

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

Globally: FMG is a harmful practice effecting millions of women and girls across the world. Around 200 million women and girls globally are living with FGM and 3 million more undergo FGM every year.

Regionally: FGM, the global problem, is most prevalent in 30 countries in Africa and a few countries in Asia and the Middle East. In some countries, such as Djibouti, Guinea, Mali, Somalia and Sudan, the prevalence of FGM is over 75% among women and girls aged 15-49 years. However, estimates indicate that although FGM remains common in a number of settings, an adolescent girl today is about a third less likely to undergo FGM compared with 30 years ago.

Egypt: Female Genital Mutilation (FGM) has been performed in Egypt since pharaonic times. An FGM prevalence of 87.2% among all women aged 15-49 in a population of nearly 95 million suggests that Egypt has the greatest number of women and girls who have experienced FGM of any country in the world. The likelihood of a woman or girl experiencing FGM is influenced by both place of residence and wealth. 77.4% of women (aged 15-49) in urban areas have undergone FGM, compared to 92.6% in rural areas. Prevalence among girls aged 1-14 is 10.4% in urban areas, compared to 15.9% in rural areas, and there is a markedly higher prevalence among girls living in Upper Egypt than among girls living in Lower Egypt and the Urban Governorates. 94.4% of women (aged 15-49) in the lowest wealth quintile have undergone FGM, compared to 69.8% of women in the highest wealth quintile.¹ (See reference, please, in footnote)

Child Marriage

Globally: Each year, about 12 million girls are married before the age of 18 years. Worldwide, girls are approximately five times as likely as boys to be married before the age of 15 years. Globally, the proportion of women who are married as children had decreased by 15% in the past decade.

Regionally: In 25 high prevalence countries, approximately 36% of women age 18-22 years were married before the age of 18 years; however, in North Africa and the Middle East, the percentage of girls married by the age of 18 years has dropped by about half, and south Asia have reduced a girls risk of marrying before age 18 years

¹ *Country Profile: FGM in Egypt* (28 TOOMANY, April 2017). Available online at: [https://www.28toomany.org/static/media/uploads/Country%20Research%20and%20Resources/Egypt/egypt_country_profile_v2_\(november_2017\)_\(1\).pdf](https://www.28toomany.org/static/media/uploads/Country%20Research%20and%20Resources/Egypt/egypt_country_profile_v2_(november_2017)_(1).pdf).

by more than a third. Less change has been observed in Latin America and sub-Saharan Africa.

Egypt Trends: The Egyptian Child Law of 2008 sets the minimum age of marriage at 18 years for both females and males. Despite the legislation, child marriage is still being practiced in some regions of the country. According to the *Egypt Census of 2017*, child marriage remains an issue. In Egypt, nearly 1 in every 20 girls (14%) between age 15 to 17 and 1 in every 10 (11%) adolescent girls 15-19 years are either currently married or were married before, with large differentials between the rural and urban residence.² (See reference, please, in footnote)

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.

The Global Programme takes a holistic approach to turn commitments into tangible action, through five strategic areas, to end child marriage:

1. *Empowering adolescent girls* - empower adolescent girls at risk of child marriage, or already married, to express their views and exercise their choices.
2. *Communicating social behaviour change for influencing gender and social norms* - engage families, communities and leaders to protect girls from harmful practices.
3. *Strengthening prevention and protection services* - strengthen the availability, accessibility, quality and responsiveness of services for adolescent girls.
4. *Strengthening legislative and policy frameworks* - develop and implement national laws that protect girls from harmful practices.
5. *Strengthening data and evidence base* - generate and use robust data and evidence to inform programmes and policies relating to adolescent girls and harmful practices.

Yemen: Over 65,000 people, of whom 45,000 are adolescents, were reached with awareness raising activities on the harms of child marriage during the year 2018. In addition, nearly 6,000 community members participated in interactive theatres to change norms and practices in favour of adolescent girls. As a result, local council representatives, elders and community leaders from six districts signed a pledge to support advocacy efforts to end child marriage.

