FACTORS AFFECTING HEALTH SYSTEM RESPONSE TO THE REDUCTION OF FGM/C IN NIGERIA, A LITERATURE REVIEW

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A thesis submitted in partial fulfillment for the requirement for the degree of Master of Public Health

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The Thesis: "**Factors affecting health system response to the reduction of FGM/C in Nigeria, A Literature Review"** is my own work.

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List of Abbreviations

FGM/C	Female Genital Mutilation / Cutting
WHO	World Health Organization
USD	United States Dollar
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
PHC	Primary Health Care
NDHIS	Nigeria Demographic and Health Survey
GDP	Gross Domestic Products
NPC	Nigeria Population Commission
VAPP Act	Violence Against Person Prohibition Act
NGOs	Non-Governmental Organizations
FMOH	Federal Ministry of Health
NHIS	National Health Information System
HCP	Health Care Providers
HRH	Human Resources for Health
SRHR	Sexual Reproductive Health Rights
NSHDP II	National Strategic Health Development Plan II(2018-2022)

Glossary

Health System: Complex adaptive social system comprising of people and organizations that constantly interacts with each other to accomplish specific health outcomes and goals shaped by underlying values and principles (Olmen et al., 2012)

Medicalization: FGM/C conducted by health care providers either in or outside a medical Facility (W.H.O, 2010)

Health Care Providers: Doctors, Nurses/Midwives, Community Health are Officers(NDHS 2019)

Health System Responses: FGM/C prevention, protection, and medical management of complication arising from FGM/C including psychological services.(Population Council, 2020)

FGM/C healthcare services: Prevention services (counselling, health education), Management of medical complications from FGM/C, psychological care, and protection services (identification of at-risk women & girls)(WHO, 2018)

Sexual Reproductive Health services: Sexual and Reproductive Health services include Antenatal, post-natal, delivery, family planning services and HIV/AIDs services

Sustainable Development Goals (SDG): 17 Global goals of the United Nations set to be achieved by the year 2030.(UNFPA, 2020)

Human Right: Set of standards of rights inherent in every human irrespective of sex, gender, race or religion secured by international laws**.** (Human Rights, United Nations)

Cultural values: Set of principles, ideals and conducts shared by community members influencing individual behaviors and community practices(28 Too Many, 2019)

Power Dynamics: Imbalance power relationship between persons. (28 Too Many, 2019)

Decision Making: Decision-making entails specific discussions and or actions that result in a girl or woman being cut or not cut.(28 Too Many, 2019)

ABSTRACT

Background:
Nigeria has the third largest population of girls and women that have undergone FGM/C globally, estimated at over 19.9 million women& girls. More women & girls are still at risk of FGM/C each year in high risk countries as population growth increases. The health system provides a good platform to protect and prevent health burden that arises from FGM/C. This study provides an analysis of the factors that affects health system responses to the reduction of FGM/C in Nigeria**.**

Methods: A Literature review was conducted , the health system dynamic framework (Van Olmen et al., 2012) was used to analyze factors affecting health systems responses for the reduction of FGM/C in Nigeria.

Results: The law provides legitimacy for involving the health system and instead of the law used as a tool to protection of women and girls at risk of cutting it is rather used to prosecute offenders driving the practice into secrecy. Cultural values and principles that favor negative gender roles such as male dominance in decision making affects how women and girls perceive and seek FGM/C prevention and care services. Health system components, governance, resources, service delivery, health workforce, health information and finance are interdependent factors that affects the overall health system function to meet the needs of the community.

Conclusion: The health system alone cannot accomplish decline in FGM/C without all the components of the health system functioning together with the population as the community actively involved in the overall responses to address the issue of FGM/C in Nigeria.

Recommendation: Health care providers should utilize the law as tool to protect women and girls from FGM/C through advocacy and community sensitization. Intensify communities based behavioral & social norm change program to address cultural values that supports FGM/C and gender inequalities at community level through active partnership between healthcare providers and the community.

Key Terms: FGM/C Health Systems, Governance, Law, Community involvement, Sexual Reproductive Health services

Thesis Word Count (12,483 words)

Introduction

The recognition of FGM/C as a public health problem and a human right issue affecting women and girls is a global concern that calls for its reduction and ultimately its elimination (UNFPA, 2020b ; UNICEF, 2016) The WHO referred to FGM/C as violation of the rights of women and girls. FGM/C is defined as "all procedures involving partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons." Major health impacts include immediate genito-urinary, gynecological , obstetric, sexual & psycho-social consequences. (WHO 2020) Beyond the health consequences of FGM/C , the cost of addressing these health impacts of FGM/C was estimated at 1.4 billion USD annually in 27 high FGM/C prevalent countries of the world. (Kimani, Muteshi & Njue, 2016) The health system offers a good platform to address the health impact that arises from the practice of FGM/C and also to mitigate the economic burden by preventing the practice. (Dirisu et al. 2020) The key objective of any national health system is to respond to the issue of FGM/C by providing prevention and protection services, medical and psychological management of complications arising from FGM/C anchored in legal / policy documents guiding actions specific to the country context (Population Council 2020).

The Nigerian government has taken steps to address the problem of FGM/C in line with global and regional commitments such as the Maputo protocol, sustainable development goals (SGD) etc. Similarly, the enactment of national legislations prohibiting the practice of FGM/C is a basis for involving the health system for prevention ,protection and management of FGM/C complications with psychological services to women and girls in the country (28 Too Many 2018) (Dirisu et al. 2020)(Population Council 2020) Building on this, the national health system has taken action to address FGM/C through development of national policies and laws guiding FGM/C reduction activities, prohibition of medicalized FGM/C among health care provider and capacity building for service provision and many more (Dirisu et al. 2020) Despite these efforts, health system responses have been referred to as suboptimal and weak in responding to the reduction of FGM/C in the country. (ibid)(NSHDP II 2018). Several factors have been implicated to affect the current responses of the health system to address this and it is my utmost interest to explore these factors and how they interact together to affect health system responses to FGM/C in Nigeria.

My keen interest in this study came from my experience as a public health officer working with civil society organizations on the UN joint program on the elimination of FGM/C in Nigeria. Findings from this study will provide fresh insight into health system factors and responses to FGM/C in Nigeria and further contribute to the overall efforts to achieve the sustainable development goal of eliminating FGM/C by 2030.

Structure of the Thesis

Chapter 1 of the thesis describe general information on Nigeria, the distribution & prevalence of FGM/C, overview of the national health system, health indicators, sexual reproductive health care services and overall health system outcomes & goals for the country specific to FGM/C. Chapter 2 provides in detail the problem statement justification for the study and study objectives. Chapter 3 focus on the methods used to pursue the study objectives i.e. the conceptual framework for analysis, study type, search strategy, inclusion & exclusion criteria. Chapters 4 to 6 presents the analysis of factors affecting health system responses for the reduction of FGM/C. Chapter 7 examines selected best practices conducted in FGM/C practicing settings contributing to a reduction in the practice of FGM/C Chapter 8 reviews findings including limitations of the framework utilized for the study. Chapter 9 is the last chapter presenting conclusions and recommendations in groups according to target stakeholders i.e. academic community, federal ministry of health to improve health system responses for the reduction of FGM/C in Nigeria.

1.0 CHAPTER ONE: BACKGROUND ON NIGERIA

This chapter describe general information on Nigeria, the distribution & prevalence, broad overview of the national health care system and its structures, health indicators, sexual reproductive health care services and health system outcomes & goals for the country.

1.1.1 General Information on Nigeria

Nigeria is a country situated in west Africa with a current estimated population of approximately 202 million people which is about half of the whole population in the region. The country is culturally diverse with multiple ethnicities organized into 36 states in a federal system of government. Geographically, the country is a southern low land merged into central hills and plateaus with mountains in the southeast and plains in the North. The country shares its boundaries with countries such as Benin, Cameroon, Chad and Niger (Nigeria country profile 2019). An estimate of about 80.2 million (49. 5%) of the country's total population are females compared to the 50.5% composition of males.(Nigeria population country meters 2020)

1.1.2 Overview of FGM/C in Nigeria

Nigeria has the third largest number of women and girls that have undergone FGM/C in the world, with a national prevalence of 20% among women (15-49 years) (UNICEF 2016). Currently, the country ranks as one of the top five (5) countries with the highest rates of FGM/C (13%) reported to have been performed by health care providers such as doctors, nurses/midwives and community health workers. (DHS 2018). FGM/C has no health benefits for girls & women, and it is also recognized as a violation of the rights of women & girls. Predominantly, FGM/C is recognized as an extreme form of discrimination against women grounded in inequalities between men and women. (UNFPA 2020a) FGM/C is known to have no health benefits, and is associated with chronic pain, infections , psychological consequences and increased risks for adverse obstetric outcomes as compared to women who had not undergone FGM (Kimani, Muteshi & Njue, 2016). In line with the W.H.O classification FGM/C is typified into four (4) major categories , according to the extent of anatomical cutting of the external female genitalia. (W H O, 2020) In Nigeria, the most common types of FGM/C practiced among women 15-49 is the type 2 (removal of the inner folds of the vulva) estimated at 41% of the overall prevalence, type 1 (removal of a part or all

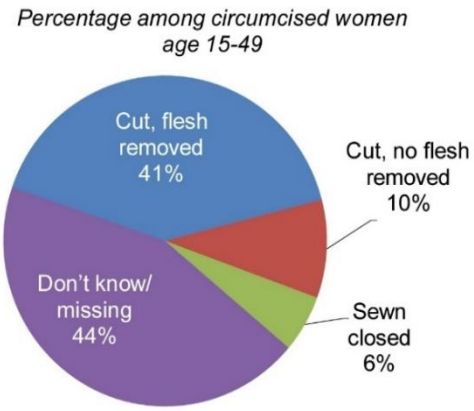

Figure 1: proportion of women 15-19 cut in Nigeria

of the clitoral tissue or glans) estimated at 10% and 6% for type 3 (infibulation, this is the narrowing of the vaginal opening) (DHS 2018).

