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The Association between Male Circumcision and Physical Intimate Partner/Spouse Violence in Kenya

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Abstract

Intimate partner violence against women is a global public health problem with many short-term and long-term effects on the physical and mental health of women and their children. Intimate partner/spouse violence is predominantly perpetrated by men against women victims. Sustainable Development Goal 5.2 aims to eliminate all forms of violence against all women and girls. This study sought to determine the association between of male circumcision and physical intimate partner/spouse violence in Kenya. Data from the nationwide and representative Kenya Demographic and Health Survey, conducted in 2014, were further analyzed. The Demographic and Health Survey utilizes a two stage stratified sampling technique. This study found that Male circumcision is very popular in Kenya **(**92.4%, n=12819). This study establishes that physical intimate partner/ spouse violence is rife in Kenya (34.5%, n=3265). A Pearson Chi Square test of independence found that there was a significant association between male circumcision status and physical intimate partner/spouse violence ($x^2(1) = 44.51^a$, $p<0.000$). Binary Logistic regression predicted that the males who were uncircumcised had over two-fold higher odds of executing physical intimate partner/spouse violence compared to those were circumcised (OR 2.44, CI 1.86-3.19). This study concludes that male circumcision is beneficial in the long-term and adds to the holistic value of men beyond the physical removal of prepuce for health reasons. This study recommends male circumcision especially with a period of seclusion. This study recommends that programs should focus on initiatives or interventions that encourage male circumcision accompanied by structured learning programs during the period of initiates' seclusion.

Keywords: *Male Circumcision, Intimate Partner/Spouse Violence, Social Cognitive Theory*

1.0 Introduction

Intimate partner violence against women is a global public health problem with many short-term and long-term effects on the physical and mental health of women and their children (Sardinha et al. 2022). Intimate partner/spouse violence refers to any physical, sexual or psychological violence and/or stalking from a past or current intimate partner. It affects either gender and over a third of all women in the United States have experienced some form of intimate partner/spouse violence in their lifetime. Intimate partner/spouse violence has huge economic implications which includes but not limited to loss of productive man-hours, medical costs, psychological support costs and litigation costs(Doyle, Knetig, and Iverson 2022). According to (Klomegah 2008) physical intimate partner violence is rampant and has reached epidemic proportions in Africa. The prevalence of physical intimate partner/spouse violence ever experienced by women in lifetime in Kenya is over 50% and about 20% in the past year(Haushofer et al. 2019; Kimuna, Tenkorang, and Djamba 2018). Intimate partner/spouse violence is predominantly perpetrated by men against women victims. However, contemporary studies seem to suggest that women perpetrators of intimate partner/spouse violence against men victims seem to be increasing steadily. Physical intimate partner/spouse violence is the most common form of it. Physical violence is often accompanied by psychological abuse and has detrimental effects on female victims' mental health(Delara 2016).

There are many factors associated with physical intimate partner/spouse violence namely socio-cultural development and support, help-seeking behaviour, accessibility of community-based services, economic limitations, cognitive or physical impairment, drugs and substance abuse, witnessing of parental violence, relationship and developmental idiosyncrasies(Gautam and Jeong 2019; Mazur, Brindis, and Decker 2018). One of the Sustainable Development Goals related to intimate partner/spouse violence is SDG 5.2 which aims to eliminate all forms of violence against all women and girls in public and private spheres, including trafficking and sexual and other types of exploitation(García-Moreno and Amin 2016).

This study explores the association of one of the socio-cultural and developmental variable or rite of passage namely male circumcision on physical intimate partner/spouse violence. Male circumcision is the removal of the penile foreskin (prepuce). It is one of the oldest and most common surgical procedures known, traditionally undertaken as a mark of cultural identity or religious importance. It's perceived to be significant in educating, preparing and initiating boys into manhood. It exposes boys to community traditions and to prepare them for manhood and roles therein(Siweya, Sodi, and Mbuyiselo 2018; Vivian 2021)

Globally male circumcision is not popular, with approximately 30% of all males across the world— representing a total of approximately 670 million men being circumcised. Of this number, about 68% are of Islamic faith, less than 1% of Jewish faith, and 13% are non-Muslim, non-Jewish Americans(UNAIDS 2022). Circumcision is standard in the United States and parts of Southeast Asia and Africa, but is rare in Europe, Latin America, and most of Asia. A personal preference in favor of circumcision is more common in Anglophone countries such as the United States, Canada, Australia, and New Zealand(World Population Review 2022).

Male circumcision is widely practised in Africa and may involves the seclusion of young males from their families into the initiation camp where they receive some informal learning process during which older men pass on information and/or skills that are considered necessary to be a man in their societies. The practice also extends to orientating boys into their multiple gender identities as sons, brothers, lovers, spouses and prospective fathers (Siweya, Sodi, and Mbuyiselo 2018). According to (World Population Review 2022), male circumcision for religious and cultural reasons is a relatively common practice in African countries, where 28 of 54 countries have a male circumcision prevalence exceeding 80% (WHO, 2009).

Male circumcision is very popular in Kenya with prevalence of over 85% (NASCOP 2009) but varies from community to another based on their cultures. It is recorded that male circumcision is lower than the national figure at around 50% in Western Kenya region especially among the communities that culturally did not practice it (Westercamp et al. 2017).