Nepal: In 2018, a Girl Summit was organized in Nepal, with various activities at local, provincial and federal level. Policy dialogues were held in 72 municipalities, engaging over 1,000 newly elected officials from local governments to sensitize them

² *Policy for Action: Ending Child Marriage* (Unicef.org, 2018). Available online at: <https://www.unicef.org/egypt/reports/policy-action-ending-child-marriage> [Accessed 3 Nov. 2019].

to the National Strategy to End Child Marriage. As a result, more than 60 per cent of the municipalities included activities to end child marriage in their annual work plans.

Zambia: Community dialogue to change gender norms in Zambia engaged over 31,000 people in 2018. Meetings with traditional leaders to support them on how to mobilize communities on ending child marriage also made them embrace project activities and reach out to an additional 2,000 people in their villages.

One common element in the brief case studies of Nepal, Yemen and Zambia was communicating social behaviour change for influencing gender and social norms using vertical (multi-level) convergence between different levels of government at national, provincial, district and community level, and between government and civil society. Engagement involves families, communities and leaders to protect girls from child marriage and uphold their rights. Parents and community members are often the primary decision makers on the fate of girls and whether they will be married as children. Transforming gender and power relations within families and communities through dialogue on the value of educating girls and the negative consequences of child marriage can change gender norms that promote child marriage.

Question 3.1:

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

While strategies that work directly with girls are essential, in many cases girls are not in a position to decide if, when, and whom to marry on their own. A range of individuals and institutions perpetuate the practice of CEFM; therefore, prevention and response strategies must engage a variety of stakeholders.

1. Community, Traditional and Religious Leaders

There are many key players at the community level who are outside of the family structure, but still have a strong influence on CEFM. Marriage-related decisions are often tied to traditional or cultural practices. Cultural, traditional, and religious leaders are often involved in helping families form marriage unions and may even preside over the marriage ceremony. Additionally, in many settings where CEFM is prevalent, community members defer to customary law and seek information and guidance from cultural and religious leaders rather than adhering to the government's laws. Because of their important role as keepers of social behaviours, it is essential to engage cultural, traditional, religious leaders in CEFM prevention and response efforts. These groups should be educated on the rights of women and girls, on the harmful outcomes associated with CEFM, and how CEFM impacts larger community development. Engaging these leaders in open dialogue provides them with the opportunity to express their viewpoints, challenge themselves and each other, and develop gender-equitable norms. In Nepal, UNICEF and the United Nations Population Fund (UNFPA) created a public service announcement that features Hindu, Buddhist, Christian, and Muslim leaders denouncing child marriage. Another

program example being adapted to address CEFM is World Vision's Channels of Hope program in East Africa. The program recruits and trains community members to mobilize faith leaders through a process of sensitization, strategizing, and empowering to spread awareness of HIV/AIDS and to develop and implement response action plans among their congregation and community. Channels of Hope is adding messaging around the harms of CEFM and how faith communities can work together to prevent CEFM.

2. Education

Teachers and school administrators have an important role to play in helping to shape students' beliefs and norms around what is acceptable behaviour and what roles are appropriate for boys/men and girls/women. Teachers can serve as role models, demonstrating how to treat boys and girls equally, value everyone's contributions, and foster confidence among all students. Teachers can also provide support and foster self-confidence in students, giving them the ability to form their own opinions and stand up for their beliefs when negotiating marriage decisions and sexual behaviours. Teachers and school administrators can also have a critical influence over students' education and norm development by choosing and using curriculum that promotes gender-equitable norms and lessons. Curriculum that presents women as empowered equals, rather than submissive wives can build girls' self-efficacy to form and act on their own dreams for the future. USAID recently developed a Guide for Promoting Gender Equality and Inclusiveness in Teaching and Learning Materials, which can be used to improve equitable learning.

