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REPORT



# The feasibility, acceptability, appropriateness and impact of implementing person-centered communication for prevention of female genital mutilation in antenatal care settings in Guinea, Kenya and Somalia

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**ABSTRACT**

**Background:** There is limited evidence on how to engage health workers as advocates in preventing female genital mutilation (FGM). This study assesses the feasibility, acceptability, appropriateness and impact of a person-centered communication (PCC) approach for FGM prevention among antenatal care (ANC) providers in Guinea, Kenya and Somalia.

**Methods:** Between August 2020 and September 2021, a cluster randomised trial was conducted in 180 ANC clinics in three countries testing an intervention on PCC for FGM prevention. A process evaluation was embedded, comprising in-depth interviews (IDIs) with 18 ANC providers and 18 ANC clients. A qualitative thematic analysis was conducted, guided by themes identified a priori and/or that emerged from the data.

**Results:** ANC providers and clients agreed that the ANC context was a feasible, acceptable and appropriate entry point for FGM prevention counselling. ANC clients were satisfied with how FGM-related information was communicated by providers and viewed them as trusted and effective communicators. Respondents suggested training

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reinforcement, targeting other cadres of health workers and applying this approach at different service delivery points in health facilities and in the community to increase sustainability and impact.
**Conclusion:** These findings can inform the scale up this FGM prevention approach in high prevalence countries.

## Introduction

Female genital mutilation (FGM) is a harmful practice that affects an estimated 230 million women and girls globally, with approximately 4.2 million girls at risk each year (UNICEF, 2024). The practice constitutes an extreme form of discrimination against girls and women and is recognised globally as a human rights violation that reflects deep-rooted gender inequality (WHO, 2008). While FGM is mainly performed by traditional practitioners, in several settings, there is evidence suggesting increasing involvement of health workers, also known as FGM medicalisation (Doucet et al., 2017; Serour, 2013; Shell-Duncan et al., 2018; WHO, 2010). Apart from contravening local laws and professional ethics, FGM medicalisation may negatively affect FGM abandonment efforts, as health workers are highly respected and influential members of their communities, and their support further perpetuates and endorses the practice (Kimani et al., 2020; Leye et al., 2019). For this reason, health workers need to be effectively engaged to not perform FGM, while also serving as change agents by providing FGM prevention services within the context of their health promotion activities during routine clinical encounters (Pallitto & Ahmed, 2021). However, there is limited evidence on the effectiveness of interventions to prepare and support health workers in this role (Dawson et al., 2015), nor on 'how' and 'why' such initiatives work and the feasibility of scaling them up (Matanda et al., 2023).

Between August 2020 and September 2021, we conducted a cluster randomised trial (CRT) in 180 antenatal care (ANC) clinics in Guinea, Kenya, and Somalia, with the objective of determining the effectiveness of a two-level intervention package targeting ANC providers to deliver FGM prevention and care services in primary care settings (Ahmed et al., 2021). We began the study with baseline data collection at all sites followed by distribution of the level one materials (Figure 1), which included policy directives and posters opposing FGM medicalisation and promoting the provision of FGM prevention and care services, World Health Organization's (WHO) guidelines on the management of FGM-related health complications (WHO, 2016a) and WHO's clinical handbook on the care of girls and women living with FGM (WHO, 2018). The level two component was

