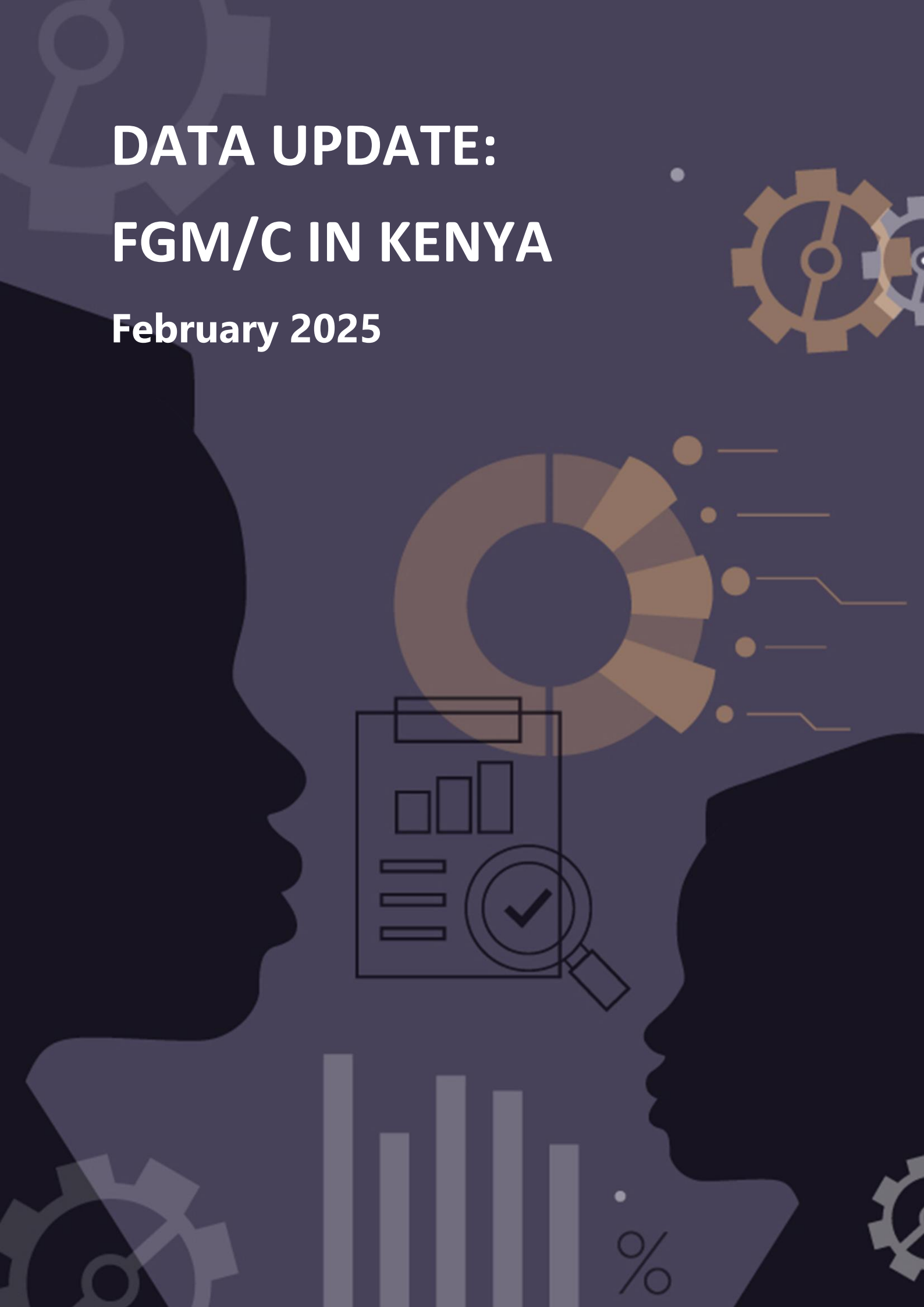
DATA UPDATE: FGM/C IN KENYA

February 2025



About Orchid Project

Orchid Project is a UK- and Kenya-based non-governmental organisation (*NGO*) catalysing the global movement to end female genital mutilation/cutting (*FGM/C*). Its strategy for 2023 to 2028 focuses on three objectives:

1. to undertake research, generate evidence and curate knowledge to better equip those working to end FGM/C;
2. to facilitate capacity-strengthening of partners, through learning and knowledge-sharing, to improve programme designs and impacts for the movement to end FGM/C; and
3. to steer global and regional policies, actions and funding towards ending FGM/C.