3. Law makers and Parliamentarians

As the creators of laws and policies, lawmakers and parliamentarians are an important group to engage in creating a legal framework that prevents and responds to CEFM. In cases where there are exceptions to minimum age of marriage laws, such as allowing girls to be married under age 18 with the consent of a parent, lawmakers should strengthen the laws to be more absolute. While minimum age of marriage laws is a necessary starting point, there are several other related laws and policies that can be developed, strengthened, and implemented to reduce CEFM, improve legal conditions for married adolescents, and contribute to gender equality. Programs should work with civil society organizations to train activists to advocate for laws and policies to safeguard the rights of women and girls. These programs should educate activists about relevant legal issues and create tools (including reports, briefs, messages, and talking points) that advocates can use when meeting with lawmakers and parliamentarians. Relevant laws and policies include, but are not limited to: inheritance, land ownership, birth and marriage registration, payment of dowry or a bride price, school re-entry, contraception use among those who are under 18 or unmarried, divorce, and violence. Advocates should push for reviews of and amendments to national family and marriage laws and policies that discriminate against women and girls, and the creation of stronger birth and marriage registration systems.

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.

First.

1. *Establish coordination structures and mechanisms to direct and operationalise multi-sectoral action*

Coordination structures (i.e. committees, councils, working groups, task forces) can be powerful mechanisms to direct and support implementation of multi-sectoral policies/programmes. These groups typically involve representatives from the relevant departments/ministries, and sometimes are broadened to include representatives from civil society and the private sector. Their mandates commonly include operationalising multi-sectoral policies/programmes by defining roles and responsibilities of relevant stakeholders, ensuring coordination and accountability of relevant stakeholders, supporting costing and budgetary allocation, promoting adequate staffing at national and subnational levels, and developing and coordinating a joint monitoring and evaluation system.

2. *Build awareness and capacity of leadership and staff at subnational levels*

Skilled leadership at subnational levels is required to carry out the respective roles and responsibilities of the department/ministry, as outlined by the national policy/programme and the coordination structure or mechanism. Importantly, these personnel should be able to drive identification of gaps, weaknesses and bottlenecks in implementation and prompt timely responses. To do this, leadership should negotiate multiple agendas and priorities, including by leveraging agreed-upon roles and responsibilities of each department/ministry,

3. *Use subnational evidence to contextualise and tailor interventions*

Collecting and using age and sex disaggregated data at subnational levels can be instrumental to better understand the nature of the issue within the specific region, communicate the relevance of the national policy/programme to subnational stakeholders and tailor interventions to the local context, based on local stakeholders' needs, experiences and understanding of the target issue. Two of the case studies demonstrated the utility of collecting age and sex disaggregated quantitative data and qualitative data at subnational levels to highlight the specific needs of populations in different regions (and the specific needs of key populations within these different regions), and tailor and target interventions accordingly. Qualitative data, especially, can reflect important information on drivers, including those related to social norms, of the target issue.

4. *Develop coordinated budgets and cost-sharing mechanisms*

Effective multi-sectoral coordination and implementation requires costings for operationalising policies/programmes, clearly allocated budget lines across

departments / ministries, and functional cost-sharing mechanisms. However, the case studies included few details about strategies or lessons learnt in this area. Most insights simply noted that lack of capacity of staff to appropriately cost activities, constrained resources at national and subnational levels, and poor cost-sharing mechanisms were some of the key obstacles to effective subnational implementation. Especially at the local level, key informants indicated a sense that funding for local coordination and implementation should come from national departments/ministries with clear mandates, rather than from pooled local resources, although we also know that the source of funding is very much dependent on whether a country has a centralised or decentralised system of governance. A key message that emerged was that civil society can be requested to support capacity building of relevant stakeholders at subnational levels, and temporarily support implementation of activities where there are resource gaps

5. Integrate M&E systems

A good quality multi-sectoral M&E system is crucial for effective subnational implementation of multi-sectoral policies/programmes. If of good quality, they can help departments/ministries coordinate their work; monitor progress against specific and time-bound targets; identify gaps, weaknesses, bottlenecks and unintended effects of the policy/programme; adjust programming based on evidence; and hold themselves and others accountable. Additionally, M&E systems should include mechanisms to ensure meaningful participation of civil society and other stakeholders. However, the eight case studies included very little information on design and operationalisation of multi-sectoral M&E systems, including theories of change and other analytical frameworks. What did emerge was a desperate need to increase the ability of sectoral M&E systems to ‘talk’ to each other, and to strengthen capacity of staff, especially at subnational levels, to implement M&E systems and report on results.