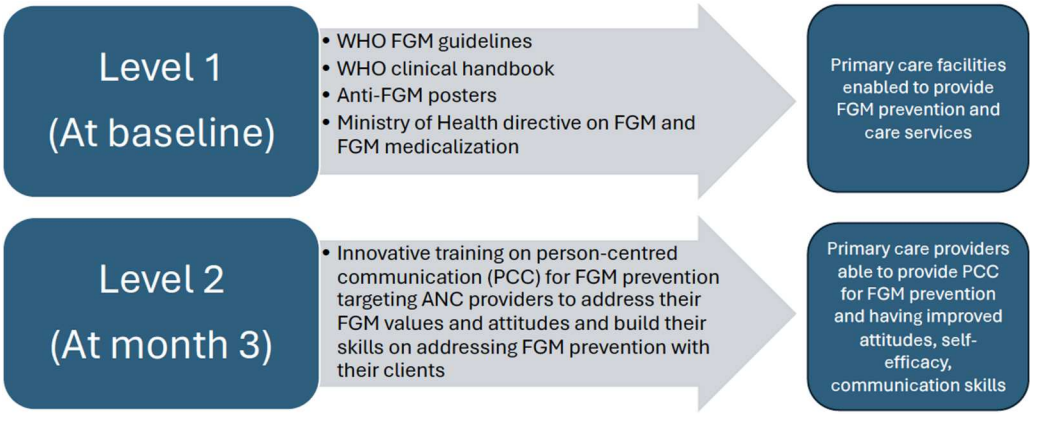


**Figure 1.** Study schema.

implemented three months later in the intervention clinics only, and involved a three-day interactive training on person-centered communication (PCC) for FGM prevention delivered to ANC providers (WHO, 2022). This counselling approach is based on social norm theory and aims to build communication skills and change the attitudes of health workers so that they can in turn, change those of their clients (Boone et al., 1977; Valente & Pumpuang, 2007). This counselling approach applies components of person-centered care, which is respectful of, and responsive to, individual patient preferences, needs and values (WHO, 2016b). Provision of person-centered care, including person-centred communication involves: (1) eliciting and understanding the patient's perspective; (2) understanding the patient within his/her unique psychosocial context; (3) reaching a shared understanding of the problem and its solution which is concordant with the patient's values and; (4) helping patients share power and responsibility by involving them in choices to the degree that they wish (Bandura, 1986; Kleinke, 1984).

The level two PCC for FGM prevention intervention component aimed to strengthen ANC providers' interpersonal communication skills to be effective change agents for FGM prevention. The four concepts above were the basis for the PCC training of health workers and were intended to guide the way they communicated with their clients in an empathetic and sensitive manner. The training also encouraged providers to question their own attitudes and values towards FGM and FGM medicalisation and to build skills in resisting requests to perform the practice. In this regard, the PCC approach was operationalised into a series of four steps (ABCD) that included: **addressing** the client's FGM status; assessing, discussing and challenging the client's **beliefs** about the practice; and then together with the client, exploring the possibility of **change** in order to **discuss** and **decide** on an appropriate course of action towards preventing the practice (Ahmed et al., 2021). The ABCD job aids were also distributed for display at clinics as part of the level two component of the intervention. The primary results from this CRT showed that ANC providers who received the intervention gained valuable skills and knowledge, were more likely to deliver the ABCD steps for FGM prevention and that their clients were less likely to support FGM or were more likely to report intentions to prevent FGM (Balde et al., 2024).

A secondary objective of the study involved conducting a process evaluation to understand 'how' and 'why' this complex intervention package worked. Guidance from the British Medical Research Council (MRC) for developing and evaluating complex interventions recognises the importance of process evaluations within clinical trials in assessing the fidelity and quality of intervention implementation, clarifying causal mechanisms, and identifying any contextual factors that may be associated with variations in intervention implementation and achievement of study outcomes (Moore et al., 2015; Skivington et al., 2021). The objective of this process evaluation was to assess the perspectives of ANC providers and their clients around the acceptability, adoption, appropriateness, and feasibility of implementing the PCC approach for FGM prevention (Peters et al., 2013) to inform scale-up and replication in other contexts (Bumbarger & Perkins, 2008).

## Methods

### *Study population*

A subset of 18 ANC clinics (six per study country) from the intervention arm were selected for the process evaluation, with one health worker and one client who participated in the study being interviewed at each selected site. Per the study protocol, only clients coming for their first ANC visit of their current pregnancy at a study clinic were recruited.

### *Sampling*

To select sites for the process evaluation in each study country, intervention sites were categorised based on the monthly client load (busy or not busy clinics), subnational setting

(county/region in the country) and perfomance on the level one intervention. Six clinics were randomly selected with an attempt to have sites equally distributed on these three characteristics. In each of the selected clinics, a convenience sample consisting of a trained ANC provider and their respective ANC client exiting a clinic visit who also completed the quantitative questionnaire were selected for in-depth interviews (IDIs) (see Annex 1 for IDI guides). Overall, a total of 18 ANC providers and 18 clients were selected. In Kenya, an additional ANC client was recruited to replace one who did not complete the interview. Members of the research team in each country, who had been trained in qualitative research methods conducted the IDIs in a private space at the health facility after gaining informed consent. All interviews were conducted following the completion of the quantitative assessment. The interviews were audio recorded; no field notes were collected, and each interview lasted approximately 30 min.

