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# A cluster randomized trial of a health system strengthening approach applying person-centered communication for the prevention of female genital mutilation in Guinea, Kenya, and Somalia

Journal: Manuscript ID	BMJ Open
Manuscript ID	
	bmjopen-2023-078771
Article Type:	Original research
Date Submitted by the Author:	11-Aug-2023
Complete List of Authors:	Balde, Mamadou; Cellulle de Recherche en Sante de la Reproduction en Guinee (CERREGUI) Ndavi, Patrick; University of Nairobi College of Health Sciences, Department of Obstetrics & Gynecology Oyaro, Vernon; World Health Organization, Department of Sexual and Reproductive Health and Research Soumah, Anne-Marie; Cellulle de Recherche en Sante de la Reproduction en Guinee (CERREGUI) Esho, Tammary; Amref International University King'oo, James; Technical University of Kenya Kemboi , Jackline; Amref Health Africa Sall, Alpha; Cellulle de Recherche en Sante de la Reproduction en Guinee (CERREGUI) Diallo, Aissatou; Cellulle de Recherche en Sante de la Reproduction en Guinee (CERREGUI) Ahmed, Wisal; World Health Organization, Department of Sexual and Reproductive Health and Research Stein, Karin; World Health Organization Nosirov, Khurshed; World Health Organization, Department of Sexual and Reproductive Health and Research Thwin, Soe Soe; World Health Organization, Department of Sexual and Reproductive Health and Research, including UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) Petzold, Max; University of Gothenburg Sahlgrenska Academy, Public Health and Community Medicine Ahmed, Muna; Somaliland Central Statistics Department Diriye, Ahmed; Data and Research Solutions Pallitto, C; World Health Organization, Department of Sexual and Reproductive Health and Research
Keywords:	EDUCATION & TRAINING (see Medical Education & Training), Patient- Centered Care, Primary Care < Primary Health Care, Primary Prevention, PUBLIC HEALTH, Behavior

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A cluster randomized trial of a health system strengthening approach applying personcentered communication for the prevention of female genital mutilation in Guinea, Kenya, and Somalia

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BMJ Open: first published as 10.1136/bmjopen-2023-078771 on 4 July 2024. Downloaded from http://bmjopen.bmj.com/ on June 13, 2025 at Agence Bibliographique de Enseignement Superieur (ABES) .

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TO BEEL EN ONL Abstract word count: 286

Text word count: 5,048

Tables: 3

Figures: 2

Introduction: There is limited evidence on effective health systems interventions for preventing female genital mutilation (FGM). This study tested a two-level health system strengthening approach at primary care level to apply person-centred communication (PCC) for FGM prevention.

Methods: Between August 2020 and September 2021, a cluster randomized trial was conducted in 180 antenatal care (ANC) clinics in Guinea, Kenya, and Somalia. At baseline, all clinics received guidance and materials on FGM prevention and care, while at month three, ANC providers at intervention sites received PCC training. Data were collected from clinic managers, ANC providers and clients at baseline, months three and six. Logistic regression models were used to analyze the effect of the intervention on study outcomes.

**Results**: Complete data were collected from 232 ANC providers in 163 clinics. Compared to providers in the control arm, those in the intervention arm had higher odds of being confident in their FGM-related knowledge (OR: 6.3, 95% CI: 1.4-28.9; p=0.02) and to communicate effectively about FGM prevention (OR: 1.7; 95% CI: 1.0-3.0; p=0.06). Additionally, ANC clients in the intervention arm had higher odds of being less supportive of FGM (OR: 2.4, 95% CI: 2.0-3.0; p<0.001) and wanting to be actively engaged in FGM prevention (OR: 2.2, 95% CI: 1.8-2.9; p<0.001) after speaking with their provider. They also had higher odds of being strongly opposed to FGM (OR: 1.7, 95% CI: 1.4-2.1; p<0.001), lower odds of intending to have their daughters undergo FGM (OR: 0.4, 95% CI: 0.3-0.5; p<0.001).

#### **SUMMARY BOX**

- The health sector has the potential to complement existing efforts to prevent female genital mutilation (FGM) through its large primary care service network. Health workers can be influential in health promotion and behaviour change given their respected status in their communities, their access to at-risk populations and the support and access to capacity building they receive through the health system. There has been limited rigorous research examining effective interventions that empower health workers to communicate on FGM prevention that could be brought to scale to support global and national efforts for FGM abandonment.
- Based on concepts from social behavioural theory and person-centred care, as well as learnings from formative research conducted in Guinea and consultations with key stakeholders in high prevalence settings, we developed and pre-tested a training package to enable ANC providers working at primary care clinics in FGM prevalent settings to provide person-centered communication on FGM prevention to their clients. Results from the present study show that ANC providers effectively implemented this FGM counselling approach and their clients were significantly more satisfied by the care provided, had lower intentions to perform FGM on their daughters and greater willingness to be engaged in FGM abandonment efforts.

- To our knowledge, this is the first randomized controlled trial that showed the effectiveness of a health system intervention to promote FGM prevention communication in the context of routine primary care.
- Further research is needed to understand how to replicate and scale-up existing findings in other settings and how to reinforce prevention messages over the long-term. This study highlights the need for greater multi-sectoral coordination and complementarity in programming in high prevalence settings.

#### INTRODUCTION

Multi-sectoral efforts are needed to achieve Sustainable Development Goal (SDG) 5.3 to eliminate the harmful practice of female genital mutilation (FGM) by 2030 in line with the United Nation's (UN) General Assembly resolution 67/146 (1), the World Health Assembly Resolution 61.16 (2) and the 2008 Interagency Statement (3), which call upon UN Member States to enact comprehensive and multi-disciplinary national action plans and strategies towards the elimination of the practice. Identifying effective strategies across sectors is an important step in ending FGM

The health system, defined as all organizations, institutions and resources that produce actions whose primary purpose is to improve health (4), has an important role to play not only in managing complications of FGM but also in preventing the practice. Health care providers, specifically nurses and midwives who constitute most of the health workforce, are highly respected members of FGM practising communities and could positively contribute to abandonment efforts (5,6). However, there is currently limited evidence to guide health programming on FGM prevention (7). In addition, some health care providers are themselves

Three countries (Guinea, Somalia, and Kenya) participated in a cluster randomized trial to test the effectiveness and implementation of a health system strengthening approach to FGM, which included the testing of an intervention to build skills of health workers on applying person-centered communication (PCC) for the prevention of FGM (14). Study countries were selected based on their high national and/or sub-national FGM prevalence. The national prevalence of FGM among women and girls aged 15 - 49 years is 98% in Somalia, 97% in Guinea and 21% in Kenya according to national population-based surveys. There are 20 hotspot counties/sub-national administrative units in Kenya with a prevalence of >80% (15), and this study focused on three of these counties. Likewise, the study countries have high rates of medicalized FGM, performed primarily by midwives, who make up between 71% to 93% of primary care providers in the three study countries (16) hence the selection of nurses and midwives as the target group for this intervention.

The purpose of this study was to test a two-level intervention package to enable ANC providers to deliver person-centered FGM counseling to their clients. This intervention package was informed by a theory of change that promotes health workers to be effective behavioral change agents because of their credibility (17) and positionality to influence the opinions, attitudes, beliefs, motivations and behaviors of their clients (18). We hypothesized that if ANC providers gained the necessary knowledge and skills to provide person-centered counseling

(Level 2) and were given the opportunity to question their beliefs and attitudes together with an enabling environment (Level 1), they could positively influence the knowledge and attitudes of their clients to abandon the practice (Figure 1).

The level one intervention consisted of making available national policy directives on the role of health care providers in providing FGM prevention and care services, WHO's FGM guidelines and clinical handbook as well as information, education, and communication (IEC) materials. These materials were distributed without any capacity building to accompany their distribution. Level two consisted of an interactive training specifically targeting ANC providers to build their knowledge on FGM, enable them to question their FGM-related values and attitudes and build their skills on counseling for FGM prevention using person-centred communication (19), a component of person-centred care, which ensures that the perspectives and preferences of individuals, carers, families and communities are at the center of decisions and that they have the information and support needed to make decisions (20). ANC providers were trained to apply a series of structured steps in which they would: 'Assess' their client's views on FGM, address and challenge her 'Beliefs', encourage 'Change' and together with the client, 'Discuss and Decide' (ABCD).

#### **METHODS**

#### **Study Design**

This cluster randomized trial applied a type 2 hybrid, effectiveness-implementation design to test the effectiveness of the delivery of a phased intervention package (Levels 1 and 2) on knowledge, attitudes and practices among ANC health workers and their clients. The methodology, analysis plan and reporting conformed to the 2010 Consolidated Standards of Reporting Trial (CONSORT) checklist (21). Ethical approval for the master protocol was

#### **Participants**

Within each study country, two or three sub-national units (regions/counties) were purposively selected according to the following eligibility criteria: (1) FGM prevalence >50% among females 15 - 49 years old; (2) more than 15 ANC clinics, seeing on average 30 new ANC clients per month and (3) accessibility in terms of security. The unit of randomization was the ANC clinic to avoid having ANC providers in the same clinic in different study arms, which could lead to contamination. In intervention sites, all providers on duty were pre-screened. To ensure participation and follow-up throughout the trial, between one and three ANC providers on duty were enrolled based on a six-month clinic rotation schedule provided by the clinic manager. Ten new clients exiting their first ANC consultation with a participating provider were recruited at each data collection point.

Individual study participants gave verbal informed consent. Data collectors collected data from the ANC providers and their clients in a private and confidential setting. While personally identifiable information was collected from ANC providers to facilitate tracking during the follow-up data collection time points, data were de-identified prior to analysis. No personally

identifiable information was collected from ANC clients who were unique at each time point. Participating ANC clients received the equivalent of 5 USD to compensate for their transport costs recognizing that participants consenting to participate might have changed their plans to accommodate the interviews. Given insecurity in carrying cash in Somalia, a mobile phone application was used to transfer the money to participants, an amendment to the original protocol, which was submitted to the ethical review committees.

#### Randomization and blinding

Based on Ministry of Health (MoH) facility administrative records of all public, primary care facilities (i.e., dispensaries and/or health centers) offering ANC services in the selected regions/counties, the average number of new ANC clients seen in November and December 2019 was compiled to create ordered listings of client loads at each of the sites by region/county. Clinics were matched into pairs based on client load so the two busiest would be randomized to different arms and so on. A uniform distribution was used for randomization using the uniform random number function in STATA 17 (StataCorp Inc., College Station, TX, USA). The clinic managers, providers and clients were blinded as to study arm allocation. Intervention clinics might have inferred they were in the intervention arm. However, both arms received the level one intervention at baseline so clinics in the control arm might have also assumed they were in the intervention group.

#### **Procedures**

Implementation of the study interventions and data collection occurred between August 2020 and September 2021 and was staggered by countries. In the intervention arm, data collection was undertaken at three time points, i.e., at baseline prior to implementing the level one intervention component; at month three, prior to implementing the level two intervention

A web-interface electronic data capture system was developed on the Kobo toolbox core system architecture (Kobo Toolbox, Harvard Humanitarian Initiative, Boston, Massachusetts, USA). User accounts were password-protected, and data sent to the server was encrypted in transit using SHA256 with RSA encryption that met the data security requirements. Personally identifiable information was not collected, and all records were anonymized with unique study numbers. Study instruments for ANC clients were translated from English into ten languages by research team members in consultation with language experts (French, Somali, Swahili, Soussou, Poular, Malinké, Keiyo, Maasai, Marakwet and Tugen) while those for ANC providers and clinic managers were translated into two languages (French and Somali). No backtranslation was performed. Field data collectors and their supervisors spoke the languages in which the questionnaires were administered. Data collection teams participated in a standardized training with WHO/HRP and the research institutions in each country. The level two intervention was implemented by master trainers in each country who had been trained remotely over a three-day period following the WHO PCC for FGM prevention facilitator's manual.

#### **Outcomes**

The primary study outcomes included the delivery of the "ABCD" approach by ANC providers measured by responses from client and provider instruments developed for this study, using validated instruments where possible, including four constructs of the operational definition of person-centered communication (22). The secondary self-efficacy outcome was assessed based on a score calculated from a validated tool for measuring general self-efficacy (23), while knowledge, attitudes, and practice (KAP) on FGM prevention and care were measured using an unvalidated KAP questionnaire similar to one used in formative research in Guinea. Questions for the health facility preparedness composite score were developed for this study and assessed availability and use of FGM prevention and care resources. (See supplementary materials). Statistical analysis To have sufficient power (80%) to detect a difference (significance level 5%) between

intervention and control arms on the primary study outcome of delivery of the PCC intervention for FGM prevention, 180 ANC clinics, equally divided across the three study countries were recruited and randomized with 1800 new ANC clients (10 per clinic) recruited at baseline and 1800 at six-month follow-up. While similar interventions have resulted in 20% difference between groups (24), a 10% difference was applied to ensure sufficient power to detect a difference if the intervention was less effective than expected and considering the minimal levels of clinical efficacy for such an intervention to be practical. This sample size also allowed for a 10% non-response and/or loss to follow-up rate and accounted for a clustering effect (ICC=0.20) on the clinic level. A relatively high level of clustering was assumed in the sample size calculations to not underestimated the needed sample size. Region/county level was not included in the multilevel model due to the low number of included regions/counties per country (Kenya

3, Guinea 2, Somalia 3) and since it would not allow for an accurate estimate of the variance between clusters.

Data were analyzed using STATA 17 software following a per-protocol approach. Data from ANC providers and their clients were analyzed if the clinic had at least one provider with follow up data at all study time points, and in the intervention arm, if the ANC provider present had undergone training on PCC for FGM prevention at month three. Clinics where providers were lost to follow-up were not included in the final analyses. All facility checklists and ANC client exit interviews were conducted as intended except at sites not accessible due to security issues or closed or converted for care of COVID-19 patients during the pandemic.

The study was designed to pre-screen providers and include in the analytic sample only those who would be available at 3 and 6 months at the clinic. Therefore, an intention-to-treat approach was not feasible. Key characteristics of the participating facilities, providers and clients were summarized. Continuous variables are presented using mean values, and standard deviation (SD) while categorical variables were summarized as counts (N) with percentages (%).

Differences in proportions were analysed for dichotomous outcomes using Fischer's exact test. For outcomes measured as summary scores, comparisons of mean scores are presented across study arms using t-tests.

Initial analyses showed that the clustering was negligible, probably due to having many small-sized clusters with only 10 patients per ANC clinic. To avoid convergence issues in the statistical analyses, we chose to not use multilevel mixed-effect modelling in the final analyses but ordinary regression models. Estimates were compared to the corresponding estimates from multilevel regression models and were found to be almost equal. To compare intervention and

control arms, logistic regression models were fitted. Linearity was assessed for the continuous covariates included in the regression models.

At month six, a comparison of study outcomes between the intervention and control arms was used to determine the combined effect of both levels of the intervention package. The multiple variable logistic regression analyses for ANC provider outcomes were adjusted for their sex, years of service, FGM status, FGM-related training, any specific training on communication/counseling and PCC, and whether the provider had conducted FGM in the past. Analyses related to ANC client outcomes were adjusted for their age, educational level, FGM status and exposure to level one IEC materials. These variables were determined a priori based on previously published literature. Unadjusted analyses are presented for outcomes that relate to composite measures based on ANC provider and client responses.

In-country data managers monitored data quality. Periodic data audits were conducted by the WHO/HRP Quantitative Assessment and Data Management team to identify any data collection gaps and data discrepancies requiring follow up by in-country teams. Weekly data monitoring meetings were held between the in-country research teams and WHO/HRP staff during data collection periods to identify, document and resolve any data discrepancies. These were virtual due to the COVID-19 pandemic. Given that there was no prospective follow-up of clients, a Data Safety and Monitoring Board was not established. Instead, local research teams documented and reported any unintended harms and/or protocol deviations to the WHO/HRP study coordination team.

#### Patient and public involvement statement

Health care providers and members of communities where the practice of FGM is prevalent in the study countries were actively involved in the design and implementation of this

study intervention. This included through formative research conducted in Guinea, during which interviews and focus group discussions were conducted with ANC clients, male community members, health workers, health systems managers and other key stakeholders. Health workers are considered integral members of FGM practicing communities who understand local community beliefs and norms with the potential to be change agents. The formative research also found that health workers can be supported by incorporating FGM content within their pre- and in-service trainings, ensuring accountability to legal and policy standards and recognition and promotion of FGM abandonment within the health sector as part of a multi-sectoral approach. These findings informed the development of the PCC training, which was subsequently pilot tested among ANC providers in Kenya before being rolled out as part of the multi-country study.

In Kenya, community health volunteers in the study counties talked about the study during their community sensitization sessions and invited pregnant women to attend routine ANC sessions where they could be approached for participation in the study. Prior to providing informed consent, health workers and pregnant women received information about the study, including the time commitment, any risks involved in their participation, and the voluntary nature of their participation.

Study dissemination meetings were conducted in Kenya and Guinea with the MoH and other stakeholders including representatives of health care providers and community members where the study was implemented. In these meetings, the in-country research partners have led the development of policy briefs identifying country-specific results relevant for local research needs, policy development and practice.

#### Role of the funders

Apart from WHO/HRP, the study funders had no role in study design or implementation. WHO/HRP, in collaboration with in-country research teams, developed the study protocol, provided data management and analytic support, and contributed to interpretation and manuscript writing. An author reflexity checklist has been included (Annex 1). This trial was registered: PACTR201906696419769 (June 3, 2019).

#### **RESULTS**

#### Recruitment and retention

Between August 2020 and September 2021, a total of 180 ANC clinics (i.e., 60 clinics per study country) were enrolled and randomized to intervention and control arms. There was some natural staggering of the start and subsequent data collection dates due to factors such as weather, COVID-19, Ramadan, and national elections. Data collection periods ranged from three to six weeks in each country at each time point. The time elapsed between the end of one data collection period to the beginning of the next data collection period ranged from three to five months.

In the intervention arm, 230 providers and 900 clients (i.e.., 10 per clinic) were interviewed. Based on a review of clinic rotation schedule to ensure participation of at least one provider from each study clinic throughout the trial, 133 providers were enrolled in the trial. In the control arm, 240 providers and 900 clients were interviewed. (*Figure 2*). At month three, data were collected at 98% (n=88) of the intervention clinics as two clinics in Kenya were inaccessible due to insecurity. One hundred and thirty (98%) ANC providers (at least one from each site) and 880 first visit ANC clients completed the month three questionnaires prior to implementing the Level 2 PCC intervention. No data collection was conducted at the control sites. At month six, 91% (n=163) of ANC clinics (81, intervention and 82, control) had at least

#### Characteristics of study sites and participants

The 163 ANC clinics with complete follow-up date at the end of the study had a mean of four ANC providers (standard deviation, SD: 3) and served on average 155 new ANC clients per month (SD: 127) with a mean catchment population of 36,754 people (SD: 126,082). In 55% (n=89) of clinics, the clinic manager reported that there were no activities promoting FGM prevention in the facilities' catchment area (*Table 1*). These characteristics were not different from the 17 ANC clinics that were enrolled at baseline but that subsequently were lost to follow-up.

Of the 232 ANC providers who contributed data for analysis at month six, 83% (n=193) were female and their mean age was 36 years (SD: 10 years). They had an average of eight years professional experience (SD: 7 years) and 68% (n=158) had studied up to Diploma level (generally 3 years post-secondary education) with 90% (n=208) identifying as either midwives, nurses, or nurse-midwives. Health cadres were defined by national licensing requirements in each country. Among these providers, at baseline, 63% (n=146) reported that they had not previously received formal clinical training on FGM prevention and care (*Table 1*). Almost two-thirds (64%, n=14) reported that they had received training on communication/counselling while half (51%, n=118) had received training on person-centered care. Further, 54% (n=126) of female providers reported that they had undergone FGM while overall, 94% (n=217) of providers reported that they had never performed FGM. These characteristics were not different when compared to the ANC providers who were on duty in the 180 ANC clinics enrolled at

baseline. The mean age of the 1,800 clients exiting their first ANC visits at baseline was 26 years (SD: 6 years), 47% (n=846) reported not having received any education, and 73% (n=1,320) reported that they had undergone FGM. These characteristics were similar to the 880 and 1,630 first visit ANC clients interviewed at month three (intervention arm only) and month six, respectively (*Table 2*).

To evaluate potential bias from differential selection of providers receiving the intervention, we assessed differences in baseline characteristics between the 133 ANC providers from intervention facilities who were screened at baseline and received PCC training at month three (i.e., included in the analysis sample) versus the 97 who were screened and did not receive the intervention (i.e., excluded from analysis sample). These groups were similar in terms of sex, educational level, professional cadre, as well as whether they had undergone or recently performed FGM, however, included providers tended to be slightly younger (by two years on average) and less likely to be of Muslim religion, although the question on religion was not administered for the Somalia sample (all were assumed to be Muslim).

#### Health facility preparedness

At month six, ANC clinics in the intervention arm had a significantly higher mean score for health facility preparedness compared to the control arm (3.4 (95% CI: 3.2-3.6) vs. 2.6 (95% CI: 2.4-2.9; p<0.001)).

#### **Utilization of level one intervention components**

A higher proportion of ANC providers in the intervention arm reported having utilized the level one intervention package components compared to those in the control arm (91% vs. 56%, p<0.001). In multiple variable analyses, ANC providers in the intervention arm had nine

times the odds of having utilized the level one intervention package components as compared to those in the control arm (AOR: 9.3, 95% CI: 4.2-20.8; P<0.001).

#### **Delivery of FGM care and ABCD components**

At month six, based on a cumulative score to specific questions on correct prevention and care service provision, including on the ABCD elements, a higher proportion of ANC providers in the intervention arm provided FGM prevention and care services correctly as compared to those in the control arm (50% vs. 34%, p=0.03). Additionally, a higher proportion of ANC providers in the intervention arm asked their clients if they had undergone FGM (78% vs. 31%, p<0.001), asked their clients' personal beliefs regarding FGM (76% vs. 27%, p<0.001) and discussed with their clients why (77% vs. 30%, p<0.001) and how (73% vs. 29%, p<0.001) FGM could be prevented. Furthermore, a higher proportion of ANC clients in the intervention compared to the control arms reported that they were satisfied with how FGM-related prevention and care services had been addressed during the visit (84% vs. 44%, p<0.001).

#### ANC providers' confidence, self-efficacy, and communication skills

A higher proportion of ANC providers in the intervention arm reported being confident in their knowledge to provide FGM prevention and care services compared to those in the control arm (98% vs. 89%, p=0.005). In multiple variable analysis, ANC providers in the intervention arm had more than six times the odds of reporting being confident in their knowledge to provide FGM prevention and care services compared to those in the control arm (AOR: 6.3, 95% CI: 1.4-28.9; p=0.02). Self-efficacy was generally high (scores 7.4 – 7.8 out of 8) with no significant difference in high scores between study arms (85% vs. 82%, p=0.36 and OR: 0.8, 95% CI: 0.4-1.6); p= 0.50).

#### ANC providers' knowledge and attitudes

The mean scores for FGM-related knowledge were higher among ANC providers in the intervention arm compared to the control arm (2.5, 95% CI: 2.2-2.8 vs. 1.9, 95% CI: 1.7-2.2; p=0.005). Overall scores were generally low, ranging from 1.6 to 2.5 out of 6. Providers had similarly unsupportive attitudes towards FGM in both groups (73% vs. 72%, p=0.54). and similar levels of support for FGM and/or medicalized FGM with most providers reporting that they did not support FGM and/or medicalized FGM at any time point (96% - 99%).

#### ANC clients' support for FGM

Compared to those in the control arm, a higher proportion of ANC clients in the intervention arm reported being less supportive of FGM after their month six clinic visit (52% vs. 29%, p<0.001). In multiple variable analysis, ANC clients in the intervention arm had nearly twice the odds of reporting being strongly opposed to FGM (AOR: 1.7, 95% CI: 1.4-2.1; p<0.001). When asked about their support for FGM after the ANC visit compared to before, clients in the intervention arm had more than twice the odds of being less supportive of FGM compared to those in the control arm (OR: 2.4, 95% CI: 2.0-3.0; p<0.001). ANC clients in the intervention clinics had lower odds of intending to have their daughters undergo FGM (OR: 0.4, 95% CI: 0.3-0.5; p<0.001) or of wanting a health care provider to perform FGM (OR: 0.4, 95% CI: 0.3-0.5; p<0.001) and higher odds of reporting that they wished to be active in FGM prevention (OR: 2.2, 95% CI: 1.8-2.9, p<0.001).

#### **DISCUSSION**

The results of this cluster randomized trial show that an intervention to strengthen health facility preparedness while building skills of ANC providers to communicate using a personcentred counselling technique on FGM prevention was effective. ANC providers exposed to the intervention had increased confidence in their communication, improved FGM-related

knowledge, and effective delivery of FGM prevention and care services. Additionally, ANC clients who had received care from these providers were less supportive of FGM and had reduced intentions to perform FGM on their daughters. This study provides evidence of a practical intervention to engage health care providers in FGM abandonment efforts whilst also providing quality care to FGM survivors. This study provides evidence of how to effectively build the capacity of health care providers at primary care to address FGM (25), an area identified as a critical gap during the formative research.

The PCC training modules not only strengthened ANC providers' knowledge and skills on FGM prevention and care but also addressed their beliefs and attitudes, which are key drivers of FGM (26). We did not find notable changes in knowledge and attitudes among ANC providers. Exposure to the intervention package also did not improve ANC providers' self-efficacy towards FGM prevention and care. This may be related to the lack of support for FGM and/or its medicalization and high self-efficacy among nearly all providers at baseline in both study arms, a finding that was also noted in formative research conducted in Guinea (27,28). In the formative phase, while the vast majority of health workers were opposed to the practice, 38% also felt that FGM limited promiscuity and 7% believed that it was a good practice, showing ambivalence and complexity in attitudes about FGM among health providers. Other studies have found that some providers support the perpetuation of the practice and even planned to have their own daughters undergo FGM or to perform it on their clients (29).

The findings in this study underscore the importance of addressing values and attitudes of both providers and clients as a means of achieving positive behavioral change. Changes observed among ANC providers were sustained across the study duration and ultimately, and importantly, resulted in reported changes in attitudes and intentions of their clients. However, this study

design did not allow us to determine whether the attitudinal changes observed among ANC clients were sustained after their clinic visit or translated into positive change in FGM prevention.

The application of these study results into programming will need to consider several factors. Firstly, the study sites were primary care facilities located in high FGM prevalence settings. The results of this intervention may not be generalizable to settings where FGM is less prevalent or to settings other than primary care. Secondly, first ANC visits are not typical of other health visits since the consultation is generally longer with a greater focus on health promotion messaging. While this is an ideal setting for implementing such an intervention, its application to other health settings and among other population groups is not known. During scale up, if the PCC approach is applied among clients seeking other sexual and reproductive health services or parents bringing their children to child immunization and wellness visits, it will be important to consider time requirements for the delivery of the 'ABCD' steps, especially in high volume clinic settings.

Thirdly, while the study found a positive impact of the PCC training on health care providers' delivery of person-centred FGM prevention counselling, the continuity and quality of FGM prevention counselling in the long-term is not known. Specifically, it will be important to assess subsequently whether providers will continue to provide prevention counselling on an ongoing basis, whether they will share their learnings with family and community members and whether clients will follow through with their intentions to not have their daughters undergo FGM. It may be important to include a supervisory mentorship component to ensure implementation of this intervention (30) in order to strengthen PCC communication practice and quality.

The implementation of this multi-country study was not without challenges and limitations. First, initiation of field data collection activities was delayed by the global COVID-19 pandemic and required some modification to trainings of the data collection teams, the master trainers and the ANC providers receiving the PCC intervention. This may have impacted the overall effectiveness of the intervention.

Second, to attempt to ensure participation of at least one provider at each site, all providers were pre-screened at baseline and clinic rotation schedules determined enrollment into the study. Selection bias might have been introduced through this process. The exploratory analysis to assess for selection and attrition bias from the pre-screen step and per protocol analysis was limited, and it is possible that differences in other unmeasured factors related to the clinics and providers might have biased the results. Findings from a process evaluation conducted as part of this study will provide additional insights on the feasibility, acceptability, appropriateness, and fidelity of the intervention implementation in these contextual settings to inform further implementation and scale up.

Third, we did not perform adjustment for multiple testing in our analysis given that the different tests are interpreted and presented separately, therefore the overall type one error rate could be higher than the individual test level of 0.05.

Finally, we acknowledge that there are many factors that could impact FGM-related decision-making: a positive and impactful interaction with a respected health care provider might not be sufficient to lead to actual changes in individual behavior and community norms.

However, the study design enabled us to compare similar sites to identify the relative effect of

this new approach since both intervention and control sites would be exposed to similar factors, and clients at these sites would face similar complexities in decision-making.

#### Conclusion

In conclusion, this study highlights the importance of addressing the values and beliefs of health care providers working at primary care level, who are subject to social norms around FGM that may conflict with medical ethics and national laws and policies as an intermediary step in preventing FGM. Empowering these health care providers with communication skills and engaging them as opinion leaders can be impactful in changing their clients' attitudes towards FGM. In conjunction with FGM prevention activities in other sectors, this intervention can contribute to positive change if brought to scale.

#### **DECLARATIONS**

#### **Contributors**

WA and CP conceptualized the study and prepared the protocol in collaboration with VM, KS, PN, TE, MDB, AMS, AD and MAA. MDB, AMS, AOS, PN, TE, JMK, AD and MAA provided oversight over study implementation while AD, JK and SA monitored data quality in countries and KN and SST monitored data quality across countries. VM prepared the first draft of the manuscript with input from WA and CP, the responsible officer of the study at WHO/HRP. MP developed the statistical analysis plan and conducted data analysis. KS coordinated the development of the PCC for FGM prevention training. KS, PN, TE, JMK, JK, MDB, AMS, AOS, AD, AD, SA, and MAA contributed to and reviewed the manuscript for proper intellectual content. All authors read and approved the final draft of this manuscript.

#### **Declaration of interests**

The authors declare that they have no competing interests.

#### **Data sharing**

De-identified dataset 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. Request for data dictionary and for dataset may be sent to <a href="mailto:pallittoc@who.int">pallittoc@who.int</a>

#### Acknowledgements

The authors would like to acknowledge the funders, the WHO country office colleagues, Dr Bernadette Dramou, Dr Cécé-Vieux Kolie, Dr Joyce Lavussa, Ms Matilda Cherono, Ms Asia Ahmed Osman in the study countries as well as MoH and national FGM stakeholders in the development of the research protocol, implementation of study interventions and field data collection. We also thank Professor Joanna Schellenberg of the London School of Hygiene and Tropical Medicine and Dr Christina Atchison of Imperial College London for their input in

conceptualizing the study as well as Dr Leyla Hussein for supporting pilot testing of the PCC intervention. This work received funding from the Governments of Norway and the United Kingdom of Great Britain and Northern Ireland as well as the UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), a cosponsored programme executed by the World Health Organization (WHO).

#### **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).

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**Table 1:** Characteristics of ANC clinics and providers included in month six analyses

	В	MJ Open	136/bmjopen-2023-078771 on 4
Table 1: Characteristics of ANC	clinics and providers included	in month six analyses	07877 <sup>,</sup> ncludi
ANC Clinics			l on 4
Characteristics	Overall	Intervention	Control se mu
	(n=163*)	(n=82)	Control es misses religion (n=81) religion (n=81) control es religion (n=81
Number of ANC providers	Mean 4 (SD: 3) Median 3 (1-14, IQR 3)	Mean 4 (SD: 2) Median 3 (1-11, IQR 3)	Mean 4 (\$12.59) Median 3 (1-14, IQE 25)
Average number of ANC clients/month	Mean 150 (SD: 127) Median 118 (3-664, IQR 141)	Mean 148 (SD: 121) Median 117 (3-500, IQR 143)	Mean 152 (5 2): 133) Median 12 (6 3)-664, IQR 140)
MoH supervisory visits in the past year	Mean 4 (SD: 3) Median 3 (0-18, IQR 2)	Mean 4 (SD: 3) Median 4 (1-18, IQR 1)	Mean 4 (
Size of catchment population served	Mean 36,754 (SD: 126,082) Median 15,972 (1,000-1,458,000, IQR 24,332)	Mean 23,649 (SD: 35,873) Median 16,022 (1,000- 290,000, IQR 22,361	Mean 50, 220 SD: 174,739) Median 15,551 (1,000-1, 358, 900, IQR 25,544
Presence of anti-FGM activities	in the catchment area		nd si
Yes	74 (45%)	43 (52%)	31 (38%) a June 50 (62%) & 0
No	89 (55%)	39 (48%)	30 (02%)6 -
Presence of pro-FGM activities	in the catchment area		ŌΝ
Yes	21 (13%)	12 (15%)	
No	140 (86%)	68 (83%)	72 (89%) g
Don't Know	2 (1%)	2 (2%)	9 (11%) es. at A A A A A A A A A A A A A A A A A A
ANC Providers			bliog
	Overall	Intervention	Control है

	(n=232)			
Characteristics	(n=232)	(n= 115)	$(n=117)$ $\frac{3}{5}$ $\frac{8}{5}$	
Age	Mean 36 (SD: 10) Median 34 (20-65, IQR 15)	Mean 35 (SD: 10) Median 33 (20-59, IQR 14)	Mean 37 (SD) 1) Median 35 (20-65) 103 16)	
Years of professional experience	Mean 8 (SD: 7) Median 6 (1-39, IQR 7)	Mean 8 (SD:7) Median 6 (1-30, IQR 8)	Mean 8 (Supplement Superieur (AB) 98 (84%) to text and data n	
Sex			2024 rela	
Female	193 (83%)	95 (83%)	98 (84%) to the second	
	U/-		vnloa nt Su o text	
Highest educational level			ided :	
Certificate	21 (5%)	12 (10%)	9 (8%) data	
Diploma	158 (68%)	72 (63%)	86 (74%) nin	
Bachelors	44 (19%)	27 (24%)		
Masters & above	1 (0.4%)	0 (0%)	17 (15%)g. bmjopen.bmjopen.bmj.com/	
Other#	8 (3%)	4 (3%)	4 (3%) gining	
Current professional role/title		1/1/	, and	
Midwife	103 (44%)	53 (46%)		
Nurse	51 (22%)	25 (22%)	50 (43%) si on June 26 (22%) ar te che 27 (23%) no June 13, 2025	
Nurse-Midwife	54 (23%)	27 (24%)	27 (23%) $\frac{3}{5}$ $\frac{3}{5}$	
Other	24 (10%)	10 (9%)	14 (12%) 025	
Received formal training on FGM	during clinical training		at Ag	
Yes	85 (37%)	44 (38%)	41 (35%) en ce	
No	146 (63%)	71 (62%)		
Don't Know	1 (0.4%)	0 (0%)	75 (64%) Bi bii 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	

		BMJ Open	136/bm jopen-2023-078771 on 4  15 (13%) for 23 (20%) for 23 (20%)
Timing of clinical training on Fo	GM		123-0
Pre-service	33 (14%)	18 (16%)	15 (13%) <u>di</u> 87
In-service	45 (19%)	22 (19%)	23 (20%) 💆 9
Both pre- and in-service	7 (3%)	4 (4%)	3 (3%)
Received formal training on con	nmunication/counselling		y 202 nseig
Yes	149 (64%)	76 (66%)	73 (62%) ed = 0
No	83 (36%)	39 (34%)	44 (38%) to the town in
Received formal training on per	son-centered care		4 July 2024. Downloaded from http:// Tanseignement Superieur (ABES)  60 (51%) data minin  57 (49%) minin  0 (0%)
Yes	118 (51%)	58 (50%)	60 (51%) a from
No	113 (56%)	56 (49%)	57 (49%) 3 B 3
Don't know	1 (0.4%)	1 (1%)	0 (0%) ining.
<u>Undergone</u> FGM		<b>C</b> 1	Al tr
Yes	126 (54%)	65 (57%)	61 (52%)
No	63 (27%)	27 (24%)	36 (31%) a 8
Don't know	2 (1%)	2 (2%)	0 (0%)
Refused to answer	2 (1%)	1 (1%)	1 (1%) ilar Ju
Conducted FGM			0 (0%) ng, 2 mj ppen.bmj.com/ on June 13, 0 (0%) 1 (1%) 1 (1%)
Yes	15 (7%)	9 (8%)	6 (5%) olo 202
			g, Al training, and similar technologies.  6 (5%)  6 (5%)  6 (5%)
Conducted FGM on a girl <18 y	ears	'	\gen
Yes	14 (6%)	8 (7%)	6 (5%) <b>8</b>

<sup>\*</sup> Total of 17 ANC clinics not included: 16 clinics were excluded (7 intervention and 9 control) due to loss-to-follow up (LTFU) of ANC provider i.e., the clinics did not have at least one ANC provider present across all study time points where one ANC clinic in

Kenya was never visited at subsequent time points due to issues with insecurity. An ANC provider from the clinics in Kenya that had been inaccessible due to insecurity attended the PCC training and was subsequently interviewed.

Table 2: Characteristics of ANC clients interviewed at each time point

Characteristic s	ANC clients interviewed at Baseline			ANC clients interviewed at Month 3	ANC clients interviewed at Monga 22		
	Overall (n=1800)	Intervention (n=900)	Control (n=900)	Intervention only (n=880)	Overalle to upper (n=175%)	Intervention (n=879)	Control (n=880)
Age	Mean 26 (SD: 6) Median 25 (15-45, IQR 10)	Mean 25 (SD: 6) Median 25 (15-45, IQR 10)	Mean 26 (SD: 6) Median 25 (15-45, IQR 10)	Mean 26 (SD 6) Median 25 (15-45, IQR 10)	Mean 26 (15):	Mean 26 (SD: 6) Median 25 (15-45, IQR 9)	Mean 26 (SD: 6) Median 25 (15-45, IQR 10)
Highest education	onal level		(6)	1	Al t		
None	840 (47%)	407 (45%)	433 (48%)	439 (50%)	806 (46 🙀) 🖁	384 (44%)	422 (47%)
Primary	484 (27%)	231 (26%)	253 (28%)	239 (27%)	553 (31%)	278 (32%)	275 (31%)
Secondary	331 (18%)	171 (19%)	160 (18%)	157 (18%)	306 (17%)	160 (18%)	146 (16%)
University	95 (5%)	61 (7%)	34 (4%)	25 (3%)	67 (4%) ar	34 (4%)	33 (4%)
Other#	50 (3%)	30 (3%)	20 (25)	20 (2%)	67 (4%) an June 37 (2%) ch 13	23 (3%)	14 (2%)
Have you underg	gone FGM?				37 (2%)g ne 13, 2025 1321 (75%)e		
Yes	1320 (73%)	677 (75%)	643 (71%)	645 (73%)	1321 (7%)	655 (75%)	666 (75%)
No	452 (25%)	209 (23%)	243 (27%)	224 (25%)	420 (24%) gg	206 (23%)	214 (24%)
Don't know	12 (1%)	10 (1%)	2 (0.2%)	5 (1%)	21 (1%)	13 (2%)	8 (1%)
Refused to answer	16 (1%)	4 (0.4%)	12 (1%)	6 (1%)	21 (1%) 8 Bibliographic	5 (1%)	2 (0.2%)

 Table 3: Results of study outcomes

	Month 6	P-	Adjusted	P-
	(Intervention vs control)	value	OR* (95% CI)	value
ANC facility preparedness				
(Intervention n=82, Control n=81)				
Clinics with ALL correct answers for facility preparedness	56 (69%) vs. 22 (27%)	<0.001		
Facility preparedness mean score (0 – 4)	3.4 (3.2-3.6) vs. 2.6 (2.4-2.9)	<0.001		
ANC provider outcomes**				
(Intervention n=115, Control n=117)				
Using level 1 intervention package	96 (91%) vs. 65 (56%)	<0.001	9.3 (4.2- 20.8)	<0.001
Providing appropriate FGM-related prevention and care services	52 (50%) vs. 40 (34%)	0.03		
With correct FGM-related knowledge responses	8 (8%) vs. 1 (2%)	0.09		
ANC providers mean knowledge score (0 – 6)	2.5 (2.2-2.8) vs. 1.9 (1.7-2.2)	0.005		
With appropriate interpersonal communication skills	74 (70%) vs. 68 (58%)	0.04	1.7 (1.0- 3.0)	0.06
ANC provider communication skills mean score (0 – 5)	4.7 (4.5-4.8) vs. 4.4 (4.2-4.5)	0.003		
With high self-efficacy	86 (82%) vs. 99 (85%)	0.36	0.8 (0.4- 1.6)	0.50
ANC providers self-efficacy mean score $(0-8)$	7.6 (7.3-7.8) vs. 7.6 (7.4-7.8)	0.94		
Reporting less supportive attitudes towards FGM	76 (72%) vs. 85 (73%)	0.54	1.0 (0.5- 1.8)	0.90
ANC provider FGM attitude mean score (0 – 8) *	7.6 (7.5-7.8) vs. 7.5 (7.4-7.7)	0.57		
With high confidence scores	103 (98%) vs. 104 (89%)	0.005	6.3 (1.4- 28.9)	0.02
Not supportive of FGM	100 (96%) vs. 114	0.44	0.8 (0.2-	0.73

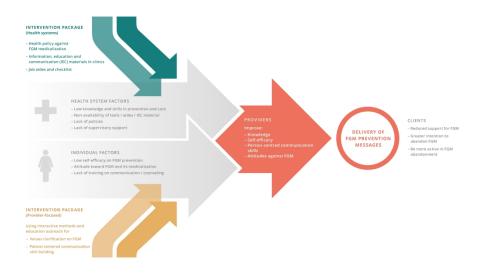
BMJ Open: first published as 10.1136/bmjopen-2023-078771 on 4 July 2024. Downloaded from http://bmjopen.bmj.com/ on June 13, 2025 at Agence Bibliographique de I Enseignement Superieur (ABES) . Protected by copyright, including for uses related to text and data mining, Al training, and similar technologies.