Orchid Project's aim to expedite the building of a knowledge base for researchers and activists is being fulfilled in the **FGM/C Research Initiative**.

A Note on Data

Statistics on the prevalence of FGM/C are compiled regularly through large-scale household surveys in developing countries, predominantly the **Demographic and Health Survey (*DHS*)** and the **Multiple Indicator Cluster Survey (*MICS*)**. For Kenya, the main DHS surveys are 1998, 2003, 2008–2009, 2014 and 2022.

All cited texts in this Data Update were accessed between 24 November 2024 and 31 January 2025, unless otherwise noted.

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ORCHID PROJECT

WORKING TOGETHER TO END
FEMALE GENITAL CUTTING

Summary

The national prevalence of female genital mutilation/cutting (FGM/C) in Kenya reduced from 37.6% of women aged 15–49 in 1998[1] to 14.8% in 2022.[2] Orchid Project estimates that prevalence will drop to approximately 10% by 2030.

This progress has been widely celebrated.

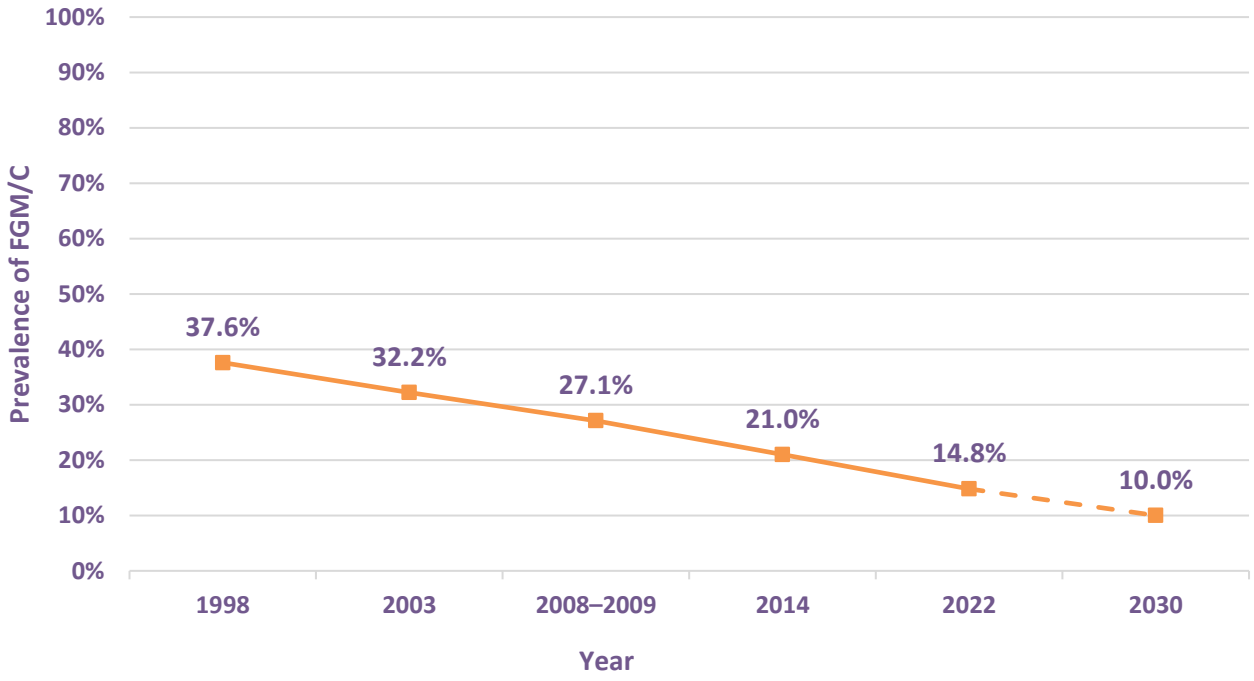

Figure 1: Prevalence of FGM/C among Kenyan women aged 15–49 (1998, 2003, 2008–2009, 2014 and 2022, and projected to 2030)[3]

This progress, however significant, is not equally distributed across the country. Ethnicity and social identity are primary drivers of FGM/C in Kenya, and this has created geographical hotspots where prevalence is well above the national average.

