SPECIFIC ISSUES RELATED TO FEMALE GENITAL MUTILATION TO CONSIDER DURING THE GENDER-TRANSFORMATIVE ACCELERATOR PROCESS

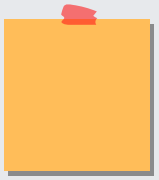
THE GENDER-TRANSFORMATIVE ACCELERATOR TOOL FACILITATES INTERACTIVE PROGRAMMATIC REFLECTION AND ACTION PLANNING. SPECIFIC ISSUES RELATED TO FGM, STRONGLY CORRELATED TO GENDER NORMS AND GENDER IMBALANCE, SHOULD BE DISCUSSED DURING THE PROCESS, IF PERTINENT IN THE CONTEXT OF THE COUNTRY.

1 Medicalization:

FGM has become increasingly medicalized even though the practice is a violation of girls' and women's human rights and their right to bodily integrity. Around one in four girls and women who have undergone it (26 per cent or 52 million) were cut by health personnel. This proportion is twice as high among adolescents (34 per cent among those aged 15 to 19 years) compared to older women (16 per cent among those aged 45 to 49 years)[1] and affected countries differently. Medicalized FGM is performed for several reasons (health-care providers who perform FGM are themselves part of the community and subjected to same social norms around FGM, still consider it their duty to support the patient's or family's requests, see medicalization as a form of harm reduction, or motivated by financial gain).

In countries affected by medicalization of FGM, specific interventions are carried out with medical systems and communities, including reinforcing legal framework around FGM medicalization, integrating FGM into health schools' curricula and capacity building for medical professionals, facilitating advocacy forums and strategic engagement with health-related regulator bodies and professional associations and, setting up surveillance system training of health professional. As other systems, medical system is affected by gender bias and inequalities[2] and strong power relationships between service providers (health professionals) and service users. During the GTA process, specific attention should be paid to categories and gender of health professionals who are performing FGM and specific adapted interventions should target them.

EXCERPTS OF ACTIONS FROM GTA IN ETHIOPIA (WITH THE GLOBAL PROGRAMME TO END CHILD MARRIAGE):



Systems-level targeted at service providers

"It was noted that in order to make meaningful change in discriminatory gender norms in the communities, it is important to integrate gender-responsive and gender-transformative approaches to already existing manuals and activities of government workforces (in particular health, justice and social service).

To make this happen, the attitudes and values regarding gender equality, including child marriage, of these service providers need to be aligned with the objectives of the programme. Limited knowledge of stakeholders on the topic of gender and policies alike leading to lower commitment have been identified as a challenge.

Therefore, capacity-building and values clarification on gender and social norms should be given to these service providers (health, justice and social service workforce) for the programme to be gender transformative through approaches such as the Social Analysis and Action (SAA) approach."

2

Alternative Rites of Passage (ARP)

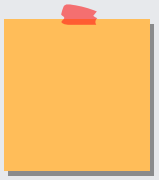
Alternative rites of passage, used in communities where FGM is part of a rite of passage, allow girls to undergo training and to graduate to womanhood without being subjected to FGM. During this process, girls are also educated on different topics and are encouraged to abandon the practice. Alternative rites facilitate community ownership and support, as they maintain key cultural practices, increase knowledge and empowerment of girls, and increase publicity about change through community celebrations. While the activities associated with ARP, such as training on the harmful effects of FGM, may lead to increased knowledge, there is limited evidence on the effectiveness of ARP in preventing girls from undergoing FGM.

In fact, while some components of ARP, such as educational programmes, can be effective in changing attitudes, the risk of exclusion, perceived loss of cultural identity, changing meanings ascribed to cultural practices, lack of precise knowledge about subjective sexual experience and negative stereotyping limit the success of such programmes[3].

UNFPA ESARO found that gender role stereotypes are emphasized and reinforced by rites of passages; including gender role stereotypes that encourage girls to be passive and that limit girls to playing only certain roles in society, directly contradicting a rights-based approach to gender equality[4].

