

A DIAGNOSTIC ASSESSMENT OF THE
HEALTH SYSTEM'S RESPONSE TO
FGM/C MANAGEMENT AND
PREVENTION IN NIGERIA

May 2020

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NIGERIA

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POPULATION COUNCIL

MAY 2020

Evidence to End FGM/C: Research to Help Girls and Women Thrive generates evidence to inform and influence investments, policies, and programmes for ending female genital mutilation/cutting in different contexts. Evidence to End FGM/C is led by the Population Council, Nairobi in partnership with the Africa Coordinating Centre for the Abandonment of Female Genital Mutilation/Cutting (ACCAF), Kenya; the Global Research and Advocacy Group (GRAG), Senegal; Population Council, Nigeria; Population Council, Egypt; Population Council, Ethiopia; MannionDaniels, Ltd. (MD); Population Reference Bureau (PRB); University of California, San Diego (Dr. Gerry Mackie); and University of Washington, Seattle (Prof. Bettina Shell-Duncan).



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Suggested Citation: Dirisu O., Adetunji A., Adediran M., Obianwu O. 2020. A Diagnostic Assessment of the Health System's Response to FGM/C Management and Prevention in Nigeria. *Evidence to End FGM/C: Research to Help Girls and Women Thrive*. New York: Population Council.

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Funded by:



This document is output from a programme funded by UK Aid from the UK government for the benefit of developing countries. However, the views expressed and information contained in it are not necessarily those of, or endorsed by the UK government, which can accept no responsibility for such views or information or for any reliance placed on them.

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List of Acronyms

CEDAW	Convention on the Elimination of Discrimination Against Women
CHEW	Community Health Extension Worker
CRC	Convention on the Rights of the Child
CSOs	Civil Society Organisations
DHIS	District Health Information Software
DPRS	Department of Planning, Research, and Statistics
FGDs	Focus Group Discussions
FGM/C	Female Genital Mutilation/Cutting
FMOH	Federal Ministry of Health
GASHE	Gender, Adolescent, School Health, and Elderly Care (GASHE) Division at FMOH
HFA	Health Facility Assessment
HIV	Human Immunodeficiency Virus
IDIs	In-depth Interviews
IEC	Information, Education, and Communication Materials
KIIs	Key Informant Interviews
LGA	Local Government Area
MD	Medical Doctor
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MSD	Multi-stakeholder Dialogue
NDHS	Nigeria Demographic Health Survey
NGOs	Nongovernmental Organisations
NMW	Nurse/Midwife
NPC	National Population Commission
NPPA	National Policy on FGM/C and Plan of Action for the Elimination of Female Genital Mutilation in Nigeria
PHCs	Primary Healthcare Centres
PM	Policymakers
SDGs	Sustainable Development Goals
SHMB	State Hospital Management Board
UN	United Nations
UNAIDS	United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNJP	UNFPA-UNICEF Joint Programme on Female Genital Mutilation
VAPP Act	Violence Against Persons (Prohibition) Act
VVF	Vesico Vaginal Fistula
WHO	World Health Organization

Acknowledgements

This publication is based on research supported by UK Aid and the UK Government through the Department for International Development (DFID)–funded project “Evidence to End FGM/C: Research to Help Girls and Women Thrive,” coordinated by the Population Council. This research process would not have been possible without our study contributors. We thank. O.A. Ladipo of the Association of Reproductive and Family Health, and Timothy Abuya, Caroline Kabiru, Jacinta Muteshi, and Michelle Hindin of the Population Council for critical review of this research report. The contributions of Salisu Ishaku and Akinwunmi Akinola are also acknowledged. We especially wish to thank Dr. Sylvia Adebajo of the Population Council, Nigeria for her continued guidance and detailed suggestions throughout this effort.

Executive Summary

Background

Globally, it is estimated that over 200 million women and girls have undergone FGM/C and are living with its consequences. In Africa, it is estimated that 27 million, 24 million, and 20 million girls and women have undergone FGM/C in Egypt, Ethiopia, and Nigeria respectively, making them the countries with the highest absolute numbers of women and girls living with FGM/C in the continent. FGM/C practise has no known medical benefit, but it results in mild to severe health (physical and psychological) complications as well as social consequences. The health complications can be immediate, short-, or long-term. The complications include, but are not limited to bleeding, infections, keloid, clitoral cysts and psychosexual complications. In addition to these complications, FGM/C is considered a violation of the rights of women.

In 2007, the WHO, UNFPA, and UNICEF issued a joint statement against the practice of FGM/C, declaring support for its abandonment. Since then, there have been concerted efforts by different stakeholders to facilitate abandonment of FGM/C. For example, in 2008, WHO and other United Nations agencies passed a joint resolution titled “Eliminating female genital mutilation: an interagency statement.’. Global and national efforts have also included the development of legal and policy frameworks addressing management and prevention of FGM/C, signing international conventions, charters, and agreement such as the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) in 1979, Convention on the Rights of the Child (CRC) in 1989, and the Sustainable Development Goals (SDGs).

Nigeria has made considerable efforts towards the eradication of FGM/C. These include constituting a National Technical Working Group on harmful traditional practices, conducting research studies and generating evidence, and drawing up a National Policy and Plan of Action (NPPA) for the elimination of FGM/C in Nigeria. The first policy in 2008 was not fully implemented and was replaced by a revised version spanning 2013–17 and adopted by the National Council on Health. In 2015, as part of a legislative framework to eliminate FGM/C, the National Assembly passed the Violence Against Persons and Prohibition (VAPP) Act, which criminalises the practice. Beyond this, Nigeria is a signatory to treaties which prohibit harmful traditional practices including FGM/C, such as: CEDAW, Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa (Maputo Protocol); Convention on the Rights of the Child; and the African Charter on Human and People’s Rights.

Like any other health-related issue, the health system is meant to address resulting complications of FGM/C and offer prevention strategies. Despite the existence of laws, policies, and plans of action that should drive the health system’s response, the practice persists at a substantial level in Nigeria. The extent of preparedness of the health system for prevention and management of complications is unclear and is yet to be documented. The goal of this study was to contribute to a reduction in the prevalence and ultimately the abandonment of FGM/C through a diagnostic assessment of the health sector’s response to FGM/C management and prevention in Nigeria and the identification of possible solutions for strengthening the existing response. The study explored how the health system implements the national policy and plan of action for FGM/C, and how the healthcare sector supports the prevention and management of FGM/C-related complications to identify possible solutions for system strengthening.

Methodology

This study utilised a qualitative approach as well as a health facility assessment to understand the health system’s response to management and prevention of FGM/C in Imo State. Data-gathering approaches, including in-depth interviews, focus group discussions, clinical meetings

among health service providers, key informant interviews, and stakeholder dialogues (national and state level), were used. A health facility assessment was also conducted to examine service delivery levels at health facilities. Descriptive statistics were used to summarise health facility assessment and qualitative interviews were digitally recorded, transcribed and analysed using NVIVO 12 software. Thematic analysis was used to explore emergent patterns and themes within the qualitative data. Ethical approval was obtained from Imo State Ministry of Health and from the Population Council's Institutional Review Board.

Findings

Findings from this study showed that the policy-development and implementation process at the national and state levels were plagued by poor participation of the relevant health system stakeholders due to limited funding and poor coordination. The lack of funds to drive activities in Imo State led to inadequate planning, supervision, and coordination of FGM/C activities in the state. Lack of political will and commitment from government at both federal and state levels for FGM/C programmes also hindered policy implementation. The level of readiness of the health facilities to handle FGM/C-related complications was low, as evidenced by poor infrastructure, lack of equipment, and limited human capacity. Study findings also showed that patients with complications of FGM/C present late and logistic/infrastructural challenges hinder effective referral. There were no guidelines or protocols for the management of FGM/C at any levels in the state and FGM/C documentation at facility-level was almost non-existent.

Conclusion

The low priority placed on FGM/C by the government affected policy development and implementation. The health system's response to prevention and management of complications was suboptimal. The findings from this study suggest that improving the health system response in the prevention and management of FGM/C complications requires government ownership at all tiers.

Implications for policy/programmes/research

Poor dissemination of policies and engagement of state stakeholders has implications for stakeholders' participation in the implementation process. The government should demonstrate greater financial commitment and ensure transition and ownership of activities beyond the tenure of FGM/C projects. Health workers should be properly trained and sensitised on the WHO guidelines on management of FGM/C complications to improve their capacity to respond to incidents. The availability of data for decision-making on FGM/C is critical, and gaps in data management must be addressed by education and improved data-management systems.

Introduction

Background

Globally, over 200 million women are cut and living with female genital mutilation/cutting (FGM/C) (UNICEF 2016), while 3 million girls are at risk of undergoing cutting each year (UNICEF 2016, UNICEF 2014). The World Health Organization defines FGM/C as any procedure that involves partial or total removal of the female external genitalia or other injuries to the female genital organs for nonmedical reasons (WHO 2008, Rymer 2003). Based on the anatomical extent of the procedure, WHO broadly classifies FGM/C into four main types, namely: Type I, partial or total removal of the clitoris and/or the prepuce (clitoridectomy); Type II, partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision); Type III, narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation); and Type IV, all other harmful procedures to the female genitalia for nonmedical purposes, including pricking, piercing, incising, scraping, and cauterisation (WHO 2008).

The magnitude of FGM/C is disproportionately spread across different ethnic groups in 30 African countries (mainly in East, North East, and West Africa), with pockets in Asia, the Middle East, Latin America, as well as North America, Europe, Australia, and New Zealand among migrant populations (UNICEF 2016, UNICEF 2014, Yoder, Wang, and Johansen 2013). In Africa, it is estimated that 27 million, 24 million and 20 million girls and women have undergone FGM/C in Egypt, Ethiopia, and Nigeria respectively, making them the countries with the highest absolute numbers of women and girls living with FGM/C in the continent (UNICEF and Gupta 2013).

In Nigeria, although the practice is considered widespread, national surveys suggest a gradual decline of FGM/C prevalence among women aged 15–49 years from 30% in 2008 to 20% in 2018 (NPC and ICF 2019). Comparison between NDHS 2013 and NDHS 2018 suggests reductions across four regions: South East (49% to 35%), South West (47.5% to 30%), South-South (25.8% to 17.7%), and North West (20.7% to 20.2%). In contrast, the prevalence remained the same in the North Central (9.9%) and increased in the North East (2.9% to 6.1%) (NPC and ICF 2014; NPC and ICF 2019). The most recent Multiple Indicator Cluster Survey (MICS) in Nigeria puts the prevalence of FGM/C at 18%, however, the prevalence in some states is still as high as 67% (NBS and UNICEF 2017).

The prevalence and practises of FGM/C in Nigeria vary across regional and ethnic divides as they are driven by social norms and cultural practices. According to the NDHS 2018, the South East and North East regions have the highest (35%) and lowest (6.1%) prevalence respectively. The state-level prevalence report reflects this, as Imo, Ekiti, Ebonyi, and Osun States (all in the southern part of the country) reported the highest prevalence by state (62%, 58%, 53%, and 45.9%), respectively. Even though the South East region, which has the highest population of Igbos, has the highest prevalence by region, the Yorubas have the highest prevalence (35%) by ethnic group, followed by the Igbos (31%) and Hausas (20%) (NPC and ICF 2019). FGM/C is regarded as a rite of passage into womanhood in some cultures or intended to prevent girls from promiscuity (Awusi 2009; Ofor and Ofole 2015). In Nigeria, FGM/C is most likely to take place during childhood (NPC and ICF 2014).

FGM/C has no health benefits. It has, however, undesirable consequences for human rights as well as health (physical, psychological, sexual, maternal and child health), and social consequences (WHO Study Group et al. 2006, Vloeberghs et al. 2012, Chibber, El-Saleh, and El Harmi 2011, Kimani et al. 2016). The health effects associated with the FGM/C can be immediate/short and/or long-term (Berg et al. 2014, Kaplan et al. 2011, Morison et al. 2001, WHO 2000, 2008; WHO Study Group et al. 2006). The short-term complications are pain,

excessive bleeding, swelling, problems with wound healing, and urine retention (Berg et al. 2014). Genital scarring, menstrual difficulties, urinary symptoms, obstetric complications, painful intercourse, formation of cysts, and psychosexual effects are all classified as long-term consequences (Dare et al. 2004; Elnashar and Abdelhady 2007; Knight et al. 1999; Njue and Askew 2004). Psychological consequences like anxiety, depression, post-traumatic stress disorder, and low self-esteem have also been reported among women exposed to FGM/C (Whitehorn, Ayorinde, and Maingay 2002; Behrendt and Moritz 2005). Some of the health complications are directly related to the extent of the cutting, the poor anatomical knowledge of providers, as well as the use of crude and non-sterilised instruments. The majority of women and girls living with FGM/C suffer complications that require medical interventions to correct or mitigate health risks (WHO Study Group et al. 2006, WHO 2016b).

Global response to end FGM/C

In 2007, the WHO alongside UNFPA and UNICEF issued a joint statement against the practice of FGM/C, declaring support for its abandonment. Since then, there have been concerted efforts by different stakeholders to promote the abandonment of the practice. These include research to generate evidence to inform interventions, advocacy, and change in public policy. In 2008, WHO, alongside nine UN agencies, passed a joint resolution entitled: “Eliminating female genital mutilation: an interagency statement” (WHO 2008). Because of the pervasive nature of the problem and the role of health workers in FGM/C, WHO with other international partners published a global strategy to stop healthcare providers from performing FGM/C (WHO 2010). This was in addition to the adoption of the Millennium Development Goals (MDG) by 191 countries as a global development agenda. Of the eight MDGs, six were directly related to the eradication of FGM/C (28TooMany 2016). At the expiration of the MDGs in 2015, the Sustainable Development Goals (SDGs) became the overriding development agenda globally. The SDGs make explicit reference to elimination of FGM/C under Goal 5.3—*Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation* (WHO 2015).