Male circumcision is primarily intended to the remove the penile foreskin for health reasons such as hygiene and to reduce the chance of contracting Human Immunodeficiency Virus (HIV). In many African Cultures, including Kenya, male circumcision has more significance beyond health underpinnings. Some of the secondary significance of male circumcision includes education of societal values and traditions, preparing and initiating boys into manhood(Vivian 2021; Siweya, Sodi, and Mbuyiselo 2018). Additionally, after surgical removal of the prepuce, the initiates are secluded from their families especially women and girls in an isolated camp (may be forest or mountains) where they receive some informal learning process during which older men pass on information and skills that are considered necessary to be a man in their societies. The practice also extends to orientating boys into their multiple gender identities as sons, brothers, lovers, and prospective fathers (Siweya, Sodi, and Mbuyiselo 2018)

There is a paucity of knowledge on the relationship between male circumcision and consequent effect on physical intimate partner/spouse violence. This study null hypothesis states that there is no significant association between male circumcision status and physical intimate partner/spouse violence in Kenya.

2.0 Theoretical Basis

This study is premised on the Social Cognitive Theory. The above theory and principles are widely used in health and social sciences in an attempt to predict and/or explain behaviours. They inform complex human behaviours and unexpected way of doing things (Bandura 2010).

Social Cognitive Theory is a theory developed by Albert Bandura initially in 1960s and he continually improved in late 1980s to 1990s. The gist of The Social cognitive Theory according to (Bandura 2010), is that human beings learn by observing others(vicarious learning), within the context of social interactions in a setting herein referred to as the environment but subject to ones cognition which entails ones personality. The learned behaviours are central to ones personality.

What makes the Social Cognitive Theory unique is that it proposes that learning considers how people maintain a learned behaviour, considers past experiences and is a collective function of Self-Efficacy, goals and Outcome expectancies. In many cultures in Kenya circumcision is accompanied by a short period of seclusion where the initiates are socialized together and develop a collective or common bond of friendship. During the period of seclusion, the initiates are informally inculcated with societal values including respect for self and the women. These initiates formed a lifetime special age group that acted peer counselling group and the people who came to counsel the initiates on various topical issues automatically became role models. Social Learning Theory states that when people observe a model performing behaviour and the consequence of the behaviour, they remember and are likely to remember the information to guide subsequent behaviour. The Social Cognitive Theory emphasizes that the dynamic interaction (Triadic Reciprocal Determinism) between people (personal factors), their behaviours and their environment as demonstrated by the following Figure 1;

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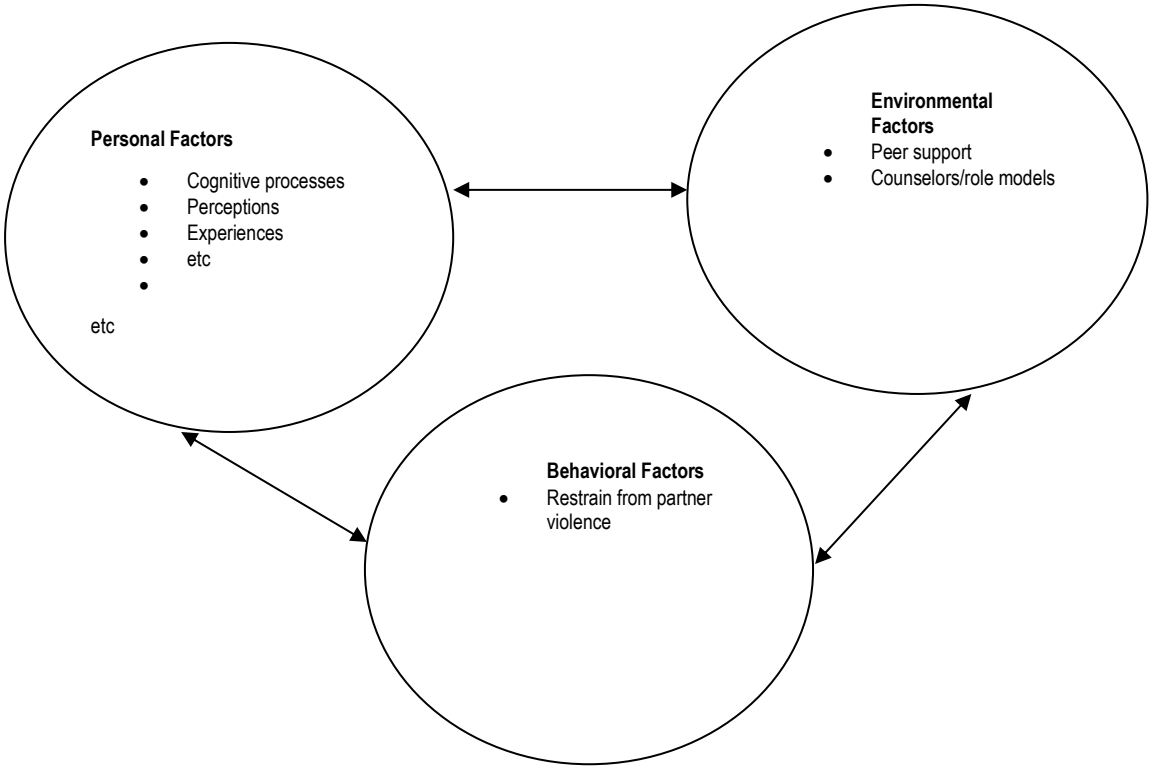

