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**A brief interactive training for health care professionals working with people affected by
'female genital mutilation': Initial pilot evaluation with psycho-sexual therapists**

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Abstract

The aim of the study was to evaluate a 90-minute professional training and education workshop on working with women affected by 'female genital mutilation' (FGM). Forty-nine psychosexual therapists attended the workshop and completed the same questionnaire eliciting FGM knowledge and attitudes at the beginning and end of the workshop. Pre and post differences in responses to the questionnaire were taken to be the effect of the workshop intervention. Participant satisfaction was independently obtained by the conference organisers.

Participants' knowledge of FGM improved significantly following the workshop. Post workshop, more participants were able to identify the year FGM was made illegal ($X^2(5, N = 97) = 32.36, p < .001$), the classification of FGM ($X^2(6, N = 97) = 29.10, p < .001$) and UK prevalence data ($X^2(6, N = 97) = 29.10, p < .001$). Participants also identified significantly more practicing communities ($t=4.6, p<0.001$) and illegal cutting procedures ($t=2.9, p=0.004$). Regarding shifts in attitude following the intervention, the participants expressed greater disagreement with circumcision on consenting adult males ($U = 806.5, p = 0.046$ (one-tailed), $r = 0.18$). This suggests that a 90-minute interactive group workshop could be highly acceptable to recipients and enhance knowledge about FGM.

Key words: female genital mutilation, professional training, psychosexual therapy, mental health

INTRODUCTION

'Female genital mutilation' (FGM) is defined as the partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons [WHO 2008]. Immediate health complications include infection, pain, haemorrhage and death [Adam et al 2012, Rymer 2006]. Girls who have undergone FGM show a significantly higher prevalence of post-traumatic stress, depressive and anxiety disorders [Kizilhan, 2011]. Girls may be subjected to FGM any time after birth with approximately half undergoing FGM under the age of five years and the rest between the ages of 10 and 14 years [UNICEF 2013].

Due to the diaspora of practising communities, there are now many women living with FGM and many girls at risk in countries where FGM is recognised as abuse and violence and therefore criminalised. In England and Wales for example, it has been estimated that over 137,000 women have undergone FGM and more than 70,000 girls under the age of 15 years have had or are at risk of FGM [Macfarlane and Dorkenoo 2014].

Children and adult safeguarding measures have been in place in the UK for some time, and there have been constant calls for health and social care providers to implement these measures and to provide appropriate care. The recent publication *Intercollegiate Recommendations for Tackling FGM in the UK* [Royal College of Midwives, 2013] for example, is the result of collaborative thinking on the topic and involving UK's Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Royal College of Nursing and advocacy groups. Professional awareness of FGM has been identified as a factor in successful implementation [Jager, Schulze, Hohlfield 2002], but collective steps have not yet been established to effectively increase awareness. There has been justifiable criticism that institutional goals have not been accompanied by a strategic action plan and corresponding resource allocation [Creighton and Liao 2013], leaving care providers with variable levels of FGM awareness and professional confidence to act and without access to education and training.

The aim of the current study was to assess FGM awareness and knowledge and to evaluate the immediate impact of a 90-minute interactive workshop to boost the skills and confidence of care providers assisting affected women and communities. The results would

offer information about feasibility, acceptability and need for further development and adaptation for a range of professional groups.

An opportunity arose to pilot the intervention with volunteer psychosexual therapists and the evaluation is the focus of the current report. We predicted an increase in awareness and factual knowledge about FGM among participants and potentially a shift in attitude.

METHODS

The current study arose opportunistically from a collaborative piece of work between the lead author (LML) and the College for Sex and Relationship Therapists in the UK (COSRT, www.cosrt.org) through professional liaison work with the conference committee (MJB). Study participants of mixed professional backgrounds were recruited from delegates attending the COSRT 2-day annual conference. They were invited to take part in the 90-minute workshop and to complete an anonymous questionnaire (Appendix A.) before and after.