Table 1: W.H.O Classification of Types of FGM/C

TYPES	BRIEF EXPLANATION
Type 1	This involves the removal of a part or all of the clitoral tissue or glans (the sensitive part of the female external genitals) and/or with the prepuce /clitoral hood (the surrounding skin fold around the clitoral area).
Type 2	this is the partial or total removal of the clitoral glans and the labia minora (the inner folds of the vulva), with or without removal of the labia majora (the outer folds of skin of the vulva).
Type 3	Known as infibulation, this is the narrowing of the vaginal opening through the creation of a covering seal either by sewing or cutting with the repositioning the labia. In some instances, it includes stitching with or without the excision of the prepuce /clitoral hood and glans.
Type 4	Known as unclassified and includes all other harmful procedures to the female genitalia for non-medical purposes, such as incising, burning, rubbing, piercing, pricking, scraping, cauterizing and introduction of corrosive substance or herbs to cause bleeding, tightening and narrowing of female external area including the vagina.

Source: (WHO 2020)

1.1.3 Prevalence and Distribution of FGM/C in Nigeria

National prevalence of FGM/C in Nigeria was estimated at 20%, contributing to the third highest absolute numbers of women and girls (19.9million) that have undergone FGM/C in the world. (UNICEF 2017)(DHS 2018) Nigeria is divided into six (6) geopolitical zones with 36 states including the federal capital territory (F.C.T). The practice of FGM/C is more pronounced in south west and south east zones of the country.(28 Too Many 2016). In details, FGM/C prevalence is highest in the South East (35%), South West (30%) and North West (20.2%). In the south west, states with the highest reported prevalence of FGM/C are Ekiti (57.9%), Osun (45.9%), Ondo (43.7%), Oyo (31.1%) and Lagos State (23.7%). In these states, over 88% of cut was performed on girls from 0 to 5 years old reflecting household decision to perform FGM/C early for girls.(Kandala et al., 2020)
Similarly, states with high FGM/C prevalence in the south west include, Imo state (61.7%), Ebonyi (53.3%) and the sates in the North West include Kaduna state (48.8%), Jigawa state (34.1%) & Kano (22.2%) respectively.(DHS 2018)

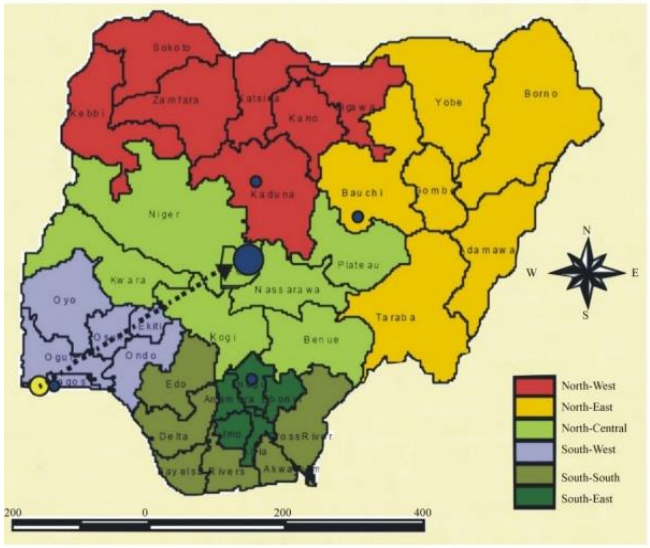

Figure 2: Six (6) Geopolitical Regions in Nigeria

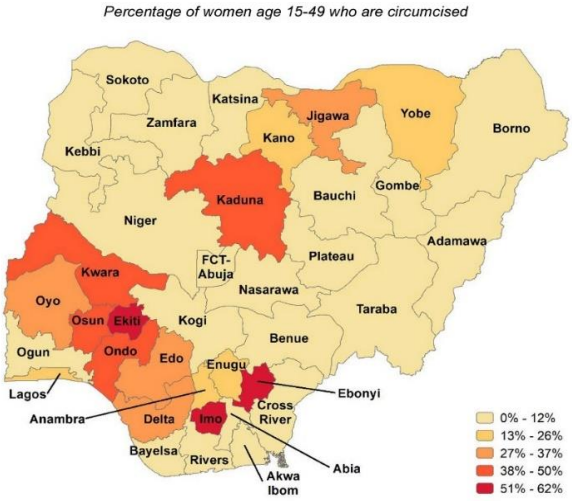

Figure 3: States with High FGM/C Prevalence

FGM/C is mostly carried out during infancy and on girls younger than 15 years, with about 86% of girls are cut between the ages of 0 and 4 (Kandala et al., 2020) (DHS 2018).

1.1.4 Overview of the National health system and structures

The Nigerian health system functions in a pluralistic system with a combination of public and private sectors providing health care services. The public sector is the major provider of health care services compared to the private sector providers of care. The overall public healthcare services is organized into three levels and it is the duty of the three tiers of government to provide oversight. (National Strategic Health Development Plan 2018 p 6)The federal ministry of health is the leading government organization providing oversight and stewardship for the overall health system functions including human resources for health both at public government and private non-governmental health care organizations in the country.(National Health Facility Survey 2017) Private health care providers could be formal and informal sector and they also play a role in the current efforts to address the issue of FGM/C in the country.(Country Policy & Information Note Nigeria: FGM, 2019)

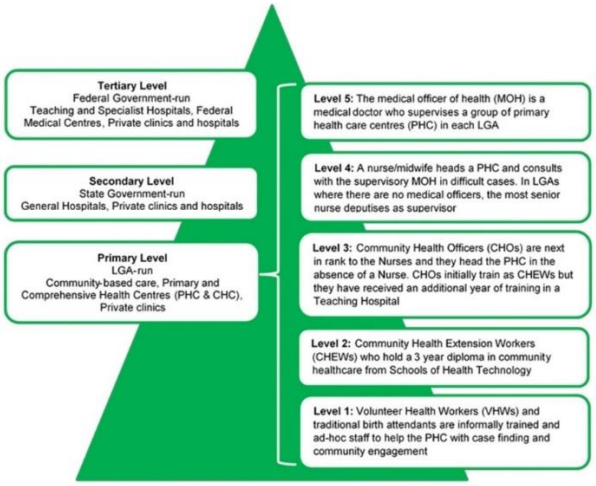

Figure 4: Nigeria Health System

The Violence Against Persons Prohibition Act provides legitimacy for the health system to address FGM/C prevention and care services including right to information and right to comprehensive sexual reproductive health services both at governmental and non-governmental health care facilities in the country.(Kimani & Otibho 2020) National policy and plan of action for the elimination of FGM (2013–2017) and national reproductive health policy (2017) are sector specific policies providing framework for health system responses in the country. These documents both outlines roles and activities of the health sector and its stakeholders such as government, non-governmental organizations including civil society organizations. In addition, these documents include health response strategies relevant for the reduction of FGM/C in the country.(National FGM policy 2013)

The policy context of Nigeria provides the roadmap and plan of action to respond to the issue of FGM/C in the country. The national policy and plan of action (2013-2017) was developed as a combined document together with the plan of action, highlighting priority activities for the elimination of FGM/C across the health sector. Priority actions highlighted include capacity building for prevention and management of FGM/C complications, integration of FGM/C into existing SRH services ,integrating FGM/C module into health care professional training curricula, advocacy for health care professionals regulatory bodies & associations including sensitization against medicalized FGM/C, monitoring & evaluation of FGM/C practices in the health sector, identification & development of data collection tools, information sharing and research.(Kimani & Otibho 2020)

Nigeria has one of the largest stocks of health workforce in Africa. The population ratio of medical doctors in the country was estimated at 38.9 doctors per 100,000 population, which is one of the highest in the region as compared to the regional (sub-Saharan African)

average of 15 doctors per 100,000 population. Similarly, the country has a population ratio of 148 nurses/midwives per 100,000 population significantly above the regional average of 72 per 100,000 population in the region. At present, the country has medical schools(27), nursing/midwifery schools(89), College of health technologies for the training of community health extension workers (56),pharmacy schools (35), schools for other paramedics (>50) and 14 regulatory bodies for health professionals in the country. (National Strategic Health Development Plan 2018 p 33) Human resources for health is currently facing shortage of health workforce due to persistent rapid migration to high income countries with urban rural maldistribution. (WHO Nigeria 2012)

Healthcare providers have been implicated to perform FGM/C i.e. medicalized FGM/C. In Nigeria, recent efforts to mitigate this has been the integration of FGM/C care and management module into the pre service curriculums for in training, engagement of health care provider associations as a means of strengthening regulation against medicalized FGM/C (WHO Nigeria, 2019). Nurses/midwives play a key role in the medicalization of FGM/C in the country, although data reveals over 85% of women & girls were primarily cut by traditional circumcisers(informal private health care providers) however , 7% of girls and 9% of women reported to be cut by medical professionals majorly nurses / midwives (DHS 2018) (Kimani & Shell-Duncan 2018).