Figue 1: Triadic Reciprocal Determinism(adopted from Bandura, 2010)

Personal Factor

According to Bandura (2010), personal factor has four construct namely; Self efficacy, expectations, expectancies and self-control or self-regulation constructs. Self-efficacy construct refers to the level of one's confidence in their ability to successfully perform a behavior or specifically the confidence to refrain from intimate partner/spouse violence. Expectation construct can also be defined as the likelihood and value of the consequences of behavioural choices. Through the informal learning of initiates during the period of seclusion, the initiates are personally made to appreciate women as dignified beings and thus should refrain from hurting them for the greater good of the society.

Expectancy construct is the value that an individual associates with the behavioural outcome. This study assumes that the informal learning that occurs during initiates' seclusion instils appropriate attitude/perceptions towards respect for women and refrain from intimate partner/spouse violence. Self-control/regulation construct is how much control over behaviour (Bandura 2010). This study assumes that the informal learning that occurs during initiates seclusion inculcates the notion that violence is detrimental to human health, thus they ought to be in a position of self-control from temptation of intimate partner/spouse violence.

Environmental Factors

Environmental factor has four constructs namely; vicarious learning construct, situation construct, reinforcement construct and collective efficacy construct. Vicarious learning is learning by observing others' behaviours and the consequences following them. There are four conditions before a behaviour is modelled; attention (the learner has to listen/see or perceive a desired behaviour), retention (the desired behaviour has to be remembered), reproduction (the

actual attempting or doing of the desired behaviour) and motivation (the self-drive to perform the desired behaviour) (Bandura 2010). There are two types of models that the initiates in seclusion and beyond vicariously learn from namely peers and mature counsellors. Collective efficacy construct is the confidence or belief in a group's ability to perform actions to bring about desired change (Bandura 2010). Collective efficacy in our case is also the willingness of peers (initiates) or mature role models to intervene in order to help others individually or collectively towards a noble cause of respect to women. This study aimed to determine the influence of male circumcision on the physical intimate partner/spouse violence and by extension respect to women.

Behavioural Factor

According to Bandura (2010), behavioural factor or construct is about the level of knowledge and skill to execute a behaviour. This was looking at a variable, male circumcision, as an informal learning opportunity that happens during the initiates' period and transcends to entire lifetime. This is enhanced by a strong bond and identity formed by the initiates age set that is underpinned by deep respect for the peers and their mature counsellors. This collegiality and deep respect for their senior counsellors propel them appreciate acceptable societal values including respect to women thus refrain from intimate partner/spouse violence. The peer influence on individual perceptions/behaviour on respect for women/intimate partner/spouse violence is what is referred to as Self-efficacy while the collective psyche on respect for women intimate partner/spouse violence is what is referred to as Collective Efficacy.

(Ghadyani et al. 2017), vouched for the social cognitive theory, a health behaviour change theory that provides a comprehensive and well-supported conceptual framework for understanding the interaction of an individual's behaviour and environment that influences healthcare providers' behaviour. Moreover, according to (Thompson and Thompson 2014), the Social Cognitive Theory provides a model that explores the factors that determine the longevity of behavioural changes resulting in successful outcomes that may be long-term. The subjects' realistic outcome expectations are likely to encourage the resilience, perseverance and long-term commitment. Bandura (2010) contends that both self-efficacy and collective efficacy beliefs people's judgment of their capabilities to organize and execute courses of action required to attain designated types of outcomes are central to well-being.

3.0 Methodology

This study uses data from the nationwide Kenya Demographic Health Surveys (KDHS) conducted in 2014. The KDHS provides a nationally representative sample of the Kenyan population and utilizes a two-stage stratified sampling design. In the first stage clusters are stratified by region and urban-rural location and randomly selected in proportion to population size. The second stage involves random selection of households within clusters. This study focused on determining the association between male circumcision and physical intimate partner/spouse violence in Kenya. Thus the unit of analysis was men who participated in the survey. Men are asked separately about background information, circumcision status, intimate partner/spouse physical violence perceptions and practices. 12819 men participated in the survey and all were therefore eligible for our analysis. Permission to get access to the data was obtained from the measure DHS program online request from http://www.dhsprogram.com. website and the data used were publicly available with no personal identifier

The outcome variable is intimate partner/spouse physical violence practices is dichotomous and herein refers to either having ever assaulted their intimate partners/spouse or not. The explanatory variables are socio-demographic factors and male circumcision status. This study considered four socio-demographic variables namely; age, region, type of place of residence

and religion. Data were analyzed using Statistical package for Social Sciences (SPSS) version 21. Descriptive statistics are presented as proportions, percentages, figures and tables for the categorical variables. In addition, a few continuous variables were presented using their measures of central tendencies.

