

Strategies to Eradicate Harmful Traditional Practices

The highly sensitive nature of dealing with harmful traditional practices is appreciated. While there are no hard and fast rules for eradicating these practices, the following may provide some guidance for field workers:

- Experience has shown that the initial step in addressing harmful traditional practices is providing education and information on such practices, with a particular focus on the negative consequences. However, action-oriented activities must follow on after initial awareness building.
- Campaigns to eliminate these practices are more likely to succeed and be accepted by the target population where they emphasise harmful **health** consequences rather than the legal or human rights aspects.
- It is necessary to have a thorough understanding of the nature and extent of the particular practice, including its roots and the social consequences it entails. This will obviously involve discussions with the refugees themselves. This underlies the importance of understanding the culture and habits of the refugees, as advocated under the People Oriented Planning (POP) approach.
- Focus on educating target populations (both men and women), namely religious leaders, traditional leaders such as chiefs, tribal elders and political leaders, traditional birth attendants, other health workers and the refugee women, men and children themselves on the harmful health consequences of these practices. In particular, it is very important to educate young girls on these issues.
- Promote, provide technical support, and mobilise resources for national and local groups that will initiate community-based activities aimed at eliminating harmful traditional practices. National Committees to eradicate harmful traditional practices exist in many countries and their expertise should be mobilised.
- In Kenya, local NGOs running campaigns aimed at eliminating FGM found it more acceptable by the refugees when the issue was dealt with in workshops covering other reproductive health issues as well, such as STDs, HIV/AIDS, and safe motherhood, rather than as a stand-alone topic. On the other hand, the campaign in Ethiopia began as a stand-alone model and was quite successful, being incorporated into a larger reproductive health programme only later. This illustrates the importance of tailoring each programme to the community involved.
- The “medicalization” of harmful practices such as FGM (i.e. supporting health care professionals to perform practices in health facilities under more hygienic conditions) should not be supported. Health workers in refugee situations must be aware that their involvement in such practices will not be tolerated and will lead to immediate termination of employment. In countries where FGM is practised, this should be stipulated in the employment contracts of health personnel.
- It is important that alternative income generating activities are found for those carrying out harmful practices such as FGM. Additionally, the community’s respect for traditional practitioners must be maintained.

- Videos have proved an excellent way of demonstrating the harmful effects of some traditional practices. Videos depicting FGM actually being performed or a woman who has not undergone FGM giving birth have proved effective.
- The use of drama and other cultural activities, such as plays or songs, can also be an effective method of disseminating information on the negative effects of harmful traditional practices. The radio and local papers may also be used to help disseminate information on harmful traditional practices.
- In the Sudan, some health workers focus mostly on men in their campaign to save girls from FGM because their decisions may have the most influence. Men are often unaware of the exact nature and severity of the procedure.
- In Uganda, support for conducting the “rites of passage” ceremony is emphasised while stopping the harmful practices of FGM. Programmes encourage the continuation of the ceremonial aspects of the “coming of age” for young women, but eradicate the “cutting”. In Sierra Leone, FGM is part of an initiation process for women’s secret societies. These societies can be very important for women’s self empowerment because they provide a support network and contacts for income generating activities. While it is important to encourage groups that empower women, it is equally important to encourage initiations which do not require FGM.
- The importance of educating girls and women cannot be underestimated. The incidence of harmful traditional practices, such as FGM and early childhood marriage, decreases with gains in female literacy. Therefore, promoting and supporting female education, both for adults and by the enrolment of girls in schools, should be a priority.
- Growing immigrant populations in industrialised countries have brought FGM with them to states where it was not usually practised. Canada, the US, Australia and many European countries now have laws prohibiting the practice. France has prosecuted a number of parents for subjecting their daughters to the procedure in France. UNHCR discourages informing refugees about the criminalisation of the practice in resettlement countries prior to departure, as this may result in mass FGM operations before resettlement occurs. Instead, the authorities of the resettlement country should be encouraged to inform refugees of these laws upon their arrival.

