Trends and shifts in the practice of FGM: facilitators/barriers to abandonment in Kenya

Samuel Kimani, University of Nairobi & Africa Coordinating Centre for Abandonment of FGM (ACCAF), Kenya

G3 Conference, Brussels, Belgium, 20th to 22nd May 2019

Co-Authors and Acknowledgements

Dr. Caroline Kabiru -Population Council, Kenya

Dr. Jacinta Muteshi -Population Council, Kenya

Dr. Dennis Matanda -Population Council, Kenya

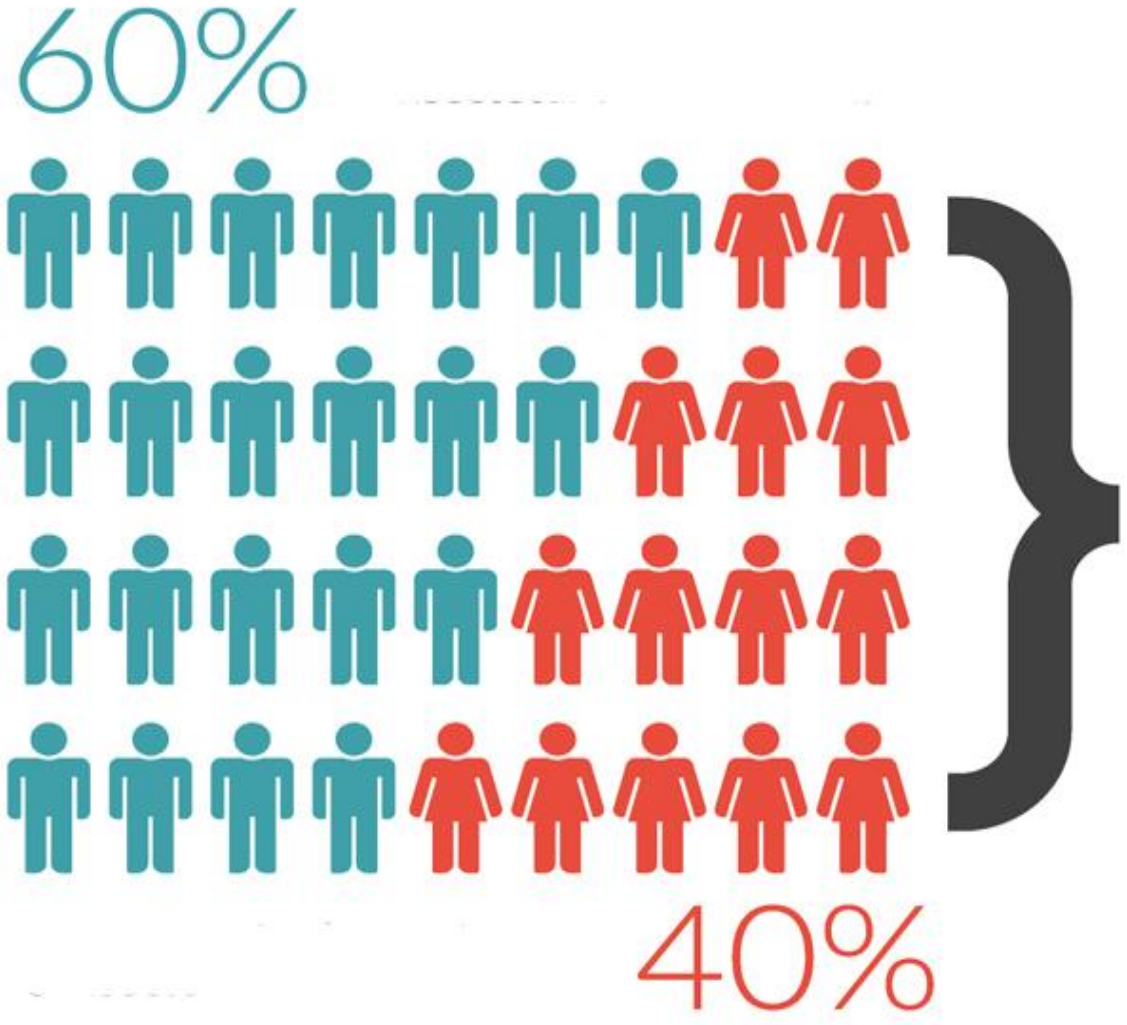
This work has been Funded by DFID

Background: FGM is a Socio-Health & Human Rights-legal problem

- Female genital mutilation (FGM) has no medical benefits, is associated with health complications, women rights abuse and violation.
- 200 million women live with FGM, while 3.6 million risk being cut annually.
- Some decline of FGM in countries like Kenya.
- Changes (shifts) in FGM-medicalization, less severe cutting and cutting at younger age are observed in Kenya.
- Data capture approaches should accurately measure FGM and related shifts for programing, policy and investments.