In the DHS 2022, prevalence in the following ethnic groups is reported to be between 57% and 87%: Somali (86.9%), Kisii (70.3%), Maasai (56.7%) and Samburu (75.9%).[4]

There is also a growing trend toward medicalised FGM/C, concerns about cross-border travel for FGM/C, and unequal reductions in different types of cutting. For example, the prevalence of FGM/C in which some flesh is cut has reduced more noticeably than the prevalence of the most severe type (infibulation).[5]

FGM/C is illegal in Kenya, and there is significant political energy behind the eradication of the practice.

FGM/C is addressed in four key pieces of legislation: the Children Act 2022,[6] the Protection Against Domestic Violence Act (2015),[7] the Penal Code (revised 2014),[8] and the Prohibition of Female Genital Mutilation Act (2011).[9]

The following Kenyan policies address FGM/C: the *National Policy for the Eradication of Female Genital Mutilation* (2019),[10] the *National Adolescent Sexual Reproductive Health Policy (2022–2032)*[11] and the *National School Health Policy* (2018).[12]

In support of these legal and policy frameworks, an anti-FGM board[13] has been established and the President has made public declarations in support of abandonment and accelerated progress.[14]

Update on FGM/C Trends

The national prevalence of FGM/C has dropped from 37.6% of women aged 15–49 in 1998[15] to 14.8% in 2022.[16]

Geographic Hotspots

Although the prevalence of FGM/C is dropping in Kenya, there are geographical hotspots where prevalence is well above the national figure (see Figure 2 below).

In the DHS 2022, prevalence in the following ethnic groups was reported to be between 57% and 87%: Somali (86.9%), Kisii (70.3%), Maasai (56.7%) and Samburu (75.9%).[17] The sample sizes for some ethnic groups were small, but considering the prevalence in each ethnic group is critical to addressing the unique needs of different communities and to prioritising resources.