Global efforts have also included the development of legal and policy frameworks addressing the management and prevention of FGM/C. Twenty-six African and Middle Eastern countries, as well as 33 countries with practising migrant populations, have adopted laws criminalising the practice (UNICEF 2016). In addition, to operationalise the management and prevention of FGM/C, in 2016 WHO developed guidelines on the management of health complications from FGM/C (WHO 2016). Other global efforts to promote abandonment include the creation in 2007 of the UNFPA-UNICEF Joint Programme (UNJP) “Female Genital Mutilation/Cutting [FGM/C]: Accelerating Change” that aimed to protect women and girls by accelerating the abandonment of the practice and enhancing care for those living with FGM/C. So far, the UNJP is one of the largest interventions to promote abandonment. It works to provide appropriate and quality services (3.2 million girls in 17 countries have benefitted from its protection and care); better community-led engagement, involving education, dialogue, and consensus-building; legal and policy frameworks, including training and enforcement (FGM/C has been banned in 13 countries with the support of the programme); government ownership (17 countries supported by the programme have a leadership/coordination mechanism and 12 of them established budget lines targeted at services to eradicate FGM/C). The programme, currently in the third phase integrates complementary interventions to end and eradicate FGM/C and other harmful practices by 2030, in line with the SDG agenda (UNFPA-UNICEF 2019).

FGM/C response in Nigeria

In addition to signing to several international conventions, charters, and agreement such as the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) of 1979, Convention on the Rights of the Child (CRC) of 1989, MDGs of 2000, and SDGs of 2015, Nigeria

has made considerable efforts towards the eradication of FGM/C. These include constituting a National Technical Working Group on harmful traditional practices, conducting research studies and generating evidence, and drawing a National Policy and Plan of Action (NPPA) for the elimination of FGM/C in Nigeria. The first policy in 2008 was not fully implemented and was replaced by a revised version spanning 2013–17 and adopted by the National Council on Health. The revised version outlines the response from government and civil society organisations (CSOs) to include community-level education on the need to eliminate FGM/C, capacity-building of stakeholders to sensitise them on negative impact of the practice, advocacy for legislation and treatment of FGM/C complications, intersectoral collaboration and integration of anti-FGM/C programmes in relevant sectors, and anti-FGM/C legislation at state levels (FMOH 2013).

In 2015, as part of a legislative framework to eliminate FGM/C, the National Assembly passed the Violence Against Persons and Prohibition (VAPP) Act, which criminalises the practice (Goldberg 2015). Section 6(1) of the VAPP Act states, *'The circumcision or genital mutilation of the girl child or woman is hereby prohibited'* (Onyemelukwe 2016). The VAPP Act only applies to the Federal Capital Territory and is yet to be domesticated in many states (28TooMany 2016). However, some of these individual states (about 13 states) including the Federal Capital Territory have other law provisions that prohibit the practice. In addition to the CEDAW and VAPP Act, Nigeria also signed other treaties which prohibit harmful traditional practices including FGM/C, such as: the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol) which was adopted in 2003, but ratified by the Nigerian government in 2004; Convention on the Rights of the Child, which was adopted in 1989 and ratified in 1991; and the African Charter on Human and People's Rights, which was adopted in 1981 and ratified in 1983. However, signing a treaty is not enough; such treaties are expected to be enshrined in the legal frameworks of the country for them to be fully effective. Thus, a major challenge has been the non-domestication of these treaties by the national and state legislatures. For instance, the Child Rights Act which also prohibits FGM/C since its adoption in 2003, has only been domesticated in 24 states as of 2019 (World Bank 2019).

Health system's response to FGM/C

The health system's response to FGM/C is achieved through the provision of care (management) to survivors and is also expected to play a significant role in prevention through i) communicating the risks and health consequences; and ii) supporting policy implementation for the abandonment of FGM/C by communities and families, which includes not providing medicalised FGM/C and fulfilling legal requirements for reporting cases of FGM/C to the authorities. In Nigeria, the existing laws do not explicitly require health workers to report incidents of FGM/C. There are limited policy documents and guidelines specific to the prevention and management of FGM/C in Nigeria. The NPPA sets targets and outlines strategies for relevant agencies (FMOH, 2013). The targets include: increasing the number of healthcare facilities that provide care, counselling, and support to FGM/C survivors; eradicating medicalisation of FGM/C; identifying appropriate indicators and developing relevant data-collection tools on FGM/C elimination for integration into the National Health Management Information Systems; and mainstreaming FGM/C issues into the national agenda through incorporation into the National Strategic Health Development Plan. In addition, the policy implementation strategy includes:

- integrating FGM/C into sexual and reproductive health /HIV services;
- advocacy for the integration of FGM/C module into the curricula of health training institutions;
- sensitising regulatory bodies and health professional associations on the medicalisation of FGM/C and penalties for the practice; and
- supporting regulatory authorities to monitor FGM/C practises in the health sector

Rationale

Despite the existence of laws, policies, and guidelines that should drive the health system's response to FGM/C, the practice persists at substantial levels in Nigeria. The progress made in creating an enabling environment for FGM/C elimination cannot be sustained without an effective response from the custodians of the Nigerian health system.

As part of the health system response to FGM/C, the extent of preparedness of health facilities (primary, secondary and tertiary) to prevent and manage complications of FGM/C is poorly understood and yet to be documented. It is also uncertain whether the health sector in Nigeria has the capacity to implement FGM/C prevention and management activities. This study seeks to address gaps in knowledge through a diagnostic assessment of the health sector's response to FGM/C management and prevention in Nigeria.

Theoretical underpinning

Policy analysis framework

To better understand the Nigerian health system's response to the prevention and management of FGM/C, this study examined FGM/C-related policies using Walt and Gilson's policy triangle model (1994) as a framework to understand the policy implementation processes. According to the framework, effective policy analysis requires examining the content of policies, the role of stakeholders and how both interact to influence policy, the processes through which the influence emerges (i.e., in formulating and implementing policy), and the context in which the different stakeholders and processes interact. The framework was applied to analyse and understand existing FGM/C-related policies in terms of the content, different policy stakeholders, and process (of formulating policy) alongside contextual stakeholders (social, political, economic) to determine the health system's implementation of FGM/C prevention and management services.

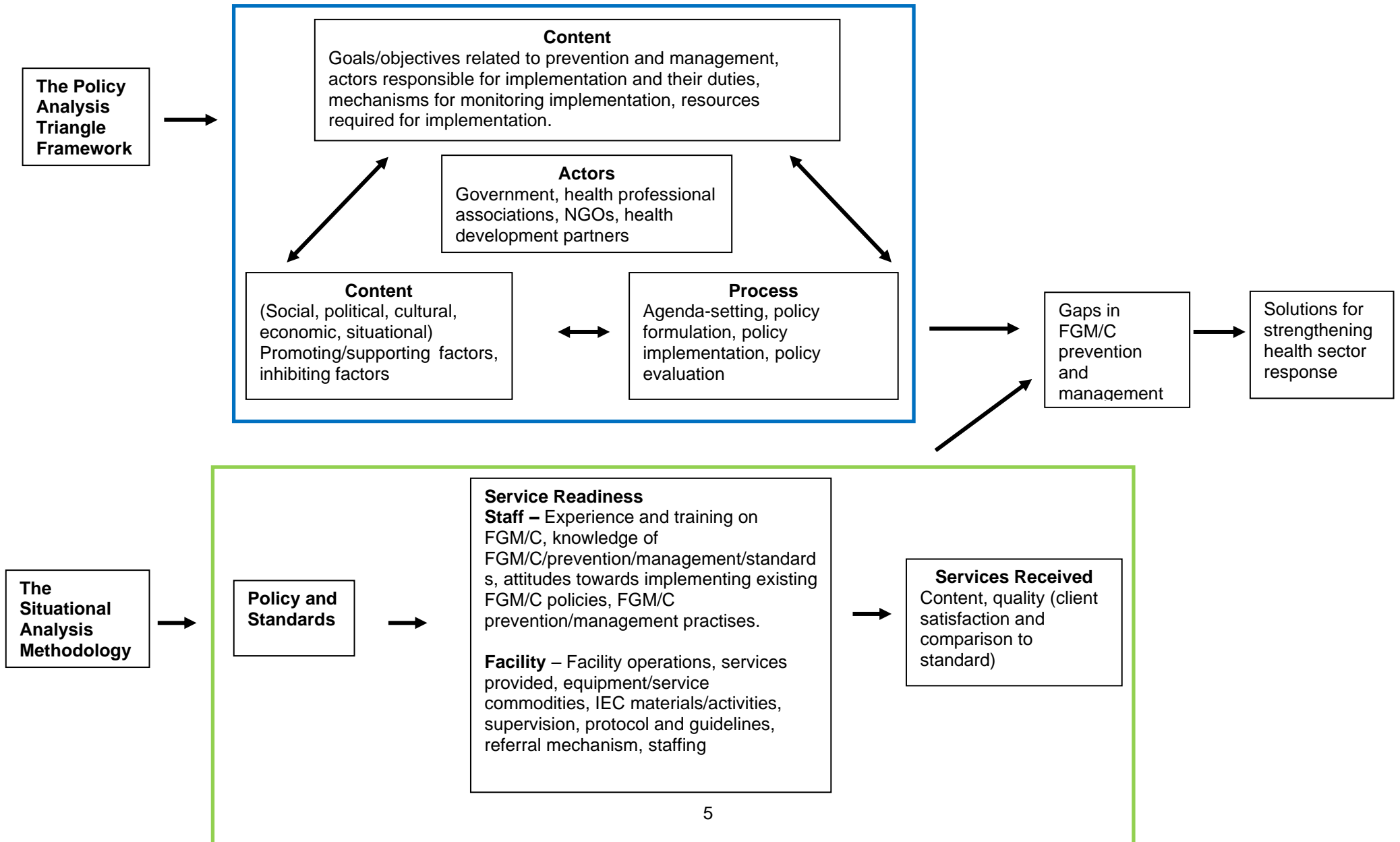
Situation analysis framework

The situation analysis framework was used to assess the health system's response to FGM/C complications and the quality of care offered to women and girls (Miller et al. 1997). As noted by Miller et al, the situation analysis framework is informed by the systems approach for Primary Health Care Operating Research (PRICOR), Ferich's Rapid Survey Methodology, and Bruce's and Jain's Quality of Care Framework, current policies and programme standards, the readiness of service delivery staff and facilities, the actual quality of service received, and impact of services on client satisfaction across service delivery points (SDPs).

Health systems framework

To organise the report and discussion of this study, the WHO health systems framework was used. The World Health Organization (WHO) in 2007 proposed a framework describing health systems in terms of six core components or "building blocks" and they are as follows: (i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines, (v) financing, and (vi) leadership/governance (Lazarus and France 2014). In essence, the building blocks contribute to the strengthening of health systems in different ways. Components, such as leadership/governance and health information systems, provide the basis for the overall policy and regulation of all the other health system blocks. Financing and the health workforce are components regarded as input to the health system while medical commodities, technologies, and service delivery reflect the immediate outputs of the health system.

Figure 1: Study theoretical framework



Objectives

Study goal

The goal of the study was to contribute to the reduction in the prevalence and ultimately the abandonment of FGM/C through a diagnostic assessment of the health sector's response to FGM/C management and prevention in Nigeria and the identification of possible solutions for strengthening the existing response.

Specific objectives

1. To examine how the healthcare sector supports the prevention of FGM/C;
2. To determine the role of the health care sector in the management of FGM/C-related complications including psychosexual effects and the quality of care offered to clients; and
3. To identify possible solutions for strengthening the healthcare sector towards management and prevention of FGM/C.

Main research questions

This study seeks to address the following key research questions:

1. How is the health sector responding to existing FGM/C-related laws and policies?
2. What role is the healthcare sector playing in the prevention of FGM/C?
3. How are contextual stakeholders supporting or inhibiting the health sector's response to FGM/C?
4. What is the availability, content, and quality of FGM/C-related service provision?
5. How is the health sector catering to the needs of women/girls who have undergone FGM/C?

Methods

Study design

This study utilised a qualitative approach as well as a health facility assessment to understand the health system's response to management and prevention of FGM/C in Imo State. The study was characterised by different data-gathering activities targeting different research participants. In all, there were seven data-gathering activities:

- 1) Structured consultative multi-stakeholder dialogues at national and state levels;
- 2) Key informant interviews (KIIs) with FGM/C policy stakeholders at national and state levels to obtain their knowledge and views about the health system's policy process related to FGM/C prevention and management;
- 3) Focus group discussions (FGDs) with health service providers to obtain information on the implementation of FGM/C prevention and management services;
- 4) In-depth interviews (IDI) with health service providers to explore their knowledge, attitudes, and practises regarding FGM/C and its management and prevention;
- 5) IDIs with clients or parents of clients who have experienced FGM/C-related complications and presented at health facilities to explore the quality of care and satisfaction with the service delivery process;

- 6) Health facility assessments in selected health facilities in Imo State to assess service readiness in terms of staffing and availability of equipment; and
- 7) A clinical grand round at a tertiary health institution.

Due to anticipated difficulty in obtaining robust information about the policy context of FGM/C and the health system's response from conventional data-gathering methods, two structured multi-stakeholder dialogues were conducted to obtain information and perspectives on the current state of the health sector's response to FGM/C, current FGM/C practise in the State, gaps in the health sector's FGM/C response, and the policy context of FGM/C. The dialogues provided a platform for relevant stakeholders to discuss their perspectives based on their experience and knowledge about the topic in focus.