Accurate data is key to FGM response

- Despite decline in FGM,
- Shifts give momentum to FGM yet poorly captured
- Accurate determination of trends and patterns can identify FGM shifts
- Shifts may facilitate or act as barriers to abandonment- need exploration



Objectives

- We conducted secondary analysis of the four most recent waves of Kenya Demographic and Health Surveys (KDHS) to assess changes in the practice of FGM

- Explored understanding of medicalized FGM among families and healthcare providers from selected communities (Kenyan Somali, Abagusii and Kuria)

Methods

Secondary analyses of the 4 most recent waves of KDHS to assess change

Qualitative approach to understand local context of medicalisation

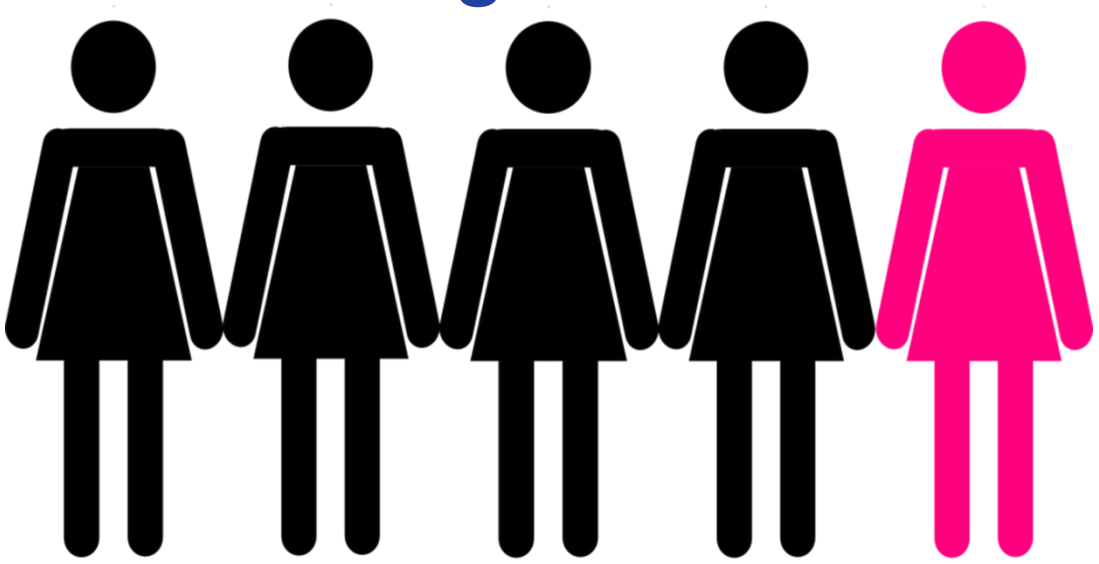
Qualitative Methods (FGDs, KIIs, IDIs)

Study Sites:Nairobi, Garissa, Kisii Counties & Kuria East

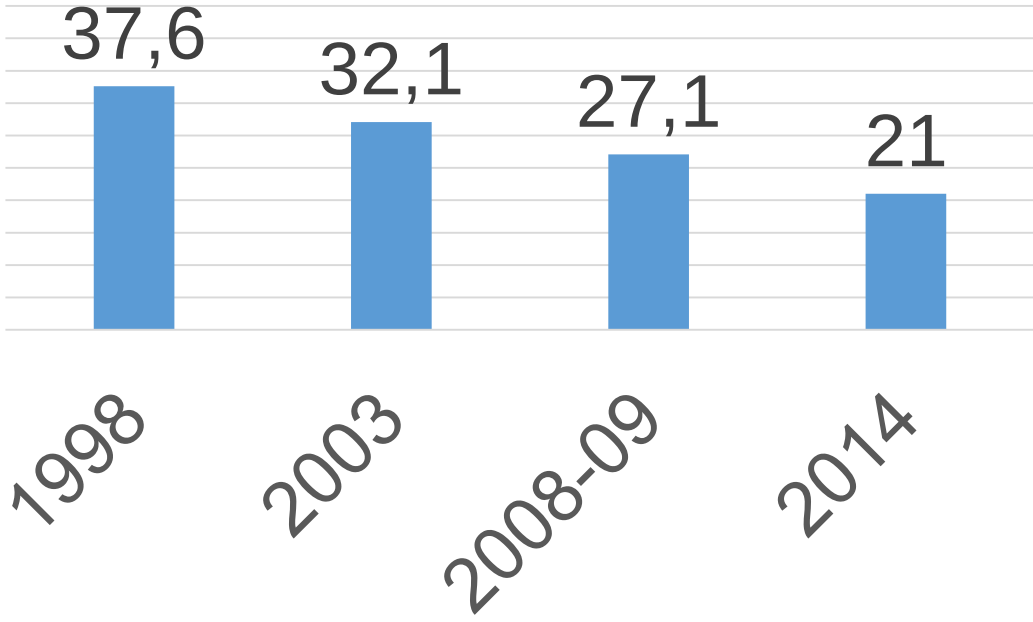
Sample: Families using medicalized/traditional FGM, & HCPs