A Pearson Chi Square test of independence was used to compare association of intimate partner/spouse physical violence by the explanatory variable namely male circumcision status. Binary logistic regression model was fitted to assess the strength and direction of associations between the outcome variable (intimate partner/spouse physical violence) and the explanatory variable namely male circumcision status. The odd ratios and corresponding 95% confidence intervals were computed for all the significant variables in the unadjusted model.

4.0 Findings

Prevalence Male Circumcision

Most (92.4%, n=12819) of the males in Kenya are circumcised compared with (7.6%, n=12819) who are not circumcised. The mean age of circumcision is 19.6 years (SD=8.4yrs). Most of the circumcisions (60.9%, n=11844) were performed by health workers, while the rest were performed by unskilled personnel. About half of the circumcisions (45.3%, n=11844) are performed in a health facility, while about a third (32.7%, n=11844) are done at parental, circumcisers', friends' home, 22.0% (n=11844) are done at the ritual sites. Circumcision status is over 90% in all age groups as demonstrated by Figure 2.

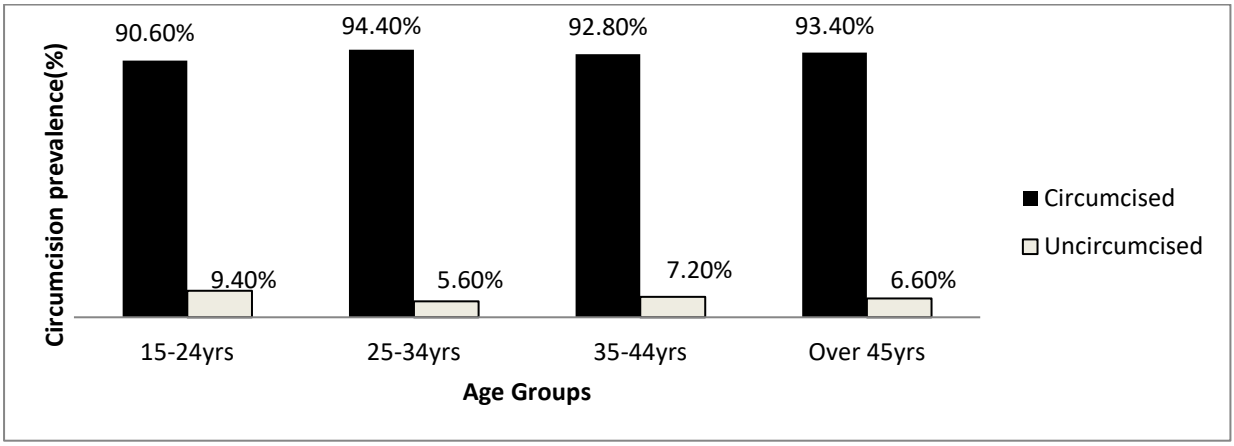

Figure 2: Circumcision prevalence by age groups

The four leading regions in Male circumcision prevalence are North Eastern (100%), Coast (98.0%), Eastern (97.0%) and Central (97.0%). Nyanza region is trailing with a prevalence of 73.10% as shown in the Figure 3.

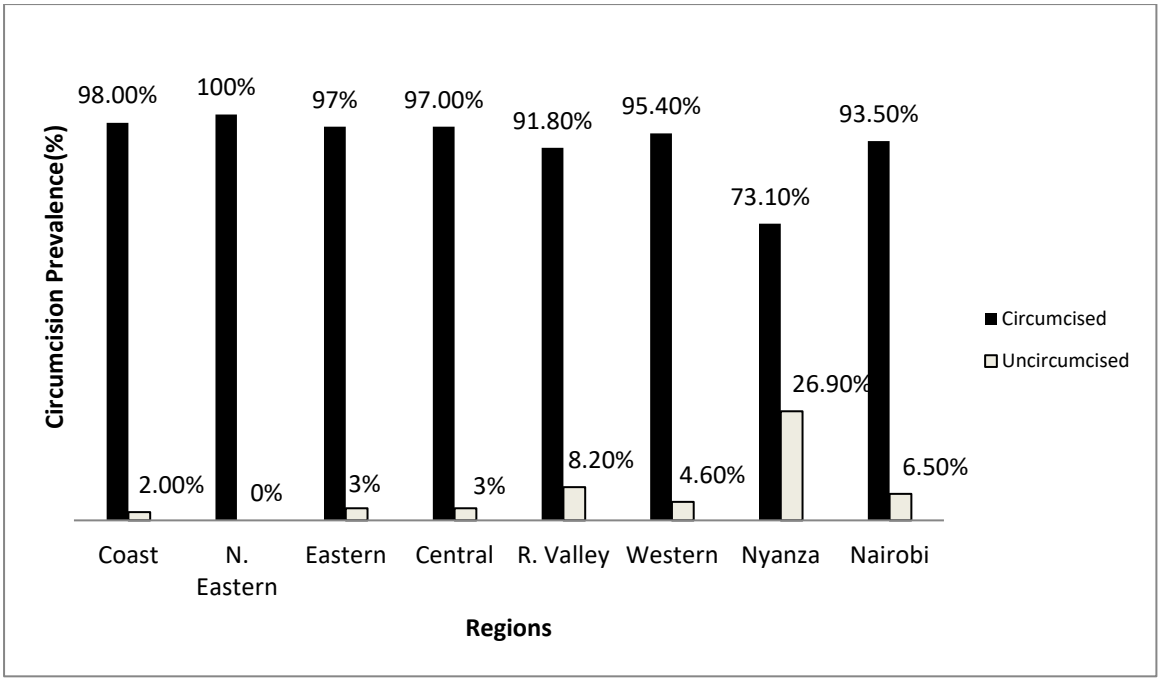

Figure 3: Circumcision prevalence by region

Male circumcision prevalence is greater in urban compared to the rural type of residences as demonstrated by Figure 4.