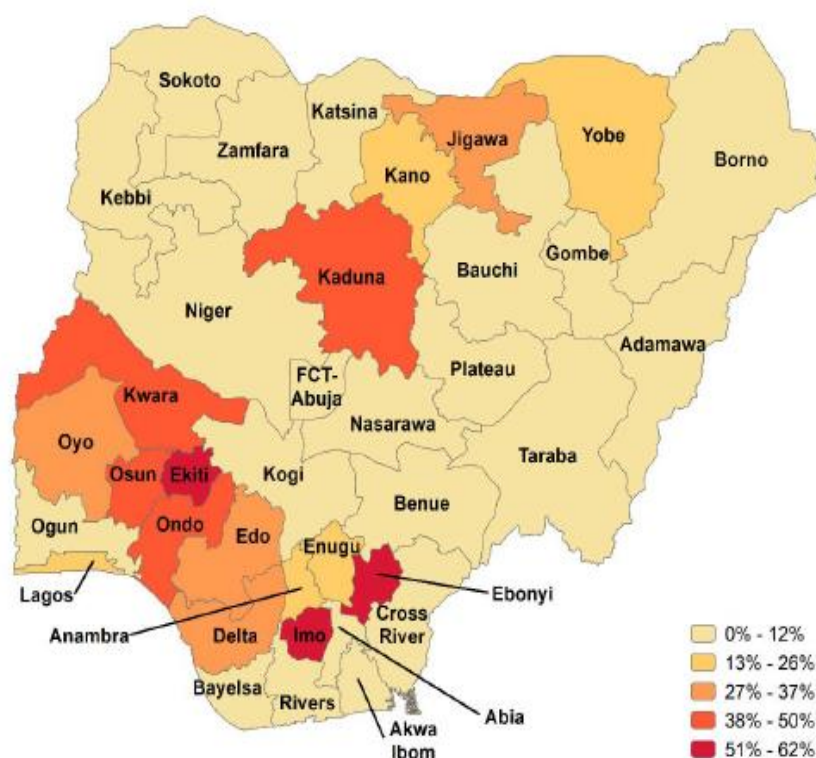
The clinical grand round is a formal meeting during which healthcare professionals (doctors/specialists, nurses, social workers, students) discuss clinical cases and recommend strategies for improved patient care. The clinical grand round facilitates interaction between health workers in a clinical setting (doctors, nurses, social workers). In this study, the grand round provided observational data to understand the process of care provided for patients with FGM/C complications. Two clinical FGM/C cases were presented at the meeting and followed by a structured discussion about diagnosis, standards of care, prevention, and follow-up. The discussion was between healthcare providers and moderated by researchers.

Study site

The study was conducted at the national level and in Imo State, in the South-East geopolitical zone of Nigeria. It was chosen for the study because it has one of the highest prevalence rates of FGM/C (68%) (NPC and ICF 2019) (see Figure 2) and 61% of FGM/C is medicalised. (NPC and ICF 2014) It is also one of the states where the UNJP is carrying out intervention programmes on FGM

Although Nigeria has about 250 ethnic groups, Hausa, Igbo, and Yoruba account for most of the population (60.7%) (CIA 2018). Imo State had an estimated population of about 4 million (49.7% female) in 2006 when the last census was conducted, and a landmass size of 5,182.8 km² (NPC 2009). The Igbo language is spoken throughout the state with slight variations in dialects. According to the NDHS 2018, 65% of men and 50% of women had completed secondary school and had more than a secondary level of education (NPC and ICF 2019). FGM/C is criminalised in Imo State under a provision of the Imo State Child Rights Law 2004 and the Imo State Female Genital Mutilation Law 2017.

Figure 2: Percentage of women age 15–49 who have undergone FGM/C



Source: NPC and ICF 2019

Participants

The study population comprised the following categories of informants:

- Anti-FGM/C advocates;
- Representatives of NGOs engaged in FGM/C abandonment interventions;
- Representatives from governmental bodies (relevant ministries and parastatals) involved in health system administration and/or the FGM/C response;
- Health development partners;
- Health professional associations;
- Health professional regulatory organisations and training institutions;
- Health service providers (doctors, nurse/midwives, and community health workers) working in tertiary, secondary, primary, and private health facilities;
- Health facility administrators of tertiary, secondary, primary, and private service delivery points; and
- Clients – women/girls who have experienced complications of FGM/C and adult men who are partners/fathers of women/girls with FGM/C-related complications.

Sampling technique

Structured consultative multi-stakeholder dialogues were conducted among a diverse group of individuals involved in the FGM/C response and the health sector at national and state levels. Participants included government stakeholders, members of health professional boards, representatives of health professional associations, health training institutions, nongovernmental

organisations (NGOs), and implementing partners working on FGM/C. Additionally, key informant interviews were conducted among different stakeholders at both the national and state levels as shown in Table 1.

Focus group discussions (FGDs) were conducted among health service providers comprising the three major cadres (medical doctors, nurse/midwives, and community health workers). In-depth interviews (IDIs) were also conducted among these participants. Additionally, IDIs were conducted among clients who had experienced complications of FGM/C and sought treatment at a health facility. The clinical grand round was conducted among diverse healthcare providers at the state level. A few of these participants were drawn from the Federal Medical Centre, Owerri while the remaining participants were drawn from the Imo State University Teaching Hospital, Orlu. The participants covered different cadres of health workers (doctors, nurse/midwives) and allied professions (such as social workers) selected from across several medical specialties/hospital units that could possibly be involved in the management of women/girls who have experienced FGM/C-related complications.

Selected health facilities were assessed for service readiness in Imo State. These health facilities were drawn across the three levels of care; primary, secondary, and tertiary. The facilities assessed also included private facilities. The primary health facilities were randomly selected across the 10 focus local government areas (LGAs) of the UNJP. The other facilities were purposively selected. These facilities were selected because the majority fall within the 10 focus LGAs of the UNJP and are also the LGAs with the highest prevalence of FGM/C in the state. The facilities that fall outside these LGAs were primarily secondary and tertiary facilities and they were chosen because of the small number available. A detailed description of the type and number of different participants is summarised in Table 1.

Selection of research participants

The selection of participants for the multi-stakeholder dialogues and the key informant interviews stemmed from the scoping visit at the state level and initial stakeholder engagement activities at the national level. Relevant organisations and governmental departments were mapped. Thereafter, the relevant stakeholders were contacted and followed up through different means such as letters, phone calls, and text messages.

For the FGDs and IDIs with health service providers, participants were selected through the health professional associations and the Imo State Hospital Management Board (SHMB). The nurses and midwives were recruited through the Imo State chapter of the National Association of Nigerian Nurses and Midwives while community health workers were recruited through the Imo State chapter of the National Association of Community Health Practitioners of Nigeria. The doctors were recruited through the SHMB. During the planning stage of the activity, the criteria for selection of health workers were sent to the associations and the Board. For the in-depth interviews with clients, three participants were drawn from two cases of FGM/C complications. As described above, one was a client while the other two were parents of a girl who had suffered complications. The parents were recruited through an FGM/C stakeholder in Imo State while the first client was recruited through the data-gathering activities that preceded the IDIs with clients.

The selection of health facilities for the HFA was guided by the following;

1. The UNJP intervention in local government areas; and
2. The information available on functioning health facilities obtained from the Imo State Primary Health Care Development Agency and the State Hospital Management Board.

According to the information gathered, it was revealed that the state had three tertiary health facilities and 11 functional public secondary health facilities also known as general hospitals. Due

to the limited number, all 11 functional public secondary facilities were assessed. Two out of three tertiary health facilities were assessed. These tertiary facilities were Imo State University Teaching Hospital, Orlu, and State Specialist Hospital, Umuguma. At least three primary healthcare (PHCs) facilities and one private health facility were selected per UNJP intervention LGA. Thirty-eight PHCs were randomly selected from a pool of 195 primary healthcare facilities. These facilities were assessed across 14 LGAs of Imo State.

Table 1: Overview of the data-gathering activities of the health system study

S/N	Data-gathering activities	Study Population	Sample size	Location of activity	Methods	Duration
1	Multi-stakeholder dialogue	Anti-FGM/C advocates, representatives of NGOs engaged in FGM/C abandonment interventions, governmental bodies involved in health system administration and/or the FGM/C response, and health professional associations	32	Federal/national and state level, neutral setting	Facilitated structured dialogues led by PI	July 21, 2018 (State-level dialogue); July 26, 2018 (National-level dialogue) July–August 2018
2	Key informant interview	Representatives from the government (relevant ministries and parastatals), private organisations, NGOs, health development partners, health professional associations, health professional regulatory organisations, and training institutions	11	Federal/national and state level, neutral setting	Face-to-face interview	July–August 2018
3	Focus group discussions with health-care workers	Healthcare workers (doctors, nurse/midwives, community health workers) working in tertiary, secondary, primary, and private health facilities	59 (doctors—13; community health workers—24; nurse/midwives—22)	State-level, neutral setting	Focus group discussions led by PC research assistants	6–8 September 2018
4	In-depth interviews with health -care workers	Healthcare workers (doctors, nurse/midwives, community health workers) working at selected service delivery points	10	State-level, health facility	Face-to-face interviews led by PC trained research assistants	10–14 September 2018
5	Health facility assessment	Health facility administrators of tertiary, secondary, primary, and private service delivery points	61	State-level, health facility	Research assistants administered facility checklist	November 19–December 4, 2018
6	Clinical grand round	Multi-specialty health workers across cadres and allied professionals involved in FGM/C care	84	State-level, health facility	Case presentations & discussions by health providers	November 2, 2018
7	In-depth interview with clients	Clients – girls and women who have experienced FGM/C-related complications and received services from the health system; parents of girls who have experienced FGM/C-related complications and received services from the health system	3	State-level, neutral setting	Face-to-face interviews led by PC trained research assistants	1–2 February 2019

Instruments

The health system study component used multiple instruments—guides for the multi-stakeholder dialogues, KIIs, FGDs, and IDIs as well as a health facility assessment (HFA) inventory. The multi-stakeholder dialogue guides contained questions targeted at assessing general knowledge of FGM/C in Nigeria and Imo State, the general response to FGM/C in Nigeria and Imo State, the health system's response to FGM/C including what is currently being done and the key stakeholders involved, prevention and management of FGM/C complications, and the effectiveness of the health system's response.

The KII guide focused on events that triggered agenda-setting on FGM/C, the input of different stakeholders in the implementation of health system FGM/C policies, implementation of the policy, and the process relating to FGM/C management and prevention strategies emanating from the policy. The FGD guide focused on eliciting responses on healthcare providers' experience and training on FGM/C, knowledge of FGM/C prevention/management standards, attitudes towards FGM/C practise, attitudes towards implementation of existing FGM/C policies, and FGM/C prevention/management practises including referral mechanisms and supervision.

The guide for IDIs with healthcare providers addressed general attitudes and knowledge on FGM/C, management of FGM/C complications, prevention of FGM/C, supervisory mechanisms and documentation of FGM/C. The HFA inventory is a 129-question tool comprising nine sections designed to garner information on facility operations; provision of services; availability of equipment and service commodities; availability of information, education and communication materials and activities; supervision; availability of protocols and guidelines; referral system related to FGM/C; and staffing. The tool was interviewer-administered with every session facilitated by two field assistants and a supervisor.

The validity of the guides and inventory was ensured through an extensive literature review to identify necessary questions and variables. The draft instruments were reviewed by four researchers at the Population Council, pretested, and revised prior to the data gathering activities.

Data collection

The data-gathering activities for this study started with the multi-stakeholder dialogues held in July 2018. This informed the methodology of the other activities as plans were modified according to field realities. The KIIs followed the dialogues and these interviews were conducted from July to August 2018. After the KIIs, the focus group discussion and in-depth interviews with health service providers were conducted consecutively in September 2018. The clinical grand round was conducted at the Imo State University Teaching Hospital in November 2018. The health facility assessment was conducted from November to December 2018. The last data-gathering activity for the study was conducted in February 2019. The data-gathering activities were conducted in safe, conducive environments with keen consideration for ethical and cultural sensitivity.

Data analysis

Qualitative data

All audio recordings and electronic copies of transcripts were stored on password-protected computers in folders on a secure network. All hard copies of inventories, checklists, and questionnaires were kept under lock and key at the Population Council office in Abuja, Nigeria and were only accessible to the members of the research team. The audio recordings were transcribed using a transcription protocol developed for the study. The qualitative data-gathering

activities addressing similar research questions and similar research participants were analysed together.

The transcribed qualitative data were reviewed by the research team and transferred to NVivo 12 software to organise the data for analysis. Thematic analysis was used to explore emergent themes from the data. Three researchers read the transcripts for initial familiarisation of data and codebook development. The codebook was developed using a hybrid approach drawing from the elements of the conceptual framework and the emerging themes. The researchers coded the same transcripts to ensure that the codes were consistently applied, and discrepancies were resolved through a consensus-building approach guided by the research objectives. The final themes were used to develop a final thematic framework.

Quantitative data

For the health facility assessment data, administered inventories were checked by data collectors after each activity. They were further checked for completeness by supervisors of each group before being sent to the Population Council Office in Abuja, where forms were rechecked and edited for completeness and accuracy by a data analyst. A serial number was appended on each copy of the tool for easy identification, and recall of any instrument with problems for correct data entry and analysis. A coding guide was also developed after a careful review of responses to facilitate coding and data entry. Data were entered with SPSS version 22 and analysed using descriptive statistics.

Ethical considerations

The study received ethical approvals from the Institutional Review Board of the Population Council, the National Health Research Ethics Committee, and the Imo State Ministry of Health. Administrative permission was sought from the Imo State Ministry of Gender Affairs and Social Development, Imo State Primary Health Care Development Agency, and the Imo State Hospital Management Board. Permissions were also sought from health facilities before assessment.

Steps were taken to minimise risk for facility heads and other interviewees that participated in the activity. Information provided by participants was treated with anonymity and confidentiality by the study team. This was done by removing personal identifiers from study materials. Participants were only required to provide verbal informed consent and, as a result, did not have their names and signatures tied to informed consent forms. During the informed consent process, the aims of the study and possible risks were thoroughly explained. Participants were assured of their rights, particularly that they could withdraw from the study at any time. They were also assured that their responses would not be shared with other parties including regulatory bodies, their supervisors or employer, and the police.

Results

As previously described, a total of 176 people comprising a wide range of stakeholders, health service providers, and clients were engaged in focus group discussions, key informant interviews, in-depth interviews, and stakeholder dialogues as shown in Table 1. In addition, facility assessments were conducted in 61 health facilities. Findings from the different data-collection approaches are integrated and discussed in line with the WHO Health Systems Framework's six building blocks: leadership and governance, finance, service readiness, health workforce, health information systems, and availability of medicines.