Evidence of declining prevalence of FGM in Kenya

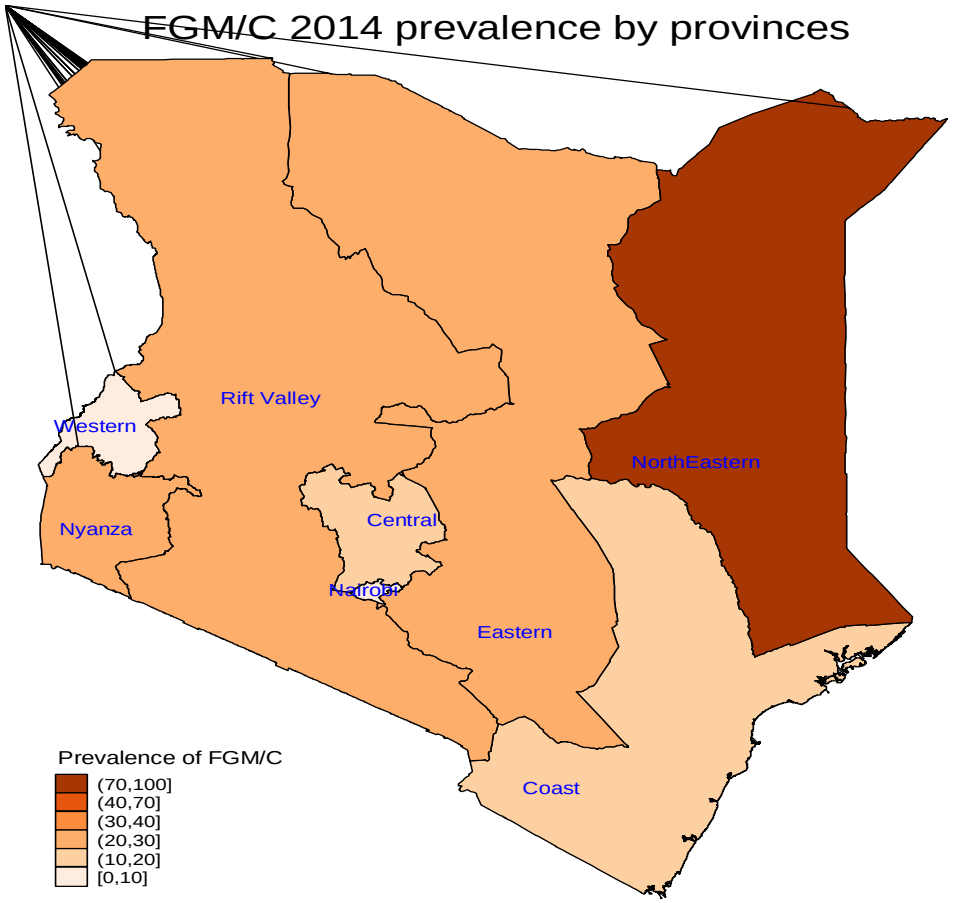
1 in 5 Kenyan women have undergone FGM/C

