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).

Globally, the practice of female genital mutilation (FGM) has become less prevalent over the last three decades [1]. Approximately 1 in 3 girls aged 15-19 have experienced FGM in 2019, compared to 1 in 2 in the late-1980's [1]. However, not all countries are experiencing the same pace of decline [1]. Female genital mutilation is most common in 30 countries in Africa, and in a few countries in Asia and the Middle East [2]. In a select number of countries, FGM is very prevalent; for example, in Djibouti, Guinea, Mali, Somalia and Sudan the prevalence of FGM is over 75% in girls and women aged 15-49 years [2]. However, UNICEF reports fast declines in prevalence among girls aged 15-19 in Burkina Faso, Egypt, Liberia and Togo [1]. The practice of FGM is also found in pockets of Europe, Australia and North America due to immigrant and refugee movements from countries where FGM still occurs [1]. My country of origin is Canada. While there are no reliable statistics on the prevalence of FGM in Canada, evidence exists to suggest that FGM is practiced [3]. For example, among G8 countries, Canada has the highest proportion of foreign-born populations among the G8 countries [3]. In Toronto specifically, it is estimated that there are 70,000 immigrants and refugees from Somalia alone [3]. Considering that the practice of FGM in Somalia is almost universal with prevalence around 90%, it is likely that FGM is occurring in these Canadian communities [3].

Child marriage is another harmful traditional practice. Globally it has declined, with the proportion of young women married as children decreasing from 1 in 4 in 2008 to 1 in 5 in 2018 [4]. South Asia and Sub-Saharan Africa are the two regions with the highest number of child brides, making up 44% and 18% (respectively) of the global distribution of women first married before 18 years old [4]. Much progress has been made in South Asia where the risk of a girl under 18 experiencing child marriage has decreased from 50% to 30% over the last decade [5]. Unfortunately, this same progress is not seen in sub-Saharan Africa and rates of child marriage are declining much slower [5]. In Canada, there was no data collected on child marriage, and the government's policy is focused on child marriage in foreign countries to assist in meeting the United Nations 2030 sustainable development targets [4, 6].

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.

In brief case studies of Nepal, Yemen and Zambia, it is evident that all three countries use a similar approach to ending child marriage by targeting cultural and social norms [5]. Zambia employed dialogues with community members and traditional leaders the change gender norms and to mobilize communities [5]. In Yemen, interactive theatres were used to change norms and practices surrounding adolescent girls at the community level [5]. A Girl Summit was held in Nepal, in which policy dialogues engaged newly elected government officials in activities to end

child marriage [5]. Therefore, all three countries utilized dialogue at diverse leadership levels as a catalyst for change.

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 which have key roles to play in ending child marriage are: the school system, legal systems and parents and community members [7]. *The school system* can enhance the access of girls to quality education, providing them an incentive to stay in school or become employed as an alternative to marriage [7]. *The legal system* has an important role in encouraging supportive laws and policies which will contribute to addressing social norms and enable programming. Additionally, *the community members and parents* play a very significant role in ending child marriage as they can alter the attitudes of future generations [7].

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.

The subnational movement to end child marriage requires a multisectoral approach that can be facilitated by five actions: 1) establishing coordination structures and mechanisms to direct and operationalise multi-sectoral action, 2) building awareness and capacity of leadership and staff, 3) using subnational evidence to contextualise and tailor interventions, 4) developing coordinated budgets and cost-sharing mechanisms, and 5) integrating monitoring and evaluation systems [8].

I believe all actions are crucial, but greatly depend on the context in which they are being implemented [8]. This requires an analysis of current initiates by multiple stakeholders to implement initiatives with the highest potential [8]. An important initial action would be to use subnational evidence to contextualise and tailor interventions. For example, in a case study of Ethiopia, national drivers for malnutrition varied from local ones [8]. By collecting data at the community level, interventions might be tailored to community needs [8].

Question 4.1:

Identify three reasons why health workers perform female genital mutilation?

Three motivations of health care providers performing FGM were identified in a literature search. Firstly, it was found that providers performing FGM are often members of societies in which FGM is the cultural norm [9]. Secondly, some providers believe that there are benefits to FGM, including a belief that it would benefit a woman's marriage if completed after childbirth [9]. Thirdly, providers were also found to perform FGM as a method of harm reduction to

prevent or reduce the risks girls would experience undergoing procedures with a traditional circumciser; for example, by offering hygienic conditions and pain management [9]. By understanding the motivations of healthcare providers performing FGM, the medicalization of the procedure can be addressed through intervention at the health sector level [9].

Question 4.2:

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

The WHO's global strategy to stop healthcare providers from performing FGM involves several elements. The first action is to mobilize political will and funding to ensure sustained development and implementation of policies guidelines and laws [10]. Another action is to strengthen the understanding and knowledge of healthcare providers, to prevent the medicalization of FGM [10]. The WHO also recommends the creation of a supporting legislative and regulatory framework, which affirms the governing bodies commitment to ending the practice of FGM and supporting women's rights [10]. Finally, the WHO suggests that monitoring, evaluation and accountability should be strengthened to allow for a more efficient approach to ending the practice [10]

References

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