Leadership and governance

FGM/C policy formulation and dissemination at the national level

There was a consensus among stakeholders that elimination of FGM/C practise in Nigeria required multi-sectoral collaboration by governmental and nongovernmental partners to drive policy formulation, facilitate policy implementation plans, and create an enabling environment for stakeholders. The NPPA and the VAPP Act shaped the implementation of FGM/C activities in Nigeria. The government's commitment to develop the policies that will facilitate an enabling environment for FGM/C programme implementation was acknowledged. Unfortunately, the government had not provided the financial resources needed for implementation.

“...the government of Nigeria is doing something because FGM eradication is important to them.... In the new law of VAPP, in the national policy and plan of action, [there are] standards and guidelines for medical management of victims of violence in Nigeria...but it is implementation that is the issue,... This is to tell you that it is important for them, but the issue now is financial involvement, which is key to get it done we are looking at to get it done. Government has not really done anything on that aspect and it's a problem....”

—Participant from multi-stakeholder dialogue

Conversations about the need for a policy agenda for FGM/C in Nigeria dates as far back as 1998 when a national baseline study on harmful traditional practices affecting women and girls was conducted indicating a high prevalence of FGM/C. Stakeholders believed that the policy and action plans were shaped by findings from the National Demographic and Health Survey (NDHS) that highlighted FGM/C prevalence in Nigeria. The first NPPA developed in 2006 was based on the findings from the 2003 NDHS; some stakeholders reported that the plan underestimated the level of response needed to facilitate abandonment because the 2003 NDHS underreported FGM/C prevalence especially in the North West. The revised 2013 NPPA was a better reflection of the FGM/C situation and action needed.

“The national policy and plan of action was done in 2006, it had a life span.... So, in 2013, we felt it has already stayed for seven years and it was time for it to be reviewed... the first policy did not show this much prevalence, but with the second policy that is the reviewed policy, it became obvious that this practice is actually prevalent, but we didn't know about it. Another reason why we reviewed it is also because the Nigerian Demographic and Health Survey (NDHS) had painted a picture that the prevalence was low, and you know when government sees that it is low, government will not give you priority.”

—Key informant, national policymaker interview

Participants reported that the policy development process was guided by international conventions and contributions from participants at national, state-level, and development organisations. National-level participants were aware of the multidisciplinary nature of FGM/C issues and noted that different stakeholders participated in the policy formulation process, such as NGOs and CSOs, professional organisations such as the Society of Gynaecologists and Obstetricians (SOGON), the National Association of Nurses and Midwives (NANM), and the Medical and Dental Council (MDCN), as well as government ministries/parastatals. Awareness of the FGM/C policy and plan of action at the national level was good as a majority of stakeholders were aware of the plans.

Although the draft NPPA document was presented to regional stakeholders for validation and adaptation based on specifics within their region prior to the policy dissemination process, which was led by the Federal Ministry of Health (FMOH), some participants felt that state-level participants were not involved. One of the key activities of the UNJP was to encourage state domestication of VAPP in Imo State, as well as other high-prevalence states.

“It was multi-stakeholder, though I cannot say it involved state-level participants. But at the federal level, CSOs, governmental organisations, people were involved in the development and we had contributions, it was highly participatory, people recognised the fact that it is a practice that must end. So, in terms of the length it went to, it did not go down to the state level...”

—Key Informant, national development actor interview

Funding issues hindered the capacity of FMOH to visit all the high-prevalence states and there was a consensus among participants that the NPPA document was not adequately disseminated to state-level stakeholders, resulting in limited awareness of the policy at the state level. The limited knowledge of policies at the state level was noted to ultimately affect policy implementation. In some high-prevalence states such as Imo State, stakeholders were not aware of the FGM/C policy document and no technical committee was constituted to implement the plan of action after the guidelines were developed. Some participants reiterated that the state stakeholders were not part of the policy formulation.

“... when I joined this programme in October 2015, I wasn't even aware of the policy at that time, I ran into someone that had the copy so I made photocopies and when I took it to the Ministry of Health in Imo State they hadn't seen the policy, I was the one that gave them the first copy of the policy and we have tried to relate with it in terms of doing our meeting with the State Technical Committee, which is one of the provisions in the policy that every state must have a multi-sectoral committee that will coordinate FGM intervention in the state. The state has not drawn its activities from the plan....In April we tried to get the committees to function according to the policy, because the policy there are eight responsibilities for the committee, so we try to form subcommittees to unbundle those responsibilities and also to use the plan of action... in advocacy to the government in terms of funds saying that there is already a policy in place and with resources we can actualise what we can so that they won't be over-dependent on joint programme activities.”

—Key informant, state development actor interview

State-level operationalisation of FGM/C policies in Imo State

Participants from Imo State reported on the complications of implementing laws and policies related to FGM/C in Imo State:

“... I am aware of The Violence Against Person's Prohibition Act of 2015...In Imo State we have the Child Rights Law of 2004 which has a provision on FGM but then we had an interesting scenario...We had the VAPP that was passed in 2012, and after one year it was repealed because there was an offensive part of that law, "termination of pregnancy," so they repealed the entire law on VAPP... But now, there is a bit of a confusion because at some point we had the VAPP law which had a provision against FGM, we also had the sexual offence bill which was also presented in the House at the same time. At the point, both bills got to second reading and then things had to stop and then House committee on health decided to go ahead with the Sexual Offence Bill because they felt it is weightier to have it as a single offence bill than to have it embedded in VAPP. I heard this directly from the head of the legal department of the House of Assembly....”

—Key informant, state development actor interview

“one of the gaps is that the existing law is not being implemented, we know that Imo State has passed this law on female genital mutilation for over 10 years now and I don't know of any arrest....I think that the political will to implement these laws [is] not there.”

—Participant from state multi-stakeholder dialogue

Despite these legal frameworks in place in Imo State, participants opined that policy implementation in the state was poor, and no offender had been convicted since the laws were

enacted. A national-level participant corroborated this point by stating that in the states that had domesticated the VAPP Act, the implementation was ineffective.

The State Technical Working Committee for FGM/C in Imo State was reported to be non-functional due to inadequate personnel dedicated to FGM/C programmes. Meetings were irregular, coordination was poor and focal staff for FGM/C lacked office space. The State Ministry of Health, which was charged with the responsibility of policy implementation was limited by resources and the government lacked the political will to prosecute offenders. In addition, stakeholders believed that the government (both Federal and State) placed a low priority on FGM/C programmes compared to other healthcare programmes and public health issue such as HIV/AIDS and Ebola that required an urgent and structured response.

“FGM in Imo State has not been viewed in terms of an emergency that needs that kind of response, like we have some AIDS victims, we know where we direct them to....but as regards FGM, everything that is being done now is either in theory, in policy formulation.”

—Participant from multi-stakeholder dialogue

“...in terms of how FGM rests on the issue of public health, I would like to say that it is not really something that is considered as a burning issue presently. As a member of the Association of Public Health Physicians of Nigeria, I will say in the last five scientific conferences we had, not even a single paper has [discussed] FGM. Things like universal health coverage, regulated tropical diseases are considered the burning issues.”

—Participant from multi-stakeholder dialogue

Challenges with policy formulation, dissemination, and domestication

Funding challenges limited the participation of relevant state stakeholders during the policy formulation process. Many participants at the national level asserted that the limited involvement of states and relevant ministries during the policy formulation and dissemination process adversely affected the policy implementation process. Poor dissemination of the policy by the FMOH resulted in little or no awareness of the existing policies and poor communication between ministries, departments and agencies also meant that they did not understand the linkages and synergies required for policy implementation. This ultimately impacted the sensitisation of CSOs working on advocacy and, consequently, the public. Finally, the state activities were not driven by activities described in the policy and action plan because of a lack of awareness.

“Because you have a plan of action, plan of action comes with funding anyway, so if the funding is not there it limits what you can do in terms of implementation. So, even if there are relevant personnel who by the way are not enough. Even if they are there and there is no allocation of funds to support the implementation, it's still a gap.”

Participant from national multi-stakeholder dialogue

In Imo State, the Ministries of Gender Affairs and Health had shared responsibilities for coordinating the activities in the policy and action plan. There were, however, issues with coordination of meetings between these ministries. Other relevant health system stakeholders such as the State Primary Health Development Care Agency (SPHCDA) and Department of Planning, Research and Statistics (DPRS) were not properly engaged in policy implementation, resulting in poor collaboration between health system and FGM/C response organisations such as NGOs, CSOs, the health professional associations, and regulatory bodies. This consequently led to a suboptimal response for prevention and management of FGM/C.

“The other problem that I see is that the policy says that Ministry of Health is the convener and Ministry of Women Affairs is the co-convener, so depending on the state and who has the resources to organise the meetings. There have been power dynamics in terms of holding those meetings and then implementing the resolutions. If you look at the 20 statutory people listed on that committee, six of them come from Ministry of Health showing clearly that this sector contributes more.... So, if you look at all the people who

are involved, they are those who are responsible for generating the report from that sector and implementing the programme, but it hasn't really worked out that way...."

—Key informant, state development actor interview

"... the professional associations are not really doing the work they are supposed to be doing.... How many of their members understand these issues as real health challenges? It is an issue, be it National Association of Community Health Practitioners, be it the nurses, and be it NMA. Are they addressing these issues from such a perspective that they want to assist government?"

—Participant from national multi-stakeholder dialogue

In addition to the funding from the UNJP for FGM/C programmes in Nigeria, the government's funding commitment was also noted to be important for the ownership and sustainability of programmes. Some participants noted that the paucity of funds at the federal and state levels resulted from delays in budget approval and slashing of budgets at the approval stage. At national/state level, government's commitment was low because FGM/C was not a priority.

These issues resulted in low motivation of health workers, poor engagement of relevant stakeholders such as health professional associations and private health facilities. Private health facilities were considered important stakeholders because a large proportion of women visit them, and staff capacity was low because they did regularly receive formal training, some were not licensed/registered, and possibly they did not possess a sound knowledge of FGM/C and its consequences.

Finance

Budgeting and funding for FGM/C activities

There was consensus among participants that most of the funding for prevention activities for the ministries, departments, and agencies was from development partners and international NGOs resulting in funded activities centred on donor priorities. Although the government expressed interest in addressing FGM/C, this interest was not backed by financial investments in advocacy and programme or policy implementation. Some stakeholders pointed out that domiciling FGM/C in the gender department as opposed to the reproductive health unit as in the case of vesicovaginal fistula (VVF) affected funding and commitment to FGM/C. Some state stakeholders reported using personal funds to implement the FGM/C activities.

"... UNFPA has been wonderful in terms of support. If not UNFPA and UNICEF, for us as Federal Ministry of Women Affairs, we would have been doing nothing as far as FGM is concerned and I think one of the big gaps at government level is the issue of budget. It's one thing to budget for FGM, it's another thing for the budget to get approved by the national assembly...."

—Participant from national multi-stakeholder dialogue

"The response is always the lack of funds, even to set up technical working groups, the policy provides that technical working groups, and national advisory or state advisory groups hold meetings for such things to be established, that they are not encouraged, the states are not even thinking in that direction. So, it's always been that we will provide the policy, provide the guidelines, but the money has to be spent by the state and most times they just tell you that [there are] no resources..."

—Key informant, national policymaker interview

The FGM/C activities were limited to UNJP focal states and selected communities; participants expressed concerns that FGM/C activities did not cover communities outside UNJP coverage. To mitigate the challenge of funding multiple programmes, some stakeholders recommended the integration of FGM/C services into existing programmes such as reproductive health. The future

sustainability of FGM/C programmes was also discussed as well as the need for the federal and state governments to take ownership.

“Whatever we are doing in the Federal Ministry of Health is under donor support. Outside donor support, no kobo [money], nothing from the government that is motivating the work on FGM. My own observation that is supposed to be integrated into reproductive health and not standing alone....”

—Participant from national multi-stakeholder dialogue

“You know they [international donors] can’t be there for life for us. That’s why the issue of ownership is key. We just have to see it as our project. At least for now it is a bit stable, you know they themselves are gathering money from donors....”

—Key informant, national NGO interview

Service readiness

Services provision

There were two categories of services that were provided by the health system and FGM/C programme implementers—community-based services and health-based interventions.

Community-based services

Community-based services ranged from community dialogues, sensitisation of community leaders, training of FGM/C champions, school sensitisation, and social media advocacy to provision of alternative income for cutters as shown in Table 2. Innovative ways of reaching community members in Imo State included church meetings, and women’s programmes, as platforms to gather all community-level stakeholders in the state—especially the influencers of FGM/C such as mothers-in-law, women leaders, and elders—to sensitise them on FGM/C and its effects. Champions were also trained to do house-to-house advocacy in states with high prevalence rates of FGM/C. The capacity of community-based teams to provide services to communities was limited by logistic issues that made it difficult to gain access to remote areas.

