Integration of FGM/C within healthcare services in the Horn of Africa

A summary of evidence and learning

Background

The Global Research Agenda to Strengthen Evidence Generation and Utilisation to Accelerate the Elimination of FGM was produced by UNFPA, UNICEF, WHO, and Population Council - Kenya in 2022 (1) building on a systematic review of evidence on interventions to reduce prevalence of FGM/C (2). The research agenda and review of evidence point to where there has been progress in developed evidence on strategies to address FGM/C and where gaps still remain.

The *Knowledge Sharing Dialogues on FGM/C: Evidence-based Strategies for Success* approach intends to support closing of gaps in research and practice through exploration of available evidence and insights from regional practitioners, activists, academics, and policymakers.

Orchid Project hosted a series of knowledge sharing dialogues between September 2024-March 2025 resulting in three knowledge products which were launched in April 2025. These products outline the key research gaps, strategies to address FGM/C that are having an impact, and recommendations to accelerate change in the region.

Building on this initiative, a group of co-hosts, which include Belt of Somali Women, Somaliland Family Health Association (SOFHA), Silver Lining Kenya, and Orchid Project, are continuing the knowledge sharing dialogue process focusing on emerging and relevant issues for practitioners, researchers, and policymakers working to end FGM/C in the Horn of Africa.

The theme of the October 2025 dialogue is Integration of FGM/C prevention and care within healthcare services in the Horn of Africa.

About Belt of Somali Women

Belt of Somali Women is a Somali-led, membership organization and platform that bridges the link between Somali diaspora and the Horn of Africa. Belt of Somali Women strives to prevent and eliminate Female Genital Mutilation/ Cutting (FGM/C) within Somali community in the Horn of Africa. Belt of Somali Women organizes webinars and in-person events, serving as a platform for Somali communities to connect, share expertise, and drive change from within.

About Silver Lining Kenya

Silver Lining Kenya is a community-based organization dedicated to advancing sustainable development and fostering social transformation on issues related to maternal health, FGM/C, gender-based violence (GBV), and sexual and reproductive health and rights (SRHR). Silver Lining Kenya works with pastoralist communities in North-Eastern Kenya.

About Somaliland Family Health Association (SOFHA)

SOFHA is a women-led, mostly female organization working in SRHR since 2009 and an accredited member association of the International Planned Parenthood Federation (IPPF). SOFHA operate two 24-hour clinics and a mobile team reaching eight rural villages, and provide comprehensive SRHR clinical services, GBV response, fertility support, and nutrition care.

About Orchid Project

Orchid Project is a UK- and Kenya-based non-governmental organisation (*NGO*) aiming to catalyse the global movement to end FGM/C Orchid Project's research department aim to fill gaps in knowledge through the curating and conducting research, and promoting evidence uptake through the **FGM/C Research Initiative**.

All cited texts in this short report were accessed between September and October 2025, unless otherwise noted.

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Knowledge sharing dialogue – meeting summary

A knowledge sharing dialogue was hosted on October 9, 2025, bringing together over 30 practitioners, academics, researchers, and activists from across the Horn of Africa and the diaspora to share knowledge, experience, and evidence on what works to integrate FGM/C within healthcare services in the region. Prior to the dialogue, a light-touch review of published evidence was conducted to support learning and evidence uptake.

More detail on the dialogue presentations, key point in the discussion, and next steps is available in the meeting summary

A summary of published evidence is available here.

What works when integrating FGM/C into healthcare services in the Horn of Africa

Healthcare needs of Somali FGM/C survivors

Many Somali survivors face lifelong complications of FGM/C, such as chronic infections, infertility, or chronic pain (1). As the type of FGM/C changes among Somali populations, the needs of survivors also changes. Older FGM/C survivors have different needs than those from younger generations (1). Somali FGM/C survivors face increased risks of complications during labour and delivery as a result of Type 3 FGM/C (infibulation). This can lead to increased risk of emergency caesarean section, non-progressing/ induced labour, neonatal morbidity and mortality (2).