While Alternative Rites of Passage could create an opportunity to improve girls 'agency and girls' empowerment, it is not easy to monitor as secrecy around rites of passage is encouraged and expected. If a country has adopted ARP as a strategy to eliminate FGM, the content and curricula of the ARP should be discussed during the GTA process, as well as the monitoring and evaluation process of such a strategy.

EXCERPTS OF ACTIONS FROM GTA IN INDIA (WITH THE GLOBAL PROGRAMME TO END CHILD MARRIAGE):



Agency-building

"Adolescent girls-focused programmes at the local and national levels do not always include a holistic approach to address issues at all layers of the SEM. It has been observed that most of the programmes fail to connect their efforts to the system and structural level engagement. Moreover, a larger proportion of girls-focused programmes limit their implementation towards knowledge building and skill development but barely address the social and gender norms at the family and community levels, which restricts girls' agency and rights even when they have higher awareness levels.

To address such barriers, it is important to leverage connections with different systems and institutions, including local, government and private entities, which provide life skills and livelihood training and facilitate employability and employment opportunities to connect education with upskilling approaches/opportunities. There is also a need for addressing the 'how' given the plethora of guidance and technical notes produced under the Global Programme on gender-transformative life skills strategies responding to transferrable skills."

3

Stigmatization of uncut girls

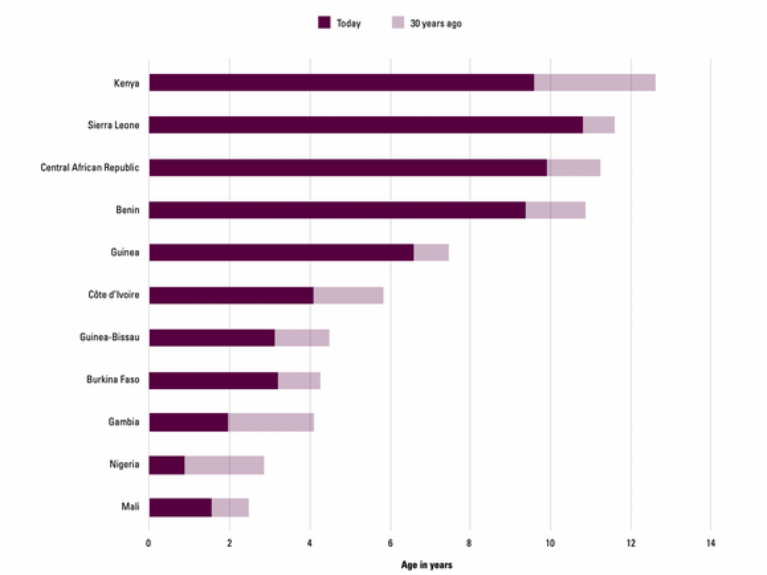
In societies where FGM is still surrounded by strong social norms and where most girls have undergone FGM, uncut girls may face social stigma and discrimination. This stigma is part of social sanctions that maintain FGM as a social norm. If individuals conform to the norm, they expect to be socially accepted or rewarded. If they do not conform, they expect to be socially punished or excluded . Programs must be skilled at addressing the risk of stigmatizing of uncut girls while providing for the specific needs of FGM survivors, without making girls and women feel devalued for having/not having undergone FGM. While the Joint Programme emphasizes girls' empowerment, a gender analysis must question whether these empowerment programs target most vulnerable girls, FGM survivors and girls at risk of stigmatization.

4

Reduction in the age of cutting

FGM is practiced differently within different cultures, and the age at which it is performed varies across contexts. In some countries, it is carried out very early in life, while in others it occurs in adolescence. Where FGM is practiced on very young girls, there is a short window of opportunity to intervene. In some countries this window is getting narrower, as a larger proportion of FGM is being performed on the youngest girls. In half of practicing countries, the average age at which FGM is performed is lower today than it was 30 years ago. Stakeholders who can protect a girl from undergoing FGM are not necessarily the same people when FGM is performed on a young girl or a teenager girl and surveillance mechanisms must be adapted.