Table 2: Service provision (FGM/C activities led by health and FGM/C stakeholders)

Community-based activities	
Community dialogue and sensitisation	<i>[Among] The traditional rulers, after having a meeting with them and telling them the dangers involved and the number of people dying as a result of mutilation, during the training we found out that some of them are also... experiencing such problems, they cannot fully have marital sex because of the danger of mutilation. It is through our sensitisation and dialogue that they started knowing what it is... So, they started restricting, there was even a time most of the communities started coming up for declaration and they have their certificate. —Key informant, state policymaker interview</i>
Training of Champions	<i>You know we have trained some of the champions who monitor the women when they are pregnant, follow them until they deliver, follow the child until the child is up to 2 months. We trained them, they will go to their Eze and do advocacy....They will be going house to house and also finding those that are mutilated and those who are not mutilated. Those that are pregnant, up to their delivery they monitor these people and give us feedback. — Key informant, state policymaker interview</i>
Social media advocacy	<i>We are really engaging the youth. We realised that the youth of nowadays if you want to catch them, use social media. So, we have a social media advocacy group, on Instagram, everywhere and then every Thursday there is a Twitter conference between 5 and 7 pm. There is also a frown challenge, [where] we frown at FGM. It is part of the advocacy to end it. And next week the topic is, “what are the roles of students/youth in FGM eradication”, to ensure that people come together and discuss it.... —Participant from state multi-stakeholder dialogue</i>
School sensitisation	<i>...the main programme we did then was school sensitisation on FGM. The programme was grouped into three but was mainly about sensitising the schoolchildren about FGM and making sure they actively participate... but some of them were not within our direct programme...We visited about seven schools, but it was mainly in the areas with the high prevalence rate.... That was my first time having direct contact with FGM. —Key informant, state policymaker interview</i>
Training and provision of alternative income-generation for cutters	<i>This quarter we planned for an alternative source of livelihood (for traditional cutters). When we are stopping them from taking ₦2000 for a child, to “not cut again,” we then gave them ₦10,000 to start another business, when we are not there they will always go back to the table and start cutting. —Key informant, state policymaker interview</i>
Health-based interventions	
Health workers training on prevention and management of complications	<i>We’ve carried out interventions that are targeting state ministries of health providing them with [information about] what FGM is, the types that are [practised] and what could be done for those who have been mutilated, and we’ve also provided the information on how it could be prevented by way of discouraging doctors who may wish to do that, whether in government facilities or outside government facilities, providing them information on the dangers of FGM. —Key informant, national policymaker interview</i>
Inclusion of FGM/C topics in the curriculum of health professional school	<i>This has always been enshrined in our curriculum. From the training of junior CHEWs (community health extension workers) to the senior CHEWs and to the community health officers, the senior cadre of them. This has always been a robust part of their curriculum and when we do our ANC in the primary healthcare centre, FGM teaching forms the bulk of the health education delivered to mothers when they come to antenatal clinics. — Participant from national multi-stakeholder dialogue</i>

Results from the Health Facility Assessment (HFA)

Services provided at the facility level

It is necessary to understand the scope of services provided at the different levels of care to better describe the performance of the health system as a whole in addressing FGM/C as well as service readiness. Services pertaining to FGM/C include sexual and reproductive health services as well as psychosexual services. The services assessed are those that would indicate the capacity of the health facility to respond to the possible cases of FGM/C complications.

The provision of services per facility is highlighted in Table 3. Most PHCs provided services on HIV testing (92.1%), HIV counselling (92.1%), family planning (81.6%), antenatal care (97.4%), childbirth and delivery (94.7%), postpartum care (92.1%), essential newborn care (97.4%), child immunisation (100%), child growth monitoring (89.5%), and emergency outpatient care (94.7%). Specific FGM/C management services were provided by 63.2% of PHCs. In contrast, fewer PHCs provided the following services: screening and treatment of sexually transmitted infections (STIs) (28.9%), HIV treatment and care (7.9%), prevention of mother-to-child transmission (15.8%), assisted vaginal delivery (13.2%), and psychological/psychiatric services (21.1%).

For secondary/tertiary health facilities, all provided services on HIV testing, HIV counselling, antenatal care, and emergency outpatient care. Most provided services on screening and treatment STIs (95.7%), family planning (87%), infertility consultation (82.6%), pelvic exams (95.7%), childbirth/delivery (95.7%), postpartum care (91.3%), post-abortion care (95.7%), and sexual and gender-based violence treatment and counselling (91.3%). The proportion of secondary/tertiary facilities that provided specific FGM/C services was 69.6%. Only 39.1% provided psychological/psychiatric services.

Most health facilities had general protocols and guidelines, but none had a protocol on FGM/C. Of the types of protocols and guidelines available, more (31.6%) health facilities had the basic guide on immunisation for health service providers in Nigeria. Protocols and guidelines were used at 79.6% of assessed health facilities

Table 3: Provision of services from the Health Facility Assessment (HFA)

% of services provided per facility	PHC (n=38)		Secondary/tertiary (n=23)	
	(n)	Percent	(n)	Percent
Screening and treatment of sexually transmitted infections	11	28.9	22	95.7
HIV testing	35	92.1	23	100
HIV counselling	35	92.1	23	100
HIV treatment and care	3	7.9	13	56.5
Prevention of mother-to-child transmission	6	15.8	13	56.5
Family planning	31	81.6	20	87.0
Infertility consultation	17	44.7	19	82.6
Pelvic exams (inspection of the vulva and vaginal examination)	24	63.2	22	95.7
Whether specific FGM/C management services were provided for women/girls who have had FGM/C-related complications	24	63.2	16	69.6
<i>FGM/C management services</i>				
<i>Episiotomy</i>	18	47.4	15	65.2
<i>Counselling</i>	11	28.9	13	56.5
<i>Control of bleeding</i>	4	10.5	2	8.7
<i>Management of VVF</i>	0	0.0	1	4.3
Antenatal care	37	97.4	23	100
Childbirth/delivery	36	94.7	22	95.7
Assisted vaginal delivery	5	13.2	13	56.5
Caesarean section	1	2.6	22	95.7
Postpartum care	35	92.1	21	91.3
Post-abortion care	22	57.9	22	95.7
Essential newborn care	37	97.4	21	55.3
Child immunisation	38	100	14	60.9
Child growth monitoring	34	89.5	16	69.6
Emergency outpatient care	36	94.7	23	100
Psychological/psychiatric services	8	21.1	9	39.1
Typology of psychological/psychiatric services (n=16)				
<i>Counselling</i>	5	13.2	4	17.4
<i>Give drugs and injection</i>	2	5.3	2	8.7
<i>Management of mild cases</i>	0	0.0	2	8.7
<i>Manage schizophrenia, depression, drug abuse/addiction</i>	0	0.0	1	4.3
Sexual and gender-based violence treatment and counselling	21	55.3	21	91.3
Laboratory services	25	65.8	22	95.7
Availability of protocols and guidelines				
Availability of protocols and guidelines in the facility (n=61)	34	89.5	12	52.2
Use of protocols and guidelines (n=54)	31	81.6	12	52.2
Whether available protocols and guidelines for delivering reproductive health have been reviewed in the last five years (n=54)	31	81.6	12	52.2
Whether latest version of protocol is available (n=51)	31	81.6	11	47.8

Supervision of health facilities and availability of protocols and guidelines

Supervision of health facilities helps to ensure service readiness by monitoring the implementation of services and addressing real-time service gaps that might occur. As a result, supervision ensures quality of services, especially those focused on FGM/C.

The average number of weeks between supervisory visits to facilities was 9.0 ± 12.5 weeks, the median was 5 weeks with the minimum and maximum number of weeks being 0 and 52 weeks, respectively. Less than half (42.6%) of the health facilities assessed were visited 5 weeks or less before the assessment, while 36% of health facilities were visited 6 weeks or more before the assessment. As shown in Table 4, the Imo State Ministry of Health visited more (41.4%) health facilities than other organisations. During visits, supervisors inquired about service problems (66.7%), examined records (82.8%), and made suggestions for improvement (69%). Few supervisors were reported to check infrastructure (5.2%), check basic equipment (1.7%), check essential drugs (3.4%), and check staffing (3.4%).

Table 4: Supervision of the health facilities from the Health Facility Assessment (HFA)

Information on supervision per health facilities	(n)	Percent
Number of weeks before assessment that facility was visited (n=61)		
None	13	21.3
≤5	26	42.6
6–10	11	18.0
≥11	11	18.0
Mean = 9.0 ± 12.5 weeks; Median = 5 weeks; Minimum = 0 week; Maximum = 52 weeks		
Organisation that visited health facilities (n=29)		
<i>Imo State Ministry of Health</i>	12	41.4
<i>Government – Local Government Area</i>	7	24.1
<i>Hospital Management Board</i>	4	13.8
<i>State Primary Health Care Development Agency</i>	3	10.3
<i>Federal Ministry of Health</i>	1	3.4
<i>Nongovernmental Organisation</i>	1	3.4
<i>State Ministry of Finance</i>	1	3.4
Whether the supervisor:		
Observed the delivery of service (n=56)	36	64.3
Inquired about service problems (n=57)	38	66.7
Examined records (n=58)	48	82.8
Made suggestions for improvement (n=58)	40	69.0
Checked infrastructure (n=58)	3	5.2
Checked basic equipment (n=58)	1	1.7
Checked essential drugs (n=58)	2	3.4
Checked staffing (n=58)	2	3.4

Health-based interventions

Training of health workers and inclusion of FGM/C topics (prevention and management of complications) into the health-professional training curriculum was considered a key component of health-based interventions. Participants at state and federal levels pointed out that a smaller version of these trainings was organised for health workers who work with girls and women at the community level. Healthcare workers were also sensitised on how to educate pregnant women about FGM/C and examine newborns who were brought to the facilities for weighing and immunisation. Health workers were expected to fill FGM/C reporting forms and pass them to the

state authorities. Private health facilities and traditional cutters in Imo State were also trained on harmful effects of FGM/C as well as referral pathways for clients who have undergone FGM/C and experienced complications. These activities were carried out by the Ministry of Gender Affairs and supported by UNFPA.

Complications of FGM/C

Participants who provide FGM/C services reported that they had provided treatment and care for a wide range of complications as shown in Table 5. Some of the immediate complications mentioned were bleeding and infections, while long-term complications were clitoral cyst, Vesicovaginal Fistula (VVF), vaginal adhesions, keloids, difficulty with labour/delivery and psychosexual dysfunction.

Management of immediate and long-term complications

There was consensus among health service providers that the management of FGM/C complications was guided by three key factors—the severity of the complication, the availability of the right equipment and supplies to manage complications, and the expertise of the health service provider. In instances where a patient with severe bleeding as a complication of FGM/C presented at a primary healthcare clinic with no access to blood transfusion services, the patient was stabilised and immediately referred. A health service provider also reported an instance where a patient with VVF was stabilised, treated for urinary tract infection, and then referred to a fistula repair centre for further treatment.

Psycho-sexual complications

There were mixed views among stakeholders in Imo State on the occurrence, importance, and management of psycho-sexual complications. While some did not view it as important enough to warrant treatment/counselling, others felt it was an important complication that required more attention than it was currently getting. Some of the complications mentioned include sexual dysfunction, dyspareunia, and depression. Counselling of the woman and her partner was considered critical in the management of psycho-sexual complications. In addition, a health service provider highlighted the importance of home visits and sex education. Health service providers, however, reported that they did not have technical expertise to conduct psychotherapy and provide other psychological services needed. Women who needed surgical procedures for vaginal stenosis or required mental health services were referred to specialists.

Table 5: Health service providers' perception of immediate and long-term complications of FGM/C from Focus Group Discussions and Clinical Conference with Service Providers

Complications type	Management
Bleeding	<p><i>For bleeding, it depends on the severity of the bleeding. If it is a minor one, I will arrest it by applying pressure for a long time and it stops. But when the bleeding is much and the child has stayed too much at home, we refer to the hospital for further management. Sometimes they do transfusion and at times they suture that region —Nurse/midwife</i></p> <p><i>When I was in Osu, I delivered a child. The mother-in-law of the lady insisted that the child will be circumcised. I usually give a health talk on the implications of FGM/C. After I instructed them, they went home. These young mothers are often intimidated. This mother-in-law took the baby to a local TBA [traditional birth attendant]. After circumcision, the bleeding became uncontrollable. They had no other option than to call me back to arrest the bleeding. When I got there, I was mad at them. But by His mercy, I was able to arrest the bleeding and the child survived. —Nurse/midwife</i></p>
Infections	<p><i>If it's an infection, you culture the organism then you treat. —Medical doctor</i></p>
Clitoral cyst	<p><i>A patient comes with clitoral cyst, naturally the patient will ask "but Doctor, what may have caused this?" You know, ladies being what they are, the next thing is that [they will ask], "is it infection?" It's the commonest thing and any doctor will just explain, "well, this is because you did female genital mutilation." And what can be done about it?"We'll have to remove it and of course, if you do it for your daughters, it will happen." —Clinical Conference participant</i></p>
Urinary tract infection	<p><i>During the visit we saw a 6-year-old girl; she [was] having this urinary tract infection as a result of the mutilation. The UNICEF and the World Health representatives that accompanied us to the programme took her to Abakaliki where they told the parents that they will keep on managing the girl till 12 years where she will be corrected through operation. The girl is now on medication. —Nurse/midwife</i></p>
Constriction of the vagina and vesicovaginal fistula	<p><i>As a gynaecologist, when we see such patients ... with constriction of the vagina, most times we can do what we call vaginoplasty, just a reconstructive surgery.... Sometimes we can actually do a reconstructive surgery vaginoplasty for a patient. [But many] of them can also come with what we call vesicovaginal fistula especially in the north where they usually do Angura or Gishiri cuts. There's a fistula repair centre we have in the south east, in Ebonyi state; most times we refer them where the treatment is free. So, most of them can come with fistula so we do a fistula repair either trans-abdominal or trans-vagina. —Medical doctor</i></p>

Labour and delivery complications	<p><i>That scar tissue formation makes a child unable to come out because of the vagina and the other parts that assist during delivery should be elastic but because of the scar tissue formation, it makes it to be stiff. This can lead to bleeding and the woman deliver through caesarean section because the head of the child will not pass through the birth canal because of the scar tissue formation. —Clinical conference participant</i></p> <p><i>I have also worked in a labour ward, where a young lady came; she was already in labour. When they wanted to examine her, the first midwife went and told the senior midwife, “sister, I didn’t see where to put my hand (finger).” I went there; her vagina was completely sealed with a small opening.... So, this is a clear case of CS, it was done, and another surgery was done on the vulva, it was separated... —Nurse/midwfe</i></p>
Psycho-sexual complications	
Sexual dysfunction/vaginal stenosis	<p><i>The most we know is to talk to them to relax; fear is already in them so there is a lot of counselling to ensure that that fear is removed. Then the next thing is to teach them other methods of sexual acts that will enhance their pleasure, but if there is a problem with penetration it means you ... refer, but I am yet to come up with such a case.... —Nurse/midwfe</i></p> <p><i>You try as much as possible to talk to the woman, if there is nothing much you can do and there are not so [many] drugs that can help in this situation, all you need to do is to talk to the woman and then educate her on the better way to enjoy sex because some of them do not even know. They think that the reason that makes them enjoy sex is the clitoris but there are other things that you can apply in the foreplay. So you now need to train the woman there and then, that “look at what to do and then extend your foreplay, and before you know it you now begin to enjoy yourself like others who have not been mutilated” —Medical doctor</i></p>
Sexual dysfunction (psychological)	<p><i>When it goes beyond what you can handle, where probably the person has started displaying some mental disorder when it begins to affect the person’s sanity, that is where you know that you should direct the person to the right place. But if it borders on just emotions and not something that is causing depression you can counsel the person based on the knowledge you have—that this thing has been done for years and you should not allow it to affect your life like I said; you can bring your partner into it and let the person know that this person can still have a normal sexual life. —Nurse/midwfe</i></p> <p><i>This psychotherapy now is for that kind of woman and the husband. If you get a man who has slept with different women before getting married, in most cases, the person may have had different experiences, you get what I’m saying. You have to give psychotherapy to the man, to know that it is not the woman’s fault because she did not cause it. So, he will be able the follow such a woman at her own pace so she wouldn’t feel bad because if she is neglected by the husband, because of that, she will also suffer some psychological trauma, which the damage has been done and nothing can be done about it. You should explain to both of them and they can live together based on the love they share and understanding between her and the partner. —Nurse/midwife</i></p>

Preparedness to manage and prevent complications

Health service providers were asked about their perceptions of facilities and providers' readiness to respond effectively to the prevention and management of FGM/C complications. A majority of nurses and community health extension workers (CHEWs) expressed a willingness to address issues relating to FGM/C and were involved in raising awareness in the communities, holding talks in the clinics, and discouraging traditional cutters from continuing the practice. Unfortunately, they were limited by a variety of factors like lack of training and availability of supplies. Therefore, readiness to manage complications was broken down into components such as adequate knowledge/expertise, availability of equipment, and a good referral structure.