The 2016 national health facility SARA (Service Availability and Readiness - SARA2) assessment report, described health care services has mostly clinic-based with minimal health service outreaches conducted to homes or community except for national vaccination activities for children. Referral systems are generally considered from the primary basic care to the secondary and then tertiary health facilities; however the reality often is that tertiary health facilities provide basic primary care services including FGM/C related obstetric care. (National Health Facility Survey 2017)

The national health Information system is built on the DHIS collected in paper-based forms across health facilities in the country. These paper-based forms are collected from routine health facility data harvested from public primary, secondary and private facilities. The paper forms include tools collected monthly at community levels and for patient's care as aggregated data from the local government levels to the national health information system and then to the DHIS. (Gayawan & Lateef 2019) In 2017, the DHIS has an average reporting rate of 72% and remains low at 63%. Most of the DHIS 2 data comes from the primary and secondary health facilities and gross under reporting from the tertiary health facilities and the private providers of health care services . (Nigeria Health Information System Policy 2014)

The Nigerian government spends less on health than any country in the world reflecting under - prioritization of the sector. In 2016, only 0.6% of GDP was spent on health. Financing programs and interventions related to FGM/C has faced persistent low priority by governments in the country. Current activities to address the issues of FGM/C are donor driven with donor funds supporting activities carried out at ministry levels, and implementation activities conducted by selected CSOs over specific high FGM/C prevalent communities across the country.(Dirisu et al., 2020)

Community participation and ownership is recognized has essential for the successful delivery and sustainability of health care services at PHC level. The national health system prioritized community involvement through collaboration and joint decision making with recognized community groups such as the ward health groups, local government development committees at ward level and facility health taskforce team as a means of involving community members in health decisions and programs(NSHDP II, 2018 p 54).

1.1.5 HEALTH INDICATORS

In Nigeria, nearly one third of women (15-49) have no education compared to only 22% of women without education. About half of the population of women (52%) experience at least one difficulty in reaching the nearest health care services with women in rural areas are disproportionately affected. Maternal Mortality is still remarkably high at 512 deaths per 100,000 live births and 43% deliveries are only attended by skilled health personnel.(DHS 2018)

Nigeria ranks 152 out of 157 on the 2018 human capital development index. Human development investment index for the country remains weak due to under investment. General government expenditure on health as a percentage of total government expenditure (2014) was estimated at 8.17(Nigerian note) which is one of the very lowest in the world. Available human resources for health report shows the ratio of physician density has 0.376 per 1000 population while Nurse/Midwife personnel density was 1.489 per 1000 population. (World Bank 2020)Obstetric cost to mitigate the consequences of FGM among women of reproductive age was estimated at almost 600million USD (2018) while economic cost for immediate health complications arising from FGM/C among girls was estimated at almost 400 million USD per annum in Nigeria.(WHO FGM Cost Calculator 2020)

1.1.6 Overview of Sexual Reproductive Health Services in Nigeria

In Nigeria, essential package of health care services includes reproductive services as important components categorized as RMNCAH+N (Reproductive, Maternal, Newborn, Child, and Adolescent plus Nutrition) services. This essential package includes antenatal,

delivery, postnatal, family planning, basic & emergency obstetric services and other specialized RMNCAH+N services. Advancing sexual reproductive health and rights particularly for women is essential to address gender-based discrepancies for the achievements of global SDG goals. (Starrs et al., 2018)The Guttmacher lancet commission highlighted essential package for sexual reproductive health interventions related to FGM/C include the prevention, detection, immediate services, and referrals of cases of sexual & gender-based violence. The Guttmacher Lancet Commission offers a framework for a comprehensive view for defining sexual reproductive health and rights. Integrating components of SRHR into programs and services must "address all aspects of sexual reproductive health and rights effectively and equitably"(Boyer, 2018)

1.1.7 Health System Goals

Sustainable Development goal (SDG) goal 3 and 5 are health-related goal that emphasized good health & wellbeing for all and goal to achieve gender equality by empowering all women & girls. Target 5.3 of SDG goal 5 highlights the need to intensify all efforts to eliminate FGM and all other forms of harmful traditional practices. (Sustainable Development Goals 2015) As part of the SDG development agenda it is essential to address inequalities and violence against women and girls. The health system a plays crucial role to address this through providing support and care including identification and prevention of violence against women & girls. The World health assembly has also called for strengthening the role of the health system to address violence against women and girls. (García-Morenoa & Amina, 2016)

2.0 CHAPTER TWO: PROBLEM STATEMENT, JUSTIFICATION AND OBJECTIVES

Global efforts to eradicate the practice of FGM/C has been unsuccessful with reported uneven decline in prevalence across countries over the last three decades.(Rushwan, 2013; UNICEF 2016; Ashford, Naik & Greenbaum, 2020 pg. 7) While major social behavior change responses have been reported ,little is known about the health system responses to the elimination of FGM/C. (Ashford, Naik & Greenbaum, 2020 p 11) Studies have revealed that global responses from the health care system to achieve reduction in FGM/C has been weak and unclear in most high prevalent countries including Nigeria. (Andro & Lesclingand, 2017),(Shell, 2018) Responses of the health system to address FGM/C goes beyond prevention of medicalized FGM/C. Recent findings have suggested various factors plays a role affecting the overall response of the health system to the issue of FGM/C. (Johansen et al., 2018)

The health system provides good opportunity to facilitate not only the care of FGM/C survivors but also to provide prevention & protection services with the goal of contributing to the overall reduction of FGM/C in Nigeria. However, the national health system response to address FGM/C is suboptimal and weak in providing prevention, protection and medical management of FGM/C as appropriate responses to the reduction of FGM/C in the country.(Dirisu et al., 2020 p 40)(Shell, 2018)

Challenges regarding poor capacity of health care providers to address and provide prevention or management of FGM/C complications has been recognized has either lacking or poor in the country. (Dirisu et al., 2020). (UN Joint Programme phase II, 2018 p 34,85) Similarly, community involvement and linkages with the health system is unclear as the practice of FGM/C is driven by shared cultural values and norms (Obiora, Maree & Nkosi-Mafutha,2020) In addition, the link between national or state legislations prohibiting FGM/C cannot be ascertained and this has been identified to undermined and cripple effective responses of the health system to achieve reduction in the practice of FGM/C in the country.(Kimani & Otibho, 2020)(Dirisu et al., 2020).

The growing population of girls at risk of FGM/C requires coordinated multi sectoral efforts to prevent future cuts through prevention and protection services for women and girls at risk of FGM/C (Matanda, 2020b). The health system has been recognized to offer immense opportunities to mitigate the health impact of FGM/C on women and girls. Health system responses have been identified to include the prevention, and management of complications of FGM/C with policies & protocols guiding sector specific interventions(Shell-Duncan et al., 2020). The W.H.O has called on national governments to improve coordination and regulations of the national health system has instrument for steering the health system effectively.(WHO 2010) Furthermore, global efforts towards

the achievement of the sustainable development goal 5, target 5.3 "intensify efforts to eliminate FGM/C" calls for collaborative efforts across all relevant sectors to achieve this goal.(UNFPA 2020a) To this end, this study reviews health system dynamics as factors affecting responses to the reduction of FGM/C practice among women and girls in Nigeria.

2.2 OBJECTIVES

2.2.1 Study Objectives

The general objective of this study is to analyze factors affecting health system responses to the reduction of FGM/C Nigeria.

2.2.1 Specific Objectives

1.To examine country context such as the law and regulations prohibiting the practice of FGM/C as factors affecting health system responses for the reduction of FGM/C in Nigeria.

2. To discuss underlying values and principles such as cultural values norms, gender & power dynamics affecting health system responses to the reduction of FGM/C.

3. To analyze components of the health system affecting core functions of the health system to responses to the reduction of FGM/C in the country.

4. To explore best practices and interventions conducted in high FGM/C settings that has contributed to the improvement of health system responses for the reduction of FGM/C

5. To provide recommendations to relevant stake holders academic community and the Nigerian ministry of health, improve health system responses to the reduction of FGM/C.

3.0 CHAPTER THREE: METHODOLOGY, STUDY TYPE, SEARCH STARTEGIES

This chapter presents an overall description of the study, study type, search strategies, introduction of the framework, limitations of the study methodology, search terms presented in a table as well inclusion & exclusion criteria.

3.1 Study Type

The study methodology is a rapid review of literature of peered review grey documents, annual national reports, publications from various organizations working on the reduction of FGM/C, fact sheets, national policy documents, research briefs and report of relevant webinars etc. The study provides the analysis of factors such as context factors(legislations and regulations against the practice of FGM/C) , values and principles (cultural values, power dynamics including gender roles) and health system components and population as factors affecting health system responses to the reduction of FGM/C practice in Nigeria. In addition, the study attempts to explore in a different literature search evidence-based intervention in similar high FGM/C prevalent settings as best practices has that contributed to an improved health system response globally. The study was conducted over a period of four (4) months.

3.2 Search Strategies

A systematic overview of search strategy for this study can be found in table 3 of this chapter. Databases such as BMJ, PubMed, Cochrane, Plos One, Vu Library, Research Gates, Academia, Population Council data base, Population reference bureau database were consulted. Grey literature was also obtained from the World Bank, World Health Organization, Population council publication cite, Federal Ministry of Health (FMOH) Nigeria and 28 Too Many reports, UNFPA and UNICEF dashboards KIT evaluation reports. Other relevant grey literatures include project implementation reports, articles, journals, and reports of FGM/C interventions from Tostan organization were retrieved through snowballing.