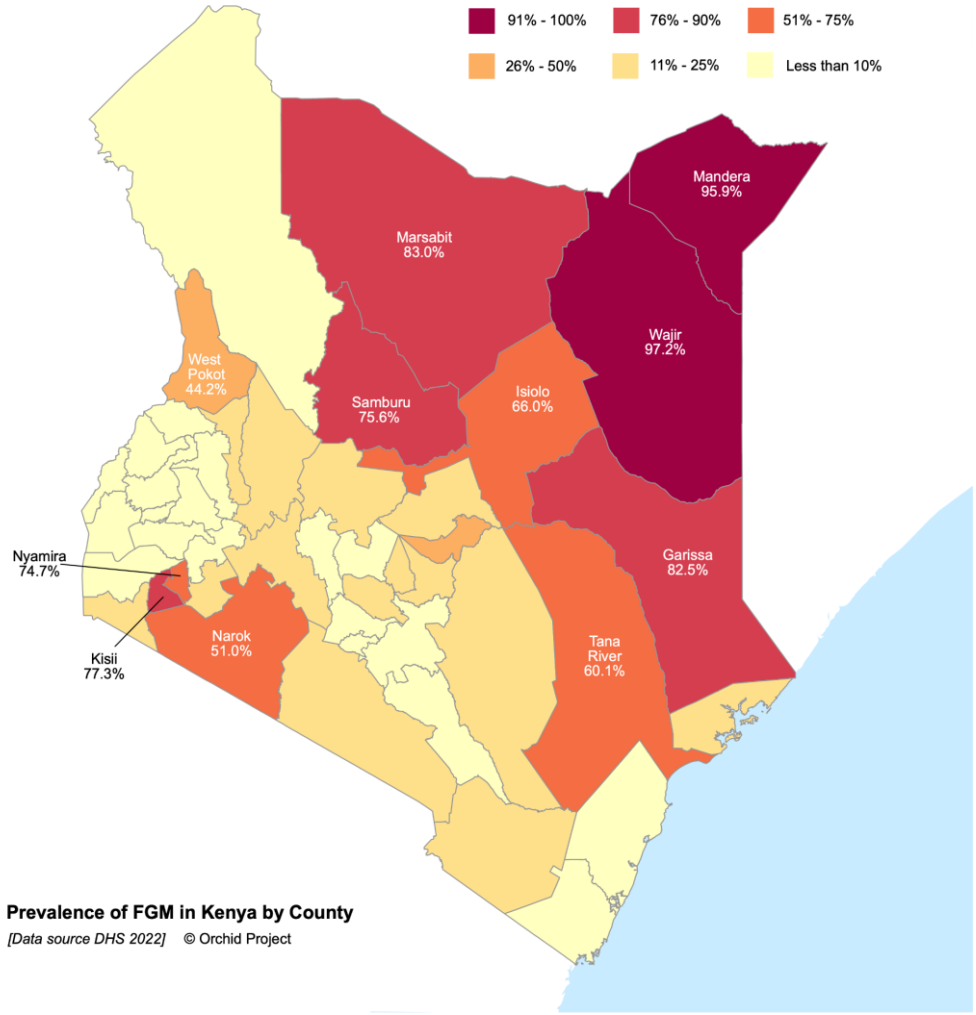

Figure 2: Prevalence of FGM/C in each Kenyan county[18]

According to the DHS 2022, the counties with the highest prevalence are Wajir (97.2%), Mandera (95.9%), Marsabit (83.0%), Garissa (82.5%), Kisii (77.3%), Samburu (75.6%), Nyamira (74.7%), Isiolo (66.0%) and Tana River (60.1%).[19]

Figure 3 below shows the change in prevalence over time, between 1998 and 2022. Reductions in prevalence can be seen particularly in the western parts of the country, but there are minimal changes in the eastern parts, especially the north-east.

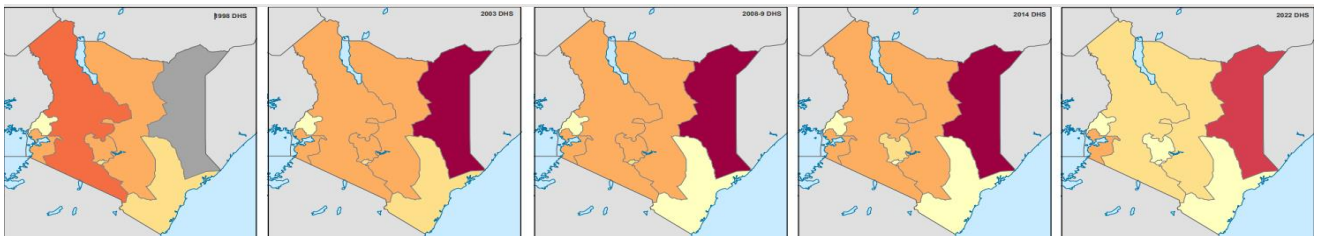

Figure 3: Map showing changes in FGM/C prevalence in Kenyan counties over time (1998, 2003, 2008–2009, 2014, 2022)[20]

Medicalisation

In Kenya, 16.9% of women aged 15–49 and 15.9% of girls aged 10–14 are reportedly cut by health professionals.[21] That places Kenya in the top five countries for cases of medicalised FGM/C (Egypt – 38%, Sudan – 67%, Guinea – 15%, and Nigeria – 13%).[22]

The prevalence of medicalised FGM/C among women aged 15–49 has dropped from 19.7% in 2008/2009,[23] which has been attributed to awareness-raising campaigns among health professionals.[24]

Medicalisation is linked to less severe forms of cutting and to lower ages of cutting. It is also more common among specific ethnic groups in Kenya, including the Somali.[25]

A study by Kimani *et al.* among the Abagusii and Somali in 2020 found that urban families tended to practise less severe forms of cutting and were more likely to pursue medicalised FGM/C.[26]

Kimani *et al.* also found that some health professionals who conduct FGM/C refer to it as 'genital modification', to categorise it as a form of plastic surgery. The authors of the study argue that efforts to hide the practice are increasing.[27]

Cross-Border FGM/C

A baseline study conducted by UNICEF in 2017 found that communities along the Uganda, Ethiopia, Somalia and Tanzania borders may be engaged in cross-border FGM/C, particularly members of the Pokot, Rendille, Somali and Maasai ethnic groups, to prepare girls for early marriages.[28]