Field staff are advised to plan their strategy for eradication carefully, in conjunction with the refugee community, implementing partners and any other relevant UN organisations. Working with the refugee community is important to ensure measures taken are as effective as possible. In addition, local NGOs and the government, who may already have active campaigns in the country, and host communities could be involved. In particular, UNHCR staff could benefit from the expertise and experience of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children which has national committees (local NGOs) in 26 African countries and groups/sections in some European countries. Staff should consult Headquarters for advice where necessary. A document entitled “HOW TO GUIDE - From Awareness to Action: Eradicating FGM in Somali Refugee Camps in Eastern Ethiopia” (December 1997) detailing concrete methodology for conducting anti-FGM campaigns is available from Programme and Technical Support Section (PTSS) in Headquarters.

This Annex provides information on the following harmful traditional practices:

- I. Female Genital Mutilation
- II. Early Childhood Marriage
- III. Son Preference
- IV. Dowry

I. Female Genital Mutilation

Female genital mutilation (FGM), sometimes referred to as female circumcision, is a practice which involves the cutting away of all or part of the external female genitalia or all other procedures involving other injury to the female genital organs.

This procedure is performed on approximately 2 million girls each year. Most of the girls and women that have undergone FGM live in 28 African countries, although some live in Asia.¹ (See the attached map and statistics).

Definition

Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons.

Classification

The different types of female genital mutilation known to be practised are as follows:

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| Type I | Excision of the prepuce, with or without excision of part or all of the clitoris (also known as clitoridectomy). |
| Type II | Excision of the clitoris with partial or total excision of the labia minora (also known as excision). |
| Type III | Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation, also known as Pharonic circumcision). |
| Type IV | Unclassified: includes pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterisation by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it; and any other procedure that falls under the definition of female genital mutilation given above. |

The procedures described above are irreversible and their effects last a lifetime.

¹ "Female Genital Mutilation", Joint WHO/UNICEF/UNFPA statement, Geneva 1997, p. 5. See also, Preliminary report submitted by the Special Rapporteur on violence against women, its causes and consequences, Mrs. Radhika Coomaraswamy, E/CN.4/1995/42, para. 146, which lists the countries where FGM is traditionally practised: Somalia, Djibouti, Sudan, Ethiopia, Egypt, Mali, the Gambia, Ghana, Nigeria, Liberia, Senegal, Sierra Leone, Guinea, Guinea-Bissau, Burkina Faso, Benin, Cote d'Ivoire, Tanzania, Togo, Uganda, Kenya, Chad, Central African Republic, Cameroon, Mauritania, Indonesia, Malaysia, Yemen.

Approximately 15% of women and girls subjected to FGM are infibulated, while the majority receive a clitoridectomy or excision. The incidence of infibulation is much higher in Djibouti, Somalia and northern Sudan, with a higher rate of complications. Infibulation is also reported in southern Egypt, Eritrea, Ethiopia, northern Kenya, Mali and Nigeria.²

There may be both immediate and long term health consequences to the practice of FGM. Immediate complications include severe pain, shock, haemorrhage, urine retention, ulcerations of the genital region and injury to adjacent tissue. Haemorrhage and infection can cause death. More recently, there have been concerns regarding the transmission of HIV/AIDS when a circumcisor uses the same unsterilized, sharp object to perform the FGM procedure on a group of girls or women one after the other.

Long term consequences include cysts and abscesses, keloid scar formation, damage to the urethra resulting in urinary incontinence, dyspareunia (painful sexual intercourse) and sexual dysfunction. Infibulation carries additional complications, including recurring infections and infertility. Complications during delivery are common. Closing of the vagina after birth is also practised, further causing pain and suffering. Some reports also indicate that the risk of maternal death and stillbirths greatly increase as a result of FGM. Additionally, the psychological health of the girl or woman may also be adversely affected.