Separate structured interview guides were used for the ANC provider and client interviews. The guides were developed by the research team, pretested in each study country and adapted accordingly based on feedback from the pretest. The ANC providers' guide included questions on how FGM was perceived by their clients, how they themselves felt about using the PCC approach for FGM prevention, the feasibility of conducting the ABCD steps during routine clinic visits, their perception of the effectiveness of this approach, and facilitators and barriers of implementing the intervention. The ANC clients' guide included questions on their own knowledge and beliefs on FGM practice, any perceived community changes in the practice, their role in decision making about their daughter having FGM, their satisfaction with care received and their perceptions on how FGM-related services were provided during the clinic visit. ANC provider interviews were conducted in English, French or Somali, depending on the study country, while ANC client interviews were conducted in the local language, that is, Somali in Somalia; Soussou, Poular or Malinké in Guinea; and Swahili, Keiyo, Maasai, Marakwet or Tugen in Kenya. The interview guides were translated into all of these languages prior to fieldwork.

### *Definition of study outcomes*

Study outcomes were evaluated based on responses from ANC clients and their providers. These included feasibility, acceptability, fidelity and impact as described below. The IDI guides included questions to solicit responses related to each of these concepts.

Feasibility was assessed as the ability of ANC providers to deliver the ABCD approach during ANC visits and the factors that may have affected implementation. For example, providers were asked 'Are you able to carry out the ABCD steps? What is working and what is not working?' Acceptability referred to how well the ABCD approach was received by both ANC providers and clients, whether the ANC provider was the appropriate person to discuss FGM prevention and whether the ANC clinic setting was the appropriate place for this conversation. Providers were asked, 'How do you feel about discussing FGM with your patients?', and clients were asked, 'Do you think this discussion should be continued in ANC or elsewhere?'. Fidelity (i.e. whether the intervention was delivered as intended) was assessed by interrogating the ANC providers' awareness and utilisation of the level one intervention components and whether they followed the ABCD steps of the PCC for FGM prevention counselling approach. Providers were asked to describe the ABCD steps. Finally, impact was defined as the perceived effect of the intervention package on FGM-related knowledge, attitudes and practices of ANC providers and their clients. Clients were asked how the discussion on FGM with their provider impacted their support for FGM, and providers were asked if they felt that the discussions with antenatal patients would make any difference to the practice of FGM in the community.

### Ethical considerations

Ethical approval for the multi-centre protocol was obtained from the World Health Organization (WHO) Ethical Review Committee (ERC) (#P151/03/2014). Each study country submitted country-specific protocols to national institutional review boards. Ethical approval was obtained in Kenya from the Kenyatta National Hospital/University of Nairobi ERC (P805/09/2019) and the National Commission for Science, Technology, and Innovation (NACOSTI/P/20/5721); in Somalia from the Department of Planning, Policy and Strategic Information, Unit of Research (MOHD/DG: 2/11526/2019); and in Guinea from the *Comité National d'Ethique Pour la Recherche en Santé* (CNERS) (105/CNERS/19).

### Data analysis

All qualitative interviews were transcribed, and for those that were conducted in other languages, translated into English. During transcription in Guinea, the local languages were first translated into French and then into English, while in Kenya and Somalia, the transcripts were translated directly into English. Study participants did not review the transcripts. Translation and transcription were done by members of the in-country research teams who spoke the languages of interest. Where relevant i.e. if they spoke the language of interest, both the PI and co-PI cross-checked the translations and transcripts for errors. Cross-country qualitative data analysis was conducted on the English translations by an independent consultant who is an experienced qualitative researcher and had not been involved in implementation of the CRT or analysis of data on main study outcomes to reduce the possibility of bias in the analysis of study data (CM). Based on a detailed reading of a subset of transcripts from ANC providers and clients from each country, a draft code list was developed that was then tested on additional transcripts and refined iteratively. It was shared with three investigators (CP, WA and VM) for input and clarification, and to ensure the reliability of the identified codes. After testing and refining the draft code list, a master code list with definitions was created. A qualitative data analysis software programme (NVivo version 12, QSR International) was used to organise, code, and analyse the IDIs following a thematic analysis approach into the pre-defined themes and any new emergent themes. Key thematic areas identified included general FGM knowledge and practices, feasibility, acceptability, fidelity, coverage and reach (impact), and suggestions for improving intervention scale up. The focus of this manuscript is on feasibility, acceptability, fidelity, and impact. Information on participants' region, ethnic group and religion were considered sensitive and were not collected.