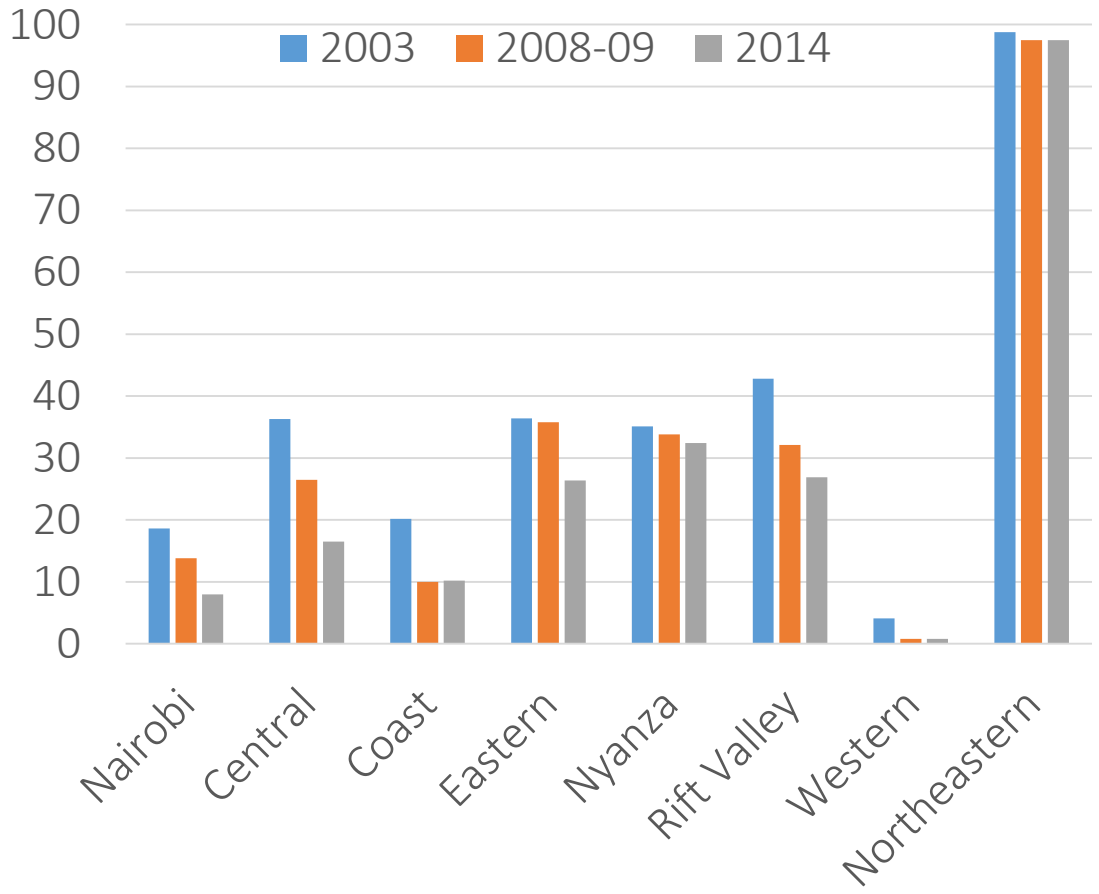


Decline in FGM in Kenya



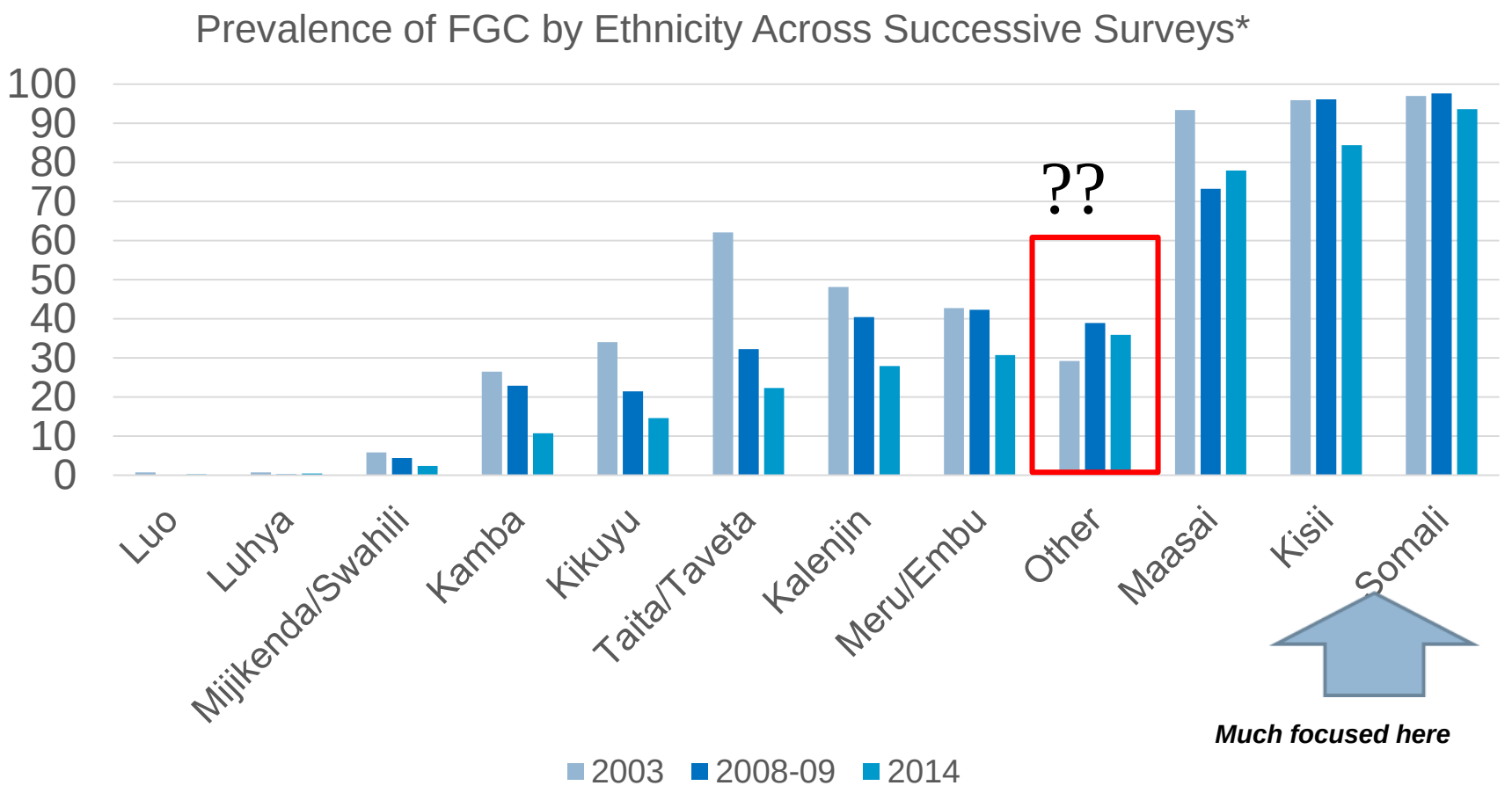
National prevalence with sub-national variations





