Lessons learnt in scaling up evidence-based comprehensive health sector responses addressing female genital mutilation in highly prevalent settings

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ABSTRACT
Female genital mutilation (FGM) affects over 200 million girls and women. Its health complications include acute and potentially lifelong urogenital, reproductive, physical, mental health complications with estimated health treatment costs of US$1.4 billion per year. Moreover, there is a concerning rise in the trend of FGM medicalisation with almost one in five FGM cases being performed by a health worker.

The WHO developed several evidence-based resources to apply a comprehensive health approach to strengthen FGM prevention and care services. However, there has been limited uptake of this comprehensive approach in FGM prevalent settings. To address this, a three-step multicountry participatory process was used to engage health sector players from FGM prevalent settings to develop comprehensive action plans, implement foundational activities and harness the learnings to inform subsequent planning and implementation. Support to adapt evidence-based resources and seed funding were also provided to initiate foundational activities that had potential for scale up.

A total of 15 countries participated in this three-step approach between 2018 and 2022. Ten countries developed comprehensive national action plans and eight WHO resources were adapted for foundational activities. This scale up approach can be strengthened by increasing the frequency of multicountry experience sharing meetings and possibly sending country champions to continuously advocate for FGM integration within (public and private) health services and securing stable funding to implement foundational activities. Documentation of each country's experience as case studies including monitoring and evaluation are essential to expand the learning and quality of the health interventions addressing FGM.

INTRODUCTION
Female genital mutilation (FGM) is a harmful practice that encompasses all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. Globally, an estimated 200 million girls and women have undergone FGM with 8000 new cases added every day. The drivers for this practice are diverse and vary by setting. It can be a rite of passage to womanhood, a means of maintaining virginity before marriage and fidelity thereafter, a religious or marriageability requirement, or an obligation for cleanliness and aesthetic purposes. FGM is often performed on girls between the ages of 5 and...
9 years old and is mainly conducted by traditional practitioners.\(^4\) There is, however, a concerning trend of health workers’ involvement in this practice also known as FGM medicalisation. FGM violates the right to health, bodily integrity and children’s rights\(^4\) and its medicalisation violates the health professional code of conduct of ‘do no harm’. Moreover, FGM has no health benefits and is associated with immediate to long-term health complications that include pain, bleeding, infection, scarification, psychological and sexual problems, with an estimated treatment cost of US$1.4 billion per year.\(^5\)

The WHO has developed evidence-based resources to support the development and implementation of a comprehensive health sector response to contribute to national FGM abandonment efforts. These WHO resources include a document outlining the strategic pillars for developing country-specific comprehensive health action plans,\(^1\,\(^6\) advocacy resources\(^1\) such as the FGM country cost calculator which estimates current and projected economic costs under different FGM abandonment scenarios, guidelines on the management of FGM complications,\(^8\) a clinical handbook,\(^9\) several training manuals on prevention and care and a guide on how to integrate content within health worker training curricula.\(^1\)\(^0\)\(^\text{12}\)

The health sector in countries with high FGM prevalence has made some progress in developing and implementing a comprehensive health sector approach informed by evidence-based resources.\(^1\)\(^3\)\(^\text{16}\) However, there is a need to scale up this approach especially in FGM prevalent settings. The aim of this practice paper is to describe a multicountry participatory approach that was initiated by WHO in 2018 to facilitate the uptake and scale up of comprehensive health sector programmes in countries with high FGM prevalence. The paper describes the scale up approach used, its key achievements from programmatic reports from 2018 to 2022, an analysis of its strengths and weaknesses and proposed areas to be strengthened in future scale up efforts.

**AN OVERVIEW OF THE SCALE UP APPROACH**

Briefly, the method composed of annual cycles where ministries of health and health stakeholders from priority countries developed comprehensive national action plans, implemented prioritised foundational activities and shared the learning with other countries. A snowball approach was used to add new countries into each annual cycle to learn from other countries and subsequently develop and implement their own comprehensive national action plans (figure 1).

**STEP 1**

In 2018, WHO convened delegations from 10 priority countries (see list of countries in table 1) with high FGM prevalence to a meeting in Khartoum, Sudan. The delegation included representatives from the Ministry of Health; members of professional societies in the field of obstetrics and gynaecology, midwifery, nursing and paediatrics; other relevant non-governmental organisations working in FGM or other sexual and reproductive health issues as well as United Nations agencies.

The objective of the meeting was to strengthen planning of comprehensive action plans guided by WHO’s four strategic pillars of action. These pillars of action include (A) strengthening the political will, governance and funding for FGM related health sector interventions; (B) increasing the understanding and knowledge of health workers on FGM; (C) creating an enabling legislative and regulatory environment and (D) strengthening monitoring, evaluation and accountability.

Each country presented its achievements, challenges and lessons learnt of activities they implemented within standardised templates for the four pillars of action to not only share experiences but also provided an opportunity to identify which strategic pillars of action were not addressed. Countries then developed drafts of country specific 5-year health plans guided by FGM epidemiology, health system preparedness and the four strategic pillars of action.