Barriers in accessing care

Somali survivors face barriers in accessing care related to poor health infrastructure, long distances to health facilities, and difficulty paying for services where payment is required (3). This can lead to additional complications in childbirth, especially when women give birth at home. Somali survivors who live in rural areas without access to healthcare in close proximity to their homes face increased risk of fistula, obstructed labour, and neonatal mortality (1).

Many survivors also experience cultural and psychological barriers to accessing care, such as Somali women receiving care for FGM/C-related complications from a male doctor (1). Many women who have undergone Type 3 FGM/C report fear about childbirth, sexual health, and reproductive health, but also experience discomfort raising these issues with health providers (4). This can result in birth complications when decisions regarding de-infibulation are not made in advance or through trust-based conversations with patients (4). Survivors require confidential care and survivor-friendly counselling (1).

Punitive approaches such as safeguarding policies and responsibility to report cases of FGM/C where it is illegal, can serve as barriers for survivors to access care (5). Fear of consequences in presenting at a health facility with FGM/C can lead to delayed care seeking and negative health outcomes as a result. Non-punitive approaches create the opportunity for trust and open discussion about complications, fears, healthcare needs, and prevention for the next generation (1). Punitive approaches have a direct negative effect on health outcomes for survivors, contributing to reluctance to access health services, delayed presentation in health facilities, and higher risk of poor health outcomes as a result(5).

Facilitators for Somali survivors in accessing healthcare

Positive interactions with healthcare providers who provide services in culturally-sensitive ways, and communicate in a non-judgmental style with patients, increasing the comfort of women accessing services and creates openness to talk about FGM/C and the health consequences they experience (6). This is particularly important for OB-GYNs and midwives to support women who have undergone FGM/C through labour and delivery, and where necessary de-infibulation.

Community health workers (CHWs) are critical in identifying women who need care and support as survivors, as well as in engaging families in conversations about prevention (1). CHWs are well known by communities, build trust with families, and are well placed to provide care over the long term. In the Horn of Africa, most healthcare workers are on their own journey with abandonment, shifting their personal views about the practice at the same time as working to offer prevention and care with their patients (1). Training should be prioritised for female healthcare workers, although it is important for male healthcare workers to also understand FGM/C and how to address complications (1). Equipping community health workers and rural clinics is critical for sustained outreach (1).

Integration of FGM/C must address both prevention and care of survivors. Building prevention into maternal health care, sexual and reproductive health, and into infant and child health create opportunities to integrate prevention messages. The person-centred communication (PCC) approach has been found to be effective in the prevention of FGM/C within healthcare services (7). When the PCC approach was used within antenatal care, patients were more likely to change their support for FGM/C and less likely to have their daughters cut (7).

Shared resources and opportunities for collaboration

The Girl Generation, Africa-Led Movement to End FGM (TGG-ALM) are working to integrate FGM/C into healthcare services in Kenya, Somaliland, Senegal, and Ethiopia. They have developed a curriculum for community-based health promoters which can be used by those who are working to integrate FGM/C into healthcare services and want to strengthen the community element. The curriculum for community health promotors is available here.

ActionAid Ethiopia are working on integration of FGM/C within healthcare services and are using a Ministry of Health manual to organise trainings for community health workers, healthcare providers at the facility level, midwives, and supervisors. This can be accessed here and is available for those who want to train CHWs in Ethiopia.

The Maternal and Newborn Safety Investigations (MNSI) produced a toolkit for conducting a health equity assessment and generating a health equity warning score. The toolkit is available here and provides guidance on how to identify risks of experiencing barriers to health equity. The tool helps to highlight inequalities and identify trends that can be addressed within the healthcare system.

Bristol University hosts a research group looking at what they refer to as Female Genital Modification (FGMo). The research group aims to provide platforms for affected communities to challenge stigmatising and harmful policies, to develop evidence to inform law and policy, and to improve healthcare services for families. The research group, a summary of publications, and ongoing projects can be found here.

References

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