM status and their ability to refuse sex and ask for condom use in Models 1 and 3 respectively. To further estimate the net impacts, we added socioeconomic, demographic and psychosocial