## Results

All ANC clients and 16 out of 18 ANC providers were female (Table 1).

**Table 1.** IDIs conducted per study country.

| Study country | Number of sites (by region) |
|---|---|
| Guinea | Conakry: 3 |
| | Faranah 3 |
| Kenya | Baringo 2 |
| | Elgeyo-Marakwet 2 |
| | Kajiado 2 |
| Somalia | Awdal 2 |
| | Marodijeex 2 |
| | Togdheer 2 |
| Total | 18 |

### Feasibility

Most of the ANC providers felt that implementation of the ABCD approach was feasible while their clients felt that the ANC clinic was an appropriate setting to address FGM prevention.

> Yes, it is appropriate to continue with this discussion during antenatal visits […] A pregnant mother can be enlightened on what she didn't know before if she goes for her antenatal visits or goes to a health center (Somalia, ANC client, Low performing/high client load)

However, there were challenges noted such as insufficient time to follow the ABCD steps because of client load and ANC clients not wanting to spend much time for a clinical encounter.

> I will need more time with the clients because I feel like I do not give clients adequate time […]. (Kenya, ANC provider, Low performing/low client load)

> When few people come, we will have enough time to discuss with the mothers and listen to the stories they experienced themselves or they heard about. (Somalia, ANC provider, Moderately performing/high client load site).

There were also concerns raised regarding the health facility having a space for private and confidential discussions around sensitive topics like FGM.

> To improve monitoring … beliefs, it is necessary to have safe and appropriate places, which must be confidential … … (Guinea, ANC provider, Low performing/low client load site)

ANC providers also described the need for ongoing training reinforcement and extending training to a wider cadre of health workers to entrench the delivery of FGM prevention messaging in the health sector. Some felt that even those who may not necessarily provide clinical care should be trained.

> We also need refresher trainings […] like the training which we took was only three days, […] if we widen this training to take like a week or so […] for we to get the comprehensive approaches. (Kenya, ANC provider, High performing/low client load site)

> [E]veryone must be on an equal footing. Training must take place not only at curative PHC [primary health care] level only, but at vaccination, at nutrition, even at reception … … … … … … . Everyone must be trained, everyone must be informed because, if you aren't informed about something, it isn't easy. (Guinea, ANC provider, High performing/high client load site)

### Acceptability

Most ANC clients indicated that the FGM-related discussions they had had with their provider during the ANC visit were acceptable.

> I feel our discussion today was very important […] it has helped me to understand a lot of things I was not aware of […] it has helped me, now at least when I get home, I will sensitize others about FGM. (Kenya, ANC client, High performing/high client load site)

Most clients also expressed satisfaction with the way FGM-related information had been provided during the ANC visit. This was enhanced by ANC providers discussing and asking their clients about their personal experiences related to FGM and listening to their views about the practice.

> I'm pleased up to the point where my doctor showed me some things. She showed me some photos of women's bits [private parts] and that say FGM isn't good for women, […] It's changed my opinion on FGM, so it's not a good thing to do. (Guinea, ANC client, Low performing/high client load)

### Fidelity

Most ANC providers confirmed that the level one materials/resources distributed at baseline were still present at their clinics, and they felt that these resources facilitated effective discussions around

FGM with some variation in how much they were utilised. Similarly, while not all providers retained and implemented the ABCD approach, most applied it during their practice.

> So, we have not experienced any difficulties when we are talking about FGM because here in the facility we have posters […] they see the FGM […] so they have not that fear of talking. (Kenya, ANC provider, Low performing/high client load site)

Additionally, most providers felt comfortable implementing the intervention effectively due to '*the knowledge that I [they] got during the training. (Kenya, ANC provider, High performing/high client load site)*' and only one provider described limited to no knowledge of the intervention.

The ANC providers indicated that the materials/resources distributed at baseline, including FGM prevention posters, helped to create awareness and provided a reference point during discussions with their clients.