Second.

All actions are important in my view, but I think the most important one, particularly being aware of Egypt and its situation, which I believe is not different from other countries that face the same problems, is the action related to leadership, i.e. building awareness and capacity of leadership and staff at the subnational level. Leadership and expertise in these areas are largely lacking. By developing leadership skills it is possible to carry out the respective roles and responsibilities of the relevant departments. Skilled leaders and staff would be able to identify in timely fashion any gaps, weaknesses or difficulties that face the implementation of the policies and programmes, and mount an early and appropriate response. The same leadership will be in a position to undertake the other actions in the strategy, or ensure that they are undertaken, i.e. the establishment of coordination structures and mechanisms to direct and operationalise multi-sectoral action, using subnational evidence to contextualise and tailor interventions, developing coordinated budgets and cost-sharing mechanisms, and integrating M&E systems. But, it is important to emphasise again the important of each and every action rather than taking one in isolation.

Question 4.1:

Identify three reasons why health workers perform female genital mutilation?

1. Cultural reasons

Many health-care providers used cultural reasons to justify their practice of FGM. Midwives encourage women to undergo re-infibulation after childbirth, with the belief that it would enhance women's value and protect their marriage, as their husband would want to divorce them if they remained de-infibulated. Midwives also mentioned that re-infibulation was important for beautification and wholeness of the woman. Some nurses and medical doctors explained that they saw themselves as safeguards of the FGM tradition in Kenya.

2. Financial reasons

Material gains have been found to be an important incentive for a proportion of health-care providers performing FGM, midwives, nurses or physicians, mostly in the form of money but also in the form of gifts. Financial gain was often the preferred choice selected as the reason for practicing FGM.

3. Respond to community's request or pressures

The desire of health-care providers to satisfy the requests of the community in regards to FGM as a reason for its medicalization and to demonstrate their respect for the community's cultural values and traditions is a recognized factor. Some consider practicing FGM again in the future if they were pressured by the family to do so.

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 health-care providers from performing female genital mutilation has four parts:

- Part I: sets out the issue.
- Part II: relates the issue to global goals and concerns.
- Part III: explains the reasons why medicalization happens, why it should not happen and challenges the needs to be overcome.
- Part IV: spells out the strategy, which is based on the principles governing international human rights. The adoption and implementation of this strategy is essential to secure the elimination of all forms of FGM.

The elements of the strategy are:

1. Mobilize political will and funding

Political will and funding are necessary to ensure the development and sustained implementation of policies, guidelines, and laws.

Necessary actions in this area are to:

- i. Build strong advocacy support for investment in supporting the abandonment of FGM, engaging political leaders, other leaders, parliamentarians and government ministries.
- ii. Mobilize and coordinate the efforts of key stakeholders to support a national policy against the medicalization of FGM. This includes parliamentarians, healthcare providers, legal experts, human rights groups, government ministries, political leaders and parties, professional organizations, religious and community leaders, including leaders of migrant communities, and other persons of influence.
- iii. Advocate for sustained and coordinated planning, budgeting and actions for key stakeholders.
- iv. Advocate for the establishment of a sustainable, coordinated public and private partnership in financing FGM-abandonment programmes.

2. Strengthen the understanding and knowledge of health-care providers

A prerequisite for preventing the medicalization of FGM is that all health-care providers should be familiar with: factors surrounding the practice of FGM; the reasons why it should not be performed by health-care providers and how to resist requests to do so; how to recognize and manage complications of FGM, including suitable obstetric care; and how to counsel women and families on FGM-related issues. Guidelines should be in place, including medical, ethical and legal information, such as how to counsel and care for girls and women who have undergone FGM, including counselling against re-infibulation. Deeply rooted discriminatory norms and practices that underlie FGM, including sexual concerns and eventual religious underpinnings, should be addressed, where relevant, when designing training programmes and developing protocols. These aspects are even more relevant when training is aimed at health-care providers in countries receiving migrants, refugees and asylum seekers, as they usually do not belong to the same sociocultural environment as patients from practising communities.