Source: Shell-Duncan et al, 2017

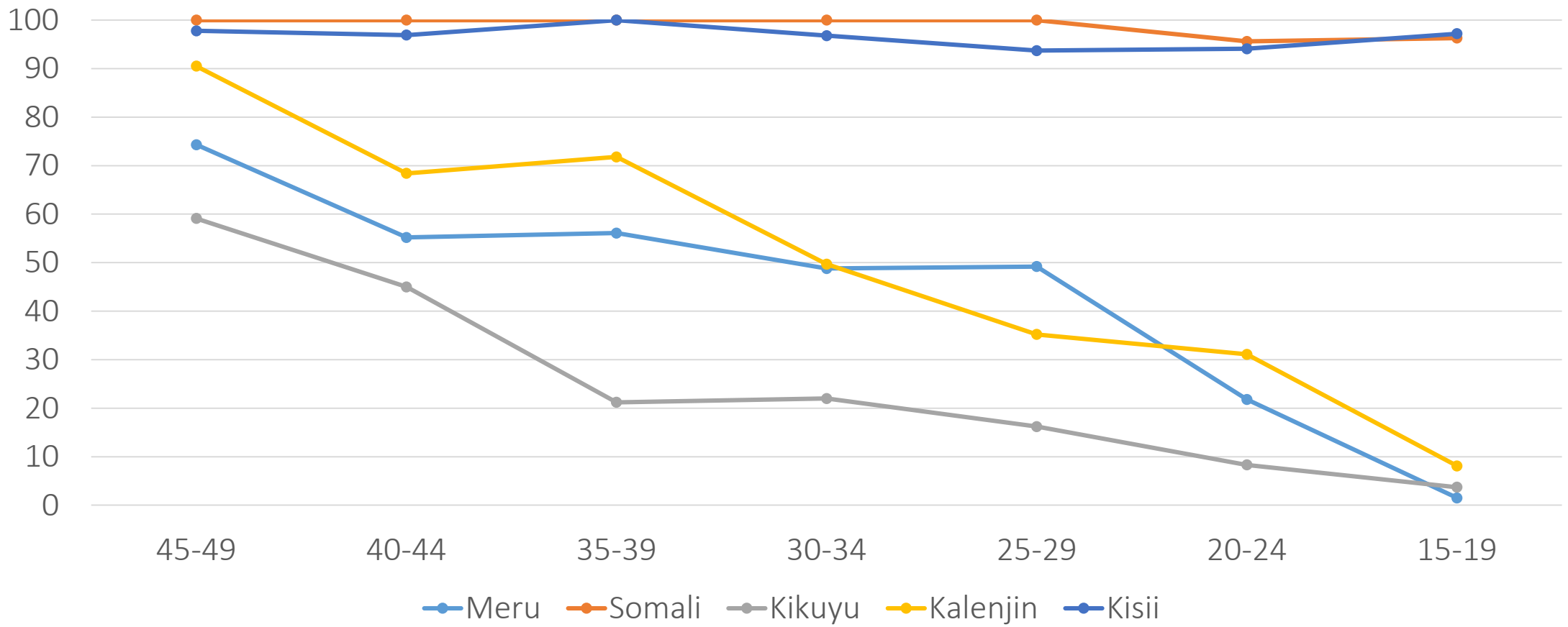
Ethnic variations in decline of FGM



Additional 2014 data

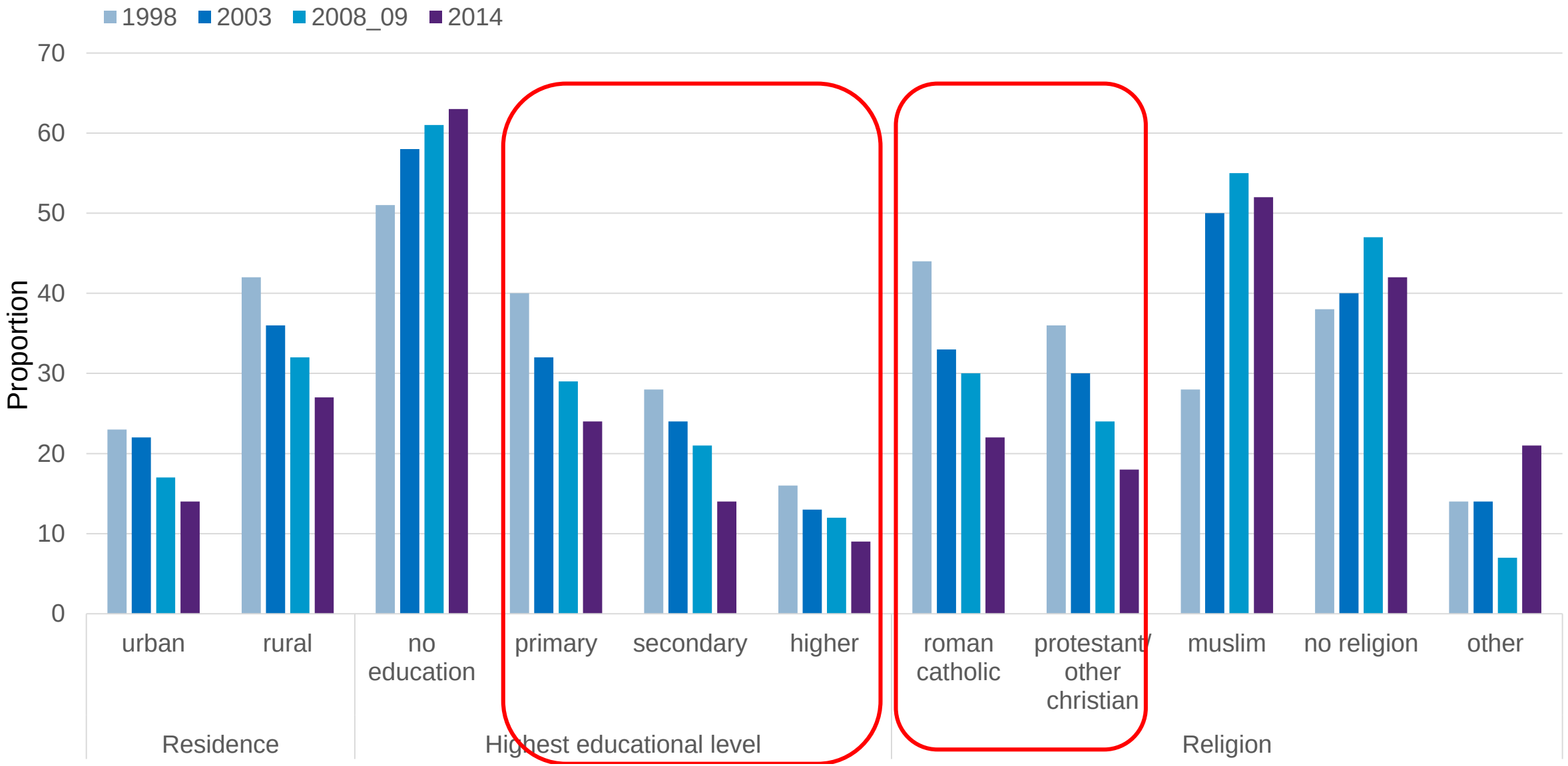
Ethnicity	Prevalence
Samburu	86
Boran	100
Gabbra	99
Kuria	86
Mbere	71
Rendille	95