Questionnaire

The questionnaire was developed from an earlier and briefer version designed by two of the authors (LML, SMC) for a previous study [Liao, Elliot, Ahmed & Creighton, 2013] and further expanded by new members of the research team. Part 1 of the questionnaire comprised nine factual questions about FGM with multiple-choice answers. These items were chosen to sample knowledge and not necessarily because they were the most vital information for health professionals. Part 2 of the questionnaire comprised 12 attitudinal statements on which participants indicated their level of agreement on a visual analogue scale that range from 1 (Strongly Agree) to 7 (Strongly Disagree). Anonymous ratings of workshop experience were independently collected by the conference organisers using their own standard evaluation form.

Data analysis

To preserve anonymity, the pre- and post-workshop questionnaires were not matched across participants. The pre-workshop questionnaire responses served as a baseline measure of knowledge and awareness of FGM among participants. These scores were compared with the post-workshop data. Nominal, ordinal and interval data drawn from the questionnaires were analysed using SPSS statistical software. Errors were treated as independent in the resulting statistical analysis.

The training intervention

The 90-minute interactive group workshop was designed by a consultant clinical psychologist and women's health specialist (LML) and co-facilitated with the assistant psychologist (CE). The aim was to increase FGM-related knowledge and skills in the participants. It deliberately moved away from didactic methods and favoured skills acquisition through questions, comments, discussion and debate. The workshop was repeated on four separate occasions during the 2-day conference to maximise attendance at parallel conference events. The number of attendees in the four groups ranged from 12 to 16 persons, although some exercises were carried out in smaller clusters of four to six people to maximise interaction.

The intervention began with a small group exercise inviting diverse reactions and questions relating to FGM. This was followed by a brief slide presentation to the entire group, with pauses between the following segments for questions and reactions. Segment 1 comprised a description of the four types of FGM, with a world map indicating the areas where it is practised, and a list of reasons typically given for FGM. Segment 2 comprised a list of possible physical and mental health problems associated with FGM. Segment 3 comprised the current UK legal position on FGM, with a brief mention of other forms of female and male genital cutting.

Approximately 35-40% of workshop time was dedicated to small group work on a case vignette with 3 clinical questions to focus on. It ended with a plenary discussion to draw out key learning points. The clinical case discussion component of the workshop was intended to be modifiable depending on the professional group. However, the facilitation of this part of the workshop should draw out the collective professional skills amongst the

participants. In order to develop professional confidence and interest in assisting affected women, trainees should feel that they have abilities to contribute to the field rather than feel overwhelmed and deskilled.

A handout based on the teaching slides and a resource list including useful websites, training videos, books and articles accompanied the workshop, and participants were encouraged to look further into the topic, discuss their learning with colleagues, and identify further needs for training and supervision.

RESULTS

Fifty-four conference attendees opted to participate in the 90-minute workshop on FGM, of whom 49 (91%) agreed to participate in the study. All 49 practised as psychosexual therapists, and a small number reported background clinical qualifications such as medicine and psychology. The mean age of the participants was 57 years (SD=8 years). The mean number of years in therapeutic practice was 16 (SD=9.2 years). The majority of participants were female (39/49; 80%) and three quarters of them self identified as White British (36/49; 74%).

Five (10%) participants reported that they had had no prior wish for more information on FGM until the workshop, 15 (30%) expressed a wish to know more out of interest, and 34 (69%) expressed a need for their professional work. In terms of exposure to the topic, two participants (4%) reported that they had no information on the topic at all prior to attending the workshop. A proportion had informally been exposed to the topic via the mass media: 15 (31%) via television coverage; 17 (35%) radio broadcast, 24 (49%) articles in the press. As for professional exposure, 19 (39%) reported having attended a professional event such as a talk or seminar. In terms of clinical practice, 33 (67%) of the participants said they had not worked with clients known to have experienced FGM, and 12 (24%) reported having worked with clients from FGM-affected communities.

Knowledge about FGM in the UK

Chi-square tests of independence were performed to examine the relation between participants' factual knowledge of FGM before and after the workshop. At baseline, only 14

participants (29%) were aware that FGM was made illegal in 1985; this increased to 39 (81%), $X^2(5, N = 97) = 32.36, p < .001$ after the workshop. Pre-workshop, 17 (35%) knew that FGM is currently classified into three to four types; after the workshop this increased to 41 (85%), $X^2(6, N = 97) = 29.10, p < .001$. Pre-workshop, 12 (25%) participants estimated correctly that more than 66,000 women in the UK were living with FGM; following the workshop this increased to 31 (65%), $X^2(5, N = 97) = 32.36, p < .001$.