Girls are most often brought from or taken to countries surrounding Kenya to undergo FGM/C, especially Tanzania. In some cases, traditional cutters are taken from Kenya to surrounding countries to perform FGM/C there.[29]

Certain studies demonstrate that some families travel out of Kenya to avoid prosecution as a result of the stringent enforcement of the law. In other cases, girls are brought to Kenya to have FGM/C conducted by medical professionals who are deemed to have more experience with cutting.[30]

Factors that contribute to cross-border FGM/C include:

- shared traditions, especially child/early marriage;
- fear of arrest in native country and feeling that there is limited prosecution in neighbouring countries;
- lack of proximity to traditional cutters in native country;
- quality and affordability of FGM/C services in a neighbouring country; and
- the absence of strong regional monitoring mechanisms for reporting.[31]

Unequal Reductions in Types of Cutting

In 2014, 1.6% of women aged 15–49 who had undergone FGM/C reported having been cut without any flesh removed, 87.2% had flesh removed, 9.3% reported being 'sewn closed' (infibulated) and 1.9% did not know what kind of cut they experienced.[32]

In 2022, the proportion of women who had undergone FGM/C but did not have flesh removed increased dramatically to 11.9%. The proportion who experienced having flesh removed decreased to 70.1%; the proportion who reported being 'sewn closed' increased to 11.6%; and the proportion who did not know what kind of cut they experienced increased to 6.5%.[33]

When taking the actual number of women and girls impacted by FGM/C into account, however, it is clear that some of the increase in the percentage of women reporting being 'sewn closed' is a reflection of the sharper drop in the number of all women undergoing any form of FGM/C (see Figure 4).

Not all ethnic groups in Kenya practise Type 3 FGM/C (infibulation, or being 'sewn closed'); approximately one-third of those who practise this type of cutting are Somali.