> I think these posters are like raising awareness […] Before it is their turn, they can read that to find out before they go into the ward where the antenatal clinic is held [… ..] It will help with the ABCD, because they already have the information […]As a result, they are already informed, and it's a great help. (Guinea, ANC provider, High performing/high client load site)

> [H]aving those posters is very, is … it will be very helpful, because you can even take them to the shopping centers […] and even churches, the community […] if they see them, they ask – 'what is this?' […] and you'll pass the message […] uh, easily. (Kenya, ANC provider, High performing/low client load site)

ANC clients described how their provider had brought up discussions on FGM and related risks. They confirmed that their provider had asked about personal FGM experiences and importantly, most of them reported that they felt that their provider had listened to their views about FGM.

> *When she asked me* questions *and then gave me advice, I listened very carefully to her, and she also listened to me. She listened carefully to what I said … (Guinea, ANC client, High performing/high client load site)*

### *Appropriateness*

Most ANC clients agreed that health workers were appropriate persons to initiate FGM-related discussions since they were trusted because of their clinical training that allowed them to understand the health implications of FGM and their knowledge of the cultural drivers of the practice.

> The health care provider is appropriate because you know here, she meets with a lot of people. […] And she is educated, she understands these things […] she understands the dangers of FGM, and she understands everything. (Kenya, ANC client, High performing/high client load site)

A few clients pointed out that it should not only be ANC providers to initiate discussions about FGM, but that other community leaders also had a role to play.

> The midwife is appropriate, or leaders or other people in the community. […] Chiefs, village elders, church leaders, and teachers too. (Kenya, ANC client, Low performing/low client load site)

Most providers and clients agreed that the ANC setting was an appropriate entry point for FGM-related discussions although some suggested that FGM discussions could also be initiated in other service delivery points (for example, maternity) within the health facility or within the community, for example, in churches, schools and during community meetings.

> [I]n my opinion they should continue [discussions on FGM] with the pregnant women, and do it elsewhere as well for example in churches. You see … […] but it is good to continue here at the clinic […] even in barazas [community meetings], you could organise seminars to educate people […] you could take this to teachers, teach teachers, teachers to teach students. Or teach the teachers because they are the ones who meet students from diverse places. Therefore, they should teach the teachers first, then the teachers will teach the students. (Kenya, ANC client, High performing/high client load site)

*[F]or us to expand these services, not only offering it at the antenatal clinics, […] it can also be offered child welfare activities clinic because clients who graduate from antenatal they go to postnatal after postnatal they can also graduate when you are a postnatal mother you can also be sick [and access other services] (Kenya, ANC provider, High performing/low client load site)*

### *Impact*

Most ANC providers demonstrated recall of the ABCD steps, with varying levels of detail, more than three months after receiving training.

> If I remember, during the training we received, they started with, first, A. A stands for Approach: how to approach the woman, because it's something like a taboo for us here. How to approach the woman. He taught us that during the training. B, now that is address Beliefs, that is the definition. You've approached the woman: now, how to address the subject. C, now, stands for Change. You've raised the client's awareness. Has she understood your awareness raising? Changing behavior, is what the C stands for. If I remember, there's one more. Hold on, it's D. Now D is Discuss and Decide. The awareness-raising is finished with the client. What has she decided? Is she going to carry on, bah! as before or does she get discouraged? Or she leaves, and when she gets home, she can pass on the message to the others to discourage FGM. (Guinea, ANC provider, High performing/high client load site)

Additionally, most providers indicated that the PCC training had improved their knowledge about FGM, had taught them how to address entrenched beliefs, and had empowered them to communicate more effectively with their clients about FGM and its risks. A few indicated that they would benefit from additional training.

> Because of this training, I am now able to raise women's awareness and persuade them about the beliefs and the disadvantages. (Guinea, ANC provider, High performing/high client load site)

> Because of this concept of PCC […] because FGM is a sensitive subject which you cannot even … you cannot freely ask anybody, you have to use this approach. […] You have to see ways of making this client first […] making the client comfortable and willing to share more. (Kenya, ANC provider, High performing/low client load site)

ANC clients indicated that they had learnt a lot about FGM because of the approach used by their providers, with some noting that they would share this information with their respective communities while recognising that FGM is a deeply rooted social norm and that it will take time for impact to be felt.