Independent samples t-tests also showed a significant difference in the number of physical health problems identified (pre: $M=3.9, SD=3.8$; post: $M=8.7, SD=3.2; t=6.2, p=0.001$). The number of practising communities identified also improved (pre: $M=3.4, SD=2.9$; post: $M=6.1, SD=2.5; t=4.6, p=0.001$). The number of illegal procedures correctly identified also improved (pre: $M=1.3, SD=1.3$; post: $M=2.1, SD=1.1; t=2.9, p=0.004$).

Expressed attitudes towards genital cutting

Pre workshop, 'Strongly Disagree' (7 on the visual analogue scale) was expressed towards allowing: mild circumcision on girls under 16 (55.1%); circumcision on consenting adult women (44.9%); re-infibulation after childbirth (47%); cosmetic genital surgery on girls (53.0%); and cosmetic genital surgery on boys (36.7%). Pre workshop, 'Strongly Agree' (1 on the visual analogue scale) was expressed towards allowing circumcision on consenting adult men (30.6%) and towards prosecuting parents who allow their daughters to be circumcised (26.7%). A Mann-Whitney test indicated that after the workshop, more participants chose 'Strongly Disagree' in response to the statement 'Male circumcision on adult men should be allowed' (pre: mean rank=40.83; post: mean rank=49.97; $U=806.5; p=0.046$ (one-tailed); $r = 0.18$). There were no other significant differences in responses to the attitudinal statements before and after the workshop among participants.

User satisfaction

Feedback was independently collected by the conference organisers. Attendees rated the FGM workshop along with other conference events in terms of Usefulness on a 5-point scale: 1 (Excellent), 2 (Good), 3 (Fair), 4 (Poor), and 5 (Bad). Thirty-nine of the 54

workshop attendees returned the conference evaluation. One hundred percent rated the workshop as either Excellent (24/39; 62%) or Good (15/39; 38%).

DISCUSSION

Main Findings

The current study is the first reported study to methodically evaluate the impact of a training intervention relating to FGM. The majority of our pilot sample of experienced psychosexual practitioners with an average of 17 years of practice reported a wish to learn more about the topic and most of them from a professional point of view. This is not surprising given that they had chosen to attend the brief training. What is more of a concern is that despite this reported need, they had had limited professional exposure, with many relying on the mass media for information.

The intervention appeared to have improved knowledge. After the workshop, more participants correctly identified UK's prevalence estimate, the year FGM was made illegal, and the number of FGM types according to current WHO classification. They also correctly identified a larger number of illegal genital cutting practices. Improvement was also found in the correct identification of a larger number of practising communities and of the health problems associated with FGM.

Before the workshop, participants most frequently expressed the strongest disagreement to what we know as FGM for girls and women, and more equivocal attitudes for genital cutting on boys and men. The shift in attitude to male circumcision was most stark. Post workshop, the participants expressed stronger disagreement with both male and female genital cutting. Although the workshop aimed only to clarify what is currently illegal in the UK, the participants had ample opportunities to interact and share their views so that a shift in attitude is not unusual.

The only area of knowledge where the scores actually deteriorated, albeit the difference was not statistically significant, relates to a level of confusion around legal (e.g. labia reduction surgery on pre-pubescent girls) versus illegal ('non-therapeutic' female genital cutting by medical practitioners on consenting adult women) practices on females.

While more participants became able to identify illegal practices after the workshop, they also identified more legal practices as illegal. This observation may be spurious, or it may reflect the current conflicted legal positions that could befuddle care providers and users.

Strengths and Limitations

A strength of the intervention was the welcoming and non-judgemental small group environment that enabled participants to voice openly their thoughts and feelings about FGM. The sensitive and encouraging approach was intended to mirror the therapeutic openness needed for clinicians to in turn work compassionately yet confidently with affected communities [Simpson, Robinson, Creighton, Hodes 2012]. The conference feedback suggested a high level of consumer satisfaction with the event. Indeed the positive feedback had since then led to an all-day study day on FGM hosted by the same organisation.