Variation in prevalence by ethnicity and age cohorts

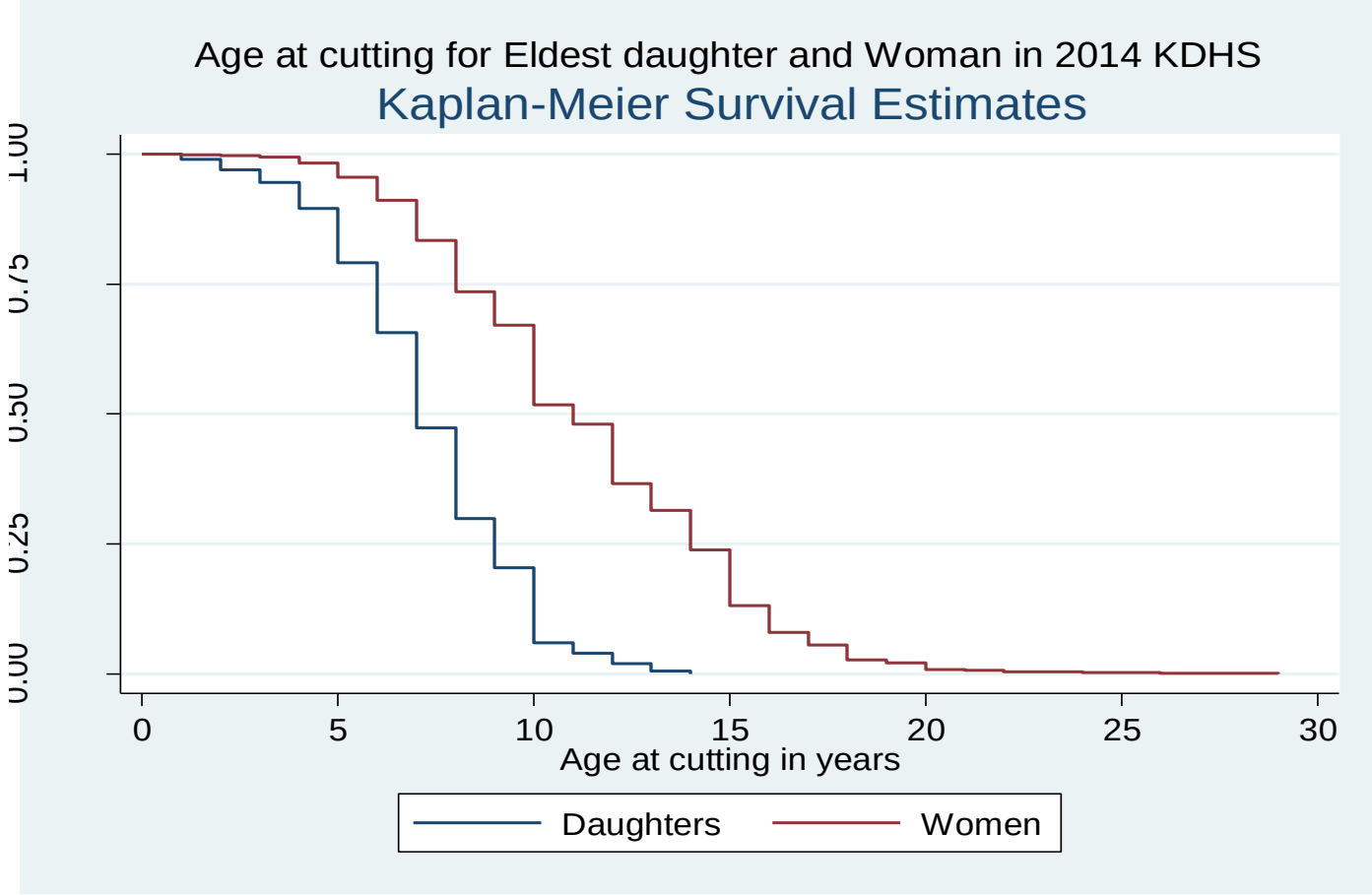


Source: Shell-Duncan et al, 2017

Do socio-demographic characteristics tell us something?