The medicalization of FGM (i.e. supporting health care professionals to perform FGM in health facilities under more hygienic conditions) cannot be tolerated as an attempt to make this procedure “safer”. Medicalization inappropriately legitimises FGM and does not eliminate the harm caused by the practice. Health workers employed in refugee situations must be informed that their involvement in “medicalizing” FGM will result in immediate termination of their contract.

The reasons for FGM tend to be culture-specific, but they include ensuring virginity at the time of marriage, suppressing a woman’s sexual desire, enhancing social integration, religious reasons and numerous myths. However, there are no proven religious justifications founded in the Christian or Muslim faith; quite the contrary, as the practice of FGM runs against the teachings of the Bible and the Koran.

There is widespread condemnation of FGM by the international community. The World Health Organisation (WHO), the United Nations Children’s Fund (UNICEF), the United Nations Population Fund (UNFPA) and the Special Rapporteur on violence against women condemn all forms of FGM and reject its justification on any grounds. UNHCR also opposes this practice as a violation of fundamental human rights.

Additional information regarding FGM can be found in WHO’s Information Kit on FGM, available in English and French, and the Joint WHO/UNICEF/UNFPA Statement on FGM.

Other References:

- Inter-Agency Field Manual on Reproductive Health in Refugee Situations (UNHCR)
- HOW TO GUIDE - From Awareness to Action: Eradicating FGM in Somali Refugee Camps in Eastern Ethiopia (PTSS 1997)
- A variety of videos on FGM in several African countries can also be obtained from PTSS.

² See note 1, Joint WHO/UNICEF/UNFPA statement.

II. Early Childhood Marriage

The World Health Organisation recommends that the minimum age of marriage for girls should be 18 years. In parts of Asia, forty percent of women are married by the age of 18, with many married before reaching puberty.³ Men, on the other hand, tend to marry at a later age. Harmful traditional marriage practices also exist in Africa. In East Africa and Nigeria, the number of girls married at an early age is increasing because young virgins are thought to be less likely to be infected with HIV/AIDS.⁴

Early childhood marriage often involves girls being withdrawn from school and early pregnancy. Early maternity lessens the life expectancy of girls and adversely affects their health, nutrition, education and employment opportunities. Their lowered economic participation rate in turn may lower their worth to families as income earners.

Early childhood marriage has been linked to extremely high maternal and child mortality rates in parts of Asia. A factor that contributes to the high mortality rates is women under 18 years having unspaced and recurrent pregnancies, often in search of a son. Since many young mothers are still physically developing themselves, there may be competition for nutrition between the foetus and the young mother, leading to nutritional deficiencies for mother and baby. According to UNICEF, no girl should become pregnant before the age of 18 because she is not yet physically ready to bear children.

Discriminatory feeding can start as soon as girls are born because boys are considered the future breadwinners for a family. When those girls become wives and start to bear children, they will generally eat the residual food at meals and will not be aware of the need to take nutritious food during pregnancy. Malnutrition is common among poor lactating mothers. Malnutrition, including anaemia, is especially prevalent among women who have many, closely-spaced pregnancies, rendering them vulnerable to diseases adversely affecting their health and the health of their family.

Female education appears to push up the female mean age at marriage, bring down infant mortality rates and depress fertility. Marriage patterns are directly related to the education levels of women. In societies where female literacy is high the proportion of married women between 15 and 19 years is very small and virtually disappears with universal female literacy. Consequently, infant mortality and total fertility (number of children) decrease as women's education level rises.

III. Son Preference

The practice of son preference is the preferential treatment by parents of male children. This often manifests itself in the neglect, deprivation or discriminatory treatment of girls to the detriment of their physical and mental health. Son preference is primarily found in Asia, but also commonly occurs in Africa. Its intensity varies from one country to another. Some of the areas that have been identified as being the most affected by this practice are South Asia (Bangladesh, India, Nepal, Pakistan), Western Asia (Jordan, Syrian Arab Republic,

³ Report of the second United Nations Regional Seminar on Traditional Practices Affecting the Health of Women and Children, E/CN.4/Sub.2/1994/10, par. 47.