	(97%)		3.7)	
Not supportive of medicalized FGM	104 (99%) vs. 116 (99%)	0.72	1.1 (0.1- 22.1)	0.94
ANC provider implementation of PCC for FGM p	revention approach (	as report	ed by client	ts)
(Intervention n=819, Control n=810)				
Provider asked client if they have undergone FGM	694 (78%) vs. 245 (31%)	<0.001		
Provider asked client about their (client's) personal beliefs regarding FGM	616 (76%) vs. 217 (27%)	<0.001		
Provider discussed with client why FGM should be prevented	629 (77%) vs. 244 (30%)	<0.001		
Provider discussed with client how FGM could be prevented	592 (73%) vs. 232 (29%)	<0.001		
Client satisfied with how FGM was addressed by provider during clinic visit	684 (84%) vs. 384 (44%)	<0.001		
Mean score of PCC approach (0 – 5)	3.9 (3.8-4.0) vs. 1.6 (1.5-1.8)	<0.001		
Mean score of PCC + appropriate FGM prevention & care (0 – 8)	6.2 (5.9-6.6) vs. 3.7 (3.2-4.1)	<0.001		
ANC client outcomes***				
(Intervention n=819, Control n=810)				
Clients reporting less support for FGM after ANC clinic visit	424 (52%) vs. 237 (29%)	<0.001	2.4 (2.0- 3.0)	<0.001
Clients reporting that they were strongly opposed to FGM	498 (61%) vs. 382 (47%)	<0.001	1.7 (1.4- 2.1)	<0.001
Clients reporting that they intend to have their daughters cut	96 (12%) vs. 209 (26%)	<0.001	0.4 (0.3- 0.5)	<0.001
Clients reporting that they would prefer health care provider to cut daughters	53 (7%) vs. 139 (17%)	<0.01	0.4 (0.3- 0.5)	<0.001
Clients wishing to be active in FGM prevention	677 (83%) vs. 535 (66%)	<0.01	2.2 (1.8- 2.9)	<0.001
	ı	1	<u> </u>	

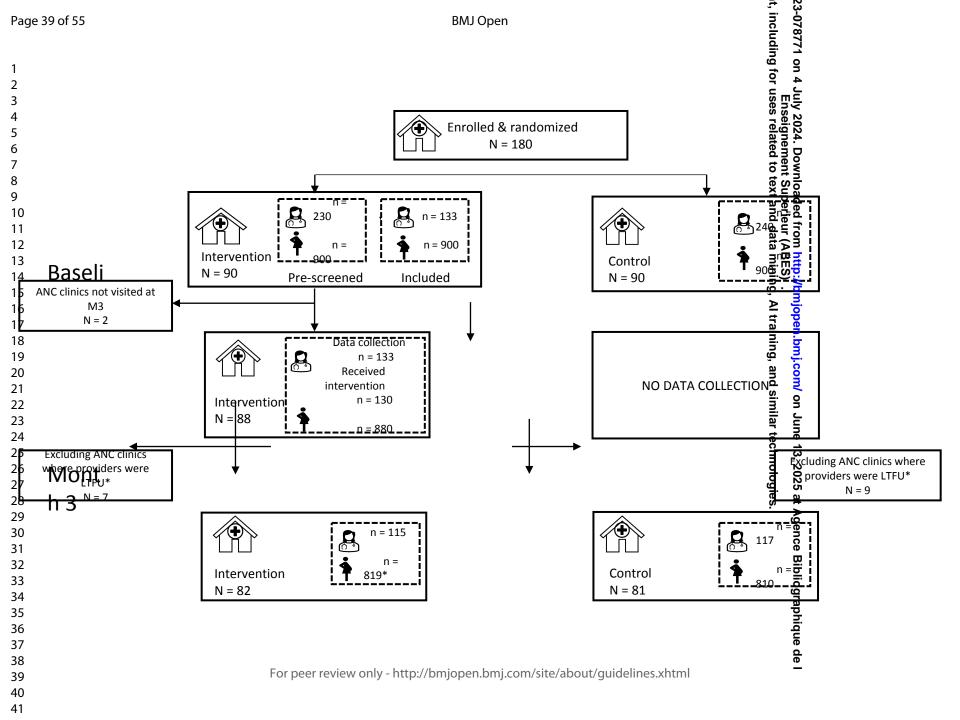
- \*Higher score indicates less supportive attitude
- \*\* Adjusted for sex, years of service, FGM status, FGM-related training, any specific training on communication/counseling and PCC, and whether the provider had conducted FGM in the past
- \*\*\* Adjusted for age, educational level, FGM status and exposure to level one IEC materials



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#### BMJ Open

A Health Systems Approach to Prevention of Female Genital Mutilation using

A Health Systems Approach to Prevention of Female Genital Mutilation using
Person-Centered Communication: A Multi-Country Implementation Research Project

**Health Facility Checklist (CHK)** 

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СНК	

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n incutation	VIII (2034)2020)	
Region/		7
4 Project ID County ID Facility ID	Study period:	
5 A 6 5 9 9 3	0 = Baseline, 2 = Six Months	
5		╛
SECTION A - FACILITY FUNCTIONALITY		
The following questions should be directed to	8a) If <i>Yes</i> , specify:	
10 the health facility manager.		
I am going to ask you a few questions about this		
12 health facility		
1. Number of ANC providers:		
15	SECTION C - FACILITY OBSERVATION	
16 2. Average number of ANC clients per month:	Check around the facility for the following:	
17		
3. Number of ANC providers who received	9. Is there an MoH policy on FGM posted	.   .
training as part of the study	on the wall?  1 = Yes  2 = No	
21 1 = All	1 = Yes	-
22 2 = Some	11 = '''	
23 3 = None ( <i>Skip to Q8</i> )	9a) If <b>Yes</b> , is it placed where health care	-
25	9a) If <b>Yes</b> , is it placed where health care providers can see/read it e.g. bulletin board?	-
3a) If <i>All</i> or <i>Some</i> , specify number trained		
27	or	
28 4. Number of MoH supervisory visits to the	10. Are there WHO FGM prevention posters on the	Ens
clinic in the past 12 months:	wall of the consultation and/or waiting room?	£.
31	1 = Yes 2 = No	<b>B</b>
32 5. How frequently are staff meetings held?	10a) If <b>Yes</b> , are they placed in a place where	Ē
33 1 = Monthly 4 - More than 12 months	ANC clients can see them?	Enseignement Superie
2 = Every 2 to 4 months 5 = Never	1 = Yes 2 = No	ber
3 = Every 6 to 12 months	1	<u>.</u> Ē
37	11. Is there a WHO FGM Clinical Handbook in the	Þ
38 6. What is the size of the population	ANC consultation room?	ur (ABES
39 served by this facility? ( <i>specify number</i> ) 40	1 = Yes 2 = No 11a) If <b>Yes</b> , is it placed where ANC providers	
SECTION B - FACILITY CONTEXT	son son it /use it?	<u>•</u>   •
12 13 I am going to ask you about anti or pro FGM activities	1 = Yes 2 = No	
43 in the area served by this health facility		
45 7. Are there anti-FGM activities that target the	12. Is there an FGM ABCD guide in the	<u>.</u>   '
population served by this health facility?	ANC association reserved	
<sup>47</sup> 1 = Yes	1 = Yes 2 = No	
18 2 - No	12a) If <b>Yes</b> , is it placed where ANC providers	
49	can see it/use it?	
51	1 = Yes 2 = No	<u>:</u>   -
7a) If <b>Yes</b> , specify:	1 = Yes 2 = No  12a) If <b>Yes</b> , is it placed where ANC providers can see it/use it?  1 = Yes 2 = No	
53 ————————————————————————————————————	COMMENTS	1
55		
56		
8. Are there pro-FGM activities that target the	Data Collector name: Signature:	7
population served by this health facility?		
59 50 1 = Yes		
2 = No	Day Month Year	
3 = I don't know		
For peer review only - http://hmioner	hbmi.com/site/about/guidelines.xhtml	
To peer review only inteparability	.bmj.com/site/about/guidelines.xhtml Time questionnaire completed (00:00 - 23:59):	
	II hours minutes	- 1

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A Health Systems Approach to Prevention of Female Genital Mutilation using Person-Centered Communication: A Multi-Country Implementation Research Project

**ANC Provider Screening Questionnaire (SCR)** 

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2 3	Region/		
4	Project ID County ID Facility ID	Provider ID	
5	A 6 5 9 9 3	-	
SE	CTION A - SOCIO-DEMOGRAPHIC INFORMATION	9. Continued	┨.
, 8	I am going to ask you a few questions about yourself	1 = Yes 3 = I don't know	
9	1. How old are you (years)? ('99' if unknown)	2 = No	
10		9c) Digital format (E-learning videos;	1   .
11	2. What is your sex? ( <b>Observe and document</b> )	smart phone app)	1
12 13	1 = Female		
14	2 = Male	9d) During clinical practice under supervision	] _
15	For Somali study site, skip to Q4	of a mentor	g
16	3. What is your religion?		Protected by
17 18	0 = None	9e) Other	] ed
10 19	1 = Muslim	9es) If <b>Other</b> , specify:	
20	2 = Christian		copyright,
21	3 = Other	10. During your pre- or post- graduate training,	rig
22	4 = Refused to answer	did you receive any formal training on	
23 24	3a) If <b>Other</b> , specify:	communication or counselling?	ncl
25		1 = Yes 3 = I don't know	including
26	4. What is the highest education level you achieved?	2 = No	og f
27	1 = Certificate		for u
28	2 = Diploma	11. During you pre or post graduate training,	Eńs uses
29 30	3 = Bachelors	did you receive any formal training on	s reig
31	4 = Masters or above	person-centered care?	ner ate
32	5 = Other	1 = Yes 3 = I don't know	Enseignement ses related to
33	4a) If <i>Other</i> , specify:	2 = No	te)
34 35		SECTION C - FGM HISTORY	Superieur (ABES text and data mini
36	5. What is your current professional title?	Now, I will ask you a few personal questions about FGM	ieu Hair
37	1 = Midwife 3 = Nurse - Midwife	If Male provider, Skip to Q13	r (A lata
38	2 = Nurse 4 = Other	12. Many women in your community have had their	J B.B.
39	5a) If <i>Other</i> , specify:	genitals cut when they were children. If you are	ning,
40 41		comfortable telling me, can I ask if you have	, A
42	6. For how many years have you been working	undergone this practice?	tra .
43	in your current professional title?('99' if unknown)	1 = Yes 3 = I don't know	Al training,
	CTION B - TRAINING	2 = No 4 = Refused to answer	9, 2
45 46	Now, I am going to ask you a few questions about		and
47	specific trainings you may have received	13. Have you ever cut the genitals of a girl	] <u>si</u>
48	7. During your clinical training, did you receive any	or a woman for non-health reasons?	similar
49	formal training on female genital mutilation?	1 = Yes 3 = Refused to answer	tec
50 51	1 = Yes 3 = I don't know ( <i>Skip to Q10</i> )	2 = No	technologies
52	2 = No ( <i>Skip to Q10</i> )	13a) If <b>Yes</b> , have you ever cut a girl <18 years?	] <u>ö</u> [
53	<u> </u>	1 = Yes 3 = Refused to answer	jies
	8. When did you receive this training?	2 = No	<u>.</u>
55 56	1 = During my studies (pre-service training)	COMMENTS	
56 57	2 = After graduation/at work (in-service training)		-
58	3 = Both options 1 and 2	<del> </del>	
59		Data Collector name: Signature:	'
60	9. What was the format of this training?		,   '
	1 = Yes 3 = I don't know	Date: Day Month Year	┧ ╽.
	2 = No		]
	9a) Classroom lessons For peer review only - http://bmjaper	.bmj.com/site/about/guidelines.xhtml	,
	9b) Workshops	Time questionnaire completed (00:00 - 23:59): hours minute	]
		i i i i i i i i i i i i i i i i i i i	-3



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# BMJ Open A Health Systems Approach to Prevention of Female Genital Mutilation using Person-Centered Communication: A Multi-Country Implementation Research Project

unication: A Multi-Country Implementation Research Proje
ANC Provider questionnaire (HCP)

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U .	
Region/  Region/  Project ID County ID Facility ID Provider ID Study po	eriod:
	line, 1 = Three months, 2 = Six Months
SECTION A - FGM KNOWLEDGE 8. When you treat or	rattend to a girl or a woman
/	tal mutilation, how confident are
	e enough knowledge to provide good
genital mutilation? quality health car	
11 1 - Vas 1 - Not confident	
12 1 - 183	
14 3 = Confident	_
15 2. Do the women in your community 4 = Refused to an	swer 9
undergo female genital mutilation?	ect
1 - Vos 3 - I don't know 9 How confident are	e you in your knowledge
	on FGM prevention?
20 1 = Not confident	o o o o o o o o o o o o o o o o o o o
21 3 Do you know of the WHO classification for 2 = Somewhat co	nfident 'ig
female genital mutilation?  3 = Confident	<u>₹</u>
$\frac{23}{24}$ 1 = Yes $\frac{23}{4}$ 4 = Refused to an	iswer <u>c</u>
female genital mutilation?  1 = Yes  2 = No ( <i>Skip to Q5</i> )  20  10. Would you like to	Protected by copyright, including for uses  e you in your knowledge on FGM prevention? Infident Inswer or receive more training related on and girls with FGM? 2 = No
26 10. Would you like to	o receive more training related 🦳 💆
27 4. Please provide the WHO classification for to care for wome to care for wome the following FGM images (to include images)	n and girls with FGM?
the following FGM images ( <b>to include images</b> )  1 = Yes	2 = No
30 1 = Type I 4 = Type IV	
31 2 = Type II 5 = I don't know 11. Would you like to	ာ receive more training 🔲 👸
	atients prevent FGM?
1 = Yes	o receive more training atients prevent FGM?  2 = No
4a) IMAGE of Type IV FGM to be inserted here	ar
4as) If <i>Other</i> , specify:     SECTION B - FGM ATTIT	Ω.
	wing statements please state if you $\overline{\hat{s}}$
38 4b) IMAGE of Type I FGM to be inserted here agree/disagree or do	
40s) if <b>Other</b> , specify:   1 = Agree	3 = I Don't know
41 Z = Disagree	4 = Refused to answer ≥
42 4c) IMAGE of Type II FGM to be inserted here	,
	3 = I Don't know 4 = Refused to answer  A training
44 45 46) IMAGE of Type III EGM to be inserted here.  13. A girl who has no	
46 4d IMAGE OF Type III TOWN to be inserted fiere 13. Agiri who has no	ot undergone FGM cannot
4ds) If <i>Other</i> , specify: be married within	n ner community
48	of undergone FGM is a disgrace on the community to the community of undergone FGM is a disgrace on the composition of the community to the community of the com
	ot undergone FGM is a disgrace
from female genital mutilation? $1 = Yes$ $2 = No$ to her family's ho	oniour no
52 1 - 163 2 - 100	
	iders who perform FGM are
54 6. Is female genital mutilation illegal in your country violating medical (specify actual study country)?	etilics
	iders who perform FGM
57 2 = No. Should be punish.	· ——
p8	eu
59 60 7. Are you aware of any existing WHO 17. FGM is a good pr	ractice
tools/guidance on FGM prevention and care?	
	n of women's and girls' rights
7a) If <b>Yes</b> , please specify; peer review only - http://bmjopen.bmj.com/site/about/guide	<u>-</u>
19. FGM is a religious	s mandate

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3 = Sometimes

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## A Health Systems Approach to Prevention of Female Genital Mutilation using

HCP

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ANC Provider questionnaire (HCP)			V1.1 (20Jul2020)
Durain at ID	Region/	President ID Study paried	
Project ID	Centre ID County ID Facility ID	Provider ID Study period:	O Cha Manadha
A 6 5 9 9 3	]	0 = Baseline, 1 = Three months,	2 = Six Months
SECTION C - FGM PRAC	CTICE	П	
	ask what you will do in specific	25. How often do you record female ge	nital
0 situations regardin		mutilation in the woman's medical fi	
	d a daughter now who was at	are aware that she has undergone Fo	•
2 an age when cut	tting occurs, what would your	1 = Always 4 = Ra	
intention to cut	-	2 = Often 5 = Ne	•
5 1 = Intend to cut		3 = Sometimes	
6 2 = Do not inten			Protected
<ul><li>7 3 = I don't know</li></ul>		SECTION D - CONFIDENCE	tec
8 $A = Refused to a$		SECTION D CONTIDENCE	l by
9	TISWCI	   Now I would like to ask you a few question	ns about how you
0 1 21. If a family broug	ght their daughter to the clinic		
	al cutting for non-health reasons,	solve problems that you face. Please tell nagree or disagree with the statements tha	of I read to you
would you perfo	_	ugree or disagree with the statements tha	incl
1 – Voc	All It.	1 = Strongly disagree	cluc
.5		2 = Disagree	ding
2 = No 3 = I don't know	, 0	3 = Neither agree nor disagree	) fo
4 = Refused to a		4 = Agree	luding for uses
9	TISWCI	5 = Strongly agree	es
0 22 How often do w	ou discourage a pregnant woman	J = Strongly agree	<u>ਵਿੰ</u> ਬ
	ve a girl, or one having a girl	26. I will be able to achieve most of the	goals related to
-	ting, from having her daughter cut?	that I have set for myself	
1 = Always	ing, nom having her daughter eat:	that Thave set for mysen	text
2 = Often		27. When facing difficult tasks, I am cert	<u>a</u>
6 3 = Sometimes		will accomplish them	da
$\frac{7}{8} \qquad 4 = Rarely$		The second secon	ផ្ល
9 5 = Never		28. In general, I think that I can obtain o	mining, Al training, and similar technologies.  y endeavour ne fectively most
6 = Refused to a	nswer	that are important to me	ng,
1			A
$^{2}_{3}$ 23. If you became a	ware of a colleague performing	29. I believe I can succeed at almost any	ر endeavour الله الله الله الله الله الله الله الل
.5	nutilation, will you	to which I set my mind	ning
5 1 = Yes	, ,		j, a
6 2 = No		30. I will be able to successfully overcon	ne □≝
3 = 1  don't know		many challenges	i iii
$\begin{array}{cc} 4 & \text{Refused to a} \\ 4 & \text{Refused to a} \end{array}$			lar
0		31. I am confident that I can perform ef	fectively $\square  \overline{\underline{\mathfrak{S}}}   $
1 23a) Report him	/her?	on many different tasks	
2	,		logi
3 23b) Explain to h	nim/her that health care	32. Compared to other people, I can do	most
4	ould not perform female	tasks very well	
6 genital mutil	•		
7	-	33. Even when things are tough, I can pe	erform $\Box$
8 24. How often do vo	ou look for female genital	quite well	
mutilation when	n performing a gynecological		
examination of t			
1 = Always	4 = Rarely		
2 = Often	5 = Never		
3 = Sometimes	For peer review only - http://bmjoper	.bmj.com/site/about/guidelines.xhtml	



**Project ID** 

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## BMJ Open A Health Systems Approach to Prevention of Female Genital Mutilation using

Region/

County ID Facility ID

Centre ID

Person-Centered Communication: A Multi-Country Implementation Research Project ANC Provider questionnaire (HCP)

**Provider ID** 

Study period:

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5	A 6 5 9 9 3	- 0 = Baseline, 1 = Three months, 2 = Six Months
6 <b>7</b> r	CCTION F. COMMUNICATION SKILLS	SECTION E LIFALTH FACILITY DEADINESS
3E 8	ECTION E - COMMUNICATION SKILLS	SECTION F - HEALTH FACILITY READINESS
8 9 10 11 12 13 14 15 16 17 18 20 21 22 23	34. I can put myself in others' shoes  1 = Always 2 = Often 3 = Sometimes 4 = Rarely 5 = Never  35. I let others know I understand what they say 1 = Always 2 = Often	These next questions relate to your clinic setting:  39. Have you seen any FGM posters at the clinic?  1 = Yes  2 = No  3 = I don't know  40. Have you referred to the WHO Clinical Handbook on FGM?  1 = Yes  2 = No, available but not referred  3 = No, not available 4 = I don't know  41. Do you think it is feasible to provide
25 26 27 28 29 30 31	4 = Rarely 5 = Never  36. In conversations with my colleagues, I perceive	FGM prevention counselling during ANC visits?
32 33 34 35 36 37 38 39	1 = Always 2 = Often 3 = Sometimes 4 = Rarely 5 = Never	2 = No 3 = I don't know  COMMENTS  COMMENTS  COMMENTS  COMMENTS  COMMENTS  COMMENTS
	37. I communicate effectively  1 = Always  2 = Often  3 = Sometimes  4 = Rarely  5 = Never  38. I communicate with others as though they are my equals  1 = Always	ing, Al training, and similar technologies
52 53 54 55 56 57 58 59 60	3 = Sometimes 4 = Rarely 5 = Never	Data Collector name: Signature:  Date: Day Month Year
	For peer review only - http://bmjope	em.bmj.com/site/about/guidelines.xhtml  Time questionnaire completed (00:00 - 23:59):  hours minutes

A Health Systems Approach td®NéGention of Female Genital Mutilation using Person-Centered Communication. A Multi-Country implementation Research Project  First ANC Client Exit Questionnaire (EXT)  Page 1/1  Participant ID  Region/  SECTION A - SOCIO-DENIOGRAPHICINFORMATION  I may going to ask you of personal questions  1. How old are you (years)? ('99' if unknown)    1	$\overline{}$					
First ANC Client Exit Questionnaire (EXT)	Pag					
Region/	`					
Project ID	1					
SECTION A - SOCIO-DEMOGRAPHIC INFORMATION   O = Baseline, 1 = Three menths, 2 = Six Months	<u>2</u> 3	-	)	Participant ID Study period:		
SECTION A - SOCIO-DEMOGRAPHIC INFORMATION	4		1		ths, 2 = Six Months	
	5		_ 			
13. What do you feel about FGM now as compared to before you came to the clinic today?  15. For Somail study sites, skip to Q3  2. What is you religion?  2. On None  3 = Other  3 = Other  3 = I feel less supportive of FGM now as compared to before I came  4 = I don't know  5 = Other  5 = Other, specify:  3 = Primary  4 = Other  3 = University  3 = Primary  4 = Other  3 = I for I know supportive are you of female genital mutilation?  2. Somewhat supportive are you of female genital mutilation?  3 = I following questions relate to your clinic visit today.  3	9		Ш			
Section   Sect	/ R	Tulli gollig to ask you a jew personal questions				
1 - Same, no change 2 - Ifeel more supportive of FGM now as compared to before I came 3 - Ifeel less supportive of FGM now as compared to before I came 3 - Ifeel less supportive of FGM now as compared to before I came 3 - Ifeel less supportive of FGM now as compared to before I came 3 - Ifeel less supportive of FGM now as compared to before I came 3 - Ifeel less supportive of FGM now as compared to before I came 4 - Idon't know 5 - Other 6 - Refused to answer 3 - Ifeel less supportive of FGM now as compared to before I came 4 - Idon't know 5 - Other 6 - Refused to answer 3 - Ifeel less supportive of FGM now as compared to before I came 4 - Idon't know 5 - Other 6 - Refused to answer 13a) If Other, specify: 1 - Formary 4 - Other 2 - Somewhat opposed 2 - Somewhat opposed 2 - Somewhat opposed 3 - Notified proposed 3 - Notified		1 How old are you (years)? ('99' if unknown)		•	<u> </u>	
2 - Secondary 4 - Other specify: 3 - On None 3 - Other 1 - Muslim 4 - Refused to answer 5 - 1 - Muslim 5 - 2 - Christian 7 - 2a) if Other, specify: 8 - On None 3 - University 9 - On None 3 - Other 1 - Muslim 4 - Refused to answer 1 - Muslim 5 - 2 - Christian 7 - 2a) if Other, specify: 8 - On None 3 - University 9 - On None 3 - University 9 - On None 9 - Other 9 -		1. How old are you (years): (33 if anknown)			. cimic today:	
to before Lame  3 = Other 10 = None 3 = Other 10 = Nulsilm 4 = Refused to answer 10 = 2 = Christian 10 = None 3 = University 11 = Primary 12 = 1 = Primary 13 = 1 Feel less supportive of FGM now as compared 13 = I feel less supportive of FGM now as compared 15 = Other, specify: 16 = Refused to answer 13a) If Other, specify: 10 = None 11 = Primary 12 = Other 12 = Secondary 13 = I feel less supportive of FGM now as compared 15 = Other 15 = Other 16 = Refused to answer 13a) If Other, specify: 11 = Primary 12 = Other 13a) If Other, specify: 14. How supportive are you of female genital mutilation? 15 = Strongly opposed 15 = Strongly opposed 15 = Somewhat opposed 16 = Refused to answer 15 = Many women in your community have had their genitals cut when they were children. If you are genitals cut when they were children. If you are genitals cut when they were children. If you are genitals cut when they were children. If you are genitals cut when they were children. If you are genitals cut when they were children. If you are genitals cut when they were children. If you are genitals cut when they were children. If you are genitals cut when they were children. If you are genitals cut when they were children. If you are genitals cut when they were children. If you are genitals cut when they were children. If you are genitals cut when they were children. If you are genitals cut when they were children. If you are genitals cut when they were children. If you are genitals cut when they were children. If you a	1	For Somali study sites, skip to O3			ow as compared	
3 = O + None 3 = Other 4 = Refused to answer 12   1 = Muslim 4 = Refused to answer 13   1 = Muslim 4 = Refused to answer 14   1 = Muslim 4 = Refused to answer 15   1 = Muslim 4 = Refused to answer 15   1 = Muslim 4 = Refused to answer 15   1 = Muslim 4 = Refused to answer 15   1 = Muslim 4 = Refused to answer 15   1 = Muslim 4 = Refused to answer 15   1 = Muslim 4 = Refused to answer 15   1 = Muslim 4 = Refused to answer 15   1 = Muslim 4 = Refused to answer 15   1 = Muslim 4 = Refused to answer 15   1 = Muslim 4 = Refused to answer 15   1 = Muslim 4 = Refused to answer 15   1 = Nuslim 4 = Refused to answer 15   1 = Nuslim 4 = Refused to answer 15   1 = Nuslim 4 = Refused to answer 15   1 = Nuslim 4 = Refused to answer 15   1 = Nuslim 4 = Refused to answer 15   1 = Nuslim 4 = Refused to answer 15   1 = Nuslim 4 = Refused to answer 15   1 = Nuslim 4 = Refused to answer 15   1 = Nuslim 4 = Refus					,	
to before I came    Section   Sectio	1				v as compared _	
## 4 = Somewhat supportive  5 = Strongly supportive  6 = Refused to answer  15. Many women in your community have had their		1 = Muslim 4 = Refused to answer		• •	Pro	
## 4 = Somewhat supportive  5 = Strongly supportive  6 = Refused to answer  15. Many women in your community have had their		2 = Christian		4 = I don't know	tect	
## 4 = Somewhat supportive  5 = Strongly supportive  6 = Refused to answer  15. Many women in your community have had their		2a) If <b>Other</b> , specify:		5 = Other	e o	
## 4 = Somewhat supportive  5 = Strongly supportive  6 = Refused to answer  15. Many women in your community have had their				6 = Refused to answer	by	
## 4 = Somewhat supportive  5 = Strongly supportive  6 = Refused to answer  15. Many women in your community have had their		3. What is the highest level of education		13a) If Other, specify:	ဝို	
## 4 = Somewhat supportive  5 = Strongly supportive  6 = Refused to answer  15. Many women in your community have had their		you achieved?			——————————————————————————————————————	
## 4 = Somewhat supportive  5 = Strongly supportive  6 = Refused to answer  15. Many women in your community have had their		0 = None 3 = University		14. How supportive are you of female g	enital 기울	
## 4 = Somewhat supportive  5 = Strongly supportive  6 = Refused to answer  15. Many women in your community have had their		1 = Primary 4 = Other		mutilation?	inc	
## 4 = Somewhat supportive  5 = Strongly supportive  6 = Refused to answer  15. Many women in your community have had their	24	2 = Secondary		1 = Strongly opposed	ud	
## 4 = Somewhat supportive  5 = Strongly supportive  6 = Refused to answer  15. Many women in your community have had their		3a) If <b>Other</b> , specify:		2 = Somewhat opposed	ing	
## 4 = Somewhat supportive    1	27	<u> </u>	IJ١	3 = Neutral (neither opposed nor sup		
30 During your visit today:  1 = Yes	ŞE	CTION B - CLINIC EXPERIENCE	Ш	4 = Somewhat supportive		
1 = Yes 3 = I don't know 2 = No 4 = Refused to answer 3				2. S. L.		
2 = No					elat [	
34 4. Did you see any FGM poster(s) in the 35 consultation and/or waiting room? 36 consultation and/or waiting room? 37 s. Did the ANC provider ask if you have 38 undergone FGM? 40 undergone FGM? 41 do Did the ANC provider explain how FGM can 42 harm your health? 43 harm your health? 44 harm your health? 45 7. Did the ANC provider ask about your personal 46 belief regarding FGM? 47 belief regarding FGM? 48 8. Did the ANC provider discuss why FGM 59 Did the ANC provider discuss how FGM 50 could be prevented? 50 Did you have any questions about FGM to 50 ask the ANC provider? 51 D. Did you have any questions about FGM to 52 ask the ANC provider? 53 T. Did you feel encouraged to ask questions 54 Did you feel encouraged to ask questions 55 Did the ANC provider ask if you have 46 undergone this practice? 4 = Refused to answer 4 = Refused to answer 4 = Refused to answer 55 Did the ANC provider explain how FGM can 56 Did the ANC provider discuss why FGM 57 Did the ANC provider discuss why FGM 58 Did the ANC provider discuss how FGM 59 Did the ANC provider? 50 Did you have any questions about FGM to 57 Did you feel encouraged to ask questions 58 Data Collector name: 58 Signature:		= 100				
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60 about FGM?	59 60	about FGM?		Data Conector name: Sig	nuture:	

12. Are you satisfied with how FGM was addressed

Day Date: Month Year during your visit with your ANC provider today?//bmjopen.bmj.com/site/about/guidelines.xhtml

Time questionnaire completed (00:00 - 23:59): minutes hours

**1. Primary Outcome:** Health facility preparedness to provide FGM prevention and care services.

**Outcome definition**: Cumulative score based on affirmative responses to Q9a, Q10a, Q11a & Q12a on the CHK form (see below).

```
Q9. Is there an MoH policy on FGM posted on the wall?
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Yes

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No

Q9a. If yes, is it placed where health care providers can see/read it e.g., bulletin board?

Ye.

No

Q10. Are there WHO FGM prevention posters on the wall of the consultation room and/or waiting room?

Yes

No

Q10a. If yes, are they placed in a place where ANC clients can see them?

Yes

No

Q11. Is there a WHO clinical handbook in the ANC consultation room?

Ye

No

Q11a If yes, is it placed where ANC providers can see/use it?

Yes

No

Q12. Is there an FGM ABCD guide in the ANC consultation room?

Yes

No

Q12a. If yes, is it placed where ANC providers can see/use it?

Yes

No

#### 2. Primary outcome: ANC provider utilization of Level 1 package components

**Outcome definition**: Affirmative response on Q40 of HCP form (see below).

```
Q40. Have you referred to the WHO Clinical Handbook on FGM?
```

Ye.

No, available but not referred

No, not available

Don't know

#### 3. Primary outcome: Provision of FGM-related care after PCC training

**Outcome definition:** Cumulative score based on affirmative responses (Provision of FGM-related care (after PCC training) either 'Always' or 'Often') on Q22, Q24 & Q25 on the HCP form (see below).

Q22. How often do you discourage a pregnant woman expecting to have a girl, or one having a girl at the age of cutting, from having her daughter cut?

**Alwavs** 

Often

Sometimes

Rarely

Never

Rarely

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Refused to answer
       Q24. How often do you look for female genital mutilation when performing a gynecological
examination of the vulva?
               Always
               Often
               Sometimes
               Rarely
               Never
               Rarely
               Refused to answer
       Q25. How often do you record female genital mutilation in the woman's medical file if you
are aware that she has undergone FGM?
               Always
               Often
               Sometimes
               Rarely
               Never
               Rarely
               Refused to answer
   4. Primary Outcome: Delivery of PCC 'ABCD' package
Outcome definition: Cumulative score based on affirmative responses on Q5, Q7, Q8, Q9 &
Q12 on the EXT form.
       Q5. Did the ANC provider ask if you have undergone FGM?
               Yes
               No
               Don't know
               Refused
       Q7. Did the ANC provider ask about your personal belief regarding FGM?
               Yes
               No
               Don't know
               Refused
       Q8. Did the ANC provider discuss why FGM should be prevented?
               Yes
               No
               Don't know
               Refused
       Q9. Did the ANC provider discuss how FGM could be prevented?
               Yes
               Nο
               Don't know
       Q12. Are you satisfied with how FGM was addressed during your visit with your ANC provider
today?
               Yes
               No
               Don't know
               Refused
```

#### 5. Secondary Outcome: Improved knowledge about FGM

**Outcome definition:** Cumulative score based on correct responses to Q4 + affirmative responses to Q5 & Q7 of the HCP form.

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Q4. Please provide the WHO classification for the following images
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Type I
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Type II

Type III

Type IV

Don't Know

Other

Q5. Do you know of any health complications arising from female genital mutilation?

Yes

No

Q7. Are you aware of any existing WHO tools/guidance on FGM prevention and care?

Yes

No

#### 6. Secondary Outcome: Improved interpersonal communication skills

**Outcome definition:** Cumulative score based on positive responses ("Always or Often") to Q34, Q35, Q36, Q37, Q38 on the HCP form.

Now I will ask you about your communication skills

34. I can put myself in others shoes

**Always** 

Often

Sometimes

Rarely

Never

Rarely

Refused to answer

35. I let others know that I understand what they say

Always

Often

Sometimes

Rarely

Never

Rarely

Refused to answer

36. In conversations with my colleagues, I perceive not only what they say but what they don't say

**Always** 

Often

Sometimes

Rarely

Never

Rarely

Refused to answer

37. I communicate effectively

**Always** 

Often

Sometimes

Rarely

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58 59 60 Never

Rarely

Refused to answer

38. I communicate with others as though they are my equals

**Always** 

Often

Sometimes

Rarely

Never

Rarely

Refused to answer

#### 7. Secondary outcome: Improved self-efficacy

**Outcome definition:** Cumulative score based on positive responses (Agree or Strongly Agree) to Q26, Q27, Q28, Q29, Q30, Q31, Q32, Q33 on the HCP form.

Now I would like to ask you a few questions about how you solve problems that you face. Please tell me how much you agree or disagree with the statements that I read to you

1 = Strongly disagree

2 = Disagree

3 = Neither agree nor disagree

4 = Agree

5 = Strongly agree

- Q26. I will be able to achieve most of the goals that I have set for myself
- Q27. When facing difficult tasks, I am certain that I will accomplish them
- Q28. In general, I think that I can obtain outcomes that are important to me
- Q29. I believe that I can succeed at almost any endeavor to which I set my mind
- Q30. I will be able to successfully overcome many challenges
- Q31. I am confident that I can perform effectively on many different tasks
- Q32. Compared to other people, I can do most tasks very well
- Q33. Even when things are tough, I can perform quite well

#### 8. Secondary outcome: Improved attitudes towards FGM

**Outcome definition**: Cumulative score based on positive responses to Q12, Q13, Q14, Q15, Q16, Q17, Q18 & Q19 on the HCP form.

For each of the following statements please state if you:

1=Agree

2=Disagree

3=Don't know

4=Refused to answer

- Q12. A girl who has not undergone FGM is unclean
- Q13. A girl who has not undergone FGM cannot be married within her community
- Q14. A girl who has not undergone FGM is a disgrace to her family's honor
- Q15. Health care providers who provide FGM are violating FGM
- Q16. Health care providers who provide FGM should be punished
- Q17. FGM is a good practice
- Q18. FGM is a violation of women and girls' rights
- Q19. FGM is religious mandate

9. Tertiary outcome: ANC provider confidence in FGM knowledge to provide care
Outcome definition: Positive responses ('Somewhat Confident' or 'Confident') to Q8 & Q9 on
the HCP form

Q8. When you treat or attend to a girl or woman with female genital mutilation, how confident are you that you have enough knowledge to provide good quality care?

1=Not confident

2=Somewhat confident

3=Confident

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4=Refused to answer

Q9. How confident are you in your knowledge to communicate on FGM prevention?

1=Not confident

2=Somewhat confident

3=Confident

4=Refused to answer

#### 10. Tertiary outcome: ANC provider support for FGM

**Outcome definition:** Positive response ('Do not intend to cut her') to Q20 on the HCP form Q20. Pretend you had a daughter now who was at an age when cutting occurs, what would your intention to cut her be?

1=Intend to cut her

2=Do not intend to cut her

3=Don't know

4=Refused to answer

#### 11. Tertiary outcome: ANC provider support for medicalized FGM

**Outcome definition:** Correct response ('No') to Q21 on HCP form

Q21. If a family brought their daughter to the clinic requesting genital cutting, for non-health reasons, would you perform it?

1=Yes

2=No

3=Don't know

4=Refused to answer

#### 12. Tertiary outcome: ANC client change in support for FGM after ANC visit

**Outcome definition:** Response to Q13 on EXT form

Q13. What do you feel about FGM now as compared to before you came to the clinic today?

1= Same, no change

2=I feel more supportive of FGM now as compared to before I came

3=I feel less supportive of FGM now as compared to before I came

4=Don't know

5=Other

6=Refused to answer

#### 13. Tertiary outcome: ANC client support or opposition to FGM

**Outcome definition:** Response to Q14 on EXT form

Q14. How supportive are you of female genital mutilation?

1=Strongly opposed

2=Somewhat opposed

3=Neutral

4=Somewhat supportive

5=Strongly supportive 6=Refused to answer

#### 14. Tertiary outcome: ANC client intention to cut after ANC visit.

#### Outcome definition: Response to Q16 on EXT form

Q.16 Pretend you had a daughter now who was at an age where cutting occurs, what would your intention to cut her be?

1=Intend to cut her

2=Do not intend to cut her

3=Don't know

4=Refused to answer

#### 15. Tertiary outcome: ANC client choice of who to cut their daughters.

#### Outcome definition: Response to Q17 on EXT form

Q17. If intending to cut, who would you prefer to do the cutting?

1=Traditional practitioner

2=Health care provider

3=Other

4=Refused to answer

#### 16. Tertiary outcome: ANC client wish to be active in FGM prevention

#### Outcome definition: Response to Q18 on EXT form

Q.18 Do you wish/want to be active in preventing FGM?

1=Yes

2=No

3=Don't know

*4=Refused to answer* 

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Page

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Introduction

Based on the CONSORT guidelines.

## Instructions to authors

Complete this checklist by entering the page numbers from your manuscript where readers will find each of the items listed below.

Your article may not currently address all the items on the checklist. Please modify your text to include the missing information. If you are certain that an item does not apply, please write "n/a" and provide a short explanation.

Upload your completed checklist as an extra file when you submit to a journal.

In your methods section, say that you used the CONSORTreporting guidelines, and cite them as:

Schulz KF, Altman DG, Moher D, for the CONSORT Group. CONSORT 2010 Statement: updated guidelines for reporting parallel group randomised trials

Title and Abstract

Title #1a Identification as a randomized trial in the title. 1

Abstract #1b Structured summary of trial design, methods, results, and conclusions

Background and objectives	<u>#2a</u>	Scientific background and explanation of rationale	BMJ Open: fire
Background and objectives	<u>#2b</u>	Specific objectives or hypothesis	st published as Pı 6
Methods			10.1136/k rotected
Trial design	#3a	Description of trial design (such as parallel, factorial) including allocation ratio.	omjopen-2023 by copyright, 7
Trial design	#3b	Important changes to methods after trial commencement (such as eligibility criteria), with reasons	BMJ Open: first published as 10.1136/bmjopen-2023-078771 on 4 July 2024. Enseignt Protected by copyright, including for uses relat 7
Participants	<u>#4a</u>	Eligibility criteria for participants	άΨ <u></u>
Participants	<u>#4b</u>	Settings and locations where the data were collected	Downloaded from ment Superieur ( <i>t</i> id to text and data ∞ ∞
Interventions	<u>#5</u>	The experimental and control interventions for each group with sufficient details to allow replication, including how and when they were actually administered	9,10 9,10
Outcomes	<u>#6a</u>	Completely defined prespecified primary and secondary outcome measures, including how and when they were assessed	jopen.bmj.com/ on June 13, 2025 at Agence Bibliographique de l Al training, and similar technologies.
Sample size	<u>#7a</u>	How sample size was determined.	Jence Bib
Sample size	#7b	When applicable, explanation of any interim analyses and stopping guidelines  w only - http://bmjopen.bmj.com/site/about/guidelines.xhtml	oliographique de l A N

Randomization -	<u>#8a</u>	Method used to generate the random allocation	
Sequence generation		sequence.	
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Randomization -	<u>#8b</u>	Type of randomization; details of any restriction (such	7
Sequence generation		as blocking and block size)	iected
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Randomization -	<u>#9</u>	Mechanism used to implement the random allocation	9
Allocation concealment		sequence (such as sequentially numbered containers),	
mechanism		describing any steps taken to conceal the sequence	<u> </u>
		until interventions were assigned	53   G
Randomization -	<u>#10</u>	Who generated the allocation sequence, who enrolled	9 6
Implementation		participants, and who assigned participants to	2
		interventions	2 2 2 3
Blinding	<u>#11a</u>	If done, who was blinded after assignment to	9 <b>9</b>
		interventions (for example, participants, care providers,	9
		those assessing outcomes) and how.	<u>چَ</u> عاد ن
Blinding	<u>#11b</u>	If relevant, description of the similarity of interventions	N/A
Statistical methods	<u>#12a</u>	Statistical methods used to compare groups for	12
		primary and secondary outcomes	<u>g</u> ico.
Statistical methods	<u>#12b</u>	Methods for additional analyses, such as subgroup	12
		analyses and adjusted analyses	

Outcomes	<u>#6b</u>	Any changes to trial outcomes after the trial commenced, with reasons	BMJ Open: first published as 10.1136/bmjopen-2023-078771 on 4 July 2024. Enseigne Protected by copyright, including for uses relat  A  A  N  N  N  N  N  N  N  N  N  N  N
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diagram (strongly		randomly assigned, received intended treatment, and	tected
recommended)		were analysed for the primary outcome	/bmjope I by cop
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Funding

#25 Sources of funding and other support (such as supply

of drugs), role of funders

Notes:

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## BMJ Open

# A cluster randomized trial of a health system strengthening approach applying person-centered communication for the prevention of female genital mutilation in Guinea, Kenya, and Somalia

Journal:	BMJ Open
Manuscript ID	bmjopen-2023-078771.R1
Article Type:	Original research
Date Submitted by the Author:	02-Apr-2024
Complete List of Authors:	Balde, Mamadou; Cellulle de Recherche en Sante de la Reproduction en Guinee (CERREGUI) Ndavi, Patrick; University of Nairobi College of Health Sciences, Department of Obstetrics & Gynecology Oyaro, Vernon; World Health Organization, Department of Sexual and Reproductive Health and Research Soumah, Anne-Marie; Cellulle de Recherche en Sante de la Reproduction en Guinee (CERREGUI) Esho, Tammary; Amref International University King'oo, James; Technical University of Kenya Kemboi , Jackline; Amref Health Africa Sall, Alpha; Cellulle de Recherche en Sante de la Reproduction en Guinee (CERREGUI) Diallo, Aissatou; Cellulle de Recherche en Sante de la Reproduction en Guinee (CERREGUI) Ahmed, Wisal; World Health Organization, Department of Sexual and Reproductive Health and Research Stein, Karin; World Health Organization, Department of Sexual and Reproductive Health and Research Thwin, Soe Soe; World Health Organization, Department of Sexual and Reproductive Health and Research, Including UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) Petzold, Max; University of Gothenburg Sahlgrenska Academy, Public Health and Community Medicine Ahmed, Muna; Ministry of Planning and National Development, Central Statistics Department; MUFEIS Multidisciplinary Consultancy Firm , CEO Diriye, Ahmed; Data and Research Solutions Pallitto, C; World Health Organization, Department of Sexual and Reproductive Health Argenization, Department of Sexual and
<b>Primary Subject Heading</b> :	Health services research
Secondary Subject Heading:	Evidence based practice, Reproductive medicine, Research methods, Communication, Complementary medicine

Keywords: EDUCATION & TRAINING (see Medical Education & Training), Patient-Centered Care, Primary Care < Primary Health Care, Primary Prevention, PUBLIC HEALTH, Behavior

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Abstract word count: 293

Text word count: 5,314

Tables: 4

Figures: 1



BMJ Open: first published as 10.1136/bmjopen-2023-078771 on 4 July 2024. Downloaded from http://bmjopen.bmj.com/ on June 13, 2025 at Agence Bibliographique de l Enseignement Superieur (ABES) .

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#### **ABSTRACT**

**Introduction**: There is limited evidence on effective health systems interventions for preventing female genital mutilation (FGM). This study tested a two-level health system strengthening approach at primary care level to apply person-centred communication (PCC) for FGM prevention.

Methods: Between August 2020 and September 2021, a cluster randomized trial was conducted in 180 antenatal care (ANC) clinics in Guinea, Kenya, and Somalia. At baseline, all clinics received guidance and materials on FGM prevention and care, while at month three, ANC providers at intervention sites received PCC training. Data were collected from clinic managers, ANC providers and clients at baseline, months three and six. Multi-level and single-level logistic regression models were used to analyze the effect of the intervention on study outcomes.

Protected by copyright, including for uses related **Results**: Complete data were collected from 232 ANC providers in 163 clinics. Compared to providers in the control arm, those in the intervention arm had higher odds of being confident in their FGM-related. and data mining, Al training, and similar technologies knowledge (OR: 6.3, 95% CI: 1.4-28.9; p=0.02) and to communicate effectively about FGM prevention (OR: 1.7; 95% CI: 1.0-3.0; p=0.06). Additionally, ANC clients in the intervention arm had higher odds of being less supportive of FGM (AOR: 5.4, 95% CI: 2.4-12.4; p<0.001] and wanting to be actively engaged in FGM prevention (AOR: 3.2, 95% CI: 1.6-6.2; p=0.001) after speaking with their provider. They also had higher odds of being strongly opposed to FGM (AOR: 2.4, 95% CI: 1.1-5.2; p=0.023), lower odds of intending to have their daughters undergo FGM (AOR: 0.3, 95% CI: 0.1-0.7; p=0.004) or seeking medicalized FGM (AOR: 0.2, 95% CI: 0.1-0.5; p<0.001).

**Conclusion**: This is the first randomized trial to provide evidence of an effective intervention to promote FGM prevention that can be delivered in primary care settings and scaled up in high prevalence countries.

#### **SUMMARY BOX**

- This hybrid-effectiveness implementation research study conducted in primary care public health facilities in three countries with high prevalence of female genital mutilation (FGM) assessed the role of health workers in providing FGM prevention communication in the context of routine Protected by copyright, including for uses related to text and antenatal care (ANC).
- It will be important to assess the effectiveness of the person-centred communication approach in other service delivery points, e.g., child immunization, and with other cadres of health workers, e.g., community health workers, to assess its effectiveness beyond ANC care.
- Many factors influence FGM-related decision-making, and while primary care health workers were found to be effective communicators, and the randomized design controlled for some external factors, the impact of a health sector intervention in conjunction with multi-sectoral initiatives requires futher investigation.
- To ensure participation of at least one ANC provider at each site through each time point, eligibility of health workers was based on clinic rotation schedules, which may have introduced a selection bias although the included and excluded providers did not appear to differ significantly.

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INTRODUCTION

Multi-sectoral efforts are needed to achieve Sustainable Development Goal (SDG) 5.3 to eliminate the harmful practice of female genital mutilation (FGM) by 2030 in line with the United Nation's (UN) General Assembly resolution 67/146 (1), the World Health Assembly Resolution 61.16 (2) and the 2008 Interagency Statement (3), which call upon UN Member States to enact comprehensive and multi-disciplinary national action plans and strategies towards the elimination of the practice. Identifying effective strategies across sectors is an important step in ending FGM.

The health system, defined as all organizations, institutions and resources that produce actions whose primary purpose is to improve health(4), has an important role to play not only in managing complications of FGM but also in preventing the practice. Health care providers, specifically nurses and midwives who constitute most of the health workforce, are highly respected members of FGM practising and midwives who constitute most of the health workforce, are highly respected members of FGM practising and medicalization), despite national laws and medical ethics forbidding it (8–11). Developing evidence-based tools to build skills of health care providers and address their underlying beliefs could contribute to FGM abandonment efforts and complement existing resources on management of complications (12,13) to ensure comprehensive and high quality care.

Three countries (Guinea, Somalia, and Kenya) participated in a cluster randomized trial to test the effectiveness and implementation of a health system strengthening approach to FGM, which included the testing of an intervention to build skills of health workers on applying person-centered communication.

(PCC) for the prevention of FGM (14). Study countries were selected based on their high national and/or sub-national FGM prevalence. The national prevalence of FGM among women and girls aged 15 - 49 years is 98% in Somalia, 97% in Guinea and 21% in Kenya according to national population-based surveys. There are 20 hotspot counties/sub-national administrative units in Kenya with a prevalence of >80% (15), and this study focused on three of these counties. Likewise, the study countries have high rates of medicalized FGM, performed primarily by midwives, who make up between 71% to 93% of primary health care providers in the three study countries (16) hence the selection of nurses and midwives as the target group for this intervention.

The purpose of this study was to test a two-level intervention package to enable ANC providers

to deliver person-centered FGM counseling to their clients. This intervention package was informed by a theory of change that promotes health workers to be effective behavioral change agents because of their credibility (17) and positionality to influence the opinions, attitudes, beliefs, motivations and behaviors of their clients (18). We hypothesized that if ANC providers gained the necessary knowledge and skills to provide person-centered counseling (Level 2) and were given the opportunity to question their beliefs and attitudes together with an enabling environment (Level 1), they could positively influence the knowledge and attitudes of their clients to abandon the practice (Supplementary file 1).

The level one intervention consisted of making available national policy directives on the role of health care providers in providing FGM prevention and care services, WHO's FGM guidelines and clinical handbook as well as information, education, and communication (IEC) materials. These materials were distributed without any capacity building to accompany their distribution. Level two consisted of an interactive training specifically targeting ANC providers to build their knowledge on FGM, enable them to question their FGM-related values and attitudes and build their skills on counseling for FGM prevention using person-centred communication (19), a component of person-

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centred care, which ensures that the perspectives and preferences of individuals, carers, families and communities are at the center of decisions and that they have the information and support needed to make decisions (20). ANC providers were trained to apply a series of structured steps in which they would: 'Assess' their client's views on FGM, address and challenge her 'Beliefs', encourage 'Change' and together with the client, 'Discuss and Decide' (ABCD).

#### **METHODS**

#### **Study Design**

This cluster randomized trial applied a type 2 hybrid, effectiveness-implementation design (21) to test the effectiveness of the delivery of a phased intervention package (Level 1 and 2) on knowledge, attitudes and practices among ANC health workers and their clients. This type of implementation research design assesses the effectiveness of the intervention and implementation factors in real world settings. The methodology, analysis plan and reporting conformed to the 2010 Consolidated Standards of Reporting Trial (CONSORT) checklist (22). Ethical approval for the master protocol was obtained from the World Health Organization (WHO) Ethical Review Committee (ERC) (#P151/03/2014). Each study country submitted country-specific protocols to local 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).

#### **Participants**

Within each study country, two or three sub-national units (regions/counties) were purposively selected according to the following eligibility criteria: (1) FGM prevalence >50% among females 15 -

Al training, and similar technologies

49 years old; (2) more than 15 ANC clinics, seeing on average 30 new ANC clients per month and (3) accessibility in terms of security. The unit of randomization was the ANC clinic to avoid having ANC providers in the same clinic in different study arms, which could lead to contamination. In intervention sites, all providers on duty were pre-screened. To ensure participation and follow-up throughout the trial, between one and three ANC providers on duty were enrolled based on a six-month clinic rotation schedule provided by the clinic manager. Ten new clients exiting their first ANC consultation with a participating provider were recruited at each data collection point.

Individual study participants gave verbal informed consent. Data collectors collected data from the ANC providers and their clients in a private and confidential setting. While personally identifiable information was collected from ANC providers to facilitate tracking during the follow-up data collection

time points, data were de-identified prior to analysis. No personally identifiable information was collected from ANC clients who were unique at each time point. Participating ANC clients received the equivalent of 5 USD to compensate for their transport costs recognizing that participants consenting to participate might have changed their plans to accommodate the interviews. Given insecurity in carrying cash in Somalia, a mobile phone application was used to transfer the money to participants, an amendment to the original protocol, which was submitted to the ethical review committees.

#### Randomization and blinding

Based on Ministry of Health (MoH) facility administrative records, all public, primary care facilities (i.e., dispensaries and/or health centers) offering ANC services in the selected regions/counties the average number of new ANC clients seen in November and December 2019 was compiled to create ordered listings of client loads at each of the sites by region/county. Clinics were matched into pairs based on client load so the two busiest would be randomized to different arms and so on. A uniform distribution was used for randomization using the uniform random number function in STATA 17

(StataCorp Inc., College Station, TX, USA). Study teams organized data collection and intervention trainings based on the randomization lists. Attempts were made to blind clinic managers, ANC providers and their clients to study arm allocation. Since both study arms received the level one intervention component at baseline, and the providers and managers at control sites were unaware of the training that took place at intervention sites, it is conceivable that they were not aware of their study arm.

Presumably, intervention clients would assume they were the intervention arm, but they were also not aware of what might have been offered to other sites. ANC clients, however, were completely blinded as intervention since a distinct set of clients was interviewed at each time point, and they would not be aware of the training the provider had had. Field data collectors were also blinded to study arm allocation as much as possible, although some might have determined intervention arm during the study.

#### **Procedures**

Implementation of the study interventions and data collection occurred between August 2020 and September 2021 and was staggered by countries. In the intervention arm, data collection was undertaken at three time points, i.e., at baseline prior to implementing the level one intervention component; at month three, prior to implementing the level two intervention component and at month six. In the control arm, data collection was done at two time points, i.e., at baseline and at month six. Study instruments included one for ANC clients, one for health workers and a health facility checklist completed by clinic managers. Instruments were pretested among ANC clients and providers from non-participating sites in all countries, and country teams provided feedback on the structure and appropriateness of each question prior to finalizing the instruments.

A web-interface electronic data capture system was developed on the Kobo toolbox core system architecture (Kobo Toolbox, Harvard Humanitarian Initiative, Boston, Massachusetts, USA). User accounts were password-protected, and data sent to the server was encrypted in transit using SHA256

with RSA encryption that met the data security requirements. Personally identifiable information was not collected, and all records were anonymized with unique study numbers. Study instruments for ANC clients were translated from English into ten languages by research team members in consultation with language experts (French, Somali, Swahili, Soussou, Poular, Malinké, Keiyo, Maasai, Marakwet and Protected by copyright, including for uses related Tugen) while those for ANC providers and clinic managers were translated into two languages (French and Somali). No backtranslation was performed. Field data collectors and their supervisors spoke the languages in which the questionnaires were administered. Data collection teams participated in a standardized training with WHO/HRP and the research institutions in each country. The level two intervention was implemented by master trainers in each country who had been trained remotely over a three-day period following the WHO PCC for FGM prevention facilitator's manual.