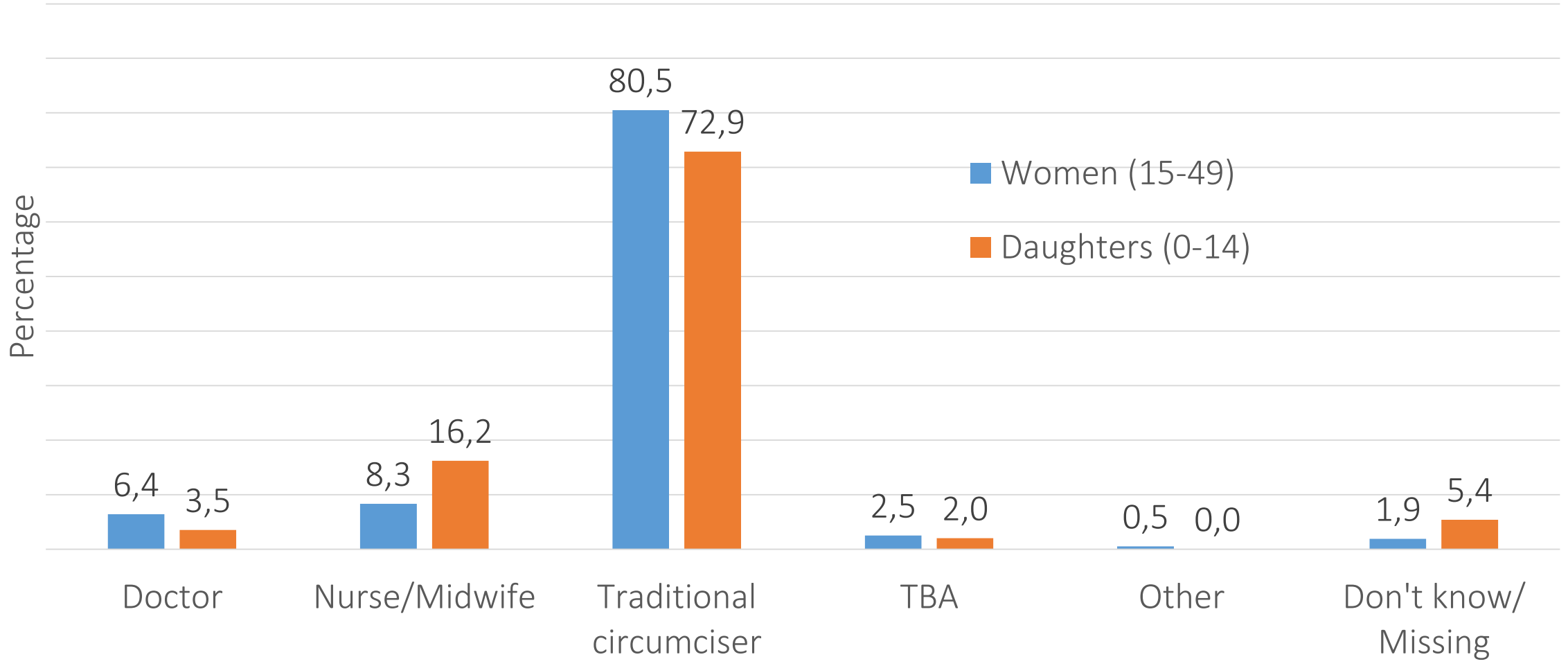
Age of cutting among girls is decreasing