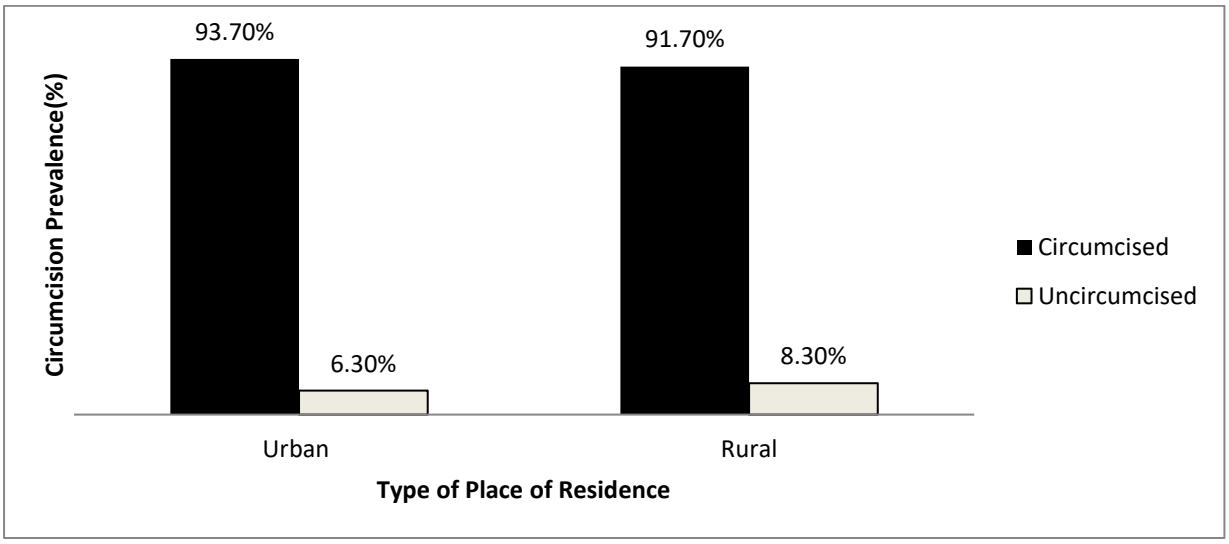

Figure 4: Circumcision prevalence by Type of place of residence

The study also finds that male circumcision is very popular with the Muslims as shown in Figure 5

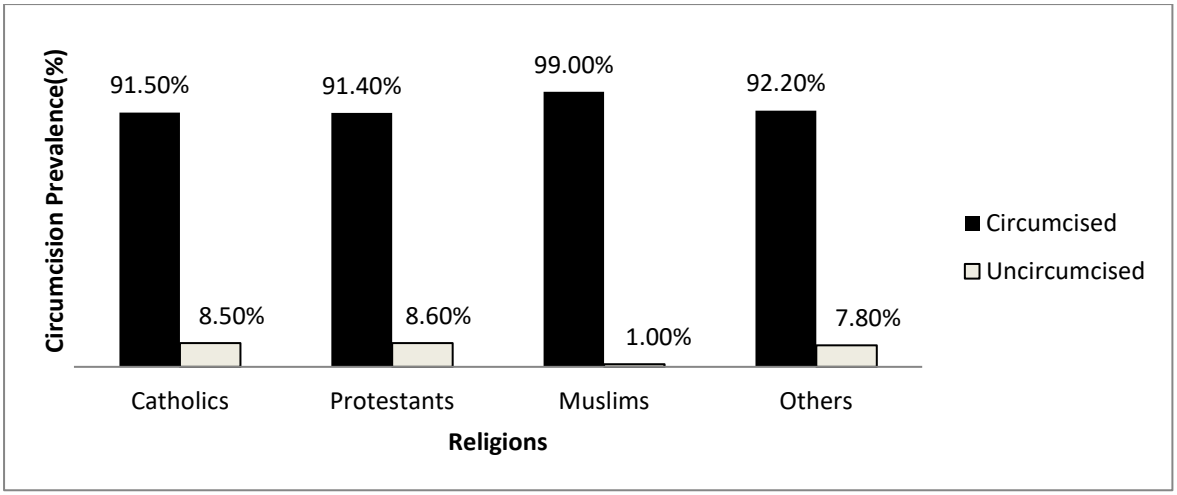

Figure 5: Circumcision prevalence by religion

Intimate partner/spouse violence perceptions

Table 1
Comparison By Male Circumcision Status Versus Intimate Partner Violence (IPV) Perception
(Affirmative For The Specific Circumstances When Violence Was Deemed Justified)