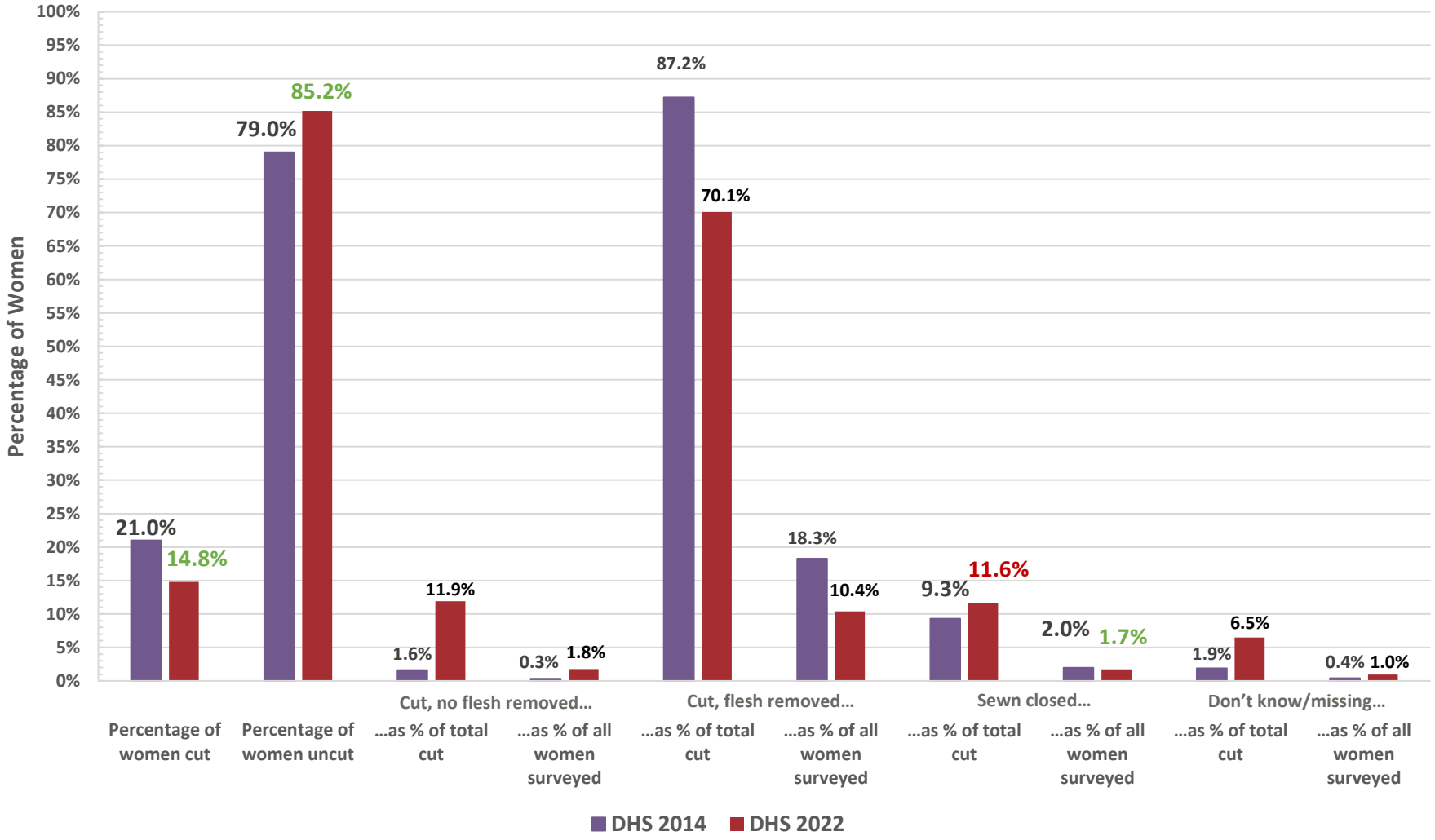

Figure 4: Types of FGM/C undergone by Kenyan women aged 15–49, 2014 and 2022[34]

Context

In 2019, during the International Conference on Population and Development (also known as the Nairobi Summit or the ICPD +25), President Kenyatta committed to ending FGM/C by 2022 and to addressing FGM/C in government instruments.[35]

Following the declaration that FGM/C should end in Kenya by the year 2022, a multi-agency technical committee was formed with representatives drawn from ten government ministries and state offices considered pivotal in ending FGM/C, namely the:

- Ministry of Public Service and Gender;
- Ministry of Interior and Coordination of National Government;
- Ministry of Health;
- Ministry of Education, Science and Technology;
- Ministry of East African Community and Regional Development;
- Ministry of Labour and Social Protection;
- Ministry of ICT, Innovation and Youth Affairs;
- Office of the Director of Public Prosecution;
- State Law Office/Department of Justice; and
- National Treasury.

Together with the UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation, a costed action plan was developed to work toward the goal of FGM/C abandonment in Kenya.[36]

A multi-agency technical committee operates at a national level and has county-level anti-FGM steering commitees that are co-chaired by national gender officers and county commissioners.[37]

President William Ruto has continued to espouse abandoning FGM/C through political statements, support for FGM/C programmes, increased budgetary allocation to the Anti-FGM Board and policy directives through the Ministry of Public Service and Gender.

The Anti-FGM Board operates under a Strategic Plan for 2023–2027.[38]

Despite the robust Kenyan politico-legal environment, the system was tested in 2017 when a petition was filed against the FGM/C Act by a medical professional, who claimed that it was unconstitutional. However, in 2021, the High Court in Nairobi upheld and validated the law as constitutional.[39]

One of the presiding judges, Justice Achode, said,

The Constitution grants the freedom for one to exercise their culture. However, that freedom has to be carried out in line with other constitutional provisions. From the law, we observe that culture entails various modes of expression, and therefore what is limited is any expression that will cause harm to a person or by a person to another person. FGM/C falls into the latter category.[40]

Research

Locally-led initiatives create change: A study by Mwendwa *et al.* in 2020[41] found that locally-led initiatives create substantial changes in the cultural norms around FGM/C and the number of families who continue with the practice. Participants reported that the following factors were most important to bringing about change in Meru county, Kenya: (1) supporting alternative rites of practice; (2) encouraging fathers to be more involved in raising their daughters; (3) discussing FGM/C within the education curriculum and in public fora; (4) strengthening community policing; and (5) setting up community centers for young people.