Main key words used: FGM/C, FGM and or FGC , Health System, Policy, Law, Health care providers, medicalization, prevalence, Nigeria, VAPP Law, health services, FGM/C services, Sexual Reproductive Health services, Outcomes, Goals, Community, Cultural Norms AND OR Values, Gender Based Violence, Harmful Traditional Practices ,Best practice, Evidence Based Practice, Evaluation etc. Key definitions of terms can be found in the glossary. Search strategy will combine key search terms using the Boolean operators AND, OR (see full search table below). Primary search engines include Google and Bing.

Table 2: Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
• Relevant studies on FGM/C in African countries including destination countries of migrants from Africa e.g. UK, Netherlands, Australia, and the United States	• Literature published before 2010. • Literatures published in other languages
• Published literatures in English language from 2010 till date.	• Local CSO implementation report on FGM/C
• Published literatures from 2010 till date.	
• Project report from donor agencies e.g. UNICEF, UNFPA, 28TooMnay, Population council.	

Table 3: Search Table

SOURCES	OBJECTIVE 1	OBJECTIVE 2	OBJECTIVE 3	OBJECTIVE 4
PUBMED Annals of Medical and Health Sciences Research Journals Science Direct Elsevier's Population Council publication BMJ Google Scholar NCBI UNFPA Dashboard WHO Database UNICEF Dashboard	Context FGM AND FGM/C Policy Laws, Legislations AntiFGM Law VAPP law Nigeria Prohibition Political Policy	Health System Health system AND Governance Health system AND leadership AND Health Sector Health services Human resources for Health FGM/C services SRH services Reproductive Health services Capacity Building Obstetric care	Values Cultural norms Cultural Dynamics Power dynamics Decision making Health care seeking beliefs Cultural norms Social AND OR Cultural belief	Best Practices Success stories Successful Interventions Evidence Based Actions Sustainable impacts Sustainable goals

International Journal of Sexual Health **Academia** **Research Gates**		**National Health Information system** **SARA tools** **Health Facility register** **Health Finance** **FGM/C fund OR Budget** **Medicalization AND FGM/C** **Community empowerment** **Quality of FGMC services**		

3.3 Analytical Framework: Health System Dynamic Framework

The framework incorporated the six (6) WHO building blocks and goes beyond, to consider its interaction with the population, in a specific country context. It recognizes the health system as a social system comprising of people and organizations that constantly interacts with each other. The framework further describes the health system as an open system adapting and responding to the environment. (Olmen et al., 2012)

The health system dynamic framework is an integrated framework that serves as a tool for analyzing the health system as part of the society with population i.e. people playing a central role in the overall function of the health system. In addition, it serves to analyze the practice of FGM/C not only a health issue, but a social issue driven by people's beliefs and cultural practices with adverse health implications. The framework is a tool that acknowledge that the health system is composed of many actors and organizations that interact with each other, geared towards specific health outcomes and goals constantly influenced by values and principles. Furthermore, the framework asserts that the health system is constantly adapting and responding to its environment which include legal, and policy environment that can determines health outcomes and goals (i.e. reduction and elimination of FGM/C) in a specific population.(Olmen et al., 2012)

The frame work consists of ten parts organized from 1)the overall goals and Outcomes 2) Values and principles 3) service delivery 4) the population 5) the context 6) leadership & governance, and the last part is collectively referred to resources that includes 7) finance 8) human resources 9) infrastructures and supplies 10) information & knowledge.

For this purpose of this study, these ten (10) parts of the framework will be analyzed in three (3) parts in line with the study objectives. The first part is the Context, then Values & principles and thereafter Health system.

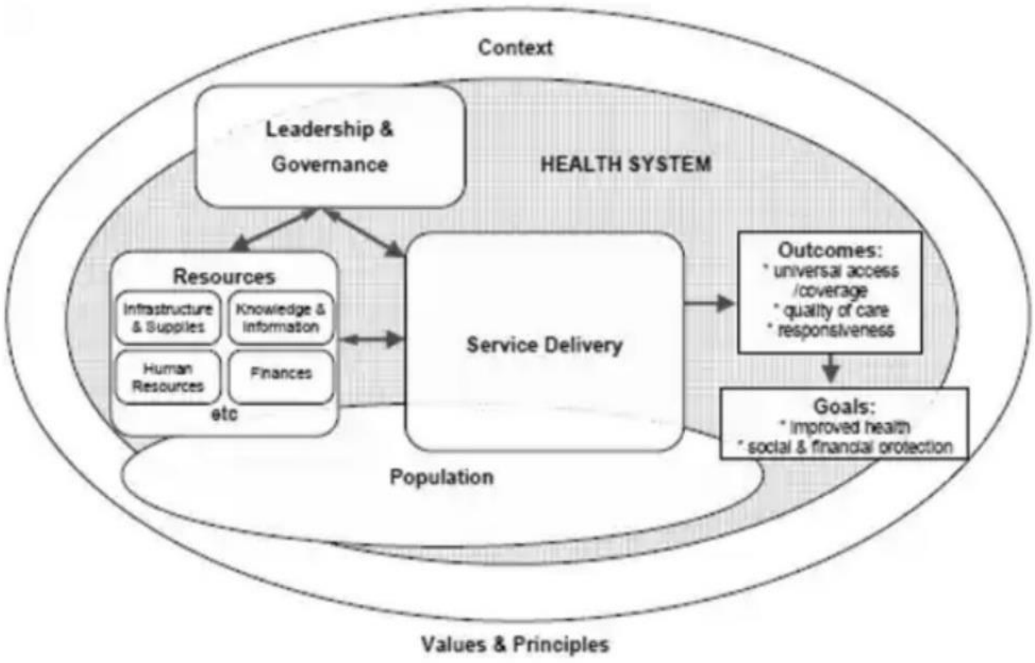

Figure 6: The Health System Dynamic Framework(Olmen et al., 2012)

3.4 Limitations of the methodology

Literature search for this study is based on published and grey literature written only in English language. Studies written in Arabic, French, Swahili and Spanish were excluded from the study. Snowball strategy was used to identify some literature of best practice. Similarly, some literature may be unconsciously omitted due to publisher restrictions however, important, and useful documents were utilized for the purpose of this study.

4.0 CHAPTER FOUR: CONTEXT

This chapter presents the country context i.e. law and regulations prohibiting FGM/C as factors affecting health system responses for the reduction of FGM/C practice in Nigeria.

Review analysis of the law and legal landscape for the health system in Nigeria revealed rich legal and policy environment guiding responses for the reduction of the prevalence of FGM/C (Kimani & Otibho 2020) The core framework for Nigeria's response to the reduction of FGM/C practice is the legislative recognition and protection of the fundamental human rights and the rights to the dignity of persons. (Ngozi, Iyioha & Durojaye, 2018) Review of global and regional commitments recognized Nigeria together with other thirteen (13) African countries has nations that has adopted and ratified these commitments into national constitutions, legal & programmatic framework has responses in place at country level. (Anouka et al., 2018) p 38 - 40).

At country level, the VAPP Against Persons (Prohibition) (VAPP) act of 2015 is recognized as key response aimed to eliminate gender- based violence in private and public life by criminalizing violence against women and girls including harmful traditional practices such as FGM/C. The VAPP act is both protective and preventive in its measures which provides legitimacy for the health system to perform both roles as a response to the elimination of FGM/C in the country(Ngozi, Iyioha & Durojaye, 2018). However, the impact of the VAPP act has been reported as limited due to the existing legal structure of the country that requires all the 36 states of the federation to adopt and enact laws at state levels. Currently only 14 out of 36 states so far as adopted the VAPP law prohibiting FGM/C.(Country Policy Information Nigeria 2020) States who are yet to adopt the law may hamper efforts to curb coordinated response as girls are been taken to other states where the VAPP law is not in effect for demand of FGM/C services from health care providers. (Otibho,2020)

In broader context, laws prohibiting FGM/C has been reported to be more effective in facilitating prosecution of violators of the law rather than protecting women and girls who are at risk of FGM/C. (Kandala & Komba, 2015 p 845) The current legal provisions prohibiting the practice of FGM/C by health care professionals is not clearly stated in the VAPP act and thus addressed in the broad context as a criminal offence punishable by law (Ngozi, Iyioha & Durojaye, 2018). Regulation of medical malpractices by authorities regulating professional codes and conducts for medical doctors issued specific penalties, under the medical dental practitioners rule and the 2004 medical act criminalizing the act of performing FGM/C by any registered medical doctor in Nigeria(28 Too Many 2018).