#### **Outcomes**

The primary study outcome was delivery of the "ABCD" approach by ANC providers measured by responses from their client using tools developed for this study based on previously validated instruments, including four constructs of the operational definition of person-centered communication

(23). We also assessed ANC provider delivery of FGM care services and their utilization of the level one Al training, and similar technologies intervention components. Health facility preparedness to offer FGM prevention and care was assessed using a composite score developed for this study. (Supplementary file 2). The secondary self-efficacy outcome was assessed based on a score calculated from a validated tool for measuring general selfefficacy (24) while knowledge, attitudes, and practice (KAP) on FGM prevention and care were measured using an unvalidated KAP questionnaire similar to one used in formative research in Guinea. Study instruments can be found in Supplementary file 3.

#### Statistical analysis

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To have sufficient power (80%) to detect a difference (significance level 5%) between intervention and control arms on the primary study outcome of delivery of the PCC intervention for FGM prevention, 180 ANC clinics, equally divided across the three study countries were recruited and randomized with 1800 new ANC clients (10 per clinic) recruited at baseline and 1800 at six-month follow-up. While similar interventions have resulted in 20% difference between groups (25), a 10% difference (based on an assumed 20% in the control arm and 30% in the intervention arm) was applied to ensure sufficient power to detect a 10% difference and considering the minimal levels of clinical efficacy for such an intervention to be practical. This sample size also allowed for a 10% non-response and/or loss to follow-up rate and accounted for a clustering effect of (ICC=0.20) at clinic level. A relatively high level of clustering was assumed in the sample size calculations to not underestimate the needed sample size. Region/county level was not included in the multilevel model due to the low number of included regions/counties per country (Kenya 3, Guinea 2, Somalia 3) and it would then not be possible to get an accurate estimate of the variance between clusters.

Data were analyzed using STATA 17 software following a per-protocol approach. Data from ANC providers and their clients were analyzed if the clinic had at least one provider with follow up data at all study time points, and in the intervention arm, if the ANC provider present had undergone training on PCC for FGM prevention at month three. Clinics where providers were lost to follow-up were not included in the final analyses. All facility checklists and ANC client exit interviews were conducted as intended except at sites not accessible due to security issues or closed or converted for care of COVID-19 patients during the pandemic. As the study was designed to pre-screen ANC providers at baseline and include in the final analytic sample only those clinics and providers who were available at 3 and 6 months, an intention-to-treat approach was not feasible. Key characteristics of the participating facilities,

providers and clients were summarized. Providers and clinics that were screened but not eligible are compared in Supplementary file 4.

Continuous variables are presented using mean values, and standard deviation (SD) while categorical variables are summarized as counts (N) with percentages (%). Differences in proportions were analysed for dichotomous outcomes using Fischer's exact test. For outcomes measured as summary scores, comparisons of mean scores are presented across study arms using t-test.

Initial analyses showed that the clustering was negligible at the provider level since most sites only included one provider in the study. Therefore, multilevel regression models were not used to compare outcomes among providers in intervention vs. control arms. However, analyses based on client level outcomes applied multilevel mixed effect logistic regression models to assess differences between the study arms. Multilevel analyses were attempted for the models in which ANC clients reported on provider actions, but given the complexity of the models, convergence problems arose leading to unreliable results. In these cases, results of ordinary models are presented. Linearity was assessed for the continuous covariates included in the regression models using the Box-Tidwell test in Stata.

At month six, a comparison of study outcomes between the intervention and control arms was used to determine the combined effect of both levels of the intervention package. Multilevel multivariable logistic regression analyses for ANC provider outcomes were adjusted for their sex, years of service, FGM status, FGM-related training, any specific training on communication/counseling and PCC, and whether the provider had conducted FGM in the past. Analyses related to ANC client outcomes were adjusted for their age, educational level, FGM status and exposure to level one IEC materials. These variables were determined a priori based on previously published literature. Analyses related to provider actions as reported by clients were adjusted for client characteristics as it was not possible to definitively link a client with a particular provider. Unadjusted analyses are presented for

outcomes that relate to composite measures based on ANC provider and client responses (e.g., provision of FGM prevention and care services).

To determine the separate effect of the two levels of the intervention package, additional sub-analyses were conducted restricted to the intervention arm. Changes from baseline to month 3 within the intervention arm were used to determine the effect of the level one intervention component while changes from month 3 to month 6 within the same study arm were used to determine the effect of the level two intervention component. The study was not powered for these sub-analyses, however, and these results are presented in Supplementary file 4.

In-country data managers monitored data quality. Periodic data audits were conducted by the WHO/HRP Quantitative Assessment and Data Management team to identify any data collection gaps and data discrepancies requiring follow up by in-country teams. Weekly data monitoring meetings were held between the in-country research teams and WHO/HRP staff during data collection periods to identify, document and resolve any data discrepancies. These were virtual due to the COVID-19 pandemic. Given that there was no prospective follow-up of clients, a Data Safety and Monitoring Board and identify, document and resolve any data discrepancies. These were virtual due to the COVID-19 pandemic. Given that there was no prospective follow-up of clients, a Data Safety and Monitoring Board and or protocol deviations to the WHO/HRP study coordination team.

Patient and public involvement statement

Health care providers and members of communities where the practice of FGM is prevalent in the study countries were actively involved in the design and implementation of this study intervention. This included the formative research conducted in Guinea, which identified health care providers as integral members of FGM practicing communities who understand local community beliefs and norms, making them effective change agents. The formative research also found that

their training, ensuring accountability to legal and policy standards and promoting FGM abandonment as part of a multi-sectoral approach. Based on this formative work, the PCC training was developed and subsequently piloted among ANC providers in Kenya before being rolled out as part of the multicountry study.

Additionally, the research partners in Guinea, Kenya and Somalia actively engaged health care providers and community members as part of their in-country work towards FGM prevention. In Kenya as part of mobilization of study participants, community health volunteers in the study counties talked about the study during their community sensitization sessions and invited pregnant women to attend routine ANC sessions where they could be approached for participation in the study. Both health care providers and pregnant women were provided with information about the study, including the burden of the intervention as to time, any risks involved in their participation, the voluntary nature of their participation, and were recruited only after providing informed consent.

At present, study dissemination meetings have been conducted in Kenya and Guinea that have involved the MoH, other stakeholders as well as representatives of health care providers and community members where the study was implemented. In these meetings, the in-country research partners have led Al training, and similar technologies the development of policy briefs identifying country-specific results relevant for local research needs, policy development and practice.

#### Role of the funders

Apart from WHO/HRP, the study funders had no role in study design or implementation. WHO/HRP, in collaboration with in-country research teams, developed the study protocol, provided data management and analytic support, and contributed to interpretation and manuscript writing. WHO/HRP coordinated the successful implementation of this study. The data collection platform was developed and maintained by an outsourced vendor (First Data, LLC, Kenya); data management was

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coordinated by the local implementing partners (CERREGUI, DARS and University of Nairobi) and statistical data analysis was conducted by an external statistician (Dr. Max Petzold, Gothenburg University). All these functions were conducted with utmost integrity following ICH-GCP guidelines. This trial was registered: PACTR201906696419769 (June 3, 2019).

#### **RESULTS**

### Recruitment and retention

Protected by copyright, including for uses Between August 2020 and September 2021, a total of 180 ANC clinics (i.e. 60 clinics per study country) were enrolled and randomized to intervention and control arms. There was some natural staggering of the start and subsequent data collection dates due to factors, such as weather, COVID-19, Ramadan, and national elections. Data collection periods ranged from three to six weeks in each country at each time point. The time elapsed between the end of one data collection period to the beginning of the next data collection period ranged from three to five months.

In the intervention arm, 216 providers and 900 clients (i.e., 10 per clinic) were interviewed. Based on a review of clinic rotation schedule to ensure participation of at least one provider from each study clinic throughout the trial, 133 providers were enrolled. In the control arm, 220 providers and 900 clients were interviewed. (Figure 1). At month three, data were collected at 98% (n=88) of the intervention clinics as two clinics in Kenya were inaccessible due to insecurity. One hundred and thirty (98%) ANC providers (at least one from each site) and 880 first visit ANC clients completed the month three questionnaires prior to implementing the Level 2 intervention PCC. No data collection was conducted at the control sites. At month six, 91% (n=163) of ANC clinics (81, intervention and 82, control) had at least one ANC provider (intervention n=110 and control n=122) on duty who was previously enrolled in the study. The client questionnaire was applied to 819 and 810 first visit ANC

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clients, respectively in the intervention and control sites.

# Characteristics of study sites and participants

The 163 ANC clinics retained to the end of the study, had a mean of four ANC providers (standard deviation, SD: 3) and served on average 155 new ANC clients per month (SD: 127) with a mean catchment population of 36,754 people (SD: 126,082). In 55% (n=89) of clinics, the clinic manager reported that there were no activities promoting FGM prevention in the facilities' catchment area (*Table 1*). These characteristics were not different from the 17 ANC clinics that were enrolled at baseline but that subsequently were not included in the final analysis (Annex 1).

Of the 232 ANC providers who contributed data for analysis at month six, 83% (n=193) were female and their mean age was 36 years (SD: 10 years). They had an average of eight years professional experience (SD: 7 years) and 68% (n=158) had studied up to Diploma level (generally 3 years postsecondary education) with 90% (n=208) identifying as either midwives, nurses, or nurse-midwives. Health cadres were defined by national licensing requirements in each country. Among these providers, at baseline, 63% (n=146) reported that they had not received formal clinical training on FGM prevention and care (Table 2). Almost two-thirds (64%, n=149) reported that they had received training on communication/counselling while half (51%, n=118) had received training on person-centered care. Further, 54% (n=126) of female providers reported that they had undergone FGM while overall, 94% (n=217) of providers reported that they had never performed FGM. These characteristics were not different when compared to the ANC providers who were on duty in the 180 ANC clinics enrolled at baseline (Annex 2). The mean age of the 1,800 clients exiting their first ANC visits at baseline was 26 years (SD: 6 years), 47% (n=846) reported not having received any education, and 73% (n=1,320) reported that they had undergone FGM. These characteristics were similar to the 880 and 1,630 first visit. ANC clients interviewed at month three (intervention arm only) and month six, respectively (*Table 3*).

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To evaluate potential bias from differential selection of providers receiving the intervention, we assessed differences in baseline characteristics between the 133 ANC providers from intervention facilities who were screened at baseline and received PCC training at month three (i.e., included in the analytic sample) versus the 97 who were screened and did not receive the intervention (i.e., excluded from analytic sample). The reasons for this included the fact that some of the providers had been transferred from the study clinics or could not be released to attend the training so as not to affect service delivery. Both groups were similar in terms of sex, educational level, professional cadre, as well as whether they had undergone or recently performed FGM. However, included providers tended to be slightly younger (by two years on average) and less likely to be of Muslim religion, although the question on religion was not administered for the Somalia sample since all respondents were assumed to be Muslim (Annex 3).

ANC providers implementation of ABCD elements of the PCC approach

Table 4 presents the analysis of study outcomes by arm at month six. Compared to ANC

Table 4 presents the analysis of study outcomes by arm at month six. Compared to ANC providers in the control arm, those in the intervention arm were nearly nine times as likely to ask their clients if they had undergone FGM (OR: 8.9, 95% CI: 6.9-11.5; p<0.001), nearly ten times as likely to ask their clients' personal beliefs regarding FGM (OR: 9.7, 95% CI: 7.5-12.5; p<0.001), more than nine times as likely to discuss with their clients why FGM should be prevented (OR: 9.2, 95% CI: 7.1-11.9; p<0.001) and nearly eight times as likely to discuss with their clients how FGM could be prevented (OR: 7.7, 95% CI: 6.0-9.9; p<0.001). Further, ANC clients in the intervention arm were nearly seven times as likely to report that they were satisfied with how FGM had been addressed by their provider during the clinic visit compared to those in the control arm (OR: 6.6, 95% CI: 5.1-8.4; p<0.001). In the intervention arm, the mean score of implementing the ABCD elements of the PCC approach was more

than twice as likely (OR: 2.1, 95% CI: 1.6-2.6; p<0.001) to be higher in the intervention [3.9 (3.8-4.0)] compared to the control arm [1.6 (1.5-1.8)].

# ANC clinic preparedness to provide FGM prevention and care services

A significantly higher proportion of ANC clinics in the intervention arm had all correct repornses to facility preparedness to provide FGM prevention and care services compared to those in the larm (68% vs. 27%, p<0.001). Additionally, ANC clinics in the intervention arm had a cantly higher mean score for preparedness compared to those in the control arm [3.4 (95% CI: 5) vs. 2.6 (95% CI: 2.4-2.9; p<0.001)].

\*\*Providers utilizing level one intervention components\*\*

A higher proportion of ANC providers in the intervention arm reported having utilized the level. related to facility preparedness to provide FGM prevention and care services compared to those in the control arm (68% vs. 27%, p<0.001). Additionally, ANC clinics in the intervention arm had a significantly higher mean score for preparedness compared to those in the control arm [3.4 (95% CI: 3.2-3.6) vs. 2.6 (95% CI: 2.4-2.9; p<0.001)].

# ANC providers utilizing level one intervention components

one intervention package components compared to those in the control arm (83% vs. 56%, p<0.001). In multivariable analyses, ANC providers in the intervention arm were nine times as likely to report having utilized the level one intervention package components compared to those in the control arm (AOR: 9.3. 95% CI: 4.2-20.8; P<0.001).

ANC providers offering appropriate FGM prevention and care services

At month six, based on a cumulative score to specific questions on provision of appropriate

FGM-related prevention and care services, a higher proportion of ANC providers in the intervention arm reported that they had provided FGM prevention and care services correctly compared to those in the control arm (45% vs. 34%, p=0.03).

ANC providers' confidence, self-efficacy, and communication skills

A higher proportion of ANC providers in the intervention arm reported being confident in their

knowledge to provide FGM prevention and care services compared to those in the control arm (98% vs. 89%, p=0.005). In multivariable analysis, ANC providers in the intervention arm had more than six

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times the odds of reporting being confident in their knowledge to provide FGM prevention and care services compared to those in the control arm (AOR: 6.3, 95% CI: 1.4-28.9; p=0.02). Self-efficacy was generally high (scores 7.4 – 7.8 out of 8) with no significant difference in high scores between study arms (85% vs. 82%, p=0.36 and OR: 0.8, 95% CI: 0.4-1.6); p= 0.50).

# ANC providers' knowledge, attitudes and support for FGM/medicalized FGM

The mean correct scores for FGM-related knowledge were higher among ANC providers in the intervention arm compared to the control arm (2.5, 95% CI: 2.2-2.8 vs. 1.9, 95% CI: 1.7-2.2; p=0.005) but 8% vs. 2% (p=0.16) had correct responses on the FGM-related knowledge questions, showing low knowledge overall, and particularly on the FGM typology. Providers had similarly unsupportive attitudes towards FGM in both groups and similarly unsupportive attitudes about medicalized FGM with most providers reporting that they did not support FGM (82% vs. 85%, p=0.73) and/or medicalized FGM (72% vs. 73, p=0.94%).

# ANC clients' support for FGM, intention to have their daughters undergo FGM and being involved in FGM prevention efforts

Compared to those in the control arm, a higher proportion of ANC clients in the intervention arm reported being less supportive of FGM after their month six clinic visit (52% vs. 29%, p<0.001). In multivariable analysis, ANC clients in the intervention arm had more than twice the odds of reporting that they were strongly opposed to FGM (AOR: 2.4, 95% CI: 1.1-5.2; p=0.023, ICC: 0.61). When asked about their support for FGM after the ANC visit compared to before, clients in the intervention arm had more than five times the odds of being less supportive of FGM compared to those in the control arm (OR: 5.4, 95% CI: 2.4-12.4; p<0.001, ICC:0.66). ANC clients in the intervention clinics had lower odds of intending to have their daughters undergo FGM (OR: 0.3, 95% CI: 0.1-0.7; p=0.004, ICC: 0.60) or of wanting a health care provider to perform FGM (OR: 0.2, 95% CI: 0.1-0.5; p<0.001, ICC: 0.54) and

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higher odds of reporting that they wished to be active in FGM prevention (OR: 3.2, 95% CI: 1.6-6.2, p=0.001, ICC: 0.50).

To understand the impact of the level one intervention relative to the level two intervention, a comparison of study outcomes restricted to the intervention arm was done between baseline and month three and between months three and six (Annex 3). Although not statistically powered for this analyses, we found that a significantly higher proportion of ANC clients in the intervention arm reported that their provider had asked about the different PCC components at month three versus basleine and at month six versus month three. Similarly, a significantly higher proportion of ANC clinics in the intervention arm were prepared to provide FGM-related prevention and care services at month three compared to baseline and at month six compared to month three. No statistically significant differences were seen in the proportion of ANC providers with the secondary outcomes apart from high confidence scores seen between month six and month three. Finally, ANC client outcomes were significantly higher among intervention clients in month three versus baseline and in month six versus month three.

### **DISCUSSION**

The results of this cluster randomized trial show that an intervention to strengthen health facility greater preparedness while building skills of ANC providers to communicate using a person-centred counselling technique on FGM prevention was effective. ANC providers exposed to the intervention had increased confidence, improved FGM-related knowledge, and effective delivery of FGM prevention and care services. Additionally, ANC clients who had received care from these providers were less supportive of FGM and had reduced intentions to perform FGM on their daughters. This study provides evidence of a practical intervention to engage health care providers in FGM abandonment efforts whilst also providing quality care to FGM survivors. This study provides evidence of how to effectively build the capacity of

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health care providers at primary care to address FGM(26), an area identified as a critical gap during the formative research.

The PCC training modules strengthened ANC providers' skills on FGM prevention and care and helped to clarify their beliefs and attitudes, which are key drivers of FGM (27). We did not find notable changes in knowledge and attitudes among ANC providers. The knowledge scores overall were low, and upon further investigation, it appears that questions on typology captured through visually drawn images on a tablet device were consistently answered incorrectly. These results perhaps show measurement and knowledge limitations but do not necessarily relate to service provision or quality of care. Attitudes in the intervention and control groups were generally unsupportive of FGM and do not appear to be heavily impacted by the training intervention. Exposure to the intervention package also did not improve ANC providers' self-efficacy towards FGM prevention and care. This may be related to the lack of support for FGM and/or its medicalization and high self-efficacy among nearly all providers throughout the study in both study arms, a finding that was also noted in formative research conducted in Guinea (28,29). In the formative phase, while the vast majority of health workers were opposed to the practice. 38% also felt that FGM limited promiscuity and 7% believed that it was a good practice, showing ambivalence and complexity in attitudes about FGM among health providers. Other studies have found that some providers support the perpetuation of the practice and even planned to have their own daughters undergo FGM or to perform it on their clients (30).

38% also felt that FGM limited promiscuity and 7% believed that it was a good practice, showing ambivalence and complexity in attitudes about FGM among health providers. Other studies have found that some providers support the perpetuation of the practice and even planned to have their own daughters undergo FGM or to perform it on their clients (30).

The findings in this study underscore the importance of addressing values and attitudes of both providers and clients as a means of achieving positive behavioral change. Changes observed among ANC providers were sustained across the study duration and ultimately, and importantly, resulted in reported changes in attitudes and intentions of their clients. However, this study design did not allow us

to determine whether the attitudinal changes observed among ANC clients were sustained after their clinic visit or translated into positive change in FGM prevention.

The application of these study results into programming will need to consider several factors. Firstly, the study sites were primary care facilities located in high FGM prevalence settings. The results of this intervention may not be generalizable to settings where FGM is less prevalent or to settings other than primary care. Secondly, first ANC visits are not typical of other health visits since the consultation is generally longer with a greater focus on health promotion messaging. While this is an ideal setting for implementing such an intervention, its application to other health settings and among other population groups is not known. During scale up, if the PCC approach is applied among clients seeking other sexual and reproductive health services or parents bringing their children to child immunization and wellness visits, it will be important to consider time requirements for the delivery of the 'ABCD' steps, especially in high volume clinic settings.

Thirdly, while the study found a positive impact of the PCC training on health care providers' delivery of person-centred FGM prevention counselling, the continuity and quality of FGM prevention counselling in the long-term is not known. Specifically, it will be important to assess subsequently whether providers will continue to provide prevention counselling on an ongoing basis, whether they will share their learnings with family and community members and whether clients will follow through with their intentions to not have their daughters undergo FGM. It may be important to include a supervisory mentorship component to ensure implementation of this intervention (31) in order to strengthen PCC communication practice and quality.

### Limitations

data mining, Al training, and similar technologies

The implementation of this multi-country study was not without challenges and limitations. First, initiation of field data collection activities was delayed by the global COVID-19 pandemic in 2020 – 2021 and required some modification to trainings of the data collection teams, the master trainers and

the ANC providers receiving the PCC intervention. This may have impacted the overall effectiveness of the intervention.

Second, to attempt to ensure participation of at least one provider at each site, all providers were pre-screened at baseline and clinic rotation schedules determined enrollment into the study. Selection bias might have been introduced through this process. The exploratory analysis to assess for selection and attrition bias from the pre-screen step, did not reveal significant differences between included and excluded health workers except for slightly lower age (Supplementary file 4), and a per protocol analysis required, but it is possible that differences in other unmeasured factors related to the clinics and providers might have biased the results. Findings from a process evaluation conducted as part of this and data mining, Al training, and similar technologies study will provide additional insights on the feasibility, acceptability, appropriateness, and fidelity of the intervention implementation in these contextual settings to inform further implementation and scale up.

Third, we did not perform adjustment for multiple testing in our analysis given that the different tests are interpreted separately and no overall conclusion will be stated. Given that the null hypotheses of no differences are true, we estimate that the overall type one error rate is higher than the individual test level of 0.05.

Finally, we acknowledge that there are many factors that could impact FGM-related decisionmaking and a positive and impactful interaction with a respected health care provider might not be sufficient to lead to actual changes in community behavior. However, the study design enabled us to compare similar sites to identify the relative effect of this approach since both intervention and control sites would be exposed to similar factors, and clients at these sites would face similar complexities in decision-making.

# Conclusion

In conclusion, this study highlights the importance of addressing the values and beliefs of health care providers working at primary care level, who are subject to social norms around FGM that may conflict with medical ethics and national laws and policies as an intermediary step in preventing FGM. Empowering these health care providers with communication skills and engaging them as opinion leaders can be impactful in changing their clients' attitudes towards FGM. In conjunction with FGM prevention activities in other sectors, this intervention can contribute to positive change if brought to scale.

DECLARATIONS

Contributors

WA and CP conceptualized the study and prepared the protocol in collaboration with VM, KS, PN, TE, MDB, AMS, AD(1) and MAA. MDB, AMS, AOS, PN, TE, JMK, AD(1) and MAA provided oversight over study implementation while AD(2), JK and SA monitored data quality in countries and KN and SST monitored data quality across countries. VM prepared the first draft of the manuscript with input from WA and CP, the responsible officer of the study at WHO/HRP. MP developed the statistical analysis plan and conducted data analysis. KS coordinated the development of the PCC for FGM prevention training. KS, PN, TE, JMK, JK, MDB, AMS, AOS, AD(1), AD(2), SA, and MAA contributed to and reviewed the manuscript for proper intellectual content. All authors read and approved the final draft of this manuscript.

Declaration of interests

The authors declare that they have no competing interests.

Data sharing

De-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP e

# **Funding statement**

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# **Ethics approval:**

The following research ethics committees approved the protocol:

- 1. World Health Organization (WHO) Ethical Review Committee (ERC) (#P151/03/2014).
- 2. Kenya: Kenyatta National Hospital/University of Nairobi ERC (P805/09/2019) and the National Commission for Science, Technology, and Innovation (NACOSTI/P/20/5721)
- 3. Somalia: the Department of Planning, Policy and Strategic Information, Unit of Research (MOHD/DG: 2/11526/2019)
- 4. Guinea: the Comité National d'Ethique Pour la Recherche en Santé (CNERS) (105/CNERS/19).

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### **TABLES & FIGURES:**

Figure 1: Study CONSORT Diagram

**Table 1:** Characteristics of ANC clinics included in month six analyses

**Table 2:** Characteristics of ANC providers included in the month six analyses

**Table 3:** Characteristics of ANC clients interviewed at each time point

**Table 4:** Analysis of study outcomes

### SUPPLEMENTARY FILES

**Supplementary file 1:** Theory of change framework

**Supplementary file 2:** Measurement of study outcomes

**Supplementary file 3:** Data collection instruments

**Supplementary file 4:** Additional analyses (Appendices 1-3)

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**Table 1:** Characteristics of ANC clinics included in month six analyses

Characteristics	Overall (n=163*)	Intervention (n=82)	Control (n=81)
Number of ANC providers	Mean 4 (SD: 3) Median 3 (1-14, IQR 3)	$\vec{z}_{3}$	Mean 4 (SD: 3) Median 3 (1-14, IQR 4)
Average number of ANC clients/month	Mean 150 (SD: 127) Median 118 (3-664, IQR 141)	, , , , , , , , , , , , , , , , , , ,	Mean 152 (SD: 133) Median 120 (3-664, IQR 140)
MoH supervisory visits in the past year	Mean 4 (SD: 3) Median 3 (0-18, IQR 2)	Mean 4 (SD: 3) Median 4 (1-18, 19)	Mean 4 (SD: 3) Median 3 (0-12, IQR 2
Size of catchment population served	Mean 36,754 (SD: 126,082) Median 15,972 (1,000-1,458,000, IQR 24,332)	_ · · · · · · · · · · · · · · · · · · ·	
Presence of anti-FGM activities in the catc	hment area	age ct a	•
Yes	74 (45%)	43 (5 <b>22</b> / <b>a</b> ) 2	31 (38%)
No	89 (55%)	39 (4 <b>8</b> ∕ <b>5 5</b>	50 (62%)
Presence of pro-FGM activities in the catcl	nment area	ta (AE	
Yes	21 (13%)	12 (1 🕏 🣆	9 (11%)
No	140 (86%)	68 (8 <b>葉</b> 省)	72 (89%)
Don't Know	2 (1%)	2 (2%)	0 (0%)

<sup>\*</sup>Total of 17 ANC clinics not included: 16 clinics were excluded (7 intervention and 9 control) due to loss-to-follow up (LTFU) of ANC provider i.e., the clinics of an one of the clinics in Kenya was never visited at subsequent time points due to issues with insecurity. An ANC provider from one of the clinics in Kenya that had been inaccessible due to insecurity attended the PCC training and was subsequently interviewed.

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**Table 2:** Characteristics of ANC providers included in the month six analyses

Γ <b>able 2:</b> Characteristics of ANC pr		NJ Open 1 six analyses	136/bmjopen-2023-078 cted by copyright, includ
Characteristics	Overall (n=232)	Intervention (n= 115)	äCorerol ∃n=+17)
Age	Mean 36 (SD: 10) Median 34	Mean 35 (SD: 10) Median 33	Mean 37 (SB:11) Median 35
rige	(20-65, IQR 15)	(20-59, IQR 14)	20-65, IQR 16)
Years of professional experience	Mean 8 (SD: 7) Median 6 (1-39,	Mean 8 (SD:7) Median 6 (1-30,	Mean 8 (S <b>D</b> : <b>D</b> ) Median 6 (1-39.
	IQR 7)	IQR 8)	IOR 7)
Sex	(== 1)	(== =)	ela ela
Female	193 (83%)	95 (83%)	Mean 8 (See 17) Median 6 (1-39, 1QR 7)  Mean 8 (See 17) Median 6 (1-39, 1QR 7)  Poly Median 6 (1-39, 1Q
			j to
Highest educational level	Uh		t s
Certificate	21 (5%)	12 (10%)	x u o o o o o o o o o o o o o o o o o o
Diploma	158 (68%)	72 (63%)	anceried 86 (74%)
Bachelors	44 (19%)	27 (24%)	a To 17 (15%)
Masters & above	1 (0.4%)	0 (0%)	<b>a a b a</b> 1 (1%)
Other#	8 (3%)	4 (3%)	3.₩ 4 (3%)
Current professional role/title			nin
Midwife	103 (44%)	53 (46%)	<u>ت</u> 50 (43%)
Nurse	51 (22%)	25 (22%)	<b>≥ 5</b> 26 (22%)
Nurse-Midwife	54 (23%)	27 (24%)	<u>a</u> 27 (23%)
Other	24 (10%)	10 (9%)	목· <b>늘</b> 14 (12%)
Received formal training on FGM during	g clinical training		, <del>1</del>
Yes	85 (37%)	44 (38%)	<b>an o</b> 41 (35%)
No	146 (63%)	71 (62%)	<b>s</b> 75 (64%)
Don't Know	1 (0.4%)	0 (0%)	75 (64%)  1 (1%)  1 (1%)  1 (1%)  1 (1%)  1 (1%)  1 (1%)  1 (1%)  1 (1%)  2 (20%)  3 (3%)  9 (3%)  9 (3%)  9 (3%)  1 (62%)
Timing of clinical training on FGM			Jur lar
Pre-service	33 (14%)	18 (16%)	<b>6 6</b> 15 (13%)
In-service	45 (19%)	22 (19%)	ਤੋਂ <mark>ਤੌ</mark> 23 (20%)
Both pre- and in-service	7 (3%)	4 (4%)	<u>o</u> 80 3 (3%)
Received formal training on communicat			ogie
Yes	149 (64%)	76 (66%)	73 (62%)
No	83 (36%)	39 (34%)	44 (38%)
Received formal training on person-center			one.
Yes	118 (51%)	58 (50%)	60 (51%)
No	113 (56%)	56 (49%)	57 (49%)
Don't know	1 (0.4%)	1 (1%)	<b>li</b> 0 (0%)
<u>Undergone</u> FGM			95. at 73 (62%) 44 (38%) 96. 60 (51%) 97. 60 (0%) 98. 60 (51%) 99. 60

Yes	126 (54%)	65 (57%)	7,
No	63 (27%)	27 (24%)	2
Don't know	2 (1%)	2 (2%)	2
Refused to answer	2 (1%)	1 (1%)	ď
onducted FGM			7
Yes	15 (7%)	9 (8%)	\$
onducted FGM on a girl <18 years			
Yes	14 (6%)	8 (7%)	

61 (52%)

36 (31%)

0 (0%)

1 (1%)

6 (5%)

6 (5%)

Table 3: Characteristics of ANC clients interviewed at each time point

Characteristics	at Baseline			ANC clients interviewed at Month 3	8771 o	ANC clients interviewed at Month 6			
	Overall (n=1800)	Intervention (n=900)	Control (n=900)	Intervention only (n=880)	Overall 5 (n=1259) 4	Intervention (n=879)	Control (n=880)		
Age	Mean 26 (SD: 6) Median 25 (15- 45, IQR 10)	Mean 25 (SD: 6) Median 25 (15- 45, IQR 10)	Mean 26 (SD: 6) Median 25 (15- 45, IQR 10)	Mean 26 (SD 6) Median 25 (15-45, IQR 10)	178771 on 4 July 2015 (n=1752025 for Appending Mean 26 (appending Median) 15-4	Mean 26 (SD: 6) Median 25 (15- 45, IQR 9)	Mean 26 (SD: 6) Median 25 (15- 45, IQR 10)		
Highest educational			, , , ,		e ji D	, , , ,	, , ,		
None	840 (47%)	407 (45%)	433 (48%)	439 (50%)	8 <b>%</b> ₹4 <b>\$</b> %)	384 (44%)	422 (47%)		
Primary	484 (27%)	231 (26%)	253 (28%)	239 (27%)	5 <b>\$ £3\$</b>	278 (32%)	275 (31%)		
Secondary	331 (18%)	171 (19%)	160 (18%)	157 (18%)	306618%)	160 (18%)	146 (16%)		
University	95 (5%)	61 (7%)	34 (4%)	25 (3%)	<b>₹</b>	34 (4%)	33 (4%)		
Other#	50 (3%)	30 (3%)	20 (25)	20 (2%)	8 7 (2%)	23 (3%)	14 (2%)		
Have you undergone	. , .	(- (- (- (- (- (- (- (- (- (- (- (-		- (-, -)	5%t (m/s) 5%t (m/s) 3(m/s) 13(m/s) 13(m/s) 13(m/s) 13(m/s)	- (-', 4)	(= / *)		
Yes	1320 (73%)	677 (75%)	643 (71%)	645 (73%)	132 (25%)	655 (75%)	666 (75%)		
No	452 (25%)	209 (23%)	243 (27%)	224 (25%)	420.(23%)	206 (23%)	214 (24%)		
Don't know	12 (1%)	10 (1%)	2 (0.2%)	5 (1%)	<b>3</b> 21 ( <b>7</b> %)	13 (2%)	8 (1%)		
Refused to answer	16 (1%)	4 (0.4%)	12 (10/)	((10/)	<del>7</del> (0 <del>2</del> %)	5 (1%)	2 (0.2%		
				6 (1%)	%%%%%%%%%%%%%%%%%%%%%%%%%%%%%%%%%%%%%%				
	_			.com/site/about/quidelines.x	phique de l		35		

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**Table 4:** Analysis of study outcomes

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Table 4: Analysis of study outcomes				023-(	
, , , , , , , , , , , , , , , , , , ,				0787	
Primary Outcomes		encor non		<u> </u>	
ANC clients reporting that their provide			11	Paralue	ICC
	Intervention (n=819)	Control (n=810)	Adjusted OR# (95% CI)	o 4	icc
Provider asked client if they have undergone FGM	634 (77%)	245 (30%)	8.9 (6.9-11.5)	<u> </u>	N/A
Provider asked client about the client's personal beliefs regarding FGM	616 (75%)	217 (27%)	9.7 (7.5-12.5)	© m ⊆ <0.001	N/A
Provider discussed with client why FGM should be prevented	629 (77%)	244 (30%)	9.2 (7.1-11.9)	<b>6 7 8 8 8 8 8 8 8 8 8 8</b>	N/A
Provider discussed with client how FGM could be prevented	592 (72%)	232 (29%)	7.7 (6.0-9.9)	<u> </u>	N/A
Client satisfied with how FGM was addressed by provider during clinic visit	684 (84%)	348 (43%)	6.6 (5.1-8.4)	<b>20.001 3 3 4 3 3 6 3 1 3 3 3 1 3</b>	N/A
	331(81,3)	210 (1071)	*** (*** ***)	Section   Sect	
			Difference in mean	6 <u>5</u> <u>8</u>	
			scores (95% CI)		
Mean score of implementing PCC approach (out of 5)	3.9 (3.8-4.0)	1.6 (1.5-1.7)	2.3 (2.1-2.5)	주 등 호 <0.001	N/A
Mean score of PCC + appropriate FGM prevention and care (out of 8)	6.2 (5.9-6.6)	3.7 (3.2-4.1)	2.6 (2.0-3.2)	2 P P S <0.001	N/A
				0 0 3	
ANC clinic prepared	lness to offer FGM prevent				
	Intervention	Control	Adjusted OR&	יש ש -value	ICC
	(n=82)	(n=81)	(95% CI)	3.B	
Clinics with ALL correct responses for preparedness	56 (68%)	22 (27%)	-	<0.001	N/A
M	24(2220)	2 ( (2 4 2 0)		<b>3</b> <0.001	NT/A
Mean score of clinic preparedness (out of 4)	3.4 (3.2-3.6)	2.6 (2.4-2.9)	-	<u> </u>	N/A
·	Intervention	Control	Adjusted OR&	Poalue	ICC
	(n=115)	(n=117)	(95% CI)		icc
Providers using level 1 intervention package	96 (83%)	65 (56%)	9.3 (4.2-20.8)	Palue n 3 <0.001	N/A
Troviders using level 1 intervention package	70 (6370)	03 (3070)	7.5 (1.2 20.0)	• -	17/11
				an co	
Secondary Outcomes*				<b>(0</b>	
Providers with appropriate interpersonal communication skills	74 (64%)	68 (58%)	1.7 (1.0-3.0)	<b>3</b> 0.060	N/A
Providers with high self-efficacy	86 (75%)	99 (85%)	0.8 (0.4-1.6)	0.453 ے	N/A
Providers reporting less supportive attitudes towards FGM	76 (66%)	85 (73%)	1.0 (0.5-1.8)		N/A
Providers with high confidence scores	103 (90%)	104 (89%)	6.3 (1.4-28.9)		N/A
Providers not supportive of FGM	100 (87%)	114 (97%)	0.8 (0.2-3.7)	β ω 0.726	N/A
Providers not supportive of medicalized FGM	104 (90%)	116 (99%)	1.1 (0.1-22.1)	0 0.938 0 0.16	N/A
Providers with correct FGM-related knowledge responses	8 (8%)	1 (2%)	5.0 (0.5-47.8)	<b>9 1</b> 0.16	N/A
		` /	, ···)	es at	
Mean score of FGM-related knowledge (out of 6)	2.5 (2.2-2.8)	1.9 (1.7-2.2)		<b>6</b> 0.005	N/A
ivicali score di l'Oivi-telateu kilowieuge (out 01 0)	2.3 (2.2-2.8)	1.7 (1.7-2.2)	-	7 0.005 9 0.005	1N/A
OIL ANG P. 4. 4 **				<del></del>	
Other ANC client outcomes**	Intervention	Control	Adjusted OR&	P-walue	ICC
	(n=819)	(n=810)	(95% CI)	5	
Clients reporting less support for FGM after ANC clinic visit	(n=819) 424 (52%)	(n=810) 237 (29%)	(95% CI) 5.4 (2.4-12.4)	0.023	0.66

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				öpyri	pen-	
				igh	20	
Clients reporting that they intend to have their daughters cut	96 (12%)	209 (26%)	0.3 (0.1-0.7)	t,	ü 0.004	0.60
Clients reporting that they would prefer health care provider to cut daughters	53 (7%)	139 (17%)	0.2 (0.1-0.5)	Ĭ	<b>9</b> <0.001	0.54
Clients wishing to be active in FGM prevention	677 (83%)	535 (66%)	3.2 (1.6-6.2)	пį	<b>8</b> 0.001	0.50

ICC = Intra-cluster Correlation Coefficient

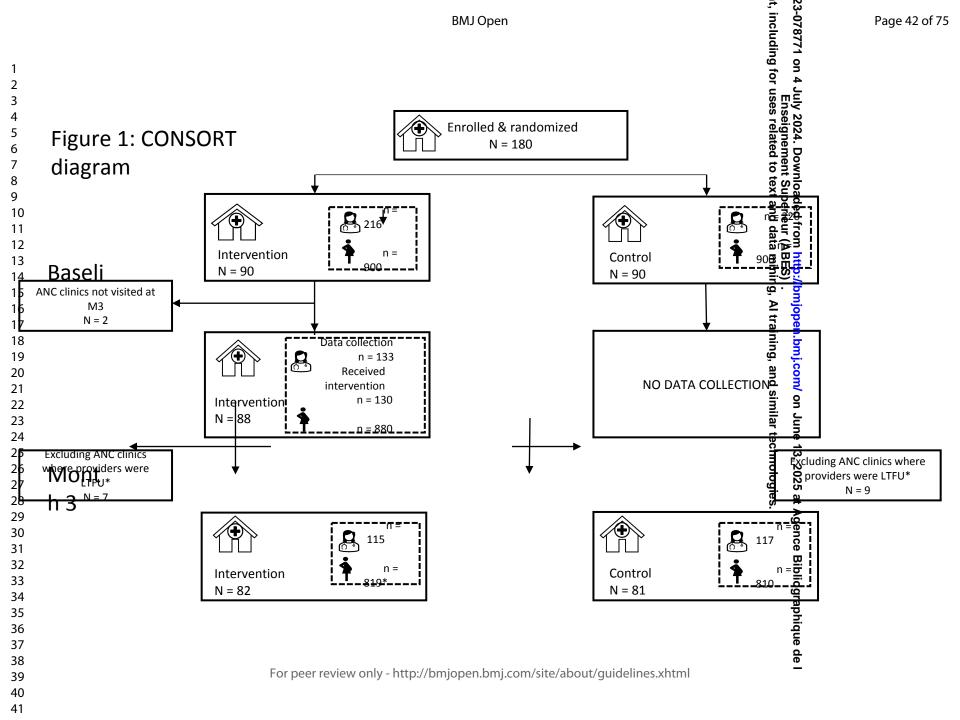
<sup>#</sup>Single-level multi-variable adjusted models

<sup>&</sup>amp;Multi-level multi-variable adjusted models

<sup>....</sup>and level, FGM status and exposure to level one IEC materials \*Provider outcomes adjusted for sex, years of service, FGM status, FGM-related training, any specific training on communication/counseling and PCC, and the past

<sup>\*\*</sup> Client outcomes adjusted for age, educational level, FGM status and exposure to level one IEC materials

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### **INTERVENTION PACKAGE** (Health systems)

- Health policy against **FGM** medicalization
- Information, education and communication (IEC) materials in clinics
- Job aides and checklist



#### **HEALTH SYSTEM FACTORS**

- Low knowledge and skills in prevention and care
- Non-availability of tools / aides / IEC material
- Lack of policies
- Lack of supervisory support



#### INDIVIDUAL FACTORS

- Low self-efficacy on FGM prevention
- Attitude toward FGM and its medicalization
- Lack of training on communication / counseling

# **INTERVENTION PACKAGE** (Provider-focused)

Using interactive methods and education outreach for

- Values clarification on FGM
- Patient-centered communication skill building



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- erson-centred communication
- Killion Hattitudes against FGM aining.

**DELIVERY OF FGM PREVENTION MESSAGES** 

#### CLIENTS

- Reduced support for FGM
- Greater intention to abandon FGM
- Be more active in FGM abandonment



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### Supplementary file 2: Measurement of study outcomes

**1. Primary Outcome:** Health facility preparedness to provide FGM prevention and care services.

**Outcome definition**: Cumulative score based on affirmative responses to Q9a, Q10a, Q11a & Q12a on the CHK form (see below).

```
Q9. Is there an MoH policy on FGM posted on the wall?
```

Yes

1 2 3

4 5

6 7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23 24

25

26

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29 30

31

32 33 34

35

36

37

38 39

40 41

42

43

44

45

46

47 48 49

50

51

52

53

54 55

56

57

58

59

60

No

Q9a. If yes, is it placed where health care providers can see/read it e.g., bulletin board?

Yes

No

Q10. Are there WHO FGM prevention posters on the wall of the consultation room and/or waiting room?

Yes

No

Q10a. If yes, are they placed in a place where ANC clients can see them?

Yes

No

Q11. Is there a WHO clinical handbook in the ANC consultation room?

Yes

No

Q11a If yes, is it placed where ANC providers can see/use it?

res

No

Q12. Is there an FGM ABCD guide in the ANC consultation room?

Yes

No

Q12a. If yes, is it placed where ANC providers can see/use it?

Yes

No

# 2. Primary outcome: ANC provider utilization of Level 1 package components

Outcome definition: Affirmative response on Q40 of HCP form (see below).

```
Q40. Have you referred to the WHO Clinical Handbook on FGM?
```

Yes

No, available but not referred

No, not available

Don't know

### 3. Primary outcome: Provision of FGM-related care after PCC training

**Outcome definition:** Cumulative score based on affirmative responses (Provision of FGM-related care (after PCC training) either 'Always' or 'Often') on Q22, Q24 & Q25 on the HCP form (see below).

Q22. How often do you discourage a pregnant woman expecting to have a girl, or one having a girl at the age of cutting, from having her daughter cut?

**Always** 

Often

Sometimes

Rarely

4

5

6

7

8

9

11

13

21

23

24

27

31

37

49

51

```
Never
                             Rarely
                             Refused to answer
                     Q24. How often do you look for female genital mutilation when performing a gynecological
             examination of the vulva?
                             Always
                             Often
10
                             Sometimes
12
                             Rarely
                             Never
14
                             Rarely
15
                             Refused to answer
16
                     Q25. How often do you record female genital mutilation in the woman's medical file if you
17
             are aware that she has undergone FGM?
18
19
                             Always
20
                             Often
                             Sometimes
22
                             Rarely
                             Never
                             Rarely
25
                             Refused to answer
26
                 4. Primary Outcome: Delivery of PCC 'ABCD' package
28
29
             Outcome definition: Cumulative score based on affirmative responses on Q5, Q7, Q8, Q9 &
30
             Q12 on the EXT form.
                     Q5. Did the ANC provider ask if you have undergone FGM?
32
                             Yes
33
                             No
34
35
                             Don't know
36
                             Refused
                     Q7. Did the ANC provider ask about your personal belief regarding FGM?
38
                             Yes
39
                             No
40
                             Don't know
41
                             Refused
42
                     Q8. Did the ANC provider discuss why FGM should be prevented?
43
                             Yes
44
45
                             No
46
                             Don't know
47
                             Refused
48
                     Q9. Did the ANC provider discuss how FGM could be prevented?
                             Yes
50
                             No
                             Don't know
52
                             Refused
54
                     Q12. Are you satisfied with how FGM was addressed during your visit with your ANC provider
55
             today?
56
                             Yes
57
                             No
58
                             Don't know
59
                             Refused
60
```

# 5. Secondary Outcome: Improved knowledge about FGM

**Outcome definition:** Cumulative score based on correct responses to Q4 + affirmative responses to Q5 & Q7 of the HCP form.

```
Q4. Please provide the WHO classification for the following images
```

```
Type I
```

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23 24 25

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58 59

60

Type II

Type III

Type IV

Don't Know

Other

Q5. Do you know of any health complications arising from female genital mutilation?

Yes

No

Q7. Are you aware of any existing WHO tools/guidance on FGM prevention and care?

Yе

No

# 6. Secondary Outcome: Improved interpersonal communication skills

**Outcome definition:** Cumulative score based on positive responses ("Always or Often") to Q34, Q35, Q36, Q37, Q38 on the HCP form.

Now I will ask you about your communication skills

34. I can put myself in others shoes

Always

Often

Sometimes

Rarely

Never

Rarely

Refused to answer

35. I let others know that I understand what they say

**Always** 

Often

Sometimes

Rarely

Never

Rarely

Refused to answer

36. In conversations with my colleagues, I perceive not only what they say but what they don't say

**Always** 

Often

Sometimes

Rarely

Never

Rarely

Refused to answer

37. I communicate effectively

Always

Often

```
Sometimes
Rarely
Never
Rarely
Refused to answer

38. I communicate with others as though they are my equals
Always
Often
Sometimes
Rarely
Never
Rarely
Refused to answer
```

# 7. Secondary outcome: Improved self-efficacy

**Outcome definition:** Cumulative score based on positive responses (Agree or Strongly Agree) to Q26, Q27, Q28, Q29, Q30, Q31, Q32, Q33 on the HCP form.

Now I would like to ask you a few questions about how you solve problems that you face. Please tell me how much you agree or disagree with the statements that I read to you

```
1 = Strongly disagree
```

- 2 = Disagree
- 3 = Neither agree nor disagree
- 4 = Agree
- 5 = Strongly agree
- Q26. I will be able to achieve most of the goals that I have set for myself
- Q27. When facing difficult tasks, I am certain that I will accomplish them
- Q28. In general, I think that I can obtain outcomes that are important to me
- Q29. I believe that I can succeed at almost any endeavor to which I set my mind
- Q30. I will be able to successfully overcome many challenges
- Q31. I am confident that I can perform effectively on many different tasks
- Q32. Compared to other people, I can do most tasks very well
- Q33. Even when things are tough, I can perform quite well

### 8. Secondary outcome: Improved attitudes towards FGM

**Outcome definition**: Cumulative score based on positive responses to Q12, Q13, Q14, Q15, Q16, Q17, Q18 & Q19 on the HCP form.

For each of the following statements please state if you:

```
1=Agree
```

- 2=Disagree
- 3=Don't know
- 4=Refused to answer
- Q12. A girl who has not undergone FGM is unclean
- Q13. A girl who has not undergone FGM cannot be married within her community
- Q14. A girl who has not undergone FGM is a disgrace to her family's honor
- Q15. Health care providers who provide FGM are violating FGM
- Q16. Health care providers who provide FGM should be punished
- Q17. FGM is a good practice
- Q18. FGM is a violation of women and girls' rights
- Q19. FGM is religious mandate

9. Tertiary outcome: ANC provider confidence in FGM knowledge to provide care
Outcome definition: Positive responses ('Somewhat Confident' or 'Confident') to Q8 & Q9 on
the HCP form

Q8. When you treat or attend to a girl or woman with female genital mutilation, how confident are you that you have enough knowledge to provide good quality care?