Mean age at cutting for

- Women: 11.3 years
- Daughters: 7.8 years

FGM among mothers compared to daughters, KDHS, 2014



Findings: FGM is undergoing Significant Shifts

Type

- Shift to lesser severe cutting (from III, I to I/IV) across the communities

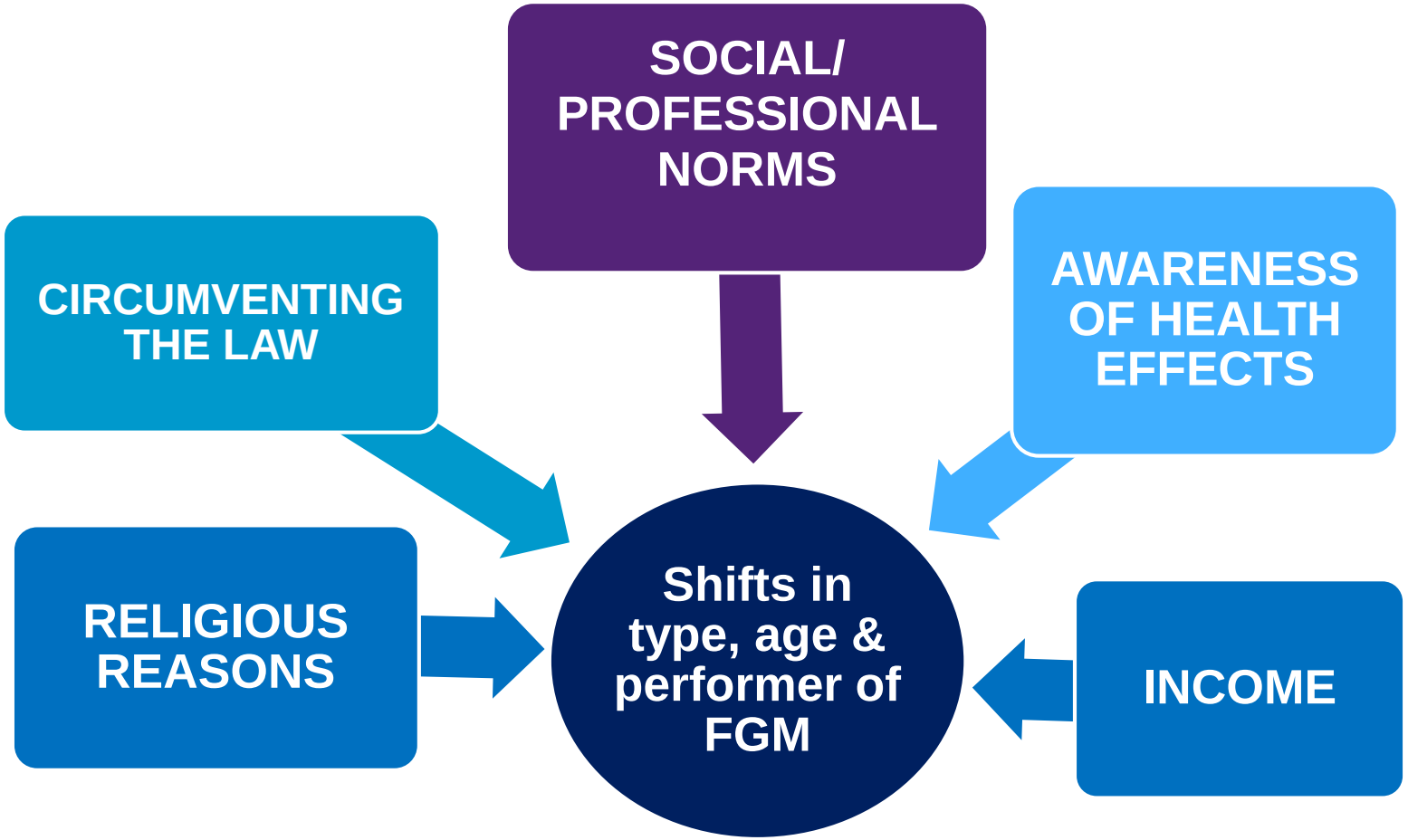
Age

- Shift to younger age (except among Kuria)

Performer

- Shift to medicalization (Except among Kuria)

Key findings: Drivers for the Shifts



Findings: Why communities choose providers to perform FGM?

“Nurse does the cutting, because one can encounter a big problem and she will address. She will stitch the girl if there is a problem like bleeding, and she gives medicine”
Mothers to cut girls, FGD, Eastleigh, Kenya

“The difference is that back in old days, girls were cut having reached a certain age, and was a little mature but these days because it is being done secretly the girl is being taken when she is still very young and doesn’t know what is happening”
Married men, FGD, Kisii, Kenya

Findings: Why Do health care providers perform FGM?

“For us it’s more of like I said earlier; doing a less severe form of FGM/C. We mainly focused on providing counselling and educating the mothers who were coming to our facility on the effects of severe forms of FGM/C. If we failed to convince them to abandon FGM/C, we would decide to perform a less severe form of FGM/C.”
Clinical officer, KII, Eastleigh

“When it is done by medics under medication, the probability of having severe complications is very minimal. If there are complications, the probability of solving them is very high so there will be a possibility of less complications.”
Clinical officer, KII, Eastleigh

Facilitators to FGM abandonment

- National FGM Data from KDHS
- Hot spots for FGM identified including medicalization
- Favourable legislative environment
- Vibrant Government-led anti-FGM board, funders, NGOs and researchers
- Availability of tools for FGM-prevention and intervention-WHO, MOH
- Favourable social-economic determinants-shifting of norms

Barriers to FGM abandonment

- Data not micro-analyzed
- Shifts in FGM including medicalization transcending socioeconomic status
- Some critical stakeholders lagging behind
- Lack of integration of FGM in critical sectors eg health
- Political double speak
- Change resistance
- Poverty and remoteness
- Unrest and civil unrest

Policy / Program Implications of These Findings

Differential decline in prevalence of FGM calls for community-specific interventions.

Shifts in FGM across communities highlighting the need for community-specific interventions to address norms underpinning the changes

Medicalisation of FGM creates implicit approval of the practice sustaining it, a need to target communities and health care providers

Medicalization appear to normalizes/modernizes FGM a call for more research/scale up appropriate interventions

FGM modules captures FGM and its related changes but there need for re-analyses of DHS/MICS data for accuracy, while supplementary health sector generated data is urgently required.

Call for Action

- Strengthen health system to prevent and respond to FGM including medicalization.
- Regular and structured mainstreaming of FGM in HCPs curricula and trainings.
- Partnerships between HCPs, and communities to promote understanding norms underpinning FGM including Medicalisation
- FGM intervention programs need to take advantage of debates over these shifts.
- Strengthening & establishment of health system-related FGM monitoring surveillance system to curb medicalization

Summary

DHS & MICS will continue to be an important source of FGM information but health sector-generated data is required to identify some changes in the practice and help respond to barriers in abandonment within the high prevalent settings.

https://www.popcouncil.org/uploads/pdfs/2017RH_FGMC-ModelingMappingKenyaDHS.pdf.