A weakness of the study is that the participants who had opted for the workshop may not be representative of the professional group. It could be said that the effects were due to their receptivity. However, the annual conference was not specific to FGM, so that attendees had not chosen to go to an FGM event as such. Furthermore, the workshop was repeated four times so that participants did not have to forego other conference events in favour of attending the workshop.

A further weakness is that in order to minimise performance anxiety and peer scrutiny, the pre- and post- questionnaires were anonymised and could not be matched. This could have reduced the power to detect significant effects.

We need more care providers to take an interest in FGM and it would have been helpful to find out if the training managed to increase professional commitment and confidence, which could be assessed by adding items to the questionnaire in future.

Interpretation

There have been calls from many quarters to raise awareness of a topic of national concern (and arguably neglect despite powerful rhetoric) [Creighton and Liao 2012].

Professional training to raise awareness and improve skills is inevitably complex but, in today's economic climate, it would have to be realistic in terms of resources. Our study with an opportunistic sample of psychosexual practitioners suggests that there is a wish to learn and that a 90-minute session within a professional conference is a viable and acceptable option leading to an improvement in knowledge.

An earlier survey [Leye, De Bruyn, Meuwese 1998] of European health professionals suggested a greater level of FGM awareness among UK workers compared to the current study. For example, 54% were aware of specific law concerning FGM. This might have been due to a higher level of practice exposure (68%), or perhaps the low response rate of 15% reflecting a selection bias. A number of therapists in the current study showed an initial awareness, even though only 12% reported having worked with any clients affected by FGM. This could be due to recent increases in exposure through the mass media. The popularity of this brief training exercise could be suggestive of a professional acknowledgement among UK practitioners of the importance of FGM awareness.

Future development of professional education in FGM may need to focus more on the distinction between FGM and FGCS (female genital cosmetic surgery). Currently two legal statures are running side by side on female genital cutting, separated thinly by rhetoric. Care providers may feel challenged by FGM-affected care users on what is often considered a double standard [Wade 2013]. FGM practising communities may question why their cultural practice is prohibited while FGCS procedures such as labiaplasty and hymenoplasty are permitted [Leye, Powell, Nienhuis, Claeys 2006]. The adoption of a compassionate and professional stance in the face of dilemmatic and conflicted views is at the heart of clinical consultation and the interactive nature of the workshop is aptly suited for exploring the conundrum.

CONCLUSION

There is increasing interest in developing professional education in FGM in the UK. The intervention being developed is a 90-minute interactive workshop. Currently in its pilot phase, the intervention is psychologically informed, taking into account potential emotional reactions that could interfere with learning unless they could be incorporated. The current

report is based on an initial evaluation with an opportunistic sample of psychosexual practitioners. Our findings suggest that a proportion of these care providers had worked with clients affected by FGM, had wanted more information on the topic, but until the workshop had had limited exposure to professional education. Our initial evaluation suggests that first of all, the brief group intervention is acceptable to learners and secondly, it could lead to improved knowledge and potentially to changes in attitude.

The ultimate test of any such training would be to investigate more precisely the relationships between knowledge, skills, confidence and motivation, and to test whether such a combination of attributes would translate to clinical effectiveness and patient experience. This level of evaluation however is much more complex and requires substantial investment and several steps further down the line.

The next step is to refine the current intervention and learn from further piloting with a larger number of health professionals from a wider range of disciplines. Professional conferences could be a suitable avenue for further piloting. The evaluation questionnaire should be expanded to include an assessment on motivation and commitment to work in FGM. More detailed planning and closer liaison with conference organisers would enable us to find out more about how representative the participants are of their professional groups.

Disclosure Statement

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Contribution to Authorship

Charmaine Elliott – Substantial contribution to conception and design, data collection, analysis and interpretation, drafting and revising for important intellectual content, final approval of version to be published. Sarah M Creighton – Substantial contribution to design, drafting and revising for important intellectual content, final approval of version to be published. Meg Barker – Substantial contribution to conception and design, final approval of version to be published. Lih-Mei Liao – Substantial contribution to conception and design, supervision of data collection and analysis, overall interpretation of data, drafting and revising for important intellectual content, final approval of version to be published.

Ethics Approval

The study was approved as a research project by University College London Clinical, Educational, and Health Psychology Research Department Ethics Committee (CEHP/2012/017).