Variable (Specific circumstances)	**Uncircumcised (n=437)**	**Circumcised (n=4483)**
Neglecting children	77.6%	77.2%
Arguing with husband/partner	63.8%	56.5%
Going out without telling the husband/partner	55.4%	57.2%
Refusing to have sex with husband/partner	26.1%	33.0%
Burning of burns food	11.9%	15.4%

Intimate partner/spouse violence Practices

Slightly over a third of all men in Kenya (34.5%, n=3265) have physically assaulted intimate partner/spouse in their lifetime. The frequency of the physical intimate partner/spouse violence in their last one year is ranging from sometimes (95.5%, n=422) to often (4.5%, n=422). Physical intimate partner/spouse violence increases with age with those over 45 years with the highest prevalence at 39% (n=629) and with those under 25 years with the highest prevalence at 30.3% (n=198) as shown by the Figure 6.

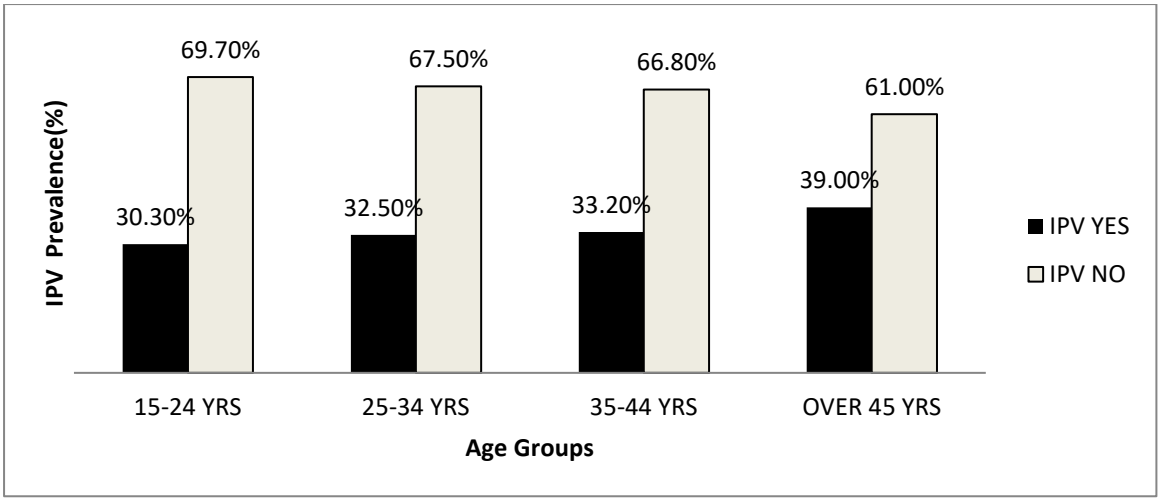

Figure 6: Physical intimate partner/spouse violence prevalence by age groups

The leading two regions in prevalence are Nyanza (55%, n=456) and Nairobi (44.7%, n=123) while the lowest prevalence was recorded at the North Eastern region (3%, n=132) as shown by the Figure 7.