In the first in-person meeting in 2018, country teams worked in groups to conduct situational assessment and develop context-specific 5-year plans aligned to the four pillars of action recommended by WHO. Technical support was provided throughout these exercises during the meeting.

There was no meeting held in 2019 and because of COVID-19-related travel restrictions and prioritised travel for emergencies, subsequent meetings in 2021 and 2022 were held virtually. The country representation...
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<th>#</th>
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FGM, female genital mutilation.

Table 1 Country participation in annual scale up cycles and status in uptake of WHO's recommended health sector approach and WHO's implementation resources between 2018 and 2022.
in virtual meetings was the same as the 2018 in-person meeting with a higher number of participants per institution. These meetings were 3-hour long where countries prepared in advance standardised PowerPoint templates to share their achievements, challenges and lessons learnt for each pillar of action as well as share planned activities for the following year.

In the beginning of annual cycles, additional countries were invited to observe and learn experiences shared by participating countries to encourage them to initiate the development of action plans guided by WHO’s four strategic pillars of action.

Following the multicity experience sharing and preliminary planning meetings, country teams under the leadership of ministries of health with WHO’s financial and technical support worked with a wider in-country health stakeholder group to refine and finalise the national and subnational health plans. Countries were encouraged to integrate these finalised health action plans within existing Ministry of Health sexual, reproductive, maternal, neonatal, child and adolescent health (SRMNCAH) and other health system strengthening plans.

**STEP 2**

The Ministry of Health teams and WHO then identified foundational activities within the pillars of action (figure 2) that had high potential for sustainability in light of existing in-country resources and processes following an initial stage of seed money with WHO funding. Examples of these foundational activities included development of FGM training content for preservice and in-service trainings, development of clinical guidelines, standard operating procedures or accountability frameworks or carrying out feasibility assessments for FGM measurement models within health information systems.

![Figure 2](https://example.com/figure2.png)

*Figure 2* Examples of foundational activities within the WHO’s strategic pillars of action for a comprehensive health sector approach to address female genital mutilation (FGM).

**STEP 3**

The ‘final’ step of this approach is not necessarily delineated from the previous two steps but because of its importance was designated a separate step. There was continuous learning and mentoring throughout the annual cycles. Supportive mentoring on WHO resource adaptation was provided through onsite visits and virtual meetings. The selection, development and implementation of foundational activities included discussions and reflections from each country and intercountry experiences to identify appropriate and feasible activities that had a high potential to continue without substantial new funding. In addition, during implementation, new knowledge was generated or gaps identified in guidance or evidence-based technical resources. The reflection, discussion and experience sharing created a ‘living’ learning platform to improve on the design, quality or results of foundational activities. Furthermore, the documentation of this learning generated a need to develop additional WHO guidance such as the practical guide for integrating FGM content within midwifery curricula and a facilitator guide for person-centred communication for FGM prevention.

**ACHIEVEMENT HIGHLIGHTS FROM 2018 TO 2022**

Since 2018, three annual cycles of this three-step approach were completed. In 2018, 10 countries participated in a 3-day in-person meeting with 56 participants. In 2021, 13 countries participated virtually with a total of 70 participants. While in 2022, 7 countries participated virtually with 25 participants.

Ten preliminary health plans were developed, out of which seven were finalised, and proceeded to implement foundational activities. These foundational activities ranged from national guidelines to FGM training content for preservice and in-service training to job tools for health workers that were adapted from eight different WHO resources and tools. It is important to mention that not all countries that started in the first annual cycle continued to the second and third cycles. About five countries integrated FGM-related material within existing RMNCAH interventions or preservice or in-service training curricula for health professionals. Table 1 details the progress of countries that developed national action plans during 2018–2022.

**REFLECTIONS ON THE SCALE UP APPROACH**

The successful uptake of WHO’s recommended comprehensive health sector approach using evidence-based resources in implementation was facilitated by several factors. First, ministries of health and related in-country stakeholders value WHO related products because of the scientific rigour used in their development. Second, the adaptation of WHO resources to the country context in consultation with relevant stakeholders improved their relevance and acceptability. Third, the multicity experience sharing created a community of practice to...
support implementation of FGM-related health interventions that were ‘new’ to health systems. The follow-up, mentorship and bidirectional cross learning and monitoring and evaluation improved the uptake processes too. In addition, the showcasing of country achievements in planning meetings and discussions provided important insights and foresight in planning while creating comradery and pride in achievements.

The in-person multicountry and in-country meetings were more successful compared with virtual meetings in engaging participants. This is probably because in-person meetings remove participants away from their workplace enabling them to focus on the meeting proceedings and group work. However, virtual meetings provided an opportunity to invite more countries and participants at no cost and saved time related to travel. Some challenges faced in virtual participation were the inability to recruit or engage additional countries due to competing priority health issues such as COVID-19 or due to passive email invitation. The virtual multicountry meetings were short (approximately 3 hours) and the time was too short for in-depth discussions compared with in-person meetings. This necessitated multiple subsequent one-on-one meetings with countries to provide more in-depth discussions during planning and implementation of foundational activities.

