African Population and Health Research Center

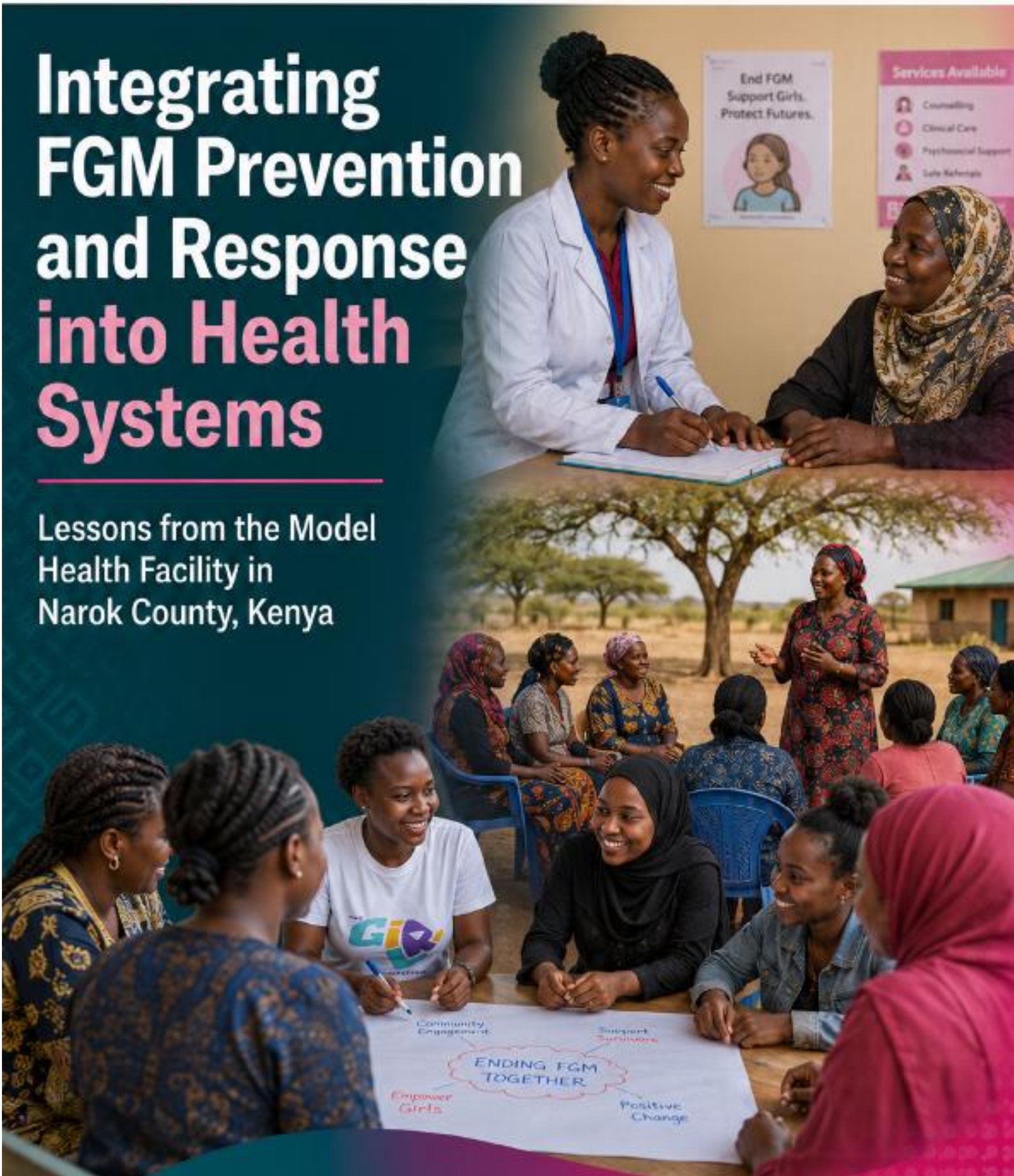
THE GIRL GENERATION

Learning brief

June 2026

Integrating FGM Prevention and Response into Health Systems

Lessons from the Model Health Facility in Narok County, Kenya



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Introduction

The Girl Generation – Support to the Africa-Led Movement to End Female Genital Mutilation (FGM) (TGG-ALM) programme is funded by UK International Development and supports locally led action to end FGM across Kenya, Ethiopia, Senegal, and Somaliland. Implemented by a consortium led by Options, including Amref Health Africa, ActionAid, Orchid Project, and the Africa Coordination Centre for the Abandonment of FGM, TGG-ALM works closely with Population Council's Data Hub, the programme's data and measurement arm. The programme takes a girl-centred approach and implements coordinated interventions at individual, community, sub-national, and national levels to address FGM, with complementary advocacy at African regional and global levels.