Reassessing social and cultural norms: A study conducted by Matanda *et al.* in 2018[42] in Narok and Kisii counties found that social and cultural norms related to FGM/C are being reconsidered. In relation to marriageability, FGM/C has previously been seen as a prerequisite for marriage, but, within this study, the authors found that men are developing a preference for uncut women to improve sexual satisfaction within marriage. A health-consequences narrative has increased people's understandings of the harmful effects of FGM/C, and, although abandonment has not yet been reached, the study found evidence that social and cultural norms are being reassessed.

Missed opportunities in healthcare: A study conducted by Kimani *et al.* in 2022[43] assessed the quality of healthcare services related to FGM/C that are provided to women in West Pokot county. Although a significant percentage of respondents were cut between the ages of 11 and 15 years (76%), only 14.8% of healthcare workers identified FGM/C and its related complications (11.5%) in consultations. FGM/C-prevention opportunities are being missed, as only 4.9% receive information, education and communication materials. 16% of healthcare facilities/workers explain the negative consequences of FGM/C to patients. Within antenatal care, postnatal care and family-planning consultations, no information on FGM/C or its complications is provided.

Barriers to healthcare: A qualitative study conducted by Kimani *et al.* in 2020[44] explored the barriers for Kenyan Somali women to seeking healthcare for issues related to FGM/C. It found structural barriers such as a high cost of care; large distances to healthcare facilities; and concerns about the quality of care, particularly the healthcare workers' abilities to provide culturally-sensitive care for FGM/C. There are also cultural barriers, such as discussing issues related to sexual health with male healthcare workers and fears of legal sanctions for bringing up issues related to FGM/C (in the context of the Kenyan anti-FGM/C law).

The role of informal education in FGM/C abandonment: A study conducted by Yam in 2021[45] utilised in-depth interviews to understand how Kenyan women learn about FGM/C through informal education in the form of social interactions with three primary groups of people: family members, role models in the community and women from non-practising communities. Social interactions with these three groups support women to navigate redefining social and cultural norms – what it means to be a 'good woman', a 'good wife' and 'part of a particular community' in the absence of FGM/C. Women who are only exposed to formal mechanisms of education, in school or through anti-FGM/C campaigns, and do not have opportunities to engage in social interactions with these groups are unable to renegotiate the social norms and, therefore, they undergo FGM/C.

The roles of community-driven alternative rites of passage and open dialogue on FGM/C: A study conducted by Kimani *et al.* in 2023 found that utilising community-driven alternative rites of passage (designed and implemented by communities themselves) led to a shift in the perception that FGM/C was a necessary part of Samburu and Maasai culture. In addition to community-driven alternative rites of passage, community dialogues, the radio and community performances were used to shift the dominant social norms surrounding the practice. The study found a reduction in prevalence among girls aged 0–14 years, increased agency in girls to influence decision-making regarding FGM/C, and a more positive view of uncut girls within the community.[46]

Recommendations

Programming, political will and continued advocacy appear to have played parts in reducing the overall prevalence of FGM/C in Kenya, but concerns remain about the incidence of medicalised FGM/C, changes in the types of cutting performed and cross-border travel to perform or undergo FGM/C.

While there has been progress made in reducing the types of cutting that remove flesh, the most severe form of FGM/C ('sewn closed'/infibulation) and the least severe (nicking/cutting without taking flesh) are not reducing at the same speed.

There is evidence to suggest that the politico-legal environment in the country has driven Kenyans towards medicalised FGM/C, which is characterised by less severe types of cutting and a changing of the language to avoid referring to cutting as, for example, 'FGM/C' or 'circumcision'. Policy interventions are sometimes associated with under-reporting of FGM/C due to fears of prosecution. This so-called 'social desirability bias' affects the reliability of data on FGM/C.

To make progress toward complete abandonment in Kenya, Orchid Project calls for the following:

- to reduce the prevalence in hotspots, programming and advocacy that adapts and responds to the specific social and religious drivers in different people groups;
- cross-border coordination mechanisms to reduce the practice across porous borders;
- further work with healthcare professionals to deter medicalised cutting; and
- collection of nuanced data that provides insights into regional and ethnic differences, to direct programming where it is most needed.

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