Every cycle had a different set of countries developing national comprehensive action plans or implementing foundational activities at different paces, with some dropping off to focus on other competing SRMNCAH topics and COVID-19-related activities. FGM was also perceived as a social issue and considered ‘new’ or an additional burden to already stretched health systems and often deprioritised to other health topics.

We found very limited programme data to examine the impact of the comprehensive health sector approach on health workers and FGM prevention and care services for the countries that implemented foundational activities. This could explained partly because the foundational activities were not rolled out to scale together with the absence of FGM related monitoring and evaluation systems. Strengthening monitoring and evaluation of foundational activity processes would need to go hand in hand during implementation and continued thereafter.

The provision of seed funding for foundational interventions was an important step for countries to initiate health sector interventions. However, the amount of funding and donor funding cycles timelines for implementing these interventions introduced challenges in achieving meaningful outcomes. For instance, the development of national FGM training content in curricula for health workers takes more than 1 year to complete as it entails the development of training content, pretesting it and together with training master trainers or mentors before the training content can be rolled out into existing training programmes. Because of the non-continuous funding cycles, foundational activities would be interrupted losing momentum especially when other larger funded health initiatives are underway. While working with ministries of health as the lead coordinator of the national health response and main implementer was a strength, it also limited scale up by other implementing entities. Furthermore, if the representatives from the ministries of health who attended the multicountry meetings do not have leadership roles, the buy in and uptake of comprehensive health sector plans and ensuing activities will be limited. Finally, the private sector, a main health provider in many settings was often not engaged during planning and implementation of activities.

The experience sharing enabled bidirectional learning between countries and WHO. The involvement of three levels of WHO ensured global, regional and in-country technical support, learning and coordination. The close partnership in planning and implementation identified implementation areas that needed evidence-informed guidance. For example, the lack of evidence on effective approaches to provide FGM prevention services at the time of the initial meetings was an impetus for developing training materials and testing them in three countries. Similarly, a gap was also identified in monitoring and evaluating health sector interventions that led to feasibility assessments and pilot projects of several indicators and measurement models, which informed the development of a guidance document on measurement to be published in 2023.

Finally, the COVID-19 pandemic affected the scale up approach process. The travel restrictions limited the in-person participation of WHO regional and headquarter staff to support in-country national planning exercises and implementation of activities. This may have limited the scale of implementation given competing demands of WHO in-country teams. However, the use of virtual meetings reduced time, costs and administrative processes as well as carbon footprints in the preparation of and attendance in in-person meetings.

**WAY FORWARD**

Based on the reflections from the 3 years’ experience of applying this approach, we provide some areas to be considered or strengthened in future cycles.

**MULTICOUNTRY EXPERIENCE SHARING DURING PLANNING AND IMPLEMENTATION**

Where possible, interactive in-person multicountry experience sharing meeting can be continued including subnational experience sharing within countries. The virtual modality for multicountry meetings has a great potential in reaching more international audience in a cost-effective and more environmentally friendly manner. The virtual sessions could be strengthened to be more interactive, which could potentially improve engagement and discussions. Documentation of country experiences as case studies or annual reports would also provide a rich resource to share detailed information on plans and implementation.
IN-COUNTRY ADOPTION PROCESSES

As the comprehensive health sector approach for FGM interventions is relatively new within health systems, it would be important to identify in-country leadership and champions or advocates to recognize and invest into FGM as a public health issue. Further, the numbers of in-country experts/mentors would need to be increased to disseminate and facilitate the adaptation of evidence-based resources during implementation. The champions/advocates and technical pool of expertise could be expanded by including members of health professional associations and academia.

The foundational activities are often complex requiring more than 1 year to complete. This would require continuous funding support sought from alternative funding sources within countries including private foundations to avoid activity interruptions.

Though countries were encouraged to consider contextual and health systems readiness when designing foundational activities, however, it will be essential to monitor implementation and impact of these FGM interventions. The development of training materials and training of health workers for instance may not necessarily translate into FGM prevention and care service provision. This cascade of interventions would need to be monitored closely as well as efforts made to strengthen monitoring and evaluation systems to generate programmatic data systematically.

Often, the newly developed national health action plans are not integrated within the wider national multi-sectoral response plans limiting higher impact with other partners. There is a need to include wider stakeholders from other sectors involved in FGM abandonment efforts as well as the private health sector during multicountry and in-country health action plans development and evaluation meetings.

CONCLUSION

This three-step approach that was implemented by WHO was useful in scaling up the uptake of a comprehensive health sector approach to address FGM in national action plans as well as the adaptation of evidence-based resources during implementation in several countries. The multicountry engagement enriched knowledge sharing across countries and may have potentially saved resources and time on “trial and error”. This scale up approach could be of use for other health topics that are relatively “new” to the health systems as it creates motivation and comradery in tackling challenges and celebrating successes. Finally, the suggested modifications for this approach would need to be tested and assessed to examine whether it impacts uptake of evidence-based interventions, roll out of foundational activities at national scale or resulting in the provision of appropriate FGM prevention and care services to girls or women at risk or affected by FGM. More research would be needed to investigate the degree to which the factors mentioned in the reflection section or other factors may have affected the uptake of comprehensive health sector response, adaptation of WHO resources and impacted the scale up process.

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