Integrating FGM prevention and survivor care into primary healthcare is a critical strategy for promoting women's and girls' health, reducing FGM, and strengthening the health system's capacity to prevent, identify, and manage FGM-related complications during pregnancy, childbirth, and across the lifespan.

This learning brief summarizes learning from the Model Health Facility (MHF) in Narok County, Kenya.

Integrating FGM prevention and response into routine healthcare

Integrating Female Genital Mutilation (FGM) prevention and response into routine healthcare is a core pillar of the programme's theory of change. Led by the Africa Coordinating Centre for the Abandonment of Female Genital Mutilation (ACCAF), this component positions FGM as a critical public health priority and establishes sustainable prevention and survivor support within national healthcare systems.

Key interventions include:

- Designing pre-service medical and nursing curricula to equip current and future healthcare workers with the knowledge and skills necessary to prevent FGM, support survivors, and directly combat the medicalisation of the practice.
- Equipping lecturers at universities and medical colleges to integrate these modules into health-related programmes. The lecturers then cascade this training down to medical students and healthcare professionals.
- Developing FGM prevention and response training curriculum for Community Health Promoters (CHPs). This trains community health workforces to support prevention and response through household visits, identify complications early, and initiate referrals of those with complications to the health facility, and refer those recovering to the community.

The Model Health Facility approach in Narok

The Model Health Facility (MHF) was established in 2024 at Nairegie Enkare Level IV Hospital in Narok East, Narok County, Kenya. Narok County was selected due to its high prevalence of FGM, estimated at 51% (KDHS, 2022), with notable disparities across the county. Studies conducted in Narok East Sub-County indicate that FGM prevalence remains extremely high ranging from between 56 and 88%, with cases occurring through both traditional cutting and medicalisation.[1,2,3] As a predominantly rural setting, Narok East provides extensive opportunities for students and trainees to engage directly with

women and girls at risk of, or affected by FGM, compared to urban tertiary facilities where the practice is less prevalent.

As a first-of-its-kind initiative in Africa, the MHF integrates FGM prevention and care directly into routine maternal, newborn, and child health (MNCH) service points. By embedding these services within antenatal care (ANC), maternity wards, family planning clinics, nutrition services, and child growth monitoring sessions, the facility ensures a seamless interface with women and girls.

This integration is driven by trained healthcare professionals and CHPs who provide personalised FGM screening, counselling, and targeted health education as part of routine care for mothers and children. This proactive approach ensures that survivors, who often suffer in silence from complications like fistula, scarring, or psychological trauma, are identified and given professional support during routine hospital visits.

To extend its impact beyond the facility, the MHF reaches into surrounding and hard-to-reach communities through household visits and other community outreach initiatives, delivered by ACCAF trained CHPs and medical students.

Finally, to ensure high-quality, empathetic care, the facility features a specialized Skills Lab. Here, students and healthcare providers use humanised models to practice clinical and communication skills, building confidence and competence before interacting directly with patients.

Objectives and data sources

This learning brief outlines the outcomes and learnings from the TGG-ALM-supported MHF. The findings were collated from qualitative interviews including a three-day observation at the health facility which observed the operational dynamics and patient-provider interactions. This primary data was complemented with secondary quantitative data and programme documents (including reports) sourced from ACCAF and Options.