> There are many things I did not know about 'excision' [referring to FGM] and learned today […] Now, when I get home, I can pass on words from my discussion with the woman to my neighbors and relatives […] because we, we are not educated women. (Guinea, ANC client, Low performing/low client load site)

Both ANC providers and clients reported that the shared nature of decision making on FGM in the communities they came from, involving mothers-in-law, their husbands, and local community gatekeepers, made it difficult to achieve changes in FGM practice, especially if these secondary decision-makers were not targeted as well.

> Because you give a clear explanation but, at D[referring to ABCD approach], they now say, 'mum, I've understood you but, hold on! If I go home and tell this to my husband, I will come and tell you the answer he gives me, because our sole problem is our husband.' (Guinea, ANC provider, Low performing/low client load site)

> The way to improve these discussions … […] at present, […] what the chiefs say goes, whether you accept it, or not. That's how it is (Guinea, ANC client, high performing/low client load site)

Some clients discussed the difficulty in changing customs and the importance of starting the conversation and raising awareness little by little.

> To discontinue a custom is not easy, but we must continue to raise their awareness, provide counselling, little by little. (Guinea, ANC provider, Low performing/high client load site)

## Discussion

Findings from this process evaluation conducted as part of a CRT evaluating the effectiveness of a complex, two-level intervention package for the prevention and care of FGM within the health sector indicate that providing structured FGM prevention counselling during ANC visits was appropriate, feasible and acceptable to both ANC providers and their clients. Given the lack of rigorous studies on the effectiveness of FGM prevention interventions in general and in the health sector in particular, this study contributes not only to the evidence base on what works but on some of the implementation considerations (Ahmed et al., 2023). Implementation of the intervention package (both levels one and two) was considered feasible. This process evaluation also found that acceptability was enhanced by ANC providers discussing and asking their clients about their personal experiences related to FGM and listening to their views about the practice. However, lack of time for implementing the ABCD steps during routine clinic visits and limited space for private and confidential discussions in the health facility were reported as challenges to fidelity in implementing FGM prevention counselling.

The focus on prevention was considered relevant in this context and the findings complemented existing research on the appropriateness, feasibility, and acceptability of providing FGM care in the health sector to women who have already undergone FGM and are seeking services for FGM-related health problems (Dixon et al., 2021; Isman et al., 2013), Overall, the ANC setting was considered an appropriate setting for FGM prevention counselling and ANC providers were considered an appropriate group to do so.

The PCC approach is based on the concept of person-centered care, a key component of quality health care, that involves respectful, caring, and collaborative clinical approaches to help women and girls make their own health care decisions (Coulter & Oldham, 2016). Application of a person-centred care approach has not been a fundamental component of FGM prevention and care (Dawson et al., 2022). ANC providers in this study reported challenges in changing inherent beliefs around FGM, many of which were linked to deeply rooted cultural and/or religious beliefs and traditions, and one clinic visit was not considered adequate to address these cultural beliefs. Other influential players such as community leaders and male partners need to be involved, in addition to health workers.

The findings from this process evaluation complement quantitative findings from the CRT that showed that the intervention package was effective in improving FGM prevention and care practices of ANC providers and changes in FGM-related intentions for their clients (Balde et al., 2024). These findings also provide additional context in understanding 'why' and 'how' the intervention package achieved its effect. However, they need to be interpreted in the context of several limitations. First, qualitative data collection is dependent on the skills of the researcher and could be influenced by their personal biases. In this study, field data collectors used semi-structured interview guides in their discussions with respondents. Although standardised training was conducted prior to field work, it is possible that there may have been differences in qualitative research skills affecting the extent of probing, which could have influenced the depth of qualitative information obtained in the different study countries. The data obtained from this process evaluation, however, aligns and contextualises the quantitative information obtained from the main CRT.

Second, this process evaluation sought information on pre-determined implementation factors to understand 'why' and 'how' the intervention may have been effective. Field data collectors asked questions and probed along these themes as opposed to using open-ended questions for a more broad-based enquiry. This approach could potentially have led to biased or curtailed responses from the respondents, although in most cases the interviewers elicited rich information from the participants despite the semi-structured nature of the guides. Third, by selecting one ANC provider and one ANC client in each of the sampled clinics, we cannot assure that we achieved a sample size that reached thematic saturation. We did however, spread out the sample across various sites within each country and across the three study countries to ensure that varied perspectives were captured

and the findings across these varied sites had many similarities pointing towards thematic saturation.

