

Training course in adolescent sexual and reproductive health 2019

Harmful traditional practices prevention

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Background

Female genital mutilation (FGM) refers to “all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons (1). It can cause long-term health and social consequences, such as post-traumatic stress disorder, menstrual problems, and pain and discomfort during intercourse (2). It is estimated that over 200 million girls and women mostly under the age of 18 years are living with the effects of FGM (3). Interventions that are multi-component including community mobilization and female empowerment strategies, are noted to be effective in improving a range of adolescent sexual and reproductive health outcomes and could reduce FGM (4).

Child marriage refers to a formal marriage or informal union before the age of 18 years (5). Each year about 12 million girls are married before the age of 18 years (6). 90% births to adolescents aged 15–19 years globally occur within marriage, and child marriage is likely to be the cause of early childbirth for 75% of the girls who have their first child before the age of 18 years in 25 high-prevalence countries (7). Adolescent pregnancies are associated with a range of negative health outcomes, especially among girls aged 10–14 years. To prevent child marriage, interventions must be multi-sectoral to address the numerous drivers of the issue by establishing and implementing laws and policies; mobilizing families and communities; providing health, social and legal services; and empowering girls (8).

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?

Female Genital Mutilation: It is estimated that at least 200 million girls and women in 30 countries have undergone FGM though exact worldwide prevalence is still unknown (3).

Available data suggests that the practice of FGM is highly concentrated in Africa and in a few countries in Asia and the Middle East with wide variations in prevalence. Eight countries in which more than 80 per cent of girls and women of reproductive age have undergone FGM: Somalia, Guinea, Djibouti, Egypt, Eritrea, Mali, Sierra Leone and Sudan. The data show that in high and low prevalence countries alike, the expected prevalence of FGM/C is generally highest among daughters of women with no education and tends to decrease substantially as a mother's educational level rises (3). Evidences from small studies also suggests that FGM exists in places including Colombia, India, Malaysia, Oman, Saudi Arabia, the United Arab Emirates and pockets of Europe and in Australia and North America.

Overall, the FGM practice has declined over the years but the decline is uneven. In girls aged 15 to 19 years the prevalence has decreased from 49% in 1988 to 34% in 2018. Fast decline among girls aged 15 to 19 has occurred across countries with varying levels of FGM prevalence including Burkina Faso, Egypt, Kenya, Liberia and Togo.

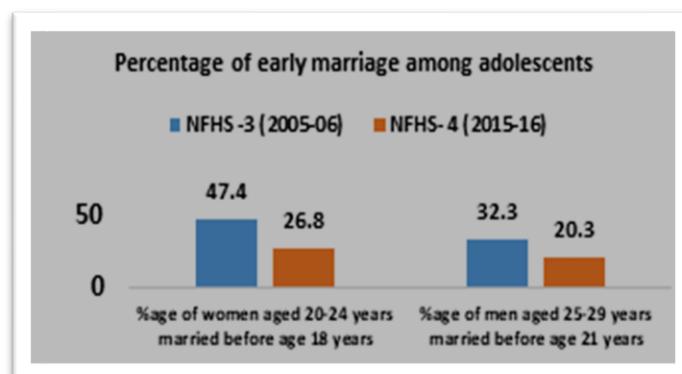
In India, there is no representative data on prevalence, however, there are small studies and some anecdotal accounts on FGM practice in India. Female genital mutilation or cutting (FGM/C) as it is practiced in India is known as “khatna” or “khafz”, and involves the removal of the clitoral

hood or the clitoris. This practice is common amongst the Bohra community, whose members live in 5 States of India such as Gujarat, Maharashtra, Rajasthan, Madhya Pradesh and Kerala. A study published by WeSpeakOut, a survivor-led movement, revealed that 75% of daughters (aged seven years and above) of all respondents in the sample, from the Bohra community, were subjected to FGM/C (9).

Child Marriage: Each year about 12 million girls are married before the age of 18 years (6). Across the globe, levels of child marriage are highest in sub-Saharan Africa, where nearly 40% young women were married before age 18, followed by South Asia, where 30% were married before age 18. Latin America and Caribbean, the Middle East and North Africa, and Eastern Europe and Central Asia have lower levels of child marriage.

Approximately 650 million girls and women alive today were married before their 18th birthday and around 115 million (20% of girls and women) were married before age 18. The practice of child marriage has continued to decline around the world. Based on the latest data available 21 per cent of young women (aged 20 to 24) were married as children as compared to 25% in last decade. India has made a huge contribution in decreasing the proportion of child marriages across the globe (6).

India has seen a substantial decline in rates of early marriage amongst both men and women between National Family Health Survey – 3 (NFHS-3) (2005-06) and National Family Health Survey – 4 (NFHS-4) (2015-16) (10).



Despite the progress, there is a huge interstate variation and the data suggests that eight out of the 36 states/UTs in the country still have especially high rates of early marriage (30%-41%) amongst women. Analysis of the NFHS 4 data also reveals that a girl from a poor family is more likely to getting married at a younger age than a girl from a wealthier family.

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 these three countries, community mobilization is the common intervention adopted to prevent child marriages. In Nepal, the programme involved municipalities and sensitized newly elected officials from the local governments to prevent child marriages. In Yemen, adolescents as well as community members were reached to increase their awareness on the harms of child marriage. The intervention focused on challenging existing norms and harmful practices that encourage child marriage. In Zambia, community dialogues were conducted to change gender norms.

Child marriage is seen as a deeply rooted practice amongst many communities which they considered as an integral part of their culture for generations. It is critical to change or shift those values and norms which support the practice of child marriage. Working with families and the wider community to raise awareness of the harmful consequences of child marriage can change attitudes and reduce the acceptance among those who make the decision to marry girls as children.