The weak link between the law (VAPP) and regulatory body for health care professionals such as the Nigerian Medical Association, Nursing Midwifery Council of Nigeria and other allied health care providers revealed nil evidences of enforcement against the practice of FGM/C.(28 Too Many 2018)

A recent study argued that the intent of legislations prohibiting the practice of FGM/C is to serves as a catalyst for social change and foster enabling environment. (Nabaneh &

Muula, 2019) However, this claim has been perceived as driving the practice underground and not necessarily a guarantee that women and girls will be protected from FGM/C. Evidences from various studies reported that local variations in the practice of FGM/C by health care providers occurs alongside a substantial decline in the rates of FGM/C from 38% to 21% over a period of 16 years (Serour, 2013;Shell-Duncan, Moore & Njue, 2017 pp 22 - 23;Shell-Duncan, 2018 p 11; Bedri et al., 2018; Nabaneh & Muula, 2019)

Various literature and policy reviews emphasized that the law serves as a formal framework and legitimacy for the health system to prevent and prohibit the medicalization of FGM/C. Similar findings also reiterated the dilemma healthcare providers encounters between ethical duties and disclosure of FGM/C status to law enforcement authorities thereby raising issues of confidentiality.(Kandala & Komba, 2015)(Shell-duncan, 2018)(Kimani & Shell-Duncan, 2018)(Kimani et al., 2020b).Evidences from 25 countries also reflected that the extent of FGM/C legal regulation to reduce medicalized FGM/C could not be established as a casual association and ongoing debates on the effect of the law on regulation of medicalized FGM/C is still a hot debate (Shell-Duncan, Moore & Njue, 2017; Leye et al., 2019). Similar trends was observed in Senegal where the enforcement of anti FGM/C law is driving the practice of FGM/C underground due to fear of prosecution from law enforcement agencies. (Kandala & Komba, 2015) Another cross sectional qualitative study conducted in Ethiopia reiterated the potential for legal restrictions and enforcement of the law can become a major hinderance and limitation to the success of FGM/C programs.(Mehari et al., 2020)

Conflicting view about the law prohibiting FGM/C in Burkina Faso linked harsh enforcement and complementary implementation of the Law prohibiting FGM/C proved beneficial. The view identified respect for the law as a major driver for abandonment for some families.(Wouango, Susan & Mwanga, 2020)

5. 0 CHAPTER FIVE: VALUES AND PRINCIPLES

Values and principles form the underlying factor of the health system dynamic framework. This chapter presents cultural values and principles and gender roles especially the role of men and older women in decision making as factors affecting health system responses to the decline of FGM/C.

5.1 Cultural values and principles

FGM/C is rooted in deep cultural values shared and accepted by individuals and communities affecting values people place on the health system (Sheikh, Ranson and Gilson, 2014) In Nigeria, cultural values driving the demand and practice of FGM/C is rooted in the belief that FGM/C curbs promiscuity among unmarried women, provides aesthetic view of the female genital, physical sign of marriageability, to control women's sexuality and the belief that it enhances fertility etc. (Oyefara, 2014;Onyima, 2015) A study, pointed out that the strong influence of shared cultural principles on the issues of sexuality and FGM/C plays a role in decision to use health care services.(Evans et al., 2019) For instance, in some settings ,marriageability , search for suitable male partner and ideology that the female sexual drive must be controlled by men has been identified as reasons given for the practice of FGM/C (Moreau & Shell-Duncan 2020 p 34 -38)

Five (5) studies conducted in Nigeria identified that health care providers who share the same cultural values that promotes the practice of FGM/C with the community they live in favor the practice of FGM/C. The supply of FGM/C performed by health care providers increase in such communities as health care providers are themselves part of the social system that drives the supply of FGM/C. These findings reemphasized the influence of common shared belief and perception of FGM/C as a major drive for the practice of FGM/C within the health system.(Okeke, Anyaehie & Ezenyeaku, 2012; Shell-Duncan, Moore & Njue, 2017; Mberu, 2017).

Another study identified cultural norm as a factor affecting how individual seek care and how care services are delivered. The study, reiterated that these norms around health and sexuality influences behaviors that hinders the use of healthcare services Example of such include the norm of accepting the consequences of FGM/C as a woman's burden and avoiding male health care providers during health facility visits etc. This strong cultural norms imposed on women and girls hampers the prevention role and provision of medical care for women & girls. (Evans et al., 2019) Similar studies conducted in semi urban high FGM/C prevalent communities in Nigeria associated individual perception of health as a driver for attitude towards health and ultimately health care seeking behaviors.

The study revealed that women with poor perception of FGM/C are not likely to seek FGM/C counseling and management services despite bearing the burden of the

consequences of FGM/C (Olabisi, Olumuyiwa & Saidat, 2019). Another cross-sectional study conducted among young Somalis migrants in Norway who have undergone FGM/C reported that lower proportion of women using FGM/C care services and attributed it to poor perception of the consequences of FGM/C among women & girls. (Mbanya et al., 2018) The overall effect of this cultural values and practices is a violation of human rights and the right to health imposed on women & girls subjected to FGM/.(Fisaha, 2016)

5.2 Gender and FGM/C

Gender roles assigned to men and women in the community influences decision to cut women and girls in high FGM/C prevalent communities.(28 Too Many 2019)

In Nigeria, patriarchy is reinforced by gender norms driven by cultural & religious beliefs as male dominance is socially acceptable. This male dominance practice reflect from household domestic level to discriminatory practices in public structures that encourage gender exclusion from both private and public decision arenas. (Igbelina-Igbokwe, 2013)

In Nigeria, decision to perform FGM/C is not without the father's knowledge and Fathers hold the power in the final decision to perform FGM/C and by whom. Women are merely enforcers of decision taken by men, as mothers are the ones who will take the child or the woman for cutting but this does not undermine that the decision-making power of men over women's decision. In some settings grandmothers or mother in law influence the decision making especially in South east Nigeria compared to the male dominance in the Northern Nigeria driven by religious rules.(Obianwu, Adetunji & Dirisu, 2018)

A cross sectional study conducted in Sudan presented similar decision making structure where men are listed as key decision makers for FGM/C even though older women such as mother in law are enforcers of the decision to cut(Gamal et al , 2018 p 30; Kandala, et al., 2020 p 34) Others studies have revealed that the perception of FGM/C as a means to curb promiscuity and maintain polygamy because it reduces the likelihood of premarital sex is a major driver for men to support FGM/C in countries like Senegal, Mali , Guinea and Somalia.(Ruiz et al., 2014 pg 635 - 638; Varol et al., 2015) A descriptive study conducted in Gambia among men revealed the divide between married men /male household heads who takes major decisions on behalf of the family compared to men who are not married who are less involved in decision making. The study further shows that decision making process for FGM/C at household levels is influenced by multiple actors such as mother, relatives, and community members. Likewise women without husbands support for not cutting daughters face risk for community / family sanctions or social isolation in a patriarchal society.(Kaplan et al., 2013 p 4, 9)

A recent land scape review of literature conducted across sub-Sahara Africa countries on women who have undergone FGM/C identified decision making power as an important

barrier influencing decision to use of FGM/C health care services. Husband and family members such as mother in law or grandmothers are key decision makers to seek healthcare. This decision-making structure place the woman as subordinates creating a barrier for her to contact the health care system for health needs arising from the practice of FGM/C. In the advent that women and girls do not receive appropriate support from primary decision maker (male household heads), demand for health care services tend to be constantly hampered due to lack of financial support from the man and fear of facing the risk of family /community sanctions. Cultural/ social values that does not place value on women's autonomy and rights over her body and the right to informed decision about their health and health care services are major obstacles for health system response to address the issues of FGM/C in high prevalent communities.(Mbanya et al., 2020)

6.0 CHAPTER SIX: HEALTH SYSTEM

The chapter examines expected outcomes of the health system and its components of the health system itself such as governance & leadership, service delivery, resources for health as factors affecting overall responses to the reduction of FGM/C in Nigeria.

6.1 OUTCOMES

Expected outcome of the health system is the reduction of FGM/C through the provision of prevention, protection, medical and psychological management of FGM/C and accurate measurement of results of declines of FGM/C cases in the country.

6.1.1. Responsiveness

The health system responds to address the issues of FGM/C through prevention, protection and medical management of complications arising from cutting including psychological counselling of women & girls in communities practicing FGM/C. (Population Council 2020) The WHO guidelines on the management of health complications from FGM/C is a global standardized guideline providing evidence informed recommendations for the management of health complications arising from FGM/C.(WHO 2016) In Nigeria, the absence of guidelines for the management of complications of FGM/C for medical doctors, nurses/midwives is a huge deficiency that negatively impacts quality of health services provided to women and girls with or at risk of FGM/C. The lack of clinical guidelines has been associated with health care providers relying on personal judgements about the health care needs of women & girls, thereby providing inconsistent treatment approaches and subsequent poor quality of care that negatively affects health outcomes.(Dirisu et al., 2020)

6.1.2 Measurement of Decline of FGM/C

The two main sources of nationally FGM/C data are the DHS and MICS surveys. Reference guides suggest the need to compare data from multiple surveys with considerations on subnational alterations, shifts in borders & boundaries and alterations of sample size across different subregions in the country. (Population Reference Bureau 2018) In recent times issues around measurement are emerging and the constant debate of what are valid measures and appropriate tracking of change is crucial to understand the progress towards expected outcome of reducing the prevalence of FGM/C. Measures of change heavily relies on the availability of quality data as evidences for responses to address the issue of FGM/C.(Population Council 2020; Matanda,2020a)National prevalence of FGM/C in Nigeria among women 15-49 increased from 2003 and peaked in 2008 thereafter experience an overall decline form 2008 till 2017 however among girls 0-14 less pronounced decline was observed which reflects a persistent FGM/C practice in the country. National prevalence tends to mask subnational variations including hotspots,

observed in the steady decline in the South West zone in contrast with an increase in prevalence in the North West part of the country. (Kandala et al., 2020)(Population Council 2020) Similarly, recent growing discussion on the health system offering an enabling environment supporting the documentation of FGM/C by health care providers. Hospital visits presents an opportunity to discuss prevention of FGM/C and reduce error of under or mis reporting that comes with self-reporting of FGM/C status. In addition, the potential of the health system to collect routine FGM/C data at clinical level compensate for the infrequent national population surveys data on FGM/C generated every 5 years. The limitation of national population surveys in countries with law prohibiting FGM/C increases the chances of under reporting or mis reporting and the health system provides a rich source of real time data.(Matanda, 2020a)