⁴ Preliminary Report of the Special Rapporteur on traditional practices affecting the health of women and children, Mrs. Halima Embarek Warzazi, E/CN.4/Sub.2/1995/6, par. 29.

China) and some parts of Africa (Algeria, Cameroon, Egypt, Liberia, Libyan Arab Jamahiriya, Senegal, Tunisia, Morocco).⁵

While the historical roots of son preference are attributed to the existence of patriarchal societies, it is perpetuated by the traditional role of men in agriculture and as property owners. Additionally, in Africa the preference for sons may be based on erroneous religious interpretations. In situations of extreme poverty, the parents may feel it is more important to ensure the survival of sons rather than daughters.

Son preference manifests itself in a number of ways, all of which have negative repercussions for girls and women. Discriminatory treatment of girls and women can arise in the following areas:

- family nutrition: Girls will be breastfed for a shorter period than boys in order to hasten conception to try to produce a boy. In families where food is scarce, the most nutritious food is reserved for boys and men, who may also be fed first, with the leftovers feeding women and girls resulting in higher incidences and degrees of malnourishment and mortality among female children.
- health care: Boys are likely to receive medical attention before girls. Additionally, girls may be taken to traditional healers, while boys are more likely to be taken to qualified physicians. Expenditures for treatment of girls may be half of that spent on boys. One country found that when measles immunisation was provided free of cost the proportion of boys and girls being immunised was almost equal, but when a small fee was charged the proportion of girls fell to 25%.
- education: Families with higher incomes may send both boys and girls to school, but poorer families choose to send the boy rather than the girl. Girls may also be kept out of school to work in the home or fields. In some parts of Asia, women form two thirds of the illiterate population. In addition to extending educational opportunities to women, the curricula, textbooks and teaching material must not reflect gender stereotypes.
- age of marriage: Some parents prefer to marry their daughters at an early age because girls are an economic liability; an Asian proverb which reflects this sentiment states “bringing up girls is like watering the neighbour’s garden.” WHO recommends that the minimum age of marriage be 18 years old. (See Early Childhood Marriage)
- inheritance: In some societies, property and other possessions are only passed down to the son or revert back to the father’s family. Wives and daughters will not only be deprived from sharing in the family’s wealth, but may find themselves economically destitute upon the death of a husband or father.
- recreation: Girls from poor families are expected to help with house and fieldwork, while boys may be exempted from this type of responsibility. As a result, girls may be allowed less time for recreation which is essential to their growth and development.
- employment: Compared with men in certain areas, women have fewer opportunities for remunerative wage employment and less access to skills training which makes employment possible. Women may also be denied access to better paid positions.
- female foeticide or infanticide: In certain South Asian communities, amniocentesis tests and sonograms for sex determination are followed by abortion of female fetuses.

⁵ Preliminary Report of the Special Rapporteur on traditional practices affecting the health of women and children, E/CN.4/Sub.2/1995/6, par. 25.

IV. Dowry

Dowry is a socially-legitimised payment normally given by the bride's family to the groom. Historically in many societies dowry was socially beneficial for the woman, so that in times of emergency the woman had assets of her own to rely on. It is the violent reactions by the groom and/or his family when the bride's family fails to pay dowry that can make this a harmful traditional practice.

In parts of South Asia, dowry crimes are on the rise.⁶ Failure to provide the appropriate amount of dowry can mark the beginning of family violence against the woman. She may be verbally abused, mentally and physically tortured, starved and, in certain communities, even burnt alive by the husband and/or his family members. The practice of dowry is condemned by the international community in situations where brides are harmed due to unmet dowry payments. In such cases, the state is obliged to intervene, although in some countries or areas it may not. An additional concern is that younger brides may fetch lower dowries, encouraging parents to marry off daughters at a young age. Moreover, girls may intentionally be fed less by families because some believe that a high caloric diet makes girls reach puberty faster and hastens the need to arrange for dowries.

⁶ Report of the second United Nations Regional Seminar on Traditional Practices Affecting the Health of Women and Children, E/CN.4/Sub.2/1994/10, par. 55.