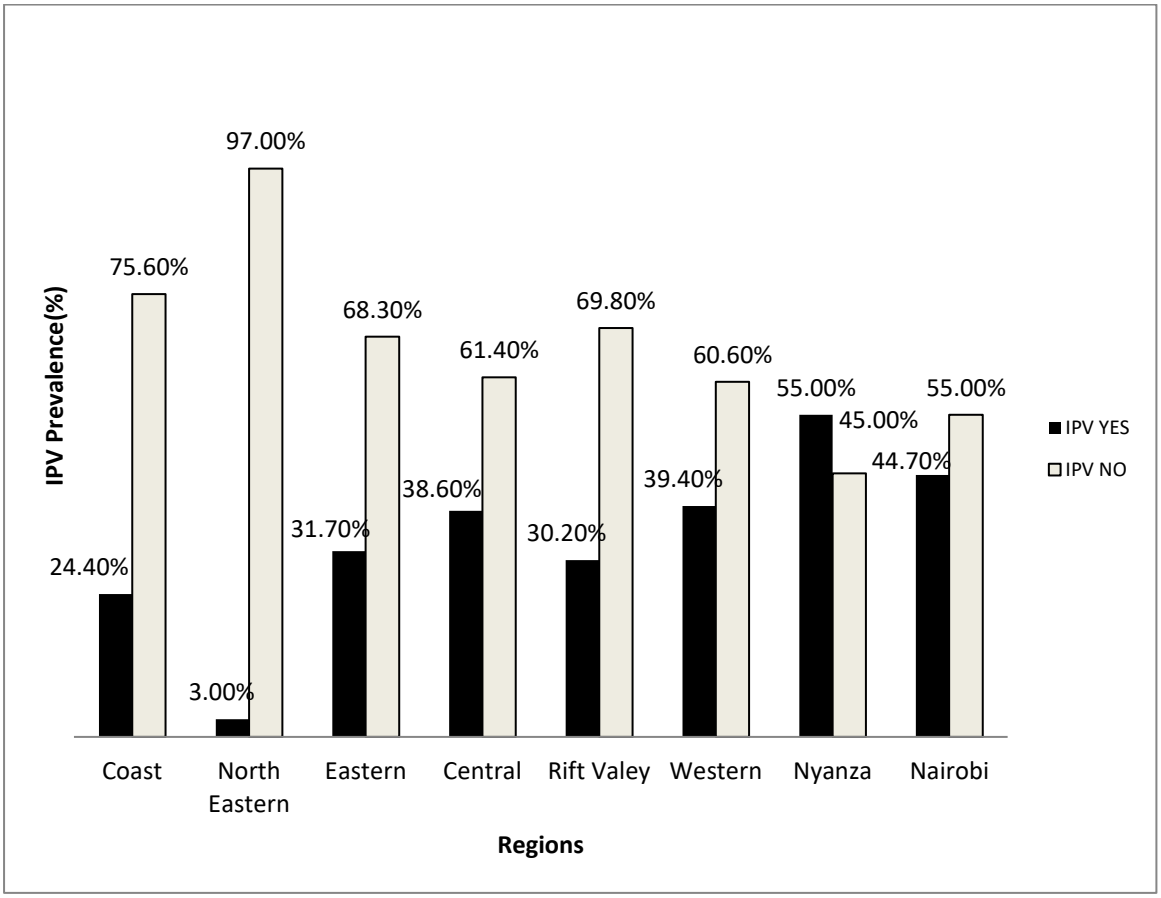

Figure 7: Physical intimate partner/spouse violence prevalence by Regions

Physical intimate partner/spouse violence is more prevalent in rural types of residence (35.9%, n=1935) compared to urban types of residence (32.4%, n=1330) as shown in Figure 8.

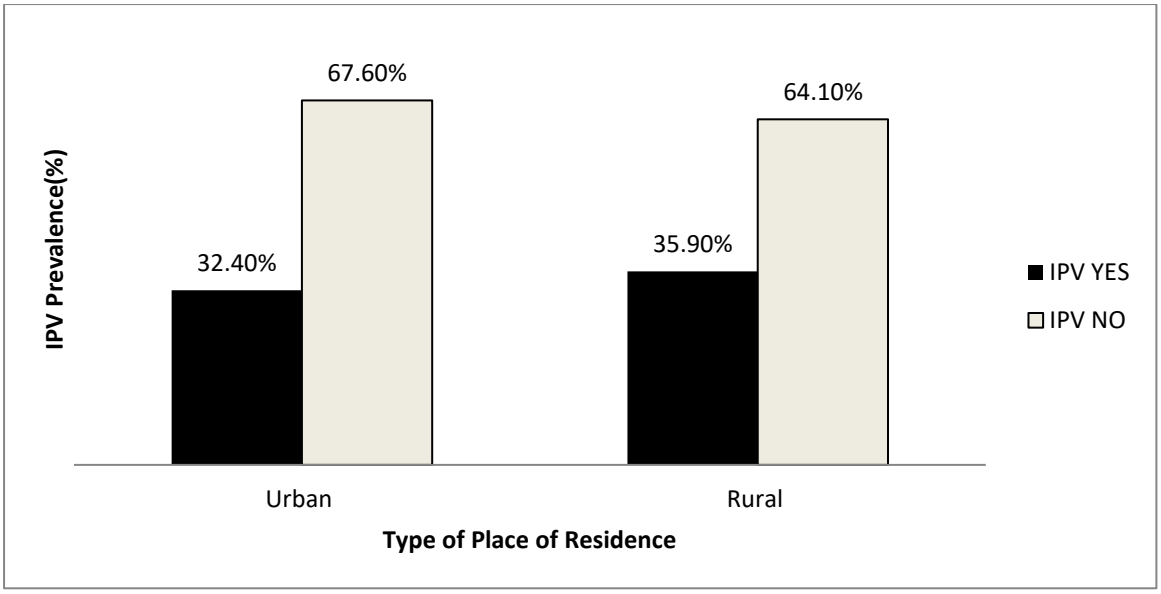

Figure 8: Physical intimate partner/spouse violence prevalence by Type of place of residence

Physical intimate partner/spouse violence is least prevalent among the Muslims (19.4%, n=356) compared to other religious groupings as shown in the Figure 9.