6.2 Health Governance and Leadership

The ministry of health as the leading organization providing oversight of health services by developing guidelines including monitoring health service operation and providers of health care services both at government and non-government organization in the country. The VAPP law provides legitimacy for the health system to address FGM/C prevention and care services including right to information of available health services and entitlement to comprehensive sexual reproductive health services both at governmental and non-governmental agencies in the country.(Kimani & Otibho, 2020). The national policy of FGM/C document is saddled with duplication of roles and responsibilities with unclear links for collaboration between different stakeholders and actors relevant to health system function(National FGM policy 2013; Uneke et al., 2012; Dirisu et al., 2020) A review of subnational health system efforts reflects ineffective coordination of anti FGM/C activities and program at state levels despite the existence of state ministry of health and committees for health such as the child protection unit (CIPN) (Dirisu et al., 2020)(Kimani & Otibho, 2020). Similarly, the same review identified the absence of standard guidelines and for the medical management of victims of FGM/C visiting health care facilities the country (Dirisu et al., 2020)

The national FGM/C policy and action plan (2013-2017) is both a combined policy and plan of action document was developed to aid the simultaneous completion of policy formulation and avoid undue fatigue of prolonged policy process.(National FGM policy 2013) However the impact of this combined approach to policy development has not been reviewed.(Kimani S. & Otibho, 2020) Findings revealed absence of specific guidelines for the prevention and management of FGM/C instead the government alternatively developed standard guidelines for the medical management of victims of violence in Nigeria developed the federal ministry of health to provide guidance for health care services.(Kimani and Shell-Duncan, 2018)(Kimani & Otibho, 2020)

A recent study from population council Nigeria revealed poor government ownership and prioritization of FGM/C programs which hinders its sustainability. Poor coordination and linkages between different levels of care has resulted into unclear roles and duplication of duties which may hinder FGM/C response both at national, state, and local levels. The unclear responsibilities implies ineffective FGM/C responses for a sustained change.(Dirisu et al., 2020)

Two (2) recent studies, similarly, highlighted weak coordination and collaboration existing between the government and relevant health system stakeholders such as the health professional associations and its regulatory bodies, non-governmental organizations including civil society organizations. Findings identified unclear role of these healthy sector stakeholders at national and state levels in policy processes and implementation, contributing to the weak efforts of the health system in the reduction of prevalence of FGM/C (Mberu, 2017;Dirisu et al., 2020)

6.3: Service Delivery

Globally, health providers have been said to lack knowledge on the management and care of FGM/C. A systematic review of literature found scanty quality studies assessing the experiences of health care professionals in clinical settings providing care and management of FGM/C. (Kmietowicz, 2015) . In Nigeria, findings from a case study conducted in Imo state by population council reiterated that health workers indicated limited capacity and skills to provide psychosexual support, counseling, and management of FGM/C complications. The same study identified that only a few selected health facility have at least one health care provider that can provide psychological/psychiatric services to victims of FGM/C (Dirisu et al., 2020 p38)

Similar findings was revealed in a systematic qualitative review of literature from 14 destination countries for African migrants coming from high FGM/C prevalent countries of origin , shows that FGM/C related services can be hampered and suboptimal due to the poor skill and expertise of health care providers to address complications of FGM/C. Similarly, poorly skilled health care providers tend to increasingly refer women and girls in need of FGM/C services. Inconsistent or unclear referral pathways impedes the provision of appropriate health care services as it leaves women and girls lost within the health system, having no clue of where to obtain appropriate services (Evans et al., 2019) A qualitative purposive study conducted among immigrants from SSA who have undergone FGM/C identified lack of information and knowledge of the health system structures and services, pose a barrier that hinders the ability to navigate or use health care services for FGM/C (Mbanya et al., 2020)

Concerns and fear of arrest and reporting have been identified as barriers to seeking care from public health facilities by victims of FGM/C. A qualitative study conducted in Kenya among Somali women noted late presentation for care and deteriorating complications arising from FGM/C continues under conditions of secrecy and fear of arrest. The study also associated fear of legal sanctions and arrests as limitation to the decision to seek much-needed emergency health services for women with FGM/C complications.(Kimani et al., 2020a)

Similarly, women who have undergone FGM/C indicated that seeking health care services is strongly influenced by the wider accepted cultural norms & values. Example of such norms include women and girls to avoiding male health care providers as this is seen as a culturally unacceptable etc. This strong cultural norm and beliefs imposed on women and girls creates a barrier for decision making to seek health care services (Mbanya et al., 2020)

6.3.1 FGM/C care services integrated into Sexual Reproductive Health Services

The call for integrated health services to address the risk for morbidity and mortality associated with barriers to seeking care for women living with FGM/C. (Kimani *et al.*, 2020a) The national FGM/C policy and plan of action boldly prioritizing actions for the integration of FGM/C into existing SRH/HIV services including integrating FGM/C module into health care professional training curricula however few documents were found to support nationwide integration of this plan into existing health service structures. A case study from Imo state, reported integration of FGM/C topics into antenatal care services however, no further report supported similar interventions in other high FGM/C prevalent states. The same study also reflected huge gap in guidelines the provision of FGMM/C services such as psychosexual support services including management of FGM/C complications at health facility levels especially at primary health care (PHC) level. Overall findings of the , indicated lack of guidelines and protocols for the integration of FGM/C at PHC levels for FGM/C services .(Dirisu et al., 2020)

6.3.2 Link with FGM/C and other related SRH services

Recent findings revealed that woman & girls who need FGM/C related services sometimes receive suboptimal care due to lack of appropriate referral , reporting pathways and unclear processes (Evans et al., 2019) Likewise, healthcare professionals face unclear structures within the healthcare system such as appropriate referral pathways and specialist services for women and girls with FGM/C complications or for girls who may be at risk of FGM/C (Zurynski et al., 2015) In addition, fragmented and unclear referral pathways has increased the risk for loss to follow up among users of health services who cannot find their way within the healthcare system.(Dirisu et al., 2020)

6.3.3 Medicalization of FGM/C

Conflicting views on the role of medicalization of FGM/C in the abandonment efforts requires the health care system to take strategic lead to confront the practice and actively position healthcare providers as collaborators and advocates for the complete eradication of FGM/C in Nigeria. In Nigeria, studies revealed that FGM/C prevention and management components have been integrated into the continuous professional development programs for health care professionals both pre service and in service in a bid to address social, professional and legal norms underpinning medicalized FGM/C. (Kimani & Caroline, 2018 pg. 38; Obianwu, Adetunji & Dirisu, 2018; Leye et al., 2019; Kimani et al., 2020b). No study has been able to establish the effect of this on the practice of medicalized FGM/C.

A study conducted in Egypt identified motivation for medicalized FGM/C include clients demand for services and financial gains, belief that medicalization of FGM/C would lead to the abandonment of the practice. It was also reported that health care providers belief that medicalization provides the opportunity to perform less severe forms of the practice and eventually prevent future cuts and ultimate abandonment of the practice . (El-Gibaly, Aziz & Abou Hussein, 2019)This debate has been refuted by the WHO and the UN assembly which calls for the prohibition of all medicalized form of FGM/C globally. (WHO 2016)

In Sudan, a qualitative study conducted in two(2) high prevalent communities revealed that medicalization of FGM/C drives the shift from some types of FGM/C (type 3) to a perceived less severe type (type 1) in a bid to prevent or reduce health consequences of FGM/C. Similar studies also revealed the implication of the law on FGM/C has driving the practice underground and outside of the health facilities rather than reduce the practice by medical professionals.(Bedri et al., 2018) Similar lessons from Egypt also revealed increased perceived acceptability of medicalized FGM/C as less harmful as compared to the traditional forms of FGM/C.(Ramadan, Abdel-Tawab & Salem, 2020)

National shifts towards medicalized FGM/C in some communities in Nigeria reveals that medicalization is attributed to trust in the quality of services provided by health workers. On the part of the health care provider, the supply of medicalized FGM/C was associated with shared cultural beliefs , financial reasons and perceived harm reduction (performing a perceived less severe type of FGM/C especially type 1 instead of other types of FGM/C) (Obianwu, Adetunji & Dirisu, 2018)

6.4 POPULATION

Population refers to target or beneficiaries of the health system. They can be viewed as people, or communities with rights entitlements and duties and they contribute to the functioning of the local health system(Olmen et al., 2012)

6.4.1 Community Participation

In Nigeria, link between the health system and community structure is weak and runs vertically. The health system provides services and implements FGMC program as either community-based services or clinic -based interventions. The community-based interventions include activities such as community dialogues, training of FGM/C champions & advocates, school and community sensitization including social media advocacy. The clinic based interventions include training of health care providers and management of complications (Dirisu et al., 2020). A recent qualitative study in Nigeria, revealed that community participation for FGM/C has been directed towards abandonment of FGM/C practice and health care workers major players significant role as champions supporting community abandonment efforts in high prevalent communities.(Obianwu, Adetunji & Dirisu, 2018)

A qualitative study exploring the roles of communities emphasized that community participation is essential for successful delivery of FGM/C health care services including the prevention of the practice in affected high FGM/C prevalent communities. Creating enabling environment for community organizations to take part in health policy processes and decision making is essential for sustainability response of the health system to address FGM/C. However, community participation can experience set back especially in communities with negative gender norm and poor power dynamics promoting the culture of silence and restricting open communication or engagement of women and girls in need of health care services or at risk of being cut (Connelly et al., 2018)

