Training course in adolescent sexual and reproductive health 2019

Harmful traditional practices prevention

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Question 1:

What are the long-term trends globally and regionally, in female genital mutilation and child marriage? What are the trends in your country? (Provide authoritative sources to back up your statements about your country).

Female genital mutilation (FGM)

Global long-term trends in FGM are:

- More than 200 million girls and women have been subjected to FGM[i].
- Globally, FGM has been declining over the last three decades. In the 30 countries with nationally representative prevalence data, approximately 1 in 3 girls aged 15 to 19 today have undergone FGM, as compared to 1 in 2 in the late-1980s[ii].

Regional long-term trends in FGM are:

- Growing migration has increased the number of girls and women living outside their country of origin who have undergone FGM, such as in European countries and the US[iii].
- The prevalence of FGM has varied widely among and within countries and regions during the past 30 years. The decline in FGM was steepest in East Africa (where prevalence fell from 71.4% in 1995 to 8% in 2016), followed by North Africa (from 58% in 1990 to 14% in 2015). In West Africa, prevalence fell from 73.6% in 1996 to 25.4% in 2017[iv].
- In the Middle East, FGM has gone up, rising by 1% in 1997, and by just under 16% in 2013[v].
- Trends are not consistent within regions, and there is much variation among countries. FGM has been declining slowly and steadily for 30 years in many countries, such as Ivory Coast, Nigeria, Ethiopia and Kenya, while in Chad and Sierra Leone, reductions are more recent[vi]. FGM has remained high and relatively stable in Mali and the Gambia for 30 years. There have been small declines in Guinea, Mali and Egypt, but the practice is still almost universal, with over 90% prevalence[vii].
- Rates of infibulation have risen in Mali (from 6 to 15%) and in Sierra Leone (from 6 to 8%) over the last 30 years. Symbolic nicking of the genitals is relatively rare but has become more common in some Western and Central African countries (Burkina Faso, Chad, Guinea and Mali)[viii], which may indicate a shift from more severe forms of FGM to less severe forms in some areas.
- In some countries, a growing proportion of FGM is performed by health care providers. For example, in Egypt, the percentage of girls who had FGM performed by a health worker was 55% in 1995 but increased to 77% in 2008. In Kenya, it increased from 34% to 41% in one decade[ix].

FGM is not practiced in Mozambique.

Child Marriage

Global long-term trends in child marriage:

- Globally, the proportion of women who were married before the age of 18 has declined by 15% in the past decade, but progress has been uneven across regions[x].
- The global rate of reduction in child marriage has been 1.9 percentage points per year over the past ten years, compared to 0.7 percentage points per year over the past 25 years, showing accelerated progress[xi].

Regional long-term trends in child marriage:

- Levels of child marriage are highest in sub-Saharan Africa, where nearly 4 in 10 young women were married before age 18, followed by South Asia, where it is 3 in 10 women. Lower levels of child marriage are found in Latin America and Caribbean (25%), the Middle East and North Africa (18%), and Eastern Europe and Central Asia (11%)[xii].
- The greatest decline in child marriage has been in South Asia, where a girl's risk of marrying before age 18 dropped by more than a third, from nearly 50% to 30%[xiii].
- In North Africa and the Middle East, the percentage of girls married before the age of 18 fell by about half in the last decade[xiv].
- In South Asia, girls' risk of being married before 18 has reduced by over a third in the last decade.
- In Latin America and sub-Saharan Africa, change has been slower than in North Africa, the Middle East, and South Asia[xv].

In Mozambique:

- In Mozambique, child marriage rates have remained steady for the past four decades. Almost 50% of girls are married before the age of 18[xvi].

Question 2:

In the flyer titled: Turning commitments into solid actions (UNFPA-UNICEF Global Programme to End Child Marriage, 2019), identify one common element in the brief case studies of Nepal, Yemen and Zambia.

One common element used to combat child marriage in Nepal, Yemen and Zambia was the implementation of school-based interventions. In Zambia and Nepal, parent-teacher associations and school management committees were mobilized and trained to support girls' education. In Yemen, actions were taken to reduce school-based violence against girls. In Zambia, teachers were trained in how to support girls to stay in school, and in Nepal, girls received school materials and uniforms. Zambia also invested in "second chance education" for girls to gain basic numeracy and literacy, and open learning centers for out-of-school girls.

Question 3.1:

Name three sectors which have key roles to play in ending child marriage and the specific contribution that could make.

Three sectors that have key roles to play in ending child marriage, and the contribution they could make are:

a) Food security and nutrition: Poverty and food insecurity are drivers of child marriage, since marrying girls young reduces the number of mouths to feed. Supporting families to have improved food security, whether through agriculture, livestock, training, livelihoods, market, social protection or other interventions, can help ensure that girls are not married in childhood. It can also facilitate girls' continuing in school.
b) Education: This sector should put in place measures that allow girls to stay in school, including the transition to and completion of secondary school. Interventions could include water and sanitation infrastructure for menstrual management; cash transfers; building parents' and leaders' awareness of the importance of school for girls; provision of school materials, fees, or uniforms; combatting GBV in schools; favorable educational laws and policies; and comprehensive sexuality education in schools that includes information on child rights and child marriage.
c) Democracy, human rights, and governance. This sector should ensure that laws are in place and enforced to prohibit child marriage. However, laws are not enough; leaders, parents, civil society in general, and youth need to be engaged and gain a greater understanding of human rights, child rights, gender equity, and the negative consequences of child marriage.