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Appendix A

A SURVEY ON HEALTH PROFESSIONALS' PERCEPTIONS OF
'FEMALE GENITAL MUTILATION' (FGM)

Thank you for completing this ANONYMOUS SURVEY. It is designed to explore what you know about female genital mutilation before the workshop. Your answers will help us address information gaps during the workshops at this conference and at future training and education events.

A. Quiz about FGM

Treat this as a quiz rather than a test. If you don't know the answer just tick *Don't know*. Otherwise have a go and pick an answer.

A1. What do you understand by the term 'female genital mutilation'?

A2. Different terms are used to refer to the same practice, which – if any – of the following makes the most sense to you? (Please tick one box only)

- | | |
|----------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Female genital mutilation (FGM) | <input type="checkbox"/> Female genital cutting (FGC) |
| <input type="checkbox"/> Female circumcision | <input type="checkbox"/> Depends on the type / severity |
| <input type="checkbox"/> No preference | <input type="checkbox"/> Undecided / unsure |

A3. According to the only available estimate, how many women living in the UK are estimated to have undergone FGM? (Please tick one box only)

- | | | |
|------------------------------------------|-------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> 0 – 20,000 | <input type="checkbox"/> 20,001 – 40,000 | <input type="checkbox"/> 40,001 - 60,000 |
| <input type="checkbox"/> 60,001 - 80,000 | <input type="checkbox"/> 80,001 - 100,000 | <input type="checkbox"/> More than 100,000 |
| <input type="checkbox"/> Don't know | | |

A4. FGM is currently divided into: (Please tick one box only)

- 1-2 types 3-4 types 5-6 types Don't know

A5. FGM has been illegal in the UK since: (Please tick one box only)

- 1898 1921 1951 1985 2008 Don't know

A6. Which of these communities are known to practise FGM currently? (Please tick all boxes that apply)

- | | | | |
|--------------------------------------|--------------------------------------|----------------------------------------|------------------------------------|
| <input type="checkbox"/> Bangladeshi | <input type="checkbox"/> Egyptian | <input type="checkbox"/> Eritrean | <input type="checkbox"/> Ethiopian |
| <input type="checkbox"/> Ghanaian | <input type="checkbox"/> Ivory Coast | <input type="checkbox"/> Iraqi Kurdish | <input type="checkbox"/> Kenyan |

- | | | | |
|-----------------------------------|---------------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Liberian | <input type="checkbox"/> Libya | <input type="checkbox"/> Mauritian | <input type="checkbox"/> Nigerian |
| <input type="checkbox"/> Somali | <input type="checkbox"/> Sudanese | <input type="checkbox"/> Tanzanian | <input type="checkbox"/> Turkish |
| <input type="checkbox"/> Ugandan | <input type="checkbox"/> South Africa | <input type="checkbox"/> Zimbabwean | <input type="checkbox"/> Don't know |

A7. Which – if any – of the following reasons for FGM has been identified in the literatures: (Please tick all boxes that apply)

- | | | | |
|---------------------------------------------------------|----------------------------------------|-----------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Custom/tradition | <input type="checkbox"/> Religion | <input type="checkbox"/> Social acceptance | <input type="checkbox"/> Family honour |
| <input type="checkbox"/> Sexual pleasure for the couple | | <input type="checkbox"/> Aesthetics / hygiene | |
| <input type="checkbox"/> Fidelity | <input type="checkbox"/> Aid fertility | <input type="checkbox"/> Other (specify) | |
| <input type="checkbox"/> Don't know | | | |

A8. Which of the following are known to be associated with FGM? (Please tick all boxes that apply)

- | | | |
|----------------------------------------------------|----------------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Painful intercourse | <input type="checkbox"/> Infertility | <input type="checkbox"/> Painful periods |
| <input type="checkbox"/> Benign ovarian cysts | <input type="checkbox"/> Faecal Incontinence | <input type="checkbox"/> Delay in labour |
| <input type="checkbox"/> Premature labour | <input type="checkbox"/> Painful orgasm | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Traumatic stress symptoms | <input type="checkbox"/> Increased risk of HIV infection | |
| <input type="checkbox"/> Don't know | | |

A9. Which of the following are currently illegal in the UK? (Please tick all boxes that apply)