Referral

Minor cases such as mild bleeding, STIs, and urinary tract infections were managed in primary health centres or private health facilities and referrals were made to either secondary or tertiary facilities for severe (severe bleeding, keloids) cases. There was a consensus among health service providers that it was better to refer as quickly as possible to ensure that the patient's condition does not deteriorate.

"In our facilities... I'm talking about private sector, when that kind of complication comes to you, and you assess this child. There is nothing you can do apart from first aid and you refer the child. You cannot do what you don't know how to do. So instead of treating or curing the baby, you end up sending the baby to the grave. The best thing is to do the one you can and refer to a secondary or tertiary facility...."

—Nurse/midwife from focus group discussion

"We have not done any referral because this is a secondary level of the health facility. The doctors are here, the nurses are here. We are trained nurses and midwives, who can even suture any first-degree, second-degree, or third-degree tear when it arises without the doctor being around. Because if you wait for the doctor to come, the woman might bleed to death....What we don't do is go into the theatre to do caesarean section...."

—Nurse/midwife, In-depth state interview

Assessment of referral system at health facilities

Referrals are important in determining the scale and quality of services received. In most practising communities, the primary and secondary facilities are the first port of call in addressing health issues, especially FGM-related. However, since a major proportion of the FGM/C complications require specialist care, it is crucial to assess how such cases have been referred across healthcare levels.

A referral system was in place in 86.9% of the health facilities with the proportion of PHCs and secondary/tertiary being 81.6% and 95.7%, respectively. The majority of PHCs (81.6%) and secondary/tertiary facilities (82.6%) had ever referred a case. The majority (68.4%) of PHCs had made ≤ 20 referrals while 13.2% had referred ≥ 21 referrals per year. Less than half (47.8%) of secondary/tertiary facilities made ≤ 20 referrals while 34.8% had made ≥ 21 referrals per year. This information is presented in Table 6 below.

Table 6: Referrals for clients from Health Facility Assessment (HFA)

Referral system at the facility level	PHCs (n=38)		Secondary/tertiary (n=23)	
	(n)	Percent	(n)	Percent
Existence of a referral system	31	81.6	22	95.7
Ever referred	31	81.6	19	82.6
Frequency of referrals per year				
21 or more referrals	5	13.2	8	34.8
20 or fewer referrals	26	68.4	11	47.8
Services clients are referred for				
FGM/C complications	2	5.3	2	8.7
STI	7	18.4	4	17.4
HIV/AIDS	17	44.7	8	34.8
Family planning	4	10.5	4	17.4
Antenatal care	6	15.8	3	13.0
Postpartum care	2	5.3	3	13.0
Essential newborn care	2	5.3	5	21.7
Child immunisation	1	2.6	5	21.7
Complicated labour	2	5.3	6	34.8
Blood transfusion	5	13.2	5	21.7
Surgery	1	2.6	2	8.7
Bleeding/haemorrhage	3	7.9	0	0.0
Delivery	2	5.3	1	4.3
Feedback after referral	18	54.5	15	65.2

Knowledge/expertise to handle complications

Participants opined that health service providers in tertiary facilities were better equipped to handle complications compared to those in primary health facilities because of better exposure of the former to capacity-building opportunities. There were, however, gaps in expertise at the tertiary centres in handling severe complications such as extensive scarring, fibrosis, and gynaetresia (narrowing of the female genital tract). There was a consensus that the government was not doing enough to improve and strengthen health service providers' skills in the state. Unfortunately, PHC facilities, which were closest to the girls and women who needed the services most, were poorly equipped to handle prevention activities.

“The higher level may be equipped with that knowledge but at the lower level I believe that the majority of them are not really equipped with the knowledge. But for you to really go and teach somebody so that the person will abstain from it you must, first of all, know the complications. Some people just hear FGM, “don’t circumcise”, they don’t know. They are still health workers, they don’t know the complications involved in it, so that’s why when participant seven talked earlier today about training and retraining of the health workers it’s a very vital area. So, I won’t say that all the health workers are equipped with the wherewithal to handle complications.”

—Medical doctor from focus group discussion

Perception of quality of care

Across the interviews, health service providers and clients reported that the quality of care for FGM/C clients was low. Nurses complained that non-inclusion of FGM/C topics in the nursing training curriculum limited their capacity to handle complications. Lack of knowledge about FGM/C management, poor working conditions in Imo State, the lack of materials/equipment, and inadequate staff were cited as key issues affecting the quality of care. For tertiary institutions, lack of funding and an inadequate number of skilled personnel were two key drivers of quality

care for FGM/C. Some providers noted that the quality of care was higher in tertiary health institutions than in lower-level facilities.

For tertiary health institutions, I believe they receive quality standard care because we have an in-built mechanism that within the arrival of the patient to the unit obstetric emergency or paediatric emergency, 30 minutes is the standard time set to do all things humanly possible, collect the blood sample, cross-match the blood, if it is for bleeding, within 30 minutes, that's half an hour we have already done all these and there should be blood ready for obstetric and gynaecology services...everything you needed either to suture this woman with or without deposit will be ready and the quality of care given is a quality nursing care that is standard.

—Nurse/midwife from focus group discussion

From a client perspective, poor resolution of symptoms after treatment was considered a defining issue for quality of care. Complete resolution of symptoms was considered an indication that the quality of care received was good.

"I wanted it to heal. I didn't want such, it's embarrassing. Why I kept quiet is because my husband is not with us. Had it been he was with us ...(hisses) it is somehow now. So that's why I just kept it for myself... I was not satisfied, I was not. Like I told you, I cannot say that the repair has been totally done. It failed."

—In-depth client interview

Logistics, infrastructures, and supplies

Some of the barriers to FGM/C management identified by health service providers included: poor funding, lack of access roads to rural communities, lack of communication materials, and lack of political will. Prevention activities were hindered by poor funding for activities, which meant that health service providers could not deliver health talks and organise engagement meetings in rural and hard-to-reach communities. Some of the rural areas also lacked access roads. Health workers also lacked communication materials such as pictorial images depicting the types of FGM/C and complications to facilitate easier conversations with community members. Poor functioning of the PHC system meant overburdening the tertiary facilities.

"Like in our facility, our environment is very far from the facility. But if we say let's go to home visit, like today, you will see that there are some communities you cannot go until two days after this rain, due to bad roads so if you don't have enough money or mobile something, you cannot go."

—Community health worker focus group discussion

"The current health system in Nigeria is not surprising. [It is] epileptic. The health sector is saddled with so many things and there is a lot of poverty in the land. When it comes to the girl child or the child health, there are a lot of programmes [that are] well-funded and that is where you see public health workers going into. For female genital mutilation I will say there is nothing on the ground now, even for information collection to say nothing of planning, to say nothing of implementation. I will say the health system now is poor or not ready."

—Medical doctor, state focus group discussion

Monitoring and maintenance of equipment and information on facility infrastructure

Table 7 shows information on facility infrastructure and monitoring and maintenance of equipment. Only 56.5% of secondary/tertiary health facilities and 28.9% of PHCs had a system for monitoring and maintaining materials, equipment, and supplies. Seventy-eight percent of secondary or tertiary facilities used water piped from a borehole compared to 21% of PHCs. Just over half (52.6%) of PHCs had electricity as opposed to 95.7% for secondary/tertiary health facilities.

Table 7. Monitoring and maintenance of equipment and information on facility infrastructure from the Health Facility Assessment (HFA)

% of facilities with a system for monitoring and maintenance of equipment and information and facility infrastructure	PHCs (n=38)		Secondary/tertiary (n=23)	
	(n)	Percent	(n)	Percent
System for monitoring and maintaining materials, equipment, and supplies	11	28.9	13	56.5
Availability of waiting area with shelter from sun and rain at the facility	37	97.4	23	100
Where pelvic exams and STI testing take place				
Separate room, with no ability to see into the room from outside	37	97.4	22	95.7
<i>Behind a curtain</i>	1	2.6	1	4.3
Source of water				
<i>Water piped from borehole</i>	8	21.1	18	78.3
<i>Purchase water from borehole</i>	9	23.7	1	4.3
<i>Public tap</i>	6	15.8	2	8.7
<i>Public borehole</i>	7	18.4	0	0.0
<i>Rainfall</i>	5	13.2	1	4.3
<i>No running water available</i>	4	10.5	0	0.0
<i>Public well</i>	1	2.6	1	4.3
<i>Stream</i>	1	2.6	0	0
Availability of electricity	20	52.6	22	95.7
Source of electricity				
<i>Generator and power from the electricity distribution company</i>	5	13.2	9	39.1
<i>Generator alone</i>	2	5.3	8	34.8
<i>Power for electricity distribution company alone</i>	9	23.7	0	0.0
<i>Power from the electricity distribution company, generator, and solar</i>	0	0.0	3	13.0
<i>Solar and power from the electricity distribution company</i>	2	5.3	0	0.0
<i>Power from the electricity distribution company, generator, and inverter</i>	0	0	1	4.3

Health workforce

The shortage of manpower for FGM/C programmatic activities and health care was considered a major hindrance to FGM/C activities in the state. New personnel were not being employed by the state despite the continued retirement of existing personnel. Personnel who were available provided suboptimal services because they lacked supplies, had limited capacity/training, had a heavy workload, and lacked transportation to reach communities under their jurisdiction. One key informant noted that although 27 new general hospitals had been commissioned, poor manpower meant that the facilities were underutilised. A midwife corroborated this by saying that even where infrastructure was available, there were no materials or nurses to do the work. In the same vein, some participants reported that they partnered with NGOs and development partners like UNICEF, to receive FGM/C-specific training.

“Shortage of manpower. Nurses should be engaged in secondary and primary healthcare levels. We have a serious shortage of nurses in particular. If you go to some general hospital you will see just two nurses covering morning shift and evening shift in a whole general hospital. Because of this you will see that they might not work well

because they are human beings not machines. There is a need to employ staff at the secondary and the primary healthcare level, I don't know about the tertiary level, maybe they have.”

—Community health worker from focus group discussion

“I always feel that our greatest problem is human resource as it affects healthcare professionals. When you have hospitals with 250 bed spaces and you cannot use up to 50, how will you be complaining about infrastructure or equipment. You don't do that and currently the governor decided to build 27 brand new general hospitals....But presently what we think is that manpower, improvement in the manpower is the main thing as it is now...What we are doing right now is that, in most of our hospitals now, when the shortage of staff is very acute, mainly nurses, we hire local nurses, possibly the retired ones and pay them some stipends so that they continue to help our system to function...”

—Key informant, state policymaker interview

Staffing per facility type

With respect to secondary/tertiary facilities, 82.6% employed two or more medical doctors, only 30.4% employed obstetricians and gynaecologists, with 17.4% employing just one. About 1 in 4 (26.1%) secondary/tertiary health facilities employed two certified nurses or more. Certified nurse/midwives were employed at 95.7% of secondary/tertiary facilities with 78.3% employing two or more. In contrast, less than half (47.4%) employed nurse/midwives at PHCs with 31.6% employing just one. Community health extension workers (CHEWs) were the major type of community health workers employed by health facilities with the majority (61.2%) employed at the PHC level. Less than half (47.4%) of PHCs employed two or more CHEWs. A detailed breakdown is presented in Table 8 below.