Question 3.1:

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

It is well understood that efforts of only one sector cannot prevent child marriages, it should be multiple sectors implementing a comprehensive program in an integrated manner. Therefore, prevention and response services need to be integrated across various sectors to create a comprehensive strategy for reducing and mitigating the effects of child marriage, as well as meeting the needs of married adolescents. In my country out of all the sectors Education, Women & Child Development and Legal sectors are playing crucial role through following strategies to prevent child marriages.

Improve access to quality education and other vocational and learning opportunities:
Education emerges as a driver of change almost universally. Almost every study on child marriage reports a positive correlation between the decrease in child marriage and an increase in school participation rates. Access to affordable secondary education reduces direct costs for parents and, therefore, could act as a constraint to withdraw the girl from school and marry her off in absence of other choices. Access to affordable and safe schools starts influencing parental decisions for continued schooling; it also influences the social norm when more and more parents from the community start sending their girls to school.

Education sector is playing crucial role in following aspects:

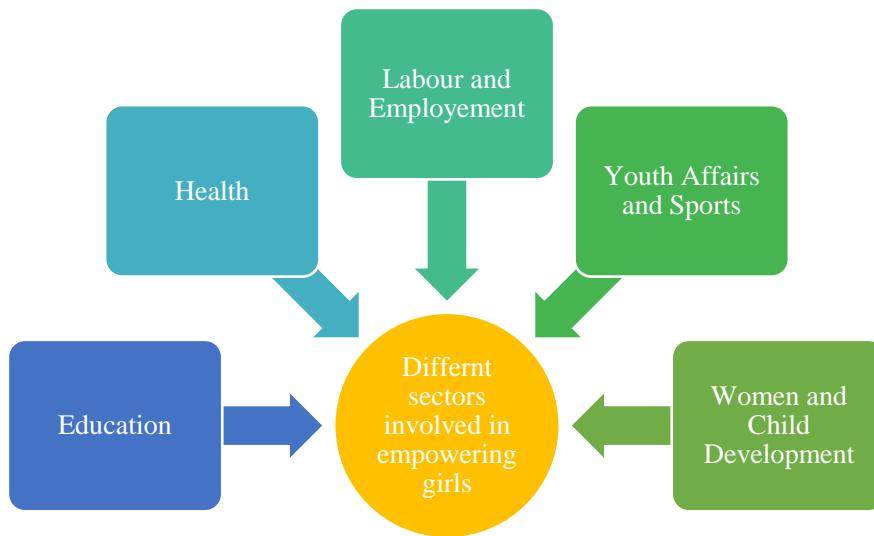
- Mainstreaming gender related issues and prevention of harmful practices, such as child marriage, violence and exploitation in school curriculum and teacher training.
- Promoting schools as safe learning environments for girls.
- Enhancing educational opportunities (scholarships, bridge courses) and vocational opportunities

Empowerment of women and girls and engaging with men and boys: The prevalence of child marriage reduces when women are exposed to new ideas, gain confidence and voice, and start questioning and demanding their rights in every sphere, including the household and social

practices. Girls' groups act as support systems for questioning practices like child marriage. Such groups have also empowered girls to refuse unacceptable social practices and negotiate their rights, especially on child marriage.

In India, a scheme called SABLA (or the Rajiv Gandhi Scheme for the Empowerment of Adolescent Girls) which is community intervention focuses on adolescent girls. The scheme works through community-based adolescent girls' groups that include both school-going and out-of school girls, and have linkages with anganwadi centres. The schemes aim at providing life skill and vocational training, literacy and numeracy skills, health and nutrition awareness and, through these, postponing marriage.

Though Women and Child Development is playing a major role, but other sectors have equivalent responsibility to empower girls and women.



Effective implementation of Acts and relevant legislation: Legal Sector can play a critical role by defining entitlements and ensuring that all existing laws and practices speak the same language, and the enforcement is strong.

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.

Five actions that can contribute to multi-sectoral coordination at the subnational level, identified in the paper by Lo Forte et al (2019) are:

1. Establish coordination structures and mechanisms to direct and operationalise multi-sectoral action
2. Build awareness and capacity of leadership and staff at subnational levels

3. Use subnational evidence to contextualize and tailor interventions
4. Develop coordinated budgets and cost-sharing mechanisms
5. Integrate M&E system

Though all actions are important, but I believe Integrating M&E systems is crucial as it ensure effective subnational implementation of multi-sectoral policies/programmes. After drafting several Health programme guidelines at National level, I have understood that integrated M&E systems at the sub-national level is often not available. Until unless we define roles and responsibilities and measure accountability through defined and specific set of indicators of each sector, the multi-sectoral implementation will not happen at the grass root level. I believe that ***what is monitored is implemented.*** Good M&E systems 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.

Question 4.1:

Identify three reasons why health workers perform female genital mutilation?

The main findings about the motivations of health-care providers to practice FGM were:

1. The belief that performing FGM would be less harmful for girls or women than the procedure being performed by a traditional practitioner (the so-called “harm reduction” perspective)
2. the belief that the practice was justified for cultural reasons
3. the financial gains of performing the procedure
4. responding to requests of the community or feeling pressured by the community to perform FGM

Question 4.2:

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

The critical elements of WHO’s global strategy to stop health-care providers from performing female genital mutilation are:

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

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
- 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?
- How to counsel women and families on FGM-related issues?

Create supporting legislative and regulatory framework: 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 practicing communities to abandon the practice.

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.

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