1=Not confident

2=Somewhat confident

3=Confident

6

7 8

9

10

11

12

13

14

15

16 17

18

19

20

21 22

23

24 25

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40 41

42 43

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53 54 55

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59

60

4=Refused to answer

Q9. How confident are you in your knowledge to communicate on FGM prevention?

1=Not confident

2=Somewhat confident

3=Confident

4=Refused to answer

# 10. Tertiary outcome: ANC provider support for FGM

**Outcome definition:** Positive response ('Do not intend to cut her') to Q20 on the HCP form Q20. Pretend you had a daughter now who was at an age when cutting occurs, what would your intention to cut her be?

1=Intend to cut her

2=Do not intend to cut her

3=Don't know

4=Refused to answer

### 11. Tertiary outcome: ANC provider support for medicalized FGM

Outcome definition: Correct response ('No') to Q21 on HCP form

Q21. If a family brought their daughter to the clinic requesting genital cutting, for non-health reasons, would you perform it?

1=Yes

2=No

3=Don't know

4=Refused to answer

# 12. Tertiary outcome: ANC client change in support for FGM after ANC visit

**Outcome definition:** Response to Q13 on EXT form

Q13. What do you feel about FGM now as compared to before you came to the clinic today?

1= Same, no change

2=I feel more supportive of FGM now as compared to before I came

3=I feel less supportive of FGM now as compared to before I came

4=Don't know

5=Other

6=Refused to answer

# 13. Tertiary outcome: ANC client support or opposition to FGM

Outcome definition: Response to Q14 on EXT form

Q14. How supportive are you of female genital mutilation?

1=Strongly opposed

2=Somewhat opposed

3=Neutral 4=Somewhat supportive 5=Strongly supportive 6=Refused to answer

#### 14. Tertiary outcome: ANC client intention to cut after ANC visit.

#### **Outcome definition:** Response to Q16 on EXT form

Q.16 Pretend you had a daughter now who was at an age where cutting occurs, what would your intention to cut her be?

1=Intend to cut her 2=Do not intend to cut her 3=Don't know 4=Refused to answer

#### 15. Tertiary outcome: ANC client choice of who to cut their daughters.

#### **Outcome definition:** Response to Q17 on EXT form

Q17. If intending to cut, who would you prefer to do the cutting?

1=Traditional practitioner 2=Health care provider 3=Other 4=Refused to answer

#### 16. Tertiary outcome: ANC client wish to be active in FGM prevention

#### **Outcome definition:** Response to Q18 on EXT form

Q.18 Do you wish/want to be active in preventing FGM?

2=No 3=Don't know 4=Refused to answer

1=Yes

#### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

#### ANC PROVIDER SCREENING QUESTIONNAIRE (SCR)

Participant ID:

	Project ID: Country ID: Facility ID:
Instruct	ions: Observe and report findings from the health facility.
1.	MoH policy on FGM posted on the wall?  ☐ Yes ☐ No  1a. If yes, is it placed where health care providers can see/read it e.g. bulletin board? ☐ Yes ☐ No
2.	Are there FGM prevention posters on the wall of the waiting room? ☐ Yes ☐ No  2a. If yes, is it placed in place where ANC clients can see it ☐ Yes ☐ No
3.	Is there WHO FGM Clinical Handbook in the ANC consultation room? ☐ Yes ☐ No  3a. If yes, is it placed where ANC provider can see /use it? ☐ Yes ☐ No
4.	Is there FGM ABCD guide in ANC consultation room?  ☐ Yes ☐ No  4a. If yes, is it placed where ANC provider can see /use it ☐ Yes ☐ No
	ions: Assess health facility factors that may facilitate/constrain intervention delivery by reviewing health facility administrative and notes and by meeting with the health facility manager.
5.	Number of ANC providers
6.	Average number of ANC clients per month
7.	Number of ANC providers trained on PCC on FGM prevention  All (specify number trained):  Some (specify number trained):  None
8.	Indicate the number of MoH supervisory visits to the clinic in the past year

## A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993) ANC PROVIDER SCREENING QUESTIONNAIRE (SCR)

Participa Participa	ant ID:		
<u> </u>		Project ID:	Country ID: Facility ID:
Version 2 – 18 <sup>th</sup> October 2019			
A 6	5 9 9 3		
9. How frequently are staf	f meetings held?		
☐ Monthly	i meetings nera.		
□ Every 2 to 4 i	months		
□ Every 6 to 12			
□ Never	anonting		
10. What is the size of the p	onulation convod by this for	oilitu? (anaoifu numbar)	
_			
11. Are there country/regio	n-specific FGM laws that a	re enforced?	
□ Yes			
□ No			
12. Are there anti-FGM act	ivities that target the popul	lation served by this healt	th facility?
□ Yes			
□ No			
13. Are there pro-FGM acti	ivities that target the popul	ation served by this healt	h facility?
☐ Yes			
□ No			
Additional comments:			

#### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993) ANC PROVIDER SCREENING QUESTIONNAIRE (SCR) Participant ID: Project ID: Country ID: Facility ID: Protected by copyright, including for uses related Version 2 – 18th October 2019 3 What is your age? What is your sex? ☐ Female ☐ Male What is your religion? ☐ Muslim 2. ☐ Christian 3. □ Other 4. □ None 5. ☐ Refused What is your occupation/designation? 1. ☐ Midwife □ Nurse 2. ☐ Other, specify \_\_ What is the highest education level of education you achieved? ☐ Certificate ng, Al training, and similar technologies 2. ☐ Diploma 3. □ Bachelors 4. ☐ Masters or above 5. □ Other, specify For how many years have you been working in your field? \_ During you clinical training, did you receive any formal training on female genital mutilation? 1. ☐ Yes. ☐ No. Go to section B

☐ I don't know. Go to section B

When did you receive the training?

1. ☐ During my studies (pre-service training)

2. ☐ After graduation/at work (in-service training)

3. □ Both

2

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55 56 57

58 59

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☐ I don't know

7. ☐ Not applicable

# A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993) ANC PROVIDER SCREENING QUESTIONNAIRE (SCR)

Participant ID:		
	Project ID:	Country ID: Facility ID:
To be completed by data collector:		
Data Collector ID:	Date:	
Signature:	Day M	lonth Year
Signature:		2 0

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#### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

ANC PROVIDER SCREENING QUESTIONNAIRE (SCR)

		Participant ID:  Project ID: Country ID: Facility ID:  A 6 5 9 9 3
9.	Wl	nat was the format of the training? (Check all that apply)
	1.	☐ Classroom lessons
	2.	□ Workshops
	3.	☐ Digital format (E-learning videos; smart phone app)
	4.	☐ During clinical practice under supervision of a mentor
	5.	☐ Other, specify
	7. l	☐ Not applicable
10.	Du	ring your pre- or post- graduate training, did you receive any formal training on communication or counselling
	1.	□ Yes.
	2.	□ No.
	3.	□ I don't know
11.	Du	ring you pre or post graduate training, did you receive any formal training on person-centred care?
	1.	□ Yes.
	2.	□ No.
	3.	□ I don't know
12.	Ha	ve you ever cut the genitals of a girl (<=18 years old) for non-health reasons?
	1.	□ Yes.
	2.	□ No.
	3.	□ I don't know

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# A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993) ANC PROVIDER QUESTIONNAIRE (HCP) Participant ID:

Participant ID:		
	Project ID:	Country ID: Facility ID
To be completed by data collector:		
Data Collector ID:	Date:	
Signature:	Day M	1onth Year
		2 0
A 6 5 9 9 3		
1. Have you ever heard about female genital mutilation	on?	
□ Yes		
□No		
2. Do the women in your community undergo female  ☐ Yes	genital mutilation?	
□ No		
☐ I don't know		
3. Do you know of the WHO classification for female	genital mutilation?	
□Yes		
□ No. Skip to Q5		
4. Please provide the WHO classification for the follo	wing FGM images (to in	clude images)
a. IMAGE of Type III FGM to be inserted he	ere	
i. □ Type I		
ii. □ Type II		
iii. □ Type III		
•		
iv. □ Type IV		
v. □nDon't know		
b. IMAGE of Type I FGM to be inserted her	e	
i. 🗆 Type I		
ii. 🗆 Type II		
iii. □ Type III		
Version 2 – 6 <sup>th</sup> November 2019		
		1
To be completed by data collector:		

To be completed by data collector:

Data Collector ID:

Signature:

Day

Month

Year

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#### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

#### ANC PROVIDER QUESTIONNAIRE (HCP)

	Participant ID:		
		Project ID:	Country ID: Facility ID:
	iv. □ Type IV		
	v. □nDon't know		
	c. IMAGE of Type II FGM to be insert	ed here	
	i. 🗆 Type I ii. 🗆 Type II		
	A 6 5 9 9 3		
	iii. □ Type III		
	iv. □ Type IV		
	v. □nDon't know		
	d. IMAGE of Type III FGM to be inserted	ed here	
	i. □ Type I		
	ii. □ Type II		
	ііі. 🛘 Туре III		
	iv. □ Type IV		
	v. □nDon't know		
	e.		
5.	Do you know of any health complica	tions arising from female genital	mutilation?
	Yes		
	No. Skip to Q6		
6.	Is female genital mutilation illegal in	your country (specify actual stu	dy country)?
1.	□ Yes		
	□ No		
	☐ I don't know		
7.	Are you aware of any existing WHO		
1.	☐ Yes. If yes, please specify		
2.			
Version 2 –	6 <sup>th</sup> November 2019		
			l l

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	ANC PROVIDER	R QUESTIONNAIRE (HCP)	
	Participant ID:		
		Project ID:	Country ID: Facility ID:
8.	When you treat or attend a girl or a woma	O	n, h <del>ow confident are you t</del> hat you have
enough	knowledge to provide good quality health care?	Rate between 1 – 4	
1.	☐ Not confident at all		
2.	☐ Not very confident		
3.	☐ Fairly confident		
4.	☐ Fully confident		
	A 6 5 9 9 3		
0			FOM 41 9
9.	How confident are you in your FGM know	reage to communicate of	n FGM prevention?
e betwee	$n \ 1-4$		
	<ol> <li>□ Not confident at all</li> </ol>		
	2. □ Not very confident		
	3. □ Fairly confident		
	4. □ Fully confident		
each of	the following statements please state if you agree/	disagree or don't know.	
10.	A girl who has not undergone FGM is uncl	lean.	
1.	□ Agree		
2.	☐ Disagree		

Rat

- 3. □ I don't know
- A girl without FGM cannot be married within her community.
- ☐ Agree 1.
- 2. ☐ Disagree
- 3. □ I don't know
- 12. A girl who has not undergone FGM is a disgrace to her family's honour.
- 1. ☐ Agree
- 2. ☐ Disagree

Version 2 – 6<sup>th</sup> November 2019

To be completed by data collector:							
Data Collector ID:	Date:						
Signature:	Day	Mont	th		Υe	ar	
				2	0		

# A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993) ANC PROVIDER QUESTIONNAIRE (HCP) Participant ID:

							ANC I	PROV	IDER QU	ESTIO	NNA	IRE (I	HCP)						
			Parti	cipan	t ID:			-											
								1		Pro	ject I	D:		Cou	ntry l	D:	Facil	ity I	ID:
	3.	□ I don't k	now					<u> </u>											
	13.	Health	n care	provi	iders	who j	perfor	m F(	GM are v	violati	ing n	nedic	al ethi	ics.					
	1.	☐ Agree																	؟ ق
	2.	☐ Disagree																	
	3.	□ I don't k	now																7
	14.	Healtl	ı care	provi	iders	who j	perfor	m F(	GM shou	ıld be	puni	ished	•						Ú
	1.	☐ Agree																	
	2.	☐ Disagree	e																
			Α	6	5	9	9	3											
																			9
	3 Г	☐ I don't kno	<b>311</b> 7																9
15				•															Č
15.		M is a good	praci	ice															
	1. 2.	☐ Agree ☐ Disagree																	ì
	3.	☐ I don't k																	
1.0				c	<b>,</b>			1. 4.											9
10.		M is a viola	tion o	ı won	ien's	ana g	giris' i	ngnts	i										\$
	1. 2.	☐ Agree ☐ Disagree	a																
	3.	☐ I don't k																	
17		M is a religi		anda	ıta														g
1/.	1.	□ Agree	ious iii	anua	ite														
	2.	☐ Disagree	a,																9
	3.	☐ I don't k																	,
18.				aught	er no	w wh	o was	at ar	age wh	en cu	tting	occu	ırs. wh	at wor	ıld vo	nır iı	ntenti	on 1	to cut her be? 1.
		ntend to cut							r uge Wil	011 001	8								9
	2.	☐ Do not i		o cut	her														
	3.	☐ Undecid	ed																9
	4.	Refused to	answe	r															
19.	If a it?	family bro	ught t	heir d	laugh	iter to	) the c	linic	requesti	ng ge	nital	cutti	ng for	non-h	ealth	reas	sons,	wou	ıld you perform

Version 2 – 6<sup>th</sup> November 2019

To be completed by data collector:

Data Collector ID:

Signature:

Day Month Year

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### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

#### ANC PROVIDER QUESTIONNAIRE (HCP)

2. 3. <i>Now I would</i>	Participant ID:  Project ID: Country ID: Facility ID:  No  I don't know  like to ask you a few questions about how you solve problems that you face. Please state how much you agree or a the statements that I read, , where 1=Strongly disagree; 2=Disagree; 3=Neither agree nor disagree; 4=Agree; agree
20. I wi	ll be able to achieve most of the goals that I have set for myself.
1.	☐ Strongly disagree
2.	□ Disagree
3.	□ Neither agree nor disagree
4.	□ Agree A 6 5 9 9 3
5.	☐ Strongly agree
6.	□ Don't know
21. Wh	en facing difficult tasks, I am certain that I will accomplish them.
1.	☐ Strongly disagree
2.	□ Disagree
3.	□ Neither agree nor disagree
4.	□ Agree
5. 6.	☐ Strongly agree ☐ Don't know
	eneral, I think that I can obtain outcomes that are important to me.  Strongly disagree  Disagree  Neither agree nor disagree
Version 2 – 6	5 <sup>th</sup> November 2019
	To be completed by data collector:
	Data Collector ID:  Date:

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#### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

#### ANC PROVIDER QUESTIONNAIRE (HCP)

	ANCT NO VIDER QUESTION VALUE (NET)
	Participant ID:
	Project ID: Country ID: Facility ID
4.	□ Agree
5.	□ Strongly agree
5. 6.	□ Don't know
0.	Don't know
23. I b	elieve I can succeed at most any endeavour to which I set my mind.
1.	☐ Strongly disagree
2.	□ Disagree
3.	☐ Neither agree nor disagree
4.	□ Agree
5.	☐ Strongly agree
6.	□ Don't know
24. I w	rill be able to successfully overcome many challenges.
1.	□ Strongly disagree
2.	□ Disagree
3.	□ Neither agree nor disagree
4.	□ Agree
5.	□ Strongly agree
	A 6 5 9 9 3
6.	□ Don't know
25. I a	m confident that I can perform effectively on many different tasks.
1.	☐ Strongly disagree
2.	☐ Disagree
3.	☐ Neither agree nor disagree
4.	□ Agree
5.	☐ Strongly agree
6.	□ Don't know
Version 2 –	6 <sup>th</sup> November 2019
	To be completed by data collector:

Data Collector ID:

Signature:

Date:

Day Month Year 

#### **BMJ** Open A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993) ANC PROVIDER QUESTIONNAIRE (HCP) Participant ID: Project ID: Country ID: Facility ID: 26. Compared to other people, I can do most tasks very well. 1. $\square$ Strongly disagree 2. □ **Disagree** ☐ Neither agree nor disagree 4. **☐ Agree** 5. □ Strongly agree 6. □ Don't know 27. Even when things are tough, I can perform quite well. 1. $\square$ Strongly disagree 2. ☐ Disagree ☐ Neither agree nor disagree 4. **☐ Agree** 5. ☐ Strongly agree □ Don't know 28. Would you like to receive more training related to care for women and girls with FGM? 1. □ Yes 2. □ No ☐ I don't know 29. If a pregnant woman is expected to have a girl, do you discourage her from having her daughter cut?

Version 2 – 6<sup>th</sup> November 2019

To be completed by data collector:							
Data Collector ID:	Date:						
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#### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993) ANC PROVIDER QUESTIONNAIRE (HCP) Participant ID: Project ID: Country ID: Facility ID: □ Alway 2. ☐ Often □ Sometimes 4. ☐ Rarely 5. □ Never 30. If you heard of or saw a colleague performing female genital mutilation, what would you do? (Tick all that apply) 1. ☐ I would report him/her to the authorities ☐ I would discuss with him/her and explain to him/her that health care providers should not perform female genital mutilation 3. □ I would not get involved 4. □ I don't know 31. How often do you look for female genital cutting/excision when performing a gynecological examination of the vulva? ☐ Always 2. ☐ Often □ Sometimes 4. ☐ Rarely □ Never 32. How often do you record the female genital mutilation in the women's medical file if you are aware that she has undergone FGM? 1. □ Always 2. ☐ Often □ Sometimes 4. ☐ Rarely □ Never 33. Would you like to receive more training on how to help patients to prevent FGM? 1. □ Yes 2. $\square$ No ☐ I don't know 3 6 34. I can put myself in others' shoes

1. □ Always

☐ Often

Version 2 – 6th November 2019

To be completed by data collector: Data Collector ID: Date: Dav Month Year Signature:

#### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

#### ANC PROVIDER QUESTIONNAIRE (HCP)

		Partici	pant ID:	•						
				•			Project	ID:	Country ID:	Facility ID
	3.	□ Sometimes								
	3. 4.	□ Rarely								
	5.	□ Never								
35.		ners know I und	derstand	what t	hev sav	7				
	1.	□ Always			3					
	2.	☐ Often								
	3.	☐ Sometimes								
	4.	☐ Rarely								
	5.	□ Never								
36.	In conv	ersations with	my colle	agues, l	I perce	ive not on	ly what th	ey say but v	what they don'	t sav
	1.	□ Always	J	8 /			•	v	v	v
	2.	☐ Often								
	3.	☐ Sometimes								
	4.	☐ Rarely								
	5.	□ Never								
37.	I comm	unicate effectiv	vely							
	1.	□ Always	•							
	2.	☐ Often								
	3.	☐ Sometimes								
	4.	☐ Rarely								
	5.	□ Never								
38.	I comm	unicate with of	thers as	though	they aı					
	1.	☐ Always								
	2.	☐ Often								
	3.	☐ Sometimes								
	4.	☐ Rarely								
	5.	□ Never								
		Α	6 5	9	9 :	3				
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Version 2 – 6<sup>th</sup> November 2019

To be completed by data collector:									
Data Collector ID:	Dat	te:							
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3.

☐ I don't know

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#### **BMJ** Open A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993) **ANC PROVIDER QUESTIONNAIRE (HCP)** Participant ID: Project ID: Country ID: Facility ID: These next questions relate to your clinic setting: 39. Have you seen the posters on FGM at the clinic? 1. □ Yes 2. □ No 3. □ I don't know 40. Have you referred to the clinical handbook on FGM that is available in your clinic? 1. □ No ☐ I don't know 41. Do you think it is feasible to provide FGM prevention counselling during ANC visits? 1. □ Yes 2. $\square$ No

Comments	
-	

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To be completed by data collector: Data Collector ID: Date: Day Month Year Signature:

### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

		Participant ID:
		raticipant ib.
		Project ID: Facility ID:
		FIRST ANC CLIENT EXIT QUESTIONNAIRE (EXT)
		ڭ 5
		Country ID:  A 6 5 9 9 3  old are you? (years)  t is your religion?  Christian  Christian
		A 6 5 9 9 3
1.	How	old are you? (years)
2.		t is your religion?
	1.	□ Muslim
	2.	□ Christian
	3.	□ Other
	4.	□ None
	5.	□ Refused
3.	What	t is the highest level of education you achieved?
	1.	□ None
	2.	□ Primary
	3.	□ Secondary
	4.	☐ University ☐ Other, specify
	5.	
4.		y women in your community have had their genitals cut when they were children, if you are comfortable telling me, ask if you have undergone this practice?
	1.	□ Yes
	2.	□ No
	3.	□ I don't know
	4.	□ Refused
5.	How	supportive are you of female genital mutilation?
	1.	□ Strongly opposed
	2.	☐ I don't know ☐ Refused  supportive are you of female genital mutilation? ☐ Strongly opposed ☐ Somewhat opposed ☐ Neutral (Neither opposed or supportive) ☐ Somewhat supportive
	3.	□ Neutral (Neither opposed or supportive)
	4.	□ Somewhat supportive
	5.	☐ Strongly supportive

The following questions relate to your visit today. During your visit today:

6. Did you see any FGM poster(s) in the waiting room?

1. □ Yes

- 2. □ No
- 3. □ I don't know

### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

	Participant ID:	
	Project ID: Fac	ility ID:
7	7. Did the ANC provider ask if you have undergone FGM?	
,	1. ☐ Yes	
	2. □ No	
	3. □ I don't know	
8	8. Did the ANC provider explain how FGM can harm your health?	
	1. □ Yes	
	2. □ No	
Va	ersion 2 – 6 <sup>th</sup> November 2019 1 FIRST ANC CLIENT EXIT QUESTIONNAIRE (EXT)	
v e	ersion 2 – 6 <sup>th</sup> November 2019 1 <b>FIRST ANC CLIENT EXIT QUESTIONNAIRE (EXT)</b>	
	Country ID:	
	A 6 5 9 9 3	
	3. □ I don't know	
9.	Did the ANC provider ask about your personal belief regarding FGM?	
	1. □ Yes	
	2. □ No	
	3. □ I don't know	
10.	D. Did the ANC provider discuss why FGM should be prevented?	
	1. □ Yes	
	2. □ No	
	3. □ I don't know	
11.	1. Did the ANC provider discuss how FGM could be prevented?	
	1. ☐ Yes	
	<ul><li>2. □ No</li><li>3. □ I don't know</li></ul>	
12		
14.	2. Did you have questions about FGM to ask the ANC provider?  1.   Yes	
	2. □ No	
	3. □ I don't know	
13	3. Did you feel encouraged to ask questions about FGM?	
10.	1. ☐ Yes	
	2. □ No	
	3. □ I don't know	

14. Are you satisfied with how FGM was addressed during your visit with your ANC provider today?

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#### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

		Participant ID:
		Project ID: Facility ID:
	1.	□ Yes
	2.	$\square$ No
	3.	□ I don't know
15. Wha	at d	o you feel about FGM now as compared to before you came to the clinic today?
	1.	☐ Same, no change
	2.	☐ I feel more supportive of FGM now as compared to before I came
	3.	☐ I feel less supportive of FGM now as compared to before I came
	4.	☐ I do not know
	5.	□ Other, specify
16. Pret	end	you had a daughter now who was at an age when cutting occurs, what would your intention to cut her be?
		☐ Intend to cut her
	2.	☐ Do not intend to cut her
		wish/want to be active in preventing FGM?
	2.	$\square$ No
	3.	□ I don't know
	2	6 <sup>th</sup> November 2019
version	2 – (	5" November 2019
		□ Yes □ No □ I don't know  6 <sup>th</sup> November 2019

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#### Supplementary file 3: Additional analyses (appendices 1-3)

Characteristics	Facilities included in final analysis (n=163)	Facilities Facilities	s excluded* from final analysis (n=17)
Number of ANC providers	Mean 4 (SD: 3) Median 3 (1-14, IQR 3)	s e se	Mean 3 (SD: 3) Median 2 (1-9, IOR
Average number of ANC clients/month	Mean 150 (SD: 127) Median 118 (3-664, IQR 141)	Mea 462	(SD: 147) Median 100 (25-600, IQR 20)
MoH supervisory visits in the past year	Mean 4 (SD: 3) Median 3 (0-18, IQR 2)	ed e	Mean 5 (SD: 4) Median 4 (0-12, IQR
Size of catchment population served	Mean 36,754 (SD: 126,082) Median 15,972 (1,000-1,458,000, IQR 24,332)	Mean 11,735 ext superieur (ABES) text and data min	: 14,62) Median 7,800 (1,200-63,000, I 7,5
Presence of anti-FGM activities in the catchi	ment area	ct a	
Yes	74 (45%)	ed and	9 (53
No	89 (55%)	ur da	8 (47
Presence of pro-FGM activities in the catchr	ment area	ia (⊋ i	
Yes	21 (13%)	BE BE	2 (12
No	140 (86%)	<u> ت</u>	15 (88
Don't Know	2 (1%)	ů.	
udy time points while one ANC clinic in Kenya was ne	uded (7 intervention and 9 control) due to loss-to-follow up (LTFU) of ANC provides were visited at subsequent time points due to issues with insecurity. An ANC providely interviewed.	ler from one of the	in Kenya that had been inaccessible due to
Total of ANC clinics not included: 16 clinics were excluted time points while one ANC clinic in Kenya was nensecurity attended the PCC training and was subsequent	ver visited at subsequent time points due to issues with insecurity. An ANC provid	der i.e., the clinics in a linical reference on the similar technolog	in Kenya that had been inaccessible due to
tudy time points while one ANC clinic in Kenya was ne	ver visited at subsequent time points due to issues with insecurity. An ANC provid	der i.e., the clinics in millar technologies.	in Kenya that had been inaccessible due to
tudy time points while one ANC clinic in Kenya was ne	ver visited at subsequent time points due to issues with insecurity. An ANC provid	der i.e., the clinics in a line is in the clinics i	in Kenya that had been inaccessible due to
tudy time points while one ANC clinic in Kenya was ne	ver visited at subsequent time points due to issues with insecurity. An ANC provid	der i.e., the clinics in name is, 2025 at Agence ler from one of the and similar technologies.	in Kenya that had been inaccessible due to
tudy time points while one ANC clinic in Kenya was ne	ver visited at subsequent time points due to issues with insecurity. An ANC provid	der i.e., the clinics in name is, 2025 at Agence ler from one of the and similar technologies.	in Kenya that had been inaccessible due to
tudy time points while one ANC clinic in Kenya was ne	ver visited at subsequent time points due to issues with insecurity. An ANC provid	der i.e., the clinics in name is, 2025 at Agence ler from one of the and similar technologies.	in Kenya that had been inaccessible due to
tudy time points while one ANC clinic in Kenya was ne	ver visited at subsequent time points due to issues with insecurity. An ANC provid	der i.e., the clinics in name is, 2025 at Agence ler from one of the and similar technologies.	in Kenya that had been inaccessible due to
tudy time points while one ANC clinic in Kenya was ne	ver visited at subsequent time points due to issues with insecurity. An ANC provid	der i.e., the clinics in name is, 2025 at Agence ler from one of the and similar technologies.	in Kenya that had been inaccessible due to
tudy time points while one ANC clinic in Kenya was ne	ver visited at subsequent time points due to issues with insecurity. An ANC provid	der i.e., the clinics in agence sibiliographique ler from one of the g, and similar technologies.	in Kenya that had been inaccessible due to
tudy time points while one ANC clinic in Kenya was ne	ver visited at subsequent time points due to issues with insecurity. An ANC provid	der i.e., the clinics in agence sibiliographique ler from one of the g, and similar technologies.	in Kenya that had been inaccessible due to
tudy time points while one ANC clinic in Kenya was ne	ever visited at subsequent time points due to issues with insecurity. An ANC providily interviewed.	der i.e., the clinics in a name is, 2025 at Agence Bibliographique ae ler from one of the g, and similar technologies.	in Kenya that had been inaccessible due to
tudy time points while one ANC clinic in Kenya was ne	ver visited at subsequent time points due to issues with insecurity. An ANC provid	der i.e., the clinics in a name is, 2025 at Agence Bibliographique ae ler from one of the g, and similar technologies.	in Kenya that had been inaccessible due to

Appendix 2: Comparison of baseline characteristics of ANC providers

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Appendix 2: Comparison of baselin	e characteristics of ANC provide  Providers recruited at Baseline (n=436)	Providers enrolled with complete data at Month 6 (n=232)  36 (20-65; SD: 10) 8 (1-39; SD: 7) 8	Providers no	ot enrolled with no data at  Month 6 (n=204)
Age	37 (20-65; SD: 10)	36 (20-65; SD: 10)	ign gn	38 (21-62; SD: 10)
Years of professional experience	9 (1-39; SD: 7)	8 (1-39; SD: 7)	en D	10 (1-36; SD: 8)
Sex		តី	` <del>'</del> ' Š	
Female	361 (83%)	193 (83%) 39 (17%)	t Sin	168 (82%)
Male	75 (17%)	39 (17%)	up ad	36 (18%)
Highest educational level	- / h	n a	ed ed	
Certificate	44 (3%)	21 (5%)	from (A	23 (11%)
Diploma	309 (71%)	الله (68%) ما الله الله الله الله الله الله الله ا	<u>≽</u> 3	151 (74%)
Bachelors	64 (15%)	21 (5%) 158 (68%) 44 (19%) 1 (0.4%)	. E	20 (10%)
Masters & above	3 (0.7%)	1 (0.4%)	.) (S)	2 (1%)
Other#	16 (4%)	8 (3%)	Ĭ	8 (4%)
Current professional role/title		2	jopen	
Midwife	198 (45%)	103 (44%) <b>2</b>		95 (47%)
Nurse	95 (22%)	51 (22%)		44 (22%)
Nurse-Midwife	94 (22%)	54 (23%)	_ 루	40 (20%)
Other	49 (11%)	24 (10%)	ğ	25 (12%)
Received formal training on FGM during		<u>v</u>		
Yes	158 (36%)	85 (37%)	9	73 (36%)
No	275 (63%)	146 (63%) <sup>a</sup>		129 (63%)
Don't Know	3 (0.7%)	1 (0.4%)		2 (1%)
Timing of clinical training on FGM			. ͺω	
Pre-service	63 (14%)	33 (14%)	2025	30 (15%)
In-service	81 (19%)	45 (19%) <b>2</b>		36 (18%)
Both pre- and in-service	14 (3%)	7 (3%) 7	at A	7 (3%)
Received formal training on communicati				
Yes	287 (66%)	149 (64%)	nce	138 (68%)
No	149 (34%)	83 (36%)	<u> </u>	66 (32%)
Received formal training on person-cente			<u> </u>	100/20
Yes	227 (52%)	118 (51%)	ဝဋ္ဌ	109 (53%)
No	207 (47%)	131 (56%)	<u>a</u>	94 (46%)
Don't know	2 (0.5%)	1 (0.4%)	gence Bibliographiqu	1 (0.5%)

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226 (52%) 128 (29%) 4 (0.9%) 3 (0.7%) 35 (8%) 32 (7%)	126 (54%) IS 63 (27%) IS 2 (1%) Red to the control of the control	100 (49%) 65 (32%) 65 (32%) 1 (0.5%) 1 (0.55) 1 (0.55) 1 (0.55) 1 (0.55) 1 (0.55) 1 (0.55) 1 (0.55) 1 (0.55) 1 (0.55) 1 (0.55) 1 (0.55) 1 (0.55) 1 (0.55) 1 (0.55) 1 (0.55) 1 (0.55) 1 (0.55) 1 (0.55)
128 (29%) 4 (0.9%) 3 (0.7%) 35 (8%)	15 (7%) text  14 (6%) and data mining.	20 (10%) 20
4 (0.9%) 3 (0.7%) 35 (8%)	15 (7%) text  14 (6%) and data mining.	20 (10%) 20
3 (0.7%)	15 (7%) text  14 (6%) and data mining.	20 (10%) 20
35 (8%)	15 (7%) text  14 (6%) and data mining.	20 (10%)  18 (9%)  18 (9%)
	14 (6%) and data mining	20 (10%)  The state of the stat
	14 (6%) and data mining	t period from htt
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Appendix 3: Comparison of study outcomes between baseline vs. month 3 and month 3 vs. month 6 in the intervention arm

nseline ention only)	Month 3	,			
• • • • • • • • • • • • • • • • • • • •	(Intervention only)	P-value	(Intercention only)	Month 6 (Intervention only)	P-value
			use use		
vider impleme	ented components of PC	C for FGM	prevention (S		
48 (6%)	298 (37%)	< 0.0001	<b>9 7 8</b> (37%)	694 (78%)	< 0.0001
38 (5%)	239 (29%)	< 0.0001	a 239 (29%)		< 0.0001
56 (7%)	243 (30%)	< 0.0001	<b>8 3 4 9</b> (30%)		< 0.0001
48 (6%)	224 (28%)	< 0.0001	<del>5</del> 2 (28%)		< 0.0001
	` /		= 344 (43%)	` /	< 0.0001
	\ /		<b>3</b> 1 <del>5</del> 7 <b>8</b> 1.5-1.8)	\ /	< 0.0001
` /			<u>a</u> 308 <b>6</b> .8-3.8)		< 0.0001
1.0 (1.0 2.1)	2.5 (2.6 2.6)	(0.0001	<u> </u>	0.2 (0.5 0.0)	10.0001
ess to offer FG	M prevention and care	services	<u> </u>	l l	
			E C B		
0 (0%)	42 (52%)	< 0.0001	<b>⇒ ™</b> 42 (52%)	56 (69%)	< 0.01
.1 (0.01-0.2)	3.1 (2.9-3.4)	< 0.0001	<b>53</b> 2.9-3.4)	3.4 (3.2-3.6)	0.18
	, ,		j j		
1 (1%)	61 (58%)	< 0.0001	≥ (58%)	96 (91%)	< 0.0001
11 (11%)	20 (19%)	< 0.0001	(19%)		< 0.0001
			ain 5	( , , , ,	
	4/0		<del>- 5                                   </del>	l l	
0 (0%)	1 (3%)	0.47	1 (20%)	8 (8%)	0.06
- (/				\ /	0.11
			<u> </u>		0.17
			<b>—</b> • • • • • • • • • • • • • • • • • • •		0.50
	\ /		<b>8</b> ± (77%)		< 0.001
	\ /		10 (96%)		1.0
	` /				0.75
2 (21,14)		0.00			
104 (24%)	235 (20%)	0.01	218 (20%)	124 (52%)	< 0.0001
			<b>0</b> 3/ <b>6</b> (/3%)		< 0.0001
			184 (23%)	` /	< 0.0001
. ,					< 0.001
530 (65%)	547 (68%)	0.003	547 (68%)	677 (83%)	< 0.001
	48 (6%) 176 (21%) 0.5 (0.4-0.5) 1.8 (1.6-2.1)  ess to offer FC  0 (0%) 0.1 (0.01-0.2)  1 (1%) 11 (11%)  0 (0%) 49 (49%) 85 (85%) 67 (67%) 84 (83%) 91 (91%) 98 (97%)  194 (24%) 367 (45%) 249 (30%) 141 (17%)	48 (6%) 224 (28%) 176 (21%) 346 (43%) 0.5 (0.4-0.5) 1.7 (1.5-1.8) 1.8 (1.6-2.1) 3.3 (2.8-3.8)  ess to offer FGM prevention and care  0 (0%) 42 (52%) 0.1 (0.01-0.2) 3.1 (2.9-3.4)  1 (1%) 61 (58%) 11 (11%) 20 (19%)  0 (0%) 1 (3%) 49 (49%) 62 (59%) 85 (85%) 94 (90%) 67 (67%) 75 (71%) 84 (83%) 81 (77%) 91 (91%) 101 (96%) 98 (97%) 104 (99%)  194 (24%) 235 (29%) 367 (45%) 345 (43%) 249 (30%) 184 (23%) 141 (17%) 117 (14%)	48 (6%) 224 (28%) <0.0001 176 (21%) 346 (43%) <0.0001 0.5 (0.4-0.5) 1.7 (1.5-1.8) <0.0001 1.8 (1.6-2.1) 3.3 (2.8-3.8) <0.0001 ess to offer FGM prevention and care services  0 (0%) 42 (52%) <0.0001 1.1 (0.01-0.2) 3.1 (2.9-3.4) <0.0001 11 (11%) 61 (58%) <0.0001 11 (11%) 20 (19%) <0.0001 11 (11%) 62 (59%) 0.08 85 (85%) 94 (90%) 0.18 67 (67%) 75 (71%) 0.26 84 (83%) 81 (77%) 0.30 91 (91%) 101 (96%) 0.16 98 (97%) 104 (99%) 0.36  194 (24%) 235 (29%) 0.01 367 (45%) 345 (43%) 0.38 249 (30%) 184 (23%) <0.0001 141 (17%) 117 (14%) 0.003	176 (21%) 346 (43%) <0.0001	48 (6%)   224 (28%)   <0.0001   6 3 3 (28%)   592 (73%)     176 (21%)   346 (43%)   <0.0001

Section/Topic	ltem No	Standard Checklist item	Extension for cluster designs	Page No *
Title and abstract				
	1a	Identification as a randomised trial in the title	Identification as a cluster randomised trial in the title	1
	1b	Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) <sup>1,2</sup>	See table 2	3
Introduction				
Background and objectives	2a	Scientific background and explanation of rationale	Rationale for using a cluster design	5-6
	2b	Specific objectives or hypotheses	Whether objectives pertain to the cluster level, the individual participant level or both	7
Methods				
Trial design	3a	Description of trial design (such as parallel, factorial) including allocation ratio	Definition of cluster and description of how the design features apply to the clusters	7
	3b	Important changes to methods after trial commencement (such as eligibility criteria), with reasons		N/A
Participants	4a	Eligibility criteria for participants	Eligibility criteria for clusters	7-8
	4b	Settings and locations where the data were collected		6-7
Interventions	5	The interventions for each group with sufficient details to allow replication, including how and when they were actually administered	Whether interventions pertain to the cluster level, the individual participant level or both	6
Outcomes	6a	Completely defined pre- specified primary and	Whether outcome measures pertain to the cluster level, the	10

		secondary outcome measures, including how and when they were assessed	individual participant level or both	
	6b	Any changes to trial outcomes after the trial commenced, with reasons		N/A
Sample size	7a	How sample size was determined	Method of calculation, number of clusters(s) (and whether equal or unequal cluster sizes are assumed), cluster size, a coefficient of intra-cluster correlation (ICC or k), and an indication of its uncertainty	10-11
	7b	When applicable, explanation of any interim analyses and stopping guidelines		12
Randomisation:				
Sequence generation	8a	Method used to generate the random allocation sequence	,	8-9
	8b	Type of randomisation; details of any restriction (such as blocking and block size)	Details of stratification or matching if used	8-9
Allocation concealment mechanism	9	Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned	Specification that allocation was based on clusters rather than individuals and whether allocation concealment (if any) was at the cluster level, the individual participant level or both	9
Implementation	10	Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions	Replace by 10a, 10b and 10c	
	10a		Who generated the random allocation sequence, who enrolled clusters, and who assigned clusters to interventions	8

	10b		Mechanism by which individual participants were included in clusters for the purposes of the trial (such as complete enumeration, random sampling)	8
	10c		From whom consent was sought (representatives of the cluster, or individual cluster members, or both), and whether consent was sought before or after randomisation	8
Blinding	11a	If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how		8-9
	11b	If relevant, description of the similarity of interventions		8-9
Statistical methods	12a	Statistical methods used to compare groups for primary and secondary outcomes	How clustering was taken into account	10-13
	12b	Methods for additional analyses, such as subgroup analyses and adjusted analyses		12-13
Results			4	
Participant flow (a diagram is strongly recommended)	13a	For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome	For each group, the numbers of clusters that were randomly assigned, received intended treatment, and were analysed for the primary outcome	15
	13b	For each group, losses and exclusions after randomisation, together with reasons	For each group, losses and exclusions for both clusters and individual cluster members	Figure 2

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Interpretation	22	Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence	23-24
Other information			
Registration	23	Registration number and name of trial registry	15
Protocol	24	Where the full trial protocol can be accessed, if available	15
Funding	25	Sources of funding and other support (such as supply of drugs), role of funders	In Funding Statement

<sup>\*</sup> Note: page numbers optional depending on journal requirements

## **BMJ Open**

## A cluster randomized trial of a health system strengthening approach applying person-centered communication for the prevention of female genital mutilation in Guinea, Kenya, and Somalia

Journal:	BMJ Open
Manuscript ID	bmjopen-2023-078771.R2
Article Type:	Original research
Date Submitted by the Author:	02-May-2024
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<b>Primary Subject Heading</b> :	Health services research
Secondary Subject Heading:	Evidence based practice, Reproductive medicine, Research methods, Communication, Complementary medicine

Keywords: EDUCATION & TRAINING (see Medical Education & Training), Patient-Centered Care, Primary Care < Primary Health Care, Primary Prevention, PUBLIC HEALTH, Behavior

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Abstract word count: 299

Text word count: 6,084

Tables: 4

Figures: 1



BMJ Open: first published as 10.1136/bmjopen-2023-078771 on 4 July 2024. Downloaded from http://bmjopen.bmj.com/ on June 13, 2025 at Agence Bibliographique de l Enseignement Superieur (ABES) .

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#### **ABSTRACT**

**Introduction**: There is limited evidence on effective health systems interventions for preventing female genital mutilation (FGM). This study tested a two-level intervention package at primary care applying person-centred communication (PCC) for FGM prevention.

Methods: A cluster randomized trial was conducted in 2020 - 2021 in 180 antenatal care (ANC) clinics in Guinea, Kenya, and Somalia. At baseline, all clinics received guidance and materials on FGM prevention and care, while at month three, ANC providers at intervention sites received PCC training. Data were collected from clinic managers, ANC providers and clients at baseline, months three and six. Multi-level and single-level logistic regression models were used to analyze the effect of the intervention on study outcomes.

Results: Providers in the intervention arm were more likely to implement the PCC for FGM prevention approach compared to those in the control arm, including inquiring about clients' FGM status (OR: 8.9, 95% CI: 6.9-11.5; p<0.001) and FGM-related beliefs (OR: 9.7, 95% CI: 7.5-12.5; p<0.001) and discussing why (OR: 9.2, 95% CI: 7.1-11.9; p<0.001) or how (OR: 7.7, 95% CI: 6.0-9.9; p<0.001) FGM should be prevented. They were also more confident in their FGM-related knowledge (OR: 6.3, 95% CI: 1.4-28.9; p=0.02) and communication skills (OR: 1.7; 95% CI: 1.0-3.0; p=0.06). ANC clients in the intervention arm were less supportive of FGM (AOR: 5.4, 95% CI: 2.4-12.4; p<0.001], more interested in being actively engaged in FGM prevention efforts (AOR: 3.2, 95% CI: 1.6-6.2; p=0.001) and had lower intentions of having their daughters undergo FGM (AOR: 0.3, 95% CI: 0.1-0.7; p=0.004) or seeking medicalized FGM (AOR: 0.2, 95% CI: 0.1-0.5; p<0.001) compared to those in the control arm.

**Conclusion**: This is the first study to provide evidence of an effective intervention to promote FGM prevention that can be delivered in primary care setting in high prevalence countries.

#### **SUMMARY BOX**

- This hybrid-effectiveness implementation research study conducted in primary care public health facilities in three countries with high prevalence of female genital mutilation (FGM) assessed the role of health workers in providing FGM prevention communication in the context of routine Protected by copyright, including for uses related to text and antenatal care (ANC).
- It will be important to assess the effectiveness of the person-centred communication approach in other service delivery points, e.g., child immunization, and with other cadres of health workers, e.g., community health workers, to assess its effectiveness beyond ANC care.
- Many factors influence FGM-related decision-making, and while primary care health workers were found to be effective communicators, and the randomized design controlled for some external factors, the impact of a health sector intervention in conjunction with multi-sectoral initiatives requires futher investigation.
- To ensure participation of at least one ANC provider at each site through each time point, eligibility of health workers was based on clinic rotation schedules, which may have introduced a selection bias although the included and excluded providers did not appear to differ significantly.

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INTRODUCTION

Multi-sectoral efforts are needed to achieve Sustainable Development Goal (SDG) 5.3 to eliminate the harmful practice of female genital mutilation (FGM) by 2030 in line with the United Nation's (UN) General Assembly resolution 67/146 (1), the World Health Assembly Resolution 61.16 (2) and the 2008 Interagency Statement (3), which call upon UN Member States to enact comprehensive and multi-disciplinary national action plans and strategies towards the elimination of the practice. Identifying effective strategies across sectors is an important step in ending FGM.

The health system, defined as all organizations, institutions and resources that produce actions whose primary purpose is to improve health(4), has an important role to play not only in managing complications of FGM but also in preventing the practice. Health care providers, specifically nurses and midwives who constitute most of the health workforce, are highly respected members of FGM practising and midwives who constitute most of the health workforce, are highly respected members of FGM practising and medicalization), despite national laws and medical ethics forbidding it (8–11). Developing evidence-based tools to build skills of health care providers and address their underlying beliefs could contribute to FGM abandonment efforts and complement existing resources on management of complications (12,13) to ensure comprehensive and high quality care.

Three countries (Guinea, Somalia, and Kenya) participated in a cluster randomized trial to test the effectiveness and implementation of a health system strengthening approach to FGM, which included the testing of an intervention to build skills of health workers on applying person-centered communication.

(PCC) for the prevention of FGM (14). Study countries were selected based on their high national and/or sub-national FGM prevalence. The national prevalence of FGM among women and girls aged 15 - 49 years is 98% in Somalia, 97% in Guinea and 21% in Kenya according to national population-based surveys. There are 20 hotspot counties/sub-national administrative units in Kenya with a prevalence of >80% (15), and this study focused on three of these counties. Likewise, the study countries have high rates of medicalized FGM, performed primarily by midwives, who make up between 71% to 93% of primary health care providers in the three study countries (16) hence the selection of nurses and midwives as the target group for this intervention.

The purpose of this study was to test a two-level intervention package to enable ANC providers

to deliver person-centered FGM counseling to their clients. This intervention package was informed by a theory of change that promotes health workers to be effective behavioral change agents because of their credibility (17) and positionality to influence the opinions, attitudes, beliefs, motivations and behaviors of their clients (18). We hypothesized that if ANC providers gained the necessary knowledge and skills to provide person-centered counseling (Level 2) and were given the opportunity to question their beliefs and attitudes together with an enabling environment (Level 1), they could positively influence the knowledge and attitudes of their clients to abandon the practice (Supplementary file 1).

The level one intervention consisted of making available national policy directives on the role of health care providers in providing FGM prevention and care services, WHO's FGM guidelines and clinical handbook as well as information, education, and communication (IEC) materials. These materials were distributed without any capacity building to accompany their distribution. Level two consisted of an interactive training specifically targeting ANC providers to build their knowledge on FGM, enable them to question their FGM-related values and attitudes and build their skills on counseling for FGM prevention using person-centred communication (19), a component of person-

centred care, which ensures that the perspectives and preferences of individuals, carers, families and communities are at the center of decisions and that they have the information and support needed to make decisions (20). ANC providers were trained to apply a series of structured steps in which they would: 'Assess' their client's views on FGM, address and challenge her 'Beliefs', encourage 'Change' and together with the client, 'Discuss and Decide' (ABCD).

### **METHODS**

# **Study Design**

Protected by copyright, including for uses related to text and This cluster randomized trial applied a type 2 hybrid, effectiveness-implementation design (21) to test the effectiveness of the delivery of a phased intervention package (Level 1 and 2) on knowledge, attitudes and practices among ANC health workers and their clients. This type of implementation research design assesses the effectiveness of the intervention and implementation factors in real world settings. The methodology, analysis plan and reporting conformed to the Consolidated Standards of Reporting Trial (CONSORT) 2010 statement: extension for cluster randomized trials checklist (22). Ethical approval for the master protocol was obtained from the World Health Organization (WHO) Ethical Review Committee (ERC) (#P151/03/2014). Each study country submitted country-specific protocols to local 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).

# **Participants**

Within each study country, two or three sub-national units (regions/counties) were purposively selected according to the following eligibility criteria: (1) FGM prevalence >50% among females 15 -

49 years old; (2) more than 15 ANC clinics, seeing on average 30 new ANC clients per month and (3) accessibility in terms of security. The unit of randomization was the ANC clinic to avoid having ANC providers in the same clinic in different study arms, which could lead to contamination. In intervention sites, all providers on duty were pre-screened. To ensure participation and follow-up throughout the trial, between one and three ANC providers on duty were enrolled based on a six-month clinic rotation schedule provided by the clinic manager. Ten new clients exiting their first ANC consultation with a participating provider were recruited at each data collection point.

Individual study participants gave verbal informed consent. Data collectors collected data from the ANC providers and their clients in a private and confidential setting. While personally identifiable information was collected from ANC providers to facilitate tracking during the follow-up data collection

time points, data were de-identified prior to analysis. No personally identifiable information was collected from ANC clients who were unique at each time point. Participating ANC clients received the equivalent of 5 USD to compensate for their transport costs recognizing that participants consenting to participate might have changed their plans to accommodate the interviews. Given insecurity in carrying cash in Somalia, a mobile phone application was used to transfer the money to participants, an amendment to the original protocol, which was submitted to the ethical review committees.