A recent strongly associated decline in demand for FGM/C is heavily influenced by community involvement and engagement to increase awareness of the negative consequences and human right violation of FGM/C at community level. (Mberu, 2017)

6.5 RESOURCES

6.5.1. Knowledge & Information

A recent review of health information related to FGM/C identified a major gap in collection and documentation of FGM/C data at health care delivery levels. The finding further emphasized the absence of guidelines and tools to capture routine FGM/C prevention and management of complication activities at PHC and Secondary care facilities (Kimani & Otibho, 2020). In Nigeria, FGM/C indicators for data collection have not been integrated into the NHIS with 91,8% of facilities deficient in routine documentation of FGM/C status of women and girls at facility levels.(Dirisu et al., 2020) Similar opinion observed lack of reporting tools to facilitate care psychological and counselling services to survivors of FGM/C at health facility level.(Ashford, Naik and Greenbaum, 2020) It has been argued that routine documentation of FGM/C services obtained from health facilities have huge

potentials to provide real time information on new cases including tracking current practices of FGM/C at district and state levels (Matanda, 2020a). The Nigerian National Health Information System(NHIS) policy emphasized the responsibilities of health system to generate data for evidence based health planning and highlighted the roles of health facilities to provide monthly summary of health facility reports into the national data health information pool.(Nigeria Health Information System Policy 2014)

Matanda (2020) also emphasized that the need to address ethical challenges that may also influence the documentation of FGM/C cases by health care providers such as dilemmas of reporting new cases of FGM/C to social authorities requires urgent attention. In Nigeria, the adoption of the VAPP law prohibiting the practice of FGM/C has been identified as a potential to alter for under reporting and mis reporting in the next round of population survey exercise that heavily rely on self-reported FGM/C status.(Shell-Duncan, 2016;Country Policy Information FGM Nigeria 2019).

Recent opinions from researchers have emphasized combining multiple approaches in collecting data to boost the accuracy of measuring the prevalence of FGM/C. Combining self-reported surveys from DHS reports and the use of clinical examination by healthcare providers for verification of type and extent of cut is becoming an increasing debate for measuring current practices of FGM/C .Recent recommendations have also highlighted the need to integrate clinical examination and routine facility documentation into regular routine reproductive health services (ante natal, post-natal ,family planning clinics)and other services such as the welfare / under 5 clinics. (Matanda, 2020b) Various discrepancies have disputed this recommendation, as unnecessary and unethical (Bjälkander et al., 2013)

6.5.2. Infrastructure & supplies

Only one facility assessment report was found that specifically provided an assesses of facilities and supplies related to FGM services in the country using SARA[1] tools. The assessment was conducted only one state (Imo State) in the south eastern part of the country with high prevalence of FGM/C and may not be generalizable to other states in the country. Result of the health facility assessments revealed that most health facilities are poorly funded and lacks available equipment's and service commodities to combat FGM/C related emergencies and complications particularly at the primary health care level. This was implicated as poor preparedness and service readiness of health facilities to

[1] **The Service Availability and Readiness Assessment (SARA) is a health facility assessment tool designed to assess and monitor the service availability and readiness of the health sector and to generate evidence to support the planning and managing of a health system. SARA is designed as a systematic survey to generate a set of tracer indicators of service availability and readiness (W H O)**

implement FGM/C related health care activities. (Dirisu et al., 2020) The state of insufficient equipment and limited resources undermine the quality of FGM/C related care if provided at all. (Ashford, Naik & Greenbaum, 2020)

6.5.3. Human Resources

According to the healthcare dynamic framework, human resources are crucial to the health system and can be narrowly referred to as health workforce which involves all people engaged in actions whose primary intent is to enhance health.(Olmen et al., 2012) A scoping review conducted in Nigeria described the overall health workforce in Nigeria has deteriorating and in crises. The current health workforce for health is poorly distributed and grossly unequipped.(Adeloye et al., 2017) A case study of one of the high FGM/C prevalent state in south east Nigeria revealed shortage of manpower for FGM/C healthcare services and programmatic activities (Dirisu et al., 2020). Similarly, overall poor renumeration with irregular payment of salaries at subnational levels has resulted in the paralysis of the health sector over extent periods.(National Strategic Health Development Plan II 2018) Similarly, evidence from another study conducted to assess human resources for health in one of the south eastern states of Nigeria indicated that human resources and development operations are suboptimal in the country with 70% of health work force participants reported poor supervision. (Uneke et al., 2012)

6.5.4 Finance

Globally, report revealed that efforts to combat FGM has been underfunded. (Adam et al., 2010). The Nigerian government provided no budgetary allocation specific to FGM/C unlike other high FGM/C prevalent countries like Burkina Faso, Egypt, Ethiopia, Kenya and Mali (Johansen *et al.*, 2018*)*. FGM/C programs is domiciled within other departments such as the gender department of the nation al ministry of health and this structural organization has been associated with diversion of funds into other programs. At the state level, there exist no budget specific for FGM/C which reflect weak commitment of the government to fund FGM/C programs. Another study described the current low priority placed on FGM/C by the government as a public health issue at both the national and state levels with no specific budget line to carry out implementation activities (Mberu, 2017). A qualitative study revealed that only selected focal communities scattered across high FGM/C prevalent states receive donor funds and they sustain this by integrating FGM/C services into existing reproductive health funded programs. Similarly, current FGM/C interventions are housed under other gender related interventions which may be associated with low priority and underfunding of FGM/C activities. The government expressed several commitments in various regional and national commitments yet there no budgetary allocation or funds available for FGM/C specific activities. Current donor

driven interventions are not sustainable without alternative sources for funding.(National FGM policy, 2013;Dirisu et al., 2020)

7.0 CHAPTER SEVEN: Best Practices on responses contributing to the reduction of FGM/C

This chapter provide demonstrated best practices conducted in high FGM/C settings contributing to improved health system responses in the reduction of FGM/C. A separate literature search was done on best practices in high FGM/C practice settings from 1990 till dates. Criteria for selecting good practices that works well and is transferable was from the European Institute for Gender Equality approach to Good practice i.e. **Relevance, Efficiency, Effectiveness, Impact and Sustainability and possible transferability** to other contexts, regions and/or countries.(European Instituite for Gender Equality 2013)

7.1 Provision of FGM/C services: African Well Woman Clinic United Kingdom

African well woman clinic in the United Kingdom was selected because it complies with the selection criteria. The clinic was established exclusively to provide obstetric and gynecological (reproductive services) care to women & girls affected by FGM/C. United Kingdom has one of the largest percentages of African migrants from Africa where FGM/C prevalence is high, countries like Nigeria, Kenya, Egypt, Sudan and other anglophone speaking African countries.

Since 1993 the African well woman clinic has been operating in the United Kingdom providing obstetric and gynecological (i.e. antenatal, postnatal and pregnancy related services) care to women affected by FGM/C. The clinic is cost effective and sustainable as it is anchored within the overall national health care system and providing comprehensive services in a cost effective manner "one stop clinic" where women with FGM/C complications obtains counselling and have surgical care on the same day thereby saving time and money. The clinic prioritizes the health and psychological needs of girls and women who have been subjected to FGM/C. The clinic is fully operating in 15 locations in England with 11 clinics in London alone due to vast population of migrant communities from high FGM/C prevalent countries located in the area. Evaluation report of this innovative response was documented as responding to the specific needs of girls and women with FGM/C. Besides this, the clinic actively contributed to policymaking advocating against FGM/C and involved with engaging and empowering affected communities. (European Institute for Gender Equality, 2013).The identified weakness of this practice is that community support was evaluated as weak with clients reporting different operating times and difficulty with women and girls who are not literate constantly facing barriers to obtain care.

7.2. Community Empowerment Efforts

A. TOSTAN COMMUNITY EMPOWEREMNT PROGRAM SENEGAL

Since 1991, TOSTAN community empowerment program in Senegal is a community initiative for declaration of abandonment of FGM/C. The program is a community empowerment intervention that promotes positive social norm change through non formal community-based education on human rights. TOSTAN is centered around the community through participatory engagement activities such as dialogue, discussions, and public declaration of FGM/C abandonment. This community engagement program focuses on women and girls and in recent times included men to address negative gender norms through community education. This intervention that revealed community engagement strengthens social commitments for total abandonment of FGM/C. Over 8,800 communities spread across 112 countries. This has now been replicated in ten (10) other African countries including Nigeria.(UNESCO, 2016; Tostan International 2018)

B) YES, I DO PROGRAM KENYA

The Yes I do program Kenya has one of its priorities on fostering sustainable engagement with communities to address and discuss the underlying cultural norms and social values driving FGM/C amongst other harmful traditional practices such as child marriage and adolescent SRH problem of teenage pregnancies in Kenya. The intervention demonstrated positive community member engagement in the active change of attitudes and cultural practices that favors FGM/C in Kenya. The evaluation reveals community engagement of different groups especially such as men groups, women, young girls, and boys in gender transformative community-based education to address issues of gender equality in target community. The strength of this approach to community-based program is that it is addresses gender inequality in a systematic approach at every level of the community.(Gitau et al., 2018)

8.0 CHAPTER EIGHT: DISCUSSION

This chapter presents key findings from the analysis.

8.1 Key Findings

From the findings of the literature analysis presented in chapters 4 to 7, factors affecting health system responses are intertwined and highly dependent on one another for it to achieve its set outcome i.e. reduction of FGM/C.