Table 8: Staff employed per facility type from the Health Facility Assessment (HFA)

Type and number of staff employed per facility	PHCs (n=38)		Secondary/tertiary (n=23)	
	(n)	Percent	(n)	Percent
Medical doctor				
1	7	18.4	3	13.0
≥2	0	0.0	19	82.6
Obstetricians and gynaecologists				
1	0	0.0	4	17.4
2	0	0.0	3	13.0
Certified nurse				
1	1	2.6	3	13.0
2	0	0.0	6	26.1
Certified nurse/midwife				
1	12	31.6	4	17.4
≥2	6	15.8	18	78.3
Community health officer				
1	5	13.1	0	0.0
2	0	0.0	1	4.3
Junior community health extension officer				
1	7	18.4	0	0.0
≥2	6	15.8	2	8.7
Community health extension officer				
1	14	36.8	0	0.0
≥2	18	47.4	3	13.0
Psychologists				
1	1	2.6	2	8.7

Type and number of staff employed per facility	PHCs (n=38)		Secondary/tertiary (n=23)	
	(n)	Percent	(n)	Percent
Social worker				
3	0	0.0	1	4.3
Laboratory scientists				
1	3	7.9	12	52.2
2	0	0.0	4	17.4
Laboratory technicians				
1	5	13.1	6	26.1
2	2	5.3	5	21.7
Health educator				
1	3	7.9	3	13.0
2	2	5.3	1	4.3
Counsellor				
1	0	0.0	3	13.0
≥2	0	0.0	1	4.3
Health assistants				
1	18	47.4	0	0.0
≥2	9	23.7	0	0.0
Pharmacists				
1	0	0.0	2	8.7

According to the minimum standards for primary health care in Nigeria, it is recommended that if available, there should one medical officer—usually a medical doctor—attached to PHCs. A PHC should have at least four nurse/midwives, one community health officer, three community health extension officers, and six junior community health extension officers. Table 9 shows the recommended health personnel and number per primary healthcare facility.

Table 9: Recommended personnel for primary healthcare centre

Recommended personnel of the facility	Recommended personnel per facility
Medical officer (a medical doctor if available)	1
Nurse/midwife	4
Community health officer	1
Community health extension officer	3
Junior community health extension officer	6
Environmental officer	1
Medical records officer	1
Pharmacy technician	1
Laboratory technician	1
Health attendant/assistant	2
Security personnel	2
General maintenance staff	1

Health information system

Having a concrete information system on FGM/C at the health facility level is important to understand the real-time pattern and burden of the practice. Just like data are collected on other health issues, availability of data on FGM/C shows that health system is ready to address the practice as data gathered allow for ease of FGM/C-focused programming.

Collection of FGM/C data

FGM/C data is not part of the variables assessed for the National Health Information Management System and most (91.8%) of the health facilities did not record the FGM/C status of women and girls (Table 10). Data on FGM/C status were recorded on case notes, checklists and delivery charts. Because FGM/C-related data were not collected at the health facilities, service providers noted that it was difficult to track new cases and most patients who presented for care were lost to follow-up/tracking and feedback. Similarly, cases of FGM/C complications were not recorded by 85.7% of the health facilities.

Table 10: Collection of FGM/C data

Information on FGM/C data collection	(n)	Percent
Whether health service providers record FGM/C status (n=60)	5	8.2
Where FGM/C status is recorded (n=5)		
Case notes	2	40
Checklists	2	40
Delivery chart	1	20
Whether cases of FGM/C complications are recorded (n=60)	5	8.2
Where cases of FGM/C complications are recorded (n=5)		
Case notes	3	60
Delivery chart	1	20
Patients' card	1	20

Reasons given by health service providers for not documenting FGM/C cases included perceptions that the practice of FGM/C had reduced/stopped, there was inadequate manpower to capture records, and that there was no provision to capture FGM/C status in the facility register.

We have registers, registers bear their columns, but there is no register that bears the columns of where we can put the record. But all I know is that when a patient comes in with any condition, in our admission register, we have a column that bears diagnosis, so if a patient comes with such a case the diagnosis will be that.

—Medical doctor, in-depth interview

We don't even keep track of them, where we keep track of them is when they come to you for family planning, insertion of IUCD, and then during their birth that is when you will know it, and we use that opportunity.... "Please since you are circumcised you don't have to circumcise your female babies, I know you have not been finding things easy, even childbirth. So, you don't go for it."

—Nurse/midwife, in-depth interview

Underpinning the lack of documentation for FGM/C was the poor knowledge among health workers on the importance of documenting FGM/C-related cases. For example, a health worker reported that she did not see the need to record the details of patients who already had FGM/C, as the practice cannot be undone. Another nurse from a general hospital reported that the hospital where she worked does not keep track of women and girls who were cut, but did so when they encountered a woman who was cut who presented for family planning or delivery services. The service providers took a mental note of those who were cut, in order to sensitise them and to discourage the practice, as the concern was to prevent younger girls from being cut as well. One nurse, however, noted that she keeps FGM/C records in her facility. Health service providers noted their willingness to receive guidance on how to keep FGM/C records and improve documentation in the future.

FGM/C routine data collection challenges

The national representative of the DPRS reported that the routine data challenges were related to the fact that secondary facilities did not report on the same platform as the primary healthcare centres and private health facilities do not report data at all. The UNJP was planning to introduce FGM/C data columns in the register and, ultimately, on the District Health Information Software (DHIS) platform. However, there were concerns that the UNJP only works in five states, which would limit the coverage for representative data gathering. In addition, a policymaker noted that data collection would be suboptimal if health workers were not trained on how to counsel a patient who had undergone FGM/C or document FGM/C status or complications. The level of preparedness at facilities for FGM/C services was also noted to impact the capacity of health workers to report FGM/C indicators. There was a consensus that training was needed to ensure the health system was prepared to report data on FGM/C.

...my issue with FGM, it's one thing for you to put data on the platform, it is another for you to plan accordingly. Is the health system offering this service?...For example now, we put counselling because UNFPA pushed for counselling, fine they are working in five states. What is the level of awareness of people working in other states, even in [those] five states? Because you can't give what you don't have. Now we are putting FGM on counsel, have they been trained on how to counsel people? At the end of the day in the next two, three years...that data will be there, but it will be redundant so of what use than to just remove it and put another thing...?

—Key informant, national policymaker interview

Availability of medicines, equipment, and supplies

As discussed earlier, poor funding affected the preparedness of health facilities to implement FGM/C-related activities. The lack of funding affected the availability of information, education, and communication (IEC) materials, pictorial guides, and videos to educate people on FGM/C. Some participants, however, mentioned that they sometimes received FGM/C-specific IEC materials and job aids from international NGOs, and development partners for use in FGM/C activities; at other times, they improvised.

Limited funding also impacted on outreach workers' ability to conduct activities and home visits in the rural areas because of lack of accommodation, public address systems, vehicles. The poor state of roads and insecurity also limited outreach workers' activities.

"...Other stakeholders hindering us from winning the war against FGM include good roads, communication, how do you get to this women—even when you pump in money into a system and there are no good roads—to these areas, especially those in the creeks, in the hinterlands where these things are prevalent... there is also a place of the mass media..."

—Medical doctor from focus group discussion

"In terms of the readiness of the health system to tackle FGM in Imo State I will say that we are not ready. I remember in one of the occasions that I was given one pamphlet on FGM and why it must be stopped; if we have such pamphlets scattered all over the place, distributed to the women, and then we also have materials to show them some pictorial views or even some videos on the adverse effects of this... if we are ready we will make an avenue to have some of these things—you know leaflets, pamphlets—you have some of these preparations that can be shown to some of these women that come to antenatal ... you have over 500 women on antenatal, so imagine talking to 500 women and then dissuading them from doing this, you have done a great deal, and they will also tell others..."

—Medical doctor from focus group discussion

Availability of equipment and service commodities at health facilities

A key component of the health system is the availability of equipment and service commodities. This is particularly important for FGM/C as related complications emanating from the practice are best addressed with these materials. Level of availability of equipment and service commodities will show the level of readiness at the facility level. It is worth noting that in this study, the equipment and service commodities assessed were those obtainable to address general sexual and reproductive health issues and not specific for FGM/C. This is because the FGM/C-related complications are similar and mostly fall under the broad sexual and reproductive health response.

Few PHCs had the following equipment and service commodities: delivery forceps (28.9%), autoclave (15.8%), urine catheter (34.2%), urine bags (2.6%), cervical/vaginal swabs (7.9%), strong analgesics (5.3%), intravenous local anaesthetic (36.8%), anti-depressants (5.3%), and anti-psychotics (5.3%). For secondary/tertiary facilities, fewer than half had the following: blood bank (13%), ultrasound machine (47.8%), strong analgesics (43.5%), anti-depressants (47.8%), and anti-psychotics (39.1%). Only two tertiary facilities and a private facility had blood banks. None of the general hospitals had a blood bank. A detailed description of the availability of equipment and service commodities is provided in Table 11.

Table 11: Availability of equipment and service commodities based on the Health Facility Assessment (HFA)

% of equipment per health facility	PHCs (n=38)		Secondary/tertiary (n=23)	
	(n)	Percent	(n)	Percent
Flashlight/lamp	24	63.2	21	91.3
Blood pressure measuring equipment	34	89.5	23	100
Stethoscopes	37	97.4	23	100
Sterile needles and syringes	37	97.4	23	100
Vaginal speculum	25	65.8	21	91.3
Delivery forceps	11	28.9	14	60.9
Surgical forceps	34	89.5	23	100
Episiotomy scissors	34	89.5	21	91.3
Sutures	26	68.4	22	95.7
Needle holder	23	60.5	22	95.7
Autoclave	6	15.8	15	65.2
Sterile swabs or sterile gauze	19	50.0	19	82.6
Cotton wool	35	92.1	21	91.3
Sterile gloves	17	44.7	22	95.7
Disposal containers	38	100	21	91.3
Examination couch or table	29	76.3	21	91.3
Functioning delivery bed	25	65.8	21	91.3
Operating theatre	2	5.3	22	95.7
Blood bank	0	0.0	3	13.0
Intravenous (IV) line	29	76.3	18	78.3
Blood-giving set	0	0.0	14	60.9
Urine catheter	13	34.2	22	95.7
Urine bags	1	2.6	22	95.7
Cervical/vaginal swab	3	7.9	14	60.9

% of equipment per health facility	PHCs (n=38)		Secondary/tertiary (n=23)	
	(n)	Percent	(n)	Percent
Ultrasound machine	0.0	0.0	11	47.8
Medicines				
Strong analgesics	2	5.3	10	43.5
Intravenous local anaesthetic	14	36.8	21	91.3
Tetanus vaccine	20	52.6	12	52.2
Folic acid	29	76.3	23	100
Iron	28	73.7	21	91.3
Antibiotics	32	84.2	21	91.3
Non-steroidal anti-inflammatory drugs	29	76.3	21	91.3
Oxytocin	32	84.2	21	91.3
Anti-depressants	2	5.3	11	47.8
Anti-psychotics	2	5.3	9	39.1

Table 12 highlights participants' health system–related recommendations on FGM/C. These perceived recommendations are ordered according to the six health system blocks.

Table 12: Participants' recommendations on FGM/C-related issues

Recommendations	
Leadership and governance <i>(health system and FGM/C response stakeholders)</i>	<p>FGM/C programme integration into existing health facility programmes.</p> <p>Provision of guidelines for the management of FGM/C complications.</p> <p>Engaging youths and educational institutions in the campaign against FGM/C.</p> <p>Improved stakeholders' collaboration and coordination as well as increased role of the Federal Ministry of Health in the FGM/C programmes.</p> <p>United Nations Joint Programme scale-up.</p> <p>Creating awareness through media and educational advocacies</p> <p>Creating awareness about FGM/C practise and associated complications using community platforms.</p> <p>Enforcement of anti-FGM/C laws.</p> <p>Provision of alternative income for FGM/C cutters.</p> <p>National Health Insurance Scheme coverage for women and girls who have suffered complications.</p> <p>Provision of stipends for state government stakeholders.</p> <p>Provision of specialised facilities for the management of FGM/C.</p>
Funding	<p>FGM/C inclusion in the budget for federal and state ministries of health as well as women affairs and also increased funding at the facilities.</p>
Strengthening service readiness	<p>Increasing collaboration between health service providers and FGM/C response stakeholders to ensure a robust referral of FGM/C complication cases.</p> <p>Providing free services to women and girls who have suffered complications.</p> <p>Sensitisations and awareness using community platforms like August meetings* and religious gatherings.</p>
Health workforce	<p>Recruit health workforce.</p> <p>Build the capacity of health service providers to prevent and manage FGM/C complications.</p>
Health information system	<p>FGM/C data documentation at the health facilities.</p>

Recommendations	
Availability of medicines, equipment, and supplies	Provision of job aids, commodities, and supplies for the management of FGM/C complications. Provision of infrastructure at the facilities.

*Communal meeting for women mostly in eastern Nigeria, held yearly in August.

Discussion

This study explored the health sector's role in the prevention and management of FGM/C complications as well as the response to FGM/C policies. Similar to the way the findings from this study were reported, this section was organised according to the components of the health systems framework. As a result, subsections are on the following; leadership and governance; financing; service delivery/readiness; health workforce; health information system; and availability of medicines, equipment, and supplies. Findings show that the health sector was poorly equipped to handle FGM/C prevention and complications because of a lack of capacity, and funding and poor political commitment.

Leadership and governance

The Nigerian health system has been described as weak because of a lack of coordination and fragmentation of services; the inadequacy of resources, drugs, and supplies; poor infrastructure; inequity in resource distribution; and poor access to quality care (Nigerian National Health Conference 2009). The National Strategic Health Development Plan Framework (2009–15) highlighted the need to strengthen the health system to cater to an increasing population served by scarce skilled health professionals. Apart from poor budgetary provisions for health, poor political will to implement policies has also been identified as a major setback to the health system response (FMOH 2010; Omoleke and Taleat 2017). While the effort of the federal government at setting up the FGM/C Technical Advisory Committee and FGM/C Technical Committee at the three tiers of government is commendable, not much is known about their functionality at state and local-government levels.

Leadership and governance in health systems encompasses the development and implementation of appropriate policy frameworks, effective oversight, collaboration, regulation, and accountability (UNAIDS et al. 2010). Key indicators include the existence of national policies and evidence of their implementation, as well as other determinants of healthcare governance including ownership arrangements and stakeholder participation (UNAIDS et al. 2010). Despite the existence of laws, policies, and plans of action that should drive the health system's response in Nigeria, study findings reveal several challenges that hinder the effective implementation of these policies.