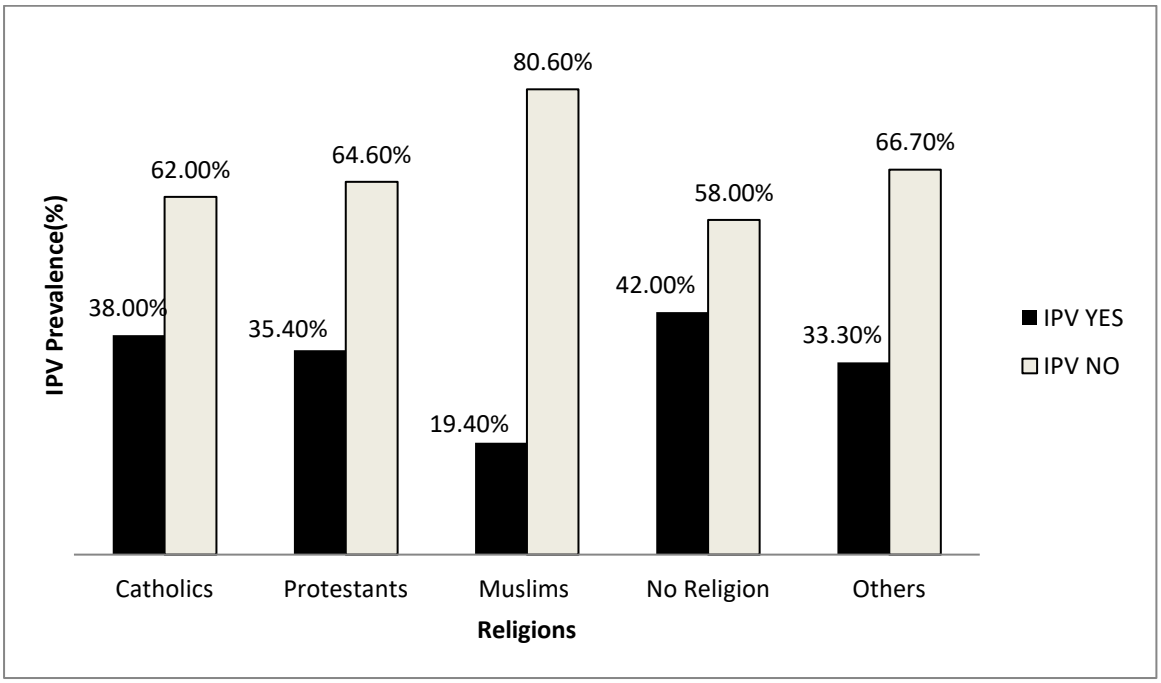

Figure 9: Physical intimate partner/spouse violence prevalence by Religion

Association between male circumcision and intimate partner/spouse violence practices

Table 2
Comparison of Cirumcision Status Versus Physical Intimate Partner/Spouse Violence(IPV)

Variable		Frequency of violence	Percentage	X^2	p-value
Group	Uncircumcised	127	54.5%	44.51[a]	.000
	Circumcised	999	32.9%		

A Pearson Chi Square test of independence was calculated comparing the instances of physical intimate partner/spouse violence by male circumcision status. A significant interaction was found ($x^2(1) = 44.51^a$, $p<0.000$) as shown in the Table x above.

Additionally, Binary Logistic regression was used to determine if male circumcision status could predict male intimate partner/spouse violence practice. This study established that those who were uncircumcised had over two times higher odds of executing intimate partner/spouse violence compared to those were circumcised (OR 2.44, CI 1.86-3.19).

Discussion

Over fifty percent men are likely to justify physical intimate partner/spouse violence against women under different circumstances namely when they neglect their children, arguing with husband and going out without permission regardless of their circumcision status. This correspond to findings by a study done on intimate partner violence in Zambia with going out without telling the partner being top most (Klomegah 2008).

Slightly over a third of all men in Kenya (34.5%, n=3265) have physically assaulted intimate partner/spouse in their lifetime. The frequency of the physical intimate partner/spouse violence in their last one year is ranging from sometimes (95.5%, n=422) to often (4.5%, n=422). This is comparable to the regions figures as captured by Kiwuwa-Muyingo and Kadengye (2022) that previous year intimate partner/spouse physical violence prevalence ranges from 16.8% (Ethiopia) to 26.6% (Tanzania) and ever experienced intimate partner/spouse violence prevalence ranging from 26.7% to 39.3% for intimate partner/spouse violence.

On applying Pearson Chi Square test of independence to measure the association between male circumcision status and physical intimate partner/spouse violence established a highly significant association ($p<0.000$). Furthermore, on using Binary Logistic regression to measure the strength of association found that the men who were uncircumcised had over two times higher odds of executing intimate partner/spouse violence compared to those were circumcised (OR 2.44, CI 1.86-3.19). It is obvious that male circumcision especially when accompanied by a period of seclusion marks an important milestone in initiates' value system insofar as restrain from physical intimate partner/ spouse violence. From the foregoing, this study 'rejects' the null hypothesis that stated there is no significant association between male circumcision status and physical intimate partner/spouse violence in Kenya.

5.0 Conclusion and Recommendation

This study found that Male circumcision is very popular in Kenya**.** This study deduces that male circumcision is beneficial in the long-term and adds to the holistic value of men beyond the physical removal of prepuce for health reasons. The male circumcision in the Kenyan context is accompanied by a period of seclusion where intensive informal learning and socialization occurs. This study postulates that initiates go through a process that individually and collectively come to realize crucial societal values including respect for women as posited

by (Siweya, Sodi, and Mbuyiselo 2018; Vivian 2021; Westercamp et al. 2017). It is also a conclusion of this study, that human beings value system is continually are perfected by vicarious learning process from role models especially the one that male initiates encounter during circumcision seclusion. These role models/counsellors are held in high esteem and tower as point of reference throughout life of the young initiates.

From the foregoing conclusion, this study recommends male circumcision especially with a period of seclusion. This male circumcision process should be carefully considered and structured for better outcome. The selection of both initiates and the role models/counsellors should be cautiously done to ensure the initiates interact with upright peers and role models/ counsellors who are socio-morally upright and of good standing in the society owing to their entire life influence. This study recommends that programs should focus on initiatives or interventions that encourage male circumcision accompanied by structured learning programs during the period of initiates' seclusion.

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