Key Outcomes

Integration of FGM services into routine healthcare delivery

Routine clinic visits are a safe, natural entry point to talk about FGM

To normalize screening and discussion around FGM, prevention and response services were integrated across four primary healthcare touchpoints: antenatal care (ANC), child welfare, family planning, and maternity services. By leveraging these routine clinical interactions, the MHF ensures that every female client is reached, regardless of her primary reason for visiting. Clients receive targeted counselling, educational messaging, physical screening, or specialized treatment. The observation notes below illustrates how providers can introduce the topic of FGM sensitively during a normal family planning consultation:

> *[…] Inside, the nurse gives counselling on family planning methods, gives her options […], when the nurse asks how many children she has, she answers one adding "Na sitaki mwingine sahii" (I don't want another one now). The nurse asks whether she's undergone FGM. She answers yes, and as counselling continues, the woman is not in support of FGM, as she credits FGM for why she does not want more children, as her birth was difficult due to the act she underwent at 15. She is taken through the different forms of family planning (Observation notes, Model Health Facility)*

Integrated triage is critical for saving high-risk adolescents

In addition to routine counselling, the integrated model strengthens timely identification and triage for women at heightened obstetric risk including pregnant adolescents. The notes below capture the urgency of timely, skilled care:

> *Around 11:35 AM, a heavily pregnant girl came in, visibly distressed. Staff quickly led her directly to the maternity ward. Her friends, standing nearby, showed visible anxiety. Between their hurried whispers, it emerged she was underage and had been in labour for a long time, raising concerns about delayed care-seeking and potential risk factors, including FGM-related complications or lack of support at home (Observation notes, MHF).*

Private, one-on-one spaces are essential for disclosure

Because FGM is such a sensitive and private issue, providers typically discussed it in private during one-to-one consultations rather than group sessions, supporting confidentiality and safeguarding. Clients widely accepted and appreciated this private approach, as noted by an antenatal patient:

> *"When we are waiting here, they come and ask us how we are doing, how the baby is doing in the womb, and the problems you are facing; they ask you that, but for FGM, they ask me personally inside there". (IDI, patient 003)*

Separating general group education from private, individual history-taking is what gives women the confidence and safety they need to share their experiences

Specialized tools change screening from an afterthought to a system

This integrated approach ensures that FGM screening is no longer an afterthought but a structured institutionalized component into maternity history-taking. It also helps with the documentation and monitoring of FGM in the community, which is the catchment for the health facility. Providers noted that the availability of specialised registers and screening tools developed by ACCAF allows for the systematic tracking of FGM status and identification of the number of at-risk females within a household. This robust screening framework has directly led to the diagnosis and referral of severe, previously hidden FGM complications, including obstetric fistulas and deep-seated psychological trauma.

Ultimately, individual counselling builds a woman's confidence to speak out about FGM and gender-based violence. This proof shows that maternal and reproductive health service points are highly practical and acceptable places to identify survivors, treat their complications, and open up real discussions about community prevention.

The model strengthened clinical capacity and increased services uptake

Students' placements increased workforce capacity

The "Model Health Facility" status brought in a steady stream of medical students, interns and ambassadors from universities and colleges (Egerton, University of Nairobi, Daystar and Tenwek college). Between 2024 and 2025, about 105 medical students were attached to the MHF. In public health facilities, usually characterised by chronic understaffing, having over 15 students in the MHF at any given time ensured that "the queue moves swiftly," which led to rebuilt community trust in public healthcare.

“The number of clients within the facility increased... because the students that have been placed there are now helping with the reduction of workload for the nurses. The turnaround time would be fast. So, most people would prefer to come to the facility”. (IDI, Student)

By leveraging the facility’s status as a training ground, the program created a reliable, revolving pool of human resources that absorbed the heavy administrative and clinical workload from regular healthcare staff.

Faster service improved patient experience and rebuilds community trust.
When an influx of students reduces the workload, the immediate result is that the patient experience improves because "the queue moves swiftly." This operational efficiency had a direct, massive impact on how the community viewed public healthcare.

As a student and a nurse explained in interviews:

> *"The number of clients within the facility increased... because the students that have been placed there are now helping with the reduction of workload for the nurses. The turnaround time would be fast. So, most people would prefer to come to the facility."* (IDI, Student)

> *"We are the first [FGM] model [health] facility in Kenya, and there has been a lot of positive feedback from even the community. They have benefited especially now that we have the ACCAF [medical] students[...] unlike when they come sick, or they have come in a hurry, and you don’t get enough [time] to talk to them."* (IDI, Nurse)

Faster access to health services at health facilities is a massive incentive for increased healthcare utilization. Patients were so confident they would be attended to quickly that some willingly travelled long distances, spending 300 to 500 KES (approx. 4 dollars) on motorbike taxis just to bypass closer clinics and come to the MHF.