First, although the involvement of stakeholders at all levels in the development and dissemination of law, policies, and action plans is critical to facilitating ownership and implementation at the community level, participation of stakeholders in policy and action planning at the state level appears to be limited. This nonparticipation may stifle the implementation of laws, policies and plans of action. For example, the repeal of the VAPP Act, which is the only national law that bans and criminalises FGM/C, at the state level was attributed to the limited engagement of stakeholders as part of the policy formulation process. Poor engagement and inclusion of private sector stakeholders were also reported as a major challenge to implementation of FGM/C policies.

Second, poor coordination of inter-ministerial roles; weak linkages between complementary ministries, departments, and agencies; and duplication of roles between them may impede the FGM/C response both at state and national levels. Unfortunately, the 1999 Constitution of Nigeria and the 2014 National Health Act, which serve as legislative frameworks for governance, are not clear on shared responsibilities of the three tiers of government for health systems (FMOH 2016). This could have huge implications in terms of provision of resources by government for health services. If responsibilities are not well mapped out, especially where they converge and diverge, there is the possibility of duplication of efforts or, worse, abdication of responsibilities.

Third, stakeholders reported that FGM/C is a low priority on government's agenda, hence has not been considered an issue of public health importance. Government ownership and prioritisation of FGM/C-related programmes ultimately affects sustainability. This further implies that the FGM/C response will not be effective enough for a sustained change. Additionally, the abandonment efforts will be limited to a reduced proportion of the country.

Financing

The health systems framework suggests that a good health financing system is able to raise adequate funds for health (WHO 2010). In the same vein, it has been stated that at the extreme, without the necessary funds, no health workers would be employed, no medicines would be available, and no health promotion or prevention would take place (WHO 2010). Also, financing is expected to be achieved in ways that ensure clients can use needed services without being impoverished or plunged into financial catastrophe associated with having to pay for them (WHO, 2007). From this study, there was a consensus that gaps in funding constitute the most significant barrier to FGM-related prevention and management activities in terms of policy dissemination, implementation, and domestication at both federal and state levels. This gap, which was identified at two levels—poor budgetary provision and poor disbursement—stifled the capacity of the coordinating ministries (Women Affairs and Health) to implement programmes to prevent and manage FGM/C. This pattern is consistent with evidence from a public expenditure review of the health sector, which suggests that, on average, most states in Nigeria spend less than 5% of their total outlay on health care. Expenditure from all tiers of government amounts to less than 6% of total government expenditure in the country (Ichoku and Okoli 2015). The 2016 National Health Policy also reports that total allocation from the federal budget to health rose from 3.9% to 6% between 2010 and 2012 but fell again to 4% in 2013. The policy further reinforced that there was a paucity of data on the state budgetary allocation to health (FMOH, 2016). A recent health budget analysis for Nigeria (BudgIT 2018) revealed that the health budget of Imo State was not publicly available, which makes it difficult to ascertain the level of spending and financial accountability of health systems in the state.

The paucity of funds to drive activities in Imo State has led to poor planning, supervision, and coordination of FGM/C activities in the state. Poor political will and lack of commitment from both federal and state governments for FGM/C programmes explain the over-reliance on the UNJP for financing activities and threatens sustainability after the donor exits. For example, the funding for donor agencies was reported to have dwindled, resulting in non-operationalising of some activities on the action plan for the Federal Ministry of Health. The reliance on donor funding for projects also skews implementation in favour of donor-priority states and donor-focused activities as seen in this study. This negatively impacts the capacity of the government to achieve scale in addressing emerging issues relating to FGM/C in other states. Within the context of limited resources, stakeholders' recommendation that prevention activities should be prioritised as a means of cost-effective FGM/C response is commendable. Similarly, to improve cost-

effectiveness, integrating FGM/C with other programmes to prevent overlap and duplicates is essential, but care must be taken such that such programmes do not overshadow FGM/C.

Service delivery/readiness

According to the WHO health systems framework, a good health system is one that delivers effective, safe, quality personal and nonpersonal health interventions to those that need them, when and where needed, with minimum waste of resources (WHO 2007). This was evident in efforts made to address the practice at the state level. For example, in Imo State, the use of sensitisation, outreach, and visitations led to increased awareness of the practice because they targeted women's groups, August meetings, and utilised local influencers such as FGM/C champions and traditional leaders to advocate for its abandonment. The integration of FGM/C topics into antenatal care at PHCs is commendable as majority of the health facilities assessed provided such services. These efforts must be reinforced by sustained engagement of traditional cutters to develop alternative means of livelihood and ultimate abandonment of the practice. The gaps in training and data management highlighted by health service providers need to be urgently addressed to forestall complete failure of the health system's response. The inclusion of FGM/C in the curriculum of health training institutions was limited to the training of CHEWs, but not nurses, midwives, and doctors, reflecting a huge capacity gap. The absence of guidelines for the management of complications of FGM/C implied that health workers utilised their best judgement to evaluate the needs of their patients and in some instances make urgent decisions about treatment and referral. The challenge with this approach is that there may be inconsistencies in treatment approach and outcomes that could significantly impact the quality of care. This is more so because health workers consistently complained about the lack of training opportunities, meaning that they may not have the technical competence required to manage FGM/C complications without guidance.

The findings from the qualitative interviews regarding the treatment of complications are reinforced by the findings from the HFA showing that the provision of FGM/C-specific services was limited. As health workers indicated, the capacity to provide support for psycho-sexual complications of FGM/C was limited and only a few facilities provided psychological/psychiatric services. The overall level of preparedness of the health facilities to handle FGM/C related complications was relatively low as evidenced by poor infrastructure and lack of equipment and human capacity. The low referral rate for FGM/C may be a combination of factors such as late presentation, lack of technical competence to properly diagnose FGM/C complications, and lack of infrastructure/logistics to support the referral process. The lack of guidelines and protocols for management of FGM/C at all levels in the state reflects the poor readiness to manage FGM/C.

Health workforce

For a health workforce to be regarded as a high-performing one, it is expected to be responsive, fair, and efficient, to achieve the best health outcomes possible, given available resources and circumstances (i.e., there are sufficient staff, fairly distributed; they are competent, responsive and productive) (WHO 2010). Also, it has been stated that the ability of a country to meet its health goals depends largely on the knowledge, skills, motivation, and deployment of the people responsible for organising and delivering health services. (WHO 2010). A huge gap found in this study was the lack of knowledge for FGM/C-specific prevention and management. While FGM/C has no specific services to distinguish it from other reproductive health issues, it is important that health service providers have a clear understanding of what to do when they come in contact with FGM/C-related complications or find themselves in position to advocate for the abandonment of FGM/C. A study on innovative training approaches for nurse/midwives in high-prevalence settings found that there was need for training interventions to increase the knowledge and empower health workers for management of FGM/C-related complications and

prevention (Kimani et al. 2018). Another study highlighted the importance of training and increasing the awareness level of healthcare providers (Kimani, Muteshi, and Njue 2016).

The HFA highlighted the issues with shortage of manpower at all levels of care. For example, the low number of obstetricians and gynaecologists in secondary and tertiary facilities reflects potential gaps in readiness for management of long-term complications of FGM/C. Similar findings were reported by a study in Southwestern Nigeria (Adekanle, Isawumi, and Adeyemi 2011). The inadequate availability of nurse/midwives at the PHC level is not in line with the stipulations of the Minimum Standards for Primary Health Care in Nigeria (NPHCDA 2015).

CHEWs were the frontline staff across the facilities, reflecting the dearth of health workers in the Nigerian health sector. An important indicator of a strong health system is the availability of efficient and skilled health personnel (Rigoli and Dussault 2003). However, in Nigeria, it has been estimated that the health workforce to population ratio is 1.95 per 1000, and this problem is compounded by inequity in health workforce distribution (WHO 2016; Abimbola et al. 2016; Gyuse, Ayuk, and Okeke 2018). The weak health workforce majorly stems from inadequate resources to employ skilled personnel, brain-drain in the health sector and poor working environment. This subsequently results in a weakened health system (Chen and Boufford 2005; Ike 2007). This has a series of implications; health workers are stretched because of the workload (Willis-Shattuck et al. 2008) and could be forced to render services they are not qualified for. To lend credence to this, nurse/midwives who were supposed to be the facility heads were not available in many of the facilities assessed (NPHCDA 2015).

Health information system

Reliable information is needed for good decisionmaking across all the health system building blocks. In view of this, a well-functioning health information system is one that ensures the production, analysis, dissemination, and use of reliable and timely information on health determinants, health system performance, and health status (WHO 2010). In contrast to this, findings showed that issues of FGM/C were not documented at the health facility and, as a result, data were almost nonexistent. FGM/C-related data generated from health facilities and the community would be helpful in providing information on the incidence of the practice and complications. However, insufficient manpower to document FGM/C cases could be a major factor contributing to the unavailability of data. One way to efficiently advocate for allocation of resources and push for policy implementation regarding FGM/C is the use of timely data. The perception that FGM/C was a low priority issue in this study may be related to lack of data. The poor orientation of health workers about data management for FGM/C was a key issue identified that can be addressed by training. It is possible that cases of FGM/C-related complications that occur are not reported at the facilities. This has already been identified by other studies (Mbanya et al. 2018). Unavailability of data is a symptom of poor health performance and is synonymous with poor policy and decision-making process (Sambo, Lewis, and Sabitu 2005). A review of the previous National Health Strategic Development Plan 2010-2015 showed that incomplete or missing data make it difficult to know if health interventions are working (Oyibocho et al. 2014).

Availability of medicines, equipment, and supplies

In describing the health system framework component on medicines and related medical products, WHO stated that a well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use (WHO 2007; WHO 2010). This study showed that medicines, equipment, and supplies were inadequate at health facilities. This was a gap highlighted by health system stakeholders, health service providers, and the HFA. Although poor funding was a major issue relating to the availability of supplies, lack of a

system for monitoring/maintaining materials, equipment, and supplies in most of the facilities was another key issue. Service delivery is difficult when equipment and commodities are not available. This challenge is not specific to FGM/C as it mirrors the state of the health system in the country. The poor state of the health system has been documented (Uneke et al. 2007; Efe 2013). Another reason that could explain unavailability of necessary commodities could be the concentration of health care in urban settings and its neglect in the rural areas. Most of the health facilities assessed in this study were concentrated in the rural areas of Imo State. It has been established that most facilities located in rural areas do not function properly (Ajilowo and Olujimi 2007). Unavailability of necessary materials at facilities as found in this study contributes significantly to the challenges that health workers face in service delivery (Chankova et al. 2007).

Limitations

Study findings should be interpreted in light of the following limitations. First, a major limitation of this study was that most health facilities were selected from within the pre-selected 10 UNJP intervention local government areas in Imo State. Only six facilities were assessed outside these 10 LGAs bringing the representation of LGAs to 14, which is just over half of the LGAs in Imo State. As a result, study findings cannot be generalised to all facilities in Imo State and other states given marked differences in contexts, social norms, governance, and availability of health system-related resources. Second, it was difficult to recruit the desired number of patients and their families because of the hidden nature of the practice making it difficult to fully explore issues around satisfaction and quality of care from a limited number of clients. Nonetheless, results shed light on the pattern of complications seen in Imo State and the response in terms of management and prevention of the practice.

Conclusion

Findings from this study highlighted key gaps that have serious implications for the health system and its function in addressing FGM/C. The ineffective implementation of policies is attributable to the low priority placed on FGM/C. It was shown in this study that funding constitutes the most significant barrier to FGM/C related prevention and management activities. Findings also revealed that coupled with the shortage of manpower at assessed facilities, there was lack of knowledge for FGM/C-specific prevention and management. Additionally, issues of FGM/C were not documented at the health facility and, as a result, data were almost nonexistent; and medicines, equipment, and supplies were inadequate at health facilities. While it was recorded that in Imo State, there has been use of sensitisation, outreach, and visitations, and integration of FGM/C topics into antenatal care at PHCs, the health system's response to prevention and management of complications was suboptimal. Overall, the findings from this study suggest improving the health system response in the prevention and management of FGM/C complications requires government ownership at all tiers.

Implications for Policy/Programmes/Research

Programmatic implications

- While multisectoral collaboration was a useful strategy in reviewing the NPPA for the elimination of FGM/C at the national level, several state stakeholders who statutorily should be on the FGM/C technical committees were unaware and not knowledgeable about the policy or its content. This reflects poor dissemination of policies and engagement of state stakeholders and has implications for stakeholders' participation in the implementation process. Efforts to ensure widespread dissemination of policy documents to all actors involved in the FGM/C response are warranted.

- The ownership and coordination role of the government in the FGM/C response is discouraging because of poor financial commitment on its part and over-reliance on donor funding. This may threaten the sustainability of FGM/C programmes and reverse gains achieved. The government should demonstrate more financial commitment and ensure transition and ownership of activities beyond the tenure of FGM/C projects.
- As a result of poor reporting of FGM/C cases at the secondary and tertiary facilities, health workers and critical stakeholders perceive that FGM/C was not a public health concern that should receive government priority and attention. This issue must be addressed through education of health service providers and improved data management systems.
- Health workers should be properly trained and sensitised on the WHO guidelines on the management of FGM/C complications to improve their capacity to respond to incidents.

Policy implications

- Even though the VAPP Act criminalises FGM/C and other traditional harmful practices, it does not criminalise failure to report cases. This might be responsible for the gross underreporting of FGM/C cases as evidenced in this study. The policy should be strengthened to provide incentives for reporting or punishments for failure to report incidents.
- Multisectoral involvement of stakeholders at the national and state levels in the policy formulation process is critical to ensure that all contextual issues that could act as barriers to policy implementation are addressed.

Research implications

- Given the context in which VAPP was repealed in Imo State, it is possible that similar reasons might be related to the non-domestication of the Act in other states. Research to explore stakeholders' perceptions about the issues affecting the domestication and implementation of VAPP Sct in Nigeria would be invaluable.
- Only a few clients were interviewed for client satisfaction in this study because of the difficulty in recruitment because of the short timeframe for the research activity. Research should be commissioned to explore client satisfaction, quality of care and management of FGM/C complications.

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