Training should also cover the social conventional nature of the practice to enable health-care providers to appreciate how medicalization will reinforce the social convention and perpetuate the harm, and how they can play a key role in helping practising communities to abandon the practice and permanently remove the risk of future harm.

Necessary actions in this area are:

- i. Appropriate national authorities should develop national guidelines for various health-care providers on how to deal with issues related to FGM,

- including how to care for complications and on how to resist pressure to perform any form of FGM, including re-infibulation.
- ii. Training modules on FGM for inclusion in pre- and in-service curricula and training, including refresher courses and updates for all health-care providers, should be developed. This includes nurses, midwives, and medical doctors as well as various health outreach workers. Comprehensive training would include information on factors related to the practice, prevalence, motivations and trends of FGM; how to identify and treat complications; and how to counsel individuals, families, and communities on the health risks and possible treatments for complications from FGM and re-infibulation.
 - iii. Training of health-care providers should be integrated at the community level with other community-based activities promoting the abandonment of FGM.

3. Create supportive legislative and regulatory frameworks

States should adopt, implement and enforce specific legislation addressing FGM, in order to affirm their commitment to stopping the practice and to ensure women's and girls' human rights. Alternatively, existing laws should be enforced in the absence of specific legislation on FGM, such as child-protection laws and criminal laws on physical harm. To avoid defiance and the practice going underground, it is important that all legal action takes into account the degree of social acceptance of the practice, and that it is part of a broader initiative that includes direct activities to empower practising communities to abandon the practice.

Necessary actions in this area are:

- i. Health-care providers should be informed without delay about human rights and ethical perspectives as well as the harmful consequences of FGM, and that performing FGM, including re-infibulation, would give rise to civil and criminal liability. Appropriate ethical guidelines on FGM should be incorporated into the training curricula of health-care providers.
- ii. The Ministry of Health and professional regulatory bodies should issue a joint policy statement against the medicalization of FGM, and laws and policies and/ or the application of existing laws and policies should address the role health-care providers play in the elimination of FGM and forbid the performance of any type of FGM, including re-infibulation.
- iii. Training on how to deal with medicalization of FGM should also be provided to juridical staff and law-enforcement and security personnel.
- iv. Professional organizations should adopt and disseminate clear standards condemning the practice of any type of FGM and issue firm guidelines for their members not to perform FGM, and not to accept or support its practice. This should be backed up by the application of strict sanctions against practitioners who violate those standards and guidelines.
- v. Performing FGM, including re-infibulation, should give rise to legal and professional sanctions. Licensed health-care practitioners must be subject to the maximum available criminal penalties that apply to anyone performing

FGM. Offending practitioners may be suspended, or their licences withdrawn if they perform FGM

- vi. Women and girls should be educated about their human rights and be empowered to access legal remedies specified by law to prevent FGM. Women and girls should have the right to bring civil action suits to seek compensation from practitioners, or to protect themselves from undergoing FGM. Wherever possible, health-care providers should assist by providing evidence supporting the claims of the girl or woman who has undergone FGM.

4. Strengthen monitoring, evaluation and accountability

Monitoring and evaluation are essential for improving health-care providers' approaches to FGM and for refining plans to promote abandonment of the practice. Government participation is critical for gathering data and broadening national monitoring mechanisms.

Necessary actions in this area are to:

- i. Monitor health-sector training and implement the lessons learned.
- ii. Develop mechanisms to increase accountability at facility and district levels.
- iii. Routinely collect data on FGM (e.g. antenatal records).
- iv. Monitor providers of FGM, including legislative measures taken against them.
- v. Integrate FGM, including reinfibulation, into existing monitoring and evaluation systems in the country (sexual and reproductive health, HIV/AIDS, gender-based violence, demographic and health surveys data collection, etc.).
- vi. Report to UN human rights treaty bodies and other international and regional human rights bodies.
- vii. Institutionalize feedback mechanisms to the communities.