- A medical doctor performing a pin prick symbolic circumcision on a girl under 16 yrs with the girl's and the parents' consent
- A medical doctor performing a pinprick symbolic circumcision on a consenting adult woman
- A midwife de-infibulating a consenting adult woman during labour (i.e., opening the vagina entrance which has been closed)
- A medical doctor re-infibulating a consenting adult woman after childbirth (i.e., closing the vagina entrance again at her request)
- A medical doctor re-infibulating a consenting adult woman after childbirth (i.e., closing the vagina entrance again at her request)
- A medical doctor reducing the size of the inner labia and clitoris on a girl under 16 years old for aesthetic reasons with parental consent
- A medical doctor reducing the size of the inner labia and clitoris on a consenting adult woman for aesthetic reasons
- A medical doctor narrowing the vagina entrance of a consenting adult woman for aesthetic reasons

- A medical doctor narrowing the vagina entrance of a consenting woman aged 16 or older following childbirth
- Genital piercing on a girl under 16 years old with written parental consent or in the presence of a parent or guardian
- Don't know

Section B: Your personal views on female genital mutilation

With the UK in mind, please indicate your dis/agreement with each of the following statements by circling a point on the scale. Feel free to note down additional thoughts on the margins.

B1. With informed consent from parents and daughter, mild circumcision (e.g. a symbolic pin prick) by a doctor on girls (under 16) should be allowed.

1	2	3	4	5	6	7

Strongly agree

Strongly disagree

B2. Mild circumcision (e.g., a symbolic pin prick) on consenting adult women by a doctor should be allowed.

1	2	3	4	5	6	7

Strongly agree

Strongly disagree

B3. After childbirth, re-infibulation (re-closing of the vagina entrance) by a doctor on a consenting adult woman who had been infibulated (closed) before the birth should be allowed.

1	2	3	4	5	6	7

Strongly agree

Strongly disagree

B4. With informed consent from the parents and daughter, cosmetic surgery on girls (under 16) to change the external genital appearance should be allowed.

1	2	3	4	5	6	7

Strongly agree

Strongly disagree

B5. Cosmetic surgery on consenting adult women to change the external genital appearance should be allowed.

|_____| |_____| |_____| |_____| |_____| |_____| |_____|
1 2 3 4 5 6 7

Strongly agree

Strongly disagree

B6. Male circumcision on boys (under 16) should be allowed.

|_____| |_____| |_____| |_____| |_____| |_____| |_____|
1 2 3 4 5 6 7

Strongly agree

Strongly disagree

B7. Male circumcision on consenting adult men should be allowed.

|_____| |_____| |_____| |_____| |_____| |_____| |_____|
1 2 3 4 5 6 7

Strongly agree

Strongly disagree

B8. With informed consent from parents and son, cosmetic surgery on boys (under 16) to change the genital appearance should be allowed.

|_____| |_____| |_____| |_____| |_____| |_____| |_____|
1 2 3 4 5 6 7

Strongly agree

Strongly disagree

B9. Cosmetic surgery on consenting adult men to change the genital appearance should be allowed.

|_____| |_____| |_____| |_____| |_____| |_____| |_____|
1 2 3 4 5 6 7

Strongly agree

Strongly disagree

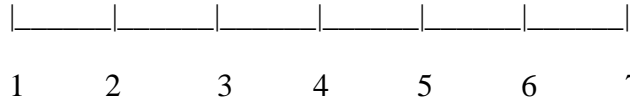
B10. All forms of genital cutting should NOT be allowed (e.g. illegal).

|_____| |_____| |_____| |_____| |_____| |_____| |_____|
1 2 3 4 5 6 7

Strongly agree

Strongly disagree

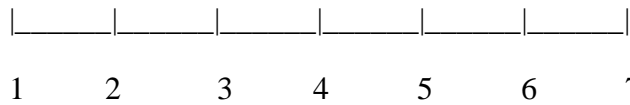
B11. Parents who allow their daughter (under 16) to be circumcised in any way or form should be prosecuted.



Strongly agree

Strongly disagree

B12. Parents who allow their daughter or son (under 16) to have cosmetic genital surgery should be prosecuted.



Strongly agree

Strongly disagree