Training course in adolescent sexual and reproductive health 2021

Harmful traditional practices (child marriage and female genital mutilation) prevention and response

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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).

- Over 200 million girls and women are estimated to be living with the effects of FGM, which is predominantly performed on girls under the age of 18 years. FGM is a global problem, most prevalent in 30 countries in Africa and in 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 (1).
- 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. In 25 high-prevalence countries, approximately 36% of women aged 18–22 years were married before the age of 18 years. Globally, the proportion of women who were married as children has decreased by 15% in the past decade) However, progress has been uneven across regions: while north Africa and the Middle East have decreased the percentage of girls married by age 18 years by about half, and south Asia has reduced a girl's risk of marrying before age 18 years by more than a third, less change has been observed in Latin America and sub-Saharan Africa Meanwhile, country-level studies point to immense subnational variability in child marriage prevalence (1).
- Based on study from **Iran,** the results clearly show the regional differences in FGM prevalence. The first table shows that the percentage of circumcised women is high in Hormozgan province, where it can reach 60% in some of the villages of Qeshm, Hormuz and Larak islands. It is at its lowest in villages of Persian, at 31%; Northern parts of the province were FGM free. Kermanshah province had the second-highest prevalence of 41% in villages of Paveh.(2) FGM is a common practice in rural areas of Southern Iran.one study reported among the participants, 535 (68.5%) had undergone FGM (3) On the other study The prevalence of FGM was 55.7% and the mean age of the women undergoing FGM was 9.2±14.2 years (4)
- According to the latest statistics from the **Iranian** Census Bureau, the proportion of women who married under the age of 15 in 2016, and also earlier years, was about 5.5%. However, based on other reports, 17% of girls in Iran are married before the age of 18 and 3% are married before the age of 15(5). According to the last UNICEF report in 2016, in Iran women who married before ages 15 and 18 in different regions this percentage were 3% and 14% respectively (6)

Question 2

What are the projected effects of COVID-19 on child marriage and on female genital mutilation? Can you point to one report on this subject from your country?

- COVID-19 will disrupt efforts to end child marriage, potentially resulting in an additional 13 million child marriages taking place between 2020 and 2030 that could otherwise have been averted (7)
- Due to The COVID-19 pandemic, meeting the Sustainable Development Goals (SDGs), including the elimination of female genital mutilation by 2030, will be disrupted, and anestimated two million additional cases of female genital mutilation will need to be averted.
- According to recent study from Iran, there are numerous and confusing perspectives regarding FGM. The lack of specific rules and knowledge about the psychological, sexual, and physical effects of FGM lead to the continuation of this practice (8)
- Result from one study from Iran show that Economic factors, Sociocultural factors, Individual factors, family factor and Structural factors are reason for child marriage in Kurdish regions of Iran (9)
- There is not any report from Iran about effects of COVID-19 on child marriage and on female genital mutilation

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Question 3.1

How is "medicalization of FGM" defined by the World Health Organization?

The World Health Organization (WHO) defines medicalization as "the situation in which FGM/C is practiced by any category of healthcare provider, whether in a public or a private clinic, at home or elsewhere" These medical health professionals may include physicians, nurses and/ or midwives. Demographic and Health Surveys (DHS) data shows that medicalization has increased particularly in Egypt, Sudan, Kenya, Nigeria, Guinea, Yemen and, more recently, in Indonesia. In many of these countries at least one-third of women reported that their daughters were cut by a trained healthcare provider.

Question 3.2

In what ways can sexuality education contribute to the reduction of FGM practice?

Sexual education should be included in school curriculum and integrated in social marketing campaigns for FGM/C abandonment. It should tackle not only FGM/C as a practice, but also correct its associated misconceptions. Moreover, information on FGM/C health and legal consequences should be integrated within the medical school curriculum framing FGM/C within a wider sexual health discourse. This will help in changing the mindset of medical practitioners to see the long-term effects of FGM/C. A team of experts would be instrumental in ensuring that the topic is tackled from all different perspectives (10)

Health care providers need to be equipped with the appropriate counseling skills on FGM/C to be better able to convince clients to abandon the practice. The use of innovative methods in training and role plays with well-prepared scenarios of different customers' requests of FGM/C and how to deal with each should be integrated in training sessions. Religious, moral and legal aspects of FGM/C need to be included in training sessions and in awareness raising activities to ensure the

delivery of a holistic multi-dimensional message. Furthermore, the medical syndicate should take punitive measures against physicians who practice FGM/C by revoking their license (10).

Question 3.3

From the options provided, identify two reasons that were presented by the physicians for performing FGM/C.

a. Financial benefits*
b. Forced by the law
c. Religious duty/Sunna*
d. Practice (improving skill)
e. Ensuring client influx
f. Cosmetic improvements

Question 3.4

What are the underlying factors for the continued practice of FGM/C in your community/country that need to be addressed in FGM/C abandonment efforts? Provide relevant references.