The law prohibiting FGM/C practice in the country as a tool for regulation, prohibiting the practice of FGM/C in the country. The law provides legitimacy for actions especially in states that have domesticated the VAPP law prohibiting FGM/C in Nigeria. The law against FGM/C also interplays with cultural values and norms, where cultural values that supports the practice of FGM/C is shared by health care providers. This shared cultural value is said to be a major driver for healthcare providers performing FGM/C and due to fear of the law performs this in secrecy away from possible arrest. (Obianwu, Adetunji & Dirisu, 2018) Gender norms that takes away right of women& girls to take primary decisions over their body to refuse FGM/C or take decision to seek care is a thriving setting for the practice of FGM/C. Emerging debate argues that the law has proven ineffective to protect women and girls from such communities with cultural values and principles that supports FGM/C. Rather than protect the law is now used as a tool for prosecution of defaulters and not for protection of women and girls at risk of cutting.(Kandala & Komba, 2015)

The strong influence of cultural norms and values on the health system components of service delivery. It was made known that cultural values affect how women and girls perceive and seek FGM/C prevention and care services they need. Decision to seek care is heavily influence by gender roles especially the role of men has primary decision maker at household levels. Example cited to support this is health care services that are not culturally accepted tend to result in low proportion of women and girls using FGM/C care services.(Mbanya *et al.*, 2020)Similarly, the influence of gender play within the health system especially health workforce pose as a barrier to seeking care in a culturally sensitive community with high FGM/C prevalence. Although the issue of culturally sensitive care for FGMC survivor is beyond the scope/objectives of this study it is vital to consider this overarching influence of gender preference as reflection of cultural values and norms affecting the provision of FGM/C care services for women and girls (Evans et al., 2019)

Expected outcome of the health system is the reduction of FGM/C through the provision of prevention, protection, medical and psychological management of FGM/C however this outcome cannot be achieved alone by the health system. The role of the law providing legitimacy for policy actors and actions with the health system reveals the intertwined influences the law provides in relation to prohibiting the practice of FGM/C within the health

care system. The influence of the law against the practice of FGM/C provided legitimate reasons for Doctors and other allied health care providers to abandon the practice and advocate as champion against FGM/C. However, the law and prohibition of FGM/C practice among health care providers has been recommended to show positive effect together with community involvement and participation (W.H.O, 2010 p 10) Examples of such positive effect was presented under the section of best practices in Senegal that is the Tostan community empowerment program in Chapter 7 of the thesis. Similarly, Community engagement was also attributed to strong regulation and enforcement of the law in the case of Burkina Faso that resulted into about 5% decline in the risk of been cut among young girls. This result has been disputed by many studies as a positive impact that arise from enforcing laws prohibiting FGM/C.

The community as the population as primary beneficiaries of the health care system must be involved in high prevalent FGM/C settings as they are key drivers to achieve complete abandonment of FGM/C. The need to involve community in decision ,policy process and delivery of FGM/C health care services is necessary to create an enabling environment for women and girls to obtain relevant health care, prevent complications and also be protected from FGM/C in the communities they live. In Kenya, the Yes I do program is another community based intervention program that address and discuss the underlying cultural norms and social values driving FGM/C delivered that heavily relies on community as drivers for social norm change for abandonment of FGM/C in Kenya(Gitau et al., 2018).

The role of health system leadership and governance influence health system functions and response to the needs of the community as population. Accuracy for measuring outcomes such as decline of FGM/C is vital for measuring of change across different parameters to monitor progress. The increasing urgency to identify hotspots for strategic prevention of girls and risk of FGM/C in a growing population demands active health system and community engagement.(UNFPA 2018) The lack of framework or guiding tools for the integration of FGM/C prevention, care and psychological services into existing sexual reproductive services leaves women and girls with suboptimal healthcare services. (Dirisu et al., 2020) The interconnecting nature of health system resources i.e. human resources, infrastructure, health information tools and finance cannot be undermined as core resources needed for health system functions to achieve desired response to FGM/C in Nigeria. The issue of poor payment of salaries and harsh working conditions affects motivation of health care workers to perform their roles. Poor skill of heath care providers together with infrastructure with poor supplies also contributes to poor capacity to provide clinical management of complications arising from FGM/C. Recent discuss on the need for the accurate measurement of decline of FGM/C calls for better data health information management system as a critical tool to protect the rights of women and girls especially

with the observed population growth of girls and women who are at risk of FGM/C in a large population country like Nigeria.(UNFPA 2018)

8.4 Limitations and Strength of the Study

Relevance and strength of the framework

The thesis focus on health systems however the complexity of the framework and the socio-cultural nature of FGM/C as a public health problem required the use of the health system dynamic framework beyond the traditional WHO six building blocks of the health system. The relevance of this framework is that it includes population as the community and the need to integrate and involve the community through active participation in decision making provide me the opportunity to analyze the community as factor affecting health system response to FGM/C. Similarly, the values and principles as components of the framework allows for the analysis of cultural values and norms driving other parts of the health system relevant to address the issue of FGM/C. The framework was used because of its interdependent nature of factors as constantly interacting with each other in a social system with the community as the beneficiary pf the overall health system outcome.

Limitation

Firstly, gender factor as components of the framework is missing. FGM/C is a gender-based violence and addressing the problem of FGM/C only from the provision of clinical services alone has been discouraged by many studies.

However, to overcome this limitation the role of Gender was analyzed under the components of values and principles as a cultural norm that affects the overall health system responses to FGM/C.

Secondly, the political context as a subsection of the context components of the framework was not analyzed as this is beyond the scope and objectives of the study. The Political environment is a crucial factor that drives the overall national health system to prioritize FGM/C. To overcome this limitation, recommendations will be made for future research.

Thirdly, sub sections of the outcome component of the framework such as utilization of services (access, coverage, and quality of services) were not analyzed because it is beyond the scope of the study objectives. To overcome this limitation future recommendations for research will be suggested to the academic community.

9.0 CHAPTER NINE: CONCLUSIONS AND RECOMMENDATIONS

9.1 Conclusion

In context of the Law prohibiting FGM/C and regulation in Nigeria provides legitimacy for the health system to be actively involved in the reduction of FGM/C. The law is generally weakness and ineffectiveness of FGM/C rather, the law has driven the practice into secrecy as people fear prosecution by law enforcement agencies. The law alone cannot achieve any positive change without the community getting involved and participating in actions to stop demand for FGM/C services both within and outside of the health system. The law prohibiting the practice of FGM/C can only act as a tool for protecting women and girls at risk of FGM/C only by engaging the community to adopt positive cultural norms and values that empowers the right of women and girls to be free from violence including FGM/C in the community.

Values and principles in cultures that favors the practice of FGM/C influences demand for FGM/C. Communities that practice FGM/C tend to demand FGM/C services from healthcare providers who can be compelled to provide it in secrecy due to fear of prosecution . decision to seek and use health care services. Gender roles in decision making process at household levels and cultural values affects the decision to seek care and use health care services. Decision making power dynamic that puts women in a subjective role under the men or older women limits the ability of women & girls to take charge of her own health, refuse FGM or prevents complication of FGM/C practice when they can use appropriate health care services.

The health system alone cannot accomplish set outcomes without all the components of the health system functioning together with the population as the community central to the overall response of the health system to the issue of FGM/C . Community participation that involves all components of the health system from the policy development to the setting up of FGM/C prevention, protection and management services will achieve positive outcomes of decline of FGM/C. Community participation will also promote culturally appropriate health care services that responds to the need of women & girls in the community. Also, the community provides a suitable platform for the protection of women and girls from FGM/C when enabling environment in the community is put in place by the community themselves after adopting positive cultural/social norm.

Overall response of the health system to the needs of the population relies on all parts of the system effectively functioning together. The interconnecting nature of the parts health system reflects that a deficiency in one of the components affects the overall response to reach the set outcomes and goals i.e. the reduction in FGM/C and ultimately the abandonment of the practice. For a health system to respond to the need of the

population, all parts must be work together, interdependently with the community at the center.

9.2 Recommendations

Recommendations will be presented according to their intended targets guided by the study objectives

Recommendations on the Law

- Health care providers should be reoriented about the use of the law as a tool to protect women and girls from FGM/C. The law prohibiting the practice of FGM/C should be used as a tool to advocate and champion the abandonment of the practice in locally acceptable languages and ways with less emphasis on the punitive measures but rather promoted as a tool for protection. This can be carried out with carefully designed I.EC materials provided at the health care facilities during routine health information activities.

Recommendations for the Community

- Communities based behavioral change education should be carried out at different levels of the community by community-based healthcare workers during routine home/community visits to address gender norms that support violence against women and with other community health education programs dissuade the community from demanding FGM/C. This can best be carried out in Nigeria at the primary health care(basic unit of the health system) to address FGM/C through community based activities carried out by community based health care workers who are already both part of the community and the health system.

Recommendation for the Ministry of Health and other stakeholders related to Health System.

- Develop standardized national indicator to capture FGM/C at both community-based health system and hospital-based care. Thereafter, train health care workers and managers of care on how to utilize the tool for efficient data flow and management.
- Engage the community as active stakeholders and decision-making in the planning and intervention efforts to address the issue of FGM/C at national, state and local government levels. Actively involve community groups including women and girls' groups , vulnerable groups and minority groups in the community in decision making will serve to reinforce women empowerment goals , address gender inequalities and increase representation and participation of more women & girls at the decision-making table in the community

Recommendations for Research (Academic community)

- Health system research that explores political factors affecting the health system and utilization of FGM/C services should be conducted to provide evidence for planning , advocacy and interventions that strengthens the health system to address FGM/C not only in Nigeria but in other high FGM/C prevalent countries in Africa.

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