Question 3.2:

Identify the five actions that can contribute to multisectoral coordination at the subnational level, identified in the paper by Lo Forte et al (2019). Which one (or ones) of them do you believe are crucial and why.

At the subnational level, five actions that can contribute to multisectoral coordination to end child marriage are:

a) Establish coordination structures and mechanisms to direct and operationalize multisectoral action
b) Build awareness and capacity of leadership and staff at subnational levels
c) Use subnational evidence to contextualize and tailor interventions
d) Develop coordinated budgets and cost-sharing mechanisms
e) Integrate M&E systems

Of these, I believe the first three are crucial.

- Coordination structures are important because single-sector interventions have not been successful in reducing child marriage. Coordination is important at the district and community level, since this is where the implementation happens of national multisectoral policies and programs.
- Strengthened awareness and leadership at subnational levels is key, because these leaders and implementers need to understand their role and become advocates for the cause to keep the focus on this objective. Given competing agendas and limited resources, it is vital for subnational government staff and implementers to have sufficient training and support.

- Generating and using subnational data is crucial to understand the drivers of child marriage at local level, differences among age bands, sex, wealth data, religion, etc. This will help design and target appropriate interventions.

Question 4.1:

Identify three reasons why health workers perform female genital mutilation?

Three reasons why health workers perform FGM are:

a) "Harm reduction". Some health workers believe that carrying out FGM under hygienic conditions or with access to anesthesia reduces harm for girls. Some prefer to carry out the procedure rather than have it done by traditional circumcisers who have no medical training.
b) Cultural reasons. Some health workers believe in the benefits of FGM or subscribe to the cultural norms around FGM. They also face pressure from families and communities, and may see themselves as safeguarding cultural values and traditions.
c) Financial gain. Health workers often value the money and gifts they receive from the families, especially where their salaries are very low.

Question 4.2:

What are the elements of WHO's global strategy to stop health-care providers from performing female genital mutilation

The elements of WHO's Global Strategy to Stop Medicalization of FGM[xvii] are:

a) Mobilizing political will and funding
b) Strengthening the understanding and knowledge of health care providers
c) Creating supportive legislative and regulatory frameworks
d) Strengthening monitoring, evaluation and accountability.

Activities to carry this out include:

a) Operationalizing the global strategy with support to countries
b) Understanding motivations of health care providers in carrying out FGM (a review of existing literature was carried out by Doucet et al.[xviii] and countries/communities should conduct their own formative research)
c) Developing interventions targeting the health sector and health providers
d) Testing interventions through research.

[i] WHO recommendations on adolescent sexual and reproductive health and rights. Geneva: World Health Organization; 2018. License: CC BY-NC-SA 3.0 IGO.

[ii] UNICEF. Female genital mutilation, October 2019. https://data.unicef.org/topic/child-protection/female-genital-mutilation/

[iii] Eliminating Female genital mutilation: an interagency statement. OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO. World Health Organization 2008.

[iv] Ngianga-Bakwin Kandala, Martinsixtus C Ezejimofor, Olalekan A Uthman, Paul Komba. Secular trends in the prevalence of female genital mutilation/cutting among girls: a systematic analysis**.** *BMJ Global Health*, 2018; 3 (5): e000549 DOI: 10.1136/bmjgh-2017-000549

[v] Ibid.

[vi] Koski A et al. Thirty-year trends in the prevalence and severity of female genital mutilation: a comparison of 22 countries. BMJ Glob Health. 2017; 2(4): e000467. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5717946/

[vii] Ibid.

[viii] Ibid.

[ix] Doucet et al. Understanding the motivations of health-care providers in performing female genital mutilation: an integrative review of the literature. *Reproductive Health* (2017) 14:46.

[x] WHO recommendations on adolescent sexual and reproductive health and rights. Geneva: World Health Organization; 2018. License: CC BY-NC-SA 3.0 IGO.

[xi] UNICEF. New Global Estimates of Child Marriage. UNICEF. 2018. https://www.girlsnotbrides.org/wp-content/uploads/2018/03/CM_burden_release_webinar_15Mar18_final_.pdf

[xii] UNICEF. Child Marriage. October 2019. https://data.unicef.org/topic/child-protection/child-marriage/

[xiii] Ibid.

[xiv] Ibid.

[xv] Ibid.

[xvi] Turning Commitments into Solid Actions: UNFPA-UNICEF Global Programme to Accelerate Action to End Child Marriage. 2018 Annual Report

[xvii] Global strategy to stop health-care providers from performing female genital mutilation. World Health Organization. 2010

[xviii] Doucet et al. Understanding the motivations of health-care providers in performing female genital mutilation: an integrative review of the literature. *Reproductive Health* (2017) 14:46.