Operational efficiency translates directly into increased service uptake
The routine data from the MHF confirmed an increase in the service uptake in the facility by community members. During the period 2024-2025, the number of people who accessed the integrated FGM services at the MHF was estimated at 6,710. During the same period, antenatal care, family planning services and hospital deliveries uptake increased by 22.6%, 49.5% and 33.3% respectively (see Figure 1).

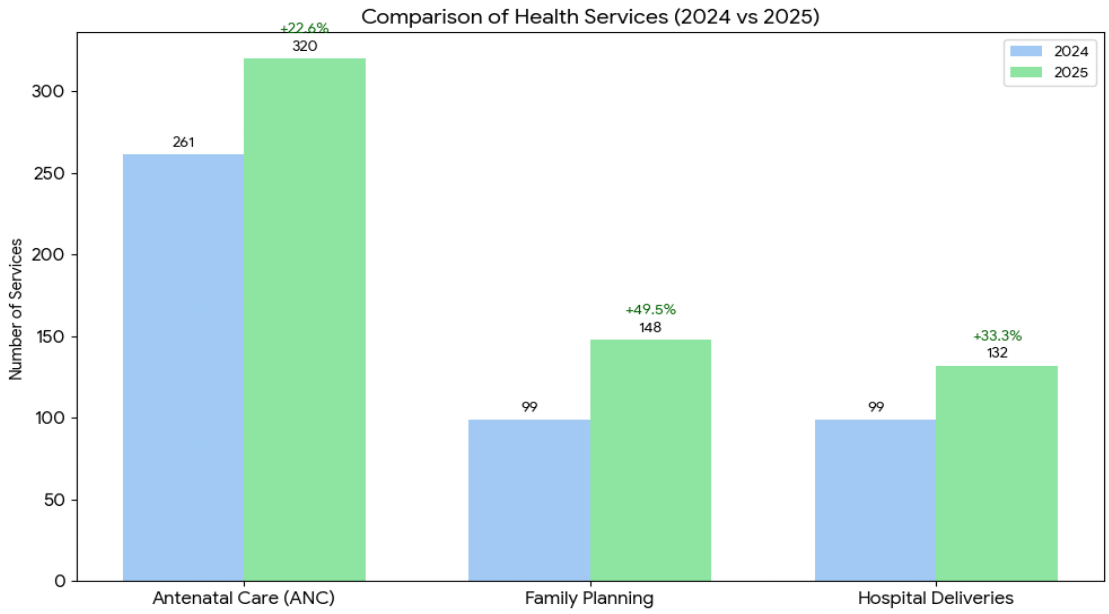

Figure 1: Comparison of Maternal and Reproductive Health Services Uptake (2024 vs 2025)

Reduced workload frees up the cognitive space needed for sensitive FGM conversations

The most critical lesson is that it is not feasible and sustainable for overworked, stressed-out nurses to screen and conduct deep, empathetic conversations about FGM. When staff are drowning in a massive backlog of patients, there is impaired practice of taking patients history. A Community Health Assistant recalled how difficult it used to be before the ACCAF intervention:

> *"Before, one had so much workload that speaking to a patient and asking them things like that[...] yeah. But when ACCAF came, things became good because when you go to every station... collecting data is easy". (IDI, Community Health Assistant)*

Bringing in additional personnel and distributing the workload did not just improve speed; it gave providers the time and emotional energy they needed to look past basic service delivery. With the pressure off, providers finally had the space to engage patients deeply, probe for FGM status, and offer the kind of personal, tailored counselling that these women truly need.

Training improved technical skills, confidence, and quality of care.

Dedicated training tools prevent "learning on patients"

A critical success factor for learning and mastering new skills was the establishment of the Skills Lab. Before this, medical students and staff had to learn complex procedures on actual patients. The establishment of a dedicated lab allowed medical students, interns, and staff to bridge theory and practice through practical simulations using manikin. This ensured that before a provider ever encountered a survivor with severe Type III FGM in the delivery room, they were already fully confident in the exact surgical steps required. As a nurse explained:

> *"Like right now, where we are in this room, we call it a skill lab [...] there are those types of FGM that we need to go about them here in the lab, and we were taught how to go about them, of which those are some of the skills we didn't know". (IDI, Nurse).*

Mastering technical, life-saving procedures prevents critical complications

One significant technical skill reported by providers and students is the mastery of de-infibulation to address type III FGM (where the vaginal opening has been narrowed by scar tissue). They were able to provide de-infibulation services, a life-saving procedure of opening the scar tissue before or during labour to prevent obstructed birth, fistula, and foetal distress.