## Conclusion

The findings from this process evaluation identified factors related to intervention feasibility, acceptability, appropriateness, fidelity and coverage that could have led to variations in intervention implementation and achievement of study outcomes. This understanding is important for effective translation into policy and practice towards ensuring that health workers are effectively engaged and enabled to provide FGM prevention services as part of their health promotion activities. The findings from this process evaluation will be useful in informing further implementation research including identifying and addressing specific contextual factors, barriers and facilitators that could affect scale up and sustainability of implementing FGM prevention and care services within the health sector.

## Declarations

### Author contributions

WA and CP conceptualised the study and prepared the protocol in collaboration with VM, KS, PN, TE, MDB, AMS, AD and MAA. MDB, AMS, AOS, AD, PN, TE, JMK, JC, SK, JJ, JO, AD and MAA provided oversight over study implementation. CM analysed the qualitative data and prepared a report of the findings that provided the basis of an initial manuscript draft prepared by VM with input from WA, CM, KS and CP, the responsible officer of the study at WHO/HRP. All the authors contributed to and reviewed the manuscript for proper intellectual content and have read and approved the final draft.

### Data sharing

De-identified data will be retained in the WHO HRP electronic archival system. Any use of the de-identified analytic dataset for secondary research purposes will be governed by the WHO data use regulation. Requests for data may be sent to pallittoc@who.int.

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### Disclaimer

The named authors alone are responsible for the views expressed in this publication and do not necessarily represent the decisions or the policies of the UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) or the World Health Organization (WHO).

## Disclosure statement

No potential conflict of interest was reported by the author(s).

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## Appendix

**A Health Systems Approach to Prevention of Female Genital Mutilation**
**using Person-Centered Communication:**
**A Multi-Country Implementation Research Project**
**In-depth interview guide (ANC clients)**

**Socio-demographic characteristics of the interviewee**
Age:
Marital status:
Highest level of education:
Number of children:
Religion (*Not asked in Somaliland)*:

1. Can you tell me what you know about FGM?
2. How common is FGM in your community? How has this changed from when you were a child?
3. Did you discuss FGM with your ANC provider today? If yes, what did you discuss?
4. Do you think that the nurse/midwife listened to you about your opinion on FGM? Please explain.
5. Do you think that the discussion with the nurse/midwife made you feel more or less supportive of FGM? Please explain.
6. How could these discussions be improved?
7. Who makes decisions about FGM in your household? What is your role in decision-making about FGM for your children?
8. How satisfied were you with the care you received today? (Probe about counselling in particular)
9. Do you think the discussion on FGM was appropriate?
10. Do you think the nurse/midwife is the right person to do this?
11. Do you think this discussion should be continued in ANC or elsewhere? Please explain.

**A Health Systems Approach to Prevention of Female Genital Mutilation using Person-Centered Communication: A Multi-Country Implementation Research Project In-depth interview guide (ANC providers)**

**Socio-demographic characteristics of the interviewee**
Age:
Marital status:
Highest level of education:
Professional title:
Number of years of experience in the health facility:
Number of years of experience in total:
Religion (*Not asked in Somaliland)*:

1. In general, how do your patients view the practice of FGM?
2. How do you feel about discussing FGM with your patients?
3. Do you recall the ABVD's of FGM prevention counselling? Can you describe those steps to me?
4. Are you able to carry out the ABCD steps? What is working and what is not working? How can it work better?
5. Can you describe a discussion on FGM with a patient that went well?
6. Can you describe a discussion on FGM with a patient that was difficult? How did you handle the situation?
7. How easy or difficult would it be to use ABCD steps to communicate about FGM prevention with patients attending other services, including immunization services?
8. What do you feel can help you to provide FGM prevention?
9. What do you feel makes it difficult to provide FGM prevention?
10. Do you think having posters or policies or job aids facilitates the implementation of ABCDs of FGM prevention? Explain how.
11. Do you think the training you received was useful? How? Why?
12. How can discussions with patients on FGM be done better? (facilitating factors)
13. Do you believe discussions with antenatal patients will make any difference to the practice of FGM in the community?