# Randomization and blinding

Based on Ministry of Health (MoH) facility administrative records, all public, primary care facilities (i.e., dispensaries and/or health centers) offering ANC services in the selected regions/counties the average number of new ANC clients seen in November and December 2019 was compiled to create ordered listings of client loads at each of the sites by region/county. Clinics were matched into pairs based on client load so the two busiest would be randomized to different arms and so on. A uniform distribution was used for randomization using the uniform random number function in STATA 17

(StataCorp Inc., College Station, TX, USA). Study teams organized data collection and intervention trainings based on the randomization lists. Attempts were made to blind clinic managers, ANC providers and their clients to study arm allocation. Since both study arms received the level one intervention component at baseline, and the providers and managers at control sites were unaware of the training that took place at intervention sites, it is conceivable that they were not aware of their study arm.

Presumably, intervention clients would assume they were the intervention arm, but they were also not aware of what might have been offered to other sites. ANC clients, however, were completely blinded as intervention since a distinct set of clients was interviewed at each time point, and they would not be aware of the training the provider had had. Field data collectors were also blinded to study arm allocation as much as possible, although some might have determined intervention arm during the study.

### **Procedures**

Implementation of the study interventions and data collection occurred between August 2020 and September 2021 and was staggered by countries. In the intervention arm, data collection was undertaken at three time points, i.e., at baseline prior to implementing the level one intervention component; at month three, prior to implementing the level two intervention component and at month six. In the control arm, data collection was done at two time points, i.e., at baseline and at month six. Study instruments included one for ANC clients, one for health workers and a health facility checklist completed by clinic managers. Instruments were pretested among ANC clients and providers from non-participating sites in all countries, and country teams provided feedback on the structure and appropriateness of each question prior to finalizing the instruments.

A web-interface electronic data capture system was developed on the Kobo toolbox core system architecture (Kobo Toolbox, Harvard Humanitarian Initiative, Boston, Massachusetts, USA). User accounts were password-protected, and data sent to the server was encrypted in transit using SHA256

with RSA encryption that met the data security requirements. Personally identifiable information was not collected, and all records were anonymized with unique study numbers. Study instruments for ANC clients were translated from English into ten languages by research team members in consultation with language experts (French, Somali, Swahili, Soussou, Poular, Malinké, Keiyo, Maasai, Marakwet and Protected by copyright, including for uses related Tugen) while those for ANC providers and clinic managers were translated into two languages (French and Somali). No backtranslation was performed. Field data collectors and their supervisors spoke the languages in which the questionnaires were administered. Data collection teams participated in a standardized training with WHO/HRP and the research institutions in each country. The level two intervention was implemented by master trainers in each country who had been trained remotely over a

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### **Outcomes**

The primary study outcome was delivery of the "ABCD" approach by ANC providers measured by responses from their client using tools developed for this study based on previously validated instruments, including four constructs of the operational definition of person-centered communication

(23). We also assessed ANC provider delivery of FGM care services and their utilization of the level one intervention components. Health facility preparedness to offer FGM prevention and care was assessed using a composite score developed for this study. (Supplementary file 2). The secondary self-efficacy outcome was assessed based on a score calculated from a validated tool for measuring general selfefficacy (24) while knowledge, attitudes, and practice (KAP) on FGM prevention and care were measured using an unvalidated KAP questionnaire similar to one used in formative research in Guinea. Study instruments can be found in Supplementary file 3

three-day period following the WHO PCC for FGM prevention facilitator's manual.

# Statistical analysis

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To have sufficient power (80%) to detect a difference (significance level 5%) between intervention and control arms on the primary study outcome of delivery of the PCC intervention for FGM prevention, 180 ANC clinics, equally divided across the three study countries were recruited and randomized with 1800 new ANC clients (10 per clinic) recruited at baseline and 1800 at six-month follow-up. While similar interventions have resulted in 20% difference between groups (25), a 10% difference (based on an assumed 20% in the control arm and 30% in the intervention arm) was applied to ensure sufficient power to detect a 10% difference and considering the minimal levels of clinical efficacy for such an intervention to be practical. This sample size also allowed for a 10% non-response and/or loss to follow-up rate and accounted for a clustering effect of (ICC=0.20) at clinic level. A relatively high level of clustering was assumed in the sample size calculations to not underestimate the needed sample size. Region/county level was not included in the multilevel model due to the low number of included regions/counties per country (Kenya 3, Guinea 2, Somalia 3) and it would then not be possible to get an accurate estimate of the variance between clusters.

Data were analyzed using STATA 17 software following a per-protocol approach. Data from ANC providers and their clients were analyzed if the clinic had at least one provider with follow up data at all study time points, and in the intervention arm, if the ANC provider present had undergone training on PCC for FGM prevention at month three. Clinics where providers were lost to follow-up were not included in the final analyses. All facility checklists and ANC client exit interviews were conducted as intended except at sites not accessible due to security issues or closed or converted for care of COVID-19 patients during the pandemic. As the study was designed to pre-screen ANC providers at baseline and include in the final analytic sample only those clinics and providers who were available at 3 and 6 months, an intention-to-treat approach was not feasible. Key characteristics of the participating facilities,

Continuous variables are presented using mean values, and standard deviation (SD) while categorical variables are summarized as counts (N) with percentages (%). Differences in proportions were analysed for dichotomous outcomes using Fischer's exact test. For outcomes measured as summary scores, comparisons of mean scores are presented across study arms using t-test.

Initial analyses showed that the clustering was negligible at the provider level since most sites only included one provider in the study. Therefore, multilevel regression models were not used to compare outcomes among providers in intervention vs. control arms. However, analyses based on client level outcomes applied multilevel mixed effect logistic regression models to assess differences between the study arms. Multilevel analyses were attempted for the models in which ANC clients reported on provider actions, but given the complexity of the models, convergence problems arose leading to unreliable results. In these cases, results of ordinary models are presented. Linearity was assessed for the continuous covariates included in the regression models using the Box-Tidwell test in Stata.

At month six, a comparison of study outcomes between the intervention and control arms was used to determine the combined effect of both levels of the intervention package. Multilevel multivariable logistic regression analyses for ANC provider outcomes were adjusted for their sex, years of service, FGM status, FGM-related training, any specific training on communication/counseling and PCC, and whether the provider had conducted FGM in the past. Analyses related to ANC client outcomes were adjusted for their age, educational level, FGM status and exposure to level one IEC materials. These variables were determined a priori based on previously published literature. Analyses related to provider actions as reported by clients were adjusted for client characteristics as it was not possible to definitively link a client with a particular provider. Unadjusted analyses are presented for

outcomes that relate to composite measures based on ANC provider and client responses (e.g., provision of FGM prevention and care services).

To determine the separate effect of the two levels of the intervention package, additional sub-analyses were conducted restricted to the intervention arm. Changes from baseline to month 3 within the intervention arm were used to determine the effect of the level one intervention component while changes from month 3 to month 6 within the same study arm were used to determine the effect of the level two intervention component. The study was not powered for these sub-analyses, however, and these results are presented in Supplementary file 4.

In-country data managers monitored data quality. Periodic data audits were conducted by the WHO/HRP Quantitative Assessment and Data Management team to identify any data collection gaps and data discrepancies requiring follow up by in-country teams. Weekly data monitoring meetings were held between the in-country research teams and WHO/HRP staff during data collection periods to identify, document and resolve any data discrepancies. These were virtual due to the COVID-19 pandemic. Given that there was no prospective follow-up of clients, a Data Safety and Monitoring Board and identify, document and resolve any data discrepancies. These were virtual due to the COVID-19 pandemic. Given that there was no prospective follow-up of clients, a Data Safety and Monitoring Board and or protocol deviations to the WHO/HRP study coordination team.

Patient and public involvement statement

Health care providers and members of communities where the practice of FGM is prevalent in the study countries were actively involved in the design and implementation of this study intervention. This included the formative research conducted in Guinea, which identified health care providers as integral members of FGM practicing communities who understand local community beliefs and norms, making them effective change agents. The formative research also found that

their training, ensuring accountability to legal and policy standards and promoting FGM abandonment as part of a multi-sectoral approach. Based on this formative work, the PCC training was developed and subsequently piloted among ANC providers in Kenya before being rolled out as part of the multicountry study.

Additionally, the research partners in Guinea, Kenya and Somalia actively engaged health care providers and community members as part of their in-country work towards FGM prevention. In Kenya as part of mobilization of study participants, community health volunteers in the study counties talked about the study during their community sensitization sessions and invited pregnant women to attend routine ANC sessions where they could be approached for participation in the study. Both health care providers and pregnant women were provided with information about the study, including the burden of the intervention as to time, any risks involved in their participation, the voluntary nature of their participation, and were recruited only after providing informed consent.

At present, study dissemination meetings have been conducted in Kenya and Guinea that have involved the MoH, other stakeholders as well as representatives of health care providers and community members where the study was implemented. In these meetings, the in-country research partners have led Al training, and similar technologies the development of policy briefs identifying country-specific results relevant for local research needs, policy development and practice.

### Role of the funders

Apart from WHO/HRP, the study funders had no role in study design or implementation. WHO/HRP, in collaboration with in-country research teams, developed the study protocol, provided data management and analytic support, and contributed to interpretation and manuscript writing. WHO/HRP coordinated the successful implementation of this study. The data collection platform was developed and maintained by an outsourced vendor (First Data, LLC, Kenya); data management was

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coordinated by the local implementing partners (CERREGUI, DARS and University of Nairobi) and statistical data analysis was conducted by an external statistician (Dr. Max Petzold, Gothenburg University). All these functions were conducted with utmost integrity following ICH-GCP guidelines. This trial was registered: PACTR201906696419769 (June 3, 2019).

### **RESULTS**

### Recruitment and retention

Between August 2020 and September 2021, a total of 180 ANC clinics (i.e, 60 clinics per study country) were enrolled and randomized to intervention and control arms. There was some natural staggering of the start and subsequent data collection dates due to factors, such as weather, COVID-19, Ramadan, and national elections. Data collection periods ranged from three to six weeks in each country at each time point. The time elapsed between the end of one data collection period to the beginning of the next data collection period ranged from three to five months.

In the intervention arm, 216 providers and 900 clients (i.e.., 10 per clinic) were interviewed. Based on a review of clinic rotation schedule to ensure participation of at least one provider from each study clinic throughout the trial, 133 providers were enrolled. In the control arm, 220 providers and 900 clients were interviewed. (Figure 1). At month three, data were collected at 98% (n=88) of the intervention clinics as two clinics in Kenya were inaccessible due to insecurity. One hundred and thirty (98%) ANC providers (at least one from each site) and 880 first visit ANC clients completed the month three questionnaires prior to implementing the Level 2 intervention PCC. No data collection was conducted at the control sites. At month six, 91% (n=163) of ANC clinics (81, intervention and 82, control) had at least one ANC provider (intervention n=110 and control n=122) on duty who was previously enrolled in the study. The client questionnaire was applied to 819 and 810 first visit ANC

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clients, respectively in the intervention and control sites.

# Characteristics of study sites and participants

The 163 ANC clinics retained to the end of the study, had a mean of four ANC providers (standard deviation, SD: 3) and served on average 155 new ANC clients per month (SD: 127) with a mean catchment population of 36,754 people (SD: 126,082). In 55% (n=89) of clinics, the clinic manager reported that there were no activities promoting FGM prevention in the facilities' catchment area (Table 1). These characteristics were not different from the 17 ANC clinics that were enrolled at baseline but that subsequently were not included in the final analysis (Supplementary file 4).

Of the 232 ANC providers who contributed data for analysis at month six, 83% (n=193) were female and their mean age was 36 years (SD: 10 years). They had an average of eight years professional experience (SD: 7 years) and 68% (n=158) had studied up to Diploma level (generally 3 years postsecondary education) with 90% (n=208) identifying as either midwives, nurses, or nurse-midwives. Health cadres were defined by national licensing requirements in each country. Among these providers, at baseline, 63% (n=146) reported that they had not received formal clinical training on FGM prevention and care (Table 2). Almost two-thirds (64%, n=149) reported that they had received training on communication/counselling while half (51%, n=118) had received training on person-centered care. Further, 54% (n=126) of female providers reported that they had undergone FGM while overall, 94% (n=217) of providers reported that they had never performed FGM. These characteristics were not different when compared to the ANC providers who were on duty in the 180 ANC clinics enrolled at baseline (Supplementary file 4). The mean age of the 1,800 clients exiting their first ANC visits at baseline was 26 years (SD: 6 years), 47% (n=846) reported not having received any education, and 73% (n=1,320) reported that they had undergone FGM. These characteristics were similar to the 880 and 1,630 first visit ANC clients interviewed at month three (intervention arm only) and month six, respectively (*Table 3*).

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To evaluate potential bias from differential selection of providers receiving the intervention, we assessed differences in baseline characteristics between the 133 ANC providers from intervention facilities who were screened at baseline and received PCC training at month three (i.e., included in the analytic sample) versus the 97 who were screened and did not receive the intervention (i.e., excluded from analytic sample). The reasons for this included the fact that some of the providers had been transferred from the study clinics or could not be released to attend the training so as not to affect service delivery. Both groups were similar in terms of sex, educational level, professional cadre, as well as whether they had undergone or recently performed FGM. However, included providers tended to be slightly younger (by two years on average) and less likely to be of Muslim religion, although the question on religion was not administered for the Somalia sample since all respondents were assumed to be Muslim (Supplementary file 4).

ANC providers implementation of ABCD elements of the PCC approach

Table 4 presents the analysis of study outcomes by arm at month six. Compared to ANC

Table 4 presents the analysis of study outcomes by arm at month six. Compared to ANC providers in the control arm, those in the intervention arm were nearly nine times as likely to ask their clients if they had undergone FGM (OR: 8.9, 95% CI: 6.9-11.5; p<0.001), nearly ten times as likely to ask their clients' personal beliefs regarding FGM (OR: 9.7, 95% CI: 7.5-12.5; p<0.001), more than nine times as likely to discuss with their clients why FGM should be prevented (OR: 9.2, 95% CI: 7.1-11.9; p<0.001) and nearly eight times as likely to discuss with their clients how FGM could be prevented (OR: 7.7, 95% CI: 6.0-9.9; p<0.001). Further, ANC clients in the intervention arm were nearly seven times as likely to report that they were satisfied with how FGM had been addressed by their provider during the clinic visit compared to those in the control arm (OR: 6.6, 95% CI: 5.1-8.4; p<0.001). In the intervention arm, the mean score of implementing the ABCD elements of the PCC approach was more

than twice as likely (OR: 2.1, 95% CI: 1.6-2.6; p<0.001) to be higher in the intervention [3.9 (3.8-4.0)] compared to the control arm [1.6 (1.5-1.8)].

# ANC clinic preparedness to provide FGM prevention and care services

A significantly higher proportion of ANC clinics in the intervention arm had all correct repornses to facility preparedness to provide FGM prevention and care services compared to those in the larm (68% vs. 27%, p<0.001). Additionally, ANC clinics in the intervention arm had a cantly higher mean score for preparedness compared to those in the control arm [3.4 (95% CI: 5) vs. 2.6 (95% CI: 2.4-2.9; p<0.001)].

\*\*Providers utilizing level one intervention components\*\*

A higher proportion of ANC providers in the intervention arm reported having utilized the level. related to facility preparedness to provide FGM prevention and care services compared to those in the control arm (68% vs. 27%, p<0.001). Additionally, ANC clinics in the intervention arm had a significantly higher mean score for preparedness compared to those in the control arm [3.4 (95% CI: 3.2-3.6) vs. 2.6 (95% CI: 2.4-2.9; p<0.001)].

# ANC providers utilizing level one intervention components

one intervention package components compared to those in the control arm (83% vs. 56%, p<0.001). In multivariable analyses, ANC providers in the intervention arm were nine times as likely to report having utilized the level one intervention package components compared to those in the control arm (AOR: 9.3. 95% CI: 4.2-20.8; P<0.001).

ANC providers offering appropriate FGM prevention and care services

At month six, based on a cumulative score to specific questions on provision of appropriate

FGM-related prevention and care services, a higher proportion of ANC providers in the intervention arm reported that they had provided FGM prevention and care services correctly compared to those in the control arm (45% vs. 34%, p=0.03).

ANC providers' confidence, self-efficacy, and communication skills

A higher proportion of ANC providers in the intervention arm reported being confident in their

knowledge to provide FGM prevention and care services compared to those in the control arm (98% vs. 89%, p=0.005). In multivariable analysis, ANC providers in the intervention arm had more than six

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times the odds of reporting being confident in their knowledge to provide FGM prevention and care services compared to those in the control arm (AOR: 6.3, 95% CI: 1.4-28.9; p=0.02). Self-efficacy was generally high (scores 7.4 – 7.8 out of 8) with no significant difference in high scores between study arms (85% vs. 82%, p=0.36 and OR: 0.8, 95% CI: 0.4-1.6); p= 0.50).

# ANC providers' knowledge, attitudes and support for FGM/medicalized FGM

Protected by copyright, including for uses The mean correct scores for FGM-related knowledge were higher among ANC providers in the intervention arm compared to the control arm (2.5, 95% CI: 2.2-2.8 vs. 1.9, 95% CI: 1.7-2.2; p=0.005) but 8% vs. 2% (p=0.16) had correct responses on the FGM-related knowledge questions, showing low knowledge overall, and particularly on the FGM typology. Providers had similarly unsupportive attitudes towards FGM in both groups and similarly unsupportive attitudes about medicalized FGM with most providers reporting that they did not support FGM (82% vs. 85%, p=0.73) and/or medicalized FGM (72% vs. 73, p=0.94%).

# ANC clients' support for FGM, intention to have their daughters undergo FGM and being involved in FGM prevention efforts

Compared to those in the control arm, a higher proportion of ANC clients in the intervention arm reported being less supportive of FGM after their month six clinic visit (52% vs. 29%, p<0.001). In multivariable analysis, ANC clients in the intervention arm had more than twice the odds of reporting that they were strongly opposed to FGM (AOR: 2.4, 95% CI: 1.1-5.2; p=0.023, ICC: 0.61). When asked about their support for FGM after the ANC visit compared to before, clients in the intervention arm had more than five times the odds of being less supportive of FGM compared to those in the control arm (OR: 5.4, 95% CI: 2.4-12.4; p<0.001, ICC:0.66). ANC clients in the intervention clinics had lower odds of intending to have their daughters undergo FGM (OR: 0.3, 95% CI: 0.1-0.7; p=0.004, ICC: 0.60) or of wanting a health care provider to perform FGM (OR: 0.2, 95% CI: 0.1-0.5; p<0.001, ICC: 0.54) and

higher odds of reporting that they wished to be active in FGM prevention (OR: 3.2, 95% CI: 1.6-6.2, p=0.001, ICC: 0.50).

To understand the impact of the level one intervention relative to the level two intervention, a comparison of study outcomes restricted to the intervention arm was done between baseline and month three and between months three and six (Supplementary file 4). Although not statistically powered for this analyses, we found that a significantly higher proportion of ANC clients in the intervention arm reported that their provider had asked about the different PCC components at month three versus baseline and at month six versus month three. Similarly, a significantly higher proportion of ANC clinics in the intervention arm were prepared to provide FGM-related prevention and care services at month three compared to baseline and at month six compared to month three. No statistically signiofiocant differences were seen in the proportion of ANC providers with the secondary outcomes apart from high confidence scores seen between month six and month three. Finally, ANC client outcomes were significantly higher among intervention clients in month three versus baseline and in month six versus month three.

### **DISCUSSION**

The results of this cluster randomized trial show that an intervention to strengthen health facility preparedness while building skills of ANC providers to communicate using a person-centred counselling technique on FGM prevention was effective. ANC providers exposed to the intervention had increased confidence, improved FGM-related knowledge, and effective delivery of FGM prevention and care services. Additionally, ANC clients who had received care from these providers were less supportive of FGM and had reduced intentions to perform FGM on their daughters. This study provides evidence of a practical intervention to engage health care providers in FGM abandonment efforts whilst also providing quality care to FGM survivors. This study provides evidence of how to effectively build the capacity of

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health care providers at primary care to address FGM(26), an area identified as a critical gap during the formative research.

The PCC training modules strengthened ANC providers' skills on FGM prevention and care and helped to clarify their beliefs and attitudes, which are key drivers of FGM (27). We did not find notable changes in knowledge and attitudes among ANC providers. The knowledge scores overall were low, and upon further investigation, it appears that questions on typology captured through visually drawn images on a tablet device were consistently answered incorrectly. These results perhaps show measurement and knowledge limitations but do not necessarily relate to service provision or quality of care. Attitudes in the intervention and control groups were generally unsupportive of FGM and do not appear to be heavily impacted by the training intervention. Exposure to the intervention package also did not improve ANC providers' self-efficacy towards FGM prevention and care. This may be related to the lack of support for FGM and/or its medicalization and high self-efficacy among nearly all providers throughout the study in both study arms, a finding that was also noted in formative research conducted in Guinea (28,29). In the formative phase, while the vast majority of health workers were opposed to the practice. 38% also felt that FGM limited promiscuity and 7% believed that it was a good practice, showing ambivalence and complexity in attitudes about FGM among health providers. Other studies have found that some providers support the perpetuation of the practice and even planned to have their own daughters undergo FGM or to perform it on their clients(30).

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The findings in this study underscore the importance of addressing values and attitudes of both providers and clients as a means of achieving positive behavioral change. Changes observed among ANC providers were sustained across the study duration and ultimately, and importantly, resulted in reported changes in attitudes and intentions of their clients. However, this study design did not allow us

to determine whether the attitudinal changes observed among ANC clients were sustained after their clinic visit or translated into positive change in FGM prevention.

The application of these study results into programming will need to consider several factors.

Firstly, the study sites were primary care facilities located in high FGM prevalence settings. The results of this intervention may not be generalizable to settings where FGM is less prevalent or to settings other than primary care. Secondly, first ANC visits are not typical of other health visits since the consultation is generally longer with a greater focus on health promotion messaging. While this is an ideal setting for implementing such an intervention, its application to other health settings and among other population groups is not known. During scale up, if the PCC approach is applied among clients seeking other sexual and reproductive health services or parents bringing their children to child immunization and wellness visits, it will be important to consider time requirements for the delivery of the 'ABCD' steps, especially in high volume clinic settings.

Thirdly, while the study found a positive impact of the PCC training on health care providers' delivery of person-centred FGM prevention counselling, the continuity and quality of FGM prevention counselling in the long-term is not known. Specifically, it will be important to assess subsequently whether providers will continue to provide prevention counselling on an ongoing basis, whether they will share their learnings with family and community members and whether clients will follow through with their intentions to not have their daughters undergo FGM. It may be important to include a supervisory mentorship component to ensure implementation of this intervention (31) in order to strengthen PCC communication practice and quality.

# Limitations

The implementation of this multi-country study was not without challenges and limitations. First, initiation of field data collection activities was delayed by the global COVID-19 pandemic in 2020 – 2021 and required some modification to trainings of the data collection teams, the master trainers and the ANC providers receiving the PCC intervention. This may have impacted the overall effectiveness of the intervention.

the intervention.

Second, to attempt to ensure participation of at least one provider at each site, all providers were pre-screened at baseline and clinic rotation schedules determined enrollment into the study. Selection bias might have been introduced through this process. The exploratory analysis to assess for selection and attrition bias from the pre-screen step, did not reveal significant differences between included and excluded health workers except for slightly lower age (Supplementary file 4),and a per protocol analysis wasrequired, but it is possible that differences in other unmeasured factors related to the clinics and providers might have biased the results. Findings from a process evaluation conducted as part of this study will provide additional insights on the feasibility, acceptability, appropriateness, and fidelity of the intervention implementation in these contextual settings to inform further implementation and scale up.

Third, we did not perform adjustment for multiple testing in our analysis given that the different tests are interpreted separately and no overall conclusion will be stated. Given that the null hypotheses of no differences are true, we estimate that the overall type one error rate is higher than the individual test level of 0.05. In terms of assumptions regarding clustering, sample size was calculated based on an ICC of 0.20. However, the observed ICC:s were all above 0.50 leading to statistically conservative conclusions of the non-significant results due to being under-powered to find an association.

Finally, we acknowledge that there are many factors that could impact FGM-related decision-making and a positive and impactful interaction with a respected health care provider might not be

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### Conclusion

In conclusion, this study highlights the importance of addressing the values and beliefs of health care providers working at primary care level, who are subject to social norms around FGM that may conflict with medical ethics and national laws and policies as an intermediary step in preventing FGM. Empowering these health care providers with communication skills and engaging them as opinion leaders can be impactful in changing their clients' attitudes towards FGM. In conjunction with FGM prevention activities in other sectors, this intervention can contribute to positive change if brought to scale.

DECLARATIONS

Contributors

WA and CP conceptualized the study and prepared the protocol in collaboration with VM, KS, PN, TE, MDB, AMS, AD(1) and MAA. MDB, AMS, AOS, PN, TE, JMK, AD(1) and MAA provided oversight over study implementation while AD(2), JK and SA monitored data quality in countries and KN and SST monitored data quality across countries. VM prepared the first draft of the manuscript with input from WA and CP, the responsible officer of the study at WHO/HRP. MP developed the statistical analysis plan and conducted data analysis. KS coordinated the development of the PCC for FGM prevention training. KS, PN, TE, JMK, JK, MDB, AMS, AOS, AD(1), AD(2), SA, and MAA contributed to and reviewed the manuscript for proper intellectual content. All authors read and approved the final draft of this manuscript.

Declaration of interests

The authors declare that they have no competing interests.

Data sharing

De-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP e

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Atchison of Imperial College London for their input in conceptualizing the study as well as Dr Leyla Hussein for supporting pilot testing of the PCC intervention.

# **Funding**

This work received funding from the Governments of Norway and the United Kingdom of Great Britain and Northern Ireland as well as the UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), a cosponsored programme executed by the World Health Organization (WHO).

# **Ethics approval:**

The following research ethics committees approved the protocol:

- 1. World Health Organization (WHO) Ethical Review Committee (ERC) (#P151/03/2014).
- 2. Kenya: Kenyatta National Hospital/University of Nairobi ERC (P805/09/2019) and the National Commission for Science, Technology, and Innovation (NACOSTI/P/20/5721)
- 3. Somalia: the Department of Planning, Policy and Strategic Information, Unit of Research (MOHD/DG: 2/11526/2019)
- 4. Guinea: the Comité National d'Ethique Pour la Recherche en Santé (CNERS) (105/CNERS/19).

# 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).

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**TABLES & FIGURES:** 

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Figure 1: Study CONSORT Diagram

**Table 1:** Characteristics of ANC clinics included in month six analyses

**Table 2:** Characteristics of ANC providers included in the month six analyses

**Table 3:** Characteristics of ANC clients interviewed at each time point

**Table 4:** Analysis of study outcomes

### SUPPLEMENTARY FILES

**Supplementary file 1:** Theory of change framework

**Supplementary file 2:** Measurement of study outcomes

**Supplementary file 3:** Data collection instruments

**Supplementary file 4:** Additional analyses (Appendices 1 - 3)

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**Table 1:** Characteristics of ANC clinics included in month six analyses

Characteristics	Characteristics Overall (n=163*)		Control (n=81)		
Number of ANC providers	Mean 4 (SD: 3) Median 3 (1-14, IQR 3)	$\vec{z}_{3}$	Mean 4 (SD: 3) Median 3 (1-14, IQR 4)		
Average number of ANC clients/month	Mean 150 (SD: 127) Median 118 (3-664, IQR 141)	, , , , , , , , , , , , , , , , , , ,	Mean 152 (SD: 133) Median 120 (3-664, IQR 140)		
MoH supervisory visits in the past year	Mean 4 (SD: 3) Median 3 (0-18, IQR 2)	Mean 4 (SD: 3) Median 4 (1-18, 19)	Mean 4 (SD: 3) Median 3 (0-12, IQR 2		
Size of catchment population served	Mean 36,754 (SD: 126,082) Median 15,972 (1,000-1,458,000, IQR 24,332)	_ · · · · · · · · · · · · · · · · · · ·			
Presence of anti-FGM activities in the catc	hment area	age ct a	•		
Yes	74 (45%)	43 (5 <b>22</b> / <b>a</b> ) 2	31 (38%)		
No	89 (55%)	39 (4 <b>8</b> ∕ <b>5 5</b>	50 (62%)		
Presence of pro-FGM activities in the catcl	nment area	ta (AE			
Yes	21 (13%)	12 (1 🕏 🣆	9 (11%)		
No	140 (86%)	68 (8 <b>. \$</b> 8)	72 (89%)		
Don't Know	2 (1%)	2 (2%)	0 (0%)		

<sup>\*</sup>Total of 17 ANC clinics not included: 16 clinics were excluded (7 intervention and 9 control) due to loss-to-follow up (LTFU) of ANC provider i.e., the clinics of an one of the clinics in Kenya was never visited at subsequent time points due to issues with insecurity. An ANC provider from one of the clinics in Kenya that had been inaccessible due to insecurity attended the PCC training and was subsequently interviewed.

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**Table 2:** Characteristics of ANC providers included in the month six analyses

<b>Fable 2:</b> Characteristics of ANC pr	oviders included in the month	NJ Open 1 six analyses	136/bmjopen-2023-078 cted by copyright, includ		
Characteristics	Overall (n=232)	Intervention (n= 115)	aconerol an= <del>11</del> 7)		
Age	Mean 36 (SD: 10) Median 34	Mean 35 (SD: 10) Median 33	Mean 37 (SE:11) Median 35		
1190	(20-65, IQR 15)	(20-59, IQR 14)	20-65, IQR 16)		
Years of professional experience	Mean 8 (SD: 7) Median 6 (1-39,	Mean 8 (SD:7) Median 6 (1-30,	Mean 8 (S <b>p</b> . <b>T</b> ) <b>S</b> Median 6 (1-39		
Tomo or protocolorum emperiorio	IQR 7)	IQR 8)	IOR 7)		
Sex			024 rela		
Female	193 (83%)	95 (83%)	Mean 8 (Str. Median 6 (1-39, IQR 7)  Mean 8 (Str. Median 6 (1-39, IQR 7)  Plant Seignement Superior  To the seigne		
			nen (		
Highest educational level	Uh		nt S		
Certificate	21 (5%)	12 (10%)	<b>X b d</b> 9 (8%)		
Diploma	158 (68%)	72 (63%)	eric 86 (74%)		
Bachelors	44 (19%)	27 (24%)	a T (15%)		
Masters & above	1 (0.4%)	0 (0%)	<b>富 万 3</b> 1 (1%)		
Other#	8 (3%)	4 (3%)	<b>3.8</b> 4 (3%)		
Current professional role/title			nin S)		
Midwife	103 (44%)	53 (46%)	<b>9</b> 50 (43%)		
Nurse	51 (22%)	25 (22%)	26 (22%)		
Nurse-Midwife	54 (23%)	27 (24%)	<u>a</u> . <u>9</u> 27 (23%)		
Other	24 (10%)	10 (9%)	<b>a</b> 14 (12%)		
Received formal training on FGM during			<u> </u>		
Yes	85 (37%)	44 (38%)	an o 41 (35%)		
No	146 (63%)	71 (62%)	<b>9</b> 75 (64%)		
Don't Know	1 (0.4%)	0 (0%)	<u>a</u> n 1 (1%)		
Timing of clinical training on FGM			lar Jun		
Pre-service	33 (14%)	18 (16%)	<b>6 6</b> 15 (13%)		
In-service	45 (19%)	22 (19%)	<b>3</b> 3 (20%)		
Both pre- and in-service	7 (3%)	4 (4%)	26 (22%) 27 (23%) 14 (12%) 28 (22%) 29 (23%) 14 (12%) 20 (24%) 21 (12%) 21 (12%) 22 (20%) 23 (20%) 23 (20%) 25 (25%) 26 (22%) 27 (23%) 27 (23%) 28 (21%) 29 (21%) 29 (21%) 20 (22%) 20 (23%) 20		
Received formal training on communicat			gie		
Yes	149 (64%)	76 (66%)	73 (62%)		
No	83 (36%)	39 (34%)	طط (38%) و 44 (38%)		
Received formal training on person-center		<b>-</b> 6 /	0		
Yes	118 (51%)	58 (50%)	60 (51%)		
No	113 (56%)	56 (49%)	57 (49%)		
Don't know	1 (0.4%)	1 (1%)	89. at 73 (62%) 44 (38%)  e 60 (51%) 57 (49%)  lioi 0 (0%)		
<u>Undergone</u> FGM			<u>a</u>		

Yes	126 (54%)	65 (57%)	<u>.</u> .
No	63 (27%)	27 (24%)	<u>nc</u>
Don't know	2 (1%)	2 (2%)	n d
Refused to answer	2 (1%)	1 (1%)	ing
Conducted FGM			ð
Yes	15 (7%)	9 (8%)	7 _
			ses
Conducted FGM on a girl <18 years			- Fe
Yes	14 (6%)	8 (7%)	lat
			ed
			jht, including for uses related to text and data mining, Al training, and similar technologies.

61 (52%)

36 (31%)

0 (0%)

1 (1%)

6 (5%)

6 (5%)

Table 3: Characteristics of ANC clients interviewed at each time point

Characteristics	ANC clients interviewed at Baseline			ANC clients interviewed at Month 3	78771 cluding	ANC clients interviewed at Month 6			
	Overall (n=1800)	Intervention (n=900)	Control (n=900)	Intervention only (n=880)	Overall 5 (n=1759) 4 (n=1759) 4	Intervention (n=879)	Control (n=880)		
Age	Mean 26 (SD: 6) Median 25 (15- 45, IQR 10)	Mean 25 (SD: 6) Median 25 (15- 45, IQR 10)	Mean 26 (SD: 6) Median 25 (15- 45, IQR 10)	Mean 26 (SD 6) Median 25 (15-45, IQR 10)	Overall Section (n=1/2024 Downson 1886) Media apped 1886 (Section 1886) Section (n=1/2024 Downson 1886) Section (n=1/2024 Down	Mean 26 (SD: 6) Median 25 (15- 45, IQR 9)	Mean 26 (SD: 6) Median 25 (15- 45, IQR 10)		
Highest educational	level		, , , ,		8 <u>8</u> D	, , , ,	, , ,		
None	840 (47%)	407 (45%)	433 (48%)	439 (50%)	8 <b>%</b> ₹4 <b>\$</b> %)	384 (44%)	422 (47%)		
Primary	484 (27%)	231 (26%)	253 (28%)	239 (27%)	5 <b>\$</b> £3 <b>\$</b> %)	278 (32%)	275 (31%)		
Secondary	331 (18%)	171 (19%)	160 (18%)	157 (18%)	306718%)	160 (18%)	146 (16%)		
University	95 (5%)	61 (7%)	34 (4%)	25 (3%)	<b>₹</b> ( <b>4</b> %)	34 (4%)	33 (4%)		
Other#	50 (3%)	30 (3%)	20 (25)	20 (2%)	55% (Sone data manifesta) 134%	23 (3%)	14 (2%)		
Have you undergone	. , .				2 P Z		,		
Yes	1320 (73%)	677 (75%)	643 (71%)	645 (73%)	13 🚉 🌠 5%)	655 (75%)	666 (75%)		
No	452 (25%)	209 (23%)	243 (27%)	224 (25%)	420.(23%)	206 (23%)	214 (24%)		
Don't know	12 (1%)	10 (1%)	2 (0.2%)	5 (1%)	<b>2</b> 1 <b>2</b> %)	13 (2%)	8 (1%)		
Refused to answer	16 (1%)	4 (0.4%)	12 (10/)	((10/)	<del>4</del> (0.4%)	5 (1%)	2 (0.2%)		
				6 (1%)	(Moren.bmj.com/ on June 13, 2025 at Agence Bibliographique de l		35		
	Fo	or peer review only -	http://bmiopen.bmi	.com/site/about/guidelines.x	ique de l		33		

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**Table 4:** Analysis of study outcomes

r implemented components	the the terms of t		136/bmjopen-2023-07877 cted by copyright, incl <mark>u</mark> d	
Intervention	ence For		)78 nclu	
Intervention	ence rest		- 7	
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	Control	Adjusted OR#	in 2 Q Paralue or 4	ICC
(n=819)			June 1 5	icc
` ′			<u> &lt;0 001</u>	N/A
			<b>8 m⊆</b> <0.001	N/A
			<b>9 9 9 9 9 9 9</b>	N/A
			<u>©</u> © N <0.001	N/A
			<b>6</b> • <0.001	N/A
	` ′	,	<u>a</u> a o	
		Difference in mean	<u>8</u> ₹	
		scores (95% CI)	€ v =	
3.9 (3.8-4.0)	1.6 (1.5-1.7)	2.3 (2.1-2.5)	<u>੨ੇ 5 ਕੁੱ</u> <0.001	N/A
6.2 (5.9-6.6)	3.7 (3.2-4.1)	2.6 (2.0-3.2)	<u> </u>	N/A
			<u> </u>	
			ລ ≱P-₹alue	ICC
		(95% CI)	3 M 3	27/4
56 (68%)	22 (27%)	-	2.000 < 0.001	N/A
24(2226)	26(2420)		<b>6</b> · <b>2</b>	N/A
3.4 (3.2-3.0)	2.0 (2.4-2.9)	<u> </u>		
Intervention	Control	Adjusted OR&		ICC
			\frac{1}{2} \cdot \frac{1}{2} \cdot \frac{1}{2} \cdot \cdo	ice
<del>                                     </del>			5 <0.001	N/A
7 (0270)	(00,70)	710 (NE 2010)	<del>-</del> -	
			3 2	
			(0	
74 (64%)	68 (58%)	1.7 (1.0-3.0)	S 0.060	N/A
86 (75%)	99 (85%)	0.8 (0.4-1.6)	0.453 ے	N/A
76 (66%)	85 (73%)	1.0 (0.5-1.8)	<b>5</b> 0.901	N/A
103 (90%)	104 (89%)	6.3 (1.4-28.9)	0.018	N/A
100 (87%)	114 (97%)	0.8 (0.2-3.7)	<u>υ</u> 0.726	N/A
104 (90%)	116 (99%)	1.1 (0.1-22.1)	<u>0</u> <u>N</u> 0.938	N/A
8 (8%)	1 (2%)	5.0 (0.5-47.8)	<b>Q X</b> 0.16	N/A
(3,3)	- (-,*)	(3.20)	<u> </u>	
25(2220)	10(1722)		> 0.005	N/A
2.3 (2.2-2.8)	1.9 (1.7-2.2)	<del>-</del>	0.005	IN/A
			<del></del>	
Intervention	Control	Adjusted OR&		ICC
I I				icc
			<del>0</del> <0 001	0.66
			9 0.023	0.62
	6.2 (5.9-6.6)  ness to offer FGM prevent Intervention (n=82) 56 (68%)  3.4 (3.2-3.6)  Intervention (n=115) 96 (83%)  74 (64%) 86 (75%) 76 (66%) 103 (90%) 100 (87%)	Control (n=81)   Control (n=115)   Control (n=115)   Control (n=117)   Control (n=	Control (n=82)	Control (n=81)   Control (n=115)   Control (n=115)   Control (n=115)   Control (n=117)   Control (n=115)   Control (n=117)   Control (n=116)   Control (n=117)   Control (n=117)   Control (n=117)   Control (n=116)   Control (n=117)   Control (n=117)   Control (n=116)   Control (n=116)   Control (n=116)   Control (n=117)   Control (n=1117)   Control (n=1117)   Control (n=1117)   Control

	BMJ Open				136/hmionen-20	
Clients reporting that they intend to have their daughters cut	96 (12%)	209 (26%)	0.3 (0.1-0.7)		0.004 ب	0.60
Clients reporting that they would prefer health care provider to cut daughters	53 (7%)	139 (17%)	0.2 (0.1-0.5)	<u>in</u>	<0.001	0.54
Clients wishing to be active in FGM prevention	677 (83%)	535 (66%)	3.2 (1.6-6.2)	'n.	0.001	0.50

ICC = Intra-cluster Correlation Coefficient

Grant on 4 details and conducted from http://bmjopen.bmj.com/ on June 13, 2025 at Agence Bibliographique de la ding for test and data mining, Al training, and similar technologies.

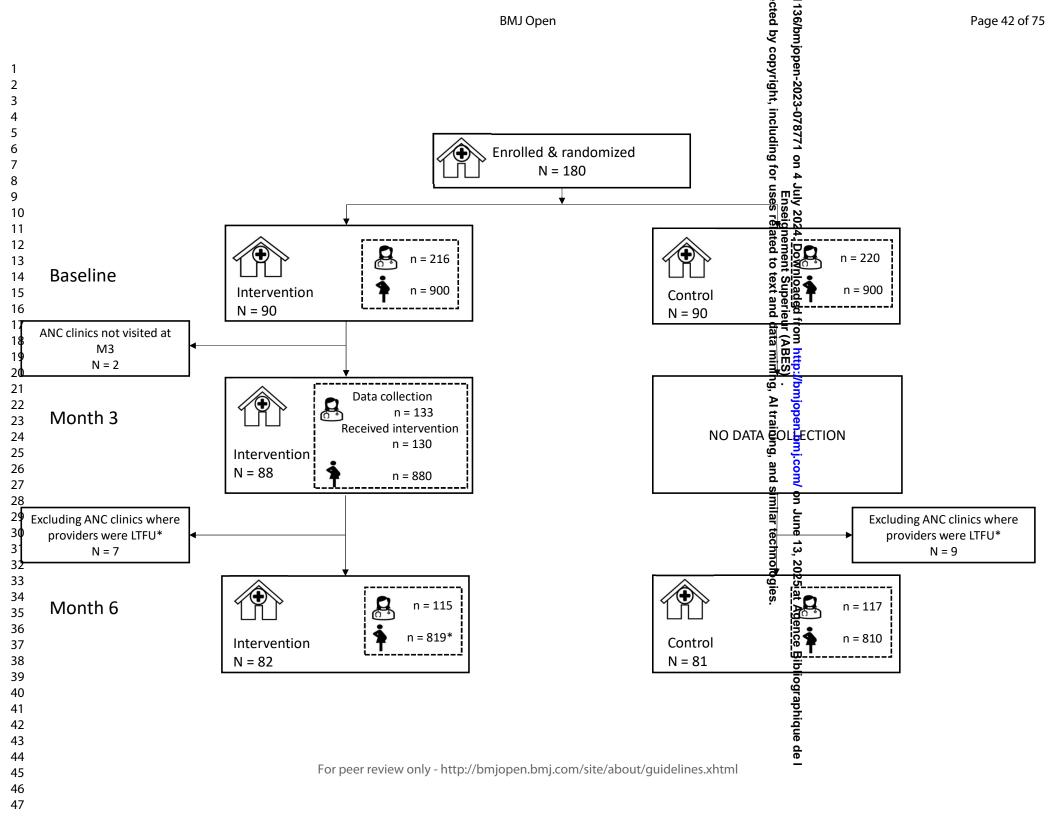
<sup>#</sup>Single-level multi-variable adjusted models

<sup>&</sup>amp;Multi-level multi-variable adjusted models

<sup>....</sup>ated training, any specific training on communication
.....nat level, FGM status and exposure to level one IEC materials \*Provider outcomes adjusted for sex, years of service, FGM status, FGM-related training, any specific training on communication/counseling and PCC, and the past

<sup>\*\*</sup> Client outcomes adjusted for age, educational level, FGM status and exposure to level one IEC materials

Totoe exterior only



#### **INTERVENTION PACKAGE** (Health systems)

- Health policy against **FGM** medicalization
- Information, education and communication (IEC) materials in clinics
- Job aides and checklist



#### **HEALTH SYSTEM FACTORS**

- Low knowledge and skills in prevention and care
- Non-availability of tools / aides / IEC material
- Lack of policies
- Lack of supervisory support



#### INDIVIDUAL FACTORS

- Low self-efficacy on FGM prevention
- Attitude toward FGM and its medicalization
- Lack of training on communication / counseling

#### **INTERVENTION PACKAGE** (Provider-focused)

Using interactive methods and education outreach for

- Values clarification on FGM
- Patient-centered communication skill building



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and

similar technologies.

on June 13, 2025 at Agence

- erson-centred communication
- Killion Hattitudes against FGM aining.

**DELIVERY OF FGM PREVENTION MESSAGES** 

#### CLIENTS

- Reduced support for FGM
- Greater intention to abandon FGM
- Be more active in FGM abandonment



#### Supplementary file 2: Measurement of study outcomes

**1. Primary Outcome:** Health facility preparedness to provide FGM prevention and care services.

**Outcome definition**: Cumulative score based on affirmative responses to Q9a, Q10a, Q11a & Q12a on the CHK form (see below).

```
Q9. Is there an MoH policy on FGM posted on the wall?
```

Yes

1 2 3

4 5

6 7

8

9

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11

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14

15

16

17

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22

23 24

25

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38 39

40 41

42

43

44

45

46

47 48 49

50

51

52

53

54 55

56

57

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59

60

No

Q9a. If yes, is it placed where health care providers can see/read it e.g., bulletin board?

Yes

No

Q10. Are there WHO FGM prevention posters on the wall of the consultation room and/or waiting room?

Yes

No

Q10a. If yes, are they placed in a place where ANC clients can see them?

Yes

No

Q11. Is there a WHO clinical handbook in the ANC consultation room?

Yes

No

Q11a If yes, is it placed where ANC providers can see/use it?

res

No

Q12. Is there an FGM ABCD guide in the ANC consultation room?

Yes

No

Q12a. If yes, is it placed where ANC providers can see/use it?

Yes

No

#### 2. Primary outcome: ANC provider utilization of Level 1 package components

Outcome definition: Affirmative response on Q40 of HCP form (see below).

```
Q40. Have you referred to the WHO Clinical Handbook on FGM?
```

Yes

No, available but not referred

No, not available

Don't know

#### 3. Primary outcome: Provision of FGM-related care after PCC training

**Outcome definition:** Cumulative score based on affirmative responses (Provision of FGM-related care (after PCC training) either 'Always' or 'Often') on Q22, Q24 & Q25 on the HCP form (see below).

Q22. How often do you discourage a pregnant woman expecting to have a girl, or one having a girl at the age of cutting, from having her daughter cut?

**Always** 

Often

Sometimes

Rarely

4

5

6

7

8

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21

23

24

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31

37

49

51

```
Never
                             Rarely
                             Refused to answer
                     Q24. How often do you look for female genital mutilation when performing a gynecological
             examination of the vulva?
                             Always
                             Often
10
                             Sometimes
12
                             Rarely
                             Never
14
                             Rarely
15
                             Refused to answer
16
                     Q25. How often do you record female genital mutilation in the woman's medical file if you
17
             are aware that she has undergone FGM?
18
19
                             Always
20
                             Often
                             Sometimes
22
                             Rarely
                             Never
                             Rarely
25
                             Refused to answer
26
                 4. Primary Outcome: Delivery of PCC 'ABCD' package
28
29
             Outcome definition: Cumulative score based on affirmative responses on Q5, Q7, Q8, Q9 &
30
             Q12 on the EXT form.
                     Q5. Did the ANC provider ask if you have undergone FGM?
32
                             Yes
33
                             No
34
35
                             Don't know
36
                             Refused
                     Q7. Did the ANC provider ask about your personal belief regarding FGM?
38
                             Yes
39
                             No
40
                             Don't know
41
                             Refused
42
                     Q8. Did the ANC provider discuss why FGM should be prevented?
43
                             Yes
44
45
                             No
46
                             Don't know
47
                             Refused
48
                     Q9. Did the ANC provider discuss how FGM could be prevented?
                             Yes
50
                             No
                             Don't know
52
                             Refused
54
                     Q12. Are you satisfied with how FGM was addressed during your visit with your ANC provider
55
             today?
56
                             Yes
57
                             No
58
                             Don't know
59
                             Refused
60
```

#### 5. Secondary Outcome: Improved knowledge about FGM

**Outcome definition:** Cumulative score based on correct responses to Q4 + affirmative responses to Q5 & Q7 of the HCP form.

```
Q4. Please provide the WHO classification for the following images
```

```
Type I
```

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Type II

Type III

Type IV

Don't Know

Other

Q5. Do you know of any health complications arising from female genital mutilation?

Yes

No

Q7. Are you aware of any existing WHO tools/guidance on FGM prevention and care?

Yе

No

#### 6. Secondary Outcome: Improved interpersonal communication skills

**Outcome definition:** Cumulative score based on positive responses ("Always or Often") to Q34, Q35, Q36, Q37, Q38 on the HCP form.