> *"[...] we learnt how to give quality care, for example, performing a certain procedure of de-infibulation where we can restore the vaginal opening for a woman who had undergone type three FGM. I was able to gain that skill so I can confidently do the de-infibulation"* (IDI, Nurse)

Soft skills are just as critical as clinical skills for patient care

In addition to the technical skills, the learning of soft skills (survivor counselling) and the enhanced knowledge on FGM increased their confidence in initiating discussions, documenting cases, and providing appropriate care and referrals. Staff learned how to seek proper consent, handle sensitive disclosures and provide psychological first aid to survivors.

A nurse and a patient shared how this looked in practice:

> *"I gained skills in how to communicate sensitive issues, how to get consent [....], and there was good counselling on prevention. Good counselling skills and supporting women, like psychological support and counselling women who have undergone FGM". (IDI, Nurse).*

> *"It's because of how it is. They are organised; how they welcome people is friendly; even when you come pregnant, they teach you things. When you come here, there are lessons; there is a woman who teaches us. I don't know her name; she has never said it. But they teach us that they even showed us on the phone how to ask questions if you are pregnant, and there is also a clinic" (Patient, Narok)*

Educating a patient creates an advocate who protects the next generation

Evidence showed that capacity building inside the clinics does not stay inside the clinic. When providers have the time and skill to deliver high-quality health education, patients absorb that knowledge and actively pass it on to their families and community members. On patient captured this ripple effect:

> *"They have really helped me because I have known its effects and, I have known the importance of avoiding FGM, at least even my younger siblings who want to undergo it, like my sister, she was saying she wants it, but when I taught her what I had been taught here, she removed that from her mind, now she doesn't want it […] I have seen changes when they were educated about FGM's effects and the importance of stopping FGM. They have understood more. " (Patient, Narok).*

Empowering a single woman at a routine clinic visit is likely to create a natural information diffusion effect at the household level, effectively stopping FGM before it can happen to younger girls.

Community outreach as a frontline strategy against FGM

Combining medical trainees and CHPs sustains care despite hospital staffing shortages.

Medical students attached to the MHF conducted community outreaches under the chaperone and support of Community Health Promoters (CHPs). They actively contributed to identifying, diagnosing,

and referring women with complications at the community level. This improved access to the integrated services by the vulnerable women and girls at the household level. One provider shared:

> *"The integration made it stronger because now the [medical] students can take services to households and even to the farthest*-to-reach communities and *in the households". (IDI, nurse)*

Involving the medical students in outreach activities expanded the programme's reach to more households and hard-to-reach communities. This demonstrates that engaging medical trainees and CHPs sustains community engagement and outreach, even with limited staff at the facility level.

Household-level health education triggers immediate, life-altering decisions

A major takeaway is that consistent, culturally sensitive communication at the household level creates a safe space for open dialogue. This targeted education often leads to immediate behavior change, blocking imminent FGM plans.

This dynamic was captured by a local CHP who recounted a joint visit with medical students from the University of Nairobi:

> *After the TGG programme came and educated us, and we went to the village, the change has come, at least the number of FGM cases has really reduced…sometimes back we went with students from Nairobi University, and we were talking to the community. My neighbour is Somali, and he was telling me that his daughter must get circumcised*[1]*. The girl was supposed to go back with her mother to Marsabit, but when we went there, we gave him the health education about the effects of FGM, and I think we talked about those keloids…the girl never went with her mother to Marsabit. She has become more of an ambassador; she is more open in talking about FGM" (IDI, CHP)*

Creating a visible "Ambassador Effect" inspires broader aspirations for education

One unintended lesson from this model is the broader social change sparked by the mere presence of the medical students. Through an "ambassador effect," young, educated medical students served as role models, demonstrating that women can be successful, respected, and empowered without undergoing FGM. Their presence inspired boys and girls and demonstrated to the community that sons and daughters from the Maasai community can pursue higher education and become healthcare professionals, thereby encouraging families to value education and future career aspirations.