In my community/country the results of Ahmady et al.'s study (2015) showed that the highest rates of FGM/C can be found in the province of Hormozgan, Kurdistan, Kermanshah, and West Azerbaijan (11). The result of other study shows that Ancient traditions in the area (57.1%) were mentioned as the most important factor leading to FMG/C (2). this study mentioned that FGM is associated with increased age, illiteracy, Sunni Islam religion, Afghan nationality, and positive family history. Lack of knowledge toward FGM/C is the main cause of its high prevalence and continuation in the area (in Hormozgan, a southern province of Iran near the Persian Gulf) (3)

Question 4.1

Identify four key lessons learnt from the Yemen case study on addressing a sensitive topic such as early child marriage.

- **Program Planning**
    - Maximize reach through collaboration with government initiatives: Coordinate the startup activities, especially the dates of training workshops with major government activities.
    - Promote local buy-in: Work through local and national organizations to counter local suspicion about the motives of foreign aid in supporting changes in social habits. Actively engage religious leaders, the main gatekeepers in rural communities, to increase the acceptance of the project. (12)

- **Cultural**

- Counteract gender inequities by addressing special needs of female community educators: Since Yemen is a patriarchal society and enforces gender segregation, the female community educators were reticent to ask questions and voice their concerns during the training workshop. Their literacy skills and basic knowledge on reproductive health and family planning were lacking, as compared to their male counterparts.
- Incorporate outreach activities that build on cultural preferences: Male community educators used poetry to convey the harmful social and health consequences of child marriage, whereas female educators used stories. (12)

- **Political**

  - Minimize political and religious opposition: Make the effort to select community educators who belong to the major political parties in the country. Become familiar with the arguments for and against the child marriage and rights of the girl child to minimize the politicization of the issue and accusations such as: "This is a western project", "they want to spread sin", and "they want to limit the Muslim population."
  - Engage political leaders in basic project messages: Share the negative social and health consequences of child marriage with political leaders and parliamentarians. (12)

- **Capacity Building**

  - Strengthen capacity of implementing agency: Take the time to assess the knowledge and skills of the staff, especially planning, implementing, monitoring and supervising project activities. Develop a step-by-step guide, including checklists, to improve the efficiency and effectiveness of YWU coordinators. Work with implementing agency to appoint a full-time project coordinator at the implementation site to supervise and monitor senior YWU coordinators overseeing the project activities of community educators. Replace traditional/hierarchical supervision with supportive supervision.
  - Strengthen facilitation skills of community educators: Train community educators on a range of facilitation techniques to use when disseminating their messages to lessen message fatigue on child marriage. (12)

<u>Question 4.2</u>

Which approaches did the community educators use to conduct outreach educational activities in the Yemen case study?

Outreach Educational Activities

- Each community educator was responsible for holding a minimum of four awareness-raising sessions per month, using a range of techniques, such as: discussions, role-plays, storytelling, poetry recitations, and debates. The sessions were held in schools, literacy classes, health centers, mosques, YWU branches, and during other social gatherings.
- The community educators also organized and held monthly fairs, where BHS's mobile clinic was present to provide family planning /reproductive health /maternal and child health services to mothers and children. The mobile clinic attracted many women, and some health

fairs featured influential speakers, such as the governor, representatives from the Ministry of Public Health and Population, the Ministry of Education, and key religious leaders. In addition, community educators set up information booths and showed a local movie about a Yemeni girl who was married off at a young age and died in labor. The movie was followed by a discussion facilitated by the community educators on the consequences of child marriage.

- The community educators worked with the YWU coordinators to engage 9- to15-year-old students to develop and perform school plays on the health and social consequences of early marriage and to launch a magazine competition between 20 schools. Students submitted stories, poems and caricatures on the social and health consequences of child marriage and the importance of completing high school education. Copies of the winning magazine were distributed to community members.
- The community educators were involved in the selection of 10 model families (five per district) who not only delayed the marriage of their daughters, but ensured that they completed 12th grade. These families were awarded a plaque for their role during the end of project ceremony officiated by the Amran governor. The community educators also conducted an end line survey to assess changes in knowledge, attitudes and behaviors related to child marriage. (12)

Question 4.3

In your opinion, which of the major lessons learnt from the Yemen case study is the most applicable to your country context and why? Please provide relevant references.

In my opinion, Political, Cultural and Capacity Building are the major lessons learnt from the Yemen case study is the most applicable to my country context. Due to sociocultural factors (social customs, cultural beliefs, community encouragement, social learning, gaining prestige, and social support) are main reasons of child marriage in Iran (13). Result from one study from Iran show that Economic factors, sociocultural factors, Individual factors, family factor and Structural factors are reason for child marriage in Kurdish regions of Iran (9).

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