2019

Using Demographic and Health Surveys in the campaign to end FGM/C: A Kenyan example

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INTRODUCTION

To design effective interventions to end FGM/C, we need to map where FGM/C is practised and what factors influence it. Data from the Demographic and Health Surveys (DHS), nationally representative surveys conducted in low- and middle-income countries every five years, give us the opportunity to explore how FGM/C is influenced by both individual and community-level factors. Where FGM/C prevalence is not uniform, various research and analysis techniques can be used to improve estimates and draw further information from DHS data.

In this brief, we share insights from two studies carried out in Kenya using DHS data collected in 1998, 2003, 2008 and 2014. The first study explored when, where and how FGM/C has been carried out, and trends in changes in the practice. The second examined geographic patterns for the burden of FGM/C and related risk factors among girls aged 0-14 years.

METHODS

In the first study, descriptive statistics were used to explore trends over time in FGM/C prevalence, and factors related to FGM/C. The second study used advanced Bayesian geo-additive modelling techniques to better understand the burden of FGM/C among girls aged 0-14 years and to enhance knowledge of the geographic and socio-economic distribution of this practice over time.
FINDINGS
What did we learn?

Using all four rounds of data, the descriptive analysis showed a downward trend in national prevalence of FGM/C among 15- to 49-year-old women from 38 percent in 1998 to 21 percent in 2014. Prevalence across 5-year age cohorts showed a steady, long-term decline in rates of FGM/C that began in the early 1980’s. However, the declines did not occur evenly among women from all ethnic groups with rates remaining very high among ethnic Somali women. Rates of FGM/C were high in older cohorts of Maasai and Kisii women but declined among younger cohorts of women. Other changes over time include a trend toward younger age at cutting and increased medicalisation (cutting performed by a health care professional as opposed to a traditional practitioner).

Bayesian geo-additive modelling using data for girls aged 0-14 years showed that whereas there is a national-level decline, the rates of decline have not been uniform across regions (Figure 1). The likelihood of FGM/C among girls was significantly higher if their mothers had no education, were Muslim, were from the Kisii or Somali ethnic communities, and lived in poorer households and in rural communities.

What next?

- **Target interventions:** By understanding where FGM/C persists despite national level declines, DHS data can highlight potential sites for more intensive research and tailored interventions.
- **Collect data over time:** In communities where FGM/C persists, it would be helpful to conduct more in-depth research. This could include monitoring these counties to better understand prevalence, as well as collecting qualitative data to understand why FGM/C persists, sometimes in spite of targeted interventions.
- **More research using the DHS in other settings:** Taking advantage of multiple rounds of the DHS provided both trend analysis at the national level, as well as a more nuanced analysis of patterns within sub-groups. Bayesian geo-additive modelling using data for girls aged 0-14 years can help differentiate individual and community factors in FGM/C abandonment. The exploration of FGM/C as a practice potentially maintained by both individual factors and collective social norms can be examined empirically with the increasingly rich body of survey data now available in other settings.

FULL REPORTS AVAILABLE:


Suggested citation:


Figure 1. Predicted provincial FGM/C prevalence in Kenya 1998 to 2014 derived from spatial-temporal regression model