Lessons learned

The evidence from the Narok MHF highlights five practical lessons for integrating FGM prevention and survivor care into routine health systems.

1. **Trusted messengers are critical in challenging harmful norms:** Information delivered by trusted healthcare providers (committed to improved healthcare outcomes) and CHPs is effective in encouraging community members to critically reflect on and question deeply rooted beliefs related to FGM.

[1] Note on language: The term "circumcision" is only utilized within this text when it is a directly translated word spoken by a research respondent. In all other program contexts, the term Female Genital Mutilation (FGM) is strictly maintained.

2. **Individualised counselling drives confidence and social change:** One-on-one counselling strengthens women's confidence to discuss sensitive issues such as FGM and gender-based violence, leading to increased awareness and contributing to gradual shifts in social norms.
3. **Engaging medical students and CHPs can extend reach despite workforce constraints:** Involving medical students alongside CHPs expands outreach to more households and hard-to-reach areas sustaining community engagement and improving access to FGM prevention and response services, even where staff capacity is limited. The engagement of trainees also shifts health providers' workload and frees up time and cognitive space for them to meaningfully engage patients in counselling and discussions that would previously have been overlooked.
4. **Integrating FGM into routine service points strengthens identification and response:** Integrating FGM discussions into routine healthcare visits fosters open communication between female clients and healthcare providers, improves information exchange and awareness, and reinforces community-level prevention efforts.
5. **The young, educated students serve as role models**, showing that "modern" women can be successful and respected without undergoing the cut. This has potential to motivate the communities to invest in the education of girls and boys, breaking the gender norms of girls being married off early.

Overall, the MHF model shows that integrating FGM prevention and care in routine health services strengthens health workers' capacity (both technical and interpersonal skills) on FGM matters, while making the system more responsive to client needs. It also offers a scalable solution, even when resources and staff are limited.

Unlocking the full potential of the MHF: challenges and recommendations for scalability and sustainability

Key challenges

While the concept of the MHF approach has proven to be effective, addressing the following challenges could help unlock its full potential for scale-up and sustainability.

Gaps in workforce continuity and transition planning

While students temporarily ease workload and expand outreach, their departure strains already understaffed facilities and disrupts consistent FGM services and community engagement. The heavy workload in an understaffed public facility means that when students rotate out, the remaining permanent staff are often overwhelmed. This bottleneck directly undermines the continuity of care, leading to immediate gaps in consistent FGM screening, routine counselling, and proactive community follow-up.

> *"We have staff workload because you found I was the only one working today, that is why I was in the maternity department. So, sometimes we find it difficult even integrating the services… the workload is a lot so sometimes you might not do FGM screening [….] One is understaffing, and that is the biggest because when the students go away, then the limited number of staff that we have will not be able to handle the population that is now coming to the facility to seek services" (KII, Provider)*

Difficulties engaging men and boys at the MHF and during community outreach

A significant structural barrier is the persistent absence of men during both facility visits and standard household outreaches. Because men remain primary decision-makers and custodians of cultural norms, leaving them out of the conversation limits the domestic support system needed for women and girls to access care safely. Men are unavailable during the day or rarely accompany women to the facility except during acute maternity crises. To mitigate this obstacle, outreach teams and medical interns have shifted away from the clinic walls, creating creative, community-based interventions to reach men in their own spaces. For example, teams have successfully integrated FGM education and dialogue into local youth football matches, engaging men, and boys in a familiar, non-threatening environment

> *"We had difficulty interacting with the men within the household. When we went for the household visit the men were not there, so we would mostly come in and talk to the women. But men are the custodians of culture, so they were a little bit left out, and we had to devise other, let me say, creative ways of getting them […] so that we can talk to them about the whole FGM issue." (IDI, student)*

Limited resources for wider training scale-up

While the training package successfully transformed the clinical capacity of those targeted, funding limitations mean the intervention remains localized rather than systemic. The program was only able to train about 3% of the entire county health workforce. Training 23 healthcare workers in a facility framework where the broader county employs over 700 staff creates an institutional gap that local governments cannot currently bridge alone.