Now I will ask you about your communication skills

34. I can put myself in others shoes

Always

Often

Sometimes

Rarely

Never

Rarely

Refused to answer

35. I let others know that I understand what they say

**Always** 

Often

Sometimes

Rarely

Never

Rarely

Refused to answer

36. In conversations with my colleagues, I perceive not only what they say but what they don't say

**Always** 

Often

Sometimes

Rarely

Never

Rarely

Refused to answer

37. I communicate effectively

Always

Often

```
Sometimes
Rarely
Never
Rarely
Refused to answer

38. I communicate with others as though they are my equals
Always
Often
Sometimes
Rarely
Never
Rarely
Refused to answer
```

#### 7. Secondary outcome: Improved self-efficacy

**Outcome definition:** Cumulative score based on positive responses (Agree or Strongly Agree) to Q26, Q27, Q28, Q29, Q30, Q31, Q32, Q33 on the HCP form.

Now I would like to ask you a few questions about how you solve problems that you face. Please tell me how much you agree or disagree with the statements that I read to you

```
1 = Strongly disagree
```

- 2 = Disagree
- 3 = Neither agree nor disagree
- 4 = Agree
- 5 = Strongly agree
- Q26. I will be able to achieve most of the goals that I have set for myself
- Q27. When facing difficult tasks, I am certain that I will accomplish them
- Q28. In general, I think that I can obtain outcomes that are important to me
- Q29. I believe that I can succeed at almost any endeavor to which I set my mind
- Q30. I will be able to successfully overcome many challenges
- Q31. I am confident that I can perform effectively on many different tasks
- Q32. Compared to other people, I can do most tasks very well
- Q33. Even when things are tough, I can perform quite well

#### 8. Secondary outcome: Improved attitudes towards FGM

**Outcome definition**: Cumulative score based on positive responses to Q12, Q13, Q14, Q15, Q16, Q17, Q18 & Q19 on the HCP form.

For each of the following statements please state if you:

```
1=Agree
```

- 2=Disagree
- 3=Don't know
- 4=Refused to answer
- Q12. A girl who has not undergone FGM is unclean
- Q13. A girl who has not undergone FGM cannot be married within her community
- Q14. A girl who has not undergone FGM is a disgrace to her family's honor
- Q15. Health care providers who provide FGM are violating FGM
- Q16. Health care providers who provide FGM should be punished
- Q17. FGM is a good practice
- Q18. FGM is a violation of women and girls' rights
- Q19. FGM is religious mandate

9. Tertiary outcome: ANC provider confidence in FGM knowledge to provide care
Outcome definition: Positive responses ('Somewhat Confident' or 'Confident') to Q8 & Q9 on
the HCP form

Q8. When you treat or attend to a girl or woman with female genital mutilation, how confident are you that you have enough knowledge to provide good quality care?

1=Not confident

2=Somewhat confident

3=Confident

6

7 8

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21 22

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24 25

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4=Refused to answer

Q9. How confident are you in your knowledge to communicate on FGM prevention?

1=Not confident

2=Somewhat confident

3=Confident

4=Refused to answer

#### 10. Tertiary outcome: ANC provider support for FGM

**Outcome definition:** Positive response ('Do not intend to cut her') to Q20 on the HCP form Q20. Pretend you had a daughter now who was at an age when cutting occurs, what would your intention to cut her be?

1=Intend to cut her

2=Do not intend to cut her

3=Don't know

4=Refused to answer

#### 11. Tertiary outcome: ANC provider support for medicalized FGM

Outcome definition: Correct response ('No') to Q21 on HCP form

Q21. If a family brought their daughter to the clinic requesting genital cutting, for non-health reasons, would you perform it?

1=Yes

2=No

3=Don't know

4=Refused to answer

#### 12. Tertiary outcome: ANC client change in support for FGM after ANC visit

**Outcome definition:** Response to Q13 on EXT form

Q13. What do you feel about FGM now as compared to before you came to the clinic today?

1= Same, no change

2=I feel more supportive of FGM now as compared to before I came

3=I feel less supportive of FGM now as compared to before I came

4=Don't know

5=Other

6=Refused to answer

#### 13. Tertiary outcome: ANC client support or opposition to FGM

Outcome definition: Response to Q14 on EXT form

Q14. How supportive are you of female genital mutilation?

1=Strongly opposed

2=Somewhat opposed

3=Neutral 4=Somewhat supportive 5=Strongly supportive 6=Refused to answer

#### 14. Tertiary outcome: ANC client intention to cut after ANC visit.

#### **Outcome definition:** Response to Q16 on EXT form

Q.16 Pretend you had a daughter now who was at an age where cutting occurs, what would your intention to cut her be?

1=Intend to cut her 2=Do not intend to cut her 3=Don't know 4=Refused to answer

#### 15. Tertiary outcome: ANC client choice of who to cut their daughters.

#### **Outcome definition:** Response to Q17 on EXT form

Q17. If intending to cut, who would you prefer to do the cutting?

1=Traditional practitioner 2=Health care provider 3=Other 4=Refused to answer

#### 16. Tertiary outcome: ANC client wish to be active in FGM prevention

#### **Outcome definition:** Response to Q18 on EXT form

Q.18 Do you wish/want to be active in preventing FGM?

2=No 3=Don't know 4=Refused to answer

1=Yes

#### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

#### ANC PROVIDER SCREENING QUESTIONNAIRE (SCR)

Participant ID:

	Project ID: Country ID: Facility ID:
Instruct	ions: Observe and report findings from the health facility.
1.	MoH policy on FGM posted on the wall?  ☐ Yes ☐ No  1a. If yes, is it placed where health care providers can see/read it e.g. bulletin board? ☐ Yes ☐ No
2.	Are there FGM prevention posters on the wall of the waiting room? ☐ Yes ☐ No  2a. If yes, is it placed in place where ANC clients can see it ☐ Yes ☐ No
3.	Is there WHO FGM Clinical Handbook in the ANC consultation room? ☐ Yes ☐ No  3a. If yes, is it placed where ANC provider can see /use it? ☐ Yes ☐ No
4.	Is there FGM ABCD guide in ANC consultation room?  ☐ Yes ☐ No  4a. If yes, is it placed where ANC provider can see /use it ☐ Yes ☐ No
	ions: Assess health facility factors that may facilitate/constrain intervention delivery by reviewing health facility administrative and notes and by meeting with the health facility manager.
5.	Number of ANC providers
6.	Average number of ANC clients per month
7.	Number of ANC providers trained on PCC on FGM prevention  All (specify number trained):  Some (specify number trained):  None
8.	Indicate the number of MoH supervisory visits to the clinic in the past year

## A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993) ANC PROVIDER SCREENING QUESTIONNAIRE (SCR) Participant ID:

Participant ID:			
<u> </u>		Project ID:	Country ID: Facility ID:
Version 2 – 18 <sup>th</sup> October 2019			
A 6 5	9 9 3		
9. How frequently are staff meet	ings held?		
☐ Monthly			
☐ Every 2 to 4 months	S		
☐ Every 6 to 12month	s		
□ Never			
10. What is the size of the popula	tion served by this facility	? (specify number)	
11. Are there country/region-spec			
☐ Yes		anor cou.	
□ No			
12. Are there anti-FGM activities	that target the nonulation	n served by this healtl	n facility?
☐ Yes	that target the population	if served by this heart.	Tuchity.
□ No			
	that tauget the nanulation	a gammad her this boolth	footlite.9
<b>13. Are there pro-FGM activities</b> □ Yes	mat target the population	i served by this health	racinty:
□ No			
Additional comments:			
			<u> </u>

#### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

#### ANC PROVIDER SCREENING OUESTIONNAIRE (SCR)

	ANCT NOVIDER SCREENING QUESTIONNAINE (SCR)
	Participant ID:
	Project ID: Country ID: Facility ID:
Vorsion	12 – 18 <sup>th</sup> October 2019
V CI SIOI	12 - 16 October 2015
	A 6 5 9 9 3
1.	What is your age?
2.	What is your sex?
	1. □ Female
	2. □ Male
3.	What is your religion?
	1.   Muslim
	2. □ Christian
	3. □ Other
	4. □ None
	5. □ Refused
4.	What is your occupation/designation?
	1. ☐ Midwife
	2. □ Nurse
	3.  Other, specify
5.	What is the highest education level of education you achieved?
	1.  □ Certificate
	2. □ Diploma
	3. □ Bachelors
	4. ☐ Masters or above
	5.
6.	For how many years have you been working in your field?
7.	During you clinical training, did you receive any formal training on female genital mutilation?
	1. □ Yes.
	2. □ No. Go to section B
	3. □ I don't know. Go to section B
8.	When did you receive the training?
	1. □ During my studies (pre-service training)
	2. ☐ After graduation/at work (in-service training)
	3. □ Both
	4. □ I don't know
	7. □ Not applicable

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#### ANC PROVIDER SCREENING QUESTIONNAIRE (SCR)

Participant ID:			
	Project ID:	Country	ID: Facility ID:
		, 	
To be completed by data collector:			
Data Collector ID:	Date:		
Signature:	Day Mo	onth	Year
			2 0

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#### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

ANC PROVIDER SCREENING QUESTIONNAIRE (SCR)

		Participant ID:	Project I	ID:	Country ID:	Facility ID:
		A 6 5 9 9 3				
9.	Wh	nat was the format of the training? (Check all that a	pply)			
	1.	☐ Classroom lessons				
	2.	□ Workshops				
	3.	☐ Digital format (E-learning videos; smart phone app	)			
	4.	☐ During clinical practice under supervision of a men	tor			
	5.	☐ Other, specify				
	7. 🗆	☐ Not applicable				
10.	Du	ring your pre- or post- graduate training, did you re	ceive any	formal traini	ing on commu	nication or counselling?
	1.	☐ Yes.				
	2.	□ No.				
	3.	☐ I don't know				
11.	Du	ring you pre or post graduate training, did you recei	ve any for	mal training	on person-cer	ntred care?
	1.	☐ Yes.				
	2.	□ No.				
	3.	☐ I don't know				
12.	Ha	ve you ever cut the genitals of a girl (<=18 years old)	for non-h	ealth reason	s?	
	1.	☐ Yes.				
	2.	□ No.				
	3.	☐ I don't know				

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# A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993) ANC PROVIDER QUESTIONNAIRE (HCP) Participant ID:

T di dicipante 15.				
	Drainet ID:	Cour	+m / ID:	Fooility ID
	Project ID:	Cour	itry ID:	Facility ID
To be completed by data collector:				
Data Collector ID:	Date:			
Signature:	Day	Month		Year
			2	0
A 6 5 9 9 3  1. Have you ever heard about female genital mutilation	n?			
☐ Yes	·II.•			
□ No				
2. Do the women in your community undergo female	genital mutilation?			
□Yes				
□No				
☐ I don't know				
3. Do you know of the WHO classification for female	genital mutilation?			
□ Yes				
☐ No. Skip to Q5				
4. Please provide the WHO classification for the follow	wing FGM images (1	to include im	ages)	
a. IMAGE of Type III FGM to be inserted he	ere			
i. □ Type I				
ii. □ Type II				
iii. □ Type III				
· -				
iv. □ Type IV				
v. □nDon't know				
b. IMAGE of Type I FGM to be inserted here	2			
i. □ Type I				
ii. □ Type II				
iii. □ Type III				
Version 2 – 6 <sup>th</sup> November 2019				
TOTAL O THOTOLOGIE				

To be completed by data collector:

Data Collector ID:

Signature:

Day Month Year

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#### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993) **ANC PROVIDER QUESTIONNAIRE (HCP)** Participant ID: Project ID: Country ID: Facility ID: v. □nDon't know c. IMAGE of Type II FGM to be inserted here i. □ Type I ii. □ Type II 3 iii. □ Type III ☐ Type IV □nDon't know d. IMAGE of Type III FGM to be inserted here $\square$ Type I ☐ Type II iii. □ Type III ☐ Type IV □nDon't know e. 5. Do you know of any health complications arising from female genital mutilation? ☐ Yes □ No. Skip to Q6 Is female genital mutilation illegal in your country (specify actual study country)? 6. ☐ Yes 1. $\square$ No 2. 3. ☐ I don't know 7. Are you aware of any existing WHO tools/guidance on female genital mutilation and its complications? 1. ☐ Yes. If yes, please specify..... 2. $\square$ No Version $2 - 6^{th}$ November 2019

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## A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

	ANC PROVIDER QUESTIONNAIRE (HCP)	
	Participant ID:	
	Project ID: Country ID: Facility ID:	
8.		have
enough	h knowledge to provide good quality health care? Rate between 1 – 4	
1.	□ Not confident at all	
2.	□ Not very confident	
3.	☐ Fairly confident	
4.	☐ Fully confident	
	A 6 5 9 9 3	
9.	How confident are you in your FGM knowledge to communicate on FGM prevention?	
Rate betwee		
Raic beinee		
	1. □ Not confident at all	
	2. □ Not very confident	
	3. □ Fairly confident	
	4. □ Fully confident	
For each of	of the following statements please state if you agree/disagree or don't know.	
10.	O. A girl who has not undergone FGM is unclean.	
1.	□ Agree	
2.	□ Disagree	
3.	☐ Disagree ☐ I don't know	
11.		
1.		
2	□ Disagree	

- 3. ☐ I don't know
- 12. A girl who has not undergone FGM is a disgrace to her family's honour.
- 1. ☐ Agree
- 2. ☐ Disagree

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Data Collector ID:	Date:					
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#### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

					ANC	PROV	IDER QU	IESTIO	NNA	۱RE (	HCP)								
		Part	ticipant	ID:		_													
						_		Pro	ject I	D:		Cou	ıntry l	ID:	Fac	ility I	D:		
																			_
	3. □	I don't k <del>now</del>					I												Ş
	13.	Health care	e provi	ders w	ho perfo	orm FG	3M are	violati	ing n	nedic	al ethi	ics.							ć
	1. 🗆	Agree																	2.5
	2. □	Disagree																	,
	3. □	I don't know																	70 91
	14.	Health care	e provi	ders w	ho perfo	orm FC	3M show	ıld be	puni	ished	l <b>.</b>								ď
	1. 🗆	Agree																	,
	2. □	Disagree																	ב ב
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	2 🗆 1	don't know																	9
15			42																<u>.</u>
15.		s a good prac Agree	uce																,101
		Disagree																	ž
		I don't know																	į
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10.		s a violation o Agree	)1 WOIII	en s a	na giris	rights	1												2
		Disagree																	2
		I don't know																	
17.		s a religious 1	nandat	e															Ģ
<b>-</b> /•		Agree	nanaa																2
		Disagree																	2
		I don't know																	g
18.	Preten	d you had a d	laughte	er now	who wa	s at an	age wh	en cu	tting	occu	ırs, wh	at wou	uld yo	our i	ntent	ion t	o cut	her be	? 1.
		nd to cut her																	<u> </u>
	2. □	Do not intend	to cut l	ner															
	3. □	Undecided																	= {
	4. Re	fused to answ	er																
19.	If a fan	nily brought	their d	aughte	er to the	clinic 1	requesti	ing ge	nital	cutti	ing for	non-h	nealth	reas	sons,	wou	ld you	perfo	rm c

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#### ANC PROVIDER QUESTIONNAIRE (HCP)

2. 3. <i>Now I would</i>	Participant ID:  Project ID: Country ID: Facility ID:  No  I don't know  like to ask you a few questions about how you solve problems that you face. Please state how much you agree or a the statements that I read, , where 1=Strongly disagree; 2=Disagree; 3=Neither agree nor disagree; 4=Agree; agree
20. I wi	ll be able to achieve most of the goals that I have set for myself.
1.	☐ Strongly disagree
2.	□ Disagree
3.	□ Neither agree nor disagree
4.	□ Agree A 6 5 9 9 3
5.	☐ Strongly agree
6.	□ Don't know
21. Wh	en facing difficult tasks, I am certain that I will accomplish them.
1.	☐ Strongly disagree
2.	□ Disagree
3.	□ Neither agree nor disagree
4.	☐ Agree
5. 6.	☐ Strongly agree ☐ Don't know
	eneral, I think that I can obtain outcomes that are important to me.  Strongly disagree  Disagree  Neither agree nor disagree
Version 2 – 6	5 <sup>th</sup> November 2019
	To be completed by data collector:
	Data Collector ID:  Date:

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A HEALTH SYSTEMS APPROACH	TO PREVENTION OF FEMALE GENITA	AL MUTILATION USING PERSO	N-CENTRED COMMUNICATION
IMPLEN	IENTATION RESEARCH PROJECT IN G	GUINEA, SOMALIA AND KENYA	(A65993)

#### ANC PROVIDER OUESTIONNAIRE (HCP)

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			Partio	ipant	ID:		7							
							_		Proie	ect ID:		Count	rv ID:	Facility ID:
	4.	□ Agree												
	5.	□ Strong	gly agree	•										
	6.	□ Don't	know											
23.	I be	elieve I car	n succee	d at m	ost any	endea	vour t	o which	ı I set m	v min	d.			
	1.	□ Strong			·					•				
	2.	☐ Disagr	-											
	3.	☐ Neithe		nor di	sagree									
	4.	□ Agree	_											
	5.	□ Strong		•										
	6.	□ Don't												
24.	I w	ill be able	to succe	ssfully	v overc	ome m	anv ch	allenge	s.					
	1.	□ Strong												
	2.	☐ Disagr	-											
	3.	☐ Neithe		nor di	sagree									
	4.	□ Agree	_		0									
		□ Strong		•										
		Α	6 5		9	9	3							
	_	□ D	1											
	6.	□ Don't	Know											
	_						_							
25.		n confider		_	erform	effecti	vely on	many	differei	it tasks	S.			
	1.	□ Strong		ree										
	2.	□ Disagr												
	3.	□ Neithe	_	nor di	sagree									
	4. -	☐ Agree												
	5.	□ Strong	-	9										
	6.	□ Don't	know											
Version	2 –	6th Novem	ber 2019											
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Da			ANC I	PROVI	DER Q	UESTIC	NNA	IRE (I	HCP)						
Pa	rticipant	t ID:		]											
								_					_		
Γ						Pro	ject I	D:		Ī	Countr	у ір:	Fac	cility	וט:
Compared to othe		e, I can d	lo most t	tasks v	very w	ell.									
1. □ Strongly di	sagree														
2. □ Disagree															
3. □ Neither agi	ee nor d	disagree													
4. □ Agree															
<ul><li>5. □ Strongly ag</li><li>6. □ Don't know</li></ul>															
6. □ Don't knov	,														
Even when things	are toug	gh, I can	perforn	n quit	e well.										
l. □ Strongly di	_	• •													
2. □ Disagree	Ü														
_															
3. □ Neither agi	ee nor d	disagree													
8	ee nor d	disagree													
4. □ Agree		disagree													
4. □ Agree 5. □ Strongly ag	ree	lisagree													
4. □ Agree 5. □ Strongly ag	ree	disagree		9	(										
4. □ Agree 5. □ Strongly ag	ree	lisagree		9		0									
4. □ Agree 5. □ Strongly ag	ree	lisagree		9		0									
4. □ Agree 5. □ Strongly ag	ree	lisagree		9											
4. □ Agree 5. □ Strongly ag	ree	disagree		<u> </u>	(	2									
4. □ Agree 5. □ Strongly ag	ree	disagree		9				1							
4. □ Agree 5. □ Strongly ag	ree	disagree		9		7									
l. □ Agree 5. □ Strongly ag	ree	disagree													
A. □ Agree 5. □ Strongly ag	ree	disagree						1							
4. □ Agree 5. □ Strongly ag	ree	disagree 5 9	9	3					C						
4. □ Agree 5. □ Strongly ag 6. □ Don't knov	ree		9	3				1							
Agree  Agree  Don't knov	6	5 9													

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To be completed by data collector:

Data Collector ID:

Signature:

Day Month Year

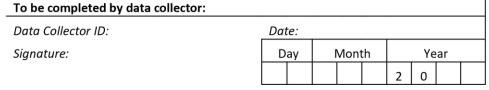
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#### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

#### ANC PROVIDER QUESTIONNAIRE (HCP)

		ANG THOUSEN GOESTIONNAINE (HEI')	
		Participant ID:	
		Project ID: Country ID: Facility ID:	
	1.	□ Always	70
	2.	□ Often	ceci
	3.	□ Sometimes	Q
4	4.	□ Rarely	y
:	5.	□ Never	g
30. If yo	ou h	neard of or saw a colleague performing female genital mutilation, what would you do? (Tick all that apply)	Protected by copyright,
	1.	☐ I would report him/her to the authorities	=
2	2.	$\square$ I would discuss with him/her and explain to him/her that health care providers should not perform female genital	JCIU
		mutilation	ging
	3.	☐ I would not get involved 4. ☐ I don't know	910
31. How	v oft	ten do you look for female genital cutting/excision when performing a gynecological examination of the vulva?	בי ע
	1.		es
	2.	□ Often	ela
	3.	□ Sometimes	Ced
	4.	Rarely	100
		□ Never	ext
		ten do you record the female genital mutilation in the women's medical file if you are aware that she has one FGM?	elated to text and data mining,
	1.	□ Always	ala
	2.	□ Often	
	3.	□ Sometimes	g
4	4.	□ Rarely	
:	5.	□ Never	נוש
33. Wou	ıld y	you like to receive more training on how to help patients to prevent FGM?	Ai training, and
	1.	□ Yes	j,
	2.	□ No	
	3.	□ I don't know	Ē
		A 6 5 9 9 3	ar
			ecn
34. I can	יות ח	at myself in others' shoes	similar technologies.
	-	□ Always	gje
		□ Often	ý
			o
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#### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

#### ANC PROVIDER QUESTIONNAIRE (HCP)

		Partici	pant ID:	•						
				•			Project	ID:	Country ID:	Facility ID
	3.	□ Sometimes								
	3. 4.	□ Rarely								
	5.	□ Never								
35.		ners know I und	derstand	what t	hev sav	7				
	1.	□ Always			3					
	2.	☐ Often								
	3.	☐ Sometimes								
	4.	☐ Rarely								
	5.	□ Never								
36.	In conv	ersations with	my colle	agues, l	I perce	ive not on	ly what th	ey say but v	what they don'	t sav
	1.	□ Always	J	8 /			•	v	v	v
	2.	☐ Often								
	3.	☐ Sometimes								
	4.	☐ Rarely								
	5.	□ Never								
37.	I comm	unicate effectiv	vely							
	1.	□ Always	•							
	2.	☐ Often								
	3.	☐ Sometimes								
	4.	☐ Rarely								
	5.	□ Never								
38.	I comm	unicate with of	thers as	though	they aı					
	1.	☐ Always								
	2.	☐ Often								
	3.	☐ Sometimes								
	4.	☐ Rarely								
	5.	□ Never								
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#### **BMJ** Open A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993) **ANC PROVIDER QUESTIONNAIRE (HCP)** Participant ID: Project ID: Country ID: Facility ID: These next questions relate to your clinic setting: 39. Have you seen the posters on FGM at the clinic? 1. □ Yes 2. □ No 3. □ I don't know 40. Have you referred to the clinical handbook on FGM that is available in your clinic? 1. □ No ☐ I don't know 41. Do you think it is feasible to provide FGM prevention counselling during ANC visits? 1. □ Yes 2. $\square$ No

**Comments** 

3.

☐ I don't know

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#### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

	Destining and ID.
	Participant ID:
	Project ID: Facility ID:
	FIRST ANC CLIENT EXIT QUESTIONNAIRE (EXT)
	FIRST AIRC CLIENT EXTT QUESTIONINAIRE (EXT)
	Control And Color LATT Question LATT
	Country ID:  A 6 5 9 9 3
	A 6 5 9 9 3
1.	How old are you? (years)
2.	What is your religion?
	1. □ Muslim
	2. ☐ Christian
	3. □ Other
	4. □ None
	5. □ Refused
3.	What is the highest level of education you achieved?
	1. □ None
	2. □ Primary
	3. □ Secondary
	4. □ University
	5. □ Other, specify
4.	Many women in your community have had their genitals cut when they were children, if you are comfortable telling me,
	can I ask if you have undergone this practice?
	1. □ Yes
	2. □ No
	3. □ I don't know
_	4. □ Refused
5.	How supportive are you of female genital mutilation?
	<ol> <li>☐ Strongly opposed</li> </ol>
	2. □ Somewhat opposed
	<ol> <li>□ Strongly opposed</li> <li>□ Somewhat opposed</li> <li>□ Neutral (Neither opposed or supportive)</li> </ol>
	4. ☐ Somewhat supportive
	5. □ Strongly supportive
The f	ollowing questions relate to your visit today. During your visit today:

6. Did you see any FGM poster(s) in the waiting room?

- 1. □ Yes
  - 2. □ No

- 3. □ I don't know

### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

		ſ	Partici	ipant IC	): 								
		L			<u> </u>						Projec	t ID:	Facility ID:
_	<b>D.</b> 1				_		T.G						
7		the ANC pro	vider a	sk if yo	ou have	under	gone FG	iM? ∟					
	1.	□ Yes											
	2.	□ No											
0	3.	☐ I don't kr		, .	. E	73.6		,	141.0				
8	. Dia i 1.	the ANC prov □ Yes	vider e	xplain	now FC	JM cai	n narm y	our ne	eaith?				
	1. 2.	□ Yes											
	۷.	□ NO											
Ver	sion 2 –	6 <sup>th</sup> November	r 2019	1 <b>F</b>	IRST AN	C CLIE	NT EXIT C	QUESTI	IONNAIR	RE (EXT)			
									Country	ID:			
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	3.	□ I don't kno	337										
_				_									
9.	Did the	e ANC provid		about	your p	ersona	l belief r	egardi	ing FGM	1?			
9.	<b>Did tho</b>	e ANC provid		about	your p	ersona	l belief r	egardi	ing FGM	Л?			
9.	Did the 1. 2.	e <b>ANC provid</b> □ Yes □ No	ler ask	about	your p	ersona	l belief r	egardi	ing FGM	1?			
	1. 2. 3.	e ANC provid Yes  No I don't kr	ler ask							1?			
	Did the 1. 2. 3. Did the	e ANC provid Yes No I don't kr	ler ask							1?			
	Did the 1. 2. 3. Did the 1.	e ANC provide Yes  □ Yes □ No □ I don't kree ANC provide □ Yes	ler ask							1?			
	Did the 1. 2. 3. Did the 1. 2.	e ANC provided Yes  No I don't know the ANC provided Yes  No	ler ask now ler dis							1?			
10.	Did the 1. 2. 3. Did the 1. 2. 3.	e ANC provided Yes  No I don't known the ANC provided Yes  No I don't known the Yes	now ler dise	cuss wl	ny FGM	I shoul	d be pre	evented	1?	1?			
10.	Did the 1. 2. 3. Did the 2. 3. Did the	e ANC provided Yes  No I don't know the ANC provided Yes  No I don't know the ANC provided Yes  No I don't know the ANC provided Yes	now ler dise	cuss wl	ny FGM	I shoul	d be pre	evented	1?	1?			
10.	Did the 1. 2. 3. Did the 2. 3. Did the 1. 1. 1.	e ANC provided Yes  No I don't known Yes ANC provided Yes No I don't known Yes ANC provided Yes Yes	now ler dise	cuss wl	ny FGM	I shoul	d be pre	evented	1?	1?			
10.	Did the 1. 2. 3. Did the 1. 2. 3. Did the 1. 2. 2.	e ANC provided Yes  No I don't known Yes No I don't known Yes No I don't known Yes No I don't known Yes No No No No No No	now der dise now der dise	cuss wl	ny FGM	I shoul	d be pre	evented	1?	1?			
10. 11.	Did the 1. 2. 3. Did the 1. 2. 3. Did the 1. 2. 3.	e ANC provided Yes  No I don't known yes ANC provided Yes No I don't known yes ANC provided Yes No I don't known yes I don't known yes	now ler dise	cuss wl	ny FGM ow FGM	I shoul I could	d be pre	evented?	i?	1?			
10. 11.	Did the 1. 2. 3. Did the 1. 2. 3. Did the 1. 2. 3.	e ANC provided Yes  No I don't know yes No I don't know yes No I don't know yes No I don't know yes	now ler dise	cuss wl	ny FGM ow FGM	I shoul I could	d be pre	evented?	i?	1?			
10. 11.	Did the 1. 2. 3. Did the 1. 2. 3. Did the 2. 3. Did the you	e ANC provided Yes  No I don't known yes ANC provided Yes No I don't known yes ANC provided Yes No I don't known yes I don't known yes	now ler dise	cuss wl	ny FGM ow FGM	I shoul I could	d be pre	evented?	i?	1?			
10. 11.	Did the 1. 2. 3. Did the 1. 2. 3. Did the 1. 2. 3. Did the 3. 2. 3. Did you 1.	e ANC provided Yes  No I don't know Yes No I don't know Yes No I don't know Yes No I don't know Yes No I don't know Yes No I don't know Yes No I don't know Yes	now how how how how how	cuss wl	ny FGM ow FGM	I shoul I could	d be pre	evented?	i?	1?			
<ul><li>10.</li><li>11.</li><li>12.</li></ul>	Did the 1. 2. 3. Did the 1. 2. 3. Did the 3. Did you 1. 2. 3. Did you 3. 3.	e ANC provided Yes  No I don't know the ANC provided Yes No I don't know the ANC provided Yes No I don't know the ANC provided Yes No I don't know the ANC provided Yes No I don't know the ANC provided Yes No I don't know the ANC provided Yes No	now how how how how how	cuss wh	ny FGM ow FGM	I shoul I could	d be prev	evented?	i?	1?			
<ul><li>10.</li><li>11.</li><li>12.</li></ul>	Did the 1. 2. 3. Did the 1. 2. 3. Did the 3. Did you 1. 2. 3. Did you 3. 3.	e ANC provided Yes  Yes  No I don't know the ANC provided Yes  No I don't know the ANC provided Yes  I don't know the ANC provided Yes  Yes  No I don't know the Yes	now how how how how how	cuss wh	ny FGM ow FGM	I shoul I could	d be prev	evented?	i?	1?			
<ul><li>10.</li><li>11.</li><li>12.</li></ul>	Did the 1. 2. 3. Did the 2. 3. Did you 1. 2. 3. Did you 3. Did you 3. Did you 3. Did you 3.	e ANC provided Yes  No I don't know the ANC provided Yes No I don't know the ANC provided Yes No I don't know the ANC provided Yes No I don't know the ANC question Yes No I don't know the ANC question Yes	now how how how how how	cuss wh	ny FGM ow FGM	I shoul I could	d be prev	evented?	i?	1?			

14. Are you satisfied with how FGM was addressed during your visit with your ANC provider today?

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#### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

		Participant ID:
		Project ID: Facility ID:
	1.	□ Yes
	2.	□ No
	3.	□ I don't know
15.	What d	lo you feel about FGM now as compared to before you came to the clinic today?
	1.	☐ Same, no change
	2.	☐ I feel more supportive of FGM now as compared to before I came
	3.	☐ I feel less supportive of FGM now as compared to before I came
	4.	☐ I do not know
	5.	☐ Other, specify
16.	Pretend	d you had a daughter now who was at an age when cutting occurs, what would your intention to cut her be
	1.	☐ Intend to cut her
	2.	☐ Do not intend to cut her
17.	Do you	wish/want to be active in preventing FGM?
	1.	□ Yes
	2.	□ No
	3.	□ I don't know
Vor	cion 2	6th November 2010

#### Supplementary file 3: Additional analyses (appendices 1-3)

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3	Supplementary file 3: Additional ar	nalysas (annondicas 1 3)	incl	
4	Supplementary me 3. Additional ar	naryses (appendices 1 – 3)	udii	
5	Appendix 1: Comparison baseline cha	aracteristics of ANC facilities	ng f	
6 7	Characteristics	Facilities included in final analysis	Facilities	s excluded* from final analysis
8		(n=163)	Ens uses	(n=17)
9	Number of ANC providers	Mean 4 (SD: 3) Median 3 (1-14, IQR 3)	7 <u>e. 20</u>	Mean 3 (SD: 3) Median 2 (1-9, IQR 1)
10	Average number of ANC clients/month	Mean 150 (SD: 127) Median 118 (3-664, IQR 141)	Mea <b>ti 4</b> 6	(SD: 147) Median 100 (25-600, IQR 200)
11	MoH supervisory visits in the past year	Mean 4 (SD: 3) Median 3 (0-18, IQR 2)	ted Do	Mean 5 (SD: 4) Median 4 (0-12, IQR 4)
12	Size of catchment population served	Mean 36,754 (SD: 126,082) Median 15,972 (1,000-1,458,000,	Mean 11,73 <b>7</b> (\$)[§:	: 14,62) Median 7,800 (1,200-63,000, IQR
13		IQR 24,332)	nloaded f t Superied text and	7,505
14	Presence of anti-FGM activities in the catch		t al	
15	Yes	74 (45%)	nd f	9 (53%)
16	No Section 1	89 (55%)	from eur (A data	8 (47%)
17	Presence of pro-FGM activities in the catch			2 (120()
18	Yes	21 (13%)	BES)	
19	No Dook Ko	140 (86%)		15 (88%)
20	Don't Know	2 (1%)	, Al tr	-
22 23 24 25 26 27 28 29 30 31	*Total of ANC clinics not included: 16 clinics were excludy time points while one ANC clinic in Kenya was not insecurity attended the PCC training and was subsequen	luded (7 intervention and 9 control) due to loss-to-follow up (LTFU) of ANC providever visited at subsequent time points due to issues with insecurity. An ANC providitly interviewed.	ler i.e., the clinics⊞id not installed instal	in Kenya that had been inaccessible due to
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Appendix 2: Comparison of baseline characteristics of ANC providers

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Appendix 2: Comparison of baselin  Characteristics	Providers recruited at Baseline (n=436)	Providers enrolled with complete data at Month 6 (n=232)  36 (20-65; SD: 10) at 8 (1-39; SD: 7) at 100 at 1	O Providers not enrolled with no data at
Age	37 (20-65; SD: 10)	36 (20-65; SD: 10)	38 (21-62; SD: 10)
Years of professional experience	9 (1-39; SD: 7)	8 (1-39; SD: 7) <b>2</b>	10 (1-36; SD: 8)
Sex		<del>c</del>	¥ š
Female	361 (83%)	193 (83%) (8	168 (82%)
Male	75 (17%)	39 (17%)	36 (18%)
Highest educational level		<u>a</u>	7. <u>0</u>
Certificate	44 (3%)	21 (5%)	23 (11%) (23 (11%)
Diploma	309 (71%)	158 (68%)ធី	<b>2</b> 151 (74%)
Bachelors	64 (15%)	21 (5%) 158 (68%) 44 (19%) 1 (0.4%)	20 (10%)
Masters & above	3 (0.7%)	1 (0.4%) 5	2 (1%)
Other#	16 (4%)	8 (3%)	8 (4%)
Current professional role/title		2	95 (47%)
Midwife	198 (45%)	103 (44%) <b>a</b>	
Nurse	95 (22%)	51 (22%)	
Nurse-Midwife	94 (22%)	54 (23%)	40 (20%)
Other	49 (11%)	24 (10%)	25 (12%)
Received formal training on FGM during	<u> </u>	<u>v</u>	
Yes	158 (36%)	85 (37%)	
No	275 (63%)	146 (63%) <sup>a</sup>	129 (63%) 2 (1%)
Don't Know	3 (0.7%)	1 (0.4%) <b>g</b>	2 (1%)
Timing of clinical training on FGM		n n	
Pre-service	63 (14%)	33 (14%) <del>0</del>	30 (15%) 36 (18%)
In-service	81 (19%)	45 (19% <b>)</b>	0)
Both pre- and in-service	14 (3%)	7 (3%).	7 (3%)
Received formal training on communicati		440 (212)	
Yes	287 (66%)	149 (64%)	138 (68%)
No	149 (34%)	83 (36%)	<b>©</b> 66 (32%)
Received formal training on person-cente		110 (510)	<u>D</u>
Yes	227 (52%)	118 (51%)	<b>ö</b> 109 (53%)
No Dan't Image	207 (47%)	131 (56%)	94 (46%)
Don't know	2 (0.5%)	1 (0.4%)	138 (68%) 66 (32%) 5 7 109 (53%) 7 7 94 (46%) 7 1 (0.5%)

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	Providers recruited at Baseline (n=436)	at Month 6	Providers not enrolled with no data at  Month 6  (n=204)
<u>Undergone</u> FGM		for	o (n=204)
Yes	226 (52%)	126 (54%) <b>5</b> m	<u>c</u> 100 (49%)
No	128 (29%)	126 (54%) 5 m 63 (27%) 6 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	<b>S</b> 65 (32%)
Don't know	4 (0.9%)	2 (1%) <u>ම</u> ජූ	1 (0.5%)
Refused to answer	3 (0.7%)	2 (1%) at a nem	1 (0.55)
Conducted FGM	27 (0.1)	ne n	O (10)
Yes	35 (8%)		<u>\$</u> 20 (10%)
Conducted FGM on a girl <18 years Yes	22 (72)	14 (6%) a a a	ଅଧି ପ୍ରକ୍ରି 18 (9%)
		Superieur (ABES) . ext and data mining, Al training, and similar technologies 14 (6%) 14	rom http://bmjopen.bmj.com/ on June 13, 2025 at Agence Bibliographique de l

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Appendix 3: Comparison of study outcomes between baseline vs. month 3 and month 3 vs. month 6 in the intervention arm

seline ention only)	Month 3	P-value	<u> </u>		
	(Intervention only)	r-value	Monti 23 (Intercention only)	Month 6 (Intervention only)	P-value
			use use		
ider impleme	nted components of PC	C for FGM	prevention of N		
48 (6%)	298 (37%)	< 0.0001	<b>9</b> (37%)	694 (78%)	< 0.0001
38 (5%)	239 (29%)	< 0.0001	<b>a 239</b> (29%)	616 (76%)	< 0.0001
56 (7%)	243 (30%)	< 0.0001	<b>8 3</b> 4 <b>7</b> (30%)		< 0.0001
48 (6%)	224 (28%)	< 0.0001	<del>5</del> <del>9</del> <del>2</del> (28%)		< 0.0001
			<del>= 34</del> (43%)	`	< 0.0001
_ `	\ /		¥1 <del>5</del> 7 <b>8</b> 1.5-1.8)	\ /	< 0.0001
\ /			<u>2</u> 3 <b>6 6</b> .8-3.8)		< 0.0001
110 (110 211)	2.2 (2.0 2.0)	(0.0001	<u> </u>	0.2 (0.5 0.0)	10.0001
ss to offer FG	M prevention and care	services	<u> </u>	<u> </u>	
	<b>.</b>		E C E		
0 (0%)	42 (52%)	< 0.0001	<b>₹ ₩</b> (52%)	56 (69%)	< 0.01
.1 (0.01-0.2)	3.1 (2.9-3.4)	< 0.0001	<b>53 2</b> .9-3.4)	3.4 (3.2-3.6)	0.18
	ì		308	Ì	
1 (1%)	61 (58%)	< 0.0001	≥ 6 (58%)	96 (91%)	< 0.0001
11 (11%)	20 (19%)	< 0.0001	<b>5</b> (19%)		< 0.0001
			<u> </u>	(-111)	
			<del>5                                    </del>	<u> </u>	
0 (0%)	1 (3%)	0.47	1 (20/)	8 (8%)	0.06
- (/				\ /	0.11
			2 (000()		0.17
			<u> </u>		0.50
	\ /		81 (77%)		< 0.001
	\ /		10 (96%)		1.0
					0.75
20 (2110)		0.00		201(27,0)	
104 (24%)	235 (20%)	0.01	218 (20%)	124 (52%)	< 0.0001
			0 3/65 (/3%)		< 0.0001
			184 (23%)	`	< 0.0001
· /					< 0.001
530 (65%)	547 (68%)	0.003	547 (68%)	677 (83%)	< 0.001
(	48 (6%) 176 (21%) 0.5 (0.4-0.5) 1.8 (1.6-2.1)  ess to offer FG  0 (0%) .1 (0.01-0.2)  1 (11%) 11 (11%)  0 (0%) 49 (49%) 85 (85%) 67 (67%) 84 (83%) 91 (91%) 98 (97%)  194 (24%) 367 (45%) 249 (30%) 141 (17%)	48 (6%) 224 (28%) 176 (21%) 346 (43%) 0.5 (0.4-0.5) 1.7 (1.5-1.8) 1.8 (1.6-2.1) 3.3 (2.8-3.8)  28 to offer FGM prevention and care  0 (0%) 42 (52%) 1.1 (0.01-0.2) 3.1 (2.9-3.4)  1 (1%) 61 (58%) 11 (11%) 20 (19%)  0 (0%) 1 (3%) 49 (49%) 62 (59%) 85 (85%) 94 (90%) 67 (67%) 75 (71%) 84 (83%) 81 (77%) 91 (91%) 101 (96%) 98 (97%) 104 (99%)  194 (24%) 235 (29%) 367 (45%) 345 (43%) 249 (30%) 184 (23%) 141 (17%) 117 (14%)	48 (6%)       224 (28%)       <0.0001	176 (21%) 346 (43%) <0.0001	48 (6%)   224 (28%)   <0.0001   6 3 2 (28%)   592 (73%)     176 (21%)   346 (43%)   <0.0001

Section/Topic	Item	Standard Checklist item	Extension for cluster	Page
	No		designs	No *
Title and abatus at				
Title and abstract				
	1a	Identification as a	Identification as a cluster	1
	14	randomised trial in the title	randomised trial in the title	-
		randomised that in the title	randomised that in the title	
	1b	Structured summary of trial	See table 2	3
		design, methods, results,		
		and conclusions (for specific		
		guidance see CONSORT for		
		abstracts) <sup>1,2</sup>		
		,		
Introduction				
Background and	2a	Scientific background and	Rationale for using a cluster	5-6
objectives		explanation of rationale	design	
	2b	Specific objectives or	Whether objectives pertain to	7
		hypotheses	the cluster level, the individual	
			participant level or both	
80.111.				
Methods				
Trial design	3a	Description of trial design	Definition of cluster and	7
Trial acsign	Ju	(such as parallel, factorial)	description of how the design	'
		including allocation ratio	features apply to the clusters	
		merading anocation ratio	reduces apply to the clusters	
	3b	Important changes to		N/A
		methods after trial		
		commencement (such as		
		eligibility criteria), with		
		reasons		
Participants	4a	Eligibility criteria for	Eligibility criteria for clusters	7-8
		participants		
	4b	Settings and locations		6-7
		where the data were		
		collected		
Internal (12)	-	The interpretation (	M/h ath an internal	
Interventions	5	The interventions for each	Whether interventions pertain to	6
		group with sufficient details	the cluster level, the individual	
		to allow replication,	participant level or both	
		including how and when		
		they were actually		
		administered		
Outcomes	6-2	Completely defined are	Whather outcome massing	10
Outcomes	6a	Completely defined pre-	Whether outcome measures	10
		specified primary and	pertain to the cluster level, the	

		secondary outcome measures, including how and when they were assessed	individual participant level or both	
	6b	Any changes to trial outcomes after the trial commenced, with reasons		N/A
Sample size	7a	How sample size was determined	Method of calculation, number of clusters(s) (and whether equal or unequal cluster sizes are assumed), cluster size, a coefficient of intra-cluster correlation (ICC or k), and an indication of its uncertainty	10-11
	7b	When applicable, explanation of any interim analyses and stopping guidelines		12
Randomisation:				
Sequence generation	8a	Method used to generate the random allocation sequence		8-9
	8b	Type of randomisation; details of any restriction (such as blocking and block size)	Details of stratification or matching if used	8-9
Allocation concealment mechanism	9	Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned	Specification that allocation was based on clusters rather than individuals and whether allocation concealment (if any) was at the cluster level, the individual participant level or both	9
Implementation	10	Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions	Replace by 10a, 10b and 10c	
	10a		Who generated the random allocation sequence, who enrolled clusters, and who assigned clusters to interventions	8

	10b		Mechanism by which individual participants were included in clusters for the purposes of the trial (such as complete enumeration, random sampling)	8
	10c		From whom consent was sought (representatives of the cluster, or individual cluster members, or both), and whether consent was sought before or after randomisation	8
Blinding	11a	If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how		8-9
	11b	If relevant, description of the similarity of interventions		8-9
Statistical methods	12a	Statistical methods used to compare groups for primary and secondary outcomes	How clustering was taken into account	10-13
	12b	Methods for additional analyses, such as subgroup analyses and adjusted analyses		12-13
Results			4	
Participant flow (a diagram is strongly recommended)	13a	For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome	For each group, the numbers of clusters that were randomly assigned, received intended treatment, and were analysed for the primary outcome	15
	13b	For each group, losses and exclusions after randomisation, together with reasons	For each group, losses and exclusions for both clusters and individual cluster members	Figure 2

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Interpretation	22	Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence	23-24
Other information			
Registration	23	Registration number and name of trial registry	15
Protocol	24	Where the full trial protocol can be accessed, if available	15
Funding	25	Sources of funding and other support (such as supply of drugs), role of funders	In Funding Statement

<sup>\*</sup> Note: page numbers optional depending on journal requirements

### BMJ Open

## A cluster randomized trial of a health system strengthening approach applying person-centered communication for the prevention of female genital mutilation in Guinea, Kenya, and Somalia

Journal:	BMJ Open
Manuscript ID	bmjopen-2023-078771.R3
Article Type:	Original research
Date Submitted by the Author:	20-May-2024
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<b>Primary Subject Heading</b> :	Health services research
Secondary Subject Heading:	Evidence based practice, Reproductive medicine, Research methods, Communication, Complementary medicine

Keywords: EDUCATION & TRAINING (see Medical Education & Training), Patient-Centered Care, Primary Care < Primary Health Care, Primary Prevention, PUBLIC HEALTH, Behavior

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Abstract word count: 299

Text word count: 6,084

Tables: 4

Figures: 1



BMJ Open: first published as 10.1136/bmjopen-2023-078771 on 4 July 2024. Downloaded from http://bmjopen.bmj.com/ on June 13, 2025 at Agence Bibliographique de l Enseignement Superieur (ABES) .

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## **ABSTRACT**

**Introduction**: There is limited evidence on effective health systems interventions for preventing female genital mutilation (FGM). This study tested a two-level intervention package at primary care applying person-centred communication (PCC) for FGM prevention.

Methods: A cluster randomized trial was conducted in 2020 - 2021 in 180 antenatal care (ANC) clinics in Guinea, Kenya, and Somalia. At baseline, all clinics received guidance and materials on FGM prevention and care; at month three, ANC providers at intervention sites received PCC training. Data were collected from clinic managers, ANC providers and clients at baseline, month three and month six on primary outcomes, including delivery of PCC counseling, utilization of level one materials, health facility preparedness for FGM prevention and care services, and secondary outcomes related to clients' and providers' knowledge and attitudes. Data were analyzed using multi-level and single-level logistic regression models.

Results: Providers in the intervention arm were more likely to deliver PCC for FGM prevention compared to those in the control arm, including inquiring about clients' FGM status (OR: 8.9, 95% CI: 6.9-11.5; p<0.001) and FGM-related beliefs (OR: 9.7, 95% CI: 7.5-12.5; p<0.001) and discussing why (OR: 9.2, 95% CI: 7.1-11.9; p<0.001) or how (OR: 7.7, 95% CI: 6.0-9.9; p<0.001) FGM should be prevented. They were more confident in their FGM-related knowledge (OR: 6.3, 95% CI: 1.4-28.9; p=0.02) and communication skills (OR: 1.7; 95% CI: 1.0-3.0; p=0.06). Intervention clients were less supportive of FGM (AOR: 5.4, 95% CI: 2.4-12.4; p<0.001] and had lower intentions of having their daughters undergo FGM (AOR: 0.3, 95% CI: 0.1-0.7; p=0.004) or seeking medicalized FGM (AOR: 0.2, 95% CI: 0.1-0.5; p<0.001) compared to those in the control arm.

**Conclusion**: This is the first study to provide evidence of an effective FGM prevention intervention that can be delivered in primary care settings in high prevalence countries.

Trial registration and date: PACTR201906696419769 (June 3<sup>rd</sup>, 2019)

## **SUMMARY BOX**

- This hybrid-effectiveness implementation research study conducted in primary care public health facilities in three countries with high prevalence of female genital mutilation (FGM) assessed the prole of health workers in providing FGM prevention communication in the context of routine antenatal care (ANC).

  It will be important to assess the effectiveness of the person-centred communication approach in other service delivery points, e.g., child immunization, and with other cadres of health workers, c.g., community health workers, to assess its effectiveness beyond ANC care.

  Many factors influence FGM-related decision-making, and while primary care health workers were found to be effective communicators, and the randomized design controlled for some external factors, the impact of a health sector intervention in conjunction with multi-sectoral initiatives requires futher investigation.