The position and decision-making power of the mother may also vary: if girls are cut at a younger age, mothers are also more likely to be younger when deciding whether to cut their daughters. The power relationships between the mother, her husband, her husband's family, and other older women of the community are then different and strongly affected by gender imbalance (and even more so in contexts where there is an overlap between child marriage and FGM). The age of cutting must be considered in a gender analysis as well as the position of decision-makers regarding FGM (mother, father, paternal grandmother, maternal grandmother, etc.) in order to adapt programs (for example positive parenting or counseling during pregnancy targeting both parents, etc.).



Percentage distribution of girls aged 10 to 14 years (or 15 to 19 years) who have undergone FGM, by age at cutting. United Nations Children's Fund, The Power of Education to End Female Genital Mutilation, UNICEF, New York, 2022.*

5 Men and boys' engagement

Men and boys are visible partners and allies against FGM. Out of 11 countries supported by the Joint Programme, and where data are available, FGM opposition in nine countries is approximately the same among girls and women, and boys and men (Burkina Faso, Kenya, Mali, Nigeria, and Senegal) or greater among men and boys (Eritrea, Ethiopia, Guinea and Sudan)[6]. Unlike other types of gender-based violence, which are mostly perpetrated by men, FGM is often practiced by women in the community. However, many men contribute explicitly or tacitly by consenting to the perpetuation of the practice in their families and communities. However, our goal for ending FGM should not be simply because men have been permitted to end FGM; but because it is the right thing to do as FGM violates girls and women. So, our work with men should focus on helping them recognize this violation and for them to actively support the action of ending it. They can do this by openly letting mothers and other men in the community know that they don't support FGM. While men and boys should be engaged in interrogating and challenging gender norms, we must be careful not to reinforce unequal power relations between men and women when working with men and boys.

EXCERPTS OF ACTIONS FROM GTA IN INDIA (WITH THE GLOBAL PROGRAMME TO END CHILD MARRIAGE):

Positive Masculinity

"More often an instrumental approach has been adopted for engaging men and boys and addressing masculinity in almost all government programmes. One clear indication emphasizes the need to look for more opportunities to work with men and boys with the largest focus at the core areas of the content, approaches and methodologies. Areas that emerged from the further reflection that are currently missing include: 1) Questioning patriarchy power and privilege at all levels. 2) Demystify gender construct and need to understand gender equality within such a framework. 3) Sharing power and dismantling it at all levels of the relationship."

ENDNOTES

[1]UNFPA-UNICEF-WHO (2018), Factsheet on FGM Medicalization.The countries where the percentage of girls aged 0-14 years who underwent FGM performed by health professionals is highest are Egypt (78 percent) and Sudan (77 percent). These are followed by Indonesia (62 percent), Guinea (31 percent), Djibouti (21 percent), Kenya (20 percent), Iraq (14 percent), Yemen (13 percent) and Nigeria (12 percent).
[2] UNICEF WCARO (2019), Gender relations in community health systems in West and Central Africa.
[3]Matanda Dennis, Groce-Galis Melanie, Gay Jill & Hardee Karen (2021). Effectiveness of Interventions Designed to Prevent or Respond to Female Genital Mutilation: A Review of Evidence. UNFPA, UNICEF, WHO and Population Council, Kenya.
[4] UNFPA ESARO (2020), The Impact of Rites of Passage and Cultural Practices on Adolescents' and Young People's Sexual and Reproductive Health in East and Southern Africa. A Review of the Literature.
[5]https://www.unicef.org/media/100791/file/JP%202020%20ACT%20social%20norms%20desk%20review.pdf
[6]UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation, 2020 Global Annual Report: Eliminating Female Genital Mutilation during COVID-19: Sustaining the momentum, UNFPA, UNICEF, New York, 2021.