> *Then another thing is that as a county, when ACCAF and the partner were training, we only managed to train quite a few staff, I told you about 23, while the county has more than 700 workers. So, you see, this is just a drop in the ocean, and the county does not have that kind of resource to continue training (KII, SCHMT).*

Recommendations for scalability and sustainability

National Government (Ministry of Health and relevant national bodies)

- **Learning and scale-up platform:** Recognise the Narok MHF as a national demonstration site and learning hub to support peer-to-peer exchanges, operational research, and replication in other high-prevalence counties.
- **Human resources and continuous professional development (CPD):** Include FGM competencies (clinical management such as de-infibulation, trauma-informed counselling, legal/ethical practice) in national CPD requirements and mentorship packages for nurses, midwives, and clinical officers.
- **Data and accountability:** Integrate core FGM indicators into routine health information systems and supportive supervision so that screening, referrals, and service uptake can be tracked and acted on at health facility, county, and national levels.

County Governments —with a focus on Narok County

- **Scale the model within Narok:** Gradually replicate key components of the MHF (integrated service points, screening tools/registers, referral pathways, and outreach linkages) to other sub-counties, prioritising Narok East hotspots and hard-to-reach wards.

- **Budgetary ownership and resourcing:** Reduce reliance on external funding by ring-fencing county resources for integrated FGM prevention and survivor care (training, commodities, outreach, referrals, and safeguarding) within the county health budget and annual workplans.
- **Address workforce gaps** by developing a staffing versus workload plan for high-volume facilities (including Nairagie Enkare Level IV) to maintain routine screening and counselling when student placements end through targeted deployment, task-sharing, mentorship, and supportive supervision.
- **Leverage community health system and gender-transformative approach for effective integration:** 1) Invest in Community Health Promoters (CHPs) as cultural bridges that support regular household visits, follow-up, and referrals, and 2) embed gender transformative engagement approaches that actively include men not only as participants, but as key decision makers and custodians of cultural norms, to challenge harmful gender norms and support sustained abandonment of FGM.

Healthcare facilities (including the MHF)

- **Sustain integration and expand through the catchment network:** Provide continuous support to safeguard and maintain the gains already achieved by the MHF. Rather treating integration as a timebound programme, FGM prevention and response must permanently remain embedded within all routine maternal and child healthcare processes. To scale this impact sustainably, the MHF should transition into a local mentorship hub, actively supporting and supervising the replication of this integrated care model across all smaller satellite clinics and dispensaries within its geographical catchment area.
- **Protect quality through mentorship and skills practice:** Sustain the Skills Lab approach (simulation before patient contact) and implement on-site mentorship for clinical procedures (e.g., de-infibulation), trauma-informed care, and referral management.
- **Strengthen referral pathways:** Formalise referral linkages for complex obstetric and gynaecological care, reconstructive surgery and psychosocial support, including feedback loops so referred clients are followed up.
- **Use outreach as an extension of the facility:** Plan outreach jointly with CHPs and trainees to reach remote households; prioritise approaches that safely include men and community influencers while maintaining confidentiality and safeguarding for girls and survivors.

Training institutions (universities, medical and nursing colleges)

- **Better phase medical student placements**, with structured handover and transition protocols (e.g., joint shifts, shared documentation, and mentorship) to ensure continuity when students rotate out. This smoother transition, combined with longer or overlapping placements, will help sustain integrated FGM services and reduce service disruptions.
- **Optimise rural placements for competence and coverage:** Improve placement planning (transport, supervision, outreach mapping) so students can cover dispersed settlements in Narok and meaningfully contribute to continuity of care.
- **Scale the 'Skills Lab + rural placement' package:** Replicate the MHF-linked skills lab model in other high-prevalence hotspots to ensure trainees build confidence through simulation and supervised practice before working with patients.

- **Strengthen partnerships with counties and facilities:** Formalise collaboration agreements with county health departments and teaching sites to align learning objectives with service delivery needs, including joint mentorship, data use, and quality improvement.

Conclusion

Overall, the Narok MHF demonstrates that when FGM prevention and survivor care are integrated into routine service delivery, the health system becomes more responsive for every mother and child. This underscores the effectiveness of the MHF concept. But sustainability depends on institutionalising the model through government ownership, facility-level quality improvement systems, and strengthened training pipelines would support sustainable scale-up across other high-FGM-prevalence settings in Kenya.

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