  To ensure participation of at least one ANC provider at each site through each time point, eligibility of health workers was based on clinic rotation schedules, which may have introduced a selection bias although the included and excluded providers did not appear to differ significantly.

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# **INTRODUCTION**

Multi-sectoral efforts are needed to achieve Sustainable Development Goal (SDG) 5.3 to eliminate the harmful practice of female genital mutilation (FGM) by 2030 in line with the United Nation's (UN) General Assembly resolution 67/146 (1), the World Health Assembly Resolution 61.16 (2) and the 2008 Interagency Statement (3), which call upon UN Member States to enact comprehensive and multi-disciplinary national action plans and strategies towards the elimination of the practice. Identifying effective strategies across sectors is an important step in ending FGM.

The health system, defined as all organizations, institutions and resources that produce actions whose primary purpose is to improve health(4), has an important role to play not only in managing complications of FGM but also in preventing the practice. Health care providers, specifically nurses and midwives who constitute most of the health workforce, are highly respected members of FGM practising communities and could positively contribute to abandonment efforts (5,6). However, there is currently limited evidence to guide health programming on FGM prevention (7). In addition, some health care providers are themselves supportive of this harmful practice, and might even perform it (i.e., FGM medicalization), despite national laws and medical ethics forbidding it (8–11). Developing evidence-based tools to build skills of health care providers and address their underlying beliefs could contribute to FGM abandonment efforts and complement existing resources on management of complications (12,13) to ensure comprehensive and high quality care.

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Three countries (Guinea, Somalia, and Kenya) participated in a cluster randomized trial to test the effectiveness and implementation of a health system strengthening approach to FGM, which included the testing of an intervention to build skills of health workers on applying person-centered communication (PCC) for the prevention of FGM (14). Study countries were selected based on their high national and/or sub-national FGM prevalence. The national prevalence of FGM among women and girls aged 15 - 49 and 15 - 49 years is 98% in Somalia, 97% in Guinea and 21% in Kenya according to national population-based surveys. There are 20 hotspot counties/sub-national administrative units in Kenya with a prevalence of >80% (15), and this study focused on three of these counties. Likewise, the study countries have high rates of medicalized FGM, performed primarily by midwives, who make up between 71% to 93% of primary health care providers in the three study countries (16) hence the selection of nurses and midwives as the target group for this intervention.

The purpose of this study was to test a two-level intervention package to enable ANC providers to deliver person-centered FGM counseling to their clients. This intervention package was informed by a theory of change that promotes health workers to be effective behavioral change agents because of their credibility (17) and positionality to influence the opinions, attitudes, beliefs, motivations and behaviors of their clients (18). We hypothesized that if ANC providers gained the necessary knowledge and skills to provide person-centered counseling (Level 2) and were given the opportunity to question their beliefs and attitudes together with an enabling environment (Level 1), they could positively influence the knowledge and attitudes of their clients to abandon the practice (Supplementary file 1).

Al training, and similar technologies The level one intervention consisted of making available national policy directives on the role of health care providers in providing FGM prevention and care services, WHO's FGM guidelines and clinical handbook as well as information, education, and communication (IEC) materials. These materials were distributed without any capacity building to accompany their distribution. Level two

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consisted of an interactive training specifically targeting ANC providers to build their knowledge on FGM, enable them to question their FGM-related values and attitudes and build their skills on counseling for FGM prevention using person-centred communication (19), a component of personcentred care, which ensures that the perspectives and preferences of individuals, carers, families and communities are at the center of decisions and that they have the information and support needed to make decisions (20). ANC providers were trained to apply a series of structured steps in which they would: 'Assess' their client's views on FGM, address and challenge her 'Beliefs', encourage 'Change' and together with the client, 'Discuss and Decide' (ABCD).

## **METHODS**

# **Study Design**

Protected by copyright, including for uses related to text and This cluster randomized trial applied a type 2 hybrid, effectiveness-implementation design (21) to test the effectiveness of the delivery of a phased intervention package (Level 1 and 2) on knowledge, attitudes and practices among ANC health workers and their clients. This type of implementation data mining, Al training, and similar technologies research design assesses the effectiveness of the intervention and implementation factors in real world settings. The methodology, analysis plan and reporting conformed to the Consolidated Standards of Reporting Trial (CONSORT) 2010 statement: extension for cluster randomized trials checklist (22). Ethical approval for the master protocol was obtained from the World Health Organization (WHO) Ethical Review Committee (ERC) (#P151/03/2014). Each study country submitted country-specific protocols to local 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).

# **Participants**

Within each study country, two or three sub-national units (regions/counties) were purposively selected according to the following eligibility criteria: (1) FGM prevalence >50% among females 15 -49 years old; (2) more than 15 ANC clinics, seeing on average 30 new ANC clients per month and (3) accessibility in terms of security. The unit of randomization was the ANC clinic to avoid having ANC providers in the same clinic in different study arms, which could lead to contamination. In intervention sites, all providers on duty were pre-screened. To ensure participation and follow-up throughout the trial, between one and three ANC providers on duty were enrolled based on a six-month clinic rotation schedule provided by the clinic manager. Ten new clients exiting their first ANC consultation with a participating provider were recruited at each data collection point.

Individual study participants gave verbal informed consent. Data collectors collected data from the ANC providers and their clients in a private and confidential setting. While personally identifiable information was collected from ANC providers to facilitate tracking during the follow-up data collection time points, data were de-identified prior to analysis. No personally identifiable information was collected from ANC clients who were unique at each time point. Participating ANC clients received the equivalent of 5 USD to compensate for their transport costs recognizing that participants consenting to participate might have changed their plans to accommodate the interviews. Given insecurity in carrying cash in Somalia, a mobile phone application was used to transfer the money to participants, an amendment to the original protocol, which was submitted to the ethical review committees.

## Randomization and blinding

Based on Ministry of Health (MoH) facility administrative records, all public, primary care facilities (i.e., dispensaries and/or health centers) offering ANC services in the selected regions/counties the average number of new ANC clients seen in November and December 2019 was compiled to create

based on client loads at each of the sites by region/county. Clinics were matched into pairs based on client load so the two busiest would be randomized to different arms and so on. A uniform distribution was used for randomization using the uniform random number function in STATA 17

(StataCorp Inc., College Station, TX, USA). Study teams organized data collection and intervention trainings based on the randomization lists. Attempts were made to blind clinic managers, ANC providers and their clients to study arm allocation. Since both study arms received the level one intervention component at baseline, and the providers and managers at control sites were unaware of the training that took place at intervention sites, it is conceivable that they were not aware of their study arm.

Presumably, intervention clients would assume they were the intervention arm, but they were also not aware of what might have been offered to other sites. ANC clients, however, were completely blinded as to study arm allocation since a distinct set of clients was interviewed at each time point, and they would not be aware of the training the provider had had. Field data collectors were also blinded to study arm allocation as much as possible, although some might have determined intervention arm during the study.

## **Procedures**

Implementation of the study interventions and data collection occurred between August 2020 and September 2021 and was staggered by countries. In the intervention arm, data collection was undertaken at three time points, i.e., at baseline prior to implementing the level one intervention component; at month three, prior to implementing the level two intervention component and at month six. In the control arm, data collection was done at two time points, i.e., at baseline and at month six. Study instruments included one for ANC clients, one for health workers and a health facility checklist completed by clinic managers. Instruments were pretested among ANC clients and providers from non-participating sites in all countries, and country teams provided feedback on the structure and appropriateness of each question prior to finalizing the instruments.

A web-interface electronic data capture system was developed on the Kobo toolbox core system architecture (Kobo Toolbox, Harvard Humanitarian Initiative, Boston, Massachusetts, USA). User accounts were password-protected, and data sent to the server was encrypted in transit using SHA256 with RSA encryption that met the data security requirements. Personally identifiable information was not collected, and all records were anonymized with unique study numbers. Study instruments for ANC clients were translated from English into ten languages by research team members in consultation with language experts (French, Somali, Swahili, Soussou, Poular, Malinké, Keiyo, Maasai, Marakwet and Tugen) while those for ANC providers and clinic managers were translated into two languages (French and Somali). No backtranslation was performed. Field data collectors and their supervisors spoke the languages in which the questionnaires were administered. Data collection teams participated in a standardized training with WHO/HRP and the research institutions in each country. The level two intervention was implemented by master trainers in each country who had been trained remotely over a three-day period following the WHO PCC for FGM prevention facilitator's manual.

## **Outcomes**

The primary study outcome was delivery of the "ABCD" approach by ANC providers measured by responses from their client using tools developed for this study based on previously validated instruments, including four constructs of the operational definition of person-centered communication (23). We also assessed ANC provider delivery of FGM care services and their utilization of the level one intervention components. Health facility preparedness to offer FGM prevention and care was assessed using a composite score developed for this study. (Supplementary file 2). The secondary self-efficacy outcome was assessed based on a score calculated from a validated tool for measuring general self-efficacy (24) while knowledge, attitudes, and practice (KAP) on FGM prevention and care were

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measured using an unvalidated KAP questionnaire similar to one used in formative research in Guinea. Study instruments can be found in Supplementary file 3

## Statistical analysis

To have sufficient power (80%) to detect a difference (significance level 5%) between intervention and control arms on the primary study outcome of delivery of the PCC intervention for FGM prevention, 180 ANC clinics, equally divided across the three study countries were recruited and randomized with 1800 new ANC clients (10 per clinic) recruited at baseline and 1800 at six-month follow-up. While similar interventions have resulted in 20% difference between groups (25), a 10% difference (based on an assumed 20% in the control arm and 30% in the intervention arm) was applied to ensure sufficient power to detect a 10% difference and considering the minimal levels of clinical efficacy for such an intervention to be practical. This sample size also allowed for a 10% non-response and/or loss to follow-up rate and accounted for a clustering effect of (ICC=0.20) at clinic level. A relatively high level of clustering was assumed in the sample size calculations to not underestimate the needed sample size. Region/county level was not included in the multilevel model due to the low number of included regions/counties per country (Kenya 3, Guinea 2, Somalia 3) and it would then not be possible to get an accurate estimate of the variance between clusters.

needed sample size. Region/county level was not included in the multilevel model due to the low number of included regions/counties per country (Kenya 3, Guinea 2, Somalia 3) and it would then not be possible to get an accurate estimate of the variance between clusters.

Data were analyzed using STATA 17 software following a per-protocol approach. Data from ANC providers and their clients were analyzed if the clinic had at least one provider with follow up data at all study time points, and in the intervention arm, if the ANC provider present had undergone training on PCC for FGM prevention at month three. Clinics where providers were lost to follow-up were not included in the final analyses. All facility checklists and ANC client exit interviews were conducted as intended except at sites not accessible due to security issues or closed or converted for care of COVID-19 patients during the pandemic. As the study was designed to pre-screen ANC providers at baseline and

Continuous variables are presented using mean values, and standard deviation (SD) while categorical variables are summarized as counts (N) with percentages (%). Differences in proportions were analysed for dichotomous outcomes using Fischer's exact test. For outcomes measured as summary scores, comparisons of mean scores are presented across study arms using t-test.

Initial analyses showed that the clustering was negligible at the provider level since most sites only included one provider in the study. Therefore, multilevel regression models were not used to compare outcomes among providers in intervention vs. control arms. However, analyses based on client level outcomes applied multilevel mixed effect logistic regression models to assess differences between the study arms. Multilevel analyses were attempted for the models in which ANC clients reported on provider actions, but given the complexity of the models, convergence problems arose leading to unreliable results. In these cases, results of ordinary models are presented. Linearity was assessed for the continuous covariates included in the regression models using the Box-Tidwell test in Stata.

At month six, a comparison of study outcomes between the intervention and control arms was used to determine the combined effect of both levels of the intervention package. Multilevel multivariable logistic regression analyses for ANC provider outcomes were adjusted for their sex, years of service, FGM status, FGM-related training, any specific training on communication/counseling and PCC, and whether the provider had conducted FGM in the past. Analyses related to ANC client outcomes were adjusted for their age, educational level, FGM status and exposure to level one IEC materials. These variables were determined a priori based on previously published literature. Analyses

related to provider actions as reported by clients were adjusted for client characteristics as it was not possible to definitively link a client with a particular provider. Unadjusted analyses are presented for outcomes that relate to composite measures based on ANC provider and client responses (e.g., provision of FGM prevention and care services).

To determine the separate effect of the two levels of the intervention package, additional sub-analyses were conducted restricted to the intervention arm. Changes from baseline to month 3 within the intervention arm were used to determine the effect of the level one intervention component while changes from month 3 to month 6 within the same study arm were used to determine the effect of the level two intervention component. The study was not powered for these sub-analyses, however, and these results are presented in Supplementary file 4.

In-country data managers monitored data quality. Periodic data audits were conducted by the WHO/HRP Quantitative Assessment and Data Management team to identify any data collection gaps and data discrepancies requiring follow up by in-country teams. Weekly data monitoring meetings were held between the in-country research teams and WHO/HRP staff during data collection periods to identify, document and resolve any data discrepancies. These were virtual due to the COVID-19 pandemic. Given that there was no prospective follow-up of clients, a Data Safety and Monitoring Board was not established. Instead, local research teams documented and reported any unintended harms and/or protocol deviations to the WHO/HRP study coordination team.

Patient and public involvement statement

Health care providers and members of communities where the practice of FGM is prevalent in the study countries were actively involved in the design and implementation of this study intervention.

This included the formative research conducted in Guinea, which identified health care providers as integral members of FGM practicing communities who understand loca

making them effective change agents. The formative research also found that the health sector can support these health care providers to be effective change agents by incorporating FGM content within their training, ensuring accountability to legal and policy standards and promoting FGM abandonment as part of a multi-sectoral approach. Based on this formative work, the PCC training was developed and subsequently piloted among ANC providers in Kenya before being rolled out as part of the multicountry study.

Additionally, the research partners in Guinea, Kenya and Somalia actively engaged health care providers and community members as part of their in-country work towards FGM prevention. In Kenya as part of mobilization of study participants, community health volunteers in the study counties talked about the study during their community sensitization sessions and invited pregnant women to attend routine ANC sessions where they could be approached for participation in the study. Both health care providers and pregnant women were provided with information about the study, including the burden of the intervention as to time, any risks involved in their participation, the voluntary nature of their participation, and were recruited only after providing informed consent.

At present, study dissemination meetings have been conducted in Kenya and Guinea that have At present, study dissemination meetings have been conducted in Kenya and Guinea that have involved the MoH, other stakeholders as well as representatives of health care providers and community members where the study was implemented. In these meetings, the in-country research partners have led the development of policy briefs identifying country-specific results relevant for local research needs, policy development and practice.

Role of the funders

Apart from WHO/HRP, the study funders had no role in study design or implementation.

Apart from WHO/HRP, the study funders had no role in study design or implementation. WHO/HRP, in collaboration with in-country research teams, developed the study protocol, provided data management and analytic support, and contributed to interpretation and manuscript writing.

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WHO/HRP coordinated the successful implementation of this study. The data collection platform was developed and maintained by an outsourced vendor (First Data, LLC, Kenya); data management was coordinated by the local implementing partners (CERREGUI, DARS and University of Nairobi) and statistical data analysis was conducted by an external statistician (Dr. Max Petzold, Gothenburg University). All these functions were conducted with utmost integrity following ICH-GCP guidelines.

## **RESULTS**

## Recruitment and retention

Between August 2020 and September 2021, a total of 180 ANC clinics (i.e, 60 clinics per study country) were enrolled and randomized to intervention and control arms. There was some natural staggering of the start and subsequent data collection dates due to factors, such as weather, COVID-19, Ramadan, and national elections. Data collection periods ranged from three to six weeks in each country at each time point. The time elapsed between the end of one data collection period to the beginning of the next data collection period ranged from three to five months.

In the intervention arm, 216 providers and 900 clients (i.e.., 10 per clinic) were interviewed. Based on a review of clinic rotation schedule to ensure participation of at least one provider from each study clinic throughout the trial, 133 providers were enrolled. In the control arm, 220 providers and 900 clients were interviewed. (Figure 1). At month three, data were collected at 98% (n=88) of the intervention clinics as two clinics in Kenya were inaccessible due to insecurity. One hundred and thirty (98%) ANC providers (at least one from each site) and 880 first visit ANC clients completed the month three questionnaires prior to implementing the Level 2 intervention PCC. No data collection was conducted at the control sites. At month six, 91% (n=163) of ANC clinics (81, intervention and 82, control) had at least one ANC provider (intervention n=110 and control n=122) on duty who was

previously enrolled in the study. The client questionnaire was applied to 819 and 810 first visit ANC clients, respectively in the intervention and control sites.

# Characteristics of study sites and participants

The 163 ANC clinics retained to the end of the study, had a mean of four ANC providers (standard deviation, SD: 3) and served on average 155 new ANC clients per month (SD: 127) with a mean catchment population of 36,754 people (SD: 126,082). In 55% (n=89) of clinics, the clinic manager reported that there were no activities promoting FGM prevention in the facilities' catchment area (Table 1). These characteristics were not different from the 17 ANC clinics that were enrolled at baseline but that subsequently were not included in the final analysis (Supplementary file 4).

Protected by copyright, including for uses related to text and Of the 232 ANC providers who contributed data for analysis at month six, 83% (n=193) were female and their mean age was 36 years (SD: 10 years). They had an average of eight years professional experience (SD: 7 years) and 68% (n=158) had studied up to Diploma level (generally 3 years postsecondary education) with 90% (n=208) identifying as either midwives, nurses, or nurse-midwives. Health cadres were defined by national licensing requirements in each country. Among these providers, at baseline, 63% (n=146) reported that they had not received formal clinical training on FGM prevention and care (Table 2). Almost two-thirds (64%, n=149) reported that they had received training on communication/counselling while half (51%, n=118) had received training on person-centered care. Further, 54% (n=126) of female providers reported that they had undergone FGM while overall, 94% (n=217) of providers reported that they had never performed FGM. These characteristics were not different when compared to the ANC providers who were on duty in the 180 ANC clinics enrolled at baseline (Supplementary file 4). The mean age of the 1,800 clients exiting their first ANC visits at baseline was 26 years (SD: 6 years), 47% (n=846) reported not having received any education, and 73% (n=1,320) reported that they had undergone FGM. These characteristics were similar to the 880 and

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1,630 first visit ANC clients interviewed at month three (intervention arm only) and month six, respectively (*Table 3*).

To evaluate potential bias from differential selection of providers receiving the intervention, we assessed differences in baseline characteristics between the 133 ANC providers from intervention facilities who were screened at baseline and received PCC training at month three (i.e., included in the analytic sample) versus the 97 who were screened and did not receive the intervention (i.e., excluded from analytic sample). The reasons for this included the fact that some of the providers had been transferred from the study clinics or could not be released to attend the training so as not to affect service delivery. Both groups were similar in terms of sex, educational level, professional cadre, as well as whether they had undergone or recently performed FGM. However, included providers tended to be slightly younger (by two years on average) and less likely to be of Muslim religion, although the question on religion was not administered for the Somalia sample since all respondents were assumed to be Muslim (Supplementary file 4).

# ANC providers implementation of ABCD elements of the PCC approach

Table 4 presents the analysis of study outcomes by arm at month six. Compared to ANC providers in the control arm, those in the intervention arm were nearly nine times as likely to ask their clients if they had undergone FGM (OR: 8.9, 95% CI: 6.9-11.5; p<0.001), nearly ten times as likely to ask their clients' personal beliefs regarding FGM (OR: 9.7, 95% CI: 7.5-12.5; p<0.001), more than nine times as likely to discuss with their clients why FGM should be prevented (OR: 9.2, 95% CI: 7.1-11.9; p<0.001) and nearly eight times as likely to discuss with their clients how FGM could be prevented (OR: 7.7, 95% CI: 6.0-9.9; p<0.001). Further, ANC clients in the intervention arm were nearly seven times as likely to report that they were satisfied with how FGM had been addressed by their provider during the clinic visit compared to those in the control arm (OR: 6.6, 95% CI: 5.1-8.4; p<0.001). In the

intervention arm, the mean score of implementing the ABCD elements of the PCC approach was more than twice as likely (OR: 2.1, 95% CI: 1.6-2.6; p<0.001) to be higher in the intervention [3.9 (3.8-4.0)] compared to the control arm [1.6 (1.5-1.8)].

# ANC clinic preparedness to provide FGM prevention and care services

A significantly higher proportion of ANC clinics in the intervention arm had all correct repornse related to facility preparedness to provide FGM prevention and care services compared to those in the control arm (68% vs. 27%, p<0.001). Additionally, ANC clinics in the intervention arm had a significantly higher mean score for preparedness compared to those in the control arm [3.4 (95% CI: 3.2-3.6) vs. 2.6 (95% CI: 2.4-2.9; p<0.001)].

# ANC providers utilizing level one intervention components

Protected by copyright, including for uses related A higher proportion of ANC providers in the intervention arm reported having utilized the level one intervention package components compared to those in the control arm (83% vs. 56%, p<0.001). In multivariable analyses, ANC providers in the intervention arm were nine times as likely to report having

utilized the level one intervention package components compared to those in the control arm (AOR: 9.3, 95% CI: 4.2-20.8; P<0.001).

ANC providers offering appropriate FGM prevention and care services

At month six, based on a cumulative score to specific questions on provision of appropriate FGM-related prevention and care services, a higher proportion of ANC providers in the intervention arm reported that they had provided FGM prevention and care services correctly compared to those in the control arm (45% vs. 34%, p=0.03).

ANC providers' confidence, self-efficacy, and communication skills

# ANC providers' confidence, self-efficacy, and communication skills

A higher proportion of ANC providers in the intervention arm reported being confident in their knowledge to provide FGM prevention and care services compared to those in the control arm (98% vs. BMJ Open: first published as 10.1136/bmjopen-2023-078771 on 4 July 2024. Downloaded from http://bmjopen.bmj.com/ on June 13, 2025 at Agence Bibliographique de I

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# ANC providers' knowledge, attitudes and support for FGM/medicalized FGM

The mean correct scores for FGM-related knowledge were higher among ANC providers in the intervention arm compared to the control arm (2.5, 95% CI: 2.2-2.8 vs. 1.9, 95% CI: 1.7-2.2; p=0.005) but 8% vs. 2% (p=0.16) had correct responses on the FGM-related knowledge questions, showing low knowledge overall, and particularly on the FGM typology. Providers had similarly unsupportive attitudes towards FGM in both groups and similarly unsupportive attitudes about medicalized FGM with most providers reporting that they did not support FGM (82% vs. 85%, p=0.73) and/or medicalized FGM (72% vs. 73, p=0.94%).

# ANC clients' support for FGM, intention to have their daughters undergo FGM and being involved in FGM prevention efforts

Compared to those in the control arm, a higher proportion of ANC clients in the intervention arm reported being less supportive of FGM after their month six clinic visit (52% vs. 29%, p<0.001). In multivariable analysis, ANC clients in the intervention arm had more than twice the odds of reporting that they were strongly opposed to FGM (AOR: 2.4, 95% CI: 1.1-5.2; p=0.023, ICC: 0.61). When asked about their support for FGM after the ANC visit compared to before, clients in the intervention arm had more than five times the odds of being less supportive of FGM compared to those in the control arm (OR: 5.4, 95% CI: 2.4-12.4; p<0.001, ICC:0.66). ANC clients in the intervention clinics had lower odds of intending to have their daughters undergo FGM (OR: 0.3, 95% CI: 0.1-0.7; p=0.004, ICC: 0.60) or of

To understand the impact of the level one intervention relative to the level two intervention, a comparison of study outcomes restricted to the intervention arm was done between baseline and month three and between months three and six (Supplementary file 4). Although not statistically powered for this analyses, we found that a significantly higher proportion of ANC clients in the intervention arm reported that their provider had asked about the different PCC components at month three versus basleine and at month six versus month three. Similarly, a significantly higher proportion of ANC clinics in the intervention arm were prepared to provide FGM-related prevention and care services at month three compared to baseline and at month six compared to month three. No statistically signiofiocant differences were seen in the proportion of ANC providers with the secondary outcomes apart from high confidence scores seen between month six and month three. Finally, ANC client

apart from high confidence scores seen between month six and month three. Finally, ANC client outcomes were significantly higher among intervention clients in month three versus baseline and in month six versus month three.

DISCUSSION

The results of this cluster randomized trial show that an intervention to strengthen health facility preparedness while building skills of ANC providers to communicate using a person-centred counselling stechnique on FGM prevention was effective. ANC providers exposed to the intervention had increased confidence, improved FGM-related knowledge, and effective delivery of FGM prevention and care services. Additionally, ANC clients who had received care from these providers were less supportive of FGM and had reduced intentions to perform FGM on their daughters. This study provides evidence of a practical intervention to engage health care providers in FGM abandonment efforts whilst also providing

quality care to FGM survivors. This study provides evidence of how to effectively build the capacity of health care providers at primary care to address FGM(26), an area identified as a critical gap during the formative research.

The PCC training modules strengthened ANC providers' skills on FGM prevention and care and helped to clarify their beliefs and attitudes, which are key drivers of FGM (27). We did not find notable changes in knowledge and attitudes among ANC providers. The knowledge scores overall were low, and upon further investigation, it appears that questions on typology captured through visually drawn images, in a tablet device were consistently answered incorrectly. These results perhaps show measurement and knowledge limitations but do not necessarily relate to service provision or quality of care. Attitudes in the intervention and control groups were generally unsupportive of FGM and do not appear to be heavily impacted by the training intervention. Exposure to the intervention package also did not improve ANC providers' self-efficacy towards FGM prevention and care. This may be related to the lack of support for FGM and/or its medicalization and high self-efficacy among nearly all providers throughout the study in both study arms, a finding that was also noted in formative research conducted in Guinea (28,29). In the formative phase, while the vast majority of health workers were opposed to the practice. 38% also felt that FGM limited promiscuity and 7% believed that it was a good practice, showing ambivalence and complexity in attitudes about FGM among health providers. Other studies have found that some providers support the perpetuation of the practice and even planned to have their own daughters undergo FGM or to perform it on their clients(30).

The findings in this study underscore the importance of addressing values and attitudes of both providers and clients as a means of achieving positive behavioral change. Changes observed among ANC providers were sustained across the study duration and ultimately, and importantly, resulted in

ning, Al training, and similar technologies

reported changes in attitudes and intentions of their clients. However, this study design did not allow us to determine whether the attitudinal changes observed among ANC clients were sustained after their clinic visit or translated into positive change in FGM prevention.

The application of these study results into programming will need to consider several factors. Firstly, the study sites were primary care facilities located in high FGM prevalence settings. The results of this intervention may not be generalizable to settings where FGM is less prevalent or to settings other than primary care. Secondly, first ANC visits are not typical of other health visits since the consultation is generally longer with a greater focus on health promotion messaging. While this is an ideal setting for implementing such an intervention, its application to other health settings and among other population groups is not known. During scale up, if the PCC approach is applied among clients seeking other sexual and reproductive health services or parents bringing their children to child immunization and wellness visits, it will be important to consider time requirements for the delivery of the 'ABCD' steps, especially and data mining, Al training, and similar technologies in high volume clinic settings.

Thirdly, while the study found a positive impact of the PCC training on health care providers' delivery of person-centred FGM prevention counselling, the continuity and quality of FGM prevention counselling in the long-term is not known. Specifically, it will be important to assess subsequently whether providers will continue to provide prevention counselling on an ongoing basis, whether they will share their learnings with family and community members and whether clients will follow through with their intentions to not have their daughters undergo FGM. It may be important to include a supervisory mentorship component to ensure implementation of this intervention (31) in order to strengthen PCC communication practice and quality.

## Limitations

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The implementation of this multi-country study was not without challenges and limitations. First, initiation of field data collection activities was delayed by the global COVID-19 pandemic in 2020 – 2021 and required some modification to trainings of the data collection teams, the master trainers and the ANC providers receiving the PCC intervention. This may have impacted the overall effectiveness of the intervention.

the intervention.

Second, to attempt to ensure participation of at least one provider at each site, all providers were pre-screened at baseline and clinic rotation schedules determined enrollment into the study. Selection bias might have been introduced through this process. The exploratory analysis to assess for selection and attrition bias from the pre-screen step, did not reveal significant differences between included and excluded health workers except for slightly lower age (Supplementary file 4),and a per protocol analysis wasrequired, but it is possible that differences in other unmeasured factors related to the clinics and providers might have biased the results. Findings from a process evaluation conducted as part of this study will provide additional insights on the feasibility, acceptability, appropriateness, and fidelity of the intervention implementation in these contextual settings to inform further implementation and scale up.

Third, we did not perform adjustment for multiple testing in our analysis given that the different tests are interpreted separately and no overall conclusion will be stated. Given that the null hypotheses of no differences are true, we estimate that the overall type one error rate is higher than the individual test level of 0.05. In terms of assumptions regarding clustering, sample size was calculated based on an ICC of 0.20. However, the observed ICC:s were all above 0.50 leading to statistically conservative conclusions of the non-significant results due to being under-powered to find an association.

Finally, we acknowledge that there are many factors that could impact FGM-related decision-making and a positive and impactful interaction with a respected health care provider might not be

, Al training, and similar technologies

## Conclusion

In conclusion, this study highlights the importance of addressing the values and beliefs of health care providers working at primary care level, who are subject to social norms around FGM that may conflict with medical ethics and national laws and policies as an intermediary step in preventing FGM. Empowering these health care providers with communication skills and engaging them as opinion leaders can be impactful in changing their clients' attitudes towards FGM. In conjunction with FGM prevention activities in other sectors, this intervention can contribute to positive change if brought to scale.

DECLARATIONS

Contributors

WA and CP conceptualized the study and prepared the protocol in collaboration with VM, KS, PN, TE, MDB, AMS, AD(1) and MAA. MDB, AMS, AOS, PN, TE, JMK, AD(1) and MAA provided oversight over study implementation while AD(2), JK and SA monitored data quality in countries and KN and SST monitored data quality across countries. VM prepared the first draft of the manuscript with input from WA and CP, the responsible officer of the study at WHO/HRP. MP developed the statistical analysis plan and conducted data analysis. KS coordinated the development of the PCC for FGM prevention training. KS, PN, TE, JMK, JK, MDB, AMS, AOS, AD(1), AD(2), SA, and MAA contributed to and reviewed the manuscript for proper intellectual content. All authors read and approved the final draft of this manuscript.

Declaration of interests

The authors declare that they have no competing interests.

Data sharing

De-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP electronic archival system. Any use of the de-identified dataset will be retained in the WHO HRP e

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Atchison of Imperial College London for their input in conceptualizing the study as well as Dr Leyla Hussein for supporting pilot testing of the PCC intervention.

# **Funding**

This work received funding from the Governments of Norway and the United Kingdom of Great Britain and Northern Ireland as well as the UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), a cosponsored programme executed by the World Health Organization (WHO).

# **Ethics approval:**

The following research ethics committees approved the protocol:

- 1. World Health Organization (WHO) Ethical Review Committee (ERC) (#P151/03/2014).
- 2. Kenya: Kenyatta National Hospital/University of Nairobi ERC (P805/09/2019) and the National Commission for Science, Technology, and Innovation (NACOSTI/P/20/5721)
- 3. Somalia: the Department of Planning, Policy and Strategic Information, Unit of Research (MOHD/DG: 2/11526/2019)
- 4. Guinea: the Comité National d'Ethique Pour la Recherche en Santé (CNERS) (105/CNERS/19).

# 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).

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## **TABLES & FIGURES:**

Figure 1: Study CONSORT Diagram

**Table 1:** Characteristics of ANC clinics included in month six analyses

**Table 2:** Characteristics of ANC providers included in the month six analyses

**Table 3:** Characteristics of ANC clients interviewed at each time point

**Table 4:** Analysis of study outcomes

## SUPPLEMENTARY FILES

**Supplementary file 1:** Theory of change framework

**Supplementary file 2:** Measurement of study outcomes

**Supplementary file 3:** Data collection instruments

**Supplementary file 4:** Additional analyses (Appendices 1-3)

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**Table 1:** Characteristics of ANC clinics included in month six analyses

Characteristics	Overall (n=163*)	Intervention (n=82)	Control (n=81)
Number of ANC providers	Mean 4 (SD: 3) Median 3 (1-14, IQR 3)	$\vec{z}_{3}$	Mean 4 (SD: 3) Median 3 (1-14, IQR 4)
Average number of ANC clients/month	Mean 150 (SD: 127) Median 118 (3-664, IQR 141)	, , , , , , , , , , , , , , , , , , ,	Mean 152 (SD: 133) Median 120 (3-664, IQR 140)
MoH supervisory visits in the past year	Mean 4 (SD: 3) Median 3 (0-18, IQR 2)	Mean 4 (SD: 3) Median 4 (1-18, 19)	Mean 4 (SD: 3) Median 3 (0-12, IQR 2
Size of catchment population served	Mean 36,754 (SD: 126,082) Median 15,972 (1,000-1,458,000, IQR 24,332)	1 · · · · · · · · · · · · · · · · · · ·	
Presence of anti-FGM activities in the catc	hment area	age ct a	•
Yes	74 (45%)	43 (5 <b>22</b> / <b>a</b> ) 2	31 (38%)
No	89 (55%)	39 (4 <b>8</b> ∕ <b>5 5</b>	50 (62%)
Presence of pro-FGM activities in the catcl	nment area	ta (AE	
Yes	21 (13%)	12 (1 🕏 🣆	9 (11%)
No	140 (86%)	68 (8 <b>. \$</b> 8)	72 (89%)
Don't Know	2 (1%)	2 (2%)	0 (0%)

<sup>\*</sup>Total of 17 ANC clinics not included: 16 clinics were excluded (7 intervention and 9 control) due to loss-to-follow up (LTFU) of ANC provider i.e., the clinics of an one of the clinics in Kenya was never visited at subsequent time points due to issues with insecurity. An ANC provider from one of the clinics in Kenya that had been inaccessible due to insecurity attended the PCC training and was subsequently interviewed.

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**Table 2:** Characteristics of ANC providers included in the month six analyses

<b>Fable 2:</b> Characteristics of ANC pr	oviders included in the month	NJ Open 1 six analyses	136/bmjopen-2023-078 cted by copyright, includ
Characteristics	Overall (n=232)	Intervention (n= 115)	aComerol an=#17)
Age	Mean 36 (SD: 10) Median 34	Mean 35 (SD: 10) Median 33	Mean 37 (SE:11) Median 35
1190	(20-65, IQR 15)	(20-59, IQR 14)	20-65, IQR 16)
Years of professional experience	Mean 8 (SD: 7) Median 6 (1-39,	Mean 8 (SD:7) Median 6 (1-30,	Mean 8 (S <b>p</b> . <b>T</b> ) <b>S</b> Median 6 (1-39
Tomo or protocolorum emperiorio	IQR 7)	IQR 8)	IOR 7)
Sex			024 rela
Female	193 (83%)	95 (83%)	Mean 8 (Str. Median 6 (1-39, IQR 7)  Mean 8 (Str. Median 6 (1-39, IQR 7)  Plant Seignement Superior  To the seigne
			nen Ow
Highest educational level	Uh		nt S
Certificate	21 (5%)	12 (10%)	<b>X b d</b> 9 (8%)
Diploma	158 (68%)	72 (63%)	eric 86 (74%)
Bachelors	44 (19%)	27 (24%)	a T (15%)
Masters & above	1 (0.4%)	0 (0%)	<b>富 万 3</b> 1 (1%)
Other#	8 (3%)	4 (3%)	<b>3.8</b> 4 (3%)
Current professional role/title			nin S)
Midwife	103 (44%)	53 (46%)	<b>9</b> 50 (43%)
Nurse	51 (22%)	25 (22%)	26 (22%)
Nurse-Midwife	54 (23%)	27 (24%)	<u>a</u> . <u>9</u> 27 (23%)
Other	24 (10%)	10 (9%)	<b>a</b> 14 (12%)
Received formal training on FGM during			<u> </u>
Yes	85 (37%)	44 (38%)	an o 41 (35%)
No	146 (63%)	71 (62%)	<b>9</b> 75 (64%)
Don't Know	1 (0.4%)	0 (0%)	<u>a</u> n 1 (1%)
Timing of clinical training on FGM			lar Jun
Pre-service	33 (14%)	18 (16%)	<b>6 6</b> 15 (13%)
In-service	45 (19%)	22 (19%)	<b>3</b> 3 (20%)
Both pre- and in-service	7 (3%)	4 (4%)	26 (22%) 27 (23%) 14 (12%) 28 (22%) 29 (23%) 14 (12%) 20 (24%) 21 (12%) 21 (12%) 22 (20%) 23 (20%) 23 (20%) 25 (25%) 26 (22%) 27 (23%) 27 (23%) 28 (21%) 29 (21%) 29 (22%) 29
Received formal training on communicate			gie
Yes	149 (64%)	76 (66%)	73 (62%)
No	83 (36%)	39 (34%)	طط (38%) و 44 (38%)
Received formal training on person-center		<b>-</b> 6 /	Ö
Yes	118 (51%)	58 (50%)	60 (51%)
No	113 (56%)	56 (49%)	57 (49%)
Don't know	1 (0.4%)	1 (1%)	89. at 73 (62%) 44 (38%)  e 60 (51%) 57 (49%)  lioi 0 (0%)
<u>Undergone</u> FGM			<u>a</u>

Yes	126 (54%)	65 (57%)	<u>.</u> .
No	63 (27%)	27 (24%)	<u>nc</u>
Don't know	2 (1%)	2 (2%)	ud
Refused to answer	2 (1%)	1 (1%)	ing
Conducted FGM			ð
Yes	15 (7%)	9 (8%)	7 _
			ses
Conducted FGM on a girl <18 years			- Fe
Yes	14 (6%)	8 (7%)	lat
			ed
			jht, including for uses related to text and data mining, Al training, and similar technologies.

61 (52%)

36 (31%)

0 (0%)

1 (1%)

6 (5%)

6 (5%)

Table 3: Characteristics of ANC clients interviewed at each time point

Characteristics	AN	C clients interviewe at Baseline	ed	ANC clients interviewed at Month 3	8771 a	NC clients interviewe at Month 6	ed
	Overall Intervention (n=1800) (n=900)		Control (n=900)	Intervention only (n=880)	Overall on (n=1759) Land Mean 28 (38)	Intervention (n=879)	Control (n=880)
Age	Mean 26 (SD: 6) Median 25 (15- 45, IQR 10)	Mean 25 (SD: 6) Median 25 (15- 45, IQR 10)	Mean 26 (SD: 6) Median 25 (15- 45, IQR 10)	Mean 26 (SD 6) Median 25 (15-45, IQR 10)	Mean 28 (35) 6)  Media 28 (35) 5-  4 32 20 15  4 32 20 15  4 32 20 15  8 0 15	Mean 26 (SD: 6) Median 25 (15- 45, IQR 9)	Mean 26 (SD: 6) Median 25 (15- 45, IQR 10)
Highest educational			, , , , , ,	'	8 <u>8</u> 0	, , , , ,	, ,
None	840 (47%)	407 (45%)	433 (48%)	439 (50%)	805 ₹45%)	384 (44%)	422 (47%)
Primary	484 (27%)	231 (26%)	253 (28%)	239 (27%)	5 <b>\$</b> \$	278 (32%)	275 (31%)
Secondary	331 (18%)	171 (19%)	160 (18%)	157 (18%)	366718%)	160 (18%)	146 (16%)
University	95 (5%)	61 (7%)	34 (4%)	25 (3%)	₹ <u>₹</u>	34 (4%)	33 (4%)
Other#	50 (3%)	30 (3%)	20 (25)	20 (2%)	5 Superiour (ABES) 133196	23 (3%)	14 (2%)
Have you undergone			<b>N</b> ,		2 B 2		
Yes	1320 (73%)	677 (75%)	643 (71%)	645 (73%)	13 🕏 💢 📆 (%)	655 (75%)	666 (75%)
No	452 (25%)	209 (23%)	243 (27%)	224 (25%)	420.(23%)	206 (23%)	214 (24%)
Don't know	12 (1%)	10 (1%)	2 (0.2%)	5 (1%)	<b>2</b> 1 ( <b>2</b> %)	13 (2%)	8 (1%)
Refused to answer	16 (1%)	4 (0.4%)	12 (10/)	((10/)	<del>4</del> (0 <del>.2</del> %)	5 (1%)	2 (0.2%
				0 (1%)	(Nowen.bmj.com/ on June 13, 2025 at Agence Bibliographique de l		
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**Table 4:** Analysis of study outcomes

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Table 4: Analysis of study outcomes				023-(	
				0787	
Primary Outcomes  ANC clients reporting that their provide		CDCCC FCM		<del> </del>	
ANC chents reporting that their provide	Intervention	Control	Adjusted OR#	Paralue	ICC
	(n=819)	(n=810)	(95% CI)	9 4 P	icc
Provider asked client if they have undergone FGM	634 (77%)	245 (30%)	8.9 (6.9-11.5)	<u> </u>	N/A
Provider asked client about the client's personal beliefs regarding FGM	616 (75%)	217 (27%)	9.7 (7.5-12.5)	© m ⊆ <0.001	N/A
Provider discussed with client why FGM should be prevented	629 (77%)	244 (30%)	9.2 (7.1-11.9)	<b>6 7 8 8 8 8 8 8 8 8 8 8</b>	N/A
Provider discussed with client how FGM could be prevented	592 (72%)	232 (29%)	7.7 (6.0-9.9)	<u>P</u> Q S <0.001	N/A
Client satisfied with how FGM was addressed by provider during clinic visit	684 (84%)	348 (43%)	6.6 (5.1-8.4)	<0.001	N/A
				Section   Sect	
			Difference in mean	6 3 8	
			scores (95% CI)	le sol	
Mean score of implementing PCC approach (out of 5)	3.9 (3.8-4.0)	1.6 (1.5-1.7)	2.3 (2.1-2.5)	주 등 호 <0.001	N/A
Mean score of PCC + appropriate FGM prevention and care (out of 8)	6.2 (5.9-6.6)	3.7 (3.2-4.1)	2.6 (2.0-3.2)	<u> </u>	N/A
ANC clinic prepared	lness to offer FGM prevent				
	Intervention	Control	Adjusted OR&	יש ש -value	ICC
	(n=82)	(n=81)	(95% CI)	3.B	
Clinics with ALL correct responses for preparedness	56 (68%)	22 (27%)	-	<0.001	N/A
M C 1' ' 1 ( 4 CA)	2462226	2 ( (2 4 2 0)		<b>3</b> <0.001	NI/A
Mean score of clinic preparedness (out of 4)	3.4 (3.2-3.6)	2.6 (2.4-2.9)	-	<u> </u>	N/A
	Intervention	Control	Adjusted OR&	Poalue	ICC
	(n=115)	(n=117)	(95% CI)		icc
Providers using level 1 intervention package	96 (83%)	65 (56%)	9.3 (4.2-20.8)	Palue n 3 <0.001	N/A
110 riders doing level 1 intervention package	70 (0370)	05 (5070)	7.5 (1.2 20.0)	• -	1071
				an co	
Secondary Outcomes*				<b>(0</b>	
Providers with appropriate interpersonal communication skills	74 (64%)	68 (58%)	1.7 (1.0-3.0)	<b>3</b> 0.060	N/A
Providers with high self-efficacy	86 (75%)	99 (85%)	0.8 (0.4-1.6)	0.453 ے	N/A
Providers reporting less supportive attitudes towards FGM	76 (66%)	85 (73%)	1.0 (0.5-1.8)		N/A
Providers with high confidence scores	103 (90%)	104 (89%)	6.3 (1.4-28.9)		N/A
Providers not supportive of FGM	100 (87%)	114 (97%)	0.8 (0.2-3.7)	β ω 0.726	N/A
Providers not supportive of medicalized FGM	104 (90%)	116 (99%)	1.1 (0.1-22.1)	0 0.938 0 0.16	N/A
Providers with correct FGM-related knowledge responses	8 (8%)	1 (2%)	5.0 (0.5-47.8)	<b>9 1</b> 0.16	N/A
	- ()	( )	()	ies at	
Mean score of FGM-related knowledge (out of 6)	2.5 (2.2-2.8)	1.9 (1.7-2.2)		<b>6</b> 0.005	N/A
ivicali score di l'Oivi-telateu kilowieuge (out 01 0)	2.3 (2.2-2.8)	1.7 (1.7-2.2)	-	7 0.005 9 0.005	1N/A
OIL ANG P. 4. 4 **				<u> </u>	
Other ANC client outcomes**	T 4 4*	Control	Adjusted OR&	ο P- <b>xz</b> alue	ICC
	Intervention				
	Intervention (n=819)			5	
Clients reporting less support for FGM after ANC clinic visit	(n=819) 424 (52%)	(n=810) 237 (29%)	(95% CI) 5.4 (2.4-12.4)	© <0.001 0.023	0.66

				<u> </u>		
Clients reporting that they intend to have their daughters cut	96 (12%)	209 (26%)	0.3 (0.1-0.7)	<del>-</del> 13	0.004	0.60
Clients reporting that they would prefer health care provider to cut daughters	53 (7%)	139 (17%)	0.2 (0.1-0.5)	.07 jni	< 0.001	0.54
Clients wishing to be active in FGM prevention	677 (83%)	535 (66%)	3.2 (1.6-6.2)	187	0.001	0.50

ICC = Intra-cluster Correlation Coefficient

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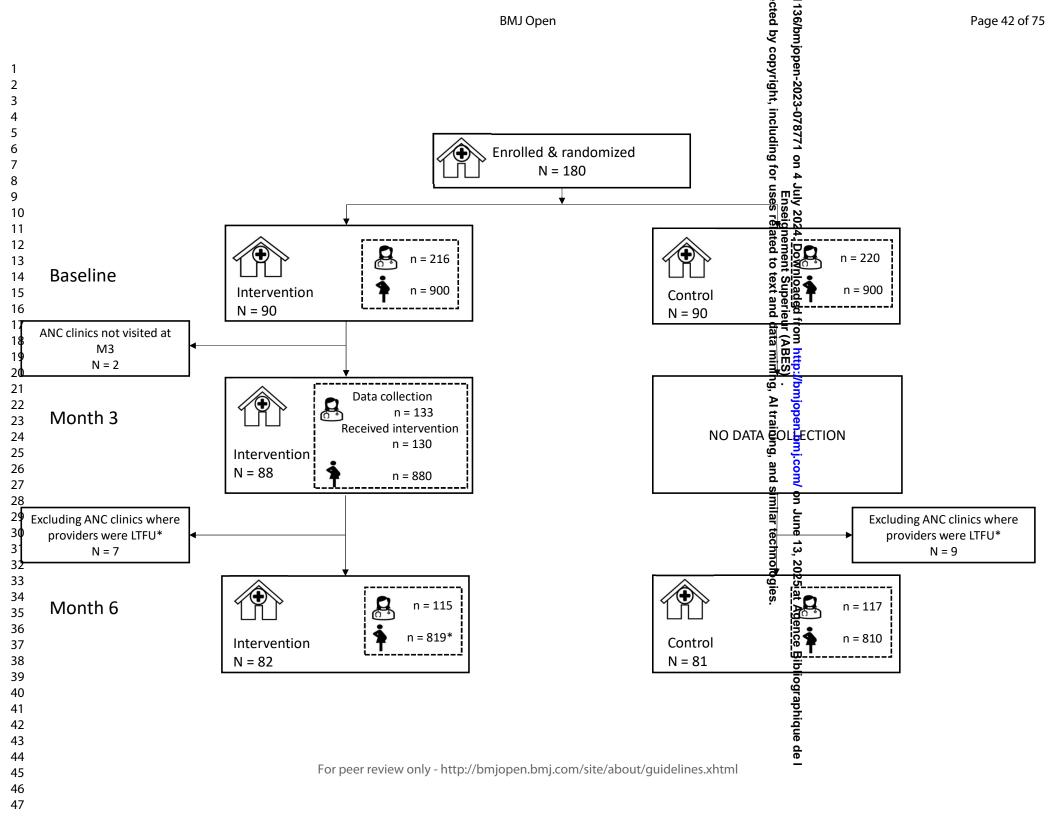
<sup>#</sup>Single-level multi-variable adjusted models

<sup>&</sup>amp;Multi-level multi-variable adjusted models

<sup>\*</sup>Provider outcomes adjusted for sex, years of service, FGM status, FGM-related training, any specific training on communication/counseling and PCC, and the past

<sup>\*\*</sup> Client outcomes adjusted for age, educational level, FGM status and exposure to level one IEC materials

Totoe exterior only



#### **INTERVENTION PACKAGE** (Health systems)

- Health policy against **FGM** medicalization
- Information, education and communication (IEC) materials in clinics
- Job aides and checklist



#### **HEALTH SYSTEM FACTORS**

- Low knowledge and skills in prevention and care
- Non-availability of tools / aides / IEC material
- Lack of policies
- Lack of supervisory support



#### INDIVIDUAL FACTORS

- Low self-efficacy on FGM prevention
- Attitude toward FGM and its medicalization
- Lack of training on communication / counseling

#### **INTERVENTION PACKAGE** (Provider-focused)

Using interactive methods and education outreach for

- Values clarification on FGM
- Patient-centered communication skill building



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on June 13, 2025 at Agence

- erson-centred communication
- Killion Hattitudes against FGM aining.

**DELIVERY OF FGM PREVENTION MESSAGES** 

#### CLIENTS

- Reduced support for FGM
- Greater intention to abandon FGM
- Be more active in FGM abandonment



#### Supplementary file 2: Measurement of study outcomes

**1. Primary Outcome:** Health facility preparedness to provide FGM prevention and care services.

**Outcome definition**: Cumulative score based on affirmative responses to Q9a, Q10a, Q11a & Q12a on the CHK form (see below).

```
Q9. Is there an MoH policy on FGM posted on the wall?
```

Yes

1 2 3

4 5

6 7

8

9

10

11

12

13

14

15

16

17

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19

20

21

22

23 24

25

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29 30

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32 33 34

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38 39

40 41

42

43

44

45

46

47 48 49

50

51

52

53

54 55

56

57

58

59

60

No

Q9a. If yes, is it placed where health care providers can see/read it e.g., bulletin board?

Yes

No

Q10. Are there WHO FGM prevention posters on the wall of the consultation room and/or waiting room?

Yes

No

Q10a. If yes, are they placed in a place where ANC clients can see them?

Yes

No

Q11. Is there a WHO clinical handbook in the ANC consultation room?

Yes

No

Q11a If yes, is it placed where ANC providers can see/use it?

res

No

Q12. Is there an FGM ABCD guide in the ANC consultation room?

Yes

No

Q12a. If yes, is it placed where ANC providers can see/use it?

Yes

No

#### 2. Primary outcome: ANC provider utilization of Level 1 package components

Outcome definition: Affirmative response on Q40 of HCP form (see below).

```
Q40. Have you referred to the WHO Clinical Handbook on FGM?
```

Yes

No, available but not referred

No, not available

Don't know

#### 3. Primary outcome: Provision of FGM-related care after PCC training

**Outcome definition:** Cumulative score based on affirmative responses (Provision of FGM-related care (after PCC training) either 'Always' or 'Often') on Q22, Q24 & Q25 on the HCP form (see below).

Q22. How often do you discourage a pregnant woman expecting to have a girl, or one having a girl at the age of cutting, from having her daughter cut?

**Always** 

Often

Sometimes

Rarely

4

5

6

7

8

9

11

13

21

23

24

27

31

37

49

51

```
Never
                             Rarely
                             Refused to answer
                     Q24. How often do you look for female genital mutilation when performing a gynecological
             examination of the vulva?
                             Always
                             Often
10
                             Sometimes
12
                             Rarely
                             Never
14
                             Rarely
15
                             Refused to answer
16
                     Q25. How often do you record female genital mutilation in the woman's medical file if you
17
             are aware that she has undergone FGM?
18
19
                             Always
20
                             Often
                             Sometimes
22
                             Rarely
                             Never
                             Rarely
25
                             Refused to answer
26
                 4. Primary Outcome: Delivery of PCC 'ABCD' package
28
29
             Outcome definition: Cumulative score based on affirmative responses on Q5, Q7, Q8, Q9 &
30
             Q12 on the EXT form.
                     Q5. Did the ANC provider ask if you have undergone FGM?
32
                             Yes
33
                             No
34
35
                             Don't know
36
                             Refused
                     Q7. Did the ANC provider ask about your personal belief regarding FGM?
38
                             Yes
39
                             No
40
                             Don't know
41
                             Refused
42
                     Q8. Did the ANC provider discuss why FGM should be prevented?
43
                             Yes
44
45
                             No
46
                             Don't know
47
                             Refused
48
                     Q9. Did the ANC provider discuss how FGM could be prevented?
                             Yes
50
                             No
                             Don't know
52
                             Refused
54
                     Q12. Are you satisfied with how FGM was addressed during your visit with your ANC provider
55
             today?
56
                             Yes
57
                             No
58
                             Don't know
59
                             Refused
60
```

#### 5. Secondary Outcome: Improved knowledge about FGM

**Outcome definition:** Cumulative score based on correct responses to Q4 + affirmative responses to Q5 & Q7 of the HCP form.

```
Q4. Please provide the WHO classification for the following images
```

```
Type I
```

6 7

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23 24 25

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Type II

Type III

Type IV

Don't Know

Other

Q5. Do you know of any health complications arising from female genital mutilation?

Yes

No

Q7. Are you aware of any existing WHO tools/guidance on FGM prevention and care?

Yе

No

#### 6. Secondary Outcome: Improved interpersonal communication skills

**Outcome definition:** Cumulative score based on positive responses ("Always or Often") to Q34, Q35, Q36, Q37, Q38 on the HCP form.

Now I will ask you about your communication skills

34. I can put myself in others shoes

Always

Often

Sometimes

Rarely

Never

Rarely

Refused to answer

35. I let others know that I understand what they say

**Always** 

Often

Sometimes

Rarely

Never

Rarely

Refused to answer

36. In conversations with my colleagues, I perceive not only what they say but what they don't say

**Always** 

Often

Sometimes

Rarely

Never

Rarely

Refused to answer

37. I communicate effectively

Always

Often

```
Sometimes
Rarely
Never
Rarely
Refused to answer

38. I communicate with others as though they are my equals
Always
Often
Sometimes
Rarely
Never
Rarely
Refused to answer
```

#### 7. Secondary outcome: Improved self-efficacy

**Outcome definition:** Cumulative score based on positive responses (Agree or Strongly Agree) to Q26, Q27, Q28, Q29, Q30, Q31, Q32, Q33 on the HCP form.

Now I would like to ask you a few questions about how you solve problems that you face. Please tell me how much you agree or disagree with the statements that I read to you

```
1 = Strongly disagree
```

- 2 = Disagree
- 3 = Neither agree nor disagree
- 4 = Agree
- 5 = Strongly agree
- Q26. I will be able to achieve most of the goals that I have set for myself
- Q27. When facing difficult tasks, I am certain that I will accomplish them
- Q28. In general, I think that I can obtain outcomes that are important to me
- Q29. I believe that I can succeed at almost any endeavor to which I set my mind
- Q30. I will be able to successfully overcome many challenges
- Q31. I am confident that I can perform effectively on many different tasks
- Q32. Compared to other people, I can do most tasks very well
- Q33. Even when things are tough, I can perform quite well

#### 8. Secondary outcome: Improved attitudes towards FGM

**Outcome definition**: Cumulative score based on positive responses to Q12, Q13, Q14, Q15, Q16, Q17, Q18 & Q19 on the HCP form.

For each of the following statements please state if you:

```
1=Agree
```

- 2=Disagree
- 3=Don't know
- 4=Refused to answer
- Q12. A girl who has not undergone FGM is unclean
- Q13. A girl who has not undergone FGM cannot be married within her community
- Q14. A girl who has not undergone FGM is a disgrace to her family's honor
- Q15. Health care providers who provide FGM are violating FGM
- Q16. Health care providers who provide FGM should be punished
- Q17. FGM is a good practice
- Q18. FGM is a violation of women and girls' rights
- Q19. FGM is religious mandate

9. Tertiary outcome: ANC provider confidence in FGM knowledge to provide care
Outcome definition: Positive responses ('Somewhat Confident' or 'Confident') to Q8 & Q9 on
the HCP form

Q8. When you treat or attend to a girl or woman with female genital mutilation, how confident are you that you have enough knowledge to provide good quality care?

1=Not confident

2=Somewhat confident

3=Confident

6

7 8

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21 22

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24 25

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4=Refused to answer

Q9. How confident are you in your knowledge to communicate on FGM prevention?

1=Not confident

2=Somewhat confident

3=Confident

4=Refused to answer

#### 10. Tertiary outcome: ANC provider support for FGM

**Outcome definition:** Positive response ('Do not intend to cut her') to Q20 on the HCP form Q20. Pretend you had a daughter now who was at an age when cutting occurs, what would your intention to cut her be?

1=Intend to cut her

2=Do not intend to cut her

3=Don't know

4=Refused to answer

#### 11. Tertiary outcome: ANC provider support for medicalized FGM

Outcome definition: Correct response ('No') to Q21 on HCP form

Q21. If a family brought their daughter to the clinic requesting genital cutting, for non-health reasons, would you perform it?

1=Yes

2=No

3=Don't know

4=Refused to answer

#### 12. Tertiary outcome: ANC client change in support for FGM after ANC visit

**Outcome definition:** Response to Q13 on EXT form

Q13. What do you feel about FGM now as compared to before you came to the clinic today?

1= Same, no change

2=I feel more supportive of FGM now as compared to before I came

3=I feel less supportive of FGM now as compared to before I came

4=Don't know

5=Other

6=Refused to answer

#### 13. Tertiary outcome: ANC client support or opposition to FGM

Outcome definition: Response to Q14 on EXT form

Q14. How supportive are you of female genital mutilation?

1=Strongly opposed

2=Somewhat opposed

3=Neutral 4=Somewhat supportive 5=Strongly supportive 6=Refused to answer

#### 14. Tertiary outcome: ANC client intention to cut after ANC visit.

#### **Outcome definition:** Response to Q16 on EXT form

Q.16 Pretend you had a daughter now who was at an age where cutting occurs, what would your intention to cut her be?

1=Intend to cut her 2=Do not intend to cut her 3=Don't know 4=Refused to answer

#### 15. Tertiary outcome: ANC client choice of who to cut their daughters.

#### **Outcome definition:** Response to Q17 on EXT form

Q17. If intending to cut, who would you prefer to do the cutting?

1=Traditional practitioner 2=Health care provider 3=Other 4=Refused to answer

#### 16. Tertiary outcome: ANC client wish to be active in FGM prevention

#### **Outcome definition:** Response to Q18 on EXT form

Q.18 Do you wish/want to be active in preventing FGM?

2=No 3=Don't know 4=Refused to answer

1=Yes

#### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

#### ANC PROVIDER SCREENING QUESTIONNAIRE (SCR)

Participant ID:

	Project ID: Country ID: Facility ID:
Instruct	ions: Observe and report findings from the health facility.
1.	MoH policy on FGM posted on the wall?  ☐ Yes ☐ No  1a. If yes, is it placed where health care providers can see/read it e.g. bulletin board? ☐ Yes ☐ No
2.	Are there FGM prevention posters on the wall of the waiting room? ☐ Yes ☐ No  2a. If yes, is it placed in place where ANC clients can see it ☐ Yes ☐ No
3.	Is there WHO FGM Clinical Handbook in the ANC consultation room? ☐ Yes ☐ No  3a. If yes, is it placed where ANC provider can see /use it? ☐ Yes ☐ No
4.	Is there FGM ABCD guide in ANC consultation room?  ☐ Yes ☐ No  4a. If yes, is it placed where ANC provider can see /use it ☐ Yes ☐ No
	ions: Assess health facility factors that may facilitate/constrain intervention delivery by reviewing health facility administrative and notes and by meeting with the health facility manager.
5.	Number of ANC providers
6.	Average number of ANC clients per month
7.	Number of ANC providers trained on PCC on FGM prevention  All (specify number trained):  Some (specify number trained):  None
8.	Indicate the number of MoH supervisory visits to the clinic in the past year

# A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993) ANC PROVIDER SCREENING QUESTIONNAIRE (SCR) Participant ID:

Participant ID:			
<u> </u>		Project ID:	Country ID: Facility ID:
Version 2 – 18 <sup>th</sup> October 2019			
A 6 5	9 9 3		
9. How frequently are staff meet	ings held?		
☐ Monthly			
☐ Every 2 to 4 months	S		
☐ Every 6 to 12month	s		
□ Never			
10. What is the size of the popula	tion served by this facility	? (specify number)	
11. Are there country/region-spec			
☐ Yes		anor cou.	
□ No			
12. Are there anti-FGM activities	that target the nonulation	n served by this healtl	n facility?
☐ Yes	that target the population	if served by this heart.	Tuchity.
□ No			
	that tauget the nanulation	a gammad her this boolth	footlite.9
<b>13. Are there pro-FGM activities</b> □ Yes	mat target the population	i served by this health	racinty:
□ No			
Additional comments:			
			<u> </u>

#### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

#### ANC PROVIDER SCREENING QUESTIONNAIRE (SCR)

	ANCT NOVIDER SCREENING QUESTIONNAINE (SCR)
	Participant ID:
	Project ID: Country ID: Facility ID:
Vorsion	12 – 18 <sup>th</sup> October 2019
V CI SIOI	12 - 16 October 2015
	A 6 5 9 9 3
1.	What is your age?
2.	What is your sex?
	1. □ Female
	2. □ Male
3.	What is your religion?
	1.   Muslim
	2. □ Christian
	3. □ Other
	4. □ None
	5. □ Refused
4.	What is your occupation/designation?
	1. ☐ Midwife
	2. □ Nurse
	3.  Other, specify
5.	What is the highest education level of education you achieved?
	1.  □ Certificate
	2. □ Diploma
	3. □ Bachelors
	4. ☐ Masters or above
	5.
6.	For how many years have you been working in your field?
7.	During you clinical training, did you receive any formal training on female genital mutilation?
	1. □ Yes.
	2. □ No. Go to section B
	3. □ I don't know. Go to section B
8.	When did you receive the training?
	1. □ During my studies (pre-service training)
	2. ☐ After graduation/at work (in-service training)
	3. □ Both
	4. □ I don't know
	7. □ Not applicable

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#### ANC PROVIDER SCREENING QUESTIONNAIRE (SCR)

Participant ID:			
	Project ID:	Country	ID: Facility ID:
		, 	
To be completed by data collector:			
Data Collector ID:	Date:		
Signature:	Day Mo	onth	Year
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ANC PROVIDER SCREENING QUESTIONNAIRE (SCR)

		Participant ID:	Project I	ID:	Country ID:	Facility ID:
		A 6 5 9 9 3				
9.	Wh	nat was the format of the training? (Check all that a	pply)			
	1.	☐ Classroom lessons				
	2.	□ Workshops				
	3.	☐ Digital format (E-learning videos; smart phone app	)			
	4.	☐ During clinical practice under supervision of a men	tor			
	5.	☐ Other, specify				
	7. 🗆	☐ Not applicable				
10.	Du	ring your pre- or post- graduate training, did you re	ceive any	formal traini	ing on commu	nication or counselling?
	1.	☐ Yes.				
	2.	□ No.				
	3.	☐ I don't know				
11.	Du	ring you pre or post graduate training, did you recei	ve any for	mal training	on person-cer	ntred care?
	1.	☐ Yes.				
	2.	□ No.				
	3.	☐ I don't know				
12.	Ha	ve you ever cut the genitals of a girl (<=18 years old)	for non-h	ealth reason	s?	
	1.	☐ Yes.				
	2.	□ No.				
	3.	□ I don't know				

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T di dicipante 15.				
	Drainet ID:	Cour	+m / ID:	Fooility ID
	Project ID:	Cour	itry ID:	Facility ID
To be completed by data collector:				
Data Collector ID:	Date:			
Signature:	Day	Month		Year
			2	0
A 6 5 9 9 3  1. Have you ever heard about female genital mutilation	n?			
☐ Yes	·II.•			
□ No				
2. Do the women in your community undergo female	genital mutilation?			
□Yes				
□No				
☐ I don't know				
3. Do you know of the WHO classification for female	genital mutilation?			
□ Yes				
☐ No. Skip to Q5				
4. Please provide the WHO classification for the follow	wing FGM images (1	to include im	ages)	
a. IMAGE of Type III FGM to be inserted he	ere			
i. □ Type I				
ii. □ Type II				
iii. □ Type III				
· -				
iv. □ Type IV				
v. □nDon't know				
b. IMAGE of Type I FGM to be inserted here	2			
i. □ Type I				
ii. □ Type II				
iii. □ Type III				
Version 2 – 6 <sup>th</sup> November 2019				
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To be completed by data collector:

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Signature:

Day Month Year

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	ANC PROVIDER QUESTIONNAIRE (HCP)	
	Participant ID:	
	Project ID: Country ID: Facility ID:	
8.		have
enough	h knowledge to provide good quality health care? Rate between 1 – 4	
1.	□ Not confident at all	
2.	□ Not very confident	
3.	☐ Fairly confident	
4.	☐ Fully confident	
	A 6 5 9 9 3	
9.	How confident are you in your FGM knowledge to communicate on FGM prevention?	
Rate betwee		
Raic beinee		
	1. □ Not confident at all	
	2. □ Not very confident	
	3. □ Fairly confident	
	4. □ Fully confident	
For each of	of the following statements please state if you agree/disagree or don't know.	
10.	O. A girl who has not undergone FGM is unclean.	
1.	□ Agree	
2.	□ Disagree	
3.	☐ Disagree ☐ I don't know	
11.		
1.		
2	□ Disagree	

- 3. ☐ I don't know
- 12. A girl who has not undergone FGM is a disgrace to her family's honour.
- 1. ☐ Agree
- 2. ☐ Disagree

Version 2 – 6<sup>th</sup> November 2019

To be completed by data collector:						
Data Collector ID:	Date:					
Signature:	Day	Month		Ye	ar	
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#### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

					ANC	PROV	IDER QU	IESTIO	NNA	۱RE (	HCP)								
		Part	ticipant	ID:		_													
						_		Pro	ject I	D:		Cou	ıntry l	ID:	Fac	ility I	D:		
																			_
	3. □	I don't k <del>now</del>					I												Ş
	13.	Health care	e provi	ders w	ho perfo	orm FG	3M are	violati	ing n	nedic	al ethi	ics.							ć
	1. 🗆	Agree																	2.5
	2. □	Disagree																	,
	3. □	I don't know																	70 91
	14.	Health care	e provi	ders w	ho perfo	orm FC	3M show	ıld be	puni	ished	l <b>.</b>								ď
	1. 🗆	Agree																	,
	2. □	Disagree																	ב ב
		Α	6	5	9 9	3													
																			3
	2 🗆 1	don't know																	9
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15.		s a good prac Agree	uce																,101
		Disagree																	ž
		I don't know																	į
16			ofom	. o <b>n ?</b> a a	nd airle?	ui ahta													2
10.		s a violation o Agree	)1 WOIII	en's a	na giris	rights	1												2
		Disagree																	2
		I don't know																	
17.		s a religious 1	nandat	e															Ģ
<b>-</b> /•		Agree	nanaa																2
		Disagree																	2
		I don't know																	g
18.	Preten	d you had a d	laughte	er now	who wa	s at an	age wh	en cu	tting	occu	ırs, wh	at wou	uld yo	our i	ntent	ion t	o cut	her be	? 1.
		nd to cut her																	<u> </u>
	2. □	Do not intend	to cut l	ner															
	3. □	Undecided																	= {
	4. Re	fused to answ	er																
19.	If a fan	nily brought	their d	aughte	er to the	clinic 1	requesti	ing ge	nital	cutti	ing for	non-h	nealth	reas	sons,	wou	ld you	perfo	rm c

Version 2 – 6<sup>th</sup> November 2019

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### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

#### ANC PROVIDER QUESTIONNAIRE (HCP)

2. 3. <i>Now I would</i>	Participant ID:  Project ID: Country ID: Facility ID:  No  I don't know  like to ask you a few questions about how you solve problems that you face. Please state how much you agree or a the statements that I read, , where 1=Strongly disagree; 2=Disagree; 3=Neither agree nor disagree; 4=Agree; agree
20. I wi	ll be able to achieve most of the goals that I have set for myself.
1.	☐ Strongly disagree
2.	□ Disagree
3.	□ Neither agree nor disagree
4.	□ Agree A 6 5 9 9 3
5.	☐ Strongly agree
6.	□ Don't know
21. Wh	en facing difficult tasks, I am certain that I will accomplish them.
1.	☐ Strongly disagree
2.	□ Disagree
3.	□ Neither agree nor disagree
4.	□ Agree
5. 6.	☐ Strongly agree ☐ Don't know
	eneral, I think that I can obtain outcomes that are important to me.  Strongly disagree  Disagree  Neither agree nor disagree
Version 2 – 6	5 <sup>th</sup> November 2019
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A HEALTH SYSTEMS APPROACH	TO PREVENTION OF FEMALE GENITA	AL MUTILATION USING PERSO	N-CENTRED COMMUNICATION
IMPLEN	IENTATION RESEARCH PROJECT IN G	GUINEA, SOMALIA AND KENYA	(A65993)

#### ANC PROVIDER OUESTIONNAIRE (HCP)

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			Partio	ipant	ID:		7							
							_		Proie	ect ID:		Count	rv ID:	Facility ID:
	4.	□ Agree												
	5.	□ Strong	gly agree	•										
	6.	□ Don't	know											
23.	I be	elieve I car	n succee	d at m	ost any	endea	vour t	o which	ı I set m	v min	d.			
	1.	□ Strong			·					•				
	2.	☐ Disagr	-											
	3.	☐ Neithe		nor di	sagree									
	4.	□ Agree	_											
	5.	□ Strong		•										
	6.	□ Don't												
24.	I w	ill be able	to succe	ssfully	v overc	ome m	anv ch	allenge	s.					
	1.	□ Strong												
	2.	☐ Disagr	-											
	3.	☐ Neithe		nor di	sagree									
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	_	□ D	1											
	6.	□ Don't	Know											
	_						_							
25.		n confider		_	erform	effecti	vely on	many	differei	it tasks	S.			
	1.	□ Strong		ree										
	2.	□ Disagr												
	3.	□ Neithe	_	nor di	sagree									
	4. -	☐ Agree												
	5.	□ Strong	-	9										
	6.	□ Don't	know											
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Pa	rticipant	t ID:		]											
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Γ						Pro	ject I	D:		Ī	Countr	у ір:	Fac	cility	וט:
Compared to othe		e, I can d	lo most t	tasks v	very w	ell.									
1. □ Strongly di	sagree														
2. □ Disagree															
3. □ Neither agi	ee nor d	disagree													
4. □ Agree															
<ul><li>5. □ Strongly ag</li><li>6. □ Don't know</li></ul>															
6. □ Don't knov	,														
Even when things	are toug	gh, I can	perforn	n quit	e well.										
l. □ Strongly di	_	• •													
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_															
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8	ee nor d	disagree													
4. □ Agree		disagree													
4. □ Agree 5. □ Strongly ag	ree	lisagree													
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A. □ Agree 5. □ Strongly ag	ree	disagree						1							
4. □ Agree 5. □ Strongly ag	ree	disagree 5 9	9	3					C						
4. □ Agree 5. □ Strongly ag 6. □ Don't knov	ree		9	3				1							
Agree  Agree  Don't knov	6	5 9													

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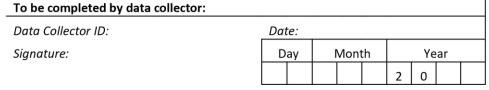
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#### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

#### ANC PROVIDER QUESTIONNAIRE (HCP)

		ANCT NOVIDEN QUESTIONNAME (NCI)	
		Participant ID:	
		Project ID: Country ID: Facility ID:	
	1.	□ Always	70
	2.	□ Often	ceci
	3.	□ Sometimes	Q
4	4.	□ Rarely	y
:	5.	□ Never	g
30. If yo	ou h	neard of or saw a colleague performing female genital mutilation, what would you do? (Tick all that apply)	Protected by copyright,
	1.	☐ I would report him/her to the authorities	=
2	2.	$\square$ I would discuss with him/her and explain to him/her that health care providers should not perform female genital	JCIU
		mutilation	ging
	3.	☐ I would not get involved 4. ☐ I don't know	910
31. How	oft	ten do you look for female genital cutting/excision when performing a gynecological examination of the vulva?	בי ע
	1.		es
	2.	□ Often	ela
	3.	□ Sometimes	Ced
	4.	Rarely	100
		□ Never	ext
		ten do you record the female genital mutilation in the women's medical file if you are aware that she has one FGM?	elated to text and data milning,
	1.	□ Always	ala
	2.	□ Often	
	3.	□ Sometimes	g
4	4.	□ Rarely	
:	5.	□ Never	נוש
33. Wou	ıld y	you like to receive more training on how to help patients to prevent FGM?	Ai training, and
	1.	□ Yes	j,
	2.	□ No	
	3.	□ I don't know	Ē
		A 6 5 9 9 3	ar
			ecn
34. I can	יות ח	at myself in others' shoes	similar technologies.
	-	□ Always	gje
		□ Often	ý
			o
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#### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

#### ANC PROVIDER QUESTIONNAIRE (HCP)

		Partici	pant ID:	•						
				•			Project	ID:	Country ID:	Facility ID
	3.	□ Sometimes								
	3. 4.	□ Rarely								
	5.	□ Never								
35.		ners know I und	derstand	what t	hev sav	7				
	1.	□ Always			3					
	2.	☐ Often								
	3.	☐ Sometimes								
	4.	☐ Rarely								
	5.	□ Never								
36.	In conv	ersations with	my colle	agues, l	I perce	ive not on	ly what th	ey say but v	what they don'	t sav
	1.	□ Always	J	8 /			•	v	v	v
	2.	☐ Often								
	3.	☐ Sometimes								
	4.	☐ Rarely								
	5.	□ Never								
37.	I comm	unicate effectiv	vely							
	1.	□ Always	•							
	2.	☐ Often								
	3.	☐ Sometimes								
	4.	☐ Rarely								
	5.	□ Never								
38.	I comm	unicate with of	thers as	though	they aı					
	1.	☐ Always								
	2.	☐ Often								
	3.	☐ Sometimes								
	4.	☐ Rarely								
	5.	□ Never								
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### **BMJ** Open A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993) **ANC PROVIDER QUESTIONNAIRE (HCP)** Participant ID: Project ID: Country ID: Facility ID: These next questions relate to your clinic setting: 39. Have you seen the posters on FGM at the clinic? 1. □ Yes 2. □ No 3. □ I don't know 40. Have you referred to the clinical handbook on FGM that is available in your clinic? 1. □ No ☐ I don't know 41. Do you think it is feasible to provide FGM prevention counselling during ANC visits? 1. □ Yes 2. $\square$ No

**Comments** 

3.

☐ I don't know

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#### A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

	Destining and ID.
	Participant ID:
	Project ID: Facility ID:
	FIRST ANC CLIENT EXIT QUESTIONNAIRE (EXT)
	FIRST AIRC CLIENT EXTT QUESTIONINAIRE (EXT)
	Control And Color LATT Question LATT
	Country ID:  A 6 5 9 9 3
	A 6 5 9 9 3
1.	How old are you? (years)
2.	What is your religion?
	1. □ Muslim
	2. ☐ Christian
	3. □ Other
	4. □ None
	5. □ Refused
3.	What is the highest level of education you achieved?
	1. □ None
	2. □ Primary
	3. □ Secondary
	4. □ University
	5. □ Other, specify
4.	Many women in your community have had their genitals cut when they were children, if you are comfortable telling me,
	can I ask if you have undergone this practice?
	1. □ Yes
	2. □ No
	3. □ I don't know
_	4. □ Refused
5.	How supportive are you of female genital mutilation?
	<ol> <li>☐ Strongly opposed</li> </ol>
	2. □ Somewhat opposed
	<ol> <li>□ Strongly opposed</li> <li>□ Somewhat opposed</li> <li>□ Neutral (Neither opposed or supportive)</li> </ol>
	4. ☐ Somewhat supportive
	5. □ Strongly supportive
The f	ollowing questions relate to your visit today. During your visit today:

6. Did you see any FGM poster(s) in the waiting room?

- 1. □ Yes
  - 2. □ No

- 3. □ I don't know

## A HEALTH SYSTEMS APPROACH TO PREVENTION OF FEMALE GENITAL MUTILATION USING PERSON-CENTRED COMMUNICATION: IMPLEMENTATION RESEARCH PROJECT IN GUINEA, SOMALIA AND KENYA (A65993)

		ſ	Partici	ipant IC	): 								
		L			<u> </u>						Projec	t ID:	Facility ID:
_	<b>D.</b> 1				_		T.G						
7		the ANC pro	vider a	sk if yo	ou have	under	gone FG	iM? ∟					
	1.	□ Yes											
	2.	□ No											
0	3.	☐ I don't kr		, .	. E	73.6		,	141.0				
8	. Dia i 1.	the ANC prov □ Yes	vider e	xplain	now FC	JM cai	n narm y	our ne	ealtn?				
	1. 2.	□ Yes											
	۷.	□ NO											
Ver	sion 2 –	6 <sup>th</sup> November	r 2019	1 <b>F</b>	IRST AN	C CLIE	NT EXIT C	QUESTI	IONNAIR	RE (EXT)			
									Country	ID:			
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			Α	6 5	9	9	3						
	2												
	3.	□ I don't kno	337										
_				_									
9.	Did the	e ANC provid		about	your p	ersona	l belief r	egardi	ing FGM	1?			
9.	<b>Did tho</b>	e ANC provid		about	your p	ersona	l belief r	egardi	ing FGM	Л?			
9.	Did the 1. 2.	e <b>ANC provid</b> □ Yes □ No	ler ask	about	your p	ersona	l belief r	egardi	ing FGM	1?			
	1. 2. 3.	e ANC provid Yes  No I don't kr	ler ask							1?			
	Did the 1. 2. 3. Did the	e ANC provid Yes No I don't kr	ler ask							1?			
	Did the 1. 2. 3. Did the 1.	e ANC provide Yes  □ Yes □ No □ I don't kree ANC provide □ Yes	ler ask							1?			
	Did the 1. 2. 3. Did the 1. 2.	e ANC provided Yes  No I don't know the ANC provided Yes  No	ler ask now ler dis							1?			
10.	Did the 1. 2. 3. Did the 1. 2. 3.	e ANC provided Yes  Yes  I don't known the ANC provided Yes  No  I don't known the Yes	now ler dise	cuss wl	ny FGM	I shoul	d be pre	evented	1?	1?			
10.	Did the 1. 2. 3. Did the 2. 3. Did the	e ANC provided Yes  No I don't know the ANC provided Yes  No I don't know the ANC provided Yes  No I don't know the ANC provided Yes	now ler dise	cuss wl	ny FGM	I shoul	d be pre	evented	1?	1?			
10.	Did the 1. 2. 3. Did the 2. 3. Did the 1. 1. 1.	e ANC provided Yes  No I don't known Yes ANC provided Yes No I don't known Yes ANC provided Yes Yes	now ler dise	cuss wl	ny FGM	I shoul	d be pre	evented	1?	1?			
10.	Did the 1. 2. 3. Did the 1. 2. 3. Did the 1. 2. 2.	e ANC provided Yes  No I don't known Yes No I don't known Yes No I don't known Yes No I don't known Yes No No No No No No	now der dise now der dise	cuss wl	ny FGM	I shoul	d be pre	evented	1?	1?			
10. 11.	Did the 1. 2. 3. Did the 1. 2. 3. Did the 1. 2. 3.	e ANC provided Yes  No I don't known yes ANC provided Yes No I don't known yes ANC provided Yes No I don't known yes I don't known yes	now ler dise	cuss wl	ny FGM ow FGM	I shoul I could	d be pre	evented?	i?	1?			
10. 11.	Did the 1. 2. 3. Did the 1. 2. 3. Did the 1. 2. 3.	e ANC provided Yes  No I don't know yes No I don't know yes No I don't know yes No I don't know yes	now ler dise	cuss wl	ny FGM ow FGM	I shoul I could	d be pre	evented?	i?	1?			
10. 11.	Did the 1. 2. 3. Did the 1. 2. 3. Did the 2. 3. Did the you	e ANC provided Yes  No I don't known yes ANC provided Yes No I don't known yes ANC provided Yes No I don't known yes I don't known yes	now ler dise	cuss wl	ny FGM ow FGM	I shoul I could	d be pre	evented?	i?	1?			
10. 11.	Did the 1. 2. 3. Did the 1. 2. 3. Did the 1. 2. 3. Did the 3. 2. 3. Did you 1.	e ANC provided Yes  No I don't know Yes No I don't know Yes No I don't know Yes No I don't know Yes No I don't know Yes No I don't know Yes No I don't know Yes	now how how how how how	cuss wl	ny FGM ow FGM	I shoul I could	d be pre	evented?	i?	1?			
<ul><li>10.</li><li>11.</li><li>12.</li></ul>	Did the 1. 2. 3. Did the 1. 2. 3. Did the 3. Did you 1. 2. 3. Did you 3. 3.	e ANC provided Yes  No I don't know the ANC provided Yes No I don't know the ANC provided Yes No I don't know the ANC provided Yes No I don't know the ANC provided Yes No I don't know the ANC provided Yes No I don't know the ANC provided Yes No	now how how how how how	cuss wh	ny FGM ow FGM	I shoul I could	d be prev	evented?	i?	1?			
<ul><li>10.</li><li>11.</li><li>12.</li></ul>	Did the 1. 2. 3. Did the 1. 2. 3. Did the 3. Did you 1. 2. 3. Did you 3. 3.	e ANC provided Yes  Yes  No I don't know the ANC provided Yes  No I don't know the ANC provided Yes  I don't know the ANC provided Yes  Yes  No I don't know the Yes	now how how how how how	cuss wh	ny FGM ow FGM	I shoul I could	d be prev	evented?	i?	1?			
<ul><li>10.</li><li>11.</li><li>12.</li></ul>	Did the 1. 2. 3. Did the 2. 3. Did you 1. 2. 3. Did you 3. Did you 3. Did you 3. Did you 3.	e ANC provided Yes  No I don't know the ANC provided Yes No I don't know the ANC provided Yes No I don't know the ANC provided Yes No I don't know the ANC question Yes No I don't know the ANC question Yes	now how how how how how	cuss wh	ny FGM ow FGM	I shoul I could	d be prev	evented?	i?	1?			

14. Are you satisfied with how FGM was addressed during your visit with your ANC provider today?

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		Participant ID:
		Project ID: Facility ID:
	1.	□ Yes
	2.	□ No
	3.	□ I don't know
15.	What d	lo you feel about FGM now as compared to before you came to the clinic today?
	1.	☐ Same, no change
	2.	☐ I feel more supportive of FGM now as compared to before I came
	3.	☐ I feel less supportive of FGM now as compared to before I came
	4.	☐ I do not know
	5.	☐ Other, specify
16.	Pretend	d you had a daughter now who was at an age when cutting occurs, what would your intention to cut her be
	1.	☐ Intend to cut her
	2.	☐ Do not intend to cut her
17.	Do you	wish/want to be active in preventing FGM?
	1.	□ Yes
	2.	□ No
	3.	□ I don't know
Vor	cion 2	6th November 2010

#### Supplementary file 3: Additional analyses (appendices 1-3)

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3	Supplementary file 3: Additional ar	nalysas (annondicas 1 3)	incl	
4	Supplementary me 3. Additional al	naryses (appendices 1 – 3)	udii	
5	Appendix 1: Comparison baseline cha	aracteristics of ANC facilities	ng f	
6 7	Characteristics	Facilities included in final analysis	Facilities	s excluded* from final analysis
8		(n=163)	Ens uses	(n=17)
9	Number of ANC providers	Mean 4 (SD: 3) Median 3 (1-14, IQR 3)	7 <u>e. 20</u>	Mean 3 (SD: 3) Median 2 (1-9, IQR 1)
10	Average number of ANC clients/month	Mean 150 (SD: 127) Median 118 (3-664, IQR 141)	Mea <b>ti 4</b> 6	(SD: 147) Median 100 (25-600, IQR 200)
11	MoH supervisory visits in the past year	Mean 4 (SD: 3) Median 3 (0-18, IQR 2)	ted Do	Mean 5 (SD: 4) Median 4 (0-12, IQR 4)
12	Size of catchment population served	Mean 36,754 (SD: 126,082) Median 15,972 (1,000-1,458,000,	Mean 11,73 <b>7</b> (\$)[§:	: 14,62) Median 7,800 (1,200-63,000, IQR
13		IQR 24,332)	nloaded f t Superied text and	7,505
14	Presence of anti-FGM activities in the catch		t al	
15	Yes	74 (45%)	nd f	9 (53%)
16	No S	89 (55%)	from eur (A data	8 (47%)
17	Presence of pro-FGM activities in the catch			2 (120()
18	Yes	21 (13%)	BES)	
19	No Double Wood	140 (86%)		15 (88%)
20	Don't Know	2 (1%)	, Al tr	-
22 23 24 25 26 27 28 29 30 31	*Total of ANC clinics not included: 16 clinics were exc study time points while one ANC clinic in Kenya was no insecurity attended the PCC training and was subsequen	luded (7 intervention and 9 control) due to loss-to-follow up (LTFU) of ANC providever visited at subsequent time points due to issues with insecurity. An ANC providitly interviewed.	ler i.e., the clinics Hid not be it.e., the clinics Hid not be it.	in Kenya that had been inaccessible due to
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Appendix 2: Comparison of baseline characteristics of ANC providers

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Appendix 2: Comparison of baselin  Characteristics	Providers recruited at Baseline (n=436)	Providers enrolled with complete data at Month 6 (n=232)  36 (20-65; SD: 10) at 8 (1-39; SD: 7) at 100 at 1	O Providers not enrolled with no data at
Age	37 (20-65; SD: 10)	36 (20-65; SD: 10)	9 2 38 (21-62; SD: 10)
Years of professional experience	9 (1-39; SD: 7)	8 (1-39; SD: 7) <b>2</b>	10 (1-36; SD: 8)
Sex		<del>c</del>	¥ š
Female	361 (83%)	193 (83%) (8	168 (82%)
Male	75 (17%)	39 (17%)	36 (18%)
Highest educational level		<u>a</u>	7. <u>0</u>
Certificate	44 (3%)	21 (5%)	23 (11%) (23 (11%)
Diploma	309 (71%)	158 (68%)ធី	<b>2</b> 151 (74%)
Bachelors	64 (15%)	21 (5%) 158 (68%) 44 (19%) 1 (0.4%)	20 (10%)
Masters & above	3 (0.7%)	1 (0.4%) 5	2 (1%)
Other#	16 (4%)	8 (3%)	8 (4%)
Current professional role/title		2	95 (47%)
Midwife	198 (45%)	103 (44%)	
Nurse	95 (22%)	51 (22%)	
Nurse-Midwife	94 (22%)	54 (23%)	40 (20%)
Other	49 (11%)	24 (10%)	25 (12%)
Received formal training on FGM during	<u> </u>	<u>v</u>	
Yes	158 (36%)	85 (37%)	
No	275 (63%)	146 (63%) <sup>a</sup>	129 (63%) 2 (1%)
Don't Know	3 (0.7%)	1 (0.4%) <b>g</b>	2 (1%)
Timing of clinical training on FGM		n n	
Pre-service	63 (14%)	33 (14%) <del>0</del>	30 (15%) 36 (18%)
In-service	81 (19%)	45 (19% <b>)</b>	0)
Both pre- and in-service	14 (3%)	7 (3%).	7 (3%)
Received formal training on communicati		440 (212)	
Yes	287 (66%)	149 (64%)	138 (68%)
No	149 (34%)	83 (36%)	<b>©</b> 66 (32%)
Received formal training on person-cente		110 (510)	<u>D</u>
Yes	227 (52%)	118 (51%)	<b>ö</b> 109 (53%)
No Dan't Image	207 (47%)	131 (56%)	94 (46%)
Don't know	2 (0.5%)	1 (0.4%)	138 (68%) 66 (32%) 5 7 109 (53%) 7 7 94 (46%) 7 1 (0.5%)

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	Providers recruited at Baseline (n=436)	at Month 6	Providers not enrolled with no data at  Month 6  (n=204)
Undergone FGM		<b>.</b>	9 (n=204) 4
Yes	226 (52%)	126 (54%) <b>டு</b>	<u>L</u> 100 (49%)
No	128 (29%)	126 (54%) 5 m 63 (27%) 6 s e 2 (1%) 6 g 2 (1%) 6 g 1	<b>S</b> 65 (32%)
Don't know	4 (0.9%)	2 (1%) 💆	1 (0.5%)
Refused to answer	3 (0.7%)	2 (1%)	1 (0.55)
Conducted FGM	27 (0.1)		0
Yes	35 (8%)	15 (7%) ම <b>න</b>	20 (10%)
Conducted FGM on a girl <18 years Yes	22 (70()	ងមុខ 14 (6%) <u>a e</u> 1	<b>8</b> 18 (9%)
		Superieur (ABES) . ext and data mining, Al training, and similar technologies 14 (6%) 14	l8 (9%

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Appendix 3: Comparison of study outcomes between baseline vs. month 3 and month 3 vs. month 6 in the intervention arm

Month 3 (Intervention only) mented components of PC 298 (37%) 239 (29%) 243 (30%) 224 (28%) 346 (43%) 1.7 (1.5-1.8) 3.3 (2.8-3.8)	<0.0001 <0.0001 <0.0001	Montion (Interdention only)  September 19 (1998)  Prevention (1998)  P	Month 6 (Intervention only) 694 (78%) 616 (76%) 629 (77%) 592 (73%) 684 (84%)	<0.0001 <0.0001 <0.0001 <0.0001
224 (28%) 346 (43%) 1.7 (1.5-1.8)	<0.0001 <0.0001 <0.0001	S	616 (76%) 629 (77%) 592 (73%)	<0.0001 <0.0001 <0.0001
224 (28%) 346 (43%) 1.7 (1.5-1.8)	<0.0001 <0.0001 <0.0001	preventions N (37%)	616 (76%) 629 (77%) 592 (73%)	<0.0001 <0.0001 <0.0001
224 (28%) 346 (43%) 1.7 (1.5-1.8)	<0.0001 <0.0001 <0.0001	107 (37%) 107 (37%) 107 (30%) 107 (30%)	616 (76%) 629 (77%) 592 (73%)	<0.0001 <0.0001 <0.0001
224 (28%) 346 (43%) 1.7 (1.5-1.8)	<0.0001 <0.0001 <0.0001	29%)  1 (29%)  2 (29%)  2 (29%)  3 (29%)  4 (29%)  5 (29%)  6 (29%)  6 (29%)  6 (29%)  7 (29%	616 (76%) 629 (77%) 592 (73%)	<0.0001 <0.0001 <0.0001
224 (28%) 346 (43%) 1.7 (1.5-1.8)	<0.0001 <0.0001 <0.0001	6 3 4 (30%) 6 3 4 (28%) 6 4 (43%) 6 4 6 (43%)	629 (77%) 592 (73%)	<0.0001 <0.0001
224 (28%) 346 (43%) 1.7 (1.5-1.8)	<0.0001 <0.0001 <0.0001	to 24 (28%)	592 (73%)	< 0.0001
346 (43%) 1.7 (1.5-1.8)	<0.0001 <0.0001	<b>6 6</b> (43%)	` /	
1.7 (1.5-1.8)	< 0.0001	9 <u>9 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3</u>		< 0.0001
		<b>⊃</b> 1≒/601.5-1.8)	3.9 (3.8-4.0)	< 0.0001
(=10 010)	< 0.0001	<u>a</u> 368 <del>fa</del> .8-3.8)	6.2 (5.9 – 6.6)	< 0.0001
	10.0001	<u> </u>	0.2 (0.5 0.0)	10.0001
GM prevention and care	e services	from eur (A data		
		<u> </u>		
42 (52%)	< 0.0001	<b>₹ ₩</b> 42 (52%)	56 (69%)	< 0.01
3.1 (2.9-3.4)	< 0.0001	<b>53/4</b> (2.9-3.4)	3.4 (3.2-3.6)	0.18
, i		<u> </u>	ì	
61 (58%)	< 0.0001	<b>≥</b> 6 (58%)	96 (91%)	< 0.0001
	< 0.0001	<b>5</b> (19%)		< 0.0001
		<b>5 5</b>	(- 111)	
		<u> </u>		
1 (3%)	0.47	1 (20/)	8 (8%)	0.06
			\ /	0.11
		2 (000)		0.17
		<u> </u>		0.50
		<u>84 (77%)</u>		< 0.001
\ /		10 (96%)		1.0
				0.75
	0.00		(	
235 (20%)	0.01	2 2 (20%)	124 (52%)	< 0.0001
		0 3/65 (/3%)		< 0.0001
		184 (23%)	` /	< 0.0001
				< 0.0001
		547 (69%)		< 0.001
))))))	3.1 (2.9-3.4)  3.1 (2.9-3.4)  61 (58%) 20 (19%)  75 (71%) 75 (71%) 75 (71%) 76 (101 (96%) 77 (104 (99%) 78 (43%) 79 (43%) 70 (14%) 70 (14%)	3.1 (2.9-3.4) <0.0001  61 (58%) <0.0001  20 (19%) <0.0001  1 (3%)	1 (3%)   0.47   0.0001   0.0	1

Section/Topic	Item	Standard Checklist item	Extension for cluster	Page
	No		designs	No *
Title and abatus at				
Title and abstract				
	1a	Identification as a	Identification as a cluster	1
	10	randomised trial in the title	randomised trial in the title	•
		randomised that in the title	randomised that in the title	
	1b	Structured summary of trial	See table 2	3
		design, methods, results,		
		and conclusions (for specific		
		guidance see CONSORT for		
		abstracts) <sup>1,2</sup>		
		·		
Introduction				
Background and	2a	Scientific background and	Rationale for using a cluster	5-6
objectives		explanation of rationale	design	
	0.1	C C L	Miles de la caleta	7
	2b	Specific objectives or	Whether objectives pertain to	7
		hypotheses	the cluster level, the individual	
			participant level or both	
Methods				
Wiethous				
Trial design	3a	Description of trial design	Definition of cluster and	7
Ŭ		(such as parallel, factorial)	description of how the design	
		including allocation ratio	features apply to the clusters	
	3b	Important changes to		N/A
		methods after trial		
		commencement (such as		
		eligibility criteria), with		
		reasons		
Participants	4a	Eligibility criteria for	Eligibility criteria for clusters	7-8
		participants		
	4b	Cottings and locations		6-7
	40	Settings and locations where the data were		0-7
		collected		
		conected		
Interventions	5	The interventions for each	Whether interventions pertain to	6
	-	group with sufficient details	the cluster level, the individual	
		to allow replication,	participant level or both	
		including how and when		
		they were actually		
		administered		
Outcomes	6a	Completely defined pre-	Whether outcome measures	10
		specified primary and	pertain to the cluster level, the	

		secondary outcome measures, including how and when they were assessed	individual participant level or both	
	6b	Any changes to trial outcomes after the trial commenced, with reasons		N/A
Sample size	7a	How sample size was determined	Method of calculation, number of clusters(s) (and whether equal or unequal cluster sizes are assumed), cluster size, a coefficient of intra-cluster correlation (ICC or k), and an indication of its uncertainty	10-11
	7b	When applicable, explanation of any interim analyses and stopping guidelines		12
Randomisation:				
Sequence generation	8a	Method used to generate the random allocation sequence		8-9
	8b	Type of randomisation; details of any restriction (such as blocking and block size)	Details of stratification or matching if used	8-9
Allocation concealment mechanism	9	Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned	Specification that allocation was based on clusters rather than individuals and whether allocation concealment (if any) was at the cluster level, the individual participant level or both	9
Implementation	10	Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions	Replace by 10a, 10b and 10c	
	10a		Who generated the random allocation sequence, who enrolled clusters, and who assigned clusters to interventions	8

	10b		Mechanism by which individual participants were included in clusters for the purposes of the trial (such as complete enumeration, random sampling)	8
	10c		From whom consent was sought (representatives of the cluster, or individual cluster members, or both), and whether consent was sought before or after randomisation	8
Blinding	11a	If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how		8-9
	11b	If relevant, description of the similarity of interventions		8-9
Statistical methods	12a	Statistical methods used to compare groups for primary and secondary outcomes	How clustering was taken into account	10-13
	12b	Methods for additional analyses, such as subgroup analyses and adjusted analyses		12-13
Results			4	
Participant flow (a diagram is strongly recommended)	13a	For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome	For each group, the numbers of clusters that were randomly assigned, received intended treatment, and were analysed for the primary outcome	15
	13b	For each group, losses and exclusions after randomisation, together with reasons	For each group, losses and exclusions for both clusters and individual cluster members	Figure 2

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Interpretation	22	Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence	23-24
Other information			
Registration	23	Registration number and name of trial registry	15
Protocol	24	Where the full trial protocol can be accessed, if available	15
Funding	25	Sources of funding and other support (such as supply of drugs), role of funders	In Funding Statement

<sup>\*</sup> Note: page numbers optional depending on journal requirements